Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

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

10:00am on Tuesday 14 July 2020

AGENDA

No	Item	Presenter	Enc.
	OPENING BUSINESS		
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 12 May 2020	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Freedom to Speak Up Guardian's Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.1	Annual Research and Development Report	Minoo Irani, Medical Director/Katie Warner, Head of Research and Development	Enc.
6.2	Annual Complaints Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Quality Accounts 2019-20	Minoo Irani, Medical Director	Enc.
6.4	Annual Medical Appraisal and Revalidation Report	Minoo Irani, Medical Director	Enc.
6.5	Six Monthly Safe Staffing Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.6	Quality Assurance Committee Meeting - 19 May 2020 a) Minutes of the meeting b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Chair of the Quality Assurance Committee/ Minoo Irani, Medical Director	Enc.
6.7	NHS Infection and Prevention Control Board Assurance Framework (COIVD-19) Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.8	Volunteer, Work Experience and Honorary Contract Annual Report	Debbie Fulton, Director of Nursing and Therapies	Enc.

No	Item	Presenter	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 02 2020/21 Finance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.1	Month 02 2020/21 Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Vision Metrics Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.3	Annual Place Survey Results	David Townsend, Chief Operating Officer	Enc.
STRATEGY			
9.0	Equalities Update Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
9.1	COVID-19 Recovery Plan Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting held on 27 May 2020 – Minutes of the Meeting	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	Trust Seal	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
10.2	Corporate Risk Register – New Risk - Nosocomial Infections	Debbie Fulton, Director of Nursing and Therapies	Enc.
10.3	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 08 September 2020	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 12 May 2020

(conducted via Microsoft Teams because of COVID-19 social distancing requirements)

Present:	Martin Earwicker	Chair
	Chris Fisher	Non-Executive Director
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	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
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary

20/060	**Welcome** (agenda item 1)
	The Chair welcomed everyone to the meeting including Dr Garyfallia Fountoulaki, Consultant Psychiatrist who was observing the meeting. The Chair commented that ordinarily the Trust Board would meet in public, but due to the Covid-19 pandemic, the meeting was being conducted virtually via Microsoft Teams. It was noted that the meeting would be recorded, and the video would be published on the Trust's website. The Chair said that the next public Trust Board meeting on 14 July 2020 would be lived streamed with an opportunity for members of the public and governors to submit questions in advance. The questions would be answered at the meeting. **Action: Company Secretary**
20/061	**Apologies** (agenda item 2)
	Apologies were received from Mehmuda Mian, Non-Executive Director.

20/062	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
20/063	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
20/064	**Minutes of the previous meetings – 11 February 2020 and 14 April 2020** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 11 February 2020 and the Trust Board meeting held in private on 14 April 2020 were approved as a correct record.
20/065	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The Chair pointed out that a number of actions had been postponed because of the Trust's focus on the COVID-19 pandemic. The following action was considered further: **a) Equality Strategy** The Chair noted that the original timescale for the new Equality Strategy was April 2020 and asked when the new strategy was likely to be developed. The Acting Executive Director of Strategy explained that the new Equality Strategy was being developed as part of the Trust's refreshed three-year Strategy. The Acting Executive Director of Strategy said that work on completing the new three-year Strategy and Equality Strategy would re-commence once the Trust had completed its COVID-19 Recovery phase which was due to end in September/October 2020. It was noted that the timescale may slip again if there was a second COVID-19 peak. **Action: Acting Executive Director of Strategy** **b) Finance Report** Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the March 2020 Finance, Investment and Performance Committee had received the requested information about the increase over time in the number of administrative posts and whether this had resulted in greater efficiencies elsewhere in the Trust, but due to the Trust's focus on preparing for the COVID-19 pandemic, the Committee had not had sufficient time to consider the issue in any detail. It was agreed that the action would remain open on the action log. **Action: Company Secretary** The Chair commented that it would be important for the Trust Board to have an opportunity to reflect and to learn any lessons from the Trust's response to the COVID-19 pandemic. **Action: Chief Executive**

20/066	**Quality Assurance Processes During the COVID-19 Pandemic Report** (agenda item 6.0)
	The Director of Nursing and Therapies reported that the paper set details of the national guidance in relation to quality assurance processes during the COVID-19 pandemic together with an overview of how the Trust had responded to the national guidance and was ensuring continued oversight of patient and staff safety. The Director of Nursing and Therapies stressed that the majority of the Trust's quality and safety systems and processes for providing assurance were continuing. Areas such as complaints and DATIX incident reporting had seen less activity which reflected that the Trust was seeing fewer patients due to the COVID-19 Lock Down. However, it was noted that activity had increased in respect of safeguarding and infection and control. The Director of Nursing and Therapies explained that the Trust was continuing to implement actions and any learning identified through the Serious Incident investigation process. It was noted that further national guidance was published on 1 May 2020 by the National Patient Safety Team and that the guidance supported the Trust's approach and highlighted practice which the Trust was already doing. The Medical Director reported that the Trust's mortality review and learning from deaths systems and processes were also continuing during the COVID-19 pandemic. The Trust had also implemented additional requirements in response to national guidance. The Medical Director reported that the Trust was also continuing its Clinical Audit work. The latest published national clinical audit reports would be submitted to the Quality Assurance Committee meeting on 19 May 2020. The Medical Director reported that the Trust's governance processes in relation to NCIE Guidance remained uninterrupted for review and implementation. NICE Guidance relating to COVID-19 had been forwarded to the relevant services within 24 hours of publication. The Medical Director reported that in response to the COVID-19 pandemic, the Trust had established an Ethics Framework comprising the Ethics Consideration Group, chaired by the Lead Clinical Director which reported to the COVID-19 Clinical Strategy Group jointly chaired by the Director of Nursing and Therapies and the Medical Director. It was noted that the Ethics Consideration Group had referred 12 ethical issues to the Clinical Strategy Group for consideration as set out in the paper (page 48 of the agenda pack). David Buckle, Non-Executive Director thanked the Director of Nursing and Therapies and the Medical Director for their paper and said that it provided him with assurance about the Trust's clinical governance systems and processes during the COVID-19 pandemic. Dr Buckle cautioned that many staff from across the health sector had been re-deployed to meet the challenge of COVID-19 and were working in unfamiliar environments and therefore it was important to recognise that there was a risk that quality standards may not always be applied with the same constituency across the Trust. The Chair asked how long it would take for the Trust to resume its full clinical governance arrangements as part of the recovery process.

	The Director of Nursing and Therapies explained that the Trust was continuing to undertake Initial Findings Reviews of Serious Incidents and was deploying clinical staff who were shielding to conduct the reviews. The review process currently did not include a face to face session with patients and/or family members etc but other elements of the investigation process were continuing as usual, including the identification and implementation of any learning. The Medical Director confirmed that both he and Director of Nursing and Therapies had personally taken on greater responsibility for clinical governance systems and processes in order to free up Clinical Directors to focus on frontline activities. Naomi Coxwell, Non-Executive Director asked whether the Ethics Consideration Group and the COVID-19 Clinical Strategy Group would continue now the COVID-19 peak had been passed. The Medical Director confirmed that the Ethics Framework would remain in place because the COVID-19 pandemic was on-going. The Chair thanked the Director of Nursing and Therapies and the Medical Director and commented that the paper was comprehensive and provided the Board with assurance that the Trust's quality and safety systems and processes were carrying on during the COVID-19 pandemic and that the Trust's approach was in line with national guidance. **The Trust Board:** noted the paper.
20/067	**Patient Experience Quarter 4 Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • 50 complaints had been received during the fourth quarter; • 2 services saw an increase in the number of complaints received: - Crisis Resolution Home Treatment team had received 6 which was the most in any quarter this year although this still only equated to 0.04% of contacts. No specific themes were identified. - Community Mental Health Team had received 13 complaints. 6 out of the 13 complaints related to related to Windsor, Ascot and Maidenhead (with 2 complaints being from the same patient). The majority of the Community Mental Health Team complaints related to the level and/or type of treatment being offered; • CAMHS and Community Nursing saw a reduction to the lowest numbers received for any quarter this year. The Out of Hours Service (WestCall) saw a return to a more comparable number of complaints (1 complaint) following a spike of 7 complaints during Quarter 3; • The response rate to complaints within agreed timescale was 100%; • Of the 56 complaints closed in the quarter 60.18% were partially or fully upheld which was consistent with previous quarters. • 1,436 compliments were received which remained comparable with previous quarters.

Patient Experience during the COVID-19 Pandemic

- On 27 March 2020, NHS Providers organisations 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 choses to withdraw their complaint.
- In addition, the Parliamentary and Health Service Ombudsman had stopped accepting new NHS complaints and had stopped work on open cases.
- Collation and submission of the Friends and Family Test was also suspended, and the introduction of the new Friends and Family Test question scheduled for April 2020 had been postponed;
- The Trust had continued to respond in writing to all complaints opened prior to this time and offered local and or informal resolution as an alternative for all new complaints; and
- The Trust had continued to log, review and triage all complaints received and where informal resolution was not possible, complaints would be formally responded to as soon as services were able.

The Director of Nursing and Therapies reported that stage 1 of the Trust's new patient experience tool had been completed and was ready to progress to consultation.

The Chair referred to page 54 of the agenda pack and asked whether there were any complaint themes concerning the Community Mental Health Team in Windsor, Ascot and Maidenhead.

The Director of Nursing and Therapies said that she had reviewed the complaints and pointed out that a couple of the complaints were from the same person. The Director of Nursing and Therapies confirmed that that there were no themes from the complaints.

The Chair referred to page 61 of the agenda pack which set out data on complainants broken down by protected characteristics and commented on the relatively low number of complaints from people from Black, Asian and Ethnic Minorities.

The Director of Nursing and Therapies pointed out that a quarter of patients do not declare their ethnicity. The Director of Nursing and Therapies said that she hoped that the Trust's new patient experience tool would enable staff to help and encourage a wider group of patients to feedback their views.

The Chair referred to the report appendix which summarised feedback from Non-Executive Director and Governor 15 Step Visits and asked whether this was a helpful process.

The Director of Nursing and Therapies pointed out that the 15 Steps Programme was a national initiative and commented that it was one of a number of mechanisms for gaining insight about the patient experience.

Mark Day, Non-Executive Director said that he personally found the 15 Steps visits very helpful but queried whether the summarised reports presented to the Board could be enhanced by including the full reports.

Action: Director of Nursing and Therapies

Chris Fisher, Non-Executive Director agreed with Mr Day and said that as the 15 Step visits were unannounced it was also a good opportunity to identify examples of good

	practice as well as any areas for further improvement. Naomi Coxwell, Non-Executive Director said that as it was likely to be some while before Non-Executive Directors would be able to undertake physical visits to services, it would be helpful for the Board to consider alternative ways of engaging with the frontline. **Action: Director of Nursing and Therapies** **The Trust Board:** noted the paper.
20/068	**Executive Report (**agenda item 7.0)
	The Executive Report had been circulated. The following issue was discussed further: **a) COVID-19 NHS Second Phase** The Chief Executive reported that the Trust Board would have an opportunity to review the Trust's COVID-19 Recovery Plan in response to the letter from the NHS Chief Executive and Chief Operating Officer to GPs and NHS provider organisations setting out the second phase of the national NHS response to the COVID-19 Pandemic in the In Committee part of the meeting. **b) Care Homes** The Chief Executive pointed out that Care Homes were a complicated and fragmented market and that over the last few years, Care Homes had struggled with staff shortages and financial pressures with many Care Homes going into liquidation. The Chief Executive reported that COVID-19 has had a particularly hard impact on Care Homes. Aileen Feeney, Non-Executive Director asked whether there were likely to be any changes to the provision of Care Homes. The Chief Executive pointed out that Local Authorities had a statutory relationship with Care Homes but said that going forward it was likely that Integrated Care Systems would have a greater role in coordinating support to Care Homes. The Director of Nursing and Therapies reported that the Trust was providing Care Homes across Berkshire with infection control support. The Director of Nursing and Therapies reported that in West Berkshire, the Trust's Care Home In-reach team were supporting Care Homes, for example, by testing their residents and by providing end of life care. **c) Trust Response to the Impact of COVID-19 on Black, Asian and Minority Ethnic Communities (BAME)** The Chief Executive reported that The Chief Operating Officer reported that there was emerging evidence that Black, Asian and Minority Ethnic communities were being disproportionately affected by the COVID-19 pandemic. In addition, there were concerns about the over-representation of Black, Asian and Minority Ethnic health and care professionals among the COVID-19 fatalities. Other risk factors included: age; gender; obesity; and underlying health conditions. The Chief Operating Officer reported that the Trust had taken action to protect staff identified as at greater risk of COVID-19, for example, moving pregnant women from frontline patient facing work.

	The Chief Operating Officer reported that in the light of the emerging evidence relating to the increased risks for Black, Asian and Minority Ethnic staff, the Trust: • Had analysed BAME staff data and developed a risk assessment to determine which staff the Trust needed to engage and what measures needed to be implemented to protect BAME staff • Would develop guidance for teams to support our BAME population • Would reassure BAME staff by informing them of the actions the Trust was taking, ensure that staff can raise concerns and establish communication channels to keep staff updated and informed • Would continue to review emerging data, analysis, studies and reports to review the suitability of the Trust's response and take the measures required from the national study The Chief Operating Officer reported that the Trust was working closely with the BAME Network. It was noted that the Chief Operating Officer had briefed all staff about the Trust's response as part of the weekly Executive All Staff Briefing on 7 May 2020. The Chief Operating Officer said that the Trust was also identifying agency and NHS Professional staff who may also be at greater risk of COVID-19. The Chair said that he watched the weekly Executive All Staff Briefings and commented that he had found the Chief Operating Officer's presentation on the emerging evidence relating to the increased COVID-19 risks for BAME staff and the actions the Trust was taking very informative. The Chair said that he was pleased that the weekly briefings were open to all staff and that staff had an opportunity to ask questions via the online Chat function. Chris Fisher, Non-Executive Director commented that he felt reassured by the Trust's response to the emerging evidence of the increased risk of COVID-19 amongst BAME communities. David Buckle, Non-Executive Director asked how the Trust managed staff concerns about COVID-19. The Chief Operating Officer explained that the Trust had dealt with staff on an individual basis and in some cases, this involved moving high risk staff to other duties, making other adjustments and referring staff to Occupational Health. **The Trust Board:** noted the report.
20/069	**Month 12 2019-20 Finance Report** (agenda item 8.1)
	The Deputy Chief Executive and Chief Financial Officer presented the report and confirmed that the Trust had achieved its financial Control Total for 2019-20 and in addition the Trust had: • Finished the year with a reported surplus of £0.3m excluding Provider Sustainability Funding, this included £0.6m of centrally allocated Mental Health Investment funding. This was £0.7m ahead of the financial plan; • Would report a statutory surplus of £1.0m, after further accounting for £2.4m of Provider Sustainability Funding 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 the financial plan;
- Recorded £0.3m of costs resulting from our response to the COVID-19 pandemic, against which matching income had been accrued;
- Delivered £4.6m of savings, surpassing our £4.0m NHS Improvement commitment;
- Finished the year with £26.4m at the bank, £3.2m higher than planned, with the timing of capital payments, Provider Sustainability Funding bonus and central Mental Health funding all contributing to performance;
- Spent £10.3m on the Capital Programme, £1.6m less than planned;
- NHS Trusts were now required to account for changes in employers pension contributions. The Department of Health had been covering the cost of additional employer pension contributions
- Staff costs had increased, with additional costs incurred covering annual leave being taken before the end of March 2020, and costs relating to combatting the COVID-19 pandemic. Excluding COVID-19 and year end pension costs, the Trust had overspent its annual pay plan by £3.6m
- Non-pay costs remained within the financial plan for the year.

The Chair congratulated the Trust on its strong financial performance. The Chair asked whether there were any indications about the national financial settlement for the next year or two.

The Deputy Chief Executive and Chief Financial Officer said that announcements were expected to be made during July 2020 with financial planning starting from the autumn. It was noted that the Trust kept up to date with developments by participating in regular national webinars.

The Deputy Chief Executive and Chief Financial Officer confirmed that the Trust was continuing its work to ascertain its underlying cost base and to understand the potential impact of the new ways of working in terms of increased efficiencies and productivity.

The Chair said that he welcomed the Trust's focus on reducing costs and increasing productivity for the benefit for patients.

Chris Fisher, Non-Executive Director asked about the System Control Totals.

The Deputy Chief Executive and Chief Financial Officer explained that the Trust's financial performance was only linked to the Frimley Health and Care Integrated Care System which had delivered its Control Total.

Mr Fisher asked whether the Cost Improvement Programme savings were recurrent.

The Deputy Chief Executive and Chief Financial Officer confirmed that the savings in relation to specialist placements were recurrent savings but continued focus on the Bed Optimisation Programme would be needed to sustain performance in relation to reducing the number of short-term adult acute out of area placements.

Mr Fisher asked whether the £8m pension charge was a recurrent change.

The Deputy Chief Executive and Chief Financial Officer agreed to check the guidance out and update the Audit Committee.

Action: Deputy Chief Executive and Chief Financial Officer

Chris Fisher, Chair of the Audit Committee reported that on behalf of the Trust Board, the

	Audit Committee was scheduled to approve the Annual Accounts on 27 May 2020. Mr Fisher said that other Non-Executive Directors were very welcome to join the Audit Committee. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee said that moving forward it would be helpful if the financial report would separate out COVID-19 related expenditure so the Finance, Investment and Performance Committee could continue to focus on driving efficiencies. The Deputy Chief Executive and Chief Financial Officer agreed to share the new month 1 financial reporting format which detailed the underlying costs base with the Finance, Investment and Performance Committee. **Action: Deputy Chief Executive and Chief Financial Officer** **The Trust Board noted:** the following summary of the financial performance and results for Month 2019-20: (The Trust reports to NHS Improvement its "Use of Resources" rating which monitors risk monthly, "1" is the highest rating possible and "4" is the lowest). Year to date (Use of Resource) metric: • The Trust's overall Use of Resources rating was "1" (the plan was "1") • Capital Service Cover rating was 2 • Liquidity days rating was 1 • Income and Expenditure Margin rating was 2 • Income and Expenditure Variance rating was 1 • Agency target rating was 1 Year to date Income Statement (including Provider Sustainability Funding) excluding donations: • Plan: £1.9m surplus • Actual: £2.7m surplus • Variance: £0.8m better than plan Year to date Cash: £26.4m versus plan of £23.2m Year to date Capital expenditure: £10.3m versus plan of £11.9m
20/070	**Month 12 2019-20 "True North" Performance Scorecard Report** (agenda item 8.2)
	The Month 12 "True North" Performance Scorecard Report had been circulated. The Deputy Chief Financial Officer and Chief Financial Officer pointed out that some performance indicators had been suspended due to national COVID-19 guidance (for example, financial planning) or because of changes in operational priorities and ability to collect data (for example, the Friends and Family Test). These indicators were highlighted in gray on the Performance Report. The Deputy Chief Executive and Chief Financial Officer highlighted that he hoped that as the Trust moved to the COVID-19 Recovery Phase, the Trust would be able to focus on its True North priorities.

	Aileen Feeney, Non-Executive Director asked whether the falls technology had been rolled out to other wards. The Director of Nursing and Therapies reported that the falls technology was currently in use at West Berkshire Community Hospital and had been due to be rolled out to Wokingham Hospital, but this had been put on hold because of the COVID-19 pandemic. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee asked whether the performance report could include some COVID-19 related performance indicators to shed light on how the Trust was managing the pandemic. **Action: Deputy Chief Executive and Chief Financial Officer** **The Trust Board:** noted the report.
20/071	**COVID-19 Recovery Plan on a Page** (agenda item 9.0)
	The Acting Executive Director of Strategy presented the paper and reported that the Trust had amended its Annual Plan on a Page 2020-21 in the light of the COVID-19 pandemic. It was noted that many of the original goals remained valid and were included in the updated COVID-19 Recovery Plan on a Page. The Acting Executive Director of Strategy highlighted that the Trust was keen to identify new ways of working which had been developed because of the COVID-19 pandemic and should continue post COVID-19 Recovery. This included maximising the use of digital including virtual patient consultations etc. The Acting Executive Director of Strategy said that the Trust would be gaining feedback from patients and their families/carers including those who for whatever reason were not able to access services digitally. The Chair commented that the COVID-19 pandemic had necessitated the Trust to find new and innovative ways of delivering services and that it was important that the Trust continued its transformational work. **The Trust Board:** noted the paper.
20/072	**Draft Annual Report 2019-20** (agenda item 10.0)
	The Chair explained that the Draft Annual Report 2019-20 was not included with the published meeting paper pack and was circulated to member of the Board only because legislation required that the Annual Report could not be published until the final version was laid before Parliament in July 2020. It was noted that the Trust's External Auditors had still to undertake their audit of the draft Annual Report. The Company Secretary agreed to inform the Board of any changes between the draft circulated and the final document. **Action: Company Secretary** The Chair drew attention to his introduction to the draft Annual Report which had highlighted two key issues for the Trust over the last year: Care Quality Commission's rating of the Trust as "Outstanding"; and the Trust's response to the Covid-19 pandemic.

	The Chair paid tribute to the work of the Executive and Staff. **The Trust Board**: approved the draft Annual Report 2019-20 subject to any amendments made in response to the Trust's External Auditors and the correction of any typological and formatting errors.
20/073	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that the Council of Governors meetings were currently suspended because of the COVID-19 Pandemic. The Chair reported that he had agreed with the Lead Governor that the Council meeting scheduled to take place on 17 June 2020 would take the form of a Live Broadcast. Governors would have an opportunity to use the "chat" function to ask questions. The Chair commented that it was unlikely that face to face meetings would be feasible for the foreseeable future and therefore he was discussing options for continuing with Governor meetings with the Lead Governor. The Chair invited Non-Executive Directors to join the meeting. **Action: Company Secretary**
20/074	**Use of the Trust Seal Report** (agenda item 10.2)
	It was noted that the Trust's Seal had been affixed to documents concerning a deed of variation for refurbishment works on Jasmine Ward Refurbishment works. **The Trust Board**: noted the paper.
20/075	**Any Other Business** (agenda item 11)
	Flu Vaccination Programme Campaign The Chair asked for an update about the Trust's annual autumn Flu Vaccination Programme. The Director of Nursing and Therapies reported that it would be even more important to ensure that staff were vaccinated against flu given the COVID-19 pandemic. The Director of Nursing and Therapies reported that the Quality Executive Group meeting on 11 May 2020 had received a report setting out the proposed Campaign which would include addressing the additional challenge of vaccinating staff who were remote working.
20/076	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 14 July 2020. The meeting would be conducted via Microsoft Teams and would be live streamed via the Trust's website.
20/077	**CONFIDENTIAL ISSUES:** (agenda item 12)

	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 12 May 2020.

Signed…….. Date 14 July 2020
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 14/07/20

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	18/138	Equality Strategy Annual Report	The Director of Strategy and Corporate Affairs to include a section on gender pay equality when the Equality Strategy was refreshed.	Oct 2020	**KM**	Work has started on refreshing the Equalities, Diversity and Inclusion strategy with a provisional due date of September 2020 for the 1st draft.	
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	Sept 2020	**DF**	The percentage of shifts with less than 2 registered staff is included in the six-	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			future reports.			monthly Safe Staffing report which is on the agenda for the meeting.	
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.	July 2020	**AG**	Completed - to be discussed further at the July 2020 Finance, Investment and Performance Committee meeting.	
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.	July 2020	**AG**	Will be kept under review, in line with operational performance impact through Covid-19 transition.	
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	**AG**	Holding of the review whilst the Trust's Strategy and True North objectives are refreshed during Covid-19 transition. Latest vision metrics update reports good progress over	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						2019/20, supported by an Outstanding overall Care Quality Commission rating.	
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	**JE/AG**	The Trust is continuing to try to influence the system in line with these principles set out in the NHS Providers briefing on NHS Operational Planning and Contracting Guidance 2020-1.	
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	**MI/DF**	Action deferred due to COVID-19 work.	
11.02.20	20/014	Strategy Implementation Plan	A post project review of the Trust's new Intranet to be undertaken in order to learn any lessons for future	December 2020	**KM**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		2019-20	initiatives.				
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	**JH**	A training event was arranged for 6 May 2020, but this has been deferred due to COVID-19 social distancing requirements	
14.04.20	20/056	"Dido Harding" Letter	The Finance, Investment and Performance Committee to receive a comprehensive report on the Trust's Disciplinaries and Grievances.	July 2020	**AG/JN**	On the agenda for the July 2020 Finance, Investment and Performance Committee	
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	**AG/JN**	This will be updated on as part of six-monthly action plan update to Board.	
12.05.20	20/060	Virtual Board Meetings	The next Public Trust Board meeting on 14 July 2020 to be "live streamed" with an opportunity for governors and members of the public to submit questions in advance which will be answered at	July 2020	**JH**	The IT Team need time to test the new equipment needed to be able to live stream the MS Teams Board meeting. The meeting will be recorded, and	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			the meeting.			the video will be published on the Trust's website. Members of the public will be invited to submit questions to the Board.	
12.05.20	20/065	Matters Arising - Equality Strategy	The Equality Strategy to be developed as part of the Three-Year Strategy Refresh.	Oct 2020	**KM**	Trust Board has agreed to have a dedicated Equalities, Diversity and Inclusion Strategy. This work has started with a provisional due date of Sept 20 for the 1st draft.	
12.05.20	20/065	Matters Arising – Finance Report	The action (min 19/206) from the meeting on 19 November 2019 set out below to remain on the action log until the Finance, investment and Performance Committee has had an opportunity to review the issue: The Finance, Investment and Performance Committee to be provided with more information about the increase in the number of	July 2020	**AG**	The March 2020 FIP Committee received the information but did not have time for an in-depth discussion because the focus of the meeting was on the Trust's COVID-19 response. The information will be	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			admin roles and whether this resulted in greater efficiencies elsewhere in the Trust.			reviewed again at the July 2020 FIP Committee meeting.	
12.05.20	20/065	Finance Report	The Trust Board to have an opportunity to reflect and to learn any lessons from the Trust's response to the COVID-19 pandemic.	June 2020	**CE**	The June 2020 Trust Board Discursive meeting reviewed the lessons learnt from the COVID-19 pandemic.	
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit Reports as part of the Patient Experience Report.	September 2020	**DF**	To be included in the next Quarterly Patient Experience Report.	
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider alternative ways Non-Executive Directors could engage with frontline staff during the COVID-19 pandemic.	July 2020	**DF**	Non-Executive Directors have been invited to contact the Company Secretary if they would like to "virtually" visit any services/teams.	
12.05.20	20/069	Finance Report	The Deputy Chief Executive and Chief Financial Officer to check the guidance on accounting for employer's pension contributions	TBC	**AG**	No further guidance available at this time. The Deputy Chief Executive and Chief	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			and update the Audit Committee.			Financial Officer will update via Audit Committee.	
12.05.20	20/069	Finance Report	Members of the Finance, Investment and Performance Committee to receive the proposed month 1 new reporting format which would detail the underlying cost base.	July 2020	**AG**	Completed, Board receiving financial reporting of underlying cost base pre-Covid-19 costs (m1-2). July 2020 Finance, Investment and Performance Committee to review reporting as appropriate.	
12.05.20	20/070	Performance Report	The Deputy Chief Executive and Chief Financial Officer to consider including some COVID-19 related performance indicators in the Performance Report.	July 2020	**AG**	Current indicator set to be maintained, provides for focus on key operating indicators as Covid-19 response transitions through to recovery. Gold meeting receiving updates on infection incidence on wards (currently minimal).	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.05.20	20/072	Annual Report	The Company Secretary to circulate any key changes to the draft Annual Report 2019-20.	July 2020	**JH**	Completed	
12.05.20	20/073	Council of Governors Meeting – 17 June 2020	Non-Executive Directors to be invited to the Council of Governors Live Broadcast on 17 June 2020.	June 2020	**JH**	Completed	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th July 2020
Title	**Freedom to Speak Up Report**
Purpose	To update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months.
Business Area	Corporate
Author	Freedom to Speak Up Guardian – Mike Craissati
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	All UK NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	Good links have been maintained during the period with the 3 Staff Networks, the Freedom to Speak Up Guardian has promoted the concept of Freedom to Speak Up and has supported network members for any concerns they may have had around EDI issues. Of the total number of "staff experience" concerns raised, it's estimated that 65% come from staff of a BAME background and approx. 50% of those concerns relate to BAME issues such as exclusion or perceived racial prejudice or bullying.
SUMMARY	The post of Freedom to Speak up Guardian was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for December 2019 to June 2020 The paper includes: • a summary of communication activity being undertaken by the FTSUG

	• data from the most recent report to the National Guardians Office • key points about improving FTSU culture • action taken to address the FTSU internal audit report • recommendations from the Freedom to Speak Up Guardian who will be attending the Trust Board meeting to present the report.
Impact of Covid-19	Throughout the period March to date all FTSU activity has continued as much as possible including • Promotion of Freedom to Speak Up and a "Speak Up" culture • Responding to concerns raised • Feeding back to the Organisation on lessons learnt/trends etc.
ACTION REQUIRED	The Trust Board is asked: a) to note the contents of this report by the Freedom To Speak Up Guardian; and b) to provide support for the Guardian's recommendations detailed in this report

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

Freedom to Speak up Guardian - Report for December 2019 – June 2020

Background

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

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. As part of our regular policy review process, the FTSU policy has been reviewed by the FTSUG pending consideration by Human Resources colleagues and out Joint Staff Consultative Committee.

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

The Role of the Freedom to Speak Up Guardian

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

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

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

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

Debbie Fulton, Director Nursing and Therapies is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, is nominated Non-Executive Director for Freedom to Speak Up.

Communication

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

The plan includes the following (Showing progress on plans and relevant target dates):

- Creating an animation (final version published in 2019)
- Presentations and attendance at management/team meetings (ongoing)
- FTSU month, focused promotion across the trust during October of each year (Activities will be dependent on C-19)
- Production and dissemination of posters, leaflets and cards etc (ongoing though see above)
- Market stall at Corporate Induction (now direct presentation to all inductees via MS Teams broadcast)
- Regular session as part of junior doctor induction (see above)
- Presentation at Essential Knowledge for New Managers training (to be reviewed Q 2 2020-21)
- Presentation at student nurse induction (as above)
- Presentation at teams meetings (a recorded presentation is available as well as live presentation)
- Supporting all Equality & Diversity/Network Events (to be resurrected as the Networks review their events schedule)
- Supporting a team of FTSU Champions recruited from a variety of services across the organisation (ongoing, Champion activity has abated during C-19 but will be reviewed Q2 2020-21).
- Membership of the Safety Culture Steering Group
- Membership of the Ethical Considerations Committee

Contribution to the Regional and National Agenda

The Guardian is a member of the Thames Valley and Wessex Regional FTSU Network and a more local network consisting of all NHS Trusts in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.

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

The NGO requests and publishes quarterly speaking up data.

Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

Cases are described as "those concerns raised which require action from the FTSUG".

Outlined below are the national and local number of cases raised for FY 2019/20.

Q4 National data returns have not been published as of this date.

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

	2019/20	Cases Raised	Anon	%	# Cases with element of patient safety	%	# cases with element of bullying & harassment	%	# cases causing some form of harm or detriment	%
NATIONAL	Q1	3156	439	14	767	24	1213	38	116	4
	Q2	3473	455	13	884	25	1240	36	127	4
	Q3	4120	468	11	915	22	1496	36	147	4
	Q4									
TOTAL		10749	1362	13	2566	24	3949	37	390	4

	2019/20	Cases Raised	Anon	%	# Cases with element of patient safety	%	# cases with element of bullying & harassment	%	# cases causing some form of harm or detriment	%
BHFT	Q1	6	2	33	0	0	4	67	0	0
	Q2	11	2	18	1	9	8	73	1	9
	Q3	7	1	14	2	29	4	57	0	0
	Q4	7	0	0	1	14	6	86	0	0
TOTAL		**31**	**5**	16	**4**	13	**22**	71	**1**	3

Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- Returns show very few cases are raised via FTSU around patient safety
- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity.
- The Guardian receives very few anonymous concerns.
- A significantly high proportion of cases are around the "staff experience" and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients of the public at large – this would normally be highlighted via Datix).
- Q3 & Q4 is showing a higher proportion of cases of B&H that have a racial aspect to them. It is presumed that increased FTSU exposure at 2019 Equality & Diversity Roadshows, the B&H video & posters is having a positive effect in encouraging staff to come forward.
- Of the total number of "staff experience" concerns raised, it's estimated that, during the period, 65% come from staff of a BAME background and approx. 50% of those concerns relate to BAME issues such as exclusion or perceived racial prejudice or bullying.

- There is no data on concerns raised by members of other staff networks that may relate to membership of that network.
- Q1 2020-12 data – It's estimated that 12 cases were raised within this quarter with approx. 6 relating to Covid-19

Impact of Covid-19

From March 2020 to date, FTSU activities have continued as before (wherever possible) to ensure "business as usual".

- **Promotional work** – Awareness has continued via Social Media, Corporate Induction, Intranet, Covid-19 weekly emails, direct meetings with services, use of MS Teams etc
- **Response to concerns –** As per usual, it has been easier for staff to communicate with the Guardian in confidence as many staff are working from home and there is no requirement to meet off site.
- **Cases –** March to June saw a reduction in the number of cases raised but those cases that did come to the Guardian were primarily around PPE issues, re-deployment and end of re-deployment. Mid June to date has seen a busy period with number of cases raised increasing and the type of concern returning to types associated with pre C-19. This mirrors trends both regionally and nationally.
- During this time the Guardian supported the wellbeing hub and HR function to ensure staff were aware of FTSU support available.
- Feedback to the Organisation on cases, lessons learnt and any trends continued as normal.

Improving FTSU Culture

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

From personal observations and feedback from those who have spoken up, the following is highlighted:

- To achieve an open culture around speaking up, all elements of good, effective communication need to be included in the process. Speaking Up is only part of this, and is relatively easy to address.
- An effective process is only achievable if the other elements are addressed, namely improving the Listening Up Culture and removing barriers to communication.
- Part of the Listening Up process should include improved feedback to those who raise concerns, including timescales, expectations around outcomes.

- **Membership of the Safety Culture Steering Group** – Part of the Terms of Reference for this newly formed group is to promote the concept of a just and learning culture with equal emphasis on accountability and learning that is required to support and promote a culture of psychological safety, enabling all staff to feel safe to raise/ report and discuss safety incidents thus enabling learning, to improve safety and deliver against the requirements within the NHS safety Strategy. Psychological safety is the MH equivalent of a physically safe workplace and aims to promote a culture where staff feel able to raise concerns, talk about any mistakes made and learn from them. This compliments the aims of the Guardian and so the membership includes the FTSU Guardian and a FTSU Champion.

Learning and Improvement

The FTSU Status Exchange between the FTSUG, Chief Executive, Director of Nursing and Therapies and Head of Operational HR continues to provide a good forum for a structured information exchange, triangulation of information, and ensuring action is completed regarding concerns raised. A regular meeting between the FTSUG and Head of Operational HR has also been added to our standard work to enable direct communication about case work in a confidential manner.

The Guardian ensures that any learning from cases raised is communicated to the Organisation through this status exchange, through regular 1:1's with the Executive lead for Freedom to Speak Up.

Those who raise concerns are offered continual feedback on any investigation work undertaken as a result of speaking up and are supported throughout the whole process, the Guardian also obtains feedback from those who raise concerns on their views of the process and this learning is reviewed and considered by the Guardian.

On occasions where reports of case reviews undertaken by the National Guardian's Office are published, the Guardian will review these reports and communicate recommendations to the Organisation.

Review of NGO recommendations -Whittington Health NHS Trust case review

The recently published NGO report reviewed various aspects of that Organisation's Speaking Up function to identify any learning and potential improvement as well as any good practice or innovation.

The published report was reviewed by the Guardian and HR function, the following areas of good practice were found within Berkshire Healthcare:

- Investigation times are good and the average resolution time is within the target timescale for casework resolution of 53 days
- Regular meetings are held between the FTSU Guardian and HR to promote trust and understanding regarding respective roles – status exchange meetings also take place between the CEO, Director of Nursing, Head of Operational HR and FTSU Guardian
- The Berkshire Healthcare Raising Concerns policy is in line with the national standard integrated policy and was reviewed last year

The recommendations for improvement made in the Whittington review focus largely on the role of the FTSU Guardian and in particular, improving the understanding of the purpose and remit of the role within the wider workforce. Having reviewed these recommendations, minor actions have been identified to improve the Organisation's approach to Speaking Up and are being implemented.

Recommendations from the Freedom to Speak Up Guardian

The Trust Board is asked to support the following:

- Seek assurance that any patient safety issues are raised and addressed by methods other than via the FTSU process.
- Support and encourage initiatives to address "Staff Experience" concerns, specifically those that include an element of bullying & harassment and those concerns that may affect Network members.
- Support and encourage initiatives to improve a Listening Up culture, so that all staff will feel more able to challenge in a positive way, to encourage positive suggestions that may improve ways of working, the patient experience or efficiencies. In turn this will make raising more traditional FTSU concerns easier and more a part of the culture.
- Assist in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so.
- Improved FTSUG/HR joint working to provide a more structured approach to dealing with FTSU cases to provide those raising cases with better feedback.

Author and Title:

Mike Craissati, Freedom to Speak Up Guardian

July 2020

Trust Board Meeting	14 July 2020
Title	Research and Development Annual Report 2019/20
Purpose	This report presents a summary of research and related activity for the year 2019/20
Business Area	Corporate (Medical Directorate)
Author	Katie Warner, Head of Research and Development
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff, Good patient Experience and Money Matters
CQC Registration/Patient Care Impacts	Clinical research provides patients with access to the latest care, treatments, medication and therapies. It also provides patients, carers and staff members with opportunities to contribute to the generation of evidence to improve current best practice and identify new and improved treatment options offering better outcomes. The CQC have now included key research questions with the 'well-led' domain of their inspection framework.
Resource Impacts	The Research and Development department are predominantly funded by the National Institute for Healthcare Research (NIHR). The majority of this is Activity Based Funding (ABF) and is received via the Local Clinical Research Network (CRN) Thames Valley and South Midlands. This is then supplemented by NIHR Research Capability Funding (RCF), a small commercial income and some trust finance. Funding is allocated annually and a number of team members hold short term contracts as funding is based on previous years' research activity.
Legal Implications	Operating according to the UK Policy Framework for Health and Social Care Research. This includes maintaining compliance with relevant UK legislation when conducting research and ensuring all Trust Research Governance processes are aligned to Health Research Authority (HRA) Approval processes.
Equality & Diversity Implications	Berkshire Healthcare is committed to delivering the objectives of the National Institute for Health Research (NIHR) to continue to increase patient equality in terms of access to clinical trials. The Research and Development (R&D) department's long-term vision is to offer research participant opportunities to all Trust patients.
SUMMARY	This report details BHFT research activity for the current financial year in comparison with the past four years. Impacts, benefits, communications and participant experience are noted. Details of finance, structure, operations and performance are also provided.
Action required	The Board is asked to note the contents of the report, progress made during the year and future direction for the coming year.

Research and Development Annual Report Template

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1. Executive Summary

Berkshire Healthcare NHS Foundation Trust (BHFT) is a research active organisation. Our aim is for all patients to have access to research opportunities which are relevant to them. In 2019/20 we ranked 7th out of the 49 benchmarked mental health and community trusts for the volume of research activity that we provide.

In the last four years we have delivered 174 research projects, including 79 in 2019/20. This includes a range of research from smaller scale student projects involving a subsection of our patients to national multi-centre clinical trials involving numerous NHS sites. Much of our research is observational, led by another non-commercial entity such as an NHS Trust or University and involves adult mental health services. Nursing and medical staff provide leadership in roughly equal measure to the research projects which take place with either BHFT patient, staff, carers or data. They are closely followed by Psychological Therapists. Local smaller scale research projects tend to be driven by PhD students and Clinical Psychology Doctoral trainees placed at local/regional universities.

By BHFT participating in research our patients are provided with access to assessments, treatments and interventions which they would not otherwise receive as part of routine care. Staff, patient and carers are also able to contribute to the evidence base for conditions which are most of interest to them. 96% of our research participants in 2019/20 strongly agreed or agreed that they had had a good experience of taking part in the research study.

The Research and Development (R&D) department is working hard to address all elements of equity of access including ensuring research opportunities are accessible in all clinical areas, to all patients, carers and staff as far as study eligibility criteria and sample sizes allow us to. We are also working to better understand what research opportunities patients in neighbouring organisations have access to and are mirroring these where possible.

Research opportunities relating to current open studies and available support for staff members undertaking their own projects are communicated and promoted through induction, social media, our webpages, intranet, posters in waiting rooms, team meetings and attendance at key events.

During 2019/20 we had 30 full or part time permanent or fixed term research nurses/AHP's, clinical research practitioners and assistants who were either based in clinical services or with the R&D department core team. The vast majority of our funding is provided by the NIHR Local Clinical Research Network (LCRN): Thames Valley and South Midlands.

We have continued to review our governance arrangements including research activity oversight, standard operating procedures, policies, monitoring and data management. This has resulted in the development of a new process for Trust sponsored research studies and a comprehensive audit plan.

Externally specified performance objectives were achieved, however we had difficulty attracting and recruiting patients and carers to Dementia and Neurodegeneration studies. This reflects the national picture. We continue to work with services to support the CQC clinical research requirements which feature in the well-led framework focussing on equity, facilitation and awareness.

The BHFT R&D department are proud to be involved in numerous partnerships and collaborations and look forward to further aligning with BHFT core priorities in 2020/21 via our plan on a page. In particular offering research opportunities in the areas of self-harm, suicidality, pressure ulcers, falls and COVID-19 and embedding new remote working practices in addition to developing our strategy.

2. Introduction

Clinical research involves gathering information from patients and healthy volunteers to improve the medications, therapies and services that we offer to patients. By participating in clinical research, patients may be able to access assessments and treatments that are not available as part of routine NHS care.

Research is an integral component in the delivery of Trust priorities. Specifically, involvement in clinical research is one way that we demonstrate our commitment to actively improving the clinical treatments, care and outcomes for our patients and providing safer services. Research into new ways of working and technologies can assist us in delivering more efficient and financially sustainable services. Supporting our staff in the delivery of research has the potential to strengthen skills and increase engagement.

Berkshire Healthcare has a well-established portfolio of research which is updated regularly as new research projects open and close. Research projects at Berkshire Healthcare last from several months to several years depending on the nature of the study. Projects involve patients, staff, carers and members of the public.

Our aim is for all patients to have access to research opportunities which are relevant to them. During the course of 2019/20 our patients were able to access research relating to bipolar disorder, dementia, eating disorders, autism, diabetes, schizophrenia, Chronic Obstructive Pulmonary Disease, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, anxiety and depression.

We have implemented a robust research governance system to ensure research is designed, conducted and delivered to the highest standards. We continually improve and monitor this system to ensure it is fit for purpose.

3. Research and Development at BHFT - the last 4 years

3.1 Number of Research Projects

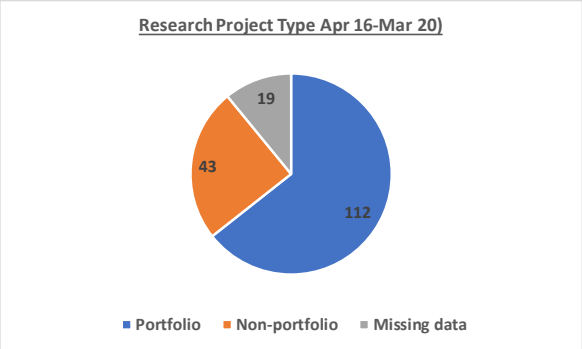
In the last four financial years 1st April 2016 - 31st March 2020 Berkshire Healthcare conducted 174 research projects. Some of these projects overlapped financial years but have only been counted once. A period of four financial years has been chosen as we feel confident in the accuracy of the data captured in relation to the research projects for this period. In the last financial year 1st April 2019 - 31st March 2020 Berkshire Healthcare conducted 79 research projects. 42 research projects were set up in 2019/20 (26 NIHR portfolio and 16 non-NIHR portfolio, see below for distinction). A list of 2019/20 research projects and summaries can be found in Appendix 1.

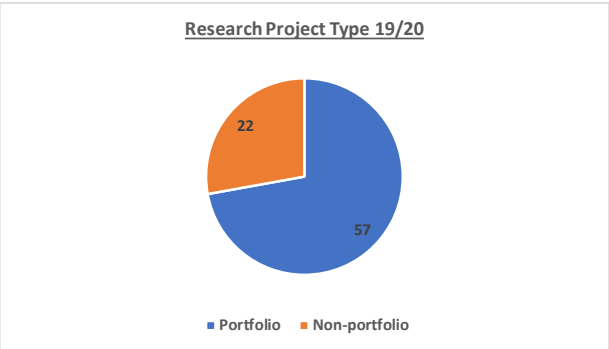
3.2 NIHR portfolio v non-portfolio

Most of the research studies that we invite our patients to participate in are National Institute of Health Research (NIHR) portfolio studies. The NIHR portfolio is a national list of high-quality studies which have received particular sources of funding. We receive external funding to deliver NIHR portfolio projects. Our other high-quality research studies (non-portfolio projects) are conducted in part fulfilment of qualifications e.g. MSc or by a member of staff but will not have received funding from a relevant funding source. We receive internal Trust funding for part of the salaries of our Research Governance Facilitator and R&D Manager to enable us to support the set up and governance of these projects which have not been adopted onto the NIHR portfolio.

All research has a sponsoring organisation. By sponsoring the research the organisation is accepting overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project. Historically BHFT have not acted in the role of sponsor very frequently. There have only been six occasions in the last four years where BHFT have acted in the role of sponsor. Three of these projects were open in the last financial year.

In the last four years BHFT have worked on 112 portfolio and 43 non-portfolio research projects. There are an additional 19 projects where project type will need to be confirmed. In 19/20 we worked on 57 portfolio and 22 non-portfolio projects. Some of these were in active recruitment phase whilst others were in follow up phase.

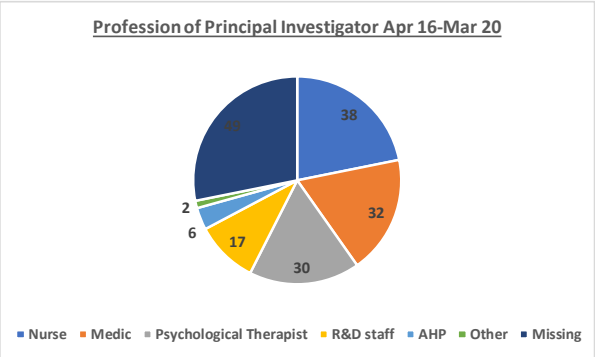


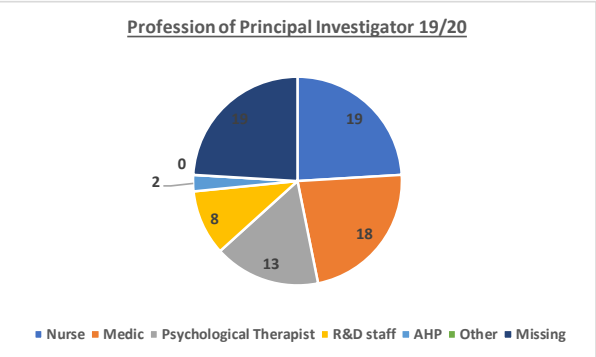


3.3 Professional Group of the Principal Investigator

All research projects should have a Chief Investigator and if operating at multiple sites (e.g. different NHS Trusts), a Principal Investigator (PI) should be in place at each research site. On analysing the professional backgrounds of Principal Investigators over the last four years we found that 38 were nurses, 32 were medics, 30 were Psychological Therapists (including Psychologists and Psychotherapists), 17 were R&D staff members from unqualified clinical backgrounds (low risk, low complexity studies and usually termed Local Collaborator rather than PI) and 6 were Allied Health Professionals. A further 2 were other professionals and in the case of 49 research projects the professional group which the Principal Investigator belonged to was not recorded. It should be noted that work is ongoing to ascertain the professional groups of these individuals to further enrich future analysis.

The proportions of each professional group acting as Principal Investigator are reflective of the latest financial year 19/20. 18 Principal Investigators were medics, 19 were nurses, 13 were Psychological Therapists and 8 were R&D staff from unqualified clinical backgrounds. 2 were Allied Health Professionals and in 19 cases the professional group was not recorded.

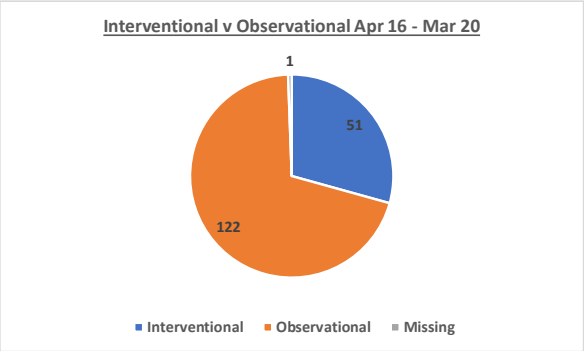


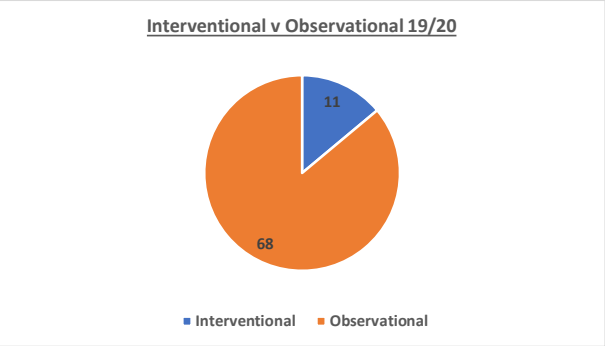


3.4 Interventional v Observational research

The majority of BHFT research is observational. Research projects termed as interventional studies are those in which patients receive specific interventions in line with the research protocol. Observational studies are those in which the investigators do not seek to intervene, but simply observe the course of events.

In the last four years BHFT have conducted 122 observational studies, 51 interventional studies and one study did not have the research type recorded. This compares to 19/20 when 11 interventional and 68 observational studies were undertaken.

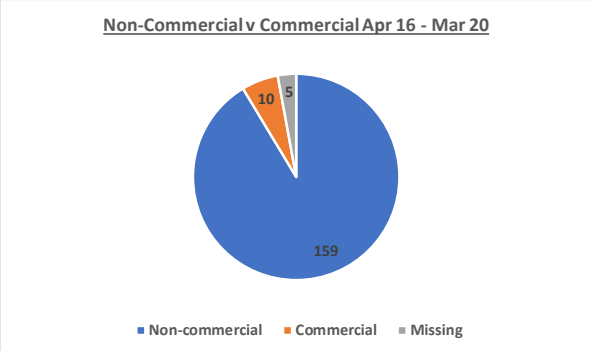


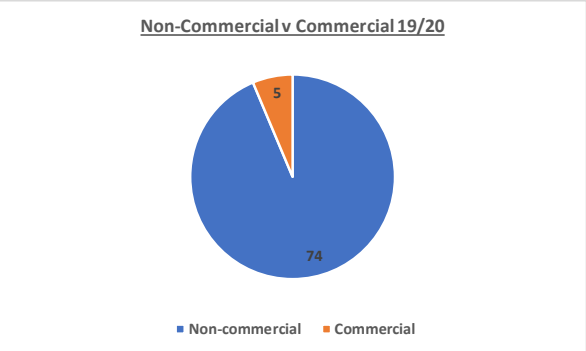


3.5 Commercial v Non-Commercial

The majority of the research that BHFT undertakes is non-commercial Research. This is for a number of reasons in particular neighbouring Trusts being better established, with enhanced facilities and more expertise and experience in commercial trials e.g. London and Oxford Mental Health and Community Trusts. This makes it difficult to compete when submitting expressions of interest. In the last four years BHFT undertook 10 commercial and 159 non-commercial research projects. Data was missing for 5 research projects. Of the 10 commercial research projects, BHFT were a Patient Identification Centre (PIC) rather than a full site in three cases. This means we explain the study to potential participants and with their permission forward their contact details to the study team to undertake the detailed consent procedure and deliver the research project. We would act as a PIC site where we have the patient population but not necessarily the expertise, experience and/or facilities to deliver the research ourselves.

In 2019/20 we undertook 5 commercial and 74 non-commercial research projects. In three cases we acted as Patient Identification Centres for studies on the NIHR portfolio and in the remaining two cases we acted as a site for non-portfolio commercial studies.





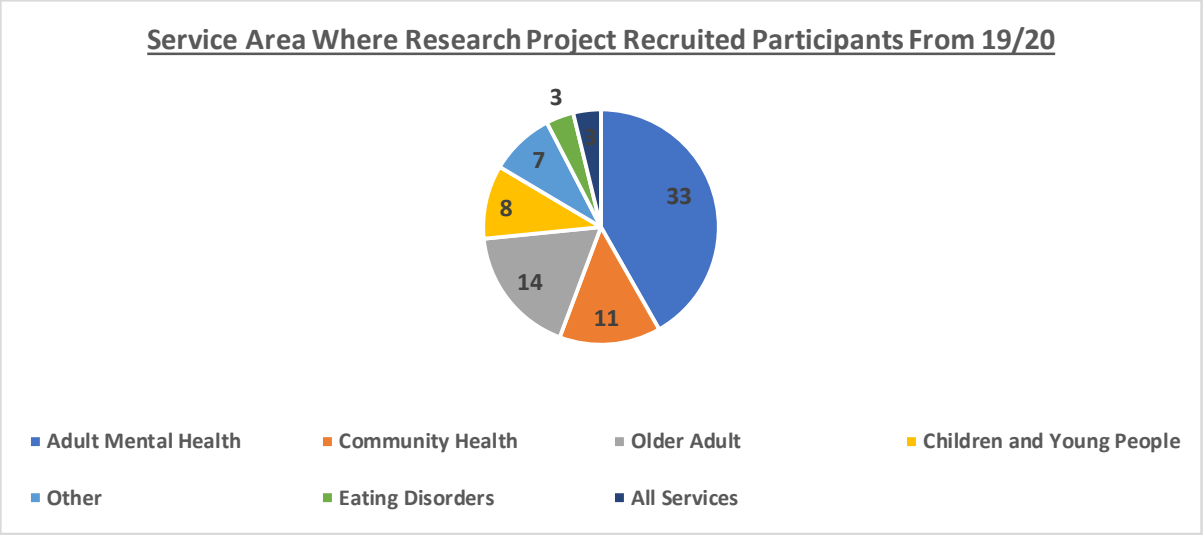
The department expressed an interest in nine Commercial NIHR Portfolio and Non-Portfolio Trials in 2019/20 (see table below). We hosted two non-portfolio commercial trials (sponsored by Silvercloud Health) and supported three studies as a Participant Identification centre (PIC).

Studies the department expressed an interest in 2019/20

ID Number	Study Summary	Type of expression of interest submitted	Success
MENT 37773	Improving Access to Psychological Therapy: An examination of outcomes across three step 2 low intensity psychological treatment intervention	Site Intelligence	Successful
MENT 41399	Internet-delivered CBT intervention for perinatal depression and anxiety: a pilot trial	Site Intelligence	Successful
MENT 43228	A phase II randomized, double-blinded, placebo controlled parallel group trial to examine the efficacy and safety of 4 oral doses of BI 1358894 once daily over 12 week treatment period in patients with Borderline Personality Disorder	Site identification	Unsuccessful
MENT 40219	A Phase 2, Randomized, Double-Blind, Multiple-Dose, Placebo-Controlled Study to Evaluate the Safety and Efficacy of BIIB104 in Subjects With Cognitive Impairment Associated With Schizophrenia (CIAS)	Site identification	Unsuccessful
MENT 43198	An Observational, Prospective UK Study Examining Clinical Outcomes of patients, Carer Burden and Direct Health Care Costs for Patients with Symptoms of Moderate to Severe Major Depressive Disorder (MDD) that have Active Suicidal Ideation with Intent	Site identification	Successful
DEME 43189	Surrogate biomarkers from speech and language for successful clinical trials in presymptomatic and preclinical Alzheimer's (ADVOX 1)	Site identification	Unsuccessful
CHIL 35805	Bumetanide in Children with Autism Spectrum Disorder	Site identification	Successful
MENT	Understanding the information practices and data needs	Site identification	Successful
MENT	Precision in Psychiatry Study (PIPS)	Site Identification	Successful

3.6 Studies broken down by recruiting service area

A large proportion of the active research projects recruit from Adult Mental Health Services, followed by Older Adult, Community Health and Children and Young People. This is true for the last four years as well as the most recent financial year 2019/20.

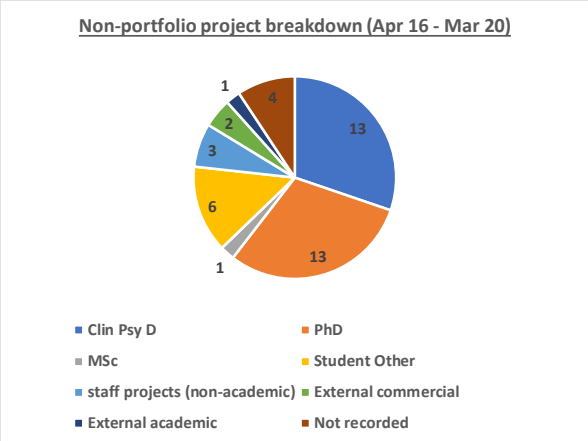


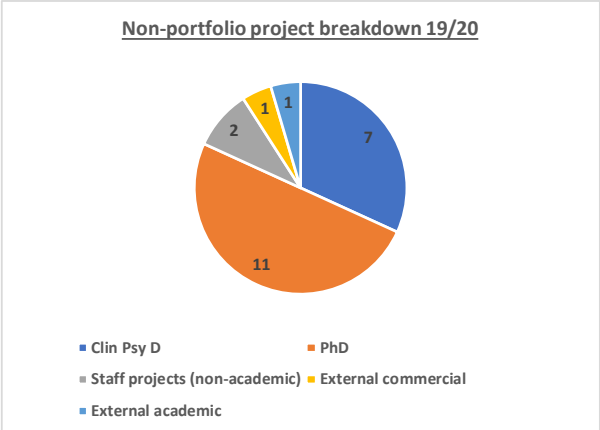
In 2019/20 'other' includes research projects which recruited from Learning Disabilities, Corporate and joint Adult and Older Adult mental health services project.

3.7 Non-portfolio project breakdown

The 43 non-portfolio projects which took place in the last four years were conducted as part of a Clinical Psychology Doctorate (13), MSc (1), PhD (13) and other academic courses (6). In addition three projects were undertaken by staff not linked to academic courses, two were undertaken by an external commercial company/BHFT service and another by an external academic. In four cases this information is not recorded.

In 19/20 11 of the 22 active non-portfolio research projects were conducted as part of PhD and seven were conducted as part of Clinical Psychology Doctorate courses. The remaining projects were staff projects not linked to an academic course (2), external academic (1) or external commercial (1).



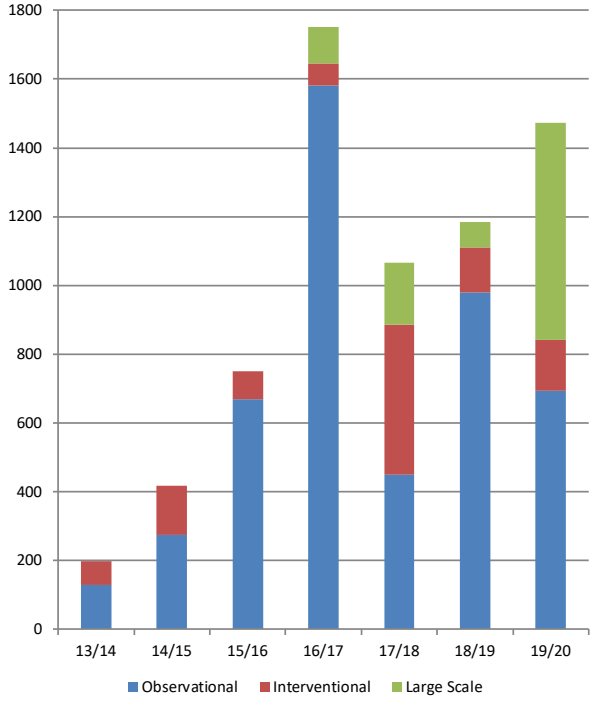


3.8 Portfolio project breakdown (graphs provided by Local Clinical Research Network (LCRN): Thames Valley & South Midlands)

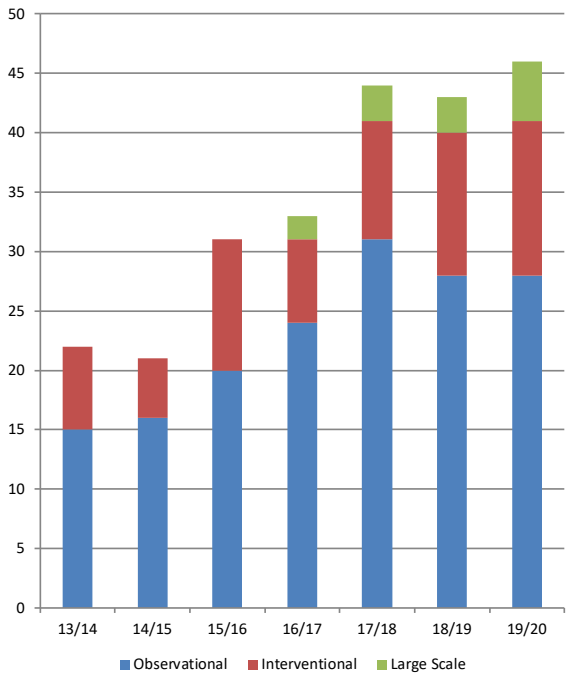
When we look specifically at the NIHR portfolio projects which we have recruited to in recent years the term large scale is also noted as a project category by the CRN which refers to large scale surveys. Within our data sets we have termed these observational although recording will be brought into line with NIHR LCRN practices in future reports. Please note the number of portfolio projects captured by the LCRN is lower than that recorded as part of our own systems above. This is

because LCRN figures relate to those studies which were recruiting only, by contrast, we have noted all NIHR portfolio projects which were open to ensure the total volume of research activity is understood within BHFT. This would include projects in recruitment, in follow up and where we acted as Patient Identification Centres only.

Participant Recruitment to NIHR Portfolio Studies at BHFT (excluding commercial)



Number of Recruiting NIHR Portfolio Studies at BHFT (excluding commercial)



3.9 Further Analysis

Future reports will feature analysis by 1) specialty area and/or condition e.g. bipolar disorder or diabetes services 2) further service area breakdown 3) participant breakdown e.g. patient, staff, carer 4) recruitment numbers where possible.

3.10 Partnership Working- the last four years

Partnership working is of paramount importance to the research we deliver in Berkshire Healthcare. We have worked with 41 universities and 20 NHS organisations over the past four years to bring research opportunities to patients, staff and carers of Berkshire Healthcare (see appendix 2 for details). The relationship with these institutions was in their role as sponsor, employer of the Chief Investigator or base for the study team. Further information on partnership working and collaboration can also be found in section 12 of this report.

Berkshire Healthcare are also members of the UK Research and Development (UKRD) which is a community of R&D Leaders, colleagues with responsibilities to Board for the R&D function in their organisation. Currently the group is feeding their expertise into key government departments to inform ministerial discussions. Our involvement in this group is via the Head of R&D. In addition, a number of staff members in the R&D department link into the NHS R&D Forum (RDF) which is a UK–wide community of practice and professional network for the health and care research management, support and leadership workforce.

4. Impacts and Benefits- What difference did it really make

The current report and previous annual reports have evidenced the high level of research activity which takes place at Berkshire Healthcare NHS Foundation Trust with staff, patients, carers and the public acting as research participants.

Evidence show clinically research active hospitals have better patient care outcomes (Boaz et al, 2015; Jonker & Fisher, 2018; Jonker et al, 2019. However, it is important to ensure that we are clear on the outputs and outcomes of the research that BHFT have been involved in. This will ensure our efforts and resource amount to time and money which is well invested for the benefit of those we serve and who work within our organisation.

To this end, this year we have provided further analysis to help us to better understand the benefits and impacts of the research that BHFT patients, carers and staff have participated in and supported in recent years. A summary can be found below and further details and links to findings from studies that we have participated in will be available on our website shortly.

Our analysis comprised a review of documents which have been published by members of the study teams for closed or long-term open NIHR portfolio projects that we have participated in. These include NIHR reports, peer-reviewed journal articles, guidance documents and other reports.

In summary we can say that the research that we have been involved in previously has resulted in:

- Developing and assessing a tool to understand emotional well-being and need for support for carers of people with dementia.
- Further understanding of the effectiveness of medication in the treatment of Alzheimer's.
- Identifying a valid and reliable new quality of life questionnaire which more adequately considered the impact of long-term health conditions.
- Better understanding stigma and equality for those living HIV/Aids. This information has been used to inform government reports.
- Improving the understanding regarding the neuroscience of Alzheimer's Disease with a view to reviewing current treatments, developing new treatments and a greater understanding of potential treatments.
- Building a repository of information including socio-economic, environmental impact and social support on cognitive decline in dementia.
- Better understanding the delays that can be experienced in providing support and moving forward to improve the experience and quality of life for individuals with young onset dementia. This has resulted in the production of guidance on good practice.
- Individuals with dementia co-producing research regarding medications management. The Alzheimer's Society use this as an example to recommend getting involved in research.
- Identifying clinician related barriers to supporting children with PTSD.
- Better understanding the psychological treatment of panic disorder in adolescence.
- Providing a bespoke smoking cessation intervention for people with severe mental illness.
- Better understanding the complexities of the presentation of patients with psychosis.
- Validation of measures to assess suitability for psychological therapies for distressing voices.
- Developing an online self-help toolkit for friends and relatives of people with mental health problems associated with Psychosis or bipolar disorder.
- Understanding more about contingency management as an intervention for reducing time to acute psychiatric admission or reducing cannabis use in psychosis.

Please note that it has not been possible to obtain outputs and outcomes for all previous research projects that we have participated in due to some projects not having yet published their findings. We will continue to build our repository of outcomes and impacts and share these routinely with BHFT patients, carers and staff. Example service reports which we plan to use to keep staff members up-to-date on research in their areas can be found in appendix 4. We will be trialling these 20/21.

Research that we are currently involved in aims to:

- Explore the psychological impact of COVID-19 outbreak and the resultant restrictions in terms of behavioural, emotional and social factors.
- Better understand current attitudes, practices, training needs, and perceived barriers and facilitators to address and implement smoking cessation treatments.
- Understand the cause and prevalence of memory problems in people with mental health, neurodevelopmental and neurodegenerative disorders.
- Explore and identify themes around how females with both Autistic Spectrum Disorder (ASD) and Bipolar Disorder (BPD) perceive self-harm, abandonment and their diagnosis, in order to learn more about the overlapping features of ASD and BPD.
- Explore clinical efficacy and dose response of a medication for use in Alzheimer's Disease.
- Explore patient preferences for psychological therapies for hearing distressing voices.
- Test automated virtual reality cognitive therapy for patients with fears in social situations.
- Establish the prevalence of pathogenic antibodies in patients with first episode psychosis.
- Understand the views and preferences of staff working in the CRHTT regarding the use of Brief Suicide-specific Psychological Interventions (BSPI) within a Crisis Resolution and Home Treatment Team (CRHTT) service.
- Evaluate whether training in brief suicide-specific psychological interventions (BSPI) with Mental Health Practitioners within a Crisis Resolution and Home Treatment Team (CRHTT) service to support suicidal patients produces measurable changes in nursing practice and patient care.
- Establish patient and public views on the sharing of identified NHS/HSC health data (for clinical purposes) and de-identified health data (for research) within the UK.
- Evaluate the clinical and cost effectiveness of a standardised diagnostic assessment (SDA) tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS).

Please note: only a selection of current research project aims are included above.

We can conclude that as a research active Trust BHFT are providing:

- **Patients** with the opportunity to receive assessments, treatments, therapies and interventions that they would not otherwise have received as part of standard care.
- **Carers** with the opportunity to share their experiences and support their loved ones to participate in research.
- **Staff** with the opportunity to share their experiences, preferences, training needs and barriers re: the delivery of current services and interventions as research participants.
- **Staff** with the opportunity to drill down thoroughly into an area of concern where Quality Improvement, Audit or Service Evaluation methodologies are not sufficient.
- **All research participants** (including the general public for some studies) the chance to contribute to the evidence base on topics that are important to them.
- **Our organisation** with the opportunity to receive funding to provide all of the above opportunities and to support staff interested in research to lead or participate where relevant.

65 publications, which include BHFT staff members as authors, were identified in 2019/20 by the BHFT Library Service. Please see Appendix 3 for list of 2019/20 publications.

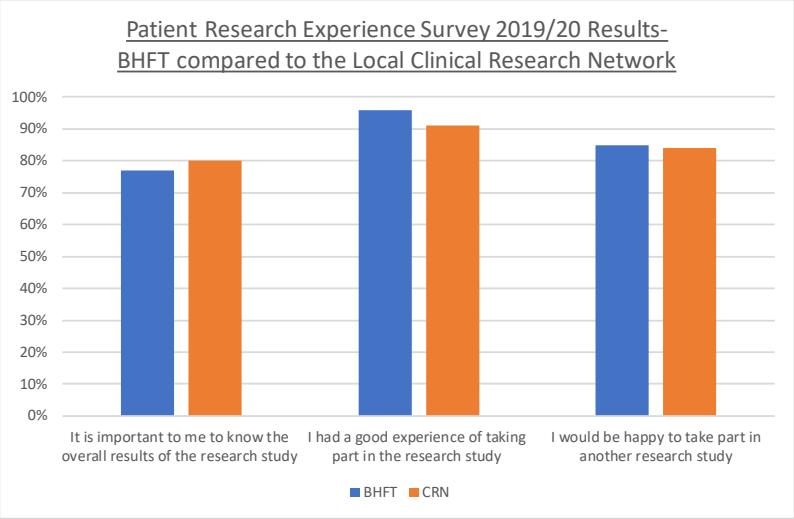
5. Experience of Research Participants - What do research participants tell us?

All NHS Research Departments are required to take part in the national Participant Research Experience Survey. This is developed and led by the National Institute for Healthcare Research (NIHR) and supported locally by the NIHR Local Clinical Research Networks.

BHFT are set a target for the number of survey responses that we need to collect and each year the Research and Development staff members work to promote the survey amongst the research participants that we engage with. It should be noted that where studies are accessed online or anonymously it is more difficult to contact the research participants to promote the survey.

This year our target was 30 survey response, but we collected 106 responses in total. This is 7% of the total number of research participants who accessed a research opportunity with BHFT.

The key findings for BHFT as compared to the wider Thames Valley and South Midland region are as follows:



- The most popular reason for why participants took part in research was to help others (44% BHFT; 39.5% LCRN).
- Most respondents (77% BHFT, 80.1% LCRN) agreed or strongly agreed that it was important to them to know the overall results of the research study.
- Most (96% BHFT, 91.1% LCRN) strongly agreed or agreed that they had had a good experience of taking part in the research study.
- Most respondents (85% BHFT, 84.3% LCRN) agreed or strongly agreed that they would be happy to take part in another research study.

We have also received feedback from our research participants which have been captured in case studies by the communications team at the LCRN. Links to the full publicly available case studies are provided at the bottom of the page.

Research Participant Feedback

To read real-life stories in full from those participating in research from Berkshire Healthcare and the wider Thames Valley and South Midlands region please use the following link: https://local.nihr.ac.uk/lcrn/patient-stories/?custom_in_LCRN=22640

What will we do with our research participant experience information?

The feedback from the research participants who took part in the national survey was overwhelmingly and comparatively positive. Potential improvements to our service to further improve participant experience have been suggested by the R&D team. These include:

- Providing feedback about the results of the research projects that people have participated in routinely in a more structured and accessible way.
- Reviewing the procedures that we have in place to ensure that participants do not become 'research tired'. This should include adequate monitoring of participants who are approached for multiple research projects, ensuring participants would like to remain registered on our research interest list and ensuring continuity of researcher where possible.
- Develop our offering to ensure that patients and the public can be involved in all stages of the research process at BHFT.

6. Equity of Access- What we know about equity of access to research opportunities at BHFT

Equity of access is of key importance to BHFT. One of the strategic objectives in the BHFT Equality and Diversity strategy (2016-20) states: "We want to engage with diverse groups in particular BME, LGBT and disabled people to inform our understanding of their needs, ensuring a good patient experience and equity of access in both mental and community health".

Equity of access is one of the principles by which the work of the NIHR Coordinating Centre and Local Clinical Research Networks are guided: "We work to ensure patients, carers, the public, and healthcare professionals….have opportunities to participate in and benefit from the widest range of high-quality health and social care research studies…..people should have the opportunity to participate in studies relevant to their health condition, conducted in accessible locations".

The BHFT R&D department aims to provide as many people as possible with research opportunities i.e. access to the latest treatments, interventions and assessments which would not otherwise be available as part of standard care. In 2019/20 we ranked 7th out of 49 Trusts for the volume of high-quality research projects that we recruited participants into. We offer more opportunities for research participants to participate in observational and non-commercial studies compared to interventional and commercial studies but are working to provide greater access to interventional and commercial studies. This will be balanced with needs and priorities of our patients and carers.

Wherever possible we invest in a range of clinicians who are embedded within clinical services to support the development and delivery of research rather than within a central R&D department. This helps to provide local access to opportunities which are relevant to local populations. In 19/20 clinicians were funded to undertake research in Older Adults, CAMHS, Talking Therapies, Sexual Health, Learning Disabilities, Perinatal, Cardiac and Respiratory and Diabetes Services. These clinicians are located across the county of Berkshire from Thatcham in the West to Slough in the East, work in many settings- hospitals, clinics, community bases, universities and people's homes.

Whilst aiming to provide research opportunities to all as part of routine care we also maintain a Research Interest List (RIL) which clinicians can refer to/patients and carers can sign up to in order to receive information about relevant research projects. The national 'Join Dementia Research (JDR)' database is also accessed in order to identify local research interested individuals.

The following areas are being explored to better understand equity of access in R&D:

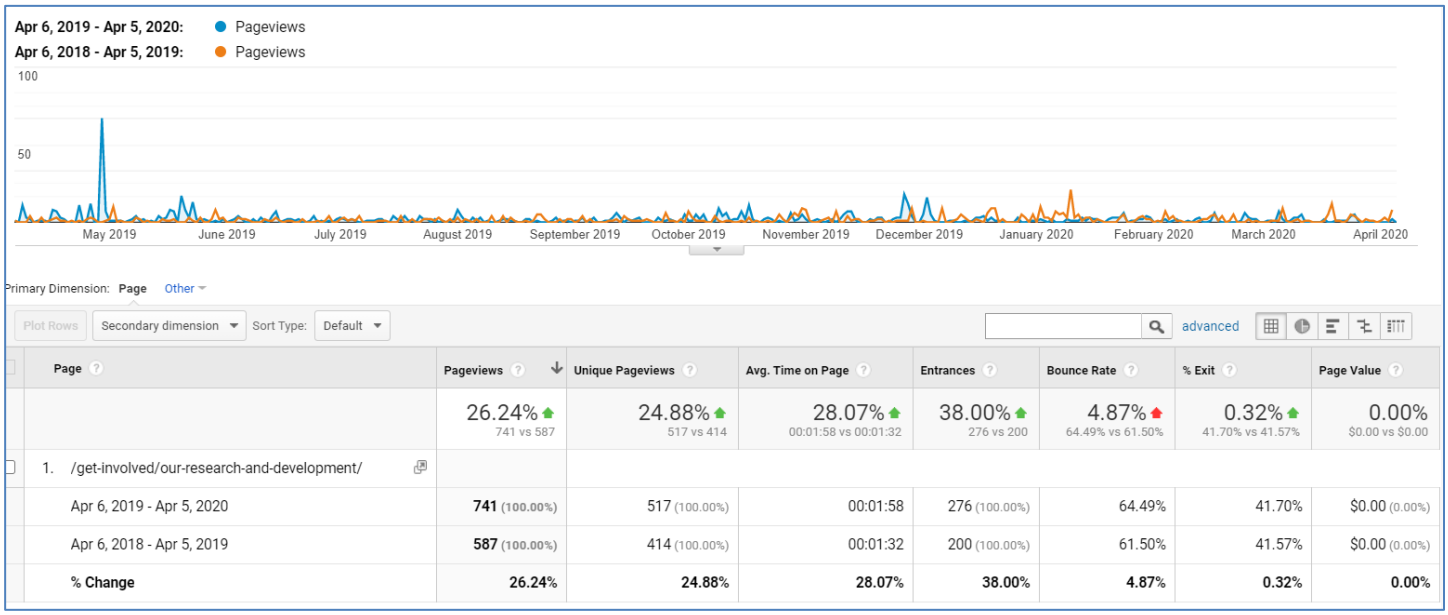
Question	Current knowledge	Next steps
To what extent are research opportunities available across BHFT?	Lead Research Nurse or Clinical Research Practitioner providing oversight Trustwide. Research staff employed in some Trust services.	Consider feasibility of having dedicated research active individuals in each service area.
To what extent is our Research Interest List representative of the communities we serve?	80% of our RIL is comprised people age 65+ due to the list originating in older adult services. There is a fairly even split between genders. 75% are British and whilst the majority of localities in Berkshire have 13-16%, Wokingham residents account for (23%) of interested individuals.	Research interest question is being incorporated into forms on RiO. This should increase the number of people who are able to be contacted about research opportunities significantly.
How representative are our research participants of the communities we serve?	This is difficult to analyse as many research participants sign up online or data goes directly to the study team in line with the consent process. Study eligibility criteria is key to identifying and providing access to participants.	Ensure that our RIL is representative and that individuals are told about research projects as part of routine care. Challenge study teams where groups are excluded.
To what extent are Berkshire residents able to access the same opportunities as those in neighbouring counties?	Each Trust provides slightly different research opportunities. This is based on local needs, expertise, funding, required samples and networks but equity of access can be improved.	Review neighbouring Trust research portfolios to identify inequity. Work together to provide greater equity where possible.

7. Communication and Promotion- How do we promote and communicate research at BHFT?

The Research and Development team continually promote research and related opportunities.

Website – a list of open research studies has been added to our webpages and some content updated. We are currently reviewing our webpage which will be updated further in 20/21. Our web metrics report is presented below. Spikes in figures are often due to social media posts, news items, or the team attending an event. External variables such as time of the year and news reports (e.g. BBC report on a new vaccine) can also lead to people Googling our services. Highlights include:

- Increase in unique pageviews (24%)
- Users spending longer on the page (~26 seconds more on average)
- Significant spike noticed in May, potentially due to #IAmResearch campaign
- In 19/20, more users went on to the 'take part' page (119) compared to 18/19 (58)



Primary Dimension: Page Other

Plot Rows | Secondary dimension | Sort Type: Default | advanced

Page	Pageviews	Unique Pageviews	Avg. Time on Page	Entrances	Bounce Rate	% Exit	Page Value
	26.24% 741 vs 587	24.88% 517 vs 414	28.07% 00:01:58 vs 00:01:32	38.00% 276 vs 200	4.87% 64.49% vs 61.50%	0.32% 41.70% vs 41.57%	0.00% $0.00 vs $0.00
1. /get-involved/our-research-and-development/							
Apr 6, 2019 - Apr 5, 2020	**741** (100.00%)	517 (100.00%)	00:01:58	276 (100.00%)	64.49%	41.70%	$0.00 (0.00%)
Apr 6, 2018 - Apr 5, 2019	**587** (100.00%)	414 (100.00%)	00:01:32	200 (100.00%)	61.50%	41.57%	$0.00 (0.00%)
% Change	**26.24%**	**24.88%**	**28.07%**	**38.00%**	**4.87%**	**0.32%**	**0.00%**

Social media: We are increasingly using social media platforms to promote research and specific research participation opportunities. Specifically, Twitter, Facebook and LinkedIn.

Post
International Clinical Trials day – our team visiting hospitals across the region
International Clinical Trials day – find out more about our research
International Clinical Trials day – research helps us develop new treatments – find out more
Our R&D team share what research means to them
Our R&D team were at Broad Street Mall
Promoting a study to people who provide caring support for a loved one with psychosis
Social media posts to inform participants of a potential Bipolar Disorder study

Promotional events and initiatives attended by the R&D department – 19/20

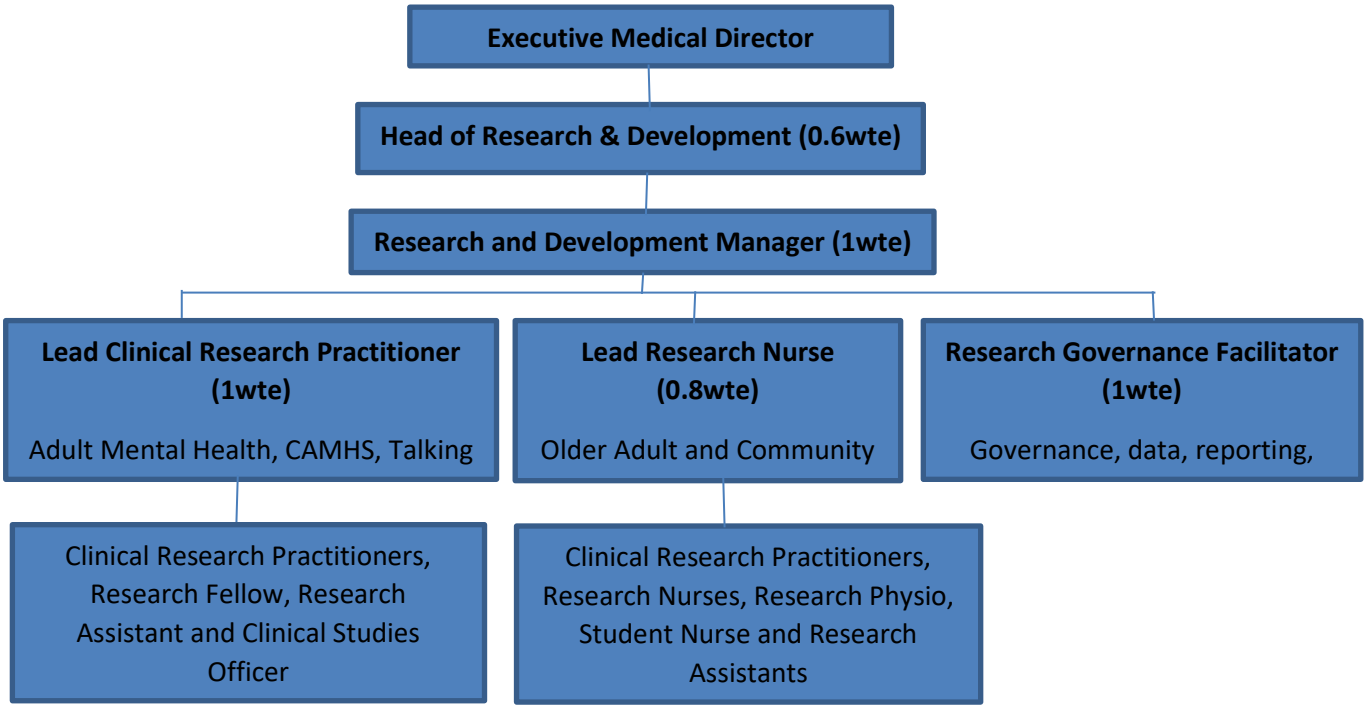
- 5th Annual Primary Care Research Symposium, Green Park Conference centre.
- Raising awareness at Oracle shopping centre on February 2020.
- Work to improve the information provided to services regarding relevant open research studies. Beginning in memory clinics, this included posters in waiting areas and Psychology Assistant support for clinicians to help identify patients who may be eligible for specific studies.
- Monthly Trust induction and Junior Doctors Induction
- Psychological Therapies Research Showcase event at UoR for BHFT Psychological Therapies staff. The purpose of the event was to share and thank staff members for their research contributions.

8. People and Finances- Who delivers research at BHFT and how is it funded?

8.1 R&D department structure and staffing

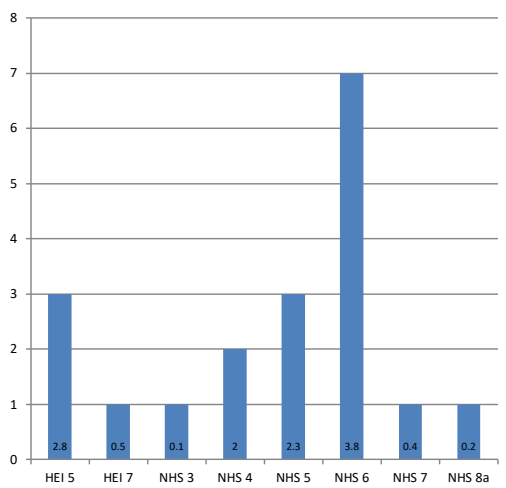
The core BHFT R&D team are based at the University of Reading in the School of Psychology and Clinical Language Sciences.

Our core team comprises:

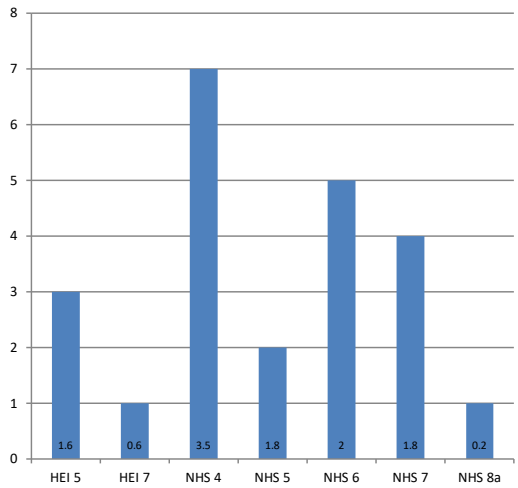


The Head of Research and Development joined the department in May 2019. During the course of 2019/20 we have had 30 full or part time permanent and fixed term research nurses/AHP's, clinical research practitioners and assistants who are either based in clinical services or with the R&D department core team. Posts vary each year depending on turnover, research funding and requirement. The majority of staff funding comes from the NIHR LCRN (19 posts; 12.1wte in 18/19 and 23 posts; 11.5wte in 19/20). Additional funding is provided by individual project income (see below) and BHFT contribution (£33k).

LCRN funded posts wte 18/19



LCRN funded posts wte 19/20



As part of international clinical trials day 2019 R&D staff shared why they want to be part of research:

8.2 Research and Development External Funding

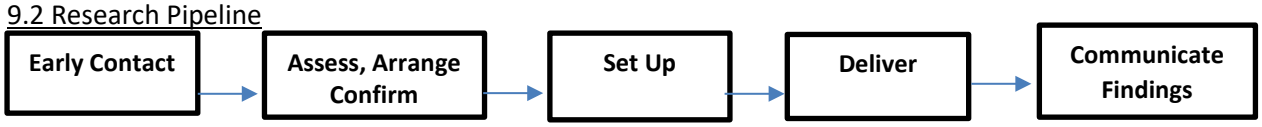
Source	2017/18	2018/19	2019/20
NIHR CRN **CRN contingency funding** **CRN Greenshoots funding**	392,792 12,432 0	400,000 39, 413 0	420, 000 5, 000 13, 358
ETC Funding re qtr 4 2018/19	0	0	3, 106
Research Capability Funding (RCF)	25,016	20,000	20, 000
Commercial Income	13,247	10,453	2, 414
Other Funding			
PoMeT Research project	11,056	0	0
IBER Study	0	5,258	150, 353
STADIA	0	0	7,003
ASCEND	0	0	2,755
Totals	**454,543**	**475,124**	**623,990**

9. Governance- How do we ensure research at BHFT is delivered safely and effectively?

9.1 Overview

Research governance refers to the broad range of regulations, principles and standards of good practice that ensure high quality research. The R&D department is responsible for ensuring BHFT comply with the UK Policy Framework for Health and Social Care Research and related regulations.

9.2 Research Pipeline



9.3 Research Activity Oversight

The R&D department is responsible for being aware of and registering all research activity that takes place involving BHFT staff, patients, carers or data. In 19/20 we ran a series of communications to ensure that all staff members were aware of this requirement. This included reminders and an open invitation to inform the R&D department about any research that staff may be aware of past, present or future. Communications took place via Trust and local Clinical Effectiveness Groups/Newsletter, Team Brief, Clinical Directors, induction and as part of our attendance at events.

