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 10 November 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 8 September 2020	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Staff Story – Prospect Park Hospital Preceptee	Debbie Fulton, Director of Nursing and Therapies	Verbal
6.1	Patient Experience Report – Quarter 2 Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Six Monthly Safe Staffing Report *(NB the Finance, Investment and Performance Committee reviews the monthly Safe Staffing Reports)*	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Staff Flu Vaccination Update Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.4	Infection Prevention and Control Board Assurance Framework	Debbie Fulton, Director of Nursing and Therapies	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.0	Month 06 2020/21 Finance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.1	Month 06 2020/21 Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	a) Finance, Investment and Performance Committee meeting held on 29 October 2020	Naomi Coxwell, Chair, Finance, Investment and Performance Committee	Verbal Enc.

No	Item	Presenter	Enc.
	b) Committee's Terms of Reference – minor amendments		
STRATEGY			
9.0	People Strategy	Alex Gild, Deputy Chief Executive and Chief Financial Officer/Jane Nicholson, Director of People	Enc.
9.1	Equalities, Diversity and Inclusion Strategy	Alex Gild, Deputy Chief Executive and Chief Financial Officer/Nathalie Zacharias, Equality and Diversity Director	Enc.
9.2	Strategy Implementation Plan Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
9.3	COVID-19 Recovery Plan Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
CORPORATE GOVERNANCE			
10.0	a) Audit Committee Meeting held on 28 October 2020 – Minutes of the Meeting b) Committee's Terms of Reference – minor amendments	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	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 – 8 December 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 08 September 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
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Deputy Chief Executive and Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Dr Minoo Irani	Medical Director
	Kathryn MacDermott	Acting Executive Director of Strategy
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Joe Pither	Graduate Trainee, Sexual Health Service *(present for agenda item 6)*

20/134	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. The Chair reported that members of the public and Governors had been invited to submit questions about the Trust Board papers in advance of the meeting. The Chair reported that the that the Trust had received one public question, but this was a general enquiry and did not relate to the matters under discussion at today's meeting. It was agreed that a response would be forwarded to the member of the public outside of the meeting. **Action: Chief Operating Officer/Company Secretary**

20/135	**Apologies** (agenda item 2)
	There were no apologies.
20/136	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
20/137	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
20/138	**Minutes of the previous meeting – 14 July 2020** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 14 July 2020 were approved as a correct record.
20/139	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The Chair requested that the action log be reviewed before the next meeting as there were a number of the actions which had been paused because of the COVID-19 pandemic which had been greyed out. **Action: Company Secretary** Naomi Coxwell, Chair of the Finance, Investment and Performance Committee said that there were a couple of actions which related to the Finance, Investment and Performance Committee meeting on 30 July 2020. Ms Coxwell said that she would report back on the Committee's discussion when she gave her verbal update about the meeting later on the agenda. **The Trust Board:** noted the action log.
20/140	**Patient Story – Sexual Health and the Move to the Digital Model (**agenda item 6.0)
	The Chair welcomed Joe Pither, Graduate Trainee, Sexual Health Service to the meeting. Joe Pither gave a presentation about the Sexual Health Service moving to a more digital model during the COVID-19 pandemic and highlighted the following points: • The Trust's Sexual Health Service was an integrated service providing care for Genito-Urinary Medicine (Sexually Transmitted Infections), Reproductive Healthcare (Contraception) and HIV; • Prior to the COVID-19 pandemic, the Sexual Health Service was planning to develop new digital ways of working.

	• During the COVID-19 pandemic, the Walk-In service was halted and replaced with telephone/virtual consultations or booked face to face appointments as appropriate; HIV prescriptions were extended to limit clinical attendances; young and vulnerable patients were immediately referred for teleconsultation regardless of other symptoms and welfare calls were undertaken for high risk patients; • Patients were triaged when booking their appointments via an algorithm built into the website; • For face to face appointments, self-check-in devices were mounted at Reception allowing patients to privately arrive themselves; • Patients arrived for their scheduled appointment time with minimal waiting required • Triaging meant that patients were seen by the appropriately skilled clinician based on their complexity as identified through the triage process Joe Pither reported that the service had reflected on what had worked well during the COVID-19 pandemic. This included the introduction of the triage system, communication with staff and the engagement with young and vulnerable patients. Joe Pither reported that in terms of what could have been better, it was disappointing that there was limited buy-in from staff for video consultations. The reduction in face to face clinics for non-urgent appointments had resulted in a significant waiting list for Long-Acting Reversible Contraception and deferred Genito-urinary treatments. Joe Pither reported that moving forward, the Service was exploring a range of permanent new ways of working, for example: • The potential to maintain an appointment only service. This was currently being discussed with the Commissioners; • More work was being undertaken to promote the use of virtual consultations where possible, particularly for HIV patients; • The launch of Self-Check-in to limit the interaction with Reception staff and improve confidentiality; • Relationships with the wider health system were being consolidated to provide the best support to vulnerable patients; • Maintain audit and safeguarding practices which were successful during the COVID-19 pandemic; • Increase flexibility for staff to work from home where appropriate; • Greater focus on health and wellbeing for staff; • Regular use of MS Teams and virtual meetings. Chris Fisher, Non-Executive Director commented that the presentation was excellent. Mr Fisher asked whether there were any particular reasons why some staff had been reluctant to embrace online consultations. Mr Pither said that one of the challenges was around seeing patients for the very first time and discussing very personal issues was difficult online and in addition, some staff lacked confidence in using the virtual consultations technology. David Buckle, Non-Executive Director said that as a former GP, he was very supportive of using technology but pointed out that some patients found using technology such as Self-Check-In challenging. Mr Pither pointed out that Reception staff would be available to help patients use the Self-Check-In devices and pointed out that all the changes to the service were the results of responding to patient feedback.

	Naomi Coxwell- Non-Executive Director observed that many of the changes had been planned pre-COVID-19 and the pandemic had accelerated those changes. Aileen Feeney, Non-Executive Director asked how the lessons learnt would be disseminated to other services. Mr Pither reported that there were monthly project meetings with the Divisional Director with clear processes in place for disseminating lessons learnt. The Chair said that whilst he welcomed the Trust using new technology to improve services and the patient experience, it was important to remember that not everyone was confident in using and/or had access to IT and that mitigations needed to be put in place to ensure that patients were not disadvantaged. The Chair thanked Joe Pither for his presentation.
20/141	**Patient Experience Report – Quarter 1** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • During the Quarter 1, the Trust had received 44 complaints. This was lower than any previous quarter of the last two years. 50% of the complaints were received in June; • Whilst a very small number could be attributed to the COVID pandemic, for example, dissatisfaction with discharge arrangements due to changed processes, most of the complaints were around communication and dissatisfaction with clinical care and were not related to COVID-19 or to the Trust's pandemic response; • Of the 35 complaints closed in the quarter, 71% were partially or fully upheld which was higher than in the previous quarters which was usually around 60% of the complaints; • During the quarter, the Trust had received 873 compliments which was significantly lower than in previous quarters, but this was not surprising given that many of the Trust's planned services were not seeing patients for routine care during the COVID-19 pandemic; • The national Friends and Family test reporting was suspended during the COVID-19 pandemic but NHS England had confirmed that reporting would formally start from 1 October 2020 and would be based on a new Friends and Family Test question around rating of care rather than a recommendation to others. Locally, the Trust had made the decision to start the new Friends and Family Test from 1 September 2020 in readiness for the NHS England launch Chris Fisher, Non-Executive Director asked whether there were any underlying reasons for the four complaints relating to Bluebell Ward. The Director of Nursing and Therapies reported that the ward had experienced some staffing changes and now had a new Ward Manager and was recruiting to other vacancies on the ward. The Chair noted that the ethnicity of complainants was unknown in around 25% of complaints.

	The Director of Nursing and Therapies reported that the Trust was working to improve the capture of ethnicity data for all complainants and that this would include ensuring that ethnicity was recorded on the electronic patient record system for all patients. Naomi Coxwell, Non-Executive Director asked about the joint Campaign by Healthwatch and the Care Quality Commission to encourage feedback (not just complaints) called "Because We Care". The Director of Nursing and Therapies reported that the national campaign had been paused because of the COVID-19 pandemic but reported that the Trust was working with local Healthwatch organisations on how the Trust could support the campaign locally. The Director of Nursing and Therapies pointed out that the Trust's work to develop the new patient experience tool would contribute to the campaign. Mehmuda Mian, Non-Executive Director referred to the section on Compliments and asked whether compliments were used as part of the formal appraisal process. The Director of Nursing and Therapies explained that all compliment received were fed back to the individual staff members and services and commented that the feedback may form part of individual's appraisals. Aileen Feeney, Non-Executive Director asked about the "Memory Boxes" which were referred to in the report. The Director of Nursing and Therapies explained that during the COVID-19 pandemic, in-patient wards had been largely closed to visitors, so relatives were given empty boxes for them to fill with personal items belonging to the patient such as photos, letters etc. which would be given to the patients. The Chair commented that he particularly found the comments in the compliment section of the report helpful because they helped to paint a picture about the care given to individual patients. **The Trust Board:** noted the paper.
20/142	**Quality Assurance Committee Meeting – 18 August 2020** (agenda item 6.2)
	a) Minutes of the Meeting held on 18 August 2020 The minutes of the Quality Assurance Committee meeting held on 18 august 2020 had been circulated. The quarterly Learning from Deaths and Guardians of Safety Working reports which were reviewed by the Committee had also been circulated. David Buckle, Chair of the Quality Assurance Committee reported that in addition to the Committee's standing items, the meeting had received a presentation on the Trust's Carer's Strategy, an update on the progress made to implement the national Care Quality Commissions' recommendations on Sexual Safety on Mental Health and Learning Disability wards and the plans for the Trust's Staff Flu Campaign. It was noted that in view of the COVID-19 pandemic, the Care Quality Commission had asked all NHS Provider organisations to complete an Infection Prevention and Control Board Assurance Framework which was then assessed by the Care Quality Commission. Dr Buckle reported that the Committee had received assurance from the Care Quality

	Commission that they were fully satisfied with the Trust's Infection, Prevention and Control systems and processes. Dr Buckle reported that the Committee had discussed the frequency of meetings and had agreed not to change the current pattern which was quarterly. It was noted that the Committee had the option to hold additional meetings if required. The Committee had also confirmed that they were happy with the format, length and volume of papers presented to the Committee. **b) Learning from Deaths Quarterly Report** The Learning from Deaths Quarterly Report which was discussed at the Quality Assurance Committee had been circulated with the Board papers for information. Dr Buckle reported that the Trust had robust systems and processes in place to ensure that any Learning from Deaths was identified and disseminated across the Trust. Mark Day, Non-Executive Director said that he would be interested in finding out more about the Trust's virtual training for clinicians in empathetic listening skills. **Action: Director of Nursing and Therapies** **c) Guardians of Safe Working Quarterly Report** The Guardians of Safe Working Quarterly Report discussed at the Quality Assurance Committee had been circulated with the Board papers. Dr Buckle reported that the Trust's Guardians of Safe Working Hours had provided assurance to that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation. The Chair thanked Dr Buckle for his update. **The Trust Board**: noted the: a) Minutes of the Quality Assurance Committee meeting held on 18 August 2020 b) Quarterly Learning from Deaths Paper c) Quarterly Guardians of Safe Working Paper
20/143	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following sections were considered further: **a) Staff Flu Campaign** The Chair noted that last year 70% of staff had received the flu vaccination and noted that the Department of Health and Social Care wanted 100% of clinical staff to be vaccinated and asked how confident the Trust was around increasing the uptake of the flu vaccination. The Director of Nursing and Therapies reported that the COVID-19 pandemic had raised awareness about the importance of being vaccinated against flu this winter and it was hoped that this would lead to a greater uptake in the vaccination.

	b) Staff Pulse Check Survey 2020 The Chief Executive reported that he was delighted with the results of the Staff Pulse Check Survey. The Trust had undertaken the Staff Pulse Check Survey since 2012. It was noted that the 2020 results were positive across all areas increasing between 4% to 21% on the previous scores. The Chief Executive that it was clear the Executive's All Staff Briefings which were introduced at the start of the COVID-19 pandemic had helped to make staff feel connected. The Chief Executive singled out the following results: • 80% of staff felt that the Trust had managed the COVID-19 situation well; • 82% of staff would recommend the Trust to friends and family as a place to work; • 88% of staff would recommend the Trust to friends and family if they needed care or treatment. On behalf of the Board, the Chair congratulated the Trust for achieving outstanding results in the Staff Pulse Check 2020. **The Trust Board**: noted the paper.
20/144	**Month 04 2020-21 Finance Report** (agenda item 8.0)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • The Trust continued to operate under the interim COVID-19 finance regime with central funding being accrued to cover COVID-19 response costs, ensuring the Trust was able to report breakeven year to date; • The interim COVID-19 regime was expected to be in place for September 2020. The Trust was waiting to hear about the replacement regime which would include system allocations for COVID-19 expenditure; • NHS England/Improvement had asked NHS Provider organisations to contribute to system financial forecasts for the remainder of the financial year. Chris Fisher, Non-Executive Director referred to the balance sheet and asked whether the increase in debtors related to delays in receiving monies from NHS Property Services. The Deputy Chief Executive and Chief Financial Officer said that the increase in debtors was a timing issue and did not pose a risk. The Deputy Chief Executive and Chief Financial Officer reported that the Trust's underlying financial cost base was better than expected pre-COVID-19 and reflected savings from remote working etc. It was noted that moving forward there was uncertainty about how the two systems would allocate funding and any determine any efficiency targets. Aileen Feeney, Non-Executive Director asked whether the high increase in the cost of the Trust's 4G data charges had been resolved. The Deputy Chief Executive and Chief Financial Officer confirmed that the Trust had increased the data cap to reflect the increase usage of 4G with more staff working at home.

	Naomi Coxwell, Non-Executive Director asked whether there would be tensions at the national level between an expectation around cost reductions during the COVID-19 pandemic becoming permanent and the possibility of a COVID-19 second wave. The Deputy Chief Executive and Chief Financial Officer reported that the Centre was likely to make an efficiency assumption which would be challenging for the system particularly in respect of the acute hospitals. The Chair referred to capital expenditure and pointed out that spending on IM&T was well behind plan. The Deputy Chief Executive and Chief Financial Officer said that this was a timing issue and confirmed that he was confident that this would be spent at year end. **The Trust Board noted:** the following summary of the financial performance and results for Month 04 2020-21: The Trust continued to operate under the interim COVID-19 finance regime with central funding being accrued to cover the COVID-19 response costs. This was to ensure that the Trust was able to report a breakeven position year to date. The report reflected financial performance against both an NHS Improvement calculated plan as well as the Trust's own internal forecast. Year to date cash was £47.2m versus the financial plan of £46.5m Year to date capital expenditure was £0.6m versus the financial plan of £1.0m.
20/145	**Month 04 2020-21 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 04 "Trust North" Performance Scorecard had been circulated. Chris Fisher, Non-Executive Director asked for more information about the Trust's clustering performance. The Chief Executive explained that there clustering was complex and pointed out that for people with eating disorders it was much easier to allocate them to the correct "cluster" than those patients who were referred via the Accident and Emergency Service to the Common Point of Entry Service. The Chief Operating Officer explained that the original clustering target was 95% but this had been reduced to 80% because the Trust had not achieved 95% target and moving the indicator from a tracker to a driver metric gave the Trust greater visibility. It was noted that once the clustering performance above 80% had been sustained, the indicator would revert to a tracker metric in line with the Trust's business rules. **The Trust Board:** noted the report.
20/146	**Finance, Investment and Performance Committee Meeting – 22 July 2020** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee referred to the Trust Board action log for the meeting and reported that on behalf of the Trust Board,

	the Committee had reviewed the increase in the number of management and administrative posts since April 2018. Ms Coxwell provided assurance to the Trust Board that the increase related to planned service growth and to those staff who were undertaking work related to the Trust's Global Digital Exemplar work. Ms Coxwell pointed out that it was important that clinical staff were supported by administrative staff to ensure that as much of their time as possible related to patient facing activities. It was noted that the Finance, Investment and Performance Committee would keep the number of management and administrative posts under review. Ms Coxwell also reported that the Finance, Investment and Performance Committee had received a report on the number of staff disciplinaries and grievances. It was noted that the report had also set out proposals aimed by reducing the time senior staff spend on investigating disciplinaries and staff grievances. The Chair thanked Ms Coxwell for her update and asked for more information about the proposals to reduce the time spent on investigations. The Deputy Chief Executive and Chief Financial Officer explained that the Trust was working with system colleagues to develop a pool of staff who would be able to investigate disciplinaries and grievances which would reduce the burden on system managers and be more cost effective.
20/147	**Workplace Disability Equality Standard Report** (agenda item 9.0)
	The Acting Executive Director of Strategy presented the paper and thanked Thanda Mhlanga (Organisational Development Lead for Equality and Diversity) and Joe Smart, Head of Training and Development for drafting the report. The Acting Executive Director of Strategy presented the paper and highlighted that the Trust had continued to make progress against the previous year's scores and paid tribute to the work of the Trust's "Purple" Network for disabled staff. The Acting Director of Strategy highlighted the key areas for improvement: • Reducing the amount of work-related stress that was reported • Improving experience of staff with a disability to make suggestions to improve the work of their teams • Improving the rates of declaration of disability by our staff • Implementation of the new (July 2020) Reasonable Adjustment Policy. It was noted that the Trust's performance compared favourably with other Trusts in the benchmark group. The Acting Executive Director of Strategy reported that an action plan would be developed and overseen by the Diversity Steering Group. The Director of Nursing and Therapies pointed out that section 6 of the report (relative likelihood of entering for formal capability process) was confusing because in one section it referred to 0.02 (5 out of 213) of disabled staff entering the formal capability process but later in the same section, it referred to the relative likelihood of a disabled member of staff entering the formal capability in comparison to a non-disabled member of staff being 9.61.

	The Acting Executive Director of Strategy said that this was helpful feedback and pointed out that the report referred to two different data sources: The Trust's Electronic Staff Record system and the results of the National NHS Staff Survey. The Acting Executive Director of Strategy agreed to make this clearer in the published report. **Action: Acting Executive Director of Strategy** Mark Day, Non-Executive Director said that it would have been useful if the report had included more narrative about the actions needed to reduce the incidence of bullying and harassment and workplace stress experienced by disabled staff and suggested a strong focus on these two areas in the action plan. The Acting Executive Director of Strategy thanked Mr Day for his feedback and said that the report would be amended to include more narrative in these two important areas. **Action: Acting Executive Director of Strategy** The Chief Executive said that what was missing from the report was a sense of how well the Trust was doing and pointed out that the Trust wanted to amongst the top performers and asked about the size of the benchmark group. The Acting Executive Director confirmed that it was a small benchmark group which was why the report also included data from the National NHS Staff Survey results. Mehmuda Mian, Non-Executive Director noted the comment in the report that disabled staff were more likely to feel pressure to come into work if they were unwell. Ms Mian asked whether this pressure came from the staff themselves or whether managers put disabled staff under pressure to come to work. The Acting Executive Director of Strategy reported that the Purple Staff Network for disable staff was helping the Trust to gain a better understanding of the lived experience of disabled staff. The Trust Board: **a)** noted the paper **b)** Agreed that the report should be amended to make it clearer about the two data sources and to include more narrative about reducing the incidence of bullying and harassment and work-related stress **c)** Approved the publication of the Workforce Disability Employment Standard results and the development of an action plan
20/148	**Workplace Race Equality Standard Report** (agenda item 9.1)
	The Acting Executive Director of Strategy presented the paper and thanked Thanda Mhlanga (Organisational Development Lead for Equality and Diversity) and Joe Smart, Head of Training and Development for drafting the report. The Acting Executive Director of Strategy highlighted that the Trust's performance was above average in most key indicators and that gradual progress was being made in closing the gap between white and black and minority ethnic (BME) staff's lived experience, but more work was required. The Acting Executive Director of Strategy said that there was an under representation of BME staff throughout middle and senior management bands (Agenda for Change 8a-Very

	Senior Manager pay scales). It was noted that there was further work to be done to reduce the percentage of BME staff experiencing bullying and harassment and the likelihood of BME staff entering the formal disciplinary process compared to white staff. The Acting Executive Director of Strategy reported that the Trust was in the process of developing an action plan to address the areas where further actions were required. The action plan would be approved and overseen by the Diversity Steering Group. Chris Fisher, Non-Executive Director referred to appendix 2 of the report and commented that the Trust had made progress in getting better BME representation in senior clinical roles but there was less progress in getting better BME representation in senior non-clinical roles. The Acting Executive Director of Strategy pointed out the overall number of senior roles was relatively low. The Chief Operating Officer reminded the meeting that the Trust had focused its work on getting better BME representation in posts agenda for change bands 7-8A on the basis that it was this cohort of staff who were likely to be the senior managers of the future rather than focusing on external recruitment in to senior positions. Mr Fisher said that he welcomed the Trust's approach to "growing your own" staff so they would be eligible to apply for senior positions. The Chief Executive said that he found it very frustrating that the Workforce Race Equality Standard reporting process only included staff on agenda for change and very senior manager contracts and excluded doctors. The Chief Executive pointed out that two of the Trust's Clinical Directors from a BME background were doctors and were therefore excluded from the data. Naomi Coxwell, Non-Executive Director asked whether there was any external expertise which the Trust could tap into to help reduce the gap between BME and white staff's lived experience. The Chief Executive said that the Trust had greatly benefitted from the support from Stonewall in terms of sexual orientation but unfortunately there were no similar organisations for race or disability. The Chair said that it was important that the Trust developed a standard process to check against to ensure that all staff with protected characteristics were not treated less fairly than other staff. **Action: Acting Executive Director of Strategy** The Trust Board: **d)** noted the paper. **e)** Approved the publication of the Workforce Race Equality Standard results and the development of an action plan
20/149	**COVID-19 Pandemic Recovery Plan Update Report** (agenda item 9.2)
	The Acting Executive Director of Strategy presented the paper and highlighted the following points:

	• Community Health services were now fully operational with a 'blended' model of appointments for many services; • Mental Health services were currently being considered by the Service Recovery Prioritisation Group; • Most staff that had been re-deployed at the start of the COVID-19 pandemic had now been returned to their substantive posts. A review of the re-deployment process had been completed. The learning from the review would inform any future re-deployment needs **The Trust Board**: noted the report.
20/150	**Strategy Implementation Plan Report** (agenda item 9.3)
	The Acting Executive Director of Strategy presented the paper and reported that whilst the impact of the COVID-19 pandemic on the progression of the Trust's key programmes and projects was in the short term, profound, it had been possible to maintain, or more recently resume impetus within many initiatives. All the Trust's Mission Critical schemes were now being actively progressed or were re-mobilising. The Acting Executive Director of Strategy reported that several initiatives had now been concluded or were moving to business as usual. Chris Fisher, Non-Executive Director asked for an update on the Emotionally Unstable Disorder Pathway (EUPD) project. The Medical Director reported that the EUPD project was slightly behind schedule due to the COVID-19 pandemic and key staff leaving the Trust. The Medical Director confirmed that elements of the pathway had already been delivered and recruitment for the vacant posts had resumed. Mr Fisher reminded the meeting that one of the objectives of the EUPD pathway was around supporting Emotionally Unstable Personality Disorder patients in the Community rather than in inpatient settings which in turn would reduce the number of inappropriate out of area placements. Mr Fisher expressed disappointment that the Frimley Health and Care Integrated Care System had paused the redevelopment of East Berkshire Community Hospitals. **The Trust Board**: noted the report.
20/151	**Audit Committee Meeting – 22 July 2020** (agenda item 10.0)
	Chris Fisher, Non-Executive Director reported that the Audit Committee meeting held on 22 July 2020 had received an excellent presentation on how the Trust was using the Apprenticeship Levy. The Chair reported that he had had a very useful follow up meeting with the Interim Director of People to find out more about the Trust's workforce planning work. Mr Fisher reported that the virtual Audit Committee had worked very well. Mr Fisher said that the Committee's lunchtime personal development sessions had been postponed until the COVID-19 social distancing restrictions had been lifted.

	The Trust Board: noted the minutes of the Audit Committee meeting held on 22 July 2020.
20/152	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that Paul Myerscough was the only nomination received for the role of Lead Governor and Susana Carvalho was the only nomination received for the role of Deputy Lead Governor. The appointments for Lead and Deputy Lead Governor would be made at the next Council of Governors meeting on 23 September 2020. The Chair also reminded the Board that the Trust's virtual Annual General Meeting would also be held on 23 September 2020.
20/153	**Trust Board Schedule of Meetings 2021** (agenda item 10.2)
	The Schedule of meetings for 2021 had been circulated. The Board: noted the paper.
20/154	**Any Other Business** (agenda item 11)
	There was no other business.
20/155	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 10 November 2020.
20/156	**CONFIDENTIAL ISSUES:** (agenda item 13)
	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 8 September 2020.

Signed……. Date 10 November 2020
(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 10/11/20

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
10.12.19	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.	February 2021	**AG**	The Executive Team will review the True North and Vision Metrics prior to Christmas with view to agreeing the position with the Board in the new year, alongside the launch of the new strategy.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
11.02.20	20/014	Strategy Implementation Plan 2019-20	A post project review of the Trust's new Intranet to be undertaken in order to learn any lessons for future initiatives.	December 2020	**KM**	Nexus has now been successfully launched and an options paper for evaluating the project will be considered at the next programme board.	
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.	November 2020	**JH**	In consultation with the Chair and Lead Governor this training session will not now take place. New governors are encouraged to attend the NHS Providers Governor Core Skills training.	
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**	The Equalities, Diversity and Inclusion Strategy is on the agenda for the meeting.	
12.05.20	20/067	Patient Experience	The Director of Nursing and Therapies to consider including	Paused due to	**DF**	15 Step Visits are currently paused	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		Report	more detail of the 15 Step Visit Reports as part of the Patient Experience Report.	Covid-19		because of COVID-19. The action will be completed when 15 Step Visits resume.	
14.07.20	20/112	COVID_19 Pandemic Recovery Plan Update Report	The Governors to be kept informed about services coming back online.	September 2020	**KM**	An update was provided at the September 2020 meeting of the Council of Governors	
08.09.20	20/134	Public Question	The Trust to respond to a public question relating to a general inquiry about mental health services for refugees/asylum services.	October 2020	**DT/JH**	A response was forwarded to the member of the public.	
08.09.20	20/139	Action Log	The Company Secretary to review the action log as there were a number of actions which had paused because of COVID-19	November 2020	**JH**	The action log has been reviewed and updated.	
08.09.20	20/142	Learning from Deaths Report	The Director of Nursing and Therapies to arrange for Mark Day, Non-Executive Director to meet with the relevant person to find out more about the Trust's clinical training in empathic listening skills.	November 2020	**DF**	The Deputy Director of Nursing has contracted Mark Day to arrange a meeting.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
08.09.20	20/147	Workplace Disability Equality Standard Report	The report to make it clearer that the information on the likelihood of disabled staff entering the formal capability process in comparison to non-disabled staff related to two different data sets – the NHS Staff Survey and information on the Trust's Electronic Staff record system.	October 2020	**KM**	The Trust Board received an update at the Discursive meeting in October meeting 2020. The work is also referenced in the Draft Equalities, Diversity and Inclusion Strategy on the November 2020 In Committee agenda.	
08.09.20	20/147	Workplace Disability Equality Standard Report	The report to include more narrative about the actions the Trust was taking to reduce workplace stress and the incidence of bullying and harassment.	October 2020	**KM**	See above	
08.08.20	20/148	Workplace Race Equality Standard Report	The Trust to develop a standard process to check against to ensure that all staff with protected characteristics were not treated less fairly than other staff.	October 2020	**KM**	Included in the draft Equalities, Diversity and Inclusion Strategy on the November 2020 In Committee agenda.	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date	10th November 2020
Title	Patient Experience Report Quarter 2 (July-September 2020)
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 2
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience
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
Resource Impacts	N/A
Legal Implications	N/A
Equalities and Diversity Implications	N/A
SUMMARY	Toward the end of March 2020, to enable providers to focus on responding to the COVID-19 pandemic, there was national direction issued that 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 were to remain open until further notice, unless an informal resolution could be achieved, or the complainant chose to withdraw their complaint. Whilst we continued to respond to as many formal complaints as possible there were a few that were paused. During Quarter 2 all paused complaints were investigated and closed and usual timescales for investigation and response resumed. During March 2020, the Parliamentary and Health Service Ombudsman had stopped accepting new NHS complaints or working on open cases; PHSO activity resumed on 1 July 2020. Collation and submission of Friends and Family Test which has been suspended has also now recommenced during September using new questions. National data submission recommences on 1st December 2020.

	During the quarter there was an increase in complaint activity compared with quarter one - however when looking at Quarter 1 & 2 together the complaint activity is comparable with same period for 2019-20. Usual methods of patient experience collation have not all taken place during the quarter however many services are collating feedback via alternative methods, with examples included within the report. For example, the patient experience team has worked with wards in both physical and mental health services, to telephone patients who have given consent to be telephoned after their discharge and community mental health services have also used electronic means to gather experience data. This year we have chosen to participate in the Mental Health Inpatient survey; this is a voluntary survey that is due to be launched in coming weeks and is for all adults who had a mental health inpatient stay of at least 48 hours in the period 1st January – 30th June 2020 inclusive; it provides us with a further opportunity to understand patient experience, particularly during the COVID pandemic response. Highlights of the report • 62 complaints were received • There were no areas that saw a significant increase in complaints compared to last year. • The services with the highest number formal complaints during the quarter were inpatient wards (both Physical and Mental Health) and CMHT. Whilst a very small number could be attributed to the COVID pandemic most of the complaints were around communication and dissatisfaction with clinical care not related to COVID or the pandemic response. • 2 of the 3 formal CAMHS complaints received during the quarter related to service wait times and 2 MP complaints were also received related to wait times for CAMHS during the quarter. The service continues to explore alternative ways to reduce wait lists for ASD/ ADHD pathways. • Bluebell ward received 2 complaints both related to staff attitude • The response rate for complaints within agreed timescale was 99% • Of the 67 complaints were closed in the quarter 60% were partially or fully upheld which is back in line with previous quarters following an increase to 71% in Q1 where much fewer complaints were received/ closed. • Compliments at 975 were increased on Q1 but remain significantly lower than previous quarters, however given many of our planned services have been in a phase of

	restoration for routine care this is perhaps not surprising. • For 34% of our complaints the ethnicity of the complainant is unknown and therefore it is not possible to draw any comparisons with local population demographics; work is required to improve the capture of ethnicity data for all complainants, the gender split was approximately 60:40 (female: male) this quarter, this remains slightly different from last year where almost 75% of complainants were women. • There are 4 open ombudsman complaints at present, for 2 of these investigations are underway and for the remaining 2 further information has been requested by PHSO in order to decide on progressing to investigation. • After a decrease in MP enquires to 5 in Q1 and increase back to 8 was seen in Q2 this is more in line with usual quarterly enquires received. These all related to Mental Health services (CAMHS, CMHT, CPE, Talking Therapies and Health Visiting) There were no themes or trends of note in the quarter 2 patient experience data The 2nd stage for development of a new patient experience measure is currently out to tender.
ACTION REQUIRED	The Board is asked to: Note the report.

Berkshire Healthcare
NHS Foundation Trust

Quarter Two – Patient Experience Report (July to September 2020)

Main Report

1. Introduction

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

From mid-March 2020, to align with national guidance and directives, the active collection of the FFT was suspended; National data collation for FFT is recommencing in December, ahead of this local collation has recommenced during September.

The national pause placed on complaint handling and Parliamentary and Health Service Ombudsman (PHSO) in March, was lifted at the end of June.

Whilst the Complaints Office had triaged and dealt with as many incoming complaints as possible during wave 1 of the COVID pandemic, as at 30 June 2020 there were 12 formal complaints on pause by the Trust. All 12 of the paused complaints were completed during Quarter two

2. Complaints received

2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2019-20 and 2020-21 by service, enabling a comparison. During Quarter two 2020-21 there were 62 complaints received (including re-opened complaints), This is an increase compared to 2019-20 where there were 54 for the same period. However, when comparing the total number of complaints received in Q1 and Q2 2019-20 (104) with the number received in Q1 and Q2 2020-20 (106) the totals are comparable.

There were 122,348 reported contacts and discharges from our inpatient wards, giving a complaint rate of 0.05%.

Table 1: Formal complaints received

	2019-20						2020-21				
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Change to Q1**	**Q2**	**Total for year**	**% of Total**
CMHT/Care Pathways	8	10	6	13	**37**	**16.02**	4	↑	11	**15**	**14.15**
CAMHS - Child and Adolescent Mental Health Services	10	8	8	4	**30**	**12.99**	2	↑	3	**5**	**4.72**

	2019-20						2020-21				
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Change to Q1**	**Q2**	**Total for year**	**% of Total**
Crisis Resolution & Home Treatment Team (CRHTT)	2	2	4	6	**14**	**6.06**	4	↓	2	**6**	**5.66**
Acute Inpatient Admissions – Prospect Park Hospital	5	3	7	6	**21**	**9.09**	7	↓	4	**11**	**10.38**
Community Nursing	4	3	6	2	**15**	**6.49**	2	↓	1	**3**	**2.83**
Community Hospital Inpatient	6	1	5	3	**15**	**6.49**	5	↑	6	**11**	**10.38**
Common Point of Entry	2	6	2	2	**12**	**5.19**	1	-	1	**2**	**1.89**
Out of Hours GP Services	0	1	7	1	**9**	**3.90**	4	↓	0	**4**	**3.77**
PICU - Psychiatric Intensive Care Unit	0	0	1	0	**1**	**0.43**	2	↓	0	**2**	**1.89**
Urgent Treatment Centre	1	1	1	0	**3**	**1.30**	1	↓	0	**1**	**0.94**
Older Adults Community Mental Health Team	1	0	0	0	**1**	**0.43**	1	-	1	**2**	**1.89**
14 other services in Q2	11	19	21	22	**73**	**31.60**	11	↑	33	**44**	**41.51**
Grand Total	**50**	**54**	**68**	**59**	**231**		**44**	↑	**62**	**106**	

Eight of the 33 (other complaints, not specified) were about Health Visiting and corporate services and were from the same person. The remaining 25 are from across a range of Trust services.

Complaints are reported against the geographical locality where the care was received which is the most meaningful way of recording. The following tables show a breakdown of the formal complaints that have been received during Quarter two and where the service is based. Complaints relating to end of life care are considered as part of the Trust mortality review processes.

Appendix one contains a listing of the formal complaints received during Quarter two.

2.2 Adult mental health service complaints received in Quarter two

29 of the 62 (47%) complaints received during Quarter two were related to adult mental health service provision.

Table 2: Adult mental health service complaints

	Geographical Locality						
Service	Bracknell	**Isle of Wight**	Reading	Slough	West Berks	Wokingham	Grand Total
A Place of Safety			2				2
Adult Acute Admissions - Bluebell Ward			2				2
Adult Acute Admissions - Daisy Ward			2				2
CMHT/Care Pathways	1		1	5	2	2	11
CMHTOA/COAMHS - Older Adults Community Mental Health Team					1		1
Common Point of Entry				1			1
Complex Treatment for Veterans/TILS			4				4
Criminal Justice Liaison and Diversion Service		1					1
Crisis Resolution and Home Treatment Team (CRHTT)				1	1		2
Talking Therapies	1		1		1		3
Grand Total	2		16	2	1	2	29

2.2.1 Number and type of complaints made about a CMHT

11 of the 62 complaints (17%) received during Quarter two related to the CMHT service provision. In Quarter one, there were 4 complaints. There were 13,607 reported attendances for CMHT and the ASSiST service during Quarter one giving a complaint rate of 0.08% compared to 0.02% in Quarter one and 0.10% in Quarter four.

Table 3: CMHT complaints

	Geographic Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Access to Services					1	1
Attitude of Staff				1		1
Care and Treatment			3	1	1	5
Communication	1					1
Confidentiality		1				1
Medication			2			2
Grand Total	1	1	5	2	2	11

There were no complaints received about the CMHT based in Windsor and Maidenhead.

There were no specific trends about complaints for the other localities including Slough CMHT.

2.2.2 Number and type of complaints made about CPE

There was one complaint received about CPE, where the patient felt they were not receiving the care and treatment they needed.

There were 1,977 contacts with CPE during Quarter one, giving a complaint rate of 0.05%, which is the same as Quarter one, and was 0.09% in Quarter four.

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

During Quarter two, 4 of the 62 complaints (6%) related to Adult Acute mental health inpatient wards (2 for Bluebell ward and 2 for Daisy Ward). This is a reduction to numbers received in Quarter one and Quarter four (2019-20). In addition, there were no formal complaints about Snowdrop ward, Rose Ward or PICU (Sorrel Ward).

There were 263 reported discharges from mental health inpatient wards during Quarter one giving a complaint rate 1.52% compared to 2.81% in Quarter one and 2.21% in Quarter four.

Table 4: Mental Health Inpatient Complaints

	Ward					
Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	PICU - Sorrel Ward	Grand Total
Attitude of Staff	2					2
Care and Treatment		1				1
Communication		1				1
Grand Total	2	2				4

All the complaints received about Bluebell Ward were about attitude of staff, and this was the same for complaints about Bluebell Ward received in Quarter one. This was not a theme across any of the other wards.

The Clinical Director is aware of the complaint activity on Bluebell Ward and is working with the ward leadership team about addressing these issues.

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

In Quarter two, 2 of the 62 complaints (3%) were attributed to CRHTT, a decrease from 4 in Quarter one.

There were 15,924 reported contacts for CRHTT during Quarter one giving a complaint rate of 0.01%, compared to 0.02% in Quarter one and 0.04% in Quarter four.

Table 5: CRHTT complaints

Main subject of complaint	Number of Formal Complaints
Attitude of Staff	1
Confidentiality	1

The complaint about attitude of staff was around staff not adhering to a culture-based request (removing shoes in their home).

2.3 Community Health Service Complaints received in Quarter two

During Quarter two 11 of the 62 complaints (18%) related to community health service provision.

Table 6: Community Health service complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Henry Tudor Ward					1		1
Jubilee Ward			2				2
Oakwood Ward		1					1
Windsor Ward						1	1
Donnington Ward				1			1
District Nursing (Community Nursing)	1						1
Podiatry		2					2
Continence				1			1
Rapid Response				1			1
Grand Total	1	3	2	3	1	1	11

Jubilee Ward and Podiatry received the most complaints, with two each, Henry Tudor, Oakwood, Windsor and Donnington wards all received one each.

2.3.1 Community Health Inpatient Ward Complaints

During Quarter two, 6 of the 62 complaints (9%) received related to inpatient wards. There were 544 reported discharges from community health inpatient wards during Quarter two giving a complaint rate of 1.10%, compared to 0.81% in Quarter one and 0.52% in Quarter four.

Table 7: Community Health Inpatient complaints

	Ward					
Main subject of complaint	Donnington	Henry Tudor Ward	Jubilee Ward	Oakwood Ward	Windsor Ward	Grand Total
Care and Treatment		1	1			2
Communication	1			1	1	3
Attitude of staff			1			1
Grand Total	1	1	2	1	1	6

There are seven community health inpatient wards and the top theme for Quarter two was communication (3 complaints) and this was across three wards. The Clinical Directors have been made aware of the communication issues to action going forward.

2.3.2 Community Nursing Service Complaints

In Quarter two, 1 of the 62 complaints (1.5%) were related to care and treatment within community nursing services. The complaint was for the team based in Bracknell.

There were 73,487 reported attendances for the Community Nursing Service during Quarter two giving a complaint rate of 0.001%, compared to 0.004% in quarter one and 0.005% in Quarter four. This continues to be a very small complaint rate well below the Trust overall rate of complaints per contact.

Table 8: Community Nursing Service complaints

	Service and Geographical Locality	
	District Nursing	
Main subject of complaint	Bracknell	Grand Total
Attitude of staff	1	1
Grand Total	1	1

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

There were 15,434 reported attendances for WestCall in Quarter two and no complaints were received.

2.4 Children, Young People and Family service Complaints

2.4.1 Physical Health services for children complaints

During Quarter two, 13 of the 62 complaints (21%) were about children's physical health services. Eight of these were from the same person and were primarily around communication. Of the 5 remaining complaints there were no specific themes.

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

	Geographical Locality			
Service	Bracknell	Reading	West Berks	Grand Total
Children's Speech and Language Therapy - CYPIT		2		2
Health Visiting	1	2	8 (same complainant)	11
Grand Total	**1**	**4**	**8**	**13**

2.4.2 CAMHS complaints

During Quarter two, 5 of the 62 complaints (8%) were about CAMHS services (including CPE and Willow House). Two of the complaints were about CAMHS Autism Assessment Team (AAT), one was about CAMHS and two were about Willow House (inpatient ward). There were 8,268 reported attendances for CAMHS during Quarter two giving a complaint rate of 0.06%, compared to 0.04% for quarter one and 0.05% in Quarter four.

Table 10: CAMHS Complaints

	Main subject of complaint				
Service/Geographical Locality	Access to services	Care and Treatment	Communication	Admission	Grand Total
Adolescent Mental Health Inpatients - Willow House		1		1	2
CAMHS – AAT –West Berks	1		1		2
CAMHS		1			1
Grand Total	1	2	1	1	5

Care and Treatment related to individual circumstance was the most common reason for the complaints. There was one complaint about delay in accessing the service, one regarding admission and one regarding communication.

There was no commonality between the two complaints about Willow House.

2.5 Learning Disabilities

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

3. KO41A return

Each quarter the complaints office submits a quarterly return, called the KO41A.

This looks at the number of new formal complaints that have been received by profession, category, age and outcome. The information is published a quarter behind.

The collection and reporting of this data was paused by NHS Digital due to Covid-19 and whilst the pause has been lifted, the figures for quarter two have not yet been submitted. The window for submission has not opened as at the end of this quarter.

4. Complaints closed

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). During Quarter two there were 67 complaints closed compared to 35 in Quarter one, 56 in Quarter four and 61 in Quarter three.

4.1 Outcome of closed formal complaints

Table 11: Outcome of formal complaints closed

	2019-20						2020-21			
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 19/20**	**Q1**	**Comparison to Q1**	**Q2**	**% of 20/21**
Case not pursued by complainant	0	0	0	0	0	0	1	-	1	1.96
Consent not granted	1	0	0	0	1	0.45	0	-	0	0.00
Local Resolution	1	1	0	0	2	1.92	0	-	0	0.00
Managed through SI process	0	0	0	0	0	0	0	↑	1	0.00

	2019-20						2020-21			
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 19/20**	**Q1**	**Comparison to Q1**	**Q2**	**% of 20/21**
Referred to another organisation	1	0	0	0	1	0.45	0	-	0	0.00
Not Upheld	16	20	23	24	83	37.56	9	↑	25	33.51
Partially Upheld	17	22	28	23	90	40.72	13	↑	34	46.33
Upheld	11	13	10	9	43	19.46	12	↓	6	17.88
Disciplinary Action required	0	1	0	0	1	0.45	0	-	0	0.00
Grand Total	**47**	**57**	**61**	**56**	**221**		**35**		**67**	

The 40 complaints closed and either partly or fully upheld in the quarter were spread across several differing services. 19 of these related to care and treatment (no themes identified) whilst 6 related to attitude of staff.

Table 12: Complaints upheld and partially upheld relating to attitude of staff and care and treatment

	Main subject of complaint		
Service	**Care and Treatment**	**Attitude of Staff**	**Grand Total**
Adolescent Mental Health Inpatients - Willow House	2		2
Adult Acute Admissions - Bluebell Ward		2	2
Adult Acute Admissions - Daisy Ward	2		2
Adult Acute Admissions - Rose Ward	1		1
CAMHS - Child and Adolescent Mental Health Services	1		1
Children's Speech and Language Therapy - CYPIT	1		1
CMHT/Care Pathways	1		1
Community Hospital Inpatient Service - Jubilee Ward	2	1	3
Community Hospital Inpatient Service - Oakwood Ward	1		1
Crisis Resolution and Home Treatment Team (CRHTT)		2	2
District Nursing	1		1
Health Visiting		1	1
Older Peoples Mental Health (Ward Based) - DO NOT USE	1		1
Out of Hours GP Services	1		1
Patient Experience	2		2
Rapid Response	1		1
Talking Therapies - Admin/Ops Team	1		1
Urgent Treatment Centre	1		1
Grand Total	**19**	**6**	**25**

4.2 **Response Rate**

The table below shows the response rate within a negotiated timescale, as a percentage total.

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

Table 13 – Response rate within timescale negotiated with complainant

2020-21		2019-20				2018-19				2017-18				2016-17			
Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
99%	100%	100%	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

5. **Characteristic data**

5.1 Ethnicity

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

The tables below show the characteristics of patients who have had complaints raised about their care between July and September 2020. This does not include where a different organisation was leading the investigation, or re-opened complaints.

Table 14: Ethnicity

Ethnicity	Number of patients	%	Census data %
Black African	0	0.00	1%
Black Caribbean & Other	2	4.26	
Not stated/Other	16	34.04	-
Other Asian	2	4.26	15.10%
Other Mixed	2	4.26	-
White British	16	34.04	80%
White Other	9	19.15	-
Grand Total	47	100.00	

As a way of improving ethnicity recording information is sent back to services where this is not documented on RiO.

5.2 Gender

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

Table 15: Gender

Gender	Number of patients	%	Census data %
Female	29	61.70	50.90%
Male	18	38.30	49.10%
Grand Total	47		

5.3 Age

Table 16: Age

Age Group	Number of patients	%	Census data %
Under 12 years old	15	31.91	31.60%
12 - 17 years old	4	8.51	
18 - 24 years old	2	4.26	14.90%
25 - 34 years old	4	8.51	
35 - 44 years old	3	6.38	15.40%
45 - 54 years old	6	12.77	19.30%
55 - 64 years old	2	4.26	
65 - 74 years old	3	6.38	
75 years old or older	8	17.02	18.70%
Not known	0	0.00	-
Grand Total	47		

In Quarter two there was a higher number of complaints about children under 12 years old than there were in Quarter one (n4). However, eight of the 12 were about the same child.

6. Parliamentary and Health Service Ombudsman

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

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

In response to the Covid-19 pandemic from mid-March 2020, the PHSO suspended the investigation of existing investigations and accepting new cases. This restarted at the end of June 2020. This means that during Quarter one there were no new complaints taken to the PHSO. There was one new request for information received in Quarter two.

Table 17: PHSO activity

Month open	Service	Month closed	Current Stage
Dec-18	Psychological Medicines Service	Open	Investigation Underway
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
Sept 20	CPE	Open	PHSO have requested information to aid their decision on whether they will investigate

The PHSO has published the draft Complaints Standard Framework: Summary of core expectations for NHS organisations and staff. The final framework is due to be published in Spring 2021, the Complaints Team will reassess the service to ensure that it aligns with the draft standards and provide an update in Quarter three.

7. Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they are involved in but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There were six received that were led by another organisation during Quarter two, three led by Frimley Health (about MSK Physio, admission to Henry Tudor ward and concerns that the Psychological Medicines service did not visit the patient), one by NHSE (about CPE), one by SCAS (about delays on a call back from WestCall) and one by East Berkshire CCG (about a young person transitioning to adult mental health services).

8. MP enquiries, locally resolved complaints and PALS

8.1 MP enquiries

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

Table 18: MP Enquiries

	Main theme of enquiry				
Service	Access to Services	Care and Treatment	Discharge Arrangements	Waiting Times for Treatment	Grand Total
CAMHS - ADHD				1	1
CAMHS - Child and Adolescent Mental Health Services				1	1
CMHT/Care Pathways		1	1		2
Common Point of Entry	1				1
Health Visiting	1			1	2
Talking Therapies - Admin/Ops Team		1			1
Grand Total	2	2	1	3	8

There were 8 MP enquiries raised in Quarter two, and increase from 5 in Quarter one, a decrease from 10 in Quarter four and 5 in Quarter three.

8.2 Local resolution complaints

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

Table 19: Concerns managed by services – Local Resolution complaints

Service	Number of concerns resolved locally
Community Nursing	10
Podiatry	4
CMHT/Care Pathways	3
Criminal Justice Liaison and Diversion Service - (CJLD)	2
LD Intensive Support Team	1
Physiotherapy Musculoskeletal	1
Out of Hours GP Services	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Community Hospital Inpatient Service - Oakwood Ward	1
Veterans TILS Service	1
CAMHS - AAT	1
Health Visiting	1
Grand Total	27

The ten concerns resolved locally by Community Nursing Teams were spread across geographical localities (Bracknell 2, Reading 3, West Berkshire 3, WAM 1 and Wokingham 1).

There were no particular themes.

8.3 Informal complaints received

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

There have been four informal complaints received during Quarter two, which cover various aspects of care and communication with Talking Therapies, the Urgent Treatment Centre, CRHTT and CAMHS - Child and Adolescent Mental Health Services (ADHD).

8.4 NHS Choices

There were two postings during Quarter two. PALS responded to both of these with contact information and the offer of a further conversation about their experience. It was also sent on to the services for their attention.

Physiotherapy at Wokingham Hospital:

"I am very disappointed with the service I have received. I Understand things have been difficult but my physio stopped which was understandable but now have been without any physio for 6 months. I cannot understand why it should take so long to be up and running again"

Car parking at KEVII Hospital

"During this unprecedented time most people are not using cash due to being advised by government for carrying risk reasons. Therefore where I would usually have copious amounts of change I do not have any now It would be so convenient if the company that looks after the car park came into the 21st century, and with everybody's health at the forefront of their concern, and allowed contactless payment"

8.4.1 PALS Activity

PALS has continued to provide a signposting and information service throughout the pandemic response.

