Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 14 May 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 9 April 2019	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Board Visit Report – Donnington and Highclere Wards	Ruth Lysons, Non-Executive Director	Enc.
6.1	Patient Experience Quarter 4 Report	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
6.2	BHFT Quality Account 2018-19	Dr Minoo Irani, Medical Director	Enc.
6.3	Six Monthly Safe Staffing Report	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	Staff Survey Results 2018 Report	Bev Searle, Director of Strategy and Corporate Affairs/Carol Carpenter, Director of People	Enc.
	PERFORMANCE		
8.1	Month 12 2018/19 Finance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Month 12 2018/19 Performance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.3	Finance, Investment & Performance Committee meeting on 24 April 2019* *The Month 12 Finance and Performance Reports were reviewed by the FIP Committee*	Naomi Coxwell, Chair of the Finance, Investment & Performance Committee	Verbal

STRATEGY			
9.0	Strategy Implementation Plan 2018-19 Update Report	Bev Searle, Director of Strategy and Corporate Affairs	Enc.
9.1	Mental Health Strategy Update Report	Bev Searle, Director of Strategy and Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.0	Annual Report 2018-19**	Julian Emms, Chief Executive	Enc.
10.1	NHS Improvement Board Declarations	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
10.2	Audit Committee a) Minutes of the Meeting held on 24 April 2019 b) Reservation of Powers to the Board and Delegation of Powers – Trust Board to ratify changes to the Document c) Trust Board to consider delegating approval of the Annual Accounts 2018-19 to the Audit Committee	Chris Fisher, Chair of the Audit Committee	Enc.
10.3	Council of Governors Update	Martin Earwicker, Trust Chair	Enc.
10.4	Use of the Trust Seal	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 9 July 2019	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

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

Berkshire Healthcare
NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 09 April 2019

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Julian Emms	Chief Executive
	Chris Fisher	Non-Executive Director
	Alex Gild	Deputy Chief Executive and 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 Strategy and Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Carol Carpenter	Director of People (*present for item 7.1)*

19/042	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting including the observers: Linda Berry, Public Governor and Tom Wedd, Public Governor.
19/043	**Apologies** (agenda item 2)
	There were no apologies.
19/044	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.
19/045	**Declarations of Interest** (agenda item 4)

	i. Amendments to Register – none
	ii. **Agenda Items** – none
19/046	**Minutes of the previous meeting – 12 February 2019** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 12 February 2019 were approved as a correct record of the meeting.
19/047	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. Ruth Lysons, Non-Executive Director reminded the meeting that the Annual Mental Health Survey discussed at the last meeting had highlighted that a number of respondents did not know who to contact if they had a concern about their care. Ms Lysons referred to the minutes of the last meeting (page 7 of the agenda pack) and asked whether finding more effective means of communication in relation to the Trust's safety planning work needed to be added to the action log. The Acting Director of Nursing and Governance said that this did not need to be added to the action log as it was part of the Trust's Zero Suicide work around improving the safety planning process which included ensuring that patients knew who to contact when they needed support. **The Trust Board**: noted the schedule of actions.
19/048	**Board Visit Report – West Berkshire Community Nursing Team** (agenda item 6.0)
	Mark Day, Non-Executive Director presented the paper and said that his visit to the West Berkshire Community Nursing Team had been very positive. Mr Day thanked Mandy Hennessy, Integrated Community Services Manager (West) and her team for their professionalism and openness. Mr Day said that he was invited to attend the management team meeting which met weekly to review joint working across their activities and areas of operation. Mr Day said that he was particularly impressed how the team supported each other. It was noted that the service had undergone a major change programme which included cross-skilling of staff to enable them to undertake a wider range of work when meeting with patients. Mr Day reported that he had also accompanied Helen Daw, Team Leader on two Community Nursing patient visits. Mr Day said that one of the visits was in an urban setting and highlighted how technology was making a real difference to the Community Nursing role. This was in marked contrast to the second visit which was in a rural area which had poor mobile connectivity making access to the RiO (electronic patient record system) and other online systems difficult. Mr Day reported that the team had also raised frustrations about an NHS England Discharge Letter which was designed for use in a hospital setting and about the need for a dependency tool which could be used for more effective rostering and scheduling of work across the teams.

	In conclusion, Mr Day said that he was impressed by the professionalism of the team and how this group of independent workers supported one another which in turn had a positive impact on the health and wellbeing of the individual staff members. The Deputy Chief Executive and Chief Financial Officers reported that since the visit in January 2019, there had been significant progress made to improve mobile technology. It was noted that from May 2019, Community Nurses would be given iPads which did not require smart card access. It was noted that the Trust had also developed an offline App when there was no mobile coverage. Chris Fisher, Non-Executive Director asked whether there were any security concerns if staff no longer needed to access the RiO system via smartcards. The Deputy Chief Executive and Chief Financial Officer confirmed that the Trust would be using national software to access the RiO system which met stringent security requirements. The Acting Director of Nursing and Governance confirmed that the Trust had not introduced NHS England's Discharge Letter for Community Nursing because the current discharge letter included all the information NHS England required. The Acting Director of Nursing and Governance also reported that the dependency tool was being developed nationally. The Acting Director of Nursing and Governance agreed to contact the team and clarify the position in relation to the discharge letter and the dependency tool. **Action: Acting Director of Nursing and Governance** Mark Day, Non-Executive Director welcomed the update on the improvements to mobile technology and suggested that the Berkshire West Community Nursing Team be informed about the new developments. **Action: Acting Director of Nursing and Governance** On behalf of the Trust Board, the Chair thanked Mark Day, Non-Executive Director for his Board Visit report.
19/049	**Quality Assurance Committee** (agenda item 6.1)
	a) Minutes of the February 2019 Quality Assurance Committee Ruth Lysons, Chair of the Quality Assurance Committee reported that the meeting on 19 February 2019 had discussed the following key issues: • **Quality Concerns** – there were no new concerns; • **Electronic Prescribing and Medicines Administration (ePMA) presentation** by the Lead Clinical Director. The presentation had highlighted the key patient safety benefits in terms of reducing medication errors. The Committee had also discussed the Trust's increasing dependency around access to online systems and the associated cyber security risks; • **New Mental Health Pathways presentation**; the Committee had warmly welcomed the development of the new pathways; • **Review of Themes from Board Visits** – this was the first time that the Committee had received an overview of the key themes from Board Visits. It was clear from the discussion that there was a variety of approaches to Board Visits with some Non-Executive Directors submitting written reports of their visits and others preferring to

raise issues verbally at the relevant meetings. In addition, Executive Directors were undertaking a significant number of visits to frontline staff as part of the Quality Improvement Programme. The Committee had suggested that there should be a discussion about how the Board gained "Floor to Board" assurance.

- **CAMHS Waiting Times** – the Committee had discussed the increasing demand for CAMHS services, in particular, waiting times for Autistic Spectrum Disorder diagnosis.
- **Quality Accounts 2018-19** - the Committee had discussed the third quarter Quality Accounts Report which was almost the final version. The draft report had been circulated to the Governors and Stakeholders for their comments. The final version of the report would be submitted for approval to the May 2019 Public Trust Board meeting.

Ms Lysons reported that the Committee had also discussed the development of the new Carers Strategy and had asked the Executive Team members to consider whether there needed to be a full Board discussion or whether this should be discussed at the Quality Assurance Group meeting.

The Company Secretary reported that at the request of the Governors, there would be a presentation on the Trust's work with Carers at the July 2019 Joint Non-Executive Directors and Council of Governors meeting.

David Buckle, Non-Executive Director reported that he was pleased that the Trust had implemented the e-PMA system which would reduce the likelihood of medication errors. Dr Buckle said that his key concern was around the risk of cyber security and connectivity issues.

The Deputy Chief Executive and Chief Financial Officer said that the Audit Committee had discussed the Trust's business continuity planning process which included IT and confirmed that there were specific arrangements in place in relation if the e-PMA system was not functioning which would enable Clinicians to access and print off patients' medication information.

Naomi Coxwell, Non-Executive Director said that she was pleased that the Quality Assurance Committee was reviewing CAMHS waiting times.

The Chief Operating Officer said that the Commissioners had provided additional investment in the CAMHS service a couple of years ago, but the reduction in local authority and the voluntary sector budgets had reduced services for children which in turn had increased demand for the Trust's children's services.

The Chief Operating Officer pointed out that the longest waits were for autistic spectrum disorder diagnosis and because a diagnosis enabled schools to access additional special educational needs funding. It was noted that the Trust ensured that those on the waiting list did not have any other conditions which needed to be addressed to ensure patient safety was maintained whilst on the waiting list.

The Chief Executive said that Children's Services provided by local authorities were fragmented across Berkshire which added to the complexity.

The Chair asked whether there was scope to offer more online assessments.

The Chief Executive said that parents wanted their children to have a face to face consultations rather than an online assessment.

Chris Fisher, Non-Executive Director pointed out that those parents who could afford to, were able to have assessments done privately and therefore there were health inequality issues with less well-off parents having to wait for their children to be assessed.

The Chief Executive said that CAMHS waiting times was one of the Trust's quality concerns but stressed that this was because of the negative impact on patient experience and was not a patient safety concern.

b) Learning from Deaths Quarterly Report

The Chair suggested that where there had been a lapse in care that this was highlighted in the body of the report and not just on the cover sheet.

Action: Medical Director

David Buckle, Non-Executive Director referred to the section on the National Learning Disability Mortality Review (LeDeR) notifications (page 47 of the agenda pack) and asked whether the Trust received any feedback from the LeDeR process.

The Medical Director said that the LeDeR process did not provide case by case feedback but produced a national report with the key themes. It was noted that the Trust conducted its own full structured judgment review of any deaths involving patients with learning disabilities.

Dr Buckle referred to page 47 of the agenda pack and commented that it was concerning that 13 deaths related to patients who were transferred from a community inpatient ward to an acute hospital following a deterioration in their health and died within 7 days of that transfer and asked whether it would be better for patients who were at end of life not to be transferred to an acute hospital.

The Acting Director of Nursing and Governance said that in some cases transferring to an acute hospital was what the patient and/or their families wanted even though they were aware that the patient was at end of life.

Mehmuda Mian, Non-Executive Director referred to page 49 of the agenda pack and noted that the Crisis Resolution Home Treatment Team had adopted a model of 360 learning from the Serious Incident Requiring Investigation process into their routine practice and asked whether this could be applied to other teams.

The Acting Director of Nursing and Governance confirmed that other teams were already using the 360 learning methodology.

The Chief Executive said that the Executive Report later on the agenda included NHS Providers' briefing on the outcome of the Kark Review into the Fit and Proper Persons Test and pointed out that the Francis Report into failings of care at Midstaffordshire NHS Foundation Trust was that the Board took no action to understand the underlying causes of their high mortality rate compared with similar acute hospitals.

David Buckle, Non-Executive Director paid tribute to the Medical Director for developing and implementing a robust mortality review process and said that the quarterly reports were informative and provided assurance to the Board that any learning from deaths was identified and disseminated.

The Chief Executive reported that the Care Quality Commission had recently published the outcome of their review of the first year of NHS provider organisations implementing the

	national learning from deaths guidance and had included the Trust as an exemplar of good practice. The Chief Executive said that a summary of the report would be presented to the May 2019 Quality Assurance Committee meeting. **Action: Medical Director/Company Secretary** **c) Guardians of Safe Working Report** The Medical Director presented the paper and reported that during the reporting period (1 November 2018-5 February 2019) there was one exception report totaling an extra 1.5 hours worked over and above the trainee's work schedule. 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. **The Trust Board:** noted the report.
19/050	**Quality Impact Assessment Annual Report** (agenda item 6.2)
	The Acting Director of Nursing and Governance presented the paper and reported that the Cost Improvement Programme 2018-19 had initially identified three clinical areas for inclusion: • Out of Area Placements; • WestCall Out of Hours GP services; and • Crisis Resolution Home Treatment Team. The Acting Director of Nursing and Governance said that a Quality Impact Assessment was completed for the Out of Area Placements Programme in May 2018 and did not identify or anticipate any risks to quality or safety. A further Quality Impact Assessment would be undertaken once the work programme for the continued Out of Area Placement reduction had been formally approved by the relevant Executive Committee. For the other two clinical Cost Improvement Programme schemes, tender model processes were completed to ascertain realistic assumptions of any savings and no savings were released for the 2018-19 financial year, although some small changes to workforce and skill-mix had been made. It was noted that the Medical Director and the Acting Director of Nursing and Governance had met with WestCall and the Crisis Resolution Home Treatment Team Service Leads and responsible Clinical Directors during February 2019 to review the quality impact of the changes made of 2018-19 and potential plans made to achieve any Cost Improvement Programme savings in 2019-20. The Acting Director of Nursing and Governance confirmed that based upon the discussions with Operational Directors, Service Leads and Clinical Directors and available data, the Medical Director and herself were satisfied that the changes made to the workforce and skill-mix within these services had not had a detrimental impact on service provision. Where changes were made to workforce and skill-mix over 2019-20, Quality Impact Assessments would be required. David Buckle, Non-Executive Director asked whether the Medical Director and Acting Director of Nursing and Governance had worked together when reviewing the Quality Impact Assessments. The Acting Director of Nursing and Governance confirmed that this was the case.

	Ruth Lysons, Non-Executive Director asked about the timing of the Quality Impact Assessments. The Medical Director confirmed that the Quality Impact Assessments were prospective in respect of any significant Cost Improvement Programme scheme and that the quality impacts would also be reviewed after the schemes had been implemented. Ruth Lysons. Non-Executive Director pointed out that the Quality Impact Assessment process was in place for clinical schemes and asked whether there was a process in place to review any quality impacts in relation to non-clinical Cost Improvement Programme schemes. The Medical Director said that the Quality Improvement Programme also included a Quality Impact Assessment process. The Deputy Chief Executive and Chief Financial Officer said that to date there had not been any significant non-clinical Cost Improvement Programme schemes. The Director of Strategy and Corporate Affairs pointed out that the Trust Business Group had oversight of the Cost Improvement Programme. The Lead Clinical Director was a member of the Group. **The Trust Board:** noted the report.
19/051	**Executive Report (**agenda item 7.0)
	The Executive Report had been circulated. The following issues were discussed further: **a) Reliance on Overseas Doctors** Chris Fisher, Non-Executive Director commented that it was concerning that the United Kingdom was so reliant on recruiting overseas doctors. The Chief Executive paid tribute to the work of the Medical Director in recruiting Doctors which meant that the Trust was not experiencing the same shortages of Doctors as many other Trusts. **b) Workforce Report** The Chief Executive urged members of the Board to read the Health Foundation's NHS Workforce Report entitled Closing the Gap which highlighted the extent of the NHS Workforce challenge. The Chief Executive said that the Finance, Investment and Performance Committee were overseeing the Trust's retention work which was a key area of focus for the Trust. **The Trust Board:** noted the report.
19/052	**Gender Pay Gap Report** (agenda item 7.1)
	The Chair welcomed the Director of People to the meeting.

	The Director of People presented the paper and reported that it was a mandatory requirement to report the gender pay gap each year. It was noted that the Trust's pay gap remained at 20% (the same as for the previous year). The Director of People highlighted the following points: • The gender split for the Trust's workforce was: 82% women and 18% men. However, the proportion of women in the lowest quartile of the pay bands was higher than 82% and lower than 82% in the highest quartile; • The proportion of the female workforce which worked part time and used the salary sacrifice scheme was higher than 82%; • The number of male medical consultants applying and receiving clinical excellence awards was disproportionate and an independent report commissioned by the Trust had made recommendations as to what the Trust can do to improve the situation. • The Trust was currently analysing the workforce pay data to gain a deeper understanding about the gender pay gap. The Director of People said that it was important that the Trust did not take steps to improve the gender pay gap if this meant changes to other policies which benefited staff, for example, the salary sacrifice scheme and part time working. The Medical Director reported that the Trust employed around 50-60 consultants who were eligible to apply for a Clinical Excellence Award. The Trust had accepted in full the recommendations from the independent review which was commissioned to understand the reasons why women did not apply for Clinical Excellence Awards. This included encouraging female consultants to join the Clinical Excellence awarding panel and the Medical Director and Chief Executive encouraging female consultants to apply for Clinical Excellence Awards. **The Trust Board:** noted the report.
19/053	**Month 11 2018-19 Finance Report** (agenda item 8.0)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • The Finance, Investment and Performance Committee had received the month 11 Finance Report in detail; • At the end of the financial year end, the Trust had £25m of cash; • NHS Property Services had now paid the outstanding £5m debt The Chair asked as a minimum, how much cash the Trust needed. The Deputy Chief Executive and Chief Financial Officer said that taken in the round, the Trust needed around £15m of cash. The Chief Executive pointed out that it was difficult to give an exact answer because one of the key reasons why the Trust wanted to maintain a healthy cash balance was to fund its capital programme. However, some capital expenditure was externally funded whilst other schemes needed to be funded internally.

	The Deputy Chief Executive and Chief Financial Officer said that the Trust needed to develop a strategic capital investment plan.
	Action: Deputy Chief Executive and Chief Financial Officer
	
	The Trust Board noted: the following financial summary of the financial performance and results for Month 11 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: £2.2m surplus
	• Actual: £3.6m surplus
	• Variance: £1.4m better than plan
	
	Year to Date Cash: £21.5m (Plan £22.8m)
	Year to Date Capital Expenditure: £8.6m versus plan of £9.8m.

19/054	**Financial Plan 2019-20 Report** (agenda item 8.1)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • The Financial Plan 2019-20 had been reviewed by the Finance, Investment and Performance Committee prior to its submission to NHS Improvement on 4 April 2019; • The plan had been built to deliver the Trust's £1.8m Improvement Control Total; • During the planning process, the Trust had agreed a fair contract with Commissioners; • The Trust was able to set a plan which required the delivery of a realistic £4m Cost Improvement Programme in line with NHS Improvement's efficiency expectations for 2019-20; • The Mental Health Investment Standard had also been confirmed with key service investments supporting continued progress towards national commitments; • The Trust's cash forecast remained strong with a closing balance expected to be £21.2m after in year capital investment of £12.4m The Deputy Chief Executive and Chief Financial Officer referred to page 104 of the agenda pack and reported that the Trust had decided to spread the cost of the Agenda for Change pay award which included a non-consolidated one-off bonus payment to staff at the top of their pay bands across two quarters. This would mean that the Trust's "Use of Resources" rating for would be at "2" for two quarters. The Deputy Chief Executive and Chief Financial Officer highlighted that the key risks to the delivery of the financial plan 2019-20 were out of area placements, delivery of the cost improvement programme and containing the underlying pay bill at current levels, excluding new service investments and inflation.

	The Trust Board: a) Approved the Financial Plan 2019-20; and b) Approved the Control Total of £1.8m
19/055	**Month 11 2018-19 Performance Report** (agenda item 8.2)
	The Month 11 2018-19 Performance Summary Scorecard and detailed Trust Performance Report had been circulated. The Deputy Chief Executive and Chief Financial Officer presented the paper and reported that the Finance, Investment and Performance Committee had reviewed it in detail at their last meeting. It was noted that Service and Efficiency was RAG rated "red" and People was RAG rated "amber" in February 2019. **The Trust Board**: noted the report.
19/056	**Board Vision Metrics Report** (agenda item 8.3)
	The Chair suggested that the format of the Board Vision Metrics Report be discussed as part of the Trust Board's Strategic Planning Away Day in October 2019. **Action: Deputy Chief Executive and Chief Financial Officer/Company Secretary** Chris Fisher, Non-Executive Director said that it would be helpful to set some short-term targets to better gauge the extent of any progress. **Action: Deputy Chief Executive and Chief Financial Officer** The Deputy Chief Executive and Chief Financial Officer said that he was also planning to incorporate some of the quality improvement programme breakthrough objectives as part of the Board Vision Metrics Report. **Action: Deputy Chief Executive and Chief Financial Officer** The Acting Director of Nursing and Governance referred to the Friends and Family Test performance (page 142 of the agenda pack) and reported that the Trust was the "star trust" for both Community and Mental Health nationally in January 2019 in respect of its response rate (Community Health response rate: 21% and Mental Health response rate: 15%). The Acting Director of Nursing and Governance said that this demonstrated the Trust's continued significant improvement in the response rate. The Chair said that it was disappointing that the Trust's performance in respect of reducing the use of prone restraint had dipped. The Chief Executive pointed out that the data related to the previous year and that improvements had been made over the course of the year. **The Trust Board**: noted the report.

19/057	**Finance, Investment and Performance Committee (February 2019 and March 2019) Meetings** (agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee congratulated the Deputy Chief Executive and Chief Financial Officer and his team for delivering the 2018-19 Financial Plan and for developing a robust Financial Plan for the coming year which included an ambitious capital programme. The Chair thanked Ms Coxwell for her update.
19/058	**Council of Governors Update** (agenda item 9)
	The Chair reported that the Regional Director (West) had attended the last Council of Governors meeting and had given an informative presentation on the Community Mental Health Team service. The Chair reported that the Company Secretary had invited the Governors to complete a self-assessment survey about the effectiveness of the Council of Governors. The Chair also reported that elections were taking place for a number of public governor seats. **The Trust Board:** noted the update.
19/059	**Any Other Business** (agenda item 10)
	There was no other business.
19/060	**Date of Next Meeting** (agenda item 11)
	Tuesday, 14 May 2019
19/061	**CONFIDENTIAL ISSUES:** (agenda item 12)
	The Board resolved to exclude press and public from the remainder of the meeting on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 09 April 2019.

Signed……. Date 14 May 2019
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 14/05/2019

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 Strategy and Corporate Affairs to include a section on gender pay equality when the Equality Strategy was refreshed.	TBC	**BS**		
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 taken to address the issues.	09.07.19	**DF**	This will be included in the Annual Complaints Report reported to the Trust Board in July 2019.	
12.02.19	19/015	Equality, Diversity and	Future reports to include information	09.07.19	**BS**	The next update is	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		Inclusion Strategy Update Report	about BAME staff in senior clinical roles.			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	19/021	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.	
09.04.19	19/048	Board Visit Report – West Berkshire Community Nursing Team	The West Berkshire Community Nursing Team to be informed that the Trust was not changing the Discharge Letter because the current version included the information required by NHS England. The Team also to be informed that a dependency tool was being developed nationally.	14.05.19	**DF**	Completed	
09.04.19	19/048	Board Visit Report –	The West Berkshire Community	14.05.19	**DF**	Completed	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		West Berkshire Community Nursing Team	Nursing Team to be informed about the IT developments in relation to mobile working.				
09.04.19	19/049	Quality Assurance Committee – Learning from Deaths	The main report to highlight where there had been a lapse of care in addition to this referred to in the cover sheet.	09.07.19	**MI**		
09.04.19	19/049	Quality Assurance Committee – Learning from Deaths	The Care Quality Commission's report on the outcome of their review of the first year of NHS provider organisations implementing the national learning from deaths guidance to be submitted to the Quality Assurance Committee.	21.05.19	**MI/JH**	On the agenda of the May 2019 meeting of the Quality Assurance Committee.	
09.04.19	19/053	Month 11 Finance Report	A strategic capital investment plan to be developed.	TBC	**AG**		
09.04.19	19/056	Board Vision Metrics Report	The format of the Board Vision Metrics Report to be discussed as part of the Board's Annual Strategic Planning Away Day in October 2019.	08.10.19	**AG/JH**		
09.04.19	19/056	Board Vision Metrics Report	The Board Vision Metrics to include some short term targets in order to gauge the extent of any progress.	09.07.19	**AG**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
09.04.19	19/056	Board Vision Metrics Report	Quality Improvement Breakthrough Objectives to be incorporated into the Board Vision Metrics.	09.07.19	**AG**		

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	**Board Visit Report – Donnington and Highclere Wards**
Purpose	To receive the report of the Board Visit undertaken by Ruth Lysons, 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
NHS Foundation Trust

BHFT BOARD VISIT TO DONNINGTON & HIGHCLERE WARDS, WEST BERKSHIRE COMMUNITY HOSPITAL, THATCHAM : 18 February 2019

People participating:

Ruth Lysons, NED
Ruth Davey, Donnington Ward Matron
Rachel Green, Highclere Ward Matron

Introduction

I was welcomed by Ruth and Rachel. After an initial conversation with them, I was shown around the wards.

The work of Donnington Ward

- **The Clientele.** The team cares for a wide age-range of adult men and women, mainly referrals from the Royal Berkshire Hospital, the Great Western Hospital (Swindon) and some GP referrals. Some patients have neurological diagnoses, whilst others are recovering from physical injuries (such as fractures) or illness. There is usually a proportion of patients with dementia. There are also 4 Rainbow Trust rooms (2 on each ward), which offer a quiet facility for relatives to stay with a loved one who is close to the end of their life.
- **The Service.** The team seeks to rehabilitate patients, and to liaise with carers and Social services in order to ensure an appropriate care package is in place for them when they are discharged. There is a therapeutic and sensory garden, which patients are encouraged to use and to participate in activities such as picking fruit or potting plants. The dining room in Donnington Ward is arranged to encourage social interaction between patients, with tables set out for small groups. There is also a large space for activities, which has books and craft items, but which was unoccupied when I visited. There is currently no dedicated dining room on Highclere ward, but with the new extension to the Hospital building, the large Charles Clore Room, within the ward – which until recently was used as a day room for patients with cancer- has now been made available for use by Highclere ward. Rachel has plans to convert this to a patient dining room, equivalent to the one on Donnington Ward.
- **Creation of a Single Unit.** Donnington and Highclere wards are located immediately adjacent to each other and both provide 24/7 in-patient care. In order to maximise efficiency and flexibility of deployment of staff, a programme of staff rotation and training was undertaken with a view to creating a single 'cultural' unit. When I made

my first Board visit to the wards in May 2015, this work was in its early stages, so it was very pleasing to see on this visit, that this ambition has now been fully delivered. Well done!

Observations and Discussion points

- **Recruitment difficulties.** Ruth and Rachel told me that the biggest challenge they faced was in recruitment of qualified nurses, and that they are currently working with a 50% vacancy rate (including 7 Band 5 s). They have found it easier to recruit Health Care Assistants and have been proactive in enabling some of these to upskill, by becoming *'Assistant Practitioners'* or '*Nursing Associates'*. The employment of 2 '*Care co-ordinators'* who undertake the routine administrative tasks -which nurses otherwise would need to do- in relation to patient admissions and discharges, has also been successful.
- We discussed possible reasons for the difficulties in recruitment and retention of Nurses, and the following points emerged:
    - Community nursing has a less exciting "image" than working in acute settings
    - However, the WBCH itself has great facilities, pleasant gardens & the added benefit of free staff parking. Students who undertake placements there are very likely to come and work there. Therefore, recruitment drives which bring candidates onto the site would be most likely to succeed.
    - WBCH posts do not attract London weighting, therefore it will be far more effective to focus recruitment efforts to the west (i.e. Wiltshire).
    - Local child-care facilities open at 8:00 a.m., 30 minutes *after* the Nursing shift starts. It could be worth exploring if there is a business case for BHFT to negotiate slightly earlier opening times, to enable staff to benefit from local childcare.
- **Highclere bed closures.** Ten beds were suspended in September 2018 and have now been permanently closed. Both Ruth and Rachel were very clear that this was the right decision to make in the interests of patient safety, given the staffing shortfall. They are aware of plans to increase the proportion of neurological rehabilitation beds on the ward and use the additional space for physiotherapy. They are keen for the changes to be taken forward with urgency, as they feel the current situation of a half-closed ward, creates a bad public perception.
- **Quality Management Improvement System (QMIS).** Ruth and Rachel were very enthusiastic about the QMIS initiative and it was evident from the notice boards on the wards that the staff are actively engaging with it. The "driver metrics" (risks) that they are focusing on are *Falls* and *Length of Stay.* They have taken a range of evidence-based actions, including the recent installation of 'Guardian'

falls prevention equipment. Falls are the top risk on these wards, & it is clear with the recent bed closures, that a rigorous approach to managing Length of stay is critical to maintain capacity.

- **The 'magic wand' question….** Aside from the topics discussed above, I asked if there were any particular things that Rachel and Ruth would like to see improved. The requests were for
    - an interactive electronic white board on each ward, to provide an easier and more secure way of sharing bed occupancy data between the wards
    - A change to the menu system to allow patients a genuine choice of dishes.

Conclusion

I was most impressed with the 'snap shot' insight which I gained of Donnington and Highclere wards. It was very reassuring to observe the real team work which has developed. My impression was that staff were interacting with patients in a compassionate manner and that the wards appeared clean, uncluttered, and notice boards were up to date. The large unoccupied space in Highclere ward, where beds have been closed, is disconcerting and it would be very desirable to re-purpose this as rapidly as possible.

Overall, I felt that this is a caring, innovative team, working to very high standards. Well done!

Ruth Lysons
4 March 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	Patient Experience Quarter 4 Report
Purpose	The purpose of this report is to provide the Board with information on patient experience within the trust
Business Area	Nursing & Governance
Author	Liz Chapman, Head of Service Engagement and Patient Experience Nathalie Zacharias, Professional Lead for Allied Health Professionals Debbie Fulton, Acting Director of Nursing and Governance
Relevant Strategic Objectives	True North goal of 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	Patient experience has equality and diversity implications and this information is used to consider and address these. Demographic and ethnicity data is now routinely collated for all complaints received.
SUMMARY	Boards are required to review patient feedback in detail. The Acting Director of Nursing and Governance has provided an overview at the beginning of the paper. There are no new themes or trends identified as a result of reviewing the available data. • CMHT, although receiving the highest number of complaints this quarter, saw a reduction in both formal complaints and MP enquires received from previous quarters this year. • CAMHS received the second highest number of complaints and also the most MP enquires and PALS contacts –a significant number of these are about waiting times/contacting service • Acute Mental Health Inpatient services and Westcall both saw a reduction in the number

	of complaints received this quarter when compared with previous quarters this year. **Complaints** During Quarter 4, the Trust received 50 formal complaints and 47 formal complaints were closed (24 of these of these were partly/fully upheld) The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continues to be exceptional performance. **Friends and Family Test (FFT)** During Quarter 4 our Friends and Family response rate continued to improve with 22% (almost 12,000 responses) achieved for the quarter and for the first time over 20% achieved for each of the months in the Quarter **Patient and Public Involvement** 86% of patients rated our services as good or better in the trust's internal patient survey. **Staff survey** Our 2018 staff survey results demonstrate that 61% of our staff believe that feedback from patients/ service users is used to inform decisions within their directorates and departments; whilst this is better than the average within our peer group (mental health, learning disability and community combined trusts) which is 54%, it is below the best scores achieved of 71%.
ACTION	The Board is asked to: Consider the report and reflect on the patient feedback received

Quarter Four – Patient Experience Report (Jan – March 2019)

1. Overview

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

The Board is required to consider detailed patient feedback because it provides insight into how patients, families and carers experience our services. There are many ways in which patient feedback is gathered, this report references over 18,000 pieces of feedback received into the organisation this quarter.

Our 2018 staff survey results demonstrate that 61% of our staff believe that feedback from patients/service users is used to inform decisions within their directorates and departments; whilst this is better than the average within our peer group (mental health, learning disability and community combined trusts) which is 54%, it is below the best scores achieved of 71%. The 2019/20 plan on a page encourages all services to focus on use of available patient feedback information to inform decisions around patient care/ treatment as well as service changes.

During Q4 our Friends and Family response rate continued to improve with 22% (almost 12,000 responses) achieved for the quarter and for the first time over 20% achieved for each of the months in the quarter. A response rate of at least 15% is considered to provide increased validity. The introduction of SMS texting has assisted in achieving greater response rates. Our overall Trust recommendation rate for the quarter was 93%. One of the True North metrics for the coming year is achievement of 95% recommendation rate.

The number of Carers Friends and Family Test responses has reduced slightly from Q3 but remains higher than any of the other quarters in last 2 years; the responses demonstrated a 95% satisfaction rate.

Collection of ethnicity data associated with complaints commenced in Q2 and has risen from 48% in that quarter to 84% this quarter. Gender and age is also being recorded with 100% recording achieved for the quarter.

In Q4, the Trust received 50 complaints across a range of services. The number of complaints received has reduced again this quarter and is lower than any previous quarters of this year. The reporting process has been altered to be service based as opposed to locality based so that trends and themes can be more easily identified.

When considering which services to monitor other quality indicators are also examined:

- Community Mental Health Teams (CMHTs) complaints reduced again this quarter and are at a level seen quarterly during 2017/18; they have also seen a reduction in MP enquiries with only 1 received. Themes from the complaints closed include care and treatment and communication. Work is required to manage patient expectation and the care pathways programme will support staff in this, as for each area of mental health the patient pathway will be detailed.

- Child and Adolescent Community Mental Health Services received 6 complaints; this is a decrease on the 8 received in Q3 and brings the number back more in line with Q1 and Q2 of this year. These services also received the highest number of MP enquires (5) and are the source of approximately 12% of all contacts into PALS. The main themes of all contact around patient experience is in relation to access to services / wait times and the care and treatment received. This is also reflected in the 5 CAMHS complaints closed that were upheld or partially upheld in Q4 which related to access

and wait times (2), attitude of staff (1) and care / treatment (2). CAMHS is under pressure as a service with increases in caseload, activity and wait times. A quality improvement project is in progress to improve productivity and waiting list management. A significant amount of time is invested in supporting families whilst waiting for appointments.

- Acute Mental Health Inpatients has continued to see a reduction in the number of complaints received with 3 formal received this quarter, this is lowest number received in any quarter over last 2 years. The hospital continues to have band 5 qualified nursing staff vacancies and as a consequence higher levels of temporary staff which is not optimal. The Director of People is working closely with the Locality Director on recruitment.

- Westcall, GP Out of Hours service received only 1 complaint. This is a significant decrease on Q3 where 7 were received and the lowest number seen in any quarter over the last 2 years. This service is identified as the CQC have rated it as requires improvement because of poor underpinning systems and processes to deliver good care.

- District nursing services are currently under significant pressure due to vacancy and caseload; work is in progress with commissioners to define the District Nursing offer; the service receives the highest number of locally resolved concerns; however formal concerns are low with 3 this quarter and the service receives one of the highest numbers of compliments.

Staff directly involved in the complaint are asked to reflect on the issues raised and consider how they will change their practice.

During the quarter the Trust continued to sustain a complaint response rate of 100%. 51% (24) of the 47 complaints closed during the quarter were upheld or partially upheld, these were spread across a number of differing services and there were no particular themes from any particular service; however 5 were related to attitude of staff, 4 to access to services and 12 to care and treatment provided.

The report compares the number of complaints received by other Mental Health Trusts and it can be seen that the Trust is not an outlier in complaints received

4707 patients/carers responded to our internal patient survey in Q4, this asks patients how they rate their experience, by asking 5 questions; 86% reported the service they received as good or better. The response rate is significantly higher than in Q3 where just under 3000 responses were received; the increase in responses received is mainly due to children's services (School Nursing who are now using their smart phones to capture feedback, Health Visiting and Immunisation service).Work undertaken as part of our True North has shown that the use of this survey is very inconsistent across the Trust. Work is commencing over 2019/20 to develop an improved survey that all services will use.

Finally services also registered 1,409 compliments during this quarter.

Conclusion
Patient experience is an important indicator of quality and it is important that services take steps to prevent similar concerns highlighted occurring and learn from all feedback received. Whilst each service takes complaints seriously we also need to be able to more easily demonstrate how we have used patient and service user feedback to change service delivery as well as how learning is shared across the organisation. This continues to be work in progress.

Debbie Fulton, Acting Director of Nursing and Governance

2. Complaints received

2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2017-18 and 2018-19 by service. During Quarter four 2018/19 there were 50 complaints received, this is a decrease compared to all other quarters this year.

Table 1 – Formal complaints received

	2018/19							2017/18					
Service	**Q4**	% Comparison to Q3	Q3	Q2	Q1	Total	% of Total	Q4	Q3	Q2	Q1	Total	% of Total
CMHT/Care Pathways	**9**	↓	10	11	16	46	20.00	10	12	11	11	44	22.08
CAMHS - Child and Adolescent Mental Health Services	**6**	↓	8	6	5	25	10.87	4	6	9	7	26	14.29
Crisis Resolution & Home Treatment Team (CRHTT)	**4**	↑	3	5	2	14	6.09	6	4	6	4	20	9.09
Acute Inpatient Admissions – Prospect Park Hospital	**3**	↓	8	12	9	32	13.91	6	4	9	4	23	11.04
Community Nursing	**3**	no change	3	1	1	8	3.48	3	1	4	4	12	5.84
Community Hospital Inpatient	**3**	↑	1	7	6	17	7.39	6	1	1	3	11	3.25
Common Point of Entry	**4**	↑	2	3	3	12	5.22	2	1	-	2	5	1.95
Out of Hours GP Services	**1**	↓	7	5	4	17	6.96	2	3	2	2	9	4.55
PICU - Psychiatric Intensive Care Unit	**0**	no change	0	0	0	0	0.00	-	-	-	-	0	-
Minor Injuries Unit (MIU)	**0**	↓	2	1	1	4	1.74	2	1	2	-	5	1.95
Older Adults Community Mental Health Team	**1**	↑	0	1	1	3	1.30	3	1	1	0	5	2.39
13 other services in Q4	**16**	↑	13	11	12	52	22.60	11	19	14	5	49	23.44
Grand Total	**50**		57	63	60	230	100	55	53	59	42	209	

Previously, complaints were reported against the locality that the services reported into. As this often varies from the geographical location that the patient received the service, complaints are now reported against the geographical locality where the care was received which is considered to be more meaningful. The following tables show a breakdown of the formal complaints that have been received during quarter four and where the service is based.

2.2 Adult mental health service complaints received in Q4

27 of the 50 (54%) of the complaints received during Q4 were related to mental health service provision.

Table 2: Adult mental health service complaints received

	Locality of Service						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Adult Acute Admissions		3					3
CMHT/Care Pathways	5	2		2			9
CMHTOA/COAMHS - Older Adults Community Mental Health Team						1	1
Common Point of Entry	2					2	4
Criminal Justice Liaison and Diversion Service	1						1
Crisis Resolution & Home Treatment Team (CRHTT)		2	1			1	4
Neuropsychology		2					2
Older Peoples Mental Health (Ward Based)		2			1		3
Grand Total	8	11	1	2	1	4	27

2.2.1 Number and type of complaints made about a CMHT

9 of the total 50 complaints (18%) received during Q4 related to CMHT service provision. This is a reduction on numbers compared with Q1 (16), Q2 (11) and Q3 (10); however this accounted for the same percentage of complaints as in Q3.

Table 3: CMHT complaints

	Locality of Service			
Main subject of complaint	Bracknell	Reading	West Berks	Grand Total
Attitude of Staff		1		1
Care and Treatment	3		2	5
Communication	1			1
Medical Records	1			1
Medication		1		1
Grand Total	5	2	2	9

Care and treatment (5) was the main subject for formal complaints received about CMHT, although the reasons for the concerns varied from people not being happy with their diagnosis to lack of perceived support, dissatisfaction with changes in medication and being discharged.

During Q4 Bracknell received the highest number of complaints with 5, this is a significant increase for Bracknell who had only received 1 other complaint during 2018/19. CMHT based in Windsor, Ascot and Maidenhead and Slough did not receive complaints during this quarter.

2.2.2 Number and type of complaints made about Mental Health Inpatient Services

During Quarter four, 5 of the total 50 complaints (10%) related to Inpatient mental health wards (3 to acute wards, 2 to older adults wards) this is a continued reduction on the number received in previous quarters which were Q1 (9), Q2 (12) and Q3 (8).

Table 4: Mental Health Inpatient Complaints

	Ward/Area				
Main subject of complaint	Daisy Ward	New Orchid Ward	Prospect Park Hospital	Snowdrop Ward	Grand Total
Care and Treatment		2	1		3
Communication				1	1
Discharge Arrangements	1				1
Grand Total	1	2	1	1	5

2.2.3 Number and type of complaints made about Crisis Resolution/ Home Treatment Team (CRHTT)

In Quarter four, 4 of the total 50 complaints (8%) were related to CRHTT, this is similar to the number received in previous quarters; as in all previous quarters west services received a higher number of the complaints than the East services. There are no particular themes identified in the complaints received for CRHTT.

Table 5: CRHTT complaints

	Locality of Service				
Main subject of complaint	Reading	Slough	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Attitude of Staff	1	1			2
Care and Treatment	1				1
Medical Records				1	1
Grand Total	2	1	0	1	4

2.3 Community Health Service Complaints received in Q4

During Quarter four, 14 of the total 50 complaints (28%) related to community health service provision.

Table 6: Community Health service complaints received

	Locality of Service					
Service	Bracknell	Slough	West Berks	Windsor, Ascot and Maidenhead	Reading	Grand Total
Assessment and Rehabilitation Centre		1				1
Integrated Pain and Spinal Service			1			1
Multiple Sclerosis				1		1
Outpatients	1					1
Physiotherapy (Adult)			1			1
Physiotherapy Musculoskeletal	1					1
Sexual Health		2				2
Community Nursing				1	2	3
Community Inpatient wards			2	1		3
Grand Total	2	3	4	3	2	14

During Q4 the services receiving the most complaints was community nursing and the community wards both received 3 complaints each.

2.3.1 Community Health Inpatient wards Complaints

During Quarter four, 3 of the total 50 complaints (6%) received related to inpatient wards; this is a reduction from 6 in Q1 and 7 in Q2 and increase from 1 in Q3. Both of the complaints related to West Berkshire Community Hospital were in relation to end of life care.

Table 7: Community Inpatient complaints

	Ward		
Main subject of complaint	Henry Tudor Ward	West Berkshire	Grand Total
Attitude of Staff		1	1
Care and Treatment	1	1	2
Grand Total	1	2	3

2.3.2 Community Nursing Service Complaints

In Quarter four, 3 of the 50 complaints (6%) were related to community nursing service provision, all regarding care and treatment. This is an increase from 1 received in both Q1 and Q2 and the same as the number 3 received in Q3.

Table 8: Community Nursing complaints

	Locality of service			
Main subject of complaint	Reading	West Berkshire	Windsor, Ascot and Maidenhead	Grand Total
Care and Treatment	1	1	1	3
Grand Total	1	1	1	3

2 of the complaints related to care/ treatment and communication around end of life care.

Of the 14 complaints received by community services 4 related to care/ treatment and communication around end of life care, these will all be considered as part of the Trust mortality review processes.

2.3.3 GP Out of Hours Service, WestCall Complaints

During quarter four, 1 (2%) of the 50 complaints related to out of hours service provision, compared to 4 in Q1, 5 in Q2 and 7 in Q3.

Table 9: GP Out of Hours (Westcall) complaints

	Locality of Service	
Main subject of complaint	Reading	Grand Total
Care and treatment	1	1
Grand Total	1	1

2.4 Children, Young People and Family service Complaints received in Q4

2.4.1 Physical Health services for children complaints

During Quarter four, 1 of a total 50 complaints (2%) related to children's physical health services.

Table10: Children and Young People physical health service complaints

	Locality of Service	
Service	West Berks	Grand Total
Children's Physiotherapy - CYPIT	1	1
Grand Total	1	1

2.4.2 CAMHS complaints

During Quarter four, 6 of the 50 complaints (12%) were about CAMHS services; compared to 5 in Q1 6 in Q2, and 8 in Q3. Previously the majority of these were about care and treatment; in Q4 access to the services received the highest number of complaints.

Table11: CAMHS Complaints

	Locality of Service					
Main subject of complaint	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services			1	1	1	3
Care and Treatment	1	1				2
Waiting Times for Treatment	1					1
Grand Total	2	1	1	1	1	6

2.5 Learning Disabilities

There have been no complaints for Learning Disabilities services; community or hospital based during quarter four.

3. KO41A return

Each quarter the complaints office submit a quarterly return, called the KO41A. This looks at the number of new formal complaints that have been received by profession, category, age and outcome. The information is published a quarter behind. The table below shows the number of formal complaints that were reported for mental health services, nationally and for local Trusts providing mental health services in the South England region (the same Trusts that we benchmark against in the Annual CMHT Patient Survey.

Table 12 – Mental Health complaints reported in the national KO41A return

	2017-18				2018-19		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Mental Health complaints - nationally reported	**3,461**	**3,790**	**3,451**	**3,653**	**3,598**	**3651**	**3391**
2Gether NHS Foundation Trust	14	19	15	15	17	14	21
Avon and Wiltshire Mental Health Partnership NHS Trust	81	75	63	67	78	72	77
Berkshire Healthcare NHS Foundation Trust	**40**	**58**	**56**	**59**	**49**	**45**	**38**
Cornwall Partnership NHS Foundation Trust	26	28	32	34	31	28	20
Devon Partnership NHS Trust	60	47	43	49	44	56	33
Dorset Healthcare University NHS Foundation Trust	82	84	74	79	91	90	92
Kent and Medway NHS and Social Care Partnership Trust	78	72	88	86	87	115	121
Oxford Health NHS Foundation Trust	62	56	49	70	50	56	58
Somerset Partnership NHS Foundation Trust	25	20	15	14	17	14	24
Southern Health NHS Foundation Trust	73	114	79	96	91	95	82
Surrey and Borders Partnership NHS Foundation Trust	14	28	21	26	26	36	16
Sussex Partnership NHS Foundation Trust	188	166	169	221	209	192	181

This table demonstrates a fluctuation in the number of complaints across mental health services both nationally and locally over time, with the Trust not identifying as an outlier for either the number of complaints, or complaint activity.

4. Complaints closed

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). During Q4 there were 47 complaints closed.

4.1 Outcome of closed formal complaints

Table 13: Outcome of formal complaints closed

	2018-19							2017-18					
Outcome	**Q4**	Comparison to Q4	Q3	Q2	Q1	Total	% of Total	Q4	Q3	Q2	Q1	Total	% 17/18
Case not pursued by complainant	**2**	no change	2	0	0	4	1.67	1	1	1	1	4	1.95
Consent not granted	**2**	↓	3	2	2	9	3.75	4	0	1	0	5	2.44
Local Resolution	**3**	↓	10	5	0	18	7.50	2	6	3	3	14	6.83
Managed through SI process	**1**	↑	0	2	0	3	1.25	4	Reported from Q4			4	1.95
Referred to other organisation	**0**	no change	0	0	0	0	0.00	1	0	1	0	2	0.98
No further action	**0**	no change	0	0	1	1	0.42	1	2	0	0	3	1.46
Not Upheld	**15**	↓	16	11	13	55	22.92	7	7	20	6	40	19.51
Partially Upheld	**19**	↓	36	26	25	106	44.17	28	22	19	18	87	42.44
Upheld	**5**	↓	12	15	12	44	18.33	10	10	18	8	46	22.44
Grand Total	**47**		79	61	53	240	100	58	48	63	36	205	

The 24 complaints closed and either partly or fully upheld in the quarter were spread across a number of differing services and there were no particular themes from any particular service; however 5 were related to attitude of staff, 4 to access to services and 12 to care and treatment provided.

4.2 Response Rate

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

Table 14 – Response rate within timescale negotiated with complainant

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

5. Demographic data

5.1 Ethnicity

One of the ways that the Trust can monitor the quality of its services is by seeking assurance through the complaints process, that people are not treated negatively as a result of their ethnicity or other protected characteristic.

The tables below show the characteristics of patients who have had complaints raised about their care between January and March 2019.

Table 15 – Ethnicity of patients; January to March 2019

Ethnicity	Number of patients	%	Census data
Mixed - White & Asian	1	2.00%	2.1 %
Not stated	7	14.00%	-
Other Asian	1	2.00%	13%
Other Black	1	2.00%	3.5%
Other ethnic category	1	2.00%	1%
White - British	39	78.00%	80%
Grand Total	50	100.00%	100%

5.2 Gender

There were no patients who identified as anything other than male or female during quarter four.

Table 16: Gender

Gender	Number of patients	%	Census data
Female	24	48.00%	50.9%
Male	26	52.00%	49.1%
Grand Total	50	100.00%	100%

5.3 Age

Table 17 – Age of patients

Age Group	Number of patients	%	Census data
Under 12 years old	3	6.00%	
12-17 years old	5	10.00%	
18 - 24 years old	3	6.00%	31.6%
25 - 34 years old	6	12.00%	14.9%
35 - 44 years old	8	16.00%	15.4%
45 - 54 years old	5	10.00%	19.3%
55 - 64 years old	4	8.00%	
65 - 74 years old	9	18.00%	
75 years or older	7	14.00%	18.7%
Grand Total	50	100.00%	100%

6. Parliamentary and Health Service Ombudsman

6.1 The Parliamentary and Health Service Ombudsman (PHSO) activity related to the Trust

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process. The table below shows the Trust activity with the PHSO since April 2017.

The last three investigations relating to the Trust that were escalated to the PHSO were not upheld. There was no activity during Q4.

Table 18 – PHSO activity

Month open	Service	Month closed	Current Stage
May-17	CMHT/Older Adults	May-17	Not a BHFT complaint - records requested to inform investigation about Social Care - case closed after the notes were sent
Jun-17	CMHT	Sep-17	Not Upheld
Aug-17	Talking Therapies	Apr-18	Not Upheld
Oct-17	District Nursing	Nov-17	Agreed local resolution - investigation not taken forward by PHSO
Nov-17	CMHT/Care Pathways	n/a	PHSO requested – no further action
Mar-18	Older Adults Community Mental Health Team	Oct-18	Not Upheld
Mar-18	Admin teams & office based staff	Mar-18	No further action
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	CPE	Aug-18	PHSO not proceeding
Aug-18	Out of Hours GP Service	Oct-18	PHSO not proceeding
Sep-18	Psychological Medicines Service	n/a	Investigation Underway
Nov-18	Psychological Medicines Service	Nov-18	PHSO not proceeding
Dec-18	Psychological Medicines Service	n/a	Investigation Underway
Dec-18	Community Hospital inpatient	n/a	Investigation Underway

6.2 PHSO activity in England October – December 2018

The PHSO have published a report on complaints about the NHS in England from October to December 2018. This report shows that:

The PHSO reported in Q3 that overall they assessed 1,661 cases, of which 399 progressed to investigation.

In the same quarter the Trust had three complaints against them referred to the PHSO, of which two progressed to investigation. This is comparable with Q2 where 3 complaints were referred to PHSO.

399 were accepted in principle for investigation involving 431 health organisations

464 investigations were closed involving 533 health organisations.

Of the cases that were investigated:

- 190 (41%) of the total closed cases were either fully upheld (36 or 8%) or partly upheld (154 or 33%)
- 2 (0.4%) were resolved before the investigation was concluded
- 236 (51%) of the complaints were not upheld
- 36 (8%) of the investigations were ended for other reasons, for example at the complainant's request

Of the recommendations made as a result of the investigation there were:

- 115 formal apologies
- 80 payments to make up for financial loss or to recognise the impact of what went wrong.

- This totalled £67,714.51.
- 102 service improvements, such as changing procedures or training staff.
- 33 other actions to put things right. For example, asking a GP practice to correct errors in medical records

During the same period Berkshire Healthcare had:

- 3 cases opened by PHSO – one is not being progressed by PHSO, and the investigations are underway with two

7. Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they are involved in, but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There were 6 complaints led by other organisations during quarter four.

Table 19 – Formal complaints led by other organisations

Lead organisation	Service area of complaint
East Berkshire CCG	District Nursing complaint regarding the pressure of a mattress not being set properly and not being adequately managed
Frimley Health NHS Foundation Trust	Mental Health Liaison Service and waiting time for a young person to be seen
NHS England	CMHTOA/COAMHS - Older Adults Community Mental Health Team and explanation around appointments stopping
Oxford Health	Criminal Justice Liaison and Diversion Service and repeated MHA assessments and the patient not being admitted to a psychiatric hospital
Royal Berkshire Hospital	Concerns about psychiatric medication being withdrawn during admission to the acute trust and lack of oversight/communication with mental health services
SCAS	Out of Hours GP Services and potential misdiagnosis

8. MP enquiries, locally resolved complaints and PALS

8.1 MP enquiries

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

Table 20 – Enquiries from MP Offices

Service	Number of enquiries
Assessment and Rehabilitation Centre	1
CAMHS - Child and Adolescent Mental Health Services	5
CMHT/Care Pathways	1
Common Point of Entry	1
Neuropsychology	1
Grand Total	9

There were 9 MP enquiries raised in quarter four compared with 10 in quarter three and 3 in quarter two.

The 5 CAMHS enquiries related to access to treatment (4) and care and treatment (1).

8.2 Local resolution complaints

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

Table 21 – Concerns managed by services – Local Resolution complaints

Service	Number of concerns managed directly by services
District Nursing	6
Health Visiting	5
Adolescent Mental Health Inpatients	3
Community Hospital Inpatient	2
Podiatry	2
Children's Speech & Language Therapy - CYPIT	2
CMHTOA/COAMHS - Older Adults Community Mental Health Team	2
Community Matron	2
Mobility Service	1
Adult Acute Admissions	1
Community Dietetics	1
Admin teams & office based staff	1
Minor Injuries Unit	1
Continence	1
Physiotherapy Musculoskeletal	1
Diabetes	1
Sexual Health	1
CMHT/Care Pathways	1
Children's Services Other	1
Grand Total	35

8.3 Informal complaints received

An informal complaint is managed locally by the service through discussion (written or verbal) and when discussing the complaints process, this option is explained to help the complainant to make an informed choice.

Table 22 – Informal complaints received

Service	Number of Informal Complaints
Adult Acute Admissions	1
CAMHS - Child and Adolescent Mental Health Services	2
CMHT/Care Pathways	1
Rapid Assessment Community Clinic	1
Grand Total	5

The two informal complaints about CAMHS were around information sharing and medication concerns.

8.4 NHS Choices

There were 9 postings during Quarter four; 4 were positive, 4 were negative and 1 provided positive feedback and areas for improvement.

Service	number postings	Positive Posting	Negative Posting
MIU	3	The staff in the minor injuries department were exceptional at looking after my husband and I. Once we arrived they saw my husband immediately, supported us both emotionally and looked after my husband's deteriorating physical health. We saw a wonderful nurse who looked after my little one very well. The staff were so helpful and gave great advice. Much nicer than sitting in a busy A&E waiting room and felt very well cared for.	Notices on the "night" door very confusing. A War film was showing on the wall TV in the MIU. It was very violent and not at all suitable for an audience that included a 5 year old boy.
Hearing and Balance	2	Absolutely delighted with the care and respect that was shown to my mother - lovely staff, professional, courteous and an outstanding service Kind Staff	Lack of information on website No system for re-calling patients - only discovered that my hearing should have been checked 2 years earlier when I went to a drop in clinic to have my hearing aid volume increased
Mobility	1		My son is 10 years old & has severe mental & physical disabilities the wheelchair service has struck him off their books because they say he can "walk" which is utter nonsense
Wokingham CMHT	1		My experiences with The Old Forge and its staff have been long, drawn out and consistently awful in my time dealing with them.
CRHTT (Newbury)	1	Excellent emergency care; my son was visited on a daily basis by the team when he became suicidal. They were diligent and persistent, even when he was reluctant to engage, and when he needed to see the team psychiatrists the appointments were given promptly and he was seen on time.	
Podiatry (Upton)	1		The 2 ladies that were at the podiatry 'reception' were extremely rude and told them to go to the main reception when there were clearly seats for patients to sit on

8.5 PALS Activity

There were 364 PALS contacts during Quarter four; in addition there were 77 contacts that were about non-Trust services. This is consistent with volume of enquires received in Q3 and lower than number in Q1 and Q2.

The main reasons for contacting PALS were:

- Communication; Verbal and written to patients and between organisations
- Information requests; general, finding a local service and requesting clinical information
- Choice and flexibility of access to services
- Concerns about clinical care received

Contact around choice and flexibility of access to services included:

- Information and access to CAMHS clinics and training sessions
- Trying to make an appointment with the Podiatry service, or no longer eligible to receive the service
- Access to hearing aid batteries/tubing and ear syringing with the Hearing and Balance Service
- Trying to cancel appointments with or unhappy with the access to Talking Therapies

Contact around concerns about clinical care received included:

- Referrals being passed between CAMHS and other services
- Care at Prospect Park Hospital
- Concerns about medication prescribed by a Psychiatrist

9. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. The results of the NHS England national review of the FFT are due to be published in Q1 2019/20.

The monthly FFT results, for each service and reporting locality, are shared on our intranet to make them accessible to all staff. The comments are also available online and the patient experience team are currently exploring how to share these more visually. A summary of the comments from the FFT is sent to the Clinical Directors on a monthly basis which is discussed in the locality Patient Safety and Quality Meetings.

9.1 Friends and Family test responses

9.1.1 Overall responses

Our Trust overall recommendation rates to a friend was 93% for 2018/19; for community Hospital inpatients recommendation rate was 96% whilst for Mental health Inpatients this was 70%. Combined physical and mental health community services have a recommendation rate of 93%.

Based on the number of discharges from our services, there were 54,179 patients eligible to complete the FFT during quarter four. During Q4, the response rates were;

January: 21%
February: 25%
March: 21%

There has been a significant increase in the response rate for mental health services. A group specifically focussed on collecting and understanding feedback for patients at Prospect Park Hospital has been setup which monitors the response rates of the FFT at a local level. Champions to support promotion of patient feedback are being used to good effect in children's services.

Data shows that introducing SMS as a way of providing FFT has proved very popular with approximately half of all responses being received via this method.

Table 23 – Quarterly number of Friends and Family Test responses

		Number of responses	Response Rate
2018/19	Q4	11,919	22%
	Q3	7631	12.82%
	Q2	5443	14.82%
	Q1	6625	11.64%
2017/18	Q4	5463	11.24%
	Q3	4105	6.81%
	Q2	4987	9.63%
	Q1	4238	7.04%
2016/17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015/16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

9.1.2 Inpatient ward recommendation rates

Table 24 - FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family

		2018/19				2017/18			
Ward	Ward type	Q4%	Q3%	Q2%	Q1%	Q4%	Q3%	Q2%	Q1 %
Oakwood Ward	Community Inpatient Ward	95.83	100	100	95.83	100	72.97	93.75	100
Highclere Ward		97.50	94.12	97.37	93.98	94.64	96.7	100	100
Donnington Ward									
Henry Tudor Ward		90.91	93.48	89.80	97.78	97.59	42.86	98.86	93.5
Windsor Ward		100	100	96.67	88.00	95.24	94.44	100	100
Ascot Ward		100	94.12	93.75	100.00	100	100	100	100
Jubilee Ward		92.86	100	94.92	97.50	97.83	100	100	100
Bluebell Ward	Mental Health Inpatient Ward	80	72.73	50	-	-	-	100	40
Daisy Ward		62.79	78.95	50	100.00	33.33	-	66.67	50
Snowdrop Ward		76.74	70.59	70.73	70.59	100	85.71	76.19	60
Orchid Ward		75	69.44	50	100.00	-	-	100	-
Rose Ward		45.95	62.50	0	100.00	33.33	100	50	100
Rowan Ward		100	83.33	-	-	-	-	-	100
Sorrel Ward		100	100	-	-	-	-	-	-

- = no responses received

9.1.3 Learning Disabilities

There were no surveys received for the Learning Disability Inpatient Unit, Campion Unit. The inpatient survey, incorporating the FFT is currently being updated. There were 65 responses received from patients seen by the community teams for people with a learning disability.

The recommendation rate for quarter four was 86% compared with 71% in quarter three.

9.1.4 Carer FFT

In Q4, 95% of carers would recommend the Trust to friends or family.

Table 25 - Carer FFT Responses

Number of responses			
2018/19		2017/18	
Q1	67	Q1	111
Q2	201	Q2	32
Q3	314	Q3	39
Q4	**258**	Q4	86

9.1.5 Friends and Family Test comparison information available from NHS England

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health and Social Care on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially. The table below shows the most up to date comparison information available from NHS England, which is February 2019.

Berkshire Healthcare has maintained a significantly higher response rate compared to other local Trusts, this is positive and means that the results achieved are more valid; for Feb 2019 the Trust recommendation rate dipped below 95% to 94%, this will continue to be monitored.

In January 2019, Berkshire Healthcare had the highest response rates nationally across both community and mental health Trusts.

Table 26 - Community Health services FFT data; February 2019

	Feb-19		Nov-18		Jul-18		May-18		Feb-18		Nov-17	
Trust Name	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR
Berkshire Healthcare	**17%**	**94%**	**9%**	**96%**	**11%**	**98%**	**14%**	**97%**	**9%**	**97%**	**6%**	**99%**
Solent NHS Trust	7%	98%	5%	97%	4%	97%	5%	96%	5%	96%	4%	97%
Southern Health NHS FT	5%	95%	5%	97%	5%	98%	9%	97%	12%	94%	7%	97%
Oxford Health NHS FT	4%	93%	4%	97%	3%	96%	4%	97%	5%	97%	4%	97%

%RR – Recommendation rate for table 26 and 27

Table 27 - Mental Health services FFT data; February 2019

	Feb-19		Nov-18		Jul-18		May-18		Feb-18		Nov-17	
Trust Name	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR
Berkshire Healthcare	**21%**	**86%**	**37%**	**83%**	**5%**	**87%**	**8%**	**92%**	**8%**	**88%**	**6%**	**87%**
Solent NHS Trust	13%	92%	11%	94%	9%	87%	8%	83%	8%	93%	12%	93%
Southern Health NHS FT	2%	93%	2%	92%	3%	92%	4%	89%	2%	91%	3%	89%
Avon and Wiltshire MH Partnership	14%	90%	16%	89%	13%	91%	15%	90%	14%	89%	13%	88%
Oxford Health NHS FT	9%	93%	9%	93%	9%	91%	10%	90%	10%	91%	9%	92%

10. Our internal patient survey

At the end of the quarter we have received feedback from 4707 patients or carers compared to 2974 in the last quarter.

This quarter there has been remarkable increases in responses from School Nursing who are now using their smart phones to capture feedback, Health Visiting and Immunisation service. The Immunisation service has recently had a new survey and all have allocated PPI Champions. We are constantly working with services to improve their response rates.

The highlights are:

- 86% reported the service they received as good or better
- 9 services carrying out the internal patient survey were rated 100% for good or better with a further 13 services rating 85% or above
- Out of the 63 services who routinely report patient survey results, 28 services did not log any responses during the quarter
- Of the 160 services in the Trust, 107 services received responses on their internal survey in Q4

11. Learning Disabilities survey

There were 26 survey responses by people seen by our Community Team for people with a Learning Disability during quarter four. A selection of the results is in the table below;

Table 28 – Patient survey responses – Community based Learning Disability Services

My meeting with you was helpful	%	Number	I got answers to my questions	%	Number
Not at all	0	0	Not at all	0	0
Not much	0	0	Not much	4.17	1
A little	8.33	2	A little	4.17	1
Quite a bit	0	0	Quite a bit	0	0
A lot	87.5	21	A lot	87.5	21
Question not answered	4.17	1	Question not answered	4.17	1
You were polite and friendly to me	%	Number	You listened to me	%	Number
Not at all	0	0	Not at all	0	0
Not much	0	0	Not much	0	0
A little	4.17	1	A little	4.17	1
Quite a bit	0	0	Quite a bit	0	0
A lot	91.67	22	A lot	91.67	22
Question not answered	4.17	1	Question not answered	4.17	1

12. Updates: Always Events and Patient Participation and Involvement Champions

The Always Events programme has been embedded within the WestCall service. The operational team are being supported by the Patient Experience Team with this project, a number of service led observations and visits have taken place within the quarter.

PPI Champions are fully established and embedded within the Children, Young People and Families locality. Participation representatives from the services act as champions for service user feedback and participation. The champion role provides opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation, with direct support from both their peers and corporate services. Services with a Champion are seeing an increase in the response rates for the FFT and wider participation. There are plans implement the PPI Champions across the Mental Health West and Community Health West localities in 2019/20.

Appendix Two contains the 15 Steps report for quarter four. There were 5 visits during this period; all across physical health community based services and inpatient wards.

13. Compliments

There were 1,409 compliments reported during quarter four. The services with the highest number of compliments are in the table below.

Table 29 – Compliments

Service	Number of compliments
Talking Therapies	646
ASSiST	88
Cardiac Rehab	66
Community Hospital Inpatient	65
District Nursing	62
Diabetes	44
Traumatic Stress Service	39
Community Respiratory Service	35
CMHTOA/COAMHS - Older Adults Community Mental Health Team	32
Adult Acute Admissions	31

Table 30 - Compliments, comparison by quarter

	2018/19				2017/18					
	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	17/18	16/17
Total Compliments	1,409	1670	1878	1008	968	1163	1165	1488	4784	5950

Elizabeth Chapman

Head of Service Engagement and Experience

Formal Complaints received during quarter four 2018/19

Berkshire Healthcare NHS Foundation Trust

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Windsor, Ascot and Maidenhead	Multiple Sclerosis	Low	Pt unhappy with the attitude of the staff member and feels the Trust is no longer patient oriented	Refered to other organisation	Not within our remit - moved to frimley in dec 2018
Reading	Adult Acute Admissions	Moderate	Son has raised many concerns following the coroner's inquest following his mother's death on Rowan Ward	Upheld	There were medication errors however these did not contribute to the patient's death. There was also a failure to perform CPR and activate the PIT alarms. There were care failings and there are processes taking place outside the complaints process. A Serious Incident Action Plan has previously been shared with the family.
Reading	Out of Hours GP Services	Minor	DECEASED PT: Spouse of pt feels the Dr who attended in January treated them badly and the complainant does not want this to happen again.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Older Peoples Mental Health (Ward Based)	Moderate	Family have been unhappy with the pt care from admission to PPH. From descrepancies around urine tests being done, inaccuracy of record keeping data, lack of communication with the family, incorrect medication given, mixing up patient names. Incorrect equipment booked for the home, patient falls.	Upheld	Whilst there were some aspects of the complaint not upheld, overwhelmingly the complaint is upheld as miscommunication, medication error and poor documentation.
Reading	CMHT/Care Pathways	Low	Patient is complaining about historical care and treatment whilst at Fairmile Hospital - prescribed Lithium which they say they have not been physically monitored whilst taking and they are now having surgery due to the long term affects.	Local Resolution	Contact attempted three times with complainant. Historical issues which require a discussion.
Bracknell	Common Point of Entry	Low	1. Inaccuracies in review 2. confusing statements around psychological therapy 3. inappropriate recommendations due to health problems 4. pt feels he is being discriminated against 5. His autonomy is not being respected 6. psychotherapists in appropriately assuming dental procedures to be a drain on the pt's resources ****New issue raised on 30th Jan, which is that the Trust does not afford Bracknell community psychodynamic psychotherapy.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	Outpatients	Low	Complaint about a request for a Psychiatrist opinion on a physical health concern not being actioned.	Investigation underway	
Bracknell	Admin teams & office based staff	Low	Complaint about access to NHS services as an asylum seeker. Care has previously been refused on this basis.	Investigation underway	
West Berks	Integrated Pain and Spinal Service	Moderate	following discharge from service pt sort a second opinion which concluded his neck was irreparably damaged and he will be unable to work for the rest of his life - pt feels he was therefore wrongly diagnosed	Partially Upheld	
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Minor	Brother called Crisis line for help with admission to hospital. Advised that a 'small' OD had been taken 24hrs ago but GP had not suggested pt attend A&E. Attitude of staff lacked compassion which has had a knock on effect for other family members.	Partially Upheld	practitioner gave appropriate advice, after consulting with senior colleagues. In view of distress of patient, it was appropriate to attend A&E. However, it is acknowledged that the call ended abruptly and she will reflect on this in supervision.
Slough	CAMHS - Child and Adolescent Mental Health Services	Low	Pt on wait list and parents want an update. Unhappy with key worker, Father also unhappy at being addressed as 'my dear'	Upheld	Upheld by IO. There was a failure in the process to call parents, due to staff shortages. Identifed that receptionist did not know how to deal with call, therefore training offered.
West Berks	Physiotherapy (Adult)	Low	Pt believes he has not had the correct number of sessions of physio and has now been discharged also wants the documentation removed from his book back.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	CMHT/Care Pathways	Minor	Pt unhappy with the way they were treated in their appointment, Pt feels the clinician was not concerns about their MH	Not Upheld	Apology given for how the patient felt. The clinical decision making was made in discussion with the patient.
West Berks	Community Hospital Inpatient	Moderate	DECEASED PT - Family unhappy with the care received from the Rainbow Room want to know changes will be made	Investigation underway	
Windsor, Ascot and Maidenhead	District Nursing	Moderate	Patient with LD needed a sedative for a blood test. On one occasion the sedative had worn off by the time the nurse had arrived, on the second occasion, the nurse did not arrive at all.	Upheld	1. The phlebotomist has now left the organisation. The Phlebotomist did not prioritise their work on the day in question. 2. There was a communication error between the home and the DN service as the DN service turned up at the right time but a day late. The names of the Team Lead and Clinical Lead given to the home so that the home can liaise with Team to ensure that any sedated blood requests are prioritised and will happen on the day and time that the patient is sedated.
Slough	Crisis Resolution & Home Treatment Team (CRHTT)	Minor	Pt feels the member of staff lacks compassion making her feel worthless and not deserving of help	Investigation underway	
Reading	Older Peoples Mental Health (Ward Based)	Moderate	Wife of pt has sent in 16 points of concern following her review of the pts medical records	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	Children's Physiotherapy - CYPIT	Minor	Family unhappy with the physiotherapist who they feel has gone behind their backs making appts with reps to try out new equipment. Parents feel the pt's best interests are not being met.	Not Upheld	Whilst communication could have been improved, there is no evidence that the physiotherapist acted in an inappropriate way and shared information inappropriately.
Bracknell	Criminal Justice Liaison and Diversion Service	Low	Mother of patient has concerns as she feels important mental health assessements have been ignored. She has listed three specific questions to be answered	Investigation underway	
Bracknell	Common Point of Entry	Minor	Pt saw Dr who took him off the medication he has been on for 23 years which has left the patient very anxious. He has lost confidence in the consultant and wants a see a different one.	Case not pursued by complainant	Complaint withdrawn
Slough	Assessment and Rehabilitation Centre	Moderate	Family member believe that as the pts assessment paperwork from October 2018 was not sent to the GP until January 2019 the GP was unaware they had to monitor blood pressure which led to their unnecessary untimely death.	Serious Untoward Incident Investigation	Managed through ILR
Bracknell	CMHT/Care Pathways	Low	Pt sent a letter recorded delivery with copies of assessments made whilst on Rose ward that she disagrees with	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	District Nursing	Moderate	DECEASED PT:- Complaint about community nursing care and communication between the service, hospital and GP. The family have asked for a meeting. They have previously met with the RBH and GP practice about their concerns.	Local Resolution	Meeting with family on 5 April 2019. They asked that their complaint be managed locally and no longer as a formal complaint, with any actions shared by the service. Complaints Office have asked that any further actions are uploaded into the complaint file.
Windsor, Ascot and Maidenhead	Older Peoples Mental Health (Ward Based)	Low	Family wish to fully understand how the pt was admitted to hospital without being under a section as they feel she is entitled to Sec 117 funding	Investigation underway	
Reading	Neuropsychology	Low	Patient disagrees with some elements of our response; such as inconsistencies around letters being sent/received.	Not Upheld	no inconsistencies were found from our handling of the original complaint
Reading	Neuropsychology	Low	Pt unhappy that the service did not respond to the email sent on the 19th July 2017	Not Upheld	Not upheld as we did respond previously via face to face meeting and letter
Reading	CAMHS - Child and Adolescent Mental Health Services	Moderate	Complaint about waiting time for ADHD clinic	Partially Upheld	•The on-going challenges regarding capacity and demand with the ADHD team, which are the consequence of referrals doubling over the past few years, have been raised with senior management •The IAPT Parenting workers will be reviewing the current ADHD waiting list and will contact parents and carers to offer IY parenting support whilst their children are waiting or an assessment.

