

**BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**TRUST BOARD MEETING**

(conducted electronically via Microsoft Team because of the COVID-19 pandemic)

**10:00am on Tuesday 12 May 2020**

**AGENDA**

No	Item	Presenter	Enc.
<b>OPENING BUSINESS</b>			
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 Meetings held on 11 February 2020 and 14 April 2020	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
<b>QUALITY</b>			
6.0	Quality Assurance Processes During the COVID-19 Pandemic Report	Debbie Fulton, Director of Nursing and Therapies/Dr Minoo Irani, Medical Director	Enc.
6.1	Patient Experience Quarter 4 Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
<b>EXECUTIVE UPDATE</b>			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
<b>PERFORMANCE</b>			
8.0	Month 12 2019/20 Finance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.1	Month 12 2019/20 Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
<b>STRATEGY</b>			
9.0	COVID-19 Recovery Plan on a Page	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
<b>CORPORATE GOVERNANCE</b>			
10.0	Annual Report 2019-20**	Julian Emms, Chief Executive	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal

No	Item	Presenter	Enc.
10.2	Use of the Trust Seal	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
<b>Closing Business</b>			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 9 June 2020	Martin Earwicker, Chair	Verbal
13.	<b>CONFIDENTIAL ISSUES:</b> To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

*\*\*It is a legal requirement that an NHS Foundation Trust's Annual Report is not published until the Report has been laid before Parliament in July 2020. The draft Annual Report is therefore excluded from the Public Trust Board papers on the Trust's website.*



**Unconfirmed minutes**

**BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**Minutes of a Board Meeting held in Public on Tuesday 11 February 2020**

**Boardroom, Fitzwilliam House**

<b>Present:</b>	Martin Earwicker	Chair
	Chris Fisher	Non-Executive Director
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Deputy Chief Executive and Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Dr Minoo Irani	Medical Director
Kathryn MacDermott	Acting Executive Director of Strategy	
<b>In attendance:</b>	Julie Hill	Company Secretary
	Colin Archer	Head of Learning Disability Services

<b>20/001</b>	<b>Welcome</b> (agenda item 1)
	<p>The Chair welcomed everyone to the meeting, including the observers: David Stieber, Service Development Manager, Huntercombe, Michael Sealy, Liaison Workforce and the Governors: Tom Wedd, Public Governor and Guy Dakin, Staff Governor.</p> <p>The Chair also welcomed Colin Archer, Head of Learning Disability Services who was presenting on the services' Quality Improvement Programme work.</p>
<b>20/002</b>	<b>Apologies</b> (agenda item 2)
	<p>Apologies were received from: Aileen Feeney, Non-Executive Director and David Townsend, Chief Operating Officer.</p>

<b>20/003</b>	<b>Declaration of Any Other Business</b> (agenda item 3)
	The Chief Executive reported that the Director of Nursing and Therapies would update the Board on the Trust's Coronavirus preparations under Any Other Business.
<b>20/004</b>	<b>Declarations of Interest</b> (agenda item 4)
	i. <b>Amendments to Register</b> – none
	ii. <b>Agenda Items</b> – none
<b>20/005</b>	<b>Minutes of the previous meeting – 10 December 2019</b> (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 10 December 2019 were approved as a correct record.
<b>20/006</b>	<b>Action Log and Matters Arising</b> (agenda item 5.2)
	<p>The schedule of actions had been circulated. The following action was considered further:</p> <p><b>a) Finance Report</b></p> <p>Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had not received further information about the increase in the number of administrative roles and whether this had resulted in greater efficiencies elsewhere in the Trust at the January 2020 meeting as stated in the action log.</p> <p>The Deputy Chief Executive and Chief Financial Officer confirmed that this information would be provided to the next Finance, Investment and Performance Committee meeting in March 2020. The action would therefore remain in progress.</p> <p><b>Action: Deputy Chief Executive and Chief Financial Officer</b></p> <p><b>The Trust Board:</b> noted the schedule of actions.</p>
<b>20/007</b>	<b>Quality Improvement Programme: Presentation on Reducing Patient Physical Assaults on Staff on the Champion Unit</b> (agenda item 6.0)
	<p>The Chair introduced and welcomed Colin Archer, Head of Learning Disability Services.</p> <p>The Head of Learning Disability Services gave a presentation on Reducing Patient Physical Assaults on Staff on the Champion Unit (Learning Disabilities) and played some short videos from members of staff who spoke about their experiences of using the Quality Improvement methodology. During the presentation the Head of Learning Disability Services highlighted the following points:</p> <ul style="list-style-type: none"> <li>• The Champion Unit was a 9 bedded ward for people with learning disabilities and was based at Prospect Park Hospital;</li> <li>• The Champion Unit accounted for 70% of patient physical assaults on staff reported within the Trust;</li> <li>• As part of the Quality Improvement Programme, the Champion Unit staff received</li> </ul>

training on how to use the Quality Management Improvement System (QMIS) methodology and received regular support and coaching from the Quality Improvement team;

- The first step was to review historical incident data in order to gain a better understanding about the time and in what circumstances patient physical assaults on staff were more likely to happen;
- From the data it was possible to identify that the peak time for assaults was between 8am-10am and between 12pm-1pm. The team undertook a root cause analysis and identified a number of themes, for example, patients' frustration with waiting (for example, personal care, medication and lunch), inability to communicate preferences and patients unable to regulate their feelings of hunger;
- The team used the root cause analysis to develop counter measures, for example, managing and reducing waiting times, working with individual patients to improve their communication skills and developing personalised standards around morning and lunchtime routines;
- The staff also worked with patients to develop timetables of activities from which patients were able to choose which activities they wanted to do;
- Staff were encouraged to record all physical assaults, including low level assaults which previously staff did not report;
- A standard de-brief process when staff had been assaulted was instigated and measures were put in place to prevent a similar incident occurring again;
- Given the level of patient acuity on the Unit, there was a recognition that one or two individual patients could have a significant impact on the experience of staff and other patients on the Unit;
- By using Quality Improvement methodology and through a whole team effort, there had been a sustained decrease in the number of patient physical assaults on staff.

The Chair thanked the Head of Learning Disability Services for his presentation and asked why he thought the Unit had been successful in reducing the number of patient assaults on staff.

The Head of Learning Disability Services said that the key catalyst for change was using the Quality Management Improvement Systems methodology which required taking a systemic whole team approach to problem solving and using data to determine whether counter measures were effective. The other important factor was that a mixed group of staff were trained together in the Quality Improvement methodology and this helped to ensure that everyone understood the process.

Mark Day, Non-Executive Director commented that he was surprised that prior to the QMIS work, staff were not recording all physical assaults.

The Head of Learning Disability Services said that an early stage of the Quality Improvement journey was to develop a common understanding of what constituted an assault and commented that in the past there was a tendency for some staff to accept lower level assaults as part and parcel of their daily work.

Naomi Coxwell, Non-Executive Director commended the Champion Unit's work to reduce patient physical assaults on staff and recognised the positive impact on both patient experience and the welfare of staff but asked whether the resourcing for the work was sustainable in the longer term.

The Head of Learning Disability Services explained that the QMIS approach was now embedded as standard work and had also helped the Champion Unit to meet the demands of the higher acuity of patients. In addition, reducing patient assaults on staff meant that

	<p>less time was needed for post incident de-briefs which freed up time staff time to focus on patient care.</p> <p>On behalf of the Board, the Chair thanked the Head of Learning Disability Services for his presentation and thanked the Champion Unit team for their work on reducing patient physical assaults on staff.</p>
<b>20/008</b>	<b>Annual Community Mental Health Survey Report (agenda item 6.1)</b>
	<p>The Director of Nursing and Therapies presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• The Community Mental Health Survey for 2019 was based on patients who received care from between September and November 2018. The survey was part of the Care Quality Commission’s survey programme;</li> <li>• The Trust was rated: <ul style="list-style-type: none"> <li>○ Amber (about the same as other Trusts) in nine sections;</li> <li>○ Green (better than most Trusts) for the section on “Reviewing Care”;</li> <li>○ Green/Amber (between the same as and better than most Trusts) for the section on “overall views of care and services”</li> </ul> </li> <li>• When reviewing the detail of the 11 sections, the Trust had: <ul style="list-style-type: none"> <li>○ Improved in 15 questions;</li> <li>○ Declined in 7 questions;</li> <li>○ Stayed about the same in 3 questions</li> </ul> </li> <li>• The survey results had been shared with all Community Mental Health services.</li> </ul> <p>The Chair commented that the Trust’s score had decreased for the question: “Have you been told who is in charge of organising your care and services?” and asked whether the Trust had engaged service users and their families in designing the way information was presented.</p> <p>The Director of Nursing and Therapies pointed out that the survey was based on 2018 data and commented that patients now had safety plans which were developed with carer and patient input and this included information about who to contact in a crisis.</p> <p>The Chair reminded the meeting that the national surveys were only one way the Trust gained feedback from patients and service users and reported that the Trust’s new patient experience indicator would provide valuable feedback.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/009</b>	<b>Executive Report (agenda item 7.0)</b>
	<p>The Executive Report had been circulated. The following issue was discussed further:</p> <p><b>a) Modern Day Slavery Statement</b></p> <p>The Board approved the Trust’s Modern Day Slavery Statement which would be signed by the Chief Executive on behalf of the Board and would be published on the Trust’s website and included in the Annual Report for 2019-20.</p>

	<p><b>b) Flu Campaign</b></p> <p>Mark Day, Non-Executive Director referred to the section of the report on the Staff Flu Vaccination Campaign and asked whether there were any lessons from those Trusts whose staff flu vaccination performance was higher than the Trust's.</p> <p>The Director of Nursing and Therapies pointed out that the Trust's staff flu vaccination performance was higher than for most other Trusts. The Director of Nursing and Therapies reported that some of the Trusts with higher performance had shared their learning through webinars. The Director of Nursing and Therapies reported that having a dedicated team of vaccinators was the only key difference and that this was something the Trust would consider for next year.</p> <p>David Buckle, Non-Executive Director said that it was important that the Trust stressed to staff that if they contracted flu and only had minimal or very mild symptoms they could still carry the virus and infect vulnerable patients, potentially putting their lives at risk. Dr Buckle said that people died because of flu and that this included fit young people in their 20s.</p> <p>The Chair asked whether there were moves to make the flu vaccination compulsory for frontline staff.</p> <p>The Director of Nursing and Therapies reported that the Centre had decided not to make the flu vaccination compulsory but pointed out that next year's CQUIN would only be achieved if 90% of staff received the flu vaccination.</p> <p>The Chair said that he recognised the hard work the Trust had undertaken to vaccinate as many staff as possible.</p> <p><b>Post-meeting meeting note by Dr Buckle, Non-Executive Director</b></p> <p>A recent article by the Nuffield Trust stated that in 2017/18 there was an estimated 26,408 deaths associated with seasonal flu which was 70 times higher than the swine flu pandemic in 2010.</p> <p><b>c) System Working</b></p> <p>Chris Fisher, Non-Executive Director said that he had read the full NHS Operational Planning and Contracting Guidance 2020-1 and commented that the NHS Provider's briefing included as an appendix to the Executive Report provided an excellent summary of the document. Mr Fisher referred to the section on System Planning (page 48 of the agenda pack) and suggested that the Executive encourage the System Leadership Groups to put in place the operating arrangements listed as bullet points in the briefing paper.</p> <p style="text-align: right;"><b>Action: Chief Executive</b></p> <p><b>The Trust Board:</b> noted the report.</p>
<b>20/010</b>	<b>Month 09 2019-20 Finance Report</b> (agenda item 8.1)
	<p>The Deputy Chief Executive and Chief Financial Officer presented the report and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• The Trust had a surplus of £0.8m for December 2019 and a breakeven position year to date before accounting for Provider Sustainability Funding. This was £0.1m</li> </ul>

	<p>ahead of the Trust's agreed NHS Improvement financial plan.</p> <ul style="list-style-type: none"> <li>• The Trust had delivered its Quarter 3 Control Total. After accounting for Provider Sustainability Funding and donations, the Trust had a surplus of £1.6m year to date, £0.3m ahead of its financial plan;</li> <li>• The Trust had retained its NHS Improvement forecast commitment to deliver its £1.9m Control Total.</li> <li>• The Use of Resources rating was a "1" overall, in line with the financial plan;</li> <li>• Pay costs had reduced by £0.1m although costs remained higher than planned. The year to date overspend versus recruitment assumptions had risen to £2m;</li> <li>• Non-pay costs had increased by £0.1m but remained contained within budget;</li> <li>• Cash was £3.0m higher than planned with Capital Expenditure slippage and Provider Sustainability Funding bonus payments driving performance; and</li> <li>• Capital expenditure spend was £2.8m behind plan year to date but the expectation was that Capital expenditure would be delivered in line with the plan by year end.</li> </ul> <p>The Chair referred to page 73 of the report and commented that the management and administration staff group had increased by 100.</p> <p>The Deputy Chief Executive and Chief Financial Officer reminded the meeting that further information about the increase in the management and administration roles would be presented to the Finance, Investment and Performance Committee as agreed under Matters Arising.</p> <p><b>The Trust Board noted:</b> the following summary of the financial performance and results for Month 9 2019-20:</p> <p>(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).</p> <p>Year to date (Use of Resource) metric:</p> <ul style="list-style-type: none"> <li>• The Trust's overall Use of Resources rating was "1" (the plan was "1")</li> <li>• Capital Service Cover rating was 2</li> <li>• Liquidity days rating was 1</li> <li>• Income and Expenditure Margin rating was 2</li> <li>• Income and Expenditure Variance rating was 1</li> <li>• Agency target rating was 1</li> </ul> <p>Year to date Income Statement (including Provider Sustainability Funding) excluding donations:</p> <ul style="list-style-type: none"> <li>• Plan: £1.4m surplus</li> <li>• Actual: £1.6m surplus</li> <li>• Variance: £0.2m better than plan</li> </ul> <p>Year to date Cash: £26.8m versus plan of £23.8m</p> <p>Year to date Capital expenditure: £6.4m versus plan of £9.2m</p>
20/011	<b>Month 09 2019-20 "True North" Performance Scorecard Report</b> (agenda item 8.2)
	The Month 09 "True North" Performance Scorecard Report had been circulated.



	<p>The Chair referred to page 91 of the agenda pack and asked for clarification about the numbers above the person symbol.</p> <p>The Deputy Chief Executive and Chief Financial Officer explained that this related to the number of people who had contributed to that particular metric in the month.</p> <p>The Chair referred to the tracker metrics and commented that the two patient experience trackers were less important than the other tracker metrics, for example, acute bed occupancy.</p> <p>The Chief Executive said that the current national Friends and Family Test measure was weak but it was important that the two indicators were included as tracker metrics as proxies for patient experience because patients were at the heart of the Trust's work. It was noted that the Trust's new patient experience indicator would provide more meaningful feedback from patients.</p> <p>The Chair requested that the cover sheet be expanded for future reports to identify any areas identified by the Executive for further focus.</p> <p style="text-align: center;"><b>Action: Deputy Chief Executive and Chief Financial Officer</b></p> <p>Chris Fisher, Non-Executive Director reminded the meeting that the Governors had raised the issue of waiting lists with the Non-Executive Directors and asked whether it would be possible to provide a composite figure around waiting lists.</p> <p>The Deputy Chief Executive and Chief Financial Officer explained that the True North Performance Scorecard included compliance with national standards in relation to waiting lists and pointed out that the Trust had a diversity of services and queried whether providing a composite figure across all waiting lists would be helpful.</p> <p>The Chief Executive said that that it would be more meaningful to select a metric which monitored a selection of wait times rather than looking at waiting times across all services. The Chief Executive also pointed out that the Trust's new patient experience indicator would include asking patients about waiting times.</p> <p>The Director of Nursing and Therapies reminded the Board that waiting lists were included as part of the Trust's Quality Concerns which were reported to the Quality Assurance Committee and the In Committee Board meeting.</p> <p>The Chief Executive proposed that the Medical Director and the Director of Nursing and Therapies include quarterly information about non-constitutional waiting times which they were concerned about and why together with a summary of the any actions that were put in place to address waiting times and to mitigate any patient safety risks.</p> <p style="text-align: center;"><b>Action: Medical Director/Director of Nursing and Therapies</b></p> <p><b>The Trust Board:</b> noted the report.</p>
20/012	<b>Patient Experience Report</b> (agenda item 8.3)
	<p>The Director of Nursing and Therapies presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• During Quarter 3, the Trust had received 68 formal complaints and 61 formal</li> </ul>

	<p>complaints were closed. Of the 61 complaints, 38 were partly or fully upheld;</p> <ul style="list-style-type: none"> <li>• The formal complaint response rate, including those within a timescale re-negotiated with complainants was 98% for the Quarter, with 1 complaint sent outside of the agreed timescale. This continued to be exceptional performance. Learning had been taken from the late response and actions had been put in place to mitigate any future re-occurrence;</li> <li>• The increase in the total number of formal complaints was due to increases in WestCall (7 formal complains compared with 1 in Quarter 2) and the Community Wards (5 formal complaints compared with 1 in Quarter 2);</li> <li>• During Quarter 3, the Trust’s Friends and Family Test response rate had reduced to 10.69% (with variance between 14.6% in October 2019 and 8.5% in December 2019). The Trust had seen a similar decrease in the number of responses in December for the last three years;</li> <li>• Four out of five postings about the Trust on NHS Choices were positive;</li> <li>• The format of the report had been amended to include a sample of the compliments received;</li> <li>• Appendix 3 of the report set out the recommendations from the Healthwatch England: Changing the Mindset Report on NHS Complaints together with the Trust’s self-assessment against the recommendations.</li> </ul> <p>David Buckle, Non-Executive Director said that it was pleasing that the Parliamentary and Health Service Ombudsman had not upheld any complaints against the Trust.</p> <p>Mehmuda Mian, Non-Executive Director noted that the Patient Advice and Liaison Service received more enquiries relating to non-Trust matters. The Director of Nursing and Therapies commented that a key role of the Patient Advice and Liaison Service was to signpost patients and their families to other organisations and sources of advice and information.</p> <p><b>The Trust Board:</b> noted the paper.</p>
20/013	<b>Finance, Investment and Performance Committee</b> (agenda item 8.4)
	<p>Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had received an update on the Trust’s Staff Retention work. Ms Coxwell reported that the Committee had fully endorsed the Trust’s approach which was to focus on key “hot spots” where staff retention was a particular challenge rather than taking a more holistic approach which would dilute resources too thinly.</p> <p>Ms Coxwell reported that the Committee had also discussed the development of the Trust’s financial plan 2020-21 and had acknowledged that it would be a challenging year.</p> <p>The Chair thanked Ms Coxwell for her update.</p>
20/014	<b>Strategy Implementation Plan 2019-20 – Update Report</b> (agenda item 9.0)
	<p>The Acting Executive Director of Strategy presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• Good progress was being made in most areas of the Strategy Implementation Plan</li> </ul>

	<p>with only minor slippage on target dates;</p> <ul style="list-style-type: none"> <li>• The Zero Suicide and Mental Health Pathways projects were now “business as usual”;</li> <li>• There were no initiatives that were currently at risk of not continuing, although a number had encountered challenges: <ul style="list-style-type: none"> <li>○ Workforce initiatives (impacted by sickness absence);</li> <li>○ The new Trust Staff Intranet “Nexus” had encountered technical challenges which had now been addressed. It was due to go live at the end of March 2020;</li> <li>○ Transfer of Learning Disability Inpatient facilities from the Champion Unit to Jasmine Ward (slippage on timescales including time required to secure a Deed of Variation);</li> <li>○ Transfer of CAMHs Tier 4 (Willow House) to Prospect Park Hospital (this was impacted by delays to the Jasmine scheme and also challenges in the development of the business case to NHS Improvement);</li> <li>○ The format of the Strategy Implementation Plan would be aligned to the Trust’s new three-year Strategy from Quarter 2 2000-21.</li> </ul> </li> </ul> <p>The Chair commented that he found the delay to the new Trust’s Intranet frustrating.</p> <p>The Acting Executive Director of Strategy explained that the technical challenges related to finding a process which did not require staff to have multiple log in processes to access the Intranet.</p> <p>The Chief Executive said that a post project review of the Trust’s new Intranet would be undertaken in order to learn any lessons for future initiatives.</p> <p style="text-align: right;"><b>Action: Acting Executive Director of Strategy</b></p> <p><b>The Trust Board:</b> noted the paper.</p>
20/015	<b>Equalities and Diversity – Six Monthly Update Report</b> (agenda item 9.1)
	<p>The Acting Executive Director of Strategy presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• The purpose of the paper was to provide the Board with the mid-year update regarding the Equality, Diversity and Inclusion work across the Trust and to report on the progress made against the Trust’s Equality Strategy 2016-20;</li> <li>• Work had started to develop a new Diversity, Equality and Inclusion Strategy and this would include holding an Equalities Workshop open to all members of staff;</li> <li>• Equalities and Diversity would be threaded through the Trust’s refreshed three-year strategy, but it was also proposed to have a standalone Equality and Diversity Strategy in order to profile the Trust’s work and to set out more detail about the areas of focus for the Trust;</li> <li>• The outcome of the Trust’s submission to Stonewall was expected shortly.</li> </ul> <p>The Chief Executive pointed out that the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) information in the report was based on 2018 data and reported that the data for 2019 would shortly be available.</p> <p>The Chair asked when the Board would be updated about the NHS Staff Survey results which included the WRES and WDES data.</p>

	<p>The Chief Executive reported that the latest NHS Staff Survey results were embargoed until the end of February 2019 and confirmed that the Trust Board would receive NHS Staff Survey results at the April 2020 meeting.</p> <p style="text-align: center;"><b>Action: Deputy Chief Executive and Chief Financial Officer</b></p> <p>Naomi Coxwell, Non-Executive Director asked whether the Board would have an opportunity to review the outcome of the Trust’s submission to Stonewall.</p> <p>The Acting Executive Director of Strategy agreed to update the Board on the outcome of the Stonewall submission.</p> <p style="text-align: center;"><b>Action: Acting Executive Director of Strategy</b></p> <p>The Chair commented that the paper made reference to taking a Human Rights approach to Equalities and Diversity and asked what would be different.</p> <p>The Chief Executive explained that this was around taking a holistic approach and tackling instances of micro-aggressions which made some staff groups uncomfortable and was not just around ensuring that the Trust was compliant with the requirements of Equality and Diversity legislation.</p> <p>Mehmuda Mian, Non-Executive Director said that a human rights approach was inclusive and applied to everyone, whereas issues such as discrimination only applied to the particular organisation.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/016</b>	<b>Annual Health and Safety Report</b> (agenda item 10.0)
	<p>The Chief Executive presented the paper and highlighted the following points:</p> <ul style="list-style-type: none"> <li>• There were 13 incidents under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) in the year 2019;</li> <li>• During 2019 the Trust reported 626 physical assaults against staff (a decrease of 15 compared with 2018);</li> <li>• During 2019, the Royal Berkshire Fire and Rescue Service undertook three fire safety visits to ensure that the Trust was compliant with the Regulatory Reform (Fire Safety) Order 2005;</li> <li>• 6 fires were reported during 2019 (three were accidental and three were arson);</li> <li>• Fire Awareness statutory training compliance had increased from 87.86% in 2018 to 93.95% in 2019;</li> <li>• Health and Safety statutory training compliance had averaged 94.73% during 2019 which was above the Trust’s target of 90% compliance; and</li> <li>• The number of days lost through sickness had increased from 14.6 days in 2018 to 15.4 days in 2019.</li> </ul> <p>Naomi Coxwell, Non-Executive Director referred to the section of the report on patient physical assaults on staff and asked whether the Trust prosecuted patients who had capacity and who assaulted staff.</p> <p>The Chief Executive explained that the majority of patients assaults on staff occurred on the Campion Unit (Learning Disabilities) and Sorrel Ward (Psychiatric Intensive Care)</p>

	<p>where patients did not have capacity and therefore there were relatively few people who could be prosecuted. The Chief Executive confirmed that the Trust did undertake both criminal and civil prosecutions when appropriate.</p> <p>The Deputy Chief Executive and Chief Financial Officer reported that the Trust was installing CCTV cameras at Prospect Park Hospital and that this would provide evidence to support staff in any future prosecutions.</p> <p>The Chief Executive reminded the Board about the earlier presentation by the Head of Learning Disability Services on the Quality Improvement Programme work around reducing patient assaults on staff on the Champion Unit and pointed out that for many of the Trust's in-patient services, adopting the Quality Management Improvement System (QMIS) approach was likely to be more effective in reducing patient assaults than prosecutions.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/017</b>	<b>Audit Committee Minutes - 29 January 2020</b> (agenda item 10.1)
	<p>Chris Fisher, Chair of the Audit Committee reported that the topic of the Audit Committee's personal development seminar prior to the main meeting was on Cyber Security. Mr Fisher reported that the Audit Committee had also received the Trust's Annual Cyber Security Report.</p> <p>Mr Fisher reminded the meeting that Cyber Security had been escalated from the Corporate Risk Register to the Board Assurance Framework because of the continuing threat posed by Cyber-attacks.</p> <p>Mr Fisher reported that the Head of Clinical Effectiveness and Audit had presented a "deep dive" report on the Clinical Audit process which had been very informative.</p> <p>Mr Fisher thanked Mark Day, Non-Executive Director for attending the meeting and deputising for Mehmuda Mian, Non-Executive Director who was unable to attend.</p> <p>The Chair thanked Chris Fisher for his update.</p> <p><b>The Trust Board:</b> noted the minutes of the Audit Committee meeting held on 29 January 2020.</p>
<b>20/018</b>	<b>Annual Declarations of Interest and Fit and Proper Persons Test Report</b> (agenda item 10.2)
	<p>The Company Secretary reported that the purpose of the paper was to provide assurance to the Trust Board that the Trust was compliant with the Care Quality Commission's Fit and Proper Persons Test requirement.</p> <p>The Company Secretary reported that the paper also set out the Board's declarations of interests which were also published on the Trust's website.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/019</b>	<b>Annual Trust Board Meeting Planner</b> (agenda item 10.3)

	<p>The Annual Trust Board Meeting Planner for 2020 had been circulated.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/020</b>	<b>Use of the Trust Seal Report</b> (agenda item 10.4)
	<p>It was noted that the Trust's Seal had been affixed to documents concerning the lease of Erleigh House (Science and Technology Centre Building), University of Reading.</p>
<b>20/021</b>	<b>Council of Governors Update</b> (agenda item 10.5)
	<p>The Chair reported that the Equalities and Diversity Awareness session at the Joint Non-Executive Directors and Council of Governors meeting had been excellent. The Chair reported that a similar session would be run for the Mental Health Act Managers.</p> <p>The Chair reported that he had asked the Company Secretary to arrange an NHS Providers tailored session on the role of the Governors and the relationship between the Board and the Council. The session was particularly aimed at new Governors but it would be open to all Governors and members of the Board.</p> <p style="text-align: right;"><b>Action: Company Secretary</b></p> <p><b>The Trust Board:</b> noted the update.</p>
<b>20/022</b>	<b>Any Other Business</b> (agenda item 11)
	<p><b>Coronavirus Preparations</b></p> <p>The Director of Nursing and Therapies reported that the Department of Health and Social Care, the NHS Central Alerting System and Public Health England had issued comprehensive guidance for NHS Trusts on managing the Coronavirus outbreak.</p> <p>It was noted that there was a dedicated section on the Trust's Staff Intranet with links to the latest advice to ensure that staff had access to the most up to date guidance.</p> <p>The Director of Nursing and Therapies reported that staff at the Trust's Urgent Treatment Centre at West Berkshire Community Hospital and the WestCall Out of Hours GP service had been fully briefed on managing the Coronavirus. This included directing people suspected of contracting the Coronavirus who turned up at the Urgent Treatment Centre to a dedicated POD which included a chair and a telephone so that they could contact the 111 Service for advice.</p> <p>Chris Fisher, Non-Executive Director pointed out that the advice for people infected with the Coronavirus was to self-isolate themselves to avoid spreading the infection and asked whether this posed a risk to the Trust's operations if high numbers of staff contracted Coronavirus.</p> <p>The Chief Executive said that if a significant number of staff were of sick, the Trust would invoke its Emergency Plan which would include scaling back on all non-essential activities.</p>

	<p>David Buckle, Non-Executive Director asked whether the Trust’s Infection and Control team had sufficient resources to manage the Coronavirus outbreak.</p> <p>The Director of Nursing and Therapies said that the national Coronavirus guidance included very clear flow charts on how to treat Coronavirus patients which included standard Infection and Control precautions and therefore there was no need for additional Infection and Control specialists.</p> <p>The Chief Executive said that the Director of Nursing and Therapies would inform the Board if there were any significant developments in relation to the Coronavirus outbreak.</p> <p>The Chair thanked the Director of Nursing and Therapies for her update.</p>
<b>20/023</b>	<b>Date of Next Meeting</b> (agenda item 11)
	Tuesday, 14 April 2020
<b>20/024</b>	<b>CONFIDENTIAL ISSUES:</b> (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 11 February 2020.

Signed..... Date 14 April 2020  
(Martin Earwicker, Chair)

**TRUST BOARD In Committee Meeting**

**14 April 2020**

*The Chair agreed to cancel the April 2020 Public Board meeting to enable the Trust to focus on its COVID-19 response. In view of the national social distancing requirements, this private meeting was conducted electronically via Microsoft Teams.*

The meeting papers and the unconfirmed minutes of the meeting are publicly available on the Trust's website.

**Meeting Minutes (to be confirmed as an accurate record at the next meeting)**

<b>Present:</b>	Martin Earwicker	Trust Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director (via MS Teams)
	Mark Day	Non-Executive Director
	Julian Emms	Chief Executive
	Chris Fisher	Non-Executive Director
	Minoo Irani	Medical Director
	Aileen Feeney	Non-Executive Director
	Debbie Fulton	Director of Nursing and Therapies
	Alex Gild	Deputy Chief Executive and Chief Financial Officer
	Mehmuda Mian	Non-Executive Director
David Townsend	Chief Operating Officer	

**In Attendance:**

Julie Hill	Company Secretary
Jane Nicholson	Interim Director of People

**Apologies:** Kathryn MacDermott Acting Executive Director of Strategy

<b>20/040</b>	<b>Chair's Welcome</b>
	<p>The Chair welcomed everyone to the meeting which was being conducted via Microsoft Teams because of the COVID-19 social distancing requirements.</p> <p>The Chair reported that on behalf of the Trust Board, he had written a note to all staff to thank them for their hard work in rising to the exceptional challenges posed by COVID-19. The note would be included in this week's Team Brief.</p>



20/041	<b>Declarations of Interests</b>
	There were no declarations of interests.
20/042	<b>COVID-19 Situation Update</b>
	<p>The Chief Executive reported that he had briefed the Non-Executive Directors on the Trust's COVID-19 response on 9 April 2020.</p> <p>The Chief Executive reported that the previous national COVID-19 modelling had suggested that there may be a surge of hospital admissions over the Easter period, but fortunately although the acute hospitals were busy, the surge in cases had not happened. It was noted that acute hospitals in the South East had around 68-70% occupancy rates.</p> <p>The Chief Executive reported that five COVID-19 positive patients had died on the Trust's in-patient wards. It was noted that currently the national death figures excluded COVID-19 related deaths in care homes and in the community.</p> <p>It was noted that there were currently 289 members of staff off sick with 139 of these related to COVID-19.</p> <p>The Chief Executive reported that the Trust was receiving donations from local businesses including Easter eggs for staff, cream to make wearing personal protective equipment more comfortable and financial donations to the Trust's charitable funds.</p> <p>The Chair asked about the impact on the care of the Trust's non-COVID-19 patients.</p> <p>The Chief Executive reported that the Trust had identified those patients who continued to need on-going support in terms of both mental health and community health services. In many cases, face to face consultations had been replaced with virtual and/or telephone consultations. In addition, Community Nursing staff were working with patients and their families/carers to increase self-care in order to reduce social contact.</p> <p>The Chief Executive said that it was important to ensure that meeting the challenges posed by COVID-19 did not blind side the Trust and that patient safety remained the Trust's top priority.</p> <p>The Director of Nursing and Therapies reported that the Trust conducted quality impact assessments which were signed off by the Medical Director and herself in respect of every service change. In addition, patients received letters to inform them of any service changes, including information about who to contact if they needed help.</p> <p>David Buckle, Chair of the Quality Assurance Committee requested that the Quality Assurance Committee review the service change Quality Impact Assessments as part of its assurance role.</p> <p style="text-align: right;"><b>Action: Director of Nursing and Therapies</b></p>

	<p>Naomi Coxwell, Non-Executive Director asked about COVID-19 testing.</p> <p>The Medical Director reported that the current national guidance was that all inpatients suspected of having COVID-19 were tested. Results were now being received promptly within 48 hours. In addition, staff testing was now up and running. The Medical Director reported that the Trust was in discussion about whether to offer limited testing for Police and Fire Fighters in Berkshire because there was some additional capacity to do more testing.</p> <p>David Buckle, Non-Executive Director asked about the impact on the quality of services and how this would be picked up once the current COVID-19 challenges were over.</p> <p>The Director of Nursing and Therapies confirmed that the Trust was already thinking about the recovery phase but now, the priority was around how to manage services safely whilst meeting the challenges of COVID-19.</p> <p>Aileen Feeney, Non-Executive Director commented that it would also be important to review which of the new ways of working and amendments to services should continue post-recovery.</p> <p>The Director of Nursing and Therapies agreed and said that a process would be put in place to review the learning and to identify which service changes should become business as usual.</p> <p>The Chief Executive said that NHS England/Improvement had reduced the transactional side of the NHS, for example, the commissioning function and commented that he hoped that this would continue.</p> <p>Aileen Feeney, Non-Executive Director asked whether the Trust Board could raise the issue at a national level.</p> <p>The Chief Executive said that NHS Providers represented the interests of the Trusts and would be raising the issue on behalf of provider organisations.</p> <p>Chris Fisher, Non-Executive Director commented that he had read that non-COVID-19 related Accident and Emergency attendances were significantly down.</p> <p>The Director of Nursing and Therapies said that attendances at the Trust's Minor Injury Unit were also down.</p> <p>David Buckle, Non-Executive Director said that it was a concern that people were not seeking the treatment they needed.</p> <p>The Chair thanked the Chief Executive for his update.</p>
<b>20/043</b>	<b>COVID-19 Quality Related Issues</b>
	<p>The Medical Director presented the paper and reported that NHS England/Improvement had issued guidance to Trusts on managing quality related activities during the COVID-19 outbreak.</p>

The Medical Director pointed out that the General Medical Council had also issued guidance which included the suspension of the doctors' revalidation requirements until September 2020.

The Medical Director highlighted the following points:

#### **Mortality Review Process**

- All deaths would continue to be reported on the Trust's DATIX system with new specific fields added to DATIX for COVID-19 deaths;
- The Executive Mortality Group would continue to review all DATIX reported deaths weekly (first stage review) but the second stage structured review process would be limited to deaths of learning disability patients and those where there was a complaint, or a concern raised;
- Any urgent learning would be implemented immediately but any non-urgent areas for improvement would be logged and implemented at a later stage
- Only COVID-19 deaths in hospital were nationally reported.

#### **Serious Incident Investigation and Duty of Candour**

- National reporting of serious incidents would continue;
- A decision would be made in conjunction with Commissioners regarding the level/type of investigation and whether this would be postponed;
- Full formal Duty of Candour would be revised to accommodate social distancing. Family support and the principle of being open would continue;
- Initial findings reporting to be completed for deaths by suicide;
- Inquests in Berkshire had been suspended until further notice;
- Quarterly Learning from Deaths reports would continue to be submitted to the Quality Assurance Committee

#### **Clinical Audit and NICE Guidance**

- National Clinical Audits had been suspended
- NICE were reviewing all their guidance and were prioritising therapeutically critical topics including all appraisals of cancer medicines, diagnosis and treatment of COVID-19 patients
- Published Clinical Audit reports would continue to be submitted to the Quality Assurance Committee

#### **Research and Development**

- The Research and Development function continued to operate but research projects which involved face to face contact had been suspended or closed early

#### **Ethical Decision Making in the Context of COVID-19**

- Ethics Consideration Group – had been established chaired by the Lead Clinical Director
- The Group would make recommendations to the Clinical Strategy Group
- Clinical Strategy Group – this was an Executive level decision group which would review the recommendations from the Ethics Group.

