Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING HELD IN PUBLIC

10:00am on Tuesday 10 September 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 09 July 2019	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Staff Story – Equalities and Diversity	Bev Searle, Director of Strategy and Corporate Affairs	Video
6.1	Patient Experience Report – Quarter 1	Julian Emms, Chief Executive	Enc.
6.2	The NHS Patient Safety Strategy— implications for Berkshire Healthcare Report	Dr Minoo Irani, Medical Director	Enc.
6.3	Quality Assurance Committee – 21 August 2019 a) Minutes of the Meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report d) Changes to the Committee's Terms of Reference	Ruth Lysons, Chair, Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.1	Month 4 2019/20 Finance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Month 4 2019/20 True North Scorecard Performance Report*	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.3	a) Finance, Investment & Performance Committee meeting held on 31 July 2019 b) Changes to the Finance, Investment & Performance Committee's Terms of Reference **The Month 3 Finance and Performance Reports were reviewed by the FIP Committee*	Naomi Coxwell, Chair of the Finance, Investment & Performance Committee Naomi Coxwell, Chair of the Finance, Investment & Performance Committee	Verbal Enc.
STRATEGY			
9.1	Workforce Disability Equality Standard Report	Bev Searle, Director of Strategy and Corporate Affairs	Enc.
9.2	Workforce Race Equality Standard Report	Bev Searle, Director of Strategy and Corporate Affairs	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee a) Minutes of the Meeting held on 31 July 2019 b) Changes to the Committee's Audit Committee Terms of Reference	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.2	Appointment of a Senior Independent Director	Martin Earwicker, Trust Chair	Enc.
10.3	Schedule of Meetings	Martin Earwicker, Trust Chair	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting –12 November 2019	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.1

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

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

Boardroom, Fitzwilliam House

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	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
	Debbie Fulton	Acting Director of Nursing and Governance
	Mehmuda Mian	Non-Executive Director
	Bev Searle	Director of Strategy and Corporate Affairs
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Ray Percy	Clinical Psychologist Reading University *(Present for agenda item 6.0)*
	Mike Craissati	Freedom to Speak Up Guardian *(present for agenda item 6.1)*
	Sue McLaughlin	Acting Deputy Director of Nursing *(present for agenda item 6.2)*

19/118	**Welcome** (agenda item 1)
	Martin Earwicker, Chair welcomed everyone to the meeting including the observers: Katie Warner, Head of Research and Development and Tom Lake, Public Governor.
19/119	**Apologies** (agenda item 2)
	Apologies were received from: Mark Day, Non-Executive Director and Ruth Lysons, Non-Executive Director
19/120	**Declaration of Any Other Business** (agenda item 3)

	There was no other business declared.
19/121	**Declarations of Interest** (agenda item 4)
	i. Amendments to Register – none
	ii. **Agenda Items** – none
19/122	**Minutes of the previous meeting –14 May 2019** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 14 May 2019 were approved as a correct record of the meeting.
19/123	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The following actions were considered further: **a) Strategic Capital Plan** Naomi Coxwell, Non-Executive Director asked about the timescale for the development of the Strategic Capital Plan. The Deputy Chief Executive and Chief Financial Officer reported that the Strategic Capital Plan would be developed at the same time as the Trust's Five-Year Strategy Return for NHS Improvement which was due in September 2019. It was noted the Strategic Capital Plan would be presented to the Finance, Investment and Performance Committee. **Action: Deputy Chief Executive and Chief Financial Officer** **b) Staff Survey "Aide Memoire" for Non-Executive Directors** Mehmuda Mian, Non-Executive Director said that she could not remember receiving a copy of the Aide Memoire on the Staff Survey. The Company Secretary agreed to re-circulate the Aide Memoire. **Action: Company Secretary** **The Trust Board**: noted the schedule of actions.
19/124	**Anxiety and Depression in Young People (AnDY) Presentation** (agenda item 6.0)
	The Chair introduced and welcomed, Dr Ray Percy, Clinical Psychologist and Clinical Lead for the Anxiety and Depression in Young People Research Clinic, Reading University. Dr Percy gave a presentation on Reading University's Anxiety and Depression in Young People (AnDY) Clinic and made the following key points: • The service was commissioned by Berkshire West and Berkshire East Clinical Commissioning Groups. The service was operated in collaboration with the Trust's Common Point of Entry service and had strong links with the Trust's Anxiety and

	Depression Pathway. • The service offered targeted, brief, evidence-based psychological interventions for children and young people aged 71/2 to 171/2 who were experiencing difficulties with anxiety and depression. The service worked with around 240 families per year. • Around 70% of the young people accessing the service were referred via the Trust's Common Point of Entry service. • The service aimed for a 50:50 split of service users from West and East Berkshire, but currently West Berkshire was over represented with around 70% of service users. • The service was led by Clinical Psychologists with most treatment delivered by Children's Wellbeing Practitioners. • The University conducted research into anxiety and depression which directly informed the treatments provided by the AnDY Clinic to young people and their families. • The service had a very low dropout rate with positive outcomes from treatment and high levels of satisfaction from both the young people and their families. Chris Fisher, Non-Executive Director reported that he had recently conducted a Board visit to the School Nursing Team and asked whether School Nurses had a role to play in signposting families to the AnDY clinic, particularly amongst ethnic minority families in East Berkshire who were underrepresented at the AnDY clinic. Dr Percy said that the service was working closely with the East Berkshire Clinical Commissioning Group to increase the number of referrals from East Berkshire and this included working with Local Authorities, Schools and the Trust's services. The Deputy Chief Executive and Chief Financial Officer asked whether the 240 referrals per annum was likely to be the "tip of the iceberg" and whether there were other services providing help to children and young people experiencing anxiety and depression. Dr Percy explained that effective triage processes meant that around 85-90% of young people referred to the AnDY service were accepted. It was noted that the Trust's CAMHS Anxiety and Depression pathway provided treatment for those young people who were not suitable for the AnDY service. The Deputy Chief Executive and Chief Financial Officer asked whether the AnDY clinic's evidence-based research was adopted by the wider system. Dr Percy said that he hoped that was the case, but pointed out that some non-NHS services provided non-evidence-based treatments, for example, counselling services where there was little evidence that this was effective for this client group and may even be detrimental. On behalf of the Board, the Chair thanked Dr Percy for his presentation.
19/125	**Freedom to Speak Up Annual Report** (agenda item 6.1)
	The Chair welcomed Mike Craissati, Freedom to Speak Up Guardian. Mr Craissati reported that he had taken over from Elaine Williams as the Trust's Freedom to Speak Up Guardian. It was noted that the Freedom to Speak Up Guardian was supported by Freedom to Speak Up Champions across the Trust.

	Mr Craissati outlined the role of the Freedom to Speak Up Guardian which was primarily to provide confidential, independent advice and support to members of staff who wished to speak up about issues that had an impact on patient and staff safety or issues around malpractice, wrong doing or fraud. It was noted that the Freedom to Speak Up Guardian also had a key role to play around communication and encouraging staff to Speak Up. Mr Craissati reported that he engaged with the Trust's staff networks and would be attending the Equality and Diversity Road Show in the autumn. Mr Craissati said that he hoped that Board members would support the Freedom to Speak Up Road Shows which were planned to take place across the Trust during the national Freedom to Speak Up month in October 2019. Mr Craissati reported that during 2018-19 the Freedom to Speak Up Guardian had investigated 44 cases. The Chair thanked the Freedom to Speak Up Guardian for his report and suggested that in future reports it would be helpful to know about the seriousness of the cases and what changes had been made as a result of a member of staff Speaking Up. **Action: FTSU Guardian** The Director of Strategy and Corporate Affairs reported that a review of the Trust's Freedom to Speak Up Guardian role had been added to the Internal Audit Programme for 2019-20. The Director of Strategy and Corporate Affairs reported that she was the lead Executive for Freedom to Speak Up. It was noted that the Chief Executive, Acting Director of Nursing and Governance and Director of Strategy and Corporate Affairs had regular meetings with the Freedom to Speak Up Guardian. The Chief Executive said that it was important to remember that in addition to the Freedom to Speak Up Guardian, there were several other routes staff could access in order to raise concerns. On behalf of the Board, the Chair thanked the Freedom to Speak Up Guardian for his work. **The Trust Board**: noted the report.
19/126	**Patient Story** (agenda item 6.12)
	The Chair welcomed Sue McLaughlin, Acting Deputy Director of Nursing. The Acting Director of Nursing presented a patient story concerning a 19-year-old young man *(referred to as "J" in the minutes in order to protect his anonymity)* who had attempted suicide at the age of 11 after being bullied at school. It was noted that J's father died by suicide when J was 18-year-old. The Acting Deputy Director of Nursing said that J was diagnosed with Borderline Personality Disorder and found it difficult to trust anyone. It was noted that J had a history of stopping and starting mental health treatment and had a lot of contacts with the Street Triage Service and with Accident and Emergency Services.

	It was noted that following the death of his father, J was referred to the Trust's Bereavement By Suicide service. The Acting Deputy Director of Nursing reported that she was able to adapt the service model to meet J's individual needs, including seeing him in his own home. Following treatment, J was referred to the Trust's Employment Service and was now working in the voluntary sector. It was noted that J had good IT skills and had helped the Trust to develop a patient safety app. The Acting Deputy Director of Nursing said that J continued to make good progress was had been discharged from mental health services for six months. It was noted that J also had 12 sessions with a Support Worker which was funded by the Local Authority and this helped him to re-engage with social activities, such as joining a gym. Naomi Coxwell, Non-Executive Director asked whether the Trust would expect to see J again. The Acting Deputy Director of Nursing confirmed that although J was stable now, it was likely that he would need mental health support in the future following another trauma or stressful event. The Chair thanked the Acting Deputy Director for sharing J's story and the Board wished J well for the future.
19/127	**Annual Complaints Report** (agenda item 6.3)

	The Acting Director of Nursing and Governance presented the paper and highlighted the following points:
	
	• The Trust had received 230 formal complaints from April 2018 to March 2019. This represented an increase on the 209 complaints received during the same period in 2017-18. This equated to approximately 0.02% contacts that occurred in the year resulting in a formal complaint.
	• The five service lines which received the highest number of formal complaints were:
	  ○ Community Mental Health Teams (adult and older adult) with 48 complaints against 99,587 contacts (0.05% contacts);
	  ○ Acute adult admission wards (Rose, Snowdrop, Daisy and Bluebell) with 32 complaints against 850 admissions (3.8% of admissions);
	  ○ Child and Adolescent Mental Health Services with 25 complaints received against 7,438 referrals received and approximately 32,000 contacts (0.08% of contacts and 0.3% of 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 a formal complaint) and
	  ○ Community Hospital inpatient wards received a total of 17 complaints against 1,804 admissions (0.9% of admissions)
	• There were no particular themes identified from the complaints this Quarter with many complaints being specific to individual circumstances and concerns. Although, for CAMHS, several complaints were in relation to wait time, referrals and follow up.

	• A total of 16 (7%) of formal complaints received were in relation to end of life care. • For the third consecutive year, 100% of complaints were responded to within the agreed timescales. Chris Fisher, Non-Executive Director asked for more information about the complaints relating to end of life care. The Chief Executive reported that he signed off all complaint responses and said that the Trust received a number of compliments from families about its end of life care, but some of the complaints related to families not realising that their family member was at end of life. The Chief Executive reported that the Trust was doing a lot of work around supporting staff to have difficult conversations with patients and their families about end of life. Mehmuda Mian, Non-Executive Director said that she particularly welcomed section 4 of the report which was headed "Complaints as a mechanism for change – learning" and was pleased that the Trust recognised the importance of complaints as a mechanism for improvement. **The Trust Board:** noted the report.
19/128	**Quality Assurance Committee Meeting held on 21 May 2019** (agenda item 6.4)
	David Buckle, Member of the Quality Assurance Committee said that he would like to draw the Board's attention to the Care Quality Commission's Report *Learning from Deaths – A Review of the first year of NHS trusts implementing the national guidance* which included two best practice case studies from the Trust. In was noted that the Care Quality Commission had particularly praised the Medical Director for his leadership of the mortality review and learning from deaths systems and processes. Dr Buckle said that he was very assured about the Trust's Learning from Deaths systems and processes. Mehmuda Mian, Non-Executive Director referred to page 51 of the agenda pack and asked whether there was any update about improving the operation of the Mental Health Act Managers rota. The Acting Director of Nursing and Governance reported that the Divisional and Clinical Directors for Prospect Park Hospital were leading a review of the Mental Health Act Office. It was also noted that the Mental Health Act Office had been added to the Internal Audit Programme for 2019-20. Naomi Coxwell, Non-Executive Director referred to page 68 of the agenda pack which set out further quality improvements to the Learning from Deaths process which were currently being considered and asked about the timescale. The Medical Director reported that the list of improvements had been highlighted in the Care Quality Commission's report. It was noted that the first improvement relating to a Designated Family Liaison/Bereavement Support member had been implemented. The

	Trust now had a cohort of patient safety staff who were trained to provide bereavement support, particularly following a death by suicide. The Medical Director reported that work was underway to prepare for the introduction of a new Medical Examiner role in the Trust which would need to be in place from March 2021. The Medical Director reported that work was also underway to engage local health and care partners in the Trust's mortality review and learning process. Chris Fisher, Non-Executive Director referred to page 67 of the agenda pack and asked whether work was being undertaken to ensure that staff used the tools available to manage patients' hydration. The Acting Director of Nursing and Governance confirmed that the Nutrition Steering Group was overseeing the hydration work. The Chair thanked the Medical Director, Lead Clinical Director, the Acting Director of Nursing and Governance and Acting Deputy Director of Nursing for their work to support the Trust's mortality review and learning from deaths work. The Medical Director confirmed that the Guardians of Safe Working had not identified any areas of concern in their report. **The Trust Board noted**: a) The minutes of the Quality Assurance Committee meeting held on 21 May 2019; b) The Learning from Deaths Quarterly Report c) The Guardians of Safe Working Quarterly Report.
19/129	**Peer Mentor Programme Update Report** (agenda item 6.5)
	The Acting Director of Nursing and Governance presented the paper and reported that the Peer Mentor pilot programme had started on Snowdrop Ward in June 2018 and that further work was required before the model was rolled out to other wards. The Acting Deputy Director of Nursing reported that nationally there had been a move away from the Peer Mentor model because of the challenges around working with Peer Mentors. **The Trust Board:** noted the paper.
19/130	**Statement of Compliance 2018-19 for Medical Revalidation** (agenda item 6.6)
	The Medical Director presented the paper and highlighted the following points: • The Revalidation Annual Board Report and Statement of Compliance 2018-19 was presented in a different format from previous years following the publication of the revised format by NHS England in June 2019. • 124 medical appraisals were completed in 2018-19 for 127 doctors with a connection to the Trust for revalidation purposes. The three incomplete appraisals (approved by the Responsible Officer) related to doctors on sick leave.

	• The report also detailed improvements implemented in the medical appraisal and revalidation system in the Trust. Further areas of improvement had been identified following the publication of new guidance on responding to concerns and effective clinical governance. • From 2019-20 the Responsible Officer would implement a standard process for receiving the appraisal output summary from GPs contracted to work in the Trust's Out of Hours' service and for the very small number of doctors who work in the Trust and have a connection elsewhere. • The Revalidation Team from NHS England (South) last 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 several recommendations for the Trust which have all been implemented. • The Board can be assured that the medical appraisal and revalidation process was compliant with the regulations and was operating effectively within the Trust and practices were in line with best practice in similar organisations. David Buckle, Non-Executive Director congratulated the Medical Director on achieving a near 100% appraisal rate. **The Trust Board:** having reviewed the content of the Annual Medical Revalidation Report 2019-20 confirmed that the organisation was compliant with the Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and authorised the Chair to sign the statement of compliance.
19/131	**Executive Report (**agenda item 7.0)
	The Executive Report had been circulated. The following issue was discussed further: **a) Listeria Outbreak Update** The Chief Executive pointed out that Listeria can take 70 days from exposure to the bacteria until a person becomes ill. The Acting Director of Nursing and Governance reported that in-patient staff had been informed about the potential risks of patients transferring from other hospitals who had been exposed to the Listeria bacteria. **The Trust Board:** noted the report.
19/132	**Month 02 2019-20 Finance Report** (agenda item 8.1)
	The Deputy Chief Executive and Chief Financial Officer presented the report and highlighted the following points: • The Trust had delivered to the financial plan in May 2019. The Trust remained £0.1m ahead of the Control Total pre-Provider Sustainability Funding and after accounting for Provider Sustainability Funding, the Trust's statutory deficit was £0.3m. • The Use of Resources rating was a "2" overall, which was in line with the financial plan. The rating had dropped from "1" to "2" because of the one off pay award given to staff who were at the top of their agenda for change band. The Trust was on track to recover the position to a rating of "1" in the next Quarter.

	• Pay costs in May 2019 were £0.2m above plan after absorbing recruitment assumptions. • May 2019 cash balance was £1.6m lower than planned, although £0.8m of debt was cleared in the first week of June 2019. • Capital Spend for the month was on plan, with spend remaining £0.2m below plan year to date. • The Trust's Cost Improvement Programme had delivered £0.46m of savings against a year to date plan of £0.66m. The Cost Improvement Programme delivery year end forecast was £4.9m. The Chair asked for clarification about the capital service cover. The Deputy Chief Executive and Chief Financial Officer explained that this was the amount of revenue the Trust had to cover the costs of the Private Financing Initiative buildings at Prospect Park Hospital and West Berkshire Community Hospital. Chris Fisher, Non-Executive Director said that it was disappointing that the Cost Improvement Programme had under-delivered by around 30% only six weeks into the financial year. The Deputy Chief Executive and Chief Financial Officer said that the Finance, Investment and Performance Committee would be closely monitoring delivery of the Cost Improvement Programme. The Deputy Chief Executive and Chief Financial Officer reported that the Trust had met with NHS Property Services and East Berkshire Clinical Commissioning Group to discuss progress in relation to the VAT savings Cost Improvement Programme scheme, but the VAT issue was complicated by the fact that the buildings had multi-occupancy. **The Trust Board noted:** the following summary of the financial performance and results for Month 2 2019-20: (The Trust reports to NHS Improvement its "Use of Resources" rating which monitors risk monthly, "1" is the highest rating possible and "4" is the lowest). Year to date (Use of Resource) metric: • The Trust's overall Use of Resources rating was "2" (the plan was "2") • Capital Service Cover rating was 3 • Liquidity days rating was 1 • Income and Expenditure Margin rating was 3 • Income and Expenditure Variance rating was 1 • Agency target rating was 1 Year to date Income Statement (including Provider Sustainability Funding) excluding donations: • Plan: £0.5m deficit • Actual: £0.3m deficit • Variance: £0.1m better than plan Year to date Cash: £22.6m versus plan of £24.1m Year to date Capital expenditure: £0.7m versus plan of £0.9m

	National Capital Funding Limit The Deputy Chief Executive and Chief Financial Officer reported that the Trust had received a letter from Julian Kelly, Chief Financial Officer, NHS Improvement on 2 July 2019 stating that Sustainability and Transformation Partnerships needed to try and achieve a 20% reduction in their capital spending plans. It was noted that Public Finance Initiative and Global Digital Exemplar capital funding was excluded from the 20% capital spending reduction target. The Chief Executive said that the Trust would play its role in the system and would be identifying any areas of natural slippage in the capital programme which could be counted towards the 20% reduction. The Chief Executive said that the Trust should not postpone capital schemes which were required to address patient safety and/or health and safety issues and capital spending on IT infrastructure which was required to drive efficiencies and mitigate the cyber security risks. The Chief Executive said that any significant changes to the capital programme would be presented to the Board for approval.
19/133	**Month 02 2019-20 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Deputy Chief Executive and Chief Financial Officer said that the new True North Performance Scorecard replaced the Performance Assurance Framework Report. It was noted that the True North Performance Scorecard Business Rules ensured that the Board focused on performance trends rather than reviewing changes from one month to the next. The Chair said that he welcomed the new format and the division between the "driver" and "tracker" metrics but asked whether there was anything missing from the old Performance Assurance Framework report. The Deputy Chief Executive and Chief Financial Officer said that the Finance, Investment and Performance Committee had reviewed the new True North Performance Scorecard in detail and that he was not aware of any gaps in the new Scorecard. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee said that in addition to the True North metrics, the new Scorecard included a section on regulatory compliance. Ms Coxwell said that she fully supported the new Scorecard and commented that it would focus the Trust's attention on the key strategic issues and would help to drive performance. Chris Fisher, Non-Executive Director asked whether the Counter Measure reports would be considered by the Finance, Investment and Performance Committee or by the Trust Board. The Deputy Chief Executive and Chief Financial Officer said that there would be an opportunity to discuss the True North Performance Scorecard at the Trust Board's Strategic Planning Away Day in October 2019 including how best for the Board to gain greater insight into the Trust's Counter Measures work. **Action: Deputy Chief Executive and Chief Financial Officer**

	The Trust Board: welcomed the new True North Performance Scorecard Report.
19/134	**Finance, Investment and Performance Committee (May 2019) Meeting (**agenda item 8.3)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the May 2019 meeting had reviewed Month 1 financial and performance and had noted that everyone was on track. It was noted that the Committee had not met in June 2019. The Chair thanked Ms Coxwell for her update.
19/135	**Board Vision Metrics Update Report** (agenda item 9.0)
	The Board Vision Metrics Update Report had been circulated. The Deputy Chief Executive and Chief Financial Officer said that there would be an opportunity to discuss how the Board Vision Metrics aligned with the new True North Performance Scorecard at the Trust Board's Strategic Planning Away Day in October 2019. **Action: Deputy Chief Executive and Chief Financial Officer** **The Trust Board**: noted the report.
19/136	**Equalities Annual Report** (agenda item 9.1)
	The Director of Strategy and Corporate Affairs presented the paper and highlighted the following points: • The Public Sector Equality Duty required public bodies and others that carried out public functions to 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 report set out the progress the Trust had made from 1 April 2018 to 31 March 2019 and highlighted the key achievements and activity towards fulfilling the Trust's equality objectives. • As the Trust's Equality and Inclusion Strategy 2016-2020 was coming to an end, work was underway to prepare for the next four years. The Trust was considering taking a Human Rights perspective, emphasising respect, understanding and compassion for everyone. • Following the success of the "Making it Right" for Black, Asian and Minority Ethnic (BAME) staff, the Trust had developed the "Making it Right" for Managers Programme. • The report also set out the Trust's equalities and inclusion priorities for the next six months. The Chair said that the Trust had clearly made progress in equalities and inclusion but questioned whether taking a siloed approach, for example Disability, LGBT+ and BAME was the right approach, especially as staff could be in more than one protected

	characteristic categories. The Director of Strategy and Corporate Affairs said that she hoped that by taking a Human Rights approach, the Trust would avoid taking a siloed view. Chris Fisher, Non-Executive Director referred to section on equal pay (page 199 of the agenda pack) and commented that although from a statistical point of view, the Trust needed to recruit more males in agenda pay bands 2-5 as these pay bands were dominated by female staff, in practice, the Trust would always recruit the best person for the job, regardless of their gender. The Chair said that whilst fully endorsing Mr Fisher's comment above, he hoped that given the national shortage of nursing staff, he hoped that the Trust would play its part in encouraging more men to join the NHS. Mehmuda Mian, Non-Executive Director (and Lead Non-Executive for Equalities) said that whilst she supported taking a Human Rights perspective, she would be concerned if this resulted in a dilution of the Trust's targeted work towards staff from protected characteristics when there was still work to be done to address those inequalities. The Chief Executive said that he shared Ms Mian's concerns and said that further work was needed to understand whether taking a Human Rights perspective was a more effective than the Trust's current's current approach. **The Trust Board:** noted the report and supported the recommended areas of focus for the following six months as set out in the report.
19/137	**Audit Committee** (agenda item 10.0)
	Chris Fisher, Chair of the Audit Committee reported that the Audit Committee meeting held on 22 May 2019 was a special meeting convened to approve the Trust's Annual Accounts on behalf of the Trust Board. Mr Fisher said that the Trust's External Auditors, Deloitte had been very complimentary about the Trust's Accounts and the support they had received from the Trust's during their audit. The Chair asked whether it was possible for the Trust Board to approve the Annual Accounts rather than delegating approval to the Audit Committee. Mr Fisher said that there was a timing issue because there was a very short period between the External Auditors completing their audit and the NHS Improvement's deadline for submission of the Annual Accounts. It was noted that the Chair could convene a special meeting of the Board to approve the Annual Accounts. The Chair thanked Mr Fisher for his update. **The Trust Board**: noted the minutes of the Audit Committee held on 22 May 2019.
19/138	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that following the recent elections, there were five new public

	governors. Chris Fisher, Non-Executive Director reported that he and Ruth Lysons, Non-Executive had attended the last two meetings of the Council of Governor's Living Life to the Full Group to help the Group to change the focus the meetings away from sharing information to identifying the barriers to "living life to the full". Mr Fisher reported that Dr Chris Allen, Consultant Clinical Psychologist had attended the last meeting Living Life to the Full meeting and had spoken about his work to support carers in Windsor, Ascot and Maidenhead. Mr Fisher commented that the Living Life to the Full Group had noted that from a service perspective, the beneficiaries of Dr Allen's work were broader than the Trust and included reduced attendances at GP and Accident and Emergency Services. Mr Fisher asked whether the Trust could suggest to the two Integrated Care Systems to invest in a small amount of resource for a Project Manager to see if a similar approach could be taken across Berkshire. The Chief Executive reminded the meeting that one of the key components of the Trust's Quality Improvement Programme work was around the development of the strategic project filter which ensured that a consistent approach was taken to determining strategic projects. The Chief Operating Officer reported that he would be attending Joint Non-Executive Directors and Council of Governors meeting on 23 July 2019 and would be giving a presentation on the development of the Trust's Carers' Strategy. This would provide an opportunity for Governors to share their ideas and views. **The Trust Board:** noted the update.
19/139	**Use of the Trust Seal** (agenda item 10.4)
	The Deputy Chief Executive and Chief Financial Officer corrected an error in the report as follows: "Hardwick Farm" was amended to read: "Henwick Farm". **The Trust Board:** noted that the Trust's seal had been affixed to: • 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 set 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 set out the amount of the final grant monies • Farmhouse Lower Henwick 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.

19/140	**Any Other Business** (agenda item 10)
	The Chief Executive referred to the presentation on the Anxiety and Depression in Young People (AnDY) clinic by Dr Percy, Clinical Psychologist, Reading University and commented that there was a consistent theme that there was a greater take up of services amongst residents in West Berkshire than in East Berkshire. The Chief Executive pointed out that one of the roles of the Frimley Health Integrated Care System was to address health inequalities and said that the Trust was committed to playing its role, but there were no easy solutions.
19/141	**Date of Next Meeting** (agenda item 11)
	Tuesday, 10 September 2019 *(a meeting is scheduled on 13 August 2019 if required)*
19/142	**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 July 2019.

Signed…….. Date 10 September 2019
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

AGENDA ITEM 5.2

BOARD OF DIRECTORS MEETING: 10/09/2019

Board Meeting Matters Arising Log – 2019 – Public Meetings

Key:

Purple - completed
Green – In progress
Unshaded – not due yet
Red – overdue

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
10.07.18	18/136	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.	
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**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
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	19/016	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/JH**	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	19/05	Month 11 Finance Report	A strategic capital investment plan to be developed.	25.09.19	**AG**	The strategic capital investment plan would be presented to the September 2019 meeting of the Finance, Investment and Performance Committee.	
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	08.10.19	**AG/JH**	On the agenda for the Trust Board Away Day	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Planning Away Day in October 2019.			on 8 October 2019.	
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**	To be considered at the Board Strategic Planning Away Day on 8 October 2019.	
09.07.19	19/123	Matters Arising	Development of a Strategic Capital Plan	25.09.19	**AG**	The Strategic Capital Plan would be presented to the Finance, Investment and Performance Committee following the Trust's Five-Year Strategy Return for NHS Improvement which was due in September 2019.	
09.07.19	19/123	Matters Arising	Staff Survey "Aide Memoire" for Non-Executive Director Board Visits	10.07.19	**JH**	The Staff Survey "Aide Memoire" for Non-Executive Director Board Visits was re-circulated on 10 July 2019.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
09.07.19	19/125	Freedom to Speak Up Guardian Report	Future reports to give an indication about the seriousness of the cases and what changes had been implemented as a result of the member of staff speaking up.	08.12.19	**FTSU Guardian**	The next six monthly report was due in December 2019.	
09.07.19	19/133	Month 2 True North Performance Scorecard Report	The Trust Board to have an opportunity to review the True North Performance Scorecard at the Board's Annual Strategic Away Day on 8 October 2019.	08.10.19	**AG**	On the agenda for the Away Day	
09.07.19	19/135	Board Vision Metrics Update Report	The Board Vision Metrics to be reviewed at the Board's Annual Strategic Away Day on 8 October 2019.	08.10.19	**AG**	On the agenda for the Away Day	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th September 2019
Title	Patient Experience Quarter 1 report
Purpose	The purpose of this report is to provide the Board with information on patient experience within the trust
Business Area	Nursing & Governance
Author	Liz Chapman, Head of Service Engagement and Patient Experience Heidi Ilsley, Deputy Director Nursing Debbie Fulton, Director of Nursing and Therapies
Relevant Strategic Objectives	True North goal of Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	Patient experience has equality and diversity implications and this information is used to consider and address these. Demographic and ethnicity data is now routinely collated for all complaints received.
SUMMARY	Boards are required to review patient feedback in detail. The Director of Nursing and Therapies has provided an overview at the beginning of the paper. There are no new themes or any trends identified as a result of reviewing the available data. **complaints** During Q1 the Trust received 50 formal complaints and 47 formal complaints were closed (28 of these of these were partly / fully upheld) The formal complaint response rate, including those within a timescale re-negotiated with complainants was 100% for the quarter which continues to be exceptional performance. **Friends and Family Test (FFT)** During Q1 our Friends and Family response rate reduced to 12% despite there being a continued increase in response rate (11,721 this quarter

	compared to 6,625 in QI 2018/19); this is due to increase in number of discharges alongside more accurate reporting of discharges. The patient experience team are working with services to improve their response rates further and are also looking at how any qualitative comments received are able to be more easily provided back to services **Internal Patient Survey** 89% of patients rated our services as good or better in the trust's internal patient survey. **2018 Staff survey** Our 2018 staff survey results demonstrate that 61% of our staff believe that feedback from patients/ service users is used to inform decisions within their directorates and departments; whilst this is better than the average within our peer group (mental health, learning disability and community combined trusts) which is 54%, it is below the best scores achieved of 71%.
ACTION	The Board is asked to: Consider the report and reflect on the patient feedback received

Berkshire Healthcare
NHS Foundation Trust

Quarter One– Patient Experience Report (April – June 2019)

1. Overview

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

The Board is required to consider detailed patient feedback because it provides insight into how patients, families and carers experience our services. There are many ways in which patient feedback is gathered, this report references over 19,000 pieces of feedback received into the organisation this quarter. During the same time period we have had over 200,000 contacts and over 700 inpatient discharges. This means that we are still only capturing a small percentage of feedback that is potentially available to us (0.07%).
One of the Trust True North metrics is for services to ensure that they use feedback from patients/ carers to inform their service offer and any changes made; whilst our 2018 staff survey results demonstrate that 61% of our staff believe that feedback from patients/ service users is used to inform decisions within their directorates and departments, a score that is above the 54% average scoring within our peer group and we also know that feedback is being used to very good effect in some services; work is still required to ensure that this is consistent across the Trust.

Work is also being undertaken as part of our True North to develop an improved survey as we know that currently use of our internal survey is variable

During Q1 our Friends and Family response rate has reduced to 12%, this is because despite having a continued increase in the number of responses (11,721 this year compared to 6,625 in QI 2018/19) more accurate capture of discharge numbers means that the percentage of completed responses against discharges has reduced. In Line with our True North scorecard business rules a countermeasure summary detailing actions to continue to improve response rate has been developed. Our Trust overall recommendation rate was 92%; for community services the recommendation rate was 93% whilst for mental health services was 87%. One of the True North metrics for the coming year is achievement of 95% recommendation rate.

The number of Carers Friends and Family Test responses continues to increase with 335 responses in quarter one which is the highest number ever returned; the responses demonstrated a 96% satisfaction rate.

Collection of ethnicity data associated with complaints achieved 70% in quarter one with 30% not stating. Gender and age is also being recorded with 100% recording achieved for the quarter.

In Q1, the Trust received 50 complaints across a range of services. The number of complaints received is the same as the number received in Q4 2018/19 and less than the other quarters of 2018/19.

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

- Community Mental Health Teams (CMHTs) complaints reduced again this quarter and are below the number seen in any quarter for the last 2 years. In addition there were no

MP enquiries received and there were 6 locally resolved concerns. Themes from the complaints closed include care and treatment. It is expected that the work on defining CMHT pathways will support staff with communication around service offer and will therefore positively impact on the ability to manage patient expectation.

- Child and Adolescent Community Mental Health Services received 10 complaints; this is an increase and more than received in any quarter of 2018/19; the complaint rate per contact is 0.14% although some of the complaints relate to wait lists rather than people seen. The theme that runs through most of these complaints relates to the understanding of what the service is able to offer and communication around wait times and expectations. These services also received the highest number of MP enquires (5). The main themes of all contact around patient experience are in relation to access to services / wait times and the care and treatment received. This is also reflected in the 6 CAMHS complaints closed that were upheld or partially upheld in Q1.CAMHS is under pressure as a service with increases in caseload, activity and wait times. A quality improvement project is in progress to improve productivity and waiting list management. A significant amount of time is invested in supporting families whilst waiting for appointments.

- Acute Mental Health Inpatients a slight increase in the number of complaints (5) compared to the 3 formal received in Q4 2018/19 there were all in relation to the acute adult wards this is remains lower than the number received in the other quarters of 2018/19. The hospital continues to have band 5 qualified nursing staff vacancies and as a consequence higher levels of temporary staff which is not optimal. The Director of People is working closely with the Locality Director on recruitment.

- District nursing services are currently under significant pressure due to vacancy and caseload; however their number of complaints remain very low with formal complaints received being 4. When triangulated with number of contacts this is below the average number complaints per contact for the organisation. Work is in progress with commissioners to define the District Nursing offer.

During the quarter the Trust continued to sustain a complaint response rate of 100%. 60% (28) of the 47 complaints closed during the quarter were upheld or partially upheld, these were spread across a number of differing services and there were no particular themes from any particular service.

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

5236 patients/ carers responded to our internal patient survey in Quarter 1, this asks patients how they rate their experience, by asking 5 questions, an increase in response rate has been seen from just under 3000 in Q3 and 4700 in Q4 of 2018/19.

- Community Health Services had responses from 3905 patients and carers with 89% of them reporting the service they received as excellent or good;
- Mental Health Services responses increased 1331 in the last quarter, with 75% of patients and carers rating the service provided as excellent or good;

Finally services also registered 1,404 compliments during this quarter.

Conclusion
Patient experience is an important indicator of quality and it is important that services take steps to prevent similar concerns highlighted occurring and learn from all feedback received. Whilst each service takes complaints seriously we also need to be able to more easily

demonstrate how we have used patient and service user feedback to change service delivery as well as how learning is shared across the organisation. This continues to be work in progress.

Debbie Fulton, Director of Nursing and Governance

2. Introduction

This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, the Friends and Family Test, PALS and our internal patient survey programme (which is collected using paper, online, text, kiosks and tablets).

This report looks in detail at information gathered from 1 April 2019 to 30 June 2019 and uses data captured from the Datix reporting system, CRT (our internal survey) and the results of the Friends and Family Test captured via SMS, online and hard copy feedback.

3. Complaints received

3.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2017-18 and 2018-19 by service, enabling a comparison with quarter one. During Quarter one 2019/20 there were 50 complaints received, this is a decrease compared to 2018/19 where there were 60 for the same period.

Table 1 – Formal complaints received

	2018/19						2019/20		
Service	Q1	Q2	Q3	Q4	**Total**	% of Total	Change to Q4	Q1	% of Total
CMHT/Care Pathways	16	11	10	9	**46**	20	↓	8	16.00
CAMHS - Child and Adolescent Mental Health Services	5	6	8	6	**25**	10.87	↑	10	22.00
Crisis Resolution & Home Treatment Team (CRHTT)	2	5	3	4	**14**	6.09	↓	2	4.00
Acute Inpatient Admissions – Prospect Park Hospital	9	12	8	3	**32**	13.91	↑	5	10.00
Community Nursing	1	1	3	3	**8**	3.48	↑	4	8.00
Community Hospital Inpatient	6	7	1	3	**17**	7.39	↑	6	12.00
Common Point of Entry	3	3	2	4	**12**	5.22	↓	2	4.00
Out of Hours GP Services	4	5	7	1	**17**	6.96	↓	0	0.00
PICU - Psychiatric Intensive Care Unit	0	0	0	0	**0**	0	=	0	0.00
Minor Injuries Unit (MIU)	1	1	2	0	**4**	1.74	↑	1	2.00
Older Adults Community Mental Health Team	1	1	0	1	**3**	1.3	=	1	2.00
13 other services in Q4	12	11	13	16	**52**	22.6	↓	11	20.00
Grand Total	60	63	57	50	**230**			50	

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

Appendix one contains a listing of the formal complaints received during Quarter one. Since 2018/19 the severity of the complaint has been extracted from the completed Investigating Officers Report; complaints under investigation at the end of Quarter one will not have this information.

3.2 Adult mental health service complaints received in Q1

22 of the 50 (44%) complaints received during Quarter one was related to adult mental health service provision. There were 71,873 reported contacts during Quarter one giving a complaint rate of 0.03%.

Table 2: Adult mental health service complaints

Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
CMHT/Care Pathways	4			2	2		8
Adult Acute Admissions		4	1				5
Psychological Medicine Service		1	1				2
Common Point of Entry	2						2
Crisis Resolution & Home Treatment Team (CRHTT)	1	1					2
Community Team for People with Learning Disabilities (CTPLD)						1	1
Adolescent Mental Health Inpatients						1	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team						1	1
Grand Total	**7**	**6**	**2**	**2**	**2**	**3**	**22**

3.2.1 Number and type of complaints made about a CMHT

8 of the 50 complaints (16%) received during Quarter one related to the CMHT service provision. This is a reduction on numbers compared with 2018-19 Q1 (16), Q2 (11), Q3 (10) and Q4 (9). There were 12,512 reported attendances for CMHT during Quarter one giving a complaint rate of 0.06%.

Table 3: CMHT complaints

	Locality of service			
Main subject of complaint	**Bracknell**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Grand Total**
Attitude of Staff		1	2	3
Care and Treatment	4	1		5

Grand Total	**4**	**2**	**2**	**8**

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

The Bracknell CMHT has had the highest number of complaints for two consecutive quarters; this is an increase for the Bracknell service who had only received 6 complaints during 2018/19. The Head of Service Engagement and Experience visited the service to talk them through the complaints process and to troubleshoot some of the difficulties they have been having. The growing number of complaints was escalated to the Clinical Director. Bespoke training is being arranged for the services based out of Churchill House, including the older adults CMHT about complaint management, including how to locally resolve complaints. CMHT based in Reading, Slough and Wokingham did not receive complaints during this quarter.

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

During Quarter one, 5 of the 50 complaints (10%) related to mental health inpatient wards (all of these were about acute wards) this is sustained since Q4 (5) and a reduction on the number received in previous quarters for 2018-19 which were Q1 (9), Q2 (12) and Q3 (8). There were 236 reported discharges from mental health inpatient wards during Quarter one giving a complaint rate of 2.11%.

Table 4: Mental Health Inpatient Complaints

	Ward/Area				
Main subject of complaint	**Bluebell Ward**	**Daisy Ward**	**Rose Ward**	**Ward 10 - historical care**	**Grand Total**
Attitude of Staff	1	1			2
Care and Treatment			2	1	3
Grand Total	**1**	**1**	**2**	**1**	**5**

The historical complaint is about care provided to a patient who took their own life. The Trust responded based on the Serious Incident report that was produced.

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

In Quarter one, 2 of the 50 complaints (4%) were attributed to CRHTT, a reduction on previous quarters. There are no particular themes identified in the complaints received for CRHTT. There were 16,096 reported contacts for CRHTT during Quarter one giving a complaint rate of 0.01%.

Table 5: CRHTT complaints

	Locality of service		
Main subject of complaint	**Bracknell**	**Reading**	**Grand Total**
Attitude of Staff	1		1
Confidentiality		1	1
Grand Total	**1**	**1**	**2**

3.3 Community Health Service Complaints received in Q1

During Quarter one, 16 of the 50 complaints (32%) related to community health service provision. There were 136,708 reported contacts and inpatient discharges during Quarter one giving a complaint rate of 0.01%.

Table 6: Community Health service complaints

	Locality of service					
Service	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot and Maidenhead**	**Wokingham**	**Grand Total**
Community Hospital Inpatient			2	2	2	6
Community Nursing	3	1				4
Minor Injuries Unit			1			1
Sexual Health		1				1
Rapid Assessment Community Clinic				1		1
Admin teams & office based staff			1			1
Dental Services		1				1
Health Visiting					1	1
Grand Total	**3**	**3**	**4**	**3**	**3**	**16**

During Q1 the services receiving the most complaints was community nursing (4) and the community wards (6).

3.3.1 Community Health Inpatient wards Complaints

During Quarter one, 6 of the 50 complaints (12%) received related to inpatient wards. There were 499 reported discharges from community health inpatient wards during Quarter one giving a complaint rate of 1.20%.

Table 7: Community Health Inpatient complaints

	Ward/Area					
Main subject of complaint	**Ascot Ward**	**Donnington Ward**	**Henry Tudor Ward**	**Windsor Ward**	**Highclere Ward**	**Grand Total**
Access to Services	1					1
Attitude of Staff		1				1
Care and Treatment			1	1	2	4
Grand Total	**1**	**1**	**1**	**1**	**2**	**6**

3.3.2 Community Nursing Service Complaints

In Quarter one, 4 of the 50 complaints (8%) were related to community nursing service provision. This is an increase from 2018-19, 1 received in both Q1 and Q2 and 3 received in Q3 and Q4 2018/19. There were 71,715 reported attendances for the Community Nursing Service during Quarter one giving a complaint rate of 0.005%.

Table 8: Community Nursing Service complaints

	Locality of service		
Main subject of complaint	**Reading**	**Slough**	**Grand Total**
Attitude of Staff	2		2
Care and Treatment		1	1
Communication	1		1
Grand Total	**3**	**1**	**4**

3.3.3 GP Out of Hours Service, WestCall Complaints

There were no complaints about out of hours provision during quarter one, this is a reduction on each quarter of last year where complaints were received in every quarter.

3.4 Children, Young People and Family service Complaints

3.4.1 Physical Health services for children complaints

During Quarter one, 1 of a total 50 complaints (2%) related to children's physical health services. The attendance and discharge information was not available for Quarter one.

Table 9: Children and Young People physical health service complaints

	Locality of service	
Service	**Wokingham**	**Grand Total**
Health Visiting	1	1
Grand Total	**1**	**1**

3.4.2 CAMHS complaints

During Quarter one, 10 of the 50 complaints (20%) were about CAMHS services; compared to 2018-19 - 5 in Q1, 6 in Q2, 8 in Q3 and 6 in Q4. Complaints about care and treatment were the main theme in Q1. There were 6,998 reported attendances for CAMHS during Quarter one giving a complaint rate of 0.14%.

Table10: CAMHS Complaints

	Locality of service					
Main subject of complaint	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Access to Services					1	1
Attitude of Staff					1	1
Care and Treatment		2	1		3	6
Communication				1		1
Confidentiality	1					1
Grand Total	**1**	**2**	**1**	**1**	**5**	**10**

Having reviewed the complaints about Wokingham CAMHS, communication between teams and with families is an underlying factor across the complaints. In addition to the community based CAMHS complaints, there was also one complaint about communication in our adolescent mental health unit, Willow House.

3.5 Learning Disabilities

There was one complaint about the community based team for people with a Learning Disability during quarter one. This was about equipment being purchased which was not suitable for the patient's needs. There have been no complaints for the inpatient ward. The attendance information was not available for Quarter one.

4. KO41A return

Each quarter the complaints office submit a quarterly return, called the KO41A. This looks at the number of new formal complaints that have been received by profession, category, age and outcome. The information is published a quarter behind (Q4 data). The table below shows the number of formal complaints that were reported for mental health services, nationally and for local Trusts providing mental health services in the South England region (the same Trusts that we benchmark against in the Annual CMHT Patient Survey.

Table 11 – Mental Health complaints reported in the national KO41A return

	2017-18				2018-19			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mental Health complaints - nationally reported	**3,461**	**3,790**	**3,451**	**3,653**	**3,598**	**3,651**	**3,391**	**3,450**
2Gether NHS Foundation Trust	14	19	15	15	17	14	21	20
Avon and Wiltshire Mental Health Partnership NHS Trust	81	75	63	67	78	72	77	51
Berkshire Healthcare NHS Foundation Trust	**40**	**58**	**56**	**59**	**49**	**45**	**38**	**51**
Cornwall Partnership NHS Foundation Trust	26	28	32	34	31	28	20	30
Devon Partnership NHS Trust	60	47	43	49	44	56	33	45
Dorset Healthcare University NHS Foundation Trust	82	84	74	79	91	90	92	54
Kent and Medway NHS and Social Care Partnership Trust	78	72	88	86	87	115	121	118
Oxford Health NHS Foundation Trust	62	56	49	70	50	56	58	56
Somerset Partnership NHS Foundation Trust	25	20	15	14	17	14	24	18
Southern Health NHS Foundation Trust	73	114	79	96	91	95	82	68
Surrey and Borders Partnership NHS Foundation Trust	14	28	21	26	26	36	16	26
Sussex Partnership NHS Foundation Trust	188	166	169	221	209	192	181	173

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

5. Complaints closed

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

5.1 Outcome of closed formal complaints

Table 12: Outcome of formal complaints closed

	2018-19						2019-20		
Outcome	Q1	Q2	Q3	Q4	Total	% 18/19	Q1	% of 19/20	Comparison to Q4
not pursued by complainant	0	0	2	2	4	1.67	0	0	Case ↓
Consent not granted	2	2	3	2	9	3.75	1	2.13	↓
Local Resolution	0	5	10	3	18	7.5	1	2.13	↓
Managed through SI process	0	2	0	1	3	1.25	0	0	↓
Referred to other organisation	0	0	0	0	0	0	1	2.13	↑
No further action	1	0	0	0	1	0.42	0	0	=
Not Upheld	13	11	16	15	55	22.92	16	34.04	↑
Partially Upheld	25	26	36	19	106	44.17	17	36.17	↓
Upheld	12	15	12	5	44	18.33	11	23.40	↑
Grand Total	53	61	79	47	240		47		

The 28 complaints closed and either partly or fully upheld in the quarter were spread across a number of differing services and there were no particular themes from any service; however, 6 were related to attitude of staff and 13 to care and treatment provided.