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	CMHT/Care Pathways	Moderate	Dr took pt off their medication the family as a direct consequence the pt became unwell and was admitted to hospital. Family do not want this to happen to anyone else	Consent Not Granted	Generic response sent
Wokingham	Crisis Resolution & Home Treatment Team (CRHTT)	Minor	Complaint about response from CRHTT staff on the telephone. Patient accessed discharge letter online (as not received) and says that this contains inaccurate diagnosis information. Has also asked for copies of medical notes and telephone transcripts.	Investigation underway	
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Minor	Complaint about a lack of care from CAMHS following multiple referrals. Mum is also worried about being prosecuted about non attendance at school.	Investigation underway	
Reading	Crisis Resolution & Home Treatment Team (CRHTT)	Moderate	Pt not provided info on his rights, wasn't advised of advocacy, procedures for assessing and documenting consent were not followed, he did not receive a copy of his care plan thus no clarity of what he was prescribed.	Partially Upheld	Patient consented to CRHTT treatment however did not receive information on the MHA or advocacy services.
West Berks	CMHT/Care Pathways	Low	Discharged pt feels she needs regular support from services. Forwarded concerns in December but has asked they are now raised formally	Partially Upheld	Points 1 & 2 not upheld. Point 3 uphheld

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	CMHT/Care Pathways	Low	Pt feels she is not getting any support from CMHT and feels she needs a CPN	Investigation underway	
Bracknell	CMHT/Care Pathways	Minor	patient is unhappy with incorrect diagnosis, ineffective care and treatment, poor attitude and communication from Bracknell CMHT	Investigation underway	
Reading	Adult Acute Admissions	Low	Further issues Brother has taken over as main complainant. Patient is unhappy with our response and has indicated where they want further information, an apology from the Dr and that id things got bad for her again, she would be allowed longer on the ward. They have contacted the PHSO who have said they need to come back to us in the first instance. Original complaint Pt unhappy that she was discharged from the ward, felt they should have waited till her brother was back from his holiday as she had no one to provide support. Pt said the Dr had not let her know she would be discharged at all	Not Upheld	Discharge was appropriate and both patient and her broter had been included in discharge planning meetings.

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	Community Hospital Inpatient	Moderate	Family unhappy at the perceived lack of support they were given by staff in the Rainbow Room. Pt belongings were given to the family but were not the pts. correspondence relating the DOD were incorrect.	Investigation underway	
Bracknell	CMHT/Care Pathways	Moderate	Patient has been informed that there is information on his patient records relating to a prison sentence that is not accurate.	Partially Upheld	it is upheld that records are incorrect but no evidence that this has impacted on patient's care.

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Adult Acute Admissions	Moderate	OOA pt admitted to PPH Snowdrop ward having been picked up by the police and admitted with an underlying physical infection, which the family feel may have a bearing on his MH. Family were told on the 4th Feb that his home town hospital would not accept him and he would be discharged the next day, which the family were not happy about and they felt that was a risk to him and the wider community. Following discharge the pt was picked up in London under a section and admitted to Newham MH Unit. Family question how a pt can go being lucid and no longer a risk to being in need of police intervention to ensure safety within 12 hours. Family feel there may be a more organic cause to his condition and feel his discharge was hasty, they believe PPH disregarded their duty of care and released an acutely unwell psychiatric patient to an unknown locality without means or mental capacity to ensure his own safety.	Consent Not Granted	No consent received

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	CMHTOA/COA MHS - Older Adults Community Mental Health Team	Low	Pt attended the memory clinic and family unhappy with the way the pt was treated. Family wish an apology for the treatment and a follow up apt with a more suitable Dr	Investigation underway	
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	Moderate	Family feel the pt deteriorated whilst on the ward, they question the lack of rehab and communication, pt's mobility minimal on discharge. Family report that since discharge with private 1:1 physio the pt is almost back to original mobility and are therefore unhappy with the lack of rehab at St Marks	Investigation underway	
Reading	District Nursing	Moderate	Deceased pt: Family unhappy at the length of time taken to sort the medication drive at the pts home and the lack of equipment the nurses had when they visited to sort the issue. Family feel they made the end experience even more distressing by what they call sub-standard service.	Partially Upheld	Point one not upheld as DNs were not contacted to come any earlier Point two partially upheld as it was not routine for DNs to carry scissors to EOL visit, but now they will.
West Berks	CAMHS - Child and Adolescent Mental Health Services	Low	Complaints about lack of contact and flexibility of appointment for daughter. Also about medication being prescribed over the telephone.	Case not pursued by complainant	Family happy they are being supported by services now

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Slough	Sexual Health	Minor	Wrong blood pressure recorded with wrong advice being given to pt. Pt wants to know that this won't happen again.	Partially Upheld	Point one - Dr recognises she should have discussed her clinical rationale with patient Point 2 - noting to uphold Point 3 - no evidence of negligence by Dr point 4 - seeking reassurance and given in response
Wokingham	Common Point of Entry	Low	Patient feels as though CPE do not listen to him or consider his autism when he calls them.	Investigation underway	
Reading	CAMHS - Child and Adolescent Mental Health Services	Minor	Family of ADHD and Autism pt struggling with the length of time they have had to wait.	Not Upheld	No change. Referred to PHSO. Original Complaint: Apology sent for waiting time.
West Berks	CMHT/Care Pathways	Low	Pt with many concerns. Centred around Aspergers waiting times, help and support in the interim, staff attitude toward him, discharge from services without knowing where he is to go next and the need to know when his psychiatrist apt is. No's 2,6,9,12,13,15 do not relate to our trust	Investigation underway	
Slough	Sexual Health	Low	Patient had been trying to call Garden clinic for three weeks until he had to go into the clinic and then he says the receptionist was rude to him	Partially Upheld	Patient had poor experience in trying to access service

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Windsor, Ascot and Maidenhead	CAMHS - Child and Adolescent Mental Health Services	Minor	Complaint received from both Mother of patient and Senior Social Worker from Slough Children's Services Trust. Concern about lack of follow up care by CAMHS after being discharged from London Hospital where the young person was admitted due to a suicide attempt. Two specific outcomes requested: Complete the YP's assessment asap Schedule appropriate therapy inline with the YP's needs	Partially Upheld	Based on IO findings
Bracknell	Physiotherapy Musculo-skeletal	Low	Pt unhappy with the response and wants it re-written and withdrawn from the Dr's ORIGINAL RESPONSE Pt unhappy with the attitude of the staff member, so distressed she said it resulting in her trying to take her own life	Partially Upheld	clinical care was appropriate and the reasons for various tests have been explained. We have apologised that distress was caused at the appointment and that the discharge letter appeared compassionless. The team are planning to develop the skills of staff completing discharge letters to ensure content is understandable and well received.
Wokingham	Common Point of Entry	Minor	Member of staff insisted pt look her in the eye during assessment and told her to get over her problems as she was 23 now.	Partially Upheld	Point one - IO found that reasonable adjustments were made to accommodate patient's selective mutism. Point two - upheld. IO acknowledges that an increased understanding is required and this will be addressed with staff Point three - We have apologised on this point

15 Steps Challenge

Quarter 4 2018/19

There have been 5 visits during quarter 4 making a total of 20 visits during 2018/19. Staff continue to be engaged with the visits and appreciate the constructive feedback. Availability of volunteers continues to be an issue but two new volunteers have recently been recruited to the 15 Steps Challenge and it is hoped they will be able to support the 2019/20 visits.

Reoccurring Themes this visit

- Staff continue to show their dedication to their patients ensuring their needs are met and they are well cared for.
- All staff encountered were professional, friendly and welcoming and demonstrated good interaction with their colleagues and patients.
- Storage space for the services continues to be a challenge as does parking at all sites.
- A large amount of information is on display and available for patients and visitors, much is not pertinent and key messages are at risk of getting lost.

Bluebell

The good relationships between staff and patients was evident during this visit. The ward had a relaxed and supportive atmosphere and patients spoken to spoke highly of the care they were receiving.

Henry Tudor

The professional and caring attitude shown by the staff was evident in all areas observed and the ward had a warmth about it that was therapeutic and engaging. Lots of information that could be streamlined to highlight key messages.

Highclere

This friendly, well run ward and their dedicated staff was a pleasure to visit. The staff provide empathic professional care to all their patients in a calm environment.

MIU

A busy unit that appears to enjoy a good reputation in the community with efficient, friendly, helpful and professional staff who are dedicated to providing a good quality service.

Mobility

The staff were very welcoming, fully committed to providing excellent patient care in limited surroundings.

Friends and family team discussion:

All members of the 15 Steps Challenge teams felt that, should a family member or friend be referred to any of the services visited, they would be confident that they would receive professional high quality and therapeutic care.

Pam Mohomed-Hossen and Kate Mellor
Professional Development Nurses
March 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th May 2019
Title	**Quality Account 2018/19**
Purpose	NHS Foundation Trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations"). For the Trust this provides an opportunity to present a balanced account of its quality priorities and performance against these. The report includes some mandated content which can be complex, but should, in general, be accessible for members of the public.
Business Area	Trust Wide
Executive Lead	Medical Director
Authors	Head of Clinical Effectiveness and Clinical Effectiveness Facilitator.
Relevant Strategic Objectives	True North Goal 1- Harm Free Care, True North Goal 2- Supporting Our Staff, True North Goal 3- Good Patient Experience
CQC Registration/Patient Care Impacts	Does not negatively impact on registration or patient care.
Resource Impacts	None
Legal Implications	The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The NHS Improvement annual reporting guidance for the quality report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations and additional reporting requirements set by NHS Improvement.
Equality and Diversity Implications	None
SUMMARY	The Quality Account for 2018/19 consists of three main sections in line with Department of Health and NHS Improvement requirements. Part 1 is the Chief Executive's Statement. Part 2 is a report on the priorities for improvement and statements of assurance from the Board. The priorities for improvement show our achievement against the objectives of the Trusts True North Annual Plan, and are divided into sections relating to; patient experience, patient safety, clinical effectiveness and supporting our staff. Pages 4 and 5 of the Quality Account detail a summary of the Trust achievement against the 2018/19 priorities. The priorities for 2019/20 are directly linked to the True North Annual Plan. Clinicians, Trust Governors and other stakeholders have been consulted through various mechanisms to help agree the priorities. Statements of Assurance from the Board are included and this section must cover specified areas in relation to Clinical Audit, Research, CQUINs, CQC, Data Quality, Information Governance and Learning from Deaths.

	As mandated by NHSI, new updated sections on Freedom to Speak Up and Junior Doctor rota gaps are included in this part. Part 3 is a review of quality performance in 2018/19 and must include at least 3 measures in each of the areas of quality - patient safety, clinical effectiveness and patient experience. The draft Quarter 3 Quality Account was shared with the required stakeholders including the Clinical Commissioning Groups, Health Overview and Scrutiny Committees, Council of Governors and Health and Wellbeing Boards. Comments received are predominantly positive with some areas of clarification identified which we have responded to, all support the consistency of the Quality Account with data and information they are aware of (Appendix G). The Trust Quality Assurance Committee have reviewed the draft account in Q1, Q2 Q3, and Q4 all required actions identified by the QAC have been incorporated within this final version. Our external auditors, Deloittes, are currently auditing the content of the Quality Account to ensure that it meets the requirements set out in 'The detailed requirements for Quality Accounts 2018/19' NHS Improvement (2018). They will then provide an independent assurance report to the Trust Audit Committee in May 2019 which will be submitted with the Quality Accounts to NHS Improvement in May 2019 and published on NHS Choices in June 2019. Board members are asked to note that this version of the Quality Account does not contain details of the following as we are awaiting national publications: • CQUIN achievement, including Cardiometabolic CQUIN results for 2018/19 • National figures for the 7 day follow-up and Gatekeeping core indicators These will be added once published.
ACTION REQUIRED	The Board is asked to seek any clarification required and approve the 2018/19 Quality Account. Directors are asked to consider the Statement of Directors' Responsibilities in Respect of the Quality Account (page 59), and ensure they are satisfied with the quality account in relation to the requirements detailed in this statement. Directors must confirm to the best of their knowledge and belief they have complied with the requirements detailed on page 59 in preparing the Quality Report, and the statement must then be signed by the Chair and Chief Executive by order of the Board to confirm this.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2018/19

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

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

What is a Quality Account?

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

About the Trust

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

We are rated as 'Good' by the Care Quality Commission and our ambition is to achieve a CQC rating of 'Outstanding'. We are currently rated as 'outstanding' in the Well-Led domain.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. This will allow us to transform patient care through new technologies.

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

We have a major focus on the contribution we can make to the local population by working in collaboration with our commissioners and partner providers to identify new ways of working to benefit patients.

As a foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability and have placed us in segment 1, which reflects the highest level of performance for finance and use of resources.

Table of Contents for Quality Account 2018/19

Quality Account Positive Highlights and Overall Summary 2018/19

Highlights

Patient Experience Priorities

- 95% or more of patients responding to the Friends and Family Test (FFT) stated they were likely or extremely likely to recommend many of our services. 71% of respondents stated they would recommend our mental health inpatient services.
- 96% of carers responding to the FFT stated that they were likely or extremely likely to recommend our services.
- The Trust worked with its health and social care partners to improve system-wide patient satisfaction and outcomes, as part of Integrated Care Systems (ICS).

Patient Safety Priorities

We have continued to implement our Quality Improvement and Zero Suicide programmes which have had specific impact on the following.

- Preventing patient falls on our community inpatient wards.
- Self-harm incidents continue to reduce and were below the target threshold.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits and ensured that appropriate actions are taken and improvements made.
- We have a robust system for reviewing NICE guidance to ensure that care is delivered in line with national standards.
- Ensuring patients can access care locally is a high priority and we remain below the local threshold for patients having to be treated elsewhere due to availability of beds.
- The Trust continues reviewing, reporting and learning from deaths in line with national guidance.

Supporting our Staff Priorities

We have met our target to reduce staff vacancies to below 10% in the year to date and to train an additional 24 services in our Quality Improvement System.

Care Quality Commission (CQC) Rating

The Trust continues to be rated as 'Good' overall and is rated as 'Outstanding' in the Well-Led Domain.

2019/20 Trust Priorities

Patient Safety Priorities

1. We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia. Specific targets are detailed in main body of report
2. At least 95% of our reported incidents will be low or no harm to patients.
3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20. All our support services will work with patient facing services to identify ways that they can support safety of patients.
4. With our health and social care partners, we will work to achieve reduced urgent admissions and delayed transfers of care.

Clinical Effectiveness Priorities

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities in this report.
2. We will continue to review, report and learn from deaths in line with new national guidance as published

Patient Experience Priorities

1. We will achieve a 95% satisfaction rate and 15% response rate in our FFT, with 60% of staff reporting use of patient feedback to make informed decisions
2. All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population.
3. We will reduce instances of prone restraint to no more than 2 per month
4. With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

Supporting our Staff Priorities

1. We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of staff feeling they can make improvements at work to above 70%, with more than 85% of staff recommending our Trust as a place to receive treatment.
2. We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%.
3. We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%.
4. We will achieve our objectives for equality of opportunity and staff wellbeing.
5. With our health and social care partners we will enhance career development opportunities and improve our workforce planning.

Figure 1- Summary of Trust achievement against 2018/19 Quality Account Priorities

Priority, Indicator and target		Results 2017/18	Results 2018/19	Comment & Change from 17/18- 18/19
Patient Experience				
Patient Friends and Family Test (FFT) - % of patients stating they are likely or extremely likely to recommend the service to a friend or family member. (Target ≥95% of respondents)	Community Services (Mental health and physical health combined).	96%	**94%**	**Target Not Met**
	Mental Health Inpatients.	67%	**71%**	**Target Not Met**
	Community Hospital Inpatients.	97%	**96%**	**Target Met**
	Minor Injury Unit.	98%	**98%**	**Target Met**
Trust Patient Satisfaction Survey- % of Patients rating the service they received as good or very good	Community Mental Health.	85%	**85%**	**No Change**
	Community Physical Health.	93%	**89%**	**Change -4%**
	Mental Health Inpatients.	72%	**66%**	**Change -6%**
	Patients in Community Hospitals.	97%	**98%**	**Change +1%**
Carer Friends and Family Test (FFT) - % of carers likely or extremely likely to recommend the service to a friend or family member.		97%	**96%**	**Change -1%**
Staff report using service user feedback to make informed decisions in their department. (Target- ≥60% of staff, Source- National NHS Staff Survey).		57%	**61%**	**Target Met**
Reduce use of prone restraint (Target ≤2 cases by the end of March 2019).		N/A	**3 in March 19**	**Target Not Met**
The Trust will contribute to Integrated Care Systems (ICS) to improve patient experience and outcomes.		N/A	**Met**	**Target Met**
Reduce Delayed Transfers of Care across inpatient services. (Target <7.5%).		11.3%	**9.0%**	**Target Not Met**
National Community Mental Health Survey- Overall result (score out of 10).		7.3	**7.2**	**Change -0.1**
Patient Safety				
Continue Trust Quality Improvement (QI) Programme.		N/A	**Met**	**Target Met**
Continue Trust Zero Suicide Programme.		Met	**Met**	**Target Met**
Reduce patient falls on wards for older people (Target 50% reduction).		345	**468**	**Target Not Met**
Reduce the Rate of inpatient falls on wards for older people (Target ≤8 per 1000 bed days).	Older Peoples Mental Health Wards	9.66	**16.59**	**Target Not Met**
	Community Health Wards	4.65	**6.02**	**Target Met**
Reduce patient self-harm incidents (Target ≤87 per month)		N/A	**78**	**Target Met**
Achieve an 'Outstanding' overall Care Quality Commission (CQC) Rating		Good	**Good**	**Target Not Met**
Reduce the total number of bed days patients spend in an Inappropriate Out of Area Mental Health Placement (OAP). (Targets set by Berkshire East CCG and Berkshire West CCG- see main report)		N/A	**Met**	**Target Met**
Clinical Effectiveness				
Compliance with NICE Guideline on long term management of Self Harm		N/A	**96%**	**Target Met**
Continue to review, report and learn from deaths in line with new national guidance as it is published		Met	**Met**	**Target Met**
Supporting our Staff				
Staff report feeling they can make improvements at work (Target- ≥66% of staff, Source- National NHS Staff Survey)		N/A	**64.4%**	**Target Not Met**
Staff agree or strongly agree they would recommend the Trust as a place to receive treatment (Target- ≥75% of staff, Source- National NHS Staff Survey)		75%	**73.6%**	**Target Not Met**
Reduce assaults on staff (Target <36 per month)		N/A	**45**	**Target Not Met**
Reduce Staff Vacancies (Reduce to below 10%)		N/A	**Met**	**Target Met**
Train an additional 24 services in the Trust Quality Improvement System		N/A	**Met**	**Target Met**
Achieve objectives set out in equality plans for each area		N/A	**Met**	**Target Met**
Participate in Integrated Care System ICS) work streams to enhance job satisfaction and career development opportunities		N/A	**Met**	**Target Met**

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

Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients through 2018/19. We have a Trust-wide vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust continues to be rated as 'Good' by the Care Quality Commission (CQC) and has been awarded an 'Outstanding' rating in the Well-Led Domain. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities has also been rated as 'Outstanding' following assessment this year.

We continue to implement our Quality Improvement (QI) programme across the Trust, with more staff being trained in its methodology. This allows us to apply a consistent approach to continuous improvement, resulting in a better experience and outcome for patients and staff. Several of the improvements arising from this programme are included in this Quality Report.

We are committed to ensuring that patients have a positive experience of the care we provide and we continue to prioritise learning from patient experience surveys, complaints and compliments. Feedback from patient surveys has been largely positive this year and we aim to improve on and learn from this feedback.

Patient safety will always be of paramount importance to us, and our Trust board monitors performance in this area through scrutiny of a variety of patient safety metrics, several of which are shared in this report. We maintain robust governance, patient safety, incident and mortality reporting systems which are able to highlight areas for improvement in a timely manner allowing for learning. This year, we have focused on improving safety in a number of areas, including reducing prone restraint and self-harm, and we will continue striving to improve in these areas.

Our clinical effectiveness agenda helps to ensure that we are providing the right care to the right patient at the right time and in the right place. Our clinical audit and NICE programmes allow us to measure our care against current best practice leading to improvement. This report details the work undertaken in this area.

Our programme of learning from deaths is important as it allows us to systematically and continuously review the care we have provided.. It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunities for learning from deaths are not missed, together with learning from the review of the care provided and the experience in the period prior to the person's death. This work is scrutinised by our Board and reported publicly.

Following the publication of the report into the deaths at Gosport War Memorial Hospital, it is increasingly important that Trusts have robust systems in place that enable staff to 'speak up' about potential patient safety issues without fear of repercussions. This report outlines how we enable our staff to do this.

Our Trust is committed to the principles of system working and is actively involved with the Berkshire West and Frimley Integrated Care Systems in finding sustainable population based solutions for meeting the physical and mental health needs of our patients and service users. This report details some of our activity to achieve this with our partners during the year.

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

I would like to thank all staff for their hard work and commitment, and the vital contribution they make to the lives of our patients.

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

Julian Emms CEO

"My elderly relative was admitted to the care of Rowan Ward at the end of 2018. At which point she had hit crisis point and we were really shocked and distressed at her behaviour! She was diagnosed with dementia with Lewy bodies and was extremely poorly! The staff on Rowan Ward were unbelievably supportive and caring not only to her but to us as a family. They remained positive and provided endless encouragement, even though at times we found the situation extremely difficult! After nearly six weeks through their care, support and professionalism, my relative returned home with a support package! As a family we cannot thank these wonderful people enough, from the bottom of hearts we thank them all for giving us our relative back! Each and every one of them are an absolute credit to the NHS and they all went above and beyond the call of duty. It just goes to show with the right support and care miracles do happen!!"

From a relative of a patient- Rowan Ward, Prospect Park Hospital, Reading

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

2.1. Achievement of Priorities for Improvement for 2018/19

ⓘ This section details the Trust's achievements against its quality account priorities for 2018/19. These priorities were identified, agreed and published as part of the Trust's 2017/18 quality account.

These quality account priorities support the goals detailed in the Trust's 2018/19 True North Annual Plan (see Appendix A). The Trust's Clinical Effectiveness Strategy also supports this through the following six elements:

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

2.1.1 Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2018/19.

Our 2018/19 Patient Experience Priorities:

1. To achieve a 95% satisfaction rate in our Friends and Family Test (FFT) and 60% of staff reporting use of service user feedback to make informed decisions in their department
2. To reduce our use of prone restraint by 90% by the end of 2018/19 (Target: ≤2 cases by the end of March 2019)
3. All our services will focus on understanding and supporting outcomes of care that are important to patients
4. At a system level, to contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes and reduce delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

Trust performance in relation to complaints, compliments and the 2018 National Community Mental Health Survey is also detailed in this sub-section.

Patient Friends and Family Test (FFT)

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

Response Rate

The Trust aims to achieve a response rate of at least 15%. It should be noted that in 2018/19 the Trust changed its methodology on how it reports the Friends and Family Test and therefore this year's performance should not be compared with that of last year. Figure 2 below demonstrates the response rate each quarter. During the whole of 2018/19 the overall response rate was above the 15% target at 15.2%.

Satisfaction Rate- Target 95%

One of the trust's targets for 2018/19 is to achieve a 95% satisfaction rate in the FFT. Figures 3 and 4 below demonstrate the Trust's achievement in relation to this target by showing the percentage of respondents stating they were extremely likely or likely to recommend services.

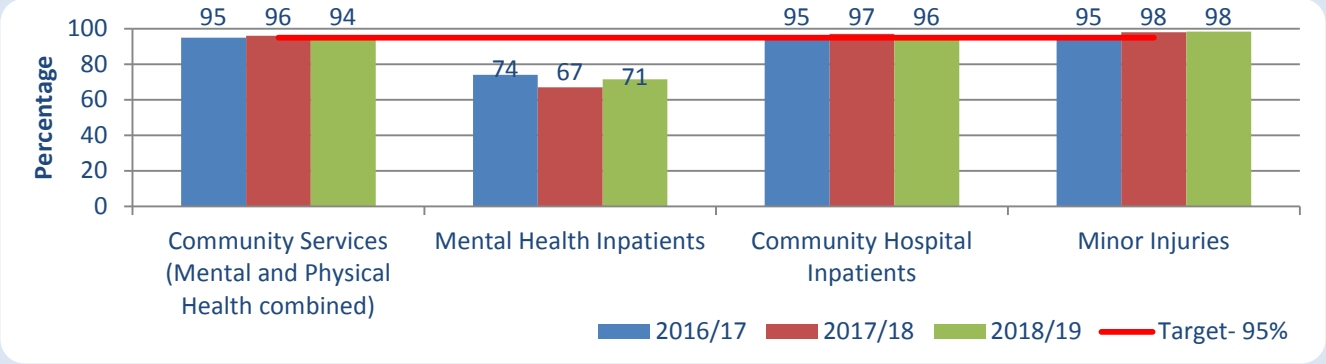
The figures show that the Trust's community inpatient services and minor Injury services met the target during 2018/19. Community services (mental health and physical health combined) were close to meeting the target with a rating of 94%. Mental Health inpatients were below target at 71%, but this is above the 2017/18 figure.

Figure 2- Response Rate for Patient FFT

2018/19 Quarter	Q1	Q2	Q3	Q4	2018/19 Full Year
% Response Rate	11.8	14.8	12.8	22.0	15.2

Source: Trust Patient Experience Reports

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



Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk-In Centre prior to its transfer to another organisation in September 2017

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

Survey and Service	2017/18			2018/19		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
Community Services- Mental Health & Physical Health Combined	15399	14718	96	**30078**	**28321**	**94**
Mental Health Inpatients	87	58	67	**480**	**343**	**71**
Community Hospital Inpatients	1057	1028	97	**930**	**894**	**96**
Minor Injuries Unit	3094	3035	98	**2245**	**2209**	**98**

Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk In Centre prior to its transfer to another organisation in September 2017

Carer Friends and Family Test (FFT)

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

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test and detail the percentage of respondents that stated they were extremely likely or likely to recommend Trust services. The figures show that the 2018/19 score (96%) is just below that of the 2017/18 full year finding, and is based on a greater number of respondents.

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

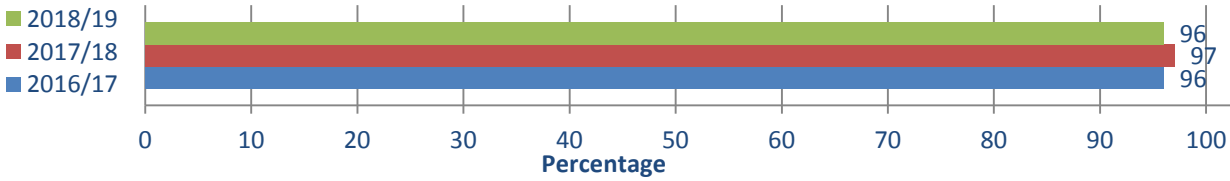


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2017/18			2018/19		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	269	261	97	**849**	**815**	**96**

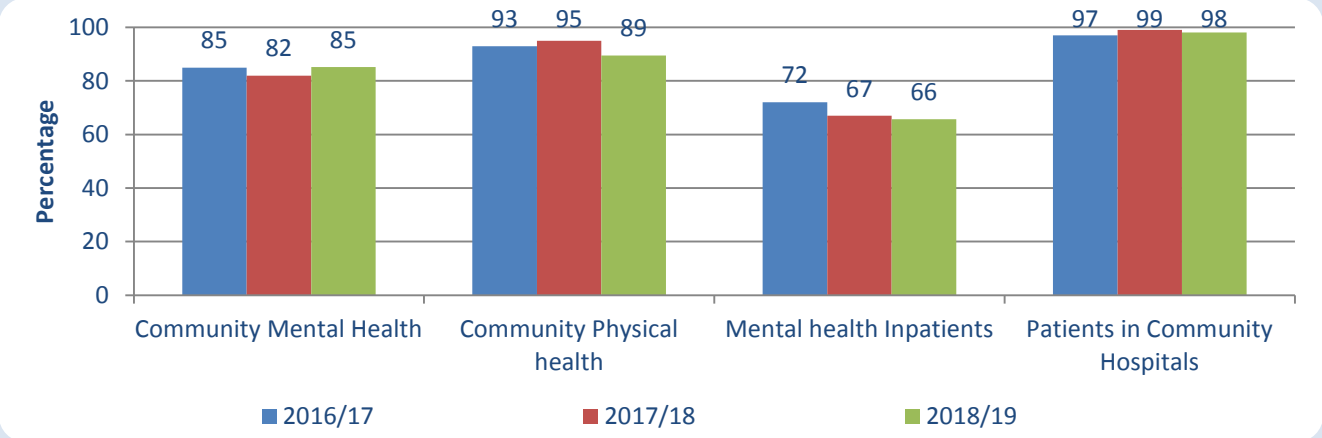
Source: Trust Patient Experience Reports Please note that the Trust does not have a response rate for this survey.

Trust Patient Satisfaction Survey

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

Figures 7 and 8 below demonstrate the Trust's performance in relation to this survey. The figures show that in 2018/19, 98% of respondents rated the care they received in community hospitals as good or very good, but this figure is based on a smaller number of respondents than in 2017/18. Community mental health and community physical health services were also highly rated. 66% of mental health inpatient respondents rated the service as good or very good in 2018/19, and this is based on a greater number of respondents when compared with the 2017/18 figures.

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



Source: Trust Patient Experience Report

Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2017/18			2018/19		
	Total number of respondents	Total rating service as good or very good	% rating service as good or very good	Total number of respondents	Total rating service as good or very good	% rating service as good or very good
Community Mental Health	1203	985	82	**3197**	**2722**	**85**
Community Physical Health	12193	11559	95	**7896**	**7062**	**89**
Mental Health Inpatients	6	4	67	**417**	**274**	**66**
Patients in Comm. Hospitals	341	336	99	**53**	**52**	**98**

Source: Trust Patient Experience Reports

Staff Use of Service User Feedback to make Informed Decisions about their Department

ⓘ One of the Trust's targets for 2018/19 is that 60% of staff will report that they use service user feedback to make informed decisions about their department.

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question and so this target has been met.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments during the year. Figures 9 and 10 below show the number of complaints and compliments received by the Trust.

There were a total of 230 formal complaints received during 2018/19 compared with 209 in 2017/18.

During Quarter 4 of 2018/19, the trust received 50 formal complaints- a decrease compared with all other quarters during the year (60 in Q1, 63 in Q2 and 57 in Q3).

Of the 50 complaints reported in Q4 of 2018/19:

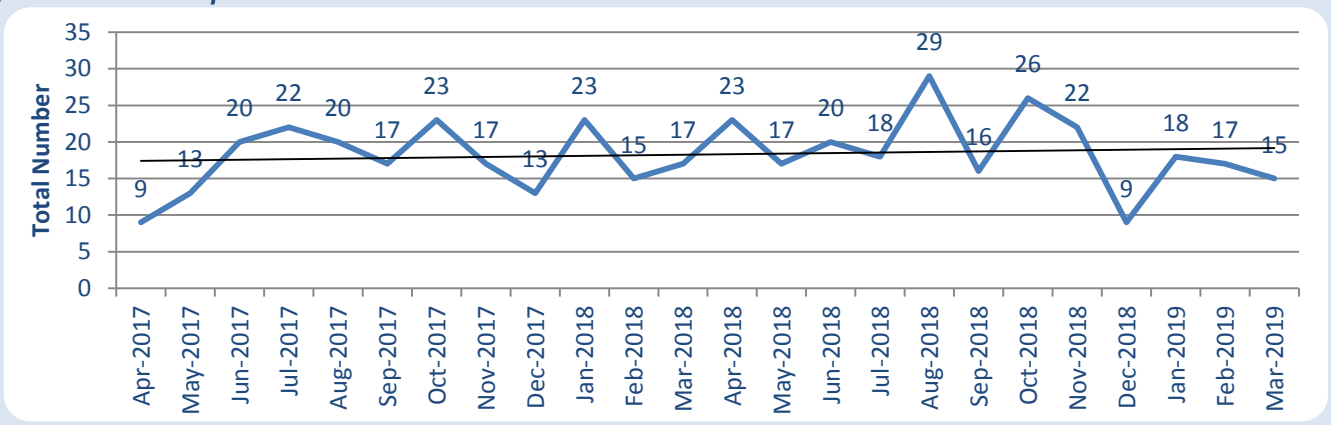
- 27 (54%) related to adult mental health service provision, of which:
  - 9 (18%) related to Community Mental Health Teams (CMHT), a reduction compared with Q1 (16), Q2 (11) and Q3 (10).
  - 5 (10%) related to Mental Health Inpatient services, a reduction compared with Q1 (9), Q2 (12) and Q3 (8).
  - 4 (8%) related to Crisis Resolution and Home Treatment Teams (CRHTT)- a similar number to those received in previous quarters.
- 14 (28%) related to community health service provision
- 6 (12%) related to Child and Adolescent Mental Health services (CAMHS) compared with 5 (Q1), 6 (Q2) and 8 (Q3).

Each service takes complaints seriously, with staff directly involved in the complaint asked to reflect on the issues raised and consider how they will change their practice.

100% of complaints were acknowledged within three working days during 2018/19, with 100% being resolved within the timescale agreed with the complainant.

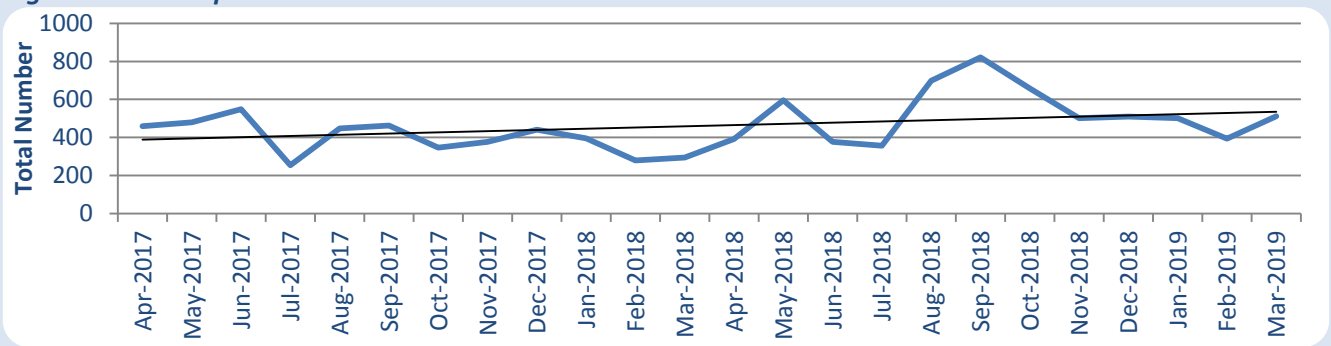
Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

Figure 9- Complaints received



Source: Trust Complaints Report

Figure 10- Compliments received



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

Use of Prone (Face-Down) Restraint

ⓘ Prone restraint is a type of physical restraint where a person is held chest down, whether the patient placed themselves in this position or not, is resistive or not and whether the person has their face down or to the side. Guidance from the Department of Health, places an increasing focus on the use of preventive approaches and de-escalation for managing violent and aggressive behaviour. All restrictive interventions should be for the shortest time possible and use the least restrictive means to meet the immediate need.

All restraint positions have risks however with prone restraint there is a risk of positional asphyxia (difficulty breathing) which is why it is only to be used as a last resort.

One of the Trust's targets for 2018/19 is to reduce the use of prone restraint by 90% by the end of 2018/19. This means that there should be ≤2 cases reported by the end of March 2019.

A project group has been established at Prospect Park Hospital to address this target using Quality Improvement (QI) methodology. Following a rapid improvement event, the following measures were initiated in July 2018 and are being tested using the plan, do, study, act (PDSA) approach:

- Safety Huddle on Snowdrop Ward – this is still being tested
- A response/debrief role on Sorrel Ward- the hospital Psychiatric Intensive Care Unit (PICU). – this is still being tested
- Early warning signs forms on Sorrel Ward (PICU) – this is still being tested
- Use of a bean bag for seclusion exits- this has been tested and now implemented
- Training in the use of supine (face-up) restraint and how to administer Intramuscular (IM) medication in this position- This has also been tested and now implemented across all wards.

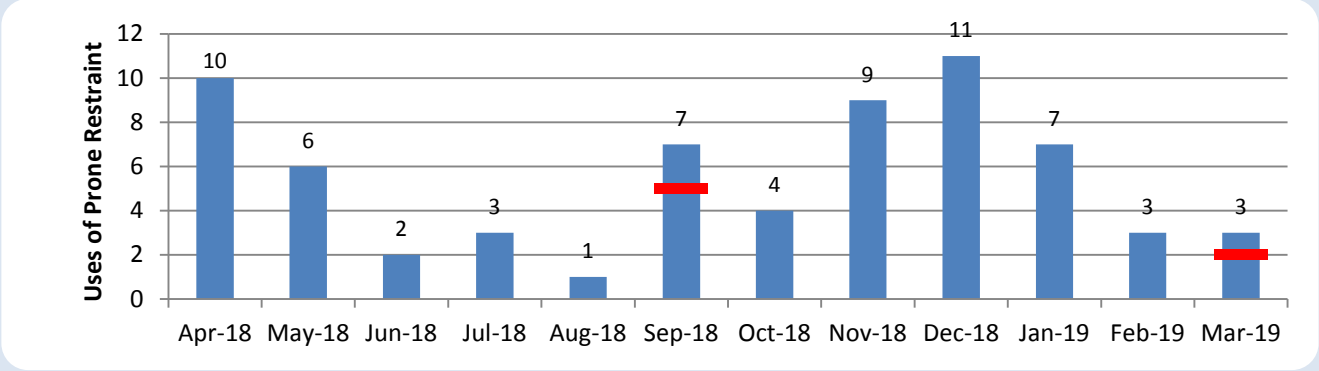
In addition to these measures, a number of other 'quick- win' measures have been implemented to address this target. These include:

- Public Health Model (PHM) management planning
- Introduction of post incident review meetings to support the PHM process of risk formulation and management.
- Detailed focus on and assessment of non-physical skills in Prevention Management of Violence and Aggression (PMVA).
- A poster highlighting the risks of prone restraint has been developed and now displayed in staff areas on the ward.
- Each episode of prone restraint is thoroughly reviewed by the nurse consultant to pick up themes and reasons for any use of prone restraint.
- Changes have been made to the Datix incident database structure to ensure accurate reporting and better understanding of the incidents.

The monthly number of cases of prone restraint in Trust mental health care is detailed in Figure 11 below and shows that the target of having no more than two cases of prone restraint in March 2019 was just missed, with three cases of prone restraint in this month.

The Trust will continue to prioritise reducing prone restraint in 2019/20.

Figure 11- Monthly uses of prone restraint in Trust mental health services Target- 5 per month by September 2018 then 2 per month by March 2019



Source- Trust Tableau Dashboard

Understanding and Supporting Outcomes of Care that are Important to Patients

ⓘ One of the trusts priorities for 2018/19 is to ensure that all services focus on understanding and supporting outcomes of care that are important to patients

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question.

Contributing to Integrated Care Work Streams to Improve Patient Experience and Outcomes

ⓘ Integrated Care Systems (ICS) are partnerships between NHS Organisations, Local Authorities and other stakeholders which aim to improve the health and care of the population they serve. Organisations in each ICS take collective responsibility for managing resources and delivering NHS Standards across their population.

The Trust is a member of two ICS:

- Berkshire West ICS- covering covers a population of approx. 528,000 residents in Reading, West Berkshire and Wokingham. Berkshire West CCG and The Royal Berkshire NHS Foundation Trust are also part of this ICS, which is now aiming to align its work with the "Berkshire West 10 Integration Partnership", including Local Authority partners.
- Frimley Health and Care ICS cover a population of approx.726,000 residents in East Berkshire, North East Hampshire and Farnham and Surrey Heath. Berkshire East CCG, Frimley Health NHS Foundation Trust (including Wexham Park Hospital) and our Local Authority partners in Bracknell, Slough, Windsor and Maidenhead and Bracknell Forest County Council.

During 2018/19, the Trust has participated in the following workstreams to improve patient experience and outcomes:

- The ongoing development of the Berkshire-wide Connected Care programme which will deliver joined up care planning and delivery across health and social care through shared electronic records.
- The mental health priorities in Frimley Health and Care ICS are Out of Area Placements, Crisis Care, Perinatal Mental Health and access to Child and Adolescent Mental Health Services. A reference group, made up of service user and carer representatives, has been set up to inform our planning of services.
- Integrated Care Decision Making Hubs in Frimley Health and Care ICS are being developed to enable patients to receive more joined up out of hospital care, minimising non-elective admissions and delayed transfers of care.
- A Musculoskeletal (MSK) pathway in Berkshire West ICS is being developed to provide more treatment in community based services. This involves joint working between the Trust, Royal Berkshire Hospital Foundation NHS Trust, GPs and Physiotherapy Alliances

Reducing Mental Health Delayed Transfers of Care

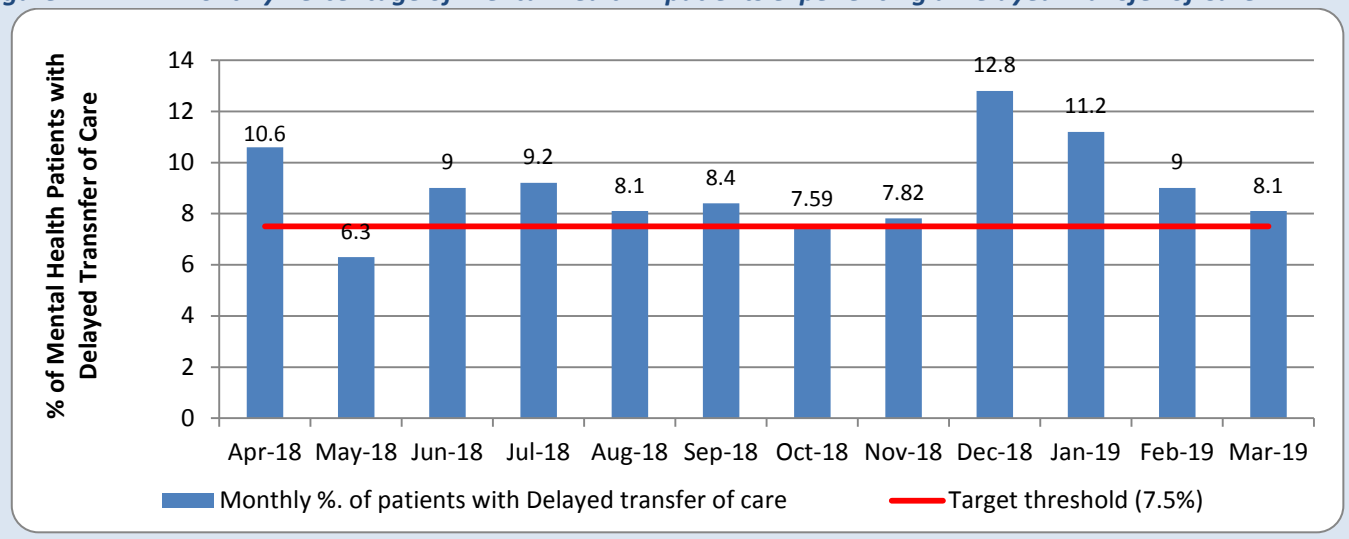
A mental health delayed transfer of care occurs when a patient is ready for discharge and is still occupying a bed.

One of the Trust priorities for 2018/19 is to reduce the number of mental health delayed transfers of care. This is achieved through:

- Closer monitoring and action to prevent potential delays for patients e.g. patients who may not have accommodation to return to.
- Weekly Reporting of actual delays (i.e. where a patient no longer needs to be in hospital for treatment, and daily discussion with clinical teams at the bed meeting).
- Close working with Local Authority and Clinical Commissioning Group (CCG) partners to minimise any delays that could be related to funding decisions.
- Setting an intended discharge date earlier in a patient's admission, so that they, their family members family and other parties have clear expectations to work towards
- Monthly review of delays and monitoring against targets to reach and sustain targets

Figure 12 below demonstrates performance against this priority. The chart shows that performance in this is in breach of the 7.5% target threshold, with a monthly average of 9.0% of mental health inpatients experiencing a delayed transfer of care in 2018/19.

Figure 12- Monthly Percentage of Mental Health inpatients experiencing a Delayed Transfer of Care



Source- Trust Tableau Dashboard

"My relative was rushed in for assessment - staff were amazing. The staff in the minor injuries department were exceptional at looking after my relative and I. We were advised to head straight there following a call with a 111 doctor. Once we arrived they saw my relative immediately, supported us both emotionally and looked after my relative's deteriorating physical health. They contacted the emergency ambulance service very quickly and did everything they could to make our experience as easy as possible. I was and am very impressed by the staff that we saw that evening. A huge thank you!

From a relative of a patient- Minor Injuries Unit, West Berkshire Community Hospital, Newbury

National NHS Community Mental Health Survey 2018

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

The Survey Sample

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 September 2017 and 30 November 2017. Responses were received from 270 people meeting these criteria, representing a 33% response rate. This is a 4% increase from the Trust response rate in 2017 and 5% above the 2018 national response rate.

About the Survey and how it is scored

The 2018 survey contained 37 questions organised across 11 sections. Individual survey responses were converted into scores on a scale from 0 to 10, with 10 representing the best and 0 the worst possible response. Each Trust score was then graded according to where it ranked against all participating trusts.

Summary of Trust results

The Trust scored about the same as other Trusts across all sections of the 2018 survey- the same as in the 2017 survey. The Trust also scored about the same as other Trusts across all questions in the 2018 survey, with the exception of two questions where the trust scored amongst the best performing trusts:

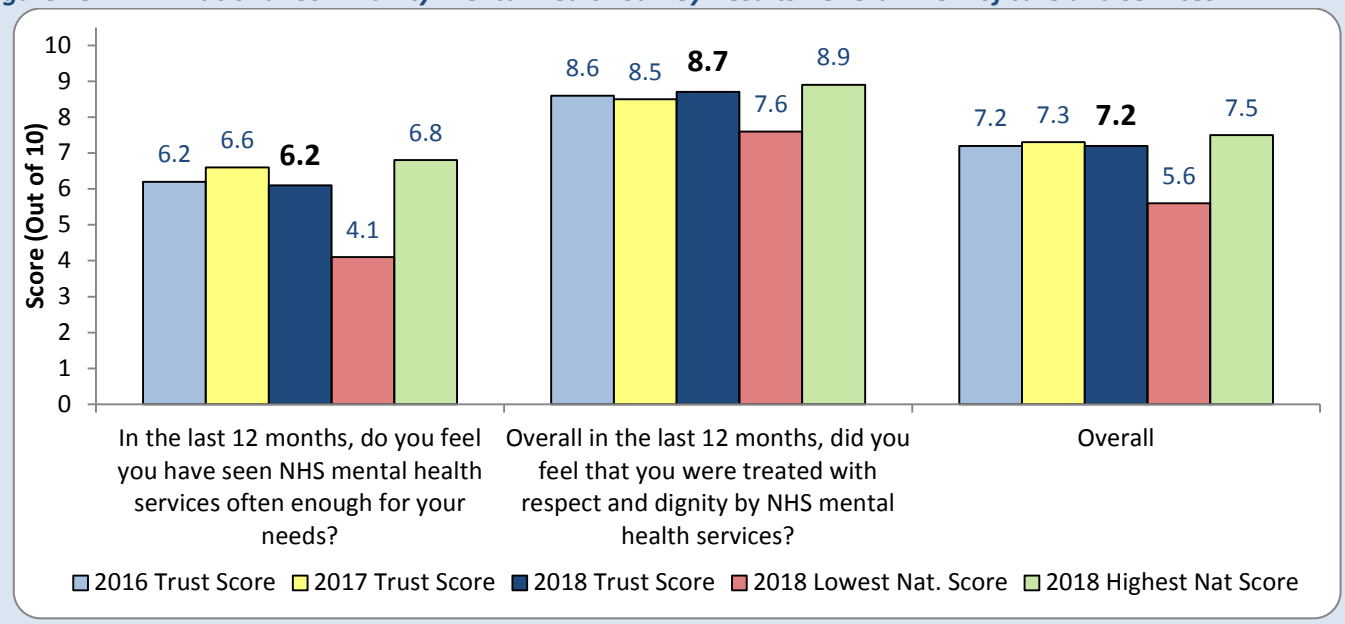
- Support and Wellbeing- Q36. Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?
- Overall views of care and services- Q38: Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Respondents' overall view of care and experience

Figure 13 below gives an overview of scores for the Trust in relation to respondents' overall views of the care and service they received and their overall experience. The 2018 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved by other Trusts in 2018 (the red and green bars), and with the comparable Trust score in both 2016 and 2017 (the light blue and yellow bars).

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

Figure 13- National Community Mental Health Survey Results - Overall view of care and services



Source: National Community Mental Health Survey

2.1.2 Patient Safety

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

Our 2018/19 Patient Safety Priorities:

1. To drive quality improvement through the continued delivery of the Trust Quality Improvement Programme
2. To align our efforts and work to deliver the following harm-free objectives:
   - Reducing patient falls incidents on Older People's Inpatient Wards by 50%
   - Reducing patient self-harm incidents by 30%
   - Reducing rates of suicide of people under our care by 10% by 2021
3. All our services will contribute towards achieving an "Outstanding" overall Care Quality Commission (CQC) rating. Please note that this priority is reported on in the CQC sub-section of the "Statements of Assurance from the Board" section later in this report
4. At a system level, to achieve reductions in urgent admissions (Inappropriate Out of Area Mental Health Placements).

The Trust's aim throughout the year has been to foster an environment where staff members can be confident to raise concerns about patient safety. In support of this, a 'Freedom to Speak Up' policy has been implemented, and this is described further Section 2.1.4- Organisational Culture

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

Learning occurs across the organisation with respect to errors, incidents, near misses and complaints. The Trust has continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaborative.

Further information on Incidents is contained within section 3 of this report, with additional Trust patient safety thermometer metrics, including those relating to various types of harm included in Appendix D.

The Trust Quality Improvement Programme

ⓘ The Trust introduced an organisational Quality Improvement (QI) Programme in 2017/18. This programme enables a consistent approach to continuous improvement across the whole Trust. This is achieved by introducing new techniques, education, tools and training that focus on reducing waste and adding value for patients and staff.

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

The QI programme has four workstreams and a brief summary of progress with each is given below.

1. **The Quality Improvement (QI) Office-** *Ensuring structured accountability, support and dedicated resources are in place for improvement activity. Developing capabilities for improvement across the Organisation.*

The QI team and the Trust have been accredited as a Lean Organisation with the Lean Competency System (LCS) - the first NHS Trust in the UK to do so. This is a great achievement for both the Trust and the QI team and allows training to be run in-house, rather than relying on external consultancies. This will mean that bespoke Lean training can be delivered to meet specific Trust needs. 42 members of staff have been accredited by the Trust as Yellow Belt practitioners, with 20 members of staff due to qualify as Green Belt practitioners soon.

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

Waves 6 and 7 of QMIS training (with 7 teams in each wave) are now underway. Out of a total of 160 teams, 40 teams will have been trained once Wave 7 has been completed

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

True North is now well established in the Trust. The Annual Plan on a Page, showing the goals and metrics for each element of the Trust's True North, has been disseminated throughout the organisation.

4. **Improvement Projects:-** *Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques*

The Emotionally Unstable Personality Disorder Pathway Project (EUPD) continues in its Implementation phase. This project aims to develop an end-to-end pathway for some of our most challenging mental health patients, including those with non-psychotic personality disorder. Roll out of implementation is taking place in Bracknell and Wokingham localities.

Reducing Falls on Older People's Inpatient Wards

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

The Trust has set a priority to reduce falls on its older people's inpatient wards by 50% during 2018/19 compared with 2017/18.

Trust clinicians have worked closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidence-based ways of reducing falls in services. This has included implementing the Royal College of Physicians FallSafe care bundles, which involves the analysis of falls data on each ward, completing a gap analysis and then identifying suitable care bundles to implement on each ward to reduce falls.

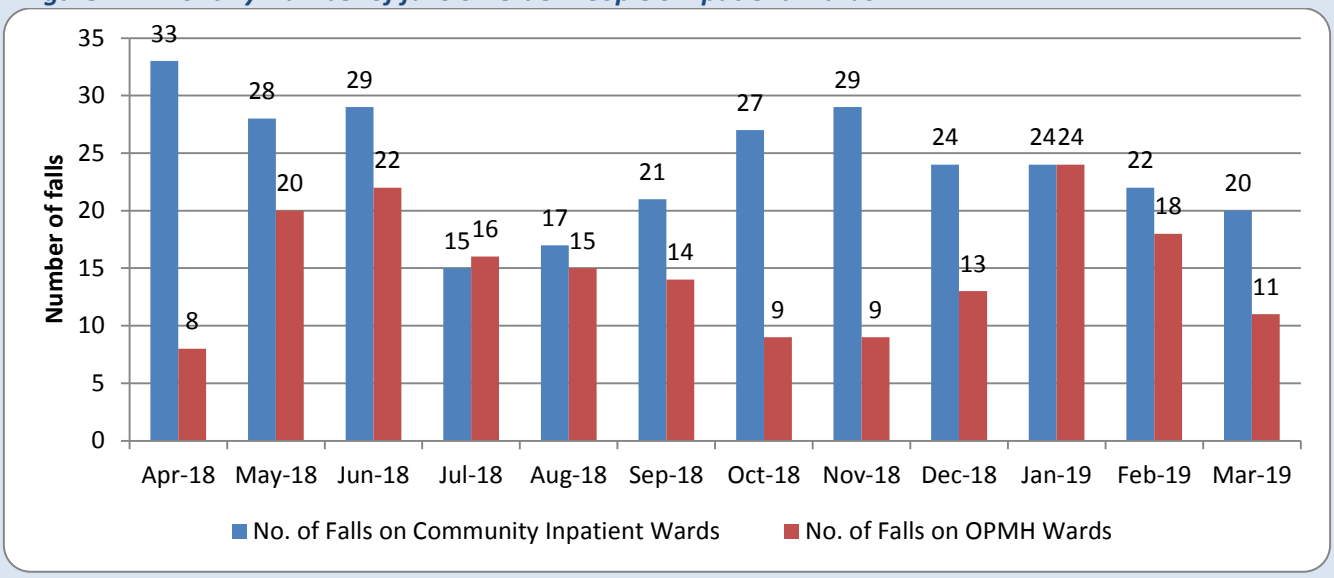
In order to address the target, both of the Trust's Older Peoples Mental Health (OPMH) wards at Prospect Park Hospital are working to reduce the number of falls as part of a Quality Improvement initiative during 2018/19. They will be analysing their falls data to understand why the falls occurred and then implement preventative measures using the Plan Do Study Act (PDSA) methodology. We continue to explore options for assistive technologies to help staff monitor patients at risk of falls. The risk of a patient falling and mitigation is recorded on the patients clinical record (RiO) used on the OPMH wards.

Progress against this priority will also be monitored against a target of no more than 8 falls per 1000 bed

days (taken from a National Patient Safety Agency target developed in 2007). Figures 14 and 15 below detail the number of falls and achievement against the target rate.

The figures show that Community Hospital inpatients have maintained achieved a rate of below 8 during the year, at 6.02 falls per 1000 bed days. Falls on OPMH wards were above the threshold at 16.59 falls per 1000 bed days for the year. OPMH wards cared for a number of patients who fell numerous times during the year. As a result, the falls assessment has been reviewed and is due to be incorporated in the risk summary on RIO. Patient specific care plans relating to falls management are also being reviewed together with the process that is carried out following a patient falling on one the older adult wards.

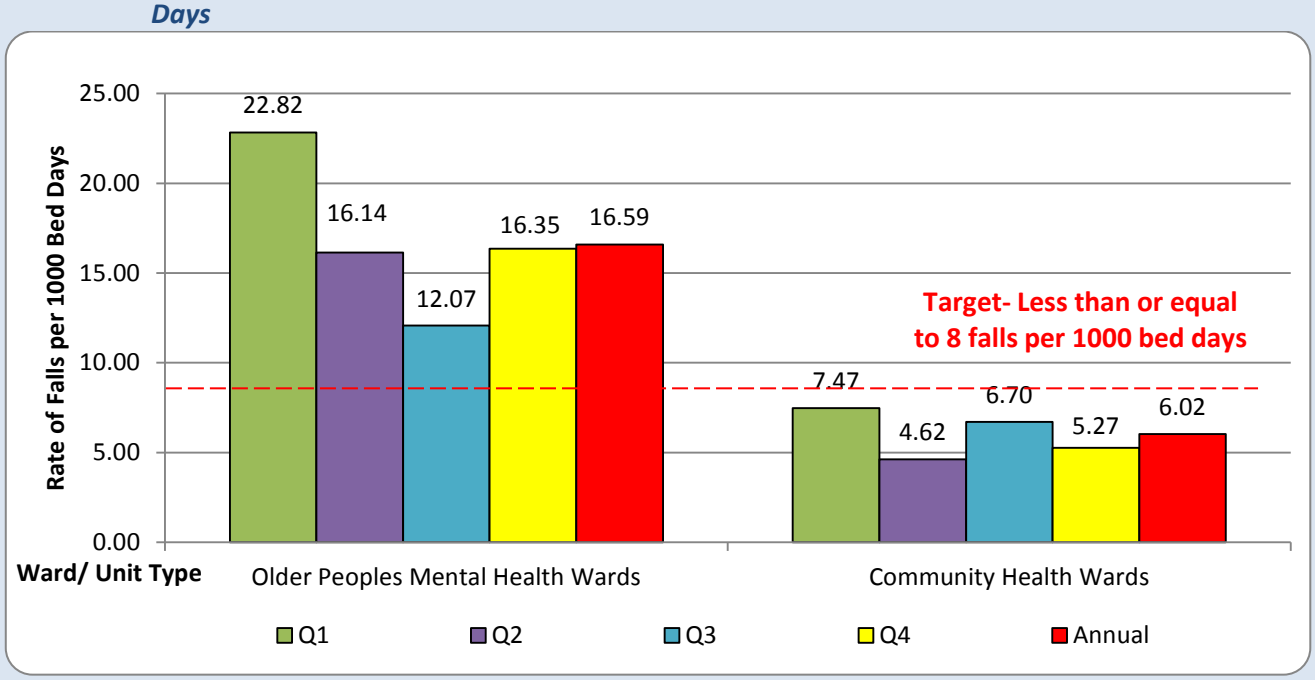
Figure 14- Monthly Number of falls on Older People's Inpatient Wards



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

Source- Trust Tableau Dashboard

Figure 15- Rate of falls per 1000 bed days- Split by Ward Type (Target- less than or equal to 8 per 1000 bed Days



Sources- Trust Falls and Occupied Bed Days data provided on Tableau

Reducing Self-Harm Incidents

ⓘ Self-harm is when an individual intentionally injures themselves as a way of dealing with or expressing overwhelming emotional distress. It is sometimes carried out when individuals feel they have no other option

The Trust has set a priority to reduce patient self-harm incidents reported for patients under trust care by 30%. The target is to have ≤87 such incidents each month.

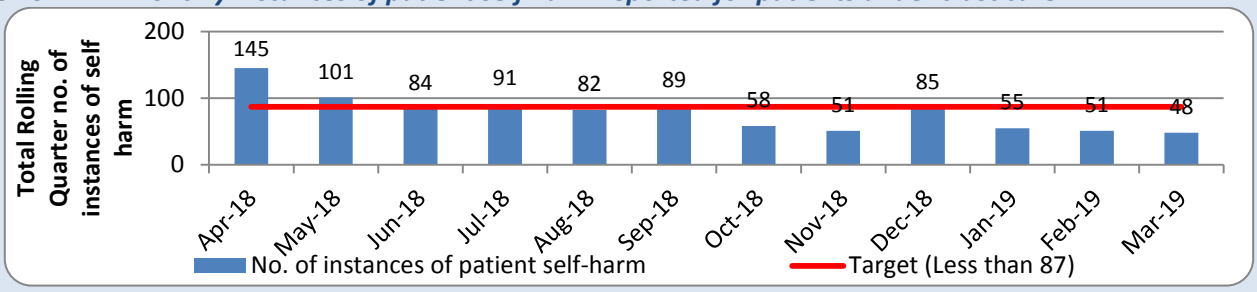
Using Quality Improvement methodology (QMIS), four of the adult mental health wards at Prospect Park Hospital and Willow House Adolescent Unit have identified the reduction of self-harm incidents as a priority. Each ward has developed actions in an attempt to reduce the number of such incidents on their units. Progress against this is reported.

The following factors have been identified as contributing to self-harm:

- Boredom in the evening (18.00-20.00)
  We are trialling an activity room approach in the early evening.
- Communication of distress in the early hours of the morning (01.00-02.00)
  We are investigating the case data on communication of distress and bad news mitigation with psychology colleagues to understand if this is a theme.
- Searches unable to detect contraband items
  Use of therapeutic searching.

Figure 16 below shows trust performance during 2018/19. As can be seen, the monthly number of self harm incidents reported was below target for 8 of the 12 months in the year, with an average number of 78 self-harm incidents reported per month which is below the threshold of 87.

Figure 16- Monthly instances of patient self harm reported for patients under trust care



Source- Trust Tableau Dashboard

Suicide Prevention- Zero Suicide

ⓘ The trust vision is to focus on suicide prevention by developing staff skill and knowledge, creating a no blame culture and supporting service users and their families through safety planning.

The Trust has set a target to maintain a 10% reduction from the 2015/16 baseline rate of suicides of people under Trust mental healthcare by 2020/21.

The 2018 "Zero Suicide" programme of work has focused on 4 main areas, with the following achieved in 2018/19:

1. Despite the increase in the numbers of suicide compared to 2017/18, the Trust is on target to see a reduction of 10% in the overall suicide rate compared to the 2016 baseline (9.2 deaths per 10,000 people under MH care) by April 2021. It has been repeatedly highlighted that suicide rates should be viewed over a 5-10 year period and we must be mindful that changes based on year-on-year data could be natural fluctuations rather than the beginning of a longer-term trend.
2. We have seen a decrease in the number of staff reporting they feel blamed when a suicide occurs compared to baseline data down to 8% from 16% (Zero Suicide Workforce Survey)
3. Leadership around communicating the key messages and expectations across the organization about suicide prevention being a priority for the Trust has been an important element of the project this year. 86% of staff reported that Leaders have explicitly communicated that suicide prevention is a priority.

4. Training - significant resource has been dedicated to the 3 day bespoke training, e- learning, ad-hoc training, workshops and a conference in December 2018 has seen staff reporting an increase in the skills and confidence compared to baseline (80% of staff admin and clinical compared to 62%).

Figures 17 and 18 below show the monthly number and yearly rate of suicides per 10,000 people under Trust mental healthcare. Figure 16a shows that the trust rate has again fallen to below the 10% reduction target rate (compared to the baseline 15/16 rate of 9.2 per 10,000 people under mental healthcare). However, it is important to continue to monitor the rate to determine if this can be sustained.

Figure 17- Number of suicides per 10,000 people under Berkshire Healthcare NHS Foundation Trust Mental Healthcare

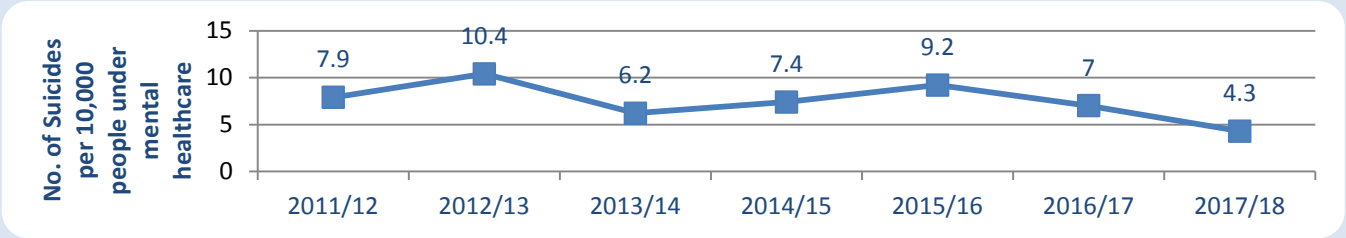
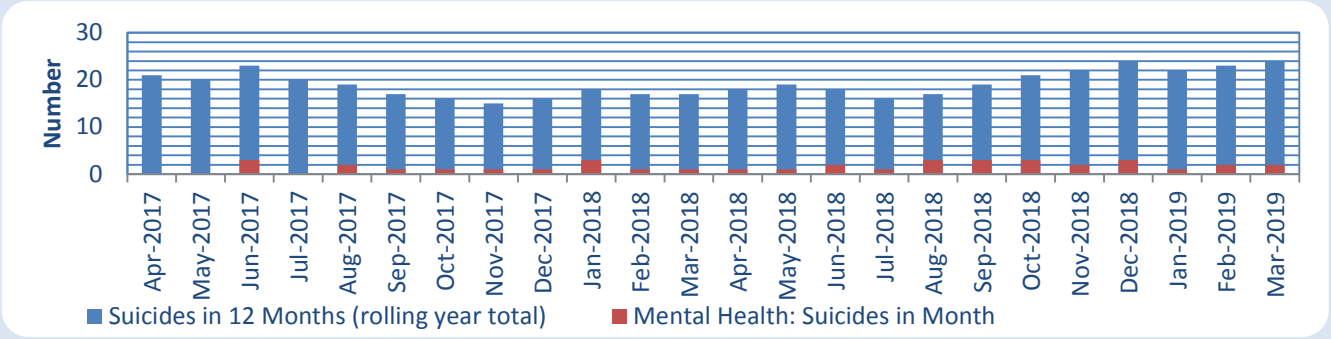


Figure 18- Suicides of patients under Berkshire Healthcare NHS Foundation Trust mental healthcare Number per month and rolling year total per month



Source- Trust Tableau Dashboard

Reducing Inappropriate Out of Area Acute Mental Health Placements

ⓘ An 'out of area placement' (OAP) for acute mental health in-patient care occurs when a person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of the usual local network of services. There are circumstances where this may be appropriate (e.g. for safeguarding reasons), but where the OAP is due to a lack of capacity in the local inpatient unit then it will be inappropriate. The government has set a national ambition to eliminate such inappropriate OAPs by 2020/21.

In order to achieve this, the Trust is focused on reducing the length of stay for inpatients and ensuring alternatives to admissions have been fully considered.

The approach to bed management has been changed, gatekeeping functionality has been enhanced and discharge planning improved to support patient flow and the experience.

Achievement against this target is measured with reference to the total number of occupied bed days that patients spend in Out of Area placements.

Figure 19 below demonstrates performance against this priority. The figure shows that the trust has achieved its target overall during 2018/19, with an average of 185 bed days spent as an OAP each month during the year. It should be noted that the number of OAPs was above the target set by NHS Berkshire West in Q3 of 2018/19 and above the target set by NHS Berkshire East CCG in Q4. In line with the national demand on Mental Health services, the Trust continues to experience variation in Inpatient Mental Health bed occupancy leading to the use of Inappropriate Beds in alternative providers. The

ongoing programme of work has resulted in a reduction of patients being treated away from home in the last financial year, as well as reduced associated costs, however further improvement is required to eliminate this practice. The programme aims to achieve this by a reset of the programme which will look at the Prospect Park offer; local ownership of the initiatives to improve the use of inpatient beds; alongside an increased focus on Length of Stay to look to achieve a reduction in bed occupancy with the ideal being 85%, in order to offer the right care, in the right place, at the right time.

The OAPs indicator has been a challenging process to develop as there are a number of complex steps in the process. Significant progress has been made since the last audit of this indicator, but we still need to address the use of a spreadsheet to control part of the process and a programme of work is in place to address this. The trust is performing well against the Single Oversight Framework indicator and has achieved it quarterly target of reducing inappropriate OAPs throughout the year.

Figure 19- Quarterly and annual number of Inappropriate Out of Area Placements

CCG of patient	Out of Area Placement Occupied Bed Days in 2018/19									
	Q1		Q2		Q3		Q4		2018/19	
	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)
NHS Berkshire West	**299**	436	**366**	396	**397**	356	**167**	316	**1229**	1504
NHS East Berkshire	**324**	418	**116**	380	**196**	342	**356**	304	**992**	1444
Grand Total	**623**	854	**482**	776	**593**	698	**523**	620	**2221**	2948
Average Per Month	**208**		**161**		**198**		**174**		**185**	

Source: Trust Out of Area Placement Report

Quality Concerns

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

The Trust was inspected by the Care Quality Commission (CQC) during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

Acute adult mental health inpatient bed occupancy is above 90% at Prospect Park Hospital

Bed occupancy continues to be consistently above 90% at Prospect Park Hospital which means that patients might not receive a good experience all the time. Delayed discharges have stabilised and the female wing of Sorrel Ward opened in December 2018. The new bed management system is working well and the number of out of area placements has reduced but the pressure remains on local beds.

Shortage of permanent nursing and therapy staff

Mental and physical health inpatient and West Berkshire community services are now affected by shortages of permanent nursing and therapy staff. This has a potential impact on the quality of patient care and experience, and increases our costs. Community nursing services are experiencing significant staff shortages alongside increased demand for care. We have reduced the bed base by ten beds in West Berkshire Community Hospital and have invested in therapy and specialist roles. This will support an additional 3 dedicated neuro beds and provide additional therapy input to improve patient outcomes so that patients return back to their usual place of residence in a timely manner Prospect Park Hospital continues to have qualified nursing pressures. A recruitment and retention programme is being developed by the Director of People and further details of this and its achievements to date are included in the 'Reducing Staff vacancies' section of this report.

Duty of Candour

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

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

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

The Trust process for formal Duty of Candour include meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate. The Duty of Candour supports the Trust learning from deaths programme detailed in Section 2.3.6. Figure 20 below details the total number of incidents requiring formal duty of candour during the year. The trust considers that the Duty of Candour was met in all cases.

Figure 20- Incidents requiring formal duty of candour (DOC)

Month	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Incidents with formal DOC	26	44	28	31	25	28	26	36	30	25	37	21

2.1.3 Clinical Effectiveness

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

Our 2018/19 Clinical Effectiveness Priorities are as follows:

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

   In addition, this section also includes a statement on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps.

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

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

Self-harm

To support the Trust's suicide prevention and self-harm priorities, an assessment of compliance against NICE Clinical Guideline 133 on self harm in over 8's has been undertaken. This exercise has been undertaken with the Clinical Directors for the Trust Adult Mental Health services and senior representatives of the Trust Child and Adolescent Mental Health Service (CAMHS).

An assessment of compliance has been produced and approved by the Trust Clinical Effectiveness Group in March 2019. The assessment concluded that the trust is meeting 53 (96%) of the 55 relevant recommendations in the NICE Guideline. The two unmet recommendations relate to:

1. Prompting clinicians to ask patients as part of a risk assessment whether they have access to family members', carers' or significant others' medications. Action is in place to add this.

2. If stopping self harm is unrealistic in the short term, advising the patient of less destructive techniques. This is not met as in all cases clinicians will try to stop the patient from self harming rather than advising them of a less destructive method. This would be undertaken as part of a risk assessment.

NHS Doctors in Training- Rota Gaps and Plans for Improvement

ⓘ The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 requires NHS Trusts to make a statement in their Quality Report on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps

The Trust appointed two 'Guardians of Safe Working' in February 2017. These guardians work within the Trust as Consultant Psychiatrists and have a duty to advocate for safe working hours for junior doctors and to hold the board to account for ensuring this. As part of this duty, the Guardians of Safe Working report to the Board on activity relating to Junior Doctor working hours, including rota gaps.

Figure 21 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust between 1st April 2018 and 31st March 2019. The table shows that all but one of the requested gaps in shifts were covered and worked.

The gaps are the result of core training vacancies. To reduce rota gaps, the Trust has participated in the Medical Training Initiative (MTI) scheme. This brings experienced doctors from outside the European Union into the Trust for two years and, after an initial introduction to the NHS, they are then able to participate in the junior doctor's Out of Hours rota. This is the first year the Trust has participated in the scheme, and has received one doctor. Following the very positive feedback, the Trust will be looking to increase its number of MTI Drs and will always try and recruit doctors into the gaps.

The Trust has also increased, and continues to increase, its number of bank doctors to ensure that the rota is always covered and patient safety is not compromised.

Figure 21- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2018 – 31st March 2019

Rota Gaps	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
	258	257	206	51	0	2561	2548.5	2087	461.5	0

Source- Trust Guardians of Safe Working Board Reports

2.1.4. Supporting our Staff

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

Our 2018/19 Supporting our Staff Priorities are as follows:

1. To achieve improvements in the following key areas:
   - 66% of our staff feeling they can make improvements at work
   - 75% of our staff recommending our Trust as a place to receive treatment
   - A 20% reduction in assaults on staff
2. Our recruitment and retention plans will reduce vacancies to below 10%
3. An additional 24 services will be trained in our Quality Improvement System
4. To achieve the objectives set out in the Equality Plans for each area
5. At a system level, to participate in Integrated Care System work streams, enhancing job satisfaction and career development opportunities.