#### **Alignment with internal and external ethics policies and processes**

	<ul style="list-style-type: none"> <li>Existing Trust guidance and policy and national guidance and policy were continually reviewed as part of submission to the Ethics Consideration Group</li> <li>The Quality Executive Group and Trust Board would receive monthly reports from the COVID-19 Clinical Strategy Group;</li> <li>Communications to Trust staff would be via rapid service level briefings by clinical directors and information updates on the COVID-19 intranet page</li> </ul> <p>Naomi Coxwell, Non-Executive Director expressed concern that COVID-19 related deaths in the community and in care homes were not centrally recorded.</p> <p>The Medical Director said that the Trust was recording some community patient deaths but pointed out that nationally there was a need for consistent guidance with the COVID-19 data for deaths in the community and in care homes since there was risk of some double counting of deaths if different providers reported the same death.</p> <p>The Chair asked for assurance that the Trust was recording COVID-19 deaths in accordance with national requirements.</p> <p>The Medical Director confirmed that the Trust was recording and reporting all inpatient Covid-19 deaths as per national guidance and has also started recording community based deaths if a staff member reports this via Datix and this meant we were recording more information than was currently nationally required.</p> <p>David Buckle, Chair of the Quality Assurance Committee said that the approach outlined by the Medical Director was very sensible given the challenges of COVID-19. Dr Buckle pointed out that many of the key sources of quality related assurance originated from complaints, duty of candour, serious incident reviews etc which were presently suspended or slimmed down, therefore he would be discussing with the Trust Chair how best the Quality Assurance Committee could undertake its role in gaining assurance whilst enabling the Executive to focus on the COVID-19 challenges.</p> <p><b>Action: Dr Buckle, Chair of the Quality Assurance Committee/Trust Chair</b></p> <p><b>The Trust Board:</b> noted the paper.</p>
20/044	<b>COVID-19 Workforce and Staff Wellbeing</b>
	<p>The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted two key topics:</p> <ul style="list-style-type: none"> <li><b>Staff redeployment</b> – to ensure that the right people are deployed to services at the right time;</li> <li><b>Staff wellbeing</b> – to ensure that staff receive the support they need to cope with the COVID-19 challenges.</li> </ul> <p>The Interim Director of People reported that the Trust’s COVID-19 Workforce Project aimed to ensure that the Trust had the maximum number of staff and other workers trained and available to respond to COVID-19 demands and that</p>

staff were treated fairly and that measures were put in place to support staff wellbeing.

The Interim Director of People reported that a number of non-urgent services had been stood down and therefore it was important that those staff were redeployed to services under pressure in order to support frontline staff.

It was noted that the Trust had developed an online Corporate Induction Programme so staff were still able to join the Trust. Essential Clinical Education training, for example, resuscitation training was still taking place with arrangements in place to respect social distancing requirements.

The Deputy Chief Executive and Chief Financial Officer reported that the Trust had developed a full package of support for staff using the Trust's in-house Psychological Services and trauma expertise. The staff support offer was additional to the Trust's standard wellbeing offer and was to support staff coping with the challenges posed by COVID-19. The wellbeing offer had also been extended to NHS staff in the wider system.

The Deputy Chief Executive and Chief Financial Officer explained that in order to access support, staff completed an online questionnaire and/or contacted the Wellbeing Support Telephone Line. Psychologists were then able to triage staff to the appropriate service.

Naomi Coxwell, Non-Executive Director referred to the slide on redeployment (page 24 of the agenda pack) which identified staff suitable for redeployment and asked whether the 750 staff had been found alternative roles.

The Interim Director of People explained that 170 staff had been redeployed in the first week to support frontline staff particularly on the Trust's inpatient wards. It was noted that work was ongoing to find suitable roles for other staff which also included roles across the wider system.

The Chief Operating Officer also pointed out that staff were being moved around to cover workforce gaps on a daily basis.

The Interim Director of People said that the Trust had planned what would happen if the system went into crisis but pointed out that this was looking less likely as the initial modelling which had indicated a significant surge of cases over the Easter period had not materialised and acute hospitals still had capacity.

The Chair referred to the slide on workforce modelling (page 22 of the agenda pack) and asked about the annual leave and sickness projections for clinical staff.

The Interim Director of People said that the Trust had not placed a blanket ban on staff taking leave and was encouraging staff to continue to take their leave.

David Buckle, Non-Executive Director fully endorsed the Trust's decision not to ban leave.

Mark Day, Non-Executive Director asked whether the Trust would offer staff the opportunity to buy back annual leave.

	<p>The Interim Director of People reported that staff were able to carry forward their annual leave for two years but commented that the Trust would consider individual requests on a case by case basis.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/045</b>	<b>COVID-19 Programme Structure and Governance Presentation</b>
	<p>The Director of Nursing and Therapies reported that the purpose of the presentation was to provide the Board with an overview of the Trust's COVID-19 Programme Structure and Governance arrangements.</p> <p>The Director of Nursing and Therapies paid tribute to the Trust's Project Management Office staff who were supporting the Trust's COVID-19 work.</p> <p>It was noted that the COVID-19 programme structure was aligned to the statutory Emergency Preparedness Resilience and Response arrangements which existed and the relationship the Trust had with its Local Health Resilience Forums. It was also noted that NHS England/Improvement required both Frimley Health and Care and Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Systems to have a single overarching co-ordination role across all Health partners within the system.</p> <p>The Chair referred to page 35 of the agenda pack and said that he was pleased that each of the Executive key roles had an assigned deputy and asked whether there was a similar deputy arrangement in place for the operational teams.</p> <p>The Chief Operating Officer confirmed that key roles in the operational structure also had assigned deputies.</p> <p>The Chair referred to the COVID-19 Risk Log (page 44 of the agenda pack) and asked whether any of the risks were causing concern.</p> <p>The Director of Nursing and Therapies confirmed that all the identified risks had mitigations put in place but pointed out that national guidance was published daily and therefore the Risk Log was regularly updated.</p> <p><b>The Trust Board:</b> noted the paper.</p>
<b>20/046</b>	<b>Reducing the Burden – NHS England and NHS Improvement Letter – Trust Response</b>
	<p>A paper setting out the Trust's response to NHS England/Improvement's "Reducing the Burden" to ensure NHS provider organisations were able to focus their efforts on meeting the COVID-19 challenges guidance had been circulated.</p> <p>The Director of Nursing and Therapies reported that in addition, the Trust had changed the complaints process which ensured that complainants received a verbal response to the issue raised wherever possible.</p> <p><b>The Trust Board:</b> noted the paper.</p>

20/047	<b>Finance and Infrastructure Briefing Paper</b>
	<p>The Deputy Chief Executive and Chief Financial Officer presented the paper and reported that NHS England/Improvement had suspended the operational planning process for four months (April-July 2020) as part of its approach to reducing the burden on NHS provider organisations so they could focus on responding to the challenge of COVID-19.</p> <p>The Deputy Chief Executive and Chief Financial Officer reported that the Department of Health and Social Care had given a commitment that all COVID-19 related additional costs (both revenue and capital) would be funded centrally.</p> <p>It was noted that all NHS provider organisations on block contracts would receive a guaranteed income block plus inflation with additional “top up” payments where costs were projected to be in excess of income.</p> <p>The Deputy Chief Executive and Chief Financial Officer reported that the Trust’s investment in IT infrastructure meant that the Trust was able to maintain its operational and corporate functions with many staff working remotely at home. In addition, the weekly All Staff Executive Live Broadcasts were watched by around 3,000 staff with other staff able to watch the recordings at their convenience.</p> <p>Aileen Feeney, Non-Executive Director said that she watched the Live Broadcasts and congratulated the Executive on both the content and style of the Broadcasts.</p> <p>The Chair echoed Ms Feeney’s comments and said that it was important that the Trust captured the learning about ways of communicating with a geographically spread workforce.</p> <p>The Deputy Chief Executive and Chief Financial Officer reported that the remedial works at Willow House had been completed but work to build the new unit at Prospect Park Hospital had been paused.</p> <p><b>The Trust Board:</b> noted the paper</p>
20/048	<b>Board Sub-Committees</b>
	<p><b>a) Quality Assurance Committee Meeting – 18 February 2020 Minutes</b></p> <p>The minutes of the Quality Assurance Committee meeting held on 19 February 2020 had been circulated.</p> <p>David Buckle, Chair of the Quality Assurance Committee said that in addition to the standard items, the Committee had also received an informative presentation from the Assistant Director of Performance and Information on the Systems and Processes for Assuring the Quality of Data and a presentation from the Regional Director (East) on the Trust’s Carers Strategy.</p> <p>Dr Buckle reported that the Committee had also discussed the outcome of the National Clinical Audit Reports on Anxiety and Depression and Prescribing for</p>

	<p>Depression in Adult Mental Health Services. Dr Buckle confirmed that the audits had indicated a few concerns within a minority of audits, but these had been investigated in detail and where necessary, the Trust had responded appropriately. Dr Buckle confirmed that the Committee was assured that systems and processes had been put in place to address any areas for improvement.</p> <p><b>b) Finance, Investment and Performance Committee Meeting – 26 March 2020 Minutes</b></p> <p>The minutes of the Finance, Investment and Performance Committee meeting held on 26 March 2020 had been circulated.</p> <p>Naomi Coxwell, Chair of the Finance, Investment and Performance Committee requested an update on the year-end financial position.</p> <p style="text-align: center;"><b>Action: Deputy Chief Executive and Chief Financial Officer</b></p> <p><b>The Trust Board:</b> noted the Board Sub-Committee minutes.</p>
<b>20/049</b>	<b>COVID-19 Communications</b>
	<p>The Director of Nursing and Therapies reported that the Trust’s COVID-19 Communications included:</p> <ul style="list-style-type: none"> <li>• A dedicated COVID-19 email box for staff to raise issues;</li> <li>• Daily all staff COVID-19 related emails;</li> <li>• A dedicated section on Teamnet for all COVID-19 related information;</li> <li>• Weekly all staff executive briefings; and</li> <li>• Delivery of key campaigns (for example, staff wellbeing, deployment, staff bank and staff testing).</li> </ul> <p>The Director of Nursing and Therapies reported that the Trust’s external communications included:</p> <ul style="list-style-type: none"> <li>• Communication of service changes (for example, information on the Trust’s website, letters to patients, integrated care system and Healthwatch advising of changes);</li> <li>• Management of donations and fundraising including setting up a “Just Giving” page;</li> <li>• Recruitment drive via social media;</li> <li>• Dedicated section for COVID-19 on the Trust’s website;</li> <li>• Providing wellbeing and mental health support via the web and social media;</li> <li>• Chair’s email to all Members and Governor updates.</li> </ul> <p>Mehmuda Man, Non-Executive Director asked whether the letters to patients advising them of service changes gave an indication about when normal service would resume.</p> <p>The Chief Operating Officer said that the Trust was not in position to advice patients about the timescale of the service changes but for many services, patients were able to access support via telephone or via virtual consultations.</p>



	<b>The Trust Board:</b> noted the paper
<b>20/050</b>	<b>COVID-19 Process for Capturing Lessons Learnt</b>
	<p>The Chair said that it was important that the Trust captured any lessons learnt from the handling of the COVID-19 health emergency</p> <p>The Chief Executive confirmed that the Trust was logging any learning at the daily Executive meetings. The Chief Executive invited Non-Executive Directors to contribute to the process by highlighting any areas of learning.</p>
<b>20/051</b>	<b>Future Governance Structures and Issues including Quality</b>
	<p>The Chair reported that the national guidance required that Trust's Quality Committees continue but other Board Sub-Committee meetings could be suspended during the COVID-19 lock-down period.</p> <p>The Chair suggested that he and David Buckle, Chair of the Quality Assurance Committee discuss which quality related issues would be considered by the full Trust Board and which would be discussed by the Quality Assurance Committee.</p> <p style="text-align: right;"><b>Action: Trust Chair and Chair of the Quality Assurance Committee</b></p> <p>The Chief Executive said that for virtual future Board meetings, the Trust could post the recording of the public Board meeting on the website.</p> <p>David Buckle, Non-Executive Director supported the proposal and suggested that in addition it would be helpful if governors and members of the public were able to submit questions to the Board. Dr Buckle said that these questions should relate to the Trust rather than to national policy issues.</p> <p>Aileen Feeney, Non-Executive Director said that the recording should also be accompanied by the Board meeting papers. Ms Feeney suggested that the meeting should be divided into the public Board meeting and a private Board meeting and that the recording of the public Board meeting should be posted on the Trust's website.</p> <p style="text-align: right;"><b>Action: Company Secretary</b></p> <p>The Chief Executive confirmed that none of the papers presented to today's meeting were confidential and could be published on the website together with the minutes of the meeting.</p> <p style="text-align: right;"><b>Action: Company Secretary</b></p> <p>Naomi Coxwell, Non-Executive Director suggested discussing the arrangements for future "public" Trust Board meetings with the Lead Governor.</p> <p style="text-align: right;"><b>Action: Trust Chair</b></p> <p><b>The Trust Board:</b> agreed to record future public Trust Board meetings and post the video on the Trust's website.</p>
<b>20/052</b>	<b>COVID-19 Board Assurance Framework Risk</b>

	<p>The COVID-19 Board Assurance Framework Risk had been circulated.</p> <p>Naomi Coxwell- Non-Executive Director suggested that the risk summary should explicitly refer to COVID-19.</p> <p style="text-align: right;"><b>Action: Company Secretary</b></p> <p><b>The Trust Board:</b> noted the Covid-19 Board Assurance Framework Risk.</p>
<b>20/053</b>	<b>Care Quality Commission Inspection Outcome</b>
	<p>The Chair congratulated the Trust on achieving an Outstanding rating by the Care Quality Commission.</p> <p>The Director of Nursing and Therapies reported that the Trust was currently developing an action plan to address the Care Quality Commission’s “Should Do” and “Must Do” areas for further improvement. The “Must Do” action plan would be presented to the May 2020 Quality Assurance Committee and the “Should Do” action plan would be presented to the Committee at a later stage.</p> <p style="text-align: right;"><b>Action: Director of Nursing and Therapies</b></p> <p><b>The Trust Board:</b> noted the paper</p>
<b>20/054</b>	<b>Gender Pay Gap Report</b>
	<p>The Deputy Chief Executive and Chief Financial Officer reminded the meeting that it was a mandatory requirement to report the gender pay gap each year. It was noted that the Trust’s gender pay gap remained at 20%.</p> <p><b>The Trust Board:</b> noted the paper</p>
<b>20/055</b>	<b>Staff Survey Results Report</b>
	<p>The Deputy Chief Executive and Chief Financial Officer presented the paper and said that the Trust had increased its response rate to NHS National Staff Survey from 51% in 2018 to 61% in 2019. It was noted that the Trust’s Staff Engagement score had improved again and that the Trust had retained the joint second highest score of all combined Mental Health and Community Health Trusts.</p> <p>The Deputy Chief Executive and Chief Financial Officer drew attention to table 2 of the paper (page 102 of the agenda pack) which broke down the response rates by divisions and table 4 which provided an overview of the key themes from the NHS Staff Survey 2019. The Deputy Chief Executive and Chief Financial Officer said that it was very positive that the scores for the quality of appraisals and the safety culture had improved.</p> <p>The Deputy Chief Executive and Chief Financial Officer pointed out that the Equality, Diversity and Inclusion theme was below the average for similar Trusts and confirmed that Equality, Diversity and Inclusion would continue to be a focus for the Trust.</p>

	<p>The Chair commented that the NHS Staff Survey 2019 results were very positive and fully supported the Trust's continuing focus on Equality, Diversity and Inclusion.</p> <p>Aileen Feeney, Non-Executive Director said that she was surprised that the score for morale was not higher. The Deputy Chief Executive and Chief Financial Officer said that it was important to view morale in the context of the high score for staff engagement.</p> <p><b>The Trust Board:</b> noted the paper</p>
20/056	<p><b>Human Resources Practices Assurance Paper in response to a letter from NHS England/NHS Improvement</b></p>
	<p>The Interim Director of People presented the paper and reported that Dido Harding, Chair of NHS Improvement had written to NHS Chairs and Chief Executives on 24 May 2019 with a request that Boards review and assess their current disciplinary and grievance procedures and processes against the recommendations set out in the letter.</p> <p>The Interim Director of People drew attention to the appendix to the report which set out an assessment of the Trust's compliance against each of the recommendations together with the proposed actions to address any gaps.</p> <p>It was noted that the Trust's current disciplinary and grievance procedures and processes generally compared well against Dido Harding's recommendations, but it was acknowledged that there was always room for improvement.</p> <p>Mark Day, Non-Executive Director asked whether it would be better for a comprehensive report on the Trust's disciplinary and grievance cases to be submitted to the Finance, Investment and Performance Committee with a summary going to the Trust Board.</p> <p><b>Action: Deputy Chief Executive and Chief Financial Officer/Interim Director of People</b></p> <p>Mehmuda Mian, Non-Executive Director asked about the timescale for completing the actions.</p> <p>The Interim Director of People said that given the current workforce challenges around COVIS-19, the completion of the action plan would be dependent on workloads.</p> <p>The Chief Operating Officer suggested linking the Dido Harding recommendations into the Trust's Staff Survey work, particularly in relation to equalities and diversity.</p> <p>The Interim Director of People thanked the Chief Operating Officer for his suggestion and agreed to review the role of the Networks as part of the action plan.</p> <p><b>Action: Interim Director of People</b></p> <p>Naomi Coxwell, Non-Executive Director asked about the annual number of disciplinaries and grievances. The Interim Director of People agreed to circulate the information.</p> <p><b>Action: Interim Director of People</b></p>

	<b>The Trust Board:</b> noted the paper.
<b>20/057</b>	<b>Appointments and Remuneration Committee – Executive Directors Non-Consolidated Pay Award 2020-21</b>
	<p>Mark Day, Chair of the Appointments and Remuneration Committee reminded the meeting that the Committee had awarded non-consolidated pay awards to those Executive Directors whose remuneration was above NHS Improvement’s benchmarked salaries and that these non-consolidated pay awards would end on 31 March 2020.</p> <p>It was noted that the publication of the Executive Directors’ national benchmarked salary information was delayed and therefore the Committee would not have the information they needed to review Executive Directors’ salaries at the current time.</p> <p>Mr Day reported that the Chair and the Non-Executive Directors had held a virtual meeting on 9 April 2020 and had agreed to extend the current non-consolidated payments until the national benchmarking data was available.</p> <p><b>The Trust Board:</b> agreed to continue with the current non-consolidated pay awards for the relevant Executive Directors until the Appointments and Remuneration Committee were in a position to review Executive Directors’ remuneration.</p>
<b>20/058</b>	<b>Any other business</b>
	<p><b>a) Sterilisation of Equipment</b></p> <p>Mehmuda Mian, Non-Executive Director asked whether the Trust was sterilising personal protective equipment.</p> <p>The Director of Nursing and Therapies confirmed that the Trust’s supply of personal protective equipment was single use with the exception of goggles which could be re-used.</p> <p><b>b) Post Lock-Down</b></p> <p>Naomi Coxwell, Non-Executive Director asked whether the Trust’s post lock-down recovery phase would be guided by the System.</p> <p>The Chief Executive confirmed that the recovery phase would be dictated by the Centre and reported that for the Trust it was likely that mental health services which had constitutional standards would be the first services to be up and running.</p> <p>The Medical Director said that social distancing measures were effective in reducing COVID-19 infection rates but pointed out that there was considerable uncertainty about whether relaxing the lock-down would result in a resurgence of infections.</p>

	<p>Ms Coxwell said that it was important that the Board was clear about what decisions the Trust was able to make and which decisions would be taken at a system or at a national level.</p> <p><b>c) COVID-19 Impact on Mental Health Services</b></p> <p>The Chief Operating Officer said the Trust was expecting to see an increase in demand for mental health services as part of the recovery phase. The Chief Operating Officer said that the national COVID-19 modelling had changed and that the acute sector was no longer expecting a surge in COVID-19 patients but the impact on services would be over a longer timeframe.</p> <p><b>d) Meeting Review</b></p> <p>The Chair said that he was in discussion with the IT Department about standardising the way the Board accessed online meetings.</p> <p>The Chief Executive said that it was helpful if Board members used the online chat function to signal when they wanted to ask a question.</p> <p>The Chief Executive confirmed that the papers and minutes of the meeting would be available on the Trust website.</p> <p>The Chair thanked the Executive and Staff for the work they were doing to respond to the COVID-19 challenge.</p>
<b>20/059</b>	<b>Date of Next Meeting</b>
	12 May 2020

I certify that this is a true record, accurate and complete set of the Minutes of the business conducted at the In-Committee Board meeting held on 14 April 2020.

Signed..... Date ..... 12 May 2020

Martin Earwicker (Chair)



**BOARD OF DIRECTORS MEETING 12/05/20**

**Board Meeting Matters Arising Log – 2020 – 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.	TBC	<b>KM</b>	To be considered when the three-year strategy is refreshed. Work on the new Strategy is currently suspended due to Covid-19.	
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	April 2020	<b>KM</b>	To be reviewed as part of the Strategy Review.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Equality Strategy was refreshed.				
12.11.19	19/202	Six Monthly Staffing Report	The percentage of shifts with less than two registered nurses for the previous six months to be shown in future reports.	June 2020	<b>DF</b>		
12.11.19	19/206	Finance Report	The Finance, Investment and Performance Committee to be provided with more information about the increase in the number of admin roles and whether this resulted in greater efficiencies elsewhere in the Trust.	March 2020	<b>AG</b>	Completed	
10.12.19	19/247	True North Performance Scorecard	The Deputy Chief Executive and Chief Financial Officer to consider having incremental targets for reducing the length of stay and occupancy at Prospect Park Hospital.	TBC	<b>AG</b>	Action deferred due to COVID-19.	
10.12.19	19/248	Vision Metrics	The Deputy Chief Executive and Chief Financial Officer to present options for linking True North and the Vision Metrics to the Finance, Investment and Performance Committee.	TBC	<b>AG</b>	Action deferred due to COVID-19.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
11.02.20	20/090	Executive Report – System Working	The Executive to encourage the System Leadership Groups to put in place the operating arrangements listed as bullet points in NHS Providers briefing on the NHS Operational Planning and Contracting Guidance 2020-1.	TBC	<b>JE</b>	Action deferred due to COVID-19.	
11.02.20	20/011	True North Performance Scorecard	The cover sheet to be expanded for future reports to identify any areas identified by the Executive for further focus.	April 2020	<b>AG</b>	See M12 2019/20 cover sheet – per business rules re driver metrics, action updates provided by exception.	
11.02.20	20/011	True North Performance Scorecard	The Medical Director and Director of Nursing and Therapies to include quarterly information about non-constitutional waiting times which they were concerned about and why together with any actions that were put in place to address waiting times and to mitigate any patient safety risks.	TBC	<b>MI/DF</b>	Action deferred due to COVID-19.	
11.02.20	20/014	Strategy Implementation Plan 2019-20	A post project review of the Trust's new Intranet to be undertaken in order to learn any lessons for future	TBC	<b>KM</b>	Action deferred due to COVID-19.	



Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			initiatives.				
11.02.20	20/015	Equalities and Diversity Six Monthly Update Report	The NHS National Staff Survey Results to be presented to the April 2020 Trust Board meeting.	April 2020	<b>AG</b>	Completed – paper taken at April 2020 Board meeting.	
11.02.20	20/015	Equalities and Diversity Six Monthly Update Report	The Board to receive the outcome of the Stonewall submission.	April 2020	<b>KM/JH</b>	The Trust was placed 142. There were over 500 participants from across all sectors (an increase of 58 organisations compared with the previous year). There were 64 entrants from Health and Social Care. The Trust achieved a ranking of 15 amongst the Health and Social Care entrants.	
11.02.20	20/021	Governor Update	The Company Secretary to arrange a Joint Board and Council of Governors' session on the role of the Governors and the relationship between the Council and the Board.	TBC	<b>JH</b>	A training event was arranged for 6 May 2020, but this has been deferred due to COVID-19.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.04.20	20/042	COVID-19 Situation Update	The Quality Assurance Committee to review the COVID-19 service change Quality Impact Assessments.	19.05.20	<b>DF/JH</b>	On the agenda for the May 2020 Quality Assurance Committee meeting.	
14.04.20	20/043/ 20/051	COVID-19 Quality Related Issues	The Trust Chair and Chair of the Quality Assurance Committee to consider how best the QAC could undertake its role in gaining assurance whilst enabling the Executive to focus on the COVID-19 challenges.	May 2020	<b>ME/DB</b>	An item is on the agenda for the May 2020 Trust Board meeting.	
14.04.20	20/048	Board Sub-Committees	The end of year financial position to be circulated to members of the Board.	May 2020	<b>AG</b>	The year-end financial position was circulated to the Board.	
14.04.20	20/051	Future Governance Structures including Quality	Virtual Trust Board meetings to be divided into public” and “In Committee” with public Trust Board meetings recorded and the recording published on the Trust’s website.	May 2020	<b>JH</b>	Virtual Trust Board agendas follow the same format as physical meetings with “public” and “In Committee” agendas. The “public” Trust Board meeting will be recorded and published on the Trust’s website.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.04.20	20/051	Future Governance Structures including Quality	The papers and minutes of the April 2020 Trust Board “In Committee” meeting to be published on the Trust’s website.	May 2020	<b>JH</b>	The papers and the minutes of the April 2020 are published on the Trust’s website.	
14.04.20	20/051	Future Governance Structures including Quality	The Trust Chair to discuss the proposed arrangements for holding virtual Trust Board meetings with the Lead Governor.	May 2020	<b>ME</b>	The Trust Chair has discussed the proposed arrangements for holding virtual Trust Board meetings with the Lead Governor. The Lead Governor has confirmed that he is happy with the proposed arrangements.	
14.04.20	20/052	COVID-19 BAF	The risk summary of the COVID-19 BAF risk to be amended to refer to COVID-19.	May 2020	<b>JH</b>	The COVID-19 Risk summary has been amended.	
14.04.20	20/053	Care Quality Commission	The May Quality Assurance Committee to receive the “Must Do” action plan in response to the Care Quality Commission’s recommendations.	May 2020	<b>DF/JH</b>	The “Must Do” Care Quality Commission Action Plan in on the agenda of the May 2020 Quality Assurance Committee	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						meeting.	
14.04.20	20/056	“Dido Harding” Letter	The Finance, Investment and Performance Committee to receive a comprehensive report on the Trust’s Disciplinary and Grievances.	Sept 2020	<b>AG/JN</b>	Due to COVID-19, The timing of the report to be confirmed. It is proposed that the first report to cover 2019/20 and quarter 1 2020/21.	
14.04.20	20/056	“Dido Harding” Letter	The Interim Director of People to review the role of the Networks as part of the Trust’s action plan in response to the “Dido Harding” letter.	July 2020	<b>AG/JN</b>	This will be updated on as part of six-month action plan update to Board.	
14.04.20	20/056	“Dido Harding” Letter	The Board to be informed about the number of disciplinary and grievances.	May 2020	<b>JN</b>	Action completed	

## Trust Board Paper

<b>Meeting Date</b>	12 May 2020
<b>Title</b>	Quality Assurance Processes during COVID-19 Pandemic
<b>Purpose</b>	<p>The purpose of this report is to provide assurance to the Trust Board of the current quality assurance processes within the Trust, including national guidance issued as a result of the COVID-19 pandemic and the organisational response to this.</p> <p>The paper includes ethics processes and decision making established within the Trust for Covid-19 related matters</p>
<b>Business Area</b>	Nursing and Medical Directorates
<b>Author</b>	Nursing and Medical Directorates Presented by Debbie Fulton (Director Nursing and Therapies) & Dr Minoo Irani (Medical Director)
<b>Relevant Strategic Objectives</b>	True North goals of Harm free care, Supporting our staff and Good patient Experience
<b>CQC Registration/Patient Care Impacts</b>	Supports maintenance of CQC registration and oversight of patients' safety and quality in the organisation
<b>Resource Impacts</b>	N/A
<b>Legal Implications</b>	N/A
<b>Equalities and Diversity Implications</b>	N/A
<b>SUMMARY</b>	<p>This paper details relevant national guidance and organisational quality assurance processes in place during the COVID-19 pandemic that ensure continued oversight of patient and staff safety.</p> <p>The paper includes processes in relation to:</p> <ul style="list-style-type: none"> <li>• Datix Incident Reporting</li> <li>• Learning from deaths</li> <li>• Serious Incidents</li> <li>• Duty of Candour</li> <li>• Central Alerting System (CAS)</li> <li>• Patient Experience</li> <li>• Safe Staffing</li> <li>• Safeguarding</li> <li>• Infection control</li> <li>• Clinical Concerns</li> <li>• NICE Guidance</li> <li>• National Clinical Audit and Confidential Inquiries</li> <li>• Quality Accounts</li> </ul> <p>On 1 May 2020, the National Patient Safety Team released a Patient Safety COVID-19 update; this document is attached and supports the</p>

	<p>approach the organisational approach taken.</p> <p>This paper also summarises the output from Clinical Strategy Group. This Group approves ethical considerations of significant foreseeable concern taken through the Ethics Group.</p> <p>Both Groups will continue throughout the period of the Covid-19 pandemic.</p> <p>The Clinical Strategy Group also considers complex issues which have an ethical component may be directly referred to the Clinical Strategy Group via the Medical Director or Director of Nursing and Therapies.</p>
<b>ACTION REQUIRED</b>	<p>The Trust Board is asked to:</p> <ul style="list-style-type: none"> <li>• Note the report</li> </ul>

# Quality Assurance Processes during COVID-19 Pandemic

## 1. Introduction

Whilst many of the processes within the NHS have been scaled back or suspended to free up capacity to respond to the COVID-19 pandemic, usual governance systems and processes that provide oversight of patient and staff safety have continued to be prioritised.

This paper details processes in place and how they have been adapted to support continued oversight of our governance processes that support safety across the organisation.

On 1<sup>st</sup> May 2020, the National Patient Safety Team released a Patient Safety COVID-19 update; this document is attached and supports the approach we have taken.

## 2. Datix - first line incident reporting

Use of Datix (online incident reporting system) as a first line for incident reporting continues to be encouraged with patient safety facilitator scrutiny of all submitted Datix incidents extended to 7-days per week to ensure timely reporting of COVID-19 deaths.

A new field has been created in Datix to enable analysis of incidents thought to be specifically related to/or because of the current pandemic.

Reporting in April 2020 (n=750) is reduced compared to April 2019 (n=1056). Given that a number of services are scaled back and there has been a significant reduction in occupied bed days across both mental and physical health wards, this is not totally unexpected. A total of 149 incidents have been flagged as relating to the COVID-19 pandemic.

Staff who are shielding have been assisting in reviewing and investigation of Datix incidents to support frontline staff. The process for review and escalation of our most serious incidents is unchanged.

## 3. Learning from deaths: Mortality Review Process

### 3.1 National Guidance:

There has been no national guidance about amendment to the existing Mortality Review/Learning from Deaths guidance, although additional national guidance has been published:

#### **COVID-19 Deceased Notification System. 23<sup>rd</sup> March 2020 (NHS Improvement)**

Since March 2020, trusts have been required to report Inpatient COVID-19 related deaths by submitting forms via the Regional Single Points of Contact and this was a temporary measure. NHS Improvement have now developed the COVID-19 Patient Notification System (CPNS) so that all COVID-19 deaths can be reported on one central system.

**Coronavirus Act – excess death provisions: information and guidance for medical practitioners: 31 March 2020 (NHS Improvement):**

- 1) Guidance for any medical practitioner with GMC registration to be able to complete the Medical Certificate of Cause of Death (MCCD) and requirement to have seen the patient within 5 days changed to 28 days.
- 2) Cause of Death to be to the best of their knowledge and belief, diagnostic proof can be submitted when received for suspected COVID-19 deaths.
- 3) All MCCDs to now be submitted electronically to local Registry Offices.

**COVID-19 Patient Notification System (CPNS) Reporting (Ref:001559) 6<sup>th</sup> April 2020 (NHSI)**

- 1) Updated to reflect reporting is required within 24 hours of death, 7 days a week for all inpatients with a positive swab result.
- 2) Updated to include if a patient also worked for the NHS.

**COVID-19 Patient Notification System (CPNS) Reporting (Ref:001559) 27<sup>th</sup> April 2020 (NHS Improvement)**

- 3) Updated to include all inpatient deaths where COVID-19 has been recorded (as either part 1 or 2) on the MCCD, irrespective of whether a swab had been taken or was recorded as negative.

**COVID-19: Revised reporting process for the deaths of healthcare workers (REF:001559) 28<sup>th</sup> April 2020 (NHS Improvement)**

- 4) Updated to include a Rapid process for notification of the death of a member of NHS staff to understand the impact of COVID-19 on the NHS workforce (including non-inpatient deaths).

**3.2 Organisational Response:**

The Trust's Learning from Deaths and Mortality Review process remains uninterrupted. All new national guidance has been implemented and we have governance processes in place to ensure we report to the CPNS within 24 hours.

To date between 30<sup>th</sup> March 2020 and 30<sup>th</sup> April 2020 we have reported 11 Community Inpatient deaths where a patient was positive for COVID-19. The age range was between 69–104 years, 4 patients were female and 7 were males. All patients had additional comorbidities.

We have enhanced the first stage (Datix) review by the Executive Mortality Review Group (EMRG) to reduce the number of routine requests for 2<sup>nd</sup> stage reviews (SJR's). The number of 1<sup>st</sup> stage reviews have increased from an average of 33 per month over Q4 to 49 in April 2020.

2<sup>nd</sup> stage reviews continue for all deaths of patients with a learning disability, deaths where a formal complaint (or concern about care) by family/carer or staff or a concern from the Coroner has been received. We will also be selecting some deaths where COVID-19 was suspected for a 2<sup>nd</sup> stage review to understand that care was appropriate and other causes/diagnosis were not missed.

The Trust Mortality Review Group continues to meet monthly (as usual) to review the 2<sup>nd</sup> stage reviews and ensure that the relevant learning and any significant risk is identified and shared. The national requirements to report learning from deaths to the Board on a quarterly basis continue to be met. The Q4



Learning from deaths report for 2019/20 has been submitted for the Quality Assurance Committee meeting on 19 May 2020.

## **4. Serious Incidents**

### **4.1 National Guidance:**

Serious incident reporting has continued and there has been no specific guidance issued around this, Frimley Health and Care Integrated Care System have undertaken a Quality Impact Assessment (QIA) for the system which has been approved by NHS England/Improvement which states that:

Providers will continue to report cases meeting the Serious Incident criteria on the national Strategic Executive Information System (STEIS), to maintain local, regional and national visibility. Serious Incident reporting will be modified as follows:

- There will be a temporary suspension of the requirement to carry out a full investigation of Serious Incident cases and for reports to be submitted to the Commissioners within 60 working days.
- Providers may carry out rapid short-form Serious Incident reviews, with findings documented on a concise template (for example, the 72-hour reporting template). It is advisable to carry out at least a 72-hour case review to establish any significant lapses in standards and any actions required to address.
- Providers may decide, on an individual case basis, to carry out more thorough investigations or to schedule more thorough investigations to be conducted at a later date, if postponement is required due to lack of available clinical and administrative resource during the pandemic. This is likely to be for cases with very serious or fatal outcomes. Any reporting duties required by statutory safeguarding, domestic homicide, policy or other statutory investigations will need to be maintained. Information required by HM Coroner, including any witness or expert statements, will still need to be provided when requested.

### **4.2 Organisational Response:**

Our Serious Incident process has been streamlined and we are utilising Quality Improvement methodology to test the efficacy of this approach and ensure rapid learning. We have been using staff who are shielding/senior retired staff on NHS Professionals to support the serious incident process.

- A stepped approach to investigation depending upon severity is in place.
- Decisions are made in conjunction with Commissioners regarding the level/type of investigation required
- Initial Findings Reports are completed in the usual way. A more detailed Initial Findings Review is required if it is anticipated an incident will not progress to full Serious Incident investigation
- Rapid reviews of suicides during Covid-19 to ensure we capture themes quickly

## **5. Learning from Incidents**

- Learning discussions and the sharing of learning is taking place using Microsoft Teams and very close working with Clinical Directors
- Patient Safety and Quality Meetings are in place via teams (monthly as usual) to disseminate learning
- Clinical Director status exchange twice weekly attended by the Deputy Director Nursing

- Learning from incident using a “Talking Heads” team training approach for example: the 3 suicides this month have all been reviewed and initial learning identified as (although not believed to be causative) lack of questions around impact of social distancing media and also the need for a softer questioning about suicidal ideation over the phone. To share this a very brief phone role play is being put together, this will be recorded and put on Microsoft Teams for Crisis Resolution Home Treatment and Community Mental Health Team staff.