PALS have continued to facilitate the Message to Loved One service (collating messages for patients that are then hand delivered on the ward) that was available across all inpatient areas. This PALS have held regular meetings with Advocates who would ordinarily be based at PPH and ensured that updated information on advocacy support was circulated to the wards.

There were 473 PALS contacts during Quarter two (an increase from 408 last quarter). In addition, there were 131 contacts which were related to non-Trust services. The main reasons for contacting PALS were:

- Concerns and enquiries about how to access services

(such as information about transferring care into Berkshire, delays in referrals being made to other services and people asking for contact information for services)

- Concerns about Care and Treatment

(such as concerns about a patient at Prospect Park Hospital, unhappy with CMHT diagnosis, waiting times for ASD/ADHD Pathways and the use of PPE)

9. The Friends and Family Test

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

NHSE/I issued a national pause on the mandatory active collection and reporting of the FFT in March 2020. The Trust has continued to collect the FFT via non-contact methods such as SMS, online link and by telephone for local learning and service development. The Patient Experience Team has worked with wards in both physical and mental health services, to telephone patients who have given consent to be telephoned after their discharge. The feedback has been positive, and staff were able to also speak with family members and carers on several calls. From May 2020, in addition to the FFT, patients were prompted to share their experience of being in hospital during the pandemic (*Q2: Please can you tell us why you gave your answer?* (Prompt to find out more about PE, feeling safe, assured, hand hygiene, visiting restrictions).

NHSE have said that the FFT reporting will formally start again from December 2020. When the FFT is reinstated, it will be the new FFT question (rating of care rather than recommendation to others) which was due to be launched from 1 April 2020 (and paused). The Trust started the new FFT locally from 1 September 2020 in readiness for the NHSE launch.

Examples of the feedback received from the telephone calls are:

"Most of the staff were very helpful, there was some delays as staff didn't know all of my problems but the service was good and friendly"

"I truly felt looked after and safe, my children also told me that they felt the staff were all very helpful answering questions"

"I found staff to be friendly and attentive which reassured me" (daughter echoed these sentiments)

"It could have been better if I had visitors for longer and was allowed to see visitors on the weekend" (Jubilee Ward)

"The staff were very caring and attentive"

Comments by husband – "I think at times my wife was not really happy with the night staff as she would call be a little bit upset saying the staff were not helping me, but in reality I think it was actually the staff who were trying to help my wife become more independent" (Donnington Ward)

"Everybody was great, all staff from top to bottom were very sympathetic and kind to me. I have been in several hospitals and this is the first time someone has called me to ask how my experience was"

"Maybe a bigger library selection of books but nothing serious"

"I was very satisfied with everything that happened and in particular the Physiotherapy was very good"

"I was pleased with the help considering the virus"

"It was nice I was able to be contacted by my family"

The feedback was shared anonymously to the wards.

10. Our internal patient survey

The existing patient survey programme was paused from mid-March, alongside the collection and reporting of the FFT. Some services have continued to collect this information for internal service monitoring and development use, but the use of handheld devices to collect feedback has now recommenced. The Patient Experience Team has liaised with colleagues in Infection Prevention and Control, and wherever possible cards will be reintroduced by services locally scanning and emailing cards across.

Development of the new Patient Experience Measurement tool is currently within the procurement phase, the aim of the new tool is to improve Berkshire Healthcare's measurement, analysis and dissemination of patient feedback across all Community and Mental Health Services, this will complement the Friends and Family Test.

11. Learning Disabilities survey

As this is part of our Internal Patient Survey, this was paused during Quarter two as part of the pandemic response.

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

There is no activity to report for Always Events, Patient Participation and Involvement Champions and 15 Steps as these were not carried out as part of the pandemic response.

The quarterly Healthwatch meeting has been suspended. There have been open and regular channels of communication between the Patient Experience Team and the Healthwatch organisations across Berkshire, on individual cases and for sharing communication with communities. From 1 July 2020, a Partners Meeting for Healthwatch Orgs based in the West of Berkshire, the Trust and RBH have taken place (as the Trust and RBH were both meeting separately).

13. Compliments

There were 975 compliments reported during Quarter two. The services with the highest number of recorded compliments are in the table below.

Table 20: Compliments

Service	Number of compliments
Talking Therapies - Admin/Ops Team	534
District Nursing	92
Community Respiratory Service	35
CMHTOA/COAMHS - Older Adults Community Mental Health Team	28
Heart Function Service	21
Children's Speech and Language Therapy - CYPIT	20
Crisis Resolution and Home Treatment Team (CRHTT)	17
Community Matron	16
Community Hospital Inpatient Service - Windsor Ward	16
Community Hospital Inpatient Service - Donnington Ward	12

Table 21: Examples of compliments received during Quarter two

Community Nursing – Bracknell *"Thank you. Nurses are supportive, the team are caring towards my husband"*	Children's SALT – West Berkshire Healthcare NHS Foundation Trust *"Thank you for your thorough email advice and telephone conversation. You have given me a clear direction and practical strategies that I feel confident to implement at home. Much appreciated!"*
Integrated Care Home Service – Wokingham *"Our family wishes to express our heartfelt appreciation for the kindness and excellent care of our father. Of course we are very saddened by his death but we are comforted in knowing that he received the best care available. The sensibility and support of your staff helped us through a very difficult time and we will never forget your kindness"*	Traumatic Stress Service – Reading *"I just wanted to express my profound gratitude to you for your support, attention and care. You helped me for over 7 months and you assisted me to talk about things I haven't talk about it in details. I know it wasn't always easy; I wasn't always easy. When we met, I secretly rebelled against even a tiny hint of a suggestion of how to handle things. I challenged you every chance I got. You didn't give up. You always protected yourself by keeping distance. In a way that's helped me not to get attached to you but on the other hand at times it made it difficult for me to open myself during the sessions.* *Thank you for every single thing you had done to help me and keep me safe"*
Garden Clinic – Slough *"I am writing to you as I would like to share my gratitude about your service. In the past year I saw you on a regular basis and I would like to say a huge thank you! You are a very nice person, gave me the "tools" I needed to be a more confident person. I'm gutted my experience with you had to come to an end, so I'm writing to let*	Rose Ward – Prospect Park Hospital *"Thank you for the kindness, compassion and care you have shown me during my stay with you* *Mental illness isn't the easiest thing to navigate but you all made it feel less daunting!"*

you know that I'm very happy you provide such an amazing professional service. Thank you very much for all you've done for me"	
CMHT - West Berkshire *"To my Hero* *Thanks so much for everything you have dine in this short amount of time"* OPMH - Wokingham *Daughter of patient who attends the virtual cognitive therapy group session: "mum is so full of beans when she has been on the virtual group and mum said it great, she has somebody to talk to"* *Compliment from a carer - first remote assessment "I wanted to say thank you so much for all your support"*	Prospect Park Hospital *"I want to start off by saying sorry to you and all you staff when I was there on the ward, breaking things most days on the ward, upsetting your staff and not taking my tablets consistently which I regret because now I am taking them every day and my depot and I am feeling much calmer and chilled out but most of all I want to say a BIG THANK YOU to you for helping me with so much, the pens, paints, chats and sometimes a firm talking to that I deserved and needed at the time. But you were good to me and for that I am grateful to you and all of your staff".* *"I would just like to say how much I have appreciated your care and help with my dad. He has been so settled and happy within Rowan Ward thanks to all the wonderful team who have looked after him during these complicated times. More than anything i would like to say how much I have appreciated the chance to see him and spend some valuable time with him, i feel very blessed that you could make this possible. I am in awe of your work on the ward and how you manage the patients"*
Community Dental Service *'We are very fortunate to have access to the domiciliary service for my father and we were so grateful that you were able to attend and see him at home yesterday. Thank you for the care and attention that you gave him'* *TDAC is Tilehurst Dental Access Clinic. At the time dental practices were closed and were providing urgent dental care at Tilehurst and Skimped Hill clinics for patients who were Shielded, High risk or vulnerable.* *Patient was receiving dental care in an urgent dental clinic. They were very complimentary about the seamless teamwork between the dentist and nurse and how things seemed to flow well. The patient is a former pilot who has experience in how crucial this kind of teamwork and flow is.*	Jubilee Ward *Verbal complaint I received over the phone from the wife a patient. Staff met the wife and the patient the next day to discuss their concerns and they were impressed of the quick response. They were happy with the actions in response to their concerns and patient agreed to stay in the ward instead of self-discharging. The patient was pleased with the conversations he had with the Ward Consultant and his wife praised the Occupational Therapist of discussing the discharge plan with her. The patient also confirmed that he had seen changes with the attitude of staff following the concerns both of them raised. This was resolved locally and prevented a formal complaint being raised.*
CYPIT West *"Thank you for never making me feel like it was my fault that XXX had difficulties. Lots of other professionals made me feel like I caused some of the things, which made me feel worse about everything, and you never did. Thank you for listening to me when I was worried"*	Health Visiting - West "*I wanted to say a heartfelt thank you for all your support and encouragement over the past few months. From coming into the clinic in tears to today you've really been amazing through every step of the journey. You don't know how special that is and I will always remember that kindness.*

"SLT has done a wonderful job delivering speech and language therapy online to XX over the past 6 weeks. She has made the sessions fun, interactive, and has kept him fully engaged. It has really helped him to stay motivated and continue with the sessions"	*It's such a scary ride having a newborn, let alone in these crazy times and you were and are beyond amazing….. Thank you!"*
CMHT – West Berkshire and Rose Ward *"As you are aware, I quite recently experienced a relapse with regards to my bi-polar condition. This resulted in me being voluntarily admitted into hospital where I was given a bed on Rose Ward. Here, I was put under the care of Dr XX and his clinical team.* *The care and support I was given was nothing short of outstanding. The staff delivered a high professional standard of care bespoke to my individual needs. This included access to a physiotherapist, an occupational therapist and a ward psychologist* *This reflects my overall experience with the service which I have been under for approx. 15 years. You have been with me every step of the way during that time and have been my guardian angel. You simply have given me unwavering support and have been robust in providing immediate clinical intervention when necessary.* *You have ensured my psychiatric treatment has evolved and adapted to the changes and challenges that my condition presents and, as you know, it has been extremely challenging. Overall you have provided me with hope. You have my most sincerest gratitude and highest regards.* *I'd like to mention XX who is a remarkable lady and a huge asset to the team there. XX has made the role she is employed in her own and as a result has enhanced the level of support that she provides to the Drs and patients whom I know have the highest regards for.* *The community teams have also been incredible and have been an invaluable pillar of support. Despite the challenges my condition presents, the team have persevered and have been most helpful in opening opportunities for me to gradually reintegrate back into the community but this is just one of many interventions and support provided by the team"*	
CRHTT – West *"I am writing to thank you and your team for the wonderful support we received during this difficult time for my son. Over the past several days you have played a huge role by answering all my questions and continually offering much needed assistance.* *Navigating the healthcare systems between Prospect Park Hospital, the GP surgery and the police has been extremely challenging due to the lack of information to assess my son's current state. The Crisis team has been the only constant providing open lines of communication, compassion and reassurance.* *Thank you for being a ray of hope for my family during this difficult time. I felt that my concerns were heard and your dedication to patients was exemplary. Thank you for being on the front lines of mental health care. Thank you for your kindness, dedication and perseverance. Thank you for always putting your patients first and going above and beyond no matter how gruelling your day has been.* *We thank you for providing an empathetic and compassionate ear when navigating this challenging time in seeking support. Thank you for standing alongside my family and for being so understanding and patient.* *Lastly, thank you for everything that you have done, and continue to do, to support us. It does not go unnoticed. We really do appreciate it.* *With much love and respect* *Mother and family"*	
CRHTT East	

'*The WAM HTT and CRHTT doggedly pursued a thoughtful, safe and compassionate outcome for a gentleman who was in Crisis and support for his wife, children, unborn child, and elderly father who resides in France. The piece of work involved the Prevent Team, French Medical records, Safeguarding, EDT, Police Street Triage Workers, TVP. The Met Police. Heathrow Authorities (need I go on?!).*

Table 22: Compliments, comparison by quarter

	2018/19					2019/20					2020/21	
	Q1	Q2	Q3	Q4	18/19	Q1	Q2	Q3	Q4	20/21	Q1	Q2
Compliments	1,008	1878	1,670	1,409	5,965	1,404	1,389	1,437	1,436	5,666	873	975

14. Changes made as a result of feedback

Lower Limb Service – Bracknell:

'The lower limb service continued to deliver treatment throughout lockdown.

Some of our patients were required to shield which made treatment plans challenging as we are a clinic-based service.

We were able to support some patients in self-managing their wounds by supplying dressings and maintaining weekly telephone contact.

Those patients with wounds which were complex in nature were visited at home by members of our team as we knew that the district nurses would not have capacity to help.

I spoke to one patient's husband who told me that he felt the lower limb team had gone "above and beyond" what he would have expected in providing care and support for his wife as well as for himself as he was dressing her leg for her.

Another patient reported how reassured both he and his wife felt to know that his leg would be dressed every week and continually described the care he received as "wonderful".

Understandably, many of our shielding patients were very anxious at the prospect of coming back to clinic as restrictions eased but we have been able to assure them that their safety, along with that of our staff, is a priority, and now everyone has returned to clinic'.

15. Shifting the mindset – a closer look at NHS Complaints

This action plan has been put on hold. Healthwatch and the CQC are launching a campaign to encourage feedback (not just complaints) called 'Because we all care'. The Trust are working with local Healthwatch organisations on how we can support the campaign locally.

Elizabeth Chapman

Head of Service Engagement and Experience

Formal Complaints closed during Quarter Two 2020.21

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7562	Reading	Adult Acute Admissions - Snowdrop Ward	Moderate	Family raised concerns with CQC regarding communication between the ward / them and New Horizons	Partially Upheld	Next of Kin/ Nearest relative must be clearly recorded in 'Personal Contacts' on RiO in their capacity as first contact. Family members, if service user defines who they wish to involve, should be offered the opportunity to engage in the information assessment process and be sent copies of care plan and contribute to its formulation. If service user objects. This must be clearly documented in the service user's records on RiO and family informed.	Communication
7633	Reading	Health Visiting	Minor	Complaint from a soon to be father about a referral to Social Services.	Not Upheld	Complaint withdrawn	Attitude of Staff
7603	Reading	Adult Acute Admissions - Daisy Ward	Low	Pt states they were promised Psychological support which they did not get. Assistant psychologist made appts but did not show up to any of them, did not apologise, give notice or explain. Pt attempted suicide on the ward (said they bought aspirin when out but was not searched when coming back on the ward). Pt said they overheard staff breaching confidential info re pt from another ward, ridiculing which has made pts feel bad. Pt said CRISIS team member who they were left with when brought into PPH swore at them.	Partially Upheld	Review of current search policy	Care and Treatment
7605	Reading	Adult Acute Admissions - Rose Ward	Low	Patient has raised concerns about aspects of care on the ward, and he does not agree that he should be in hospital. He complains that staff do not knock his door before entering, he does not have a key, medication issues, and he has not been hive cream for his eczema.	Partially Upheld	Rose ward staff to be reminded to knock before entering patient bedrooms or using privacy vison panel both via email and in team meeting. Implement plan for patients to have their own bedroom keys.	Care and Treatment
7588	Slough	Community Hospital Inpatient Service - Jubilee Ward	Low	Re-opened as complainant says response has not fully satisfied his concerns ORIGINAL COMPLAINT: Family unhappy the pt did not get the full time of rehab at Upton Hospital and was transferred to a Windsor Care Centre against the complainants documented wishes	Partially Upheld	Discharge summaries not to be written in advance, and acute detail not to be copied over to prevent confusion and error as to who has initiated what. Focus to be on progress on ward, investigations, new diagnosis and any medical changes on the ward To ensure families are involved in/informed about decisions where the patient has requested this. Improved communication with families especially whilst they cannot visit relatives on the ward	Care and Treatment
7612	Reading	Out of Hours GP Services	Low	Patient made four calls to NHS 111, with one resulting in a referral to OOH GP. Call was passed the two hour disposition and when patient was called back, Dr booked her in for scan the following day but she later miscarried.	Partially Upheld	WestCall did not achieve the target call back time. There were unusual capacity pressures for the overnight GP's with regard to a number of outstanding calls from earlier the previous evening. An apology is appropriate for missing the target call back time.	Care and Treatment
7599	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Moderate	Pt unhappy with a diagnosis given to him which he only found out through his GP some months later. Disagrees with the letter received that he accepted this when he met with psychiatrist in January	Partially Upheld	CRHTT to discuss whether there is a need for change in their practice in terms of copying clinic letters to the patients routinely. There are issues about practicalities, therefore only a detailed discussion is recommended.	Communication
7610	West Berks	District Nursing	Low	Pt discharged from hospital following operation to remove abscess. Family say after 2 visits DN's refused to go out as pt could walk	Partially Upheld	All staff manning dressing clinic to use laptops and not Ipads to ensure that they are able to access full clinic details even if patients have not been allocated to them.	Care and Treatment

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7594	Reading	CAMHS - Anxiety and Depression Pathway	Low	complainant feels that agreements made over the phone were not honoured and pt was discharged	Not Upheld	Clinical care was appropriate - a review took place with a clinician not known to the patient who agreed with the discharge. Information on support and signposting provided.	Discharge Arrangements
7568	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward		Family unhappy with verbal responses from staff when they call, feel there is a discrepancy on what can and can not be shared.	Case not pursued by complainant	Complainant did not wish to pursue	Communication
7601	Slough	Psychological Medicine Service	Low	MH professional documented pt sexuality which is a breach of confidentiality and the pt is extremely unhappy	Upheld	For any mention of historical gender identity issues and the fact she is transgender to be removed from the frequent attender's care plan and the updated version to be recirculated with the request to destroy the old version. Should there be any change in presentation and the issue of transgender become relevant to current risk factors and / or management plans, this may need to be revised as the decision to remove from this one care plan is not indicative that it should never be mentioned again, more so that it is felt that it does not need to be discussed with the wider agencies outside of the mental health organisation for now.	Confidentiality
7620	Reading	Patient Experience	Low	Complainant unhappy about the lack of response from PALS	Upheld	Apologise and acknowledge that there has been a service failure,	Care and Treatment
7604	Reading	Out of Hours GP Services	Minor	Child prescribed Clarithromycin, mother discovered the dose was double what it should be for the childs age	Partially Upheld	Both clinicians in this complaint accept that the dose prescribed was too high and have taken appropriate individual learning for their prescribing practice moving forward. The learning from this complaint and points for prescribing practice will be shared via the Urgent Care medicines bulletin and at GP monthly meetings. Formal apology will be offered to for prescription of a higher than standard dose of clarithromycin for her child.	Medication
6913	Reading	Older Peoples Mental Health (Ward Based) - DO NOT USE	Moderate	Following receipt of the pts medical records, a further complaint is being raised ORIGINAL Wife of pt has sent in 16 points of concern following her review of the pts medical records	Partially Upheld	There was a breakdown in communication and relationship with the family but there were failings on both sides.	Care and Treatment
7555	Reading	CMHT/Care Pathways	Low	pt believes their personal information was given to a third party organisation	Partially Upheld	Any MDT meeting must be clearly documented and minuted. A copy should be uploaded on to RiO and any information shared should be accompanied with a rationale and an agreed means of storing information. Clear rationale and explanation to patient in the case of sharing information – where this does not contraindication or disrupt the therapeutic rapport	Confidentiality
7565	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt feels let down by the Crisis team who did not follow through on her care plan, then arrived unannounced at her door without PPE or social distancing	Partially Upheld	Staff identified for telephone training	Attitude of Staff
7415	Slough	Crisis Resolution and Home Treatment Team (CRHTT)	Low	A patient assessed by CRHTT feels that staff have lied about his mental health. The patient is currently unwell and lacks insight into his mental health. The patient has clearly stated that he wants this to make a complaint. Limited further information has been provided, however two members of staff have been named who work within the service.	Not Upheld	No evidence to support patient's claims that staff lied about him or that he was assaulted. No action taken by TVP in relation to assault	Attitude of Staff

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7455	Wokingham	Adolescent Mental Health Inpatients - Willow House	Minor	Complainant unhappy with the response as she feels it is patronised and disregards the impact on the pts health. ORIGINAL COMPLAINT - Pt wishes us to investigate the lack of care they feel they received from Willow Hse and specific Dr's. Pt also wishes us to jointly look at the transition from Oxford Health to Berkshire as a joint complaint	Partially Upheld	ASD diagnosis: Communication to be made clearly and try to avoid sudden unexpected changes to plans without discussion. Develop guidelines for the ward team around supporting young people with an ASD diagnosis. Willow House team to be offered targeted autism training by an autism expert. To think abut how to support young people with autism on the unit. Review Willow House transition processes.Review process for young people placed out of area.	Care and Treatment
7540	Reading	Community Hospital Inpatient Service - Oakwood Ward	High	DECEASED PT: Transferred from the RBH, staff unaware of proteins shakes needed for the pt. No physio took place (which was advised by the RBH) due to staff sickness, resulting in the pt being left in bed and hoisted to a chair for dialysis at the RBH. Paramedic and RBH consultant agreed for pt to remain on Oakwood for EOL care	Partially Upheld	Ward Manager to ensure that the nutritional requirements of patients are made available to all staff through the nursing handover process and also on the Patient Safety at a Glance Board where key information about patients is visually available for all members of the ward team The Ward Manager to discuss this incident with the staff in a team meeting so that staff can learn from this incident, reflect and change their practice through supervision	Care and Treatment
7620	Reading	Patient Experience	Low	Complainant unhappy about the lack of response from PALS	Upheld	Follow up case with PALS Manager	Care and Treatment
7619	Reading	Adult Acute Admissions - Daisy Ward	Low	Family member extremely unhappy that they are not communicated with every time the patient goes into hospital	Partially Upheld	Ward staff to appropriately pass on requests from family and carers so these can be received by the relevant persons and actioned appropriately.	Communication
7625	Reading	Veterans TILS Service	Low	Complainant believes TiLs services commissioned by NHSE are not being provided by reading. Also - Professionals at TILs service Reading not actually knowing or conveying what the TILs service should be providing to Veterans or those transitioning out of service.	Not Upheld		Communication
7631	Bracknell	District Nursing	Moderate	DECEASED PT: Catalogue of events involving many agencies prime concerns for DN's around communication and care	Not Upheld	Share event with all Community Nursing Staff at Bracknell Forum Embed RIO EOLC Assessment Plan Restart End of Life care training for Non-malignant patients with Hospice Propose Virtual Caseload meetings with Gainsborough Practice	Attitude of Staff
7674	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward		Care and treatment whilst on Henry Tudor + breach of pt records	Serious Untoward Incident Investigation		Care and Treatment

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7586	West Berks	Urgent Treatment Centre	Moderate	Pt presented to MIU with wrist injury, radiographer did not xray scaphoid therefore diagnosed with sprained wrist. returned due to pain and nurse flatly refused to allow a re-xray, eventually done through GP portal and stated scaphoid broken	Upheld	Peer review/reflection meeting IO concerning their consultation and offer apology to complainant and patient. Share complaint investigation findings as anonymous format in Urgent Care Governance newsletter to all Urgent Care clinical staff and in all Urgent Care clinical team meetings. All UTC practitioners to revisit learning on wrist injury assessment utilising online platform tutorials suitable for this purpose. https://www.youtube.com/watch?v=-Ydcc8Pdm3c https://www.youtube.com/watch?v=DxW0rodKOGs Recommendation: For staff to attend Advanced Skills: minor injuries 3 day taught course provided by Belmatt Healthcare Training running 1-3rd November 2020 https://www.belmatt.co.uk/minorinjuries Post course competency to complete in practice. Cost: £375	Care and Treatment
7634	Windsor, Ascot and Maidenhead	CAMHS - AAT	Low	Complaint about waiting time. Parents state that their daughter has been waiting for 2 years, and have been told that it will be at least another year.	Not Upheld		Access to Services
7616	West Berks	Health Visiting	Low	Complainant wishes entire complaint to be re looked Pt 3 re DSA Further issues regarding a staff member in Point 1 &2 ORIGINAL Complainant believe West Berks HV are helping to move child to Newbury HV and communicate with spouse only when joint 50:50 custody has been awarded by the courts. Complainant concerned about impact on child 12 points raised	Partially Upheld	Learning around inappropriate open referrals the and correct provision of services to be disseminated through all relevant service leads. Clarification around “Duty Safeguarding HV” in the RiO records Improve staff documentation within RiO so that parent’s details are always clearly available and communication preferences documented. This will be disseminated through the service leads.	Access to Services
7643	Slough	Common Point of Entry	Low	pt feels he is not getting any help from MH services. issues with registering with a GP in the past. was waiting to talk to TT but wait list was too long	Not Upheld	No failings. Patient was unhappy with distance to travel for treatment but he lives outside of Berkshire, yet has Berkshire GP.	Care and Treatment
7635	West Berks	Health Visiting	Low	Mum is unhappy with phone conversation with HV. Her GP recommended a low mood assessment, but HV did not take it seriously and her general attitude to the whole situation was totally unacceptable. Resulted in mother feeling a total failure and broke down in tears. Since had appt with TT and diagnosed with Birth Trauma PTSD.	Partially Upheld	Staff to access support to receive training on effective communication Arrange peer to peer reviews to support and facilitate further learning around effective communication Organise a one off short training session on birth trauma for all Health Visiting localities, which will be facilitated by Perinatal Mental Health and Birth Trauma teams.	Attitude of Staff
7471	Bracknell	Talking Therapies	Low	Mother of patient has responded to our letter and is challenging several points. ORIGINAL COMPLAINT mother is making a complaint about the SI process. Her daughter took her own life. She has a copy of the SI report and feels there are inaccuracies in it.	Partially Upheld	There are elements we have taken learning from	Other

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7588	Slough	Community Hospital Inpatient Service - Jubilee Ward	Low	Re-opened as complainant says response has not fully satisfied his concerns ORIGINAL COMPLAINT: Family unhappy the pt did not get the full time of rehab at Upton Hospital and was transferred to a Windsor Care Centre against the complainants documented wishes	Partially Upheld	Discharge summaries not to be written in advance, and acute detail not to be copied over to prevent confusion and error as to who has initiated what. Focus to be on progress on ward, investigations, new diagnosis and any medical changes on the ward To ensure families are involved in/informed about decisions where the patient has requested this. Improved communication with families especially whilst they cannot visit relatives on the ward	Care and Treatment
7409	Bracknell	CMHT/Care Pathways	Low	Pt was assured a report would go to the GP from IO but they have not received anything. Original complaint - Pt extremely unhappy with things / assumptions that have been written about them by services in their medical records	Not Upheld	Not upheld as complaint not pursued by complainant	Communication
7609	Reading	Adult Acute Admissions - Bluebell Ward	Low	Complainant unhappy with response believes many of the points that you have been responded to, are simply not true. ORIGINAL COMPLAINT General attitude of staff on the ward during the pt's stay, 14 points raised	Partially Upheld	All staff reminded in staff meeting that they need to introduce themselves to patients at each interaction Continue the implementation of Safe Wards interventions to coach and support staff in communications skills to improve care and outcomes for patients. All staff reminded of the importance of making sure that all information is correct when talking with patients and recording in notes eg mental health act status	Attitude of Staff
7519	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Minor	Break down of relationship and trust with patient. Prescription mistakes on more than one occasion	Partially Upheld	Dr/patient relationship did breakdown and there was a medication error	Care and Treatment
7652	Reading	Talking Therapies - Admin/Ops Team		Following telephone assessment in July 2019 pt had to chase in feb 2020 as had heard nothing. pt wishes to know why they were not told you could not have 2 forms of therapy, why not notification to change was given	Partially Upheld	It was appropriate to discharge the patient when they informed the Therapist that they were also on a pathway elsewhere in the Trust. The learning is that we are developing a system to check this and to make sure that patients are aware that it is not clinically effective to be open under two pathways.	Care and Treatment
7627	Reading	Community Hospital Inpatient Service - Oakwood Ward	Low	Several points raised 1.Complainant unhappy that video calls were unavailable on a frequent basis. 2. NOK not informed of discharge before care home. 3. Why was the pt placed under DOLS when complainant was NOK and had LPA. 4. Complainant given the wrong info about funding for nursing care. 5. Why did staff not know the pt was widowed 13 years ago	Not Upheld		Communication
7690	Slough	Community Hospital Inpatient Service - Jubilee Ward	Moderate	Complaint is about attitude of Dr, missing watch and no paperwork on discharge	Partially Upheld	More robust management of patient property is needed, and a reminder of the additional impact remote conversations with clinicians is having - need more time and compassion.	Attitude of Staff

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7679	Isle of Wight	Criminal Justice Liaison and Diversion Service - (CJLD)	Minor	Concerns that assessment has been shared with GP, did not wish to be assessed in custody, feel the report is factually inaccurate.	Partially Upheld	Process for checking letters put in place. A reminder to staff that involvement with the service is voluntary.	Communication
7663	West Berks	Continence	Minor	DECEASED PT - Family unhappy with the gaps in care for EOL pt's at home, especially around incontinence care.	Upheld	Written information (regarding what to look out for and actions to take) should be provided to families who are receiving EOL care from BHFT Provision of incontinence products should be provided as a matter of course when patients are: a) Referred for EOL care b) Seen to have a deterioration in condition/cognition/mobility	Support Needs (Including Equipment, Benefits, Social Care)
7649	Reading	Podiatry	Low	Complainant disputes the response and would like a full timeline of events and a video meting to discuss when digested ORIGINAL COMPLAINT care from staff over a 13 month period including issues with the RBH	Not Upheld	Clinical care was appropriate.	Care and Treatment
7644	Slough	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt says they were made to feel inferior in their own house	Partially Upheld	CRHTT to ensure they have a good stock of shoe covers and all staff to have a supply as part of their PPE CRHTT staff should not share pens and equipment during home visits	Attitude of Staff
7667	Wokingham	Adolescent Mental Health Inpatients - Willow House	Moderate	Family feel left out of the loop with pt since admission. Concerns around medication and regularity of seizures and the fact staff keep referring to the patient as the opposite gender	Partially Upheld	• Create written leaflets explaining processes during Covid - 19 restrictions, including what to expect regarding admission process, explaining visiting times and visiting process and the process for attending MDT meetings, highlight named nurse and psychiatrist, include any additional members of the case team allocated to the young person. • Further develop the MDT template and checklist to include conversations / discussions regarding nearest relative rights and wishes for young people under a section of the mental health act. Include a discussion / feedback with the case team supporting the young person and ensure there is a process for communicating this to parents if they are unable to attend the MDT meeting. Review the process of advising parents of the young person's care plan. • Nursing staff and on call psychiatrists to be updated on the administrative process for admitting a young person on a section of the mental health act at weekends or out of hours, ensure a section 17 is competed to allow young people to leave the ward for medical treatment if required. Ensure new staff and temporary staff are made aware of this process. • Staff to be supported with understanding the need to use the young person's preferred name, and to describe the young person using their preferred pronoun. Consider specialist training regarding gender transition and identity.	Care and Treatment
7666	Reading	Children's Speech and Language Therapy - CYPIT	Moderate	Family unhappy the pt was discharged because they go to an independent school. would like acknowledgement of failings	Partially Upheld	Communication about service offer needs to be made clearer. Key conversations were not documented fully on RiO.	Care and Treatment
7658	Slough	CMHT/Care Pathways	Low	Pt unhappy with response thinks we are lying ORIGINAL COMPLAINT Pt says they are not receiving any help for services	Not Upheld		Care and Treatment

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7626	Wokingham	CMHT/Care Pathways	Low	Pt unhappy that she has been discharged from services following a discussion with CPE and CMHT that she was not party to. Letters sent to Consultant Psychiatrist from private organisations were not responded to	Not Upheld		Access to Services
7671	Slough	CMHT/Care Pathways	Low	Pt still unhappy that they are not getting the medication they wish at the does they wish, also believes claims the Dr tried to call are false ORIGINAL Pt feels medication was prescribed with the incorrect dosage and was then revoked entirely	Not Upheld		Medication
7659	West Berks	Rapid Response	Low	DECEASED PT:- DN's would not fit a catheter until Dr authorised, feel DN's should have stayed after administering drugs to see effects on pt. DN not always arrive on time.	Partially Upheld	Changes to referral process from day to community nurses to tea time service for EOL patients. Set up Palliative Care supervision/Reflective sessions.	Care and Treatment
7645	Bracknell	Health Visiting	Low	Mother feels her child has not been treated by services believing they are refusing intervention	Not Upheld		Care and Treatment
7670	Reading	Children's Speech and Language Therapy - CYPIT	Minor	family feel greatly let down as the non verbal pt has 'slipped through he net' and due to an administrative error no contact has been made	Partially Upheld	To look at all other children listed on the original spreadsheet for the Let's Connect Waiting List (Wokingham) and ensure that the parents of all these children have been contacted by the SLT department to ensure no other children waiting for this group intervention have been missed. To check all children on the original 'Intervention to be booked' (Wokingham) shared caseload spreadsheet (for any listed intervention) have had contact from Speech and Language Therapy so that no other children are missed. This spreadsheet should then be archived as completed so that all current information on children with a need for active input are held on one record within the SLT department which is regularly monitored by each responsible SLT and the manager for the service. To work towards all records being held on RiO only due to the risks of information being missed when held on spreadsheets. A discussion between the administrator, manager and the last-named therapist in relation to communicating and responding within the Wokingham SLT team to set up expected responses/action by each individual when a child's need for SLT intervention is highlighted to them. To share the learning within the wider SLT team All staff to be reminded that all telephone messages, voicemails or email correspondence in relation to children should be recorded on RIO (as this is a second mechanism for therapists to know that parents have contacted the dept). Support to be given to those staff who have been upset to realise that mistakes or omissions on their part have led to waiting for further intervention longer than he should have. Continued communication between the CAMHS service and patient's parents regarding a date for his Autism Assessment	
7696	West Berks	Health Visiting		Complainant unhappy with the contents of the meeting minutes which they feel do not represent everything that was said	Not Upheld	The complainant was advised that the notes were not verbatim minutes and note has been added that he does not agree with the content.	Communication
7653	Reading	Health Visiting		Father unhappy that clinician instructed a behaviour letter to be sent to them.	Not Upheld	Refer to complaint 7696 - complainant disagress with the notes from the meeting held with IO on 06.08.2020	Communication
7657	West Berks	Health Visiting		Complaianant unhappy at comments made in patients records about them, believes they could be misleading	Not Upheld	Refer to complaint 7696 - complainant disagress with the notes from the meeting held with IO on 06.08.2020	Communication

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7656	West Berks	Health Visiting		Staff not documenting telephone call comprehensively,and concerns that inaccurate info was provided to outside agency	Not Upheld	Refer to complaint 7696 - complainant disagress with the notes from the meeting held with IO on 06.08.2020	Communication
7677	West Berks	Health Visiting		Complainant believes staff member ignored court order	Not Upheld	Refer to complaint 7696 - complainant disagress with the notes from the meeting held with IO on 06.08.2020	Communication
	Reading	Compliance and Risk	Low	Several points raised regarding a security letter sent in 26th July 2019 and how the complainant is unhappy with the content	Not Upheld	The advice given to the clinical teams was appropriate - learning for LSMS to give complaint info however complaint in the whole is not upheld.	Communication
7660	Bracknell	CAMHS - Child and Adolescent Mental Health Services		Parents have raised complaint about the long delays in providing appropriate help to meet their daughter's needs and the quality of the service provided. They say she has been passed around various different departments and services and left without support when she most needed it and her mental health has deteriorated as a result.	Partially Upheld	Clinical care was appropriate. Upheld about communication with parents and between professionals as this could have been better.	Care and Treatment
7664	West Berks	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Member of staff allegedly spoke to family members about the pt who they are estranged from and wants no involvement with. Feels desperate as trust is broken	Partially Upheld	Remind CPE staff to check demographics at the point of referral and/or assessment Staff member has reflected and considered how they could have referred to CRHTT in more general terms	Confidentiality
7676	West Berks	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Minor	Family unhappy that police came into their home following an alleged call from services and safeguarding regarding the EOL pt	Not Upheld	The service did the right thing by raising safeguarding concerns and contacting the police. The complainant has offered to be involved with further training around this sensitive subject - to raise awareness and talk about her experience.	Communication
7637	Wokingham	Adolescent Mental Health Inpatients - Willow House	High	Father of patient is complaining about admissions/ arrival process and the poor communication and highlight some of the frustrations and challenges he has had as a parent. He feels that the lack of documented processes and procedures and general lack of communication is not acceptable.	Partially Upheld	Develop a process for clear communication to prepare young person and family for admission to a Tier 4 unit. When multiple teams are involved prior to admission identify a lead team who can support with communication prior to admission. Communicate current Covid -19 Tier 4 admission process to community CAMHS so they can help support re current guidance and help to prepare parents and young people in advance. Create written leaflets explaining processes during Covid restrictions and what to expect regarding admission, visiting times and MDT meetings. Willow House Team to ensure a clear communication pathway for parents following MDT. Seek an agreement with parents when parents are separated regarding how information will be shared. Process to be clear and documented in care plan, also document and explore with young person when the young person does not want information communicated to specific parents or carers.	Admission
7654	Reading	A Place of Safety	Minor	Pt feels report does not reflect what they said in person	Not Upheld	Not upheld as BHFT not author of report. However, IO has identified some areas that can serve as a reminder to other staff.	Communication
7580	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Minor	Family unhappy with the communication from the ward and the discharge arrangements	Partially Upheld	•To scope potential new post (across all IPUs) for a permanent 'communication liaison' role. This would be a key point of contact for communication between relatives and the medical / nursing team. Role to be defined, but would include taking queries regarding care from relatives and resolving as appropriate with medical team. •? Action around sending of electronic discharge summary •Closer working with community matron team. Unit Manager to make contact and establish referral criteria to CM team and promote appropriate refrrals at board round •Research potential dehydration risk assessment forms for implementation across the unit to highlight at risk patients	Communication

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
7435	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Pt feels CMHT cancelled the psychology appt which was agreed as part of closing the informal complaint dating back to August	Not Upheld	CMHT and Professional Leads will make expectations of service clear	Discharge Arrangements
7447	Reading	Adult Acute Admissions - Daisy Ward	Low	Complainant believes factual inaccuracies and still little care. CQC concerns ORGINAL COMPLAINT Complainant feels there has been an extreme lack of care and empathy to the pt over the last few admissions to PPH and states if nothing is done for the patient 'its not if she dies, it's when'	Partially Upheld	See details in response	Care and Treatment
7574	Reading	Adult Acute Admissions - Bluebell Ward		Much feedback on the way the Trust handle different situations, clarity required on a couple of points ORIGINAL Historic complaint relating to the attitude of a ward Dr	Upheld	The wrong diagnosis was entered into the discharge paperwork to the GP (since rectified). There is learning about how patients are asked for the feedback as part of medical appraisals and about being more sensitive when asking personal questions.	Attitude of Staff
7550	West Berks	Health Visiting	Low	Re-Opened - Father unhappy with response ORIGINAL COMPLAINT Father unhappy with a statement made by HV	Not Upheld	Refer to complaint 7696 - complainant disagress with the notes from the meeting held with IO on 06.08.2020	Attitude of Staff
7616	West Berks	Health Visiting	Low	Complainant wishes entire complaint to be re looked at 20.8.2020 Pt 3 re DSA Further issues regarding a staff member in Point 1 &2 ORIGINAL Complainant believe West Berks HV are helping to move child to Newbury HV and communicate with spouse only when joint 50:50 custody has been awarded by the courts. Complainant concerned about impact on child 12 points raised	Partially Upheld	Learning around inappropriate open referrals the and correct provision of services to be disseminated through all relevant service leads. Clarification around “Duty Safeguarding HV” in the RiO records Improve staff documentation within RiO so that parent’s details are always clearly available and communication preferences documented. This will be disseminated through the service leads.	Access to Services
7654	Reading	A Place of Safety	Minor	Pt feels report does not reflect what they said in person	Not Upheld	Not upheld as BHFT not author of report. However, IO has identified some areas that can serve as a reminder to other staff.	Communication

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th November 2020
Title	Six Monthly Safe Staffing Review – April -September 2020
Purpose	The purpose of this report is to provide board assurance of the trust's compliance with safe staffing national guidelines
Business Area	Nursing and Governance
Author	Linda Nelson - Professional Development Nurse Debbie Fulton - Director Nursing and Therapies
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
Resource Impacts	N/A
Legal Implications	N/A
Equalities 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. As required the report also details Nursing and Medical Director declaration that they are satisfied that staffing was safe; although high numbers of temporary staffing continue to have the potential to impact on quality and patient experience particularly across our mental health wards. In terms of medical staffing, numbers in the trust remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. The full declaration is detailed on page 18 of the report.

	During this reporting period some of the data has been affected by the COVID -19 pandemic, with staff deployed from other areas within the Trust and lower patient numbers especially during the first part of the 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. Programmes of work and targeted support continues to be provided to those areas with significant recruitment/ retention challenges and this is seeing positive results. 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.
ACTION REQUIRED	The Board is asked to: Consider this report and note the declaration provided by the Director of Nursing and Therapies and Medical Director

Berkshire Healthcare NHS Foundation Trust

Six Monthly Safe Staffing Review
April - September 2020

1.0 Executive Summary

The purpose of this report is to provide assurance to the board of the Trust's compliance with safe staffing in line with expectations of the National Quality Board (2016) and the National Health Service Improvement (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-19 and the redirection and streamlining of services during this time. In March 2020, the staff were redeployed from scheduled services to support wards during wave 1 although staff are now back in their substantive roles. NHSI 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.

All the community wards except for Oakwood (due to it being single rooms) have reduced bed capacity during this reporting period to ensure that 2 metre bed spacing is achieved, this is in line with infection control guidance during the pandemic.

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 increased with 463 shifts during this reporting period; in the reporting period October 2019- March 2020 there were 268 with less than 2 registered staff. The number of shifts with less than 2 registered on the wards at Prospect Park Hospital has not altered significantly since the last reporting period; the increase is almost entirely due to an increase on the community wards. Due to the impact of the COVID pandemic there has been very low bed occupancy for a number of months across the community wards and as a result a significant number of the shifts were intentionally not backfilled where there was absence/ vacancy; for example for May-July this year both east wards have been at less than 30% occupancy meaning on average they had only 5-6 patients on the wards and were therefore able to maintain safe staffing with less staff than would normally be required.

The total number of shifts with less than 2 registered nurses equates to 4.5% across the Trust. At PPH 5% of shifts had less than two registered nurses (Bluebell ward was the highest with 70 shifts, this is unchanged from the last report), other wards at PPH were able to support and a Duty Senior Nurse (DSN) is available which reduces the risk further.

The number of Willow House shifts with only 1 registered nurse continued to decrease to 3.55% compared to 4.4% in the last reporting period. Across the community wards, West Community Health Services had 7.4% of their available shifts with less than two registered nurses; Highclere ward (69) and Ascot ward (77) being the highest. In the East the Community wards reported 6.55%shifts with less than two registered nurses (Jubilee 46 and Henry Tudor 26).

At Prospect Park the recruitment of newly registered nurses toward the end of 2019 has supported staffing numbers and continuity of care on the wards, registered nurse vacancies on the wards have remained fairly static following recruitment of these preceptees (further recruitment of newly

registered nurses during October is expected to have a positive impact on the next reporting period). However, with the large number of newly registered nurses comes the extra pressure on senior staff as they support these staff through their preceptorship. Especially when this is alongside continually high occupancy in the acute mental health wards, high patient acuity and high use of temporary staff to meet patient need. The community health wards have successfully recruited to many of their vacancies.

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.

A total of 17,944 shifts were requested across the Trust to support the wards in meeting their requirements for minimal staffing as well as providing additional cover for increased observational levels each month; 15.2% of these requests were not able to be filled. 30.91% of requested shifts were for registered nurses, 4.73% (9% in last reporting period) of which remained unfilled. This is a significant improvement on the last 6-month reporting period where 27,638 shifts were requested and a similar total percentage (31% 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 within their teams to create more flexibility in covering their wards.

Non-registered Nursing Associates (NA), are included in the staffing figures reported because their training is work based and NHSI plan to monitor this training pathway within all Trusts.

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. Most incidents reported have been assessed as having low or no impact due to the mitigation put in place by staff.

1.1 Prospect Park Hospital (PPH).

The overall staffing situation at PPH across the wards throughout the past six months has improved. This was largely due to students undertaking paid placements during the Covid-19 pandemic. Wards have been able to retain many of these individuals as staff nurses once qualifying which will impact positively on vacancy. Daily staffing huddles are standard practice within the hospital and allow the Designated Senior Nurse (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 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 Rose wards who have experienced recruitment challenges and increased difficulty in securing staff to cover minimal staffing recruitment and increased levels of observation. Rowan ward alongside Orchid ward continue to care for patients with high physical as well as mental health needs. In addition, Rowan ward was used for COVID -19 patients during the pandemic and physical health nurses were redeployed to assist with the management of this patient group.

PPH continue to 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. Wards were dealing with increased patient physical health needs and associated higher levels of anxiety due to Covid-19. Staff were supported by senior staff on the ward and the senior management team. To support with the COVID management Community Mental Health Team (CMHT) staff were also redeployed into Prospect Park. Extra support workers were needed to ensure wards met the additional needs of Covid-19 during the months April-June.

10,220 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; 12.52% of these requests were not able to be filled. 25.47% of requested shifts were for registered nurses, 3.03% of which remained unfilled. These numbers have improved from the last reporting period where 15,424 shifts were requested. 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. In addition, the mental health wards are currently recruiting for Activity Coordinators following a successful pilot on Snowdrop ward earlier in the year these staff will be included in the wards safe staffing establishment. These individuals will assist in engaging patients in activities across the afternoon and evening period. 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 managing the bed flow and reducing the bed occupancy at PPH, as detailed in table 5. Rose ward continues to experience challenges with high bed occupancy throughout this reporting period where their rate has remained above 90% (except for April); some months above 95%. Bluebell and Snowdrop wards also have over 90% occupancy rates from June-September.

The number of reported shifts with less than two registered nurses on the Acute working age adult wards has decreased to 127 (365 during April 2019 - September 2019) across the hospital. Bluebell ward had the highest number of shifts with less than two registered nurses overall at 70, whilst Snowdrop ward had the lowest number with 5. There is 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 was closed until the middle of April for essential refurbishment due to the identified potential ligature risk from the bedroom windows. During this reporting period the unit has been staffed with additional staff per shift to mitigate any risk. A lower bed occupancy has been agreed at present due to support managing the young people, this is reflected in the occupancy figures seen in the report. The sickness rate has varied but is currently just above the Trust target at 4.95%

There were 1573 temporary staffing requests, 31.8 % of requested shifts were for registered nurses due to their vacancy rate which has remained high. Over the last 6 months 13% of shifts were unfilled (4.5% RN). The unit has been impacted by late notice cancellations amongst temporary staffing.

The number of shifts with less than two registered nurses has decreased when compared to the same period last year. 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 was an incident in July whereby a young person broke a window and four people absconded. During this shift there were a high level of NHSP staff on duty. There were no other incidents where safety was compromised due to staffing levels.

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. 1625 temporary shifts were requested to meet the requirements of levels of observations; 26% were requests for registered nurses. The low unfilled rate (6.6%) 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 60%. The sickness rate was at 29.1% in April but has decreased over the 6 months to 3.06% in September which is now below the Trust's threshold. Work continues to achieve the planned move of Campion in February 2021 to 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 had a high number of vacancies which had meant higher temporary staffing requests, particularly for registered nurses. The continued focus on recruitment has been successful with wards now virtually fully staffed In Wokingham there have been changes within ward leadership which has created a more stable team. Absence across the wards has meant that high numbers of temporary staff have continued to be required.

Bed occupancy has been lower than expected across all wards for this six-month period (average 69.25%) which has assisted wards to manage their safe staffing requirements. West CHS wards have continued with regular meetings with the acute Trusts locally to increase communication and support patient flow for the community beds and identify suitable patients earlier which assists with a more consistent bed occupancy across the West wards.

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. April and May were the most challenging months with absence due to the COVID pandemic. From June the total has been below 10% for all wards. During the COVID

pandemic some at risk staff were shielding and/or self-isolating which also impacted on temporary staffing need.

In March, the wards started the 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 171 shifts with less than two registered nurses in the West CHS wards, 82 were at Wokingham Hospital and 85 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.
Following some successful recruitment; staffing levels on both Henry Tudor and Jubilee have improved. Due to low bed occupancy any vacancies have not impacted the wards as much as other areas. In addition, staff were redeployed from scheduled services which helped with any shortfall.

Following a fire risk assessment review on Jubilee ward late last year a potential risk was identified concerning patient evacuation, particularly at night. Therefore, the ward has one extra unregistered nurse on the night shift to mitigate the risk while this is investigated further.

From March the wards were supporting with the management of COVID 19 and staff from scheduled services were redeployed to the community wards. However due to the reduced admissions in secondary care the impact from COVID on the wards staffing was minimal. The average bed occupancy was 38.5% during this reporting period which is very low. The total number of temporary requests was 366; 43.4% were for registered nurses with 18.3% of requests being unfilled. The sickness rate was above 3.5% in April but has decreased and both wards are currently below the Trust's sickness threshold. There were 72 shifts in the reporting period where there were less than two registered nurses (Henry Tudor ward 26; Jubilee ward 46). However, patient safety was not compromised due to the low occupancy rate on the wards during the time frame.

2.0 Main Report.

Overview:
To meet the requirements of the *Developing Workforce Safeguards* (2018) published by NHS Improvement (NHSI) the Trust need to:

- Include a specific workforce statement in their annual governance statement – this will be assessed by NHSI.
- Deploy enough suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively.
- Have a systematic approach of determining the number of staff and range of skills required to meet the needs of people using the service; keeping them safe at all times.
- Use an approach that reflects current legislation and guidance where available.

As part of the safe staffing review; both the Director of Nursing and Therapies and the 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.
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 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 is still the case but may change next month in response the second wave of the COVID pandemic.