9.4 Standard Operating Procedures and Policies

In 19/20 the R&D department undertook a review of all the existing Research policies and Standard Operating Procedures (SOPS). In line with the UK Policy Framework for Health and Social Care, these;

- Safeguard the participants of research projects
- Protect investigators/researchers by providing a robust and clear framework
- Monitor practice and performance
- Enhance the ethical and scientific quality of research
- Promote good practice and minimise risk

SOP and policy updates which have been implemented so far as a result of the review include a new process for the approval and management of Trust sponsorship for research. This has been designed with Trust Clinicians and University colleagues and features a more robust, structured peer review.

9.5 Data management

Review of processes for capturing/uploading research study information into local research databases was completed to align these to regional systems and to ensure data quality.

9.6 Research passport, honorary research contracts and letters of access

To ensure appropriate access for research purposes to our patients, staff and/or Trust premises, all researchers must have a substantive post with BHFT or be issued with an honorary research contract, or letter of access (LoA) accompanied by a complete Research Passport. In 2019/20 the department issued 54 LoA's to researchers. Local services are involved in these requests.

9.7 Reporting Arrangements

Reporting arrangements include an R&D committee which is chaired by the Head of Research and Development. The R&D Committee met twice in 19/20 and will be relaunched in 20/21. The Medical Director attends as required. R&D report every two months into the Clinical Effectiveness Group.

9.8 Monitoring Arrangements

The R&D department began the development of a comprehensive audit programme at the end of 19/20 to ensure agreed procedures and policies are being followed as part of quality assurance. No Adverse Event or Reactions were reported in 19/20.

10. Performance- How well do we meet our targets and how do we compare to similar Trusts?

10.1 Overview

The R&D Department monitors performance where possible according to three different sets of parameters namely NIHR CRN High Level Objectives, specific BHFT objectives set by the LCRN and internal team objectives which in previous years including 19/20 have generally reflected NIHR and LCRN objectives. We are formally monitored via our LCRN contract on our specific BHFT objectives and we translate these into internal department and individual objectives which we monitor through appraisals. This section of the report notes each set of performance objectives and where relevant our performance. Further performance information follows the objectives tables.

10.2 NIHR CRN High Level Objectives

Objective
1A. Increase the number of research participants
1B: Increase the number of commercial research participants.
2A Increase the proportion of research studies funded by life sciences companies that are delivered in line with the study's planned participant recruitment target and delivery time
2B: Increase the proportion of studies funded by non-commercial organisations that are delivered in line with the study's planned participant recruitment target and delivery time
3A: Increase the number of studies funded by life sciences companies which are supported by the CRN
3B: Increase the proportion of new studies funded by life sciences companies which have received clinical trial authorisation.
HLO 4 and 5 withdrawn. Replaced with new objective HLO 9
6A: Increase the proportion of NHS Trusts which are active in research
6B: Increase the proportion of NHS Trusts which are active in research funded by life sciences companies
6C: Increase the proportion of General Medical Practices active in research
6D: Increase the number of non-NHS sites recruiting research participants
7: Increase the number of participants involved in research into dementias
8: No. of NIHR CRN Portfolio study participants responding to Participant in Research Experience Survey
9A: Reduce the median time it takes to set up research studies funded by life sciences companies by 5%
9B: Reduce the median time it takes to set up research studies funded by non-commercial organisations by 5%

10.3 BHFT specific objectives allocated by LCRN 2019/20

For 2019/20 the LCRN set the following specific objectives for BHFT in line with their Annual Plan:

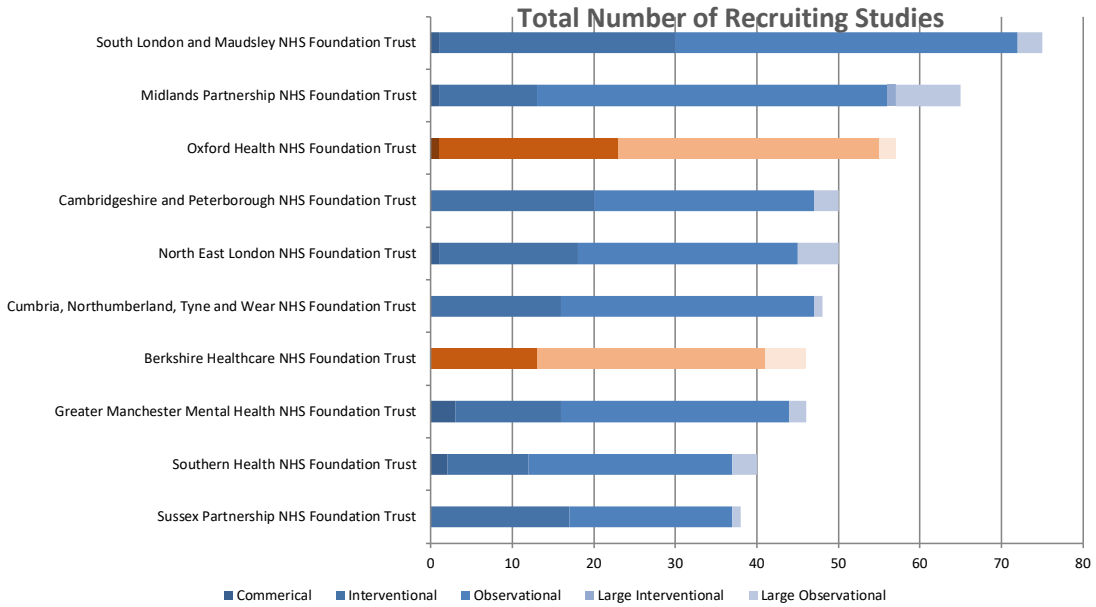
BHFT specific objective (set by LCRN)	**Performance**
Overall recruitment target of 1300 (HLO1a)	Exceeded
Support the LCRN communications and engagement team to deliver three press releases about trust research, with patient case study.	All press release requests delivered
Deliver 30 responses to the Patient Research Experience Survey (LCRN)	Exceeded
Submit quarterly financial returns on time (4/4 returns submitted by deadline)	Achieved
Undertake financial controls visit during the financial year	Achieved
Attend monthly LCRN R&D meetings	Achieved
Ensure that 100% of studies upload recruitment promptly to LPMS (Studyline)	Achieved

10.4 The R&D department objectives 2019/20

Research & Development Objectives for 2019/20				
Objective		**Measure**	Target	Met?
1	Deliver significant levels of participation in NIHR CRN Portfolio studies ensuring: • Studies achieve set up time, • Recruit first participant early • Recruit to time and target. • We support at least one commercial trial	Number of participants recruited to NIHR CRN Portfolio studies	1300	1488
		Eligible studies achieving set up within 40 calendar days (from "Date Site Selected" to "Date Site Confirmed")	80%	90%
		Proportion of Commercial/Non-commercial contract studies achieving first participant recruited within 30 days confirmed (from "Date Site Confirmed" to "Date First Participant Recruited")	80%	Yes
		Proportion of commercial/Non-Commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period.	80%	Yes
		Host new Non-CTIMP commercial contract studies	1	No
2	Deliver significant levels of participants recruited into NIHR Portfolio Dementias and Neurodegeneration studies.	Number of participants recruited into Dementias and Neurodegeneration (DeNDRoN) studies on the NIHR CRN Portfolio	TBC	No
3	Promote clinical research across Trust services.	Trust wide research events initiated by the department. The number of new Principal Investigators of NIHR Portfolio studies	5 5	No TBC
4	Patients and Public involvement in research	The number of patients; • responding to patient experience survey • Signing up to Patient Research Ambassadors Program	 50 5	 Yes TBC

10.5 Additional Performance Information

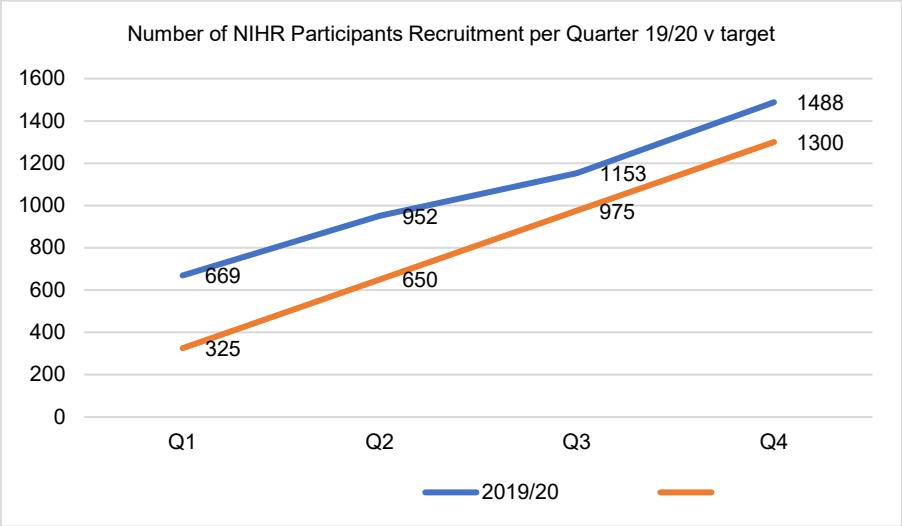
10.5.1 Recruitment to NIHR Portfolio Research Projects at Mental Health and Community Trusts- Top 10 (Graph provided by Clinical Research Network: Thames Valley & South Midlands)



BHFT ranked 7th out of 49 benchmarked Trusts in England.

10.5.2. NIHR portfolio set up and recruitment

Our NIHR participant recruitment target was 1300, we exceeded the target by 188 participants due mainly to our dedicated team, new recruitment strategies and recruitment drives, strengthening the leadership team and embedding clinical research practitioners wherever possible in clinical teams. In 2019/20 the highest recruiting study had 214 participants compared to 133 in 2018/19.



10.5.3 Clinical Trials Performance (CTP)

The Department of Health and Social Care is committed to improving clinical trial performance and reducing site set up and participant recruitment time. To this end NHS providers are required to report delays which have affected or may affect agreed clinical trial study timelines. In particular we are required to publish information on recruitment to clinical trials and delivery to time and to target for commercial clinical trials on our website using a Clinical Trials Performance report.

Eight of the NIHR Portfolio studies that we participated in (see table below) were eligible for the Clinical Trial Performance (CTP) report. To access our 2019/20 CTP reports please visit the link https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development/. Three of these studies did not recruit the first participant in 30 days because no patient consented.

Table show studies that were eligible for the BHFT CTP report.

IRAS Number	Name of Trial
256895	The gameChange Trial: A randomised controlled trial testing automated virtual reality cognitive therapy for patients with fears in everyday social situations
196438	Effective Home Support in Dementia Care: Project 2.1 Dementia Early Stage Cognitive Aids New Trial (DESCANT)
240881	Imagery Based Emotion Regulation for Bipolar Disorder
238744	Early Youth Engagement in first episode psychosis (EYE-2) RCT
258585	Smoking Cessation Intervention for severe Mental Ill Health Trial (SCIMITAR Plus):
254963	Internet-delivered CBT intervention for sleep disorder: a pilot trial
255635	STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties (STADIA)
259611	Re-evaluation of Annual Cytology using HPV testing to Upgrade Prevention (REACH UP): a feasibility study in Women Living with HIV

10.6 Research and Development Annual Report 2018/19

As part of our 2018/19 annual report the R&D department set out a number of activities for completion during the financial year 19/20. The activities together with progress is noted below:

Activity	Progress
R&D Department Baseline Review	Completed October 2019
Research and Development strategy As a minimum a future Trust R&D strategy will need to include:	Postponed until 2020/2021 due to workload
Trust priority alignment- increased research activity aligned to Berkshire Healthcare True North Goals and service specific priorities.	Plan on a page completed in line with True North Goals (see section 12).
Research Development support for locally led research- helping clinicians to receive support to develop, deliver, analyse and write up research ideas as well as apply for research funding.	Review of current demand, capability and required resource is underway.
Research into Practice initiatives- clear mechanisms to feed research results back into the organisation and to implement research findings where clear evidence has been established.	Findings included in R&D annual report. Service specific research reports designed for discussion with clinical services. Showcase event held in Psychological Therapies
Clear roles and integration of Patient and Public in all research activity	PPI plan in development
Equality and Diversity focus- ensuring all services are supported to offer all available research opportunities to all eligible patients and carers, that Berkshire residents receive the same research opportunities as neighbouring counties, including the latest treatments and interventions as part of commercial and non-commercial trials.	See section 6.
Building our commercial research capability and capacity- enabling more patients to receive medications as part of pharmaceutical company sponsored clinical trials.	Links made with regional experts to provide support, training and mentoring for involvement in clinical trials. Clinical Trials Pharmacist appointed begins 20/21.
Establishing sustainable relationships with partners- enhancing the research opportunities available to patient, carers and staff members by partnering with and supporting local academics, industry, voluntary sector and other health and social care organisations.	See section 11.

10.7 CQC Requirements

In September 2018 the CQC signed off the incorporation of clinical research in its Well Led Framework (NHS Trusts). The focus is on how well an NHS Trust as a whole supports research activity at three levels. These are noted below and addressed in numerous sections throughout this report:
Research equity – *how does the organisation support the research programme across the breadth of its services?*

Research facilitation – *how does the organisation proactively support the delivery of research from board level to the clinical setting(s)?*

Research awareness – *how does the organisation make research opportunity known to patients, the public and healthcare professionals?*

11. Partnerships and Collaborations

A summary of key partnerships and collaborations together with activities in 2019/20 were as follows:

11.1 NIHR Local Clinical Research Network (LCRN) Thames Valley and South Midlands

The NIHR Clinical Research Network comprises 15 Local Clinical Research Networks that cover England. They coordinate and support the delivery of research in the NHS and wider health and social care landscape. The LCRN that we relate to is Thames Valley and South Midlands which covers Berkshire, Buckinghamshire, Milton Keynes and Oxfordshire.

As discussed earlier in the report the LCRN is our main funder however they also provide networking and training opportunities, expert support, guidance and national and regional updates. As an organisation we attend meetings and contribute to initiatives at Executive, Head of Service, Manager and Lead practitioner/Research Nurse level.

11.2 University of Reading including Thames Valley Clinical Trials Unit

Our main research collaborations with the University of Reading are with the School of Psychology and Clinical Language Sciences. In the last year we have supported academics with developing research proposals, linked academics with clinicians to work on research ideas, funded academics to support the development of key research areas, funded staff to support NIHR portfolio delivery, acted as lead NHS organisation or participating site for University of Reading led NIHR portfolio studies, reviewed the work and function of the Thames Valley Clinical Trials Unit and met regularly with the Heads of School to ensure we are prioritising areas of mutual interest. Masters course information including placement opportunities were also shared by University of Reading colleagues at our recent Psychological Therapies showcase event.

Outside of the School of Psychology and Clinical Language Science we have also supported research projects and/or funding applications with the School of Pharmacy and Department of Food and Nutritional Sciences. We have also met with the Department of Computer Science, Henley Business School- Informatics stream and Biomedical engineering to explore potential opportunities relating to our digital and technological developments as part of the Global Digital Exemplar. These will be further explored in 20/21.

11.3 Oxford Health NHS Foundation Trust

Over the last year BHFT have developed a relationship with its near neighbour Oxford Health. We have reviewed similar objectives and complementary interests and are looking to put ourselves in a position to exploit any joint opportunities. This is at an early stage, but Oxford Health have already presented a number of opportunities for us to act as a Patient Identification Centre (PIC) for some of their research projects. Learning has also been shared around 'consent to contact' for research, the national opt out requirements for research, Information Commissioner Officer visits and sponsorship processes to prevent duplication of effort. A joint meeting was also held to discuss how we might better work with GP's to identify research participants. This collaboration is endorsed by the Thames Valley and South Midlands Clinical Research Network.

11.4 Royal Berkshire Hospitals NHS Foundation Trust

In January 2020 BHFT and RBH met to discuss potential collaboration opportunities. Information regarding department structures and team skill sets were shared. It was felt that collaborations relating to Dementia and Neurodegeneration studies might bring the most benefit to Berkshire

residents as RBH open relatively few NIHR portfolio studies in this specialist area and it is a national priority area. Meanwhile BHFT have expertise in the team to deliver these studies but not necessarily the equipment and medical back up that may be required. We will continue to explore these opportunities later in 20/21.

11.5 Oxford Academic Health Science Network (AHSN)

BHFT are represented on the Oxford AHSN R&D group by the Head of R&D. Chaired by Joe Harrison, Chief Executive of Milton Keynes University Hospital NHS Foundation Trust, and led by Prof Gary Ford, Chief Executive of the Oxford AHSN, the R&D group comprises representatives from universities, NHS trusts and related bodies in the Oxford AHSN region. The group meets approximately three times a year and its remit is to provide opportunities for collaboration between the NHS and university partners within the region in all aspects of R&D impacting on health and healthcare. During 2019 the Oxford AHSN worked with regional research partners to implement the findings of a national survey of local NHS research and innovation needs commissioned by the AHSN Network with the National Institute for Health Research (NIHR) and NHS England.

Benefits of representation at the R&D group include the receipt of key updates for example AHSN programmes, NIHR Applied Research Collaborations, Clinical Trials Unit review and the UK Clinical Research Collaboration.

12. Strategic Alignment- R&D as a core part of the BHFT offer

The R&D Department have been working in 19/20 to further align ourselves with the wider BHFT vision and objectives. In particular we have focussed on the True North Goals. Our plan on a page is presented below. In relation to the BHFT vision one of the ways we can be recognised as a leading mental health and community service provider is by offering opportunities to access the latest treatments and interventions which would not otherwise be available as part of standard care. This can be achieved by participating in national research projects and we benefit free resource to deliver these interventions whilst on trial.

In addition to delivering externally led research projects within BHFT we also support individuals within the organisation to undertake their own research. This is just one 'tool' in a BHFT staff member's toolbox which can assist them to better understand and improve the services that they provide. The other tools are audit, quality improvement and service evaluation:

Research- allows us to drill down into an area which we would like to better understand e.g. why do some groups of the population not access services? Does service model x work better than service model y? Something will usually be classed as research if i) it involves randomising people into different groups, ii) the study protocol requires changes to treatment, care or services from accepted standards or iii) the study is designed to produce generalisable or transferable findings.

Audit- enables us to find out if are we following specific standards set out for us as part of policies and guidelines e.g. NICE guidelines.

Quality Improvement- allows us to make incremental changes to existing processes and services. BHFT has a comprehensive programme of training and support in relation to QI methods and tools.

Service evaluation- enables us to answer the questions- is this service doing what it set out to do?/what standard does this service achieve? It seeks to measure existing services and generally involves some or all of the following: i) staff or patient experience ii) safety iii) effectiveness iv) service utilisation and v) cost benefit.

Team name: Research and Development

TEAMS Plan on a page 2020/21 (Team Objectives)

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

True North goal 1: Harm-free care

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

We will do this by:

1. Increasing the proportion of research projects which relate to COVID-19 and the reduction of falls, pressure ulcers, self-harm and suicide.
2. Ensuring increased visibility for clinical and service leads of all current research and proposed future research.

True North goal 2: Supporting our staff

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

We will do this by:

1. Improving our research development support offering for individuals who would like to develop and/or deliver research studies
2. Better support research career development pathways
3. Increase retention by understanding and better supporting staff wellbeing
4. We will support staff to embed working remotely for a significant part of their role and to develop the necessary skills to operate safely and effectively.

True North goal 3: Good patient experience

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

We will do this by:

1. Using the patient research experience survey feedback to make necessary improvements to our service including specific engagement on new ways of working where relevant
2. Work with our partners to increase the proportion of interventional v observational research
3. Increasing access to research opportunities in service areas where there are no current active research projects

True North goal 4: Money matters

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

We will do this by:

1. Reviewing approval, screening and delivery processes to ensure that they are as efficient and effective as possible.
2. Identify an increased number of research projects that focus on technologies which reduce clinical time for BHFT services.
3. Move to electronic systems and eliminate paper where possible.

IMPORTANT: depending on the focus of your team, you may have just one team objective under one True North goal and four or five under another section e.g. most Human Resources Team objectives will relate to True North 2

See reverse for guidance

13. 20/21 Highlights- What has been happening in R&D to date this financial year?

In the first part of 20/21 the R&D department focus has been responding to the impacts of the COVID-19 pandemic on existing research, supporting the wider COVID-19 effort within BHFT and supporting new COVID-19 research. More specifically:

- Adapting to working remotely
- 12 of our existing NIHR portfolio studies were paused due to the in-person delivery method.
- 12 amendments were processed to allow research projects to move from face-to-face delivery to online delivery.
- All staff embedded in clinical services were given permission to use their research funded time for clinical work as required.
- Two staff members were redeployed part time to the staff redeployment bureau.
- Three staff members were redeployed part time to the Royal Berkshire Hospital between April 2020 and June 2020 to support the COVID-19 ISARIC. The aim was to study the COVID-19 disease to better understand its spread and behaviour by analysing biological samples and data from patients with confirmed cases of the disease across the UK. The study team collected samples and data from COVID-19 patients in 166 UK hospitals to answer many urgent questions about the virus in real time. This was Europe's largest analysis of hospitalised patients with COVID-19. BHFT staff supported with the lengthy documentation completion for participants which RBH found it difficult to resource alongside it's numerous other COVID-19 studies.
- The NIHR Clinical Research Network have asked us to prioritise Urgent Public Health studies, followed by other COVID-19 projects. We continually review all projects in these categories and whilst earlier studies were tailored to acute hospitals we are now seeing more that BHFT could potentially take on/be involved with as part of wider collaborations.
- To date we have opened two COVID-19 studies – Psychological Impact of COVID-19 and COVID-19- enforced social isolation and mental health.
- More recently we have also been asked to prioritise the national RESTART initiative which as the name suggest requires us to now restart all paused research and to start any NIHR portfolio project that are in our pipeline but we have delayed starting due to COVID-19.

14. Future Direction- Where next for R&D at BHFT

Over and above the plan on the page that we have developed for 20/21 and COVID-19 requirements we will be working to restart the development of the BHFT R&D strategy. This will include:

- Clarity around the extent to which BHFT wish to engage in **commercial research** and agreed approaches for doing so.
- **Further alignment with service priorities** via plans on a page, QMIS project filters, service plans.
- **Patient and Public Involvement plan** for research linking in with existing groups if possible.
- **People plan** to better support and increase the expertise of R&D funded staff members
- **In-house research support services improved offer** within existing resources and capabilities with a potential investment case outlining what could be achieved with further investment.
- **Exploring the value of the R&D department as a wider research and evidence function** as opposed to a department supporting design and delivery of research only, with a view to further supporting evidence-based decision making across the organisation.
- **Partnership and collaboration plan**- including other neighbouring NHS acute Trusts, NHS mental health Trusts, Universities and the charitable sector.

Appendix 1

Summary of All Studies in Berkshire Healthcare FY2019/20 by Condition/Topic Area

Dementia – 2019/20 projects			
Study title and lead	Summary	Reference	Study end date
Alzheimer's Dementia Genetics **(PI- Nick Woodthorpe)**	ADG is a study run by Cardiff University looking for DNA bio-markers specifically related to Alzheimer's disease. This involves a blood test preferably but samples of saliva can be collected where bloods are not available. Cognitive measures, a quality of life questionnaire and family history are collected in addition to the samples. (Study on hold)	2014-31b	31/03/2021
BDR3 **(PI- Gwen Bonner)**	Brains for Dementia Research is a study whereby participants have donated their brains to the research project following their death. In a longitudinal approach participants are reviewed on an annual basis to understand their cognitive function, physical health and other specified markers which are then paired with brain tissue analysis following harvest of the brain.	2018-14	31/03/2021
Dementia with Lewy Bodies Genetic study **(PI- Nick Woodthorpe)**	DLB Genetic study is a study run by Cardiff University looking for DNA bio-markers specifically related to dementia with Lewy bodies. This is a branch of the original Alzheimer's Dementia Genetics study and has the same samples to be collected including blood test (or saliva where this is not possible), cognitive measures, quality of life questionnaire and family history.	2019-05	31/07/2020
Nutrition, hydration and care for people with dementia at the end of life: How can we best support family carers? **(PI- Adebayo Anjorin)**	The aims of this University College London study are to explore carers' understanding of how best to manage eating and drinking at the end of life for someone with dementia; establishing if there are gaps in their knowledge and also identifying what information Practitioners provide to carers. We will set the scene for developing a carer resource if this appears desirable.	2019-20	31/07/2020
Exploring and managing dementia in black African and Caribbean Elders – EMBRACE **(PI- Stephen Zingwe)**	Our Older adult services will collaborate with University College London to conduct a qualitative study with semi-structured interviews and participant observations to explore how people from the UK's Black ethnic groups and their families and friend carers conceptualise and manage memory problems and dementia, their expectations of and attitudes towards treatment and care, and the lived experience of the individuals with dementia who continue to live independently at home or move to a care home, and their family carers. (2019-19)	2019-19	31/05/2021
Living well and enhancing active life: The IDEAL-2 study **(PI- Nick Woodthorpe)**	IDEAL-2 is a longitudinal study utilising questionnaire approach to understand the lived experience of individuals living with dementia and that of their carers. This is a multi-site multi-organisation study that is aiming to build a database of information that can be accessed by researchers in the future. This study is currently in its fourth year coming into the fifth and has produced several research papers from the data collected to date.	2018-17	30/06/2020
PriDem: Primary care led support in dementia: Developing best practice **(PI – Nick Woodthorpe)**	New recommendations have been made about the types of help needed by people with dementia. We want to find out what you think about these recommendations and how to put them into practice. This will help us to develop a new model for support people after a diagnosis of dementia. PriDem are looking to interview you and/or a family member or friend about your experiences. They are looking for people with a diagnosis of any type of dementia. They would also like to talk to family members or friends of people with dementia. You can participate together or separately.	2019-08	03/06/2020
Current practice relating to Assistive Technology within Memory Services **(PI – Gwen Bonner)**	This project aims to determine current practice of professionals working in memory services in the provision of information on, and access to, Assistive Technology for families living with dementia.	2018-28	31/05/2019 On hold

IASIS dementia use case **(LC – Sarra Blackman)**	To obtain confirmatory evidence that the relevance of factors which may be related to the onset, type, clinical phenotype and rate of progression (as measured using serial documentation of MMSE or MoCA scores or other clinical cognitive measures) of neurodegenerative dementia, can be validated and quantified in data stored in electronic clinical records.	2020-01	31/03/2020
Clarity-AD **(LC – Sarra Blackman)**	This is a multinational, 28pprox.28tre, double-blind, placebo-controlled, parallel-group study using a Bayesian design with response adaptive randomization across placebo or 5 active arms of BAN2401 to determine clinical efficacy and to explore the dose response of BAN2401 using a composite clinical score (ADCOMS)	2019-27	31/03/2021
GRADUATE II **(LC – Sarra Blackman)**	The purpose of this study is to find out the effects, good or bad, of gantenerumab (new study drug) compared to a placebo (inactive) drug on participants with early Alzheimer's disease (AD) and their memory problems, cognition and day to day functioning.	2019-45	29/02/2020
FREE-COG **(PI – Dr Nick Woodthorpe)**	To test the Free Combined Cognitive and Functional Assessment (FREE-COG) in naturalistic clinical settings to compare scores with existing, commonly used cognitive tests. We hypothesise that there will be no significant difference between the FREE-COG and these tests.	2018-35	31/08/2019
The cognitive and neurological effects of bilingualism on the progression of dementia **(Academic project PhD – Toms Voits)**	This study fills an important gap in the literature, by directly addressing claims that bilingualism can provide protection against cognitive decline and brain deterioration in older age.	2018-08	01/01/2020
Better Conversations with Primary Progressive Aphasia (BCPPA) **(PI – A Volkmer)**	The primary objective of this study is to pilot the BCPPA program with a no treatment group over participating sites to establish for a main trial whether a trial of BCPPA can be delivered as intended in an NHS setting.	2017-26	01/10/2021

Mental Health – 2019/20 projects			
Study title and lead	**Summary**	**Reference**	**Study end date**
	ADHD		
PROUD **(PI – Dr James Jeffs)**	Aims to evaluate the effectiveness of a new intervention to prevent comorbid depression and obesity in ADHD	2017-34	30/07/2020
	Anxiety		
Genetic Links to Anxiety and Depression (GLAD) **(PI – Dr Amir Zamani)**	Kings College London will explore genetic and environmental factors associated with risk for depression and anxiety disorders in the UK, to understand these common disorders and help develop better treatments. The participants will be recruited into an existing biobank, the NIHR BioResource for Translational Research in Common and Rare Diseases, a re-contactable biobank. Our recruitment will help towards forming the largest re-contactable biobank of participants diagnosed with or suffering from two very common disorders, depression and anxiety, who will be primarily recruited through an online platform.	2019-13	01/09/2028

Autism			
Females with Autism Spectrum Disorder and Borderline Personality disorder – the overlap **(PI- Trevor Powell)**	Using Interpretative Phenomenological Analysis, explore and identify themes around how females with both ASD and BPD perceive self-harm, abandonment and their diagnosis, in order to learn more about the overlapping features of ASD and BPD.	2019-17	30/12/2020
Elucidating the relationship and co-development of sensory reactivity and mental health symptoms in autism **(PI -Teresa Tavassoli)**	This project will explore if sensory reactivity, such as being oversensitive to sounds, is associated with anxiety and related mental health symptoms. To do so we will follow 100 3-4 year old autistic children and 100 5-6 year old autistic children for 5 years.	2019-23	01/05/2023
SPRINT: The Prevalence of Social Communication Problems in Adult Psychiatric InpaTients **(PI – Mary Waight)**	Aims: 1) To estimate the prevalence of Autism Spectrum Disorders (ASD's) amongst adults who have been admitted to psychiatric hospitals (including those with intellectual disabilities) population of adult psychiatric inpatients. 2) To examine the association between other mental and physical health conditions in adults who meet diagnostic criteria for ASD's with those who do not meet such criteria (all of whom have been admitted to a psychiatric hospital).	2020-06	01/06/2021
Autism diagnosis as social process an exploration of clinicians' diagnostic decision **(PI – Trevor Powell)**	The aim of the project is to explore the key issues for healthcare professionals in diagnostic decision-making around Autism Spectrum Disorders (ASD). We are interested in healthcare professionals' beliefs, practices and decision-making processes when undertaking ASD assessments in secondary care.	2017-13	31/07/2019
Borderline Personality Disorder			
A questionnaire study examining the link between experiences of betrayal and Borderline Personality Disorder (BPD) **(Clinical Psychology Doctorate – Stephanie Barningham)**	This study will investigate whether experiences of betrayal (betrayal sensitivity and betrayal of others) are a key feature of BPD and will compare betrayal responses across the three groups (BPD, OCD clinical control and non-clinical control group). Student project	2019-30	25/09/2020
Bipolar			
Imagery Based Emotion Regulation (IBER) **(PI – Craig Steel)**	BHFT have collaborated with the University of Reading to do a study to test whether a psychological therapy, called Imagery Based Emotion Regulation (IBER), can help with the symptoms of anxiety within people already diagnosed with bipolar disorder. Recent research suggests that most people diagnosed with bipolar disorder may also suffer from anxiety, but they rarely get assessed, diagnosed or treated for this part of their mental health.	2018-06	30/09/2020

Depression			
Genetic Links to Anxiety and Depression (GLAD) **(PI – Dr Amir Zamani)**	Kings College London will explore genetic and environmental factors associated with risk for depression and anxiety disorders in the UK, to understand these common disorders and help develop better treatments. The participants will be recruited into an existing biobank, the NIHR BioResource for Translational Research in Common and Rare Diseases, a re-contactable biobank. Our recruitment will help towards forming the largest re-contactable biobank of participants diagnosed with or suffering from two very common disorders, depression and anxiety, who will be primarily recruited through an online platform.	2019-13	01/09/2028
Exploring loss of interest and pleasure in depressed adolescents **(Academic Project, PhD – Rebecca Watson)**	This study is looking to understand more about teenagers' experiences of pleasure and enjoyment. This research aims to help us understand depression in young people and how it relates to not enjoying activities and experiences and hopes that it will help develop new and better ways to help young people and to prevent depression.	2018-25	02/09/2019
The Examination of Parent-Adolescent interactions in the treatment of adolescents with depression **(LC – Monika Parkinson)**	The aim of this research is to help us better understand depression in adolescents: Study 1 – To understand the impact of low mood on adolescents' memory and thinking processes. Study 2 – To explore how adolescents and their parents get along and to see if this has an impact on depression treatment success.	2015/52	31/12/2019
Eating Disorders			
TRIANGLE **(PI – Dr Elma Ramly)**	Our Eating Disorder service is collaborating with King's College London on a project involving patients with anorexia nervosa and their carers. The project investigates whether providing extra information on how to cope with the illness to both patients and carers improves their wellbeing up to 18 months post-admission. The aim is to ensure a smooth transition between inpatient treatment and integration in the community. The project also entails measuring symptom burden with questionnaires at different time points. Patients will be reimbursed for completing the questionnaires.	2017-01	30/06/2020
The influence of social communication styles and cognitive profiles on restrictive eating disorders in women **(Academic Project, PhD – Janina Brede)**	This current study aims to assess the role of autism-specific factors for the development and maintenance of restrictive eating disorders (REDs) in autistic individuals, via a comparison of autistic women with AN, women with AN who are not on the autism spectrum, and autistic women who do not have an eating disorder.	2020-02	31/12/2020
An exploration of the relationships between attachment, expressed emotion and early symptom change in family therapy for adolescent anorexia nervosa **(Clinical Psychology Doctorate – Francesca Glover)**	The study is trying to find out more about why family therapy for Anorexia Nervosa might be more helpful for certain people and less helpful for others. In order to investigate this, we are going to use questionnaire measures to explore the effect of two things on the outcome of treatment: 1) Adolescents' emotional bond (or 'attachment') to their main caregiver. 2) The ways in which emotions are communicated ('expressed emotion') between adolescents and their parents.	2020-03	16/04/2021

Psychosis			
THRIVE **(LC- Emma Donaldson)**	A randomised controlled trial comparing Virtual Reality Confidence Building with VR Mental Relaxation for people with fears about others	2018-19	30/09/2020
EYE-2 **(PI – Katherine Mckinnon)**	A randomised controlled trial that aims to evaluate the effectiveness of a team based intervention in Early Intervention Psychosis teams.	2018-31	01/03/2021
Molecular Genetics of Adverse Drug Reactions (MolGen) **(PI- Dr Sharif Ghali)**	A biomarker study that aims to define the genetic and non-genetic risk factors predisposing to adverse drug reactions to clozapine.	2013-04	30/04/2021
PpiP2 **(PI- Dr Sanjoo Chengappa)**	A study that aims to establish the prevalence of pathogenic antibodies in patients with first episode psychosis.	2017-44	01/09/2020
The Game Change Trial **(LC – Emma Donaldson)**	The gameChange Trial: A randomised controlled trial testing automated virtual reality cognitive therapy for patients with fears in everyday social situations.	2019-22	01/06/2021
Exploring Unusual Feelings **(PI – Emma Cernis)**	This study is a questionnaire study where 1000 patients with non-affective psychosis will answer a pack of 10 questionnaires (31pprox.. 30 minutes), and some brief demographic details (age, gender, ethnicity). They will answer the questionnaires once only (a “cross-sectional” design). We will then use the latest statistical methods (network analyses based on probability estimations) to understand the likely causal relationships between the psychological factors measured. Specifically, the aim of the study is to better understand what factors cause dissociation, and whether dissociation might cause psychotic symptoms	2019-32	30/04/2020
Hearing Nasty Voices **(PI – Sanjoo Chengappa)**	The overall purpose of the research is to better understand the problem of hearing derogatory or threatening voices	2020-09	30/09/2020
Improving self-esteem in patients with persecutory delusions **(Clinical Psychology Doctorate – Ava Forkett)**	This study is for people who have concerns that others are trying to harm them. The purpose is to find out whether a talking therapy will help to increase self-compassion and feelings of safety Student project	2018-22	02/03/2020
Does being more satisfied with romantic relationship status increase wellbeing in people who experience psychosis? (LC – Emma Donaldson)	Questionnaire study to measure if increased satisfaction with romantic relationship status is associated with better wellbeing outcomes in people who experience psychosis	2020-04	01/09/2020
Attitude to Voices **(LC – Emma Donaldson)**	A limited literature suggests that clinicians can find it difficult to talk to patients about their voice-hearing experiences. These difficulties may reduce the likelihood of patients gaining access to evidence-based treatments. This study aims to explore clinicians’ views, attitudes and experiences with regards to working with patients who hear distressing voices.	2019-09	30/09/2019

EMPA Vision **(PI – Cathy Darby)**	The objective of this trial is to assess the effect of empagliflozin on cardiac physiology and metabolism aiming to provide a scientific explanation of the underlying mechanism by which empagliflozin improves Heart Failure (HF) related outcomes in patients with chronic heart failure.	2018-33	31/08/2019
Model fidelity of Early Intervention services for first-episode Psychosis in England **(LC – Emma Donaldson)**	A survey that will collect information about how early intervention for psychosis (EIP) services are being delivered across England. This information will be used to describe EIP fidelity nationally (i.e. how closely EIP services across England adhere to the intended EIP model), examine whether EIP services have reduced suicide and hospitalizations in people experiencing early psychosis, and assess whether 'fidelity' to the EIP model of care influences this relationship.	2019-35	07/01/2020
Mental Health Practitioner Survey **(LC – Emma Donaldson)**	This is a prospective study over 4-6 months. We will be examining behavioural and psychological factors in patients with long-term conditions in primary and secondary care.	2018-37	30/04/2019
Enhancing Future Directed Thinking in People with First Episode Psychosis **(Clinical Psychology Doctorate – Kelsey Smith)**	**Primary Objective** Does a positive guided imagery intervention increase positive future directed thinking more than a neutral guided imagery intervention? **Secondary Objectives** Is future directed thinking related to levels of negative symptoms in people with first episode psychosis?	2018-26	31/05/2019
AppROVE **(LC – Emma Donaldson)**	This study aims to evaluate the psychometric properties of two new measures of assertive responding to: 1) distressing voices ('auditory hallucinations'); and 2) other people.	2018-03	31/08/2019
EFFIP **(PI – Jacqueline Sin)**	Randomised controlled trial commencing with an internal pilot RCT to evaluate the effectiveness of an online intervention to promote carers' wellbeing.	2017-41	31/12/2020
The SlowMo Trial **(PI – Gwen Bonner)**	This study aims to test the clinical efficacy of SlowMo, a new therapy, and determine the mechanism through which it reduces paranoia severity, over 24 weeks, and to identify participant characteristics that moderate its effectiveness (either by moderating the degree of change in the mechanism, or by influencing adherence to the intervention).	2016-77	01/09/2020
PTSD			
Stop-PTSD **(PI – Anke Ehler)**	The design is a single blind (assessors of treatment outcome blinded) randomised controlled trial comparing two therapist-assisted internet-based psychological treatments for posttraumatic stress disorder and a wait-list condition, with an embedded process study	2017-39	30/09/2020
Schizophrenia			
Smoking Cessation Intervention for Severe Mental Ill Health Trial (SCIMITAR): Extended follow up. **(PI – Sanjoo Chengappa)**	To establish the clinical effectiveness of a bespoke smoking cessation intervention compared with usual GP care, for people with severe mental ill health in facilitating smoking cessation.	2019-15	01/03/2020

Suicide			
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) **(PI – Louis Appleby)**	Establishing and regulating working practices for safeguarding the receipt, disclosure and holding of identifiable patient information	2018-38	04/01/2022
Qualitative study with Mental Health Practitioners' **(Academic Project, PhD – Zaid Hosany)**	The purpose of this study is to understand the views and preferences of staff working in the CRHTT (Mental Health Practitioners, Senior Mental Health Practitioners, Advanced Mental Health Practitioners, Managers, Psychologists and Assistant Psychologists and Psychiatrists) regarding the use of Brief Suicide-specific Psychological Interventions (BSPI) within a Crisis Resolution and Home Treatment Team (CRHTT) service.	2018-36a	06/01/2021
Quantitative study with Mental Health Practitioners **(Academic Project, PhD – Zaid Hosany)**	The purpose of this study is to evaluate whether a training in brief suicide-specific psychological interventions (BSPI) with Mental Health Practitioners (MHPs) within a Crisis Resolution and Home Treatment Team (CRHTT) service to support suicidal patients produces measurable changes in nursing practice and patient care.	2018-36b	06/01/2021
Suicide by middle aged men **(PI – Louis Appleby)**	This study will combine multiple sources of information to examine factors related to suicide in this hard-to-reach group, including barriers to accessing services.	2019-28	31/10/2020
IAPT (Talking Therapies)			
Understanding SilverCloud Supporter Information Practices & Data Needs **(PI- Sue Scuphum)**	A brief 35 minute interview with Psychological Wellbeing Practitioners, who are currently using the SilverCloud service as 'supporters' to look at their experiences of working with SilverCloud	2019-33	30/06/2020
Internet-delivered CBT intervention (Space for Sleep) for sleep disorder: a pilot trial **(PI – Sarah Sollesse)**	The current study seeks to investigate the feasibility of an internet-delivered CBT-based intervention for sleep disorder. CBT for Insomnia is evidence based and recommended as first line treatment in NICE clinical guidelines in the UK and the evidence based intervention for the management of sleep problems (Schutte-Rodin, et al., 2008). The findings will be used to understand the feasibility of an online intervention for sleep disorder/difficulties and to improve the programme in accordance with user needs.	2019-14	01/07/2020
The Bigger Picture – IAPT **(LC – Grace Jell)**	This project will identify patient groups at risk of disengagement and/or poor outcome. The follow-up project then will purposively select and interview people in (and working with) these groups to identify associated causal mechanisms, including a focus on positive deviance (services performing better than predicted)	2019-38	01/06/2021
Non-specific mental health			
Cause and Prevalence of Memory Problems (CAP-MEM) **(LC- Stephen Zingwe)**	A questionnaire study that aims to explore the cause and prevalence of memory problems in people with mental health, neurodevelopmental and neurodegenerative disorders.	2018-23	30/09/2021

Peer Support in Mental Health Services **(Academic Project, PhD – Tishna Uttamlal)**	Aims: 1) To understand the identity of a PSW and how this is constructed. 2) To examine how and why PSWs may construct or be implicated in a liminal space based on their identity construction. 3) Use this to understand organisationally, how PSWs fit into the current workforce and make recommendations for future steps in developing and sustaining the PSW role. 4) To see what factors contribute to the notion of liminality in peer support workers 5) Which of these are seen as positive and which of these are seen as negative and how this influences a PSWs identity	2019-41	01/09/2021
ESCAPE – Views about smoking cessation and mental health **(LC – Emma Donaldson)**	This study is inviting health care professionals working with patients with mental health difficulties in *any* context to take part in an online survey to help us understand current attitudes, practices, training needs, and perceived barriers and facilitators to address and implement smoking cessation treatments.	2020-15	TBC

Children and Young People (CYP) – 2019/20 projects			
Study title and lead	Summary	Reference	Study end date
STAndardised Diagnostic Assessment for children and adolescents with emotional difficulties (STADIA): **(PI- Tamsin Marshall)**	Population: Children and young people (age 5-17 years) presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS). The aim of the study is to evaluate the clinical and cost effectiveness of a standardised diagnostic assessment (SDA) tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS).	2018-20b	30/04/2022
Parents' experiences of parenting a child with Obsessive Compulsive Symptoms/Disorder **(Academic Project, PhD – Chloe Chessell)**	This study aims to explore parents' experiences of parenting a child (aged 7 to 12 years) with OCD, their views and preferences towards different levels of parent involvement in CBT for OCD. Student project	2019-07	29/08/2020
Treatment of Panic Disorder in Adolescents (PANDA Study) **(PI – Polly Waite)**	A research project to compare two talking therapies, that involve working with a therapist one-to-one, for the treatment of panic disorder in young people aged 11-17½ years	2019-34	30/09/2021
Nursing-led Interventions to support the psychological and emotional wellbeing of children and young people **(LC – Emma Donaldson)**	The study has been established to explore, across the four countries of the UK, nurse led interventions for young people's mental health and wellbeing.	2019-40	14/09/2019

Physical Health Service – 2019/20 projects			
Study title and lead	Summary	Reference	Study end date
All Long-Term Conditions (LTC)			
Psychological risk factors for fatigue in Rheumatoid Arthritis **(PI – Cathy Beresford)**	The study investigates a number of factors which may influence levels of fatigue, distress and disability in patients with long-term conditions. It specifically focusses on behavioural and psychological factors including quality of sleep, anxiety and depression, beliefs about fatigue and coping strategies.	2018-37	01/04/2021
Sexual Health Services			
PrEP Impact Trial Study **(PI – Dr Nisha Pal)**	The PrEP Impact Trial aims to address outstanding questions about PrEP, eligibility, uptake and duration of use of PrEP though expanding the assessment to the scale required to obtain sufficient data. In addition the trial will assess under real world conditions the impact of PrEP on new HIV diagnoses and on sexually transmitted infections, compared to historical controls.	2017-30	01/09/2020
Re-Evaluation of Annual Cytology using HPV testing to Upgrade Prevention (REACH UP): a feasibility study in Women Living With HIV **(PI – Nisha Pal)**	To estimate HPV prevalence in women living with HIV to calculate sample size of the main study	2019-16	31/01/2021
Safetxt **(PI – Nisha Pal)**	Safetxt will reliably demonstrate the effects of the intervention on STIs at one year. The effects of the intervention on partner notification, condom use and STI testing will be reported. Understanding which intervention components (behaviour change techniques) are effective could generate principles to inform the content of future interventions. Which interventions are effective will be explored by collecting data on the theoretical constructs influenced by the intervention components and on the pathway to behaviour change.	2016-40	30/08/2019
Diabetes service			
Startright (Getting the right classification and treatment from diagnosis in adults with diabetes) **(PI- Dr Mohammadi Alizera)**	Our Diabetes at King Edwards VII are teaming up with University of Exeter Medical school to support recruitment into this study aiming to achieve more accurate early classification of diabetes and identification of which patients will rapidly require insulin treatment. The clinicians will record clinical features and biomarkers that may help to determine diabetes type at diagnosis and follow participants for 3 years to assess the development of severe insulin deficiency (measured using C-peptide) and insulin requirement. Findings will be integrated into a freely available clinical prediction model.	2018-02	30/06/2020
Embedding Diabetes Education RCT **(PI- Alison Marie Jones)**	As part of the Embedding Diabetes Education study (an NIHR funded PgfAR) Leicester diabetes centre are going to be working with the Diabetes Education provider team at Berkshire Healthcare NHS Foundation Trust to assess whether the embedding Package reduces HbA1C in patients with type 2 Diabetes Mellitus compared to usual care	2019-04	31/01/2021
Exploring patient and healthcare-professional perspectives on barriers and facilitators towards foot self-care practices in diabetes (Academic Project, PhD – Andrew Hill)	This study primarily seeks to explore patient and healthcare-professional perspectives on perceived barriers and facilitators to foot self-care practices in diabetes. In addition, this study will explore whether similarities and/or differences between patient and healthcare-professional perspectives in this context contribute to these barriers and/or facilitators	2020-08	31/12/2021

Cardiac and Respiratory Specialist Services (CARSS)			
TANDEM (Tailored intervention for Anxiety and Depression Management in COPD) **(PI- Katherine Beckford)**	Our Cardiac and Respiratory Specialist Service is collaborating with Queen Mary University of London Research study for patients with Chronic Obstructive Pulmonary Disease (COPD); also known as chronic bronchitis or emphysema. To investigate the benefits of offering people with moderate to very severe Chronic Obstructive Pulmonary Disease (COPD) and mild or moderate anxiety or depression, the opportunity to receive structured, one to one support and advice delivered by a trained respiratory health care professional (nurse, physio or occupational therapist). The sessions are based on a Cognitive Behavioural approach. COPD can affect many aspects of such patients; breathing difficulties can limit their day-to-day activities and can make them feel worried (anxious) or feel low (depressed).	2018-29	30/06/2021
Brain Injury			
The influence of changes in self-concept after brain injury **(Clinical Psychology Doctorate – Christina Cusack)**	Aims and Objectives of the study: 1. Is carer burden influenced by brain injury survivors' perceptions of self-concept? 2. Is carer burden influenced by their perceptions of changes in self-concept of the brain injury survivor? 3. Is perceived social support influenced by brain injury survivors' and relatives' perceptions of self-concept changes in the brain injury survivor? Are the factorial and psychometric properties of the HISD-III-R equivalent to those of the patient's version of the HISD-III? (exploratory)	2019-10	01/05/2020
Dental			
(Dental Caries Study) Public Health England Dental Public Health Dental Epidemiology Programme survey of five-year-old children 2018/19 **(LC – Stephen Zingwe)**	The aim of the survey is to measure the prevalence and severity of dental caries among 5-year-old children within each lower-tier local authority. The resulting reports give details of caries levels and other clinical measures and provide information for local authorities, the NHS and other partners.	2020-13	30/06/2019
Digestion			
Assessing the ecological role of yeast in the gut **(Academic Project, PhD – Grace Ward)**	This study will analyse the biological and chemical content of the samples. We will analyse the stool samples provided by you, to capture information on the composition of microorganisms present in the gut. The samples will also be analysed using analytical chemistry approaches to study the metabolic activity of the microorganisms.	2019-24	30/09/2021
Pregnancy			
Patients perceptions of perinatal mental health services in Berkshire **(PI – Amir Zamani)**	This study seeks to explore the perinatal service user's perspective regarding the perinatal mental health services within the Berkshire locality	2018-13	30/09/2019

Non-health related studies – 2019/20 projects			
Study title and lead	Summary	Reference	Study end date
	Data		
CLIMB: University of Cambridge NHS/HSC Health Data Consent Survey **(LC – Sarra Blackman)**	To establish patient and public views on the sharing of identified NHS/HSC health data (for clinical purposes) and de-identified health data (for research) within the UK.	2020-10	30/06/2020
Infrastructuring Data Integration between Multiple Socio-Technical Contexts of Care **(Academic Project, PhD – Andrey Elizondo)**	How is the integration of data across care settings negotiated between different actors? What –intended and unintended- early consequences arise as a result of data integration? Student project	2019-29	30/04/2020
EMHEP 3: Efficiency, cost and quality of mental healthcare provision **(LC – Emma Donaldson)**	This research will analyse the efficiency, cost and quality of mental healthcare provision in the English NHS.	2020-05	30/04/2021
	Culture		
Culture and difference within the supervisory relationship. **(Clinical Psychology Doctorate – Charlotte McCann)**	How are issues of culture and difference in clinical psychology training and practice perceived and explored within the supervisory relationship?	2019-39	01/10/2020
The lived experiences of career progression of NHS BME Very/Senior Managers/Executives in South West of England and Greater London **(Academic Project, PhD – Stephen Zingwe)**	The researcher wishes to examine the experiences of career progression of NHS BME staff working in senior/very senior management positions that are in the South West of England Region and Greater London.	2020-12	31/01/2021
Does feeling connected and valued affect the way people feel about themselves and their lives in people aged 50 years and older from different cultures **(Clinical Psychology Doctorate – Iman Hassan)**	The study aims to see if feeling connected and valued affect the way people feel about themselves and their lives in people aged 50 years old and above. We are particularly interested in thoughts related to suicide. We are also interested in seeing if there are any differences in people from cultures that place more importance on being part of a group, such as a close family or community network, compared to people from cultures that place more emphasis on the individual.	2019-31	31/07/2020

Appendix 2- Academic institutions and NHS Trusts we have worked with to deliver research in the last four years

Academic Institution (N.B. Name of institution at the time of collaboration)

Aston University	University of Edinburgh
Brunel University London	University of Exeter
Buckinghamshire New University	University of Greenwich
Cardiff University	University of Leeds
Edge Hill University	University of Leicester
Imperial College London	University of Lincoln
King's College London	University of Liverpool
Lancaster University	University of Northampton
McGill University, Canada	University of Oxford
London School of Hygiene & Tropical Medicine	University of Reading
Oxford Brookes University	University of Sheffield
University of Plymouth	University of Surrey
Queen Mary, University of London	University of Sussex
Royal Holloway, University of London	University of Warwick
Sheffield Hallam University	University of West London
St George's, University of London	University of York
Trinity College Dublin	University of Newcastle
University of Manchester	University of Nottingham
University of Bath	London Metropolitan University
University of Bristol	University of East Anglia
University of Cambridge	

NHS Trusts (N.B. Name of Trust at time of collaboration)

Cambridgeshire & Peterborough NHS Foundation Trust	Southern Health NHS Foundation Trust
East Kent Hospitals University NHS Foundation Trust	Sussex Community NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust	Sussex Partnership NHS Foundation Trust
Imperial Healthcare NHS Trust	University College London Hospitals NHS Foundation Trust
King's College Hospital NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust
South London and Maudsley NHS Foundation Trust	Guy's and St Thomas' NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Leeds Teaching Hospitals NHS Foundation Trust
Northumberland, Tyne and Wear NHS Foundation Trust	NHS Greater Glasgow and Clyde
Nottinghamshire Healthcare NHS Foundation Trust	Royal Free London NHS Foundation Trust
Oxford Health NHS Foundation Trust	Royal Devon and Exeter NHS Foundation Trust

Appendix 3- List of Staff Publications

ALLEN, C. & LI, I. 2019. The path from individual therapy to co-production and community-based projects. *Psychology of Older People: The FPOP Bulletin***,** 41-46.
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CASACCIA, S., BEVILACQUA, R., SCALISE, L., REVEL, G. M., *ASTELL, A.J.,* SPINSANTE, S. & ROSSI, L. Assistive sensor-based technology driven self-management for building resilience among people with early stage cognitive impairment. 2019 IEEE International Symposium on Measurements & Networking (M&N), 8-10 July 2019 2019. 1-5.
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Appendix 4- Example Service Level Research Report (currently NIHR portfolio studies only) for discussion and sharing with relevant clinical services

Children and Young People (CYP) sample research report (NIHR portfolio)

Past

Studies in last 5 years (with same breakdowns as earlier)

Study	Study Summary	Year(s) Active
A-CAT	The study aimed to inform the development of targeted interventions designed to improve rates of access to treatment for child anxiety disorders	November 2016 to 31/07/2018
N-CAT National Survey	The study aimed to improve access to treatment for children with anxiety disorders in England	June 2016 to 31/07/2017
Development of an online treatment programme for child anxiety	This study aimed to (i) design and develop an online and smartphone application treatment programme for childhood anxiety disorders and (ii) test the usability of the online tool to ensure that it is easy to use and appealing to those who it is aimed at (i.e. parents, children and clinicians)	24/10/2016 to 31/07/2017
Understanding what maintains social anxiety disorder in children	The overall aim of the study was to understand what psychological mechanisms maintain social anxiety in children	25/11/2016 to 03/09/2018
PTSD in childhood: A clinician survey	This study aimed to systematically examine and synthesise relevant quantitative, qualitative and mixed-method literature relating to clinicians' perceived barriers and facilitators to the implementation of evidence-informed interventions at all levels of the system for individuals with PTSD	09/04/2018 to 27/09/2018
Psychological treatment of panic disorder in adolescence: the view of CAMHS clinicians	The aim of this study was to establish what training National Health Service (NHS) Child and Adolescent Mental Health Services (CAMHS) clinicians have received in psychological therapies and panic disorder and how they identify and treat panic disorder in adolescents	01/04/2018 to 31/12/2018
Cost of Autism	The study aimed to find out the amount of clinician time it takes to assess a child for possible Autistic Spectrum Disorder (ASD) and from this calculate the resulting costs to the NHS	19/06/2018 to 31/08/2018

Present

Studies in 19/20

Study	Study Summary
STADIA	The aim of the study is to evaluate the clinical and cost effectiveness of a standardised diagnostic assessment (SDA) tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS)
PANDA	The study aims to extend previous research by evaluating the brief form of cognitive therapy developed by Clark et al. (1999) with adolescents with panic disorder

Future

Studies in 20/21

- STADIA
- PANDA

Accepted studies (either just started recruitment or currently in set up):

Study	Study Summary
ASCEND	The aim is to carry out a feasibility study which will inform a future pilot/full trial to test whether an intervention focussing on early social communication skills is effective in improving language skills before children with Down syndrome start school.
MAPS	The study aims to develop a set of music-assisted intervention programmes to increase spoken language ability in 24-60-month-old, nonverbal or minimally verbal children with autism spectrum disorder (ASD)
P-TAC	This study aims to determine the feasibility of a definitive RCT comparing Online Support Intervention to face-to-face parent-guided treatment for children with anxiety disorders
IVY	The aim of this study is to establish the effectiveness and cost-effectiveness of Intensive Community Care Services compared with Usual Inpatient Care, Treatment As Usual (TAU) in young people with severe psychiatric disorders

Potential Studies (still undergoing feasibility assessment):

Study	Study Summary
Early evaluation of the Children and Young People's Mental Health Trailblazer programme	The study aims to examine the development, implementation and early progress of the trailblazer programme. The evaluation will explore how service delivery models and implementation strategies differ across trailblazer areas, highlighting factors (e.g. local contexts) that are promoting or hindering progress towards programme goals, and drawing out the practical implications of the findings for the development of the programme and the longer-term evaluation
Online PTSD Treatment for Young People and Carers	The study aims to evaluate an Internet-delivered Cognitive Therapy (iCT) programme for the treatment of PTSD in adolescents
Olfaction in adolescent-onset psychosis study	The study aims to examine the brain mechanisms underlying olfaction in those with adolescent-onset schizophrenia (AOS), compared to healthy adolescent controls
Using virtual reality to test fears among adolescents with social anxiety disorder: A multiple case series	The study aims to assess whether young people experience performance fears and associated negative cognitions in virtual reality social scenarios

Impacts

The CYP service has supported 9 portfolio studies over the past 5 years.

PTSD in childhood: a clinician survey identified four barriers related to supporting this patient population, these barriers were inflexibility of manualised approaches, a fear of increasing client distress, working with comorbidities and a lack of training and support. The most dominant theme within clinician related barriers was a lack of training, which further linked to a number of other clinician barriers identified including an uncertainty of how to approach trauma, a lack of knowledge, and a lack of confidence in using evidence-informed interventions. Future research is needed to explore the nature of the training and supervision needed by clinicians.

The psychological treatment of panic disorder in adolescence: the view of CAMHS clinicians study found that only half of CAMHS clinicians identified panic disorder from a vignette and although CBT treatments are widely offered, only a minority of adolescents with panic disorder are receiving treatments developed for and evaluated with young people with panic disorder. The researchers

concluded that there is a vital need for clinician training, the use of tools that aid identification and the implementation of evidence-based treatments within CAMHS.

Other studies that have recruited from within CAMHS services have highlighted the need and guidance on identifying child anxiety difficulties and ensuring sufficient provision is available to allow families to access support promptly.

The studies have enabled families to have a voice and comment on the services provided, they have been able to help identify what helps them to access support and what the barriers are when trying to access services. The research has provided them with the opportunity to contribute to service changes and improvements. The studies have provided further understanding regarding the treatments available, knowledge and skill set of clinicians and effectiveness of current treatments. The studies have also helped to inform the development of new treatments and interventions for the patient population. These studies have helped to inform future research to improve treatments and service provision which will help to improve outcomes for this patient population.

Equity of access

No information regarding equity of access due to the fact patients have either been recruited via online methods or directly from the AnDY clinic or CAMHS service.

Talking Therapies sample research report (NIHR portfolio)

Past

Studies in last 5 years (with same breakdowns as earlier)

Study	Study Summary	Year(s) Active
E-COMPARED	The study aimed to gain knowledge on the clinical and cost-effectiveness of blended depression treatment compared to treatment-as-usual in routine care	05/09/2016 to 31/03/2017
DIGITAL IAPT	The study aimed to evaluate the immediate and longer-term impact, as well as the cost effectiveness of internet-delivered interventions for depression and anxiety	22/06/2017 to 30/04/2018
A survey of mindfulness and self-compassion in IAPT	The study aimed to test if people with clinically significant OCD symptoms showed disproportionately poor mindfulness and self-compassion skills when compared to non-OCD clinical controls and to healthy controls	31/07/2017 to 31/03/2018

Present

Studies in 19/20

Study	Study Summary
STOP PTSD	The study aims to compare a trauma-focused (internet-delivered Cognitive Therapy for PTSD, iCT-PTSD) and a non-trauma focused therapist-assisted online psychological therapy (internet-based stress management therapy, iStress-PTSD)
Understanding the information practices and data needs	The study aims to identify suitable data methods, including innovative machine learning approaches, to better understand: (1) how users of an online mental healthcare intervention (SilverCloud Health) are making use of this service; and (2) how such insight can be leveraged to improve that service
The Bigger Picture	The study aims to investigate the impact of neighbourhood deprivation on IAPT (Improving Access to Psychological Therapies) service outcomes

Future

Studies in 20/21

- STOP PTSD
- Understanding the information practices and data needs
- The Bigger Picture

Accepted studies (either just started recruitment or currently in set up):

Study	Study Summary
Precision in Psychiatry Study (PIPS)	The study aims to develop a tool that can be used by doctors to improve their ability to identify the best treatment for each unique person - helping people get better, faster

Potential Studies (still undergoing feasibility assessment):

Study	Study Summary
The Implementation of Digital Interventions in Healthcare Services	The study aims to explore stakeholder experiences (mental healthcare workers, patients, intervention developers) of the implementation of an internet-delivered intervention in NHS IAPT Services
Integration of a smartwatch within an internet-delivered intervention for depression: a randomized trial on feasibility, satisfaction and acceptance	The study aims to examine the feasibility and acceptance of using a smartwatch to monitor patients' mood, sleep and physical activity in order to support an internet-delivered CBT based Intervention
The PROMISE Study Version 1	The study aims to see which components of the two psychological models can predict participant engagement with Headspace

Impacts

The Talking Therapies service has supported 6 portfolio studies over the past 5 years.

A survey of mindfulness and self-compassion in IAPT study found that participants with clinically significant obsessive-compulsive disorder symptoms reported lower trait mindfulness and self-compassion compared to participants with clinically significant anxiety/depression and to non-clinical controls.

The E-Compared study found that patients showed a significant decrease in depressive symptoms when treated via E-COMPARED's blended cognitive behavioural therapy compared to control groups undergoing regular therapy sessions. Participants valued the easy-to-use interface and the use of digital tools. Therapists also welcomed the technology, they felt it provided them greater insights into patients' symptoms and enabled them to treat patients more effectively. The data generated by the digital tools can enable researchers to improve and personalise treatment approaches for depression. Researchers hope that it may predict which patient groups would benefit most from internet-based, standard or blended treatment by modelling patient characteristics.

Both studies contribute to understanding and as a result will enable review of current treatments and development of new treatments. The findings will also help to inform potential future treatments and interventions for this patient population. The Talking Therapies service has welcomed online treatments and are currently working with Silvercloud to continue to increase the number of online interventions we can offer to patients.

Equity of access

No information regarding equity of access due to the fact patients have been recruited via online methods.

Eating Disorders sample research report (NIHR portfolio)

Past

Studies in last 5 years (with same breakdowns as earlier)

Study	Study Aim
SHARED	The study explored the efficacy of adding a guided self-help intervention (*Recovery* MANTRA) to treatment as usual for anorexia nervosa

Present

Studies in 19/20

Study	Study Aim
TRIANGLE	Aims to examine whether the addition of a patient and carer skill sharing intervention improves long-term patient wellbeing following hospital treatment for anorexia nervosa

Future

Studies in 20/21

- Triangle

Potential Studies (still undergoing feasibility assessment):

- DAISIES Trial

Impacts

The Eating Disorders service have supported 2 portfolio studies over the past 5 years.

The SHARED study found that augmenting outpatient treatment for adult anorexia nervosa with a focus on recovery and motivation produced short-term reductions in anxiety and increased confidence to change and therapeutic alliance.

The SHARED study provides a greater understanding regarding online treatments for anorexia nervosa and how these can help improve outcomes. The study enabled Berkshire Healthcare patients to access a new intervention to help support their recovery and was positively received by the service. The SHARED study was important in assessing whether this kind of treatment is feasible within Eating Disorder services and has led onto other studies looking at online treatments for anorexia nervosa. Overall the SHARED study will contribute to overall understanding about online interventions and how these can be implemented in practice as standard.

Equity of access

100% of patients screened were female

90% of patients were White British and 10% were from other ethnic backgrounds

36% of patients were from West Berkshire, 27% were from Reading, 19% were from Wokingham, 9% were from Bracknell and 9% were from WAM. No one took part from Slough locality.

55% were aged between 18-25, 9% were aged between 26-35, 18% were aged between 36-45 and 18% were aged between 46-55.

Liaison and Diversion sample research report (NIHR portfolio)

Past

Studies in last 5 years (with same breakdowns as earlier)

Study	Study Aim
Outcome Evaluation of Offender Liaison and Diversion Trial Schemes	The study aimed to evaluate the implementation of the national model for liaison and diversion services in ten sites across the U.K.
Improving Healthcare for Probationers: Mapping the Landscape	The study examined how healthcare is provided for people under probation supervision in the community, what research suggests about good practice for improving the health of people under probation supervision, and what mechanisms can be used to measure and facilitate improvements in the quality of healthcare provision for this population

Studies in 19/20

No studies recruited from Liaison and Diversion services in 2019/20.

Future

Studies in 20/21

There are currently no studies going through feasibility, but a search will take place to find out if there are any studies that Berkshire Healthcare could potentially support.

Impacts

The Liaison and Diversion service have supported 2 portfolio studies over the past 5 years.

The Outcome Evaluation of Offender Liaison and Diversion Trial Schemes study found that stakeholders from partner agencies and those delivering Liaison and Diversion services were overwhelmingly positive about the National Model. It was perceived to have resulted in an increase in useful information about vulnerabilities being provided to decision-makers in the criminal justice system and closer working between mental health, and other professionals, and the police and courts. There is some evidence that the National Model may have decreased remand to custody from court slightly, at least in some areas, but this needs to be explored further.

The Improving Healthcare for Probationers: Mapping the Landscape study concluded that the key to improving healthcare for people in contact with probation lies in four main areas; commissioning, policy, practice and research. The researchers designed a toolkit for commissioners and practitioners. This toolkit aims to raise awareness of probationers' likely health needs, what is known about the most effective ways of providing healthcare, models of good practice, and how barriers to providing good quality and accessible healthcare for probationers can be overcome.

Both of these studies improve our understanding and will inform and enable further development of clear pathways, support mechanisms and service provision for this patient population. These studies may enable greater understanding of interventions and treatments needed in order to improve the outcomes.

Equity of access

No information regarding equity of access due to no active studies in 2019/20 and the sensitivity of this patient group.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	14th July 2020
Title	Berkshire Healthcare NHS Foundation Trust Annual Complaints Report. April 2019 - March 2020
Purpose	The purpose of this report is to provide the Board with Annual complaint information in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Business Area	Nursing & Governance
Author	Elizabeth Chapman – Head of Service Engagement and Experience Heidi Ilsley - Deputy Director Nursing
Presented by	Debbie Fulton, Director Nursing and Therapies
Relevant Strategic Objectives	True North goal of Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	The report looks at the application of the formal complaints process in the Trust. The Trust continues to have robust processes in place for receiving and responding to formal complaints in a timely manner. This was recognised in our recent CQC inspection of November/December 2019 which details that services treated concerns and complaints seriously with lessons learnt. During 2019/20 there were 231 formal complaints received, this is comparable with the 230 received in 2018/19 and equates to 0.02% of recorded contacts that occurred within Berkshire Healthcare across the year. Adult Mental Health services account for 64% of the total number formal complaints received with 29% being adult community health services and 17% children's services. Quarterly patient experience data

	presented to the Board consistently demonstrates that concerns raised around community health services are much more likely to be raised as an informal concern than a formal complaint with local resolution achieved, whereas most Mental Health concerns are received as formal complaints. During 2019/20- 221 formal complaints were closed with 1 of these breaching the negotiated timescale. Of these 60% were partially or fully upheld. Care and treatment remain the most likely reason for someone to make a formal complaint, these are very specific to an individual's care and treatment received and there are no trends or themes in relation to these. Data within model hospital demonstrates the number of formal complaints received to be comparable with other Trusts rated as outstanding (14.85 per 1000 WTE staff and below the national median of 15.56) The Parliamentary Health Service Ombudsman (PHSO) received 5 complaints in relation to Berkshire Healthcare during 2019/20 and of these the PHSO are not proceeding with 3 and 2 are currently under review.
ACTION REQUIRED	This report is for noting at the Board

Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2019 to March 2020

Contents

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1. Introduction and executive Summary

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

This report looks at the application of the Complaints Process within the Trust from 1st April 2019 to 31st March 2020 and uses data captured from the Datix incident reporting system.

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

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

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

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

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

During 2019/20 there were 231 formal complaints received, a slight increase from 230 received in 2018/19; a sustained increase on the 209 received in 2017/18. The number of formal complaints closed was 221, of these 60% were either fully or partially upheld and 38% were not upheld. The remaining complaints were either not progressed, locally resolved or investigated via a differing process. Against one million contacts, 231 complaints received equates to 0.02% resulting in a formal complaint.

Using the Model Hospital programme (and data from Dec 2019), the Trust has a value of 14.85 formal complaints per 1000 WTE staff – this comparable with other outstanding trusts (14.85) and is less than the peer median of 16.18 and national median of 15.56.

The Trust had one breach in responding to a complaint within agreed timescale; the first in four years. The service carried out a review of what happened and have put actions in place locally to prevent this from happening again.

The Trust continues to monitor the number of locally resolved and informal complaints through the quarterly Patient Experience Report. Complaint files are managed in real time and information is available on a dashboard that is accessible to the Locality and Clinical Directors.

The services with the high numbers of formal complaints received were:

- Adult Community Mental Health teams (CMHT), with 37 complaints against 52,460 contacts (0.07% contacts)

- Acute adult admission wards, with 21 complaints against 1,028 discharges (2.04%)

- CAMHS - Child and Adolescent Mental Health Services with 30 received against 28,307 contacts (0.11%)

- Out of Hours GP Services providing care in the West of Berkshire, with 9 complaints against 69,190 contacts (0.01%)

- Community Hospital inpatient wards received 15 complaints against 2,083 discharges (0.72%)

- Crisis Resolution/Home Treatment Team (CRHTT) received 14 complaints against 62,299 contacts (0.02%)

The main theme of complaints received during 2019/20 was care and treatment with 46.75%, followed by attitude of staff with 19.48% and communication with 11.69%. This is compared to care and treatment accounting for 51.74% of formal complaints and 14.78% for both attitude of staff and communication received during 2018/19. In 2017/18 care and treatment was 57.89% and attitude of staff was 16.75%.

There are no particularly specific themes that are able to be extracted from the complaints received within each of these categories; many complaints are very specific to individual circumstance and concern. Further detail with regard to the services with higher numbers of complaints is detailed within the report.

Nationally, complaint statistics are reported on a quarterly and annual basis, with 2019/20 annual reported data not available until September 2020.

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 was also introduced, which saw the Complaints Office supporting Investigating Officers with compiling response to complaints, triaging complaints in a different way to escalate concerns about patient safety, and following a review, placing a small number of formal complaints on hold (or paused). These complainants were all contacted and informed of this, advising them to contact the Complaints Office if they had any concerns. New complaints continued to be logged.

2. Complaints received – activity

2.1 Overview

During 2019/20 231 formal complaints were received into the organisation**.** Table 1 evidences the number of formal complaints by service and compares them to the previous financial year.
The information in this report excludes complaints which are led by an alternative organisation, unless specified.

Table 1: Formal complaints received

	2019/20						Change (annual)	2018/19					
Service	Q1	Q2	Q3	Q4	**Total**	% of Total		Q1	Q2	Q3	Q4	**Total**	% of Total
CMHT/Care Pathways	8	10	6	13	**37**	**16.02**	↓	16	11	10	9	**46**	20
CAMHS - Child and Adolescent Mental Health Services	10	8	8	4	**30**	**12.99**	↑	5	6	8	6	**25**	10.87
Crisis Resolution & Home Treatment Team (CRHTT)	2	2	4	6	**14**	**6.06**	No change	2	5	3	4	**14**	6.09
Acute Inpatient Admissions – Prospect Park Hospital	5	3	7	6	**21**	**9.09**	↓	9	12	8	3	**32**	13.91
Community Nursing	4	3	6	2	**15**	**6.49**	↑	1	1	3	3	**8**	3.48
Community Hospital Inpatient	6	1	5	3	**15**	**6.49**	↓	6	7	1	3	**17**	7.39
Common Point of Entry	2	6	2	2	**12**	**5.19**	No change	3	3	2	4	**12**	5.22
Out of Hours GP Services	0	1	7	1	**9**	**3.9**	↓	4	5	7	1	**17**	6.96
PICU - Psychiatric Intensive Care Unit	0	0	1	0	**1**	**0.43**	↑	0	0	0	0	**0**	0
Minor Injuries Unit (MIU)	1	1	1	0	**3**	**1.3**	↓	1	1	2	0	**4**	1.74
Older Adults Community Mental Health Team	1	0	0	0	**1**	**0.43**	↓	1	1	0	1	**3**	1.3
15 other services in Q4	11	19	21	22	**73**	**31.6**	↑	12	11	13	16	**52**	22.6
Grand Total	**50**	**54**	**68**	**59**	**231**			60	63	57	50	**230**	

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT) remained consistent and Community Nursing, CAMHS, have increased compared with the previous year. Acute Inpatient Admissions (Prospect Park Hospital), Community Hospital Inpatients, Community Mental Health Teams (CMHT) and Out of Hours GP Services (Westcall) experienced decreases in the number of formal complaints received.

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

Table 2: Themes of Complaints received

Main subject of complaint	Number of complaints	Percentage of total complaints
Care and Treatment	108	46.75%
Attitude of Staff	45	19.48%
Communication	27	11.69%
Access to Services	25	10.82%
Confidentiality	6	2.60%
Environment, Hotel Services, Cleanliness	5	2.16%
Discharge Arrangements	5	2.16%
Waiting Times for Treatment	2	0.87%
Other	2	0.87%
Admission	2	0.87%
Medication	2	0.87%
Medical Records	1	0.43%
Support Needs (Including Equipment, Benefits, Social Care)	1	0.43%

The main theme of complaints received during 2019/20 was care and treatment with 46.75%, followed by attitude of staff with 19.48% and communication with 11.69%. This is compared to care and treatment accounting for 51.74% of formal complaints and 14.78% for both attitude of staff and communication received during 2018/19. In 2017/18 care and treatment was 57.89% and attitude of staff was 16.75%.

There have been no specific themes identified with regard to complaints received although it is worthy of note that 7 of the complaints relating to access to services and both of the complaints about waiting times for treatment were in relation to CAMHS services and 5 of the total 27 complaints related specifically to communication was about our CAMHS services.

The complaints raised in relation to attitude of staff are spread across a range of services those services with more than 3 were CMHT, CRHTT and Admin and office based staff (3 were around the complainant being unhappy with the response from the complaints office, and 1 was about being reportedly hung up on by reception staff at a CMHT). All of the complaints about CRHTT were about the service based in the West of the County.

The complaints in relation to communication again cover a broad range of services, CAMHS (5), Talking Therapies (3), Acute Inpatient Admissions – Prospect Park Hospital (3) and CMHT (3).

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

The Trust Business Group structure (also known as reporting locality) has previously been used as the main mechanism for reporting complaint information; however, as this may differ from the geographical locality of where the service is based, it brings more value to report the latter. The following tables show a breakdown for 2019/20 of the formal complaints that have been received and where the service is based.

2.2 Mental Health service complaints

Table 3 below details the mental health service complaints received, this shows that the main services where formal complaints are attributed to are CMHT and Adult acute Admissions wards. 43.24 % of the complaints were about care and treatment (which is around the same as in 2018/19 with 43.47% and a sustained increase from 29.54% of mental health service complaints in 2017/18). Complaints about adult mental health services accounted for 64% of the total complaints received in 2019/20.

Table 3: Mental Health Service complaints

Service	Number of complaints
A Place of Safety	2
Admin teams and office-based staff	4
Adult Acute Admissions - Bluebell Ward	7
Adult Acute Admissions - Daisy Ward	5
Adult Acute Admissions - Rose Ward	3
Adult Acute Admissions - Snowdrop Ward	5
CMHT/Care Pathways	37
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Common Point of Entry	12
Community Team for People with Learning Disabilities (CTPLD)	1
Crisis Resolution & Home Treatment Team (CRHTT)	2
Crisis Resolution and Home Treatment Team (CRHTT)	12
Early Intervention in Psychosis	2
Eating Disorders Service	2
Learning Disability Service Inpatients	1
Learning Disability Service Inpatients - Campion Unit	2
Older Peoples Mental Health (Ward Based)	2
Other or unknown location	1
Perinatal	1
PICU - Psychiatric Intensive Care - Sorrel Ward	1
Psychological Medicine Service	5
Talking Therapies	6
Traumatic Stress Service	1
Grand Total	115

2.2.1 Mental Health Complaints by service

The adult mental health services receiving higher numbers of formal complaints in 2019/20 are detailed further below.

Community Mental Health teams (CMHT)

As detailed in table 4, Within CMHT services most complaints were received by Windsor, Ascot and Maidenhead (30%) and Bracknell (24%). In both of these service areas there were multiple complaints from the same patients.

Reading has continued to see a reduction, down to 8% of all CMHT complaints compared to 27% in 2018/19. Wokingham CMHT also saw a reduction from 22% last year to 14% in 2019/20.

Table 4: CMHT complaints

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services	2			1			3
Attitude of Staff		1		1	3	2	7
Care and Treatment	5	2		6	6	2	21
Communication	1		1			1	3
Discharge Arrangements					2		2
Medical Records	1						1
Grand Total	9	3	1	8	11	5	37

Adult mental health inpatients

As detailed in table 5, 57% of complaints received by the acute adult admission wards were about clinical care/ care and treatment; these were individual to specific patient circumstances.

In addition, there was one complaint received in relation to Sorrel ward in 2019/20. There were two complaints received about our Older Adult Mental Health Wards (one each for Rowan Ward and Orchid Ward) were around general care and communication.

Table 5: Adult mental health inpatient ward complaints

	Ward					
Main subject of complaint	Bluebell Ward	Snowdrop Ward	Daisy Ward	Rose Ward	Ward 10 (Historical)	Grand Total
Access to Services	1					1
Attitude of Staff	1	2	1			4
Care and Treatment	3	2	3	3	1	12
Communication	1	1	1			3
Confidentiality	1					1
Grand Total	7	5	5	3	1	21

CRHTT

Table 6 below demonstrates that there were 14 complaints received about CRHTT in 2019/20, the same number as in 2018/19; and a sustained reduction on the 20 received in 2017/18.

As with previous years, a higher percentage were in relation to services received in the West of the county and predominantly Reading where the main hub for the west is located.

Table: 6 CRHTT complaints

	Geographical Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Attitude of Staff	1	2	2	2		7
Care and Treatment	1	2			2	5
Confidentiality		2				2
Grand Total	2	6	2	2	2	14

Older adult services

There was one formal complaint about the Older Adults Community Mental Health Team received in 2019/20 which was about the attitude of staff in the Wokingham based service. This is compared with 3 received in 2018/19; all of which were also about the Wokingham based service.

2.3 Community Health Service Complaints

29% of formal complaints received into the organisation in 2019/20 were about community health services; this is the same as in 2018/19.

Table 7 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (21%), Westcall out of hours services (13%) and Community Nursing (District Nursing 22%).

56% of the total complaints were about care and treatment. There were no particular themes with complaints raised around specifics of care delivery and patient's individual circumstances.

Table 7: Community Health Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Admin teams & office-based staff				1			1
Community Hospital Inpatient		2	3	1	6	3	15
Dental Services			1				1
District Nursing	4	5	6				15
GP General Practice (Historical)			1				1
Health Visiting						1	1
Hearing and Balance Services			1		2		3
Integrated Pain and Spinal Service - IPASS		1		1		1	3
Intermediate Care				1			1
MIU/Urgent Care Centre				3			3
Occupational therapy			1				1
Out of Hours GP Services		2		5		2	9
Physiotherapy (Adult)	2			1	2		5
Podiatry	1				1	2	4

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Rapid Assessment Community Clinic					1		1
Sexual Health			3				3
Tissue Viability					1		1
Grand Total	7	10	16	13	13	9	68

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2019/20 are detailed further below.

Community Nursing

As detailed in table 8, 9 of the 15 complaints were regarding care and treatment, review of these has not identified any themes within these.

Table 8: Community Nursing Service complaints

	Geographical Locality			
Main subject of complaint	Bracknell	Reading	Slough	Grand Total
Care and Treatment	2	2	5	9
Attitude of Staff	1	2		3
Communication	1	1		2
Other			1	1
Grand Total	4	5	6	15

Community Health Inpatient Wards

Table 9: Community Health Inpatient Ward Complaints

	Ward							
Main subject of complaint	Ascot Ward	Donnington Ward	Henry Tudor Ward	Highclere Ward	Jubilee Ward	Oakwood Unit	Windsor Ward	Grand Total
Care and Treatment			4	2	2		2	10
Attitude of Staff		1				1		2
Discharge Arrangements						1		1
Environment, Hotel Services, Cleanliness					1			1
Access to Services	1							1
Grand Total	1	1	4	2	3	2	2	15

The Community Inpatient wards saw a decrease in the number of complaints received in comparison with 2018/19, from 17 to 15; in 2017/18 there were 11 complaints.

Care and treatment continues as the main subject for complaints received about Community Inpatient wards. 40% of the complaints about care and treatment were about Henry Tudor Ward.

Westcall Out of Hours GP Service

As shown in table 10 Westcall received 9 complaints in 2019/20, a reduction from 17 in 2018/19.

The complaints for the out of hours GP service were found to be about the attitude and communication from Doctors, and access to the service

Table 10: Westcall Out of Hours GP Service complaints

Main subject of complaint	Westcall
Attitude of Staff	3
Access to Services	2
Care and Treatment	2
Medication	1
Confidentiality	1
Grand Total	9

2.4 Children, Young People and Families

Table 11 below details the children, young people and families' complaints received, with 17% of all complaints received attributable to these services. The main services where formal complaints are attributed to are our CAMHS services.

Table 11: Children, Young People and Family Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Adolescent Mental Health Inpatients - Willow House						2	2
CAMHS - Child and Adolescent Mental Health Services	1	7	4	5	3	11	31
Children's Speech & Language Therapy - CYPIT	1	1		1			3
Community Paediatrics			2				2
Health Visiting						1	1
Grand Total	2	8	6	6	3	14	39

CAMHS

Child and Adolescent Mental Health Services received 31 complaints in 2019/20 compared to 25 in 2018/19 and 26 received in 2017/18.

Access to CAMHS services saw an increase in 2019/20 to 7 from 3 formal complaints in 2018/19. The number of formal complaints about the attitude of staff remained the same (2 each year) and there was an increase in complaints about communication (up to 4 from 2) and confidentiality (1 complaint this year and none last year).

The CAMHS Urgent Care Service continues to bring positive clinical outcomes for young people. CAMHS have worked hard over the past two years to improve the support offered to 'waiters', with the aim of improving communication with the young people who are waiting to be seen and their

cares. In addition to this, there is more signposting to services such as the Emotional Health Academy and parent support services.

Table 12: CAMHS Complaints

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services		3			1	3	7
Attitude of Staff			1			1	2
Care and Treatment		3	3	2		7	15
Communication				1	2	1	4
Confidentiality	1						1
Waiting Times for Treatment				2			2
Grand Total	1	6	4	5	3	12	31

3 Complaints closed – activity

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

Table 13: Outcome of closed formal complaints

	2018-19						2019-20						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 18/19**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 19/20**	**Change (Annual)**
Case not pursued by complainant	0	0	2	2	4	1.67	0	0	0	0	0	0	↓
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	↓
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	↓
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	↓

	2018-19						2019-20						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 18/19**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 19/20**	**Change (Annual)**
Disciplinary Action required	0	0	0	0	0	0	0	1	0	0	1	0.45	↑
Grand Total	**53**	**61**	**79**	**47**	**240**		**47**	**57**	**61**	**56**	**221**		

The national reporting statistics (including GP and dental service complaints) for 2018-19 showed that:

Upheld	32.8%
Partially Upheld	30.9%
Not Upheld	36.3%

Complaints can cover a number of services and issues which are investigated as individual points which contributes towards higher partially upheld outcomes.

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. During Quarter 3, the Trust had its first breach in responding outside the timescale agreed with the complainant. This was within the Mental Health Inpatients Division and that service have revised their local processes to prevent this from recurring.

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%

4 Complaints as a mechanism for change – learning

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

What we were told: Mental Health Inpatients Wards aren't keeping an accurate log for patient property on the wards, meaning that the Trust has to pay to replace items.
What we have done: Supported wards with refresher information on recording patient property.

What we were told: Staff in The Place of Safety were not clear on the difference between PALS and independent advocacy services.
What we have done: Staff education on the differences between PALS and Advocacy so to manage patient expectations and signpost them to the right support.

What we were told: Patients don't always understand that rationale that staff used for making decisions about care on Mental Health Inpatient Wards.

What we have done: Reminded clinicians that a timely and clear rationale/explanation should be provided to patients for discharge or when a treatment/service they have requested is not considered clinically appropriate. Patients' understanding of the rationale provided should be checked.

What we were told: There needs to be clarity about the use of text messaging between patients and staff.
What we have done: Reminder to clinicians that they should be mindful about the language and tone of text messages sent to patients and make it clear that they will only be able to respond to patients' texts during working hours. Patients should be advised not to use texts for urgent communications.

What we were told: A family were unclear on whose responsibility it was to manage the behaviour of a young person during an appointment.
What we have done: Where child/ren become undisciplined/disruptive during consultation, parents/guardians should be quickly reminded of the need for them to supervise their child/ren independently of staff. This ensures that where such an event occurs, (1) parents/guardians feel empowered to act and do not wait for staff to direct child/ren and (2) that this non-home environment does not imply to parents/guardians that child/ren cannot be controlled by parents/guardians like they would be at home. A reminder to staff that they should quickly and proactively remind parents/guardians to supervise child/ren independently, where child/ren become disruptive or unruly.

What we were told: There have been delays in referrals due to change in clinicians (within CYPIT):
What we have done: Staff will check that there are no previous actions outstanding when there is a change of clinician and will action where appropriate.

What we were told: Patients who are discharged from hospital to the care of the Continence Advice Service don't have everything that they need.
What we have done: For all referrals received to the Continence Service for new catheter patients, whether temporary or permanent, Triage will make contact with the patient concerned to ensure that the hospital discharged them with all equipment they need, and they were shown in hospital how to change leg bag. They will also make sure that the patient has the service contact details in case they need advice.

5 Parliamentary and Health Service Ombudsman

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

Table 15: PHSO activity

Month open	Service	Month closed	Current Stage
Jun-18	District Nursing	Aug-18	Not a BHFT complaint – statement provided by our staff to inform the investigation
Jul-18	CPE	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
Nov-18	Psychological Medicines Service	Nov-18	PHSO not proceeding
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

In January 2020, Healthwatch England published a report looking at the improvements that have been made in the NHS Complaints handling, called Shifting the mindset – a closer look at NHS Complaints. This is based on the findings of the report produced by Sir Robert Francis QC, as part of the public inquiry into the serious failings at Mid Staffordshire Foundation Trust. The Head of Service Engagement and Experience was part of the review team in this inquiry, focussing on the complaint processes and learning; when joining the Trust 7 years ago, the existing complaints processes and reporting were completely revised.

The recommendations and actions from this report are monitored on a quarterly basis through the quarterly Patient Experience Report.

6 Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they contribute to but are not the lead organisation (such as NHS England and Acute Trusts). Table 16 below details this activity.

