Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 09 July 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 14 May 2019	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Anxiety and Depression in Young People Presentation	Dr Ray Percy, Clinical Psychologist & Clinical Lead AnDY Research Clinic	Verbal
6.1	Freedom to Speak Up Annual Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.2	Patient Story	Sue McLaughlin, Deputy Director of Nursing	Verbal
6.3	Annual Complaints Report	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
6.4	Quality Assurance Committee – 21 May 2019 a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Member of the Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
6.5	Peer Mentor Programme Update Report	Debbie Fulton, Acting Director of Nursing and Governance	Enc.
6.6	Statement of Compliance 2018/19 for Medical Revalidation	Dr Minoo Irani, Medical Director	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			

No	Item	Presenter	Enc.
8.1	Month 2 2019/20 Finance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Month 2 2019/20 True North Scorecard Performance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.3	Finance, Investment & Performance Committee meeting held on 29 May 2019 **The Month 1 Finance and Performance Reports were reviewed by the FIP Committee*	Naomi Coxwell, Chair of the Finance, Investment & Performance Committee	Verbal
STRATEGY			
9.0	Vision Metrics Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
9.1	Equalities Annual Report	Bev Searle, Director of Strategic and Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee - Minutes of the Meeting held on 22 May 2019	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.2	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 –10 September 2019 *(a meeting is scheduled on 13 August 2019 if required)*	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 14 May 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
	Jayne Reynolds	Regional Director East (deputising for David Townsend, Chief Operating Officer)
In attendance:	Julie Hill	Company Secretary
	Carol Carpenter	Director of People (*present for item 7.1)*

19/079	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting including the observers: Ray Fox, Public Governor, Ruth Carmichael, Staff Governor, Reva Stewart, Divisional Director, Community Health West and Mark Davison, Chief Information Officer.
19/080	**Apologies** (agenda item 2)
	Apologies were received from: David Townsend, Chief Operating Officer.
19/081	**Declaration of Any Other Business** (agenda item 3)
	There was no other business declared.

19/082	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none
19/083	**Minutes of the previous meeting – 09 April 2019** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 09 April 2019 were approved as a correct record of the meeting.
19/084	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board**: noted the schedule of actions.
19/085	**Board Visit Report – Donnington and Highclere Wards, West Berkshire Community Hospital** (agenda item 6.0)
	Ruth Lysons, Non-Executive Director presented the paper and said that her visit to Donnington and Highclere Wards, West Berkshire Community Hospital had been very positive and constructive. Ms Lysons reported that she had the two wards were adjacent to each other and that 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. It was noted that the two wards worked well together and staff were positive about the Quality Improvement Programme. Ms Lysons reported that staff had expressed frustration that following the decision to close 10 beds on Highclere Ward, the space occupied by the beds had not yet been re-purposed. Chris Fisher, Non-Executive Director referred to page 20 of the agenda pack and asked for more information about the two "Rainbow Trust Rooms". The Acting Director of Nursing and Governance explained that these were enhanced single rooms, donated by the Newbury Cancer Trust and were used by patients close to end of life so that family members would be more comfortable. It was noted that the delivery of care was the same as for other patients. Naomi Campbell, Non-Executive Director referred to page 21 of the agenda pack and asked whether there were plans to address the areas singled out for improvement by staff, namely interactive white boards and a menu system to allow patients a genuine choice of dishes. The Acting Director of Nursing and Governance reported that interactive white boards were being rolled out across all wards over the next two years. The Acting Director of Nursing and Governance also reported that the Head of Facilities was looking into concerns raised about the lack of menu choices. **Action: Chief Operating Officer/Head of Facilities**

	The Chair thanked Ruth Lysons, Non-Executive Director for her Board Visit report.
19/086	**Patient Experience Quarter 4 Report** (agenda item 6.1)
	The Acting Director of Nursing and Governance presented the paper and highlighted the following points: • There were no new themes or trends identified in Quarter 4. • The highest number of complaints related to the Community Mental Health Team (CMHT), but there was a reduction in both formal complaints and MP enquiries received compared with previous Quarters this year • CAMHS had received the second highest number of complaints and the most MP enquiries and PALs contacts. A significant number of these related to waiting times and contacting the service • The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continued to be exceptional performance • During Quarter 4, the Friends and Family response rate had continued to improve with 22% achieved for the quarter and for the first time over 20% achieved for each of the months in the Quarter. The main reason for the improved response rate was due to using SMS • The NHS Staff Survey results demonstrated that 61% of staff believed that feedback from patients was used to inform decisions within their directorates and departments. Whilst this was better than the national average within the Trust's peer group (54%), it was below the best national score achieved which was 71%. The Chair referred to page 26 of the agenda pack and asked for more information about the Trust's work with Commissioners around defining the Community Nursing offer. The Acting Director of Nursing and Governance reported that range of services provided by Community Nurses was different in each locality and often depended on the expectations of individual GP Practices. The objective of the work with Commissioners was to define the activities which were within the scope of the Community Nursing service and to identify those activities which were outside of the service. David Buckle, Non-Executive Director said that it was appropriate for the Trust and Commissioners to undertake the review, but cautioned that it was important that patients were not adversely impacted if it was decided that the Community Nursing team would no longer provide a particular service. Dr Buckle congratulated the Trust on increasing the Friends and Family Test response rate. Dr Buckle also commented that the NHS Staff Survey results highlighted that only 61% of staff felt that the Trust used patient feedback from patients to inform decisions and whilst this was higher than the national average for the Trust's peer group, it was nevertheless disappointing. The Acting Director of Nursing and Governance reported that the Trust was undertaking a lot of work around increasing and acting on patient feedback, including introducing Champions in each of the localities. In addition, an important component of the Quality Improvement Programme was around utilising patient and service user feedback to

	improve services. The Chief Executive reported that the Trust had also commissioned a piece of work to develop a bespoke patient experience tool. The Chief Executive pointed out that asking a recently detained patient whether they would recommend the service to their friends and family was not a very helpful question to ask. Ruth Lysons, Non-Executive Director referred to page 26 of the agenda pack which mentioned that staff directly involved in a complaint were asked to reflect on the issues raised and consider how they would change their practice and asked whether there was any follow-up action taken to ensure that this happened. The Acting Director of Nursing and Governance confirmed that this was done at the locality level. **The Trust Board:** noted the report.
19/087	**BHFT Quality Account 2018-19** (agenda item 6.2)
	The Medical Director presented the paper and reported that the Trust's External Auditors (Deloitte) were currently auditing the Quality Account 2018-19 to ensure that the contents met NHS Improvement's requirements and would be presenting the results of their audit to the Audit Committee on 22 May 2019. Ruth Lysons, Non-Executive Director confirmed that the Quality Assurance Committee had reviewed the development of the Quality Account at each of their quarterly meetings and the Committee's comments had been incorporated into the final version. **The Trust Board:** a) Considered the Statement of Directors' Responsibilities in Respect of the Quality Account 2018-19 and ensured that they were satisfied with the Quality Account in relation to the requirements detailed in the statement. b) Confirmed to the best of their knowledge and belief that they had complied with the requirements detailed in the statement in preparing the Quality Report c) Authorised the Chair and Chief Executive to sign the Statement of Responsibilities.
19/088	**Six Monthly Safe Staffing Report** (agenda item 6.3)
	The Director of Nursing and Governance presented the paper and highlighted the following points: • The main risks associated with safe staffing continued to be the significant number of registered nurse vacancies on the Acute Mental Health wards, West Berkshire Hospital Community wards and Willow House. Registered nurse vacancies reflected the national picture. • Work was on-going within the Trust around both recruitment and retention. • The number of shifts reported with less than two registered nurses had reduced since the last six monthly report (455 shifts with less than two registered nurses during this period, compared to 561 shifts in the previous six months). • Willow House was the unit with the highest number of shifts with only one

registered nurse.

- Each month, the Director of Nursing and Governance was required to make a declaration regarding safe staffing based on available information which was reported to the Finance, Investment and Performance Committee.
- Following the publication of Developing Workforce Standards in October 2018, there was also a requirement as part of the safe staffing review, for the Director of Nursing and Medical Director to confirm in a statement to their respective Boards that they were satisfied with the outcome of any assessment that staffing was safe, effective and sustainable.
- The outcome of the six monthly staffing review had indicated that for the Community wards, Willow House, Rowan, Orchid and Sorrel wards, baseline staffing with additional support to accommodate increased patient observations as and when required was continuing to provide a safe staffing model which was in line with national benchmarking and the use of available tools.
- For the Acute Mental Health wards, benchmarking and other tools, indicated that consideration as to how these wards were staffed needed to be given and that additional staffing may be required to meet acuity levels and patient need, particularly if the acuity and occupancy remained at the level seen over the last six months.
- The Acting Director of Nursing and Governance and Medical Director confirmed that all wards had senior support and mitigation in place for when there were gaps in rotas and this included the use of senior staff and the deployment of staff across wards.
- Given the current challenges in recruitment and NHS Professionals' fill rate, differing staff roles such as Assistant Psychology/Activity Co-ordinator 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 new acuity and dependency tool for mental health, learning disability and community nursing was due to be published this year. Once released, this would be used to aid assessment of workforce and planning.

David Buckle, Non-Executive Director referred to table 7 on page 169 of the agenda pack which set out the wards and the number of occasions where there had been less than two registered nurses on duty (excluding supernumerary roles of ward manager, matron, clinical development lead and advanced nurse practitioner) and commented that whilst the mitigation that had been put in place had ensured that there were no direct patient safety impacts, the staffing level was sub-optimal for both patients and staff.

Naomi Coxwell, Non-Executive Director referred to table 2 Prospect Park Hospital Wards (page 160 of the agenda pack) and asked whether the Trust was planning to close the gap between the current establishment of 231.03 (whole time equivalents) and the recommended establishment from February 2019 review of 287 (whole time equivalents).

The Acting Director of Nursing and Governance explained that the recommended establishment was a "snap shot" based on the current occupancy and acuity of the patients at Prospect Park Hospital at the time of the review. It was noted that the recommended establishment varied each day and depended on whether patients needed increased observations etc.

Mark Day, Non-Executive Director pointed out that Willow House was the unit with the highest incidence of shifts with only one registered nurse and asked whether it would be possible to expedite the move of Willow House to Prospect Park Hospital which would mitigate the risk of this being an isolated unit. Mr Day acknowledged that the move of

	Willow House was dependent on other service moves. The Chief Executive explained that the two year timescale for the Willow House move was realistic given that Prospect Park Hospital was a Public Finance Initiative building and NHS England had not yet formally approved the capital costs. The Chair said that given the national shortage of registered nurses, it was important that the Board considered how safe staffing could be maintained by deploying other staff on the wards, for example, Activity Co-ordinators and Occupational Therapists which were currently not counted towards safe staffing because the budget for these staff rested with the operational rather than nursing budgets. The Chief Executive said that the Executive Team needed to review the issue and then bring forward a paper to the Board. **Action: Deputy Chief Executive and Chief Financial Officer** The Chair said that he would welcome an opportunity for the Board to discuss the deployment of roles other than nurses on the wards, but said that if other roles were to be counted towards safe staffing, it was important that safe clinical practice was maintained. The Deputy Chief Executive and Chief Financial Officer said that it would be important to discuss any proposed changes to the skills mix on the wards with NHS Improvement and the Care Quality Commission to ensure that the Regulators were happy with the changes. Ruth Lysons, Non-Executive Director referred to the Community Nursing section which was an area that was experiencing workforce challenges together with increased demand for the service and asked whether there had been any patient safety issues because of staffing shortages. The Acting Director of Nursing and Governance said staff reported staff shortages onto the DATIX incident reporting system and this data was triangulated with other incidents to check whether there was a correlation between the staffing shortfall and incidents. It was noted that in the overwhelming majority of recorded staffing incidents there was either no or low harm to patients. **The Trust Board:** noted the Safe Staffing Declaration provided by the Acting Director of Nursing and Governance and the Medical Director.
	Executive Report (agenda item 7.0)
	The Executive Report had been circulated. The following issue was discussed further: **Productivity in the NHS** The Chief Executive reported that the Centre for Health Economics at York University had published a report into productivity in the NHS and had found that productivity had grown twice the rate of the wider economy (both public and private). However, although the NHS was treating more patients, waiting times had been getting longer since 2009/10. The Chief Executive reported that the Secretary of State for Health and Social Care was keen to use technology to further increase the level of activity and to address rising demand for services with less staff.

	The Trust Board: noted the report.
19/090	**NHS National Staff Survey Results 2018 Report** (agenda item 7.1)
	The Chair welcomed the Director of People to the meeting. The Director of Strategy and Corporate Affairs thanked the Director of People and her team for leading the work to increase the response rate to the NHS National Staff Survey by 7% compared with the previous year. The Director of People presented the paper and highlighted the following points: • Overall the results of the 2018 NHS National Staff Survey were positive and when benchmarked against other similar Community and Mental Health Trusts, the Trust came third. • The results highlighted a number of areas where the Trust had improved against last year and done well in comparison to the rest of the NHS. For 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%. • There was more work to be done, particularly in relation the following areas: wellbeing; appraisal; bullying; harassment and discrimination; feeling empowered to make changes; protected characteristics; specific services (Children and Young People Services, Mental Health Inpatients and Estates and Facilities); and equality and inclusion. • A number of actions were being taken to address the areas for improvement highlighted in the Staff Survey 2018. This included developing line manager training to ensure managers understood their role in building engagement and improving staff retention and well-being and developing the "Great Place to Work for Everyone" recruitment and retention work. The Chair referred to the workforce race equality standard results (page 181 of the agenda pack) and commented that it was particularly disappointing that the percentage of Black, Asian and Minority Ethnic (BAME) staff who believed that the Trust provided equal opportunities for career progression or promotion had dropped, especially given the Trust's focus on this area over the last year. The Director of People reported that further analysis was being undertaken to gain a better understanding about why performance in this area had deteriorated and a report would be presented to the Diversity Steering Group. The Chair said that it was important that the Trust gained a better understanding about what would make the Trust "a Great Place to Work" for all sections of the workforce. The Chair also said that it was important to build an understanding across the different protected characteristics rather than taking a silo approach. The Director of People pointed out that the Diversity Steering Group played a key role in ensuring that best practice, views and initiatives were shared across the different strands of the Trust's equalities and diversity work. Mark Day, Non-Executive Director congratulated the Senior Leadership Team for increasing the Staff Survey response rate. Mr Day referred to the section on the role of the Board (page 181 of the agenda pack) and said that it would be helpful if the Non-Executive Directors had a short "aide memoire" of the current actions the Trust was taking in

	response to the Staff Survey results which could then be shared with staff when visiting services. **Action: Director of People** The Director of People suggested that Non-Executive Directors also ask Frontline Managers what changes they had made as a result of the NHS Staff Survey results. Mehmuda Mian, Non-Executive Director commented that it was concerning that 31% of BAME staff and 22% of white staff had reported that they had experienced harassment, bullying or abuse from patients, relatives or the public and asked whether the Trust encouraged staff to report these incidence. The Director of People said that one of the questions in the Staff Survey was around reporting incidence of harassment, bullying and abuse and that the Trust scored relatively highly for this question. The Director of People acknowledged that there was further work to be done in this area. Naomi Coxwell, Non-Executive Director said that the Trust was introducing CCTV on wards and that this would support staff when reporting incidents. Ruth Lysons, Non-Executive Director asked why Estates and Facilities was one of the services targeted for additional work. The Director of People explained that she was working with the Director of Estates and Facilities to gain a better understanding about why the Staff Survey engagement score was lower in this service and other metrics, such as turnover and sickness absence rates were higher compared with other most other services. The Chief Executive also pointed out that the Estates and Facilities team was a dispersed service and a number of staff did not have access to computers and were therefore "out of the loop" in terms of communications. The Chief Executive said that the Staff Survey engagement scores for the Children and Young People Services were also less favourable and that this reflected the fact that the service had been subject to three re-organisations in a short space of time and that the local authorities tendered children's services every three years and this put significant pressure on staff. **The Trust Board:** noted the report.
19/091	**Pre-Audit Financial Summary Report - Month 12 2018-19** (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 12 Finance Report in detail; • The Trust had a strong year-end financial position. The Trust had generated a £1.5m surplus and a pre-Provider Sustainability Funding breakeven Control Total. • After accounting for Provider Sustainability Funding, Donations and Impairment charges, the Trust's statutory surplus was £6.5m. This included receipt of additional Provider Sustainability Funding allocation, including a bonus of £0.9m for achieving the £1.5m Control Total, £1.1m general allocation and £0.1m towards the Agenda for Change staff pay award pressures. • Pay costs for March 2019 were £0.6m ahead of plan with annual leave related

	Bank usage a key factor in a £300k increase in costs in Month 12. • Year-end cash balance was £3.5m higher than planned due to the brought forward Global Digital Exemplar funding and the year-end surplus. • Capital spend for the year was £9.9m which was only £0.1m below plan. The Chief Executive paid tribute to the Operational Team for their strong budget management and financial controls. **The Trust Board noted:** the following financial summary of the financial performance and results for Month 12 2018-19: **Year to Date (Use of Resource) metric:** • Overall rating 1 (plan 1 – lowest risk rating) o Capital Service Cover rating 2 o Liquidity days rating 1 o Income and Expenditure Margin rating 1 o Income and Expenditure Variance rating 1 o Agency target rating 1 **Year to Date Income Statement** (including Provider Sustainability Funding, excluding donations and impairments): • Plan: £2.4m surplus • Actual: £6.0m surplus • Variance: £3.6m better than plan £2.4m planned Control Total Provider Sustainability Funding achieved, plus year-end bonus and national reserve allocation of £2.1m. Total of £4.5m Provider Sustainability Funding supported the year-end position of £6.0m surplus. **Year to Date Cash:** £25.6m (Plan £22.1m) **Year to Date Capital Expenditure**: £9.9m versus plan of £10.0m. £1.1m of donated capital to complete the Renal and Cancer Units at West Berkshire Community Hospital.
19/092	**Month 12 2018-19 Performance Report** (agenda item 8.2)
	The Month 12 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 March 2019. The Chief Executive reported that the format of the Performance Report was changing from next month and would be replaced by a Quality Improvement True North Scorecard and report. It was noted Trust Board Discursive meeting on 11 June 2019 would be used

	to update the Board on the Quality Improvement Programme. The Deputy Chief Executive and Chief Financial Officer reported that the new Performance Report would be presented that the May 2019 meeting of the Finance, Investment and Performance Committee. **The Trust Board**: noted the report.
19/093	**Finance, Investment and Performance Committee (April 2019) Meeting (**agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee echoed the comments made by the Chief Executive (min 19/091) and said that the Trust's ability to control its finances, whilst ensuring operational integrity and safety was exemplary. Ms Coxwell paid tribute to the Deputy Chief Executive and Chief Financial Officer and his team for their accurate forecasting throughout the financial year. Chris Fisher, Chair of the Audit Committee echoed Ms Coxwell's comments and reported that the Trust's Internal Auditors had awarded the Trust the 2nd best overall rating in their year-end opinion on the Trust and that the only reason why the Trust had not received the top rating was because the Internal Auditors wanted to see the Trust sustain its performance over a longer timeframe. Ms Coxwell reported that she was looking forward to the Committee receiving the new Performance Report which would help the Committee and the Board to focus on the right areas, rather than spending time discussing monthly changes in particular metrics which did not constitute trends. Ms Coxwell also congratulated the Trust for the delivery of the Capital Programme. The Chair thanked Ms Coxwell for her update.
19/094	**Strategy Implementation Plan Update Report** (agenda item 9.0)
	The Chief Executive presented the paper which provided an overview of the development and content of the Strategy Implementation Plan for 2019-20. The paper also set out the outcomes and initiatives in the 2018-19 plan as the basis for the development of this year's plan. It was noted that significant progress had been made towards the achievement of the Trust's strategic aims during 2018-19. Ruth Lysons, Non-Executive Director referred to True North Goal 3 (to provide good outcomes from treatment and care) and commented that she would have expected a bullet point about how the Trust used feedback from patients and carers. The Chief Executive reported that the Trust was undertaking a lot of work in relation to patient experience, including developing a tool which would be a more appropriate measure of patient experience than the Friends and Family Test. It was noted that the patient care plan included input from family and carers. The Acting

	Director of Nursing and Governance said that family and carer involvement was integral to the Trust's safety planning process which had been developed as part of the Zero Suicide Programme. The Acting Director of Nursing and Governance agreed to meet with Ruth Lysons, Non-Executive Director to discuss the Trust's work around patient experience and the involvement of family and carers. **Action: Acting Director Nursing and Governance** Naomi Coxwell, Non-Executive Director referred to page 234 of the agenda pack and asked for more information about the risks posed by Microsoft's decision not to continue to support the SharePoint system which hosted the Trust's internal staff intranet site. The Deputy Chief Executive and Chief Financial Officer said that the Trust had mitigated the cyber security risk and that the risk was largely in terms of staff frustration around non-essential information not being available until the new intranet was fully functioning. **The Trust Board**: noted the report.
19/095	**Mental Health Strategy Update Report** (agenda item 9.1)
	The Director of Strategy and Corporate Affairs presented the paper and pointed that the Mental Health Strategy had been written in 2016 and would be refreshed in 2021. It was noted that a number of the Trust's strategies were due to be refreshed in the near future, including the Trust's Three Year Strategy, Quality, Equalities and Estates Strategies. The Director of Strategy and Corporate Affairs said that there was an opportunity for the Board to consider whether it would be helpful to have one overarching strategy for the Trust which would then be supported by implementation plans for the various strands. The Chair said that it was an interesting idea to have an overarching strategy supported by implementation plans and agreed that this would be considered by the Board at the Annual Strategic Planning Away Day 8 October 2019. **Action: Director of Strategy and Corporate Affairs** **The Trust Board:** noted the paper.
19/096	**Annual Report 2018-19** (agenda item 10.0)
	The draft Annual Report 2018-19 had been circulated. The Company Secretary had also tabled a list of queries and amendments from the External Auditors together with the relevant revised sections of the Annual Report. The Company Secretary reported that she would email the Board with any further amendments. **Action: Company Secretary** **The Trust Board:** approved the draft Annual Report 2018-19 for submission to NHS Improvement, subject to any final additions and amendments and delegated authority to the Chair and Chief Executive to give Board approval to the final document.

19/097	**NHS Improvement Board Declarations** (agenda item 10.1)
	The Trust Board: confirmed the positive assurance statements in relation to the Provider Licence conditions and approved the signing by the Chair and the Chief Executive of the certifications.
19/098	**Audit Committee** (agenda item 10.2)
	Chris Fisher, Chair of the Audit Committee extended an invitation to all Non-Executive Directors to attend the Audit Committee meeting on 22 May 2019 which had been convened to approve the Annual Accounts 2018-19 on behalf of the Trust Board. Mr Fisher reported that one of the areas identified in last year's annual review of the Audit Committee's effectiveness for improvement was around personal development and ensuring that Committee members had the opportunity to keep up to date with key developments. It was noted that the Committee had agreed to hold four development sessions per year starting on 31 July 2019 which would take place at 1pm before the Committee meeting started at 2pm. Mr Fisher extended an invitation to other Non-Executive Directors to attend these personal development sessions. The sessions would be facilitated by the External Auditors with one session per year facilitated by either the Internal Auditors or the Counter Fraud Specialist. Ruth Lysons, Non-Executive Director referred to page 271 of the agenda pack and commented that she was surprised that the Counter Fraud Specialist had rated the Trust "amber" in respect of travel and subsistence expenses. Mr Fisher explained that the "amber" rating reflected the volume of staff enquiries about travel and subsistence rather than any concerns about the Trust's controls. It was noted that the Audit Committee had requested that the Deputy Chief Executive and Chief Financial Officer undertake a proactive review of expenses. Mr Fisher reported that the Audit Committee had recommended that the Trust Board ratify the changes made to the Reservation of Powers to the Board and Delegation of Powers. It was noted that the changes related largely to changes in job titles and names of organisations. The Audit Committee had also recommended including a section on the Audit Committee's role in approving the Annual Accounts on behalf of the Trust Board. The Chair thanked Mr Fisher for his update. The Trust Board: a) Noted the minutes of the Audit Committee held on 24 April 2019 b) Ratified the changes as highlighted in red type to the Reservation of Powers to the Board and Delegation of Powers policy which included delegating responsibility for approving the Annual Accounts to the Audit Committee.

19/099	**Council of Governors Update** (agenda item 10.3)
	The Chair reported that the Medical Director had delivered a very interesting presentation on Healthcare innovation at the Joint Board and Council of Governors meeting on 8 May 2018. Chris Fisher, Non-Executive Director commented that he had welcomed the longer time allocated for the Non-Executive Director table discussions with Governors. The Chair reported that Adrian Edwards appointed Governor for West Berkshire Council had not been re-elected in the recent local government elections and would therefore no longer be a Governor. The Company Secretary reported that local councils would be making their appointment to outside bodies, including to the Council of Governors at their first Council meeting post-election and therefore there may be other changes to the appointed Governors. **The Trust Board:** noted the update.
19/100	**Use of the Trust Seal** (agenda item 10.4)
	The Trust Board: noted that the Trust's seal had been affixed to a 10 year lease granted to the Royal Berkshire NHS Foundation Trust for part of the 1st floor of the recently completed Cancer Care Unit at West Berkshire Community Hospital.
19/101	**Any Other Business** (agenda item 10)
	There was no other business.
19/102	**Date of Next Meeting** (agenda item 11)
	Tuesday, 9 July 2019
19/103	**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 09 July 2019
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 09/072019

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 Annual 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/HI**	Completed	
10.07.18	18/136	Strategy Summary Document 2018-21	The Trust's strategy to be distilled into three or four lines of text which would be discussed at the Board's Annual Strategic Planning Away Day in October 2018.	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
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**	An item is on the agenda for the meeting.	
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/HI**	The Annual Complaints Report on the agenda includes more narrative in relation the complaint themes.	
12.02.19	19/015	Equality, Diversity and Inclusion Strategy Update Report	Future reports to include information about BAME staff in senior clinical roles.	09.07.19	**BS**	On the agenda for the meeting.	
12.02.19	19/015	Equality, Diversity and Inclusion Strategy	Future reports to include information about the percentage of BAME staff in	09.07.19	**BS**	On the agenda for the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		Update Report	agenda for change bands 2-6.			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	19/053	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**	On the agenda for the Trust Board Away Day on 8 October 2019.	
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**	Progress on key vision metrics (quality/safety) will be tracked through "True North" Performance Scorecard. Board discussion suggested to consider the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						interplay of vision metrics versus True North and in year breakthrough objectives covered by the new and developing performance system.	
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**	As above. Considered to be a duplication with our True North Performance Scorecard, to report breakthrough objectives in vision metrics.	
14.05.19	19/085	Board Visit Report – Donnington and Highclere Wards	An update to be provided on the Head of Facilities work to provide more menu choices at West Berkshire Community Hospital	09.07.19	**DT**	At the May PLACE meeting at West Berkshire Community Hospital it was agreed that all patient food choices would be submitted a day in advance by the Housekeepers or by 10am on the day in the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						worse-case scenario. If the wards get their orders in the day before there should not be an issue and the ward staff will have a copy of the patient meal selections.	
14.05.19	19/088	Six Monthly Safe Staffing Report	The Executive Team to review whether to transfer the staffing budget for Activity Co-ordinators, Occupational Therapists to the nursing staffing budget so they could be counter towards the wards safe staffing.	09.07.19	**AG**	Centralised Prospect Park Hospital Therapy budget will be maintained as most suitable way to manage deployment of resources across Prospect Park Hospital activities (Occupational Therapy staff are not linked to individual wards). Valuable Allied Health Professional contribution to safe staffing levels in being considered by the Trust and also CQC. A business case for additional activity co-	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						ordinators on each ward is being considered.	
14.05.19	19/090	NHS National Staff Survey Results	The Director of People to produce an "aide memoire" for NEDs on the key actions being undertaken by the Trust in response to the NHS Staff Survey so they could discuss this when they visited services.	09.07.19	**CC**	Completed – the aide memoire has been circulated to members of the Board.	
14.05.19	19/094	Strategy Implementation Plan Update Report	The Acting Director of Nursing and Governance to discuss the Trust's work around patient experience and the involvement of family and carers with Ruth Lysons, Non-Executive Director.	09.07.19	**DF/RL**	The Acting Director of Nursing and Governance has contacted Ruth Lysons to arrange a discussion around patient experience and the involvement of family and carers.	
14.05.19	19/095	Mental Health Strategy Update Report	The Board to consider whether it would be better to produce an overarching strategy supported by implementation plans for the different strands at the Board's Strategic Planning Away Day on 8 October 2019.	08.10.19	**BS**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.05.19	19/096	Annual Report 2018-19	The Company Secretary to circulate any amendments to the Annual Report to members of the Board.	24.05.19	**JH**	Completed	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th July 2019
Title	**Executive Report**
Purpose	The purpose of the Report is to update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months.
Business Area	Corporate
Author	Freedom to Speak Up Guardian – Mike Craissati
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	All UK NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	N/A
SUMMARY	The Freedom to Speak up Guardian is a relatively newly established role within the NHS and was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for January – June 2019 The Freedom to Speak up Guardian will be attending the Trust Board meeting to present the report.
ACTION REQUIRED	The Trust Board is asked: a) to note the contents of this report by the Freedom To Speak Up Guardian; and b) to provide assurance that the Board supports the Government's recommendations detailed in this report

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

Freedom to Speak up Guardian - Report for Q3 & Q4 - FY 2018/19

For Information

Executive Summary

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

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. The Trust policy has been reviewed by the FTSUG and is currently with HR & JSCC.

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

The Role of the Freedom to Speak Up Guardian

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

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

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

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

Bev Searle, Director of Corporate Affairs is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, has taken on the role of nominated Non-Executive Director for Freedom to Speak Up.

Communication

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

The plan includes the following:

- Creating an animation (final voiceover in progress – to be ready for October latest)
- Presentations and attendance to managers/team meetings
- FTSU month, focused promotion across the trust during October of each year
- Production and dissemination of posters, leaflets and cards
- FTSU Teamnet page
- Market stall at Corporate Induction
- Regular session as part of junior doctor induction
- Present at Essential Knowledge for New Managers training
- Present at student nurse induction
- Present at teams meetings
- Supporting all Equality & Diversity/Network Events
- Support a team of FTSU Champions recruited from a variety of services across the Organisation (currently 10 champions).

Contribution to the Regional and National Agenda

The Guardian is a member of the National Community, Mental Health and Learning Disability FTSU Network and the Thames Valley and Wessex Regional FTSU Network.

Organisational response to staff speaking up

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

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

The NGO requests and publishes quarterly speaking up data; there have been 21 contacts or cases of concerns raised for Q's 3 and 4 2018/19. Contacts are described as 'enquiries from colleagues that do not require any further support from the FTSUG'.

Cases are described as 'those concerns raised which require action from the FTSUG'. Of the 21 the themes have included elements of bullying and harassment; communication/relationship within teams; patient safety; asking for guidance; whistleblowing process. The concerns have been resolved through varying degrees of intervention depending on what the person who is speaking up wants. Examples include signposting, a listening ear, facilitating a conversation, requesting internal and external investigation. The post holder has been able to quickly obtain support from the exec team and the senior leadership team as required.

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

BHFT FTSU Returns FY 2018/19					
	Total number of cases brought to Freedom to Speak Up Guardians and Champions	**Number of cases raised anonymously**	**Number of cases with an element of patient safety/quality**	**Number of cases with an element of bullying or harassment**	**Number of cases where people indicate that they are suffering detriment as a result of speaking up**
Q1	6	1	0	5	0
Q2	17	0	6	7	0
Q3	14	0	5	8	1
Q4	7	0	2	3	0
TOTAL	**44**	**1**	**13**	**23**	**1**

Annual returns for all UK small Trusts (up to 5,000 staff)

NHS Trust	Region	Type of trust	Annual return FY 2018/19
2gether NHS FT	South West	MH/LD/Comm	**15**
Barnet Enfield and Haringey Mental Health NHS Trust	London	MH/LD/Comm	**35**
Berkshire Healthcare NHS FT	South East	MH/LD/Comm	**44**
Black Country Partnership NHS FT	Midlands	MH/LD/Comm	**1**
Bradford District Care NHS FT	North East and Yorkshire	MH/LD/Comm	**60**
Cambridgeshire and Peterborough NHS FT	East of England	MH/LD/Comm	**69**
Cheshire and Wirral Partnership NHS FT	North West	MH/LD/Comm	**28**
Cornwall Partnership NHS FT	South West	MH/LD/Comm	**25**
Coventry and Warwickshire Partnership NHS Trust	Midlands	MH/LD/Comm	**53**
Cumbria Partnership NHS FT	North West	MH/LD/Comm	**92**
Derbyshire Healthcare NHS FT	Midlands	MH/LD/Comm	**163**
Humber NHS FT	North East and Yorkshire	MH/LD/Comm	**59**
Leeds and York Partnership NHS FT	North East and Yorkshire	MH/LD/Comm	**53**
North West Boroughs Healthcare NHS FT	North West	MH/LD/Comm	**133**
Northamptonshire Healthcare NHS FT	Midlands	MH/LD/Comm	**135**
Oxleas NHS FT	London	MH/LD/Comm	**44**
Rotherham Doncaster and South Humber NHS FT	North East and Yorkshire	MH/LD/Comm	**38**
Somerset Partnership NHS FT	South West	MH/LD/Comm	**18**
Worcestershire Health and Care NHS Trust	Midlands	MH/LD/Comm	**13**

The post holder meets with the Chief Executive, the Director of Corporate Affairs (as Exec. Lead) and the Acting Director of Nursing and Governance on a monthly basis to reflect on

concerns raised, support received and to discuss themes. This is to help triangulate knowledge and maybe able to support teams where it appears there are difficulties.

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

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

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

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

- The Government will consider how best to strengthen protection for whistleblowers within the NHS in order to support patients, families and staff to raise concerns.
- The Government is committed to ensuring that where staff speak up their concerns are investigated; and to making it more transparent in the way individual NHS trusts manage these cases. The Government will legislate, subject to Parliamentary time, to make all NHS trusts in England publish annual reports on concerns of this type.
- The National Guardian will continue to champion those who speak up through the network of Freedom to Speak Up Guardians, and will publish an independent annual report to be laid before Parliament to showcase best practice, hold the Government and the system to account and advocate for change.
- The National Guardian has started to take a more active approach in looking at how organisations handle concerns raised by staff that speak up and will continue to implement its approach for staff in NHS trusts.
- The Government will place listening to and learning from feedback at the heart of care and improving care with a new strategy to be published this year.

Recommendation

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

Author and Title:

Mike Craissati, Freedom to Speak Up Guardian

June 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th July 2019
Title	Berkshire Healthcare NHS Foundation Trust Annual Complaints Report. April 2018 to March 2019
Purpose	To inform the Board of complaints activity for year April 2018-March 2019
Business Area	Nursing & Governance
Author	Elizabeth Chapman – Head of Service Engagement and Experience Heidi Ilsley - Deputy Director Nursing Debbie Fulton – Acting Director Nursing and Governance June 2019
Relevant Strategic Objectives	True North Metrics of Good patient Experience and Harm free care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC Well-Led and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	Ethnicity information is recorded as part of the complaints monitoring process.
SUMMARY	As mandated in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, this report details complaints for period 2018/19 The Trust formally reports patient experience through our Quality Executive and Trust Board on a quarterly basis, alongside other measures including compliments, the Friends and Family Test, PALS and our internal patient survey programme. Of note within the report: • 230 formal complaints were received which is an increase on the 209 received in 2017/18. This equates to approximately 0.02% contacts that occurred in the year resulting in a formal complaint. • The 5 service lines receiving the most formal complaints were: ➢ Community mental teams (adult and older adult), with 48 complaints against 99,587 contacts (0.05% contacts) ➢ Acute adult admission wards (Rose, Snowdrop, Daisy and Bluebell) received 32 complaints against 850 admissions (3.8% admissions) ➢ CAMHS - Child and Adolescent Mental Health Services with

	25 received against 7438 referrals received and approximately 32,000 contacts (0.08% contacts/ 0.3% referrals) ➢ Out of Hours GP Services providing care in the West of Berkshire, with 17 complaints against 70,921 contacts (0.024% contacts resulting in formal complaint) ➢ Community Hospital inpatient ward received a total of 17 complaints against 1804 admissions (0.9% admissions) • The main category of reason for complaints received during 2018/19 was care and treatment with 51.74%, followed by communication and attitude of staff both with 14.78%. This is a small reduction in care and treatment as well as staff attitude complaints compared to 2017/18. There has been a slight increase in complaints associated with communication at 14.78% this year compared with 11.48% in 2017/18. • A total of 16 (7%) formal complaints received across our services were in relation to an aspect of end of life care. • There are no particularly specific themes that are able to be extracted from the complaints with many complaints being very specific to individual circumstance and concern. Although for CAMHS a number of the complaints are in relation to wait time, referrals and follow-up in part but not exclusively in relation to ADHD and ASD pathways. • 240 formal complaints were closed, of these 62% were either fully or partially upheld and 23% were not upheld. The remaining 15% were not progressed, locally resolved or investigated via a differing process. • For the third consecutive year 100% of complaints being responded to within the agreed timescales were maintained throughout 2018/19.
ACTION REQUIRED	The report is for noting at the Board

Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2018 to March 2019

Elizabeth Chapman – Head of Service Engagement and Experience
Heidi Ilsley - Deputy Director Nursing
Debbie Fulton – Acting Director Nursing and Governance
June 2019

Contents

1. Introduction and executive Summary

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

This report looks at the application of the Complaints Process within the Trust from 1st April 2018 to 31st March 2019 and uses data captured from the Datix incident reporting system.

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

- Ensuring processes are in place to resolve potential and verbal complaints before they escalate to formal complaints. These include developing systems and training to support staff with local resolution;

- An awareness of other services such as the Patient Advice and Liaison Service (PALS – internal to the Trust) and external services including Healthwatch and advocacy organisations which ensure that the NHS listens to patients and those who care for them, offering both signposting and support;

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

When people contact the service, the complaints office will discuss the options for complaint management. This gives them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint informally.

During 2018/19 there were a total of 230 formal complaints received which is an increase on the 209 received in 2017/18. The number of formal complaints closed was 240, of these 62% were either fully or partially upheld and 23% were not upheld. The remaining 15% were not progressed, locally resolved or investigated via a differing process. Against the approximate one million contacts the 230 complaints received equate to a 0.02% contacts resulting in a formal complaint.

For the third consecutive year 100% of complaints being responded to within the agreed timescale was maintained throughout 2018/19.

The number of local resolution complaints that the Patient Experience team have been notified about has reduced to 126 in 2018/19, from 205 received in 2017/18. Information on local resolution complaints is captured in real time on a dashboard that is accessible to the Locality and Clinical Directors. There have been 20 informal complaints logged, which is the same as last year.

The five services with the highest number of formal complaints received were:

- Community mental teams (adult and older adult), with 48 complaints against 99,587 contacts (0.05% contacts)

- Acute adult admission wards (Rose, Snowdrop, Daisy and Bluebell) received 32 complaints against 850 admissions (3.8% admissions)

- CAMHS - Child and Adolescent Mental Health Services with 25 received this is against 7438 referrals received and approximately 32,000 contacts (0.08% contacts/ 0.3% referrals)

- Out of Hours GP Services providing care in the West of Berkshire, with 17 complaints this is against 70,921 contacts (0.024% contacts resulting in formal complaint)

- Community Hospital inpatient ward received a total of 17 complaints against 1804 admissions (0.9% admissions)

There were no formal complaints for Rowan Ward, Ascot Ward, Willow House and Sorrel ward.

The main category of reason for complaints received during 2018/19 was care and treatment with 51.74%, followed by communication and attitude of staff both with 14.78%. This is a small reduction in care and treatment as well as staff attitude complaints compared to 2017/18 where the care and treatment was 57.89% and attitude of staff was 16.75%. There has been a slight increase in complaints associated with communication at 14.78% this year compared with 11.48% in 2017/18.

A total of 16 (7%) formal complaints received across our services were in relation to an aspect of end of life care.

There are no particularly specific themes that are able to be extracted from the complaints received within each of these categories; many complaints are very specific to individual circumstance and concern. Although for CAMHS a number of the complaints are in relation to wait time, referrals and follow-up in part but not exclusively in relation to ADHD and ASD pathways. Further detail with regard to the services with higher numbers of complaints is detailed within the report.

Nationally, complaint statistics are reported on a quarterly and annual basis, with 2018/19 annual reported data not available until September 2019. Nationally formal complaints relating to care and treatment accounted for 26.2% of the complaints received in 2017/18 whilst within Berkshire Healthcare the percentage was 51.74%. Data available on Model hospital for 2017/18 demonstrated that the Trust was below the national and peer median in terms of complaints received when compared to number of complaints per 1000wte staff and per 100M turnover.

2. Complaints received – activity

2.1 Overview

During 2018/19 a total of 230 formal complaints were received into the organisation**.** Table 1 evidences the number of formal complaints by service and compares them to the previous financial year.

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

Table 1: Formal complaints received

	2018/19							2017/18					
Service	Q1	Q2	Q3	Q4	**Total**	% of Total	Change	Q1	Q2	Q3	Q4	Total	% of Total
CMHT/Care Pathways	16	11	10	9	**46**	20	↑	11	11	12	10	44	22.08
CAMHS - Child and Adolescent Mental Health Services	5	6	8	6	**25**	10.87	↓	7	9	6	4	26	14.29
Crisis Resolution & Home Treatment Team (CRHTT)	2	5	3	4	**14**	6.09	↓	4	6	4	6	20	9.09
Acute Inpatient Admissions – Prospect Park Hospital	9	12	8	3	**32**	13.91	↑	4	9	4	6	23	11.04
Community Nursing	1	1	3	3	**8**	3.48	↓	4	4	1	3	12	5.84
Community Hospital Inpatient	6	7	1	3	**17**	7.39	↑	3	1	1	6	11	3.25
Common Point of Entry	3	3	2	4	**12**	5.22	↑	2	0	1	2	5	1.95
Out of Hours GP Services	4	5	7	1	**17**	6.96	↑	2	2	3	2	9	4.55
PICU - Psychiatric Intensive Care Unit	0	0	0	0	**0**	0	No change	0	0	0	0	0	0
Minor Injuries Unit (MIU)	1	1	2	0	**4**	1.74	↓	0	2	1	2	5	1.95
Older Adults Community Mental Health Team	1	1	0	1	**3**	1.3	↓	0	1	1	3	5	2.39
13 other services in Q4	12	11	13	16	**52**	22.6		5	14	19	11	49	23.44
Grand Total	60	63	57	50	**230**			42	59	53	55	209	

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT) and Community Nursing have decreased compared with the previous year. Acute Inpatient Admissions (Prospect Park Hospital), Community Hospital Inpatients, Out of Hours GP Services and the Common Point of Entry experienced increases in the number of formal complaints received. Whilst Community Mental Health Teams, CAMHS, Minor Injury Unit and the total number received by other services across the organisation have remained comparable with 2017/18

Table 2 below details the main themes of complaints and the percentage breakdown of these.

Table 2: Themes of Complaints received

Category of Complaint received	Number of complaints	Percentage of total complaints
Abuse, Bullying, Physical, Sexual, Verbal	4	1.74%
Access to Services	11	4.78%
Attitude of Staff	34	14.78%
Care and Treatment	119	51.74%
Communication	34	14.78%
Confidentiality	7	3.04%
Discharge Arrangements	2	0.87%
Discrimination, Cultural Issues	1	0.43%
Financial Issues/Policy	1	0.43%
Management and Administration	1	0.43%
Medical Records	4	1.74%
Medication	5	2.17%
Other	1	0.43%
Patients Property and Valuables	2	0.87%
Support needs	2	0.87%
Waiting Times for Treatment	2	0.87%

The main theme of complaints received during 2018/19 was care and treatment with 51.74%, followed by communication and attitude of staff both with 14.78%. This is a small reduction in care and treatment as well as staff attitude complaints compared to 2017-18 where the care and treatment was 57.89% and attitude of staff was 16.75%. There has been a slight increase in complaints associated with communication at 14.78% this year compared with 11.48% in 2017/18.

There have been no specific themes identified with regard to complaints received although it is worthy of note that both the complaints about wait time and 3 of the 11 complaints relating to access to services were in relation to CAMHS services although only 2 of the total 34 complaints related specifically to communication was about our CAMHS services; this would appear to demonstrate that work undertaken around support to 'waiters' and the communication to these services users and their carers is effective although a number of the complaints that are received across all categories are in relation to waiting times, referral and follow-up.

The complaints raised in relation to attitude of staff are spread across a range of services those services with 3 or more were mental health Inpatients, CMHT, CRHTT and sexual health services although none were specific to 1 ward/ location. CRHT West received the most (4). There is on-going work with CRHTT staff around communication/ telephone handling to support improvement.

The complaints in relation to communication again cover a broad range of services, Common point of Entry (6), CMHT (7) and Westcall (4) received the highest numbers although there were no specific themes.

Complaints received in relation to care and treatment are wide ranging and focus very much on individual circumstances and therefore it has not been possible to pick up particular themes or areas for specific action by services in relation to these.

The Trust Business Group structure (also known as reporting locality) has previously been used as the main mechanism for reporting complaint information; however, as this may differ from the geographical locality of where the service is based, it brings more value to report the latter. The following tables show a breakdown for 2018/19 of the formal complaints that have been received and where the service is based.

2.2 Mental Health service complaints

Table 3 below details the mental health service complaints received, this shows that the main services where formal complaints are attributed to are CMHT and Adult acute Admissions wards. 43.47% of the complaints were about care and treatment (an increase from 29.54% of complaints in 2017/18). Complaints about adult mental health services accounted for 55% total complaints received in 2018/19.