2018 National NHS Staff Survey

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

The Trust participated in the 2018 NHS National Staff Survey between September and November 2018.

Differences between the 2017 and 2018 Survey

For the 2018 survey, the 32 Key Findings seen in the 2017 survey have been replaced by 10 themes. These themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 2,067 (51%) of whom responded. This is higher than the Trust's 2017 response rate of 44% and the 2018 national response rate of 45% for similar Trusts (31 combined mental health, learning disability and community health services Trusts).

Summary of Trust Results.

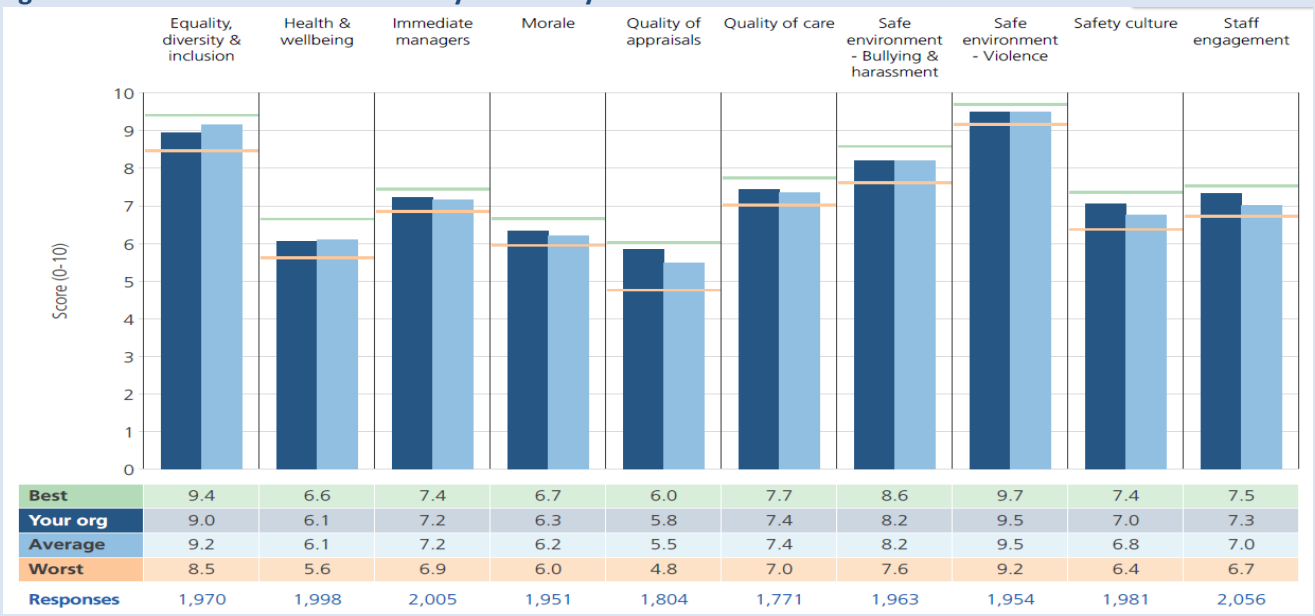
The Trust results were benchmarked against the other 31 similar Trusts and showed:

- Better than average scores for 4 of the 10 themes
- Equal to the average scores for 5 of the 10 themes
- Worse than average scores for 1 of the 10 themes

Figure 22 below details the Trust results by theme and shows that there is more work to do in areas such as health and wellbeing, and in creating an environment free from discrimination and bullying. An analysis of individual questions shows that 82% of responding staff said that 'care of service users is the organisation's top priority', which is well above the NHS average of 70%. In addition, 80% of responding staff said that 'my organisation acts on concerns raised by service users' (NHS average 76%).

The staff engagement score for the Trust in the 2018 survey was 7.3 out of 10 which is the third highest engagement score for all mental health, community and learning disability trusts and puts us in the top 20% of all trusts. This is important due to the link between staff engagement and the provision of good quality, safe services.

Figure 22- 2018 Trust NHS Staff Survey Results by theme



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.0	6.1	7.2	6.3	5.8	7.4	8.2	9.5	7.0	7.3
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	1,970	1,998	2,005	1,951	1,804	1,771	1,963	1,954	1,981	2,056

Source- 2018 NHS Staff Survey- Trust benchmark Report

Staff feeling they can make improvements at work

One of the Trust targets for 2018/19 was that at least 66% of staff responding to the staff survey state 'yes' to Question 4d, 'I am able to make improvements happen in my area of work'. The survey results show that 64.4% of responding staff answered yes to this question, and so the target was just missed.

Staff recommending the trust as a place to receive treatment

One of the Trust targets for 2018/19 was that at least 75% of staff responding to the staff survey state 'yes' to Question 21d of the survey, 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. The survey results show that 73.6% of responding staff answered yes to this question, and so the target was just missed.

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, with some of these indicators based on the Trust's National Staff Survey results. Figure 23 below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff. The Trust recognise there are concerns here that need addressing, and work is underway to build on some of the things that are already have in place, such as the Making it Right programme. The Trust will make a consistent and sustained commitment over time to make progress in this area, and have in place a programme of work to achieve this.

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

Indicator and Description	Race	Trust Scores (%) 2015 (%)	2016 (%)	2017 (%)	2018 (%)	2018 Average (median) for combined MH/LD and community Trusts (32 Trusts)
Ind.5- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	23	22	22	23	26
	BME	25	27	27	31	31
Ind.6- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	18	18	20	21
	BME	27	26	21	26	26
Ind.7- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	91	90	89	89	88
	BME	74	68	74	68	76
Ind.8- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5	5	7	7	6
	BME	14	17	11	17	13

Source- 2018 National Staff Survey

Reducing Mental Health Patient Physical Assaults on Staff

ⓘ The NHS has had a 'zero tolerance' attitude towards violence since 1999, and NHS staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives.

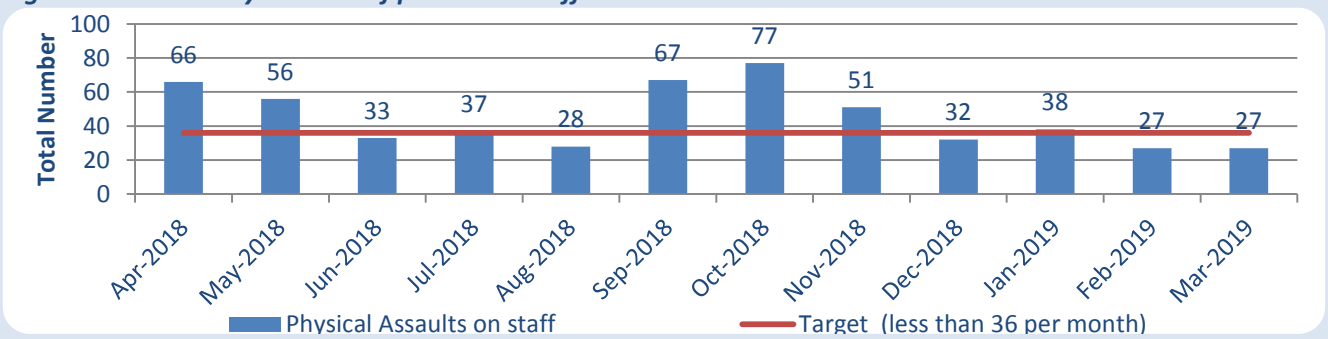
The trust has set a target of reducing the number of assaults on staff by 20% in 2018/19.

Figure 24 below details the number of patient to staff assaults. The figure shows that the number of patient physical assaults on staff was above the threshold of 36 in 7 of the 12 months in 2018/19 with an average number of 45 assaults per month during the year.

Sorrel Ward, the Psychiatric Intensive Care Unit (PICU) at Prospect Park Hospital is focusing on completing Datix incidents reports accurately to help them fully understand the situation. They are also using a key worker board so that patients can clearly see who their allocated person is for that shift to avoid any communication breakdowns. Work is also being undertaken on Sorrel Ward to standardise the level 4 (general) observations. These actions have been reviewed in light of the Q3 findings and will be further reviewed at the end of March 2019 to ensure they are meeting objectives.

Information on patient to patient assaults is included in part 3 of this report.

Figure 24- Monthly number of patient to staff assaults



Source- Trust Tableau Dashboard

Reducing Staff Vacancies

ⓘ Ensuring the Trust is staffed with the appropriate number and mix of clinical professionals is vital to the delivery of quality care and in keeping patients safe from avoidable harm. It is also important that both new and existing staff are supported and encouraged to remain with the Trust.

The trust set a target of reducing its staff vacancies to below 10% through its recruitment and retention action plan.

From April to November 2018 the Trust recruited 516 new starters and 450 staff left the organisation, a positive variance of 66 Full Time Equivalent (FTE).

The Trust has a Recruitment and Retention working group which meets once per month to deliver the action plan. In addition we have developed action plans for District Nursing, Prospect Park Hospital and West Berkshire Community Hospital. One significant action is an advertising campaign to attract new recruits to vacancies now and planned for the months ahead. This campaign covers radio, buses, newspapers and social media advertising, plus open days and school and university fair attendance.

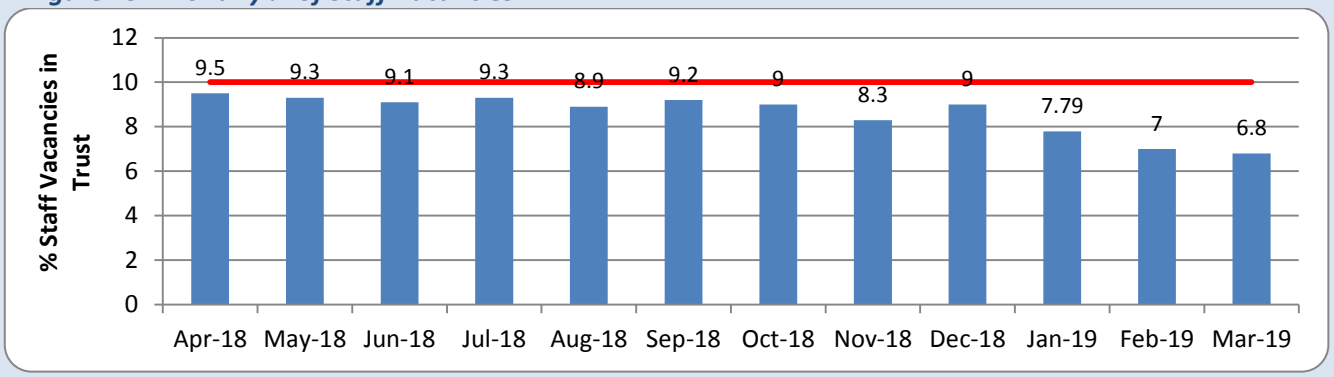
West Berkshire Community Hospital held a recruitment open day in April 2019 attended by 90 potential applicants. The trust will hold another open day in May 2019 at Prospect Park Hospital with the aim of recruiting band 5 nurses.

The Trust has decided to fund a three year project to improve the health and wellbeing offer and improve employee engagement with the aim of making this a great place to work. Over the longer term it is anticipated that this work will have a positive impact on recruitment and retention.

The operational, clinical education team and HR are working together to build better data for workforce planning and a new People Hub has been set up with an increased focus on recruitment and retention. The People Hub allows the recruitment team to review the data for all teams, professions and priorities the recruitment and retention activity. The team have, developed the use of social media to target applicants, redrafted job descriptions and adverts, streamlined elements of the recruitment process, designed new advertising material, improved the school and university fair offer and set up a contract with an agency to recruit community nurses.

Figure 25 below details monthly achievement against this target and shows that a staff vacancy rate of below 10% was met throughout 2018/19. The trust continues to focus on strategies to reduce the vacancy rate for substantive band 5 nurses, which was at nearly 35% (full time equivalent) as at 1 January 2019. This vacancy factor is managed through use of temporary nursing staff in addition to staff from a different nursing band.

Figure 25- Monthly % of Staff Vacancies



Source- Trust Tableau Dashboard

Training Staff in Quality Improvement

The Trust wants to provide all staff with the right support, knowledge and skills to give them the confidence to make changes and take away the frustrations that stop them focusing on the important parts of their job which really make a difference to patient care and experience.

The Trust set a target to train 24 teams in its Quality Improvement System (QMIS) in 2018/19. 26 teams have been trained in QMIS during this period and so the target has been met.

Achieving Objectives in Trust Equality Plans

At Berkshire Healthcare we passionately believe that being inclusive in our service provision and fair in our employment practice is integral to providing excellent customer service and is the backbone of our staff recruitment, retention and engagement. Delivery of objectives set out in our Trust Equality Plans will help us meet this goal.

Examples of work undertaken so far this year to meet objectives include the following:

As of the end of December 2018 the first and second cohort of staff have successfully completed the 'Making it Right' (MIR) Programme for BAME staff. The third cohort is due to begin in May 2019. A MIR mentor's workshop was conducted in November 2018 to up-skill mentors with the knowledge and requirement of being a MIR mentor.

In the last quarter we have employed a new member of the equality team to help support the staff networks. This role is able to publicise events, share information, and ensure that there is administration support for all the activity we try to deliver.

The Learning and Development team in collaboration with staff, managers and the networks, have developed a new course called 'Making it Right for Managers'. The aim is to share the data about our workforce (national staff survey, recruitment, turnover, sickness) and provide a forum for discussion about the actions that are required by all managers to improve how it feels to be a member of staff with a protected characteristic.

In March 2019 the Trust's Purple Network hosted a disability symposium, entitled 'Maximising our Ability,' with guest speakers and attendance by more than 100 members of staff. The event allowed attendees to be involved in finding solutions to some of the challenges our staff, managers and carers face. As a result of this a number of the actions will be taken forward during 2019, specifically developing our managers and improving how we support staff needing a reasonable adjustment.

The NHS national staff survey took place in October 2018 and the results were published in February 2019. A team of managers have reviewed the data to look at themes and priority areas of focus. The results were shared at the Diversity Steering Group and the Director of People took an action to review the feedback in detail with the lead for each staff network and the Executive sponsor for that network. The aim is to have an agreed understanding of the key messages, next steps and to ensure actions are in place to make a significant improvement over the coming months.

Following the submission of the Workforce Race Equality Standard report and the accompanying action the board agreed the following actions:

- Review local population data and consider whether a target above our current level of 20% BAME staff in bands 8a-d is achievable
- Review the actions set out in the current action plan and determine how we engage white managers in the conversation about why there is an over-representation of BAME staff in disciplines and grievance
- Develop talent pools and improve our external advertising and ensure all band 8a and above roles are advertised
- Set up focus groups with non-BAME managers, unions, black and minority staff and develop learning and development interventions, communication tools and new ways of working that create a new Berkshire Healthcare way of working to shift from 'Making It Right' to 'It Being Right'

The finance team are ensuring that all staff members have a work place assessment and that wellbeing is asked about and explored as part of the appraisal process. The team have also been openly discussing types of disabilities to help people declare a disability if they so wish.

Staff Networks

The Trust has three staff inclusion networks that play a vital role in delivering workplace equality and advising on service inclusion issues. They are open to interested members of staff from any background.

The Black, Asian and Minority Ethnic (BAME) Network was formed in 2016 to help the trust meet its statutory duty to promote racial equality and eliminate discrimination in line with the Workforce Race Equality Standard (WRES). The network's mission is "to create equal career prospects and advancement opportunities for BAME staff by enriching their working lives through caring for the individual, being committed to providing quality patient care and working together to develop innovative solutions". During the year 2018/19, the network continued to support the delivery of the Making It Right (MIR) Programme and hosted a high profile conference to celebrate Black History month. Additionally, members of the network organised road shows and local networking events to foster dialogue, advance cohesion and raise awareness of issues that may affect BAME staff members. The network has identified key priorities for 2019/20 which include continued support for the MIR Programme, Reverse Mentoring, Working with Equality and Diversity lead on inclusion strategies, supporting the Freedom To Speak Up initiative and celebrating events and achievements.

The LGB&T and Friends Network provide focused advice and assistance to the Trust to ensure sexual orientation equality in employment and service delivery. The network has three new co-chairs who have agreed the 10 priority areas to work on including improving membership, building the allies network, taking actions on the feedback from Stonewall, and ensuring the staff survey feedback is reviewed and actions taken. The network also engage with the local LGB&T community and are a supportive network for LGB&T staff, providing personal support and mentoring where required. The LGB&T network is

open to LGBT staff as well as heterosexual staff as there are a great many heterosexual staff members who are very supportive of this work. The network aims to make issues of sexual orientation and transgender open and visible within the organisation ensuring all members of staff feel able to bring their whole self to work.

The Purple Network was formed in 2018 to support trust staff with disabilities, impairments, physical disabilities, neuro-diverse conditions, mental health conditions and caring responsibilities. The network supports the trust to increase its disability confidence, address barriers and promote a culture of openness in line with the new Workforce Disability Equality Standard (WDES). During the year 2018/19, the network celebrated and raised awareness of a number of national events including; persons with disability day, purple light-up day, and Time to Talk. In addition, the network undertook a survey of 'purple staff'. This activity culminated in a successful and well-attended conference in March 2019 entitled 'Maximising our Ability'. The network has identified key priorities for 2019/20 which include; producing blogs to raise awareness of the experiences of purple staff, promoting the voices of purple staff, celebrating equality days both in the trust and on social media, attending the 2019 disability summit, supporting the introduction in the trust of the WDES and implementing suggestions from the 'Maximising our Ability' conference.

Participating in Integrated Care System Work Streams to enhance job satisfaction and career development opportunities

ⓘ Integrated Care Systems (ICS) are partnerships between NHS Organisations, Local Authorities and other stakeholders which aim to improve the health and care of the population they serve. Organisations in each ICS take collective responsibility for managing resources, delivering NHS Standards across their population.

The Trust is a member of both West Berkshire ICS and Frimley Health and Care ICS, the make-up of which is described in the Patient Experience Section earlier in this report. The Trust is involved in activity that covers the following areas with the aim of delivering best practice:

- Occupational health
- Medical staffing
- Statutory and Mandatory training
- Recruitment

The outcomes should ensure that NHS staff who move between trusts are able to do so more easily, at pace and more efficiently.
In addition, organisations are working together to improve the capability of the workforce to ensure that enough staff are trained to undertake roles following remodelling of services. For example we offer advanced history taking and prescribing courses. The ICS are also working together to improve workforce modelling data and capability.

All Human Resources Directors of Trusts in the Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership (BOB STP) have met and drafted a new People Strategy with the aim of having a single agreed document and joint working teams finding solutions aligned to priorities. The development process included a day with local authorities, social care providers and the CCG to ensure the People Strategy covers all providers' concerns and to build consensus on priorities and focus areas. The strategy will then work at ICS and individual trust level too. The group now meets weekly to progress this work on behalf of the Local Workforce Action Board.

The Trust are currently looking at good practice in statutory and mandatory training across the country with the aim of finding a better solution for the Strategic Transformation Partnership (STP) that also works for our staff. The recruitment streamline project is progressing and changes have been made by us to align to other STP providers, which will speed up our recruitment processes. There are issues with Electronic Staff Record usage and functionality as all providers use the system differently and therefore ICS or STP data is difficult to produce

Freedom to Speak Up

ⓘ Following a review by Sir Robert Francis in 2015, a national standard 'Freedom to Speak up' policy was published by NHS Improvement and NHS England. This policy has the aim of developing a more open and supportive culture for staff to raise any issues of patient care, quality or safety. The Trust has subsequently adopted this standard policy in its own policy.

The Trust's policy and procedure in relation to this area is contained within ORG013- Freedom to Speak Up: Raising Concerns (Whistleblowing). This policy emphasises the importance of staff being able to speak up about any concern in order to ensure the safety and effectiveness of our services.

Under the policy, trust staff members are encouraged to raise concerns (confidentially, unless required to disclose by law) about risk, malpractice or wrongdoing that they may think is harming the services the trust delivers. Such examples may include, amongst others, unsafe patient care, unsafe working conditions, inadequate training or a culture of bullying.

How does the Trust ensure that staff do not suffer detriment from speaking up?
If a member of staff raises a genuine concern then they will not be at risk of losing their job or suffering from any form of reprisal as a result. The trust will not tolerate any harassment or victimisation of anyone raising a concern. In addition, providing that the staff member is acting honestly, it will not matter if the staff member is mistaken or if there is an innocent explanation for the concern.

How can staff speak up?
Staff are encouraged to raise concerns in a number of ways:

1. By raising the concern with their line manager, lead clinician or tutor (for students). This may be raised orally or in writing and advice can be sought from a trade union if the employee is a member.
2. If the member of staff does not feel they can raise the issue with their line manager, or they feel the line manager has not addressed their concerns, then it can be raised with any of the following; their Locality or Corporate Services Director, The Trust Freedom to Speak up Guardian, The Trust Executive Director with Responsibility for Whistleblowing (Currently the Director of Nursing); the Risk Management Team; through a dedicated confidential external telephone line or e-mail service, or through the local Counter Fraud Specialist.
3. If the above channels have been followed, and the member of staff still has concerns, then the Trust Chief Executive or nominated Non-Executive Director can be contacted via e-mail or by letter about the concern.
4. Alternatively, concerns can be raised formally with external bodies such as NHS Improvement, the Care Quality Commission and NHS England

How is feedback given to staff raising a concern?
Feedback is given as appropriate to each case and would depend on the concern raised and if the information is confidential or not. The aim is to share learning from concerns raised.

The role of the Freedom to Speak Up Guardian
The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement. This is achieved by ensuring that; workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and Issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between April 2018 and March 2019 44 cases where brought to the Trust's Freedom to Speak up Guardian.

Whistleblowing Cases
During the three month period in Quarter 4 2018/19, there has been only one whistleblowing case which has now been fully investigated and closed. All parties have received feedback and the appropriate action has been taken and is on-going. The concern raised did not include any patient safety concerns.

At the time of writing there are no live whistleblowing cases.

2.1.5. Other Service Improvement Highlights in 2018/19

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

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

2.1.6. Improvements in Community Health Services for Adults

West Berkshire Community Hospital Inpatient Unit in Newbury has implemented daily board rounds involving trust and social care staff. These occur around each ward base PSAG board (Patient Status at a Glance). All members of the Multi-Disciplinary Team (MDT) are present and the meetings on each ward last approx. 30 minutes. Only patients designated as medically fit have their discharge plan reviewed and tasks are assigned daily and reviewed daily. As a result, the average length of stay on the wards is below the trust target. Patient discharge plans are discussed on a daily basis to facilitate this and a Development Lead role has also been introduced to the Unit. The unit plan to increase therapist input this further.

Oakwood Community Inpatient Unit at Prospect Park Hospital in Reading has achieved a falls target of less than three falls per months for three consecutive months. They have also introduced board rounds to improve patient flow and introduced a weekly staff support group.

Wokingham Community Hospital Inpatient Wards have introduced a number of improvements including; board rounds (see above), focusing on improvements in early warning system escalation (NEWS), induction and pressure ulcer prevention.

Wokingham Intermediate Care Service achieved a 'Good' rating in their recent CQC inspection and has introduced a Units based system which has enabled to them to better manage their demand. A robust Lone working procedure has been introduced for Therapists with better monitoring systems. Service provision has been expanded to include mobility visits (rehab visits) at the weekend and the team also raised funds in Wokingham as part of the NHS70 celebrations.

West Berkshire Intermediate Care Service undertook a green belt project to produce a single pathway for all community therapy patients so that patients are seen at the right time by the right clinician. This involved; merging three existing pathways into one, clearing a backlog of patients, re-designing patient triage and developing a standard work process for all staff to follow. After eight months of intensive work, the new pathway became operational resulting in the waiting list reducing from 11 months to 1 week. The new pathway is allowing more focused, quality time with patients on visits.

The Community Podiatry Service participated in a Rapid improvement Event (RIE) to address their capacity and demand. The event identified quick wins and longer term action which focused around collecting and using data to improve capacity. This work is still ongoing. The service has also implemented a new 0300 telephone number for East Berkshire (St Marks, King Edward and Upton sites). This new system includes a call queuing system and informs patients that their calls will be answered within a certain time.

The Nutrition and Dietetics Service has been involved in the development of a new Irritable Bowel Syndrome (IBS) service within Frimley Integrated Care System (ICS). In addition, the service continues to work with the Daisy Garland charity to provide a full time dietician that supports the Paediatric team at the Royal Berkshire Hospital in running a Ketogenic Diet service. This is a service for children with a confirmed diagnosis of epilepsy who have been identified by a Paediatrician as suitable to move to a ketogenic diet. Such a change in diet can reduce the number of seizures the child has and the impact of them on the child's quality of life. In addition, the dietetics service at The Royal Berkshire Hospital (RBH) undertook a

pilot of the Low Calorie Liquid Diet (LCLD) approach for diabetes remission using a group model, the first known of its kind in the UK. The outcomes were highly successful resulting in a remission in diabetes of 46% and a mean weight loss of 10kg after 1 year. Discussions are being held with commissioners as a result of these findings.

The Musculoskeletal (MSK) Physiotherapy Service has introduced a GP helpline so that advice can be sought from the service via e-mail on a daily basis.

The Integrated Pain and Spinal Service (IPASS) have introduced an 'opt in' system that has helped reduce their waiting list for initial assessment of pain management to within target. The 'Did Not Attend' (DNA) rate for spinal assessment has also reduced from between 7-11.5% to 5%. Pain clinicians have introduced a detailed pathway to ensure consistency in practice and more effective triaging of patients into the correct part of the service. In addition, 'Cauda Equina' cards have been developed and distributed. These are small cards with essential advice for patients who are at risk of having a spinal medical emergency.

The Community Speech and Language Therapy (SLT) Service have introduced 'soaking solutions' for puree snacks on community inpatient wards. Patients on these wards that require a modified diet now have improved access to suitably appropriate snacks and this has led to increased nutritional intake, greater patient choice and an increased sense of dignity and inclusion at snack time. The team have also been working collaboratively Berkshire wide to produce a 'feeding with acknowledged risk' policy. When finalised and adopted, this policy will ensure clear communication and continuity of care across settings for clients with identified eating and drinking issues. In collaboration with the Dietetics Service, the team have also started the International Dysphagia Diet Standardisation Initiative (IDDSI). This extensive piece of work has involved delivering training and changing leaflets, ward signage, ward menus and notation used in record keeping etc. The team will be fully compliant with this initiative by April 2019.

The Adult Acute Speech and Language Therapy (SLT) Service completed a service review in October 2018 that resulted in the development of a new team structure and new SLT posts. The team have worked with other hospital staff at the Royal Berkshire Hospital (RBH) to introduce the International Dysphagia Diet Standardisation Initiative (IDDSI) fluid descriptors. These descriptors are global and provide a standard framework for everyone to work from. A full time head and neck cancer post has also been created which allows the RBH to provide an outreach service/satellite service to head and neck cancer patients at Wexham Park Hospital in Slough so they do not need to travel to Reading. Finally, a Quality improvement project was undertaken with the aim of improving the SLT service for patients with Parkinson's disease. The poster for this work won First Prize in the Royal Berkshire Hospital NHS Foundation Trust Audit Competition.

The Continence Advisory Service has started paediatric group sessions for parents of children with underlying constipation**.** This has empowered parents to help manage their children's constipation, as well as reducing waiting times for input from continence services for families. In addition, a pilot specialist catheter clinic was instigated to re-catheterise mobile patients within the Wokingham community, rather than being added to the District Nursing caseloads.

The Phlebotomy Service now have access to the Royal Berkshire Hospital Pathology (ICE) system, allowing staff to print blood request forms for patients that have been referred for a blood tests by their GP.

The Berkshire Integrated Hub has reduced their process time for routine referrals from 7 days to 3 days. A revised training programme has been introduced for new staff, and staff and user surveys have been introduced.

East Berkshire Community Nursing Services have been involved in developing standard work processes to improve consistency across the service. Catheter clinics have commenced in Bracknell and Maidenhead, and are planned for Slough. Staffing-skill mix has been reviewed, with a phlebotomy role introduced and extension of the health carer role**.** The use of I-pads is being trialled to support mobile working and a community nursing video has been filmed for sharing with patients.

Wokingham Community Nursing Services have consolidated their community teams into larger, more effective teams located within GP surgeries. A restructure of team resources has been undertaken to take account of the skill mix of staff and the need to provide a better visible governance and support structure for the teams.

Nurse Led Do Not Attempt Cardio–Pulmonary Resuscitation (DNACPR). A training and competency programme has been developed for senior nurses, Advanced Nurse Practitioners and specialist nurses relating to DNACPR conversations and the completion of the relevant paperwork to record the DNACPR decision. Previously, these senior experienced nurses may have had DNACPR conversations with patients where this was appropriate, but would then need to request that a GP or senior medic have a further conversation to complete the paperwork. The new DNACPR programme is facilitated by Trust Geriatricians, a Hospice consultant and a senior Trust nurse. To date, the training has been well evaluated, with 60 nurses completing the programme.

Community Cardiac and Respiratory Specialist Service (CARSS). The Cardiac Rehabilitation team has been certified as an accredited service, have improved their home exercise programme and updated their education sessions. The Heart Function Team has established a cardio-renal Multidisciplinary Team (MDT) with a consultant at the Royal Berkshire Hospital. They have also strengthened their relationship with The Great Western Hospital in Swindon allowing better sharing of information for patients who have a GP in Berkshire West**.** The Respiratory Team have introduced phone-call assessments for patients with sickle cell anaemia requiring home oxygen review. These assessments have saved patient time and travelling. The Pulmonary Rehabilitation Team have updated their education sessions and introduced coffee mornings/afternoons where specific topics can be discussed. In 2019/20, the team plan to further integrate the various teams to ensure a streamlined approach for service delivery and less repetition for patients (e.g. by initiating joint visits).

Integrated Care Home Service (ICHS). The Rapid Response and Treatment Teams (RRAT) and Care Home Support Team (CHST) across Reading, Wokingham and West Berkshire localities have now merged to become the Integrated Care Home Service (ICHS) with one service manager. The team now functions in an integrated way which enhances the quality of service delivered. The ICHS Occupational Therapist and Physiotherapist have worked with the care homes and the ambulance trust to; review care home falls policies, train falls champions, implement telecare and analyse falls incident data. This has resulted in; a 55% reduction in falls over 6 months in one care home, a 90% reduction in 999 calls with an associated 41% reduction in falls in another care home, and a 66% reduction in another care home that now has falls champions. The ICHS Specialist Nurse Practitioners have delivered the 'Six Steps' programme to the care homes with the aim of enhancing end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. The ICHS Speech and Language Therapist set a challenge for care home staff to help residents enjoy their puree meals and snacks and stop residents losing weight. The chefs in the care homes rose to the challenge and designed some very appetising dishes which they have shared with each other. The winner went on to win a national competition 'Care Dine with Me'.

The Home First Rapid Response Service participated in in the first Green Belt project to be completed by the Trust QI team. The Length of Stay (LoS) on their caseload was in a breach of the service specification which stated that patients should be on the pathway for up to 14 days. The project group designed a new patient pathway and standard work for staff to follow, which they rolled out and continuously reviewed over a 6 month period. The outcomes have been positive for the service and patients and have seen the Length of Stay (LoS) on caseload reduced to 1-15 days.

The High Tech Care Service has sourced a venue for a new Peripherally Inserted Central Catheter (PICC) clinic in Reading to support District Nursing. The team are also working with The Rosemary Appeal, a Dialysis and Cancer care Charity in West Berkshire, to ensure the team have suitable treatment rooms when they move to their new premises based at West Berkshire Community Hospital (WBCH). This move has the potential to realise other benefits such as increasing the number of patients that can be seen at the WBCH IV clinic.

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

Urgent Care Services, including Westcall GP Out- of-Hours Service, Emergency Department (ED) Streaming and the Thames Valley 111 (TV111) Clinical Advisory Service

A new process for management of controlled drugs (CDs) has been put in place. Previously CDs were issued to individual GPs for them to use and record in their own registration books and on the Adastra patient system. When a doctor had used all their CDs they would return to WestCall to collect more or return expired medications. Under the new system CDs are much more tightly controlled with clear Standard Operating Procedures issued to doctors, nurses and drivers. The ordering, stock control, management and reconciliation of these medicines are tightly audited and controlled in order to reduce incidents and waste.

A new and improved process for non-answered calls to patients has been put in place and this has resulted in increased safety-netting and visibility of cases that are not answered upon call back.
Pathology results are now checked by a named GP on a daily basis at 1900hrs. This improves care by ensuring that all pathology requests made by WestCall GPs are both audited and followed up in a timely way

The Urgent Care administration team has been restructured to ensure named individuals have delegated responsibilities. A team leader has also been introduced to the team.

Nurse and paramedic practitioners have been introduced onto the clinical rotas. This has improved the skill mix of the team, enabling it to be more responsive and effective.

An experienced Urgent Care Matron specialising in out of hours care has been added to the senior leadership team. This ensures that non-medical practitioners and clinical support staff are well led.

A Clinical Governance Lead post has been introduced, and the service governance structure improved. This was undertaken in response to CQC feedback and ensures that clinical governance and quality standards remain robust, well embedded and audited.

The WestCall GP out-of-hours service has introduced the ability for 111 call centres to book patients directly into the service if appropriate to do so. This represents an improvement in the patient journey as, prior to this change, patients had to await call back from the service before being given an appointment. WestCall GP out of hours also now accepts patient self-referrals through 111 online.

The GPs in the TV111 Clinical Advisory Service are focusing on re-triaging patients who would otherwise have been told to attend the Emergency Department (ED) or be sent a 999 ambulance. This has resulted in less ambulances being dispatched and less patients attending ED which improves the whole system.
The Westcall GP out-of-hours service has introduced a new home triage role. This role supports clinicians to manage patients remotely using equipment provided by the service.

The service have introduced a FastTrack GP recruitment procedure and can now move a GP from enquiry to employed in the space of only a few hours if required.

Minor Injuries Unit (MIU), West Berkshire Community Hospital, Newbury
The service have trained two of their reception staff as Healthcare Assistants (HCAs) to support the practitioners doing initial assessments on patients as they arrive, as well as other tasks.

An office has been converted into a treatment room, allowing staff to do observations on patients there rather than in the waiting room. A new treatment room has been equipped with a Bariatric trolley with pressure relieving mattress. In addition, the staff toilet has been converted into a specimen toilet which allows patients to do their specimen in the toilet and leave it there to be tested rather than it being tested in a clinical room.

An appointment system has been introduced via 111, which allows patients to be seen at a suitable time, with the team endeavouring to see these patients within 30mins of this set time regardless of the wait time for walk-in patients. It is hoped this will become more popular with patients and allow workload to be spread throughout the day. In addition, a direct referral pathway has been set up with Podiatry

The service has developed a working relationship with a local GP Surgery to allow their staff to work with the duty GP and the Nurse Practitioners to develop their

minor illness skills. The Service has made a reciprocal offer to the GP Surgery.

Three members of staff are attending a Masters level course on Minor Illness to allow the service to see more patients that present with medical problems. In addition, a member of staff is attending a Non-Medical prescribing course to enhance patient treatment plans.

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

Participation Champions. Service users are crucial to the development of feedback mechanisms to ensure services meet needs. CYPF services have a vibrant network of participation champions who promote participation and the collection and analysis of service user feedback within the service. They meet on a quarterly basis to share ideas and good practice.

The Looked after Children Nursing Teams have been working with children and young people in care in order to develop their young person's feedback form. Team members have linked in with children in Care Youth Councils across Berkshire, where young people who are in Local Authority care or who are care leavers are able to meet and discuss their views. Having the involvement of young people at the earliest opportunity ensures the team are able to ask the right questions about the service they deliver and how it can be improved.

Child and Adolescent Mental Health Services (CAMHS) have produced a mini report on the findings of recent service user feedback. This is available for children, young people and their families to read when accessing our services. Whilst there are multiple ways to collect feedback and involve young people and families in participation activities, reporting back the outcomes of their input is essential. This helps ensure service users know that their contribution has been heard, that it is valued and that changes have been made as a result.

The Children and Young People Integrated Therapies (CYPIT) Service have developed a form that captures feedback gathered at parent groups. The form enables the facilitator to detail actions that are needed in response to parent feedback, who is responsible and when this will happen. This not only ensures that the service is collecting qualitative feedback, but makes sure that SMART actions are put in place and assigns responsibility.

Reading School Nursing Team is commissioned to deliver health promotion within the Reading locality, with one of the areas of focus being substance misuse. Following a scoping exercise and consultation with children and teachers, it was agreed that the best way to address this would be through a film made by the young people in Reading, for the young people of Reading. As a result, the team have been working in partnership with schools in Reading to develop a film called 'Taylors' Story'. The film will form the centrepiece of a health promotion session and contains three scenarios that are designed to be paused to allow for discussion about what Taylor's choices are and what the consequences might be. Filming has now taken place and the team are awaiting the edited version.

A new model of delivery has also been developed by Reading School Nursing Team. By separating the roles of School Nurses within the team into two areas of focus, Safeguarding and Public Health, they hoped that their safeguarding commitments would be managed effectively whilst allowing half of the School Nurses in the team to focus on their Public Health/early intervention role, which had historically received less attention. The pilot of this new approach commenced on 5th September 2017 and completed in August 2018. Evaluation of the pilot found a number of benefits including; a significant increase in face-to-face and telephone contact with families, a significant reduction in the number of safeguarding meetings which needed to be attended and an increased amount of health promotion being delivered.

The Berkshire School-Aged Immunisation Team continues to successfully carry out their core work of delivering immunisations in primary and secondary schools across Berkshire. In addition, the team have embraced additional work to deliver timely responses to outbreaks of disease amongst children and adults within Berkshire. In the spring of 2018/19 the team responded to a small outbreak of Hepatitis B at a school. This required the service to mobilise a small team of nurses, engage with the Health Protection Agency and Public Health Teams and provide a rapid

response to an outbreak, usually within 48 hours. The team was called upon again in the summer to provide a rapid response to an outbreak of Meningitis B at a nursery school of 3 – 4 year old children during the height of the summer holiday. The service rose to the challenge, with staff coming in from their summer break to deliver prophylactic antibiotics and injections to children and staff.

Reading Health Visiting (HV) Team and Reading Community Nursery Nurse (CNN) Team are trialling two innovative solutions to improve uptake of the Healthy Child Programme scheduled development reviews. Firstly, the CNN team are working in partnership with a number of local nurseries to improve uptake of the 27 month development review. When a nursery identifies a child that has not had their 27 month review then, with the consent of the parent, this review can be arranged to be undertaken with a CNN at a convenient date. This has resulted in 60 reviews to date within a Nursery setting. Secondly, the team have started a number of health promotion sessions in local supermarkets in an attempt to identify children that have either missed a scheduled development review or are due one soon, and also to identify expectant mothers/parents to be that have not accessed an Antenatal contact.

Transition from Child to Adult Mental Health Services- Commissioning for Quality and Innovation (CQUIN) This relates to improving the quality of transition from children's mental health services to adult mental health services and requires the audit of four aspects:

1. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider
2. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider: Young people are meant to have a discharge plan and this must be shared with the young person
3. The percentage of young people who in their pre-transition survey reported feeling prepared at point of discharge
4. The percentage of young people who in their post-transition survey reported that they met their transition goals

An audit has found that all four of these aspects have been met by the Trust for the year April 2018 to end of March 2019.

2.1.9. Improvements in Services for Adults with Learning Disabilities

Campion Unit Learning Disability Inpatient Unit at Prospect Park Hospital in Reading has undertaken several service improvements during the year. These include training all staff on the ward on the use of active communication and active support to ensure that patients have adequate social and emotional stimulation during their stay on the ward. Work has been undertaken looking at the skill mix on the ward, with staff feeling more confident and up-skilled to undertake their new roles. This in turn has resulted in reduced delayed transfers of care and improved quality of care for our patients. Work has also been undertaken to reduce the numbers of people in out-of-area placements and this has also resulted in reduced rates of admission to the ward. The unit are currently using Quality Management Information System (QMIS) methodology to focus on reducing the number of assaults on their staff.

Community Teams for People with Learning Disabilities (CTPLD)

CTPLD Team Slough. Over the past 18 months the team have developed some innovative quality improvements. This has included translating an epilepsy care plan into the persons preferred language and translating hospital passports into three languages; Urdu, Punjabi and polish. This enables the team to address the needs of the local community and promotes diversity and inclusion.

The team have also worked closely with Public Health to run a successful 16 week weight loss programme in line with national obesity targets. There is little evidence of implemented programmes which include reasonable adjustments to address the needs of people with LD and obesity, and encouraging people with a learning disability to attend and commit can be challenging. Individual easy read diaries were also developed by the team to enable people with LD and their carers to record tips during the session, to use when they return home to maintain their weight loss. All educational material was also developed by the team, and at the end of the 16 weeks 6 out of 9 attendees lost weight.

A pilot screening tool has also been developed due to the number of inappropriate referrals received by the CTPLD Slough team. This project is ongoing and has

the aim of using the psychologists time more effectively.

Alongside the CTPLD in Bracknell, the Slough team have started a Postural Management Clinic for people with Profound and Multiple Learning Disability (PMLD). People with PMLD are highly vulnerable to the adverse effects of poor positioning, and are often unable to communicate their concerns. The physiotherapist is able to carry out a full assessment of their multiple and complex needs at this clinic with the aim of maintaining, protecting and restoring body shape, maximising comfort and promoting health and wellbeing in addition to other benefits.

CTPLD Team Bracknell. There is a national drive to promote annual health checks by GPs for people with LD and the Bracknell and Slough Health Lead has worked hard to build relationships with the GP's in those localities. There is still some distance to go with this, but improvement has been seen over the years. Initiatives have included the development of GP LD registers and LD training being delivered to some GPs and practice staff by the LD Lead. This has resulted in improved healthcare and preventative healthcare for people with LD.

The team have recently delivered LD training to the Parapet Breast Screening Unit staff at King Edward VII Hospital in Windsor. This has raised awareness of LD and the required reasonable adjustments amongst the Parapet team and it is intended that this will be delivered every year.

The Occupational Therapists have been working with the 'Dogs for Good' charity to introduce a community dog as an aid to improve independent life skills for people with LD. A pilot of 8 clients for 8 sessions ran from March 2017 to November 2018. Due to the success of the pilot, a new branch in the service was created with a full time dog handler with a dog and a full time Occupational Therapy Assistant to meet the needs of people with a LD. The new service has developed a waiting list and a second dog should be allocated to a dog handler in the next 6 months to address this.

The team have also facilitated a Relationship/Sexual Health programme for final year students at a school over a period of 4 weeks. The feedback was extremely positive from the school and the students.

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

Talking Therapies- Improving Access to Psychological Therapies (IAPT). The service has introduced the 'Our Space' cafés to offer support to patients following treatment in order to stay well and prevent relapse. These cafes take place at St Mark's hospital in Maidenhead, Reading University, Wokingham Hospital, Upton Hospital, West Berkshire Community Hospital and Bracknell Open Learning Centre. The service also initiated a Black, Asian and Minority Ethnic (BAME) access and recovery project in slough that has led to an increase in BAME referrals from 2014/15 to 2017/18. The IAPT Post Traumatic Stress Disorder (PTSD) pathway has been extended to treat more patients with a single complex trauma. Access to the service has also been increased for patients with anxiety and depression alongside other long term conditions (LTC) as part of the service's IAPT-LTC pathway.

East Berkshire: Admiral Nurse for Young People with Dementia. Admiral Nurses are registered nurses with specific knowledge of dementia care. They provide support to individuals and families living with dementia as well as education, leadership, development and support to other colleagues and service providers. The Trust was commissioned by East Berkshire CCG to provide a part time (3 days per week) Admiral Nurse for younger people with dementia. This represents a new partnership in east Berks between BHFT and the national charity Dementia UK. The nurse has worked with approximately 30 families this year, as well as signposting others to appropriate sources of support. Satisfaction and impact has been high with reported reductions in visits to other services such as GPs, and delayed need for more intensive care and support.

Trust Memory Clinic Services successfully in achieved reaccreditation for the next two years and, as part of this, have been awarded a sustainable Mental Health Service Commendation by the Royal College of Psychiatrists Sustainability Committee.

Individual Placement and Support Employment Service (IPS). Following a successful bid for funding

from NHS England, the Trust has increased the size of its IPS Employment Service team from five staff to eleven, so that the service now covers the whole of Berkshire. This service provides one to one support to active clients of secondary mental health services helping clients into work. The focus is on competitive paid work and works closely to ensure the job matches with the client's preferences, skills and ambitions. Employment Specialists are now integrated into all Community Mental Health Teams (CMHTs) and Early Intervention in Psychosis clinical teams and use a person centred, strengths based approach to identify work goals. Collectively, the service has worked with approximately 100 service users this year, and is beginning to show promising job outcomes for people under the care of CMHTs.

Improving the physical health of people with severe mental illness. People with severe mental illness have significantly poorer physical health than the general population and can have a reduced life expectancy of up to 20 years. The Trust has been working with their local Clinical Commissioning Groups, Public Health teams and voluntary sector partners to address this issue in Berkshire. In East Berkshire, the Trust introduced a physical health lead in mental health services to oversee the initiatives**.** Physical Health CQUIN targets for 2017/18 were met and work is progressing to support achievement for 18/19.

Recovery Colleges in East Berkshire. The Trust is commissioned to provide Recovery Colleges in Windsor, Ascot and Maidenhead (WAM), and in Slough. In WAM, Opportunity Recovery College is in its second year of operation, and in Slough Hope College has been operating for 4 years. One of the key principles of these colleges is to offer an education based route to recovery, with peer-led education and training programmes as a partnership within mental health services. The colleges continue to offer wide range of courses, including courses aimed at promoting wellbeing, physical health, employment related initiatives, and leisure.

Family Safeguarding Service. The Trust is a partner in the Family Safeguarding model which is being implemented in the Bracknell and West Berkshire localities. This model adopts a whole system approach to Child Protection Services, focusing on risk due to Domestic Abuse, Mental Health and Substance Misuse. The Trust provides six expert adult mental health practitioners to work in a multi-agency service, alongside child protection social workers, domestic abuse workers and drug and alcohol specialists. The mental health interventions provided to parents, together with the formulations and insights provided to colleagues are beginning to show a positive impact.

Community Mental Health Team (CMHT) accreditation. Bracknell CMHT is one of the first teams to undertake accreditation with the Royal College of Psychiatrists. This programme works with staff to assure and improve the quality of community mental health services. A final accreditation decision is due in March 2019.

Structured Clinical Management. The Trust is introducing Structured Clinical Management as part of the newly emerging pathway for people with personality disorder. This is a new evidence based intervention which can be delivered to trained practitioners working within CMHTs. Training has now been provided to 90 practitioners across all Trust CMHTs, and implementation is now in the early stages across all teams.

Reading Community Mental Health Team (CMHT) has started a project to build its resilience following its uncoupling from Reading Adult Social Care Team. This focused on four areas that the team found challenging; supervision, team culture, team organisation and team development. Each identified area has team members allocated to it and priorities identified. This work is ongoing, but some actions have already been undertaken and the team are presenting as stronger and more resilient as a result.

Wokingham Community Mental Health Team recruited a psychology lead in October 2018 which has led to reductions in waiting lists and waiting time for therapy.

East Berkshire Crisis Resolution and Home Treatment Team (CRHTT) identified their response time as their main area of improvement. There is a national expectation that by 2020/21 all areas within the UK will offer a 24 hour crisis service which will be truly responsive. The team aspiration is to see all referrals within 4 hours or even faster and develop a rapid response element within the service. However, historically such "4 hour crisis referrals" were only available to GPs making a referral to the service via the Common Point of Entry (CPE). The service has now opened up these "4 hour crisis referrals" to all referrers, resulting in an increase in assessments being completed within 4 hours.

East Berkshire Psychological Medicine Service formed in January 2018 and comprises a specialist dedicated team of Nurses, Social Workers and Psychologists delivering a 'Core 24' service to the A&E Department and wards at Wexham Park Hospital (WPH). The team work with WPH staff to ensure patients with mental health needs receive the best possible care in the acute hospital setting. The service is consistently meeting their performance targets

The Early Intervention in Psychosis Service (EiP) has implemented an online support forum called 'SHARON for EiP' for carers. This forum has received good uptake and information is being developed to increase the resources available. SHARON for EiP Service users is due to go live in February 2019.

Hillcroft House shares a site with West Berkshire Community Hospital in Thatcham and houses multiple teams, including primary and secondary mental health services, Community Health Services and partners such as Adult Social care. Work began on the building in November 2018 to better meet the needs of service users and staff. These include significant changes to the reception and waiting room areas, increasing the usable clinical space and improving the safety of the building. Office space has also been upgraded to include more breakout and meeting space, a more comfortable climate and upgrade of staff rest areas.

Thames Valley Criminal Justice Liaison and Diversion (CJLD) Service were awarded a commendation for Service of the Year at the Howard League for Penal Reform Awards in October 2018. The service was also awarded the tender for the Hampshire and Isle of Wight Liaison & Diversion Service from 1st April 2019.

Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT). IMPACTT is a specialist service which provides comprehensive assessment and evidence-based treatments for individuals aged 18 and over with a diagnosed personality disorder, primarily Borderline Personality Disorder/Emotionally Unstable Personality Disorder (BPD/EUPD). The service offers two evidence-based treatments: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT), as recommended by the NICE guidelines. The service has been rolling out training events across the organisation on working with personality disorder and these have been very well received. A new initiative known as Psychologically Informed Consultation and Training (PICT) is currently in development. This which will continue to grow the consultation and training arm of IMPACTT and further support the organisation in working with patients with personality disorder.

Adult Mental Health Inpatient Services at Prospect Park Hospital have been involved in numerous quality improvement projects during the year, many of which are listed in earlier sections of this quality report. In addition a Green Belt Project has been undertaken to increase the number of Friends and Family Test (FFT) responses received for this service. This has resulted in 140 responses to the FFT in the 7 months since the start of the project compared to 22 responses in previous 7 months. The Project is ongoing with work concentrating on sustaining changes and reporting back to service users.

2.1.11. Improvements in Medicines Management

Patient safety

Our Pharmacists play a vital role in ensuring the safe and effective use of medicines. They work with the multidisciplinary team to ensure systems and processes are in place to support medication safety. Our drive to improve the safer use of medicines includes the use of short memos to increase awareness around medication safety initiatives.

Our Medication Safety Officer is a member of the National Medication Safety Network and ensures that good practice is shared and embedded across the Trust.

Our Pharmacists ensure that we respond to, and take appropriate action, on national medication safety alerts. This includes sharing medication safety information through publication of regular Medication Safety Bulletins (shared trust-wide), and producing posters, for example, on the safe supply of valproate to females of child bearing potential.

The Pharmacists provide training to doctors to improve their knowledge of medicines safety. Pharmacists provide in-house teaching to doctors on a number of medication related topics, including Medication Safety and Rapid Tranquillisation Medicines.

The Deputy Chief Pharmacist has developed a Pharmacy Improvement and Innovation Programme to facilitate the embedding of a rolling, annual programme of medicines-related audits, and timely follow up of actions arising out of the findings of these audits. This shall improve patient safety and ensure compliance with national standards.

Patient experience

Our Pharmacists shall continue to review all medicines for effectiveness and adverse effects, and provide support to service users. Pharmacists continue to offer 1:1 sessions for inpatients, facilitate patient education sessions in inpatient units, support inpatient carer sessions, and contribute to patient and carer Recovery College workshops.

Pharmacy has continued to invest in staff development to ensure, that staff have the skills required to work effectively and efficiently.

In line with the Carter Report (NHS Operational Productivity: unwarranted variations: Mental Health Services, Community Health Services, 2018), our Pharmacy Department ensures pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation. We are committed to increasing specialist pharmacy professionals including ACP qualified pharmacists and pharmacist prescribers to add capacity, expertise and value to patient care.

Electronic Prescribing and Medicines Administration [ePMA]

The Trust is a Mental Health Global Digital Exemplar site. We have implemented Electronic Prescribing and Medicines Administration (ePMA) at all our mental health inpatient wards, and in November 2018, ePMA was rolled out to the first mental health outpatient service, namely Windsor, Ascot and Maidenhead Depot Clinic. The introduction of ePMA in the outpatient clinic has enabled depot antipsychotic injections to be prescribed and ordered electronically, facilitating a seamless link to the dispensing and supply system within Pharmacy.

Our Specialist Informatics Pharmacist supports all aspects of technical configuration, and clinical content relating to medicines management within the ePMA system. ePMA has been effectively used to support the national valproate Pregnancy Prevention Programme for women and girls of child bearing potential.

2.2. Setting Priorities for Improvement for 2019/2020

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2019/20 (see Appendix A). Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders

2.2.1. Patient Safety Priorities

To provide safe services, prevent self harm and harm to others

1. We will reduce harm to our patients by reducing:
   - Self harm incidents by 30%. Target: no more than 61 per month.
   - Suicides of people under trust mental health care by 10% by 2021
   - Falls on our community inpatient wards and older adult inpatient wards by 50%. Target: no more than 4 per 1000 bed days
   - Medication errors graded moderate and above by 20%. Target: fewer than 4 per year
   - Category 3 and 4 pressure ulcers due to a lapse in care by trust staff. Target: At least 180 days between the development of these ulcers. In areas where this target is already being met, a 10% improvement against current baseline is to be applied.
   - Gram negative bacteraemia due to a lapse in care on our inpatient community wards by 50%. Target: No more than 1 per ward.
2. At least 95% of our reported incidents will be low or no harm to patients

3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
4. All our support services will work with patient facing services to identify ways that they can support safety of patients
5. With our health and social care partners: We will work to achieve reduced urgent admissions and delayed transfers of care.

2.2.2. Clinical Effectiveness Priorities

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. We will continue to review, report and learn from deaths in line with new national guidance as it is published

2.2.3. Patient Experience Priorities

To provide good outcomes from treatment and care

1. We will achieve a 95% satisfaction rate with a minimum 15% response rate in our Friends and Family Test (FFT) and 60% of staff reporting use of patient feedback to make informed decisions in their department
2. All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population
3. To reduce instances of prone restraint to no more than 2 per month
4. With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

2.2.4. Supporting our Staff Priorities

To strengthen our highly skilled and engaged workforce and provide a safe working environment

1. We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
2. We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
3. We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
4. We will achieve our objectives for equality of opportunity and staff wellbeing
5. With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2019/20.

2.3. Statements of Assurance from the Board

During 2018/19 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 relevant health services.

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

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2018/19.

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

2.3.1. Clinical Audit

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

National Clinical Audits and Confidential Enquiries

During 2018/19, 16 national clinical audits and 0 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=16/16) national clinical audits of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2018/19 are shown in the first column of Figure 26 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2018/19.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2018-19 are also listed below in Figure 26 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of fig. 26).

Figure 26- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=16)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National audit of Anxiety and Depression 2017	Data Collection: June 2018 – September 2018. 73 (100%) patient's submitted across, 1 service. Report due: August 2019
National audit of Anxiety and Depression 2017 - Spotlight 1 - Psychological Therapies	Data Collection: October 2018 – January 2018. 150 (100%) patient's submitted across, 5 services. Report due: TBC 2019
National Sentinel Stroke Audit (2018/19)	Data Collection: 1st April 2018 – 31st March 2019 (Continuous). 571 (99%) patients submitted for 2018/19, across 3 services , 185 6-month follow-ups. Report due: TBC 2020
National Audit of Care at the End of Life (2018/19)	Data Collection: June 2018 – October 2018 33 (100%) patient's submitted, across 1 service. Report due: May 2019
National Diabetes Audit - Secondary care 2018	Data Collection: May 2018 (data 2017/18). 1747 (100%) patients submitted, across 1 service. Report due: June 2019. Insulin Pump Report Due: July 19
Learning Disability Mortality Review Programme (LeDeR) (2018/19)	Data collection: 1st April 2018 – 31st March 2019 Report due: Annually
National Diabetes Footcare (Community Podiatry care) (2018/19)	Data Collection: 1st Jul 18 – 31st Mar 19 (Continuous). 64 patients submitted across 1 service (Final figure not yet available). Report due: TBC 2020
The National Clinical Audit of Psychosis - EIP spotlight audit	Data Collection: October 2018 – November 2018. 86 (100%) patient's submitted, across 1 service. Report due: August 2019
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: 1st Mar 19 – 31st Mar 20 Continuous. xx patient's submitted, across 1 service (Final figure not yet available) Report due: TBC 2021
National Audit of Inpatient Falls	Data Collection: Continuous, starts 1st Jan 19. Organisational audit completed Jan 19. No Submissions required for core data collection during 2018/19. Report due: TBC
Non- NCAPOP Audits	
POMH Topic 16b - Rapid Tranquilisation re-audit (May 2018)	Data Collection: March 2018 – May 2018. 41 (100%) patient's submitted, across 5 services. Report published: November 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
POMH Topic 18a Prescribing clozapine (June 2018)	Data Collection: June 2018 – July 2018. 106 (100%) patient's submitted, across 3 services. Report published: February 2019
POMH - Topic 6d - Assessment of the side effects of depot antipsychotics- Sept-Oct 18	Data Collection: September 2018 – November 2018. 151 (100%) patient's submitted, across 6 services. Report due: June 2019
POMH Topic 7f – Monitoring of patients prescribed Lithium	Data Collection: February 2019 – March 2019. 108 (100%) patient's submitted, across 10 services. Report due: July 2019
National Audit of Cardiac Rehabilitation (2018/19)	Data Collection: Continuous, 1st April 2018 – 31st March 2019 Number of patients submitted (100%) 314 event records; 376 initial assessments; 313 post assessments. Report due: January 2020
National Audit of Intermediate Care (2018)	Data Collection: 21st May 2018 – 31st August 2018 Data submitted across 4 Intermediate care service types. Crisis response, home based intermediate care, bed based intermediate care and re-ablement services. Benchmarking Project. Reported: Jan 2019
National Confidential Enquiries (N=0)	

Source: Trust Clinical Effectiveness Department

The reports of 9 (100%) national clinical audits were reviewed by the Trust in 2018-19. This included national audits for which data was collected in earlier years with the resultant report being published in 2018/19. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 48 local clinical audits were reviewed by the Trust in 2018/19 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.

2.3.2. Research and Development (R&D)

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

The number of patients receiving relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by Health Research Authority was 1209 from 45 active NIHR Portfolio studies.

As part of the Clinical Research Network Trust Patient Research Ambassador initiative, we now recruited 6 research ambassadors in 2018/19. These are patients who have taken part in research and help us promote research by, for example, presenting at our various research events telling their story about how and why they got involved in research and giving their thoughts about research participation.

Our research activity reflects that we are now a mental health and community Trust, our portfolio of research whilst dominated by mental health research also incorporates research in other non-mental health services such as Diabetes Centre at King Edward VII Hospital in Windsor, the Community Cardiac and Respiratory Specialist Service (CARSS) and Health Visiting service.

The trust held its inaugural research conference in May 2018. This provided the opportunity to celebrate the Trust's contribution to research and to raise awareness locally. Entitled 'Research Collaborations for Better Patient Care' – guest speakers included, amongst others, Keynote speaker Dr Jonathan Sheffield, Chief Executive Officer, NIHR Clinical Research Network (CRN), Professor Belinda Lennox, Clinical Senior Lecturer, Honorary Consultant Psychiatrist, Clinical Director NIHR CRN, Oxford University Hospitals, Professor Adrian Williams, Research Dean, University of Reading and Jennifer Harrison, HRA Approval Change Manager, Health Research Authority. Everyone who

completed an evaluation form on the day gave positive feedback about the event and for a first event it was a fantastic to have 121 delegates attend.

The Trust also publishes the Department of Health mandated "Performance in Initiating and Delivering" (PID) research data on a quarterly basis. This allows the trust to benchmark its performance nationally with some of this data also published on the R&D pages of the Trust's Internet site, the data is available on the following link.
https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development.

The Care Quality Commission (CQC) has now included key research related questions in its inspection framework as part of the "well-led" domain. Further information is available at https://www.nihr.ac.uk/news/support-for-clinical-research-further-recognised-in-the-cqc-inspection-framework/9497?diaryentryid=36923

The Trust Research and Development department registered 19 publications by Trust Staff during 2018/19. Publications of Trust Staff research indicate a growing number and diversity of clinician involvement in health research in the Trust. This helps demonstrate the growth of research awareness.

2.3.3. CQUIN Framework

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

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period can be found in Appendix E & F.

The income in 2018/19 conditional upon achieving quality improvement and innovation goals is FIGURE TBC. The associated payment received for 2017/18 was £2,135,032 against named CQUINs with a further £1,708.000 against STP conditions.

2.3.4. Care Quality Commission (CQC)

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

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

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2018/19.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. The Trust was inspected by the Care Quality Commission during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

1. How older people move through the health and social care system in Reading, with a focus on how services work together. The reviews looked at how hospitals, community health services, GP practices, care homes and home care agencies work together to provide seamless care for people aged 65 and over living in a local area. Review dates- 29th October 2018- 2nd November 2018
2. Joint targeted area inspection of the multi-agency response to sexual abuse in the family in Bracknell Forest. Review Dates 21-25 January 2019.

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

1. An action plan has been developed as a system response through the Berkshire West Integrated Care System. Leads have been identified for each of the actions.
2. A multi-agency response including actions is to be produced by the Director of Children's Services in the Local Authority by 20th June 2019.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2019 in taking such action:

1. Actions have been developed and progressed as a system response through the Berkshire West Integrated Care System
2. Progress to be detailed following production of action plan.

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

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2018/19 financial year at Prospect Park Hospital

- 17th October 2018- Bluebell Ward
- 23rd January 2019- Rose Ward
- 5th February 2019- Rowan Ward

2.3.5. Data Quality and Information Governance

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

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

— Which included the patient's valid NHS number was:
99.7% for admitted patient care
99.9% for outpatient care and
100% for accident and emergency care.

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

Information Governance

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

Berkshire Healthcare NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 'Standards Met'

The Information Governance Group is responsible for maintaining and improving standards in this area with the aim of being satisfactory across all aspects.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.

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

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

Data Quality and Data Assurance audits are carried out throughout the year as part of the Information Assurance Framework (IAF) and where data issues are identified internal action plans are put in place. The data is monitored until assurance is gained that the Trust can have a high confidence level in the data being reported. The assurance reports are included in the monthly Finance, Performance and Risk Executive committee alongside the Performance Assessment Framework (PAF) and reviewed in monthly and quarterly Locality meetings. External Data Quality reports published on the NHS Digital website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a full detailed audit took place in November 2018, which showed that 90% of primary and 92.8% of secondary diagnoses were coded correctly

Indicators chosen for external audit

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

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral- *Mandated indicator*
2. Inappropriate out-of-area placements for adult mental health services- *Mandated indicator*
3. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital- *Governors' Choice*

In March and April 2019 Deloitte LLP carried out external audits on these areas. For each indicator the auditor met with a relevant staff member of staff to understand how the data is used and collected to calculate the indicator. A sample of items was selected from the data set for the auditor to carry out the audit with the designated clinician for each indicator.

"Absolutely delighted with the care and respect that was shown to my relative at an ENT Consultant Outpatients appointment - lovely staff, professional, courteous and an outstanding service, thank you.

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

2.3.6. Learning from Deaths

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

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

An audit of this was undertaken by internal auditors as part of the approved internal audit plan for 2017/18. The audit reviewed the Trust's adherence to the National Guidance on Learning from Deaths and found that the Trust is effectively identifying, reporting, investigating, monitoring and learning from deaths of patients in their care. Substantial assurance was given that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death. In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further.

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

Figure 27 below details the number of deaths of trust patients in 2018/19. This is presented alongside the number of case record reviews and investigations of these deaths that were undertaken over the same period, as well as an assessment of the number of deaths that were more likely than not to have been due to problems in care provided. Please note that the table contains statements that are mandated by NHS Improvement for inclusion.

Figure 27- Deaths of trust patients in 2018/19- case reviews and investigations carried out in 2018/19

	1. Total number of Deaths	2. Total number of reviews and investigations carried out			3.Deaths more likely than not due to problems in care
Mandated Statement	During 2018/19 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2019, the following number of case record reviews and investigations have been carried out in relation to 3474 of the deaths included above.			The number and percentage of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient are detailed below. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)
		1st Line Case Record Reviews (Datix)	2nd Line Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 18/19	**3474** ↓	**320**	**134** ↓	**40**	**3, representing 0.08%*** ↓
Mandated Statement	This comprised the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 18/19	**812**	**73**	**42**	**6**	**1, representing 0.12%**
Q2 18/19	**788**	**77**	**25**	**14**	**0**
Q3 18/19	**983**	**95**	**28**	**14**	**1, representing 0.10%**
Q4 18/19	**891**	**75**	**39**	**6**	**1, representing 0.11%**

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

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. The impact of actions is monitored through the Serious Incident process.

Figure 28 below details the number of deaths of trust patients in 2017/18 that had case note reviews and investigations carried out in 2018/19. This is presented alongside an assessment of the number of these deaths that were more likely than not to have been due to problems in care provided and, as a result, a revised estimate of the number of deaths that were more likely than not due to problems in care in 2017/18 Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 28- Deaths of trust patients in 2017/18- case reviews and investigations carried out in 2018/19

	1. Reviews and investigations carried out		**2.Deaths more likely than not due to problems in care**	**3. Revised estimate of deaths in 2017/18 that were more likely than not due to problems in care**
Mandated Statement	The number of case record reviews and investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2018)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2017/18 that are judged to be more likely than not to have been due to problems in the care provided to the patient.
	Case Record Reviews	Investigations		
Total	**34**	**9**	1 (representing 0.03%) lapse of care has been identified and reported subsequently as an SI in May 2018 following review of the report by the Trust Mortality Review Group: The death occurred in 2017/18. Included in Table 27 above. *	**2, representing 0.05%***

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

2.4. Reporting against core indicators

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

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

Figure 29	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	97.8%	97.7%	**98.7 (Average Monthly %)**	**Awaiting National Data**	**Awaiting National Data**
Data relates to all patients discharged from psychiatric inpatient care on Care Programme Approach (CPA)					
Note: The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 7 days of discharge. This is agreed and arranged with patients before discharge and this facilitates our high compliance level					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust meets the minimum requirement set by NHS Improvement of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source- Trust Tableau Dashboard

Figure 30	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	99.1%	99.2%	**99.1% (12M Average Percentage)**	**Awaiting National Data**	**Awaiting National Data**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision- making process					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service					

Figure 31	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	6.2%	7.9%	**6.9% (Average Monthly %)**	**Not Available** (National Indicator last updated 2013)	**Not Available** (National Indicator last updated 2013)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. A Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 32	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
				For combined MH/LD and community Trusts	
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *This finding has been taken from the % of staff respondents answering 'yes' to Question 21d of the National NHS Staff Survey: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*	74.8%	75.1%	**73.6%**	**66.2%**	**55.9%-79.1%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average and this is maintained.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a five year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care. In addition, the Trust runs a compassionate Leadership course and excellent manager programme which are well attended with positive feedback. Several interventions are also in place to help make it a better place to work despite the challenges around recruiting and retaining staff.					

Source- National Staff Survey

Figure 33	2016/17	2017/18	2018/19	National Figures 2018/19	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.2	7.3	7.2	**6.8** (median figure for all participating trusts)	**5.6- 7.5**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trusts score is in line with other similar Trusts					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 34	2016/17	2017/18	2018/19	National Figures 2018/19	Highest and Lowest
The number of patient safety incidents reported	**3195** *	**4824** *	**4518** *	**169,041** **	**16- 9,204** **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**29.1** *	**45.9** *	**46.2** *	**48.8** ** (Median)	**24.9- 114.3** **
The number and percentage of such patient safety incidents that resulted in severe harm or death	**35 (1.1%)** *	**44 (1.1%)** *	**40 (0.9%)** *	**1834 (1%)** **	**1- 239** **
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data reported to the NRLS. In the NRLS/ NHSI most recent organisational report published in March 2019, the median reporting rate for the Trust is given as 75.2 incidents per 1000 bed days (but please note this covers the 6-month period April 2018-Sept 2018). High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans. Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.					

Sources: ** Trust Figures reported to the NRLS. Please note that these figures are representative of the number of incidents reported at the time the report is sent and are subject to change over time.*

*** NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between April 18- Sept 2018 relating to 50 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2018/19

ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive Group, the Quality Assurance Committee and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. Information relating to specific areas of Trust quality and safety performance in 2018/19 is detailed below.

Incidents and Serious incidents (SIs)

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

The Trust aims to maximise reporting of incidents whilst reducing their severity level through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture. The annual number of patient safety incidents reported by the Trust is detailed section 2.4 above.

Never Events

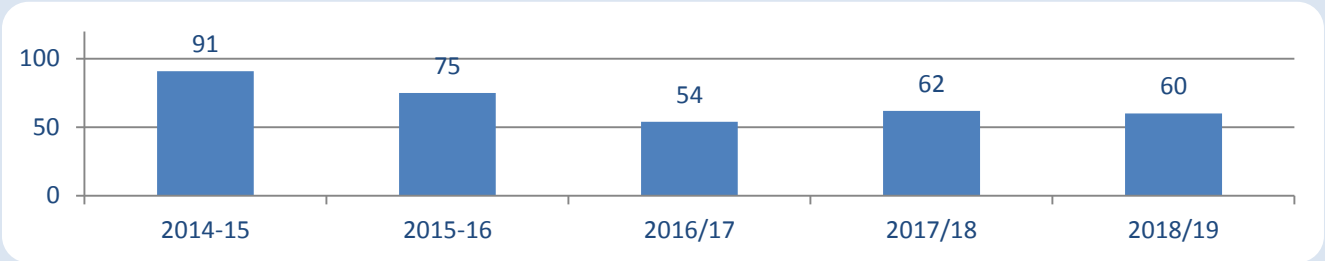
ⓘ Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2018/19.

Figure 35 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

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

Figure 35- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Quarter 4 2018/19 Serious Incident (SI) reporting

During Q4 there were a total of 13 serious incidents originally reported. At the time of writing this, 2 have been downgraded and therefore 11 serious incidents have been included. This is a reduction on the number reported in the previous quarters (18 in both Q3 and Q2 of 2018/19). All 11 of the serious incidents reported were related to mental health services; 5 to Community Mental Health West, 3 to Community

Mental Health East and 3 to Mental Health Inpatient Services. There were no serious incidents reported for Community Physical Health or Children's Services.

The serious incidents reported during Q4 were:

- **Suspected Suicide Cases:** 5 cases were reported in Q4- 3 fewer than in Q3 of 2018/19.
- **Unexpected Deaths:** 1 case was reported- significantly fewer than the 6 reported in Q3.
- **Falls:** 1 fall resulting in moderate harm met the SI reporting threshold as it required surgical repair.
- **Patient on Staff Assault:** 1 case was reported in Q4 of a serious assault by a patient on a doctor during an inpatient Mental Health Managers meeting.
- **Patient on Family Member Assault:** 1 case was reported in Q4 of a patient attempting to murder a family member who was critically injured.
- **Allegation of Sexual Assault by a Member of Staff:** During Q2 of 2018/19, a female patient made an allegation of sexual assault against a member of staff on one of the Trust's mental health inpatient wards. The patient was appropriately safeguarded and the police were contacted at the time who informed the Trust that there would be no further investigation. The Police subsequently contacted the Trust again in March 2019 to inform them that the investigation was active and that additional evidence had been established. This was logged by the Trust as a Serious Incident at this point.
- **Other:** 1 reported serious incident in Q4 related to a serious alleged non-accidental injury to a baby whose mother was in receipt of a targeted health visiting service.
- **Pressure Ulcers:** In Q4 no pressure ulcers were reported as serious incidents. There were 6 learning events held for incidents of category 2, 3 and 4 pressure damage that developed in our care and where there was a potential lapse in that care that may have contributed to the development. Following the learning events, 4 pressure ulcers were agreed to be as a result of a lapse in care in community settings. There were no learning events for Inpatient Units for developed pressure ulcers where a lapse in care was concluded.
- **Preventing Future Death reports (Reg. 28):** The Trust had input into 17 inquests during Q4- 10 more than in Q3. No Regulation 28s were issued but the Trust did receive criticism at two inquests in which a narrative outcome was delivered. Both of these were for deaths which occurred in Prospect Park Hospital and were in relation to a death by natural causes and also a suicide of a person detained under the Mental Health Act. Action plans were already in place to address concerns raised by Coroner.