5.2 Response Rate

Table 13 shows the response rate within a negotiated timescale, as a percentage total. The sustained 100% response rate achieved since 2016-17 demonstrates the commitment of the complaints office, Clinical Directors and clinical staff to work alongside complainants.

There are weekly open complaints situation reports (SITREP) sent to Clinical Directors, as well as on-going communication with the complaints office throughout the span of open complaints to keep them on track as much as possible.

Table 13 – Response rate within timescale negotiated with complainant

2019-20	2018-19				2017-18				2016-17			
Q1	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

6. Demographic data

6.1 Ethnicity

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

The tables below show the characteristics of patients who have had complaints raised about their care between April and June 2019. This includes where a different organisation was leading the investigation.

Table 14 – Ethnicity

Ethnicity	Number of patients	%	Census data %
Asian-Other	2	4	15.1
Black-Caribbean	1	2	3.5
Mixed-Other	2	2	-
Not stated	15	30	-
Other Ethnic Group	1	4	1
White-British	27	54	80
White-Other	2	4	-
Grand Total	**50**	**100**	

6.2 Gender

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

Table 15: Gender

Gender	Number of patients	%	Census data %
Female	30	60	50.9
Male	20	40	49.1
Grand Total	**50**	**100**	

6.3 Age

Table 16 – Age

Age Group	Number of patients	%	Census data %
Under 12 years old	8	16	31.6
12 - 17 years old	8	16	
18 - 24 years old	2	4	
25 - 34 years old	7	14	14.9
35 - 44 years old	6	12	15.4
45 - 54 years old	4	8	19.3
55 - 64 years old	3	6	18.7
65 - 74 years old	1	2	
75 years old or older	8	16	
Not known	3	6	
Grand Total	**50**	**100**	

7. Parliamentary and Health Service Ombudsman

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

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

During Quarter one there was one request for information and two investigations were closed; both were not upheld.

Table 17 – PHSO activity

Month open	Service	Month closed	Current Stage
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	CPE	Aug-18	PHSO not proceeding
Aug-18	Out of Hours GP Service	Oct-18	PHSO not proceeding
Sep-18	Psychological Medicines Service	n/a	Not Upheld
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	Not Upheld
Jun-19	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate

8. Multi-agency working

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

Table 18 – Formal complaints led by other organisations

Lead organisation	**Service area of complaint**
East Berkshire CCG	Complaint about the waiting time for the Assessment and Rehabilitation Centre (ARC)
Royal Berkshire Hospital	Complaint about the attitude of the Doctor at the GP out of hours service
SCAS	Family were unhappy about the length of time for a call back from the GP out of hours service
SCAS	Family unhappy with the advice on the telephone from the Minor Injuries Unit
West Berkshire CCG	Complaint about the lack of services commissioned for CAMHS
West Berkshire CCG	Complaint about waiting times for CAMHS

9. MP enquiries, locally resolved complaints and PALS

9.1 MP enquiries

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

Table 19 – Enquiries from MP Offices

Service	Number of enquiries
CAMHS - Child and Adolescent Mental Health Services	5
Common Point of Entry	1
Crisis Resolution & Home Treatment Team (CRHTT)	1
Early Intervention in Psychosis	1
Podiatry	1
Grand Total	**9**

There were 9 MP enquiries raised in Quarter one, the same as in Quarter four 2018-19, compared with 10 in Quarter three and 3 in Quarter two.

The 5 CAMHS enquiries related to access to treatment (1), communication (1) and care and treatment (3). The complaints relating to care and treatment were about safeguarding concerns, and the responsiveness to a patient's risk. The subject that complaints are logged under is the largest area of the complaint.

9.2 Local resolution complaints

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

Table 20 – Concerns managed by services – Local Resolution complaints

Service	Number of concerns managed directly by services
Podiatry	10
CMHT/Care Pathways	6
District Nursing	4
Other	3
Physiotherapy - Musculoskeletal	2
CMHTOA/COAMHS - Older Adults Community Mental Health Team	2
Neuropsychology	2
Health Visiting	2
District Nursing Out of Hours Service	1
Diabetes	1
School Nursing	1
Integrated Pain and Spinal Service - IPASS	1
CAMHS - Child and Adolescent Mental Health Services	1
Mental Health Liaison Service for Older Adults	1
Psychological Medicine Service	1
Minor Injuries Unit	1
Admin teams & office based staff	1

Community Team for People with Learning Disabilities (CTPLD)	1
Grand Total	**41**

9.3 Informal complaints received

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

Table 21 – Informal complaints received

Service	Number of Informal Complaints
Assessment and Rehabilitation Centre	1
CAMHS - Child and Adolescent Mental Health Services	2
Children's Physiotherapy - CYPIT	1
Community Hospital Inpatient	2
Hearing and Balance Services	1
IMPACTT	1
Physiotherapy (Adult)	1
Grand Total	**9**

9.4 NHS Choices

There were 13 postings during Quarter one; 7 were positive and 6 were negative.

Service	Number of postings	Positive	Negative
Minor Injuries Unit	4	A fantastic service. A wonderful and caring nurse. Excellent professional service. It was kind, quick and professional. All the staff were lovely and it is a well-managed unit. The staff were so helpful and gave great advice and felt very well cared for. Thank you so much for great service today. Had a very thorough assessment by a nurse who put me at ease by saying there was no severe damage. Thank you.	
CRHTT	2	Good support from the Crisis Resolution Home Treatment Team. Was impressed by how efficiently and rapidly the team followed up with home visits and then appointments at the hospital.	Seeing lots of different people. A plan was put together at the start of treatment but nothing happened.
Podiatry	2	Excellent Professional Care. The treatment could not have been better.	Impossible to contact the podiatry service. Incredibly poor communication and organisation of the service - it's impossible to raise them on the "new" 0300 number.
Phlebotomy	1		Problems with new booking system. Saw someone face to face in the end.
WAM CMHT	1		The service they are supposed to provide is awful the staff do not provide any form of support.
St Marks Hospital	1	From car parking through to every staff member the service was exceptional.	
Neuro-psychology	1		Length of wait for an autism assessment. Took two years.

King Edward	1		Unhelpful staff. Had a time "slot" at 9.00 only to be told it wasn't an appointment only an advised time to be there. Still waiting 2 hours later to be told by the reception staff patients just have to wait.

9.5 PALS Activity

There were 567 queries during this period. There were 193 non BHFT queries reported by PALS. This is an increase in activity compared to 2018-19 Quarter three and Quarter Four.

The main reasons for contacting PALS were:

- Communication with other organisations;
- General information requests;
- Choice and flexibility of access to services;
- Long wait for an appointment.

Issues around Choice and flexibility of access included:

- Ability to continue using Hearing and Balance service following award of contract, Short notice for transfer of care;
- Eligibility for home visits – District Nursing /Podiatry;
- Availability of equipment i.e. a Flash Glucose Monitoring System;
- Availability of face to face booking for appointments rather than just on line;
- Cancelling / rescheduling appointments;

Issues around a long wait for an appointment included:

- Delay in appointment as patient needed to be referred to a doctor;
- Long wait for an appointment with CAMHS ADHD pathway. Support needed during transition. Pressure on service but helpline available for enquirers. Behaviour escalating;
- Children's CPE. Online referral made but delay in responding. Behaviour escalating. Sometimes reports are not received from other agencies. Waiting list for routine triage;
- Long wait for appointment with CAMHS ASD pathway. Information on external support provided and contact with clinicians can be requested;
- Significant wait for appointment with Children's OT. Will provide initial advice and signpost to online resources.

10. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. The results of the NHS England national review of the FFT have been published and the FFT question will be changing from April 2020 to Overall, how was your experience of our service.

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

The introduction of SMS and dedicated PPI Champions within the Children, Young People and Families locality are contributing to an increase in the number of responses to the FFT. The inclusion of FFT as one the Trusts' True North objectives has increased the focus on it within services.

10.1 Friends and Family test responses

10.1.1 Overall responses

Our Trust overall recommendation rate to a friend was 92% for Quarter one; for community services the recommendation rate was 93% whilst for Mental health services was 87%.

Data shows that introducing SMS as a way of providing FFT has proved very popular with 38% of responses being received via this method.

Based on the number of discharges from our services, there were 100,160 patients eligible to complete the FFT during Quarter one. Our response rate has been impacted by the increase in the discharge data provided to the Patient Experience Team; this continues to be monitored on a monthly basis.

April: 11%
May: 13%
June: 12%

Table 22 – Quarterly number of Friends and Family Test responses

		Number of responses	Response Rate
2019/20	Q1	11,721	12.20%
2018/19	Q4	11,919	22%
	Q3	7631	12.82%
	Q2	5443	14.82%
	Q1	6625	11.64%
2017/18	Q4	5463	11.24%
	Q3	4105	6.81%
	Q2	4987	9.63%
	Q1	4238	7.04%
2016/17	Q4	3696	5.10%
	Q3	4024	5.10%
	Q2	5357	2.20%
	Q1	6697	2.70%
2015/16	Q4	4793	2.10%
	Q3	5844	4.20%
	Q2	6130	4.50%
	Q1	7441	6.60%

10.1.2 Inpatient ward responses

Table 23 - FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family

		2019/20	2018/19				2017/18			
Ward	**Ward type**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1 %**
Oakwood Ward	Community Inpatient Ward	95.83%	95.83	100	100	95.83	100	72.97	93.75	100
Highclere Ward		100%	97.5		97.37	93.98	94.64	96.7	100	100
Donnington Ward				94.12						
Henry Tudor Ward		97.44%	90.91	93.48	89.8	97.78	97.59	42.86	98.86	93.5
Windsor Ward		-	100	100	96.67	88	95.24	94.44	100	100
Ascot Ward		-	100	94.12	93.75	100	100	100	100	100
Jubilee Ward		95.45%	92.86	100	94.92	97.5	97.83	100	100	100
Bluebell Ward	Mental Health Inpatient Ward	60%	80	72.73	50	-	-	-	100	40
Daisy Ward		75%	62.79	78.95	50	100	33.33	-	66.67	50
Snowdrop Ward		71.11%	76.74	70.59	70.73	70.59	100	85.71	76.19	60
Orchid Ward		84.48%	75	69.44	50	100	-	-	100	-
Rose Ward		62.50%	45.95	62.5	0	100	33.33	100	50	100
Rowan Ward		93.33%	100	83.33	-	-	-	-	-	100
Sorrel Ward		-	100	100	-	-	-	-	-	-

- = no responses received

10.1.3 Learning Disabilities

There were no surveys received for the Learning Disability Inpatient Unit, Campion Unit. The inpatient survey, incorporating the FFT is currently being updated. There were 96 responses received from patients seen by the community teams for people with a learning disability, compared to 26 in Quarter four.

The recommendation rate for quarter one was 83% compared with 86% in Quarter four and with 71% in Quarter three.

10.1.4 Carer FFT

There has been a continued increase in carer responses. In Quarter one, 96% of carers would recommend the Trust to friends or family compared to 95% in Quarter four.

Table 24 - Carer FFT Responses

Number of responses					
2019/20		**2018/19**		**2017/18**	
Q1	**335**	Q1	67	Q1	111
		Q2	201	Q2	32
		Q3	314	Q3	39
		Q4	**258**	Q4	86

10.1.5 Friends and Family Test comparison information available from NHS England

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

Table 25 - Community Health services FFT data; April 2019

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

%RR – Recommendation rate

Berkshire Healthcare has maintained a significantly higher response rate compared to other local Trusts, this is positive and means that the results achieved are more valid; for April 2019 the Trust recommendation rate has remained at 94% for community services; this continues to be monitored.

Table 26 - Mental Health services FFT data; April 2019

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

%RR – Recommendation rate

For April 2019 the Trust recommendation rate has increased slightly to 87% for mental health services; this continues to be monitored.

There has been a significant increase in the response rate for mental health services, with targeted work from the patient experience team, supporting services to increase the awareness of the FFT and encouraging people to give feedback. A group specifically focussed on collecting and understanding feedback for patients at Prospect Park Hospital has been setup which monitors the response rates of the FFT at a local level.

As the Family and Friends Test response rate decreased in Quarter one, achieving an average of only 12% overall a piece of analysis has been undertaken as to why there has been a deterioration and an action plan for improvement has been put in place.

11 Our internal patient survey

At the end of the quarter we have received feedback from 5236 patients or carers compared to 4707 in the last quarter.

This quarter there has seen a remarkable increase in Mental Health Services, especially within the Inpatient wards, CRHTT and CMHT. Immunisation and School Nursing responses continue to remain high using tablets and surveys downloaded onto work mobiles. Psychological Medicine Services have now got two new surveys which were developed within QMIS Training and responses continue to increase within the east and west of Berkshire.

The highlights are:

- 86% reported the service they received as good or better – the same as in Quarter four;
- Community Health Services had responses from 3905 patients and carers with 89% of them reporting the service they received as excellent or good;
- Mental Health Services responses increased 1331 in the last quarter, with 75% of patients and carers rating the service provided as excellent or good;
- 14 services carrying out the internal patient survey were rated 100% for excellent or good with a further 18 services rating 85% or above.
- The service with the lowest satisfaction rate was Specialist Children's Services with 22.73% based on 44 responses (meaning a low response rate and not necessarily statistically relevant). The Patient Experience Team is following this up with the service, along with a piece of work to support services not currently carrying out a survey.

12 Learning Disabilities survey

There were 96 survey responses by people seen by our Community Team for people with a Learning Disability during Quarter one – a significant increase from 26 in Quarter four. A selection of the results is in the table below;

Table 27 – Patient survey responses – Community based Learning Disability Services

My meeting with you was helpful	%	Number	I got answers to my questions	%	Number
Not at all	1.09	1	Not at all	0	0
Not much	0	0	Not much	1.09	1
A little	4.35	4	A little	4.35	4
Quite a bit	0	0	Quite a bit	1.09	1
A lot	89.13	82	A lot	85.87	79
Question not answered	5.43	5	Question not answered	7.61	7
You were polite and friendly to me	**%**	**Number**	**You listened to me**	**%**	**Number**
Not at all	1.09	1	Not at all	0	0
Not much	0	0	Not much	0	0
A little	1.09	1	A little	2.17	2
Quite a bit	0	0	Quite a bit	1.09	1
A lot	92.39	85	A lot	91.3	84
Question not answered	5.43	5	Question not answered	5.43	5

13 Updates: Always Events and Patient Participation and Involvement Champions

The Always Events programme has been embedded within the WestCall service. The operational team are being supported by the Patient Experience Team with this project, a review of the feedback from the service led observations has taken place and the analysis from this is being drawn up to create the Always statement for the service.

PPI Champions are fully established and embedded within the Children, Young People and Families locality. Participation representatives from the services act as champions for service user feedback and participation. The champion role provides opportunities for passionate and enthusiastic staff, at all levels, to play an active role in generating a positive focus towards the progression of service user feedback and participation, with direct support from both their peers and corporate services. Services with a Champion are seeing an increase in the response rates for the FFT and wider participation. Appendix Two contains an update from the PPI Champions in CYPF.

PPI Champions are in the process of being rolled out across the community health west and mental health west localities.

Appendix Three contains the 15 Steps report for quarter four. There were 8 visits during this period; six in inpatient wards and two were in community based service.

14 Compliments

There were 1,404 compliments reported during quarter one. The services with the highest number of compliments are in the table below.

Table 28 – Compliments

Service	Number of compliments
Talking Therapies	622
ASSiST	215
Cardiac Rehab	82
Community Nursing	50
Community Hospital Inpatient	49
Community Matron	32
CMHT/Care Pathways	26
Community Respiratory Service	25
CMHTOA/COAMHS - Older Adults Community Mental Health Team	23
Older Peoples Mental Health (Ward Based)	22

Table 29 - Compliments, comparison by quarter

	2018/19					2019/20
	Q1	Q2	Q3	Q4	18/19	Q1
Total Compliments	1,008	1878	1,670	1,409	5,965	1,404

Elizabeth Chapman

Head of Service Engagement and Experience

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Formal Complaints received during Quarter one 2019/20

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Minor	Complaint about the lack of support following the request for a change in Therapist in 2018.	Partially Upheld	Main issues were due to unavailability of staff compounded by family taking her off the waiting list to go private and then deciding to return to NHS care. Evidence her needs were prioritised. However, we did not discuss this with her.
Bracknell	CMHT/Care Pathways		Client unhappy with treatment from Care Co-ordinator, wishes to be allocated a new CPN.	Investigation underway	
Bracknell	Common Point of Entry	Minor	Following a review by service the pt feels the Trust and the solicitors have falsely purported that no psychology review was required	Not Upheld	All complaints previously responded to. Unreasonably persistent complainant status.
Bracknell	Common Point of Entry	Minor	Complaints about CPE and FOI act.	Not Upheld	All points previously responded to. Unreasonably persistent complainant status.
Reading	District Nursing	Low	Complaint about attitude of staff, communication and lack of care.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Slough	Dental Services	Minor	Complainant rang on behalf of parent regarding dental service at WIC in Upton. Consent ok. Complainant and parent had to pay a fee of £22.70 up front before being seen, yet was only in with the dentist for a very short time. Dental pain was not resolved and examination cursory. Dentist was abrupt and unhelpful, insisting parent spoke not complainant, but parent had poor English. Feels poor value for money as issue not resolved.	Partially Upheld	
Reading	Adult Acute Admissions	Low	Pt very unhappy with the attitude and language with a member of staff on the ward.	Partially Upheld	Apology given. Staff to ensure that physical health care plans are clearly documented in risk assessments with appropriate actions.
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Moderate	The young person is being told that they cannot be open to both the Eating Disorder Service and Specialist CAMHS Team. She is being 'bounced' between the services and not responding to the needs of, and what is effective for the young person.	Partially Upheld	Communication between teams and the change in the patient's clinical presentation created confusion. Learning includes: Any changes to care plan to be discussed with the service user and carer / parents ahead of review meetings or when referred to different pathways within CAMHS. When care is shared between teams and pathways ensure any considerations regarding changes to plans are discussed jointly in advance so that information shared with the service user and their parents is accurate. Ensure communication regarding changes to care plans is discussed with the service user and their parents and clearly communicated verbally and in writing.

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Psychological Medicine Service		DECEASED PT:- Patient attended RBH following an overdose of medication. He was then discharged from the hospital and the family do not feel he received adequate care for his mental health. He went on to take his own life.	Investigation underway	
Wokingham	CAMHS - Child and Adolescent Mental Health Services		Complainant feels elements still have not been addressed and wishes to have a LRM. ORIGINAL COMPLAINT BELOW Family unhappy with the lack of care and support for their child with ASD, they are also waiting for a report from the psychiatrist dating back to April.	Investigation underway	
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	not completed	DECEASED PT:- Unhappy with complaint and SI response. ORIGINAL COMPLAINT Family unhappy with the care and treatment their father received on Highclere ward.	Upheld	Also an SI. NEWS scores were not acted upon as they should have been as identified in the SI findings.
West Berks	Minor Injuries Unit	Moderate	Family believe they received a misdiagnosis	Upheld	The break was misdiagnosed and the clinical advice was not appropriate. A review of cases has been carried out and 6 future cases are to be reviewed. The member of staff has carried out reflective practice.
Wokingham	Community Team for People with Learning Disabilities (CTPLD)	Low	Family purchased equipment that was recommended by the trust, but isn't useable and is now non-refundable.	Upheld	Mobility aid was purchased on the advice of staff and was not appropriate for the patient. Apology and refund.
Reading	Adult Acute Admissions	Low	Complainant unhappy that following a conversation with ward staff who assured her the patient was not being discharged, the patient was discharged and then had to be readmitted. Complainant does not understand why staff have not listened to the family.	Partially Upheld	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Pt and family unhappy with the care and treatment provided by the care co-ordinator. Formal complaint required following LRM.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Slough	Sexual Health	Moderate	Pt felt the Dr was quite rude and judgmental and did not think the examination was appropriately handled.	Partially Upheld	
West Berks	Community Hospital Inpatient	Low	Complaint about the attitude of the nursing staff, which the family feel led to the patient shouting out. This in turn led to her being declined a place in the preferred nursing home. Also a wheelchair order was cancelled by the ward.	Partially Upheld	There are areas that we can learn from in terms of the information provided to the patients and relatives about the wheelchair provision and movement of the patient between bay and side room areas. Care provided was appropriate. Staff and therapists often went above and beyond to provide the Patient with the time and reassurance that she needed.
Slough	District Nursing	Minor	Patient unhappy with the lack of timely care from the DN's and the lack of treatment with dignity and respect.	Partially Upheld	
Bracknell	Crisis Resolution & Home Treatment Team (CRHTT)	Moderate	Unhappy with communication and support from CRHTT. Received a second complaint stating the pt felt unsupported following a diagnosis of EUPD.	Partially Upheld	The consent to speak with the patient's partner was not updated at the time it was given. The patient was discharged appropriately.
Reading	Adult Acute Admissions	Minor	Informal pt believes she was kept illegally on the ward when requesting leave on multiple occasions. She wishes an apology for this and the handling of the situation. She wishes for staff to learn about the Rights of informal patients.	Not Upheld	
Wokingham	Adolescent Mental Health Inpatients		Family unhappy the way the pt's expectations are being managed and the fact the parents feel they are being kept out of the loop.	Investigation underway	
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	Low	Pt felt his stay on Henry Tudor was a degrading waste of time 1. toilet visits had to be accompanied no matter the urgency 2. No exercise 3. on 30 mins of physio 4. medication timings not adhered to	Not Upheld	Physio and care provided were appropriate. Apology given that the patient felt that they were not treated with dignity and respect.

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	CMHT/Care Pathways		Care and treatment received from CMHT over the course of a few yrs .	Investigation underway	
Wokingham	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	Pt feels the consultant was confrontational during his apt at the memory clinic.	Not Upheld	No evidence of clinical failing.
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Pt feels she was left hanging by services as she had to chase between appointments, she states the attitude of the Dr was such that the service lead needed to enter the consultation to mediate.	Investigation underway	
West Berks	CMHT/Care Pathways		Patient has concerns around her care and treatment from CMHT and BHFT Patient experience staff. Patient also feels they have been discriminated against for having made an informal complaint previously.	Investigation underway	
Reading	District Nursing	Minor	Relative of patient emailed to say patient had been found in garden having fallen and been outside all night and DN did not contact NOK. Also element of RBH complaint.	Investigation underway	
Reading	Adult Acute Admissions	Moderate	Family unhappy with care and treatment the patient has received from PPH.	Not Upheld	Consent not received, internal investigation to be undertaken by Patient Safety team.
Windsor, Ascot and Maidenhead	Rapid Assessment Community Clinic	Minor	Escalated from informal complaint. Daughter unhappy about the disparities between care provided in the East and West especially with Rapid Response Team.	Not Upheld	
Reading	CAMHS - Child and Adolescent Mental Health Services	Minor	Parent feels the Dr has dismissed all the symptoms relating to anxiety leaving the pt with no advice / support. As pt remains on the ASD wait list parents believe this contradicts Dr's previous decision.	Partially Upheld	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	CAMHS - Child and Adolescent Mental Health Services	Moderate	Pt's anxiety is resulting in her not attending school. Mother has requests CAMHS assistance with the school, which has been refused. Dr sent a letter to the school without seeing the pt or the Mother's knowledge.	Not Upheld	Clinical care was appropriate - the doctor did all they could to support the young person.
Bracknell	CMHT/Care Pathways		Pt feels he has lost 13yrs of his life following a recent diagnosis of ASD. Therefore wishes to raise a complaint of clinical negligence.	Investigation underway	
Reading	CAMHS - Child and Adolescent Mental Health Services	Low	Pt been on the list since April 2016.	Partially Upheld	Waiting times were acknowledged and communication could have improved while the child was waiting to be seen. Waiting time was appropriate, as although a private assessment had been carried out, a medical review was required before prescribing.
Reading	District Nursing		Pt feels the DN was extremely rude to her on the phone shouting and accusing her of lying.Pt wants an apology DN also said they would not go out to her again.	Investigation underway	
West Berks	Admin teams & office based staff	Low	Sister unhappy as the patient has had a referral blocked which was made to Community Neuro Rehab.	Not Upheld	No conflict of interest found.
Wokingham	Health Visiting	Low	Father unhappy with the input from HV member of staff, says she is too involved and prepared to do anything for the mother of the child. Wants a new HV assigned.	Not Upheld	Complaint not upheld - no evidence seen to substantiate complaint.
Bracknell	CAMHS - Child and Adolescent Mental Health Services	Minor	Mother states there was a breach of her son's information to another parent.	Upheld	Human error led to information being entered incorrectly. Processes to mitigate this have been introduced into the admin office.
Slough	Early Intervention in Psychosis		Pt on waiting list for a year and a half, calls frequently for an update and is told someone will call her back but they never do. Mother has lost faith in the service.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Slough	Psychological Medicine Service		Pt seen by EBMH team at Wexham Park on 2 occasions. Pt extremely unhappy that she was visited and disagrees with the report that was written following the meeting. Pt wishes for the report to be removed from her records and other organisations it was sent to.	Investigation underway	
West Berks	CMHT/Care Pathways	Moderate	Complaint about a lack of response from the CRHTT when the family called for help as their daughter was nearly catatonic.	Partially Upheld	Partially upheld as it seems advice given was appropriate. IO acknowledges phone conversations may not have been fully recorded, but no evidence to suggest otherwise. Learning identified for team and service, especially when CPN is not available.
Windsor, Ascot and Maidenhead	Estates	Minor	Partition fell onto a patient sat in a waiting room waiting for their Talking Therapies appointment. This has caused the patient further anxiety as a result and they are asking for further appointments and acupuncture as a result.	Partially Upheld	Apology that the structure fell - it was knocked by a patient leaning back onto it. This was removed following the incident.
Slough	Adult Acute Admissions	High	DECEASED PT: Family feel BHFT were negligent in the care of an informal pt. Pt found deceased on the day they left the ward on leave.	Upheld	Information in response is from previous SI. Lots of learning.
Wokingham	CAMHS - Child and Adolescent Mental Health Services		Mother unhappy with the general care and treatment / attitude of staff members / lack of communication and lost property	Investigation underway	
Reading	Crisis Resolution & Home Treatment Team (CRHTT)		Patient complaining via advocate re breach of confidentiality and being locked in a corridor whilst under the care of CRHTT at PPH and also lack of dignity when in Yew Tree Lodge. Patient wants an explanation and assurance personal info is not disclosed unnecessarily.	Investigation underway	
Wokingham	Community Hospital Inpatient		Family feels Wokingham hospital have not looked after the patient satisfactorily. Pt has been sent back to the RBH twice and they feel staff do not have the training to look after her.	Investigation underway	

Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	CAMHS - Child and Adolescent Mental Health Services	Low	1. Why did the service contact the school without inforing the family? 2. Following the meeting on the 22nd May why did the clinician deliver the diagnosis directly in front of the pt? 3. Why was the complainant told if they do not attend family therapy they may have to get safeguarding involved? 4. Family wish a second opinion	Partially Upheld	Not Upheld in the majority.
Wokingham	Community Hospital Inpatient	Low	DECEASED PT: Family unhappy that the ward said they were unable to transfer /refer the patient to the Memory clinic as the local policy forbade it.	Not Upheld	Complaint withdrawn by complainant.
Reading	CAMHS - Child and Adolescent Mental Health Services	Minor	Mother unhappy with original response and the fact staff will not give her relevant info about her son. She would still like a copy of the assessment report which she sates she is legally entitled to. Mother also unhappy with the way she is spoken to and treated by staff. ORIGINAL COMPLAINT Mother wishes to know why services appear not to engage with her. She would like a copy of her son's assessment which was sent to the GP. Wants to know if a safeguarding was ever raised when the father shut down the CAMHS involvement when the pt was having suicidal thoughts.	Not Upheld	We cannot share patient's information with mother as he has not consented. Due to confidentiality we do not give information over phone. No evidence patient's father was obstructing referral.

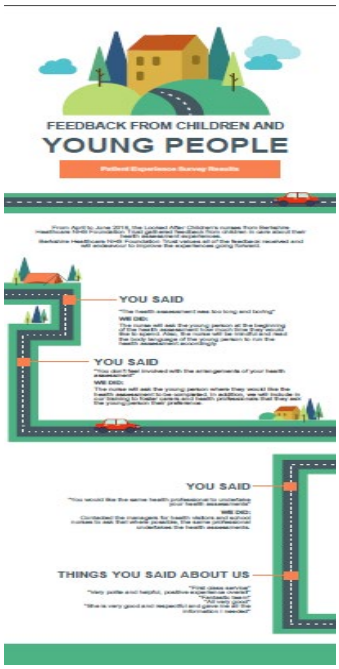
Geographical Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	CMHT/Care Pathways	Minor	PHSO has said local resolution has not been resolved so pt wants to know if she can meet with services to discuss treatment options. ORIGINAL COMPLAINT Pt feels she has suffered significant harm due to being misdiagnosed in 2012. She would like an apology for the delays around diagnosis, access to a PTSD treatment path, the most suitable could include an inpatient stay in a facility such as Khiron House.	Not Upheld	no evidence of misdiagnosis. timely and appropriate treatment was given.
Windsor, Ascot and Maidenhead	Community Hospital Inpatient		DECEASED PT:- Unhappy with complaint and SI response. ORIGINAL COMPLAINT Family unhappy with the care and treatment their father received on Highclere ward.	Upheld	Also an SI. NEWS scores were not acted upon as they should have been as identified in the SI findings.

Quarterly report: Participation and Feedback in Children, young people and family services (CYPF). April, 2019.

By Daryl Nicholas, Service user experience and participation lead for CYPF

We are pleased to welcome Becca Bird (CAMHS) and Tani Prindiville (Willow House) to our team of participation champions. Our participation champions have continued to work hard in their progression towards achieving the participation levels, outlined within the Participation strategy, this quarter. A growing focus has been given to 'You said, we did' outcomes and many services having now developed effective methods of feedback, response, and action. The depth and wide ranging nature of actions, taken in response to service user participation and feedback, has been pleasing to see. We have also witnessed a growing ownership of participation across individual services. A new reporting template has been developed to reflect the growing emphasis on outcomes and also to ensure our services are mindful and progressive in their endeavours to ensure their participation and feedback structure meets the equality, diversity, and inclusion agenda. Collectively, the team have met for a participation champion's workshop and for a 'catch up' meeting during the quarter with several 1:1/service specific meetings also taking place. Our network meeting included an emphasis on Equality, Diversity and SEND, and the use of Devices and tablets to aid feedback.

Looked after Children Nursing



Data from feedback forms, which are completed by Looked After Children and Young People and their Foster Carers, following Review Health Assessments, is discussed at LAC nursing monthly team meetings where themes are identified and solutions considered. 'You said, we did' posters are displayed to service users and their Foster Carers. LAC Nurses have also demonstrated that they have taken on board and acted on the suggestions made by Foster Carers in regards to improving the training sessions that the LAC Nurses deliver.

The 'Participation Champion' within the LAC team is regularly rotated to keep engagement fresh and enthusiasm high. There is a whole team approach to the Participation process with everyone's input being valued.

LAC Nurses consulted Young People via 'Children In Care Councils' in regards to developing the feedback form they would prefer the team to use following health reviews. The service is waiting for an electronic version of this form to be finalised. This will then be downloaded to the LAC Nurses' smart phones and hand held devices for ease of use and to

improve date collection.

Foster Carers were also asked, via focus groups, or during regular support meetings/coffee mornings that are facilitated by LA's, for their thoughts in regards to ways the service could improve the training sessions the LAC Nurses deliver. The feedback has now been acted on and training packages revamped accordingly.

YOU SAID….	WE DID…..
Foster Carers: You would like training that was interactive and relevant	Held focus groups, gathered feedback of carers' views and arranged further training for nursing staff through Learning and Development to improve our training delivery. Individual training 'packages'/health topics were then revamped by LAC Nurses.
Children & Young People: The health assessment was too long and boring	The nurse will ask the young person at the beginning of the health assessment how much time they would like to spend. Also, the nurse will be mindful and read the body language of the young person to run the health assessment accordingly.
Children & Young People: Our feedback forms are too long to complete	We changed the feedback form for young people and asked for your input in the new design (the new feedback form will also be downloaded to our smart phones to make it a more 'young person friendly' way of gathering feedback data).
Children & Young People: You don't feel involved with the arrangements of your health assessment	The nurse will ask the young person where they would like the health assessment to be completed. In addition, we will include in our training to foster carers and health professionals that they ask the young person their preference.

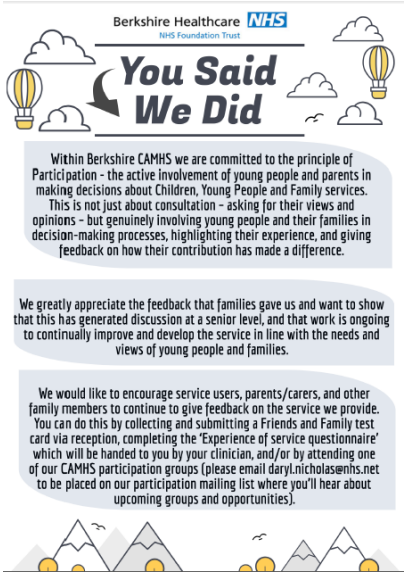
CAMHS

Service users, parents, carers, and other family members, share their experience of the service via monthly participation meetings, which have taken place in Reading, Wokingham and Slough in recent months. This allows for both consultation and co-production.

These groups allow young people and families to provide their view on various developments of the service for example, updating the BHFT CYPF website. Young people and families were able to identify ways the website could be improved, areas not to change, as well as comment on the content and design of the website.

Young people and parents have also:

- Reviewed the recently published 'You said, we did' final document.
- Advised on 'what would service users like to know about CYPF and the senior management team?'
- Service users have put together a paragraph to describe the role of the care-coordinator to other service users.
- Reviewed the consent to treatment and Sharing of Information.



CAMHS offered the participation groups several opportunities to report back on their experience of their 'service journey' and to highlight areas for improvement or concern. CAMHS continues to receive a substantial amount of feedback responses via the Experience of Service Questionnaire, completed by 95% of service users, and the Friends and Family Test cards which are distributed on a six weekly cycle.

The service user's priorities were taken to the monthly CYPIAPT meeting for exploration and action. The feedback is taken to the CAMHS leadership meetings to discuss decisions further. "You said, we did" posters are then developed which are displayed in waiting rooms at all site locations. Hand-outs are also put in waiting rooms for people to read through. Discussions are also held at the monthly participation group meeting in order to hear young people feedback on the decisions made.

YOU SAID….	WE DID…..
It is often difficult to get through to CAMHS on the phone.	Berkshire Healthcare recognise the difficulty that people sometimes have in contacting some of the CAMHS teams by phone and understand how frustrating that is. The Trust's Children, Young People and Families directorate have been working to review the administrative needs and resources across all services over the last 6 months and have allocated dedicated reception staff to some areas of particularly high need. They have also updated their telephone phone systems at several specialist CAMHS sites with the aim of making it easier for service users to get through. The impact of these changes will be monitored over the coming months.
The waiting times we can expect to experience before entering CAMHS are unclear.	Whilst it is challenging to give precise waiting times due to the fact that we have to prioritise those young people most at risk at any one time,

	and that this changes frequently, all teams within the CAMH service try to give clear information on the likely waiting times for appointments. We regularly review waiting times and have processes in place to provide support and communicate with people while they are waiting but we are working with our service users to think about how we can communicate these more effectively in the future.
It is often difficult to get a referral to CAMHS from GPs.	Berkshire Healthcare CAMHS are active members of the Berkshire East and Berkshire West CAMHS transformation partnerships and have worked closely with the Clinical Commissioning Groups and other partners to promote the message that the best person to make a referral is someone who knows the young person and their needs and difficulties well. That is often not their GP, but could be a teacher, youth worker, parent/carer or if over 16, the young person themselves. It takes time for this message to be embedded but we continue to promote it, through our website, our single on-line referral form, in our training and meetings with schools, through GP forums and via information on the GP IT systems.
Clinicians tell us they are going to do something (such as make a referral to another pathway), but it does not happen. We have to chase them.	We agree that this is not acceptable. Fortunately, it happens infrequently however we would encourage any young people or families who may have experienced this situation to contact the relevant clinician and if unable to do so, to contact the service manager so that they can resolve the issue quickly. If a referral has not been made when it should have been, when the young person is transferred to the new pathway/team, the referral is backdated to the initial referral date so that families are not disadvantaged by potential errors by the Service. We are keen to ensure that the service that we provide is the best that it can be and want to learn from when things do not work well, so that we can make changes. Information about how to make a complaint is clearly displayed in all CAMHS clinics and on the CAMHS website and if necessary, young people and families can make a formal complaint. However we hope that will not be necessary.
We feel that the anxiety and depression pathway	The anxiety and depression pathway is a specialist

needs an autism specialist for incidences of co-morbidity.	service that offers cognitive behavioural therapy (CBT) – based treatments to young people with moderate to severe anxiety, depression, OCD and PTSD. There is good evidence that these treatments can be successful for those with autism, if adapted appropriately and the team frequently see young people with neurodevelopmental difficulties, including autism, and do offer one-to-one CBT that is adapted to young persons' needs. Members of the anxiety & depression team have undertaken specialist training in autism and the team have employed a number of clinical psychologists who have expertise in autism to help further develop interventions for this group of young people. The team have been working closely with the autism specialists in our Autism Assessment team to design and deliver joint training more widely across the service; members of the anxiety and depression pathway provide support to families via the autism teams' Young SHaRON on-line network and the teams are developing joint workshops for families of young people with autism and anxiety.
There is a lack of early help when mental health problems arise. It feels as though we need to reach crisis point/hospitalisation before any action is taken.	We agree that more help needs to be available for children and young people as soon as mental health difficulties begin to emerge. This is an issue that does not only impact families in Berkshire – several national initiatives are currently being undertaken to address the need for earlier support, and the government have pledged funding to develop these strategies. Although Berkshire Healthcare CAMHS work primarily with children and young people with moderate/severe mental health difficulties, whose symptoms have often been occurring over several months, we have developed a number of resources that contribute to early help. Our on-line resource provides information and guidance for families and links to other self-help resources; the Young SHaRON on-line network provides immediate peer-moderated support to families of young people referred for an autism assessment and the anxiety and depression pathway run workshops for parents, carers and adolescents to provide early help following initial referral to the

	service. Information on early help services available in each of the Berkshire localities is available on our website and we work closely with our partners in the Clinical Commissioning Group and Local Authorities to support the development of more early help.
Parking is an issue. It's difficult to find a space.	Limited parking is a recognised problem across some Berkshire Healthcare sites. Initiatives have been put in place to improve parking for both service users and staff at Wokingham Hospital. The CAMH service in Reading has recently been moved to a new site with much better access to parking and further locality moves are currently being explored.
The attitude of (non-CAMHS) staff is sometimes a worry when we access A&E services.	The issue of stigma around mental health, including from some health care professionals is something that has been highlighted as a concern nationally and there are a number of national initiatives that are seeking to address it. Young people who had been seen by the CAMHS rapid response team shared examples that related to their experiences of this locally while taking part in focus groups to explore their experiences of care. These examples have been shared with the relevant organisations, which have put in place actions to tackle this issue.
We would like to see changes in the way the 'was not brought' policy is communicated to young people/families when they do not arrive for appointments.	We have worked with our service user participation groups to review the letters that we send when families miss appointments. We are also working to include information on this and other important policies on our website and to ensure that information is clearly displayed in all of our service waiting areas. Missed appointments mean that time clinicians could be spending seeing young people is wasted, contributing to long waiting times for our services. Whilst in most of our teams the number of missed appointments is low, with around 16% of appointments to the ADHD team being missed.

School Nursing

The West Berkshire school nursing team have undertaken two focus groups in March:

One of these was with a small group of parents that were targeted by the Calcot children's hub. Parents were given the opportunity to identify what had been helpful and how the session could be improved when a 'school readiness' session is delivered.

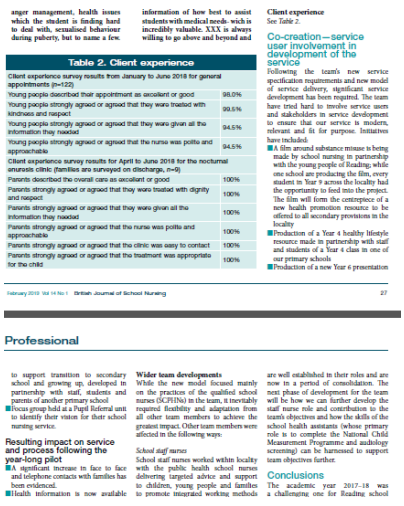
A school nurse attended the localities 'school health champions' annual conference where a focus group had been held. The school nurse discussed the feedback received from last year as well as facilitating the students in the completion of a survey monkey, currently being circulated by Public health in the local authority, which will inform future commissioning of the service.

In Reading, the film to support the substance misuse resource has been completed; the team are now working with students on still images, including joint work with the local police force, for a social media project. A workshop is being planned immediately after Easter to prepare the team to deliver some pilot sessions using the film. Students will be given the opportunity for feedback in schools during the summer term.

Ten pilot sessions for a new Year 4 healthy lifestyle resource are currently underway in Reading schools; the resource was produced in partnership with a local primary school, Emmer Green primary, their year 4 teacher and class pupils. The teacher and class discussed and planned the content, the session which is quite interactive was then trialled by the class who gave feedback and then alterations were made accordingly.

Discussions at patient participation Champions workshop encouraged the service to openly acknowledge the service users concerns of issues relating to overall provision by BHFT, such as parking, and the service plans to circulate alternative travel information to support the use of public transport where this could be preferable to driving.

Amended feedback surveys, which include the Friends and family test questions, are in the process of being placed onto team iPhones and will be operational after the Easter break. The Friends and family test questions cards are being used to collect feedback from families who have received a care package but only had telephone contact with our service. These will complement school nursing surveys on IPhones which collect quantitative data at Nocturnal Enuresis clinics and 1:1 appointments. The feedback is explored and action is taken within team meetings leading to the production of 'you said, we did' actions. These are displayed in clinic settings and in schools using info graphics from Piktochart.



anger management, health issues which the student is finding hard to deal with, sexualised behaviour during puberty, but to name a few.

information of how best to assist students with medical needs which is incredibly valuable. XXX is always willing to go above and beyond and

Table 2. Client experience

Client experience survey results from January to June 2018 for general appointments (n=122)	
Young people described their appointment as excellent or good	98.0%
Young people strongly agreed or agreed that they were treated with kindness and respect	99.5%
Young people strongly agreed or agreed that they were given all the information they needed	94.5%
Young people strongly agreed or agreed that the nurse was polite and approachable	94.5%
Client experience survey results for April to June 2018 for the nocturnal enuresis clinic (families are surveyed on discharge, n=9)	
Parents described the overall care as excellent or good	100%
Parents strongly agreed or agreed that they were treated with dignity and respect	100%
Parents strongly agreed or agreed that they were given all the information they needed	100%
Parents strongly agreed or agreed that the nurse was polite and approachable	100%
Parents strongly agreed or agreed that the clinic was easy to contact	100%
Parents strongly agreed or agreed that the treatment was appropriate for the child	100%

Client experience
See Table 2.

Co-creation—service user involvement in development of the service

Following the team's new service specification requirements and new model of service delivery, significant service development has been required. The team have tried hard to involve service users and stakeholders in service development to ensure that our service is modern, relevant and fit for purpose. Initiatives have included:

- A film around substance misuse is being made by school nursing in partnership with the young people of Reading, while one school are producing the film, every student in Year 9 across the locality had the opportunity to feed into the project. The film will form the centrepiece of a new health promotion resource to be offered to all secondary provisions in the locality
- Production of a Year 4 healthy lifestyle resource made in partnership with staff and students of a Year 6 class in one of our primary schools
- Production of a new Year 6 presentation

February 2019 Vol 14 No 1 British Journal of School Nursing 27

Professional

to support transition to secondary school and growing up, developed in partnership with staff, students and parents of another primary school
- Focus group held at a Pupil Referral unit to identify their vision for their school nursing service.

Resulting impact on service and process following the year-long pilot

- A significant increase to face to face and telephone contacts with families has been evidenced.
- Health information is now available

Wider team developments

While the new model focused mainly on the practices of the qualified school nurses (SCPHNs) in the team, it inevitably required flexibility and adaptation from all other team members to achieve the greatest impact. Other team members were affected in the following ways:

School staff nurses

School staff nurses worked within locality with the public health school nurses delivering targeted advice and support to children, young people and families to promote integrated working methods are well established in their roles and are now in a period of consolidation. The next phase of development for the team will be how we can further develop the staff nurse role and contribution to the team's objectives and how the skills of the school health assistants (whose primary role is to complete the National Child Measurement Programme and audiology screening) can be harnessed to support team objectives further.

Conclusions

The academic year 2017–18 was a challenging one for Reading school

A recent article, written by Beverley Wheeler, School Nurse Manager, was published in the British Journal of School Nursing featuring a section on 'Co-creation: service user involvement in development of the service'.

British journal of school nursing Februa

YOU SAID….	WE DID…..
Feedback from young people in Reading: The health promotion resource should include, 'real people, telling real stories in real language'	Development continues on substance misuse resource following the 'you said' from service users.
Feedback from a previous quarter from young people in Reading requesting a 'male member of staff' in pupil referral unit	Male student nurse on placement with the team, targeted work to be planned that student can support with. Integrated working with other male colleagues from other services is happening as and when needed.
Feedback from service users in school nursing surveys re parking issues at nocturnal enuresis clinic.	Parking and travel information being produced which can support alternatives to driving to venues. Feedback posters to acknowledge concerns regarding parking and state that Berkshire healthcare have a strategy to improve the issues.

CYPIT

Given the structural changes within the service, the champions have found it challenging to allocate time to maintain progress on their feedback and participation mechanisms this quarter. Despite this, the service has put significant efforts into continuing the development of the questionnaire. The continued aim is to produce a standardised questionnaire for piloting with service users. As part of a SEND focus, the CYPIT team are considering the use of images, such as smiley faces, and colours to support the understanding of younger children with additional needs. The service is also planning to add diversity and inclusion questions within the CYPIT wide questionnaire.