Table 16: Formal complaints led by other organisations

Organisation	Summary of element of complaint relating to Berkshire Healthcare services
Berkshire East CCG	Complaint about the attitude of CMHT staff
CCG East Berkshire	Patient is unhappy with the way that the Hearing Aid service was transferred to another provider
East Berkshire CCG	Joint complaint with CCG MH Commissioning team regarding a request for funding
Frimley Park Hospital	Complainant wishes to know if staff are trained to deal with hypoxic brain jury on a community inpatient ward
NHSE	Following an injury in 2017, patient is unhappy with care provided by MSK physio in Church Hill House
NHSE	NHSE complaint with an element relating to effectiveness of Talking Therapies and CPE declining referrals
Royal Berkshire Hospital	Complaint made to RBH re care and treatment received. However, complainant wishes to know why a referral was not made for domiciliary physio before discharge from Wokingham Inpatients
Royal Berkshire Hospital	Family of patient complaining of poor discharge from ICU of patient who had involvement with the Psychological Medicines Service
SCAS	Family feel OOH GP took too long to call back
SCAS	Patient states they did not get a call from Westcall after speaking to 111
Royal Berkshire Hospital	Comments were made by the Dr likening a mistake to a pizza delivery
SCAS	Pt's mother feels she had to wait too long for a call back from the Dr having called 111 and being told they would call within 2 hours
Berkshire West CCG	Complaint about waiting time for CAMHS. The Young person has been seen by a private Psychiatrist and is currently 24/37 on the waiting list for local CAMHS care
SCAS	Father of patient unhappy with the way the WestCall person spoke to his partner
Berkshire West CCG	Father complained to CCG about lack of commissioned services around CAMHS
NHS East Berkshire CCG	CCG require more content to our letter covering why concerns with Community Nursing occurred
Royal Berkshire Hospital	Deceased pt: Pt transferred from RBH - family extremely unhappy with the care and treatment the pt received
NHS East Berkshire CSCSU	Pt was unaware that they were no longer under BHFT
Royal Berkshire Hospital	Family feel pt was transferred to Oakwood from RBH too early and do not want the patient to go to a care home as a result from our ward
NHS East Berkshire CCG	DECEASED PT: - prolonged delays in medication sourcing, DN's unable to attend due to capacity, emergency cover also struggling to attend.

7 Complaints training

The Complaints Office has continued to offer a programme of complaint handling training, which is accessible through the Learning and Development Department. Over the last year, the Complaints Office has delivered training to 56 delegates. Bespoke training, on a one to one basis, has been given to support individuals who are new in post and who need to have training ahead of the scheduled dates. The final face to face training session planned for March 2020, with 20 confirmed delegates, has had to be postponed due to the Covid-19 pandemic. This session will be rescheduled, hopefully for autumn 2020.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets on a monthly basis and the Complaints Office feeds information into this group. There were 13 formal complaints forwarded to the MRG during 2019/20.

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

Table 17: Complaints forwarded to TMRG

Service	Number of complaints
Community Hospital Inpatient	5
District Nursing	2
Corporate (Policy)	2
Psychological Medicine Service	1
GP Practice	1
Out of Hours GP Services	1
Adult Acute Admissions	1
Grand Total	13

The two complaints under 'Corporate' were both complaints around the Serious Incident process. In one case the family felt their letter was not looked at as part of the Serious Incident process, and in the second case the family felt there were inaccuracies in the SI report. The original services these patients were under are Acute Adult Admissions and Talking Therapies respectively.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	Quality Account 2019/120
Purpose	NHS Foundation Trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010 as amended by the NHS (Quality Accounts) Amendments Regulations 2011 and the NHS (Quality Accounts) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations"). For the Trust this provides an opportunity to present a balanced account of its quality priorities and performance against these. The report includes some mandated content which can be complex, but should, in general, be accessible for members of the public.
Business Area	Trust Wide
Executive Lead	Medical Director
Authors	Head of Clinical Effectiveness & Audit and Quality Account Lead
Relevant Strategic Objectives	True North Goal 1- Harm Free Care, True North Goal 2- Supporting Our Staff, True North Goal 3- Good Patient Experience
CQC Registration/Patient Care Impacts	Does not negatively impact registration or patient care.
Resource Impacts	None
Legal Implications	The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The NHS Improvement annual reporting guidance for the quality report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations and additional reporting requirements set by NHS Improvement.
Equality and Diversity Implications	None
SUMMARY	This is the 2019/20 report of the Trust's Quality Account for final approval by the Board. The Quality Assurance Committee have reviewed and approved this document. In line with the regulations the Q3 version of the Trust Quality Account was shared for consultation with our stakeholders at the beginning of March 2020, this included the Clinical Commissioning Groups, Trust Council of Governors and local Health Overview and Scrutiny Committees. Responses are positive and support the consistency of the Quality Account with data and information they are aware of (Appendix G). NHSI and NHS England added an additional Quality Account reporting requirement this year, specifically that: "Providers of mental health services are asked to include a statement on their progress in bolstering staffing in their adult and older adult community mental health services, following additional investment from local CCGs' baseline funding.". A statement meeting this requirement has been added

	to the "Statements of Assurance from the Board" section in part 2.3.7. of this report. The quality account priorities for 2019/20 support the goals detailed in the Trust's 2019/20 True North Annual Plan, and achievement is summarised below. **Patient Experience (Section 2.1.1)** **Priorities meeting the required targets** • The 95% patient satisfaction rate continues to be met by community inpatient services (96%) and the Minor Injuries Unit (97%) in the Friends and Family Test • The Trust continues to contribute to the Berkshire East Integrated Care System and Berkshire West Integrated Care Partnership Workstreams to improve patient experience and outcomes • The percentage of mental health delayed transfers of care were below the target threshold of less than 7.5%. Areas where trust targets are not currently being met are as follows: • The trust-wide response rate for the patient Friends and Family Test is below the 15% target (10.6%). The accuracy of discharge data has improved, and this continues to be monitored on a monthly basis. • Community services achieved a patient satisfaction rate of 92% for the Friends and Family Test during the year, with mental health inpatients achieving 71%- the same result as in 2018/19. Historically it has been recognised that this group of patients are less likely to recommend services. • The local target of having no more than two cases of prone restraint per month was missed in two of the three months in Q4. However, the target has been met in six of the months in 2019/20. **Patient Safety (Section 2.1.2)** **Priorities meeting the required targets** • Two medication errors resulting in moderate harm were reported (against a target of no more than four annually) • There were fourteen category 3 or 4 pressure ulcers due to a lapse in care by trust staff reported (against a target of no more than 18 annually). • There were two cases of gram-negative bacteraemia due to lapse in care by trust staff reported, each on different wards (against a target of no more than one case per ward during the year) • The number of bed days that patients spend as an inappropriate Out of Area Placement (OAP) was below the quarterly target figures set during the year • The number of reported self-harm incidents was below the target threshold for all three months in Q4. • The Zero Suicide Project continues achieving its goals **Areas where trust targets are not currently being met are as follows:** • The rate of falls per 1000 bed days during the year was above the threshold of four for Older Peoples Mental Health (OPMH) wards (10.57) and Community inpatient wards (5.34). The older adult mental health wards continue to have falls as a driver for improvement. • There have been 30 category 2 pressure ulcers due to a lapse in care by trust staff during the year (against a target of no more than 19). This issue will be discussed at the Pressure Ulcer Steering Group with a push for a renewed focus on prevention. • 89.7% of incidents reported between 1st April 2019 and 29th February 2020 were of no harm or low harm to patients (against a target of 95%). The trust

	continues to review incidents, with serious incidents fully investigated to allow for trust-wide learning. **Clinical Effectiveness (Section 2.1.3)** All priorities are being met • NICE Guidance compliance remains above 80%. • The Trust is participating in all mandated national clinical audits and continues to progress several initiatives to support research. • The Trust continues to report and learn from deaths of patients **Supporting our Staff (Section 2.1.4)** Priorities meeting the required targets • The staff vacancy level was below the 10% target threshold and was recorded as 5.9% in March 2020 • Staff turnover was below the 16% target threshold and was recorded as 14.7% in March 2020 Areas where trust targets are not currently being met are as follows: • The staff sickness level has been above the 3.5% threshold in all months of 2019/20. Levels of sickness absence for anxiety/stress/depression continue to be high and the work associated with the reduction of this links in with some of our health and wellbeing activity. • The number of reported patient-to -staff assaults on mental health inpatient wards was above the target threshold of 36 in March 2020, but below this threshold in seven of the months in 2019/20 • The staff engagement score from the National NHS Staff Survey was below the target of 8 at 7.3, but this was 0.1 above our 2018/19 score. From the staff survey, 65.7% of staff reported feeling that they can make improvements at work (against a target of 70%) and 74.4% strongly agreed they would recommend the Trust as a place to receive treatment (against a target of 85%). Both scores were an improvement over the previous year. The Trust priorities for 2020/21 have been updated to include the revised version of the plan on a page to take into account our recovery plan for COVID 19 (Detailed in Appendix A). **Updated National Guidance in relation to COVID 19.** In April it was confirmed that NHS providers were no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20, this was in line with reducing the burden during the COVID 19 pandemic. In addition, NHS foundation trusts were informed that we were no longer required to include a quality report in their annual report for 2019/20, and that the June publication date for the Quality Accounts on NHS choices would be extended. On 1st May 2020 NHSI published an update to the regulations which stated that while primary legislation continues to require providers of NHS services to prepare a quality account for each financial year, the amended regulations mean there is no fixed deadline by which providers must publish their 2019/20 quality account. NHS England and NHS Improvement recommends for NHS providers that a revised deadline of 15 December 2020 would be appropriate, in light of pressures caused by COVID-19. Draft quality accounts should be provided to stakeholders (for 'document assurance' as required by the quality accounts regulations) in good time to allow scrutiny and comment. For finalising quality accounts by 15 December, a date of 15 October would be reasonable for this.

	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 for 2019/20 which was be received by the May Quality Assurance Committee. For this year external assurance is gained through our stakeholder consultation which was completed and noted at the Audit Committee in May 2020. We will now be maintaining our quality account process and from June will be working on our 2020/21 Quality Account.
ACTION REQUIRED	The Board is asked to seek any clarification required and approve the 2019/20 Quality Account. Directors are asked to consider the Statement of Directors' Responsibilities in Respect of the Quality Account (page 59), and ensure they are satisfied with the quality account in relation to the requirements detailed in this statement. Directors must confirm to the best of their knowledge and belief they have complied with the requirements detailed on page 59 in preparing the Quality Report, and the statement must then be signed by the Chair and Chief Executive by order of the Board to confirm this.

Berkshire Healthcare
NHS Foundation Trust

Quality Account 2019/20

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

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

What is a Quality Account?

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

About the Trust

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

We are rated overall as 'Outstanding' by the Care Quality Commission.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. This allows us to transform patient care through use of technology.

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

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

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

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Quality Account Positive Highlights and Overall Summary 2019/20

Care Quality Commission (CQC) Rating

The Trust is rated as 'Outstanding' overall. Our Community Physical Health services for adults and our End of Life service join our Learning Disability In-Patients and our Older Peoples Community Mental Health services in being rated as 'Outstanding'. All our services are now rated as either outstanding or good.

Patient Experience Priorities

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

Patient Safety Priorities

1. We have met the following annual targets:
   - ≤4 medication errors resulting in moderate harm or above. Result: 2.
   - ≤18 grade 3 or 4 pressure ulcers due to a lapse in care by Trust staff. Result: 14.
   - ≤1 gram-negative bacteraemia per ward due to lapse in care by Trust staff. Current Result: 2 across all wards- each one on a different ward
   - The number of inappropriate Out of Area Mental Health placements.
2. We have continued implementing our Zero Suicide programme as well as embedding patient safety in clinical and support teams.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits, ensuring that appropriate actions are taken, and improvements made.
- We continue to have a robust system for reviewing NICE guidance to ensure that care is delivered in line with national best practice standards.
- We continue reviewing, reporting and learning from deaths in line with national guidance.

Supporting our Staff Priorities

We have reduced our staff vacancy rate to 5.9% and staff turnover rate to 14.7%. We continue promoting a compassionate culture with zero tolerance of aggression, bullying and exclusion.

2020/21 Trust Priorities

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
- Ensure that we have safe levels of staffing to meet service demands
- Engage with all services over next six months to agree a plan to safely bring all services back to full operation
- Continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all our services
- Recognise and respond promptly to physical health deterioration on our in-patient wards
- Strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

Clinical Effectiveness Priorities. We will demonstrate our delivery of evidence-based services by; reporting on implementing NICE guidance related to Trust priorities and continue learning from deaths in line with national guidance.

Patient Experience Priorities. 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
- Manage patient flow effectively, with minimum delays and make sure that patients stay within our services for no longer than is clinically appropriate
- Engage and communicate with patients and the public to make sure that they understand how to access the right help at the right time
- Support patients to manage any direct or indirect adverse impact of COVID-19

Supporting our Staff Priorities. To support our people and be a great place to work we will:

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

Figure 1- Summary of Trust achievement for the 2019/20 Quality Account

Indicator (Click on links to access the related main sections of the report)		2019/20 Target	Results 18/19	Results 19/20	Comment & Change from 18/19- 19/20
Patient Experience					
Patient Friends and Family Test- Response Rate		≥15%	15.2%	**10.6%**	**Target Not Met**
Patient Friends and Family Test (FFT) - % of patients stating they are likely or extremely likely to recommend the service to a friend or family member	Community Services (Mental health and physical health combined).	≥95%	94%	**92%**	**Target Not Met**
	Mental Health Inpatients.	≥95%	71%	**71%**	**Target Not Met**
	Community Hospital Inpatients.	≥95%	96%	**96%**	**Target Met**
	Minor Injury Unit.	≥95%	98%	**97%**	**Target Met**
Carer Friends and Family Test (FFT) - % of carers likely or extremely likely to recommend the service to a friend or family member		No target set	96%	**95%**	**Change: -1%**
Staff report using service user feedback to make informed decisions in their department (National NHS Staff Survey)		≥60%	61%	**62.8%**	**Target Met**
Instances of prone restraint		≤2 per month	Not met	**3**	**Target Not met**
Delayed Transfers of Care		≤7.5%	9.0%	**6.8%**	**Target met**
National Community Mental Health Survey - Overall result out of 10		No target set	7.2	**7.3**	**Change: +0.1**
Patient Safety					
Self-harm incidents by Mental Health Inpatients by 30%		≤46 per month	N/A	**25**	**Target met**
Rate of inpatient falls on wards for older people	Older Peoples Mental Health Wards	≤4 falls per 1000 bed days	16.59	**10.57**	**Target Not Met**
	Community Health Wards		6.02	**5.34**	**Target Not Met**
Medication errors graded moderate and above		≤4 per year	N/A	**2**	**Target met**
Pressure ulcers (PU's) due to lapse in care by Trust staff	Number of Category 2 PUs due to lapse in care by Trust staff	≤19 per year	15	**30**	**Target Not Met**
	Number of Category 3&4 PUs due to lapse in care by Trust staff	≤18 per year	18	**14**	**Target met**
	Days between development of Category 3&4 PUs due to lapse in care by Trust staff	≥180 days between development	N/A	**Not met at end of Q4, but had been met earlier in the year**	
Gram negative bacteraemia due to lapse in care on community inpatient wards due to lapse in care by trust staff		≤1 per ward during year	N/A	**2 cases on different wards**	**Target Met**
Reported incidents that resulted in low or no harm to patients		≥95% per year	N/A	**89.7%***	**Target Not Met**
Urgent Admissions: Number of inappropriate out of area placements		As per NHSI (see main report)	Target Met	**Target Met**	**Target Met**
Clinical Effectiveness					
Compliance with recommendations contained in NICE Clinical Guidelines	Post-Traumatic Stress Disorder	≥80%	N/A	**88%**	**Target Met**
	Care and Support of People Growing Older with Learning Disabilities	≥80%	N/A	**96%**	**Target Met**
	Depression in Children and Young People	≥80%	N/A	**88%**	**Target Met**
Supporting our Staff					
Staff Engagement Score in the National Staff Survey		≥8 out of 10	7.3	**7.4**	**Target Not Met**
Staff report feeling they can make improvements at work (National NHS Staff Survey)		≥70%	64.5%	**65.7%**	**Target Not Met**
Staff agree or strongly agree they would recommend the Trust as a place to receive treatment (National NHS Staff Survey)		≥85%	73.6%	**74.4%**	**Target Not Met**
Staff vacancy level		<10%	8.6%	**5.9%**	**Target Met**
Staff turnover rate		<16%	N/A	**14.7%**	**Target Met**
Staff sickness level		<3.5%	N/A	**4.1%**	**Target Not Met**
Assaults on staff on Mental Health inpatient wards		≤44 per month	N/A	**57**	**Target Not Met**

* Please note that the incident data represents incidents between 1st April 2019 and 29th February 2020. Publication of data has been temporarily ceased at national level due to operational pressures

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

Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients throughout 2019/20. This supports our vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust is now rated as Outstanding by the Care Quality Commission, all our services are individually rated as either outstanding or good and I take great pride in congratulating our staff for this.

We are committed to the principles of system working and continue to be actively involved with our health and social care partners across Berkshire, including the third sector, to implement sustainable population-based solutions for meeting the physical and mental health needs of our patients and service users. We have also seen some expansion of our services outside of the Berkshire county borders, recognising the expertise of our teams in these areas.

It is essential that patients have a positive experience of our services and we continue to utilise Trust-wide systems to measure and learn from this experience. We prioritise learning from patient experience surveys, complaints and compliments and aim to continuously improve on and learn from this important feedback.

Patient safety will always be of paramount importance to us, and our Trust Board monitors performance in this area through scrutiny of a variety of patient safety metrics, several of which are shared in this report. Robust governance, patient safety, incident and mortality reporting systems are maintained throughout the Trust, with these processes used to highlight areas for improvement in a timely manner allowing for learning. We have focused on improving safety in several areas this year, including self-harm and medication errors, and we will continue striving to improve in these areas.

Our clinical effectiveness systems help to ensure that we are providing the right care to the right patient at the right time and in the right place. Our clinical audit and NICE programmes allow us to measure our care against current best practice leading to improvement.

We are also a research-active organisation. This report details the work undertaken in this area.

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

This report details the breadth of improvement work that has been undertaken by Trust services throughout the year. Our staff have shown a commitment to improve their services and our Quality Improvement (QI) programme continues with more staff being trained in its methodology each year.

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

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

Julian Emms CEO
(Date and signature to be added in final version)

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

2.1. Achievement of Priorities for Improvement for 2019/20

ⓘ This section details the Trust's achievements against its quality account priorities for 2019/20. These priorities were identified, agreed and published as part of the Trust's 2018/19 quality account.

These quality account priorities support the goals detailed in the Trust's 2019/20 True North Annual Plan (see Appendix A). The Trust's Quality Strategy also supports this through the following six elements:

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

Although the areas of efficiency and equity do not have their own sub sections in this report, please note that they are covered in other sections of the report where it is relevant to do so.

2.1.1. Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2019/20.

Our 2019/20 Patient Experience Priorities:

To provide good outcomes from treatment and care:

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

Trust performance in relation to complaints, compliments and the 2019 National Community Mental Health Survey is also detailed in this section.

Patient Friends and Family Test (FFT)

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

Please note that the Friends and Family Test was suspended nationally in Quarter 4 of 2019/20 due to the COVID-19 pandemic. Data presented here is accurate to the point of this suspension.

Response Rate - Target 15%

The Trust aims to achieve a response rate of at least 15%. Figure 2 below demonstrates the response rate for 2019/20 and shows that a rate of 10.6% was achieved during the year which is below target. The response rate has been impacted by the increase in the discharge data provided to the Patient Experience Team. We are now more assured on the accuracy of the data and this continues to be monitored on a monthly basis with a root cause and planning document being taken to the Trust Finance, Performance and Risk Committee meeting.

Satisfaction Rate - Target 95%

One of the Trust's targets for 2019/20 is to achieve a 95% satisfaction rate in the FFT. Figures 3 and 4 below demonstrate the Trust's achievement in relation to this target by showing the percentage of respondents stating that they were extremely likely or likely to recommend services. The figures show that the 95% threshold has been achieved for community hospital inpatients and minor injuries services. Community services missed the target by 3%. Mental health inpatients scored 71% which is below the 95% threshold and equal to their 2018/19 annual figure.

Figure 2- Response Rate for Patient FFT - Target 15%

2019/20 Quarter	Q1	Q2	Q3	Q4	2019/20 Full Year
% Response Rate	12.2%	10.9%	10.7%	9.3%	10.6%

Figure 3- Patient Friends and Family Test (FFT): Percentage of patients extremely likely or likely to recommend the service to a friend or family member - Target 95%

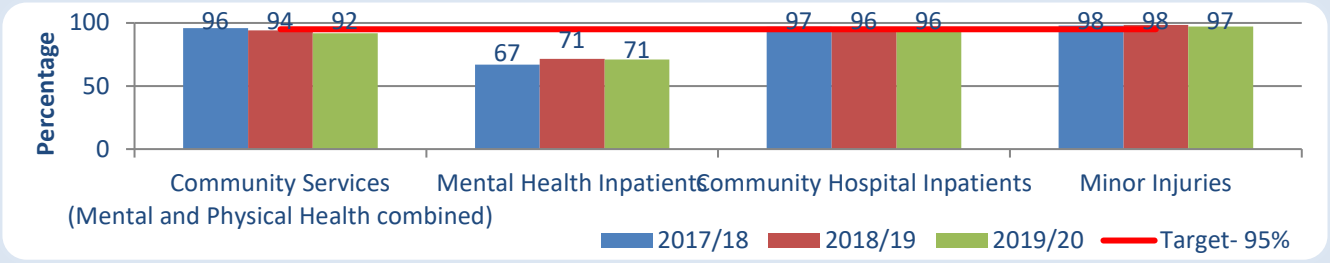


Figure 4- Patient Friends and Family Test- total number of responses

Survey and Service	2018/19 Total no. of respondents	2018/19 Respondents likely or extremely likely to recommend service No.	2018/19 Respondents likely or extremely likely to recommend service %	2019/20 Total no. of respondents	2019/20 Respondents likely or extremely likely to recommend service No.	2019/20 Respondents likely or extremely likely to recommend service %
Community Services- Mental Health & Physical Health Combined	30078	28321	94	44515	40828	92
Mental Health Inpatients	480	343	71	920	654	71
Community Hospital Inpatients	930	894	96	621	594	96
Minor Injuries Unit	2245	2209	98	715	694	97

Source for figures: Trust Patient Experience Reports. Please note that the 2017/18 figure for minor injuries also includes data for Slough Walk-In Centre prior to its transfer to another organisation in September 2017

Carer Friends and Family Test (FFT)

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

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test and detail the percentage of respondents that stated that they were extremely likely or likely to recommend Trust services.

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

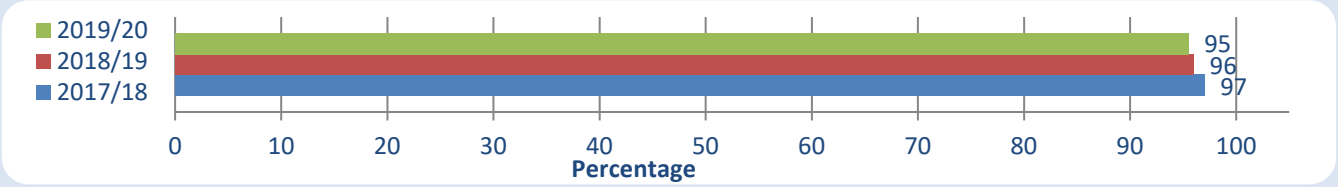


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2018/19			2019/20		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	849	815	96	1473	1404	95

Source for both figures: Trust Patient Experience Reports

Please note that the Trust does not have a response rate for this survey.

Trust Patient Satisfaction Survey

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

Figures 7 and 8 below demonstrate performance in relation to this survey by showing the proportion of respondents that would rate services as good or very good.

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

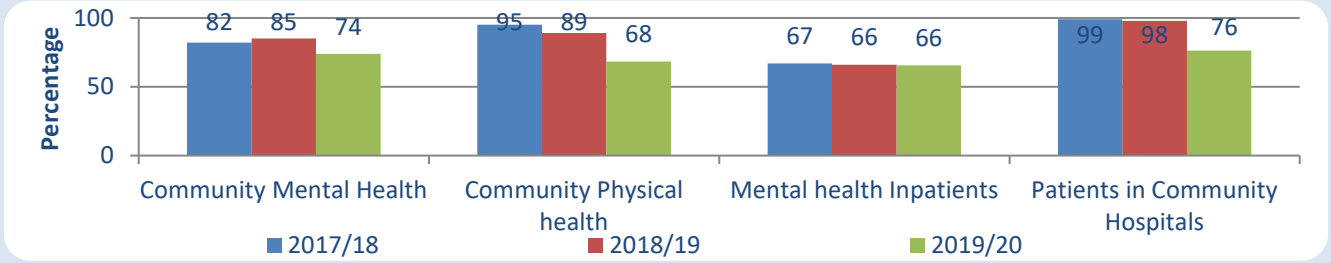


Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2018/19			2019/20		
	Total number of respondents	Total rating service as good or very good	% rating service as good or very good	Total number of respondents	Total rating service as good or very good	% rating service as good or very good
Community MH	3197	2722	85	2454	3321	74
Community Phys H	7896	7062	89	7725	11292	68
MH Inpatients	417	274	66	615	937	66
Pts in Comm. Hosp.	53	52	98	1330	1745	76

Source for both figures: Trust Patient Experience Reports

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

ⓘ One of the Trust's targets for 2019/20 is that 60% of staff will report that they use service user feedback to make informed decisions about their department.

Performance against this target is measured with reference to Q22c in the 2019 National NHS Staff Survey, which asks whether ""Feedback from patients/service users is used to make informed decisions within my directorate/department".

From the results of the 2019 staff survey it is evident that 62.8% of our respondents agreed or strongly agreed with this statement. This finding is above the average result for other comparable trusts (55.5%) and above the Trust's 2018/19 result of 61%.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments during the year. Figures 9 and 10 below show the monthly number of complaints and compliments received by the Trust. A total of 231 complaints were received during 2019/20 compared with 230 in 2018/19.

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.

36 (61%) of these 59 complaints related to adult mental health service provision. Of these complaints:

- 13 related to Community Mental Health Teams (CMHT), with varied reasons for these.
- 6 related to mental health inpatient wards
- 6 related to the Crisis Resolution/ Home Treatment Team (CRHTT)

13 (22%) of the 59 complaints related to adult community health services. Of these complaints:

- 4 were received by adult physiotherapy services
- 4 related to community nursing services
- 3 related to community hospital inpatients

4 (7%) of the 59 complaints were about Child and Adolescent Mental Health Services (CAMHS), and 3 (5%) were about children's physical health services.

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

100% of complaints were acknowledged within three working days during Q4 of 2019/20, with 100% resolved within the timescale agreed with the complainant. Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

Examples of learning and changes made throughout the year as a result of feedback are detailed below:

Mental Health Inpatients:

- Better recording of patient property as a lack of documentation has resulted in the Trust needing to replace items.
- It is important to have a consistent approach to the clinical risk assessment of informal inpatients requesting leave from the ward

Mental Health Services East Division:

- When patients request a correction or amendment to clinical correspondence or records the change should be made as quickly as possible and confirmation sent to the patient.
- A timely and clear explanation should be provided to patients for discharge or when a treatment/service they have requested is not considered clinically appropriate. Patients' understanding of the rationale provided should be checked.
- It is important to keep patients informed regarding waiting times for assessment/ treatment/ decisions regarding their care.
- Clinicians should be careful about the language and tone of text messages sent to patients and make it clear that they will only be able to respond to patients' texts during working hours. Patients should be advised not to use texts for urgent communications.

Out of Hours GP (WestCall):

- Communication in the Urgent Care Medicines Bulletin reminding GPs of the correct mixing when reconstituting suspensions.

Children, Young People and Families Division:

- A reminder has been given to staff that they should provide clear context when communicating with patients/parents, as if patient/parent are not party to knowledge they cannot always deduce the correct context for their understanding/assessment to what is actually intended/meant.
- Ongoing work is happening to review processes, utilise technology, increase capacity and to work with commissioners as well as providing information, advice and review of risk regarding young people on waiting lists.
- Staff have been reminded that young people and their families should be asked about an observation happening prior to entering the clinic room and that they should be reassured that there choice will not impact on their treatment.

Community inpatient wards

- Introduce cognition reassessment prior to discharge
- MDT discharge checklist to be implemented
- Information Board for relatives now displays a poster re how the multi-disciplinary team makes decisions with regards length of stay
- Be aware of special days and plan with family
- Improve communication with relatives through Discharge coordinator & ward manage

Figure 9- ***Complaints received*** **(excluding re-opened complaints)**

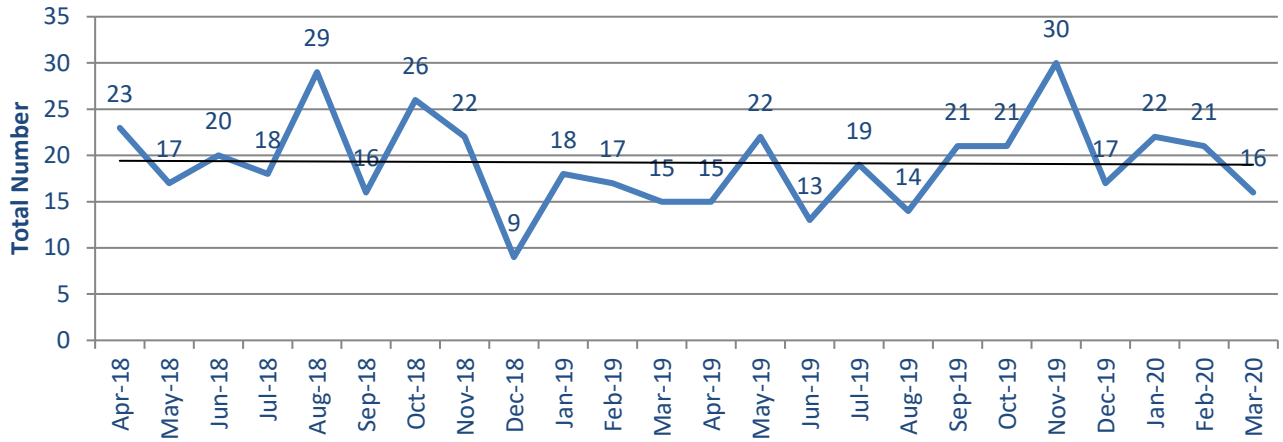
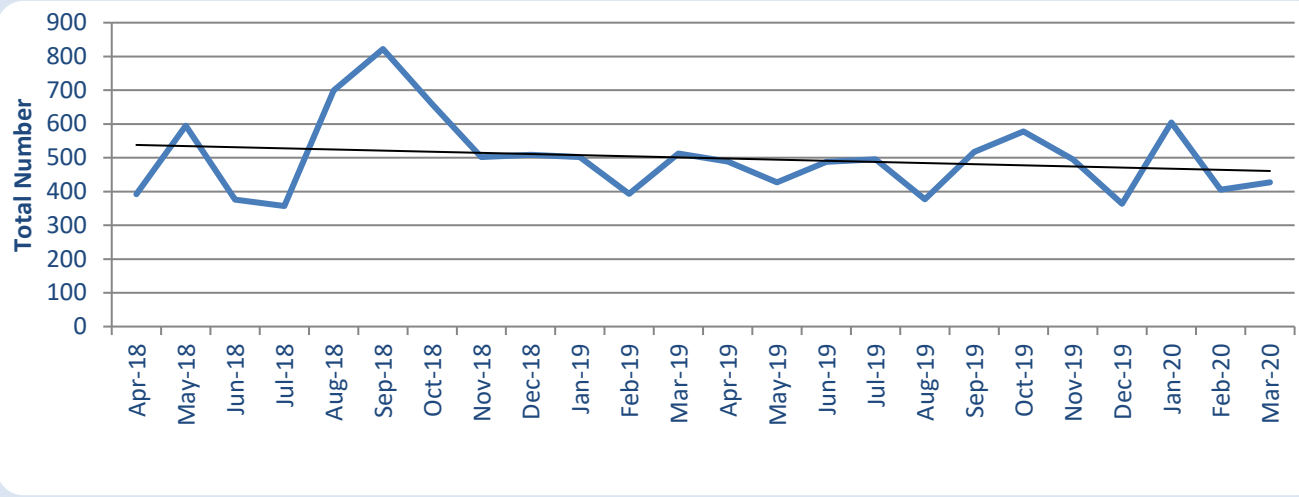


Figure 10- ***Compliments received***



Sources: Trust Complaints and Compliments Reports- this is based on compliments being submitted voluntarily by service

Understanding and Supporting Outcomes of Care that are Important to Patients

ⓘ One of the Trust's priorities for 2019/20 is to ensure that all services focus on understanding and supporting outcomes of care that are important to patients

Performance against this target is measured with reference to Q22c in the 2019 National NHS Staff Survey, which asks whether ""Feedback from patients/service users is used to make informed decisions within my directorate/department".

From the results of the 2019 staff survey it is evident that 62.8% of our respondents agreed or strongly agreed with this statement. This finding is above the average result for other comparable Trusts (55.5%) and above the Trust's 2018/19 result of 61%.

Use of Prone (Face-Down) Restraint

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

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

One of the Trust's targets for 2019/20 is to reduce the use of prone restraint to no more than 2 per month during the year.

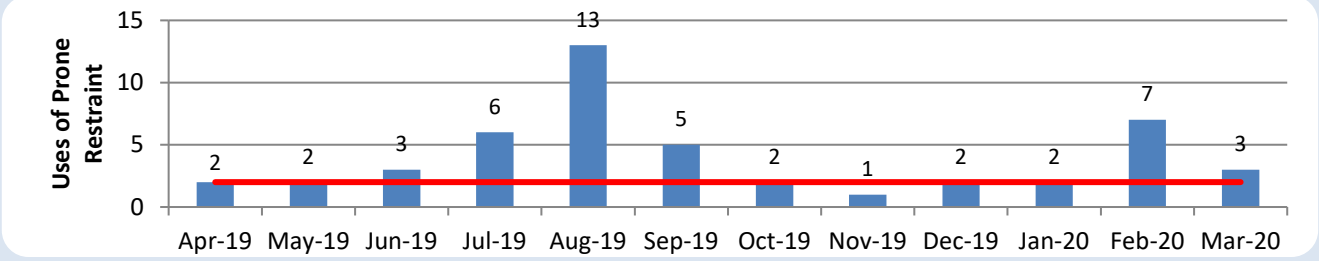
The monthly number of cases of prone restraint in Trust mental health care is detailed in Figure 11 below and shows that the target has been met in six of the months in 2019/20. The seven instances of prone restraint in December 2020 were for varying reasons including one undertaken by the police whilst bringing a patient into hospital.

Quality Improvement work continues on adult mental health inpatient wards. The service expects there to be peaks in data and these restraints are monitored on a monthly and weekly basis. The highest contributor to the need for a prone restraint is when giving Intramuscular (IM) medication to a patient. Staffing levels may also impact on this due to supine restraint requiring an extra member of staff.

The Clinical Director for adult mental health inpatients is working with the PMVA team to ensure that clear messages are given regarding the position to use when giving IM in supine restraint. The Clinical Director is also linking this with rapid tranquilisation training.

The use of prone restraint on Trust adult mental health inpatient wards has reduced by 61% during the last 18 months (exceeding their target of a 50% reduction). This service is now benchmarked below the mean line for prone restraint in national benchmarking data, having been above the mean line for this previously.

Figure 11- Monthly uses of prone restraint in Trust mental health services. Target- No more than 2 per month.



Source- Trust Tableau Dashboard

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

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

The Trust is a member of two Integrated Care Systems (ICS):
Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System that covers a population of 1.8 million people, stretching from Banbury in the North to Wokingham/Riseley in the South, and from Hungerford in the West to Amersham in the East. As part of the BOB ICS Berkshire West is a key partner in the Berkshire West Integrated Care Partnership (ICP) covering a population of approximately 528,000 residents in Reading, West Berkshire and Wokingham. Berkshire West CCG and The Royal Berkshire NHS Foundation Trust are also part of this ICP, which is now aiming to align its work with the "Berkshire West 10 Integration Partnership", including Local Authority partners.

Frimley Health and Care ICS covers a population of approximately 726,000 residents in East Berkshire, North East Hampshire and Farnham and Surrey Heath. Berkshire East CCG, Frimley Health NHS Foundation Trust (including Wexham Park Hospital) and our Local Authority partners in Bracknell, Slough, Windsor and Maidenhead and Bracknell Forest County Council.

Berkshire West ICP

Project Prioritisation. The ICP Delivery Group took part in a quality improvement style workshop in August and September 2019 using a strategic filter process to identify the key projects for the ICP work programme. As part of this, all Programme Boards completed a key facts document for all their projects which then were presented to the Delivery Group for categorisation into mission critical, important, wait or needs more information. Projects that were prioritised as "mission critical" form the core ICP work programme with any resource requirements for these projects flagged for support. A further prioritisation workshop was held in February 2020 to test the 'long list' of projects and narrow the field of work, focusing on the projects that will have the most impact. This will be considered by the ICP Unified Executive in February 2020. Further work will continue. The ICP has a standardised approach to the development and governance of projects/programmes to ensure there is enough control over their identification and authorisation, thus increasing the likelihood of successful project delivery. The ICPs Digital Vision will be a key enabler for high-quality delivery of services.

The Trust has participated in several ICP work-streams to improve patient experience and outcome including: Urgent and Emergency Care (UEC) Strategy, Mental Health Crisis Care, Anticipatory Care Planning in Multi-disciplinary teams, Joint Health & Wellbeing Strategy, Community Reablement, Mental Health Act Section 117 Aftercare and Care Homes. Separately, there are also several work-streams that are redesigning pathways including respiratory, diabetes, CVD, dermatology and Musculoskeletal (MSK).

Frimley Health and Care ICS

Berkshire East has several work-streams improving patient care. Examples include the following:

Improving Diabetes Services. The Diabetes Structured Education Courses for East Berkshire have increased in number in 2019/20 and continue to be run during the day, evenings and at weekends. An online course is also available. An evaluation of people attending these education courses indicates that they have an average reduction in HbA1c of 9mmol/mol, with the largest reduction of 60mmol/mol. There was also an average reduction in weight of 6kg, with the largest weight reduction of 20kg. To improve the uptake of the education further we have proposed to the Primary Care Networks that more sessions are delivered in GP practices. The Diabetes Inpatient Specialist Nurse Team has increased from 1.6 to 4.8 whole time equivalent staff and is now running a 7-day service, with most patients seen within 5 hours of being referred. The service also provides regular diabetes education to ward staff.

Integrated Care Decision Making (ICDM). The ICDM approach enables teams from the health, social care and voluntary sectors to work together with much more flexibility, focused on a person's needs and not on organisational boundaries or responsibilities. By working together, services can best meet the needs of the local population and help them to remain in their

own homes for as long as possible. The model reduces duplication and effort across system partners and ensures patients get a coordinated, holistic response to meet their identified needs. There are five components within the model:

- An Anticipatory Care Planning approach (to support early identification of people with complex needs and allow the introduction of personalised and proactive Care and Support plans)
- Local Access points (between health and social care to jointly triage and assess people)
- Co-located community teams with primary and social care partners
- Multi-Disciplinary Team (MDT) / Clusters (to manage complex patients and reduce points of crisis)
- Hospital In-reach approach to proactively sign post people back into community services

The Trust is also the system leader on the Start Well Ambition included in the Frimley ICS five-year plan.

Reducing Mental Health Delayed Transfers of Care

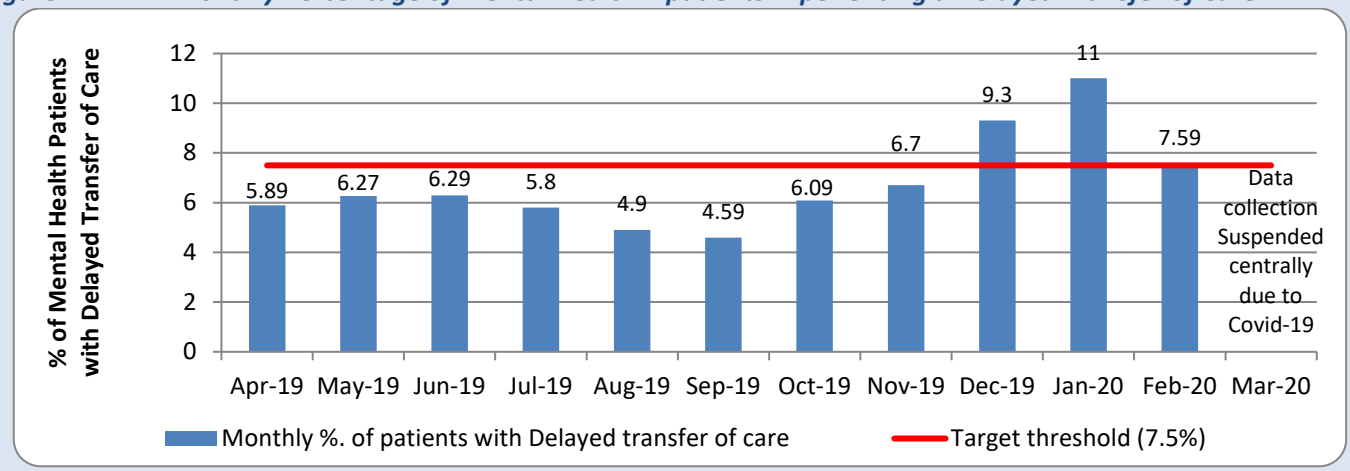
ⓘ A mental health delayed transfer of care occurs when a patient is ready for discharge and is still occupying a bed.

One of the Trust priorities for 2019/20 is to reduce the number of mental health delayed transfers of care against a target threshold of no more than 7.5%. This is achieved through:

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

Figure 12 below demonstrates performance against this priority for 2019/20. During Quarter 3, the mental health inpatient wards managed a few patients with a personality disorder diagnosis waiting to move to specialist placements and this increased their stay on the wards. In addition, some patients staying on Trust older adult mental health wards required discharge to specialist dementia care homes, of which there are only a few that will accept people with challenging behaviours or who are in their 60s. Waiting for these assessments to take place and then for a bed to become available in these care homes resulted in delays to transfer of care.

Figure 12- Monthly Percentage of Mental Health Inpatients Experiencing a Delayed Transfer of Care



Source- Trust Tableau Dashboard

National NHS Community Mental Health Survey 2019

ⓘ The National Community Mental Health Survey is undertaken annually to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of these services is crucial in highlighting good care and in identifying risks to service quality

The Survey sample. People were eligible to receive the survey if they were aged 18+, were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 Sept and 30 Nov 2018. Responses were received from 197 (24%) people meeting these criteria. This is 9% below the Trust's 2018 response rate.

About the Survey and how it is scored. The survey contained several questions organised across 11 sections. Responses to each question and section were converted into scores from 0 to 10 (10 representing the best response). Each score was then benchmarked against 55 other English Providers of NHS Mental Health Services, resulting in a Trust rating of 'better', 'about the same' or 'worse' being given.

Summary of Trust results. The Trust was rated as 'better' than the other mental health service providers in two of the eleven sections:

- Reviewing care (8.2/10)
- Overall views of care and services (7.7/10)

The Trust was rated as 'about the same' as other providers for all the other nine sections.

The Trust achieved the highest score of all English mental health providers for the following questions:

- Reviewing your care: Did you feel that decisions were made together by you and the person you saw during this discussion? (Trust score: 8.4/10)
- Support and wellbeing:
  - In the last 12 months, has someone from NHS mental health services supported you in joining a group or taking part in an activity? (6.1/10)
  - Have NHS mental health services involved a member of your family or someone else close to you, as much as you would like? (7.7/10)
  - Have NHS mental health services given you information about getting support from people with experience of the same mental health needs? (4.6/10)

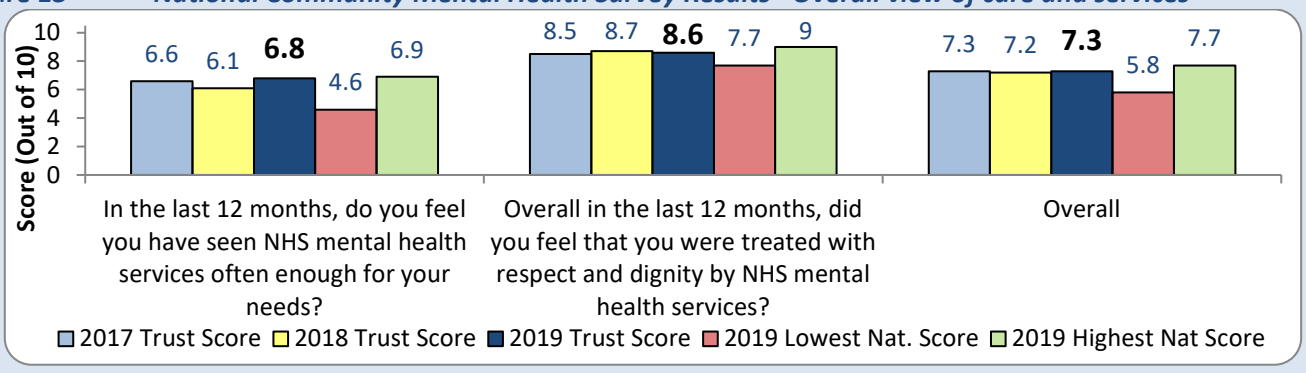
When compared with its 2018 results, the Trust scored the same or better in 2019 in all but four comparable questions:

- Organising care: Have you been told who is in charge of organising your care and services? -0.2 (2019- 7.6/10, 2018- 7.8/10)
- Medicines: Were you as involved as much as you wanted to be in decisions about which medicines you receive? -0.1 (2019- 7.1/10, 2018- 7.2/10)
- NHS Therapies: Were you as involved as much as you wanted to be in deciding what NHS Therapies to use? -0.3 (2019- 6.8/10, 2018- 7.1/10)
- Overall views of care and services: Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services? -0.1 (2019- 8.6/10, 2018 8.7/10)

Respondents' overall view of care and experience

Figure 13 gives an overview of Trust scores for overall experience. The 2019 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved (the red and green bars), and with the Trust score in 2017 and 2018 (the light blue and yellow bars).

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



2.1.2. Patient Safety

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

Our 2019/20 Patient Safety Priorities:

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

1. We will reduce harm to our patients by reducing:
   a. Self-harm incidents by 30%. Target: No more than 42 such incidents each month on mental health inpatient wards (excluding Learning Disability patients)
   b. Suicides of people under Trust mental health care by 10% by 2021
   c. The rate of falls on our community inpatient wards and older people's mental health inpatient wards to no more than 4 falls per 1000 bed days
   d. Medication errors graded moderate and above by 20%. Target: no more than 4 per year
   e. Pressure Ulcers:
      i. No more than 19 Category 2 pressure ulcers due to a lapse in care by Trust staff
      ii. No more than 18 Category 3 and 4 pressure ulcers due to a lapse in care by Trust staff
      iii. At least 180 days between the development of category 3 and 4 pressure ulcers due to a lapse in care by Trust staff
   f. Gram negative bacteraemia due to a lapse in care on our inpatient community wards by 50%. Target: No more than 1 per ward due to lapse in care by Trust staff.
2. At least 95% of our reported incidents will be low or no harm to patients
3. All patient facing teams will have evidence-based objectives for reducing patient harm in their plans for 2019/20
4. All our support services will work with patient facing services to identify ways that they can support safety of patients
5. With our health and social care partners: We will work to achieve reduced urgent admissions and delayed transfers of care. Please note that delayed transfers of care are reported on in the patient experience section above

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

The Trust is signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning, and support staff to help them understand and improve on when things go wrong. Learning occurs across the organisation with respect to errors, incidents, near misses and complaints. The Trust has continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaborative.

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

Reducing Self-Harm Incidents

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

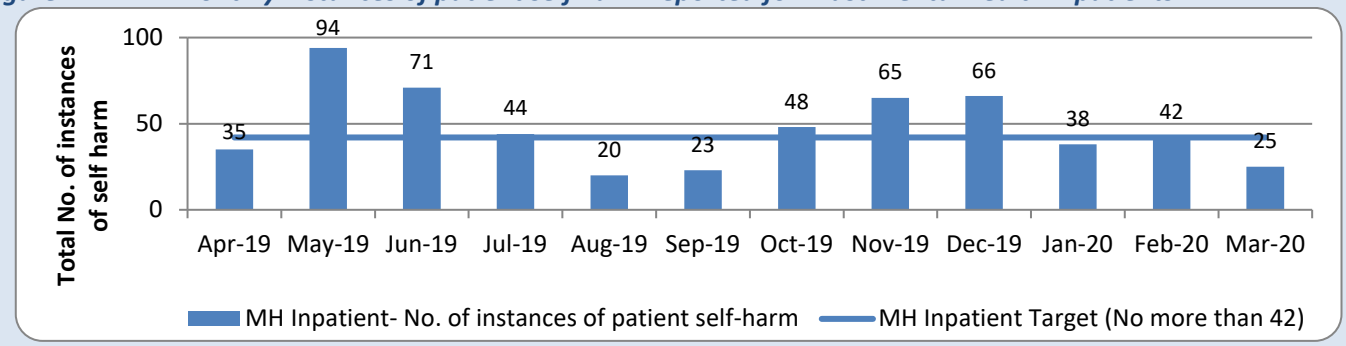
The Trust has set a priority to reduce self-harm incidents reported for patients under Trust care on mental health inpatient wards by 30%. The target is to have <42 such incidents each month on mental health inpatient wards (excluding Learning Disability patients).

A rapid improvement event was held in June 2019 to look at how quality improvement methods can be used to reduce these incidents. This is a complex problem, and the number of incidents may fluctuate depending on the service users presenting at any one time. At the improvement event some countermeasures (actions) were identified to be tested. One of these countermeasures is being used on the two highest contributing areas -Willow House Berkshire Adolescent Unit and Bluebell Ward at Prospect Park Hospital. It concerns the use of the safety plan in collaboration with the service user and displaying this on the observation board so staff can more easily identify things that the person has said can help. None of the self harm incidents reported for Bluebell Ward were as a result of a lapse in care by trust staff.

Willow House is continuing its Quality Improvement work on reducing self harm. It was recognised that there were clusters of incidents happening in the evening, particularly over the period during a shift change. As a result, a 'Sundown Meeting' has been introduced to keep patients engaged and to promote interaction between night staff and patients. A review of the number of bank vs substantive staff in place during that time is also being undertaken.

Figure 14 below shows monthly Trust performance during 2019/20 and shows that the target has been met in the last three months of the financial year.

Figure 14- Monthly instances of patient self harm reported for Trust mental health inpatients



Source- Trust Tableau Dashboard

Suicide Prevention- Zero Suicide

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

The Zero Suicide Project

This project commenced in 2016/17 in response to the Five-Year Forward View to reduce the rate of suicide by 10% by 2020. Every local authority was tasked with developing a multi-agency suicide prevention plan that demonstrated how they will implement interventions targeting high-risk locations and supporting high-risk groups.

In 2019, NHS England produced guidance recommending a specific focus on Mental Health Inpatient Services. The Trust has increased its Mental Health Inpatient focus as a result of this and is paying attention to those areas with higher rates of self harm. Suicide prevention work has continued across all localities and has moved to "Business as Usual' from August 2019.

Suicide Rates

In order to achieve the 10% reduction in the rate of suicide from 2016/17, there must be less than 8.4 suicides per 10,000 people under Trust mental health care by 2020. As can be seen in figure 15, the Trust is achieving this target so far, with a 2018/19 rate of 6.9 suicides per 10,000 people under mental health care. The 2019/20 figure will be available in the latter half of 2020/21.

There were 6,507 suicides registered in the UK in 2018, representing an age-standardised rate of 11.2 deaths per 100,000 population. This rate is significantly higher than that in 2017 and represents the first increase since 2013. The latest suicide statistics for England for the first half of 2019 indicate a rising picture with the reasons for this being complex. Recent changes in coronial law in England and Wales are in part a factor (prior to mid-2018, a higher standard of proof was used by coroners to determine whether a death was caused by suicide), but other factors are also important. Men are still at higher risk and there has been an overall increase in suicides of those aged under 25. Rates have increased, particularly in females aged 10–24 to 3.3 per 100,000, the highest level on record.

Outcomes and measurements against Trust Plan

Priority 1 - Zero Suicides in our Inpatient Units (measured by number of deaths)

- In quarter 3 there were zero inpatient deaths by suicide

Priority 2 - Safety planning will be a collaborative and individualised process and will focus on 4 key areas: means restriction, problem solving and coping skills (including distraction), enhancing social support and identifying emergency contacts

- An audit of risk documentation has been reviewed and moved onto an electronic Tableau dashboard to enable clinicians and managers to view compliance with the standards for safety planning in real time. This dashboard is currently being built and trialled.
- A Bucks, Oxon and Berkshire West Integrated Care System (BOB ICS) Trailblazer Project was presented to Public Health England, receiving positive feedback in this area.
- The Trust is on track to deliver a safety planning App for patients.

Priority 3- Staff will feel the organisation has a learning, not blaming, culture (measured by staff survey)

- The Trust Medical Director and Director of Nursing are leading a programme of work focusing on a "just culture" and restorative practice. The overall aim is to ensure that in our daily practice, our conduct and our dealings with each other is honest, kind and has an emphasis on learning rather than blaming. We are in the process of collecting data to establish a baseline of how staff perceive the organisation in these areas, and this will be utilised to inform the next steps for the programme.
- We are also undertaking a review of our Serious Incident process. This is currently in the planning stages and will be driven using our quality improvement expertise.
- The Head of Psychological Therapy is coordinating a stepped care model of staff support which will be presented to the Trust business and strategy group in February 2020.

Figure 15- Number of suicides per 10,000 people under Berkshire Healthcare Trust Mental Healthcare

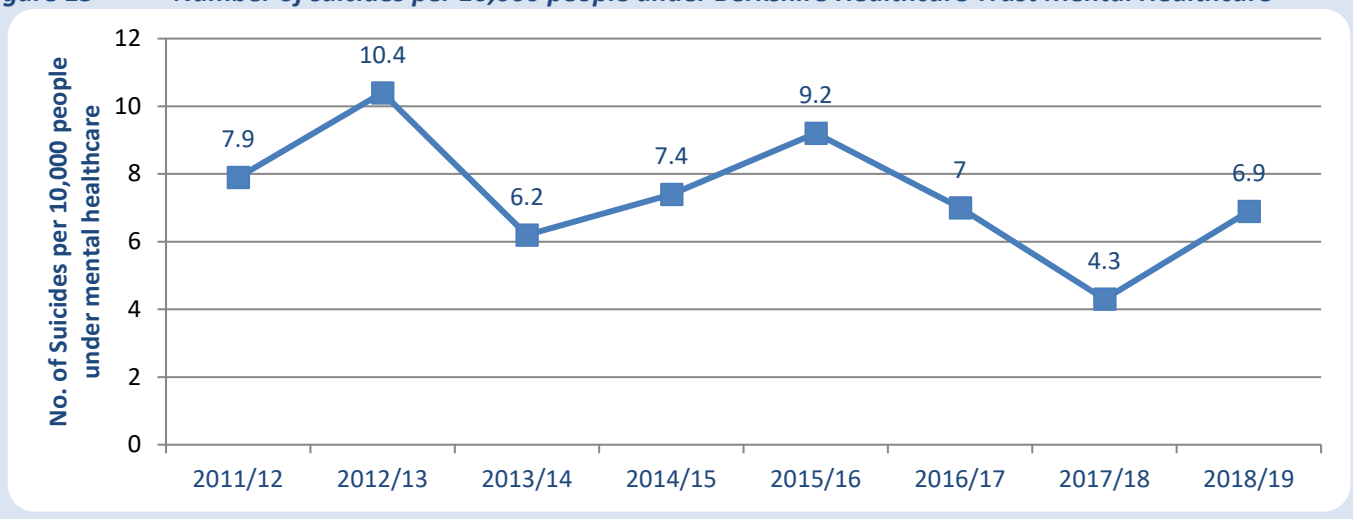
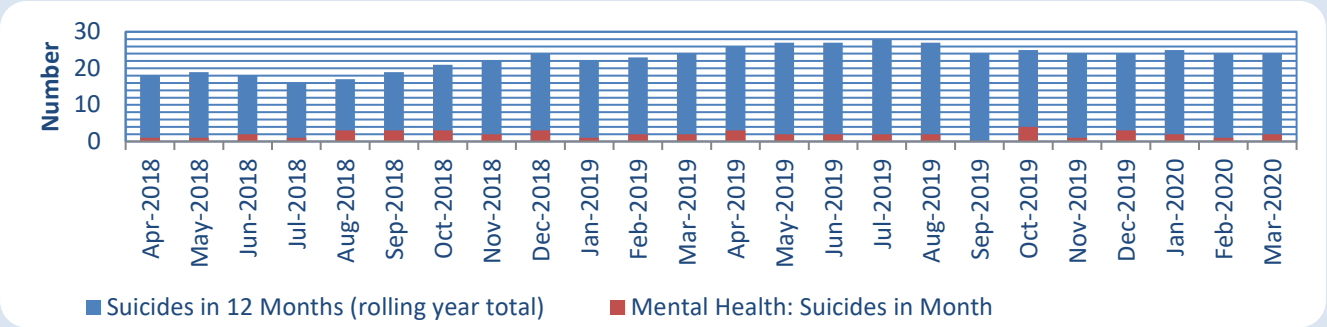


Figure 16- Suicides of patients under Berkshire Healthcare Trust mental healthcare
Number per month and rolling year total per month



Source- Trust Tableau Dashboard

Reducing Falls on Older People's Inpatient Wards

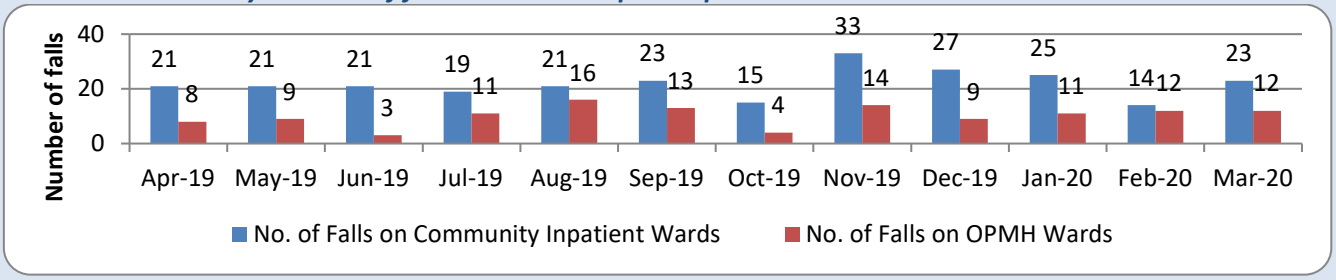
The Trust considers prevention of falls a high priority. The Royal College of Physicians reports that falls are the most commonly reported type of patient safety incident in healthcare. Although most people falling in hospital experience no or low physical harm (such as minor cuts and bruises), others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

The Trust has set a priority to reduce falls on its older people's inpatient wards to no more than 4 falls per 1000 bed days during 2019/20.

Figures 17 and 18 below detail the monthly number of falls on older people's inpatient wards and the rate of falls per 1000 bed days against the target rate. The figures show that the number of falls on both Trust community inpatient wards and Older People's Mental Health (OPMH) wards is above the target threshold of 4 per 1000 bed days during the year.

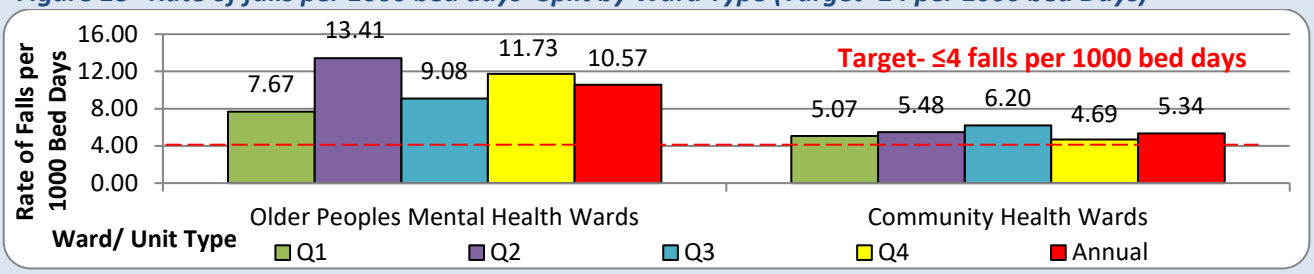
A new falls risk assessment was implemented on the community wards and mental health wards in December 2019 to support staff in identifying risks and putting in place individualised falls risk management plans. The older adult mental health wards and community wards continue to have falls as a driver for improvement. Orchid Ward at Prospect Park Hospital have implemented the Quality Management Improvement System (QMIS) to reduce falls. They identified that most falls were happening in patient bedrooms and at night time. Several measures have been implemented and tested, including a weekly 'staying steady' group for patients, increasing patient observations, use of call bells for high risk patients and a hydration station in the patient lounge area. This has resulted in a 41% reduction in falls from March 2019 – October 2019. Orchid and Rowan wards had 16.96 falls per 1000 bed days average for Q1-3 in 2018/2019 and this year that has reduced to 10.6 per 1000 bed days over the same period.

Figure 17- Monthly Number of falls on Older People's Inpatient Wards



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

Figure 18- Rate of falls per 1000 bed days- Split by Ward Type (Target- ≤4 per 1000 bed Days)



Source for both figures: Trust Tableau Dashboards

Reducing medication errors graded moderate and above

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

The Trust has set a priority to reduce the number of medication errors graded as moderate and above by 20%, with a target that there should be no more than four medication errors graded moderate or above during the year.

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

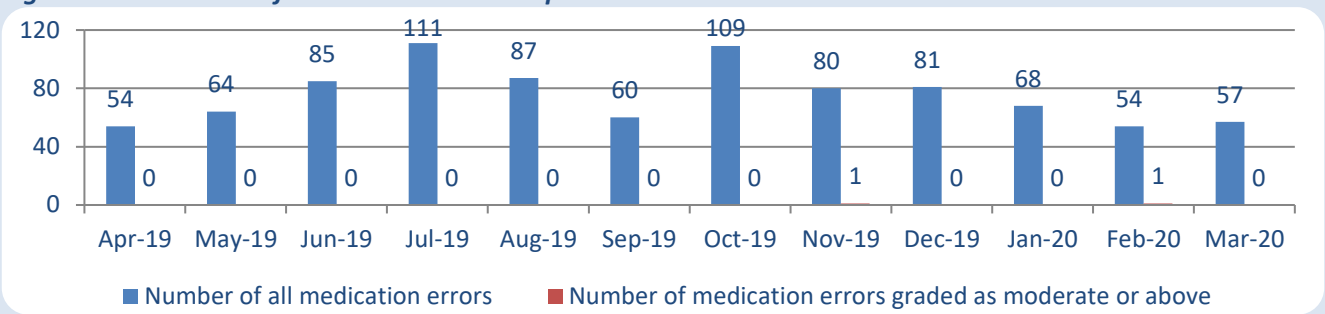
The figure below shows that the Trust target has been met, with two moderate medication incidents reported during the year.

The first moderate incident occurred in November 2019 and resulted in a patient requiring emergency admission following an adverse drug reaction. The patient was not known to have an allergy to the drug prescribed and was unable to answer questions related to this due to a medical condition. This reaction was unlikely to have been avoidable as a result, but learning has been identified and shared during a clinical supervision event. A Trust-wide circular has also been sent out.

The second moderate incident occurred in February 2020 and related to a patient who developed a proven DVT during admission due to not receiving appropriate prophylaxis. Policy and trust-wide training requirements are being reviewed in light of this.

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

Figure 19: Number of Medication Errors Reported Each Month



Source: Medicines Safety Quarterly Report

Preventing Pressure Ulcers

Pressure ulcers, sometimes known as 'bed sores' or 'pressure sores', are damage to the skin and underlying tissues caused by pressure or pressure and friction. They can range in severity from a red patch or blister to a complex open wound. Pressure ulcers are graded from 1 (superficial) to 4 (most severe).

The Trust has set three targets to prevent pressure ulcers in 2019/20:

1. To have no more than 19 grade 2 pressure ulcers due to a lapse in care by Trust staff
2. To have no more than 18 grade 3 or 4 pressure ulcers due to a lapse in care by Trust staff
3. At a service level, starting from 1st April 2019, having at least 180 days between the development of grade 3 and 4 pressure ulcers due to a lapse in care by Trust staff. This includes those that are unstageable or appear to be a Deep Tissue Injury (DTI) but further categorisation has not been achieved.

In pursuance of this target, the Trust has continued to ensure that all clinical staff have had relevant training in pressure ulcer prevention and management. All developed pressure ulcers of category 3 and 4 that are potentially due to a lapse in care by Trust staff are discussed at a learning summit with practitioners and managers to investigate whether there is anything that could have been done differently to help prevent the skin damage or to identify where improvements in the care we provide can be made. Actions are identified and taken forward by the teams and themes are reviewed at a strategic level to ensure training remains relevant and wider improvements can be made. Inpatient units review all developed pressure damage category 2 and above to ensure there are no opportunities for improvement missed.

Figures 20a, b and c below detail progress against these targets. Figures 19a and b show that the targets were met in relation to category 3 and 4 pressure ulcers, but not for category 2 pressure ulcers. This will be raised at the Pressure Ulcer Steering Group with a push for a renewed focus on prevention. Outside the Covid-19 period, we continue to undertake learning summits and action plans for all Category 2 PU's on the inpatient wards. Figure 19c shows that the 180-day target has not been achieved at the end of Q4, although it had been achieved earlier in the year.

Figure 19a- Developed Category 2 Pressure Ulcers due to a Lapse in Care

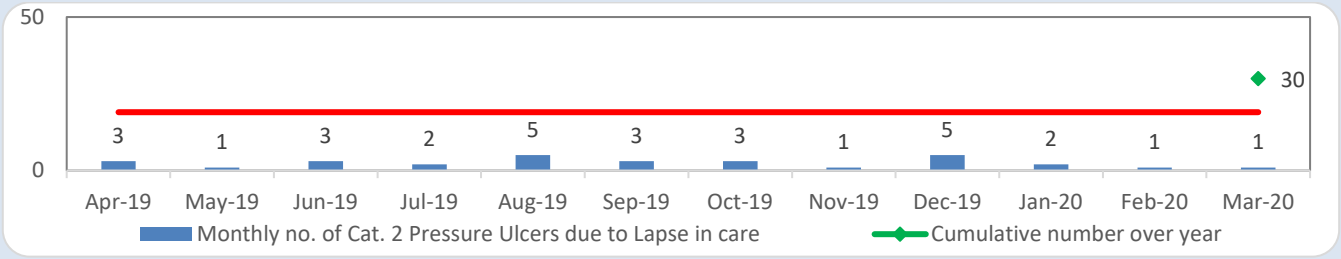


Figure 19b- Developed Category 3 and 4 Pressure Ulcers due to a Lapse in Care

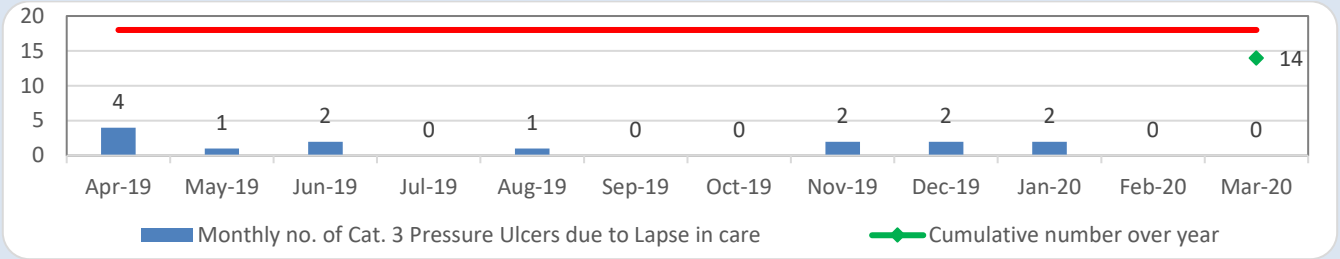


Figure 19c- Number of Days since last category 3 or 4 pressure ulcer due to lapse in care by Trust staff (as at 31st March 2020) target ≥180 days

Berkshire East Community	129 days
Berkshire West Community	84 days
Community Inpatient Units	101 days

Sources: Trust Quarterly Pressure Ulcer Report

Reducing Gram Negative Bacteraemia

ⓘ Gram-negative bacteraemia cause infections including bloodstream infections and pneumonia. There is a national ambition to reduce healthcare associated Gram-negative bloodstream infections by 25% by 2021/2022 and by 50% by 2023/2024.

In pursuance of this target, the Trust has set itself a target of no more than one case of Gram-negative bacteraemia due to lapse in care by Trust staff per inpatient ward. Early identification and management of such cases can also be linked to a reduction in cases of sepsis.

During 2019/20, there were 21 cases of Gram-negative bacteraemia identified with two cases due to a lapse in care on the community inpatient wards. These cases were on different wards. Shared learning from post infection reviews are disseminated within the organisation.

Incidents and Serious incidents (SIs)

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

The Trust aims to maximise reporting of incidents whilst reducing their severity level through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture.

Preventing Harm to patients

For 2019/20, the Trust has set a target that at least 95% of its reported incidents will be of low or no harm to patients. Figure 20 below details the number of patient safety incidents reported by the Trust broken down by severity of harm to patients. Please note that publication of this data by the national team was temporarily ceased from April 2020 due to operational pressures. Therefore, the figures below present data between 1stApril 2019 and 29th February 2020. This will be updated with the March 2020 data when it becomes available nationally. The Trust continues to promote near-miss and no harm reporting.

Please note that the annual number of patient safety incidents reported by the Trust is also detailed in section 2.4 below as it is a core indicator.

Figure 20- Incidents reported by the Trust in 2019/20, by degree of harm

	Incidents Reported in 2019/20									
	Q1		Q2		Q3		1st Jan 20- 29th Feb 20*		1st April 2019- 29th Feb 2020*	
Degree of harm	No	%	No	%	No	%	No	%	No	%
No harm	636	61.7	863	63.7	792	50.3	442	38.8	2,909	53.9
Low	314	30.5	405	29.9	637	40.4	476	41.8	1,933	35.8
Moderate	68	6.6	75	5.5	133	8.4	210	18.4	507	9.4
Severe	2	0.2	1	0.1	0	0	0	0.0	3	0.1
Death	10	1.0	10	0.7	13	0.8	11	1.0	47	0.9
Total	1030	100	1354	100	1575	100	1,139	100	5,398	100.0
Low or no Harm	**950**	**92.2**	**1268**	**93.6**	**1429**	**90.1**	**918**	**80.6**	**4842**	**89.7**

Source: National Reporting and Learning System (NRLS) Monthly Report- England

** Please note that publication of this data by the national team was temporarily ceased from April 2020 due to operational pressures. Therefore, these represent incidents between 1st April 2019 and 29th February 2020..*

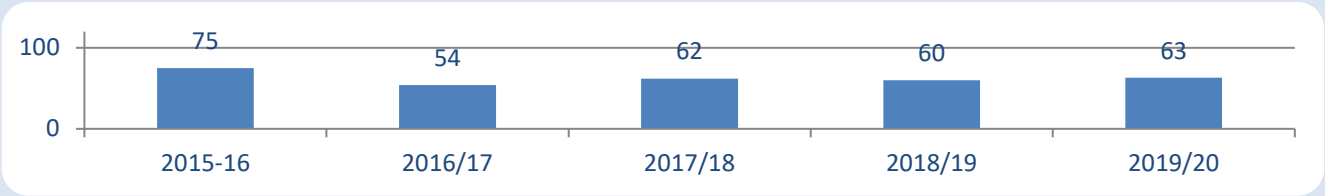
Never Events

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

The Trust has reported 0 never events in 2019/20

Serious Incidents (SIs) Figure 21 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

Figure 21- Number of SIs reported by the Trust- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Serious Incident (SI) reporting

In summary for the year; a total of 63 incidents were reported as serious incidents by the Trust. This compares to 60 for this previous year.

In 2019-2020, 86% of SIs have been reported by mental health services, 12% by community physical health services and 2% by children's services. Of the SIs reported by mental health, 56% were attributable to Mental Health West. Of the SIs reported by physical health, 88% were attributable to Community Health West. Serious incidents for unexpected deaths currently stand at 21 for 2019-2020 compared to 18 for 2018-2019 whilst suspected suicides are 19 for 2019-2020 compared to 22 for 2018-2019. Falls with harm has decreased from 5 in 2018-2019 (excluding downgrades) to 2 this year. The top 3 reporting categories in 2019-2020 were unexpected deaths (n=21), suspected suicides (n=19), pressure ulcers, IG breaches and attempted suicides (n=4). The top 3 reported categories in 2018-2019 were suspected suicides (n=22), unexpected deaths (n=18) and falls (n=5).

Inquest activity: In the year 2019-2020 the Trust provided evidence to 60 inquests which is an increase of 19 inquests from 2018-2019

Preventing Future Death (PFD) reports (Reg 28): The total number of PFDs issued to the Trust in 2019/2020 to 2. PFD evidence is still to be heard following an Article 2 inquest in December 2019

Key themes identified in SI investigation reports together with actions taken to improve services:

A review of the completed reports has identified that there were several investigations that did not identify specific care delivery problems in relation to the incident being investigated but identified broader system improvement opportunities and incidental learning as well as areas of good practice. Key themes identified from a review of good practice includes;

- Working with others – there is some good evidence of joint agency working with other partners as well as a multi-disciplinary approach to patient care.
- There were 2 deaths of patients approved, both of which identified similar recommendations including;
    - Leave process – to review how the leave process is being implemented which will include ensuring a conversation takes place about safety, whereabouts, searching process and the safeguarding considerations
    - Physical health monitoring – the need to continue to embed the work stream in relation to physical health assessments, monitoring and related documentation for patients admitted to a mental health inpatient setting.

Actions are being undertaken to address these main themes.

Embedding patient safety in clinical and support teams

ⓘ Patient safety is a top priority for the Trust, and it is important that this is embedded within its clinical and support teams. This will help minimise the risk of harm to patients and ensure that a safety culture is in place across the whole organisation

The Trust has set two objectives to help ensure that patient safety activity is embedded across both clinical and support teams:

1. All patient facing teams will have evidence-based objectives for reducing patient harm in their plans for 2019/20
2. All Trust support services will work with patient facing services to identify ways that they can support safety of patients.

To date, the following has been achieved in relation to these objectives. Many further examples can be seen in Section 2.1.5 of this report- 'Other Service Improvements'.

A new patient safety incident reporting form was implemented on 1st February 2020. This form is more intuitive and relevant to individual services and will improve the quality of patient safety incident reporting whilst reducing the time taken to complete incident reports. Divisional data will be available at the time of incident submission rather than at the time of incident approval, positively impacting on patient safety monitoring. The impact of the new form is currently being evaluated.

In line with CQC standards, a programme of work is underway looking at the use of restrictive practices. This programme is using quality improvement methodology to see how restrictive interventions can be reduced, and a reducing restrictive practice group has been set up to oversee this. Use of prone restraint is now below the national average. Quality improvement work continues on Sorrell Ward (our inpatient Psychiatric Intensive Care Unit) and we have seen the continued reduction in assaults on staff this quarter. Safety huddles are also becoming embedded on Sorrel, Snowdrop and Bluebell wards at Prospect Park Hospital.

Training now has an emphasis on de-escalation, with iPads being used to record the training, allowing staff to reflect on this. Safety planning work has been refreshed and a new dashboard has been implemented to monitor compliance against core standards in real time for use in supervision. Prevention Management of Violence and Aggression (PMVA) training for staff now includes Safewards, trauma informed care and the Human Rights Act. Videos of service user and staff views of restraint are also shown to give trainees this perspective. Regular monthly restrictive practice meetings are chaired by the Clinical Director. Finally, feedback is gathered from staff and service users to gauge what they understand about restrictive practices.

Reducing Urgent Admissions- Inappropriate Out of Area Acute Mental Health Placements

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

One of the Trust's priorities for 2019/20 is to continue reducing the number of inappropriate out of area placements (OAPs) to below the targets set by NHS Improvement (NHSi) in the Single Oversight Framework (SoF).

To achieve this, the Trust has continued its focused approach on reducing the length of stay for inpatients, reducing occupancy in our acute inpatient wards at Prospect Park Hospital (PPH) and ensuring alternatives to admissions have been fully considered. We have continued to develop a Bed Management team to manage the flow of patients both in and out of the hospital, as well as Community Liaison workers to assist

the community and inpatient teams to expedite discharges.

An escalation process has been instigated which details a clearly defined process for when localities go above their allocated occupancy. We have also commenced work with our teams to look at extended lengths of stay, over 60 days, to assist with any issues that teams are finding difficult to resolve. The Psychiatric Intensive Care Unit (PICU) is also carrying out quality improvement work on the step-down process to facilitate more timely transfers to the acute wards. Overall, the approach to bed management has been changed, gatekeeping functionality has been enhanced and discharge planning improved to support both patient flow and experience.

Achievement against the target is measured with reference to the total number of occupied bed days that patients spend in Out of Area Placements. Figure 22 below demonstrates performance against this priority and shows that the Trust has over-achieved against target in each quarter during 2019/20.

In line with the national demand on Mental Health services, the Trust experienced variation in Inpatient Mental Health bed occupancy leading to the use of Inappropriate Beds in alternative providers. For example, for the majority of October and December 2019 we had zero patients out-of-area and this has been assisted by a clearer escalation procedure. The ongoing programme of work has resulted in a reduction of patients being treated away from home in the last financial year overall, with associated reduced costs. However, whilst numbers are significantly lower, this remains a fluctuating picture and continued focus is required to bring down occupancy to the benchmarked target of 85% and average Length of Stay (LoS) to 31 days, so that there is always available capacity.

Local ownership of this target is now well established. The OAPs indicator has been a challenging process to develop as it involves several complex steps, but significant progress continues to be made.

Figure 22- Quarterly and annual number of Inappropriate Out of Area Placements

	Out of Area Placement Occupied Bed Days in 2019/20								
	Q1		Q2		Q3		Q4		2019/20
	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days
Occupied Bed Days	**288**	542	**412**	464	**177**	386	**149**	308	**1026**
Average Per Month	**96**		**137**		**59**		**50**		**86**

Source: Trust Out of Area Placement Report

Quality Concerns

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

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

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

Shortage of permanent nursing and therapy staff

Mental and physical health inpatient services and West Berkshire community services are now affected by shortages of permanent nursing and therapy staff. This has a potential impact on the quality of patient care and experience and increases our costs. Community nursing services are experiencing significant staff shortages alongside increased demand for care. We have reduced the bed base by ten beds in West Berkshire Community Hospital and have invested in therapy and specialist roles. This will support an additional 3 dedicated neuro beds and provide additional therapy input to improve patient outcomes

so that patients return to their usual place of residence in a timely manner. Prospect Park Hospital continues to have qualified nursing pressures. A recruitment and retention programme is being developed by the Director of People.

Duty of Candour (DOC)

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

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

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

The Trust process for formal Duty of Candour include meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate. The Duty of Candour supports the Trust learning from deaths programme detailed in Section 2.3.6. Figure 23 below details the total number of incidents requiring formal duty of candour during the year.

The Trust considers that the Duty of Candour was met in all cases.

Figure 23- Incidents requiring formal Duty of Candour (DOC)

Month	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20
Incidents with formal DOC	50	43	54	38	16	21	9	28	38	51	33	43

2.1.3. Clinical Effectiveness

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

Our 2019/20 Clinical Effectiveness Priorities are as follows:

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. We will continue to review, report and learn from deaths in line with national guidance. Please note that this priority is detailed in section 2.3 of this report as it is also a required statement of assurance from the Board

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

Implementing National Institute for Health and Care Excellence (NICE) Guidance

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

Post-Traumatic Stress Disorder (PTSD). An assessment of compliance against NICE Clinical Guideline 116- Post Traumatic Stress Disorder (PTSD)- has been completed with input from clinical leads in both Adult Mental Health and Child and Adolescent Mental Health (CAMHS) Services. The assessment included a review of 52 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: recognition of PTSD, assessment and coordination of care, access to care, principles of care, language and culture, management of PTSD, care for people with PTSD and complex needs and disaster planning. The assessment found that the Trust was meeting 46 (88%) of the 52 recommendations.

Areas not meeting recommendations include:

- Waiting time for individual trauma- focused Cognitive Behavioural Therapy is greater than 1 month for children and young people aged under 18 years with a diagnosis of acute stress disorder or clinically important symptoms of PTSD- A substantial piece of work is being undertaken to address some of the underlying causes of this, as well as some specific process work to improve the current management of referrals
- An individual trauma-focused Cognitive Behavioural Therapy (CBT) intervention is not currently offered for children aged 5 to 6 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event- this is being looked at as part of a developing pathway project
- Eye Movement Desensitisation and Reprocessing (EMDR) therapy is not currently available in CAMHS – this is being looked at as part of a developing pathway project mentioned above.

Care and Support of people growing older with Learning Disabilities. An assessment of compliance against NICE Clinical Guideline 96- Care and Support of People Growing Older with Learning Disabilities- has been undertaken with input from the Trust Consultant Nurse for People with Learning Disabilities and the Health Lead for the Community Team for People with Learning Disabilities. The assessment included a review of 50 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: overarching principles, organising and delivering care and support, identifying and assessing care and support needs, planning and reviewing care and support, identifying and managing health needs, end of life care and staff skills and expertise.
The assessment found that the Trust was meeting 53 (96%) of the 55 recommendations.

Areas not meeting recommendations included: identifying a single lead practitioner as a point of contact for people with LD and their family members and ensuring staff in older people's services have expertise to support people growing older with LD. Discussions are ongoing on how to achieve these.

Depression in Children and Young People- Identification and Management. An assessment of compliance against NICE Clinical Guideline NG134- Depression in Children and Young People- Identification and Management- has been undertaken with input from Consultant Clinical Leads in the Child and Adolescent Mental Health Services. The assessment included a review of 102 NICE recommendations that were deemed to be applicable to the Trust, covering the areas of: care of all children and young people with depression, stepped care, detection, risk profiling and referral, recognition, managing mild depression, managing moderate to severe depression and transfer to adult services.
The assessment found that the Trust was meeting 90 (88%) of the 102 recommendations.

Areas not meeting recommendations included:

- Introducing primary mental health workers (or CAMHS link workers) into each secondary school and secondary pupil referral unit as part of Tier 2 provision- this is being looked at in relation to provision of new school's mental health teams in the east and west of the county
- The Trust team do not currently offer all the therapies recommended in the guideline. However, clinicians would like to be able to offer all of these and this is currently being evaluated as part of a clinical pathway project

- There are currently long waits for psychological therapy. To address this, patients that are already on medication are prioritised for psychological therapy, but the recommendation is that the two should be concurrent. This is also being addressed as part of current clinical pathway work
- Patients in remission that are on medication are followed up within the recommended 12 months, but those not on medication will not be. In addition, when a child or young person is in recurrent remission, they are not followed up within the recommended 24 months. Both issues are due to resource and is also being evaluated as part of current clinical pathway work.

NHS Doctors in Training- Rota Gaps and Plans for Improvement

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

The Trust has appointed two Consultant Psychiatrists who are jointly our 'Guardians of Safe Working' and have a duty to advocate for safe working hours for junior doctors and to hold the Board to account for ensuring this. As part of this duty, the Guardians of Safe Working report quarterly to the Board on activity relating to Junior Doctor working hours, including rota gaps.

Figure 24 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust during 2019/20. The gaps on the rota were a combination of Health Education England Thames Valley recruitment shortfalls, as they provide the trainees, and short-term sickness. The Trust continues to cover all rota gaps without the need for agency. Whilst the Trust continues to grow its medical bank to ensure continued coverage. We were only unable to cover one shift in the last quarter and that was short notice at a weekend. At present our system for cover is working as normal, with gaps being quickly filled

Figure 24- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2019 – 31st March 2020

Rota Gaps	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	249	248	134	114	0	2294.5	2280.5	1319	961.5	0

Source- Trust Medical Staffing Team

2.1.4. Supporting our Staff

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

Our 2019/20 Supporting our Staff Priorities are as follows:

1. We will achieve high levels of staff engagement across all our services - scoring four or more (≥8/10) in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
2. We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
3. We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
4. We will achieve our objectives for equality of opportunity and staff wellbeing
5. With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

National NHS Staff Survey 2019

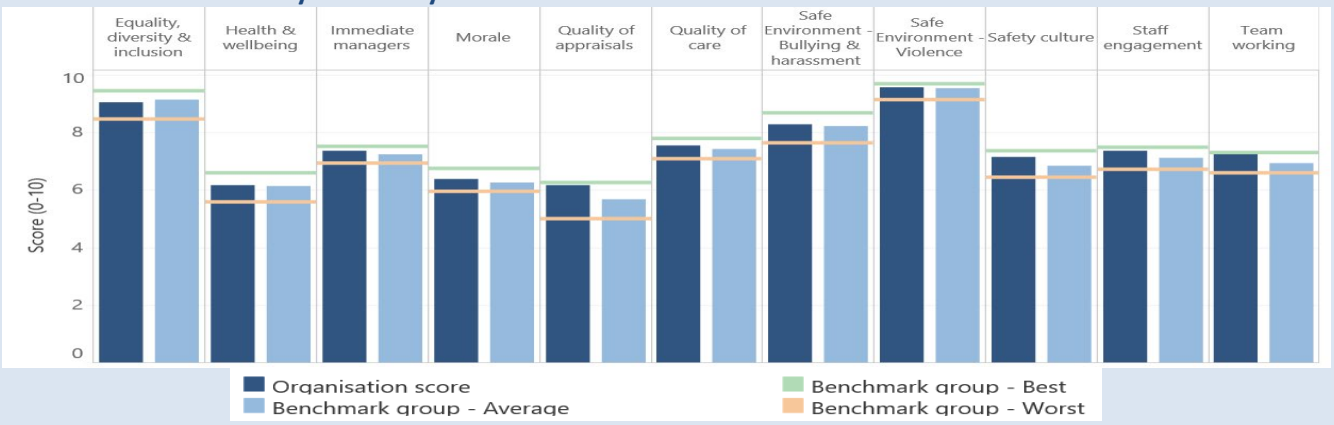
The results from the National NHS Staff Survey are used by the Trust to inform local improvements in staff experience and wellbeing. This is important as a positive staff experience plays an important part not only in staff welfare, but also in helping to maintain and improve on patient safety and experience.

The Trust participated in the 2019 NHS National Staff Survey between September and November 2019.

The Survey Sample.
The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees. Our response rate for the 2019 National Staff Survey increased by 10% to 61% this year. This is our highest response rate ever and is also 10% higher than the average for all other Community and Mental Health Trusts.

Summary of Trust Results.
The figure below details the Trust results by theme.

2019 Trust NHS Staff Survey Results by theme



Source- 2019 NHS Staff Survey- Trust Benchmark Report

Staff engagement
One of the Trust's priorities for 2019/20 is to achieve a score of four or above (≥8/10) for staff engagement. The results of the survey show that the Trust has scored 7.4/10. This is 0.1 higher than our 2018/19 score.

Staff feeling they can make improvements at work
One of the Trust targets for 2019/20 is that at least 70% of staff responding to the staff survey state 'yes' to Question 4d, 'I am able to make improvements happen in my area of work'. The results of the survey show that 65.7% of respondents answered 'yes' to this question. This is a 1.2% improvement on our score last year.

Staff recommending the Trust as a place to receive treatment
One of the Trust targets for 2019/20 is that at least 85% of staff responding to the staff survey state 'yes' to Question 21d of the survey, 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'. The results of the survey show that 74.4% of respondents agreed or strongly agreed to this question. This is a 0.7% improvement on our score last year.