2.1 Current Situation.
Berkshire Healthcare NHS Foundation 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 demonstrates the actual and agreed staffing level on each shift.

Table 1: Current Staffing establishment, bed numbers and shift patterns April-September 2020 (from October 2020 the FTE and Planned Shift Pattern will be reviewed to reflect the increase in establishment for the mental health wards)

	Beds	FTE Establishment in budget 2019/20	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	**20**	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	weekdays 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

	Beds	FTE Establishment in budget 2019/20	Professional judgement FTE	Planned shift pattern (Early-late-night)
			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 ward manager + 0.8 matron = 60.8	13-10-7
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

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At times across a month, wards may require additional staff above what is planned within the establishment. This is to both meet patient need and the increased dependency needs of the patients. The staffing levels are reviewed daily and monthly alongside a range of quality and workforce indicators to monitor the impact and experience for patients. From October 2020 the establishments for the acute working age mental health wards will increase to reflect the agreement of the activity coordinator role on shift each afternoon across 7 days a week.

3.0 Review of staffing establishment.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tool is used to assist in the triangulation of data, alongside benchmarking and clinical judgement. It is recognised that this modelling tool uses a snapshot of dependency of patients on a given day and that dependency can fluctuate, therefore review of the tools uses collation of the daily data over a period of time (20 days) to understand the average dependency for each ward. This is an increased snapshot reporting period from previous reports.

3.1 Review using workforce modelling tool.

The 20-day review to assess staffing against acuity using the current available Keith Hurst tools has not been undertaken during this reporting period. This is due to COVID- pandemic and variable patient numbers and acuity meaning undertaking review in this period may not be reflective of on-going need.

3.2 Care Hour per Patient Day (CHPPD) Data Collection.

Lord Carter's review: 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations' (2016); highlighted the importance of the non-acute sectors in ensuring

efficiency and quality across the whole NHS health economy. One obstacle identified to eliminate 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. However, 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. 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 'outstanding'. The table below shows the CHPPD for each of the wards over this six-month period alongside nationally available data using peer and national median.

Table 2: BHFT CHPPD:

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Peer Medium	National Medium
Bluebell	9.20	9.00	8.60	9.70	7.50	7.70	10	9
Daisy	11.70	12.20	9.20	9.10	8.50	8.30	10	9
Rose	9.20	8.80	8.50	8.10	8.70	7.90	10	9
Snowdrop	9.10	8.70	6.80	8.60	8.40	9.00	10	9
Orchid	14.30	14.40	14.50	11.50	10.10	12.20	11	11
Rowan	19.00	27.00	22.40	21.60	21.30	16.90	11	11
Sorrel	21.30	31.70	21.30	20.00	21.40	20.60	19	18
Campion	26.60	27.00	27.20	31.00	57.80	70.80	28	28
Willow House	0.00	29.50	26.70	24.80	47.40	39.10	19	17
Donnington	7.00	7.70	9.30	9.00	6.90	7.50	7	7
Highclere	6.50	7.70	8.50	7.80	5.80	7.00	7	7
Oakwood	9.80	12.80	12.90	9.30	7.80	8.00	7	7
Ascot*	7.40	11.50	11.90	7.10	8.00	8.60	7	7
Windsor*	6.20	6.60	7.10	6.10	5.50	6.70	7	7
Henry Tudor	9.70	13.20	23.20	21.00	13.50	10.20	7	7
Jubilee	12.30	12.30	18.20	21.30	16.70	12.00	7	7

*Wokingham: (Windsor separated out from Ascot January 2020).

Campion Unit CHPPD data figures for September are high due to the high amount of level 2 observation (5-6 cases), patients who required 2 on 1 supervision for safety/safeguarding reasons and another patient needing 2 to 1 supervision. For this group of patients' levels of risk carries higher priority than the number of patients in the unit.

3.3 Model Hospital (November 19) National Median and Peer Median.

This data acts as a guide in terms of benchmarking for the Mental Health Wards However, it can be easily skewed if there are several 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. In addition, there is also a national variation regarding what is included within the CHPPD as the data is pulled from e-roster. This therefore includes variation in staff who feature on a ward roster including allied health professionals where they are rostered. Model Hospital data has not been updated during this reporting period due to NHS responding to COVID-19 pandemic.

3.4 Bed occupancy.

Table 3 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 3: Bed Occupancy:

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Average
Bluebell	74.10%	88.30%	94.70%	90.50%	97.50%	92.60%	90%
Daisy	59.90%	61.90%	81.80%	87.00%	98.10%	93.70%	80%
Rose	82.10%	93.00%	94.80%	97.40%	96.00%	92.40%	93%
Snowdrop	78.60%	84.60%	97.30%	94.10%	97.70%	91.80%	91%
Orchid	71.50%	77.10%	80.70%	69.00%	73.40%	87.70%	77%
Rowan	40.00%	33.20%	34.20%	39.80%	46.90%	56.30%	42%
Sorrel	84.20%	66.90%	90.00%	96.50%	92.10%	89.10%	86%
Campion	67.40%	77.80%	72.20%	66.30%	44.10%	29.60%	60%
Willow House	*14.40%	50.20%	65.60%	70.60%	38.70%	45.90%	48%
Donnington	72.70%	54.00%	59.30%	59.70%	77.60%	70.70%	66%
Highclere	63.20%	55.00%	45.30%	54.00%	76.90%	67.10%	60%
Oakwood	55.87%	62.66%	51.00%	80.90%	62.17%	84.30%	66%
Ascot	82.40%	46.60%	37.40%	80.60%	80.80%	75.10%	67%
Windsor	73.90%	85.70%	80.90%	81.60%	93.70%	86.10%	84%
Henry Tudor	52.40%	28.50%	21.40%	23.70%	44.50%	62.50%	39%
Jubilee	45.90%	26.80%	25.30%	25.90%	43.60%	63.10%	38%

*Willow house was closed until middle of April 2020 for essential work.

PPH aim is to have 90% bed occupancy; as demonstrated in Table 5. There was a reduction across PPH wards especially during April and May when the COVID pandemic affected hospital admission numbers and bed occupancy was reduced. In the previous six months all acute wards were consistently above 89%. All other areas have been lower than expected during this reporting period.

4.0 Workforce data

Several 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.

4.1. Vacancies.

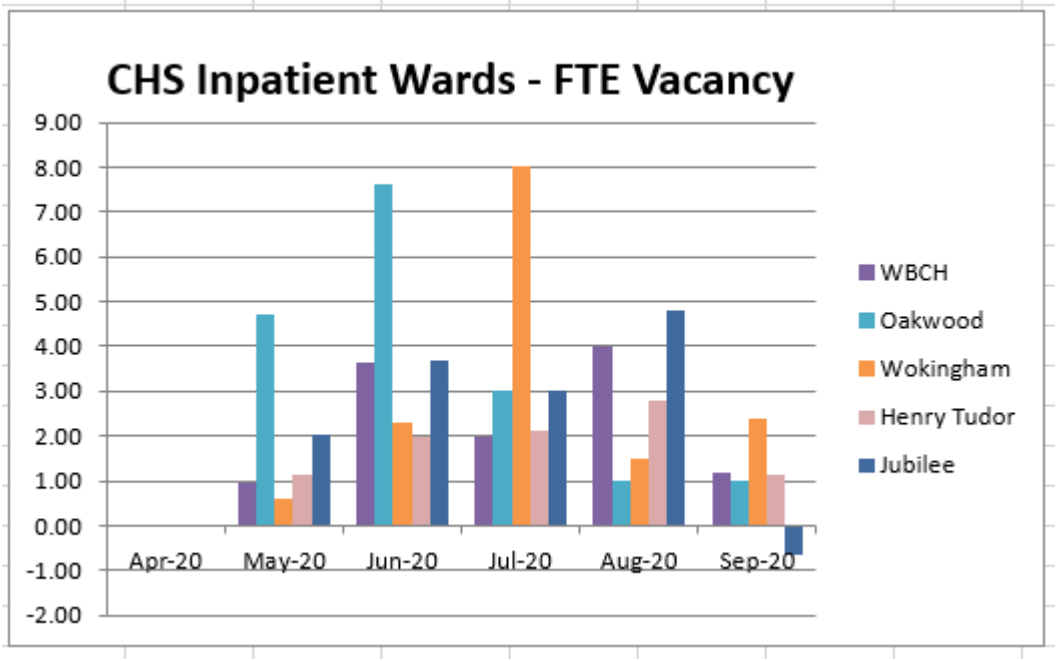
Table 6 below shows the combined whole-time equivalent vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. All wards continue to be challenged by recruitment, particularly for registered nurses. Data collection was suspended for April 2020 due to COVID therefore this demonstrated in the table below by 0 for April 2020.

Table 4: Whole Time Equivalent (WTE) vacancy of registered nursing and healthcare worker combined:

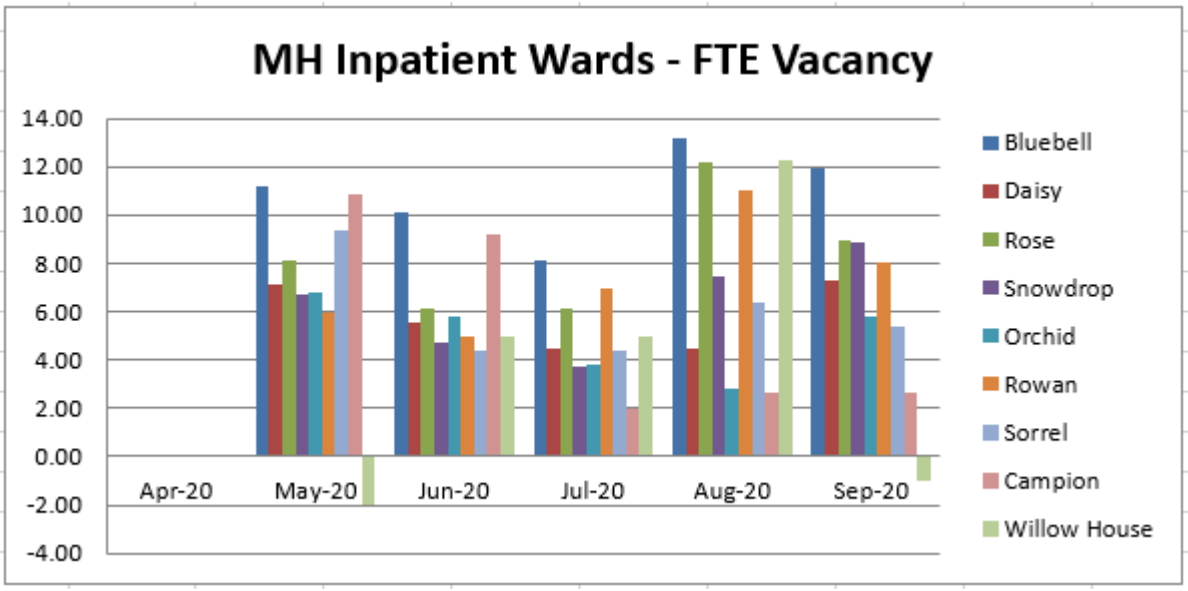
		Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
MH Wards	Registered	0.00	27.88	23.24	23.24	31.24	26.24
	Unregistered	0.00	27.46	18.50	14.50	26.20	26.00
CHS Wards	Registered	0.00	9.00	12.27	10.50	11.00	4.07
	Unregistered	0.00	0.49	6.97	7.60	3.10	1.04
Campion	Registered	0.00	3.20	3.20	2.00	0.00	0.00
	Unregistered	0.00	7.68	6.04	0.00	2.68	2.68
Willow House	Registered	0.00	-2.00	3.00	3.00	5.00	-1.00
	Unregistered	0.00	0.00	2.00	2.00	7.30	0.03

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:



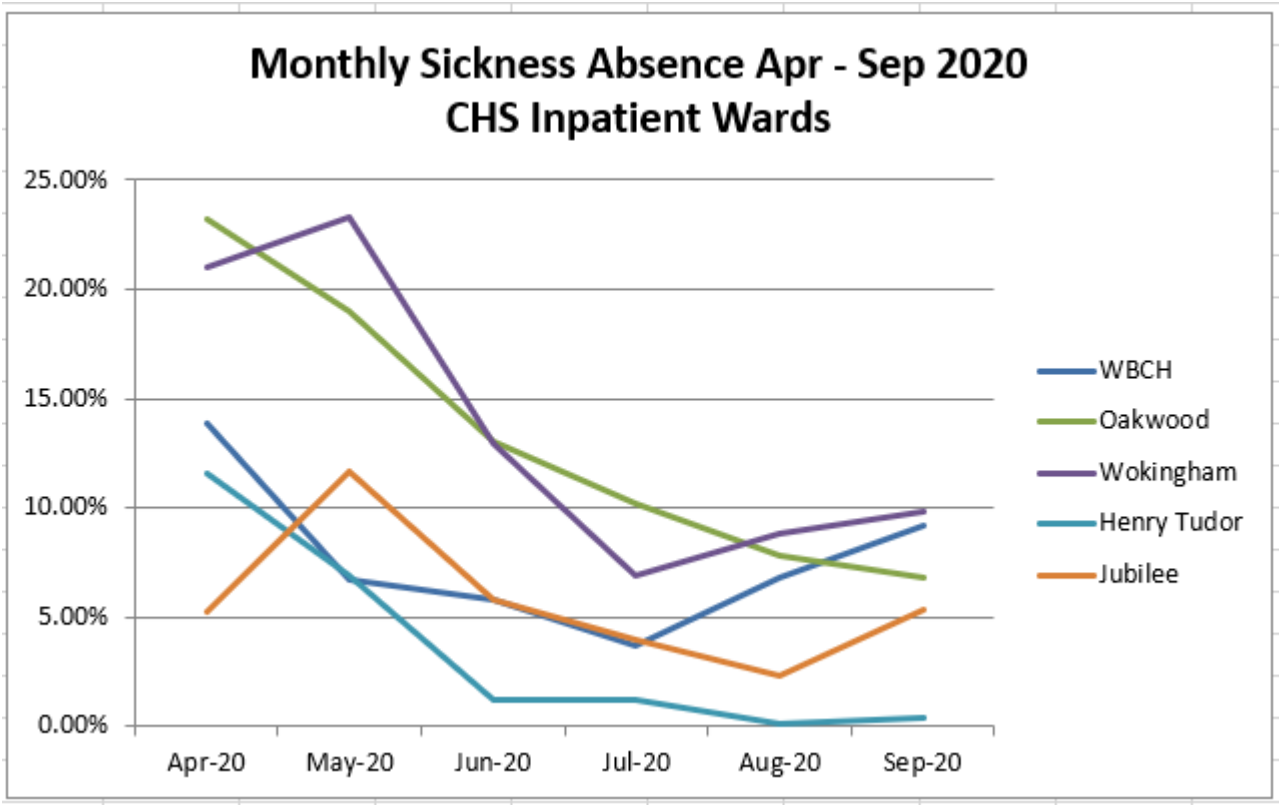
4.2 Sickness absence.

Graphs 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.

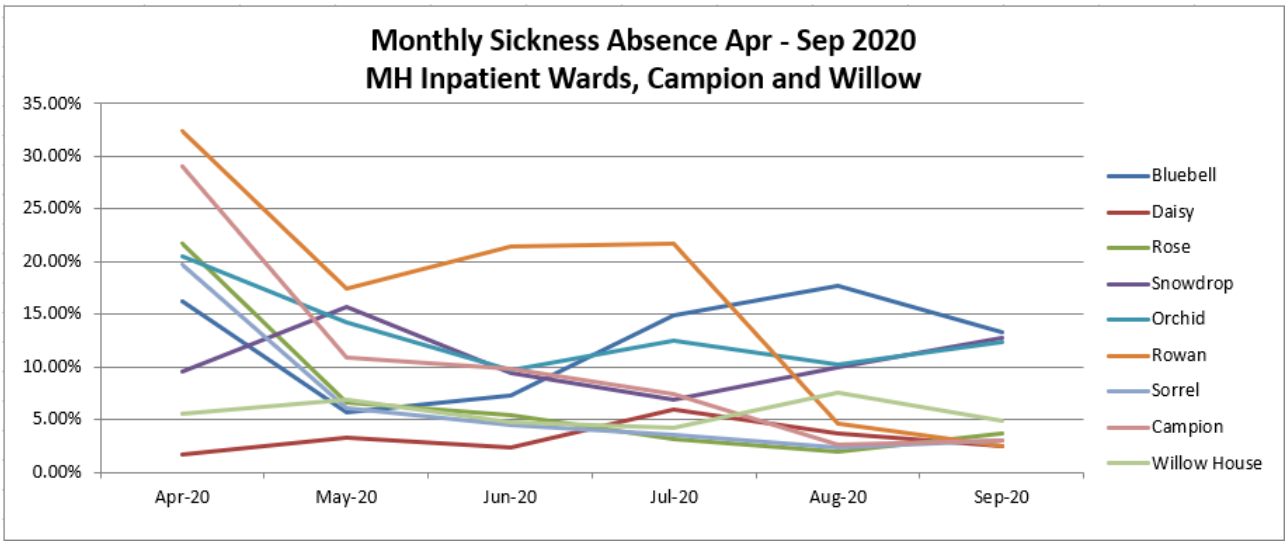
The Trust sickness absence target is 3.5% and the majority of wards exceed this at the time of this report (apart from Campion Unit, Daisy, Sorrel and Henry Tudor wards). The Trust has a sickness absence policy which with support from the Human Resources department, ensures that appropriate action is taken to support staff and managers with sickness related absenteeism.

There are several wards with a high sickness absence due to a combination of both long and short-term sickness factors. These wards are working closely with Human Resources and Occupational Health providers to ensure that appropriate support is offered, and action being taken. A Health, Wellbeing and Engagement Manager is now in post to support actions aimed at reducing sickness absence. In addition, several new initiatives have been introduced to address both physical and mental health care needs of staff. These can be accessed via Nexus the Trust internet site. During the COVID pandemic, as demonstrated in the graphs there was high levels of sickness across the wards, in addition there were some staff members who were shielding or self-isolating for differing reasons. Many of these were working from home. Staff were supported via regular one to ones and meetings via teams with colleagues and managers. In addition, they were given information on how to access the support systems especially in relation to mental wellbeing as it is seen to be beneficial especially for those individuals working in isolation.

Graph 3: Sickness absence for wards as a percentage of total ward staffing (Community Wards):



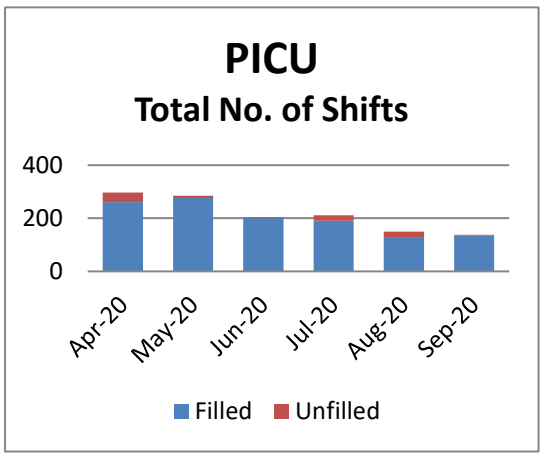
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Mental Health, Wards, Learning Disability and Willow House):

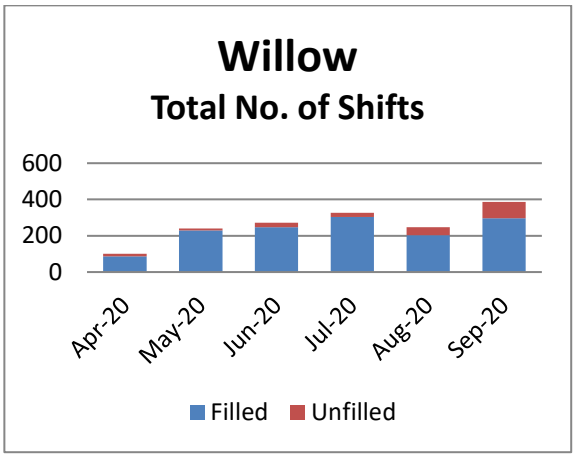


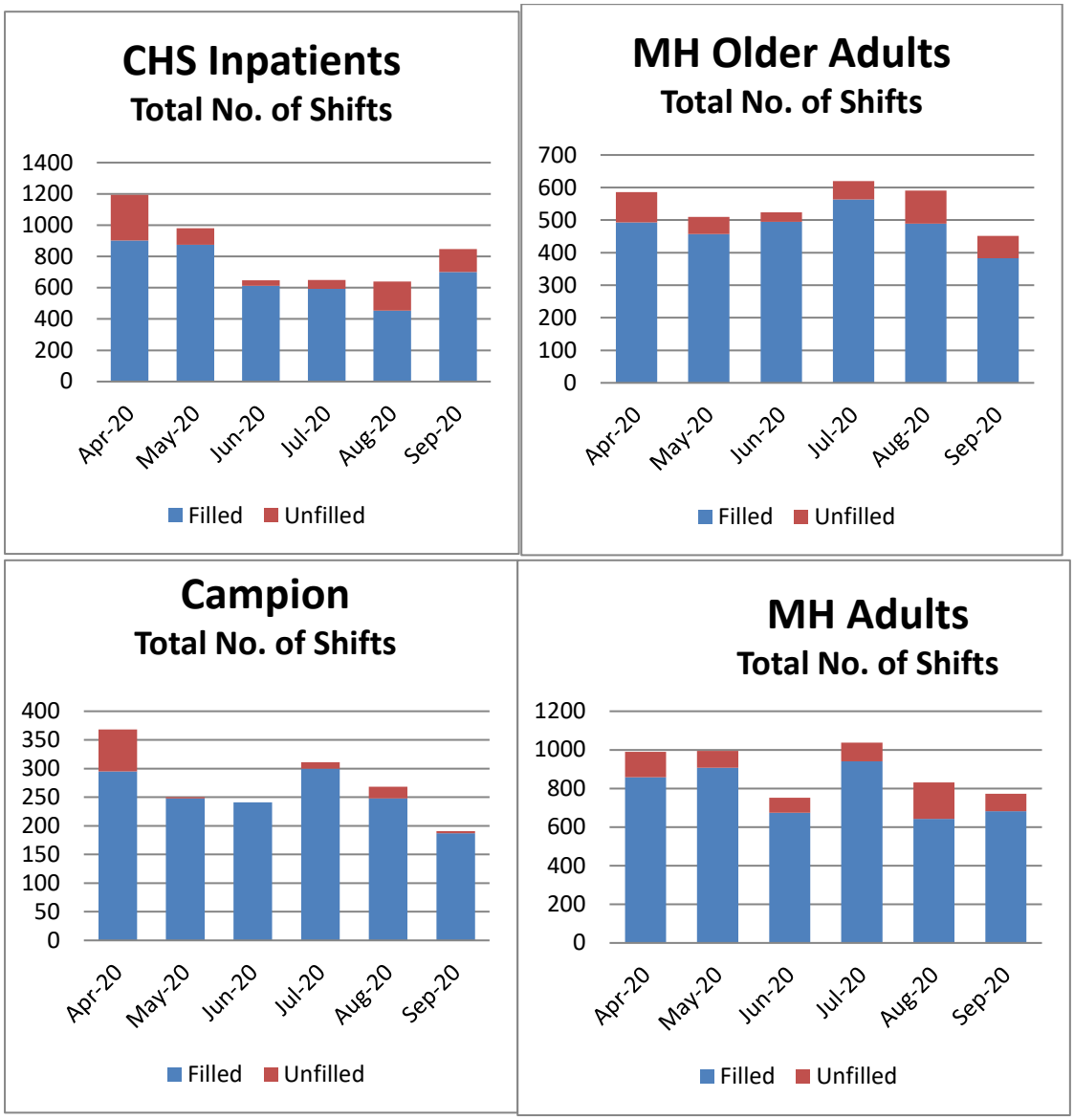
4.3 Temporary staffing.

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 of care. 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 had difficulty in filling required shifts.







5.0 Displaying planned and actual registered and care staff on the wards.

All the wards within the trust have a display board which shows the number of staff that the ward had planned to have on shift and the number of staff on shift. This is clear to visitors to the ward as to the number of registered nurses and care staff on the ward at the time. The nurse in charge of the shift portrayed so that visitors can identify who to contact if they have a concern or want to speak to them. These boards are monitored during quality visits to individual wards throughout the year by senior managers to ensure they are current.

6.0 Safety on our wards.

The NHSI in its workforce safeguarding recommendations recommends 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 the Care Quality Commission's (CQC) fundamental standards. Therefore, it is just as important to have the appropriate staff

capability alongside the number of staff to ensure that they can deliver a safe and quality service to all patients.

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 discussions are held with senior staff from each ward area to discuss staffing data along with the listed 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 recommenced in April 2020 following a break in March 2020 to focus on the management of COVID 19.

Table 5: Quality metric for mental health inpatient wards (April to September 2020):

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	15	1	14	20	8	11	71
Daisy	12	4	21	22	1	11	11
Rose	9	7	15	17	1	5	13
Snowdrop	18	5	15	30	6	4	51
Orchid	1	8	1	6	0	0	0
Rowan	0	5	16	18	1	0	0
Sorrel	6	5	15	28	3	52	18
Campion	0	0	17	30	0	13	2
Willow House	8	0	1	4	4	6	80
Total	**69**	**35**	**115**	**175**	**24**	**102**	**246**

* correct at time of report

There has been an overall decrease in incidents reported during this period compared to the previous six months. This could have been affected by COVID 19 and the reduction in admissions

/ reduced bed occupancy over this time. However there has been an increase in incidents of prone restraint and seclusion. This is possibly due to higher levels of patient acuity.

Table 6: Quality metric for community physical health inpatient wards (April to September 2020):

Ward	Drugs	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	21	17	14	1
Highclere	9	11	3	0
Oakwood	18	19	4	2
Wokingham	30	27	5	2
Henry Tudor	14	10	5	0
Jubilee	10	3	1	1
Total	**102**	**87**	**32**	**6**

* correct at time of report

There has been a decrease in incidents reported during this six-month period (297 to 227). This is possibly due to the decreased level of occupancy in the community wards. Pressure ulcer desk top reviews and learning events are a new approach to ensure learning is shared within teams across the Trust. This ensures information is disseminated. 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; 2014 and 2018).It has been well documented that a shift with less than two registered staff on duty should be perceived as a red flag incident.

Table 7 demonstrates the number of occasions by ward and month where there were 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 provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and able to take an overview of the wards and redeploy staff to areas of most need as necessary.

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):

	Apr-20		May-20		Jun-20		Jul-20		Aug-20		Sep-20		Total for ward	%
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night		
Bluebell	12	5	3	1	7	3	8	7	2	7	8	7	**70**	**19.12%**
Daisy	2	3	0	0	0	0	0	1	0	0	7	0	**13**	**3.55%**
Rose	14	3	2	1	4	0	1	0	8	0	6	0	**39**	**10.65%**
Snowdrop	2	1	0	0	0	0	0	0	1	1	0	0	**5**	**1.36%**
Orchid	5	8	2	1	1	2	0	1	3	1	5	0	**29**	**7.92%**
Rowan	12	6	1	2	3	2	2	4	5	5	1	1	**44**	**12.02%**
Sorrel	0	0	0	0	0	0	1	0	0	0	2	1	**4**	**1.09%**
Campion	0	0	0	0	0	0	5	0	0	0	0	0	**5**	**1.36%**
Willow House	0	1	0	0	3	1	2	1	3	2	0	0	**13**	**3.55%**
Donnington	0	0	0	2	0	0	0	1	0	0	11	2	**16**	**4.37%**
Highclere	4	15	0	7	1	3	6	5	12	4	9	3	**69**	**18.85%**
Oakwood	0	2	0	2	0	0	0	0	0	0	0	0	**4**	**1.09%**
Ascot	5	7	14	12	23	13	2	0	0	1	1	0	**78**	**21.31%**
Windsor	0	6	0	2	0	0	0	0	0	0	0	0	**8**	**2.18%**
Henry Tudor	4	3	11	0	3	0	2	0	1	2	0	0	**26**	**7.10%**
Jubilee	0	0	12	5	18	0	5	6	0	0	0	0	**46**	**12.56%**
Total for month	**120**		**80**		**87**		**60**		**58**		**64**		**469**	

For the community wards there were higher numbers of shifts with only 1 registered nurse on duty, however at these times the bed occupancy was much lower than usual and it was on many occasions assessed that the ward was safe with only 1 member of staff on Ascot ward where assistance could be obtained from Windsor ward if required. For Jubilee ward during April and May the ward had very low patient numbers of less than 5 patients at times meaning that it was assessed that 1 member of registered staff was enough.

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 the publication of Developing Workforce Safeguards (NHSI, 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 continued rely on a high number of temporary staff to meet patient need over the reporting period although this as reduced since the last 6-month reporting period

and there has been some successful recruitment. Whilst there was no correlation between staffing levels and patient safety incidents, there is, limited assurance that care was always of a high quality and it is possible that patient experience was compromised due to use of temporary staffing. The staffing review indicates that the agreed establishments with flexibility to meet additional patient need through temporary staffing is appropriate and further substantive recruitment will improve quality and experience further.

The community wards all had lower bed occupancy within the period of April to September 2020. In addition, redeployed staff assisted in covering required shifts during wave 1 COVID pandemic and as a result the need for temporary staffing was reduced. Higher sickness rates and excess levels of annual leave in August contributed to the increased level of requests for temporary staffing in the West Berkshire Community Hospital wards. 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 until mid-April 2020. Willow House has been declared as causing some concerns throughout this reporting period due to the high number of registered nurse vacancies. The occupancy level is currently capped at 50% for this reason. There appears to be potential correlation between the high numbers of temporary staff used on a shift and an incident during the reporting period, this was reported and investigated as a serious incident.

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.

Medical staffing numbers remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards.

Out of hours medical cover is provided by GPs for all our community health wards and Campion Unit.

Out of hours medical cover is provided by junior doctors for the 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, whereby 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 with localities providing cross cover when able. 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 enough to meet demand. Unable to accept any new referrals.

Table 8: Community Nursing actual staffing against current agreed WTE establishment:

Locality	April	May	June	July	August	September
West Berks	83.1%	81.1%	94.4%	96.2%	99.8%	96.4%
Reading	85.5%	92.9%	79.2%	72%	76.6%	78.9%
Wokingham	94.4%	97%	97.7%	90.6%	91%	97.1%
Bracknell	94.3%	103.1%	101%	103.5%	109.5%	107.4%
Windsor & Maidenhead	81.2%	89.3%	97%	89.1%	88%	91%
Slough	93.3%	97.2%	96.7%	92.9%	97.8%	97.4%

The RAG rating for community nursing is based on staffing levels and does not include the additional unpaid hours that staff work to meet demand and work is on-going to review staffing requirements. Although Reading locality figures portray staffing as having less than 25% reduction; professional judgement regarding patient acuity has been used to RAG rate them as amber on the last 3-month reports.

The focus on recruitment and retention within community nursing has had a positive impact on staffing levels with all localities apart from Reading, being at over 90%. This has improved from the previous 6 months when only 2 localities achieved that figure. In June there were 19 staff going through employment checks and the resourcing and retention team are proactive in sending new applications through to the localities.

9.0 Nursing Associates.

The Nursing Associate (NA) role is a new nursing role which has been created due to the inability to recruit enough registered nurses. In addition, it will bridge the skills gap between healthcare support workers and registered nursing professionals. It is 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 workforce development within the Trust. Qualified NAs are registered with the Nursing and Midwifery Council (NMC).

There are now 17 qualified NAs working in a range of services (community nursing, community mental health teams, community health wards). Cohort 2 qualified at end of June (they were fast tracked to be able to register earlier than planned due to the Covid-19 pandemic). 13 trainee NAs are at different stages of their training across all services from Cohort 3, 4 and 5 (plus one from cohort 2). The Trust has recently recruited 3 trainees to the September 2020 cohort. This makes a total of 16 trainees across the Trust.

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 March 2021 across all inpatient areas using agreed national toolkits.

- Continue with focused recruitment plans which have achieved some positive results in securing new staff, particularly third year students. Support the preceptorship programme to ensure preceptee fell confident to fulfil their role on the wards.

- Continue with the recruitment of activity coordinator role on all the acute mental health wards following the successful pilot on Snowdrop ward.

- Support the Nurse Associate pathway and recruitment post qualifying.

- Develop a tool to measure community nursing patient dependency.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board	10th November 2020
Title	Delivery of the 2020 Flu Campaign - Board update November 2020
Purpose	To provide an update to the Board on progress against this years flu campaign
Business Area	Nursing and Governance
Author	Debbie Fulton; Director Nursing & 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
Equality and Diversity Implications	None
Summary	On 24th July 2020 the Department of Health and Social Care announced the expansion of the annual flu vaccination programme to support plans to ''ready the NHS – both for the risk of a second peak of coronavirus cases, and to relieve winter pressures''. Importantly for our staff, the announcement included the ask for all frontline workers to take up the offer of a free flu vaccination. The ask is that this year's NHS workers flu vaccination programme is completed by end November. The paper includes the operational delivery and communication plan alongside current progress. As of 28th October, **36% total staff (1550 staff)** have had their flu jab this includes **34% of clinical staff (1128 staff).** This year's uptake has been slower than expected (and compared to previous years) despite promoting the need to receive the vaccine, making available multiple ways of obtaining it and all professional bodies being very clear regarding the expectation around flu vaccination. The paper details additional promotional initiatives that are currently being deployed to increase uptake. The healthcare worker flu vaccination best practice management checklist required to be submitted to the Board and NHSE/I for public assurance on delivery of the trusts flu programme is attached to the paper.
Action	The Board is asked to: note the report and the further actions to promote uptake. The Board is also asked to note the attached completed assurance checklist.

Berkshire Healthcare
NHS Foundation Trust

Delivery of the 2020 Flu Campaign
Board update November 2020

1. Introduction

On 24th July 2020 the Department of Health and Social Care announced the expansion of the annual flu vaccination programme to support plans to ‘’ready the NHS – both for the risk of a second peak of coronavirus cases, and to relieve winter pressures’’, covering a wider cohort of people than in previous years

Importantly for our staff, the announcement also included the ask for all frontline workers to take up the offer of a free flu vaccination. Over the last few years within Berkshire Healthcare we have achieved an uptake of around 70% frontline staff; to achieve 100% of all Berkshire Healthcare staff being vaccinated (clinical and non-clinical) requires a further 1000 staff to be vaccinated.

During week of 26th October all providers were advised of the revised ask to have their flu vaccination programmes completed by end November.

Currently uptake this year has been slower than had been expected (and compared to previous years) despite promoting the need to receive the vaccine, making available multiple ways of obtaining it and all professional bodies being very clear regarding the expectation around flu vaccination. This appears in part to be as a consequence of so many staff working remotely and therefore it being less easy for peer vaccinators to encourage staff whilst they are on site and visible and also less chance for colleagues to support with uptake in the same way as when everyone is sharing the same physical space. The campaign has, as in previous years been widely promoted using a variety of media platforms / communication channels and as detailed within the paper other promotional ideas are currently being deployed to increase uptake.

2. Operational Delivery Plan

Communication strategy

Over the last few months, we have had regular briefings in Team Brief, screensavers, information to the Directorate flu champions and through the Live Team Briefing to staff. The

Nexus staff flu information is maintained and updated regularly. The communications team has worked closely with the campaign leads to support the delivery of the clinics booking systems and IT detail.

In addition to further improve uptake given the challenges that we are experiencing we are taking additional actions including:

- Understand barriers by carrying out a quick poll in Team Brief on 28th October; asking staff about barriers to getting their flu jab to help us mitigate these where possible.
- Further promoting 'Get a jab, give a jab' for Oxfam in Team Brief, on screensavers – help staff to feel they are making a difference to someone else who doesn't have the same opportunity.
- Looking to share photos from the clinics – particularly the drive thrus – to reassure staff, to help them navigate and remove any concerns – also demonstrates the extra lengths we're going to this year to help staff get their jab.
- Prospect Park are promoting friendly competition and the ward with highest uptake will receive some assistance to improve their staff room
- Some teams are using their QMIS/ huddles for example the Team Lead in Slough Community nursing ahs raised a ticket around encouraging the whole team to get a flu jab
- Use of Gemba visits to encourage uptake
- Looking with marcomms as to how we can target messages to those working from home to highlight the routes available, how easy they are etc.
- Using teams' live event on 4th November for 2 staff to share their experiences of having flu
- All senior leaders promoting the messages around 'why haven't you had your jab' rather than 'have you had your jab'

Delivery of the campaign

Consideration to Covid-19 regarding social distancing when delivering the flu vaccination has been key. With the booked clinic appointments and drive thru's at both Ascot Racecourse and West Berkshire Community Hospital, to enable social distancing to be maintained at all times.

The ward and District Nursing peer vaccinators continue to vaccinate their teams locally, allowing for some flexibility on timings for individuals shifts.

Vouchers are also available for those who would find receiving their vaccine at a local pharmacy a better option; although pharmacies have experienced challenges in procuring vaccine this year, they are all expected to get further stocks in first half November.

As in previous years all board members are expected to have the vaccination and the clinic for the board took place at the end of September. Monthly reporting on vaccination uptake will be provided to the Board and made public throughout the campaign.

Vaccination supply / logistics

- The vaccine delivery has been split into four tranches, the first and second planned delivery arrived by the end of September.
- Further vaccine has been requested through the regional pharmacy lead to allow for 100% of staff being vaccinated.
- Vouchers are also being used for those that prefer to receive their vaccination at a local pharmacy and further vouchers can be procured mid campaign if required.

3. Progress

The campaign commenced at the end beginning October and as indicated in the introduction has been slower than had been expected. As of 28th October, total uptake was 36% (1550 staff vaccinated) with Clinical uptake 34% (1128 staff vaccinated.

	CYPF	Corporate	MH East	MH West	MH inpatients	Other health services	CHS East	CHS West
Baseline	642	625	230	933	306	169	602	938
Actual	228	238	63	255	112	68	248	343
Percentage	**35.5%**	**38.1%**	**27.4%**	**27.3%**	**36.6%**	**40.2%**	**41.2%**	**36.6%**

Staffing figures split by clinical/ non-clinical staff

	CYPF	Corporate	MH East	MH West	MH inpatients	Other health services	CHS East	CHS West
Baseline clinical	525	124	161	765	281	164	508	740
Actual clinical	185	53	42	207	99	63	201	278
Percentage	**35.2%**	**42.7%**	**26.1%**	**27.1%**	**35.2%**	**38.4%**	**39.6%**	**37.6%**
Baseline admin	117	501	69	168	25	5	94	198
Actual admin	43	185	21	48	13	5	47	65
Percentage	**36.8%**	**36.9%**	**30.4%**	**28.6%**	**52.0%**	**100.0%**	**50.0%**	**32.8%**

Debbie Fulton
Director Nursing & Therapies
30th October 2020

Appendix: Healthcare worker flu vaccination best practice management checklist

For public assurance via trust boards by December 2020

A	Committed leadership	Trust self-assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Y
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Y
A3	Board receive an evaluation of the flu programme 2019/20, including data, successes, challenges and lessons learnt	Y
A4	Agree on a board champion for flu campaign	Y
A5	All board members receive flu vaccination and publicise this	Y
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Y
A7	Flu team to meet regularly from September 2020	Y
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Y
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Y
B3	Board and senior managers having their vaccinations to be publicised	Y
B4	Flu vaccination programme and access to vaccination on induction programmes	Y
B5	Programme to be publicised on screensavers, posters and social media	Y
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	Y
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Y
C2	Schedule for easy access drop in clinics agreed	Y
C3	Schedule for 24 hour mobile vaccinations to be agreed	Y

D	Incentives	
D1	Board to agree on incentives and how to publicise this	Y
D2	Success to be celebrated weekly	Y

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	10th November 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. This has subsequently been updated on 15th October 2020 (attached). 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 previous version of the assurance framework has been reviewed by CQC and NHS England/Improvement; with no concerns raised.

	Review of our current processes against the framework does not demonstrate any 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. This includes on-going support and messaging around hand-space-face messaging for all staff. 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

Publications approval reference: 001559

Infection prevention and control board assurance framework

15th October. Version 1.4

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, PHE and related guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have 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.

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.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating

and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively.

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 (V4 31/07/2020) includes requirements for admission screening and 5-7-day screening. SOP also reflects PHE guidelines in investigation and initial clinical management of possible cases, management of staff and exposed patients and residents in health and social care settings and guidance for stepdown of infection control precautions within hospitals and discharging COVID-19 patients from hospital to home settings 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) Audit of admission screens undertaken by IPCT with results of audit feedback to wards. Checklist for OPD/ Clinic services implemented including Rio and paper version introduced September 2020 in line	MH services to review and assessment to include patients on leave; consideration on how long away from the setting, where they have been, whether they have been able to maintain social distancing and whether they have worn a face covering. For all periods of overnight leave, a COVID-19 test should be taken MH wards not achieving over 90% compliance with swabbing	RIO alerts being used to support. Wards introducing swab form process including user guides as part of standard work and Hanover to ensure swabs undertaken. Guidelines and competence for swab taking recirculated to all wards

	with remobilisation guidance. Instructions disseminated to clinical teams Identification of risk category for services in high, medium or low pathways undertaken. All patient facing services in medium risk pathway, moving to high risk pathway of symptomatic or confirmed cases identified. Low risk pathways assigned to virtual consultations		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission	Covid-19 inpatient isolation and cohorting SOP (V4 31/07/20) Individual ward guidelines for management of patient pathways aligned to inpatient isolation & cohorting SOP being developed Risk assessment document developed for all wards to complete Review of positive cases by Infection prevention and control Team with advice on management provided Screening of patients at day 14 post onset symptoms/ + test result prior to transfer both internally and to care homes.	All inpatient wards to complete for sign -off by chief Operating Officer/ Medical and Nursing Directors In progress but not yet completed for all wards	
• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	All patients being transferred to care homes are swabbed prior to discharge Patient advice letter following contact with confirmed case Compliance with Letter from Tom Surrey, Director for Social Care Quality DHSC re. Winter Discharges - Designated Settings issued 14.10.20	Waiting confirmation of designated homes within Berkshire to enable dissemination of information	

• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice	Resource pack available and disseminated to all wards / services ICP Compliance tool completed monthly and provided to divisional PSQ PPE competence tool for all staff – check at beginning each shift that all on duty have completed; Spreadsheet of all competed assessments held by ward Posters and signage to support compliance Patient equipment monitoring being undertaken by IPCT for inpatient units.		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
• monitoring of compliance with PPE, consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	PPE competence document for all staff – check at beginning each shift that all on duty have completed Spreadsheet of all completed assessments held by wards IPC compliance tool undertaken by inpatient and community services Ad hoc IPC support calls/ meeting with clinical services	Currently no guardians or safety champions in place.	Currently being explored through wave 2 planning along with other communication strategies to support staff confidence in challenging poor practice
• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase	Information available to staff Around Access to both Pillar 1 and 2 testing. Pillar 21 testing available for all symptomatic staff seeing patients face to face and their households. Process in place to source staff testing in areas of outbreak Monitoring of all results by IPC team to flag outbreaks / healthcare transmission Use of intranet/ staff briefings and newsletters to support staff knowledge of self -isolation requirements		

• training in IPC standard infection control and transmission-based precautions are provided to all staff	Mandatory IPC training for clinical staff Updated IPC training presentation completed October 2020 including recorded version for teams to undertake. IPC mandatory training compliance reviewed monthly and included in IPC monthly reports Resource IPC resource pack available for all this includes standard/ transmission-based precautions as well as PPE related information and guidance	Ensuring that all non-clinical staff use resources and training opportunities available	
• IPC measures in relation to COVID-19 should be included in all staff Induction and mandatory training	Updated IPC training presentation completed October 2020 including recorded version for teams to undertake. This presentation is used for mandatory training and induction training		
• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Newsletter/ teams live events/ posters/ intranet / screen savers all used to promote mask- hand hygiene and social distancing		
• 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	COVID -19 PPE page on Nexus links to updated guidelines Posters demonstrating how to Don and Doff and mask and other PPE available for all staff. this was disseminated through newsletters as well as being available on Nexus		

the appropriate setting and context as per national guidance	Individual staff PPE competence checklist provided to clinical services for local use. – register of assessments completed held by wards Monthly compliance tool completion for all clinical areas supportive calls for train trainer provided by IPCT to support those returning to F2F contacts as part of recovery Visits to clinical teams by IPCT 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 IPC mandatory training video and resources produced for induction and redeployed staff IPC resource pack produced for all staff to use that collates all the available support documents/ videos - this has been shared in newsletter and direct with Clinical Directors for dissemination	Assurance of compliance and competence tool use at service level Ongoing challenges with individual compliance in non-clinical and clinical settings	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ Frequent reinforcement of messages through newsletters/ teams live/ service visits/ posters and local processes
• national IPC 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 Trust wide 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. Nexus dedicated space for all IPC and COVID-19 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 Compendium /local record of national guidance and required actions in place and updated as new guidance published		
• changes to guidance are brought to the attention of boards and 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		

	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 IPC BAF reviewed at Quality &Performance Executive Group, Quality Assurance Committee and submitted to board July 2020 and NHSE w/c 3rd August 2020. updated BAF to October QPEG and November Board		
• risks are reflected in risk registers and the board assurance framework where appropriate	COVID -19 risk added to Board assurance, reviewed at Board.; Audit committee 15.6.20 - New Corporate risk (Nosocomial infection) added to corporate risk register submitted to board and Audit committee July 2020, QAC received August 2020 September 2020 - COVID-19 BAF and CRR updated		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC policies IPC routine surveillance Post infection reviews IPC monthly report presented to QPEG Quarterly shared learning reports Quarterly Datix review of IPC incidents Policy review programme		
• that Trust CEOs or the executive responsible for IPC approve and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate	Process in place for Medical / Nursing Director sign- off of daily submissions in relation to healthcare acquired (post 8 day) cases following review by IPC teams		

measurement and testing of patient protocols are activated in a timely manner.			
• ensure Trust Board has oversight of ongoing outbreaks and action plans.	Discussion at Gold steering group this has executive representation. Executive attendance at any outbreak meetings convened following identification of more than 1 post 8 day linked case Information provided to Board through Executive Director Nursing		
2. Provide and maintain a clean and 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 are assigned to care for and treat patients in COVID-19 isolation or cohort areas	Covid-19 PPE training resources available on intranet/ as a resource pack Risk assessment document for all wards to complete - this includes ensuring all appropriate measure in place PPE competency document - completed for all clinical staff with process in place to check at start of shift that all staff on duty have completed PPE videos for donning & Doffing disseminated to teams and available on intranet PPE posters on team net and printed copies made available to services	Risk assessment document completion in progress	

	Support visits by IPCT, DN & DDN as well as local managers and clinical leads. Sampling guidelines include swabbing technique and competency checklist IPCT mandatory training video and resources produces for induction and redeployed staff (updated October 2020) 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 PPH included questions around PPE and managing COVID in standard work and handovers Trust Isolation and cohorting SOP for inpatient units & individual ward guidelines FIT testing in place for staff that may undertake AGP as part of their clinical work		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas	In -patient wards have designated cleaning teams Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE / I • 01 Cleaning Process COVID 19 within 1 metre of patient • 02 Cleaning process COVID 19 High risk units where AGPs being conducted		

	• 03 Cleaning Process COVID 19 cohort no patient contact • NHS Cleaning and Decontamination Training - Covid-19 (Coronavirus) These documents are available electronically and in a printed format to all relevant teams		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other 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		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
• increased frequency at least twice daily of cleaning in areas that have higher environmental contamination rates as set out in the PHE and other national guidance	Inpatient SOP E&F cleaning and environmental SOP Cleaning schedules in place which include enhanced twice daily cleaning requirements Wipes and cleaning products available for staff to use on desks / workstations in non-clinical areas	Assurance required regarding twice daily cleaning of all sites with clinical activity Confirmation that twice daily cleaning of PFI sites required	EFM Director supporting to ensure that this is in place
• 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	E&F cleaning and environmental SOP EFM monitoring of wards has continued throughout this period Chlorclean used Monitored as part of inpatient IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy		

control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses			
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products as per national guidance	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Staff have all been trained in the use of Chlorclean as per National standards of cleanliness and the Healthcare cleaning manual Guidance for safe use including storage of Chlorclean included in IPC mandatory training and information posters available in clinical areas/ Nexus.		
• 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails should be decontaminated more than twice daily and when known to be contaminated with secretions, excretions or body fluids • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards should be cleaned a minimum of twice daily • rooms/areas where PPE is removed must be	Monitored as part of inpatient IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy Cleaning schedules in place to include enhanced twice daily cleaning requirements Touch points – doors/handles and handrails 4 times per day in patient areas. Staff information on keeping safe at work including desk space clean and clutter free, cleaning of devices etc.		

decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)			
• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken	IPC compliance tool ICC020 Management of Linen and Laundry Standard Operating Procedure for Placement of Covid-19 Inpatients NHSE / I SOPs for EFM in place - 13. Linen and laundry Process COVID19 within 2 metre of patient - 13. Linen and laundry Process COVID19 high risk areas - 13. Linen and laundry Process COVID19 not within 2 metre of patient - COVID 19 Linen and Laundry policy Linen Handling and Disposal Monitoring undertaken in July 2020 in line with IPC annual monitoring programme		IPC compliance tool is being undertaken by inpatient wards and clinical services monthly. 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		Clinical Directors to have process for assuring compliance from services within their Directorates and through already

			established meetings such as PSQ
• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance	Ward equipment cleaning schedules IPC compliance tool SOP for cleaning of reusable goggles ICC026 Environmental/Equipment Cleaning and Disinfection Policy Patient equipment monitoring (inpatient units) part of IPC annual monitoring programme being undertaken in Q3		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
• ensure cleaning standards and frequencies are monitored in non- clinical areas with actions in place to resolve issues in maintaining a clean environment	All areas monitored as in line with frequency - Healthcare cleaning manual. Spot checks have been increased EFM national SOPs for cleaning, catering, estates and portering circulated to all staff. Reminders sent to managers.		
• ensure the dilution of air with good ventilation e.g. open windows, in admission and waiting areas to assist the dilution of air	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 with reminders through COVID newsletters including heatwave advice for staff September 2020 - review of fan use - allowed in non-clinical areas, 2 metre social distancing and mask wearing must be maintained in shared office spaces	All staff to be advised to keep windows open in waiting areas where possible	Draft national ventilation guidelines under review by EFM
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before	**Review undertaken and No patient facing clinical areas within BHFT have ben assessed as being in low risk pathway**		

choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants			
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 process are in place to ensure:			
• arrangements around antimicrobial stewardship is 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 with guidance circulated to wards. This includes ensuring ability to contact trace visitors if required and checking for any COVID related symptoms and other restrictions such as those needing to self-isolate prior to visiting Guidance provided to wards to support visitors for end of life patients in line with national guidance 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 use outside spaces where possible. IPAD for promoting virtual visiting in place for all wards		
• areas in which suspected or confirmed COVID-19 patients are being treated in areas clearly marked with appropriate signage and have restricted access	Isolation signage Covid-19 inpatient isolation and cohorting SOP		

• 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 information reminding visitors and patients attending appointments to use face coverings in place 08.09.20 – updated checklist, information sheet placed on intranet and internet; SMS updated, and information sheet provided to all receiving an appointment letter		
• 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. Monitoring of IHTF part of IPC annual monitoring programme and being undertaken during Q3 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		
• there is clearly displayed and written information available to prompt patients' visitors and staff to comply with hands, face and space advice.	Signage available in clinical areas Signage available in public areas including waiting rooms and toilets and at entrances Written information to patients who receive written OPD letters		

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**
• screening and triaging of all patients as per IPC and NICE Guidance within all health and other care facilities must be undertaken to enable early recognition of COVID-19 cases	This guidance is for planned and elective care (elective surgery and other planned treatments and procedures (including diagnostics and imaging). Dental team reviewing updated guidelines for recommencing planned surgery/ treatment. All clinic setting have checklist for use to screen patients just prior to on arrival		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from Non COVID- 19 cases to minimise the risk of cross-infection as per national guidance •	Trust does not have an A&E admission are generally planned unless admission through Place of safety. Covid-19 inpatient isolation and cohorting SOP – this includes cohorting of possible and confirmed cases away from patients who are asymptomatic waiting results and those with negative result		
• staff are aware of agreed template for triage questions to ask	Template triage tool circulated through email, newsletter and PPE clinical reference group. Also available electronically on RIO.		
• triage undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible	Admission triaging by accepting clinician Admission and cohorting inpatient SOPs (ward specific)		Assurance gained through divisional patient safety and quality meetings
• face coverings are used by	Signage at entrances		

all outpatients and visitors	Masks, hand gel and bins available at entrances Patients reminded of need to wear face coverings		
• face masks are available for patients with respiratory symptoms	Masks available		
• provide clear advice to patients on use of face masks to encourage use of surgical facemasks by all inpatients in the medium and high-risk pathways if this can be tolerated and does not compromise their clinical care	Need to complete risk assessment included in ward risk assessment template	Risk assessment currently being carried out by wards around wearing of masks for symptomatic patients	
• ideally segregation should be with separate spaces, but there is potential to use screens, e.g. 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 Use of triage tool prior to or on attending appointments enabling staff to risk assess placement of patient where appointment necessary Virtual consultation to remain default where possible UTC provide swabbing facility as drive through to mitigate risk or transmission. SOP in place for this process EFM review of all sites as part of recovery process and screens/ partitions provided where appropriate		
• for patients with new-onset symptoms, isolation, testing and instigation of contact	Inpatient SOP details need	Need to ensure embedded in practice	

tracing is achieved until proven negative	Information to wards to remind them of prompt isolation and testing Included as part of handover/ standard work		
• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly •	Isolation policy Covid-19 inpatient isolation and cohorting SOP IPCT daily review of cases Routine IPC surveillance Information to wards to remind them of prompt isolation and testing Included as part of handover/ standard work		
• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Triage tool used on arrival or prior to attendance All patients treated as potentially positive with appropriate PPE worn The CMHT's are triaging ahead of appt IPC mandatory training & resource pack cover management of symptomatic patients		

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their 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:			
• separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas	Where high volume of activity exists separate entrances and exits are provided with signage to encourage one-way flow or to walk on one side of a corridor. Trust is providing significant levels of activity virtually removing the necessity for physical visits As part of the Trust recovery process departments are required to consider how to maintain social distancing at all points of the physical journey. Arrangements include asking patients to remain in their vehicle until their appointment time and being collected by service staff rather than using the waiting room		
• all staff (clinical and non-clinical) have appropriate training, in line with latest national guidance to ensure their personal safety and working environment is safe	Posters/ newsletters / teams live events and screen savers used to disseminate information including hand - face space messages Handovers used on Inpatient areas IPC training resource pack available and updated IPCT Mandatory training presentation updated to reflect remobilisation guidelines. Recorded version available.		
• all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to Don and Doff it safely	PPE videos for donning & Doffing included within IPC resource pack PPE competency for all clinical staff providing face to face patient care – wards check at start of shift that all staff on duty have undertaken PPE competency training	Assurance around competency assessment	

	PPE posters on Nexus and printed copies made available to services Mandatory IPC training covers PPE, includes induction		
• a record of staff training is maintained	Record of general IPC training is maintained on ESR PPE competence tool for staff with local records kept		
• appropriate arrangements are in place that any reuse of PPE in line with the MHRA CAS Alert is properly monitored and managed	**No PPE is being reused**		
• any incidents relating to the re-use of PPE are monitored and appropriate action taken	**No PPE is being reused**		
• adherence to PHE national guidance on the use of PPE is regularly audited	Monthly IPC service compliance tool IPCT and senior staff visits to monitor PPE compliance	Consideration of reintroduction of PPE guardians/ supporters	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as: • hand hygiene facilities	Posters in place in clinical and non-clinical areas Monthly and quarterly hand hygiene observations submitted by inpatient and community services Hand hygiene technique included in IPC training and resource pack Social distancing signage		

including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Signage for use face coverings Catch it, Kill it, Bin it posters Regular social media use to promote need for visitors to wear face covering IPC Compliance tool for clinical areas to ensure adherence Equipment cleaning schedules in clinical areas Patient equipment monitoring included in IPC annual monitoring programme		
• the use of hand air dryers should be avoided in all clinical areas. 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	Paper towels are available in all clinical areas		
• a rapid and continued response through ongoing surveillance of rates of infection transmission	DoN participation in Frimley and BOB ICS IPC meetings to discuss local intelligence and learning from any local outbreaks		

within the local population and for hospital/organisation onset cases (staff and patients/individuals)	Attendance at regional Webinar for IPC Feedback from ICS DoN from local PH chaired outbreak meetings Attendance at local and regional IPC meetings by Head of IPC		
• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Process in place Single case and outbreak identification and management process in place in working hours and out of working hours (including test & trace) Reporting outbreak action cards in on call Director pack Outbreak management and reporting (IIMARCH) in place for in and out of hours		
• robust policies and procedures are in place for the identification of and management of outbreaks of infection	IPC Policy for outbreak management Single case and outbreak identification and management process in place in working hours and out of working hours (including test & trace)		
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:			
• restricted access between pathways if possible, (depending	On PPH site wards segregated to provide cohorting with restrictive access between		

on size of the facility, prevalence/ incidence rate low/high) by other patients/individuals, visitors or staff	On community wards - cohorting in bays due to size of facility Inpatient SOP in place to support and risk assessment tool completed by all wards		
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas		Posters and signage in cohorting areas but visible barriers not in use on cohorted wards	
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Isolation policy Isolation and cohorting SOP	October 20 - Agreement of specific isolation wards/ cohorting for wave 2 in progress	patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate
• 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	Isolation Policy Isolation and cohorting SOP Risk assessment tool Reduced number beds on wards to ensure compliance with 2m distancing Compliance tool	Risk assessment tool required to be completed for all wards	
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Isolation policy IPC surveillance Annual IPC training to support understanding		

	Laboratory weekly and monthly data report reviewed by IPCT		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
• ensure screens taken on admission given priority and reported within 24hrs	**BHFT do not provide laboratory services**		
• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available	**BHFT do not provide laboratory services** IPCT monitor turnaround times Concerns / issues are reported to Laboratory provider and ICS DoN and IPC leads		
• testing is undertaken by competent and trained individuals	Guidance and competency assessment provided to all inpatient and swabbing teams. Support from physical health lead at PPH to support training Quarterly BSPS meetings include review of turnaround times		
• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance	Admission screening compliance review undertaken by IPCT and reported to Gold command meetings. Screening undertaken on admission, at day 5-7, if appropriate on discharge and if symptomatic Guidance for staff regarding requirements and process for staff testing on Nexus/ in newsletters/ screen savers. Dedicated COVID testing email	Process for the ward to review / audit compliance with 5-7-day screening in progress initial screening compliance audit undertaken	PPH Senior leadership team developing action plan for improved compliance with admission and 5-7 days screening Work to produce alert in RIO to assist / remind

	Pillar 1 testing available for clinical staff providing face to face care and their symptomatic household members Inpatient SOP includes testing of patients on admission, at day 5-7, if symptomatic and prior to discharge to Nursing /care homes	100% compliance on Mental Health wards	staff of need for 5-7-day screen being developed
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC monitor admission screening IPCT receive daily COVID 19 testing reports provided by BSPS Liaison with Acute Trusts and laboratory services/ BSPS leads		
• screening for other potential infections takes place	IPC mandatory surveillance processes in place Daily, weekly & monthly mandatory surveillance data provided by laboratory/ acute trusts Deteriorating patient procedures in place to include being alert to potential sepsis and transfer of unwell patients to acute providers as appropriate		
8. 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 that:			
• 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 monitoring 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 QPEG IPC champions in place across the Trust IPC surveillance with IPC guidance provided		
• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff	COVID in box for receiving all guidance and process in place logging of all guidance and considering at COVID steering group. Gold command supported by PMO resource to ensure guidance disseminated to appropriate managers COVID -19 Nexus 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/ webinars, 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		
• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance	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/ Waste management SOP Feedback from waste suppliers regarding non-compliance Linen and laundry monitoring part of IPC annual monitoring programme (undertaken July 2020) Posters to support waste and linen segregation		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ
• PPE stock is appropriately stored and accessible to staff who require it	PPE held at central locations with dedicated team responsible for managing and distributing Over £50,000 was invested to bring a designed for purpose storage facility into operation All items have at least 14 days of current stock Separate arrangements made for winter / adverse weather contingency plans to reduce change of disruption in supply Stock control and distribution arrangements in place as well as process for estimating burn rate		

	Trust is an active user of the national Palantir system PPE stock catalogue PPE supply and stock review meetings are held twice a week involving nursing, procurement, PMO and the PPE team PPE included in daily Sit reps ICS-wide Process in place for mutual aid should stock levels become an issue and shared warehouse with additional stock beginning to operate Email for all staff to request PPE in place Redeployed staff used to deliver PPE to services		

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

Covid -19: Guidance for the remobilisation of services within health and care settings. Infection prevention and control recommendations issued August 2020
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectID=19747856

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 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 10 November 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. Never Long COVID

Some patients who develop COVID continue to have impacts over a longer term. These can include tiredness, PTSD type symptoms, mood changes, cough and fatigue and they can be intermittent.

It is estimated that 60,000 people are impacted and that this will rise as infection rates increase. Older people and women are more likely to be affected and it is not yet clear if ethnicity is a higher risk factor.

Research, definition of the condition, understanding prevalence, pathway development, training resources and a taskforce (with user involvement) is underway Most people will be identified through primary care, but education will be needed across range of clinicians and settings.

Self-management will also be a key part of the response and support. The first phase of this is already set up – your COVID recovery, and 100,000 have already used the hub. There will be a wider communication plan starting on 13 November 2020.

£10 million is being made available to regions to set up and run Long COVID clinics. The expectation is that each system will have access to a multidisciplinary team working to a new service specification which will be based on the Multi-Disciplinary Team approach pioneered at University College Hospital, London. They have already assessed and provided over 1,000 patients with management plans. The role of the first NHS Seacole Centre in Surrey which opened in May to provide community/ step down care to help manage demand and flow may be part of the solution for our region.

Recovery Status

The Trust has an agreed Recovery Strategy and an established COVID Recovery programme that 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 Recovery 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, including oversight of Implementation of Phase 3 of the NHS response to the COVID-19 pandemic
- Provide reassurance to our patients regarding their care and 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

We have made excellent progress and this reflects the hard work and commitment of all of our staff. All Community Health services that were paused or partially closed have now completed the formal recovery service prioritisation process and are now fully operational with a 'blended' model of remote and face to face appointments. All but two of the Mental Health services have been formally approved and are operational. The last two are expected to be fully operational again within the next few weeks.

All staff that were redeployed to support front line services have returned to their substantive roles. A number of staff continue to support wards and the Hospital Discharge service on top of their substantive posts. Conversations are current with commissioners to ensure continuity of the 24/7-day services through the Winter period

A separate task and finish group chaired by Jayne Reynolds, regional Director East, has been established to oversee delivery of a Wave 2 Surge/Winter plan and reports to GOLD Command. It provides a regular update to the Recovery Programme Board on any scenarios/issues that may impede the progress of recovery.

There has been an impact on the waiting times for some services. We now have a clear picture of this and are currently modelling the capacity required to bring waiting lasts back down to pre-COVID near normal levels. We are using this opportunity to understand the capacity that would be required for services that had long waits pre-COVID.

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. The restoration process includes services considering any new or additional digital requirements. Equality Impact Assessments are being completed to ensure we understand and minimise any negative impact of a move to remote working and appointments.

There will be the full COVID Recovery highlight report for the Trust Board on the 10 November 2020.

COVID Surge planning and Wave 2 Readiness

Jayne Reynolds, Regional Operations Director, has led a team working on our planning for Wave 2.

This has used Quality Improvement methodology and project management support to manage the complex planning needed to respond and manage the impacts of a surge on our services.

Planning has been based around 3 scenarios –

- Level 1: Situation remains stable. Continue recovery.
- Level 2: Increase in COVID cases impacting some services and/or localities and system. Escalated response and maintain service delivery
- Level 3: Number COVID cases impacting on ability to safely deliver services, and/or local restrictions in a few localities, and/or NHS response moved to level 4 incident and/or mutual aid required by partners or systems. Increased response, Business Continuity planning arrangements enacted.

A review of lessons learnt and benefits from wave 1 response has been undertaken. Plans have been developed for:

- Redeployment of staff
- Communications
- PPE management
- Staff support
- Staff risk management
- Homeworking & use of Technology
- Infection prevention & control
- Situation reporting

Operational planning including flow through hospitals, support to care homes, pharmacy support.

New service development and continuity including hospital discharge service, 24/7 mental health crisis line, increased neuro rehab bed capacity and 111 First programme.

Executive Lead: David Townsend, Chief Operating Officer

Executive Lead:

Presented by Julian Emms
Chief Executive
November 2020

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2020
Title	Financial Summary Report – M6 2020/21
Purpose	To provide the Month 6 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 M6 2020/21 financial position.
ACTION REQUIRED	The Board is invited to note the following summary of financial performance and results for Month 6 2020/21 (September 2020): The Trust continues to operate under the interim COVID finance regime, with central funding being provided to cover Covid response costs, ensuring the Trust is able to report breakeven YTD. **YTD Cash** £50.2m vs Plan £46.5m. **YTD Capital expenditure:** £1.9m vs Plan £2.1m.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2020/21

September 2020

Purpose

To provide the Board & Executive with a summary of the Trusts financial performance for the period ending 30th September 2020.

Version	*Date*	*Author*	*Comments*
1.0	16/10/2020	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 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	21.0	20.8	0.2	126.4	124.6	1.7	21.0	21.2	(0.2)	126.4	127.0	(0.6)
Other Income	1.2	1.9	(0.7)	6.6	11.5	(4.9)	1.2	1.1	0.1	6.6	6.5	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)***	***132.9***	***136.1***	***(3.2)***	***22.2***	***22.2***	***(0.1)***	***132.9***	***133.4***	***(0.5)***
Staff In Post	15.1	14.5	0.6	88.7	86.8	1.9	15.1	14.7	0.4	88.7	88.9	(0.2)
Bank Spend	1.3	1.4	(0.1)	7.3	8.2	(0.9)	1.3	1.2	0.1	7.3	8.1	(0.8)
Agency Spend	0.3	0.4	(0.1)	1.5	2.1	(0.6)	0.3	0.2	0.0	1.5	1.6	(0.1)
Total Pay	***16.6***	***16.2***	***0.4***	***97.4***	***97.2***	***0.3***	***16.6***	***16.1***	***0.5***	***97.4***	***98.6***	***(1.1)***
Purchase of Healthcare	1.4	1.2	0.3	7.1	6.9	0.2	1.4	1.1	0.3	7.1	6.8	0.4
Drugs	0.4	0.5	(0.1)	2.5	2.7	(0.2)	0.4	0.4	(0.0)	2.5	2.5	(0.0)
Premises	1.4	1.4	(0.0)	8.0	8.4	(0.4)	1.4	1.3	0.0	8.0	8.7	(0.7)
Other Non Pay	1.5	1.7	(0.2)	8.5	10.2	(1.8)	1.5	1.4	0.1	8.5	9.7	(1.2)
PFI Lease	0.5	0.5	0.0	3.3	3.2	0.1	0.5	0.6	(0.0)	3.3	3.3	(0.0)
Total Non Pay	***5.2***	***5.2***	***(0.1)***	***29.2***	***31.5***	***(2.3)***	***5.2***	***4.8***	***0.3***	***29.2***	***31.0***	***(1.8)***
Total Operating Costs	***21.8***	***21.4***	***0.3***	***126.6***	***128.7***	***(2.0)***	***21.8***	***21.0***	***0.8***	***126.6***	***129.6***	***(2.9)***
EBITDA	***0.4***	***1.2***	***(0.9)***	***6.3***	***7.4***	***(1.1)***	***0.4***	***1.3***	***(0.9)***	***6.3***	***3.8***	***2.5***
Interest (Net)	0.3	0.3	0.0	1.9	1.8	0.1	0.3	0.3	(0.0)	1.9	1.9	0.0
Depreciation	0.7	0.6	0.1	3.9	3.6	0.3	0.7	0.6	0.0	3.9	4.0	(0.1)
PDC	0.1	0.2	(0.1)	0.9	1.0	(0.1)	0.1	0.2	(0.1)	0.9	1.0	(0.1)
Total Financing	***1.1***	***1.1***	***0.0***	***6.7***	***6.4***	***0.4***	***1.1***	***1.1***	***(0.1)***	***6.7***	***7.0***	***(0.2)***
Surplus/ (Deficit)	***(0.7)***	***0.2***	***(0.9)***	***(0.4)***	***1.1***	***(1.5)***	***(0.7)***	***0.1***	***(0.8)***	***(0.4)***	***(3.1)***	***2.7***
COVID Pay Costs	*0.2*			*3.4*								
COVID Non Pay Costs	*0.3*			*1.8*								
Top Up Payment	***1.2***			***5.6***								
Surplus/ (Deficit)	***(0.0)***	***0.2***	***(0.2)***	***(0.0)***	***1.1***	***(1.1)***						

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.

From October, spend will be monitored against our submitted NHSI forecast for the remainder of the year.

Internal Forecast

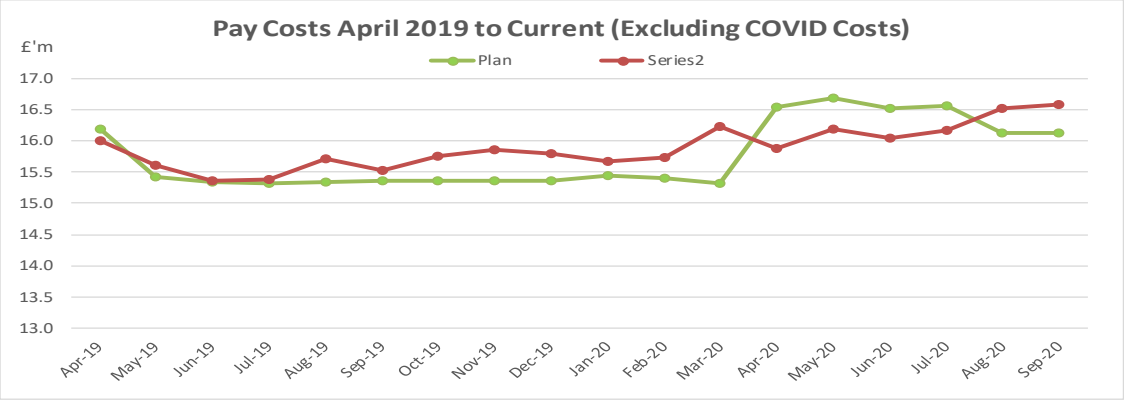
The Trust is reporting a £0.7m deficit excluding COVID costs which moves the Trust to a YTD deficit of £0.4m.

The deficit reported this month reflects a £0.1m increase in Pay costs, incorporating backdated Consultant pay award, and Non Pay costs increasing by £0.5m. The Non Pay increase being a combination of one-off items, and the continuation of recovery costs increases.

NHSI Plan

After the inclusion of £0.5m of COVID costs, a £1.2m Top Up payment has been assumed to enable breakeven. YTD COVID response costs are estimated at £5.2m and our breakeven position is inclusive of £4.6m of COVID Funding and £1.0m of Retrospective Top Up support. Marginal COVID cost continued to reduce, with costs falling a further £50k in September to £0.5m. In month COVID costs are at c2.2%, which is at the lower end of costs across the region.

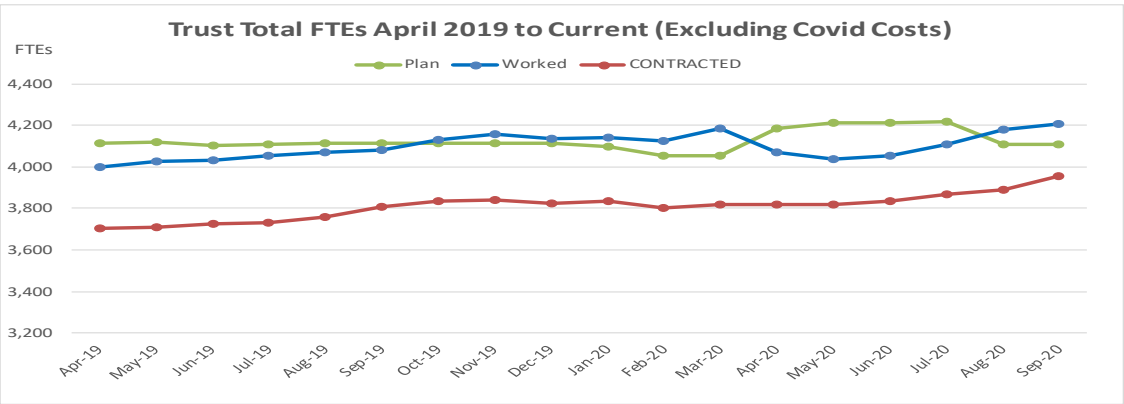
Workforce



Staff Costs

YTD	£'m
2020/21	97.7
2019/20	93.6
▲	4%

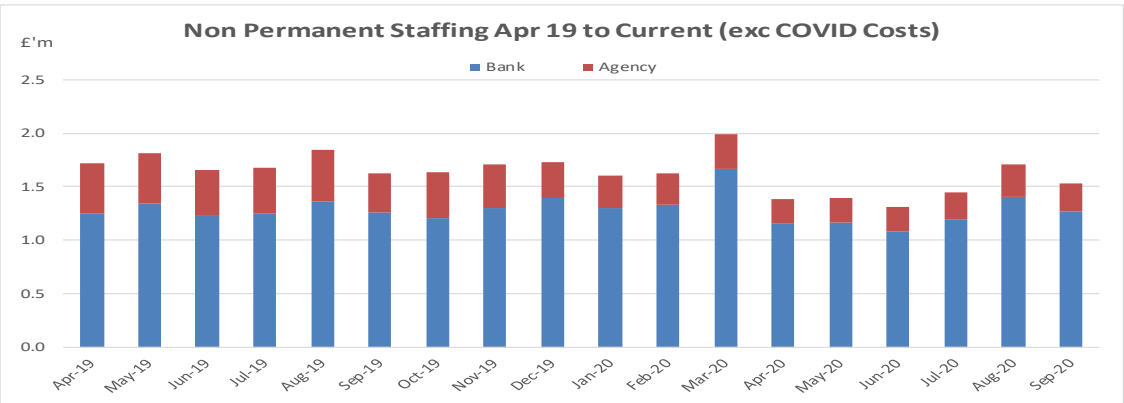
Prior Yr	£'m
Sep-20	16.6
Sep-19	15.5
▲	7%



FTEs

Prior Mth	CFTE	WFTE
Sep-20	3,957	4,204
Aug-20	3,891	4,180
	2% ▲	1% ▼

Prior Yr	CFTE	WFTE
Sep-20	3,957	4,204
Sep-19	3,809	4,080
	4% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2020/21	7.4	1.5
2019/20	7.7	2.7
	-4% ▼	-42% ▼

£'m	Bank £'m	Agency £'m
Sep-20	1.3	1.3
Sep-19	1.3	1.3
	2% ▼	2% ▼

Key Messages

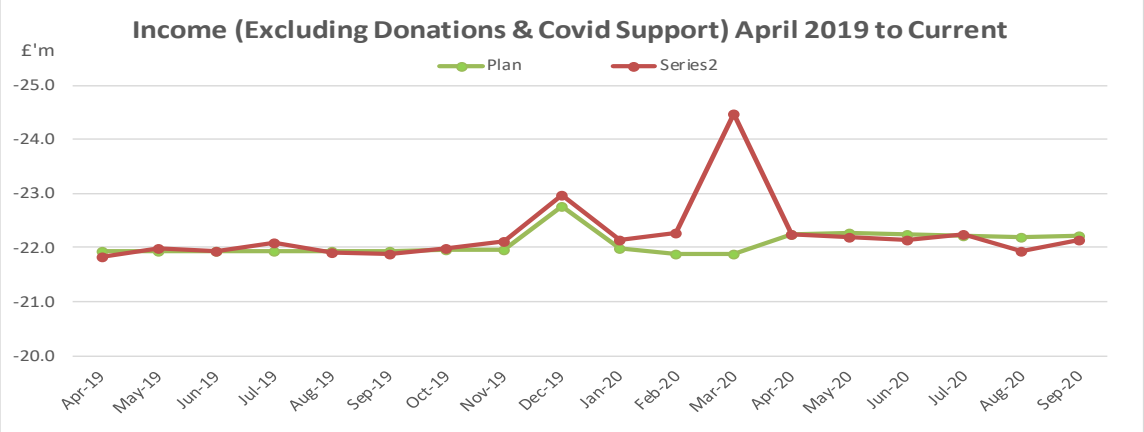
Pay costs, rose a further £0.1m in September excluding COVID expenditure, taking overall pay costs to £16.6m.

Substantive costs rose by £0.3m, but this included £0.2m of backdated Medical pay award and £0.05m of Bank Holiday enhancements. There were further increases with the appointment of a number of students, who supported the Trust through the initial COVID wave, taking up permanent positions. Overall substantive FTEs rose by 66 in the month.

Offsetting the increase in substantive numbers was a £0.2m decrease in temporary staffing costs, adjusting for bank holiday payments in the prior month and reflecting a reduction in the volume of temporary shifts employed. Overall temporary staffing costs continue to show signs of recover to prior years levels. Q1 spend was £1.4m less than in 19/20; this gap reduced to £0.5m in Q2, with spend in September only £0.1m less than the prior year.

Monthly COVID cost were £0.2m, representing a £0.1m decrease on last month with sickness and temporary staffing usage falling, in addition to students leavers.

Income & Non Pay



Income

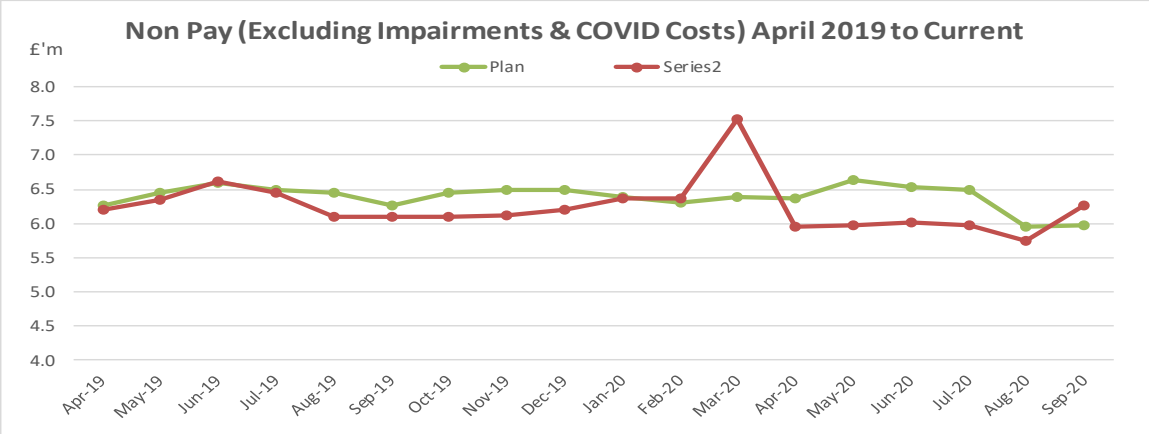
YTD	£'m
2020/21	132.9
2019/20	131.7
▲	1%
Prior Yr	**£'m**
Sep-20	22.2
Sep-19	21.9
▲	1%

Key Messages

Income in September was £22.3m, reflecting a £0.2m increase on the prior month.

The majority of income remains under our pre-calculated block values, with the increase arising from the YTD corrections to Health Education England funding made last month.

Work will be concluded by the end of October which will confirm the revisions to our existing block funding arrangements and clarify planned investments for the remainder of 20/21.



Non Pay

YTD	£'m
2020/21	36.2
2019/20	37.8
▼	-4%
Prior Yr	**£'m**
Sep-20	6.3
Sep-19	6.1
▲	3%

Key Messages

Non Pay costs were £6.3m, an increase of £0.5m and £0.2m higher than September 19/20.

The increase seen this month is a combination on one-off items and costs recovering from the lows seen earlier in the year.

There were one-off adjustments totalling £0.2m for assessment costs, equipment purchases and consultancy cost.

Clinical Supplies spend increased by £0.1m in month, with most notable increases across Inpatient Services and the Continence Service. Recovery continues to impact with costs across Community Services rising by 15% during Q2.

Out of Area Placements are increasing with an average of 4 beds utilised in September, over and above those charged to COVID. This has resulted in an increase of £20k. In addition long term placements costs have risen by £60k, incorporating a £28k prior period adjustment, a new placement at £24k and increased observation costs.

Overall Income Statement Including COVID Cost

	In Month			YTD		
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m
Operating Income	21.0	21.2	(0.2)	126.4	127.0	(0.6)
Top Up Funding	1.2	0.0	1.2	5.6	0.0	5.6
Other Income	1.2	1.1	0.1	6.6	6.5	0.1
Donated Income	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)
Total Income	**23.4**	**22.2**	**1.2**	**138.6**	**133.4**	**5.1**
Staff In Post	15.2	14.7	0.5	90.1	88.9	1.3
Bank Spend	1.4	1.2	0.2	9.0	8.1	0.9
Agency Spend	0.3	0.2	0.1	1.8	1.6	0.2
Total Pay	***16.8***	***16.1***	***0.7***	***100.9***	***98.6***	***2.3***
Purchase of Healthcare	1.4	1.1	0.3	7.1	6.8	0.4
Drugs	0.4	0.4	(0.0)	2.5	2.5	(0.0)
Premises	1.4	1.3	0.1	8.5	8.7	(0.2)
Other Non Pay	1.7	1.4	0.3	9.5	9.7	(0.2)
PFI Lease	0.5	0.6	(0.0)	3.3	3.3	(0.0)
Total Non Pay	***5.5***	***4.8***	***0.6***	***31.0***	***31.0***	***(0.0)***
Total Operating Costs	***22.3***	***21.0***	***1.3***	***131.9***	***129.6***	***2.3***
EBITDA	***1.1***	***1.3***	***(0.2)***	***6.7***	***3.8***	***2.9***
Interest (Net)	0.3	0.3	(0.0)	1.9	1.9	0.0
Depreciation	0.7	0.6	0.0	3.9	4.0	(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	0.1	0.2	(0.1)	0.9	1.0	(0.1)
Total Finanacing	***1.1***	***1.2***	***(0.1)***	***6.7***	***7.0***	***(0.3)***
Surplus/ (Deficit)	***(0.0)***	***0.1***	***(0.1)***	***(0.0)***	***(3.2)***	***3.1***

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.

This is the final month of the current financial regime in which funding will be provided to guarantee breakeven.

From October, monitoring will be against submitted NHSI forecast, which will include both a fixed £2.8m Top Up and pre-agreed COVID funding allocation via the BOB ICS.

2.0 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	7.0	5.7	5.7	0.0	5.7	5.7	0.0	8.7
Property, Plant & Equipment (non PFI)	37.5	36.8	37.5	(0.7)	36.8	37.5	(0.7)	37.1
Property, Plant & Equipment (PFI)	57.3	57.3	56.9	0.4	57.3	56.9	0.4	57.6
Total Non Current Assets	**102.7**	**99.8**	**100.1**	**(0.3)**	**99.8**	**100.1**	**(0.3)**	**103.4**
Trade Receivables & Accruals	11.3	12.2	12.5	(0.3)	12.2	12.5	(0.3)	11.3
Other Receivables	0.1	0.1	0.3	(0.2)	0.1	0.3	(0.2)	0.1
Cash	26.4	50.2	46.5	3.7	50.2	46.5	3.7	22.7
Trade Payables & Accruals	(24.8)	(27.3)	(24.8)	(2.5)	(27.3)	(24.8)	(2.5)	(25.5)
Current PFI Finance Lease	(1.5)	(1.5)	(1.5)	(0.1)	(1.5)	(1.5)	(0.1)	(1.6)
Other Current Payables	(2.5)	(24.9)	(24.6)	(0.3)	(24.9)	(24.6)	(0.3)	(2.5)
Total Net Current Assets / (Liabilities)	**9.6**	**8.8**	**8.4**	**0.4**	**8.8**	**8.4**	**0.4**	**4.5**
Non Current PFI Finance Lease	(27.0)	(26.2)	(26.1)	(0.1)	(26.2)	(26.1)	(0.1)	(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***	***80.5***	***80.5***	***0.0***	***80.5***	***80.5***	***0.0***	***80.5***
Income & Expenditure Reserve	29.1	27.9	27.9	(0.0)	27.9	27.9	(0.0)	27.7
Public Dividend Capital Reserve	19.2	19.2	19.2	0.0	19.2	19.2	0.0	19.4
Revaluation Reserve	33.4	33.4	33.4	(0.0)	33.4	33.4	(0.0)	33.4
Total Taxpayers Equity	***82.4***	***80.5***	***80.5***	***(0.0)***	***80.5***	***80.5***	***(0.0)***	***80.5***

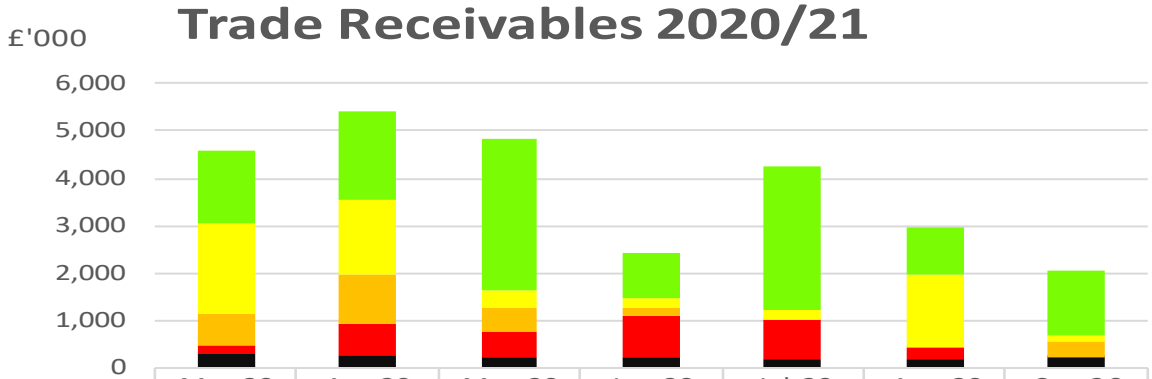
Cashflow		19/20 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	20/21 Plan £'m
Operating Surplus/(Deficit)	+/-	6.4	(0.7)	0.4	(1.2)	1.6	2.1	(0.5)	5.3
Depreciation and Impairments	+	8.5	0.6	0.7	(0.0)	3.9	3.3	0.6	8.1
Operating Cashflow		***14.9***	***(0.1)***	***1.1***	***(1.2)***	***5.5***	***5.4***	***0.1***	***13.4***
Net Working Capital Movements	+/-	***1.4***	***2.3***	***0.6***	***1.7***	***23.8***	***19.5***	***4.3***	***(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)	(0.6)	(0.1)	(0.5)	(2.8)	(2.4)	(0.4)	(8.6)
Investments		***(9.8)***	***(0.6)***	***(0.1)***	***(0.5)***	***(2.8)***	***(2.4)***	***(0.4)***	***(8.6)***
PFI Finance Lease Repayment	-	(1.2)	(0.1)	(0.1)	(0.0)	(0.7)	(0.6)	(0.1)	(1.5)
Net Interest	+/-	(3.6)	(0.3)	(0.3)	(0.0)	(1.9)	(1.6)	(0.3)	(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)***	***(0.5)***	***(0.4)***	***(0.0)***	***(2.7)***	***(2.2)***	***(0.4)***	***(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***	***1.1***	***(0.1)***	***23.8***	***20.1***	***3.7***	***(3.6)***
Opening Cash		25.6	49.2	45.4	3.8	26.4	26.4	0.0	26.4
Closing Cash		***26.4***	***50.2***	***46.5***	***3.7***	***50.2***	***46.5***	***3.7***	***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, £50.2m, offset by a £21m increased in deferred income reflected in Other Payables. We await confirmation of the phasing of block payments over the remainder of the year.

The closing cash at £22.7m, reflects the latest forecast submitted to NHSI and assumes the recovery of the additional block payment before the end of March.

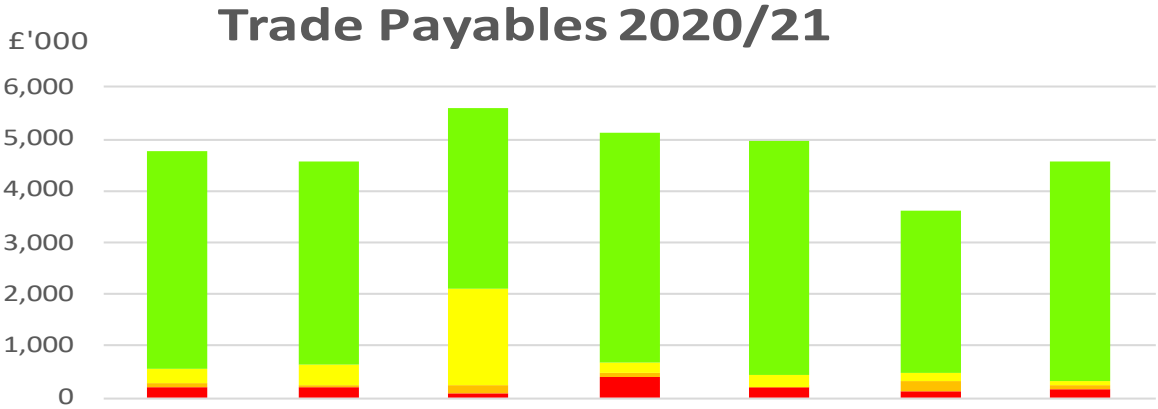
Cash Management



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
<30 Days	1,562	1,870	3,230	973	3,032	1,000	1,377
>30 <60 Days	1,904	1,573	388	225	180	1,535	136
>60 <90 Days	662	1,063	500	154	34	0	327
>90 < 180 Days	177	673	538	864	802	251	25
>180 Days	295	241	197	220	182	186	200

Key Messages

Overall debtors balances decreased by £0.9m with notable decreases in balances due in 30—60 days and over 90 days. This reflects considerable targeted work done to reduce our older balance. The largest balances remaining over 60 days are with a number of our Local Authorities and we are engaged with them to clear these.



	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
<30 Days	4,209	3,924	3,486	4,438	4,531	3,117	4,245
>30 <60 Days	273	391	1,858	207	227	159	99
>60 <90 Days	88	51	182	63	27	205	74
>90 days	209	196	77	403	194	126	153

Key Messages

Overall Creditors increased by £1.0m, however our level of aged payments remains low due to continued efforts to ensure prompt payments to commercial suppliers, the elimination of commissioner billing and the majority of inter-provider charges been consolidated and pre-agreed.

3.0 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	245	78	166	650	221	428	1,021
Erleigh Road (LD etc works)	0	0	0	0	0	0	153
Wokingham Willow House Projects	7	0	7	62	197	(135)	197
Trust Owned Properties Other	2	13	(11)	2	51	(49)	111
Leased Non Commercial (NHSPS)	6	0	6	145	128	17	335
Leased Commercial	0	3	(3)	0	11	(11)	50
Various All Sites	55	48	6	55	170	(115)	510
Statutory Compliance	(12)	85	(97)	16	165	(149)	347
Subtotal Estates Maintenance & Replacement	**303**	**228**	**75**	**929**	**943**	**(14)**	**2,724**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	(4)	0	(4)	31	0	31	368
IM&T System & Network Developments	0	112	(112)	4	469	(465)	1,541
IM&T Other	62	0	62	289	145	144	445
GDE & Community Trust Funded	11	114	(102)	45	393	(348)	958
Subtotal IM&T Expenditure	**70**	**226**	**(156)**	**368**	**1,007**	**(639)**	**3,312**
Subtotal CapEx Within Control Total	**373**	**454**	**(81)**	**1,297**	**1,950**	**(653)**	**6,036**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	133	0	133	511	0	511	1,647
Other PFI Projects	1	43	(42)	5	121	(116)	295
HSLI Projects	57	17	40	113	72	41	174
Subtotal Capex Outside of Control Totals	**191**	**60**	**131**	**629**	**193**	**436**	**2,116**
Total Capital Expenditure	**564**	**514**	**50**	**1,926**	**2,143**	**(216)**	**8,153**

New COVID Pressures	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Central Funding Agreeed							
Pandemic Storage Facility	0	0	0	44	0	44	0
Point of Care Testing Bids (NHSPS sites)	36	0	36	37	0	37	0
Funding not yet agreed							
Laptops COVID-19	0	0	0	64	0	64	0
Point of Care Testing Bids (PFI - £57K)	0	0	0	0	0	0	0
Total CapEx excluded from Annual Plan	**37**	**0**	**37**	**145**	**0**	**145**	**0**

Key Messages

The overall capital spend was £0.1m higher than planned, reducing the YTD underspend to £0.2m.

Estates spend continued ahead of plan, due to phasing of the LD to Jasmine project. Additional spend was incurred on the Whiteknights project with spend relating to boiler replacement and additional car park works of £0.4m.

A number of Estates projects were recently approved at CRG which will take spend towards Control Total by the end of the year. These include Willow House Windows (£0.03m), Trust Wide Anti-Ligature (£0.08m), Medical Gas Storage St Marks & Upton (£0.04m), Air Conditioning Dental (£0.06m), BMS Installation (£0.1m), Cleaning cupboards (£0.1m).

IM&T Refresh & Replacement Programme spend is now expected to occur in Q3, giving rise to the YTD underspend.