Comparison to 2017/18: There have been 60 SIs reported in 2018/19 compared with 62 reported in 2017/18 (excluding downgrades). 18 of the SIs reported in 2017/18 were information governance (IG) breaches, whereas only 1 IG SI has been reported in 2018/19 due to a change in reporting requirements. SIs for unexpected deaths have increased from 13 in 2017/18 to 16 in 2018/19 whilst SIs for suspected suicides have increased from 13 to 24. At the time of writing the Trust do not know what percentage this is of secondary care contacts. Falls with harm SIs have decreased from 7 in 2017/18 to 6 in 2018/19. The 3 top reporting categories in 2017/18 were information governance breaches, suspected suicides, and unexpected deaths. The top 3 reported categories in 2018/19 were suspected suicides, unexpected deaths and falls.

Key themes identified in SI investigation reports approved in Quarter 4 2018/19, together with actions taken to improve services:

- **Communications with family / carers:** Failings in communication with families and carers and the documentation of such communication are a common finding in serious incident investigations.
- **Management of hydration**: This has been raised as an issue in some investigations with regards to the assessment and management for signs and symptoms of dehydration on Inpatient Units (both physical and mental health). It is important to intervene early and act on this information. At times the tools available to staff are not being robustly completed and monitoring is not being effectively carried out.
- **Multidisciplinary Team (MDT) Meetings**: The robustness and completeness of documenting what is discussed and planned in MDT meetings has been highlighted as a theme in a previous quarterly report but continues to be identified as an issue in relation to mental health MDTs.
- **Lack of robust safety** planning – whilst safety plans are now in place ongoing work is required to ensure that the quality of interventions, particularly to mitigate the likelihood of suicide, are always explored and documented clearly.

Actions are being undertaken to address these main themes.

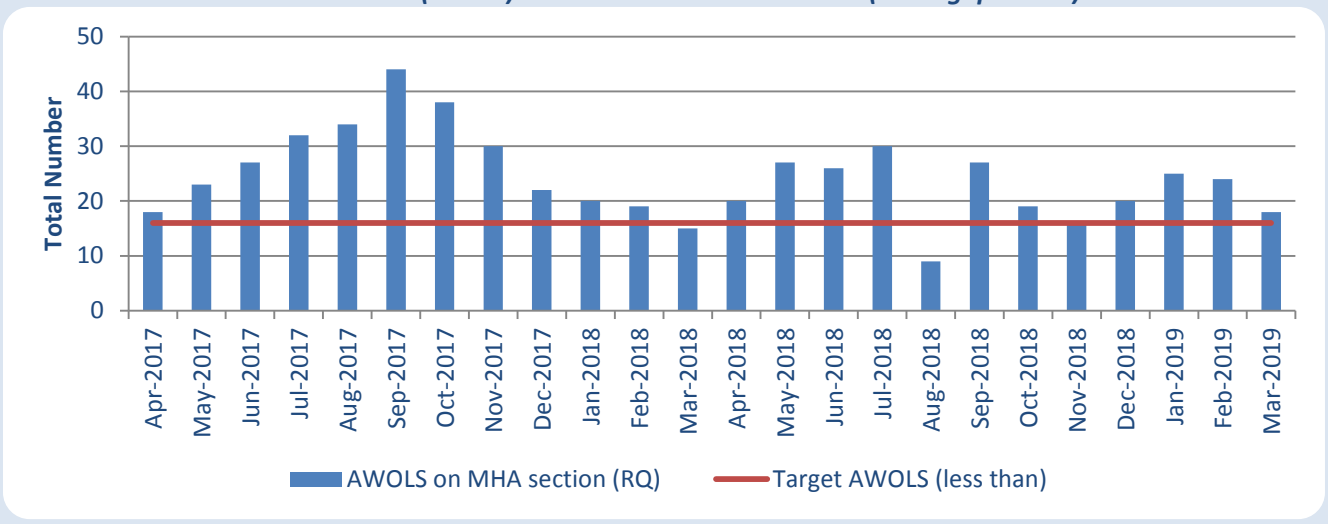
Absent without leave (AWOL) and absconsions

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

Figures 36 and 37 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

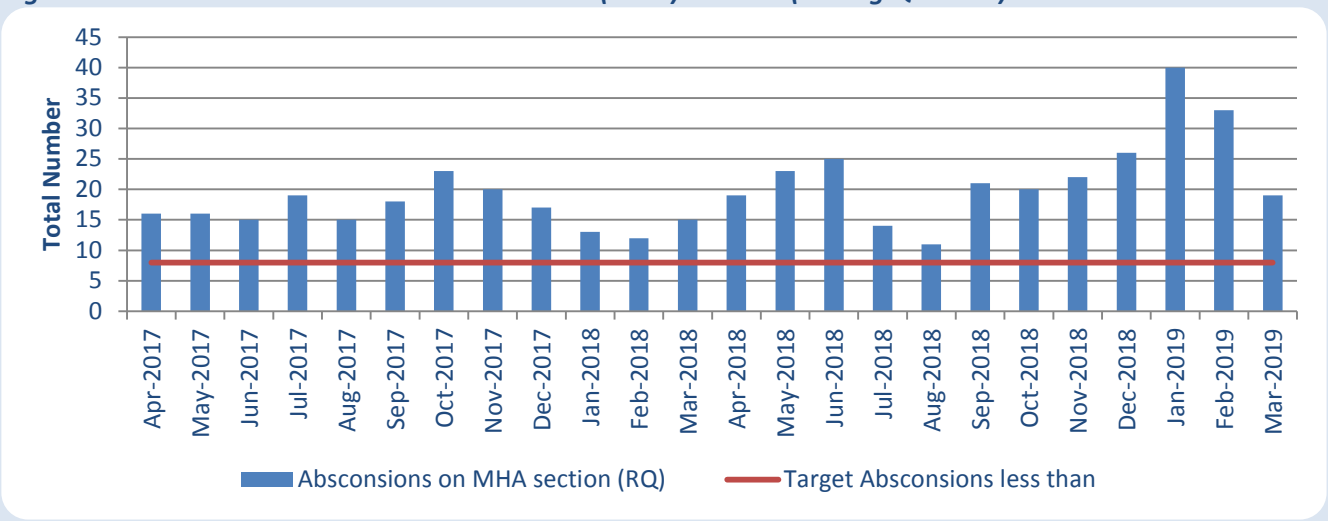
To address this target, the wards are Prospect Park Hospital are running a 'failure to return' project which aims to reduce the number of AWOLs and absconsions.

Figure 36- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source- Trust Tableau Dashboard

Figure 37- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source- Trust Tableau Dashboard

Medication errors

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

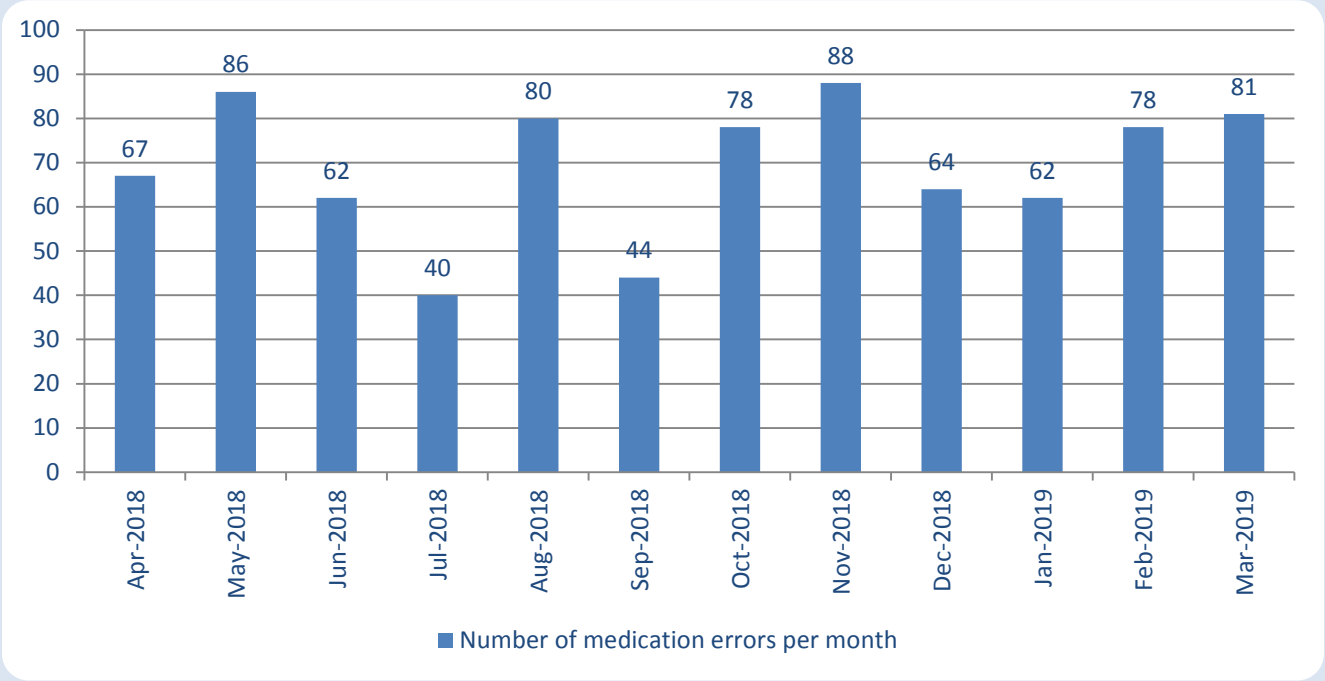
Figure 38 below details the total number of medication errors reported per month. There were a total of 830 medication errors reported in 2018/19. When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists. The data reported also includes all the near misses and documentation errors, so they are not all actual incidents. There is also evidence to suggest that not all incidents and near misses that staff acted upon were reported so any increase may be due to better reporting culture rather than a less safe organisation.

Local processes in this area are being updated by line managers. Trust-wide, there is much activity in overseeing this area including; sharing learning from incidents with summaries sent to locality Patient Quality and Safety Groups, Standardising practices around insulin doses in the community, Treatment to Take Out (TTO) tracking stickers, review of medicines management training, resolving EPMA system errors and standardising and streamlining technology to support medicines management.

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

One moderate medication error was reported during the year (during Quarter 1). This error related to Insulin and other medicines being given to an incorrect patient on a Community Health Ward. There was no harm reported for the patient.

Figure 38: Number of Medication Errors Reported Each Month



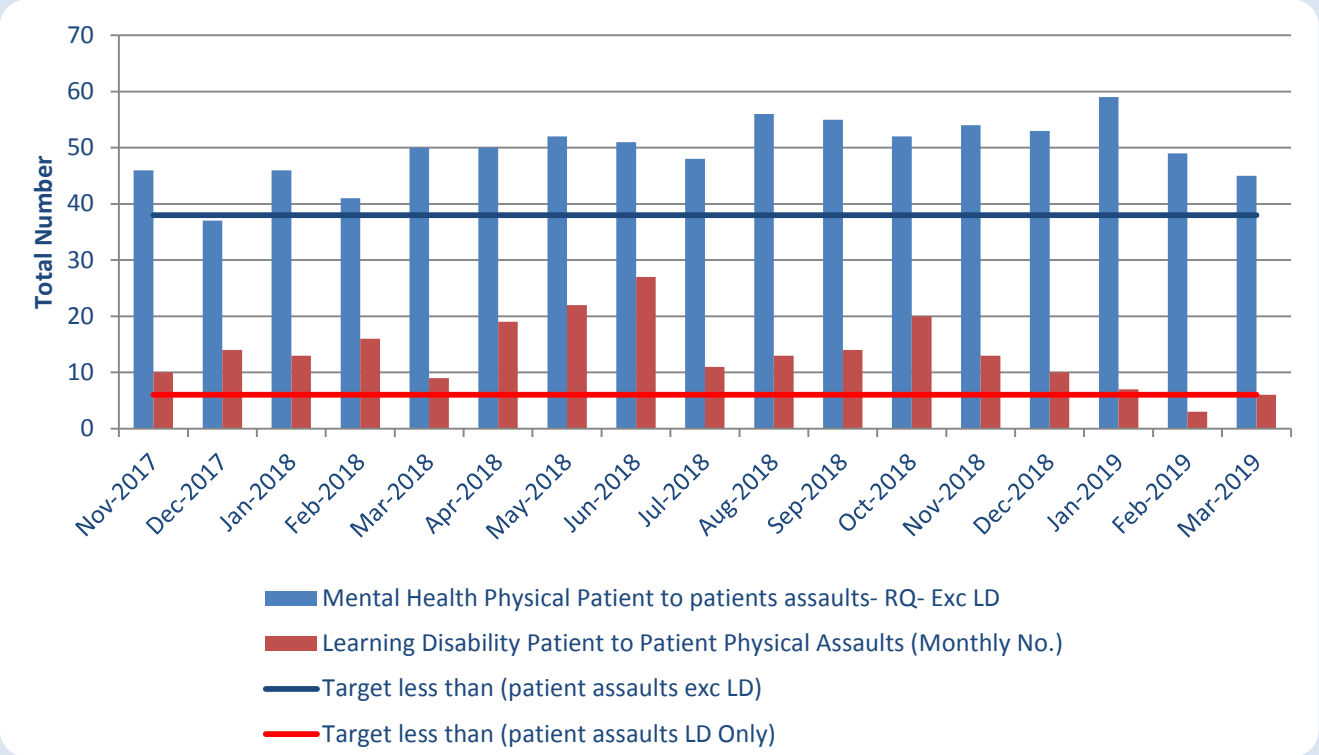
Source: Medicines Management Quarterly Report

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 39 below details the number of patient to patient physical assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD). As can be seen, the level of patient on patient assaults appears to fluctuate.

Information on patient assaults on staff is included in part 1 of this report.

Figure 39- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source- Trust Tableau Dashboard

"Excellent emergency care. My relative was visited on a daily basis by the team when he became suicidal. They were diligent and persistent, even when he was reluctant to engage, and when he needed to see the team psychiatrists the appointments were given promptly and he was seen on time. I cannot fault the follow up, and we couldn't have managed without their support and advice."

From a relative of a patient- Crisis Resolution and Home Treatment Team (CRHTT), West Berkshire

Other Quality Indicators

Please note that the following indicators have been removed from this section of the Quality Account as they are not in the Single Oversight Framework:

- CPA review within 12 months
- Completeness of Community service data
- Referral to treatment (RTT) waiting times – non-admitted –community.
- Access to healthcare score for people with a learning disability

Figure 40	Annual Target	2016/17	2017/18	2018/19	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events in year or quarter
Infection Control- MRSA bacteraemia	0	0	0	**0**	Total number of MRSA Cases in year or quarter. *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	2	3	**1 (0.01 per 1000 occupied bed days)**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust in year or quarter. *Source- Trust Infection Control Reports*
Developed Category 2 Pressure Ulcers due to Lapse in Care by Trust Staff	<19	N/A	14	**15**	Total number of Cat 2 pressure ulcers due to lapse in care by Trust in year or quarter. *Source- Trust Pressure Ulcer Reports*
Developed Category 3 and 4 Pressure Ulcers due to Lapse in Care by Trust Staff	<18	N/A	18	**19**	Total number of Cat 3 and 4 pressure ulcers due to lapse in care by Trust in year or quarter. *Source- Trust Pressure Ulcer Reports*
Medication errors	Increase Report.	N/A	N/A	**830**	Total number of medication errors reported in year or quarter. *Source- Trust Medicines Management Report*
Ensuring that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	a) 90% b) 90% c) 65%	N/A	a) 87.5% b) 88.5% c) 100%	**TBC when data available**	Percentage of patients with psychosis where cardio-metabolic assessment requirements were met. *Source- Trust CQUIN Report*
Admissions to adult facilities of patients under 16 yrs. old	0	N/A	0	**0**	Total number of patients <16 years of age admitted to adult MH Inpatient Facilities in year or quarter

Figure 40	Annual Target	2016/17	2017/ 18	2018/19	Commentary
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per CCG Targets	N/A	247	**185 (Target met)**	Average monthly total bed days spent out of area in year or quarter
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	12.38%	11.3%	**9.0%**	Average monthly % in year or quarter. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	53%	85.8%	84.5%	**81.0%**	Average Monthly % in Year or Quarter
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	N/A	58.8%	**57.4%**	Average Monthly % in Year or Quarter
Improving access to psychological therapies (IAPT):People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	98.4%	98.9%	**98.3%**	Average monthly % in year or quarter
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	99.9%	100%	**100%**	Average monthly % in year or quarter
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.5%	99.3%	**99.8%**	Average monthly % in year or quarter.
Data Quality Maturity Index (DQMI) – MHSDS dataset score (Revised Indicator)	95%	N/A	N/A	**97.8%**	Average monthly % in year or quarter.
Patient Experience					
RTT waiting times Community: Incomplete pathways	92% <18 weeks	99.9%	99.8%	**99.4%**	Average monthly % in year or quarter.
Complaints received		209	209	**230**	Total number of complaints in year or quarter
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	100% 100%	100% 100%	**100%** **100%**	Total % in year or quarter

Source- Trust Tableau Dashboard except where indicated in commentary

Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated April 2019
  - feedback from governors dated April 2019
  - feedback from local Healthwatch organisations dated April 2019
  - feedback from Overview and Scrutiny Committee dated April 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
  - the 2018 national patient survey November 2018
  - the 2018 national staff survey March 2019
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated October 2018
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

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

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

Appendix A:
Annual Plan on a Page- 2018-19

True North: Annual plan on a page 2018-2019

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

NHS
Berkshire Healthcare
NHS Foundation Trust

True North: goal 1 - Harm-free care

✓ **To provide safe services, prevent self-harm and harm to others**

- We will align our efforts and work to deliver our harm-free objectives
  - Reducing patient falls incidents by 50%
  - Reducing patient self-harm incidents by 30%
  - Reducing rates of suicide of people under our care by 10% by 2021
- All our services will contribute to an Outstanding Care Quality Commission rating

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

True North: goal 2 - Supporting our staff

✓ **To strengthen our highly skilled and engaged workforce and provide a safe working environment**

- We will achieve improvements in key areas:
  - 66% of our staff feeling they can make improvements at work
  - 75% of our staff recommending Berkshire Healthcare as a place to receive treatment
  - 20% reduction in assaults on staff
- Our recruitment and retention plans will reduce vacancies by 10%
- An additional 24 services will be trained in our Quality Improvement System
- We will achieve the objectives set out in the Equality Plans for each area

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

True North: goal 3 - Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will achieve a 95% satisfaction rate in our Friends and Family Test and 60% of staff reporting use of service user feedback to make informed decisions in their department
- We will reduce our use of prone restraint by 90% by the end of 2018/19
- All our services will focus on understanding and supporting outcomes of care that are important to patients

At a system level: We will contribute to Integrated Care System work streams to improve patient experience and outcomes.

True North: goal 4 - Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will deliver our financial plan for the year and achieve £5m internal savings
- We will continue to improve our efficiency in the way we buy goods and services and further reducing our use of agency staff
- People needing acute mental health inpatient care will be able to access it locally, eliminating the need for acute out of area treatment by 2021
- We will achieve our environmental targets, reducing our use of fuel and water

At a system level: We will contribute to the achievement of the financial targets in 'Berkshire West' and 'Frimley Health and Care' Integrated Care Systems.

Quality Improvement programme

Annual Plan on a Page- 2019-20

Annual plan on a page 2019/20

NHS
Berkshire Healthcare
NHS Foundation Trust

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

True North goal 1: Harm-free care

✓ **To provide safe services, prevent self harm and harm to others**

- We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia
- At least 95% of our reported incidents will be low or no harm to patients
- All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
- All our support services will work with patient facing services to identify ways that they can support safety of patients

With our health and social care partners:
We will work to achieve reduced urgent admissions and delayed transfers of care.

True North goal 2: Supporting our staff

✓ **To strengthen our highly skilled and engaged workforce and provide a safe working environment**

- We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
- We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
- We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
- We will achieve our objectives for equality of opportunity and staff wellbeing

With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

True North goal 3: Good patient experience

✓ **To provide good outcomes from treatment and care**

- We will achieve a 95% satisfaction rate in our Friends and Family Test (FFT) and 60% of staff reporting use of patient feedback to make informed decisions in their department
- All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population

With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

True North goal 4: Money matters

✓ **To deliver services that are efficient and financially sustainable**

- We will achieve our financial target of a £1.9m surplus so that we can continue to invest in improving our services, buildings and equipment
- All our teams will work on achieving a 2% efficiency or productivity improvement to benefit patients and staff
- We will continue to achieve reduced use of agency staff and deliver an additional 1% reduction in corporate costs

With our health and social care partners: We will play our part to achieve the financial targets in Berkshire West and Frimley Health and Care Integrated Care Systems.

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2018/19 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National audit		Description	Actions to be taken to meet recommendations
NCAPOP Audits			
1	National Clinical Audit of Psychosis (3582) (including MH CQUIN3 for community & Inpatients)	National Clinical Audit of Psychosis (NCAP) was previously known as the National Audit of Schizophrenia (NAS) from which two reports were previously published: NAS1 in December 2012 and NAS2 in November 2014. The audit has focused on four issues relating to the quality of care provided for people with psychotic disorders: management of physical health, prescribing practice, access to psychological therapies and outcomes. Twelve audit standards and two outcome measures were developed to address these issues which were measured using 29 individual metrics	The audit highlighted that we have the lowest proportion of patients on CPA when benchmarked with other The proportion of patients on CPA is wider than the NCAP and has been highlighted previously in other benchmarking reports. This is being addressed across BHFT, each locality led by the locality directors has an operational action plan in place, to ensure appropriate review of patients who should be on CPA and that specific actions required are implemented within that locality to support the compliance with the CPA policy. Assessments of carers needs: The audit identifies that we have the lowest number of patients with carers identified and that assessment of their needs is not completed when benchmarked against other similar organisations. There is a specific focus on Carers within the trust which the Clinical Director for Children's Services leads on, all mental health services have an action plan in place to specifically address the needs of carers which is being monitored through this programme of work. In addition for those patients on CPA the crisis plan specifically reviews carer's involvement. Locality risk audits are completed and reviewed quarterly by the locality through the patient safety and quality meetings. The audit looks at the service user view, carer view and safety plan (in addition to other areas), any areas of concern are raised to the Quality Executive Group (QEG), and actions are taken within the specific localities to improve compliance. The August risk assessments give assurance that appropriate carer involvement is being completed for patients on CPA. Interventions for when glucose and lipid results which are outside of the Lester tool parameters are often lifestyle and diet advice and in some cases onward referral to an appropriate specialist. In previous audits we have identified that documentation of this is not always easy to find on RiO and this can lead to inaccurate audit data submissions. There is a significant focus on physical health of mental health patients within the trust and documentation of interventions is an area they are aware of and reviewing.
2	National Diabetes Footcare audit (3586)	The National Diabetes Footcare audit (NDFA) is a measurement system of care structures, patient management and the outcomes of care for people with active diabetic foot ulcers. The NDFA is a continuous data collection audit and is part of the National Diabetes Audit (NDA) portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP)	There has been an increase year on year of the proportion of patients who are being seen more than 2 months after initial presentation, increasing from 12.8% to 24.6% To improve time from first being assessed by any Healthcare Professional (HCP) to referral into the MDfT the part time Foot Protection Lead role (community role) continues to support community Podiatry woundcare clinics in this process along with changing referral guidelines to the MDfT. Podiatry local investigation to be carried out for all major amputations from April 2018. From July 18 the community Podiatry service will be collecting data which will give more comparable data across the CCGs.

National audit		Description	Actions to be taken to meet recommendations
3	National Diabetes Secondary Care & Insulin Pump audit (3751)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. GP Practices and secondary care services were also involved in the audit to give a full picture of the diabetes care pathway. The NDA is part of the National Diabetes Audit portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP).	Significant work has been done since 2016/17 the timeframe in which these audits review, and detailed below is the improvements and actions which have been taken and are in progress. The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Board was set up in April 2017 to help support the transformational bids across the whole Frimley ICS. The Diabetes Service is also a key member of the Berkshire East Clinical Leads Group where local needs are reviewed and addressed. The service is also represented at the Thames Valley Diabetes Clinical Reference Group which looks to improve diabetes services across Thames Valley. The service is currently working as part of the Frimley ICS and is looking to redesign by moving to a more integrated diabetes service. This will include Consultant support in Primary Care and an increase in WTE of Diabetes Specialist Nurses based in the Community to up-skill Primary Care. The Diabetes service is working with the supplier of their Diabetes Database, HICOM so that that more functionality can be utilised to obtain more accurate data. The system may be able to link with RIO and ICE (the pathology system) to ensure that relevant data is entered onto the system automatically. The Specialist Service is in discussion with East Berkshire CCG in respect of commissioning more dietary interventions for people with diabetes as healthy eating and associated weight loss plus physical activity still remains the best treatment for people diagnosed with type-2 diabetes. Structured education Provide more education session including evening and weekend sessions. Sessions in other languages to meet the needs of the local population. Working in partnership with a local GP practice by piloting a locally developed type 2 education programme in Punjabi. An on-line offering of structured education for those people who do not want to attend a face to face course. The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative. The ICS is reviewing how to engage this group of people in their care and how to improve uptake to the services available. Slough are currently recruiting Diabetes Community Champions supported by Diabetes UK to work in the local community to provide support and signposting to Diabetes Care as well as highlighting the risk factors and complications related to the condition Insulin Pump All people with Type 1 Diabetes who are referred for an insulin pump and meet NICE criteria for Insulin Pump Therapy are offered Insulin Pump Therapy. A pathway is in place and agreed with East Berkshire CCG.
4	National Audit of Care at the End of Life (3588)	The National Audit of Care at the End of Life (NACEL) is a nationally-facilitated project that is mandated for Trust participation by our trust community inpatient wards and mental health inpatient wards as part of the National Clinical Audit and Patient Outcome	Review and update the Trust Individualised End of Life Care Plan template to ensure that it meets all of the current best practice requirements, and ensure all patients that require them have an end of life care plan. Ensure that all patients that require them have an End of Life Care Plan. Ensure patients have their capacity to be involved in their end of life care decisions both assessed and documented. Where mental incapacity is not suspected, ensure that this is also documented. Ensure that a senior clinician (a senior doctor or recognised competent nurse) carries out a documented

National audit		Description	Actions to be taken to meet recommendations
		Programme (NCAPOP). The audit focuses on expected hospital deaths and comprises three main aspects; an organisational audit, a patient case note audit and a 'Nominated Person' quality survey. All three parts of the audit were analysed against best practice as defined in "One Chance to get it Right (2014) and NICE Quality Standard 144 -Care of Dying Adults in the Last Days of Life (2017). This is the first time that this audit has been open to services that the Trust provides. In February 2019, the national team running the project (The NHS Benchmarking Network) released a Trust Bespoke Dashboard detailing trust findings benchmarked against all Trusts. It is the findings from this Bespoke Dashboard that are presented in this report.	discussion about CPR with both the patient and the nominated person (unless the patient does not consent to this, in which case this should also be documented). Ensure that the possibility that the patient may die is discussed and documented with the patient. Ensure that the need for routine tests (such as vital signs and blood tests) and non-routine tests is reviewed and documented in light of the patients deteriorating condition. Ensure that the recorded contact details for the nominated person include their address. Ensure that the potential side effects of medications are discussed and documented with both the patient (where possible) and the nominated person. Ensure that the patient's hydration and nutrition status are reviewed regularly (daily in the case of hydration) and that conversations are held and documented with both the patient and nominated person about the risks and benefits of hydration and nutrition options. Review the processes, support and information available immediately prior to, at the time and immediately after the patient's death. Review this interim analysis once the national report for the project is published in May 2019. Implement standardised process for sending condolence letters including BHFT Information for families following a bereavement leaflet Update trust end-of-life guidelines to include a guideline for viewing the body in the immediate time after death and a guideline for enabling rapid discharge home to die if that is the person's preference Investigate whether it would be possible to have an adult and child psychologist available to be consulted by patients, relatives and carers for trust community inpatient wards Investigate the possibility of including End-Of-Life care on trust induction & mandatory training programme
5	National Diabetes Secondary care – Care Process and Treatment Targets report (4330)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines & Quality Standards. It reviews both Primary & Secondary Care services to give a full picture of care provided across the whole diabetes care pathway. It is a requirement of the NDA for secondary care services to participate. In East Berks we are commissioned to provide a Specialist Secondary Care Diabetes Service which supports both people with diabetes primary care in the management of the condition.	The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Service has received extra non –recurrent funding in 2018 in respect of structured education to provide more education session including evening and weekend sessions, sessions in other languages as well as an on-line offering. The service is also working with a local GP practice by piloting an Asian type 2 education programme The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative . Over 70% of people who did not respond to an invitation to attend structured education when questioned felt that they did not need to attend as they had sufficient education and or another family member with type 2 diabetes.

National audit		Description	Actions to be taken to meet recommendations
Non-NCAPOP audits			
6	POMH Topic 15b: Prescribing valproate for bipolar disorder (2017) (3583)	The Prescribing Observatory for Mental Health (POMH-UK) runs clinical audit based quality improvement programmes that focus on discrete areas of prescribing practice. This report focuses on the first re-audit for POMH 15b: Prescribing valproate for bipolar disorder. The standards are derived from NICE Clinical Guideline CG185: Bipolar disorder (update): the management of bipolar disorder in adults, children and adolescents in primary and secondary care, September 2014.	Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the MHRA drug safety alert, that valproate should no longer be used in women of child bearing age unless a pregnancy prevention plan is in place. Medical Director to further communicate advice to doctors at the medical staff committee (MSC) Medication Safety update to be sent to all Patient Safety and Quality Meetings across the Trust The consultant checklist to be replaced by the Annual Risk Acknowledgement Form which is required to be completed by the specialist prescriber and the patient. This form must be completed at initiation and yearly thereafter with copies sent to the GP. Valproate Screensaver 'Stop' 'think' detailing link to pharmacy resources on all Trust computers A prompt has been added to the new CPA template and also the risk aide memoir to provide a further reminder to staff. EPMA text reminder to appear when sodium valproate is clicked on. A request has been put into EMIS for EPMA as currently there is no "alerting" functionality within EPMA unlike other systems that could remind staff at point of prescribing. Audits of prescribing for this cohort both 6 monthly and annually through FP10 and electronic systems to be undertaken and reviewed at the MSG. Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the trust audit results, reminding them of their responsibilities when prescribing valproate to patients. A programme of work is already underway to improve physical health screening for those with SMI. This will be extended to include all patients with a bipolar diagnosis prescribed valproate. Physical health leads will ensure education and information provided captures the findings from this audit and the areas to improve on in terms of physical health monitoring. This group should also be included in the shared care protocols for physical health monitoring that are underway
7	Review of the Early Intervention in Psychosis Network's (EIPN) self-assessment report on Berkshire Healthcare's EIP Service 2017/18 (3589): May 2018	The Early Intervention in Psychosis Network (EIPN), an initiative of the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI), provides supportive quality improvement reviews for EIP services. Services are reviewed against EIPN quality standards through a process of self-review and a peer-review visit. The aim of the self-assessment tool was to provide services with the opportunity to review their practice against a core set of	EIP Service to link in with the Physical Health monitoring work to identify how baseline data can be identified easier at start of being prescribed antipsychotic medication To add documenting baseline measures to the risk register To link in with Cardio-metabolic Assessment QI work. To meet with Inpatient Physical Health Leads to plan raising awareness of the need to document baseline physical health measures at start of antipsychotic medication whenever antipsychotic medication is initiated during an admission. The outcome measure forms are to be accessed online via electronic means such as RiO, iPhones, tablets and available through SHARON if possible A meeting with IT to establish what is possible electronically around forms on RiO, tablets and whether e-forms can be incorporated electronically onto clinician devices and accessed via SHARON.

National audit		Description	Actions to be taken to meet recommendations
		standards which included an assessment of their ability to offer NICE recommended interventions, deliver timely assessment and collect appropriate outcome measures. This is the second time the EIP self-assessment has been undertaken and included data relating to expectations laid out in the 'Implementing the Early Intervention in Psychosis Access and Waiting Time Standard'. The previous EIPN self-assessment was conducted in 2016/17. This National audit also included the CQUIN EIP 2017/18	To have forms created electronically. To meet with IT again to make a plan for developing the electronic forms by the end of October as part of the GDE project
8	POMH Topic 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (3975)	This report focuses on the first re-audit for POMH 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour. The standards are derived from NICE Guideline NG10: Violence and aggression: short-term management in mental health, health and community settings.	Three standards have been highlighted as areas which require improvement: A prompt debrief is completed and recorded on the patients RiO record within 24 hours (Trust policy requirement) Physical health monitoring and recording in the hour post rapid tranquilisation Physical health monitoring for at risk patients (15 minute observations). In addition to the actions which have been completed since September 2018 there are a number of other actions which have been implemented or are in the progress of being implemented. Staff training continues to be a focus of development and in the last 6 months we have introduced e-Observations which allows' staff to directly input physical observations onto an i pad and this information goes directly into the patient management system. One of its functions is to be able to set the frequency of physical observations and this is able to serve as a reminder to staff that observations are due.
9	POMH Topic 18a Prescribing clozapine (June 2018) (3996)	This baseline audit aimed to review clinical practice against national standards for prescribing clozapine. Wherever current practice diverges from best practice, as outlined in NICE Clinical Guideline CG178, Berkshire Healthcare aims to take action to make improvements and reduce risks related to prescribing clozapine. There were seven standards and a treatment target based on the NICE guidance.	Comprehensive standardised approach to physical health monitoring. Review alongside physical health monitoring for BHFT patients through physical health group and agree standards Trust wide. Defined Clozapine pathway in line with other care pathways with consistent approach to record interventions on RIO system. Develop pathway through BHFT pathway project team and transformation team. Evidence based agreed standards for prescribing and monitoring of Clozapine within BHFT. Review of guidance and consideration of side effect monitoring tool (GASS).

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	High dose or multiple antipsychotic medication use in Wokingham CMHT 4170)	This audit aimed to review whether Wokingham CMHT was meeting national NICE Guidance (NICE Schizophrenia Guideline: Clinical Guideline CG178, 2014, Psychosis and schizophrenia in adults. Although majority of the data documented in their notes CPA, clinic letters, or Clozapine clinic follow up charts it would be ideal to have an agreement to document those in one place on the system so it can be easily checked when required. Also, although it is documented somewhere on case notes that the patient is on high or multiple dose of medication, it would be ideal if it is written as a separate statement in clinic letters, therefore they can be monitored more carefully in primary care settings with given advice. Capacity and consent to treatment is also documented in all of their notes, however, a statement about patients being informed about risks of multiple or high dose of antipsychotic medication, about the risks of combining those with other medications when applicable and obtaining informed consent specifically for that can be considered and would be a better practice.
2	Audit of PGD use by Peer Vaccinators for the 2017 staff influenza vaccination campaign (4227)	The purpose of this audit was to examine the use of the influenza vaccination PGD used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff, working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. It focussed on whether the PGD for the administration of flu vaccine to staff has been used in accordance with agreed inclusion criteria and whether documentation was in line with the national recommendations. An action plan has been devised and includes: PGD to be updated and to include people who work in trust clinical areas on a voluntary basis in the inclusion criteria. Issues identified with standards: 5, 8, 11 & 15 to be clarified and re-enforced. Consent form to be updated and the questions re-ordered in order to avoid staff missing questions. Only the most up to date consent forms to be used and available on Teamnet.
3	East Berkshire audit of assessment and investigation of newly diagnosed HIV patients (3649): December 2017	BHIVA has produced extensive guidance on the initial assessment and baseline investigations for newly diagnosed HIV patients. Each patient should have a full medical history and examination plus documentation of 14 factors. Recommended investigations cover a broad range of tests. Slough Sexual Health Clinic serves East Berkshire and cares for approximately 600 people living with HIV. The audit highlighted several areas requiring improvement including the need to include DA, travel, vaccination and mental health history in the clinic proforma. Patients may not report mental health issues unless asked and, as it could affect engagement with services, medication choice and adherence, it should be recorded. Improved recording of travel histories will facilitate targeted TB and parasite testing. MSM patients should be offered the vaccine if non-immune. PHI-testing is not currently available at our local laboratory but would be useful for targeted partner notification. The findings from this audit have been reported back to the clinic and plans to update the proforma should act as an aide memoire and improve documentation. An action plan was fully completed in 2017, which involved updating proformas and presenting the findings to staff to improve compliance with physical examinations.
4	Health Visitor New Birth Assessment Audit (3855): February 2018	This re-audit had two main aims. Firstly, to identify good practice in recording of HV assessments and to establish if the RIO version of the Family Health Needs Assessment (FHNA) New Birth, had been safely embedded in practice and secondly to identify any possible areas for improvement and actions required. The template for the FHNA had been developed within RiO as recommended in the previous audits action plan. Health Visitors need to continue using the RiO CYPF New Birth FHNA template, need to improve on the recording of the outcome of the new birth FHNA in the mother's progress notes, the recording of fathers details using the personal contacts link, to improve on the synchronising of RiO details with the National Spine and need to complete their records within 24 hours, in keeping with the trust business rules. Reminders to be given at all team meetings and followed up via review of records during management supervision, All localities/managers to confirm actions completed at service improvement group. Audit tool needs to be adapt for next audit to fit with the 24hr standard not 48hr.

	Audit Title	Conclusion/Actions
5	Consent to ECT Audit (4092): January 2018	The aim of this re-audit is to ensure that Berkshire Healthcare ECT Department comply with national guidelines for consent to ECT and, in order to ensure that consent is valid, for all patients to have a robust capacity assessment with relevant documentation prior to ECT. Standards were developed from the ECT Care Pathway and the Berkshire Healthcare ECT Policy and Guidelines (CCRO). The re-audit included one additional standard when compared to the baseline: the mental capacity form is completed on RiO. Clear documentation is the best way of evidencing that the trust is meeting the standards set by its policy and the ECTAS guidelines. Therefore, we must aim to improve and reach the previous 100% compliance with re-checking capacity on the day of the ECT and recording it in the patient's notes. In addition, although lack of the RiO form being completed, does not mean that capacity was not checked on the day prior to ECT, it should be utilised more to ensure clear and detailed documentation of a capacity assessment does take place prior to each ECT treatment. Raise awareness with ward doctors about the importance of completing the capacity forms on the day prior to each ECT treatment – this can be emphasised at the junior doctor induction. To provide immediate feedback to ward doctors on the day of ECT if they have failed to complete the capacity form prior to treatment. Raise awareness with posters about the consenting process for ECT. These can be placed in office areas on the wards.
6	Blood Transfusion Audit 2018 West Infusion Clinics (4177): March 2018	There is an MHRA requirement for all clinical areas where blood transfusion occurs to undertake the British Society of Haematology national bed side audit. The audit was undertaken in the High Tech Care Team to comply with BHFT's transfusion policy (CCR133) requirement to undertake an annual audit of transfusion practice. An action plan has been developed and action has already been taken to inform blood banks that the service works alongside, about the audit results. Further action is being taken to ensure that prescribers are aware of the need to document special requirements.
7	Lurasidone (Latuda®) Evaluation within BHFT (2715)	Purpose: To evaluate the prescribing of Lurasidone to patients referred to inpatient ward Psychiatrists (BHFT) where one of the treatment goals is to manage schizophrenia and psychoses with minimal risk of weight gain and metabolic side effects. Consider treatment with Lurasidone for Berkshire patients admitted as inpatients, experiencing relapse for the following reasons: Non-adherence of current treatment due to side effects and/or weight gain or other metabolic adverse effects from current treatment. Lack of efficacy of one antipsychotic. -The formulary position of Lurasidone should be reviewed as a result of this audit within CCGs - BHFT has added this drug to its formulary but this will not be taken over by GP's.
8	10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital (3863)	For all children and young people who present to an acute hospital in a mental health crisis, our standard operating procedure recommends a "7-10 day follow up either by a telephone or face to face contact". This project aimed to measure the 10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital and an evaluation of the reasons where this has not been possible. Community 7-10 FU appointment is determined before the patient is seen in acute hospitals and offered to the patient at the crisis appointment in acute hospital. Review operational process for handovers of CYP who have out of hour assessments by engagement with PMS services and with PPH/APOS – Protocols in practice meeting. The handover protocol to be incorporated in standard work/SOP for CAMHS RR. Review operational process for handovers of CYP out of hour assessments in out of area hospitals (Basingstoke and FPH) Induction protocol embedded in standard operational procedures for new starters. Operational causes will be evaluated and we expect to implement actions to improve the compliance rate for re-audit in one year.

	Audit Title	Conclusion/Actions
9	Prescribing psychotropic medication in individuals with intellectual disability (4054)	The aim of this audit is to determine the level of compliance with the current standards of practice for the prescribing of psychotropic medication in patients with intellectual disability as outlined by the report of the Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists, alongside the NICE guidelines for challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. Make the admitting and ward doctors aware of current standards for prescribing psychotropic medication in intellectual disability, with focus on the recording of off-label medication. Inform admitting and ward doctors of the off-label use of antipsychotics for challenging behaviour and the NICE conditions. Push for clear documentation in patient notes for the rationale behind changes in medication.
10	Re-Audit of Antimicrobial Prescribing on all Berkshire Healthcare Inpatient Wards (3574)	This audit is a re-audit of Project 3494. The audit aimed to determine how compliant the Trust was with nationally recognised standards of good antimicrobial stewardship (AMS) and practice, and whether local Trust prescribing guidelines for antimicrobial prescribing is followed by prescribers. Recommendations will be managed through the BHFTs AMS Group who will have overall responsibility for taking these actions forward. Continue the wide spread use and regular update via AMSG of Trust guidelines through The Microguide app. Doctor's induction pack. Inpatient bulletin Continue staff engagement through continued staff training and awareness of AMS principles. Annual AMx Guardian campaign. Review e-learning to incorporate ongoing pertinent AMS points Raise staff awareness for full completion of allergy box on EPMA charts across all healthcare professionals. Inpatient bulletin. Continue system working Joint collaboration to streamline Trusts and CCG guidelines within the County It is expected that further improvements will be observed as EPMA is embedded. The AMS group are due to discuss the action plan at their next meeting on 16th July 2018; they will lead on this going forwards.
11	Re-Audit of compliance with sepsis early recognition tool in community health inpatient units (3713): April 2018	The NICE sepsis guidelines were published in July 2016 and a quality standard published in September 2017. An initial audit was undertaken in 2016-17 to establish baseline compliance in inpatient units following the implementation of the sepsis early recognition tool. Targeted training to continue including eLearning. HIPC to continue to provide support for staff in compliance with the sepsis early recognition tool. The sepsis page on Teamnet is to be regularly reviewed and updated, new resources and guidelines to be communicated to clinical staff. Infection Prevention and Control post infection reviews to be monitored for compliance with the early recognition of sepsis tool. Learning is to be disseminated to clinical teams via relevant post infection review reports and quarterly shared learning reports disseminated by the IPCT. Involvement with individual QMIS projects to review the use of the early sepsis recognition tool.
12	Fragility Fractures Audit Programme (FFFAP) - CSP Hip Sprint Audit 2017 (3630)	Although this was a national audit, it is not mandated (quality account reportable) or on the NCAPOP Programme. Following a review of the national report's recommendations, the following actions were devised for BHFT: Evidence based exercise programme including strength, balance, mobility and endurance in place for all hip fracture patients on Jubilee. Health coaching and goal setting used to increase adherence to programme. Continuity post discharge by referral to other ARC services – ICR, Community Physio, ARC

	Audit Title	Conclusion/Actions
13	School Nursing Nocturnal Enuresis Service Audit (4118): December 2017	The school nursing service undertakes the record keeping audit on an annual basis in order to measure compliance against the CCR153 'School Nursing: Nocturnal Enuresis Policy. Compliance against this policy is required to be monitored via the annual audit using the national enuresis service monitoring tool. An action plan was developed which includes key actions for all localities to ensure that the enuresis assessment tool is used in all cases. Further education and development of staff through pan-Berkshire staff nurse meeting and the use of the school nursing letter to distribute, findings, recommendations and further information. New automatic waiting list set up on RIO with an alert after 42days if client not yet seen, which will prompt review of clinic availability
14	Safeguarding Record Keeping Audit, School Nursing 2017 (4119): December 2017	An in-depth audit of child protection records and health assessment was conducted by the school nursing service. Spot checks will be conducted half termly via management supervision, to include reviewing whether safeguarding children's risk forms are fully completed and whether the progress notes summaries the key information including risk to the child. IT training has been provided in uploading documents and the Health assessment form is being Built into RIO.
15	Audit of Risk Summary Documentation for all Patients in the Slough Pathways Outreach Team (4318)	The purpose of the audit was to establish if all eligible patients under the care of the Slough Pathways Outreach Team (SPOT) have had risk summaries completed. In particular, whether their last risk summary update was in line with the time frame required (either 6-monthly or 12-monthly depending on necessity to have CPA meetings). There is nowhere on RiO which prompts staff that a risk summary is overdue; it is possible that this would improve compliance. Team to be made aware that risk summaries can be updated despite not having seen the patient in the case (as one of ours) when they are in a different region of the country. If there has been any contact with the patient, family or other healthcare professionals this can be documented and as long as clearly stated that the patient has not been seen and assessed, this is valid. Discussion with the MDT surrounding adding a column on the MDT handover sheet. The current form includes patient details, their last CPA, next CPA, cluster number, details of outpatients appointments and CTOs. Two columns could easily be added to include date of last risk summary and date next risk summary is due.
16	Lithium use in Wokingham CMHT: Audit of safety and quality of monitoring in the last year (4349)	Wokingham CMHT previously participated in the national POMH Lithium re-audit in June 2016. This audit measures using NICE Clinical Guideline (CG185) for Bipolar disorder: assessment and management (published September 2014). Whilst compliance with all standards prior to starting Lithium are excellent, some measures conducted during maintenance treatment could be improved upon, particularly serum calcium 6 monthly. It should not be assumed that requests for U&E's will also mean that calcium would be checked as an electrolyte; it should be requested separately.
17	Audit on use of hypnotics for insomnia in West CRHTTs in comparison with NICE guidelines (4331)	The aim of the audit was to identify patients under West CRHTT who were started hypnotics (Zopiclone, Zolpidem and Zaleplon) and to assess whether NICE guidance was followed. Patient's literature on sleep hygiene should be readily available to clinicians. Patients should be provided with information and followed up on sleep hygiene plan. MDT collaboration to review ongoing hypnotic's use. Improve awareness of NICE guidance of management of insomnia.
18	ADHD Shared Care Clinic Annual Review Audit (4094)	Adult ADHD is treated with medication and managed locally by the Adult ADHD Shared Care Clinic. Both the new and previous NICE Guidelines recommend an annual review of the condition and treatment: NICE CG 72 (2008) and NICE NG 87 (2018) respectively. . The aim of this audit was to demonstrate whether we are meeting the standards. All annual reviews should lead to communication to GP's on the pro forma. Where there is no available previous weight, a BMI should be calculated, anyway. We need to ask about sexual side effects on atomoxetine and record the outcome. We should ensure that we record comments on mental wellbeing, physical health and substance misuse at every annual review.

	Audit Title	Conclusion/Actions
19	A direct observation study of medication administration errors in a community and mental health setting (2733)	In response to a 2010 NPSA alert on omitted and delayed medicines, repeated audits of 'blank boxes' on medication administration charts have been completed; however action plans have had either a temporary or little effect (blank boxes are unsigned administration records when a medication was due, leading to uncertainty whether the medication was administered or not). In response, we completed this wide scale audit of all medication administration errors across BHFT. This aimed to document the rate of medication administration errors (MAE's) across all inpatient wards in a community and mental-health Trust, and to investigate the interrelationship between error rates and possible contributing factors. Additional information to be added to the mandatory medicines management training. Medication administration processes to be discussed at Medicines Safety Group with actions to be identified.
20	Evaluation of a Transdiagnostic Cognitive Behavioural Therapy Group in a Secondary Care Adult Mental Health Service (4088): May-18	The aim of this project was to evaluate the effectiveness and acceptability of the tCBT group. No issues were raised as a result of completing this service-evaluation and therefore no action is necessary. The evaluation demonstrated that running the tCBT group is effective and acceptable.
21	Audit of Care Pathway: People Whose Behaviour Challenges - Pre and Post Outcomes (4206)	This audit is completed every year to ensure that the LD service delivers an excellent quality of care to people following the People Whose Behaviour Challenges Care Pathway. The audit is based upon good practice standards set out in two documents: Challenging Behaviour: a unified approach (2007); and Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NICE 2015). Present findings to the Learning Disability Governance meeting (November 23rd, 2018). Re-audit in April 2019 to ensure progress is maintained and improved. The Intensive Support Team (IST), Occupational and Speech and Language therapists will be asked to contribute specialist assessments as pre and post outcome measures. A three monthly follow up, repeating outcomes measures used, will be completed as per guidelines, to enable measurement of whether the gains have been maintained following closure. This guideline will be added to the care pathway.
22	Re-audit Berkshire Perinatal Community Mental Health Service Discharge Summaries (4458): 09/08/2018	This re-audit aims to measure improvements since last years' audit. One standard relating to timeliness of reporting to the GP was added to the 2018 re-audit, while all other standards remained the same as in 2017. To discuss with the team the importance of documenting a plan for future pregnancies. Standardised Discharge Summary to be used by all perinatal clinicians
23	Better understanding of the interplay between hyperactivity, inattention and impulsiveness in the clinical assessment of ADHD (2732)	The standard assessment of ADHD in BHFT CAMHS includes the use of screening questionnaires (Conners rating scales) and neurocognitive testing combined with infrared motion analysis (QBTest). This project tried to assess whether distinct neurocognitive profiles can also be distinguished in the scoring of the Conners rating scales and what the degree of correlation will be. In order to improve the interpretation of clinical data and investigations for the benefit of making more reliable diagnoses and raising the standard of the diagnostic assessment, thus leading to better treatment plans, the following have been implemented: Results were presented at the Specialist CAMHS ADHD Team Meeting on 10.10.2017. Attention was drawn towards the careful analysis of activity levels in relation to neurocognitive profiles. Clinical advice was given with regards to the integration of investigations, i.e. clinical observation, screening questionnaires and objective measurements when assessing for a diagnosis of ADHD. Standard Assessment was introduced with aids as to how to analyse neurocognitive profiles and how to complete an ADHD assessment that will meet Bolam/Bolitho criteria.

	Audit Title	Conclusion/Actions
24	Improving Multidisciplinary Rounds on an acute Psychiatry inpatient ward (4211)	Multidisciplinary ward rounds (MDR) are an important forum wherein patients, carers and inpatient teams share information about patient's care. The outcomes were expected to aid enhanced patient engagement, service user safety, improve communication between inpatient team, carers and community mental health teams and to reduce unnecessary delays in discharges. A further review is needed to assess the views of carers and community staff, to gain a full understanding of how MDR rounds can be improved on an inpatient ward, but this is likely to be part of a separate piece of work.
25	Audit on the documentation and appropriate review of blood investigations in the inpatient services (4249)	The audit aimed to review the proportion of new admissions that had blood tests taken, whether these were documented in RiO, if documentation was timely, and if an appropriate plan was documented. Phlebotomy to be consulted as to how they can best/most easily communicate with clinicians. Mention the need to document bloods on RiO to new trainees at induction. Consultants to be made aware by email of findings of audit in order to pass the message on to the team.
26	Covert Administration Audit on Rowan Ward (4362): May 2018	. The main aim of the audit was to measure the level of adherence that healthcare professionals on Rowan Ward had to Berkshire Healthcare's SOP on covert administration. Training on where to specifically store and how to use the MRSOP; 4009 Covert Administration of Medicines forms. Nurses to be given additional training on covert administration and the importance of signing the covert administration form with their agreement. Training for pharmacists on how to use ePMA to input specific endorsements for the method of administration. Improve the covert administration process by ensuring that covert administration forms are all uploaded to RiO, to make accessible to all. Reduce the maximum official review date for covert medication from 3 months to 2 months and ensure review includes looking at if medications are still essential. Repeat audit using a regular member of the team to complete the audit prospectively over a longer period when recommendations have been implemented.
27	Parkinson's Audit (3656)	The objective of the Parkinson's patient management audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson's complies with national guidelines including the Parkinson's NICE guideline and the National Service Framework for Long Term Neurological Conditions (NSF LTNC).
28	Frequent attenders at the emergency department (2839)	The CCG asked the Psychological Medicine Service (PMS) to create a system to address the problems for individuals and services associated with people who repeatedly present to A&E at the RBH. The aim of this project was to identify the 'top 20' repeat attenders aged 16+ to RBH A&E each quarter and to implement appropriate indirect / direct interventions with the aim of reducing attendances in the following quarter(s). No specific actions are required as part of this project, though further related work will include: Continuing with CQUIN until 2020, Increasing frequent attenders pathway (requires resources). Continuing to develop the work regionally – benchmarking and networking with other Emergency Departments

	Audit Title	Conclusion/Actions
29	Audit of transition practice for young persons with ADHD (3803): June 2018	Berkshire Healthcare Trust implemented a policy on the ADHD Transition Pathway from CAMHS to Adult Services in 2015 based on NICE guidelines and recommendations. Effective and thorough transition from CAMHS to adult services in patients with ADHD is crucial to minimise the impact to patients in what can be a challenging and anxiety-provoking period for both the patients and their families. The audit sought to assess, whether the transition process was being followed by services across Berkshire in line with BHFTs transitioning tool, and to make changes where required improving the service provision for patients. The audit demonstrated that the current policy is in line with national standards and guidance. However, there are some gaps within the service based on the recommendations made: • ADHD Transition from CAMHS to Adult Services Policy should be made more widely available on the intranet by discussing with IT and appropriate professionals involved in these services. • Results of the audit to be presented at the CAMHS academic seminar, to ensure that relevant professionals are informed and made aware of areas to change. • Results of the audit presented during team meetings in each area of BHFT e.g. Maidenhead / Wokingham / Reading etc. • The ADHD transition from CAMHS to Adult Services Policy to be presented at team meetings in each area locality in order for people to become more familiar with the standards and expectations of the transition process. • Whilst this audit primarily highlights changes which can be made by CAMHS, this audit needs to be passed to the adult ADHD team in order for them to be made aware of areas for improvement including them sending receipt of referrals and sending appointments. • A proposed checklist to be created outlining in brief what needs to be completed prior to transition and during the transition process including deadlines; to be distributed amongst the teams. • In the longer-term, to consider having a prompt on RiO to ask whether clinicians are considering referral may be a helpful as a reminder.
30	An audit of current practice of Partner Notification for patients with a new diagnosis of HIV presenting 2016-17 at the Garden Clinic (4184): July 2018	Partner Notification (PN) is an important outcome to be evaluated in the commissioning of sexual health services and is also important from a public health perspective as it enables services to identify those at risk of HIV infection, particularly those at risk of primary HIV infection, who will be most at risk of transmitting the virus to new sexual partners. The HIV Partner Notification for Adults: Definitions, Outcomes and Standards published by BASHH/BHIVA in 2014 define the process whereby contacts of those with HIV are identified and offered HIV testing. The aim of this audit was to compare performance at the Garden Clinic in Slough with national results and with results of the 2012/13 PN audit. This audit highlights the need for local review of the PN process as PN information was often difficult to access and information was documented differently depending on the clinician who saw the patient. Following the audit, it became apparent that Health Advisors in the team could input PN information that was not available to other members of staff. The action plan tackles the issues of access and, through training, will ensure a consistent process if followed using the sexual contacts tab on Lille.
31	Re-Audit on the Management of Gonorrhoea in the Sexual Health Service (4186): September 2018	Antimicrobial resistance is on the rise worldwide, GRASP surveillance has issued warning regarding resistance to the currently used Cephalosporin antibiotics. Though the incidence of Gonorrhoea infection is on the rise especially in high risk individuals, is also an indication of HIV transmission. The purpose of this audit is to audit the investigation and treatment of gonorrhoea positive patients. Standards were taken from the UK National Guideline for the Management of Gonorrhoea in Adults (2011; BASHH). An audit against the same standards was conducted a year prior to the re-audit. Recommendations include: Improving attendance rates of men, such as by having clinics for men or online testing. NAATS and culture plates should be taken from all appropriate sites. Full sexual history must be taken from both men and women. If first line of treatment is not given, continue to document reasons. Written information to be given out to patients and documented on Lille. An action has been developed to set up a texting system on Lille to provide a link with patient information leaflets.

	Audit Title	Conclusion/Actions
32	Audit of the Safeguarding Children Risk Form on the RIO record (4375): April 2018	The safeguarding children at risk form was designed to enable practitioners to see at a glance the safeguarding issues for the child, whilst at the same time holding important information about the contact details for the social worker and details of the next safeguarding meetings. The form allows for all of this important information to be accessed from one place and be viewed at a glance. The purpose of this audit was to review if the safeguarding children risk forms were being used since their introduction two years ago. The initial reason for developing the form was so that the information around safeguarding was instantly accessible. The audit sought to highlight if the forms were being completed correctly. Overall, the findings of the audit were positive, the children risk forms are being used as designed for their intended purpose. Therefore, no further actions required
33	A QIP on the Physical Health Monitoring of Inpatients on Bluebell Ward (4024): June 2018	This project was carried out as it was identified that although, there was a robust monitoring system in place to assess the physical healthcare of patients on admission, there was no process where a patient's physical health examination, bloods, ECGs or other general physical health was discussed as part of the weekly MDT meetings whilst they were an inpatient. The audit sought to address the impact of this and improve this with the objective of being able to review the processes involved and identify gaps in care. The key recommendations proposed are: The physical examination, results of blood tests and ECG should be documented in the patient's electronic records. Medical aspects of the patient's clinical presentation should be adequately documented during weekly MDT discussions summarising the physical health status of the patients during the review and their treatment. The monitoring of NEWS should be consistent with the Trusts NEWS monitoring policy CCR 116 in terms of the frequency of the monitoring and contacting relevant medical professionals. 24-hour physical monitoring forms on RIO should be completed to include all parameters such as hearing, sight, dentition, bowel problems and fluid balance. The nutrition monitoring forms on RIO should be completed with eating and swallowing problems being recorded. Propose to re-audit in a years' time. All doctors on the inpatient wards will use the check list during the MDT meetings and the use of the check list will be periodically reviewed.
34	Effective Use of Anticoagulation Use in Atrial Fibrillation (4218): July 2018	Atrial Fibrillation is associated with increased risk of strokes; effective anticoagulation can minimize patients having strokes. The primary objective of this audit was to see whether all patients who need anticoagulation are on either warfarin or NOACs. Further also to find out the reasons, if patients have not been started on anticoagulants or if they are on Aspirin or Clopidogrel. To increase the awareness among GPs on CHA2DS2-VASc by arranging lectures, posters and sending emails. Display CHA2DS2-VAS score guidelines in clinical areas. To investigate if the system can have periodic pop ups of CHA2DS2-VASc score as reminder.

	Audit Title	Conclusion/Actions
35	MIU X-ray Diagnosing, Reporting and Follow Up Audit (4279): August 2018	The purpose of this audit is to review the Minor Injuries Unit's (MIU) practice relating to diagnosing, reporting and following up on patients who have x-rays. Similar audits have been completed during 2016 and 2017; however this audit has been updated (following a SIRI 2017/19265) to include two additional standards relating to follow up processes when a patient requires referral to the Virtual Fracture Clinic (VFC). The radiology department at WBCH should be printing the RBH x-ray reports and delivering them to MIU in a timely manner. Differences in diagnosis and report should be clearly documented in the notes regardless of whether it affects treatment. Patients with fractures to the proximal and middle phalanx of the fingers should be referred to VFC as per VFC recommendations. Documentation of what the x-ray report stated should be recorded correctly in the patient notes. Delay between the time a patient has their x-ray and in the checking of the x-ray report should be reduced. Checking the VFC referral has been made needs to continue and must be documented.
36	To establish, improve and maintain a personal folder for inpatients. Audit to check items in patient folders against a checklist (June 2017 to December 2017) (3701): October 2018	Campion Unit is an acute inpatient service providing intensive multidisciplinary assessment, formulation and treatment in a controlled setting. Service users have complex needs, often with multiple diagnoses. Standards have been developed based on Transforming Care Programme, which was developed by NHS England, the Association of Adult Social Services, the CQC, Dep of Health and RCoPsych. Action was taken throughout the 6 month period based on the findings of the audit. Completion of these actions has resulted in improvements for patients: - Full and complete care plans and section 17 leave documentation, which evidence patient involvement, have given clarity to the patients and their families about leave opportunities for patients to maintain contact with their families as well as leisure activities. - T2 and T3 forms were not clearly understood by all of the patients and the Responsible Clinician has since developed an easy read explanation of the SOAD process and T3 certification. Including communication passports in the patient folders has helped to embed the need for all staff to individualise communication with patients. Staff have reported that this has increased their use of, and confidence in using non-verbal methods of communication including sign supported English such as Makaton. - Storage of documentation relating to healthcare appointments at Royal Berkshire Hospital (and other healthcare sites) has been a challenge. The Responsible Clinician has devised a system for copying information related to the patient into their folder to improve practice in this area. - The CTR leaflet is being given to the patient and completed during the Mental Capacity Act process. This is documented in the progress notes.
37	First Prescription of Combined Oral Contraceptive (COC) Audit (4535): October 2018	, this re-audit aims to measure compliance (and any improvements since the 2011 audit) with the following auditable outcomes: - Prior to first prescription of COC, all women attending the service have a Body Mass Index (BMI) and blood pressure documented - Before first prescription of COC, all women attending the service have a documented record showing assessment of cardiovascular risk factors, including migraine. Key recommendations from this re-audit include: Filling out physical health details electronically while the patient is in the room so as not to forget to document results on the electronic system. Further development of the contraception proforma, including a banner at the top with a box for blood pressure, height and weight to be documented. The proforma and physical details tab should be linked if possible so that it can self-populate. Feed results back to staff, including issues relating to incorrect coding of prescriptions on SRHAD.
38	Neuro-imaging in dementia patients (4570): November 2018	Neuroimaging is an essential part of investigations in dementia patients. NICE Guidelines exist for this aspect of investigation for dementia (NICE Guidelines: 1.2.13: offer structural imaging to rule out reversible causes of cognitive decline and to assist with subtype diagnosis, unless dementia is well established and the subtype). Although full compliance was found, an action plan will be considered based on the following recommendation: create a recommended time in the local policy in which a previous scan would be acceptable. Ideally this should be within one year in order to rule out reversible causes.

	Audit Title	Conclusion/Actions
39	Audit on testing Vitamin D level in elderly patients admitted to Henry Tudor Ward after falls, as per NICE Guidelines in Falls and Vitamin D (4532): December 2018	The standard for this audit was: All patients presenting on admission with a clinical problem of falls will have a vitamin D test completed within 1 month. The purpose of the current audit was to evaluate how compliant Henry Tudor Ward is with NICE recommendations, specifically recommendation 7 which relates to testing vitamin D levels on patients presenting with a clinical problem of falls, with the aim of starting vitamin D treatment earlier for applicable patients. There have not been any recent audits on this topic in Berkshire Healthcare. The results were presented to the Clinical Governance Group on 19th December 2018, where the recommendations and action plan were agreed. Recommendations include: - Educating ward and rehab doctors on the Vitamin D NICE Guideline during weekly teaching meetings, clinical governance meetings and weekly multi-disciplinary team meetings about the need to add a vitamin D request in routine blood for all patients who have falls. - Designing a notice based on NICE Guidelines around falls and displaying the notice on notice boards in doctors' rooms and clinical rooms. - Adding a pop-up notice to computer desktops on vitamin D and falls. - If nurses are unable to book vitamin D blood tests, their ICE login should be updated. - Doctors' ICE login can be set to default to the endocrine panel where vitamin D is displayed. - Discussing any limitations to testing vitamin D with the biochemistry lab.
40	Review of patients on anti-dementia medication (ID 4276): January 2019	This audit set out to evaluate the current prescribing practice in the Bracknell Community Mental Health Team for Older People (CMHTOA). Based on the 2011 guidelines BHFT participated in a POMH (Prescribing Observatory for Mental Health) audit in 2013 on prescribing anti-dementia drugs. An action plan is being devised. Recommendations: - Clear recording of information: A standardised form to adequately record the review. - The results of the audit will be presented and discussed at a Bracknell memory clinic and CMHT business meeting.

	Audit Title	Conclusion/Actions
41	An Audit of the Antipsychotic Drugs prescribed for management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Older Adult Community Patients (4357): June 2018	The current audit uses standards developed from NICE Guideline CG42 (2016) and NG97 (2018) to audit antipsychotic prescribing for management of BPSD in patients from Slough Older Adults Community Mental Health Team (CMHT) who have dementia, with the aim of making improvements to practice where necessary. The findings of the audit were presented to the multi-disciplinary team for further discussion and analysis. At this meeting it became apparent that not all staff were aware of the timescales for completing assessments and that another reason why the three-month follow up is not always being completed is due to patients presenting as too disturbed for cognitive re-testing. The decision was made to develop an action plan for improvement and review these standards on an annual basis as per the guidelines. The action plan includes actions relating to: - Using the pain score tool to identify the severity of pain when reviewing patients prescribed antipsychotic medication. - Using medication information and leaflets to present medication effects, risks and benefits and to improve compliance with prescribed medication. - Documenting reported effects, CVA risks and the risks and benefits of antipsychotic treatment in the Psychotropic Medication section in RiO progress notes. - Using the MSE template and Physical Health section on RiO progress notes to document the Behavioural and Functional Analysis and CVA risk. - Including timescales of assessments in staff inductions and training. - Staff education via clinical supervision, appraisals and MDT meetings to highlight importance of re-assessment of cognitive function for patients prescribed antipsychotic medication. - Identifying and recording social needs using functional tools such as Bristol Activities of Daily Living, Face Overview Assessment. - Considering referrals to Occupational Therapy / Physiotherapy / Podiatry / Falls Clinic when identifying needs and deficits with living conditions and mobility. - Discussing possible psychosis in clinical meetings and adhering to NICE guidelines for management of psychosis for patients with dementia. - Reviewing after 3 months and 6 monthly subsequently as per CQUIN requirements and Royal College of Psychiatry Guidelines on prescribing psychotropic medication.
42	Capacity and Consent Issues (ID 4666): May 2018	Mental capacity is an important issue regarding patients with mental health problems. This is relevant for the psychiatric patients who are admitted informally or under the Mental Health Act. This audit aimed to review whether mental capacity was recorded on RIO for admission and treatment purposes for patients who were admitted on Rose Ward, PPH. An action plan is being devised. A recommendation includes: • Capacity for treatment is documented in three different places which make it a challenge and time consuming to pull out specific aspects of care. The medical team aim to assess capacity for treatment and admission at the first patient review or at the MDT.

	Audit Title	Conclusion/Actions
43	Audit of Physical Activities in patients with learning disabilities (ID 4166): February 2019	People with Learning Disability (PWLD) are at higher risk of developing mental illnesses and dying prematurely due to poor physical health. Reducing premature death and increasing the general well-being of PWLD is a national and organisational priority. This audit used an adaptation of IPAQ-SF, specifically designed and tested for PWLD, to quantify the level of physical activities in PWLD. • Raise awareness amongst healthcare professionals e.g. GPs, social workers, members of MDTs and carers/relatives about the current guidelines and recommended level of physical activities. This can be achieved by designing and distributing easy-read leaflets, running educational sessions and publishing papers in journals/mass media. • Develop the current audit tool (LDPAQ) in collaboration with our physio/OT colleagues to elaborate further on different vigorous activities in people with severe learning and physical disabilities. • Undertake further studies and surveys to explore the impact of different factors such as level of learning disabilities, mental and/or physical co-morbidities and presence or absence of capacity on preferred life style and level of physical activities. • Explore the possibility of using technology to measure the intensity of physical activities in a more objective way such as recoding the heart rate. • Seek advice and recommendation from a specialist about the recommended physical activity plan for complex individuals with mental and physical health co-morbidities.
44	Audit of use of Dementia Intervention Care Pathway in Learning Disability Services (ID 4471): January 2019	The aim of the project was to ascertain whether the Dementia Intervention Care Pathway tool, or the information provided by this tool, has been used by health professionals to support PWLD who have a diagnosis of dementia. An action plan is in place and includes the following recommendations: 1. Audit findings to be fed back to the six community health teams/localities for PWLD within Berkshire. 2. The Intervention Care Pathway is to be more widely publicised within the service. 3. Health teams are to be supported to develop their Dementia Planning Meetings. 4. Liaison with the End of Life Care Pathway regarding resources and appropriate tools that may be available for use when considering Future Planning when someone has a diagnosis of dementia.
45	Waiting Time Standards for CBT Treatment in Berkshire Perinatal Community Mental Health Service (ID 4483): November 2018	This audit aimed to examine the compliance of the current service provided against Pathway 4 of the perinatal EBTP, i.e. the waiting time of women with a perinatal mental health problem who are referred for psychological interventions to our team and whether they start treatment within six weeks of referral. An action plan will be devised. Recommendations include: • To repeat this audit in 12 months' time to include a longer data collection period to identify if the results are replicated. The next audit should seek to identify reasons why clients may not be offered CBT treatment within the recommended 6 week window i.e. client not ready to engage. • To further identify reasons for clinician and client cancellation across both West and East Berkshire. To identify if this is a system or administrative error that can be resolved. • To continue to explore recovery rates through psychological tools and patient feedback. To have a larger, complete data set.

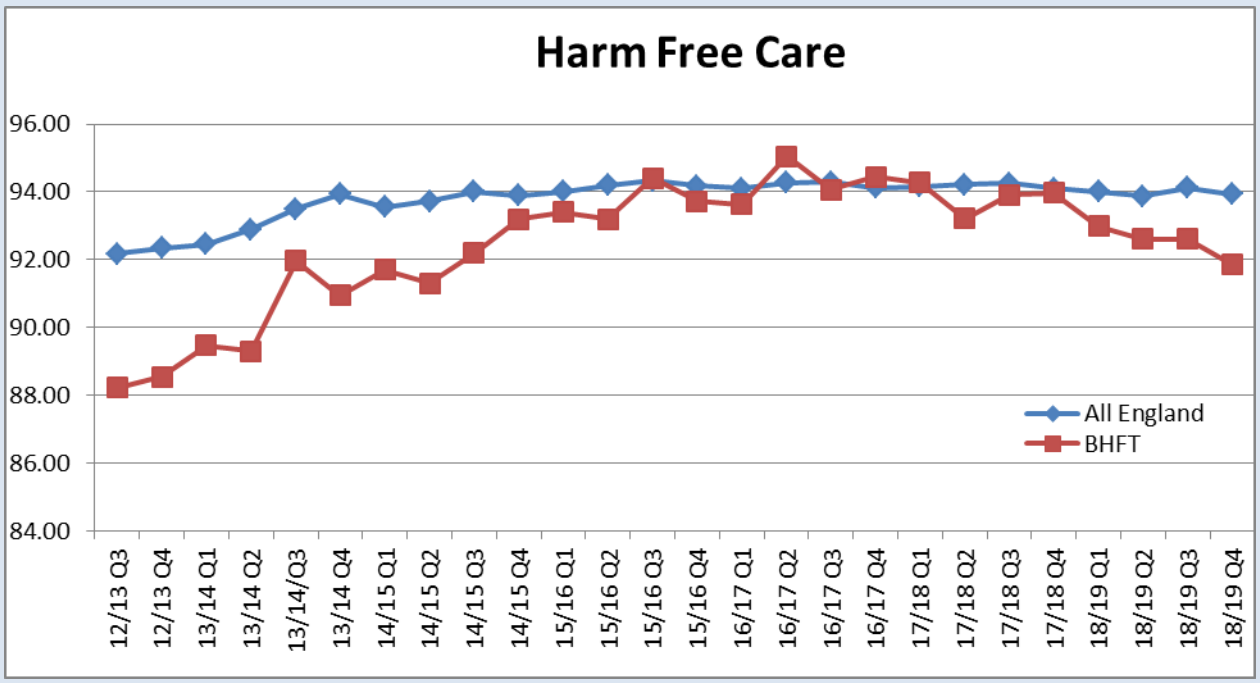
	Audit Title	Conclusion/Actions
46	UNICEF Baby Friendly Initiative Annual Audit 2018 - Health Visiting Services (4531): September 2018	The UNICEF Baby Friendly Initiative aims to provide women and their families with evidence based, sound knowledge and advice to support them with their feeding choices for their baby and to promote a close and loving relationship with their child. To maintain its level 3 accreditation, the Trust has to submit annual audit figures based on staff knowledge and mothers feedback for both breastfeeding and bottle-feeding mothers to ensure that the four standards set by the Baby Friendly Initiative have been embedded into practice. To explore other ways of contact with mothers to address the issue of informing them about continued breastfeeding once they have returned to work. This could be via text messages or use of email, the inclusion of relevant information in the 'Introduction to family foods' session and the documenting of visit conversations in the Personal Child Health Record as reference.
47	Clinical Audit of Electro-Convulsive Therapy (ECT) Outcomes: Using the Clinical Global Impression (CGI) and Hamilton Depression Scale (HAM-D) to evaluate ECT treatment (ID 4692): January 2019	Electro-convulsive therapy (ECT) is one way of treating depression, mania, schizophrenia and catatonia (NICE Guidelines, 2009). It is recommended to achieve rapid and short-term improvement of severe symptoms after inadequate trial of other treatment options has proven to be ineffective and/or the mental illness is considered to be potentially life threatening. The purpose of this project was to evaluate the ECT service provided by Prospect Park Hospital by studying who receives ECT treatment and looking at the ECT response rate. An action plan is being finalised. Recommendations: • Future audits may consider broadening the standard to include more stringent criteria for standards of patients who receive ECT treatment. • A separate audit to address the issue of increasing numbers of people having ECT and the poor post-ECT Efficacy Index rate. This could look at the quality of referrals for ECT and the appropriateness of those who receive treatment.
48	Audit of PGD use by Peer Vaccinators for the 2018 staff influenza vaccination campaign (ID: 4731): February 2019	The purpose of this audit was to examine the use of the influenza vaccination PGD (Patient Group Direction) used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. An action plan has been devised: 1. Update of PGD, including staff that are over 65 and the new egg free vaccine that will be available in 2019. 2. Quality issues identified with standards: 6, 8, 11, 13, 14 & 15 to be clarified and re-enforced at update training, prior to commencing the 2019 flu vaccination campaign. 3. Consent forms to continue to be returned to Peer Vaccinators for signing if returned unsigned. 4. Only the most up to date consent forms to be used, this will require re-iteration at training.