The CYPIT feedback form, which captures service user involvement at various stages of the participation levels, continues to be used within support groups run by the service with the identified themes being explored and actions are taken. Quantitative information is also gathered from the early years speech and language therapy 'drop in' clinic. The staff team are currently working on displaying feedback to staff and service users.

Teams in the East of the county have developed a two week period, within each quarter, where the Friends and Family Test cards are given to each family. In the West of the County, the Newbury team are trialling an online, post-drop in, survey. This is sent out by email four times a year to families who have attended one of the drop-in clinics in the previous three months. This complements qualitative feedback gained through feedback slips at the drop-ins themself. The operational lead is currently looking at the feedback that has been collected and will produce some

written information. This will be shared with service users on the portable drop in display boards alongside the current 'You said, we did' actions relating to the responses to the feedback slips. The feedback will be shared with the Early Years team at the next team meeting which is scheduled for early May.

YOU SAID….	WE DID…..
I do not see the same therapist each time	We allocated individual caseloads to the SLTs to increase consistency (Reading Early Years)
My child is not seen in the best environment	Increased home visits for children with ASD (Reading Early Years)
We have to wait a long time at drop in	Trialled a 'booking' service where families can to the local park if they wish then return for their appointment (Newbury Early Years)

Immunisations team

The immunisations team is putting a lot of work into to responding the service user feedback that they would like more flexibility with regards to clinic availability and clinics outside of school hours.

- The team will be utilising the outreach vehicle in the summer term, and hopefully within the summer holidays, to capture as many unvaccinated children as possible and to be as flexible as possible to immunise children within the holidays and allow greater access. This will double up as a promotional exercise as again it will be advertised in a range of different sources. These sessions will be reviewed using FFT/PPI tablets to gain feedback at the sessions.
- Parental feedback within the East of the county has led to the service holding more catch up clinics on Saturdays and the service are currently exploring this within the West of the county.
- The team are investigating the option of holding evening clinics at Whitley Health and Social Services Centre and West Berkshire Community Hospital.

The service distributes and collects Friends and family test cards, for parents, carers and children to complete, although these are predominantly completed by parents/carers, at signing in desk at immunisation community clinics. Feedback tablets are used within all schools for children to complete. This feedback is shared with staff via Newsletters, emails, and discussed at team meetings. The service is looking to design A3 laminated posters to be displayed within immunisation community clinics. The Immunisation team also hope to display A3 laminated posters within schools and also to send a link to the school with the feedback so that they can incorporate this into their newsletters.

The distribution and collection of the surveys are regularly discussed at Immunisation team meetings and all feedback from the Friends and family monthly report is inserted into newsletters. The service routinely asks for staff feedback to obtain ideas. The feedback themes are taken back to a termly team meeting and then onto management in order for decisions to be made jointly. These actions are then placed onto 'You said, we did' posters which are displayed to service users within service waiting areas and will be uploaded onto the immunisations website page.

Upcoming plans: the immunisation team are currently….

- Exploring the possibility of having a promotional/immunisations stand/delivery of immunisations at Salt Hill Park venue in Slough on 7.8.19. To utilise PPI tablets/FFT cards. Playday is an annual event, over 40 stalls at the event ranging from Housing to Libraries to Healthwatch and Parks accommodating up to 3000 people, which is held all over England on the same day each year.
- Exploring the possibility of having a promotional/immunisations stand/delivery of immunisations at Southcote Community Fair in Reading on 11.5.19 alongside school nurses. To utilise PPI tablets/FFT cards.
- The team will involve parents and carers, and work alongside Reading Borough Council, to assist in designing an easy to read flu leaflet to be included in their health and well-being pack for home educated families.

YOU SAID….	WE DID….
We need more flexibility with regards to clinics outside of schools	We are investigating additional clinics on Saturdays, evening clinics and clinics in the holidays.

Health Visiting

The health visiting team have been exploring options to meet the conversation and co-creation participation levels and they are in the process of planning focus groups across localities.

Regular attenders at the Early Years Panel and parents have expressed that they would like a group specifically for children with 'additional medical needs'. The Health Visiting team are the process of arranging this new group. The service has identified a venue and staff ahead of the group starting.

The service currently uses the friends and family test cards and bookmarked surveys on IPhones, with questionnaires are used at the beginning of the programme and at the end of programmes to evaluate the experience and measure the change in knowledge/skills/ confidence of families. The health visiting team are also currently designing questions to be used on Patient Experience tablets. They hope to have this working for all staff in the near future. The feedback will be explored and action will be taken at Children Centre meetings. The feedback and responses will be communicated to staff via email and displayed to service users within clinic settings and on the children's centre website.

YOU SAID….	WE DID…..
The video was too long in the post natal group presentation	We have used a smaller excerpt from the video and give out details of the link
Early Years Panel and parents have expressed that they would like a group specifically for children with 'additional medical needs'	We have set one up
You wanted more activities at the Arborfield Community Centre	We are starting a post natal group there on a 4 week rolling programme which starts in April We are currently looking at capacity for holding 'Introduction to solids' and 'School Readiness' sessions at Arborfield We have increased our capacity to complete more development reviews and 6-8 week reviews at Arborfield to reduce travelling

Specialist children's services

The service currently uses the following methods to gain feedback from service users:

- Community Paediatrics – Electronic Questionnaire
- Children's Community Nursing – mobile electronic questionnaire
- Specialist School Nursing West – Paper questionnaires.

The service is currently working on developing feedback boards within the clinic areas.

The broad nature of the service, and a number of existing and unutilised feedback methods, has inhibited the focus of the service; however they have been working to focus on a core feedback offer to service users to engage both service users and staff within the process which can then be expanded over time.

The specialist children services team are currently being supported to develop specific feedback mechanisms to engage with children and young people with learning difficulties and disabilities. We are hopeful that this will allow the service to begin to collect further qualitative feedback, to complement the range of quantitative feedback measures that are already in place, and lead to the regular generation of 'You said, we did' outcomes. Again, the plan is for this feedback, and relating actions, to be showcased to service users and staff within clinical settings.

BEDS – young people

The service utilises the Experience of Service Questionnaire (ESQ) alongside the Friends and Family Test. Experiences of Service Questionnaires are handed out as part of Routine Outcome Measures packs for young people and their parents to answer during reviews, at assessments, and at discharge. These are scored, uploaded, and collated. The service still needs to work on the

displaying of some feedback information and to proactively seek responses to the themes that are highlighted within the feedback.

The service's participation group provides the opportunity for young people to contribute feedback and ideas to relevant matters within the service. For example the group have recently been involved in highlighting information that would be helpful to include in the service leaflet. The service users have also been involved in developing the presentation of the friends and family test in the waiting room as well as the decoration in the waiting room.

As the young people's service merges with the adult service, we will work with the respective champions to ensure that a consistent and progressive feedback and participation systems are in place.

YOU SAID….	WE DID…..
You wanted better/more appropriate decoration in the waiting room and wanted your voices heard within this area.	We spent time listening to you and allowing your environment in an on-going project o decorating/changing the waiting room area to reflect your choices.
That it would be helpful for new parents starting out in the service and professionals helping support young people with eating disorders to understand some of the things that did or did not help during your recovery	We wrote down these ideas that you had in relation to what you did or did not find helpful and included it in the leaflet for the service that will be given out to parents when the leaflet is completed.
You wanted to present the you said/we did information in a different format	Discussion about how to present this.

Adult BEDS

Adults BEDs currently uses the following methods for collecting feedback:

- FFT cards available in waiting rooms
- Suggestions box in waiting room
- Awaiting electronic feedback tablets

The results of satisfaction and rating measures are displayed on posters within the staff office, emailed to the staff team, and discussed within in monthly business meetings where all feedback and comments are again shared with staff. Posters are used to display the information to service users within waiting rooms and in corridors on units.

Qualitative feedback is collected using:

- FFT cards available in waiting rooms.
- Suggestions box in waiting room.

- Day Programme patients asked for feedback every block (12 weeks)
- Home Treatment and carer's group given feedback forms every 6 months.

The feedback gathered through these means is discussed at a monthly team meeting and/or is used as part of the day programme planning day every 12 weeks. The Carer's group feedback is discussed between staff responsible and the information is collated. The feedback is taken to monthly team business meetings and planning days for exploration and action. The response is communicated through "you said, we did" information in the waiting room and on the unit corridor, community meetings, and during the first day of the new day programme block with patients, with carer's feedback being communicated in the carer's group in the next month.

The day programme patients are given a space once a month with the team to raise any issues or concerns. Ex-patients are also able to give feedback to current group in day programme. Carer's and relatives are given a questionnaire every 6 months which is then discussed in the carer's group the next month.

YOU SAID….	WE DID…..
"We'd like shorter waiting times"	Introduced new outpatients groups and self-help programme which is getting people into treatment quicker
"We'd like a greater variety of food choice in the day programme"	Adapted the programme to give patients more of a say in meal options
"The patient group room is uncomfortable"	Redesigned the group room with new furniture and layout to make it more appealing for both relaxation and therapy
"We don't want active treatment"	Introduced a support and monitoring clinic focussing on risk management and motivation

Daryl Nicholas

Service user experience and participation lead

Integrated Children, young people and family services

Berkshire Healthcare NHS Foundation Trust.

Berkshire Healthcare
NHS Foundation Trust

15 Steps Challenge

Quarter 1 2019/20

Overview of visits this quarter

Campion

- The team found the unit to be well run with dedicated, patient focused staff delivering high quality patient care. The staff showed great pride in their unit. There was discernible respect for dignity and good interaction between staff and patients.

Snowdrop

- This was a good visit to the ward which although needed a bit of TLC appeared well run and organised. All the staff encountered on the visit were engaged, professional and welcoming.

Sorrell Ward

- The team found Sorrel Ward well-run with good interaction demonstrated between patients and staff. Through observations and discussions with staff the team felt that patients were very much at the centre of care on the ward, with staff making the care appropriately therapeutic but safe with the least restrictions in place.

Willow house

- All staff were very welcoming and engaged throughout the visit and very committed to their service. Lots of clear evidence of engagement with the young people on the unit and their families which gave the team confidence in the care young people receive on the unit including the inspirational school.

Rose ward

- A lot of work through QMIS in place and staff discussed a lot of the changes and their planned work. No information boards throughout the ward and while new ones had been ordered the ward felt and looked bare with no information on display for patients or visitors. The team felt positive about seeing this on further visits.

Windsor ward

- Patients spoke well about the staff and the care they received although there were a number of issues identified, some of which had been on-going for some time. These affected the atmosphere and feel of the ward throughout the visit. New team in place with clear plans to address these issues.

Podiatry

- Professional service observed with staff focused on safe care. Challenges with shared area with other services limited signage and information available for patients.

Dental

- The team found the clinic well run with dedicated staff focused on their patients and the smooth running of their clinic. Staff were proud of their service and the patient experience they were able to provide, very willing to receive feedback and use this to improve their service further. Excellent team work was evident.

Pam Mohomed-Hossen & Kate Mellor
Professional Development Nurses
July 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Trust Board Meeting	10 September 2019
Title	The NHS Patient Safety Strategy—implications for Berkshire Healthcare
Purpose	To make the Trust Board aware of this national policy on safety and about requirements for successful implementation of the Strategy.
Business Area	Corporate
Author	Minoo Irani, Medical Director
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 'safe' care domain and 'well led' aspect of CQC inspection.
Resource Impacts	To be confirmed
Equalities and Diversity Implications	N/A
SUMMARY	In response to a request from the Secretary of State for Health and Social Care, NHS England and NHS Improvement have developed a new strategy for patient safety as a 'golden thread' running through healthcare. Delivering this Strategy in the trust will require implementation of some new initiatives although mostly will involve pragmatic changes to current patient safety culture, policies and processes in the trust. This paper summaries the priorities and timelines for doing this. If there is one take home message from this strategy, it is about removing the 'blame culture' when it comes to patient safety, so that staff can engage, report and learn from patient safety incidents without fear. This will form the initial focus of safety awareness work and involve staff in the trust, alongside implementing the 4 requirements of the patient safety system listed in the report. The remaining deliverables remain dependent upon national implementation and release of specific systems and toolkits, which the Trust will implement in due course.

ACTION REQUIRED	The Trust Board is requested to note the requirements of the Strategy and be assured that a trust level implementation plan is being developed.

Berkshire Healthcare
NHS Foundation Trust

The NHS Patient Safety Strategy

Implications for Berkshire Healthcare

Purpose of this paper

This paper aims to summarise implications of the 84 page NHS Patient Safety Strategy (July 2019) for Berkshire Healthcare. The Strategy is currently 'high-level', applies broadly to healthcare systems and requires engagement from national and regional teams, local systems and providers. Since this strategy sits alongside the NHS Long Term Plan (LTP) and the LTP Implementation Framework, it is expected that local system plans to deliver the LTP will include local elements of the safety strategy. NHS Providers brief (3 July 2019) also has a helpful summary of the terminology, definitions and main elements of the strategy.

Context

In response to a request from the Secretary of State for Health and Social Care, NHS England (NHSE) and NHS Improvement (NHSI) have developed a new strategy for patient safety as a 'golden thread' running through healthcare. With a vision to continuously improve patient safety, the NHS is required to build on two foundations—a **patient safety culture** and a **patient safety system**. Three strategic aims will support the development of both:

1. Insight: improving understanding of safety by drawing intelligence from multiple sources of patient safety information. Expected to:
    - Adopt and promote key safety measurement principles and use culture metrics to better understand how safe care is
    - Use new digital technologies to support learning from what does and does not go well, by replacing the National Reporting and Learning System (NRLS) with a new safety learning system
    - Introduce the Patient Safety Incident Response Framework (PSIRF) to improve the response to, and investigation of incidents
    - Implement a new medical examiner system to scrutinise deaths
    - Improve the response to new and emerging risks, supported by the new National Patient Safety Alerts Committee
    - Share insight from litigation to prevent harm

2. Involvement: establish principles and expectations for the involvement of patients, families, carers and other lay people in providing safer care. Expected to:

- create the first system-wide and consistent patient safety syllabus, training and education framework for the NHS
- establish patient safety specialists to lead safety improvement across the system
- ensure people are equipped to learn from what goes well as well as to respond appropriately to things going wrong
- ensure the whole healthcare system is involved in the safety agenda.

3. Improvement: designing and supporting programmes that deliver effective and sustainable change in the most important areas. Expected to:

- deliver the National Patient Safety Improvement Programme, building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions
- deliver the Maternity and Neonatal Safety Improvement Programme to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025
- develop the Medicines Safety Improvement Programme to increase the safety of those areas of medication use currently considered highest risk
- deliver a Mental Health Safety Improvement Programme to tackle priority areas, including restrictive practice and sexual safety
- work with partners across the NHS to support safety improvement in priority areas such as the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance
- work to ensure research and innovation support safety improvement.

Delivering the Strategy in Berkshire Healthcare

Although NHSE and NHSI regional teams will play a key role in delivering the commitments, local systems and providers are also expected to play a direct role in supporting the implementation of the strategy. Elements of the strategy which are of particular relevance to the trust are as follows:

Objective	What and by when
Support the development of a safety culture in the NHS	--LTP implementation plans to include how the trust will embed the principles of a safety culture. --monitor and respond to NHS Staff survey results --Adopt NHSI A Just Culture Guide -- Adhere to the well-led framework
Align reporting to systems which replace NRLS & StEIS	--connect to the new system by end Q4 2020/21 -- continuous increase in effective incident reporting (improve quality without necessarily increasing quantity)
Implement the new PSIRF	--Full implementation by July 2021 --identify PSIRF leads by Q4 2019/20 --organisation level strategic plans for patient safety investigation (Q2 2020/21) and staff training from end Q2 2020/21 onward --eliminate inappropriate performance measures from all dashboards/ performance frameworks by Q2 2020/21 --annual monitoring whether actions completed in response to patient safety incidents measurably and sustainably reduce risks

Implement the medical examiner system	--all deaths are scrutinised by medical examiner by end Q4 2020/21
Implement the National Patient Safety Alerts Committee	100% compliance declared for all Patient Safety Alerts from Q2 2019/20
Patient involvement in patient safety	--include 2 patient safety partners on safety-related clinical governance committees by April 2021
Patient safety training and education	--support all staff to receive training in the foundations of patient safety by April 2023
Contribute to a network of patient safety specialists	--identify to the national patient safety team at least one patient safety specialist by end Q4 2019/20 --release patient safety specialists for identified training by Q4 2021/22

What are the specialist areas for the trust to consider?

1. Engage with the Mental Health Safety Improvement Programme (trust engagement programme and improvement collaborative programme) and continue work to reduce restrictive practice by a third by April 2020 and nominate an inpatient ward to participate in the improving sexual safety collaborative.
2. Safety issues that particularly affect older people: safety initiatives to address falls (Falls Collaborative Programme), pressure damage (Stop the Pressure Programme), infections (preventing deterioration and sepsis) and problems related to nutrition and hydration (learning from nutrition improvement collaborative)
3. Learning Disabilities: expanding STOMP and STAMP, Ask Listen Do, Care and Treatment Reviews, Learning Disability Improvement Standards
4. Antimicrobial Resistance and Healthcare Associated Infections: reduce healthcare associated gram negative bloodstream infections, improve diagnosis and treatment of lower UTI in older people, influenza vaccination
5. The Medicines Safety Improvement Programme: continue roll out of EPMA in the trust, address drug omissions, best practice in transitioning patients with mental health needs.

Where do we start?

1. Develop a patient safety culture in the trust:

- Understand the problem: use NHS Staff Survey to understand safety culture and focus on staff perceptions of the fairness and effectiveness of incident management
- Develop a just culture (NHSI Just Culture Guide)
- Embed the principles of a safety culture

Progress on this will be monitored through :

- NHS Staff Survey metrics about fairness and effectiveness of reporting and staff confidence and security in reporting
- Proxy indicators for problematic cultures (levels of staff suspension, anonymous incident reporting,)
- Well-led framework and its eight key lines of enquiry

2. Establish a patient safety system:

- Identify a patient safety specialist from existing senior staff, notify national patient safety team and implement training (based on national patient safety syllabus developed by HEE)
- Ensure 100% compliance with all patient safety alerts
- Explore patient involvement on at least one of the trust governance committees in the first instance
- Develop implementation plans for medical examiner, new reporting systems and new PSIRF

Conclusions

The Strategy is based upon well thought through principles and there is nothing controversial or open to debate as long as the implementation does not distract from what matters to patients and the demands for assurance on the various elements of the strategy does not distract providers from changing the safety culture.

If there is one take home message from this strategy, it is about removing the 'blame culture' when it comes to patient safety, so that staff can engage, report and learn from patient safety incidents without fear.

The strategy also requires changes to current systems and processes to national reporting which trusts are expected to implement. A senior member of staff is expected to train up to be the patient safety specialist and patient involvement in patient safety governance is no longer optional.

There are specific national programmes and initiatives which the trust's mental health and community health services are expected to engage with; this is already the case in many of the services in the trust.

It would be expected that a high-level strategy of this nature is followed by a series of implementation notifications and reports, which are awaited.

Minoo Irani

Medical Director

July 2019

The NHS patient safety strategy

Introduction and summary

NHS England and NHS Improvement (NHSE/I) have published the *NHS Patient Safety Strategy*, which outlines a vision for the NHS to continuously improve patient safety and the role of a safety culture to deliver it. It sets out plans to use new digital technologies to support learning and create the first patient safety curriculum, training and education framework for the NHS. This briefing summarises key points from the strategy, but we encourage providers to read the document in full for a comprehensive overview.

Key points:

- The strategy sets out a vision for the NHS to continuously improve patient safety according to patient needs and system priorities, which is responsive to new innovations and research in patient safety.
- This strategy sits alongside the *NHS long term plan* (LTP) and the *LTP implementation framework*. Local system plans to deliver the LTP will include local elements of the strategy, with NHSE/I regional teams supporting delivery.
- Three key strategic objectives have been identified to achieve this vision:
  - to improve understanding of safety (insight)
  - to equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the system (involvement)
  - to design and support programmes to deliver effective and sustainable change in the most important areas of safety (improvement)
- Actions to improve understanding of safety include the adoption and promotion of key safety measurement principles and the introduction of a new safety learning system, a framework for responding to and investigating incidents, and a new medical examiner system.
- In order to equip patients, staff and partners with the skills and opportunities they need to improve patient safety, a consistent system-wide syllabus, training and education framework for the NHS will be created, and patient safety partners and specialists established.
- The strategy sets out a number of actions the NHS will take to meet the objective of designing and supporting programmes to deliver effective and sustainable change. These include delivering programmes for national patient safety, maternity and neonatal safety, medicines safety and mental health safety. Safety of older people and those with learning disabilities, and antimicrobial resistance are other areas highlighted as priorities.

Insight

Key safety measurement principles

Whilst the complexity of measuring patient safety is recognised, the strategy outlines ten underpinning principles for effective safety measurement. NHSE/I will adopt these principles for all safety measurement activity, and encourage all parts of the system to do likewise, and will track their implementation. The principles include:

- being clear about the purpose of each measure, 'dashboard' or 'scorecard'
- using the same measure for the same purpose across all organisations
- understanding the terms 'avoidable' and 'unavoidable' are unhelpful for patient safety
- working in partnership with analysts, patients, improvers and clinicians
- making data collection easy, using existing data where possible

A new digital system to support patient safety learning

The National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) will be replaced by a system which will rationalise these functions into a single portal, and use new digital technologies to support learning from what does and does not go well. Changes will be made to what data is collected, how data is collected and who inputs data. The system will provide a shared space to connect experts and where improvers can exchange ideas and lessons, and will also make the data and learning resources easier to access.

The Patient Safety Incident Response Framework

A new Patient Safety Incident Response Framework (PSIRF) will replace the Serious Incident Framework to improve the response to and investigation of incidents. A number of PSIRF proposals will be explored, such as:

- a broader scope, which reflects a systems approach and provides guidance and support
- taking a risk-based approach to the selection of incidents for investigation
- insulating investigations against scope creep and inappropriate use
- emphasising the role of provider boards and leaders in overseeing individual investigations
- moving away from applying a strict 60 day working day deadline for investigations
- introducing national standards and standard report templates

Early PSIRF adopters across several local systems will give insight into how the new expectations are best implemented and this will be used to support subsequent national implementation. Further support will be provided through the establishment of a national implementation group, the development of an investigation training supplier procurement framework and the development of resources for boards to include content in existing board development programmes.

The medical examiner system

The strategy describes a new medical examiner system, which will be non-statutory initially, to ensure all deaths are scrutinised independently. England will have seven regional examiners to help implement the new system. The medical examiner offices established (predominantly) in acute trusts in 2019/20 will be expanded over the course of 2020/21 to encompass all deaths, including those occurring in the community and in independent providers. Reports from regional medical examiners and the national offices will be used to identify trends or patterns that merit further exploration.

The National Patient Safety Alerts Committee

The National Patient Safety Alerts Committee (NaPSAC), set up in 2018, will continue its work to align all national alert issuing bodies and teams to ensure future alerts set out clear and effective actions that local systems must take on safety-critical issues. In the future, NaPSAC will widen its terms of reference to become a safety committee akin to the safety boards that exist for other safety critical industries.

Clinical negligence and litigation

The strategy highlights a national programme of work is in development to improve the NHS's response when things go wrong, and that a Getting it Right First Time (GIRFT) report will be published later this year on best practice guidance based on claims learning in orthopaedic surgery.

Involvement

Patient, carers, families and lay people as partners

The strategy states that more work is needed to make involving patients, their families and carers, and other lay people in improving the quality of NHS care more widespread. To this end 'patient safety partners' (PSPs) will be introduced. The national patient safety team will publish a full framework for involving PSPs in patient safety in 2019/20. The aim is for all safety-related clinical governance committees (or equivalents) in NHS organisations to include two PSPs by April 2021 and for them to have received required training by April 2022.

Patient safety education and training

Health Education England (HEE) will work to develop a plan for patient safety training for the NHS, and make safety training within professional education programmes explicit and mapped to the competencies in a national syllabus. HEE will also ensure every member of the NHS has access to patient safety training at an appropriate level, and intends to explore a credentialing approach to provide a level of confidence to the NHS in relation to the skills people acquire through their training.

Patient safety specialists

Patient safety specialists will be established (by developing existing people and roles rather than creating new posts) to lead safety improvement across their local systems. NHS organisations will be asked to identify one person to be developed as their proposed patient safety specialist by April 2020.

Improvement

The strategy sets out a number of actions the NHS will take to meet the objective of designing and supporting programmes to deliver effective and sustainable change in the most important areas of safety:

- delivering the **National Patient Safety Improvement Programme** , building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions.
- delivering the **Maternity and Neonatal Safety Improvement Programme** to support reduction in stillbirth, neonatal and maternal death and neonatal asphyxial brain injury by 50% by 2025
- developing the **Medicines Safety Improvement Programme** to increase the safety of those areas of medication use currently considered highest risk
- delivering a **Mental Health Safety Improvement Programme** to tackle priority areas, including restrictive practice and sexual safety
- working with partners across the NHS to support **safety improvement in priority areas** such as: the safety of older people, the safety of those with learning disabilities and the continuing threat of antimicrobial resistance.
- working to ensure **research and innovation** support safety improvement, through prioritising the adoption of evidence-based tools, the development of innovative solutions is a priority, and exploring further links with the wider research agenda.

Delivering the strategy

NHSE/I's integrated regional teams and the regions will both play a key role in delivering the above commitments and supporting the strategy's implementation. A summary of the commitments in the strategy and who will deliver what by when is presented in a table from pages 64-72.

NHS Providers view

We welcome that NHSE/I have set out clear commitments to bringing a more strategic, planned and aligned approach to patient safety policy across the NHS. This is vital, alongside the appropriate training, expertise and resources for NHS organisations and staff, to fully embed an effective safety culture across the NHS. We are also pleased to see the aims and principles of the strategy are in line with previous policy and proposals aligned to priorities already underway.

As we highlighted in our response to the consultation to inform the strategy's development earlier this year, the main challenges lie in facilitating and enabling the changes required for the strategy's ambition to be realised. Regulation pressures, misaligned requirements around reporting, bureaucratic burden, local

variation, and workforce shortages will all be challenges to overcome when delivering the commitments outlined in the strategy. It is also important to recognise that just culture has to be grown locally, from the 'bottom up', and takes time, sustained effort and recognition of the level of subjectivity involved. Trusts will need to be supported to prioritise this work and changes to process will need to be given time to mature. Clarity on how outcomes will be assessed and measured will also be essential.

NHS trusts and foundation trusts must be involved in taking forward the actions set out in the strategy to ensure they are effective implemented, particularly those where proposals need to be explored further as is the case with the Patient Safety Incident Response Framework. NHS Providers understand that NHSE/I intend to refresh plans annually and we will therefore be working with members to ensure their views on the strategy and their experience of its implementation are fed back to support this process.

NHS Providers media statement

Responding to the publication of the *NHS Patient Safety Strategy*, NHS Providers' head of policy Amber Jabbal said:

"The national patient safety strategy will be an important tool for NHS trusts to help foster a culture of learning in which staff feel able to speak up and contribute to continuous improvement to patient safety.

"NHS staff are committed to ensuring that patients are kept as safe as possible and this strategy helpfully sets out how we can build on this commitment through the use of technology, sharing learning and empowering staff and patients when it comes to quality of care.

"To achieve the ambitions of this strategy, there must be a culture shift within the NHS, moving away from blame, to one which is transparent and support learning from the causes of incidents. Dedicated experts within organisations will help to support this open dialogue among staff.

"It is right that NHS staff across all levels are given the training, expertise and resources needed to fully embed an effective safety culture and spot the risks of patient harm when they occur. Staff and trusts must also have the support and resource they require to adopt the digital solutions which will play a key role in delivering these aims.

"We are pleased to have supported the work carried out by Dr Aidan Fowler and will continue to work with trusts and their partners to implement the vision for patient safety set out in this strategy."

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2019
Title	**Quality Assurance Committee – 21 August 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 21 August 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 August 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 • Proposed Changes to the Committee's Terms of Reference
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered. The Trust Board is also requested to ratify the proposed changes to the Quality Assurance

	Committee's Terms of Reference (the proposed changes are highlighted in tracked changes).

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Wednesday, 21 August 2019, Fitzwilliam House, Bracknell

Present:	Ruth Lysons, Non-Executive Director (Chair) David Buckle, Non-Executive Director Julian Emms, Chief Executive Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Debbie Fulton, Acting Director of Nursing and Governance David Townsend, Chief Operating Officer
In attendance:	Julie Hill, Company Secretary

1 Apologies for absence and welcome

Apologies were received from: Mehmuda Mian, Non-Executive Director and Amanda Mollett, Head of Clinical Effectiveness and Audit.

The Chair welcomed everyone to the meeting and said that she would particularly like to focus the meeting's time on a discussion on the following agenda items:

- Quality Concerns
- Serious Incidents
- Learning from Deaths
- Clinical Audit Schedule

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 21 May 2019

The minutes of the meeting held on 21 May 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) Carers Strategy

The Chair reminded the meeting that the Chief Operating Officer had given a presentation on the development of the Trust's Carers Strategy at the Joint Non-Executive Directors and Council of Governors meeting on 23 July 2019.

The Chair said that during the presentation, the Chief Operating Officer had mentioned that the Trust was seeking to recruit a member of staff in order to progress the Carers Strategy and asked whether it would be helpful to have another discussion about the Trust's work to support Carers at either a Trust Board In Committee meeting or at this Committee.

The Chief Operating Officer reported that the Business and Strategy Group meeting on 19 August 2019 had agreed that the Trust's Carers' work should focus on high priority services (that is on services where Carers could have the greatest impact and where there were current gaps in support).

The Chief Operating Officer said that a Carers' Lead would be recruited to initially for six months and as part of their role, they would conduct Listening into Action style focus groups with Carers in order to understand how best to support Carers moving-on.

David Buckle, Non-Executive Director commented that the word "Carer" was vague and pointed out that not everyone with caring responsibilities regarded themselves as "Carers" for their family members.

The Chief Executive explained that the focus of the Trust's work would be on those individuals where there was the potential for them to play a more active role in the care and support of their loved ones over a longer timeframe and where there was currently a lack of support for Carers.

It was agreed that the Committee would receive an update on the development of the Carers' Strategy in six months' time.

Action: Chief Operating Officer

b) Diabetes Services Take Up in Deprived Communities

The Chief Executive reported that the Frimley Health and Care Integrated Care System was currently reviewing health inequalities and the wider determinants of health. The Chief Executive reported that he had raised the issue of Diabetes Services take up with the Integrated Care System.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Quality Concerns Status Report

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

- Mental Health Act Compliance
- Physical Health monitoring in Mental Health Services

It was noted that there were no new concerns and that no concerns had been removed since the last meeting.

The Director of Nursing and Governance reported that the Clinical Director for West Community Services was currently gathering information regarding any quality and safety impacts resulting from the increased referrals and wait times for the Community Based Neuro-Rehabilitation Team (CBNRT) service and the Integrated Pain and Spinal Service (IPASS) to assist in the decision making as to whether these services should be added to the Quality Concerns register.

David Buckle, Non-Executive Director said that he found the Quality Concerns report very useful and that it helped the Board to gain a common understanding about the key Quality risks and the actions that were being undertaken to address those risks.

The Chair asked for more information about the two services which were under review.

The Director of Nursing and Governance explained that both the CBNRT and IPASS services were receiving twice the number of referrals than they were commissioned to receive and she wanted to understand more about whether this posed any quality and safety risks to patients.

It was noted that both services had effective triage processes in place to assess patients.

The Chair asked about the process of identifying Quality Concerns.

The Chief Executive explained that Quality Concerns were identified through a number of different routes. This included reviewing the divisional Patient Safety and Quality minutes which were presented to the Quality Executive Group and through Finance, Performance and Risk reporting. The Chief Executive said that the Director of Nursing and Governance also triangulated information from a range of other sources, for example, complaints, serious incidents and intelligence from Clinical Directors etc.

The Chair noted that the last update in relation to the bed occupancy quality concern was June 2019. The Chair reminded the meeting that the Trust Board meeting in July 2019 had received a presentation on the Bed Optimisation Programme and commented that she was aware that a significant amount of work was being undertaken.

The Chief Operating Officer confirmed that the Programme Board met every two weeks to progress the Bed Optimisation work.

The Chair asked for more information around the Director of Nursing and Governance's role in supporting the work to improve physical health checks and well-being for mental health patients.

The Director of Nursing and Governance reported that there was a lot of positive work being undertaken in this area and that her role was to provide focus and strategic oversight in order to drive and embed the improvements.

The Committee noted the report.

5.1 Serious Incidents Report – Quarterly Report

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

- During Quarter 1, there were a total of 15 Serious Incidents.

- 13 of the Serious Incidents were reported by Mental Health Services
- The key themes identified from investigations either approved by the Commissioners or completed in Quarter 1 related to: Care Programme Approach (CPA); absence cover for Community Mental Health Teams; and Supervision
- Actions were being undertaken to address these main themes and were detailed in section 3 of the report.

David Buckle, Non-Executive Director asked for more information about the Care Programme Approach.

The Chief Executive explained that the national Care Programme Approach was implemented following the case of Christopher Clunis who fatally stabbed Jonathan Zito outside a London Tube Station. It was noted that Christopher Clunis had a diagnosis of paranoid schizophrenia but his care was uncoordinated because he regularly moved to a new area. The Chief Executive said that the Care Programme Approach was designed to ensure that high risk patients did not "fall through the cracks" when they moved home but commented that the process had become bureaucratic.

The Chief Executive suggested adding the Trust's compliance with new CPA guidance to the Horizon list of topics.

Action: Company Secretary

The Chair noted that the issue of absence cover in the Community Mental Health Teams was a recurring theme in the learning from Serious Incidents.

The Director of Nursing and Governance explained that there was a time lag between the Serious Incident and the conclusion of the investigation. It was noted that in November 2018, the Trust had developed a standard operating policy for absence cover in Community Mental Health Teams to address the issue.

The Medical Director reported that the Coroner had written to him expressing concern about when Care Co-ordinators go on leave and he was satisfied with the systems and processes the Trust had put in place to manage absence cover for high risk patients.

The Chair referred to chart 4 of the report and suggested that the format of chart 6 was easier to read.

The Director of Nursing and Governance agreed to change the format of chart 4 in future reports.

Action: Director of Nursing and Governance

The Committee noted the report.

5.2 a) Learning from Deaths Quarterly Report

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

- 802 deaths were recorded on the clinical information system (RiO) during Quarter 1 where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 90 met the criteria to be reviewed further. All 90 deaths were reviewed by the Mortality Review Group. 33 deaths were closed with no further action; 8 deaths were classified as "Serious Incidents" requiring further investigation; and 49 deaths required 'second stage'

review (using an initial findings review/structured judgement review methodology);

- During Quarter 1 the Mortality Review Group had reviewed the findings of 66 second line review reports of which eleven 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 1.
- One lapse of care had been confirmed in Quarter 1. This related to an inpatient suicide which occurred in October 2018 and the independent investigation was concluded through the Serious Incident process.

The Medical Director reported that the Trust was awaiting the notification of the appointment of regional medical examiners who would in turn appoint the Trust Medical Examiner. It was noted that the role of the Medical Examiner was to provide proportionate scrutiny to all non-coronial deaths.

The Medical Director reported that the Head of Clinical Effectiveness and Audit had conducted a review of the current death certification process in the Trust. All six Community Health Inpatient Wards were reviewed and areas for improvement had been identified.

The Chair said that the report was very thorough and provided the Trust Board with a high degree of assurance.

The Committee noted the report.

5.4 WestCall Out of Hours Service Care Quality Commission "Must Do" Actions – Assurance Report

The Director of Nursing and Governance presented the paper and reported that the WestCall Out of Hours Service Care Quality Commission "Must Do" actions had been completed and were now embedded and being monitored as appropriate.

David Buckle, Non-Executive Director referred to action 3 (GP Working Hours) and said that it was important that the Trust did everything it could to ensure that GPs who worked for more than one organisation did not work excessive hours.

The Director of Nursing and Governance confirmed that GPs were asked to self-declare the number of hours they had worked within a 24-hour period. It was noted that the Urgent Care Team conducted random surveys of the sessional GPs in which they were asked to confirm by return that a) they did not feel like they had worked excessively long hours and b) that they had adequate rest between shifts

The Director of Nursing and Governance confirmed that the Care Quality Commission's next inspection of the WestCall Out of Hours Service would be on 10 September 2019.

The Committee noted the report.

5.5 Action Plan in Response to Regulation 28 Notice

The 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 Director of Nursing and Governance confirmed that all actions had been completed or were in the progress with the exception of the recruitment of additional Senior Leadership Team cover. The additional post was being covered by NHS Professionals at present to mitigate any quality or safety concerns.

The Chair said that she was very assured by the report.

The Committee noted the report.

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

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

It was noted that all actions within the plan were progressing with no ideas identified as not being able to be achieved.

The Chair noted that the original target date for the publication of the updated Management of Sexual Relationships involving in patients in mental health wards was March 2019 but it had only been circulated for consultation in July 2019.

The Director of Nursing and Governance explained that the delay to the publication of the updated policy was because the Trust was keen to engage with patients and it had taken longer than anticipated to get real patient engagement. The Director of Nursing and Governance confirmed that the updated policy would be submitted to the September 2019 meeting of the Policy Scrutiny Group for approval.

The Chief Executive said that sexual safety on mental health and learning disability wards along with prone restraints were important issues for the Trust. The Chief Executive proposed that the Committee receive update reports on the Trust's performance.

Action: Director of Nursing and Governance

The Committee noted the report.

5.7 Funding to Improve Working Conditions for Junior Doctors

The Medical Director presented the paper and highlighted that in September 2018, the Secretary of State had announced that he was making available to NHS Trusts in England £10m to be spent in agreement with junior doctors locally to improve the working conditions of junior doctors.

It was noted that the Trust was an early adopter of the British Medical Association's Fatigue and Facilities Charter, had been allocated a higher amount of funding (£60,833.33) to improve working conditions for junior doctors in the Trust.

The Medical Director said that the Trust's aim was to spend the entire grant within the current financial year, however, given the tendering requirements, it may be necessary to carry forward any unspent money into the next financial year.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts Report 2019-20 Final Report

The Chair commented that this was the first iteration of the Quality Accounts Report 2019-20 and clearly set out how the final report would be structured.

The Chief Financial Officer pointed out that a number of the True North metrics had been reset from April 2019 and therefore it was expected to take between six to nine months to deliver the new improved targets and in some case, it may not be possible to achieve the new performance targets.

David Buckle, Non-Executive Director said that he valued having an opportunity to review the development of the Quality Accounts quarterly rather than being presented with the complete document at year end.

Dr Buckle requested further information about the NHS Safety Thermometer. The Director of Nursing and Governance agreed to brief Dr Buckle.

Action: Director of Nursing and Governance

The Committee noted the report.

6.2 Clinical Audit Reports

The Medical Director presented the paper and reported that there were delays in national reporting which meant that unfortunately there were no clinical audit reports presented to the Committee at this meeting. It was noted that the meeting in November 2019 could potentially have seven Clinical Audit Reports (which included three local re-audit reports) to review.

The Chair noted that the same Clinical Audit Assurance Report had been presented to the July 2019 Audit Committee meeting. The Medical Director explained that the purpose of the paper was to update the Committee on the current status of the Clinical Audit plan.

The Chair asked the Medical Director whether he was concerned about the delay in publication of the national audits. The Medical Director explained that he was not overly concerned, but inevitably bunching up the publication of the national audits would impact on the workload of the small Clinical Audit Team of three whole time equivalent staff since managing the end to end process of national clinical audits in the Trust formed only part of their workload.

The Committee noted the report.

7.0 Clinical Excellence Awards Report

The Medical Director presented the paper and reported that nationally negotiated changes to the Clinical Excellence Awards Scheme for Consultants in 2018-20 awards rounds now required Trust Boards to receive a formal report on the process and its outcomes.

The Chair reported that she was currently the Non-Executive Director on the Trust's Clinical Excellence Awards Committee and would need to be replaced.
The Chief Executive requested that the Medical Director ask the Trust Chair to nominate a Non-Executive Director to replace Ms Lysons on the Clinical Excellence Awards Committee.

Action: Medical Director

The Committee noted the report.

7.1 Quality Assurance Committee – Annual Review of Effectiveness Report

The Company Secretary presented the paper and reported that overall the results of the Quality Assurance Committee's Annual Review of Effectiveness were very positive. The Company Secretary said that some of the comments reflected the challenges around the complexity of the Committee's work. It was also noted that some of the comments had queried whether four meetings per year were sufficient.

David Buckle, Non-Executive Director said that having been an Executive Director he recognised that there were occasions when there were natural tensions between Non-Executive Directors and Executive Directors. Dr Buckle pointed out that the role of Non-Executive Directors was essentially to provide "high challenge and high support".

The Chief Executive said that in his view, the Committee should focus its attention on discussing the key issues and spend less time on the detail of the update reports which were for noting and had already been through the Trust's governance processes.

The Chief Executive commented that he found chairing the Quality Executive Committee the most challenging of the Executive Committees because of the broad scope of its remit and that he managed the meeting time by focussing on the key reports.

David Buckle, Non-Executive Director said that he thought four meetings per annum was only manageable because the Trust was well-run and had effective governance systems and processes but pointed out that if performance slipped, there may need to be additional meetings.

The Chief Operating Officer suggested that rather than having an additional meeting, the Committee may wish to extend the time of the meetings.

The Chief Executive suggested that David Buckle, Chair Elect and the Director of Nursing and Governance discuss in advance of the meetings how best to structure the agenda order in order to ensure the Committee made the best use of its time.

Action: Chair Elect/Director of Nursing and Governance

The Committee reviewed the Terms of Reference. The Chair asked whether the Lead Clinical Director should be listed as a full member of the Committee.

The Chief Executive pointed out that the Committee was a sub-committee of the Trust Board and therefore its membership comprised of Board members.

The Chair thanked the Company Secretary for undertaking the Committee's Annual Review of Effectiveness.

The Committee:

A) Noted the report.

B) Agreed the proposed changes to the Committee's Terms of Reference which would be presented to the September Trust Board meeting for ratification

Update Items for Information

8.0 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.

It was noted that during the reporting period (6 May 2019 to 6 August 2019) there were two hours exception reports and there was one carried forward education exception report.

It was noted that the Guardians of Safe Working Hours had provided assurance to the Trust Board that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation.

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

The Committee noted the report.

8.1 Annual Infection, Prevention and Control Report

The Annual Infection, Prevention and Control Report had been circulated. The Director of Nursing and Governance said that it was disappointing that despite the Trust's flu vaccination campaign, the Trust had not met the 75% of all clinical staff receiving the flu vaccination (the Trust's performance was 66.56%).

The Chief Executive pointed out that it would never be possible to achieve 100% vaccination rates because around 20-25% of staff were highly resistant to being vaccinated and no campaign would change their minds.

David Buckle, Non-Executive Director acknowledged the challenges and said that it was important to continue to drive performance and increase the number of staff receiving the flu vaccination.

The Medical Director pointed out that the Trust's flu vaccination performance compared well with the national benchmarking data.

The Chief Executive said that the Trust Board would be kept informed about the steps the Trust was taking to encourage staff to receive the flu vaccination and would be updated about progress.

Action: Director of Nursing and Governance

The Committee noted the report.

8.2 Annual Safeguarding Report

The Annual Safeguarding Report had been circulated.

The Committee noted the report.

8.3 Place of Safety Annual Report

The Place of Safety Annual Report had been circulated.

David Buckle, Non-Executive Director noted that there were five incidents recorded during the year where someone was declined admission to the Place of Safety due to the Place of Safety being full and asked whether any of these patients suffered any clinical harm as a consequence.

The Director of Nursing and Governance explained that these patients would have been placed in an alternative Place of Safety for assessment, for example at the Royal Berkshire Hospital.

The Committee noted the report.

8.4 Annual Mental Health Act Report

The Annual Mental Health Act Report had been circulated.

The Committee noted that the Annual Mental Health Act Report had highlighted that there had been a modest increase in the number of patients detained compared with the significant rise in the previous year.

The Chief Executive said that it would be interesting to see if this was replicated nationally. It was noted that the Committee would also receive the national Annual Mental Health Act Comparator Report which would allow the Committee to identify any national trends and any areas where the Trust was an outlier.

Action: Director of Nursing and Governance

The Committee noted the report.

8.5 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held on: 13 May 2019, 10 June 2019 and 8 July 2019 were received and noted.

Closing Business

9.0 Standing Item – Horizon Scanning

The following items were identified as future agenda topics:

- Sexual Health and Safety on in-patient wards
- Single rooms and therapeutic environment at Prospect Park Hospital
- CAMHS sustainability
- Review of the True North Patient Safety Indicators
- Carers Strategy (six months' time)
- WestCall CQC Inspection Report
- Systems and Processes for gaining assurance around patient safety (highlighted in the Annual Review of Effectiveness)
- CPA – Trust Compliance when new Guidance was published

Action: Company Secretary

9.2. Any Other Business

The Chair congratulated David Buckle, Non-Executive Director on becoming the next Chair of the Committee when she stepped down from the Board on 31 October 2019.

On behalf of the Trust, the Chief Executive thanked Ruth Lysons for her diligent and effective chairing of the Committee.

The Chief Executive commented that chairing the Quality Assurance Committee was the most challenging of all the Sub-Board Committees because it covered such a board and complex range of issues.

The Chief Executive said that Ms Lysons had set a high standard and that she would be a hard act to follow.

The Chief Executive also pointed out that a well-functioning Quality Assurance Committee freed up the time for the Trust Board to have discursive meetings to discuss emerging strategy.

The Chief Executive's comments were echoed by the rest of the Committee.