The Trust has received confirmation of the central COVID Capital funding for adjustments to our stores, £0.05m and Adopt and Adapt Funding of £0.06m towards Point of Care Testing. We are awaiting a decision the balance of the POCT bis and Laptops, the latter item being subject to a further national review, with no IT expenditure approved nationally to date.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	10th November 2020
Title	**True North Performance Scorecard** **Month 6 (September 2020) 2020/21**
Purpose	To provide the Board with the new True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and QI break through objectives for 2020/21.
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 6, 2020/21 (September 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 6** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** • Self-harm Incidents on Mental Health Inpatients Wards (excluding LD) **(Harm Free Care)** – red at 57 incidents against a target of 42. Two nineteen-year old's on two acute wards accounted for a significant proportion of incidents (38 out of the 57). Countermeasures include safety planning and restrictive interventions. • Prone (Face Down) Restraint **(Patient Experience) –** latest figures suggest three incidents on two wards. Only one incident on an acute ward (Daisy) and two at Willow House. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** at 40 days against a target of 30 days. Pressures continue on length of stay but remains a focus for teams. • Staff turnover (including fixed-term posts) **(Money Matters)** – this indicator is at 17.1% against a target of 16%. The indicator excluding fixed-term posts was green at 13.9%. • Inappropriate Out of Area Placements **(Money Matters)** – at 418 days for the quarter against 152 bed day target. Pressures within our

	inpatient units have resulted in more out of area placements. **Tracker Level 1 Metrics** • To note - Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology) – the reporting is nationally suspended, but the indicator has breached for the second month. It is not expected there will be repercussions due to the national suspension. Review in progress with service. **Tracker Metrics (where red for 4 months or more)** • Statutory Training: Fire **(Supporting our Staff)** – focussing assurance on ward environments. All but one ward is now compliant. Performance improving but slowly.
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 (September 2020)

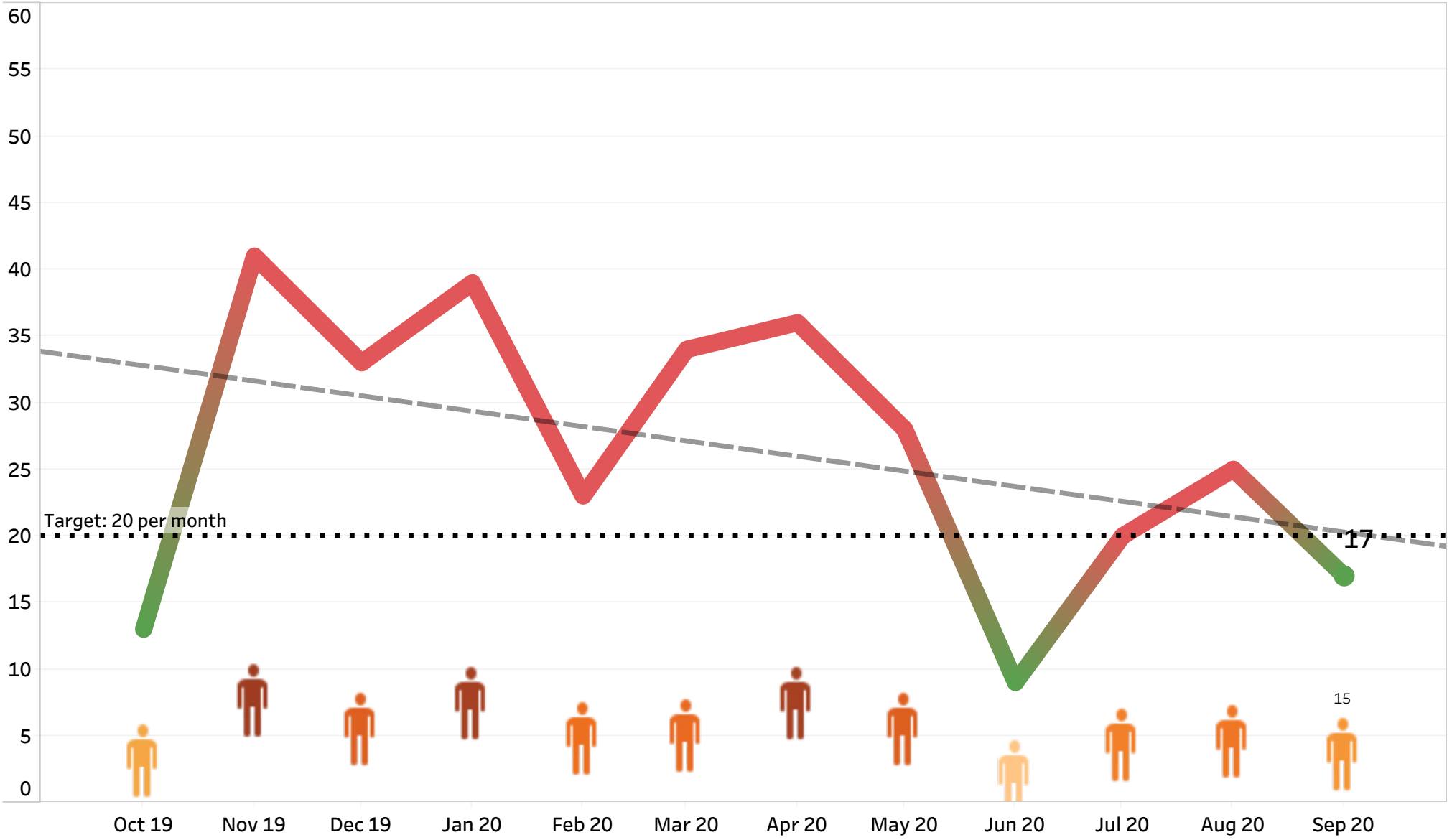
Metric	Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Harm Free Care													
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	12	39	32	34	21	29	27	20	8	16	25	17
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	48	65	66	38	42	25	15	58	37	41	40	57
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	8	13	16	19	21	22	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	4	1	3	2	1	2	2	3	1	1	1	1
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	3	0	0	0	0	0
Patient Experience													
Mental Health: Prone (Face Down) Restraint	2 per month	2	1	2	2	7	3	3	8	3	6	2	3
Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance	93.2%	93.4%	92.4%	88.9%	87.4%	91.9%						
Patient FTT response rate: % [Suspended centrally due to COVID]	15% compliance	14.6%	12.1%	8.5%	10.6%	11.7%	5.51%						
Mental Health Clustering within target: %	80% compliance	81.3%	81%	79.7%	81.2%	81.5%	80.6%	81.2%	78.7%	83.8%	83.7%	82.7%	81.5%

Performance Scorecard - True North Drivers (September 2020)

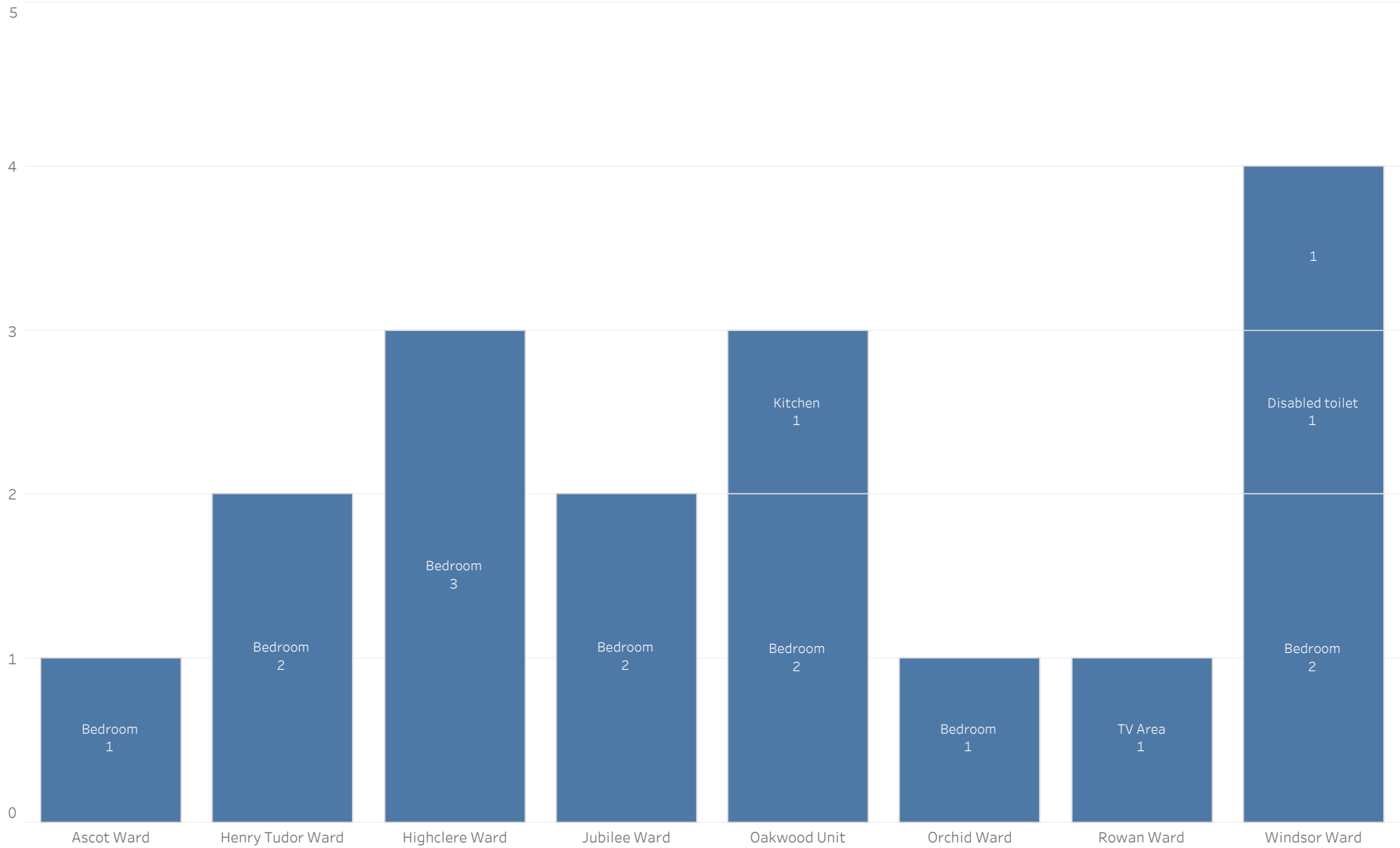
Metric	Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Supporting our Staff													
Physical Assaults on Staff	44 per month	49	39	30	35	41	57	36	27	34	53	51	26
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.29	7.29	7.29	7.40	7.29	7.29	7.40	7.40	7.40	7.40	7.40	7.40
Money Matters													
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)	£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	-£0.68M	-£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	94.4%	94.3%	91.9%	87.7%	92.6%	89.9%		81.9%	92.1%	92.2%	97.2%	92.6%
Mental Health: Acute Average Length of Stay (bed days)	30 days	45	35	39	43	37	42	37	34	37	36	47	40
Staff turnover (excluding fixed term posts)	<16% per month	14.4%	14.2%	14.6%	14.6%	14.7%	14.7%	14.6%	14.3%	13.9%	13.4%	13.3%	13.9%
Staff turnover (including fixed-term posts)	<16% per month	15.6%	15.1%	15.6%	16.2%	16.6%	16.5%	16.5%	16.2%	15.6%	15.3%	15.9%	17.1%
Inappropriate Out of Area Placements	152 bed days (cumul. Qtr)	29	163	177	49	101	140	58	93	170	148	312	418

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

Any incident (all approval statuses) where sub-category excluding Sat or lowered to floor & near miss, Location exact excluding Patient/staff home and incident type = patient

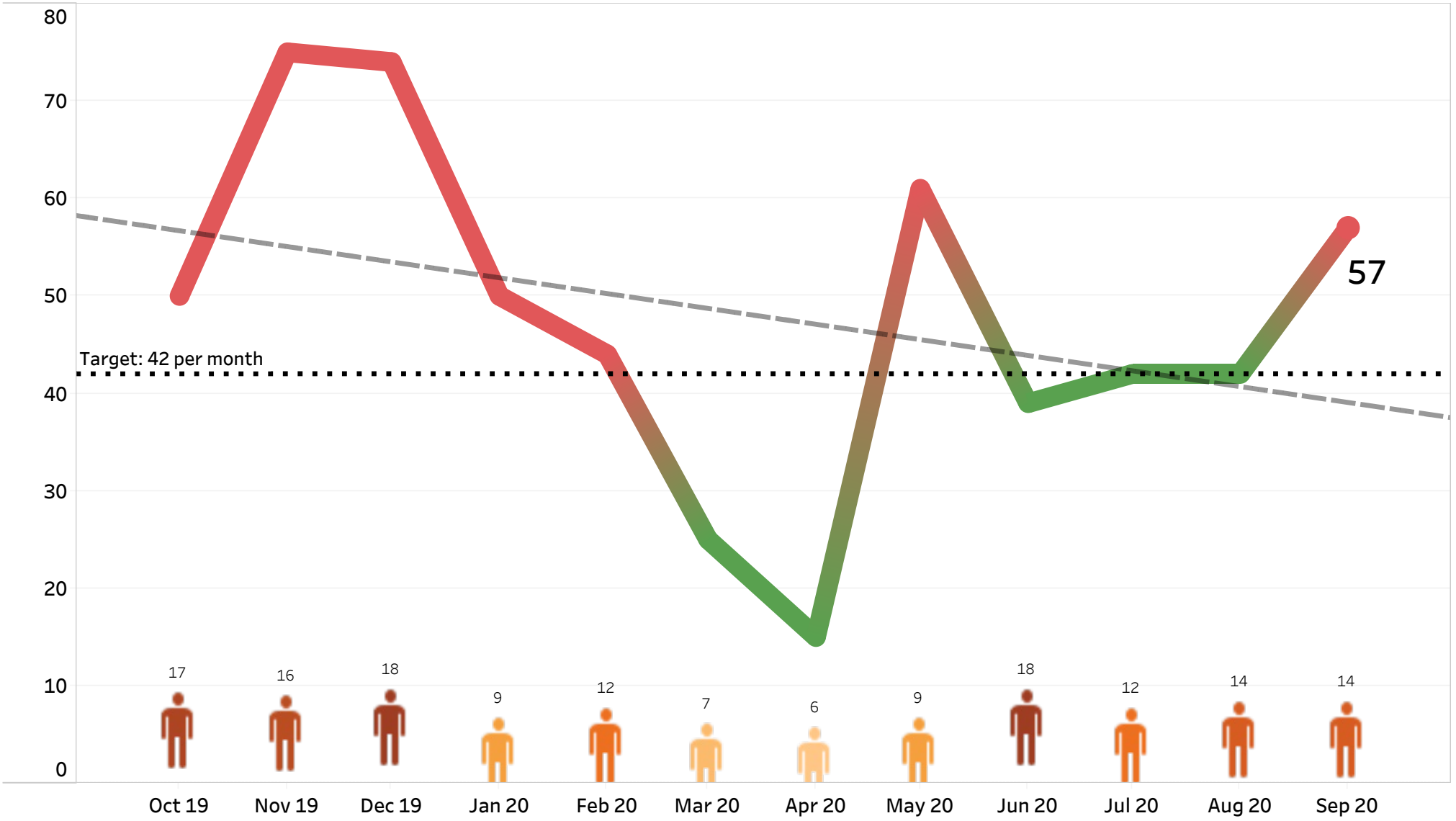


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (September)



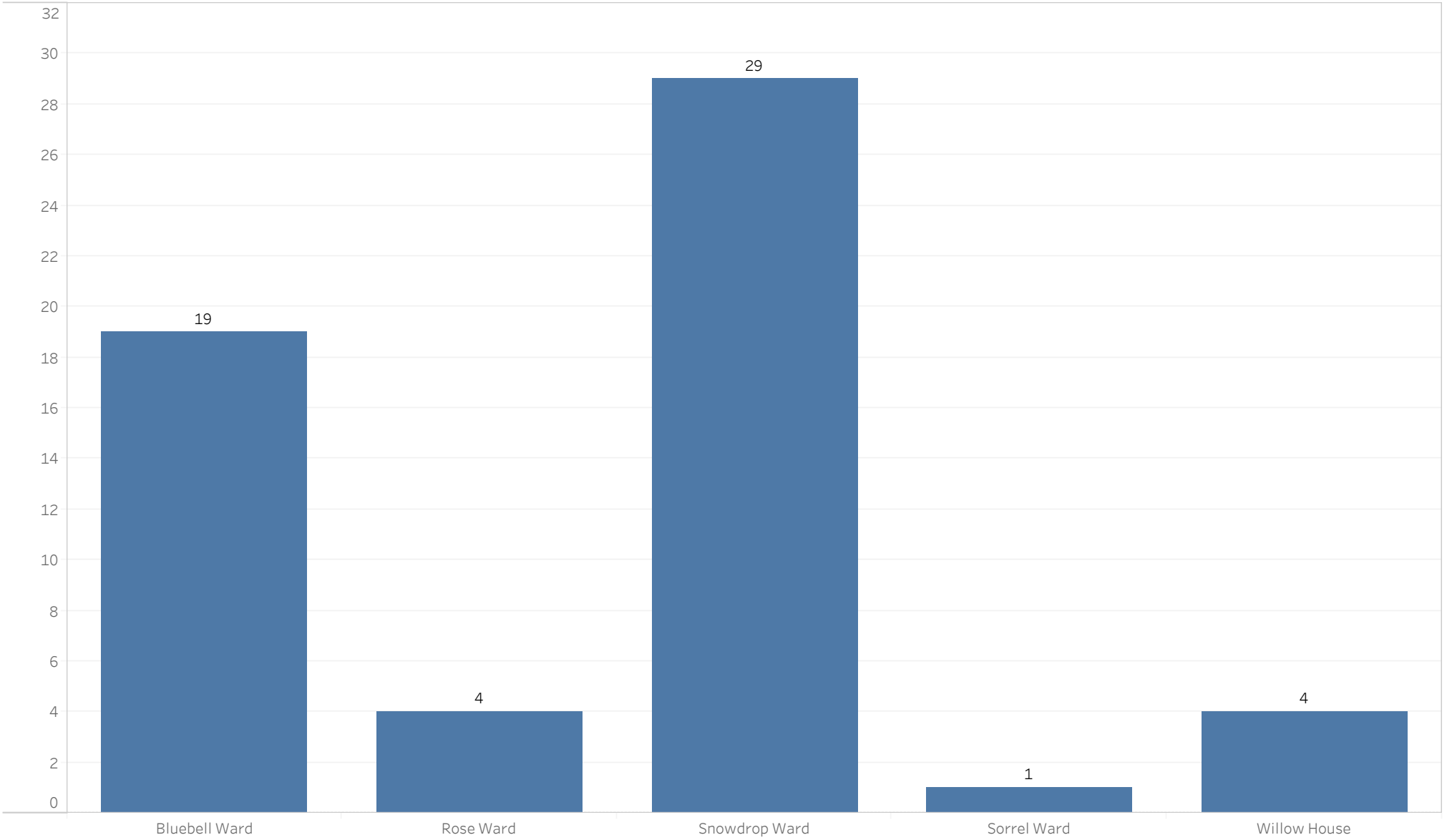
Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Oct 19 to Sep 20)

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



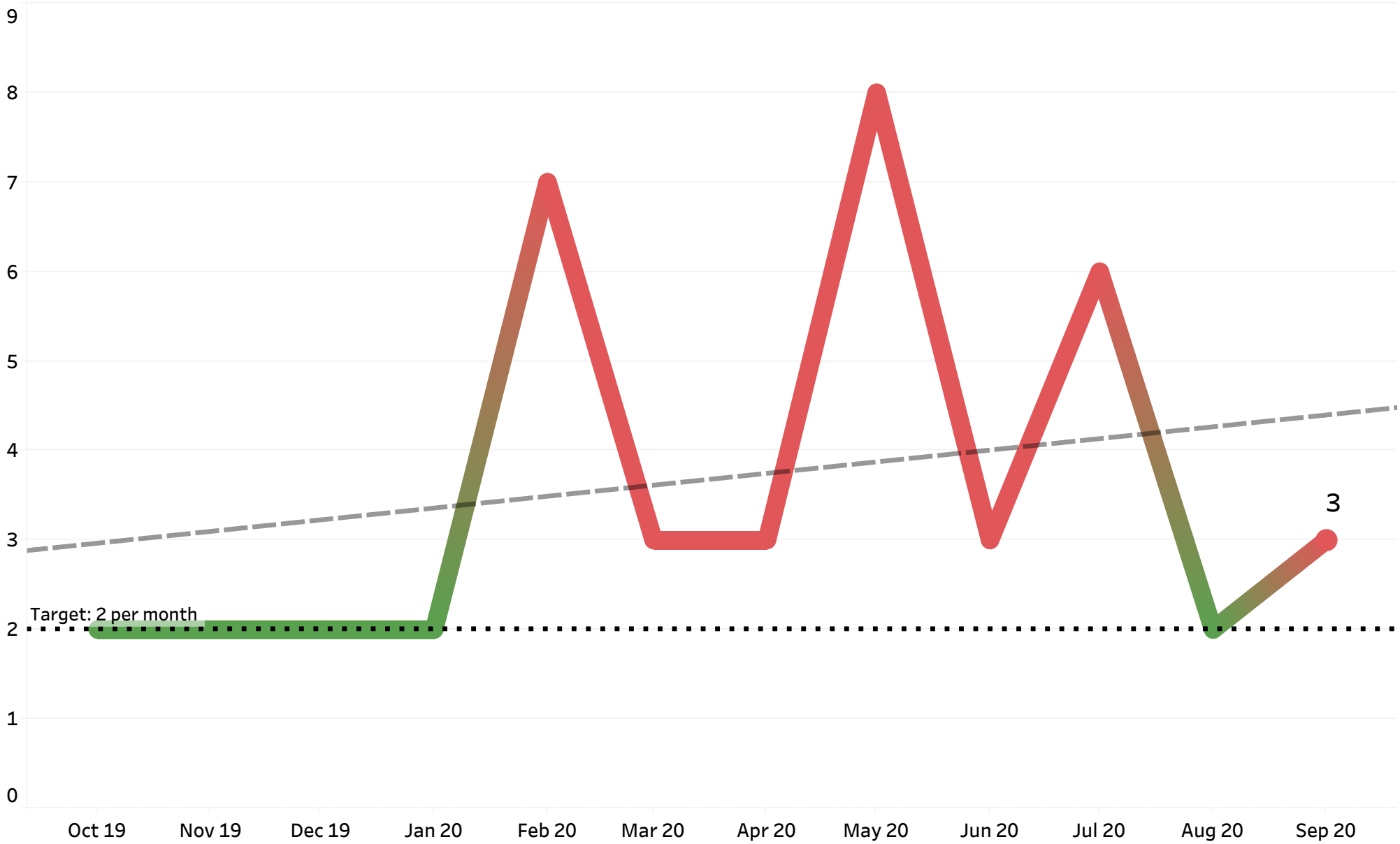
Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location

(September)

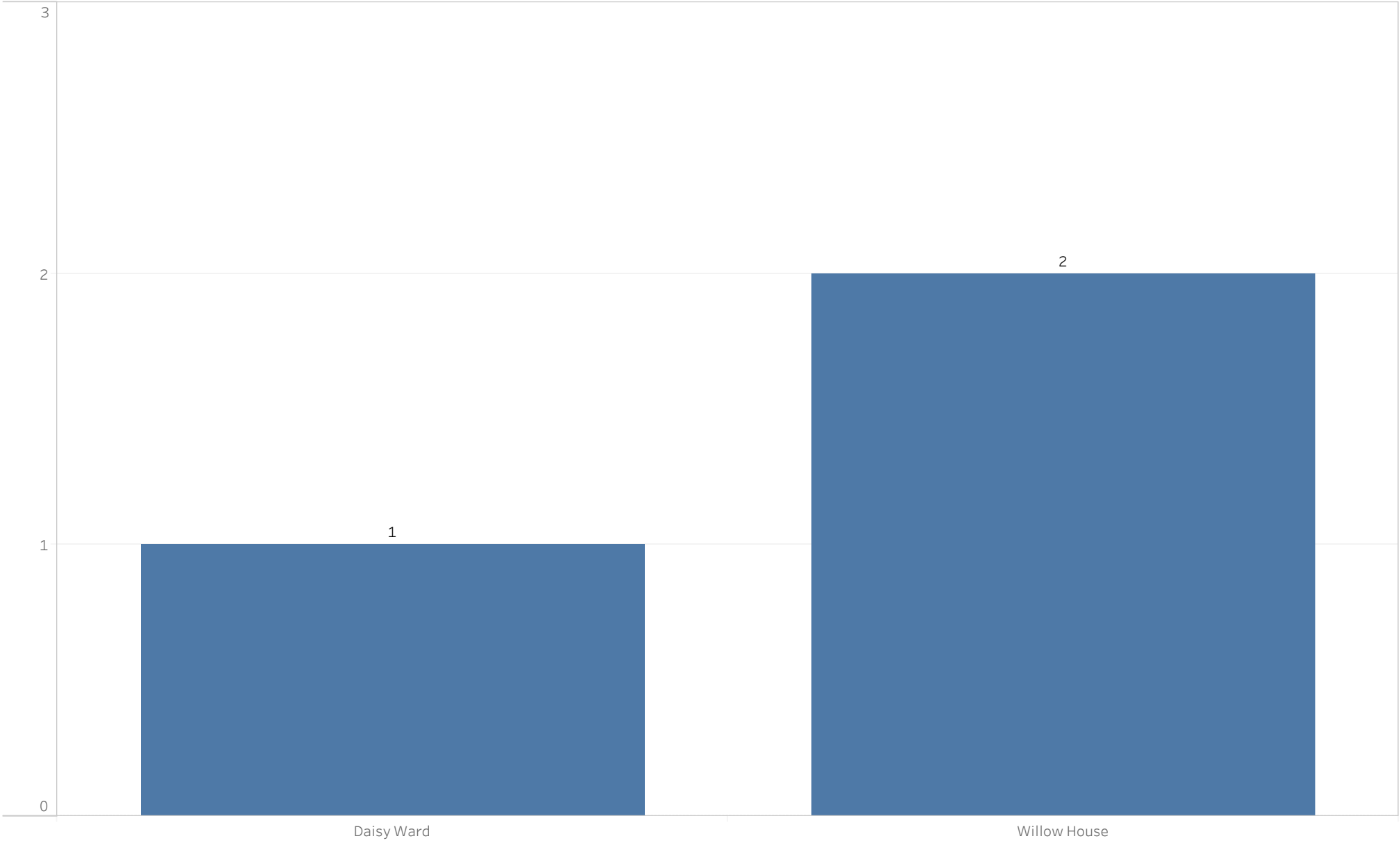


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Oct 19 to Sep 20)

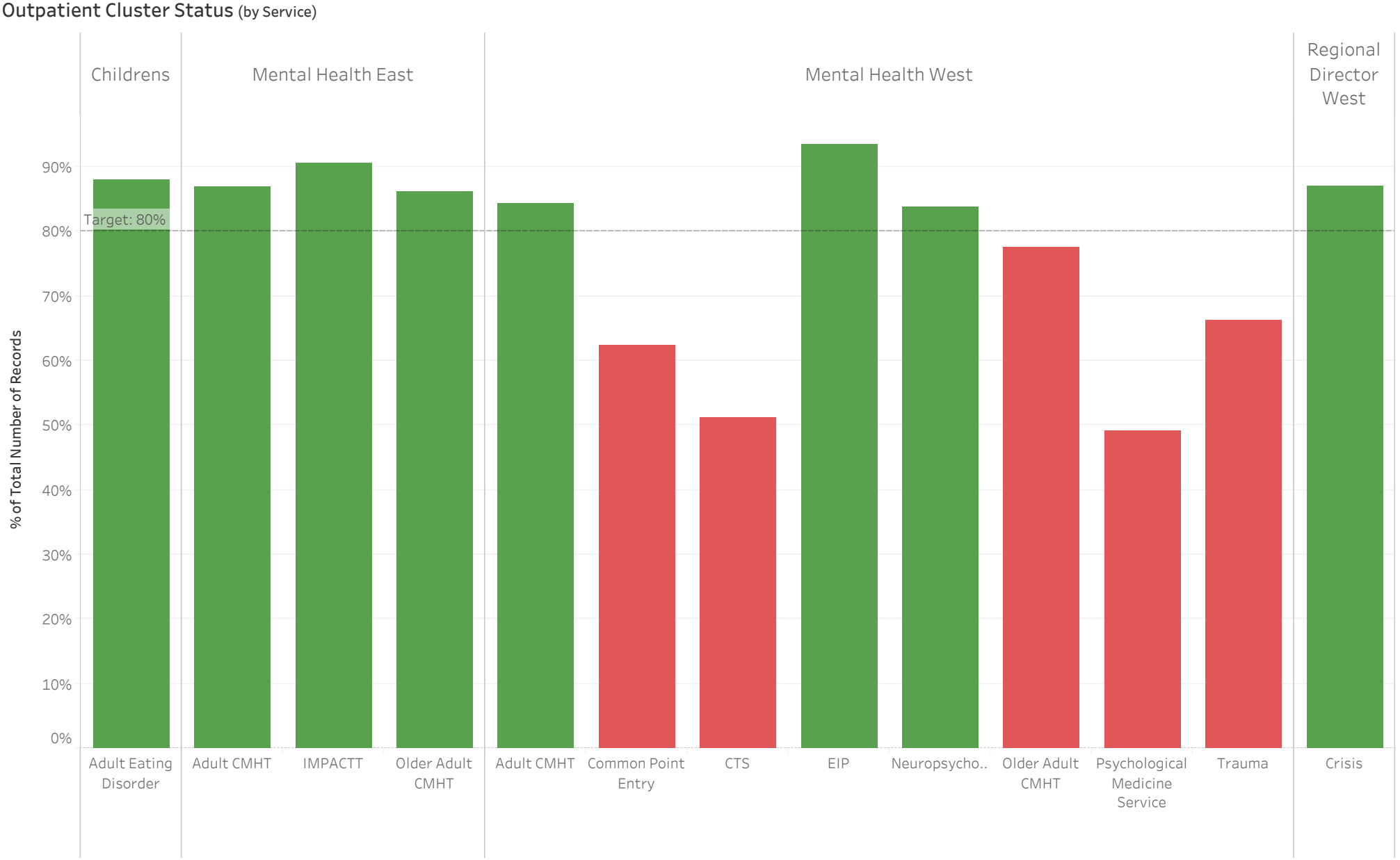
(All approval statuses)



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

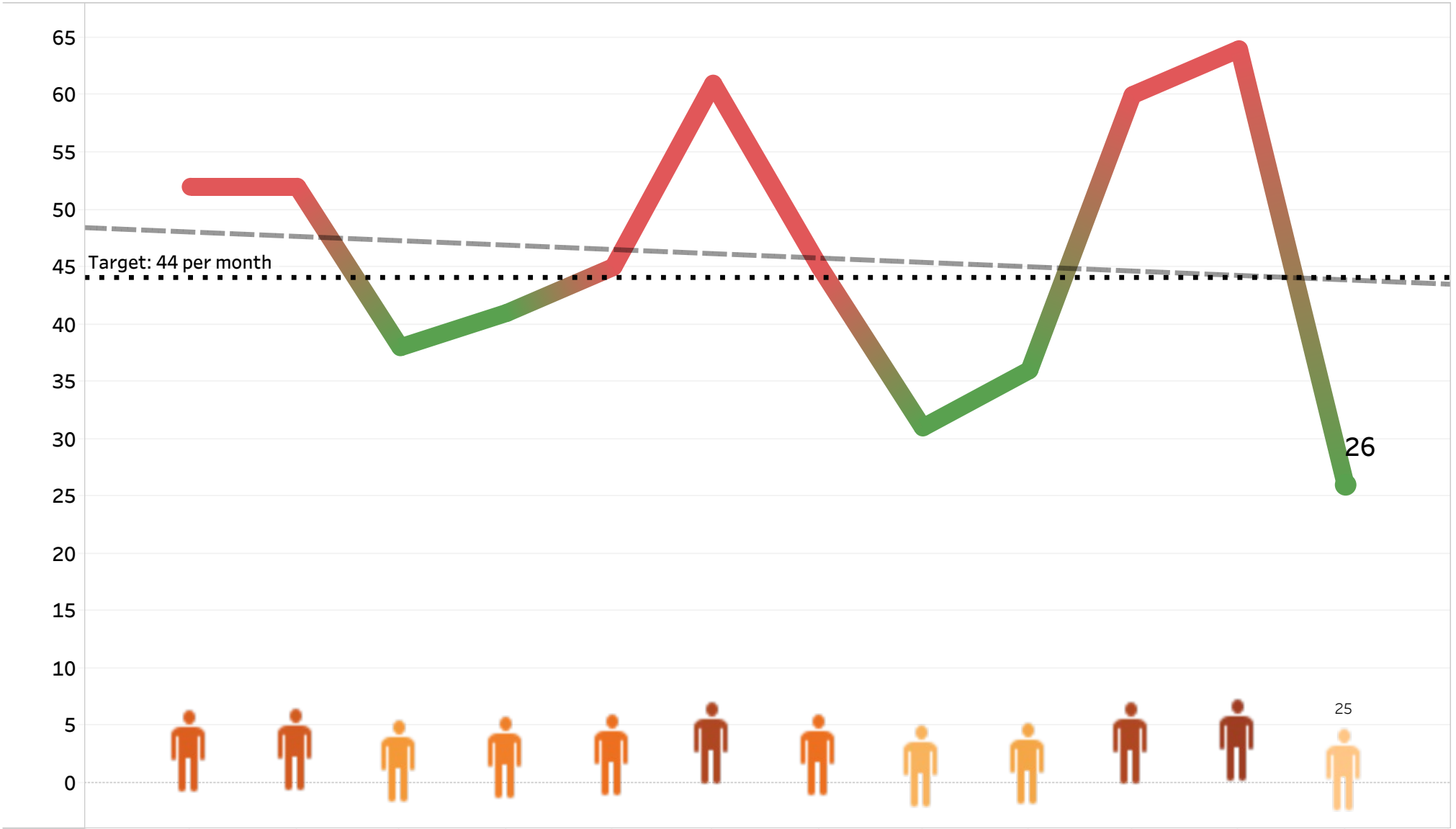


Patient Experience: Clustering breakdown (September)

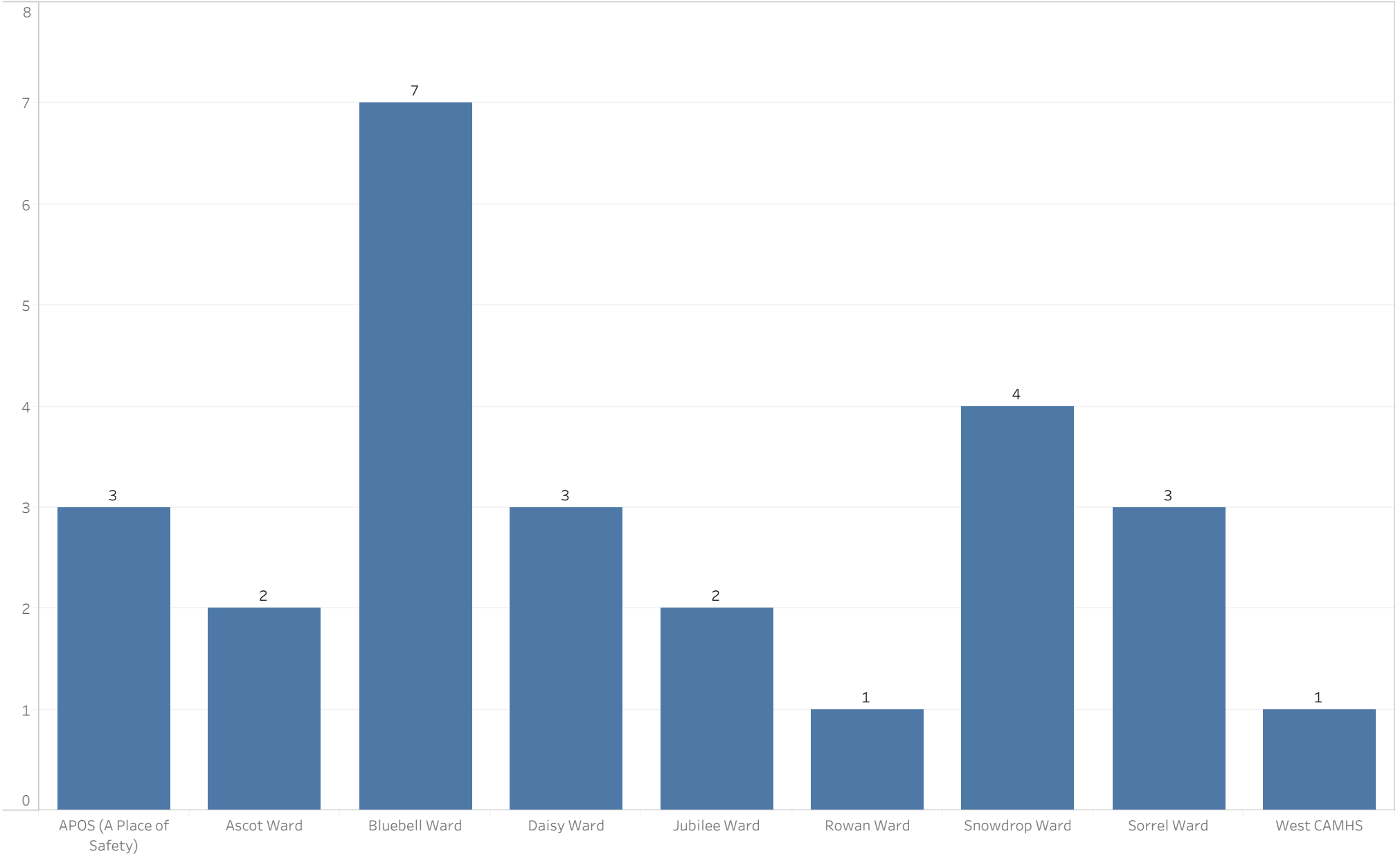


Supporting Our Staff Driver: Physical Assaults on Staff (Oct 19 to Sep 20)

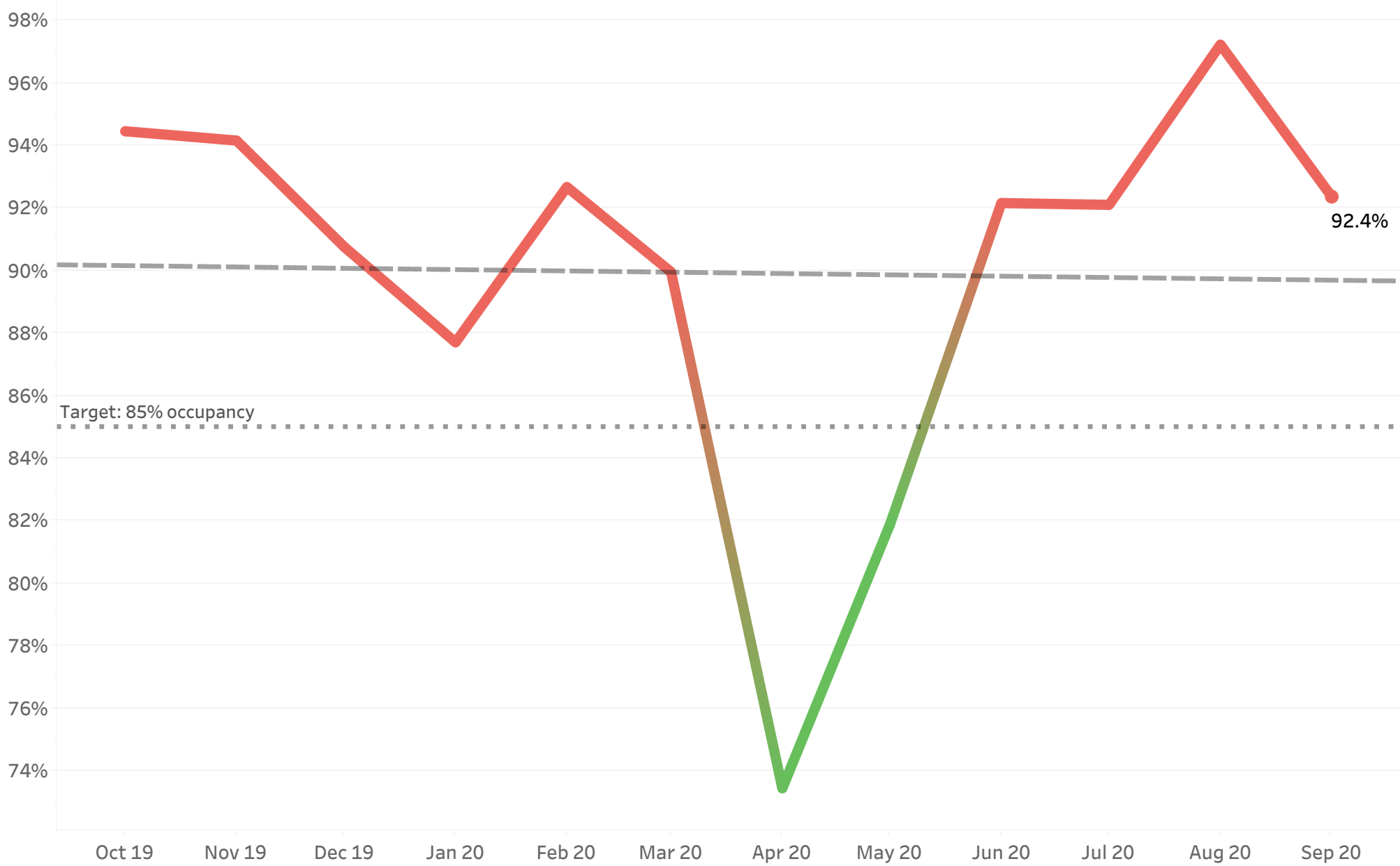
Any incident where sub-category = assault by patient and incident type = staff



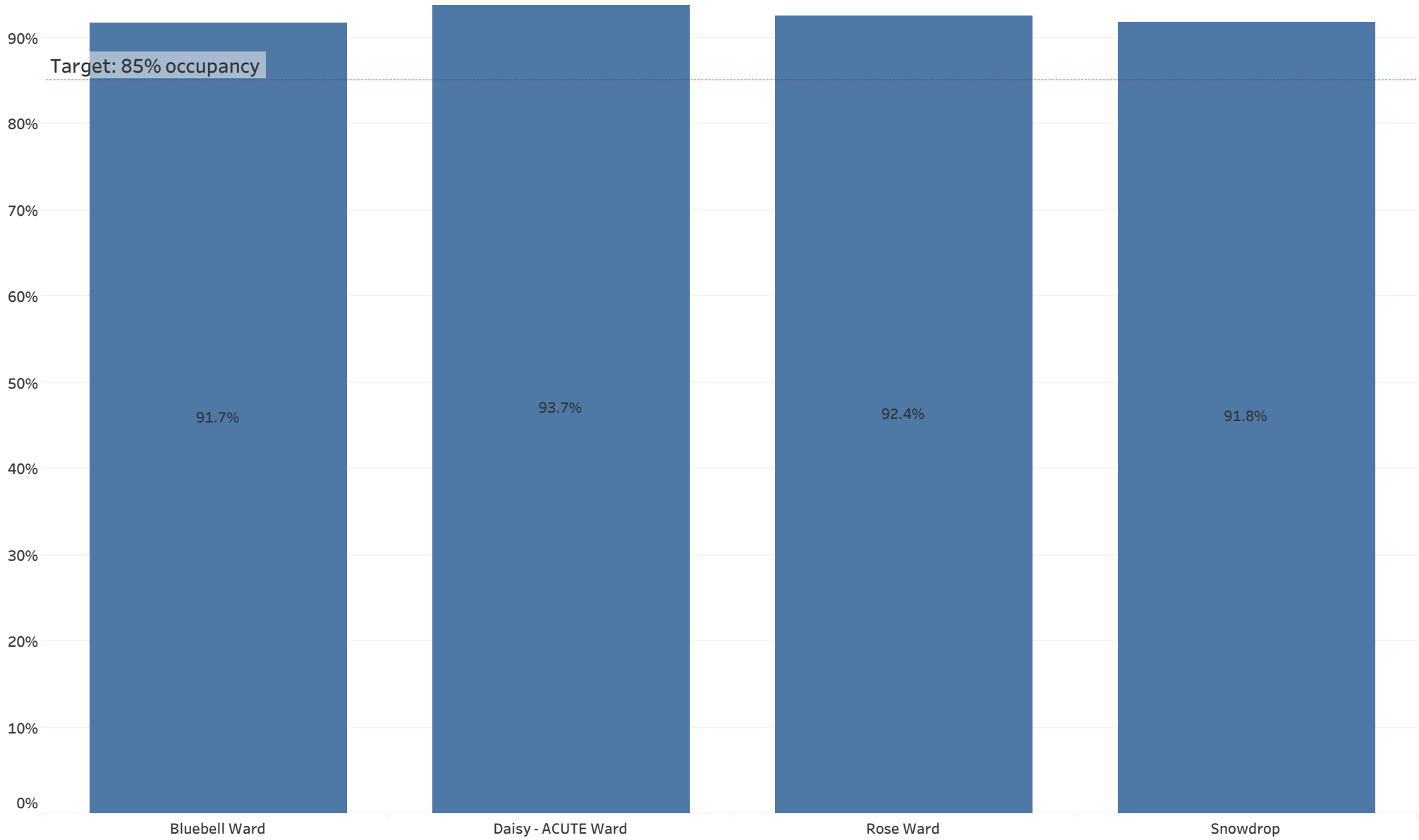
Supporting Our Staff Driver: Physical Assaults on Staff by Location (September 2020)



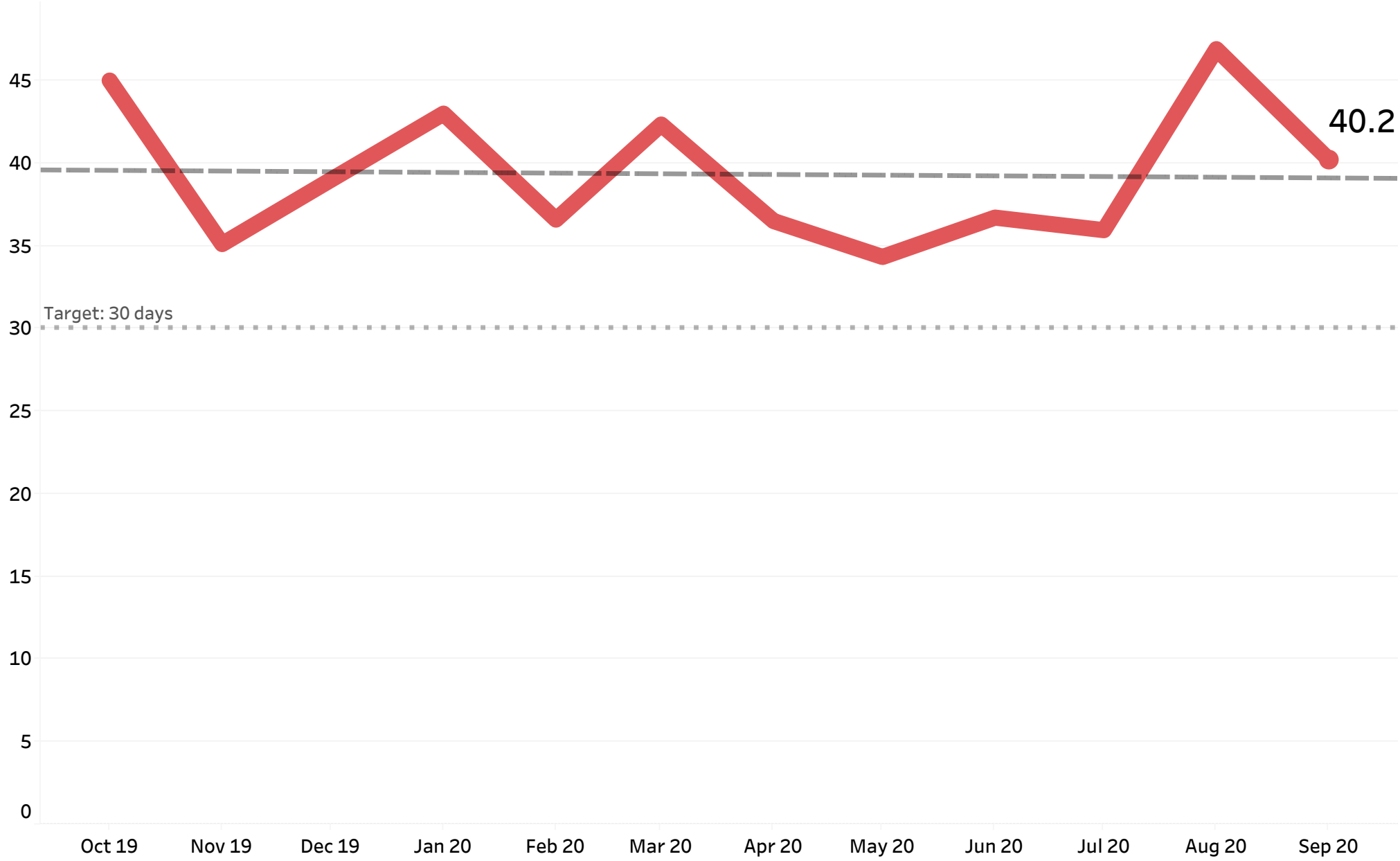
Money Matters: Mental Health Acute Bed Occupancy Rate (Oct 19 to Sep 20)



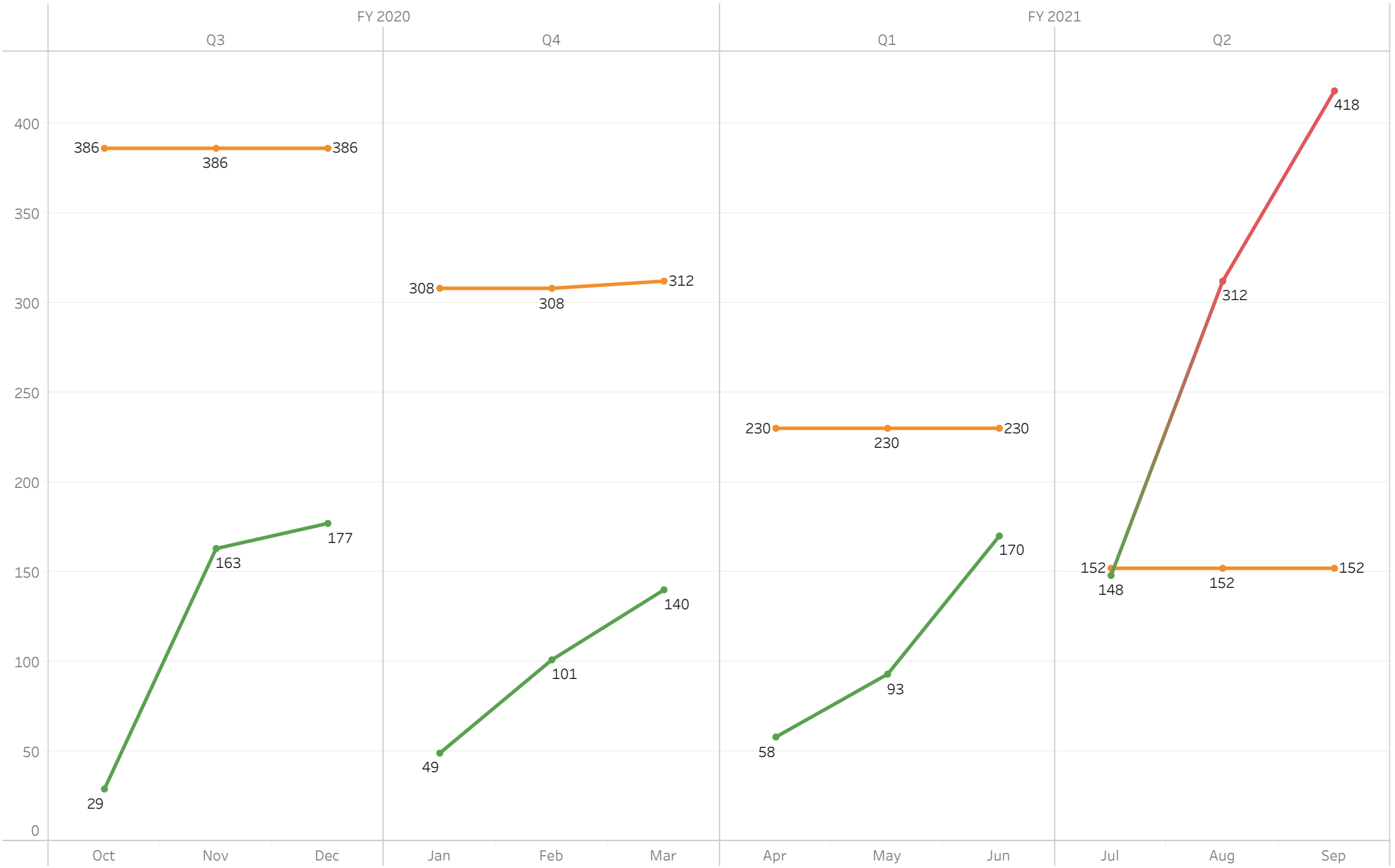
Money Matters Driver: MH Acute Bed Occupancy by Unit (September)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Oct 19 to Sep 20)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	2	3	0	2	0	1	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	3	0	1	0	1	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	2	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	18	6	8	8	5	2	2	3	3	9	2	2
Mental Health: Absconsions on MHA Section	8 per month	7	2	5	2	5	6	5	3	4	6	3	4
Mental Health: Readmission Rate within 28 days: %	<8% per month	6.04	5.63	5.26	5.97	5.09	4.42	4.29	5.42	5.86	5.22	4.95	6.33
Patient on Patient Assaults (LD)	4 per month	0	0	2	0	0	0	3	3	4	4	4	2
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	12.1%	12.5%			14.0%	13.6%	13.4%	13.3%	13.8%	13.5%	13.6%	13.7%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000			6.9	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	16	26	0	1	0	0	1	2	3	3	0	2

True North Patient Experience Summary

Tracker Metrics

		Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Patient on Patient Assaults (MH)	38 per month	19	27	15	17	14	15	15	15	20	24	12	21
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	93.9%	93.8%	90.6%	82.1%	93.9%	88.4%	89.1%	91.9%	92.6%	93.4%	91.1%	91.1%
Mental Health: Uses of Seclusion	13 in month	5	7	11	4	18	12	4	7	17	15	16	8

True North Supporting Our Staff Summary

Tracker Metrics

		Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Gross vacancies: % [Suspended centrally due to COVID]	<10%	6.80%	6.70%	7.09%	6.5%	6.09%	5.89%						
Statutory Training: Fire: %	95% compliance	93.0%	93.3%	93.9%	93.3%	91.5%	90.1%	88.4%	85.9%	87.3%	90.1%	91.3%	92.9%
Statutory Training: Health & Safety: %	90% compliance	96.4%	96.6%	96.6%	96.7%	96.4%	95.5%	96.0%	94.3%	95.5%	95.3%	95.6%	95.9%
Statutory Training: Manual Handling: %	90% compliance	92.9%	92.8%	90.2%	93.1%	93.3%	92.5%	90.0%	88.7%	90.3%	90.1%	91.1%	92.3%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID]	95% compliance	94.7%	95.2%	95.4%	94.4%	93.3%	93.9%	92.5%	90.0%	92.1%	92.6%	92.2%	94.7%
PDP (% of staff compliant) Appraisal: %	95% compliance 'Extended from 19/20. Reset in June 20'	88.9%	86.7%	86.4%	85.1%	83.9%	81.7%	80.5%	80.5%	42.1%	88.6%	87.3%	95.5%

Mental Health Inpatient Services – Fire training compliance

Org L7	Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Fire Safety Training - Whole Service	95%	89.6%	91.4%	93.9%	93.4%	93.2%	88.3%	88.4%	84.6%	90.6%	94.8%	96.9%	98.5%
371 Bluebell Ward PPH	95%	84.2%	88.0%	87.5%	87.5%	82.6%	71.4%	75.0%	72.0%	77.8%	95.5%	100.0%	100.0%
371 Daisy Ward PPH	95%	83.3%	91.3%	92.0%	96.4%	95.8%	100.0%	92.3%	92.0%	88.5%	92.3%	96.2%	93.8%
371 Orchid Ward PPH	95%	85.7%	89.7%	83.9%	81.3%	82.8%	80.0%	76.9%	76.9%	84.6%	92.3%	92.0%	96.2%
371 Rose Ward PPH	95%	87.0%	88.9%	96.0%	92.0%	100.0%	92.0%	91.3%	83.3%	91.3%	96.2%	96.3%	100.0%
371 Rowan Ward PPH	95%	92.3%	100.0%	100.0%	100.0%	97.1%	85.3%	80.0%	70.0%	77.4%	92.9%	100.0%	100.0%
371 Snowdrop Ward PPH	95%	87.5%	86.7%	93.3%	93.1%	93.1%	90.3%	93.3%	93.3%	100.0%	96.7%	96.9%	100.0%
371 Sorrell Ward PPH	95%	88.9%	88.9%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	96.2%	96.3%	93.3%	100.0%

Community Health – Fire training compliance

371 Community Health East Services	Fire Safety Training - Whole Service	95%	97.0%	94.8%	93.6%	95.1%	94.4%	93.1%	93.2%	92.4%	93.1%	94.8%	96.4%	97.8%
371 Community Health West Services	Fire Safety Training - Whole Service	95%	96.5%	94.3%	95.4%	94.8%	92.6%	89.2%	87.2%	86.3%	86.9%	90.5%	93.8%	95.6%

CH IP Fire Safety Breakdown

Org L7	Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
371 Henry Tudor Ward	95%	96.2%	91.7%	88.9%	92.9%	96.4%	96.6%	96.0%	96.6%	96.7%	93.1%	89.7%	100.0%
371 Jubilee Ward	95%	96.9%	90.0%	86.7%	93.1%	100.0%	96.9%	96.8%	100.0%	81.3%	96.8%	93.5%	100.0%
371 Oakwood Ward	95%	100.0%	100.0%	97.4%	97.6%	90.5%	87.2%	88.6%	89.5%	94.9%	100.0%	95.2%	95.7%
371 WBCH Inpatient Wards	95%	90.2%	93.9%	96.3%	95.2%	89.2%	84.5%	80.7%	77.8%	93.7%	93.9%	96.3%	96.2%
371 Wokingham InPatient Unit	95%	94.2%	91.2%	92.2%	95.5%	89.1%	88.9%	87.9%	82.8%	64.8%	86.7%	93.5%	96.7%

Campion & Willow House – Fire training compliance

Org L7	Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
371 LD - Campion Unit	95%	96.4%	100.0%	100.0%	100.0%	100.0%	96.6%	96.4%	85.7%	88.0%	71.4%	93.3%	96.9%
371 Willow House	95%	94.4%	100.0%	100.0%	84.2%	85.0%	89.5%	76.5%	78.9%	78.9%	95.0%	100.0%	100.0%

True North Money Matters Summary

Tracker 1

		Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	6.09	6.70	9.30	11	7.59			7.5	5.29	4.29	2.60	4.29

Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	75.4%	78.7%	82.5%	88.0%	90.5%	84.5%		75.4%	49%	57.3%	73.5%	72.8%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	80.07%	78.03%	77.29%	84.87%	83.09%	82.79%		63.39%	64.04%	84.74%	67.06%	75.68%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.79%	4.79%	5.20%	5.09%	4.70%	5.20%		4.20%	3.79%	4.39%	4.29%	4.59%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	9.90%	10.5%	10.8%	13.4%	17.8%			4%	2.10%	7.5%	6.5%	5.29%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
Mental Health: 7 day follow up (Quality Domain): %	95% seen	96.1	97.5	96.2	95.2	100	95.5	95.3	95.7	96.2	94.5	94.1	95.3
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	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	88	88	88	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	1	0	0	0	0	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	66.7	100	80	100	100	88.9	100	90.9	100	90.9	100	100
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98.4	97.4	95.8	97.9	96.2	94.0	92.9	98.0	97.9	96.0	98.2	98.7
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	95	95	96	95	94	95	95	94	96	95	96	98
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	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	59	57.7	56.0	60.3	57.1	54.4	53.4	53.2	55.4	56.6	56.1	57.4
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	60	60	60	59	59	59	59	59	59	59	59	59
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	11	11	11	12	12	12	12	12	12	12	12	12
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to COVID]	99% seen	100	100	100	99.7	100			100	100	100	97.8	98.2
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	96.2	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	98.9	100	100	100	100	100	100	98	100	100	100	100
Sickness Rate: %	<3.5%	4.41	4.75	5.04	4.88	4.10	4.39	5.89	4.08	3.40	3.49	3.23	
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	83	83	83	83	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	1	1	1	1	1	1						
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	96.2	97.8	98.2	98.2	98.4	98.1	98.7	98.7	98.4	98.2	98.9	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	10 November 2020
Title	**Finance, Investment & Performance Committee – Changes to the Committee's Terms of Reference**
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Naomi Coxwell, Committee Chair
Relevant Strategic Objectives	True North Goal 4 - To deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The Committee has reviewed its terms of reference and has identified a number of minor changes (highlighted in red type).
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference as agreed by the Committee on 29 October 2020.