Table 3: Mental Health Service complaints

Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot & Maidenhead	Wokingham	Grand Total
Adult Acute Admissions		32					32
CMHT/Care Pathways	6	12	6	6	6	10	46
CMHTOA/COAMHS - Older Adults Community Mental Health Team						3	3
Common Point of Entry	2	3	1	1		5	12
Criminal Justice Liaison and Diversion Service	1						1
Crisis Resolution & Home Treatment Team (CRHTT)	1	8	1	1	1	2	14
IMPACTT		1				1	2
LDS Community Patients		1					1
Learning Disability Service Inpatients		1					1
Neuropsychology		2					2
Older Peoples Mental Health (Ward Based)		3					3
Psychological Medicine Service		1	3				4
Talking Therapies			1	1		1	3
Traumatic Stress Service		2					2
Grand Total	10	63	12	9	8	22	127

2.2.1 Mental Health Complaints by service

The top 3 adult mental health services receiving formal complaints in 2018/19 are detailed further below. Older adult services are also detailed separately as they have been in previous years.

Community Mental Health teams (CMHT)

As detailed in table 4, Within CMHT services most complaints were received by Reading (27%) and Wokingham (22%) teams. For Reading this is a reduction on last year whilst for Wokingham this is an increase although review of the complaints does not show any high level themes amongst these. To

provide some context the total working age and older adult's contacts during 2018/19 were 99,587 and around 4,951 patients were discharged. The percentage of complaints against contacts was therefore 0.05% and against number of discharges was 0.97%.

Table 4: CMHT complaints

	Locality of Service						
	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Care and Treatment	1	5	3	4	3	4	20
Clinical Care Received	3			2		1	6
Communication		2			1	3	6
Confidentiality		1	2		1		4
Attitude of Staff						2	2
Healthcare Professional		1					1
Medication		1					1
Inaccurate Records	1						1
Abuse, Bullying, Physical, Sexual, Verbal			1				1
Written to Patients	1						1
Other		1					1
Financial Issues/Policy					1		1
Failure/Delay in specialist Referral		1					1
Grand Total	6	12	6	6	6	10	46

Adult mental health inpatients

As detailed in table 5, 53% of complaints received by the acute adult admission wards were about clinical care/ care and treatment; these were individual to specific patient circumstances.
There were no complaints received in relation to Sorrel ward in 2018/19.

Table 5: Adult mental health inpatient ward complaints

	Location of complaint					
Main subject of complaint	**Bluebell Ward**	**Daisy Ward**	**Non ward specific**	**Rose Ward**	**Snowdrop Ward**	**Grand Total**
Care and Treatment	3	4	5	1		13
Attitude of Staff		2	1		2	5
Clinical Care Received	2		1		1	4
Communication	1		1			2
Support needs	2					2
Abuse, Bullying, Physical, Sexual, Verbal				1		1
Discharge Planning		1				1
Lost Property				1		1
Patients Property and Valuables				1		1
Verbal to Patients				1	1	2
Grand Total	8	7	8	5	4	32

CRHTT

Table 6 below demonstrates that there were 14 complaints received about CRHTT in 2018/19; this is a reduction on the 20 received in 2017/18. As with 2017/18 a higher percentage were in relation to services received in the West of the county (71%) and predominantly Reading where the main hub for the west is located. The complaints for Reading were all related in some way to advice / care and treatment. Actions are in train within CRHTT regarding support for staff with telephone communication and holding difficult conversations. There were 22,910 contacts into CRHTT in 2018/19 so the 14 complaints relate to 0.06% of all contacts resulting in a formal complaint.

Table: 6 CRHTT complaints

	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services		1					1
Attitude of Staff	1	2	1	1			5
Care and Treatment		5			1		6
Discrimination, Cultural Issues						1	1
Medical Records						1	1
Grand Total	1	8	1	1	1	2	14

Older adult services

As detailed in table 7, formal complaints about the Older Adults Community Mental Health Team were 3 in number and all related to the Wokingham based service. There were 255 discharges for the Wokingham team last year, making a complaint rate of 1.17%.

Table 7: Older Adults Community Mental Health Team complaints

	w okingham	Grand total
Attitude of staff	1	1
Communication	2	2
Grand Total		3

The complaints for the older adult mental health inpatient wards were around physical health monitoring and documentation (handover from other Trusts and information sharing with the ward).

Table 8: Older Adults mental health inpatient wards complaints

	Location of complaint	
	Orchid Ward	Grand Total
Care and Treatment	1	1
Clinical Care Received	2	2
Grand Total	3	3

2.3 Community Health Service Complaints

29% of all complaints received into the organisation in 2018/19 were about community health services.

Table 9 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (17), Westcall out of hours services (17) and District Nursing (10 including 2 out of hours nursing). 59% of the total complaints were about care and treatment. There were no particular themes with complaints raised around specifics of care delivery and patient's individual circumstances although 11 of the 16 end of life complaints were in relation to community health services.

Table 9: Community Health Service Complaints

	Locality of Service						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Assessment and Rehabilitation Centre			1				1
Community Dental Services					1		1
Community Hospital Inpatient		6	1	9	1		17
Continence						1	1
District Nursing	1	3		2	1	1	8
District Nursing Out of Hours Service		1			1		2
Integrated Pain and Spinal Service		1		1			2
Minor Injuries Unit				4			4
Multiple Sclerosis			1		1		2
Out of Hours GP Services		12		5			17
Outpatients	1						1
Parkinson's - Specialist Nursing					1		1
Physiotherapy - Rehabilitation			1				1
Physiotherapy (Adult)	1			2			3
Physiotherapy Musculoskeletal	1						1
School Nursing					1		1
Sexual Health			4				4
Grand Total	4	23	8	23	7	2	67

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2018/19 are detailed further below.

Community Nursing

As detailed in table 10, eight of the ten complaints were regarding care and treatment, review of these has not identified any themes within these.

Table 10: Community Nursing Service complaints

	Locality of Service					
Service and main subject of complaint	**Bracknell**	**Reading**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
District Nursing	**1**	**3**	**2**	**1**	**1**	**8**
Care and Treatment		3	2	1	1	7
Attitude of Staff	1					1
District Nursing Out of Hours Service		**1**		**1**		**2**
Care and Treatment				1		1
Attitude of Staff		1				1
Grand Total	1	4	2	2	1	10

There were no complaints received directly to the Trust about the Community Nursing Service in Slough (one complaint was received via the CCG who led the complaint).

A co-created and facilitated group with the aim of 'getting to know your local Community Nursing Service', primarily for carers in the East of Berkshire was established last year, this provided patient education sessions and although attendees were small in number positive feedback was received and catheter clinics were introduced on the back of feedback. This group is currently being re-evaluated.

Community Health Inpatient Wards

Table 11: Community Health Inpatient Ward Complaints

	Location of complaint						
Main subject of complaint	**Donnington Ward**	**Henry Tudor Ward**	**Highclere Ward**	**Oakwood Unit**	**Jubilee Ward**	**Windsor Ward**	**Grand Total**
Care and Treatment	6	1	1	4		1	13
Attitude of Staff			1		1		2
Medication				1			1
Communication	1						1
Grand Total	7	1	2	5	1	1	17

The Community Inpatient wards saw an increase in the number of complaints received in comparison with 2017/18, from 11 to 17, this was against 1804 admissions (0.9% admissions resulting in a complaint) . Care and treatment continues as the main subject for complaints received about Community Inpatient wards. West Berkshire Hospital wards (Donnington and Highclere) account for 41% of these. 4 of the complaints for Donnington and Highclere wards relate to end of life although the detail of these is different in each case.
For a number of the community ward complaints related to communication between differing services and organisations.

Ascot Ward did not receive any formal complaints during 2018/19.

Westcall Out of Hours GP Service

As detailed in table 11 Westcall received 17 complaints during 2018/19 this was against 70,921 contacts which were made during the year this accounts for 0.02% contacts. The complaints for the out of hours GP service were found to be about the attitude and communication from Doctors, particularly if there has been a difference in opinion between the patient/carer and clinician, and where further care was given by another healthcare provider. There were also complaints about the time of night that patients were given a call back by a Doctor, in that it was too late and the patient had gone to bed.

Table 12: Westcall Out of Hours GP Service complaints

	Reading	West Berks	Grand Total
Out of Hours GP Services	12	5	17
Access to Services		1	1
Attitude of Staff	2		2
Care and Treatment	3	4	7
Communication	5		5
Medication	2		2
Grand Total	12	5	17

2.4 Children, Young People and Families

Table 13 below details the children, young people and families' complaints received, with 13.5% of all complaints received attributable to these services. The main services where formal complaints are attributed to are our CAMHS services.

Table 13: Children, Young People and Family Service Complaints

	Locality of Service						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot & Maidenhead**	**Wokingham**	**Grand Total**
CAMHS - Child and Adolescent Mental Health Services	3	12	2	2	5	1	25
Children's Occupational Therapy - CYPIT					1		1
Children's Physiotherapy - CYPIT				1			1
Children's Speech & Language Therapy - CYPIT						1	1
Health Visiting				1		1	2
School Nursing		1					1
Grand Total	3	13	2	4	6	3	31

CAMHS

Child and Adolescent Mental Health Services received 25 complaints in 2018/19 this is comparable with 26 received in 2017/18 and is against 7438 referrals received and approximately 32,000 contacts (0.08% contacts/ 0.3% referrals)

The theme for CAMHS complaints has been around delays in specialist referrals and clinical care, specifically following diagnosis of ADHD. Historically, the majority of complaints have been about waiting times and access to treatment. CAMHS have seen a reduction in complaints about waiting times due to the introduction of an initial assessment through the Trust Common Point of Entry service and the introduction of a Care of Waiters process, though complaints have been raised regarding delays in meetings taking place and timely referrals to other services. The CAMHS Urgent Care Service continues to bring positive clinical outcomes for young people.

Table 11: CAMHS Complaints

	Locality of Service						
Main subject of complaint	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Choice and Flexibility of Access					1		1
Clinical Care Received	1	5			1		7
Communication with Other Organisations		1					1
Failure/Delay in specialist Referral	1	2	2		2		7
Attitude of staff; Healthcare Professional		1			1		2
Inaccurate Records		2					2
Long Wait for an appointment		1		1			2
Unable to Access				1		1	2
Information; written to Patients	1						1
Grand Total	3	12	2	2	5	1	25

Table 12: Complaints about other services

	Locality of Service		
Service	**Bracknell**	**Reading**	**Grand Total**
Admin teams & office based staff	1		1
Corporate/Policy	1	2	3
Medicines Management		1	1
Grand Total	**2**	**3**	**5**

3 Complaints closed – activity

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). Table 13 shows the outcome of complaints.

Table 13: Outcome of closed formal complaints

	2018-19						Change	2017-18					
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of Total**		**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of Total**
Case not pursued by complainant	0	0	2	2	4	1.67	No change	1	1	1	1	4	1.95
Consent not granted	2	2	3	2	9	3.75	↑	0	1	0	4	5	2.44
Local Resolution	0	5	10	3	18	7.5	↑	3	3	6	2	14	6.83
Managed through SI process	0	2	0	1	3	1.25	↓	0	Only report in Q4 -4			4	1.95
Referred to other organisation	0	0	0	0	0	0	↓	0	1	0	1	2	0.98
No further action	1	0	0	0	1	0.42	↓	0	0	2	1	3	1.46
Not Upheld	13	11	15	16	55	22.92	↑	6	20	7	7	40	19.51
Partially Upheld	25	26	36	19	106	44.17	↑	18	19	22	28	87	42.44
Upheld	12	15	12	5	44	18.33	↓	8	18	10	10	46	22.44
Grand Total	53	61	79	47	240			36	63	48	58	205	

The national reporting statistics (including GP and dental service complaints) for 2017-18 showed that:

Upheld	34.9%
Partially Upheld	22.7%
Not Upheld	42.4%

The Trust has a lower percentage of complaints that are upheld or not upheld, with a greater proportion found to be partially upheld when compared to the national statistics; complaints often cover a number of services and issues which are investigated as individual points which contributes to this. During 2018/19 the process of apportioning an outcome for an investigation was changed and the Investigating Officer now apportions the outcome to their investigation.

4 Complaints as a mechanism for change – learning

Where complaints are upheld or partially upheld learning is shared with individuals, teams and the wider organisation where applicable; some examples of learning from complaints include:

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

What we were told: Wait times for ADHD are too long and families need support
What we have done: We are working closely with a service called Parenting Special Children who are providing re-assessment workshops for ADHD and are opening up their parenting courses for ADHD and sleep for children and young people on wait list. We are also recruiting a number of

emotional well-being practitioner trainees who will be able to provide some therapeutic interventions to children and young people whilst they are waiting ADHD and ASD assessments.

What we were told: Staff lacked compassion during telephone contact with CRHTT
What we have done: Telephone calls are used during clinical supervision to support learning with individuals and where appropriate the wider team. Staff are receiving training in handling of telephone calls where the caller is very distressed.

What we were told: The Daughter of a patient was concerned that staff on an inpatient ward did not appear to be concerned about a mother's pain. Whilst there was some evidence in the notes regarding pain, there was no written evidence of the patient being asked about her levels of pain through her stay.
What we have done: Pain charts are now used in conjunction with pain care plans to capture the patients experience and perspective of their pain is regularly documented to ensure that appropriate medication is always provided.

What we were told: There was no named contact for patient whilst their care coordinator was off sick resulting in a two week gap in care.
What we have done: To address this issue a new Standard Operating Procedure (SOP) for caseload management for CMHTs has been developed. The guidance contained within this SOP has been designed to ensure that all staff working within the Trust's Community Mental Health Teams (CMHTs) are fully informed about what is expected in relation to periods of planned and unplanned absence

What we were told: There was a lack of consistency around catheter care in the community.
What we have done: In addition to a review of the management for this specific patient:

- A continence and catheter pathway workshop was held as part of Community Nursing review.
- It has been acknowledged that catheters can have a huge impact on a patients' life and that Multi-Disciplinary working and improved communication could improve patient experience. A meeting is being arranged to include GP, Community Nursing and the Continence Team to explore this further.
- Introduction of a catheter passport across Trusts-to improve communication on transition of care, with clear plan for future care to be adopted by Frimley and Berkshire Health Care Trusts.
- Catheter clinic introduction-as an alternative option for patients who are not housebound.
- Review of the Trust policy flow chart, actions and responsibilities around catheter care to ensure consistency across the Trust in conjunction with the Continence Team.

5 Parliamentary and Health Service Ombudsman

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process. The table below shows the 2018/19 Trust activity with the PHSO.

Table 16: PHSO activity

Month open	Service	Month closed	Current Stage
Aug-17	Talking Therapies	Apr-18	Not Upheld
Mar-18	Older Adults Community Mental Health Team	Oct-18	Not Upheld
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	Common Point of Entry (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

The PHSO published a report on complaints about the NHS in England from October to December 2018. This report shows that 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. The data would indicate nationally that 24% complaints referred to PHSO went on to be investigated. In the same period the Trust had 66% (2 of 3) of the complaints referred progressing to investigation, although in Q2 this figures was 33% (1 of 3) due to very small numbers it is not possible to draw any real conclusions from this data.

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, 8%) or partly upheld (154, 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.0

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, including changing procedures or training staff;
- 33 other actions to put things right. For example, asking a GP practice to correct errors in medical records.

6 Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they contribute to, but are not the lead organisation (such as NHS England and Acute Trusts). Table 17 below details this activity.

Table 17: Formal complaints led by other organisations

Organisation	Summary of element of complaint relating to Berkshire Healthcare services
Acute Trust	Information contained within a report from CPE
	Parents were not happy that clinicians did not recognise that their child wasn't putting on weight
	Concern about catheter care from the District Nursing Service
CCG	Care from the WestCall Primary Care Centre
East Berkshire CCG	CRHTT, call to patient not made
	District Nursing and provision of their service
	District Nursing complaint regarding the pressure of a mattress not being set properly and not being adequately managed
Frimley Health NHS Foundation Trust	Community hospital inpatient and transfer to acute 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
	Care on Henry Tudor Ward
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	Westcall potential misdiagnosis
	WestCall, call to patient not made
	WestCall, clarification on what service offered patient overnight
	NHS 111 advised a home visit however WestCall telephoned the patient
SCAS/111	Waiting time for a visit from Westcall Services
	Patient did not get a call back from WestCall following a call with 111
South, Central & West Commissioning Support Unit	Patient not happy about a change in the waiting time for Occupational Therapy

7 Complaints training

The Complaints Office offers a programme of complaint handling training which is accessible through the Learning and Development Department. In addition, bespoke sessions are available when requested to teams or service areas that are having specific challenges. As a result of a formal complaint, a session on complaint handling has been arranged for CAMHS East and West, and Podiatry with requests from further services for 2019/20.

The course content is adapted following feedback from staff and people who have used the complaints process with the training being well received.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets on a monthly basis and the Complaints Office feeds information into this group. There were 16 formal complaints forwarded to the MRG during 2018/19 (this equates to 7% total formal complaints received from across services being in relation to end of life care)

The Medical Director is also sent a copy of complaint responses involving a death before they are signed by the Chief Executive.

Table 18: Complaints forwarded to TMRG

Service	Number of complaints
Community Hospital Inpatient	5
District Nursing	3
Psychological Medicine Service	1
Older Peoples Mental Health (Ward Based)	1
District Nursing Out of Hours Service	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Out of Hours GP Services	1
Adult Acute Admissions	1
CMHT/Care Pathways	1
Assessment and Rehabilitation Centre	1
Grand Total	16

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 July 2019
Title	**Quality Assurance Committee – 21 May 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 21 May 2019
Business Area	Corporate
Author	Julie Hill, Company Secretary for Ruth Lysons, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 21 May 2019 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 21 May 2019, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair) Mehmuda Mian, Non-Executive Director David Buckle, Non-Executive Director Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Debbie Fulton, Acting Director of Nursing and Governance Amanda Mollett, Head of Clinical Effectiveness and Audit David Townsend, Chief Operating Officer
In attendance:	Julie Hill, Company Secretary Rosemary Martin, Lead for Community & Specialist Nursing (East) *(present for agenda item 6.2)* Sara Fantham, Head of Clinical Quality & Governance & Interim Clinical Director, Adult Physical Health East Berkshire *(present for agenda item 6.2)*

1 Apologies for absence and welcome

The Chair welcomed everyone to the meeting.

Apologies had been received from: Julian Emms, Chief Executive.

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 19 February 2019

The minutes of the meeting held on 19 February 2019 were confirmed as an accurate of the proceedings.

4.2 Matters Arising Log

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

a) Carer's Strategy

The Chair noted that a presentation on the Carer's Strategy was due to be presented at the Joint Non-Executive Directors and Council of Governors

meeting on 19 July 2019 and suggested that it would also be helpful for the Board to have a private discussion about the development of the Carers Strategy.

The Chief Operating Officer reported that the presentation at the Joint Non-Executive Director and Council of Governors meeting would set the scene and would give an overview of the Trust's current work with carers together with a summary of the plans going forward.

The Chair suggested that following the meeting on 19 July 2019, if the members of the Committee had further issues they would like to discuss, this could be added to either the Committee's agenda or the next In Committee Trust Board meeting.

Action: Chief Operating Officer/Company Secretary

b) Children's Eating Disorder Review

The Chair asked whether there would be an update on the outcome of the Children's Eating Disorder review at the next meeting.

The Chief Operating Officer reported that the Trust was still reviewing the model with Commissioners and that the update report may have to be presented to the November 2019 meeting.

The Chair asked for assurance that the Trust was managing the safety concern around children and young people waiting for the Eating Disorders Service.

The Chief Operating Officer reported that the Trust had received short term investment from the Commissioners to manage the waiting list and that the review of the Children's Eating Disorder service was around creating a long-term sustainable model for the service.

c) Board Visits to Services

The Chair noted that no date had been set for a Board level discussion about the Board Visits in the light of the Quality Improvement Programme.

The Company Secretary reported that she had originally scheduled the item on the agenda of the June 2019 Trust Board Discursive meeting, but this meeting was now devoted to a full day session on the Quality Improvement Programme. The Company Secretary reported that an item would be put on the agenda for the July 2019 Trust Board In Committee meeting.

Action: Company Secretary

d) Diabetes Services in Deprived Communities

The Chair thanked the Medical Director for his update in the action log but said that she was also concerned that people with Diabetes in deprived communities were not engaging with Diabetes services. The Chair said that she accepted that the Trust did not have a public health role, but suggested that the Trust could raise the issue with the Integrated Care System partner organisations.

The Chair agreed to have a discussion with the Chief Executive about how best to address the issue with the Integrated Care System partners.

Action: Chair/Chief Executive

e) Physical Health Checks

The Chair commented that the Physical Health Check summary which was attached at appendix 2 of the action log provided a helpful overview which was also relevant for the agenda item on NEWS2 Safety Alert which was elsewhere on the agenda.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Quality Concerns Status Report

The Acting Director of Nursing and Governance presented the paper and reported that updates had been provided in respect of the following Quality Concerns:

- No 1 – Nursing and Therapy Vacancies – updated to reflect strategy focus on retention, staff well-being and flexible working
- No 5 – Mental Health Act Compliance – revised to reflect the current situation and the actions which had been developed to mitigate the concern
- No 6 – Mental Health Bed Occupancy – updated to reflect that the revised project had been through the Quality improvement Strategic filter and was agreed as “mission critical”

The Acting Director of Nursing and Governance reported that the Quality Executive Group meeting held on 13 May 2019 had agreed that the Reading Community Mental Health Team quality concern (No 7) would be reviewed further next month, with a view to removing it if the service remained in a stable position.

David Buckle, Non-Executive Director commented that recent media reports had highlighted that the number of overseas nurses coming into the United Kingdom was down by 90%.

The Acting Director of Nursing and Governance said that the national shortage of nurses was one of the key reasons why the Trust was focussing on retaining its current staff.

The Chair reported that the Finance, Investment and Performance Committee (which she was a member of) was supporting the Trust’s retention work.

The Chair referred to the Mental Health Act Office quality concern and reported that in her capacity as a Mental Health Act Manager, she had concerns around the management of the Mental Health Act Managers rota. Mehmuda Mian, Non-Executive Director and a Mental Health Act Manager echoed the Chair’s comments. The Acting Director of Nursing and Governance agreed to raise the issue with the Trust Chair.

Action: Acting Director of Nursing and Governance

The Chair asked about the Trust’s work to improve the interface between the Common Point of Entry, Crisis Resolution Home Treatment Team and the Community Mental Health Team.

The Acting Director of Nursing and Governance said that improving the internal interfaces between the different mental health services was integral to

the Trust's Mental Health Pathways work (a presentation was given at the May 2019 Trust Board In Committee meeting).

The Committee noted the report.

5.1 Serious Incidents Report – Quarterly Report

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

- For Quarter 4, there were initially 13 Serious Incidents with 2 currently downgraded;
- Trends and learning from incidents closed within the Quarter were detailed within the report together with the actions being taken to address any incident themes.

The Chair referred to page 54 of the agenda pack and asked whether the change in coronial law which changed the standard proof for a conclusion of 'suicide' or 'unlawful killing' in an inquest from 'beyond reasonable doubt' to 'on the balance of probabilities' which came into effect in July 2018 had impacted on the number of deaths by suicide in the Trust.

The Acting Director of Nursing and Governance said that the change in the inquest definition had not impacted on the Trust. The Medical Director pointed out that the figures in the report related to people who had contact with the Trust's services and that the majority of deaths by suicide occurred in people who had no contact with the Trust.

Mehumda Mian, Non-Executive Director referred to page 58 of the agenda pack and noted that the Physical Health Wards had undertaken a number of actions to improve communication with family members and carers, such as the introduction of a 72 hours checklist and asked how such initiatives and learning were disseminated across the Trust.

The Acting Director of Nursing and Governance reported that Ward Managers and Matrons met quarterly and shared good practice. It was also noted that the Patient Safety and Quality meeting minutes were presented to the Quality Executive Group meetings and that this was another way in which learning was disseminated.

The Committee noted the report.

5.2 a) Learning from Deaths Quarterly Report

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

- 891 deaths were recorded on the clinical information system (RiO) during Quarter 4 where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 75 met the criteria to be reviewed further. All 75 deaths were reviewed by the Mortality Review Group. 27 deaths were closed with no further action; 6 deaths were classified as "Serious Incidents" requiring further investigation; and 42 deaths required 'second stage' review (using an initial findings review/structured judgement review methodology);

- During Quarter 4, the Mortality Review Group had reviewed the findings of 36 second line review reports of which six related to patients with a learning disability.
- Of the 36 case reviews received by the Mortality Review Group, none were escalated as potential lapses in care for root cause analysis through the Serious Incident process in Quarter 4.
- One lapse of care had been confirmed in Quarter 4 following escalation by the Mortality Review Group in Quarter 3. The death occurred in September 2018 and was reported initially following a patient transfer. A post infection control second line review was requested and received by the Mortality Review Group in November 2018 where it was escalated to a Serious Incident and had formally been confirmed as a lapse in care in March 2019.
- In Quarter 4, the Trust Mortality Review Group identified End of Life Care as a key theme for learning from case reviews.
- The format of the report had been revised and now included a table showing a summary of deaths and reviews completed in 2018/19.

Mehmuda Mian, Non-Executive Director referred to the section on future quality improvements (page 105 of the agenda pack) and asked whether other Trusts employed a Designated Family Liaison/Bereavement Support member of staff.

The Medical Director said that he was aware that some Trusts, for example Southern Health NHS Foundation Trust had such a post.

David Buckle, Non-Executive Director said that the Learning from Deaths Report was very comprehensive and commented that he was assured by the Trust's mortality review systems and processes.

b) Care Quality Commission Review of the First Year of NHS Trusts Implementing the National Learning from Deaths Guidance

The Medical Director reported that the Care Quality Commission had undertaken a review of the first year of NHS Trusts implementing the national guidance. It was noted that the Trust had been noted as an exemplar for its leadership on learning from deaths, quality of investigations and the involvement of families and carers.

On behalf of the Committee, the Chair congratulated the Medical Director on his leadership of the mortality review systems and processes.

The Chair referred to the case studies in the report and commented that Nottinghamshire Healthcare NHS Foundation Trust offered families a choice about how they wanted to be communicated with and about the degree to which they wanted to be kept informed.

The Acting Director of Nursing and Governance pointed out that the Trust already did this as part of the Duty of Candour process. This included asking family and carers whether they wanted a face to face meeting to go through the investigation report or would prefer to receive a summary of the report's findings etc.

The Chair referred to the section on learning, next steps and recommendations (page 132 of the agenda pack) and commented that the points raised were largely administrative rather than from the point of view of patients.

The Medical Director explained that as the regulator, the Care Quality Commission wanted to ensure that NHS Provider organisations had robust mortality review systems and processes in place.

The Committee noted the report.

5.3 Investigation regarding the processing of Mental Health Act Community Treatment Order Paperwork in the Trust Report

The minutes of this agenda item will be considered as part of the In Committee meeting.

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

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

- The WestCall Out of Hours Service Care Quality Commission Inspection was undertaken in July 2018 and had identified five key areas for improvement;
- All actions to address the issues identified for improvement by the Care Quality Commission had been completed with the exception of the action around staff engagement which was on track with a staff engagement event planned in May 2019;
- To provide assurance around the completion of the plan and embedding of the actions, a mock inspection of the service, coupled with email enquiries around randomly selected actions and softer intelligence from staff working in the service would be undertaken; and
- The action plan was monitored by the Clinical Director responsible for the service and progress updates were received by the Quality Executive Group for assurance on progress and feedback on the outcome of the mock inspection would be presented to the next meeting of the Committee.

Action: Acting Director of Nursing and Governance

The Committee noted the report.

5.5 NEWS2 Safety Alert Implementation Update Report

The Acting Director of Nursing and Governance presented the paper and reported that a number of Patient Safety Alerts had been issued by NHS Improvement in relation to the detection of the deteriorating patient in support of improving patient safety. The latest of these alerts was *Resources to Support the Safe Adoption of the Revised National Early Warning Score* (NEWS2) published in April 2018 with actions for completion by 31 March 2019.

The Acting Director of Nursing and Governance pointed out that although NEWS2 was directed at Acute and Ambulance Trusts, the Trust had taken action to adopt the NEWS2 tool across Community and Mental Health Inpatient settings.

The Chair referred to the update included at appendix 2 of the action log (page 25 of the agenda pack) on the developments of physical health monitoring implemented at Prospect Park Hospital and commented that it was

positive that the Trust had implemented a range of actions to improve physical health monitoring of mental health in-patients.

The Committee noted the report.

5.6 Action Plan in Response to Regulation 28 Notice

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

The Acting Director of Nursing and Governance confirmed that all actions had been completed or were in the progress with none requiring escalation to support their completion at the present time.

It was noted that the only outstanding action related to the Speech and Language Therapy service feedback to be included in the handover and Multi-Disciplinary Team template. It was noted that the Multi-Disciplinary Team template work had shown that a bigger Quality Improvement piece of work was necessary.

The Chair asked whether there was a process in place to ensure that new staff were inducted into the new systems and processes.

The Acting Director of Nursing and Governance confirmed that there were two induction sessions per month at Prospect Park Hospital.

The Committee noted the report.

5.7 Sexual Safety on Mental Health and Learning Disability Wards Update Report

The Acting Director of Nursing and Governance presented the paper and reported that the Care Quality Commission's report *Sexual Safety on Mental Health Wards* was published in September 2018 set out recommendations on how sexual safety could be improved on mental health and learning disability inpatient wards.

The Acting Director of Nursing and Governance reported that in the Trust had developed a Sexual Safety Action Pan in response to the Care Quality Commission's recommendations.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2018-19 Final Report

It was noted that the May 2019 Trust Board meeting had approved the Quality Accounts Report 2018-19. The Medical Director reported that the External Auditors had provided a limited assurance report on the Quality Accounts.

On behalf of the Committee, the Chair thanked Amanda Mollett, Head of Clinical Effectiveness and Audit and Jason Hibbitt, Clinical Effectiveness Facilitator for their work in producing the Quality Report.

6.2 Clinical Audit Reports

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

A) Prescribing Observatory for Mental Health (POMH) - Use of Clozapine

The Medical Director said that the Clinical Director, Reading was the lead for the audit, but she was off sick. The Lead Clinical Director reported that he was a Clozapine prescriber and was responsible for delivering the audit action plan and would be happy to answer any queries about the audit.

The Lead Clinical Director reported that the audit had highlighted areas where the Trust had performed well, for example, pre-treatment screening for blood pressure, heart rate and body weight; 96% of patients on Clozapine treatment for more than a year were reviewed at least annually by a senior clinician; and 97% of patients who had been prescribed Clozapine for more than one year had their blood pressure documented within the last year and 97% had their BMI documented within the last year.

It was noted that the areas identified for improvement were around clear documentation that patients had been made aware of any risks and side effects and agrees to regular monitoring; ensuring that plasma glucose and lipids and a physical examination were reviewed prior to initiation and annually; daily monitoring of the patient in the first two weeks of treatment; weekly assessment for side effects in the first month of treatment; and ensuring that the impact of smoking status had been discussed and documented.

The Medical Director reported that the responsibility for delivering the action plan to address the areas for improvement included Consultant Psychiatrists, Crisis Resolution Home Treatment Team, Mental Health Inpatients staff, Pharmacists and Community Mental Health Teams.

The Lead Clinical Director reported that as part of the action plan, the Trust was enhancing the Clozapine care pathway which included ensuring that Clinicians recorded physical health monitoring checks etc.

David Buckle, Non-Executive Director commented that the audit had revealed that the Trust was one of the lowest in terms of its use of Clozapine and asked whether the Trust was treating the right number of patients.

The Lead Clinical Director said that the action plain included reviewing the Trust's processes for prescribing Clozapine and pointed out that unless patients were admitted to Prospect Park Hospital, it was challenging to prescribe Clozapine in the Community given the need for close monitoring of side effects.

The Head of Clinical Effectiveness and Audit informed the Committee that the Clozapine audit would be repeated in Summer 2020.

The Chair said that interventions taking place, but not being documented and issues around the interface between different IT systems (for example RiO and ICE) were common themes in Serious Incident investigations.

The Lead Clinical Director reported that in his role as the Trust's Chief Clinical Information Officer, he recognised Clinicians' frustrations about IT systems,

but currently there were no plans to integrate RiO and ICE as this would be too expensive. It was noted that the Trust's electronic Prescribing and Medicines Administration system had been introduced and was working well.

The Medical Director pointed out that audits conducted through electronic patient records often resulted in more administration for Clinicians and that this did not always result in safer clinical practice. The Chief Operating Officer pointed out that in the past, GPs and other Clinicians working out of hours would be making decisions without the benefit of IT systems.

B) National Audit End of Life Care

The Chair welcomed Rosemary Martin, Lead for Community and Specialist Nursing (East) and Sara Fantham, Head of Clinical Quality & Governance & Interim Clinical Director, Adult Physical Health East Berkshire.

The Medical Director reported that the Trust had performed above the national score for six of the nine themes in the audit. It was noted that the Trust's score for the "Families and other's experience of care" theme could not be calculated because there only three nominated people had responded to the survey.

The Medical Director pointed out that the main area highlighted by the audit for improvement was around Governance.

The Lead for Community and Specialist Nursing (East) pointed out that the main actions for improvement were around the completion of individualised end of life care plans. It was noted that the Trust was testing the electronic RiO End of Life Care Plan which was scheduled to be live from the beginning of June 2019. The Trust had also implemented the national guidance on supporting bereaved families.

It was noted that one of the areas identified for improvement was around rapid discharge to enable patients to die at home if this was their preference. The Head of Clinical Quality & Governance pointed out that rapid discharge processes were already in place, but this needed to be recorded on the patient's record.

The Chair congratulated the Trust on the impressive set of audit results.

David Buckle, Non-Executive Director echoed the Chair's comments and said that end of life care was complex and asked whether there were any areas where the Trust could further improve its practice.

The Lead for Community and Specialist Nursing (East) said that the key area for improvement was around having the confidence to have sensitive conversations with families about when to stop treatment and around the potential side effects of treatment.

The Committee noted the report.

Update Items for Information

7.1 Guardians of Safe Working Hours Quarterly Report

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

The Medical Director reported that during the reporting period (5 February 2019 to 5 May 2019), there were eight exception report totalling an extra 9 hours and 20 minutes worked over and above the trainees' work schedules.

It was noted that the Guardians of Safe Working Hours had indicated that none of the exception reports indicated problems with posts that required the work schedules to be reviewed. The current level of exception reporting suggested that Junior Doctors were not working unsafe hours and that this was confirmed by the qualitative information from the Junior Doctors Forum.

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

The Committee noted the report.

7.2 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held on: 11 February 2019, 11 March 2019 and 08 April 2019 were noted.

Mehmuda Mian, Non-Executive Director referred to page 248 of the agenda pack and noted that the Trust was process mapping systems and processes in relation to the use of the Place of Safety and was seeking best practice from other Trusts.

Closing Business

8.1 Standing Item – Horizon Scanning

The Chair suggested the following topics for future meetings:

- CAMHS sustainability
- Carers Strategy

8.2. Any Other Business

There was no other business.

8.3. Date of the Next Meeting

21 August 2019 at 10.00

These minutes are an accurate record of the Quality Assurance Committee meeting held on 21 May 2019.

Signed:-_____

Date: - 21 August 2019_____

QEG / QAC/ Trust Board	May 2019
Title	**Learning from Deaths Quarter 4 Report 2018/19**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	The trust mortality review and Learning from Deaths process has operated without any additional resource allocation since it was launched in 2016.Additional resource will be required to progress further quality improvements.
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
SUMMARY	891 deaths were recorded on the clinical information system (RiO) during Q4 where a patient had been in contact with a trust service in the year before they died. Of these 75 met the criteria to be reviewed further. All 75 were reviewed by the executive mortality review group and the outcomes were as follows: • 27 were closed with no further action • 6 were classed as Serious Incident Requiring Investigation • 42 required 'second stage' review (using an initial findings review (IFR)/ Structured Judgement Review (SJR) methodology). During Q4, the trust mortality review group (TMRG) reviewed the findings of 36 2nd line review reports (detailed on p8), of which 6 related to patients with a learning disability (these are cases reviewed in Q4 and will include cases reported in previous quarters). **Lapse in Care** Of the 36 case reviews received by the TMRG, none were escalated as potential lapse in care for root cause analysis through the Serious Incident (SI) process in Q4. One lapse of care has been confirmed in Q4 following escalation by the TMRG in Q3: The death occurred in September 2018 and was reported initially following a patient transfer, a post infection control 2nd line review was requested and received by the Trust Mortality Review Group in November 2018 where it was escalated to an SI and has formally been confirmed as a lapse in care in March 2019. **Learning from reviews and investigations** In Q4 the TMRG identified End of Life (EoL) Care as a key theme for learning from case reviews, this learning applied to, community nursing, community inpatient wards and children's services. • Communication with families

	• Management of pain • Documentation of care plans Themes identified from SI investigations are: • Communications with family / carers • Management of hydration • Multidisciplinary Team Meetings • Lack of robust safety planning • Suitability of admission from the community and management of the deteriorating patient **CQC report: Learning from deaths (Appendix 2)** A review of the first year of NHS trusts implementing the national guidance (March 2019) Berkshire Healthcare was noted as exemplar for its leadership on learning from deaths, quality of investigations and involvement of families and carers. **Further Quality Improvements** For further improvement to the Learning from Deaths process in the trust we need to consider: • A Designated family liaison/ bereavement support member of staff. The role would include the day to day management of the interaction with families and close liaison with the member of staff reviewing or investigating the death to ensure that families are treated appropriately, professionally and with respect of their needs. The role will include providing support to newly bereaved individuals, some of whom will be deeply distressed. • Preparing for the introduction of the Medical examiner. The role of the medical examiners is to provide proportionate scrutiny to all non-coronial deaths. The aim is for this process to be delivered for all deaths in secondary care by the end March 2020 and for all deaths by the end of March 2021 (Including community and mental health). In preparation for this we will need to review the Trust death certification process for community inpatient deaths. • Engaging local health and care partners in the trust mortality review and learning process. The trust is a member of the ICS mortality review group and will continue to participate and support this.
ACTION REQUIRED	The committee is asked to receive and note the Q4 learning from deaths report in order to provide assurance to the Trust Board that the Trust is complying with NHS Improvement requirements in respect of learning from deaths.

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1.0 Purpose

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

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

2.0 Scope

This report supports the Trust learning from deaths policy which was published in August 2017.

3.0 Introduction

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

The first part of the report identifies the total numbers of patients who have died, in most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further. First line review is through weekly review of Datix reported deaths by the Executive Mortality Review Group. Second line reviews (using IFR/SJR) are discussed at the monthly Trust Mortality Review Group where learning is identified and service improvement actions are followed through.

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

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

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

We are required to notify the National Learning Disability Mortality Review Process (LeDeR) of all patients who have died with a learning disability, LeDeR carry out an independent review which also involves contacting the person's family. The purpose of this is to learn from all aspects of care (Inc. primary, secondary and social care) and inform national learning.

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

Definitions:

2nd Line Case Review (SJR/IFR): A review is usually a proactive process, often without a 'problem', complaint or significant event. It is often undertaken to consider systems, policies and processes. A review is a broad overview of a sequence of events or processes. It can draw on the perceptions of a range of individuals and a range of sources. The resulting report does not make findings of fact, but it summarises the available information and makes general comments. A review may identify some areas of concern that require investigation e.g. if there is some evidence of poor practice, in which case the appropriate recommendation for an investigation should be made.

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

4. Summary of Deaths and Reviews completed in 2018/19.

Figure 1.

	17/18 total	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19	YTD 18/19
Number of deaths seen by a service within 365 days of death	4381	812	788	983	891	**3474**
Total deaths screened (Datix) 1st line review	307	73	77	95	75	**320**
Total number of 2nd line reviews requested (SJR/IFR/RCA)	153	27	24	41	42	**134**
Total number of deaths investigated as serious incidents	32	6	14	14	6	**40**
Total number of 2nd line reviews completed (SJR/IFR/RCA)	153	42	25	28	39	**134**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	1	0	1	1	**3**
Number of Community Hospital Inpatient deaths (Including patients at the end of life)	123	37	31	43	33	**144**
Total number of deaths of patients with a Learning Disability	35	8	5	9	6	**28**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	0	0	**0**

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

4.1 Total Number of deaths in Q4

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death (Figure A in Appendix 1 details the specific service). In Q4 891 deaths were recorded, this number may increase slightly due to a time lag in spine updates.

Figure 2 below details the age of the patients, this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority. The highest number of deaths is in the over 75 age group with the majority of these in receipt of community nursing services in their homes receiving care at the end of life.

	January-March 2019				
Figure 2	**A:0-17**	**B:18-65**	**C:66-75**	**D:Over 75**	**Grand Total**
Grand Total	**3**	**105**	**147**	**636**	**891**

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4.2 Total Deaths Screened (1st line review)

The Trust learning from deaths policy identifies a number of criteria which if met require the service to submit a Datix form for review on the Trust incident management system following the notification of a death. 75 deaths were submitted for review in Q4, this is consistent with previous quarters (Figure B in Appendix 1 details the specific services).

These are all reviewed weekly by the Executive Mortality Review Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

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

1. Datix form advised to be closed, no 'red flags'/ concern identified.
2. Further information requested to be able to make a decision, to be reviewed at next EMRG
3. Identified as a serious incident (SI)
4. Identified as requiring a review (SJR/IFR) report

Of the 75 deaths undergoing first line review, 27 were closed with no further action required, 42 were referred for 2nd line review and 6 were classed as serious incidents for RCA investigation.

5. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death which relates to an individual with a learning disability and these are detailed with regards to the level of involvement for those deaths reported in Q4. In addition, for all expected inpatient end of life deaths or deaths where a 2nd line review (SJR) is undertaken, the family will receive a letter of condolence with the opportunity to raise any concerns and the Trust Bereavement booklet.

6.1 2nd Line Reviews Completed

The purpose of the 2nd line review of deaths is to determine if any potential problem or lapse in care may have contributed to the person's death, to identify learning and to utilise the learning to guide necessary changes in services in order to improve the quality of patient care. It is expected that, over a period of time, these improvements in response to learning from deaths will nationally contribute to reduction in premature deaths of people with learning disabilities and severe mental health illness.

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 39 reviews have been received and considered by the group in Q4.Figure 8 details the service where the review was conducted.

Figure 8: Reviews Conducted in Q4

	Total Number	**Services**
January 2019	8	Liaison and Diversion Service: 1 Learning Disability: 5 Community Health Inpatient Ward: 2
February 2019	15	Westcall Out of Hours GP Service: 1 Community Health Inpatient Ward: 7 Adult Mental Health: 1 Common Point of Entry (CPE): 3 Crisis Resolution and Home Treatment Team: 1 Older Persons Mental Health: 2
March 2019	16	Community Health Inpatient Ward: 3 Assessment and Rehabilitation (ARC): 1 Westcall Out of Hours GP Service: 2 Older Persons Mental Health: 2 Community District Nursing: 3 Talking Therapies: 1 Psychological Medicine Services (PMS): 1 Common Point of Entry (CPE): 1 Community Dietetics: 1 Learning Disability: 1

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

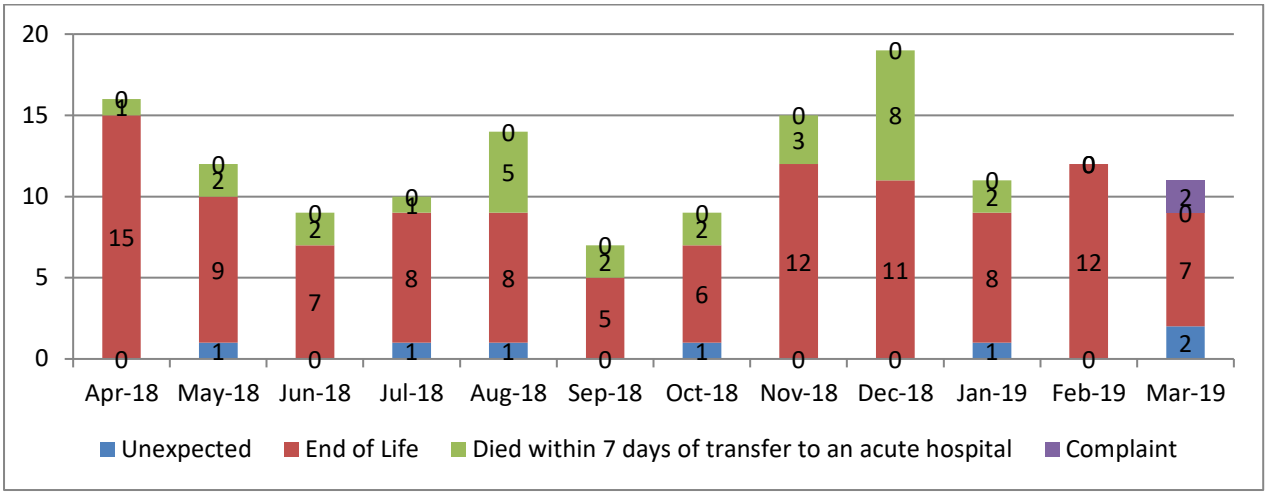
- Request further information (if required) from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service level learning and improvements
- Identify a potential lapse in care and recommend investigation through the SI process.

An action log is maintained and reviewed by the group to ensure that all actions are completed.

7 Deaths of patients receiving community nursing care including palliative care

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 3 details these.

Figure 3 Deaths occurring on the community health inpatients Wards or following deterioration and transfer to a acute hospital.



In Q4 34 deaths in total were reported by the Community Inpatient Wards, of these 27 were expected deaths and related to patients who were specifically receiving end of life care. These were reviewed by the EMRG and closed, where sufficient information had been provided to give assurance that appropriate end of life care had been given.

5 deaths were unexpected, of which 3 patients died on the community inpatient wards and 2 were transferred to an acute hospital. 2nd line reviews were completed and all 3 closed following confirmation of natural cause of death.