## **6. Duty of Candour**

### **6.1 National Guidance:**

There is currently no national directive to deviate from this regulation, so a local decision is required on how best the duty can be fulfilled while conserving clinical and administrative resources during the pandemic.

Frimley Health and Care Integrated Care System have undertaken a Quality Impact Assessment which has been signed off by NHS England/Improvement which states that:

- For moderate incidents, the relevant persons will, as a minimum, be informed that an incident has taken place, offered an apology, and given assurance that any remedial or improvement actions will be taken. The full extent of the duty will, however, only apply to ‘severe’ incidents, and not to ‘moderate’ incidents. The exception to this will be when relevant persons affected by a moderate incident specifically ask for further information or feedback.
- In carrying out the duty in relation to ‘severe’ incidents, providers may conduct discussions with relevant persons in a less formal way, e.g. via telephone, so long as:
  - a. The relevant persons are informed about what happened.
  - b. Conclusions and learning (when established) are fed back to the relevant persons.
  - c. Any specific questions asked by relevant persons are answered fully and transparently.

It is anticipated that these measures will maintain the spirit of the duty while lessening the clinical and bureaucratic burden.

### **6.2 Organisational response:**

The process has continued as near to usual as possible, whilst accommodating social distancing and use of technology instead of face to face contact.

## **7. The Central Alerting System (CAS)**

### **7.1 National Guidance:**

There is no change to the CAS process.

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care.

### **7.2 Organisational response:**

We have not changed our processes around ensuring that appropriate action is undertaken when Central Alerting System alerts are received; every alert is reviewed for relevance to Berkshire Healthcare services,

where it is relevant, we respond by ensuring the appropriate action is undertaken. We have put in an additional process to flag those that are related to COVID19 pandemic.

Since the beginning of March 2020, we have received 34 CAS alerts into the organisation.

13 related to COVID-19 and were letters from the Chief Medical Officer also disseminated centrally via other means and have been actioned; 9 were medication related all of which require and were actioned through pharmacy within 48 hours; 9 were not relevant and the remaining 3 are in progress.

## **8. Patient experience**

### **8.1 National guidance:**

On 27<sup>th</sup> March 2020 NHS provider organisations were informed that:

- the formal complaint process should be paused to reduce pressure on provider services whilst responding to COVID-19 pandemic. Acknowledgement and recording of complaints should continue, new complaints should be triaged, and immediate action taken around any patient safety or safeguarding concerns. Complaints to remain open until further notice, unless an informal resolution could be achieved, or the complainant chooses to withdraw their complaint.
- the Parliamentary and Health Service Ombudsman has stopped accepting new NHS complaints and has stopped work on open cases.
- Collation and submission of the Family and Friends Test should be suspended.

### **8.2 Organisational response:**

The Trust has continued to investigate and respond in writing to all complaints opened prior to this time and we are offering local/informal resolution as an alternative for all new complaints. We continue to log, review and triage all complaints received and where informal resolution is not possible complaints will be formally responded to as soon as services are able.

Since 1 April 2020, we have received 8 new complaints. This is lower than the average monthly figure of between 12-15 formal complaints. Given that we have fewer patient contacts at present this is not unexpected. The complaints are across differing services with no theme identified. 4 of these are being handled with verbal responses and 4 are on hold (with complainant agreement) and will be responded to in due course.

## **9. Safe Staffing**

### **9.1 National guidance:**

Collection/submission of safe staffing data (care hours per patient day) is suspended.

### **9.2 Organisational response:**

Monthly internal reporting has continued with the monthly report being presented to Quality Executive Group. All Inpatient wards and community nursing services are reporting on safety within their services daily. Datix for any incidents is still in place and there is oversight at senior level with staff redeployment and moves alongside relevant training and induction to support safe staffing.

## **10. Safeguarding**

Our safeguarding processes have been enhanced during this period with a 7-day week advice line now in place to support clinicians with child and adult safeguarding concerns and queries.

In addition, our process continues around:

- Safeguarding supervision
- Child protection conferences which are being undertaken via Skype supported by redeployed Health Visitors and School Nurses
- Domestic abuse support
- Safeguarding training
- Support with Deprivation of Liberty Standards (DOLS) applications and Mental Capacity Act.

## **11. Infection Control**

In addition to the significant amount of work being undertaken to support the organisation around COVID-19; usual infection control work has continued including monthly Infection Control reporting and investigation to ensure learning with support through a retired Infection Control nurse.

The Infection Control team are providing training for new and deployed staff, advice on personal protective equipment (PPE) and supportive spot checks. Two deployed staff are also currently supporting the infection prevention and control team as PPE advisors.

## **12. Clinical Concerns**

### **12.1 National Guidance:**

There is no national guidance explicitly related to responding to clinical concerns - raised by other professionals these around clinical care/practice received by a patient these usually required a response within 20 working days are required to be reported as part of our quality schedule. Reporting of these has been suspended along with all quality schedule reporting.

### **12.2 Organisational Response:**

Each clinical concern is triaged by the patient safety and quality team, with safety concerns and learning being addressed immediately with the relevant service. Written responses continue to be provided back to the reporting clinician although timescales may be slightly longer than usual.

## **13. Policies**

A virtual Policy Scrutiny group has been established to process policies for urgent review and approval. Where routine reviews are due extensions will be agreed on individual basis.

## **14. NICE Guidance**

### **14.1 National Guidance:**

NICE are reviewing all the guidance they have in development and are prioritising:

- therapeutically critical topics, including all appraisals of cancer medicines
- diagnosis of COVID-19
- treatment of COVID-19.
- Rapid evidence summaries

Revised timelines for all other guidance that is not related to COVID-19 or therapeutically critical will continue with development work where they can and be published.

## **14.2 Organisational Response:**

The Trust governance process remains uninterrupted for review and implementation of NICE Guidance. We will continue to review all published NICE guidance, ensuring services are aware of relevant guidelines to their service and support them to implement these. We have ensured that all COVID 19 guidance has been sent out to relevant services within 24 hours of publication. In addition, a central register of all COVID 19 NICE guidance and its relevance has been compiled and will be maintained as new guidance is published.

We will continue to report the trust compliance of all NICE guidance to the Clinical Effectiveness Group and work with service leads (Via TEAMS) to complete the required assessments.

14 NICE clinical guidelines related to COVID 19 have been published between March and April 2020 of which 11 had some relevance to the services we provide and have been cascaded to relevant services and we are supporting them to ensure they are implemented. This is an increase in activity, an average month prior to COVID 19 we would normally have between 3 and 5 NICE guidelines which are relevant for services to review.

## **15. National Clinical Audit & Confidential Inquiries**

### **15.1. National Guidance:**

Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic 28<sup>th</sup> March 2020 (NHS Improvement):

- All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, are suspended. Data collection for the child death database and Learning Disabilities Mortality Review (LeDeR) will continue as this is important in understanding the impact of COVID-19.

### **15.2 Organisational response:**

The clinical audit process in the trust remains uninterrupted. The suspension nationally of data collection requirement impacts on the following projects: POMH Prescribing for Sodium Valproate which has been delayed until September, and the data submission for continuous audits such as Diabetes which may be delayed but will be required to be submitted retrospectively. National reports continue to be published and we have four national reports going to the May 2020 Quality Assurance Committee which were published between January and March 2020.

The following national reports are still expected to be published and we will be required to review these in line with our current process:

- POMH Antipsychotic prescribing for learning disabilities: data cleansing required in April/May 2020, with the national report due to be published in July 2020.
- Diabetes footcare audit: the Q4 submission was completed in April 2020, our local data will be available for the clinical audit team to analyse in July 2020.
- The National Diabetes Insulin Pump audit is due to be published in April 2020.
- The National chronic obstructive pulmonary disease (COPD) report is due to be published in May 2020
- The Early Intervention in Psychosis (EIP) NCCAD report is due to be published in July 2020.

POMH audits are expected to resume in data collection in September 2020, with two significant audits, planned for September and October 2020. Both will require planning to start with the clinical teams in July/August to meet the planned data collection timelines.

## **16. Quality Account**

### **16.1 National Guidance:**

Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic 28<sup>th</sup> March 2020 (NHS Improvement).

- The deadline for quality accounts publication of 30 June 2020 is specified in Regulations, this deadline has been deferred and to be confirmed.
- The Quality Account is no longer required to be submitted to NHS Improvement with the accounts.
- Quality Accounts and Quality Reports assurance process: all external Auditors work stopped.

### **16.2 Organisational response:**

The Trust Quality Account is a significant piece of work and is generated throughout the year. At the time of this publication our Trust Quality Account was in its final draft and had already been shared with our external stakeholders for their comments. We have therefore continued to finalise our Trust Quality Account which will be received by the May 2020 Quality Assurance Committee and then the subsequent meeting of the Trust Board prior to publication. We will then be maintaining our Quality Account process and from June 2020 will be working on our 2020/21 Quality Account.

## **17. Ethical Decision Making in the Context of COVID-19**

Berkshire Healthcare's Covid-19 Ethics Framework continues to structure our ongoing discussion of significant, foreseeable ethical concerns throughout the period of the Covid-19 pandemic period.

The process for the consideration of ethical decisions comprises the Ethics Consideration Group and the COVID-19 Clinical Strategy Group. The Ethics Consideration Group is chaired by the Lead Clinical Director and Members include Clinical Directors, Divisional Directors and Professional Leads. The Ethics Consideration Group makes recommendations to the COVID-19 Clinical Strategy Group which is jointly chaired by the Medical Director and Director of Nursing and Therapies. Members of this group also include a non-executive lay member (Trust Chair), Lead Clinical Director, Deputy Director of Nursing and the Head of Research and Development.

The Clinical Strategy Group reviews the recommendations from the Ethics Consideration Group and approves implementation of associated guidance. In addition, but less frequently, complex issues which have an ethical component may be directly referred to the Clinical Strategy Group via the Medical Director or Director of Nursing and Therapies.

Existing BHFT guidance and policy and national guidance and policy are continually reviewed as part of submission to the Ethics Consideration Group. Alignment is also maintained with Frimley Health and Care/Berkshire West, Oxfordshire and Buckinghamshire Systems via the Lead Clinical Director.

## 17.1 Key Activities to date

- An Ethics Decision Making document and Terms of Reference for the Ethics Consideration Group and Clinical Strategy Group have been developed.
- The Ethics Consideration Group have received nine ethical issues for consideration. These have been discussed by relevant members of the group. Proformas, subsequent recommendations and associated documents have been submitted to the Clinical Strategy Group.
- The Clinical Strategy Group has met weekly since 1 April 2020. Five meetings had been held at the time of writing.
- In total 12 ethical issues have been discussed by the Clinical Strategy Group. This comprises all those received from the Ethics Consideration Group plus three which were flagged directly to the Medical Director and Director of Nursing and Therapies. The latter two ethical considerations were complex issues with ethical components requiring discussion at the CCSG.
- The outcomes of the ethical considerations discussed to date can be summarised as follows:  
Of the 12 ethical considerations, three resulted in the development and circulation of guidance documents; four were judged as not requiring guidance at this time; one was confirmed as an operational/redeployment issue with no ethical component; the remaining four ethical considerations have either resulted in new guidance development and/or existing Trust guidance document updates which are still in process.
- The three ethical consideration guidance documents that have been developed and circulated to date, have been made available to our staff members via the Ethics Consideration Group members, other relevant leads and Teamnet. The Teamnet page has been communicated to staff members via the Covid-19 email briefing. These guidance documents support ethical decision-making in situations where operational processes and options have been exhausted. This does not replace day to day ethical considerations that clinicians must make when providing patient care.

The summary table below outlines the ethical considerations discussed at the Ethics Consideration Group and COVID-19 Clinical Strategy Group, together with associated outcomes and outputs:

Ethical Considerations	Outcome/output	Current state
Use of restrictive interventions to manage behavioural disturbance in patients with suspected or confirmed COVID 19	Draft guidance development was started including for seclusion however it was agreed to halt this development and that the focus should be on practice aligned to the Code of Practice and MHA.	No further development or circulation of this draft
Covid-19 Guidance on Medical Recommendations under the Mental Health Act	A draft document to explain where no deviation from CoP allowed or required has been prepared by the BHFT MHA office to provide clarity for staff in the current period.	New guidance document being finalised and will incorporate imminent national guidance
ECT for emergency, life threatening situations	Guidance document produced	Guidance circulated
Lack of PPE for staff	Guidance document produced	Guidance circulated
Clozapine monitoring intervals	Guidance document produced	Guidance circulated
Redeployment of Psychological Therapies clinicians to staff wellbeing service	Confirmed operational/redeployment issue. No ethical component.	N/A
Discharges	Not required at this time. Revisit if we appear to be reaching capacity	No further action at this time

Ceiling of treatment decision making	Not required at this time. Revisit if we appear to be reaching capacity	No further action at this time
Decision making when wards and teams are at capacity	Not required at this time. Revisit if we appear to be reaching capacity	No further action at this time
Patients discharged from acute hospitals without NOMADS	Not required at this time.	No further action at this time
Syringe Drivers	Documents submitted to CCSG to be streamlined, finalised and circulated	New guidance document being finalised
PPE use for chest compressions during CPR in inpatient and community settings	BHFT resuscitation guidance flowchart to be updated to align with Resuscitation Council Guidelines	Existing document being updated

## 18. Patient Safety COVID-19 Update - 1 May 2020

Patient safety COVID-19 update from the NHS National Patient Safety Team

This update pulls together key information that you or your clinical governance/patient safety heads might need to know but could otherwise miss. Wider circulation is not required.

Key messages	Information for safety leaders
<ul style="list-style-type: none"> <li>Continue to report anything that concerns you and you think others need to know</li> <li>Promote the principles of a just culture</li> <li>Continue reporting maternity incidents to HSIB as normal</li> </ul>	<p><b>1. Patient safety incident reporting</b> - Encourage everyone to continue reporting anything of concern. NHS staff will not be judged or criticised for their incident reporting decisions.</p> <p>Promote the role of your <a href="#">Freedom to Speak Up</a> guardian. The whole NHS and care system must demonstrate the values of a just culture: being open and transparent while avoiding criticism of individuals who are trying their best under very difficult circumstances.</p> <p>Continue to upload incident data from local risk management systems to the <a href="#">National Reporting and Learning System</a>.</p> <p>Maternity incidents should still be reported to <a href="#">HSIB</a> although it will only investigate the most serious maternity cases.</p> <p>All NHS organisations who are employers must report COVID-19 workforce deaths that meet the criteria of the Health and Safety Executive's <a href="#">RIDDOR reporting of COVID-19 guidance</a>.</p>
<ul style="list-style-type: none"> <li>Ensure your organisation is acting on national patient safety alerts</li> </ul>	<p><b>2. National Patient Safety Alerts</b> - The national patient safety team continue to review patient safety incident reports and are developing more rapid processes to assess new issues particularly linked to COVID-19.</p> <p>National healthcare organisations have issued several COVID-19 related Patient Safety Alerts. These have short deadlines for completion of required safety-critical actions. More information is available on the <a href="#">CAS COVID -19 alerts and registration</a> web page.</p>
<ul style="list-style-type: none"> <li>Report SIs and Never Events using clinical and professional judgement to</li> </ul>	<p><b>3. Serious Incidents (SIs) and Never Events</b> - Continue to report SIs and <a href="#">Never Events</a> using your normal reporting systems. Use your clinical and professional judgement when considering what to identify as a SI.</p>



<p>prioritise learning opportunities</p> <ul style="list-style-type: none"> <li>Promote and support the rapid response to patient safety incidents, focusing on immediate risk reduction</li> </ul>	<p>The 2015 <a href="#">SI Framework</a> promotes identification and reporting of SIs based on the potential for learning, future risk reduction and the consequences of any recurrence of the incident.</p> <p>Staff shortages may make it more difficult to undertake SI investigations. Organisations do not have to meet the 60-day timeframe for investigations during this period. They should be pragmatic about the sign off and closure of investigations, noting that formal panel meetings are not required to close investigations.</p> <p>Consider approaches for rapidly responding to patient safety incidents: Use huddles, after-action reviews, risk assessments and case record reviews, as well as investigations to identify ways to reduce future risk.</p>
<ul style="list-style-type: none"> <li>Contact your local Academic Health Science Network to talk about the support they can offer via their Patient Safety Collaboratives during the COVID-19 response.</li> </ul>	<p><b>4. National patient safety improvement programmes</b> - The <a href="#">programmes</a>' COVID-19 response includes:</p> <ul style="list-style-type: none"> <li><b>Managing deterioration in adults:</b> supporting the adoption of NEWS2 and Restore 2 (a warning system that uses soft-signs of deterioration in non-acute settings, helping manage COVID-19 patients at risk of deterioration).</li> <li><b>Managing deterioration of mothers with COVID-19 during pregnancy and of babies in neonatal units:</b> supporting the use of validated early warning scores that help identify and manage deterioration.</li> <li><b>Safe tracheostomy care in adults:</b> for COVID-19 patients who receive a tracheostomy and are subsequently cared for outside ICUs. The work focuses on use of a daily care bundle of routine actions by staff, use of bedhead signs to communicate key information between carers and provision of an essential bedside kit needed to save lives in the event of an emergency.</li> </ul>
	<p><b>5. Patient safety strategy</b> - Programmes introduced in the NHS patient safety strategy either continue to be developed with amended timescales to be confirmed or have been put on hold until further notice. More information is available on the <a href="#">NHS patient safety strategy</a> web page.</p>
<p>Send any queries on this update to <a href="mailto:patientsafety.enquiries@nhs.net">patientsafety.enquiries@nhs.net</a></p>	

## In focus: Medical examiners and mortality review

Following [The Coronavirus Act 2020](#), we published a set of [information and guidance for medical practitioners](#). Medical examiner scrutiny of the death certification process remains an important way of identifying cases where patient care may have not met expectations. Legislation to support the national COVID-19 response means that, subject to local determination and where conditions in the new guidance are met, medical examiners can support the death certification process by becoming certifying doctors.

Where the number of COVID-19 cases significantly increases pressures, trusts with medical examiner offices may consider whether their medical examiner staff should provide death certification support and so free up other staff time to provide patient care. Many medical examiners and medical examiner officers will also have clinical skills that can be deployed to augment frontline patient care, and trusts may also consider this where appropriate. Where possible and pragmatic, however, organisations should maintain a level of medical examiner scrutiny of death certification.

Similarly, review of case records to support identification and escalation of any concerns remains a powerful tool for supporting improvement of both COVID-19 and wider care.

For trusts experiencing significant numbers of COVID-19 deaths, full SJR of all deaths is unlikely to be practical. Organisations should consider amending their Learning from Deaths policies, either to switch focus from previous priority patient areas to COVID-19 patients or to add them in to the existing programmes. One approach would be to replace review of deaths following cancelled electives with that for a sample of COVID-19 deaths. Organisations may need to revise the number of reviews they previously expected to do. Consideration should also be given to facilitating reviews by staff unable to provide frontline care during the COVID-19 response.



## Trust Board Paper

<b>Date</b>	12 <sup>th</sup> May 2020
<b>Title</b>	Patient Experience Report Quarter 4 (January -March 2020)
<b>Purpose</b>	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 4
<b>Business Area</b>	Nursing & Governance
<b>Author</b>	Elizabeth Chapman, Head of Patient Experience
<b>Relevant Strategic Objectives</b>	True North goals of Harm free care, Supporting our staff and Good patient Experience
<b>CQC Registration/Patient Care Impacts</b>	Supports maintenance of CQC registration and supports maintaining good patient experience
<b>Resource Impacts</b>	N/A
<b>Legal Implications</b>	N/A
<b>Equalities and Diversity Implications</b>	N/A
<b>SUMMARY</b>	<p>During the quarter there has been no significant changes or themes have been noted from the information received.</p> <ul style="list-style-type: none"> <li>• 59 complaints were received – this is comparable with previous quarters and brings year-end total to 231 (2018-19 was 230) 2 services saw an increase in the number of complaints received: <ul style="list-style-type: none"> <li>➤ CRHT received 6 which is the most in any quarter this year although still equates to only 0.04% contacts and no specific themes were identified.</li> <li>➤ CMHT received 13, with 6 of these relating to WAM (2 being for same patient and a further 1 being re-opened). Most of the CMHT complaints related to the level / type of treatment being offered.</li> </ul> </li> <li>• CAMHS and Community Nursing saw a reduction to the lowest numbers received for any quarter this year. Out of Hours (Westcall) saw a return to more comparable number of 1 following a spike of 7 in Q3</li> <li>• The response rate to complaints within agreed timescale was 100%</li> <li>• Of the 56 complaints closed in the quarter 60.18% were partially or fully upheld which is consistent with previous quarters</li> <li>• Compliments at 1436 remain comparable with previous quarters</li> <li>• For 25% of our complaints the ethnicity of the complainant is</li> </ul>

	<p>unknown and therefore it is not possible to draw any comparisons with local population demographics; almost 75% of complainants were women.</p> <ul style="list-style-type: none"> <li>• There are 3 open ombudsman complaints at present all of these will be on hold at the current time due to COVID19 pandemic.</li> <li>• MP enquires increased from 5 in Q3 to 10 in this quarter – these were spread across services although 4 were related to differing CAMHS services with 3 around wait times (this is a comparable level of MP enquires for CAMHS waits compared to previous quarters)</li> <li>• Most locally resolved complaints continue to be around physical health services (38 of the 40), 10 of these were in relation to children speech and language therapy and mostly around wait times.</li> <li>• Patient FFT saw a decrease in recommend rate to 89%, whilst Carer FFT responses continue to increase and saw a 95% recommend rate. The revised question will be implemented once the collection of FFT resumes.</li> <li>• Feedback via the internal survey increased to by over 700 responses to 4694.</li> </ul> <p><b>Patient experience during COVID-19 pandemic</b></p> <p>On 27<sup>th</sup> March 2020 providers were informed that the formal complaint process could be paused although acknowledgement and recording of complaints should continue, new complaints should be triaged, and immediate action taken around any patient safety or safeguarding concerns. Complaints to remain open until further notice, unless an informal resolution could be achieved, or the complainant chooses to withdraw their complaint.</p> <p>In addition, the Parliamentary and Health Service Ombudsman has stopped accepting new NHS complaints and has stopped work on open cases.</p> <p>Collation and submission of FFT should be suspended.</p> <p>In BHFT we have continued to respond in writing to all complaints opened prior to this time and we are offering local/ informal resolution as an alternative for all new complaints. We continue to log, review and triage all complaints received and where informal resolution is not possible complaints will be formally responded to as soon as services are able.</p>
<b>ACTION REQUIRED</b>	<p>The Board is asked to:</p> <ul style="list-style-type: none"> <li>• Note the report.</li> </ul>

## Quarter Four– Patient Experience Report (January– March 2020)

### Main Report

#### 1. 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 January 2020 to 31 March 2020 and uses data captured from the Datix reporting system, CRT (our internal survey) and the results of the Friends and Family Test (FFT) captured via SMS, online and hard copy feedback.

From mid-March 2020, to align with national guidance and directives, the active collection of the FFT was suspended and the information shown for March is taking from responses received up to this point, both in hard copy and electronically.

A revised complaints process has also been introduced nationally, as a result the Complaints Office continue to record all new complaints and are supporting Investigating Officers with compiling responses to complaints and triaging complaints in a different way to enable a verbal response where the complainant is satisfied with this. Following review and contact with complainants a small number of formal complaints are likely to be paused and responded to within longer timeframe.

#### 2. Complaints received

##### 2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2018-19 and 2019-20 by service, enabling a comparison with Quarter four. During Quarter four 2019-20 there were 59 complaints received (including re-opened complaints), this is an increase compared to 2018-19 where there were 50 for the same period.

Table 1: Formal complaints received

Service	2018-19			2019-20						
	Q4	Total	% of Total	Q1	Q2	Q3	Change to Q3	Q4	Total for year	% of Total
CMHT/Care Pathways	9	46	20	8	10	6	↑	13	37	16.02
CAMHS - Child and Adolescent Mental Health Services	6	25	10.87	10	8	8	↓	4	30	12.99
Crisis Resolution & Home Treatment Team (CRHTT)	4	14	6.09	2	2	4	↑	6	14	6.06
Acute Inpatient Admissions – Prospect Park Hospital	3	32	13.91	5	3	7	↓	6	21	9.09
Community Nursing	3	8	3.48	4	3	6	↓	2	15	6.49
Community Hospital Inpatient	3	17	7.39	6	1	5	↓	3	15	6.49
Common Point of Entry	4	12	5.22	2	6	2	-	2	12	5.19

Service	2018-19			2019-20						
	Q4	Total	% of Total	Q1	Q2	Q3	Change to Q3	Q4	Total for year	% of Total
Out of Hours GP Services	1	17	6.96	0	1	7	↓	1	9	3.90
PICU - Psychiatric Intensive Care Unit	0	0	0	0	0	1	↓	0	1	0.43
Minor Injuries Unit (MIU)	0	4	1.74	1	1	1	↓	0	3	1.30
Older Adults Community Mental Health Team	1	3	1.3	1	0	0	-	0	1	0.43
15 other services in Q4	16	52	22.6	11	19	21	↑	22	73	31.60
<b>Grand Total</b>	<b>50</b>	<b>230</b>		<b>50</b>	<b>54</b>	<b>68</b>	<b>↓</b>	<b>59</b>	<b>231</b>	

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 more meaningful. The following tables show a breakdown of the formal complaints that have been received during Quarter four and where the service is based. 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 four. 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 four will not have this information.

## 2.2 Adult mental health service complaints received in Quarter four

36 of the 59 (61%) complaints received during Quarter four were related to adult mental health service provision.

Table 2: Adult mental health service complaints

Service	Geographical Locality						Grand Total
	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	
A Place of Safety		1					1
Adult Acute Admissions - Bluebell Ward		2					2
Adult Acute Admissions - Daisy Ward		1					1
Adult Acute Admissions - Snowdrop Ward		3					3
CMHT/Care Pathways	1		1	2	6	3	13
Common Point of Entry					1	1	2
Crisis Resolution and Home Treatment Team (CRHTT)	1	3	1	1			6
Eating Disorders Service			1		1		2
Older Adults Inpatient Service - Rowan Ward		1					1
Older Peoples Mental Health (Ward Based)		1					1
Talking Therapies	1				1	1	3
Traumatic Stress Service						1	1
<b>Grand Total</b>	<b>3</b>	<b>12</b>	<b>3</b>	<b>3</b>	<b>9</b>	<b>6</b>	<b>36</b>

### 2.2.1 Number and type of complaints made about a CMHT

13 of the 59 complaints (22%) received during Quarter four related to the CMHT service provision. Up to this quarter there were between 6 and 10 complaints for CMHT in each quarter. There were 12,621 reported attendances for CMHT and the ASSiST service during Quarter four giving a complaint rate of 0.10% compared to 0.04% in Quarter three and 0.07% in Quarter two. The 2018-19 complaint rate for CMHT was 0.05%; therefore the 0.10% this quarter indicates an increase in percentage of complaints received.

Table 3: CMHT complaints

Main subject of complaint	Geographical Locality					Grand Total
	Bracknell	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	
Access to Services			1			1
Attitude of Staff				1	1	2
Care and Treatment			1	3	2	6
Communication	1	1				2
Discharge Arrangements				2		2
Grand Total	1	1	2	6	3	13

Care and treatment (6) remains the main subject for formal complaints received about CMHT, although the reasons for the concerns varied: including communication, discharge and attitude of staff.

CMHT in WAM received the highest number although 2 related to the same patient and 1 was a re-opened complaint.

The CMHT based in Reading did not receive any complaints. In addition, there was one complaint about the administrative team based at West Berkshire Community Hospital about communication.

### 2.2.2 Number and type of complaints made about CPE

There were two complaints received about CPE, one was about access to the service and the other was about staff attitude. This is a sustained decrease from the Quarter two (6) and is a reduction on the same quarter last year.

There were 2,118 contacts with CPE during Quarter four, giving a complaint rate of 0.09%, compared to 0.07% in Quarter three and 0.24% in Quarter two.

### 2.2.3 Number and type of complaints made about Mental Health Inpatient Services

During Quarter four, 6 of the 59 complaints (10%) related to mental health inpatient wards this is a reduction compared to Quarter three and is an increase compared to the same quarter last year. In addition, there was one complaint about The Place of Safety at Prospect Park Hospital.

There were 271 reported discharges from mental health inpatient wards during Quarter four giving a complaint rate 2.21% compared to 3.12% in Quarter three and 1.28% in Quarter two.

Table 4: Mental Health Inpatient Complaints

Main subject of complaint	Ward			Grand Total
	Bluebell Ward	Daisy Ward	Snowdrop Ward	
Attitude of Staff			1	1
Care and Treatment	1	1	1	3
Communication			1	1
Confidentiality	1			1
Grand Total	2	1	3	6

There were no complaints about Sorrel Ward (our Psychiatric Intensive Care Unit or PICU) during Quarter four.

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

In Quarter four, 6 of the 59 complaints (10%) were attributed to CRHTT, the highest number received in a quarter over the last year and higher than the number received in the same quarter last year. There were 13,577 reported contacts for CRHTT during Quarter four giving a complaint rate of 0.04%. Each of the complaints was specific to individuals.

Table 5: CRHTT complaints

Main subject of complaint	Geographical Locality				Grand Total
	Bracknell	Reading	Slough	West Berks	
Attitude of Staff		1	1	1	3
Care and Treatment	1	2			3
Grand Total	1	3	1	1	6

#### 2.3 Community Health Service Complaints received in Quarter four

During Quarter four, 13 of the 59 complaints (22%) related to community health service provision.

Table 6: Community Health service complaints

Service	Geographical Locality					Grand Total
	Bracknell	Reading	West Berks	Windsor, Ascot and Maidenhead	Wokingham	
Community Hospital Inpatient		1		1		2
Community Hospital Inpatient Service - Henry Tudor Ward				1		1
District Nursing	2					2
Intermediate Care			1			1
Out of Hours GP Services					1	1
Physiotherapy (Adult)	2			2		4
Podiatry				1		1
Tissue Viability				1		1
Grand Total	4	1	1	6	1	13



Adult Physiotherapy received the most complaints (4), followed by Community Hospital Inpatient Wards (3).

Two complaints (from the same patient) about the Adult Physiotherapy Service were about the service care and treatment from the team working out of Windsor, Ascot and Maidenhead. The remaining two complaints were about discharge from the team based in Bracknell (from the same patient).

As with Quarter three there were no complaints for The IPASS service, which received the highest number of complaints in quarter two. This demonstrates the changes that they made to the service have had a positive impact on patient experience.

### 2.3.1 Community Health Inpatient Ward Complaints

During Quarter four, 3 of the 59 complaints (5%) received related to inpatient wards. There were 574 reported discharges from community health inpatient wards during Quarter four giving a complaint rate of 0.52% compared with 0.95% in Quarter three and 0.20% in Quarter two.

For 2018-19 the complaint rate was 0.9%.

Table 7: Community Health Inpatient complaints

Main subject of complaint	Ward		Grand Total
	Henry Tudor Ward	Oakwood Unit	
Care and Treatment	2		2
Discharge Arrangements		1	1
<b>Grand Total</b>	<b>2</b>	<b>1</b>	<b>3</b>

### 2.3.2 Community Nursing Service Complaints

In Quarter four, 4 of the 59 complaints (7%) were related to community nursing service provision. Of these, 2 were about community nursing in Bracknell (often referred to as District Nursing) and one for the Intermediate Care Service and Tissue Viability Team.

There were 73,364 reported attendances for the Community Nursing Service during Quarter four giving a complaint rate of 0.005% compared to 0.008% in Quarter three. This is a very small complaint rate well below the Trust overall rate of complaints per contact.

Table 8: Community Nursing Service complaints

Main subject of complaint	Service			Grand Total
	District Nursing	Intermediate Care	Tissue Viability	
Attitude of Staff		1		1
Care and Treatment	1		1	2
Communication	1			1
<b>Grand Total</b>	<b>2</b>	<b>1</b>	<b>1</b>	<b>4</b>

### 2.3.3 GP Out of Hours Service (WestCall) Complaints and Urgent Care Centre

There was one complaint about the GP Out of Hours Service received in Quarter four which was around confidentiality. There were 17,518 contacts with WestCall giving a complaint

response rate of 0.005% compared to 0.03% in Quarter three and 0.006% in Quarter two. For 2018-19 WestCall had a complaint rate of 0.024%

There were no complaints about the Urgent Care Centre based in West Berkshire Community Hospital (previously this service was known as the Minor Injuries Unit and has increased service provision since the change to an Urgent Care Centre). There were

There were 6,306 contacts with the Urgent Care Centre during Quarter four. In Quarter three complaint activity was 0.01%.

## 2.4 Children, Young People and Family service Complaints

### 2.4.1 Physical Health services for children complaints

During Quarter four, 3 of the 59 complaints (5%) related to the care and treatment of children's physical health services.

Table 9: Children and Young People service physical health service complaints

Service	Geographical Locality		Grand Total
	Bracknell	Slough	
Children's Speech and Language Therapy - CYPIT	1		1
Community Paediatrics		2	2
Grand Total	1	2	3

### 2.4.2 CAMHS complaints

During Quarter four, 4 of the 59 complaints (7%) were about CAMHS services; since Quarter one 2018-19, the number of complaints received has ranged from between 6 and 10 per quarter, so this is a decrease. 3 of the complaints were about specialist CAMHS, one was about the CAMHS Rapid Response service. Care and treatment was the main theme for both areas in Quarter four. There were 7,412 reported attendances for CAMHS during Quarter four giving a complaint rate of 0.05% compared to 0.11% in Quarter three.

For 2018-19 the number of complaints per contact was 0.8%.

Table 10: CAMHS Complaints

Service/geographical locality	Main subject of complaint		Grand Total
	Care and Treatment	Communication	
<b>CAMHS - Child and Adolescent Mental Health Services</b>	<b>2</b>	<b>1</b>	<b>3</b>
Reading		1	1
Slough	1		1
West Berks	1		1
<b>CAMHS - Rapid Response</b>	<b>1</b>		<b>1</b>
Wokingham	1		1
Grand Total	3	1	4

In addition, there was a complaint about the care and treatment at Willow House, the Trust's Adolescent Mental Health Inpatient Ward.

## 2.5 Learning Disabilities

There were no complaints about the community-based team for people with a Learning Disability or Learning Disability Inpatient Ward (called the Champion Unit) during Quarter four.

### 3. KO41A return

Each quarter the complaints office submits 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 (Q3 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				2019-20		
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
<b>Mental Health complaints - nationally reported</b>	<b>3,451</b>	<b>3,653</b>	<b>3,598</b>	<b>3,651</b>	<b>3,391</b>	<b>3,450</b>	<b>3,507</b>	<b>3,502</b>	<b>3,335</b>
2Gether NHS Foundation Trust	15	15	17	14	21	20	24	16	..
Avon and Wiltshire Mental Health Partnership NHS Trust	63	67	78	72	77	51	56	67	59
<b>Berkshire Healthcare NHS Foundation Trust</b>	<b>56</b>	<b>59</b>	<b>49</b>	<b>45</b>	<b>38</b>	<b>51</b>	<b>47</b>	<b>52</b>	<b>56</b>
Cornwall Partnership NHS Foundation Trust	32	34	31	28	20	30	24	22	23
Devon Partnership NHS Trust	43	49	44	56	33	45	52	46	56
Dorset Healthcare University NHS Foundation Trust	74	79	91	90	92	54	61	60	64
Kent and Medway NHS and Social Care Partnership Trust	88	86	87	115	121	118	121	128	124
Oxford Health NHS Foundation Trust	49	70	50	56	58	56	52	61	72
Somerset Partnership NHS Foundation Trust	15	14	17	14	24	18	24	24	17
Southern Health NHS Foundation Trust	79	96	91	95	82	68	73	51	52
Surrey and Borders Partnership NHS Foundation Trust	21	26	26	36	16	26	22	28	32
Sussex Partnership NHS Foundation Trust	169	221	209	192	181	173	178	217	219

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.

In response to the coronavirus pandemic, the collection and reporting of data for Quarter four 2019/20 onwards has been suspended.

### 4. Complaints closed

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). During Quarter four there were 56 complaints closed compared to 61 in Quarter three and Quarter two (57), Quarter one (47) and Quarter four (47).