Berkshire Healthcare
NHS Foundation Trust

Finance, Investment & Performance Committee

Terms of Reference

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10	June 2019	Julie Hill	Amended following review by F,I&P Committee – for board approval September 2019
11	August 2020	Julie Hill	Updated in August 2020

1. Authority

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

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

2. Purpose

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

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

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

2.1.3 Identify areas of organisational performance for more in depth review and scrutiny

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

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

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

2.17 ~~review staff staffing in respect of community nursing.~~

2.1.~~8~~7 review the relevant risks on the Board Assurance Framework.

2.1.8 Oversee the Trust's recruitment and retention activity on behalf of the Trust Board

2.1.9 Review the Trust's Employee Casework

3. Membership

3.1 The members of the Committee shall be as follows:

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

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

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

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

4. Frequency and Administration of Meetings

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

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

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

5. Remit

5.1 Financial Policy and Performance

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

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

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

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

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

5.2 Investment Policy and Performance

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

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

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

5.2.4 To ensure adequate safeguards on investment of funds.

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

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

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

5.3.1 To review and scrutinise organisational performance as reported within the Trust's True North Performance Scorecard report in accordance with the business rules

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

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

Amended: ~~July 2019~~ August 2020

Approved by Trust Board: ~~September 2019~~

For review~~: July 2020~~ August 2021

Berkshire Healthcare
NHS Foundation Trust

TRUST BOARD MEETING PAPER

Board Meeting Date	10 November 2020
Title	Berkshire Healthcare People Strategy and Priorities Board Report
Purpose	To update the Board on the development of the Trust People Strategy, and current people priorities and invite feedback and comment.
Business Area	Corporate
Author	Jane Nicholson, People Director (interim)
Relevant Strategic Objectives	Supporting our Staff. However, there are links into all our True North objectives.
CQC Registration/Patient Care Impacts	Deliver safe, compassionate, high quality care, and a good patient experience, through a skilled and engaged workforce.
Resource Impacts	Resource impacts of the strategy work are outlined in the presentation.
Legal Implications	Legal implications of the strategy work are outlined in the presentation.
Equality and Diversity Implications	The paper references next steps for our Workforce Equality and Diversity Strategy.
SUMMARY	The purpose of this paper is to give a summary of the proposed People Strategy and People Priorities.
ACTION REQUIRED	The Board is asked to note the activity underway within the People Directorate and to provide support and feedback to take

	forward the People Strategy and programmes of work.

Berkshire Healthcare
People Strategy and Priorities

1. Executive Summary

1.1 The role of the People Directorate is to ensure that the Trust can deliver safe, compassionate, high quality care, and a good patient experience, through a skilled and engaged workforce and that we do that in a way which is efficient and financially sustainable.

1.2 The purpose of this paper is to engage and inform the Board of the current summary of the People Strategy development. A high-level visual presentation has been prepared.

1.3 The Board is asked to note the activity underway within the People Directorate, and to provide support and feedback to finalise the People Strategy and programmes of work.

2. Background and Context

2.1 The new People Strategy is being developed in line with the launch of the new Trust Strategy, Equality, Diversity and Inclusion Strategy. The People Strategy is also aligned with the new NHS People Plan, and the emergent ICS People Strategies in BOB and Frimley.

2.2 The attached presentation is a visual summary of the proposed People Strategy. A full written strategy will be developed once engagement with key stakeholders (including this Board) has been completed.

2.3 A full communications strategy will support the launch of the new People Strategy which will then be available online and via our intranet.

3. Development of Refreshed BHFT People Strategy

3.1 A Quality Improvement (QI) approach has been used to develop our revised BHFT People Strategy, and the emerging themes from this work are reflected in the proposed people priorities.

3.2 We have identified turnover as one of the greatest risks to the Trust, and therefore a proxy measure of success. High turnover is a key indicator of both a waste of resources and potential broader underlying people issues which we need to understand and address.

3.3 The focus of the People Strategy, therefore, has been to understand the reasons behind high turnover within parts of the Trust, and addressing the underlying issues which cause this.

3.4 The People Directorate has therefore engaged with a number of staff groups to understand the issues. To date, we have undertaken the following engagement activities:

- Quality improvement development workshops with areas of the trust with persistent high turnover
- Open workshops for all staff with specific invites to our networks and key professions

- Regular monthly updates to the Strategic People Group on the progress of this work

3.5 Whilst our quality improvement countermeasures continue to be refined, a number of key themes have been identified. These are summarised below with detailed feedback in appendix 1.

- Career pathways especially for clinical staff
- Training and development opportunities especially for clinical staff
- Compassionate and inclusive leadership
- Talent management and progression
- Workload and working styles
- Remote working

These themes have been reflected in the proposed People Priorities.

3.2 Key metrics are outlined in the plan and will be refined and agreed once the strategic direction has been agreed by the board.

4. People Vision and Strategy: Outstanding for Everyone

4.1 Our vision is that Berkshire Healthcare is 'Outstanding for Everyone'. We will only attract and retain our people if Berkshire Healthcare is an employer that people want to work for. We want BHFT to be a great place to work where all our people can thrive and grow. This means that everyone who works in our Trust can expect:

- we live our values
- that everyone feels they belong
- that we do not tolerate poor staff experience
- we commit to the NHS People Promise

4.2 And we can ensure that:

4.3

- The Trust can deliver safe, compassionate, high quality care and a good patient experience through a skilled and engaged workforce in a way which is efficient and financially sustainable

5. Equality, Diversity and Inclusion (EDI) Workforce Strategy

5.1 The People Strategy and its priorities is inextricably linked to our Equality, Diversity and Inclusion (EDI) Strategy. The EDI strategy sets out the key priorities for our patients and workforce for the next 3 years. Our workforce EDI strategy is intended to address differentials of experience and to make Berkshire Healthcare outstanding for everyone.

5.2 For that reason, the People Strategy is committed to delivering the Workforce elements of the EDI Strategy.

5.3 Key metrics across patients and workforce will be agreed once the strategic direction has been agreed by the board.

6. Safety/Just and Learning Culture

6.1 Aligned to our EDI strategy work and Trust Safety Culture initiatives, the Trust was exploring ways to use Just Culture principles to improve our approach to investigations and disciplinaries and to address the adverse impact of investigations on certain groups of staff. This work will also form part of the People Strategy and will report into

the Safety Culture Steering Group who are overseeing the wider Just Culture work in the Trust.

7. Wellbeing Strategy

7.1 The People Directorate continues to work closely with the Head of Psychological Therapies to deliver a staff wellbeing strategy and offer which reflects post-Covid needs.

8 Transformation Projects

8.1 We continue to focus on business transformation and improvement opportunities.

Currently we are working on a trust response to increased remote working and we continue to work closely with our colleagues in IM&T to identify how we use can use new digital technologies to improve our workforce processes and thereby the experience of our people. Our current onboarding project is an example of our collaborative working.

9 Covid-19 Response and Recovery Projects

9.1 There are separate people workstreams as part of both these projects. The workforce elements of these projects will continue to form part of our People Strategy given the enormous workforce impacts of Covid-19.

10 National NHS Workforce Plan and ICS Strategies

10.1 Our proposed People Strategy has been reviewed against the NHS People Plan which was released in the summer to ensure that it is aligned. The themes we have identified use language from the NHS People Plan for consistency.

10.2 The Trust continues to work closely with both the Buckinghamshire, Oxfordshire and Berkshire West (BOB) and Frimley Health and Care Integrated Care Systems (ICS) to develop and deliver the system people priorities and workforce plans. We focus our resources on those ICS workstreams where, we in Berkshire Healthcare can:

- Share learning
- Benefit from systems working
- Bring our expertise to support system transformation

We are currently working closely with Frimley as an ICS pilot site for our Just Culture work.

We are also benefitting from partnership working across BOB for clinical apprenticeships and international nurses.

11. Next Steps

11.2 A full written version of the strategy will be finalised.

11.3 A full staff communication plan is being developed involving communication to all staff and publication on our website and intranet.

11.4 Detailed performance indicators and metrics will be agreed.

12. Summary and Board Actions

11.1 The Board is asked to note the activity undertaken within the People Directorate to develop our refreshed People Strategy and to provide support and feedback to finalise the People Strategy and programmes of work.

Appendix 1: Key Themes from QI Workshops

1. **Career Pathways**
   Certain services/professional groups do not have roles at different levels- this included people reporting that some services and professional groups have much less of a 'flat' structure, that some of these did not need to have a flat structure and that different bands and career development pathways need to be reconsidered. This includes bands at higher levels, but also at different levels. Some professions or services feel they are particularly specialist and cannot have roles at lower bands, but others disagreed. AHP's one such area. Although people are asked to review roles between posts that there is often panic to get it filled rather than a reassessment, some posts come back round multiple times. Lack of specialist /clinical/profession specific roles available at higher levels without going into general management which many people do not want to do.

2. **Training and Development**
   Training and development (including coaching, mentoring, work experience and shadowing)- This included not knowing what training and development could be accessed and where and how to access, not being given the opportunity to do training or development either too busy, not enough money, not offered or told certain training is only for individuals at certain bands e.g. excellent managers. It was reported that some people felt the TNA process didn't allow them to react to training or development opportunities that popped up in year. There were a few mentions of career workshops, shadowing programmes and the importance of interview skills.

3. **Compassionate and Inclusive Leaders**
   Belief in individuals/relationships with manager/being enabled to progress- about managers needing to believe in you, and if they do, and if you have a good relationship, or they are supportive you can progress more than if those things are not in place. Feeling that some managers think people who have been in post for a certain length of time won't want to develop and move forward. Also included an individual being told that the level they were at was a good place to be, despite the individuals being at the same level for 10+ years having multiple sideways moves and still not progressing, but really wanting to. Mention of them feeling that the colour of their skin had gotten in the way. There was some synergy with the work-life balance theme re: all managers needing to attend excellent managers training and them being directed to let staff know when they are ready for a promotion regardless of whether they have been asked.

   Excellent managers- as you know we collected more positive and less positive stories from this. We know that excellent managers includes ensuring that we have supportive managers, that people feel able to trust their managers to do what they say they will do. To treat people consistently and fairly, and that they trust them e.g. to do their jobs even if out of sight or working flexibly. That all of our managers receive the excellent managers training, ensuring that they are supported to follow through what they have been taught, and that this is actually happening. Also to identify where this isn't happening, and put in further support to the manager. This is also about managers getting to know their staff, really understanding the personal circumstances and work, so they know how they can support them. Need good relationships between managers and staff. Making sure new managers have support. Effective 1:1's and appraisals are required. So, it almost feels like we have provided lots of training as an organisation, but we are not supporting or monitoring what happens next. There may be something here about needing to identify where the above doesn't happen and putting in specific support.

4. **Talent Management and Progression**

Managers/organisation not supporting staff with career development/promotion- ensure conversations happen in 1:1's and appraisals, managers to understand what team members want by way of career development, then to put in place things to help them. For example, work experience, shadowing, etc, encourage them, follow up in future 1:1's. Managers modelling this. Not having diversity at higher levels to act as mentors and then support a more diverse group to reach higher levels was seen as a cyclical problem.

Knowing what to do to get to the next level- this included perceived glass ceiling between bands 3 and 4 and 4 and 5, going to multiple interviews but not sure why they didn't get the job or what to do to be successful next time. Good interview feedback was felt to be very important and people gave examples of where this had been really good and helped them to get to the next level. This needs include what the person needs to do to progress and development available and how to access this. Some people concerned that they are assessed on their interview skills at interview, rather than the skills they have to do the job. How do we support those who have been through interview after interview unsuccessfully and want to stay in the organisation?

5. Workload and Working Styles

Workload - there is more involved in this than the title suggests- specifically this is about expectations being clear, job roles/descriptions being reviewed periodically because they evolve over time. Unpredictable workload, perceived or real expectations of instant responses to email, emails outside the individuals working hours that they may or may not respond to, long hours, extra hours and recognition for this. Part time not meaning part time or a difference in workload. Also, fairness/parity between members of staff in the same team, or service, on the same band with different caseload sizes, complexities. Sense of those who do more work, receive more work. There are a number of elements here which will require different solutions.

Separation from work/permission to stop work/protected breaks – this came across strongly as something very separate to workload. It includes protected time for breaks and between meetings, scheduled 'coffee breaks', taking responsibility ourselves to take breaks and switch off laptops/not do work outside of hours, feeling guilty if not working or perceiving that others will not think they are working hard. Also needing help to mentally 'switch off' at the end of the day.

6. Remote Working

Flexibility/home working- this is very different for different people and may align well with the flexible working offer that we have heard Alex mention on the staff briefing. The key points to note here is that this is very individual and needs a personal discussion with individual members of staff. For some it is home working, or working their hours in 4 days, for others it is less hours, for some it is flexible working, for others it is just being able to pick or their children from school, or activities, and attend their key school events. There was something about people not being given flexible working so they reduced to part time and have to rely on NHSP at the times they can do to make up the hours. Elements link back to the 'excellent managers' point above about people needing to feel trusted/not guilty for working flexibly or home working, managers understanding their staff's situations enough to understand what flexibility they need to be able to do their job to the best of their ability.

Berkshire Healthcare
NHS Foundation Trust

People Strategy 2020-2023 For Review and Approval by the Board

Jane Nicholson **10 November 2020**

Jane Nicholson (presenter)

Context for a new People Strategy

The new People Strategy has been developed in line with the launch of the new Trust Strategy and the Equality, Diversity and Inclusion Strategy. The strategy is also aligned with the new NHS People Plan and the ICS People Strategies in BOB and Frimley.

Context and the Focus on Retention

There are systemic shortages of clinical staff within the NHS with fewer students studying for clinical degrees than staff leaving. The Thames Valley is also the most workforce constrained region of the NHS.

These factors impact on our ability to recruit staff sustainably. This means that we need to focus on retaining and developing our people. Failure to do so will impact on our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users

Our turnover rate is currently 14.5%, (higher than the NHS Thames Valley average), with some areas at much higher rates. Nationally we benchmark 34th out of 47 similar trusts for turnover.

If we do not improve our turnover rate, we risk continuing to :

- Lose skilled and experienced staff members.
- Expend resources to attract, recruit and train new staff members to replace leavers.
- Put pressure on our stretched finances
- Increase the workload of existing staff members and whose own experience of BHFT may consequently be less positive

Our People Vision and Promise: Outstanding for Everyone

Our vision is that Berkshire Healthcare is Outstanding for Everyone. We want BHFT to be a great place to work where all our people can thrive and grow. This means that everyone who works in our trust can expect:

- we live our values
- that everyone feels they belong
- that we do not tolerate poor staff experience
- we commit to the NHS People Promise

We want to ensure that the Trust delivers safe, compassionate, high quality care and a good patient experience through a skilled and engaged workforce in a way which is efficient and financially sustainable

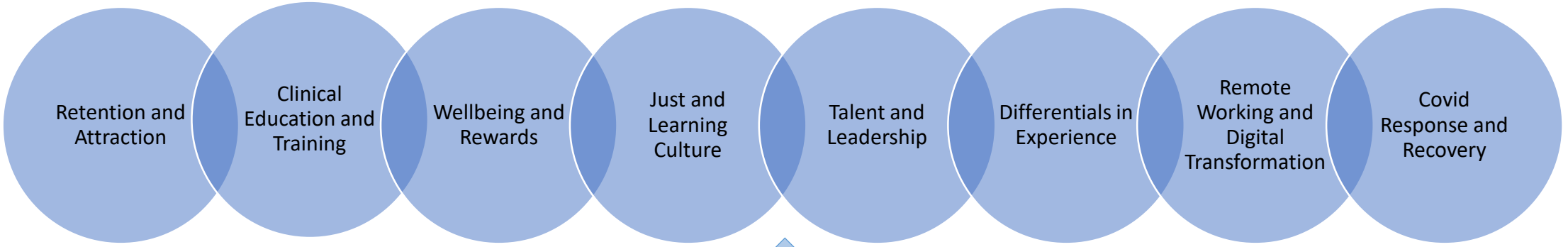
Berkshire Healthcare People Strategy and Key Priorities

People Vision

Outstanding for Everyone

Our vision is to make BHFT a great place to work, where everyone can thrive and grow. This means having the right teams and skills to give the best care to our patients and that those teams feel inclusive and supportive. To make this a great place for everyone, we need to focus our attention on those pockets of poorer experience and address these using QI principles

Growing and Retaining for the Future	Looking After our People	Belonging to the Trust	New Ways of Working



Supported by Workforce Planning

Business as Usual

QI Approach to Development of People Strategy

We have used a Quality Improvement (QI) approach, to develop our People Strategy, with a focus on understanding the reasons behind high turnover within parts of the Trust and addressing the underlying issues which cause this.
High turnover is a key indicator of both a waste of resources and potential broader underlying people issues which we need to understand and address.

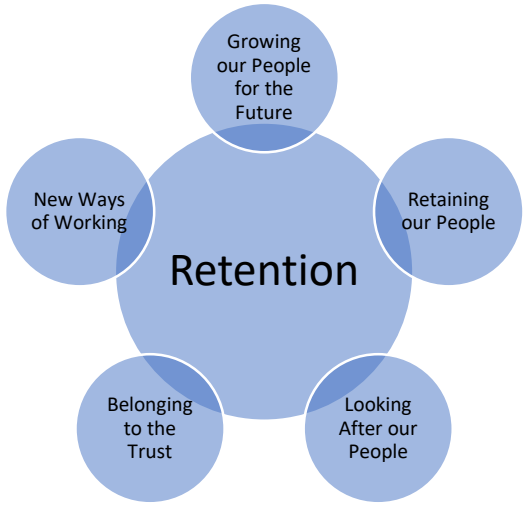
People Strategy QI Work:

Evidence from Engagement with our People

- Targeted discussions with teams experiencing high turnover
- Open workshops including representatives from our networks

Evidence from our data:

- WRES and WDES
- Staff survey results
- Frimley Mental Health Development Project



Emergent Initiatives from QI work

Equality, Diversity and Inclusion

The People Strategy and its priorities is inextricably linked to our Equality, Diversity and Inclusion (EDI) Strategy. Our EDI strategy is also intended to address differentials of experience and to make Berkshire Healthcare outstanding for everyone.

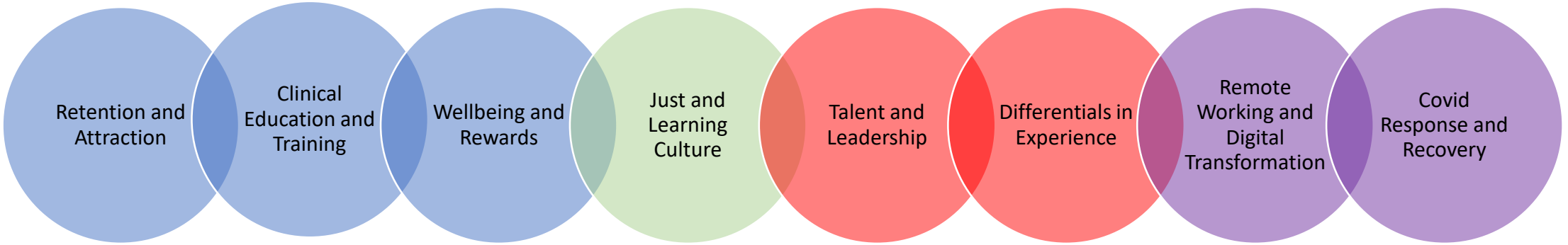
For that reason the People Strategy is committed to delivering the Workforce elements of the EDI Strategy.

Berkshire Healthcare People Strategy and Key Priorities

A number of the Priorities within the overall People Strategy will be progressed as part of wider Trust strategies and transformation initiatives as illustrated below.

The Strategic People Group, however, will retain oversight of all these initiatives and the realisation of their respective benefits.

People Strategy	Safety Strategy	EDI Strategy	Workforce Transformation Projects
Strategic People Group	Safety Culture Steering Group	Diversity Steering Group	Strategic People Group



Caring for and about you is our top priority

Committed to providing good quality, safe services

Working together to develop innovative solutions

NHS
Berkshire Healthcare
NHS Foundation Trust

Equality, Diversity and Inclusion Plan on Page Year 1

Where we are

Berkshire Healthcare is recognised as an outstanding organisation however this is not the experience of everyone, resulting in pockets of inequalities and discrimination experienced by patients and staff with protected characteristics. The impact of this is poor health outcomes, not achieving full potential, feeling of not belonging, feeling excluded and not being able to be your true self. We need to demonstrably improve culture at all levels to ensure consistency of experience for all.

Our People

- Improve inequalities and differentials in experience
- Embed inclusive and compassionate leadership approaches
- Workforce development, career progression and talent management
- Strengthen and develop our staff networks
- Develop and deliver our inclusive 'Ready for Change' programme

These will be reflected in the People Strategy

Our Patients

- Embed use of the Accessible information standard for disabled patients across all services
- Embedding and recording of patient demographics to improve health outcomes
- Identify actions and resources needed to reduce health inequalities through Community Engagement
- Promoting LGBT+ engagement and support through Stonewall and Reading Pride
- Develop inclusive recruitment with services
- Co-produce actions and resources needed for Trans patient's pathways

Where we are going

This strategy will address the disconnect between the top and the rest of the organisation and support the development of allies of this culture change at all levels over the next three years. This will lead to improved staff and patient satisfaction, good health outcomes and everyone feeling they are valued and have a voice.
This will make Berkshire Healthcare outstanding for everyone.

Growing and Retaining for the Future: Retention and Attraction

To attract, retain and train the workforce we need now and in the future

True North Goal:

Harm Free Care

Background and Problem

Given the systemic supply shortages for many of our key roles we need to focus on retaining and growing our own people. Too many people join our Trust and leave within 2 years. Once we have attracted people to BHFT, we need to keep them! Failure to do so will impact on our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users.

Retention is a key priority for the trust, as we will not be able to simply recruit our way out of these difficulties, however resourcing strategies to support and fill our difficult to fill roles are integral to the continued success of the trust.

Response

- QI process to identify key retention issues and countermeasures including why people want to stay
- Improve onboarding experience for our new starters by utilising our digital transformation programme with 1 click IT solutions.

SRO: Simon Small

Milestones

Deliverables	Start date	End date
1 click IT solutions – Appointment form changes – improved experience for both new starter and manager		Nov 2020
1 click IT solutions - Digitising recruitment paperwork to improve recruitment experience for our new starters	Nov 2020	Mar 2021
1 click IT solutions - Develop Extranet to provide a better onboarding experience for our new starters.	Oct 2020	Jan 2021
Develop resourcing strategies utilising the digital transformation programme to increase reach and pipeline.	Sep 2020	Mar 2021
Further develop targeted social media campaigns for services with high level of difficult to fil roles.	Oct 2020	Mar 2021
Develop International recruitment pipeline – working with ICS partners to develop BHFT offer, training and support network.	Oct 2020	Oct 2021

Key Risks and Issues/ Mitigation

Our turnover rate is currently 14.5% and nationally we benchmark 36th out of 48 trusts. Our analysis shows that we have high turnover within the first 2 years in role and in key areas including in-patient units, community nursing and health visitors. When combined with the ageing workforce within BHFT, this is the reason why workforce is highlighted as a major risk on our Trust Risk Register. The focus of our QI work on retention is to mitigate this risk.

Impact and Benefits

- Improved turnover rate reducing the loss of skilled staff without a pipeline of trainees to replace those lost.
- Reduce waste from continually expending resources to recruit, train and orientate new staff members to replace leavers.
- Reduce pressure on finances and on existing staff members whose workload may increase due to vacancies

Measures

- To reduce turnover of staff with less than 2 year's service by 50%.
- Reduced bank and agency spend.

Resources required (if any) for delivery

- QI Support and expertise
- Communications
- Web development team

Growing and Retaining for the Future: Clinical Education and Training

To attract, retain and train the workforce we need now and in the future

True North Goal: Harm Free Care

Background and Problem

Clinical Education aims to maximise and "future proof" the capability of our staff to deliver safe, effective and patient and family centred care.

Within our region, there will be a reduction in clinical students in the next 3 years by: 2.2% each year for adult nurses and 4.4% each for mental health nurses. Nationally there is a 9% vacancy rate across all AHP groups. If we do nothing in the next 3-5 years this will increase to 13%.

Given the systemic supply shortages for many of our key roles we need to focus on retaining and growing our own people. Failure to do so will impact on our ability to meet our commitment to providing safe clinical care and a good patient experience for our service users.

Response

- Attract and support more undergraduate students through placement expansion to expand the recruitment pool
- Support clinical apprenticeships programmes to enable progression of our HCA, NA and AP etc from band 3-4 to Band 5 registered professionals
- Provide support for internationally qualified nurses currently working as HCA to gain professional registration
- NHS Reservist Project – working with the BOB ICS to develop new clinical pipelines for
- Facilitate the development of standardised career pathways for advanced practitioners to support career development
- Improved access to training and training funds
    - Technology enhanced, accessible, Covid-smart training to empower our staff to provide harm-free care to patients
    - Fully digitalised TNA process

Milestones

Deliverables	Start date	End date
Using the funding secured from HEE through bidding, we will expand our placement capacity by 25% by September 2021 and an additional 25% by Sept 2022	September 2020	September 2021 (phase 1)
5 HCA will be supported to achieve NMC PIN through our 12 month PIN programme	October 2020	August 2021
An HEE endorsed blended learning platform **clinical skills.net** will be available to our educators. Aims to reduce the face to face teaching time by 30 % and increase the number of training sessions provided.	October 2020	December 2020
Apprenticeship strategy is developed and submitted for approval at the SPG	September 2020	January 2021
5 RND candidates will start a rotational apprenticeship programme as part of the ICS apprenticeship project Additional 5 candidates will start the programme in Feb 2021	September 2020 Feb 2021	September 2023 Feb 2024
A clear career progression pathway will be available on nexus for nurses by November 2020 (this work is underway; delayed due to Covid 19)	March 2020	November 2020
A review of advanced clinical practice development within the Trust against national standards will be carried out and a Trust strategy for developing ACP roles (HEE funded prost)	November 2020	November 2021
Digitalised training needs analysis (TNA) process will be implemented allowing flexible and all year around access to training funds for our clinical workforce	September 2020	December 2020

Key risks and issues/ Mitigation

- The success of the PIN programme depends on funding. A second Bid is submitted
- A Covid 2nd wave may delay placement expansion We are exploring blended learning with our providers.
- Lack of uptake of apprenticeship from clinical and non-clinical services . Apprenticeship team to provide awareness workshops

Impact and Benefits

- Improved turnover rate reducing the loss of skilled staff without a pipeline of trainees to replace those lost.
- Reduce waste from continually expending resources to recruit, train and orientate new staff members to replace leavers.
- Reduce pressure on finances and on existing staff members whose workload may increase due to vacancies

Measures

- 25% placement expansion across the Trust by 2021 September and an additional 25% by 2022 September
- Reduced turnover and vacancies

Resources required (if any) for delivery

- AHP Learning Environment Lead recruited following successful funding bid
- Ongoing support from the Recruitment and Retention Team
- Funding for PIN programme
- Support from BOB ICS for reservist project

SRO: Pearly Thomas and Joe Smart

Looking After Our People: Wellbeing and Rewards

To value our people and support them to thrive at work

Background and Problem

We want our people to feel engaged, valued as well as physically and psychologically supported so that they thrive at work and perform well in their roles. This is even more important due to the impact of Covid and increased home working. However our Trust absence rate remains above target of 3.5%. Anxiety , stress and depression remain our highest reason for absence and referrals for MSK and back related problems have increased.

The current rewards programme is disjointed and unevaluated and we need to understanding whether the rewards programme has any impact on employee engagement and experience.

Deliverables

- Develop a health and wellbeing plan and actions
- Develop evidence based psychological staff support offer for all staff based on Covid learning. introduce health and wellbeing assessments to all staff as part of the annual appraisal.
- Develop health and wellbeing inductions for all new starters.
- review and scope a new benefits and recognition offer

Milestones

Deliverables	Start date	End date
Review rewards programme and make recommendations	Jan 21	Apr 21
Appoint Wellbeing Guardian	Oct 20	Jan 21
Introduce Wellbeing Conversations	Oct 20	Apr 21
Deliver Health & Wellbeing Induction for all new starters	Jun 20	Oct 20
Review Healthy Workplace Ally/HWB Champions proposals for all teams	Oct 20	Dec 21
Improve access to Psychological Support for staff	Mar 20	Ongoing
Review NHS HWB Framework & NHS People Plan	Oct 20	Ongoing

Key risks and issues/ Mitigation

Psychological and physical impact of working through COVID-19 - risk of infection, staff burn-out, disillusionment, moral injury, mental health problems (potential for associated sickness and retention issues). Mitigated by our Risk Assessments, Staff Wellbeing offer and wider staff reward interventions that recognise the wellbeing and value of our people.

Financial cost of offering new services. Mitigated by commitment of Trust to this work

True North Goal: Support Staff

Impact and Benefits

Wellbeing has a direct impact on retention and staff engagement. By focusing on wellbeing, alongside compassionate leadership, staff have a greater opportunity to thrive at work through focusing on promotion, prevention and intervention. By making rewards and wellbeing a central element of our employee's experience we help to make people feel values and feel this an outstanding place to work for everyone.

Measures

- Sickness Absence reduced to at or below target
- Staff survey scores – increased engagement rates
- Retention rates improved

Resources required (if any) for delivery

- Resources for staff wellbeing offers

SRO: Steph Moakes and Bridget Gemal

Looking After Our People: Just and Learning Culture
Learning, not blame-seeking through a Safe and Just Culture

True North Goal: Support Staff

Background and Problem

The number of formal investigations especially involving BAME members of staff is still too high. Investigations take up too much time for our staff and it is difficult to source and train investigators. processes and feedback from those involved. These investigations create a culture of conflict rather than learning.

Just Culture recognises that it not always appropriate respond to an incident, or concern with formal procedures. Instead it supports consistent, constructive and fair evaluation of the actions of staff. It is completely aligned to the compassionate behaviours and leadership that are at the heart of our Trust values.

Deliverables

- Review Disciplinary and Grievance Policies to ensure they follow Just Culture principles and reduce adverse impacts on certain groups
- Centre of Excellence with investigators and mediators who are trained in the principles of Just Culture
- Embedding Just Culture in leadership training
- Review and measure staff experiences

SRO: Tracey Slegg

Milestones and Delivery Dates

Milestone	Start date	End date
Review of current policies to ensure they are aligned to just culture principles.	October 20	December 20
Consultation and agreement of policies and associated guidelines.	January 21	April 21
Embed just culture principles into management of employee relations casework.	October 20	April 21
Pilot centralised, dedicated investigators. Evaluate need for mediators and pilot.	November 20	April 21
Develop tool to monitor areas of disparity particularly linked to our BAME workforce so that improvement can be achieved	November 20	December 20

Key risks and issues/ Mitigation

- Lack of stakeholder engagement and participation in the process
- The programme will not be delivered in a timely way to support the ongoing insights work
- Withdrawal of agreed funding to support the process

Impact and Benefits

- Assurance about the way in which conduct and grievance processes are managed across the System in particular with regard to any disparities linked to BAME groups
- Opportunities to reduce 'conflict' cultures in favour of 'just' cultures where mediation is utilised more to resolve differences in the workplace
- Assurance that formal processes can be managed without undue delay because more trained investigators and mediators are available to call on by the System

Measures

- Reduction in the incidences of conflict
- Improved feedback from staff
- Improved number of cases that are resolved within the target timeframe
- Successful collaboration with ICS partners on a revised process for case work management

Resources required (if any) for delivery

Frimley ICS funding sought to support system wide implementation

Resources identified from Frimley ICS to support implementation

Belonging to the Trust: Talent and Leadership
Developing compassionate and inclusive leaders now and for the future

True North Goal: Support Staff

Background and Problem

Covid has allowed us to review the leadership style and offer required for 2021 and beyond and ask the question **'What does good leadership look like now?'** We need to review and update our leadership and talent offer continuing to embed the principles of compassionate and inclusive leadership.

BAME staff in the Trust are over represented in the lower bands and white staff are over represented in high band and VSM posts (in line with wider NHS statistics).

Response

QI A3 to understand our leadership and talent development needs and using this data:

- Develop workforce career progression and talent management offer which addresses inequalities of opportunities for those with protected characteristics.
- Refreshed leadership offer which embeds inclusive and compassionate leadership approaches

SRO: Joe Smart

Milestones

Deliverables	Start date	End date
Leadership QI working group set up to review and design replacement for Excellent Manager Program	Aug 2020	April 2021
Launch of 'Ready for Change' which replaces the Making it Right Programs for Networks	January 2021	Ongoing
Launch 'Reaching My Potential' Band 2-6 development program	December 2020	Ongoing
Develop and design Talent Management approach for all levels of the organization and launch	December 2020	March 2021
Implement agreed leadership interventions	April 2021	Ongoing
Implement agreed talent interventions	April 2021	Ongoing

Key risks and issues/ Mitigation

The workforce data when broken down by grade/banding and ethnic background shows that BAME staff are over represented in the lower bands and white staff are over represented in high band and VSM posts (in line with wider NHS statistics). The Trust has a huge commitment to Equality, Diversity and Inclusion and recognises the advantages a diverse workforce and leadership team can bring to its business.

Impact and Benefits

A leadership vision, message and development programme based on the principles of compassion and inclusion for all managers and leaders that allows reflection and consideration on their personal leadership behaviours.
Leaders understand their impact on organisational change and how to to create a future state for 2021 and beyond that will make Berkshire Healthcare outstanding for everyone.

Measures

- Representation rates in higher banded roles
- Pulse check, survey results re leadership
- Manager and staff retention rates
- Locally resolved performance and grievance situations
- Network feedback

Resources required (if any) for delivery

- QI expertise and support
- Support of organisation for Leadership Steering Group
- Network Support

Belonging to the Trust: Addressing Differentials in Experience

We are compassionate and inclusive and everyone feels valued and has a voice

Background and Problem

Berkshire Healthcare is recognised as an outstanding organisation however this is not the experience of everyone, resulting in pockets of inequalities and discrimination experienced by patients and staff with protected characteristics.
Data from the Staff Survey, WRES and WDES and our Stonewall submissions show that disabled, LGBTQ+ and BAME staff all have worse experiences compared to other staff. When intersectionality is also factored in this experience drops even lower.
We need to improve inequalities and differentials in experience and strive to make the organization 'Outstanding for Everyone'

Response

- Improve inequalities and differentials in experience through:
  - Tackling Bullying, Harassment and Discrimination
  - Tackling Micro-aggressions
  - Targeted OD Interventions
- Strengthen and develop our staff networks
- Develop and deliver our inclusive "ready for change" programme

SRO: Nathalie Zacharias

Deliverables	Start date	End date
Identify services where staff experience bullying and harassment and put in place training and resources to address this- links with FTSU	10/20	10/21
Roll out programme to reduce microaggressions – links with BAME transformational programme	09/20	10/21
Review all leadership programmes to include EDI to increase managers understanding of differentials in experience for staff with protected characteristics	In progress	ongoing
Strengthen staff networks to maximise capacity to support EDI work	09/20	ongoing
Develop, test and roll out training package developed called 'Reaching my Potential' for all staff with protected characteristics	09/20	09/21

Key risks and issues/ Mitigation

The impact of not doing this work is poor health outcomes for our patients because our people are not achieving their full potential, have a feeling of not belonging, feel excluded and not able to be their true self.

There are also legal risks of discrimination against staff, both directly and indirectly.

True North Goal: Support Staff

Benefits

We need to demonstrably improve culture at all levels to ensure consistency of experience for all
We know that the most diverse teams and organisations are the most successful ones and more importantly deliver high quality patient care.
We demonstrate explicitly that we value diversity; that everyone feels welcome and included and is supported to achieve their own potential.

Measures

- National Staff Survey results
- WRES
- WDES
- Stonewall audit
- Equal Pay audit

Resources required (if any)for delivery

- Increase Director of EDI to 4 days per week
- Parity of grading for the workforce and patient roles within the EDI team
- Project support as required

New Ways of Working: Remote Working and Digital Transformation

To reconsider how and where we work by simplifying our business processes and benefitting from new technologies

True North Goal:
Support Staff and Money Matters

Background and Problem

Covid has allowed us to reconsider how and where we work. Not only have we exploited new virtual technologies and the benefits of home working, but we are starting to consider how we can transform many of our business processes using technology.

Our next steps are to consider what options are available as we move into 2021/22 and beyond, and to make decisions about our strategy and future plans especially as many people continue to work from home. Consideration will need to be given to the impacts this will have on the delivery and efficiency of our services, and on the work-life balance and well-being of our workforce.

Response

Develop and embed the future long term remote working arrangements for our workforce taking into account many employment law and HMRC considerations
Design new training packages to support our workforce adopt new technology and ways of working.

SRO: Tracey Slegg and Joe Smart

Milestones

Deliverables	Start date	End date
Develop and deliver a Home Working policy including tax implications	October 20	January 21
Employment terms for full and partial homeworkers. Roll out new training for managers for managing remote teams	October 20	December 20
Consultation with staff and unions on homeworking policy & Wellbeing strategy for homeworkers	November 20	March 21
Remote working recruitment strategy development	December 20	March 21
Launch a QI project to raise the digital competence of the organization to ensure IT systems are being used to their full potential	October 20	March 21
Revised contract of employment and terms and conditions. Agreed with unions and network leads, consultation with affected staff and implementation.	December 20	May 21
New E-learning project to streamline delivery of training	August 20	April/May 21

Key risks and issues/ Mitigation

The impact of homeworking on our culture is significant and not to be underestimated. Since March 20, we have encountered and mainly overcome the immediate challenges, including practical equipment issues, to the well-being of those working remotely for the first time. The introduction of a formal policy will mitigate some of these risks.

Benefits

- Ability to attract a wider group of candidates for some home working roles
- Reduction in office costs as more people work wholly or partially from home
- Ability to exploit new virtual technologies more quickly e.g. Teams, cloud based document sharing
- Promote the wellbeing, flexibility and work-life balance benefits of home working
- Robust support and guidance for managers and staff that underpin our working from home

Measures

- Safe implementation of new working from home arrangements for everyone affected
- Continued provision of well being support for everyone working from home
- Full engagement of affected people, trade unions and network members.
- Update in user experience of e-learning and virtual learning

Resources required (if any)for delivery

Support from legal and tax experts
Creation of E-learning and Digital competency trainer post for L&D Team

New Ways of Working: Covid Response and Recovery
Keeping our staff and patients safe and well during Covid

True North Goal:
Support Staff and Safe Staffing

Background and Problem

Using the knowledge gained from the first wave of Covid, we have been planning for a second wave of Covid-19 and a potential period of the need to redeploy some of our staff.

Coping with the effects of Covid-19 has been challenging for many of our workforce since March 20. The challenges include an increased workload, working in a different role as a redeployee, and for some the added uncertainty and risk of caring for and working with Covid-19 positive patients.
For others, they have had the change to working from home, and whilst many have reported some key benefits with this, for others it is a concern in terms of their well-being and this is a more frequent concern month on month, as working from home continues.

Response

- Workforce forecast based on service recovery plans to inform business planning process
- Planned return of staff to services which captures learning and informs wider changes and transformation
- Trust policies and guidance on staff T&Cs in response to need
- Clear communications to staff about our Covid response

Milestones

Deliverables	Start date	End date
2nd Surge Planning learning from first phase Covid	September 20	November 20
Management of redeployment process during 2nd wave	Estimated Nov/Dec 20	Estimated March 21
Implementation of above, including staff and union consultation and agreed policy on home working	December 20	March 21
Management of staff who were shielding and assessed as high risk, to ensure their safety and to safeguard the Trust	July 20	November 20
Workforce arrangements for delivery of Covid vaccine for BHFT staff	October 20	Estimated March 21
Regular guidance to staff re Covid working arrangements	Estimated November 20	March 21

Key risks and issues/ Mitigation

Risks of infection from Covid which is being mitigated by individual risk assessments and guidance for all staff

Protracted home working for those groups where there are fewer remote working benefits will inevitably impact on our sickness absence, and this will be monitored on an on-going basis. Reasons for absence such as MSK illness, stress related illness and headaches/migrane

Further central demands for Covid related resources eg vaccinators. Working across our ICSs will mitigate some or all of this risk

Benefits

A planned workforce response will enable us to proactively meet the Covid-related resource demands whilst keeping our staff safe and well.
We can then work with our operational colleagues to understand and plan for post-covid workforce requirements

Measures

- Covid infection rate in staff
- Safe staffing levels achieved
- Our staff feel supported and informed

Resources required (if any)for delivery

HR Operations staff have been diverted to support this work and may require backfill resource

Corporate staff have been identified to support any further surge

SRO: Tracey Slegg

Workforce Planning:

Our strategy will be underpinned by clear workforce planning.

Workforce is the starting point for business planning, not the end point.

Define Available Workforce	Map Service Requirements	Map Workforce Gaps	Map workforce Costs	Gap analysis	Develop Action Plan
• Identify current and future staff availability based on current profile and deployment (workforce supply). • Agree future workforce assumptions • Cost current workforce supply including bank and agency	• Identify the skills required and the type / number of staff to deliver the service model (workforce demand). • Where are there workforce gaps which are unlikely to be filled? • Which services may be at risk?	• Where are there workforce gaps which are unlikely to be filled? • Can these be filled by bank and agency? • What service and workforce transformation can alter the picture of demand for services ?	• Identify the costs to resource the service requirement • Are they realistic against the financial baseline? • Which service lines are profitable based on workforce forecast?	• Consider existing service trend analysis • Consider demographic pressures • Understand how Trust service and transformation plans alter workforce plans • Consider wider NHS and ICS plans	• Consider relevant case studies • Model scenarios and agree on plan • Review and monitor plan and adjust for changes in assumptions

Key enablers of workforce transformation

Supply

Identifying current and future workforce availability in terms of skills, capabilities and numbers, in order to identify the appropriate workforce interventions.

Recruitment and retention interventions form part of this element of the STAR tool.

Up-skilling

To improve the aptitude for work of (a person) by additional training
the aim of which is to create:

- A competent workforce working to its maximum potential
- An agile workforce that may be flexibly deployed
- A capable workforce with future-facing knowledge and skills

New roles

Health and care roles designed to meet a defined workforce requirement, warranting a new job title; the likely ingredients including additionality to the workforce, a formal education and training requirement (whether that be vocational or academic), an agreed scope within the established Career Framework, and national recognition (although not necessarily regulatory) by clinical governing bodies.

New ways of working

Emphasis on developing an integrated workforce culture that empowers it to break through system barriers to deliver a practical response, resonating with STP needs, to person-centred care.

Virtual delivery, remote working, telemedicine and digitalization all form part of this element of the STAR tool.

Leadership

The support of individuals, organisations and systems in their leadership development – ranging from individual behaviours and skills, to organisational development of systems through partnerships.

Changes in both leadership and management form part of this element of the STAR tool.