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

Staff survey results relating to the Workforce Race Equality Standard

Indicator and Description	Race	Trust Scores (%) 2016 (%)	2017 (%)	2018 (%)	2019 (%)	2019 Average (median) for combined MH/LD and community Trusts (32 Trusts)
Ind.5- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	22	22	23	22	25
	BME	27	27	31	30	34
Ind.6- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	18	18	20	20	20
	BME	26	21	26	25	25
Ind.7- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	90	89	89	91	87
	BME	68	74	68	76	72
Ind.8- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	5	7	7	6	6
	BME	17	11	17	13	13

Source- 2019 National Staff Survey

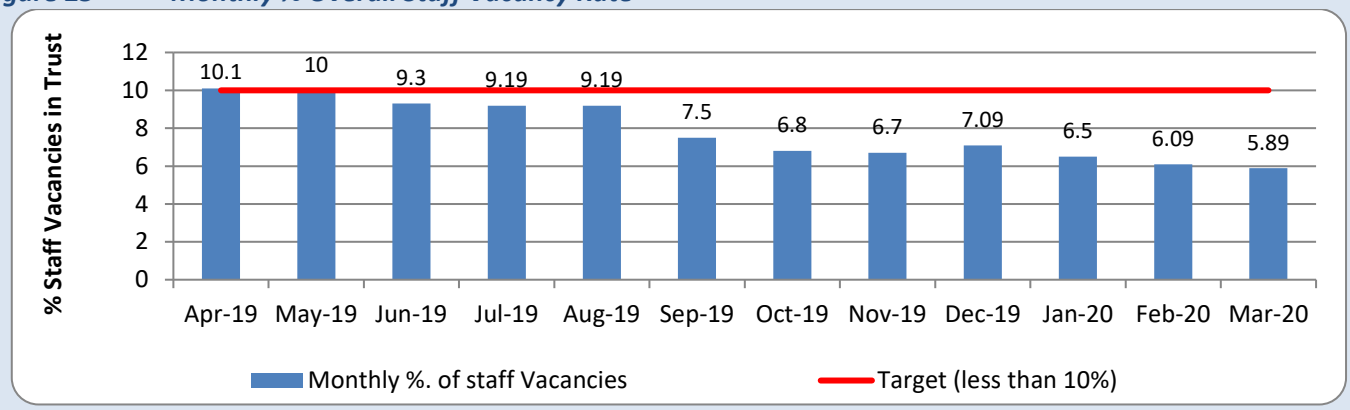
Reducing Staff Vacancies

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

The Trust has set a target in 2019/20 of maintaining its overall staff vacancy rate to below 10% through its recruitment and retention action plan.

Figure 25 below details monthly achievement against this target and shows that the target has been achieved each month since May 2019. This is attributable to our proactive recruitment work, specifically aimed at our hard to fill posts.

Figure 25- Monthly % Overall Staff Vacancy Rate



Source- Trust Tableau Dashboard

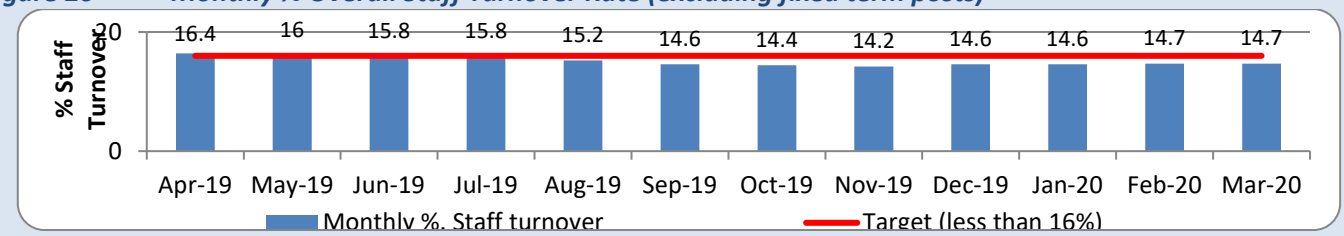
Reducing Staff Turnover

ⓘ It is important that the Trust works to retain skilled and experienced staff in order to deliver high quality care to patients. Where staff turnover is high, it can lead to difficulties in providing continuity of care and the ability to meet patient demand.

The Trust has set a target in 2019/20 of reducing its overall staff turnover rate to below 16%.

Figure 26 below details our monthly achievement against this target (excluding fixed term posts) and shows that the target has been achieved since July 2019.

Figure 26- Monthly % Overall Staff Turnover Rate (excluding fixed term posts)



Source- Trust Tableau Dashboard

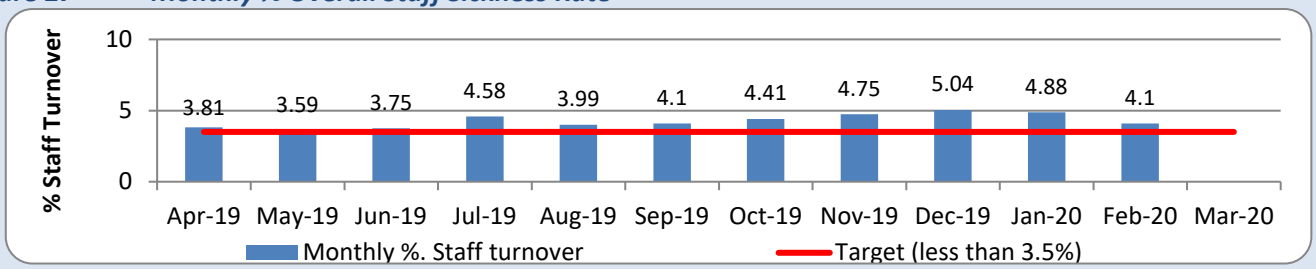
Reducing Staff Sickness

ⓘ The Trust cannot deliver quality and effective care to patients without staff who are well. The Trust has a policy and procedure on sickness absence that ensures sickness absence is managed in a timely, fair consistent and effective way.

The Trust has set a target in 2019/20 of reducing its overall staff sickness rate to below 3.5%

Figure 27 below details monthly achievement against this target and shows that the target has not been achieved to date. The sickness rate in the last quarter is showing a seasonal trend during the winter months which is consistent with previous years. Our sickness absence for anxiety/stress/depression continues to be proportionately high and the work associated with the reduction of this links in with some of our health and wellbeing activity.

Figure 27- Monthly % Overall Staff Sickness Rate



Source- Trust Tableau Dashboard

Zero Tolerance of Aggression, Bullying and Exclusion

ⓘ The Trust is committed to promoting and sustaining a working environment in which all members of staff feel valued and respected. Any kind of bullying, discrimination, harassment or acts of indignity at work are deemed as unacceptable and will be fully investigated in accordance with the Trust's Performance Management and Disciplinary Policy.

The Trust has a zero-tolerance policy for aggression, bullying and exclusion. Members of staff have the right to be treated with dignity and respect and any member of staff that raises a concern because they are subjected to behaviour or treatment that does not promote dignity and respect will be fully supported.

We will promote an inclusive and compassionate culture with zero tolerance of bullying and harassment and will achieve an increase in informal reporting and resolution of difficulties at the earliest opportunity. The number of formal disciplinary and grievance processes will be reduced, with no difference between the experience of BAME and white staff. We will increase the number of allies of people with protected characteristics, provide training and foster a 'just culture' where everyone is supported.

As well as encouraging people to speak up, we will also build our ability to 'listen up'. Further information on 'Freedom to Speak Up' is detailed later in this report.

Reducing Mental Health Patient Physical Assaults on Staff

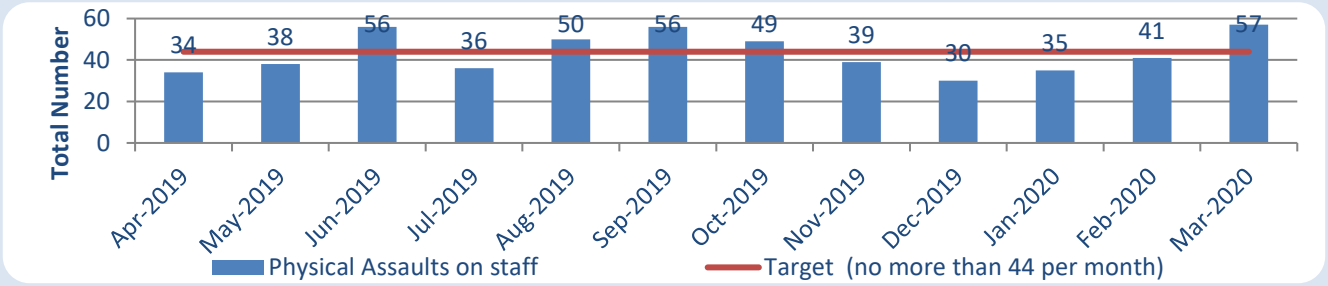
ⓘ The NHS has a 'zero tolerance' attitude towards violence, and NHS staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives.

The Trust has set a target of reducing the number of mental health assaults on staff by 20% in 2019/20. This equates to no more than 44 assaults per month.

Figure 28 below details the number of patient to staff assaults. The figure shows that the target has been met in six of the twelve months.

Sorrel Ward at Prospect Park Hospital continues its work on staff assaults. As occasional spikes in data are expected, the team look at the data over a longer period to decide if there has been improvement or whether further countermeasures need to be considered. They are currently working on introducing Safeward interventions to use, particularly when redirecting patients, as this has been identified as a highest contributor. Information on patient to patient assaults is included in part 3 of this report.

Figure 28- Monthly number of patient to staff assaults



Source- Trust Tableau Dashboard

Achieving Objectives for Equality of Opportunity

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

We know that the most diverse teams and organisations are the most successful ones- where everyone feels welcome and included and is supported to achieve their own potential. We will be demonstrably explicit that we appreciate difference within our Trust.

Equality and inclusion are at the heart of our organisation – both in relation to our patients, service users and carers, and our staff – and we want to do the right thing by them for the right reasons.

The key areas of work have been developed in line with our vision, values and our overall strategy and informed by an analysis of our statutory and regulatory requirements, as well as national guidance.

We want to provide a simple message about equality and inclusion – that it is about respect for everyone, serving our population well, and building a fair and just culture within the organisation.

We will all work together to achieve this. Our BAME, Pride and Purple Staff Networks are a key part of our work - supporting us to achieve our objectives through a united approach that values and supports everyone.

Staff feedback from the 2018 Staff Survey give us an idea of some of the key areas we need to continue to focus on. We also know from our workforce data that we still have work to do to ensure our people represent our communities at all levels in the Trust and that all staff policies (training, flexible working, disciplinary, etc.) are applied equally and fairly across all staff groups.

Staff Wellbeing

ⓘ The Trust needs staff that are healthy, well and at work in order to deliver high quality patient care. Looking after the health and wellbeing of staff directly contributes to the delivery of quality patient care.

The Trust has set an objective to improve staff wellbeing. Our Health, Wellbeing and Staff Engagement Lead started in August 2019 and has established a Health & Wellbeing Corporate Group. This group, comprising senior managers from across the Trust and representatives from our networks and trade unions, has used the NHS Health & Wellbeing Framework to identify areas of focus for the Trust. These areas will be prioritised in Q4 and an action plan will be generated.

As part of our staff wellbeing work, support has been secured from our Quality Improvement team to undertake a green-belt project into reducing our high levels of anxiety/stress/depression related sickness absence. An audit has been conducted to identify the top 10 areas where there is workplace stress related absence. Targeted support will be provided to these areas.

Roles and structure of wellbeing and engagement champions and Mental Health First Aider champions are being (re)scoped with an aim of introducing this by the end of Quarter 1 next year. The champions will keep staff informed about what's happening, support available including signposting where relevant, and promoting healthy lifestyles.

We are focused on improving the communications around the support available for staff. January 2020 saw the launch of our 'RUOK?' campaign which is designed to raise the profile of the importance we place on the good health and well-being, including mental well-being to all our staff. Anyone can be directed to several workplace support options for their mental wellbeing. Other projects include a Health & Wellbeing Calendar with a different theme for each month of the year and the launch of a Staff Health & Wellbeing Teams group.

Participating in Integrated Care System Work Streams to enhance career development opportunities and improve workforce planning

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

Following publication of the NHS Long Term Plan (LTP) Implementation Framework at the end of July 2019, and the draft NHS People Plan, STPs and ICSs were asked to develop system plans responding to the ambitions published within the LTP. A full Buckinghamshire, Oxfordshire and Berkshire West (BOB) LTP submission was made, with a chapter dedicated to workforce:

Deliverable 1 – Recruitment & Resourcing
Deliverable 2 – Productivity
Deliverable 3 – Workforce Planning & Change
Deliverable 4 – Supporting our Staff
Enabled by culture & leadership

Workstream leads will need to be identified within Berkshire Healthcare to work on these deliverables. The Frimley ICS will have similar requirements but have not yet finalised their People Plan.

Freedom to Speak Up

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

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

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

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

How can staff speak up?
Staff are encouraged to raise concerns in several ways:

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

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

The role of the Freedom to Speak Up Guardian
The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement. This is achieved by ensuring that: workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between 1st April 2019 and 31st March 2020, 31 cases were brought to the Trust's Freedom to Speak up Guardian.

2.1.5. Other Service Improvement Highlights in 2019/20

ⓘ In addition to improvements resulting from the priorities detailed above, services have undertaken additional initiatives to improve the quality, safety and experience of care provided to patients. Details of some of these improvements are detailed below in section 2.1.6 to 2.1.11 relating to areas of improvement.

2.1.6. Improvements in Community Physical Health Services for Adults

The Dental Service implemented an initiative to reduce the waiting time from referral to consultation. This has resulted in a reduction in the number of people on the waiting list, with 91% of patients seen for initial consultation within 12 weeks. The service has also employed a part-time administration assistant to remind patients of their appointments, which has resulted in a reduction of their 'Did Not Attend' (DNA) rate.

The Community Dietetic Service has produced five patient videos on nutritional support and Home Enteral Nutrition (HEN). These videos have the potential to prevent hospital admissions and reduce the length of stay in hospital. The videos can be sent to patients before an appointment allowing them to start making changes at that point. This also allows the dietitian to focus on more complex areas at the patient's first appointment, potentially reducing the total number of appointments required. A Specialist Home Enteral Nutrition (HEN) Dietician has worked with the Motor Neurone Disease Multidisciplinary Team to enable early identification of patients suitable for enteral nutrition, leading to a planned and holistic approach to their tube placement. Three new Dietetic Assistant Practitioner roles have been developed to support prevention of malnutrition in nursing homes. An enhanced service is being offered for patients with Irritable Bowel Syndrome (IBS) living in the east of the county. This has resulted in quicker and easier access to information, with the potential of reducing the number of patient appointments. Finally, the service now offers a group intervention to help patients put their Type 2 diabetes into remission.

The Acute Dietetic Team have used Quality Management Improvement System (QMIS) methodology to improve their general adult clinic utilization by over 65% in both the Brants Bridge and Townlands sites. The team hopes to roll this out to more adult and paediatric dietetic led clinics.

The Integrated Hub now receive all routine referrals into a hub e-mail account using a specific referral form. This allows routine referrals to be pre-sifted, and phone lines to be available for urgent calls.

The Adult Speech and Language Therapy Service have undertaken a Rapid Improvement Event to reduce waiting times for patients with communication and swallowing difficulties. The wait time for these patients was 9 months before this project started. Several changes have been made as a result. For example, referrals are now made via the Health Hub, triaged by Speech and Language Therapy within two working days and identified as Swallowing/Dysphagia or Communication problem. This has resulted in a significant improvement in wait time, with all dysphagia referrals now offered an appointment within 3-4 working weeks, those with communication problems offered an appointment within 4-6 weeks and those requiring communication groups offered therapy in a group setting within 6-12 weeks.

The Podiatry Service have participated in a pilot project to understand the capacity and demands on the service. The focus of the project has been on providing a consistent and effective service to long term caseload patients.

The Hi Tec Care Team, have developed Peripherally Inserted Central Catheter (PICC) clinics in each of their localities, with the support of the Assessment and Rehabilitation Centre and Community Nursing.

The Continence Advisory Service have utilised a service rebate to develop the continence service for children, and to promote continence in this group. The service has purely provided products for management of incontinence in the past and is aware that these children can become lifelong users of the service. By investing in a range of staff, the service can support families with children who have disabilities, to reach greater potential by becoming toilet trained, resulting in improved outcomes for children and decreased expenditure on products

The Berkshire West Community Diabetes Service has expanded and developed their nurse led community clinics to support people with Type 1 Diabetes. These clinics are run three times a week in community venues across Berkshire West and bring specialist care, services and technologies to patients closer to home. The success of these clinics has contributed to Berkshire West having some of the best outcomes for people with Type 1 diabetes. The service is also involved in the redesign of the Type 1 diabetes pathway across Berkshire West which will see further change and expansion to current clinic provision. For the fifth year running, the service was a winner at the national XPERT awards for their delivery of Type 2 diabetes education and improving patient outcomes.

The East Berkshire Diabetes Service is improving their insulin pump service by training more Diabetes Specialist Nurses in pump therapy, running pump clinics and improving the insulin pump process and documentation. The team is also providing 'FreeStyle Libre' education sessions which enable eligible patients to access flash glucose monitoring. The service has seen a greater use of technology overall, with more people utilising continuous glucose monitoring systems to manage their diabetes.

The East Berkshire Musculoskeletal (MSK) Physiotherapy Service have introduced a new MSK triage service across the whole of East Berkshire. All referrals to Orthopaedics are triaged to ensure primary care options have been fulfilled, with 25% of them sent back to primary care. This reduces unnecessary first outpatient appointments and subsequent interventions. Analysis shows this has resulted in reductions of 20% on outpatient spend in Bracknell, 10% in Windsor and Maidenhead and 10% in acute spend for Hip/Knee surgery. The service has also developed several staff as First Contact Practitioners in GP surgeries. These practitioners see patients that would otherwise have to be seen by a GP. This has resulted in a positive patient response, as well as helping the GP workforce. As musculoskeletal pain and symptoms have a large psychological impact on patients, the service now works with the Mental Health team to deliver a Persistent Pain Programme. The service has introduced a paid 'open gym' for patients that have finished with rehabilitation classes, allowing them to keep up the momentum of exercising by using our gym equipment for a nominal fee. A new developmental post has also been introduced to facilitate staff moving from a Band 5 to a higher Band 6 position. A Band 4 rehabilitation post has also been introduced.

The Berkshire West Musculoskeletal (MSK) Physiotherapy Service currently runs 6 different joint/ condition specific classes in order to maximise a patient's recovery and return them to previous fitness levels. A pilot shoulder rehabilitation class was introduced in August 2019 with positive patient feedback and a significant positive improvement in patient specific functional goals. A full audit of this data will be undertaken in April 2020.

The Berkshire West Musculoskeletal Oncology Physiotherapy Team has given patients the opportunity to improve on their general fitness, exercise tolerance and gain confidence to manage their holistic wellbeing and health in relation to their condition after receiving medical oncology treatment. A 12-week programme called "Aiming High" was launched which focuses on upper limb strengthening in conjunction with cardiovascular exercise. This has received very positive feedback to date.

Rehabilitation Services in Berkshire West. All Berkshire West adult community physical health services that are under the banner of rehabilitation, are now managed collectively. These services include the community inpatient beds, intermediate care services

providing rehabilitation in a patient's own home, and a range of neuro-rehabilitation services which include both bed-based and home-based services. This has strengthened their links and helped them put the patient at the centre of their care. An inpatient governance role has been introduced to the service to support the ward teams in reviewing and auditing their work, leading to improved practice and sharing of learning across the wards. The service is also working with their health and social care partners to develop a post-stroke pathway to optimise resources and avoid duplication. Community Neurology services have always been well received by our patients but have experienced increased waiting lists due to increasing demand. In response, the service has undertaken some rapid improvement work, using quality improvement methodology that has led to an agreed plan for investment in community-based neuro rehabilitation. Additional staff have been successfully recruited, which will result in a reduction in the wait time for these patients. The community falls pathway has also been reviewed to ensure it is fit for purpose and consistent for all patients that are referred for a falls assessment. The inpatient wards have also embraced new technology to help reduce the incidence of falls in their areas.

The Berkshire West health and social care system has recognised the historical variation in the delivery of intermediate care rehabilitation/reablement pathways across the three West localities. In response, the Trust has led a system-wide review of this pathway, with its health and social care partners, to identify a consistent offer for patients regardless of where their home is situated. A range of resources have been produced to support this work and the new pathway should be fully in place by the end of 2019/2020. Work has also been undertaken to improve the flow of patients into services, to ensure that patients receive timely care and that acute partners can free up their beds for those acutely unwell patients who need their care. Home and community rehabilitation services and the acute Trust hold regular operational calls to secure the right service for each patient in a timely manner.

Reading Community Nursing Team have undertaken a quality improvement project to reduce the number of missed patient visits in their service. The project team found that staff had to stay late on 90% of days to complete their workload. This was delaying patient care and impacting on staff morale. Quality Management Improvement System (QMIS) A3 principles were followed, with several countermeasures implemented and tested that had a positive impact on patient care, reducing the average number of missed patient visits from nine before the project to six between August and December 2019.

The East Berkshire Community Nursing Team have reviewed their service and developed some core new roles to enhance care and support staff. Clinical Leads have been introduced to provide clinical expertise, support new staff in developing competencies, undertake joint complex visits and carry out formal six-monthly caseload reviews**.** The majority of Band 6 district nurses / sisters have undergone additional training to obtain a Specialist Practitioner Qualification. More Band 3 staff are undertaking Nursing Associate Training and Apprentice Degree training, leading to a more skilled workforce. Two new dedicated Wound Care nurses have been recruited to provide local training, support and assessment of complex wounds. Three new Continence Health Care Assistants have been introduced, resulting in quicker assessment of patients and more robust processes to ensure patients are receiving continence pads. 3.6 whole time equivalent new phlebotomy roles have also been introduced to undertake venepuncture for patients. A care home staff nurse position has been piloted in Bracknell to work with specific care homes on dedicated days to support their patients. This has resulted in a reduction in travel and a more efficient way of working. A new clinical governance role has been introduced to help review incidents across the team and share the learning. Finally, use of iPads has allowed staff to access and update patient information more easily.

Most staff in the East Berkshire Heart Function Team are now non-medical Prescribers, allowing them to

titrate medications immediately in clinic or within the home setting.

The East Berkshire Assessment and Rehabilitation Centre (ARC) team are a supportive discharge and In-reach service facilitating safe and faster admissions to services across integrated care**.** Weekly Consultant lead MDTs are in place across the community clinics**,** with catheter and PICC line clinics now supported across the community clinics. Frailty scores are now completed on each assessment and Community Matrons are working well in each locality. Nursing staff also facilitate educational updates for social care colleagues, with positive feedback received.

The East Berkshire Lower Limb Service is now a fully commissioned service offering patients expert and timely lower limb management in either a clinic or GP practice setting. Healing rates are well above the service target of 70% of patients with non-complex lower limb wounds healed within 12 weeks (the healing rate achieved by the service was 89% in October 2019). The service follows up all patients with healed leg ulcers every six months to reduce the risk of recurrence.

Henry Tudor Ward at St Marks Hospital- Maidenhead and Jubilee Ward at Upton Hospital- Slough are community inpatient wards in East Berkshire. They have introduced twice weekly consultant ward rounds with daily medical and Advanced Nurse Practitioner cover. Their weekly Multi-Disciplinary Team (MDT) meetings now have additional Community Nursing, Matron and Local Authority input. Two new clinical admission pathways have been introduced to support patient flow and the average length of stay on these wards is under 21 days- below the national target.

The East Berkshire Specialist Wheelchair Service has relocated to a more suitable premises at Abell Gardens in Maidenhead. This has provided an improved working environment, with better patient experience also reported due to the improved wheelchair access to the waiting area, larger clinic rooms and changing facilities. All powerchairs and tilt-in-space manual wheelchairs have been reviewed, with all those over 5 years old being replaced. A quarterly Patient Focus Group has also started.

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

The WestCall GP Out-Of-Hours Service

The process of managing the results of pathology tests (such as blood, urine, swabs, cultures) ordered by the service clinicians has been considerably refined this year and was noted as an area of excellent practice at the time of the CQC inspection. All results are seen by a doctor on the evening they are published, and patients are contacted by the WestCall doctor without delay if it is necessary to change any aspect of their treatment. Any actions taken are also entered into the Adastra patient record system and notified to the GP by resending the modified clinical details. This is a first-class service and it was noted that there are no other known examples of Out-of-Hours services in the country undertaking these important tests for their patients. An audit was also carried out on pathology results which found that of the 5,000 tests carried out in the year, significantly abnormal results were found in about 1,200 cases, thus emphasising the clinical importance of this work.

WestCall carry out a monthly audit of Advanced Care Plans entered by GPs onto the Adastra patient record system, for patients who have subsequently passed away. Results are reported back to the GP practices and Clinical Commissioning Groups (CCGs) as a measure of the quality of the information provided. Since this project began, the quality of the plans has improved so that 65% are now good compared with 40% in January 2019. This means that the information given to Out of Hours doctors and nurses looking after End of Life patients is better than before and their clinical management has improved.

An audit of antibiotic use in the management of urinary tract infections in out-of-hours patients found that the service was working effectively in this area but that specific improvements could be made. Efforts to achieve this will be measured by repeating the audit the following October.

Recording of learning points discussed at WestCall clinical meetings have received increased emphasis

and are clearly listed and sent out with the minutes of each meeting to all the WestCall doctors and clinicians. This was commented upon favourably by CQC.

A monthly publication containing a Medical Bulletin and Clinical Governance Newsletter are now produced by senior clinical staff in the WestCall office.

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

Participation in Special Educational Needs and Disability (SEND) Inspections. The CYPF division have participated in both the Wokingham area SEND inspection and the Royal Borough of Windsor and Maidenhead SEND reinspection. These inspections also involved the Care Quality Commission (CQC) and the Office for Standards in Education, Children's Services and Skills (Ofsted). Findings were broadly positive for the Trust, although concerns were raised about waiting times in specific areas such as autism assessment, the Attention Deficit Hyperactivity Disorder (ADHD) service and Occupational Therapy.

A West Berkshire Wellbeing Information Sharing Pop-Up event was attended by Trust staff in October 2019, who manned promotional stands to offer advice, written information and awareness on Childhood Immunisations, Health Visiting and Speech and Language services.

Over 400 members of staff attended three CYPF Division away days in June and July 2019. An ex-service-user, who had also been part of a young person's Child and Adolescent Mental Health Service (CAMHS) participation group, delivered an inspirational and thought-provoking talk to staff at each of these events, describing their early difficulties, experiences with professionals and services and their Autistic Spectrum Disorder (ASD) diagnosis. This helped staff reflect on the way they interact with service-users and deliver the service.

Identity and Transition. CYPF services are working with an increasing number of young people who are questioning their identity or have made the decision to transition. An introduction to trans awareness session was introduced to help staff better support these young people, explain to staff how transgender people experience the world and advise on the terminology that trans people prefer.

The school-aged immunisation service has once again exceeded expectations in their delivery of the annual childhood flu programme. As in prior years, this year saw an additional year group added to the programme, resulting in all children in primary school years (Reception to Year 6) being included in the programme. Since the beginning of October 2019, the service has vaccinated approximately 55,000 school aged children in 11 weeks at over 300 school and clinic settings. Some communities remain reluctant to vaccination, and the service has adapted and found that by offering an alternative to delivery in schools, many parents are willing to bring children to a clinic. Overall the service expects to once again exceed the national target of immunising 65% of the cohort.

A new Health Inequalities Nurse position has been developed to engage with, educate and empower families regarding immunisations. This nurse can administer immunisations for those aged 5-19 years that are hard to reach and/or vulnerable and struggle to access their GP surgery. The Nurse also focuses on empowering and educating the families of children aged under 5 about immunisations.

Health Visiting and School Nursing

Delivery of the Ages and Stages Questionnaire (ASQ) has been reviewed following feedback that it was extremely reliant on parents' perception of their child's development, with limited opportunity for professional input. A group format has been implemented that gives an opportunity for children and their parents to play together with age appropriate toys in a facilitated group, as well as an opportunity for a one-to-one conversation with a health practitioner. Parents experiencing both formats, expressed that they found the new format a better and more interactive experience.

Monthly Saturday appointments are being offered in Reading to support working parents.

A targeted massage group for mothers identified with low mood has been set up in Reading, in response to evidence supporting the benefits of baby massage for this group of mothers. Eligibility for this group is based on several risk factors around perinatal mental health which are assessed by Health Visitors. The Group is

facilitated by Community Nursery Nurses and Community Staff Nurses, with positive client feedback received so far.

Baby Friendly Initiative (BFI) accreditation. The Health Visiting Service continues to audit both staff knowledge and mothers' experiences on a regular basis as part of BFI accreditation. The service scored over the 80% pass mark for all BFI Standards in 2019, with results showing that staff knowledge around the importance of breastfeeding, helping to build a close and loving relationship and safe formula feeding is high. The service plans to re-accredit again in October 2020, with a view to achieving the next level of Gold accreditation 6 months after this date.

A peer to peer record keeping audit took place in July 2019 on the health visiting and school nursing RiO records. In total 403 records (284 health visiting 119 school nursing) from 89 staff (63 health visitors, 26 school nursing team members) were audited. The audit gave positive reassurance that records were of good quality. Some issues were identified and record keeping templates have been designed to ensure consistency in the way records are written up and to save time. Training and reminders regarding the expected high standard of record keeping have been given to all staff.

Health Visitor service user feedback has grown considerably, with significant increases in Friends and Family Test card submissions as well as an increase in the use of a new online App. Feedback from service users has supported change, including development of a specialist group for children with additional medical needs.

The Children and Young People's Integrated Therapy (CYPIT) Speech and Language Therapy Early Years team in Newbury are trialling some evening parent workshops. The aim is to provide parents and carers of children under five years of age with information about the importance of speech, language and communication skills, how to support their child's development and where to get further support and information if needed. The team have run five workshops so far with a total of 55 parents and carers attending. Each session has been interactive and verbal and written feedback from those who have attended has been overwhelmingly positive.

The Team Lead for the Specialist Dietetic Service won an award for Professional Lead for the year following a recommendation from a parent

Child and Adolescent Mental Health Services (CAMHS)

Psychological Perspectives in Education and Primary Care (PPEPCare) training has been delivered by CAMHS to professionals working with children and young people and their families/ carers. This training is designed to help staff in primary care and education to recognise and understand mental health difficulties and offer appropriate support and guidance using psychoeducation and evidence based psychological techniques and resources. Verbal and written feedback consistently shows a significant increase in peoples understanding of mental health issues, confidence in talking with young people and skill in applying the ideas to everyday interactions.

Supporting Children in Care. CAMHS are involved in a two-year national pilot project which aims to understand how to improve mental health and emotional wellbeing assessments for children and young people who are entering the care system. West Berkshire Council, in partnership with NHS Berkshire Clinical Commissioning Group (CCG), were successful in becoming one of nine national sites to pilot the development of a new assessment framework for these young people.

The Children and Young People in Care Teams have continued to work with the six children's services providers in Berkshire to improve the timeliness of initial health assessments. The work with Slough Children's Services Trust has produced a significant improvement in the timeliness of initial health assessments for children placed within a 20-mile radius of Berkshire.

CAMHS service user participation groups are being held on a monthly basis allowing young people and their families to give feedback on their experience of the CAMHS service, highlight their priorities, carry out actions to achieve the priorities and to give their views on various developments.

Neurodiversity

Online autism assessments are being offered by the Autism Assessment Team following a successful proof of concept pilot. These will be offered to families where it is appropriate to do so, with appointments

conducted from the family's own home. They can also be booked in the evening and at weekends.

Parent/carer workshops to support children with anxiety and autism and/or ADHD have been successfully piloted. Positive feedback has been received from parents attending the pilot workshops, with plans to run more sessions in the coming year.

A pioneering pilot of three trainee Children's Wellbeing Practitioners (CWP) has been successful across the autism and ADHD teams. These practitioners provide brief evidence-based interventions for children and young people with anxiety, low mood and emotional regulation difficulties. This has provided valuable support for children, young people and families while their child has been waiting for assessment or following a diagnosis. Placements will be offered again this year.

24/7 online support to families of children with an autism diagnosis or who are waiting for an autism assessment continues to be offered through the Trust's online 'SHaRON Jupiter' platform. The moderating team have increased in number this year with representatives from The Autism Group and Trust colleagues in the CAMHS Anxiety and Depression Team. The team aim to add peer moderators this year and are supporting colleagues in the Anxiety and Depression Team as they go live with their own SHaRON platform.

Training on adapting therapeutic interventions for autistic children, young people, adults and their families has been provided to Trust staff in CAMHS and adult mental health services, with positive feedback. Three linked CAMHS clinical effectiveness seminars on autism are also planned and two more members of the team have been trained to deliver autism training as part of Psychological Perspectives in Education and Primary Care (PPEPCare).

Digital Appointment Correspondence has been introduced resulting in families now having online access to their appointment information.

2.1.9. Improvements in Services for Adults with Learning Disabilities (LD)

Inpatient Services for People with Learning Disabilities

The Campion Unit at Prospect Park Hospital in Reading has continued to work on the Trust breakthrough objective to reduce patient assaults on staff. The team has been working together with the Intensive Support Team to increase the confidence of staff members, increase their competence in alternative communication skills and the development of individual Positive Behaviour Support Plans. These, together with other local measures, have resulted in a significant decrease in the frequency of assaults. The support provided to staff following an incident has also been improved and is now more consistently offered since adopting quality improvement methodologies supported by the Trust Quality Improvement Team**.**

Community Teams for People with Learning Disabilities (CTPLD)

Three GP education events were held in the east of the county. The topics presented included annual health checks for people with LD, dementia, challenging situations and Deprivation of Liberty Standards/Mental Capacity Act. The Clinical Commissioning Groups (CCGs) also presented on the LD mortality work that is being undertaken. People with LD and parents also attended the event to share their powerful health stories.

An LD screening tool has been implemented in Slough CTPLD. The aim of this tool is to help ascertain whether a new person being referred to the team was likely to have a Learning Disability and therefore be eligible for Trust LD services. Training has been given to staff in this area and changes made following feedback from staff. This is now being reviewed to consider the learning and potential for wider use.

A Health Checklist has been developed for out of county teams who are planning to move people with an LD from outside the county into the Berkshire area. This tool helps to facilitate the move and aids discussion of any concerns or additional help the person may require. It also ensures that all necessary risk assessments/legal reports go with the person.

Sepsis and Constipation Educational Group Work was undertaken for people with LD and paid carers. The signs and symptoms of each were highlighted and handouts on this area disseminated together with easy read information.

Compassionate Peer Support Groups have been set up as part of the Trust's compassionate leadership charter. This initiative also supports the Trust's 'Supporting our Staff' True North Goal and will be a space where staff can be mindful about issues happening at work and ways to maintain a healthy work life balance. The aim is to introduce the practice of self-soothing techniques, such as Mindfulness into the workplace setting. The session seeks to explore the emotions felt by team members during the previous week. People are given an opportunity to explore their feelings. This has resulted in discussion about bereavement and loss as well as more practical outcomes such as organising a presentation on how to chair a meeting.

A Transition initiative is planned in Bracknell with Child and Adolescent Mental Health Services (CAMHS) and other stakeholders. As part of this plan, a health member of the CTPLD will aim to attend the person's last review at 17 ½ years to ensure all health-related documents and reports are in place and to ensure there is a sufficient handover/transfer of care. In addition, Slough CTPLD plan to develop a health transition checklist.

The Provision of Therapy for Vulnerable Adult or Intimidated Adult Witnesses Prior to a Criminal Trial (2001) documentation was summarised to help therapists decide when and when not to offer therapy to vulnerable witnesses. The Practice Guidelines for the Learning Disability Service have been circulated to therapists within and outside of the Trust LD Service.

General Data Protection Regulations (GDPR) information has been developed into an easier to read format for people with Learning Disabilities.

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

Improving Access to Psychological Therapies (IAPT)- Talking Therapies

Video Consultations are now being offered by the IAPT Talking Therapies Service allowing clients access to treatment from their home or workplace. These consultations have: improved client experience, helped the service retain experienced staff, reduced the cost of accommodation, enabled the team to work more efficiently, enabled waitlist support across Berkshire and supported the wellbeing of the IAPT clinicians. There is a plan to continually increase the number of video sessions offered each month.

Using Virtual Reality (VR) in treating height phobias. For some mental health disorders (e.g. specific phobias) the use of virtual reality can be used to improve patient outcomes as it allows them to complete exposure work within their treatment session with the therapist, rather than undertaking this on their own. It also allows patients to face feared situations which they might otherwise find difficult to come across. The team have begun the roll-out and evaluation of VR for height phobias in conjunction with Oxford VR (an Oxford University spin-off company) and building upon the research of Professor Daniel Freeman. 40 patients have been successfully treated so far with positive feedback received. The team is looking forward to potential new VR applications in the future.

The Employment Advice Service has been funded to extend its provision of advice to clients receiving treatment in Talking Therapies. 459 referrals have been received between 1st March and 30th November 2019, with excellent feedback received from both clients and therapists.

Digital Innovations. As part of the Global Digital Exemplar (GDE) programme the service has developed programmes with Silver Cloud around long- term conditions and sleep. The team has increased the number of people with access to these programmes which now have a >70% recovery rate -an improvement of 10%. A resilience programme has also been introduced which also has a >70% recovery rate. The team were shortlisted for a Health Service Journal (HSJ) award in the 'Mental Health, Working Together' category for their digital work. The service is implementing a digital patient pathway and have also established an instant access to treatment pathway where a patient can use a link (URL) to sign up to Talking Therapies and get immediate access to Silver Cloud and the service.

A new website for IAPT Talking Therapies has been created as part of the Global Digital Exemplar (GDE) Programme. This will make information and referral forms easily accessible to their clients. 'Browsealoud' software will also be added to allow clients to translate

the website content into a variety of different languages. For those with sight impairment, the software can also read aloud the website content.

Adult Mental Health Services

Slough Community Mental Health Team (CMHT) has worked with Slough Borough Council to produce an award-winning initiative entitled 'Enabling Town Slough: Slough Mental Health Services'. This initiative, which includes projects to explore and reduce isolation, and promote inclusion across Slough, was shortlisted in two categories for National Awards in Positive Practice in Mental Health, winning the award in the 'Addressing Inequalities in Mental Health Through Coproduction and Inclusion' category, and receiving a commendation for positive practice in the 'Primary and Secondary Mental Health Services' category. 'Enabling Town Slough' will also feature in the National All Age Crisis Care Pathways Report which places it on a national map of positive examples of coproduction and asset-based mental health services.

Bracknell Community Mental Health Team (CMHT) have started a Quality Management Improvement System (QMIS) project to reduce the number of re-referrals to their service. 33.8% of total referrals into the service between March 2018 and February 2019 were re-referrals of patients within 6 months of discharge. The team utilised the A3 tool to explore this problem and test some countermeasures, resulting in a 7% reduction in re-referrals since March 2019.

Physical Health Lead- East Berkshire Mental Health teams have focused on recognising the importance of providing good physical health care to patients with severe mental illness (SMI), to tackle health inequality. The teams now have senior Physical Health clinicians working in each of their CMHTs. In Bracknell a weekly physical health clinic has been set up for SMI patients who are open to secondary care in Bracknell CMHT. This has improved the percentage of patients having annual cardiometabolic checks and those on long acting injectable medication having the correct physical health screens completed. Verbal feedback from patients has also been extremely positive and, due to the success of this clinic, a similar model is going to be piloted in Maidenhead in 2020.

East Berkshire Psychological Medicine Service (PMS) has successfully gained accreditation from the Psychiatric Liaison Accreditation Network through the Royal college of Psychiatrists. Accreditation requires stringent external evaluation against a comprehensive set of standards, and this provides assurance that the service is providing a high standard of care.

Individual Placement Support (IPS) – Employment support service for people with Severe Mental Illness – the service has continued to operate successfully in all CMHTs, EIP and IMPACTT, and has supported over 100 people with a severe mental illness to access paid employment in the first 9 months of the year**.**

Family Safeguarding – The Trust provides adult mental health services to the multi-agency Family Safeguarding Teams in Bracknell and West Berkshire, to support patients with a mental health need and thus improve outcomes for children subject to safeguarding. The adult mental health workers have become fully integrated into the team, working alongside domestic abuse, substance misuse workers and children's social care, and have demonstrated positive outcomes for families as well as increase in mental health awareness amongst colleagues.

West Berkshire Psychological Medicine Service (PMS) has applied lean improvement techniques to map the route patients take through their care pathway and implement a process whereby all patients requiring a PMS assessment in the Emergency Department can be seen within the 1-hour referral criteria. Lean tools have also been embedded in day-to-day working.

Berkshire Eating Disorders Service (BEDS). 100% of service users accessing the adult BEDs service said they were either likely or extremely likely to recommend the service to a friend or family member via the Friends and Family Tests. Service users are also being involved in the recruitment process.

The Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT) is a specialist service providing comprehensive assessment and evidence-based treatments for individuals aged 18 and over with a diagnosed personality disorder, primarily Borderline Personality Disorder/Emotionally Unstable Personality Disorder (BPD/EUPD), but who may also have comorbid Antisocial Personality traits. The team consists of specialist staff who are highly skilled and experienced in working with these patients. Two NICE recommended evidence-based treatments are offered: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT). The team has created a service user group and is working with North West Boroughs NHS Trust to arrange training for staff to deliver a comprehensive carers programme. The team has also been delivering training events across

the organisation to help staff working with patients with personality disorder. Psychologically Informed Consultation and Training (PICT) for secondary care has begun, with a weekly bite-size programme also in place for all ward staff. A successful bid was made for additional funding to develop PICT for primary care in the East of Berkshire. The service has helped develop coherent therapy interventions, and development of the Personality Disorder pathway has continued throughout the year.

Community Mental Health Transformation: in September 2019, Frimley Integrated Care System (ICS) was one of 12 who were awarded funding to develop primary care mental health services in line with the newly published Community MH Framework (September 2019). The new framework describes joined up care, which is responsive to individual strengths and needs, and is delivered in partnership with the voluntary and community sectors. Since September 2019, East Berkshire has worked closely with our counterparts in Surrey, as well as with local voluntary and statutory services in East Berkshire, to develop a service model which will provide mental health expertise to patients with Severe Mental Illness in primary care and reduce barriers between primary and secondary mental health services. The service is due to be launched in selected East Berkshire Primary Care Networks in Spring 2020.

The Early Intervention in Psychosis (EIP) Service have established peer support groups in the east and west of the county to allow service users to share their experiences. This has also led to the development of further groups, such as an art group. A rolling educational programme for carers has also been developed in co-production with a carer's peer support worker.

The Berkshire West Crisis Resolution and Home Treatment Team (CRHTT) now have a dedicated person collecting and collating patient and carer feedback. The carers group continues to go from strength to strength and the team has been piloting iPads for mobile working and a Mood App for patients to access their safety plans and record their mood.

The East Berkshire Crisis Resolution and Home Treatment Team (CRHTT) is one of 14 NHS England Pilot test sites that are allocating referrals into one of three response categories: Emergency- 1-2-hour response, Urgent- 4-6-hour response, and Routine- 24-hour response. The teams are also involved in a research project looking into the use of Brief Suicide-Specific Psychological Interventions within a CRHTT service. An additional Police Street Triage Practitioner will also be recruited which will place the service in a position of readiness in case they need to extend this service over a 7-day period.

Community Mental Health Team (CMHT)- West Berkshire has introduced a new pre-therapy, compassion focused group, known as the "OuR" group. This group has sustained 12 core members for 10 months. They have also started using a Structured Clinical Management Plan in June 2019 as part of a new Emotionally Unstable Personality Disorder (EUPD) pathway. The former short-term and long-term teams have been reconfigured into the Duty and the Intervention and Treatment team respectively. The wait list management system has recently been adapted to ensure a more rapid response and reduce the likelihood of service users falling through gaps. Finally, the team has increased their Friends and Family recommendation rate to 95% and are increasing requests for feedback from service users.

Berkshire Trauma Service has developed several resources, including a client booklet, facilitators manual for the compassionate resilience group and a 'living life after trauma therapy' booklet for clients. They are also developing the content of their psychoeducation group. A service user involvement group is in the process of being set up. New outcome measures that better reflect the primary presenting problem of clients have also been introduced. Finally, a clinician has been recruited to work on a birth trauma pathway, the evaluation of which is being written up for publication.

The Common Point of Entry (CPE) Team has introduced a new system to manage requests for reviews by the Psychiatry team. Use of this new system has resulted in their waitlist reducing from approximately 300 patients to 30 patients, with reviews regularly being booked for the following day. The new system also allows a "pre-assessment" review to be booked which can prevent unnecessary full mental health assessments. A CPE Pharmacy has been introduced to undertake medication reviews, greatly reducing wait times. A 'Duty Rota' has also been produced and made accessible on Microsoft Teams, resulting in there always being at least one psychiatrist on Duty. Virtual consultations are now being offered by the team as an alternative to the traditional face-to-face appointments. A small project was also

undertaken to update CPE administrative practices. MDT discussions have been increased due to implementation of multi-disciplinary Daily Referrals Meetings and psychiatry team changes. There is now greater transparency for MDT discussion and psychiatry reviews due to the visibility of every review, which also allows for a greater deep-dive analysis. Finally, one of the CPE Psychiatrists is undertaking research comparing the quality of telephone and face-to-face assessments, the results of which will guide future consultations and inform whether different approaches are necessary.

The Veterans Mental Health Transition, Intervention and Liaison Service (TILS) and Complex Treatment Service (CTS). TILS supports veterans and those about to leave military service and provides support and advice to support their mental health and emotional wellbeing. This may include, if appropriate, referring the veteran into the Complex Treatment Service (CTS), which provides specialist mental health support for those veterans who have complex mental health issues that are military attributable. These services are delivered across Berkshire, Buckinghamshire, Oxfordshire, Hampshire and the Isle of Wight. During 2019/20 both services have received additional funding to expand further and have successfully recruited more clinical staff to support this work. Monthly veterans drop-in support sessions have been introduced at the Royal British Legion in Reading, with a wide selection of veterans' charities and other support organisations also attending these. Both TILS and CTS have also successfully moved into a local hub in Portsmouth. Regular service user forums are in place to gather feedback and this has resulted in a series of short videos being produced that explain more about the service and what happens at an appointment. The CTS team has started the 'True Strength Group' for clients which facilitates a Compassion-Focused Therapy group approach to addressing issues with anger. It was developed by Russell Koltz, an American psychologist who uses it with American veterans, and has been adapted by CTS for use with our veterans. Finally, the Trust has signed the Armed Forces Covenant, supporting its principles that: the armed forces community should not face disadvantage compared to other citizens in the provision of public and commercial services; and special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.

The Berkshire & Hampshire Liaison & Diversion (L&D) Service expanded its service footprint from April 2019 to include delivery of services across Hampshire and Isle of Wight in partnership with Nacro Organisation. An all age, extended hours delivery model is now delivered across all areas that the service covers to ensure consistent levels of delivery across each county. Following publication of the Ministry of Justices Female Offender Strategy, the L&D team have worked with partners across Criminal Justice to develop a female pathway. Armed Forces Veterans can encounter criminal justice agencies due to their needs and vulnerabilities. As a result, the Liaison and Diversion service, together with Thames Valley Police, the third sector, and a former serviceman, have worked together to create a system of identification, screening and assessment at custody, with pathways of support mapped out to the third sector and veterans' services. Additional funding has also been made available to extend the service into Winchester and Reading Crown Courts, where both services have been well received and established. A Lived Experience and Peer Support element has been added and the service has worked together with NHS England and the revolving door organisation to recruit volunteers and peer support workers with the lived experience of criminal justice and vulnerabilities. These workers will help engage those clients who are difficult to reach or entrenched with their difficulties and enable individuals to make positive changes to their health and social circumstances. The service has also developed apprenticeship opportunities for individuals with the lived experience. The feasibility of using Skype Technology to remotely assess clients detained within outlier suites is being looked into as a 'proof of concept'.

Older Peoples Mental Health Services (OPMH)

A Living with Mild Cognitive Impairment (MCI) support group has been initiated in Reading Memory Clinic to provide additional post-diagnostic support and treatment to clients diagnosed with MCI and their relatives. The aim is to offer interventions that go further than assessment, diagnosis and discharge, as difficulties (cognitive and psychosocial) can be significant and on-going. The group comprises three two-hour weekly sessions for 4/5 patients with MCI and their relatives or, sometimes a close friend. These MCI groups are currently being evaluated, with positive feedback from clients and their families alike.

Newbury Community Mental Health Service for Older Adults has initiated weekly peer supervision groups with all Community Psychiatric Nurses in the team

allocated into groups with the medics. This has resulted in regular discussion of patients on the caseload and has reduced the volume of email traffic to the medics. A West Berkshire Community Hospital liaison role has also been created to keep regularly contact and hold drop-in workshops with the ward staff about dementia specific support. Lastly, a 'priority patient' assignment has been created for new referrals that don't meet Home Treatment Team criteria but do need to be seen soon. This is a proactive approach to reduce the traffic into the Home Treatment Team.

Wokingham Memory Clinic has been working to reduce the wait time for medication prescribed in the clinic. Patients were waiting 14 days to receive the medication and a lot of waste was also identified in the process which impacted on the waiting time. Following root cause analysis and using the Plan Do Study Act (PDSA) approach, the team carried out a test using FP10 prescriptions. This method of prescribing has reduced steps in the process for patients receiving their medication and has enabled staff to have more time to spend delivering patient care. The new process has decreased wait time to an average of 3 days- a 76% reduction.

2.1.11. Improvements in Medicines Management

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

Our three Trust Medication Safety Officers (we have a pharmacist, a nurse and a doctor) work to ensure that all medication incidents are reviewed, lessons learnt, and good practice shared and embedded across the Trust. They also respond to, and take appropriate action on, national medication safety alerts. This includes sharing medication safety information through publication of regular Medication Safety Bulletins (shared Trust-wide), and producing posters, for example, on the safe supply of valproate to females of childbearing potential.

Pharmacists provide training to doctors to improve their knowledge of medicines safety, adverse incidents, and on several medication related topics e.g. Rapid Tranquillisation Medicines.

Antimicrobial Stewardship (AMS) has never been more important nationally and globally, and our antimicrobial lead pharmacist post is playing a key role in ensuring that Berkshire Healthcare is an exemplar for AMS at policy and patient level. We are collaborating with other Trusts across Berkshire and across the region to create an integrated network of AMS guidance and advice, to maintain effective antibiotic use and reduce widespread resistance, which if not countered could threaten the human race. Audits of antimicrobial use are part of the surveillance programme.

We have updated the Cold Chain Policy that underpins the correct storage of medicines that require refrigerated storage and have undertaken a full review of all drug fridges across the Trust, including their temperature calibration and new back-up thermometers (now replaced annually). Updated staff guidance has been produced and issued to Trust staff on how to handle situations where the recorded drug fridge temperature goes outside of range (2-8^{o}C), and where ambient temperature medicines storage (e.g. drug cupboards) goes above 25^{o}C.

Patient experience.
Our Pharmacists continue to review all medicines for effectiveness and adverse effects, offer 1:1 sessions for inpatients, facilitate patient education sessions in inpatient units, support inpatient carer sessions, and contribute to patient and carer Recovery College workshops. The patient medicines helpline, operated by our Medicines Information Service, continues to grow and supports patients and carers with medication guidance and advice.

Pharmacy Technicians regularly conduct medication reconciliation reviews with newly admitted patients, to ensure that the current and correct medication history is obtained – and to determine what patients are actually taking.

In line with the Carter Report (NHS Operational Productivity: unwarranted variations: Mental Health Services, Community Health Services, 2018), pharmacy staff are spending more time with patients and on medicines optimisation.

Pharmacy operate the Clozapine Clinics and in response to patient feedback we have recently introduced time bands to decrease patient waiting times and made improvements to the environment at the Prospect Park clinic. We are working to review the clozapine pathway, and to put it onto the Trust's electronic management system (RiO).

Electronic Prescribing and Medicines Administration (ePMA). Having implemented ePMA in all our mental health inpatient wards in 2017, and to the first mental health outpatient service, Windsor, Ascot and Maidenhead Depot Clinic in 2018, we have now developed plans to extend ePMA to the Community Health wards, and a full business case to support this development is currently being considered. We have introduced an ePMA Governance Group, a sub-committee of the Drug and Therapeutics Committee, to ensure that ePMA is well monitored and that all changes to ePMA are agreed and approved. The committee also monitors all safety concerns, risks and reported incidents, and works to improve the impact and benefits of ePMA on patient care, operational efficiency and user experience.

2.2. Setting Priorities for Improvement for 2020/2021

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2020/21 (see Appendix A). Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders. Several of the priorities from 2019/20 have been rolled forward to 2020/21.

2.2.1. Harm-Free Care Priorities

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

2.2.2. Clinical Effectiveness Priorities

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

2.2.3. Patient Experience Priorities

To provide good outcomes from treatment and care

- 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

2.2.4. Supporting our Staff Priorities

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.

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.

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2020/21.

2.3. Statements of Assurance from the Board

During 2019/20 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 relevant health services.

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

The income generated by the relevant health services reviewed in 2019/20 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2019/20.

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

2.3.1. Clinical Audit

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

National Clinical Audits and Confidential Enquiries

During 2019/20, 12 national clinical audits and 2 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=12/12) of national clinical audits and 100% (n=2/2) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2019/20 are shown in the first column of Figure 29 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2019/20.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2019/20 are also listed below in Figure 29 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of Figure 29).

Figure 29- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2019/20	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=12)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National Sentinel Stroke Audit (2019/20)	Data Collection: April 2019 to March 2020. 495 patients submitted, across 3 services, 187 six-month follow-ups. Report due: Annually
National Audit of Care at the End of Life- Round 2-2019-20	Data collection 3rd June 2019 - 11th October 2019. 17 (100%) patients submitted, across 1 service. Report due: July 2020
National Diabetes Footcare (Community Podiatry care) 2019/20	Data Collection: April 2019 to 31st July 2020. 524 patients submitted, across 1 service. Report due: Annually
National Clinical Audit of Psychosis 2019 - EIP Re-Audit	Data collection October 2019 to November 2019. 100 patients submitted, across 1 service. Report due: July 2020
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: March 2019 to March 2020. 147 patients submitted, across 1 service. Report due: May 2020
National Audit of Inpatient Falls	Data Collection: January 2019-March 2020. 0 patients eligible for submission, across 3 services. Report due: Annually
National Diabetes Audit - Secondary care 2018/19	Data Collection: May 2019. 1880 patients submitted, across 1 service. Report due: July 2020
National Diabetes Audit - Secondary care 2019/20	Data Collection: April 2019 to March 2020. 2366 patients submitted, across 1 service. Report due: Annually
Non- NCAPOP Audits	
National Audit of Cardiac Rehabilitation (2019/20)	Data Collection: April 2019 to March 2020. 746 patients submitted, across 1 service. Report due: tbc 2021
POMH - Topic 19a: Prescribing for Depression in Adult Mental Health Services (May 2019)	Data Collected: May 2019 to June 2019 111 patients submitted, across 6 services. Reported: November 2019
POMH - Topic 17b - Use of depot/LA antipsychotic injections for relapse prevention (Oct 2019)	Data Collection: October 2019 to November 2019. 149 patients submitted, across 8 services. Reported: March 2020
POMH – 9d Antipsychotic prescribing in people with learning disability	Data Collection: February 2020 to March 2020. 135 patients submitted, across 1 service. Report due: July 2020
National Confidential Enquiries (N=2)	
NCEPOD Long term Ventilation Study	Data Collection: April 2019 to May 2019. 1 patient submitted, across 1 service. Reported: February 2020
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: April 2019 to March 2020 Report due: Annually

Source: Trust Clinical Effectiveness Department

The reports of 9 (100%) national clinical audits were reviewed by the Trust in 2019/20. This included national audits for which data was collected in earlier years with the resultant report being published in 2019/20. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 31 local clinical audits were reviewed by the Trust in 2019/20 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.

2.3.2. Research and Development (R&D)

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

Clinical research involves gathering information from patients and healthy volunteers to improve the medications, therapies and services that we offer to patients. By participating in clinical research, patients may be able to access tests and treatments that are not available as routine NHS care.

Providing good outcomes from treatment and care and providing safe services are Trust priorities. Involvement in clinical research is one way that we demonstrate our commitment to actively improving the clinical treatments, care and outcomes for our patients.

Most of the research studies we invite our patients to participate in are National Institute of Health Research (NIHR) portfolio studies. The NIHR portfolio is a national list of high-quality studies which have received particular sources of funding. Our other high-quality research studies are conducted in part fulfilment of qualifications e.g. MSc or by a member of staff but will not have received funding from a relevant funding source. We have implemented a robust research governance system to ensure research is designed, conducted and delivered to the highest standards.

The number of patients receiving relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust to date in 2019/20 that were recruited during that period to participate in research approved by a Research Ethics Committee was 1407 from 44 NIHR portfolio studies. These figures include healthy volunteers involved in research.

Our aim is for all patients to have access to research opportunities which are relevant to them. Currently our patients can access research relating to bipolar disorder, dementia, eating disorders, autism, diabetes, schizophrenia, Chronic Obstructive Pulmonary Disease, Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder, anxiety and depression.

We rank in the top ten out of 49 similar Trusts (Mental Health and Community) for the volume of NIHR portfolio studies which we have invited people to participate in.

As part of the NIHR Research Participant Experience Survey we have had feedback from 89 (11%) research participants in BHFT about their experience taking part in research, this is an increase from 2018/19 where 68 (6%) participants provided feedback. 98% of participants strongly agreed or agreed that they had had a good experience taking part in the research study. 85% of respondents also stated that they would be happy to take part in another research project.

Staff members have contributed to 65 journal publications to date in 2019/20. Discussing topics such as smoking cessation, technology use by older adults, information for families caring for people with dementia, treatments for childhood anxiety disorder and use of diabetes treatments for depression.

Research opportunities currently being offered to Berkshire Healthcare patients include:

- Eating Disorders- patients and carers in the study are provided with extra information on how to cope with the illness to see if it improves their wellbeing up to 18 months post-admission.
- Diabetes service (King Edwards VII Hospital)- patients are participating in a study aiming to achieve more accurate early classification of diabetes and identification of which patients will rapidly require insulin treatment.
- Child and Adolescent Mental Health Service- participants are helping to evaluate the clinical and cost effectiveness of a standardised diagnostic assessment tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties.

For each research project, it is the sponsor's responsibility to ensure peer-review. An internal peer review process has been implemented for all studies where the Trust is currently the sponsor.

2.3.3. CQUIN Framework

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

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and for the following 12-month period can be found in Appendix E & F.

The income in 2019/20 conditional upon achieving quality improvement and innovation goals is TBC. This is the expected value at 100% achievement. The associated payment received for 2018/19 was £4,398,604.

2.3.4. Care Quality Commission (CQC)

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

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

The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2019/20.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. Following our CQC inspection of our core services in November 2019, and a "Well Led" inspection in December 2019 the Trust is now rated as Outstanding overall. Both our Community Physical Health services for adults and our End of Life service have been recognised as Outstanding. They join our Learning Disability In-Patients and our Older Peoples Community Mental Health services who also hold an outstanding rating. All our services are now either outstanding or good.

The CQC detailed the following actions that the Trust must take to improve:
Acute wards for adults of working age and psychiatric intensive care wards. The Trust must:

- Ensure that ligature risks are managed appropriately, ensure that patients are kept safe- for example promoting the sexual safety of people using the service, and ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12)
- Ensure that the ward environment is always adequately furnished and maintained. (Regulation 15)
- Ensure restrictions are necessary and proportionate responses to risks identified for particular individuals (Regulation 13)

Specialist community mental health services for children and young people. The Trust must:

- Continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway.

An action plan will be submitted to the CQC outlining how we plan to respond to these highlighted areas.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2019/20:

- 3rd-7th June 2019- CQC Children Looked After and Safeguarding (CLAS) Review across Slough health providers

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

- A full multi-agency action plan has been developed to address suggested areas for improvement such as reinforcing safeguarding assessments and sharing referral information. The Trust is fully participating in this action plan.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2020 in taking such action:

- Several of the actions in the multi-agency action plan have been completed by the Trust, with others in progress.

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

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2019/20 financial year at Prospect Park Hospital

- 2nd and 3rd October 2019- Sorrell Ward, Daisy Ward, Snowdrop Ward and Orchid Ward- all at Prospect Park Hospital, Reading
- 5th November 2019- Willow House Berkshire Adolescent Unit, Wokingham

2.3.5. Data Quality and Information Governance

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

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

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

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

Information Governance

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

Berkshire Healthcare NHS Foundation Trust Data Security and Protection Toolkit (DSPT) overall score for 2019/20 was 'Standards Exceeded'. The Information Governance Group is responsible for maintaining and improving standards in this area.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2019/20 by the Audit Commission.

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

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

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

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a full detailed audit took place in December 2019, which showed that 100% of primary and 97.1% of secondary diagnoses were coded correctly. The clinical coding team carry out peer reviews on a quarterly basis.

2.3.6. Learning from Deaths

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

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

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

Figure 30 below details the number of deaths of Trust patients in 2019/20. This is presented alongside the number of case record reviews and investigations of these deaths that were undertaken over the same period, as well as an assessment of the number of deaths that were more likely than not to have been due to problems in care provided. Please note that the table contains statements that are mandated by NHS Improvement for inclusion.

Figure 30- Deaths of Trust patients in 2019/20- case reviews and investigations carried out in 2019/20

	1. Total number of Deaths	2. Total number of reviews and investigations carried out			3.Deaths more likely than not due to problems in care
Mandated Statement	During 2019/20 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2020, the following number of case record reviews and investigations have been carried out in relation to 301 of the deaths included above.			The number and percentage of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient are detailed below. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)
		1st Line Case Record Reviews (Datix)	2nd Line Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 19/20	**3884** ↓	**406**	**198** ↓	**198 (43)**	**3 representing 0.077%** ↓
Mandated Statement	This comprised of the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 19/20	**967**	**90**	**49**	**57 (8)**	**1 representing 0.103%- Oct 18 death**
Q2 19/20	**930**	**108**	**65**	**75 (10)**	**1 representing 0.108%**
Q3 19/20	**1150**	**103**	**39**	**57 (18)**	**0**
Q4 19/20	**837**	**106**	**46**	**53 (7)**	**1 representing 0.119%**

Source- Trust Learning from Deaths Reports.* Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 30 and Fig 31. This is because the death of the patient occurred in 2018/19, but the investigation was completed in 2019/20

A number of learning points were identified from the review and actions arising from the learning points have been completed and monitored through the Trust mortality review group. The impact of actions is monitored through the Serious Incident process.

Figure 31 below details the number of deaths of Trust patients in 2018/19 that had case note reviews and investigations carried out in 2019/20 (to be confirmed in Q4). This is presented alongside an assessment of the number of these deaths that were more likely than not to have been due to problems in care provided and, as a result, a revised estimate of the number of deaths that were more likely than not due to problems in care in 2019/20. Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 31- Deaths of Trust patients in 2018/19- case reviews and investigations carried out in 2019/20

	1. Reviews and investigations carried out		2.Deaths more likely than not due to problems in care	3. Revised estimate of deaths in 2018/19 that were more likely than not due to problems in care
Mandated Statement	The number of case record reviews and investigations completed after 31st March 2019 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2019)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been ascertained using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2018/19 that are judged to be more likely than not to have been due to problems in the care provided to the patient.
	Case Record Reviews	Investigations		
Total	**20**	**15**	**1**	**3, representing 0.076%**

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 30 and Fig 31. This is because the death of the patient occurred in 2018/19, but the investigation was completed in 2019/20.***

2.3.7. Bolstering staffing in adult and older adult community mental health services

In East Berkshire Community Mental Health services, targeted work is being undertaken across the three locality teams to review skill mix and work with the recruitment team to fill vacancies in a timelier way. This work has started to deliver benefits. The Frimley Integrated Care System (ICS) has been successful in securing Transformation funding to introduce Mental Health Integrated Community Support teams who will work with the Primary Care Networks (PCN's) to deliver earlier intervention and support across primary and secondary Mental Health. The posts within these teams will offer exciting opportunities for new staff and will also assist the work of the core teams.

The Berkshire West region is leading a project addressing the function and workforce across all six locality CMHTs. This work is being undertaken to establish a standardised approach to providing support to people with mental health needs. This includes a further analysis of the offer and function of the community teams with a review of the skills required to develop primary care networks with mental health.

The Clinical Commissioning Groups (CCGs) are committing investment for 2020/21 to achieve the trajectory in Perinatal Mental Health.

In relation to the Berkshire West Psychological Medicine Service, the CCG investment standard has been met to comply with the 'Core 24' model for adult mental health liaison services.

There has been strong delivery of the Improving Access to Psychological Therapies (IAPT) constitutional and performance standards during the year, including national wait times standards and recovery rates. There is also system agreement to invest additional CCG baseline funding in order to recruit skilled staff.

Transformation investment has been used to enhance the crisis phone line aspect of the Berkshire West Crisis Resolution and Home Treatment Team (CRHTT) service. From late Q4 2019/20, this service will be accepting referrals from NHS111 for mental health crisis intervention. In addition, Police Street Triage is in place 7 nights a week.

A completed review of crisis service provision in Berkshire West contained 14 recommendations, and work is underway to prioritise and engage with partners to meet these. We are committed to delivering a sanctuary / safe haven as part of the long-term plan.

Reporting against core indicators

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

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

It is important to note, as in previous years, that there are several inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from many different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Data is collected by many teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.
- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years.

Figure 32	2017/18	2018/19	2019/20	National Average 2019/20	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	97.7%	98.7%	**96.5%**	**National Analysis paused due to COVID-19**	**National Analysis paused due to COVID-19**
Data relates to all patients discharged from psychiatric inpatient care on Care Programme Approach (CPA)					
Note: The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 7 days of discharge. This is agreed and arranged with patients before discharge and this facilitates our high compliance level.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust meets the minimum requirement set by NHS Improvement of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source- Trust Tableau Dashboard

Figure 33	2017/18	2018/19	2019/20	National Average 2019/20	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	99.2%	99.1%	**99.8%**	**National Analysis paused due to COVID-19**	**National Analysis paused due to COVID-19**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision- making process					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service.					

Source- Trust Tableau Dashboard

Figure 34	2017/18	2018/19	2019/20	National Average 2019/20	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	7.9%	6.9%	**6.1%**	**Not Available** (National Indicator last updated 2013)	**Not Available** (National Indicator last updated 2013)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. A Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked, and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 35	2017/18	2018/19	2019/20	National Average 2019/20 For combined MH/LD and community Trusts	Highest and Lowest For combined MH/LD and community Trusts
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *This finding has been taken from the % of staff respondents answering 'yes' to Question 21d of the National NHS Staff Survey: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."*	75.1%	73.6%	**74.4%**	**67.5%**	**57.3%-80.6%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average, and this is maintained.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a five-year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high-quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care. In addition, the Trust runs a Compassionate Leadership course and Excellent Manager Programme which are well attended with positive feedback. Several interventions are also in place to help make it a better place to work despite the challenges around recruiting and retaining staff.					

Source: National Staff Survey

Figure 36	2017/18	2018/19	2019/20	National Figures 2018/19	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.3	7.2	**7.3**	**6.8** (median figure for all participating Trusts)	**5.8-7.7**
Berkshire Healthcare NHS Foundation Trust considers that this score is as described for the following reasons: The Trusts score is in line with other similar Trusts.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 37	2017/18	2018/19	2019/20	National Figures 2019/20	Highest and Lowest
The number of patient safety incidents reported	**4824** *	**4518** *	**4842 (To 29th Feb 2020)** *	**TBC** **	**TBC** **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**45.9** *	**46.2** *	**Figures for Mar 20 not yet available nationally**	**TBC** ** **(Median)**	**TBC** **
The number and percentage of such patient safety incidents that resulted in severe harm or death	**44 (1.1%)** *	**40 (0.9%)** *	**50 (To 29th Feb 2020) (0.9%)***	**TBC** **	**TBC** **
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data reported to the NRLS. In the NRLS/ NHSI most recent organisational report published in X 2020, the median reporting rate for the Trust is given as X incidents per 1000 bed days (but please note this covers the 6-month period X-X). High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans. Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.					

Sources: ** Trust Figures reported to the NRLS. Please note that these figures are representative of the number of incidents reported at the time the report is sent and are subject to change over time.*
*** NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between X- X relating to 50 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2019/20

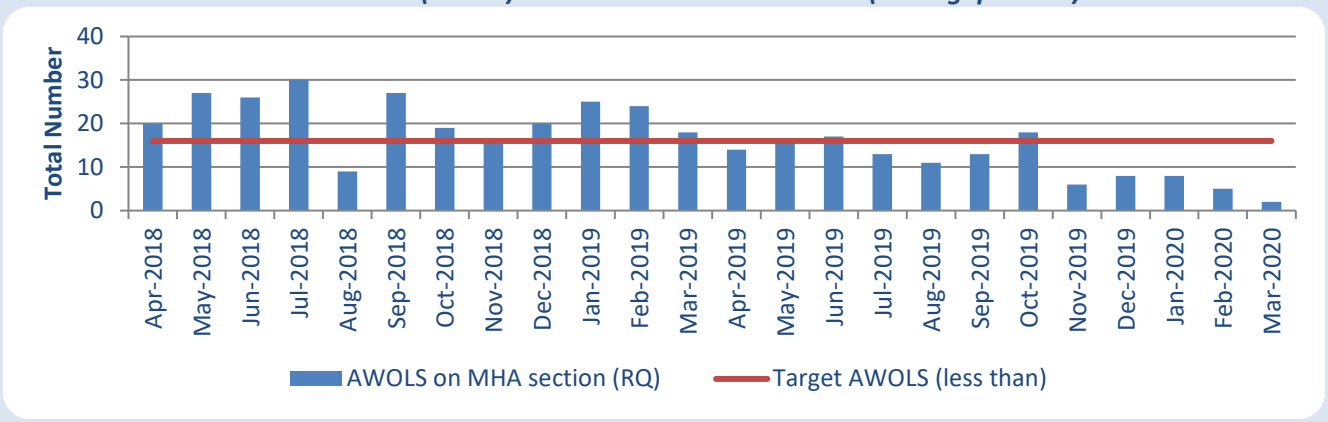
ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive Group, the Quality Assurance Committee and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. Information relating to specific areas of Trust quality and safety performance in 2019/20 is detailed below.

Absent without leave (AWOL) and absconsions

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

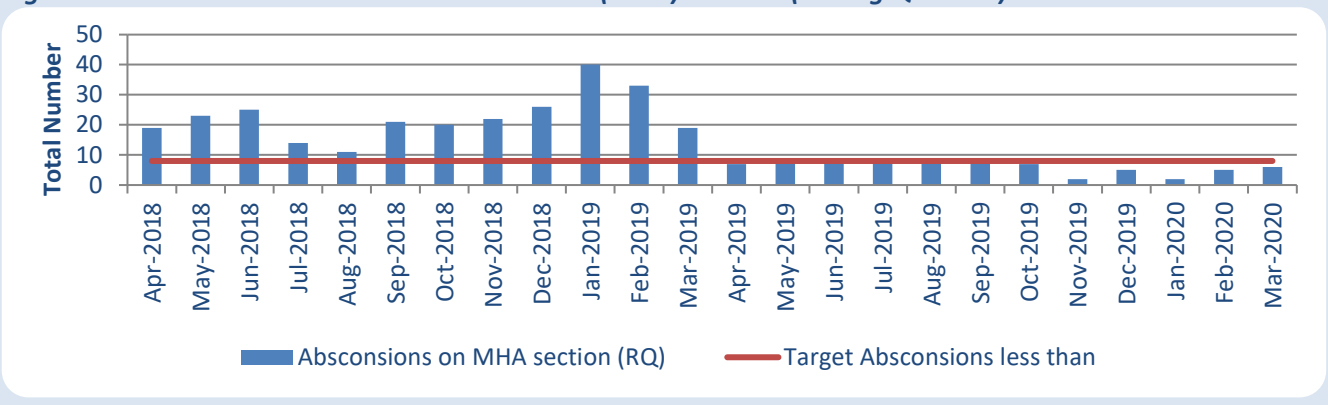
Figures 38 and 39 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 38- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source- Trust Tableau Dashboard

Figure 39- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



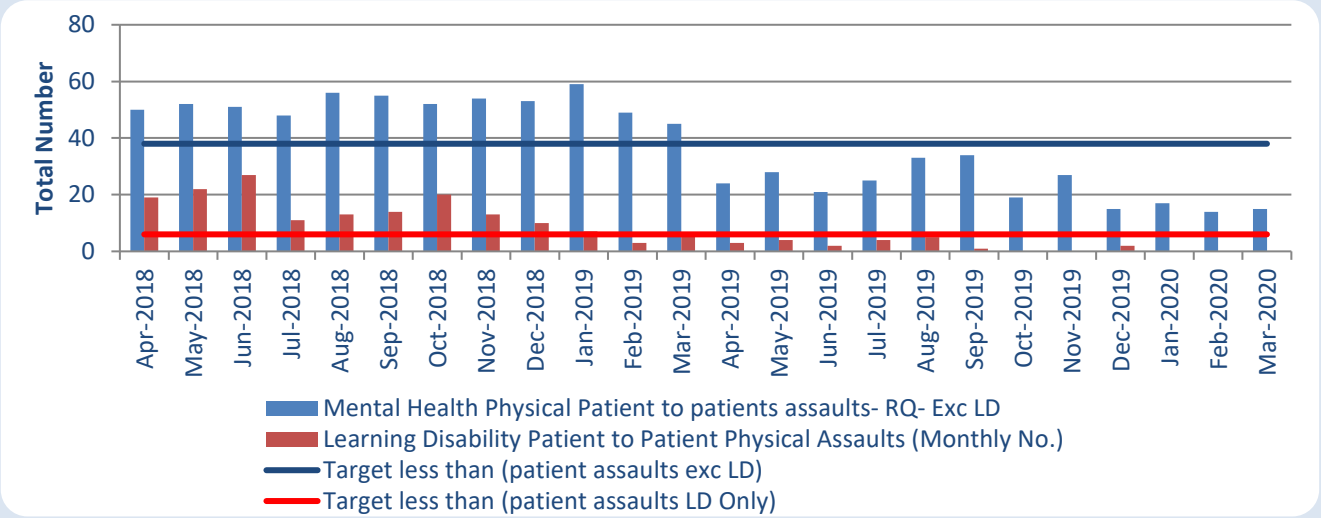
Source- Trust Tableau Dashboard

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 40 below details the number of patient to patient physical assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD). As can be seen, the level of patient on patient assaults appears to fluctuate.

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

Figure 40- Patient to Patient Physical Assaults- Rolling Quarters



Source- Trust Tableau Dashboard

Other Quality Indicators

Figure 41- Other Quality Indicators	Annual Target	2017/18	2018/19	2019/20	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events
Infection Control- MRSA bacteraemia	0	0	0	**0**	Total number of MRSA Cases *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	3	1	**1**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. *Source- Trust Infection Control Reports*
Medication errors	Increase Reporting	N/A	830	**910**	Total number of medication errors reported. *Source- Trust Medicines Management Report*
Admissions to adult facilities of patients under 16 yrs. old	0	0	0	**0**	Total number of patients <16 years of age admitted to adult Mental Health Inpatient Facilities
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per NHSI Target	247 (Target Met)	185 (Target Met)	**86 (Target Met)**	Average monthly total bed days spent out of area
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only- Health & Social Care).	<7.5%	12.38%	11.3%	**6.8%**	Average monthly %. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	53%	84.5%	82.6%	**91.7%**	Average monthly %
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	58.8%	57.4%	**56.7%**	Average Monthly %
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	98.9%	98.3%	**95.7%**	Average monthly %

Figure 41- Other Quality Indicators	Annual Target	2017/18	2018/19	2019/20	Commentary
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	100%	100%	**100%**	Average monthly %
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	99.3%	99.8%	**98.1%**	Average monthly %
Data Quality Maturity Index (DQMI) – MHSDS dataset score (Revised Indicator)	95%	N/A	97.8%	**96.5%**	Average monthly %
Patient Experience					
Community Paediatric Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	99.8%	99.4%	**99.8%**	Average monthly %
Diabetes Service- Referral to Treatment waiting times (RTT)- Incomplete pathways- How many within 18 weeks (%)	95% <18 weeks	98.9%	99.5%	**100%**	Average monthly %
Complaints received		209	230	**231**	Total number of complaints
1. Complaint acknowledged within 3 working days	100%	100%	100%	**100%**	% meeting requirement
2. Complaint resolved within timescale of complainant	90%	100%	100%	**99.5%**	% meeting requirement

Source- Trust Tableau Dashboard except where indicated in commentary

Please note that the cardio-metabolic assessment and treatment indicators were removed in 2019/20 in line with NHSI requirements.

Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2019/20 and supporting guidance detailed requirements for quality reports 2019/20
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2019 to May 2020
  - papers relating to quality reported to the Board over the period April 2019 to May 2020
  - feedback from commissioners dated April 2020
  - feedback from governors dated April 2020
  - feedback from local Healthwatch organisations dated April 2020
  - feedback from Overview and Scrutiny Committees dated April 2020
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2020
  - the 2019 national patient survey, November 2019
  - the 2019 national staff survey, February 2020
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2020
  - CQC inspection report dated October 2018
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Date and signature in Q4 **Martin Earwicker, Chairman**

Date and signature in Q4 **Julian Emms, Chief Executive**

Appendix A- Annual Plan on a Page

Annual Plan on a Page- 2019-20

Annual plan on a page 2019/20

NHS
Berkshire Healthcare
NHS Foundation Trust

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

True North goal 1: Harm-free care

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

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

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

True North goal 2: Supporting our staff

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

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

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

True North goal 3: Good patient experience

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

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

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

True North goal 4: Money matters

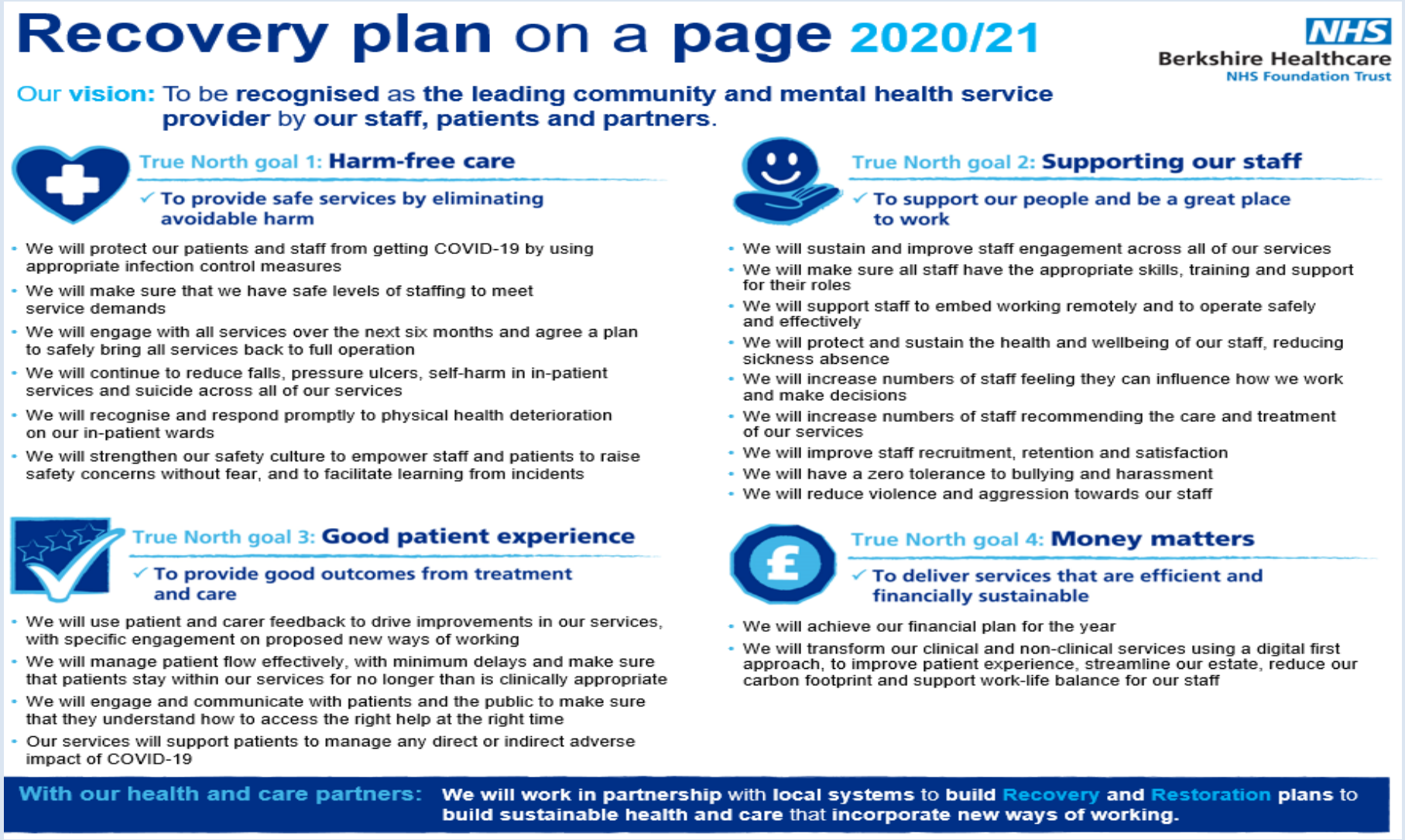
✓ **To deliver services that are efficient and financially sustainable**

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

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

Annual Plan on a Page- 2020-21

Please note that the original 2020/21 Annual Plan was been updated in May 2020, in light of the COVID-19 pandemic, to become a Recovery plan on a page



Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2019/20 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
NCAPOP Audits			
1	**The National Clinical Audit of Psychosis - EIP spotlight audit (4404)**	Early Intervention in Psychosis (EIP) services saw the introduction of an access and waiting time standard in 2016 (NHS England, NICE QS80 & QS102, NCCMH, 2016). This set targets for EIP services that require from 1st April 2016 more than 50% of those experiencing First Episode Psychosis (FEP) will be treated with a NICE-approved care package within two weeks of referral, and by 2020/21, more than 60% of people with FEP will be treated with this care package within two weeks of referral. A self-assessment exercise was conducted during 2017/18 led by the Early Intervention in Psychosis Network at the Royal College of Psychiatrists (RCPsych). In 2018/19, this became a spotlight audit by NCAP at the RCPsych and aimed to ensure that people with FEP received prompt assessment and access to the evidence-based interventions that are vital to improved mental health and recovery, including the monitoring of patient outcomes.	The EIP have been audited annually and at the time of the data collection the previous action plan had not been fully implemented and the following actions have since been implemented: 1. Full implementation of SHARON which includes and e-health education & support for carers and service users 2. A rolling education & support programme across Berkshire implemented in April 2019. 3. Ensuring 1 to 1 advice and information is captured as carer -focused education and support. Data collection has started on the next round of audit (1 October 2019). This audit also includes a service user survey, and these have been sent out to all 111 patients. The national report will be due to be published in Summer 2020. The service are planning a local analysis on the current data being submitted nationally to get a better picture of the effect of the previous action plan prior to summer 2020.
2	**National Diabetes Insulin Pump report (4330)**	The National Diabetes Insulin Pump Audit (NDA) collects information on the number and characteristics of people with diabetes using an insulin pump, the reasons for going on an insulin pump and the outcomes achieved since commencing insulin pump therapy. The National Institute for Care and Health Excellence (NICE) guidance states that Continuous Subcutaneous Insulin Infusion (CSII) or insulin pump therapy is recommended as a treatment option for adults, and children aged 12 years and over with Type 1 diabetes mellitus provided that the patient meets specific parameters.	- Discuss with Frimley ICS as to how we can ensure equity within the system for people with Type 1 Diabetes who require CSII. - To implement anxiety score for all people with Type 1 Diabetes who are under the care of the Diabetes Specialist Service. - Service due to transition from Diabetes Specific clinical database to RIO for recording of all clinical documentation. - Required data set has been added to Diabetes Assessment Sheet on RIO.
3	**National Clinical Audit of Anxiety and Depression -**	This is a new audit and it should be noted that the results reflect 2017 clinical activity. The National Clinical Audit of Anxiety and Depression (NCAAD) is a three-year quality improvement programme established to improve the quality of mental health care for people who are admitted to hospital for the treatment of anxiety and depression. This audit focuses on inpatient services, where	Two wards have countermeasures in place as part of quality improvement project, involving having a daily conversation with the service user around their safety plan. These countermeasures are: - Having a paper copy of safety plan in folder for ease of access. - Using admin to update folder.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
	Core audit 2017 (53581)	people are admitted to hospital and stay overnight for a period of time. It has measured the performance of secondary care mental health services against thirteen quality standards. These standards are derived from national and professional guidance, including those from the National Institute for Health and Care Excellence (NICE), and guidance such as the 'triangle of care' published by the Carers Trust.	- Including a question in daily status exchange between ward manager and nurse in charge re whose safety plan needs further work today. - Mental health training lead and nurse consultant are working with individual clinicians and teams to improve their skills and understanding of safety planning. - Training will involve how to have a safety planning conversation and giving a copy to the service user and carer. - The nurse consultant for in-patients, crisis team and head of MH Urgent care plan to start and monthly training session using immersive theatre for skill development. - An app is being developed for service users to have on their phone and this is due to be trialled on Bluebell ward over the next few months. - The CQUIN requiring 72-hour reporting will be taken from the Mental Health Services Data Set and will be reported by NHS England to commissioners.

4	**(NCAAD) National Clinical Audit of Anxiety and Depression - Spotlight audit (Psychological Therapies) (4408)**	This audit was the second in the NCAAD quality improvement programme following on from the main Audit of Anxiety and Depression in 2017-18. It should be noted that the results reflect 2017-18 clinical activity.
		
		This audit focuses on the delivery of psychological therapies in secondary care adult mental health services with the aim to improve accessibility and psychological care and treatment for people with anxiety and depression. It has measured performance of secondary care mental health services against eight quality standards. These standards were derived from the National Institute for Health and Care Excellence (NICE) guidelines as well as other national and professional guidance.
		
		The national report presents the audit findings group into five themes: access and waiting times, appropriateness of therapy, service user involvement, outcome measurement, and therapist training and supervision.
			- Establish a trust-wide Psychological Therapies Committee (PTC)
			- Prompts for disability and sexuality to be added to the Demographics form, to be used by all AMH therapy services
			- Work across services to renew focus on waiting times:
			  ○ Refresh IPT Group Programme
			  ○ Utilise performance data from the Psychological Therapies Tableau
			  ○ Report performance and adherence to SoPs to PTS.
			- To identify and consider options and practical solutions to address skills gaps and capacity issues, duplication and post code/services variability, and differences in ability of AMH Psychological Therapy teams to deliver the MH Pathways consistently, equitably and effectively.
			- Proposed options to be considered by PTS.
			- Information leaflets to be updated with data management, treatments and treatment choices and utilised by all services.
			- Clinical Leads to remind all therapists of the need to develop a formulation of the presenting problem early in therapy, and to use this to inform goals for intervention that are agreed with the service user.
			- All AMH Psychological Therapists to be reminded to routinely complete HoNOS, ReQol, and CORE-OM pre- and post-intervention and record this on Rio where reports can inform learning.
			- Performance monitoring by Tableau to AMH Leads meeting and PTS.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
			- The Supervision Task & Finish Group to review competency assessment requirements to ensure practising clinicians are sufficiently skilled in the therapies they deliver where accreditation is either not available or not an essential requirement for the level of practise.
5	**(NDA) National Diabetes audit (4912)**	The National Diabetes Audit is a major national clinical audit which measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards in England and Wales. NICE Guidance and NICE Quality Standards for Diabetes: 1. Type 1diabetes in adults: Diagnosis and management (NG17) 2. Type 2 diabetes in adults: management (NG28) 3. Diabetes (Type 1 and Type 2) in children and young people: diagnosis and management (NG18) 4. Diabetes in adults (QS6) 5. Diabetes in children and young people (QS125)	- All staff including Diabetes Consultants are now using RIO and diabetes assessment sheet on RIO for all people with diabetes that are under the care of the Diabetes Specialist Service - All staff aware of the importance of entering data onto the diabetes assessment sheet. on RIO - Meet with analyst team to discuss process - Data inputted into RIO will be pulled into a tableau report against parameters for NDA data set
6	**National Audit of Care at end of Life (4870)**	The second round of The National Audit of Care at the End of Life (NACEL) is a nationally facilitated project that is mandated for participation by Trust community inpatient wards as part of the National Clinical Audit and Patient Outcome Programme (NCAPOP). Mental Health inpatient wards were excluded in this round of the audit but are expected to be included in round three. The audit focuses on expected hospital deaths and comprises three main parts; an organisational audit, a patient case note review and a 'Nominated Person' quality survey. Standards for the audit are derived from best practice as defined in "One Chance to get it Right" (2014) and NICE Quality Standard 144 -Care of Dying Adults in the Last Days of Life (2017). A Trust bespoke dashboard for each participating organisation was released in February 2020 which benchmarked local findings against all participating UK acute and community trusts.	- Highlight the importance of fully completing and recording the Trust End of Life Care Plan on RiO with all staff at Ward meetings. - Emphasise where findings should be improved on and specify where these aspects should be recorded on the Trust End of Life Care Plan on RiO - Attend the Trust Ward Manager's meeting to present the findings of the report and highlight any areas requiring improvement, together with how these should be addressed - Meet with Business and Performance Manager to discuss feasibility of setting up reporting system with timescales - Launch automated EoL reporting system - Use automated reporting system to monitor completion of EoL care template and feed findings into governance meeting
Non-NCAPOP Audits			
7	**POMH - Topic 6d - Assessment of the side**	Clinical Guidelines recommend the use of LAIs as a strategy to tackle non-adherence where this is thought to be a clinical priority or where the patient expresses a preference to receive their medication as an LAI. They simplify treatment by providing a known	All medical staff reviewing patients under their care receiving LAI antipsychotic medication will perform a general physical examination to rule outside effects and document the findings.