9.3. Date of the Next Meeting

19 November 2019 at 10.00

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

Signed:-

Date: - 19 November 2019

Berkshire Healthcare
NHS Foundation Trust

Quality Assurance Committee Paoer

Date	21 August 2019
Title	**Learning from Deaths Quarter 1 Report 2019/20**
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	802 deaths were recorded on the clinical information system (RiO) during Q1 where a patient had been in contact with a trust service in the year before they died. Of these 90 met the criteria to be reviewed further. All 90 were reviewed by the executive mortality review group (first stage review) and the outcomes were as follows: • 33 were closed with no further action • 8 were classed as Serious Incident Requiring Investigation (SI) • 49 required 'second stage' review (using an initial findings review (IFR)/ Structured Judgement Review (SJR) methodology). During Q1, the trust mortality review group (TMRG) received the findings of 66 2nd stage review reports (detailed on p8), of which 11 related to patients with a learning disability (these are cases reviewed in Q1 and will include cases reported in previous quarters). **Lapse in Care** Of the 66 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 Q1. One lapse in care has been confirmed in Q1: This related to an inpatient suicide which occurred in October 2018 and the independent investigation was concluded through the SI process. **Learning from reviews and investigations** Themes identified from investigations during this quarter are: • Care Programme Approach (CPA) - There needs to be consideration of CPA

for all patients who require inpatient admission or CRHTT involvement and the rationale documented if CPA not deemed to be appropriate. The process for identifying the lead professional for clients not on CPA needs to be reviewed. The roles and responsibilities of the lead healthcare professional and responsibilities of other mental health practitioners involved needs to be clearly specified in care plans when clients are not on CPA. Safety plans need to be completed as part of the CPA framework

- Absence Cover - In November 2018, a Trust wide procedure for Absence Cover in CMHTs was introduced as a result of SI investigations identifying a need for guidance in this area of practice / caseload management. However, this continues to be identified as an issue in relation to mental health SIs closed in Q1 and work to embed this continues to be led by the Clinical Directors
- Supervision – 2 SIs in community mental health services identified on-going work is still required in relation to supervision to ensure that supervision includes a review of care coordinator's workload, staff well-being and record keeping.

Actions are being undertaken to address these main themes, these are detailed separately in the Q1 SI report.

Further Quality Improvements

In Q4 of 2018/19, we identified areas for further quality improvements in the trust Learning from Deaths process, detailed below is the progress in these 3 areas:

1. A Designated family liaison/ bereavement support member of staff. A number of the patient safety team staff have undertaken advanced training PABBS -Postvention: Assisting those Bereaved by Suicide. For those families affected by suicide, this additional counselling and support is now being offered; uptake and feedback will be monitored and improvements will be made accordingly.

2. Preparing for the introduction of the Medical Examiner (ME). The role of the medical examiner is to provide proportionate scrutiny to all non-coronial deaths. The medical examiner will be responsible for having oversight of all death certificates which are completed by BHFT staff; this will be a statutory requirement from March 2021 and notification of appointment of regional medical examiners is awaited. In preparation, a review of the current death certification process in the trust has been undertaken by the Head of Clinical Effectiveness. All six community health inpatient wards were visited and the death certificate books and counterfoils were reviewed. Areas for improvement have been identified and the following recommendations will be implemented:

- A clear process needs to be in place for the retention and administration of the certification books.
- A process for 2nd review / quality check of all certificates and counterfoils at time of completion should be implemented locally until we have a medical examiner in place.
- Quality of certification documentation was weaker in some wards and good practice needs to be shared with all ward doctors to ensure consistency.
- While we are setting up the ME system, we need to implement a governance process to link Medical Certification of Cause of Death (MCCD) with our mortality review process. This will involve quality assurance (through EMRG)

	and triangulation with Datix reporting of deaths/cause of death. • A Workshop involving relevant staff and clinicians who are responsible for the community health inpatient wards, to implement recommendations and have an understanding of the medical examiner process. 3. 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, the Head of Clinical Effectiveness attends these meetings and ensures that learning is shared and also bought back to the TMRG, this improvement action is now complete.
ACTION REQUIRED	The committee is asked to receive and note the Q1 learning from deaths report in order to provide assurance to the Trust Board that the Trust is complying with CQC and NHS Improvement requirements in respect of learning from deaths.

Table of Contents

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 and updated in March 2019.

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 'red flag' or concern is noted (as identified in our policy) we then review these deaths further. First stage review is through weekly review of Datix reported deaths by the Executive Mortality Review Group (EMRG). Second stage reviews (using IFR/SJR) are discussed at the monthly Trust Mortality Review Group (TMRG) 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. 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 (primary, secondary, community and social care) and inform national learning.

Following second stage review, any death where there is suspected to be a lapse in care which could have potentially contributed to the death of the patient would be escalated to a full investigation using a Root Cause Analysis (RCA) approach.

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

Definitions:

2nd stage 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 2019/20.

Figure 1.

	17/18 total	18/19 total	Q1 19/20	Q2 19/20	Q3 19/20	Q4 1920	YTD 19/20
Number of deaths seen by a service within 365 days of death	4381	3961	**802**				**802**
Total deaths screened (Datix) 1st stage review	307	320	**90**				**90**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	**49**				**49**
Total number of deaths investigated as serious incidents	32	40	**8**				**8**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	**1**				**1**
Number of Community Hospital Inpatient deaths (Including patients at the end of life)	123	144	**21**				**21**
Total number of deaths of patients with a Learning Disability	35	28	**11**				**11**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	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 Q1

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 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 Q1, 802 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.

	April to June 2019				
Figure 2	**A:0-17**	**B:18-65**	**C:66-75**	**D:Over 75**	**Grand Total**
Grand Total	**2**	**102**	**133**	**565**	**802**

.

4.2 Total Deaths Screened (1st stage 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. 90 deaths were submitted for review in Q1, slightly higher than the mean of 80 per quarter in 2018/19 (Figure B in Appendix 1 details the specific services).

These Datix notifications 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 90 deaths undergoing first stage review, 32 were closed with no further action required, 2 required more information, 49 were referred for 2nd stage review and 7 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 Q1. 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 and the bereavement booklet, with the opportunity to raise any concerns about the care provided to the patient..

6. 2nd Stage Reviews Completed

The purpose of the 2nd stage 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 illness.

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 66 (39 inQ4 of 2018/19) reviews have been received and considered by the group in Q1. Figure 3 details the service where the review was conducted. This increase in Q1 is due to a number of reviews from Q4 being received by the TMRG in Q1 of 2019/20.

Figure 3: Reviews Conducted in Q1

	Total Number	**Services**
April 2019	15	Westcall Out of Hours GP Service: 1 (complaint) Common Point of Entry: 2 Clozapine Clinic: 1 Older Peoples Mental Health: 2 (1 audit case) Community Inpatient Wards: 6 Community Nursing: 1 Specialist Nursing/Community Paediatrics: 1 Learning Disabilities: 1
May 2019	24	Mental Health Inpatients: 1 (complaint) Westcall out of hours GP 1 (complaint) Community Inpatients: 2 (1 complaint) Learning Disabilities: 5 Community Mental Health: 1 Community nursing: 7 Older adults mental health: 1 Criminal Justice & Liaison: 1 Heart Function service: 1 Inpatient End of life care: 4 (audit cases)
June 2019	27	Westcall out of hours GP:1 (complaint) Learning Disability: 5 Community Health Inpatient Ward: 9 (1x complaint) Older peoples Mental Health: 7 (2 audit cases) Community Nursing: 3 Community Mental Health: 1 Crisis Resolution and Home treatment team: 1

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

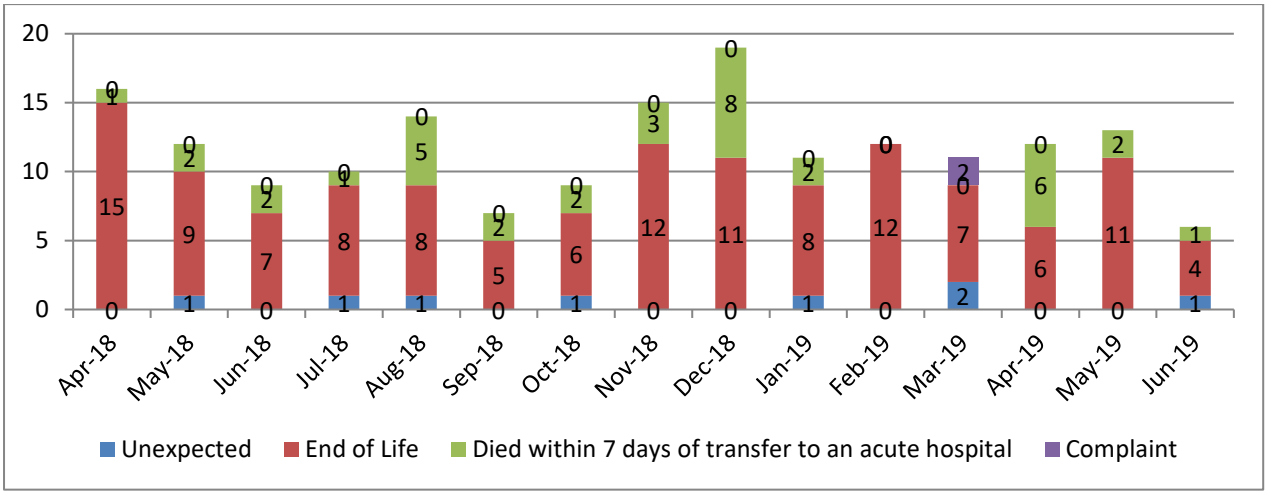
- Request further information (if required) from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service level learning and improvements

- 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 (including palliative care) on community health inpatient wards
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 4 details these.

Figure 4: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q1 31 (compared to 34 in Q4 of 2018/19) deaths in total were reported by the Community Inpatient Wards, of these 21 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.

10 deaths were unexpected (5 in Q4), of which 1 patient died on the community inpatient ward and 9 were transferred to an acute hospital. 10 2nd stage reviews were requested, 3 have been completed and closed at TMRG, 1 case has been escalated by TMRG for a full root cause analysis.

8. Deaths of Children and Young People
7 deaths were submitted as a Datix for 1st stage review in Q1, 5 of these were submitted by the Health Visiting teams where a baby was sadly born prematurely and subsequently died without leaving the acute hospital. All 5 cases were closed at EMRG 1st line review.

2 deaths were submitted where the child or young person had been in contact with the children's specialist nursing service in the year before their death. On death was unexpected with the child presenting to the acute trust very unwell and the other child was terminally ill and end of life care was being provided in the acute trust at the time of death. 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 Q1 the Trust Mortality Review Group (TMRG) reviewed a total of 11 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG

Of these 11 deaths reviewed, there was no identified lapse in care provided by Berkshire Healthcare.

Demographics:

Gender:

Female	4
Male	7

Age:

The age at time of death ranged from 20 to 77 years of age (median age: 60yrs)

Severity of Learning Disability:

Mild	1
Moderate	1
Severe	4
Not Known	5

Ethnicity:

White British	9
Other White	1
Asian Pakistani	1

Engagement with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability. Of the 11 deaths reported, 5 people's families were sent information and condolence cards. There has been 1 response received to date from those contacted in this quarter, no concerns were raised.

Of those who were not contacted, the rationale is provided below:

- 1 - the individual had no known family
- 2 - due to the extended time which had elapsed between the date of the person's death and the notification
- 2 - the individual had not been in receipt of learning disability services, therefore the information was not held by the service (LD alerts)
- 1 - The family member had left no postal address and was uncontactable by the phone number provided.

In each case where a decision had been made to refrain from contacting family, it was decided that contact would be more appropriately followed up through the LeDeR process.

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

In Q1, 8 deaths have been reported as serious incidents, figure 5details the service where the SI occurred.

Figure 5. Service (**Source Q1 Serious Incident Report)**	**Number**
Talking Therapies	2
Wokingham CMHT	2
WAM CMHT	1
West Berkshire CMHT	1
CRHTT West	1
CRHTT East	1
Total	**8**

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

Duty of Candour applied to 9 deaths in Q1 (8 SI, 1 review (RCA) following referral from TMRG).
All families have received a duty of candour letter, service phone call and offer of face to face meeting, 1 family has taken this up at this point in time. 2 families have requested on-going contact with the services but via their preferred method of communication (email and telephone). 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.

Process for Bereavement Support in the trust after Suspected Suicide

As part of the duty of candour process, families and carers are signposted to a range of support options for coping with a traumatic death or suspected suicide via the Help is at Hand resource, a copy of this is routinely provided.

The level of disruption to many aspects of life and functioning, and the debilitating effect of the trauma and grief, will be beyond what most people have experienced in their lives. Many people express fear and concern about how they are coping in terms of emotions, thinking and behaviour. One of the most effective ways of responding to any person bereaved by suicide is to provide information and education about grief, bereavement, and suicide bereavement in particular, as part of a counselling process. Educational approaches providing knowledge about the typical responses to suicide, and what is known about strategies for coping can have a powerful, healing and normalising effect.

Listening is the primary intervention along with understanding and responding to bereavement by suicide; Living memories; Exploring changes; Self-acceptance; Living with grief; Enablement and empowerment - Signposting, self-help, resources and further support;

The practitioners offering this additional support have undertaken advanced training PABBS -Postvention: Assisting those Bereaved by Suicide. The training is evidence-based theory-driven and has been informed by a three-year study, funded by the National Institute for Health Research (NIHR) Research for Patient Benefit Programme, which identified the vulnerability and perceived needs of those bereaved by suicide.

The opportunity for a further follow up and support from practitioners who have undertaken specialist training in support after suicide is now available for all families and carers who have been bereaved by suicide.

10.2 Lapse in Care

Of the 66 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 Q1.

One lapse in care has been confirmed in Q1: This related to an inpatient suicide which occurred in October 2018 and the independent investigation was concluded 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 stage review. Additional case review has been undertaken in the following areas and is reported to the TMRG:

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

The 2nd round of the National Audit of End of Life Care has started and all EOL inpatient deaths which occurred between April 2019 and June 2019 are currently being reviewed, in addition next of kin will have the opportunity to comment on the care received via an anonymous survey provided by the national team.

12.Learning from Deaths

The aim of the trust policy and process followed 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 areas of quality improvement identified in Q1

12.1 Themes and learning from serious incidents (SI)

Themes identified from investigations during this quarter are:

- Care Programme Approach (CPA) - There needs to be consideration of CPA for all patients who require inpatient admission or CRHTT involvement and the rationale documented if CPA not deemed to be appropriate. The process for identifying the lead professional for clients not on CPA needs to be reviewed. The roles and responsibilities of the lead healthcare professional and responsibilities of other mental health practitioners involved needs to be clearly specified in care plans when clients are not on CPA. Safety plans need to be completed as part of the CPA framework
- Absence Cover - In November 2018 a Trust wide procedure for Absence Cover in CMHTs was introduced as a result of SI investigations identifying a need for guidance in this area of practice / caseload management. However, this continues to be identified as an issue in relation to mental health SIs closed in Q1 and work to embed this continues to be led by the Clinical Directors
- Supervision – 2 SIs in community mental health services identified on-going work is still required in relation to supervision to ensure that supervision includes a review of care coordinator's workload, staff well-being and record keeping.

Actions are being undertaken to address these main themes, these are detailed separately in the trust Q1 SI report.

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

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

In Q1, there was evidence of good communication and information sharing across services, and externally with other organisations, with appropriate escalation and monitoring when there were concerns regarding an individual's physical health / wellbeing. There was also good evidence that there was on-going communication with family members as well as consideration of their emotional wellbeing through provision of chaplaincy services.

Trust staff continue to attend LeDeR review meetings and ensure that national learning is discussed and actioned through the TMRG.

13. Further Quality Improvements

In Q4 of 2018/19 we identified areas for further quality improvement in our Learning from Deaths process, detailed below is the progress in these 3 areas:

1. Designated family liaison/ bereavement support. Staff from the patient safety team have undertaken advanced training PABBS -Postvention: Assisting those Bereaved by Suicide. For families bereaved through suicide, this additional counselling and support is now being offered, uptake and feedback will be monitored and improvements made as required.

2. Preparing for the introduction of the Medical Examiner. The role of the medical examiner is to provide proportionate scrutiny to all non-coronial deaths. The trust is working towards having this in place by March 2021.The medical examiner will be responsible for oversight of all death certificates which are completed by BHFT staff. A review of the current Trust death certification process has been undertaken by the Head of Clinical Effectiveness. Death certificates are issued by the doctor responsible for the care of the patient who has died on our Community Health Inpatient Wards, in most cases these are for expected end of life deaths. In some cases the patient's own GP may complete the certificate where a patient dies very shortly after admission. If the death was unexpected and the cause of death was not clear, then it would be discussed with the coroner's office.

   All six inpatient wards were visited and the death certificate books and counterfoils were reviewed. A number of areas for improvement were identified and the following recommendations were made:

   - A clear process needs to be in place for the retention and administration of the certification books.
   - A process for 2nd review / quality check of all certificates and counterfoils at time of completion should be implemented locally until we have a medical examiner in place.
   - Quality of certification documentation was weaker in some wards and good practice needs to be shared with all ward doctors to ensure consistency.
   - While we are setting up the ME system, we need to consider a governance process such that MCCD links up with our mortality review process. For quality assurance (through EMRG) and triangulation with Datix deaths/cause of death.
   - A Workshop involving relevant staff and clinicians who are responsible for the wards to take the recommendations and medical examiner process forwards.

3. 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, the Head of Clinical Effectiveness attends these meetings and ensures that learning is shared and also bought back to the TMRG.

14. Conclusion

Of the 66 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 Q1.

One lapse in care has been confirmed in Q1: This related to an inpatient suicide which occurred in October 2018 and the independent investigation was concluded through the SI process.

Appendix 1

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

	April	**May**	**June**	**Total**
Nursing episode	146	113	78	337
Community health services medical	34	40	19	93
Old age psychiatry	27	29	16	72
Palliative medicine	27	17	9	53
Dietetics	17	20	8	45
Rehabilitation	17	8	10	35
Podiatry	18	11	1	30
Adult mental illness	8	12	6	26
Physiotherapy	11	10	4	25
Speech and language therapy	7	7	2	16
Cardiology	7	4	3	14
Intermediate care	7	3	3	13
General medicine	4	7	2	13
Respiratory medicine	5	4	3	12
Genito-urinary medicine	3	4	4	11
Geriatric medicine	2	1		3
Clinical psychology		1	1	2
Liaison psychiatry	1			1
Occupational therapy			1	1
Grand total	341	291	170	802

Figure B

Division	**Service**	**Total**
CHS East	Community Hospital Inpatient	4
CHS East	District Nursing	2
CHS East	Tissue Viability Nurses	1
CHS West	Community Hospital Inpatient	27
CHS West	Community Matron	3
CHS West	District Nursing	6
CHS West	Integrated Care Home Service	1
CHS West	Intermediate Care	2
CHS West	OOH GP	1
CYP&F	CCN / SSN	1
CYP&F	Health Visiting	6
MH East	CMHT	3
MH East	CMHTOA	1
MH West	CJLD	3
MH West	CMHT	4
MH West	CMHTOA	3
MH West	CPE	2
MH West	CRHTT	3
MH West	CTPLD	11
MH West	Mental Health Liaison Service	1
MH West	Reading CMHT	1
MH West	Talking Therapies	2
MH West	CMHTOA	1
Southampton	Health Visiting	1
Total		90

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	21 August 2019
Title	Guardian of Safe Working Hours Quarterly Report (May to August 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
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 6th May to the 6th August 2019. Since the last report to the Trust Board we have received two hours exception reports and we carried forward one education exception report. 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.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

Berkshire Healthcare NHS Foundation Trust

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

This report covers the period 6th May to the 6th August 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 6th May to the 6th August 2019. Since the last report to the Trust Board we have received two hours exception reports and we carried forward one education exception report.

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

Introduction

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

High level data

Number of doctors in training (total): 32 (FY1 – ST6)

Included in that figure is 1 LAS (Locum Appointment for Service) and 1 MTI (Medical Training Initiative).

Number of doctors in training on 2016 TCS (total): 32

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	1	2	3	0
Dentistry	0	0	0	0
Sexual Health	0	0	0	0
Total	1	2	3	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	0	0	0
CT	1	0	1	0
ST	0	2	2	0
Total	0	2	3	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	1	2	3	0
Dental	0	0	0	0
Total	1	2	3	0

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

In this period we have received two hours & rest exception reports totaling an extra three hours worked over and above the trainees' work schedules. 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 two hours and rest exception reports relate to one trainee, staying late an extra hour and a half on two occasions to complete clinical 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.

The one education exception report concerned missing an hours training in Oxford in order to participate in the OOH rota. No action was required and changes to the rota pattern outlined below should mitigate this in future.

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 6th May to the 6th August 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
	87	87	55	32	0	839.5	839.5	575.5	264	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	55	55	34	21	0	527.5	527.5	353	174.5	0
Sickness	32	32	21	11	0	312	312	222.5	89.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	87	87	55	32	0	839.5	839.5	575.5	264	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 cover the gap on the rota. Sickness was two doctors on long term sick leave and the usual ad-hoc illness.

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, led on changes to the format of the meeting with greater leadership from the trainees themselves.

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.

As raised in the last report the junior doctors OOH rota pattern has been reviewed and a new pattern is in place from August 2019. This pattern has been agreed with the junior doctors forum and it is hoped will significantly improve doctors work/life balance in that it reduces the pattern to 1:10 from the current 1:9, increases the amount of time spent in their core service and reduces the amount of hours worked out of hours, whilst retaining the same level of coverage as the current rota.

An issue has been raised in the forum about the availability of a range of food at weekends for junior doctors working, including suitable options for vegetarians. We understand that currently there is only a vending machine. The trainee body will be looking to work with the trust on potential solutions to this.

Issues arising

Exception reporting has returned to previous levels. 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. However, it is possible that there is under-reporting of small excess hours worked. We continue to ask trainees about any obstacles for this. Following recent feedback about the exception reporting system, we will reflect on whether there are any ways to further simplify it, but we believe it to compare favourably in this regard to other systems elsewhere.

We have reminded trainees to make sure they take breaks as per their contract. They can exception report if this does not occur.

Actions taken to resolve issues

Next report to be submitted November 2019

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. 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.

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

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

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

Document Control

Version	Date	Author	Comments
1.0	25.7.12	John Tonkin	Initial draft
2.0	31.7.12	John Tonkin	Amendments following Exec Discussion on 30 July 2012
3.0	20.8.12	John Tonkin	Amendments following Exec Discussion on 16 August 2012
4.0	11.9.12	John Tonkin	Post Board approval – 11 September 2012
5.0	5.4.14	John Tonkin	Post review with Director of Nursing & Governance
6.0	3.6.14	John Tonkin	For Board approval post QAC discussion 22 May 2014 APPROVED AT JUNE 2014 Board meeting
7.0	21.2.17	Julie Hill	Updated to include the Committee's new responsibilities in relation to receiving the Guardians of Safe Working reports and providing oversight of the Trust's mortality review process. Approved at July 2017 Trust Board meeting
8.0	July 2018	Julie Hill	Minor changes - approved by the September 2018 Trust Board meeting
9.0	June 2019	Julie Hill	Minor changes

This document is unrestricted.

Quality Assurance Committee - Terms of Reference

1. Constitution

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

2. Membership

The Committee's membership will comprise:

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

The Board will nominate the Committee Chair from amongst the Non-Executive Director members of the Committee. In the Chair's absence, another Non-Executive Director will chair the Committee.

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

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

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

3. Frequency of Meetings

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

4. Purpose

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

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

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

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

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

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

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

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

5. Reporting

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

The minutes of the Quality Assurance Committee's meetings will be received by the Trust Board along with the quarterly Learning from Deaths and Guardians of Safe Working Hours for Doctors and Dentists in training reports. The Committee will also refer the Quality Concerns report to the In Committee Trust Board meeting. The Chair of the Committee will provide an oral report to the next convenient Trust Board after each Committee meeting. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board.

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

6. Duties

a. Governance, internal control and risk management

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

b. Audit

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

To receive summary reports of national clinical audits.

c. Quality and safety

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

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

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

To receive and consider reports from the Health Service Ombudsman

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

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

To receive reports on national mandated clinical audits conducted within the Trust.

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

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

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

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

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

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

7. Reporting to the Board

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

Version 98 Approved by Trust Board in ~~September 2018~~ September 2019

For review: July 20~~19~~20

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 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 10 September 2019

EXECUTIVE REPORT

1. Never Events

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

Executive Lead: Debbie Fulton, Director of Nursing and Governance

2. Integrated Care Systems Five Year Plans

All Integrated Care Systems are required by NHS England/NHS Improvement to submit five year plans by the end of October 2019. The plans are required to demonstrate how the Integrated Care Systems will implement the NHS Long Term Plan, achieve financial stability as well as highlight the local areas identified for transformation. The time scales are very short and the Director of Strategy and Corporate Affairs will provide an update at the meeting with regard to the timescales for completion and sharing. A briefing paper from NHS Providers is attached at appendix 1.

Executive Lead: Julian Emms, Chief Executive

3. Independent Chair Appointed to the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System

David Clayton-Smith has been appointed to the role of Independent Chair of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (BOB ICS).

David is currently the Independent Chair of the Epsom and St Helier Improving Healthcare Together 2020-30 Board and the Chair of the Kent, Surrey and Sussex Academic Health Sciences Network (AHSN).

He has extensive experience in Board level roles within the NHS, having formerly been Chair of the East Sussex Healthcare NHS Trust (2016 and 2019), Chair of NHS Surrey for three years from 2010 and Chair of NHS Sussex between 2012 and 2013.

David is also a board member and Treasurer of Fairtrade International. He is director and co-founder of Andrum Consulting which specialises in supporting entrepreneurial businesses.

Throughout his career, David has held board-level positions in major blue-chip businesses, latterly as Commercial Director of Halfords and Marketing Director for Boots the Chemist.

Executive Lead: Julian Emms, Chief Executive

4. Trust Accreditation by HIMSS (Health Information and Management System Society) EMRAM (Electronic Medical Records Adoption and Maturity) at Prospect Park Hospital

As part of our Global Digital Exemplar programme accreditation, the Trust is required to achieve HIMSS EMRAM stage 5, the current national average for HIMSS EMRAM in the United Kingdom is stage 2.6 (of those assessed).

HIMSS (Health Information and Management System Society) is an internationally recognised analytics organisation which assesses health organisations' level of digital capability, and importantly, the level of digitally enabled clinical safety functions. The EMRAM (Electronic Medical Records Adoption & Maturity) assessment is an 8 stage (0-7) assessment requiring each stage to be passed before the next may be achieved.

Our accreditation is a significant achievement supported by mature use of RiO at Prospect Park Hospital, alongside implementation of electronic prescribing and patient observations systems, enhancing patient safety. The Trust is the first mental health Global Digital Exemplar to achieve HIMSS EMRAM stage 5 and this would not have been possible without the support and engagement of the Prospect Park Hospital clinical and management teams.

Executive Lead: Alex Gild, Deputy Chief Executive and Chief Financial Officer

5. Appointment of Director of Nursing and Governance

Debbie Fulton was appointed Director of Nursing and Governance on 29 July 2019. Debbie had been acting up into the role since December 2018 following the retirement of Helen Mackenzie.

Executive Lead: Julian Emms, Chief Executive

6. Retirement of the Director of Strategy and Corporate Affairs

Bev Searle, Director of Strategy and Corporate Affairs is retiring in December 2019. Bev has made an enormous contribution both to the NHS and to the Trust over many years. The Trust has launched a national recruitment campaign to appoint a new Director of Strategy and Corporate Affairs.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
September 2019

NHS Long Term Plan Implementation Framework

The NHS Long Term Plan (the long term plan), published in January 2019, set out a number of ambitions for ensuring the NHS is fit for the future, and consolidated the expectation that local partners would increasingly plan and work collaboratively within Sustainable Transformation Partnerships (STPs) and Integrated Care Systems (ICSs). The NHS Long Term Plan Implementation Framework (the implementation framework) published today, underpins the long term plan and requires system partners (within both STPs and ICSs) to create five-year strategic plans by November 2019 covering the period 2019/20 to 2023/24. The Implementation Framework sits alongside NHS England's recently published briefing Designing integrated care systems (ICSs) in England

This briefing summarises the implementation framework. It is divided into key sections of System Development, LTP Delivery, Service Transformation, Workforce, Digital, Funding and Financial Planning, Next Steps, and NHS Providers view.

Key points

- The implementation framework sets out the expectation that STPs and ICSs create five-year strategic plans by November 2019, covering the period 2019/20 to 2023/24. These plans should be based on realistic workforce assumptions and deliver the commitments in the long term plan
- The national bodies will use the aggregate assumptions within system plans to inform a national implementation plan to be published by the end of the calendar year. This will enable NHS England to cross check collective resourcing assumptions against the outcome of the Government's Comprehensive Spending Review, particularly with regard to the funding envelopes for capital, education and training, public health and social care once they are confirmed
- The implementation framework makes clear that each system plan will be unique as systems will have substantial freedoms to respond to local need and prioritise the pace of delivery for the majority of commitments However it also states that some commitments are 'critical foundations' for service transformation and system development and that systems will need to demonstrate plans for organisational financial recovery
- The implementation framework clearly asks STPs to demonstrate how they will progress against the maturity matrix to become a 'developing ICS' in addition to delivering the commitments in the long term plan
- Indicative and targeted funding allocations to deliver commitments within the long term plan over the next five years, are outlined in Annex A.

System Development

The implementation framework states that STPs will be required to show in their plans how they will develop to ICS level by April 2021, as set out in NHSE/I's recently published guidance on Designing integrated care systems (ICSs) in England. This document includes the 'maturity matrix' against which system partners can assess their progress, and the freedoms and flexibilities which could be awarded to mature systems. We provide a summary of this document and our view in our recent briefing.

In order achieve ICS status, STPs must satisfy the requirements in the 'Maturing ICS' column of the maturity matrix, particularly;

- Collaborative and inclusive multi-professional system leadership, partnerships and change capability, with a shared vision and objectives including an independent chair
- An integrated local system, with population health management capabilities which support the design of new integrated care models, strong primary care networks (PCNs) s and integrated teams and clear plans to deliver the service changes set out in the long term plan
- Developed system architecture, with clear arrangements for working effectively with all partners and involving communities as well as strong system financial management and planning including a way forward for streamlining commissioning and plans for meeting the agreed system control total and moving towards system financial balance
- A track record in delivering nationally agreed outcomes and addressing unwarranted clinical variation and health inequalities
- A coherent and defined population, where possible contiguous with local authority boundaries.

ICSs' should focus on delivering the remaining commitments of the long term plan and increased service transformation.

The implementation framework also asks systems to set out how they see the provider and commissioner landscape developing and references further important documents yet to be published by NHSE/I:

- Guidance for provider groups being published later in 2019
- A new 'fast track' approach to assessing transactions for groups in the latter part of 2020
- The Integrated Care Provider Contract during summer 2019.

Primary Care Networks (PCNs)

The implementation framework states that by July 2019 all of England will be covered by PCNs, supported by almost £1.8bn by 2023/24 linked to clear deliverables, as set out in the five-year framework for GP contract reform.

During 19/20, PCNs will implement a plan to develop further including the requirement to select and progress specific projects to improve care for their population, driven by collaboration, giving examples of anticipatory care requirements with community services, enhanced health in care homes, structured medication review requirements for priority groups, personalised care and early cancer diagnosis support.

The implementation framework outlines previously announced funding allocated to PCNs, and reconfirms commitments made in the long term plan, while reiterating the requirement for PCNs to collaborate with other system partners.

Long Term Plan Delivery

The implementation framework makes clear that systems will need to deliver all the commitments in the long term plan but that systems can prioritise how this will be achieved according to local need. The document separates more urgent deliverables within the long term plan, or 'foundational elements' (described in chapters 2 and 3), from the less urgent 'wider service transformations' (described in chapters 4 and 5), including prevention (smoking, obesity, alcohol, air pollution and antimicrobial resistance), maternity and neonatal services, services for children and young people, learning disabilities and autism, cardiovascular disease, stroke care, diabetes, respiratory disease, research and innovation, genomics, volunteering and wider social impact (see also: Annex D). For each of these areas, the framework outlines key long term plan commitments that should be addressed in system plans, funding that will be made available (with further detail in Annex A) and in most instances, further information detailing national support on how to achieve these goals.

Service Transformation

Transformed out-of-hospital care and fully integrated community-based care

The framework states that in terms of service transformation, at a minimum, system plans should focus on four things:

1. Meeting the new funding guarantee
2. Supporting the development of PCNs
3. Improving the responsiveness of community health crisis response services to deliver the service within two hours of referral and reablement care within two days of referral
4. Creating a phased plan of the specific service improvements and impacts they will enable primary and community services to achieve, year by year, taking account of the national phasing of the new five-year GP contract.

This part of the plan must ideally be agreed with community providers and other care providers, and PCN clinical directors. It should also be subject to dedicated discussion at all Health and Wellbeing Boards.

Meeting the new funding guarantee

For each of the four years from 2020/21 to 2023/24, system plans must set out, indicatively, how they are going to meet their portion of the new primary medical and community health service funding guarantee of a £4.5bn real terms increase in 2023/24 over 2018/19 planned spend. This equates to a £7.1bn cash increase and covers primary medical, community health and CHC spend. Every region must deliver its share of the additional funding to the frontline from April 2020 onwards; therefore every system will have to agree its share with the regional teams and use that figure to inform its plans In In 2023/24, the funding guarantee will directly apply to every ICS without exception.

Systems should do this openly and in consultation with their community providers and PCN clinical directors. As they do this, systems will need to ensure they fully honour the GP contract entitlements over and above existing baseline spend. They will need to show the distribution of funding across primary care, community health and CHC services.

Supporting PCNs

Systems should prioritise helping PCNs build constructive relationships with their community partners. Dedicated national funding will be made available, as set out in the paper *Implementing the NHS long term plan in primary and community services* discussed at the NHSE/I board meetings in common today.

Strategic priorities for community services

The four strategic priorities for community services are:

1. Delivering improved responsiveness of crisis response within two hours and reablement care within two days;
2. Providing 'anticipatory care' jointly with primary care (a joint enterprise with GP practices as part of PCN delivery);
3. Supporting primary care to developed enhanced health in care homes (a joint enterprise with GP practices as part of PCN delivery);
4. Building capacity and workforce to do these three things, including by implementing the Carter report and using digital innovation.

System plans must set out an initial view of the services improvements they are aiming to achieve over the next four years. Systems will need to take into account the phasing of the new GP contract including the seven new national service specifications and full implementation of the final years of the pre-existing GP Forward View commitments. The schedule of improvements must be agreed with community providers and PCN clinical directors and be linked to meeting the new funding guarantee.

Reducing pressure on emergency hospital services

System plans should show how local urgent and emergency care services will continue to develop to provide an integrated network of community and hospital based care. Where systems can reduce the pressure on their emergency services they will benefit from a financial, capacity and staffing 'dividend' that can be reinvested in local priorities. Learning from the pilot sites testing new standards under the Clinical Review of Standards will be considered before any changes are recommended for wider roll out.

Giving people more control over their own health and more personalised care

Systems will be expected to set out how they will use the funding available to them to implement all six components of the NHS comprehensive model for personalised care including the employment of social prescribing link workers by PCNs.

System plans should reflect NHSE/I's commitment to increase its contribution to funding children's palliative and end of life care services including children's hospices, by match-funding CCGs where they commit to increase their local investments.

Digitally-enabling primary care and outpatient care

By the end of July 2019, NHSE/I will confirm targeted funding for health systems as part of a programme to deliver digital first primary care. Selected sites in each region will test and validate the digital first primary care approach. Regional teams and systems will support subsequent bids for funding during summer 2019. Systems should set out in their plans how they will increase the use of digital tools to transform outpatient services and provide more options for virtual outpatient appointments. Systems should identify which specialties they will prioritise as they work towards removing up to a third of face-to-face outpatient visits a year.

Better care for major health conditions

Improving cancer outcomes

By 2023/24 over £400m of additional funding will have been distributed to Cancer Alliances on a 'fair shares' basis to support the ambitions in the Long Term Plan. Targeted funding will also be available to support the development and spread of innovative models of early identification of cancer.

The implementation framework reiterates the priority interventions for improving cancer outcomes set out in the Long Term Plan and provides an update on ambitions for the development and spread of innovative models for early diagnosis. Targeted funding will be available to support these models, which includes:

- From April 2020, lung health checks, already being established in ten areas of the country, will be continued to be rolled out across the country in areas with higher mortality rates
- By October 2019, NHSE/I will agree the next steps for Rapid Diagnostic Centres (RDCs), the first round of which are currently being implemented.

Improving mental health services

Funding to deliver the commitments set out in the Five Year Forward View for Mental Health and the Long Term Plan will be available via a mix of CCG baseline allocations and transformation funding available over the five-year period. System plans must now set out how they will meet this mental health investment standard and use the additional funding. This includes how they will deliver against the patient and carers race equality framework which NHSE/I are currently developing.

All appropriate specialised mental health services and learning disability and autism services will be managed through NHS-led provider collaboratives over the next five years. NHS-led provider collaboratives will become the vehicle for rolling-out specialist community forensic care.

The specialised commissioning mental health budget will be increasingly devolved to lead providers for adult low and medium secure mental health services, CAMHS Tier 4 services and adult eating disorder inpatient services. NHS-led provider collaboratives will be able to reinvest savings they make in improving services and pathways.

Growing CCG allocations across the five-year period are available to systems to stabilise and expand core adult and older adult community teams for adults and older adults with severe mental health illnesses. This includes delivering against adult and children and young peoples' community access standards once agreed, services for people with specific and complex needs for people with a diagnosis of 'personality disorder', Early Intervention in Psychosis (EIP), adult eating disorders, and mental health community rehabilitation. In addition, all areas will receive a fair share of transformation funding from 2021/22 to 2023/24 to deliver these services in new models of care integrated with PCNs.

The implementation framework provides more specific detail on the priority areas that were set out in the long term plan, including funding arrangements. In addition to CCG baseline funding all local areas will receive an additional fair share funding allocation to support these nationwide mental health priorities:

- 345,000 additional children and young people (CYP) aged 0-25 will be able to access support via NHS-funded mental health services (in addition to the Five Year Forward View for Mental Health's commitment to have 70,000 additional CYP accessing NHS Services by 2020/21)
- Expansion of access to specialist community perinatal mental health services in 2019/20;
  By 2020/21 there will be 100% coverage of 24/7 adult crisis resolution and home treatment teams operating in line with best practice
  The continued expansion CYP mental crisis services so that by 2023/24 there is 100% coverage of 24/7 crisis provision for CYP which combines crisis assessment, brief response and intensive home treatment functions
  The development of local mental health crisis pathways including a range of complementary and alternative services so that by 2023/24 there is 100% roll out across the country.

Further funding allocations will be made to individual systems in consultation with the regions for:

- Salary support for IAPT trainees (approximately 60% of salary), will be available from 2019/20 to all areas in accordance with the number of trainees recruited
- Development of school or college-based Mental Health Support Teams (MHSTs) in all regions, which will contribute to the additional 345,000 CYP access figure.

Detail of the funding available for each of these initiatives and allocations to individual systems will be decided through the five-year planning process.

Targeted funding will also be available to specific sites for a range of smaller initiatives and pilots. In addition to those described in the long term plan, this includes:

- Funding for the development and testing of maternity outreach clinics in 2020/21 and 2021/22 ahead of national roll-out
- Funding to pilot new models of integrated primary and community care for adults and older adults with sever mental illnesses in 2019/20 and 2020/21

- Developing a hub and spoke model for problem gambling from 2019/20
- Completing the piloting of Specialist Community Forensic Care and women's secure blended services by 2020/21.

Shorter waits for planned care

Systems need to set out how they will expand the volume of planned surgery year-on-year, cut long waits, and reduce the size of waiting lists over the next five years. Systems should confirm they are continuing to provide patients with a wide choice of options for quick elective care, including expanding provision of digital and online services.

Systems will ensure that no patient will have to wait more than 52-weeks from referral to treatment (RTT). They will also need to implement a planned NHS-managed choice process across the country for all patients who reach a 26-week wait, starting in areas with the longest waits and rolling out best practice through a combination of locally established targeted initiatives and nationally-driven pilots.

By 2023/24, all patients should have access to First Contact Practitioners (FCP), providing faster access to diagnosis and treatment for people with MSK conditions and more effective support for self-management, in line with the updated FCP specification. Mature systems will be expected to achieve a faster pace of mobilisation. Systems should also set out how they will expand access to other MSK support services, including via digital and online routes.

Systems will be supported through national improvement and clinical improvement programmes, including GIRFT and NHS RightCare.

Workforce

The implementation framework reiterates the key messages of the interim NHS People Plan published earlier this month, highlighting four priority areas for systems to address in workforce planning:

- Leadership and culture – A key focus of the interim People Plan, systems will be asked to establish the cultural values and behaviours expected from senior leaders and create a single talent management process to be used across the footprint
- NHS as the best place to work – The framework highlights the need for systems to set BME representation targets for their leadership teams and broader workforce by 2021/22 and respond to the new Workforce Disability Equality Standard, while doing more to improve staff health and wellbeing and enable flexible working
- Workforce transformation – The framework emphasises the importance of a holistic approach to staff numbers, calling for "more people, working differently". System plans should address:
    - planned workforce growth in different staff groups (taking efficiency plans into account);
    - plans for improving retention, international recruitment and use of the apprenticeship levy; and,

- workforce efficiency plans (within wider efficiency and productivity strategies), including changes in skills mix, reductions in sickness absence and "better use of scientific and technological innovation".

- Workforce devolution – As part of the new operating model for the workforce outlined in the interim People Plan, systems are being asked to describe how they will develop capacity, capability, governance and ways of working to enable more workforce activity to take place at ICS level. This will be supported by better sharing of data between HEE, systems and other arms-length bodies.

The implementation framework also sets out some assumptions for pay growth, at 2.1% (outside the AfC pay deal) per year through to 2023/24. This level is consistent with the pay rises just announced within the new junior doctor contract.

Digital

Systems will need to produce digital strategies and investment plans that describe how digital will support wider transformation plans. In their strategies systems must describe:

- How and when organisations will achieve a 'defined minimum level of digital maturity'
- How they will adopt global digital exemplar blueprints
- How they will adhere to controls and use approved commercial vehicles such as the Health System Support Framework to ensure technology vendor and platforms comply with national standards

NHSX will ensure the NHS has clear guidance and support to accelerate this digital provision. The priority will defining and mandating standards, which systems will need to comply with. These include:

- By 2021 all systems to be 100% compliant with cyber security standards, including migration to Windows 10 by June 2021
- By 2021/22 all NHS organisations will have a chief clinical information officer (CCIO) or chief information officer (CIO) on the board
- Ensure patients and authorised carers can access personal healthcare records.

Access to central funding (both revenue and capital) to support these strategies will be managed and coordinated by regional teams. ICSs and STPs will be expected to establish an 'affordable and realistic' pipeline of digital investment in each region within the funding enveloped available to them. Regional CCIOs along with regional digital directors of digital transformation will ensure investment is directed towards national strategic programmes.

Funding and financial planning

Five year CCG allocations have already been set for the period to 2023/24. In addition to this, systems will receive funding allocations on an indicative, 'fair shares' basis, to support systems meet their long term plan commitments for mental health, primary medical and community services, cancer and some other commitments. Access to this 'faire share' funding will be conditional upon systems having strategic plans

agreed with their regional teams. More mature systems will have greater autonomy over how additional resources can be used. Indicative allocation for this funding will be communicated alongside the implementation framework.

On top of the CCG allocations and 'fair share' system allocations, further funding will be made available to test specific long term plan commitments where a general distribution is not appropriate. This targeted funding will be used to support the delivery of various elements including: mental health, primary medical and community services, technology, cancer, cardiovascular disease, stroke, respiratory, children and young people and maternity. Access to this funding will be communicated at a future date.

Financial requirements

System plans will be expected to demonstrate how they will meet various commitments linked to the long term plan. These include:

- Plans must demonstrate how systems will meet the government's five financial tests set out in the long term plan. These include: returning to financial balance; achieving cash-releasing productivity growth of at least 1.1% (with an additional 0.5% for providers in deficit); reducing growth in demand for care through integration and prevention; reducing variation; and making better use of capital investment. Financial recovery plans will be required for each NHS organisation not in financial balance
- The long term plan committed national investment worth £4.5bn a year real terms (£7.1bn cash) for primary medical and community health services. System plans must set out how they will increase spending in these areas, increasing overall CCG spending plus additional allocations
- The long term plan also committed to a new ring fenced mental health local investment fund worth £2.3bn year by 2023/24. Plans need to set out how CCG spending will meet the requirement of the mental health investment standard, with additional funding spent on top of this growth
- System plans will need to set out how they will use funding to implement all six components of the NHS Comprehensive Model for Personalised Care
- Plans should identify specialties they wish to prioritise virtual outpatient appointments
- Selected sites will test and validate digital first primary care innovations. Regions will work with systems to identify accelerator sites and bid for funding
- NHS-led provider collaboratives will roll out specialist community forensic care, with specialised commissioning mental health budgets becoming increasingly devolved directly to lead providers
- Activity plans should set out how systems will use the increase in their allocations to improve the volume of elective treatments year-on-year, cut long-waits and reduce the size of the waiting list. They also need to set out how digital tools will transform outpatients, removing up to a third of face-to-face outpatient visits.

Financial assumptions for strategic plans

To aid systems with their plans, the framework sets out a number of financial assumptions for the years ahead. National tariff prices are expected to rise by 1.3% in 2020/21 and 2021/22, and then 0.9% in 2022/23

and 2023/24. These assumptions are for planning purposes so are subject to change, following tariff engagement and consultation process. Some of the core assumptions are included below:

Core tariff assumptions

Element	2020/21	2021/22	2022/23	2023/24
Agenda for change (AfC) pay deal	2.9%	0.7%		
Pay and mix effects - AfC	n/a	2.1%	2.1%	2.1%
Pay and mix – other HCHS workforces	2.1%	2.1%	2.1%	2.1%
Tariff drugs	0.6%	0.6%	0.6%	0.6%
Revenue consequences of capital	1.8%	1.9%	2.0%	2.0%
Other operating costs	1.8%	1.9%	2.0%	2.0%
Weighted inflation	2.4%	2.4%	2.0%	2.0%
Efficiency factor	-1.1%	-1.1%	-1.1%	-1.1%
Tariff uplift	**1.3%**	**1.3%**	**0.9%**	**0.9%**

Clinical Negligence Scheme for Trust (CNST) contributions are expected to grow by 10.5% on average across the sector during this period. Systems should assume that replacement funding for MRET is available on the same basis and with the same financial distribution as was agreed in 2019/20. The distribution funding in 2020/21 will be notified at a later date.

Systems should also assume that there will be no pressure on employer pension contributions; the cost is being funded centrally in 2019/20 and arrangements for future years will be notified in advance of operational planning. In June systems will be provided with provider-level figures for specialised commissioning funding, with specialised commissioning indicative allocations issued to regions.