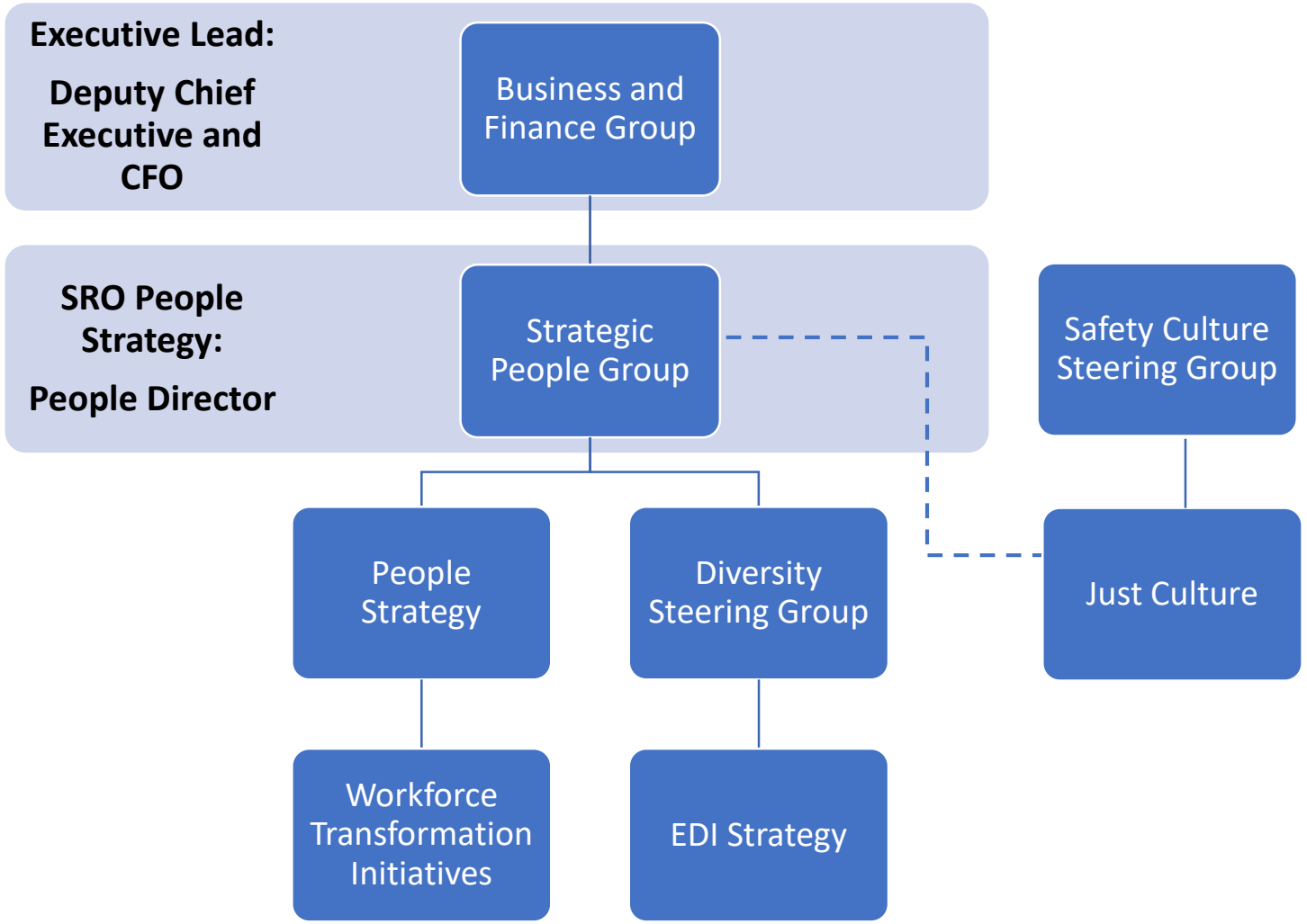
Berkshire Healthcare People Plan on a Page

Priorities (Aligned to NHS People Plan)	Initiatives	Outcomes and Benefits	KPIs
Growing and Retaining for the Future	Retention and Attraction	To attract and retain and train the workforce we need now and in the future	Reduce turnover by 50%
	Clinical Education and Training	To develop and train the clinical workforce we need now and in the future	25% placement expansion Reduced turnover and vacanciese
Looking After our People	Wellbeing and Rewards	To value our people and support them to thrive at work	Sickness Absence reduced Increased engagement rates
	Just and Learning Culture	Learning, not blame-seeking through a safe and just Culture	Reduction in the incidences of conflict
Belonging to the Trust	Talent and Leadership	Developing compassionate leaders now and for the future	Representation rates in higher banded roles Leadership from staff survey
	Differentials in Experience	We are compassionate and inclusive and everyone feels valued and has a voice	WRES WDES Stonewall results
New Ways of Working	Remote Working and Digital Transformation	To reconsider how and where we work by simplifying our business processes and benefitting from new technologies	Engagement from those affected by transformation
	Covid Response and Recovery	Keeping our staff and patients safe and well during Covid	Covid infection rate in staff Safe staffing levels achieved

Our Culture

Current	Future
Reacting to workforce gaps	Proactively identifying and planning our future workforce
Poor retention rates	High retention rates
Limited training opportunities	Training accessible for all.
Underuse of apprenticeships	Maximising value of apprenticeships
Our people are surviving at work	Supporting our people to thrive at work
Punitive blame culture	Just culture where we learn from mistakes
Compassionate culture understood but not embedded	Compassionate and inclusive culture for all
Compassionate culture in pockets	Compassionate and inclusive culture for all
Progression is unclear and sometimes feels exclusive	Progression for all is clear and inclusive
Reacting to digital opportunities	Proactively embraces the benefits of technology

People Strategy Governance



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Committee	Trust Board
Meeting Date	11th November 2020
Paper Title	Equality, Diversity and Inclusion strategy 2020-2023
Purpose	This paper sets out the key EDI priorities for our patients and workforce for the next 3 years.
Business Area	Corporate
Author	Nathalie Zacharias
Presented by	Alex Gild
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	All essential standards of care
Budget/Resource Impacts	None
Commissioner Implications	None
Equality and Diversity Implications	The EDI strategy sets out the priories for the Trust
Brief Executive Summary	The EDI strategy sets out the key priorities for our patients and workforce for the next 3 years. It has been co-produced with key stakeholders and aligns with the Trust People Strategy which will oversee the delivery of this activity over the next 3 years. Key metrics across patients and workforce will be agreed once the strategic direction has been agreed by the board

Recommendation/ Action Required	For review and approval by board

Caring for and about you is our top priority

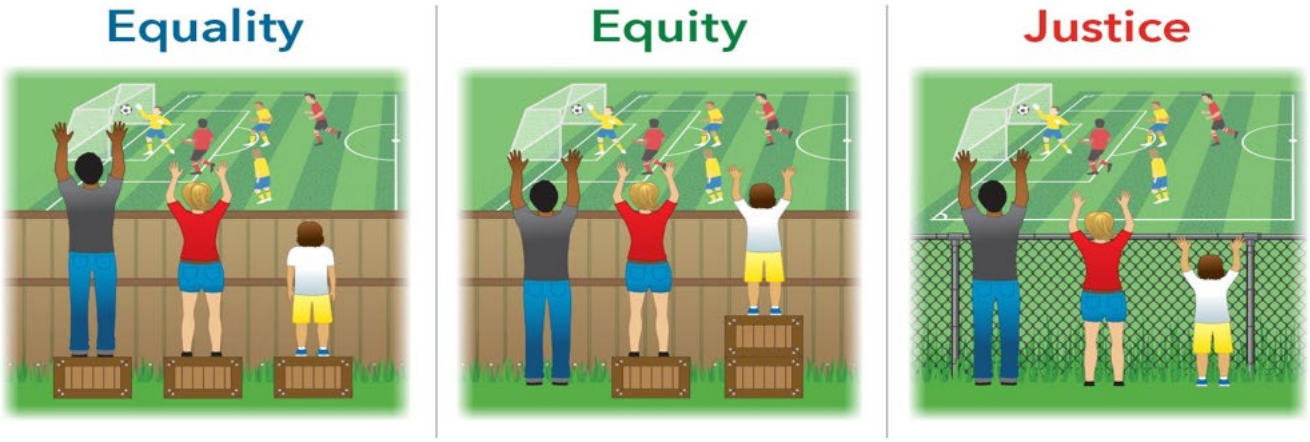
Committed to providing good quality, safe services

Working together to develop innovative solutions

NHS
Berkshire Healthcare
NHS Foundation Trust

DRAFT EQUALITY, DIVERSITY AND INCLUSION STRATEGY

2020-2023



Nathalie Zacharias: Director of Equality, Diversity and Inclusion

Our values, vision and objectives:

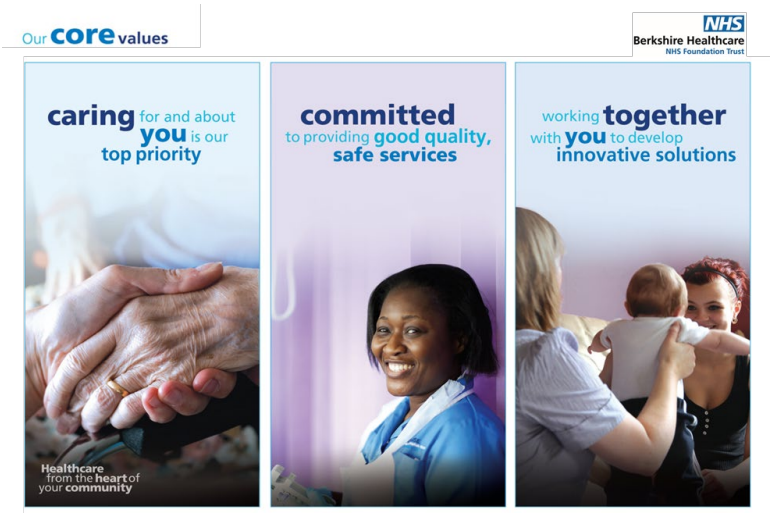
Berkshire Healthcare is proud of the diversity of its 4500 staff and wants everyone to feel equally valued and important. Berkshire Healthcare wants to be outstanding for everyone. We want this to be a great place to work for all employees as well as providing safe, compassionate, high quality care and a good patient experience all those who use our services. The Trust recognises that data from the staff survey as well as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) demonstrates that there are still pockets of inequalities affecting staff with protected characteristics resulting in differentials of experience. We see tackling these pockets of inequality and discrimination as a top priority.

It is important that this cultural change occurs at all levels of the organisation to address the disconnect between the top and the rest of the organisation. We need to nurture a network of allies of this change at all levels over the next 3 years. This includes ensuring that all our leaders are equipped to support their teams with inclusive behaviours and that they take the necessary action to create an organisational culture that supports inclusion and belonging.

Berkshire Healthcare has made a commitment to understand and improve the health inequalities experienced by the patients and communities who use our services. We will build on our existing practices of consultation, engagement and co-production to ensure that those who use our services have a voice and that it is inclusive of those communities that we have historically found hard to reach. We aim to provide accessible services that meet the needs of all individuals and focus our efforts on work that is important to those we serve.

We will continue to strengthen a just and learning culture, where everyone is respected equally, where everyone feels able to give feedback and that their ideas and concerns will be listened to and acted upon.

This Equality, Diversity and Inclusion strategy will serve as a golden thread through the Trust Strategy and People Strategy and as such, these strategies have been developed collaboratively and the workforce elements of the EDI strategy will form a critical part of our People Strategy.



Where Berkshire Healthcare will be in 3 years:

Berkshire Healthcare is recognised as an outstanding organisation however this is not the experience of everyone, resulting in pockets of inequalities and discrimination experienced by patients and staff with protected characteristics. The impact of this is poor health outcomes, not achieving full potential, feeling of not belonging, feeling excluded and not being able to be your true self. We need to demonstrably improve culture at all levels to ensure consistency of experience for all.

We know that the most diverse teams and organisations are the most successful ones and more importantly deliver high quality patient care. We will demonstrate explicitly that we value diversity within our Trust - where everyone feels welcome and included and is supported to achieve their own potential. This strategy aims to deliver this important work in a way that addresses intersectionality of our staff and patients. The term intersectionality means that each individual is a combination of many aspects of their identity and so each individual's experience is unique. People cannot be described as one thing - we are not just a race, gender or of a single sexual orientation. We are all a combination of all these things and many more. To support this, we are committed to engaging and co-producing work with both our staff, networks and patients to ensure a diversity of voices, experiences and views. As we implement this work, we will ensure we maintain our focus on the protected characteristics but will consider individual needs of our staff and patients through a nuanced lens of intersectionality.

The main themes of this strategy and our focus for year 1 are shown in the plan on a page below and are supported by an action plan. The detailed plan for years 2 and 3 will be published at the end of years 1 and 2, when we can review progress and ensure we are targeting our work in the right place.

<u>Our People:</u>

- Address and reduce inequalities and differentials in experience
- Embed inclusive and compassionate leadership approaches
- Develop workforce career progression and talent management
- Strengthen and develop our 3 staff networks
- Develop and deliver our inclusive "ready for change" programme which builds on the Making it Right programme and will be available to all staff with protected characteristics

<u>Our Patients:</u>

- Embed the Accessible Information Standard for disabled patients across all services
- Embed reasons for and recording of patient demographics to improve health outcomes
- Identify actions and resources needed to identify health inequalities through community engagement
- Promote LGBT+ engagement and support through Stonewall and Reading Pride
- Develop strengths- based inclusive recruitment with services

- Co-produce actions and resources needed for Trans patient's pathways

The priority areas of work included in this strategy have been co-produced with key stakeholders in line with our vision, values and overall Trust Strategy and are informed by an analysis of our statutory and regulatory requirements, as well as national guidance.

We want to provide a simple message about equality, diversity 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.

In order to ensure the delivery of this Equality, Diversity and Inclusion strategy, Berkshire Healthcare has aligned the EDI resources and leadership, with structures in place for regular monitoring and review of progress.

The strategy has been reviewed and approved by the Trust Diversity Steering Group who will oversee its implementation and progress.

Equality, Diversity and Inclusion Plan on a Page - Year 1

Where we are

Berkshire Healthcare is recognised as an outstanding organisation however this is not the experience of everyone, resulting in pockets of inequalities and discrimination experienced by patients and staff with protected characteristics. The impact of this is poor health outcomes, not achieving full potential, feeling of not belonging, feeling excluded and not being able to be your true self. We need to demonstrably improve culture at all levels to ensure consistency of experience for all.

Our People

- Improve inequalities and differentials in experience
- Embed inclusive and compassionate leadership approaches
- Develop workforce career progression and talent management
- Strengthen and develop our staff networks
- Develop and deliver our inclusive 'Ready for Change' programme

Our Patients

- Embed the Accessible Information Standard for disabled patients across all services
- Embed reasons for and recording of patient demographics to improve health outcomes
- Identify actions and resources needed to reduce health inequalities through community engagement
- Promote LGBT+ engagement and support through Stonewall and Reading Pride
- Develop strengths-based inclusive recruitment with services
- Co-produce actions and resources needed for Trans patient's pathways

Where we are going

Our strategy will address the disconnect between the top and the rest of the organisation and support the development of allies of this culture change at all levels over the next three years. This will lead to improved staff and patient satisfaction, good health outcomes and everyone feeling they are valued and have a voice. We want to make Berkshire Healthcare outstanding for everyone.

The following legislation underpins this EDI strategy:

Human Rights Act 1998

The human Rights Act creates a legal duty on public officials to act compatibly with the Human Rights Act rights. There are three main duties under this act:

- **Respect**: not to breach human rights
- **Protect**: To take action to safeguard people's rights
- **Fulfil:** to have the right procedures and processes in place, particularly to investigate when things have gone wrong

The Equality Act 2010

The Equality Act 2010 legally protects people from discrimination in the workplace and wider society. The Act offers protection against discrimination to individuals possessing a minimum of one of the nine characteristics (see below) in employment and service delivery. We all possess some of these characteristics. They are:

- Age
- Disability
- Race including ethnicity and national identity
- Sex
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Religion or belief, including lack of belief
- Sexual orientation

In addition to this, the Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to:

- Eliminate discrimination, harassment, victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between persons who share a relevant protected characteristic and those who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

Specific duties, set out in regulations to the Equality Act require us to:

- Publish information to demonstrate compliance with the public sector Equality Duty, annually. This information must be published in such a manner that it is accessible to

the public, either in a separate document or within another published document

- Prepare and publish equality objectives at least every four years. All such objectives must be specific and measurable.

Health and Social Care Act 2012

Under the Health and Social Care Act 2012 NHS England and Clinical Commissioning Groups (CCGs) must have regard to the need to (a) reduce inequalities between patients with respect to their ability to access health services, and (b) reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services. The purpose of this act was to put clinicians at the centre of commissioning, empower patients and give some focus to public health. We are indirectly affected by these provisions.

The current position in Berkshire Healthcare

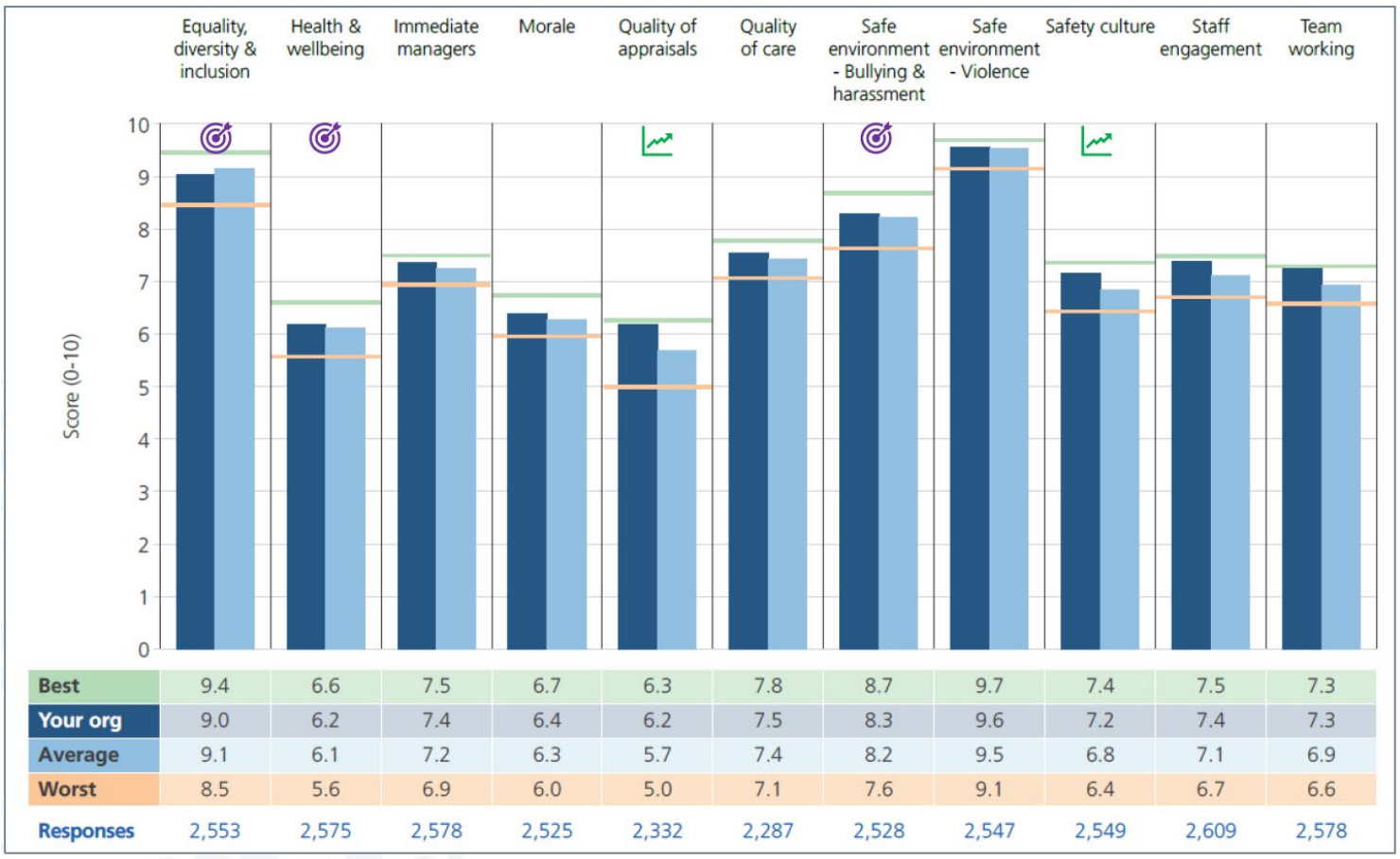
We have purposefully focused our attention on the areas which are most important to our staff and patients and what we have set out to achieve is challenging but achievable in 3 years.

We held several workshops including key stakeholders to agree these priorities which were also informed by our WRES, WDES, Stonewall and staff survey results from the past year. The strategy has been reviewed and approved by the Trust Diversity Steering Group who will oversee the implementation and progress.

Staff survey

Berkshire Healthcare had the highest response rate for the national staff survey in 2019 at 61 % (2623 responses). The engagement score was 7.4/10, the second highest for a combined trust.

The 11 themes of the survey are summarised below and show that whilst we are above national average for almost all the key performance indicators there are areas that require targeted intervention such as EDI as well as safe environment/ bullying and harassment. The EDI average for Berkshire Healthcare (9.0) was slightly below the national average (9.1) with the best performing trust scoring 9.4.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.6	7.5	6.7	6.3	7.8	8.7	9.7	7.4	7.5	7.3
Your org	9.0	6.2	7.4	6.4	6.2	7.5	8.3	9.6	7.2	7.4	7.3
Average	9.1	6.1	7.2	6.3	5.7	7.4	8.2	9.5	6.8	7.1	6.9
Worst	8.5	5.6	6.9	6.0	5.0	7.1	7.6	9.1	6.4	6.7	6.6
Responses	2,553	2,575	2,578	2,525	2,332	2,287	2,528	2,547	2,549	2,609	2,578

The NHS Workforce Race Equality Standard (WRES)

As at 31st March 2019 Berkshire Healthcare employed 4,328 members of staff: 71% were White and 23% were from a BAME background. However, by 31 March 2020 the BAME staff population had increased slightly to 25%.

The nine key indicators that underpin the WRES have played a key role in the incremental progress that the Trust is making towards the amelioration of issues around racial inequality and BAME representation.

It is required that we publish our results and the resultant action plan which covers BAME recruitment, workforce diversity, career development, disciplinaries, responses to the national staff survey on equal opportunities in career development, experiences of harassment, bullying and discrimination, and Board diversity.

This data needs to be reviewed over several years to ensure that change is embedded and maintained and to provide assurance of a cultural change in the organisation.

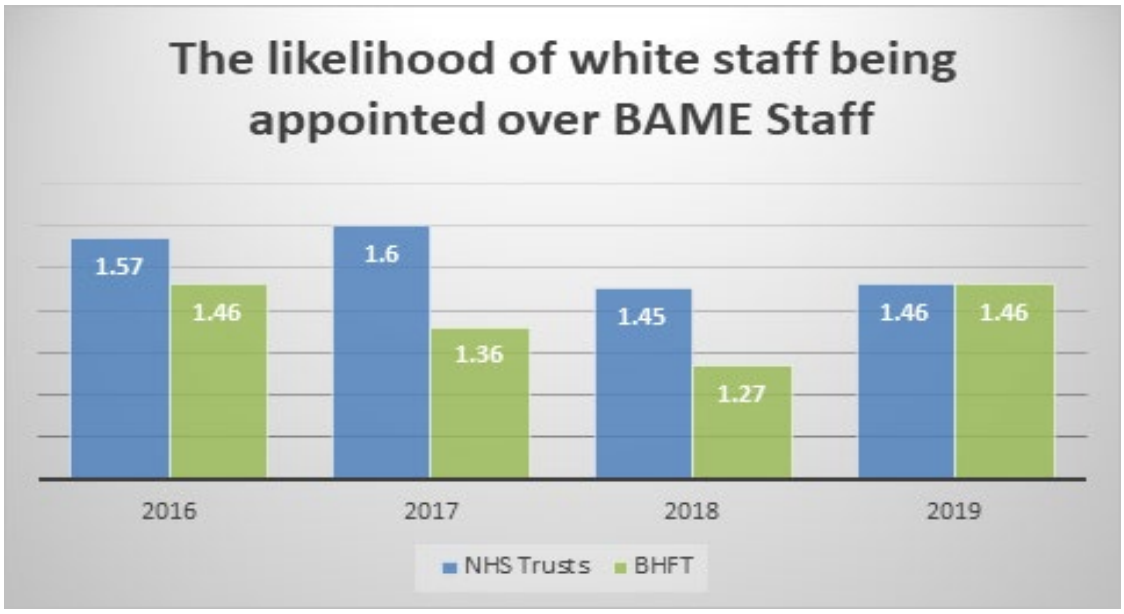
Berkshire Healthcare is focusing on reducing the gap in staff experiencing bullying and harassment as well as differentials in experience of development and promotion in this strategy. We continue to work with key stakeholders including the BAME Staff Network.

The table below highlights some of the areas where there are differentials in experience between BAME staff and their white counterparts.

	WRES 2016 NSS 2015	WRES 2017 NSS 2016	WRES 2018 NSS 2017	WRES 2019 NSS 2018	WRES 2020 NSS 2019
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**BAME 32%** White 21%	**BAME 27%** White 23%	**BAME 27%** White 22%	**BAME 31%** White 22%	**BAME 30%** White 22%
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**BAME 23%** White 19%	**BAME 27%** White 19%	**BAME 21%** White 18%	**BAME 20%** White 14%	**BAME 20%** White 15%
Percentage believing that trust provides equal opportunities for career progression or promotion	**BAME 76%** White 88%	**BAME 68%** White 91%	**BAME 74%** White 89%	**BAME 68%** White 89%	**BAME 76%** White 91%
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	No data	**BAME 17%** White 5%	**BAME 11%** White 7%	**BAME 17%** White 7%	**BAME 13%** White 6%

The Trust WRES data shows incremental progress in addressing gaps and inequalities and ameliorating differentials in experience between our BAME staff and their white colleagues over the past 4 years.

This progress however has not been embeded in all areas as shown in the table below. We are aware of further efforts needed in facilitating a fairer recruitment process: whilst the likelihood of white staff being appointed over BAME staff is at national average (1.46) the Trust made progress in 2017(1.36) and 2018 (1.27) but the data for 2019 shows we have but not retained this progress and returned to 2016 levels.



Summary of Berkshire Healthcare WRES data for 2020 showng where progress has been made/ differentials in experience between BAME and white staff:

Areas of progress

BAME employees make up 20% of BHFT workforce.
Target of 20% BAME staff in bands 5-7 surpassed.
Gradual progress in appointment of BAME staff to bands 8a-c

Likelihood of BAME staff entering formal disciplinary compared to white staff reduced by 32 % to 1.76

Differentials in experience

More work needed in appointment of BAME staff to bands 8D and VSM

30 % BAME staff compared to 25% white staff experienced bullying, harassment and abuse from patients, relatives and the public in the last 12 months

The percentage of staff experiencing harassment, bullying and abuse from staff is 20% for BAME staff, compared to 15% for white staff

13% of BAME staff compared to 6% white staff have personally experienced discrimination from a manger, team leader or colleague

The likelihood of white staff accessing non-mandatory / CPD training compared to BAME staff was in 0.97 (close to parity) but the gap has risen to 1.59 in 2020

Likelihood of white applicants being appointed compared to BAME is 1.46 (compared to 1.27 in 2018). The Trust has gone back to where it was four years ago (2016)

76% of BAME staff believe that the Trust provides equal opportunities for career development and/ or promotion compared to 91% of white staff

BAME board members remains at 15.4%- a shortfall of 7.2% in comparison to the workforce

The NHS Workforce Disability Equality Standard (WDES)

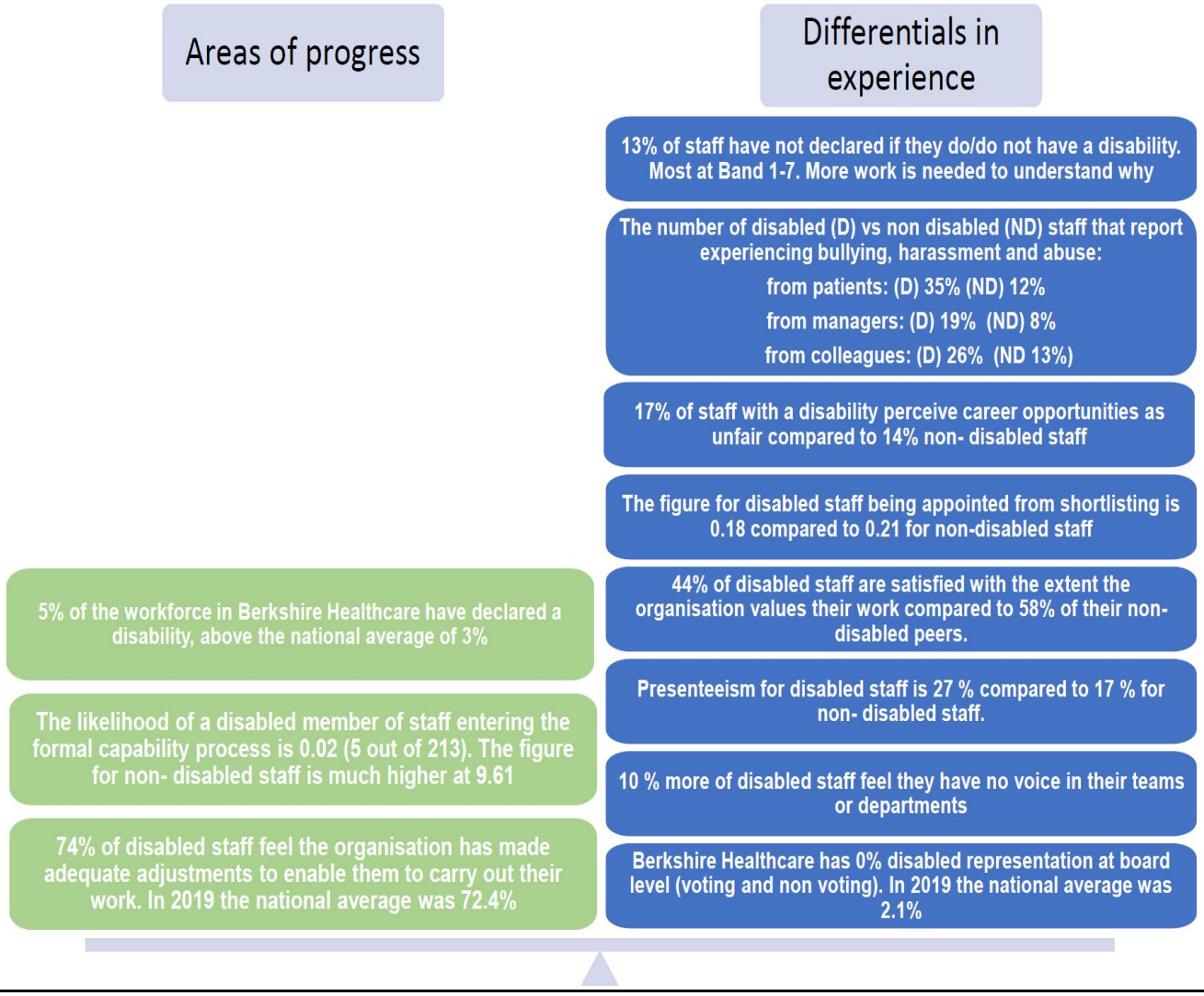
The WDES reporting requirements came into force on 1st April 2019 regarding staff with a disability. The WDES has been established to improve the experience of disabled staff working in and seeking employment in the NHS. The WDES is a set of ten evidence-based metrics that will enable NHS organisations to compare the reported outcomes and experiences of disabled and non-disabled staff. According to our Electronic Staff Record (ESR) system, 213 (5%) of our workforce of 4460 declared that they have a disability in 2019. Whilst this figure is above the national average (3%), it is significantly lower than the 505 (20%) of the National Staff Survey respondents who declared a disability. This highlights that the need to continue working towards facilitating a culture where staff are comfortable to declare their disabilities.

As with the WRES, this data will need to be tracked over a number of years to have assurance of change and the focus for Berkshire Healthcare is to reduce the gap in the number of people self-disclosing their disability. This will provide assurance of the cultural change we are aiming to achieve where staff feel confident to have conversations with their managers about their disability and reasonable adjustments needed.

Below is a summary of the 2018/2019 WDES data. These questions form part on the annual national staff survey and need to be to be considered over a number of years to ensure that change is embedded and maintained.

	2018	2019
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	**Disabled 34.7%** Non-disabled 22%	**Disabled 30.2%** Non-disabled 23.1%
Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months	**Disabled 18.8%** Non-disabled 9.4%	**Disabled 15.6%** Non-disabled 8.5%
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	**Disabled 26.1%** Non-disabled 13.1%	**Disabled 23.2%** Non-disabled 14.4%
Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	**Disabled 60.4%** Non-disabled 54.7%	**Disabled 57.3%** Non-disabled 60.5%

Summary of Berkshire Healthcare WDES data for 2020 showng where progress has been made/ differentials in experience between disabled and non disabled staff:



Stonewall Diversity Champions Programme

We have been a Stonewall Diversity Champion since 2011.The index represents one of the best and most competitive benchmarking tools for organisations wishing to improve their LGBT+ performance and involves significant work on 10 areas including staff development, promoting non-discriminatory working environments, managerial competence and community engagement. The summary of our last scores and areas for improvement for the next submission (submission in 2021 but results published 2020) below:

Summary of the Stonewall Workplace Equality Index 2022 criteria

Overall Scoring

Total score – 103 / 200
Overall Ranking – 142 / 503
Sector Ranking – 15 / 64

Areas presented well

- Promising score increase of Trans inclusion – last year 15%, this year 37%
- First year Stonewall have given scoring for bi inclusion; matching those in the top 100, scoring 66%

Areas of loss in marks

- Monitoring data is presented poorly
- Employee Lifecycle requires improvement
- Allies & Role Models requires more work

Highlights

- Network Group – score increase from 8 to 14, with evidence like those in the top 100
- Procurement – above sector average, most improved section.

1. Policies & Benefits

Policies and benefits that the Trust have in place to support LGBT staff. Policy content will be scrutinised to ensure there is sufficient provision and specific support available to LGBT staff.

Our score – 8.5
Sector average score – 5.5
Top 100 score – 10.5

2. Employee Lifecycle

How the Trust engages and supports employees throughout their journey in the workplace, starting with recruitment practices and finishing with the exit process.

Our score – 12.5
Sector average score – 10
Top 100 score – 15

3. LGBT Employee Network Group

Focus on the support given to the Trust to the LGBT employee network, the commitment to inclusivity and the activities carried out by the Trust.

Our score – 14
Sector average score – 9.5
Top 100 score – 14.5

4. Empowering Individuals

The process of engaging and empowering LGBT and non-LGBT staff to create an LGBT inclusive culture and using allies within the Trust.

Our score – 10
Sector average score – 7.5
Top 100 score – 13

5. Leadership

Empowering and engaging senior leaders and line managers in their responsibility to set an LGBT inclusive culture.

Our score – 9.5
Sector average score – 6
Top 100 score – 11

6. Monitoring

How the Trust uses data collection methods, analysis and outcomes to understand the representation and experience of our LGBT employees .

Our score – 3.5
Sector average score – 6
Top 100 score – 8.5

7. Supply Chain

What steps the Trust takes to ensure suppliers are LGBT inclusive from tendering new suppliers to monitoring current contracts.

Our score – 7
Sector average score – 4
Top 100 score – 8.5

8. External Engagement and Service Delivery – previously 2 sections

A – Community Engagement; outreach activities to support wider LGBT communities

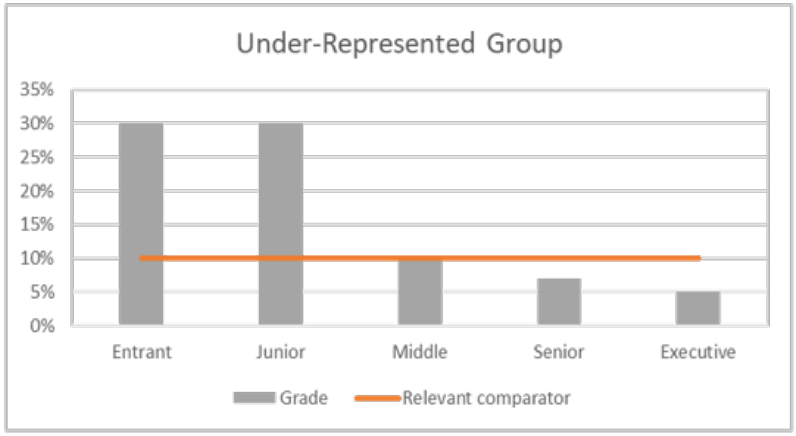
B – Sector Engagement; promoting LGBT equality to other in the sector

C - Service Delivery; meeting the needs of service users

Our score – 11 & 12
Sector average – 6 & 9
Top 100 score – 9.5 & 13.5

We will work in collaboration with the Diversity Steering Group to determine our ambitions in this area.
The specific workforce EDI targets to follow will align with the people strategy and will be presented in the format below:

Creating an Inclusive Workforce Plan



Identified Talent	10	10	10	10	10
Total URG Staff	30	30	10	7	5

Expected Vacancies	20	10	3	2	1

Strategic Ambitions:

- Priority 1
- Priority 2

Corporate Actions	Impact	Delivery Date
1.	1.	1.
2.	2.	2.
3.	3.	3.
Local Actions	Impact	Impact
1.	1.	1.
2.	2.	2.
3.	3.	3.

How we will achieve this change over the next 3 years:

Workforce and People Objectives

Objective	Evidence	Year 1	Year 2	Year 3	Impact
1. Address and reduce inequalities and differentials in experience and strive to make the organization 'Outstanding for Everyone' focusing on: Bullying and Harassment Microaggressions Just Culture (as part of the Safety Culture working group) OD Interventions for EDI	National Staff Survey results as outlined in the WRES, WDES and Stonewall action plan.  WRES Board Paper_July 2020 V5.d  WDES Board Paper_July 2020_V7.d  WDES WRES action plan V8 01.10.20 po  Stonewall Feedback Session w	Implement priorities identified in the bullying, harassment and discrimination (BHD) Work OD Steering Group and Wellbeing Group to identify areas requiring improvement and 'dig under' the behaviours that lead to Bullying and Harassment by and drive culture change to continue to move to a compassionate and inclusive culture. Continue with team level training and discussions about Micro-aggressions putting a formal plan/approach in place by January 2021- liaising with stakeholders to find out which teams are priority for focus.	Review impact of interventions and approaches in Year 1 and complete the PDSA cycle to build on the work for Year 1	Review impact of interventions and approaches in Year 2 and complete the PDSA cycle to build on the work for Year 2	Staff survey (NSS) results will show the impact of this work. True North goals- staff experience Close the gap in experience. Targets will be set but we recognise this will take years to be fully realised

		Just Culture – managed through Safety Culture work			
2. Leadership: embedding EDI - “inclusive cultures depend on inclusive leaders” (People Plan 20-21).	National Staff Survey results as outlined in the WRES, WDES and Stonewall action plan. Feedback from the Pride, BAME and Purple networks and Freedom To speak Up (FTSU)	Appointment to the Leadership and OD Lead secondment to drive the review of all Trust leadership programmes to design the leadership offer to fulfil the dual objectives of “inclusive cultures’ and ‘outstanding for everyone’ Test leadership pilot programme (skills you need to be successful as a leaders) Leadership Review and new programme to be launched Q1 2021	Roll out of new leadership programme that combines EDI, QI, Leadership and OD into one seamless package for our staff	Continue the rollout and focus on OD work to ensure the new leadership behaviours and culture are being embedded in the workplace	We want everyone to feel valued and important. It is important that our leaders demonstrate inclusive behaviours and take action to create an organisational culture where everyone feels that they belong. We believe in fairness and equity. Strengthening a just culture will result in everyone being respected equally, where everyone feels able to give feedback and

					that their ideas and concerns will be listened to and acted upon. NSS results will indicate that staff have had a more positive experience of leadership and management.
3. Workforce Development, Career progression and Talent Management (QI approach to talent issues)	National Staff Survey results as outlined in the WRES, WDES and Stonewall action plan. Feedback from the Pride, BAME and Purple Networks Improvements in career progression for underrepresented groups based on focus on QI work	Start QI evidence gathering of the gaps in career progression and talent management for all staff with protected characteristics by December 2020 and agree timetable with the QI team Review of career pathways and training and development for Bands 2 – 6 New training package developed called 'Reaching MY Potential' Skills you need to be successful and develop in your role/ prepare for new	Delivery of agreed outcomes from review	Complete PDSA cycle for new programme and make improvements and adjustments as needed	Representation rates increase- national/local norms Define for professions/ groups what is the norm?

		roles to be tested by January 2021. Wider review of Talent Management across the organisation. This will be open to all staff and will integrate with the new Making it Right (MiR) programme.			
4. Supporting Staff Networks: BAME PURPLE PRIDE	National Staff Survey results as outlined in the WRES, WDES and Stonewall action plan. Feedback from the Pride, BAME and Purple Networks	Review of infrastructure supporting networks based on national best practice from NHS and other organisations by December 2020 Proposal to be developed collaboratively with the networks and then presented to Executive for review and agreement	PDSA cycle to build on the work for Year 1	PDSA cycle to build on the work for Year 2	Being able to support our staff and enable the networks to work at their best and support them in working collaboratively, promoting intersectionality
5. Review of MIR programme and develop and deliver our inclusive "ready for change" programme "We are a diverse and inclusive team"	National Staff Survey results as outlined in the WRES, WDES and Stonewall action plan. Feedback from the Pride, BAME and Purple Networks	Review of MiR Programme by December 2020 and relaunch a new training programme by April 2021. Collaboratively developed and promoting intersectionality Wider review of Talent Management across the organisation.	Delivery of agreed programme	Complete PDSA cycle for new programme and make improvements and adjustments as needed	Forms wider view of talent management and promotion to VSM posts

 Making%20it%20Right%20Programme%20F					

Patient and Community Objectives

Objective	Evidence	Year 1	Year 2	Year 3	Impact
1. Accessible Information standard The Accessible Information Standard is legislation that was introduced in 2016. It is designed to capture the communication needs of disabled people accessing services to ensure they are not treated unfavourably in comparison to non-disabled people by providing information in formats that are accessible to them. Berkshire Healthcare has a legal requirement to meet all communication needs of our disabled patients.	https://www.england.nhs.uk/ourwork/accessibleinfo/ https://youtu.be/ZJngMo37WvA# We receive a disproportionate number of complaints from our deaf patients and a higher number of grievances from deaf staff. Reasonable adjustments and no communication tools remain the greatest reason for both. During the "you said, we did" sessions run in the East the deaf community reported lack of appropriate communication support having the greatest negative impact.	1A. To adapt the communication form within RiO and other platforms used in our services to include the four questions within the standard and ensure there is a reporting function by March 2021. Understanding if/ how this can be rolled out to the shared record for connected care in year 2. 1B. To develop and roll out training/engagement and	Review baseline data from year one and develop/ set targets. Provide additional training if required	Review data from year 2 and agree priorities	We are not currently fully compliant with this standard and although other NHS Trusts are also not compliant, we would like to be leaders in meeting all patient's communication needs across all Berkshire Healthcare services which will result in improved health outcomes.

	AIS%20Report_FINAL-%20LD.docx	communication for all services to understand the legal requirements within the standard and how to complete the form on RiO by December 2021. 1C. To purchase and distribute communication grab bags for all services and provide training for teams on how to use them by March 2021. 1D. To provide baseline information on the use of the communication forms across the Trust and set targets for the next two years by March 2021.			

2. Patient Demographics Patient equality, diversity and inclusion data relating to the 9 protected characteristics is not captured, recorded or reported consistently or in the same way across the Trust. There is no minimum standard set by NHSE or Berkshire Healthcare. This makes it difficult to ensure that services are accessible / health inequalities are being addressed	 patient%20EDand%20I%20data%20A3.ppt Ensure datasets are complete and timely, to underpin an understanding of and response to inequalities. This is now included as one of the 10 health inequality actions and the Phase 3 NHS guidance states that all NHS organisations should proactively review and ensure the completeness of patient ethnicity data by no later than 31st December 2020, with general practice prioritising those groups at significant risk of COVID-19 from 1 September 2020.	2A. To agree consistent definitions for capturing patient demographics, starting with ethnicity in RiO across the Trust by December 2020.  ethnicity%20survey.docx 2B. These definitions to be approved by DSG and implemented in RiO Trust wide. (Timescale not given a dependant on changes required and Transformation Team capacity). 2C. SLT to ensure all teams understand the importance of	Embed roll out for all protected characteristics and ensure consistency in BOB and Frimley ICS	Robust capture of data and reporting ability in place across all services	**For patients/ public** Berkshire Healthcare wants to provide excellent care to everyone who use their services. However, they are aware that certain groups of people struggle to access good healthcare. To make sure their services are available easily and are suitable for all the population they look after, they need to understand who uses our services from every part of the community. To help them achieve this, it is important to ask about things like

		reporting and report baseline data by December 2020. 2D. A clear comms plan to the wider organisation to ensure understanding of why this information is needed 2E. Alignment across the systems regarding the definitions			age, gender, sexual orientation and religion (sometimes referred to as 'demographics'). **For staff** Berkshire Healthcare wants to make sure that all their staff are treated fairly. They also know that by having employees from all groups and backgrounds, who reflect the wider population, that patients will have a better experience when using their services. To help them achieve this, it is important to ask about things like age, gender, sexual orientation

					and religion (sometimes referred to as 'demographics').
3. Post COVID recovery/Community engagement/Equality Delivery System (EDS3) COVID has shone a light on health inequalities, particularly for the BAME population and phase 3 guidance has reinforced the need for engagement and coproduction with communities as well as patients who use our services.  National voices 5_principles_statemen  Report_Health-inequalities-time-to-act-FNL.	There are areas of really effective community engagement across Berkshire Healthcare, but this is not consistent and therefore doesn't represent the full diversity of our local communities. Through community engagement Berkshire healthcare needs to identify the health inequalities experienced by our populations and the resources needed to address these. In anticipation of the EDS3, mapping of EDI reporting will need to be completed once the requirements are published.	3A. Review all health inequalities data, mapping and EDS requirements by March 2021 to be able to understand and agree the priorities of focus for engagement. 3B. Engage with community groups across Berkshire to co-develop and agree a plan to address the priority areas within the EDS including COVID recovery planning by June 2021. 3C. To ensure robust systems	EDS 3/ or our own version if EDS 3 has not yet been published by NHSE		To address the range of health inequalities a trust wide approach to community partnership and engagement is needed to meaningfully engage within our communities. We have to ask ourselves -are these communities hard to reach or easy to ignore?

		are put in place to feedback actions and findings to community groups by March 2021.			
4. Promoting LGBT+ engagement and support for staff as well as communities using our services: Berkshire Healthcare Foundation Trust has signed up to the **Stonewall Diversity champion's employer's index** for 2021 **Reading Pride** Berkshire Healthcare has long history of attending the annual Reading Pride to promote links between the Trust and the public and offering support to	The process of our annual submission provides assurance that Berkshire Healthcare makes improvements that impact on our LGBT + community; including procurement, workforce and people who use our services. Inequalities for the LGBT+ community have widened further during COVID19 and the need for focused support for our staff, patients and communities is needed.	4A. Berkshire Healthcare is aiming for improved scores for staff survey, achieving the Gold status within the new Stonewall framework with a submission date of September 2021. 4B. Prepare and plan for Reading Pride in September 2021. Recognising this	Review results and consider index 2022		Inequalities for the LGBT+ community have widened further during COVID19 focused support for our staff, patients and communities is needed to reduce health inequalities and inclusion

reduce health inequalities in the LGBT+ community.	https://nationallgbtpartnership.org/covid-19/	may be a virtual event.			
5. Trans Patients Berkshire Healthcare receives a disproportionate number of complaints from Tran's patients and staff consistently report not being confident supporting Trans patients. We are working in collaboration with NHS England who are interested in our learning from this project to share nationally as part of the LGBT+ improvement standard.	The higher prevalence of smoking, alcohol use and drug use, and lower uptake of screening programmes, are likely to contribute to increased risk of preventable ill health. There is also a significant body of evidence demonstrating high rates of suicide attempts.' Transgender people have statistically higher rates of mental ill-health than their LGB counterparts. The Stonewall School Report3 shows that 92% of young transgender people have thought about suicide and 84% have self-harmed, signalling that monitoring mental health should begin at even younger than 16 years old.	5A. Engagement and co-production with Trans Patients, Tran's community groups and national Trans charities to co-develop and co-produce priorities on a plan on a page to improve the health inequalities within the Trans community by September 2021. 5B. Develop a clear pathway for improving the systems within Berkshire Healthcare based on the agreed priorities. This can include the recording of	Focus on systems-working across BOB and remove the system barriers. Develop training package to support staff in using the system changes and better supporting our Trans patients	Review impact of project with Trans patients, community groups and national partners. Change, adapt or improve any areas that are not working.	To ensure that services are accessible and meet the needs of the Trans population who have proportionally high levels of physical and mental health inequalities

		individuals gender identity on RiO, how we address appointment letters etc by December 2021.			
6. Inclusive Recruitment within learning disabilities and Mental Health	Less than 6% of people with a Learning disability, 15% of people with Autism and 20% of people with a severe and enduring mental health condition, have access to paid employment, yet 68% of people want a paid job. The social inclusion task force identified the recruitment process remaining the greatest barrier to accessing talented people from within these communities.	6A. Working with Berkshire Healthcare Learning Disability services, three vacant posts within the trust will be identified to recruit to using a strengths-based approach by December 2020. 6B. Establishing a partnership with a local supported employment service and Berkshire Healthcare's IPS service by December 2021.	Job match in partnership with agencies. Trial- working interviews and work trials. Match right people into roles. Ensure in work support in place. Training for staff.	Review- process and roll out inclusive strengths-based recruitment into other vacant roles across all services.	Using a strengths-based approach to recruitment can reduce this inequality experienced by those with disabilities and also provide a greater level of access to all people within our community including those with protected characteristics, care givers, women returning to work and older jobseekers.

		6C. Produce accessible job descriptions, consider job carving and agree training support required with relevant stakeholders by March 2021.			