Appendix D Safety Thermometer Charts

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

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

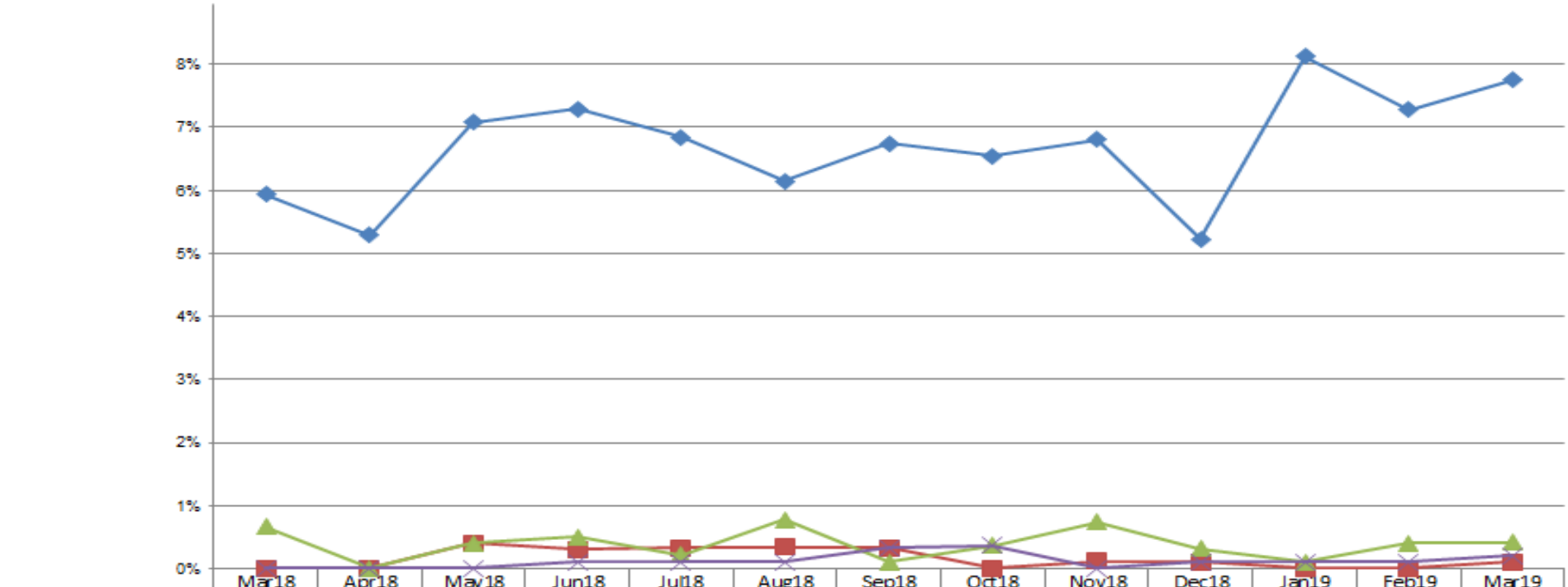
The percentage of Harm Free patients for all England in Q4 was 93.93%. The Harm Free care in Q4 for Berkshire Healthcare has dropped slightly to 91.86%. Old pressure ulcers and catheter with old UTIs, are harms which we must own despite being inherited to the Trust and therefore largely beyond our influence. In Q4 of 2018/19 these old harms made up 78.39% of our total harms.



Source: Trust Safety Thermometer Reports

Types of harm

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



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
Pressure Ulcers	5.94	5.29	7.08	7.29	6.84	6.15	6.75	6.55	6.81	5.23	8.13	7.28	7.75
Falls	0	0	0.4	0.3	0.33	0.34	0.33	0	0.12	0.1	0	0	0.11
Catheter & UTI	0.66	0	0.4	0.5	0.22	0.78	0.11	0.36	0.74	0.31	0.11	0.4	0.42
New VTE	0	0	0	0.1	0.11	0.11	0.33	0.36	0	0.1	0.11	0.1	0.21
Patients	1060	1002	989	1001	921	895	904	840	808	975	935	1003	942

Source- Safety Thermometer
UTI= Urinary Tract Infection VTE = venous thromboembolism

Appendix E CQUIN 2018/19- TBC when Available

Please note that that this is part of a 2 year contract that started in 2017/18.

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

Appendix F- CQUIN 2019-2020- TBC when Available

Appendix G- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2018/19
Response from Council of Governors of the Trust

These comments are based on the Quality Account for the third quarter circulated to the 32 members of the Council of Governors for the Trust on the 6th March 2019. This summary is prepared by the Lead Governor, Paul Myerscough.

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

Governors are interested in trends which show year on year improvement in Trust performance. Whole year figures were not available at the time of the review. We were pleased however to see the many improvement initiatives described in section 2.1 and look forwards to seeing the evidence that new processes are effective as planned and the benefit is being felt at the frontline.

Governors continue to be concerned about the well-being of staff and the level of vacancies in some parts of the service. We are pleased that management efforts are producing results in many areas and we look forward to seeing the results from the latest staff survey which was not available at review time.

We are happy that management keeps governors up-to-date on the rare occasions when service quality concerns are raised. Governors are free to question the executive in Governor Council meetings some of which are also open to the public.

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

All governors were given the opportunity to comment. There were a number of requests for clarification of figures. Some concerns were expressed on understanding the significance of the statistics when throughput figures (number of patients seen in a service) are generally not available. All feedback is passed on to the team responsible for the report.

We recognise the dichotomy between a desired culture of reporting faults and problems and consequential learning and a 'blame and shame' culture which leads to suppression of information. We feel that Berkshire Healthcare have promoted a learning culture through encouraging staff to record incidents and problems in the 'Datix' system which provides useful input to Quality Improvement initiatives throughout the Trust.

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response from the Council of Governors to its 2018/19 Quality Account.

We thank Governors for the comments made in relation to the content of the report and are pleased that it is both clear and of interest. We also wish to convey our thanks to those that have taken time to help contribute to the document throughout the year.

In relation to the Friends and Family Test (FFT), we are mandated to participate in this survey and endeavour to achieve a 15% response rate. We are also working to revise our patient experience measure and will ensure that the FFT is considered with this to avoid duplication for staff.

Responses to individual queries have been included in a separate document and sent to the Chair of the Council of Governors. We look forward to working with our Council of Governors in the future.

Commissioners Response – BHFT Quality Account 2018/19

This statement has been prepared on behalf of East Berkshire CCG and Berkshire West CCG.

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for Quarter 3 2018/19 submitted by Berkshire Healthcare Foundation Trust (BHFT).

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for 2018/19 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2019/20 are also detailed in the report.
The CCGs are committed to working with the Trust to achieve further improvements and successes in the areas identified within this Quality Account.

The Trust's Quality Priorities highlighted in the 2018/19 Quality Account were Care Quality Commission (CQC) Rating; Clinical Effectiveness; Patient Experience; Patient Safety and Organisational Culture.

Care Quality Commission (CQC) Rating

The CCGs were very pleased to receive the news that the Trust maintained an overall rating of Good at the CQC inspection in June and July 2018 with the report being published in October 2018. The CCGs wish to express their congratulations to the Trust for achieving a rating of Outstanding in the Well-Led domain.
There were examples of outstanding practice in the core service inspections for; Wards for older people with mental health problems; Acute wards for adults of working age and psychiatric intensive care units; Mental health crisis services and health based places of safety and wards for people with a learning disability or autism; Urgent care and community health services for adults.
It is also very positive to see that all of the services have now received a minimum rating of Good and no areas were identified as Requiring Improvement.

Clinical Effectiveness

It is reassuring to see that the Trust has participated in all applicable national clinical audits and that improvements have been implemented from the action plans that were identified.
The CCGs are also satisfied that the Trust review NICE guidance and provide the standard of care that is line with the national standard.

Patient Experience

The Trust continues to encourage patient and carer feedback either through the Friends and Family Test, Carers Friends and Family Test and the Trust's patient satisfaction survey. Whilst the response rate is lower than both the CCGs and the Trust would like to see, there are positive results for Community Health Services with regards to the recommended rate from patients and from carers. This remains above the 95% target. The CCGs acknowledge that there is further work to be completed within the Mental Health Services to improve this.
It is disappointing to see that the Trust did not achieve the 90% reduction in the use of prone restraint but recognise the hard work that the Trust has already done and acknowledge the work that will need to be implemented in order to achieve a reduction in 2019/20. Though this is not identified in the 2019/20 priorities the CCGs will continue to monitor progress. However from the Quality Account, the CCGs can see that there are occasions when prone restraint is used because this is the choice of the patient and that other patients have been turned very quickly when it has been necessary to restrain them prone. The CCGs would like to see the instances of prone restraint used on the dementia older adult ward are as a result of necessity rather than a lack of staff training.
The Trust did not achieve the target of reducing mental health delayed transfer of care by over 2%. The commissioners can see the effort that has been put in by the staff to bring this down and can see that the Trust are not far from being able to achieve this going forward.

Patient Safety

It is very promising to see the reduction in the self-harm incidents that are being reported by the Trust and should be commended on the work that has taken place in order to achieve this.

The CCGs would like to commend BHFT on continuing to stay below the rate of 8 falls per 1000 bed days on their Community Hospital inpatient wards and although the rate has not been achieved for those patients on the older people's mental health wards, there has been a significant reduction in the rate when compared with Q1 and Q2.
A key target to reduce is the inappropriate out of area acute mental health placements and the CCGs are reassured that the Trust has met the target for the year meaning that fewer patients are being treated away from home and reducing the amount of bed days spent away from home.
The CCGs would like to acknowledge the dedication from the staff that has been involved in all of the Quality Improvement (QI) projects and whilst we recognise that further work is required to complete the objectives set out in the 2018/19 Quality Account, the QI projects have had a very powerful impact on many other areas across the Trust.

Organisational Culture
The CCGs look forward to seeing the result of the National Staff Survey, expected in Q4.
The commissioners were very pleased to see the Trust has successfully achieved the target of having less than 10% of vacancies and have been maintaining around 9% each month throughout 2018/19. The work that is being implemented is very encouraging to see and hope that the vacancy rate continues to improve.
The Trust did not meet the target for reducing the number of physical assaults against staff. The CCGs can see the work that is being done in order to ensure that this target can be reached but recognise that this is can be a very challenging target to achieve.

The Quality Account does highlight a number of other service improvements that have been undertaken in 2018/19 and that this will be continued in 2019/20.

Priorities for 2019/20
The Trust has set out the priorities for 2019/20 which are as follows:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Culture
- Monitoring of Priorities for Improvement

The Commissioners would like to continue to be informed of any new quality concerns being identified during 2019/20 for the opportunity to support the Trust with these. The Commissioners would like to continue to work with the Trust on service redesign to improve patient outcomes.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response to its 2018/19 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs

The Trust welcomes the CCGs support of its 2019/20 priorities and is grateful for the comments made in relation to our achievement in 2018/19.

In relation to use of prone restraint on older adult mental health wards, staff on these wards have been trained in new techniques but are using them less frequently as these wards generally have fewer restraints as a whole meaning they have less opportunity to practice them. A plan is in place to address this.

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

16 April 2019

West Berkshire COUNCIL

Jason Hibbitt
Clinical Effectiveness Facilitator- NICE
Clinical Audit Department,
Berkshire Healthcare NHS Foundation Trust

Adult Social Care (Communities)
West Berkshire Council
West Street House, West Street,
Newbury, Berkshire RG14 1BZ

Please ask for: Tandra Forster
Direct Line: (01635) 519736
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tandra.forster@westberks.gov.uk

Dear Jason,

Berkshire Healthcare Foundation Trust Quality Account : West Berkshire Health and Wellbeing Board Response

Thank you for sharing the Quality Account with the West Berkshire Health Wellbeing Board and inviting comment. The Board acknowledge the broad range of priority indicators and welcome particularly the patient focus, with a clear commitment to improve service quality and safety for patients across Berkshire. Whilst the performance reporting relates to quarter 3 it is notable that the targets for a number of areas have already been met which is an indication of strong performance. However, there are number of areas where we would welcome reassurance:

- Patient safety – it is disappointing that the target to reduce falls for patients on the Older Peoples Mental wards has not been met. Whilst we appreciate that these patients will have more complex needs we would urge you to do everything possible to address this.
- Mental Health Delayed Transfers of Care – again we recognise the complexity of working with mental health patients, particularly the challenge to find appropriate ongoing support where it is required. However, we also feel that there is more that could be done to start planning discharge at an earlier point and would welcome closer working to enable this.
- Friends and Family Test – whilst the overall feedback was very positive it is notable that this is not the case for mental health in-patients and that the position has worsened compared to 2017/18. The Board feels that this needs closer attention and engagement with families so that it is clearer what actions are required to address it.

We support the priorities for 19/20 and note in particular your commitment to working with partners across the system. We feel that there are many opportunities to continue this and in particular would welcome greater progress on joint working around recruitment and retention given our shared challenge.

Yours sincerely

Tandra Forster

Tandra Forster
Acting Corporate Director (Adult Social Care)

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response from West Berkshire Health and Wellbeing Board to its 2018/19 Quality Account.

The Trust welcomes the Wellbeing Board's support of its 2019/20 priorities and is grateful for the comments made in relation to our patient focus and commitment to improve quality and safety.

In relation to falls, the Trust acknowledges that we have not met our target in relation to our older peoples' Mental Health Inpatient wards. As a result, the reduction of falls will again be a priority for us during 2019/20.

In relation to delayed transfers of care, a Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated. The trust will continue to monitor this area.

In relation to the Friends and Family Test, the Trust acknowledges the lower satisfaction rate achieved for mental health inpatients. The satisfaction level reported for this group has historically been lower than for other groups, and is also based on smaller numbers of respondents. The trust is committed to ensuring its patients have the best possible experience of the care we provide and will strive to improve this satisfaction rating where possible.

We look forward to continuing to work with you to achieve system-wide improvements and successes during the following year.

Appendix H

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

To be added when received

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
AMS	Anti-Microbial Stewardship
AWOL	Absent Without Leave
BAME	Black Asian and Minority Ethnic
BHFT	Berkshire Healthcare NHS Foundation Trust
BMI	Body Mass Index
BOB STP	Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership
CAMHS	Child and Adolescent Mental Health Service
CARRS	Community Cardiac and Respiratory Specialist Service
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CD	Controlled Drug
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CHST	Care Home Support Team
CMHT	Community Mental Health Team
CNN	Community Nursery Nurse
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CTPLD	Community Team for People with Learning Disabilities
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
CYPMHS	Children and Young People's Mental Health Services
DBT	Dialectical Behavioural Therapy
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DOC	Duty of Candour
DQMI	Data Quality Maturity Index
DTC	Drugs and Therapeutics Committee
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ED	Emergency Department
EIP	Early Intervention in Psychosis
EIPN	Early Intervention in Psychosis Network

Acronym	Full Name
EPMA	Electronic Prescribing and Medicines Administration
EUPD	Emotionally Unstable Personality Disorder
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FHNA	Family Health Needs Assessment
FTE	Full Time Equivalent
GDE	Global Digital Exemplar
HCA	Healthcare Assistant
HQIP	Healthcare Quality Improvement Partnership
HR	Human Resources
HV	Health Visitor
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
ICHS	Integrated Care Home Service
ICS	Integrated Care System
IDDSI	International Dysphagia Diet Standardisation Initiative
IM	Intramuscular
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPCT	Infection Prevention and Control Committee
IPASS	Integrated Pain and Spinal Service
IPS	Individual Placement and support (Employment Service)
IST	Intensive Support Team
KF	Key Finding
LCLD	Low Calorie Liquid Diet
LCS	Lean Competency System
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse In Care
LoS	Length of Stay
LTC	Long Term Conditions
MBT	Mentalization-Based Treatment
MDT	Multi-Disciplinary Team
MDfT	Multi-Disciplinary Footcare Team
MDR	Multi-Disciplinary Round
MH	Mental Health
MHA	Mental Health Act
MHSDS	Mental Health Service Data Set
MIR	Making it Right
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSG	Medication Safety Group
MSK	Musculoskeletal
MTI	Medical Training Initiative
NACAD	National Asthma and COPD Audit Programme

Acronym	Full Name
NAS	National Audit of Schizophrenia
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NEWS	National Early Warning Score
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NPSA	National Patient Safety Alert
NRLS	National Reporting and Learning System
NSF LTNC	National Service Framework on Long Term Neurological Conditions
OAHSN	Oxford Academic Health Science Network
OAP	Out of Area Placement
OPMH	Older Peoples Mental Health
PAF	Performance Assurance Framework
PDSA	Plan, Do, Study, Act (A Quality Improvement methodology)
PGD	Practice Group Direction
PHM	Public Health Model
PICC	Peripherally Inserted Central Catheter
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PID	Performance in Initiating and Delivering
PMLD	Profound and Multiple Learning Disability
PMS	Psychological Medicine Service
PMVA	Prevention Management of Violence and Aggression
PN	Partner Notification
POMH	Prescribing Observatory for Mental Health
PPH	Prospect Park Hospital
PSAG	Patient Status at a Glance
PTSD	Post-Traumatic Stress Disorder
QEG	Quality Executive Group
QI	Quality Improvement
QMIS	Quality Management and Improvement System
R&D	Research and Development
RBH	Royal Berkshire Hospital
RIE	Rapid Improvement Event
RiO	Not an acronym- the name of the Trust patient record system
RTT	Referral to Treatment Time
RQ	Rolling Quarters
RRAT	Rapid Response and Treatment Team
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review

Acronym	Full Name
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound (in relation to objectives and actions)
SMI	Severe Mental Illness
SOP	Standard Operating Procedure
STP	Strategic Transformation Partnership
SUS	Secondary Users Service
TCBT	Transdiagnostic Cognitive Behavioural Therapy
TV111	Thames Valley 111 Clinical Advisory Service
UTI	Urinary Tract Infection
VFC	Virtual Fracture Clinic
VTE	Venous Thromboembolism
WAM	Windsor Ascot and Maidenhead
WBCH	West Berkshire Community Hospital
WPH	Wexham Park Hospital
WRES	Workforce Race Equality Standard

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	14th May 2019
Title	Six Monthly Safe Staffing Review (October 2018 to March 2019)
Purpose	To provide the Trust Board with information that supports safe staffing review across out community wards and the safe staffing position that is derived from this information
Business Area	Nursing & Governance
Author	Heidi Ilsley, Deputy Director Nursing 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 and delivery of safe care
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	none
SUMMARY	This report supports the 2016 National Quality Board expectations for board oversight of staffing on the wards and annual review of staffing establishments using nationally available tools, benchmarking and clinical judgement. Workforce and quality data is also considered within the report. In addition in October 2018 NHS Improvement published 'Developing Workforce Safeguards' that reinforces this requirement and details additional responsibilities for the Nursing and Medical Director to confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This is detailed in full on page 19 of the report. The main risk associated with all of our wards continues to be challenges in recruitment and retention of registered nurses and ability to achieve 2 registered nurses on each shift. Many of our wards rely on NHSP to support achievement of this. There were a total of 5.2% shifts that had only 1 registered nurse on a ward on the shift. The unit with the most shifts with only 1 registered nurse on duty was Willow house where 11.5% of the shifts had only 1 registered nurse and WBCH that had only 1 nurse on one of their wards for a shift 7.7% of the time. The outcome of the staffing review is that for Orchid, Rowan, Sorrel, Campion, Henry Tudor, Jubilee, Oakwood, Donnington, Highclere and Wokingham wards current establishments alongside continued

	use of NHSP to fill gaps in rotas and additional patient observations is considered to continue to provide a safe staffing position. Willow House staffing is considered to have been safe over the last 6 months with the use of NHSP to support gaps in the rota and increased observation levels. The current establishment is considered to continue to achieve this however the fact that the unit is isolated and there is an increasing vacancy factor means that this will need to be monitored closely to ensure that safe staffing continues to be achieved. For the acute mental health wards (Rose, Snowdrop, Daisy and Bluebell) staffing tools and benchmarking indicate that the current establishment does not fully meet current acuity levels and that increased staffing support for the wards needs to be considered to achieve safe effective staffing. Given the current challenges in recruitment and NHSP fill rate, differing staff roles such as assistant psychology/ activity coordinator roles should be considered as part of the ward rota to increase staffing. This would support achievement of a therapeutic environment with increased provision of meaningful activity and patient engagement. There was no direct correlation between any specific incidents and staffing during the reporting period although it is recognised that gaps in the rota on any of the wards over the last six months had the potential to affect quality of care and patient experience. This is likely to continue to be the case until a positive impact on work around recruitment and particularity retention start to see a positive impact on overall permanent staffing position. All wards have senior support and mitigation in place for when there are gaps in rotas and this includes use of senior staff and deployment of staff across wards. In terms of medical staffing, numbers in the trust remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. The trust has one agency Specialty Doctor working on the elderly care ward at St Marks Hospital between 9 am and 5 pm to cover vacancy arising from sickness. There are no agency doctors working on our inpatient mental health wards.
ACTION	The Board is asked to: Consider this report and note the declaration provided by the Director of Nursing and Governance and Medical Director

Berkshire Healthcare
NHS Foundation Trust

Six Monthly Safe Staffing Review
October 2018 to March 2019

1. Executive Summary

In line with the 2016 National Quality Board requirement to review the staffing across inpatient wards annually, this board report details a review of the staffing for all of the inpatient wards within Berkshire Healthcare Trust.

In October 2018, *Developing Workforce Safeguards* was published by NHS Improvement (NHSI); this states the new recommendations on workforce safeguards to strengthen the commitment to safe, high quality care in the current climate. NHSI recognise that on-going workforce pressures require health systems and boards to make tough decisions to ensure services achieve best outcomes at a time of financial challenge and the document states that Boards must ensure that this does not have an adverse impact on the quality of care, as well as patient, service user and staff experience. Expectations of Trusts are outlined in the main body of the report.

The main risks associated with safe staffing continues to be the significant number of registered nurse vacancies on the acute mental health wards, West Community Wards and Willow House; registered staffing shortages reflect the national picture. Work is ongoing within the Trust around both recruitment and retention, with dedicated resource and programme of work focusing on Prospect Park Hospital.

Less than two registered staff is seen nationally as a 'red flag'; the number of shifts reported with less than two registered nurses has reduced since the last six month report, 455 shifts were reported during this period, compared to 561 in the previous six month period. During the reporting period there were 8,736 shifts across our wards and the total number of shifts (455) with less than 2 registered nurses equates to 5.2%. Willow House was the unit with the highest number of shifts with only 1 registered nurse (11.5%) whilst for WBCH the number of shifts was 7.7%. 296 shifts with one registered nurse were at Prospect Park Hospital (PPH), this equates to 3.4% shifts with less than 2 registered staff, at Prospect Park there are other wards more easily able to support and a Duty Senior Nurse available which reduces the risk.

Reporting of incidents where staffing is below the expected / required number has improved, although it appears there continues to be under reporting in some areas which experience the most challenges with staffing for example, PPH. The incidents reported are assessed as having low or no impact due to the mitigation put in place by staff.

1.1 Prospect Park Hospital (PPH)

Over the last six months PPH has continued to face challenges with staffing, particularly with covering registered nurses shifts. High levels of temporary staffing (both registered and unregistered) continue to be used, around 1800 - 2300 shifts are requested to support the wards in

meeting their requirements for minimal staffing as well as providing additional cover for increased observational levels each month; approximately 15% of these requests are not able to be filled.

PPH now have their own designated Human Resources Operations Manager which has enabled focus on staff morale, recruitment and retention. Recruitment plans have included recruitment fairs, student meet and greet days and improved job adverts on the NHS jobs. There is now a clear emphasis on the use of social media to raise the profile and presence of the hospital within the community.

A large proportion of the successful registered nursing recruitment has been newly registered nurses, these staff require a period of preceptorship from senior staff; this has proved challenging for wards especially when this is alongside continually high occupancy, high patient acuity and high use of temporary staff to meet patient need. There is recognition that there is a limit on how many preceptees the hospital can support at one time. There have been a number of changes in leadership roles across the hospital and staff turnover has remained high at between 24% and 27% over the reporting period.

In order to provide leadership support to the ward managers, the hospital has introduced matron roles, each matron post supports 2 wards. There is also a Physical Health Lead, Drug and Alcohol Lead and a Nurse Consultant who are able to provide specialist advice. Each shift has a Designated Senior Nurse (DSN) on duty who has oversight of activity and staffing across the hospital, this enables deployment/ movement of staff to support areas where there is greatest need and staffing challenges.

The wards have additional resource not captured in safe staffing which includes psychology and Occupational Therapy/ therapy assistants as well as the medical workforce.

On Sorrel Ward a focused piece of work including a change of leadership and pay enhancements has contributed to the ward achieving a position of full nursing establishment; this has had a positive impact for both staff and patients and has enabled all beds to open on the ward from the beginning January. This has followed a long period of reduced capacity due to refurbishment and then low staffing impacting on fully re-opening.

Rowan and Orchid wards continue to care for patients with high physical and mental health needs; Rowan ward's bed occupancy in the second part of this reporting period has been higher than is usually experienced which has increased the need for temporary staffing.

As detailed within this report, PPH continues to experience challenges with high bed occupancy, patient acuity and vacancy rates. Bed occupancy on Rose, Snowdrop and Bluebell wards has remained above 90%, with most months above 95%; Daisy ward bed occupancy dropped to just below 90% in October and December. Sorrel ward has been above 90% since January, this coincided with the remainder of the beds opening. Orchid and Rowan wards have had a wide variation in occupancy rates during this period.

The current vacancy rate (registered and unregistered) is 62.01wte. This is reduced to 48.21 wte once posts that have been offered are included. With the current vacancy rate of 37.38wte registered nursing staff, the ability to maintain the required two registered staff per shift for every ward remains a significant challenge; many registered nursing shifts are being filled through NHSP although these are sometimes our own staff doing additional hours over and above their contract.

The number of reported shifts with less than two registered nurses remains high at 296 shifts over the 6 month reporting period across the hospital, Daisy ward had the highest number overall at 83 within this reporting period, whilst Sorrel had the lowest number with 15 all in October 2018. The number of shifts reported with no registered nurses at the start of a shift has decreased from 27 in the last 6 monthly report to 9 over this 6 month period. Staff are moved around within the hospital to manage safety of the wards when this occurs.

The number of temporary staff requested per month at PPH has ranged from 1597 – 2272 over this period. March had the largest number (2272) due to a combination of vacancies, sickness annual leave and patient observations. Throughout this time requests for registered nurses have been approximately 33% of the temporary staffing requests.

Sickness rates have been mostly above the Trust's agreed 3.5 % throughout this period except for Daisy and Snowdrop wards who have seen a reduction in their sickness rate to 2.5% and below in March 2019.

The review of staffing on the wards at Prospect Park indicates that for Rowan, Orchid and Sorrel baseline staffing with additional staff to accommodate increased patient observations as and when required is continuing to provide a safe staffing model which is in line with national benchmarking and use of available tools.

For the acute wards, use of tools and benchmarking indicate that consideration as to how these wards are staffed needs to be given and that additional staffing may be required to meet acuity levels and patient need; given the current challenges in recruitment and NHSP fill rate, differing staff roles such as assistant psychology/ activity coordinator roles should be considered as part of the ward rota to increase staffing. This would support achievement of a therapeutic environment with increased provision of meaningful activity and patient engagement.

1.2 Willow House

Willow House's bed occupancy has increased month on month since October 2018 to above 90% in March 2019. Occupancy was well below expected occupancy in the first half of the six month period covered within this report.

Temporary staffing requests have been fairly constant with an average of 237 requests each month. The number of shifts with less than two registered nurses was low with the exception of March which saw a significant increase to 22. This reflects the units increase in vacancies. When there is one registered nurse on duty, the nursing team are supported by the ward manager and a senior manager between the hours of 9am and 5pm. Outside of these hours there is access to a manager/senior nurse on call and further support from the DSN at PPH. Where necessary especially out of hours, staff are moved from PPH to Willow house to support the unit.

Although the vacancy rate was higher in October the reduced occupancy meant that it was easier to manage the vacancy at that time. The increase in vacancy in March required increased use of temporary staffing due to the occupancy rate being 90%.

The additional challenge at Willow house is that the unit is isolated on a differing site away from the Trusts other mental health wards, This makes it more challenging if the unit is unable to achieve the agreed safe staffing levels. A move of the unit is planned to bring Willow House onto the main Prospect Park site in 2021 which will alleviate this; in the interim staff are moved from the

main site when staffing levels on the unit are not safe and clinical managers step in to support to ensure safety on the unit. There is no indication that safety has been compromised on the occasions where gaps have been unable to be filled by temporary staff.

The review of staffing at Willow House indicates that baseline agreed staffing levels with the ability to increase this with use of temporary staff as required continues to be appropriate for achieving safe staffing.

1.3 Campion Unit

There has been a considerable amount of work completed by the Campion team as part of their CQC work programme, this cumulated in them achieving an outstanding rating in October 2018. A very stable team continues to care for very complex and challenging patients who require high levels of observations. Temporary staffing is used to meet the requirements of levels of observations and temporary staffing requests have been fairly constant with an average of 318 requests each month. The unit generally use their own staff to cover additional staffing requirements and this provides continuity of care to the patients.

The average bed occupancy during the reporting period has been 81%. The sickness rate has been above the Trust target spiking in December 2018 at 11.3 %. It has reduced to 4.59% in March 2019.

The review of staffing on Campion unit indicates that baseline agreed staffing levels with the ability to increase this with use of temporary staff to provide additional support for increased patient observations when required continues to provide safe staffing on this unit.

1.4 Community Wards

The ten suspended beds at West Berkshire Community Hospital (WBCH) were permanently closed from the 1st January 2019. Bed numbers on all other wards have remained the same during the reporting period.

The community health wards (CHS) in the west have been part of a community services management restructure and under this new structure there is a lead for inpatient wards; this provides senior management across the three units. As part of this work, the Wokingham wards aim to manage their staffing as two separate wards rather than the current model of one unit. The east community services model already included a lead across their two CHS wards.

The community wards have had lower than expected bed occupancy during this reporting period, between 75-83%. For Highclere and Donnington wards occupancy percentages were skewed due to the 10 suspended beds being included in the figures. Temporary staffing requests have been fairly constant, approximately 996 requests each month until February when this has increased due to a combination of vacancies, sickness and management of annual leave.

There was only 1 shift in the reporting period where there were less than two registered nurses on the East community wards. For the wards in the West this was much higher with the highest number being at West Berkshire Community Hospital (WBCH) at 84 shifts. The wards work closely together to ensure safety on these occasions and clinical managers/ Advanced Nurse Practitioner (ANP) are also available during working hours to provide support and assistance as are Physio and Occupational Therapy staff. A recruitment day was held at WBCH in April, which was very

well attended although the majority of interest was for Health Care Assistants (HCAs). These potential candidates are being followed up with interviews.

The community health wards have struggled with recruitment of registered nurses, with the highest registered nurse vacancy rate being at WBCH. The wards continue to look at different recruitment and retention models to secure staff. All wards have advanced practitioners and there are newly registered nursing associates working on some of the wards, further trainee nurse associates are undertaking their training.

Sickness rates have been consistently above the Trust's agreed target of 3.5% throughout this period except for WBCH in March when there was a reduction to 2.77%.

The review of staffing across the community wards indicates that baseline agreed staffing levels continue to provide safe staffing on this unit. There is no indication that safety has been compromised where these levels have not been met due to inability to secure temporary staff to fill gaps.

Main Report

1. Overview

To meet the requirements of the *Developing Workforce Safeguards* published by NHS Improvement in October 2018 the Trust need to:

- Include a specific workforce statement in their annual governance statement – this will be assessed by NHSI.
- Deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Use an approach that reflects current legislation and guidance where it is available.

As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable (this can be found in section 8.1 on page 19 of this report).

Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting. An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity and performance plans, and directly involve leaders and managers of the service. The Director of People for the trust is leading this piece of work.

The directive states that establishment setting must be done annually, with a mid-year review, and should take account of:

- patient acuity and dependency using an evidence-based tool (as designed and where available)
- activity levels
- seasonal variation in demand
- service developments
- contract commissioning
- service changes
- staff supply and experience issues
- where temporary staff have been required above the set planned establishment
- Patient and staff outcome measures

Chairs and chief executives should ensure that time is allocated at board meetings or similar meetings to discuss and agree clear actions in response to the data, and they should identify the key performance indicators (KPIs) to measure success and adverse outcomes.

The new acuity and dependency tools have still not been published by NHSI. The tools have been delayed since November 2018 and currently there is still no publication date. In order to complete the required staffing review Keith Hurst tools (April 2018) have been used. These are best practice and do form the basis for the new awaited tools. These tools support safe staffing calculations on

inpatient wards to assist safe staffing decisions and are used alongside clinical judgement and benchmarking.

The work to address the registered nursing shortfall across our wards continues with a richer skill-mix of unregistered staff including band 4's being recruited to, and introducing the new nurse associate role, whilst maintaining the nationally recognised minimum of two registered staff on each shift. Support around recruitment and retention is also underway across Community Mental Health and Community nursing Teams where there are also challenges in terms of recruiting to registered practitioner vacancies.

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

2. Current Situation

Berkshire Healthcare Trust has the following wards:

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

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

Table1: Current Staffing establishment, bed numbers and shift patterns

	Beds	FTE Establishment in budget 18/19	Professional judgement FTE	Nurse : bed ratio FTE	Planned shift pattern (Early-late-night)
WBCH	49	68.38	**Donnington** 39.9 + 1 ward matron + 0.3 staff development lead = 41.2	38.2	9-6-6
			Highclere 28.48 + 1 ward matron + 0.3 staff development lead =29.78	28.4	6-5-4

Oakwood	**24**	34.04	34.04 + 1 ward manager and 1 deputy ward manager = 36.04	37	9-7-4
Wokingham	**46**	55.73	59+ 1 ward manager + 0.8 matron = 60.8	58.6	14-10-7
Henry Tudor	**24**	31.80	30.8+ 1 ward manager = 31.8	30.6	7-5-4
Jubilee	**22**	31.52	30.8 + 1 ward manager = 31.8	28	7-5-4
Campion	**9**	30.44	30.8 + 1 ward manager = 31.8	24.2	9-6-4*
Sorrel	**12**	30.00	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	29.5	6-6-5
Rose	**22**	31.00	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	29	6-6-5
Snowdrop	**22**	31.00	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	29	6-6-5
Rowan	**20**	31.5	29 + 1 ward manager + 0.5 DSN + 1 CDL = 31.5	29.7	7-7-5
Orchid	**20**	31.00	27.4 + 1 ward manager + 0.5 DSN + 1 CDL = 29.9	26.5	6-6-5
Bluebell	**22**	31.53	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	29	6-6-5
Daisy	**23**	32.00	28.8 + 1 ward manager + 0.5 DSN + 1 CDL =31.3	30.1	6-6-5
Willow House	**9**	23.02	24+1 ward Manager =25	23	Work shift pattern of long days with 6 on during day and 4 at night

* Campion staffing levels are increased above the tools because of the split across two levels on the unit.

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

3. Review of staffing establishment

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tool is used to assist in the triangulation of data, alongside benchmarking and clinical judgement. It is recognised that this modelling tool uses a snapshot of dependency of patients on a given day and that dependency can fluctuate, therefore review of the tools uses collation of the daily data over a period of time (14 days for this reporting) to understand the average dependency for each ward.

3.1 Review using workforce modelling tool

Tables 2 and 3 below show the current establishments compared to the recommended establishment from the 14 day review undertaken in February 2019 using the current available Keith Hurst tools**.**

Table 2: Prospect Park Hospital Wards

Ward	Bed Number	Current establishment (WTEs)	Additional staffed requested above establishment (WTE)	Recommended establishment from Feb 2019 review (WTEs)	Total actual establishment (including unfilled shifts requested)
Sorrel	12	30	10	24.2	40
Rose	22	31	5.3	53.5	36.3
Snowdrop	22	31	0	36.5	31
Bluebell	22	31.53	5.92	51.2	37.45
Daisy	23	32	2.28	49	34.48
Rowan	20	31.5	6.68	36.5	38.18
Orchid	20	31	0	36.1	31
Additional WTE for observations		13			
Total		231.03		287	248.41

Ward Managers and Clinical Development Posts are not included in the numbers. All wards have Allied Health professionals who support the wards who are also not included in the numbers but support the ward throughout the day with patient care and treatment, including some weekends.

Dependency scores on the acute mental health wards reflect the high patient acuity and the levels of observation required on the wards to meet the patients need.

For 3 of the acute wards (Rose, Bluebell and Daisy) there is a significant difference between actual WTE and recommended WTE. The supportive roles on the wards (Ward Manager, Clinical development lead and the Matron) need to be taken into account as well as the allied health professional (AHPs) working on the wards when considering safe numbers, these additional roles have supported the safe staffing of the wards during this period.

Table 3: Community Wards, Willow House and Campion

Ward	Bed Numbers	Current establishment	Recommended establishment from February review
Oakwood Ward	24	34.04	30.4
Wokingham Ward	46	55.73	56
WBCH	49	68.38	58.9
Henry Tudor Ward	24	31.8	27.5
Jubilee Ward	22	31.52	22.1
Campion	9	30.44	28.6
Willow	9	23.02	26

Ward Manager/Matron posts are not included in these figures. The wards all have advanced practitioner posts and allocated therapy staff who work on the ward. These roles are key members of the multi-disciplinary team but not included in these figures.

In 2019/20, reviews using staffing modelling tools will be undertaken over a 20 day period in line with the new Developing Workforce Safeguards recommendations.

3.2 Care Hour per Patient Day (CHPPD) Data Collection

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

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

CHPPD is now the main metric used to benchmark safer staffing although nationally there is limited use of this data at present. As from March the monthly safe staffing review compares the CHPPD per ward in comparison to their national medium and peer medium to other Trusts rated by CQC as 'good'. The table below shows the CHPPD for each of the wards over the 6 month period alongside nationally available data using peer and national median.

Table 4: most recent CHPPD benchmarking data available on Model Hospital (Jan19) using the national median and peer median (similar Trust rated as good by CQC)

Reported CHPPD per ward								
Ward	Oct	Nov	Dec	Jan	Feb	March	Peer median	National median
Bluebell	7.3	6.3	7	6.7	7.3	7.9	9.11	9.23
Rose	7.4	7.5	7.1	7.6	7.3	6.5		
Daisy	6	6.3	6.8	7	6.2	6.4		
Snowdrop	6.5	6.3	6.9	6.7	6.3	6.6		
Sorrel	22	27	24.6	20.6	18.5	18.5	15.79	19.20
Rowan	15.1	18	9.9	9.4	10.3	10.9	9.80	10.37
Orchid	8.7	8.5	9	7.2	7.1	7.2	9.80	10.37
Campion	25.2	26.1	27	26	29.2	30.2	23.13	23.86
Willow House	32.3	26.5	22.6	16.5	14.5	13.6	17.05	16.27
Jubilee	7.1	8.6	7.9	7.5	6.7	7	7.58	6.88
Henry Tudor	7	6.6	7	6.8	7.2	5.9		
Oakwood	7.8	7.3	8.4	8.1	6.7	6.7		
Highclere	7.4	7.4	7.5	6.9	6.9	7		
Donnington	6.7	7.7	6.8	7.1	6.7	7.5		
Wokingham	7.1	6.6	7.1	6.3	5.4	6		

The higher CHPPD for Sorrel and Willow House (October-December) and Rowan (October-November) reflects that there was lower occupancy during this period.

For our other wards there are relatively small fluctuations over time.

With the exception of Orchid and the acute mental health wards which appear to demonstrate a lower CHPPD than peer and national average; wards are either basically in line or above (with rationale for this) the peer and national average. Whilst this data is able to act as a guide in terms of benchmarking for the Mental Health Wards it can be easily skewed if there are a number of patients on a ward requiring 1:1 supervision, this is because the measure simply takes available nursing hours and divides by number of patients, there is also variation nationally around what is included within the CHPPD as the data is pulled from e-roster and therefore includes staff featuring on a ward roster including allied health professionals where they are rostered.

The data of the review including modelling tool and CHPPD would indicate that for our acute mental wards our staffing is not optimal and is lower than that of our peers for similar wards.

4. Bed occupancy

Table 5 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have consistently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards.

Table 5: Bed Occupancy

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Average
Donnington	84.30%	53.33%	71.40%	84.62%	85.60%	83.01%	77%
Highclere	49.27%	77.82%	66.30%	87.81%	86.28%	81.83%	75%
Oakwood	80.78%	87.91%	73.52%	74.06%	90.92%	89.25%	83%
Wokingham	67.77%	74.95%	64.76%	79.95%	91.93%	85.41%	77%
Henry Tudor	77.28%	86.94%	81.72%	81.32%	75.00%	87.50%	82%
Jubilee	81.09%	82.27%	74.49%	78.30%	87.18%	83.58%	81%
Campion	89.61%	81.11%	77.78%	88.17%	69.84%	78.49%	81%
Sorrel	77.42%	73.00%	82.26%	97.12%	100.00%	99.71%	88%
Rose	94.87%	97.27%	95.75%	98.09%	98.70%	98.53%	97%
Snowdrop	94.87%	98.33%	94.57%	96.63%	97.73%	94.57%	96%
Rowan	49.84%	44.17%	82.26%	96.61%	91.07%	84.03%	75%
Orchid	78.13%	77.33%	85.48%	89.35%	90.71%	90.32%	85%
Bluebell	93.40%	99.09%	92.96%	97.51%	99.19%	98.24%	97%
Daisy	89.21%	96.35%	87.25%	90.00%	98.45%	95.65%	93%
Willow House	36.90%	49.63%	55.91%	78.49%	89.29%	92.83%	67%

Bed occupancy on the Community Health wards has remained lower than expected during this reporting period. For Highclere and Donnington wards their average bed occupancy is lower due to the reduction in their bed numbers when ten beds were suspended until end December. From January the beds were permanently closed and new bed numbers (49) used to calculate occupancy. Sorrel ward's environmental work was completed and they achieved full nursing establishment in January which enabled them to open all their beds.

5. Workforce data

A number of factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancies, maternity leave and sickness absence. The position over the period October 2018 to March 2019 in relation to these two indicators is detailed below.

5.1. Vacancies

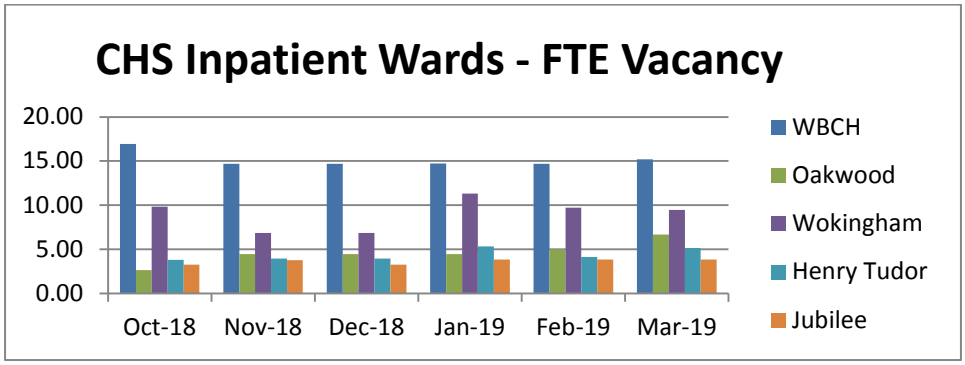
Table 6 below shows the combined whole time equivalent vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. All wards continue to be challenged by recruitment, particularly for registered nurses.

Table 6 – Whole Time Equivalent (WTE) vacancy of registered nursing and healthcare worker combined

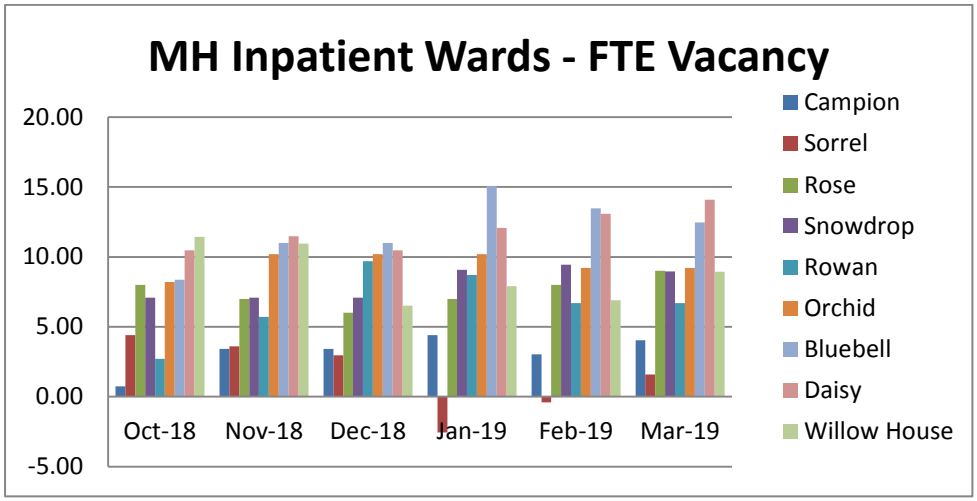
		Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
MH Wards	**Registered**	10.14	15.98	17.94	20.41	22.05	22.05
	Unregistered	39.08	40.08	39.48	39.08	37.44	39.95
CHS Wards	**Registered**	23.20	25.46	25.62	28.11	26.96	26.47
	Unregistered	13.24	13.48	13.02	11.59	10.42	15.10
Campion	**Registered**	3.94	3.54	4.61	5.61	5.24	6.24
	Unregistered	-3.20	-1.20	-1.20	-1.20	-2.20	-2.20
Willow House	**Registered**	7.73	7.73	5.73	5.12	5.12	5.16
	Unregistered	3.70	3.23	0.78	2.78	1.78	3.78

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

Graph 1: WTE on the Community Wards by month



Graph 2: WTE on the Mental Health Wards by month



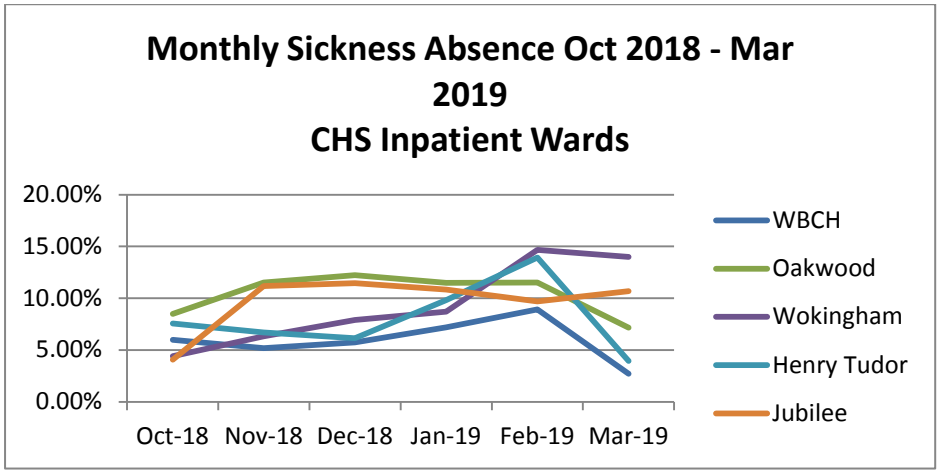
Sorrel ward have made the decision to employ all Care Support Workers (CSWs) at band 3. The over recruitment in January and February was for unregistered staff and accounted for the change from band 2 to band 3 staff on the ward.

5.2 Sickness absence

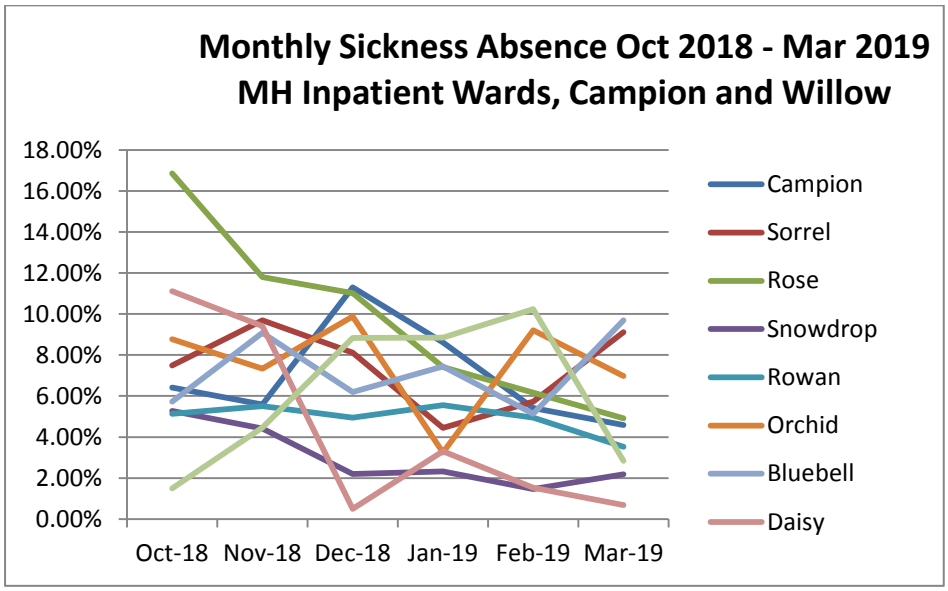
Graph 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short term sickness.

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

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



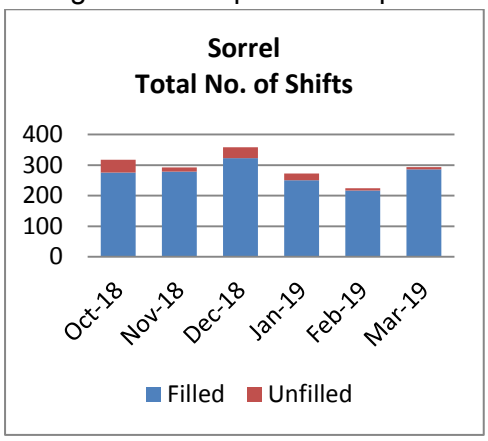
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Mental Health, Learning Disability and CAMHs Wards)

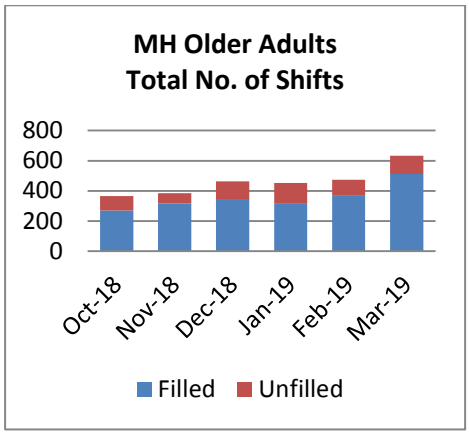


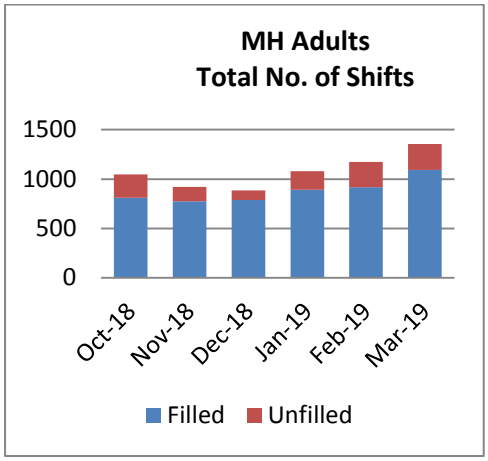
5.3 Temporary staffing

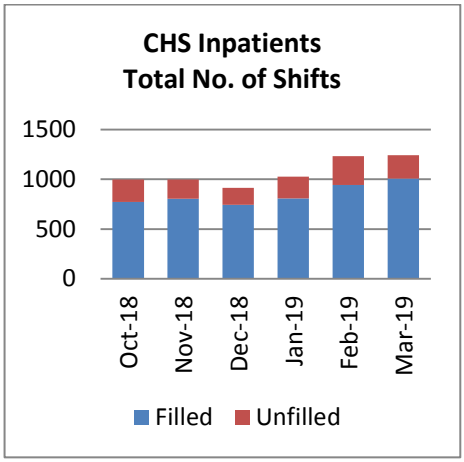
When the wards have vacancies and sickness within their nursing staff establishment they use temporary staffing (agency / bank or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are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

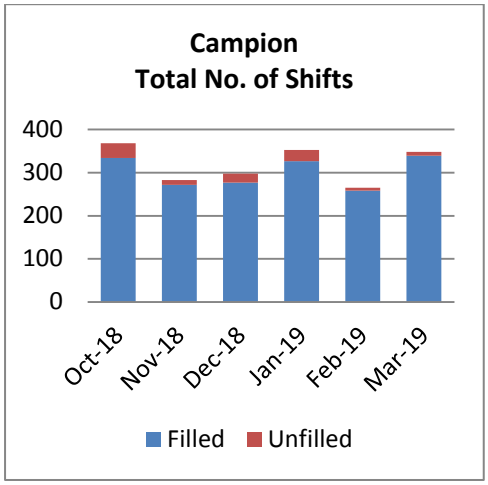
The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled. Both CHS and MH wards have experienced difficulty in filling required shifts. Campion has the lowest unfilled rate. Willow House has also increasingly faced challenges in obtaining staff. This is more for week days and often because they require staff that are PVMA trained Sorrel ward also experienced issues with obtaining PVMA trained staff during the earlier part of this period.

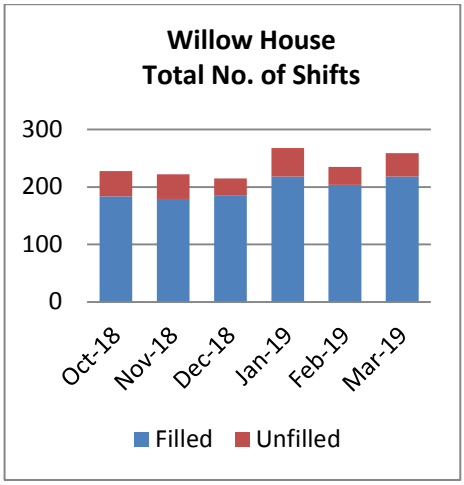












6. Displaying planned and actual registered and care staff on the wards

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

7. Safety on our wards

The NHSi in its recommendations on workforce safeguards states that organisations need to demonstrate effective governance and commitment to safety so boards can be assured that their workforce decisions promote patient safety and comply with Care Quality Commission's (CQC) fundamental standards. To comply with this it is just as important to have the appropriate staff capability to ensure that they can deliver a safe and quality service to all patients. This section of the report details how the Trust currently measures and monitors patient safety.

7.1 Quality indicators

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

<u>Community wards</u>

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

<u>Mental health wards</u>

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

- Use of prone restraint on patients;

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

Table 5: Quality metric for mental health inpatient wards (October 2018 – March 2019)

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assault	Prone Restraint	Seclusion	Self-harm
Bluebell	12	1	4	12	2	5	32
Campion	0	0	21	84	0	3	9
Daisy	28	2	6	11	4	4	19
Orchid	0	38	3	1	0	0	1
Rose	8	5	21	16	3	2	9
Rowan	0	10	15	25	2	2	2
Snowdrop	15	1	11	14	4	1	12
Sorrel	1	2	16	39	5	44	64
Willow House	1	0	10	5	8	1	104
Total	**65**	**59**	**107**	**207**	**28**	**62**	**252**

* correct at time of report

True North goals within BHFT include prone restraint, self-harm and falls. The quality improvement programme on these projects has led to a board to ward focus on reduction in incidents in these areas.

Table 6: Quality metric for community physical health inpatient wards (October 2018 – March 2019)

Ward	Medication related errors	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	17	26	6	4
Highclere	14	11	7	0
Oakwood	43	10	2	3
Jubilee	6	7	0	1
Henry Tudor	12	13	0	2
Wokingham	24	28	4	1

Total	**116**	**95**	**19**	**11**

* correct at time of report

7.2 Red flags

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

Table 7 below shows the number of occasions by ward and month where there was less than two registered staff on a shift. During the reporting period there were 8,736 shifts across our wards and therefore the total number of shifts with less than 2 registered nurses equates to 5.2%. Willow House was the single unit with the highest number of shifts with only 1 registered nurse (11.5%) whilst for WBCH the number of shifts was 7.7%. 296 shifts with one registered nurse were at Prospect Park Hospital (PPH), this equates to 3.4% shifts with less than 2 registered staff.

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

Table 7: wards and number of occasions where there was less than 2 registered staff on duty (excluding supernumerary roles of Ward Manager/ Matron/ Clinical Development Lead and ANP)

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total for ward
Donnington	6	7	11	0	1	0	25
Highclere	19	4	9	10	4	13	59
Oakwood	0	0	1	0	1	1	3
Wokingham	0	2	0	2	1	3	8
Henry Tudor	0	0	0	0	0	0	0
Jubilee	0	0	0	0	1	0	1
Campion	0	0	0	0	0	0	0
Sorrel	15	0	0	0	0	0	15
Rose	9	2	3	9	12	16	51
Snowdrop	8	12	2	3	11	22	58
Rowan	5	2	4	4	4	2	21
Orchid	4	2	8	4	2	4	24
Bluebell	1	3	6	6	14	14	44
Daisy	18	9	9	18	16	13	83
Willow House	14	10	3	7	7	22	63
Total for month	99	53	56	63	74	110	

7.3 staff survey

The 2018 NHS staff survey results showed that the Trust overall score for staff scoring of quality of care provided was 7.4 this was in line with average national aggregated Trust scores which ranged from 7.0 to 7.7. For our mental health inpatient wards the aggregated score was 7.7; for our Learning Disability the score was 7.8 and for community west 7.6 and community east 7.9 all of which demonstrate that from staff perspective levels of care being provided are high (for community services and learning disability this is combined score for the directorate and not specific to inpatient services only). For CAMHS the score was 6.6 again this is not specific to inpatient and includes all CAMHS services but does indicate a reduced satisfaction with quality of care provided compared with our other areas providing inpatient care.

8 Safe staffing declaration

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

Following publication of Developing Workforce safeguards in October 2018 there is a requirement as part of the safe staffing review for the Director of Nursing and Medical Director to confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

8.1 Declaration by Director nursing and Governance and Medical Director

Currently Orchid, Rowan and Sorrel wards are in a stable position and there is confidence that unless the situation unexpectedly changes, safe and effective staffing can be provided with no change in staffing establishment and the continued use of NHSP to fill gaps in rota and additional staffing to cover one to one observations. This is also the case for Campion and the community wards in the east (Henry Tudor and Jubilee) as well as Oakwood and Wokingham community wards in the west.

Donnington and Highclere wards at West Berkshire Community Hospital have been declared as causing some concern over the reporting period because of the sustained high number of temporary staff; although safety was maintained and there was no link between staffing levels and patient safety incidents. There is limited assurance that care was of a high quality at all times and it is possible that patient experience was compromised. The current registered vacancy position on these wards means that this is likely to remain the case over the next reporting period although the staffing review indicates that agreed staffing establishment is appropriate to meet patient need

The acute mental health wards (Rose, Snowdrop, Daisy and Bluebell) have been declared as causing some concern over the reporting period because of the sustained high number of temporary staff; although safety was maintained and there was no link between staffing levels and patient safety incidents, there is limited assurance that care was of a high quality at all times and it is possible that patient experience was compromised. The current registered vacancy position on these wards means that this is likely to remain the case over the next reporting period. In addition if high occupancy and acuity continues; staffing levels for the wards needs to be reconsidered to ensure achievement of safe and effective staffing. Given the current challenges in recruitment and NHSP fill rate, differing staff roles such as assistant psychology/ activity coordinator roles should be considered as part of the ward rota to increase staffing. This would support achievement of a therapeutic environment with increased provision of meaningful activity and patient engagement.

Willow House has been declared as safe and sustainable over the last 6 months with the staffing review demonstrating appropriate staffing establishment; however the fact that this is an isolated unit with an increasing vacancy factor means that this will need to be monitored closely to ensure that safe staffing continues to be achieved.

All wards have senior support and mitigation in place for when there are gaps in rotas and this includes use of senior staff and deployment of staff across wards.

In terms of medical staffing numbers in the trust remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. The trust has one agency Specialty Doctor working on the elderly care ward at St Marks Hospital between 9 am and 5 pm to cover vacancy arising from sickness. There are no agency doctors working on our inpatient mental health wards.

Out of hours medical cover is provided by GPs for all our community health wards.

Out of hours medical cover is provided by junior doctors on our inpatient mental health wards with Consultant Psychiatrists providing on-call cover from home.

9. Community Caseloads

There has been a focus on recruitment and retention within Community nursing and this project has introduced a locally developed monitoring tool for the community nursing service. Each month a dashboard is produced and discussed with teams in order to improve the recruitment and retention strategy. Across Berkshire, community nursing services use an Internal Escalation Triggers tool, where community nursing teams undertake a daily capacity assessment with results collated to allow an escalation process to take place where services are unable to meet their commissioned service. This has been introduced in the absence of a national community nursing staffing tool. Following the RAG rating being completed, teams can move staffing resources accordingly. This has been successful as the table below shows:

The escalation tool:

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

Table 8: Community Nursing actual staffing against current agreed WTE establishment

Locality	October	November	December	January	February	March
West Berks	85%	75%	84%	82%	84%	82%
Reading	81%	57%	76%	77%	76%	79%
Wokingham	73%	78%	86%	81%	82%	78%
Bracknell	93%	86%	105%	105%	99%	94%
Windsor	72%	59%	71%	74%	69%	86%
Maidenhead		77%	91%	95%	94%	
Slough	79%	79%	81%	79%	80%	80%

These figures do not reflect the additional unpaid hours that staff work to meet demand and work is on-going to review staffing requirements. NHSI are in the process of producing a toolkit to assist with this however this has not yet been published due to copyright issues.

2018 Community Health benchmarking would indicate that the services have below average and median clinical WTE per 100k population, higher referrals and caseloads per 100k population but lower face to face contacts. The contacts per WTE and average length of contact are nearer to the median.

10. Nursing Associates

The Nursing Associate (NA) role is a new generic nursing role, created to bridge the skills gap between healthcare support workers and regulated professionals. It was seen as offering a range of benefits working alongside more senior regulated professionals helping to improve patient care.

Health Education England (HEE) originally led the development of the role and piloted it in 35 test sites across England, including Berkshire Healthcare Trust. The NMC has consulted on and published its regulatory process and relevant skills and proficiencies.

As registered professionals, NAs are individually accountable for their own professional conduct and practice. They will be expected to uphold the NMC Code of Conduct, to work within their scope of practice and to escalate concerns where needed. They will renew their registration via the NMC revalidation process.

With the introduction of the newly registered NA role, a resource was introduced by the National Quality Board in January 2019, to support organisations safely deploy and integrate nursing associates, *Safe, sustainable and productive staffing: An improvement resource for the deployment of nursing associates in secondary care.*

Trusts have been advised to adopt a systematic approach using an evidence-informed decision-support tool triangulated with professional judgement and comparison with relevant peers when considering introducing nursing associates. When integrating the new role into teams, trusts must ensure that decisions are taken with the wider multi-professional team in mind, considering safer staffing requirements alongside workforce productivity and financial viability.

The organisation has been working with services to ensure they understand the NMC standards of proficiency for nursing associates competencies, and ensure there are escalation processes to raise concerns about the deployment of the role. All services which undertake further skill mixing are required to undertake a quality impact assessment.

In April 2019, eight nursing associates who trained within Berkshire Healthcare Trust registered with the NMC and commenced their new roles within Berkshire Healthcare Trust. Going forward, there are two training cohorts for NA's per year.

11. Conclusion and next steps

The outcome of the six months staffing review has indicated that for the community wards, Willow House and Campion and also Rowan, Orchid and Sorrel baseline staffing with additional staff to accommodate increased patient observations as and when required is continuing to provide safe staffing model which is in line with national benchmarking and use of available tools.

For the acute mental health wards use of tools and benchmarking indicate that consideration as to how these wards are staffed needs to be given and that additional staffing may be required to meet acuity levels and patient need, particularly if the acuity and occupancy remains at the level seen over the last 6 months. Given the current challenges in recruitment and NHSP fill rate, differing staff roles such as assistant psychology/ activity coordinator roles should be considered as part of the ward rota to increase staffing. This would support achievement of a therapeutic environment with increased provision of meaningful activity and patient engagement.

The on-going recruitment and retention work across all areas is focusing on retention and flexible working to support the reduction in vacancy rate. This is aimed at achieving increased stability and in turn improved quality of patient care. A health and well-being practitioner has been employed in Human Resources to support this work.

The new acuity and dependency tools for mental health, learning disability and community nursing are due to be published this year, although no date has been released. Once these are released these will be used to aid assessment of workforce and planning.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 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 14 May 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. Productivity in the NHS

Productivity in the English NHS has grown at twice the rate of the wider economy (public and private sector).

Improvements in survival rates and numbers of patients treated in the health service each year have vastly outpaced investment in staff and budgets, a comprehensive report by the Centre for Health Economics at York University found.

Pound for pound, the NHS delivered 16.5 per cent more care in 2016/17 than it did in in 2004/05. This compares to productivity growth of just 6.7 per cent for the wider economy.

Productivity rose 2.86 per cent between 2015/16 and 2016/17 alone, when the productivity across the United Kingdom was stagnant. The York report shows that the NHS is delivering 60 per cent more "care" per year than it was in 2004, including 5.2 million more operations a year than in 2004 and 60 million more patient appointments.

However, quality improvements have been slower since 2011, showing the "trade-offs" that are being made to meet increasing demand. Waiting times, in particular, have been getting longer since 2009/10, the report notes, and these reached record levels in Accident and Emergency Departments this year, despite a milder winter.

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

Presented by: Julian Emms
Chief Executive
May 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	NHS National Staff Survey (NSS) 2018 – Results, Themes and Actions
Purpose	To update the Board on the 2018 National Staff Survey results and provide reassurance that we are listening and taking action
Business Area	Corporate
Author	Carol Carpenter, Director of People
Relevant Strategic Objectives	Support our staff Listening with the intent to improve engagement, retention and improve wellbeing. Making this a great place to work for everyone.
CQC Registration/Patient Care Impacts	Improving employee engagement is relevant to all the CQC domains.
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	Some of the results will feed into the national Workforce Race Equality Standard (WRES) in September 2019 and the new Workforce Disability Standard (WDES) in August 2019. We know that staff who identify as having a protected characteristic are not as engaged in the workplace as other staff.
SUMMARY	The Trust put lots of effort into increasing the response rate to the Survey, followed by detailed analysis and communication post the results. The Trust was rated 3rd amongst all Community and Mental Health Trusts and 50th amongst all Trusts. The level of engagement is the same as last year but the response rate increased by 7% to 51% of all

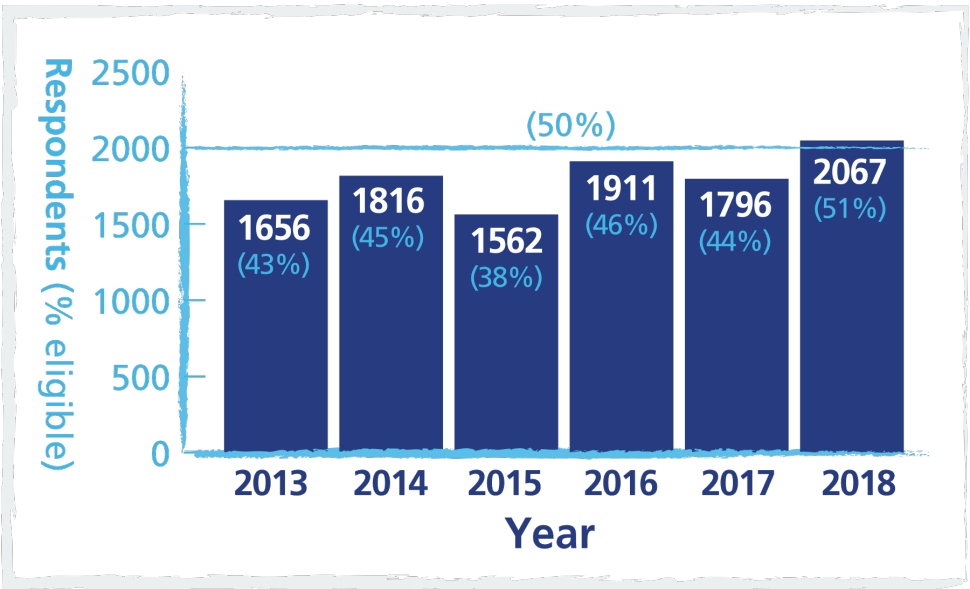
	staff. We need to focus on those members of staff with a protected characteristic, improve our offer of working flexibly and build on the QMIS work to enable people to feel empowered to make changes and improvements in the workplace.
ACTION REQUIRED	The Board is asked to: a) Note that there are links between the Survey results, turnover and vacancy data and exit survey data. b) Note that the Trust will: • Invest in managers to understand the results and take action where required. • Develop the 'Great Place to Work for everyone' piece of work leading to a new People Strategy which will focus on how it feels to work here with a focus on improving the results • Take actions to respond to the feedback from staff with protected characteristics • Deliver the Making it right programme for managers and the Allies programme for all staff. • Continue to celebrate the positive feedback we have received and build on this over the coming months.

Trust Board May 2019
NHS National Staff Survey 2018 (NSS)

Purpose:
To update the Board on the results of the National Staff Survey 2018 (NSS), the key messages and the actions we plan to take.

Background:
The NSS has been running since 2013 and each year we have made improvements to how we deploy it and how we communicate key messages and the actions we take with our workforce.

The response rate improved by 7% this year to 51%. The table below sets out how many people and the percentage of staff who have responded each year. This year the average number of responses across Community and Mental Health Trusts was 45%. Staff need to be permanently employed as September 2018 to take part.



This year we asked band 1-5 staff working in Estates and Facilities and Prospect Park Hospital to complete the survey manually on paper. This provided managers in these teams with the opportunity to talk to staff in advance and provide time away from the 'day job' to complete the survey. Prospect Park Hospital managers and the Human Resources lead based on site walked the wards engaging with people about the reason for the survey and why their feedback was important.