#### 4.1 Outcome of closed formal complaints

Table 12: Outcome of formal complaints closed

Outcome	2018-19						2019-20						Comparison to Q3
	Q1	Q2	Q3	Q4	Total	% 18/19	Q1	Q2	Q3	Q4	Total	% of 19/20	
Case not pursued by complainant	0	0	2	2	4	1.67	0	0	0	0	0	0.00	-
Consent not granted	2	2	3	2	9	3.75	1	0	0	0	1	0.45	-
Local Resolution	0	5	10	3	18	7.5	1	1	0	0	2	1.92	-
Managed through SI process	0	2	0	1	3	1.25	0	0	0	0	0	0.00	-
Referred to another organisation	0	0	0	0	0	0	1	0	0	0	1	0.45	-
No further action	1	0	0	0	1	0.42	0	0	0	0	0	0.00	-
Not Upheld	13	11	16	15	55	22.92	16	20	23	24	83	37.56	↑
Partially Upheld	25	26	36	19	106	44.17	17	22	28	23	90	40.72	↓
Upheld	12	15	12	5	44	18.33	11	13	10	9	43	19.46	↓
Disciplinary Action required	0	0	0	0	0	0	0	1	0	0	1	0.45	-
<b>Grand Total</b>	<b>53</b>	<b>61</b>	<b>79</b>	<b>47</b>	<b>240</b>		<b>47</b>	<b>57</b>	<b>61</b>	<b>56</b>	<b>221</b>		

The 32 complaints closed and either partly or fully upheld in the quarter were spread across several differing services and there were no themes from any service; however, 5 of the 6 complaints closed about Community Inpatient Wards were either partly or fully upheld. These were across wards and were mainly where care and treatment should have been better.

Of the 32 complaints found to be upheld or partially upheld, 50% (16) related to attitude and staff and care and treatment. In comparison, 63.16% in Quarter three and 74% in Quarter two.

Table 13: Complaints upheld and partially upheld relating to attitude of staff and care and treatment

Service	Main subject of complaint		Grand Total
	Care and Treatment	Attitude of Staff	
Community Hospital Inpatient	3		3
CAMHS - Child and Adolescent Mental Health Services	2		2
Common Point of Entry	1	1	2
Physiotherapy (Adult)	1		1
Crisis Resolution and Home Treatment Team (CRHTT)	1		1
Sexual Health	1		1
CAMHS - Rapid Response	1		1
Out of Hours GP Services		1	1
CMHT/Care Pathways	1		1
Psychological Medicine Service	1		1
Talking Therapies	1		1

Service	Main subject of complaint		Grand Total
	Care and Treatment	Attitude of Staff	
Adult Acute Admissions - Snowdrop Ward		1	1
Urgent Treatment Centre	1		1
Adult Acute Admissions	1		1
Adolescent Mental Health Inpatients - Willow House	1		1
Grand Total	16	3	19

## 4.2 Response Rate

Table 14 shows the response rate within a negotiated timescale, as a percentage total.

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

Table 14 – Response rate within timescale negotiated with complainant

2019-20				2018-19				2017-18				2016-17			
Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

## 5. Characteristic data

### 5.1 Ethnicity

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

The tables below show the characteristics of patients who have had complaints raised about their care between January and March 2020. This does not include where a different organisation was leading the investigation.

Table 15: Ethnicity

Ethnicity	Number of patients	%	Census data %
Asian-Other	2	3.6	15.1
Black-Caribbean	1	1.8	3.5
Mixed-Other	1	1.8	-
Not stated	15	26.8	-
Other Ethnic Group	0	0.0	1
White-British	33	58.9	80
White-Other	4	7.1	-
Black British	0	0.0	-
<b>Grand Total</b>	<b>56</b>	<b>100</b>	

### 5.2 Gender

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

Table 16: Gender

Gender	Number of patients	%	Census data %
Female	40	71.4	50.9
Male	16	28.6	49.1
Not stated	0	0.0	-
<b>Grand Total</b>	<b>56</b>	<b>100</b>	

### 5.3 Age

Table 17: Age

Age Group	Number of patients	%	Census data %
Under 12 years old	4	7.1	31.6
12 - 17 years old	4	7.1	
18 - 24 years old	3	5.4	14.9
25 - 34 years old	10	17.9	
35 - 44 years old	7	12.5	15.4
45 - 54 years old	7	12.5	19.3
55 - 64 years old	2	3.6	
65 - 74 years old	3	5.4	18.7
75 years old or older	8	14.3	
Not known	8	14.3	
<b>Grand Total</b>	<b>56</b>	<b>100</b>	

## 6. Parliamentary and Health Service Ombudsman

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

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

During Quarter four there were two new complaints taken to the PHSO. One was open and closed quickly as the Trust had not had the opportunity to attempt resolving the complaint and a local level. The other is several complaints by the same person which have been taken forward as one case.

In response to the coronavirus pandemic from mid-March 2020, the PHSO suspended the investigation of existing investigations and accepting new cases.

Table 18: PHSO activity

Month open	Service	Month closed	Current Stage
Jul-18	CPE	n/a	PHSO not proceeding
Aug-18	Out of Hours GP Service	n/a	PHSO not proceeding
Sep-18	Psychological Medicines Service	Apr-19	Not Upheld

Month open	Service	Month closed	Current Stage
Dec-18	Psychological Medicines Service	Open	Investigation Underway
Dec-18	Community Hospital inpatient	Jul-19	Not Upheld
Jun-19	CMHT/Care Pathways	n/a	PHSO not proceeding
Nov-19	Older Persons Mental Health Inpatients	n/a	PHSO not proceeding
Nov-19	CAMHS	Open	PHSO have requested information to aid their decision on whether they will investigate
Jan-20	CMHT/Care Pathways	n/a	PHSO not proceeding as Local Resolution had not been exhausted with the Trust
Mar-20	CMHT/Care Pathways	Open	Underway

## 7. Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they are involved in but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There was one complaint received that was led another organisation during Quarter four, a reduction from 5 in Quarter three and 10 in Quarter two.

This complaint was led by East Berkshire CCG and was about the care provided to a patient at the end of life and the investigation was underway at the end of Quarter four.

## 8. MP enquiries, locally resolved complaints and PALS

### 8.1 MP enquiries

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

Service	Main subject of complaint					Grand Total
	Access to Services	Care and Treatment	Communication	Medication	Waiting Times for Treatment	
CAMHS – AAT (Autism Assessment Team)					1	1
CAMHS - ADHD					1	1
CAMHS - Anxiety and Depression Pathway		1				1
CAMHS - Specialist Community Teams					1	1
Children's Speech and Language Therapy - CYPIT	1					1
CMHT/Care Pathways		1				1
CMHTOA/COAMHS - Older Adults Community Mental Health Team		1				1
Sexual Health	1			1		2
Urgent Treatment Centre			1			1
Grand Total	2	3	1	1	3	10

3 of the 4 CAMHS enquiries related to waiting times for treatment.

There were 10 MP enquiries raised in Quarter four, in an increase from 5 in Quarter three, and a decrease from 12 in Quarter Two. The number of MP complaints has varied each quarter over the last year from 3-12.

### 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 23: Concerns managed by services – Local Resolution complaints

Service	Number of concerns managed by services
Children's Speech and Language Therapy - CYPIT	10
Podiatry	8
District Nursing	4
Urgent Treatment Centre	3
Diabetes	2
Continence	2
Health Visiting	2
Children's Occupational Therapy - CYPIT	1
School Nursing	1
Physiotherapy Musculoskeletal	1
LD Intensive Support Team	1
Rapid Response	1
Looked After Children	1
Other	1
A Place of Safety	1
Intermediate Care	1
<b>Grand Total</b>	<b>40</b>

The Podiatry service continues to be in top two services logging the highest number of locally resolved concerns. The concerns varied, with no themes, and included experiences such as patients unhappy about the availability of the service in different sites and communication.

Waiting time was the main theme of the concerns about the Children's Speech and Language Therapy Service.

### 8.2 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.

There have been four informal complaints received during Quarter four, which cover various aspects of care and communication with Bluebell Ward, CAMHS - Child and Adolescent Mental Health Services, Corporate Governance Services and the Traumatic Stress Service.



### 8.3 NHS Choices

There were 8 postings during Quarter four; 2 were positive and 6 were negative.

Table 24: NHS Choices activity

Service	No of postings	Positive	Negative
Hearing and Balance KEV11 Hospital	2		<p>Arrived at hospital to get replacement batteries. Informed it is appointment only but was seen and got replacement item. Five months later tried to get appointment by ringing 03003656222 but no luck. Called 8 times and finally got somebody. This is poor. Why have we changed a procedure that works?</p> <p>I tried to contact the Hearing and Balance clinic at 4.15pm but was put through to voicemail saying they were closed until midday for training. I contacted the hospital switchboard who were unable to contact the department or any nearby department to get a message to them that their calls had been diverting to voicemail all afternoon.</p>
Urgent Care Centre. West Berkshire Community Hospital	2	<p>Very efficient personal, not a long wait and extremely professional service. I came in for a broken wrist and was very grateful for all the staff.</p> <p>I had never had to use this service before but am delighted to give a positive review. All the staff were extremely helpful and polite. I had sustained a laceration to my thumb, which bled profusely and needed expert attention, which I received. I was dealt with quickly and efficiently.</p>	
Psychology PPH	1		<p>Regrettably, the so-called CAT therapist that I consulted was extremely robotic - it was as if he is reading all his statements from a script. He was also very judgemental and lacked any empathy. He was absolutely no help whatsoever. If you value your mental health, I would avoid this Trust.</p>
Diabetes Centre KE V11	1		<p>I was telephoned to attend a diabetic education day and 4 days later, and (having phoned every phone number and leaving messages) no one has called me to book me in. I have even tried the main number. The voicemail for booking in was unprofessional - (a message from someone who was clearly walking in the wind and rain whilst recording it). I would expect better standards.</p>
CMHT Hillcroft House.	1		<p>Lacking basic resources</p>

			<p>It's a very good service from staff on the phone, but as a patient I get frustrated and isolated as the service has been cut back to nothing. An autistic person should not be going to hospital, but this still is the norm as there is nothing else. Even respite has been cut away to nothing. My care is in two places because I am asked to self-care. On the other side pressure there is pressure to cope with an autism diagnosis that was missed. It caused an incredible amount of uncertainty at the same time a large amount of expectation from the NHS towards me. Autistic people like fixed boundaries, but I am confused by a mental health service with multiple objectives that conflict with my own self-care. I went public recently to publish this kind of problem whereby lifting Autistic patients out the mental health service, when spent years trapped.</p>
Snowdrop Ward PPH	1		<p>I have a family member staying at the Snowdrop ward for the last two weeks and the support has been, to say the least, not at all suitable to treat any mental illness. There's no psychological support, no caring attitude and assessments are done as a tick box exercise. Food is microwaved, she stays in the room the full day, no one even checks if she needs anything, she is not eating any meals for the last week and no one even noticed. No attempt has been made to start any psychological support, no treatment plan has been put in place and medication seems to be the answer for everything. If you want to get well, treated properly and taken care as any patient deserves, regardless of their illness, avoid Prospect Park Hospital at all cost.</p>

#### 8.4 PALS Activity

There were 421 queries recorded during this period and in addition there were 217 contacts which referred to non-Trust services. This is overall a higher volume than received in Quarter three. The main reasons for contacting PALS were:

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

## 9. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. The results of the NHS England national review of the FFT have been published and the FFT question was due to change from April 2020 to Overall, how was your experience of our service. In response to the coronavirus pandemic, from mid-March, NHSE/I have suspended the collection and reporting of the FFT. This has resulted in a reduction in the number of responses received to and reported by the Patient Experience Team. There is now also a national delay in implementation of the revised question.

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 of the Trusts' True North objectives has increased the focus on it within services. The Patient Experience Team is also formally monitoring this as part of ongoing Quality Improvement.

### 9.1 Friends and Family test responses

#### 9.1.1 Overall responses

Data shows that introducing SMS as a way of providing FFT has proved very popular with 32% of responses being received via this method. There is on-going work to support services that do not use RiO to utilise the SMS system.

Based on the number of discharges from our services, there were 108,579 patients eligible to complete the FFT during Quarter four. 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. There has been a reduction in the number of cards during Quarter four due to their collection being stopped in mid-March.

Table 25: Quarterly number of Friends and Family Test responses

		Number of responses	Response Rate
2019-20	Q4	10,083	9.29%
	Q3	10,933	10.69%
	Q2	11,095	10.86%
	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%

		Number of responses	Response Rate
	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%

Table 26: Recommendation rate for 2019/20

	Q1	Q2	Q3	Q4
Community Mental Health Services	93%	94%	95%	91%
Mental Health Services	87%	78%	83%	83%
Trust Total	92%	91%	93%	89%

### 9.1.2 Inpatient ward responses

Table 27: FFT results for Inpatient Wards showing percentage that would recommend to Friends and Family

Ward	Ward type	2019/20				2018/19				2017/18			
		Q4%	Q3%	Q2%	Q1%	Q4%	Q3%	Q2%	Q1%	Q4%	Q3%	Q2%	Q1 %
Oakwood Ward	Community Inpatient Ward	100%	100%	100%	95.83%	95.83	100	100	95.83	100	72.97	93.75	100
Highclere Ward		100%	100%	100%	100%	97.5	94.12	97.37	93.98	94.64	96.7	100	100
Donnington Ward		-	85%	90.48%	97.44%	90.91	93.48	89.8	97.78	97.59	42.86	98.86	93.5
Henry Tudor Ward		-	-	91.89	-	100	100	96.67	88	95.24	94.44	100	100
Windsor Ward		-	-	100%	-	100	94.12	93.75	100	100	100	100	100
Ascot Ward		89.13%	99%	96.34%	95.45%	92.86	100	94.92	97.5	97.83	100	100	100
Jubilee Ward		56.25%	53%	65.22%	60%	80	72.73	50	-	-	-	100	40
Bluebell Ward	Mental Health Inpatient Ward	50%	87%	62.50%	75%	62.79	78.95	50	100	33.33	-	66.67	50
Daisy Ward		80.76%	67%	74.49%	71.11%	76.74	70.59	70.73	70.59	100	85.71	76.19	60
Snowdrop Ward		76.66%	76%	77.78%	84.48%	75	69.44	50	100	-	-	100	-
Orchid Ward		87.50%	70%	76.92%	62.50%	45.95	62.5	0	100	33.33	100	50	100
Rose Ward		54.16%	80%	86.67%	93.33%	100	83.33	-	-	-	-	-	100
Rowan Ward		50%	29%	-	-	100	100	-	-	-	-	-	-
Sorrel Ward													

- = no responses received

### 9.1.3 Learning Disabilities

There were 17 responses to the FFT from people on our Learning Disability Inpatient ward; Campion Unit. The question is asked differently in this survey and patients are supported with the question 'would you want your friends and family to come here if they were ill?'

Of the 17 responses, 3 people said yes, 6 said maybe and 8 said no.

There were 71 responses to the FFT received from patients seen by the community teams for people with a learning disability, a significant increase from 22 in Quarter three. The recommendation rate for Quarter four was 90% compared to 95% in Quarter three, 85% in Quarter two and 83% in Quarter one.

### 9.1.4 Carer FFT

There has been a substantial increase in carer responses.

In Quarter four, 95% of carers would recommend the Trust to friends or family compared to 79% in Quarter three, 95% in Quarter two and 96% in Quarter one.

Table 28: Carer FFT Responses

	2019/20	2018/19	2017/18
Q1	335	67	111
Q2	408	201	32
Q3	242	314	39
Q4	411	258	86

### 9.1.5 Friends and Family Test comparison information available from NHS England

Each month health services (both NHS and independent providing NHS services) submit a report to the Department of Health and Social Care on their FFT results and activity. As each organisation differs in the services that they provide, and the guidance for calculating the response rate differs substantially. Reporting has been suspended and the last submission contained data from February 2020. The tables below show the most up to date comparison information available from NHS England, which is February 2020 (it is usually a couple of months).

Table 29: Community Health services FFT data; February 2020

Trust Name	Feb-20		Nov-19		Aug-19		Apr-19		Feb-19	
	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR	Response Rate	% RR
Berkshire Healthcare	11%	89%	11%	96	9%	95%	11%	94%	17%	94%
Oxford Health NHS FT	4%	96%	4%	96	4%	95%	4%	95%	4%	93%
Solent NHS Trust	5%	97%	4%	97	5%	97%	3%	97%	7%	98%
Southern Health NHS FT	6%	93%	4%	98	5%	98%	6%	96%	5%	95%

%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.

Table 30: Mental Health services FFT data; February 2020

Trust Name	Feb-20		Nov-19		Aug-19		Apr-19		Feb-19	
	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR	Response R	% RR
<b>Berkshire Healthcare</b>	<b>15%</b>	<b>83%</b>	<b>17%</b>	<b>83%</b>	<b>12%</b>	<b>86%</b>	<b>19%</b>	<b>87%</b>	<b>21%</b>	<b>86%</b>
Solent NHS Trust	17%	93%	10%	91%	9%	89%	9%	92%	13%	92%
Southern Health NHS FT	2%	92%	1%	83%	3%	91%	3%	92%	2%	93%
Avon and Wiltshire MH Partnership	10%	89%	12%	88%	11%	87%	17%	89%	14%	90%
Oxford Health NHS FT	7%	91%	8%	91%	9%	92%	9%	92%	9%	93%

%RR – Recommendation rate

As the Family and Friends Test response rate is receiving less than the 15% target a countermeasure summary to support improvement has been put in place and is being monitored through the Trust Finance Performance and Risk Committee, as well as being a Driver metric for the Patient Experience Team.

#### 10. Our internal patient survey

We have received feedback from 4694 patients or carers in Quarter four, compared to 3901 in the previous quarter, an increase of 793 responses. This is fantastic achievement considering that from mid-March the Trust suspended active collection of patient surveys and there have been some changes to the IT network which have caused some issues. Community Health Services has had a significant increase in responses mainly impacted by Immunisation and School Nursing, quarter on quarter, being term time only.

The highlights are:

- 57% of people rated the service they received as excellent or good, which is lower than last quarter. This is mainly due to the low recommendation rate in Immunisation – which pulls the overall figure down (it seems that children and young people do not always complete this question therefore the % recommending is much lower than the responses received for the overall survey)
- Community Health Services had responses from 3057 patients and carers with 47% of them reporting the service they received as excellent or good
- Mental Health Services responses decreased to 1637 in the last quarter, with 76% of patients and carers rating the service provided as excellent or good
- 21 services carrying out the internal patient survey were rated 100% for excellent or good with a further 11 services rating 85% or above

#### 11. Learning Disabilities survey

There were 52 survey responses by people seen by our Community Team for people with a Learning Disability during Quarter four; an increase from 41 in Quarter three and compared to 50 in Quarter two and 96 in Quarter one. In Quarter four 2018/19 there were 26 responses. A selection of the results is in the table below:

Table 31: Patient survey responses – Community based Learning Disability Services

<b>My meeting with you was helpful</b>	<b>%</b>	<b>Number</b>	<b>I got answers to my questions</b>	<b>%</b>	<b>Number</b>
Not at all	0	0	Not at all	0	0
Not much	0	0	Not much	0	0
A little	5.77	3	A little	9.62	5
Quite a bit	5.77	3	Quite a bit	3.85	2
A lot	86.54	45	A lot	86.54	45
Question not answered	1.92	1	Question not answered	0	0
<b>You were polite and friendly to me</b>	<b>%</b>	<b>Number</b>	<b>You listened to me</b>	<b>%</b>	<b>Number</b>
Not at all	0	0	Not at all	0	0
Not much	0	0	Not much	0	0
A little	1.92	1	A little	3.85	2
Quite a bit	1.92	1	Quite a bit	1.92	1
A lot	96.15	50	A lot	92.31	48
Question not answered	0	0	Question not answered	1.92	1

The inpatient survey has been revised and below is a selection of the results from Quarter four; there were 17 responses to the survey.

Table 31: Patient survey responses – Campion Unit

<b>How do you feel about food and drink on Campion?</b>	<b>%</b>	<b>Number</b>	<b>How do you feel about talking with staff on Campion?</b>	<b>%</b>	<b>Number</b>
Positive	41.18	7	Positive	35.29	6
Not sure	23.53	4	Not sure	52.94	9
Negative	35.29	6	Negative	11.76	2
<b>How do you feel about safety on Campion?</b>	<b>%</b>	<b>Number</b>	<b>How do you feel about the help from staff on Campion?</b>	<b>%</b>	<b>Number</b>
Positive	17.65	3	Positive	52.94	9
Not sure	47.06	8	Not sure	29.41	5
Negative	35.29	6	Negative	17.65	3

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

The Always Events programme has been embedded within the WestCall service. The operational team are being supported by the Patient Experience Team with this project, a 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. This programme has been put on hold.

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. PPI Champions have been established across the community health west and mental health west localities and are in the process of developing their local plans and vision. PPI Champion Meetings have been put on hold.

Appendix Two contains the 15 Steps report for Quarter four. There were 6 visits during this period; three to community inpatient wards, two to mental health inpatient wards and one was in a community-based service (the Urgent Care Centre).

### 13. Compliments

There were 1,436 compliments reported during Quarter four. The services with the highest number of recorded compliments are in the table below.

Table 32: Compliments

Service	Number of compliments
Talking Therapies	590
ASSIST	138
Other	97
Cardiac Rehab	83
District Nursing	73
Community Respiratory Service	66
Physiotherapy Musculoskeletal	59
Integrated Care Home Service	32
CMHTOA/COAMHS - Older Adults Community Mental Health Team	26
Heart Function Service	19

Table 33: Examples of compliments received during Quarter four

<p><b>Rapid Response and Reablement Service</b></p> <p>'I didn't even know that the rapid response service existed... I am so glad that it does... to be honest without the help of yourselves and of the other staff who work for the NHS I think I would be in a box right now... Thank you all so much for your help'</p>	<p><b>Dietetics</b></p> <p>'I really appreciated you taking the time to talk through things properly with me regarding my diabetes diet rather than talking down to me. I really respect you for listening to my concerns and wishes'</p>
<p><b>CAMHS</b></p> <p>'You are dedicated professionals working together as a team who were genuinely interested in my child's progress and wellbeing. It would be fantastic if you had more funding to allow the group to assist more people. We are extremely grateful to everyone who worked with my child to help her deal with the situation and provided her with techniques to help her after treatment'</p>	<p><b>Health Visiting</b></p> <p>'I have followed your advice about helping with my child's sleep you are the first person who actually listened to me and in turn made me feel much better as well as improving our family life'</p>



had finished. Her recovery (continuing) would not have been possible without you. Thank you for your help'	
Common Point of Entry 'You made me feel comfortable and I felt calm and was able to be open. You made my day better. You were very professional, calm and positive'	Rose Ward 'The nurses and doctors have been lovely looking out for my loved one and to get them to how they are today'
Older Perons Mental Health 'I think your team is phenomenal and that you are all so lovely and obliging'	ASSIST 'I wanted to say thank you for helping me get through Thursday and Friday whilst my 1-1 therapist was away. Does mean a lot having your support. The tasks you gave me really helped and kept me busy Friday night resulting in no harm being cause'  (the patient is now 11 weeks free of self-harm)
Audiology 'A BIG THANKYOU to the Heatherwood hearing clinic yesterday, they saw my mum. You were great and she is a challenging customer - a great service'	Oakwood Ward 'Loved it. I love all of it. All good. Food good, staff lovely. Friendliness'
Older Persons Mental Health 'Thank you very much in organising the care package, equipment and assistive technology for our dad, without you it wouldn't have been possible to keep dad safe and comfortable in his last days of his life. You were the first one to help us when we were knocking for help with other services'	Heart Failure Team 'I am extremely likely to recommend the service because you treat me like a person and not a number on a bit of paper'

Table 34: Compliments, comparison by quarter

	2018/19					2019/20				
	Q1	Q2	Q3	Q4	18/19	Q1	Q2	Q3	Q4	Total
Compliments	1,008	1878	1,670	1,409	5,965	1,404	1,389	1,437	1,436	5,666

Elizabeth Chapman  
Head of Service Engagement and Experience

**Formal Complaints received during Quarter Four 2019.20**

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Moderate	Pt not provided info on his rights, wasn't advised of advocacy, procedures for assessing and documenting consent were not followed, he did not receive a copy of his care plan thus no clarity of what he was prescribed.	Partially Upheld	Patient consented to CRHTT treatment however did not receive information on the MHA or advocacy services.
Reading	Older Peoples Mental Health (Ward Based)	Moderate	Following receipt of the pts medical records, a further complaint is being raised ORIGINAL Wife of pt has sent in 16 points of concern following her review of the pts medical records	Partially Upheld	There was a breakdown in communication and relationship with the family but there were failings on both sides.
Wokingham	CMHT/Care Pathways	Moderate	Pt wishes to change care Co-Ordinator as they feel they do not understand or relate to the pt's diagnosis	Not Upheld	Complainant has had significant level of support and no longer needs a care co-ordinator anyway.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Adult Acute Admissions		Complainant unhappy with the perceived lack of care for the pt. Pt not seen by their psychiatrist in a 6 week period. Despite being under 1 to 1 care they state various life threatening incidents have taken place. When the pt has asked to speak to someone as they are struggling they have been allegedly told no.	Partially Upheld	<p>The patient to be observed by staff who knows her well. This maybe regular staff or staff who are on bank and or agency but the proviso is that they know the patient well.</p> <p>For the patient to receive psychological therapy on a weekly basis as agreed by the IMPACTT team.</p> <p>Extra psychological to be source from outside provided in order to increase the therapy to more than once a week.</p> <p>Consistent approach by all staff in their response to the patient when she requests a 1:1 with a staff member who is not allocated to her enhanced observations at the time of request.</p> <p>Consistent approach in discussing with the patient any changes in her medication and for all discussion to be documented through the electronic records.</p> <p>Consistent approach to searching each patient on return from leave from the ward</p> <p>To explore whether the availability of Art Therapy would be beneficial.</p>
West Berks	Admin teams and office based staff	Low	<p>Pt called to speak to CPN and person covering lunchtime reception allegedly refused to put them through and then allegedly hung up on them.</p> <p>Pt also unhappy that CPN called at 9.30 am on 28.11.19 to reschedule meeting that was due to take place at that exact time - pt had organised her entire day around this meeting</p>	Not Upheld	<p>There were no clinical failings. Meeting was cancelled on day it was to happen, due to sickness, but patient was notified of this. Care and treatment does not meet patient's expectations but all has been appropriate</p>

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	CMHT/Care Pathways		<p>Re-opened as issues we thought were resolved are still outstanding</p> <p>Service assured family member that pt would get a call from a different CC due to the number of cancelled appt's, no call was received</p>	Not Upheld	Not upheld as complaint withdrawn by patient.
Wokingham	Estates	Low	<p>Daughter was visiting father when she slipped on the ramp entry to Wokingham Hospital and broke her wrist. She is complaining that there was not a sign to indicate the ramp was slippery, that she had to ask for an ice pack and staff made a sling from her scarf. Also she wasn't contacted by the Trust until four weeks after. She has had surgery and will also be looking to claim compensation once the complaint has been investigated.</p>	Not Upheld	There is no evidence to suggest the accident was due to a fault by us.
Reading	A Place of Safety	Low	<p>Complaint about various aspects of her care from different services - BHFT aspect is around their stay and purpose of being taken to POS.</p>	Partially Upheld	We have not been able to answer some points as we have not been able to identify staff. However, we have apologised for the lack of information regarding PALS and if she was cold on POS.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt feels the CRHTT team were very dismissive when she was having daily check ins with them in 2019	Upheld	A teaching session will be organised for all CRHTT staff using this case (anonymised) to explore more compassionate approaches to support patients and manage similar situations in future.
Reading	Adult Acute Admissions	Low	Complainant unhappy that following a complaint in 2017 a further medication error has occurred. Complainant also feels there was failed home leave planning with services not communicating with each other	Not Upheld	Not upheld as patient not unhappy with care. Has declined to give consent and does not want information shared with complainant
Reading	CAMHS - Child and Adolescent Mental Health Services	Minor	No letter sent from the service to say discharged. Family wish a copy of the detailed report of the ADOS or profile of the patients autism as the family feel they need more insight into the diagnosis	Partially Upheld	All medical staff who carry out ADOS assessments are to include in their letter back to parents/guardians an explanation of the main principles within the ADOS assessment .
Wokingham	CMHT/Care Pathways	Low	Family and pt feel they are getting conflicting information regarding the pt's care	Partially Upheld	OPA follow up to be booked.
Windsor, Ascot and Maidenhead	Common Point of Entry	Low	Family wish to know why the first caller from CPE did not offer a full assessment F2F? What are the assessment procedures? How will the staff members manner be addressed?	Partially Upheld	Apologised for staff attitude, but assurance given that correct procedures were followed

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Windsor, Ascot and Maidenhead	Talking Therapies	Low	Pt unhappy as due to fire alarm she was delayed in attending appt. TT called to say they had not turned up so needed to reschedule. Pt distraught and staff member told them to 'move on'	Partially Upheld	Talking Therapies could review the information given to service users when appointments are booked, to include specific details of locality waiting areas. 1) Whilst the protocol is to complete the forms for each session, the Investigating Officer (IO) suggested when a session is less than two weeks apart it is not essential to complete the forms again. 2) The IO also suggests that the limits of a PWP appointment are clearly communicated during the assessment process. Specifically that the sessions are 30 minutes, the end time is fixed, and details about the questionnaires to be sent. The IO has suggested supervision and the clinical skills meeting as spaces to develop her understanding of when to pause the standard protocol of the delivering an initial assessment, and how to balance the service users' needs when responding to significant levels of distress.
Bracknell	CMHT/Care Pathways		Pt extremely unhappy with things / assumptions that have been written about them by services in their medical records	Not Upheld	Not upheld as complaint not pursued by complainant
Windsor, Ascot and Maidenhead	Community Hospital Inpatient	High	Care and treatment, moved across from an SJR / RCA possible SI Family feel the pt should have been transferred to the acute Trust	Partially Upheld	A number of points of learning identified with regards to observations, communications and processes.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Community Hospital Inpatient	Low	<p>1.Pt discharged with care package in place but carers were not at the house upon the pt's arrival, pt fell within the first hour.</p> <p>2. Pt discharged with a bag of meds which were not explained</p> <p>3. Incorrect contact detail for family members on the discharge form.</p>	Partially Upheld	<p>Add NOK details address and Telephone Number to 24 hour checklist</p> <p>Signing on a record book that TTO have been given and explained with list of Medications attached</p> <p>Admin staff to double check Telephone to ensure it is correct from 24 hour checklist Prior to been put on DC letters</p>
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Pt feels the care they have received from CMHT since an incident in October has not been sufficient. Pt feels they need a care co-ordinator	Not Upheld	
Slough	Crisis Resolution and Home Treatment Team (CRHTT)		A patient assessed by CRHTT feels that staff have lied about his mental health. The patient is currently unwell and lacks insight into his mental health.	Investigation underway	
West Berks	CAMHS - Child and Adolescent Mental Health Services	Low	Pt unable to attend school, Pt relapsed since meeting at CAMHS when they feel the clinician did not look up from the screen.	Upheld	Will be addressed with clinician on return to work

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	Physiotherapy (Adult)	Low	Service have discontinued the provision of physio to the pt and the complainant is unhappy at this decision	Upheld	Discuss next team meeting concerning patient goals, ensuring they are clearly written in the notes and communicated with the patient  Discuss at next team meeting the need for discharge planning to be documented and discussed with patients through out their treatment
Bracknell	Physiotherapy (Adult)	Low	Re-opened as above Service have discontinued the provision of physio to the pt and the complainant is unhappy at this decision	Upheld	Discuss next team meeting concerning patient goals, ensuring they are clearly written in the notes and communicated with the patient  Discuss at next team meeting the need for discharge planning to be documented and discussed with patients through out their treatment
Windsor, Ascot and Maidenhead	Physiotherapy (Adult)	Low	Pt unhappy with therapy received, feels it has increased pain to a different area	Partially Upheld	No specific fault or blame identified but have informed clinician involved - so they can reflect and be more self aware in the future. Discussed with the clinician the importance on treating the problem area as well as other areas found to be contributing on assessment.
Windsor, Ascot and Maidenhead	Physiotherapy (Adult)	Low	Re-opened as above Pt unhappy with therapy received, feels it has increased pain to a different area	Partially Upheld	No specific fault or blame identified but have informed clinician involved - so they can reflect and be more self aware in the future. Discussed with the clinician the importance on treating the problem area as well as other areas found to be contributing on assessment.



Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	Out of Hours GP Services	Low	Service called in relation to the wrong pt (twin sister) and kept using the wrong name, mother feels this is a breach of confidentiality	Not Upheld	From the calls heard, there was no evidence of the patient's name being used incorrectly
Reading	Adult Acute Admissions	Low	Via CQC - Pt feels they are not getting any physical health care or sign posting to advocate or dental services. Feels uncomfortable around staff and is concerned about being drugged	Not Upheld	IO reports that none of the points raised are upheld. Care and treatment from BHFT all appropriate
Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt unhappy that the call handler said 'you made a complaint about me' and said he would get a call back as it was shift change time. No call happened. Pt called later and the call handler shouted at him.	Not Upheld	No evidence of failings by service
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Re-opened Pt feels CMHT cancelled the psychology appt which was agreed as part of closing the informal complaint dating back to August	Investigation underway	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Pt feels CMHT cancelled the psychology appt which was agreed as part of closing the informal complaint dating back to August	Not Upheld	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	CAMHS - Rapid Response	Moderate	Parent feels the patient was not assessed in accordance with NICE guidance and believes they should be under BEDS	Partially Upheld	
Windsor, Ascot and Maidenhead	Tissue Viability	Minor	Care and treatment from the wound care clinic	Not Upheld	IO concludes that all treatment was appropriate
Reading	Adult Acute Admissions - Daisy Ward		Complainant feels there has been an extreme lack of care and empathy to the pt over the last few admissions to PPH.	Investigation underway	
Slough	Community Paediatrics	Low	Complainant believes the pt has been misdiagnosed. seeking legal advice and has complained to GMC. Has also contacted news outlets.	Not Upheld	IO found no evidence to support any of the allegations n
Slough	Community Paediatrics	Low	Re-opened as above complainant believe the pt has been misdiagnosed. seeking legal advice and has complained to GMC. Has also contacted news outlets.	Not Upheld	IO found no evidence to support any of the allegations made by the complainant
Bracknell	District Nursing		DECEASED PT: Pt received end of life care by Community Nurses. Complainant unhappy because paperwork was not collected in time by District Nurses and CHC funding will be delayed and may need to go to appeal.	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Adult Acute Admissions - Bluebell Ward		Pt over heard staff talking about them and other patients through the door and it has left them distressed. Complainant feels this is a breach of privacy under GDPR	Investigation underway	
Reading	Adult Acute Admissions - Snowdrop Ward	Low	Concern about lack of staff engagement on the ward, however the main complaint is about agreed S17 Leave arrangements being changed when care was transferred under a different Consultant.	Partially Upheld	Handover between the Consultants did not take place as promptly as it should have. Clinical care was appropriate.