2 related to complaints which were received in Q4 relating to EOL deaths reported previously in Q1 and Q3 both will have 2nd line reviews completed and will be reviewed at TMRG; this will also inform the complaints process.

8. Deaths of Children and Young People

3 deaths were recorded where the child or young person had been in contact with one of our services in the year before their death. 1 related to a neonate which was closed by the EMRG at first line review. 2 related to children with complex health needs, a 2nd line review was completed on one of these which has been closed by TMRG.
Both deaths will be reviewed by the child death overview panel, where any learning is then fed back to the TMRG by the Clinical Director for children's services.

9. Deaths of adults with a learning disability

In Q4, the Trust Mortality Review Group reviewed a total of 6 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. All 6 deaths were attributed to Diseases of the Respiratory System. 2nd line reviews (SJR) were completed for all 6 cases and no lapse in care was identified.

Of the 6 individuals whose deaths were reported, 5 people's family were sent bereavement information and condolence cards, no responses have been received to date from those contacted. Contact had not been made in 1 instance due to the extended time which had elapsed between the date of the person's death and the notification (and also not having been in receipt of services from the learning disability service) therefore it was decided that contact would be more appropriately followed up through LeDeR process.

Figure 4 details the demographics of LD patients

Gender:

Female	2
Male	4

Age: The age at time of death ranged from 24 to 78 years of age (median age: 73yrs)

Severity of Learning Disability:

Mild	1
Moderate	1
Severe	2
Not Known	2

Ethnicity:

White British	6

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

In Q4 6 deaths have been reported as serious incidents, figure 5details the service where the SI occurred.

Figure 5. Service (**Source Q4 Serious Incident Report)**	**Number**
EIP	1
Bracknell CMHT	2
Reading CMHT	1
CRHTT (W)	1
Slough CMHT.	1
Total	**6**

10.1 For all deaths which are categorised as an SI

The family is contacted in line with our duty of candour (DoC) policy and advised of the process of investigation.

Someone from the service (usually a senior clinician or manager) makes contact with the family as soon as it is known that an incident causing death has occurred. At this time they offer a face to face meeting which will include:

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

DoC applied to 10 deaths in Q4 (6 SI, 3 reviews (RCA) following referral from TMRG and 1 complaint), of these, all families were written to and offered face to face meetings, 5 families have taken this up at this point in time, further opportunities to meet or talk should they wish are offered at the point of sharing any outcomes in written format from the review or investigation.

10.2 Lapse in Care

Of the 36 case reviews received by the TMRG, none were escalated as potential lapse in care for root cause analysis through the Serious Incident (SI) process in Q4.

One lapse of care has been confirmed in Q4 following escalation by the TMRG in Q3: The death occurred in September 2018 and was reported initially following a patient transfer, a post infection control 2nd line review was requested and received by the Trust Mortality Review Group in November 2018 where it was escalated to an SI and has formally been confirmed as a lapse in care in March 2019.

The invesgiation identified learning around the suitability of admission from the community and management of the deteriorating patient, an action plan is in place and monitored through the SI process.

11. Additional Case Review

Additional case review is recommended to ensure that there is the opportunity to review deaths which don't meet the criteria for 1st line review. Additional case review is being planned and undertaken in the following areas and is reported in line with the TMRG process of review:

- Older Adult Community Mental Health (outpatient care)
- Community Hospital EOL patients
- Community Nursing EOL patients

In addition the 2nd round of the National Audit of End of Life Care has started and will review all EOL inpatient deaths which occur between April 2019 and June 2019.

12.Learning from Deaths

The aim of the policy and procedure is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details updates on learning and the new learning identified in Q4

12.1 Themes and learning from serious incidents (SI)

Themes identified from investigations either approved by commissioners in Q4 or completed during this quarter are:

- **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. We have come to expect either direct or indirect reference to communication and the perception of poor family involvement in most investigation reports both from serious incidents and complaints.

- **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. 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. This has been identified across a number of inpatient wards (physical and mental health)

- **Multidisciplinary Team Meetings** – The robustness and completeness of documenting what is discussed and planned in Multidisciplinary Team 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.

12.2 Learning from deaths in physical health services

End of Life Care has been identified as an area for learning from the 2nd line reviews completed in Q4, key areas of focus for community nursing include:

- Communication with families
- Management of pain
- Documentation of care plans

Learning events have been held within the localities for staff to look at these aspects of care. The TMRG agreed the proposal to randomly select 6 deaths per Q (1 per locality) for 2nd line review, in figure one we identified 891 deaths with the majority of these under community nursing of the 891, 124 were in receipt of care in the week before they died, it will be these cases that we initially pick our sample from to ensure maximum opportunity for learning.

The Trust participated in the first round of the national audit of end of life care in 2018, the results for this were generally reassuring and the service has identified actions to further improve EOL care for inpatients which include:

- End of life care plans to be in place and meet best practice requirements

- Documentation of assessment of capacity
- Communication with families

12.3 Learning from death of a child
When an Advanced Care Plan (ACP) is developed with a family it is important to explore the wishes of the family in the case of the chosen place of death not being available.

12.4 Learning from deaths of patients with a learning disability (LD)
Review of deaths of people with a Learning Disability in Q4, demonstrated evidence of good communication and information sharing across the various services, organisations and with family members. Services were able to demonstrate that they were responsive to the individual's needs. Referrals were also responded to promptly which enabled care to be delivered in a timely manner.

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

12.5 Learning from LeDeR reviews
Both East Berkshire and Berkshire West LeDeR Steering Groups have completed LeDeR reviews in the last quarter – with some quality checking/reporting to be completed. The details from these reviews when completed are shared with the Learning Disability Services and via Trust Patient Safety Quality meetings and information shared with the TMRG.

Berkshire West held a LeDeR workshop to raise awareness of the national learning from LeDeR and attendance was promoted across mainstream health services and local voluntary groups to raise awareness.

13. CQC report: Learning from deaths
A review of the first year of NHS trusts implementing the national guidance (March 2019)
Berkshire Healthcare was noted as exemplar for its leadership on learning from deaths, quality of investigations and involvement of families and carers. (Full Report Appended).

14. Further Quality Improvements

For further improvement to the Learning from Deaths process in the trust we need to consider:

- A Designated family liaison/ bereavement support member of staff. The role would include the day to day management of the interaction with families and close liaison with the member of staff reviewing or investigating the death to ensure that families are treated appropriately, professionally and with respect of their needs. The role will include providing support to newly bereaved individuals, some of whom will be deeply distressed.

- Preparing for introduction of the Medical examiner. The role of the medical examiners is to provide proportionate scrutiny to all non-coronial deaths. The aim is for this process to be delivered for all deaths in secondary care by the end March 2020 and for all deaths by the end of March 2021 (Including community and mental health). In preparation for this we will need to review the Trust death certification process for community inpatient deaths.

- Engaging local health and care partners in the trust mortality review and learning process. The trust is a member of the ICS mortality review group and will continue to participate and support this.

15. Conclusion

Of the 36 case reviews received by the TMRG, none were escalated as potential lapse in care for root cause analysis through the Serious Incident (SI) process in Q4.

One lapse of care has been confirmed in Q4 following escalation by the TMRG in Q3: The death occurred in September 2018 and was reported initially following a patient transfer, a post infection control 2nd line review was requested and received by the Trust Mortality Review Group in November 2018 where it was escalated to an SI and has formally been confirmed as a lapse in care in March 2019.

Appendix 1

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

Note: These are the last Specialty Teams seen before death as recorded on RiO				
	January 2019	**February 2019**	**March 2019**	**Total Q4**
Nursing episode	142	121	89	352
Old age psychiatry	43	23	17	83
Community health services medical	35	33	13	81
Palliative medicine	33	26	15	74
Podiatry	23	17	16	56
Dietetics	24	11	13	48
Rehabilitation	20	16	11	47
Physiotherapy	7	10	8	25
Speech and language therapy	16	4	3	23
Adult mental illness	12	5	6	23
General medicine	4	8	4	16
Intermediate care	7	5	3	15
Respiratory medicine	4	3	7	14
Cardiology	7	2	3	12
Genito-urinary medicine		4	2	6
Geriatric medicine	2	3		5
Clinical psychology	2		1	3
Learning disability	1	1	1	3
Occupational therapy	2			2
Public health medicine		1		1
Liaison psychiatry			1	1
General medical practice		1		1
Grand Total	**384**	**294**	**213**	**891**

Figure B – First line review Datix reported by service which the patient had contact with.

Service	**Total**
Community Hospital Inpatient Ward	33 (4T)
Community Mental Health	10
Learning Disabilities	8
Community District Nursing	5
Older adults Mental Health	3
Crisis Resolution and Home Treatment Team	3
Children's Community Specialist Nursing	2
Assessment and Rehabilitation (ARC)	1
Criminal Justice and Liaison and Divert Service	1
Common Point of Entry (CPE)	1
Early Intervention in Psychosis (EIP)	1
Eating Disorder Service	1
Heart Team	1
Intermediate care	1
Westcall Out of hours GP	2
Psychological Medicines Service (PMS)	1
Talking Therapies	1
Total Datix	**75**

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

Learning from deaths

A review of the first year of NHS trusts implementing the national guidance

Care Quality Commission

Our purpose

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

Our role

- We register health and adult social care providers.
- We monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led, and we publish what we find, including quality ratings.
- We use our legal powers to take action where we identify poor care.
- We speak independently, publishing regional and national views of the major quality issues in health and social care, and encouraging improvement by highlighting good practice.

Our values

Excellence – being a high-performing organisation

Caring – treating everyone with dignity and respect

Integrity – doing the right thing

Teamwork – learning from each other to be the best we can

Contents

Foreword

In December 2016, our report *Learning, candour and accountability* detailed our concerns about the way NHS trusts investigate and learn from the deaths of people in their care, and the extent to which families and carers are involved in the investigations process.

Guidance issued by the National Quality Board in March 2017, the specific guidance for NHS trusts on working with families and carers, published in July 2018, and the announcement of the new arrangements for introducing medical examiners are welcome developments. This report, through examples and case studies, shows that we are beginning to see the start of progress in NHS trusts in terms of implementing this guidance.

However, we are concerned that we are still seeing the same issues persist in some NHS trusts more than two years on. In particular, involvement and engagement with bereaved families and carers is an area with which some trusts continue to struggle. Issues such as fear of engaging with bereaved families, lack of staff training, and concerns about repercussions on professional careers, suggest that problems with the culture of organisations may be holding people back from making the progress needed.

In our recent report *Opening the door to change: NHS safety culture and the need for change*, we called for transformation of safety, leadership and culture. Our findings in this report emphasise the necessity of this. While there is no one factor that guarantees good practice, the report highlights the need for having an open and honest culture in place where people feel they can speak up. This also needs to happen at a system-wide level, where organisations need to engage with families and carers, be open with each other and share information and learning to improve the care they provide, rather than perpetuating a culture of blame.

Cultural change is not easy and will take time. However, the current pace of change is not fast enough. NHS trusts need to use the findings of this report to remind themselves of the key drivers to improve learning from deaths, to build on progress made so far and to accelerate the changes needed.

Our report acknowledges that to make these changes, there needs to be continued support from the centre, including support for behaviours that encourage more openness and learning across the NHS. CQC also has a role in supporting this change, and we will continue to strengthen how we look at and assess the issues identified in our report as part of our focused well-led inspections.

Professor Ted Baker

Chief Inspector of Hospitals

Introduction

Since September 2017, we have been assessing NHS trusts' implementation of national guidance on learning from deaths as part of our new well-led inspections. Now that most of these reviews have been completed, we are reporting back as part of our commitment to the Learning from Deaths Programme Board. It is very early stages, both in the implementation of the guidance and of our well-led inspections. This report provides a very first look at observations from our inspection teams, as well as an indication of the types of enablers and barriers that we have seen trusts face in implementing the guidance, and is not necessarily representative of all trusts' experiences.[1] The report acknowledges that it is early days for trusts and that it will take time to change attitudes and culture in the NHS, including how the NHS engages with families. To help encourage improvement we have included examples of good practice to inspire NHS trust staff to continue to improve how they review and learn from deaths.

Background

In December 2015, the Secretary of State for Health commissioned CQC to carry out a review of how acute, community and mental health trusts across the country investigate and learn from deaths to find out whether opportunities for preventing deaths have been missed, and identify any improvements needed. This followed the publication of NHS England's report into Southern Health NHS Foundation Trust's investigation of deaths, and in particular its handling of the investigation into the death of Connor Sparrowhawk, who had a learning disability and epilepsy, and died while under the care of the trust in 2013.[1,2] As a result, a key focus of CQC's review was how trusts investigate the deaths of people with a mental health problem or learning disability.

We published the findings from this review in December 2016. Our report, *Learning, candour and accountability* highlighted that there were generally poor experiences for families and carers in how deaths were identified and reported, in the quality of reviews and investigations, and how they were engaged in the process, with no consistent frameworks used by NHS trusts providing acute, community or mental health services.[3,4]

Following the publication of the report, the Department of Health and Social Care established the Learning from Deaths Programme Board, overseen by the National Quality Board, to implement the report's recommendations. In March 2017, the National Quality Board issued national guidance for NHS trusts on learning from deaths.[5] The purpose of the national guidance was to initiate a standardised approach on learning from deaths in NHS trusts providing acute, mental health and community health services. It included:

- the need to have processes that identify those deaths that result from problems in care
- the appointment of an executive director and non-executive director to take responsibility for oversight of progress
- having a clear policy in place for engaging with bereaved families and carers

[1] See appendix for more details on the methodology

- ensuring staff reporting deaths have appropriate skills and protected time to review and investigate deaths to a high standard
- minimum requirements on collecting data and reporting, with NHS trusts expected to collect, and publish on a quarterly basis, information on deaths of people in their care, effective from April 2017. Trusts were expected to publish their policy and approach by summer 2017, and then publish data and learning points by autumn 2017.[6]

The national guidance was followed in July 2018 with specific guidance for NHS trusts on working with families and carers.[7] This was co-produced with families and carers to provide trusts with advice on how they should support, communicate and engage with families following the death of someone in their care. This guidance expanded on the principles in the national guidance to provide more details to reflect the feedback and experiences of families and carers. It set expectations for what families can expect from NHS trusts.

Since the publication of our report, there have been a number of other reports and developments that support the findings of our review and aim to address the issues highlighted. For example, the government's response to the Gosport Independent Panel Report, published in November 2018, emphasised the importance of NHS staff, patients and families speaking up with concerns about care. This followed the government's response to a consultation in June 2018 for the introduction of medical examiners from April 2019.[8] The aim of introducing this new system is to make sure that all deaths not investigated through the coronial process are subject to a degree of independent scrutiny, with increased transparency for the bereaved and an opportunity for them to raise any concerns.

CQC's report *Opening the door to change: NHS safety culture and the need for change*, which published in December 2018, similarly called for a change in culture in the NHS to reduce the number of patients who experience avoidable harm.[9] As referenced in the report, the National Patient Safety Strategy, which is being developed by NHS Improvement, will provide another important opportunity to support NHS trusts to embed safety as a top priority.

What we did

This report is based on a qualitative analysis of interviews and focus groups with inspection staff and specialist advisors involved in well-led inspections between September 2017 and June 2018. We interviewed eight inspection staff, two CQC specialist advisors and held four focus groups with a total of 12 inspection staff. These interviews and focus groups focused specifically on understanding how well trusts have been implementing the national guidance, and the enablers of and barriers to good practice. We also used these discussions to identify examples of good practice. Some of these examples are included in this report, with text drawn from our published inspection reports. Where possible, we have engaged through trusts with local patient, family and carer groups to comment on these, and verify that they reflect their experiences.

We also carried out a case study analysis of three trusts that were rated as outstanding for well-led between September 2017 and June 2018. This focused specifically on the quality of their processes for learning from deaths and the factors that had supported good practice in learning from deaths. More details about our methods are available in appendix A.

In support of the qualitative analysis, we held a discussion with NHS trusts at our NHS co-production meeting in November 2018.

Findings have been corroborated and in some cases supplemented with expert input from our external NHS co-production group, which includes representatives of families, carers and trusts, and other stakeholders, including voluntary sector organisations, to make sure that the report represents what we are seeing in our inspections.

How well are trusts implementing the guidance?

During our first year of inspecting how trusts are learning from deaths, we have seen that how they are implementing the learning from deaths guidance varies. Trusts are at different stages of implementing the guidance, with some finding it more difficult than others to make the changes needed.

Analysis of our interviews and focus groups with inspection staff suggests that awareness of the national guidance is high, and we have seen some trusts taking action to revise policies and establish oversight of learning from deaths.

However, there is some, albeit limited, evidence to suggest that the guidance is better suited to acute trusts rather than mental health or community services. For example, people we spoke with at Norfolk Community Health and Care NHS Trust told us that they felt the guidance and surrounding frameworks are "*always acute-focused*", while a member of West Suffolk NHS Foundation Trust felt that implementation of the guidance was more challenging for community services as it "*isn't clear and prescriptive for those different [non-acute] settings.*"

This sentiment was supported by attendees at our co-production meeting who gave some examples of difficulties with applying the learning from deaths guidance in community services. These included the high number of deaths and the fact that these may not be serious incidents, for example deaths of people at the end of their lives in the normal course of events. The co-production group also suggested that it is sometimes difficult for a community-based service or mental health service to find out about the death if it occurs in the community in the first place.

These comments, and other feedback, can be used to help inform any of the ongoing development work of guidance planned by the Programme Board, for example for ambulance trusts.

Enablers and barriers to good practice

This chapter looks at the themes that we found were supporting or inhibiting trusts' ability to improve. Overall, we found that the following factors can help support trusts to implement the guidance well:

- **values and behaviours that encourage engagement with families and carers** and support for staff
- **clear and consistent leadership** and governance by a specific person who is at a reasonably high level in a trust's hierarchy
- **a positive, open and learning culture** that encourages staff to speak up about safety issues and has a focus on improving the care of patients
- **staff with the resources, training and support** to carry out reviews and investigations
- **positive working relationships with other organisations** also providing care for the person who has died, to enable the sharing of information and learning from any investigation.

These factors are not new and reinforce the findings of our original report. Where we found examples of good practice, trusts were able to build on existing strengths, such as having an open and learning culture, that the national guidance could be integrated within. This also echoes the findings of our thematic review of Never Events, *Opening the door to change*, which found that the culture of an organisation could affect how well an organisation was able to implement safety guidance.[10]

We explore the above themes in more detail in this chapter. Other contributing factors we identified included existing capabilities, and good governance and oversight, as well as the financial resources of a trust.

However, it is important to note that our analysis suggests that these enablers and barriers are interrelated and that there is not one factor on its own that guarantees good practice. All these factors need to be tackled in a coherent approach.

Values and behaviours that encourage engagement with families and carers and support for staff

In March 2017, the national guidance on learning from deaths set clear expectations for how NHS trusts should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death. It also described trust board's responsibilities for ensuring this happened.

In July 2018, additional guidance for NHS trusts on working with bereaved families and carers was published by the National Quality Board. It was developed by NHS England in collaboration with families who have experienced the death of someone in NHS care and have been involved in NHS investigations, as well as with voluntary sector organisations. It has also been informed by feedback from trusts and other NHS organisations. It advises trusts on how they should support, communicate and engage with families following the death of someone in their care. It consolidates existing guidance and provides a perspective from many family members who have experienced a bereavement in the NHS. The guidance is complemented by *Information for*

families following a bereavement in the annex, which should supplement a trust's own information and resources for bereavement support for families.[11]

There are eight guiding principles that set out what bereaved families and carers can expect. These include:

1. Being treated as equal partners
2. Receiving clear, honest, compassionate and sensitive response in a sympathetic environment
3. Receiving a high standard of bereavement care including being offered appropriate support
4. Being informed of their rights to raise concerns
5. Receiving help inform decisions about whether a review or investigation is needed
6. Receiving timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison
7. Being partners in an investigation as they offer a unique and equally valid source of information and evidence
8. Being supported to work in partnership with trusts in delivering training for staff in supporting family and carer involvement where they want to.

However, as the above guidance only came out in July 2018 we would not expect this to have been fully reflected in what our inspection staff saw in trusts.

Analysis of our interviews and focus groups with inspection staff showed that there was variation in how well trusts are engaging meaningfully with bereaved families and carers. For example, in some trusts we saw ad hoc engagement with families and carers, where contact with families and carers had only taken place after a serious incident or complaint. More needs to be done to make sure that bereaved families and carers are involved from the start.

Inspection staff found that staff can sometimes be fearful of engaging with bereaved families and carers. Reasons for this could be linked to a lack of skills or confidence to contact bereaved families, a fear of adding to families' distress and grief, a culture of blame and concerns about potential repercussions on their professional career. Creating a culture where people feel able to speak up without retribution was one of the key findings of our thematic review on Never Events, published in December 2018. *Opening the door to change* highlighted that to achieve a 'just culture' there both needed to be transparency for staff, patients and leaders, and when something goes wrong, patients and families should be involved in the investigation process from an early stage.[12] Trusts need to invest and support their staff so they have the appropriate skills and resources to engage with bereaved families and carers in a meaningful and compassionate way.

However, we have also seen some examples of positive engagement with families and carers, where trusts had clear pathways of contact, an open and transparent approach to engagement, and showed compassionate communication with families. For example, at Greater Manchester Mental Health NHS Foundation Trust, the trust had clear processes in place for how families are initially contacted, how they are given condolences and support, and how they are involved in investigations. The Director of Nursing and Governance at the trust recognised that families and carers react differently to bereavement, and described how communication needed to be

open and flexible, with support offered at multiple points over the course of any review or investigation.

Greater Manchester also showed evidence of an open, honest and person-centred culture, which was one of the factors that we found influenced good practice. Availability of specialist resource and training, and the existing capabilities of a trust were also related to good practice. For example, at West Suffolk NHS Foundation Trust we saw evidence that the way the trust engages with bereaved families and carers was well developed. However, a representative of the trust told us that it is continuing to develop its communication with families, and that it was organising Cruse training for the learning from deaths team on the best ways to support recently-bereaved people.[13]

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare was rated as good overall in October 2018. On our inspection, we looked at five serious incidents and five deaths investigations to assess the quality of the investigation and how the trust applied the duty of candour. We found that the investigations had been completed to a high standard. In all cases, families and carers had been contacted and were given an explanation of what had happened and, where appropriate, an apology. Families and carers had contributed to deciding the scope of the incident investigation, and the trust had shared the outcome of the investigations with them.

Nottinghamshire Healthcare NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust was rated as good overall in February 2018. We found that the trust had clear pathways of support for families and carers. The trust showed a sensitive approach to ensuring meaningful involvement of families and carers that was supported by a clear understanding of, and empathy for, the needs of people experiencing bereavement. The Nottinghamshire Healthcare investigation teams were able to link to existing support structures led by the family support service in the trust.

"The inspection team saw good processes in place for engaging with the family and carers of deceased patients. Communication was through a single point of contact. Initial condolences and duty of candour were applied at first point of contact. Families were seen at a place of their choosing, this could be in the home, on site, or at another site where the incident did not occur. Targets were set to make contact within three days or up to a maximum of five days. Families received choice about how they would like to be given information on the investigation process and outcome. Letters sent to families we found to be open, honest and a kind tone was used to offer condolences and explain the process clearly. There were good links with external bodies, including local authorities, clinical commissioning groups, other trusts and the local coroner, for supporting engagement with families and offering the opportunity to ask questions and gain further information. The trust offered leaflets, bereavement signposting, and provided pastoral care in the trust."

Sussex Partnership NHS Foundation Trust

Sussex Partnership NHS Foundation Trust was rated as good overall in January 2018. The trust was one of the first in England to be involved with Making Families Count, an approach developed by the charity 100Families and NHS England.[2] Through this work, the trust was one of the first in the country to implement a team of dedicated family liaison leads, which was introduced in August 2016. This team led on the investigation of serious incidents and worked with bereaved families during the process of investigating the death of their family members. There were three dedicated family liaison leads, with a further 13 staff trained to provide family liaison services. The family liaison leads were part of the serious incident team and provided root cause analysis training to senior staff who carried out reviews, which were based on a strong ethos of enabling strong engagement with families and carers. This included, as part of serious incident reports, details of family meetings and the views of the family, as well as ensuring that duty of candour requirements had been met.

[2] 100Families is a charity that supports people who have lost loved ones as a result of suicide, homicides by NHS patients or relative had died as a result of a NHS serious incident of avoidable harm. www.hundredfamilies.org

Derbyshire Healthcare NHS Foundation Trust

Although Derbyshire Healthcare NHS Foundation Trust was rated as requires improvement overall in September 2018, it had strong processes in place for engaging with bereaved families and carers. Feedback from families about support received from the family liaison team was overwhelmingly positive.

The family liaison role has evolved in line with learning from the national learning from deaths guidance. The family liaison team works with families where there has been a serious incident or unexpected death as reported through the trust's reporting system. They also work with families on referral through the process for learning from deaths, serious incident process and the complaints process where concerns have been highlighted about care.

The team start engaging with families after the death of their loved one has been identified. A single point of contact is established, initial condolences are given and the duty of candour, where applicable, is applied at the first point of contact, which can include providing the clinical team with advice.

Engagement with families is individualised and person-centred, and families are invited to contribute to the investigation's terms of reference and outline any specific questions they want answered about their relative's care and treatment. Monitoring of these actions is done through the Serious Incident Group (SIG) and the family liaison team who can review and see if the report answers the family's questions.

Families are invited to feedback on the care and treatment of their family member, and the family liaison worker meets with the family at the end of the investigation process to explain the outcome of the investigation. The family liaison team will support the family for as long as they need them up until the inquest, then work towards closure. Any additional needs are met through arranging activities such as referral to independent advocacy or psychological services.

There is also a range of information shared with families including details about the Samaritans, Public Health England's 'Help is at Hand' booklet, WAY Widowed and Young (if under 50), details of local support groups, and The Compassionate Friends leaflet. The information that is sent to families depends on the circumstances around the death of their loved one.

Clear and consistent leadership and governance

Our comprehensive inspections of NHS trusts have identified the importance of good leadership and governance in providing high-quality care.[14,15] This is echoed in our early findings on the quality of the processes for learning from deaths, which highlighted that clear leadership and governance processes can play an important role in driving forward improvements in learning from deaths.

Our first year of inspecting trusts' implementation of the guidance suggests that having a specific person, at a reasonably high level in the trust, is key to driving the work forwards. For example, at Berkshire Healthcare NHS Trust, which was rated as outstanding for well-led, the medical director was the operational trust lead on learning from deaths, with a lead non-

executive having oversight (see case study below). However, it has not always been clear if learning from deaths was a top priority for trusts.

Clarity over who is responsible and 'churn' in the leadership team were also potential influences on trusts' ability to implement the national guidance. This echoes the findings of *Opening the door to change*, which noted high turnover of staff as a challenge to implementing safety guidance.[16]

Linked to this, support from the board also influenced how well trusts are implementing the learning from deaths guidance. For example, at West Suffolk NHS Foundation Trust the board have made learning from deaths a priority, and appointed a public health consultant who was given the time and resources to consider and implement the guidance. The trust representative described to us how executive and non-executive directors had been "*very, very enthusiastic [and] very, very supportive*" of the work towards implementing the guidance.

At West Suffolk, and elsewhere, we saw evidence that strong existing governance and processes, such as review groups and systems for learning from deaths, was also a factor. For example, at Norfolk Community Health and Care NHS Trust, we saw evidence of how the trust had carried out work to expand on their existing processes for learning from deaths to make sure that the correct deaths are identified for review. However, we have also seen that challenge and interest at board level are important to make sure that these governance arrangements are robust and well adhered to. Good governance, we found, is also important in ensuring that the lessons learned from reviews are shared and acted on.

Berkshire Healthcare NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust was rated as good overall and as outstanding for well-led in October 2018. Inspection staff found that the trust had embedded its work on learning from deaths well. The trust had an executive group for learning from deaths, which was attended by the medical director, director of nursing and governance, lead clinical director, deputy director of nursing for patient safety and quality, and the head of clinical effectiveness and audit. This met on a weekly basis to review all deaths reported in the trust incident reporting system.

The medical director was the operational trust lead on learning from deaths. A lead non-executive director provided oversight. The level of investigation for deaths was considered in the weekly Executive Mortality Group, and monthly Mortality Group when the death did not meet the threshold for a serious incident. Where the threshold for reporting of a death as a serious incident on StEIS (Strategic Executive Information System) was met, this followed the usual trust serious incident processes. This committee also reviewed those deaths not reported as an incident to make sure that they were also investigated if needed.

Open and learning culture

In our State of Care 2017/18 report, we commented on the link between the culture and the performance of an organisation, and how leaders are integral to setting a good culture, with capable, high-quality leaders creating workplace cultures that are conducive to providing high-quality care.[17,18] A culture that is open and transparent, and in which staff feel able to speak up and speak out, was also previously noted as one of the most valuable aspects of driving improvement in trusts.[19]

Analysis of our interviews and focus groups with inspection staff for this review suggests that the existing culture of an organisation can be a key factor in trusts' ability to implement the guidance on learning from deaths, with inspection staff observing a difference between an open, transparent no-blame culture that is focused on learning, and an inward-looking, fearful culture, which can manifest in defensiveness and blame. As highlighted in the section on engagement with families and carers, negative cultural factors can include a fear of litigation, public perception, or confrontation with families, and a failure to engage staff with the trust's cultural values or empower them to raise concerns.

This supports the findings of our review of Never Events, *Opening the door to change,* which found that organisational and individual cultural issues could prevent the effective implementation of safety guidance.[20] In that review, we also heard from other industries that it is culture that drives the reporting of and learning from incidents.[21] To truly learn from serious incidents in the NHS, there needs be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn. This need for cultural change was highlighted in the foreword of our Never Events thematic review and in our recommendation for "*leaders with a responsibility for patient safety to make sure that the trust reviews its safety culture on an ongoing basis, so that it meets the highest possible standards and is centred on learning and improvement.*"[22]

Positive cultural factors we observed for this report included staff at all levels feeling able to speak up, a working environment that feels like "*a collaborative team, rather than a directional board downwards team*", strong patient focus, engagement of medical staff (particularly consultants), and a desire to learn as a central value of the organisation. It can also have an effect on how quickly processes are put in place and how likely any learning from reviews of deaths is shared. For example at the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, inspection staff found that the trust's learning culture acted as an enabler to developing their processes for learning from deaths, and that trust leaders were open and accountable in their approach, engaging with stakeholders in a transparent and collaborative way.

We also found that culture can also influence other factors in learning from deaths, including how a trust works with partner organisations who share the responsibilities for caring for that person, and how a trust involves bereaved families in the review, investigation and learning process.

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust

Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust was rated as good overall and outstanding for well-led in June 2018. Since its last inspection in 2015, the trust had improved the culture of the organisation. Inspection staff found that the trust had a learning culture, which acted as an enabler to developing their processes for learning from deaths and was indicative of their outstanding rating. Trust leaders were open and accountable in their approach, engaging with stakeholders in a transparent and collaborative way. Quality improvement was deeply embedded in the everyday workings of the trust through the development of team coaching, change champions and wide-reaching quality improvement training.

Staff in all areas felt empowered and had access to the right tools to drive improvements and innovate, resulting in a firmly established culture of continuous improvement. The trust had developed an innovative reporting system that enabled staff to report incidents, share improvement ideas, raise a concern or highlight good practice. When incidents did occur, investigations were timely, thorough, person-centred and led to improvements in patient safety and experience. The role of the freedom to speak up guardian (FTSG) was well embedded at the trust. Staff knew how to access the FTSG, including through the online reporting system. The FTSG made sure that any trends, themes or concerns were escalated to the trust board.

The trust produced a quarterly newsletter for all staff, which captured key learning from deaths from across the directorates. Clinical staff interviewed across the trust were aware of the newsletter and could give examples of learning from death reviews.

Providing staff with resources, training and support

Having sufficient resource (in terms of staff capacity and capability, support and training) is an important factor in a trust's ability to deliver effective reviews and investigations. Not all trusts are in an equally good position to allocate resource to learning from deaths. We have seen that trusts can face challenges in providing support and training, allowing staff time away from clinical duties and protecting time to carry out reviews. This echoes the findings of our recent report *Opening the door to change,* which also found that staff had limited time and space to attend relevant training for patient safety.[23]

Factors that influence trusts' ability to allocate resourcing include funding and commissioning, competing priorities, such as those brought about by organisational restructures, and the willingness of the board to provide adequate resources to learning from deaths. For example, at West Suffolk NHS Foundation Trust, which was rated as outstanding for well-led in November 2017, there was evidence that the board had a coherent approach to addressing the key drivers for improvement, including appointing dedicated personnel to implement the guidance.

Analysis of the feedback from our inspection teams showed that where we have seen good practice, this has been related to freeing people up from clinical commitments to take responsibility; protected time for reviews and training; and support from board and clinical commissioning groups (CCGs) for resource, such as a medical examiner or mortality technician.

City Hospital Sunderland NHS Foundation Trust

City Hospital Sunderland NHS Foundation Trust was rated as good overall in August 2018. The trust had a well-established process for reviewing and learning from deaths, which had been in place for four years. At the time of inspection, the trust was developing a process to move all information related to deaths onto a new electronic system, so that information could be obtained more effectively and to reduce the chance of transcribing errors.

The trust had a mortality review panel (MRP), which reported through the clinical governance steering group. The panel measured 'Hogan avoidability' (looking at the scale and scope of preventable deaths), Hogan quality, and national confidential enquiry into patient outcome and death (NCEPOD). The panel met on a weekly basis and comprised senior doctors and other clinical staff who critically reviewed all in-hospital deaths. The meeting excluded child and maternal deaths as they had their own statutory process; it included deaths of patients with a learning disability.

At the conclusion of each case review, the MRP provided a judgement using the review outcomes. Where there were any unexplained variations in care the reviews were referred for speciality reviews. Quarterly reports on the outcomes from the MRP reviews were presented to the mortality review group and to the clinical governance steering group. The report included articles on any reviews of deaths where there was evidence of preventability, poor care, or room for improvement, for example in death certification.

The MRP process incorporated a separate end of life review. In this process, all patients who had received either specialist palliative care or general end of life care the subject of a structured review of their death, which enabled the trust to assess the quality of end of life care. The specific reviews were based on the five core elements of care from the national implementation of care of the dying patient documentation. The outcomes of the reviews were used to target staff awareness and training sessions in care of the dying. The outcomes of these reviews were fed back to wards on a quarterly basis.

Engaging with partner organisations delivering care

Some deaths involve people whose care was provided by a number of different organisations. In these circumstances, any review or investigation needs to involve communication, information sharing and learning across these different organisations. The national guidance focuses on what individual NHS trusts need to do to review and investigate deaths. There is less information on how organisations need to work together on common issues such as engaging with families and carers or working with other non-NHS services such as the police and coroners. In addition to this, while it is usually clear whose care the person was under when they died, many trusts do not routinely record information about which other organisations were involved and what care they provided.

There was some evidence that the quality of existing relationships between organisations can affect how well trusts are working with partners on investigations into deaths. For example, our inspection staff have described how a lack of incentive or support for building relationships between system partners can be a barrier to collaborative investigations into deaths.

Difficulties in sharing information can also be a barrier. This was mentioned about obtaining information from GPs, a lack of established systems or routes for sharing information, and working across multiple CCGs. Inspection staff felt that CCGs could play a bigger role in

encouraging sharing learning and collaboration but noted that differences in approach and levels of support can be a problem, particularly for trusts that work with multiple CCGs.

We also heard that concerns about data protection when sharing information could be a barrier. This is similar to the finding of our local systems review that poor information governance, or a lack of understanding of rules and regulations for sharing information, can prevent joined-up care and support.[24] Trusts need to be confident that they understand the data protection rules and regulations, and that these are being appropriately applied when implementing the national guidance on learning from deaths.

However, we have seen pockets of good practice, for example one trust that had begun to build relationships with primary care colleagues, which included starting to work with GPs about the standard judgement framework. Other inspection staff we spoke with felt that CCGs were in a position to enable relationships between trusts and primary care, but felt that this would only be possible where they covered the hospital and the GP practice.

Case studies

In this section, we explore in more depth three trusts' overarching experiences of implementing the learning from deaths guidance. To inform these case studies, we spoke to the inspection manager who led the well-led inspection and representatives of the trust. At West Suffolk, we also spoke to a family representative to better understand their experiences, including what has helped or hindered them when putting the recommendations in place.

West Suffolk NHS Foundation Trust

West Suffolk NHS Foundation Trust is a combined acute and community trust, with a district general hospital, a community hospital and other community-based services. The trust, which serves a population of around 280,000 people across rural areas and market towns in the county, was rated as outstanding in December 2017.

Inspection staff felt that the trust has done well with implementing the guidance, with high-quality processes and systems in place to make sure that they are putting the guidance on learning from deaths into action. This was echoed by comments from the trust representative who felt that the national guidance was broadly positive and easy to implement, particularly for acute services. However, they also felt that implementation of the guidance was more challenging for community services as it *"isn't clear and prescriptive for those different [non-acute] settings."*

Strong leadership and governance played a large role in implementing the guidance at West Suffolk. A substantial, dedicated financial and human resource was given to the programme, which has been driven by the board and a medical director who is passionate about the programme.

In particular, the appointment of a public health consultant, with dedicated time and resources to consider and implement the guidance, was seen by the trust as key to driving improvement in learning from deaths. This included the appointment of administrative support for the consultant role:

> *"I have a full-time coordinator and there is no way this could work without her… I genuinely do not know how trusts have done it if they haven't been able to invest in protected time for people, and we are fortunate that our financial position meant that we could. I calculated… [we spent] £130,000… specifically for this, and without that… we wouldn't be doing a comprehensive job."*

Inspection staff also praised the trust's existing culture and practices – including an openness to learning, good staff engagement and a desire to provide high-quality care – as important factors in its ability to implement the learning from deaths guidance.

While the trust had good processes in place for learning from deaths, and was already reviewing all inpatient deaths before the guidance was published, it recognised that there was more to do in terms of identifying and reviewing deaths in the community and of people with a diagnosed mental health condition or learning disability.

The trust has built on these existing processes and continues to make improvements to comply with the requirements of the guidance. For example, the trust representative we spoke with described how they had attended the Royal College of Physicians' training on Structured Judgement Reviews (SJRs), then cascaded this learning to the medical reviewers during a full

day session on learning from deaths. They also described the steps the trust has taken to improve its quality improvement processes and learning from deaths:

> *"…we didn't at that time have a quality improvement framework, we weren't using quality improvement [QI] methods for our approach to QI… so knowing the learning was going to turn into a reliable, sustainable action was a bit of a gap…I've… introduced a quality improvement framework, we've got a head of quality improvement in post now, [and] we're training quality improvement coaches, all of that is necessary to…make change happen."*

However, the trust representative also acknowledged there needs to be further improvement to be more effective in sharing the learning, both in the trust and with other providers. One step the trust has taken to overcome these barriers is to become a member of their regional academic health sciences network, which a member of the trust described as providing *"a lot of support"*.

The trust representative described the role of families and carers, and how the trust viewed this as highly important. They also stated how valuable they see the role of the family representative in helping with the implementation of the national guidance:

> *"I can't celebrate enough the help that we have had from our family representative and if trusts can find somebody who is, without being patronising, the right kind of person,… someone who can be… [an] advocate for families, for the inputs of patient experience and family experience, and hold the professionals, the senior leaders to account very effectively, then that is extremely powerful."*

While the trust has a good approach to involving families and carers, the trust representative described how the trust is continuing to develop its communication with bereaved families:

> *"…we are iterating as we go the best way to communicate, the best way to invite people to be involved, the best way to integrate all of this with the PALS service, and make sure we have a clearly joined-up approach so families don't end up with loads of different points of contact in the hospital."*

The importance and value that the trust places on family involvement was supported by the trust's family and carer representative who was positive about their role, and described how they felt that the way families are engaged with has changed for the better since their own experience following the death of a family member. As part of their role, the family and carer representative is working with the patient experience team to identify more opportunities for bereaved families and carers to be involved:

> *"… we are actively looking to… involve more families in the process. We might, for instance, think of having more than one family representative sitting on the learning from deaths group, but whether we do that or not, the main point is that we do need to get more information about how families are interacting in the process…"*.

Greater Manchester Mental Health NHS Foundation Trust

Greater Manchester Mental Health NHS Foundation Trust provides community-based and inpatient mental health care and treatment to a population of 1.2 million people living in Salford, Bolton, Trafford and Manchester. It provides a wide range of more specialised mental health and substance misuse services, as well as in-reach services to prisons in the North of England. The trust, which was formed in January 2017 after a merger with Manchester Mental

Health Social Care Trust, was rated as good overall and outstanding for well-led in February 2018.

From the trust's perspective, the National Quality Board (NQB) guidance on learning from deaths guidance has been of limited use to them. The trust representative we spoke with felt that it was too acute focused, and that much of it was not relevant to mental health and community services. In particular, they felt that the language and methodology set out in the guidance were not always applicable to mental health settings:

> *"So for example,…there can be a very different view taken if someone has died of a surgical procedure, which can be measurable, to someone who's taken their own life in a community setting."*

However, as our inspection staff highlighted, the trust already had good existing governance and processes in place for learning from deaths in the trust, with well-established systems for investigating deaths, so had not needed to make significant changes to processes following the introduction of the guidance.

Inspection staff found that overall leadership of the trust was strong, with a leadership team who had passion and drive, which filtered down through the organisation and was reflected in their practices on learning from deaths. The inspection team described the leadership as visible, outward looking and joined-up.

Closely linked to this, the culture of the organisation was also cited as an enabler of good practice, with evidence that the trust is open, honest and person-centred. This was reflected in conversations with the person we spoke with at the trust who described the importance of the user voice and how having a strong user voice in the trust changed the thinking of the organisation and helped them to provide services that were more person-centred:

> *"…we have a number of service user forums, we have service users presenting at board, they co-produce our recovery academy… they're at the heart of what we do and they're very involved in the organisation…"*

While the culture of the organisation was described as open and honest, and the importance of a no blame culture was emphasized by the trust representative, they had concerns about the culture of the coronial system and the challenges this could create in terms of good practice in learning from deaths:

> *"It's about making sure we maintain a culture where there isn't finger pointing going on, because 90% of the time, sadly, it's [a] system failure not an individual failure. However, when it gets to the coronial system, that's when the finger pointing can be pretty horrible for clinicians."*

The person we spoke with at the trust also explained the trust's approach to identifying and reviewing deaths. They explained how the trust is known for having a high rate of reporting of incidents, including low level incidents, that broaden the cases from which to learn. All deaths in the trust, excluding expected deaths, are subject to a three-day review. The trust also carries out 'deep dives' to look at underlying themes and improve the trust's understanding of particular issues:

> *"…a year ago, we had a deep dive review on the mortality rate in our substance misuse services, there was no sort of underlying trend or theme discovered but nonetheless it gave us a greater understanding of the vulnerability of someone who's accessing such services… as well as the complexity… of the physical issues that they can have."*

The trust representative also felt that they had a robust policy in place to make sure that there was parity in reviewing the deaths of people with a learning disability, and that all deaths are reviewed in the same way.

However, resourcing of reviews for learning from deaths was identified as a challenge. Even though the trust had appropriately trained people assigned to carry out the reviews, demands on time and resource were identified as barriers to leading a high-quality review. Linked to this, the timescales of the review were also seen as problematic, with the trust sometimes having to ask for an extension:

> *"I think often timescales can be a bit challenging and that doesn't mean you want things to go on forever, but often there are very good reasons why things take time, and… having to ask for extensions… can be a bit of a bind…"*

Our inspection staff found evidence that the trust was actively using the learning from these reviews to improve quality. This was supported by feedback from the trust representative, who described how learning from deaths contributes to quality improvement at the trust. They explained how coordinated learning events are organised within two months of the report being signed off, and gave an example of quality improvement after sharing the lessons learned from one review:

> *"…in January of this year [2018], there was a homicide that had taken place very sadly in one of our areas. There was an external review… [with] both [Supported Housing Management Team] SHMT and substance misuse teams [involved in] the person's care… we had what we called a joint learning event… so we could review the whole pathway… One of the learning points… was access to probation services and information from probation services so as a result of that… [the] amount of information has improved…"*

This quote also highlights some of the good practice that we found about the trust's approach to working collaboratively. We found some evidence that the trust is collaborating well with system partners, but it was identified by the trust representative as an area for improvement. They described how it could be difficult to engage some partners for joint reviews, particularly in primary care. It was felt that learning from deaths was not a priority for some GP practices, and believed that this could be why they seemed reluctant to be involved in joint investigations.

One of the strongest areas for the trust was engagement with families, which inspection staff felt was meaningful and sensitive. They found that the trust had clear processes in place for how families and carers were initially contacted, how they were offered condolences and support, and how families were engaged in reviews. These processes make sure that families are contacted by the most appropriate person, and that staff who engaged bereaved families have the right training and support. The person we spoke with at the trust explained that these processes had been in place before the introduction of the guidance. However, since the guidance they had introduced sending a letter to families at the end of the investigations from the medical director and director of nursing and governance. Again, the trust showed a person-centred approach, with the letter drafted for each individual case rather than a standard format being used.

The trust representative described how the trust recognised that families and carers react differently to bereavement and may feel different at different times, and how communication should be open and flexible, with support offered at multiple points across any review or investigation. This supported the evidence that we found that the trust provided responsive contact and support in all aspects of investigations, in line with the national guidance.

Norfolk Community Health and Care NHS Trust

Norfolk Community Health and Care NHS Trust provides a range of services including district nursing, community services and inpatient units. The trust serves the population of Norfolk, excluding Great Yarmouth, and was rated as outstanding in June 2018.

We found evidence that Norfolk Community Health and Care NHS Trust was working to expand on their existing processes for learning from deaths, despite facing a number of challenges. At the time the guidance was published the trust already had a process in place for learning from deaths, and was reviewing all inpatient deaths. This put it in a strong position for implementing the guidance, with a trust representative describing how a 'gap analysis' of existing processes had found that it wasn't "*a million miles away*" from the new requirements. However, they acknowledged that some changes were needed, and that there were also challenges in implementing the guidance itself as it was too "*acute-focused*".