Response rates:
Estates 33%
Prospect Park Hospital 59

Results:

Overall the results are positive and when benchmarked against the rest of the NHS we came 50th and when benchmarked against other similar Community and Mental Health Trusts we came third.

The scoring system has been amended and instead of scoring out of 5 the new system scores us out of 10. We achieved 7.3. NHS Employers have converted this into a score

out of 5 so we can compare ourselves to last year. This demonstrates that we have increased our response rate and maintained the same score as last year, 3.93. The annual plan on a page sets an organisational ambition to achieve a score.

Annex 1 table 1 sets out the results of the questions which contribute to this score. Although 28 questions are asked of people these 16 questions calculate the score. The table compares our scores with other Trusts in the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership. We favour well in this cluster and we will work where appropriate to enhance scores together.

Overall the results highlight a number of areas where we have improved against last year and where we have done well in comparisons to the rest of the NHS. As an example, 'care of service users is my organisation's top priority' was agreed by 82% of the workforce, in comparison to an NHS average of 76%. Annex 1 contains an example of the positive responses.

We know that there is more work to be done and the areas we are focusing on are:

Wellbeing:
32% of the workforce said the organisation takes positive action on wellbeing. We have appointed a new Health, Wellbeing and Engagement lead and they will take forward this area of work. The Trust has invested in a new action plan for the next three years and we hope to see some really positive changes in how people feel and how we support each other.

Appraisal:
Only 24% of the workforce felt that their appraisal has a positive impact on how they do their role. We have improved the paperwork that staff and managers need to complete but this wasn't in place and used prior to the survey taking place. We have also improved the guidance and support for managers, and spoken to managers about the value of getting the conversations right.

Bullying, harassment and discrimination:
- 11% of the workforce report that they have received harassment, bullying and abuse from managers in the last 12 months.
- 16% of the workforce report that they have received harassment, bullying and abuse from their colleagues.
- We are reviewing what is meant by this and comparing with the data we hold on grievances and disciplinaries.
- We are also working with the staff networks to understand this data and will take actions accordingly.

Feeling empowered to make changes:
- 58% of the workforce report that they are involved in decisions that affect their work.
- 64% report that they are able to make improvements at work.
- Through the roll out of the QMIS project, we hope to be able to make significant improvements in these results. We want all staff to feel empowered to share ideas and make improvements and the A3, huddle board activity, QMIS training and combination of better appraisals, we hope to make further improvements in these results.

Protected characteristics:
The feedback from staff who identify as black and minority ethnic, LBGT+ or have a disability, collectively report as feeling less engaged across most questions. In response to

this we have shared the detailed results at the Diversity Steering Group. In addition each Executive lead has met with the Director of People, Head of Internal Communications and the staff network lead to discuss the results and to talk about any surprises, the key messaging and the actions to address the feedback. There are some issues that will require more analysis such as the statistical relevance of the difference between the ethnic groups, and what people mean by bullying, harassment and physical violence.

We have also concluded that we need to update some of the management training material to ensure this data and the actions required by managers are explicit. These sessions also identified that we need to take action to encourage staff to report their protected characteristics on the employee Human Resources system (ESR). As an example 4.8% of the workforce reports having a disability on the Human Resources system, but 8.8% reported a disability on the staff survey.

Services:
The staff survey feedback identifies three areas where we need to prioritise our efforts; Children and Young People Services, Mental Health In Patients and Estates and Facilities. The feedback correlates with other workforce metrics on turnover, vacancies rates and sickness. Human Resources are working on aligning support to these areas to support local managers and provide the training and confidence to tackle some issues such as the wellbeing agenda and retention. The Executive team have also invested in additional recruitment support for the Children and Young People team and this post is out to advert.

Equality and Inclusion:
Workforce race equality standard (WRES):

Below are the staff survey results which form part of the annual WRES reporting tool. Despite our investment over the last few years in the 'making it right' programme and management development, the feedback shows we still have more to do. As part of the Equality Strategy we have an action plan and work continues to ensure we address the concerns of the BAME network. We are working on the data linked to the career progression and recruitment and selection of BAME staff and we are continuing to invest in 'making it right'. Cohort three starts this month and we are about to pilot 'making it right for managers' with the senior leadership team.

	WRES 2016 NSS 2015	WRES 2017 NSS 2016	WRES 2018 NSS 2017	WRES 2019 NSS 2018
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**BAME 32%** White 21%	**BAME 27%** White 23%	**BAME 27%** White 22%	**BAME 31%** White 22%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**BAME 23%** White 19%	**BAME 27%** White 19%	**BAME 21%** White 18%	**BAME 20%** White 14%
Percentage believing that trust provides equal opportunities for career progression or promotion	**BAME 76%** White 88%	**BAME 68%** White 91%	**BAME 74%** White 89%	**BAME 68%** White 89%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	No data	**BAME 17%** White 5%	**BAME 11%** White 7%	**BAME 17%** White 7%

Workforce disability employment standard (WDES):
This year (August) the Trust will report on five questions as part of the WDES annual survey. This is a new requirement and further details will be reported to the Board. The Purple Network recently held a disability symposium and the actions from this event will lead to a number of changes especially in terms of reasonable adjustment knowledge and support, supporting people to be honest and share their disability in the workplace. We have started sharing stories on social media and through our internal briefing communications which have received positive feedback.

Other mechanisms for gathering staff feedback:
The national staff survey is just one mechanism for receiving feedback and we are comparing this data to the data on the People Dashboard, feedback from exit surveys, the Big Conversation and the Friends and Family Test.

We know that staff really want us to improve our recruitment activity and their ability to work flexibly. The free text section of the staff survey also provides feedback about IT support and hardware and the team are working hard to address these concerns and communicate all the positive changes taking place.

Role of Board:

- To recognise the mechanisms in place for gathering staff feedback and note that we are listening and taking action.

- When visiting services, talk about what you have heard and what action is being taken so we are all reinforcing the messages that we value the feedback, we do listen and we take action.

- To note the next steps listed below.

Next steps:

- Deliver the actions from the focus groups with the exec leads and staff network leads (disability, BAME and LGBT+)
- Prepare the communications for ‘you said’ and ‘we did’ to ensure staff know that we did listen and are responding
- Build a campaign to improve the data held on the HR system about each individual (noting that people share more when they believe there will be no impact) , using the Stonewall campaign ‘do ask, do tell’ to model what we need and why
- Develop the ‘Great Place to Work for everyone’ – which is a key feature of the recruitment and retention work streams
- Develop the line manager training to ensure managers understand their role in building engagement and improving retention and wellbeing. We have agreed to hold a one day event targeted at some line managers to focus on their people management responsibilities.
- Roll out the ‘making it right for line managers’
- Deliver the ‘Allies’ training day to build support for staff with protected characteristics.

Annex 1

Table 1: BOB STP comparison data on all questions which compile the engagement rate:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
BOB STP NHS Staff Survey Results 2018														
			OUH		OH		Royal Berks		BHFT		Bucks		SCAS	
EEI	Qs	Statement	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
Motivation	2a	Often/always look forward to going to work	59	59	60	61	62	65	65	63	61	62	57	58
	2b	Often/always enthusiastic about my job	73	77	73	74	74	77	78	78	73	75	72	72
	2c	Time often/always passes quickly when I am working	77	75	80	80	77	79	83	84	75	78	57	56
Advocacy	21a	Care of patients/service users is organisation's top priority	75	74	75	76	81	85	82	82	75	78	60	62
	21b	Organisation acts on concerns raised by patients/service users	70	68	61	62	79	80	81	80	71	74	51	55
	21c	Would recommend organisation as place to work	75	74	69	70	64	68	66	68	55	60	74	75
Involvement	4a	Opportunities to show initiative frequent in my role	73	72	76	74	74	74	76	78	74	74	65	65
	4b	Able to make suggestions to improve the work of my team/dept	74	73	80	77	75	75	81	81	77	77	59	59
	4d	Able to make improvements happen in my area of work	56	55	59	58	60	62	65	64	55	57	34	35
Response rate	%		38.8	48		52	42.7	46.3	44	51	49	51	61	63
Leaving?*	23a	I don't often think about leaving this organisation*	N/A	40			N/A	47	N/A	49	N/A	28	N/A	41
	23b	I am unlikely to look for a job at a new organisation in the next 12 months	N/A	49			N/A	54	N/A	54	N/A	20	N/A	47
	23c	I am not planning on leaving this organisation as soon as I find another job.	N/A	56			N/A	60	N/A	62	N/A	13	N/A	53
	21d	If friends or relatives needed treatment would be happy with the standard of care provided by organisation					77	80	75	73.1	66.5	69.9		

Areas to be positive about:

82% said that **'care of service users'** is the organisations top priority, which is well above the NHS average of 70%

80% of you said that **'my organisation acts on concerns raised by service users'**. the NHS average is 76%

94% of you said that you **had an appraisal** in the last 12 months, the NHS average 90%

76% of you said **training, learning or development** needs were identified during the appraisal (up 4% from last year)

60% of you said **your line manager supported you** to receive this training, learning or development (up from 55% last year)

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th May 2019
Title	Pre-Audit Financial Summary Report – M12 2018/19
Purpose	To provide the pre-audit Month 12 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 Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with summary of the M12 2018/19 year-end financial position.

ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for year-end Month 12 2018/19 (March 2019):
	
	The trust reports to NHSi its 'Use of Resources' rating, which monitors risk monthly, 1 is the highest rating possible and 4 is the lowest.
	
	YTD (Use of Resource) metric:
	• Overall rating 1 (plan 1)
	  ○ 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 and impairment):** • Plan: £2.4m surplus • Actual: £6.0m surplus • Variance: £3.6m better than plan £2.4m planned control total PSF funding achieved, plus year-end bonus and national reserve allocation of £2.1m. Total of £4.5m PSF funding supports the year end £6.0m surplus. **YTD Cash** £25.6m vs Plan £22.1m. **YTD Capital expenditure:** £9.9m vs Plan £10.0m. Also, recognised £1.1m donated capital to complete the Renal and Cancer Units at West Berkshire Community Hospital.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2018/19

Month 12 (March 2019)

Purpose

To provide the Board and Executive with a summary of the Trusts financial performance as at 31st March 2019.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	10/04/19	Bharti Bhoja	1st Draft
2.0	12/04/19	Paul Gray	Final
3.0	25/04/19	Paul Gray	Notification of additional PSF

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	1.5	(0.0)	1.5	▼	▲
PSF - Trust	3.6	1.5	2.2		
PSF - System	0.9	1.0	(0.1)	▲	▲
Control Total Surplus / (Deficit)	**6.0**	**2.4**	**3.6**	▲	▲
Statutory Surplus / (Deficit)	6.5	2.3	4.2	▲	▲
CIP Delivery	2.9	4.8	(1.9)	▲	▼
Agency Spend	6.0	5.3	0.7	▼	▼
OAPs - Specialist Placements (incl LD)	9.4	8.4	0.9	▲	▲
OAPs - Overspill Beds	2.3	1.1	1.1	▼	▼
Capital Expenditure	10.9	11.0	0.1	▲	▲
Cash	25.6	22.1	3.5	▲	▲

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

Key Messages & Actions

- The Trust generated a £1.5m surplus a pre PSF breakeven Control Total.
- Given the pressures faced this year, this is a tremendous result and all staff should be thanked for their help in achieving this result.
- After accounting for PSF, Donations and impairment charges, the statutory surplus is £6.5m. This includes receipt of additional PSF allocation including a bonus of £0.9m for achieving our £1.5m control total, £1.1m general allocation and £0.1m towards Agenda For Change pressures.
- Use of Resources rating for 18/19 was a "1" overall.
- Pay costs in March were £0.6m ahead of plan, with annual leave related bank usage a key factor in a £300k increase in costs in M12.
- YE Cash balance is £3.5m higher than planned due to b/fwd GDE Funding and the YE surplus.
- Capital spend for the year was £9.9m, £0.1m below our NHSI plan. In addition we recognised £1.1m of donated spend on the Renal Unit at WBCH.

Key Risks

As we move into the new financial year, the pressures will be the same risks that have been highlighted over previous months.

- Out of Area placement usage continues at a higher than planned level. Given the reduction trajectory and savings required in 19/20, the current usage presents a significant challenge and if continued at March's level would be £0.2m higher than the plan in Q1.
- We must see an immediate reduction in temporary staffing.

2.0 Income & Expenditure

Income Statement	In Month			YTD			Prior Year YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Var +/-	%
Operating Income	19.1	18.9	0.2	229.1	227.2	1.9	226.0	3.1	1.4%
DoH Pay Award	0.2	0.2	0.0	2.4	2.3	0.1	0.0	2.4	
Other Income	1.9	1.5	0.3	19.8	18.6	1.2	19.4	0.4	2.3%
Total Income	***21.2***	***20.6***	***0.5***	***251.3***	***248.2***	***3.1***	***245.3***	***5.9***	***2.4%***
Staff In Post	13.1	13.0	0.1	155.0	156.9	(1.9)	150.0	5.0	3.3%
Bank Spend	1.4	1.0	0.4	14.1	12.3	1.8	12.5	1.6	13.2%
Agency Spend	0.5	0.4	0.1	6.0	5.3	0.7	7.6	(1.6)	(20.7)%
Total Pay	***15.1***	***14.5***	***0.6***	***175.2***	***174.5***	***0.6***	***170.1***	***5.1***	***3.0%***
Purchase of Healthcare	0.9	1.1	(0.2)	15.6	13.7	1.9	16.8	(1.3)	(7.5)%
Drugs	0.5	0.4	0.1	5.9	5.0	0.9	4.8	1.1	23.6%
Premises	1.3	1.2	0.1	15.4	14.3	1.0	15.5	(0.1)	(0.9)%
Other Non Pay	1.8	2.0	(0.2)	21.1	23.4	(2.2)	21.2	(0.1)	(0.3)%
PFI Lease	0.5	0.5	(0.0)	6.4	6.3	0.0	6.2	0.2	3.5%
Total Non Pay	***5.0***	***5.3***	***(0.3)***	***64.3***	***62.7***	***1.6***	***64.5***	***(0.1)***	***(0.2)%***
Total Operating Costs	***20.1***	***19.7***	***0.3***	***239.5***	***237.3***	***2.2***	***234.6***	***4.9***	***2.1%***
EBITDA	***1.1***	***0.9***	***0.2***	***11.8***	***10.9***	***0.9***	***10.8***	***1.0***	***9.2%***
Interest (Net)	0.4	0.3	0.1	3.6	3.6	(0.0)	3.7	(0.0)	(1.1)%
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Disposals	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.1)	0.1	(99.9)%
Depreciation	0.5	0.6	(0.1)	5.0	5.6	(0.7)	4.7	0.2	4.6%
PDC	0.2	0.1	0.0	1.7	1.6	0.0	1.5	0.2	10.6%
Total Finanacing	***1.1***	***1.0***	***0.1***	***10.3***	***10.9***	***(0.6)***	***9.8***	***0.5***	***4.9%***
Surplus/ (Deficit) for PSF	***0.0***	***(0.1)***	***0.1***	***1.5***	***(0.0)***	***1.5***	***0.9***	***0.5***	***54.6%***
PSF - Trust	0.2	0.2	0.0	1.5	1.5	0.0			
PSF - System	0.0	0.1	(0.1)	0.9	1.0	(0.1)			
Incentive PSF - AFC Pressure	0.1	0.0	0.1	0.1	0.0	0.1	3.6	**0.9**	**25.9%**
Incentive PSF - General Distribution	1.1	0.0	1.1	1.1	0.0	1.1			
Incentive PSF - Bonus	0.9	0.0	0.9	0.9	0.0	0.9			
PSF - Subtotal	***2.4***	***0.3***	***2.1***	***4.5***	***2.4***	***2.1***			
Surplus/ (Deficit) for CT	***2.4***	***0.2***	***2.2***	***6.0***	***2.4***	***3.6***	***4.5***	***1.4***	***31.9%***
Donated Income	0.4	0.0	0.4	1.0	0.0	1.0	1.7	(0.7)	(42.3)%
Donated Depreciation	0.0	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	0.0	(132.3)%
Net Income from Donated Assets	***2.8***	***0.2***	***2.6***	***6.9***	***2.3***	***4.6***	***6.2***	***0.7***	***11.1%***
Impairments	0.4	0.0	0.4	0.4	0.0	0.4	0.6	(0.2)	(35.8)%
Surplus/ (Deficit) Statutory	***2.4***	***0.2***	***2.2***	***6.5***	***2.3***	***4.2***	***5.6***	***0.9***	***16.4%***

Key Messages

The Trust delivered a YE surplus of £1.5m, £1.5m ahead of plan. After incorporating PSF and donations and deducting £0.4m impairment charge, our reported surplus is £6.5m, £4.2m better than planned.

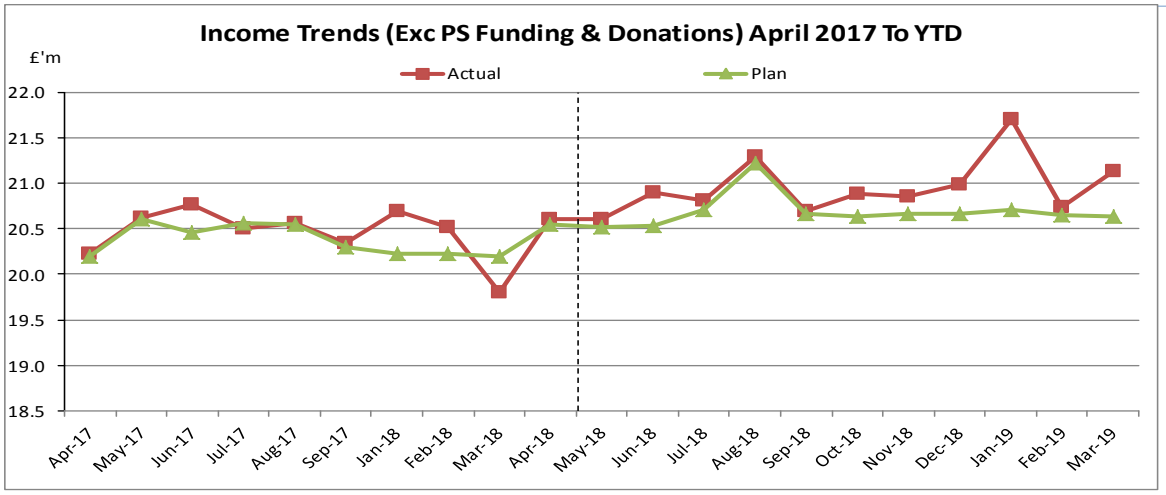
Whilst our forecast has been achieved, underlying costs increased in March, and £0.5m of additional reserves were required to be released.

The main area of increase was Pay expenditure which increases by £0.3m; predominately Bank expenditure with annual leave cover being the main reason for increased usage. The sizable pay increases seen in M12, are in the main non recurrent and therefore should not present a recurrent run rate risk moving into 19/20. That said, it is likely that costs will be at, or close to plan, next year, with staffing costs at affordable levels, after accounting for vacancy assumptions.

Non pay costs were £0.2m lower than plan. The release of reserves and non recurrent costs, masked a continuing OAPS over-spends of £0.2m, with demand for placements continuing at a high level during March.

Income & Contracts

Income Statement	In Month			YTD			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	16.8	16.5	0.3	199.6	198.2	1.4	194.0	5.7	2.9%
Tariff Income	0.2	0.3	(0.0)	2.7	3.1	(0.4)	2.9	(0.2)	(7.2)%
Pass Through Income	0.3	0.3	0.1	4.1	3.0	1.0	2.8	1.3	44.9%
DoH Pay Award	0.2	0.2	0.0	2.4	2.3	0.1	0.0	2.4	
Other Income	3.6	3.4	0.2	42.5	41.5	1.0	45.7	(3.2)	(7.1)%
Total Operating Income	***21.2***	***20.6***	***0.5***	***251.3***	***248.2***	***3.1***	***245.3***	***5.9***	***2.4%***
PSF - Trust	0.2	0.2	0.0	1.5	1.5	0.0	3.6	0.9	25.9%
PSF - System	0.0	0.1	(0.1)	0.9	1.0	(0.1)			
PSF-Incentive	2.2	0.0	2.2	2.2	0.0	2.2			
Donated Income	0.4	0.0	0.4	1.0	0.0	1.0	1.7	(0.7)	(42.3)%
Total Reportable Income	***23.9***	***20.9***	***3.0***	***256.8***	***250.6***	***6.2***	***250.6***	***6.1***	***2.4%***



Income

YTD	£'m
2018/19	251.2
2017/18	245.3
▲	*2%*

Prior Yr	£'m
Mar-19	21.1
Mar-18	19.8
▲	*2%*

Key Messages

Income was £0.5m above plan this month. Audiology AQP and NCAs income fell by £0.2m as we begin to see the impact of the loss of the AQP contract, and RBC income was adjusted by £0.1m, recognising an agreed reduction for the 0-19 service. Offsetting these adjustment, we recognised £0.1m Immunisation income for additional activity performed in year and reduced our CQUIN provision by £0.2m, mitigating performance risk. YE invoice reconciliations saw a number of smaller balances increase in month.

Pass Through and Other Income, which combined was £0.2m ahead of plan, was directly offset by IAPT & EMHP trainee costs and rechargeable drugs.

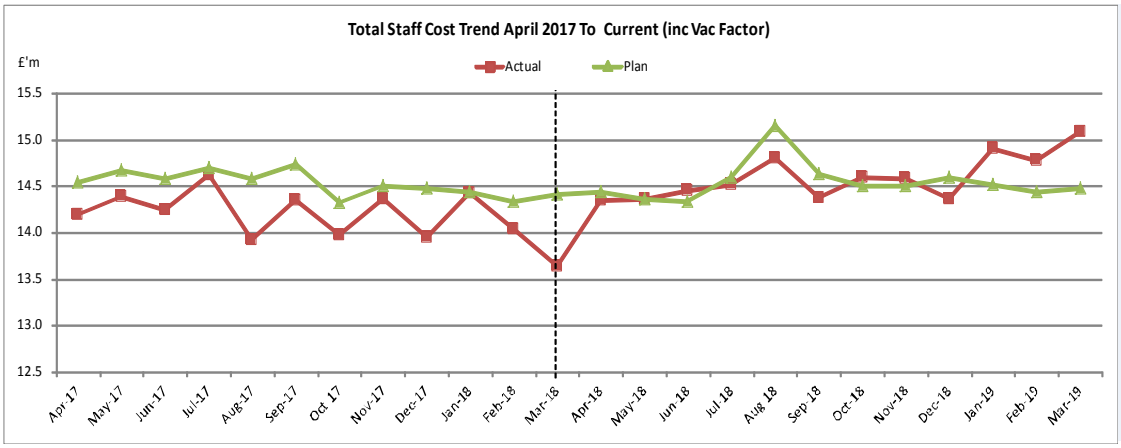
Commissioner Focus

The Trust signed contracts on the 21st March with CCGs. Negotiations are continuing with NHSE in relation to our CAMHS Tier 4 contract, with a meeting planned in late April.

System Focus

Frimley ICS have achieved their system control totals, with the aid of £0.6m of 'offset' provided by our above plan performance. Unfortunately Berkshire West ICS missed control total by £3m. As a result we lost £0.1m of system PSF allocation for the year. Next year we will be required to continue to allocate an element of PSF to system PSF, with its payment contingent of each system delivering its Control Total. The key change will be system related PSF for Berkshire West will not be incorporated into a BOB STP wide target.

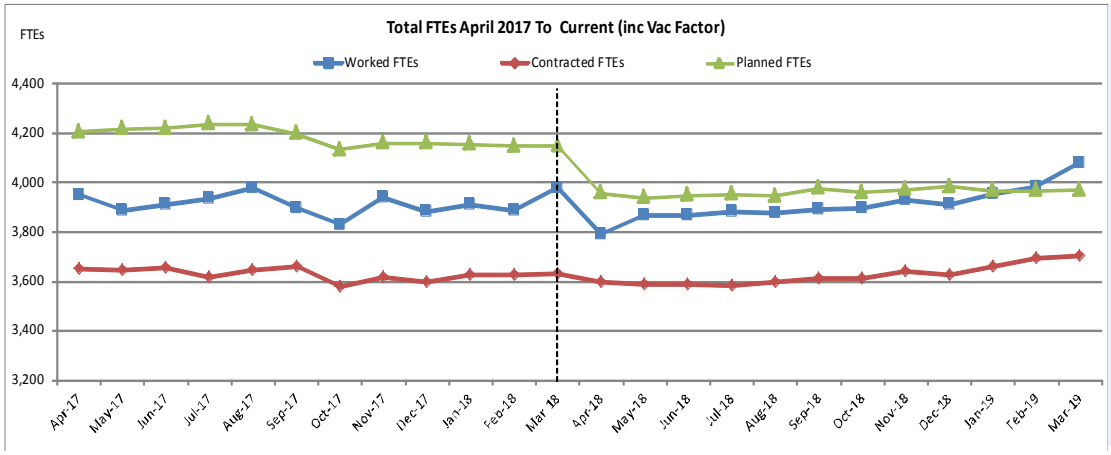
Workforce



Staff Costs

YTD	£'m
2018/19	175.2
2017/18	170.1
▲	3%

Prior Yr	£'m
Mar-19	15.1
Mar-18	13.6
▲	11%



FTEs

Prior Yr	CFTE	WFTE
Mar-19	3,703	4,078
Mar-18	3,632	3,978
	-2% ▲	-3% ▲

Prior Mth	CFTE	WFTE
Mar-19	3,703	4,078
Feb-19	3,693	3,982
	0% ▲	-2% ▲

Key Messages

Pay costs were £0.6m ahead of plan in March, resulting in Trust overspending its annual Pay budget by £0.6m.

Our overall Worked FTEs were 96 ahead of a plan including vacancy factor. This aligns to our costs being significantly above plan in the month.

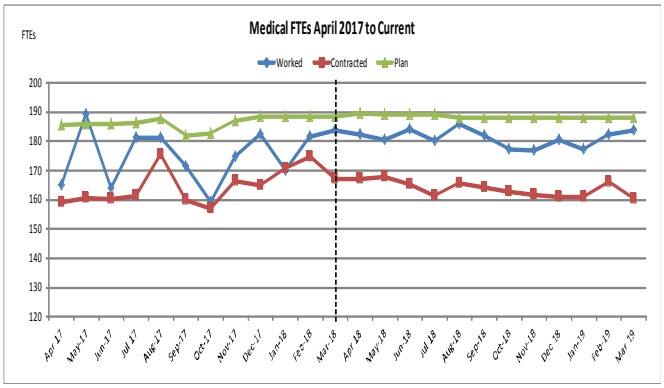
Although spend was high in March, there are elements of costs which are non recurrent and do not represent run rate risk moving into 19/20. However Q4, saw higher non permanent staffing costs than any other in year, and we must look to bring these costs down.

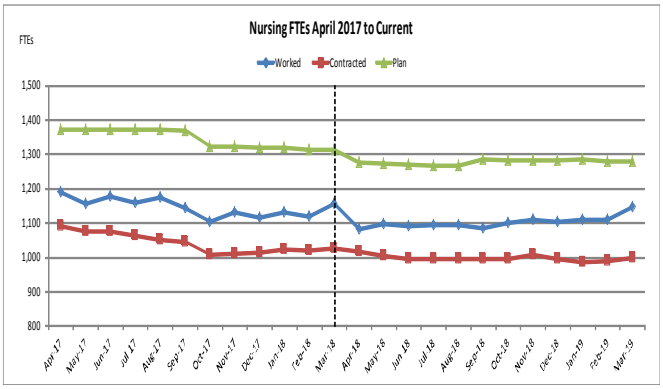
Our permanent contracted numbers remained broadly in line with FTEs and costs in February. The higher than planned expenditure March was predominantly due to increase in non permanent staff costs.

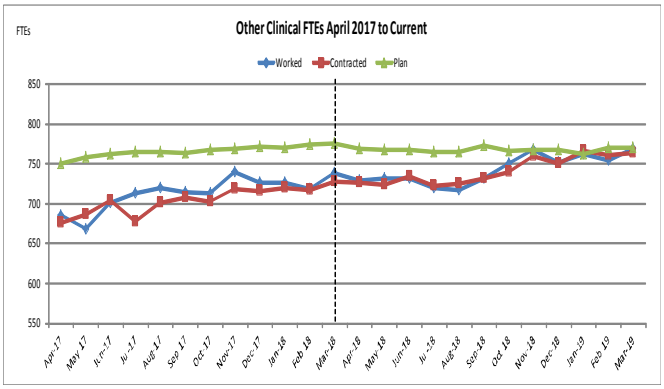
Temporary bank staffing costs increased by £0.3m in March which included a marked increase in shift being booked to cover annual leave being taken before the end of year. In addition to bank, WestCall also incurred a higher than usual number of shifts at NHSI reportable rates, again citing increased annual leave.

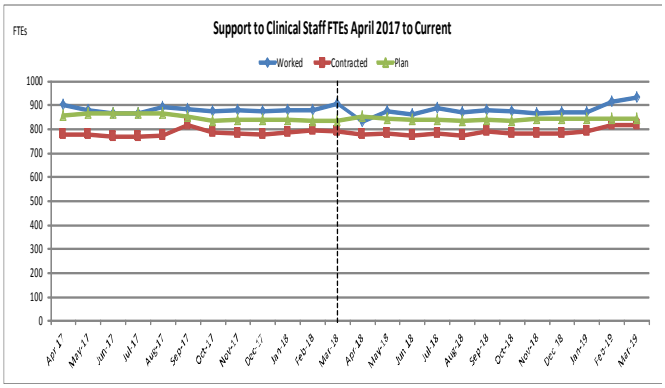
CRHTT and WestCall overspend heavily in year. CRHTT are looking to reduce costs as part of the 19/20 CIP programme, albeit at a lower level than assumed in the current plan. Campion Unit observation costs overspend for the year was £643k, with complexity of patients increasing costs in this area.

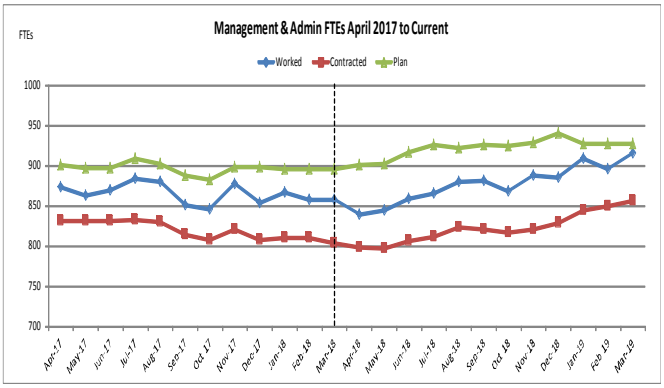
Workforce: Staff Groups

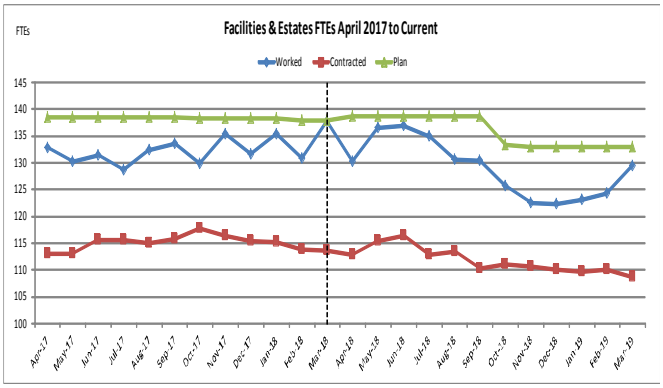












Key Messages

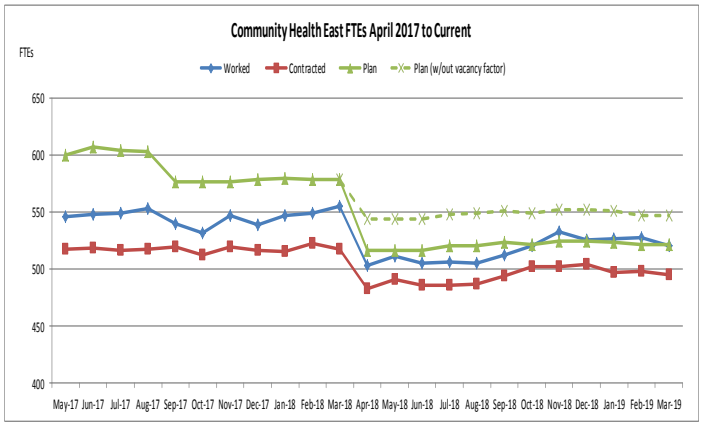
The charts above do not include the assumed vacancy factor incorporated into the plan. They indicate that all staffing groups are operating below established levels, with the exception of Support to Clinical staff who are ahead. Support to clinical staff are over recruited in some cases to offset qualified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

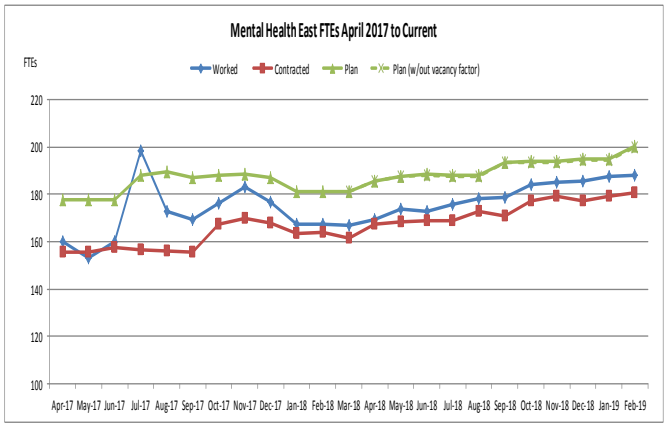
Support to Clinical Staff, increase in MH Inpatients 16 FTEs and LD Campion Unit 5 FTEs, due to a combination of increasing vacancies, acuity of patients, higher occupancy and annual leave cover.

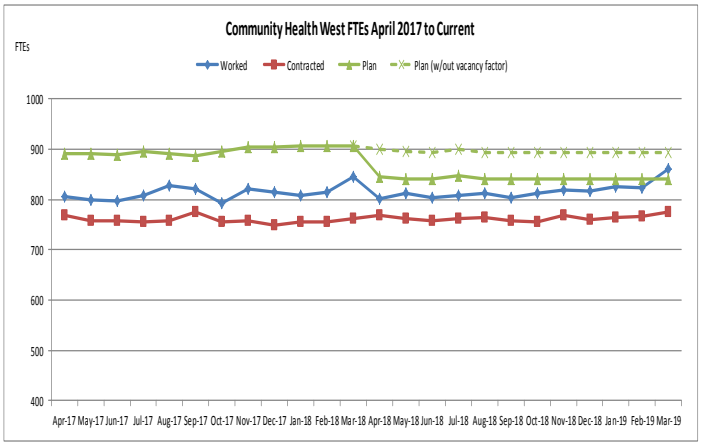
Management and Admin staffing numbers continue to increase with appointments in a number of areas including Governance, HR & Recruitment, Operations, OPMH and Intermediate Care. Some increases were also due to use of temporary administrative support in CAMHS, 4 WTEs and Community Paediatrics, 2 WTE.

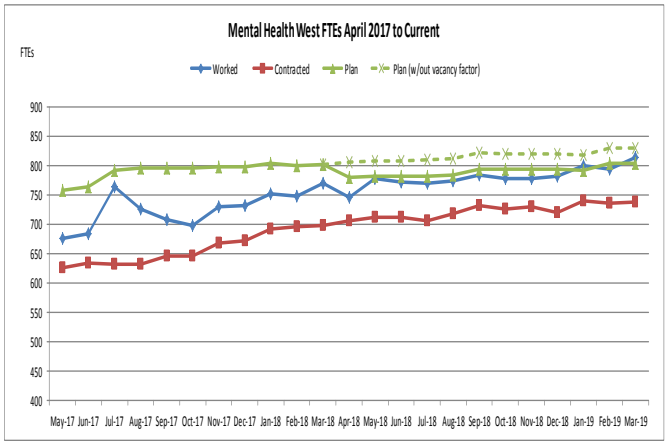
Qualified Nursing, saw a small increase in contracted numbers with recruitment in District Nursing, Psychological Medicine and Health Visiting West. The rise in WFTE, is predominantly the impact of annual leave cover by bank staff over and above contracted numbers.

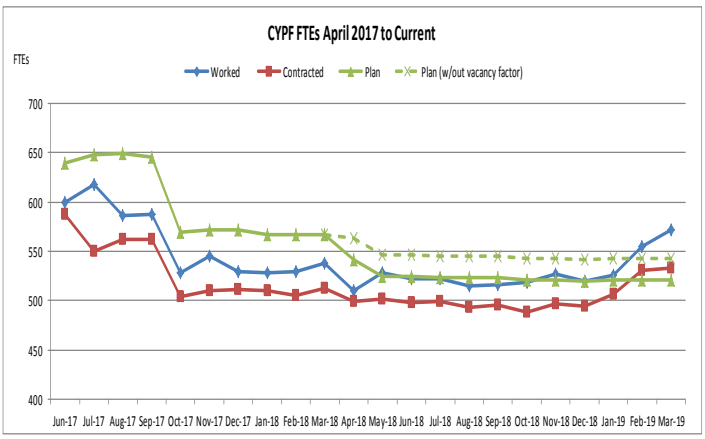
Workforce: Divisional

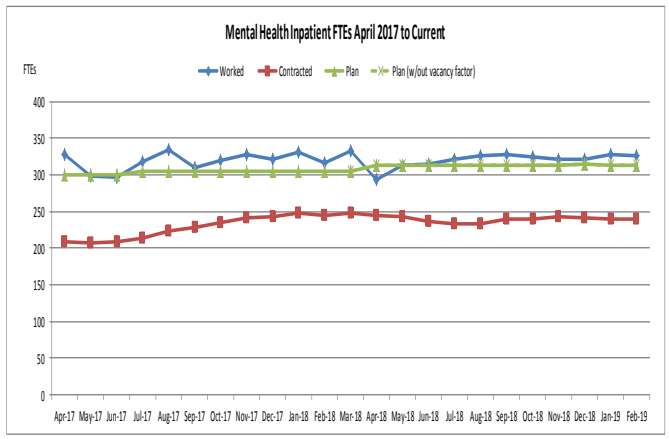


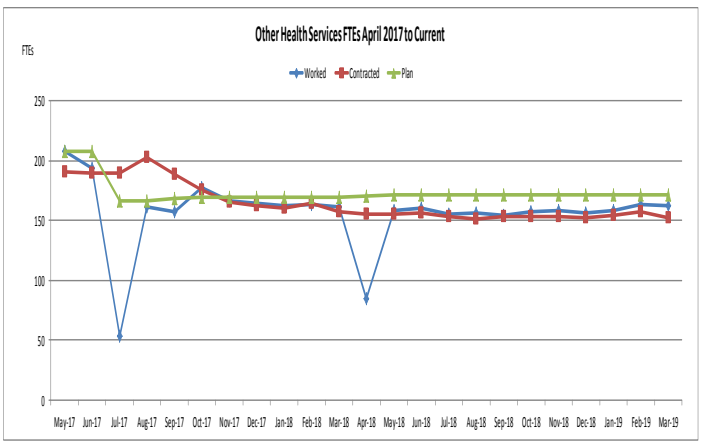


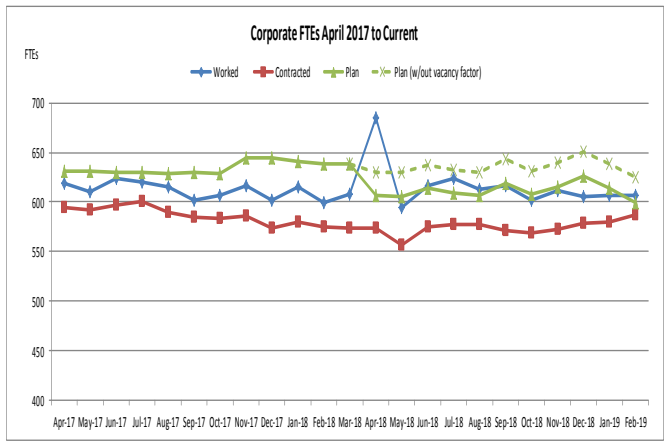




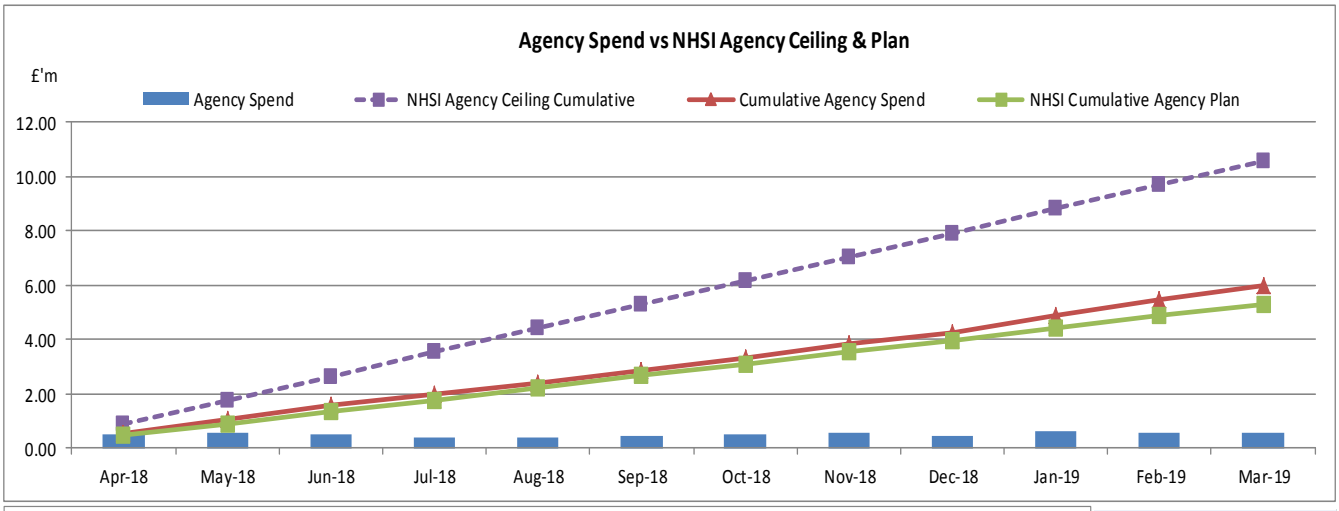


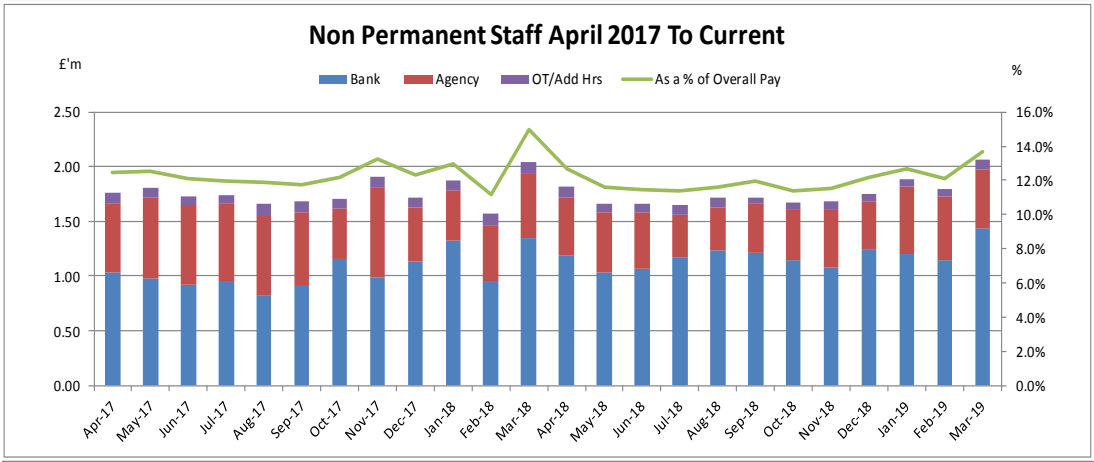






Non Permanent Pay

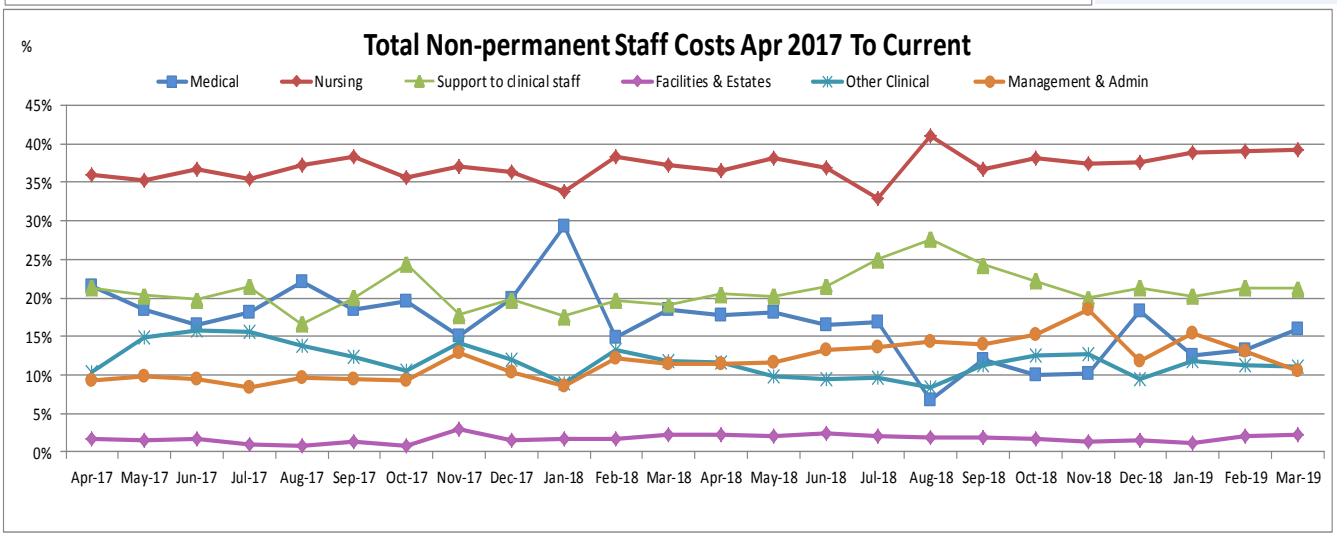




Non Permanent Pay

YTD	Bank	Agency	OT/Add Hrs
2018/19	14.1	6.0	0.9
2017/18	12.5	7.6	1.1
	12% ▲	-26% ▼	-20% ▼

Prior Yr	Bank	Agency	OT/Add Hrs
Oct-18	1.4	0.5	0.1
Oct-17	1.1	0.6	0.1
	20% ▲	-7% ▼	-10% ▼



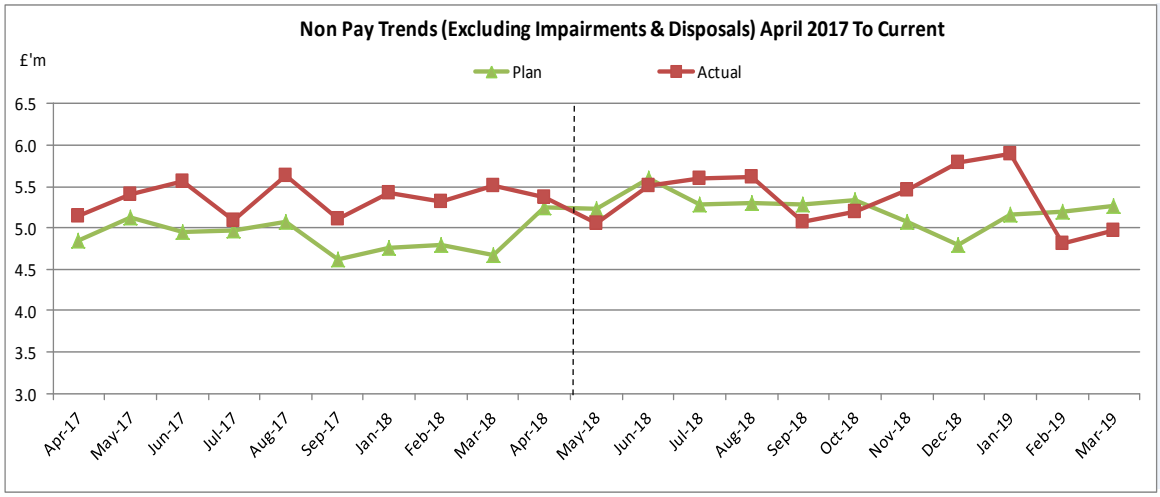
Key Messages

Costs in March (excluding overtime and additional hours) were £2.0m. Agency reduced by £40k but bank costs increased by £288k. Overall temporary staffing costs were at the highest level seen this year.

Significant increases were seen in Community Health West £193k, Mental Health West £122k and Mental Inpatients £51k. While Mental Health Inpatient cost increase was due to several reasons including increased vacancies, high occupancy, acuity of patients and some annual leave, Community and Mental Health increases were predominantly due to annual leave.

Non Pay Expenditure

Non Pay	In Month			YTD			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Purchase of Healthcare	0.9	1.1	(0.2)	15.6	13.7	1.9	16.8	(1.3)	(7.5)%
Drugs	0.5	0.4	0.1	5.9	5.0	0.9	4.8	1.1	23.6%
Premises	1.3	1.2	0.1	15.4	14.3	1.0	15.5	(0.1)	(0.9)%
Supplies and services – clinical	0.5	0.4	0.0	5.2	5.2	(0.0)	4.7	0.4	8.8%
Transport	0.3	0.3	(0.1)	3.2	3.9	(0.8)	3.4	(0.2)	(5.9)%
Establishment	0.5	0.3	0.2	3.9	3.1	0.8	4.7	(0.8)	(16.8)%
Other Non Pay	0.6	1.0	(0.4)	8.9	11.2	(2.3)	8.4	0.5	5.9%
PFI Lease	0.5	0.5	(0.0)	6.4	6.3	0.0	6.2	0.2	3.5%
Total Non Pay	**5.0**	**5.3**	**(0.3)**	**64.3**	**62.7**	**1.6**	**64.5**	**(0.1)**	**(0.2)%**



Non Pay

YTD	£'m
2018/19	64.3
2017/18	64.5
▼	*0%*

Prior Yr	£'m
Mar-19	5.0
Mar-18	5.5
▼	*-10%*

Key Messages

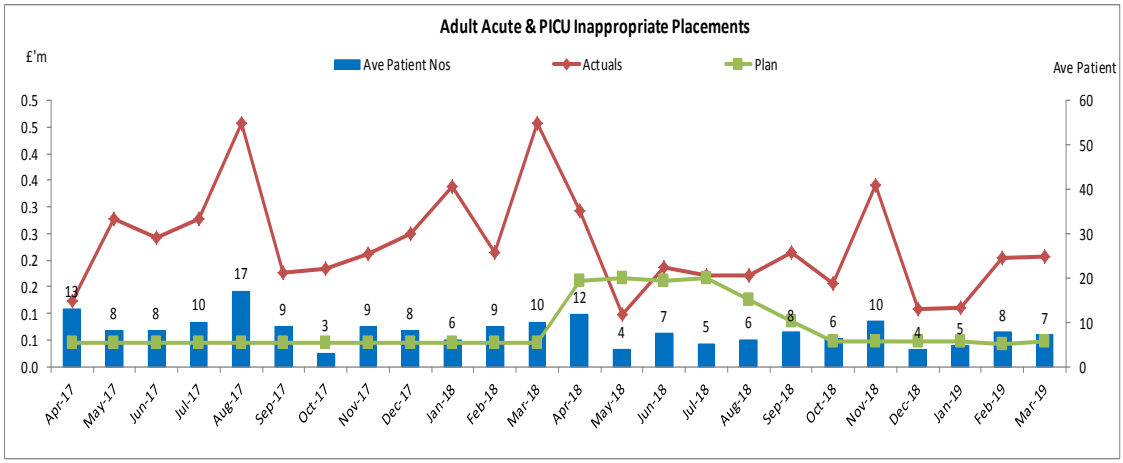
Overall the Trust overspend on Non Pay costs by £1.6m in 18/19. Of this, £0.9m was on drugs that were covered directly by income, and therefore should be discounted as a pressure. Equally, the majority of the £2.3m benefit to plan in Other Non Pay, is the unwinding of budgetary reserves, offsetting financial risks. There is also £0.5m of agreed non recurrent investments that are included in our opex. The key remaining factor in the remaining over-spend is attributable to Out of Area Placement costs, with usage above planned levels.

In March costs were £0.2m higher than February, but still below planned levels, decreased the YTD variance to plan.

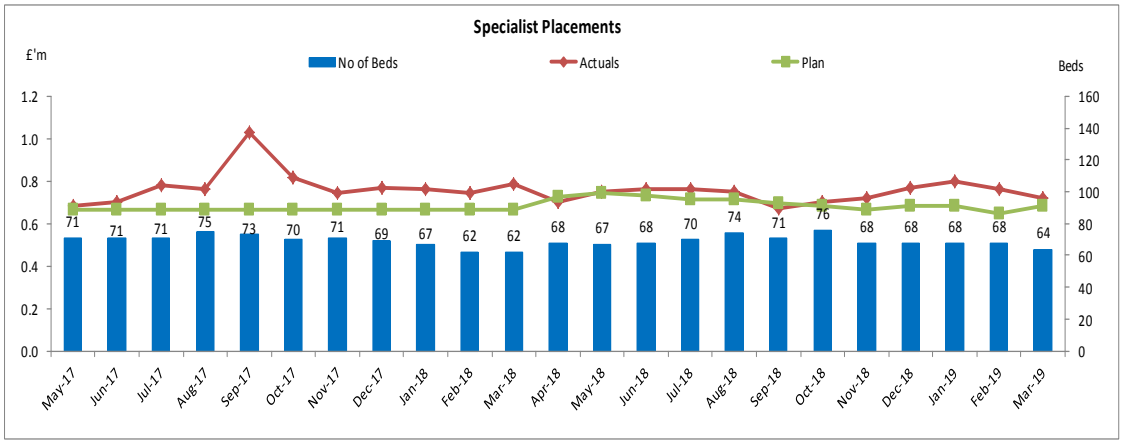
Spend this month included a number of non-recurrent items including PFI contract review, linked to CIP benefits planned in 19/20, non recurrent investment in new syringe driver equipment, and project costs relating to the QIBI programme.

The level of OAPS remained high throughout the month and the overspend in this area increased by a further £0.2m in March. This remains an area of cost which requires focus given the impact on the financial plan in 19/20. Specialist placements were £42k lower and OAPs cost increased by £56k. Two long standing LD placements are the process of being discharged, which will reduce costs moving into the new financial year.

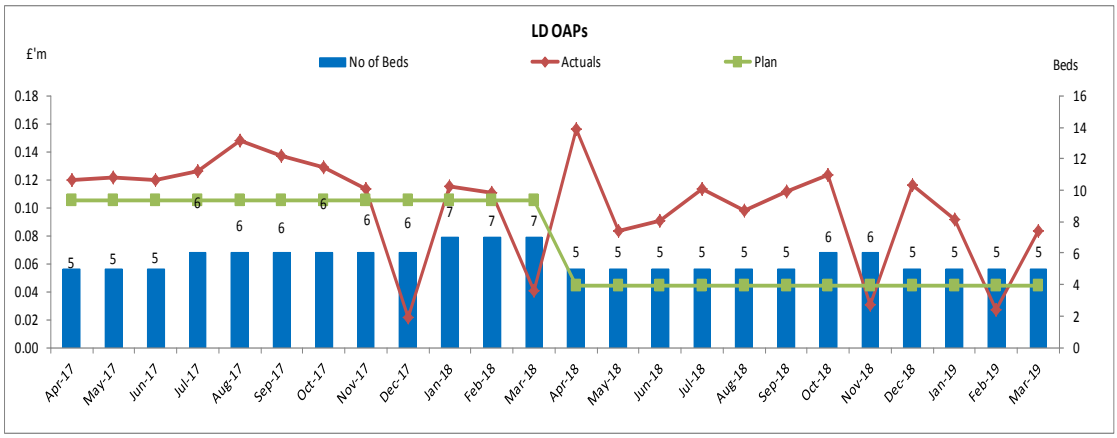
Non Pay Expenditure - Focus on OAPs



Non Pay	
YTD	£'m
2018/19	2.3
2017/18	3.2
▼	-29%
Prior Yr	£'m
Mar-19	0.2
Mar-18	0.5
▼	-55%



Non Pay	
YTD	£'m
2018/19	8.9
2017/18	9.2
▼	-4%
Prior Yr	£'m
Mar-19	0.7
Mar-18	0.8
▼	-9%



Non Pay	
YTD	£'m
2018/19	1.1
2017/18	1.3
▼	-14%
Prior Yr	£'m
Mar-19	0.1
Mar-18	0.0
▲	106%

Key Messages

Inappropriate Placement costs in March were £0.2m higher than plan but £0.2m lower March 18. YTD costs are £1.1m higher than anticipated, but still £0.9m lower than last year. In March inappropriate placements patients reduced by 1 however the cost remained the same as February.

Specialist Placements' cost were £34k overspent in March and are £0.5m overspent YTD. Again considerable efforts have been made with spend down on last year by £0.4m.

LD OAPS –costs are £0.6m overspent for the year which represents an increase of £0.2m compared to last year. The chart has been normalised for the Berkshire West LD patients funding transfer. This is an area specifically being targeted in the 19/20 CIP plan, with 2 patients already due for discharge.

3.0 Divisional Summary

Income Statement	In Month			YTD			Full Year			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Var	Act		Var
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Community Health West												
Income	0.5	0.5	0.0	5.0	5.5	(0.5)	5.0	5.5	(0.5)	4.3	0.7	17.0%
Pay	3.1	2.9	0.2	34.8	35.3	(0.5)	34.4	35.3	(0.8)	34.0	0.8	2.2%
Non Pay	0.5	0.5	(0.0)	5.7	5.7	(0.0)	5.7	5.7	(0.0)	5.3	0.4	6.6%
Net Cost	***3.1***	***3.0***	***0.1***	***35.4***	***35.5***	***(0.1)***	***35.1***	***35.5***	***0.4***	***35.0***	***0.4***	***1.1%***
Mental Health West												
Income	0.2	0.2	(0.1)	2.7	3.0	(0.3)	2.9	3.0	(0.1)	2.9	(0.3)	(9.5)%
Pay	2.9	2.9	0.1	34.2	34.1	0.1	33.9	34.1	(0.2)	30.6	3.6	11.6%
Non Pay	0.5	0.3	0.2	6.4	4.3	2.1	7.1	4.3	2.8	7.0	(0.6)	(8.6%)
Net Cost	***3.3***	***3.0***	***0.3***	***37.9***	***35.4***	***2.5***	***38.1***	***35.4***	2.7	***34.7***	***3.2***	***9.3%***
Community Health East												
Income	0.2	0.3	(0.0)	3.0	3.3	(0.3)	3.2	3.3	(0.1)	4.3	(1.3)	(29.9)%
Pay	1.8	1.8	(0.0)	21.6	22.0	(0.4)	21.6	22.0	(0.4)	22.8	(1.2)	(5.2%)
Non Pay	0.6	0.6	0.0	6.4	6.9	(0.5)	6.4	6.9	(0.5)	6.7	(0.3)	(4.1%)
Net Cost	***2.2***	***2.1***	***0.0***	***25.0***	***25.6***	***(0.6)***	***24.8***	***25.6***	(0.8)	***25.2***	***(0.2)***	***(0.7%)***
Mental Health East												
Income	0.1	0.1	0.0	1.6	1.4	0.3	1.8	1.4	0.4	1.7	(0.0)	(1.6)%
Pay	0.8	0.7	0.0	8.2	8.5	(0.3)	8.2	8.5	(0.3)	7.5	0.7	10.0%
Non Pay	0.8	0.8	0.0	10.1	9.7	0.5	10.0	9.7	0.4	10.3	(0.2)	(1.9%)
Net Cost	***1.4***	***1.4***	***0.0***	***16.7***	***16.8***	***(0.1)***	***16.5***	***16.8***	(0.3)	***16.1***	***0.6***	***3.6%***
CYPF												
Income	0.5	0.2	0.3	3.4	2.7	0.7	3.0	2.7	0.3	3.4	0.0	0.9%
Pay	1.9	1.8	0.1	22.2	22.3	(0.1)	22.3	22.3	0.0	23.4	(1.2)	(5.2%)
Non Pay	0.2	0.1	0.0	1.7	1.6	0.2	1.5	1.6	(0.0)	1.6	0.1	9.0%
Net Cost	***1.6***	***1.8***	***(0.2)***	***20.5***	***21.1***	***(0.6)***	***20.8***	***21.1***	(0.4)	***21.6***	***(1.1)***	***(5.1%)***
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	330.4%
Pay	1.0	0.9	0.1	11.7	11.1	0.5	11.5	11.1	0.4	10.8	0.9	8.1%
Non Pay	0.1	0.1	(0.0)	0.9	1.1	(0.1)	0.9	1.1	(0.1)	1.0	(0.1)	(11.3%)
Net Cost	***1.1***	***1.0***	***0.1***	***12.6***	***12.2***	***0.4***	***12.5***	***12.2***	0.2	***11.8***	***0.7***	***6.3%***
Other Health Services												
Income	0.3	0.1	0.2	2.7	1.2	1.6	2.9	1.2	1.7	1.4	1.4	100.9%
Pay	1.3	1.2	0.0	15.0	14.7	0.2	15.0	14.7	0.3	14.6	0.4	2.7%
Non Pay	0.2	0.0	0.1	1.7	0.3	1.4	1.8	0.3	1.5	0.3	1.4	396.5%
Net Cost	***1.2***	***1.2***	***(0.0)***	***13.9***	***13.8***	***0.1***	***14.0***	***13.8***	0.1	***13.6***	***0.4***	***2.8%***
Corporate												
Income	1.1	1.2	(0.1)	17.4	15.4	2.0	16.6	15.4	1.2	20.2	(2.7)	(13.6)%
Pay	2.2	2.1	0.1	27.5	26.5	1.0	27.5	26.5	1.0	26.3	(1.1)	4.4%
Non Pay	2.2	2.9	(0.6)	31.4	33.2	(1.9)	31.2	33.2	(2.0)	32.2	0.8	(2.5%)
Net Cost	***3.3***	***3.7***	**0.4**	***41.4***	***44.3***	**2.9**	***42.2***	***44.3***	(2.2)	***38.4***	**(3.1)**	**8.0%**
Corporate Income & Financing												
Income	21.0	18.3	2.7	220.8	218.2	2.6	218.1	218.2	(0.1)	212.5	8.3	3.9%
Financing	1.481	1.004	0.5	10.763	10.9560	(0.2)	10.0	11.0	(0.9)	10.5	0.3	2.7%
Surplus/ (Deficit) Statutory	***2.4***	***0.2***	**2.2**	***6.5***	***2.3***	**4.2**	***4.2***	***2.3***	**1.9**	***5.6***	**0.9**	**16.4%**

Key Messages

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

Mental Health West: Pay over due to high use of bank and agency and non-pay due to OAP overspends, income IAPT.

Community Health West: Pay overspent due to high use of bank and agency to cover annual leave.

Other Health: Non-pay variances relate to Pharmacy pass through drugs and CYPF to EMHP and IAPT funded pay costs.

Corporate & Income & Financing: Include a number of YE adjustments and provisions, obscuring relatively static performance.

4.0 Cost Improvement Programme

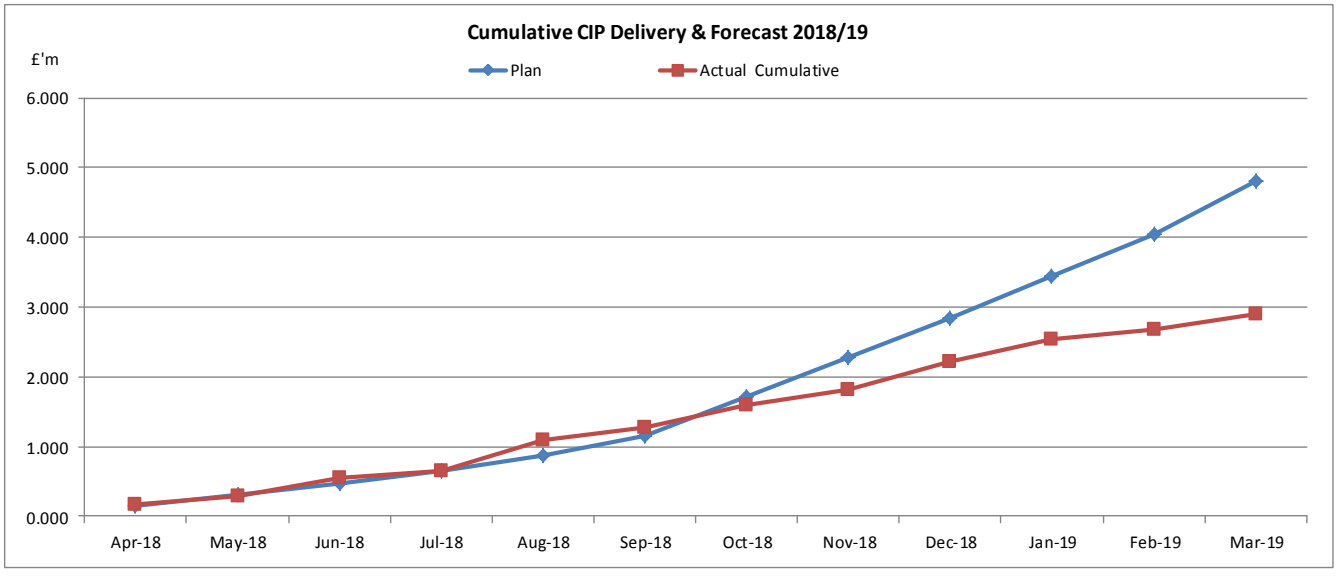
Cost Improvement Programme									
Scheme	In Month			YTD			Full Year		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m
OAPS Project									
Specialist Placements	0.01	0.07	(0.06)	0.18	0.59	(0.41)	0.30	0.59	(0.29)
Overspill Beds	0.11	0.26	(0.15)	1.16	1.82	(0.65)	1.20	1.82	(0.62)
Total OAPS Saving	***0.11***	***0.33***	***(0.21)***	***1.34***	***2.40***	***(1.06)***	***1.50***	***2.40***	***(0.91)***
Service Line Review									
WestCall	0.00	0.08	(0.08)	0.00	0.50	(0.50)	0.00	0.50	(0.50)
CRHTT	0.00	0.08	(0.08)	0.00	0.50	(0.50)	0.00	0.50	(0.50)
Total Service Line Savings	***0.00***	***0.17***	***(0.17)***	***0.00***	***1.00***	***(1.00)***	***0.00***	***1.00***	***(1.00)***
Procurement									
NHSP Contract	0.02	0.02	0.00	0.18	0.18	0.00	0.18	0.18	0.00
Procurement Spend	0.05	0.03	0.02	0.44	0.30	0.14	0.40	0.30	0.10
Total Procurement Savings	***0.06***	***0.04***	***0.02***	***0.62***	***0.48***	***0.14***	***0.58***	***0.48***	***0.10***
Other Schemes									
Community NCA	0.00	0.02	(0.02)	0.28	0.25	0.03	0.25	0.25	0.00
Liaison & Diversion Contract	0.02	0.02	0.00	0.25	0.25	0.00	0.25	0.25	0.00
Other Contracts	0.02	0.02	0.00	0.25	0.25	0.00	0.25	0.25	0.00
Scheme to be Identified	0.01	0.17	(0.16)	0.16	0.17	(0.01)	0.17	0.17	0.00
Total Other Savings	***0.06***	***0.23***	***(0.18)***	***0.94***	***0.92***	***0.02***	***0.92***	***0.92***	***0.00***
Total CIP Delivery	***0.23***	***0.77***	***(0.54)***	***2.90***	***4.80***	***(1.90)***	***3.00***	***4.80***	***(1.81)***

Key Messages

The Trust delivered £2.9m of savings against a full year plan of £4.8m.

OAPS under delivered by £1.1m. Specialist Placements shortfall was due to a number of step downs and contract negotiations taking longer than anticipated. Overspill beds saw bed requirement remaining static and ahead of planned reductions. No cost reductions were delivered from the service line review, a small amount of cost reduction is planned against CRHTT in FY 19/20.

Moving into 19/20, we anticipate tracking performance against a committed NHSI CIP target of £4m and an internal stretch target of £6m.