National Audits Reported in 2019/20		Recommendation (taken from national report)	Actions to be Taken
	effects of depot antipsychotics (3584)	dose of medication at regular intervals, administered by a health professional that is alert to clinical change and to non-adherence by monitoring missed or delayed appointments. As with all medication, side effects are a major reason for non-adherence. For LAIs, these include the same range of effects as for the equivalent oral preparation. Side effects are particularly likely when the LAI is 'topped up' by other antipsychotic medication.	Existing GASS form already has movement disorder, menstruation, and sexual side-effects listed. Depot nurses or reception staff to hand GASS checklist to the patient on arrival and upload it to RIO on completion. Rapid Improvement Event to be led by physical health leads representing each of the divisions supported by the QI team executive sponsor of the project is the Director of Nursing.
8	**POMH – Topic 7f – Monitoring of patients prescribed Lithium (4527)**	Lithium is licensed for the treatment of bipolar affective disorder and depression and its use in these conditions is supported by NICE guidelines. Its side-effect profile is well established.	Link with the Clozapine pathway work stream to develop a Lithium pathway. Rapid Improvement Event to be led by physical health leads representing each of the divisions supported by the QI team executive sponsor of the project is the Director of Nursing.

9	**POMH – 19a: Prescribing for depression in adult mental health (4395)**	This is a new Prescribing observatory for mental health (POMH) audit, the practice standards for the audit are derived from NICE guideline CG90 depression in adults: recognition and management (NICE, 2009) and the British Association for Psychopharmacology (BAP) guideline for treating depressive disorders with antidepressants.
		Depressive symptoms are common in the population and there is a continuum in the number of symptoms and their severity. Depression is a syndromal diagnosis, and covers a range of clinical presentations, co-morbidities, and aetiologies. This translates into a wide range of treatment approaches, a lack of evidence for clear superiority for one approach over another, and a high rate of benefit from non-specific factors in any treatment given. The National Institute for Health and Care Excellence (NICE) guidelines for the management of depression propose a 'stepped-care' approach to the treatment of depression based on clinical criteria and treatment needs.
			- Improvement of the number and quality of Safety Plans is a Driver Metric for CMHTs. Psychiatrists to include:
			  - adherence,
			  - therapeutic response, substance misuse and comorbidities when documenting outpatient appointments
			- For patients not open to Psychiatry, Lead Healthcare professionals to fully complete progress note proforma which addresses all these points
			- If augmentation is indicated, Psychiatrist to be reminded to consider Lithium as an option.
			- Audit results to be shared at East and West Performance Meetings and progress against Safety Plan Driver to be monitored monthly.
			- To re-enforce the message that Lithium should be considered as an augmentation option through the results being shared at the MSC and for psychiatrists to be reminded to consider Lithium
			- Email reminder to be circulated to support this message

Appendix C- Local Clinical Audits- Actions to Improve Quality

Audit Title		Conclusion/Actions
1	Consent to ECT Re-audit (4568)	This is the fourth re-audit, Standards were developed from local guidance, Electro Convulsive Therapy (ECT) Policy and Guidelines CCRO, (section 8) and national standards for consent to ECT as produced by ECTAS (www.ectas.org.uk ECT accreditation, standards section). Repeated audits and sincere efforts from the ECT team have made compliance with consent for ECT National guidelines almost 100%. A bit more attention would probably be all that would be needed to reach the perfect score. We have managed to be 100% compliant in 11 out of 13 standards, the other 2 were between 90-99%
2	Mental Capacity Act Practice in clinical practice on inpatient units in Berkshire Healthcare (4700)	A new Mental Capacity Act and DoLS policy has been adopted by the Trust since April 2018 (CCR096), providing clearer direction and guidance for practitioners and a telephone helpline service has been implemented to support staff who require advice regarding specific clinical circumstances. An action plan has been devised, including: 1. Encourage champions to take a more active role in developing MCA practice on the wards encouraging their colleagues to consider circumstances when the framework is required and better documentation of Best Interest Meetings and decisions made. 2. Work on up-skilling and supporting mental health practitioners on the mental health wards to use the MCA framework where appropriate. 3. Review training and make it more practice based including assessment tools, a focus on Human Rights and requirements of documentation encouraging the correct use of the legal terminology and legal responsibility for the MCA framework.
3	JD - Audit of completion of VTE assessment, Audit C and ECG as per admission protocol (4701)	This project aimed to see if the admission protocol criteria were met and forms filled in, for ECG's, VTE, and AUDIT C in a timely manner. Circulation of findings to all psychiatrists through the academic meeting: achieved on 14.3.19. 1. Re-circulation of admission protocol to all psychiatrists, including trainees and SAS doctors, and nursing staff. This would provide clarification that both VTE and Audit C forms are now electronic and that paper copies must not be used. 2. Trainees to be reminded that any deviation from expected standards must be documented with clear rationale. 3. Findings to be shared with Physical Health Lead and Drug and Alcohol Lead for their awareness and appropriate actions (e.g. monthly audit of a random sample of admissions to check Audit C compliance; update from Physical Health Lead on ECG machines upgrade plans to improve accessibility).
4	Re-audit of Antimicrobial Prescribing on all Berkshire Healthcare NHS Foundation Trust Inpatient Wards Project 2018-19 (4788)	This audit is a re-audit of Project 3574. The audit aimed to determine how compliant the Trust was with nationally recognised standards of good antimicrobial stewardship (AMS) and practice, and whether local Trust prescribing guidelines for antimicrobial prescribing is followed by prescribers. Actions will be managed through the BHFTs AMS Group who will have overall responsibility for taking these actions forward. 1. Work towards increasing Trust compliance to documenting allergy severity for all inpatient drug charts. 2. Continue staff engagement through continued staff training and awareness of AMS principles. Propose that the ESR e Learning antimicrobial module is mandatory for all prescribers as a stand-alone module. This will ensure compliance to all standards is adhered to. It is expected, that further improvements will be observed as EPMA is embedded.

Audit Title		Conclusion/Actions
5	Speech and Language Therapy Referrals to the Mainstream School Service in Reading: Impact of the Early Years Service (3802)	Following a re-design of the Speech and Language Therapy (SLT) Early Years Service across Berkshire in 2014, service users have been required to attend a Drop-In clinic in order to access support from speech and language therapy between the ages of 0-5 years. There were concerns that some families were not accessing this new model and the needs of these children/young people weren't highlighted until they were in a mainstream placement. This may have been having a significant impact on the mainstream speech and language therapy service. 1. The SLT service may wish to develop greater links with Early Years services and educate others about the importance of early identification and intervention of speech, language and communication needs. 2. The SLT service may wish to increase the involvement of its users in ongoing service improvement to determine what challenges these families are facing and consider what reasonable adjustments could be made to the existing model.
6	The effectiveness of Group Cognitive Behaviour Therapies in Treating Adolescent Anxiety Disorders; A Service Evaluation (2018). (4228)	The study aimed to investigate the effectiveness, in terms of treatment gains, of three routinely delivered Cognitive Behavioural Therapy (CBT) groups within the CAMHS Anxiety and Depression Pathway, for adolescents (n=27) with a primary diagnosis of anxiety. One treatment group was for 13-15-year olds and two groups were for 15-17-year olds. Include further investigation into characteristics of adolescents who decline the offer of group treatment, and further investigation into whether the groups are effective, within the service, for adolescents with increased severity of symptoms could be beneficial. Future research could be undertaken within the service into whether adolescents are re-referred into the pathway, or to other adolescent or adult services after being discharged from the groups.
7	Re-audit of Risk Assessment and Record Keeping Audit of the Berkshire Eating Disorders Service, St. Mark's Hospital (4613): May 2019	The re-audit aimed to investigate the service's compliance with standards relating to risk assessments and record keeping. The standards were developed from the Trust's Risk Assessment Policy (CCR003) and the Record Keeping Policy (ORG096). The audit includes standards relating to documentation of appointments/progress notes on RiO; assessing and communicating risk to other professionals at triage, review and discharge; and responding appropriately to high-risk patients. In order to maintain good standard on record keeping the service needs to ensure that: Clinicians should update the risk summary on RiO at assessment and on discharge; Clinicians should document identified risks to GPs; The risk summary is reviewed and updated annually. The service team are to conduct twice yearly spot check audits to ensure that the above actions are in place and compliance is being met on all standards on record keeping and risk assessment.
8	Risk recording in letters from outpatient clinics to GP's (ID: 4624). Date of report: June 2019	Berkshire Healthcare Clinical Record Keeping Standards, Policies and Procedures (ORG 096) section 9, accuracy and content of clinical record and its subsection 9.8 states "there should be evidence of risk assessment of the patient and of analysis of their presenting problems". (Risk assessment/management of MH & LD Services Policy and Procedures, Berkshire Health, February 2018). It is advised to record risk of all non-Care Programme Approach covered patients twelve monthly. The aim of this audit was to review the extent to which risk assessment was recorded on patients that are not subject to the Care Programme Approach (CPA). A detailed risk analysis recording in the RIO notes should be attempted if risks existed. However, this can be time consuming and includes multi-disciplinary risk reduction strategies. This will be a big change in practice that needs training, education and coordination from several specialists in learning disability.

Audit Title		Conclusion/Actions
9	MIU X-Ray Diagnosing, Reporting and Follow Up Audit (4941): June 2019	As part of the learning from a Serious Incident (2017/19265) that occurred in the Minor Injuries Unit (MIU), whereby a patient's notes were not sent to the Virtual Fracture Clinic (VFC) leading to delayed treatment, the MIU has introduced a new procedure of checking X-Ray notes. Staff need to be aware of the impact on patients if their diagnosis is wrong. Referring patients to VFC if there is any doubt is an excellent way of ensuring patients get the correct treatment and this practice should continue. If the diagnosis is different this should be clearly documented in the notes. The patient should be informed unless it is clear that the patient is aware the treatment will not differ, and they are happy that the report will not be shared with them. X-ray reports should continue to be checked within two days of them reaching MIU to allow for timely implementation of any change in treatment Checking that the VFC referral has been made is an effective safety net and should continue. The documenting of this check needs to be consistent, so we are sure no referrals are being missed The results of this audit will be shared with RBH X-ray department X-rays requested by GP to be documented separately in future audits as the time scale for these reports do not fall under the Royal College of Emergency Medicine Management of Radiology Results in the Emergency Department best practice guidelines
10	Re-audit of prescribing for substance misuse: alcohol detoxification (4764)	This re-audit aimed to review clinical practice against national standards for the prescribing for substance misuse: alcohol detoxification. Equipment to test for breath alcohol is held on each ward, though it's possible that staff don't know where to find it. Liaison with staff regarding the whereabouts of equipment may improve the extent of testing carried out. AUDIT C form (along with other physical health forms) to be moved to an easier to find location on RIO. Some nurses may benefit from support/training in calculating accurately the units of alcohol drunk by patients. Consider including clotting and GGT to the blood form, to act as a reminder for staff to test patients.
11	Valproate prescribing for women of childbearing age (4602)	The purpose of this audit is to provide assurance to the Quality Assurance Committee of the Trust Board that, in the time period between national audits on this topic, the trust has reviewed clinical compliance with MHRA guidance for inpatient mental health wards at Prospect Park Hospital. Following feedback from medical staff it has been agreed to include a 'treatment reason' in ePMA to enable prescribers to document tapering dose prescriptions where the plan is to stop valproate. A POMH audit of the prescribing of Valproate is due to commence in 2020, the Royal College of Psychiatrists will be holding a planning meeting in January 2020 which will be attended by trust staff.
12	VTE re-audit (4759)	The purpose of this re-audit is to provide assurance to the Quality Assurance Committee of the Board and measure compliance on the older adult wards, against the standards listed below after the implementation of recommendations from the previous audit and the introduction of revised NICE guidance in 2018. VTE online form to be amended so that the prompt to save the form (before the risk factors have been considered) will be moved to the bottom of the form; this should improve bleeding risk assessment and result in more detailed VTE assessment. VTE e-learning should be considered for inclusion into essential training requirements for doctors and nurses working on inpatient wards--this should result in greater awareness around the need to consider repeating VTE risk assessment if clinical condition changes as well as overall awareness of VTE risk and its management.

Audit Title		Conclusion/Actions
13	OAP Service Evaluation of Personality Disorder Hospital Admissions Report (4565)	The Out of Area Placement (OAP) Team manages a number of referrals for out of area placements to Out of County Hospitals (Locked Rehab, and Specialist hospital placements), to the Cloisters (locked and open rehab in Newbury under block contract) and Rosebank House (open rehab in Reading with BHFT providing medical, pharmacy and MHA input). Historically the OAPs budget became overspent, and a lot of work has gone in to rationalising and making more robust and transparent the processes in OAPs. This service evaluation was carried out because the OAP team had limited outcome evidence on which to base the advice it gives or the decisions made in the OAP Funding Panel. 1. Discuss data within OAPs and IMPACTT services and share with Associate Medical Director (for inpatients) 2. Consider improving early work with emergent Personality Disorder in CAMHS 3. Develop a system for prospective data collection around patients in such placements 4. Share findings in upcoming personality disorder OAPs workshop 5. Reflect on what is offered to these patients prior to placement, arguably not sufficient or timely enough.
14	WestCall Antimicrobial Prescribing Audit 2018_Final Report (4643)	The audit looked to assess antimicrobial prescribing for patients seen in West Berkshire by the out of hours team - WestCall in accordance with Trust policy and AMx prescribing guidelines. Propose that an audit is carried out into how many patients had their treatment changed as a result of a urine culture and susceptibility (UC+S) result showing bacterial resistance to a prescribed AMx. Education and training for WestCall staff: 1. To increase compliance of documentation of patients' allergic status. 2. Trimethoprim is no longer a front-line treatment for UTI because of a resistance rate of 33% in Berkshire West. 3. Apply attention to detail when prescribing AMx in terms of using the correct dosage and frequency of medication. 4. The procedure for sending UC+S to increase number of processes sampled. 5. Wherever possible arrange UC+S for those patients who: a. Are 65 and over and may have a UTI. b. Have evidence of an upper urinary tract infection. c. Have a UTI that has not responded to a previous course of antibiotics. d. Children e. repeat UTI 6. Improve AMx prescribed in accordance with Trust guidance. 7. Document weight (estimated) used to calculate paediatric doses, where applicable. Change the order of nitrofurantoin formulations to place modified release at the top to reduce human error with medication selection on Adastra.
15	Identifying if clients with a cluster 10-15 are currently receiving any support for voice hearing – report - (4748)	This audit was completed as part of a final module on the Psychosocial Interventions for Psychosis (PSI), an innovation-based project. The CQC report highlighted that the Slough locality did not offer a hearing voices group. The audit took place to review whether any interventions were currently being offered for voice hearing or whether they had been offered to CMHT clients previously and the date that these were last offered. Hearing voices group to be planned, co-produced and facilitated with a peer mentor (individual with lived experience) at Slough CMHT. More interventions to be offered for those who hear voices.

Audit Title		Conclusion/Actions
16	10 day follow up by CAMHS RRT following discharge from acute hospital - report (May 2019) (4789)	For all children and young people who present to an acute hospital in a mental health crisis, our standard operating procedure recommends a "7-10 day follow up either by a telephone or face to face contact". This aims to reduce, where possible, the risk of suicide and social exclusion. This project aimed to measure the 10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital and an evaluation of the reasons where this has not been possible. A SOP has been agreed and a community follow up duty shift is now rotated evenly amongst the clinicians pro-rata to ensure 7-10 day follow up of patients.
17	Audit of Transition Practice from Child Services to Adult Learning Services Final Report Oct 19 (5024)	The aims of this audit are twofold: Firstly, to establish if all young people audited since the implementation of the protocol in August 2017 who were referred to the psychology service within the adult learning disability team were appropriately transitioned according to and in line with the local trust transitioning standard operating procedure. Secondly, to audit what happens to these transition referrals when they are held under the psychology team and what input is required. 1. To disseminate and provide teaching to Psychological Services and the broader CTPLD to increase awareness of local and national best practice standards. 2. To explore the use of a transition checklist for referring professionals to complete. 3. To increase opportunities for young people to meet clinicians from the CTPLD prior to transition from child services. 4. To routinely gather feedback on transition experience from referred young people with learning disabilities and their families. 5. To improve the functional use of the referral form to encourage improved quality of referrals to the service.
18	Re-audit of use of dementia assessment care pathway in LD (5053)	The aim of the project was to ascertain whether there had been an increase in the use of the Dementia Assessment Care Pathway tool, or the information provided by this tool, by health professionals in their dementia assessments of people with learning disabilities, since the initial audit in 2013. This is the fourth audit in relation to this topic. 1. Training for some health staff in certain teams regarding the tools that are available. 2. Annual training for staff teams to include how to use the Dementia Assessment Care Pathway, how to analyse data from the dementia assessments and how to report findings. 3. Consideration of the content of Dementia planning meetings to ensure it is consistent across teams as well as an agreed upon frequency and regularity.
19	Record Keeping Audit Health Visiting and School Nursing (4887)	Serious Case Reviews and complex investigations have identified occasions where record keeping was not comprehensive and failed to inform other professionals of holistic care needs. Aim to give quality assurance of the RIO record keeping completed by Health Visiting and School Nursing teams Objectives to enable consistency across all staff groups and ensure professional, Trust and service guidelines are being adhered too and findings to facilitate updates to service manuals including guidance and service specific standards on record keeping 1. Develop templates to facilitate progress note records. 2. Review abbreviations and update SOP accordingly. 3. Meet with safeguarding team to create protocol for vulnerable children on caseloads for over 4 months. 4. Contacts training reminders for all staff and guidance in service standards.

Audit Title		Conclusion/Actions
20	JD - Audit of lipid monitoring in WAM CMHT patients on antipsychotic medication (5061)	NICE Guideline CG178 (Psychosis and schizophrenia in adults: prevention and management), recommends that all patients should have blood lipid profile measured before starting an antipsychotic drug. It is also recommended the lipid profile is measured again at 12 weeks after starting the antipsychotic medications and then again at 1 year and then annually. This audit will specifically focus on the annual lipid monitoring of patients in WAM CMHT. Additionally, the audit will also look at whether the lipid profiles measured are within the normal parameters and if not, whether any lifestyle advice was given. Audit findings to be disseminated to psychiatrists and other clinicians. • Explore idea of leaflets or posters in patient waiting areas to raise awareness of dyslipidaemia, its risks and its management. • Patient information leaflets regarding reducing cholesterol to be circulated to doctors and other clinicians within the service to raise the profile of this issue.
21	(5165) Re-audit capacity assessment on Rose Ward (inpatient general adult ward) (5165)	Carrying out mental capacity assessment is extremely important regarding psychiatric patients who are admitted either informally or under the Mental Health Act. BHFT has clear standards for documenting capacity assessment for admission and for treatment. The aim was to re-assess how well we are adhering to the standards set by the trust and notice any improvement from the previous audit. An action plan has been drafted which includes guidance to be circulated to all the medical and nursing teams for documenting capacity assessment on admission.
22	JD - Assessing the management of diabetes amongst psychiatric adult inpatients (5004)	Correct management of patients with diabetes during acute adult psychiatric admissions is crucial in order to prevent severe harm through extreme hypoglycaemia or hyperglycaemia, identify worsening end organ damage and improve glycaemic control for long term benefit. NICE provides guidance for screening on admission for patients with diabetes, actions which must be undertaken based on HbA1c and hospital admissions. This audit aimed to identify whether best practice standards for patients with diabetes admitted as psychiatric inpatients in Berkshire Healthcare, were being met. Drafting of an admissions proforma for diabetic patients
23	NICE Lower Back Pain Audit (2016), MSK East in June 2019 (5527)	Previous informal audits against NICE Lower Back Pain (LBK) and sciatica guidelines have demonstrated an overall compliance of 62% and 69% in 2017 and 2018, respectively, in the Muscoskeletal (MSK) East service. The main purpose of this formal audit is to re-assess these areas and create an action plan to improve provided. Aim to improve compliance with NICE guidelines regarding lower back pain in the Musculoskeletal (MSK) East Service. Objectives to determine compliance against the NICE guidelines and create an action plan to improve areas requiring improvement. To liaise with admin to ensure all new patients with LBK given Start Back tool, to agree with clinical staff where to document score, education Service-wide education on importance of documenting advice given Locality led IST this year will be aimed at manual therapy practise and idea sharing and TNA to include courses to support increasing manual therapy consideration and idea sharing, TNA to include courses to support objective
24	Audit of Written Directive by Peer Vaccinators for the 2020 staff influenza vaccination campaign (5747)	For the 2019 staff influenza campaign, to allow peer vaccinators to vaccinate staff, a new national Written Directive replaced the former PGD. The Written Directive is an instruction for the supply or administration of the vaccine to staff who may not be individually identified before presentation for the vaccine. The Directive provides a legal framework that allows named, authorised, registered nurses, who are not prescribers in their own right, to supply or administer the vaccine to a pre-defined group of staff requiring the vaccine described without the need for a prescription or an instruction from a prescriber. This audit examined the use of the influenza vaccination Written Directive used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. It focussed on whether the Directive was used in accordance with agreed inclusion criteria and national recommendations. Documenting the brand on the consent form - add to training. Doses should be written in millilitres, not written as pre-filled syringe - add to training. Results to be shared with peer vaccinators.

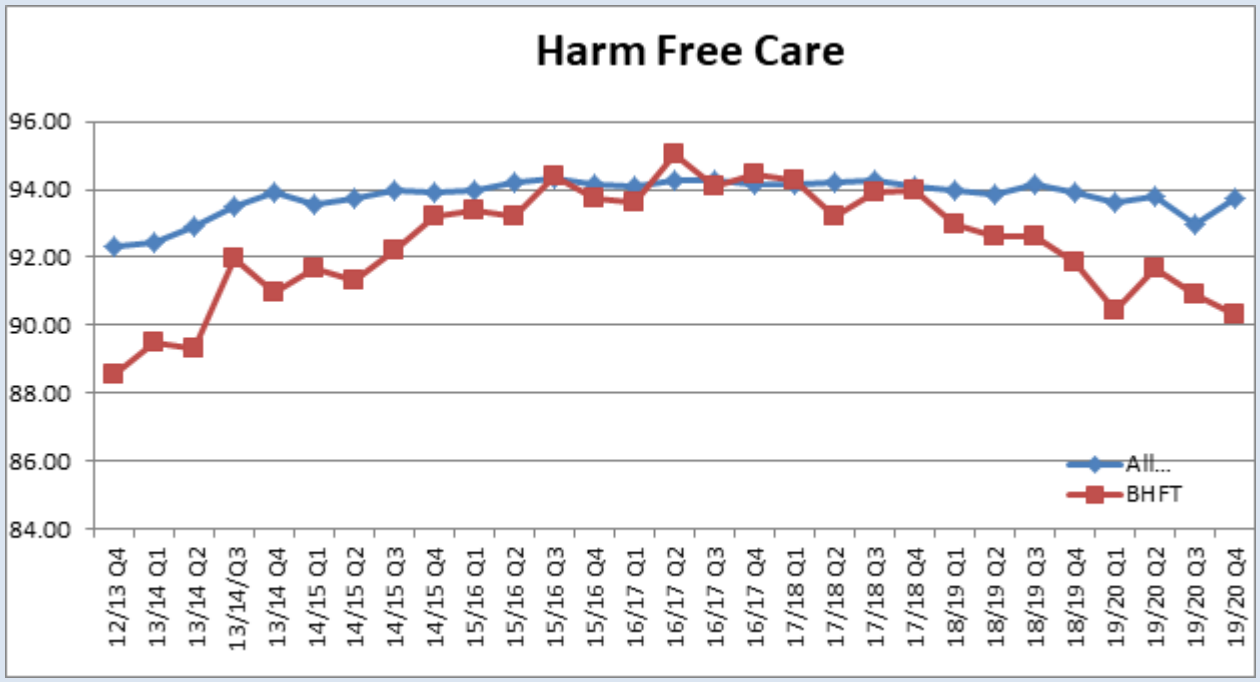
Audit Title		Conclusion/Actions
25	Junior Doctor project - Consent to Treatment with Psychotropic medications audit on Rowan and Orchid Wards (3945)	To compare how the current documentation for consent for psychotropic medications compares with the current GMC guidance "Consent: patients and doctors making decisions together on Rowan and Orchid wards. Aim to improve the consenting process for psychotropic medications on Rowan and Orchid wards Objective to determine the current extent to which documentation for consent for psychotropic medications compares with the current GMC guidance. To increase awareness of the importance of this documentation by presenting audit poster to the team during ward round. Improve availability of patient information leaflets that are clear for the patient demographic on Orchid and Rowan wards. Introduce easy template for Rio notes, to be used when a new psychotropic medication is being prescribed. Re-audit.
26	Junior Doctor project - Clinical audit - Informing PPH in-patients of DVLA guidelines (5297)	There are well established guidelines on giving patient advice in relation to driving and various physical illnesses. DVLA guidelines relating to mental health were updated in February 2019. However, the information is limited with regard to mental illness, even though mental illnesses can affect an individual's ability to drive. The aim was to assess how many patients were given this information during their admission at Prospect Park Hospital. Standards were based on the DVLA guidelines "Assessing fitness to drive – a guide for medical professions (September 2019, DVLA). A sample proforma provided to the patients admitted for them to inform the DVLA of the hospitalization voluntarily. Discussion with clinicians on the pros and cons of providing a DVLA form to every patient admitted to the hospital and either including the form in the patient admission pack or introducing it at the CPA meeting.
27	Junior Doctor project - Benzodiazepines prescription in an acute adult psychiatric setting, compared to best practice guidance. (5481)	Benzodiazepines may be required acutely in the short term for people with serious mental illness such as schizophrenia, bipolar disorder or depression. Despite all efforts to limit the risk for misuse and dependency of this class of medication, evidence suggests that this problem has been exponentially growing. An audit was required due to two recent Trust cases where patients died due to the combination of benzodiazepines with other psychotropic and pain relief medications. There was a need for an in-depth review of the size of this problem and how to better manage the way benzodiazepines are prescribed. A staff survey to gauge barriers to compliance. Identification of online learning modules. Liaison with pharmacy leads regarding potential for provision of up-to-date prescribing guide to benzodiazepines. Liaison with RIO team to identify potential for a template to aide regular medication reviews.
28	Audit of Gillick and Capacity assessments for Willow House on admission (5496)	Willow House is the Tier 4 unit for BHFT providing admission predominantly for Berkshire patients and the neighbouring counties; Buckinghamshire, Oxfordshire, Gloucestershire and Wiltshire. Willow House is composed of a full multidisciplinary team including medics. Assessment of competency (in under 16-year olds) and capacity (in over 16-year olds) are an essential part of admissions. This area in adolescent psychiatry may easily infringe upon human rights and deem admissions as unlawful if not clearly assessed and documented. Willow House needs to demonstrate compliance with the Mental Capacity Act 2005 code of practice. From the families' perspective, Willow House is keen to be understood as a law-abiding organisation which complies with regulations in addition to least restrictive practice. To revisit the knowledge of all junior doctors involved in the admission process and those new in post in Willow House. To include these assessments on the admission checklist and to print off the admission checklist in the nursing station for any junior doctor to be able to view. This would allow 100% compliance with the competency/capacity assessments. Establishing a more robust system of checking that all processes of admissions took place to the highest standards. Highlighting to the team the legal importance of these assessments will inform future practice.

Audit Title		Conclusion/Actions
29	Junior Doctor project - Study to evaluate patient risk management & safety planning for East Berks Psychological Medicine Adult Liaison Team at Wexham (5235)	East Berkshire Psychological Medicine (EBPM) Adult Liaison team is a 24/7 service based at Wexham Hospital which delivers mental health assessments and management for acutely unwell patients within an A&E setting and those admitted to acute wards with physical health issues presenting with psychiatric problems. The Royal College of Psychiatry Good Practice emphasizes the need for a high expected standard of care within a patient care-plan in which risk management and safety planning is mandatory. NICE states that a risk management plan can help people who self harm to reduce their risk of repeating. It should be based on a risk assessment and developed with the person who has self harmed, who should have joint ownership of the plan. The purpose of this audit was to detect the proportion of patients who were referred, assessed and discharged back to the community within the 2-week time frame; to evaluate whether they were actively informed of their care and signed the approved safety plan put in place; to identify the possible need for further safety planning for patients who may be admitted, referred back to the ward and reviewed for clinics. Increase staff awareness and education for the need to write up, discuss and log safety plans for all patients discharged back into the community. Type into 'progress notes' in RIO straight after FIRST contact with patient Provide same procedure of issuing a safety planning consultation for those even within wards and/or being reviewed for clinics.
30	Junior Doctor project - Driving in Dementia Re-Audit (5387)	People with early dementia may be fit to drive if sufficient skills are retained and progression is slow, however a license is issued that is subject to annual review. This audit aims to establish to what extent clinicians in the Memory Clinic are following GMC guidance. Objective to assess the quality of the clinical documentation in line with GMC guidance regarding DVLA assessments for fitness to drive. Documentation of driving status - regardless of obviousness of patients not driving, this should still be explicitly documented. Re-audit to maintain high standards of compliance.
31	Junior Doctor project - Assessment of the performance of Patient Observations undertaken on two older adult Mental Health Wards, PPH. (5401)	The existence of co-morbid chronic physical health conditions alongside mental health problems is common and the number of people living with two or more conditions is rising rapidly especially in the elderly. This audit aimed to assess the performance of regular physical observations as a means of screening for deterioration in physical health in Rowan and Orchid ward inpatients at Prospect Park Hospital. A 'Physical Health Observations – General Tips' poster was written, and five copies were distributed on each ward so that ward staff could be reminded to perform physical observations at least once a day. Increase awareness of the importance of this project's results by presenting to the team during ward round, briefly highlighting the need for better compliance. Use Datix to highlight missing physical health observations on RiO as per Trust's procedures. Raise the issue at one of the ePMA governance meetings and discuss the possibility of introducing a pop-up alert system which would alert the nurse accessing a patient's drug card on ePMA that physical health observations are required.

Appendix D- Safety Thermometer Charts

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

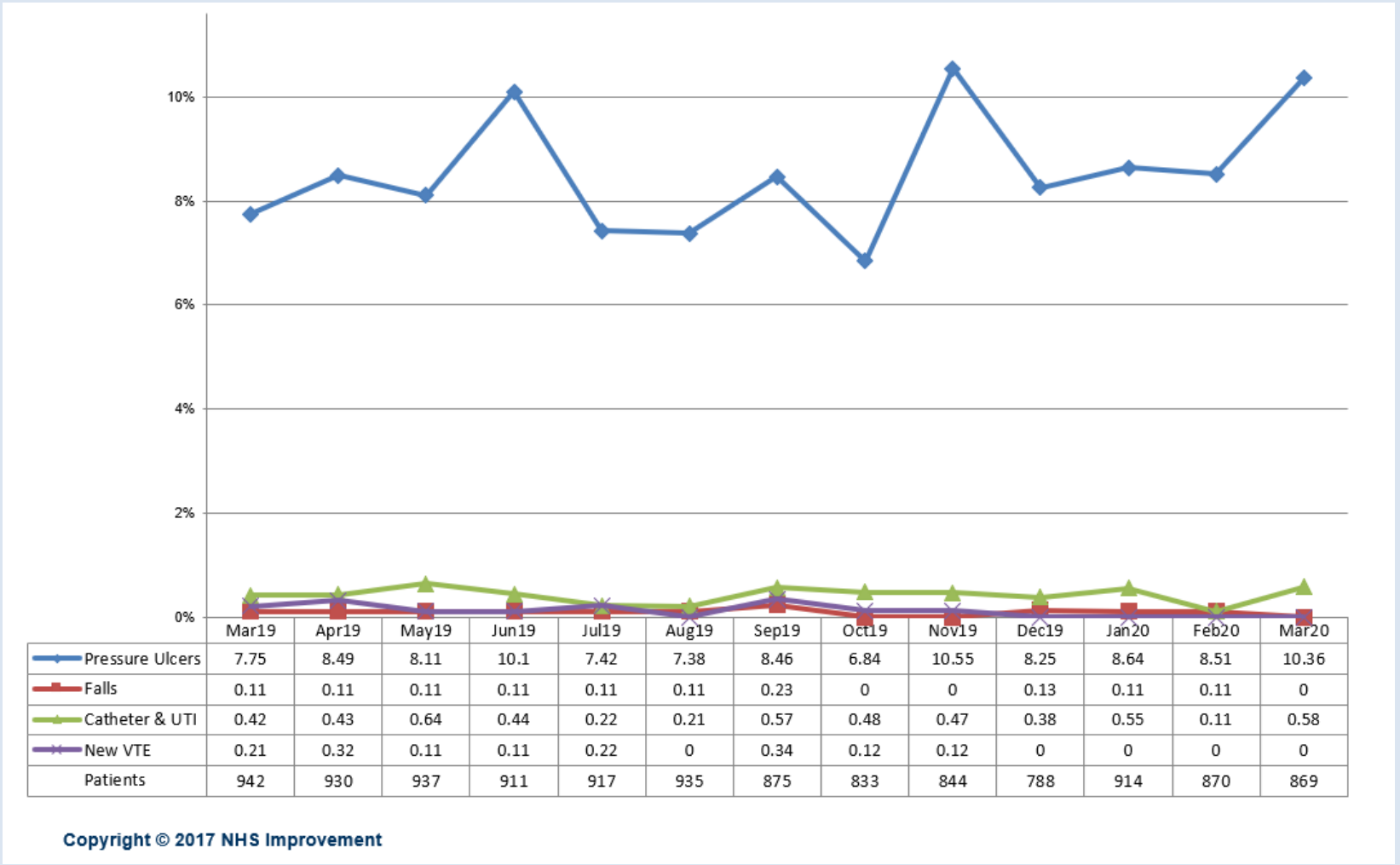
When interpreting the charts below, it should be noted that this Safety Thermometer data does not show the total number of each type of harm for the Trust, but only those that are recorded at a specific point in time each month. Old pressure ulcers and catheters with old UTIs are harms which we must own despite being inherited by the Trust and therefore largely beyond our influence.



Source: Trust Safety Thermometer Reports

Types of harm

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



	Mar19	Apr19	May19	Jun19	Jul19	Aug19	Sep19	Oct19	Nov19	Dec19	Jan20	Feb20	Mar20
Pressure Ulcers	7.75	8.49	8.11	10.1	7.42	7.38	8.46	6.84	10.55	8.25	8.64	8.51	10.36
Falls	0.11	0.11	0.11	0.11	0.11	0.11	0.23	0	0	0.13	0.11	0.11	0
Catheter & UTI	0.42	0.43	0.64	0.44	0.22	0.21	0.57	0.48	0.47	0.38	0.55	0.11	0.58
New VTE	0.21	0.32	0.11	0.11	0.22	0	0.34	0.12	0.12	0	0	0	0
Patients	942	930	937	911	917	935	875	833	844	788	914	870	869

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

Appendix E- CQUIN 2019/20

CQUIN Indicator Name
Staff Flu Vaccinations – All Staff
Alcohol and Tobacco – Mental Health Services and Community Health Services
72 Hours follow up following Discharge – Mental Health Services
Use of Anxiety Disorder Specific Measurements in IAPT
CCG5 MHSDS Data Quality

Appendix F- CQUIN 2020/21

To be added when available

Appendix G- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2019/20

Response from Council of Governors of the Trust

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

Governors are interested in trends which show year on year improvement in Trust performance. We are pleased to see that the latest review from the Care Quality Commission rates the Trust as 'outstanding' and we believe this reflects a can-do attitude among staff and management. This has been profitably channelled through the 'QI Quality Improvement' initiative which is touching all staff in the Trust, as well as other initiative many of which are described in section 2.1 of the report.

Governors are pleased about the improving trends in the performance of the Trust in relation to many of their patients. We recognise however that a good level of care this year does not automatically mean that it will be the same next year and management vigilance and hard work is necessary to maintain a level of excellence. We also want recognition of the important role carers play in a patients' recovery, and we are pleased the Trust is taking a new initiative in this area.

We are interested in the well-being of staff without which Trust services could not operate. The NHS has a mixed reputation in relation to looking after employees, and we are pleased that management responds to issues that become apparent through the nationally mandated staff survey. This is an area where being rated highly among peers is not necessarily good enough!

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

The Trust is developing a new measure of patient satisfaction. Governors are looking forward to seeing this in action, probably as a supplement to the nationally mandated measure known as the 'Friends and Family Test'. Unlike the latter, this new measure will enable patient feedback to be used as a both a prompt for change and a measure of improvement in the services delivered.

These comments are based on the Quality Account for the third quarter of 2019-2020. The draft report was circulated to the 32 members of the Council of Governors for the Trust in March 2020. All governors were given the opportunity to comment. There were a number of requests for clarification of figures and suggestions for improvement. All feedback is passed on to the team responsible for the report.

Paul Myerscough, Lead Governor.

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response from the Council of Governors to its 2019/20 Quality Account.

We thank Governors for the comments made and are grateful to those that have helped to contribute to the report during the year.

We are determined to continue providing a high level of care to our patients and acknowledge that vigilance and hard work is required to maintain this. The wellbeing of our staff is also one of our top priorities and we will continue to promote and monitor this throughout the year.

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

Commissioners Response – BHFT Quality Account 2019/20

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

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account 2019/20 submitted by Berkshire Healthcare Foundation Trust (BHFT).

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for 2019/20 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2020/21 are also detailed in the report.
The CCGs are committed to working with the Trust to achieve further improvements and successes in the areas identified within this Quality Account.

The Trust's Quality Priorities highlighted in the 2019/20 Quality Account were Patient Experience and Involvement, Patient Safety, Clinical Effectiveness and Supporting Staff.

Patient Experience and Involvement
It was disappointing that BHFT did not achieve the 15% response rate for the Friends and Family Test (FFT), but we can see that there has been a lot of work put in to trying to improve the uptake with an achievement of 11% over Q2 and Q3. Whilst it was really positive to see that the 95% satisfaction rate was achieved in Community Hospital Inpatients and Minor Injuries, it is also commendable to see that the Community Services (Mental and Physical Health combined) were just below the 95% target with 93%. Although there have been increases for the Mental Health Services from 2017/18 and 2018/19, it remains below the 95% target.
There are some great results from the Trust with regards to reducing their use of prone restraint; BHFT are below the mean line in national benchmarking data and they have exceeded their target of a 50% reduction by achieving 61%. It is however during the summer months that the target of 2 prone restraint occurrences in a month was exceeded. The CCG would like to commend the Trust on all of their hard work in this area.
The CCG's acknowledge the difficult position that the Trust is in with regards to working across two large Integrate Care Systems (ICS). The work streams that have been achieved across the Berkshire West ICP and the Frimley Health and Care ICS are admirable.

Patient Safety
The hard work already implemented into reducing the suicide rate is evident and is reflected in the data for the Trust in 2018/19. The Trust have further actions in progress to reduce this further.

Whilst it is disappointing to not see the rate of falls per 1000 bed days below the target, the work that is being implemented under the Quality Management Improvement System (QMIS) has shown a significant reduction already. It is really positive to see just one moderate medication error incident reported in the previous year and the CCG would like to congratulate the Trust on reducing the more serious medication error incidents.
We would also like to congratulate the Trust on reducing the number of category 3 and 4 pressure ulcers and the numbers are significantly below the target and although it is not the same picture for the category 2 pressure ulcers, it is positive to see that the focus will be increased into next year.

Clinical Effectiveness
It is reassuring to see that the Trust has reviewed their position against the Post-Traumatic Stress Disorder (PTSD), Care and Support of People Growing Older with Learning Disabilities and Depression in Children and Young People – Identification and Management NICE Guidance's and it is reassuring to see that actions are in place for those areas that are not quite being achieved.

Supporting Staff
The commissioners were very pleased to see the Trust has successfully achieved the target of having less than 10% of vacancies and have been below 8% since September 2019. The work that is being completed is very creditable to the Trust. This is also reflected in the staff turnover rate that has also been below the required target since September.
Although there are fluctuations in the number of physicals assaults on staff, until the end of Q3 the Trust are achieving the overall target of reduction of 20% when averaged across the year.

The Quality Account does highlight a number of other service improvements that have been undertaken in 2019/20 and that this will be continued in 2020/21.

Priorities for 2020/21
The Trust has set out the priorities for 2020/21 which are as follows:

- Harm-Free Care
- Clinical Effectiveness
- Patient Experience
- Supporting Staff
- Monitoring of Priorities for Improvement

The Commissioners would like to continue to be informed of any new quality achievements or concerns identified during 2020/21 and for the opportunity to support the Trust with these. The Commissioners would like to continue to work with the Trust on service redesign to improve patient outcomes.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response to its 2019/20 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs.

The Trust thanks the CCGs for the comments made in relation to achievements during the year and welcome the continuing support and partnership they offer to improve healthcare system-wide.

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

Appendix H- Independent auditor's report to the Council of Governors of Berkshire Healthcare NHS Foundation Trust on the quality report

The requirement to gain external assurance for the Quality Account was removed in 2019/20 to the COVID-19 pandemic. As a result, there is no independent auditors report for this account this year.

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
ASQ	Ages and Stages Questionnaire
AMS	Anti-Microbial Stewardship
ARC	Assessment and Rehabilitation Centre
ASD	Autistic Spectrum Disorder
AWOL	Absent Without Leave
BAME	Black Asian and Minority Ethnic
BEDS	Berkshire Eating Disorder Service
BFI	Baby Friendly Initiative
BHFT	Berkshire Healthcare NHS Foundation Trust
BOB STP	Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership
BPD	Borderline Personality Disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CLAS	Children Looked After and Safeguarding
CMHT	Community Mental Health Team
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CSII	Continuous Subcutaneous Insulin Infusion
CTPLD	Community Team for People with Learning Disabilities
CTS	Complex Treatment Service
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
DBT	Dialectical Behavioural Therapy
DOC	Duty of Candour
DoLS	Deprivation of Liberty Standards
DQMI	Data Quality Maturity Index

Acronym	Full Name
DTC	Drugs and Therapeutics Committee
DTI	Deep Tissue Injury
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ECTAS	Electroconvulsive Therapy Accreditation Service
EIP	Early Intervention in Psychosis
EMDR	Eye Movement Desensitisation and Reprocessing
EPMA	Electronic Prescribing and Medicines Administration
ESR	Electronic Staff Record
EUPD	Emotionally Unstable Personality Disorder
FFT	Friends and Family Test
GASS	Glasgow Antipsychotic Side-effect Scale
GDE	Global Digital Exemplar
GDPR	General Data Protection Regulations
GGT	Gamma-glutamyl transpeptidase
HCA	Healthcare Assistant
HEN	Home Enteral Nutrition
HV	Health Visitor
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
ICDM	Integrated Care Decision Making
ICP	Integrated Care Partnership
ICS	Integrated Care System
IFR	Initial Findings Report
IM	Intramuscular
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPS	Individual Placement and support (Employment Service)
LAI	Long Acting Injectable
LD	Learning Disability
L&D	Liaison and Diversion
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse in Care
LoS	Length of Stay
MBT	Mentalization-Based Treatment
MCI	Mild Cognitive Impairment
MDT	Multi-Disciplinary Team
MH	Mental Health
MHA	Mental Health Act
MHRA	Medicines and Healthcare products Regulatory Agency
MHSDS	Mental Health Service Data Set
MIU	Minor Injuries Unit

Acronym	Full Name
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
NACAP	National Asthma and COPD Audit Programme
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCCMH	National Collaborating Centre for Mental Health
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide
NDA	National Diabetes Audit
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
OAP	Out of Area Placement
Ofsted	Office for Standards in Education, Children's Services and Skills
OPMH	Older Peoples Mental Health
PCN	Primary Care Network
PDSA	Plan, Do, Study, Act (A Quality Improvement methodology)
PFD	Preventing Future Deaths
PICC	Peripherally Inserted Central Catheter
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PMS	Psychological Medicine Service
PMVA	Prevention Management of Violence and Aggression
POMH	Prescribing Observatory for Mental Health
PPEPCare	Psychological Perspectives in Education and Primary Care
PPH	Prospect Park Hospital
PTSD	Post-Traumatic Stress Disorder
PU	Pressure Ulcer
QI	Quality Improvement
QMIS	Quality Management and Improvement System
R&D	Research and Development
RBH	Royal Berkshire Hospital
RIE	Rapid Improvement Event
RiO	Not an acronym- the name of the Trust patient record system
RTT	Referral to Treatment Time
SEND	Special Educational Needs and Disability
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMI	Severe Mental Illness

Acronym	Full Name
SOF	Single Oversight Framework
SOP	Standard Operating Procedure
SUS	Secondary Users Service
TILS	Transition, Intervention and Liaison Service
UC+S	Urine Culture and Susceptibility
UEC	Urgent and Emergency Care
UTI	Urinary Tract Infection
VFC	Virtual Fracture Clinic
VR	Virtual Reality
VTE	Venous Thromboembolism
WRES	Workforce Race Equality Standard

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting Date	14 July 2020
Title	Medical Appraisal & Revalidation—Annual Board Report and Statement of Compliance for 2019/20
Purpose	To assure the Trust Board that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.
Business Area	Medical Director
Author	Dr Minoo Irani, Medical Director & Responsible Officer
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports CQC 'well led' inspection and safe patient care
Resource Impacts	Currently 0.5 wte Band 5 administrator and 1 Additional Programmed Activity for Appraisal Lead
Legal Implications	Statutory role
Equalities and Diversity Implications	N.A
SUMMARY	131 medical appraisals were completed in 2019/20 for 133 doctors with a connection to the trust for revalidation purposes. The 2 incomplete appraisals (approved by the RO) relate to doctors on long term sick leave (1 Consultants and 1 Specialty Doctor). These are extremely small numbers of missed appraisals, would benchmark very favourably against other trusts and do not raise concern. The report details improvements implemented in the medical appraisal and revalidation system in the trust and provides assurance that the trust remains compliant with good practice for medical appraisal and revalidation.
ACTION REQUIRED	Trust Board to note assurance provided by the RO that medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust. The Chairman signs the Statement of Compliance of the report annually, following receipt of this assurance from the RO. In 2020, due to the Covid 19 pandemic, assurance processes at regional and national level have been paused

	and none of this is expected to be submitted at least for now. The Medical Director is of the opinion that irrespective of national assurance requests, the trust board should receive this assurance.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

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Prepared by: Lynda Norton, Claire Brown, Maurice Conlon

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

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Introduction:

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

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

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

- **Board Report template:**

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

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

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

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

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

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

c) act as evidence for CQC inspections.

- **Statement of Compliance:**

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

Designated Body Annual Board Report

Section 1 – General:

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

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

The AOA for 2019/20 was not submitted by the Responsible Officer in line with national guidance (letter 19 March 2020 from National Medical Director *https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/letter-from-prof-powis-to-ros-and-mds-19-march-2020.pdf*) The AOA Comparator report for 2019/20 will not be available as a result of the above. This report benchmarks trust appraisal figures with other trusts (same sector and all sector). In the absence of that, to give context to the Board, given the figures below for completed appraisals, the trust is extremely likely to exceed the same sector and all sector completed appraisals benchmark. This has been the case for 2017/18 and 2018/19 as noted from the benchmark reports published for those years. 131 completed appraisals were confirmed for 2019/20, for 133 prescribed connections. 1 Consultant appraisal and 1 Specialty Doctor appraisal were approved as missed because the doctors were on long term sick leave. There are no adverse trends noted from the appraisal figures that would require specific action for 2020/21.

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

Dr Minoo Irani was appointed as Medical Director (interim) and Responsible Officer (RO) for Berkshire Healthcare and started in this role on 2 November 2015. Dr Irani has completed the required RO training, has regularly attended the NHSE (South) RO Network meetings and is member of the GMC RO Reference Group since November 2015. There are no additional training needs currently identified for Dr Irani in relation to his RO role in his medical appraisal or PDP. The Trust appraisal lead attends annual refresher training events in the region and at least one of the NHSE (South) RO and Appraisal Leads network meetings every year. During the Covid pandemic, all regular networking events related to the RO role have been suspended. The RO keeps up to date about appraisal and revalidation matters during this period from GMC newsletters, GMC website information and discussion with the GMC Employment Liaison Advisor.

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

The RO is supported by a 0.5 wte appraisal and revalidation administrator and a Consultant Psychiatrist who is appraisal lead for the trust who has one Additional Programmed Activity per week allocated for this role.

There are no pending actions from last year or additional actions required in 2020/21 in this regard.

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

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

The RO and Revalidation administrator have access to GMC connect and the RO regularly refers to this at the monthly Decision Making Group (DMG) meetings. The DMG is attended by the RO, Associate Medical Director, Appraisal Lead, Medical Workforce Manager and the revalidation administrator.

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

There are no pending actions from last year or additional actions required in 2020/21 in this regard.

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

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

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

There are no pending actions from last year or additional actions required in 2020/21 in this regard.

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

The Revalidation Team from NHS England (South) visited the trust on 12 May 2015 for a peer based Quality Assurance of the medical appraisal

process in the Trust. The visiting panel made recommendations for improvement which were all implemented by the RO in 2016/17.

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

The RO commissioned the trust internal auditors to review the medical appraisal process in July 2016 and this was reported in August 2016. The auditors identified one 'Medium' priority issue-- 'The Appraisal Policy for Medical Staff (ORG084) and relevant guidance is outdated and does not reflect current operating practice'. The RO accepted this recommendation and acknowledged that the wide-ranging improvements made in 2016 with the medical appraisal process were not part of the policy which existed at that time. The policy was re-written to reflect the improvements made in appraisal process and was published by December 2016.

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

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

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

Section 2 – Effective Appraisal

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

Whole practice appraisals on annual basis are the norm in Berkshire Healthcare and doctors and appraisers have had frequent updates about this during internal training. As part of Quality Assurance of appraisals, the appraisal lead assesses the quality of a sample of completed appraisal MAG

forms using a standardised tool (PROGRESS) and presents a summary of the quality reviews to the appraisal forum to facilitate improvement in practice and standardisation of the appraisal content and output. This process confirms that whole practice appraisals are now the standard in the trust.

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

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

Not applicable

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

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

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

The trust has 26 trained appraisers for 133 connected doctors. There was advance planning to replace appraisers who were due to retire and 4 additional doctors were appointed as appraisers in the trust in 2019/20 to offset predicted retirements in 2020.

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

The appraiser forum meeting (chaired by the RO/ appraisal lead) occurs three times a year to provide peer support and updates to appraisers with respect to revalidation and appraisal requirements. The RO provides updates from NHSE RO forum which he attends and signposts any new guidance published. The appraisal lead presents data (appropriately anonymised) from MAG forms in the previous quarter with respect to content of the MAG forms

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

and appraiser narrative and judgements. This is in the context of training for improving the quality of documentation and discussion at appraisal meetings.

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

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

A sample of MAG forms is subject to Quality Assurance by the appraisal lead using the PROGRESS tool. The RO receives this information (13 MAG forms were Quality Assured by the appraisal lead in 2019/20). When a doctor's revalidation recommendation is due, the Appraisal lead provides the RO with a summary of all MAGs and confirms that the GMC supporting information for appraisal and revalidation have been met. If there are any queries and for a sample of all completed MAGs, the RO also reviews MAG forms before making a revalidation recommendation.

Annual revalidation reports to the trust Board include information about number of doctors who have completed annual appraisals.

Section 3 – Recommendations to the GMC

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

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

37 doctors were due for revalidation in 2019/20. The RO made recommendation to revalidate for 34 doctors and to defer for 3 doctors (one of the 3 deferrals was for 6 months and hence recommended for revalidation within the year). Additionally, 3 doctors were 'under notice' for revalidation in early 2021 and were recommended for revalidation in March 2020.

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

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

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

Section 4 – Medical governance

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

Berkshire Healthcare has an effective clinical governance system for all clinical staff (including doctors) and this has been reviewed by the CQC through their well-led inspections of the trust. Doctors are supported through Trust governance processes through medical leads, Service Managers and Clinical Directors. The Clinical Effectiveness and Audit department also support doctors through implementation of NICE Guidelines and participation in national and local clinical audits.

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

Any concern about the conduct/ performance of doctors is managed through an established process involving the service manager, Associate Medical Director/medical leads, Lead Clinical Director/ Clinical Director and RO (Medical Director). The performance of doctors is monitored through a system of line management coupled with professional accountability to the Medical Director. The quality governance systems for the Trust, including with respect to incidents and complaints, support the monitoring of doctors' performance. PDP groups and peer groups provide feedback to the psychiatrists on their performance and professional expectations. Doctors engage with clinical audit activities, including national audits to assess their/ team performance which is benchmarked with other trusts. The process of enhanced medical appraisal has fostered improved engagement from doctors with respect to monitoring performance with improved visibility for appraisers and the Responsible Officer / Medical Director. This includes reflection on patient and colleague feedback. The revalidation administrator provides the appraiser and doctor with information about incidents and complaints recorded on Datix and specific to the doctor, approximately 2 months in advance of the allocated appraisal date. Reflection/ discussion of governance issues raised is monitored through the Quality Assurance of MAG forms by appraisal lead.

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

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

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

Trust Chairman and CEO are kept informed if any doctor is subject to the Trust Policy on Disciplinary Procedure for Medical and Dental Staff. This procedure was not required in 2019/20.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[4].

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

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

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

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

Clinical Governance arrangements for doctors including processes for responding to concerns about a doctor's practice are transparent and information about how decisions are made are communicated to doctors in a timely manner. All relevant trust policies have mechanisms to enable doctors to appeal a decision. The medical director will invite doctors subject to concern or investigation for a meeting to explain the process and obtain assurance about the doctor's feedback and reflection. On 18 Dec 2019, the RO led a discussion with the GMC Employment Liaison Advisor (ELA) about item 5 in the GMC Governance Handbook—Principle 3: safeguards are in place to make sure clinical governance processes for doctors are fair and free from discrimination and bias. The RO was joined in this discussion of evidence by the medical workforce manager and the Deputy Director of Allied Health Professionals and equality and diversity. The ELA was satisfied with the work done by the trust to support medical staff in this respect.

Section 5 – Employment Checks

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

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

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

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

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

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

Section 6 – Summary of comments, and overall conclusion

Engagement from doctors with the appraisal process in the trust continues to remain high, number of trained appraisers in the trust are adequate and governance processes in the trust are robust with safeguards at several levels—medical leads, service managers, clinical directors and medical director to provide assurance about the doctors' fitness to practise.

During 2019/20, the RO led the review and implementation of additional governance process in the trust for medical staff (with support from the Decision Making Group) in relation to the following:

1. A practical guide for Responding to Concerns about medical practice (NHSE, March 2019). The Associate Medical Director prepared a summary of implementation requirements for medical leads, the medical director discussed this with all medical leads and incorporated the guidance into a process flowchart for ease of reference.

2. Effective Clinical Governance for the Medical Profession handbook (CQC, GMC). The Medical Director led on a discussion with the GMC Employment Liaison Advisor and completed the self-assessment template section related to equality and diversity.

For 2020/21, the RO has also proposed a standard process for receiving the appraisal output summary from GPs contracted to work in the trust Westcall out of hours' service and for the very small number of doctors who work in the trust and have a connection elsewhere. However, given that annual medical appraisals have been paused nationally for 2020/21, the RO may not receive the appraisal outputs from these doctors as expected in the year.

Overall conclusion:

The Board is asked to receive the annual revalidation report for 2019/20. This will be made available to the higher level Responsible Officer from NHS England South upon request (since the standard process of submission of statement of compliance has been paused for 2020 in view of the Covid pandemic). The Board can be assured that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.

The Responsible Officer is confident that following continuous implementation of improvement actions from national governance recommendations and learning at national networking meetings, the Trust is in line with good practice in similar organisations with respect to medical appraisals and revalidation.

Section 7 – Statement of Compliance:

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

Signed on behalf of the designated body

Official name of designated body: Berkshire Healthcare NHS Foundation Trust

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

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

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

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board	14 July 2020
Title	Six Monthly Safe Staffing Review (October 2019 – March 2020)
Purpose	To provide the Board with information that supports safe staffing review across out community wards and the safe staffing position that is derived from this information
Business Area	Nursing
Author	Heidi Ilsley, Deputy Director Nursing
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff and Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience and delivery of safe care
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	N/A
SUMMARY	This report supports the 2016 National Quality Board and October 2018 NHS Improvement Developing Workforce Safeguard expectations in relation to board oversight of staffing on the wards and an annual review of staffing establishments using nationally available tools, benchmarking and clinical judgement. Workforce and quality data is also considered within the report. As required the report also details Nursing and Medical Director declaration that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This is detailed in full on page 17 of the report. During this reporting period the main challenge associated with all of our wards continues to be that of recruitment and retention of registered nurses and as a consequence the ability to achieve 2 registered nurses on each shift. It should however be noted that the number where 2 registered staff was not achieved equated to only 3% of total shifts (a reduction from 5.6% in last report) and for many of these occurrences ward managers and other senior clinicians who are registered nurses and therapy staff who are not counted in to the figures were available to provide support. During this reporting period senior staff and managers have continued to deploy the available staff resource to maintain safety, with all areas having mitigation and processes in place for when there are staff shortages.

	The outcome of this staffing review is that for Orchid, Rowan, Sorrel, Campion, Henry Tudor, Jubilee, Oakwood, Donnington, Highclere and Wokingham wards and also Willow House the current agreed establishments alongside use of additional staffing to meet increased acuity and observations is at the right level to achieve safe staffing. Although it is recognised that due to vacancy levels and reliance on temporary staff at times this level is not achieved For the acute mental health wards (Rose, Snowdrop, Daisy and Bluebell) the planned pilot of an activity coordinator role to provide increased care hours per patient day for patients alongside increased ability to provide therapeutic input has now been completed on Snowdrop ward and it is expected that this will now be rolled out to all 4 acute wards. Programmes of work and targeted support continue to be provided to those areas with significant recruitment/ retention challenges and this is seeing positive results. Prospect Park Hospital have 20 newly registered staff commenced over this period and a robust support and training package is in place for them. With the exception of Wokingham our community wards have also been successful in reducing their vacancy factor. In addition, there is much focus on staff well-being to support a reduction in sickness absence as well as retention with a Well-being Lead having commenced in the Trust in September 2020. In terms of medical staffing, numbers in the trust remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards.
ACTION	The Board is asked to: Consider this report and note the declaration provided by the Director of Nursing and Therapies and the Medical Director

Six Monthly Safe Staffing Review
October 2019 to March 2020

1.0 Executive Summary

The purpose of this report is to provide assurance to the board of the Trusts compliance with safe staffing in line with expectations of the National Quality Board (2016) and the NHSI Developing Workforce Safeguards guidance (2018), along with the declaration from the Director of Nursing and Therapies and the Medical Director that safe staffing is in place across the organisation. The report is limited in some areas, notably the biannual review of safe staffing benchmarking due to Covid-9 and the redirection and streamline of services during this time. In March, the staff redeployment programme was commenced. NHS Improvement suspended the collection and external reporting of Care Hours Per Patient Day (CHPPD) as the NHS responded to the COVID19 pandemic although the internal monitoring of safe staffing continued.

In January, the NHS Long Term Plan was published and set out the direction for the future health services. Part of this is ensuring that NHS providers have the appropriate number and skill mix of staff to keep patients safe and deliver high quality of care, with a focus on mental health, learning disabilities and community services.

From September, Berkshire Healthcare were required by NHSi, to include non-registered nursing associates (NA) in staffing figures reported because their training is work based and NHSi plan to monitor this training pathway within Trusts.

Registered nurse vacancies on inpatients wards remained a challenge, reflective of the national picture. Prospect Park Hospital (PPH) through their dedicated recruitment and retention programme have achieved a more staffing positive picture and currently has the lowest registered nurse vacancy rate for the past two years. Community Health wards (CHS) and Willow House are continuing to recruit to registered nurse posts.

The recruitment of newly qualified registered nurses support staffing numbers and continuity of care on the wards but with this comes the extra pressure on senior staff as they support these staff through their preceptorship especially when this is alongside continually high occupancy, high patient acuity and high use of temporary staff to meet patient need.

In line with national reporting shifts with less than two registered nurses are monitored each month. The number of shifts reported with less than two registered nurses has decreased since the last six-month report, 268 shifts were reported during this period, compared to 493, in the previous six-month period. This represents a continued decrease since last year. During the reporting period there were 9,333 available shifts across the wards and the total number of shifts (268) with less than 2 registered nurses equates to 2.9%. At PPH there were 5% of shifts with less than two registered nurses (Bluebell ward was the highest with 58 shifts), although other wards are more easily able to support and a Duty Senior Nurse (DSN) is available which reduces the risk further. Willow House number of shifts with only 1 registered nurse continued to decrease to 4.4% compared to 11.5% a year ago. West community health services had 1.7% of their available shifts with less than two registered nurses; Highclere ward and Ascot ward being the highest. All other wards had minimal shifts with less than two registered nurses; Jubilee ward reported no shifts with less than two registered nurses.

Reporting of incidents where staffing is below the expected / required number remains limited in certain areas with continued suspected under reporting in some areas which experience the most challenges with staffing for example, PPH. Most incidents reported have been assessed as having low or no impact due to the mitigation put in place by staff.

The significant number of registered nurse vacancies on inpatients wards has remained a high risk regarding safe staffing on the mental health wards and Willow House, although as detailed in this report most gaps due to vacancy are able to be covered with temporary staffing. Dedicated recruitment and retention programmes have had a positive effect on vacancies particularly with recruiting newly qualified registered nurses. This has been achieved by a focused approach to students in the last year of training, although staff shortages overall remain a challenge, reflective of the national picture.

This recruitment of newly qualified registered nurses support staffing numbers and continuity of care on the wards but with this comes the extra pressure on senior staff as they support these staff through their preceptorship especially when this is alongside continually high occupancy, high patient acuity and high use of temporary staff to meet patient need. Wards continue to support the preceptees from September 2019 at PPH and WBCH and four more have commenced at PPH, (one in October, two in December, one in March).

27,638 shifts were requested to support the wards in meeting their requirements for minimal staffing as well as providing additional cover for increased observational levels each month; 14.6% of these requests were not able to be filled. 31% of requested shifts were for registered nurses, 9% of which remained unfilled. Within PPH, the wards have been able to support each other, and support is also available from senior staff. West Berkshire community hospital and Wokingham hospital have worked with the teams to create more flexibility in covering their wards. The ability to maintain the required two registered staff per shift for every ward using substantive staff remains a significant challenge; many registered nursing shifts continue to be filled through NHSP although these are often Berkshire Healthcare staff doing additional hours over and above their contract.

1.1 Prospect Park Hospital (PPH)

The overall staffing situation at PPH has improved with the newly qualified registered nurses starting across the wards throughout the past six months and the resulting decrease in requested temporary shifts for registered nurses. There have been changes within the senior leadership team and ward leadership; daily staffing huddles are now standard practice within the hospital and allow the DSN, Matrons and Ward managers to identify staffing shortages and provide an oversight of activity within the hospital and together plan appropriate actions to ensure safe staffing cover within the hospital across the 24 hour period. This enables the Designated Senior Nurse (DSN) on duty to deploy or move staff to support areas where there is greatest need and staffing challenges which can change rapidly. This has been helpful in supporting Bluebell, Rowan and Orchid wards who have experienced recruitment challenges and increased difficulty in securing staff to cover minimal staffing recruitment and increased levels of observation. Rowan and Orchid wards, the older adult wards continue to care for patients with high physical as well as mental health needs.

PPH have commenced work with the finance team (PPH beyond budget) looking at ward hours required versus actual ward hours worked (section 3). This is looking at both qualified and unqualified staff required at any one time on the ward to meet safe staffing plus additional hours required for observation.

Patient acuity has remained high and this increased at the end in March as wards were dealing with increased patient physical health needs and associated higher levels of anxiety due to Covid - 19. Staff are supported by senior staff on the ward and the senior management team and to support with the Covid management, CMHT staff were redeployed into Prospect Park.

15,424 shifts were requested to support the wards in meeting their requirements for minimal staffing as well as providing additional cover for increased observational levels each month; 14% of these requests were not able to be filled. 27% of requested shifts were for registered nurses, 9.8% of which remained unfilled. Within PPH, the wards have been able to support each other, and support is also available from senior staff.

The wards have additional resource not captured in safe staffing which includes psychology and Occupational Therapy/ therapy assistants as well as the medical workforce. Staff who work across wards on a sessional basis are not calculated as part of the safe staffing measure.

Considerable work has been completed in manging the bed flow and reducing the bed occupancy at PPH, as detailed in table 5. Daisy and Rose wards continue to experience challenges with high bed occupancy throughout this reporting period where their rate has remained above 90%; some months above 95%. The other wards reflect the seasonal variation expected.

The number of reported shifts with less than two registered nurses has decreased to 192 (365 during March 2019 - September 2019) across the hospital. Snowdrop ward had the highest number of shifts with less than two registered nurses overall at 89, Bluebell ward were also high at 58 shifts within this reporting period, whilst Daisy ward had the lowest number with 9. The number of shifts reported with no registered nurses at the start of a shift has continued to decrease over the last two years with two (both in March) reported in this six-month period. This demonstrates the on-going work across wards on recruitment and with mobility of staff around the hospital to ensure safety of the all wards when this occurs. When this has occurred, staff are deployed from other wards and managers step in to work clinically.

Sickness rates (graph 4) have been varied across this reporting period with most wards above the Trust's target of 3.5 %.

1.2 Willow House

During this reporting period Willow House has been closed for three weeks in March for essential refurbishment due to the identified potential ligature risk from the bedroom windows. Prior to this work being completed, the unit was staffed with an extra unregistered nurse per shift to mitigate any risk. A lower bed occupancy has assisted in managing the young people who have required higher levels of observations. Willow House's bed occupancy has remained below 80% through this reporting period. The sickness rate has varied and at its lowest in December before rising above the Trust target.

There were 1687 temporary staffing requests, 35 % of requested shifts were for registered nurses due to their vacancy rate which has remained high. The unit have experienced difficulties at times to fill these shifts (12.5% were unfilled over the six months) even with using long term agency nurse placements.

The number of shifts with less than two registered nurses has decreased, with 16 shifts compared to 57 shifts reported in the previous six months. When there is one registered nurse on duty, the

nursing team are supported by the ward manager and a senior manager between the hours of 9am and 5pm. Outside of these hours there is access to a manager/senior nurse on call and further support from the DSN at PPH. Where necessary especially out of hours, staff are moved from PPH to Willow house to support the unit. There is no indication that safety has been compromised on the occasions where gaps have been unable to be filled by temporary staff. The programme to move Willow House onto the main Prospect Park site in 2021 continues as planned.

1.3 Campion Unit

Campion Unit has remained a very stable team with strong leadership; throughout the six months there has been high levels of observations for a number of patients on the unit due to safeguarding and patient and staff vulnerability. This reflects the very complex and challenging patients on the unit. 2450 temporary shifts were requested to meet the requirements of levels of observations; 26% were requests for registered nurses. The low unfilled rate (4%) is due to the unit predominantly using their own staff to cover additional staffing requirements which provides continuity of care to the patients.

The average bed occupancy during the reporting period has been 75%. The sickness rate has been above the Trust target, varying between 0-9%. Work continues on the development of the new Learning Disability Unit which will be located on Jasmine Ward at PPH.

1.4 Community Wards

West Community Health Wards (CHS)

Vacancies have varied across the wards throughout the reporting period. Oakwood and Wokingham wards have a high number of vacancies which has meant higher temporary staffing requests, particularly for registered nurses. West Berkshire Community Hospital were the first to be successful with a focused recruitment programme which Oakwood and Wokingham units are following with reasonable success. Despite this, there continues to be relatively high number of vacancies which has meant higher temporary staffing requests, particularly for registered nurses. In Wokingham there have been changes within ward leadership which are creating a more stable team.

Bed occupancy has been lower than expected across all wards for this six-month period (average 83%) which has assisted wards to manage their safe staffing requirements. West CHS wards have continued with regular meetings with the acute Trusts to increase communication and support patient flow for the community beds and identify suitable patients earlier which will assist a more consistent bed occupancy across the West wards.

January was a particularly challenging month with high patient acuity in all west wards and with continued high vacancy rates on Oakwood and Wokingham it was difficult to meet staffing requirements.

Sickness rates have been consistently above the Trust's agreed target of 3.5% in all wards due to high numbers of long-term sickness which the wards have been managing with the support of human resources procedures. January and February were the most challenging months combined with annual and Nursing Associates Trainees on placement. From the end of February improvement this improves as staff completed their phased return to work programmes

In January, Ascot and Windsor wards are now collecting the staffing figures separately to assist identification of gaps with registered nurses.

In March, the wards started to response to the Covid-19 pandemic situation and to support the management of Covid, staff from scheduled services were redeployed into the community health wards from the end of March.

There were 48 shifts with less than two registered nurses in the West CHS wards, 24 were at Wokingham Hospital and 20 at WBCH. At both these units the wards work closely together to ensure safety on these occasions and clinical managers/Advanced Nurse Practitioner (ANP) are also available during working hours to provide support and assistance as are Physiotherapy and Occupational Therapy staff.

East Community Health wards

Henry Tudor has had the high levels of vacancies, particularly for registered nurses and high levels of sickness has meant maintaining the required levels of safe staffing have been challenging at times during this reporting period. Patient acuity was high for some months which added to the difficulties in securing the necessary levels of temporary staff to cover staffing gaps. This has resulted in permanent staff working longer shifts to cover the required staffing levels. Long term placements of NHSP staff and agency staff have helped.

In October, there was a fire risk assessment review on Jubilee ward which identified a potential risk regarding patient evacuation, particularly at night. Therefore, the ward had one extra unregistered nurse on the night shift to mitigate the risk while this is investigated further.

From January, both wards flexed their admission criteria to support Frimley Healthcare Trust which meant patient acuity increased. This combined with the vacancy rate on Henry Tudor meant there were challenges in covering some shifts. In February, this became more manageable with a lower bed occupancy and lower patient acuity.

From March, the wards began to support with the management of Covid-19, with staff from scheduled services have been redeployed into the community health wards from the end of March.

The average bed occupancy was 84% during this reporting period; Henry Tudor ward has had a higher bed occupancy than Jubilee ward and was above 90% in November and January. The total number of temporary requests was 2325; 32% were for registered nurses, 9.7% were unfilled. Sickness rate on has been above 3.5% throughout this reporting period. There were ten shifts in the reporting period where there were less than two registered nurses on Henry Tudor ward, no shifts were reported on Jubilee ward.

Norovirus outbreaks occurred across all CHS wards except Wokingham during December and January which has impacted on both patients and staff with increased episodes of staff sickness during this time.

2.0 Main Report

Overview

To meet the requirements of the *Developing Workforce Safeguards* published by NHS Improvement in October 2018 the Trust need to:

- Include a specific workforce statement in their annual governance statement – this will be assessed by NHSI.
- Deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Have a systematic approach to determining the number of staff and range of skills required to meet the needs of people using the service and keep them safe at all times.
- Use an approach that reflects current legislation and guidance where it is available.

As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable (this can be found in section 8.1, page 19 of this report).
Trusts must have an effective workforce plan that is updated annually and signed off by the chief executive and executive leaders. The board should discuss the workforce plan in a public meeting. An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity and performance plans, and directly involve leaders and managers of the service. The Director of People for the trust is leading this piece of work.

The directive states that establishment setting must be done annually, with a mid-year review, and should take account of:

- patient acuity and dependency using an evidence-based tool (as designed and where available);
- activity levels;
- seasonal variation in demand;
- service developments;
- contract commissioning;
- service changes;
- staff supply and experience issues;
- where temporary staff have been required above the set planned establishment;
- Patient and staff outcome measures.

Different roles

The national minimum staffing expectation of at least two registered staff on each ward for every shift remains a requirement, however, vacancies across all the wards means that at times this has been challenging to maintain. The number of shifts where there are less than two registered staff on duty is monitored on a monthly basis at executive and board meetings. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of one registered with three support workers was best able to meet with patient need at night, this position has not been altered.

2.1 Current Situation

Berkshire Healthcare Trust has the following wards:

1 learning disability unit;
7 community hospital wards (5 units);
7 mental health wards;
1 Adolescent Unit.

All the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). Table 1 lays out the actual and agreed staffing level on each shift.

Table 1: Current Staffing establishment, bed numbers and shift patterns

	Beds	FTE Establishment in budget 19/20	Professional judgement - FTE	Planned shift pattern (Early-late-night)
Bluebell	**22**	34.15	33.3 + 1 ward manager + 0.5 DSN + 1 CDL = 35.8	6-6-5
Daisy	**23**	32.15	28.8 + 1 ward manager + 0.5 DSN + 1 CDL = 31.3	6-6-5
Rose	**22**	32.15	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	6-6-5
Snowdrop	**22**	32.15	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	6-6-5
Orchid	**20**	32.15	27.4 + 1 ward manager + 0.5 DSN + 1 CDL = 29.9	6-6-5
Rowan	**20**	34.50	29 + 1 ward manager + 0.5 DSN + 1 CDL = 31.5	7-7-5
Sorrel	**11**	30.00	27.3 + 1 ward manager + 0.5 DSN + 1 CDL = 29.8	6-6-5
Campion	**9**	31.46	30.8 + 1 ward manager = 31.8	6-6-4
Willow House	**9**	23.42	24+1 ward Manager =25	week days 6-4 (long days) weekend 4-4 (long days)
WBCH	49	64.40	**DONNINGTON** 39.9 + 1 ward matron + 0.3 staff development lead = 41.2	9-6-6
			HIGHCLERE 35.9 + 1 ward matron + 0.3 staff development lead = 37.2	6-5-4
Oakwood	**24**	40.32	45.1 + 1 ward manager and 1 dep. ward manager matron = 47.1	9-7-4
Wokingham	**46**	61.31	59+ 1 manager + 0.8 senior clinician = 60.8	13-10-7

	Beds	FTE Establishment in budget 19/20	Professional judgement - FTE	Planned shift pattern (Early-late-night)
Henry Tudor	**24**	31.06	30.8+ 1 ward manager = 31.8	7-5-4
Jubilee	**22**	31.52	30.8 + 1 ward manager = 31.8	7-5-4

*Campion staffing levels are increased above the tools because of the split across two levels on the unit.

At times across a month, wards may require additional staff above what is planned within the establishment. This is to meet patient need and is because of the increased dependency of the patients. The staffing levels are reviewed daily and also monthly alongside a range of quality and workforce indicators to monitor the impact and experience for patients.

3.0 Review of staffing establishment

The required bi-annual review of staffing on the wards was not completed during this time due to the Covid-19 pandemic and the wards focussing on this.

PPH have commenced work looking at ward hours required versus actual ward hours worked. The definition of ward hours for this work was the number of hours of qualified and unqualified staff that is required at any one time on the ward to meet safe staffing plus additional hours required for observation.

In order to calculate ward hours required they looked at the safe staffing requirement for qualified and unqualified staff through the day on the ward and added hours of unqualified staffing required to cover any observations that were not covered within the safe staffing definition.

To work out hours required for observations they collected data from the wards around the number of observations each day. This data was used to both predict how many ward hours a ward will need and then retrospectively how many ward hours they needed and then compared both to how many ward hours were worked. The graph in appendix 1 shows and explains the data collected.

In addition to required ward hours, they have also been able to analyse e-roster data to understand available and unavailable hours of substantive staff. Available are hours staff are available to be on the ward, unavailable hours are hours where staff are paid but are on leave, study, sick, off ward etc. If the number of ‘available hours’ on average a substantive staff member works, we can forecast how many temporary hours are required to cover the number of ‘ward hours’ required each day.

The next step is to work out the optimal mix of substantive/temporary staff so that there is a target for substantive recruitment for each ward. One factor that has become apparent is that because substantive staff have a significant number of ‘unavailable’ hours it is sometime more cost effective to use bank staff, of course this needs to be balanced with quality of care.

3.2 Care Hour per Patient Day (CHPPD) Data Collection

The publication of Lord Carter's review, 'Operational productivity and performance in English acute hospitals: Unwarranted variations', in February 2016 highlighted the importance of the non-acute sectors to ensure efficiency and quality across the whole NHS health economy. One of the obstacles identified to eliminating unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment. CHPPD provides this measure.

The CHPPD is calculated by taking the actual hours worked (split into registered nurses and healthcare support workers) divided by the number of patients occupying beds on the ward at midnight. It should be noted that CHPPD does not consider patient acuity, ward environmental issues, patient turnover or movement of staff for short periods.

CHPPD is now the main metric used to benchmark safer staffing although nationally there is limited use of this data at present. As from March, the monthly safe staffing review compares the CHPPD per ward in comparison to the national median and peer median to other Trusts rated by CQC as 'good'. The table below shows the CHPPD for each of the wards over six-month period alongside nationally available data using peer and national median.

Table 4: BHFT CHPPD

Wards	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total nursing Peer Medium	Total nursing National Medium
Bluebell	6.90	8.50	9.40	8.40	7.10	8.90	8	9
Daisy	7.30	6.80	7.00	7.00	7.00	7.50	8	9
Rose	2.80	6.70	7.10	7.40	7.00	7.60	8	9
Snowdrop	7.40	7.60	7.20	7.90	7.20	7.90	8	9
Orchid	8.70	9.00	9.40	8.90	8.80	0.00	13	11
Rowan	13.20	12.90	14.50	10.80	10.90	0.00	13	11
Sorrel	22.00	27.90	23.60	18.60	22.00	19.50	18	18
Campion	26.30	32.90	27.90	24.90	29.20	37.80	33	28
Willow House	17.30	23.50	21.40	21.70	24.00	32.40	20	17
Donnington	7.50	7.40	6.20	5.90	5.70	5.50	7	7
Highclere	7.00	7.80	7.20	6.60	5.40	5.70	7	7
Oakwood	8.50	7.40	7.00	6.30	6.50	7.00	7	7
Ascot	7.00	6.70	6.00	6.10	6.00	6.10	7	7
Windsor				5.20	5.10	5.70	7	7
Henry Tudor	6.50	6.20	7.20	6.10	6.20	6.80	7	7
Jubilee	7.30	7.50	7.60	7.60	7.80	8.90	7	7

*Windsor separated out from Ascot January 2020. The Wokingham wards are low due to unfilled shifts.

Model Hospital (November 19) national median and peer median.

The Model Hospital data has not been updated since November 2019. Whilst this data is able to act as a guide in terms of benchmarking for the Mental Health Wards it can be easily skewed if there are a number of patients on a ward requiring 1:1 supervision, this is because the measure simply takes available nursing hours and divides by the number of patients, there is also variation nationally around what is included within the CHPPD as the data is pulled from e-roster and therefore includes variation in staff who feature on a ward roster including allied health professionals where they are rostered.

3.3 Bed occupancy

Table 5 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have consistently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards.

Table 5: Bed Occupancy

	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Average
Bluebell	95.75%	91.21%	91.50%	83.10%	87.00%	85.60%	89%
Daisy	94.53%	94.35%	91.16%	90.80%	90.90%	91.60%	92%
Rose	97.65%	98.18%	93.84%	90.90%	92.60%	95.90%	95%
Snowdrop	89.88%	96.36%	91.50%	86.40%	88.20%	86.80%	90%
Orchid	81.45%	82.67%	87.26%	98.10%	95.00%	89.80%	89%
Rowan	81.29%	82.17%	70.00%	68.50%	64.50%	70.20%	73%
Sorrel	75.37%	62.12%	72.43%	90.60%	82.10%	93.00%	79%
Campion	89.61%	77.78%	83.15%	79.60%	65.10%	55.90%	75%
Willow House	78.14%	64.81%	73.12%	71.30%	54.40%	*25.10%	61%
Donnington	74.73%	74.89%	83.87%	88.50%	91.00%	87.70%	83%
Highclere	75.72%	70.00%	75.38%	75.90%	84.90%	84.90%	78%
Oakwood	72.84%	80.64%	75.36%	92.13%	87.20%	88.63%	83%
Ascot	62.81%	70.47%	82.52%	87.80%	87.30%	87.40%	80%
Windsor**				97.70%	90.90%	85.30%	91%
Henry Tudor	85.89%	90.56%	76.88%	91.00%	86.90%	82.40%	86%
Jubilee	89.15%	87.73%	84.75%	81.70%	78.20%	72.90%	82%

*Unit closed at the end of the month for essential work

**Windsor separated out from Ascot January 2020

PPH aim to have 90% bed occupancy; as demonstrated in October 2019 – March 2020 there has been a reduction across PPH wards. Two wards (Daisy and Rose) have been consistently above this, whereas in the previous six months all acute wards were consistently above 90%. All other areas have been lower than expected during this reporting period; Campion Units occupancy increase since June reflects the complex and challenging patients that have remained on the ward.

4.0 Workforce data

A number of factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancies, maternity leave and sickness absence. The position over the period October 2019 to March 2020 in relation to these two indicators is detailed below.

4.1. Vacancies

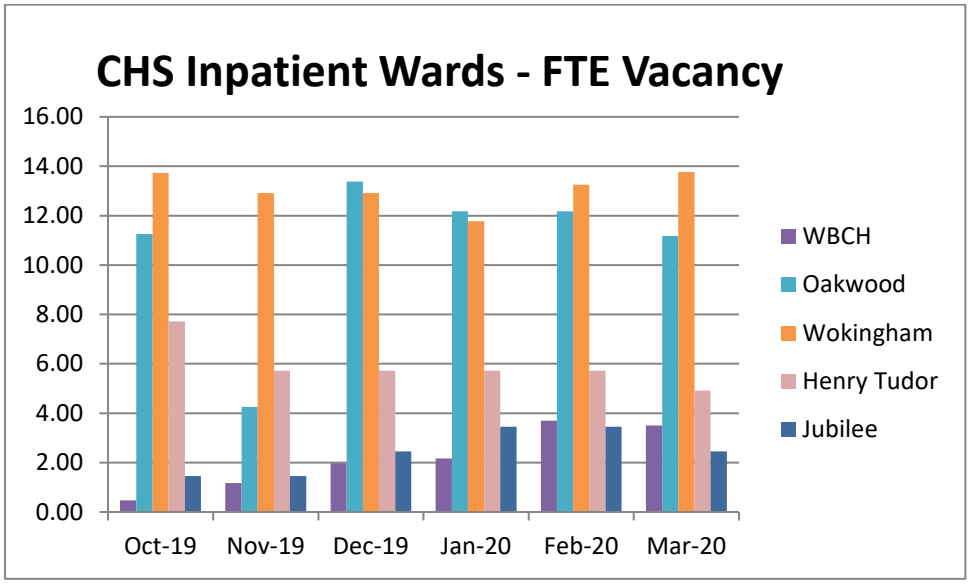
Table 6 below shows the combined whole-time equivalent vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. All wards continue to be challenged by recruitment, particularly for registered nurses.

Table 6 – Whole Time Equivalent (WTE) vacancy of registered nursing and healthcare worker combined.

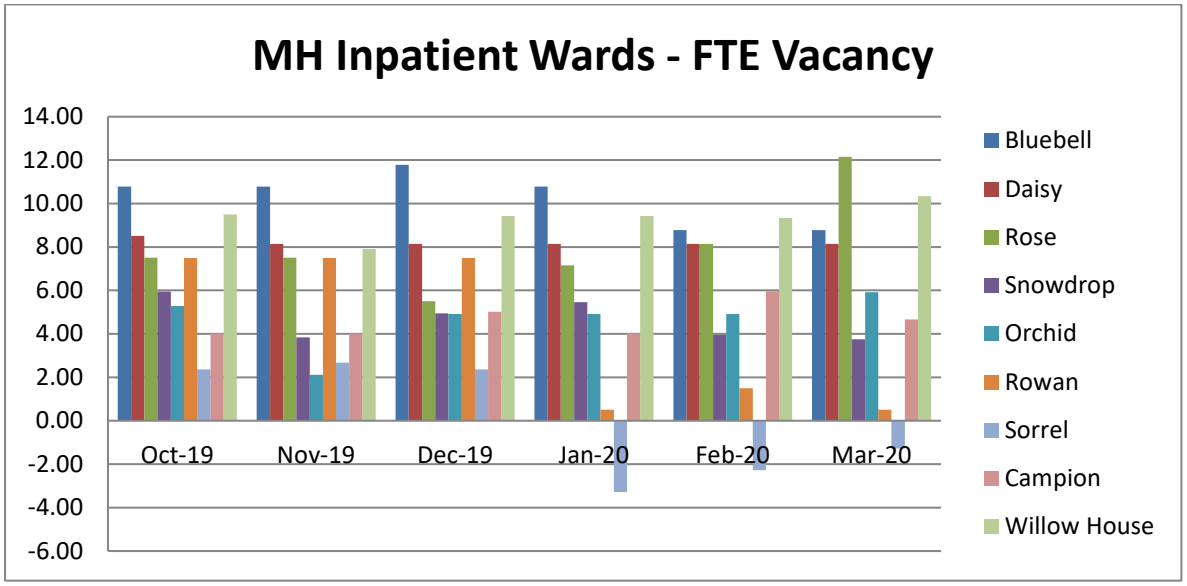
		Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
MH Wards	**Registered**	32.99	30.63	27.63	26.79	26.27	25.51
	Unregistered	14.91	11.93	17.54	6.89	6.90	9.30
CHS Wards	**Registered**	23.09	16.15	26.27	25.20	26.80	22.12
	Unregistered	11.53	9.37	10.17	10.10	11.50	13.70
Campion	**Registered**	-0.64	-0.64	0.36	-0.64	-0.64	-0.64
	Unregistered	4.66	4.66	4.66	4.66	6.60	5.30
Willow House	**Registered**	7.73	6.13	6.65	7.65	7.65	8.65
	Unregistered	1.77	1.77	2.77	1.77	1.69	1.69

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing.

Graph 1: WTE on the Community Wards by month



Graph 2: WTE on the Mental Health Wards by month



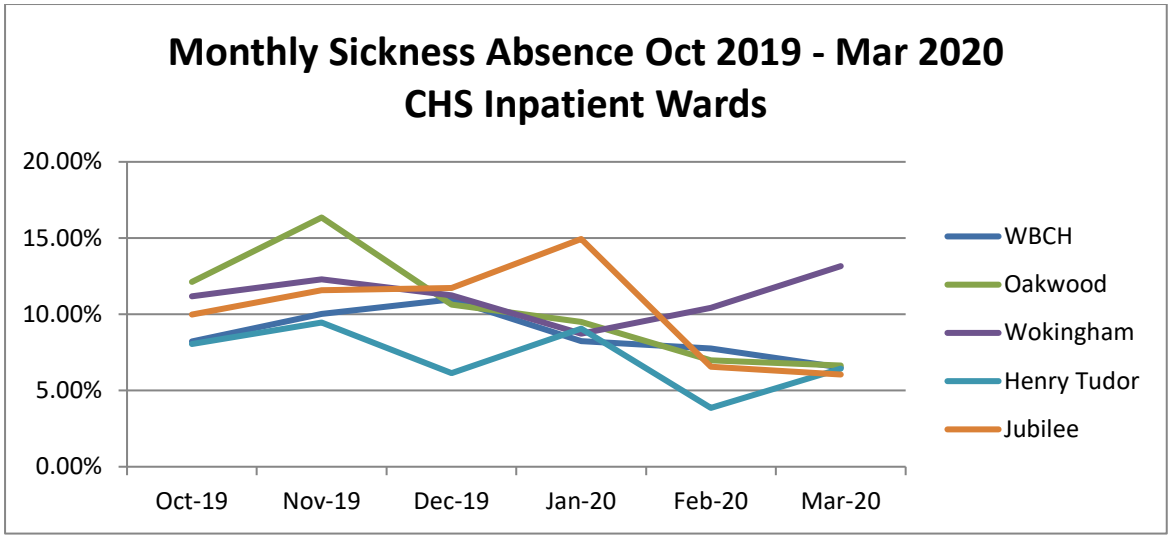
4.2 Sickness absence

Graph 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short-term sickness.