As with other trusts, leadership of the organisation was an important factor in Norfolk's implementation of the guidance. There was some evidence that the board had prioritised learning from deaths, and that the leadership team were engaged with learning from deaths. The inspector we interviewed described how "*key individuals [were] identified to lead the project*", and that this was a key factor in their implementation of the guidance. This was supported by feedback from a trust representative, who told us:

> *"I think it's really been key that our directors have supported the work… and invested in leadership, in terms of owning the agenda and taking it forward… strategic leadership and encouragement, and… dedicated resource… is really, really key."*

The trust representatives also told us that the executive team had driven developments in processes for learning from deaths, and we found evidence that Norfolk had carried out work to expand on their existing processes to make sure that the correct deaths were identified for review. While the trust was already carrying out reviews of many deaths, following the publication of the guidance it had expanded its policy to include details on how the trust makes sure that the deaths of people with a learning disability or mental health condition are treated with parity:

> *"The first thing we did in the policy when we refreshed that last year was to define which deaths we were going to review. And currently that includes all inpatient deaths…; community deaths where there are concerns raised…; learning disability deaths of anyone that's been under our service in the last year; and… anyone that would have had a known mental health diagnosis…"*

However, the trust found defining which deaths to review challenging due to the perceived focus of the national guidance on acute trusts. For example, while the national guidance states that, "*Mental health trusts and community trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach*", it does not offer further advice, creating more work for these types of trusts in defining which deaths to review.

When reviews of inpatient deaths are carried out, the trust told us that it had a two-stage approach. Stage one involves the doctor, that covered the inpatient unit where the person died, conducting a review with the senior nurse. Stage two is more in-depth and takes place if concerns are raised in stage one, and occurs in approximately 2% of deaths. This proportion is driven by the findings from the stage one reviews. The trust carries out a thematic review of stage one reviews quarterly to see if there is any further learning or review needed, as well as

recognise any good practice. The trust is currently considering whether the threshold it applies for conducting stage two in-depth reviews produces enough cases to generate learning. Stage 2 reviews are carried out by a consultant who is independent of the unit or department where the death occurred. A person we spoke with at the trust told us that the trust is encouraging multidisciplinary team reviews, which it has trialled in palliative care and found effective:

> *"…our palliative care team [will do] a multidisciplinary team review, so they will sit down each month and look at all of their deaths, and do their reviews together, and they'll have more in-depth discussions of any cases that are of interest."*

Sharing lessons learned, both inside and outside the trust, was also important, with a trust representative describing how there was *"a real keenness to share the work…"*. At a trust level, we saw how it uses technology and a range of channels to communicate learning for staff. These included, for example, weekly messages to all staff, sharing via the medical director, and a grand round focusing on the learning from deaths process.

At a regional and local level, we heard from trust representatives that the trust was a member of at least two local and regional groups that have a focus on learning from deaths. For example, they described how the trust's links with the local sustainability and transformation partnership meant that the trust could "*take a systems approach to learning*", and that the trust has found it reassuring that other trusts seem to be facing similar problems:

> *"…the learning that's coming out of other trusts that they're sharing with us… is very similar. We're all having the same kind of issues. So that's really useful…"*

However, we also found that collaborating on reviews is complex for the trust and that work is ongoing.

Another area that the trust needed to improve was its engagement with families and carers. A trust representative described this as their "*biggest challenge*" for learning from deaths. Since the introduction of the guidance, the trust had taken steps to address this including updating their policy and action plan:

> *"So what we've put in our policy and in our action plan is that obviously being open, duty of candour, the complaints and PALS process are still available for all families, and patients that are at end of life and going through that process."*

The trust also explained how they use the FAMCARE scale to assess how satisfied families are with their experience, following the death of a loved one, where the patient was in palliative care leading up to their death:[3]

> *"…so all palliative care patients go through FAMCARE survey, and we've just got the results of that. That pulls out a lot of experience of families, of how they felt going through that process, what it was like for them, so we get a lot of learning from that."*

Despite the challenges that the trust has faced in implementing this aspect of the guidance, the trust told us that they are keen to get family engagement right to avoid adding to families and carers' distress, and to this end were looking at having a patient or family representative on their mortality review group.

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[3] The FAMCARE Scale is a tool to measure family satisfaction with the care of patients with advanced cancer. The tool was originally developed for use on inpatient units, measuring different areas of care such as availability of care, physical patient care, psychosocial care and information giving.

Learning, next steps and recommendations

As we set out in the introduction, we are at the beginning of the implementation of the learning from deaths guidance, but a first look at this early stage suggests that how well trusts are implementing the guidance is variable.

Our findings have highlighted a lot of the same issues that were raised in the original report, and have shone a light on the need for NHS trusts to act now to build on the key drivers for change, including:

- encouraging values and behaviours that enable engagement with families and carers as well as support for staff
- providing clear and consistent leadership at a senior level with challenge and oversight from non-executives
- creating a positive, open and learning culture where people who use services, and staff, feel confident to speak out
- providing staff with the time, support and training to carry out robust reviews and investigations of deaths
- developing positive working relationships with partner organisations to share information and learning following the deaths of people for whom they have provided care.

This review has reinforced that there is no one factor that guarantees good practice, with enablers and barriers to implementing the guidance being interrelated. However, as we found in our report *Opening the door to change*, the existing culture of an organisation can be a key factor in trusts' implementation of guidance, and could be preventing trusts from making the progress needed. To be able to learn from serious incidents in the NHS, there needs to be a culture where staff, patients and leaders all feel able to speak up and work collaboratively to learn.

Where we have seen examples of good practice in implementing the national guidance in this first year, trusts have built on existing processes, cultures and expertise in reviewing, investigating and learning from sources of feedback, such as the investigation of serious incidents, concerns and complaints. This means that when trusts do not have these characteristics in place at the start, they need to take a long-term view to start to invest and build the necessary capabilities and capacities over the next few years.

There are also actions that others, including the Learning from Deaths Programme Board and CQC, need to take to provide further support to NHS trusts and families and carers in developing their approach to learning from deaths.

The DHSC-led Learning from Deaths programme has shone a light on the importance of learning from deaths, and provided NHS trusts with a benchmark for trusts to measure themselves against. However, there has also been comment about what the programme needs to do next to continue to support implementation, and to make sure that learning from deaths remains a priority for the NHS so there is the necessary investment made by trusts. These challenges include:

- how to align the work with related policy initiatives on introducing medical examiners, safety improvement, complaints and concerns so there is coherence and consistency in the approach

- the need to further develop a system-wide view on learning from deaths that includes clarity on which organisation leads on a death that occurs outside of a hospital, and how to encourage information sharing across NHS providers (including GPs), when investigating the death of a person who receives care from different NHS or other organisations
- the need for a focused assessment of the progress made on reviews and investigations of deaths of people with mental health problems or a learning disability (working with partners such as the Learning Disabilities Mortality Review (LeDeR) programme)
- improved support from a single set of consistent guidance for staff that is agreed across national bodies, including NHS Improvement and Healthcare Safety Investigation Branch, that helps them to carry out robust reviews and investigations of deaths and serious incidents. This should include children, people with a learning disability, people with mental ill-health and mothers.
- the need to analyse and monitor the investment made by NHS trusts in resources in learning from deaths, in terms of training and support and dedicated staff time to carry out reviews and investigations.

As part of developing our relationship management and monitoring functions, we are committed to provide further support and training for CQC inspection and other staff in understanding what good reviews and investigations look like, as well as how to engage sensitively with bereaved families and carers to hear the learning from their experiences of care. CQC will continue to monitor progress by NHS trusts through its monitoring and inspection processes.

Appendix: what we did

All of the analysis used to inform this report is generated by CQC and is qualitative in nature. Specifically, the report is based on qualitative analysis of inspection colleagues' accounts of their experiences of overseeing and/or involvement in well-led inspections at NHS trusts since September 2017. To inform this analysis, we conducted eight interviews with inspection staff, two interviews with CQC specialist advisors and four focus groups with a total of 12 inspection staff. These interviews and focus groups focused specifically on understanding the quality of trust implementation of national guidance on learning from deaths and the enablers of and barriers to good practice. All those invited to interview had led or been involved in at least two well-led inspections. All those invited to the focus groups had led or been involved in at least one well-led inspection. All interviews and focus groups were conducted between June and August 2018.

It is important to note that the findings of this analysis represent an early indication of the quality of trust implementation of national guidance on learning from deaths as described by a sample of CQC inspection staff involved in well-led inspections conducted between September 2017 and June 2018. There are several limitations to the findings, which should be acknowledged when reading this report.

- The sample is composed of CQC inspection staff with differing levels of experience of overseeing and/or involvement in well-led inspections and learning from deaths. As such, depth of knowledge and understanding among participants varied.
- Participants were asked to recount their experiences of trusts inspected since September 2017. As such, trusts discussed as part of this work have had differing lengths of time to implement the national guidance. This was not considered as a factor in the analysis.
- Findings are based on 10 interviews and four focus groups, with a total of 12 inspection staff. No claim is being made as to the extent to which these findings are representative of the overall picture across England.
- We were in the first year of implementing the learning from deaths inspection methodology when this analysis was conducted. As a result, depth of CQC organisational knowledge is limited. In addition, our analysis suggests that inspection teams may have faced some capacity and capability challenges in implementing the learning from deaths inspection methodology. In response CQC is developing its relationship management and monitoring functions, and is committed to provide further support and training for CQC inspection and other staff in understanding what a good review and investigation look like, as well as how to engage sensitively with bereaved families and carers to hear the learning from their experiences of care.

We also carried out a case study analysis of three trusts that had been awarded an outstanding rating in well-led since September 2017. This analysis focused specifically on the quality of processes for learning from deaths and the factors that had supported good practice in this area. To inform these case studies, we spoke to the inspection manager who led the well-led inspection and a representative of the trust. For the West Suffolk case study, we also spoke to a family representative who has been working with the trust to develop processes for learning from deaths. All interviews were conducted between July and October 2018. Findings are trust-specific and no claim is being made as to whether they are representative of other trusts in England.

We have attempted to corroborate these findings about individual NHS trusts with other intelligence on them that is publicly available and used by CQC and NHS Improvement.

We discussed the early findings of this work with CQC's NHS co-production group at a meeting on 8 November. This group includes representatives of families, carers and trusts, and other stakeholders including voluntary sector organisations. Where possible, we have also engaged through trusts with local patient, family and carer groups to comment on these, and verify that they reflect their experiences. We used the points raised in discussion to help inform our interpretation of the findings.

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CQC-434-032019

Berkshire Healthcare
NHS Foundation Trust

QAC Meeting Date	21 May 2019
Title	Guardian of Safe Working Hours Quarterly Report (Feb-May 2019)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Matthew Lowe, Dr James Jeffs, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time shared by the 2 Guardians
Legal Implications	Statutory role
Equality and Diversity Implications	N/A
SUMMARY	
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

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

This report covers the period 5th February to the 5th May 2019

Executive summary

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

This report focusses on the period 5th February to the 5th May 2019. Since the last report to the Trust Board we have received 8 exception report(s).

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

Introduction

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

High level data

Number of doctors in training (total): 33 (FY1 – ST6)

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

Number of doctors in training on 2016 TCS (total): 33

Amount of time available in job plan for guardian to do the role: 0.5 PAs Each (job share)

Admin support provided to the guardian (if any): Medical Staffing

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	8	8	0
Dentistry	0	0	0	0

Sexual Health	0	0	0	0
Total	0	8	8	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	1	1	0
CT	0	2	2	0
ST	0	5	5	0
Total	0	8	8	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	8	8	0
Dental	0	0	0	0
Total	0	8	8	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	1	0	0	0
CT1-3	2	0	0	0
ST4-6	2	2	1	0
Total	5	2	1	0

In this period we have received 8 exception reports totaling an extra 9 hours 20 minutes worked over and above the trainees' work schedules. This is an increase compared to previous quarters. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

The 8 exception reports relate to a small number of trainees, and compared to other trusts a small number of occasions. 2 reports related to a trainee staying after their evening shift to finish off work that was urgent on the Prospect Park rota. 6 reports relate to trainees staying late (between half an hour and 2 hours) to complete urgent work that had not been possible within their scheduled work hours. These occasions did not suggest a problem that required a work schedule review and it was agreed that time off in lieu was the appropriate action. One of the reports resulted from the required blood collection bottles not being available on Daisy ward. They went to all other inpatient wards at PPH and failed to find the required collection bottle anywhere except a single bottle on one ward. This delayed the task which required to be completed and resulted in the exception report. This was also raised through a Datix by the trainee that was escalated to the appropriate managers.

The single exception report not completed within the 7 day timescale was by a Clinical Supervisor who had agreed the process and TOIL with the trainee within the correct timescale but had not completed the computer system correctly.

Update on issues raised in the last Guardian of safe working hours report.

1. **Lack of awareness of reporting processes for Foundation Doctors**
    a. **Log-in:** In the previous report we described an oversight that meant Foundation year doctors were not issued with accounts to report exceptions. The new processes have been applied. The log-ins were sent out a few days after the new Foundation Doctors started in their rotation, as they need to have access to their Trust email accounts in order to access the log-ins. The new Foundation Doctors now have access to report exceptions; this was confirmed at the Junior Doctor Forum.
    b. **The Trainee did not initially know the names of the Guardians of Safe Working, who have not been invited to Foundation Year One (FY1) Inductions:** The Guardians are now routinely invited to the Foundation inductions and Dr Jeffs attended the last induction for Foundation Trainees.
2. **Limited Time to Submit GOSW Report:** Whilst there is little time for turnover between final collection of data on exception reports and the submission of this quarterly report, this has not been problematic on this occasion.

The trainee who made contact with the Guardians to report not having a DRS log in just before submission of the last Guardian of Safe Working Hours report was provided with a DRS log in. Unfortunately the trainee did not ultimately put in an exception report despite being advised to do so, this is within their discretion. Therefore we do not have further information about that incident. They may have addressed the issue informally with their consultant, though we strongly encourage exception reporting.

There have been no systemic concerns about working hours, within the definitions of the 2016 TCS.

b) Work schedule reviews

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

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

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

c) **Gaps**
(All data provided below for bookings (bank/agency/trainees) covers the period 5th February to the 5th May 2019

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	65	65	48	17	0	628.5	628.5	464	164.5	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	56	56	45	11	0	572	572	442.5	129.5	0
Sickness	9	9	3	6	0	56.5	56.5	21.5	35	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	65	65	48	17	0	628.5	628.5	464	164.5	0

The gaps at Core Training following February changeover were anticipated and covered from before the first half of this rotation period began. However, a gap at Foundation Year 2 from April arose unexpectedly as the doctor we were expecting from the Royal Berkshire Hospital left training and left the country, we were able to easily cover the gap on the rota.

d) **Fines**

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

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

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

Qualitative information

The Junior Doctors' Forum (JDF) continues under the oversight of the junior doctor leads, and has been well attended. The current Chair of the Junior Doctor Forum, Christopher Hopkins, is conducting a Quality Improvement project with the other members of the Committee and Supervised by the Guardians of Safe Working Hours looking at clarifying and streamlining the process and roles of the Junior Doctors Forum. This is progressing well.

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

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

Issues arising

There has been an increase in exception reports compared to previous quarters. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting

suggests that Junior Doctors are not working unsafe hours and this is confirmed by the qualitative information from the Junior Doctors Forum.

Actions taken to resolve issues

Next annual report to be submitted August 2019

Summary

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

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

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

Despite an increase in exception reports compared to previous quarters numbers remain low. We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardians at induction and at every Junior Doctor Forum. They are assured that it is a neutral act, and asked to complete exceptions so that the Guardians of Safe Working can understand working patterns in the trust.

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	9th July 2019
Title	Peer Mentor Pilot Update
Purpose	The purpose of this report is provide the Board with an update on the Peer Mentor Pilot on Snowdrop Ward at Prospect Park Hospital
Business Area	Nursing & Governance
Author	Sue McLaughlin , Deputy Director Nursing
Presented by	Debbie Fulton, Acting Director Nursing
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
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	N/A
SUMMARY	The peer mentor pilot commenced in June 2018, with 2 paid Peer mentors recruited to provide an opportunity for a coffee and chat group on the ward so that safety planning could be discussed in an informal space. The introduction of art and craft in December 2018 helped the facilitators by providing a focus for starting discussions more generally which was eventually steered towards issues relating to the ward and more specifically to safety planning. In addition the peer mentors have provided advice and input into some of the safety projects and programmes of work including self-harm and sexual safety. As detailed within the report the pilot has not been without its challenges; it has been subject to on-going evaluation and changes have been made. As detailed in next steps within the report a final evaluation will be undertaken in September 2019 and a decision made regarding
ACTION REQUIRED	Update is presented to the board for their awareness of progress against the peer mentor pilot. The Board is asked to note the update

Peer Mentor pilot update-July 2019

Background

The peer mentor pilot was trialled on Snowdrop Ward (commenced June 2018) an update on the project was provided to QEG and Board in Feb 2019. This paper will provide a further update.

Peer Mentors (PMs)

2 Peer mentors were recruited to provide an opportunity for a coffee and chat group on the ward so that safety planning could be discussed in an informal space. An initial evaluation was positive but a number of changes were suggested including the need for the peer mentors to have a PIT alarm and easier access to the room as well as a regular staff member in attendance. The introduction of art and craft in December 2018 helped the facilitators and patients as it provided a focus for getting started with a discussion more generally which was eventually steered towards issues relating to the ward and more specifically to safety planning.

The Snowdrop session encountered some difficulties in March 2019 when staff were unable to provide a safe space for the peer mentors in terms of a regular room free from interruptions. The peer mentors also felt that some patients were too unwell and disruptive to participate. There was a perceived lack of respect and structure for the group. The peer mentors were quickly able to resolve this with feedback to the ward manger who took immediate action regarding the room and the patient screening process and the sessions were able to recommence. Supervision for peer mentors was also standardised.

Unfortunately both peer mentors have had to take time off sick which resulted in a gap in the provision in late April/May. The group is now back on track and positive feedback has been received from patients attending the session which continues to use art and craft as a focus.

Ward staff on Rose ward have received feedback from patients (previously on Snowdrop) requesting the group for Rose ward and consideration is currently been given to the current group being held in the daylight room to allow wider participation and attendance from all acute wards.

The role of the peer mentor has been extremely valuable in terms of providing advice and guidance on other projects.

1. Self harm RIE
2. Sexual Safety leaflet and more recently sexual safety drop in session which is in the process of development.

The peer mentors are paid members of the ward team and have supervision from the nurse consultant, this model has not been easy to establish and we have learnt some valuable lessons from the pilot. Themes are as follows:

1. Some staff find it difficult to embrace the peer mentors as part of the team and negative attitudes have been observed
2. Staff can view the peer mentors as “additional work”
3. Peer mentors can perceive staff as judgemental
4. Without robust supervision the project breaks down quickly
5. Peer mentors bring valuable ideas and challenge to the ward environment
6. Patients report positive outcomes from peer mentor involvement
7. Staff require support to work with peer mentors
8. It is possible to overcome the issues and challenges with determination

Next steps

1. A new peer mentor (Tony) has joined Leanne and Sharon and we are working to recruit a more diverse peer mentor group at PPH.
2. Funding for peer mentor roles is not currently within team budgets and the director of nursing is funding the roles. However given the vacancy rate at PPH utilising this to fund is an appropriate next step and would provide a stepped approach to peer mentor development – a task and finish group is in the process of being established to address this.
3. Establishment of a clear supervision structure as this is a crucial element to the success of the peer mentor role
4. One of the peer mentors is in the process of expanding her role to assist with the sexual safety work stream at PPH
5. The Snowdrop group will continue on the ward until September 2019 when a final evaluation will be undertaken led by the peer mentors.
6. Success of the group will be measured using the group evaluations and patient and staff feedback.

Sue McLaughlin
Deputy Director Nursing
June 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting Date	9 July 2019
Title	Revalidation—Annual Board Report and Statement of Compliance for 2018/19
Purpose	To assure the Trust Board that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.
Business Area	Medical Director
Author	Dr Minoo Irani, Medical Director & Responsible Officer
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports CQC 'well led' inspection and safe patient care
Resource Impacts	Currently 0.5 wte Band 5 administrator and 1 Additional Programmed Activity for Appraisal Lead
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	The annual board report for revalidation (2018/19) is presented in a different format from previous years, following publication of the revised template by NHSE in June 2019. The reasons for the revised template are well laid out on page 3 of the report. 124 medical appraisals were completed in 2018/19 for 127 doctors with a connection to the trust for revalidation purposes. The 3 incomplete appraisals (approved by the RO) relate to doctors on sick leave (2 Consultants and 1 Specialty Doctor). These are small numbers which are kept under constant review and do not raise concern. The report details improvements implemented in the medical appraisal and revalidation system in the trust and proposes further improvements on page 12, following publication of new guidance on responding to concerns and effective clinical governance.
ACTION REQUIRED	Trust Board to note assurance provided by the RO that medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the Trust. The Chairman is required to sign the Statement of Compliance on

	page 13 of the report following receipt of this assurance.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

Publishing approval number: **000515**

Version number: 3.0

First published: 4 April 2014

Updated: February 2019

Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Lynda Norton on England.revalidation-pmo@nhs.net.

Contents

Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and annexes A – G. Included in the seven annexes is the Annual Organisational Audit (annex C), Board Report (annex D) and Statement of Compliance (annex E), which although are listed separately, are linked together through the annual audit process. To ensure the FQA continues to support future progress in organisations and provides the required level of assurance both within designated bodies and to the higher-level responsible officer, a review of the main document and its underpinning annexes has been undertaken with the priority redesign of the three annexes below:

- **Annual Organisational Audit (AOA):**

  The AOA has been simplified, with the removal of most non-numerical items. The intention is for the AOA to be the exercise that captures relevant numerical data necessary for regional and national assurance. The numerical data on appraisal rates is included as before, with minor simplification in response to feedback from designated bodies.

- **Board Report template:**

  The Board Report template now includes the qualitative questions previously contained in the AOA. There were set out as simple Yes/No responses in the AOA but in the revised Board Report template they are presented to support the designated body in reviewing their progress in these areas over time.

  Whereas the previous version of the Board Report template addressed the designated body's compliance with the responsible officer regulations, the revised version now contains items to help designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance[1]. This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). Some of these points are already addressed by the existing questions in the Board Report template but with the aim of ensuring the checklist is fully covered, additional questions have been included. The intention is to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. In this way the two regulatory processes become complementary, with the practical benefit of avoiding duplication of recording.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – Berkshire Healthcare NHS Foundation trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

The AOA for 2018/19 was submitted by the Responsible Officer on 2 May 2019. No actions from the previous year were noted as pending. The AOA Comparator report for 2017/18 notes that the Berkshire Healthcare response and calculated appraisal rate was 98.4% (same sector appraisal rate in 2017/18 was 93.7%). 124 completed appraisals were confirmed for 2018/19, for 127 prescribed connections. 2 Consultant appraisals and 1 Specialty Doctor appraisal were approved as missed because the doctors were on sick leave. There are no adverse trends noted from the appraisal figures that would require specific action for 2019/20.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Minoo Irani was appointed as Medical Director and RO for Berkshire Healthcare and started in this role on 2 November 2015. Dr Irani has completed the required RO training, regularly attends the NHSE (South) RO Network meetings and is member of the GMC RO Reference Group since November 2015. There are no additional training needs currently identified for Dr Irani in his medical appraisal or PDP. The Trust appraisal lead attends annual refresher training events in the region and also attends at least one of the NHSE (South) RO and Appraisal Leads network meetings every year.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The RO is supported by a 0.5 wte appraisal and revalidation administrator and a Consultant Psychiatrist who is appraisal lead for the trust and has one Additional Programmed Activity per week allocated for this role. There are no pending actions from last year or additional actions required in 2019/20 in this regard.

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

The appraisal and revalidation administrator maintains an up to date record of all doctors with a prescribed connection to the trust (database on secure shared drive).

The RO and Revalidation administrator have access to GMC connect and the RO regularly refers to this at the Decision Making Group meetings.

The RO receives notification from the GMC when a doctor has either added the trust as their designated body or if a doctor's designated body has changed. In case of any doubt, the RO triangulates this information with the medical staffing office and with the revalidation administrator.

There are no pending actions from last year or additional actions required in 2019/20 in this regard.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Appraisal Policy for Medical Staff was reviewed and re-issued in January 2019. It will be reviewed again in January 2021.

Re-skilling, Rehabilitation, Remediation and Targeted Support for Medical Staff Policy was reviewed and re-issued in January 2019. It will be reviewed again in January 2021.

There are no pending actions from last year or additional actions required in 2019/20 in this regard.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

The Revalidation Team from NHS England (South) visited the trust on 12 May 2015 for a peer based Quality Assurance of the medical appraisal process in the Trust. The visiting panel made recommendations for improvement which were all implemented by the RO in 2016/17. These improvements were detailed in the last two annual revalidation reports to the trust Board.

The RO provided a detailed report of all improvements to the Higher Level Responsible Officer (letter of 6 September 2018). An interim report about the improvements made following the 'Independent Verification Visit' was provided by the RO to NHS England South on 24 November 2016.

The RO commissioned the trust internal auditors to review the medical appraisal process in July 2016 and this was reported in August 2016. The auditors identified one 'Medium' priority issue-- 'The Appraisal Policy for Medical Staff (ORG084) and relevant guidance is outdated and does not reflect current operating practice'. The RO accepted this recommendation and acknowledged that the wide-ranging improvements made in the medical

appraisal process were not part of the policy which existed at that time. The policy was re-written and published by December 2016.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All NHS locum or short-term placement doctors appointed to the trust under trust employment contracts are provided with the full range of support with governance data, CPD, appraisal and revalidation like any other substantive doctor in the trust.

For the very small number of doctors employed through locum agencies from time to time (who do not have prescribed connection to the trust), appraisal is not offered through the trust panel of approved appraisers. These doctors are managed through the same governance processes as all other doctors in the trust and can obtain advice for appraisal and revalidation from the appraisal lead. If a training need is identified which would support the locum agency doctor to provide better quality and safer care, the trust would support this.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Whole practice appraisals on annual basis are the norm in Berkshire Healthcare and doctors and appraisers have had frequent updates about this during internal training. As part of Quality Assurance of appraisals, the appraisal lead assesses the quality of a sample of completed appraisal MAG forms using a standardised tool (PROGRESS) and presents a summary of the quality reviews to the appraiser forum to facilitate improvement in practice and standardisation of the appraisal content and output. This process confirms that whole practice appraisals are now the standard in the trust.

The revalidation administrator provides the appraiser and doctor with information about incidents, complaints and compliments recorded on Datix and specific to the doctor, approximately 2 months in advance of the allocated appraisal date.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The trust medical appraisal policy is up to date and in line with national policy, has approval from medical and BMA representative from the Local Negotiating Committee.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The trust has 25 trained appraisers for 127 connected doctors. In 2018/19, there was advance planning to replace appraisers who were due to retire and 2 additional doctors were appointed to be appraisers in the trust.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

The appraiser forum meeting (chaired by the RO/ appraisal lead) occurs three times a year to provide peer support and updates to appraisers with respect to revalidation and appraisal requirements. The RO provides updates from NHSE RO forum which he attends and an external speaker is invited to at least one forum in the year, to provide training on a specific topic. The appraisal lead presents data (appropriately anonymised) from MAG forms in the previous quarter with respect to content of the MAG forms and appraiser narrative and judgements. This is in the context of training for improving the quality of documentation and discussion at appraisal meetings.

All appraisers are encouraged to attend regional appraiser refresher training events.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

A sample of MAG forms is subject to Quality Assurance by the appraisal lead using the PROGRESS tool. The RO receives this information (20 MAG forms were Quality Assured by the appraisal lead in 2018/19). Additionally, the RO Quality Assures a sample of the completed MAG and PROGRESS forms (the RO Quality assured the QA of the appraisal lead by reviewing the MAG forms and corresponding 5 PROGRESS). The Responsible Officer scrutinises a

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

sample of Medical appraisal forms in detail to monitor quality and consistency and liaises with the appraisal lead where necessary.

Annual revalidation reports to the trust Board include information about the above.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

All revalidation recommendations to the GMC have been timely and in line with GMC requirements. There have been no delayed recommendations made by the RO to the GMC.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

When the RO makes a positive recommendation to the GMC for revalidation, the doctor receives a message from the GMC confirming this. There have been no non-engagement referrals to the GMC.

The RO or appraisal lead will always discuss any deferral recommendations with the doctor, in advance of the recommendation being submitted to the GMC.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Berkshire Healthcare has an effective clinical governance system for all clinical staff including doctors and this has been reviewed by the CQC through their well-led inspection of the trust in 2018. In addition, doctors are supported through governance processes involving medical leads in all services, Service Managers, Clinical Directors and the Medical director. The Clinical Effectiveness and audit department also support doctors through implementation of NICE Guidelines and participation in national and local clinical audits.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Any concern about the conduct/ performance of doctors is managed through an established process involving the service manager, Associate Medical Director/medical leads, Lead Clinical Director/ clinical director and RO (Medical Director).

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

The revalidation administrator provides the appraiser and doctor with information about incidents, complaints and compliments recorded on Datix and specific to the doctor, approximately 2 months in advance of the allocated appraisal date. Reflection/ discussion of governance issues raised is monitored through the Quality Assurance of MAG forms by appraisal lead.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Trust Policy on Disciplinary Procedure for Medical and Dental Staff is up to date and based upon the Maintaining High Professional Standards national policy.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[3].

Trust Chairman and CEO are kept informed if any doctor is subject to the Trust Policy on Disciplinary Procedure for Medical and Dental Staff. This was used on 2 occasions in 2018/19. Given the very small numbers, in depth data analysis is not meaningful. One investigation was the result of a patient complaint, which, following the investigation was not upheld. The second investigation was in response to a grievance from a junior doctor and was partially upheld following investigation.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

The standard Medical Practice Information Transfer form is used to request information about new connections to the trust. The RO also promptly responds to MPIT information request from other trusts. Although GPs who work in the out of hours service are employed by Berkshire Healthcare, they do not have a prescribed connection to the trust and do not get appraised within the Trust. The Medical Director of Westcall (the GP Out of Hours service) has provided assurance to the RO that the scope of GP practice in Westcall feeds into their appraisal process in primary care through a summary review that is carried out. Additionally, since 2016, the revalidation administrator provides Westcall GPs who have an employment contract with the trust, with a Datix summary of their governance data for use in their appraisal documentation and discussion. There are also doctors employed by the acute Trust who work within the services delivered by Berkshire Healthcare (Geriatricians employed and connected to the Royal Berkshire Hospital who work on elderly care wards in Berkshire West); an established RO to RO communication process is used if there were any concerns about this very small group of doctors.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Clinical Governance arrangements for doctors including processes for responding to concerns about a doctor's practice are transparent and information about how decisions are made are communicated to doctors in a timely manner. All relevant trust policies have mechanisms to enable doctors to appeal a decision. The medical director will invite doctors subject to concern or investigation for a meeting to explain the process and obtain assurance about the doctor's feedback and reflection.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

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

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

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

Candidates must satisfy these pre-employment checks prior to employment.

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

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

Section 6 – Summary of comments, and overall conclusion

The Revalidation Team from NHS England (South) visited BHFT on 12 May 2015 for a peer based Quality Assurance of the medical appraisal process in the Trust. The visiting panel made a number of recommendations for the Trust to implement and the RO engaged the trust doctors and implemented the wide-ranging recommendations over 2016/17. There are no outstanding actions from 2017/18.

For 2019/20, the RO to review and implement improvements where required in relation to the following:

1. A practical guide for Responding to Concerns about medical practice (NHSE, March 2019). RO to lead on the Decision Making Group in the trust to review the guidance and consider if the current policies and processes which apply to medical staff are fully compliant with this guidance. If any gaps identified, to make recommendations and implement improvements.

2. Effective Clinical Governance for the Medical Profession handbook (CQC, GMC). RO to lead on the Decision Making Group in the trust to complete the self-assessment template and recommend improvements where necessary.

For 2019/20, the RO will implement a standard process for receiving the appraisal output summary from GPs contracted to work in the trust out of hours' service and for the very small number of doctors who work in the trust and have a connection elsewhere.

Overall conclusion:

The Board is asked to receive the annual revalidation report for 2018/19. This will be made available to the higher level Responsible Officer from NHS England South. The Board can be assured that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.

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

Section 7 – Statement of Compliance:

The Board of Berkshire Healthcare NHS Foundation trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Berkshire Healthcare NHS Foundation Trust

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

Role: _ _ _ _ _ _ _ _ _ _ _ _

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 July 2019
Title	**Executive Report**
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 9 July 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. People Plan

At the beginning of June 2019, NHS Improvement published its interim People Plan which sets the national strategic framework for the workforce over the next five years.

The plan was ordered as part of the NHS Long Term Plan and was drawn up under NHS Improvement Chair, Dido Harding, and Senior Responsible Officer, Julian Hartley, Chief Executive of Leeds Teaching Hospital NHS Trust. A national steering group engaged extensively with stakeholders to ensure that a wide range of views fed into the document.

A summary of the plan produced by NHS Providers is included in the appendix.

Executive Lead: Julian Emms, Chief Executive

3. System Working

Andrew Lloyd has been appointed Independent chair of the Frimley Integrated Care System. He is currently chair of Surrey Heath Clinical Commissioning Group (CCG). The timing of this is still to be finalised to ensure a smooth transition from Andrew's role in Surrey Heath CCG to the Integrated Care System position and this will be confirmed in due course. Frimley Integrated Care System is currently working with stakeholders to refresh its strategy and as soon as a draft emerges this will be shared with the Trust Board.

An application by the Buckinghamshire, Oxfordshire and Berkshire West (BOB) Sustainability and Transformation Partnership to become an Integrated Care System was recently accepted by NHS England and NHS Improvement. This is the third wave of approvals (Frimley was in the first wave). Additional expectations of the Integrated Care System are not known at this stage.

The Berkshire West Integrated Care Partnership (ICP) has a development day on 18 July 2019 as part of the process of welcoming the three Local Authorities in the area into the Integrated Care Partnership.

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

4. Listeria Outbreak Update

We received a letter from Public Health England to Trusts on 7th June 2019 confirming cases of listeria contamination had been confirmed in products supplied by The Good Food Chain Company.

This was followed by a letter from Director of NHS Estates at NHS England and Improvement on 12th June 2019 requesting confirmation that all products from this supplier had been removed from NHS Trusts.

We responded to confirm that we have used products from The Good Food Chain Company and that removal of all their products was completed on the 28th May 2019.

As a result of this problem, the Trust has taken the following actions:-

1. We have checked all food suppliers and identified that this company was only being used at Prospect Park Hospital as a supplier for ISS, the facilities management company.

2. ISS were notified on 27th May 2019 by The Good Food Company of a potential problem. They stopped using the supplier immediately and rejected a delivery from the company on 27th May 2019 based on the email alert. The last date sandwiches were sold in the Prospect Park Hospital Café was 24th May 2019 (5 sandwiches were sold, one of which was chicken). The last date sandwiches were supplied to patients on our wards was Friday 24th May 2019 for mental health wards and on Saturday 25th May and Sunday 26th May 2019 for the Campion Unit.

3. ISS have confirmed in writing the actions they have taken as a result of the alert.

4. Sandwiches provided to wards at our community hospitals are produced in-house by our own Catering team. Pre-packed sandwiches sold at our cafes on these sites are from Urban Eats. We have excellent food hygiene standards (5 star rated) and we have checked that we are not using any ingredients from this supplier or the factory which supplied the products affected. (Outbreak originated in a factory and chicken products were affected, but all products from the factory have been withdrawn).

5. We have not had any positive results from tests undertaken on patients who are unwell.

6. A statement to respond to any media enquiries has been prepared.

7. Guidance has been provided to our clinical teams on symptoms of Listeriosis so we can monitor patients in services that may have been exposed to the outbreak.

8. Guidance will be provided to our staff on what we can do to reduce the risk of getting Listeriosis.

Listeria is a bacteria that can cause the infection Listeriosis if ingested. The majority of people infected barely noticed the illness but it can be fatal to high risk groups – pregnant women, babies, the elderly and those with weakened immune systems.

There is national media interest as nine cases have been confirmed and 5 hospital patients have died. The Good Food Company chain supplied 43 NHS Trusts across the UK.

Reducing the Risk of Listeria

DO:
- Wash your hands regularly with soap and water.
- Wash fruit and vegetables before eating them.
- Store ready-to-eat foods as recommended by the manufacturer.
- Make sure all hot food is steaming hot all the way through.

DON'T
- Do not eat food after its use-by date, even if it looks and smells normal.

For information – please disseminate to relevant staff

Dear all,
As you may be aware, Public Health England are currently investigating cases of Listeria identified from patients in a number of hospital settings in the UK, which has been linked to a batch of prepacked sandwiches/ salads.

The associated company withdrew the identified pre packed sandwiches and salads and have ceased to supply. All NHS organisations have been required to respond to Public Health England regarding actions taken.

Some neighbouring organisations have now reported positive cases. Within Berkshire Healthcare, Prospect Park Hospital was identified as an inpatient area that was supplied by the company (although in a small amount). No cases have been identified within Berkshire Healthcare.

Due to positive cases identified in neighbouring organisations, the following information from Public Health England may be useful if patients or visitors have questions:

- ***The health risk to the public remains low and individuals should only seek medical attention if they develop symptoms.***
- Listeriosis is a rare infection and for most people, it goes unnoticed or there are mild symptoms of gastroenteritis that usually last a short time without the need for treatment.
- Listeria infection in healthy people is usually either unnoticed or may cause very mild illness. However, it can have more serious consequences for some people, particularly those with pre-existing health conditions and pregnant women. The health risk to the public remains low and individuals should only seek medical attention if they develop symptoms

- The incubation period ranges from 24 hours to 70 days, so while the vast majority of cases are likely to be seen by healthcare professionals in the first week after infection, a few may have a delayed presentation.
- Occasionally, a more serious infection develops and spreads to the bloodstream or brain. This can happen in people who have serious underlying health conditions and can also occur in pregnant women. Pregnant women and people with underlying health conditions can find more information on the NHS website.
- Severe listeriosis is more likely to affect the elderly, very young babies, pregnant women and those with a weakened immune system. People in these groups should seek immediate medical attention if they experience symptoms of infection. (such as fever, severe body ache, headache and febrile gastroenteritis)

Staff should remain vigilant to any patients in high risk groups with unexplained symptoms of gastroenteritis especially if they were in hospital in May or transferred in to a community ward from another hospital. Standard infection control and food hygiene policies must be maintained.

Please contact the IPCT if you require any further advice (infection.control@berkshire.nhs.uk), alternatively information can also be found on the PHE and NHS websites:

https://www.gov.uk/government/news/listeria-cases-being-investigated
https://www.nhs.uk/conditions/listeriosis/

Executive Lead: David Townsend

Presented by: Julian Emms
Chief Executive
July 2019

on the day BRIEFING

NHS Providers

Interim NHS People Plan – national workforce strategy

NHS Improvement, NHS England and HEE have published the interim NHS People Plan (the plan) which sets the national strategic framework for the workforce over the next five years. The plan has been drawn up under the direction of Baroness Dido Harding, NHS Improvement Chair and senior responsible officer Julian Hartley, Chief Executive of Leeds Teaching Hospital NHS Trust. During the first quarter of 2019, a national steering group was set up to support engagement with key stakeholders and ensure wide input into the interim plan from across the sector. NHS Providers contributed significantly to the work of the steering group and its sub-groups. A final people plan will be published in the months following the 2019 spending review.

This briefing provides an overview of the key proposals within the document and a summary of each section within the plan.

Overview of key proposals

- A "new offer" to NHS staff will be developed through consultation this summer to ensure the NHS rapidly becomes a better place to work.
- A consultation on changes to pensions policy has been announced, which includes the proposed introduction of some added flexibility for senior clinicians through a "50:50" option enabling them to halve their pension growth beyond a certain point in exchange for halving their contribution.
- The NHS will engage on a "new leadership compact", establishing the cultural values and behaviours expected from leaders at all levels across the service.
- The compact will include a review of regulatory oversight frameworks and implementation of 360 degree feedback from providers, commissioners and Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) on support received from regional and national leaders.
- A "new operating model" for increase workforce devolution to regions, ICSs and local organisations will be developed, utilising an ICS maturity matrix to benchmark workforce planning capabilities.
- A series of initiatives will aim to recruit an additional 40,000 nurses to the NHS in the next five years, including a rapid expansion and review of clinical placement capacity; increasing the acceptance rate; and consolidating national recruitment campaigns with a particular focus on learning disability and mental health nurses.
- Funding for CPD should be restored to its previous levels over the next five years, depending on the spending review.
- An independent review of HR/OD best practice in the NHS will be carried out later in 2019.
- NHSE will develop a new procurement framework for approved international recruitment agencies, while STPs and ICSs will implement 'lead recruiter' arrangements for staff coming from overseas.
- The NHSI national retention programme will be expanded to all trusts and into primary care.
- The NHS will review its levels of undergraduate medical school places and launch a national conversation on what patients and the public require from 21st century medical graduates.

NHS – the best place to work

A new offer to staff

A key pillar of the plan is its aim to ensure the NHS rapidly becomes "a much better place to work". This is to be achieved through the development of a "new offer" to staff, the details of which will emerge in full following a period of consultation this summer.

The idea of a new offer comes following an acknowledgement from NHS leaders that the service needs to make significant progress to ensure healthcare careers remain an attractive option. The plan argues that jobs in the sector have become "increasingly demanding", noting that staff are overstretched and struggling from the impact of poor recruitment and retention. The document also states that the NHS is operating "in a highly competitive employment market with changing generational expectations about careers".

This reflects widespread concern around the lack of flexibility that NHS organisations – including trusts – are able to provide particularly to younger members of staff in the current environment. HEE's draft workforce strategy in 2018 first acknowledged the need to consider a different approach for "millennial" staff seeking career breaks and non-linear careers, and this requirement is reflected in the people plan's goal for the NHS to be a "modern" and "flexible" employer.

The offer will ultimately be made up from a series of new or revised commitments in the NHS Constitution and form the basis of a "balanced scorecard" under the NHS Oversight Framework which will inform future CQC well-lead assessments. It will make explicit commitments around the broad themes of:

- Creating a healthy, inclusive and compassionate culture, with a focus on equality and inclusion, bullying and harassment.
- Enabling development and fulfilling careers, with a focus on CPD, credentialing of expertise and line management.
- Ensuring voice, control and influence for NHS staff, by improving health and wellbeing, work-life balance and conditions for whistleblowers.

The document also calls for an independent review of HR/OD best practice in the NHS, to be carried out later in 2019. The plan's authors are seeking a greater focus on people issues at board level which it feels is lacking following "a quick survey of board papers" during the development of the plan.

Leadership compact and culture

The plan has placed a heavy emphasis on improving leadership and organisational culture throughout all levels of the NHS. This work comes on the back of the Developing People Improving Care Framework in 2016 which, according to document, has "not led to the widespread culture change it set out to deliver". The plan has also noted the impact of greater systems collaboration, which it says introduces new and different leadership challenges.

The plan frequently refers to the need for inclusivity, diversity, compassion and positivity in leadership and culture, stressing that these ideals apply to the NHS arms length bodies as they do to frontline leaders across the country. Its central ambition in this area is to undertake system-wide engagement on a "new NHS leadership compact" establishing the cultural values and behaviours expected from leaders. The compact will be a "gives and gets" agreement, also setting out the type of development and support local leaders can expect from the centre.

Within the leadership compact, the people plan also calls for:

- The development of competency, values and behaviour frameworks for all senior leadership roles (an extension of the Kark Review's recommendation for board members to meet specified measures of competence).
- A review of regulatory and oversight frameworks to ensure "a greater focus on leadership, culture, improvement and people management".
- Implementation of 360 degree feedback from providers, commissioners and STPs/ICSs on support received from regional and national teams.
- The roll-out of talent boards to every region and an expansion of the NHS Graduate Management Training Scheme.
- Development of a central database for directors and engagement over the remaining recommendations from the Kark report.

Pensions

The NHS workforce has been hit hard by the impact of the annual and lifetime pension allowances, causing large and unpredictable tax bills for senior doctors and managers in particular over the past year. Increasingly, NHS trusts have been struggling to stem the tide of senior medical staff leaving the NHS pensions scheme, reducing their working hours and – sometimes – leaving the NHS altogether to avoid effective 100% marginal tax rates brought about by a poorly designed taxation system.

Following extensive discussions between all key parties, including DHSC, it's arms-length bodies, the Treasury and the British Medical Association (BMA), the government has announced a policy change increasing pensions contributions flexibility for scheme members. The people plan says briefly describes a proposal to allow senior clinicians the option of halving their pension growth beyond a certain point in exchange for halving their contribution. This has been described as the "50:50" option in the sector and is similar to the offer given in local government pensions.

Alongside the release of the interim people plan, the Department of Health and Social Care (DHSC) said it was consulting on new plans enabling senior clinicians to "freely take on additional shifts to reduce waiting lists, fill rota gaps or take on further supervisory responsibilities". However, it is not clear whether this goes beyond the "50:50" option, which the doctors' union opposes. Additional funding will come from DHSC, instead of the Treasury.

Tackling nursing shortages

NHSI, NHSE and HEE have identified the nursing workforce as the key group in need of support, with a fear that the current level of vacancies – 40,000 across NHS trusts – is set to rise exponentially without concerted action to address the gap. The plan says shortages in nursing are "the single biggest and most urgent we need to address", predicting that the policy initiatives outlined in the document can grow the size of the workforce by 40,000 over the next five years "to keep pace with rising demand". It states that further action will be needed within the final people plan to hit a 5% vacancy rate target by 2028 (currently 11%).