Regional teams will work with systems to agree what a realistic and 'stretching' bottom line position is in each year. Further detail on the financial framework for 2020/21 and beyond is also expected soon.

Capital

Indicative capital assumptions will need to be produced at a system level. The framework suggests systems may also wish to produce 'well prioritised list' of further capital investments beyond the envelope available to them. Systems are asked to contain and prioritise capital spending across their ICS/STP and region, and plan within their envelope. Plans will need to take account of capital requirements across all care settings including digital transformation.

Next Steps

Systems are required to submit plans for delivery through to 2023/24. Initial plans will be submitted by 27th September 2019, with a final submission to follow by 15th November 2019. These plans will require two elements: a strategy delivery plan that sets out what will be delivered over the next five years, with a set of supporting technical material that underpins this delivery (e.g. workforce and activity plans). Templates for the latter will soon be made available. In line with the new operating model, these plans will need to be agreed with regional teams, and will also need to demonstrate how plans have been clinically-led and developed with full engagement of local stakeholders.

Milestone	Date
Publication of the long term plan implementation framework	June 2019
Main technical and supporting guidance issued	July 2019
Initial system planning submission	End of September 2019
System plans agreed with system leads and regional teams	Mid November 2019
Further operational and technical guidance issued	December 2019
Publication of the national implementation programme for the long term plan	December 2019
First submission of draft operational plans	Early February 2020
Final submission of operational plans	By end March 2020

NHS Providers View

We welcomed the ambitious and wide ranging vision in the NHS long term plan which set out, at a top level, what could be delivered for the increased investment made in the NHS by the Government. But we also argued that the 300-plus commitments in the plan needed to be prioritised, to a clear timeline, and aligned to the workforce and financial resources available so that frontline providers can deliver the plan. We also said that it was vital for those frontline organisations to have appropriate freedom to respond to local needs.

We therefore welcome this implementation framework. It brings greater, much needed, clarity for local leaders. It gives clearer priorities and milestones and sets out where there are must do national priorities and where there is scope to fashion a more local set of priorities. It also sets out what support will be available from national bodies to deliver the plan.

We particularly welcome the premise in the implementation framework that systems should phase their plans in step with their development to ICSs status, achieving 'critical foundations' for service transformation and system development first, followed by the remaining commitments set out in the long term plan. This reflects a logical acknowledgement of system variation across England, and recognises the

need for tailored support where STPs and ICSs are still developing. The framework encourages ICSs to develop plans that more urgently address the delivery of the long term plan, service transformation, workforce and digital strategies. We look forward to engaging with NHSE/I over its plans to produce further guidance in support of different organisational forms including provider groups, and to streamline the transactions process.

We also welcome the increased focus on using digital solutions to increase efficiency and system wide integration. However, more clarity is required on the definition and criteria for achieving digital maturity. NHS Providers would encourage national bodies to allow system partners to set priorities for the uptake of digital technology in response to local need.

On workforce issues, the implementation framework does not go into any further detail than the recently published interim people plan which is expected. It is likely that system submissions on areas such as planned workforce growth, transformation and skills mix will inform the NHS case nationally for increased workforce development funding in the forthcoming spending review.

On funding and financial planning, the framework worryingly shows that the tariff price assumptions look less generous than the current year, particularly during the last two years of the five year period. The implementation framework also lacks much needed detail on how access to capital will operate in a 'system' context. Regional teams have a significant role in agreeing system level finances, with plans to be agreed by regional directors who will also, with the National Service Transformation Directors, approve the release of additional 'fair share' funding to meet long term plan commitments. This is an expected, but significant, shift in relationships, and approach for NHS providers seeking to access additional funding.

Although trusts and their partners in STPs and ICSs now have much greater clarity over the expectations of system wide planning, it is unfortunate that systems will be required to begin planning in the absence of a clear workforce strategy, or a clear direction on adult social care services and the social care Green Paper. We must therefore remain realistic about how much can be delivered for the extra money provided alongside the long term plan particularly given how far the NHS has fallen behind existing performance standards, the scale of the workforce challenges facing the health and care sector, and the need to deliver more integrated care for patients and service users. We look forward to working with colleagues in NHSE/I and with trusts as they work with their partners to plan more effectively within systems as well as at an organisational level.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2019
Title	Financial Summary Report – M4 2019/20
Purpose	To provide the Month 4 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 M4 2019/20 financial position.

ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 4 2019/20 (September 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: £0.3m deficit • Actual: £0.1m deficit • Variance: £0.2m better than plan. **YTD Cash** £24.4m vs Plan £23.7m. **YTD Capital expenditure:** £1.7m vs Revised Plan submitted to NHSi £1.7m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2019/20

Month 4 (July 2019)

Purpose

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

Document Control

Version	*Date*	*Author*	*Comments*
1.0	08/08/19	Bharti Bhoja	1st Draft
2.0	15/08/19	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	(0.7)	(0.8)	0.1	▲	▲
PSF - Trust	0.4	0.3	0.1	▲	▲
PSF - System	0.2	0.2	0.0		
Control Total Surplus / (Deficit)	**(0.1)**	**(0.3)**	**0.2**	▲	▲
Statutory Surplus / (Deficit)	(0.1)	(0.3)	0.2	▲	▼
CIP Delivery	1.6	1.5	0.2	▼	▼
Agency Spend	1.8	1.7	0.1	▲	▲
OAPs - Specialist Placements (incl LD)	2.8	2.7	0.1	▼	▼
OAPs - Out of Area Placements	0.9	0.6	0.3	▼	▲
Capital Expenditure	1.7	1.7	0.0	▲	▲
Cash	24.4	23.7	0.7	▲	▲

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

- In July the Trust achieved a breakeven position pre PSF and are £0.1m ahead of plan YTD. After accounting for PSF our statutory surplus is £0.3m, £0.1m ahead of plan for the month and £0.2m ahead of plan YTD.
- Use of Resources rating is a "2" overall, in line with our plan.
- Overall Pay costs were marginally above plan, after absorbing recruitment assumptions.
- July cash balance was £0.7m better than planned with Q4 PSF payments offsetting NHSPS payment delays.
- Capital spend is in line with budget, aligning to our recent NHSi CapEx plan submission.

Key Risks

- Costs generally are being well managed against planning assumptions, however vigilance must continue particularly relating to temporary staffing costs. This will ensure we do not undo the positive progress so far this year.
- Whilst the Trust is performing well against its target to reduce 'inappropriate ' OAPs, the pressure on beds in recent weeks has increased, and our overall out of area placement numbers remain higher than planned.

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	20.2	20.2	(0.1)	80.8	80.9	(0.2)	242.4	76.2	4.6	6.0%
DoH Pay Award	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.2	(0.1)	(32.3)%
Other Income	1.6	1.6	0.1	6.3	6.3	0.1	19.4	6.5	(0.2)	(3.2)%
Total Income	***21.8***	***21.8***	***0.0***	***87.2***	***87.2***	***0.0***	***261.7***	***82.9***	***4.3***	***5.2%***
Staff In Post	13.7	13.8	(0.1)	55.5	56.3	(0.8)	167.5	51.2	4.3	8.3%
Bank Spend	1.2	1.1	0.2	5.1	4.3	0.8	12.8	4.5	0.6	13.7%
Agency Spend	0.4	0.4	0.0	1.8	1.7	(0.1)	5.0	2.0	(0.2)	(8.8)%
Total Pay	***15.4***	***15.3***	***0.1***	***62.4***	***62.3***	***0.1***	***185.2***	***57.7***	***4.7***	***8.1%***
Purchase of Healthcare	1.3	1.2	0.1	5.3	4.9	0.4	14.1	5.6	(0.3)	(5.8)%
Drugs	0.4	0.6	(0.1)	1.8	2.2	(0.4)	6.7	1.9	(0.1)	(4.4)%
Premises	1.4	1.4	0.1	5.5	5.1	0.4	15.1	4.9	0.6	13.1%
Other Non Pay	1.7	1.7	(0.0)	6.8	7.3	(0.5)	21.9	7.0	(0.2)	(3.2)%
PFI Lease	0.6	0.6	(0.0)	2.2	2.3	(0.1)	6.7	2.1	0.1	3.1%
Total Non Pay	***5.4***	***5.4***	***(0.0)***	***21.6***	***21.8***	***(0.2)***	***64.7***	***21.5***	***0.1***	***0.3%***
Total Operating Costs	***20.8***	***20.8***	***0.0***	***84.0***	***84.1***	***(0.1)***	***249.9***	***79.2***	***4.8***	***6.0%***
EBITDA	***1.0***	***1.0***	***(0.0)***	***3.3***	***3.1***	***0.1***	***11.8***	***3.7***	***(0.4)***	***(11.8)%***
Interest (Net)	0.3	0.3	(0.0)	1.2	1.2	(0.0)	3.6	1.2	0.0	0.8%
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	58.4%
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	
Depreciation	0.5	0.6	(0.0)	2.1	2.1	0.0	6.6	1.5	0.6	38.2%
PDC	0.2	0.2	0.0	0.7	0.7	0.0	2.0	0.5	0.1	22.3%
Total Finanacing	***1.0***	***1.0***	***(0.0)***	***4.0***	***3.9***	***0.0***	***12.3***	***3.2***	***0.7***	***21.9%***
Surplus/ (Deficit) for PSF	***0.0***	***(0.0)***	***0.0***	***(0.7)***	***(0.8)***	***0.1***	***(0.4)***	***0.5***	***(1.1)***	***(254.7)%***
PSF - Trust	0.2	0.1	0.1	0.4	0.3	0.1	1.4	0.5	**0.1**	**16.0%**
PSF - System	0.1	0.1	0.0	0.2	0.2	0.0	0.9			
PSF - Subtotal	***0.3***	***0.2***	***0.1***	***0.6***	***0.5***	***0.1***	***2.3***	***0.5***	***0.1***	
Surplus/ (Deficit) for CT	***0.3***	***0.1***	***0.1***	***(0.1)***	***(0.3)***	***0.2***	***1.9***	***1.0***	***(1.1)***	***(108.7)%***
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	(0.6)	(98.5)%
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	***0.3***	***0.1***	***0.1***	***(0.1)***	***(0.3)***	***0.2***	***0.0***	***1.6***	***(1.7)***	***(107.0)%***
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)%
Surplus/ (Deficit) Statutory	***0.3***	***0.1***	***0.1***	***(0.1)***	***(0.3)***	***0.2***	***1.8***	***1.6***	***(1.7)***	***(107.0)%***

Key Messages

The Trust achieved a break even pre PSF, in line with our planning assumptions. After accounting for PSF our statutory surplus was £0.3m for the month, this is £0.1m ahead of plan in month and £0.2m ahead of plan YTD. PSF is above plan due to the inclusion of an additional £0.1m allocated following national consolidation of Trusts audited accounts.

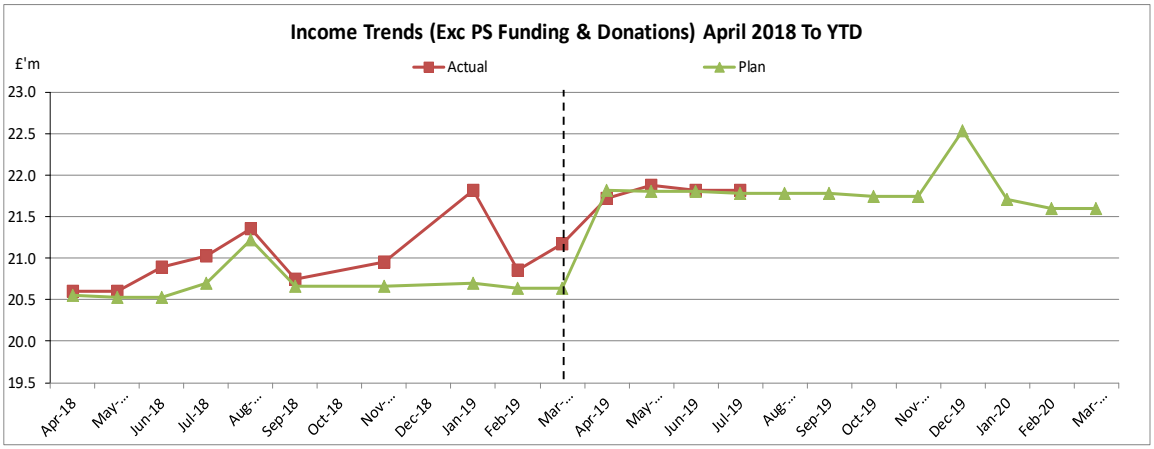
Income is to plan with only minor offsetting variances, none of which represent a risk.

Staffing costs were in line with June, marginally ahead of plan due to small increases in temporary staffing costs.

Non pay costs were to plan and YTD costs remain £0.2m lower than anticipated. Overall placement costs were the same as in June, £0.1m ahead of plan. Whilst 'inappropriate' have fallen, the total number of placements remains ahead of planned levels leading to a £0.4m overspend overall. Estates cost remain higher than planned however these are partially covered by income.

Income & Contracts

Income Statement	In Month			YTD			FY	Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Plan	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	17.8	17.8	0.0	71.4	71.2	0.2	213.2	66.2	5.2	7.8%
Tariff Income	0.2	0.2	0.0	0.7	0.7	0.1	2.0	0.9	(0.2)	(21.6)%
Pass Through Income	0.3	0.4	(0.1)	1.2	1.6	(0.4)	4.8	1.2	(0.0)	(0.2)%
DoH Pay Award	0.0	0.0	0.0	0.1	0.0	0.1	0.0	0.2	(0.1)	(32.3)%
Other Income	3.5	3.4	0.1	13.8	13.8	0.1	41.8	14.4	(0.6)	(4.0)%
Total Operating Income	***21.8***	***21.8***	***0.0***	***87.2***	***87.2***	***0.0***	***261.7***	***82.9***	***4.3***	***5.2%***
PSF - Trust	0.2	0.1	0.1	0.4	0.3	0.1	1.4	0.3	0.1	96.3%
PSF - System	0.1	0.1	0.0	0.2	0.2	0.0	0.9	0.2		
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	(0.6)	(98.5)%
Total Reportable Income	***22.1***	***21.9***	***0.2***	***87.9***	***87.7***	***0.1***	***264.0***	***84.0***	***3.8***	***4.6%***



Income

YTD	£'m
2019/20	87.2
2018/19	83.1
▲	*5%*

Prior Yr	£'m
Jul-19	21.8
Jul-18	21.0
▲	*5%*

Key Messages

Income is to plan in month and YTD. Under-recovery of pass through income is offset by under-spend in pass-through non-pay costs. The favourable variance in PSF income £0.1m relates additional 2018/19 funding resulting from a final reconciliation of audited Trust positions. This funding, along with the Q4 tranche of PSF was received in July.

Commissioner Focus

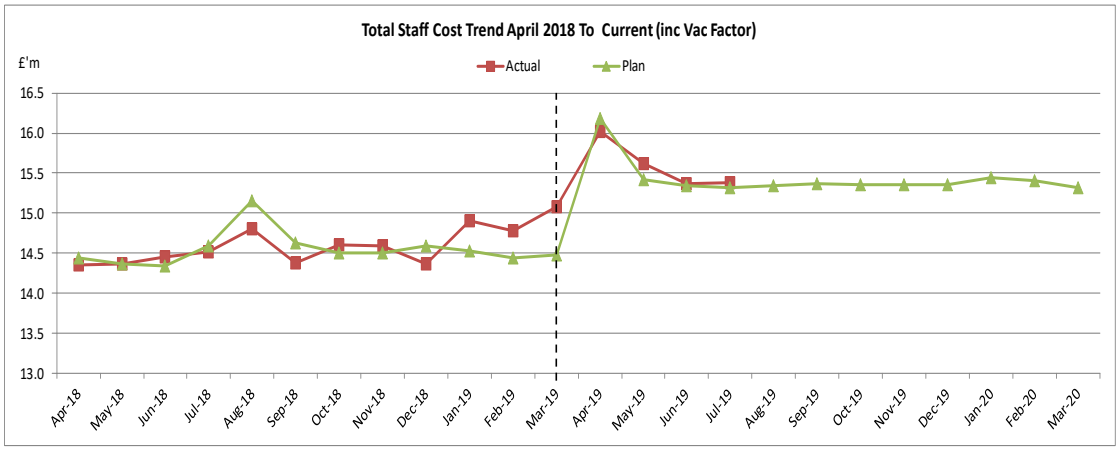
Following a successful meeting with NHSE, securing CAHMS ongoing block funding arrangement for the next 2 years, the parties met again to review the plans of the new unit at Prospect Park. The meeting was very positive, with comments for the commissioner being build into the design for the final business case.

System Focus

Of our total available £2.3m PSF, £0.9m has been allocated to Frimley system, following the same approach as in 18/19. Frimley ICS has delivered its Control Total for Q1 and continues to deliver forecast deliver. We still await allocation of system PSF in relation to the BOB system.

Attention is now focused on the completion of ICS 5 Year System plans, which will be submitted to NHSI at the end of November. This will include a financial forecast for the period, including cash, capital, efficiencies and workforce assumptions. Key will be clarity on the how new Long Term Plan funding will flow to frontline services.

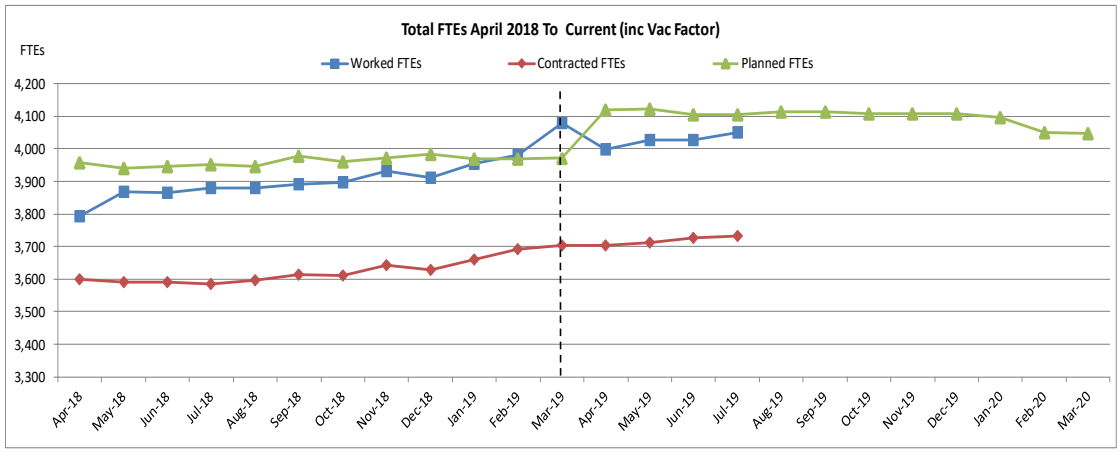
Workforce



Staff Costs

YTD	£'m
2019/20	62.4
2018/19	57.7
▲	8%

Prior Yr	£'m
Jul-19	15.4
Jul-18	14.5
▲	6%



FTEs

Prior Yr	CFTE	WFTE
Jul-19	3,733	4,049
Jul-18	3,584	3,880
	-4% ▲	-4% ▲

Prior Mth	CFTE	WFTE
Jul-19	3,733	4,049
Jun-19	3,727	4,028
	0% ▲	-1% ▲

Key Messages

Overall staff costs were £0.1m higher than plan in July and YTD. Substantive costs were in line June, the increase coming from a small rise in bank and agency costs.

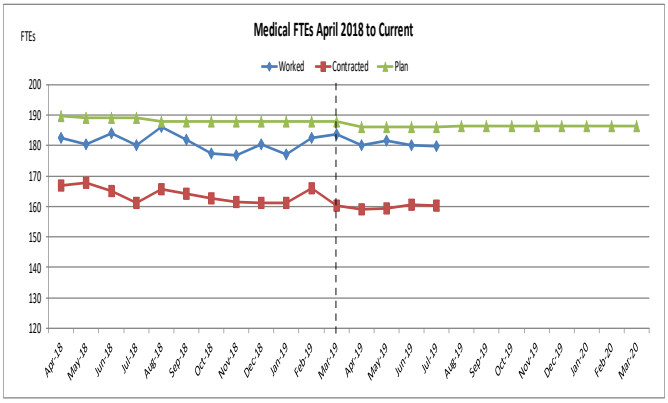
Most areas are operating within recruitment assumptions however demand pressures continue in Community and Mental Health inpatient wards, CRHTT and LD Campion Unit, which has led to increased temporary staff usage, taking overall pay costs beyond planned levels.

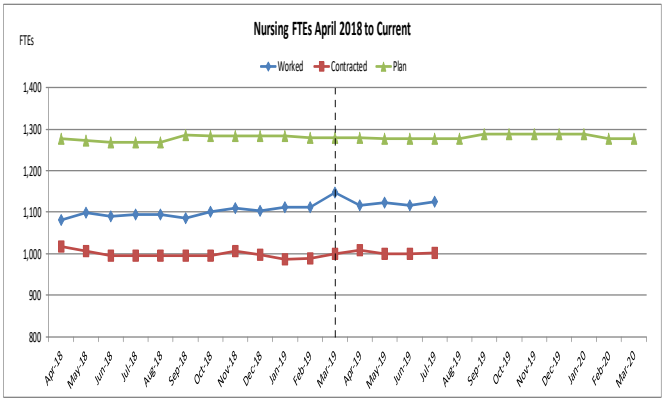
Combined with non permanent usage, the overall FTE number still remains below plan, even after factoring in re-cruitment assumptions.

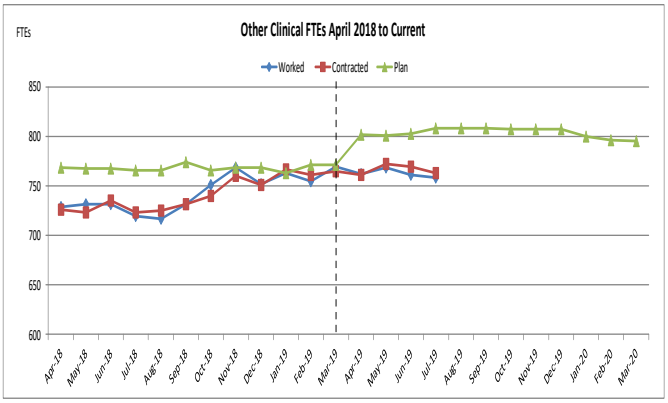
Our permanent contracted FTEs increased by 6 in July whilst our temporary staffing increased by 1 FTE reflecting slight increase in temporary staffing costs.

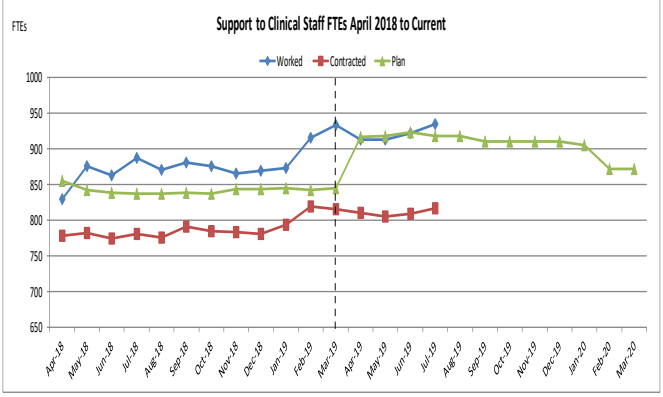
The FTE chart illustrates steady growth in contracted FTEs with permanent workforce 30 higher than at the end of 18/19 and 149 higher than July last year.

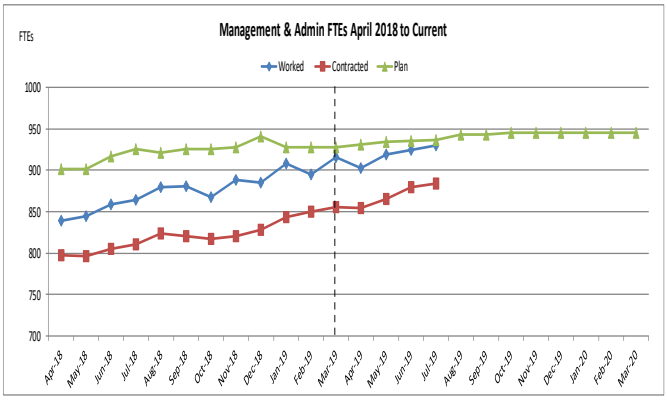
Workforce: Staff Groups

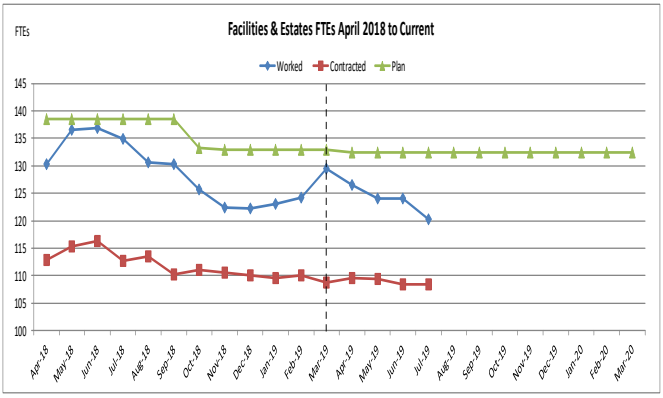












Key Messages

The charts clearly show that all staffing groups are operating below establishment levels except support to clinical who are head of plan, in most instances due to recruitment to offset qualified vacancies. Please note that the above graphs do not include the assumed vacancy factor incorporated into the plan.

Nursing worked FTEs increase due to movements in various areas but there was a notable increase of 3 FTEs in Slough District Nursing.

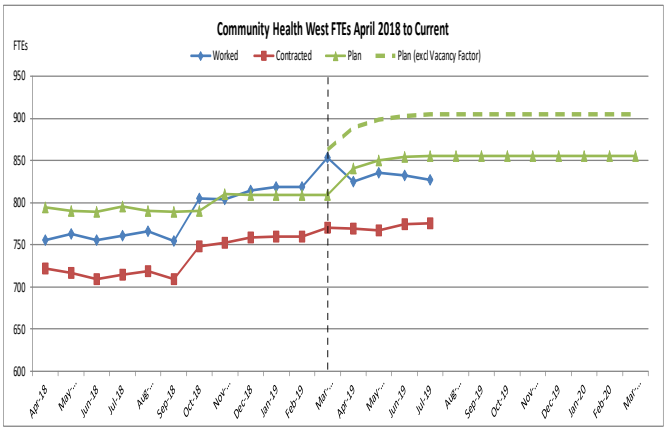
Management and Admin numbers continue to grow with an increase of 4 FTEs in worked and contracted in July. This includes previously capitalised posts working on GDE projects.

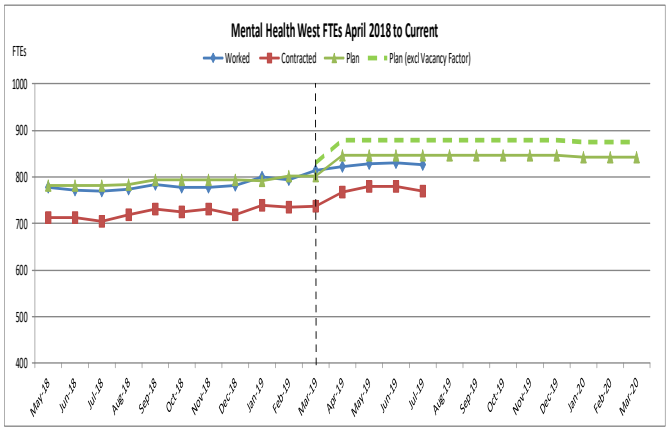
Support To Clinical staffing increased again this month due to recruitment in MH Inpatient of 8 FTEs, Bracknell District Nursing of 3 FTEs and Westcall shift increases by 2 FTEs.

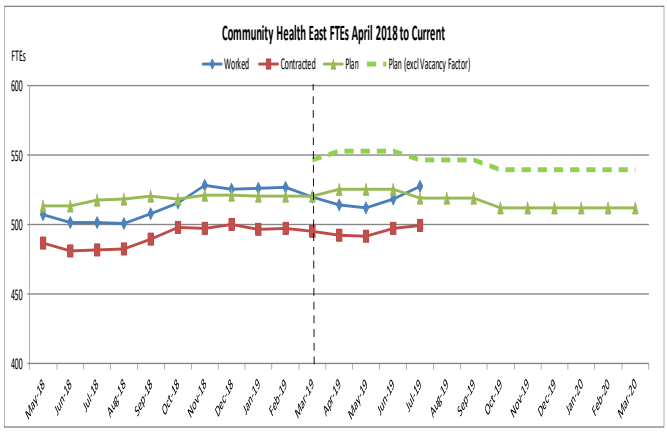
The reduction in Other Clinical staffing group is due to leavers in Podiatry 2 FTEs and 5 FTEs in IAPT West.

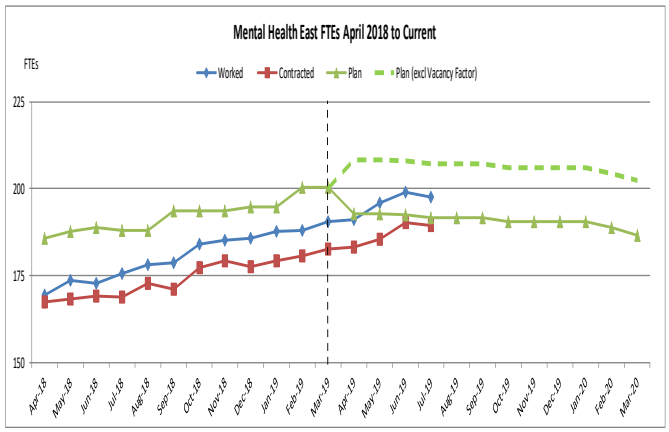
The downward movement in Estates & Facilities worked FTEs relates to 4 FTE leavers in Wokingham Domestics.

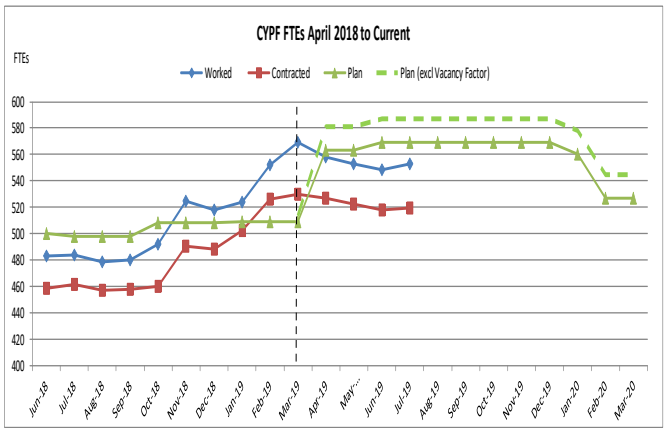
Workforce: Divisional

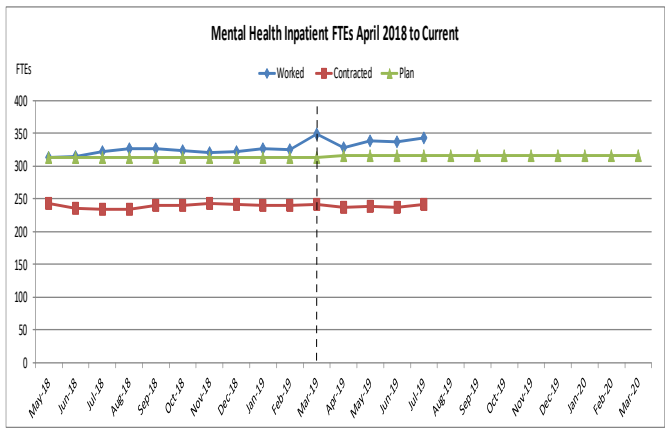


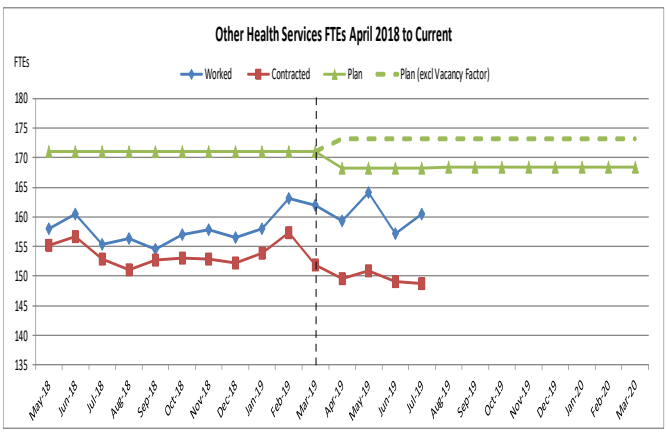


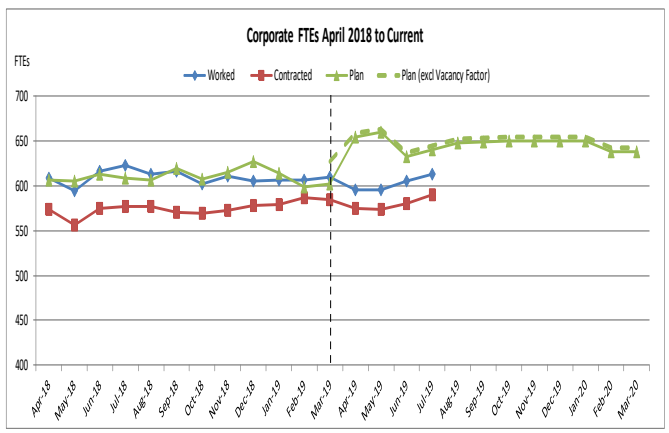




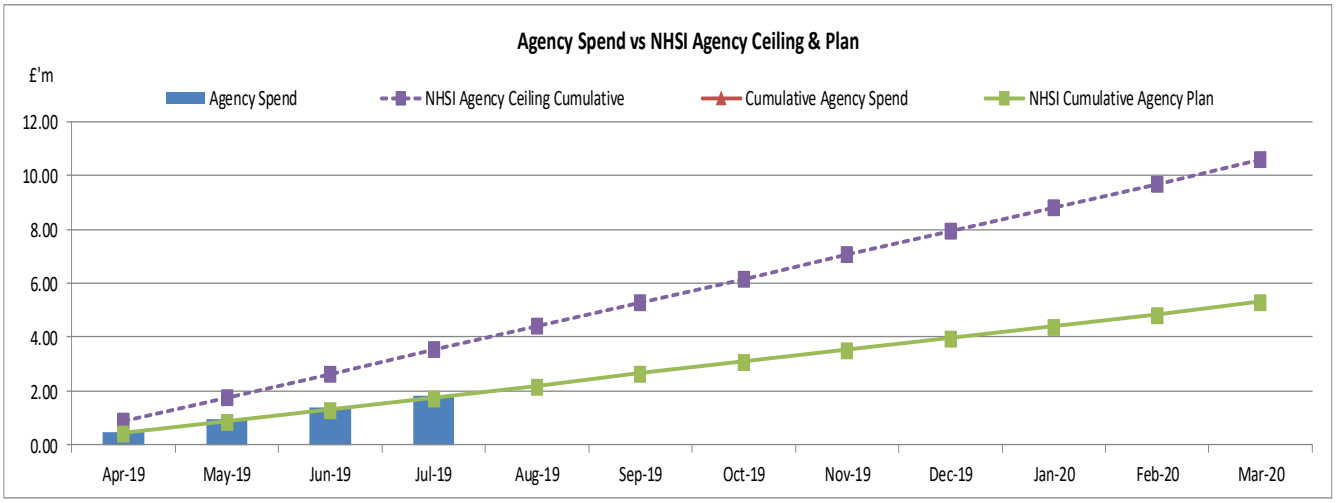


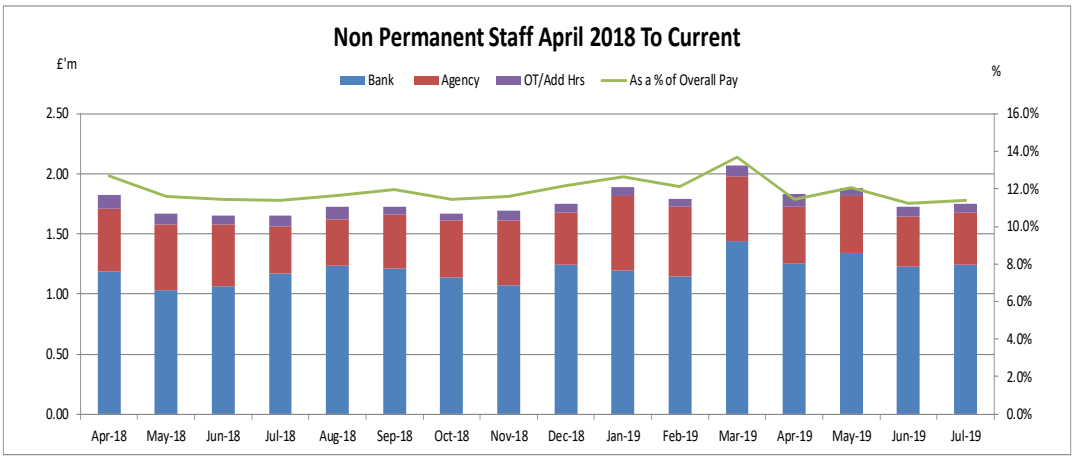






Non Permanent Pay

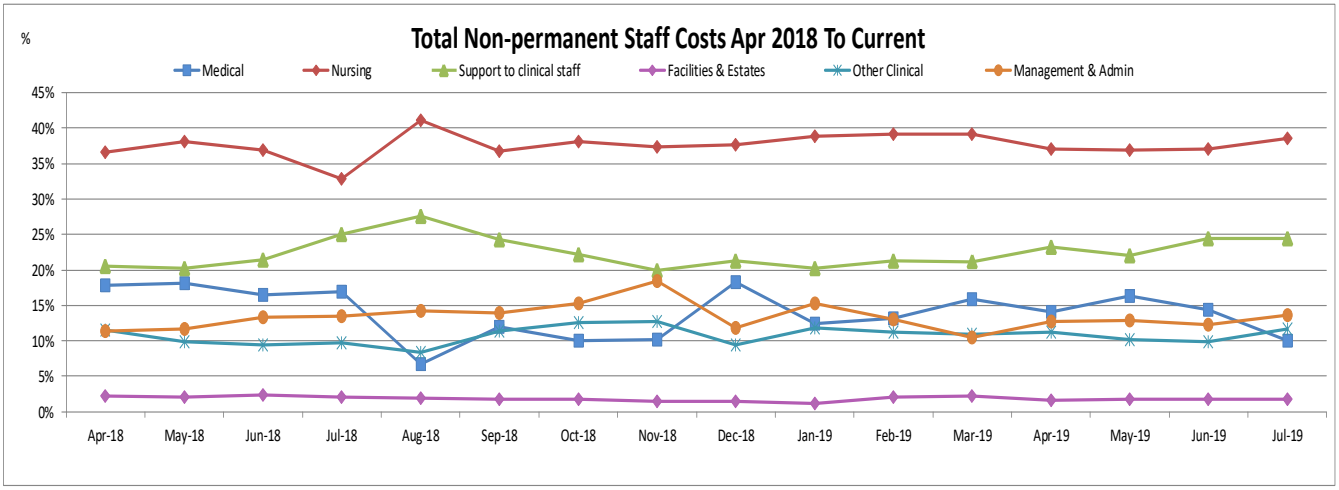




Non Permanent Pay

YTD	Bank	Agency	OT/Add Hrs
2019/20	5.1	1.8	0.3
2018/19	4.5	2.0	0.4
	12% ▲	-10% ▼	-12% ▼

Prior Yr	Bank	Agency	OT/Add Hrs
Jul-19	1.2	0.4	0.1
Jul-18	1.2	0.4	0.1
	1% ▲	3% ▲	-22% ▼



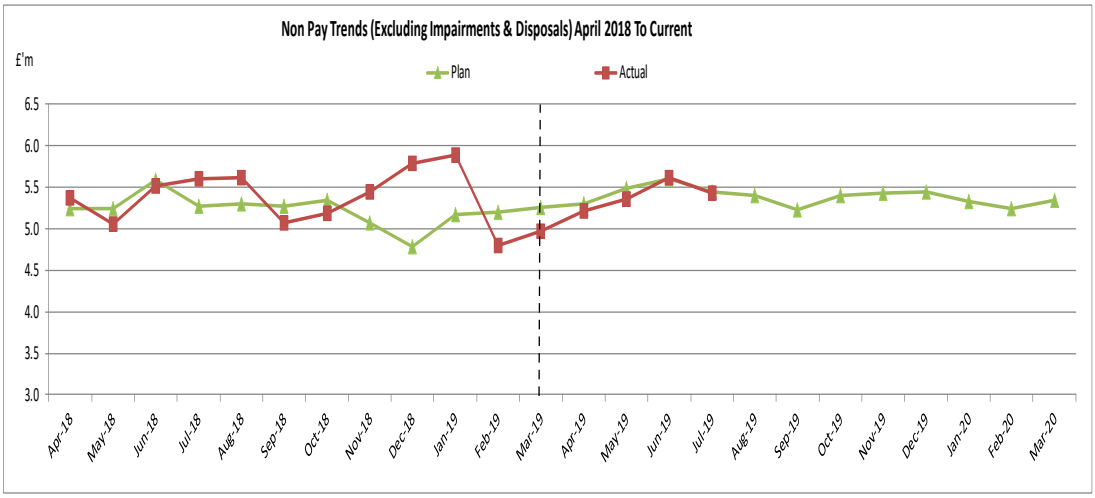
Key Messages

Non permanent staffing costs increased by £30k to £1.7m. YTD agency costs have fallen by 10%, offset by a 12% increase in bank costs. Overall Non permanent costs are £0.4m higher YTD than the same period last year.

The increases in temporary staffing costs were in Mental Health Inpatients £16k due to the increase in occupancy and higher observation levels, CAMHS £10k, this is funded by the CCG to reduce pressures on the service, and Talking Therapies £9k due increase in vacancies and higher workloads. All of these services are demand led with high vacancy levels which are covered by temporary staffing.

Non Pay Expenditure

Non Pay	In Month			YTD			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Purchase of Healthcare	1.3	1.2	0.1	5.3	4.9	0.4	5.6	(0.3)	(5.8)%
Drugs	0.4	0.6	(0.1)	1.8	2.2	(0.4)	1.9	(0.1)	(4.4)%
Premises	1.4	1.4	0.1	5.5	5.1	0.4	4.9	0.6	13.1%
Supplies and services – clinical	0.4	0.4	0.0	1.5	1.6	(0.2)	1.6	(0.1)	(7.6)%
Transport	0.3	0.3	(0.0)	1.0	1.2	(0.1)	1.0	0.0	1.2%
Establishment	0.3	0.3	0.0	1.1	1.1	0.0	1.2	(0.2)	(13.8)%
Other Non Pay	0.7	0.8	(0.0)	3.2	3.4	(0.3)	3.1	0.1	1.7%
PFI Lease	0.6	0.6	(0.0)	2.2	2.3	(0.1)	2.1	0.1	3.1%
Total Non Pay	**5.4**	**5.4**	**(0.0)**	**21.6**	**21.8**	**(0.2)**	**21.5**	**0.1**	**0.3%**



Non Pay

YTD	£'m
2019/20	21.6
2018/19	21.5
▲	*0%*

Prior Yr	£'m
Jul-19	5.4
Jul-18	5.6
▼	*-3%*

Key Messages

Non Pay costs were to plan in July, meaning the YTD underspend remained at £0.2m.

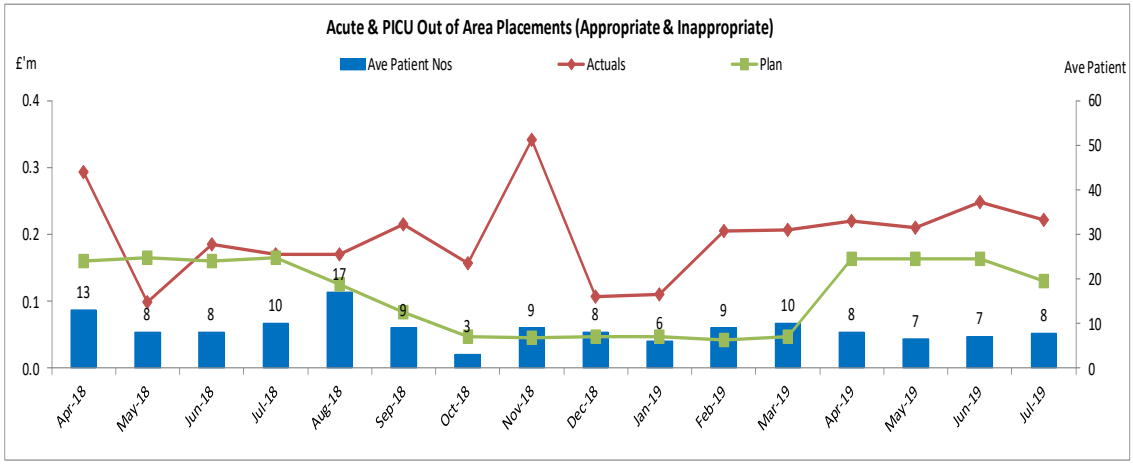
Although to plan overall there, are a small number of adverse variance to note. Premises costs were £0.1m higher due to works completed on NHSPS properties, for which we have accrued income, and Erlegh House utility costs are being accrued at a higher level than assumed in plan whilst confirmation of the recurrent costs are being re-viewed.

Overall Placement costs were £0.1m higher than planned with a higher volume of patients being placed. The mix of placements altered, with a fewer number of PICU v Acute placements in July, which reduced cost despite an overall increase in average number of placements. Overall placement costs remain higher than plan and continue to represent the key financial risk to the non pay forecast.