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Slough	CAMHS - Child and Adolescent Mental Health Services	Moderate	Complainant unhappy that services do not call back. Pt has attended A&E and GP and is continuously told to wait for CAMHS.	Upheld	<p>Ensure families understanding and expectations around whether there is an allocated worker for service users and how they will be supported eg duty. To be achieved by discussions in team meetings/ 1 to 1 supervisions as felt appropriate.</p> <p>There should be an improved interface between different elements of the services of Camhs, Rapid response and the Duty System for the East Specialist Camhs Team.</p> <p>Communication with the crisis team to confirm that staff have a responsibility to effectively manage calls from under 18's through supervision and the identification of further learning and development needs to improve confidence in practice.</p> <p>Review processes with the Common Point of Entry administration to address why the patient was directed back to the East Camhs Specialist Team when the call should have gone to Rapid Response.</p>
Wokingham	Adolescent Mental Health Inpatients - Willow House	Minor	<p>Pt wishes up to investigate the lack of care they feel they received from Willow Hse and specific Dr's.</p> <p>Pt also wishes us to jointly look at the transition from Oxford Health to Berkshire as a joint complaint</p>	Partially Upheld	<p>ASD diagnosis: Communication to be made clearly and try to avoid sudden unexpected changes to plans without discussion. Develop guidelines for the ward team around supporting young people with an ASD diagnosis. Willow House team to be offered targeted autism training by an autism expert. To think about how to support young people with autism on the unit.</p> <p>Review Willow House transition processes. Review process for young people placed out of area.</p>

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	Talking Therapies		TT text appt arrangements to the mother of a pt who had not told their parent they were under TT this has occurred 3 times	Investigation underway	
Slough	CMHT/Care Pathways	Moderate	Pt does not understand why MHP asked if the they wish to be transferred to WAM now the pt lives in Windsor but then did nothing. Believes the clinical psychologist said they should have support from MH services so does not understand why he does not have it. Pt states he does not get calls back when asking for specific staff. They feel that services have washed their hands of them.	Partially Upheld	We have apologise for poor communication and manner in which patient was spoken to. Discharge was appropriate
Bracknell	Children's Speech and Language Therapy - CYPIT		Mother is complaining about service her son has been involved with since March 2019. He has been seen by SLT and paediatrics for eating issues. They have had do all the chasing but are no further forward. They feel let down and messed around.	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Bracknell	Talking Therapies		Complaint about the SI process. Inquest was last week. She has a copy of the SI report and feels there are inaccuracies in it.	Investigation underway	
Reading	Older Adults Inpatient Service - Rowan Ward		Partner of patient has raised many areas of concern about patient's care and treatment on the ward. She is 'highly concerned by the gross neglect' of the Dr	Investigation underway	
West Berks	Crisis Resolution and Home Treatment Team (CRHTT)		Girlfriend of patient has complained about the attitude of a member of the Crisis team when they spoke to her boyfriend over the phone. She said she has never heard anyone in the NHS be so rude to a patient.	Investigation underway	
Bracknell	District Nursing		Patient had surgery and needed tinzaparin injections for six weeks. She is needle phobic and cannot administer these herself so it was agreed the DNs would visit. Now, after just two week, the DNs are withdrawing the service to her, leaving her at risk of DVT.	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
West Berks	CMHT/Care Pathways		Pt did not meet criteria for IMPACTT services. Complainant would like BHFT to consider funding pt at 'Still the Hunger' for her DID diagnosis	Investigation underway	
Slough	Eating Disorders Service		Pt extremely unhappy with the approach from the BEDS service who came across as judgemental and lacking in any empathy	Investigation underway	
West Berks	Intermediate Care		carers cancelled without notice, staff member acted patronising and then refused to speak to the complainant to discuss	Investigation underway	
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Solicitors state pt wishes for inpt admission or further support in the community as the pt is in a constant state of crisis and high risk of completing suicide - solicitor states failure to offer adequate services is potentially, therefore, negligent	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Reading	Crisis Resolution and Home Treatment Team (CRHTT)		Patient is complaining that a named member of staff told her that every member of CRHTT staff had an issue speaking to her on the phone. She continues to have unsatisfactory phone conversations with this staff member when she uses CRHTT	Upheld	Upheld as call listened to and it was clearly heard. Staff member has apologised and will attend training and have supervision
Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Patient unhappy with consultation in December saying he was not allowed to speak English during the appointment. He is asking why staff do not treat patients equally.	Not Upheld	On reviewing all notes available and discussions with other health care professionals involved, the IO has concluded there are no evidence to corroborate the claims made by the complainant.
Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward		Daughters have raised many concerns, through safeguarding, about the care of their father whilst on the ward	Investigation underway	
Wokingham	CMHT/Care Pathways		Father of patient has raised concerns about CMHT saying she has been turned away without any offer of support, CRHTT hung up on her and they are unhappy with the Snowdrop Ward too.	Investigation underway	



Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	Traumatic Stress Service		<p>Re-opened complaint about access to services and specifically:</p> <p>An urgent referral to any other CMHT</p> <p>A referral to any other trauma service than BTSS, in the UK or abroad.</p> <p>An investigation into what has happened</p>	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Wokingham	Common Point of Entry		<p>Re-opened complaint; concerned that CPE discharged her daughter, in such a short space of time, without a face to face assessment. Patient said that they didn't need help, she was fine but asks: - Why can't a face to face assessment be provided in order to get a clear picture of the needs of the patient, before a decision is made to discharge?</p> <p>Adds that the Air Ambulance Grade 5 doctor who escorted patient back to the UK, provided a report to say she will need a face to face assessment. Why was the Air Ambulance doctor's recommendation not acted upon?</p>	Investigation underway	

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome
Windsor, Ascot and Maidenhead	Podiatry		Service Lead contacted the complainant and confirmed the main concerns are: 1. <del>A</del> ttitude of the staff 2. <del>T</del> reatment of foot 3. <del>I</del> mpact financially of the additional treatments and travel to Wexham, that complainant has had since the initial problem treated by Podiatry BHFT with her right foot.	Investigation underway	
Windsor, Ascot and Maidenhead	Eating Disorders Service	Minor	Pt on a wait list for BEDS despite having been seen twice by psychologist	Upheld	Upheld as we have acknowledged the wait is longer than wanted.
Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Break down of relationship and trust with patient. Prescription mistakes on more than one occasion	Investigation underway	



## **15 Steps Challenge**

### **Quarter Q4, 2019/20**

During the first half of this quarter six visits were made, highlights detailed below.

Due to the current crisis surrounding Covid-19 it has been agreed to suspend 15 steps visits until further notice. Prior to this new volunteers had been recruited to support the programme and this will assist the team when visits re-commence.

#### **Highclere Ward, WBCH**

A good visit to a well-run ward staffed by welcoming staff who were focused on their patients care.

#### **Urgent Care Centre (formally MIU at West Berkshire Community Hospital)**

A busy unit with an enthusiastic nursing team demonstrating a professional and caring attitude to their patients who were being tolerant of the long wait.

#### **Rose Ward, PPH**

Staff were obviously proud of their ward and demonstrated this in their caring and welcoming attitude.

#### **Daisy Ward, PPH**

A well run ward with welcoming and helpful staff. All staff seen were interacting with their patients in a positive and caring way.

#### **Ascot Ward, Wokingham Hospital**

A busy ward at the time of the visit due to visiting time. Staff appeared dedicated to their patients although there were some concerns raised by a patient's relative who felt staff did not have enough time to attend to some basic needs of patients. This was discussed with the new senior leadership team following feedback and assurance was received that this would be acted upon.

#### **Windsor Ward, Wokingham Hospital**

A busy ward with a number of Quality Improvement initiatives being implemented.

#### **Friends and family team discussion:**

On the whole the teams felt that should a loved one be admitted to any of the services visited that they would receive good professional care.

#### **Pam Mohamed-Hossen and Kate Mellor**

**Lead Nurses for Professional Practice.**

**March 2020.**



**Trust Board Paper**

<b>Board Meeting Date</b>	12 May 2020
<b>Title</b>	<b>Executive Report</b>
<b>Purpose</b>	This Executive Report updates the Board of Directors on significant events since it last met.
<b>Business Area</b>	Corporate
<b>Author</b>	Chief Executive
<b>Relevant Strategic Objectives</b>	N/A
<b>CQC Registration/Patient Care Impacts</b>	N/A
<b>Resource Impacts</b>	None
<b>Legal Implications</b>	None
<b>Equality and Diversity Implications</b>	N/A
<b>SUMMARY</b>	This Executive Report updates the Board of Directors on significant events since it last met.
<b>ACTION REQUIRED</b>	To note the report and seek any clarification.



**Trust Board Meeting 12 May 2020**

**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 Therapies

**2. COVID-19 NHS Second Phase**

The NHS has set out plans for the second phase of the pandemic, including stepping up non-coronavirus urgent services over the next six weeks, as it attempts to return to normal.

In a letter to local trusts and GPs, NHS England Chief Executive, Sir Simon Stevens and Chief Operating Officer, Amanda Pritchard said urgent outpatient appointments should go ahead and routine surgery could be restarted where possible.

A copy of the letter is included in the appendix.

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

**3. Care Homes**

Covid-19 has had a particularly hard impact on Care Homes. England and Wales have not been alone in their difficulties with Care Home cases during the pandemic. Other European countries have also had high numbers of deaths in Care Homes – with the World Health Organisation (WHO) Europe recently reporting that up to 50% of Covid-19 deaths across the region were in Care Homes.

Deaths in England and Wales have been steadily increasing in Care Homes so that by the week of 17 April 2020, there were 5,162 more deaths than the five-year average (so-called 'excess deaths').

Getting a full understanding of the picture will take some time, but it is likely that systemic issues within the Care sector have played a part.

With the focus on the NHS, Social Care did not start to receive significant attention until around three weeks ago. As the NHS worked to free up hospital beds for Covid-

19 patients, Care Homes had to manage how to receive people newly discharged from hospital (some having tested positive for Covid-19 and some awaiting test results) who required strict isolation. Many Care Homes struggled to source enough personal protective equipment (PPE) and field enough staff, with pre-existing shortages exacerbated by sickness and self-isolation.

The Care Homes market also entered the crisis in fairly poor shape. Chronically underfunded, with an increasingly fragile provider market and a myriad of workforce issues, the sector was already struggling to meet the growing needs of the population. Before the crisis, 75% of councils were reporting providers closing down or handing back contracts due to dwindling fees.

Many of our teams who provide support to Care Homes have witnessed first-hand all of the above and report that their work is exceptionally demanding. It is a focus in both our systems from a reactive point of view. It is clear however that in future the management of the sector requires significant reform and far better support for the essential work it does.

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

#### **4. Trust Response to the Impact of COVID-19 on Black, Asian and Minority Ethnic Communities**

There is emerging evidence in the United Kingdom and abroad that the Black, Asian and Minority Ethnic (BAME) communities are being disproportionately affected by the COVID-19 pandemic and concerns on the overrepresentation of BAME health and care professionals among the coronavirus fatalities.

The Government has agreed to an inquiry to understand why such a high number of people from BAME backgrounds are dying from the virus. The review, to be led by NHS England and NHS Improvement and Public Health England, is expected to be published in the next month.

We already know that BAME communities have worse health outcomes (1), as some BAME groups are at higher risk of certain diseases, are more likely to have underlying health conditions, experience differences and biases in the access, quality and experience of healthcare and due to the impact of wider determinants of health such as housing, employment and other socio economic factors.

Co-morbidities and socio-economic status are being put forward as possible explanations for the high number of people from BAME backgrounds affected and the high representation of BAME staff working in health and social care settings means they work in roles where they have a higher exposure to the virus.

BAME staff from various socioeconomic backgrounds, including hospital consultants, nurses and healthcare assistants have died as a result of the virus and the impact varies for different ethnic groups (2), so understanding the impact and causes is complex.

The NHS has identified high risk conditions and nationally issued over 1million letters to vulnerable patients, undertaken review of GP records and contacted patients in high risk medical categories.

We have taken action to protect people identified as at greater risk to COVID–19 for example we have moved pregnant women from front line patient facing work, we have provided personal protective equipment (PPE) and training to front line staff, provided regular briefings and answered questions.

So to date we have responded and supported BAME staff in the same way as all other staff.

Recognising the emerging evidence, a number of Trusts have sent letters to their BAME staff alerting them to the increased risks and support available but these have not always provided reassurance to this staff group and a number of risk assessments (3) are being developed to help evaluate and respond to potential risk factors for BAME staff.

We have reviewed available literature, gathered examples of Trust letters to BAME staff, met with BAME Network Chair and staff, responded to questions from BAME staff, linked with Medical Directors network on response and gathered data on our BAME workforce to undertake a risk assessment. Our data collection on BAME staff includes:

- Age
- Ethnicity
- Gender
- Disability
- Position title
- Area of Work
- Site Name
- Absence in period December to April relating to Flu or COVID-19 symptoms.

Our actions and next steps are –

1. We have analysed our BAME staff data (4) and developed a risk assessment to determine which staff we need to engage and what measures we need to implement to protect BAME staff.
2. We will develop a risk assessment and guidance for teams to support our BAME population.
3. We will reassure our BAME staff by informing them of the actions we are taking, ensure they can raise concerns and establish communication channels to keep them updated and informed.
4. We will continue to review emerging data, analysis, studies and reports to review the suitability of our response and take the measures required from the national study.

#### Background Information

- (1) [NHS Confederation: The impact of COVID-19 on BME communities and health and care staff](#)

BME groups generally have poorer health and worse health outcomes than the overall population:

- the risk of developing diabetes is six times higher in some BME groups



- there are significantly higher rates of asthma incidence in BME population groups
- people from some BME backgrounds in the UK are at higher risk of developing heart and circulatory diseases more than white Europeans
- people from some BME backgrounds in the UK are at higher risk of developing hypertension than the general population
- the Adult Psychiatric Morbidity Survey found that black men are more likely than their white counterparts to experience a psychotic disorder in the last year.

People from BME backgrounds often have poorer access to healthcare services as well as poorer experiences of care and treatment.

They are also less likely to raise concerns or make complaints about the standards of their care.

## (2) [The Institute for Fiscal Studies: Are some Ethnic groups more vulnerable to COVID19 than others. 1 May 2020.](#)

**The impacts of the COVID-19 crisis are not uniform across ethnic groups, and aggregating all minorities together misses important differences.** Understanding why these differences exist is crucial for thinking about the role policy can play in addressing inequalities.

**Per-capita COVID-19 hospital deaths are highest among the black Caribbean population and three times those of the white British majority.** Some minority groups – including Pakistanis and black Africans – have seen similar numbers of hospital deaths per capita to the population average, while Bangladeshi fatalities are lower.

**Once you take account of age and geography, most minority groups ‘should’ have fewer deaths per capita than the white British majority.** While many minority groups live disproportionately in areas such as London and Birmingham, which have more COVID-19 deaths, most minorities are also younger on average than the population as a whole, which should make them less vulnerable.

**After accounting for the age, gender and geographic profiles of ethnic groups, inequalities in mortality relative to the white British majority are therefore more stark for most minority groups than they first appear.** Black Africans and Pakistanis would be expected to have fewer fatalities per capita than white British but at present they are comparable.

**After stripping out the role of age and geography, Bangladeshi hospital fatalities are twice those of the white British group, Pakistani deaths are 2.9 times as high and black African deaths 3.7 times as high.** The Indian, black Caribbean and ‘other white’ ethnic groups also have excess fatalities, with the white Irish group the only one to have fewer fatalities than white British.

**These disparities cannot currently be accounted for by non-hospital deaths.** Official deaths in care homes – for which the ethnicity of victims is not currently available but where over 95% of residents are white – could only explain a small part

of estimated excess fatalities recorded in hospitals for minority groups. The ethnic composition of additional deaths directly or indirectly caused by the virus but not officially attributed to it is unclear at this time.

**Occupational exposure may partially explain disproportionate deaths for some groups.** Key workers are at higher risk of infection through the jobs they do. More than two in ten black African women of working age are employed in health and social care roles. Indian men are 150% more likely to work in health or social care roles than their white British counterparts. While the Indian ethnic group makes up 3% of the working-age population of England and Wales, they account for 14% of doctors.

**At-risk underlying health conditions are especially prevalent among older Bangladeshis, Pakistanis and black Caribbeans.** Compared with white British individuals over 60 years of age, Bangladeshis are more than 60% more likely to have a long-term health condition that makes them particularly vulnerable to infection, which may explain excess fatalities in this group.

**The potential for buffering incomes within the household depends on partners' employment rates, which are much lower for Pakistani and Bangladeshi women.** As a result, 29% of Bangladeshi working-age men both work in a shut-down sector and have a partner who is not in paid work, compared with only 1% of white British men.

**Many ethnic minorities are also more economically vulnerable to the current crisis than are white ethnic groups.** The fact that larger shares of many minority groups are of working age means that these populations are more exposed to labour market conditions as a whole, but even amongst working-age populations there are clear inequalities in vulnerability to the current crisis.

**Men from minority groups are more likely to be affected by the shutdown.** While in the population as a whole, women are more likely to work in shut-down sectors, this is only the case for the white ethnic groups. Bangladeshi men are four times as likely as white British men to have jobs in shut-down industries, due in large part to their concentration in the restaurant sector, and Pakistani men are nearly three times as likely, partly due to their concentration in taxi driving. Black African and black Caribbean men are both 50% more likely than white British men to be in shut-down sectors

**Self-employment – where incomes may currently be especially uncertain – is especially prevalent amongst Pakistanis and Bangladeshis.** Pakistani men are over 70% more likely to be self-employed than the white British majority.

**While in the population as a whole young people are more likely to be affected by the shutdown, the reverse is true among Pakistanis and Bangladeshis.** While 24% of young white British and 29% of young Bangladeshis work in shut-down sectors, the figure is 14% for 30 to 44 year-old white British but 40% for 30 to 44 year-old Bangladeshis. This also means that the family circumstances of those affected by shutdown differ by ethnicity, with older workers more likely to be living in couples

**The potential for buffering incomes within the household depends on partners' employment rates, which are much lower for Pakistani and Bangladeshi women.** As a result, 29% of Bangladeshi working-age men both work in a shut-down

sector and have a partner who is not in paid work, compared with only 1% of white British men.

**Bangladeshis, black Caribbeans and black Africans also have the most limited savings to provide a financial buffer if laid off.** Only around 30% live in households with enough to cover one month of income. In contrast, nearly 60% of the rest of the population have enough savings to cover one month's income.

### (3) Risk Assessment Example

Risk assessment be carried out for BAME staff based on the ABCD-GHO Score.		
A: Age	>55=1	<55=0
B: BP/Hypertension	High=1	normal=0
C: Chest Disease (Asthma/COPD etc)	Yes=1	No=0
D: Diabetes	Yes=1	No=0
G: Gender	Male=1	Female=0
H: Heart disease	Yes=1	No=0
O: Obesity	Yes=1	No=0

A score of 4 or more must be considered high risk. Thus, a BAME male 55 years with 2 comorbid conditions would be high risk. It would be very simple for the staff member to fill out a form, followed by a more detailed assessment if needed.

Appropriate advice and redeployment of vulnerable staff be carried out to mitigate the risks.

### (4) Berkshire Healthcare BAME staff data analysis

Total BAME staff	1111
Higher risk ethnic groups	468
Higher risk ethnic groups & over 45 years old	236
Higher risk ethnic groups & over 45 years old & Male	72
Total Sickness with relevant conditions	64
Total Sickness with relevant conditions Male	14
Total Sickness with relevant conditions Female	50
BAME staff at Prospect Park Hospital	257
Higher risk ethnic groups & over 45 years old	81
Higher risk ethnic groups & over 45 years old & Male	29
BAME staff in higher risk Community services	222
Higher risk ethnic groups & over 45 years old	81
Higher risk ethnic groups & over 45 years old & Male	4

## Analysis of COVID Deaths compared to pneumonia deaths last year

**Table 8 Outcome by patient characteristics**

Patient characteristic	Patients with COVID-19 and outcome reported (N=4078)		Patients with viral pneumonia (non-COVID-19), 2017-19 (N=5782)
	Discharged alive from critical care n (%)	Died in critical care n (%)	Died in critical care (%)
<b>Age at admission (years)</b>			
16-39	240 (78.4)	66 (21.6)	(7.5)
40-49	350 (73.2)	128 (26.8)	(12.6)
50-59	568 (57.0)	429 (43.0)	(19.7)
60-69	503 (41.8)	701 (58.2)	(26.2)
70-79	293 (32.2)	617 (67.8)	(31.6)
80+	57 (31.3)	125 (68.7)	(31.5)
<b>Sex</b>			
Female	659 (55.8)	522 (44.2)	(19.6)
Male	1352 (46.7)	1543 (53.3)	(24.1)
<b>Ethnicity</b>			
White	1306 (51.6)	1227 (48.4)	(22.3)
Mixed	25 (47.2)	28 (52.8)	(15.9)
Asian	218 (42.2)	299 (57.8)	(19.8)
Black	165 (44.2)	208 (55.8)	(13.0)
Other	106 (51.2)	101 (48.8)	(20.4)
<b>Index of Multiple Deprivation (IMD) quintile *</b>			
1 (least deprived)	330 (52.1)	304 (47.9)	(22.8)
2	323 (50.2)	320 (49.8)	(23.3)
3	379 (50.6)	370 (49.4)	(22.9)
4	427 (46.7)	488 (53.3)	(20.8)
5 (most deprived)	471 (48.2)	506 (51.8)	(21.2)
<b>Body mass index</b>			
<25	515 (52.0)	475 (48.0)	(23.5)
25-<30	644 (48.5)	685 (51.5)	(23.4)
30-<40	566 (50.2)	561 (49.8)	(19.4)
40+	144 (47.4)	160 (52.6)	(15.3)
<b>Assistance required with daily activities</b>			
No	1800 (50.6)	1756 (49.4)	(19.9)
Yes	138 (38.2)	223 (61.8)	(28.0)
<b>Any very severe comorbidities *</b>			
No	1835 (50.1)	1828 (49.9)	(19.3)
Yes	121 (40.6)	177 (59.4)	(33.9)

Please note that owing to the emerging nature of the epidemic, the sample of patients with COVID-19

**Executive Lead:** David Townsend, Chief Operating Officer

Presented by Julian Emms  
Chief Executive  
May 2020



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*From the Chief Executive Sir Simon Stevens  
& Chief Operating Officer Amanda Pritchard*

To:  
Chief executives of all NHS trusts and foundation trusts  
CCG Accountable Officers  
GP practices and Primary Care Networks  
Providers of community health services  
NHS 111 providers

Copy to:  
NHS Regional Directors  
Chairs of ICSs and STPs  
Chairs of NHS trusts, foundation trusts and CCG governing bodies  
Local authority chief executives and directors of adult social care  
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

## **IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19**

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

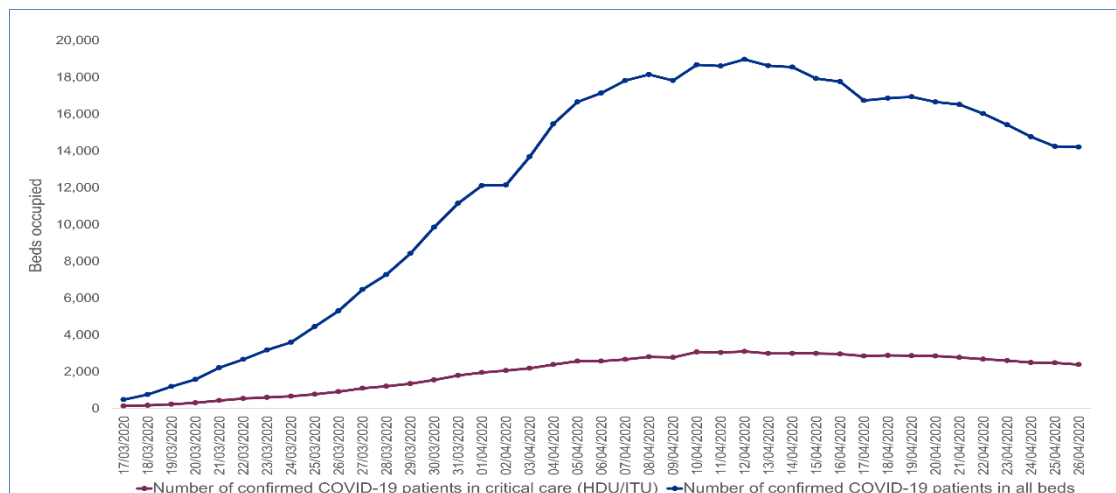
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

*Patients with confirmed Covid19 in hospital beds, England*



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS’s response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients  
<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>.
- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.
- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.
- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.
- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.
- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective 'returners' who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health**. Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the 'shielding' cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.
- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.
- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.
- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and '**surge**' capacity locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.



Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

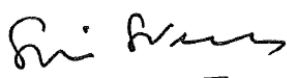
We should also take this opportunity to '**lock in**' **beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,



Simon Stevens  
NHS Chief Executive



Amanda Pritchard  
NHS Chief Operating Officer

## ANNEX

### ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

#### Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services ‘hear and treat’ and ‘see and treat’ models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf>)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

#### Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf> and <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf> ). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

### **Cardiovascular Disease, Heart Attacks and Stroke**

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

### **Maternity**

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

### **Primary Care**

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the 'shielding' cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.

- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual 'care home round' of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using 'advice and guidance' options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

### **Community Services**

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people's own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

### **Mental Health and Learning Disability/ Autism services**

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

### **Screening and Immunisations**

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

### **Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care**

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a 'patient initiated follow up' approach for suitable appointments - providing patients the means of self-accessing services if required.

**Trust Board Paper**

<b>Board Meeting Date</b>	12 May 2020
<b>Title</b>	Financial Summary Report – Year End (YE) 2019/20
<b>Purpose</b>	To provide the 2019/20 YE financial position to the Trust Board
<b>Business Area</b>	Finance
<b>Author</b>	Chief Financial Officer
<b>Relevant Strategic Objectives</b>	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
<b>CQC Registration/Patient Care Impacts</b>	N/A
<b>Resource Impacts</b>	None
<b>Legal Implications</b>	Meeting regulatory requirements
<b>SUMMARY</b>	The Financial Summary Report provides the Board with summary of the 2019/20 YE financial position.
<b>ACTION REQUIRED</b>	<p>The Board is invited to note the following summary of financial performance and results for 2019/20.</p> <p>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.</p> <p><b>YTD (Use of Resource) metric:</b></p> <ul style="list-style-type: none"> <li>• Overall rating 1 (plan 1) <ul style="list-style-type: none"> <li>○ Capital Service Cover rating 2</li> <li>○ Liquidity days rating 1</li> <li>○ I&amp;E Margin rating 2</li> <li>○ I&amp;E Variance rating 1</li> <li>○ Agency target rating 1</li> </ul> </li> </ul>

	<p><b>YTD Income Statement (control total performance including PSF Funding; excluding donations and impairments):</b></p> <ul style="list-style-type: none"><li>• Plan: £1.9m surplus</li><li>• Actual: £2.7m surplus</li><li>• Variance: £0.8m better than plan.</li></ul> <p><b>YTD Cash</b> £26.4m vs Plan £23.2m.</p> <p><b>YTD Capital expenditure:</b> £10.3m vs. Plan £11.9m.</p>
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**BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST**

**Finance Report**  
**Financial Year 2019/20**  
**March 2020**

***Purpose***

To provide the Board & Executive with a summary of the Trusts financial performance for the year ending 31st March 2020.

<b>Version</b>	<b>Date</b>	<b>Author</b>	<b>Comments</b>
1.0	15/04/20	Bharti Bhoja	1st Draft
2.0	20/04/20	Paul Gray	Final

***Distribution***

All Directors

All staff needing to see this report.

**Confidentiality**

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# 1.0 Key Messages

Key Metric	Actual £'m	YTD Plan £'m	Variance £'m	vs Last Mth	vs Prior Year
Surplus / (Deficit) for PSF	0.3	(0.4)	0.7	▲	▲
PSF - Trust	1.5	1.4	0.1	▲	▼
PSF - System	0.9	0.9	0.0	▲	▼
<b>Control Total Surplus / (Deficit)</b>	<b>2.7</b>	<b>1.9</b>	<b>0.8</b>	▲	▼
Statutory Surplus / (Deficit)	1.0	1.8	(0.8)	▼	▼
CIP Delivery	4.6	4.0	0.6	▲	▲
Agency Spend	4.7	5.0	(0.3)	▲	▼
OAPs - Specialist Placements (incl LD)	7.7	8.1	(0.4)	▲	▼
OAPs - Out of Area Placements	2.2	1.3	0.9	▼	▼
Capital Expenditure	10.3	11.9	(1.6)	▲	▼
Cash	26.4	23.2	3.2	▼	▲

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

## Key Messages

The Trust has achieved its financial Control Total for 19/20. Additionally, the Trust:

- Finished the year with a reported surplus of £0.3m excluding PSF, this includes £0.6m of centrally allocated Mental Health Investment funding. This is £0.7m ahead of our plan.
- Will report a statutory surplus of £1.0m, after further accounting for £2.4m of PSF and a net £1.7m impairment charge following the annual asset revaluation exercise.
- Retained its Use of Resources rating of “1” overall, in line with plan.
- Recorded £0.3m of costs resulting from our response to the COVID-19 pandemic, against which matching income has been accrued.
- Delivered £4.6m of savings, surpassing our £4.0m NHSI commitment.
- Finished the year with £26.4m at the bank, £3.2m higher than planned, with the timing of capital payments, PSF bonus and central MH funding all contributing to performance.
- Spent £10.3m on the Capital Programme, £1.6m less than planned.

## To Note

- All staff are to be thanked for their contribution to the success of this year’s financial results.

## 2.0 Income & Expenditure

Income Statement	In Month			YTD			Prior Year YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Operating Income	22.5	20.2	2.4	244.8	242.4	2.4	229.1	15.8	6.9%
DoH Pay Award	0.0	0.0	0.0	0.5	0.0	0.5	2.4	(1.9)	(79.8)%
Other Income	2.0	1.4	0.5	20.3	19.4	0.9	20.8	(0.5)	(2.4)%
YE Employers Pension Funding	7.9	0.0	7.9	7.9	0.0	7.9	0.0	7.9	
<b>Total Income</b>	<b>32.4</b>	<b>21.6</b>	<b>10.8</b>	<b>273.5</b>	<b>261.7</b>	<b>11.8</b>	<b>252.3</b>	<b>21.2</b>	<b>8.4%</b>
Staff In Post	14.3	13.8	0.5	168.1	167.5	0.6	155.0	13.1	8.4%
Bank Spend	1.8	1.1	0.7	16.0	12.8	3.2	14.1	1.9	13.1%
Agency Spend	0.3	0.4	(0.1)	4.7	5.0	(0.3)	6.0	(1.3)	(20.9)%
YE Employers Pension Costs	7.9	0.0	7.9	7.9	0.0	7.9	7.9	7.9	(0.0)%
<b>Total Pay</b>	<b>24.3</b>	<b>15.3</b>	<b>9.0</b>	<b>196.7</b>	<b>185.2</b>	<b>11.5</b>	<b>183.0</b>	<b>13.7</b>	<b>7.5%</b>
Purchase of Healthcare:									
- Placement Costs	0.8	0.8	0.0	10.0	9.8	0.2	12.2	(2.2)	(17.8)%
- All Other P. of Healthcare	0.5	0.4	0.1	4.7	4.4	0.3	3.4	1.3	37.3%
Drugs	0.4	0.6	(0.1)	5.4	6.7	(1.3)	5.9	(0.5)	(8.1)%
Premises	2.2	1.3	0.9	17.3	15.1	2.2	15.4	2.0	12.7%
Other Non Pay	2.2	1.8	0.4	20.4	21.9	(1.5)	21.1	(0.7)	(3.4)%
PFI Lease	0.5	0.6	(0.0)	6.5	6.7	(0.3)	6.4	0.1	1.5%
<b>Total Non Pay</b>	<b>6.7</b>	<b>5.3</b>	<b>1.3</b>	<b>64.3</b>	<b>64.7</b>	<b>(0.4)</b>	<b>64.3</b>	<b>(0.0)</b>	<b>(0.0)%</b>
<b>Total Operating Costs</b>	<b>30.9</b>	<b>20.7</b>	<b>10.3</b>	<b>261.0</b>	<b>249.9</b>	<b>11.1</b>	<b>247.4</b>	<b>13.6</b>	<b>5.5%</b>
<b>EBITDA</b>	<b>1.5</b>	<b>0.9</b>	<b>0.5</b>	<b>12.5</b>	<b>11.9</b>	<b>0.6</b>	<b>4.9</b>	<b>7.6</b>	<b>155.0%</b>
Interest (Net)	0.5	0.3	0.2	3.7	3.6	0.1	3.6	0.1	2.7%
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	(100.0)%
Depreciation	0.6	0.6	0.0	6.7	6.6	0.1	5.0	1.8	35.6%
PDC	(0.1)	0.2	(0.3)	1.7	2.0	(0.3)	1.7	0.0	0.9%
<b>Total Financing</b>	<b>0.9</b>	<b>1.0</b>	<b>(0.1)</b>	<b>12.2</b>	<b>12.3</b>	<b>(0.1)</b>	<b>10.7</b>	<b>1.4</b>	<b>13.5%</b>
<b>Surplus/ (Deficit) for PSF</b>	<b>0.6</b>	<b>(0.1)</b>	<b>0.7</b>	<b>0.3</b>	<b>(0.4)</b>	<b>0.7</b>	<b>(5.8)</b>	<b>6.1</b>	<b>(105.3)%</b>
PSF - Trust	0.2	0.2	0.0	1.5	1.4	0.1	4.5	(2.1)	(46.4)%
PSF - System	0.1	0.1	0.0	0.9	0.9	0.0			
<b>PSF - Subtotal</b>	<b>0.3</b>	<b>0.3</b>	<b>0.0</b>	<b>2.4</b>	<b>2.3</b>	<b>0.1</b>	<b>4.5</b>	<b>(2.1)</b>	
<b>Surplus/ (Deficit) for CT</b>	<b>0.9</b>	<b>0.2</b>	<b>0.7</b>	<b>2.7</b>	<b>1.9</b>	<b>0.8</b>	<b>(1.3)</b>	<b>4.0</b>	<b>(305.9)%</b>
Donated Income	0.0	0.0	0.0	(0.0)	0.0	(0.0)	0.0	(0.0)	
Donated Depreciation	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.0)	0.0	0.1	(260.8)%
Impairments	(1.7)	0.0	(1.7)	(1.7)	0.0	(1.7)	(0.4)	(1.2)	278.9%
<b>Non CT Adjustments</b>	<b>(1.7)</b>	<b>(0.0)</b>	<b>(1.7)</b>	<b>(1.8)</b>	<b>(0.1)</b>	<b>(1.7)</b>	<b>(0.4)</b>	<b>3.9</b>	<b>338.5%</b>
<b>Surplus/ (Deficit) Statutory</b>	<b>(0.8)</b>	<b>0.2</b>	<b>(1.0)</b>	<b>1.0</b>	<b>1.8</b>	<b>(0.8)</b>	<b>(1.7)</b>	<b>5.2</b>	<b>(155.5)%</b>

### Key Messages

The Trust reported a £0.6m surplus in month excluding PSF, which including a number of one-off adjustments and movements in provisions. Including PSF and after accounting for asset impairments, the Trust finished 19/20 with a reported £1.0m surplus. Both income and expenditure have been adjusted to recognises an addition 6.3% employers pension contribution, as notified by NHSI.

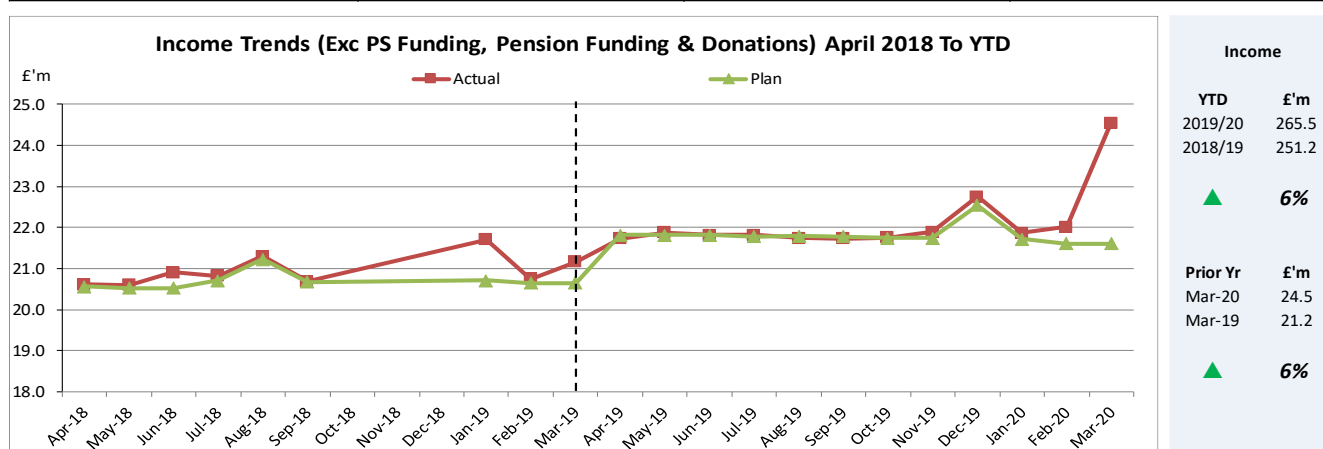
Overall income, excluding pension support, finished £3.9m higher than planned, including £0.6m of central MH funding. March also saw a number of contractual amounts being recognised resulting from variations over the final quarter of the year. The overspend on pay is partially offset by additional income for new services contracted in year.

Staff costs increased, with additional costs incurred covering annual leave being taken before the end of March, and costs relating to combatting the COVID-19 pandemic. Excluding COVID-19 and YE pension costs, the Trust overspend its annual pay plan by £3.6m.

Non Pay costs remained within plan for the year.