Increasing supply through undergraduate training

Given the time it takes to train a nurse through an undergraduate degree, the plan highlights the need to immediately increase the supply of newly trained nurses through this route. It sets out the ambition to provide capacity for all suitable applicants to secure a place. The NHS will work with higher education institutions (HEIs) to expand their intakes and identify the correct number of corresponding clinical placements by improving coordination between HEIs and trusts.

Alongside this, a more comprehensive review of current clinical placement activity will take place to identify outliers and support the removal of barriers to expanding capacity, including the potential to expand placements in primary and social care.

Further initiatives to increase undergraduate supply include:

- A rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019, with NHSE working alongside trust directors of nursing to assess organisational readiness and provide targeted infrastructure support.
- Increasing the acceptance rate from its 2018 level of 55% to 70%, with a programme of work to understand what is behind the decline, ensuring that intake levels are increased without compromising rigorous standards for entry or patient safety.
- A consolidation of current recruitment campaigns run by different national bodies, including the recent 'we are the NHS' campaign, to develop a single campaign that reflects the realities of a career in modern nursing.
- ALBs working with the Office for Students to agree a standard definition for attrition for all healthcare programmes.
- Further work with DHSC to improve awareness and effectiveness of financial support programmes for trainee nurses through the Learning Support Fund (LSF).

The full people plan will identify concentrated action in areas of nursing with the greatest shortages, including mental health, learning disability, and primary and community nursing. NHSE will work with HEIs to identify and address these shortages by promoting nursing roles in these areas and highlighting the rewarding nature of these career options.

International recruitment

The plan acknowledges the need to increase international recruitment significantly in the short and medium term to rapidly increase supply. This will involve ensuring the system for overseas recruitment is effective and achieves economy of scale. Specifically, the plan promises that:

- HEE will continue to build global partnerships and exchanges and NHSE/I regional teams will become responsible for the coordination of local health systems' recruitment efforts.
- STPs and ICSs will implement 'lead recruiter' arrangements as part of delivering their five year workforce plans.
- NHSE will develop a new procurement framework of approved international recruitment agencies for these lead recruiters to draw on to ensure consistent operational and ethical standards.
- A best-practice toolkit will be developed with NHS Employers to highlight good practice and improve the experience and retention of international nurses through improved pastoral support. NHSE will work with DHSC and professional regulators to streamline regulatory processes.

Retention and return to practice

NHSI's retention programme launched in 2017 has contributed to minor progress in nursing turnover, with rates reducing from 12.5% to 11.9% in participating trusts. The plan outlines further actions to improve retention, including:

- An expansion of the national programme to all trusts and into primary care, focusing on early years retention and providing hands-on support where the need is greatest.
- Boosting the numbers of nurses with lapsed registration to return to practice, working with Mumsnet to launch a new marketing campaign to inspire nurses to enrol in return to practice courses and make them aware of opportunities and support available.
- Further work in the full people plan to convert participation in return to practice courses into employment for mature staff and filled vacancies in shortage areas.

Continuing professional development and flexible entry

The plan admits that funding pressures on the CPD budget has led the NHS to invest less in developing current staff in order to invest in training new staff. The budget for CPD and workforce development has dropped by almost half since 2013/14. The plan's authors argue that CPD should remain a mixed model with investment from local employers supplementing the national investment from HEE.

In terms of CPD funding, action will be taken to inform the full people plan, reviewing how to increase national and local investment with the aim of achieving phased restoration over the next five years of previous funding levels for CPD. Alongside increased development opportunities for current staff, the plan has identified new entry routes as a priority, proposing:

- That the final people plan explores the potential for a blended learning nursing degree programme with an online theoretical component.
- The development of a clear model that sets out the different routes into nursing and their benefits, and an expanded pilot programme for nursing associates wishing to continue their studies to registered nurse level.
- Consideration of job guarantee approaches at system level to maximise opportunities for nurses using the blended model to qualify.

Workforce devolution

A significant policy shift is offered in the plan through its call for increased workforce devolution from the centre. The document proposes a "new operating model", arguing that a complex architecture at ALB level and a lack of alignment between workforce, service and financial planning at national and local levels has hampered efforts to put forward clear and coherent plans to tackle rising vacancies.

The plan emphasises the need for "honest conversations …about who needs to do what at which level to increase our chances of success" in workforce planning. Contrary to some reports, it does not simply demand a shift to full control for ICSs, but instead proposes differentiated responsibilities under the following principles:

National workforce activity where:

- it is necessary to meet statutory responsibilities;
- to benefit from economies of scale;

- Planning is needed over a longer timeframe, eg over 15 years;
- There are clear benefits from a national role in standardisation or coordination/implementation; and/or
- National teams have specific and scarce skills/knowledge that it is not possible or desirable to duplicate sub-nationally.

Regional workforce activity where:

- There is a need for an assurance role in delivering national priorities such as international recruitment.
- Planning is needed over a medium-term time frame, e.g. over five years.
- There is demand for improvement support on a large scale.
- There is a need to help foster capacity and capability in local health systems.
- Decisions need to be made across a regional labour market.

ICS workforce activity where:

- Regional footprints are too large to affect change.
- Strong local partnerships are required.
- Planning is needed over a short- to medium-term time-frame, eg in-year or over three years.
- Decisions need to be made across a local labour market.

Local workforce activity to:

- Develop and sustain a clear vision for the organisations aligned to the overall ambition of the ICS.
- Develop and embedding local values, derived from the NHS Constitution.
- Build an inclusive, compassionate and improvement-focused culture.
- Ensure all people are able to do their best work.
- Recruiting and retain people for a local organisation.
- Account for the wellbeing of employees and advance equality of opportunity.
- Develop and implement organisational people plans and contribute to ICS people plans.

Shifting responsibility for planning and other workforce activity will not happen immediately, particularly in respect to ICSs, with the document announcing plans for a co-produced ICS maturity framework to benchmark workforce activities at system level. This will both inform the support that systems can expect from HEE and NHSI and their regional teams, and influence decisions on the pace and scale at which systems can take on additional responsibility.

The plan underlines consistent and timely data as a key to enhanced workforce planning while – at a national level – a new People Board, chaired by the new NHS Chief People Officer Prerana Issar, and its advisory group , will oversee the development of the full people plan later in 2019/20.

Transformation and skills mix

While the headline announcements for healthcare professionals relate mostly to the nursing workforce, the document sets out its expectations for the development of other professions towards the goal of "delivering 21st century care".

The people plan calls for a "transformed workforce with a more varied and rich skills mix" to support the move towards new care models and better multidisciplinary working. This ambition reflects a drive to 'do things differently' in workforce planning: not simply relying on linear and inflexible staffing models of the past.

A vision for the future of various medical and clinical professionals outside of nursing is provided, with an acknowledgment of the need to "refine our estimates of the number and mix of new posts needed over the next five years". Further work will need to take place in this space to ensure these estimates reflect priorities set out in the Long Term Plan, and within local and national implementation plans due to be published this financial year. An "open debate" will take place on the level of growth needed in different staff groups, closely coinciding with discussions on education and training funding through the spending review.

Specific proposals around workforce transformation include:

- Recruitment of an additional 7,500 nurse associate trainees by December 2019.
- The establishment of a national programme board to address geographic and specialty shortages in doctors.
- A review of undergraduate medical school places, with potential to expand beyond the recent addition of 1,500 places.
- Work with the GMC and medical colleges to roll out credentialing.
- Expansion of the NHSI national retention programme to include allied health professional (AHP) support.
- Support for every STP/ICS to put in place a collaborative approach to apprenticeships and maximise levy use.
- Developing infrastructure for a new pharmacy foundation training programme.
- More flexible career entry routes for healthcare scientists;
- Training to ensure a core level of digital ability for all non-technical NHS staff.
- A new internal medicine training model for junior doctors, with the aim of increasing generalist expertise.
- The launch of a national consultation on what the NHS, patient and the public require from 21st century medical graduates.

NHS Providers View

Trust leaders tell us that the range of workforce challenges they face, centred on recruiting and retaining the right number of staff, and building a positive culture, are their number one concern. The interim people plan is the first, clear, public recognition from our national system leaders of the severity of this issue.

As such, it is a welcome statement, containing an important acknowledgement that solving our workforce challenge isn't just about future workforce planning and more money, important though these are. We welcome the focus on making the NHS a great place to work, changing its leadership culture and training a workforce equipped for the future. Trust leaders have a key role to play on each of these issues.

The plan also seeks to pull all of the NHS together behind this single, clear, approach: a unity of purpose that's been sadly lacking for far too long. Government, arms length bodies and front line leaders all have a vital part to play here, with more responsibility and resource rightly being devolved towards local systems. We particularly welcome the much more inclusive way this plan has been developed and the speed of the work, which have genuinely felt different.

However the publication of the interim plan also makes clear how far the NHS has to go to stabilise the workforce challenges we face. We are conscious that the development of some of the solutions helpfully flagged in the interim plan will take time and that we remain dependent, to some extent, on the publication of the final document later this year, after the 2019 spending review, and on a sustainable approach to recruitment and retention of the social are workforce.

The interim plan promises several consultations and significant further work to inform the final strategy. Itis important the positive and inclusive approach of the national steering group continues under new structures in the coming months to ensure new proposals and solutions deliver maximum benefit as they are implemented at the frontline. Consultations on leadership behaviours, HR/OD practice, and systems maturity are particularly important areas for which NHSI and NHSE must receive wide input and where there will be learning for leaders across the system, nationally, regionally at system and individual organisational levels.

Colleagues in the national bodies must also continue to work closely with national stakeholders to come to a sector-wide consensus on future workforce design and the levels of funding necessary for education and training. We cannot ignore the significance of the upcoming spending review. Priorities include a clear increase in funding for CPD; clarity over financial support and targets for international recruitment; and a revision to the currently unworkable apprenticeship levy.

NHS Providers will continue to engage closely with the work of the new National People Board, ensuring that the provider voice is heard and the momentum we have helped to create is maintained in addressing both the short, and longer term, challenges facing workforce planning for health and care

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 July 2019
Title	Financial Summary Report – M2 2019/20
Purpose	To provide the Month 2 2019/20 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
Equalities and Diversity Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with summary of the M2 2019/20 financial position.

ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 2 2019/20 (May 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 2 (plan 2)
	  ○ Capital Service Cover rating 3
	  ○ Liquidity days rating 1
	  ○ I&E Margin rating 3
	  ○ I&E Variance rating 1

	○ Agency target rating 1 **YTD Income Statement (including PSF Funding; excluding donations):** • Plan: £0.5m deficit • Actual: £0.3m deficit • Variance: £0.1m better than plan. **YTD Cash** £22.6m vs Plan £24.1m. **YTD Capital expenditure:** £0.7m vs Plan £0.9m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2019/20

Month 2 (May 2019)

Purpose

To provide the Board and Executive with a summary of the Trusts financial performance as at 31th May 2019.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	11/06/19	Tom Stacey	1st Draft
2.0	12/06/19	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Key Messages

Key Metric	YTD Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior Year
Surplus / (Deficit) for PSF	(0.6)	(0.7)	0.1	▲	▼
PSF - Trust	0.2	0.2	0.0	▼	▼
PSF - System	0.0	0.0	0.0		
Control Total Surplus / (Deficit)	**(0.3)**	**(0.5)**	**0.1**	▼	▼
Statutory Surplus / (Deficit)	(0.3)	(0.5)	0.1	▲	▼
CIP Delivery	0.4	0.6	(0.2)	▼	▲
Agency Spend	1.0	1.3	(0.3)	▼	▼
OAPs - Specialist Placements (incl LD)	1.4	1.4	0.0	▼	▲
OAPs - Overspill Beds	0.4	0.3	0.1	▼	▲
Capital Expenditure	0.7	0.9	(0.2)	▲	▼
Cash	22.6	24.1	(1.6)	▲	▲

NHSI Compliance	Actual	Plan
Capital Service Cover	3	3
Liquidity	1	1
I&E Margin %	3	3
I&E Variance From Plan %	1	1
Agency vs Target	1	1
Use Of Resources Rating	***2***	***2***

Key Messages & Actions

- The Trust delivered to plan in May. We remain £0.1m ahead of Control Total pre PSF, and after accounting for PSF our statutory deficit is £0.3m, £0.1m ahead of plan.
- Use of Resources rating is a "2" overall, in line with our plan. The rating has been driven down by the one-off pay award deficit in April, but May shows expected improvement.
- Pay costs in May were £0.2m above plan after absorbing recruitment assumptions.
- May cash balance was £1.6m lower than planned, although £0.8m of debt was cleared in the first week of June.
- Capital spend for the month was on plan, with spend remaining £0.2m below plan YTD.

Key Risks

- As in the latter months of 18/19, pay costs are peaking over affordable levels, meaning increases in substantive must be funded from reductions in non permanent costs.
- Pressure on mental adult acute and PICU beds continues and whilst our use of placements has fallen this month, the pressure and challenge to reduce usage remains an ever present risk to our forecast. Given the speed at which initiatives are likely to reduce numbers, at this stage is seems unlikely that the £2m placement savings target will achieve, emphasising our need to deliver on our 'stretch' CIP target.

2.0 Income & Expenditure

Income Statement	In Month			YTD			FY	Prior Year YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Operating Income	20.3	20.2	0.0	40.4	40.5	(0.1)	242.4	37.9	2.5	6.5%
DoH Pay Award	0.1	0.0	0.1	0.1	0.0	0.1	0.0	0.0	0.1	
Other Income	1.6	1.6	(0.0)	3.1	3.1	(0.0)	19.4	3.3	(0.1)	(3.7)%
Total Income	***21.9***	***21.8***	***0.1***	***43.6***	***43.6***	***(0.0)***	***261.7***	***41.2***	***2.4***	***5.8%***
Staff In Post	13.8	13.9	(0.1)	28.1	28.6	(0.5)	167.5	25.4	2.7	10.5%
Bank Spend	1.3	1.1	0.2	2.6	2.2	0.4	12.8	2.2	0.4	16.9%
Agency Spend	0.5	0.4	0.1	1.0	0.8	0.1	5.0	1.1	(0.1)	(11.1)%
Total Pay	***15.6***	***15.4***	***0.2***	***31.6***	***31.6***	***0.0***	***185.2***	***28.7***	***2.9***	***10.2%***
Purchase of Healthcare	1.3	1.2	0.1	2.6	2.5	0.2	14.1	2.8	(0.2)	(5.9)%
Drugs	0.5	0.6	(0.0)	0.9	1.1	(0.2)	6.7	0.8	0.1	12.2%
Premises	1.4	1.3	0.1	2.7	2.5	0.2	15.1	2.4	0.3	12.5%
Other Non Pay	1.7	1.9	(0.2)	3.2	3.5	(0.3)	21.9	3.4	(0.1)	(3.6)%
PFI Lease	0.5	0.6	(0.0)	1.1	1.1	(0.0)	6.7	1.1	0.0	2.3%
Total Non Pay	***5.4***	***5.5***	***(0.1)***	***10.6***	***10.8***	***(0.2)***	***64.7***	***10.4***	***0.1***	***1.3%***
Total Operating Costs	***21.0***	***20.9***	***0.1***	***42.2***	***42.4***	***(0.2)***	***249.9***	***39.1***	***3.1***	***7.8%***
EBITDA	***0.9***	***0.9***	***0.0***	***1.4***	***1.2***	***0.2***	***11.8***	***2.1***	***(0.7)***	***(31.7)%***
Interest (Net)	0.3	0.3	(0.0)	0.6	0.6	(0.0)	3.6	0.6	0.0	0.5%
Impairments	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	
Disposals	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	
Depreciation	0.5	0.5	0.0	1.0	1.0	0.0	6.6	0.8	0.3	38.0%
PDC	0.2	0.2	(0.0)	0.3	0.3	(0.0)	2.0	0.3	0.1	22.3%
Total Finanacing	***1.0***	***1.0***	***0.0***	***2.0***	***1.9***	***0.0***	***12.3***	***1.6***	***0.4***	***21.7%***
Surplus/ (Deficit) for PSF	***(0.1)***	***(0.1)***	***(0.0)***	***(0.6)***	***(0.7)***	***0.1***	***(0.4)***	***0.4***	***(1.0)***	***(225.4)%***
PSF - Trust	0.1	0.1	0.0	0.2	0.2	0.0	2.3	0.2	**(0.0)**	**(5.5)%**
PSF - System	0.0	0.0	0.0	0.0	0.0	0.0	0.0			
PSF - Subtotal	***0.1***	***0.1***	***0.0***	***0.2***	***0.2***	***0.0***	***2.3***	***0.2***	***(0.0)***	
Surplus/ (Deficit) for CT	***0.0***	***0.1***	***(0.0)***	***(0.3)***	***(0.5)***	***0.1***	***1.9***	***0.7***	***(1.0)***	***(147.8)%***
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(97.4)%
Donated Depreciation	(0.0)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.1)	0.0	0.0	(563.6)%
Impact of Donations	***0.0***	***0.1***	***(0.0)***	***(0.3)***	***(0.5)***	***0.1***	***0.0***	***0.7***	***(1.1)***	***(148.0)%***
Impairments	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	(0.0)%
Surplus/ (Deficit) Statutory	***0.0***	***0.1***	***(0.0)***	***(0.3)***	***(0.5)***	***0.1***	***1.8***	***0.7***	***(1.1)***	***(148.0)%***

Key Messages

The Trust recorded a £0.1m loss in month, which was in line with plan and Control Total. YTD the Trust remains £0.1m ahead of Control Total.

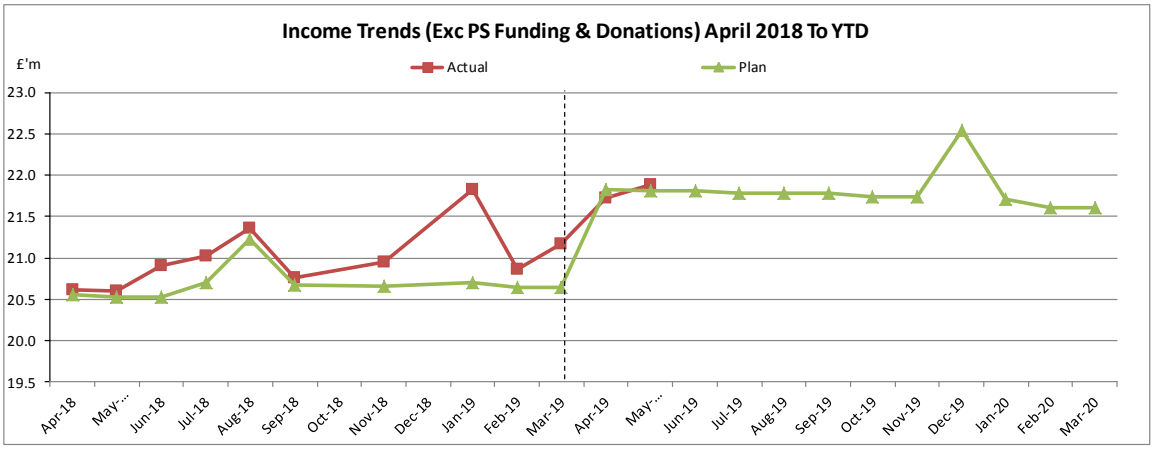
Income was ahead of plan by £0.1m reflecting the YTD element of an additional £0.4m additional DSCC funding for the pay inflation for local authority commissioned contracts.

Following the non-recurrent payment in April, May represents a normalised pay position. Overall costs were £0.2m above plan, with non-permanent usages in excess of vacancies, after accommodation of the annual vacancy factor.

Non pay costs were contained within plan, with results £0.1m lower than anticipated. Out of Area placement costs fell but remained £0.1m ahead of plan, with demand for Acute and PICU placements continuing at a higher than assumed level, and with higher observation fees than initially estimated in April.

Income & Contracts

Income Statement	In Month			YTD			FY	Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	17.9	17.8	0.1	35.7	35.6	0.1	213.2	33.1	2.6	7.9%
Tariff Income	0.2	0.2	0.0	0.3	0.3	0.0	2.0	0.5	(0.2)	(31.8)%
Pass Through Income	0.3	0.4	(0.1)	0.6	0.8	(0.2)	4.8	0.5	0.1	18.4%
DoH Pay Award	0.1	0.0	0.1	0.1	0.0	0.1	0.0	0.0	0.1	
Other Income	3.4	3.4	(0.0)	6.9	6.9	(0.0)	41.8	7.1	(0.2)	(3.1)%
Total Operating Income	***21.9***	***21.8***	***0.1***	***43.6***	***43.6***	***(0.0)***	***261.7***	***41.2***	***2.4***	***5.8%***
PSF - Trust	0.1	0.1	0.0	0.2	0.2	0.0	2.3	0.2	(0.0)	(5.5)%
PSF - System	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(97.4)%
Total Reportable Income	***22.0***	***21.9***	***0.1***	***43.8***	***43.9***	***(0.0)***	***264.0***	***41.5***	***2.4***	***5.7%***



Income

YTD	£'m
2019/20	43.6
2018/19	41.2
▲	*6%*

Prior Yr	£'m
May-19	21.9
May-18	20.6
▲	*6%*

Key Messages

Income was £0.1m ahead of plan. NHSI have confirmed that the Trust will receive £0.4m non recurrent funding to cover the cost of the AfC pay award, which could not be recouped through price increases on Local Authority commissioned contracts. The YTD impact is reflected above and is driving the higher than planned performance.

Commissioner Focus

The Trust is meeting with NHSE at the end of June in an effort to agree the CAMHS Tier 4 contract and to mitigate the risk of moving to a bed day rates contract.

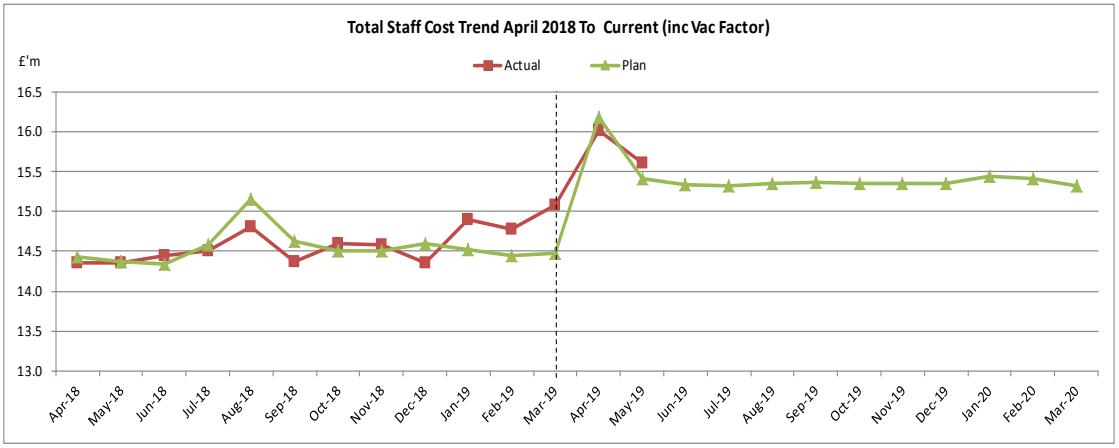
System Focus

There has been no further discussion on the System PSF allocation. Whilst it is suggested that 'offsets' will be able to be agreed locally this year, opposed to requiring NHSI sign off; to date official guidance has not been issued.

DHSC recently issued guidance for Trusts to transfer the ownership of assets from NHSPS. Work is progressing to explore this and we will be talking to system partners about this opportunity over the coming weeks.

RBH are due to receive the initial results of KPMGs financial recovery work. The wider risk that this pressure and the CCG deficit present continues to be monitored by the ICS Financial Recovery Group.

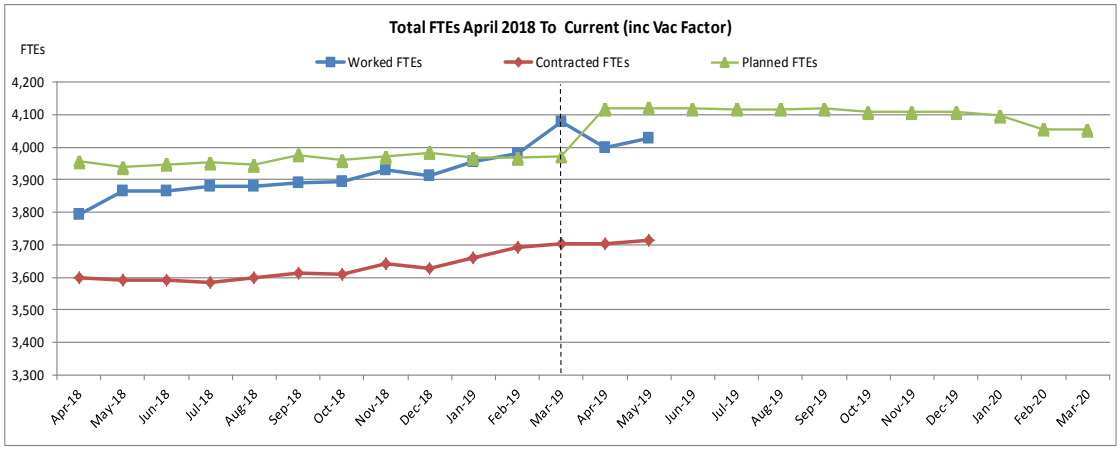
Workforce



Staff Costs

YTD	£'m
2019/20	31.6
2018/19	28.7
▲	10%

Prior Yr	£'m
May-19	15.6
May-18	14.4
▲	9%



FTEs

Prior Yr	CFTE	WFTE
May-19	3,712	4,028
May-18	3,590	3,867
	-3% ▲	-4% ▲

Prior Mth	CFTE	WFTE
May-19	3,712	4,028
Apr-19	3,704	3,999
	0% ▲	-1% ▲

Key Messages

Overall costs fell by £0.4m, but this reflects the £0.6m non-consolidated AfC payment to top of band staff in April, offset by net increases seen in May.

Underlying staff costs rose in May, with an increases in bank usages, focused on MH inpatient wards, Rehab Beds in West Berkshire and WestCall. Overall, bank usage rose by 25 FTEs with a corresponding increase in costs of £0.1m.

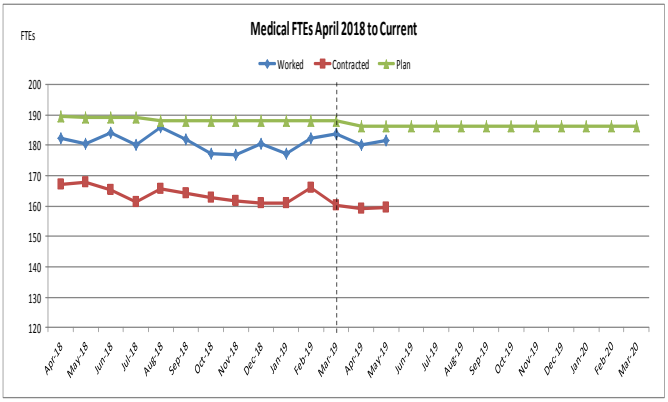
Other increases were noted, with the inclusion of some retrospective pay award costs and elements of back pay.

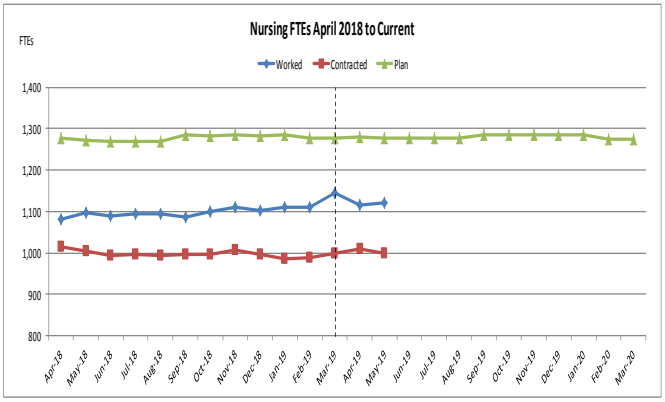
Our permanent contracted FTEs remained in line with April along with our agency usage.

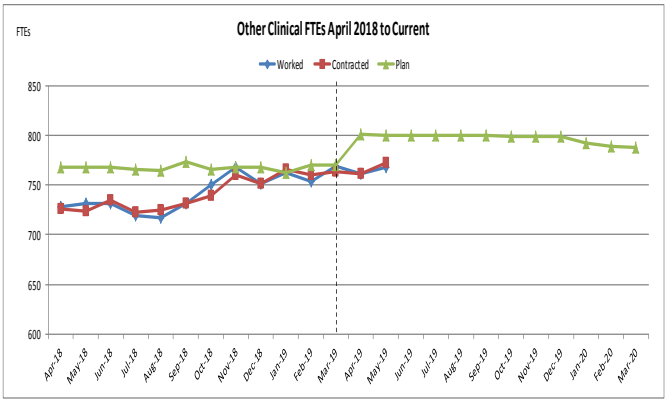
Overall spend was £0.2m higher than planned in month. Current costs are higher than affordable levels after factoring in annual recruitment assumptions. Further growth in permanent workforce costs must see a reduction in non permanent numbers or be managed within overall plan assumptions.

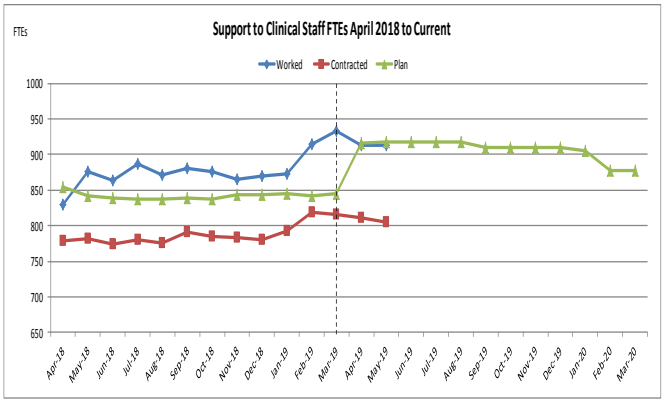
We continue to accommodate financial pressures on Campion Unit and Sorrell Ward, with combined pay costs £0.1m higher than planned, driven by patient acuity and the requirement to incur higher levels of observation costs.

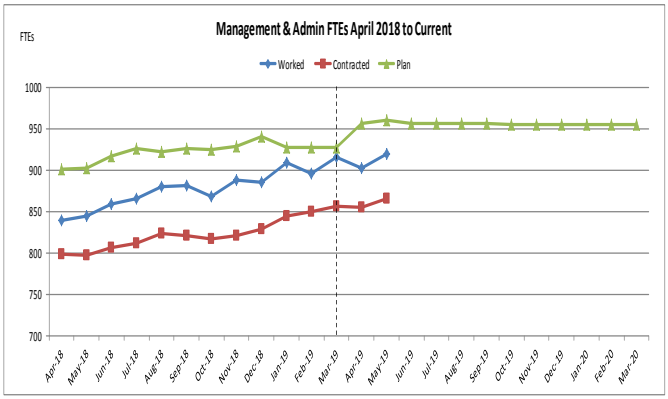
Workforce: Staff Groups

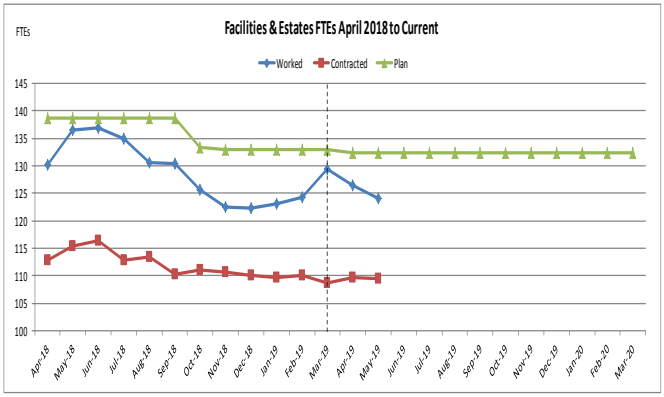












Key Messages

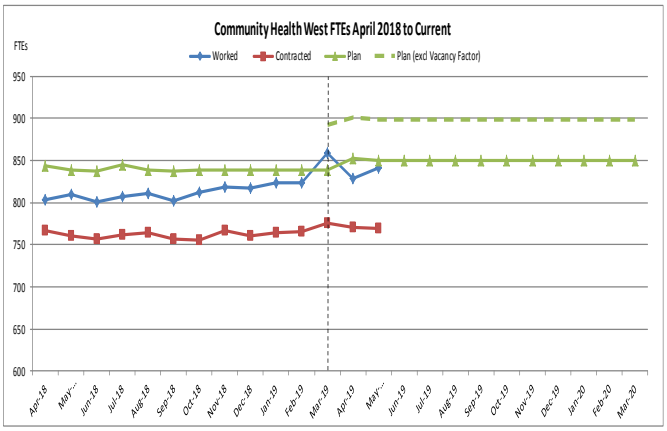
The charts above do not include the assumed vacancy factor incorporated into the plan due to it being allocated to non-specific staff groups within Divisions.

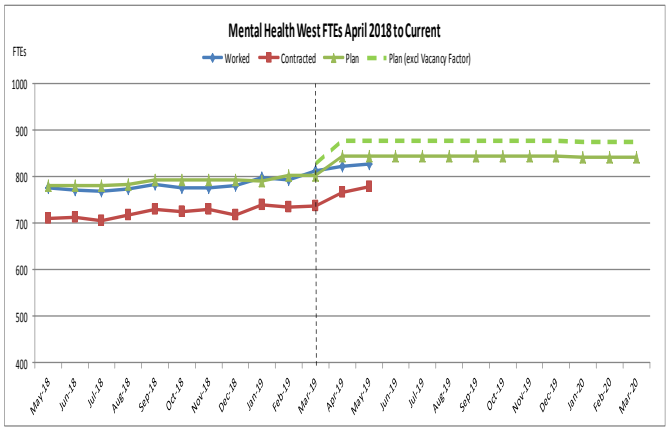
Management and Admin numbers increased by 5 FTE due to recruitment into posts for new Liaison & Diversion Hants & IoW.

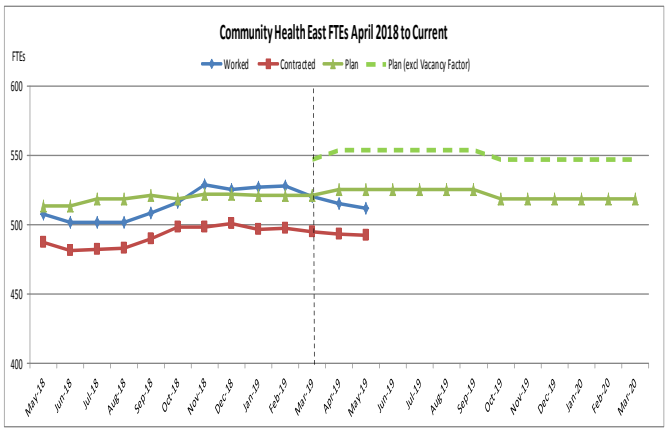
Other Clinical staffing increased with the recruitment of 5 FTEs into posts for IAPT East psychology.

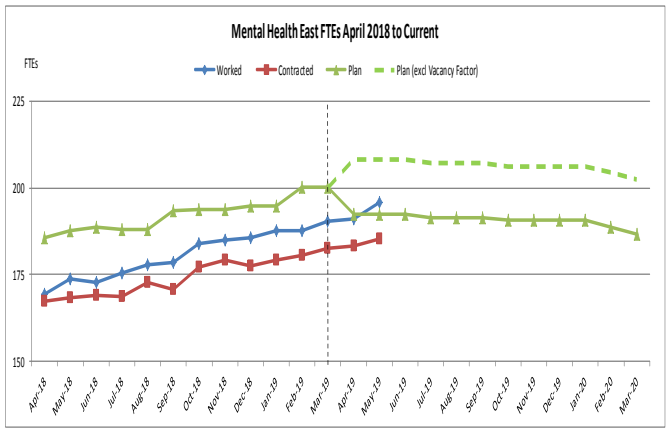
There were small movements in our qualified Nursing numbers, with a small decrease in permanent staff, being offset by an increase in bank staff. This increase was most notable on IP MH Wards, and reflects pressure from sickness and high observation costs, driven by patient acuity.

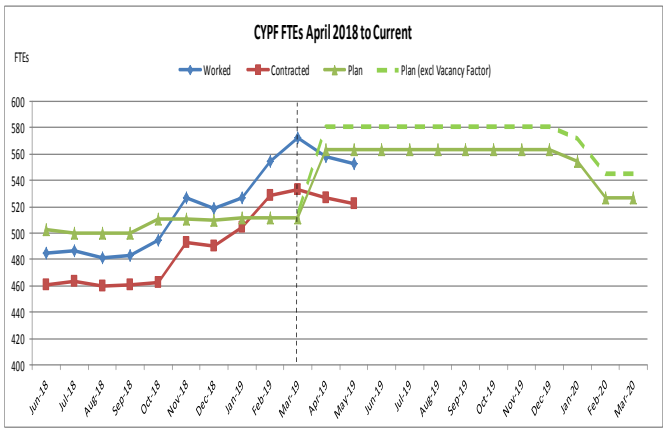
Workforce: Divisional

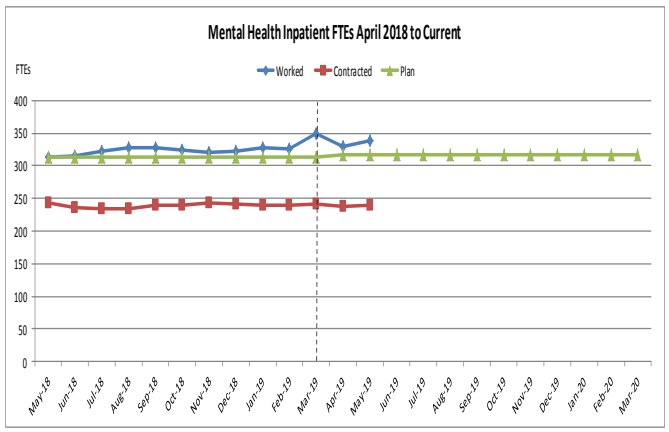


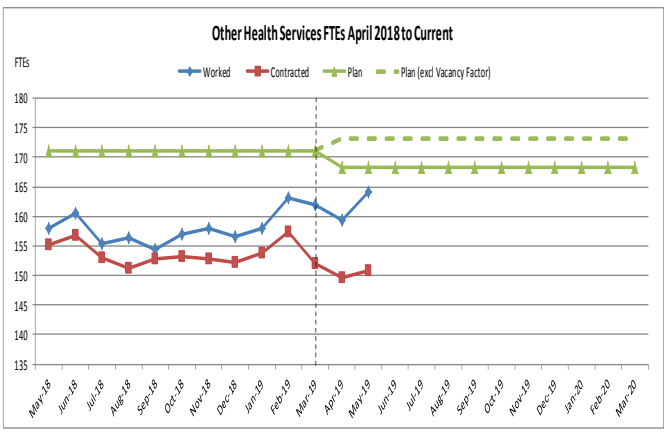


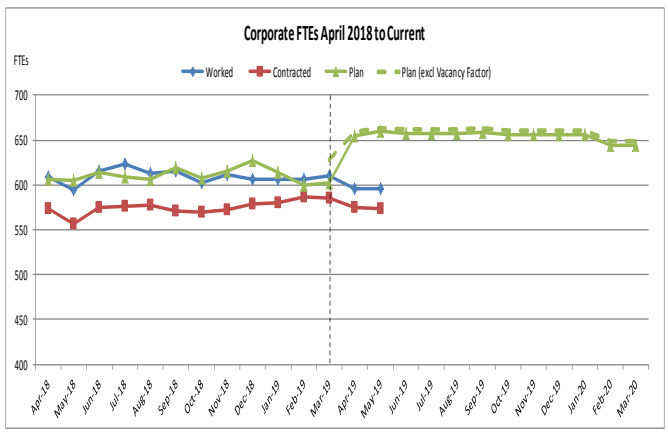




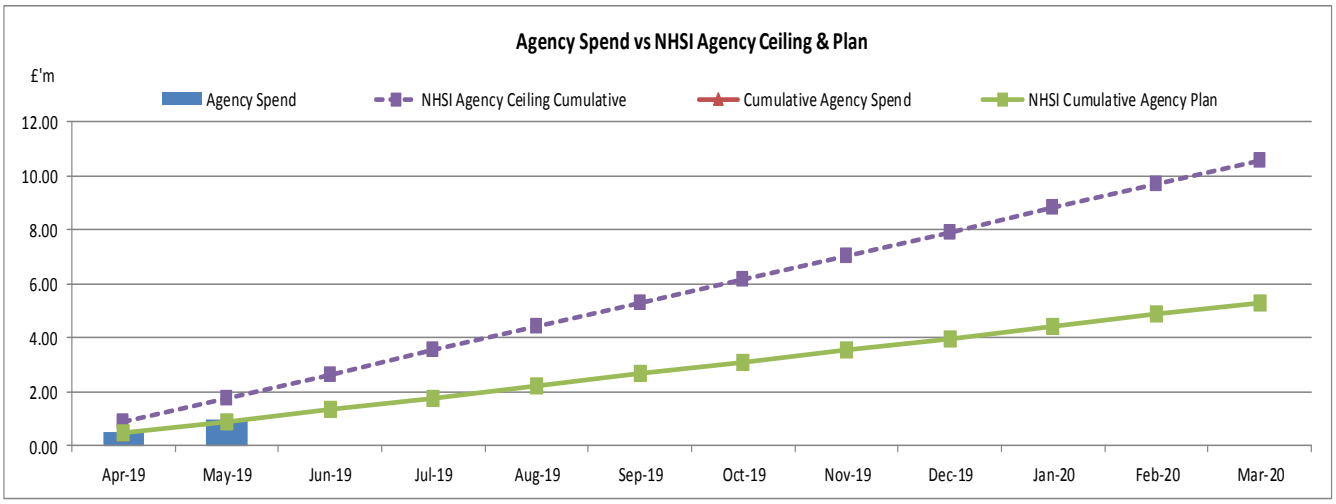


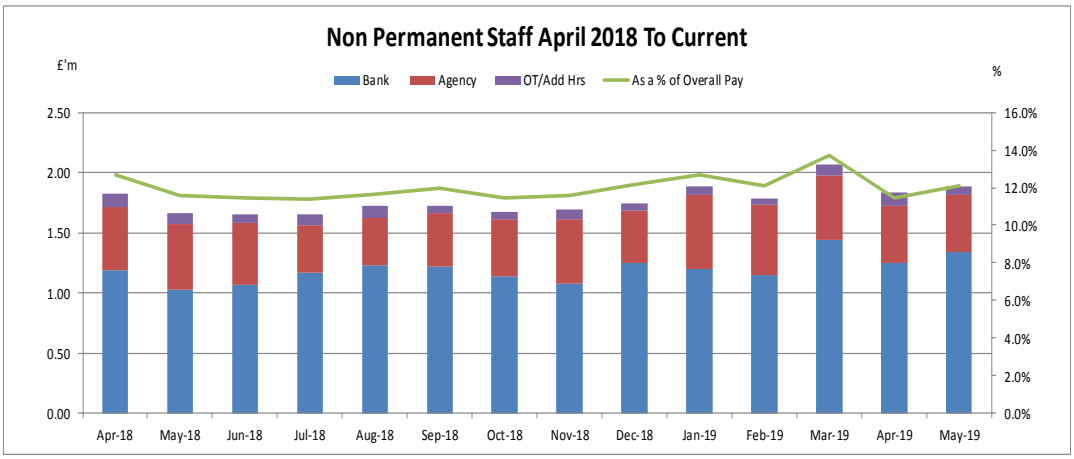






Non Permanent Pay

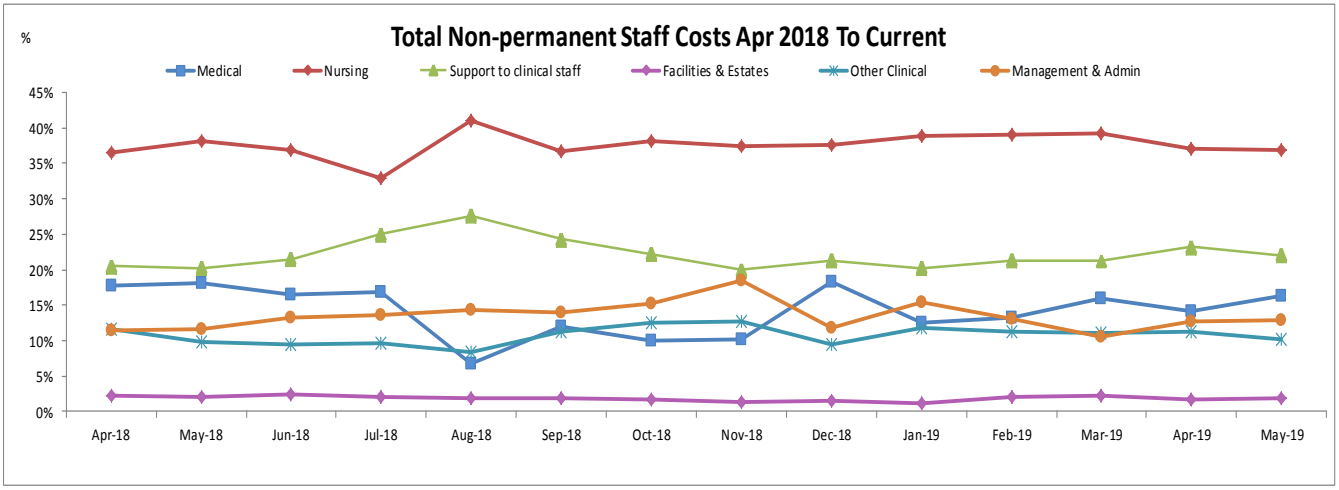




Non Permanent Pay

YTD	Bank	Agency	OT/Add Hrs
2019/20	2.6	1.0	0.2
2018/19	2.2	1.1	0.2
	14% ▲	-13% ▼	-16% ▼

Prior Yr	Bank	Agency	OT/Add Hrs
May-19	1.3	0.5	0.1
May-18	1.3	0.5	0.1
	6% ▲	1% ▲	-34% ▼



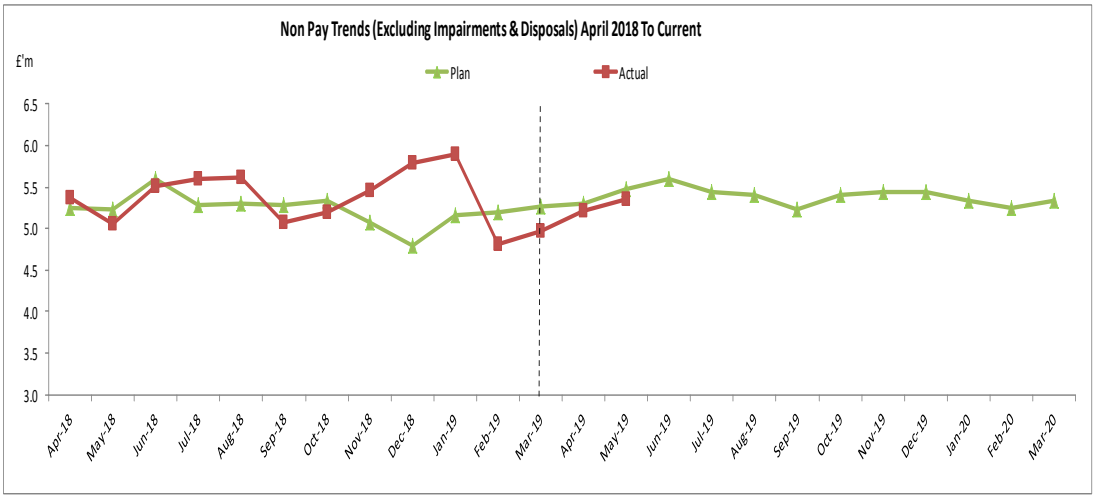
Key Messages

Overall non permanent staffing costs have remained broadly in line with last month.