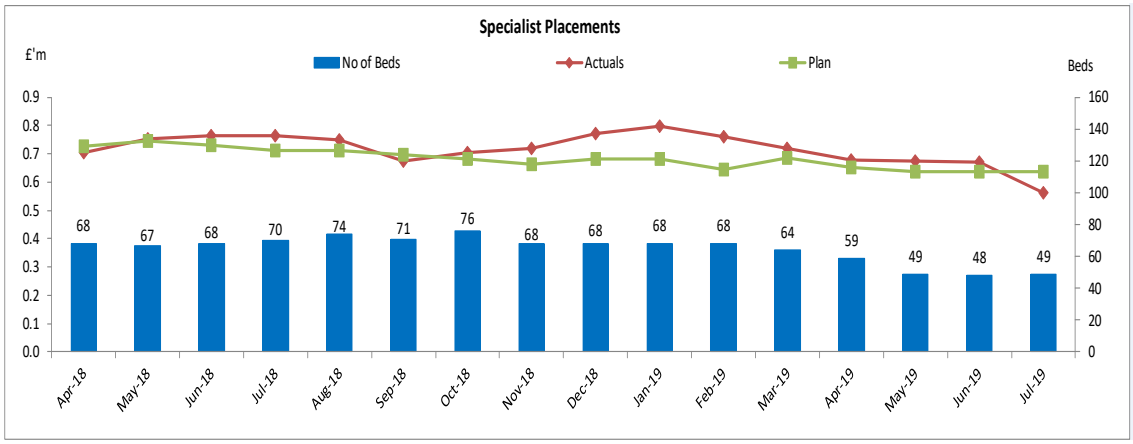
Drug costs remain below planned levels with the volume of pass through drugs issues being below planned levels, this is offset by lower income.

All other Non Pay costs remain largely to plan.

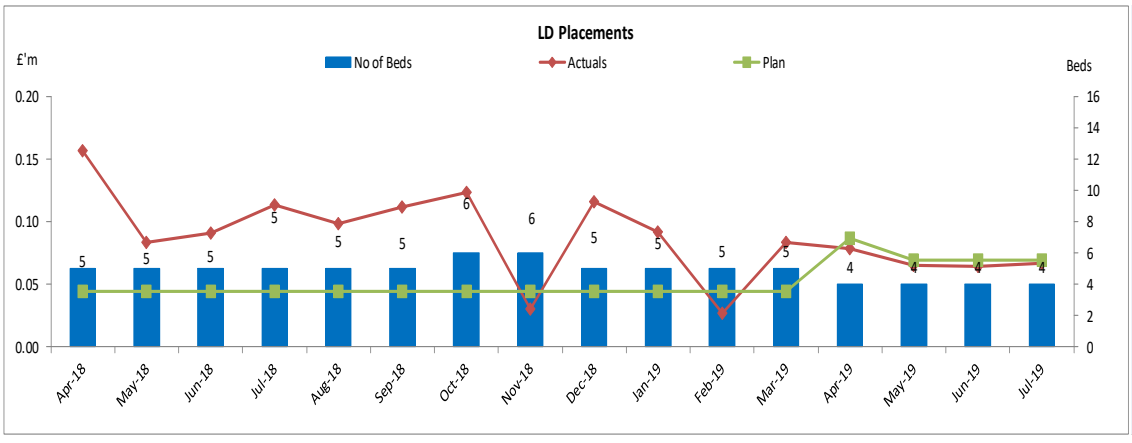
Non Pay Expenditure - Placement Costs



Non Pay	
YTD	£'m
2019/20	0.9
2018/19	0.7
▲	21%
Prior Yr	£'m
Jul-19	0.2
Jul-18	0.2
▲	30%



Non Pay	
YTD	£'m
2019/20	2.6
2018/19	3.0
▼	-13%
Prior Yr	£'m
Jul-19	0.6
Jul-18	0.8
▼	-26%



Non Pay	
YTD	£'m
2019/20	0.3
2018/19	0.7
▼	-60%
Prior Yr	£'m
Jul-19	0.1
Jul-18	0.2
▼	-62%

Key Messages

Out of Area Placement costs dropped slightly compared to June driven by the change in mix of more costly PICU v Acute placements. Despite the reduction, the volume of patients remain higher than budgeted and spend was £0.1m higher than plan in July, YTD £0.3m. The number of 'inappropriate' placements is less than prior YTD. The overall financial challenge remains though, as we are running with higher than anticipated 'appropriate' placements, with costs £0.5m higher than previous YTD.

Specialist Placement costs were £0.1m lower than planned and £0.2m lower than July 18. Costs fell this month due to an offsetting income/expenditure adjustment tied to the Rosebank contract.

LD Placement costs were underspend by £3k in the month and £47k 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	0.5	0.4	0.0	1.6	1.7	(0.1)	5.2	1.7	(0.1)	(6.1)%
Pay	3.0	3.0	0.0	12.2	12.1	0.1	35.9	10.8	1.5	13.6%
Non Pay	0.5	0.5	0.0	1.9	2.0	(0.1)	5.9	1.8	0.1	3.9%
Net Cost	***3.0***	***3.0***	***0.0***	***12.5***	***12.4***	***0.1***	***36.6***	***10.8***	***1.6***	***15.1%***
Mental Health West										
Income	0.2	0.2	0.0	0.6	0.6	(0.0)	1.9	1.0	(0.4)	(38.0)%
Pay	3.1	3.1	(0.0)	12.5	12.7	(0.1)	37.6	11.0	1.6	14.3%
Non Pay	0.6	0.5	0.1	2.3	2.1	0.2	5.8	2.4	(0.1)	(4.3%)
Net Cost	***3.5***	***3.4***	***0.1***	***14.3***	***14.2***	***0.1***	***41.5***	***12.4***	***1.8***	***14.9%***
Community Health East										
Income	0.1	0.2	(0.1)	0.6	0.7	(0.2)	2.2	1.1	(0.6)	(50.6)%
Pay	1.9	1.9	0.0	7.6	7.6	(0.0)	22.2	6.9	0.6	9.2%
Non Pay	0.5	0.6	(0.0)	1.9	2.2	(0.4)	6.6	2.2	(0.4)	(16.6%)
Net Cost	***2.3***	***2.2***	***0.0***	***8.9***	***9.1***	***(0.2)***	***26.7***	***8.0***	***0.8***	***10.4%***
Mental Health East										
Income	0.1	0.1	(0.1)	0.5	0.5	(0.1)	1.6	0.7	(0.3)	(35.7)%
Pay	0.7	0.7	0.0	3.0	3.0	(0.0)	8.9	2.5	0.5	18.5%
Non Pay	0.7	0.8	(0.1)	3.0	3.0	(0.0)	9.0	3.4	(0.4)	(11.1%)
Net Cost	***1.3***	***1.4***	***(0.0)***	***5.5***	***5.5***	***0.0***	***16.3***	***5.2***	***0.4***	***6.8%***
CYPF										
Income	0.4	0.3	0.0	1.6	1.4	0.2	3.9	0.8	0.8	95.7%
Pay	2.0	2.0	(0.1)	7.9	8.2	(0.3)	24.5	6.7	1.2	18.3%
Non Pay	0.1	0.1	0.0	0.6	0.5	0.1	1.5	0.6	(0.0)	(1.5%)
Net Cost	***1.7***	***1.8***	***(0.1)***	***6.9***	***7.3***	***(0.5)***	***22.1***	***6.4***	***0.4***	***6.4%***
Mental Health Inpatients										
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1,205.9%
Pay	1.1	0.9	0.1	4.2	3.8	0.4	11.4	3.7	0.5	13.7%
Non Pay	0.1	0.1	0.0	0.3	0.3	(0.0)	1.0	0.3	(0.0)	(3.2%)
Net Cost	***1.1***	***1.0***	***0.1***	***4.5***	***4.1***	***0.4***	***12.3***	***4.0***	***0.5***	***11.7%***
Other Health Services										
Income	0.2	0.3	(0.0)	0.9	1.0	(0.1)	3.2	0.6	0.3	46.4%
Pay	1.3	1.3	(0.1)	5.2	5.4	(0.2)	16.1	4.9	0.4	7.5%
Non Pay	0.1	0.2	(0.0)	0.6	0.7	(0.1)	2.1	0.3	0.3	96.1%
Net Cost	***1.2***	***1.2***	***(0.1)***	***4.9***	***5.1***	***(0.2)***	***15.0***	***4.5***	***0.4***	***7.7%***
Corporate										
Income	1.4	1.2	0.1	5.3	5.0	0.3	15.8	6.0	(0.8)	(12.6)%
Pay	2.4	2.4	0.0	9.7	9.4	0.3	28.6	11.3	1.6	(13.9%)
Non Pay	2.8	2.8	0.0	11.0	11.0	0.1	32.7	10.5	(0.6)	5.5%
Net Cost	***3.8***	***3.9***	***(0.1)***	***15.5***	***15.3***	***0.1***	***45.5***	***15.7***	**0.2**	**(1.4)%**
Corporate Income & Financing										
Income	19.3	19.2	0.1	76.7	76.7	0.1	230.3	71.7	5.0	7.0%
Financing	1.011	1.037	(0.0)	3.994	3.9609	0.0	12.4	3.3	0.7	22.7%
Surplus/ (Deficit) Statutory	***0.3***	***0.1***	**0.1**	***(0.1)***	***(0.3)***	**0.2**	***1.8***	***1.3***	**(1.4)**	**(107.1)%**

Key Messages

All localities continue to be on or below plan overall with few exceptions.

Mental Health West: Non-pay overspend relates to OAPs.

Community Health East: Income under-achievement relates to pass through drugs and is offset by non-pay underspent.

Mental Health East: Income variance relates to Rose bank contract adjustment offset by OAPs non-pay underspend.

Mental Health Inpatients: Pay overspent is due to use of bank and agency to cover vacancies, sickness, high bed occupancy and high levels of patient observations. Overall occupancy level have increase by 5% compared to June.

4.0 Cost Improvement Programme - NHSI Plan

Scheme	In Month			YTD			Full Year		
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Var
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Placement Projects									
Inappropriate Out of Area Placements	0.07	0.07	0.01	0.38	0.17	0.22	1.00	1.00	0.00
Long Term Specialist Placement Contracts	0.10	0.09	0.01	0.35	0.33	0.02	1.01	1.02	(0.01)
Total OAPS Saving	***0.17***	***0.15***	***0.02***	***0.73***	***0.49***	***0.24***	***2.01***	***2.02***	***(0.01)***
Operations									
CRHTT	0.00	0.01	(0.01)	0.00	0.03	(0.03)	0.03	0.10	(0.07)
Total Service Line Savings	***0.00***	***0.01***	***(0.01)***	***0.00***	***0.03***	***(0.03)***	***0.03***	***0.10***	***(0.07)***
Procurement									
Procurement Spend	0.02	0.02	(0.00)	0.09	0.07	0.02	0.30	0.30	0.00
NHS Supply Chain	0.00	0.02	(0.02)	0.01	0.08	(0.07)	0.03	0.25	(0.22)
Medicine Optimisation	0.00	0.00	(0.00)	0.00	0.02	(0.02)	0.05	0.05	0.00
Total Procurement Savings	***0.02***	***0.04***	***(0.02)***	***0.10***	***0.17***	***(0.07)***	***0.38***	***0.60***	***(0.21)***
Contracts									
Sexual Health	0.00	0.04	(0.04)	0.00	0.14	(0.14)	0.08	0.43	(0.35)
Liaison & Diversion Hampshire	0.07	0.06	0.01	0.29	0.27	0.02	0.64	0.62	0.02
Veterans	0.07	0.03	0.05	0.17	0.12	0.05	0.32	0.27	0.05
Total Other Savings	***0.14***	***0.12***	***0.02***	***0.45***	***0.53***	***(0.08)***	***1.04***	***1.32***	***(0.28)***
Total CIP Delivery (NHSi Plan)	***0.33***	***0.32***	***0.01***	***1.29***	***1.23***	***0.06***	***3.46***	***4.04***	***(0.57)***
Internal Stretch									
Long Term Placements (LD)	0.03	0.03	(0.01)	0.12	0.03	0.09	0.32	0.30	0.02
Immunisations Technology	0.03	0.02	0.01	0.11	0.02	0.09	0.14	0.14	(0.00)
Contract - SLT	0.01	0.01	0.00	0.02	0.02	0.00	0.06	0.06	0.00
Corporate Benchmarking	0.00	0.01	(0.01)	0.00	0.01	(0.01)	0.00	0.15	(0.15)
Temporary Staffing	0.01	0.01	0.00	0.04	0.04	0.00	0.14	0.20	(0.06)
NHSPS VAT	0.00	0.06	(0.06)	0.00	0.11	(0.11)	0.62	0.62	0.00
PFI Benchmarking Review	0.00	0.01	(0.01)	0.00	0.01	(0.01)	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)
Contract - Community Health West	0.05	0.00	0.05	0.05	0.00	0.05	0.11	0.10	0.01
Other	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Unidentified	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.20	(0.20)
Total CIP Delivery (Internal Stretch)	***0.13***	***0.15***	***(0.02)***	***0.35***	***0.25***	***0.10***	***1.51***	***2.00***	***(0.49)***
Total CIP Delivery	***0.46***	***0.48***	***(0.02)***	***1.63***	***1.48***	***0.16***	***4.98***	***6.04***	***(1.06)***

Key Messages

The Trust has delivered £1.6m of savings, £0.2m ahead of plan.

Spend on 'inappropriate' out of area placements (Acute/PICU) is £0.3m, a decrease of £0.4m against prior YTD spend. However the number of placements have increased in July. In August a plan will be put in place for locality focussed 'Spring to Green' where allocated bed numbers are exceeded.

As anticipated, savings from NHS Supply Chain are less than planned with savings predicted to be £0.2m lower than their estimates. This has been raised with Supply Chain who have offered to review our volumes, but not committed to further savings.

The next iteration of the PFI review is due mid August, focusing on refinancing and insurance opportunities.

A pricing adjustment in Podiatry has presented a new income benefit, and YTD £0.05m has been recognised for Community Health West. This opportunity was identified through the QIBI pilot, currently being undertaken. This combined with other new opportunities has reduced the 'Unidentified' balance to £0.2m.

The Trust is continuing to work through the NHSPS VAT savings with the CCG with the Q2 milestone being missed.

Full year forecast is £5.0m against a NHSi commitment of £4.0m and an internal stretch target of £6.0m. Key forecast movement this month recognises slippage against the implementation of the revised Sexual Health staffing model, delaying planned in year services contribution.

5.0 Balance Sheet & Cash

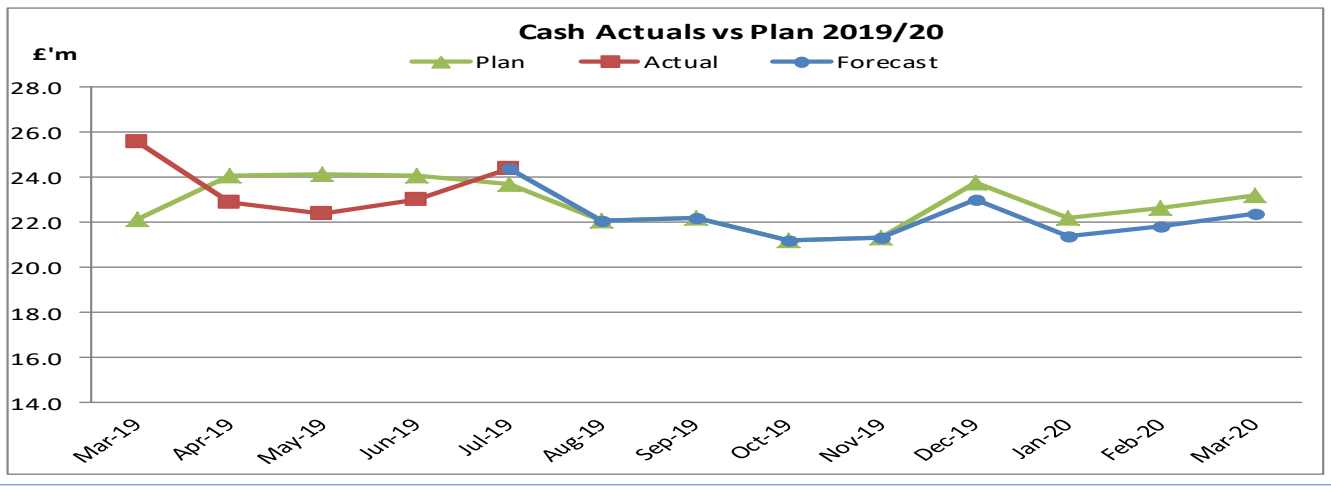
Balance Sheet	18/19 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	19/20 Plan £'m
Intangibles	5.2	5.3	5.8	(0.5)	5.3	5.8	(0.5)	6.3
Property, Plant & Equipment (non PFI)	37.7	36.2	34.6	1.6	36.2	34.6	1.6	36.4
Property, Plant & Equipment (PFI)	59.8	60.8	64.1	(3.4)	60.8	64.1	(3.4)	65.4
Total Non Current Assets	**102.7**	**102.3**	**104.5**	**(2.3)**	**102.3**	**104.5**	**(2.3)**	**108.1**
Trade Receivables & Accruals	11.8	16.2	10.8	5.4	16.2	10.8	5.4	10.8
Other Receivables	0.2	0.2	0.3	(0.1)	0.2	0.3	(0.1)	0.3
Cash	25.6	24.4	23.7	0.7	24.4	23.7	0.7	23.2
Trade Payables & Accruals	(23.9)	(25.3)	(28.0)	2.7	(25.3)	(28.0)	2.7	(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)	(4.7)	(2.3)	(2.4)	(4.7)	(2.3)	(2.4)	(2.3)
Total Net Current Assets / (Liabilities)	**9.6**	**9.5**	**3.1**	**6.4**	**9.5**	**3.1**	**6.4**	**2.4**
Non Current PFI Finance Lease	(28.5)	(28.0)	(28.0)	0.0	(28.0)	(28.0)	0.0	(27.0)
Other Non Current Payables	(1.5)	(1.5)	(1.6)	0.1	(1.5)	(1.6)	0.1	(1.6)
Total Net Assets	***82.4***	***82.3***	***78.1***	***4.2***	***82.3***	***78.1***	***4.2***	***81.9***
Income & Expenditure Reserve	28.1	28.0	24.5	3.5	28.0	24.5	3.5	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***	***82.3***	***78.1***	***4.2***	***82.3***	***78.1***	***4.2***	***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	0.7	0.6	0.1	1.7	1.5	0.2	7.5
Depreciation and Impairments	+	5.5	0.5	0.6	(0.0)	2.1	2.1	0.0	6.8
Operating Cashflow		***17.3***	***1.3***	***1.2***	***0.1***	***3.9***	***3.6***	***0.2***	***14.3***
Net Working Capital Movements	***+/-***	***(0.2)***	1.3	(0.2)	***1.5***	***(1.0)***	***(0.6)***	***(0.3)***	***(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)	(0.8)	(1.0)	0.1	(2.5)	(3.1)	0.6	(11.3)
Investments		***(9.5)***	***(0.8)***	***(1.0)***	***0.2***	***(2.5)***	***(3.1)***	***0.6***	***(11.3)***
PFI Finance Lease Repayment	-	(1.0)	(0.1)	(0.1)	(0.0)	(0.4)	(0.4)	0.0	(1.2)
Net Interest	+/-	(3.6)	(0.3)	(0.3)	0.1	(1.2)	(1.3)	0.1	(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)***	***(0.4)***	***(0.4)***	***0.0***	***(1.6)***	***(1.7)***	***0.1***	***(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***	***1.4***	***(0.4)***	***1.8***	***(1.2)***	***(1.7)***	***0.6***	***(2.3)***
Opening Cash		22.3	23.0	24.1	(1.1)	25.6	25.6	0.0	25.6
Closing Cash		***25.6***	***24.4***	***23.7***	***0.7***	***24.4***	***23.7***	***0.7***	***23.2***

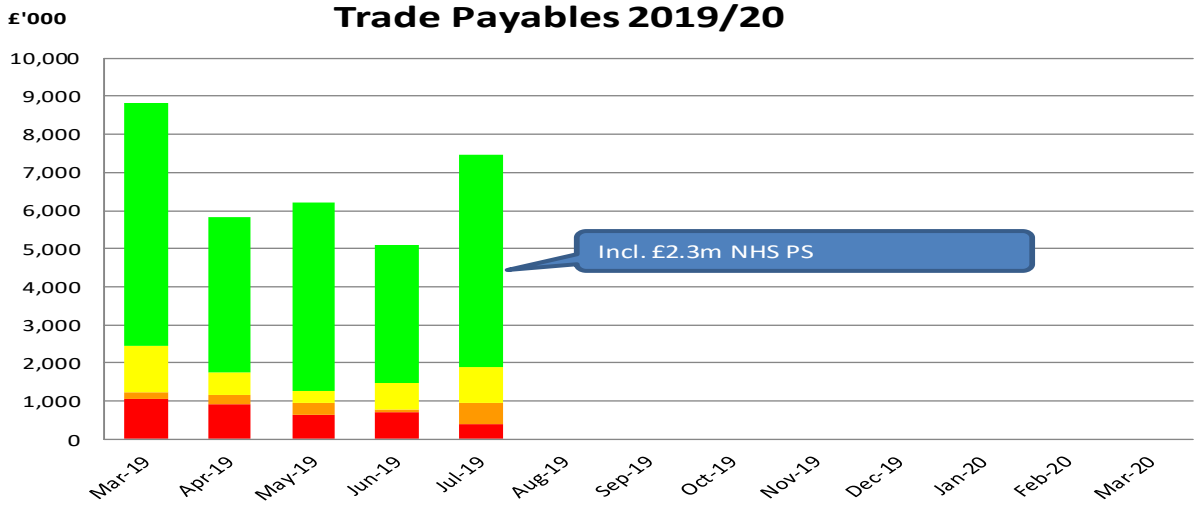
Key Messages

The cash balance at the end July was £24.4m, £0.7m above the plan.

The main factors contributing to the higher balance relate to payment of Q4 PSF, including bonus payments, offsetting continued delays in securing NHSPS payments. The revised contract arrangement with RBH whereby a single payment is made by both parties, was made at the end of July, reducing transaction volumes by c1,000 per annum and mitigating habitual payment delays.



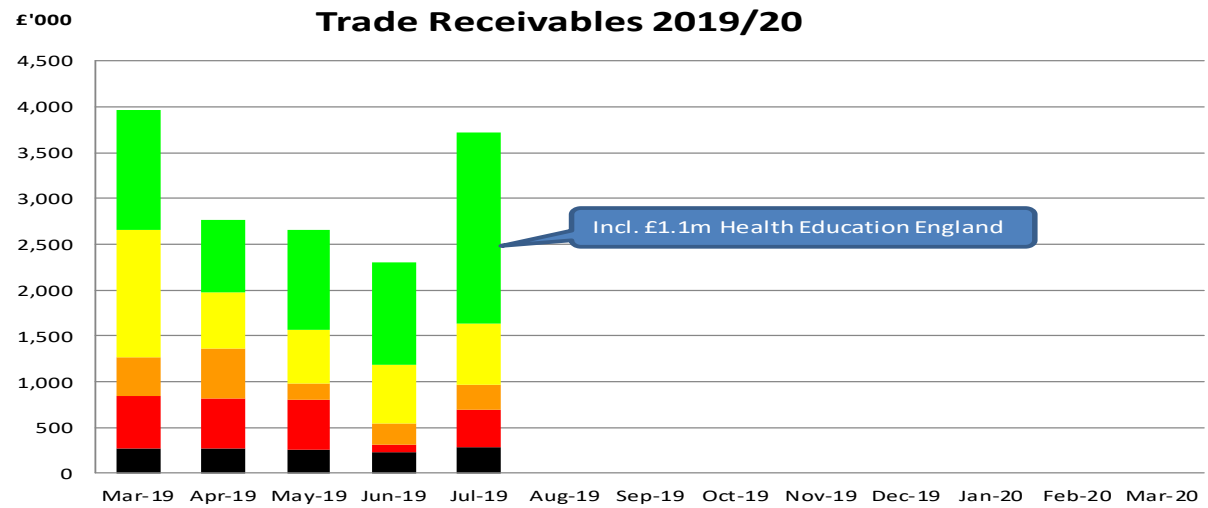
Cash Management



	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	6,353	4,086	4,962	3,621	5,590								
>30 <60 Days	1,242	593	299	700	952								
>60 <90 Days	177	231	305	73	530								
>90 days	1,047	933	653	706	406								

Key Message

The Trust has still to resolve the outstanding billing issues with NHSPS. The matter has been escalated to CFOs, but there remains an impasse. A meeting has been requested to unlock the remaining issues. As a result of NHSPS related payables increased by £2.3m in month. Overall payables rose by £2.0m, with the NHSPS increase being offset with a reduction of £0.4m against Frimley Health balance.



	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	1,311	800	1,088	1,117	2,098								
>30 <60 Days	1,387	604	579	644	663								
>60 <90 Days	429	557	185	226	278								
>90 < 180 Days	564	545	551	83	403								
>180 Days	273	264	250	229	287								

Key Message

Overall receivables increased by £1.4m, with £1m increase in current receivables relating to Health Education England and £0.3m increase in debt over 90 days. The largest balances remaining over 60 days are with NHS PS (£0.1m), Royal Berkshire FT (£0.1m), Reading Borough Council (£0.1m) and combined remaining CCG debt of £0.3m.

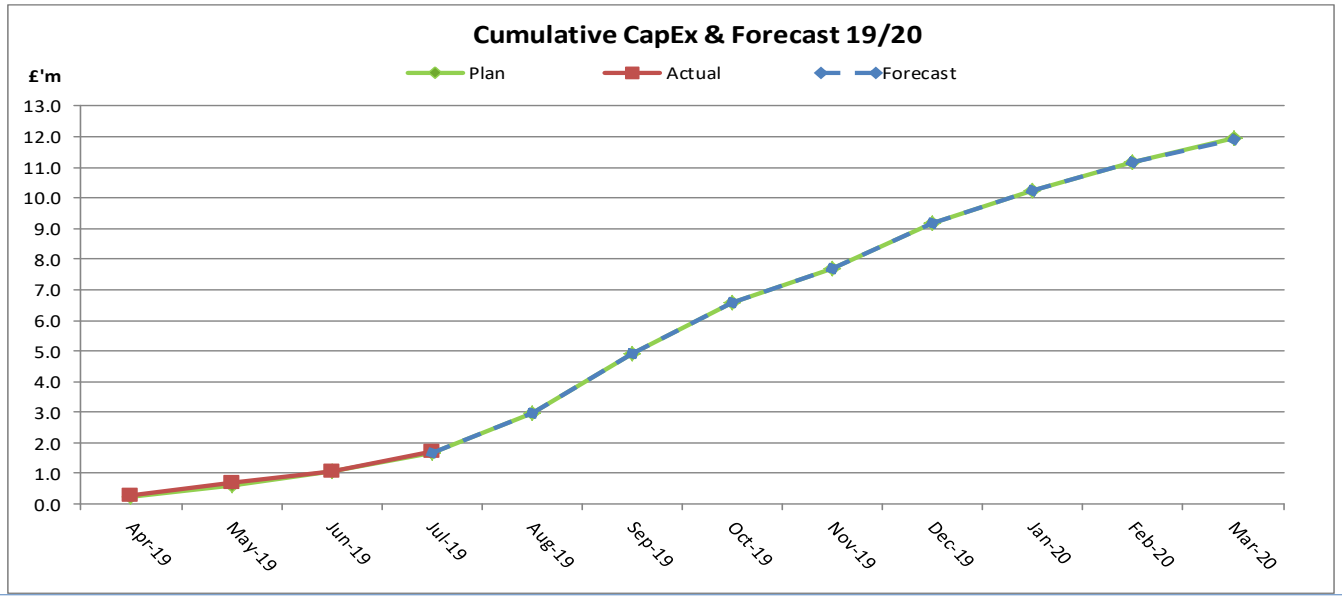
6.0 Capital Programme

Schemes	Current Month Actual £'000	Current Month Plan £'000	Current Month Variance £'000	Year to Date Actual £'000	Year to Date Plan £'000	Year to Date Variance £'000	FY Plan £'000
Estates Maintenance & Replacement Expenditure							
STC Phase 3/Erlegh House	103	163	(60)	264	316	(52)	3,200
LD to Jasmine	0	0	0	5	5	(0)	1,533
Abel Gardens - Mobility Relocation	32	26	6	36	26	9	400
Upton Hospital Upgrade of Accommodation	0	0	0	0	0	0	0
PPH Ligature Removal Works	96	76	20	212	193	19	250
Trust Owned Properties	14	86	(72)	83	135	(52)	135
Leased Non Commercial (NHSPS)	78	44	34	112	101	11	382
Leased Commercial	0	0	0	1	0	1	0
Statutory Compliance	0	31	(31)	(8)	31	(39)	200
PFI	0	0	0	2	0	2	580
Subtotal Estates Maintenance & Replacement	**324**	**426**	**(102)**	**705**	**807**	**(102)**	**6,680**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	0	0	0	320
IM&T System & Network Developments	30	31	(1)	104	160	(56)	2,415
IM&T Other	0	15	(15)	0	0	0	30
IM&T Locality Schemes	82	0	82	137	15	122	55
HSLI Community Mobile Working	52	0	52	101	49	52	239
Subtotal IM&T Expenditure	**164**	**46**	**118**	**343**	**224**	**119**	**3,059**
GDE Expenditure							
GDE Trust Funded	161	166	(5)	624	629	(6)	795
GDE Trust Funded	0	0	0	0	0	0	1,258
Subtotal GDE Expenditure	**161**	**166**	**(5)**	**624**	**629**	**(6)**	**2,053**
Other Locality Schemes	7	0	7	29	22	7	150
Total Capital Expenditure	**656**	**638**	**18**	**1,701**	**1,682**	**18**	**11,942**

Key Message

The CapEx plan in the table above reflect the revisions as submitted to NHSI on the 29th July, with the overall plan reducing by £0.4m.

YTD capital spend was broadly in line with the plan at £1.7m, with slippage on Estates projects being offset with overspend on the IM&T programme. The locality IM&T spend is £0.1m this month represents a bulk order for kit to satisfy demand over the coming months. This spend remains a pressure as the budget was reduced and processes revised to focus on the identification and recycling of existing dormant kit.



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper – Public

Board Meeting Date	10th September 2019
Title	**True North Performance Scorecard** **Month 4 (July 2019) 2019/20**
Purpose	To provide the Board with the "True North" Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, QI break through objectives for 2019/20 and national regulator and performance standards.
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 True North Performance Scorecard for Month 4 2019/20 (July 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 4** **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) –** Executive action to refine this indicator to apply to inpatient self-harm only (data line includes community based self-harm re CRHTT caseloads) and review the target. • Prone (Face Down) Restraint **(Patient Experience)** • Patient FFT response rate **(Patient Experience)** • Staff Engagement Score (Staff Survey) **(Supporting our Staff)** • Staff turnover **(Money Matters)**

	Tracker Level 1 Metrics • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards **(Regulatory Compliance)** – reviewing collection methods which are impacting recording of this measure • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP **(Regulatory Compliance)** – as above • Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the Audit of Community Health Services (people on CPA) **(Regulatory Compliance)** – as above • Sickness Rate **(Regulatory Compliance)** – This is not a "hard" compliance focus with NHSI but is tracked, consideration required on threshold. • Mental Health Data Set Data Quality Maturity Index Score (DQMI) **(Regulatory Compliance)** – This is not a "hard" compliance focus with NHSI but is tracked. Expected to be within threshold next month. **Tracker Metrics** • Patient FFT Recommend Rate **(Patient Experience)** – counter measure activities underway and an A3 was reviewed last month by the Executive • Mental Health Clustering **(Patient Experience)** – Executive agreed to escalate to a driver metric, MH divisions informed • Statutory Training – Fire **(Supporting Our Staff)** – Executive agreed an A3 will be developed before further action is taken • Statutory Training – Information Governance **(Supporting Our Staff) –** Executive agreed to defer driver escalation on this indicator as it is close to target • Mental Health: Acute Occupancy rate (excluding Home Leave) **(Money Matters) –** Executive agreed to escalate to a driver metric for Community Mental Health Teams (CMHTs), MH divisions informed • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) -** Executive agreed to escalate to a driver metric for Mental Health

	Inpatients, PPH division informed
Action	The Board is asked to review the True North Scorecard and metric actions, in line with business rules.

Performance Scorecard - True North Drivers (July 2019)

Harm Free Care

Metric	Target	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Falls incidents in Inpatient Wards	19 per month	37	44	40	39	47	41	36	32	26	22	28
Self Harm incidents	61 per month	89	58	51	85	55	51	48	56	121	96	72
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4	<18 per year	1	0	0	0	3	0	0	1	0	0	0
Medication errors (moderate patient impact and above)	5 in a year					0	0	0	0	0	0	0
Number of suicides (per month)	3 per month	3	3	2	3	1	2	2	3	2	2	2
Gram Negative Bacteraemia	1 per ward per year								0	1	0	0

Patient Experience

Mental Health: Prone (Face Down) Restraint	2 per month	7	4	9	11	7	3	3	2	2	3	6
Patient FTT response rate: %	15% compliance	17.2%	15.1%	14.6%	27.7%	21%	25.1%	20%	11%	12.5%	12.4%	12%

Performance Scorecard - True North Drivers (July 2019)

Supporting our Staff

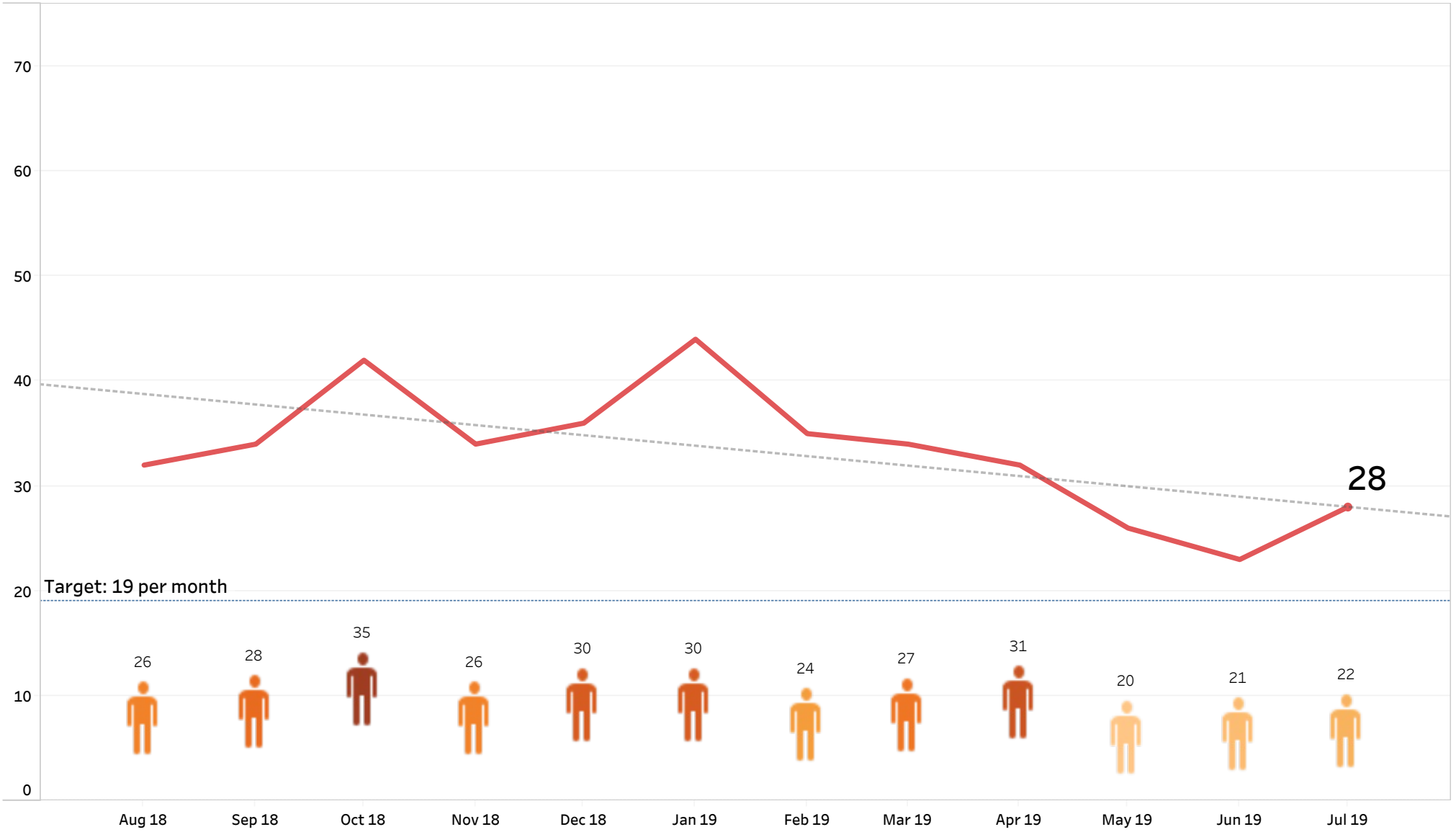
Metric	Target	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Physical Assaults on Staff	44 per month	67	77	51	32	38	27	18	34	38	56	36
Staff Engagement Score (Annual Staff Survey)	Score of 4							3.93	3.93	3.93	3.93	3.93

Money Matters

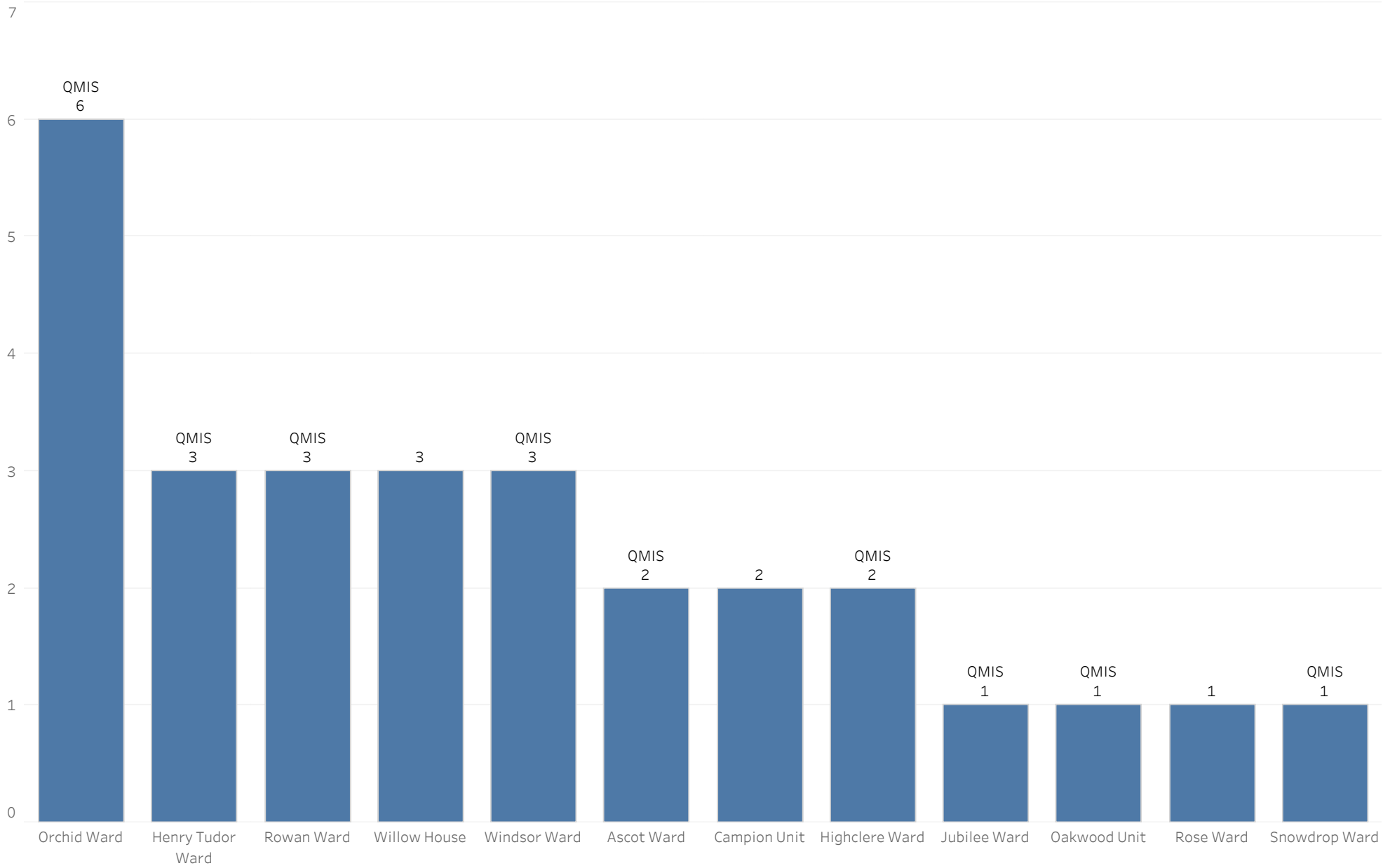
CIP target (£k): (Cumulative YTD)	£4m (annual)								£248k	£461k	£1175k	£1633k
Financial surplus £k (excl. STF): (Cumulative YTD)	-£0.4m								£488k	£560k	£703k	£697k
Staff turnover: %	<16% per month	16.5%	16.9%	17%	17.1%	17.1%	17.1%	17.5%	17.4%	17.1%	16.7%	
Inappropriate Out of Area Placements	464 bed days (cumulative for Qtr)	149	336	160	438	590	150	323	467	136	207	288	109

Harm Free Care Driver: Fall incidents in Inpatient Wards (Aug 18 to Jul 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

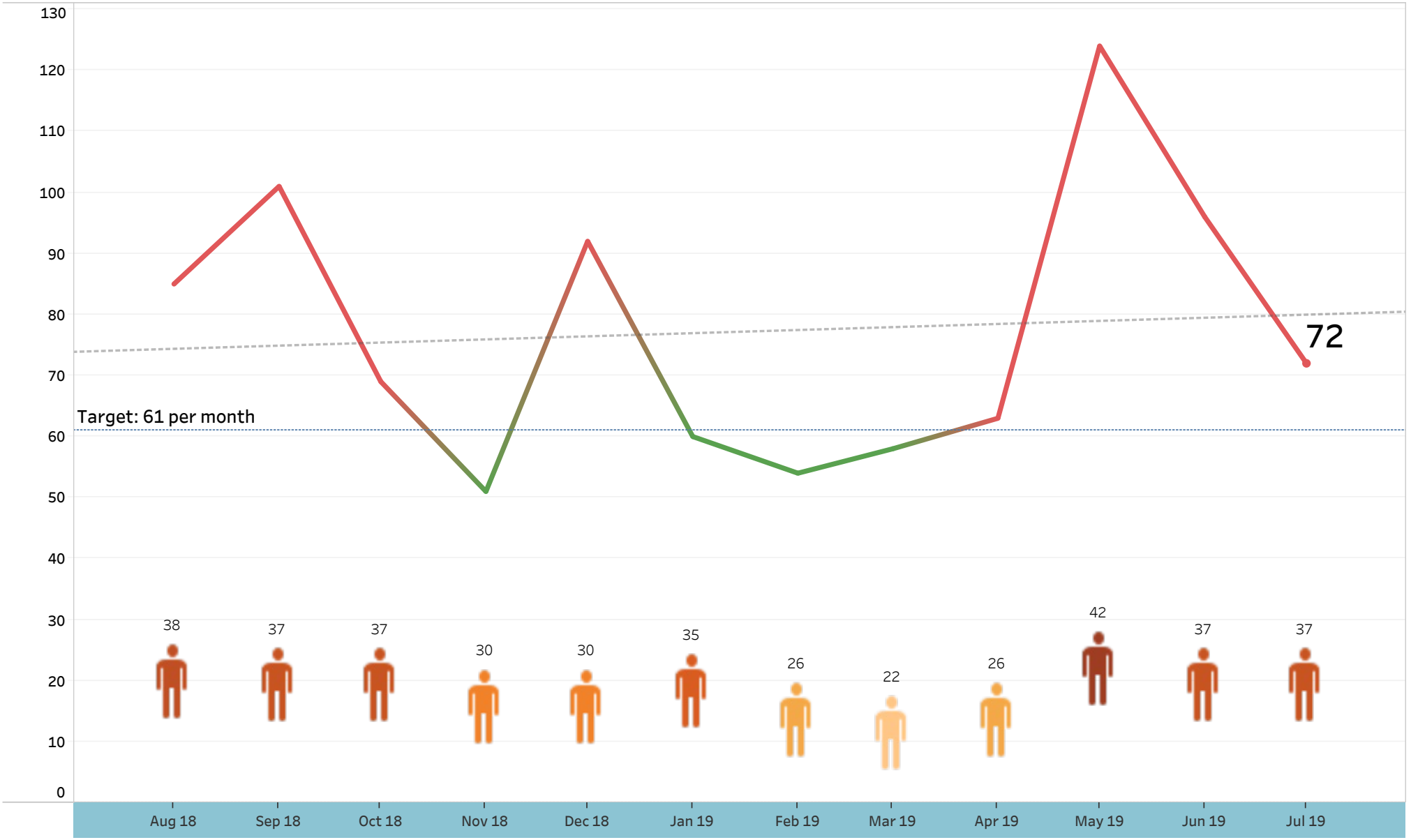


Harm Free Care Driver: Fall incidents in Inpatient Wards(July)