# Income & Contracts

Income Statement	In Month			YTD			Prior YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Var	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%
Block Income	19.9	17.7	2.2	216.5	213.2	3.3	199.6	16.8	8.4%
Tariff Income	0.1	0.2	(0.1)	1.9	2.0	(0.1)	2.7	(0.8)	(28.6)%
Pass Through Income	0.3	0.4	(0.1)	3.7	4.8	(1.1)	4.1	(0.4)	(10.3)%
DoH Pay Award	0.0	0.0	0.0	0.5	0.0	0.5	2.4	(1.9)	(79.8)%
Other Income	4.2	3.3	0.9	43.1	41.8	1.3	43.5	(0.4)	(0.9)%
YE Employers Pension Funding	7.9	0.0	7.9	7.9	0.0	7.9	0.0	0.0	
<b>Total Operating Income</b>	<b>32.4</b>	<b>21.6</b>	<b>10.8</b>	<b>273.5</b>	<b>261.7</b>	<b>11.8</b>	<b>252.3</b>	<b>21.2</b>	<b>8.4%</b>
PSF - Trust	0.2	0.2	0.0	1.5	1.4	0.1	3.6	(2.1)	(7.6)%
PSF - System	0.1	0.1	0.0	0.9	0.9	0.0	0.9	(0.0)	
Donated Income	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	(0.0)	
<b>Total Reportable Income</b>	<b>32.7</b>	<b>21.9</b>	<b>10.8</b>	<b>275.9</b>	<b>264.0</b>	<b>11.9</b>	<b>256.8</b>	<b>19.1</b>	<b>7.4%</b>



## Key Messages

The Trust finished the year with £4.0m more income than originally planned. This excludes £7.9m of income to cover the 6.3% pension increase which until now has been paid centrally by DHSC, and which we are required to include for year-end per guidance.

Income further includes £0.6m central MH investment funding which was notified towards the end of March, and which was required to be declared in excess of existing Control Total forecast. In addition we have accrued £0.3m of central income to cover COVID-19 related costs incurred to the end of March.

Other key movements in March include £0.4m contribution from the Royal Berkshire Hospital for works undertaken at Erleigh House, £0.4m relating to contract variations, and £0.8m movement in provisions, including CQUIN.

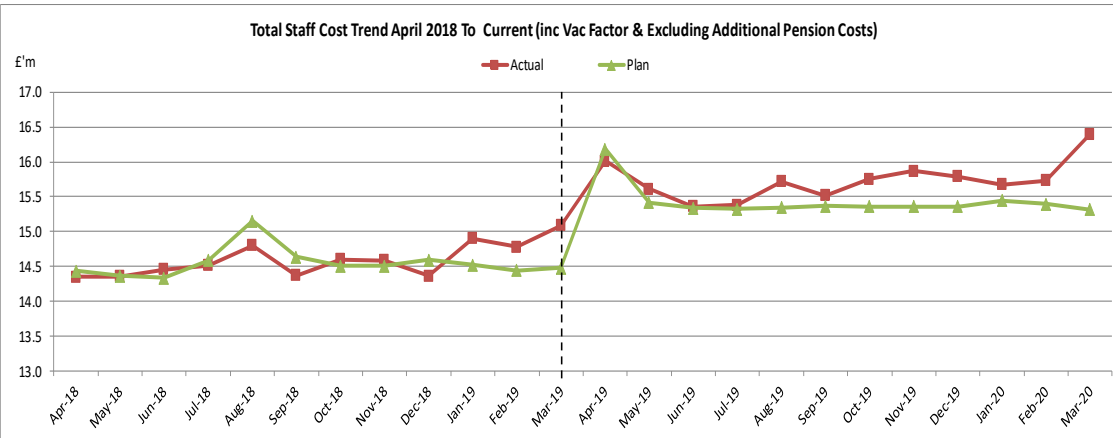
## Commissioner Focus

With the suspension of Operational Planning until the end of July, the 20/21 contract discussions are on hold. The Trust has received its first two allocated block payments under the guaranteed income regime which is in operation during this interim period. Funding for key Transformation projects have been deferred, with spend and timelines to be agreed with commissioners at a future date.

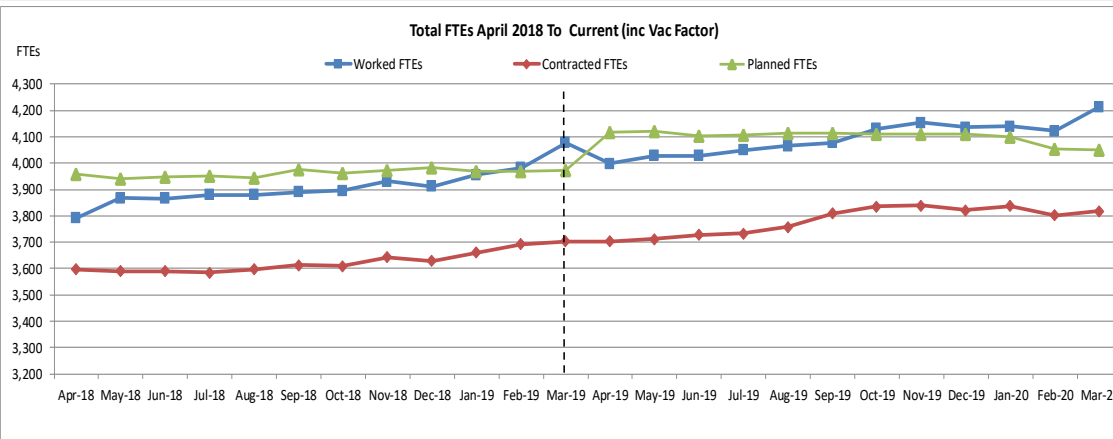
## System Focus

Both ICSs finished the year as forecast, with BOB missing its system Control Total and Frimley delivering to plan. This result secures all PSF the Trust had allocated to system delivery.

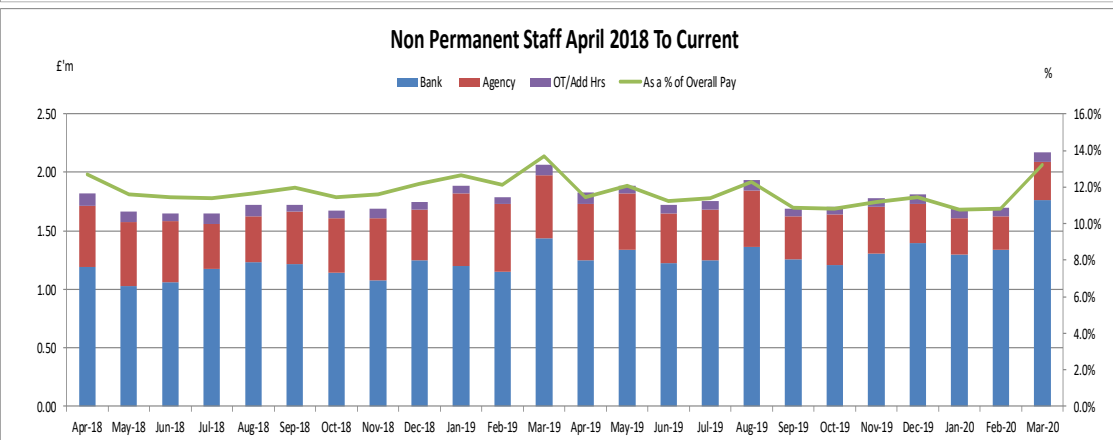
# Workforce



Staff Costs	
YTD 2019/20	£172.4
2018/19	160.1
	<b>▲ 8%</b>
Prior Yr Mar-20	£16.4
Mar-19	15.1
	<b>▲ 9%</b>



FTEs		
Prior Yr Mar-20	CFTE 3,819	WFTE 4,213
Mar-19	3,703	4,078
	<b>▲ 3%</b>	<b>▲ 3%</b>
Prior Mth Mar-20	CFTE 3,819	WFTE 4,213
Feb-20	3,802	4,122
	<b>▲ 0%</b>	<b>▲ 2%</b>



Non Permanent Pay			
YTD 2019/20	Bank 16.0	Agency 4.7	OT/Add Hrs 0.9
2018/19	14.1	6.0	1.0
	<b>▲ 12%</b>	<b>▼ 26%</b>	<b>▼ 4%</b>
Prior Yr Mar-20	Bank 1.8	Agency 0.3	OT/Add Hrs 0.1
Mar-19	1.3	0.3	0.1
	<b>▲ 24%</b>	<b>▲ 12%</b>	<b>▼ 19%</b>

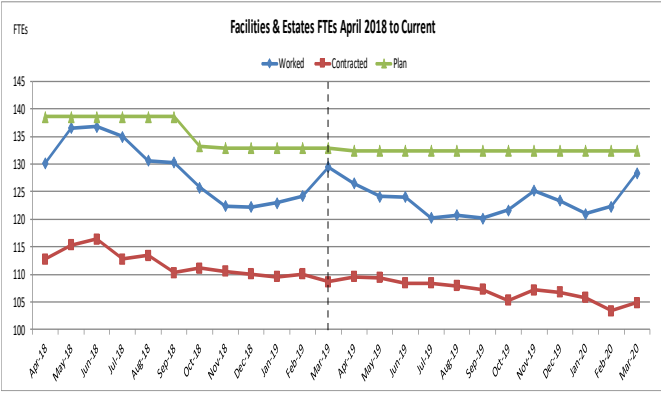
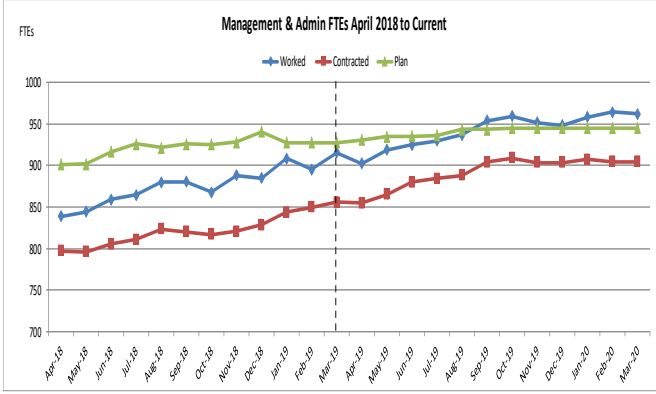
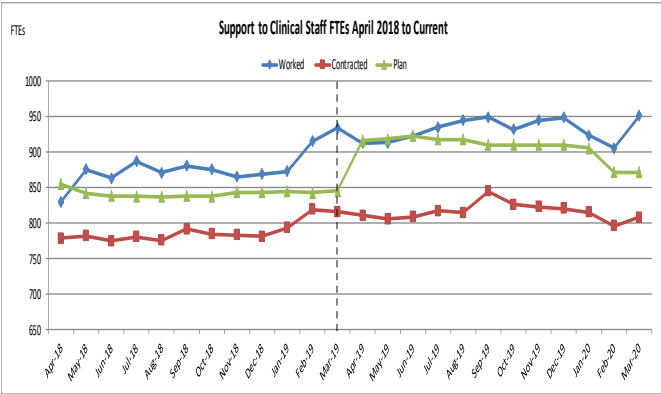
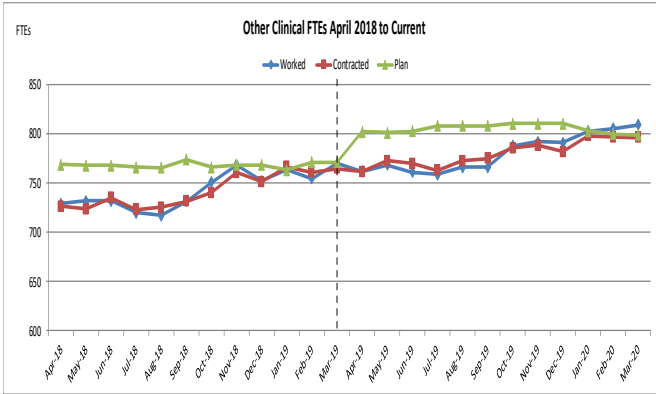
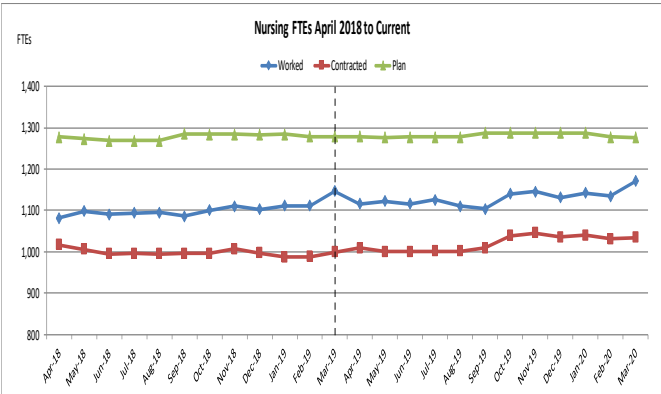
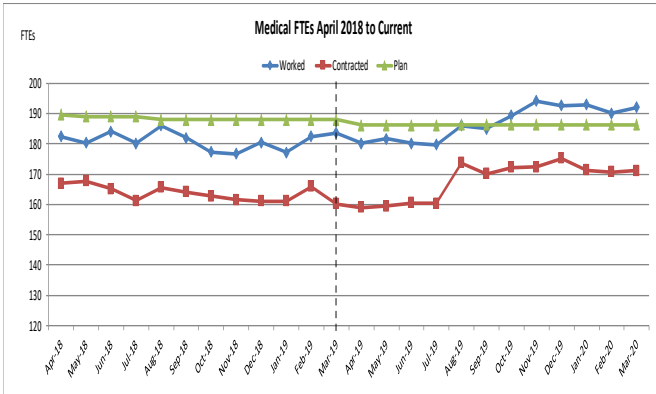
## Key Messages

Over the course of the year, the Trust has seen continued investment in its workforce, increasing substantive staffing numbers by 116 FTE. Overall costs were £3.6m higher than anticipated for the year. This excludes additional pension costs.

Overall staff costs increased in March by £0.6m, of which £0.4m was an increase in Non Permanent staffing costs. The increase in temporary staffing costs, as in previous years, is driven by an increase in shifts booked covering annual leave being taken before the end of March cut-off; this has seen costs rise by £0.3m. A further £0.1m of temporary staffing costs were incurred to cover winter pressures, this cost was fully funded by the commissioners. Within the overall pay-bill, £0.2m of costs have been incurred in direct response to the current COVID-19 pandemic, with these expected to increase further in April.

Substantive costs increased by £0.2m, driven by a small net increase of 17 FTE during March, which does not represent a significant risk to salary costs moving into 20/21, and £0.1m additional costs to cover Covid 19 and winter pressures.

# Workforce: Staff Groups



## Key Messages

The above graphs do not include the assumed vacancy factor incorporated into the overall plan. Increases in March, dominated by annual leave cover and additional shifts responding to COVID-19.

Medical Staffing FTE increased with additional hours worked by WestCall GPs in response to COVID-19.

Contracted Nursing numbers increased marginally, with appointments in Community Nursing, District Nursing and across Community Wards. A significantly larger increase was seen across a number of areas with higher levels of temporary staffing covering annual leave commitments and shifts covering COVID-19 absences.

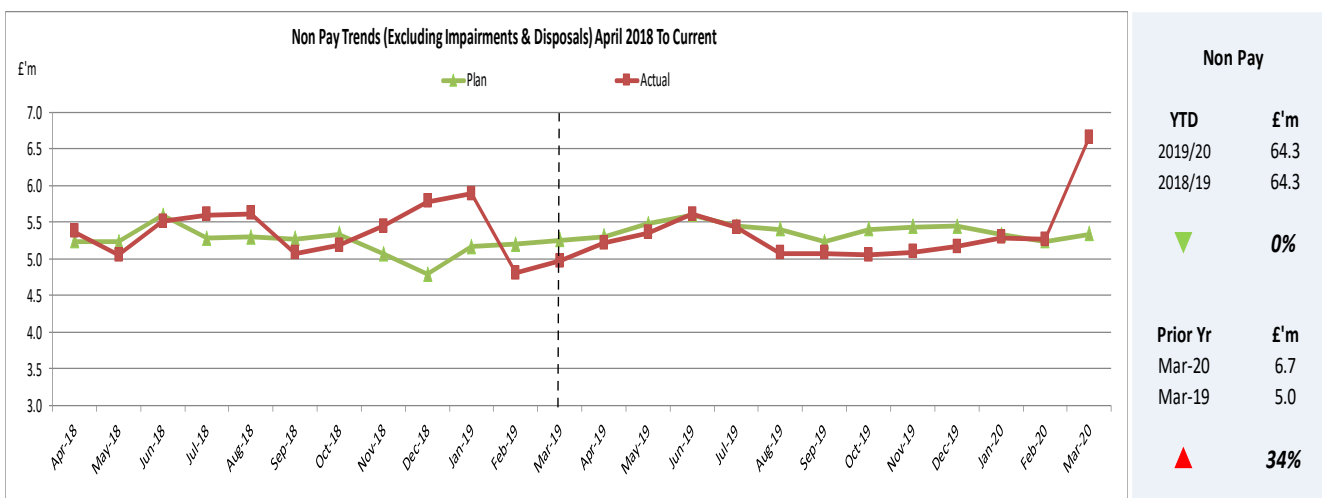
Other Clinical Staff numbers increased with additional hours worked by IAPT and recruitment in CAMHS.

Facilities & Estates staffing numbers showed a marked increase with recruitment in Domestic at Upton and Willow House and increased use of temporary staffing across all sites due to Covid 19.

Supporting Clinical Staff saw recruitment in Health Visiting, CAMHS and at PPH as well as additional shifts supporting the response to COVID-19.

# Non Pay Expenditure

Non Pay	In Month			YTD			FY			Prior YTD			
	Act	Plan	Var	Act	Plan	Var	Forecast	Plan	Forecast Var	Act	Var		
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	+/-	%	
Purchase of Healthcare:													
- Placement Costs	0.8	0.8	0.0	10.0	9.8	0.2	10.0	9.8	0.3	12.2	(2.2)	(17.8)%	
- All Other P. of Healthcare	0.5	0.4	0.1	4.7	4.4	0.3	4.6	4.4	0.2	3.4	1.3	37.3%	
Drugs	0.4	0.6	(0.1)	5.4	6.7	(1.3)	5.5	6.7	(1.2)	5.9	(0.5)	(8.1)%	
Premises	2.2	1.3	0.9	17.3	15.1	2.2	16.4	15.1	1.3	15.4	2.0	12.7%	
Supplies and services – clinical	0.5	0.4	0.1	4.7	4.9	(0.3)	4.7	4.9	(0.2)	5.2	(0.5)	(9.7)%	
Transport	0.3	0.3	(0.0)	3.3	3.5	(0.2)	3.2	3.5	(0.2)	3.2	0.1	4.5%	
Establishment	0.3	0.3	0.1	3.5	3.2	0.3	3.4	3.2	0.3	3.9	(0.5)	(11.6)%	
Other Non Pay	1.1	0.9	0.2	9.0	10.4	(1.4)	7.9	10.4	(2.5)	8.9	0.1	1.1%	
PFI Lease	0.5	0.6	(0.0)	6.5	6.7	(0.3)	6.6	6.7	(0.2)	6.4	0.1	1.5%	
<b>Total Non Pay</b>	<b>6.7</b>	<b>5.3</b>	<b>1.3</b>	<b>64.3</b>	<b>64.7</b>	<b>(0.4)</b>	<b>62.4</b>	<b>64.7</b>	<b>(2.2)</b>	<b>64.3</b>	<b>(0.0)</b>	<b>(0.0)%</b>	



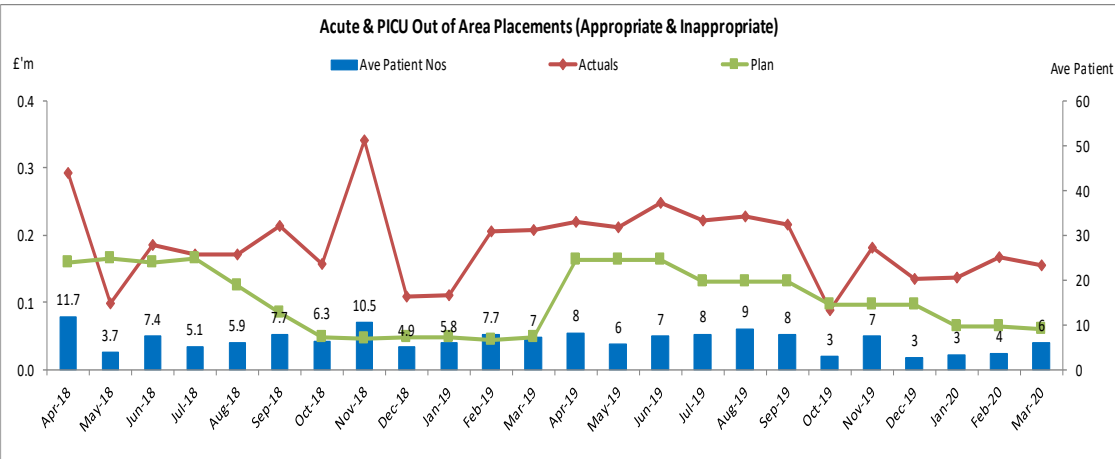
## Key Messages

Overall the Trust contained Non Pay costs within budget this year. Although costs increased markedly in March, by £1.4m, this included a number of one-off items, movements in provisions and £0.1m of COVID-19 related costs. It is therefore not assumed to reflect an increase in underlying cost run-rate.

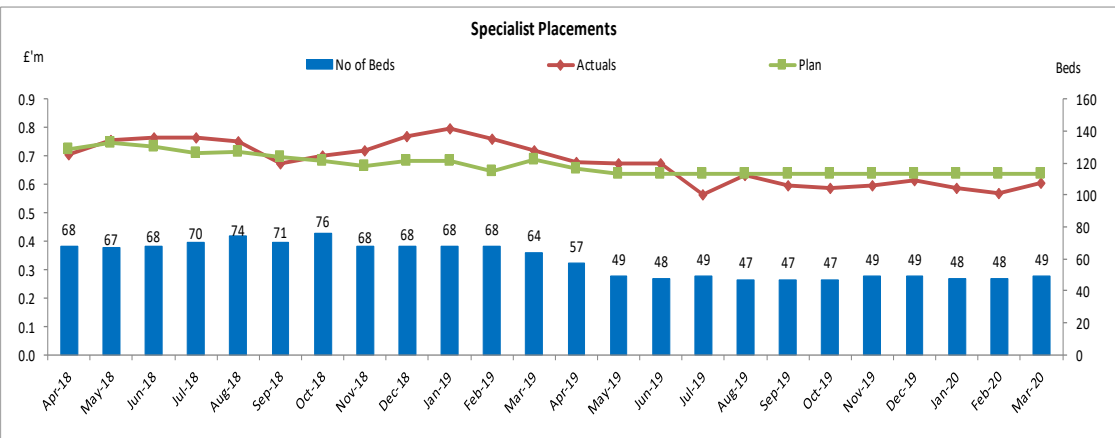
The Trust continued to have more 'Out of Area Placements' than planned in March. Overall costs only rose by £10k in March due to the step down of a costly PICU placement. Whilst the number of 'Out of Area Placements' remains higher than hoped, overall placement costs have reduced significantly this year, with a total reduction of £2.2m over all categories.

Other key movements this month include £0.2m capital to revenue adjustments, £0.1m VAT adjustment and £0.2m accrual for IT network upgrades.

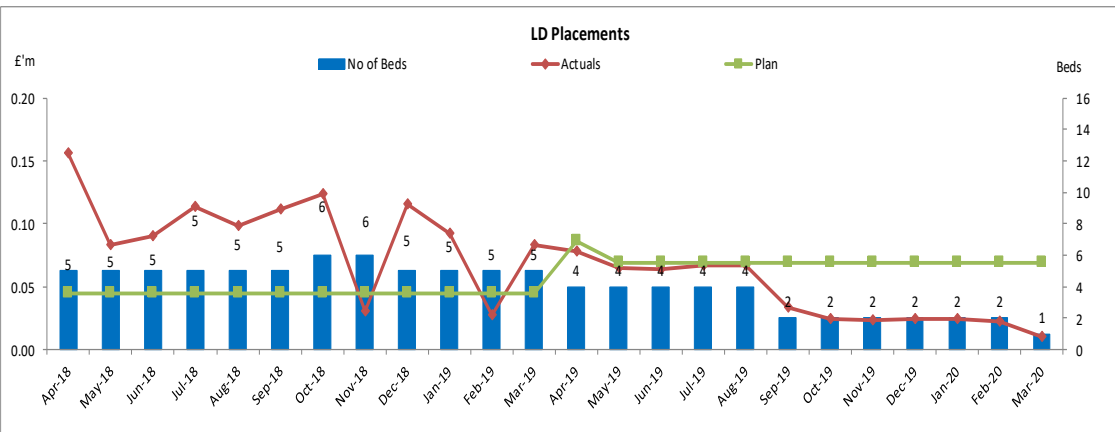
# Non Pay Expenditure - Placement Costs



Non Pay	
YTD	£'m
2019/20	2.2
2018/19	2.3
	<b>-2%</b>
Prior Yr	£'m
Mar-20	0.2
Mar-19	0.2
	<b>-25%</b>



Non Pay	
YTD	£'m
2019/20	7.4
2018/19	8.9
	<b>-17%</b>
Prior Yr	£'m
Mar-20	0.6
Mar-19	0.7
	<b>-16%</b>



Non Pay	
YTD	£'m
2019/20	0.5
2018/19	1.1
	<b>-55%</b>
Prior Yr	£'m
Mar-20	0.0
Mar-19	0.1
	<b>-88%</b>

## Key Messages

**Out of Area Placement.** The average number of placements increased in March from 3.5 to 5.9 however the costs decreased in March due to the step down of one high cost PICU placement. Spend in 19/20 was £0.9m higher than budget but £0.1m lower than in than 18/19.

**Specialist Placement** costs were £35k below plan. March costs were £35k higher than February reflecting the longer month however 19/20 costs were £1.5m lower than 18/19 which reflect savings made in year including the bed reduction at Cloisters.

**LD Placement** costs continue to be lower than planned levels driven by lower placement numbers with March being £59k lower than plan. Spend was £0.3m below plan YTD and reflects a £0.6m reduction vs 18/19.



## 3.0 Cost Improvement Programme

Scheme	In Month			YTD			Full Year		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Forecast £'m	Plan £'m	Var £'m
<b>Placement Projects</b>									
Inappropriate Out of Area Placements	0.01	0.14	(0.13)	0.77	1.00	(0.23)	0.77	1.00	(0.23)
Long Term Specialist Placement Contracts	0.12	0.09	0.03	1.16	1.02	0.13	1.16	1.02	0.13
<b>Total OAPS Saving</b>	<b>0.13</b>	<b>0.22</b>	<b>(0.10)</b>	<b>1.93</b>	<b>2.02</b>	<b>(0.09)</b>	<b>1.93</b>	<b>2.02</b>	<b>(0.09)</b>
<b>Operations</b>									
CRHTT	0.00	0.01	(0.01)	0.00	0.10	(0.10)	0.00	0.10	(0.10)
<b>Total Service Line Savings</b>	<b>0.00</b>	<b>0.01</b>	<b>(0.01)</b>	<b>0.00</b>	<b>0.10</b>	<b>(0.10)</b>	<b>0.00</b>	<b>0.10</b>	<b>(0.10)</b>
<b>Procurement</b>									
Procurement Spend	0.00	0.03	(0.03)	0.14	0.30	(0.16)	0.14	0.30	(0.16)
NHS Supply Chain	0.01	0.02	(0.01)	0.06	0.25	(0.18)	0.06	0.25	(0.18)
Medicine Optimisation	0.01	0.00	0.00	0.08	0.05	0.03	0.08	0.05	0.03
<b>Total Procurement Savings</b>	<b>0.02</b>	<b>0.06</b>	<b>(0.04)</b>	<b>0.28</b>	<b>0.60</b>	<b>(0.31)</b>	<b>0.28</b>	<b>0.60</b>	<b>(0.31)</b>
<b>Contracts</b>									
Sexual Health	0.00	0.04	(0.04)	0.00	0.43	(0.43)	0.00	0.43	(0.43)
Liaison & Diversion Hampshire	0.08	0.03	0.05	0.88	0.62	0.26	0.88	0.62	0.26
Veterans	0.01	0.01	0.00	0.30	0.27	0.03	0.30	0.27	0.03
<b>Total Other Savings</b>	<b>0.10</b>	<b>0.08</b>	<b>0.02</b>	<b>1.18</b>	<b>1.32</b>	<b>(0.14)</b>	<b>1.18</b>	<b>1.32</b>	<b>(0.14)</b>
<b>Total CIP Delivery (NHSi Plan)</b>	<b>0.24</b>	<b>0.37</b>	<b>(0.13)</b>	<b>3.39</b>	<b>4.04</b>	<b>(0.65)</b>	<b>3.39</b>	<b>4.04</b>	<b>(0.65)</b>
<b>Internal Stretch</b>									
Long Term Placements (LD)	0.07	0.03	0.04	0.56	0.30	0.26	0.56	0.30	0.26
Immunisations Technology	0.02	0.02	(0.00)	0.19	0.14	0.05	0.19	0.14	0.05
Contract - SLT	0.01	0.01	0.00	0.06	0.06	0.00	0.06	0.06	0.00
Corporate Benchmarking	0.00	0.02	(0.02)	0.00	0.15	(0.15)	0.00	0.15	(0.15)
Temporary Staffing	0.01	0.02	(0.01)	0.16	0.20	(0.04)	0.16	0.20	(0.04)
NHSPS VAT	0.00	0.06	(0.06)	0.00	0.62	(0.62)	0.00	0.62	(0.62)
PFI Benchmarking Review	0.00	0.01	(0.01)	0.00	0.13	(0.13)	0.00	0.13	(0.13)
Carter - eRoster	0.00	0.02	(0.02)	0.00	0.10	(0.10)	0.00	0.10	(0.10)
New Contract - Community Health West	0.01	0.00	0.01	0.15	0.00	0.15	0.15	0.15	0.00
New Contract - Community Health East	0.00	0.00	0.00	0.03	0.00	0.03	0.03	0.03	0.00
New Contract - Mental Health West	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
New Contract - CYPF	0.01	0.00	0.01	0.07	0.00	0.07	0.07	0.07	0.00
Unidentified	0.00	0.05	(0.05)	0.00	0.30	(0.30)	0.00	0.06	(0.06)
<b>Total CIP Delivery (Internal Stretch)</b>	<b>0.12</b>	<b>0.24</b>	<b>(0.12)</b>	<b>1.21</b>	<b>2.00</b>	<b>(0.79)</b>	<b>1.21</b>	<b>2.00</b>	<b>(0.79)</b>
<b>Total CIP Delivery</b>	<b>0.36</b>	<b>0.61</b>	<b>(0.25)</b>	<b>4.60</b>	<b>6.04</b>	<b>(1.44)</b>	<b>4.60</b>	<b>6.04</b>	<b>(1.44)</b>

### Key Messages

The Trust has delivered £4.6m of savings in 19/20 surpassing its NHSi committed plan of £4.0m.

The Trust delivered or bettered its planned savings in a number of areas this year, with specialist and LD placement savings being of particular note. Schemes that have not delivered have done so for a combinations of factors including capacity in the case of Procurement, known challenges in implementing a new operating model in Sexual Health, and agreed slippage to manage risk in relation to the NHSPS VAT saving.

The Trust was £1.4m short of delivering its own 'Internal Stretch' target of £6.0m. It should be noted that planning for savings in excess of our NHSi commitment, ensured its delivery this year.

With Operating Planning suspended, there is no efficiency requirement during the current pause period. We await guidance on the return to business as usual, and will ensure that the work undertaken on the previous 20/21 programme is able to be re-started, including capturing delivered savings which will deliver from April.

## 4.0 Balance Sheet & Cash & CapEx

Balance Sheet	18/19	Current Month			YTD			19/20
	Actual £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Intangibles	5.2	6.8	6.3	0.5	6.8	6.3	0.5	6.3
Property, Plant & Equipment (non PFI)	37.7	37.5	36.4	1.1	37.5	36.4	1.1	36.4
Property, Plant & Equipment (PFI)	59.8	57.3	65.4	(8.1)	57.3	65.4	(8.1)	65.4
<b>Total Non Current Assets</b>	<b>102.7</b>	<b>101.6</b>	<b>108.1</b>	<b>(6.5)</b>	<b>101.6</b>	<b>108.1</b>	<b>(6.5)</b>	<b>108.1</b>
Trade Receivables & Accruals	11.8	11.4	10.8	0.6	11.4	10.8	0.6	10.8
Other Receivables	0.2	0.2	0.3	(0.1)	0.2	0.3	(0.1)	0.3
Cash	25.6	26.4	23.2	3.2	26.4	23.2	3.2	23.2
Trade Payables & Accruals	(23.9)	(24.8)	(28.1)	3.3	(24.8)	(28.1)	3.3	(28.1)
Current PFI Finance Lease	(1.2)	(1.5)	(1.5)	0.0	(1.5)	(1.5)	0.0	(1.5)
Other Current Payables	(2.7)	(2.9)	(2.3)	(0.7)	(2.9)	(2.3)	(0.7)	(2.3)
<b>Total Net Current Assets / (Liabilities)</b>	<b>9.6</b>	<b>8.9</b>	<b>2.4</b>	<b>6.4</b>	<b>8.9</b>	<b>2.4</b>	<b>6.4</b>	<b>2.4</b>
Non Current PFI Finance Lease	(28.5)	(27.0)	(27.0)	0.0	(27.0)	(27.0)	0.0	(27.0)
Other Non Current Payables	(1.5)	(1.8)	(1.6)	(0.2)	(1.8)	(1.6)	(0.2)	(1.6)
<b>Total Net Assets</b>	<b>82.4</b>	<b>81.7</b>	<b>81.9</b>	<b>(0.2)</b>	<b>81.7</b>	<b>81.9</b>	<b>(0.2)</b>	<b>81.9</b>
Income & Expenditure Reserve	28.1	29.1	26.6	2.5	29.1	26.6	2.5	26.6
Public Dividend Capital Reserve	18.0	19.2	18.3	1.0	19.2	18.3	1.0	18.3
Revaluation Reserve	36.2	33.4	37.0	(3.6)	33.4	37.0	(3.6)	37.0
<b>Total Taxpayers Equity</b>	<b>82.4</b>	<b>81.7</b>	<b>81.9</b>	<b>(0.2)</b>	<b>81.7</b>	<b>81.9</b>	<b>(0.2)</b>	<b>81.9</b>

### Key Messages

The closing cash balance for 19/20 was £26.4m, £3.2m higher than planned. This is the result of £2.1m unplanned 18/19 PSF bonus, £0.6m central MH funding and Capital expenditure being less than planned.

The Trust finished the year spending £10.3m on capital assets, £1.7m less than planned. The sign off of works at Erleigh House was delayed resulting in recognised spend being £0.9m less than forecast by the YE.

The annual revaluation of the Trusts assets resulting in an overall decrease, with £3m being written off the to the revaluation reserve and a further £1.7m relating to work carried out at Abel Gardens and Erleigh House being absorbed in the I&E.

Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
<b><u>Estates Maintenance &amp; Replacement Expenditure</u></b>							
STC Phase 3/Erleigh House	380	300	80	2,305	3,200	(895)	3,200
LD to Jasmine	0	290	(290)	8	1,533	(1,525)	1,533
Abel Gardens - Mobility Relocation	10	0	10	333	394	(60)	388
Wokingham Willow House Projects	313	0	313	342	0	342	0
PPH Ligature Removal Works	0	0	0	254	250	4	250
PPH Willow House	0	0	0	182	0	182	0
Trust Owned Properties	45	0	45	162	135	27	147
Leased Non Commercial (NHSPS)	140	0	140	543	388	155	382
Leased Commercial	(0)	0	(0)	0	0	0	0
Statutory Compliance	68	0	68	123	200	(77)	200
PFI	266	0	266	403	580	(177)	580
<b>Subtotal Estates Maintenance &amp; Replacement</b>	<b>1,221</b>	<b>590</b>	<b>631</b>	<b>4,656</b>	<b>6,680</b>	<b>(2,024)</b>	<b>6,680</b>
<b><u>IM&amp;T Expenditure</u></b>							
IM&T Business Intelligence and Reporting	118	0	118	267	320	(53)	320
IM&T System & Network Developments	157	0	157	2,437	2,415	22	2,415
IM&T Other	(1)	0	(1)	29	30	(1)	30
IM&T Locality Schemes	103	0	103	592	55	537	55
HSLI Community Mobile Working	16	20	(4)	231	239	(8)	239
HSLI Bed Management	107	0	107	161	0	161	0
HSLI Ward Digitalisation	60	0	60	81	0	81	0
<b>Subtotal IM&amp;T Expenditure</b>	<b>559</b>	<b>20</b>	<b>539</b>	<b>3,799</b>	<b>3,059</b>	<b>740</b>	<b>3,059</b>
<b><u>GDE Expenditure</u></b>							
GDE Trust Funded	0	0	0	795	795	0	795
GDE Trust Funded	153	127	(4)	894	1,258	(364)	1,258
<b>Subtotal GDE Expenditure</b>	<b>153</b>	<b>127</b>	<b>(4)</b>	<b>1,689</b>	<b>2,053</b>	<b>(364)</b>	<b>2,053</b>
Other Locality Schemes	10	42	(32)	128	150	(22)	150
<b>Total Capital Expenditure</b>	<b>1,942</b>	<b>779</b>	<b>1,133</b>	<b>10,271</b>	<b>11,942</b>	<b>(1,671)</b>	<b>11,942</b>



### Trust Board Paper

<b>Board Meeting Date</b>	12 <sup>th</sup> May 2020
<b>Title</b>	<b>True North Performance Scorecard Month 12 (March 2020) 2019/20</b>
<b>Purpose</b>	To provide the Board with the latest available trust level performance information
<b>Business Area</b>	Trust-wide Performance
<b>Author</b>	Deputy Chief Executive and Chief Financial Officer
<b>Relevant Strategic Objectives</b>	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.
<b>CQC Registration/Patient Care Impacts</b>	All relevant essential standards of care.
<b>Resource Impacts</b>	None.
<b>Legal Implications</b>	None.
<b>Equality and Diversity Implications</b>	None.
<b>Summary</b>	<p>The True North Performance Scorecard for Month 12 2019/20 (March 2020) is included.</p> <p>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.</p> <p>The business rules apply to three different categories of metric:</p>

	<ul style="list-style-type: none"> <li>• <b>Driver metric:</b> the few key improvement drivers with target performance and will be the focus of meeting attention.</li> <li>• <b>Tracker Level 1 metric:</b> 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.</li> <li>• <b>Tracker metric:</b> 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.</li> </ul> <p><b>Note</b> - some performance indicators have been suspended due to national covid guidance (e.g. financial plan) or because of change in operational priorities and ability to collect data (e.g. FFT). These indicators are highlighted in grey.</p> <p><b>Month 12</b></p> <p><b>2019/20 business rule exceptions, red rated with the True North domain in brackets:</b></p> <p><b>Driver Metrics</b></p> <ul style="list-style-type: none"> <li>• Falls incidents in Community and Older Adult mental health Inpatient wards (<b>Harm Free Care</b>) - reduced falls incident target based on review. Donnington, Orchid, Rowan and Ascot wards are not achieving their targets. Majority of falls are unwitnessed in the bedroom. Countermeasure reviews to be updated by Prospect Park Hospital and Berkshire West community services.</li> <li>• Prone (Face Down) Restraint (<b>Patient Experience</b>) – report of three incidents (down from seven in February), including one at Willow House and one used during police return of a patient to Prospect Park Hospital. These are relatively low incident numbers at the start of a significantly reduced trend, further to improvement action over time.</li> <li>• Patient FFT Recommend rate (<b>Patient Experience</b>) – suspended, unable to collect data</li> <li>• Patient FFT Response rate (<b>Patient Experience</b>) - suspended, unable to collect data</li> </ul>
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	<ul style="list-style-type: none"> <li>• Mental Health Clustering (<b>Patient Experience</b>) – clustering information for MH patients remains important to understanding the needs and progress of individuals receiving care in our services. Executive reviewing priority focus of this indicator in context of current covid phase.</li> <li>• Physical Assaults on Staff (<b>Supporting our Staff</b>) - a single patient on Sorrell Ward (PICU) has driven the increase in month. The staff assault trend is downward for the year but can take just one unwell and challenging patient to affect performance. It remains a priority for the Prospect Park Hospital wards and countermeasures are regularly reviewed.</li> <li>• Mental Health: Acute Average Length of Stay (bed days) (<b>Money Matters</b>) – pressures continue on length of stay but remains a focus for teams.</li> <li>• Staff turnover (<b>Money Matters</b>) – has been split to show inclusion and exclusion of fixed-term contracts ending. Excluding fixed term contracts turnover indicator rates as green, including them rates as red. Review of fixed term contract use to understand levels of reliance across services. Fixed term contracts are used where new non recurrent service funding is provided by commissioners.</li> </ul> <p><b>Tracker Level 1 Metrics</b></p> <ul style="list-style-type: none"> <li>• A&amp;E: maximum wait of four hours from arrival to admission/transfer /discharge: % (<b>Regulatory Compliance</b>) – the WBCH Minor Injuries Unit in scope of this target, was affected by COVID-19 disruption in March impacting performance. It is expected that performance will recover for April.</li> <li>• Sickness Rate (<b>Regulatory Compliance</b>) – this is not a compliance focus with NHSI but is tracked. Notably during the initial covid 19 response in March and April, we have seen non covid sickness absence reducing (alongside covid absence). Reasons for this trend are being checked through HR and divisions.</li> </ul> <p><b>Tracker Metrics (where red for 4 months or more)</b></p> <ul style="list-style-type: none"> <li>• Pressure ulcers acquired due to lapse in (Community East) (<b>Harm Free Care</b>) – 180 days was achieved in year but has since reduced.</li> <li>• Statutory Training – Fire (<b>Supporting Our Staff</b>) – Executive agreed to hold this as a tracker metric as is close to the target. Ward</li> </ul>
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	level data now reported for inpatient units. Fire training compliance during initial covid response remains a safety priority, particularly with redeployed staff.
<b>Action</b>	The Board is asked to note the True North Scorecard.

## True North Performance Scorecard – Business Rules & Definitions

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

<b>Driver</b> - True North / break through objective that has been prioritised by the organisation as its area of focus	<b>Tracker Level 1</b> - metrics that have an impact due to regulatory compliance	<b>Tracker</b> - important metrics that require oversight but not focus at this stage in our performance methodology
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Rule #	Metric	Business Rule	Meeting Action
1	<b>Driver</b> is <b>Green</b> in current reporting period	Share success and move on	<b>No action</b> required
2	<b>Driver</b> is <b>Red</b> in current reporting period	Share top <b>contributing reason</b> , the amount this contributor impacts the metric, and <b>summary of initial action(s)</b> being taken	Standard structured <b>verbal</b> update
3	<b>Driver</b> is <b>Red</b> for <b>2+</b> reporting periods	Produce full structured <b>countermeasure summary</b>	Present full written <b>countermeasure analysis and summary</b>
4	<b>Driver</b> is <b>Green</b> for <b>6</b> reporting periods	Retire to <b>Tracker</b> level status	Standard structured <b>verbal</b> update and retire to <b>Tracker</b>
5	<b>Tracker 1 (or Tracker)</b> is <b>Green</b> in current reporting period	<b>No action</b> required	<b>No action</b> required
6	<b>Tracker</b> is <b>Red</b> in current reporting period	Note metric performance and move on unless they are a <b>Tracker Level 1</b>	If <b>Tracker Level 1</b> , then structured <b>verbal</b> update
7	<b>Tracker</b> is <b>Red</b> for <b>4</b> reporting periods	Switch to <b>Driver</b> metric	Switch and replace to <b>Driver</b> metric (decide on how to make capacity i.e. which <b>Driver</b> can be a <b>Tracker</b> )

## Performance Scorecard - True North Drivers (March 2020)

		Harm Free Care											
Metric	Target	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	19 per month	32	26	22	28	35	33	12	39	32	34	21	29
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	35	94	71	44	20	23	48	65	66	38	42	25
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	4	5	7	7	8	8	8	8	8	10	11	11
Number of suicides (per month)	Equal to or less than 3 per month	3	2	2	2	2	0	4	1	3	2	1	2
Gram Negative Bacteraemia	1 per ward per year	0	1	0	0	0	0	0	0	0	0	0	0
		Patient Experience											
Mental Health: Prone (Face Down) Restraint	2 per month	2	2	3	6	13	5	2	1	2	2	7	3
Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance	93%	92.2%	90.6%	92.4%	91.7%	94.1%	93.2%	93.4%	92.4%	88.9%	87.4%	91.9%
Patient FFT response rate: % [Suspended centrally due to COVID]	15% compliance	11%	12.5%	12.4%	12%	9.15%	10.9%	14.6%	12.1%	8.5%	10.6%	11.7%	5.51%
Mental Health Clustering within target: %	90% compliance	80.2%	79.3%	78.9%	77.7%	80.5%	80%	81.3%	81%	79.7%	81.2%	81.5%	80.6%

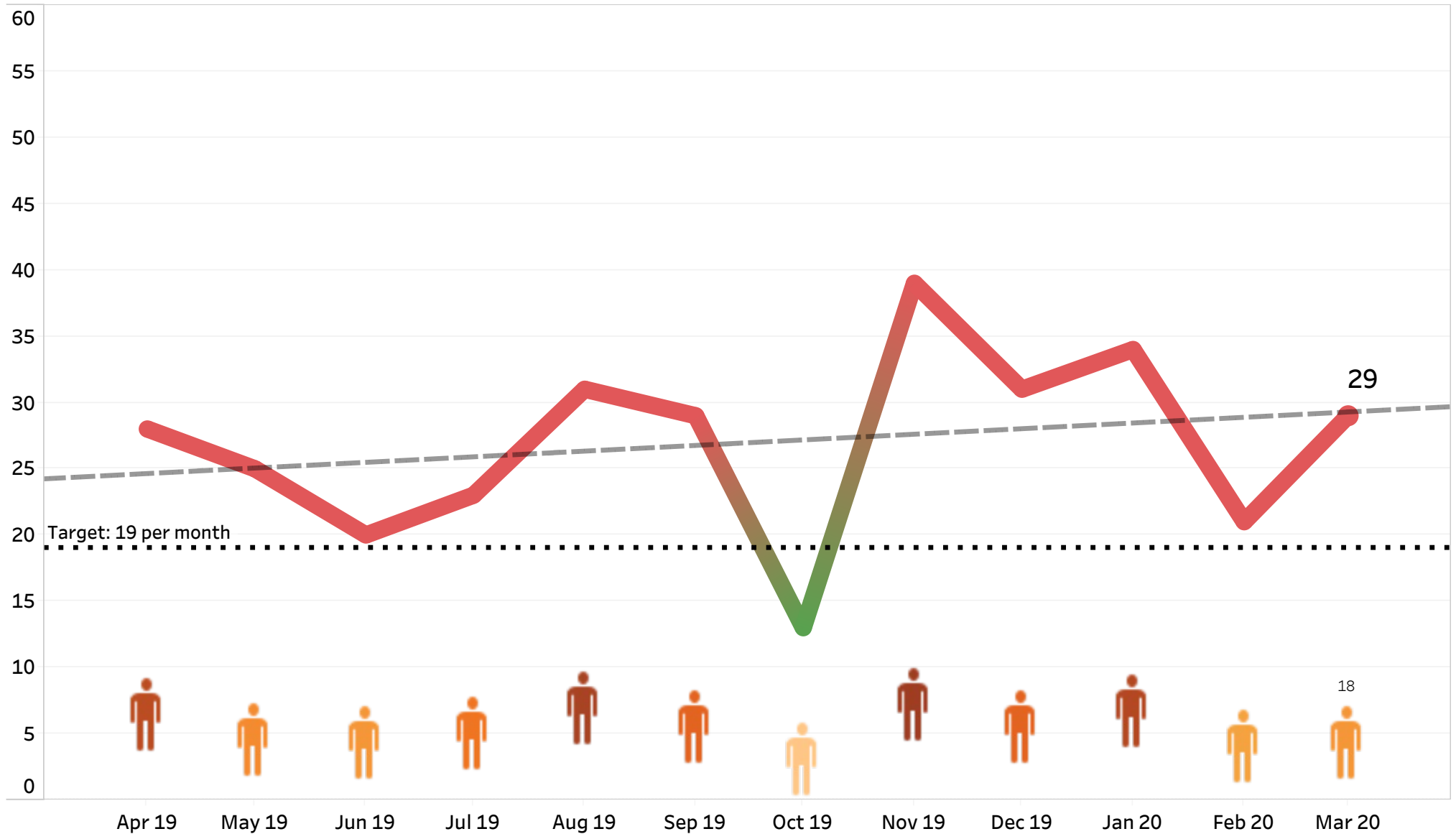


## Performance Scorecard - True North Drivers (March 2020)

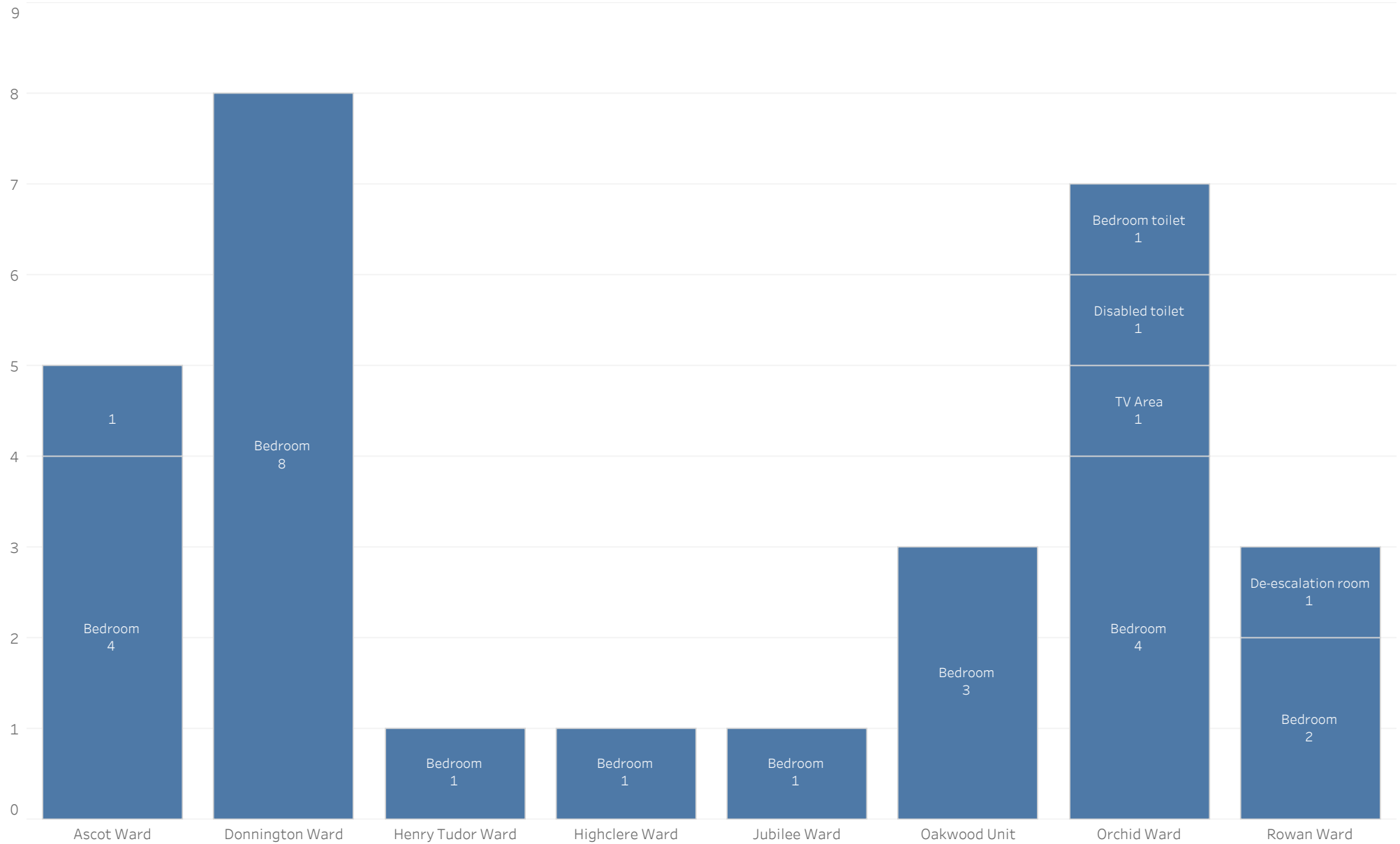
		Supporting our Staff											
Metric	Target	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Physical Assaults on Staff	44 per month	34	38	56	36	50	56	49	39	30	35	41	57
Staff Engagement Score (Annual Staff Survey) [Suspended centrally due to COVID]	Score of 10	7.29	7.29	7.29	7.29	7.29	7.29	7.29	7.29	7.29	7.40	7.29	7.29
		Money Matters											
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)	£0.25M	£0.46M	£1.17M	£1.63M	£2.02M	£2.36M	£2.66M	£3.19M	£3.51M	£3.90M	£4.24M	£4.60M
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]	-£0.4m	-£0.49M	-£0.56M	-£0.70M	-£0.70M	-£0.76M	-£0.60M	-£0.68M	-£0.81M	-£0.01M	-£0.20M	-£0.28M	£0.26M
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	95.9%	94.5%	97.8%	98.7%	97.0%	95.7%	94.4%	94.3%	91.9%	87.7%	92.6%	89.9%
Mental Health: Acute Average Length of Stay (bed days)	30 days	37	39	36	38	41	42	45	35	39	43	37	42
Staff turnover (excluding fixed term posts)	<16% per month	16.4%	16.0%	15.8%	15.8%	15.2%	14.6%	14.4%	14.2%	14.6%	14.6%	14.7%	14.7%
Staff turnover (including fixed-term posts)	<16% per month	17.4%	16.9%	16.5%	16.3%	15.8%	15.6%	15.6%	15.1%	15.6%	16.2%	16.6%	16.5%
Inappropriate Out of Area Placements	386 bed days (cumulative for Qtr)	136	207	288	109	266	412	29	163	177	49	101	149

# Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Apr 19 to Mar 20)

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

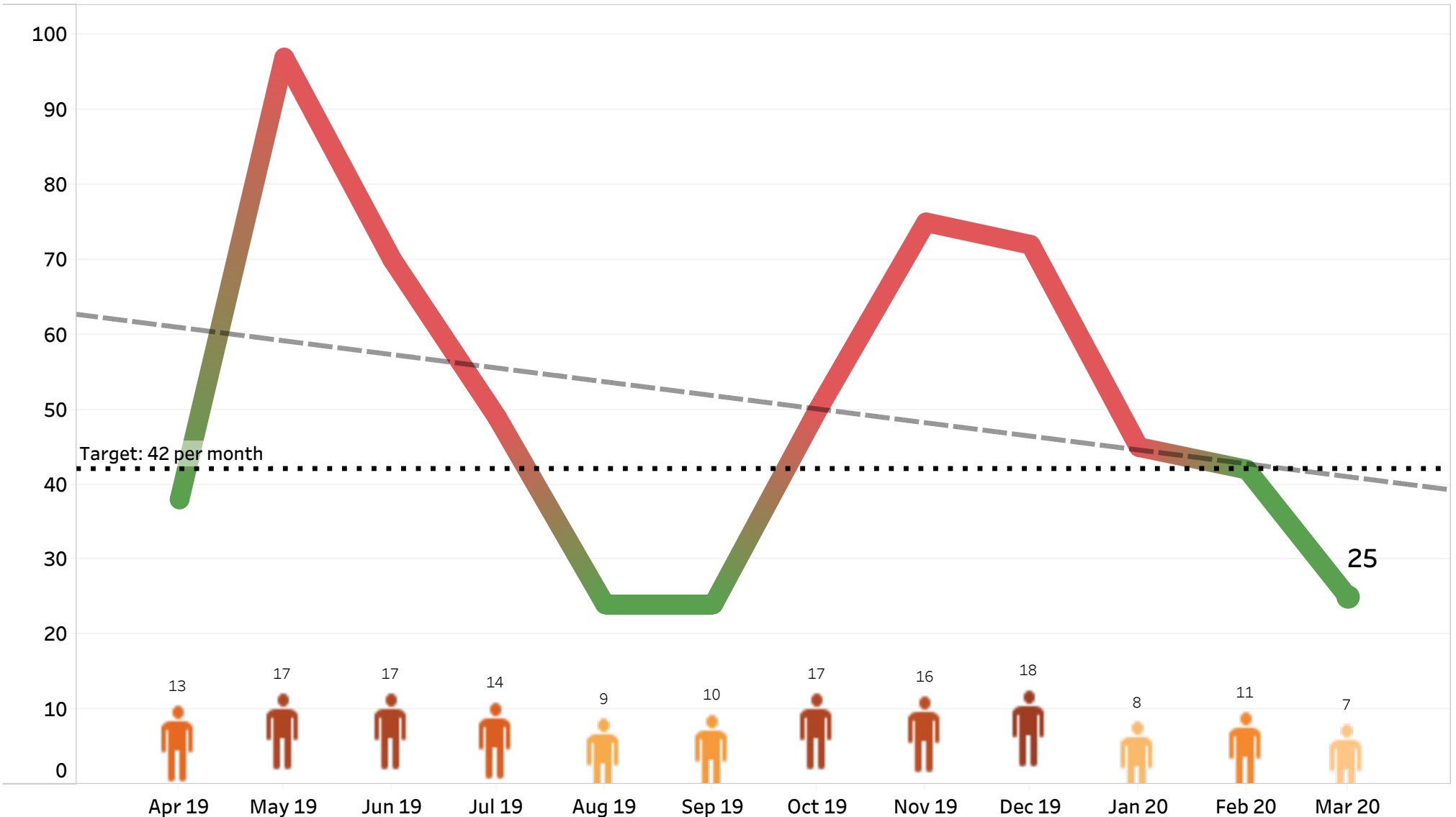


## Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (March)

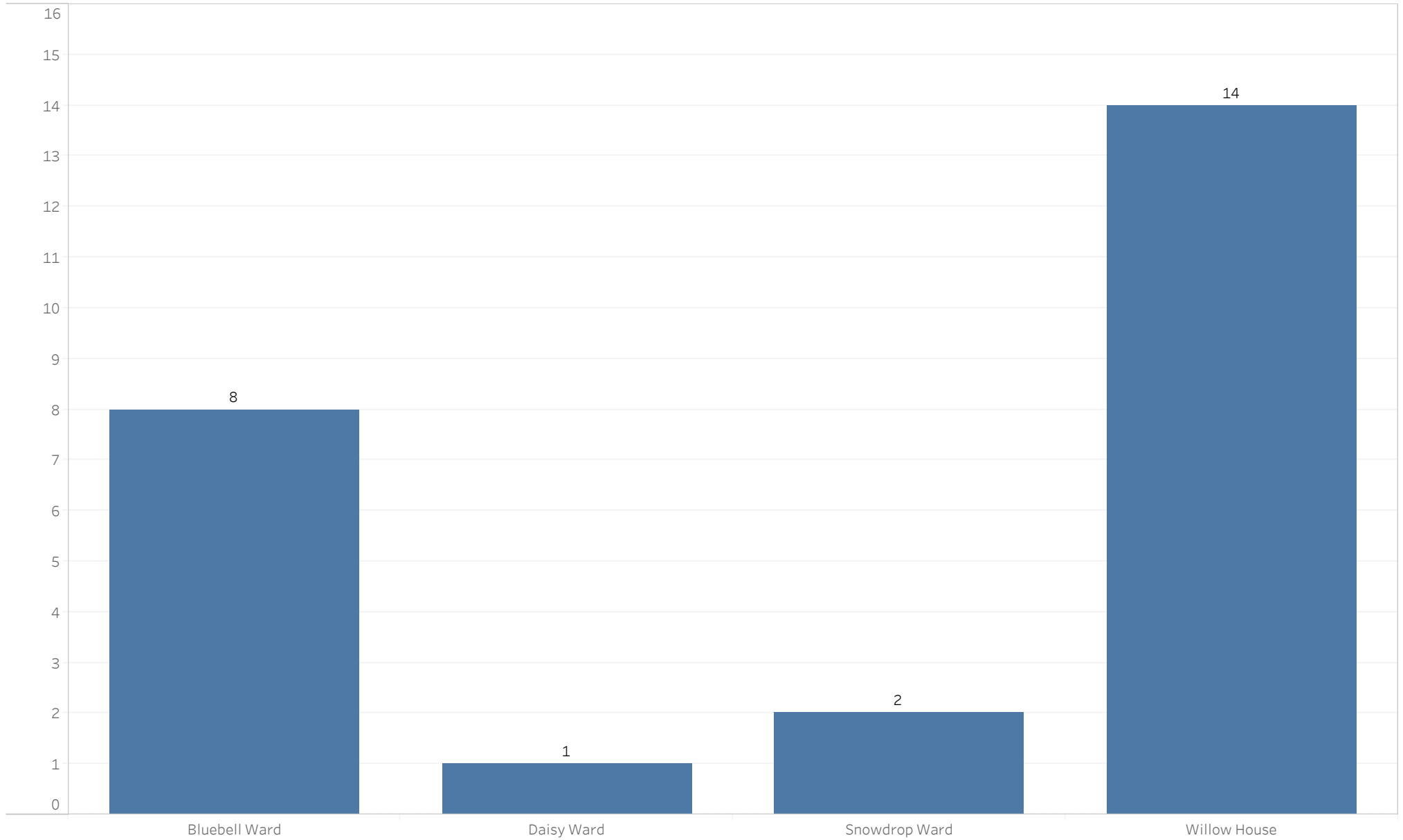


# Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Apr 19 to Mar 20)

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

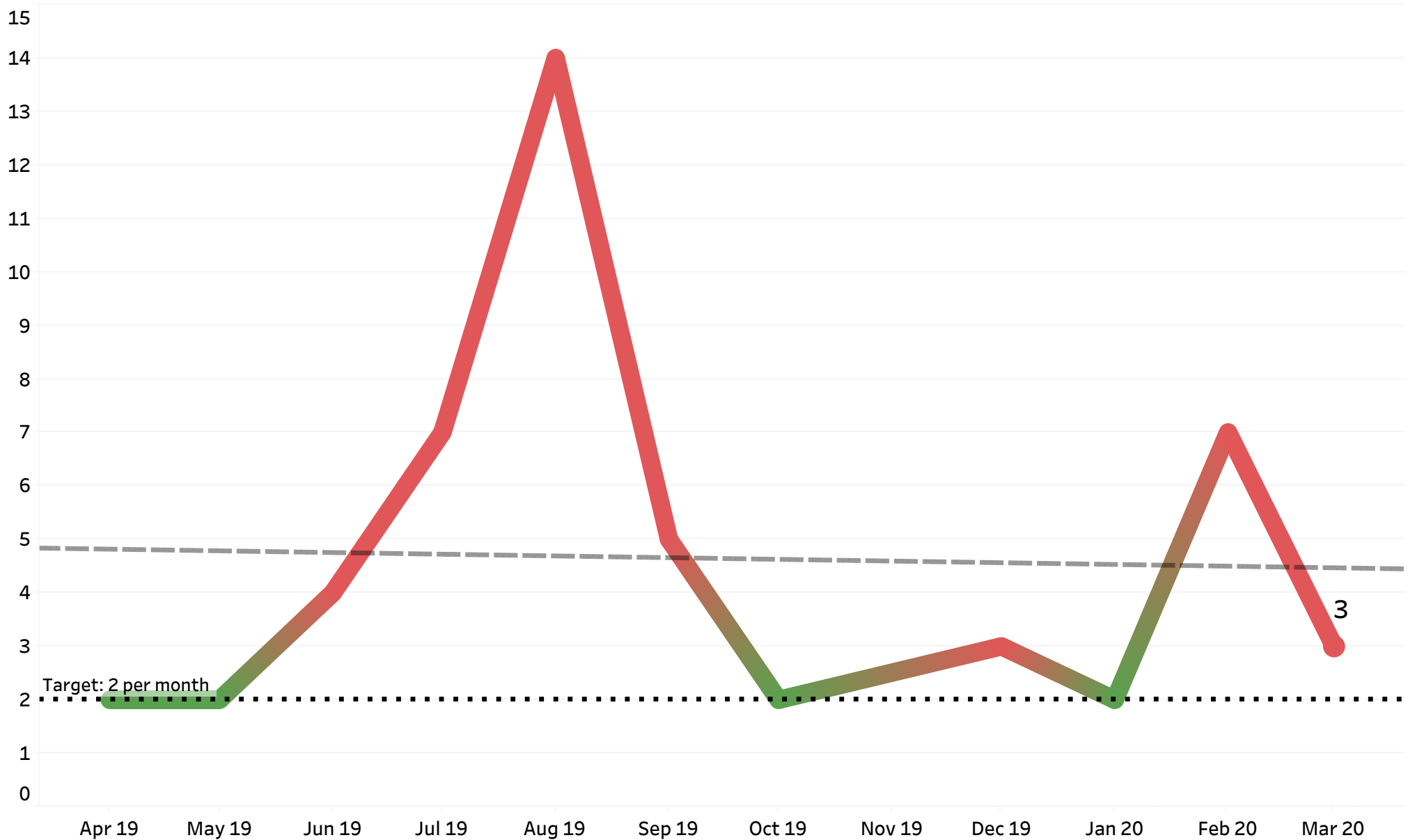


## Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (March)

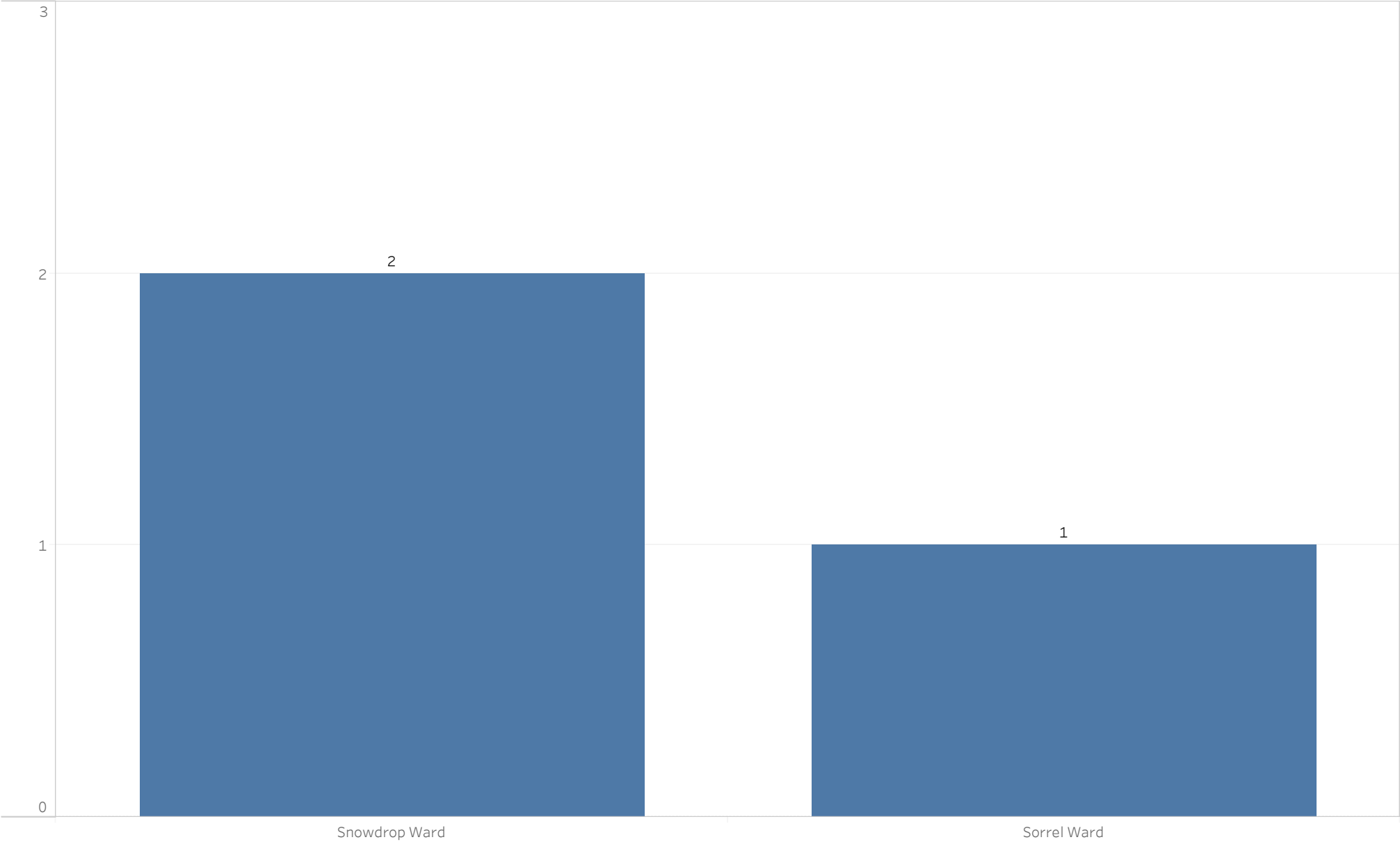


# Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Apr 19 to Mar 20)

(All approval statuses)

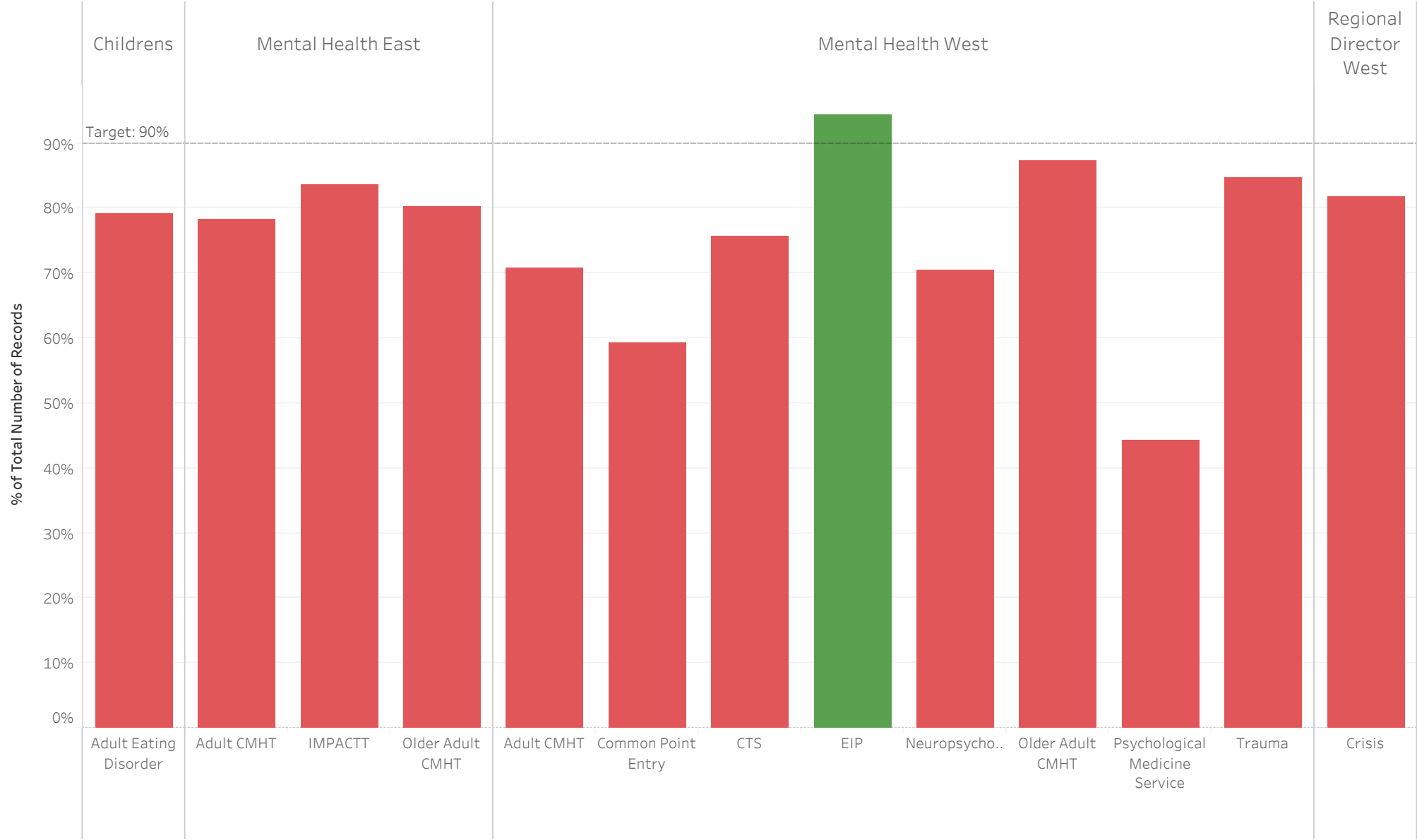


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (March)