Bank costs have risen by £0.1m, whilst agency costs and overtime have remained static. These increases have been across MH IP wards, with high requirements for observations due to patient acuity and sickness cover. In addition there has been and increase in Medical cover being employed within the WestCall service.

Non Pay Expenditure

Non Pay	In Month			YTD			FY			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Forecast Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Purchase of Healthcare	1.3	1.2	0.1	2.6	2.5	0.2	16.7	14.1	2.5	2.8	(0.2)	(5.9)%
Drugs	0.5	0.6	(0.0)	0.9	1.1	(0.2)	6.2	6.7	(0.5)	0.8	0.1	12.2%
Premises	1.4	1.3	0.1	2.7	2.5	0.2	14.9	15.1	(0.2)	2.4	0.3	12.5%
Supplies and services – clinical	0.3	0.4	(0.1)	0.7	0.8	(0.1)	4.9	4.9	(0.0)	0.8	(0.1)	(11.5)%
Transport	0.3	0.3	(0.0)	0.5	0.6	(0.0)	3.0	3.5	(0.4)	0.5	0.0	0.0%
Establishment	0.2	0.3	(0.0)	0.5	0.5	(0.0)	3.7	3.2	0.6	0.6	(0.1)	(16.1)%
Other Non Pay	0.8	0.9	(0.1)	1.5	1.6	(0.1)	8.8	10.4	(1.6)	1.4	0.1	4.9%
PFI Lease	0.5	0.6	(0.0)	1.1	1.1	(0.0)	6.4	6.7	(0.3)	1.1	0.0	2.3%
Total Non Pay	**5.4**	**5.5**	**(0.1)**	**10.6**	**10.8**	**(0.2)**	**64.7**	**64.7**	**0.0**	**10.4**	**0.1**	**1.3%**



Non Pay

YTD	£'m
2019/20	5.2
2018/19	5.4
▼	*-3%*

Prior Yr	£'m
May-19	5.4
May-18	5.1
▲	*6%*

Key Messages

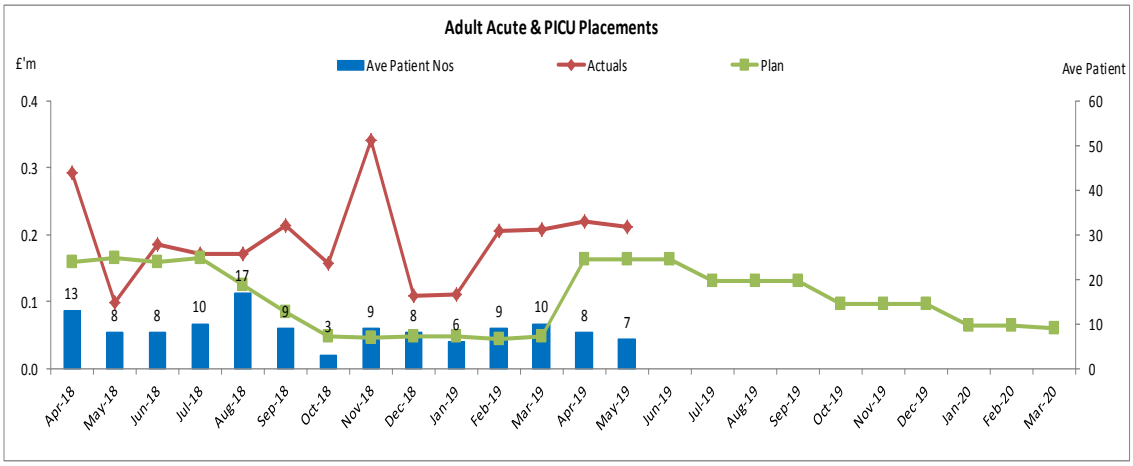
Our Non Pay costs were contained within plan, £0.1m below anticipated spend, increasing the YTD underspend.

Premises costs were £0.1m higher than planned, with estate building and engineering works being undertaken on NHSPS properties, for which the Trust will be reimbursed.

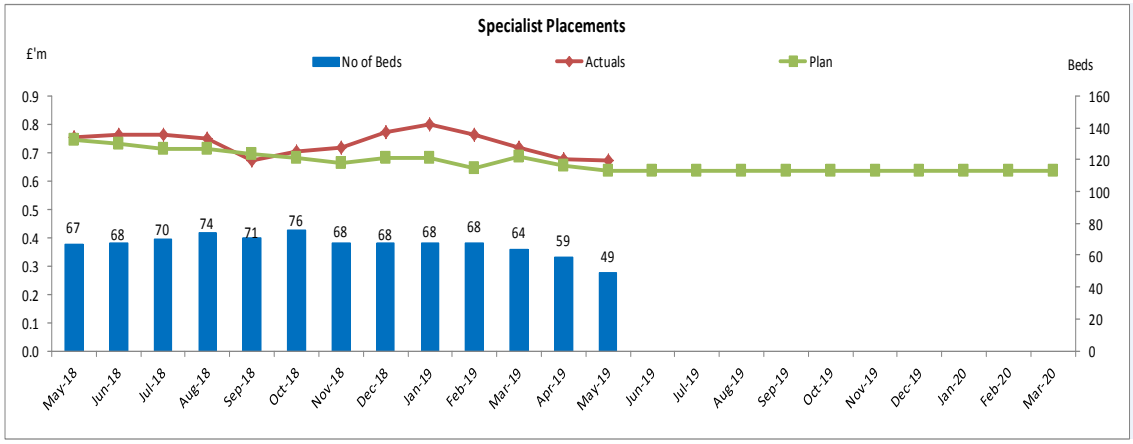
Placement costs were £0.1m higher than plan, with a higher volume of patients being placed than planned, although spend has reduced by £0.1m compared to last month. Whilst the reduction in costs is encouraging, key initiative to reduce placement costs are unlikely to generate any material benefit until later in the year, meaning costs are likely to continue above plan for the remainder of this and next quarter.

All other Non Pay costs remain largely to plan.

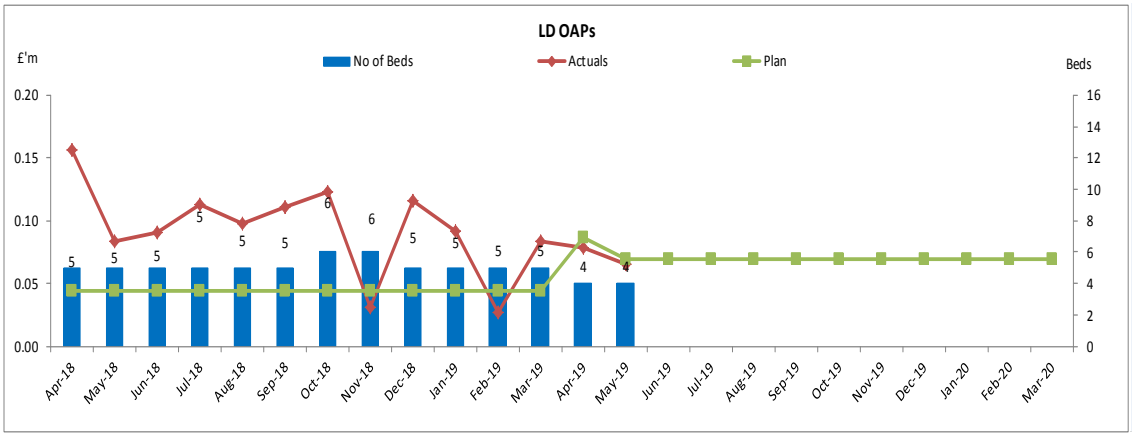
Non Pay Expenditure - Focus on OAPs



Non Pay	
YTD	£'m
2018/19	0.4
2017/18	0.4
▲	*10%*
Prior Yr	**£'m**
May-19	0.2
May-18	0.1
▲	*115%*



Non Pay	
YTD	£'m
2018/19	1.4
2017/18	1.5
▼	*-7%*
Prior Yr	**£'m**
May-19	0.7
May-18	0.8
▼	*-11%*



Non Pay	
YTD	£'m
2018/19	0.1
2017/18	0.4
▼	*-60%*
Prior Yr	**£'m**
May-19	0.1
May-18	0.1
▼	*-55%*

Key Messages

Acute & PICU Placement costs in May were £0.1m higher than plan with 6.5 patients on average. The plan reflects the need to reduce placement numbers to zero by the end of 21/22, with a max of 6 assumed in the plan for Q1.

Specialist Placements' cost fell by £0.1m but costs were £37k higher than planned in May. This months spend shows a continuing reducing trajectory started in Q4 last year.

LD Placements: are underspend by £4k in the month and £81k lower than this period last year, reflecting the reduction in the number of placements.

3.0 Divisional Summary

Income Statement	In Month			YTD			Full Year	Prior YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m	Act £'m	+/-	Var %
Community Health West										
Income	0.4	0.4	(0.1)	0.8	0.9	(0.1)	5.2	0.9	(0.1)	(10.2)%
Pay	3.1	3.0	0.1	6.3	6.2	0.0	35.9	5.7	0.6	10.3%
Non Pay	0.5	0.5	(0.0)	0.9	1.0	(0.1)	5.9	0.9	0.0	3.2%
Net Cost	***3.2***	***3.1***	***0.1***	***6.4***	***6.3***	***0.1***	***36.6***	***5.7***	***0.7***	***12.3%***
Mental Health West										
Income	0.1	0.2	(0.0)	0.3	0.3	(0.0)	1.9	0.5	(0.2)	(43.6)%
Pay	3.1	3.1	0.0	6.3	6.4	(0.1)	37.6	5.5	0.9	16.0%
Non Pay	0.5	0.5	0.0	1.1	1.1	0.0	5.8	1.3	(0.1)	(9.5%)
Net Cost	***3.5***	***3.5***	***0.0***	***7.2***	***7.2***	***(0.0)***	***41.5***	***6.2***	***1.0***	***15.7%***
Community Health East										
Income	0.2	0.2	(0.0)	0.3	0.4	(0.1)	2.2	0.5	(0.3)	(50.0)%
Pay	1.9	1.9	(0.0)	3.8	3.9	(0.1)	22.2	3.5	0.3	9.7%
Non Pay	0.5	0.6	(0.1)	0.9	1.1	(0.2)	6.7	1.1	(0.2)	(18.8%)
Net Cost	***2.2***	***2.3***	***(0.1)***	***4.4***	***4.6***	***(0.2)***	***26.8***	***4.0***	***0.4***	***10.0%***
Mental Health East										
Income	0.1	0.1	0.0	0.3	0.3	0.0	1.6	0.3	(0.0)	(15.0)%
Pay	0.7	0.7	(0.0)	1.5	1.5	(0.0)	8.9	1.2	0.3	21.6%
Non Pay	0.8	0.7	0.0	1.6	1.5	0.0	9.0	1.6	(0.1)	(4.1%)
Net Cost	***1.4***	***1.4***	***0.0***	***2.8***	***2.8***	***0.0***	***16.3***	***2.6***	***0.2***	***9.7%***
CYPF										
Income	0.4	0.3	0.1	0.8	0.7	0.1	3.9	0.4	0.4	101.1%
Pay	2.0	2.0	(0.1)	4.0	4.2	(0.2)	24.5	3.4	0.7	19.9%
Non Pay	0.1	0.1	0.0	0.3	0.3	0.0	1.5	0.3	0.0	12.1%
Net Cost	***1.7***	***1.8***	***(0.1)***	***3.5***	***3.7***	***(0.2)***	***22.1***	***3.2***	***0.3***	***8.7%***
Mental Health Inpatients										
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	26,870.4%
Pay	1.1	0.9	0.1	2.1	1.9	0.2	11.4	1.8	0.3	15.4%
Non Pay	0.1	0.1	(0.0)	0.1	0.2	(0.0)	1.0	0.2	(0.0)	(10.3%)
Net Cost	***1.1***	***1.0***	***0.1***	***2.2***	***2.1***	***0.2***	***12.3***	***2.0***	***0.3***	***12.7%***
Other Health Services										
Income	0.2	0.3	(0.0)	0.5	0.5	(0.1)	3.2	0.2	0.2	83.2%
Pay	1.4	1.3	0.0	2.7	2.7	(0.1)	16.1	2.4	0.2	9.5%
Non Pay	0.1	0.2	(0.0)	0.3	0.3	(0.1)	2.1	0.1	0.2	341.6%
Net Cost	***1.3***	***1.2***	***0.0***	***2.5***	***2.6***	***(0.1)***	***15.0***	***2.2***	***0.3***	***11.2%***
Corporate										
Income	1.4	1.2	0.1	2.7	2.5	0.2	15.6	2.8	(0.1)	(3.0)%
Pay	2.4	2.3	0.1	4.9	4.7	0.3	28.6	5.3	0.3	(6.2%)
Non Pay	2.7	2.8	(0.0)	5.3	5.3	0.0	32.6	5.1	(0.3)	5.1%
Net Cost	***3.8***	***3.8***	**0.1**	***7.6***	***7.5***	**(0.1)**	***45.5***	***7.6***	**(0.0)**	**0.2%**
Corporate Income & Financing										
Income	19.2	19.2	(0.0)	38.3	38.3	(0.1)	230.4	35.7	2.5	7.1%
Financing	1.0	1.0	(0.0)	2.0	1.9	(0.0)	12.4	1.6	(0.4)	22.4%
Surplus/ (Deficit) Statutory	***0.0***	***0.1***	**(0.0)**	***(0.3)***	***(0.5)***	**0.1**	***1.8***	***0.6***	**(0.9)**	**(158.1)%**

Key Messages

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

Community Health West: Pay is overspent predominantly on Community Inpatients Wards.

Mental Health Inpatients: Pay overspent due to use of bank and agency to cover vacancies, sickness and high levels of patient observations.

Corporate & Income & Financing: Pay overspent relates to jointly funded post which is covered by additional income from University of Reading.

4.0 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 Projects									
Bed Optimisation (Acute/PICU)	0.00	0.03	(0.03)	0.00	0.07	(0.07)	0.50	1.00	(0.50)
Long Term Placement Contracts	0.08	0.09	(0.01)	0.16	0.16	0.00	1.02	1.02	0.00
Total OAPS Saving	***0.08***	***0.12***	***(0.04)***	***0.16***	***0.22***	***(0.07)***	***1.52***	***2.02***	***(0.50)***
Operations									
CRHTT	0.00	0.01	(0.01)	0.00	0.02	(0.02)	0.10	0.10	0.00
Total Service Line Savings	***0.00***	***0.01***	***(0.01)***	***0.00***	***0.02***	***(0.02)***	***0.10***	***0.10***	***0.00***
Procurement									
Procurement Spend	0.03	0.01	0.01	0.04	0.03	0.01	0.30	0.30	0.00
NHS Supply Chain	0.01	0.02	(0.01)	0.02	0.04	(0.02)	0.25	0.25	0.00
Medicine Optimisation	0.00	0.00	(0.00)	0.00	0.01	(0.01)	0.05	0.05	0.00
Total Procurement Savings	***0.04***	***0.04***	***(0.00)***	***0.06***	***0.08***	***(0.02)***	***0.60***	***0.60***	***0.00***
Contracts									
Sexual Health	(0.04)	0.04	(0.07)	0.00	0.07	(0.07)	0.33	0.43	(0.10)
Liaison & Diversion Hampshire	0.08	0.07	0.01	0.15	0.14	0.00	0.62	0.62	0.00
Veterans	0.03	0.03	0.00	0.06	0.06	0.00	0.27	0.27	0.00
Total Other Savings	***0.07***	***0.14***	***(0.06)***	***0.21***	***0.28***	***(0.07)***	***1.22***	***1.32***	***(0.10)***
Total CIP Delivery (NHSi Plan)	***0.19***	***0.30***	***(0.12)***	***0.42***	***0.59***	***(0.17)***	***3.44***	***4.04***	***(0.60)***
Internal Stretch									
Long Term Placements (LD)	0.00	0.00	0.00	0.01	0.00	0.01	0.30	0.30	0.00
Immunisations Technology	0.00	0.00	0.00	0.00	0.00	0.00	0.14	0.14	0.00
Contract - SLT	0.01	0.01	0.00	0.01	0.01	0.00	0.06	0.06	0.00
Corporate Benchmarking	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.15	(0.15)
Temporary Staffing	0.02	0.01	0.01	0.02	0.02	(0.01)	0.20	0.20	0.00
NHSPS VAT	0.00	0.02	(0.02)	0.00	0.03	(0.03)	0.62	0.62	0.00
PFI Benchmarking Review	0.00	0.00	0.00	0.00	0.00	0.00	0.13	0.13	0.00
Carter - eRoster	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.10	(0.10)
Unidentified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.30	(0.30)
Total CIP Delivery (Internal Stretch)	***0.02***	***0.03***	***(0.01)***	***0.04***	***0.06***	***(0.03)***	***1.45***	***2.00***	***(0.55)***
Total CIP Delivery	***0.21***	***0.34***	***(0.12)***	***0.46***	***0.66***	***(0.20)***	***4.89***	***6.04***	***(1.15)***

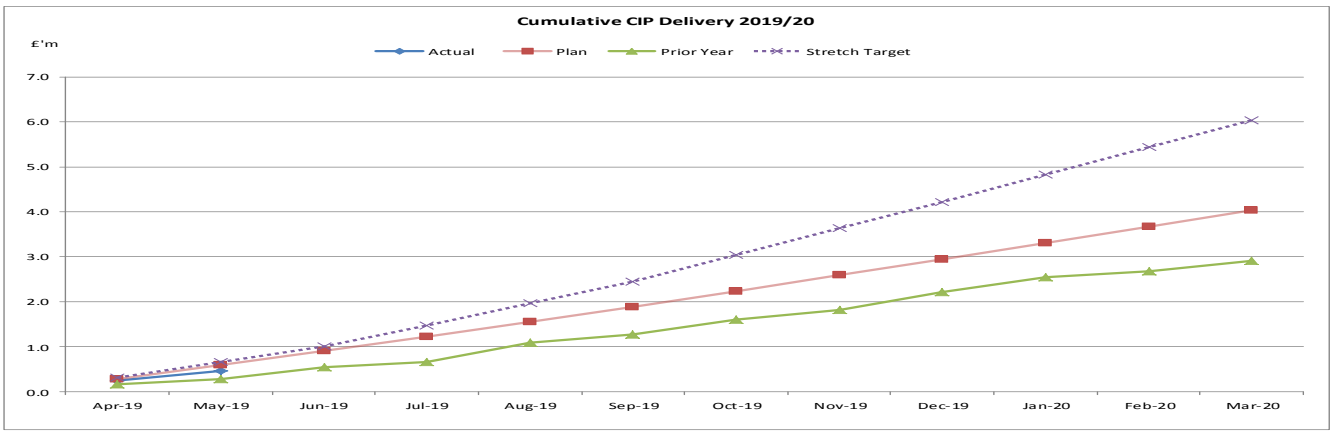
Key Messages

The Trust has delivered £0.46m of savings against a year to date plan of £0.66m. The forecast is £4.9m reflecting know risk and maturity of schemes.

Acute and PICU OAPs spend reduced from last month, but was still £0.1m more than plan and therefore no cost improvement was recognised. The workstreams in train to identify sustainable improvements are unlikely to deliver reductions before Q3 and this is reflected in the forecast. Learning Disability placements have delivered a saving, £0.1m full year, sooner than anticipated resulting from a step down placement completed in April.

Saving delivered from a reduction in the use of non permanent Admin staff compared to the same period last year is recognised (£0.02m YTD), with stricter guidance now in place around approval, and exit plans agreed for all non clinical agency staff, with the exception of those working on GDE funded IT projects and patient facing facilities staff.

The Trust met with NHSPS and EBCCG to progress the VAT savings, with positive progress made. Before progressing further, the impact of 'opting to tax' needs to be considered to ensure it has no detrimental impact on the potential NHSPS asset transfer.



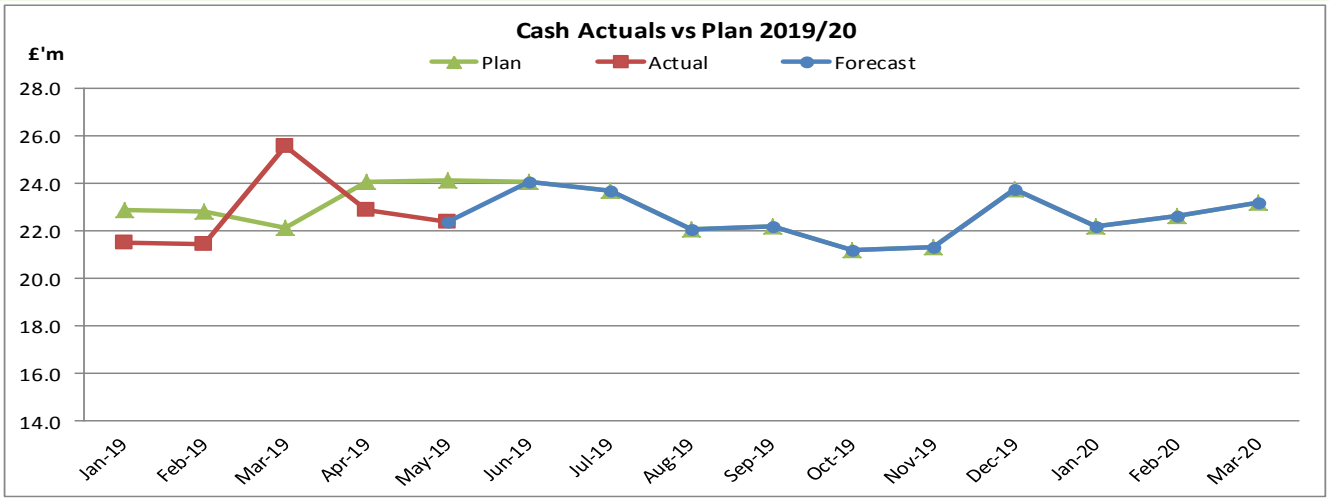
5.0 Balance Sheet & Cash

Balance Sheet	18/19 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	19/20 Plan £'m
Intangibles	5.2	5.0	5.7	(0.7)	5.0	5.7	(0.7)	6.3
Property, Plant & Equipment (non PFI)	37.7	36.3	34.6	1.7	36.3	34.6	1.7	36.4
Property, Plant & Equipment (PFI)	59.8	61.0	62.1	(1.1)	61.0	62.1	(1.1)	65.4
Total Non Current Assets	**102.7**	**102.3**	**102.4**	***(0.1)***	**102.3**	**102.4**	***(0.1)***	**108.1**
Trade Receivables & Accruals	11.8	15.0	10.8	4.2	15.0	10.8	4.2	10.8
Other Receivables	0.2	0.2	0.3	(0.1)	0.2	0.3	(0.1)	0.3
Cash	25.6	22.6	24.1	(1.6)	22.6	24.1	(1.6)	23.2
Trade Payables & Accruals	(23.9)	(23.8)	(26.3)	2.5	(23.8)	(26.3)	2.5	(28.1)
Current PFI Finance Lease	(1.2)	(1.3)	(1.3)	0.0	(1.3)	(1.3)	0.0	(1.5)
Other Current Payables	(2.7)	(3.2)	(2.3)	(0.9)	(3.2)	(2.3)	(0.9)	(2.3)
Total Net Current Assets / (Liabilities)	**9.6**	**9.5**	**5.4**	***4.1***	**9.5**	**5.4**	***4.1***	**2.4**
Non Current PFI Finance Lease	(28.5)	(28.3)	(28.3)	0.0	(28.3)	(28.3)	0.0	(27.0)
Other Non Current Payables	(1.5)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)
Total Net Assets	***82.4***	***82.0***	***77.9***	***4.1***	***82.0***	***77.9***	***4.1***	***81.9***
Income & Expenditure Reserve	28.1	27.8	24.4	3.4	27.8	24.4	3.4	26.6
Public Dividend Capital Reserve	18.0	18.0	16.5	1.5	18.0	16.5	1.5	18.3
Revaluation Reserve	36.2	36.2	37.0	(0.8)	36.2	37.0	(0.8)	37.0
Total Taxpayers Equity	***82.4***	***82.0***	***77.9***	***4.1***	***82.0***	***77.9***	***4.1***	***81.9***

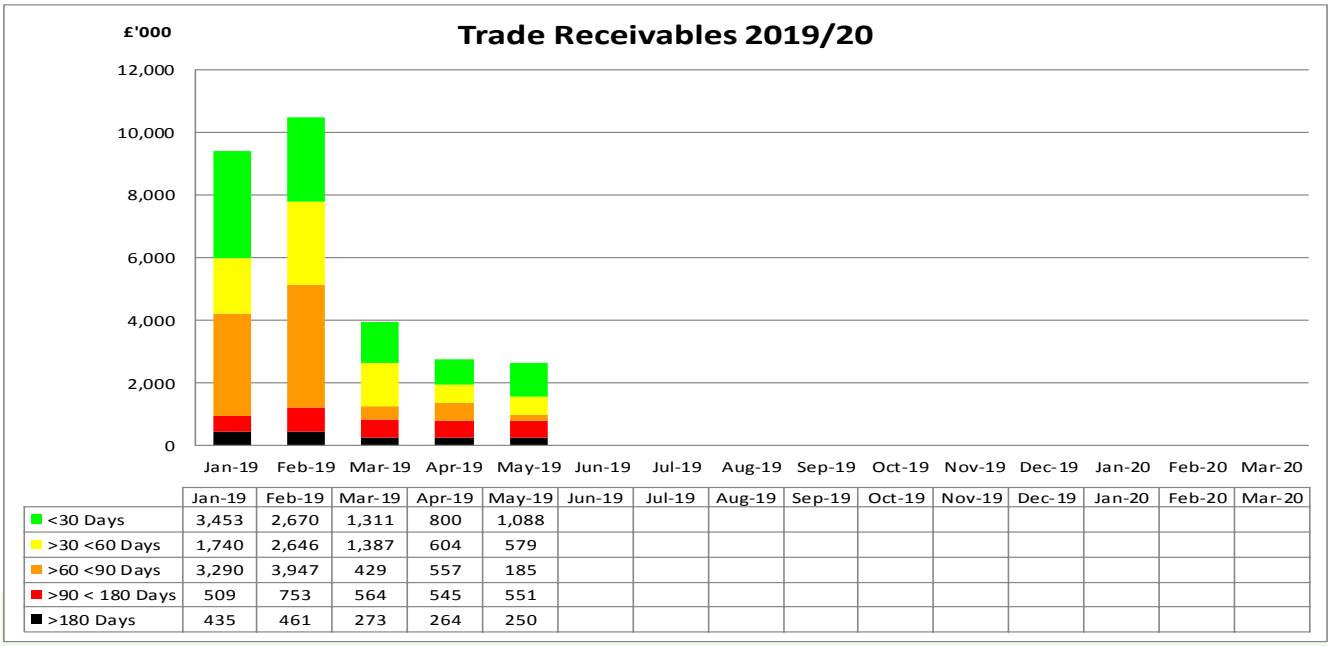
Cashflow		18/19 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	19/20 Plan £'m
Operating Surplus/(Deficit)	+/-	11.8	0.6	0.5	0.1	0.6	0.5	0.1	7.5
Depreciation and Impairments	+	5.5	1.1	0.5	0.6	1.1	1.0	0.0	6.8
Operating Cashflow		***17.3***	***1.6***	***1.0***	***0.6***	***1.6***	***1.5***	***0.2***	***14.3***
Net Working Capital Movements	***+/-***	***(0.2)***	***(2.6)***	***(0.2)***	***(2.5)***	***(2.6)***	***(0.3)***	***(2.3)***	***(0.1)***
Proceeds from Disposals	+	0.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	-	(10.3)	(1.2)	(0.4)	(0.8)	(1.2)	(1.6)	0.5	(11.3)
Investments		***(9.5)***	***(1.2)***	***(0.4)***	***(0.7)***	***(1.2)***	***(1.6)***	***0.5***	***(11.3)***
PFI Finance Lease Repayment	-	(1.0)	(0.2)	(0.1)	(0.1)	(0.2)	(0.2)	(0.0)	(1.2)
Net Interest	+/-	(3.6)	(0.6)	(0.3)	(0.3)	(0.6)	(0.6)	0.0	(3.7)
PDC Revieved	+	2.1	0.0	0.0	0.0	0.0	0.0	0.0	1.7
PDC Dividends Paid	-	(1.7)	0.0	0.0	0.0	0.0	0.0	0.0	(2.0)
Financing Costs		***(4.3)***	***(0.8)***	***(0.4)***	***(0.4)***	***(0.8)***	***(0.8)***	***0.0***	***(5.2)***
Other Movements	+/-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/ (Out) Flow		***3.3***	***(2.9)***	***0.0***	***(3.0)***	***(2.9)***	***(1.3)***	***(1.7)***	***(2.3)***
Opening Cash		22.3	25.6	24.1	1.5	25.6	25.6	0.0	25.6
Closing Cash		***25.6***	***22.6***	***24.1***	***(1.6)***	***22.6***	***24.1***	***(1.6)***	***23.2***

Key Messages

The cash balance at the end May was £22.6m, £1.6m less than planned, although £0.8m of outstanding debt was cleared in the first week of June. The Trust is currently working on revised charging agreements with RBH which will substantially reduce administrative burden and improve cashflow. Gaining agreement on the process is taking longer than anticipated, and combined with delays in getting POs from NHSPS, are adversely impacting cash by £0.6m.



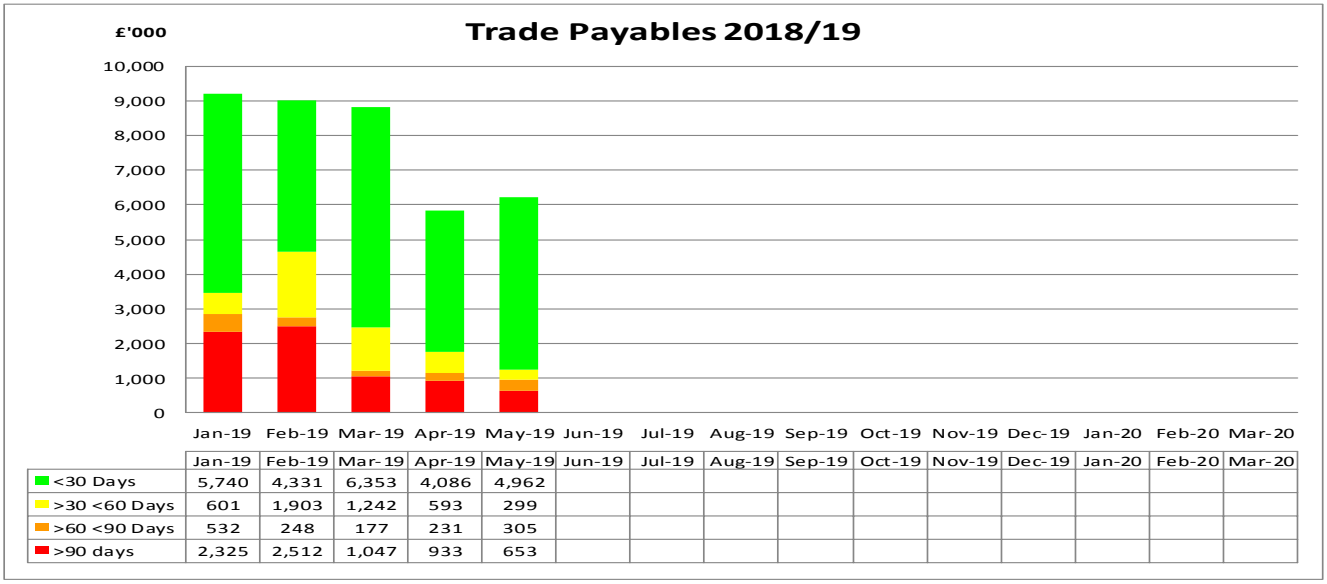
Cash Management



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<30 Days	3,453	2,670	1,311	800	1,088										
>30 <60 Days	1,740	2,646	1,387	604	579										
>60 <90 Days	3,290	3,947	429	557	185										
>90 < 180 Days	509	753	564	545	551										
>180 Days	435	461	273	264	250										

Key Message

Overall receivables reduced by £0.1m, with overdue debt falling by £0.3m. Progress has been made to recover £0.4m of aged Local Authority debt. The key balances over 60 days are with NHS Hampshire, Isle of Wight & Portsmouth (£0.3m), Royal Berkshire FT (£0.1m), Bracknell Forest Council (£0.2m) and Reading Council (£0.1m) and combined remaining CCG debt of £0.3m.



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
<30 Days	5,740	4,331	6,353	4,086	4,962										
>30 <60 Days	601	1,903	1,242	593	299										
>60 <90 Days	532	248	177	231	305										
>90 days	2,325	2,512	1,047	933	653										

Key Message

Overdue payables have continued to reduce, with a further £0.2m reduction in month.

6.0 Capital Programme

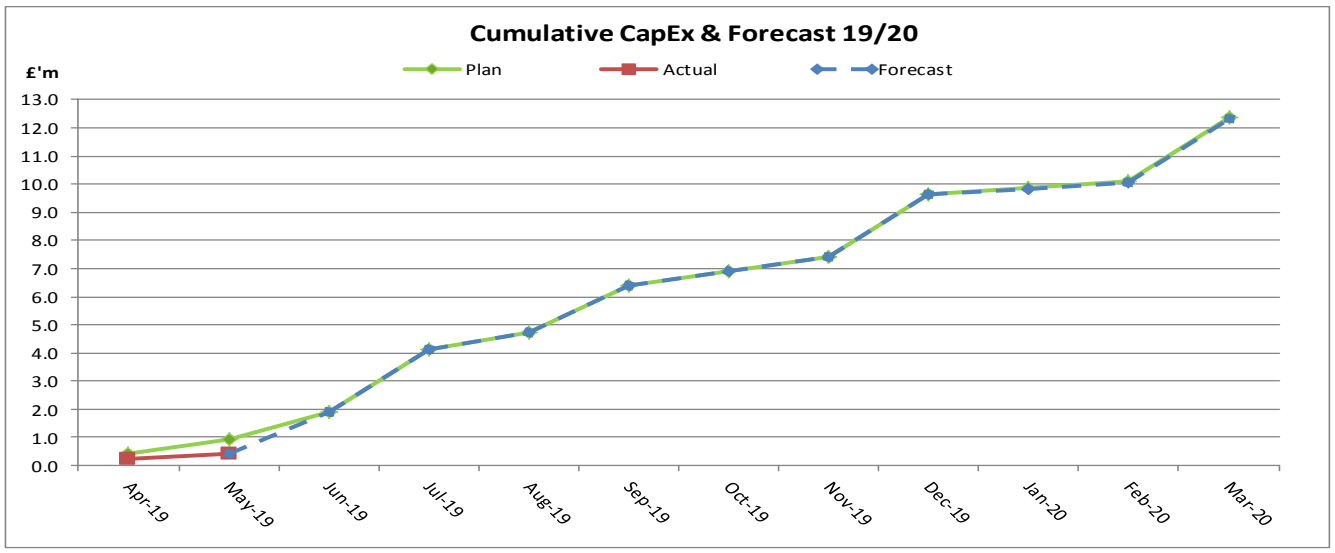
Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
STC Phase 3/Erlegh House	51	0	51	92	0	92	2,343
LD to Jasmine	1	0	1	4	0	4	2,250
Abel Gardens - Mobility Relocation	4	53	(49)	6	97	(91)	400
Upton Hospital Upgrade of Accommodation	0	0	0	0	0	0	350
PPH Ligature Removal Works	23	55	(32)	26	105	(79)	290
Trust Owned Properties	99	57	42	93	113	(20)	342
Leased Non Commercial (NHSPS)	32	50	(18)	29	70	(41)	240
Leased Commercial	(0)	0	(0)	0	0	0	100
Statutory Compliance	(1)	0	(1)	1	0	1	250
PFI	0	0	0	1	0	1	574
Subtotal Estates Maintenance & Replacement	**209**	**215**	**(6)**	**253**	**385**	**(132)**	**7,139**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	0	0	0	320
IM&T System & Network Developments	43	0	43	44	0	44	2,355
IM&T Other	0	0	0	0	0	0	60
IM&T Locality Schemes	13	0	13	22	0	22	0
HSLI Community Mobile Working	35	20	15	47	40	7	239
Subtotal IM&T Expenditure	**91**	**20**	**71**	**113**	**40**	**73**	**2,974**
GDE Expenditure							
GDE Trust Funded	159	241	(82)	320	481	(161)	795
GDE Trust Funded	0	0	0	0	0	0	1,258
Subtotal GDE Expenditure	**159**	**241**	**(82)**	**320**	**481**	**(161)**	**2,053**
Other Locality Schemes	2	0	2	0	0	0	200
Total Capital Expenditure	**461**	**476**	**(15)**	**687**	**906**	**(219)**	**12,366**

Key Message

The Trust has set an ambitions £12.4m CapEx programme for 19/20. The table below illustrates the key scheme outside of the routine maintenance and upkeep programmes.

The IM&T programme included no plan for locality equipment and is predicated on the efficient use of existing equipment issued to teams. IM&T have identified significant volumes of usable equipment which has laid dormant, ie has not been connect to the network for months. In the first instance we are working to redistribute this kit rather than purchasing new. This is separate to the existing rolling replacement programme, which ensure the kit being used is up-to-date and compliant with cyber security requirements.

YTD the overall CapEx programme is £0.2m behind plan, with spend in month in line with plan.



Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th July 2019
Title	**True North Performance Scorecard** **Month 2 (May 2019) 2019/20**
Purpose	To provide the Board with the new True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and QI break through objectives for 2019/20. The FIP committee has reviewed the True North Performance Scorecard and positively supports the revised scorecard format and driver metric focus approach. The Ture North Performance Scorecard replaces the summary performance report to the Board, and the Performance Assurance Framework (PAF) report taken at Executive and FIP committees. Board members will recall the QI development day in June where we were able to go and see key components of divisional QMIS in action at Prospect Park Hospital. Observation included continuous improvement “huddles” at ward level, and a ward manager reporting counter measures against PPH divisional driver metric priorities where that ward was a top contributor to division driver performance. The True North Performance Scorecard represents the top level of the developing performance system, pulling together division driver metric performance, and as such provides the key assurance to traction on our improvement ambitions for 2019/20, and over a longer period for True North.
Business Area	Trust-wide Performance
Author	Deputy Chief Executive and 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 new True North Performance Scorecard for Month 2 2019/20 (May 2019) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. Business rules are included within the paper and have been agreed by the Executive and FIP committee. The business rules apply to three different categories of metric: • **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention. • **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to “must do” national standards or areas of focus. Update required if threshold performance is missed in one month. • **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity. These metric classifications support the “inch wide, mile deep” philosophy of our QI approach and will ensure the performance system and meeting time from ward to board is more effectively focused to our improvement goals. **Month 2** **2019/20 business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics**

	Context and update to driver performance to be provided in discussion of counter measure action and development: • Falls incidents in Inpatient Wards **(Harm-free care)** • Self-harm incidents **(Harm-free care)** • Patient FFT response rate **(Patient Experience)** • Staff Engagement Score (Staff Survey) **(Supporting our Staff)** • CIP Target (£k) cumulative year to date **(Money Matters)** • Financial Surplus (£k) (excluding STF) cumulative year to date) **(Money Matters)** • Staff turnover **(Money Matters)** **Tracker Level 1 Metrics** • Mental Health: 7 day follow up **(Regulatory Compliance) –** performance expected to recover in June. • Sickness Rate **(Regulatory Compliance) –** sickness reduction activity to be updated in discussion. This is not a "hard" compliance focus with NHSI but is tracked. **Tracker Metrics** • No updates required as confirmed by scorecard business rules.
Action	The Board is asked to note the new True North Scorecard and provide feedback to support development.