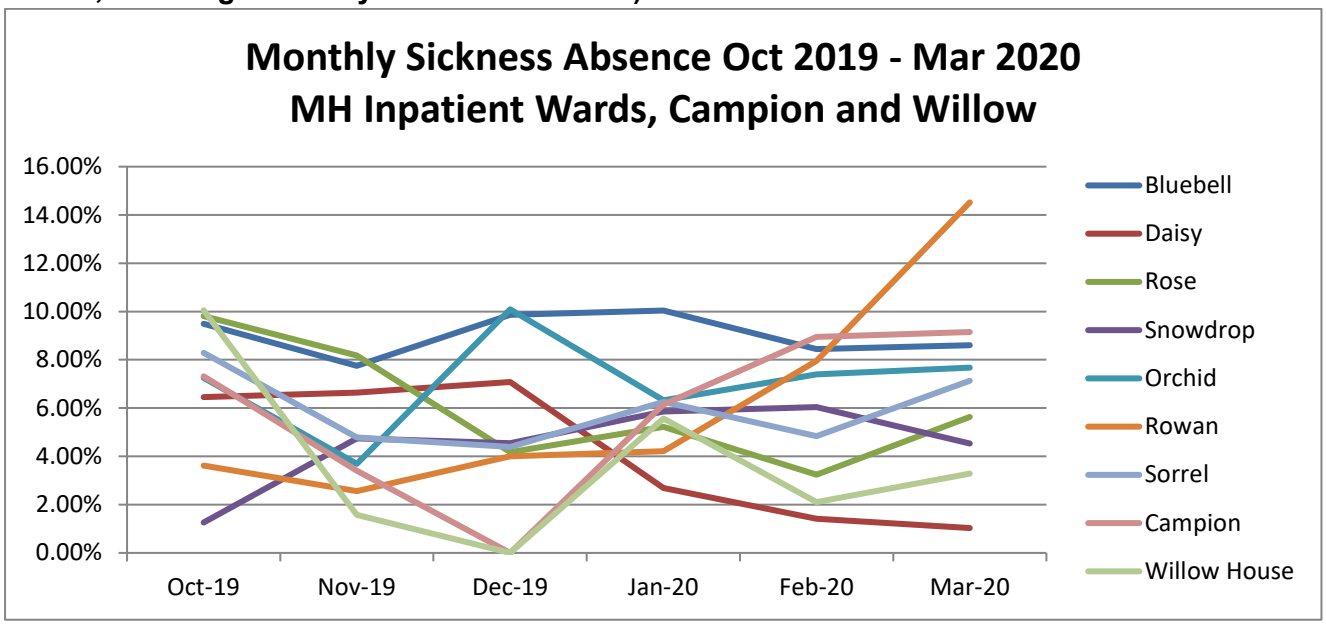
The trust sickness absence target is 3.5%; the majority of wards are exceeding this. The Trust has a sickness absence policy which with support from the Human Resources department, ensures that appropriate action is taken to support staff and their managers with sickness related absenteeism. There are several wards with a high sickness absence factor due to a combination of both long- and short-term sickness. These wards are working closely with Human Resources and Occupational Health providers to ensure that appropriate support is offered, and actions are

being taken. In addition, there are several initiatives to support staff health and wellbeing and a wellbeing lead has recently commenced within the Trust to support actions aimed at reducing sickness absence.

Graph 3: Sickness absence for wards as a percentage of total ward staffing (Community Wards)



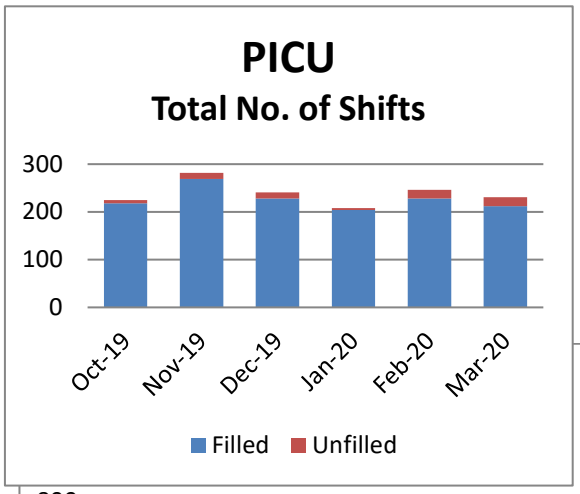
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Mental Health, Wards, Learning Disability and Willow House)

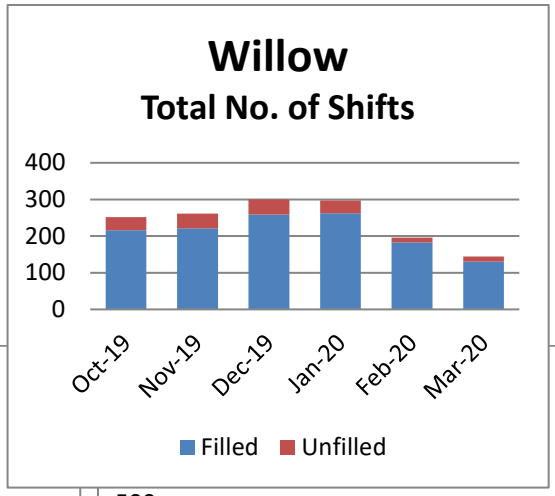


4.3 Temporary staffing

When the wards have vacancies and sickness within their nursing staff establishment, they use temporary staffing (agency / bank or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are required. It is recognised that increased numbers of agency and bank staff have the potential to impact on quality and therefore the wards continue to work hard with the support of the recruitment team to fill vacancies with the aim to reduce the reliance on temporary staffing.

The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled. Both CHS and MH wards have experienced difficulty in filling required shifts.





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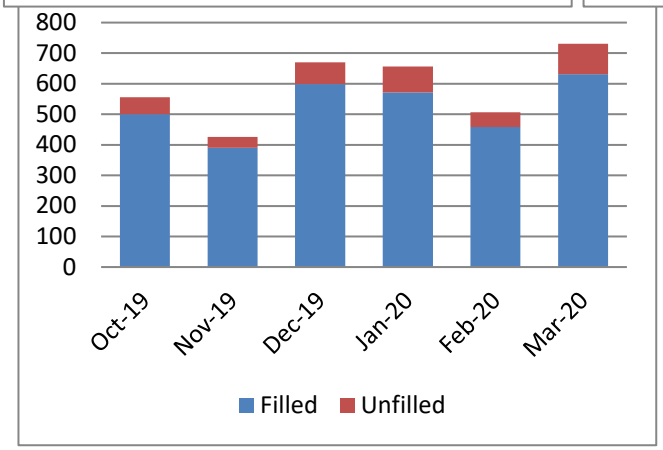
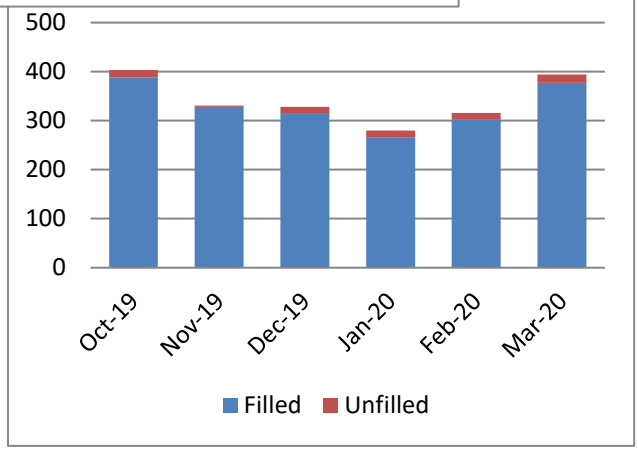
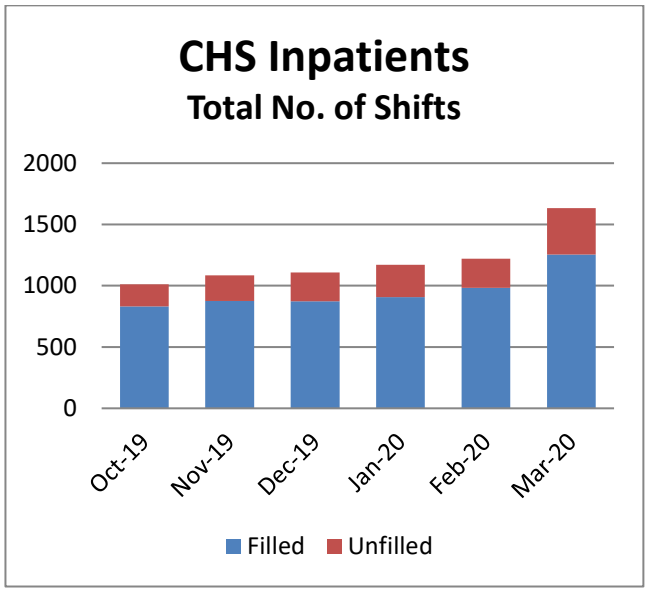
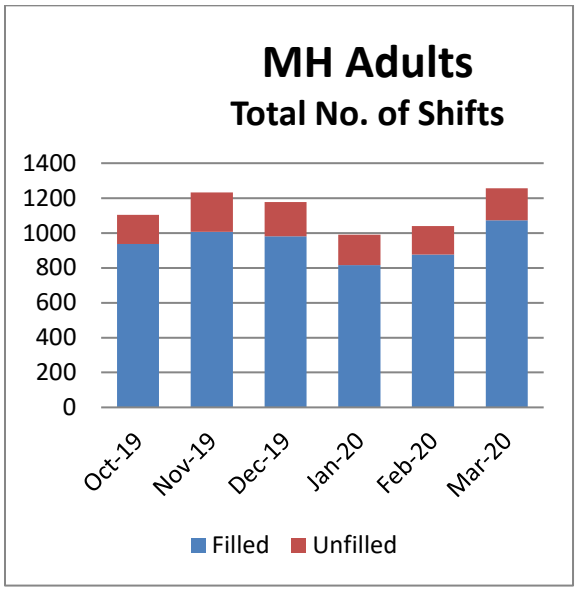








Displaying planned and actual registered and care staff on the wards

All of the wards within the trust have a display board which shows the number of staff that the ward had planned to have on the shift and the number of staff actually on the shift. This allows visitors to the ward to be clear about the number of registered nurses and care staff on the ward at the

time. The boards also show who the nurse in charge is so that visitors know who to contact if they have a concern or would like to speak to the nurse in charge. These boards are monitored during quality visits to individual wards throughout the year by senior managers.

6.0 Safety on our wards

The NHSi in its recommendations on workforce safeguards states that organisations need to demonstrate effective governance and commitment to safety so boards can be assured that their workforce decisions promote patient safety and comply with Care Quality Commission's (CQC) fundamental standards. To comply with this, it is just as important to have the appropriate staff capability to ensure that they can deliver a safe and quality service to all patients. This section of the report details how the Trust currently measures and monitors patient safety.

6.1 Quality indicators

To monitor safety of care delivered on the wards the Director of Nursing and Therapies and the board reviews a range of quality indicators on a monthly basis alongside the daily staffing levels. These indicators are:

Community wards

- Falls where the patient is found on the floor (an unobserved fall);
- Developed pressure ulcers;
- Patient on staff assaults;
- Moderate and above medication related incidents.

Mental health wards

- AWOL (Absent without leave) and absconsion;
- Self-harm;
- Falls where the patient is found on the floor (an unobserved fall);
- Patient on patient physical assaults;
- Seclusion of patients;
- Use of prone restraint on patients;
- Patient on staff assaults.

Monthly teleconferences are held with senior staff from each of the ward areas to discuss the staffing data along with these indicators, any concerns are highlighted in the monthly safer staffing board report and inform the safe staffing declaration provided by the Director of Nursing and Therapies. This was suspended in March when wards were focused on the management of Covid 19; this will be reviewed once the pandemic has moved to the next stage.

Table 5: Quality metric for mental health inpatient wards (October 2019 – March 2020)

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	16	3	19	10	1	2	102
Daisy	24	3	10	19	1	2	5

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Rose	18	6	23	20	2	0	65
Snowdrop	15	4	12	37	3	3	7
Orchid	1	26	12	8	1	2	3
Rowan	1	15	16	29	2	0	1
Sorrel	2	2	18	47	5	61	17
Campion	0	1	3	19	1	1	28
Willow House	6	0	7	5	1	1	102
Total	**83**	**60**	**120**	**194**	**17**	**72**	**330**

* correct at time of report

There has been increased reporting across wards which may account for the overall increase of incidents reported during this reporting period. Work programmes are in place to support the true north goals for many of these areas as part of the quality Improvement plan.

Table 6: Quality metric for community physical health inpatient wards (October 2019 – March 2020)

Ward	Medication related incidents	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	26	35	15	0
Highclere	16	7	4	2
Oakwood	32	14	14	0
Wokingham	36	25	3	1
Henry Tudor	15	16	4	1
Jubilee	21	6	2	2
Total	**146**	**103**	**42**	**6**

* correct at time of report

There has been an increase in incidents reported during this reporting period. Pressure ulcer summits are an embedded process to ensure shared learning which have continued as desktop reviews during the Covid-19 pandemic. This will be more formally reviewed moving forward. All medication incidents have been reported as being low or causing no harm.

6.2 Red flags

The ability to achieve a position of at least two registered staff on duty is also perceived as a metric of quality, NICE guidance (2014) on safe staffing, identified that a shift with less than two registered staff on duty should be perceived as a red flag (incident).

Table 7 below shows the number of occasions by ward and month where there was less than two registered nursing staff on a shift.

For all the wards where there are less than two registered nurses, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and is able to take an overview of the wards and redeploy staff to areas of most need.

Table 7: wards and number of occasions where there were less than two registered nursing staff on duty (excluding supernumerary roles of Ward Manager/ Matron/ Clinical Development Lead and ANP)

	Oct-19		Nov-19		Dec-19		Jan-20		Feb-20		Mar-20		Total for ward	%
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night		
Bluebell	13	1	11	5	1	5	3	0	6	2	10	1	58	10.56%
Daisy	0	0	1	0	0	0	0	1	0	0	2	0	4	0.73%
Rose	0	0	0	0	2	3	6	0	1	0	3	0	15	2.73%
Snowdrop	6	3	1	0	6	0	6	0	0	0	9	0	31	5.65%
Orchid	0	0	0	0	5	3	4	4	1	0	6	7	30	5.46%
Rowan	3	2	5	0	1	2	3	4	4	1	16	4	45	8.20%
Sorrel	5	1	0	0	0	0	0	0	1	0	2	0	9	1.64%
Campion	0	0	0	0	0	0	0	0	1	0	1	0	2	0.36%
Willow House	1	0	4	0	3	0	3	0	1	0	4	0	16	4.37%
Donnington	0	1	0	0	0	0	0	0	0	0	0	0	1	0.18%
Highclere	3	1	2	0	1	0	2	0	1	1	2	6	19	3.46%
Oakwood	1	1	0	0	0	0	0	0	0	0	0	0	2	0.36%
Ascot	2	1	6	0	1	2	2	2	1	2	1	4	24	4.37%
Windsor							0	0	0	0	0	2	2	0.36%
Henry Tudor	1	0	1	0	1	0	3	1	1	0	2	0	10	1.82%
Jubilee	0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%
Total for month	46		36		36		44		24		82		268	

7.0 Safe staffing declaration

Each month the Director of Nursing and Therapies is required to make a declaration regarding safe staffing based on the available information.

Following publication of Developing Workforce safeguards in October 2018 there is a requirement as part of the safe staffing review for the Director of Nursing and Therapies and the Medical Director to confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

7.1 Declaration by Director of Nursing and Therapies and Medical Director

The mental health wards have, over the six month period, continued to raise some concern because of the sustained high number of temporary staff and redeployed staff, however, there has been successful recruitment and there was no correlated link between staffing levels and patient safety incidents, there is however, limited assurance that care was of a high quality at all times and it is possible that patient experience was compromised.

The Berkshire West Community wards have been declared as causing some concern over the reporting period because of the sustained high number of temporary staff; although safety was maintained and there was no link between staffing levels and patient safety incidents. There is limited assurance that care was of a high quality at all times and it is possible that patient experience was compromised. The staffing review indicates that the agreed staffing establishment is appropriate to meet patient need.

Willow House was closed for a short period for maintenance work in March. Willow House has been declared as causing some concerns throughout this reporting period due to the high number of registered nurse vacancies. There appears to be no direct correlation between staffing levels and any specific incidents that occurred, although the high numbers of temporary staff required may have affected patient experience.

All wards have senior support and mitigation in place for when there are gaps in rotas and this includes use of senior staff and deployment of staff across wards.

In terms of medical staffing, numbers in the trust remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. There is a 0.6 wte agency locum doctor working on our inpatient mental health ward to provide cover for a doctor who is shielding from Covid 19.

Out of hours medical cover is provided by GPs for all our community health wards.

Out of hours medical cover is provided by junior doctors on our inpatient mental health wards with Consultant Psychiatrists providing on-call cover from home.

8.0 Community nursing Caseloads

Each month a dashboard is produced and discussed with teams in order to improve the recruitment and retention strategy. Across Berkshire, community nursing services are discussed at board level due to the high number of vacancies and high turnover. The community nursing service use an Internal Escalation Triggers tool, where community nursing teams undertake a daily capacity assessment with results collated to allow an escalation process to take place where services are unable to meet their commissioned service. This has been introduced in the absence of a national community nursing staffing tool. Following the RAG rating being completed, teams can move staffing resources accordingly. This has been successful as the table below shows:

The escalation tool:

Green	Less than 25% reduction in staffing.
Amber	26-35% reduction in staffing. Professional judgement of dependency of patients to be taken into account as well as levels of staffing.
Red	36-45% reduction in staffing. Amber staffing status moves to red once continuous for over 1-week period. Professional judgement of dependency of patients to be taken into account as well as levels of staffing.
Dark red	46-60% reduction in staffing. Red staffing status moves to dark red once continuous for over 1-week period. Professional judgement of dependency of

	patients to be taken into account as well as levels of staffing.
Black	61% plus reduction in staffing. Capacity in all teams not sufficient to meet demand. Unable to accept any new referrals.

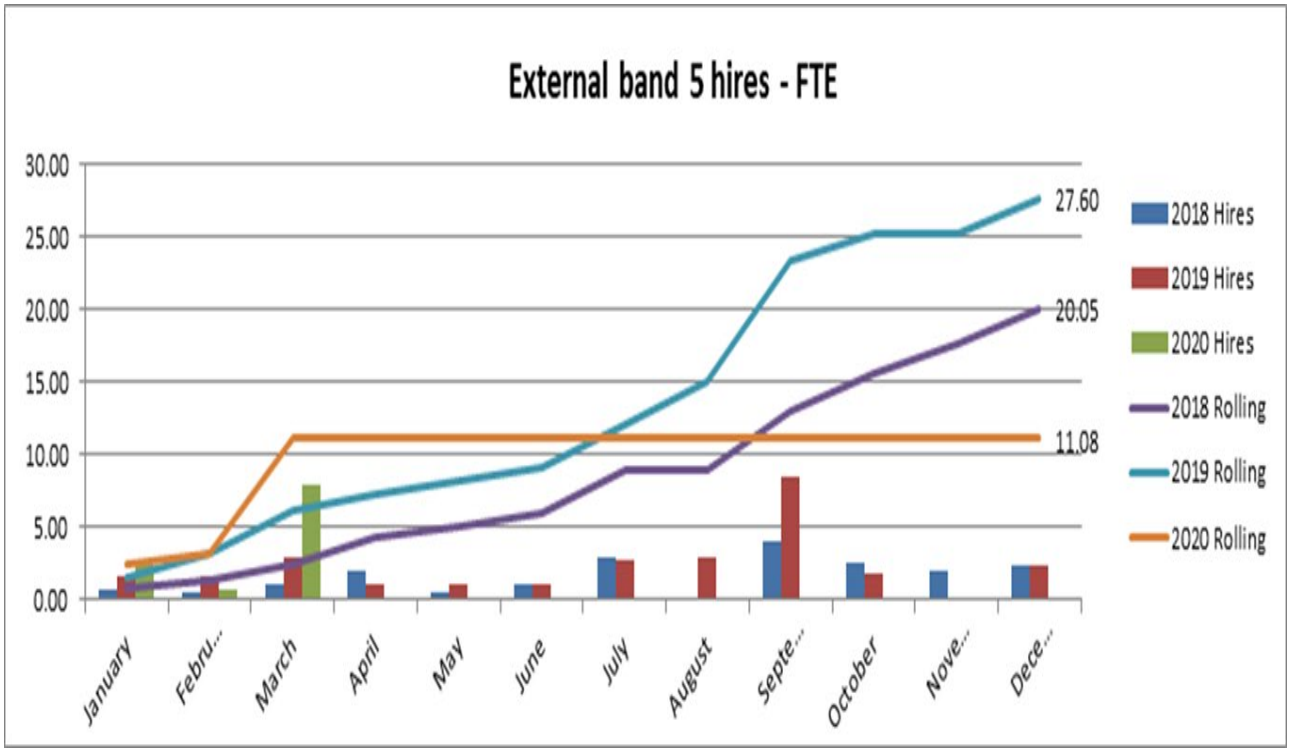
Table 8: Community Nursing actual staffing against current agreed WTE establishment.

Locality	October	November	December	January	February	March
West Berks	87%	92.3%	86.3%	84.6%	81.1%	
Reading	82.3%	86.3%	85.2%	81%	83.5%	
Wokingham	95.5%	92.6%	92.7%	94.4%	92.6%	
Bracknell	100.4%	105.4%	100.4%	97.9%	99.6%	
Windsor & Maidenhead	74.6%	76.5%	76.4%	84.1%	80.8%	
Slough	98.6%	98%	95.2%	93.2%	89.7%	

*Reporting suspended due to teams responding to Covid 19 pandemic

The RAG rating for community nursing is based exclusively on staffing levels and does not include acuity of patients. These figures do not reflect the additional unpaid hours that staff work to meet demand and work is on-going to review staffing requirements. The toolkit from NHSi to assist with this has still not be published.

The focus on recruitment and retention within Community nursing has had a positive impact with all areas declaring green RAG rating (less than 25% reduction in staffing) over the past six months except for an amber declaration from Windsor & Maidenhead in October. The chart below shows band 5 external recruitment of all new starters up until the 31st March 2020. There are 11.08 FTE new starters within Jan 20 – Mar 20 and a further 18 candidates sitting under offer on top of that which will increase recruitment numbers from last year.



9.0 Nursing Associates

The Nursing Associate (NA) role is a new generic nursing role, created to bridge the skills gap between healthcare support workers and registered nursing professionals. It was seen as offering a range of benefits working alongside more senior regulated professionals helping to improve patient care and a career pathway development opportunity. This role is an important part of the workforce development within the Trust.

There are now eight qualified NAs working in a range of services (Community nursing, community mental health team, community health wards). Cohort 2 are due to qualify end of June (they have been fast tracked to be able to register earlier than planned due to Covid-19 pandemic as they were due to register in September 2020). 30 trainees NAs are at different stages of their training across all services from Cohort 3, 4 and 5. The trust will not be recruiting to Cohort 6 in May due to the current Covid-19 situation but hope to recruit for a September cohort

10.0 Conclusion and next steps

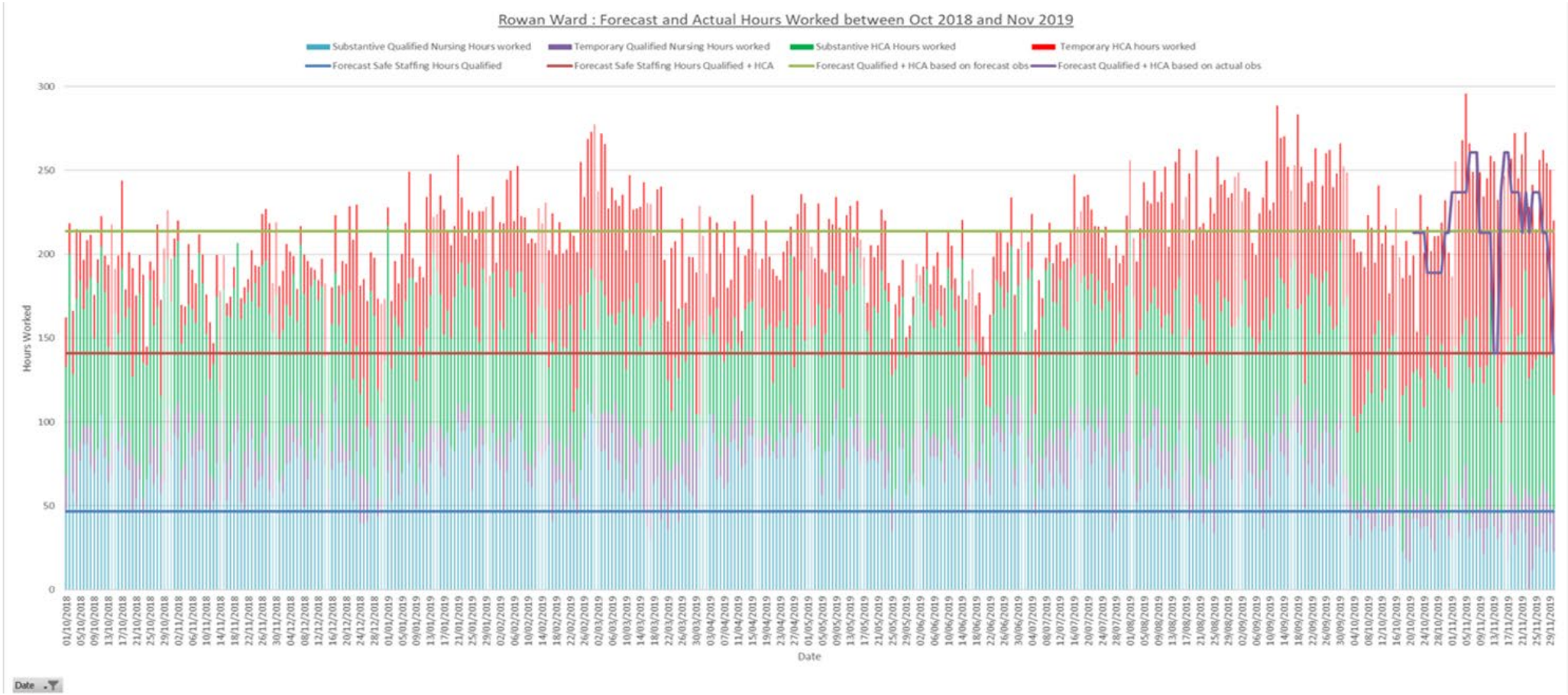
- Work with the PPH Beyond Budgeting project to establish safe staffing requirements on the wards at PPH which incorporates staffing needed for observational levels.

- Complete staffing review in August across all inpatient areas using agreed national toolkits.

- Continue with focused recruitment plans which have achieved some positive results in securing new staff, particularly aimed at third students. Support the preceptorship programme to ensure preceptee fell confident to fulfil their role on the wards.

- The previous 6-monthly report highlighted the need for additional staffing on the acute mental health wards; it was agreed that an activity coordinator role to support engagement of patients in meaningful activity across the afternoon/ evening shift 7/7 would best support the wards and patients. A pilot of this role has taken place on Snowdrop ward and this now needs to be evaluated and progressed to implementation across the other three acute wards.

APPENDIX 1



The straight lines are the ward hours required (lowest is qualified, middle is qualified plus HCA's to meet safe staffing and top is qualified plus HCA to meet safe staffing including observations), the purple line is the actual ward hours required based on actual observations recorded, the bars are actual hours worked per day (different colours distinguish between qualified/unqualified and substantive/temporary).

By comparing the purple line to the bars it is possible to see whether there was enough staff working each day; currently the model only does 24 hours but there are plans to look at refining this to look hour by hour if the data collection can be automate (currently manually collected and formulated) . The source data for ward hours is e-roster for substantive staff and NHSP for temporary staff; Calculation of number of

substantive/temporary staff required. The fluctuations in actual ward hours required demonstrated that a level of flexibility is required, and this is also true of the ability to cover unplanned absence at short notice and planned absence in a flexible way. There will be an optimal mix of substantive and temporary hours worked to achieve this.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	**Quality Assurance Committee – 19 May 2020**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 19 May 2020
Business Area	Corporate
Author	Julie Hill, Company Secretary for David Buckle, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 19 May 2020 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 19 May 2020, Fitzwilliam House, Bracknell

Present:	David Buckle, Non-Executive Director (Chair) Mehmuda Mian, Non-Executive Director Aileen Feeney, Non-Executive Director Julian Emms, Chief Executive David Townsend, Chief Operating Officer Dr Minoo Irani, Medical Director Dr Guy Northover, Lead Clinical Director Debbie Fulton, Director of Nursing and Therapies Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Kerry Harrison, Clinical Director, Adult Mental Health Services *(present for agenda item 6.0)* Bridget Gamal, Head of Psychological Therapies *(present for agenda item 6.0)* Sara Fantham, Interim Clinical Director, East Adult Physical Health Services *(present for agenda item 6.0)* Jan Durrant, Head of Community Diabetes Services *(present for agenda item 6.0)* Sue McLaughlin, Deputy Director of Nursing (present for
Observers:	Dr Garyfallia Fountoulak Dr Peter Graves

The meeting was conducted virtually via Microsoft Teams because of the COVID-19 pandemic social distancing requirements.

1 Apologies for absence and welcome

There were no apologies.

The Chair welcomed everyone to the meeting and reported that this was the first Quality Assurance Committee meeting to be conducted virtually because of the COVID-19 social distancing requirements.

The Chair said that along with other NHS provider organisations, the Trust was prioritising responding to the COVID-19 pandemic in accordance with national guidance. The Chair stressed that during the pandemic it was important that the Trust continued to focus on patient safety and quality.

The Chair highlighted paper 5.7 and with the changes due to Covid-19 in mind, asked the Executive members present who were introducing specific papers, to start with a brief summary of any changes in governance or process that were relevant to that particular item.

2. Declaration of Any Other Business

There were no items of Any Other Business.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 18 February 2020

The minutes of the meeting held on 18 February 2020 were confirmed as an accurate of the proceedings.

4.2 Matters Arising from the Minutes and Matters Arising Log

The Matters Arising Log had been circulated. It was noted that a number of actions had been postponed because of the COVID-19 pandemic.

The Company Secretary confirmed that the actions would remain on the action log until the actions had been completed.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Serious Incidents Report – Quarterly Report

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

- During Quarter 4 there were initially 18 Serious Incidents with two currently downgraded taking the number to 16 These related to the following areas:
    - Suspected suicide cases (4)
    - Unexpected deaths (3)
    - Attempted suicide cases (3)
    - Self-harm case (1)
    - Misdiagnosis cases (2)
    - Pressure ulcer cases (3)
- Trends and learning from incidents closed within the Quarter were:
    - working with others – good evidence of joint agency working with other partners as well as a multi-disciplinary approach to patient care
    - Leave process to be reviewed which would include ensuring that a conversation took place about safety and safeguarding issues etc
    - Physical heath monitoring – the need to continue to embed the workstream in relation to physical health assessments, monitoring and related documentation for patients admitted to a mental health inpatient setting
    - Robustness of safety planning – work was underway to improve this
    - Managing referrals in the Common Point of Entry service – work was in train to implement a new model and standard operating procedure for downgrading referrals.

The Director of Nursing and Therapies confirmed that during the COVID-19 pandemic, the Trust was continuing to investigate serious incidents. It was noted that the duty of candour process was continuing via telephone or digital meetings without face to face meetings (unless requested).

It was noted that the Coroner was re-starting paper-based inquests with the full inquest process commencing in July 2020.

The Committee noted the report.

5.1 Learning from Deaths Quarterly Report

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

- The Medical Director reported that the Trust's mortality review process was continuing during the COVID-19 pandemic with a few adaptations, for example, an enhanced first stage weekly review and a slimmed down second stage review process (unless the death related to a patient with a learning disability or if there were concerns from family/carers or staff about the care provided in which case a full second stage review was required);
- In Quarter 4 of 2019/20, 837 deaths were recorded on the clinical information system (RiO) where a patient had been in contact with a Trust service in the year before they died;
- Of the deaths, 106 met the criteria to be reviewed further. All 106 deaths were reviewed by the Mortality Review Group. 60 deaths were closed with no further action; 7 deaths were classified as "Serious Incidents" requiring further investigation; and 39 deaths required 'second stage' review (using an initial findings review/structured judgement review methodology);
- During Quarter 4 the Mortality Review Group had reviewed the findings of 51 second line review reports of which 14 related to patients with a learning disability.
- Of the 51 case reviews received by the Mortality Review Group, 2 reviews were escalated as potential lapses in care and 1 case had been confirmed as a lapse in care following root cause analysis. The second case was still under investigation.

The Medical Director reported that following a number of unexpected deaths across the geography supported by the Criminal Justice Liaison and Diversion Service, the Trust had undertaken a deep dive review to identify any themes or concerns related to these deaths. No systemic issues of concern were identified in this review. The Medical Director said that improvement and learning opportunities were identified and would be taken forward by the service with the support of the Clinical Directors.

The Chair said that he always found the quarterly Learning from Deaths Reports helpful and informative. The Chair said that as part of his preparation for taking over the chairing of the Committee, he had attended a meeting of the Quality Executive Group. One of the items under discussion was the senior staff time involved in undertaking investigations. The Chair asked whether aiming for the "gold standard" in terms of investigations was a good use of resources.

The Medical Director reminded the meeting that the Care Quality Commission had identified the Trust's Learning from Deaths process as an example of good practice. The Medical Director said that the Trust allocated the right level of resources and that during the COVID-19 pandemic, the Trust had streamlined some of the processes to reduce the burden on clinical staff. From June 2020, the monthly mortality review

meetings will be fully re-instated (virtually), although the efficiencies of the past 3 months will be retained.

The Committee noted the report.

5.2 Well-Led Care Quality Commission Inspection Must Do Action Plan

The Director of Nursing and Therapies presented the paper and reported that following the November-December 2019 inspection, the Care Quality Commission had rated the Trust as “Outstanding”. As part of the inspection, the Care Quality Commission had assessed two core services (Specialist Community Mental Health Services for Children and Young People and Acute Wards for Adults of Working Age and Psychiatric Intensive Care Wards) where the Trust must take action.

It was noted that an action plan had been developed to address the “Must Do” actions. The Director of Nursing and Therapies reported that in respect of the “Must Do” actions around changing the fire doors and fixed call bells at Prospect Park Hospital there were conflicting views on best practice. It was noted that the Trust was currently reviewing the safest options before changing the fire doors and call bells.

Mehmuda Mian, Non-Executive Director reminded the meeting that the Trust had installed new fire doors following the fire at Prospect Park Hospital in 2015.

The Director of Nursing and Therapies explained that the Care Quality Commission had not raised concerns about the viability of the fire doors and were concerned about the potential ligature risk at the top of the doors.

Aileen Feeney, Non-Executive Director noted that the Care Quality Commission had expressed a concern about waiting lists for Community Mental Health Services for Children and asked in view of the COVID-19 pandemic what the Care Quality Commission would expect the Trust to have done to address waiting times when they next inspected the Trust.

The Chief Executive explained that the Care Quality Commission would expect NHS provider organisations to demonstrate how they had mitigated patient safety risks whilst people were waiting to access services. The Chief Executive reported that during the COVID-19 pandemic, children and young people had been able to access online consultations and that this had been positively received by the children and young people.

The Committee noted the report.

5.3 Zero Suicide Report

The Chair welcomed Sue McLaughlin, Deputy Director of Nursing to the meeting.

The Deputy Director of Nursing presented the paper which updated the Committee on the Trust’s Suicide Prevention work. It was noted that the paper also set out the approach the Trust would take over the coming months to respond to the impact of the COVID-19 pandemic on self-harm and suicide prevention.

The Committee noted the report.

5.4 Quality Impact Assessment (Temporary Service Changes Due to COVID-19) Report

The Director of Nursing and Therapies presented the paper which set out the Trust's Quality Impact Assessment process for clinical service changes in response to the COVID-19 pandemic.

It was noted that the Trust had completed over 40 individual Quality Impact Assessments since the start of the COVID-19 pandemic.

The Chair commented that it was important that the Trust had a robust system in place to identify and mitigate any potential patient safety and quality issues due to service changes in response to the COVID-19 pandemic.

The Chair thanked the Director of Nursing and Therapies for her paper.

The Committee noted the report.

5.5 Action Plan in Response to Regulation 28 Notice

The Director of Nursing and Therapies presented the paper which set out the Trust's response to the Coroner's Section 28 report to prevent future deaths issued.

The Director of Nursing and Therapies explained that on 2 March 2020, following the inquest of Sophie Booth, the Coroner had issued a Section 28 report in relation to four areas of concern:

- Ensuring salient information was best captured by referrers when completing and sending referral forms to the Trust's Common Point of Entry service;
- The importance of effective due diligence when triaging referrals where the potential client had experienced an episode of mental health crisis abroad;
- Assurance that downgrading referrals from red to amber was consistently conducted in a rational and proportionate manner, including seeking further information from the referrer or potential client as required; and
- Ensuring that mental health services communicate effectively – particularly in relation to information sharing where someone was referred into more than one service.

The Director of Nursing and Therapies confirmed that the Trust had developed an action plan to address the Coroner's concerns.

The Committee noted the report.

5.6 COVID-19 Board Assurance Framework Risk

The Chair reported that the May 2020 Trust Board meeting had also discussed the COVID-19 Board Assurance Framework Risk.

The Director of Nursing and Therapies reported that following the comments made at the Board meeting, the risk had been updated to include assurances on the controls.

The Committee noted the report.

5.7 Quality Assurance Processes During the COVID-19 Pandemic

The Director of Nursing and Therapies and Medical Director presented the paper which detailed the relevant national guidance and organisational quality assurance processes put in place during the COVID-19 pandemic to ensure continued oversight of patient and staff safety.

The Chair commented that he found the paper very helpful and reported that the paper had also been submitted to the May 2020 Trust Board meeting.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Reports

The Committee reviewed the outcome of the following national Clinical Audits:

- **National Clinical Audit of Anxiety and Depression – Psychological Therapies** report published 9 January 2020
- **National Diabetes Audit – Care Process & Structured Education** local data published January 2020
- **National Audit of Care at End of Life (Round 2) -** local report published February 2020
- **POMH – National audit of depot / Long-acting antipsychotic medication for relapse prevention -** report published 12 March 2020.

The Medical Director reported that due to the COVID-19 pandemic all national clinical audits and confidential enquiries were currently suspended with regards to data collection. Data collection relating to the child database and MBRRACE-UK perinatal surveillance data and deaths of patients with a learning disability (LeDeR) would continue as this was important in understanding the impact of COVID-19.

The Medical Director reported that for the Trust this meant that data collection for the national audit on Prescribing Sodium Valproate had been delayed until September 2020 and the data submission for continuous audits such as Diabetes maybe delayed but will be required to be submitted retrospectively.

The Medical Director said that Trust was continuing its clinical audit work in relation to the national audits already published and in relation to its internal clinical audits.

It was noted that the full Clinical Audit Reports listed above had been circulated to the Non-Executive Directors of the Committee.

The following clinical audits were discussed further at the meeting:

a) **National Clinical Audit of Anxiety and Depression Psychological Therapies**

The Chair welcomed Bridget Gamal, Head of Psychological Therapies and Kerry Harrison, Clinical Director, Adult Mental Health Services to the meeting.

The Chief Operating Officer referred to the second recommendation from the audit in relation to the demographic form used at assessment being amended to include disability and sexual orientation questions and asked whether a question on ethnicity was already included on the form.

The Head of Psychological Therapies confirmed that ethnicity was included as one of the questions on the form.

Aileen Feeney, Non-Executive Director drew attention to recommendation 3 and asked whether the Trust had a plan to address waiting times especially in the light of the COVID-19 pandemic.

The Chief Operating Officer reported that managing waiting lists was part of the Trust's COVID-19 Recovery Plan which was submitted to the May 2020 Trust Board meeting. The Chief Operating Officer explained that the Trust was expecting to see a surge in the number of people requiring mental health services post COVID-19 lock down.

The Chair asked whether there was more the Trust could do to address the interface between mental health and physical health monitoring.

Kerry Harrison, Clinical Director, Adult Mental Health Services reported that the Trust had done a lot of work to improve the interface between mental and physical health services including piloting physical health clinics as part of mental health services. It was agreed that the Committee would receive an update report on improving physical health monitoring for mental health patients at the November 2020 meeting.

Action: Clinical Director, Adult Mental Health Services

b) **National Diabetes Audit – Care Process & Structured Education**

The Chair welcomed Sara Fantham, Interim Clinical Director, East Adult Physical Health Services, Jan Durrant, Head of Community Diabetes Services to the meeting.

The Chair commented that the national increase in the prevalence of Diabetes was a concern and was one of the COVID-19 risk factors. The Chair said that he knew from his role as a GP that his patients valued the Diabetes educational programmes on how to self-manage their Diabetes.

The Chair reminded the meeting that a previous clinical audit had highlighted relatively low rates of the use of insulin pumps across Berkshire. The Chair commented that this audit had indicated that the Trust's performance in relation to the blood test for glucose control (Hba1c) in respect of people with type 2 Diabetes was below the benchmark.

Sara Fantham, Interim Clinical Director, East Adult Physical Health Services pointed out that the Trust had improved its data collection process since it had submitted its data to this audit.

Jan Durrant, Head of Community Diabetes Services explained that the service was confident that this was a data quality rather than a patient safety issue and that patients were receiving blood tests for glucose control. These blood tests were now recorded on the RiO system which would address the data recording issues.

The Chair said that in his experience many of the issues raised in clinical audits related to data quality rather the patient safety but pointed out that it was difficult for the Committee to make that judgement.

The Head of Community Diabetes Service said that it was important that the Committee viewed the audit in the round and that when compared with specialist Diabetes Services, the Trust was performing well.

The Chair asked for assurance that the Trust had taken sufficient action to improve the quality of its data recording processes.

The Interim Clinical Director, East Adult Physical Health Services reported that since the Community Diabetes Service had moved to the RiO system for recording blood tests for glucose control, the Trust was able to track performance monthly.

The Chief Executive suggested that the Committee receives an assurance paper on the Trust's performance in relation to blood tests for glucose control in six months-time.

Action: Interim Clinical Director, East Adult Physical Health Services

The Committee noted the report.

6.1 Quality Accounts Report 2019-20

The Head of Clinical Effectiveness and Audit presented the paper and reported that NHS England/Improvement had suspended the requirement for the Quality Accounts Report 2019-20 to be externally audited as part of the external audit of the Trust's annual accounts.

The Head of Clinical Effectiveness and Audit reported that the Trust had completed the Quality Accounts which would be submitted to the July 2020 Trust Board meeting for approval and would be published in the autumn.

The Chair commented that he was pleased that the Trust had taken the decision to complete the Quality Accounts 2019-20 to the original timetable.

The Chief Executive said that the Quality Accounts 2019-20 was a well-written and informative document as usual.

The Chair asked whether there was any national guidance relating to next year's Quality Accounts and asked whether the Committee would receive the quarter 1 report at its next meeting in August 2020.

The Head of Clinical Effectiveness and Audit explained that there was no national requirement to produce quarterly reports and confirmed that the she would present the Quality Accounts 2020-21 first quarter report as usual at the August 2020 meeting.

The Committee noted the report.

Update Items for Information

7.0 Guardians of Safe Working Hours Quarterly Report

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

It was noted that during the reporting period (5 February 2020 to 30 April 2020) there were six "hours and exception reports totalling an extra 8 hours and 15 minutes worked over and above the trainees' work schedules.

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

The Committee noted the report.

7.1 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held in February 2020, March 2020 and April 2020 were received and noted.

Closing Business

8.0 Standing Item – Horizon Scanning

The Committee had identified the following items for future meetings.

- Trust's compliance with the new CPA Guidance
- Single room and therapeutic environment at Prospect Park Hospital
- Review of the Quality Improvement Programme True North Patient Safety Indicators
- Sexual Safety Update
- Eating Disorder Service and the Wider System
- Review of the MSK Pathway
- Carer's Strategy

The Chair invited the Committee to identify any other items for inclusion in the Committee's work programme.

The other agenda items were proposed:

- Post COVID-19 Lock Down and its impact on the Trust's demand for services (particularly mental health services)
- Managing the interface between physical health and mental health

Action: Company Secretary

The Chief Executive reported that the Trust Board Discursive meeting on 09 June 2020 would have an opportunity to discuss how the Trust's response to the COVID-19 pandemic had been a catalyst to changing the way many services were accessed and provided. This included families and carers undertaking some of the tasks that were previously done by District Nurses in patients' homes.

The Chief Executive said that post-COVID-19 it was important that the Trust got the balance right between going back to traditional service delivery and continued with its Digital First transformation.

The Chair said that he would welcome an opportunity to discuss the new ways of working and to understand both the patient and organisational benefits and any risks.

8.1. Any Other Business

There was no other business.

8.2. Date of the Next Meeting

18 August 2020

These minutes are an accurate record of the Quality Assurance Committee meeting held on 19 May 2020.

Signed:-_____

Date: - 18 August 2020_____

Berkshire Healthcare
NHS Foundation Trust

QAC	May 2020
Title	**Learning from Deaths Quarter 4 Report 2019/20**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	The trust mortality review and Learning from Deaths process has operated without any additional resource allocation since it was launched in 2016. Additional resource will be required to progress further quality improvements.
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
Summary	837 deaths were recorded on the clinical information system (RiO) during Q4 where a patient had been in contact with a trust service in the year before they died. Of these 106 met the criteria to be reviewed further. All 106 were reviewed by the executive mortality review group (first stage review) and the outcomes were as follows: • 60 were closed with no further action • 7 were classed as Serious Incident Requiring Investigation (SI) • 39 required 'second stage' review (using an initial-findings review (IFR)/ Structured Judgement Review (SJR) methodology). During Q4, the trust mortality review group (TMRG) received the findings of 51 2nd stage review reports (detailed on p8), of which 14 related to patients with a learning disability (these are cases reviewed in Q4 and will include cases reported in previous quarters). Of the 51 reviews received by the TMRG, 2 reviews were escalated as potential lapse in care and 1 case has been confirmed as a lapse in care (see below) following Root Cause Analysis (RCA). The 2nd case is being investigated. A separate 2nd stage review which had been escalated in Q3 was closed following RCA with no lapse in care noted. **Lapse in Care** 1 lapse in care has been identified and related to a case escalated following 2nd stage review in January 2020. The learning from this case related to importance of timely transfer of the patient for acute hospital care in accordance with the trust policy: Assessment and identification of the deteriorating patient (using the National Early Warning score (NEWS 2) tool in the adult in-patient setting). **Learning from Serious Incidents** Themes which have been identified as learning from outcome of SI investigations.

- **Working with others:** positive learning with good evidence of joint agency working with partners as well as a multi-disciplinary approach to patient care.
- **Leave process:** to ensure that patient leave from inpatient mental health care will include ensuring a conversation takes place about safety, whereabouts, searching process and the safeguarding considerations
- **Physical health monitoring –** Prospect Park Hospital to continue to embed the work stream in relation to physical health assessments, monitoring and related documentation for patients admitted to a mental health inpatient setting.

Learning from the mortality review process (first and second stage review of deaths) Mental Health Inpatients

Positive learning was identified in the following areas:

- Effective communication using processes e.g. handover
- Following process in order to escalate deteriorating patient
- Making sure the family knew what was happening
- Team knowledge- provided by training, coaching and role modelling on the ward

Areas for improvement include a review of access to IT equipment to support record keeping.

Criminal Justice liaison and diversion service (CJLD).

Following a number of unexpected deaths across the geography supported by this service, it was identified that there was a need to undertake a deep dive review to identify any themes or concerns related to these deaths, as well as to determine whether current governance processes were sufficient to support the extended services. No systemic issues of concern were identified in this review. Improvement and Learning opportunities were identified and will be taken forwards by the service with the support of the Clinical Director.

Medical Examiner process

In Q2 we identified the work we would be implementing in preparation for the introduction of the national medical examiner process for mental health/community trusts in April 2021. A meeting was held with the local acute trust in February to start the implementation of this work. Due to COVID 19 the medical examiner process has been suspended nationally for all trusts, this work will be re started in the future in line with national guidance.

COVID 19 (C19)

In response to the COVID 19 pandemic new national guidance was published specifically relating to the following:

1) Medical Certificate for Cause of Death (MCCD)

- Guidance for this period allows any medical practitioner with GMC registration to complete the MCCD and requirements to have seen the patient within 5 days have changed to 28 days.
- The cause of death can be 'to the best of their knowledge and belief' diagnostic proof can be submitted when received for suspected COVID 19 deaths in order not to delay the MCCD.
- All MCCDs to now be submitted electronically by email to local Registry Offices by Wards.

The updated guidance has been shared with all relevant staff and processes were put in place for all wards to submit the MCCDs electronically to the relevant registry offices and

	ensure that the paper copies are stored securely as we will be required to submit these at a later date. **2) National reporting of Inpatient deaths where the patient has tested positive for C19** The COVID 19 patient notification system (CPNS) is the central database where we are required to submit information on all Inpatient deaths where a patient tested positive for COVID19 or COVID 19 was stated as part 1 or 2 of the MCCD. **Rapid process for notification of the death of a colleague to understand the impact of COVID-19 on the NHS workforce** In addition to inpatient deaths we are required to report to the CPNS : • Any colleague death in an inpatient setting (irrespective of employer): to be reported by the **organisation where the death occurred** • Any colleague death not in an inpatient setting: to be reported **by their employing organisation** **Impact of COVID-19 on mental health services (01 May 2020 CQC)** Requirement to notify the CQC of deaths where a patient detained under the Mental Health Act was transferred to an acute hospital for specialist care because it has been confirmed or is suspected that they are infected with COVID-19 and subsequently died. In some cases, mental health service providers may discharge the patient from the Mental Health Act before transferring the patient to the care of the acute hospital, these must still be reported. Governance processes have been implemented to ensure that we can submit the required information within the 24 hour window of the patient dying. **Mortality Review Process** The Trust learning from deaths & mortality review process remains uninterrupted. We have enhanced the first stage review by the executive mortality review group (EMRG) to reduce the number of routine requests for 2nd stage reviews. The number of 1st stage reviews have increased slightly from an average of 33 per month over Q4 to 49 in April 2020. 2nd stage reviews will continue for all deaths of patients with a learning disability, deaths where a formal complaint (or concern about care) by family/ carer or staff, concern from coroner has been received. We will also be selecting some deaths where COVID 19 was suspected for 2nd stage review to ensure that care was appropriate and other causes/diagnosis were not missed. The trust mortality review group continues to meet monthly to review the 2nd stage reviews and ensure that the relevant learning and any significant risk is identified and shared.
ACTION REQUIRED	The committee is asked to receive and note the Q4 learning from deaths report in order to provide assurance to the Trust Board that the Trust is complying with CQC and NHS Improvement requirements in respect of learning from deaths.

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1.0 Purpose

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

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

2.0 Scope

This report supports the Trust learning from deaths policy which was published in August 2017 and updated in March 2019.

3.0 Introduction

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

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

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

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

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

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

Definitions:

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

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

4. Summary of Deaths and Reviews completed in 2019/20.

Figure 1.

	17/18 total	18/19 total	Q1 19/20	Q2 19/20	Q3 19/20	Q4	YTD 19/20
Number of deaths seen by a service within 365 days of death	4381	3961	967	930	**1150**	**837**	**3884**
Total deaths screened (Datix) 1st stage review	307	320	90	108	**103**	**106**	**406**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	49	65	**39**	**46**	**198**
Total number of deaths investigated as serious incidents	32	40	8	10	**18**	**7**	**43**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	1	1	**0**	**1**	**3**
Number of Community Hospital Inpatient deaths reviewed(Including patients at the end of life)	123	144	21	22	**35**	**46**	**124**
Total number of deaths of patients with a Learning Disability	35	28	11	13	**9**	**14**	**47**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	0	**0**	**0**	**0**

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

4.1 Total Number of deaths in Q4

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 1 identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death (Figure A in Appendix 1 details the specific service). In Q4, 837 deaths were recorded, this number may increase slightly due to a time lag in spine updates.

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

	January to March 2020				
Figure 2	**A:0-17**	**B:18-65**	**C:66-75**	**D:Over 75**	**Grand Total**
Grand Total	**4**	**102**	**133**	**598**	**837**

4.2 Total Deaths Screened (1st stage review)

The Trust learning from deaths policy identifies a number of criteria which if met require the service to submit a Datix form for review on the Trust incident management system following the notification of a death. 105 deaths were submitted for review in Q4.

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

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

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

Of the 106 deaths undergoing first stage review, 60 were closed with no further action required, 39 were referred for 2nd stage review and of these 7 were classed as serious incidents for RCA investigation.

5. Involvement of families and carers in reviews and investigations

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

6. 2nd Stage Reviews Completed

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

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 51 (45 in Q3 of 2018/19) reviews have been received and considered by the group in Q4. Figure 3 details the service where the review was conducted.

Figure 3: Reviews Conducted in Q4

	Total Number	**Divisions**
January 2020	13	Learning Disabilities: 5 East Physical Health: 2 West Mental health: 5 East Mental Health 1
February 2020	18	Learning Disabilities: 2 West Physical Health: 7 East Physical Health:3 West Mental Health:4 East Mental Health:1 Children's and Young People: 1
March 2020	20	Learning Disabilities: 7 East Physical Health: 2 West Physical Health:5 West Mental Health:5 Children's and Young People: 1

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

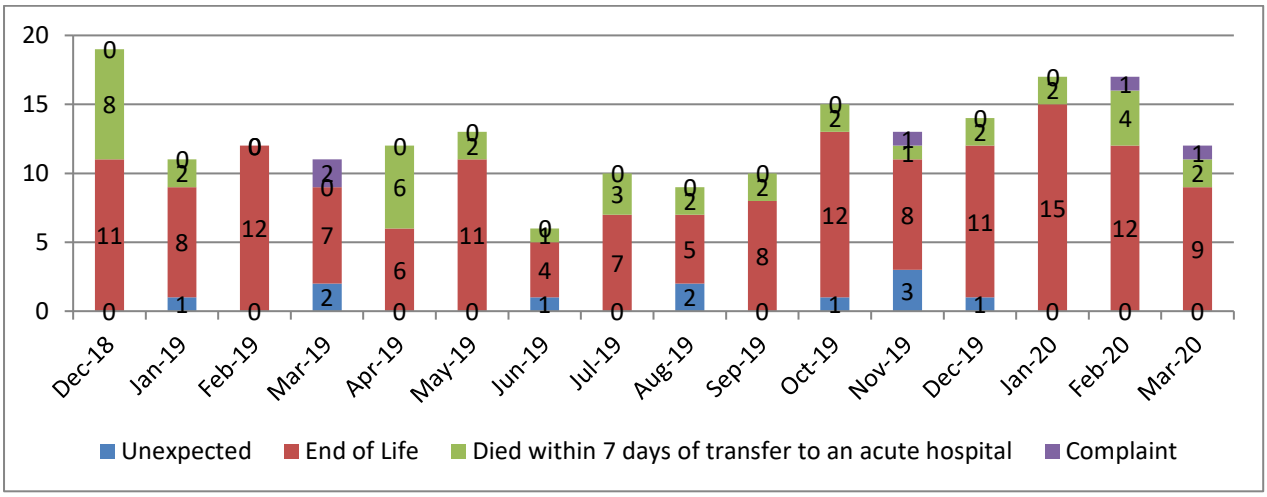
- Request further information (if required) from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service and trust level learning and improvements
- Identify a potential lapse in care and recommend investigation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

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

7. Deaths of patients (including palliative care) on community health inpatient wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 4 details these.

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



In Q4 46 (compared to 39 in Q3 of 2018/19) deaths in total were reported by the Community Inpatient Wards and one death was reported on a mental health ward.

Of these 36 were expected deaths and related to patients who were specifically receiving end of life care. These were reviewed by the EMRG and closed where enough information had been provided to give assurance that appropriate end of life care had been given.

8 deaths were unexpected (12 in Q3), of which all 8 were transferred to an acute hospital where they subsequently died within 7 days of transfer, 2nd Stage reviews were completed for 5. 3 2nd stage reviews were not considered as priority and have been suspended due to the COVID 19 response.

2 of the second stage reviews related to complaints from families where the patient had received care on our community wards prior to their death; of these 1 concern was raised by the coroner on the family's behalf and in response to this notification an SJR was promptly completed and reviewed at March TMRG.

8. Deaths of Children and Young People

5 deaths were submitted as a Datix for 1st stage review in Q4. 4 cases were closed at EMRG following 1st stage review, 1 case is being taken forwards for a 2nd stage review to feed into a safeguarding meeting.

9. Deaths of adults with a learning disability

In Q4 the Trust Mortality Review Group (TMRG) reviewed a total of 14 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 13 deaths there were no identified lapses in care provided by Berkshire Healthcare. 1 case is still open pending provision of further information, the outcome of which will be included in 20-21 Q1 report.

The deaths were attributed to the following causes:

7- Diseases of the Respiratory System

2- Cancer

2- Diseases of the Digestive System

1 – Diseases of the Nervous System

2 – Unknown at the time of report.

Demographics:

Gender:

Female	4
Male	10

Age:

The age at time of death ranged from 33 to 80 years of age (median age: 64yrs)

Severity of Learning Disability:

Mild	3
Moderate	5
Severe	4
Profound	0
Not Known	2

Ethnicity:

White British	13
Other Asian Background	1

Engagement and feedback with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability - there has been no specific feedback or concerns raised through this contact.

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

In Q4, 7 deaths (18 in Q3) have been reported as serious incidents; figure 5 details the service where the SI occurred.

Figure 5. Service (**Source Q4 Serious Incident Report)**	**Number**
West Berkshire Community Mental Health	3
Crisis Resolution and Home Treatment	2
Bracknell Community Mental Health	1
Wokingham Community Mental Health	1
Total	**7**

10.1 For all deaths which are categorised as an SI

The family is contacted in line with our duty of candour (DoC) policy and advised of the process of investigation. Someone from the service (usually a senior clinician or manager) makes contact with the family as soon as it is known that an incident causing death has occurred. At this time they offer a face to face meeting which will include:

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

Duty of Candour (DoC) applied to 9 deaths in Q4 (all were originally declared as SIs but 2 have subsequently been downgraded from SI status at the time of writing the Q4 report). Phone contact has been attempted with all families or nominated next of kin (NoK). Only one phone contact has gone unanswered. However, a DoC letter and written communication providing condolences, with an explanation of the investigation and offering support has been sent to all families or NoK .

1 family took up the offer of a face to face meeting with the service at this stage. Some families may not take up the offer of a meeting with the service but have met later with the IO as part of the investigation. In addition, further opportunities to meet or talk, should they wish, are offered at the point of sharing any outcomes in written format from the review or investigation.

10.2 Lapse in Care

Of the 51 case reviews received by the TMRG. 2 reviews were escalated as a potential lapse in care, 1 case has been confirmed as a lapse in care (see below) and the 2nd one will be investigated using root cause analysis methodology. 1 outstanding case from Q3 was closed following review with no further action.

Lapse in Care

1 lapse in care has been identified and related to a case escalated following 2nd stage review in January 2020. The learning from this case related to importance of timely transfer of the patient for acute hospital care in accordance with the trust policy: Assessment and identification of the deteriorating patient (using the National Early Warning score (NEWS 2) tool in the adult in-patient setting).

11.Learning from Deaths

The aim of the trust policy and process is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details areas of quality improvement identified in Q4.

11.1 Themes and learning from serious incidents (SI)

10 investigations have been approved by the Commissioners during this quarter which related to reported deaths and suspected suicides. A review of the completed reports has identified that there were a number of investigations that did not identify specific care delivery problems in relation to the incident being investigated but identified broader system improvement opportunities and incidental learning as well as areas of good practice; one of the key themes identified from a review of good practice includes;

Working with others: Positive learning with good evidence of joint agency working with partners as well as a multi-disciplinary approach to patient care.

Leave process: To ensure the leave process is being implemented at prospect park hospital which will include ensuring a conversation takes place about safety, whereabouts, searching process and the safeguarding considerations

Physical health monitoring – Prospect Park Hospital to continue to embed the work stream in relation to physical health assessments, monitoring and related documentation for patients admitted to a mental health inpatient setting.

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

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

There is ongoing evidence of good communication across a range of Trust services and with colleagues in acute care and other services. In one instance, where there was a lack of clarity which service would be best served to meet the individuals need, staff worked together to ensure provision of the most appropriate service.

There was one instance where the district nursing team put in place reasonable adjustments regarding a request to cover nurses' uniform when attending to take bloods. This was actioned in order to minimise unnecessary distress to the individual. There was also evidence of end of life planning taking place, including discussion in regard to supporting carers and people with disabilities in coping with grief and loss.

11.3 Mental Health Inpatients

Positive learning was identified in the following areas:

- Effective communication using processes e.g. handover
- Following process in order to escalate deteriorating patient
- Making sure the family knew what was happening
- Team knowledge- provided by training, coaching and role modelling on the ward

Areas for improvement were also identified, although record keeping was adequate staff felt that it could have been even better. They felt that some of the technology on the ward doesn't help accurate record keeping e.g. only having desktops to access medical records, not enough laptops and poor connectivity.

11.4 Learning from deaths of patients who access the Criminal Justice liaison and diversion service (CJLD).

Since the early 1990's Berkshire Healthcare Foundation Trust (BHFT) has operated a court divert service which has evolved and grown significantly since its inception. The service based in Reading CMHT set the foundations for the National model of Criminal Justice Liaison and Diversion (CJLD) which has been mandated since 2014. The service has evolved and expanded over time and services sitting under BHFT currently operate across Thames Valley (TV) and Hampshire / Isle of Wight (IoW). To deliver the service we have subcontracting arrangements with Oxford Health NHS Foundation Trust, Central and North West London NHS Foundation Trust (CNWL) and Nacro for parts of the service provision. Unexpected deaths across these services indicated a need to review the delivery model and undertake a deep dive review to identify any themes or concerns related to these deaths, as well as review whether current governance processes were sufficient to support the extended services.

Findings

The staff who participated in the deep dive were dedicated, skilled, and showed great compassion towards their client group with the service delivering a three step national model for case identification, screening and assessment. Visits to six custody suites provided assurance that the model was being delivered but that there was a need to refresh understanding of the model, and consider a number of recommendations highlighted in this report.

An unexpected finding related to the needs of our staff when their loved ones (or themselves) find themselves detained in custody and a review of processes and supports is indicated.

Recommendations

1. Refresher across all CJLD teams to remind them of the requirements and boundaries of the three step model, risk assessment, to include documentation of decision making and rationale
2. Leadership team to consider ongoing audit of supervision to support assurance of continued good practice
3. Refresher to CJLD teams around the role of STR worker
4. Service to consider any additional training or refresh for STR workers around documentation
5. Share the concerns raised in this report around high risk suspects of sexual offences released on bail with CJLD Programme Board to escalate to national team to influence police processes
6. CJLD teams to consider methods of reviewing processes related to intoxicated prisoners to ensure that good practice is maintained over time
7. Head of Service to consider trialling (possibly time limited secondment) a dedicated governance role across the service to ensure robust oversight across the teams, assist in the mortality review and SI processes, and scope out future requirements of governance resource for this growing service.
8. Head of Service to share concern with Project Board for escalation to National team around CJLD staff whose loved ones are conveyed to a custody suite where that member of staff is based.

The TMRG accepted the recommendations which are for the team and therefore the team should identify how to implement and put the required action plans in place, this piece of work will be led by the Clinical Director.

12. Medical Examiner process

In Q2 we identified the work we would be implementing in preparation for the introduction of the national medical examiner process for community trusts in April 2021. A meeting was held with the local acute trust in February to start the implementation of this work. Due to COVID 19 the medical examiner process has been suspended nationally for all trust's, this work will be re started in the future in line with national guidance.

13 Conclusion

Of the 51 reviews received by the TMRG, 2 reviews were escalated as potential lapse in care and 1 case has been confirmed as a lapse in care (see below) following Root Cause Analysis (RCA). The 2nd case is being investigated,
A separate 2nd stage review which had been escalated in Q3 was closed following RCA with no lapse in care noted.

Lapse in Care

1 lapse in care has been identified and related to a case escalated following 2nd stage review in January 2020. The learning from this case related to importance of timely transfer of the patient for acute hospital care in accordance with the trust policy: Assessment and identification of the deteriorating patient (using the National Early Warning score (NEWS 2) tool in the adult in-patient setting).

Appendix 1

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

	January	February	March	Total
NURSING EPISODE	165	130	82	377
COMMUNITY HEALTH SERVICES MEDICAL	34	24	15	73
PALLIATIVE MEDICINE	26	18	18	62
OLD AGE PSYCHIATRY	30	16	15	61
DIETETICS	18	16	16	50
PODIATRY	20	12	12	44
REHABILITATION	14	11	5	30
ADULT MENTAL ILLNESS	10	10	4	24
PHYSIOTHERAPY	14	6	1	21
RESPIRATORY MEDICINE	9	7	3	19
GENERAL MEDICINE	7	5	7	19
CARDIOLOGY	8	1	4	13
SPEECH AND LANGUAGE THERAPY	4	6	2	12
INTERMEDIATE CARE	5	6	1	12
GENITO-URINARY MEDICINE	3	2	3	8
GERIATRIC MEDICINE	4			4
CLINICAL PSYCHOLOGY	1	1		2
LEARNING DISABILITY	1	1		2
CHILD and ADOLESCENT PSYCHIATRY		1		1
GENERAL MEDICAL PRACTICE	1			1
OCCUPATIONAL THERAPY		1		1
COMMUNITY PAEDIATRICS			1	1
Grand Total	374	274	189	837

Berkshire Healthcare
NHS Foundation Trust

QAC Meeting Date	May 2020
Title	Guardian of Safe Working Hours Quarterly Report (February to April 2020)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Matthew Lowe, Dr James Jeffs, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time shared by the 2 Guardians
Legal Implications	Statutory role
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 5th February to the 30th April 2020. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

Berkshire Healthcare
NHS Foundation Trust

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

This report covers the period 5th February to the 30th April 2020

Executive summary

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

This report focusses on the period 5th February to the 30th April 2020. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' reports.

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

Introduction

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

High level data

Number of doctors in training (total): 41 (FY1 – ST6)

Included in the above figure are 3 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 41

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

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

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

a) **Exception reports (with regard to '*hours & rest*')**

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	6	0
Sexual Health	0	0	0	0
Total	0	6	6	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	2	2	0
CT	1	4	5	0
ST	0	0	0	0
Total	0	6	7	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	1	6	7	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	1	1	0	0
CT1-3	0	1	4	0
ST4-6	0	0	0	0
Total	1	2	4	0

In this period, we have received six '*hours and rest'* exception reports where the trainees worked hours in excess of their work schedule, totaling an extra 8 1/4 hours worked over and above the trainees' work schedules. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

There was one exception report not closed from the previous report. This was closed on 11th Feb with the trainee stating no further action was required.

Four of the six '*hours and rest'* exception reports received related to unpredictable situations where urgent duties were prioritized during the junior doctors working day meaning that the doctor stayed late by on average 1.5 hours to complete that work and any regular work that could not be handed over. Two exception reports related to a trainee attending Covid-19 related non-clinical meetings which had to be scheduled at times that meant they were not possible to be part of their normal working pattern. All 6 were appropriate reasons for working beyond their work schedules and all have been approved by the appropriate supervisors.

It has been the opinion of Medical Staffing and the Guardians of Safe Working that in most cases "time off in lieu" is the most appropriate action following an exception report to minimize the effects of excessive work, however during the Covid-19 crisis we have agreed to change the emphasis such that payment for the extra hours worked is an equally valid outcome. For all 6 exception reports "time off in lieu" was the agreed outcome.

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

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardians at induction and at every Junior Doctor Forum. The JDF

Chair, with the encouragement of the Guardians, has been actively involved in setting up an online "Exception Reporting Survey" of trainees across the Thames Valley region looking at barriers for junior doctors in exception reporting across all trusts in the area and we await the results which were originally scheduled for June 2020.

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 5th February to the 30th April 2020

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	48	47	17	30	0	486	473.5	190.5	283	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	18	18	10	8	0	213	213	119	94	0
Sickness	4	4	3	1	0	49	49	36.5	12.5	0
Covid-19	26	25	4	21	0	224	211.5	35	176.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	48	47	17	30	0	486	473.5	190.5	283	0

d) **Fines**

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

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

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

Qualitative information

As with previous rotations gaps that we were aware of before the rotation began, cover was in place ahead of the start of the rotation.

In terms of gaps caused by Covid-19 these started on the 13th March and are a result of self/family isolation, pregnancy, or a serious underlying health condition. We were only unable to cover one shift and that was short notice at a weekend, the doctor in question developed symptoms out of hours on Friday with their shifts being weekend long days, therefore the Saturday saw only one junior doctor on at PPH, however, the Sunday shift was covered.

At present our system for cover is working as normal, with gaps being quickly filled.

Currently the OOH rota is still operating at 1:12 even though we have four doctors unable to participate as a result pregnancy/serious underlying health condition. The trainees, as well as their OOH duties, are also providing support to the isolation and other wards at PPH, therefore at this present time we are not looking to reduce the frequency of the OOH rota as we do not wish to increase the burden on our junior doctors. However, should the situation worsen we have already created back-up rotas to ensure we can still provide two junior doctors OOH at PPH.

We have also for the duration of the current situation agreed to change our default action from only giving TOIL, to giving trainees the choice of payment for extra hours worked or TOIL. This is because it was felt that trainees should have the flexibility to continue to support and to keep services safe, as long as their working remains safe.

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

This report covers unprecedented times for the working patterns of junior doctors due to the Covid-19 crisis. The Trust has been active in working with the junior doctors to involve them in decisions about changes. The Junior Doctors Forum (JDF), in particular the Chair, Parul Jha has been actively involved in setting up Microsoft Teams based support sessions for the junior doctors and in sourcing 150 “scrubs” and 200 gowns donated by the public. The JDF created a Redeployment Team to organize redeployment of junior doctors from the community to support gaps at PPH and to facilitate support for them. The JDF also created a “COVID-19 Taskforce” working with the Inpatient Divisional Director and Medical Director amongst others to work on the Covid-19 response on the wards. The renovation of the Doctors On call rooms has been completed and they are now in full use. The renovation of Doctors Lounge are on hold due to Covid-19 and will be restarted when it is safe to do so.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there is under-reporting of small excess hours worked.

Actions taken to resolve issues

Next report to be submitted August 2020.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No trainee has breached the key mandated working limits of the new contract.

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

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

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

Work Schedule – A work schedule is a new concept for junior doctors that is similar to a Job Plan for Consultants. A work schedule sets out the expectations of the clinical and educational work that a Junior Doctor will be expected to do and have access to. Before entering each post, the Junior Doctor will have a “Generic Work Schedule” that the

Clinical Supervisor and Medical Staffing feels sums up the expectations and opportunities for the that post. At the initial meeting between Clinical Supervisor and trainee this will be personalized to a “Specific Work Schedule” giving the expectations of that trainee in that post. If exception reporting or other information indicates a need to change the work schedule this is called a work schedule review. The new policy indicates the procedures for this process and appeal if it is not considered satisfactory.

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

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

Appendix B

Factsheet: Safety limits and rest

The below table highlights the changes to the safety limits and rest provisions between the 2016 terms and conditions and the 2018 contract refresh. For full details please refer to schedule 3 of the terms and conditions of service (TCS).

2016 terms and conditions	2018 contract refresh
Maximum of 72 hours work in any 7 consecutive day period.	Maximum of 72 hours work in any 168-hour consecutive period.
46-hours rest required after 3-4 consecutive night shifts.	46-hours rest required after any number of rostered nights.
Doctors paid at nodal point 2 are exempt from the requirements that no doctor shall be rostered for work at the weekends greater than 1 week in 2 for one placement during their foundation year.	No doctor shall be rostered for work at the weekend at a frequency of more than 1 week in 2.
No doctor shall be rostered for work at the weekend at a frequency of greater than 1 week in 2.	All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends.
Where 8 shifts of any length are rostered or worked on 8 consecutive days, there must be a minimum 48-hours rest rostered immediately following the conclusion of the eighth and final shift.	Maximum of 7 shifts of any length can be rostered or worked on 7 consecutive days. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days*.
No more than 5 long shifts shall be rostered or worked on consecutive days. Where 5 long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.	No more than 4 long shifts shall be rostered or worked on consecutive days. There must be a minimum 48-hour rest period rostered immediately following the conclusion of the final long shift*.
A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours, and • a second 30 minute paid break for a shift rostered to last more than 9 hours.	A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours • a second 30 minute paid break for a shift rostered to last more than 9 hours • A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	14th July 2020
Title	NHS Infection Prevention and Control Board Assurance Framework (COVID-19)
Purpose	To provide assurance to the board around assessment against and compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance
Business Area	Nursing & Governance
Author	Diana Thackray – Head of Infection Prevention and Control Heidi Ilsley - Deputy Director Nursing Debbie Fulton- Director Nursing and Therapies
Presented by	Debbie Fulton, Director Nursing and Therapies
Relevant Strategic Objectives	True North goal of harm free care, supporting our staff
CQC Registration/Patient Care Impacts	Supports maintenance of CQC
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	The Infection Prevention Infection and Control Board Assurance Framework was first published in May 2020 with the aim of supporting all healthcare providers to effectively self-assess their compliance with Public Health England (PHE) and other COVID-19-related infection prevention and control guidance. Thereby providing assurance to boards that organisational compliance has been systematically reviewed. The framework has been structured around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It is also structured to provide assurance in relation to the Health and Safety at Work Act 1974 and the wide-ranging duties placed on both employers and employees in the protection of the 'health, safety and welfare' at work

	The review of our current processes against the framework does not demonstrate gaps in Trust implementation of any guidance; where there is potential for gaps around ongoing local assurance, oversight through usual patient safety and quality assurance processes is identified as mitigation as agreed with Clinical Directors. The assurance framework is reviewed through the PPE Clinical Reference Group and the Quality and Performance Executive Group.
ACTION REQUIRED	This report is for noting at the Board

NHS Infection Prevention and Control Board Assurance Framework (COVID-19)

This framework has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained

The framework is structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In addition the Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
Infection risk is assessed at the front door and this is documented in patient notes	Dissemination of Covid-19 inpatient isolation and cohorting SOP (v1 14/04/2020 & v2 01/05/2020) includes requirements for admission screening. SOP for flagging suspected and confirmed Covid 19 cases for both inpatient and community patients on Rio alerts. IPCT review Rio notes for record of results as part of admission screening and review of number of positive cases.		

	All patients treated as potentially COVID+ with appropriate infection prevention and control measure in place in line with PHE guidelines to mitigate risk of transmission. (community and inpatient care) Spot check of patient records and review by IPCT to ensure all admission screens undertaken	Spot check covering 1st May 2020 till 7th June 2020 demonstrated 89% compliance	Results provided back to wards with support for improvement as required
Patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission	Covid-19 inpatient isolation and cohorting SOP (v2 01/05/2020) Review of positive cases by Infection prevention and control Team. Ward management of isolation and cohorting positive cases Screening of patients at day 14 post onset symptoms/ + test result prior to transfer both internally and to care homes.		
Compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patients	Dissemination of Department of Health and Social Care (DHSC) adult social care plan. All patients being transferred to care homes are swabbed prior to discharge Patient advice letter following contact with confirmed case		
All staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	Review and overview of stock levels and supply of PPE by Deputy Director Nursing and Estates and Facilities Management Channels of communication in ICS for raising potential shortages with mutual aid available to ensure suitable PPE available System in place for PPE to be held in central stores and delivery to frontline services -22.6.20 - dedicated email for requests		

	System in place for checking any donated PPE is quality assured prior to release into supply chain Covid -19 PPE page on Teamnet with links to updated guidelines Posters demonstrating how to Don and Doff and mask and other PPE available PPE supporters' visits were in place to support compliance - now stood down PPE supporters undertook Hand hygiene and PPE compliance spot check monitoring tool IPC compliance tool provided to inpatients and community services to support team compliance Individual staff PPE competence checklist provided to services for local use. Visits to clinical teams by IPCT & PPE supporters have been undertaken Deputy Director Nursing & Head IPC supportive meetings with community services to aid infection prevention and control & PPE understanding Systems in place to ensure dissemination of relevant aids such as Posters provided to support understanding; Community staff video of donning and doffing in community circulated Standard work produced at PPH to support staff understanding of correct PPE IPCT mandatory training video and resources produced for induction and redeployed staff Gemba visits in person by DoN and executive teams calls to teams Weekly Teamslive event for whole organisation includes Q&A for any concerns	Assurance of compliance and competence tool use at service level	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

	PPE clinical reference group to assist Clinical Directors with questions raised around PPE Clinical Strategy Group in place for agreeing any deviation from PHE guidance with rationale - Decision log in programme management workbook to log decisions Risk assessment for all staff in high risk categories at start of outbreak. All BAME staff being risk assessed w/c 8th June 2020 CAS alerts related to PPE acted on within timescales with appropriate actions undertaken PPE oversight group established (DoN. DDN, IPCT, COO, Lead CD, PPH associate medical Director and all Clinical Directors) to provide forum for any concerns/ challenges and new guidance to be discussed and agreed to allow Divisional Clinical Directors to provide support in their divisions. COVID all staff newsletter provides links to updates/ posters and information on PPE Information and support provided following implementation of wearing of masks in non-clinical areas w/c 15th June. Type 1/ 2 masks provided to all sites through Divisional senior leaders along with poster and guidance around where and how to wear.		
National IPC PHE guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way	COVID-19 inbox for receipt of all new guidance, guidance log and process for dissemination in place CMO /CNO letters received with process for dissemination in place IPCT review of PHE updates Participation in local ICS and national / regional CNO calls/ Webinars to gain understanding of new guidance		

	Trustwide newsletter initially daily now at least weekly and when new guidance is published used to cascade all new information All staff briefings -commenced weekly 25th March 2020, reduced to alternate weeks end May - currently ongoing alternate weeks - this is a live broadcast which is also published on Teams and includes live Q&A to support questions on practical application of guidance. Teamnet space for all IPC information Posters disseminated to clinical areas detailing latest guidance PPE oversight group and local divisional/ service and teams meetings/ handovers used to disseminate information. Availability of Infection Prevention and Control alongside other senior staff to provide support with application of new guidance Services visits by Infection control, Director Nursing and Clinical Directors as well as divisional managers to support implementation of guidance Compendium /local record of national guidance and required actions in place and updated as new guidance published		
changes to PHE guidance are brought to the attention of boards any risks and mitigating actions are highlighted	Project management workbook to collate all new guidance with system in place to receive and disseminate to gold command meetings with action log in place. Attended by Exec Directors Clinical Strategy group for any ethical or risk issues associated with guidance attending by MD, DoN and Trust Chair		

	Action plan in place to manage PPE shortages in line with CAS alert issues Clinical Directors PPE clinical reference group & TOR Overarching COVID (Risk 8) BAF put in place March 2020 reviewed at Board and sub committees New Risk added to corporate risk register June 2020 following publication of letter around Nosocomial transmission COVID part of monthly board discussions IPCT BAF reviewed at Quality &Performance Executive Group		
risks are reflected in risk registers and the Board Assurance Framework where appropriate	COVID -19 risk added to Board assurance, reviewed monthly at Board. 15.6.20 - New Corporate risk (Nosocomial infection) added to corporate risk register		
robust IPC risk assessment processes and practices are in place for non COVID-19 infection and pathogens	IPC policies IPC routine surveillance Post infection reviews IPC monthly report presented to QEG Quarterly shared learning reports Quarterly Datix review of IPC incidents		
2. Provide and maintain a clean appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

Designated teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas	Covid-19 PPE training resources available on intranet PPE videos for donning & Doffing disseminated to teams and available on intranet Community Nursing video for donning & doffing PPE posters on Teamnet and printed copies made available to services Support visits by IPCT, DN & DDN as well as local managers and clinical leads. Sampling guidelines include swabbing technique IPCT mandatory training video and resources produces for induction and redeployed staff COVID Newsletter to disseminate information to teams Local induction checklists for services to include PPE Clinical skills training for staff deployed to new areas includes use of PPE for tasks Additional support provided to Rowan ward (During April and May when this was designated as COVID ward) including from Physical Health lead PPH included questions around PPE and managing COVID in standard work and handovers		
Designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	Estates and facilities cleaning SOP Staff designated to ward areas, process in place for management of waste, meal provision etc. to prevent crossover or facilities staff managers regularly monitor/ support staff		
Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance	IPC compliance tool E&F and ward staff checks ICC026 Environmental/Equipment Cleaning and Disinfection Policy		

	Domestic staff on ward have been trained and issued relevant Sops. Site coordinators also check		
increased frequency, at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance	Inpatient SOP E&F cleaning and environmental SOP Cleaning schedules		Compliance with cleaning schedules E&F cleaning monitoring scores
attention to the cleaning of toilets/bathrooms, as COVID-19 has frequently been found to contaminate surfaces in these areas	E&F cleaning and environmental SOP Cleaning schedules Monitored as part of inpatient IPC compliance tool which has been provided to wards for local completion	Assurance around Local overview of IPC compliance tool at service level	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
Cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine, as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	E&F cleaning and environmental SOP EFM monitoring of wards has continued throughout this period Monitored as part of inpatient IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy	Assurance around Local overview of IPC compliance tool at service level	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ Disinfectant solutions/products	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Staff have all been trained in the use of Chlor clean as per National standards of cleanliness and the Healthcare cleaning manual		
manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/ disinfectant solutions/ products as per national guidance: ○ 'frequently touched' surfaces, e.g door/toilet handles, patient call bells, over-bed tables and bed rails, should be decontaminated at least twice daily and when known to be contaminated with secretions, excretions or body fluids ○ electronic equipment, eg mobile phones, desk phones, tablets, desktops and keyboards should be cleaned at least twice daily ○ rooms/areas where PPE is removed must be decontaminated, timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	ICC026 Environmental/Equipment Cleaning and Disinfection Policy E&F cleaning and environmental SOP Cleaning schedules Staff information on keeping safe at work including desk space clean and clutter free, cleaning of devices etc.		

linen from possible and confirmed COVID-19 patients is managed in line with PHE national guidance and the appropriate precautions taken	IPC compliance tool ICC020 Management of Linen and Laundry Standard Operating Procedure for Placement of Covid-19 Inpatients	Assurance around Local overview of IPC compliance tool at service level	IPC compliance tool to be undertaken by inpatient wards. Action plans to be monitored by ward managers/ matrons. Immediate action to be taken to correct deficiencies Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
Single use items are used where possible and according to single use policy	IPC compliance tool Patient equipment monitoring included in IPC annual monitoring programme ICC008 Single Use Medical Devices Considerations for acute personal protective equipment (PPE) shortages Berkshire Healthcare NHS Foundation Trust action plan	As above	As above
reusable equipment is appropriately decontaminated in line with local and PHE national policy	Ward equipment cleaning schedules IPC compliance tool SOP for cleaning of reusable goggles ICC026 Environmental/Equipment Cleaning and Disinfection Policy	As above	As above

review and ensure good ventilation in admission and waiting areas to minimise opportunistic airborne transmission	Fans not in use in any Trust setting - communication out to staff regarding this has occurred Review of all aircon on trust sites undertaken with risk assessment and guidance issued - 22.6.20 guidance circulated through service management including list of air con for use; also circulated through all staff email		
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
arrangements around antimicrobial stewardship are maintained	Pharmacy antimicrobial stewardship strategy Antimicrobial Stewardship Group programme of work that encompasses the requirements of Criterion 3 of the H&SC Act (2008) in order to demonstrate compliance. Antimicrobial stewardship group meeting minutes Antimicrobial stewardship annual audit		
mandatory reporting requirements are adhered to and boards continue to maintain oversight	The programme to be monitored by the AMS Group and progress reported to the IPCSG quarterly Mandatory surveillance of reportable infections in place and reported via monthly/ QEG reports. Post infection reviews and associated learning disseminated and reviewed at PSQ		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

implementation of national guidance on visiting patients in a care setting	Implementation of all guidance around Visiting implemented including visiting suspended for inpatient units except at end of lifehttps://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0030_Visitor-Guidance_8-April-2020.pdf Guidance provided to wards to support visitors for end of life patients in line with national guidance 8.6.20 - Visiting guidance updated to reflect changes to national social distancing and visitor guidance this has been disseminated to al wards and included in all staff newsletter. 15.6.2020 -masks, hand rub and bins available at entrances for visitors not wearing face coverings. Posters to remind visitors to wear face covering, social media and internet also issued to promote message. Each ward has process in place for monitoring visitor numbers, support to sue outside spaces where possible. IPAD for promoting virtual visiting in place for all wards		
areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access	Isolation signage Covid-19 inpatient isolation and cohorting SOP		Wards managing Covid - 19 patients in line with SOP. 20.06.2020 - Berkshire Healthcare does not have standalone Covid-19 wards.
information and guidance on COVID-19 is available on all Trust websites with easy read versions	External webpage has relevant information and is updated Easy read information has been disseminated to services via COVID-19 newsletter and is available on website		

	Trust website has clear information for patients/ carers/ families and the public 20.6.20 – information reminding visitors and patients attending appointments to use face coverings in place		
infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	Completion of inter healthcare transfer form ICC017 Isolation and Movement of Patients IPC surveillance of admissions, discharges and transfers. Flagging of positive and suspected cases on Rio Robust links with local acute providers Review of Datix if non-compliance identified		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate them from non COVID-19 cases to minimise the risk of cross infection	Trust does not have an A&E admission are generally planned unless admission through Place of safety. Covid-19 inpatient isolation and cohorting SOP All patients treated as potentially positive with appropriate IPC measure in place to minimise transmission All patients swabbed on admission where this has not been undertaken by transferring hospital	EFM review of one-way systems and marking social distancing in patient communal areas in progress	
mask usage is emphasized for suspected individuals	Included in: • inpatient SOP • IPC principles for home visits • IPC principles for clinic/ outpatient settings		

	Promotion of use of face coverings for all visitors to trusts sites at entrances, with paper coverings, bin and hand rub available for those who have not brought a material face covering to use.		
ideally segregation should be with separate spaces, but there is potential to use screens, eg to protect reception staff	Berkshire healthcare does not have separate spaces for most services, patients known or suspected to be positive would not be attending clinics/ Trust premises other than when being admitted into wards UTC provide swabbing facility as drive through to mitigate risk or transmission. SOP in place for this process		
for patients with new-onset symptoms, it is important to achieve isolation and instigation of contract tracing as soon as possible	Inpatient SOP 20.6.2020 - Process for all staff to alert when contacted by test and trace in place through COVID inbox. Test and trace processes highlighted at all staff briefings and in all staff newsletter. IPCT support with contact tracing Process ~~being~~ established for out of hours using established on-call arrangements PHE provided with on-call contact details to support contact tracing if required Outbreak processes in place 25.6.20 - RCA will be undertaken for every probable healthcare associated COVID-19 inpatient infection i.e. patients diagnosed more than 7 days after admission. Participation in weekly ICP meeting to discuss infection status		

patients with suspected COVID-19 are tested promptly	Guidelines for swabbing included in inpatient SOP Checking process in place through IPC to ensure all new admissions tested. All wards have access to swabs to enable timely testing Inpatient management and investigation and management of suspected cases		
patients that test negative but display or go on to develop symptoms of COVID-19 are segregated promptly and re-tested and contacts traced	Isolation policy Covid-19 inpatient isolation and cohorting SOP IPCT daily review of cases Routine surveillance		
patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	IPC principles for clinic and outpatient settings disseminated Signage produced for all clinic/ out-patient areas EFM review of marking social distancing and one-way systems Process in place for staff to ring ahead of any planned appointments to patients' homes or if invited into a clinical setting being undertaken to confirm patient is asymptomatic 20.6.2020 - all visitors asked to wear face covering / paper coverings supplied if required to mitigate asymptomatic transmission. Social distancing and use of PPE for staff. Recovery plans with EFM and QIA I place and signed off prior to recommencement of any face to face services		EFM assessment undertaken as part of service restoration and recovery planning

6. Systems to ensure that all care workers (including contractors and volunteers) are aware and discharge responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
all staff (clinical and non-clinical) have appropriate training, in line with latest PHE guidance, to ensure their personal safety and working environment is safe	Covid -19 resources Links to PHE guidance Weekly all staff executive teamslive briefing COVID-19 newsletter includes latest guidance for all staff which is also available in COVID section of Teamnet IPC/ DDN teams meetings to support understanding Weekly exec teams meetings with specific teams includes Q&A Covid-19 briefings IPC/ PPE considerations as part of recovery planning QIA for recommencing services includes PPE/ safety questions Local induction for deployed and new staff PPE advisors routinely visit ward areas to support training and compliance Compliance tool in place to provide assurance Aids such as posters, videos available and disseminated to staff Regular ward visits by IPC to wards to aid training and compliance Skills training made available to all IPC training video produced for staff redeployed to clinical areas		

	Messaging around Social distancing reinforced in teamslive events, newsletter and other communication channels. Alternative space provided to non-clinical staff who need to be in work to support social distancing		Further visual aids and Trust campaign to support social distancing currently being explored
all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it	PPE videos for donning & Doffing Community Nursing video for donning & doffing PPE posters on Teamnet and printed copies made available to services Support visits by IPCT, PPE supporters, DN & DDN Resources available on Trust intranet IPC regularly visit wards to provide support, IPC involved in service recovery programme of work and are supporting services with information / teams calls and visits to ensure correct PPE available and understanding of use before they commence face to face contacts	Assurance around local compliance with competency assessment/ induction	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
a record of staff training is maintained	Record of general IPC training is maintained on ESR PPE competence tool for staff Workshops for champions to support sign-off	Record to be commenced and maintained by individual services	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed	Considerations for acute personal protective equipment (PPE) shortages Trust action plan completed. Process in place to monitor PPE to enable this to be enacted in timely manner if required List of current stock levels and burn rate monitored by EFM/ with stores held centrally.		