# Patient Experience: Clustering breakdown (February)

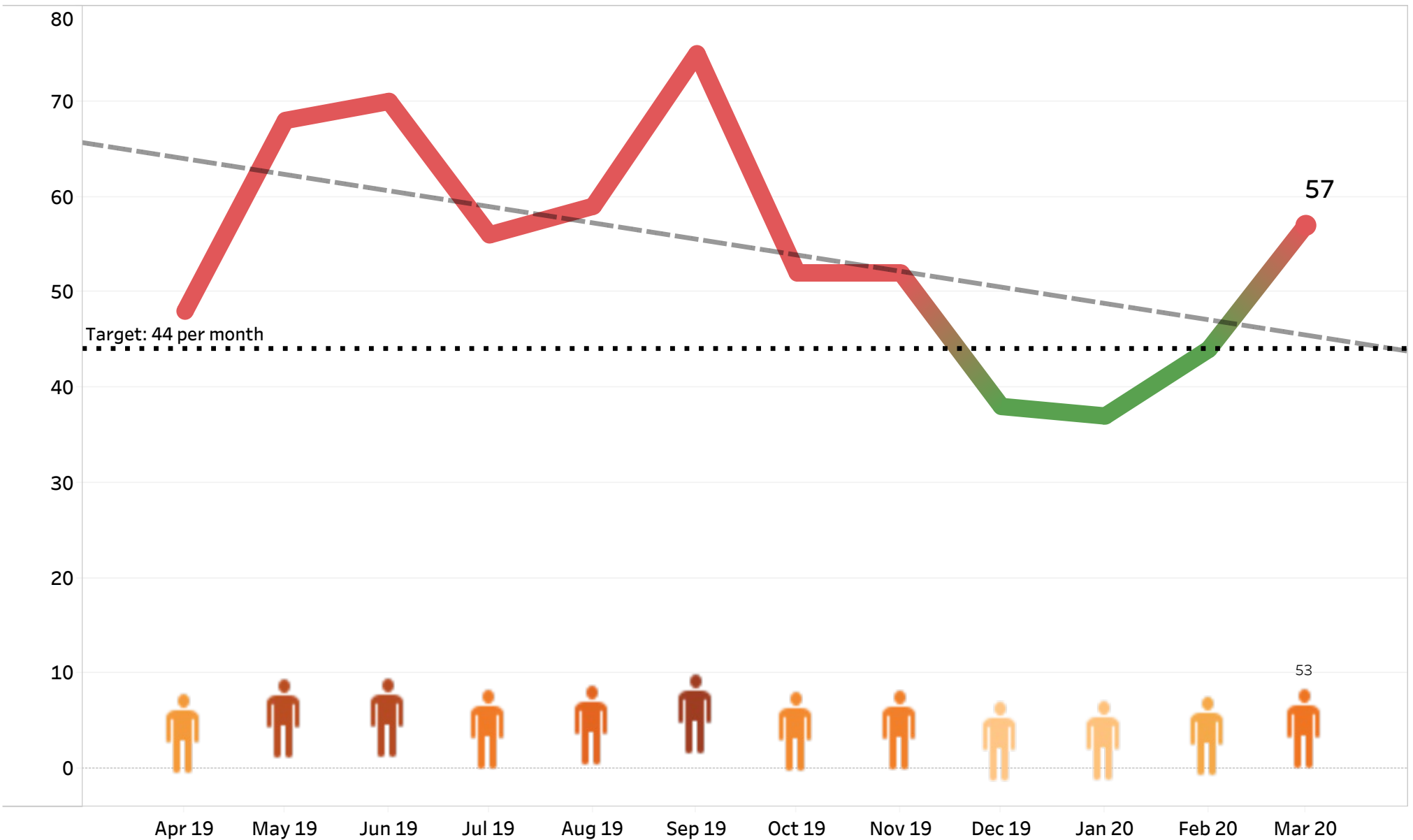
Outpatient Cluster Status (by Service)



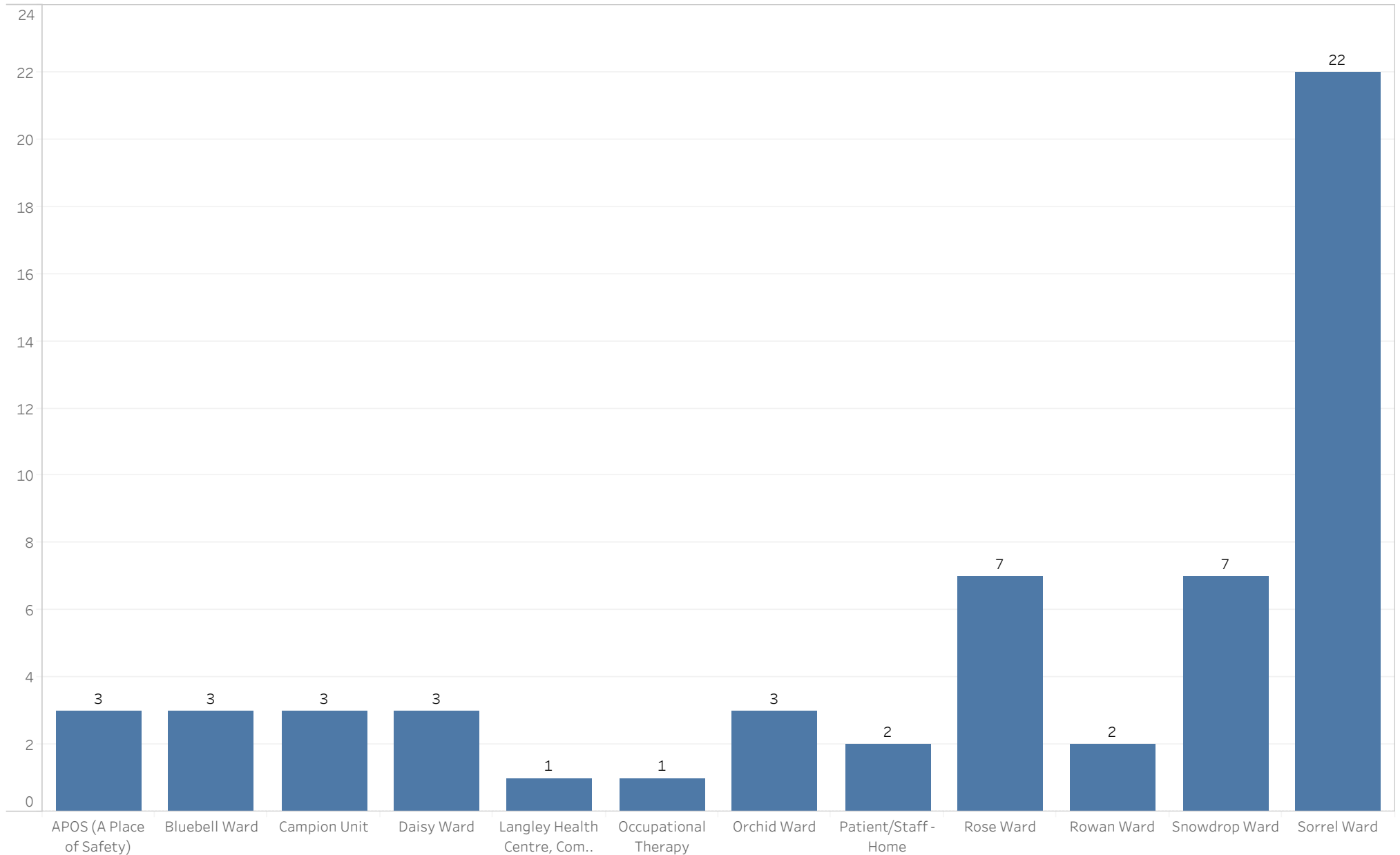


# Supporting Our Staff Driver: Physical Assaults on Staff (Apr 19 to Mar 20)

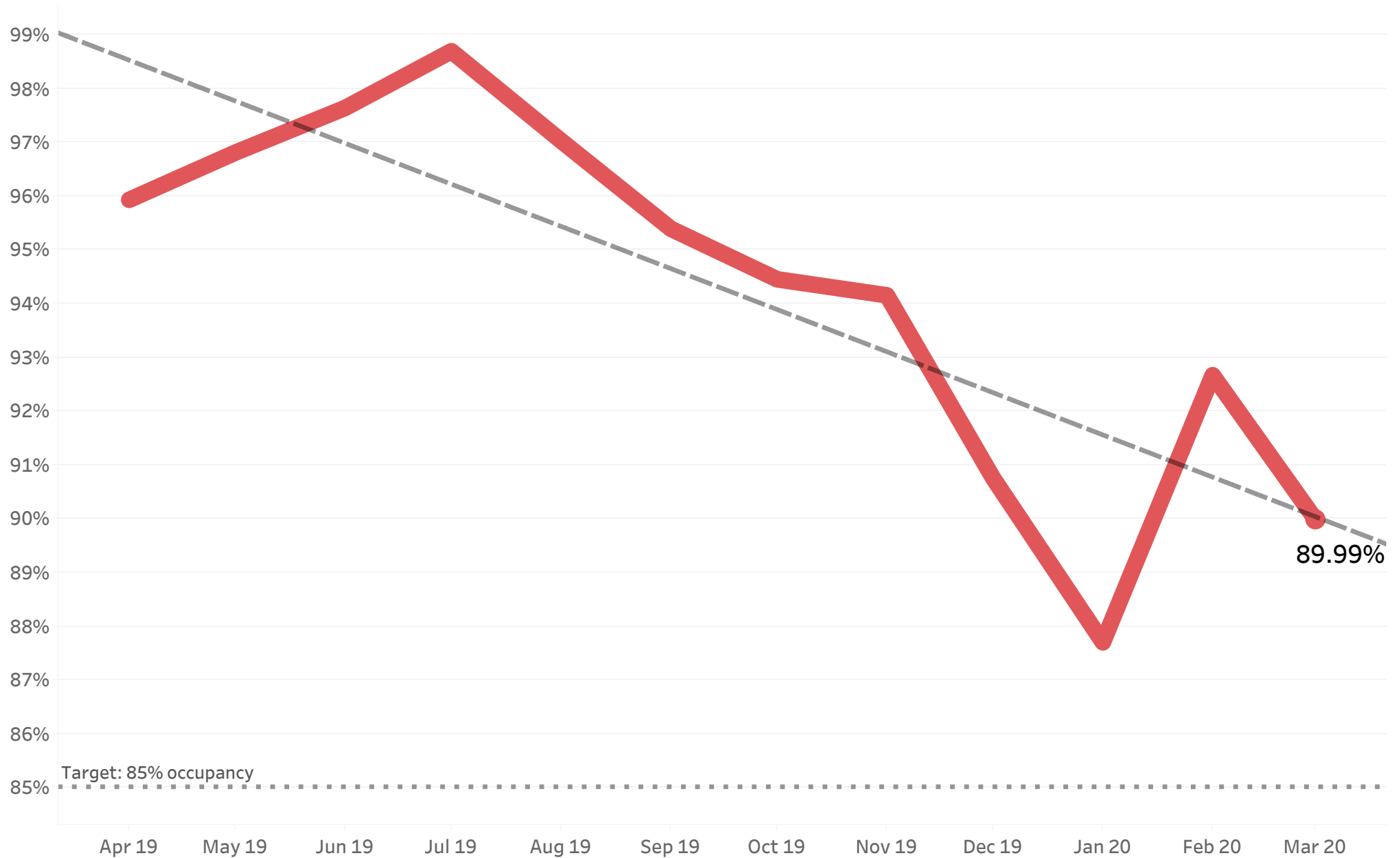
Any incident where sub-category = assault by patient and incident type = staff



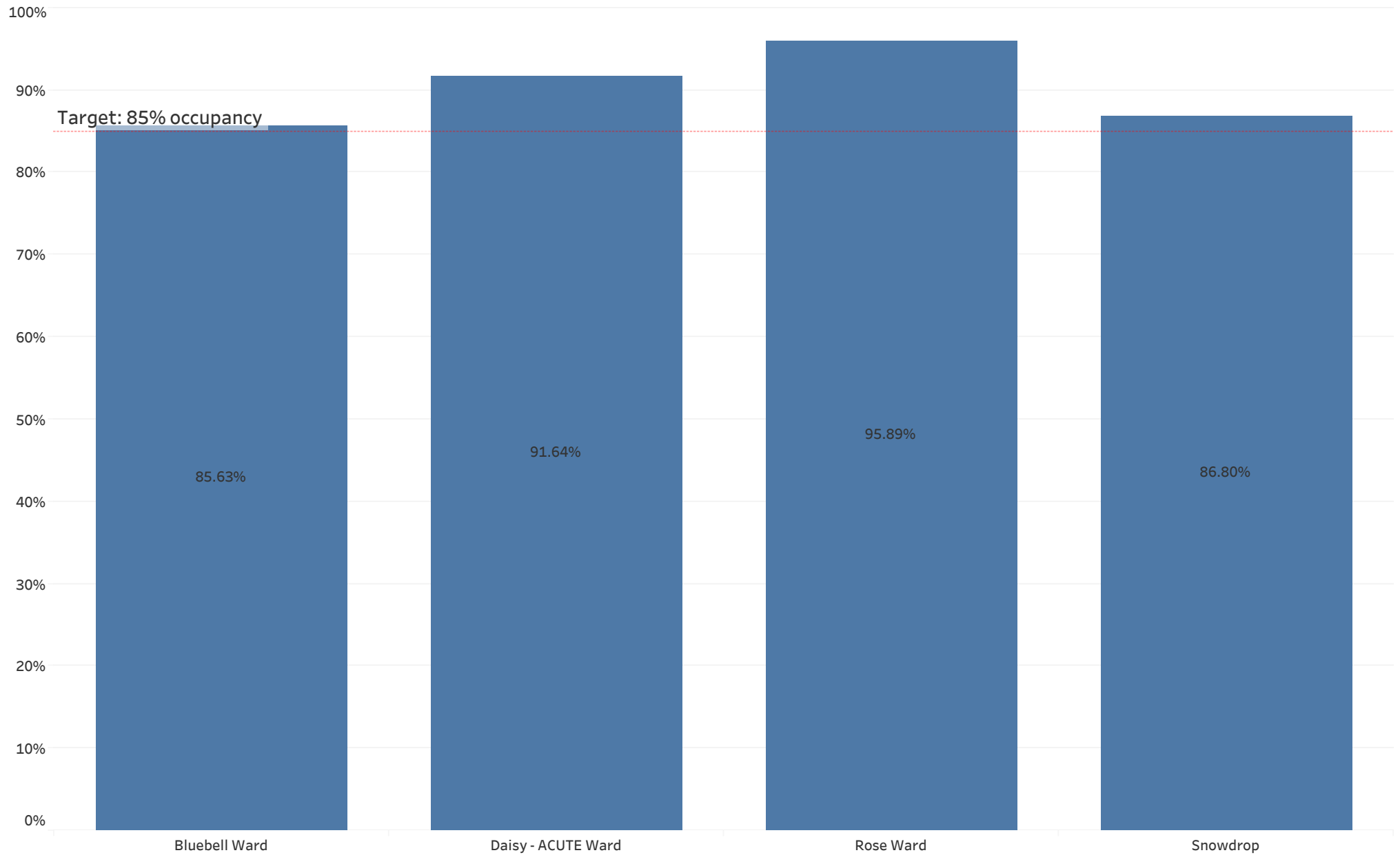
## Supporting Our Staff Driver: Physical Assaults on Staff by Location (March 2020)



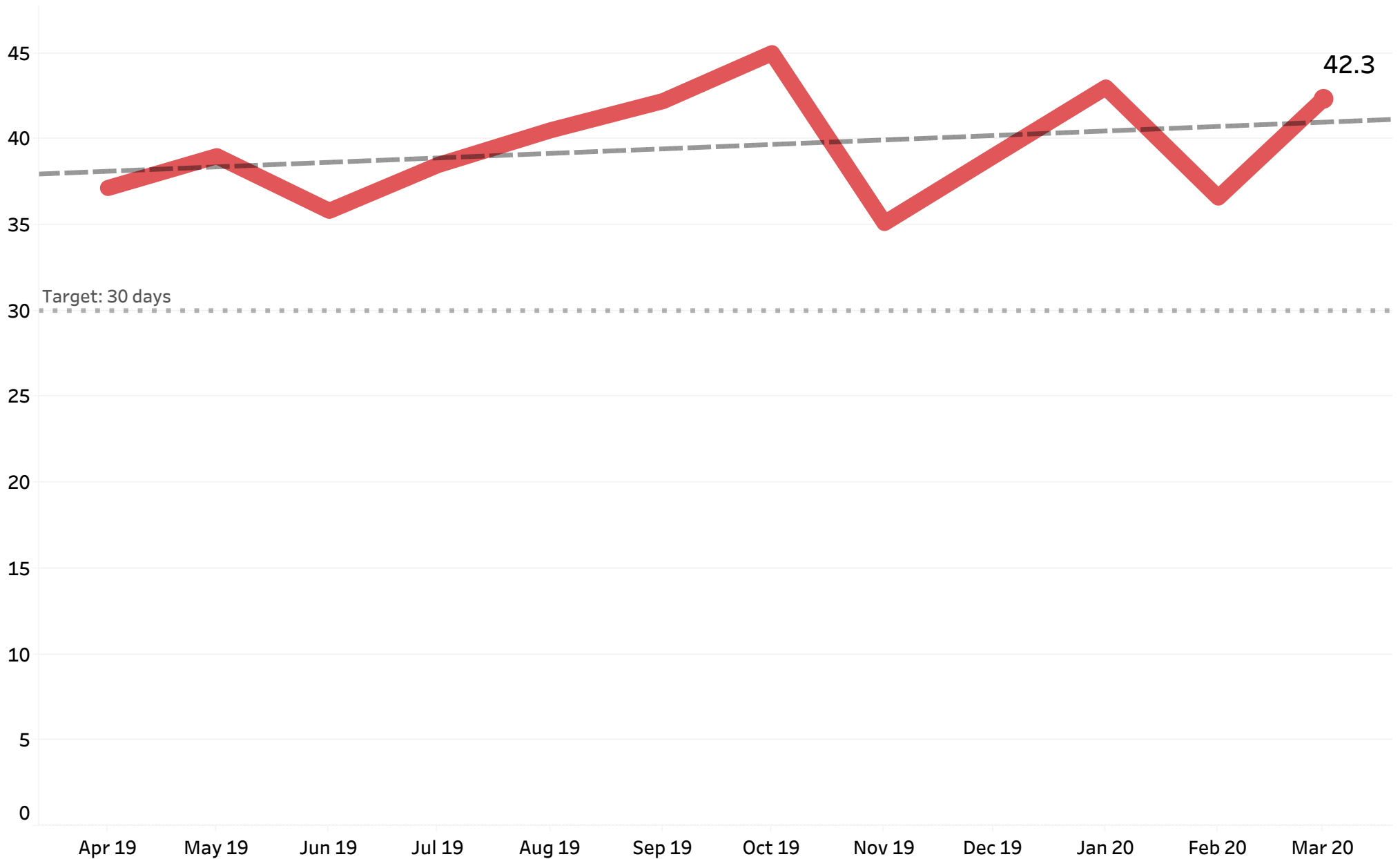
# Money Matters: Mental Health Acute Bed Occupancy Rate (Apr 19 to Mar 20)



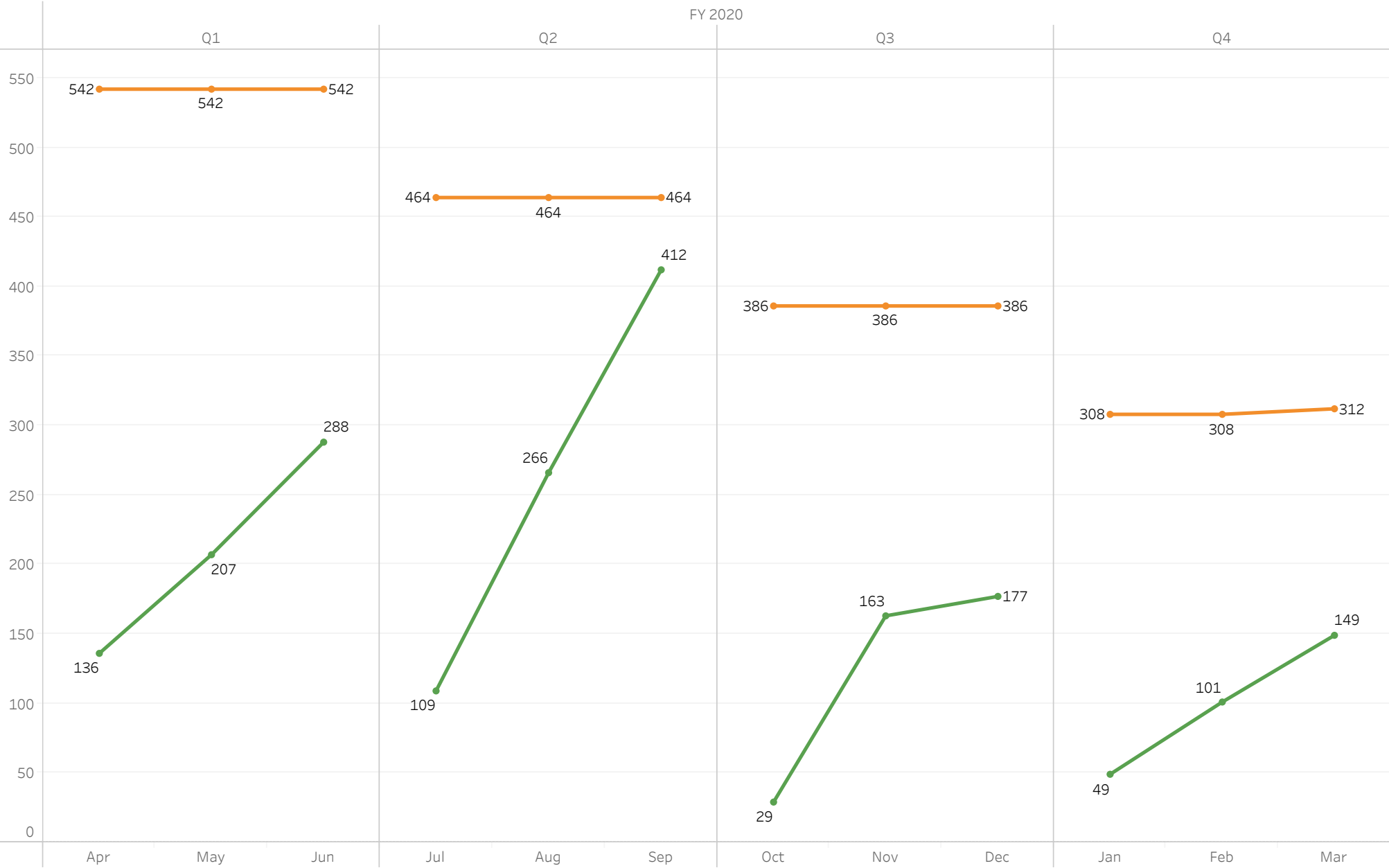
# Money Matters Driver: MH Acute Bed Occupancy by Unit (March)



# Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Apr 19 to Mar 20)



# Money Matters Driver: Inappropriate Out of Area Placements (March)



# True North Harm Free Care Summary

## Tracker Metrics

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Pressure ulcers acquired due to lapse in (Inpatient Wards)	180 days free in the year	30	61	91	52	83	122	153	183	214	245	82	70
Pressure ulcers acquired due to lapse in (Community East)	180 days free in the year							214	244	131	69	98	98
Pressure ulcers acquired due to lapse in (Community West)	180 days free in the year							159	189	220	251	271	53
Mental Health: AWOLs on MHA Section	16 per month	14	16	17	13	11	13	18	6	8	8	5	2
Mental Health: Absconsions on MHA Section	8 per month	7	8	9	9	8	9	7	2	5	2	5	6
Mental Health: Readmission Rate within 28 days: %	<8% per month	7.92	6.90	6.25	7.29	6.56	6.25	6.04	5.63	5.26	5.97	5.09	4.42
Patient on Patient Assaults (LD)	4 per month	3	4	2	4	5	1	0	0	2	0	0	0
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019[Suspended centrally due to COVID]	15% by March 2020; 20% by June 2021	11.2%	14.4%	11.8%	15.1%	12.7%	16.5%	12.1%	12.5%			14.0%	13.6%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000									6.9	5	5	5
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	11	22	19	31	23	29	16	26	0	1	0	0

## True North Patient Experience Summary

### Tracker Metrics

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Patient on Patient Assaults (MH)	38 per month	24	28	21	25	33	34	19	27	15	17	14	15
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	92.0%	90.6%	97.1%	94.0%	93.8%	90.0%	93.9%	93.8%	90.6%	82.1%	93.9%	88.4%
Mental Health: Uses of Seclusion	13 in month	15	11	12	11	6	12	5	7	11	4	18	12



## True North Supporting Our Staff Summary

### Tracker Metrics

	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Gross vacancies: % [Suspended centrally due to COVID] <10%	10.1%	10%	9.30%	9.19%	9.19%	7.5%	6.80%	6.70%	7.09%	6.5%	6.09%	5.89%
Statutory Training: Fire: % 95% compliance	88.5%	90.2%	90.7%	92.1%	94.3%	93.2%	93.0%	93.3%	93.9%	93.3%	91.5%	90.1%
Statutory Training: Health & Safety: % 90% compliance	94.8%	95.2%	95.2%	95.9%	96.0%	96.5%	96.4%	96.6%	96.6%	96.7%	96.4%	95.5%
Statutory Training: Manual Handling: % 90% compliance	90.8%	92.2%	92.6%	93.0%	93.2%	92.2%	92.9%	92.8%	90.2%	93.1%	93.3%	92.5%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID] 95% compliance	93.6%	94.0%	93.3%	94.6%	94.8%	93.4%	94.7%	95.2%	95.4%	94.4%	93.3%	93.9%
PDP (% of staff compliant) Appraisal: % [Suspended centrally due to COVID] 95% compliance by end of May 2019	9%	75.9%	95%	87.7%	91.1%	87.8%	88.9%	86.7%	86.4%	85.1%	83.9%	81.7%

## Mental Health Inpatient Services – Fire training compliance

Fire Safety Training	95%	87.0%	88.7%	91.6%	90.3%	92.4%	89.8%	89.6%	91.4%	93.9%	93.4%	93.2%	88.3%
<b>Org L7</b>	<b>Target</b>	<b>Apr 19</b>	<b>May 19</b>	<b>Jun 19</b>	<b>Jul 19</b>	<b>Aug 19</b>	<b>Sep 19</b>	<b>Oct 19</b>	<b>Nov 19</b>	<b>Dec 19</b>	<b>Jan 20</b>	<b>Feb 20</b>	<b>Mar 20</b>
371 Bed Management - OAPS Acute/PICU beds	95%											80.0%	80.0%
371 Bluebell Ward PPH	95%	73.9%	71.4%	85.0%	85.0%	90.0%	84.2%	84.2%	88.0%	87.5%	87.5%	82.6%	71.4%
371 Daisy Ward PPH	95%	95.0%	95.5%	96.0%	91.7%	92.0%	92.0%	83.3%	91.3%	92.0%	96.4%	95.8%	100.0%
371 ECT	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
371 General Manager	95%	100.0%	100.0%	87.5%	77.8%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	100.0%	100.0%
371 Inpatient (MH) Management	95%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%	75.0%	80.0%
371 Inpatients Medical Secretaries	95%	75.0%	75.0%	80.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
371 Medical Records West Berkshire	95%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	100.0%
371 Occupational & Physio Therapy MH Inpatients	95%	88.9%	88.9%	88.2%	82.4%	82.4%	84.2%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%
371 Orchid Ward PPH	95%	80.0%	83.3%	85.2%	85.7%	89.3%	89.3%	85.7%	89.7%	83.9%	81.3%	82.8%	80.0%
371 Rose Ward PPH	95%	69.6%	81.0%	86.4%	85.7%	90.9%	91.7%	87.0%	88.9%	96.0%	92.0%	100.0%	92.0%
371 Rowan Ward PPH	95%	96.7%	96.4%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	97.1%	85.3%
371 Snowdrop Ward PPH	95%	95.0%	95.2%	95.2%	100.0%	100.0%	86.4%	87.5%	86.7%	93.3%	93.1%	93.1%	90.3%
371 Sorrell Ward PPH	95%	100.0%	96.0%	95.8%	92.6%	92.3%	83.3%	88.9%	88.9%	96.4%	100.0%	100.0%	100.0%

# True North Money Matters Summary

## Tracker 1

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	5.89	6.27	6.29	5.80	4.90	4.59	6.09	6.70	9.30	11	7.59	

## Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	81.6%	74.9%	81.8%	76.7%	71.1%	76%	75.4%	78.7%	82.5%	88.0%	90.5%	84.5%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	83.59%	92.82%	65.65%	76.59%	85.70%	88.42%	80.07%	78.03%	77.29%	84.87%	83.09%	82.79%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	5.29%	4.90%	5%	4.90%	5%	5%	4.79%	4.79%	5.20%	5.09%	4.70%	5.20%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	4.70%	4.79%	4.79%	9.70%	10.9%	9.70%	9.90%	10.5%	10.8%	13.4%	17.8%	

## Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Mental Health: 7 day follow up (Quality Domain): %	95% seen	99	94.3	95.3	95.1	98.3	96.0	96.1	97.5	96.2	95.2	100	95.5
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	1	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	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP: %	90% treated	93	93	88.4	88.4	88.4	88.4	88.4	88.4	88.4	88.4	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	93	100	21	21	21	21	21	21	21	21	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	1	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed-sex accommodation breaches [Suspended centrally due to COVID]	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	100	100	75	100	100	66.7	100	80	100	100	88.9
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.5	99.9	100	98.8	99.7	99.7	98.4	97.4	95.8	97.9	96.2	94.0
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	98	97	96	95	96	96	95	95	96	95	94	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	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	57.5	56.0	56.0	55.0	56.2	55.1	59	57.7	56.0	60.3	57.1	54.4
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	69	66	66	66	66	66	60	60	60	59	59	59
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	12	12	12	12	12	12	11	11	11	12	12	12
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to COVID]	99% seen	100	100	100	100	100	99.5	100	100	100	99.7	100	
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	98.5	100	100	100	98.9	100	100	100	100	100
Sickness Rate: %	<3.5%	3.81	3.59	3.75	4.58	3.99	4.10	4.41	4.75	5.04	4.88	4.10	
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null	84	84	84	84	84	84	84	84	84	84	83	83
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	3	2	2	2	2	1	1	1	1	1	1	1
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	96.5	96.5	91.5	94.2	94.5	97.7	96.2	97.8	98.2	98.2	98.4	98.1
Patient Safety Alerts not completed by deadline	0			0	0	0	0	0	0	0	0	0	0

**Trust Board Paper**

<b>Board Meeting Date</b>	12 <sup>th</sup> May 2020
<b>Title</b>	Recovery Plan on a Page 2020/21
<b>Purpose</b>	The purpose of this paper is to provide Trust Board with an update on the amended Recovery Plan on a Page for 2020/21
<b>Business Area</b>	Strategy
<b>Author</b>	Kathryn MacDermott, Acting Executive Director Strategy
<b>Relevant Strategic Objectives</b>	All
<b>CQC Registration/Patient Care Impacts</b>	N/A
<b>Resource Impacts</b>	N/A
<b>Legal Implications</b>	N/A
<b>Equalities and Diversity Implications</b>	N/A
<b>SUMMARY</b>	<p>The Annual Plan on a Page provides the Trust with a clear set of objectives for the year and enables clarity for the divisional and corporate teams in setting their objectives. Trust Board agreed the Annual Plan on a Page for 2020/21 at its February 2020 meeting.</p> <p>The amended version attached has been updated to reflect the impact of COVID-19. Many of the original goals remain valid and are included in the Recovery Plan on a Page.</p> <p>Keeping our staff and patients safe and well remains a priority for us, and the plan reflects this. In the period following COVID-19 Phase 1 we will be restoring the services we provide. In doing so we want to use the recovery and restoration time to learn about all the new ways of working that have been so effective, and how we can use this to transform our services going forward. This is reflected in the recovery goals as is the need to continue to engage with staff and patients.</p>

<b>ACTION REQUIRED</b>	The Trust Board is asked to: <ul style="list-style-type: none"><li>• Comment and approve on the proposed Recovery Plan on a Page for 2020/21</li></ul>
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# Recovery plan on a page

Comments to:

[kathryn.macdermott@berkshire.nhs.uk](mailto:kathryn.macdermott@berkshire.nhs.uk)



# Recovery plan on a page 2020/21

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



## True North goal 1: Harm-free care

✓ To provide safe services by eliminating avoidable harm

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will make sure that we have safe levels of staffing to meet service demands
- We will engage with all services over the next six months and agree a plan to safely bring all services back to full operation
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents



## True North goal 2: Supporting our staff

✓ To support our people and be a great place to work

- We will sustain and improve staff engagement across all of our services
- We will make sure all staff have the appropriate skills, training and support for their roles
- We will support staff to embed working remotely and to operate safely and effectively
- We will protect and sustain the health and wellbeing of our staff, reducing sickness absence
- We will increase numbers of staff feeling they can influence how we work and make decisions
- We will increase numbers of staff recommending the care and treatment of our services
- We will improve staff recruitment, retention and satisfaction
- We will have a zero tolerance to bullying and harassment
- We will reduce violence and aggression towards our staff



## True North goal 3: Good patient experience

✓ To provide good outcomes from treatment and care

- We will use patient and carer feedback to drive improvements in our services, with specific engagement on proposed new ways of working
- We will manage patient flow effectively, with minimum delays and make sure that patients stay within our services for no longer than is clinically appropriate
- We will engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time
- Our services will support patients to manage any direct or indirect adverse impact of COVID-19



## True North goal 4: Money matters

✓ To deliver services that are efficient and financially sustainable

- We will achieve our financial plan for the year
- We will transform our clinical and non-clinical services using a digital first approach, to improve patient experience, streamline our estate, reduce our carbon footprint and support work-life balance for our staff

**With our health and care partners:** We will work in partnership with local systems to build Recovery and Restoration plans to build sustainable health and care that incorporate new ways of working.

**Trust Board Paper**

<b>Board Meeting Date</b>	12 May 2020
<b>Title</b>	Draft Annual Report 2019/20 - approval
<b>Purpose</b>	This paper provides the Trust Board with the Draft Annual Report 2019/20 for approval
<b>Business Area</b>	Corporate
<b>Author</b>	Chief Executive Officer/Company Secretary
<b>Relevant Strategic Objectives</b>	N/A
<b>CQC Registration/Patient Care Impacts</b>	N/A
<b>Resource Impacts</b>	N/A
<b>Legal Implications</b>	Maintaining compliance with terms of authorisation and meeting regulatory requirements
<b>Equalities and Diversity Implications</b>	N/A
<b>SUMMARY</b>	<p>Attached is a draft of the Trust's Annual Report 2019/20 for comment and approval.</p> <p>The financial figures contained within the draft Annual Report are subject to verification by the Auditors and details of the Annual Accounts will be included/appended following the Audit Committee meeting on 27 May 2020.</p> <p>Board members will note that a small number of items of information are awaited/require clarification and these will be added as soon as they become available. It is not expected that this will materially affect the content of the report. If any changes of significance arise then these will be discussed with and approval sought from the Trust Chair and Chief Executive and notified to other Trust Board members as appropriate.</p> <p>The report will also be further reviewed for consistency, typographical/grammatical accuracy and style.</p>

<b>ACTION REQUIRED</b>	The Board is invited to: <ol style="list-style-type: none"><li>1. Consider and offer any comments on the draft Annual Report 2019/120;</li><li>2. Approve the draft for submission subject to any final necessary additions and amendments and to delegate authority to the Chair and Chief Executive to give Board approval to the final document in light of the timetable for submission to NHS Improvement.</li></ol>

**Trust Board Paper**

<b>Board Meeting Date</b>	12 May 2020
<b>Title</b>	<b>Use of Trust Seal</b>
<b>Purpose</b>	This paper notifies the Board of use of the Trust Seal
<b>Business Area</b>	Corporate
<b>Author</b>	Chief Financial Officer
<b>Relevant Strategic Objectives</b>	N/A
<b>CQC Registration/Patient Care Impacts</b>	N/A
<b>Resource Impacts</b>	None
<b>Legal Implications</b>	Compliance with Standing Orders
<b>Equalities and Diversity Implications</b>	N/A
<b>SUMMARY</b>	<p>The Trust's Seal was affixed to the following document:</p> <ul style="list-style-type: none"> <li>Jasmine Ward Refurbishment Works - Deed of Variation</li> </ul>
<b>ACTION</b>	To note the update.