True North Performance Scorecard – Business Rules & Definitions

The following metrics are defined as and associated business rules applied to the True North Performance Scorecard:

Driver - True North / break through objective that has been prioritised by the organisation as its area of focus	**Tracker Level 1-** metrics that have an impact due to regulatory compliance	**Tracker -** important metrics that require oversight but not focus at this stage in our performance methodology

Rule #	Metric	Business Rule	Meeting Action
1	**Driver** is **Green** in current reporting period	Share success and move on	**No action** required
2	**Driver** is **Red** in current reporting period	Share top **contributing reason**, the amount this contributor impacts the metric, and **summary of initial action(s)** being taken	Standard structured **verbal** update
3	**Driver** is **Red** for **2+** reporting periods	Produce full structured **countermeasure summary**	Present full written **countermeasure analysis and summary**
4	**Driver** is **Green** for **6** reporting periods	Retire to **Tracker** level status	Standard structured **verbal** update and retire to **Tracker**
5	**Tracker 1 (or Tracker)** is **Green** in current reporting period	**No action** required	**No action** required
6	**Tracker** is **Red** in current reporting period	Note metric performance and move on unless they are a **Tracker Level 1**	If **Tracker Level 1,** then structured **verbal** update
7	**Tracker** is **Red** for **4** reporting periods	Switch to **Driver** metric	Switch and replace to **Driver** metric (decide on how to make capacity i.e. which **Driver** can be a **Tracker**)

Performance Scorecard - True North Drivers (May 2019)

Harm Free Care

Metric	Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Falls incidents in Inpatient Wards	19 per month	34	37	37	44	40	39	47	41	36	32	26
Self Harm incidents	61 per month	91	82	89	58	51	85	55	51	48	56	121
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4	<18 per year	0	3	1	0	0	0	3	0	0	1	0
Medication errors (moderate patient impact and above)	5 in a year							0	0	0	0	0
Number of suicides (per month)	tbc	1	3	3	3	2	3	1	2	2	3	2
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000						4.3					
Gram Negative Bacteraemia	1 per ward per year										0	1

Patient Experience

Mental Health: Prone (Face Down) Restraint	2 per month	3	1	7	4	9	11	7	3	3	2	2
Patient FTT response rate: %	15% compliance	12.8%	14.2%	17.2%	15.1%	14.6%	27.7%	21%	25.1%	20%	11%	12.5%

Performance Scorecard - True North Drivers (May 2019)

Supporting our Staff

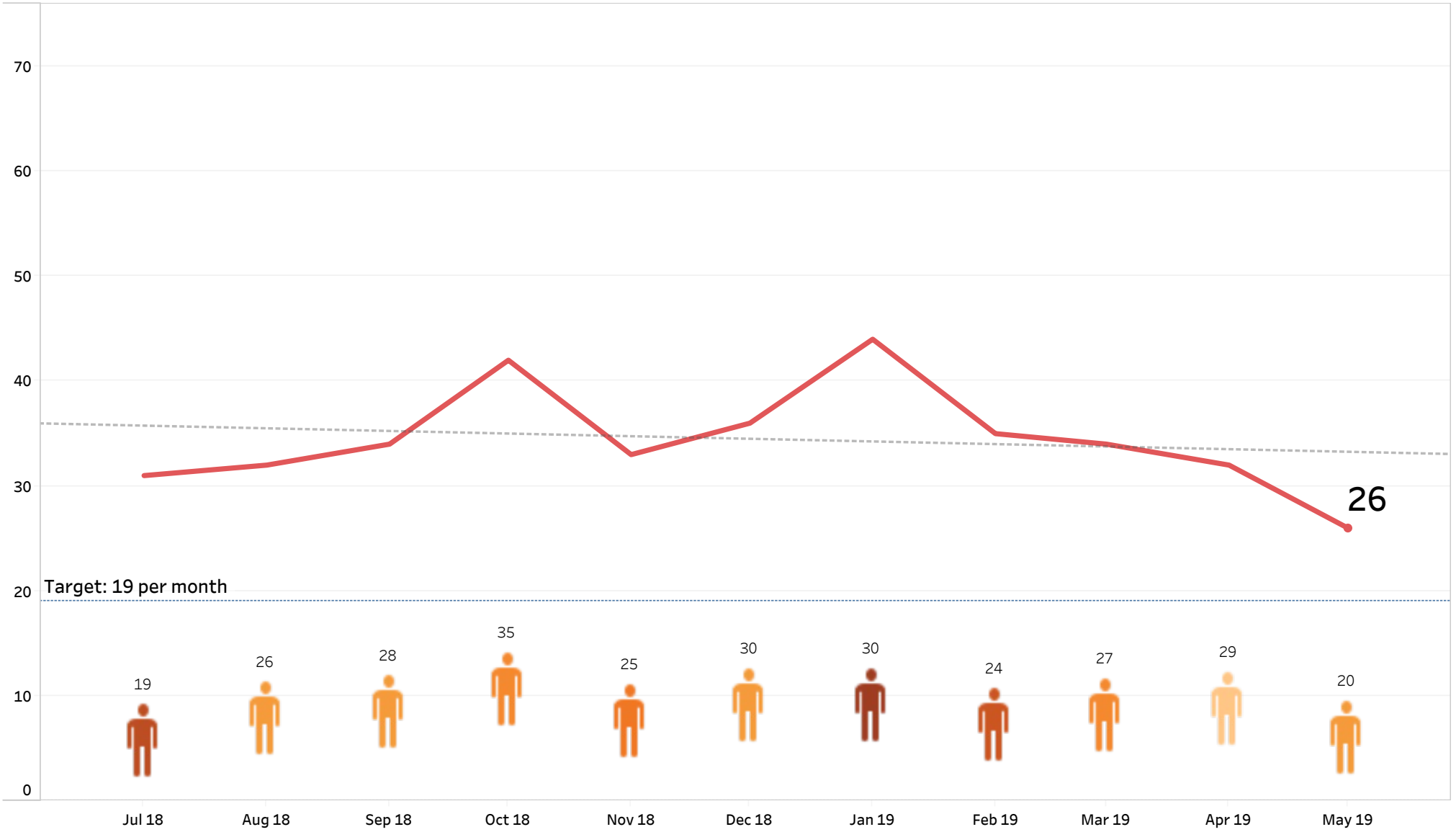
Metric	Target	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Physical Assaults on Staff	44 per month	37	28	67	77	51	32	38	27	18	34	38
Staff Engagement Score (Staff Survey)	Score of 4									3.93	3.93	3.93

Money Matters

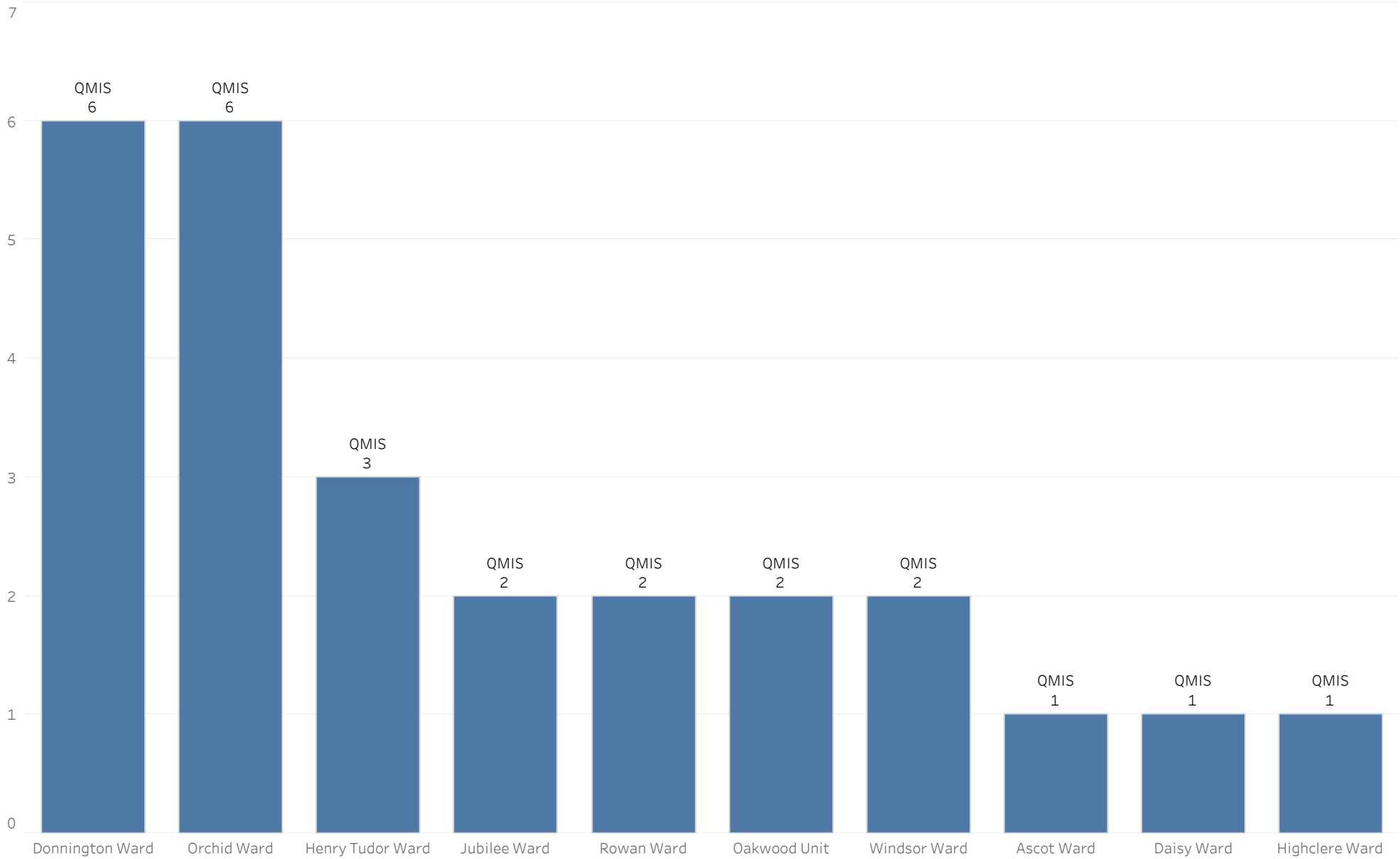
CIP target (£k): (Cumulative YTD)	£6.03m (annual)										£248k	£461k
Financial surplus £k (excl. STF): (Cumulative YTD)	-£0.4m										£488k	£560k
Inappropriate Out of Area Placements (Bed Days)	542 bed days (cumulative for Qtr)	135	284	482	163	440	625	119	336	523	168	270
Staff turnover: %	<16% per month	16.6%	16.9%	16.5%	16.9%	17%	17.1%	17.1%	17.1%	17.5%	17.4%	17.1%

Harm Free Care Driver: Fall incidents in Inpatient Wards (Jul 18 to May 19)

Any incident (all approval statuses) where sub-category = fall from chair/bed, level surface, found on floor/unwitnessed fall, Location exact excluding Patient/staff home and incident type = patient

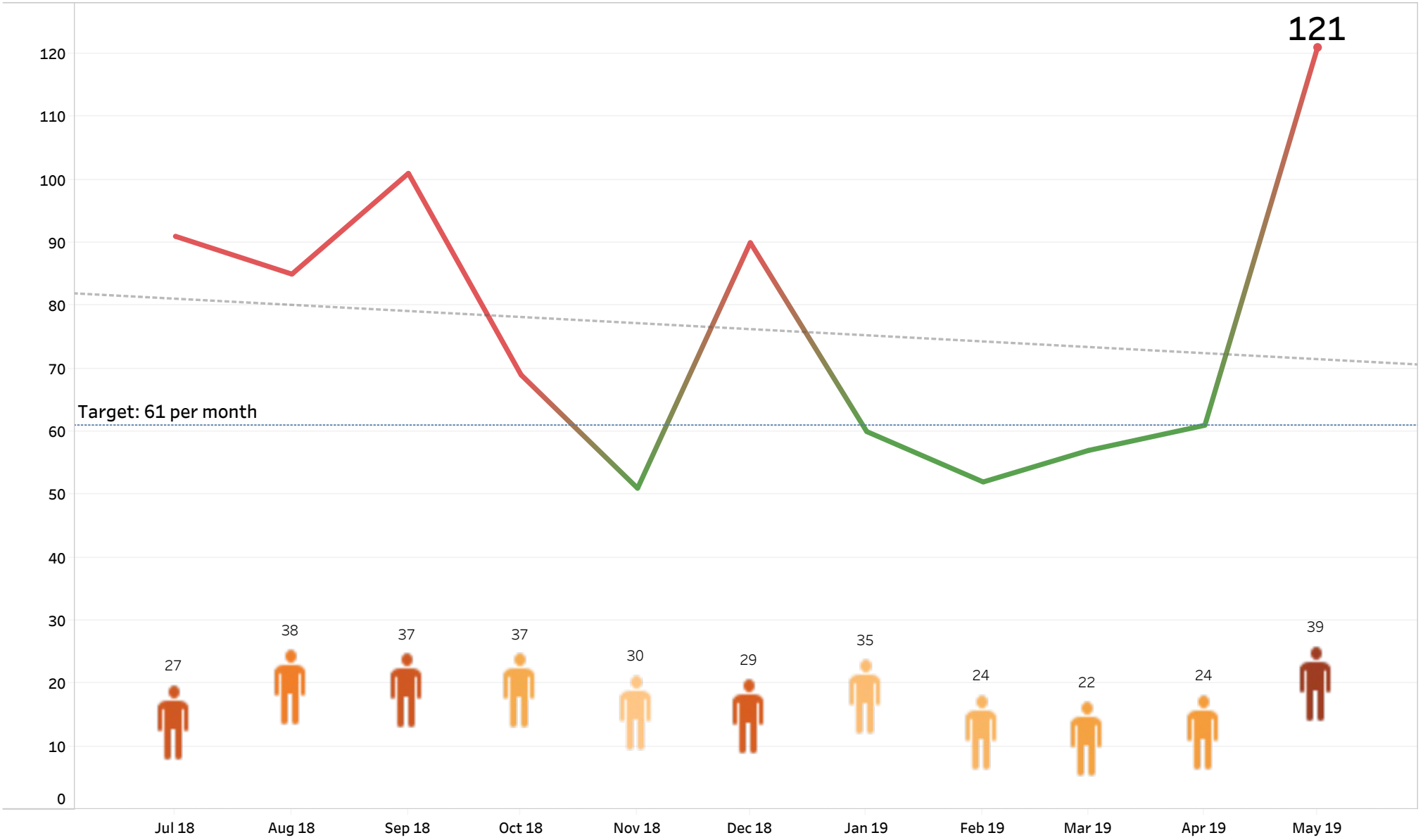


Harm Free Care Driver: Fall incidents in Inpatient Wards(May)

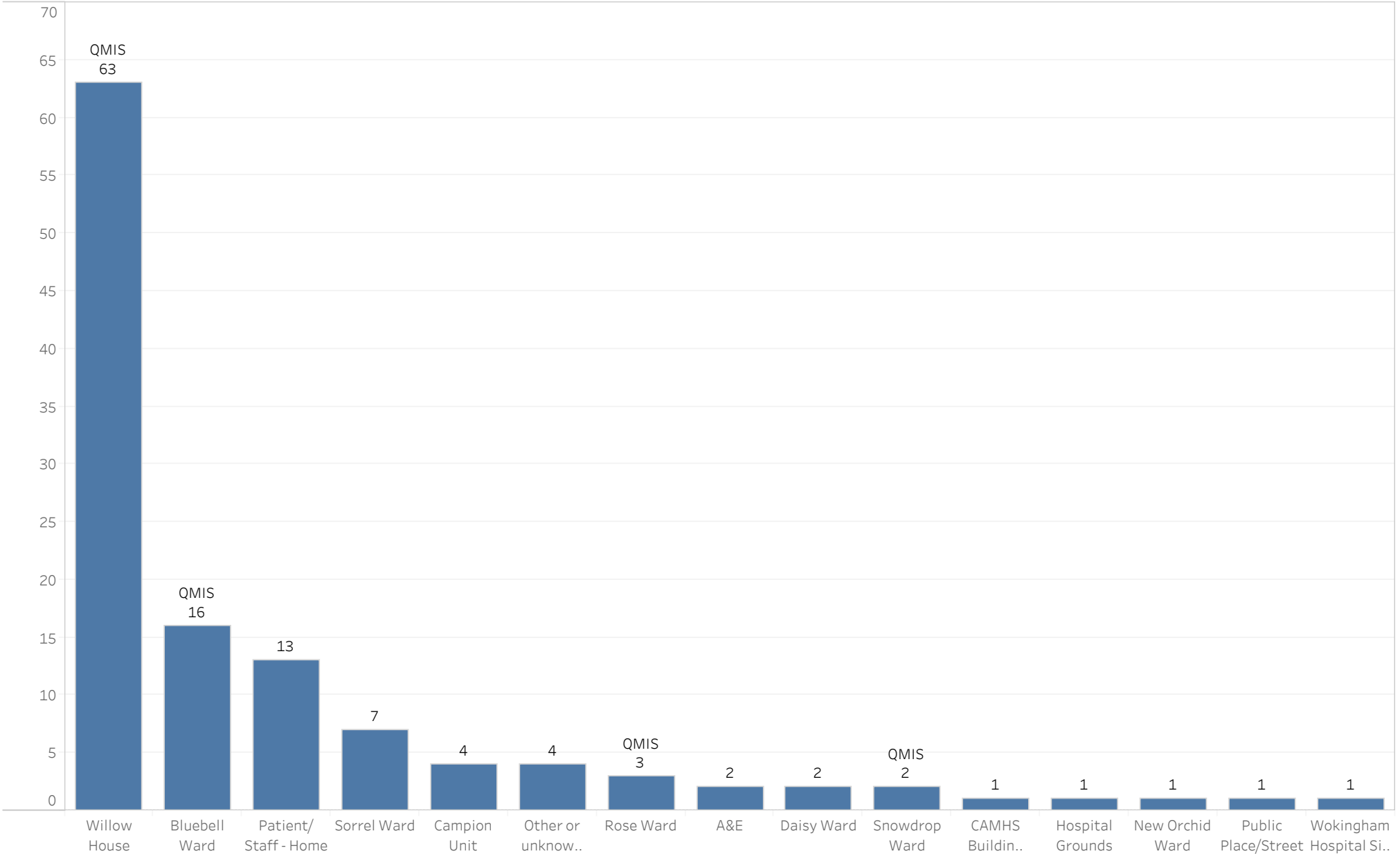


Harm Free Care Driver: Self-Harm incidents (Jul 18 to May 19)

Any incident (all approval statuses) where category = self harm

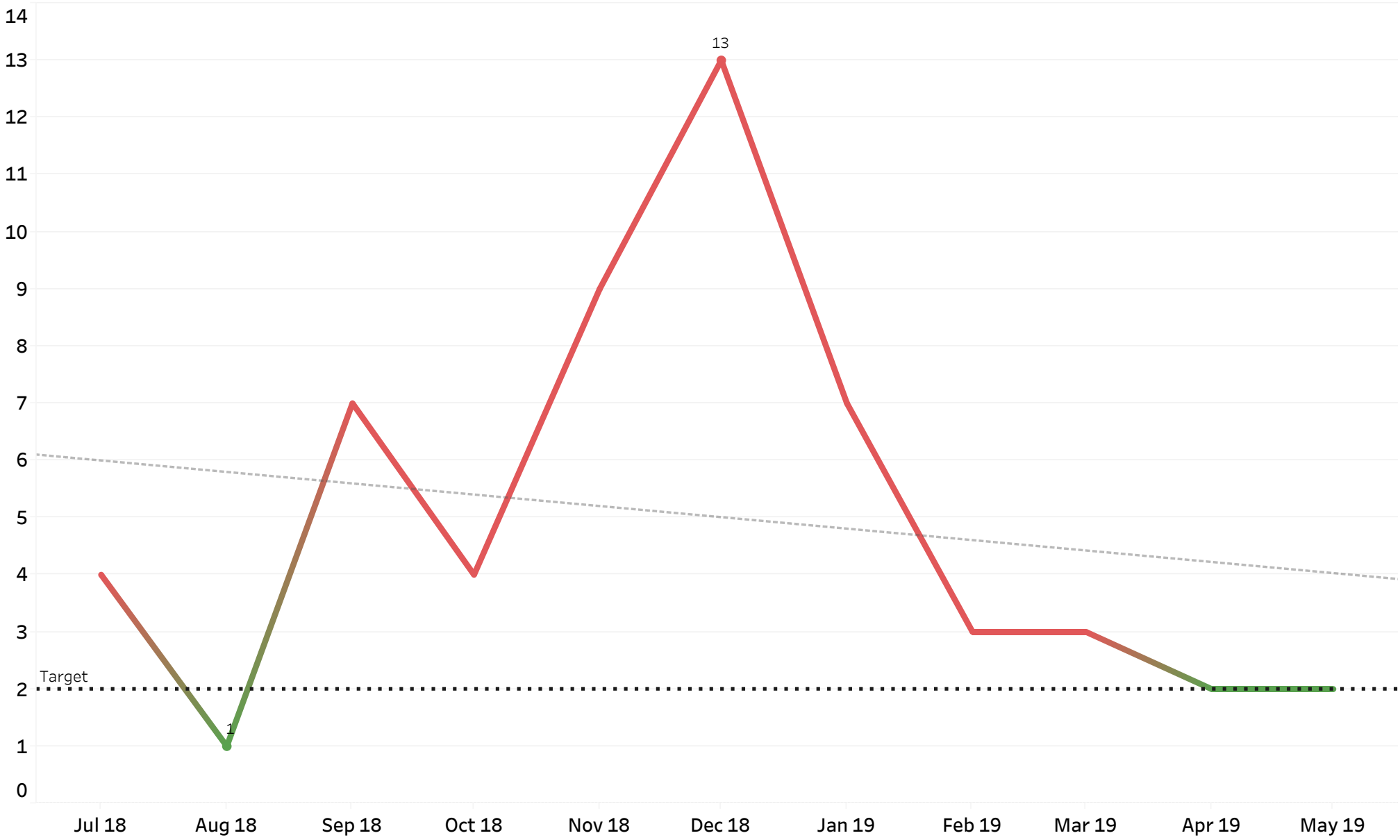


Harm Free Care Driver: Self-Harm incidents by location (May)



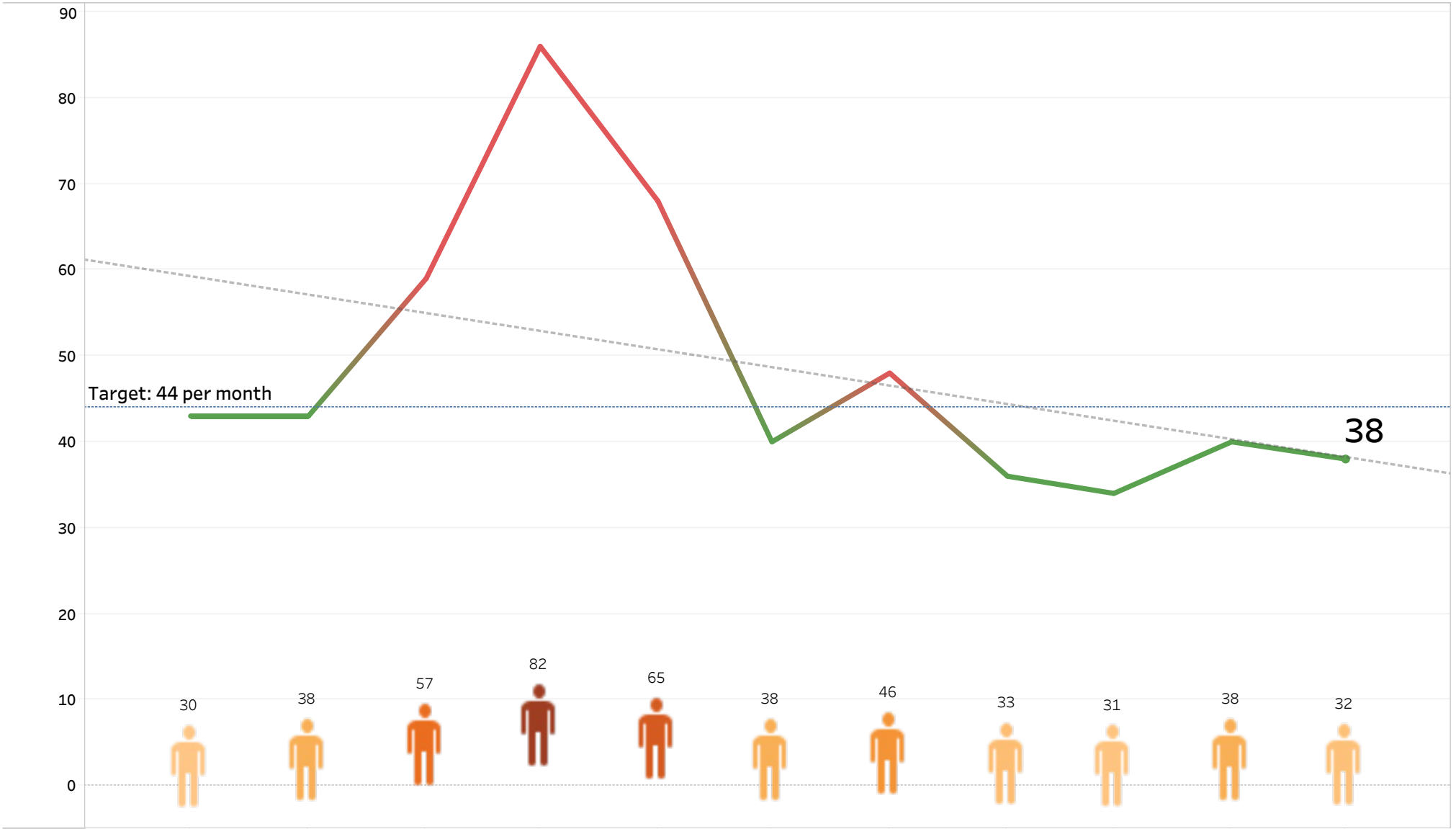
Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Jul 18 to May 19)

(All approval statuses)

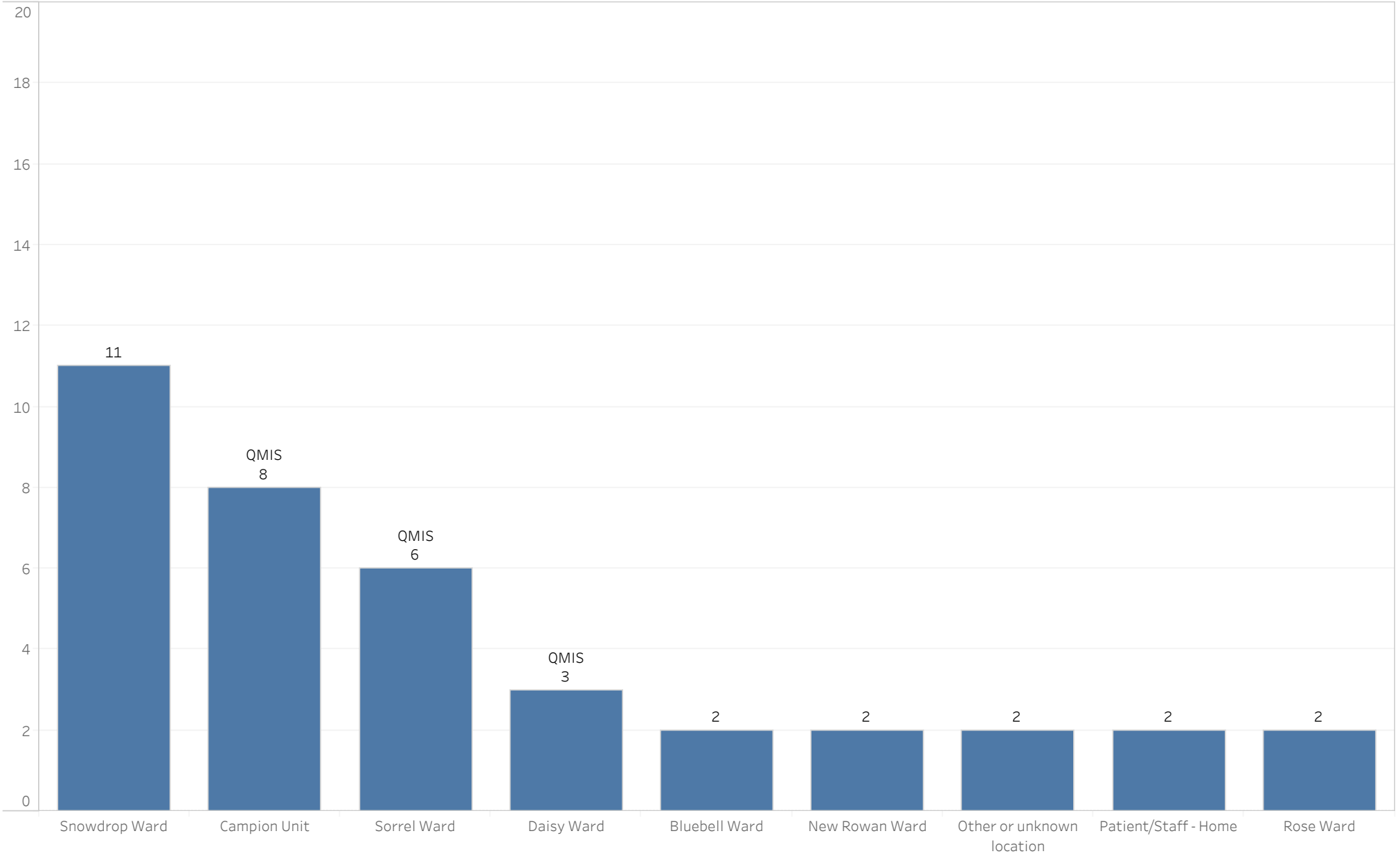


Supporting Our Staff Driver: Physical Assaults on Staff (Jul 18 to May 19)

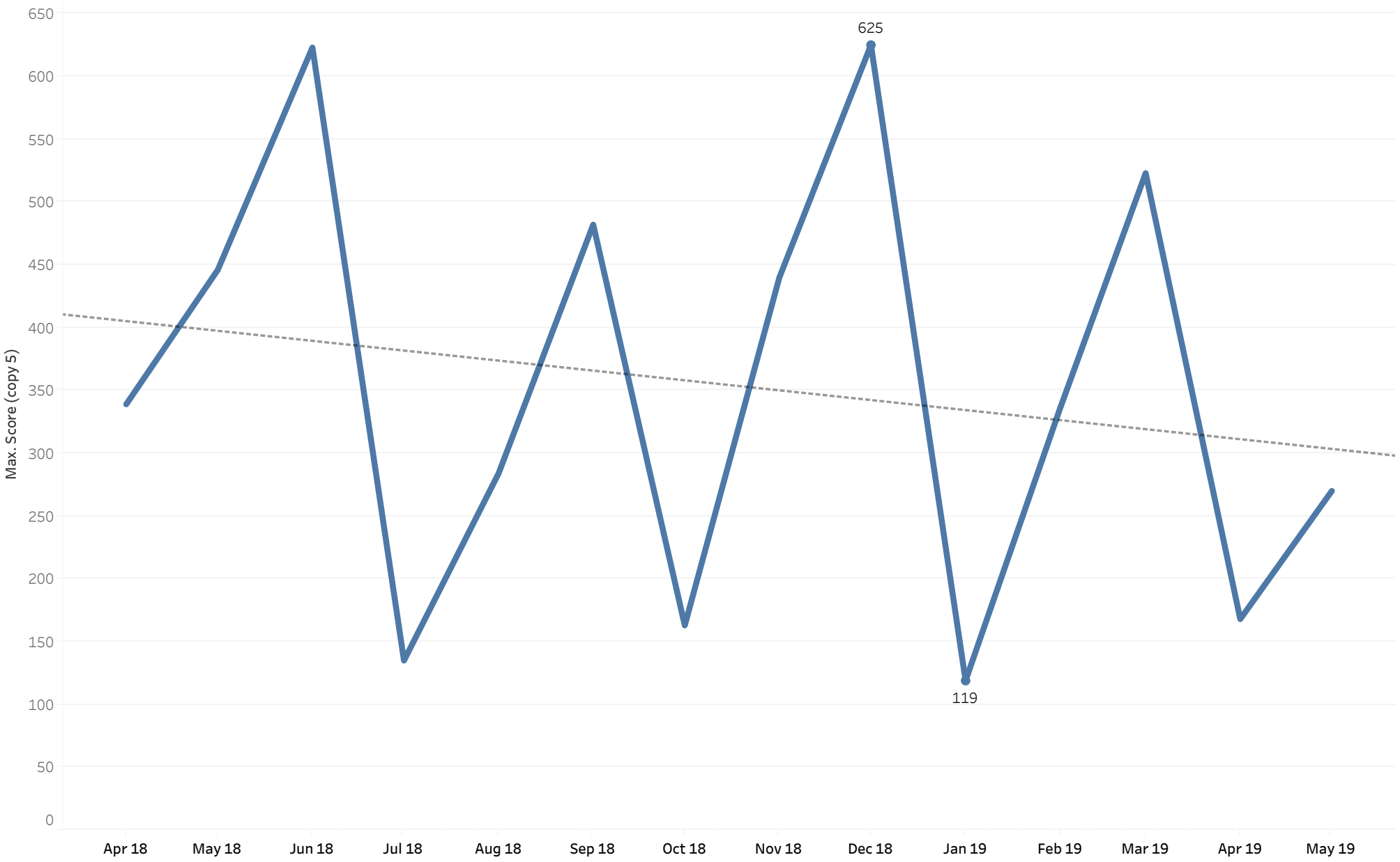
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (May 2019)



Money Matters Driver: Inappropriate Out of Area Placements(Apr 18 to May 19)



True North Harm Free Care Summary

Tracker Metrics

Pressure ulcers acquired due to lapse in care (Community Nursing & IP wards) ytd days	180 days free in the year										30	61
Mental Health: AWOLs on MHA Section	16 per month	26	30	9	27	19	16	20	25	24	18	14	16
Mental Health: Absconsions on MHA Section	8 per month	25	14	11	21	20	22	26	40	33	19	7	8
Uses of Learning Disability Strategy for Crisis Intervention & Prevention (SCIP)	10 per month	7	8	7	5	6	13	3	0	0	8	4	5
Mental Health: Readmission Rate within 28 days: %	<8% per month	8.30	8.30	5.43	6.21	4.87	4.58	6.32	6.74	7.87	7.50	7.92	6.90
Safety Plan for Patients on CPA (formerly MH Crisis Plans for Patients on CPA): %	90% compliance	96.2	95.7	96.0	96.3	96.2	95.8	95.9	96.7	96.3	96.9	97.0	97.2
Patient on Patient Assaults (LD)	6 per month	27	11	13	14	20	13	10	7	3	6	3	4
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health	25% by Sept 2019; 40% by March 2020												

True North Patient Experience Summary

Tracker Metrics

Patient on Patient Assaults (MH)	38 per month	51	48	56	55	52	54	53	59	49	45	24	28
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	91.0%	92.7%	94.5%	93.5%	90.7%	89.9%	90.4%	92.3%	90.6%	94.2%	92.0%	90.6%
Mental Health: Uses of Seclusion	13 in month	6	14	15	4	8	15	18	12	10	8	15	11
Patient FFT Recommend Rate: %	95% compliance	98%	96%	96%	97%	95%	94%	94%	94%	92%	89.7%	93%	92.2%
Learning Disability: Seclusion	0	0	1	1	0	2	0	2	0	0	0	0	0
Community Inpatient Average Length of Stay (bed days)	<28 days	28.6	23	24.3	24.4	21.3	23	20.2	22.1	22	21.1	22.3	22.6
Mental Health Clustering within target: %	90% compliance	84.3%	86.4%	83.4%	84.5%	82.1%	82.9%	82.8%	79.2%	78.0%	78.7%	80.2%	79.3%

True North Supporting Our Staff Summary

Tracker Metrics

Gross vacancies: %	<10%	9.09%	9.30%	8.90%	9.19%	9%	8.30%	9%	7.79%	7.00%	6.80%	10.1%	10%
Statutory Training: Fire: %	95% compliance	89.5%	89.2%	89.0%	89.2%	90.1%	89.9%	87.8%	87.2%	87.9%	88.7%	88.5%	90.2%
Statutory Training: Health & Safety: %	90% compliance	91.3%	93.0%	93.7%	93.7%	93.9%	94.1%	93.5%	94.0%	94.5%	94.6%	94.8%	95.2%
Statutory Training: Manual Handling: %	90% compliance	91.3%	90.8%	91.5%	90.9%	91.6%	92.1%	88.9%	89.2%	90.2%	90.2%	90.8%	92.2%
Mandatory Training: Information Governance: %	95% compliance	92.4%	90.5%	88.1%	91.2%	93.3%	94.0%	94.5%	88.7%	92.1%	94.2%	93.6%	94.0%
PDP (% of staff compliant) Appraisal: %	95% compliance by end of May 2019	90.0%	95.2%	95%	93.0%	91.5%	89.6%	88.0%	86.9%	85.0%	82.6%	9%	75.9%

True North Money Matters Summary

Tracker 1

Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly	7.50%	8.95	9.22	8.07	8.38	7.59	7.82	12.8	11.2	9.00	8.09	5.89	6.27

Tracker Metrics

Community Inpatient Occupancy: %	80-85% Occupancy	70.5%	77.7%	70.2%	77.7%	74.7%	76%	71.6%	81.3%	86.5%	82.7%	81.6%	74.9%
Mental Health: Acute Occupancy rate (excluding Home Leave): %	85% Occupancy	94.1%	96.1%	96.6%	97.8%	97.6%	98.5%	93.5%	97.5%	98.5%	93.3%	95.9%	94.5%
Mental Health: Acute Average Length of Stay (bed days)	30 days	39.9	34.9	39	45	48.0	51.4	47.2	43	39	41	37.1	39
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	65%	71.4%	79.4%	80.4%	69.2%	64.3%	83.5%	93.4%	92.8%	87.0%	83.5%	92.8%
DNA Rate: %	5% DNAs	4.85%	4.87%	4.76%	4.66%	4.87%	4.75%	4.70%	4.76%	4.79%	4.85%	5.29%	4.90%
Community: Delayed Transfers of Care (NHSI target) Monthly and Quarterly	7.5% Delays	8.95%	9.22%	5.29%	8.38%	7.63%	7.82%	12.8%	10.1%	9.67%	9.90%	4.70%	4.79%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Mental Health: 7 day follow up (Quality Domain): %	95% seen	97.5	100	100	94.3	98	97.0	97.5	96.2	96.9	99	99	94.3
C.Diff due to lapses in care YTD	0	0	0	0	0	1	1	1	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	97.8	97.8	97.8	97.8	97.8	97.8	97.8	97.8	97.8	97.8	97.8	97.8
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP: %	90% treated	93	93	93	93	93	93	93	93	93	93	93	93
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the Audit of Community Health Services (people on CPA): %	65% treated	100	100	100	100	100	100	100	100	100	93	93	100
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	No target - report number	1	0	0	0	0	1	0	1	0	1	0	0
Mixed-sex accommodation breaches	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of children and young persons under 16 who are admitted to adult wards (Safe Domain)	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	56% treated	85.7	100	90.9	50	80	100	60	100	90	62.5	90	100
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.8	99.6	100	100	100	100	100	100	99.9	99.7	99.5	99.9
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	98	98	99	98	98	99	99	97	98	99	98	97
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	60	56.9	55.0	56.9	55.0	55.0	56.9	57.9	57.9	57.5	57.5	56.0
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	71	67		67	68	70	70	71	71	69	69	66
% clients in Mental Health Services in Employment	9% in Employment	14.0	12		12	12	12	12	12	12	12	12	12
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	99% seen	100	100	100	98.7	99.7	100	100	100	100	100	100	100
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	97.4	100	98.2	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	98	100	100	100	100	100	100	100	99.1	100	100	100
Sickness Rate: %	<3.5%	3.74	3.71	3.83	4.07	4.42	4.65	4.10	4.41	4.59	3.89	3.81	3.59
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null	84	94			86	84	84	84	84	84	84	84
Finance Score - Was Continuity of Services Risk Rating now Use of Resources	Month 1=3, months 2 to 5 =2 then month 6 onward=1	1	1	1	1	1	1	1	1	1	1	3	2
Mental Health Data Set Data Quality Maturity Index Score (DQMI)	95% achieved	97.5	94.1	94.1	94.1	99.7	99.7	99.7	99.9	99.9	99.9	96.5	96.5

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 July 2019
Title	Board Vision Metrics Update
Purpose	To provide the board with a performance update on metrics agreed in measuring progress towards achieving our vision
Business Area	Performance
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
Equalities and Diversity Implications	N/A
SUMMARY	Vision metric performance is provided at annex 1 of the paper. Indicators are YTD May 2019 performance unless otherwise stated within the narrative. To note: • The Trust dropped from 2nd to 3rd position in combined trust cohort staff survey rankings. • No inpatient death from self-harm since October 2018. • FFT response rate has dropped below 15% target for the second period running, due to feedback device issues. • Stakeholder survey to be considered for refresh. • CQC compliance actions and Good overall rating will remain until next core services inspection.

	• Segment 1 regulatory autonomy maintained since segmentation began. Trust financial plan set to strengthen to lowest risk rating of 1 by second half of the year. • Benchmark positions to be refreshed in quarter 4 19/20. QI focus on assaults and restraint seeing sustained reduction in year.
ACTION REQUIRED	The Board is asked to note the update.

Board Vision Metrics: performance update to end May 2019

Supporting Delivery of the Trust's Vision

Trust Board – public meeting

Alex Gild, Chief Financial Officer
9th July 2019

Purpose

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

Document control

Version	*Date*	*Author*	*Comments*
0.1	26/06/2019	I Hayward & C Magee	
1.0	28/06/2019	I Hayward & C Magee	

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*

Contents

1. Introduction

Background

1.1. Our vision is:

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

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

- Quality
- Safety
- Engagement
- Regulatory Compliance

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

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

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 55 English providers and the 32 combined Mental Health and Community Trust respondents in 2017/18. Indicator performance has been updated from the 2016/17 data set previously reported, to the latest available.

2. Rationale for Metric Inclusion

Sections

By dashboard section (appendix 1) the following metrics were identified by the Board as having an impact on assessing our level of performance in support of delivering our vision.

Quality

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

2.2. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is

available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2017/18 benchmarking results have been updated to the dashboard as follows:

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

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

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2017/18 and the Trust is ranked 20th out of 55 English benchmarking respondents, which shows a worsening in our position from 2016/17, where the Trust was below the mean and ranked 19th out of 55 English benchmarking respondents. The Trust ranks 12th out of 32 combined Mental Health & Community respondents and this was an improvement from our 2016/17 position where the Trust was below the mean and ranked 13th out of 32 combined Mental Health & Community respondents. This indicator is a driver metric in our QI programme.

2.3. The next update on this section will be Quarter 4 2019/20.

Safety

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

- **Falls** – where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group in April 2017. In the financial year 2017/18: two relevant incidents occurred in the year, and there were two incidents confirmed in 2018/19, with one further fall on Rowan Ward currently under investigation, but not yet confirmed as due to a lapse in care. This indicator is a driver metric in our QI programme.

- **Mental Health Inpatient Deaths because of self-harm** – the metric threshold is zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm was in October 2018. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction

of all self-harm is a QI programme objective.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown here were the occupancy rate in May 2019 and shows 95% against a target of 85%. This is a decrease from 99% in February 2019.

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

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to a lapse in care in our community health services. The cumulative total was 17 incidents in the period 1st April 2018 to 31st March 2019, which was an improvement from 18 in the year 2017/18. There has been one case so far in 2019/20 which is a Category 3 case identified as due to a lapse in care. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain.

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

Engagement

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

- **Commissioner Satisfaction - Net Commissioner Investment Maintained –** achieved in line with last four years for 2019/20. Most of the investment addressed significant pay cost inflationary pressures with some direct service investment to maintain perinatal and IAPT services, previously funded on a non-recurrent basis by NHSE.

- **Stakeholder Satisfaction - Survey of System Partners –** a survey was developed in the second half of 2017/18; Results were positive with only 11% giving a neutral response to the Trust's leadership, quality, governance and service delivery within the two Integrated Care Systems it operates in. Survey respondents included our six Local Authorities, NHS commissioners and provider system partners. Refresh of survey and target to be agreed.

- **Patient Friends & Family Test Response Rate** – 12.5% in May 2019 against the target of 15% is a decrease from February 2019 (21%). This is a QI driver metric and performance has suffered in recent months due to issues with the rating devices.

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

Regulatory Compliance

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

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

- **NHSI Segmentation -** maintained segment 1 of the Single Oversight Framework in the latest assessment. This is the highest level of autonomy, with no NHSI support required. Also maintaining NHSI Finance Score of 1 (previously the Use of Resources rating) (lowest financial risk rating available on scale of 1 to 4). For 2019/20 the plan was to be a 3 for Month 1, improving to a 2 for Month's 2 to 5 (May 2019 was 2) and achieving 1 from Month 6 onwards.

- **Number of CQC Compliance Actions –** there are four compliance actions, 1 for Willow House, which forms part of our core services and 3 for WestCall which does not form part of our core services. Review of these compliance issues are subject to the outcome of the current CQC core services inspection. There has been no change since last reported in February 2019.

Appendix 1 – Board Vision Metrics

Trust Board Vision Metrics

As at: May 2019

		Quality			Safety					
Target		Mental Health Patient on Patient Assaults Top 3	Mental Health Patient on Staff Assaults Top 3	Mental Health Use of Restraint Top 3	Falls Due to Lapse in Care 0	Mental Health Inpatient Deaths from Self Harm 0	Mental Health Bed Occupancy 85%	Never Events 0	Pressure Ulcers 10% Reduction	Suicide Rate per 10,000 under Mental Health care 10% Reduction Target 8.2
	Performance trend since last report (October 2018)	↑	↑	↓	↑	↔	↑	↔	↑	↔
Actual	All English NHS Mental Health Providers (out of 55)	19th	24th	20th	0	1	95%	0	1	4.3
	Joint English Mental Health and Community Trusts (out of 32)	11th	15th	12th						
	Map to True North Domains	Harm-free care - Tracker metric	Supporting our staff - Driver metric	Harm-free care - Driver metric	Harm-free care - Driver metric	Harm-free care	Money Matters - Tracker metric	Harm-free care / Regulatory Compliance	Harm-free care - Driver metric	Harm-free care - Driver metric

		Engagement			Regulatory Compliance		
Target		CCG Net Investment Green	CCG Satisfaction Survey To be defined	Patient FFT Response Rate 15%	Staff Survey Engagement Rating (out of 32) 3rd	CQC Rating Outstanding	CQC Compliance Actions 0	NHSI Segment 1
		↔	-	↓	↓	↔	↔	↔
Actual		✓	✓	12.50%	3rd	Good	4	✓
		-	-	Patient Experience - Driver Metric	Supporting our staff - Drive Metric	-	-	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th July 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.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Annual Equality Report 2018/2019

How we meet the public sector duty

Stonewall DIVERSITY CHAMPION

1. Introduction

As a NHS Foundation Trust providing community and mental health services, Berkshire Healthcare Foundation Trust is committed to understanding and responding to the needs of the communities we serve and supporting and empowering our diverse workforce.

We employ approximately 4,300 people and operate from over 100 bases, with most of our contacts with patients and service users in their own homes.

The Trust's Equality and Inclusion Strategy 2016-2020 set out the seven equality objectives that support the staff and diversity networks across the organisation giving a clear vision to ensure it is a great place to work for everyone. The Trust continues to develop diversity and inclusion as the golden thread through all the work we undertake to ensure that everyone is treated with respect, dignity and compassion.

1.1 The Public Sector Equality Duty

The public sector equality duty is a general duty on public bodies and others that carry out public functions. It ensures that public bodies consider the needs of all individuals in their day to day work in shaping policy, in delivering services, and in relation to their own employees.

The equality duty has three aims. It requires public bodies such as Berkshire Healthcare to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act 2010
- advance equality of opportunity between people who share a protected characteristic and people who do not share it
- foster good relations between people who share a protected characteristic and people who do not share it.

The protected characteristics covered by the equality duty are:

- age
- disability
- gender reassignment
- marriage and civil partnership (but only in respect of eliminating unlawful discrimination)
- pregnancy and maternity
- race—this includes ethnic or national origins, colour or nationality
- religion or belief—this includes lack of belief
- sex
- Sexual orientation.

The general equality duty is supported by two specific duties which require public bodies such as Berkshire Healthcare to:

- publish information to show their compliance with the equality duty
- set and publish equality objectives, at least every four years.

Equality Strategy 2016-2020

The Trust's Equality and Inclusion Strategy was approved by the Trust Board in June 2016 and the seven goals of the strategy support compliance under the public sector equality objectives, as required by the Equality Act 2010.

1. Increase the representation of Black, Asian and Minority Ethnic (BAME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades. This reflects the Berkshire population.
2. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BAME staff (as measured by our annual NHS Staff Survey).
3. Reduce harassment and bullying as reported by staff and in particular, BAME staff, in the annual NHS Staff Survey. We are aiming to reduce experiences of harassment and bullying to lowest quartile rankings compared with other Mental Health Trusts in the NHS Staff Survey index. We also wish to achieve equity in reporting between BAME and white staff.
4. Significantly improve the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness.
5. Take a more robust approach to making reasonable adjustments for disabled people – in particular implementation of the NHS Accessible Information Standard.
6. Attain Top 100 Workplace Equality Index Employer status with a ranking in the top five health and social care providers.
7. Engage with diverse groups, in particular Black, Asian and Minority Ethnic, lesbian, gay bisexual and transgender, and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both Mental and Community Health Services.

The Trust Strategy identified three key target groups and established staff networks to address the associated inequalities with these protected characteristics. Three staff networks have been established and each has a Trust Board sponsor who is responsible for ensuring a clear pathway between the operational activity and the Trusts strategic vision. The target groups are as follows:

- Black, Asian and Minority Ethnic people {BAME network}
- Individuals with a Disability {Purple network}
- Lesbian, Gay, Bi and Trans people {LGBT and friends network}

The Trust is building continued opportunities for the networks to come together and promote an Inclusive network for all, by recognising intersectionality and promoting human rights.