	Mutual aid processes in place if required prior to resorting to reuse.		
any incidents relating to the re-use of PPE are monitored and appropriate action taken	If PPE action plan for reuse was to be enacted all services would be asked to escalate concerns immediately and to record via Datix 20.6.2020 - this has currently not been required. Datix review/ investigation of any incidents Riddor process		
adherence to PHE national guidance on the use of PPE is regularly audited	IPCT and senior staff visits to monitor PPE compliance IPC compliance tool Visits to services PPE clinical review group to support compliance	Local oversight of compliance tool	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
staff regularly undertake hand hygiene and observe standard infection control precautions	Monthly and quarterly hand hygiene observations IPC compliance tool	Local oversight of compliance tool	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
hand dryers in toilets are associated with greater risk of droplet spread than paper towels. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination, as per national guidance	EFM have undertaken review of placement of hand dryers and work in progress to add hand towel dispensers Completed, where hand dryers have not been removed hand towel dispensers have been added		

guidance on hand hygiene, including drying, should be clearly displayed in all public toilet areas as well as staff areas	Hand hygiene posters in public areas Hand hygiene technique on some soap dispensers in public areas		
staff understand the requirements for uniform laundering where this is not provided for on site	Guidance disseminated in newsletters & briefings and on Teamnet page. IPC principles documents		
all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if they or a member of their household display any of the symptoms.	PHE guidance issued via Newsletters and all staff teamslive events Information links on Teamnet page: • Self-isolation • Staff testing • Staying safe at work Supporting guidelines for managers Dedicated Covid-19 inbox for advice Screen savers 20.6.2020 - Information on Test and Trace disseminated through newsletter, intranet and all staff briefings Use of COVID mailbox for all staff to alert Trust if contacted and advice can be provided at pint of contact		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate	Isolation policy Isolation and cohorting SOP provides guidance to all wards Surveillance data Admission screening review IPCT available for support		
areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance	Inpatient and isolation SOP Reduced number beds on wards to ensure compliance with 2m distancing		
patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	IPC surveillance Laboratory weekly and monthly data report reviewed by IPCT Isolation policy		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
testing is undertaken by competent and trained individuals	Guidance for taking swabs document provided to all inpatient and swabbing teams. Support from physical health lead at PPH to support training.		

patient and staff COVID-19 testing are undertaken promptly and in line with PHE national guidance	Admission screening compliance review undertaken by IPCT and reported to Gold command meetings Guidance for staff regarding requirements and process for staff testing on Teamnet/ in newsletters/ screen savers Inpatient SOP includes testing of patients at day 14 and prior to discharge to Nursing /care homes Process in place to enable staff access to swabbing locally - mailbox to request		
screening for other potential infections takes place	IPC mandatory surveillance processes in place Deteriorating patient procedures in place to include being alert to potential sepsis and transfer of unwell patients to acute providers as appropriate		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC training recorded on ESR and monitored Dedicated IPC email for support and advice Guidance for keeping safe at work including social distancing produced and disseminated. Support / visits from managers, Clinical Directors and IPCT Regular IPC audit programme in place Sharing of learning from incidents and post incident reviews Monthly IPC report shared through Divisional patient safety and quality processes as well as QEG		

any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	Covid -19 Teamnet page links to PHE guidance enabling most up to date to always be available COVID-19 newsletters and all staff briefings used to highlight changes visits to wards by managers/ IPCT to ensure latest guidance adhered to Posters updated to reflect any new guidance are disseminated directly to wards and relevant clinical areas New guidance and SOP are shared with clinical directors to support dissemination and compliance COVID-19 in box receives all updates and process in place to record and action these and can also be used by any member of staff with queries Participation in ICS meetings, CNO / PPE and other relevant webinars where new guidance is highlighted. Services use handovers, meetings and PSQ to update on changes PPE review group to discuss guidance and dissemination Meetings for use of fans aircon and also social distancing have taken place 20.6.2020 - new guidance regarding wearing of masks in non-clinical areas and face coverings for visitors and outpatients circulated via newsletter 12th June 2020 and again Monday 15th June and Friday 19th June. Teams live event and FAQ		

all clinical waste related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current PHE national guidance	Links to waste guidelines IPC compliance tool Waste management included in Trust guidance documents and posters including flyer for community patients Policy on waste management https://www.england.nhs.uk/coronavirus/publication/covid-19-waste-management-standard-operating-procedure/ 3.7.2020 - SOP for waste management updated and shared		
PPE stock is appropriately stored and accessible to staff who require it	PPE held at central locations Stock control and distribution arrangements in place as well as process for estimating burn rate PPE stock catalogue PPE supply and stock review meetings PPE included in daily Sit reps Process in place for mutual aid should stock levels become an issue Email for all staff to request PPE in place Volunteers used to deliver PPE to services		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

staff in 'at-risk' groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	Risk assessment completed for all staff identified in at-risk group with individual conversation and risk mitigation put in place 20.6.2020 – risk assessment process for all BAME staff commenced 8.6.20 Trust wide tiered well-being offers in place alongside nationally available support. Available on Teamnet, published in newsletters and on-screen savers Access to Occupational Health Advice through HR teams FTSU guardian available should staff feel concerned Active staff networks for disability, LGBT+ and BAME		Process in place to monitor that risk assessments are recorded electronically
staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained	Record of trained fit testers within the organisation High risk staff groups identified Fit testing records kept by individual teams and forwarded to IPCT Reusable respiratory hoods available at all inpatient sites. Training resources and video available		
consistency in staff allocation is maintained, with reductions in the movement of staff between different areas and the cross-over of care pathways between planned and elective care pathways and urgent and emergency care pathways, as per national guidance	Inpatient isolation and Cohorting SOP EFM staff allocated to specific wards for duration of shift 20.6.2020 - currently no positive patients on IP wards. Community staff organise themselves to minimise crossover and /or visit known positive patients at end of day		

all staff adhere to national guidance on social distancing (2 metres) wherever possible, particularly if not wearing a facemask and in non-clinical areas	Information on keeping safe at work and managing social distancing at work disseminated to managers and staff Information regarding importance of staff social distancing in non-clinical environments/ communal areas Posters, screen savers and information available on intranet, importance of social distancing on all staff exec briefings 20.6.20 - Social distancing comms campaign being agreed Need for social distancing factored into recovery of services Service visits by managers, clinical directors to support message Staff working from home where able Guidance on use of face masks for all staff in non-clinical areas and face coverings for visitors / outpatients in line with new guidance issues 12.6.20 Posters, bins, hand rub and masks available at entrance to all hospital sites Programme of work to ensure signage to support social distancing in place across trust sites Staff aware of test and trace processes and importance of social distancing in relation to this	EFM review of marking social distancing in communal areas and offices in progress Social distancing comms campaign in planning	
consideration is given to staggering staff breaks to limit the density of healthcare workers in specific areas	Information on keeping safe at work and managing social distancing at work disseminated to managers and staff. Alternative spaces used for staff to support ability to social distance		

staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absence is monitored daily through ESR/ SITREP Well-being support offered Staff supervision and teams' meetings to provide support Dedicated staff testing email to provide support and national home testing also promoted through trust intranet, COVID newsletter and screen savers. In line with usual process managers keep in touch with staff when absent from work 20.6.20 – process in place for staff to advice if contacted by test and trace 20.6.20 - BAME risk assessments and risk assessments for high risk staff returning to workplace in progress	Ability to report staff isolating following contact through test and trace requires manual process due to ESR field not available to capture this specific data	National ESR update to enable specific capture of test and trace contact as reason for absence from 6th July - staff made aware through COVID email
staff that test positive have adequate information and support to aid their recovery and return to work.	Returning to work after self-isolation guidance on Teamnet and disseminated via trust briefings and COVID newsletter. Human resources Q&A for managers and staff Well-being programme of support in place Access to occupational health		

Links to guidance referenced in framework:

https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103031

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0030_Visitor-Guidance_8-April-2020.pdf

https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/

Minimising Nosocomial Infection -letter of 9th June 2020

FAQ on use of masks and coverings in hospital settings

Healthcare associated COVID-19 infections – further action – 24th June 2020

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting Paper

Meeting Date	14 July 2020
Title	Volunteer, Work Experience and Honorary Contract Annual Report
Purpose	To provide assurance of the governance of the employment checks and training of individuals working in the trust as volunteers or on honorary contracts.
Business Area	Nursing & Governance
Author	Julie Addison- Volunteer and Work Experience Manager Nathalie Zacharias- Deputy Director of Allied Health Professions
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience and safe and effective services.
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	Services across Berkshire Healthcare currently employ 167 volunteers. Over the past 12 months 9 people employed in Berkshire Healthcare on honorary contracts/ volunteers, gained paid employment in the Trust in a combination of permanent posts and work on NHS Professionals. Berkshire Healthcare has been awarded the Queen's Award for Voluntary Services
ACTION REQUIRED	The Board is asked to: • note the report

Berkshire Healthcare
NHS Foundation Trust

Volunteer / Work Experience Annual Report

April 2020

Julie Addison
Volunteer and Work experience Manager

Welcome to our review of the year, April 2019 – March 2020

Our volunteers continue to do an outstanding job enhancing our services with much appreciation from staff and service users.

Volunteers support services such as, help for dementia patients, mental health peer support, administration, occupational therapies, ward help, gardening, and spiritual services.

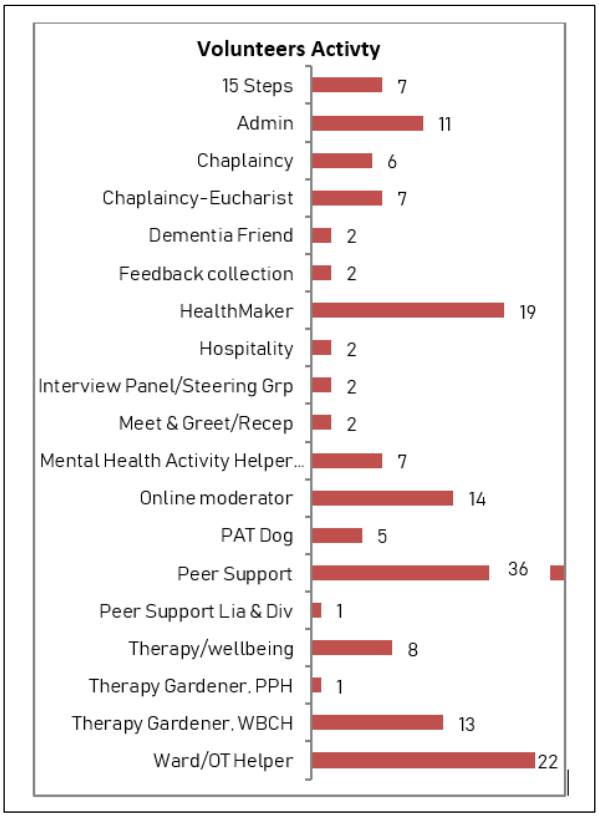
Volunteering in numbers

121 (2017/18) 160 (2018/19) 167 (2019/20)

Locality	Total
Bracknell	**24**
Newbury	**32**
Reading	**45**
Slough	**28**
WAM	**17**
Wokingham	**21**

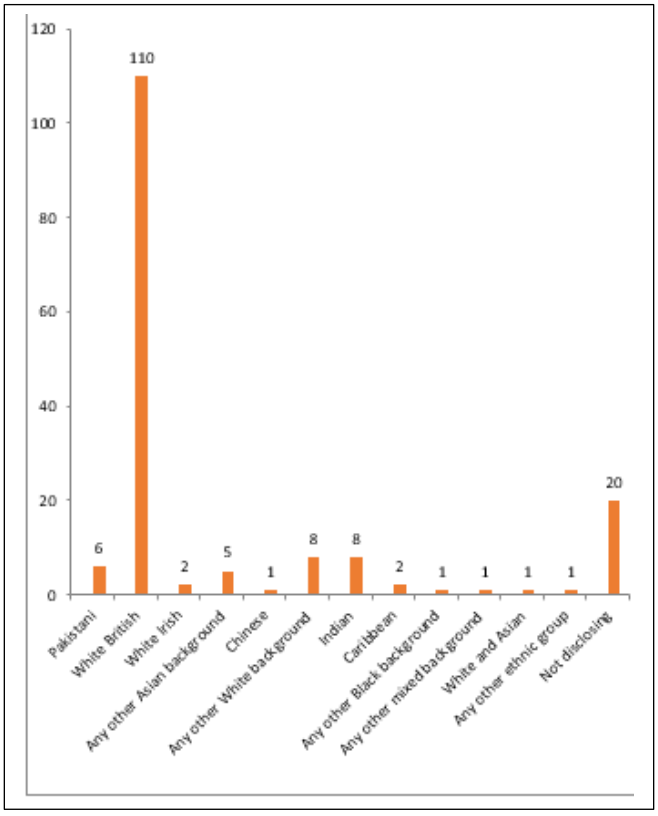
167	Volunteers up from 160 in 2018/2019
159	Work Experience visits up from 125 in 2018/2019
122 persons	Currently working on honorary contracts down from 125 in 2018/2019

Volunteer Activity



We estimate that our volunteers donated approx. 20,800 hours of their time to supporting the trust and services to service users.

Equality & Diversity data

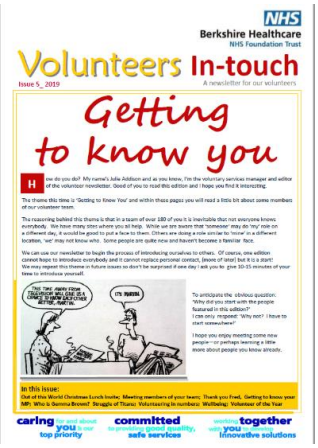


We have an ethnically diverse volunteer team. 36% of our volunteers declaring their ethnicity are BAME.

Volunteers and Honorary Contract staff moving on within the NHS.
A total of 7 of our honorary contract candidates and 2 of our volunteers have successfully gained employment at Berkshire Healthcare (Includes bank staff-NHSP) in the last 12 months.

Key Achievements 2019/20

- **We have won the Queen's Award for Voluntary Services (QAVS) – The equivalent of the MBE for volunteer services. It is awarded for outstanding achievement to groups of volunteers who regularly devote their time, skills and energy for the benefit of others. This is a prestigious National Honour.**
- Celebrated contribution of our volunteers at the annual thank you event attended and hosted by the volunteer manager, volunteer administrator and Deputy Director of Allied Health Professions and Volunteer services.
- Supporting QI aiming to improve and generate increased service user engagement; recruited 2 new volunteers and 3 existing volunteers. We are utilising the volunteers to help co design a tool specifically aimed at making it easier for service users to provide feedback.
- We have increased the number of Pat Dog visitors at WBCH (by popular request) to 5.
- A record number of volunteers nominated (13) for the 'Volunteer of the Year Award'.
- Volunteer policy updated meeting 2 yearly review date.
- Annual newsletter distributed.
- Work experience has seen a 27% increase in requests/attendance up from 125 to 159
- Undertook volunteer survey 2019. Results mirrored previous 2017 survey in that 100% felt their work was valued and respected among those they help (both staff and service users). Broadly speaking, the main motivations for applying to volunteer are, access to jobs/credible experience for applications, give something back, exploring career/change of career, time on hands/social engagement.
- Promoted Volunteers' Week by showcasing different volunteers daily through twitter.
- Attended AGM with a stand promoting the volunteer service.
- Supported the widening participation team by establishing an 'exit evaluation survey' for their apprenticeship programme.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Volunteers In-touch

Issue 5_2019

A newsletter for our volunteers

Getting to know you

caring committed together

A copy of the newsletter(s) is available from Voluntary Services.

Health and Safety tracking

The health, safety and welfare of our volunteers remains a high priority. All our volunteers receive an induction at commencement of their volunteering with their placement supervisor and yearly refresher training is carried out.

DBS 100% compliant

Training activity:

	Compliant
Yearly training	97%
2-yearly training	100%
3-yearly training	100%
Total No of volunteers **167**	

Current position 04/2020

Tracking training activity

New starters (5 volunteers) awaiting induction/commencement in placement (currently suspended due to COVID).

5 volunteers non-compliant for annual training, currently being followed-up

Developing our services/ Looking to the future

A risk assessment, role descriptor and guidance has been arranged to recruit peer support volunteers to help our Liaison & Diversion service. One volunteer recruited and trained.

A role descriptor and poster were arranged to recruit gardeners for PPH. Additionally, we contacted local mental health charities and engaged with the Ridgeline Trust who were interested in working with us. Unfortunately, due to proposed changes to service locations recruitment is on hold for the time being.

There has been limited volunteer recruitment at PPH 2019/20 due to ongoing issues with access to their training courses, dysphagia, fire and breakaway. This has impacted overall volunteer recruitment. Work is ongoing to try and resolve the situation.

We have seen a significant increase this year in the number of ward helpers from 8 to 22. This has been realised due to Jubilee, Ascot & Windsor and Henry Tudor Wards engaging with recruiting to this role. WBCH remains committed to the role with 10 volunteers.

Overall numbers of our mental health peer support volunteers helping in our recovery colleges, WAM, Slough and Reading have fallen this year. Numbers can and do vary due to the nature of the volunteer's own wellbeing and availability. Equally, there is a balance of the number of peer mentors we have and the roles available. Recruitment courses are expected to run again as soon as current circumstances allow.

COVID_19

All existing volunteer roles relying on social connection/face-to-face were suspended. However, many of our peer support, HealthMaker and SHaRON moderator volunteers remain active but only where they are working remotely and using virtual technologies.

We are remaining in contact with our over 70s volunteers through regular wellbeing telephone calls.

New challenges and demands to meet the Covid_19 were implemented and processes adapted accordingly. The application process was streamlined, and pre-placement checks were aligned to national policy. Many of our processes had already been adapted to meet the Covid_19 demands prior to national guidelines being made available and we were subsequently found to be compliant with requirements.

We are recruiting to 3 specific roles:

- Wellbeing telephone callers
- Drivers – e.g. Driving PPE across sites, collecting prescriptions for services etc.
- Admin roles

Currently volunteer applications exceed the number of roles we have. We are continuing to engage with services to promote the availability of volunteers to support them.
Berkshire Healthcare has maintained the high quality, established volunteer service during this pandemic and has not needed to access any additional volunteers via the NHS volunteer responder scheme (GoodSam).

Queen's Award for Voluntary Service

A signed certificate from Her Majesty The Queen will be presented by the Lord-Lieutenant for Berkshire.
A crystal award with the QAVS insignia will be presented with the certificate.
All our volunteers will receive a signed letter of thanks from Julian Emms as well as a Queen's Award pin badge.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	**Executive Report**
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 14 July 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. Berkshire Healthcare Volunteers

We are very proud that the Berkshire Volunteers have won the Queen's Award for Voluntary Services this year. This award is the MBE for volunteer groups and is the highest award given to local volunteer groups across the United Kingdom to recognise outstanding work done in the local community. The nomination for the Berkshire Healthcare award was focused on the contribution our volunteers make in peer mentor and patient support roles, but the award also recognises all of our volunteer roles as outstanding.

The volunteer services in Berkshire Healthcare grows each year. At the end of March 2020, we employed 167 volunteers, of which 36% are BAME. These volunteers work in a number of roles including gardening, administrative support, peer mentors and chaplains.

At the start of the COVID-19 pandemic, all volunteers in the at risk category were stepped down and ward based patient facing roles suspended. We introduced 3 new roles to support clinical services during the pandemic; wellbeing calls to those isolated and shielding, assistance in collecting prescriptions/delivering PPE and non-patient facing admin support for services. A number of our existing volunteers offered to support these roles and we have recruited an additional 69 volunteers to support the COVID-19 response.

(The Trust's Annual Volunteers Report is at item 6.8 on the agenda for the July 2020 Public Trust Board meeting).

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. COVID-19 Staff Risk Assessment Update

A Trust risk and wellbeing assessment was developed from NHS England guidance, recent national reports, evidence available and best practice examples from other Trusts. The risk factors and wellbeing topics which are being used in our assessment represent the latest and best evidence currently available. This assessment gives a framework for a manager/staff member conversation regarding an individual's risk and covers the following:

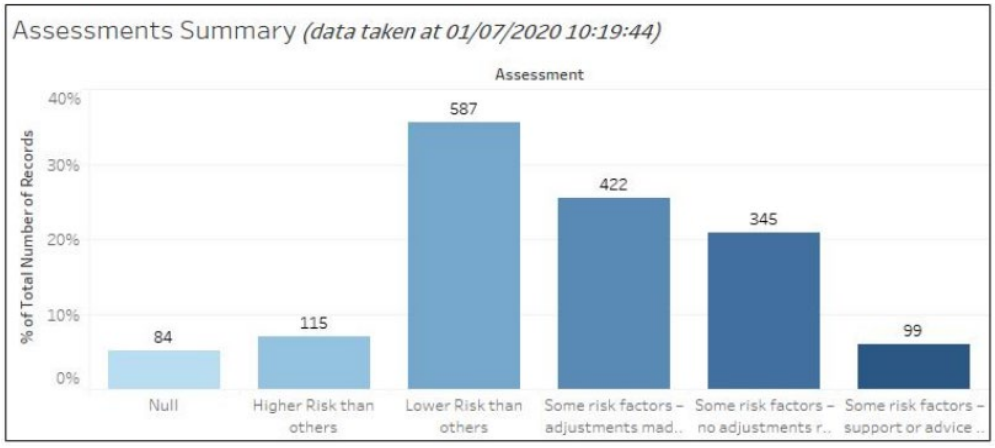
- Employee Details: information on whose assessment this is and who has completed it
- Risk Assessment: to determine a personal risk score and type of risk factor
- Wellbeing Assessment: covering additional factors which could impact a staff member
- Assessment Summary: overall outcome and any agreed actions

Due to the increased risk for BAME staff, staff were identified utilising our Staff Electronic Record and names of those at greater risk requiring timely completion of the assessment tool and conversation were shared with Divisional/Corporate Directors.

Progress since the Covid19 Risk Assessment tool was launched just over 3 weeks ago, is as follows -

Number of staff risk-assessed and percentage of whole workforce (35%)	1652
Number and percentage of BAME staff risk assessments completed (85%)	1162

A summary of the results of the assessments completed is shown below



Following completion of the tool less than 10% of staff have been identified as being a higher risk than others, however around a quarter of assessments have resulted in some risk factors being identified that require us to make further adjustments to minimise the risk posed. The type of adjustments range based on individual need but more commonly involve home working, reduced face-to-face clinical activity and changes to working base.

Since introducing the risk assessment for all our BAME staff, we have been asked by NHS England to complete this for all BAME staff by **21 July 2020** and report our

progress against this new target. To meet this target, we are following up with all Divisions and Corporate services to identify any BAME member of staff who has not had an assessment undertaken, so this can be completed.

Our agency workers are also being risk assessed by NHS Professionals directly, data on completion of which we will receive in due course. Work is underway to ensure the Covid19 Risk Assessment dovetails into the Return to Work and New Starter processes, to make sure all staff have this conversation going forward.

Executive Lead: David Townsend, Chief Operating Officer

4. Operational Delivery of the 2020 Staff Flu Campaign

This year's staff flu campaign will commence in September 2020. With the potential for increased sickness absence and services pressures due to COVID-19, it is imperative that staff take up the offer of the flu vaccination. This will reduce added pressures on services from flu outbreaks in the Trust and wider community.

To maximise availability and ease of staff gaining their vaccine, this year's campaign will, like last year, be delivered through a peer vaccinator model. Peer vaccinators have been recruited; this includes each inpatient ward having two peer vaccinators to manage their staff vaccinations. Learning from other Trusts with higher uptake last winter, the use of two part-time workers whose role will be to undertake staff vaccinations is also being explored through NHS Professionals (NHSP).

The model of delivery will be different to last year due to the Covid-19 outbreak; social distancing and the use of PPE will always be paramount. A survey monkey is being sent to staff to ascertain how they would like to receive their vaccine and several options will be available including through roving vaccinators on Trust sites, clinics on Trust sites and drive through clinics are also being explored. All models of delivery will require the additional management of social distancing and availability of PPE factored in.

The number of flu vouchers ordered has been increased this year to enable flexibility for staff receiving their vaccine at alternative venues if that is more convenient to them and more can be purchased mid campaign if required.

The plans for delivery are expected to be finalised by mid-August.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

Presented by Julian Emms
Chief Executive
July 2020

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	Financial Summary Report – M2 2020/21
Purpose	To provide the Month 2 2020/21 financial position to the Trust Board
Business Area	Finance
Author	Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	The Financial Summary Report provides the Board with summary of the M2 2020/21 financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 2 2020/21 (May 2020): The Trust continues to operate under the interim COVID finance regime, with central funding being accrued to cover Covid response costs, ensuring the Trust is able to report breakeven YTD. The report reflects financial performance against both an NHSI calculated plan, as well as our internal forecast. **YTD Cash** £46.8m vs Plan £45.9m. **YTD Capital expenditure:** £0.2m vs Plan £0.3m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2020/21

May 2020

Purpose

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

Version	*Date*	*Author*	*Comments*
1.0	11/06/2020	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

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1.0 Summary Financial Commentary

Financial Regime

We continue to operate in a COVID influenced financial regime. Although discussed, no official guidance has been received either extending the current regime, or detailing any changes. The overriding principle remains therefore that providers will report breakeven during this period, made possible by 'Top Up' payments, covering both additional costs incurred in response to COVID and underlying deficits.

The key components of this regime remain:

- There is no financial Control Total, instead NHSI have provided us with a centrally calculated plan till July 2020.
- Use of Resource Rating is not being monitored.
- There is no efficiency requirement, effectively putting our Cost Improvement Programme on hold.
- We have no contracts with CCGs, these have been replaced by centrally calculated block allocations.
- These central allocations only make provision for inflation, no allowance for MHIS or service development.
- All other sources of income are expected to be billed, noting the impact of COVID of services being provided.
- Expenditure to continue per run rate at the end of 19/20 adjusted for inflation only.

Plan for Remainder of 20/21

At present we are focused on monitoring spend against an internal forecast of actual spend to the end of July, opposed to the formulated NHSI's plan. This this will allow us to better understand performance against our anticipated costs, excluding direct COVID cost, and consequently an understanding of the changes in our cost base arsing from COVID.

It was expected that further financial guidance would have been issued by now and as such we have held off agreeing our planning approach for the period beyond the end of July. Given timing and in absence on a national steer, we can no longer wait and have begun planning for the remainder of the year.

The approach for the remainder of the year will be based on the approach taken for April to July, in that our plan will be reflective of actual forecast costs, which may, or may not be reflective of historical establishments and cost. This articulation of forecast vs establishment will be key to addressing our longer term affordability moving into 21/22 and beyond, and will link into the wider workforce planning work being led by HR.

It is fair to say that there will be additional complexities in forecasting for the remainder of the year given the operational status of some services being far from historic norms, as well as assessing the on-going impact of recovery. We aim to have forecasts complete by the end of July, but anticipate that they will need to be kept under review for the remainder of the year as the on-going response the pandemic continues and national guidance is forthcoming.

2.0 Income & Expenditure

	NHSI ALLOCATED PLAN						TRUST FORECAST Excluding COVID & TOP UP					
	In Month			YTD			In Month			YTD		
	Act	Plan	Var	Act	Plan	Var	Act	Forecast	Var	Act	Forecast	Var
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	21.2	20.8	0.4	42.4	41.5	0.8	21.2	21.2	0.0	42.4	42.3	0.0
Other Income	1.0	1.9	(0.9)	2.1	3.8	(1.7)	1.0	1.1	(0.1)	2.1	2.2	(0.1)
Donated Income	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Total Income	***22.2***	***22.7***	***(0.5)***	***44.4***	***45.4***	***(0.9)***	***22.2***	***22.3***	***(0.1)***	***44.4***	***44.5***	***(0.1)***
Staff In Post	14.8	14.5	0.3	29.3	28.9	0.4	14.8	15.0	(0.2)	29.3	29.8	(0.5)
Bank Spend	1.2	1.4	(0.2)	2.3	2.7	(0.4)	1.2	1.4	(0.2)	2.3	2.8	(0.5)
Agency Spend	0.2	0.4	(0.1)	0.4	0.7	(0.3)	0.2	0.3	(0.1)	0.4	0.6	(0.1)
Total Pay	***16.2***	***16.2***	***(0.0)***	***32.1***	***32.4***	***(0.3)***	***16.2***	***16.7***	***(0.5)***	***32.1***	***33.2***	***(1.2)***
Purchase of Healthcare	1.0	1.2	(0.1)	2.1	2.3	(0.2)	1.0	1.2	(0.1)	2.1	2.2	(0.1)
Drugs	0.5	0.5	0.1	1.0	0.9	0.0	0.5	0.5	0.1	1.0	0.9	0.1
Premises	1.3	1.4	(0.1)	2.7	2.8	(0.1)	1.3	1.5	(0.2)	2.7	3.0	(0.3)
Other Non Pay	1.4	1.7	(0.3)	2.9	3.4	(0.5)	1.4	1.7	(0.3)	2.9	3.4	(0.5)
PFI Lease	0.5	0.5	0.0	1.1	1.1	0.0	0.5	0.5	(0.0)	1.1	1.1	0.0
Total Non Pay	***4.8***	***5.2***	***(0.4)***	***9.8***	***10.5***	***(0.7)***	***4.8***	***5.4***	***(0.6)***	***9.8***	***10.7***	***(0.9)***
Total Operating Costs	***21.0***	***21.4***	***(0.5)***	***41.9***	***42.9***	***(1.0)***	***21.0***	***22.1***	***(1.1)***	***41.9***	***43.9***	***(2.0)***
EBITDA	***1.2***	***1.2***	***(0.0)***	***2.6***	***2.5***	***0.1***	***1.2***	***0.2***	***1.0***	***2.6***	***0.6***	***2.0***
Interest (Net)	0.3	0.3	0.0	0.6	0.6	0.0	0.3	0.3	0.0	0.6	0.6	0.0
Depreciation	0.7	0.6	0.1	1.3	1.2	0.1	0.7	0.7	(0.0)	1.3	1.4	(0.1)
PDC	0.3	0.2	0.1	0.3	0.3	0.0	0.3	0.3	0.0	0.3	0.3	0.0
Total Financing	***1.2***	***1.1***	***0.2***	***2.3***	***2.1***	***0.2***	***1.2***	***1.3***	***(0.0)***	***2.3***	***2.3***	***(0.1)***
Surplus/ (Deficit)	***(0.0)***	***0.2***	***(0.2)***	***0.3***	***0.4***	***(0.0)***	***(0.0)***	***(1.1)***	***1.0***	***0.3***	***(1.7)***	***2.0***
COVID Pay Costs	*1.0*			*1.8*								
COVID Non Pay Costs	*0.3*			*0.6*								
Top Up Payment	***1.3***			***2.1***								
Surplus/ (Deficit)	***0.0***	***0.2***	***(0.2)***	***0.0***	***0.4***	***(0.3)***						

The table above illustrates financial performance against both our NHSI plan and our internal forecast, both excluding COVID costs. Costs incurred due to COVID and subsequent Top Up payments are indicated separately. A fully consolidated Income Statement can be found on Page 7.

Internal Forecast

The Trust is reporting breakeven in month, excluding £1.3m of costs assigned to the COVID response. This is in contrast to the anticipated £1.1m deficit forecast. YTD the surplus is £0.3m, £2.0m better than anticipated.

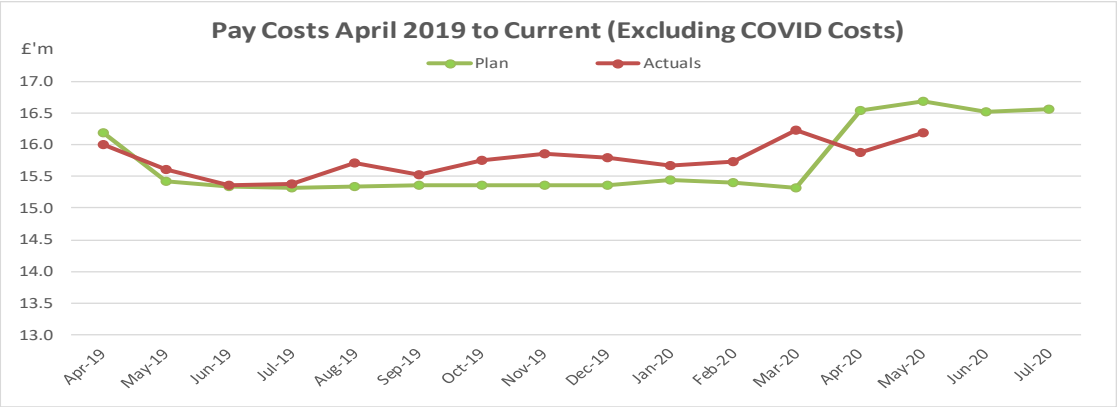
Expenditure rose in month, driven by increased pay cost, but overall continues below forecast rates. Service closures, home working and our focus on pandemic response continuing to impact the cost base. Overall expenditure is now £2.0m less than forecast, with both Pay and Non Pay costs below originally anticipated levels..

NHSI Plan

After the inclusion of £1.3m of COVID costs, a £1.3m Top Up payment has been assumed to enable breakeven to be reported in May.

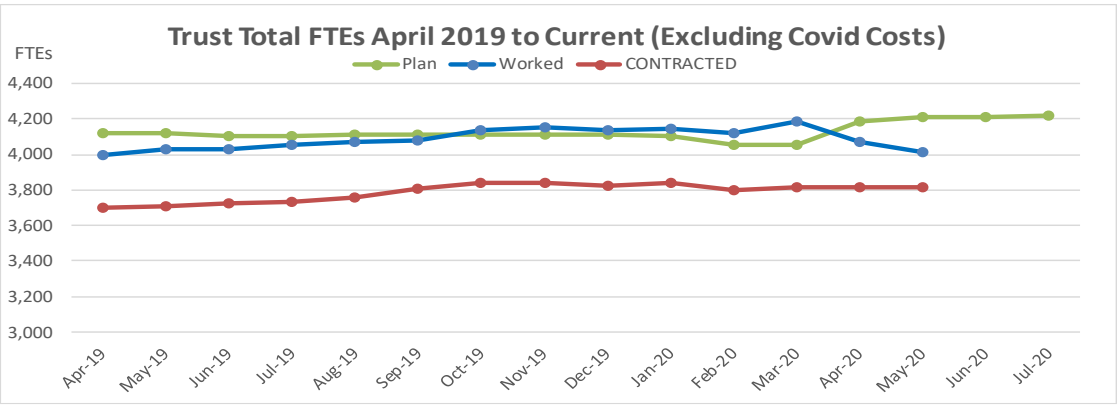
YTD COVID response costs are estimated at £2.4m and our breakeven position is inclusive of £2.1m of support. In response to the national level of COVID costs, NHSI/E have increased the reporting requirements with higher level of scrutiny expected than during the initial phase of the response.

Workforce



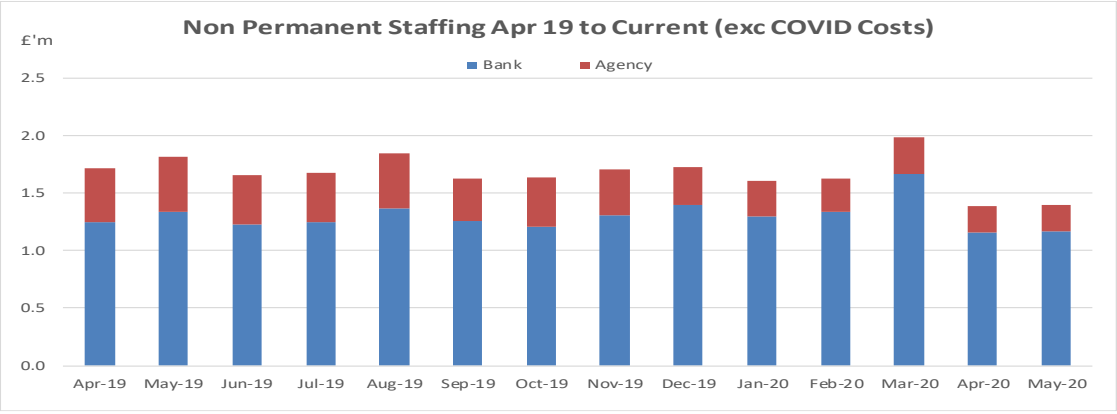
Staff Costs

YTD	£'m
2020/21	32.1
2019/20	31.6
▲	1%
Prior Yr	**£'m**
May-20	16.2
May-19	15.6
▲	4%



FTEs

Prior Mth	CFTE	WFTE
May-20	3,818	4,012
Apr-20	3,819	4,069
	0% ▲	-1% ▼
Prior Yr	**CFTE**	**WFTE**
May-20	3,818	4,012
May-19	3,710	4,027
	3% ▲	0% ▼



Staff Costs

YTD	Bank £'m	Agency £'m
2020/21	2.3	0.4
2019/20	2.6	1.0
	-10% ▼	-53% ▼
£'m	**Bank £'m**	**Agency £'m**
May-20	1.2	0.2
May-19	1.3	0.5
	-13% ▼	-53% ▼

Key Messages

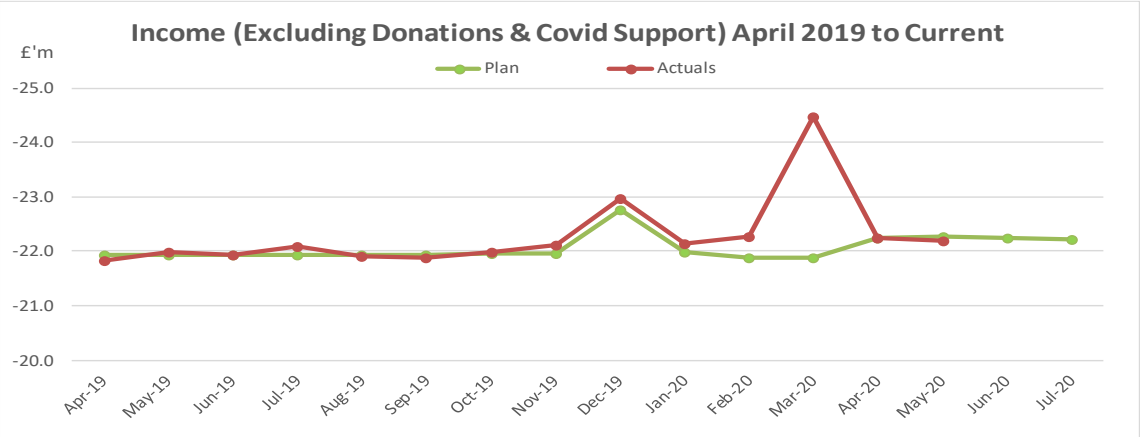
Pay costs, excluding COVID were £16.2m, an increase of £0.3m, but £0.5m lower than forecast. YTD costs are now £1.2m less forecast. The increase in costs this month relate to CEA award payments of £0.2m and retrospective bank holiday payments of £0.1m. Outside of these, underlying workforce costs have held, as illustrated by static contractual FTEs.

Monthly COVID cost were £1.0m, an increase of £0.2m. These included additional costs of £0.1m for Student Nurses and £0.2m in retrospective enhancements and excess mileage payments, offsetting a reduction in sickness cover.

Temporary staffing costs not assigned to COVID, continue at lower than historic levels, with occupancy, service suspension and redeployment all combining to reduce requirement. There are notable reductions across MH and Community Inpatients, CRHTT and District Nursing, plus others. As service resume costs are likely to move closer to historic levels.

The overall number of CFTE has remained constant in month, whilst WFTEs has continued to reduced. These figures exclude the recent increase in student numbers as these are assumed to be COVID related appointments.

Income & Non Pay



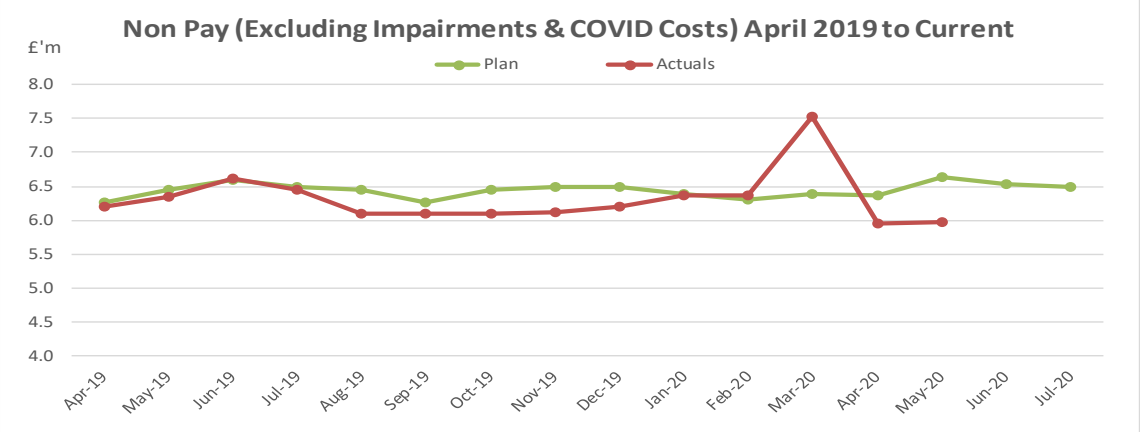
Income

YTD	£'m
2020/21	44.4
2019/20	43.8
▲	1%
Prior Yr	**£'m**
May-20	22.2
May-19	22.0
▲	1%

Key Messages

Income in April was £22.2m, on forecast. The chart reflect our fixed income position to the end of July.

Overall there has been very little movement in month unsurprisingly given the majority of our income is on a fixed block and all ad-hoc billing to CCGs has been suspended. Further we have agreed interim contractual arrangement with Frimley Health and the Royal Berkshire Hospital fixing our main inter-provider charges.



Non Pay

YTD	£'m
2020/21	12.1
2019/20	12.6
▼	-4%
Prior Yr	**£'m**
May-20	6.0
May-19	6.4
▼	-5%

Key Messages

Overall the Non Pay costs have remained in line with April, with costs excluding identified COVID expenditure, down £0.5m on last year. After adjusting for anticipated increased in depreciation, IM&T and estates costs, our YTD spend is down £1.3m.

This reduction reflects the impact of placement savings delivered last year, c£0.5m, with the remainder being variable cost savings due to suspending services and moving to home working.

Spend in areas such as Travel, Meeting Room Hire and Stationary continue at substantially reduced rates, with overall spend £0.3m lower than last year, whilst Estates Maintenance and Minor Works spend are £0.2m lower. These costs clearly driven by our increase in remote consultations, home working and service suspensions. It is these areas that re-current gains are possible, albeit dependent upon the recovery model adopted by services and future use of our estate.

The remaining areas where costs are materially below last years level are clinical supply costs, recruitment and educa-tion and training, which are expected to increase as operational services return.

Overall Income Statement Including COVID Cost

	In Month			YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m
Operating Income	21.2	20.8	0.4	42.4	41.5	0.8
Top Up Funding	1.3	0.0	1.3	2.1	0.0	2.1
Other Income	1.0	1.9	(0.9)	2.1	3.8	(1.7)
Donated Income	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)
Total Income	**23.5**	**22.7**	**0.8**	**46.6**	**45.4**	**1.2**
Staff In Post	15.1	14.5	0.7	29.9	28.9	0.9
Bank Spend	1.7	1.4	0.4	3.4	2.7	0.7
Agency Spend	0.3	0.4	(0.0)	0.6	0.7	(0.1)
Total Pay	***17.2***	***16.2***	***1.0***	***33.9***	***32.4***	***1.5***
Purchase of Healthcare	1.0	1.2	(0.1)	2.1	2.3	(0.2)
Drugs	0.5	0.5	0.1	1.0	0.9	0.0
Premises	1.5	1.4	0.1	3.1	2.8	0.3
Other Non Pay	1.5	1.7	(0.2)	3.1	3.4	(0.3)
PFI Lease	0.5	0.5	0.0	1.1	1.1	0.0
Total Non Pay	***5.1***	***5.2***	***(0.2)***	***10.4***	***10.5***	***(0.1)***
Total Operating Costs	***22.3***	***21.4***	***0.8***	***44.3***	***42.9***	***1.4***
EBITDA	***1.2***	***1.2***	***0.0***	***2.3***	***2.5***	***(0.2)***
Interest (Net)	0.3	0.3	0.0	0.6	0.6	0.0
Depreciation	0.7	0.6	0.1	1.3	1.2	0.1
Disposals	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.3	0.2	0.1	0.3	0.3	0.0
Total Finanacing	***1.2***	***1.1***	***0.2***	***2.3***	***2.1***	***0.2***
Surplus/ (Deficit)	***0.0***	***0.2***	***(0.2)***	***0.0***	***0.4***	***(0.3)***

Key Messages

The table above represents the Trusts overall income statement, including COVID costs incurred and offsetting income, and is reflective of the financial reporting statements submitted monthly to NHSI.

3.0 Balance Sheet & Cash

Balance Sheet	19/20 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	20/21 Plan £'m
Intangibles	6.8	6.4	6.8	(0.4)	6.4	6.8	(0.4)	8.7
Property, Plant & Equipment (non PFI)	37.1	37.1	37.4	(0.3)	37.1	37.4	(0.3)	37.1
Property, Plant & Equipment (PFI)	57.1	57.1	57.1	(0.0)	57.1	57.1	(0.0)	57.6
Total Non Current Assets	**102.7**	**100.6**	**101.3**	***(0.7)***	**100.6**	**101.3**	***(0.7)***	**103.4**
Trade Receivables & Accruals	11.3	14.2	10.8	3.4	14.2	10.8	3.4	11.3
Other Receivables	0.1	0.1	0.3	(0.2)	0.1	0.3	(0.2)	0.1
Cash	26.4	46.8	45.9	0.9	46.8	45.9	0.9	22.7
Trade Payables & Accruals	(24.8)	(26.0)	(22.3)	(3.7)	(26.0)	(22.3)	(3.7)	(25.5)
Current PFI Finance Lease	(1.5)	(1.5)	(1.5)	(0.0)	(1.5)	(1.5)	(0.0)	(1.6)
Other Current Payables	(2.5)	(23.8)	(23.8)	0.0	(23.8)	(23.8)	0.0	(2.5)
Total Net Current Assets / (Liabilities)	**9.6**	**9.8**	**9.4**	***0.4***	**9.8**	**9.4**	***0.4***	**4.5**
Non Current PFI Finance Lease	(27.0)	(26.8)	(26.8)	0.0	(26.8)	(26.8)	0.0	(25.5)
Other Non Current Payables	(1.9)	(1.9)	(1.9)	(0.0)	(1.9)	(1.9)	(0.0)	(1.9)
Total Net Assets	***82.4***	***81.7***	***81.9***	***(0.2)***	***81.7***	***81.9***	***(0.2)***	***80.5***
Income & Expenditure Reserve	29.1	29.1	26.6	2.4	29.1	26.6	2.4	27.7
Public Dividend Capital Reserve	19.2	19.2	18.3	1.0	19.2	18.3	1.0	19.4
Revaluation Reserve	33.4	33.4	37.0	(3.6)	33.4	37.0	(3.6)	33.4
Total Taxpayers Equity	***82.4***	***81.7***	***81.9***	***(0.2)***	***81.7***	***81.9***	***(0.2)***	***80.5***

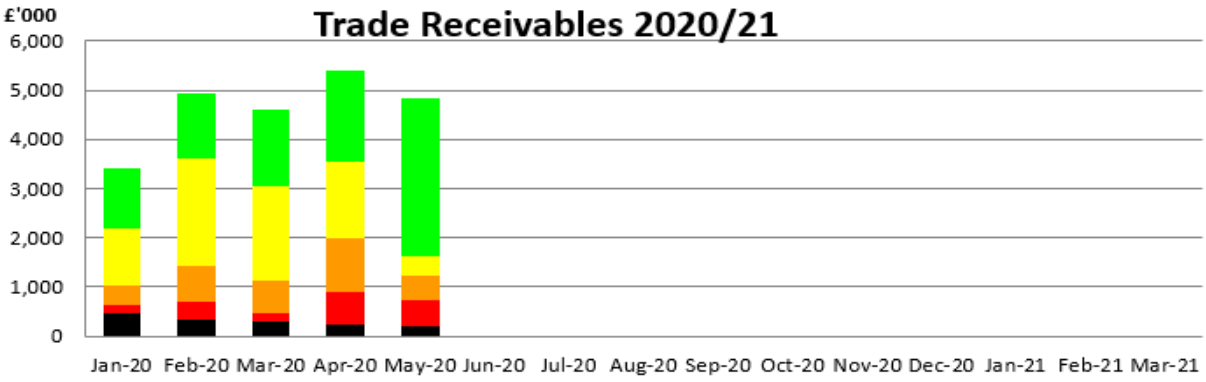
Cashflow		19/20 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	20/21 Plan £'m
Operating Surplus/(Deficit)	+/-	6.4	0.4	0.4	(0.1)	0.8	0.9	(0.1)	5.3
Depreciation and Impairments	+	8.5	0.7	0.7	(0.0)	1.3	1.3	(0.0)	8.1
Operating Cashflow		***14.9***	***1.0***	***1.1***	***(0.1)***	***2.1***	***2.2***	***(0.1)***	***13.4***
Net Working Capital Movements	***+/-***	***1.4***	***0.6***	***0.0***	***0.6***	***20.5***	***19.9***	***0.6***	***(1.7)***
Proceeds from Disposals	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	-	(9.8)	(0.2)	(0.1)	(0.1)	(1.3)	(1.6)	0.3	(8.6)
Investments		***(9.8)***	***(0.2)***	***(0.1)***	***(0.1)***	***(1.3)***	***(1.6)***	***0.3***	***(8.6)***
PFI Finance Lease Repayment	-	(1.2)	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	(0.0)	(1.5)
Net Interest	+/-	(3.6)	(0.3)	(0.3)	(0.0)	(0.6)	(0.6)	(0.0)	(3.9)
PDC Received	+	1.2	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.2
PDC Dividends Paid	-	(2.1)	0.0	0.0	0.0	0.0	0.0	0.0	(1.7)
Financing Costs		***(5.7)***	***(0.4)***	***(0.4)***	***(0.0)***	***(0.9)***	***(0.8)***	***(0.0)***	***(6.8)***
Other Movements	+/-	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/ (Out) Flow		***0.8***	***1.0***	***0.5***	***0.5***	***20.4***	***19.6***	***0.9***	***(3.6)***
Opening Cash		25.6	45.8	45.4	0.4	26.4	26.4	0.0	26.4
Closing Cash		***26.4***	***46.8***	***45.9***	***1.0***	***46.8***	***46.0***	***0.8***	***22.7***

Key Messages

In order to ease the liquidity pressure on providers, both April and Mays block allocations were made in April, hence the significant level of cash being held, £46.8m, offset by increased deferred income reflected in Other Payables. It is anticipated that this will be corrected in either July or August when no SLA payment will be received, and we will release the current deferred income of circa £21m.

The Balance Sheet and Cashflow plan takes into account the additional cash received in April, the capital plan that has been submitted to the ICS and assumes a breakeven I&E forecast.

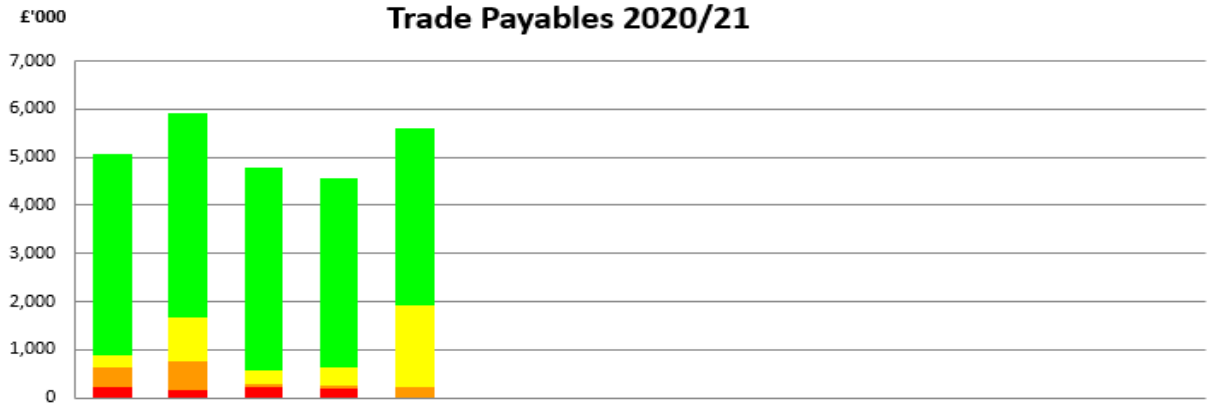
Cash Management



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
<30 Days	1,244	1,329	1,562	1,870	3,230										
>30 <60 Days	1,161	2,183	1,904	1,573	388										
>60 <90 Days	406	739	662	1,063	500										
>90 < 180 Days	140	346	177	673	538										
>180 Days	478	345	295	241	197										

Key Messages

Overall receivables balances decreased by £0.6m, with reductions across all aged days. Over 90 days includes invoices outstanding to Brighter Futures for Children and Wessex Specialist Commissioning where actions are being taken to pro-actively resolve the outstanding issues. Since the end of May, NHS Property Services have settled £2.1m of outstanding invoices in respect of Q1 estates management SLA, reflected above.



	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
<30 Days	4,199	4,253	4,209	3,924	3,682										
>30 <60 Days	251	916	273	391	1,709										
>60 <90 Days	403	574	88	51	204										
>90 days	218	171	209	196	8										

Key Messages

In line with issued DHSC Procurement guidance, we are making every effort to minimise the payment period to suppliers during the pandemic period. In response we have all but cleared balances over 90 days. The £1.4m increase in creditors over 30 to 60 days, relates to invoices from NHS Property Services for rent and service charges for Q1 2020/21, all of which were paid on the 1st June. The vast majority of remaining payables are now current and <30 days.

4.0 Capital Expenditure

Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
STC Phase 3/Erlegh House	2	0	2	3	0	3	1,021
LD to Jasmine	0	0	0	(0)	0	(0)	1,647
Erleigh Road (LD etc works)	0	0	0	0	0	0	153
Wokingham Willow House Projects	56	61	(5)	84	136	(52)	197
Trust Owned Properties Other	0	0	0	(1)	0	(1)	111
Leased Non Commercial (NHSPS)	3	11	(8)	7	11	(4)	335
Leased Commercial	0	1	(1)	0	1	(1)	50
Varuious All Sites	(1)	8	(10)	(1)	17	(18)	510
Statutory Compliance	(23)	0	(23)	6	26	(20)	347
PFI Other	1	1	0	(3)	2	(4)	295
Subtotal Estates Maintenance & Replacement	**38**	**82**	**(45)**	**95**	**192**	**(97)**	**4,666**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	0	0	0	368
IM&T System & Network Developments	0	46	(46)	4	46	(42)	1,541
IM&T Other	64	0	64	87	0	87	245
HSLI Bed Management	2	0	2	5	0	5	74
HSLI Ward Digitalisation	2	0	2	5	0	5	100
Subtotal IM&T Expenditure	**69**	**46**	**23**	**100**	**46**	**54**	**2,328**
GDE Expenditure							
GDE Trust Funded	19	26	(7)	37	52	(14)	1,158
Subtotal GDE Expenditure	**19**	**26**	**(7)**	**37**	**52**	**(14)**	**1,158**
Total Capital Expenditure	**126**	**154**	**(28)**	**232**	**290**	**(58)**	**8,152**

Key Messages

The above plan was submitted to BOB ICS and NHSI at the end of May. This incudes £6.2m of spend counted against the ICS control total and £2.0m against PFI schemes which is excluded as historically they would have been treated as 'off-balance sheet' capital expenditure by DHSC. The consolidation of capital plans submitted by all BOB ICS partners remains in excess of the overall control total and NHSI/Es response to this is still awaited.

A short process in now underway to assess the original assumptions underpinning the £8.2m submission taking into account the latest view on contractors re-engaging on estates projects and service recovery requirements.

It is likely that with existing commitments and a capped capital ceiling, the ability to approve and undertake work not already planned will be limited, and robust forecasting to identify slippage and therefore flexibility will be key through out the year.

In addition to the programme outlined above, the Trust has bid for £0.1m of external COVID capital funding to cover the cost of expanding PPE storage facilities at Wokingham and St Marks Hospitals and the purchase of IT kit laptops. These bids have passed regional scrutiny and are now with DHSC central team for decision.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th July 2020
Title	**True North Performance Scorecard** **Month 2 (May 2020) 2020/21**
Purpose	To provide the Board with the True North Performance Scorecard, reporting progress against our driver (improvement) metric focus, supporting delivery of True North objectives.
Business Area	Trust-wide Performance
Author	Deputy Chief Executive and Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care and consistently meet or exceed the standards of CQC and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 2, 2020/21 (May 2020) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. The business rules apply to three different categories of metric:

	• **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention. • **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month. • **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity. **Note** - several indicators have been temporarily suspended either nationally of locally due to the COVID-19 pandemic. These are highlighted in grey to indicate this status. **Month 2 20/21** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Falls incidents in Community and Older Adult mental health Inpatient wards **(Harm Free Care)** - revised reduced target based on review. Donnington and Oakwood falls for April and May were mostly patients with dementia / Covid positive delirium. Wards supported by redeployed staff. The majority of falls unwitnessed in the bedroom area. Countermeasures in place to provide training for redeployed staff, to move high risk of falling patients to more visible bedrooms and use of falls assessment in RiO. • Self-harm incidents on Mental health Inpatient Wards (excluding LD) **(Harm Free Care)** – challenging patient on a ward has driven a spike in performance. Counter measures include use of individualised care plans for challenging patients. • Prone (Face Down) Restraint **(Patient Experience) –** latest figures suggest 8 incidents on 2 wards.

	• Patient FFT Recommend rate **(Patient Experience) –** temporarily suspended • Patient FFT Response rate **(Patient Experience) -** temporarily suspended • Mental Health Clustering **(Patient Experience) –** A3 and counter measures being developed after a pause due to the pandemic. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** pressures continue on length of stay but remains a focus for teams. • Staff turnover (including fixed-term posts) **(Money Matters) –** has been split to show inclusion and exclusion of fixed-term contracts ending. Excluding these contracts is green rated, including them is red. People strategy development focused on A3 to improve turnover, both in total % in highest contributing units and with focus on short length of stay re staff leaving within 1-2 years. **Tracker Level 1 Metrics** • Sickness Rate **(Regulatory Compliance)** – this is not a compliance focus with NHSI but is tracked. **Tracker Metrics (where red for 4 months or more)** • The metrics reset from Month 1, April, so none to note.
Action	The Board is asked to note the new 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:

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

Rule #	Metric	Business Rule	Meeting Action
1	**Driver** is **Green** in current reporting period	Share success and move on	**No action** required
2	**Driver** is **Red** in current reporting period	Share top **contributing reason**, the amount this contributor impacts the metric, and **summary of initial action(s)** being taken	Standard structured **verbal** update
3	**Driver** is **Red** for **2+** reporting periods	Produce full structured **countermeasure summary**	Present full written **countermeasure analysis and summary**
4	**Driver** is **Green** for **6** reporting periods	Retire to **Tracker** level status	Standard structured **verbal** update and retire to **Tracker**
5	**Tracker 1 (or Tracker)** is **Green** in current reporting period	**No action** required	**No action** required
6	**Tracker** is **Red** in current reporting period	Note metric performance and move on unless they are a **Tracker Level 1**	If **Tracker Level 1,** then structured **verbal** update
7	**Tracker** is **Red** for **4** reporting periods	Switch to **Driver** metric	Switch and replace to **Driver** metric (decide on how to make capacity i.e. which **Driver** can be a **Tracker**)

Performance Scorecard - True North Drivers (May 2020)

Harm Free Care

Metric	Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	19 per month	22	28	35	33	12	39	32	34	21	29	27	20
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	71	44	20	23	48	65	66	38	42	25	15	58
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	7	7	8	8	8	13	16	19	21	22	0	0
Number of suicides (per month)	Equal to or less than 3 per month	2	2	2	0	4	1	3	2	1	2	2	3
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	3	0

Patient Experience

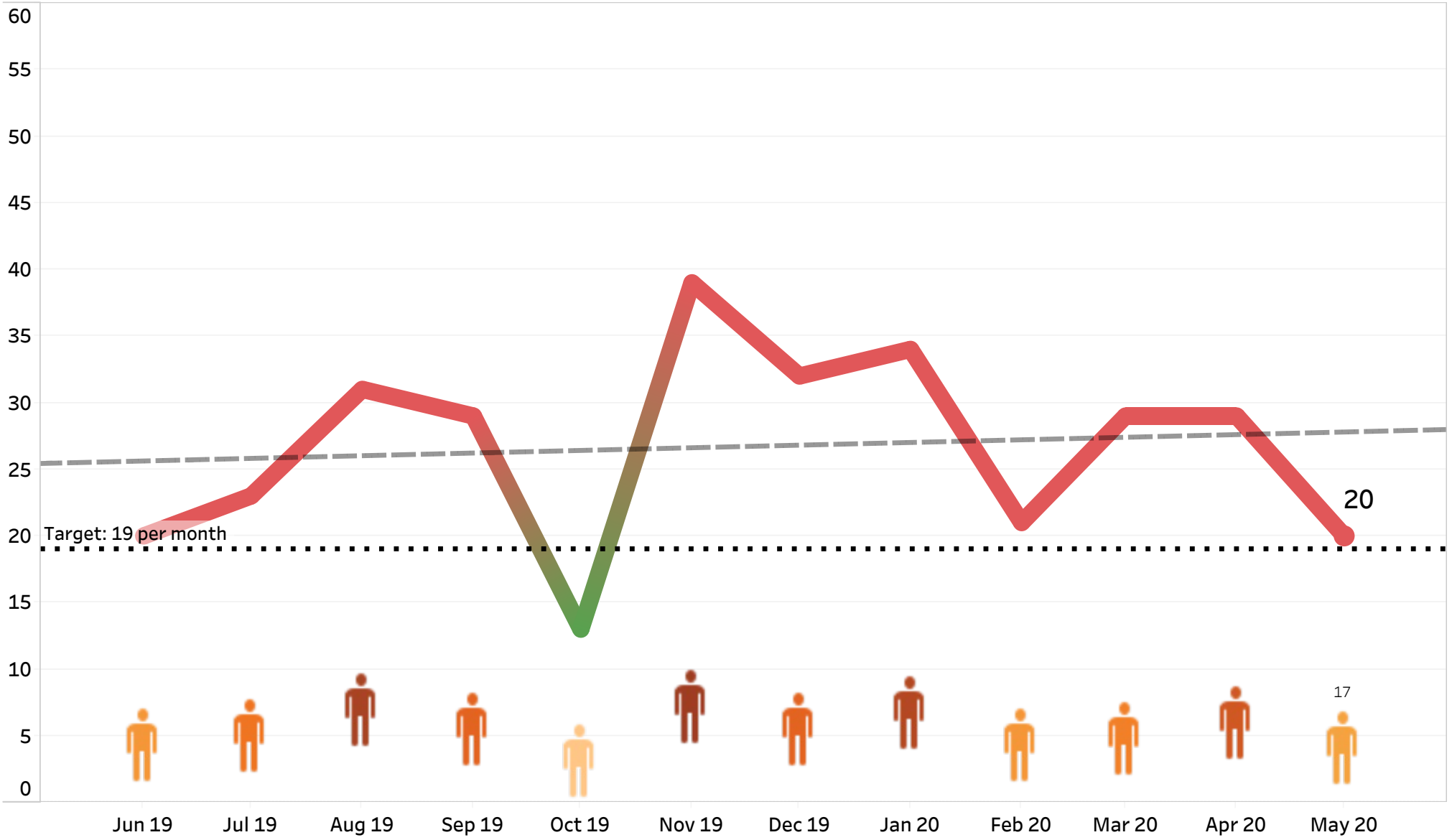
Mental Health: Prone (Face Down) Restraint	2 per month	3	6	13	5	2	1	2	2	7	3	3	8
Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance	90.6%	92.4%	91.7%	94.1%	93.2%	93.4%	92.4%	88.9%	87.4%	91.9%		
Patient FTT response rate: % [Suspended centrally due to COVID]	15% compliance	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	78.9%	77.7%	80.5%	80%	81.3%	81%	79.7%	81.2%	81.5%	80.6%	81.2%	78.7%

Performance Scorecard - True North Drivers (May 2020)

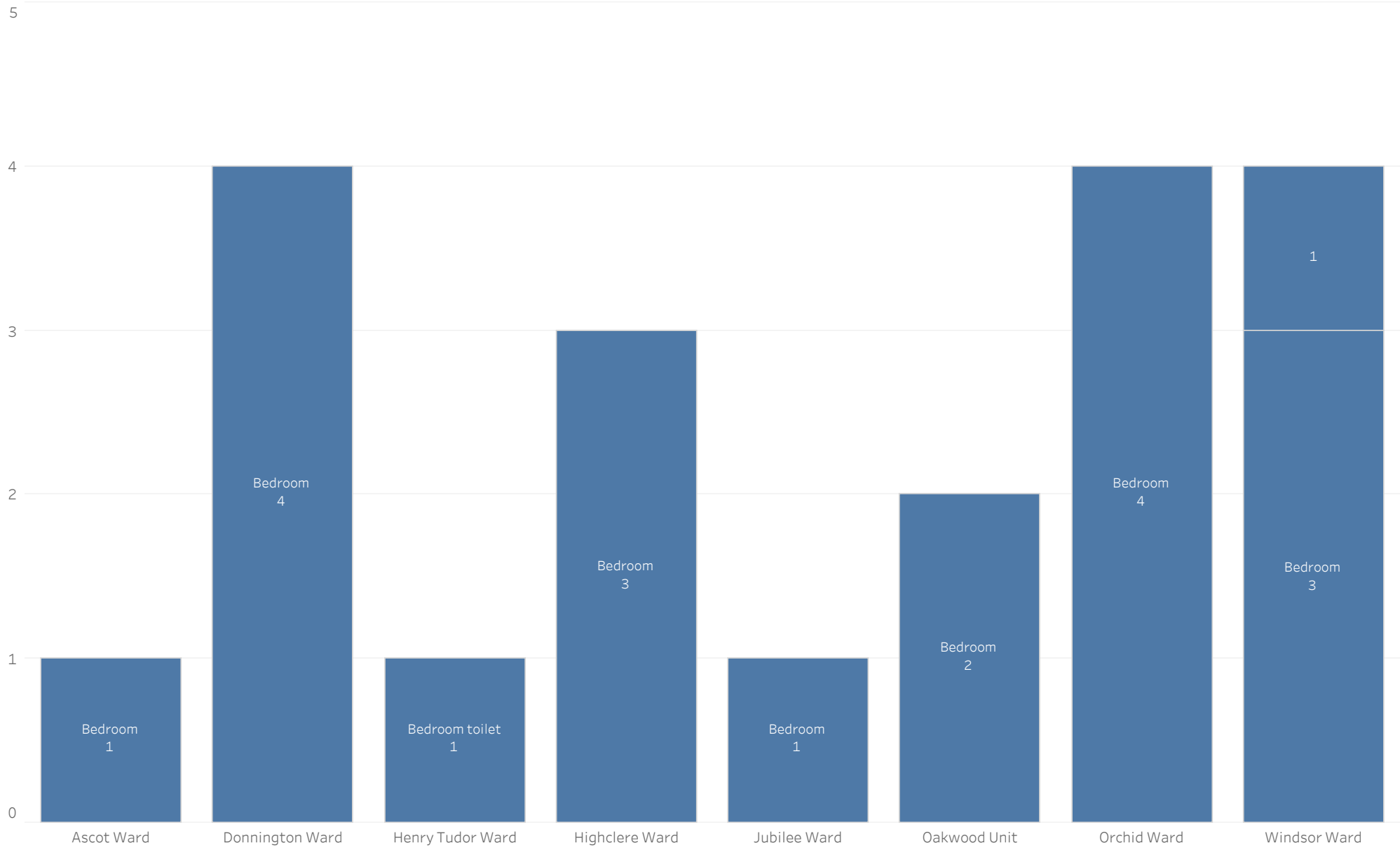
Metric	Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Supporting our Staff													
Physical Assaults on Staff	44 per month	56	36	50	56	49	39	30	35	41	57	36	27
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.29	7.29	7.29	7.29	7.29	7.29	7.29	7.40	7.29	7.29	7.40	7.40
Money Matters													
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)	£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	-£0.70M	-£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	97.8%	98.7%	97.0%	95.7%	94.4%	94.3%	91.9%	87.7%	92.6%	89.9%		81.9%
Mental Health: Acute Average Length of Stay (bed days)	30 days	36	38	41	42	45	35	39	43	37	42	37	34
Staff turnover (excluding fixed term posts)	<16% per month	15.8%	15.8%	15.2%	14.6%	14.4%	14.2%	14.6%	14.6%	14.7%	14.7%	14.6%	14.2%
Staff turnover (including fixed-term posts)	<16% per month	16.5%	16.3%	15.8%	15.6%	15.6%	15.1%	15.6%	16.2%	16.6%	16.5%	16.5%	16.1%
Inappropriate Out of Area Placements	230 bed days (cumulative for Qtr)	81	109	266	412	29	163	177	49	101	140	58	93

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Jun 19 to May 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



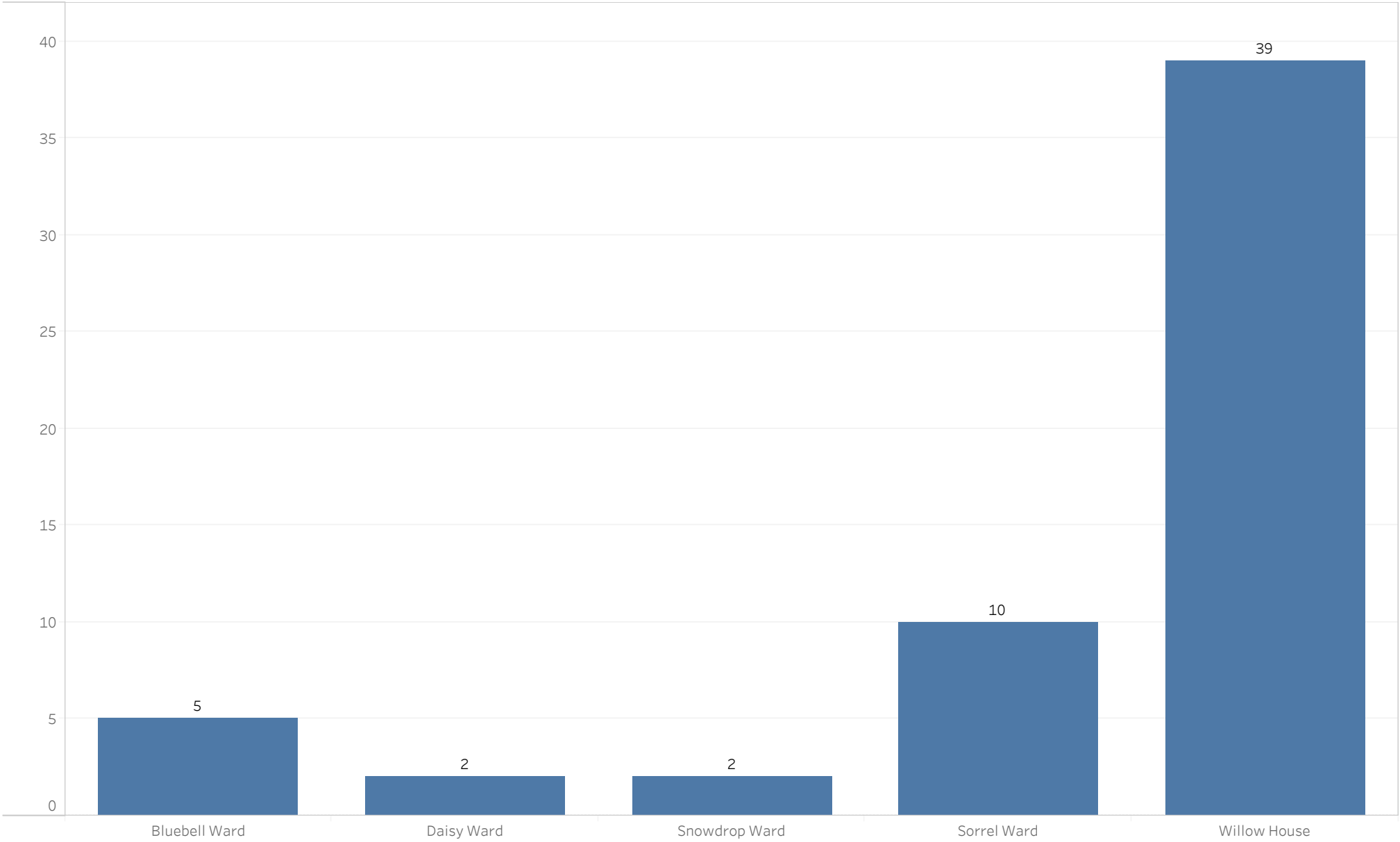
Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (May)



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

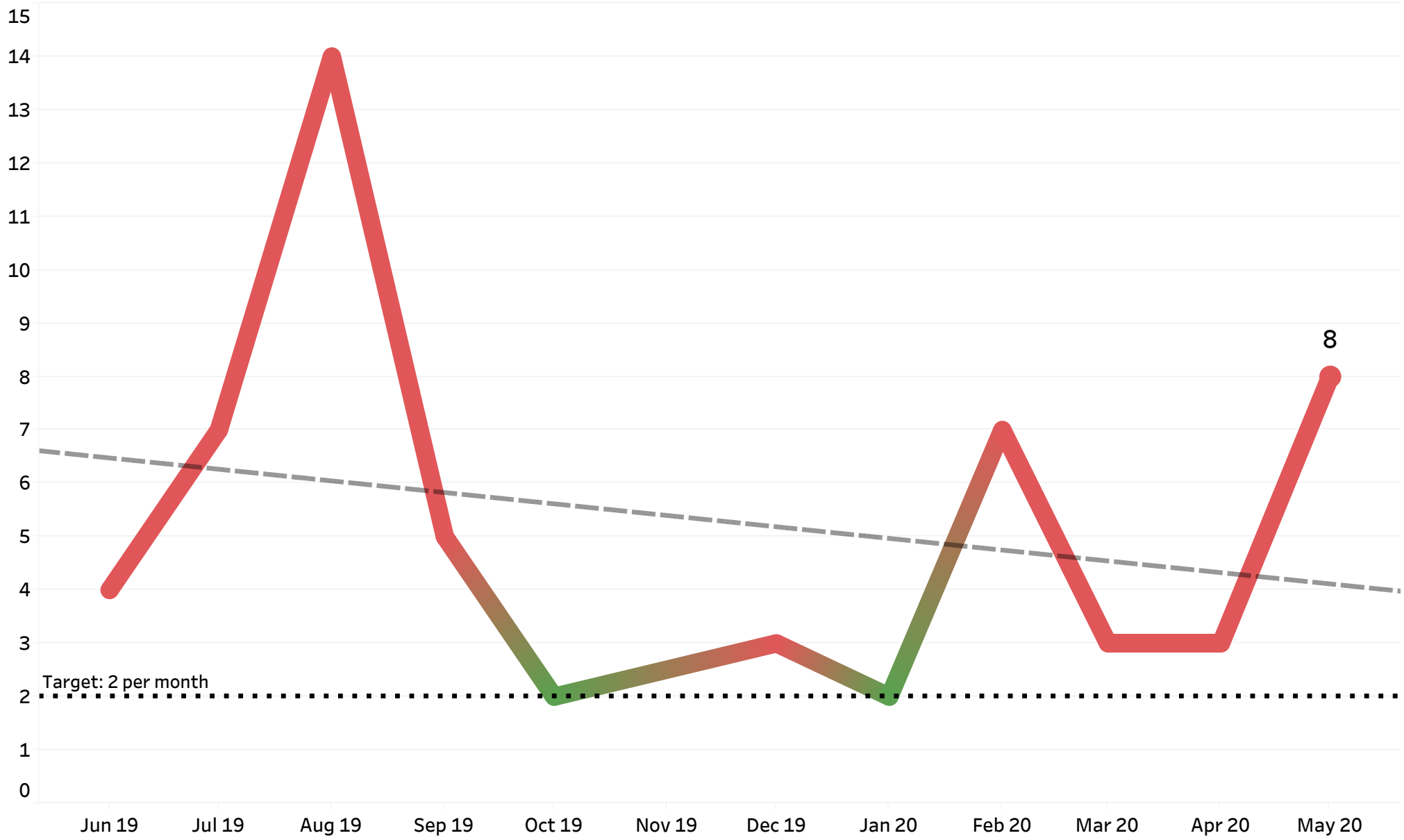
Any incident (all approval statuses) where category = self harm

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

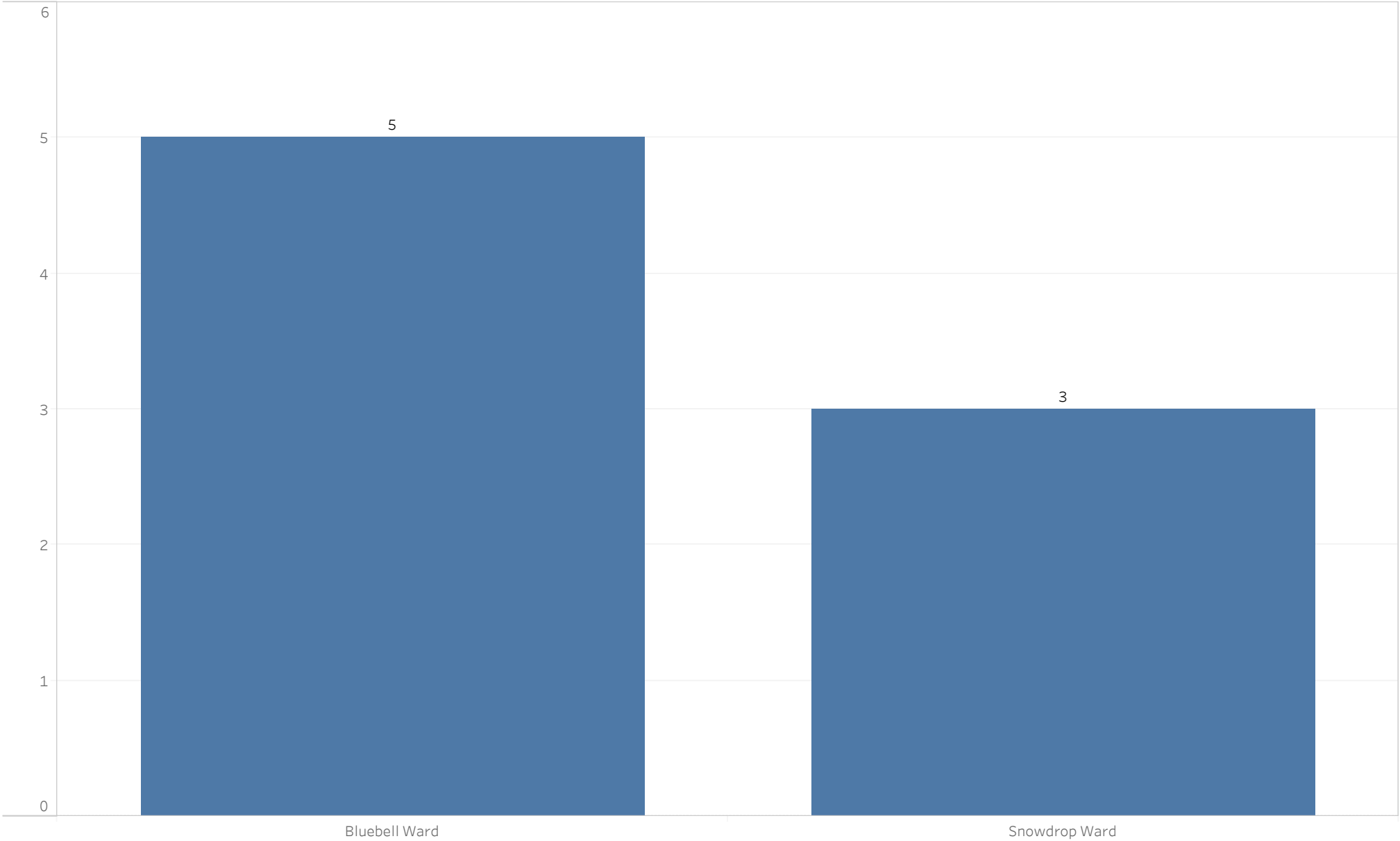


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Jun 19 to May 20)

(All approval statuses)

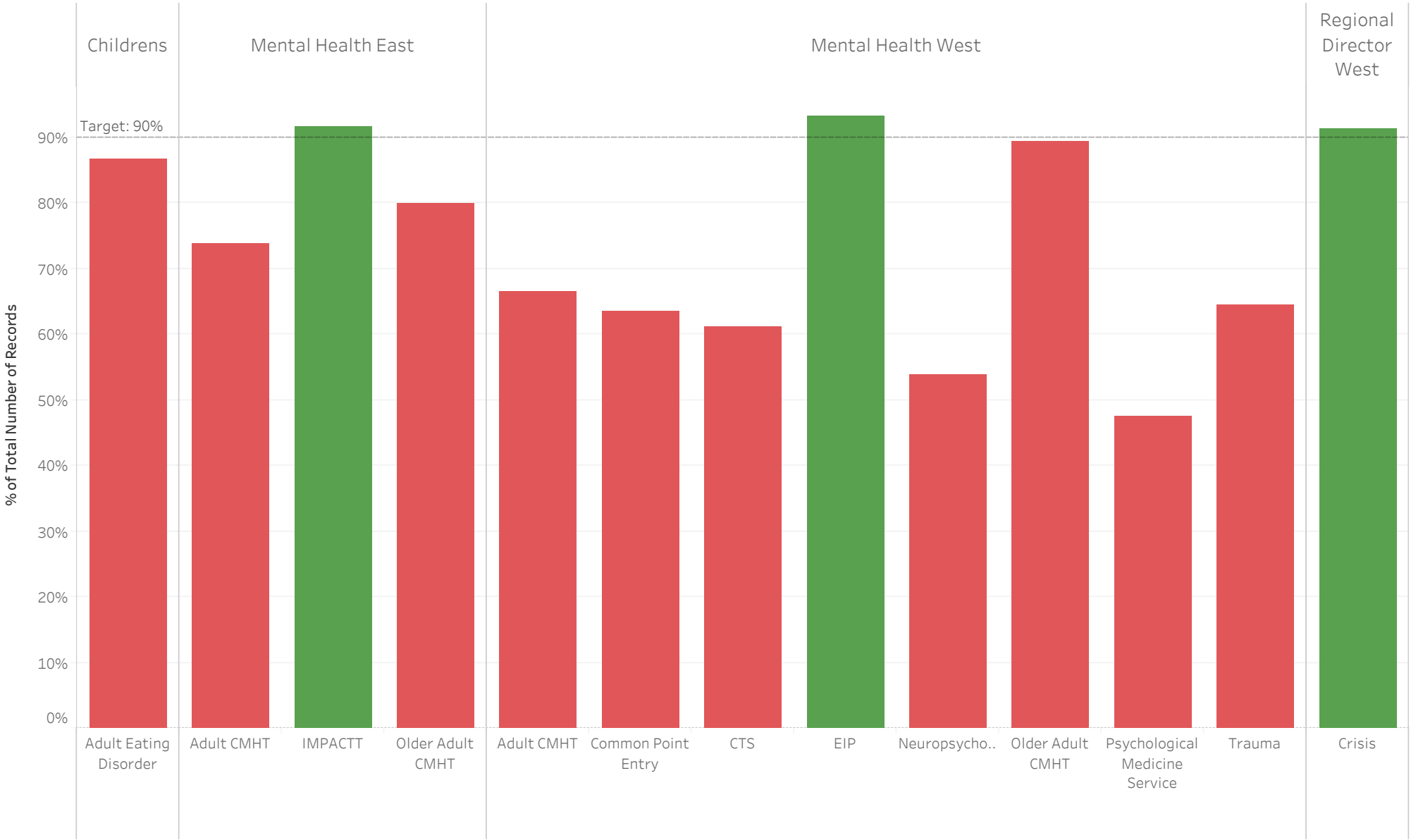


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (May)