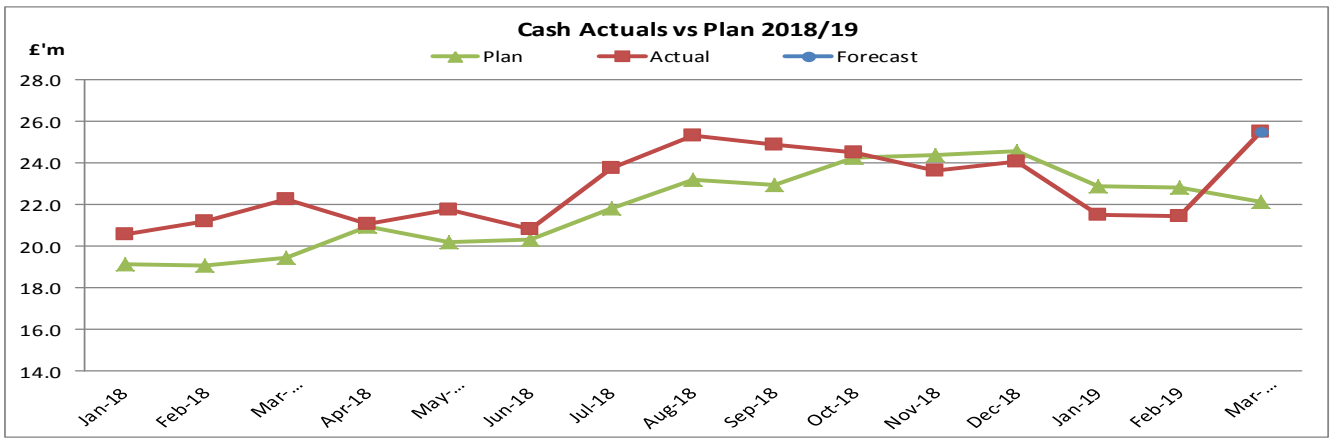
5.0 Balance Sheet & Cash

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	5.2	5.5	(0.2)	5.2	5.5	(0.2)	5.5
Property, Plant & Equipment (non PFI)		35.1	37.7	38.5	(0.8)	37.7	38.5	(0.8)	38.5
Property, Plant & Equipment (PFI)		55.6	59.8	55.6	4.2	59.8	55.6	4.2	55.6
Total Non Current Assets		**95.2**	**102.7**	**99.6**	**3.2**	**102.7**	**99.6**	**3.2**	**99.6**
Trade Receivables & Accruals		13.4	10.0	10.8	(0.7)	10.0	10.8	(0.7)	10.8
Other Receivables		0.3	0.2	1.3	(1.1)	0.2	1.3	(1.1)	1.3
Cash		22.3	25.6	22.1	3.5	25.6	22.1	3.5	22.1
Trade Payables & Accruals		(23.7)	(24.3)	(24.6)	0.3	(24.3)	(24.6)	0.3	(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)	(2.7)	(2.3)	(0.4)	(2.7)	(2.3)	(0.4)	(2.3)
Total Net Current Assets / (Liabilities)		**9.0**	**7.6**	**6.1**	**1.4**	**7.6**	**6.1**	**1.4**	**6.1**
Non Current PFI Finance Lease		(29.7)	(28.5)	(28.5)	0.0	(28.5)	(28.5)	0.0	(28.5)
Other Non Current Payables		(1.6)	(1.5)	(1.6)	0.1	(1.5)	(1.6)	0.1	(1.6)
Total Net Assets		***72.9***	***80.3***	***75.6***	***4.7***	***80.3***	***75.6***	***4.7***	***75.6***
Income & Expenditure Reserve		19.9	26.0	22.2	3.8	26.0	22.2	3.8	22.2
Public Dividend Capital Reserve		16.0	18.0	16.3	1.7	18.0	16.3	1.7	16.3
Revaluation Reserve		37.0	36.2	37.0	(0.8)	36.2	37.0	(0.8)	37.0
Total Taxpayers Equity		***72.9***	***80.3***	***75.6***	***4.7***	***80.3***	***75.6***	***4.7***	***75.6***

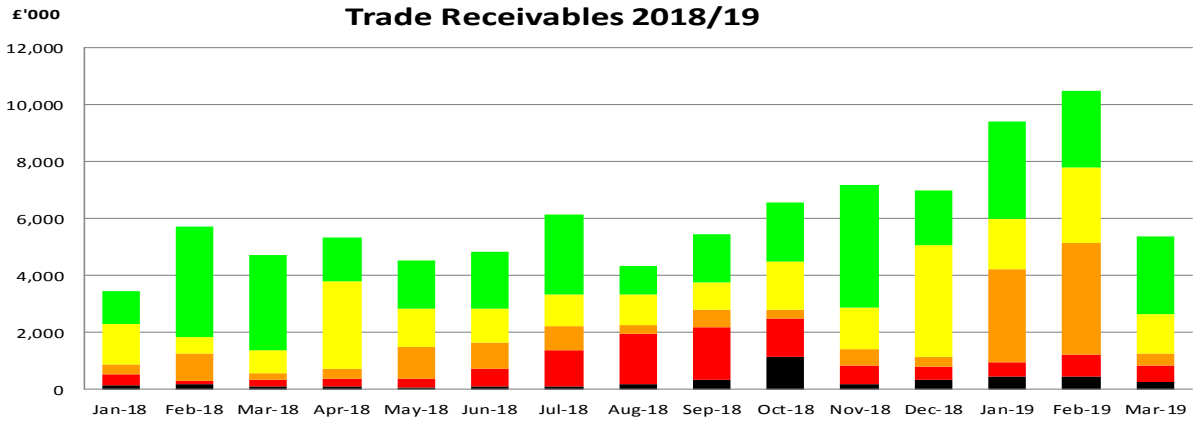
Cashflow		17/18 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	18/19 Plan £'m
Operating Surplus/(Deficit)	+/-	10.7	0.8	0.8	0.1	9.7	7.7	1.9	7.8
Depreciation and Impairments	+	5.4	0.9	0.6	0.4	5.5	5.7	(0.2)	5.7
Operating Cashflow		***16.1***	***1.8***	***1.3***	***0.4***	***15.1***	***13.4***	***1.7***	***13.4***
Net Working Capital Movements	***+/-***	***(2.1)***	***5.3***	***0.2***	***5.1***	***1.9***	***0.8***	***1.1***	***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)	(1.9)	(1.0)	(1.0)	(10.3)	(9.1)	(1.2)	(9.1)
Investments		***(10.2)***	***(1.9)***	***(1.0)***	***(0.9)***	***(9.5)***	***(8.3)***	***(1.2)***	***(7.5)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	(0.0)	(1.0)	(1.0)	(0.0)	(1.0)
Net Interest	+/-	(3.5)	(0.4)	(0.3)	(0.1)	(3.6)	(3.6)	0.0	(3.6)
PDC Revieved	+	1.8	0.2	0.0	0.2	2.1	0.3	1.7	0.3
PDC Dividends Paid	-	(1.6)	(0.7)	(0.8)	0.1	(1.6)	(1.7)	0.1	(1.7)
Financing Costs		***(4.3)***	***(1.0)***	***(1.2)***	***0.2***	***(4.2)***	***(6.1)***	***1.8***	***(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***	***4.1***	***(0.7)***	***4.8***	***3.3***	***(0.1)***	***3.5***	***(0.3)***
Opening Cash		20.7	21.5	22.9	(1.4)	22.3	22.3	0.0	22.3
Closing Cash		***22.3***	***25.6***	***22.1***	***3.5***	***25.6***	***22.1***	***3.5***	***22.0***

Key Messages

Closing cash balance was £25.6m which is £3.5m above the plan closing cash of £22.1m. The reasons for higher surplus of cash is due to receipt of Public Dividend Capital/Cash in respect of GDE brought forward from 2019/20, £1.3m; operating surplus higher than plan £1.7m; positive working capital movement £1.1m, offset by higher capital expenditure outlay of £1.2m, net of capital accruals. Cash expected from the sale of Craven Road site is no longer available as planning issues have resulted in the loss of sale. The site is no longer available for redevelopment or disposal in the immediate future. Options for other uses are currently being considered.



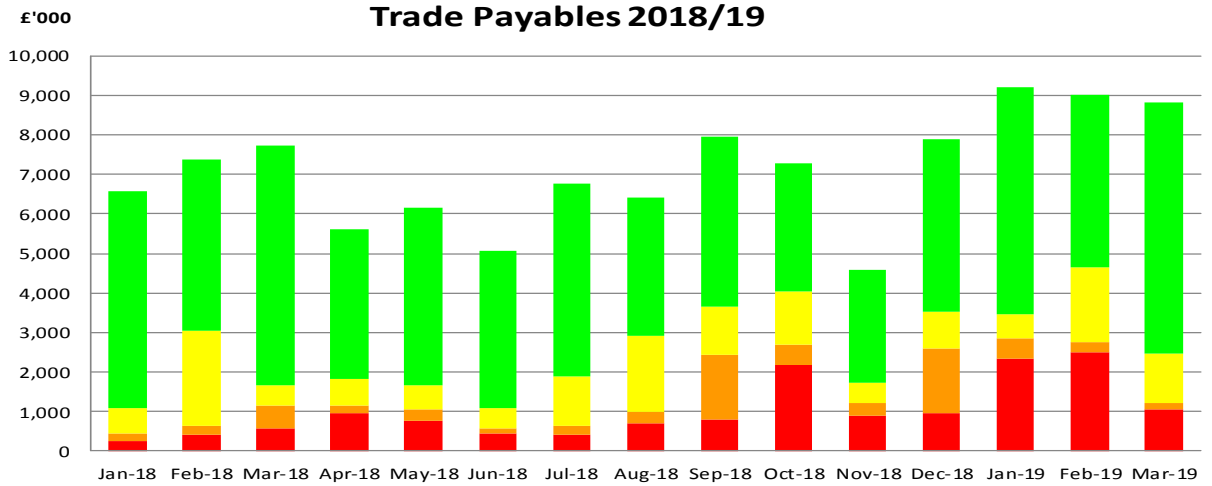
Cash Management



	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	2,670	2,711
>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	1,387
>60 <90 Days	337	941	196	313	1,141	942	858	330	605	314	572	367	3,290	3,947	429
>90 < 180 Days	361	128	246	297	272	617	1,256	1,763	1,858	1,341	655	467	509	753	564
>180 Days	161	188	110	94	88	93	119	187	325	1,164	187	328	435	461	273

Key Message

Trade Receivables reduced by £6.5m in March with NHSPS settling £5.1m of overdue debt. At the end of March NHSPS owed £0.6m, £0.5m of which was settled in early April. Our higher value outstanding balances include £0.3m with Royal Berkshire, £0.3m with NHS England, £0.4m with Reading Borough Council, all of which are being actively pursued.



	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	6,353
>30 <60 Days	627	2,396	520	659	585	536	1,247	1,940	1,230	1,350	509	931	601	1,903	1,242
>60 <90 Days	204	252	559	193	306	124	238	288	1,617	509	314	1,617	532	248	177
>90 days	257	400	582	964	763	436	415	701	808	2,185	897	965	2,325	2,512	1,047

Key Message

As a result of receiving settlement for NHSPS receivables, the payment of £3.1m owed to NHSPS was released in the month, which contributed to the reduction in Trade Payables in month by £2.2m. There remains £1.0m of payments outstanding >90day at the YE. £0.4m of this related to NHS debt, being £0.2m NHSPS and £0.2m queried charges with Frimely Health. The remainder is due to Non NHS organisations including OAPS invoices, Priory and Cygnet, some IT related spend, and Archiving review fees.

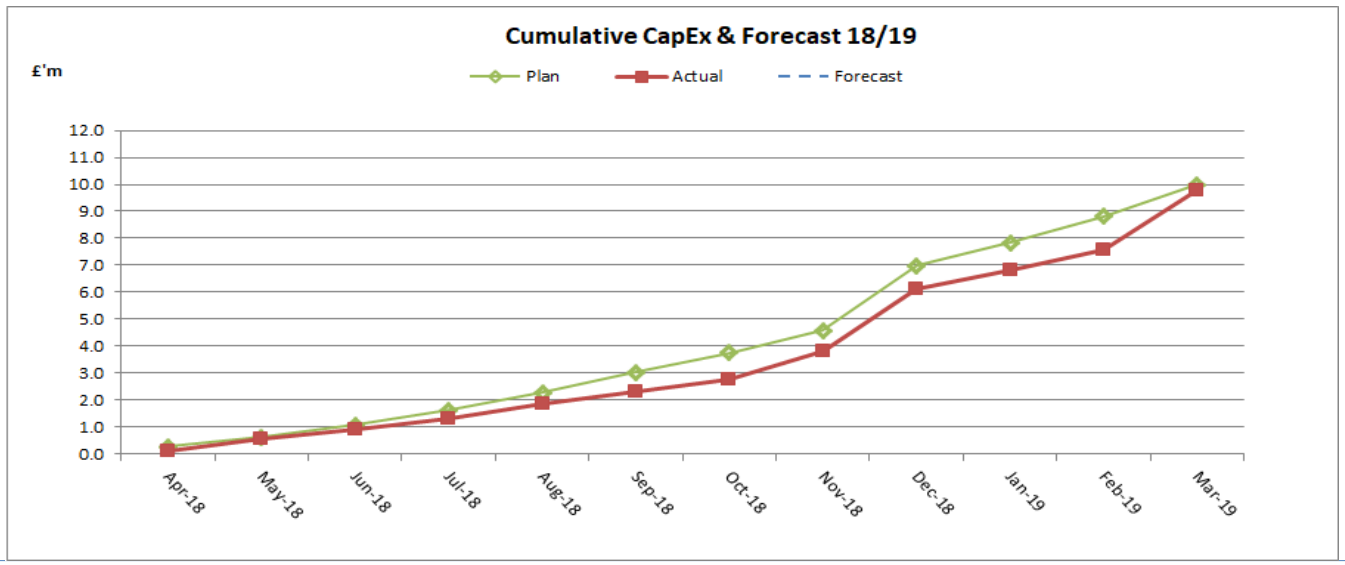
6.0 Capital Programme

Schemes	Current Month Actual £'000	Current Month Plan £'000	Current Month Variance £'000	Year to Date Actual £'000	Year to Date Plan £'000	Year to Date Variance £'000	FY Plan £'000
Estates Maintenance & Replacement Expenditure							
Trust Owned Properties	310	13	297	632	755	(123)	755
Leased Non Commercial (NHSPS)	107	25	82	664	735	(71)	735
Leased Commercial	13	0	13	28	0	28	0
Statutory Compliance	117	65	52	398	448	(50)	448
Locality Consolidations	2	300	(298)	62	1,600	(1,538)	1,600
PFI	205	430	(225)	922	1,380	(458)	1,380
Subtotal Estates Maintenance & Replacement	**753**	**833**	**(80)**	**2,705**	**4,918**	**(2,213)**	**4,918**
IM&T Expenditure							
IM&T Refresh & Replacement	791	219	572	3,928	3,187	741	3,187
IM&T RiO Licences	0	0	0	57	0	57	0
IM&T Business Intelligence and Reporting	44	5	39	119	130	(11)	130
IM&T System & Network Developments	0	0	0	(3)	0	(3)	0
IM&T Other	2	2	(0)	45	95	(50)	95
IM&T Locality Schemes	158	0	158	658	200	458	200
HSLI Community Mobile Working	213	0	213	267	0	267	0
Subtotal IM&T Expenditure	**1,208**	**226**	**982**	**5,071**	**3,612**	**1,459**	**3,612**
GDE Expenditure							
GDE Trust Funded	304	132	172	1,952	2,320	(368)	2,320
Subtotal GDE Expenditure	**304**	**132**	**172**	**1,952**	**2,320**	**(368)**	**2,320**
Other Locality Schemes	57	0	57	143	150	(7)	150
Subtotal Capital Expenditure	**2,322**	**1,191**	**1,131**	**9,871**	**11,000**	**(1,129)**	**11,000**
Assumed Slippage within NHSI Plan	0	(1,000)	1,000		(1,000)	1,000	(1,000)
Subtotal Capital Expenditure vs NHSI Plan	**2,322**	**191**	**2,131**	**9,871**	**10,000**	**(129)**	**10,000**
Donated Assets							
Renal Unit at WBCH	22	22	0	1,086	1,086	0	1,086
Subtotal Donated Assets	**22**	**22**	**0**	**1,086**	**1,086**	**0**	**1,086**
Total Capital Expenditure	**2,344**	**213**	**2,131**	**10,956**	**11,085**	**(129)**	**11,085**

Key Message

Expenditure for YE 18/19 March was £9.9m, against a plan of £10m. Spend in March was £1.1m higher than planned and included the finalisation of a number of schemes across both Estates and IT.

The Trusts owned land and buildings were revalued at the end of March 2019 resulting in net valuation increase of £1m. The Renal Unit donated asset was also revalued at the end of March 2019, resulting in a £0.4m impairment charge to revenue. Due to the nature of the impairment, it does not count towards Control Total.



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th May 2019
Title	**Summary Board Performance Report M12 2018/19**
Purpose	To provide the Board with a performance summary dashboard, including narrative and KPI exception highlights.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
SUMMARY	The enclosed summary performance report provides information against the Trust's performance dashboard for March 2019. **Month 12** **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 **(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 (Excluding Home Leave) **(Service Efficiency & Effectiveness)** • **SE-06b -** Mental Health: Acute Occupancy rate by Locality (Excluding 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 **(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

M12: 2018/19 March 2019

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 perio 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; M12: March 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
- Mental Health Services Data Set (MHSDS) – Data Quality Maturity Index (DQMI)
- A&E maximum waiting time of 4 hours, Referral to Treatment (RTT) Incomplete Pathways, IAPT 6 Weeks and 18 weeks, reduction in OAPS against agreed trajectory
- Failure against published thresholds for Infection Control rates for Clostridium Difficile, E-Coli, MSSA and MRSA.

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

Subjective

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

Exception report

Summary of Red Exceptions M12: 2018/19			
Indicator	**Indicator No**	**Comments**	**Section**
Mental Health Physical Patient to Patient Assaults	US 02a	Reduced from 49 to 45	User Safety
Self-Harm incidents	US 05	Decreased from 193 to 156	User Safety
Prone Restraint Usage	US 19	Remained at 3	User Safety
Staff Turnover	PM 01	Increased from 17.2% to 17.6%	People Management
Sickness rate	PM 03	Increased from 4.42% to 4.59%	People Management
Mental Health Acute Average Length of Stay	SE 03	Increased from 39 days to 41 days	Service Efficiency
Mental Health Acute Snapshot Length of Stay	SE 03a	Increased from 47 days to 49 days	Service Efficiency
Mental Health Acute Occupancy Rate by Locality and Ward	SE 06 a & b	Reduced from 99% to 93%	Service Efficiency
Mental Health Non-Acute Occupancy Rate	SE 07	Reduced from 93% to 87%	Service Efficiency
New Birth Visits within 14 days	SE 08	Increased from 91% to 94%	Service Efficiency
Mental Health Clustering	SE 10	Increased from 78% to 78.7%	Service Efficiency

User Safety Commentary

There were 4 serious incidents in March 2019, including two suspected suicides; 1 each for Bracknell Care Pathways and 1 for Early Intervention in Psychosis, 1 attempted murder by an Early Intervention in Psychosis (EIP)/Crisis Team East client and 1 alleged sexual assault.

The number of assaults on staff decreased to 60 in the rolling quarter to March 2019 and is amber rated. In the rolling quarter, mental health inpatients reported 57 incidents (same as last month), 12 incidents were reported on Sorrel ward (14 last month), 5 on Daisy ward (7 last month), 7 incidents on Bluebell ward (4 last month), 9 on Snowdrop ward (6 last month), 12 on Rowan ward (15 last month), 10 incidents were reported on Rose ward (8 last month). In addition, 1 incident occurred in the place of safety and 1 in Hospital grounds. In the rolling quarter, 1 incident was reported at Willow House (CAMHS) (8 last month). 2 incidents have been reported by mental health west. At the time of reporting, all incidents in March 2019 were rated as low or minor risk.

For Learning Disabilities there was an increase in the number of assaults on staff from 39 in the rolling quarter to February 2019 to 41 in the rolling quarter to February 2019. This shows a decreasing trend.

Patient to Patient Assaults have reduced to 45 in the rolling quarter to March 2019 and remains red rated against a local target. 1 incident occurred in Willow House in the rolling quarter. 41 incidents occurred in mental health inpatients in the rolling quarter and these were as follows; 7 incidents took place on Sorrel ward (4 last month), 4 on Rowan ward (5 last month), 2 on Daisy ward (4 last month), 18 on Rose ward (20 last month), 2 on Bluebell ward (1 last month), 2 on Snowdrop ward (1 last month), 1 incident was reported in place of safety, 1 in a corridor, and 1 in an unknown location. In the rolling quarter, in the community 1 incident each was reported by the Crisis team, and Mental Health Liaison service and Common Point of Entry. All incidents in March 2019 were rated as low or minor risk. At the time of reporting a total of 21 clients carried out assaults on other patients including 1 client who carried out 15 assaults. This shows an increasing trend.

Learning Disability Patient to Patient Assaults increased to 6 (previously 3) in the rolling quarter to March 2019 and is rated as green against a local target. The incidents were rated as low or minor risk and the assaults were carried out by 3 clients. This shows a decreasing trend.

Slips Trips and falls - Orchid ward (8 falls), Ascot ward (4 falls), and Henry Tudor ward (5 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 decreased to 156 in the rolling quarter to March 2019 and remains rated as red against a local target. In Willow House there were 67 incidents (52 last month) reported in the rolling quarter and 2 incidents reported by Community CAMHS services in the rolling quarter. There were a total of 47 incidents reported in the rolling quarter to March 2019 by mental health inpatients; which is reduced from 97 in the rolling quarter to February 2019. Of these, 5 incidents were reported on Rose ward (same as last month), 8 on Bluebell ward (9 last month), 7 on Daisy ward (11 last month), 21 on Sorrel ward (60 last month) and 2 on Snowdrop ward (5 last month).

There were also incidents reported as follows; 1 at Prospect Park Hospital (no specific location) and 3 at unknown location. In the community in the rolling quarter 36 incidents were reported by mental health west; 28 Crisis team, 4 for Talking Therapies, 1 each for South Central Veterans service, psychological medicines, Common Point of Entry, and West Berkshire Older Persons Service. For Mental Health East, 3 incidents were reported by Care Pathways and 1 by IMPACTT. All incidents in March 2019 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 5 in the rolling quarter to March 2019. This shows a decreasing trend.

Mental Health AWOLs and Absconsions covers only those clients detained on a Mental Health Act Section and is measured against a local target. AWOLS (24 to 18) and Absconsions (33 to 19) decreased in the rolling quarter to March 2019. In March 2019, there were no absconsions reported. In March 2019 there were 3 AWOLs; 1 from Daisy ward and 2 from Rose ward.

PMVA (Control and Restraint of Mental Health patients) – at the time of reporting, there were 39 uses of PMVA in March 2019. There were 17 uses on Sorrel ward, 7 uses on Bluebell ward, 6 on Rose ward, 2 each on Daisy ward and Place of Safety, and 1 each at Snowdrop ward, Orchid ward, Rowan ward, Willow House, and Slough CMHT.

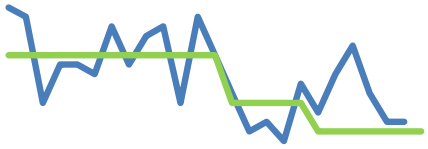
There were 3 uses of prone restraint in March 2019, 1 each on Sorrel ward, Daisy ward and Rose ward. The trend for use of prone restraint is downwards when measured over a 3-year period. A programme of work is in place to reduce the use of prone restraint on the wards by 90% by the end of 2018/19. Target is less than 2 per month.

There were 8 uses of Strategy for Crisis Intervention and Prevention (SCIP) in March 2019 for two patients including 1 client for whom there were 5 uses.

Seclusion uses in March 2019 in Mental Health Inpatients reported 8 incidents, the longest incident was 36 hours and 55 minutes. There were no uses of seclusion in Learning Disability Services.

User Safety Exception Report Month 12: 2018/19

KPI	Target	Mar-19	Trend	Context/Reasons	Commentary of Trend
Mental Health Physical Patient to Patient Assaults	<40	45		Physical patient to patient assaults were carried out by 21 patients in the rolling quarter. One of which carried out 15 assaults. This is measured against a local target.	In 2017/18 NHS Mental Health Benchmarking exercise, the Trust was below the mean for physical violence to patients at 311 incidents per 100,000 occupied bed days excluding home leave.

Self-harm incidents	**<75**	**156**		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 Willow House (CAMHS) inpatients.	Self-harm is a quality improvement breakthrough objective for Mental Health Inpatients including Willow House (CAMHS).
Uses of Prone Restraint	**<2**	**3**		The Trust target reduced to 2 from September 2018. In March 2019 there were 3 uses of Prone Restraint; 1 each on Sorrel ward, Daisy ward and Rose ward.	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 home leave.

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; 3 are red (Staff turnover, Sickness rates for March 2019), 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 February was 4.59%. However, there was a decrease in the cost of absences in February which was £412,841.

• There has been a slight increase in the short-term sickness rate in February to 1.28% from 1.22% in January 2019. This is attributed to an increase in the short-term absences due to chest and respiratory problems.

• There has been an increase in the long-term sickness rate to 2.25% in February (from 2.18% in January). This is attributed to an increase in the long-term absence due to musculoskeletal illness which increased in February to 0.48%, from 0.43% in January. The total sickness rate for this reason also increased in February to 0.75%, from 0.68% in January. Further analysis of the data shows that there has been an increase in the number of new episodes of musculoskeletal absences in the last two months; the number of new episodes in February was 57, although this compares favourably with an average over the previous six months of 68 new episodes per month. Management information from occupational health shows that there were a total of 28 musculoskeletal related referrals in February, and therefore the HR Managers will be working with their divisions to increase the number of referrals for musculoskeletal absences and the timeliness of referrals.

• The total sickness rate attributed to anxiety/stress/depression increased in February to 1.25% (from 1.18% in January) and there has been an associated proportional increase with absences for this reason accounting for 27.1% of all absences in February (from 26.3% in January). However, the long-term sickness rate for this reason has decreased to 0.82% in February, from 0.92% in January. A Health & Wellbeing Lead is currently being recruited and the role will focus on implementing the health & wellbeing action plan, which includes a focus on stress and mental health at work.

• In April, a ‘flexible working statement’ will be launched which will set out our approach to flexible working and include FAQs to support managers with implementing flexible working within their teams. This is in response to feedback via the staff survey and Big Conversations which indicate that increased flexible working patterns will assist with retention and people feeling valued. It is anticipated that this initiative will impact positively on sickness absence and retention and with the equality of opportunity for flexible working arrangements across the Trust.

Recruitment

• The #greatplacetowork recruitment campaign has now resulted in 268 leads across all advertising channels and two job offers have been made as a direct result of the campaign. The success of the campaign is being analysed and will be reported next month.

• An open day took place at West Berkshire Community Hospital on 6th April, which had been advertised via social media and a leaflet drop in the Newbury area. 232 pre-registered for the event and a total of 90 attended. There was social media activity on the day to promote the event and publicity on BBC radio Berkshire. One individual was offered a community staff nurse post on the day.

• An open day is being arranged at Prospect Park Hospital on 18th May which will focus on attracting qualified staff, and a second student 'meet and greet' event is planned for 12th April. To coincide with the open day in May, social media content has been developed to raise awareness of Prospect Park, including interviews with staff focusing on their three favourite things about working there.

Turnover

• The Trust-wide turnover rate in March has increased to 17.6%, from 17.2% in February.

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

  o an induction booklet, which has been developed for all new starters to provide a more standardised induction programme and experience for new joiners, has been finalised and will be issued shortly.

  o A process has been developed to track review meetings taking place under the probation policy, to ensure that these meetings take place consistently and in a timely way and that consequently, staff have the right support during their probation period. The aim is to reduce the number of staff leaving in the first 6-12 months of employment.

Statutory and Mandatory Training

Information Governance (IG) training compliance reached 95.32% by 20th March 2019 to meet requirements for the IG Toolkit, however compliance reduced to 94.3% by end of March. Staff can still access the quick and easy form to complete to update their compliance and this will remain in the short-term, however this does have an impact on resources both for the IG team and Training which is being addressed. Further work is being undertaken to look at improving compliancy rates across the

Trust which will also cover IG compliancy.

Clinical Risk - more courses are being urgently made available and staff who are not compliant are being sent a reminder and being asked to book onto one of the new course dates (their manager is also being copied in). There is a meeting planned early May to review and if necessary update the content and plan the requirements of courses for the next 12 months to ensure enough places are being offered. A gap analysis will be undertaken to identify any areas where more resources are required and will be escalated as required.

Manual Handling compliance rate for medium risk has increased from last month in both Mental Health East and West services. The rate for inpatient services (mental health) has increased from 44% to 57% and the HR manager and Ergonomics lead are working closely with the ward managers to ensure staff are booking onto courses and also running bespoke courses as required for both medium and high risk.

Personal Safety training - additional courses have been added to support PSTS and PMVA training however, due to staff turnover, there a limited number of qualified trainers (both full-time in the personal safety team and part-time tutors who are released 2 days a month to support the training) able to deliver these courses. An internal 3-week course to train another cohort of trainers is planned in July to train both the 2 new full-time members of the team and 8-10 ward staff who can then be released to train 2 days a month. Once there is a larger cohort of trainers available the intention will be to deliver more courses to increase compliancy rates.

An A3 workshop is currently being planned in April, to include all relevant stakeholders, to improve compliancy levels across all statutory and mandatory training.

Appraisals target for May 2018 was achieved.

People Exception Report Month 12 - 2018/19

KPI	Target	Mar-19	Trend	Context/Reasons	Commentary of Trend
Staff Turnover % year to date	**<15.2%**	**17.6%**		Increase in turnover target from September 2016. This remains a challenging stretch target for the Trust. Turnover rates 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 there at the start of the period that do not leave the specified group (e.g. organisation, staff group or the NHS in England) during the period in question. The Trust score of 81.62% is lower than an England average of 88.38%. Locally Oxford Health scored 78.85%, Surrey and Borders Partnership 77.02%, and Southern Health at 80.22%. The next report is due in July 2019.

Sickness percent	**<3.5%**	**4.59%**		Both short-term sickness has increased to 1.28%, and the long-term sickness has increased to 2.25%.	The most recently published NHS Staff Sickness Absence rates published on 25th April 2019 show that for the period for December 2018 the sickness rate for England was 4.44%, and 4.08% for Thames Valley.

Other Key Performance Highlights for this Section

- Sickness has worsened from 4.42% in January 2019 to 4.59% in February 2019.
- Staff Turnover has worsened from 17.2 % in February 2019 to 17.6% in March 2019.
- Gross vacancies have improved from 7.0 % in February 2019 to 6.8% in March 2019.
- Statutory Training: Fire Training has improved from 88% in February 2019 to 89% in March 2019.
- Mandatory Training: Information Governance training has improved from 92 % in February 2019 to 94.3% in March 2019.

NHS Improvement Non-Financial and Financial Commentary

The Single Oversight Framework for 2018/19 which is rated as green.

DM01 – 6-week compliance for Audiology Diagnostics was 100% March 2019.

The Trust was given an overall score for the Data Quality Maturity Index (DQMI) of 99.9% from the Mental Health data set, against a target of 95% according to the most recent data published in February 2019.

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

• whether support is required (if OAPs are substantially higher than predicted by the trajectory)
• whether quality and safety are being maintained (if OAPs are substantially lower than predicted by the trajectory, e.g. sudden reductions in OAPs can result in unintended consequences such as increased pressure on EDs). In the period until September, discussions will be triggered if substantial increases or decreases in OAPs are noted from one month to another. We are committed to supporting providers to eliminate inappropriate OAPs by 2021 whilst ensuring safe care."

For Quarter 4 2018/2019 the Trust combined figure is 523 bed days against at a total target of 620 bed days; the CCG quarter to date data is below overall but above target for the East:

- Berkshire West CCG - 167 inappropriate OAP bed days against a Quarter 4 2018 target of 316 bed days.
- East Berkshire CCG - 356 inappropriate OAP bed days against a Quarter 4 2018 target of 304 bed days.

• Proportion of people completing treatment who move to recovery (from IAPT minimum dataset). For March 2019 the Trust achieved 57.54% 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 March 2019 there was 1 case of Methicillin-sensitive Staphylococcus aureus (MSSA) on Jubilee ward and 1 case of E coli bacteraemia on Henry Tudor ward.

The Single Oversight Framework will continue to include an annual rating on the Cardio Metabolic CQUIN. For 2018/19 submission is 22nd April 2019, and CCG review is due to take place on 23rd May 2019. The Trust rates for Q4 2017/18 show that we are above targets shown below:

- Inpatients – 97.86% compliance against 90% target
- Community – 100% compliance against 65% target
- Early Intervention in Psychosis (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 Service Length of Stay, Mental Health Readmissions, Community Health Service Occupancy rate and Crisis plans. None are rated as “Amber”. 7 are rated “Red”, Mental Health Average and Snapshot Length of Stay, Mental Health Acute occupancy by ward and by locality, Non-Acute Occupancy, Clustering and New Birth Visits, 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 4.80% in February 2019 to 4.85% in March 2019 but remains green. East Mental Health (8.01%) and West Mental Health (6.91%) and Children, Young People and Families (CYPF) (7.60%) are above target. This indicator shows a decreasing trend.

In Common Point of Entry (CPE), the DNA rate reduced from 8.67% in February 2019 to 8.66% in March 2019.

In Children and Families; Community Paediatrics at 9.80%, Health Visiting 9.40%, School Nursing 8.70%, CAMHS 8.50%, were above the 5% target.

For Mental Health East; IMPACTT at 13.12%, East Adult CMHTs at 10.14% are above target. In West Mental Health, Clinical Health Psychology 12.73%, Adult Mental Health 8.69%, Trauma 8.84%, Neuropsychology 14.14% are above target. The portal, an interactive voice message and SMS text messaging service can be used for reminders for appointments which take place in clinics provided that a mobile number is collected and entered into RiO in the correct format. In March 2019, 22,704 messages were sent.

Community Health Services Inpatient Average Length of Stay reduced to 21 days with all areas below target. Delayed transfers of care, there have been some worsening of performance with Slough at 16.7% (6.3% last month) and Reading 16.6% (last month 14.6%), WAM 3.7% (2.6% last month) and West Berkshire 12.4% (last month 8.7%). There was an improvement in Wokingham 3.7% (last month 16.2%). A total of 48 patients’ discharges were delayed in March 2019, 18 of these are the responsibility of the NHS, and 13 are the responsibility of social care and 17 are joint health and social care responsibility. The most common reason for a delay was awaiting care package in own home (total 34; 11 for health, 9 for social care, and 15 joint responsibility health and social care). 7 are awaiting care home placement (3 are social care responsibility and 2 are NHS responsibility and 2 are joint health and social care responsibility).

Mental Health Acute Occupancy excluding home leave decreased to 93% in March 2019.

Average Acute Length of Stay for Mental Health (41 days) increased and the snapshot length of stay reduced (49 days). Of the 198 clients discharged during January 2019 to March 2019, the median length of stay was 25 days. 27 clients who were discharged in the period had lengths of stay above 90 days, including 24 above 100 days and 1 at 256 days. There are a number of clients who have accommodation needs for which funding must be obtained and placements sought before they can be discharged from the ward. As at 10th April 2019 including potential delays, there were a total of 5 acute clients; 3 on Snowdrop ward and 2 on Bluebell ward. By locality, there are 2 for Windsor and Maidenhead and 1 each for Reading, Slough and West Berkshire.

There is 1 Wokingham client delayed on Campion Unit, who is detained under the Mental Health Act who was discharged on 12th March 2019, however the new provider returned the client to the ward on 14th March 2019 as there were challenges with the placement and now remains a delay.

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 Slough and Bracknell remain above target.

Older Adults Mental Health wards length of stay is 88 days for Rowan ward and 78 days for Orchid ward for clients discharged.
As at 10th April 2019, there were 8 adult acute placements out of are including 1 PICU placement.

Community Health Services Inpatient Occupancy reduced to 83% and remains rated as green.

Mental Health readmission rates reduced to 7.5% in March 2019 which is below the 9% target, with only Bracknell above target.

Mental Health clustering has increased to 78.7% compliance but remains below the 95% target. The revised figure excludes some historical clustering data.

Place of Safety (POS) has increased to 62 uses in March 2019 and includes 3 uses for minors. Of these 62 uses of the place of safety, 22 were admitted following assessment including 20 detained under Section 2 of the Mental Health Act. 18 clients waited over 8 hours for an assessment, but 2 had no waiting time recorded, however 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. 15 out of the 62 assessments were carried out by Berkshire Healthcare NHS Foundation Trust Section 12 Doctors. The most common time in March 2019 to be brought to the place of safety was between 12 noon and 3 pm followed by 9 pm to midnight. The most common days for detention in March 2019, were Friday with 14 detentions followed by Sunday with 10 detentions.

Health Visiting is below target at 94% however this compares favourably from the most recently published national data which shows that in Quarter 2 2018/19 only 89.6% of New Birth Visits took place within 14 days. Of the 28 cases not seen within 14 days 53% (15) were due to baby being in hospital, 21% (6) family declined appointment and 11% (3) each no access visit or late notification.

System Resilience – Frimley Health NHS Foundation Trust achieved 83.3% for Type 1 A&E attendances in March 2019.

In the West, the A&E waiting times national return for March 2019 shows the Royal Berkshire Hospital achieved 88.5% Tier 1 A&E attendances and 99.6% against Tier 1-3 attendances. Nationally only 79.5% 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 86.6% for all Tier 1-3 attendances during March 2019. The Trust's Minor Injury Unit (MIU) achieved 99.72% for discharged, admitted transferred within 4 hours of arrival.

The system wide report showed, Reading Rapid Access had limited capacity on 10th April 2019. In terms of inpatients on 10th April 2019, there were a total of 18 community beds available at our community hospitals in Berkshire West area including 9 on Ascot ward. There were 17 patients waiting for admission to the community wards, including 4 waiting for admission to Oakwood ward, 10 waiting for admission to West Berkshire Community Hospital wards, and 3 waiting for Wokingham Community Hospital wards.

Service Efficiency And Effectiveness Exception Report Month 12: 2018/19

KPI	Target	Mar-19	Trend	Context/Reasons	Commentary of Trend
Mental Health: Acute Average Length of Stay	**<30 Days**	**41**		Bed optimisation project underway to look at alternatives to admission, productive stay and productive discharge. Median length of stay was 25 days. One client discharged after 256 days (excluding home leave).	Delayed transfers of care 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**	**49**		Performance reflects the acuity of clients and number of delayed transfers of care and impact on long stayers.	

Mental Health Acute Occupancy rate (excluding Home leave by Ward / Locality) (Note - 2 indicators)	**< 90%**	**93%**		All localities are above target except Bracknell and Slough. New bed management process including gatekeeping of clients introduced. There was an increase in the number of clients brought in on Section 135 or 136 (62) to Place of Safety, 22 of these clients which were subsequently admitted to hospital and of these 20 were detained under Section 2 of the Mental Health Act.	Increase in the number of patients admitted whilst detained under the Mental Health Act. For 2018/19 there was a 43% increase in the number of admissions of detained patients in comparison to 2017/18. This is the fourth year in a row that there has been an increase in the number of detained patients.

Mental Health: Non-Acute Occupancy rate (excluding Home Leave)	**< 80%**	**87%**		Reduction previous month. In March Sorrel ward had 96% occupancy, Orchid ward 87% and Rowan ward 82%.	
Health Visiting: New Birth Visits Within 14 days	**95%**	**94.3%**		Of the 28 cases not seen within 14 days 53% (15) were due to baby being in hospital, 21% (6) family declined appointment and 11% (3) each no access visit or late notification.	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.

KPI	Target	Mar-19	Trend	Context/Reasons	Commentary of Trend
Mental Health Clustering within target	**95%**	**79%**		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 as a priority. Clustering Lead is attending the Locality Managers Business Meeting to ensure that focus is maintained. The process is shifting to business as usual in June 2019.

Other Key Performance Highlights for this Section

- Community Health Services Inpatient Average Length of Stay has improved from 22 days in February 2019 to 21 days in March 2019.
- Mental Health readmission rates have improved from 7.9 % in February 2019 to 7.5% in March 2019.
- Mental Health Crisis Plans for clients on CPA have improved from 96% in February 2019 to 97% in March 2019.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	2019/20 Strategy Implementation Plan
Purpose	This paper provides the Board with an overview of the development and content of the 2019/20 Strategy Implementation Plan
Business Area	Corporate
Author	Director of Projects.
Relevant Strategic Objectives	Supports the delivery of all of our True North goals
CQC Registration/Patient Care Impacts	The plan includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience
Resource Impacts	Budget and resource implications are the responsibility of the governing body of each strategic project
Legal Implications	None
Equality and Diversity Implications	The plan includes delivery of our Equality and Inclusion Strategy. Equality and Diversity implications of each initiative are the responsibility of its governing body.
SUMMARY	The attached paper provides the Trust Board with an overview of the development and content of the Strategy Implementation Plan for 2019/20. It also sets out the outcomes of initiatives in the 2018/19 plan, as a basis for the development of this year's plan. Significant progress has been made towards the achievement of Berkshire Healthcare's strategic aims during 2018/19. Our strategy implementation plans for 2019/20 demonstrate our commitment to our Vision "To be recognised as the leading community and mental health service provider by our staff, patients and partners". They are a comprehensive and stretching set of initiatives which focus on

	providing services which are safe, highly regarded by people who access them, and achieve good or outstanding CQC ratings. The plan reflects our investment in service quality and innovation through our Quality Improvement programme, our workforce strategy, estates strategy and information technology roadmap. We are also full partners in our wider health and social care systems, supporting integration, improving efficiency, and developing new ways of working together. The Strategy Implementation Plan will be used to monitor our progress to meet our True North goals during 2019/20 through monthly reports to the Business and Strategy Executive and quarterly progress reports to the Board.
ACTION REQUIRED	The Board is asked to review and note the attached paper and summary Plan.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

APPROVAL OF STRATEGY IMPLEMENTATION PLAN 2019/20

Author: Neil Murton, Director of Projects

Director: Bev Searle, Director of Corporate Affairs

Date: 24 April 2019

Purpose

This document has been prepared to update the Trust Board on the development of the Strategy Implementation Plan 2019/20. This plan summarises the major strategic initiatives planned for the year and beyond to deliver the Trust's vision and True North Goals.

Members of the Trust Board are asked to note the plan.

Document Control

Version	Date	Authors	Comments
1	03/05/18	Neil Murton	For Trust Board

This document is considered to be Commercial in Confidence and is therefore not to be disclosed outside of the Trust without the prior consent of the Author or a Director of the Trust.

Distribution:

All Trust Board members

Document References

Document Title	Date	Published By

CONTENTS

INTRODUCTION

1. The Strategy Implementation Plan captures the key activities required over the financial year and beyond to ensure successful implementation of the Trust's strategy. Progress against the 2018/19 Plan was reviewed every two months at Business and Strategy Executive meetings during the year. Progress reports were presented to the Board in September, November and February.

2. This paper presents the summary Strategy Implementation Plan for review and approval by the Trust Board, highlighting those initiatives that have concluded during 2018/19 or are now 'business as usual' and therefore will not feature in the 2019/20 Strategy Implementation Plan, those initiatives that will continue from 2018/19 into 2019/20, and those initiatives that are new for 2019/20.

3. The detailed Strategy Implementation Plan, showing activity gateways and target dates, and setting out delivery structures, is used by the senior leadership team to monitor delivery. This detailed plan is available to the Board on request.

2018/19 PLAN

4. 2018/19 has been another challenging year in the NHS with resource constraints, particularly in the recruitment and retention of staff, and the implementation of initiatives for long term sustainability set out in the Five Year Forward View. For Berkshire Healthcare this has meant a focus on initiatives to maintain or improve service quality and efficiency, organisational development to support our staff, and working with our system partners to establish effective structures and programmes within our Sustainability and Transformation Partnerships and Integrated Care System (ICS) areas.

5. The Trust achieved a Use of Resource Rating of "1" overall. The organisation delivered a year end surplus of £1.5m, £1.5m ahead of plan. After incorporating £2.9m of Provider Sustainability Funding and donations and deducting £0.4m impairment charge, the reported surplus is £4.5m, £2.1m better than planned. The pressures in 2019/20 will be the risks of higher than planned Out of Area placement usage and the continuing need to reduce temporary staffing. In 2018/19, the Trust under-delivered on its Out of Area Placements savings target by £1.1m and overspent its annual pay budget by £0.6m.

6. The Quality Improvement Programme, designed to empower and equip staff to solve problems locally, and ensure the whole organisation is aligned on the delivery of our core strategy, described within our "True North" goals). The tools and approaches are increasingly used to good effect throughout the organisation, including within projects.

7. As part of introducing the Quality Improvement methodology, a number of breakthrough objectives were established around reduction of falls, self harm and assaults on staff. These are all work in progress and there is focus on those areas with high incidence, for which bespoke targets have been established. The increased focus on these areas has led to increased reporting, providing better

visibility of the situation, but masking true performance against targets. Targets have been reset for 2019/20 and three new targets added, relating to reductions in pressure ulcers, medication errors and gram negative bacteraemia. The breakthrough objectives are monitored by the Finance, Performance & Risk Committee.

8. Regarding the seven services inspected during last year's well-led CQC inspection, there were no "must do" actions and "should do" actions are progressing and being monitoring through the Quality Executive (QEG). Where "must do" actions were identified for WestCall, these are also monitored through the QEG, along with a mock inspection to test that progress is being made as identified in our action plan, which will inform any further work required.

9. Within our Workforce Strategy, we have focussed on attracting and retaining staff in a challenging labour market and developing robust workforce plans. Through our Equality and Inclusion Strategy we have invested in initiatives to support equality in opportunity for our staff, particularly those from Black Asian and Minority Ethnic backgrounds, and to promote fairness in the way we support staff and deliver our services.

10. Our Global Digital Exemplar Programme with its 19 associated projects has attracted significant additional investment to improve our clinical and staff support systems and continues into 2019/20.

11. We have continued to optimise our use of estates, particularly in Reading where we have brought together dispersed services and offices into a hub on the University of Reading campus and will extend this in 2019/20 with a further phase which will release area at Prospect Park and also enable the vacating of 25 Erleigh Road.

12. We have continued our focus on mental health services with the delivery of our Mental Health Strategy, including our Zero Suicide initiative and our programme to eliminate overspill from our acute facilities, improve bed management and optimise rehabilitation and recovery in long term placements.

13. The NHS Long Term Plan will have profound implications for the organisation, although at present, clarity is awaited regarding how some of the elements will be progressed. The establishment of Primary Care Networks is a developing picture and one that presents both potential opportunities and risks. Following their authorisation, much will depend on the stance of the new Networks and in particular their openness to partnership arrangements. In light of the need for this clarity, there is not as yet, any element of the Strategy Implementation Plan that directly seeks to influence the development of the new arrangements, but there is recognition that this will soon be required.

2019/20 PLAN DEVELOPMENT

14. Development of the 2019/20 plan has been informed by our strategy deployment process, which was introduced as part of our Quality Improvement (QI) programme. Initiatives in our 2019/20 plan are expressed within the framework of our four True North Goals. Trust projects and programmes

are assessed using a strategic filter, designed to prioritise against these goals, and inform the effective deployment of our resources.

15. The Strategy Implementation Plan sets out development initiatives pertinent to the delivery of our strategy. Through the deployment process these are classified as either Mission Critical or Important and in addition to their respective governance arrangements, the executive will regularly review these, informed by a Summary Projects Report at the monthly Business and Strategy Executive meetings.

16. The plan was developed in collaboration with senior managers and project leads and has been compared with the major projects featuring in the Programme Management Office and with our strategic risk register. The plan has been reviewed and approved by the executive team.

17. Progress related to the delivery of the 2019/20 Strategy Implementation Plan will be reviewed monthly at Business and Strategy Executive meetings through a joint report with Projects, and reported to the Trust Board quarterly during the course of the financial year through summary reports.

2018/19 INITIATIVES NOT INCLUDED IN THE 2019/20 STRATEGY IMPLEMENTATION PLAN

18. The following initiatives/programmes in the 2018/19 plan have not been included in the 2019/20 plan, due to their completion or changes made in scope. The initiatives are shown in the framework of our True North Goals.

True North Goal 3: To provide good outcomes from treatment and care

- A new seclusion suite and staff office were completed on Sorrel Ward at Prospect Park Hospital.
- It was decided to describe our continued ambition for improvement at Prospect Park Hospital to focus on ensuring the hospital is meeting key standards and working towards a CQC rating of "Outstanding". This replaces the "Centre of Excellence" title previously given to this work.
- The Children, Young People & Families (CYPF) services for Slough and Windsor, Ascot & Maidenhead, moved to one site - Upton Hospital – with a spoke at St Mark's Hospital.
- Our *Learning Disability Service Development* continued during 2018/19. The work of the Intensive Support Team is now well embedded into everyday practice for the Learning Disability services and the team were inaugural winners of the Trust's Excellence in Clinical Practice Staff Award. Also, the Campion Unit team achieved an "Outstanding" rating from the CQC inspection (the plan includes the scheme to transfer the facilities from Campion to a refurbished Jasmine Ward at Prospect Park Hospital). The Trust will continue to participate in the system-wise Transforming Care Partnership programme Board.

- The commissioner-lead Integrated Neurology Pathway (Frimley) was concluded, with community neurology staff transferring to Frimley Health under TUPE arrangements. The initiative established a local neurology pathway to reduce the flow of patients to London.

True North Goal 4: To deliver services that are efficient and financially sustainable

- The arrangements established by the Agency & Bank Project for temporary staffing and to control related expenditure are now embedded as business as usual.

- The *New Renal/Cancer Care Unit* at West Berkshire Community Hospital was completed in 2018/19, with services delivered by the Royal Berkshire Hospital NHS Foundation Trust, and the Sue Ryder charity.

INITIATIVES THAT WILL CONTINUE FROM 2017/18 INTO 2018/19

19. The following initiatives/programmes will roll forward to 2019/20.

True North Goal 1: To provide safe services, prevent self-harm and harm to others

- The *Quality Improvement Programme* will continue in 2019/20, including the continuing roll out of our Quality Management improvement System (QMIS). Progress is reflected in a reclassification of the programme from Mission Critical in 2018/19 to Important, although full embedding of the QI processes, tools and methodologies to become business as usual will not be fully achieved until June 2022. The plan includes on-going training provision to increase the number of staff qualified in either Yellow or Green Belt skills and able to undertaken improvement projects. The plan includes the breakthrough objectives for Harm Free Care including targets for reduction of falls and self-harm, with new targets relating to reduction in medication errors, pressure ulcers an in gram negative bacteraemia due to lapse in care. Development of Quality Improvement Business Intelligence (QIBI) had featured as a placeholder in 2018/19 and is to be piloted.

- The *Zero Suicide* programme will continue for this year. Nationally there is a focus on crisis response and inpatients. The project will continue in the provision of training and will build on its work to improve safety planning and documentation (the CQC inspection provided positive feedback on the risk summary incorporating a service user safety plan). Following the successful conference held in December 2018, there will be a conference in 2019/20 which will focus on staff working in mental health inpatient areas.

- The *Development of Integrated Hubs* is a major programme in the Frimley Health and Care Integrated Care System (ICS), focusing on the development of an integrated care model within communities for residents with moderate to severe care needs, improving health outcomes for people with long term conditions or frailty. Our community health services in East Berkshire form a significant element of this programme. During 2018/19 there was a refresh and re-launch

of multi-disciplinary cluster meetings with primary care and in this financial year, there will be a focus on local access points for each local area.

True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment

- Our *Workforce Strategy* continues into 2019/20. This year has seen progression with the talent management agenda and preparation to roll out the process to the operational leadership team. We have laid the foundations to ensure we can recruit more staff and we have plans for retaining new starters. The new social media officer has had a significant impact and we are the temporary Health and Wellbeing business partner has started work which we can progress over the next three years. Resourcing and recruitment plans are in place and we have built a new data hub and People Hub. The team now have recruitment material and access to social media to inform potential applicants of the posts we have available and early signs are positive. In January 2019 to March 2019 we saw a 26% increase in applications to the Trust.

- *Delivering Our Equality and Inclusion Strategy 2016-20* programme - we have continued with activity to improve equality, diversity and inclusion. The Trust will run a third cohort for 'Making it Right' starting in May. This year the Purple network (supporting staff with a disability, those who line manage a disabled colleague and those staff who have caring responsibilities outside of work) has grown in size and has delivered a number of events but significantly the Disability Symposium. The Symposium had 100 attendees who contributed to the development of a plan of activity for the year ahead. The Trust continues to work on actions to improve how it feels to be a BAME member of staff. We have continued with the Making it right course and the third cohort will commence in May. We have also developed a Making it Right course for managers so they are aware of the data, the action plans and their contribution to helping resolve some of the issues we have. We have also developed an Allies training day to encourage more staff to improve their awareness of protected characteristics and what they can do to support patients and colleagues. The LGBT+ network have three new co-chairs supporting our work to build this network and take forward this agenda. We know there is much to do following the national staff survey and Stonewall feedback about how our workforce feels. But the data and work over recent years indicates there are signs of improvements, better awareness and a growth in numbers in the workforce. Our Stonewall rating fell in 2018/19, but the Trust still performed well (13th out of 54 in our sector, plus it should be highlighted that there are more organisations participating). Acting on the feedback received (including regarding procurement arrangements) there is confident that the Trust will be better placed in 2019/20.

- The introduction of *Quality Management Improvement System* (QMIS) forms a key part of the Quality Improvement Programme (see above) and the plan shows the continuation of QMIS training (up to Wave 9) and Divisional QMIS training (up to Wave 5). Training of all teams and managers is planned to be achieved by June 2022.

- The *New Intranet* featured as a placeholder in the 2018/19 plan and was established later in the year. The withdrawal in July 2019 of support by Microsoft to the current intranet poses high risks to the Trust's information systems and alternative arrangements must be in place in that timescale. This need also brings the opportunity for significantly enhanced functionality. A basic intranet will be launched in July (with limited/high priority information) and then subsequently developed to achieve a final intranet solution with all information and new functionality by April 2020.

True North Goal 3: To provide good outcomes from treatment and care.

- Our *Mental Health Pathways Project* is moving to business as usual and will be concluded by the end of Quarter 1. The pathways have been published and practice is supported by RiO care pathways. The Pathways Team also undertook a successful Recovery Transition initiative, transferring patients out of the service for more appropriate support via primary care. The number of people within mental health clusters 1 – 3 reduced by 70%, along with reductions in the numbers within clusters 4 and 11.

- Our *Emotionally Unstable Personality Disorder (EUPD) Pathway* carries over from 2018/19, following work led by the Quality Improvement Team (as a QI improvement Project) to confirm the future service model. With locality teams now trained in structure clinical management, along with recruitment for psychologically Informed Consultation and Training (PICT) the focus has turned to scoping other elements of the pathway, which in its complete form will go live in the final quarter of 2019/20

- The Friends & Family Test for this year features under *Improving Patient Experience*. Last year, the Trust received al level of feedback at 22%, which is over the threshold deemed to be valid (15%). The improvement was assisted by SMS texting. Overall satisfaction was 93%. For the hospitals, this was 70% satisfaction for mental health and 96% for physical. We will continue the *Development of the University of Reading as a primary Trust site* with improved facilities and environments for staff and patients. Now to be called Erlegh House, the plan reflects the delay in Royal Berkshire FT services moving to the site (Phase 2), a slightly later timescale for Phase 3 and also the need to explore options for the vacated 3/5 Craven Road following McCarthy & Stone's unsuccessful planning appeal (and their formal withdrawal).

- The *Prospect Park Development Programme* includes the transfer of our Learning Disability assessment and treatment facilities from the current Campion Unit to Jasmine Ward at Prospect Park Hospital (to be completed mid-2020) and continuation of the project to achieve the transfer of our CAMHS Tier 4 inpatient facilities at Willow House, Wokingham Hospital, to Prospect Park (currently estimated to be achieved in Spring 2021). The facility will utilise the Campion and Hazelwood buildings and consequently this scheme is dependent on the move of the Campion Unit to Jasmine Ward and the transfer of the Older People Mental Health services in Hazelwood to the Whiteknights site.

- The commissioner-led *Berkshire West Integrated Adult MSK/Physiotherapy Service initiative* will continue in 2019/20. Last year, the clinical pathway was defined and agreement from key parties secured. In 2019/20, the risk position for partners will be addressed along with the arrangements for savings, prior to procurement being conducted for the elements of the new service, including triage and tier 2 in the community.

- The *Information Technology Roadmap* programme will continue in 2019/20, including the completion of Windows 10 deployment/migration as part of the *IT Architecture Strategy*. Our *Global Digital Exemplar* programme will also continue. It comprises 19 projects structured around four objectives: Direct Patient Access and Communication, Digital Wards and Services; Digital Workforce; and Research and Quality Improvement. This a major programme for the Trust with significant investment, which will deliver benefits for patient outcomes and experience, enhance staff working experience, and improve our operating efficiency.

True North Goal 4: To deliver services that are efficient and financially sustainable.

- Our *Cost Improvement Plans* (CIPs) initiative features within *Maintaining our NHS Improvement Use of Resource Rating of 1* on the Plan, together with meeting our 2018/19 Control Total. In 2018/19, the Trust delivered £2.9m of savings against a full year plan of £4.8m. The CIP target for 2019/20 is £4m. For 2018/19, our Use of Resource Rating was "1" overall. The Finance, Performance & Risk Executive and the Trust Business Group receive detailed reports on financial management on a monthly basis, with the strategy implementation plan providing an overview.

- Under *Optimising the use of mental health inpatient services* there is a major programme – Eliminating overspill; Optimising Rehabilitation & Recovery – to deliver the national requirement to reduce the number of Berkshire residents receiving mental health care as out of area placements, reducing spending on those placements and to improve rehabilitation and recovery services. Although the savings on placements were less than planned (under-delivering by £1.1m), the programme has been successful in establishing control mechanisms, avoiding costs and in moving patients on to more appropriate care environments. The contractual arrangements with our key local providers have been successfully negotiated and funding for a number of patients has been transferred to CCGs and local authorities. In light of the progress made, the initiative has been re-scoped, with the arrangements for the regular review of patients in long term placements moving fully to business as usual in Quarter 1 and the programme focusing on internal processes, including the Prospect Park care offer(s) and length of stay.

- We will continue to explore options for our *Trust Headquarters* during the year, with our current building part of the Bracknell town centre redevelopment/regeneration programme. At present, the leases on Fitzwilliam House continue to 2022 and the Trust is unlikely to be able to continue at the premises beyond that time.

INITIATIVES NEW TO THE 2018/19 STRATEGY IMPLEMENTATION PLAN

20. The following initiatives/programmes have been introduced to the 2018/19 Strategy Implementation Plan.

True North Goal 1: To provide safe services, prevent self-harm and harm to others.

- Two workforce projects were established at the end of 2018/19 which are new to the plan. Both are supported by funding from Health Education England and their scope includes addressing staffing challenges in the face of a national shortage of qualified nursing staff: *Community & Primary Care Network Workforce* and *Community Mental Health Teams Function & Workforce.* The remit of the latter includes clarifying the key functions and skill set of the Community Mental Health Teams in the absence of a nationally agreed model.

- An initiative is being established for Transforming Urgent Care Pathways. At this stage it has been included in the plan as a placeholder, with details to be added once the scheme has been scoped and planned.

True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment,

- A new project has been agreed to support the development of a Wellbeing Culture across the Trust. The Health, Wellbeing and Engagement post will focus on improving attendance in the workplace and reducing turnover. The main focus will be on analysing the data and instigating Trust wide activity to make changes. The data review will include detailed analysis of the sickness data, national staff survey results and exit surveys. The post will support the development of line managers to build their confidence and capability to deal with people management issues with the aim of making this a great place to work for all

True North Goal 3: To provide good outcomes from treatment and care.

- Developments at Prospect Park Hospital include moves to facilitate a new *Approved Place of Safety* (APOS) facility in the current therapy area – specifically, moving the Crisis Response Home Treatment Team to Prospect House and moving therapy facilities into the vacated area. The new APOS will be built in 2021/22.

- Following contract award in early 2019, the *Sexual Health Services Transformation (Berkshire East)* project will be revising the service model for this provision in accordance with commissioner requirements. The service must move to one which is primarily nurse delivered and with enhanced digital provision for service users. The revised service commences in July 2019.

- *Digital – Population Health Management*. This is a priority that features in the narrative plans for Berkshire West and Frimley Health & Care ICSs and Berkshire West, Oxfordshire and Buckinghamshire Sustainability & Transformation Partnership.

- *Community Health Services tender North-East Hampshire & Farnham/Surrey Health* CCGs – at this stage, the involvement of the Trust is yet to be confirmed.

- *Pain pathway transformation programme* (Frimley ICS led). The plan will be developed once plans have been agreed and there is clarity regarding the Trust's role.

- *Developing a Berkshire Healthcare Community Health Strategy* has been included as a placeholder in the plan. Proposals for this are to be presented to the Executive in May 2019.

True North Goal 4: To deliver services that are efficient and financially sustainable.

- There are no new initiatives in this section of the plan, however there are a number of programmes brought forward from the 2019/19 plan which are continuing or have further significant developments in 2019/20.

CONCLUSION

Significant progress has been made towards the achievement of Berkshire Healthcare's strategic aims during 2017/18. Our strategy implementation plans for 2018/19 demonstrate our commitment to our Vision "To be recognised as the leading community and mental health service provider by our staff, patients and partners" and delivering our four True North goals and metrics. They are a comprehensive and stretching set of initiatives which focus on providing services which are safe, highly regarded by people who access them, and achieve good or outstanding CQC ratings. The plan also reflects our investment in service quality and innovation through our Quality Improvement programme, our workforce strategy, estates strategy and information technology roadmap. We are also full partners in our wider health and social care systems, supporting integration, improving efficiency, and developing new ways of working together.

ACTION

Members of the Trust Board are asked to note the summary 2019/20 Strategy Implementation Plan.

2019/20 Strategy Implementation Plan Summary

INITIATIVE	Class	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
True North Goal 1: To provide safe services, prevent self-harm and harm to others.													
QUALITY IMPROVEMENT (QI) PROGRAMME													
Strategy Deployment	IMP												
Improvement Projects (training programme delivery)	IMP												
Quality Improvement Business Intelligence (QIBI)	IMP												
Comments :													
HARM FREE CARE													
Reduction of falls	IMP												
Reduction of self-harm	IMP												
Reduction in medical errors													
Reduction in pressure ulcers													
Reduction in Gram Negative Bacteraemia													
Comments : This is on-going work, with focus on areas of high incidence, for which there are bespoke targets. New targets yet to be rated.													
COMMUNITY MENTAL HEALTH TEAMS FUNCTION AND WORKFORCE	IMP												
Comments :													
COMMUNITY AND PRIMARY CARE NETWORK WORKFORCE	IMP												
Comments :													
REDUCING CHILD AND ADOLESCENT MENTAL HEALTH SERVICES WAITING TIMES	MC												
Comments : Scoping and planning of the project has taken longer than expected due to the complexity of factors impacting on the CAMHS waiting times. Project plan now in place and rating should improve.													
TRANSFORMING URGENT CARE PATHWAYS													
Berkshire West	TBC												
Berkshire East	TBC												
Comments: To commence during 2019/20.													
ZERO SUICIDE	IMP												
Comments:													
FRIMLEY INTEGRATED CARE SYSTEM: DEVELOPMENT OF INTEGRATED HUBS	IMP												
Comments : Amber rating is the overall rating from the most recent ICS Programme Report.													
True North Goal 2: To strengthen our highly skilled and engaged workforce and provide a safe working environment.													
WORKFORCE STRATEGY													
Grow our own workforce	MC												
Develop and promote our employer brand													
Align our workforce and service models													
Plan and meet demand sustainably													
Know our numbers													
Build our strategic workforce planning capability													
Breakthrough Objective: Reduction of harm to staff	IMP												
Comments: Regarding the one Red rating - one outcome of focusing on these issues has been for reporting to increase sharply. In light of this, targets have been revised for 2019/2020.													
QUALITY MANAGEMENT IMPROVEMENT SYSTEM (QMIS) - programme delivery	MC												
Comments :													
NEW INTRANET	MC												
Comments : Amber status is a reflection of the challenging timescale (new platform operational by 09/07/2019) and associated risks.													
DELIVERING OUR EQUALITY AND INCLUSION STRATEGY 2016-20													
Mandatory/Statutory requirements													
Other priorities													
Developing our 2020-25 Equality and Inclusion Strategy													
Comments :													
True North Goal 3: To provide good outcomes from treatment and care.													
MENTAL HEALTH PATHWAYS	IMP												
Comments : This initiative will have moved to business as usual by the end of Quarter 1.													
EMOTIONALLY UNSTABLE PERSONALITY DISORDER (EUPD) PATHWAY (QI PROJECT)	MC												
Comments : The initiative is rated at Amber, in recognition of the size and complexity of the implementation.													
IMPROVING PATIENT EXPERIENCE - PATIENT SATISFACTION													
Staff recommending the Trust and responding to feedback													
Transformation of sexual health services in East Berkshire	MC												
Comments :													
DEVELOPMENT OF UNIVERSITY OF READING AS A PRIMARY TRUST SITE													
Phase 2 Erlegh House - Royal Berkshire Hospital NHS Foundation Trust services relocation													
Phase 3 Erlegh House (final phase) - relocation of services to Erlegh House	IMP												
Future of Craven Road	IMP												
Future of Erleigh Road	IMP												
Comments: Reported as Amber in April but there is now more certainty regarding the progression of Phase 2. Overall programme is one month later than originally planned. Original disposal plan for 3/5 Craven Road has had to be abandoned.													

INITIATIVE	Class	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
PROSPECT PARK HOSPITAL (PPH) DEVELOPMENT PROGRAMME													
Move of Learning Disability Assessment & Treatment Unit from Campion Unit to Jasmine Ward	MC												
Children and Adolescent Mental Health Tier 4 inpatient service (Willow House) transfer from Wokingham Community Hospital to PPH	IMP												
Approved Place of Safety													
Comments: Later timescale for delivery of the move of the learning disability facilities from Campion to Jasmine has impacted on the plans for the transfer of Willow House (now estimated to be in Spring 2021).													
HEALTH AND SOCIAL CARE SYSTEMS INITIATIVES (not covered elsewhere)													
Berkshire West Integrated Care System (ICS) - Adult MSK/Physio services													
Berkshire West ICS Digital Programme													
Frimley Health & Care ICS Community Health Services tender													
Frimley Health & Care ICS Pain pathway transformation programme													
Developing a Berkshire Healthcare Community Health Services Strategy													
System Population Health Management programme													
Sustainaibility and Transformation Partnership (STP) Formal Review of Estates													
West Berkshire, Oxfordshire and Buckinghamshire (BOB) and Frimley Health & Care STP Connected Care programme	IMP												
Berkshire Wellbeing Project	MC												
Comments : Greater clarity is required regarding the role of the Trust in some of these system initiatives (e.g. the Community Health Services tender)													
INFORMATION TECHNOLOGY ROADMAP													
Global Digital Exemplar (GDE) - Direct patient access and communication	MC												
GDE - Digital Wards and services													
GDE - Digital workforce													
GDE - Research and quality improvement													
GDE - Payment milestones													
Information Technology Architecture Strategy	MC												
Comments:													
True North Goal 4: To deliver services that are efficient and financially sustainable.													
MAINTAINING OUR NHS IMPROVEMENT USE OF RESOURCE RATING OF 1													
Achieving our Control Total													
Delivering our Cost Improvement Plan													
Comments:													
OPTIONS FOR TRUST HEADQUARTERS													
Comments:													
OPTIMISING THE USE OF MENTAL HEALTH INPATIENT SERVICES													
Eliminating overspill; optimising rehabilitation and recovery	MC												
Comments : Programme being re-scoped following Quarter 1. Amber rating is a reflection of continuing levels of out of area placements.													

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

RAG Key:	
P	Action will not be delivered
R	Significantly at risk and major action is required
A	An element of the project is at risk and action is required
G	Progressing in accordance with planned timescales, resource commitment and quality requirements
	Project yet to commence

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th May 2019
Title	Mental Health Strategy Progress Update
Purpose	To provide a progress report on the implementation of the Board's strategy as at the end of April 2019.
Business Area	Corporate
Author	Director of Corporate Affairs
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	Our mental health strategy supports delivery of safe, good quality care and a good experience of care for patients.
Resource Impacts	Achievement of the key priorities within our mental health strategy will provide financial benefits and mitigation of financial risk.
Legal Implications	None
Equality and Diversity Implications	Our Mental Health Strategy aims to address inequalities experienced by people with mental health problems through the achievement of Five Year Forward View for Mental Health Targets. This includes physical health inequalities resulting in lower life expectancy. Inclusion and equality of opportunity for our mental health workforce is addressed within our overall Workforce Strategy, and we will reflect relevant aspects of this in our Mental Health Workforce Plan submissions to Health Education England/NHS England.
SUMMARY	The attached paper provides a report on progress against the key priorities within the strategy approved by the Trust Board in December 2016. The paper provides an overview of: Developments in national policy/local operating context since November 2018 when the last progress update was provided; How we have taken forward key initiatives and strategic intentions;

	Progress against key targets. Good progress has been achieved in meeting targets within the Five Year Forward View for Mental Health – and most targets have either been achieved, or are on course for delivery by 2021. The key areas of challenge remain delivery of the target for zero out of area placements for people needing acute inpatient care, and the achievement of access targets for children and young people. Areas of priority focus are currently: Continued focus on our **Quality Improvement** approach to empower front line staff to work on improvements in priority areas identified within our Plan on a Page and at local level. Development of **Primary Care Networks** which include an effective response to the mental health needs of our population – across the range of need from mild-moderate difficulties through to serious mental illness. Delivery of our **Global Digital Exemplar Programme** – and maximising the use of technology to improve safety and help us manage demand and capacity. Further exploration of measurement of **patient experience and outcomes** across our mental health services. Continuing to refine and implement our **Workforce Plan** for mental health –this includes focus on both inpatient and community services with the establishment of our CMHT Function and Workforce initiative. **Progressing mental health initiatives within our ICSs**. This will include work with partners to reduce out of area placements, achievement of FYFV MH targets and ensuring mental health is effectively represented in all work streams. The completion of five year system plans during the summer will require a significant focus on mental health. Working with commissioners to ensure that the **Mental Health Investment Standard** is met, and that Mental Health Investment Strategies reflect funding provided to commissioners to achieve FYFV MH targets: the investment standard is being met currently, but progress on reducing OAPs will enable investment in local, prevention-focussed initiatives. **Forward planning for the refresh of our Three Year Strategy in April 2020,** informed by the NHS

	Long Term Plan and implementation guidance. Ensuring that we are able to recruit and retain staff with required skills and capabilities continues to present a significant risk, and regular workforce strategy update will continue to be provided to the Trust Board.
ACTION	The Board is asked to note the progress made against the strategy priorities.

Berkshire Healthcare NHS
NHS Foundation Trust

Mental Health Strategy 2016 – 21

Progress Update

May 2019

Berkshire Healthcare NHS Foundation Trust

Mental Health Strategy Summary 2016 - 2021

Berkshire Healthcare NHS
NHS Foundation Trust

Effective and compassionate help

- Evidence-based pathways
- Safe, effective services achieving outcomes which are meaningful to service users
- Inpatient services represent a "centre of excellence"
- Suicide Prevention.

Supporting our staff

- Recruiting and retaining skilled, compassionate staff
- Developing new roles
- Enabling creativity, innovation and effective delivery
- Building strong clinical and managerial leadership, a quality improvement and research culture.

Working with service users and carers

- Guiding development of our services
- Supporting self management.

Safer, improved services with better outcomes, supported by technology

Good experience of treatment and care

- Personalised care supporting recovery and quality of life
- Meeting both physical and mental health needs.

Straightforward access to services

- Meeting national targets
- Effective and integrated urgent care
- Expanding online and telehealth services
- Tackling discrimination and stigma.

Working with partners and communities

- Partnerships with primary care, social care and voluntary sector organisations
- Integrating mental health within locality services, and system sustainability and transformation plans
- Supporting prevention, early intervention and peer support.

Our Mental Health Strategy – progress since December 2016

Berkshire Healthcare NHS
NHS Foundation Trust

The Trust Board approved our mental health strategy in December 2016, ensuring it was aligned with our vision, values and key strategic objectives. The priority areas of focus were confirmed as:

Safer, improved services

with better outcomes, supported by technology

Progress updates were provided to the Trust Board in May and November 2017, July and November 2018, and this paper provides an overview of changes since then:

- Developments in national policy/local operating context since November 2018
- Our progress in taking forward our key initiatives, strategic intentions and achieving national targets
- Planned next steps

Developments in national policy since November 2018

Publication of the NHS Long Term Plan – specific references to mental health by chapter as follows:
New service model includes development of out of hospital care through a new urgent care offer, Primary Care Networks, support to people in care homes and supporting people to age well – all of which are relevant to mental health and the design of mental health services.
More action on prevention and health inequalities - highlighting the higher risk of poor health experienced by people with severe mental illness.
Further progress on care quality and outcomes – including children and young peoples mental health services as well as adult mental health services.
NHS Staff will get the backing they need – including reference to increasing recruitment and retention in medical staff and development of new roles
Digitally enabled care will go mainstream across the NHS – includes the mental health GDE programme, digitally enabled therapy in IAPT services, and children's mental health services. Development of Population Health Management will be underpinned by development in capture/use of mental health data.
Taxpayers investment will be used to maximum effect – references efficiency improvement in mental health services – including use of "Getting it Right First Time" (GIRFT) which has been applied to physical health specialities to date.

The national **Mental Health Delivery Plan 2019/20** published by NHSE/I in April 2019, sets out the performance targets linked to existing commitments in the Five Year Forward View for Mental Health (FYFV MH), and these will form part of the five year system plans system plans (of which 19/20 is year one) required in summer 2019. Our Berkshire West, Frimley and BOB system plans for 2019/20 all have mental health sections which reference FYFV targets and our priority initiatives. Mental Health Delivery Plans continue to be submitted to NHS England through our Sustainability and Transformation Partnerships . In addition, we have provided Mental Health Workforce Plans via Health Education England, as well as confirmation that the Mental Health Investment Standard is being met locally.
An **Independent Review of the Mental Health Act** was published in December 2018, and followed by the CQC publication **Monitoring the Mental Health Act in 2017/18** published in February 2019.

Progress in Berkshire-wide mental health initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Our **Quality Improvement initiative** has continued to progress well, with the training of additional mental health services, managers and corporate services. Our performance management reporting system has been aligned to reflect our priorities and approach with effect from May 2019, and use of visual management is well established at Executive and Prospect Park Hospital meetings.
Mental Health continues to have a higher profile in the work of **A&E Delivery Boards** in both halves of the county, and with Frimley Integrated Care System (ICS) we are now part of a test of appropriate standards for urgent and emergency mental health (14 sites have been selected nationally for this work). Support of partners continues to be needed to achieve our aspiration to reduce average length of stay .
Progress of our prioritised mental health projects is outlined on pages 8 – 10. Key headlines are:

- Our **bed optimisation programme** has been successful in reducing out of area placements from last year's levels . However, this work remains very challenging in terms of meeting targets for 2019/20.
- Our **Early Implementer IAPT Programme** to increase access and develop services for people with long term physical health problems continues to show reduced GP and A&E attendances.
- We are working in partnership with CCGs on the establishment of our **CPE/Wellbeing** Service to enable effective support and signposting for people with mental health issues who do not need to access secondary mental health services.
- The **Connected Care** Programme continues to progress well and work is developing on Population Health Management across the county – which will incorporate mental health alongside physical health.
- In terms of longer term care, we have supported a successful bid for funds to develop **Individual Placement Support** services across the Berkshire West, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Partnership (STP), supporting people with serious mental health problems to access employment opportunities.
- Our **Zero Suicide Plan** was submitted to NHSE and commissioners via our STPs in March 2019 and is progressing in line with key milestones.
- We have established a **Community Mental Health Team (CMHT) Function and Workforce** initiative in recognition of the workforce challenges being faced by these teams, which provide the foundation of much of our work in secondary mental health services.