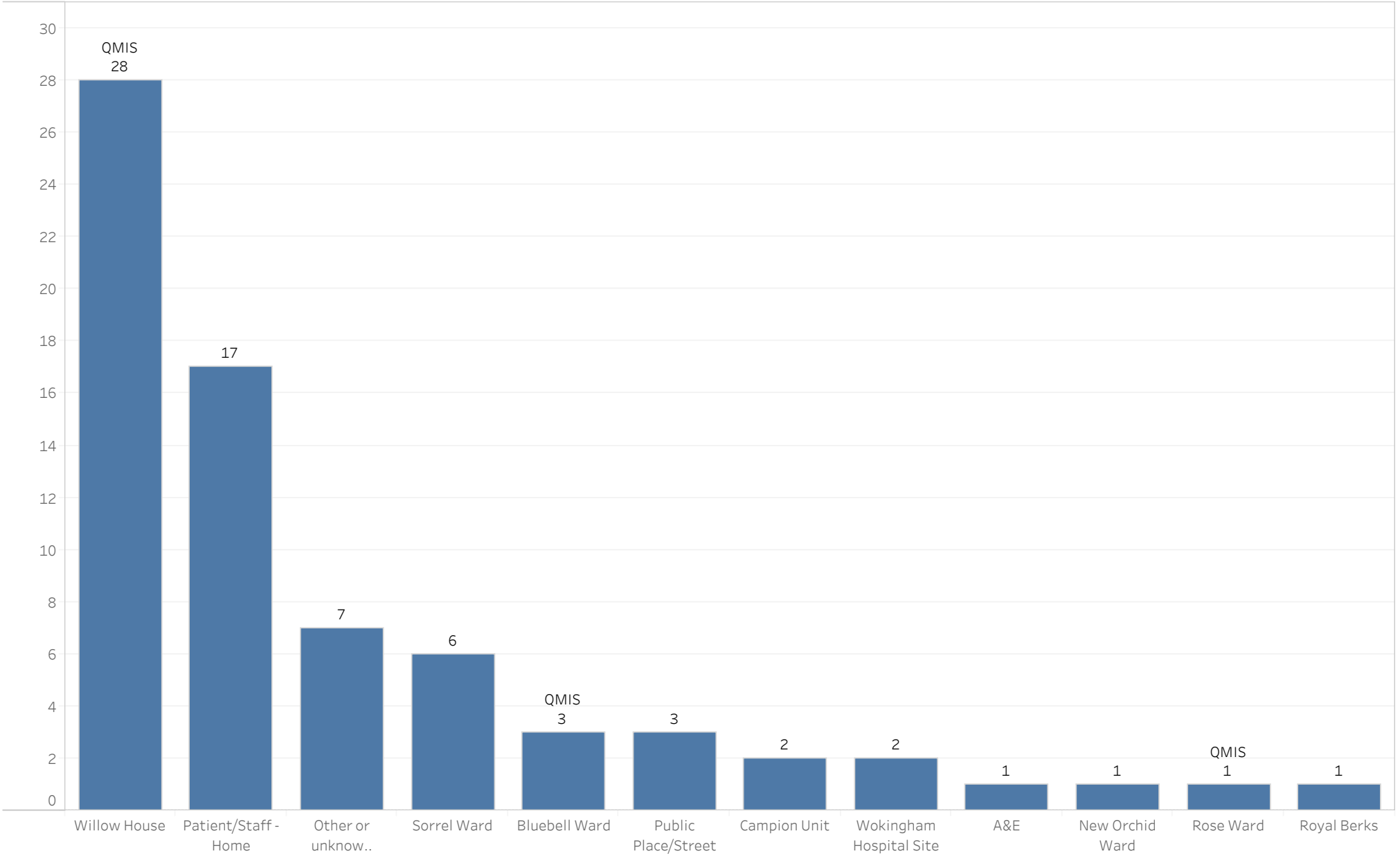


Harm Free Care Driver: Self-Harm incidents (Aug 18 to Jul 19)

Any incident (all approval statuses) where category = self harm

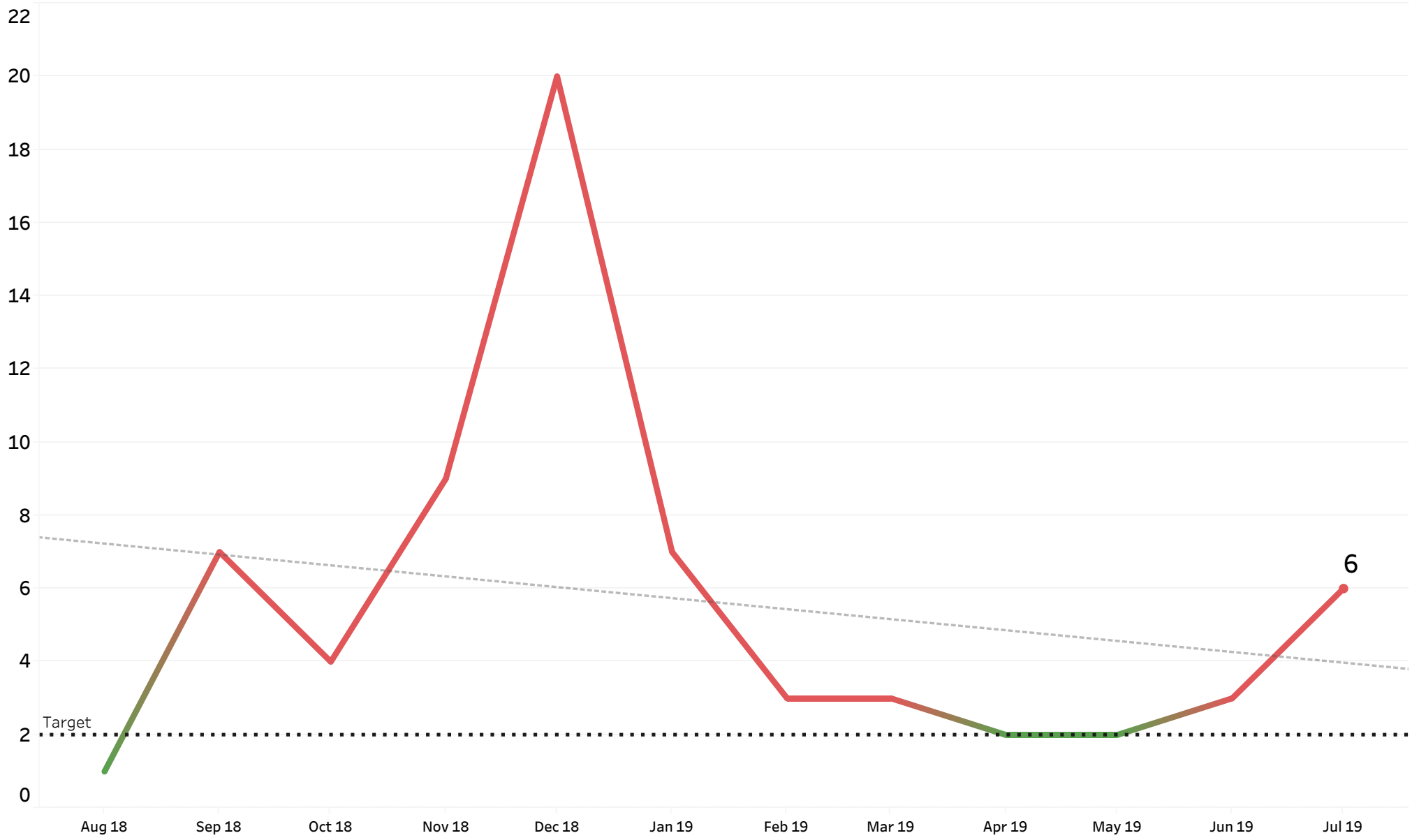


Harm Free Care Driver: Self-Harm incidents by location (July)

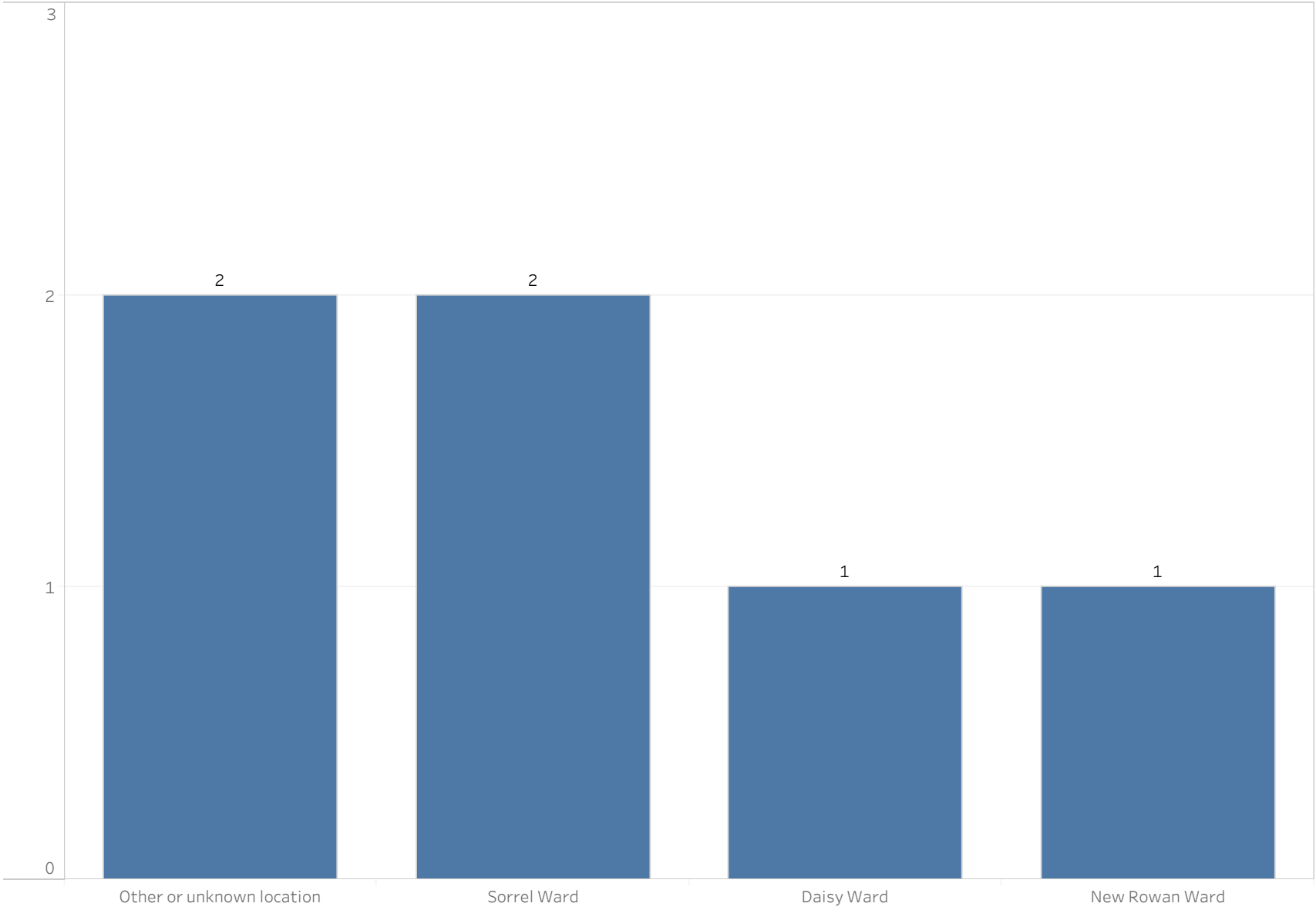


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Aug 18 to Jul 19)

(All approval statuses)

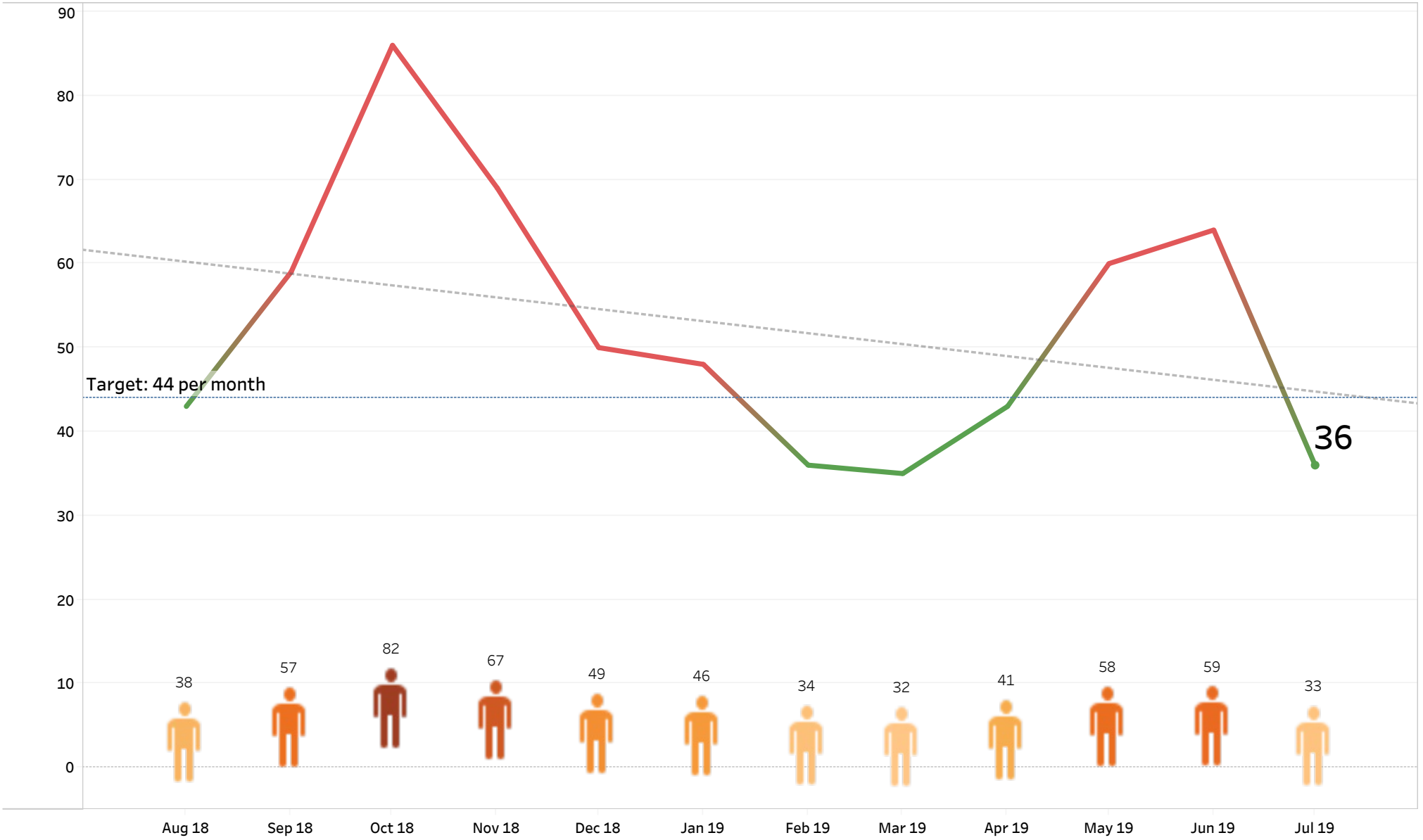


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (July)

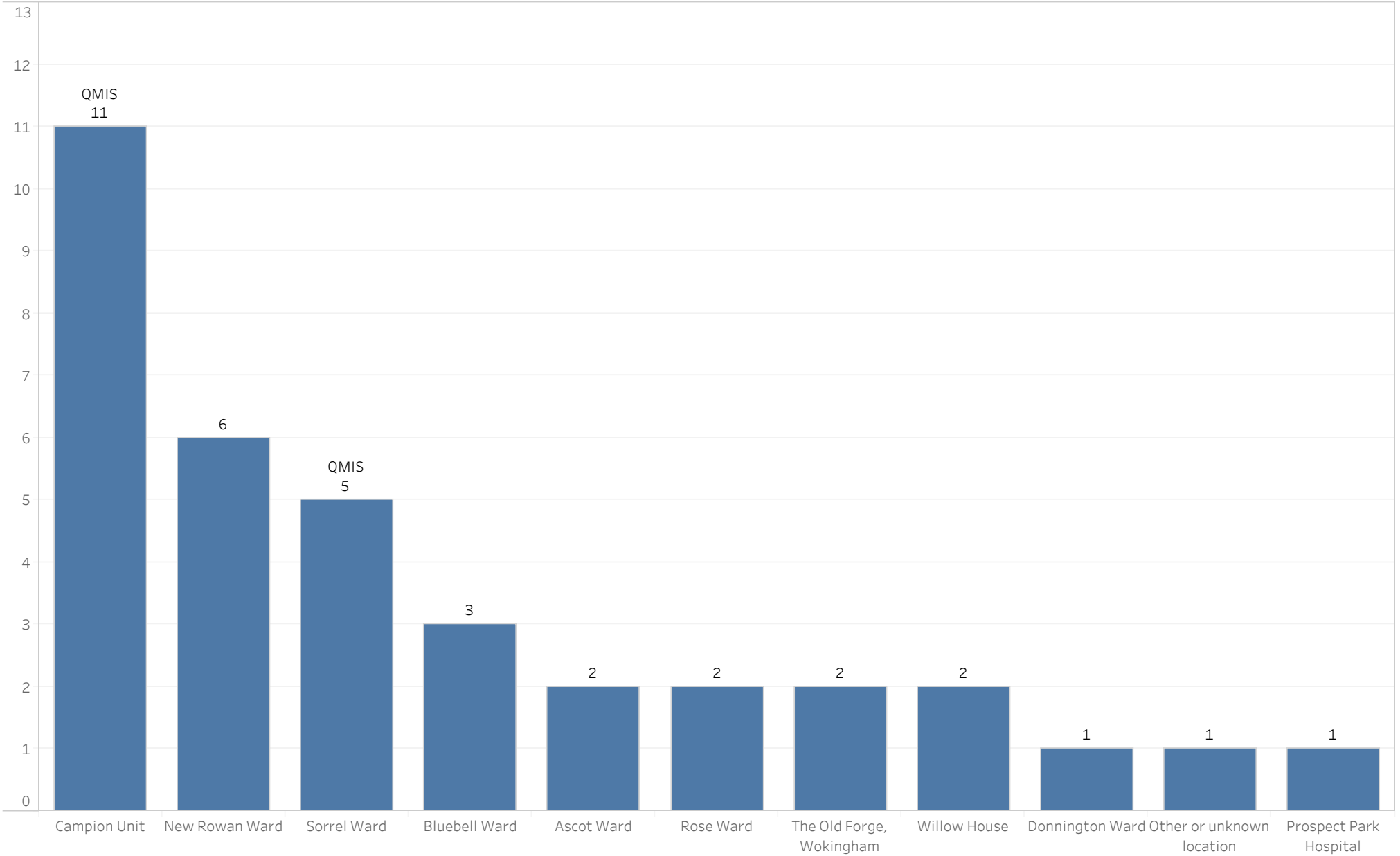


Supporting Our Staff Driver: Physical Assaults on Staff (Aug 18 to Jul 19)

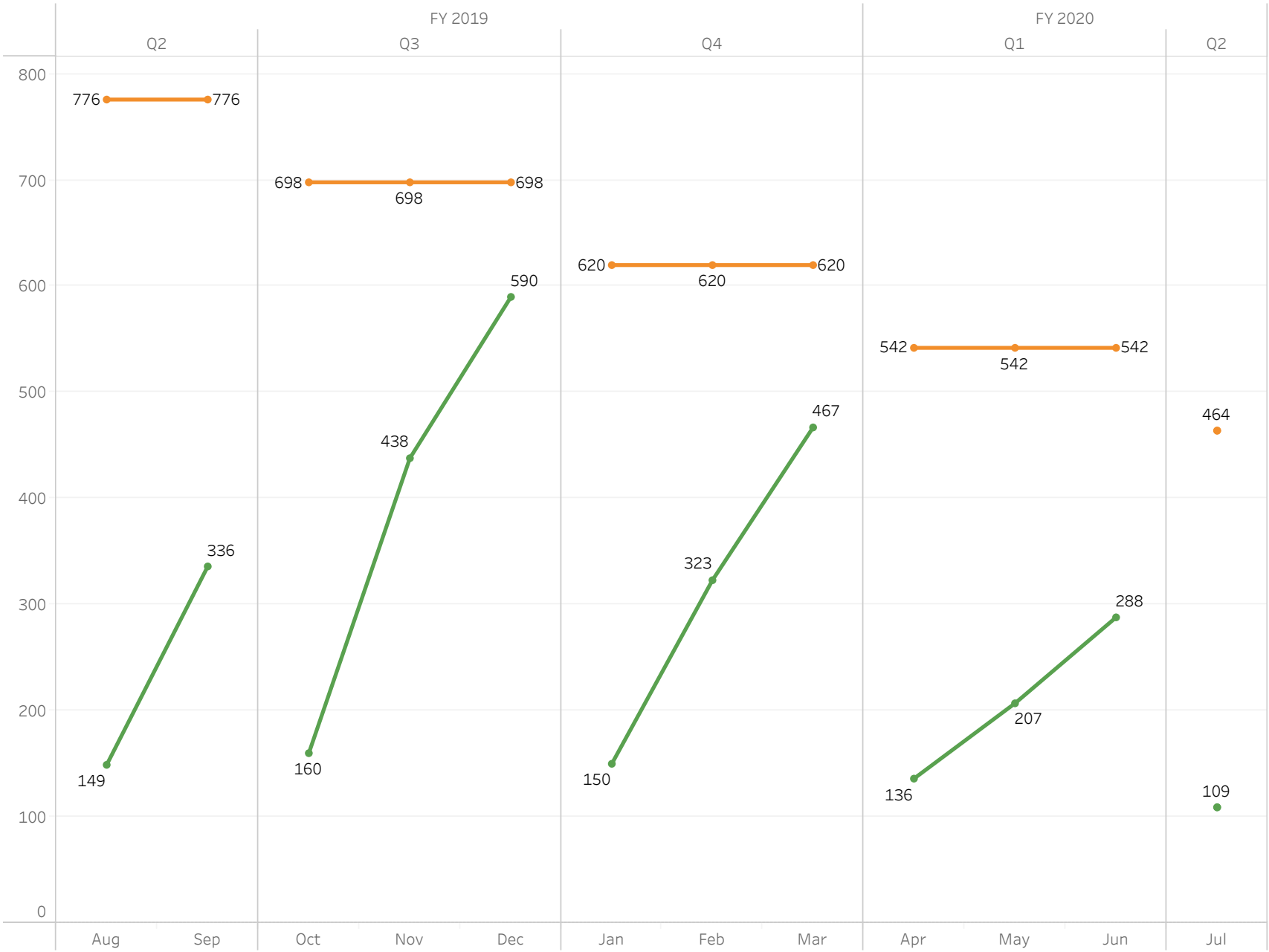
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (July 2019)



Money Matters Driver: Inappropriate Out of Area Placements(July)



True North Harm Free Care Summary

Tracker Metrics

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Pressure ulcers acquired due to lapse in care (Community Nursing & IP wards) ytd days	180 days free in the year									30	61	91	122
Mental Health: AWOLs on MHA Section	16 per month	9	27	19	16	20	25	24	18	14	16	17	13
Mental Health: Absconsions on MHA Section	8 per month	11	21	20	22	26	40	33	19	7	8	9	9
Uses of Learning Disability Strategy for Crisis Intervention & Prevention (SCIP)	10 per month	7	5	6	13	3	0	0	8	4	5	7	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.43	6.21	4.87	4.58	6.32	6.74	7.87	7.50	7.92	6.90	6.25	7.29
Safety Plan for Patients on CPA (formerly MH Crisis Plans for Patients on CPA): %	90% compliance	96.0	96.3	96.2	95.8	95.9	96.7	96.3	96.9	97.0	97.2	97.2	96.6
Patient on Patient Assaults (LD)	6 per month	13	14	20	13	10	7	3	6	3	4	2	4
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health	25% by Sept 2019; 40% by March 2020												10.1%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000					4.3							

True North Patient Experience Summary

Tracker Metrics

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Patient on Patient Assaults (MH)	38 per month	56	55	52	54	53	59	49	45	24	28	21	25
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	94.5%	93.5%	90.7%	89.9%	90.4%	92.3%	90.6%	94.2%	92.0%	90.6%	97.1%	94.0%
Mental Health: Uses of Seclusion	13 in month	15	4	8	15	18	12	10	8	15	11	12	11
Patient FFT Recommend Rate: %	95% compliance	96%	97%	95%	94%	94%	94%	92%	89.7%	93%	92.2%	90.6%	92.4%
Learning Disability: Seclusion	0	1	0	2	0	2	0	0	0	0	0	0	0
Community Inpatient Average Length of Stay (bed days)	<28 days	24.3	24.4	21.3	23	20.2	22.1	22	21.1	22.3	22.6	22.6	26.1
Mental Health Clustering within target: %	90% compliance	83.4%	84.5%	82.1%	82.9%	82.8%	79.2%	78.0%	78.7%	80.2%	79.3%	78.9%	77.7%

True North Supporting Our Staff Summary

Tracker Metrics

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Gross vacancies: %	<10%	8.90%	9.19%	9%	8.30%	9%	7.79%	7.00%	6.80%	10.1%	10%	9.30%	9.19%
Statutory Training: Fire: %	95% compliance	89.0%	89.2%	90.1%	89.9%	87.8%	87.2%	87.9%	88.7%	88.5%	90.2%	90.7%	92.1%
Statutory Training: Health & Safety: %	90% compliance	93.7%	93.7%	93.9%	94.1%	93.5%	94.0%	94.5%	94.6%	94.8%	95.2%	95.2%	95.9%
Statutory Training: Manual Handling: %	90% compliance	91.5%	90.9%	91.6%	92.1%	88.9%	89.2%	90.2%	90.2%	90.8%	92.2%	92.6%	93.0%
Mandatory Training: Information Governance: %	95% compliance	88.1%	91.2%	93.3%	94.0%	94.5%	88.7%	92.1%	94.2%	93.6%	94.0%	93.3%	94.6%
PDP (% of staff compliant) Appraisal: %	95% compliance by end of May 2019	95%	93.0%	91.5%	89.6%	88.0%	86.9%	85.0%	82.6%	9%	75.9%	95%	87.7%

True North Money Matters Summary

Tracker 1

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly	7.50%	8.07	8.38	7.59	7.82	12.8	11.2	9.00	8.09	5.89	6.27	6.29	5.80

Tracker Metrics

Community Inpatient Occupancy: %	80-85% Occupancy	70.2%	77.7%	74.7%	76%	71.6%	81.3%	86.5%	82.7%	81.6%	74.9%	81.8%	76.7%
Mental Health: Acute Occupancy rate (excluding Home Leave): %	85% Occupancy	96.6%	97.8%	97.6%	98.5%	93.5%	97.5%	98.5%	93.3%	95.9%	94.5%	97.8%	98.7%
Mental Health: Acute Average Length of Stay (bed days)	30 days	39	45	48.0	51.4	47.2	43	39	41	37.1	39	35.8	38.4
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	79.4%	80.4%	69.2%	64.3%	83.5%	93.4%	92.8%	87.0%	83.5%	92.8%	65.6%	76.5%
DNA Rate: %	5% DNAs	4.76%	4.66%	4.87%	4.75%	4.70%	4.76%	4.79%	4.85%	5.29%	4.90%	5%	4.90%
Community: Delayed Transfers of Care (NHSI target) Monthly and Quarterly	7.5% Delays	5.29%	8.38%	7.63%	7.82%	12.8%	10.1%	9.67%	9.90%	4.70%	4.79%	4.79%	9.70%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Mental Health: 7 day follow up (Quality Domain): %	95% seen	100	94.3	98	97.0	97.5	96.2	96.9	99	99	94.3	95.3	95.1
C.Diff due to lapses in care YTD	0	0	0	1	1	1	0	0	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	42.1	42.1
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	88.4	88.4
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	93	93	100	21	21
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	0	0	0	1	0	1	0	1	0	0	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	90.9	50	80	100	60	100	90	62.5	90	100	100	75
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	100	100	100	100	100	100	99.9	99.7	99.5	99.9	100	98.8
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	99	98	98	99	99	97	98	99	98	97	96	95
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	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	55.0	56.9	55.0	55.0	56.9	57.9	57.9	57.5	57.5	56.0	56.0	55.0
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation		67	68	70	70	71	71	69	69	66	66	66
% clients in Mental Health Services in Employment	9% in Employment		12	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	98.7	99.7	100	100	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	97.4	100	98.2	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	99.1	100	100	100	98.5	100
Sickness Rate: %	<3.5%	3.83	4.07	4.42	4.65	4.10	4.39	4.59	3.89	3.81	3.59	3.75	
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null			86	84	84	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	3	2	2	2
Mental Health Data Set Data Quality Maturity Index Score (DQMI)	95% achieved	94.1	94.1	99.7	99.7	99.7	99.9	99.9	99.9	96.5	96.5	91.5	94.2

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2019
Title	**Finance, Investment & Performance Committee – Changes to the Committee's Terms of Reference**
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Naomi Coxwell, Committee Chair
Relevant Strategic Objectives	True North Goal 4 - To deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The Committee has reviewed its terms of reference and has identified a number of minor changes (highlighted in red type).
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference as agreed by the Committee on 31 July 2019.

Berkshire Healthcare
NHS Foundation Trust

Finance, Investment & Performance Committee

Terms of Reference

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10	June 2019	Julie Hill	Amended following review by F,I&P Committee – for board approval September 2019

1. Authority

1.1 The Finance, Investment & Performance Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out as below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from within and outside the Trust if it considers this necessary to discharge its duties.

2. Purpose

2.1. To conduct independent and objective review of financial and investment policy and to review financial and operational performance information and issues. To discharge this duty the Committee will:

2.1.1 scrutinise and review current financial performance, ensuring that there are robust plans in place to correct any material adverse variances from financial plan.

2.1.2 scrutinise and review ~~both tier 1 and tier 2~~ organisational performance as reported within the Trust's True North Performance Scorecard ~~Assurance Framework report~~ in accordance with the agreed business rules ensuring that there are robust plans in place to correct any material adverse variances from target.

2.1.3 Identify area ~~-~~for more in depth review and scrutiny

2.1.4~~3~~review the Trust's Investment Strategy and Policies and maintain scrutiny and oversight of investments and significant transactions ensuring compliance with the regulator and Trust Policy.

2.1.5~~4~~examine the Trust's medium term financial strategy and provide assurance that the Trust's future strategic service plans support continued compliance with NHS Improvement's Provider Licence and the Single Oversight Framework.

2.1.6~~5~~review the progress against national requirements for maintaining safe staffing ~~on the Trust's inpatient wards~~

2.1.8~~6~~review the relevant risks on the Board Assurance Framework.

3. Membership

3.1 The members of the Committee shall be as follows:

- Three Non-Executive Directors
- Chief Executive
- Chief Financial Officer ~~Director of Finance, Performance & Information~~ (Lead Executive Director)
- Chief Operating Officer or Deputy
- Director of Nursing & Governance or Deputy Director of Nursing
- Director of Finance will be in attendance at the meetings

3.2 The Chair of the Audit Committee shall not be a member.

3.3 The Chair of the Committee will be a Non-Executive Director.

3.4 A quorum shall be three members, including at least two Non-Executive Directors.

4. Frequency and Administration of Meetings

4.1 The Committee will meet at least 4 times a year. It may meet more frequently at any time should circumstances require.

4.2 The Committee will be supported by the Company Secretary who will agree the Agenda for the meetings and the papers required, directly with the Chair.

4.3 Minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

5. Remit

5.1 Financial Policy and Performance

5.1.1 To review and scrutinise current financial performance and assess adequacy of proposed rectification to bring performance in line with plan (where necessary).

5.1.2 To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity.

5.1.3 To examine the Trust's annual financial plan and maintain an oversight of Trust's income sources and contractual safeguards.

5.1.4 To initiate in-depth investigations and receive reports on key financial, investment and performance issues affecting the Trust.

5.1.5 The committee will review long term financial projections, those overarching the more detailed review of annual budget proposals.

5.2 Investment Policy and Performance

5.2.1 To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions.

5.2.2 To scrutinise all investment proposals for financial implications and consistency with strategic plans prior to submission to the Board when required.

5.2.3 To receive and scrutinise future service and business development proposals, including enhancements to existing contracts, acquisitions, etc to ensure proper financial evaluation, including impact on future risk ratings.

5.2.4 To ensure adequate safeguards on investment of funds.

5.2.5 To receive reports as appropriate on actual or potential breaches of the Prudential Borrowing Code.

5.2.6 To review, at least annually, credit ratings, report on benchmarking of investments and borrowing activities since the date of the last review.

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

5.3.1 To review and scrutinise ~~tier 1 and 2~~ organisational performance as reported within the Trust's True North Performance Scorecard ~~Assurance Framework~~ report in accordance with the business rules~~.~~

5.3.2 To assess the appropriateness of remedial action to address material variances from target and to monitor progress.

5.3.3 To consider the overall adequacy of the True North performance Scorecard ~~assurance framework~~ and the monitoring metrics and to recommend changes as necessary to maintain appropriate levels of Board assurance.

Amended: ~~May 2017~~ July 2018

Approved by Trust Board: ~~11 July 2017~~

For review: July 2020~~8~~

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th September 2019
Title	Workforce Disability Employment Standard (WDES)
Purpose	To update the Board on the Workforce Disability Employment standard (WDES) and to seek authorisation for publication of required information in September 2019.
Business Area	Corporate
Author	Equality Employment Programme Administrator Director of People
Relevant Strategic Objectives	Providing a supportive and fair working environment for our disabled staff is a key part of our "Supporting our Staff" goal. We recognise the added value that a diverse workforce brings to our organisation and want to make sure that all staff have a positive experience of working for Berkshire Healthcare.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty.
Equality and Diversity Implications	The Workforce Disability Employment Standard (WDES) is now a requirement for all NHS Trusts and part of the NHS standard contract. The WDES is an important means of identifying and informing our response to differences in the experience of disabled staff.
SUMMARY	The WDES came into force this year, and is similar in its approach to the Workforce Race Equality Standard. There are 10 metrics covering the workforce profile, recruitment and capability processes, experience of disabled staff, board make up and the opportunity that disabled staff have to voice and air their concerns and to be heard. Key areas for improvement for us are: • Improvement in rates of declaration of disability • Improving the experience of disabled staff as measured through the national NHS Staff

	Survey • Completion of our work to guide managers and staff in terms of reasonable adjustments. Our Purple Network for disabled staff has had a very successful year, and has helped to raise awareness and understanding. We will continue to work in collaboration with the network to achieve the objectives set out in our WDES action plan.
ACTION	To note the WDES results and associated action plan and approve their publication as required.

Workforce Disability Employment Standard (WDES)

1.0. Purpose

This paper informs the Board of the new reporting requirements regarding staff with a disability – the Workforce Disability Employment Standard (WDES). This came into force on 1st April 2019, and is due for publication in September 2019. The paper explains the requirement, the information we will report and actions linked to it.

2.0. Background

4.9% (215 headcount) of staff working for Berkshire Healthcare have a disability, as recorded in our Electronic Staff Record (ESR) system. The 2011 census shows 12.7% of the Berkshire population have a disability. The national average percentage of staff stating that they are disabled on ESR is 3%, at the same time an average 18% declare that they have a disability on the NHS National Staff Survey (NSS) – a 15% difference in the declaration rate. The ESR system is used for administrative and managerial purposes, whereas the NSS is confidential between the individual and NSS provider: we know both from research and anecdotal evidence, that many disabled staff are reluctant to disclose to their employer that they have a disability.

The Workforce Disability Employment Standard (WDES) has been established to improve the experience of disabled staff working in, and seeking employment in, the NHS: Results of the NSS show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities.

At Berkshire Healthcare, we have an ambition to make this a great place to work for everyone, to continue to improve the diversity of our workforce, and therefore improve the outcomes we can achieve for patients, as well as to reflect the population we serve in the makeup of our workforce.

The WDES is a set of ten evidence-based metrics that will enable NHS organisations to compare the reported outcomes and experiences of disabled and non-disabled staff. Metrics 1, 2, 3 and 10 compare the profile of disabled and non-disabled staff in terms of a) pay bands, b) recruitment processes, c) capability processes, and d) board make up. Metrics 4-8 are comparing the experiences of disabled and non-disabled staff as shown by responses to specific NSS questions. Metric 9 is focused on assessing the extent to which disabled staff have the opportunity to voice and air their concerns and to be heard. Organisations are expected to publish their results and develop action plans to address any areas of improvement highlighted.

Our results and associated action plan will be published on our website in September and will also be shared with East Berkshire and Berkshire West Clinical Commissioning Groups as required by NHS England.

Key points about the WDES are as follows:

- Metrics will be reported from 1 April 2019 based on 2018/19 financial year data.
- It is mandated in the NHS Standard Contract.
- It is restricted to NHS Trusts and Foundation Trusts in the first two years of implementation.
- Information must be published by 30th September 2019
- It is voluntary for national health bodies

- It does not currently apply to Clinical Commissioning Groups or the independent sector – engagement work will take place in 2019.
- The CQC inspection will not include WDES in the first year (the Workplace Race Equality Standard is in scope of inspections currently).

3.0. Positive outcomes the WDES will bring to the Trust

- Building on progress – the data we collect will be used to undertake year on year comparisons. This will highlight areas of improvement and areas where further work is needed. We can also compare results with other Trusts.
- Cultural change – we will share our WDES results with our staff, and work with our Purple Network to analyse and confirm priority actions in response to our results. This will include: continuing to increase the diversity of our workforce; providing effective and appropriate reasonable adjustments; ensuring a positive experience at work for our disabled staff.
- Improved data – we will work to increase the declaration rate of disabled staff and as a result we will have more accurate data reporting and analysis.

4.0. WDES 2019 Results: workforce makeup

The numbers of disabled and non-disabled staff employed in our trust at various bands is set out below. Although it is pleasing to see that our results are higher than those of our benchmark group, it is important to remember that our records are incomplete given the low level of declaration of disability on ESR – although this is a national issue, and our declaration rate is slightly above the national average.

	Disabled	Benchmark (against trust type)	Not disabled	Missing or not declared
Total	**4.9%**	**4.6%**	**79.6%**	**15.6%**
Bands 1-4	**5.1%**	**4.7%**	**79.6%**	**15.3%**
Bands 5-7	**4.5%**	**4.9%**	**82.1%**	**13.6%**
Bands 8a-8b	**5.2%**	**3.6%**	**81.2%**	**13.6%**
Bands 8c-9 and VSM	**6.0%**	**2.6%**	**74%**	**20%**

	Disabled	Benchmark (against trust type)	Not disabled	Missing or not declared
Medical and Dental Consultant	**3.5%**	**2.2%**	**50.4%**	**46.1%**
Medical and Dental non Consultant Career Grade	**5.0%**	**4.4%**	**66.7%**	**28.3%**
Medical and Dental trainee Grades	**0%**	**6.2%**	**0%**	**100%**

Our Trust Board does not include any members with a disability at present.

5.0. WDES 2019 Results: relative likelihood of appointment

The likelihood of disabled staff being appointed from shortlisting is 0.23 (241 shortlisted and 55 appointed). The likelihood of disabled staff being appointed from shortlisting compared to non-disabled staff is 0.99, where a score of 1 would indicate exactly the same relative likelihood.

6.0. WDES 2019 Results: relative likelihood of entering the formal capability process

This metric is a voluntary one in this first year of the WDES. Our results show the likelihood of a disabled member of staff entering the formal capability process is 0.01. The likelihood of a disabled member of staff entering the formal capability process in comparison to a non-disabled member of staff is 9.66. It is important to note that this data is derived from 3 members of staff entering the formal capability process.

Although not a WDES requirement, we have also analysed our disciplinary and grievance resolution time for disabled and non-disabled staff and our data analysis shows that average resolution times for disabled staff are lower than the overall average for both disciplinary and grievance cases in 2018/19.

Disciplinary (2018/19)

- Disabled staff 41 days
- Non-disabled staff 46 days

Grievance (2018/19)

- Disabled staff 57 days
- Non-disabled staff 68 days

7.0. WDES 2019 Results: NSS responses

The total number of disabled people working for our Trust who responded to the NSS in 2018 was 380 - 8.8% of the total headcount of the Trust. Those who identified as having a disability were 18.3% of the total number of responses. The ESR system shows 4.9% of our workforce reporting that they have a disability. The relatively high number of responses from disabled staff to the NSS can probably be credited to our staff network (the Purple Network) and its supporters – and it is encouraging that we are hearing from a large number of people with a disability.

However, in line with national trends, our responses show a number of important differences in the experience of our staff with a disability which are a cause for concern: greater experience of harassment, bullying and abuse; a lower level of belief that the Trust provides equal opportunities for career development; a lower level of satisfaction that the Trust values their work. However, a slightly higher percentage of staff with a disability have reported their last experience of harassment, bullying or abuse.

NSS Q	Question	Overall Trust	Staff with a disability	Staff with no disability
11e	Not felt pressure from manager to come to work when not feeling well enough	81.0%	73.1%	83.1%
5f	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work	55.1%	44.2%	58.4%
13a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	75.0%	65.3%	78.0%
13b	Not experienced harassment, bullying or abuse from managers	88.4%	81.2%	90.6%
13c	Not experienced harassment, bullying or abuse from other colleagues	83.9%	73.9%	86.9%
13d	Last experience of harassment/bullying/abuse reported	56.4%	60.4%	54.7%
14	Organisation acts fairly: career progression	85.1%	82.6%	86.2%
28b	Disability: organisation made adequate adjustment(s) to enable me to carry out work	73.6%	73.6%	*

Where a breakdown or question had less than 11 respondents, the score was recorded as ''*

The overall staff engagement score for our organisation is 7.4 and the score for our disabled staff is 7 (the same as the average engagement score for our type of trust). It is our ambition that all our staff in all services and locations are well engaged and having a positive experience of working at Berkshire Healthcare.

These results have been shared and discussed with our Purple Network, and have informed development of actions that we will be taking forward to improve our results. We recognise that this will require a long term and consistent commitment.

8.0. WDES 2019 Results: action taken to facilitate the voice of disabled people being heard.

Our Purple Network for staff with a disability has had a really successful year – and highlights include:

- The "Maximising Our Ability" conference held in March.
- Promotion of World Mental Health Awareness Week, "Time to Talk" day and World Autism Awareness Week as well as "Purple Light Up Day" last December

As stated above, the results of the NSS were discussed with network representatives, and the network has also undertaken its own survey to support our understanding of the experience of staff with a disability, and enable us to take action in response. This has informed our action plan as well as the priorities and goals of the network, which are:

- Increasing Purple confidence, and raising network profile
- Addressing barriers and issues faced by "Purple People"
- Supporting reasonable adjustments process
- Making a positive impact on staff wellbeing and work related stress, and promoting the 'Time to Talk initiative'

9.0. Action requested of the Trust Board:

- Note the action being taken in response to our results, summarised in the action plan in appendix 1.
- Approve the publication of the WDES data in line with national requirements

10.0. **Action Plan**

The Purple Network, Human Resources, Operational Managers and Clinical Leaders will work together on the following:

Action	Progress	Next Steps	Timescale
Support our Purple Network in the achievement of their objectives	The Purple Network has made great progress this year, and has a well- established leadership and growing membership: the Maximising our Ability Conference was held in March 2019; the network pages on our intranet has much improved information and access to resources for our staff.	Review our WDES data with the Purple Network and use good practice evidence from the national WDES team, other NHS Trusts and the international Purple Space organisation to inform further work.	By end Dec 19
Increase disability declaration rates on ESR	Our "Do ask, do tell" approach has been commenced and promoted through our Trust Leaders and Managers Forum. Our declaration rates are slightly above the national average, but are significantly short of Staff Survey response numbers. .	Ensure managers can access information about appropriate and sensitive ways of handling sensitive staff disability information. Communicate a reminder about the importance of declaration to all staff, and how they can use ESR Self Service functionality to update their personal information.	By end Dec 19
Continue to attract a diverse range of applicants to work for us.	We have achieved a good level of likelihood of appointment from shortlisting of disabled staff in comparison to non-disabled staff.	Profile the value of the contribution of disabled staff through the Purple Network and internal communications.	By April 19
Address the poorer experience of disabled staff reported through the NSS.	Our Making it Right for Managers course has been piloted this year and results are now being used to inform further development. Our Freedom to Speak Up Guardian is linked into all our staff networks to facilitate support for people who may wish to raise concerns confidentially	Develop and implement Making it Right for Disabled Staff. Review the need for further/amended content for our management training courses to ensure understanding of the experience of disabled staff and how to support a positive experience at work for them.	By April 19
Complete policy and guidance work on reasonable adjustments and capability procedures.	A targeted piece of work has been undertaken this year, to improve our guidance on reasonable adjustments for staff. The policy work is almost complete and ready for formal approval.	Complete the policy approval process and publish guidance for staff and managers on reasonable adjustments. Use good practice guidance to inform capability policy separation on the grounds of ill-health and capability on the grounds of performance and complete and secure approval for required changes.	By April 19

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th September 2019
Title	**Workforce Race Equality Standard Report (WRES) 2019**
Purpose	To provide a summary of our 2019 Workforce Race Equality Standard (WRES) results and request approval for their publication, along with the associated action plan
Business Area	Corporate
Author	Bev Searle, Director of Strategy and Corporate Affairs
Relevant Strategic Objectives	Providing a supportive and fair working environment for our Black, Asian and Minority Ethnic (BAME) staff is a key part of our "Supporting our Staff" goal. We recognise the added value that a diverse workforce brings to our organisation and want to make sure that all staff have a positive experience of working for Berkshire Healthcare.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes. The WRES is part of the CQC "Well-led" domain.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty.
Equality and Diversity Implications	The WRES is a requirement for all NHS Trusts and part of the NHS standard contract. The WRES results are an important driver of our equality and inclusion activity in relation to our BAME staff.
SUMMARY	This paper presents the 2019 Workforce Race Equality Standard (WRES) report and action plan which must be shared with the Board prior to publication within a template provided by NHS England Improvements have been achieved in some elements of our workforce composition and we continue steady progress in closing the gap between white and BME staff in terms of likelihood of

	appointment from shortlisting. A number of WRES indicators are measured by the responses to our national NHS Staff Survey which were reported to the board in May 2019. These continue to give rise to concern and our WRES action plan is focused on achieving improvement in rates of bullying and harassment and discrimination experienced by our BME staff. We are continuing to implement our Making it Right Programme and to work in collaboration with our BAME network to achieve the improvements needed, which will require consistent and concerted effort over time. The Diversity Steering Group will continue to monitor the implementation of the action plan and progress will be reported to the board as part of equality update reports on a regular basis. Note: The category BME rather than BAME is used by NHS England, and for consistency, is also used in this report to refer to Black and Minority Ethnic staff.
ACTION	To note the 2019 WRES results and action plan To approve the publication of the WRES results and action plan. To authorise the Director of Strategy and Corporate Affairs to complete the NHS England template for publication on behalf of the Trust Board.

Workplace Race Equality Standard Report 2019

1. Introduction

This paper sets out our Workforce Race Equality Standard (WRES) results for 2019, along with our associated action plan. Subject to Board approval, both will be published on our website, as required by NHS England, by 27th September. This year's WRES report includes additional information enable comparison with previous year's results as well as with results from other trusts.

2. Background

The WRES was introduced in April 2015 by NHS England to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment at work. We know that a motivated, included and valued workforce supports delivery of high quality patient care – including both better safety and experiences of care. The WRES was mandated through the NHS standard contract from 2015 and requires organisations to review their data against nine key indicators, and produce action plans to close the gaps in workplace experience between white and black and ethnic minority (BME) staff and improve BME representation, including at Board level. We are also required to publish our results and our action plan.

Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses upon BME representation on boards.