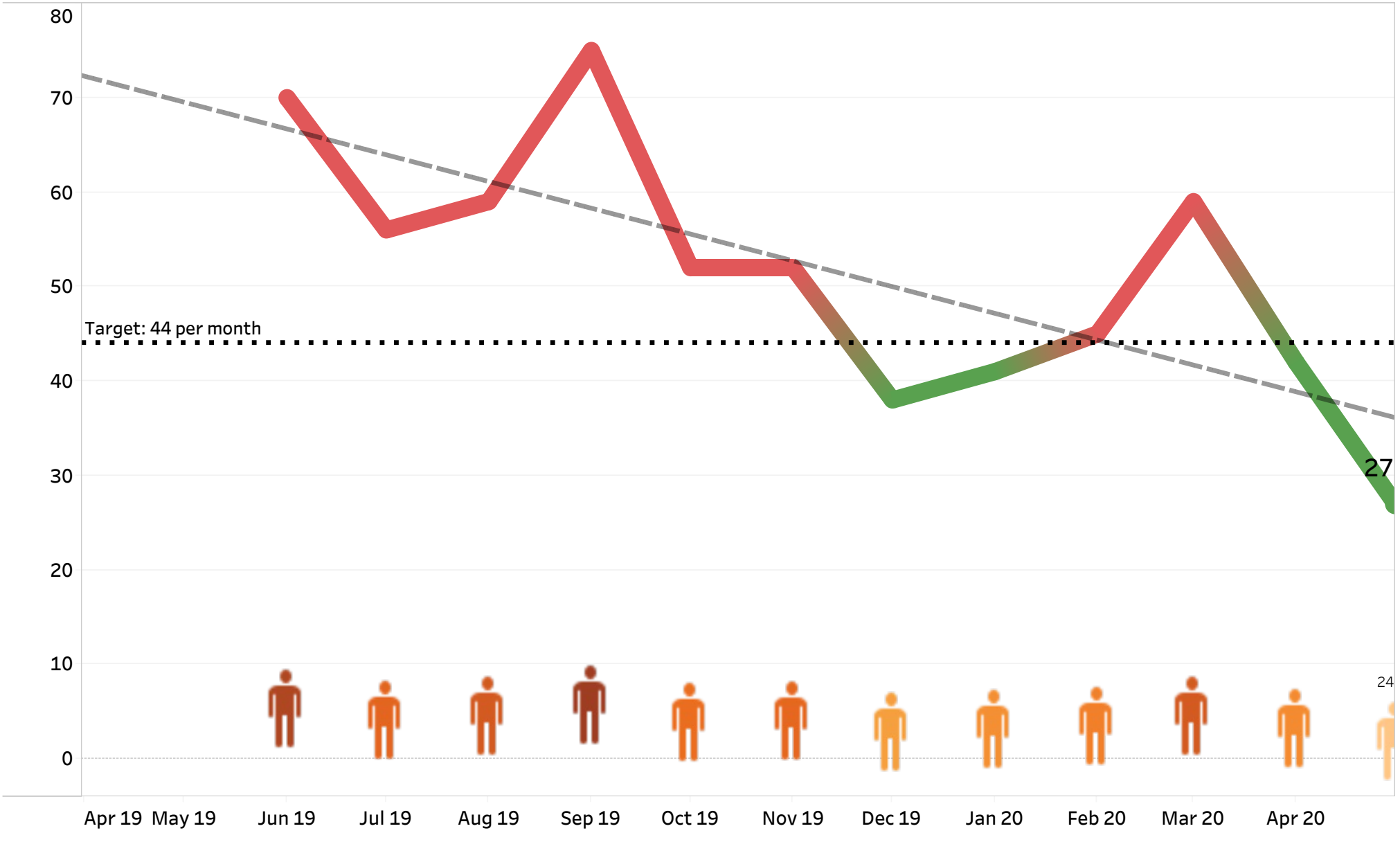
Patient Experience: Clustering breakdown (May)

Outpatient Cluster Status (by Service)

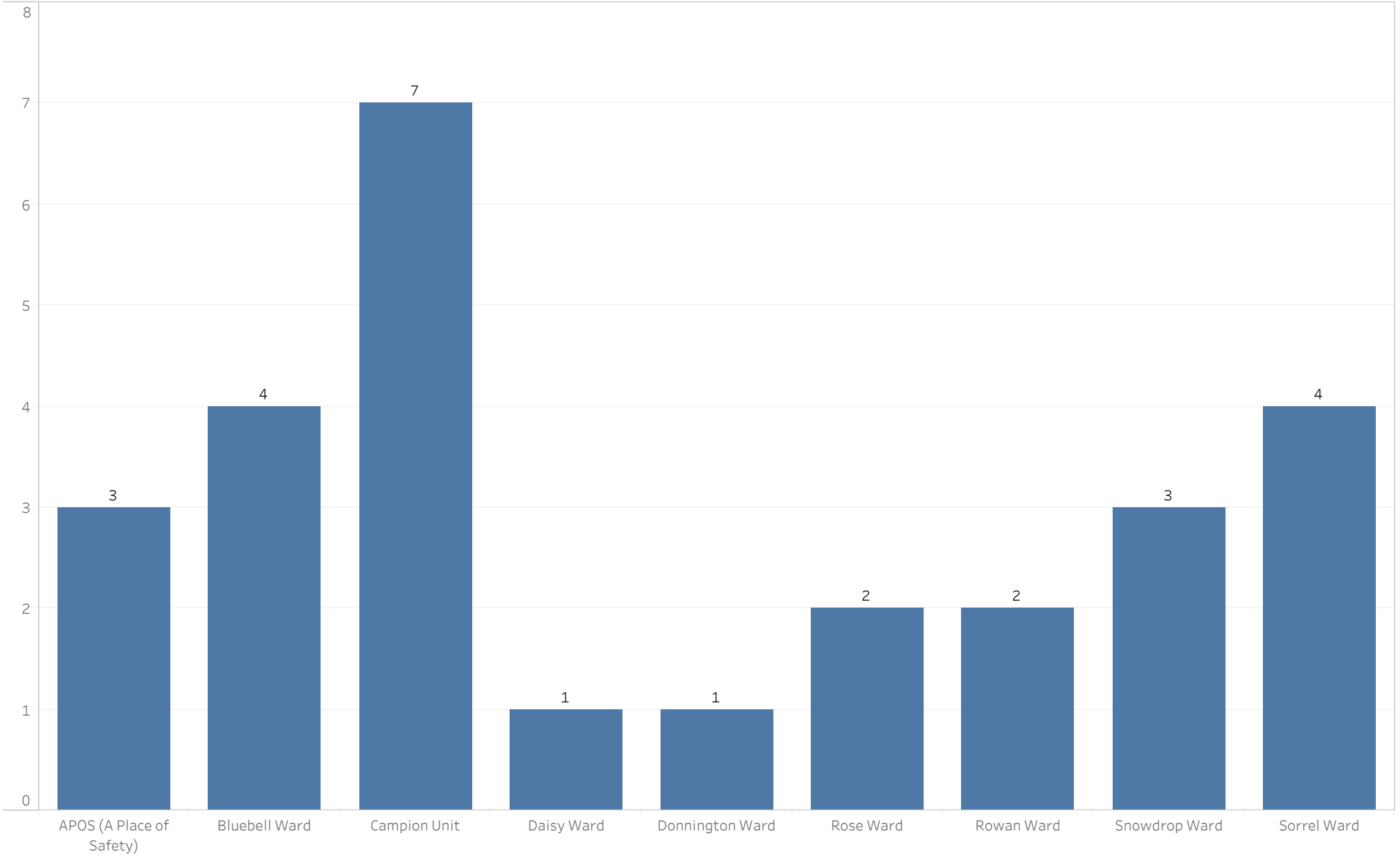


Supporting Our Staff Driver: Physical Assaults on Staff (Jun 19 to May 20)

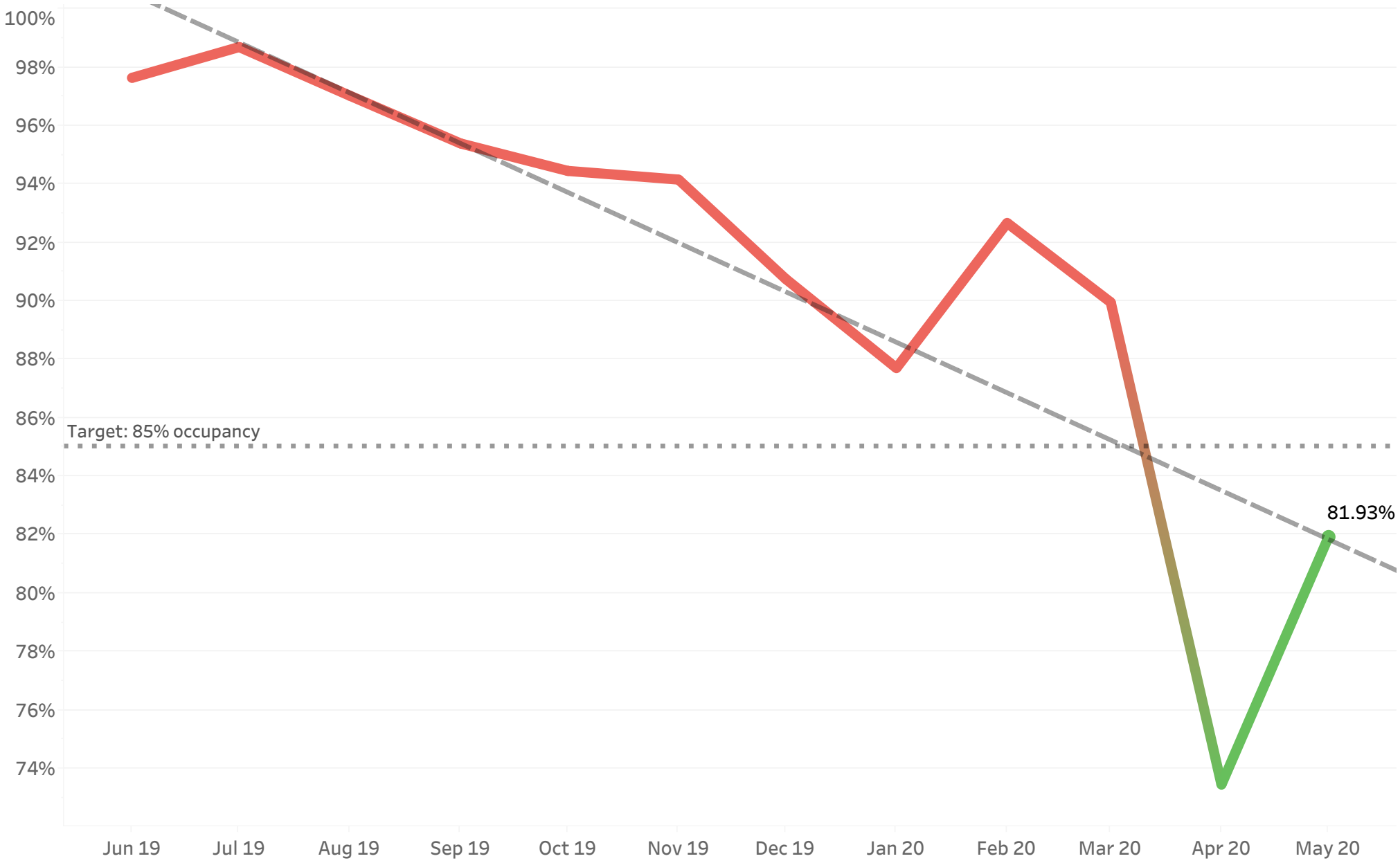
Any incident where sub-category = assault by patient and incident type = staff



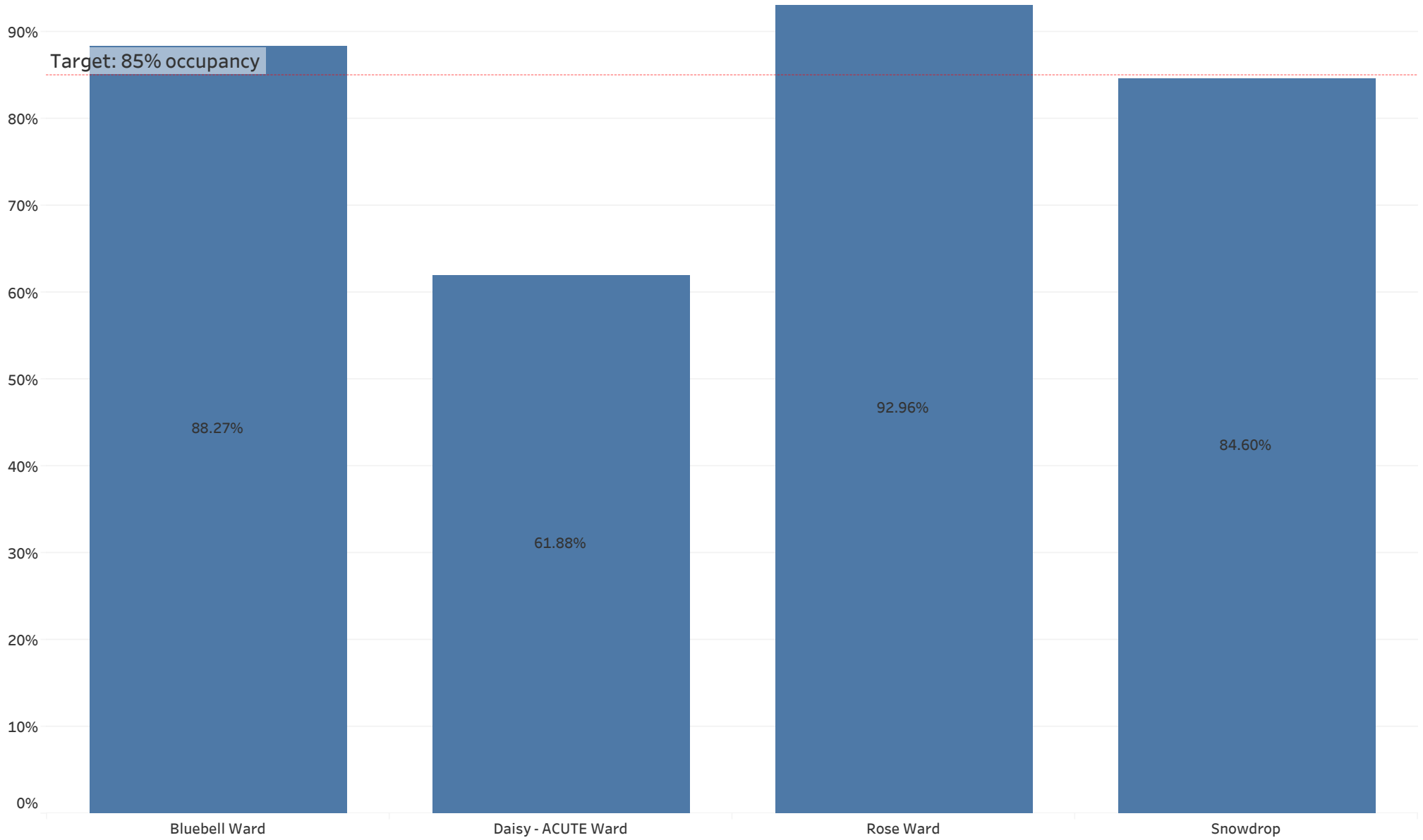
Supporting Our Staff Driver: Physical Assaults on Staff by Location (May 2020)



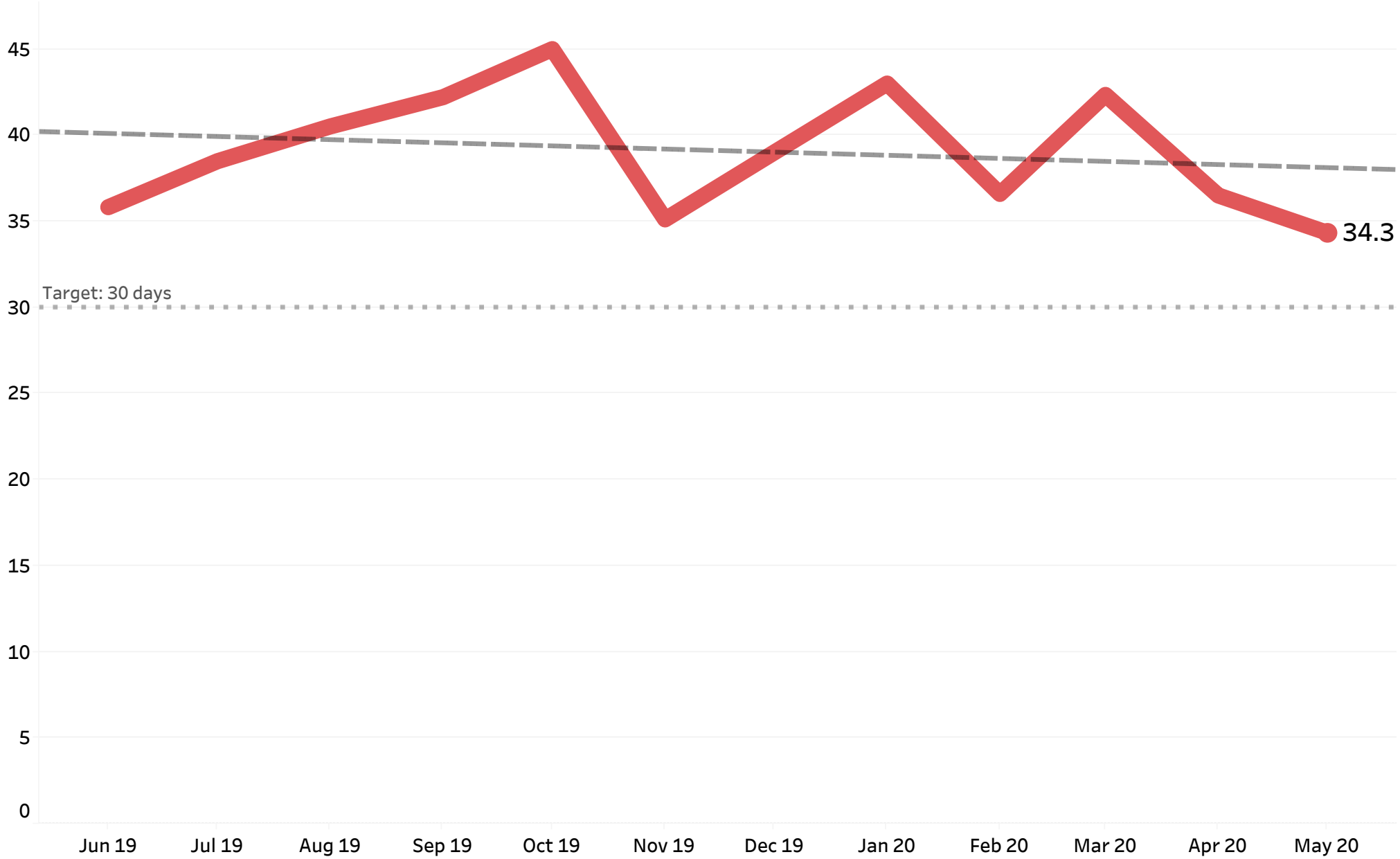
Money Matters: Mental Health Acute Bed Occupancy Rate (Jun 19 to May 20)



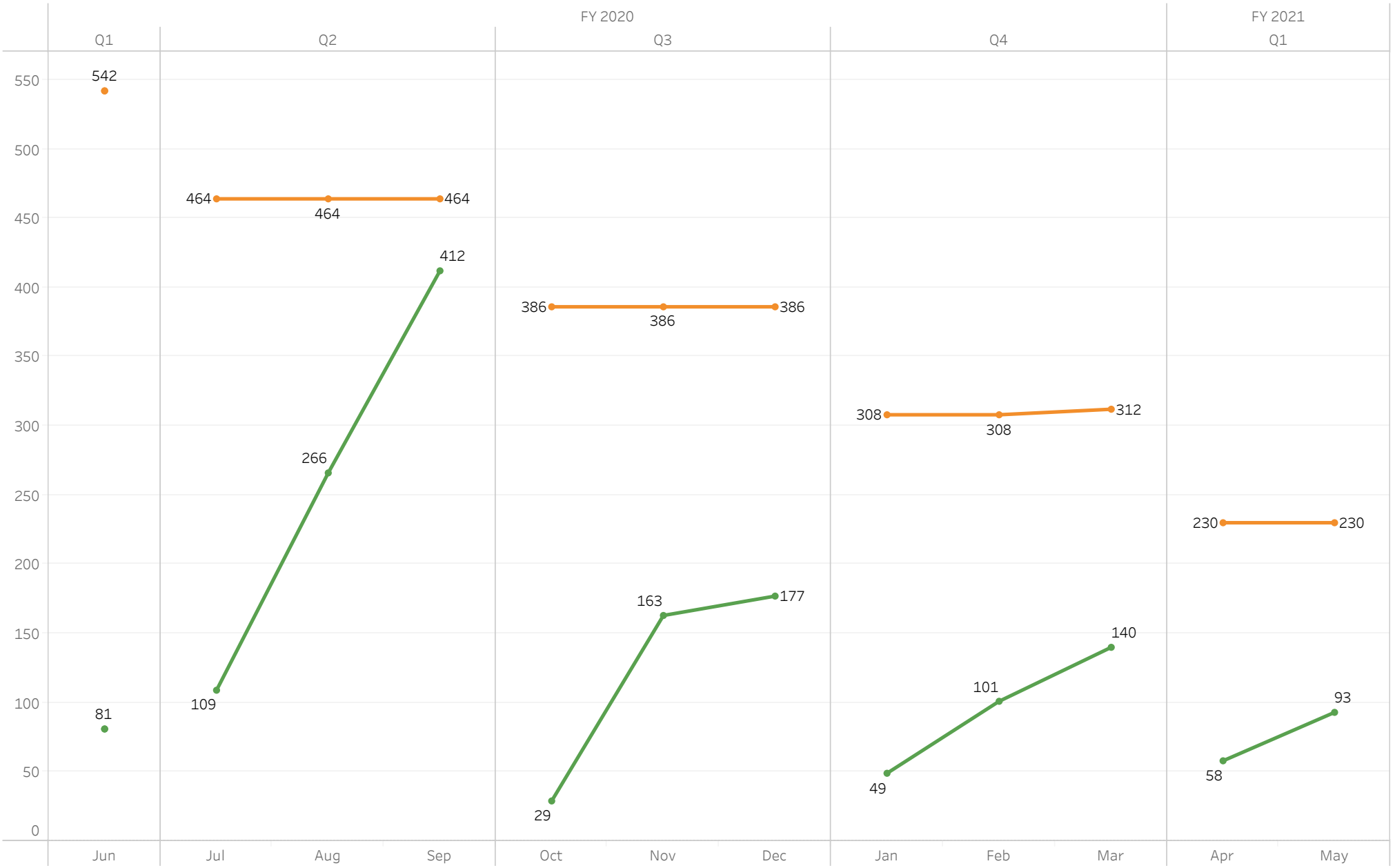
Money Matters Driver: MH Acute Bed Occupancy by Unit (May)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Jun 19 to May 20)



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



True North Harm Free Care Summary

Tracker Metrics

		Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Pressure ulcers acquired due to lapse in (Inpatient Wards)	180 days free in the year	91	52	83	122	153	183	214	245	82	70	131	95
Pressure ulcers acquired due to lapse in (Community East)	180 days free in the year					214	244	131	69	98	98	159	80
Pressure ulcers acquired due to lapse in (Community West)	180 days free in the year					159	189	220	251	271	53	114	145
Mental Health: AWOLs on MHA Section	16 per month	17	13	11	13	18	6	8	8	5	2	2	3
Mental Health: Absconsions on MHA Section	8 per month	9	9	8	9	7	2	5	2	5	6	5	3
Mental Health: Readmission Rate within 28 days: %	<8% per month	6.25	7.29	6.56	6.25	6.04	5.63	5.26	5.97	5.09	4.42	4.29	5.42
Patient on Patient Assaults (LD)	4 per month	2	4	5	1	0	0	2	0	0	0	3	3
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	11.8%	15.1%	12.7%	16.5%	12.1%	12.5%			14.0%	13.6%	13.4%	13.3%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000							6.9	5	5	5	5	5
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	19	31	23	29	16	26	0	1	0	0	1	2

True North Patient Experience Summary

Tracker Metrics

		Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Patient on Patient Assaults (MH)	38 per month	21	25	33	34	19	27	15	17	14	15	15	15
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	97.1%	94.0%	93.8%	90.0%	93.9%	93.8%	90.6%	82.1%	93.9%	88.4%	89.1%	91.9%
Mental Health: Uses of Seclusion	13 in month	12	11	6	12	5	7	11	4	18	12	4	7

True North Supporting Our Staff Summary

Tracker Metrics

		Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Gross vacancies: % [Suspended centrally due to COVID]	<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	90.7%	92.1%	94.3%	93.2%	93.0%	93.3%	93.9%	93.3%	91.5%	90.1%	88.4%	85.9%
Statutory Training: Health & Safety: %	90% compliance	95.2%	95.9%	96.0%	96.5%	96.4%	96.6%	96.6%	96.7%	96.4%	95.5%	96.0%	94.3%
Statutory Training: Manual Handling: %	90% compliance	92.6%	93.0%	93.2%	92.2%	92.9%	92.8%	90.2%	93.1%	93.3%	92.5%	90.0%	88.7%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID]	95% compliance	93.3%	94.6%	94.8%	93.4%	94.7%	95.2%	95.4%	94.4%	93.3%	93.9%	92.5%	90.0%
PDP (% of staff compliant) Appraisal: %	95% compliance 'Extended from 19/20. Reset in June 20'	95%	87.7%	91.1%	87.8%	88.9%	86.7%	86.4%	85.1%	83.9%	81.7%	80.5%	80.5%

Mental Health Inpatient Services – Fire training compliance

Org L7	Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Fire Safety Training - Whole Service	95%	91.6%	90.3%	92.4%	89.8%	89.6%	91.4%	93.9%	93.4%	93.2%	88.3%	88.4%	84.6%
371 Bluebell Ward PPH	95%	85.0%	85.0%	90.0%	84.2%	84.2%	88.0%	87.5%	87.5%	82.6%	71.4%	75.0%	72.0%
371 Daisy Ward PPH	95%	96.0%	91.7%	92.0%	92.0%	83.3%	91.3%	92.0%	96.4%	95.8%	100.0%	92.3%	92.0%
371 Orchid Ward PPH	95%	85.2%	85.7%	89.3%	89.3%	85.7%	89.7%	83.9%	81.3%	82.8%	80.0%	76.9%	76.9%
371 Rose Ward PPH	95%	86.4%	85.7%	90.9%	91.7%	87.0%	88.9%	96.0%	92.0%	100.0%	92.0%	91.3%	83.3%
371 Rowan Ward PPH	95%	100.0%	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	97.1%	85.3%	80.0%	70.0%
371 Snowdrop Ward PPH	95%	95.2%	100.0%	100.0%	86.4%	87.5%	86.7%	93.3%	93.1%	93.1%	90.3%	93.3%	93.3%
371 Sorrell Ward PPH	95%	95.8%	92.6%	92.3%	83.3%	88.9%	88.9%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%

Community Health – Fire training compliance

371 Community Health East Services	Fire Safety Training - Whole Service	95%	94.2%	94.6%	96.3%	96.0%	97.0%	94.8%	93.6%	95.1%	94.4%	93.1%	93.2%	92.4%
371 Community Health West Services	Fire Safety Training - Whole Service	95%	95.2%	96.4%	97.8%	96.2%	96.5%	94.3%	95.4%	94.8%	92.6%	89.2%	87.2%	86.3%

CH IP Fire Safety Breakdown

Org L7	Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
371 Henry Tudor Ward	95%	58.6%	74.1%	89.3%	96.0%	96.2%	91.7%	88.9%	92.9%	96.4%	96.6%	96.0%	96.6%
371 Jubilee Ward	95%	92.9%	92.9%	100.0%	100.0%	96.9%	90.0%	86.7%	93.1%	100.0%	96.9%	96.8%	100.0%
371 Oakwood Ward	95%	95.2%	90.0%	97.5%	97.4%	100.0%	100.0%	97.4%	97.6%	90.5%	87.2%	88.6%	89.5%
371 WBCH Inpatient Wards	95%	93.8%	97.5%	97.4%	93.7%	90.2%	93.9%	96.3%	95.2%	89.2%	84.5%	80.7%	77.8%
371 Wokingham InPatient Unit	95%	94.2%	95.7%	98.6%	91.2%	94.2%	91.2%	92.2%	95.5%	89.1%	88.9%	87.9%	82.8%

True North Money Matters Summary

Tracker 1

		Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	6.29	5.80	4.90	4.59	6.09	6.70	9.30	11	7.59			7.5

Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	81.8%	76.7%	71.1%	76%	75.4%	78.7%	82.5%	88.0%	90.5%	84.5%		75.4%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	65.65%	76.59%	85.70%	88.42%	80.07%	78.03%	77.29%	84.87%	83.09%	82.79%		63.39%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	5%	4.90%	5%	5%	4.79%	4.79%	5.20%	5.09%	4.70%	5.20%		4.20%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	4.79%	9.70%	10.9%	9.70%	9.90%	10.5%	10.8%	13.4%	17.8%			4%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
Mental Health: 7 day follow up (Quality Domain): %	95% seen	95.3	95.1	98.3	96.0	96.1	97.5	96.2	95.2	100	95.5	95.3	95.7
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	1	0	0	0	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	42.1	42.1	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	88.4	88.4	88.4	88.4	88.4	88.4	88.4	88.4	88.4	88.4	88	88
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	21	21	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	1	0	0	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
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	100	75	100	100	66.7	100	80	100	100	88.9	100	90.9
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	100	98.8	99.7	99.7	98.4	97.4	95.8	97.9	96.2	94.0	92.9	98.0
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	96	95	96	96	95	95	96	95	94	95	95	94
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	56.0	55.0	56.2	55.1	59	57.7	56.0	60.3	57.1	54.4	53.4	53.2
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	66	66	66	66	60	60	60	59	59	59	59	59
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	12	12	12	12	11	11	11	12	12	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	99.5	100	100	100	99.7	100			100
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	96.2
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	98.5	100	100	100	98.9	100	100	100	100	100	100	98
Sickness Rate: %	<3.5%	3.75	4.58	3.99	4.10	4.41	4.75	5.04	4.88	4.10	4.39	5.89	
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	83	83	83	83
Finance Score - Was Continuity of Services Risk Rating now Use of Resources [Suspended centrally due to COVID]	Month 1=3, months 2 to 5 =2 then month 6 onward=1	2	2	2	1	1	1	1	1	1	1		
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	91.5	94.2	94.5	97.7	96.2	97.8	98.2	98.2	98.4	98.1	98.7	98.7
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th July 2020
Title	Board Vision Metrics Update
Purpose	To provide the board with a performance update on metrics agreed in measuring progress towards achieving our vision: ***"To be recognised as the leading community and mental health service provider by our staff, patients and partners"***
Business Area	Performance
Author	Deputy Chief Executive and Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	2019/20 vision metric performance is provided at annex 1 of the paper. Indicators are YTD March 2020 performance unless otherwise stated within the narrative. To note: • The Trust dropped from 2nd to 3rd position in last combined trust cohort staff survey rankings. • No inpatient death from self-harm since October 2018. • FFT response rate deteriorated to below 10%. Programme underway to design and commission new system for collecting patient experience

	information across Mental Health and Community services. • CQC overall rating of “Outstanding” achieved in March 2020, including “Outstanding” for well led. Ratings report included six “must do” compliance actions, noted here in the vision metrics update. • Segment 1 regulatory autonomy maintained since segmentation began. Trust financial position delivering lowest financial risk rating of 1 YTD as planned to end of March 2020. • Benchmark positions to be refreshed once detailed analysis toolkits are available (delayed by the covid pandemic.
ACTION REQUIRED	The Board is asked to note the update.

Board Vision Metrics: Performance Update to end March 2020

Supporting Delivery of the Trust's Vision

Trust Board – public meeting

Alex Gild, Deputy Chief Executive and Chief Financial Officer
14th July 2020

Purpose

Update the Finance Performance and Risk Executive and Trust Board on Vision Metrics.

Document control

Version	*Date*	*Author*	*Comments*
1.0	15/06/2020	I Hayward & C Magee	

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*

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3. Quality Improvement Programme: supporting delivery of our vision Error! Bookmark not defined.

Appendix 1 – Board Vision Metrics 8

1. Introduction

Background

1.1. Our vision is:

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

1.2. The Board Vision metrics monitor the Trust's progress across key indicators of vision delivery, split into the following sections:

- Quality
- Safety
- Engagement
- Regulatory Compliance

1.3. These sections cover the key indicators in order to assure the Trust on its progress towards the vision.

1.4. This is a performance update as per the quarterly interval (or as agreed with the Board). A number of the indicators are annual, so updates will occur when information is available via a dashboard, see Appendix 1.

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 57 English providers and the 32 Combined Mental Health and Community Trust respondents. Indicator performance has been updated to the latest available.

2. Rationale for Metric Inclusion

Sections

2.1. By dashboard section (appendix 1) the following metrics were identified as having an impact on assessing our level of performance in delivering our vision. Unless otherwise stated performance presented is for year to end March 2020, prior to covid pandemic, which has impacted availability of some data.

Quality

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

2.3. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of

all Mental Health service providers in the national benchmarking cohort, however, where data is available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2018/19 benchmarking results have been updated to the dashboard as follows:

- **Mental Health Patient on Patient Physical Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean for 2018/19, but above the median per 100,000 occupied bed days excluding leave and is ranked 44th out of 57 English Mental Health respondents. The Trust ranks 23rd out of 32 combined Mental Health & Community Health Trust respondents. This is a worsening in our performance from our 2017/18 position, where the Trust was ranked 19th out of 55 Mental Health trusts and 11th out of 32 combined Mental Health and Community Health Trusts.

- **Mental Health Patient on Staff Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean for 2018/19 and is in the upper quartile per 100,000 occupied bed days, excluding leave. The Trust is ranked 42nd out of 57 English Mental Health benchmarking respondents. The Trust ranks 22nd out of 32 combined Mental Health & Community Trust respondents. This is a worsening in our performance from our 2017/18 position, where the Trust was ranked 24th out of 55 Mental Health trusts and 15th out of 32 combined Mental Health and Community Health Trusts. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our Quality Improvement (QI) programme and improvements are expected in the 2019/20 benchmarking.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean for 2018/19 and the Trust is ranked 49th out of 57 English benchmarking respondents. The Trust ranks 27th of 32nd joint Community and Mental Health Trusts. This is a worsening of our performance. In 2017/18, the Trust ranked 20th out of 55 Mental Health Trusts and 12th out of 32 combined Mental Health & Community respondents. Absolute and benchmark improvement in this area is a driver metric (seeking "breakthrough" improvement) within our QI programme.

- The Trust's reporting of the incidents in these categories has increased because of the focus on QI and Harm Free Care, together with other Trusts reporting fewer incidents has led to the apparent change in position.

- The next update on this section will be Quarter 4 2020/21 (subject to availability of data in this pandemic).

Safety

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

- **Falls –** where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group. There were no incidents in 2019/20 which is an improvement on 2018/19 when there were 2. Reduction in falls is a focus for a QI programme breakthrough objective.

- **Mental Health Inpatient Deaths because of Self-harm –** the metric has been updated to zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm was in October 2018. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction of all self-harm is a QI programme breakthrough objective. There has been no change since reported in October 2019.

- **Mental Health Bed Occupancy** – for mental health acute beds. The figure shown here was the occupancy rate in March 2020 and shows 90% against a target of 85%. This is an increase from 88% in January 2020.

- **Never Events –** This is all never events that occur in the Trust. None have been reported in Quarter 4 2019/20.

- **Pressure Ulcers -** Reduction in the level of developed category 3 and 4 pressure ulcers due to lapse in care in our community health services. There have been 22 Category 3 & 4 pressure ulcers identified due to lapse in in 2019/20, this is an increase from 17 incidents in the same period (April 2018 to March 2019) last year. Pressure ulcers are an improvement focus under the QI programme's Harm Free Care domain.

- **Suicide Rate -** By 2020/21, the Five-Year Forward View (FYFV) for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to 2015/16 levels. The Trust's suicide rate increased to 4.3 per 10,000 under mental health care in 2017/18 to 5.2 per 10,000 people in contact with mental health services in 2018/19. This local threshold was based on a 10% reduction on the 2015/16 suicide level of 9.2 per 10,000 people under mental health care and has achieved a 43.5% reduction on this rate. The next update will be in Quarter 4 2020/21. Our zero-suicide initiative and QI programme around self-harm provide complementary improvement activities in this critical safety area.

Engagement

2.5. Key metrics on how our patients, carers, staff and stakeholders view us and our contribution to the local system and performance:

- **Commissioner Satisfaction - Net Commissioner Investment Maintained –** achieved in line with last three years for 2019/20; with commissioner investment in mental health and community physical health contract demand growth, FYFV IAPT service expansion into Long Term Conditions and NHSE investment in Individual Placement Support (employment) services for people with severe mental illness, and court liaison and diversion services.

- **Stakeholder Satisfaction - Survey of System Partners –** Results of last survey were positive with in relation to the Trust's leadership, quality, governance and service delivery within the two Integrated Care Systems it operates in. Survey respondents included our six local authorities, and NHS commissioner and provider system partners.

- **Patient Friends & Family Test Response Rate –** 9.29% in January to March 2020 against the target of 15%, which is a decrease from October 2019 (14.7%). This is a QI driver metric. The metric was suspended due to the pandemic in quarter 1.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 18th February 2020. Our position remains unchanged from last year, with Trust Staff Engagement Score of 7.4, an increase from 7.3 in 2018/19.

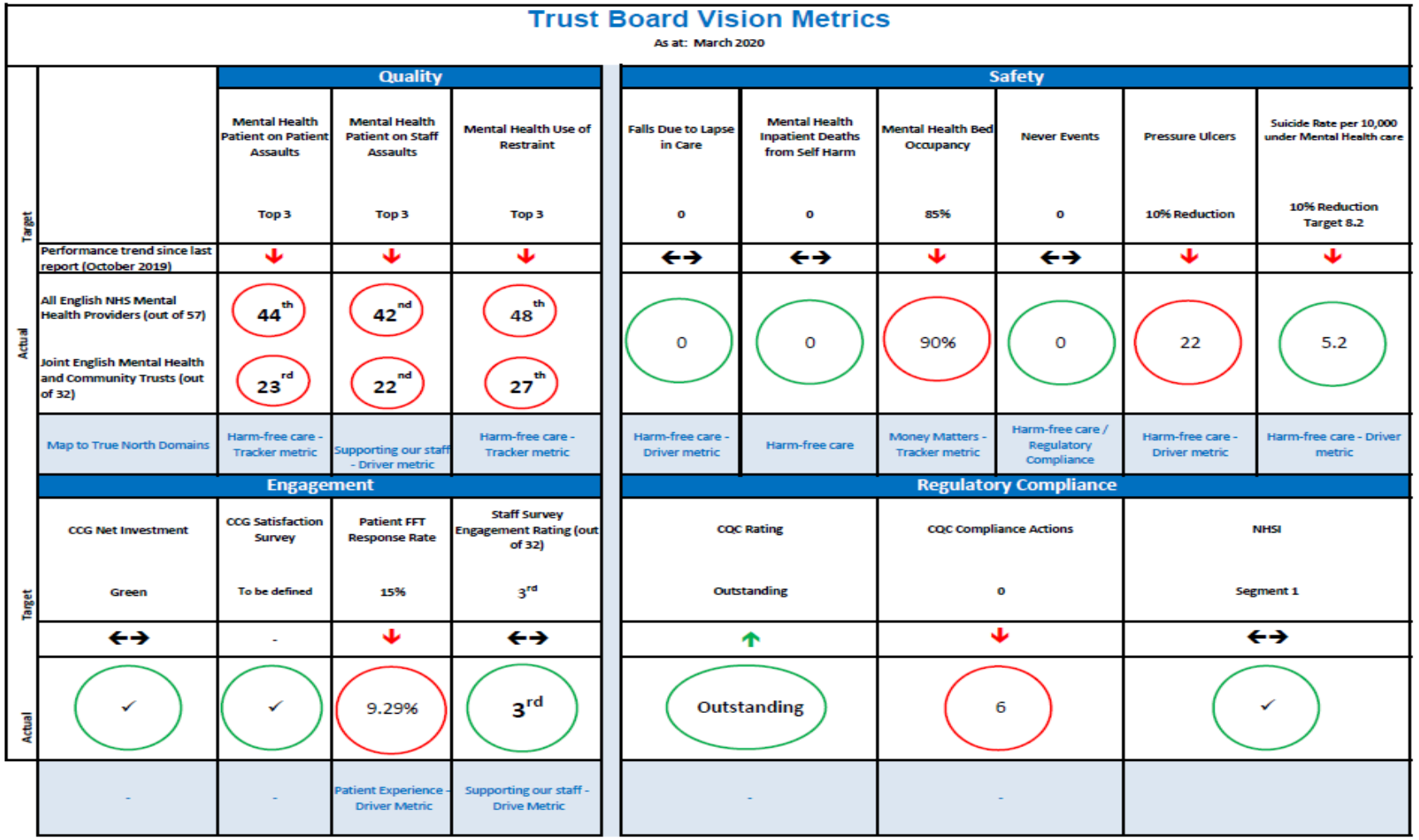
Regulatory Compliance

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

- **Care Quality Commission Rating –** Outstanding overall rating achieved in March 2020, including outstanding for Well Led.
- **NHSI Segmentation -** maintained segment 1 of the Oversight Framework (formerly the Single Oversight Framework) in latest assessment. 1 is the highest level of autonomy, with no NHSI support required. Finance score (formerly the Use of Resources) rating of 1 (lowest level of financial risk rating on scale of 1 to 4) in line with plan.
- **Number of CQC Compliance Actions –** There are 6 compliance actions from the most recent CQC inspection (action plans in place), which are as follows:

  - *CAMHS* - provider must continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway.
  - *Adult Acute Wards* **-** The trust must ensure that ligature risks are managed appropriately (Regulation 12). *This was specifically in relation to fire doors with hinges on the wards*
  - The trust must ensure that the ward environment is always adequately furnished and maintained. (Regulation 15).
  - The trust must ensure that patients are kept safe. For example, promoting the sexual safety of people using the service (Regulation 12).
  - The trust must ensure restrictions are necessary and proportionate responses to risks identified for individuals (Regulation 13).
  - The trust must ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12).

Appendix 1 – Board Vision Metrics



Trust Board Vision Metrics

As at: March 2020

		Quality			Safety					
		Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care	Mental Health Inpatient Deaths from Self Harm	Mental Health Bed Occupancy	Never Events	Pressure Ulcers	Suicide Rate per 10,000 under Mental Health care
Target		Top 3	Top 3	Top 3	0	0	85%	0	10% Reduction	10% Reduction Target 8.2
	Performance trend since last report (October 2019)	↓	↓	↓	↔	↔	↓	↔	↓	↓
Actual	All English NHS Mental Health Providers (out of 57)	44th	42nd	48th	0	0	90%	0	22	5.2
	Joint English Mental Health and Community Trusts (out of 32)	23rd	22nd	27th						
	Map to True North Domains	Harm-free care - Tracker metric	Supporting our staff - Driver metric	Harm-free care - Tracker metric	Harm-free care - Driver metric	Harm-free care	Money Matters - Tracker metric	Harm-free care / Regulatory Compliance	Harm-free care - Driver metric	Harm-free care - Driver metric

		Engagement				Regulatory Compliance		
		CCG Net Investment	CCG Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSI
Target		Green	To be defined	15%	3rd	Outstanding	0	Segment 1
		↔	-	↓	↔	↑	↓	↔
Actual		✓	✓	9.29%	3rd	Outstanding	6	✓
		-	-	Patient Experience - Driver Metric	Supporting our staff - Drive Metric	-	-	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	Place Results 2019
Purpose	To provide the Board with the results from the annual PLACE audit
Business Area	Estates & Facilities Management
Author	Chief Operating Officer
Relevant Strategic Objectives	To provide accessible and safe environments which keep patients safe, supports our staff, provides good patient experience and is cost effective.
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and the delivery of safe and responsive care
Resource Impacts	None
Legal Implications	None
Equalities and Diversity Implications	N/A
SUMMARY	The attached presentation provides the Board with the Trust's PLACE results, highlighting key areas of performance and comparisons to other Trusts. PLACE is the national system for assessing the quality of the patient environment. Assessments are undertaken by patient assessors and look at cleanliness, food, condition, privacy and dignity, dementia and disability. The Trust remains above national and regional averages for all Trusts and Mental Health Trusts. We have – • The highest average score of Mental Health Trusts regionally (6 organisations) • The second highest average score of all Mental Health Trusts nationally (45) • The ninth highest average score all Trusts nationally (209)

ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare NHS
NHS Foundation Trust

PLACE 2019

Results review

Patient-led Assessment of the Care Environment

Introduction

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections.

The assessments primarily apply to hospitals and hospices providing NHS-funded care in both the NHS and private/independent sectors but others are also encouraged and helped to participate in the programme.

The assessments involve local people (known as Patient Assessors) going into premises as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia.

From 2016 the assessment also started to look at aspects of the environment in relation to those with disabilities.

For further information see https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place

Introduction

The PLACE assessment considers the following criteria.

- how clean the environments are
- the condition – inside and outside – of the building(s), fixtures and fittings
- how well the building meets the needs of those who use it, for example through signs and car parking facilities
- the quality and availability of food and drinks
- how well the environment protects people's privacy and dignity
- how well the environment supports people with dementia
- how well the environment supports people with a disability

Please note that the PLACE questions were revised considerably between 2018 and 2019 making direct comparisons questionable. However the trends in data will still provide a strong indication of performance

Overview - 2019

Berkshire Healthcare NHS
NHS Foundation Trust

National picture

- No comparison of performance with last year possible due to extent of change
- *1,144 assessments undertaken compared to 1198 in 2018*

BHFT - for all indicators

- Remain above national and regional averages for all Trusts and MHTs
- Top of MH Trusts regionally in all indicators (excl food, 2nd)
- Top three of MH Trusts nationally (Ex cleaning 7th, food 13th) in all indicators

BHFT - Absolute performance

- Highest average score MHTs regionally (6 organisations)
- Second highest average score all MH Trusts nationally (45)
- Ninth highest average score all Trusts nationally (209)

BHFT – Site specific

- All sites significantly above national and regional average and only two out of thirty below MHT average
- St Marks below Trust average and specific review on feedback will be conducted

Comparative performance
Trust-wide (1) - 2019

Berkshire Healthcare NHS
NHS Foundation Trust

		Cleaning %	Food %	Privacy & Dignity %	Condition %	Dementia %	Disability %
	2019 results	*99.76*	*95.29*	*96.65*	*99.20*	*98.86*	*97.66*
	2018 results	99.87	96.25	94.37	98.67	98.83	97.64
	2017 results	99.82	96.69	96.67	98.91	98.89	98.72
	2016 results	98.95	95.49	98.05	98.64	98.58	97.19
Vs 2019 scores	Average (All Trusts)	98.57	92.12	86.92	96.33	82.84	83.64
	Average (MH Trusts)	98.48	92.23	91.74	95.40	89.29	87.01
	vs MHTs regional (6)	1st	2nd	1st	1st	1st	1st
	vs MHTs national (45)	8th	13th	3rd	3rd	1st	1st

Comparative performance
Trust-wide (2) – ranking

Berkshire Healthcare NHS
NHS Foundation Trust

	Cleaning %	Food %	Privacy & Dignity %	Condition %	Dementia %	Disability %	Average
Vs MHTs region (6)	1	2	1	1	1	1	1
Vs MHTs national (45)	7	13	3	3	1	1	2
Vs All Trusts (209)	35	56	9	21	2	6	9

Comparative performance
Sites (1) – vs BHFT average

Berkshire Healthcare NHS
NHS Foundation Trust

	Cleaning %	Food %	Privacy & Dignity %	Condition %	Dementia %	Disability %	Average
BHFT average	99.76	95.29	96.65	99.20	98.86	97.66	97.30
Prospect Park	99.71	93.90	98.96	99.63	99.21	97.77	98.20
Wokingham	99.88	97.25	95.35	99.70	98.54	97.77	98.08
St Marks	99.49	97.82	90.14	94.54	95.11	93.33	95.07
Upton	100.00	97.52	93.75	99.18	99.08	97.39	97.82
West Berkshire	99.90	96.95	93.20	99.49	99.53	99.38	98.08

Performance more than two percentage points below the Trust average for 2019

Comparative performance *Sites (2) – vs MHTs average*

Berkshire Healthcare NHS
NHS Foundation Trust

	Cleaning %	Food %	Privacy & Dignity %	Condition %	Dementia %	Disability %	Average
MHTs average	98.48	92.23	91.74	95.40	89.29	87.01	92.36
Prospect Park	99.71	93.90	98.96	99.63	99.21	97.77	98.20
Wokingham	99.88	97.25	95.35	99.70	98.54	97.77	98.08
St Marks	99.49	97.82	90.14	94.54	95.11	93.33	95.07
Upton	100.00	97.52	93.75	99.18	99.08	97.39	97.82
West Berkshire	99.90	96.95	93.20	99.49	99.53	99.38	98.08

Performance more than two percentage points above the MHT average for 2019

Performance more than two percentage points below the MHT average for 2019

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th July 2020
Title	Equality, Diversity and Inclusion report mid-way review
Purpose	The purpose of this report is to provide the Board with mid-year update regarding the Equality, Diversity and Inclusion work across the Trust
Business Area	Strategy
Author	Kathryn MacDermott- Acting Executive Director of Strategy Nathalie Zacharias- Deputy Director of AHPs and Equality and Diversity Director Lead Laura Davis- Equality, Diversity and Inclusion Manager
Relevant Strategic Objectives	True North- Supporting our staff and Good patient experience
CQC Registration/Patient Care Impacts	People who use our services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	• To meet our statutory equality and diversity requirements • To provide an inclusive environment for our staff as well as people who use our services
SUMMARY	Overview of the activity and outcomes against our statutory reporting. Highlighting the work that has been undertaken across the trust to promote inclusion and recommendations for future reporting against the Equality, Diversity and Inclusion strategy.

ACTION REQUIRED	The Board is asked to: Note the report and progress.

Equality, Diversity and Inclusion report mid-way review

1. Introduction

This report provides a mid-year review to the Trust Board on the progress made against the Trust's Equality Strategy 2016-20 and highlights the achievements made over the past six months. It also sets out the key areas of focus for the first four months of 2020 to ensure delivery of our objectives and prepare for a new strategy to take effect towards the end of 2020, with a greater focus on inclusion and belonging.

Since the last report, the Equality and Diversity work focusing on our staff has continued to build momentum with some positive outcomes being achieved. This is in line with the objectives of our strategy, building a clearer communication around making this a great place to work for everyone.

We have begun work to implement the stronger message around Equality, Diversity, Inclusion and Human Rights and this has been achieved through much closer collaboration between Human Resources, Communications, Learning development and the Equality, Diversity Manager. Through this approach we have begun to develop awareness on micro aggressions, inclusion cards to support those difficult conversations and starting to review of all of the equality and inclusion training.

A focus group of staff received training from the British Institute of Human Rights, to further inform our thinking in becoming fully inclusive and respectful of all our staff and patients, This training provided an opportunity to reflect and support our thinking in developing an equality, diversity and inclusion strategy that all staff can engage with, without losing the important focus areas for each of the protected characteristics. Human Rights applies to everyone, with overarching themes of participation, accountability, non-discrimination, Empowerment and legality, after all, we are all connected as Human Beings.

Often people see equality and human rights as a problem – not a solution, especially in times of financial constraint. Yet, there are ethical, business, economic and legal arguments for providers to pay attention to equality and human rights. Human rights principles of fairness, respect, equality, dignity and autonomy are at the heart of good care provision. There is a strong link between the quality of care and equality for staff that requires work on basic fairness and building an inclusive culture that recognises and celebrates diversity. There is also a link between the quality of care and whether people who use services say their human rights are upheld- taken from British Institute of Human Rights

The communications team has worked hard this year in supporting greater visibility for all areas of inclusion, with a narrative focused on inclusion and belonging.

Working in partnership with all the three staff networks, we have been able to celebrate a range of events across the Diversity and Inclusion calendar.

2. Equality Strategy: current progress towards our goals

The table below provides a summary of progress against the 7 goals of our Equality Strategy.

Equality Strategy- Goal	Progress
1. Increased representation of BAME staff in bands 7 and 8a-d. Goal: 20% representation at each of these grades Although our current Equality and Inclusion Strategy target is to achieve 20% BME staff in bands 7 and above, we are aware that this reflects the 2011 census for Berkshire as a whole. The population has increased since then, and the percentage of people from BME backgrounds varies considerably across the county. Both of these factors will be taken into account when preparing the refresh of our strategy planned for April 2020.	Trend: increased representation of BME staff in bands 7/8a/8b The percentage of BME staff employed by the Trust is 21.85%, and therefore broadly reflects the Berkshire population of 20% BME people recorded at the 2011 census. Our records showed that 5% of our staff had undisclosed ethnicity. We have achieved a steady improvement in the likelihood of a white person being appointed compared to a BME person from 1 ½ times more likely 4 years ago to 1 ¼ times last year. We have achieved more than 20% BME staff in bands 5, 6 and 7.
2. Equalise opportunities for BME staff career development Measured by: Annual Staff Survey	The percentage of BAME staff who believed that the Trust provided equal opportunity for career development and/or promotion in the 2018 staff survey stood at 68.4% (the score decreased from 74.4% in 2017). The percentage for white staff was down from slightly from 89.3% to 89.2%. We have established a process which enables training applications and decisions to support or decline these to be monitored centrally and will review this process during the coming year to identify its impact and any amendments required.
3. Reduce harassment and bullying of BAME staff Measured by: Comparison against other mental health trusts in the NHS staff survey index.	The percentage of BME staff experiencing harassment, bullying and abuse from staff) was 26.2% in 2018 - an increase from the 20.9% reported the previous year. For a white member of staff, the percentage was 20%, up from 18.2% reported the previous year. Nationally, the percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months increased from 26.3% in 2016, to 27.8% in 2018. We have started cohort 4 of our Making it Right programme for our BAME staff and will

Equality Strategy- Goal	Progress
	developing our approach for disabled staff this year, followed by our LGBT staff. Making it Right continues to include content to enable staff to identify and address bullying and harassment and highlight the support that is available within the organisation. This year, we have also piloted Making It Right for Managers, which includes raising managers' awareness of the experience of staff with protected characteristics. Feedback has indicated that the most valuable learning was gained from hearing about people's experience, rather than simply presenting data. Our Freedom to Speak Up Guardian has made good links with our staff networks, and our Freedom to Speak Up champions are a diverse group based at several trust locations. We recognise how serious an impact that bullying, harassment and abuse can have on individuals, and therefore will continue our work to ensure that our training for managers includes best practice content regarding reducing bullying and harassment.
4. Improve the working experiences of disabled staff and a reduction in the proportion of staff experiencing stress related sickness absence	Disabled staff has twice as much sickness per employee (12.92 days) then those staff who are not disabled (6.24 days). The percentage of stress anxiety related sickness for disabled staff is 69.8%, compared to 9.7% for non-disabled staff. There is need for a coordinated approach to improve staff health and well-being for all our staff, but disabled staff in particular.
5. Stonewall Workplace Equality Index -to regain the Trust's status in the top 100 employers and maintain a ranking in the top five health and social care providers	We received our 2019 feedback and placed 133, 54th in our sector, which remains a strong placing although outside of the top 100. We continue to strive to improve our placing while focusing our efforts on doing the right thing for staff and patients. The 2020 submission was entered on time and the support across the organisation to gather evidence was outstanding. We wait to hear the results in early 2020.
6. To meaningfully engage with a range of diverse groups, reflective of our population, in particular focus on BAME, LGBT and People with a Disability. To provide services that embrace human rights, providing positive experiences and equity of access in both mental health and community health services.	East Berkshire successfully recruited a post to deliver targeted engagement across the East and to work in partnership with the West for children's services. The Community Engagement Officer post has delivered Equality and Diversity training within services. Building relationships with WAMCF multi faith group and women's group to hold open discussions on mental health.

Equality Strategy- Goal	Progress
	Linked with domestic violence research group with focus on barriers for BAMER communities in accessing services In the west, our Community Development Officer continued to engage effectively within the community and working collaboratively across the county for children's services. This post has supported a community champions program, bringing together community groups from across the west of Berkshire. This included: working in partnership with Wokingham Borough Council around mental health services; helping to run a Men's Summit working within Reading; sharing a Healthwatch report looking at experiences of the LGBT+ community in health services. Both posts across the East and the West are providing invaluable connection into the communities we serve. Our Equality, Diversity and Inclusion manager has continued to co-chair the Thames Valley Employers LGBT+ which has enabled great opportunities for collaboration and training opportunities to support our LGBT+ staff and patients. We have attended two events arranged by the Thames Valley Race Equity and Cultural Harmony group run by Oracle, Thames Water and Reading University. Our Director of People presented at the first event in May 2019. The chair of the BAME network attended the second event in October 2019 and some amazing links across the Thames valley have been developed.
7. A more robust approach to making reasonable adjustments for people with a disability with particular focus on the NHS Accessible information standard.	We successfully recruited to an Access Officer post that started in June 2019 and the post holder has undertaken an organisation wide review of the compliance with the Accessible information standard. A clear set of recommendations have been developed and are currently being reviewed by the Diversity Steering Group for implementation. The post holder worked with HR and the Purple network to develop a set of guidelines for staff around reasonable adjustments and these are currently being reviewed by the HR team and were presented to the DSG in December 2019.

3. Statutory reporting

Workforce Race Equality Standard
Our Workforce Race Equality standard {WRES} was submitted in September 2019, and steady progress is being made with the Making it Right programme is starting to have an impact. However, this improvement is not yet reflected in the experiences of our staff through the National Staff Survey and therefore further work is needed to see the improvements we aspire to. The NHS England WRES Team has provided the Trust with specific aspirational targets and we are planning to undertake some more detailed analysis to inform our proposed workforce targets. These will be informed by the aspirational targets and our assessment of workforce supply at different bands to ensure we are working on the right things.

Workforce Disability Equality Standard
2019 was the first year of submitting a return and there were delays in receiving the template from NHS England. Our Workforce Disability standard {WDES} was submitted in September 2019. Disclosure rates remain lower than expected and staff report that they do not feel that reasonable adjustments are being made that will improve well-being and engagement. {Full report attached appendix B}

4. Staff networks updates

BAME network- Our BAME network has continued to grow and has further developed a vibrant membership including champions. In 2019 they ran three key events to celebrate dates within the Diversity Calendar.

- Asian Heritage Month
- Windrush
- Black History Month

Each of these events were well attended, with additional tickets needing to be released for the Black History Month event. The events have continued to raise the visibility of the amazing contributions our BAME staff make to the organisation, community and wider society. The network works closely with Executive Directors, senior leadership and other departments, providing advice, guidance and scrutiny, to ensure we are developing an inclusive organisation.

The BAME network has continued to champion and promote the Making It Right initiative across the organisation. In September 2019, cohort 4 of the program started and candidates have completed the workshops. To date more than a third of Making it Right graduates have already secured promotion and other have been seconded to more senior positions.

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

- The “Maximising Our Ability” conference held in March.

- Promotion of World Mental Health Awareness Week, “Time to Talk” day and World Autism Awareness Week as well as “Purple Light Up Day” last December

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

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

PRIDE Network- the Pride Network was re-launched this year with three new co-chairs. They have rebranding to ensure they are fully inclusive of everyone, including allies and planning for their formal launch event in February 2020 is well underway.

The network has grown in the past six months from less than 10 confirmed members to over 100, and this number continues to grow. They have partnered with a number of other networks to learn and grow together, including the Thames Valley LGBT+ employers’ network, RBH LGBT+ network and GSK staff network.

The network supported Reading Pride 2019, which was our most successful Pride to date with over 70 volunteers from across the organisation, positively representing the organisation as both an employer and provider of services.

Our Stonewall Equality Index was submitted in September 2019 and the network were involved in the submission and we await the outcome of this in February 2020. The Network launched the Rainbow Pins and pledges across the organisation, with 138 people requesting a pin and making a pledge in the first week of launching.

Working together- All three networks have established a close working relationship, are producing a joint newsletter, promoting the shared experience and reflecting the intersectionality within our workforce. The networks are planning a joint conference in 2020 to celebrate intersectionality and harmony.

The 2018 NHS Staff Survey that showed "25% of our staff had experienced bullying, harassment or abuse from patients, service users, their relatives or members of the public". When we look closer at the statistics for staff with protected characteristics, these numbers are even higher. The networks have also worked closely with Executive Directors and Marketing and Communications Team and the “Together we can stop bullying and Harassment” campaign was launched by David Townsend, Chief Operating Officer, in November 2019.

5. Diversity Roadshows

The diversity roadshows have been rolled out across the trust again in 2019, with a total of seven roadshows taking place in both the west and east of the county. The

roadshows were well attended by the staff networks, freedom to speak up and unions and there were high levels of engagement.

6. Progress against our Recommendations from the Annual Report

- We have started to develop a new Diversity, Equality and Inclusion strategy for inclusion in our refreshed 3 Year Strategy. Our work to date is based on a Human Rights perspective, emphasising respect, understanding and compassion for everyone, and investing in training to support this ambition.
- Using the “Equality Delivery System 3” framework to align the Trust Diversity, Equality and Inclusion strategy, Workforce Race Equality Standard, Workforce Disability Equality Standard, accessible information standard and CQC standards.

What we have done:

We have worked over the past six months to inform the development of the new strategy. In October 2019 the British Institute of Human Rights, delivered training on Embedding Human Rights. In November 2019 we undertook a mapping exercise reviewing all of the Equality, Diversity and Inclusion statutory reporting, NHS Equality Delivery frameworks, accessible information and CQC requirements and comparing these to what the National Staff Survey was showing us. We are committed to developing a strategy that focuses on the areas that will be most impactful for our staff and patients.

- Continuing to build a more inclusive workforce and environment for all our staff and patients and developing a zero tolerance on behaviour that does not align with the Trusts values.

What we have done:

During anti bullying week in November 2019 we saw the launch of the “together we can stop bullying and harassment” campaign. We are developing some guidance for staff to support the conversations to address bullying and harassment. The micro aggressions posters are being shared across the organisation and Inclusion cards have been developed to support the difficult conversations that are needed within teams.

- Ensuring our services are inclusive of our Trans community, as a population that has largely been unrecognised in previous reporting.

A trust wide project has been approved to address both the reporting and experience of our Trans patients across all services. This program is being managed by the Equality, Diversity and Inclusion Manager with support from the Information Governance and the Digital transformation team. This project aims to improve the complexities of recording patient data and supporting our staff to build confidence in

supporting our Trans patients. This program will be co-produced with individuals who have lived experience.

- Improving our understanding of how well we are serving our communities and rates of access of our services by people with protected characteristics

What we have done:

We have undertaken an A3 analysis to develop improvements in recording patient data around the protected characteristics. We are developing a clear narrative around why this is important and making sure our staff are confident in asking the right questions. We have identified an NHS Employers demographics tool and plan to compare this to the census data to support a more accurate and robust picture of the makeup of the local communities in which we serve. The Community Engagement posts in the West and East have continued to undertake targeted work within the community and feed this intelligence to support better service planning.
We have made progress against each of the recommendations made in the annual report and will continue to develop initiatives that promote inclusion and belonging for all staff and patients.

7. Recommendations

Following on from the mapping exercise, we propose an amendment to the reporting cycle to align the Equality Diversity and Inclusion reporting with the Trust annual plan, WRES, WDES and Stonewall feedback

- We propose reporting in November and a midway report in May from 2021. This paper provides the midway update. The 2020 Equality, Diversity and Inclusion strategy refresh has been delayed to December 2020, so the next Equality Report would be provided one month later this year in December 2020 (delayed by COVID).

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14th July 2020
Title	COVID 19 Recovery Programme Highlight Report
Purpose	The purpose of this report is to provide the Board with an update on the Recovery and Restoration process for BHFT
Business Area	All
Author	Karen Watkins / Neil Murton, PMO
Relevant Strategic Objectives	All
CQC Registration/Patient Care Impacts	People who use our services experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
Resource Impacts	Yes, currently unquantified
Legal Implications	N/A
Equality and Diversity Implications	We will be completing Equality Impact Assessments on a number of the Recovery elements of work.
SUMMARY	BHFT has commenced its process of recovery and restoration in line with the Recovery Strategy agreed by the Trust Board. The initial work has focused on prioritizing the re-opening/extending of services. The prioritization process requires a service to complete a Quality Impact Assessment (QIA) that sets out how the service will be operating and how risks are managed. The QIAs are approved by either the Director of Nursing or Medical Director. Alongside the QIA services are required to complete an Estates

	Facilities Management (EFM) template that sets out the requirements for PPE and estates. This template must be approved by the Director of Estates before the Service Prioritization Group will consider the service. As at the date of this report 37 services have been approved to recover and 20 are awaiting approval. There has been a significant increase in the use of remote working across all services. This has included telephone triage to direct patients to the right service/professional, follow up appointments and diagnostics completed via One Consultation or Teams, assessments completed via One Consultation and Teams.
ACTION REQUIRED	The Board is asked to: Note the report and progress.

Project Highlight Report	Month: July 2020

Programme Title	COVID 19 Recovery Programme

Summary Description	The scope of programme covers the whole of Berkshire and the Trust's commissioned service delivery across Children's and Families, Community Health, Mental Health, Inpatients and Corporate services. The programme aims are: • Restore full capacity, quality and resilience of our physical and mental health services to meet ongoing and emerging post COVID-19 community needs. A key aim is to stabilise our workforce with a particular focus on retention, providing support to staff and team resilience and wellbeing following the social and psychological shock of responding to COVID-19. • Enable physical and mental health services to meet the health needs of individuals, staff, and the community including the new models of care tested during the COVID-19 period • Promote self-sufficiency and continuity of the health and wellbeing of affected individuals; particularly the needs of children, seniors, people living with disabilities, whose members may have additional functional needs, people from diverse origins, people with limited English proficiency, and underserved populations • Reconnect displaced populations with essential physical and mental health services • Work co-productively with commissioners and partners to embed new ways of working as a part of the standard operating model

Deployment Status: M/I	Mission Critical	Project Life Cycle Status:	Initiation	Planned Completion Date:	Sept 2021

I = Mission Critical I = Important Initiation/ In Progress/ Moving to Business as Usual/ Closed

Author	Karen Watkins / Neil Murton	Overall Project Status*:	

*Show status as Red / Amber / Green.

Summary Commentary re status & progress:	**Overall Progress** We continue to remain in the active phase of the COVID 19 response although the impact is now reduced and services that were paused or partially closed are now going through a formal prioritisation process. Staff that were redeployed to support front line services are starting to be returned to their substantive roles. A project charter has been completed and project management tools including milestone planner and risk log continue to be developed. Review of lessons learned during the response stage of the COVID 19 pandemic have been collated and are informing the recovery

programme.

The programme structure has continued to evolve with a formal “Service Recovery Prioritisation Group” now in place to manage the prioritisation process. This includes the completion and approval of a QIA and EFM form for each service.

Once complete the Service Recovery Prioritisation Group asks six questions regarding the restart and makes the decision to approve/no approve.

1. Where are staff currently located? Re-deployed in another service? Working from home?
2. For services with re-deployed staff - What will be the impact on the service if staff move back to substantive roles? If there is a possible negative impact has phasing a return been considered?
3. Requested start date
4. Key risks for the operational expansion of service / key risks for non-start of service?
5. Have the changes and adaptations impacted on any groups of staff or those with protected characteristics more than others?
6. Do we need to make specific adaptations to ensure that staff are not disadvantaged in any way?

As at the date of this report 37 services have been approved to recover and 20 are awaiting approval (see attached QIA/EFM Log extract, appendix 1).

Impact on staff

A number of the psychologists in the IPASS service have been redeployed to the Staff Wellbeing Service, therefore whilst IPASS keen to become fully operational asap a phased approach over a number of weeks has been agreed to allow the Staff Wellbeing Service to plan accordingly.

Physio’s from the MSK Physio East and West services were redeployed to support the Hospital Discharge Service/Rapid Community Discharge. Utilisation of Rapid Community Discharge and Community Beds. We would not have been able to operationalise the urgent community response without the redeployed staff. The East and West MSK Physio services are now extending their service offer and the MSK staff are being returned to their substantive posts. Workforce modelling has taken into account the bed capacity needed to support actual demand, the requirement to continue to provide 7-day services and the impact of new ways of working (i.e. remote consultations and the reduced number of face to face appointments when compared with pre COVID numbers). We are currently engaging with MSK physio staff to support the continuation of 7 day working on community wards.

Digital Technology

	There has been a significant increase in the use of remote working across all services. This has included telephone triage to direct patients to the right service/professional, follow up appointments and diagnostics completed via One Consultation or Teams, assessments completed via One Consultation and Teams. As part of the restoration process services are required to consider any new or additional digital requirements and these are taken into account in the service prioritisation process.

Planned Benefits –

Ref.	Benefit	Timescale / date to be realised	Responsibility	Achieved Yes/No	Comment
	Services restored	Ongoing	Divisional Directors	In progress	Rolling programme considering service prioritisation including approval of the proposed operating model, PPE requirements and any changes to the estate.
	New ways of working embedded	March 2021	SRO/Divisional Directors/Director People	In progress	New ways of working include a number of positive opportunities including remote appointments increasing access opportunities and decreasing patient transport and waiting times. Negative impacts include the reduced capacity of our services due to COVID cleaning guidance and social distancing in our clinics/services.
	Digital technology incorporated into Business as Usual	March 2021	Deputy Chief Executive and Chief Financial Officer	In progress	Significant uptake in digital technologies across services has been significant with staff engaging with technology in a way many thought was not possible pre COVID.

Top Risks & Issues

Key Observations / Risks / Issues to be raised

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment
Our people availability - There is a risk that we will not have enough staff available to support critical services		Established “Team Berkshire” and a Staff Bureau that oversaw the redeployment of staff across BHFT services. Workstream supported by Strategy and PMO Teams.	April 2020	Redeployment completed for phase 1 and staff now returning in a phased manner to their substantive roles.
Our People Wellbeing - There is serious risk to the wellbeing of our staff due to staff shortages, self-isolation, re-deployment, traumatic incidents etc)		Staff wellbeing psychological support and wellbeing packages in place. Workstream supported by the PMO. Continue to monitor our MH and anxiety sickness levels to anticipate any growing issues or needs. Risk that may demand for psychological support may increase during Recovery. Exec has agreed a business case to continue to provide wellbeing support for the Recovery phase (up to March 2021).	March 2021	
Our People - There is a risk that we do not have the right numbers of staff trained with the required skills (including orientation into a new working environment)		Maximise the numbers of staff released for refresher training. Ensure local induction in place for necessary orientation, including fire procedures and evacuation. Ensure clinical skills training addressed as required.	April 2020	Refresher training was accelerated through BHFT. Some local induction suffered due to levels of staff sickness on the wards in April.
Workforce Availability - Inadequate staffing due to the absence of a robust process and adequate resources for forecasting of workforce requirements		Being addressed in part through workforce work stream along with the Trust's involvement with the system workforce modelling.	September 2020	
COVID-19 – Risk of second wave de-railing the recovery process – leading to delay in the recovery programme		Learning from first wave to ensure readiness for second wave. PPE stocks and process in place to mitigate first wave issues. Recovery plans to include second wave planning		

	Completed / On Track		On Track / Known risks being managed		Off Track

Current Milestones Report

Milestone	Due date	Current Status (RAG)	Actions / Comments
Recovery Programme Structure in place	June 2020		Due to the changing requirements of recovery the structure has had to evolve with prioritisation currently the key priority. The need for a programme board has been identified to address the longer-term issues relating to the recovery process – this is in process of being set up.
Stakeholder Engagement and Communications Plan in place.	June 2020		Need for a separate Recovery Comms Group identified and being set up.
Service lessons Learned and feedback collated	June 2020		Lessons learned summary collated. Services lessons learned included in QIAs – currently being used to inform case studies for the Recovery newsletter
QIA and EFM Complete for all services	June 2020		Services have requested longer timeframe for completion of services where recovery is not imminent.
Plan for Corporate Services new ways of working developed	July 2020		
Recovery Planning Demand Modelling Tool Developed	June 2020		
Use of the demand modelling tool to assess future capacity of services	Sept 2020		Capacity of BI Team is limited – initial list of services to be modelled to be produced by the Recovery Team.
Prioritisation and approval of services for recovery compete with start dates or phasing identified.	Aug 2020		Prioritisation group meeting twice weekly with approvals being made at every meeting.

	Completed / On Track		On Track / Known risks being managed		Off Track

Key Activity during Next Period

Activity/Product to be delivered	Action/notes	By when
Continuation of recovery prioritisation process	Service Recovery Prioritisation Groups	Ongoing
Template for patient letters	Comms to provide template – services to use as appropriate and save in Teams folders.	02/07/20
Set up programme board and agree ToRs and Standard Work	KM/KW to progress	15/07/20
Re-draw structure to include programme board.	KW to progress	02/07/20

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	**Audit Committee – 27 May 2020**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 27 May 2020
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Audit Committee Meeting held on

Wednesday, 27 May 2020

(conducted via MS Teams because of the COVID-19 social distancing requirements)

Present: Chris Fisher, Non-Executive Director, Committee Chair
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

In attendance: Alex Gild, Deputy Chief Executive and Chief Financial Officer
Graham Harrison, Head of Financial Services
Monika McEwen, Financial and Capital Accountant
Paul Gray, Director of Finance
Amanda Mollett, Head of Clinical Effectiveness and Audit
Minoo Irani, Medical Director
Ben Sheriff, External Auditors, Deloitte
Clive Makombera, Internal Auditors, RSM
Melanie Alflatt, TIAA
Aileen Feeney, Non-Executive Director
Julie Hill, Company Secretary

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	The Chair welcomed everyone to the meeting and explained that the meeting was being conducted via Microsoft Teams because of the COVID-19 social distancing requirements.	
1.B	**Apologies for Absence**	
	There were no apologies.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Annual Accounts 2019-20, including the Annual Governance Statement**	
	The Annual Accounts 2019-20 and Annual Governance Statement had been circulated. It was noted that members of the Committee had been given the opportunity to review the draft Annual Accounts 2019-20 and Annual	

	Governance Statement prior to the meeting. The Chair confirmed that his questions had been fully answered by the Finance Team. The Chair commented that the Annual Accounts 2019-20- were excellent and confirmed that he had no further comments. Naomi Coxwell, Non-Executive Director and Mehmuda Mian, Non-Executive Director echoed the Chair's comments. The Deputy Chief Executive and Chief Financial Officer congratulated the finance and audit teams for completing the final year accounts and audit within the original timescale despite the additional challenges around COVID-19 social distancing requirements. The Deputy Chief Executive and Chief Financial Officer reported that the Trust had finished the year with a statutory surplus of £1m after further accounting for £2.4m of provider sustainability funding and a net £1.7m impairment charge following the annual asset revalidation exercise. It was noted that the Trust had also to account for an increase in the Employers pension contributions of around £8m.	
4.	**External Auditors Report on the Annual Accounts 2019-20 and Independent Auditor's Report and Management Representation Letter in respect of the Financial Statements**	
	Ben Sheriff, External Auditors, Deloitte, referred to the ISA 260 Memorandum which summarised the key issues identified during Deloitte's audit of the Trust's financial statements. Mr Sheriff thanked the Finance team for their co-operation and help during the course of the external audit which had been more challenging this year because of COVID-19. It was noted that the External Auditors' key judgements in the audit process related to: • The assumptions made in completion of the land and buildings revaluation, especially in the light of the material uncertainty contained in the Valuer's final report due to COVID-19; • Key judgements affecting achievement of control totals and the Provider Sustainability Funding income received, in particular, valuation of year end accruals. • There were no significant audit adjustments or disclosure deficiencies. • Based on the current status of the audit work, the External Auditors envisaged issuing an unmodified audit opinion with no reference to any matters in respect of the Trust's arrangements for securing the economy, efficiency and effectiveness of the use of resources or the Annual Governance Statement. • In the Key Audit Matter related to the valuation of land and buildings, the External Auditors would make reference to the material uncertainty in the Valuer's report. This reflected the uncertainties around the impact of COVID-19 and was in line with national guidance; • The Trust had followed the format prescribed by NHS Improvement in the Trust Annual Reporting Manual; • As a non-acute NHS Provider organisation, there had been limited financial impact from COIVD-19 in 2019-20. Additional expenditure had been incurred in the early part of 2020-21 and this was likely to continue for several months. The government had committed to	

	ensuring additional expenditure related to the response to the virus would be covered through income. The Chair commented that the uncertainties around the valuation of land and buildings due to COVID-19 did not impact on how the Trust delivered its services and therefore its only significance was in relation to the Trust's final accounts. Mr Sheriff reported that the External Auditors were waiting for confirmation from NHS Improvement about accounting for COVID-19 monies before finalising their final report. The Chair referred to the agency and contract costs benchmarking chart on page 86 of the agenda pack and asked whether the Trust was number 21 (highlighted in red). Ben Sheriff confirmed that was the case and agreed to update the key relating to the chart. The ISA 260 Audit Memorandum was received and noted.	**BS**
5.	**Letter of Representation**	
	Ben Sheriff, External Auditors, Deloitte reported that the Trust was required to sign a management representation letter in respect of the Financial Statements. On behalf of the Trust Board, the Committee authorised the Chief Executive to sign the Management Representation Letter.	
6.	**Formal Approvals**	
	It was noted that the Trust Board had delegated full authority to the Audit Committee to issue all necessary approvals in respect of the 2019-20 Annual Accounts on its behalf. It was also noted that the Trust Board had approved the Annual Report. The Company Secretary reported that since the Trust Board meeting on 12 May 2020, the Annual Report had been updated to reflect comments made by the External Auditors. A copy of the changes had been circulated to all Board members for comment. The Company Secretary confirmed that she had not received any comments. The Committee noted and approved the following relating to the Annual Accounts for 2019/20: • *Audit Memorandum* The ISA 260 Audit Memorandum was received and noted. • *Annual Accounts 2019/20* The Annual Accounts for 2019/20 were approved: • *Management Representations* The proposed Trust Management Representations response to Deloitte was approved: • *Annual Governance Statement* The Annual Governance Statement was approved.	

7.	**Quality Accounts 2019-20**	
	The Head of Clinical Effectiveness and Audit reported that due to the COVID-19 pandemic, NHS England/Improvement had informed NHS provider organisations that they were no longer required to gain assurance from the External Auditors on the Quality Accounts and that the Quality Accounts would not form part of the Trust's Annual Report for 2019-20. The Head of Clinical Effectiveness and Audit reported that the Trust was still required to produce the Quality Accounts for 2019-20 and to publish the document on the Trust's website by October 2020. It was noted that the Quality Assurance Committee had reviewed and draft Quality Accounts 2019-20 which would be formally approved by the July 2020 Trust Board meeting. The Head of Clinical Effectiveness and Audit reported that the Trust Chair had reviewed the Quality Accounts and had suggested that the External Auditors be requested to provide assurance on the content of the Quality Accounts as usual with the exception of auditing the performance indicators because this would involve frontline clinical staff. Ben Sheriff, Deloitte commented that the external auditors were only able to give a qualified limited assurance on the Quality Accounts and that the weight of their work was around testing the indicators. Mr Sheriff queried whether reviewing the content of the Quality Accounts against the guidance, but without auditing the performance indictors would provide the Trust Chair with any additional assurance. Having said that, Mr Sheriff confirmed that Deloitte would be happy to undertake the review of the Quality Accounts if requested to do so. The Deputy Chief Executive and Chief Financial Officer said that he was happy to support an external review of the content of the Quality Accounts if this provided additional assurance to the Trust Board. The Medical Director said that in his view, it was the external audit of the indicators which added value to the Trust but echoed the comments made by the Deputy Chief Executive and Chief Financial Officer. The Chair proposed that the Deputy Chief Executive and Chief Financial Officer, the Medical Director and himself discuss the issue with the Trust Chair and inform Deloitte of the outcome of their discussions. The Chair thanked the Head of Clinical Effectiveness and Audit for her update.	**CF/AG/MI**
8.	**Internal Audit**	
	a) Internal Audit Report 2019-20 Clive Makombera presented the paper and reported that the Head of Internal Audit's Opinion for 2019-20 for the Trust was that "the organisation has an adequate and effective framework for risk management, governance and internal control". This was the Internal Auditors highest level of assurance.	

	It was noted that the Internal Auditors had taken into effect the positive assurance ratings in respect of the individual audit reviews over the course of the last year and management's response to addressing any areas for improvement when assigning an internal audit opinion: The Chair reminded the meeting that last year he had asked Mr Makombera what the Trust would need to do to gain the highest level of assurance in respect of the Head of Internal Audit's Opinion and had been informed that the Trust had to sustain its high performance. Mehmuda Mian, Non-Executive Director referred to page 105 of the agenda pack and asked why in view of the Internal Auditor's Opinion, so many internal audits had been rated as "reasonable" rather than "substantial" assurance. Mr Makombera explained that a "reasonable" rating often reflected that the management actions needed time to embed. It was noted that the Head of Internal Audit's Opinion was based on the whole year's internal audit programme. The Committee noted the Internal Audit Report 2019-20 and the Head of Internal Audit's Opinion. **b) Internal Audit Plan 2020-23** Clive Makombera, RSM presented the Internal Audit Plan 2020-23 which had been discussed and approved by the Executive Team. Mr Makombera pointed out that the Internal Audit Plan included a range of areas of the Trust's business, including patient safety and COVID-19 related issues. Mr Makombera asked whether the Committee had any suggestions for other areas which should be included as part of the Internal Audit Plan. The Chair reported that he and Naomi Coxwell, Chair of the Finance, Investment and Performance Committee had exchanged emails prior to the meeting around whether the Internal Audit Plan should include how the Trust had prepared for and had responded to the COVID-19 pandemic. The Deputy Chief Executive and Chief Financial Officer suggested that the Internal Auditors review how the Trust had handled the COVID-19 pandemic after the Trust's COVID-19 Recovery Plan had been implemented. Ms Coxwell said that she would be happy to conduct an audit after the implementation of the Trust's COVID-19 Recovery Plan. Ms Coxwell asked whether the Trust was sufficiently resourced to meet national reporting COVID-19 reporting requirements. The Deputy Chief Executive and Chief Financial Officer confirmed that this was the case and pointed out that the Trust had effective data collection systems in place.	**AG/CM**

	Ben Sheriff, Deloitte reported that the national guidance for External Auditors was to treat COVID-19 as an issue for 2020-21. Mr Sheriff also reported that the value for money assessment was changing in 2020-21 and pointed out that outcome of the Internal Audit Programme would feed into their value for money assessment. The Deputy Chief Executive and Chief Financial Officer reported that he would be reviewing get scope of the Quality Improvement Programme with Clive Makombera. The Committee noted that if issues emerged during the course of the year, the Trust had the option of changing the Internal Audit Programme to add new reviews. The Committee approved the Internal Audit Plan 2020-23.	
9.	**Counter Fraud**	
	a) Counter Fraud Annual Report 2019-20 Melanie Alflatt, TIAA presented the Counter Fraud Annual Report 2019-20 which was approved by the Committee. **b) Counter Fraud Self Review Tool Ratings 2019-20** Melanie Alflatt, TIAA the outcome of the Trust's Counter Fraud Self Review Tool ratings for 2019-20. The Chair asked what more the Trust could do to turn the amber ratings green. Ms Alflatt said that some areas, for example, in the "inform and involve" section were relatively easy to address but others, for example in the "prevent and deter" section were more difficult. Ms Alflatt commented that the Trust was not alone in finding the "prevent and deter" activities challenging. Mehmuda Mian, Non-Executive Director referred to page 164 of the agenda pack and said that she appreciated that the report was in draft but asked when the table would be completed. Ms Alflatt said that the table would be completed ahead of the submission date and circulated to the Chair and Deputy Chief Executive and Chief Financial Officer so they could formally approve the submission. The Committee approved the Counter Fraud Self Review Tool Ratings 2019-2020 subject to the completion of the table on page 164 of the agenda pack. **c) Counter Fraud Annual Work Programme 2020-21** Melanie Alflatt, TIAA presented the Counter Fraud Annual Work Programme for 2020-21. Ms Alflatt drew attention to the fraud risk matrix analysis on page 180 of the agenda pack which followed the same format as the Trust's own risk management matrix.	**MA**

	It was noted that an additional risk, had been added in relation to the additional COVID-19 fraud risks. The Chair reminded the meeting that he had agreed with Ms Alflatt's predecessor that TIAA would run a personal development session for the Committee on the Bribery Act but unfortunately the April 2020 had been cancelled due to COVID-19. Ms Alflatt confirmed that running a session on the Bribery Act was included as part of the Counter Fraud Annual Work Programme. The Deputy Chief Executive and Chief Financial Officer confirmed that he was happy with the Counter Fraud Annual Work Programme. The Committee approved the Counter Fraud Annual Work Programme 2020-20.	
10.	**Any Other Business**	
	Resuming Audit Committee Meetings The Chair reminded the meeting that the scheduled meeting of the April 2020 Audit Committee meeting had been postponed to enable the Trust to focus on its COVID-19 response. The Chair asked whether attendees would be happy for virtual Audit Committee meetings to resume from July 2020 onwards. The Deputy Chief Executive and Chief Financial Officer confirmed that he would be happy for the Audit Committee meetings and the personal development training sessions to resume subject to external partners capacity. Audit Committee members and attendees all confirmed that they were also happy for virtual meetings to re-start from July 2020.	
11.	**Chair's Closing Remarks**	
	The Chair thanked the Finance Teams for their work on the Trust's Annual Accounts 2019-20 and commented that producing and auditing the Annual Accounts had been made more challenging this year because of the COVID-19 pandemic. The Chair said that the Trust should be proud that it managed to adapt so well to the new operating environment. The Chair also paid tribute to the Trust's External Auditors (Deloitte), the Trust's Internal Auditors (RSM) and Counter Fraud Specialist (TIAA)	
12.	**Date of the Next Meeting**	
	22 July 2020 at 2pm	

These minutes are an accurate record of the Audit Committee meeting held on 27 May 2020.

Signed:- _____

Date: - 22 July 2020 _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 July 2020
Title	**Use of Trust Seal**
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Chief Financial Officer
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to: • a Deed of Variation in relation to Jasmine Ward works • a lease in respect of 4th and 5th floor, Nicholson House, Maidenhead
ACTION	To note the update.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	14 July 2020
Title	New Corporate Risk Register Risk – Nosocomial Infections
Purpose	The Trust has identified a new severe corporate risk in relation to Nosocomial infections. New evidence has highlighted the risk of staff to staff transmission of COVID-19.
Business Area	Nursing
Author	Debbie Fulton, Director of Nursing and Therapies
Relevant Strategic Objectives	The risk in particularly relevant to patient and staff safety.
CQC Registration/Patient Care Impacts	Relates to the CQC Well-Led domain
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	N/A
SUMMARY	
ACTION REQUIRED	The Committee is asked to; a) Approve that inclusion of the risk of nosocomial infections on the Trust's Corporate Risk Register.

Risk Title	Nosocomial Infections
Risk Description:	There is a potential for staff to staff transmission of COVID-19. This may result in an outbreak of COVID -19, harm to staff and patients including the risk of death and also disruption of service delivery both of which have consequent implications to the Trust Letters issued 9th and 24th June 2020 detailing steps required by organisations to minimise the risk.
Executive Director	Debbie Fulton, Director of Nursing and Therapies
Relevant Strategic Objectives(s)	To provide safe services, prevent self-harm and harm to others
Initial Risk Score	**Severe** **Risk Score 15 (Major x possible)**
Controls in place:	• All staff in Clinical roles wear PPE in line with national PHE guidance when in the clinical area • Posters, guidance, competence checklist, FAQ are in place • COVID specific teams space on Teamnet for all COVID related materials • Regular all staff newsletter to provide updates • All staff (non-clinical and clinical) not in a clinical area to wear a face mask in line with national guidance • Standard Operating Procedure in place that details requirements and exceptions to wearing of a mask in non-clinical areas (where they are in a workspace and are able to social distance by at least 2 metres, clean their desk and equipment at least twice daily and practice regular hand decontamination) • Compliance checklist and competency assessment to support services for PPE and also face masks • Masks, bins and hand gel available for non-clinical use across all sites • Central store with system in place for receipt and distribution of PPE push stock. • Point of contact for staff contacted by Test and Trace who have been advised to self-isolate in place • System in place for receiving and distributing PPE/ masks for non-clinical use • Process in place for receipt and consideration of all new guidance • Inpatient testing in line with guidance in place • Staff testing in line with guidance in place • Process for undertaking staff risk assessments in place
Controls assurance	• Reporting of any transmissions/ outbreaks • Communication processes in place to alert staff on social distancing; PPE; Test and Trace • Infection Control Team with audit and compliance processes in place • PPE senior oversight group established • Gold steering group receives all new guidance and agrees actions • Daily SITREP
Positive Assurance	• Reporting processes for Test and Trace, outbreaks and test results in place

	• IPCT Board Assurance Framework • Staff risk assessment data
Control/Assurance Gaps	
Current Risk Score:	**High** **Risk Score 10 (Major x unlikely)**
Target Risk Score:	**High** **Risk Score 5 (Major x rare)**
Progress:	
Further actions planned (June-September 2020)	• Compliance tools and competency assessments in progress • Social distancing campaign • Monitoring of adherence to masks and social distancing in non-clinical areas and when staff not in full PPE
Target Date	March 2021
Date of Update	New risk June 2020
Review Date	September 2020