1.2 Our approach to governance on equality and inclusion

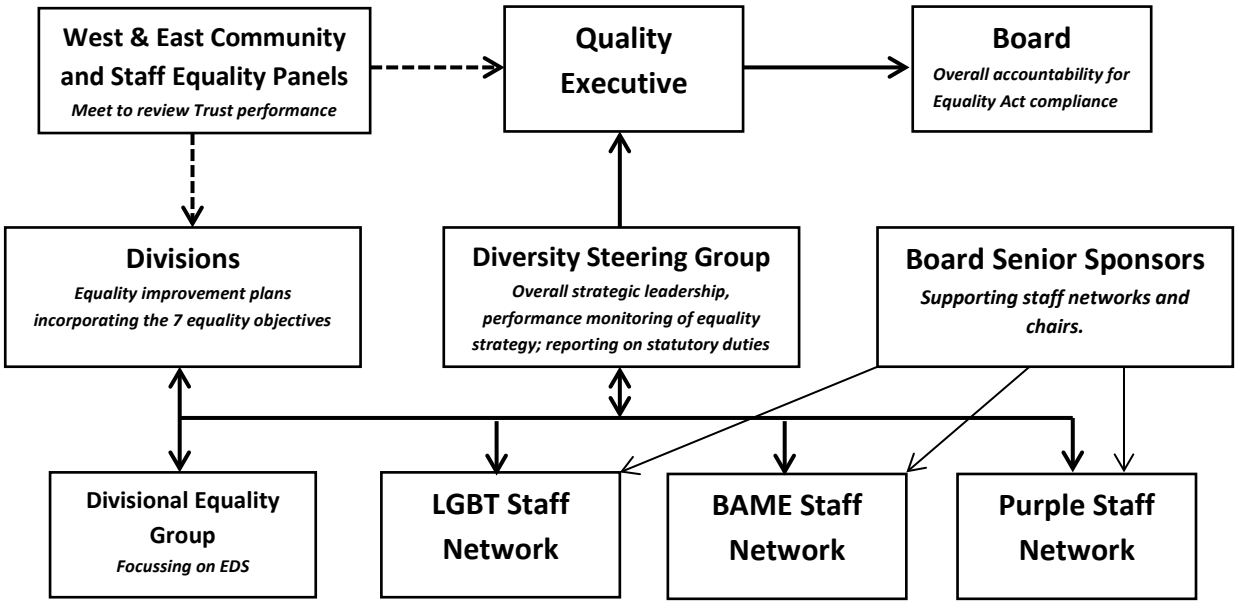
Berkshire Healthcare's Equality and Inclusion Strategy, ensures there are systems in place across the organisation to consider equality and inclusion for our workforce and service delivery. The Diversity Steering Group, with Executive and Non-Executive membership, provides strategic leadership and performance monitoring to ensure that we fulfil our equality duty. The Diversity Steering Group is chaired by the Executive Director of Corporate Affairs.

The Trust also has 4 senior sponsors, 11 equality leads, over 100 equality champions and three staff networks. Our virtual dedicated Equality and Inclusion team includes the Equality and Diversity lead director, the Director of People, Equality and Diversity Manager, Equality Human Resources Manager and an Equality Employment Programme Administrator.

Within Marketing and Communications there are named leads to support each of the staff networks and strategic commitment to support the inclusion agenda. We also have workforce information and information analysts to provide support. The diagram below shows our overall governance framework, enabling coordination of our work and monitoring of progress.

The Trust's equality objectives for the period 2016 - 2020 were agreed by the Board in September 2016. These were introduced to over 100 Equality Champions by Julian Emms, CEO, at the Trust's first equality conference on 13 October 2016. The infographics below illustrate three of our key goals:

Figure 1: Berkshire Healthcare governance of equality and inclusion



1.3 Compliance with the equality duty

This report describes the progress we have made from 1st April 2018 to 31st March 2019, highlighting key achievements and activity towards fulfilling our equality objectives. It also provides recommendations for next steps.

The specific duties of the Act require the Trust to publish relevant and proportionate information relating to our workforce and service users. Detailed data tables for the period 1 April 2018 - 31 March 2019 will be updated and available to view on our website. In line with NHS data protection standards we cannot publish data that relates to less than five people.

This report covers all protected characteristic data we hold on job applications, short-lists, appointments, pay, turnover, harassment and disciplinary processes. This year we have also published data on the following services: Community Health East, Mental Health East, Community Health West and Mental Health West.

As we come to the end of the four year cycle for our equality and diversity strategy, planning has begun to prepare for the next four years, aiming to bring our work together within a Human Rights perspective. Once the new strategy has been developed we will formally review our performance every four years.

2. Data headlines

2.1 Berkshire demographic

Berkshire is a county of around 861,870 people (2011 Census), living in six local authority areas. In the East of the county there is: Bracknell Forest, Royal Borough of Windsor and Maidenhead and Slough and in the West - Reading, Wokingham and West Berkshire.

According to the 2011 census, the population distribution is as follows: 50% women and 50% men; 25% of the population aged 0 – 19 years; 61% aged 20 – 64 years; 12% aged 65 – 84 years; 2% aged 85 years and over. 0.3% of the population have severe learning disability (Berkshire Learning Disability Register). 1.7% of respondents to the Annual Population Survey (2016) identify as lesbian, gay and bisexual. The most accurate assessment of British same sex experiences is the National Survey of sexual attitudes and lifestyles (2010) which estimates same sex experiences to be between 8-16% for women and 5-7% for men.

Ethnic minority groups represent 20% of the Berkshire population. When we refer to 'Black and Minority Ethnic' (BME) in this report we are counting only non-white ethnic minorities. In terms of age bands, the proportion of minority ethnic people is significantly less for older age groups: 7.2% at 65-84 years and 3% for those aged over 85 years.

We have used the following summary categories in this report:

Summary ethnic categories	*2011 Census population estimate*[1]
White British	73.0%
White Other (including EU nationals, Irish, Gypsies & Travellers)	7.0%
Asian (Indian, Pakistani, Bangladeshi, Chinese, any other Asian)	13.0%
Black (African, Caribbean, any other Black background)	3.5%
Mixed	2.6%
Other ethnic group (Arab and any other ethnic group)	1.0%

Religion and belief	*2011 Census*
Christian	56.2%
Atheist	0.1%
Islam	6.5%
Hindu	2.7%
Other	27.7%
Not Declared	6.9%

2.2 Workforce data summary

2.2.1 Workforce diversity

The Trust employed 4,341 staff as at 31st March 2019, which is a slight increase from this time last year. Workforce diversity is outlined below:

- 82.4% female, 17.6% male. The Trust continues to have a trend of recruiting significantly more women than men.
- 71.4% white, 8.9 % black, 11.1 % Asian 2.1% mixed heritage, 2.1% other and 5.4% not stated. The Trust ethnicity profile as at March 2019 shows that all ethnicities and the 'undisclosed' status have not changed from the previous year; none of them have increased or decreased by more than 1.00 percentage points. The Trust employs 22.4% BME staff which is just above the Berkshire population of 20% BME people. 5.7% of our staff are under 25 while 24.4% are aged 35-44, making this the largest age range in our workforce. 13.5% are 65 and over. The Trust age profile has remained stable but there have been very slight increases in the 35-44 and over 55+ age groups.
- 80.5% of staff have declared they don't have a disability, 5% have declared a disability, compared to 12.7% of the Berkshire population and 14.5% have not declared.

- 81.4% of staff have identified as being heterosexual, 2.1% identified as being LGBT+ and 16.6% haven't declared. There has been a slight increase in numbers of people who have identified LGBT+ compared to the time last year which was 1.9%.
- 50.7% of staff have declared being Christian, 3.3% Islam, 2.9% Hindu , 10.2% other and 20.1% have chosen not declare. 12.8% of staff have stated they are atheist compared to 0.1% of the Berkshire population

The workforce profile has remained broadly similar for the last 6-7 years. Declaration for both disability and sexual orientation has seen some increase but there is still a higher proportion of not declaring than for other protected characteristics. We have seen a 0.6% increase in the proportion of male staff, and a 1% increase in BME staff compared with last year. Efforts to encourage staff to review equality data held on their staff record this year led to a very small 1 – 2% increase in data completeness in data fields relating to sexual orientation, disability and religion and belief. The 'LGBTQIA+ & Heterosexual ' status for sexuality has very slightly increased, this shows in the decrease within the 'Not Declared' status.

The Workforce Race Equality Standard

The executive has approved a two year Workforce Race Equality Strategy {WRES} action plan, including a business case to support the actions. The WRES Action Plan is embedded in the Equality Employment Plan {EEP}. There has been good progress in implementing both plans and the related work streams. The Equality Employment Plan is seeking to bring about a sustained change in attitudes and behaviours, using interventions that will develop and empower BAME staff, as well as increase the competence of managers. The Trust now has an action plan which is informed by best practice.

2.2.2 Recruitment and selection

In the financial year 2018/19 there were a total of 12,411 job applicants, 5,044 shortlisted applicants and 882 newly appointed staff. Applicant data is collected by NHS Jobs and our TRAC system on gender, age, ethnicity, disability, religion and belief and sexual orientation.

- The applicant profile remains very similar to that of the previous year, with 58% Non-BME to 42% BME. The number of applicants not disclosing their ethnicity remains the same as this time last year 2.5%. The proportion of successful candidates with 'Not Stated' ethnic origin shows the biggest increase by over 10%.
- The application profile for gender has remained broadly the same as the previous year, however there is a slight increase in males. The percentage of males being recruited has increased by over 5% this year.
- The age of applicants has remained very stable this year with a slight increase of nearly 2% aged over 45+. By age profile, staff appointed within the 25-34, have increased by nearly 3% this year, whereas the new starters aged between 45- 54 has decreased by over 4%.
- The same number of individuals with a declared disability has applied, with a slight increase in the numbers of people who have stated they don't have a disability, being shortlisted.

There have been decreases in non-disabled successful candidates since last year. This is due to the large increase in starters not declaring their disability this year.

- There has been a very slight increase in heterosexual applicants. Applications received show that just fewer than 7% of applicants do not disclose their sexuality. The sexuality of applicants being shortlisted mirrors the applicant profile. The Trust is monitoring population data to ensure we are making efforts to recruit in a way that mirrors the communities that we serve. Our social media and recruitment activity has focussed on increasing applications form underrepresented groups. The number of starters not declaring their sexual orientation increased by over 8% from last year.
- Applications received show that only 11% of applicants have not disclosed their religious belief. The religious belief of applicants being shortlisted shows very slight increases within Islam and Hindu. The number of starters declaring their religious belief has decreased by over 7% from last year.

The data is clear that we are currently not accessing the full talent pool from within the community, with under representation for individuals with a disability and from the LGBT+ communities. We are working on how we can improve on this. We will continue to work with staff networks to understand why people do not declare their protected characteristic when applying for roles and once employed by the Trust.

2.2.3 Equal Pay

The majority of the Trust's posts are on the Agenda for Change pay banding system, which is designed, together with the policy on starting salaries, to reduce pay inequality between the individuals who do like for like work.

. Based on average hourly rates of basic salaries, the average pay gap between female and male staff was 20.0% on an average hourly salary. The Trust has looked into the factors that contribute to this most significantly and it falls into two categories. Firstly we need to recruit more males in to our lower pay bands (2-5) as this pay group is dominated by more females. In the top quartile of pay we have 26% males which is above the total workforce profile of 18%. Through enhancing our development and recruitment processes we will work to encourage more females to apply for band 8a and above posts.

The ethnic minority pay gap is 6% and is monitored annually to determine the impact on the pay gap as more BAME staff apply for roles within BHFT and progress their careers through to the senior roles. The equality action plans and Making It Right for bands 2-5 and Making it Right programme for managers are interventions to help address the inequality.

2.2.4 Turnover

Over the reporting period, there was a turnover rate of 17.79%. Due to a change in reporting systems the full information for each protected characteristic was unavailable. However, this will be possible again once the system has been updated. We have a retention plan in place to ensure we focus on retaining all members of our workforce irrespective of their protected characteristics and make this a great place to work. The True North objectives for the year are to reduce turnover from 17.7% to 16% and develop strategies to reduce it below this by developing management capability and focussing on the key reasons as to why people leave, namely ability to work flexibly, their

relationships with their colleagues and their ability to develop their career. We have several mechanisms across the Trust to listen to our staff and act on their feedback. Two significant pieces of work are the analysis and changes linked to the annual National Staff Survey and the other is the Big Conversation events where staff work through a number of questions to identify what the priority changes are and then they work on the solutions. Members of the senior team focus on making the changes and reporting back progress to our staff.

3. Equality Objectives agreed in the 2016-2020 Equality Strategy

Objective 1: Increase representation of black and minority ethnic (BME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades. This reflects the Berkshire population

391 internal candidates achieved a grade increase this year. Of these, 72.9% were white, 9.7% were black, 12.5% were Asian and 1.3% didn't declare. There has been a 5% increase in Asian staff receiving a grade increase. There has been a 3% increase in males receiving a grade increase; however 89% of grade increases were female. There has been a 3% increase in staff aged 35-54 and a 6% of heterosexual staff who have received an increase in grade this year.

Figure 2: % of BME clinical and non-clinical staff

Table 11: Berkshire Healthcare Foundation Trust - March 2019											
Breakdown of Clinical/Non-Clinical Staff by Ethnicity											
As at 31st March 2019 total number of clinical staff was 3180 and total number of non clinical staff was 1161											
Pay Band	*Total Clinical Staff*	*Total Clinical Staff (BME)*	*% of Clinical Staff (BME)*	*% of Clinical Staff (Non-BME)*	*% of Clinical Staff (Ethnicity Undisclosed)*	*Total Non-Clinical Staff*	*Total Non-Clinical Staff (BME)*	*% of Non Clinical Staff (BME)*	*Total Non-Clinical Staff (Non BME)*	*% of Non Clinical Staff (Non BME)*	*% of Non Clinical Staff (Ethnicity Undisclosed)*
Band 1						*38*	*11*	*28.9%*	*24*	*63.2%*	*7.9%*
Band 2	*166*		*48.8%*	*46.4%*	*4.8%*	*130*	*16*	*12.3%*	*107*	*82.3%*	*5.4%*
Band 3	*370*		*23.5%*	*73.0%*	*3.5%*	*261*	*42*	*16.1%*	*214*	*82.0%*	*1.9%*
Band 4	*339*		*17.1%*	*77.9%*	*5.0%*	*241*	*53*	*22.0%*	*175*	*72.6%*	*5.4%*
Band 5	*419*		*30.8%*	*62.5%*	*6.7%*	*112*	*21*	*18.8%*	*84*	*75.0%*	*6.3%*
Band 6	*824*		*22.2%*	*73.5%*	*4.2%*	*124*	*29*	*23.4%*	*91*	*73.4%*	*3.2%*
Band 7	*557*		*21.7%*	*75.8%*	*2.5%*	*85*	*25*	*29.4%*	*54*	*63.5%*	*7.1%*
Band 8a	*194*		*17.0%*	*79.9%*	*3.1%*	*68*	*10*	*14.7%*	*55*	*80.9%*	*4.4%*
Band 8b	*59*		*10.2%*	*89.8%*	*0.0%*	*32*	*2*	*6.3%*	*28*	*87.5%*	*6.3%*
Band 8c	*23*		*13.0%*	*78.3%*	*8.7%*	*31*	*6*	*19.4%*	*25*	*80.6%*	*0.0%*
Band 8d	*18*		*0.0%*	*100.0%*	*0.0%*	*10*	*2*	*20.0%*	*6*	*60.0%*	*20.0%*
Band 9	*3*		*0.0%*	*100.0%*	*0.0%*	*4*	*1*	*25.0%*	*2*	*50.0%*	*25.0%*
*Other **	*208*		*41.8%*	*34.1%*	*24.0%*	*25*	*2*	*8.0%*	*14*	*56.0%*	*36.0%*
Grand Total	*3180*		*24.8%*	*69.8%*	*5.4%*	*1161*	*220*	*18.9%*	*879*	*75.7%*	*5.3%*

9.1% of all BME staff are clinical staff Band 8 compared to 10.9% non BME. 9.5% of all BME non clinical staff are Band 8 compared to 13.1% non BME.

Action taken: *We have achieved our target for band 7 and continue to focus on the band 8 pay bands as well as developing staff in band 6 roles*

Equality Strategy- Goal	Progress
Increased representation of BAME staff in bands 7 and 8a-d. Goal: 20% representation at each of these grades	Trend: increased representation of BME staff in bands 7/8a/8b **Clinical**: Band 6 =21.6% (+2%) Band 7 =20% (+3.3%) Band 8a =14.9% (+1%) Band 8b =9.2% (no change) Band 8c-9 >6 = (no change)* VSM =1 (no change) **Non-clinical** Band 6= 29.7% (-1.1%) Band 7= 21.9% (-1.7%) Band 8a= 13.8% (+2.3%) Band 8b= 19.4% (+9.4%) 8c- 9>6 = (no change) * VSM= 0 (no change) *Bands 8c-9 are based on headcount

Objective 2: Ensure there is no difference in perceptions of equal opportunity in career progression between white and BME staff (as measured by our annual NHS staff survey)

The staff annual survey showed there was a 6% increase in the number of BME staff who believed that the Trust provided equal opportunity for career development and/or promotion from 68% to 74%.

The percentage for white staff was down 2% from 91% to 89%.

The Trust is committed to developing talent within the organisation and recognises the experiences of our staff members are not always equitable across the organisation. Continuing professional development (CPD) opportunities and/or training and development are linked to career progression. Out of the 487 CPD opportunities, 77.2% of the continued professional development opportunities were undertaken by white staff, compared to 10.72% undertaken by black staff and 9.03% by Asian staff. Only 2.87% of applications felt confident to declare that they are LGBTQ+ compared to 85.42% self-declaring as heterosexual. There have been increases of 5% in the percentage of non-disabled receiving CPD opportunities this year. Current data on learning and development shows BME staff are 1.11 times more likely to access non-mandatory training and CPD (continuous professional development). This is a continuation of an improving trend.

Action taken: *Our internal development programme 'Making It Right' is designed to address barriers and perceptions of unfairness. The programme for cohort 3 has concluded and we have developed*

and piloted a e "Making It Right" for managers programme. This will be rolled out to all managers over the course of this year.

Objective 3: Reduce harassment and bullying as reported by staff and in particular, BAME staff, in the annual NHS Staff Survey. We are aiming to reduce experiences of harassment and bullying to lowest quartile rankings compared with other Mental Health Trusts in the NHS Staff Survey index. We also wish to achieve equity in reporting between BAME and white staff.

Disciplinary

There has been national concern for some years around levels of BME disciplinary cases in the NHS. Between 1st April 2018 and 31st March 2019, 64.91% of disciplinary processes were raised for white staff, 12.28% raised for black staff and 14.04% raised for Asian staff.

56.14% of disciplinary were raised for staff, who are Christians and the next highest is undeclared with 15.79%. Male staff form 18% of the workforce but 40.35% of all disciplinary cases. Female staff form 82% of the workforce but only 59.65% of all disciplinary cases.

Action taken: *The Making it Right {MIR} positive action programme has been piloted, evaluated and three cohorts of BAME staff have been through the programme with positive feedback. . The Making It Right programme is still in its infancy but more than a third {8} of the graduates have already secured promotion and others have been seconded to higher positions. The programme deals with confidence and skills to progress and manage selection processes but one of the sessions also deals with disciplinary and grievance cases. Given the data in the National Staff Survey and the casework statistics above we have developed and piloted the Making if Right for Managers programme and are working on an Allies programme to build management awareness and the skills to tackle these issues.*

Harassment and victimisation

In the 12 month period, there were six formal complaints brought under the Dignity at Work policy, which addresses allegations of harassment, bullying or victimisation. All six were brought by white, female, heterosexual staff, all of whom had a declared disability.

The NHS national taff survey results (2018, published Feb 2019) demonstrated reductions in two of the WRES indicators and one remaining the same:
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months- BME 27% (no change from 2017)
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months - BME 21% down from 27%
In the last 12 months have you personally experienced discrimination at work from any of the following?
Manager/team leader or other colleagues - The results for BME staff has reduced to 11% down from 17% in the previous year.

Action taken: *To address the continued experience of our BAME staff who experience harassment, bullying or abuse from patients, relatives or abuse from patients, a set of clear guidelines are being developed, initially with Community Health West and then rolled out across the Trust. This work will*

focus on a zero tolerance approach and training for staff to manage these situations with compassion. The Trust has also developed a "Making it Right for Managers" in recognition that we want to make it a great place to work for everyone and will help to open up the conversations, enable managers to understand, talk about and own their behaviours..

Objective 4: Significantly improve the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness

Disabled staffs have twice as much sickness per employee (12.92 days) than those staff who are not disabled (6.24 days).

Stress/anxiety related sickness is experienced by disabled staff is significantly higher than that experienced by non -disabled staff. Work is underway to understand this data and there is need for a coordinated approach to improve staff health and well-being for all our staff, but disabled staff in particular.

The newly formed Purple Network is completing a survey to establish the priorities of disabled staff in the Trust.

Action taken: *At the end of 2018 the Purple Network completed a survey of all staff employed in the Trust that considered themselves, or knew/ cared for someone with a disability. This survey has given them key priorities to focus on. In addition to this a Health, Wellbeing and Engagement HR Manager has been recruited (starting Sept 2019) focusing on resources for staff wellbeing across the Trust.*

Objective 5: Take a more robust approach to making reasonable adjustments for disabled people – in particular implement the NHS Accessible Information Standard.

Funding was agreed for a fixed term Access Officer post, which has now been recruited to , to ensure that guidance for managers and staff regarding reasonable adjustments is accurate and readily available, including funding required for practical arrangements. The role also includes accessible information for service users across the Trust.

HR operations have also drafted reasonable adjustment guidance for staff and managers. This is currently being reviewed by the Purple Network.

Action taken: *Our accessible information standard was launched in July 2016 and new patient data codes were created to capture service user data. The standard has been publicised widely and will be re-launched when the work above is completed*

Objective 6: Attain the Top 100 Workplace Equality Index Employer (WEI) status with a ranking in the top five health and social care providers by 2020

Berkshire Healthcare Foundation Trust remains committed to improving the lives of both our staff and patients from the LGBT+ community and took part in the Workplace equality index.

Although we did not achieve a place in the top 100, we are proud to have come 133 in the ranking out of 445 organisations that took part. We placed 13th in the healthcare sector out of 54 entrants and only 33 points away from being in the top 100.

The Equality and Diversity Manager will lead the 2019 submission and a working group has already been established to ensure work is undertaken throughout the year. Connections are being made with other organisations in the top 50 in order to learn from their experiences.

Action taken: *The LGBT+ staff network has been re-established with three new co-chairs and have a focused strategy to increase visibility and membership. An LGBT+ allies program is being developed in partnership with the staff network, Support U and a Trans specific trainer. Targeted work is going to take place within our Children Young People and Families' (CYPF) team to improve the confidence of managers and front line staff supporting young trans people. We have invested in Rainbow pins and these will be launched along with a pledge of commitment and we are aiming to launch this in July 2019. The procurement team have reviewed and updated all policies to ensure they are inclusive of our LGBT+ communities.*

Objective 7: Engage with diverse groups in particular BME, LGBT and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both mental and community health services.

East Berkshire services have a clear plan on a page which includes positive engagement within the community. Although work has been undertaken by some services, a number of the outcomes have not yet been achieved and specific targeted work is now needed. A job role has been identified to undertake specific work within the community and lead on the Equality Delivery System implementation.

In the west, our Community Development Officer (Cecily Mwaniki) has led on a number of community engagement events which have helped to shape service design. Cecily's work was recognised in her Local Heroes award from Reading Place of Culture, and our own non-clinical employee of the year award.

Action taken: *Objective 7 is devolved to divisional improvement plans and guided by the Equality Delivery System service priorities. In the West, a community engagement lead post is well established, engaging with local BME groups across the region, in particular to improve take up of primary and secondary mental health services. In the East, an equivalent post has just been recruited to. We are awaiting the final publication of EDS 3 to review and refine the divisional equality plans, continuing to work on staff related goals, but to increase our focus on those regarding our patients. A series of resources have been developed to improve the confidence of staff and promote the important conversations in order to understand and meet the needs of individuals accessing services.*

4. Making It Right Programme

Making It Right has been delivered successfully piloted and delivered to three cohorts. A total of 52 people have been through the programme and the feedback about the content and mentoring is

positive. We have set dates for the rest of the year and will encourage many more BAME staff from bands 5-7 to participate.

This year we have also developed a Making it Right session for managers. The feedback from the National Staff Survey, the employee casework data, and conversations with network leads and managers highlighted a gap in our manager development programmes. We collect data and analyse it, but there was no mechanism for sharing it with managers and talking about what we all need to do personally to change and improve how it feels for all staff. We know that many staff love working for the Trust, but for the others it doesn't feel like a good place to work and we have committed to changing this.

The Making it Right for managers programme has been piloted and we are developing the roll out plan for the rest of the year.

5. Service Delivery

The data analysis in this section is focussed on key mental health and community services including: Children and Adolescent Mental Health Services (CAMHS), Children, Young People and Families (CYPF), Crisis resolution and Home Treatment Team (CRHTT), Improving Access to Psychological Therapies (IAPT), Mental Health Inpatients , Community Health East, Mental Health East, Community Health West and Mental Health West.

The community and mental health services data have been separated into east and west, reflecting our divisional structure.

5.1 Age

Berkshire Healthcare provides services that range from universal health visiting to families of children aged 0-5 years to end of life care on a community hospital ward. Some of these services are only delivered to young people aged 0-19 such as CAMHS and others are disproportionately used by older people as a result of disability or ill health in older age. For example, rehabilitation services, memory clinics, hearing and balance. The Community Health Services are used most by people in the 20-64 years age category accounting for 44.71% in the east and 55.05% in the west.

5.2 Gender

Patterns of service access by gender are in line with previous years, with the number of females accessing services, slightly outnumbering males. For example in our community health team in the East of Berkshire, 34.01% of those aged 65-84 are female, compared to 28.83% of Males.

However, in children's services, it is the opposite with males slightly outnumbering the number of females accessing services. Within the children and adolescent mental health services, 56% were males compared to 44% of females between 1st April 2018 and the 31st March 2019.

Historically men have been over-represented in inpatient mental health services, however this year we have seen a slight decrease in the numbers of men with 48.92% male and 51.08% female, compared to 56% males in the previous year. Women also make up the largest group accessing Improving Access to Psychology Therapy with females making up 66% and 34% males.

Males slightly outnumber females in access to Audiology with 49% compared to 47.9% females.

With an aging population and women on average living longer by 5.3 years, this is a trend we may continue to see within community and mental health services.

5.3 Ethnic minorities

It remains challenging to access accurate data for ethnicity across all divisions and the high levels of not stated recorded remain a concern in some services. We will continue to work to improve this, working with services on sharing good practice.

Consistent with 2017/18 data, the data from Improving Access to Psychological Services (IAPT) and Inpatient Mental Health services (Prospect Park Hospital - PPH) continues to be exemplary, with only 7.2% not stated or Null (IAPT)} and 2.63% not stated (PPH).

There has been continued improvement within community mental health service ethnicity data, from 10% not stated in 2016 to 3.19% as of 31st March 2019.

Capturing ethnicity data from services where the user group is older continues to prove difficult and this can be seen from the data within services such as audiology.

There continues to be a national concern of the over -representation of people from a Black background (i.e. people from an African, African-Caribbean and other Black background) in mental health inpatient services. Data from the Mental Health Foundation shows that in England people from a Black background are 3 to 5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. Data from the Mental Health Foundation shows that in England people from a Black background are 3 to 5 times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia. In Berkshire, people from a Black background comprise 6.3% of the mental health inpatient population in 2018/19 – this compares with 3.5% of the population according to the 2011 census.

Rates of Crisis Response and Home Treatment and community mental health service usage by people of a black background are in line with population averages (3.3%)} compared to 3.5% in Berkshire population. People from a black background are also slightly under-represented as IAPT service users (2.8%).

Rates within children and adolescent mental health services for young people of a black background are 1.99% compared to 54.10% from a white background.

People from an asian background represent 10.67% of all of the mental health hospital admissions, which is a 1% increase from last year's data. There has been an increase in the numbers of people from an asian background that used Crisis Response and Home Treatment from 8.5% in to 13.9% and IAPT from 9.3% to 9.7% .

There are higher numbers of people from a BAME background accessing community health services in the east, compared to the west, reflecting the demographics in these areas. People from an asian background represent 19.18% in the east of the county, compared to 4.16% in the west of the county. People aged 20-64 make up the highest numbers of people accessing services across both the east (55.05%) and the west (44.71%) of the county.

5.4 Religion and belief

Recording for religion remains low with Christian being the highest proportion at 3.34% in the east and 4.37% in the west, compared to those unknown reporting at 94.79% in the east and 85.56% in the west.

Religious belief data is collected inconsistently across the Trust as it is not a mandatory data requirement. 1.8% declined to disclose. There was no data available for the experience within the inpatients service in Prospect Park Hospital, a survey is being co-developed within the hospital with staff and patients, as part of our Quality Improvement Programme.

5.5 Disability

Disability codes are rarely used at the Trust since many of our patients attend specific services dealing with long-term or disabling conditions; however this highlights a training need as patients may have other disabilities or conditions that do not relate to their treatment. We have reviewed this situation and will be updating the disability codes on Datix, to ensure these reflect the codes used within all other reporting systems.

From 1st August 2016 onwards, it became a legal requirement that all organisations providing NHS care and / or publicly-funded adult social care follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. A fixed term post starting in April 2019, has been agreed for an Accessible information and Access lead, who will review our current status regarding this requirement, informing targeted action required. The role will also enable a specific piece of work to be completed to enable managers to have access to information that they need to make reasonable adjustments for staff with disabilities.

Within the national community mental health survey, there was evidence of an association between the poorest experience and disability. Work will continue to ensure a better understanding of the experience of people with a disability who access our services.

5.6 Sexual orientation

The Mental Health Foundation has identified that people who are from the LGBT+ community are at a higher risk of experiencing poor mental health, this includes those needing both community and inpatient services. Our reporting for LGBT+ remains low. The collection of sexual orientation data is inconsistent across the Trust, and we continue to experience a challenge in asking the right questions in an appropriate way about people's sexual orientation and gender identity to ensure we capture accurate data.

Community Mental Health services capture information about sexual orientation with 64.24% identifying as heterosexual/straight, 2.01% gay/lesbian, 1.70% bisexual, 29.41%, null/other or prefer not to say and 1.55% unknown.

The Trust doesn't currently capture data around our Trans community and this is an area being developed particularly within our children and adolescent mental health services and children, young people and families, who have all seen an increase in the numbers of young people who are trans, gender fluid or gender neutral.

5.7 Interpretation services

To promote equality and ensure people who use our services are not discriminated against in clinical assessment and care planning, we provided interpretation services to a value of £152,616 for people whose first language is non-English or who are hard of hearing/deaf. This is an increase from the previous year. A total of 2,111 people received interpreting support, 93% of this was support was for individuals where their first language is not English and 7% for individuals who are hard of hearing or deaf. The Trust continues to provide British Sign Language interpretation for BSL speakers whenever required.

A review will take place to compare the experiences of those accessing interpretation via the telephone compared to face to face to ensure the current balance of provision meets people's needs.

5.8 Patient experience

Patient experience data is collected for six protected characteristics via national surveys such as the community nursing survey. Although they provide valuable insights, numbers of respondents with protected characteristics are often small. Minorities are significantly under-represented in all samples and the same groupings/ protected characteristics are not collected in the different surveys.

In Community Nursing 574 people completed the friends and family test, 226 females and 183 male, 434 of those respondents said the service was excellent. The greatest response was from white patients at 449, Asian Indian, Pakistani, Chinese, or other Asian background 46 and Black African, Caribbean, or other Black background 20.

391 people declared having a disability and 299 of those said the service was excellent. 413 people said they were heterosexual, 5 people Lesbian or Gay and 146 people didn't specify.

In the Health Visiting East 116 people responded, 104 females and 10 males, 90 of those respondents said the service was excellent. The greatest response was from those aged 25-34 with the least from 65-74. 51 people declared being Christian, 19 Atheist and 2 Islam. 107 stated they didn't have a disability, 7 declared having a disability and 2 people didn't specify. 109 people stated they were heterosexual, 1 person bi-sexual and 6 people didn't specify.

In the Health Visiting West 970 women responded with 720 of those respondents said it was excellent, 90 men with 72 stating the service was excellent. The highest numbers of respondents was from those aged 25- 34 with 599 respondents, 55-64, 2 respondents. Asian Indian, Pakistani, Chinese, or other Asian background 122 responses, Black African, Caribbean, or other Black background 35 responses and White British, Irish, or other White background 829.

Across all services people from Black Asian and Minority Ethnic communities, individuals with a disability, LGBT+ Communities and those over the aged of 55 are significantly less likely to provide feedback on their experiences of services. Data around the protected characteristics do not represent the proportion of the community that have declared having them. Therefore as a Trust we need to improve the recording of this information.

5.9 Complaints

From the 1st April 2018 to the 31s March 2019 170 formal complaints were received.

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. Collection of ethnicity data associated with complaints has significantly improved over the last year, and has risen from 48% in quarter 2 to 84% in quarter 4, shown in the tables below.

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%

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

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

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. NHS Equality Delivery System

The Equality Delivery System was introduced by the NHS in England to assist NHS organisations in complying with the public sector duty; it is the NHS's equality benchmarking tool. It drives improvements and strengthens the accountability of services to patients and the public.

NHS England has been reviewing the Equality Delivery process and is in the process of producing the Equality Delivery System 3. This aims to stream line the process and map the objectives against the

other statutory reporting requirements within the workforce race equality standard, the workforce disability equality standard, the accessible information standard and the learning disability improvement standards. Berkshire Healthcare Foundation Trust has aligned the Equality Delivery System grading process in line with the Equality and Inclusion strategy refresh. Therefore no formal grading took place this year but work continued within each division against the agreed objectives.

To continue to promote equality and inclusion and the work we are doing to achieve our strategic objectives, our diversity road shows were launched in May 2018. The objective was to communicate our equality and diversity programme in a fun and interactive way to staff that would ordinarily not engage. The format was for each locality/directorate to host their individual road show using local and corporate resources. Five areas held a road show. The main aims were to:

- Introduce what the Trust and the locality is doing on Equality and Diversity in 2018 in a local setting
- Clarify what the Trust means by diversity
- Provide an opportunity for staff to meet with staff inclusion networks and other resources e.g. Wellbeing initiatives, hate crime awareness, Making It Right etc.
- Provide information for staff to know where to get help should this be needed

Average attendance for the road show was 70, above our target of 60 staff. Activities were educational as well as entertaining, enabling staff to make connections and engage in good quality conversations. At one of the road shows, staff represented more than 20 different nationalities. Members of the Board and the senior leadership team were in attendance at many of the road shows. There is a recommendation that the road shows will continue in 2019, as they have proven to be a more accessible vehicle than a single organisation-wide conference. However equality leads, networks and regional directors are being engaged to ensure this approach is working for all, and that 2019 events are informed by their views.

Recommendations

Board members are asked to support the following priorities for the coming six months:

1. Focussing the development of our new Diversity, Equality and Inclusion strategy 2020 on Human Rights perspective, emphasising respect, understanding and compassion for everyone, and investing in training to support this ambition.
2. Developing the allies training to be rolled out across the Trust
3. Using the Equality Delivery System 3 framework to align the Trust Diversity, Equality and Inclusion strategy, Workforce Race Equality Standard, Workforce Disability Equality Standard, accessible information standard and QCQ standards.
4. Continuing to build a more inclusive workforce and environment for all our staff and patients and developing a zero tolerance on behaviour that does not align with the Trusts values.
5. Ensuring our services are inclusive of our trans community, as a population that has largely been unrecognised in previous reporting.
6. Improving our understanding of how well we are serving our communities and rates of access of our services by people with protected characteristics

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9 July 2019
Title	**Audit Committee – 24 May 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 24 May 2019.
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting 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.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Audit Committee Meeting held on

Wednesday, 22 May 2019, Fitzwilliam House, Bracknell

Present: Chris Fisher, Non-Executive Director, Committee Chair
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

In attendance: Alex Gild, Deputy Chief Executive and Chief Financial Officer
Graham Harrison, Head of Financial Services
Monika McEwen, Financial and Capital Accountant
Paul Gray, Director of Finance
Amanda Mollett, Head of Clinical Effectiveness and Audit
Minoo Irani, Medical Director
Ben Sheriff, External Auditors, Deloitte
Chris Randall, External Auditors, Deloitte

Julie Hill, Company Secretary

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	There were no apologies.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Annual Accounts 2018-19, including the Annual Governance Statement**	
	The Annual Accounts 2018-19 and Annual Governance Statement had been circulated. It was noted that members of the Committee had been given the opportunity to review the draft Annual Accounts 2018-19 and Annual Governance Statement prior to the meeting. The Chair commented that the Annual Accounts 2018-19 were excellent and confirmed that he had no comments. Naomi Coxwell, Non-Executive Director and Mehmuda Mian, Non-Executive Director echoed the Chair's	

	comments. The Deputy Chief Executive and Chief Financial Officer reported that the Annual Governance Statement had been updated to reflect the comments made by the External Auditors in relation to the risks around a No Deal Brexit and its impact on workforce shortages. The Deputy Chief Executive and Chief Financial Officer asked the Committee for confirmation that the Annual Governance Statement in their view accurately described the Trust's key risks. Members of the Committee confirmed that this was the case.	
5.A	**ISA 260 Audit Memorandum**	
	Ben Sheriff, External Auditors, Deloitte, referred to the ISA 260 Memorandum which summarised the key issues identified during Deloitte's audit of the Trust's financial statements and quality accounts. Mr Sheriff thanked the Finance and Quality Accounts teams for their co-operation and help during the course of the external audit. It was noted that the External Auditors' key judgements in the audit process related to: • The assumptions made in completion of the land and buildings revaluation; • Key judgements affecting achievement of control totals and the Provider Sustainability Funding income received, in particular, valuation of year end accruals. • There were no significant audit adjustments or disclosure deficiencies. • Based on the current status of the audit work, the External Auditors envisaged issuing an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources or the Annual Governance Statement. • The Trust had followed the format prescribed by NHS Improvement in the Trust Annual Reporting Manual. • The External Auditors were planning to issue a clean Quality Report opinion. The findings from the External Auditors' work were set out in the separate Quality Report External Assurance Review paper and this would also be presented to the Council of Governors. Ben Sheriff, External Auditors reported that Deloitte's property specialists, Deloitte Real Estate had reviewed the assumptions and methodology used to value the estate and had confirmed that the costs assumed for valuing buildings were consistent with the amounts reflected in the Building Cost Information Service database of building costs and were within the range reported elsewhere. Mr Sheriff pointed out that in the previous financial year, the Trust had intended to sell land at West Berkshire Community Hospital, but during the year, the transaction did not occur. The asset had now been moved back and was included in the overall land value. Mr Sheriff commented that the implementation of IFRS 16 (Leases) to be implemented in 2020-21 was expected to have a greater and more complex impact upon most NHS bodies than the adoption of IFRS 9 and	

	15. Mr Sheriff said that Deloitte recommended early consideration following the impact analysis of actions required to embed IFRS 16 accounting into the Trust's underlying accounting systems. The Head of Financial Services reminded the meeting that the Audit Committee had discussed the impact of the new accounting standards, including IFRS 16 at its meeting in October 2018. The Trust referred to page 72 of the agenda pack and commented that he was slightly surprised by the headline: "Most trusts have not delivered their planned pay savings. The Trust has achieved 28.8% of planned pay savings". The Deputy Chief Executive and Chief Financial Officer said that the under-delivery of the planned pay savings largely related to the WestCall and the Crisis Resolution Home Treatment Team services. It was noted that the Trust did not report vacancies as "planned pay savings", unlike some other trusts. Mr Sheriff asked members of the Audit Committee whether they were aware of any matters of fraud which had not been reported to the Local Counter Fraud specialists. Members of the Audit Committee confirmed that they were not aware of any fraud issues which had not been or were in the process of being investigated by the Trust's Local Counter Fraud specialists. On behalf of Deloitte, Ben Sheriff thanked the Deputy Chief Executive and Chief Financial Officer and the Finance Team for their work in finalising the Trust's financial statements. The ISA 260 Audit Memorandum was received and noted.	
4B.	**Assurance Report on the 2018-19 Quality Report**	
	Chris Randall, External Auditors, Deloitte, introduced the report which summarised the findings of Deloitte's external assurance work completed on the 2018/19 Quality Report. It was noted that the work was mandated by NHS Improvement and that the work had been completed in line with the requirements laid out in the detailed guidance for external assurance of Quality Reports. Mr Randall reported that the External Auditors anticipated giving an unmodified opinion on the Quality Report 2018-19. It was noted that the External Auditors had not identified any significant issues when undertaking their testing of the indicators, but had identified a small number of areas which were satisfactory, but where there were minor issues. These areas related to: • **Early Intervention in Psychosis indicator** – in the External Auditors testing, there were three cases where the clock was stopped inappropriately. In none of these cases was the breach status of the patient affected; • **Inappropriate Out of Area Placements indicator** – in two cases, there was an incorrect discharge date used; in one case, there was an incorrect admission date used; inappropriate placements were	

recorded through a daily bed state report which was sent to a reviewing officer who recorded the data in excel; and the Out of Area Placements team was unaware of how often the patients care co-ordinator visited the patients.

Mr Randall reported that overall the Quality Report was a clear account of the quality performance of the Trust in the year. The Trust had clearly identified priorities and progress towards achievement of priorities against measurable targets. A particular area of good practice was in relation to the presentation of the learning from deaths which was very clear and understandable.

Mr Randall outlined the possible areas for improvement for next year:

- Some metrics do not fully align with the related priority. There were limits upon what was measurable.
- For example, the quality priority of ensuring "all services focus on understanding and supporting outcomes of care that are important to patients" was measured using the NHS Staff Survey responses. However, granularity was not available as to which services staff worked in, meaning that this did not necessarily give clarity about "all services" as responses could vary from service to service.
- One of the patient safety priorities for 2019-20 had a target that at least 95% of reported incidents would be low or no harm to patients. This was unusual, given that organisations will not have complete reporting on incidents, but will typically capture more serious ones. This was therefore achievable either through changing the underlying level of incidents, or just increasing reporting of lower impact incidents.

The Medical Director commented that these were valid points and stressed that the Quality Improvement Programme used proxy indicators which did not necessarily correlate well to being audited.

Mr Sheriff said that he was impressed by the Trust's quality assurance processes.

The Chair referred to the External Auditors conclusion (page 118 of the agenda pack) and commented that the wording: "the quality report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust annual reporting manual and supporting guidance" sounded negative.

Mehmuda Mian, Non-Executive Director asked whether any other trusts had a more positive statement.

Mr Sheriff explained that the wording was mandated by NHS Improvement and confirmed that this was the most positive statement a trust could expect to receive on the Quality Report.

The Audit Committee noted that the report's conclusion was that Deloitte were satisfied that there was sufficient evidence to provide a limited assurance opinion on the content of the Quality Report.

On behalf of Deloitte, Ben Sheriff thanked the Trust's Quality Accounts Team for their support.

6.	**Independent Auditor's Report and Management Representation Letter in respect of the Financial Statements and the Quality Accounts**	
	Ben Sheriff, External Auditors, Deloitte reported that the Trust was required to sign management representation letters in respect of the Financial Statements and the Quality Accounts. On behalf of the Trust Board, the Committee authorised the Chief Executive to sign the Management Representation Letter.	
7.	**Formal Approvals**	
	It was noted that the Trust Board had delegated full authority to the Audit Committee to issue all necessary approvals in respect of the 2018-19 Annual Accounts on its behalf. It was also noted that the Trust Board had approved the Annual Report, Quality Accounts and that Quality Assurance Committee had provided detailed scrutiny of the Quality Accounts on behalf on the Trust Board. The Company Secretary reported that since the Trust Board meeting on 14 May 2019, the Annual Report had been updated to reflect comments made by the External Auditors. A copy of the changes had been circulated to all Board members for comment. The Company Secretary confirmed that she had not received any comments. The Committee noted and approved the following relating to the Annual Accounts for 2018/19: • *Audit Memorandum* The ISA 260 Audit Memorandum was received and noted. • *Annual Accounts 2018/19* The Annual Accounts for 2018/19 were approved: • *Management Representations* The proposed Trust Management Representations response to Deloitte was approved: • *Annual Governance Statement* The Annual Governance Statement was approved.	
8.	**Chair's Closing Remarks**	
	The Chair thanked the Finance Team and the Quality Accounts Team for their work on the Trust's Annual Accounts 2018-19 and the Quality Accounts 2018-19.	
9.	**Date of the Next Meeting**	
	31 July 2018 at 2pm	

These minutes are an accurate record of the Audit Committee meeting held on 22 May 2019.

Signed:- _____

Date: - _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 July 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 documents: • Side letter in respect of the charitable grant for the construction of the shell and core of the new Renal and Cancer Unit at West Berkshire Hospital. The side letter sets out the amount of the final grant monies; • Side letter in respect of the charitable grant for the fit out of the Cancer Care Unit at West Berkshire Hospital. The side letter sets out the amount of the final grant monies • Farmhouse Lower Hardwick Farm – Renewal Lease between Trustees and BHFT • Underlease for part of the ground floor of Erleigh House (Science and Technology Centre) University of Reading to the Royal Berkshire NHS Foundation Trust plus an agreement for the RBH to surrender their occupation of the site at 3-5 Craven Road, Reading.

ACTION	To note the update.