The Trust has completed an annual WRES submission from 2015 onwards, which has assisted us in implementing our own Equality and Inclusion Strategy, and has been an important driver of our Making It Right initiative which was initially piloted with our BAME staff.

3. WRES results: findings and conclusions

3.1 WRES indicator 1: Percentage of staff in each of the Agenda for Change pay bands 1-9, and VSM (Very Senior Manager) grades.

As at 31st March 2019 the Trust employed 4,341 members of staff - 82.4% female and 17.6% male. The Trust ethnicity profile as at March 2019 shows that all ethnicities and the 'undisclosed' status have not changed from last year - none of them have increased or decreased more than one percentage point. The percentage of BME staff employed by the Trust is 21.85%, and therefore broadly reflects the Berkshire population of 20% BME people recorded at the 2011 census. Our records showed that 5% of our staff had undisclosed ethnicity.

Our workforce profile has remained broadly similar for the last six years. However, for the 2018/19 reporting year, there was a 4.7% increase in the proportion of male staff. Efforts to encourage staff to review equality data held on their staff record this year led to a small increase in data completeness for all our protected groups.

Table 1 below shows the numbers and percentages of BME and non-BME staff employed across the Agenda for Change pay bands. Key points to highlight are as follows:

- The largest numbers of BME staff are employed in bands 1 -7, with under-representation in relation to the Berkshire BME population starting at band 8a.
- We have maintained achievement of our target of 20% BME staff employed in bands 5-7, which we also met last year.
- BME staff employed in non-clinical roles at band 5 is 18.8%, and is an increase from the 11.6% reported last year.
- We have seen a decrease in BME staff employed in non-clinical roles at bands 6, 7 and 8b in comparison to last year, but an increase in bands 8c and 8d.
- Although the 17% of BME staff employed in clinical roles at Band 8a is not yet at our 20% target, this is an improvement on the 14.9% we reported last year.
- There are very limited changes in the percentages of BME staff employed in clinical roles at bands 8b and above, which given the smaller numbers of staff included, are not statistically significant.

Table 1. Percentage of BME and non-BME staff in Agenda for Change pay bands in clinical and non-clinical roles.

Pay Band	Total Clinical Staff	% of Clinical Staff (BME)	% of Clinical Staff (Non-BME)	% of Clinical Staff (Ethnicity Undisclosed)	Total Non-Clinical Staff	% of Non Clinical Staff (BME)	% of Non Clinical Staff (Non BME)	% of Non Clinical Staff (Ethnicity Undisclosed)
Band 1					38	28.9%	63.2%	7.9%
Band 2	166	48.8%	46.4%	4.8%	130	12.3%	82.3%	5.4%
Band 3	370	23.5%	73.0%	3.5%	261	16.1%	82.0%	1.9%
Band 4	339	17.1%	77.9%	5.0%	241	22.0%	72.6%	5.4%
Band 5	419	30.8%	62.5%	6.7%	112	18.8%	75.0%	6.3%
Band 6	824	22.2%	73.5%	4.2%	124	23.4%	73.4%	3.2%
Band 7	557	21.7%	75.8%	2.5%	85	29.4%	63.5%	7.1%
Band 8a	194	17.0%	79.9%	3.1%	68	14.7%	80.9%	4.4%
Band 8b	59	10.2%	89.8%		32	6.3%	87.5%	6.3%
Band 8c	23	13.0%	78.3%	8.7%	31	19.4%	80.6%	
Band 8d	18		100.0%		10	20.0%	60.0%	20.0%
Band 9	0				<6	25.0%	50.0%	25.0%
Other *	208	41.8%	34.1%	24.0%	25	8.0%	56.0%	36.0%
Grand Total	**3180**	**24.8%**	**69.8%**	**5.4%**	**1161**	**18.9%**	**75.7%**	**5.3%**

As at 31st March 2019, 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.

50.47% of Consultants are from a BME background, 13.08% did not state their ethnicity.
36.84% of Dentists are from a BME background, 10.53% did not state their ethnicity.
10.00% Junior Doctors are from a BME, 80.00% did not state their ethnicity.

VSM grade numbers are very small and as at 31st March 2019, we had 3 VSM posts, with no BME staff employed at that grade.

The Making it Right (MIR) programme is aimed at supporting the development of our band 5-7 BME staff, and we will start cohort 4 later this month, with a good proportion of band 6 and 7 participants. However, we recognise that we also need to combine internal development opportunities with external recruitment of BME staff in order to achieve our ambition. We will review the work undertaken by other organisations to identify what additional steps could be taken to have the greatest impact, and discuss these with our BAME Network, our managers and leaders and our Joint Staff Consultative Committee.

Although our current Equality and Inclusion Strategy target is to achieve 20% BME staff in bands 7 and above, we are aware that this reflects the 2011 census for Berkshire as a whole. The population has increased since then, and the percentage of people from BME backgrounds varies considerably across the county. Both of these factors will be taken into account when preparing the refresh of our strategy planned for April 2020.

As part of our work to better understand our WRES data over time, we have undertaken some more detailed analysis of previous submissions for comparison purposes. This has identified some important points which are reflected in the information set out below as part of our results for WRES indicators 2 to 9. Comparisons between our results and those of other trusts have been included, based on information provided in the NHS England WRES report published in January 2019.

3.2 WRES Indicator 2: relative likelihood of white applicants being appointed from shortlisting compared to BME applicants.

Our data shows that a white member of staff was 1.27 times more likely to be shortlisted and appointed than a BME member of staff in 2018/19. We have seen a gradually improving trend in this indicator over the last four years, and as a result of the work carried out this year, have a much better understanding of our data. Internal and external applicants are now included in our analysis, which was not previously the case. The table below shows the change in this indicator since 2015/16, and includes a likelihood of 1.23 for 2018/19 which *excludes* internal applicants, so that a like for like comparison with previous years is possible.

2015/2016	2016/2017	2017/2018	2018/2019
1.46	**1.36**	**1.33**	**1.23**

Comparison with national likelihood data set out below, shows that we are achieving slightly better average results:

2015/2016	2016/2017	2017/2018
1.57	**1.60**	**1.45**

In 2017/18, 210 (91.7%) of trusts, white applicants were more likely to be appointed from shortlisting. In 31 trusts, the relative likelihood of white staff being appointed from shortlisting compared to BME staff was greater than 2.0. In six of the 31 trusts, the relative likelihood of white staff being appointed from shortlisting compared to BME staff was greater than 3.0. At 1.19, the smallest gap between BME and white staff likelihood of being appointed from shortlisting is amongst mental health trusts. Our aim is to eliminate the gap between BME and white staff in the likelihood of appointment from shortlisting.

3.3. Indicator 3: Relative likelihood of a BME member of staff entering the formal disciplinary process compared to white staff.

A BME member of staff employed by Berkshire Healthcare was 1.27 times more likely to enter the disciplinary process than a white member of staff during 2018/19. This data is still being checked against ESR data submitted in our WRES in previous years, but is drawn from data we use for Executive reporting of casework by protected characteristic. Our figure is slightly above the national average of 1.24 included in the national WRES report in 2018. We are taking forward work as part of our action plan to achieve improvement in this area, with the aim of achieving parity between white and BME staff, while working to minimise the need for formal processes in general.

3.4. Indicator 4: Relative likelihood of white staff accessing non-mandatory training and continuous professional development (CPD) compared to BME staff.

As at 31st March 2019, the relative likelihood of a white member of staff accessing non-mandatory training and CPD was 0.97, which is very close to parity. Nationally, the data for this indicator improved in 2018 and fell within the non-adverse range of 0.8 to 1.2.

3.5. Indicator 5: Percentage of BME staff experiencing harassment, bullying and abuse from patients, relatives or the public in last 12 months.

This indicator, along with indicators 6, 7 and 8, takes information from our NSS which was reported to the board in May 2019. For 2018, the figure for this indicator was 31.2%. This is significantly higher than the response from white colleagues at 22.5%. This was an increase from 21.7% reported by white staff the previous year, but the increase for BME staff was much greater, given 26.5% reported in the previous year.

Nationally, 28.7% of BME staff reported the experience of harassment, bullying or abuse from patients, relatives or the public. This is the same figure as the previous year. BME staff in Ambulance Trusts represent the highest average percentage against this indicator (38.3% in 2018) and the percentage for Mental Health Trusts was 33.3% in 2018.

Reducing bullying and harassment is a big priority for us, and has also been prioritised by our BAME staff network as an area for action in 2019/20.

Our annual plan on a page for 2019/20 includes the statement "We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%"
A video has been produced for use in internal training and staff events, and posters will be used in staff and patient areas to provide a clear message that bullying and harassment is unacceptable, and to encourage staff to address incidents and follow them up appropriately.

3.6. Indicator 6: Percentage of staff experiencing harassment, bullying and abuse from staff in the last 12 months.

The percentage of BME staff experiencing harassment, bullying and abuse from staff) was 26.2% in 2018 - an increase from the 20.9% reported the previous year. For a white member of staff the percentage was 20%, up from 18.2% reported the previous year.

Nationally, the percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months increased from 26.3% in 2016, to 27.8% in 2018.

Reducing bullying and harassment from staff is arguably more under our own influence than that exhibited by members of the public, and therefore we are prioritising the continued implementation of our Making It Right initiative. We are about to start cohort 4 for our BAME staff, and will developing our approach for disabled staff this year, followed by our LGBT staff. Making it Right continues to include content to enable staff to identify and address bullying and harassment, and highlight the support that is available within the organisation. This year, we have also piloted Making It Right for Managers, which includes raising managers' awareness of the experience of staff with protected characteristics. Feedback has indicated that the most valuable learning was gained from hearing about people's experience, rather than simply presenting data.
Our Freedom to Speak Up Guardian has made good links with our staff networks, and our Freedom to Speak Up champions are a diverse group based at a number of trust locations.
We recognise how serious an impact that bullying, harassment and abuse can have on individuals, and therefore will continue our work to ensure that our training for managers includes best practice content regarding reducing bullying and harassment.

3.7. Indicator 7: Percentage of staff believing that their trust provides equal opportunities for career development or promotion.

The percentage of BAME staff who believed that the Trust provided equal opportunity for career development and/or promotion stood at 68.4% (the score decreased from 74.4% in 2017). The percentage for white staff was down from slightly from 89.3% to 89.2%.

National data from 2018 showed that 71.5% of BME staff believed that their trust provides equal opportunities for career progression or promotion, a decrease from the 75.5% reported for 2017. In contrast, 86.6% of white staff believed that their trust provides equal opportunities for career progression or promotion. This is slightly worse than the 88% reported in the previous year.

We have taken action to introduce a process which enables training applications and decisions to support or decline these to be monitored centrally, and will review this process during the coming year to identify its impact and any amendments required.

We will also publicise the equality of access to non-mandatory training and CPD, specific opportunities that have been taken up by our BAME staff, the achievements gained by individuals as well as the increasing numbers of BME staff in higher bands.

3.8. Indicator 8: In the last 12 months have you personally experienced discrimination at work from a manager, team leader or other colleague.

The percentage of BAME staff that personally experienced discrimination from a manager, team leader or colleague was 16.9% an increase from 11.1% the previous year. The percentage increased from 6.5% for white staff to 6.8%.

The national WRES report showed the percentage of BME staff that experienced discrimination in 2018 had increased from 13.8% to 15.0%, with 6.6% of white staff personally experiencing discrimination at work.

Our work to reduce discrimination is focussed on:

- Leadership behaviour
- Provision of good quality management training
- Communications
- Use of reliable and robust data – to understand the experiences of our staff and proactively using data to address areas of concern

3.9. Indicator 9: Percentage difference between the organisation's board voting membership and its overall workforce.

Our percentage of BME Board members is 15.4%. There is a shortfall of 7.2% BME Board representation in comparison to the workforce. The overall NHS average BME membership of trust boards is 7%, with 5.4% unknown.

4. Progress since the 2018 WRES report

We have made improvements in some indicators, where we are making slow but steady progress and the Making It Right programme is starting to have an impact. However, we recognise that indicators using NSS responses have shown deterioration since last year and therefore require further work to improve.

We are seeking to bring about a sustained change in attitudes and behaviours using interventions that will develop and empower BME staff, as well increase the competence of managers, and therefore improve the experience of our BME staff and achieve our targets for equality and inclusion. As with our other organisational development initiatives, we recognise that implementation and realisation of the benefits will take time and require consistent commitment.

Our BAME staff network continues to grow and has become a powerful source of support, awareness raising, information sharing and inspiration for our organisation. Our WRES action plan includes prioritisation of support for the network and collaboration with the network on actions to address workforce composition,

likelihood of entering the formal disciplinary process and experience of bullying and harassment.

Our Making It Right initiative has been piloted, evaluated and rolled out. We are currently working on cohort 4 due to start in September 2019. This cohort has attracted more band 6 and 7 staff than before. Making It Right is made up of four one day workshops which are aimed at developing participants' attitude, knowledge and skills, enabling them to: communicate in a range of professional settings; compete effectively for jobs; and feel empowered to conduct themselves constructively when faced with discrimination or conflict at work. An important part of the programme is individual mentorship provided by senior leaders and managers within the trust.

More than a third of Making It Right graduates have already secured promotion and others have been seconded to higher positions, attributing a significant role in their success to the intensive support they were given in the Making It Right programme.

Making It Right for managers has been developed and piloted this year, and evaluation is in progress. The pilot included sharing information about our workforce (NSS responses, recruitment, turnover and sickness data) and provided a forum for discussion about the actions required to improve the poorer experiences of BME, disabled and LGBT staff.

In addition to the MIR programme there have been a number of Human Resources initiatives regarding recruitment, case management, CPD and mentoring.

4.1. Recruitment

A number of options to increase rates of appointment of BME staff from shortlisting have been considered, including inclusion of BME representation in shortlisting and interview processes. This work will be reviewed with the BAME Network, Joint Staff Consultative Committee and operational managers to identify practical steps to enhance our BME staff recruitment and retention at bands 8a and above, supported by clear targets and trajectories agreed.

"Enhanced Application and Interview Skills" continues to form part of the Making It Right programme.

4.2. Casework

Human Resource Casework reports are provided every six months to the trust executive, and include a breakdown of case by protected characteristics.

The development of our Making It Right for Managers initiative will include a particular focus on the over-representation of BME staff in formal disciplinary processes.

We have identified the Royal College of Nursing Cultural Ambassador programme as a source of learning for potential local implementation. This programme is designed to recruit staff from BAME backgrounds at Band 6 and above, and place them alongside investigating managers and disciplinary and grievance panels involving BAME staff, in order to identify and challenge any potential bias and discrimination. The programme works in partnership between the RCN and NHS Trusts, with the

RCN offering training and ongoing support under a reflective model. Trusts commit, to release CA candidates for training and to fulfil the role.

Training in mediation in employee relations issues has taken place with the aim of enabling us to resolve problems without entering into formal processes.

Unconscious bias training has been in place since January 2017, and we have trained trainers, who deliver statutory, mandatory and core management training, in how to avoid unconscious bias in their training materials and delivery. They have reviewed and amended their courses accordingly, adding an unconscious bias section as necessary. This review has included leadership programmes such as Excellent Manager, Essential Knowledge for New Managers, Values Based Recruitment and Human Resources case management and investigations.

4.3. CPD and Mentoring

An online application system has been implemented to monitor the access of CPD and training. This allows our Learning and Development team to more readily monitor the protected characteristics of applicants who are shortlisted and approved and whose applications are not approved. This process will now be reviewed to understand its impact and to identify changes needed.

Working with the BME staff network, the Training and Organisational Development team have been expanding the number and diversity of the pool of mentors available, encouraging staff from across the Trust to register and ‘sign up’ for the Making It Right specific mentoring and coaching training. The feedback received about the mentoring element of the Making It Right programme has identified how important this is to the success of the programme.

5. WRES Action Plan 2019/20

Mentoring

Priority	Action	Timescale
Support our BAME Network in the achievement of their objectives	• Reduce bullying and harassment • Engagement with staff at Prospect Park Hospital – with a particular focus on night staff and health and wellbeing • Reverse mentoring – BAME network and Exec team to undertake • MIR programme – supporting delivery of next cohorts for BAME staff and Managers programme • Education and awareness – Black history Month, Inspire & Empower event in October 2019, Trust Leaders and Managers Forum presentation, Diversity Roadshows	By April 2020
Workforce composition	We will achieve a workforce that reflects the population we serve at all levels of seniority, recognising that diverse teams and leadership deliver the best results and will: • Communicate the value of a diverse workforce through our Diversity Roadshows and internal communications. • Maintain 20% or more BAME staff at bands 5-7 and increase our percentage at bands 8a and above. • Confirm arrangements for BAME staff involvement in recruitment processes with the BAME network, JSCC, Human Resources and operational leaders. • Complete the analysis needed to specify targets and timescales for our new Equality and Inclusion Strategy	By Jan 2020 By April 2020 By Feb 2020 By April 2020
Increase ethnicity declaration rates on ESR	Communicate a reminder about the importance of declaration to all staff, and how they can use ESR Self Service functionality to update their personal information.	By Jan 2020
Reduce the percentage of BAME staff entering the formal disciplinary process	We will confirm our approach regarding the Cultural Ambassador programme through joint work with our BAME Network, JSCC, Human Resources and operational leaders. We will review the diversity of our pool of investigating officers, and take steps to provided targeted training to ensure that it is representative.	By Feb 2020

Address the poorer experience of BAME staff reported through the NSS.	Bullying and Harassment • Continue to implement Making it Right. • Evaluate and implement Making It Right for Managers. • Complete and implement the use of our videos and posters for internal training and events to promote our zero tolerance message about bullying and harassment.	By April 2019
	Discrimination • Leadership behaviour – providing training, mentoring and reverse mentoring to increase awareness and ability to act as effective role models in recognising and addressing discrimination. • Provision of good quality management training – ensuring that our management training provides people with the tools and capabilities needed to prevent and tackle discrimination. This will include review of training needs of our Human Resources directorate. • Communications – researching and applying good practice evidence about the impact of internal communications, and ensuring managers have access to good quality materials to support them in delivering clear and effective messages in their own teams. • Use of reliable and robust data – to understand the experiences of our staff and proactively using data to address areas of concern. We will work with the BAME Network to improve our use of soft intelligence about people's experience, in combination with data from Human Resources and Freedom to Speak Up processes.	By April 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2019
Title	**Audit Committee – 31 July 2019**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 31 July 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's terms of reference highlighting proposed changes are also attached for ratification by the Trust Board.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered. b) To ratify the proposed changes to the Audit Committee's terms of reference.

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 31 July 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 Clive Makombera, Internal Auditors, RSM Chris Randall, Deloitte, External Auditors Debbie Kinch, Counter Fraud, TIAA Arti Scott, Counter Fraud, TIAA Julie Hill, Company Secretary Minoo Irani, Medical Director Amanda Mollett, Head of Clinical Effectiveness and Audit David Townsend, Chief Operating Officer *(present for item 5)*

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Debbie Fulton, Director of Nursing and Governance, Paul Gray, Director of Finance and Ben Sheriff, External Auditors, Deloitte.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 24 April 2019 and 22 May 2019**	
	The Minutes of the meetings held on 24 April 2019 and 22 May 2019 were confirmed as a true record of the proceedings after the Deputy Chief Executive and Chief Financial Officer's job title had been corrected in the minutes of the meeting held on 24 April 2019.	
4.	**Action Log and Matters Arising**	
	Action Log	

	The Action Log had been circulated. The following action was discussed further: **Losses and Special Payments Report – Benchmarking Data** The Deputy Chief Executive and Chief Financial Officer confirmed that there was no available benchmarking data in respect of the volume of lost or stolen iPhones and laptops. **Matters Arising** **a) System Control Totals** The Chair referred to page 5 of the agenda pack and asked whether the system control totals for 2019-20 had been agreed. The Deputy Chief Executive and Chief Financial Officer reported that the national bodies had not yet approved the system control totals. **b) Patient Level Costing** The Chair referred to page 5 of the agenda pack and asked whether the Trust had selected a software provider for patient level costing. The Deputy Chief Executive and Chief Financial Officer confirmed that the Trust had appointed a Company called CACI to provide the patient level costing software. The Committee noted the responses to the matters arising and noted the action log.	
5.	**Corporate Risk Register Risk "Deep Dive" – Physical Environment of Prospect Park Hospital**	
	The Chair welcomed the Chief Operating Officer to the meeting. The Chief Operating Officer said that the purpose of the paper was to outline the current position regarding the Prospect Park Hospital Environmental Corporate Risk Register risk and to facilitate the Audit Committee's consideration of the controls, assurance and further actions in progress to mitigate the risk. The Chief Operating Officer highlighted the following key points: • The risk was identified at an Executive Committee meeting following discussion about the investment that Prospect Park Hospital had received over recent years in response to changes in legislation, national alerts (for example, the ligature risk posed by bathroom taps) and awareness of new design and technology being used within mental health in patient settings • The risk cannot be eliminated completely and the monitoring of environmental risks and developments will remain a high priority for the Trust; • The Trust had appointed a Private Finance Initiative (PFI) Contract Manager who was responsible for monitoring the performance of the PFI provider.	

	• Prospect Park Hospital had introduced "ward walks" to review the environment and the Executive Directors undertook site environment inspections periodically; • The Trust had recently set up an Estates Oversight Group which reviewed all the Estates programmes and development, including Prospect Park Hospital; • Good progress had been made on environmental improvements at Prospect Park Hospital to ensure that it maintained safety; met regulatory requirements; and kept up with the latest safety innovations, • There were effective controls in place and good evidence of improvement which provided assurance that the risk was being effectively managed and mitigated. On behalf of the Committee, the Chair thanked the Chief Operating Officer for his report and said that it provided significant assurance. The Chair asked how the Trust kept up to date with good practice and new safety innovations. The Chief Operating Officer reported that Estates and Facilities staff now attended the Annual Estates Conference which showcased innovations in design and kept up to date by reading relevant publications. It was also noted that Estates staff visited other Units which had innovative designs or were using new technology and had engaged the King's Fund to help with the design of the Dementia Ward. The Chair asked whether NHS Improvement's request to reduce the national capital spend by 20% this year would impact on the Trust's estates work at Prospect Park Hospital. The Deputy Chief Executive and Chief Financial Officer reported that the Finance, Investment and Performance Committee meeting earlier that day had discussed the 20% target and had noted that the Integrated Care Systems had identified a number of schemes which could be deterred until next year. It was noted that the 20% cut in capital spending did not include PFI buildings. The Chair suggested that the Committee review the Prospect Park Hospital Estates Programme of work on an annual basis. The Committee noted the paper.	**DT/JH**
6.A	**Board Assurance Framework**	
	The Board Assurance Framework had been circulated. The Chair referred to risk 3 (system working) and commented that the Trust Chair had reported that the Frimley Health Integrated Care System event for governors and other stakeholders hosted by Surrey and Borders Partnership NHS Foundation Trust held on 24 July 2019 had been successful. The Chair asked about the implications for the Trust of the Buckinghamshire, Oxfordshire and Berkshire West Sustainability and Transformation Partnership becoming a wave 3 Integrated Care System. The Deputy Chief Executive and Chief Financial Officer said that how this would impact on the Berkshire West Integrated Care System was currently unclear.	

	The Deputy Chief Executive and Chief Financial Officer said that the Berkshire West Integrated Care System was now working more closely with local authorities and that this was a positive step forward. The Chair referred to risk 7 (demand outstripping supply) and reported that the July 2019 Trust Board meeting had received a presentation on the Trust's work to reduce inappropriate Out of Area Placements and had noted that there had been a 43% increase in the number of detained patients at Prospect Park Hospital compared with the previous year. The Chief Operating Officer pointed out that the increase in the number of detained patients was partly offset by the decrease in the number of voluntary patients. The Chief Operating Officer said that if the Trust had not undertaken its work to reduce admissions, reduce the length of stay and improve its discharge processes, there was no doubt that the number of inappropriate Out of Area Placements would have been significantly higher. The Committee noted the report.	
6.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chair queried the scoring of the ligature risk. It was noted that the initial risk score was severe (15) and the current risk score was also severe (15) despite the actions that had been put in place to reduce the risk of ligatures (for example, including replacing taps at Prospect Park Hospital). The Chief Operating Officer said that the risk score would always be severe because of the risk matrix which rated a consequence of "death" as "severe" even if the likelihood score was reduced. The Chair reported that the last Trust Board meeting had discussed the Mental Health Act Office as this was one of the Trust's Quality Concerns and asked whether there had been any progress since the July 2019 Trust Board meeting. The Chief Operating Officer confirmed that the review of the Mental Health Act Office had now started. The Deputy Chief Executive and Chief Financial Officer reported that the Mental Health Act Office was also on the Internal Audit Plan for 2019-20. The Chair referred to the Brexit risk and asked whether the Trust was making any additional preparations for a "No Deal" Brexit from those which were reported to the Trust Board. The Deputy Chief Executive and Chief Financial Officer confirmed that there were no new contingencies. The Chief Operating Officer pointed out that the Trust undertook regular contingency planning exercises around a number of different emergency scenarios. The Committee noted the report.	

7.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from April 2019 to June 2019 had been circulated. The Chair asked for more information about the Document Management contract. The Deputy Chief Executive and Chief Financial Officer explained that this was an exercise to transfer all records for storage to one supplier The Chair noted that one of the single waivers was to use LinkedIn for the recruitment of band 5 nurses and asked whether this had been successful. The Deputy Chief Executive and Chief Financial Officer agreed to find out and inform the Committee. The Committee approved the single waivers as set out in the report.	**AG**
8.	**Information Assurance Framework Update Report**	
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • A total of five indicators were audited during quarter 1. Two indicators were rated with high confidence (green) and three were rated with moderate confidence (amber) for data quality. All five indicators received high assurance (green) data assurance ratings. • Action plans had been put in place to address any issues. • The indicators audited were: - Mental Health 7 Day Follow Up (amber) - Falls in Month (green) - Mental Health Gatekeeping Admissions (amber) - Mental Health Readmission 28 Days (green) - Mental Health Preventing and Managing Violence and Aggression (PMVA) (green) • In March 2019, Deloitte LLP undertook an audit of the Quality Accounts 2018-19 and gave a “limited assurance” rating and there were no significant issues identified with the indicators selected for audit. The Deputy Chief Executive and Chief Financial Officer clarified that the highest rating that External Auditors could give to non-financial statements was “limited assurance”. Naomi Coxwell, Non-Executive Director asked whether the national performance target of mental health in-patients receiving a follow up within 48 hours of their discharge was a new indicator. The Deputy Chief Executive and Chief Financial Officer confirmed that this was the case. The Medical Director pointed out that the majority of the Trust’s mental health in-patients were followed up within 48 hours of discharge. The Committee noted the report.	

9.	**Losses and Special Payments Report -**	
	Due to the small number of losses and special payments here was no report this quarter.	
10.	**Clinical Audit Report**	
	The Chair reminded the meeting that the outcome of the Clinical Audits was reviewed by the Quality Assurance Committee and that the Audit Committee's role was to assure itself about the effectiveness of the Clinical Audit systems and processes. The Chair said that as part of the assurance role, it would be helpful for the Committee if a paper could be presented which selected a completed Clinical Audit and explained the cycle from the start of the audit through to the actions that were implemented as a result. Mehmuda Mian, Non-Executive Director asked how much work would be involved in producing the report. The Medical Director said that he was happy to support the Committee's request as this would be a one-off report and appreciated that it would bring the clinical audit process to life for the Committee. The Head of Clinical Effectiveness and Audit presented the paper and reported that there were delays with NHS England publishing the national clinical audit reports. It was noted that in addition to the national clinical audits, the team were also undertaking local clinical audits at the request of the Quality Assurance Committee. The Chair asked whether the clinical audit programme was on track. The Head of Clinical Effectiveness and Audit confirmed that there were currently no risks identified with the implementation of the clinical audit programme 2019-20, The Head of Clinical Effectiveness and Audit confirmed that there were currently no risks identified with the implementation of the clinical audit programme 2019-20. Although this could change in the next few months given the delays in national reporting, requirements for data submission for new audits and limited clinical audit facilitator resource. The Head of Clinical Effectiveness and Audit reported that a new full-time member of staff would be joining the team next Monday and this would fill the 0.6 wte vacancy, bringing the Clinical Audit Facilitator staffing resource to 3.0 wte. The Committee noted the report.	**AM/MI**
11.	**Clinical Claims and Litigation Report Quarterly Report**	
	The Clinical Claims and Litigation Report for Quarter 1 had been circulated. It was noted that during Quarter 1 there were two new claims received and that this was consistent with all Quarters in 2018-19. In addition, two claims had been closed.	

	Naomi Coxwell, Non-Executive Director commented that the two new claims related to a patient with learning disabilities and a patient with mental health issues being violent and aggressive towards staff and said that it was important that the Trust had a zero tolerance approach to verbal and physical assaults. The Deputy Chief Executive and Chief Financial Officer said that staff were supported to refer incidents of patient violence and aggression to the Police, but staff were often unwilling to press charges. The Committee noted the report.	
12.	**Internal Audit Progress Report**	
	Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and reported that since the meeting, the Internal Auditors had finalised the Fire Safety Report and field work was in progress in relation to the Medical Job Planning and Rostering reviews. Mr Makombera reported that the Internal Auditors given "reasonable assurance" following the Fire Safety Review. The key areas for improvement related to a lack of understanding amongst some staff about the key roles and responsibilities in the event of a fire incident, although these were clearly set out in the Trust's Fire Safety Policy. Another area identified for management action was in relation to the lack of an Authorising Engineer to provide external technical assurance around the performance of fire safety management processes. Mehmuda Mian, Non-Executive Director said that the lack of awareness around roles and responsibilities in relation to fire incidents was particularly disappointing given the focus of fire safety work following the Daisy Ward Fire and other recent fire incidents. The Chair agreed to highlight the Committee's concerns around the lack of staff awareness about roles and responsibilities for fire incidents when he presented the minutes of the Trust Board in September 2019. Naomi Coxwell, Non-Executive Director pointed out that mandatory fire training compliance performance was a "tracker" metric on the Trust's "True North" Performance Scorecard and had been RAG rated "red" for the last three months. The Chair asked whether plans were in place to appoint an Authorising Engineer. The Deputy Chief Executive and Chief Financial Officer confirmed that the Chief Operating Officer had approved the post and the post would be out for recruitment shortly. Mr Makombera reported that there was only one overdue action and this related to an advisory management action. Mr Makombera referred to page 106 of the agenda pack and reported that the Trust had proposed that the review of IT Project Management be undertaken in 2020-21 to allow the planned IT projects to be completed and post project	**CF**

	evaluations to be undertaken. The Committee agreed to add the review of IT Project Management to next year's Internal Audit Plan. The Chair reported that following the Trust Board's Quality Improvement event on 11 June 2019, he had been struck by the different project management teams within the Trust and interfaces between the different teams. The Chair asked whether it would be helpful for the Internal Auditors to review the Trust's project management systems and processes. The Deputy Chief Executive and Chief Financial Officer said that the Trust was reviewing its approach to Project Management and therefore it would be better to undertake an internal audit review once any changes had been implemented. Mehmuda Mian, Non-Executive Director asked whether the Trust was using Skype for patient consultations following NHS England's comments in the "Health Matters" section of the report (page 109 of the agenda pack) that the NHS Skype scheme had prevented 3,000 avoidable visits to Accident and Emergency Departments and 2,000 GP appointments. The Deputy Chief Executive and Chief Financial Officer confirmed that the Trust's IAPT Service used Skype and using Skype for patient consultations was part of the Trust's Global Digital Exemplar work. Naomi Coxwell, Non-Executive Director referred to page 130 of the agenda pack and asked for more information about the "Getting it Right First Time" Programme (GIRFT) for Mental Health and Community Services. The Deputy Chief Executive and Chief Financial Officer explained that the initiative had originally been developed for the acute sector and had recently been adopted by the mental health sector and that objective was to reduce unwarranted variation. It was noted that the Trust's Lead Clinical Director was leading the Trust's work on CAMHs. It was agreed that the Lead Clinical Director would be asked to update the Committee on the GIRFT Programme. The Chair referred to the Health Matters section of the report and commented that this provided a useful overview of key national developments and initiatives. It was agreed that the Health Matters report would be circulated to the Executive Team for information. The Committee noted the report.	**AG/CM** **GN** **JH**
13.	**Counter Fraud**	
	Debbie Kinch, TIAA reported that this would be her last Audit Committee meeting as she would be leaving TIAA to join NHS England's Counter Fraud Specialist Service. On behalf of the Trust, the Chair thanked Ms Kinch for the excellent support she had provided to the Trust over many years and wished her well in her new role. Ms Kinch introduced Arti Scott, TIAA who would be taking over from her as the	

	TIAA representative for the Trust. Ms Kinch thanked the Chair for his warm words and said that it had been a pleasure to work with the Trust. Ms Kinch presented the report and highlighted the following points: • The NHS Counter Fraud Authority had issued a new fraud prevention notice in relation to fraud which targeted salary payments. This was where the perpetrator claimed to be an existing member of staff of an NHS organisation and asked for their bank details to be changed in order to receive salary payments. • The Home Office Immigration Enforcement's Local Partnership Manager had provided an Immigration Awareness talk to staff from across the Trust. As a result staff were more confident in undertaking their own immigration status checks and the number of queries referred to the Counter Fraud Specialist had decreased. Ms Kinch referred to the reactive cases (page 153 of the agenda pack) and confirmed that the equipment retained by a former Trust employee had now been recovered. Ms Kinch reported that the former member of staff had not responded to letters requesting the return of the equipment so she had visited the ex-member of staff at her home and had retrieved the Trust's property. Ms Kinch reported that the Fraud Stop Newsletter and Client Digest had been circulated for information. The Chair referred to page 155 of the agenda pack which referred to the Government's response to the Inquiry into the deaths at Gosport War Memorial Hospital and asked whether there was any further learning for the Trust. The Deputy Chief Executive and Chief Financial Officer agreed to raise the issue with the Director of Nursing and Governance. The Medical Director pointed out that the deaths at Gosport Hospital occurred before the requirement to have a mortality review process. The Chair referred to the thematic review on Consultant Job Planning and asked the Medical Director whether there were any issues for the Trust. The Medical Director confirmed that the Internal Auditors were reviewing the Trust's Consultant Job Planning systems and processes following the introduction of a new process last year. Naomi Coxwell, Non-Executive Director referred to the emerging risk identified by NHS England around the unauthorised use of Propofol, an anaesthetic which was not classed as a controlled drug (page 149 of the agenda pack) and asked whether this was an issue for the Trust. The Medical Director confirmed that Propofol was not widely used at the Trust and that the Trust had systems and processes in place to mitigate the risk of unauthorised use of drugs. Clive Makombera, Internal Auditors said that following the Internal Audit review of medicines management at the WestCall Out of Hours Service, The Trust had implemented a number of actions to improve medicines management.	**AG/DF**

	Ms Coxwell suggested adding WestCall to the Internal Audit Programme. The Committee noted the report.	**AG/CM**
14.	**External Audit Report**	
	There was nothing to report at this meeting.	
15.	**Minutes of the Finance, Investment and Performance Committee meetings held on 24 April 2019 and 29 May 2019**	
	The minutes of the Finance, Investment and Performance Committee meetings held on 24 April 2019 and 29 May 2019 were received and noted.	
16.	**Minutes of the Quality Assurance Committee held on 21 May 2019**	
	The minutes of the Quality Assurance Committee meeting held on 21 May 2019 were received and noted.	
17.	**Minutes of the Quality Executive Committee held on 8 April 2019, 13 May 2019 and 10 June 2019**	
	The minutes of the Quality Executive meetings held on 8 April 2019, 13 may 2019 and 10 June 2019 were received and noted.	
18.	**Committee's Annual Review of Effectiveness and Review of the Terms of Reference**	
	The results of the Committee's Annual Review of Effectiveness and revised Terms of Reference had been circulated. The Chair reported that he had raised the issue of Audit Committee Chair's succession planning with the Trust Chair. The Committee: a) Noted the outcome of the Annual Review of Effectiveness b) Approved the proposed changes to the Committee's Terms of Reference which would be submitted to the next Trust Board meeting for ratification.	
19.	**Annual Work Plan**	
	The Chair reminded the meeting that the Committee's private meeting with the External Auditors would take place after the October 2019 meeting. The Chair suggested that the Annual Work Programme be amended to delete the Clinical Audit Annual Report as this was presented to the Quality Assurance Committee. The Chair asked for suggestions for the next Audit Committee Seminar. The following possible topics were identified: • Alignment between the External and Internal Audit Plans, Counter	**JH**

	Fraud and the Trust's key risks • Bribery Act • Integrated Care Systems and Governance The Chair agreed to discuss the topic for the October 2019 Audit Committee seminar with the Deputy Chief Executive and Chief Financial Officer and Company Secretary. The Committee noted the work programme.	**CF**
20.	**Any Other Business**	
	There was no other business.	
21.	**Date of Next Meeting**	
	30 October 2019	

These minutes are an accurate record of the Audit Committee meeting held on 31 July 2019.

Signed:-

Date: - 30 October 2019

Berkshire Healthcare
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

This document contains the terms of reference for the Trust Audit Committee.

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance – Ref: 080902
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018 – Board approved September 2018

Document References

Document Title	Date	Published By
NHS Audit Committee Handbook	2005	Department of Health & Healthcare
The NHS Foundation Trust Code of Governance	2006	NHS Improvement, Independent Regulator of NHS Foundation Trusts

Authority

1.1 The Audit Committee is constituted as a Standing Committee of the Trust Board of Directors. Its constitution and terms of reference shall be set out as below, subject to amendment at future Board of Directors' meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

Purpose

2.1 To conclude upon the adequacy and effective operation of the Trust's overall internal control system and independently review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

2.2 To review the disclosure statements that flow from the Trust's assurance processes ahead of its presentation to the Trust Board, including:

a. Annual Governance Statement, included in the Annual Report and Accounts and the Annual Plan together with the external and internal auditors' opinions.

b. Annual Plan declarations relating to the Assurance Framework.

Membership

3.1 The membership of the Committee shall comprise three Non-Executive Directors, at least one of whom shall have recent and relevant financial experience, plus, ex officio, the Chair of the Finance, Investment & Performance Committee. The Chair of the Quality Assurance Committee will attend as and when there are appropriate matters to discuss with the Audit Committee.

3.2 The Chair of the Trust and the Chief Executive shall **not** be members.

3.3 The Chair of the Committee will be a Non-Executive Director and will not be a member of any other standing Committee of the Board.

3.4 A quorum shall be two members.

In attendance at meetings

4.1 The Committee will be supported by the following in attendance:

- Chief Financial Officer
- Director of Finance
- Medical Director
- Head of Clinical Effectiveness and Audit

- Director of Nursing and Governance or Deputy Director of Nursing
- The Company Secretary

4.2 The Committee can invite the Chairman and Chief Executive as well as other Trust Directors or Officers to attend to discuss specific issues as appropriate.

4.3 The Committee will be attended by representatives of the following:

- External Audit
- Internal Audit
- Counter Fraud
- Clinical Audit

4.4 The Committee will consider the need to meet privately, at least once a year, with both the internal and external auditors. The internal and external auditors may request a private meeting with the Committee at any time.

Frequency and Administration of Meetings

5.1 The Committee will meet at least 4 times a year. It may meet more frequently at any time should circumstances require.

5.2 It will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.

5.3 Minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

Duties

Governance Risk Management and Internal Control

6.1 The Committee shall review the establishment and maintenance of an effective system of integrated Governance, risk management and internal control, across the Trust's clinical and non-clinical activities that support the achievement of its objectives.

6.2 The Committee shall ensure that the Board Assurance Framework is effective in enabling the monitoring, controlling and mitigation of risks to the Trust's strategic objectives.

6.3 In particular, the Committee will review the adequacy of the following:

a. All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to endorsement by the Board;

b. The underlying assurance processes that indicate the following:

- The degree of the achievement of corporate objectives
- The effectiveness of the management of principal risks

- The appropriateness of the disclosure statements

c. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

6.4 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance (including clinical audit and data quality), risk management and internal control.

Audit & Counter Fraud

6.5 The Committee shall ensure that there is an effective internal audit function and clinical audit function that provide appropriate independent assurance to the Audit Committee and includes the following:

a. Review the Internal Audit Plan, operational plan and programme of work and recommend this for acceptance by the Trust Board of Directors.

b. The review of the findings of internal audits and the management response.

c. Discussion and agreement with the External Audit of the nature and scope of the External Audit annual plan.

d. The review of all external audit reports, including the agreement of the annual audit letter before submission to the Board and any work completed outside the External Audit annual plan.

e. Review and approval of the Counter Fraud Plan and operational plans.

f. The review of the findings of the Counter Fraud plan and the management response.

6.6 Clinical Audit

The Committee shall ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans.

6.7 The Committee shall ensure that Internal Audit, External Audit and Clinical Audit recommendations are implemented promptly by management.

Financial Reporting

6.8 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board.

6.9 It will ensure that the financial systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

6.10 It will review the annual accounts of the Charitable Trustees prior to submission.

Reporting

6.11 The Committee will routinely review the minutes of:

- Finance, Investment & Performance Committee
- Quality Assurance Committee
- Quality Executive Committee

and will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee.

6.12 The Minutes of the Audit Committee will be formally submitted to the Trust Board.

6.13 The Chair of the Committee shall report to the Board any concerns and assurances relating to the Trust and the Committee's work.

6.14 The Audit Committee Chair will produce an Annual Audit Report setting out the work of the Committee and highlighting any issues raised during the course of year by the Trust's Internal and External Auditors and the Counter Fraud Specialist. It will report annually to the Council of Governors Trust Board through an 'Audit and Governance Report' which will include the following:

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

d. The Committee's self-assessment and any action required.

Other functions

6.15 The Committee will review and monitor compliance with Standing Orders and Standing Financial instructions.

6.16 It will review the following:

a. Schedules of losses & compensations and making recommendations to the Board

b. Any decision to suspend Standing Orders

c. Decision to waive the competitive tendering rules when requested by the Board

~~c.~~d. New and existing claims

Formatted: List Paragraph, No bullets or numbering, Tab stops: Not at 0.5 cm

6.17 It will approve changes in accounting policies.

6.18 It will review the performance of the Audit Committee through self-assessment and independent review to be completed at least annually. It will also review the output from the annual self-assessment exercises conducted by other Board Committees.

6.19 It will provide oversight of the Trust's processes for ensuring robust data quality and will review periodic reports on data quality performance.

6.20 The Committee shall provide assurance on the quality checks of data used in the preparation of the Performance Assurance Framework.

6.21 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

~~6.22 The Committee shall encourage the sharing of, and learning from, lessons learnt across the Trust from serious incidents.~~

Amended: July 2019
Board approved: September 2019 (TBC)

Next review: July 2020

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2019
Title	**Appointment of a New Senior Independent Director**
Purpose	The purpose of this item is to set out the process for the appointment of a new Senior Independent Director to replace Ruth Lysons who steps down from the Board on 31 October 2019.
Business Area	Corporate
Author	**Julie Hill, Company Secretary**
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	Relates to the Well-Led Domain
Resource Impacts	None
Legal Implications	NHS Foundation Trusts are required to appoint one of the Trust's Non-Executive Directors to the role of Senior Independent Director.
Equality and Diversity Implications	N/A
SUMMARY	The Trust Board is responsible for appointing one of the Non-Executive Directors as the Trust's Senior Independent Director in consultation with the Council of Governors. The next Council of Governors meeting is on 18 September 2019. The Chair will consult with the Council about the Board's preferred candidate of for the role. The Senior Independent Director Role Profile is attached at appendix 1.

ACTION REQUIRED	The Trust Board is requested to: Approve the appointment of one of the Trust's Non-Executive Directors as the Trust's Senior Independent Director with effect from 1 November 2019 subject to consultation with the Council of Governors.

Berkshire Healthcare
NHS Foundation Trust

Appendix 1

SENIOR INDEPENDENT DIRECTOR ROLE DESCRIPTION

In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to serve as an intermediary for the other directors when necessary.

The senior independent director should be available to governors if they have concerns that contact through the normal channels of chair, chief executive, deputy chief executive, or company secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could also be the vice chair.

Led by the senior independent director, the non-executive directors should meet without the chair present, at least annually, to appraise the chair's performance, and on other such occasions as are deemed appropriate.

Where directors have concerns that cannot be resolved about the running of the trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chair for circulation to the board, if they have any such concerns.

In addition to the duties described here the senior independent director has the same duties as the other non-executive directors.

THE SENIOR INDEPENDENT DIRECTOR, THE CHAIR AND NON-EXECUTIVE DIRECTORS

The senior independent director should hold a meeting with the other non-executive directors in the absence of the chair at least annually as part of the appraisal process.

There may be other circumstances where such meetings are appropriate. Examples might include the appointment or re-appointment process for the chair, where governors have expressed concern regarding the chair or when the board is experiencing a period of stress as described below.

THE SENIOR INDEPENDENT DIRECTOR AND THE COUNCIL OF GOVERNORS

While the council of governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on their behalf as set out as best practice in the code of governance.

The senior independent director might also take responsibility for an orderly succession process for the chair role where a reappointment or a new appointment is necessary.

The senior independent director should also be available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

In rare cases where there are concerns about the performance of the chair, the senior independent director should provide support and guidance to the council of governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action. Where the trust has appointed a lead governor the senior independent director should liaise with the lead governor in such circumstances.

THE SENIOR INDEPENDENT DIRECTOR AND THE BOARD

In circumstances where the board is undergoing a period of stress the senior independent director has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the council of governors regarding the chair's performance; where the relationship between the chair and chief executive is either too close or not sufficiently harmonious; where the trust's strategy is not supported by the whole board; where key decisions are being made without reference to the board or where succession planning is being ignored. In the circumstances outlined above the senior independent director will work with the chair, other directors and/or governors, to resolve significant issues.

Boards of directors and councils of governors need to have a clear understanding of the circumstances when the senior independent director might intervene so that the senior independent director's intervention is not sought in respect of trivial or inappropriate matters.

Trust Board - Meeting Dates for 2020

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board	14		10			9				13		
Trust Board		11		14	12		14	11 (if required)	8		10	8
Audit Committee	22			22	20		22			28		
Finance, Information and Performance (FIP)	22		25	22			22		23	28		
Quality Assurance Committee (QAC)		18			19			18			17	

Council of Governors Dates 2020

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			18			17			23 (+AGM)			2
Trust Board / Council Meeting		05 (NED)			06 (Board)		29 (NED)				04 (Board)	