Actions following external review/monitoring

Following the 2018 routine **Care Quality Commission** inspection, no "must do" actions were identified, and good progress is being made against the "should do" actions, which is reported on a quarterly basis to the Quality Executive Group (QEG).

The annual **Community Mental Health Survey** was reported to QEG in January 2019 with an increase in response rate (up to 33% from 29% last year and a national rate of 28 %) but limited overall change in levels of satisfaction (11 sections of 21 were comparable to last year, an improvement was shown in 4 sections and a decline in 6 sections).
Improvement themes identified as important for our service users were:
• Minimising the impact of patients experiencing a change in their healthcare worker:
• Being seen often enough by services to meet their needs
• Support and wellbeing in relation to work, access of benefits and physical healthcare
Work is in progress to address all 3 of these themes, and is outlined in relevant sections of this progress update.
A Berkshire wide "**mental health summit**" was held in December 2018 to address the need for alignment in expectations regarding key initiatives – in particular, IAPT, our Common Point of Entry and Out of Area Placements. This was successful in achieving required clarity which informed both investment plans and key milestones and will be followed up through regular meetings of commissioner and provider leads throughout 2019.
As part of our work to align strategic planning across commissioner and provider functions, in line with the collaborative approach required of Integrated Care Systems, our **Mental Health Development Group** now includes commissioner members. The key function of this group is to identify and address interdependencies between our major initiatives, avoiding duplication of effort and enabling clarity about objectives.
We have agreed a **CQUIN** with commissioners for 2019/20 to focus on achievement of 72 hr follow up post hospital discharge (from the current 7 day target). We have already been prioritising at risk people for 48 hr follow up in line with NICE guidance, and performance as at April 2019 is 84%.

Mental Health Strategy and system working

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire East

The Frimley Health and Care ICS Mental Health Programme initially prioritised 3 key areas of work:

- **Significantly reduce Out of Area Placements (OAPs) by 2020.** Targets for 2018/19 were achieved by the ICS, but remain very challenging to deliver in 2019/20.
- **Ensure there are easily accessible urgent, emergency and liaison Mental Health Services.** Liaison services are now in place across the ICS, and this priority initiative will now focus on the overall pathway
- **Ensure access to perinatal mental health care.** This has now been achieved across the ICS footprint and therefore this priority has been replaced by **improving access to Children and Young People's Mental Health Services**

The ICS Mental Health steering group is also accountable for oversight of delivery of FYFV MH targets as well as to ensure that mental health is embedded within all ICS priority initiatives. The most challenging targets to deliver continue to be the OAPs and children and young people's access to services, but the majority of the remainder have been delivered or are on course for delivery.

Effective working relationships have been established with colleagues in Surrey and Borders Partnership Trust and local commissioners, and our staff have made a strong contribution to the work of the programme.

Work is now in progress to review progress against Key Performance Indicators included in the national Mental Health Delivery Plan published in April 2019.

Funding to enhance mental health workforce planning in the system has been secured from the Local Workforce Action Board, and although work has been delayed due to recruitment difficulties, this will provide the necessary resource to support this key task.

Berkshire West

The Berkshire West Mental Health Delivery Group is the key forum for oversight of FYFV MH targets and implementation of local strategy within the ICS and in partnership with Local Authorities. Permanent appointments to mental health commissioner roles have now commenced, which will facilitate greater progress in 2019/20.
Berkshire West has also prioritised the reduction of **out of area placements**, and although good progress has been made in achieving the required trajectory, this work continues to present a significant challenge.

Funding secured from Health Education England has supported the recruitment of a **Mental Health Workforce Project Lead**, focussing on our Community Mental Health Teams, undertaking a similar approach to that successfully used in our inpatient services. This will also be informed by our **Mental Health Pathways** project, facilitating the delivery of a standard offer, along with monitoring of activity and outcomes.

A Mental Health Steering Group is now well established as part of the B**uckinghamshire, Oxfordshire and Berkshire West (BOB) STP.** This group is chaired by the CEO of Oxford Health NHS Foundation Trust, with the role of Senior Responsible Officer being provided by the Director of Corporate Affairs from Berkshire Healthcare. Good progress has been made in developing greater clarity about work required at the different population levels identified by NHSE (i.e. Neighbourhood, Place and System), both in terms of mental health specific and wider BOB strategy. Good progress has been made with the New Models of Care for forensic tier four CAMHS and Eating Disorder Services, which has seen the establishment of provider networks taking responsibility for provision of care closer to home and effective management of resources across the whole care pathway.

A successful **winter planning event**, focussed on mental health, took place at BOB level, supported by the Thames Valley Strategic Clinical Network.

Mental Health Strategy priorities and governance - a reminder

Berkshire Healthcare NHS
NHS Foundation Trust

Key priorities
There is a good alignment between our vision, values, organisational priorities and our mental health strategy priorities:
Safer, Improved services with better outcomes, supported by technology

Our Trust Board Vision metrics that are specifically relevant to our mental health strategy priorities include:

- Patient assaults
- Use of restraint
- Inpatient deaths
- Suicide rate for people under mental health care
- Bed occupancy

Our "True North" metrics relevant to our mental health services that are listed on our 2019/20 Plan on a Page for 2019/20 are:

- Reducing harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia
- At least 95% of our reported incidents will be low or no harm to patients
- All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
- All our support services will work with patient facing services to identify ways that they can support safety of patients
- **With our health and social care partners:** We will work to achieve reduced urgent admissions and delayed transfers of care.

We have used our Strategy Deployment process to help us prioritise key initiatives, which is now starting to incorporate local projects and initiatives. This guides our project resourcing decisions and guards against individual clinical or corporate services being over-burdened at any one time.
The following slide shows the significant initiatives within our mental health strategy, which will be enabled by technology and use of quality improvement methodology. This is followed by an outline of progress regarding each of the key initiatives listed.

Governance
Our **Mental Health Development Group**, accountable to the Business and Strategy Executive continues to oversee implementation of the Mental Health Strategy and enables project leads to understand and address interdependencies between initiatives, and now includes commissioner leads as members. Projects in scope of this group include: Bed Optimisation, EUPD Pathway , CPE Development and Eliminating Overspill; Optimising Rehab and Recovery.

Our IAPT service development continues to be implemented as "business as usual", reporting progress into Trust Business Group and Quality and Finance Executive meetings as required.

The **Zero Suicide** initiative reports to our Quality Executive and is linked to the Berkshire suicide prevention steering group.

Urgent Care developments are managed through our operational management structures and our membership of A&E Delivery Boards. The management of "acute overspill" **out of area placements** is managed through a project board led by the Regional Director for Berkshire East. This also provides oversight of contractual arrangements for the provision of **Longer Term Care**, reported into our Trust Business Group.

A **Global Digital Exemplar Board, chaired by our Chief Executive is well** established and oversee delivery of objectives set out within our bid.

The following slide provides the high level implementation "road map" for the key initiatives included in the strategy approved by the Trust Board.

Mental Health Strategy

Implementation roadmap December 2016

Berkshire Healthcare NHS
NHS Foundation Trust

	2016 - 18	2018 - 19	2019 - 21
PPH Development	Staffing, bed optimisation and centre of excellence projects established and meeting targets	Medium –term actions delivered, pathways and patient/carer engagement well established	Long term actions delivered. Strategy reviewed and future priorities confirmed
Pathways	Implementation of priority pathways – initial focus on people with personality disorder	All evidence based pathways established and tariff implications confirmed with commissioners	Outcomes reviewed and benchmarked to inform further work required
Zero suicide	Completion and implementation of strategy linked to system suicide prevention plan	Medium –term actions delivered	Long term actions delivered. Strategy reviewed and future priorities confirmed
Urgent Care	System reviewed including PMS, PoS, CRHTT and CMHT pathways	Alternatives to admission reviewed and priority actions confirmed and implemented	Long term actions delivered. Strategy reviewed and future priorities confirmed
IAPT	Early implementer programme: increasing access and delivering for priority long term conditions	Plans for future sustainability completed and agreed with commissioners	Services covering wide range of long term conditions and delivering positive outcomes
Longer term care	Priority actions for Out of Area Placement reduction confirmed and implemented	Partnership actions with UAs, Vol. sector & housing providers confirmed and implemented	Long term actions delivered. Strategy reviewed and future priorities confirmed

Technology enabled service delivery: online programmes, skype and SHaRON expansion. Informatics development.

Quality Improvement methodology enabling safer, evidence-based services with better outcomes

Progress on Key Initiatives

Berkshire Healthcare NHS
NHS Foundation Trust

Prospect Park Hospital Development

Bed Optimisation:
This project was established to achieve:

- No Out of Area Placements (OAPs) as a result of acute overspill by 2020
- Acute adult bed occupancy consistently below 90%

Executive approval processes for OAPs remain in place, and additional work has taken place recently to identify priority actions using our QI methodology and engagement of staff. Support is needed from partner providers and commissioners to achieve our objectives and reduction of out of area placements is a key area of focus in both ICS Delivery Plans as described on page 5. This project is now part of the "Eliminating Overspill , Optimising Recovery and Rehabilitation" described on page 9.

Staffing:
The Staffing Project successfully implemented a number of key changes in skill mix, new roles and new approaches to recruitment. Vacancies have been significantly reduced in bands 2,3 and 4, but remain a major challenge in bands 5 and above. Good progress has been made Sorrell Ward which previously experienced the highest numbers of vacancies at this level. Dedicated recruitment resources are in place, and our focus in 2019/20 will be on retention of staff as well as further consideration of actions needed to maintain safe staffing levels.
A specific focus will be on the development of resilience and sustainability of the Mental Health Act Office: in common with other organisations, we have seen a significant rise in the number of compulsory admissions to our inpatient services, and need to ensure that we have the right resources in place to manage processes effectively and compassionately.

Quality Improvement:
Following training in our Quality Management Improvement System, focus on driver metrics – and working on achievement of our True North goals (see page 6), work is now progressing on our ambition to move towards an "outstanding" CQC rating .

IAPT

Our key initiatives are now incorporated into regular operational management and reporting arrangements, and our service continues to exceed access and recovery targets. Although it is not likely that we will be able to maintain waiting time performance in Berkshire West due to resource constraints, the service is working closely with commissioners to minimise impact until further investment can be achieved.
A Common Point of Entry/Wellbeing project is well established to provide an effective response to those people coming through our CPE, who do not need secondary mental health services. Agreement of objectives has been achieved across the county to ee the establishment of an integrated response incorporating IAPT and signposting to community and voluntary sector services.

Zero suicide

This initiative include four key priority areas of focus :

- A reduction in the rate of suicide of people under mental health care
- Increase in positive staff attitude and a proactive approach to suicide prevention
- An optimised RiO system for recording risk
- Families, carers and staff will feel supported and know where they can get support after a suicide

An evaluation report provided for our Quality Executive in Feb 2019 gave assurance that all of the actions in the 2018/19 action plan had been fully implemented. The Trust is on target to achieve the reduction of 10% in the overall suicide rate compared to the 2016 baseline (9.2 deaths per 10,000 people under MH care) by April 2021. Work is currently in progress to combine the work undertaken on suicide and self harm prevention so we can improve our focus in the areas where there is a greater potential for change/results.
A self assessment against NHSE Quality Check pointers was carried out in March 2019, and all areas rated green or amber, indicating that we are on target for achievement. Our suicide prevention plan was submitted via our STPs as required in April 2019.

Progress on Key Initiatives

Pathways and Clustering

This programme was set up to optimise service delivery and to understand and improve outcomes for service users, while also positioning the Trust to meet anticipated development of payment by results in mental health. While the policy focus has shifted to population based funding as part of Integrated Care Systems, this initiative will continue to make a significant contribution to our understanding of how well we are serving local people. Work is currently in progress To complete the final stage of the programme which will support the implementation of the blueprint of the core clinical offer. A transition plan to business as usual has been developed and will be followed through to planned project closure in June 2019. Posters for supercluster pathways circulated to teams. ePathways are being rolled out, enabling reporting on provision of core specification and timelines - will be mandated for new patients from 1st April. Outcome measures (CROM/ReQoL and PROM/HoNOS) and pathway specific measures now in use with reporting arrangements in place.

Emotionally Unstable Personality Disorder (EUPD) Project

The development phase of this initiative was completed in 2018 and implementation is now in progress (Introduction of Structured Clinical Management (**SCM)** & Psychologically Informed Consultation & Training (**PICT**). The recruitment of PICT workers has been completed (including the team leader) and all roles are expected to be taken up over the next 2 months. Stage 2 - the operational design and implementation of the remaining elements of the EUPD care pathway (Assessment, Assertive Stabilisation and Recovery) are now in design phase. The implementation of the EUPD pathway is operationally led, supported by the PMO and the QI office. A project plan is in place and benefits identified. The project was rated as “amber” as at April 2019 due to complexity and risks associated with implementing the EUPD clinical pathway. This is in recognition that the pathway will impact staff and EUPD patients across all of BHFTs mental health services.

Longer term care

The **Eliminating Overspill, Optimising Rehab and Recovery** seeks to address the 5YFV aim of eliminating acute out of area placements as well as development of a range of rehabilitation & recovery options. Great progress has been made over the last 12 months against the initial aims and objectives. The rehab and recovery element has reached a point where this work should be business as usual from the end of Q1 2019/20. The Eliminating Overspill element requires further work which has included delineation of a clear problem statement, key areas of work to target and confirmation of local accountabilities .

Regional work to develop a New Model of Care for people needing **low and medium secure services** has progressed well achieving both quality improvements and financial savings. Year 2 of the pilot will focus on reducing length of stay and Berkshire work will focus on development of step up and step down services.

CMHT Function and Workforce

This initiative was commenced during 2018/19 and aims to have completed the following by March 2020:

- To have defined and implemented a revised service offer which removes unwarranted variation across Berkshire
- To address current challenges in recruitment and retention of CMHT staff, including the completion of a workforce plan

The resulting model will need to be delivered within existing resources. However, project costs are supported by Health Education England funding.

Urgent Care

Work is continuing to optimise the performance of our Common Point of Entry, Crisis Response Home Treatment Services, and our Inpatient Wards.

Following the “tender” model review of our CRHTT undertaken last year, action has been taken to strengthen leadership and staffing.. Although it was not possible to achieve the financial savings targets identified for 2018/19, work has now been undertaken to set appropriate budgets for 2019/20 . Work has continued to ensure that accurate data is used to inform agreed actions. through our A&E Delivery Boards in East and West of Berkshire, including numbers of bed days lost due to delayed transfers of care.

Technology enabled service delivery

Berkshire Healthcare NHS
NHS Foundation Trust

The use of technology to enable the delivery of a new model of care in mental health is at the centre of our ambition as a "Global Digital Exemplar" for mental health, confirmed in April 2017.
Our GDE Programme consists of 19 projects within four GDE initiatives:
- Direct Patient Access & Communication
- Digital Wards & Services
- Digital workforce
- Research & Quality improvement

The programme continues to progress well and is continuing to work at pace towards milestone 3 – which is a particularly demanding part of the programme.
ePMA is live in Outpatients WAM depot clinic. Options for wider roll out to Outpatient clinics have been assessed and supplier delivery of ePMA road map, enabling clear vision of future developments and system optimisation is in progress.
Early Intervention in Psychosis (EIP) Support Hope and Recovery Online Network is now live, along with Online Consultations with our IAPT service.

Work following the above elements includes:
- Further expansion of Digital Appointment Correspondence across CAMHS
- Visual E-observations implementation into Prospect Park Hospital
- Tableau based app of the bed management dashboard will be available for mobile access within the Trust
- Continued deployment of mobile devices to CRHTT, EIP & adult services
- Enhanced self-help and signposting content updated for all MH services on Trust website

Progress in other related programmes

Information Technology Architecture Strategy Implementation Programme
Is planned to run until March 2020 and comprises six elements including Office 365 migration and movement of departmental systems to the Cloud. Good progress has been made with Community of Interest Network capability completed, e-mail migration completed, secure e-mail implemented and Windows 10 implementation on target.

Connected Care shared record programme
The Berkshire Connected Care Portal went live at the end of January 2016, and has been developed to enable access to GP data and acute hospital admissions, discharge & transfer data.
Berkshire Healthcare staff have continued to increase their access into Connected Care to view information which supports delivery of safe, good quality care, improved patient experience, and effective use of resources.
Governance arrangements for the programme have been reviewed to ensure effective links to work in progress in each locality, as well as oversight of the programme by the ICS Population Health & Digital Development Board.
We have continued our use of **online programmes** as part of our **Talking Therapies** service, enabling us to achieve access targets, including our offer across major long term physical health conditions. Our partnership with Silvercloud has enabled us to collaborate on the development of programmes for people with long term physical health problems , which continues to show encouraging results as identified on page 7.

Informatics development remains an important priority – and we are able to access a wide range of tableau dashboards for our mental health services, enabling staff and managers to understand referral, activity and caseload information, at service and team level. We have also aligned ESR and financial information to provide vacancy and other workforce information as part of the "People Dashboard" which is crucial to our workforce planning activity. We are contributing to the development of our Population Health Management capability – which will enable us to use data to better understand the needs of our population, patterns of activity and outcomes to improve patient experience and outcomes, as well as our use of resources.

Measuring our progress and next steps

Berkshire Healthcare NHS
NHS Foundation Trust

Our Mental Health Delivery Plan Submissions identified overall good progress in delivery of FYFVMH targets (please see page 11 for a summary of the key targets from NHS England).
Areas prioritised as requiring further work are:

- Elimination of out of area placements for people requiring acute care by 2021. As described on page 7 this is linked to our bed optimisation work and requires work on internal as well as system solutions.
- Achievement of CAMHS access targets, given continued growth in demand.

Our Trust Board Vision measures and True North metrics described on page 5 provide a clear focus on our priorities as an organisation. These are at the centre of our Quality Improvement work, which will enable improvements identified by our front line staff.

We have robust arrangements for measuring progress against key mental health targets, and reviewing qualitative and quantitative information through our Executive meetings:

- User safety, people, NHS Improvement, service efficiency and effectiveness and contractual metrics monitored at our Finance Executive
- Patient Safety and Experience issues are reported to our Quality Executive
- Progress of key projects is monitored by our Business and Strategy Executive

These groups support the work undertaken by our Trust Board Committees (Quality Assurance, Finance, Investment & Performance and Audit) in their detailed review of performance and key risks to delivery of Trust Board priorities for our mental health services.

Next Steps

In addition to continuing to progress our identified mental health initiatives, the following activities are currently being prioritised for action :

- Continued focus on our **Quality Improvement** approach to empower front line staff to work on improvements in priority areas identified in our Plan on a Page and at local level.
- Development of **Primary Care Networks** which include an effective response to the mental health needs of our population – across the range of need from mild-moderate difficulties through to serious mental illness.
- Delivery of our **Global Digital Exemplar Programme** – and maximising the use of technology to improve safety and help us manage demand and capacity.
- Further exploration of measurement of **patient experience and outcomes** across our mental health services.
- Continuing to refine and implement our **Workforce Plan** for mental health – this includes focus on both inpatient and community services with the establishment of our CMHT Function and Workforce initiative.
- **Progressing mental health initiatives within our ICSs**. This will include work with partners to reduce out of area placements, achievement of FYFV MH targets and ensuring mental health is effectively represented in all work streams. The completion of five year system plans during the summer will require a significant focus on mental health.
- Working with commissioners to ensure that the **Mental Health Investment Standard** is met, and that Mental Health Investment Strategies reflect funding provided to commissioners to achieve FYFV MH targets: the investment standard is being met currently, but progress on reducing OAPs will enable investment in local, prevention-focussed initiatives.
- **Forward planning for the refresh of our Three Year Strategy in April 2020,** informed by the NHS Long Term Plan and implementation guidance.

Five Year Forward View for Mental Health. **By 2020:**

70,000 more children will access evidence based mental health care interventions . Community eating disorder teams in place for children & young people

Intensive home treatment will be available in every part of England as an alternative to hospital

No acute hospital is without all age mental health liaison services with at least 50% meeting the "core 24" standard

At least 30,000 more women each year can access evidence-based specialist perinatal mental health care

10% reduction in suicide and all areas to have multi-agency suicide prevention plans in place by 20 17

Increased access to evidence-based psychological therapies will reach 25% of need, helping 600,000 more people

The number of people with SMI who can access evidence-based Individual Placement Support will have doubled

280,000 people with SMI will have access to evidence based physical health checks and interventions

60% of people experiencing a first episode of psychosis will access NICE concordant care within 2 weeks

Inappropriate out of area placements will have been eliminated for adult acute mental health care

New models of care for tertiary MH will deliver care closer to home, reduced inpatient spend and increased community provision

There will be the right number of CAMHS inpatient beds in the right place, reducing the number of inappropriate out of area placements

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	Draft Annual Report 2018/19 - approval
Purpose	This paper provides the Trust Board with the Draft Annual Report 2018/19 for approval
Business Area	Corporate
Author	Chief Executive Officer/Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	Maintaining compliance with terms of authorisation and meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	Attached is a draft of the Trust's Annual Report 2018/19 for comment and approval. The financial figures contained within the draft Annual Report are subject to verification by the Auditors and details of the Annual Accounts will be included/appended following the Audit Committee meeting on 22 May 2019. Board members will note that a small number of items of information are awaited/require clarification and these will be added as soon as they become available. It is not expected that this will materially affect the content of the report. If any changes of significance arise then these will be discussed with and approval sought from the Trust Chair and Chief Executive and notified to other Trust Board members as appropriate. The report will also be further reviewed for consistency, typographical/grammatical accuracy and style.

ACTION REQUIRED	The Board is invited to: 1. Consider and offer any comments on the draft Annual Report 2018/19; 2. Approve the draft for submission subject to any final necessary additions and amendments and to delegate authority to the Chair and Chief Executive to give Board approval to the final document in light of the timetable for submission to NHS Improvement.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	Board Declarations re NHS Foundation Trust Provider Licence Conditions
Purpose	The Board is asked to agree positive certifications in support of 2019/20 licence condition compliance assurance process outlined by NHS Improvement.
Business Area	Corporate Governance
Author	Director of Finance
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	Contributes to the Well-Led CQC domain.
Resource Impacts	None
Legal Implications	Meeting Regulatory Requirements
SUMMARY	Each year certain declarations are required as part of the FT provider licence self-certification assurance process. For 2019/20, as in previous years, NHSi do not require the attached certifications to be submitted, but do ask that Boards complete certification by the deadlines outlined below. NHSI retain the option of contacting a select number of trusts to ask for evidence that they have self-certified, either by providing the completed or relevant board minutes and papers recording sign-off. There are four declarations. In each case the Board is being invited to positively declare 'Confirmed' against the relevant statements attached, in respect of the following conditions: ➢ ***General Condition 6*** *of the NHS provider license: Systems For Compliance with License Conditions* ➢ *See positive assurance statements proposed*

	➢ *Due 31 May 2019.* ➢ *This statement is required to be published no later than 30 June 2019.* ➢ ***Continuity of Services Condition 7** of the NHS provider license: Availability of resources and accompanying statement for Foundation Trusts designated Commissioner Requested Services (CRS) providers only* ➢ *See positive assurance statements proposed* ➢ *Due 31 May 2019* ➢ ***Corporate Governance Statement** - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)* ➢ *see positive assurance statements proposed and proforma risk mitigation evidence as required* ➢ *Due 30 June 2019* ➢ ***Certification on Training of Governors** - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)* ➢ *see positive assurance statement proposed* ➢ *Due 30 June 2019*
ACTION REQUIRED	The Board is asked to confirm the positive assurance statements attached in relation to the provider licence conditions outlined above, and approve the signing by the Chair and CEO of the certifications.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates | 2019/20 | Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Commissioner contracted services are contracted for the coming year, with sufficient resources available to deliver contracted clinical services.These have been reviewed and confirmed during the 19/20 planning process.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature	**Signature**
Name Martin Earwicker	**Name** Julian Emms
Capacity Chairman	**Capacity** CEO
Date	**Date**

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | **2019/20** | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	Recent CQC inspections rated the Trust as 'Outstanding' in the Well Led domain.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Commpany Secretary communicates updates. Audit Committee receives updates from internal and external auditors. NHSI communications routinely reviewed.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	Clear Board governance, committee and reporting framework in place as confirmed by CGC Well Led review.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Mitigations include: Board Performance and Financial Reporting, audit functions, internal audit plan / annual governance statement and assurance over system of internal controls. Annual operating plan and budget approval. Board assurance and risk management frameworks. Compliance and assurance reporting re CQC and other regulatory standards.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Assurance provided by CQC comprehensive review and 'Outstanding' Well Led rating and 'Good' overall quality of care ratings. Quality Accounts including engagement with external stakeholders / governors. Quality governance framework including Quality Executive Committee and Board Quality Assurance Committee.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	Workforce shortage risks for key staff groups and service lines identified within workforce BAF risk and workforce reporting and risk mitigations tracked through Finance, Investment and Performance Committee and Audit Committees of the Board.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature **Signature**

Name Martin Earwicker **Name** Julian Emms

Further explanatory information should be provided below where the Board has been unable to confirm declarations under

A

Please Respond

Worksheet "Training of governors" | **Financial Year to which self-certification relates** | 2019/20 | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Martin Earwicker	**Name**	Julian Emms
Capacity	Chairman	**Capacity**	CEO
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	**Audit Committee – 24 April 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 24 April 2019.
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	3. - Strategic Goal: deliver sustainable services based on sound financial management
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached. The Committee reviewed the Reservation of Powers and Delegation of Powers policy document and agreed the proposed changes (highlighted in red type).
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered. b) To ratify the changes to the Reservation of Powers to the Board and Delegation of Powers (changes are highlighted in red type) c) To consider whether in view of the timing of NHS Improvement's deadline for the submission of the Annual Accounts 2018-19 on 29 May, to delegate approval of the Annual Accounts to the Audit Committee.

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 24 April 2019, Fitzwilliam House, Bracknell

Present:	Chris Fisher, Non-Executive Director, Committee Chair Naomi Coxwell, Non-Executive Director Mark Day, Non-Executive Director (*deputising for Mehmuda Mian, Non-Executive Director)*
In attendance:	Alex Gild, Deputy Chief Executive and Chief Financial Officer Clive Makombera, Internal Auditors, RSM Chris Randall, Deloitte, External Auditors Debbie Kinch, Counter Fraud, TIAA Debbie Fulton, Acting Director of Nursing and Governance Julie Hill, Company Secretary Paul Gray, Director of Finance Minoo Irani, Medical Director (via Skype) Amanda Mollett, Head of Clinical Effectiveness and Audit

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Mehmuda Mian, Non-Executive Director and Ben Sheriff, External Auditors, Deloitte.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 30 January 2019**	
	The Minutes of the meeting held on 30 January 2019 was confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	
	Matters Arising **a) Frimley Health Integrated Care System Assurance Group**	

	The Chair reported that he would be representing the Trust on the Frimley Health Integrated Care System Assurance Group. The first meeting was on 10 May 2019. **b) Audit Committee – Training and Development** The Chair reminded the meeting that one of the areas identified for improvement in last year's self-assessment of the Committee's effectiveness was around providing more opportunities for training and development for members of the Committee. The Chair suggested holding a development session at 1-2pm (with a sandwich lunch) before the Committee's meetings (with the exception of the special meeting in May to approve the annual accounts). This would enable the members of the Finance, Investment and Performance Committee to attend the training sessions. It was noted that the External Auditors had indicated that they would be happy to facilitate the training sessions. The Chair suggested that one of the four meetings could be used for a training session facilitated by either the Internal Auditors or the Counter Fraud service. Chris Randall, External Auditors, Deloitte suggested a few seminar topics, for example, corporate governance and the roles of the committees; integrated care and the impact of population health management; and the changes to IFRS 16. It was agreed that the topic for the July 2019 seminar would be corporate governance. The Chair suggested that running the seminars for a year and then taking a decision about whether or not to continue with the seminars. **Action Log** The Action Log had been circulated. The following actions were discussed further: **A) Single Waiver Tender Report** It was noted that the Clinical Commissioning Group had not yet responded to the Trust's request that they provide assurance that they followed an appropriate procurement processes before recommending that the Trust accepted a supplier. The Chair said that it was important that the Trust was assured that there were no conflicts of interests etc before the Clinical Commissioning Groups mandated the Trust to use a particular supplier. The Director of Finance agreed to build this into the Trust's Standard Waiver process. The Committee noted the action log.	**CF/JH** **PG**

5.A	**Board Assurance Framework**	
	The Board Assurance Framework had been circulated. The Chair said that he would invite Naomi Coxwell, Non-Executive Director to update on the Finance, Investment and Performance Committee's role in supporting the Trust's work to mitigate the workforce shortage risk (**Risk 1**) later on in the meeting. The Chair referred to Risk 2 (finance) and asked for more information about the Trust's patient level costing work. The Deputy Chief Executive and Chief Financial reported that the main objective was to get more visibility on the Trust's expenditure within the block contract. It was noted that suppliers of the software had to be accredited by NHS Improvement and there were only about 12 suitably qualified suppliers. The Director of Finance reported that progress had been delayed because the Trust needed assurance from the supplier that the patient level costing software would integrate with the Trust's other systems. It was noted that the Finance, Investment and Performance Committee would receive the initial data once the system was up and running. The Chair asked for more information about the external Public Private Financing (PFI) review. The Deputy Chief Executive and Chief Financial Officer reported that this was the Trust's first formal review of the two Public Private Finance initiatives (Prospect Park Hospital and West Berkshire Community Hospital). It was noted that the Trust had an initial meeting with the PFI providers in May 2019 to discuss the outcome of the external review. **Risk 3 (system working)** The Chair asked when the Trust would be informed about the system control totals. The Deputy Chief Executive and Chief Financial Officer reported that the Royal Berkshire Hospital had not yet agreed their system control total with NHS Improvement. The Committee noted the report.	
5.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Company Secretary reported that a new risk had been added to the Corporate Risk Register in respect of a "no deal Brexit". The Chair asked which group had oversight of the Trust's work to reduce the number of inappropriate Out of Area Placements. The Deputy Chief Executive and Chief Financial Officer confirmed that the relevant programme board was chaired by the Chief Operating Officer. Naomi Coxwell, Non-Executive Director reported that the Finance, Investment and Performance Committee had discussed Out of Area Placements at its	

	meeting earlier in the day and it was agreed that an update on the Trust's Bed Optimisation work would be presented at the June 2019 Trust Board Discursive meeting. This would also include an update on the Quality Improvement Programme work on developing the Emotionally Unstable Personality Disorder Pathway. The Committee noted the report.	
6.0	**Finance, Investment and Performance Committee's Role in Supporting Staff Retention**	
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had held a workshop event in January 2019 with the Director of Strategy and Corporate Affairs and Director of People to discuss how best to support the Trust's work to mitigate the risks in relation to Workforce (Risk 1 on the Board Assurance Framework). It was noted that the Committee had identified Retention as its area of focus. Ms Coxwell reported that the Trust was currently undertaking work to gain a better understanding of why staff left the Trust. The Chair shared that he was sometimes uncomfortable in some of the Workforce discussions that the issue may be seen as being the responsibility of the Human Resources Department rather than as a Trust-wide responsibility and welcomed the Finance, Investment and Performance Committee's role in supporting the Trust's Retention work. Mark Day, Non-Executive Director and a member of the Finance, Investment and Performance Committee said that the Committee was also keen to look at areas which were going well, for example, Sorrel Ward which had new leadership and was now fully staffed, to see if approaches could be replicated elsewhere. The Chair thanked Ms Coxwell for her update.	
7.0	**Scheme of Delegation** **a) Application of Financial Limits to the Scheme of Delegation – Proposed Amendments** The Director of Finance presented the paper and highlighted that the most significant change was around the approval of invoices. It was noted that currently Executive Directors needed to approve invoices above £75k and three Executive Directors were required to approve invoices above £100k. It was proposed that there be an approval level of up to £100k for Executive Director Reports and for invoices over £100k, the authorisation would be one Executive Director. For invoices over £300k, the requirement was that these would be approved by the Chief Executive. The other proposed amendments related to changes in job titles and management tiers. Naomi Coxwell, Non-Executive Director reported that the Finance, Investment and Performance Committee had discussed the proposed changes to the policy at its meeting earlier in the day and had supported the amendments. The Chair asked whether Deloitte, External Auditors had any concerns about	

	the proposed changes. Chris Randall, Deloittes confirmed that he was happy with the proposed changes. On behalf of the Trust Board, the Committee approved the proposed changes to the Application of Financial Limits to the Scheme of Delegation **b) Reservation of Powers to the Board and Delegation of Powers** The Director of Finance reported that the proposed changes mainly related to updated job titles, changes in Committee name and the wording in relation to conflicts of interest. The changes were highlighted in red type. The Chair suggested that the Audit Committee's role in approving the annual accounts should be included as part of the Board's delegation. The Committee approved the proposed changes to the Reservation of Powers to the Board and Delegation of Powers which would be ratified at the May 2019 Trust Board meeting.	**JH/PG** **JH**
8.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from January 2019 to March 2019 had been circulated. Naomi Coxwell, Non-Executive Director commented that six of the single waivers concerned software companies and asked whether this was an emergent trend. The Deputy Chief Executive and Chief Financial Officer explained that two of the software single waivers concerned services which were not covered by the Trust's core clinical systems (Sexual Health on-line testing and Wheelchair service software) and had been running on antiquated systems. Other software procurement involved specialist providers. The Committee approved the single waivers as set out in the report.	
9.	**Information Assurance Framework Update Report**	
	The Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • A total of four indicators were audited during quarter 4. One indicator was rated with high confidence (green) and three were rated with moderate confidence (amber) for data quality; four had received green (high assurance) for data assurance ratings. • Action plans had been put in place to address any issues. • The indicators audited were: - Mental Health 7 Day Follow Up (amber) - Slips, Trips and Falls (green) - CPA Reviews (green) - Inappropriate Out of Area Placements (amber) The Chair referred to appendix 1 of the report (page 117 of the agenda pack)	

	and commented that the same indicators were rated as “red” as in the previous quarter. The Acting Director of Nursing and Governance explained that the indicators had not yet been re-assessed and would therefore remain “red”. Naomi Coxwell, Non-Executive Director referred to page 114 of the agenda pack and asked when the national CQUIN for Mental Health to move the 7 day follow ups to a review within 72 hours of discharge and asked about the impact on the Trust. The Acting Director of Nursing and Governance reported that the Trust had reviewed the data for January-March 2019 and around 80% of patients already received a follow up within 72 hours of discharge from Prospect Park Hospital. It was noted that patients assessed as being at risk of suicide received a follow up within 48 hours of discharge. The Committee noted the report.	
10.	**Losses and Special Payments Report**	
	The Losses and Special Payments made during January 2019 to March 2019 had been circulated. The Chair referred to item 3 of the report (damage to buildings, property etc) which concerned nine losses totalling £6,371,42 relating to 7 lost or stolen iPhones and 2 laptops and asked whether this was out of the ordinary given the degree of mobile working across the Trust. The Deputy Chief Executive and Chief Financial Officer said that he would look at benchmarking data to ensure that the Trust was not out of line with other similar Trusts. The Chair asked whether there were any information governance issues as a result of the loss of the iPhones and laptops. The Deputy Chief Executive and Chief Financial Officer confirmed that all the Trust’s iPhones and laptops were encrypted and were switched off immediately they were reported as being lost or stolen. Naomi Coxwell, Non-Executive Director referred to section 5.2 of the report which was headed “other” and asked for more information about why the Trust had agreed to pay a total of £405 in respect of costs awarded to a claimant for their expenditure in a re-action disclosure application which was being dealt with via NHS Resolution. The Acting Director of Nursing and Governance agreed to provide more information to the Committee. Mark Day, Non-Executive Director referred to section 4 of the report headed “special payments – other” and asked why there had been a special payment	**AG** **DF**

	in respect of dilapidations following termination of a lease. The Director of Finance agreed to check how dilapidations were articulated in the NHS Improvement Trust Return. The Committee noted the report.	**PG**
11.	**Clinical Audit Report**	
	The Medical Director reported that the Clinical Audit team comprised of 2.6 members of staff who were responsible for running the whole Clinical Audit Programme. It was noted that the part time member of staff had resigned and would be leaving the Trust in June 2019. The Medical Director reported that he had agreed with the Head of Clinical Effectiveness and Audit that priority would be given to the national audits pending the recruitment and training of a new member of the team. The Head of Clinical Effectiveness and Audit presented the paper and made the following points: • The Annual Clinical Audit Plan 2019-20 was detailed in table 1 of the report; • There were currently 28 national quality account reportable projects open and three projects requested for audit by the Quality Assurance Group to gain additional assurance between the national audit cycles; • Two national reports were due to be received by the May 2019 Quality Assurance Committee: national audit of end of life and prescribing Clozapine Naomi Coxwell, Non-Executive Director asked whether it would be easier to recruit a full time person to replace the part-time post. The Head of Clinical Effectiveness and Audit pointed out that the service staffing establishment was 2.6 members of staff. Ms Coxwell asked about the consequences of not participating on the national clinical audits if it was not possible to recruit to the post quickly. The Head of Clinical Effectiveness and Audit reported that the Trust was contractually obliged to participate in the national audits. The Medical Director said that in many Trusts, the Clinical Audit team had a smaller remit with the expectation that the operational teams would be responsible for developing and overseeing the clinical audit action plans. The Committee noted the report.	
12.	**Clinical Claims and Litigation Report Quarterly Report and Year End Summary**	
	The Clinical Claims and Litigation Report for quarter 4 and year end summary had been circulated. The Acting Director of Nursing and Governance reported that there were three new claims opened in quarter 4. Two of the new claims related to employer liability claims and the third one was a clinical negligence claim.	

	The Chair commented that the cost of the Trust's premium to NHS Resolution was based upon its claims history and asked how quickly the premium was adjusted after the Trust had ceased running services, such as the two GP Surgeries. The Deputy Chief Executive and Chief Financial Officer agreed to contact NHS Resolution to find out. The Committee noted the report.	**AG**
13.	**Internal Audit**	
	A) Internal Audit Progress Report Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and reported that: • Since the last Audit Committee, reviews had been completed in respect of: Clinical Audit Assurance Process (substantial assurance rating); and GDPR Governance (advisory); • There were only three overdue management actions; • The draft Head of Internal Audit Opinion 2018-19 rating was amber-green which was that: "the organisation has an adequate and effective framework for risk management, governance and internal controls. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective". The Chair asked what further improvements would the Trust have to make in order to receive the highest Head of Internal Audit opinion. Clive Makombera, RSM explained that the Trust would need to sustain its current position over the course of the new financial year. **B) Annual Internal Audit Report 2018-19** The Annual Internal Audit Report 2018-19 had been circulated. Clive Makombera, RSM reported that It was the first time since RSM were appointed as the Trust's Internal Auditors that there were no amber red (partial assurance) or red (no assurance) ratings. The Chair asked how the Internal Audit Report fitted into the External Auditors work. Chris Randall, Deloittes said that the Internal Auditors' annual report contributed to the External Auditors' view of the Trust's value for money review. Naomi Coxwell, Non-Executive Director asked whether the Internal Auditors had any insights as to why there were no amber red/red ratings during 2018-19. Mr Makombera pointed out that each year was different and reported that the Trust was well run and had effective controls in place to manage risk. The Committee noted the report.	

14.	Counter Fraud	
	a) Counter Fraud Annual Report 2018-19 Debbie Kinch, Counter Fraud Specialist, TIAA presented the paper which set the Counter Fraud work during 2018-19. It was noted that the Self-Review Tool which was the Trust's assessment against the NHS Counter Fraud Authority's Standards for Providers; fraud, bribery and corruption had been completed in draft with an overall assessment of a green rating. Final approval of the Self Review Tool was required from the Deputy Chief Executive and Chief Financial Officer and the Audit Committee Chair prior to submission by 30 April 2019. It was noted that there were three ambers ratings in the Self-Review Tool: • Board level evaluation of effective counter fraud, bribery and corruption activity could not be demonstrated at the time of completion. This exercise is due to be implemented during 2019-20 • Standards of business conduct – declaration of gifts, hospitality, business interests and commercial sponsorship – staff knowledge was checked via surveys and through the submission of annual Declarations of interests. However, the test of knowledge is not specific to the code of conduct and the effectiveness was therefore not specifically tested as stipulated in the Standards • Review of processes – knowledge of policies was measured during staff and fraud awareness surveys and monitoring of fraud referrals. However as above, the evaluation was not focused specifically to the success of measures in place to reduce fraud, bribery and corruption. **b) Counter Fraud Risk Assessment and Annual Plan 2019-20** Debbie Kinch, Counter Fraud Specialist, TIAA presented the paper and said that the number of days allocated for the Counter Fraud work was 130 days which was the same as in previous years. The Chair referred to the Counter Fraud risk area (pages 200-202 of the agenda pack and asked why expenses and fraud awareness had been assessed as being amber risks for the Trust. Ms Kinch reported that expenses had been rated as amber to reflect the subject matter of referrals received in the last year which mainly related to mileage and time sheet claims, therefore indicating that there is a risk of fraud in this area. Fraud awareness had been assessed as amber to reflect the continuous intake of new staff to the Trust who may not have any awareness of fraud. The Deputy Chief Executive and Chief Financial Officer suggested that the Trust undertakes a proactive review of expenses. Naomi Coxwell, Non-Executive Director asked whether there were any concerns in relation to the Trust's capital programme. The Deputy Chief Executive and Chief Financial Officer confirmed that he was not aware that any fraud risks had been raised and commented that the Trust had robust processes in place in relation to fees etc but agreed to check with the members of the Capital Review Group to see whether they were aware of any issues.	**AG** **AG**

	The Committee noted the reports and approved the Counter Fraud Annual Plan 2019-20.	
15.	**External Audit Report**	
	Chris Randall, Deloitte, External Auditors reported that work on audited the Trust's Quality Accounts 2018-19 was progressing well. It was noted that the audit of the Trust's financial accounts 2018-19 would start next week. The Deputy Chief Executive and Chief Financial Officer reported that the Trust had delivered the financial plan 2018-19 with £1.5m over the control total. In addition, NHS Improvement had awarded the Trust with an additional provider sustainability funding bonus of £2.1m which had resulted in the Trust delivering a statutory surplus of £6.5m. It was noted that the additional central funding would be added to the Trust's capital programme. The Director of Finance reported that the Trust had submitted the draft financial accounts 2018-19 to NHS Improvement a day ahead of the deadline. The Chair requested that if the External Auditors raised any material issues, the Chair of the Finance, Investment and Performance Committee and himself be informed.	**AG**
16.	**Minutes of the Finance, Investment and Performance Committee meetings held on 22 February 2019 and 26 March 2019**	
	The minutes of the Finance, Investment and Performance Committee meetings held on 22 February 2019 and 26 March 2019 were received and noted.	
17.	**Minutes of the Quality Assurance Committee held on 19 February 2019**	
	The minutes of the Quality Assurance Committee meeting held on 19 February 2019 were received and noted.	
18.	**Minutes of the Quality Executive Committee held on 14 January 2019, 11 February 2019 and 11 March 2019**	
	The minutes of the Quality Executive meetings of 14 January 2019, 11 February 2019 and 11 March 2019 were received and noted.	
19.	**Annual Work Plan**	
	The Committee noted the work programme.	
20.	**Any Other Business**	
	a) Approval of the Final Accounts The Chair said that in view of the timing of NHS Improvement's deadline for the submission of the Final Accounts 2018-19, the May 2019 Trust Board would need to either arrange a special meeting of the Board or delegate approval of the Final Accounts to the special meeting of the Audit Committee scheduled on	

	22 May 2019. **b) Meeting of Chairs of the Sub-Committees** The Chair said that it would be helpful to have a meeting with the Chairs of the Sub-Committees to discuss the effectiveness of the governance arrangements.	**JH**
21.	**Date of Next Meeting**	
	22 May 2019 *(special meeting to approve the annual accounts 2018-19)*	

These minutes are an accurate record of the Audit Committee meeting held on 24 April 2019.

Signed:-_____

Date: - 31 July 2019_____

Berkshire Healthcare
NHS Foundation Trust

ORG001c

RESERVATION OF POWERS TO THE BOARD AND DELEGATION OF POWERS

Policy & Procedures

Berkshire Healthcare NHS Foundation Trust

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Berkshire Healthcare NHS
NHS Foundation Trust

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POLICY DEVELOPMENT

ORG001c - RESERVATION OF POWERS TO THE BOARD AND DELEGATION OF POWERS

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Version 7: References to Finance Director amended to Chief Financial Officer. References to Monitor amended to NHS Improvement. Approved by Audit Committee - TBC

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Version 3: approved by the Trust Board, March 2008.

Version 2: approved by the Trust Board, February 2006.

Designated Lead: Chief Financial Officer

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1. INTRODUCTION

The NHS Foundation Trust Code of Governance (July 2014) for NHS Boards requires the Board of Directors to draw up a Schedule of decisions reserved to the Board only and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation. However, the Board of Directors remains accountable for all of its functions, including those, which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain its monitoring role.

All powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board Committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions, which the Chief Executive shall perform personally and those delegated to other Directors or Officers. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

The Chief Executive Officer should also ensure he or she complies with the NHS Foundation Trust Accountable Officer Memorandum.

2. FUNCTIONS WHICH ARE RESERVED FOR DECISION BY THE BOARD OF DIRECTORS:

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD OF DIRECTORS	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD OF DIRECTORS	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 4.2.1 5. Approve a scheme of delegation of powers from the Board to committees, Officers or other bodies**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity this would comprise details of the structure of the Board and its sub-committees and the Directorate structure of the Trust. Organisational structures below Executive and Clinical Director are the responsibility of the Chief Executive. 10. Receive reports from committees including those that the Trust is required by the Secretary of State, NHS Improvement or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property.

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		14. Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 4.5 17. Approval of the disciplinary procedure for Officers of the Trust. 18. Discipline members of the Board or Officers who are in breach of statutory requirements or Sos. 19. Approval of the Trust's Major Incident Plan 20. Specification of Financial and Performance Reporting Arrangements
NA	THE BOARD OF DIRECTORS	**Appointments/ Dismissal** 1. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 2. Through the Appointments and Remuneration Committee, appoint, appraise, discipline and dismiss Executive Directors (subject to S 25 of the Trust's Constitution). 3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 4. Approve proposals of the Appointments and Remuneration Committee regarding directors.
NA	THE BOARD OF DIRECTORS	**Strategy, Business Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored 3. Approve proposals for ensuring quality and developing clinical governance, risk management in services provided by the Trust, having regard to any guidance issued by the Secretary of State and/or NHS Improvement. 4. Approve the Trust's policies and procedures for the management of risk. 5. Approval annually of integrated business plan 6. Approve Final Business Cases for Capital Investment above £300K 7. Approve budgets and annual financial plans. 8. Approve Trust's proposed organisational development proposals. 9. Ratify proposals for acquisition, disposal or change of use of land and/or buildings. 10. Approve PFI proposals.

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		11. Approve the opening and closing of any commercial bank accounts 12. Approve any Working Capital Facility 13. Approve proposals on individual contracts of a capital or revenue nature amounting to, or likely to amount to Investment in Fixed Assets < £0.5m, Contracts / services generating EBITDA < £175k pa, Contracts / services generating Income < £2.5m pa. 14. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) previously approved by the Board. 15. Approve individual compensation payments made outside of legal / statutory or mandatory requirements. 16. Approve proposals for action on litigation against or on behalf of the Trust. 16. Review use of **NHS Resolution** risk pooling schemes (LPST/CNST/RPST). 17. Approve, subject to Council of Governors agreement, proposals to enter into significant or material transactions as defined by NHS Improvement's Single Oversight Framework 18. Approve, subject to Council of Governors agreement, any proposal for the merger, acquisition, disaggregation, separation or dissolution of the Trust
	THE BOARD OF DIRECTORS	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	THE BOARD OF DIRECTORS	**Audit** 1. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
NA	THE BOARD OF DIRECTORS	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. The Board of Directors may choose to delegate authority to approve the Annual Accounts to the Audit Committee in order to meet NHS Improvement's deadline for submission of the Annual Accounts.

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		2. Receipt and approval of the Trust's Annual Quality Account
NA	THE BOARD OF DIRECTORS	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require of reports from directors, committees, and Officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and/or NHS Improvement and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from Chief Financial Officer on financial performance against income and expenditure budget and business plan.

3. DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 2.1.1 & SO 5.1	AUDIT COMMITTEE	See Terms of reference As mentioned above, The Board of Directors may choose to delegate authority to approve the Annual Accounts to the Audit Committee in order to meet NHS Improvement's deadline for submission of the Annual Accounts.
SO 5.1	FINANCE, INVESTMENT & PERFORMANCE COMMITTEE	See Terms of reference
SO 5.1	**APPOINTMENTS & REMUNERATION COMMITTEE**	See Terms of reference
	QUALITY ASSURANCE COMMITTEE	See Terms of Reference
SO 5.1	CHARITABLE FUNDS COMMITTEE	See Terms of reference

4. SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
3.2.2	CHAIRMAN	Call meetings.
3.7	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.8.1	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity (including procedure on handling motions) of meetings and the interpretation of any SO or SFI.
3.13.1	CHAIRMAN	Having a second or casting vote
3.15.1	BOARD	Suspension of Standing Orders
3.15.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.16	BOARD	Variation and amendment of Standing Orders
4.2.1	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency or in the need for an urgent decision be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
4.4.2	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.1	THE BOARD	Declare **any actual or potential, direct or indirect, financial interests which is material to any discussion or decision the Board of Directors are involved or likely to be involved in making in relation to** any contract, proposed contract or other matter under consideration by the Board of Directors.
7.16.4	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
8.1.1	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff” the

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		Code of Conduct for NHS Managers 2002 and Code of Governance for NHS Foundation Trusts (July 2014)
8.4.2	DIRECTORS AND EVERY MEMBER AND OFFICER	Disclose to the CEO any relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board)
9.	CHIEF EXECUTIVE	Tendering and contract procedure.
9.3.2	CHIEF EXECUTIVE/ CHIEF FINANCIAL OFFICER	Waive formal tendering procedures.
9.3.4	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
APPENDIX 1 PARA 2.3 of SFI	CHIEF EXECUTIVE OR NOMINATED OFFICER	Responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.
APPENDIX 1 PARA 4.8 of SFI	CHIEF EXECUTIVE AND **CHIEF FINANCIAL OFFICER**	Where only one tender is sought and/or received shall as far as practicable ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
APPENDIX 1 PARA 4.3 of SFI	CHIEF EXECUTIVE OR NOMINATED OFFICER	Responsible for treatment of 'late tenders'.
9.4.5	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
APPENDIX 1 PARA 5.1 of SFI	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
APPENDIX 1 PARA 5.1.2 of SFI AND 5.3	CHIEF EXECUTIVE AND **CHIEF FINANCIAL OFFICER**	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote where it is impractical to use a potential contractor from the list of approved firms/individuals or where a list has not been prepared. Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CEO.
9.4.8	CHIEF EXECUTIVE OR NOMINATED OFFICER	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
9.5.1.1	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
9.5.1.3	BOARD OF DIRECTORS	All PFI proposals must be agreed by the Board of Directors.
9.7.1	CHIEF EXECUTIVE	The Chief Executive shall nominate Officers with delegated authority to enter into and manage contracts of employment of other Officers and enter into contracts for the employment of agency staff or temporary staff service contracts.
9.4.8	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house.
11.4	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
12.1.1 AND 12.3.1	CHIEF EXECUTIVE OR NOMINATED OFFICER	Keep seal in safe place and maintain register of sealing
13.1	CHIEF EXECUTIVE	Approve and sign all documents which will be necessary in legal proceedings

5. SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
Introduction	**CHIEF FINANCIAL OFFICER**	Approval of all financial procedures.
Interpretation	THE CHAIRMAN ON THE ADVICE OF THE CHIEF EXECUTIVE AND THE **CHIEF FINANCIAL OFFICER**	Advice on interpretation or application of SFIs.
Compliance	ALL MEMBERS OF THE BOARD AND OFFICERS	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible together with full details of the non-compliance and the circumstances around non-compliance.
1.1.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure that the Board of Directors meets its obligations to perform its functions within the available financial resources, and has overall executive responsibility for the Trusts' activities, is responsible to the Chairman and the Board of Directors for ensuring that its financial targets and obligations are met and has overall responsibility for the System of Internal Control.
1.1.5	CHIEF EXECUTIVE & **CHIEF FINANCIAL OFFICER**	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.1.6	CHIEF EXECUTIVE	To ensure all existing Directors and Officers and all new appointees, present and future, are notified of and understand Standing Financial Instructions.
1.1.7	**CHIEF FINANCIAL OFFICER**	Responsible for: a) Implementing the Trust's financial policies and for coordinating corrective action necessary to further these policies; b) Maintaining an effective system of internal financial control including ensuring detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to the Trust, other than to the Board of Directors and Officers; e) Preparing and maintaining such accounts, certificates, estimates, records and reports as are required for the Trust to carry out its statutory duties. f) The design, implementation and supervision of systems of internal control.
1.1.8	ALL MEMBERS OF THE BOARD AND OFFICERS	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions the Scheme of Delegation.
1.1.9	CHIEF EXECUTIVE	Ensure that any Officer including a contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1.3	CHAIR OF THE AUDIT COMMITTEE	Where there is evidence of ultra vires transaction or improper acts or other important matters these should be raised with the Chief Financial Officer
2.2.1	**CHIEF FINANCIAL OFFICER**	a) Ensure that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function b)Ensure that the internal Audit Function meets NHS Improvement's internal Audit standards and provides sufficient independent and objective assurance to the Audit Committee and the Accounting Office c) decide at what stage to involve the police in cases of misappropriation and fraud d) Ensure the annual audit and Governance report is prepared for consideration by the Audit Committee and the Board of Directors covering the detail specified at SFI 2.2.1.4
2.3.1-2.3.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Standards and best practice and provide to the Audit Committee a risk based plan of internal audit work, regular updates, reports on the management progress on the implementation of action agreed as a result of internal audit findings, an annual opinion, a report supporting assurances to the Healthcare Commission and any additional reports as required by the Audit Committee.
2.4	CHIEF EXECUTIVE & **CHIEF FINANCIAL OFFICER**	NHS Improvement and ensure compliance with the guidance issued by the DOH and NHS Improvement on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
2.4.4	**CHIEF FINANCIAL OFFICER**	Preparation of the Fraud Response Plan

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2.4.5	ANY OFFICER	Immediately inform their Head of Services or Department on the discovery or suspicion of any loss.
2.4.5	ANY OFFICER	Immediately inform the Chief Executive and Chief Financial Officer or an Officer charged with investigating loss or fraud or confidentiality on receipt of any information concerning the discovery of or suspicion of fraud
2.4.5	CHIEF EXECUTIVE AND **CHIEF FINANCIAL OFFICER**	Immediately inform the LCFS and Operational Fraud Team on receipt of information concerning the discovery or suspicion of fraud.
2.4.5 – 2.4.7	**CHIEF FINANCIAL OFFICER**	Immediately inform the police if theft or arson is involved but in the case of fraud or corruption will determine the appropriate stage in which to involve the police based on the facts of the case. Notify the Board and the Auditor of losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness except if trivial or where fraud is not suspected.
2.5.1	EXTERNAL AUDIT	Ensure cost-effective External Audit and compliance with NHS Improvement's Audit Code.
3.2.1	CHIEF EXECUTIVE	Compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
3.2.2 & 3.2.3	**CHIEF FINANCIAL OFFICER**	Submit revenue and capital budgets annually to the Board for approval. NHS Improvement performance against budgets and the business plan; periodically review them and report to the Board of Directors.
3.2.5	**CHIEF FINANCIAL OFFICER**	Ensure adequate training is delivered on an on going basis to budget holders.
3.3.1	CHIEF EXECUTIVE	Delegate the management of a budget to permit the performance of a defined range of activities to budget holders.
3.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board of Directors.
3.4.1	**CHIEF FINANCIAL**	Devise and maintain systems of budgetary control.

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	OFFICER	
3.4.2	BUDGET HOLDERS	Ensure that a) any significant or wilful deviation likely to result in overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the line manager. b) the amount provided in the approved budget is not used in whole or in part for any other than specified purpose , subject to rules of virement; c) no permanent Officers are appointed without the approval of the CEO other than those provided for within available resources and manpower establishment as approved by the Board of Directors.
3.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Business Plan.
3.6.1	CHIEF EXECUTIVE	Submit monitoring returns
4.1	**CHIEF FINANCIAL OFFICER**	Preparation of financial returns, annual accounts and reports to HM Treasury and NHS Improvement as necessary.
5.1 – 5.3	**CHIEF FINANCIAL OFFICER**	Managing banking arrangements, advising the Trust on the provision of banking services and operation of accounts including: a) the provision and operation of bank accounts and GBS accounts, establishing: bank accounts and GBS accounts and separate bank accounts for Exchequer funds, ensuring payments do not exceed the amount credited to the account, reporting to the Board of Directors all arrangements for accounts to be overdrawn and monitoring compliance with guidance issued by the DOH, NHS Improvement and any other relevant guidance on the level of cleared funds. b) ensuring that detailed instructions are in place for the operation of bank and GBS accounts, the conditions under which such accounts are to be operated, the limits to be applied to any overdraft and specify the authorised signatories to sign cheques and orders drawn on the Trusts accounts c) advising the GBS of the conditions under which each account will operate, the limits to be applied to any overdraft, the limitation on single signatory payments and details of any officers authorised to release money or draw cheques. (Board approves arrangements.)
5.4	**CHIEF FINANCIAL**	a) Review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	and represent best value for money by periodically seeking competitive tenders for the Trusts' commercial banking business. b) Ensure competitive tenders are sought at least every 3 years for commercial bank accounts and the results of such a tendering exercise reported to the Board of Directors.
6.1 – 6.2.	CHIEF FINANCIAL OFFICER	Designing and maintaining and ensuring compliance with systems for the proper recording, invoicing and collection of monies and coding of all monies including but not limited to prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for Officers whose duties include collecting or holding cash.
6.2.4	ALL OFFICERS	Duty to inform Chief Financial Officer promptly of money due from transactions which they initiate/deal with.
7.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services
8.1.1	BOARD OF DIRECTORS	Establish an **Appointments and Remuneration Committee**
8.1.2	**APPOINTMENTS & REMUNERATION COMMITTEE**	Advise the Board on and make recommendations on the remuneration and terms of service of the CEO and Executive Directors and other **Very Senior Managers** to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; NHS Improvement and evaluate the performance of individual Executive Directors and Senior Senior Managers of the Trust; Advise on and oversee appropriate contractual arrangements for all Directors and **Very Senior Managers** including proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate.
8.1.3	**APPOINTMENTS & REMUNERATION COMMITTEE**	Report in writing to the Board of Directors its advice and its basis about remuneration and terms of service of the Chief Executive and other Executive Directors and senior Officers.
8.1.4	BOARD OF DIRECTORS	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those officers not covered by the Remuneration Committee.
8.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
8.3	CHIEF EXECUTIVE	Authorisation of the engagement, re-engagement, re-grade, hire or change in remuneration of any Officer including agency staff engaged either on a temporary or permanent basis, within the limit of the approved budget and funded establishment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
8.4.1 – 8.4.2	**CHIEF FINANCIAL OFFICER**	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; issuing instructions.
8.4.5	NOMINATED MANAGERS	Submission of time records and notifications in accordance with agreed timetables. Completion of time records and other notifications in accordance with the Chief Financial Officer's instructions and in a form prescribed by the Chief Financial Officer. Submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement Notifying the Chief Financial Officer immediately where an Officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.
8.4.6	**CHIEF FINANCIAL OFFICER**	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
8.5	NOMINATED OFFICER MANAGER	Ensure that all Officers are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
9.1.1	BOARD OF DIRECTORS	Approve the level of non-pay expenditure on an annual basis
9.1.1. AND 9.1.2	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to Budget Managers, including a list of Officers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.
9.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.

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9.2.2	REQUISITIONING OFFICER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement and Logistics Manager on supply shall be sought. Where this advice is not acceptable to the requisitioner the advice of the Chief Financial Officer and or the Chief Executive should be consulted. For requisitions over £172,514 (excluding VAT) the requisitioning Officer should consult the Head of Procurement.
9.2.4.3	**CHIEF FINANCIAL OFFICER**	Shall be responsible for the prompt payment of accounts and claims.
9.2.4	**CHIEF FINANCIAL OFFICER**	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable which shall provide for the matters listed at SFIs 9.2.4.4.1 - 9.2.4.4.4; e) Be responsible for a timetable and submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to Officers regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received except those obtained by pre-payment.
9.2.5.2	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment, setting out all the relevant circumstances of the purchase and the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments
9.2.5.3	**CHIEF FINANCIAL OFFICER**	Approve proposed prepayment arrangements taking into account the EU public procurement rules where the contract is above a stipulated financial threshold.
9.2.5.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform as necessary the appropriate Director or the Chief Executive Officer if problems are encountered).
9.2.6.2	**CHIEF FINANCIAL**	Approve the form of Official Orders

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	
9.2.6.4	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
9.2.8	OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and the requirements detailed at SFI 9.2.8.1 to 9.2.8.13.
9.2.9	**CHIEF FINANCIAL OFFICER**	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.
10.1	**CHIEF FINANCIAL OFFICER**	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 75 of the NHS Act 2006.
11.1	**CHIEF FINANCIAL OFFICER**	The Chief Financial Officer will advise the Board of Directors on the Trust's ability to pay dividend on, and repay PDC and any proposed new borrowing and report, periodically, concerning the PDC debt and all loans and overdrafts.
11.2	BOARD OF DIRECTORS	Agree a list of Officers (including specimens of their signatures) authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Financial Officer.)
11.3	**CHIEF FINANCIAL OFFICER**	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval and inform the Board of Directors of all short term borrowings at the next Board Meeting.
11.7	BOARD OF DIRECTORS	Authorise temporary cash surpluses
11.8	**CHIEF FINANCIAL OFFICER**	Will advise the Board on investments and report, periodically to the Board on performance of same.
12.1.1– 12.1.2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans b) be responsible for the management of all stages of capital schemes and for ensuring that they are delivered on time and within cost;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		c) ensure that capital investment is not undertaken without confirmation of purchaser support and the availability of resources to finance all revenue consequences, including capital charges; d) ensure that a business case is produced for every capital proposal setting out the matters referred to at SFI 12.1.2.1.1 – 12.1.2.1.3.
12.1.2.2	**CHIEF FINANCIAL OFFICER**	Certify the costs and revenue consequences detailed in the business case for capital investment and involve appropriate Trust personnel and external agencies in the process.
12.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts for capital schemes involving stage payments incorporating the recommendations of Concode
12.1.3	**CHIEF FINANCIAL OFFICER**	Assess on an annual basis the requirement for the operation of the construction industry taxation deduction scheme in accordance with HMRC guidance.
12.1.3	**CHIEF FINANCIAL OFFICER**	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
12.1.4 – 12.1.5	CHIEF EXECUTIVE	Issue to the Officer responsible for any capital scheme specific authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
12.1.6	**CHIEF FINANCIAL OFFICER**	Issue procedures governing financial management, including variations to contracts of capital investment projects and valuation of accounting processes fully taking into account the delegated limits for capital schemes as referenced in guidance issued by NHS Improvement
12.1.7	**CHIEF FINANCIAL OFFICER**	Ensure that NHS Improvement's Annual Reporting Manual ('ARM') is followed in the production of the Trust's annual accounts and reports
12.2.1.1	**CHIEF FINANCIAL OFFICER**	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
12.2.1.2	BOARD OF DIRECTORS	Proposal to use PFI must be specifically agreed by the Board.
12.3.1	CHIEF EXECUTIVE	Maintenance of asset registers taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

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12.3.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.3.8	CHIEF FINANCIAL OFFICER	Calculate and pay capital charges as specified in the Annual Reporting Manual issued by NHS Improvement.
12.4.1	CHIEF EXECUTIVE	Overall responsibility for the control of fixed assets.
12.4.2	CHIEF FINANCIAL OFFICER	Approval of asset control procedures.
12.4.5	MEMBERS OF THE BOARD, SENIOR OFFICERS	Responsibility to apply routine security practices in relation to Trust property as may be determined by the Board of Directors. Any breach should be reported in accordance with agreed procedures.
13.2	CHIEF EXECUTIVE AND NOMINATED OFFICER	Overall responsibility for control of stocks and stores may be delegated to an Officer. Further delegation for day-to-day responsibility to departmental Officers subject to such delegation being recorded in a record available to the Chief Financial Officer.
13.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for the control of any Pharmaceutical stocks
13.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
13.3	DESIGNATED MANAGER	Responsibility for defining in writing the security arrangements relating to the custody of keys for all stores and locations
13.4	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores including receipt of goods, issues, returns to stores and losses.
13.5	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.

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13.6	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
13.7	CHIEF FINANCIAL OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles.
13.7	DESIGNATED MANAGER*	Operate a system approved by the Chief Financial Officer for slow moving and obsolete stock, for condemnation, disposal and replacement of unserviceable articles and report to the Chief Financial Officer evidence of significant overstocking and any negligence or malpractice.
13.8	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores
13.8	REQUISTIONING OFFICER	Check receipt of goods against the delivery note before forwarding the note to the Chief Financial Officer
13.8	CHIEF FINANCIAL OFFICER	Satisfy themselves that the goods received from the NHS Supplies Store have been received before accepting the recharge.
14.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for disposal of assets in accordance with the 'Asset register and disposal of assets: guidance for providers of commissioner requested services (April 2014)' guidance issued by NHS Improvement including condemnations and ensure that these are notified to managers.
14.1.2	HEAD OF DISPOSALS AND CONDEMNATIONS OR AUTHORISED DEPUTY	Inform the Chief Financial Officer of the estimated market value of any disposal item taking account of professional advice where appropriate
14.2.1	CHIEF FINANCIAL OFFICER	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments
14.2.2	BOARD OF DIRECTORS	Approve write off of losses above the level delegated to the CEO and Chief Financial Officer in the Financial Limits specified in the SFIs.
14.2.3	CHIEF FINANCIAL OFFICER	Take the necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations
14.2.4	CHIEF FINANCIAL OFFICER	Consider whether any insurance claim can be made.

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14.2.5	CHIEF FINANCIAL OFFICER	Maintain losses and special payments register in which write off action is recorded
15.1.1	CHIEF FINANCIAL OFFICER	Responsibility for the accuracy and security of computerised financial data and ensuring that the adequate controls, procedures and management trails as specified at SFI 15.1.1.1 to 15.1.1.4 are in place.
15.1.2	CHIEF FINANCIAL OFFICER	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
15.2.1	OTHER DIRECTORS AND OFFICERS	Send proposals for general computer systems to the Chief Financial Officer specifying the details of the outline design of the system and any operational requirements in the cases of packages acquired from either a commercial organisation, the NHS or from another public sector organisation.
15.3.1– 15.3.2	CHIEF FINANCIAL OFFICER	Ensure that contracts for computer services for financial applications with other health organisations or any other agency shall clearly define the responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation where such a computer service is provided for financial applications.
15.4	CHIEF FINANCIAL OFFICER	Ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to migrate or control risk including the preparation and testing of appropriate disaster recovery and business continuity plans.
15.5.1	CHIEF FINANCIAL OFFICER	Where computer systems have an impact on corporate financial systems satisfy themselves that: a) systems acquisition, development and maintenance are in line with corporate policies such as the Information Technology Strategy; b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists; c) The Chief Financial Officer and staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
15.5.3	CHIEF FINANCIAL	Ensure that separate control procedures are put in place for computer systems including: the acquisition and disposal of IT systems and equipment and the decommissioning of systems containing confidential

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	data.
16.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed before or at admission either by notices or information booklets or orally that the Trust will generally not accept responsibility or liability for patients' property unless it is deposited for safe custody and a copy of the patient's property record is obtained as a receipt.
16.3	CHIEF FINANCIAL OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients.
16.4	CHIEF FINANCIAL OFFICER	Approve arrangements put in place for the opening and operation of separate accounts for the management of patient moneys
16.6	DEPARTMENTAL MANAGERS	Inform Officers on appointment of their responsibilities and duties for the administration of the property of patients.
17.1 -17.9	CHIEF FINANCIAL OFFICER	Ensure compliance with the obligations specified at SFI 17.1 to 17.9 relating to Funds held on Trust
18.1	CHIEF FINANCIAL OFFICER	Ensure all Officers are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by Officers
19.1	CHIEF EXECUTIVE	Maintaining Archives for all documents Retention of document procedures in accordance with the Records Management Code.
19.3	CHIEF EXECUTIVE	Authorise the destruction of documents
20.1	DIRECTOR OF NURSING & GOVERNANCE	Publish and maintain a Freedom of Information Publication Scheme or adopt a model Publication scheme approved by the Information Commissioner.
21.1	CHIEF EXECUTIVE	Ensure that the Trust has a risk management programme which shall contain the detail specified at SFI 21.2

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
21.1	BOARD OF DIRECTORS	Approve and monitor risk management programme.
21.4	BOARD OF DIRECTORS	Decide whether the Trust will insure through the risk pooling schemes administered by the **NHS Resolution** or self-insure for some or all of the risks covered by the risk pooling scheme. Decisions to self-insure should be reviewed annually.
21.6-21.7	**CHIEF FINANCIAL OFFICER**	Where the Board decides to use the risk pooling schemes administered by the **NHS Resolution** the **Chief Financial Officer** shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the **NHS Resolution** for any one or other of the risks covered by the schemes, the **Chief Financial Officer** shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
21.8	**CHIEF FINANCIAL OFFICER**	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

6. DELEGATION BY FUNCTIONAL AREA

	FUNCTIONAL AREA	SCOPE	RESPONSIBILITY
1.	Competitive Tendering	- See S0 9	
2.	Sealing Documents	- See SO12	
2.1	The seal		Held by the Chief Executive or a Nominated Officer
2.2	Sealing Documents		Board of Directors
3.	Budgets	See SFI 3	Reported to: Chief Executive, Chief Financial Officer and Trust Board
3.1	Business Plan		Chief Executive and Trust Board
	Overall Income & Expenditure Annual Plan		Overall responsibility led by: Chief Financial Officer
3.2	Expenditure Budgets		**Chief Financial Officer**
3.4	Capital Programme - Business Cases		Chief Executive
	- Initiating spending on Capital schemes		Chief Executive and Chief Financial Officer
	- Managing Capital Projects		Chief Executive
3.5	Capital Expenditure		Chief Executive

4.	Bank Accounts and Procedures Opening Bank Accounts	See SFI 5	Chief Financial Officer and Board of Directors Chief Financial Officer
5.1 5.2	Legally binding Agreements Signing Agreements with Commissioners. Amendment to Agreements	SFI 7	Chief Executive Chief Executive Chief Executive
6.	Management of Stocks General Drugs Fuel, Oil and Coal	SFI 13	**Chief Financial Officer** & Departmental Managers/Officers Pharmaceutical Officer Estates Manager
7.	Management and Control of Computer Systems	SF1 15 – Specialist and general systems	**Chief Financial Officer** & all responsible Directors and Officers
8.	Losses and Condemnations	SFI 14	**Chief Financial Officer** and Board of Directors

COMMENTS / FEEDBACK (This form can be photocopied as needed)

ORG001c - RESERVATION OF POWERS TO THE BOARD AND DELEGATION OF POWERS

Name _____ Date _____

Address

_____

Return comments for consideration three months prior to review date to the designated policy lead or Governance Administration Manager, 2nd Floor, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ. Tel: 01344 415623.

Page: Paragraph:	
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General comments:	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 May 2019
Title	**Use of Trust Seal**
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Chief Financial Officer
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to the following document: • A 10 lease for part of the 1st floor of the recently completed Cancer Care unit was granted to the Royal Berkshire Hospital NHS Foundation Trust. • The lease can be exited on 12 months' notice if the Royal Berkshire Hospital ceases to have a clinical contract for the delivery of services at the location.
ACTION	To note the update.