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board meeting date	10th November 2020
Title	Status Report on Trust Strategic Initiatives as impacted by the COVID-19 Pandemic.
Purpose	This document updates Board members on the current status of the Trust's key programmes and projects, including those remaining paused or partially paused as a consequence of the organisational impact of the COVID-19 pandemic.
Business Area	Corporate
Author	Director of Projects
Presented by	Director of Strategic Planning
Relevant Strategic Objectives	The portfolio of initiatives addresses all the Trust's True North goals
CQC Registration/Patient Care Impacts	The portfolio of programmes and projects includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience
Legal implications	As per individual programmes and projects
Equality & Diversity Implications	The portfolio of initiatives includes those progressing the delivery of our Equality and Inclusion Strategy. Equality and Diversity implications of each initiative are the responsibility of its governing body.
Brief Executive Summary	In May each year, the Trust Board would usually receive the annual Strategy Implementation Plan (detailing the organisation's portfolio of programmes and projects together with other priorities and initiatives) followed by quarterly updates on progress. The onset of the COVID-19 pandemic redirected resources and energies into other immediate priorities and progress on many initiatives has been either fully or partially halted. Work on developing a Plan for 2020-19 was also curtailed. To update Board members, a brief commentary is provided regarding the key initiatives and the document includes the summary report on key programmes, projects and other priorities that is submitted monthly to the Business & Finance Executive. The report (which was submitted to the October 2020 meeting) identifies the current status of our key schemes - in addition to RAG status and associated commentary, it indicates those initiatives that are fully or partially paused.

	Whilst the continued focus of the organisation on its response to the pandemic and Service Recovery has required the commitment of significant resources normally assigned to programmes and projects, it has been possible to reactivate and progress all Mission Critical schemes and most of those prioritised as Important. Several schemes are now closed or moving to business as usual. In the previous report to the Trust Board these included Frimley Integrated Decision-Making Hubs and PMVA accreditation, but to this list can now be added, the Carer Strategy Review, Sexual Health Services (East) Transformation, Trust induction and Erlegh House Phase 3. In addition, the Trust has been developing its People Strategy, Equality, Diversity & Inclusion Strategy and Estates Strategy, all for consideration in November 2020.
Recommendation/ Action Required	The Board is asked to note the status of the Trust's key initiatives.

Berkshire Healthcare
NHS Foundation Trust

Status Report on Trust Strategic Initiatives as impacted by the COVID-19 Pandemic

Author: Neil Murton, Director of Projects

Director: Kathryn MacDermottt, Director of Strategic Planning

Date: 27th October 2020

Purpose

This document has been prepared to update the Trust Board at its November 2020 meeting regarding the current status – as impacted by the COVID-19 pandemic - of the organisation's portfolio of programmes and projects together with other priorities and initiatives that would normally be summarised and presented in the Strategy Implementation Plan to deliver the Trust's vision and Trust North Goals.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	21.10.2020	Neil Murton	The document includes an updated version of the Combined Projects/SIP Report submitted to the Business & Finance Executive on 26th October 2020
2.	27.10.2020	Neil Murton	Revisions to the Combined Projects/SIP Report to reflect discussion at Business & Finance Executive.

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
2019/20 Strategy Implementation Plan – Summary and commentary presented to Trust Board	May 2019	Neil Murton
Strategic Implementation Plan 2019/20 update to 30 June 2019 presented to the Business & Strategy Executive	July 2019	Neil Murton, Director of Projects
Strategic Implementation Plan 2019/20 update to 30 September 2019	Nov 2019	Neil Murton, Director of Projects
Strategic Implementation Plan 2019/20 progress report to December 2019	Jan 2020	Neil Murton, Director of Projects
Status Report on Trust Strategic Initiatives as impacted by the COVID-19 Pandemic	June 2020	Neil Murton Director of Projects
Status Report on Trust Strategic Initiatives as impacted by the COVID-19 Pandemic	Sept 2020	Neil Murton Director of Projects
Monthly combined SIP and Projects Report presented to Business & Finance Executive (previously Business & Strategy Executive)	Monthly	Neil Murton, Director of Projects.

CONTENTS

INTRODUCTION

Background

1. This document updates Board members on the current status of the Trust's key programmes and projects. This includes highlighting any continuing impact of the COVID-19 pandemic on those initiatives, including schemes paused or with significantly reduced progress as a consequence.
2. In May each year, the Trust Board would usually receive the annual Strategy Implementation Plan capturing the key activities required over the financial year and beyond to ensure successful implementation of our strategy, and operational plan. The plan itself is structured to reflect initiatives to deliver each True North goal.
3. The Board would normally receive a quarterly summary progress report on the delivery of that plan. Combined projects and strategy implementation plan progress reports are produced every month for review by the Business and Finance Executive (previously the Business & Strategy Executive).
4. The onset of the COVID-19 pandemic required redirection of resources and energies into other immediate priorities and consequently, progress on a range of initiatives was either fully or partially curtailed.
5. In turn, work on development of a Strategy Implementation Plan for 2020-21 was paused. A key focus of the Trust for the next 12 to 18 months remains the recovery of its services to previous functioning, incorporating new ways of working as informed by the experience of and lessons learned from COVID-19. The Business & Finance Executive reviewed and confirmed the priority status of the current initiatives, taking account of current pandemic commitments and priorities.
6. A 'Plan on a Page' for 2020-21 reflecting Recovery priorities was produced to provide our staff and key stakeholders with an accessible depiction of the Trust's priorities and to support staff with their annual service and team plans, personal development plans and personal objectives.

STATUS OF KEY PROGRAMMES, PROJECTS AND PRIORITIES

Combined Programme/Project and Strategy Implementation Plan (SIP) Report

7. The document provided with this report is the monthly update on key programmes, projects and SIP priorities, which was provided to the Business & Finance Executive in October 2020.
8. The report identifies the current status of our key schemes, but differs from its usual format in that in addition to previous or current RAG status and associated commentary, it indicates those initiatives that remain fully or partially paused as a consequence of the pandemic and where possible, an indication of anticipated timing of the resumption of activities.

9. Where relevant, the Report includes the classification of the initiative following their assessment with reference to our strategic filter (in the column headed "Deployment Status"): M = Mission Critical; I = Important; "to BAU" = moving to business as usual; ✓ = Completed.

10. The initiatives within the report are linked to the True North Goals that they primarily support. As a reminder, these are:

    - **True North Goal 1** To provide safe services by eliminating avoidable harm
    - **True North Goal 2** To strengthen our people and be a great place to work
    - **True North Goal 3:** To provide good outcomes from treatment and care
    - **Trust North Goal 4:** To deliver services that are efficient and financially sustainable

Exception report approach

11. The report provides a RAG rated overview of initiatives to identify trends and highlight areas of risk. Initiatives are conservatively RAG rated in this paper. Note that the rating declared may reflect considerations other than simply attainment of milestones. It may for example, reflect a reduction in the anticipated level of benefits ultimately realised or a high level of uncertainty and risk.

    Programmes and projects report to the Business & Finance Executive either monthly, bi-monthly or quarterly in accordance with the reporting schedule.

    Note that the project status declared relates to the previous month (September).

Impact of COVID-19 Pandemic

12. All initiatives were to some extent been impacted by the organisational response to the pandemic with many being halted or partially so. For some schemes, project resourcing will continue to be a key issue. A considerable level of Trust resource remains committed to the organisation's response to the pandemic and to service recovery activities and there is limited capacity both in operational and support services to support change. Some schemes will be vulnerable if the resource needed to support increased demand during the second or subsequent waves require redirection to support the Trust's response.

    However, as highlighted in previous reports, it has been possible to resume work on a number of schemes, with several now closed or moving to business as usual. These included Frimley Integrated Decision-Making Hubs and PMVA accreditation, but to this list can now be added, the Carer Strategy Review, Sexual Health Services Transformation, Trust induction and Erlegh House Phase 3. In addition, the Trust

has been developing its People Strategy, Equality, Diversity & Inclusion Strategy and Estates Strategy, all for consideration in November 2020.

Status of Key initiatives

Supporting True North Goal 1

- **Quality Improvement** – Work was significantly impacted during the early stages of the pandemic as most of the team were redeployed, although some ad hoc coaching and support continued. Now, all the work streams are being progressed and the team have developed numerous virtual resources including virtual huddle, virtual status exchanges, virtual workshops and improvement events. The programme has a revised Roadmap, to which it is working. It is now considered to be moving to business as usual.
- **Community & Primary Care Network workforce** – Work currently paused.
- **CMHT Function & Workforce** – Work currently paused, but the intention is to progress this through Recovery activities.
- **CAMHS Pathways** – Work was paused whilst resources were devoted to COVID and Recovery-related activities but re-activated in September. Four priority pathways (anxiety disorders, psychosis/mania, eating disorders and PTSD) have been agreed as the focus for 2020/21.
- **Frimley Integrated Clinical Decision-Making Hubs** – As previously reported, following receipt of a closure report, this initiative is now business as usual.
- **Carers Strategy** – A Closure Report was presented to the Business & Strategy Executive in September and closure approved. The Summary Report lists the achievements of the initiative.
- **Recovery** – The impact of the 1st wave has been managed and BHFT services are in full recovery and restoration mode. All Community Health services that were paused or partially closed have now completed the formal recovery service prioritisation process and are now operational (but not at pre-COVID levels of activity) with a 'blended' model of remote and face to face appointments. Staff that were redeployed to support front line services have returned to their substantive roles. A key focus is on capacity and demand, for which a task & finish group was established. A separate task and finish group was established to oversee the development of a Wave 2 Surge/Winter plan. A further group regarding equality impact assessment is established to consider the impact of recovery on patients and mitigate any potential negative impacts.

Supporting True North Goal 2

- **Workforce Strategy** – The Strategic People Group has overseen the development of a refreshed People Strategy using a QI approach. This work was informed by the new NHS People Plan (which aligns well with the Trust's principles and approach to people). The People Strategy is due to be presented to the Trust Board at its November meeting. Work on health and wellbeing has been a key priority during the pandemic and numerous resources being made available for staff to access for advice and support. The profile of health and wellbeing within the organisation is now significantly enhanced. In July, accreditation was secured of our PMVA training.
- **Embracing Diversity** –. Staff were diverted to work on other priorities during COVID-19, but activity resumed, and a key appointment commenced in July. The Equality, Diversity & Inclusion Strategy is due to be presented to the Trust Board in November 2020.
- **Trust Intranet** – Progress on the new intranet stopped with the onset of COVID-19. Work to address outstanding securing issues and final testing resumed in June, with the new intranet – Nexus – finally going live on 18th August 2020. A Closure Report with lessons learned is due to be presented to the Business & Finance Executive in November 2020.
- **BAME Transformation Plan** – A newly-established initiative that was prioritised as Mission Critical, to harness the desire and opportunity to deliver positive changes for people from a BAME background. There are multiple priorities, many improvement opportunities and numerous participants, but a lack of clarity, ownership, focus, delivery and visibility on what needs to be done to make difference. An A3 has been developed with problem statement, current situation and goals developed. Target areas to work on have been identified, with 4 workstreams using Quality Improvement methodology, actions and measurables.

Supporting True North Goal 3

- **Emotionally Unstable Personality Disorder (EUPD) Pathway** – Following impeded progress during the first wave of the pandemic, this initiative is now progressing well. The remaining elements of the pathway (assessment, assertive stabilisation and service user networks) are currently being piloted in two Localities (Bracknell and Wokingham) and following evaluation, the pathway will be rolled out to the other four Localities in early 2021.
- **Frimley Mental Health Transformation** – Progress was interrupted in March 2020 and recruitment delayed due to the Covid-19 pandemic. However, the implementation phase is now in progress and on target to achieve its revised

timescales. The project includes two elements mental health integrated community services (MHICS) and a personality disorder element. Most key Trust posts are recruited and East Berkshire sites will become operation during Autumn 2020.

- **Integrated MSK/Physio Service (Berkshire West)** – Work was on hold, but the pre-COVID service is now back up and running and work on the wider project for all MSK services has been resumed.
- **Frimley Pain Pathway Transformation** – System work remains on hold.
- **Sexual Health Services (East) Transformation** – The closure report with lessons learned was presented and approved in September 2020.
- **Improving Patient Experience** – The first phase was successfully concluded and following a delay due to resources being diverted elsewhere, tendering for phases 2 and 3 (via OJEU) is under way. The contract is due to commence from end December 2020.
- **Erlegh House, University of Reading, Whiteknights** – Building work was curtailed with the onset of the pandemic but has since been re-activated and is on track to be completed during October.
- **Move of Learning Disability Assessment & Treatment Unit from Campion Unit to Jasmine Ward** – Alternations work to Jasmine Ward was curtailed due to the pandemic. It was reactivated in June and the building programme is on course for completion in January 2021.
- **Transfer of CAMHS Tier 4 service (Willow House) to Prospect Park** – This remains the only initiative reporting a Red status. NHS England Commissioners had been engaged in the development of the business case and this ceased with the on-set of the pandemic. Regular weekly meetings with NHSE and other network members are in place to confirm the commissioning needs and service model, along with future contractual arrangements (as commissioning of CAMHs Tier 4 services is due to transfer from NHSE specialised commissioning to Oxford Health from April 2021). Consequently, the business case is delayed, along with the anticipated completion date. Delays beyond end of October may start to increase risks for the project as this was the date funding was to be confirmed.
- **Gateway to all Mental health Services (previous Mental health Wellbeing)** – The overall project was partially halted due to Covid 19 but the East Well Being Service was in a position to 'soft launch' from May 2020 (receiving internal referrals from IAPT and opening to CPE referrals from 1st August) and the launch of The Gateway is now planned for November 2020.
- **BOB Ageing Well Programme** - The original programme was suspended, but non-recurrent money is being made available for Rapid Community Response in Berkshire, Bucks and Oxford. The update in the report relates

specifically to Berkshire West Ageing Well Accelerator site, which is progressing well.

- **Connected Care** – There has been a significant – 50% - increase in usage that can be attributed to the impact of the pandemic. However, progress regarding pathology functionality is unlikely to resumed for another year, given the commitments of the pathology laboratories and the impact of COVID on other activity.
- **Global Digital Exemplar** – Work on remaining elements is on track.
- **Information Technology Architecture Strategy (ITAS)** – Some delay due to COVID, but otherwise this continues to progress well.

Supporting True North Goal 4

- **Maintaining our NHS Improvement use of Resource Rating of 1** – The monitoring of NHSIs Use of Resource rating has been suspended in 20/21.
- **Replacement for Fitzwilliam House including Trust Headquarters** – Following a pause because of COVID-19, work on securing alternative premises has resumed with options being actively explored.
- **Redevelopment of East Berkshire Community Hospitals (Frimley ICS)** – Previously on hold. Frimley ICS Estates Group has restarted with this programme as a key piece of work. The CCG has commissioned consultants to draft a Programme Business Case which the Trust has reviewed and provided feedback.
- **Just to Zero** – The programme is now closed.

CONCLUSION

13. Whilst the continued focus of the organisation on its response to the pandemic and Service Recovery has required the commitment of significant resources normally assigned to programmes and projects, it has been possible to reactivate and progress all Mission Critical schemes and most of those prioritised as Important. Moreover, a number have now been successfully concluded and work on key Trust strategies progressed.

ACTION

14. Members of the Trust Board are asked to:

- review and note the report.

COMBINED PROGRAMME/PROJECT & STRATEGY IMPLEMENTATION PLAN STATUS REPORTING

27th October 2020

= Paused

= Reduced progress

August	September	Deployment Status	INITIATIVE	SUMMARY DESCRIPTION (as required)	Planned Completion Date	Lead	Initiation	In Progress	Moving to B A U	Reason to Amber or Red Status	COMMENTARY ON RED/AMBER STATUS (including new Significant Risks & Issues)	ACTIVITY IN NEXT PERIOD
True North Goal 1: To provide safe services by eliminating avoidable harm												
PRIORITIES FOR QUALITY												
		M	**Recovery Plan**	Objectives include restoring full capacity, quality and resilience of physical and mental health services to meet ongoing and emerging post COVID-19 community needs; Stabilise our workforce with a particular focus on retention, providing support to staff resilience and wellbeing following the social and psychological shock of responding to COVID-19.	**Nov-21**	**KM**		✓			The latest highlight report is included with October meeting papers. The impact of the 1st wave has been managed and BHFT services are in full recovery and restoration mode. All Community Health services that were paused or partially closed have now completed the formal recovery service prioritisation process and are now fully operational with a 'blended' model of remote and face to face appointments. The restoration process includes services considering any new or additional digital requirements. All but two of the Mental Health services have been formally approved. Staff that were redeployed to support front line services have returned to their substantive roles. A number of staff continue to support wards and the Hospital Discharge service on top of their substantive posts. A Capacity and Demand Task and Finish Group was established - the group presented their findings following reviewing all tools and determining requirements, a paper will be shared with Exec to decide the way forward. A separate task and finish group was established to oversee delivery of a Wave 2 Surge/Winter plan and its work is now moving to business as usual. An EIA Task & Finish Group is established to consider the impact of recovery on patients and mitigate any potential negative impacts.	Capacity & demand Task & Finish Group - Recommendation to Exec that this be included in the A3 on Access and Flow. Approval of remaining mental health services recovery.
		I	**Quality Improvement Programme**	Introduction of quality improvement systems and methodology via the following work streams: QI Office; Strategy Deployment; Quality Management & Improvement System (QMIS); Improvement Projects.	**Jun-22**	**JE**			✓		The programme is now considered to be moving to business as usual. The latest report was included with the September B&F meeting papers. The QI programme continues to run all workstreams uninterrupted. The QI team have developed a number of virtual resources including virtual huddle, virtual status exchanges, virtual workshops and improvement events. E-learning white belt training also developed, where one can find an interactive way of learning basic QI skills and knowledge. Some of these tools are available via Nexus. The report includes updates regarding Green and Yellow Belt training and also QMIS. The QI projects are listed, showing their prioritisation status, as determined by the new QI prioritisation filter (based on the tool used across the Trust).	QI road map 2020 - 2021 was included with papers for the July 2020 meeting. Activities include for the next few months include Wave 12 QMIS and supporting the EUPD pathway pilots.
		I	**CMHT Function & Workforce**	By March 2020:- To have defined and implemented a revised service offer which removes unwarranted variation across Berkshire To address current challenges in recruitment and retention of CMHT staff, including the completion of a workforce plan The resulting recommended model will need to be delivered within existing resources. However, there is investment from HEE of £100k	**01/03/2020 - now September 2020**	**GC**		✓			The project manager role has been extended until 30th September 2020 with funding available within the original HEE resource. As at 15/05/2020, GC confirmed this initiative remains on hold.	Awaiting reactivation. This is likely to be conducted as part of the transformation of mental health services in Berkshire West. When reactivated, its priority status may change to Mission Critical.
		I	**Community & Primary Care network Workforce**	To develop and test a model for an integrated practice nursing and district nursing workforce, ensuring integration of new roles To develop a joint approach to training and supervision of both staff groups To develop a joint approach to the recruitment and retention of staff Supported by HEE funding.	**Nov-20**	**RS**		✓			The project has been paused and the project support staff have been redeployed. No discussions yet regarding restarting due to other priorities associated with COVID across Primary Care. Given the Leg Ulcer Club model proposed was reliant on face to face group consultations in a community setting, the model will need a refresh and / or review other opportunities to look at integrating the workforce.	Business & Finance Exec have confirmed this initiative as paused for the time being.
		M	**CAMHS Pathways**	Formerly "Improving CAMHS waiting times" this initiative has been rescoped and the work is centred around clarifying what should be delivered, where this should be delivered, a review of the current clinical provision and any skills gaps. Several initiatives are being undertaken alongside this project to support the reduction of CAMHS waiting times whilst the longer term work on pathways is being implemented.	**01/08/2020**	**BG with Hayley Clarke**		✓			Highlight Report included with October Business & Finance papers. Following pausing in March 2020 due to Covid19, this project was restarted in Sept 2020. The project and risk plan have been reviewed by the steering group. The Transition pathway will become a Green Belt project as it would benefit from a problem solving QI approach, but will report into this project's steering group as well as QI. Four priority pathways (anxiety disorders, psychosis/mania, eating disorders and PTSD) have been agreed. The report identifies the areas of focus up to April 2021, plus benefits and risks.	Review 4 priority pathways for steering group sign off. Review clinical systems and current reports.
			Transforming Urgent Care Pathways	(In Strategy Implementation Plan as placeholder but not progressed. However, the Trust will include strategic direction for urgent care within its over-arching three year strategy refresh)								
✓	✓		**Frimley Integrated Clinical Decision Making Hubs**	Establishment of integrated care to those people requiring high level of support from multiple providers. There should be a reduction in non-elective admissions as a consequence. This is an ICS priority.		**JR/CW**			✓		The Frimley Health & Care document "The ICDM Journey So Far" was included with meeting papers for the June 2020. Agreed that this initiative can be shown as Closed.	

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	✓	I	**Carers Strategy Review**	This will achieve a review, revision and subsequent adoption of the Trust's Carer Strategy, including defining the Trust's Carers Officers		**JR with Dan Groves**			✓		Dan Groves attended the QAC on 18th August to present an update on the carers strategy and work to date. A Closure Report was submitted to the September Business & Finance meeting which highlighted the following achievements: •A revised Carers Strategy and development of a carer offer that have been constructed using national best practice guidance and local engagement. •The design of a robust methodology to enable services to self-assess what level of carer offer they should implement. •Engagement with carers and the local authorities in Berkshire in the creation and content of the carer offer. •The creation of a list of recommendations and actions that Berkshire Healthcare will need to complete to ensure the successful implementation of the strategy and carer offer. The report includes commentary on the risks and lessons learned.	Business & Finance confirmed closure of the project.
True North Goal 2: To support our People and be a Great Place to Work												
PEOPLE STRATEGY DELIVERY PLAN												
		M	**People Strategy** ***Includes:*** **- Attraction. Recruitment and Retention (Mission Critical)** **- Workforce Planning**	Using a QI approach and working with ops colleagues to identify the areas of highest staff turnover. Turnover is a proxy for underlying people issues. the resulting counter measures will help us to develop a refreshed People Strategy and Action Plan.		**AG (JN/AJ)**		✓			Draft of the People Strategy is included with October Business & Finance meeting papers. Previous update: The Strategic People Group is overseeing the development of a refreshed People Strategy using a QI approach, starting with an A3 problem statement. A3 for presented to Execs and feedback received. A3 also formed part of the paper to the Board who supported the approach. The new NHS People Plan aligns well with the Trust's principles and approach to people specifically the tone and language resonates well with the focus of our current values and principles, inc. compassionate and inclusive leadership and staff wellbeing. We are now engaging in staff workshops to further develop the A3 and a high level vision for the strategy has been developed in alignment with the new trust strategy and the EDI strategy.	Continue with staff engagement workshops. Update on progress to FIP Written narrative to be developed Draft People Strategy to be considered at October Business & Finance Exec in advance of presentation to Trust Board
			Health and Wellbeing project	To achieve a managed transition of the COVID-19 staff support offer in to a sustainable and integrated Staff Support model that can continue to benefit BHFT and the wider healthcare system.		**JN**		✓			Our model has been reviewed and relaunched with the staff wellbeing psychological support now forming part of ongoing job descriptions . 3 leads in post have been identified and a staff support post-incident pathway has been developed. We have been actively engaged in the development of 2 systems bids for staff wellbeing and occupational health interventions. The BHFT model has been used as the foundation for both of these bids. The wellbeing steering group has been re-established to agree the ongoing programme of work in the wellbeing space.	Staff wellbeing psychological support to move into business as usual. Outcome of system bids Agreement of wellbeing work programme
			Organisational Development Objectives	To support the organisation with OD interventions which help us deliver a great place to work		**JN**		✓			Paper proposing the establishment of an Organisational Development Group (OD) taken to SPG for comments and feedback. The aim of this group is to identify and support areas of poor organisational experience through a multi-disciplinary and QI lens. First meeting of Leadership Steering Group held.	Formal approval of OD Group including terms of reference and priorities Ongoing QI work in development of leadership strategy.
	✓		**Design an induction programme fit for purpose**	Proposal was made to the SPG and is moving into the implementation phase.	30/04/2020	**JN**			✓		Update report was included with September 2020 Business & Finance meeting papers. The People Team are working on several programs to ensure our new members of the Trust have the best possible experience. As part of this work three projects were established: •Streamlining the onboarding process •Review & redesign of the Corporate Induction •Dedicated website (Extranet) for new starters which contains key information and welcomes them to the Trust The report highlights E-Induction, A-form changes and first day experience and identifies the improvements being secured through the new arrangements.	This work is transferring to business as usual . The SPG has reviewed the future of the corporate Trust induction and agree to the adoption of a hybrid induction (face to face/virtual) when it is safe to do so. The update report identifies how each element will be taken forward Outstanding decision on which onboarding platform to be used needs to be agreed between MarComms and IT.
✓	✓		**PMVA/ Personal Safety RRN Accreditation**		31/03/2020	**JN**					In letter dated 13th July 2020, Bild Association of Certified Training informed the Trust that the "decision has been made to award your training service Certification as complying with the RRN Training Standards subject to contract. Certification is in accordance with the Restraint Reduction Training Standards Version 1.1 and the Certification Procedural Handbook V3" [PMVA/Personal Safety training was initially paused during Covid whilst a safe way to deliver training was developed with the accreditation body . Training has resumed with a plan to address the backlog of staff requiring training]	This work has been completed.
		I	**Quality Management Improvement System (QMIS)**	**Part of the Quality Improvement Programme**							See updates for QI Programme above.	See updates for QI Programme above.
		M	**Trust Intranet**	To introduce a new intranet solution (replacing our current intranet which is now failing and has an end of life of July 2019) that is: - easy to navigate - provides improved functionality and efficiency - enhances staff engagement and retention - integrates with and enhances the experiences of Microsoft O365 (ITAS) - sustainable for the future	30/04/2020 (with key milestone of 09/07/2019) Was paused and now reactivated and due to Go Live Mid August 2020	**CS**		✓		**Technical difficulties (including single sign-on) have impacted on timescale**	Progress was put on hold in March with work reactivated in recent months. The highlight report is included with papers.365 integration functionality is highlighted in the report. User acceptance test workshops held during June and July with a number of adjustments made as a consequence. Pen testing is now complete, with a fix required by the supplier. The project board met on 27th July to agree the plan to launch. That plan included the integration of 365 with Nexus. Previously the timing for the final launch was end July and was moved to 18th August.	Formal launch of Nexus on 18th August 2020 (achieved). Compilation of Lessons Learned and Closure Report.

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		M	**BAME Transformation Plan**	There is a desire and opportunity to deliver positive changes for people from a BAME background. There are multiple priorities, many improvement opportunities and a number of people involved, but lack of clarity, ownership, focus, delivery and visibility on what needs to be done to make difference.		**DT/GC**	✓				Key Facts considered in August 2020 and initiative confirmed as Mission Critical. An A3 has been developed with problem statement, current situation and goals developed. The latest workshop identified 4 target areas to work on, there will be 4 workstreams work with QI methodology, actions and measurables. Not RAG rated as this initiative has yet to report. This links to the People Plan, for which the reporting arrangements are to be clarified.	
EMBRACING DIVERSITY												
		I	**Delivering our Equality & Inclusion Strategy 2016-2020**		**Oct-20**	**KM**		✓			ED&I Strategy included with meeting papers. EDI strategy and priorities have been signed off at DEG/SPG and will go to the Trust board in November. There will now be one centralised EDI tea, lead by the Director of EDI that will report to the Trust People Director. AG is now the Exec Lead for EDI.	We will be reviewing how best now to deliver the agreed EDI strategy and priorities within the new structure. Presentation of Strategy to Trust Board.
		I	**Equality Employment Programme (EEP)**			**JN/NZ**					Rolling out strengths based recruitment programme, starting with the LD services is part of the new strategy. Work is underway to look at revising the "making it right" programme to be inclusive of all staff with protected characteristics	
		I	**Equality Delivery System (EDS) Priorities**	**Delivered via the Equality Employment Programme**		**JN/NZ**		✓			Still awaiting the publication of EDS 3 from NHSE but will focus on community engagement via the strategy work in the interim which will include securing a community engagement lead post in the East (CM is already in post in the West).	
		I	**Implementation of the Workforce Race Equality Standard and EDS 2 objectives**	**Delivered via the Equality Employment Programme**		**JN/NZ**		✓			See above	
		I	**Regain Top 100 ranking in Stonewall work place equality index**	**Delivered via Stonewall Action Plan**	**Oct-21**	**KM**		✓		**Target not met, but positive feedback received.**	Due to the pandemic the submissions/ requirements this year have been amended but we are still signed up for 2020/21 and continue to meet monthly to monitor progress ***Previous update:*** This year's submission to Stonewall was made on 9th September and planning has already commenced for next year. Results are now available. We didn't achieve the top 100, but are really proud that our score went up. The Trust was ranked 142 out of 500 participants across all sectors (58 more organisation participated this year) - down 9 but our score is 103 (up 4). The Trust was ranked 15th for health & social care organisations (out of 64). It was noted by the account manager the dedication and improvements made in this year's submission and he shares our excitement for the year ahead, as we have so many things that couldn't be included in this year's submission.	The goal of regaining a top 100 ranking is to be retained.
True North Goal 3: To provide good outcomes from treatment and care												
MENTAL HEALTH SERVICE DEVELOPMENT												
		M	**EUPD Pathway implementation (previously Cluster 8)**	Delivery of an operational end to end pathway for EUPD patients which will be based upon the Trust's True North Objectives.	**Spring 2021**	**MI/SY**		✓			Highlight report was included with September meeting papers. The detailed operational model for assessment , assertive stabilisation and recovery (SUN) was introduced to each operational team in Feb/March. Team leaders for , Assertive Stabilisation (ASSIST) and SUN are in post and successful recruitment has enabled the implementation of a pilot within Bracknell and Wokingham Locality which has commenced. High level plan was included with the report, which includes time for pilot implementation review, PDSA and the roll out into the remaining localities. Programme Lead retired at end September and PMO is providing now project management. Pilots and their evaluation are being supported by the QI team. The report also updated on data collection and RiO arrangements.	Continuation of pilots in Wokingham and Bracknell followed by evaluation, refinements as necessary to the pathway and subsequent roll out to the other four localities. Report to Business & Finance Exec in December.
		M	**Community Mental Health Transformation - Frimley ICS**	Transformation of CMH services in line with LTP and CMH Framework, to re-design place-based, multi disciplinary service across health, social care and VCSE sectors, aligned to PCNs. Improve access to MH service for people with SMI, and improve provision for people with personality disorder.	**01/03/2021**	**SY**				**Progress was delayed due to COVID but now re-started**	Highlight report is included with October Business & Finance meeting papers. Progress was interrupted in March 2020 and recruitment delayed due to the Covid-19 pandemic. However, the implementation phase is now in progress and on target to achieve revised timescales. Updates re. MHICS include: •Local Implementation Groups (LIGs) are established for each PCN •Local stakeholder engagement is being progressed •Recruitment to the key posts for the MHICS teams for each PCN is complete •A clinical sub-group has been established to specify details around the MHICS clinical model, clinical pathway and interfaces that provide 'easy in - easy out' provision. •As early implementor, there are opportunities to be involved with Kings Fund CMH Transformation learning network Updates re Primary Care Personality disorder also included in the report.	Full sign off of digital solution, data flow and DPIA Stakeholder engagement events to be completed for later PCNs PD - Tier 1 intervention to the trialled Full go live for Bracknell PCNs following soft launch in limited number of practices Soft launch for Windsor and Slough LOCC.
		I	**Improving Patient Experience**		**01/03/2021**	**NZ**		✓			Part 1 is now complete, with a report submitted to the Quality Executive in June. NZ is liaising with Tim Shannon regarding the tender for the phases 2 and 3 of this work, which requires the OJEU route. Tenders are due on 28th October, with contract award planned for end December	Receipt and evaluation of tenders. Tender presentations followed by recommendations.
	✓	to BAU	**Sexual Health Services Transformation**	1	**01/09/2020 Completed**	**JR/CW**			✓		Agreed at B & F July meeting that this initiative is now business as usual. Lessons learned report was presented to Business & Finance Exec in September.	Confirmed as complete at Business & Finance Exec. September meeting.

August	September	Deployment Status	INITIATIVE	SUMMARY DESCRIPTION (as required)	Planned Completion Date	Lead	Initiation	In Progress	Moving to B A U	Reason to Amber or Red Status	COMMENTARY ON RED/AMBER STATUS (including new Significant Risks & Issues)	ACTIVITY IN NEXT PERIOD
OPTIMISING ESTATES												
		M	**Development of University of Reading as a Primary Trust site / Erlegh House**	Rationalisation has included the concentration of functions/services at Cremyll Road and the phased occupation of the STC building at Whiteknights, facilitating disposal or re-use of 3/5 Craven Road and 25 Erleigh Road.	**Mar-20**	**AG**		✓		**Was Amber due to delay to car park work and impact on move of services. Now reporting Green.**	Highlight report for rationalisation of Reading estate is included with October Business & Finance Exec papers. Final works (car park and boiler replacement) due for completion in October. Specialist services moved in August. SALT to move to EH as they have been put under notice by UoR to vacate Harry Pitt. Final decisions required regarding transfer of services. Responsibility for building transitioning from the project team to FM. The sale of 3/5 Craven Road is underway with soft marketing and appointment of valuation / planning consultants.	Completion of car park extension works and replacement boiler at Erlegh House. Official opening on 27th October 2020.
PROSPECT PARK HOSPITAL DEVELOPMENT PROGRAMME												
		I	**Move of Assessment & Treatment Unit from Campion Unit to Jasmine Ward**	(See Reconfiguration of Prospect Park above and also LD Service Optimisation and Redesign)	**Jan-21**	**NP**		✓			All approvals now in place (including DoV in Jan 2020) and works commenced 15th June. All appropriate social distancing and comms in place and contractor aware of sensitivity of site and services. Construction meetings being held fortnightly. Handover date now estimated as 17/01/2021 and overall project plan revised to reflect this (building period only four week over run despite COVID delay). Currently going to plan with good feedback from staff on the conduct of the contract. Some potential delays due to manufacture and suppliers having difficulties following Covid closedown.	Construction work on-going. Also Comms. Work on transition plan and reviewing of policies/protocols/ procedures.
		M	**Tier 4 Phase 2 - Transfer of Willow House**	To deliver relocation of a compliant Tier 4 CAMHS service from the current site at Wokingham Hosp. (Willow House) to Prospect Park by April 2020.	**01/08/2022**	**DT**	✓			**Delays to business case and project timescales.**	Update was provided to the August Business & Finance meeting. NHS England Commissioners have been engaged in the development of the business case and we were due to progress the discussions with them in March 2020, but delayed due to COVID. Now re-engaged with NHSE and meeting with them and other network members weekly to confirm the commissioning needs and service model, along with future contractual arrangements as commissioning of CAMHs Tier 4 services is due to transfer from NHSE specialised commissioning to Oxford Health from April 2021. The business case is delayed as a consequence of the above, along with the anticipated completion date.. Delays beyond end of October may start to increase risks for the project as this was the date funding was to be confirmed.	The current forecast is that the weekly meetings will allow confirmation of arrangements going forward by mid October 2020 and further updates will be provided on outcomes at this time.
			Approved Place of Safety	Scheme comprises the move of CRHTT from the therapy area to Prospect House; move of therapy facilities into the area vacated by CRHTT and a new Place of Safety in the current therapy facility	**Jul-21**	**DT/SG**					Paused and there is a dependency on a decision to be made regarding the service model.	
HEALTH AND SOCIAL CARE SYSTEMS INITIATIVES												
			ASC Integrated MSK/Physio Service (Berkshire West)	MSK business case approved in May 2019 by the Unified Executive with a service start date planned for Dec 2019 which the Nov Unified Exec agreed could be put back to Jan 2020. The programme comprises the following interventions: - GP Champions - GP education - First contact Physios - Expanded Shared Decision making - Triage - Community Specialist Service	**Previously April 2021, but now under review due to COVID delay.**	**RS Lesley Holmes**		✓			The Pre-COVID service (Phase 1, for knees) is now back up and running. Carl Davies is the MSK Director, which is joint funded and all meetings have been reactivated. Over the next three months, Phase 1 is to be evaluated and requirements worked up for Phases 2 and 3.	See update
			Digital - Population Health Management	Detail to be added when available	**(TBC)**	**AG/MD**					Will report to Digital Board	
			Frimley - Pain Pathway transformation programme	Gateways to be clarified once plans are agreed. Role of the Trust to be clarified		**RS**	✓				System work is on hold. However, Frimley is looking to undertake internal redesign following the experience of COVID and this could be positive. As at 27th August, there is no change, but with Frimley specific work on-going.	See update
			(Berkshire-wide) Developing a Berkshire Healthcare Community Health Strategy			**KM**	✓				This will now form part of the combined three year strategy.	
			System use of estates - Sustainability and Transformation Partnership (STP) led programme	formal review of estates strategies for BOB and Frimley (further milestones to be added later)	**Dec-19**	**AG/DT/ IG**						
			Connected Care - BOB and Frimley STP areas		**Jul-20**	**MD**				**Amber due to poor LA take up and issues around pathology reporting.**	Previously reported as Amber in relation to low take up by Local Authorities and also issues with pathology functionality. There has been a significant - 50% - increase in usage by staff (15,000 per month in April compared to 10,000 in previous months). Progress regarding pathology functionality is unlikely to resumed for another year, given the commitments of the pathology laboratories with regard to COVID activities and the impact of COVID on other activity.	See update.
		M	**Gateway to all Mental Health Services (previously Mental health Wellbeing - CPE/IAPT)**	A phased approach to transform entry into mental health services combining IAPT/CPE/Third Section.	**Apr-20**	**JC**	✓			**Had been reporting Amber due to uncertainties over East service model and acknowledgement of later timescale. Next report may change this to Green**	Latest highlight report is included with meeting papers. The Project name changed to The Gateway to all Mental Health Services to be inclusive of all services (Wellbeing, Talking Therapies & Adult Mental health services/Common Point of Entry) . Overall project was partially halted due to Covid 19 but the East Well Being Service went live from May 2020 and has received over 250 internal referrals. The Wellbeing Service Joint Berkshire Healthcare/East Commissioner monthly Steering Group continues and CCG have remarked positively on progress to date. West Berkshire Wellbeing Service awaiting a commissioning/implementation decision. Linking in 111 with CPE and the Gateway pathways has gone live. E-referral went live 1st April 2020 The Gateway launch has been agreed to go live in a phased way and this is currently scheduled for early November having been delayed from August due to new systems requiring testing and clinical governance sign off.	Final GP testing of e-referral and DXS form final amendments Phase 1 launch of Gateway. Leadership: Suzannah Johnston appointed as CPE/Gateway Governance lead and Matt Poll will be Head of Access services (the Gateway) from 1st November.

August	September	Deployment Status	INITIATIVE	SUMMARY DESCRIPTION (as required)	Planned Completion Date	Lead	Initiation	In Progress	Moving to B A U	Reason to Amber or Red Status	COMMENTARY ON RED/AMBER STATUS (including new Significant Risks & Issues)	ACTIVITY IN NEXT PERIOD
		M	**BOB Ageing Well Programme/ Berkshire West Ageing Well Accelerator Site**	To increase the capacity and responsiveness of intermediate care services to provide crisis response within two hours of need and reablement within two days to both avoid unnecessary hospital admission and support early discharge for medically optimised older people to leave hospital on time. National Accelerator Site for Urgent Community Response Programme. BHFT has been appointed as the BOB System-wide lead for the programme	**Original milestones: MDTs operational Sept 2020 Anticipatory Care Planning April 2021 Urgent Community Response 200/21 (as BOB is an accelerator site)**	**KM/KW**	✓			**(Authorisation now secured regarding recruitment)**	The Berkshire West Ageing Well accelerator site highlight report is included with meeting papers. Overall project is on track to deliver key milestones. Recruitment commenced with some level of success. However, recruitment of staff remains key risk, mitigated by NHSP and skill mix change First test file for CSDS submitted. **Progress of individual schemes:** *Extended and enhanced Rapid Response and Care Home Support* •Successful recruitment of 2 x Band 8a and 6 x Band 7 nurses. •Pathway, project plans and risk register agreed for 2hr response. *Community Rehabilitation Pathway* •KPIs for 91 day / Patient Outcome Measures/ Patient Experience - data captured for September •Recruited to Triage Coordinator posts / 2 Physiotherapy posts •Extension to the rehabilitation pathway underway – Pulmonary rehab project has been scoped and start date planned for October 20 for Reading pilot. Papers also include the newsletter for the BOB Ageing Well Programme for information.	Data set for CSDS and Service reporting (submission being tested) Review initial metrics data and clarify additional BOB/NHSEI metrics Explore capacity and demand tool proposed by NHSEI Scoping to be undertaken for shielding patient rehabilitation offer Review referral process for Rapid Response and determine care capacity requirements.
INFORMATION MANAGEMENT - Next updates due March 2018												
		M	**Global Digital Exemplar (including roll out of ePMA)**	19 projects within four GDE initiatives: - Direct Patient Access & Communication - Digital Wards & Services - Digital workforce - Research & Quality improvement	**Jun-21**	**MD**	✓				Overall status is green backed on delivery against plan, NHS E/D monitoring and achievement of identified requirements. All activities delayed through COVID have now resumed. Projects currently deploying are patient observations (eOBS), bed management and patient status (FLOW), medicines management (ePMA). The papers include updates on blueprinting and accreditation. The Trust is on track to achieve all elements for accreditation, with the majority already achieved. Amongst the topics covered in the papers is patient feedback regarding their experience of using One Consultation.	See update. **Next update is due December 2020.**
		M	**Information Technology Architecture Strategy**	Implementation of new technology and Cloud computing. Comprises six elements including Office 265 migration to Cloud and movement of departmental systems to Cloud. Email upgrade/replacement and Wide Area Data Network to be completed this financial year.	**31/03/2020**	**MD**		✓		**Amber due to the delays as detailed in update.**	CoIN completed, e-mail migration completed, secure e-mail implemented, Windows 10 migration completed, Home Drive and Outlook Personal folders migrated. Shared Drive Migration underway. The following are reported as Amber: *Corporate Guest Wifi* - Delayed due to Covid19 but project now restarted. BHFT sites going live by October. *Departmental shared drives to be moved to SharePoint* - Delayed due to Covid19 – now underway and due for completion by March 2021	*For completion in October and November 2020*: Create communications and migrations plan for departmental shared drives to be moved to SharePoint and accessible via Teams. Full implementation of Office 365 Desktop on all Trust Laptops and PCs following participation in the N365 national licensing programme. **Next update is due December 2020.**
True North Goal 4 To deliver services that are efficient and financially sustainable												
			Maintaining our NHS Improvement use of Resource Rating of 1	**Includes: - Achieving our Control Total - Delivering our Cost Improvement Plans**	**01/03/2020**	**AG/PG**		✓			The monitoring of NHSIs Use of Resource rating has been suspended in 20/21	See update.
			Replacement for Fitzwilliam House including Trust Headquarters		**Mid 2021**	**IG**	✓				Fitzwilliam House needs to be vacated in 2022. Paper went to the Exec w/c 03/02/2020 setting out options for the HQ with London House used as a model. Three options are being developed (including Do Minimum) as part of the production of a business case. Schedules of accommodation are being worked up. A key question is the inclusion or otherwise of Learning & Development in the scheme.	Conclusion of exploration of options by end December 2020.
			Redevelopment of East Community Hospitals (Frimley ICS integrated care hub programme)	Delivery of the Integrated Care Hubs across the ICS to enable the implementation of the ICDM. Projects include ICHs or equivalent in Fleet (NE Hants), Surrey Heath, Ascot, Bracknell, Windsor, Slough, Maidenhead. These will be a mixture of new build and refurbishments with NHS and partner assets used	**end 2024**	**(IG)**					**Critical issue is lapse of time since money was awarded**	Previously on hold. Frimley ICS Estates Group has restarted with the ICH programme as a key piece of work. The CCG has commissioned consultants to draft a Programme Business Case which the Trust has reviewed and provided feedback. A number of issues were identified as points of concern and these have been communicated. Further work will review the principles of the service model and some of the assumptions made before progressing to the next stage	See update.
✓	✓	M	**Just to Zero (J2O)**	The project seeks to continue address the 5YFV aims around eliminating acute overspill, achieving the NHSi ambition to eliminated Acute OAPs by April 2021. Elimination of acute overspill being addressed though four new work streams:	**Closure report due August 2020**	**JR**			✓	**Completed.**	A closure report was considered and approved at the August meeting of the Business & Finance Executive. The effectiveness of the initiative was been particularly evident during the pandemic with significantly fewer out of area placements required in comparison to that of neighbouring services. Work on length of stay will continue as part of the Recovery programme. Work will continue at Prospect Park regarding PICU.	Business as usual.

Key:

M Mission Critical

I Important and in progress

✓ Project Closed

JE = Julian Emms DF - Debbie Fulton MI = Minoo Irani DT = David Townsend GC = Gerry Crawford AG = Alex Gild IG = Ian Greggor SG = Steph Gould MD = Mark Davison NZ = Nathalie Zacharias

JR = Jayne Reynolds BG = Bridget Gemal JB = Julie Bennett CS = Cathy Saunders KM - Kathryn Macdermott CW = Claire Williams RS = Reva Stewart JN = Jane Nicholson NP = Nick Pugh

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th November 2020
Title	COVID 19 Recovery Plan Report
Purpose	The purpose of this report is to provide the Board with an update on the Recovery and Restoration process for BHFT services.
Business Area	All
Author	Jenny Jones, Head of Strategic Development
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 several elements of the Recovery programme of work.
SUMMARY	We continue to remain in the active phase of the COVID 19 response with planning for the 2nd wave in progress. Any potential impact of the 1st wave on the Recovery process will be reported via the Recovery Programme Board. At this point in time we are not reporting a negative impact. All community physical health services that were paused or partially closed have completed the formal

	prioritisation process and are now fully operational with a 'blended' model of appointments for many services. The last two mental health services will be approved via Chairs action. All of the staff that had been re-deployed in wave 1 have now been returned to their substantive posts and a review of the re-deployment process has been completed, the learning from which has informed the wave 2 planning.
ACTION REQUIRED	The Board is asked to: Note the report and progress, including an update on the capacity and demand modelling.

Berkshire Healthcare NHS
NHS Foundation Trust

Recovery Project Highlight Report	Month: October 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, including oversight of Implementation of Phase 3 of the NHS response to the COVID-19 pandemic. • Provide reassurance to our patients regarding their care and 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:**	In Progress	**Planned Completion Date:**	September 2021

I = Mission Critical I = Important Initiation/ In Progress/ Moving to Business as Usual/ Closed

Author	Kathryn MacDermott, Acting Executive Director of Strategy	**Overall Project Status*:**	

***Show status as Red / Amber / Green.**

Summary Commentary re status &	**Overall Progress** We continue to remain in the active phase of the COVID-19 response, now known as Phase 3. The impact of the 1st wave has been managed and BHFT services are in full recovery and restoration mode. All Community Health services that were paused or partially closed have now completed the

progress:	formal recovery service prioritisation process and are now fully operational with a 'blended' model of remote and face to face appointments. All but two of the Mental Health services have been formally approved and the Service Prioritisation Steering Group has now been stood down. Chairs action will be taken on the two remaining mental health services to be formally approved, with oversight of the Recovery Programme Board. Staff that were redeployed to support front line services have returned to their substantive roles. A number of staff continue to support wards and the Hospital Discharge Service on top of their substantive posts. Whilst this arrangement is operational for the recovery phase it is not sustainable on a longer-term basis. Conversations are current with commissioners to ensure continuity of the 24/7-day services through the Winter period. The Recovery Programme Board established a time limited Capacity and Demand Task and Finish Group to consider the tools and methodologies available to support capacity and demand planning. The aim was to identify one tool that provided information on Activity, Waiting Times, Workforce, Estates and Finance. Following consideration at the Recovery Programme Board and Executive discussion, it has been agreed that the recovery capacity and demand work will be incorporated into the Strategic Initiative Access and Flow work to enable one consistent approach to capacity and demand planning across the Trust. A separate task and finish group chaired by Jayne Reynolds, Regional Director East, has been established to oversee delivery of a Wave 2 Surge/Winter planning and reports to GOLD Command. It provides a regular update to the Recovery Programme Board on any scenarios / issues that may impede the progress of recovery. **Reporting** The Recovery Project Managers have met to discuss and simplify the reporting format to the Programme Board and inform a Recovery Dashboard. A new report format is currently in development to include; Estates & Facilities Management (EFM), Quality Impact Assessment (QIA), Service Status, Phase 3 Actions, priority ordering of services for the Capacity and Demand Tool, system impact and ICS engagement. Following SRO sign off we hope to launch the new format for January 2021. **Impact on staff** Wave 2 planning includes the backstop option of redeploying staff. Currently the preferred option is to redeploy corporate staff to enable all community physical and mental health services continue. Should healthcare staff be required to redeploy the impact on recovery trajectories will need to be remodelled. Staff training, induction and support are all in place for redeployed staff. **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, diagnostics and assessments are completed via One Consultation or Teams platforms. Services continue to consider new or additional digital requirements to optimised service delivery.

	Equality Impact Assessments We have a agreed a set of EIAs to be completed. Frimley have taken the lead from BHFT and established an EIA Task & Finish Group to consider the impact of recovery on patients and mitigate any potential negative impacts. **Impact of Wave 2** We are seeing an increase in Covid-19 within the broader community and BHFT staff. Whilst the numbers of staff currently off with COVID is small there is an increasing number of staff with COVID related absences (requirement to self-isolate). This may at some point impact Recovery of services, the Recovery Programme board has oversight of this potential impact.

Benefit	Timescale / date to be realised	Responsibility	Achieved Yes/No	Comment
Services restored	October 2020	Divisional Directors	Yes	All but two mental health services are now operational. The last two services are expected to be approved imminently.
New ways of working embedded	March 2021	SRO/Divisional Directors/Director People	In progress	New ways of working include positive opportunities such as remote appointments increasing access opportunities and decreasing patient transport and waiting times. Negative impacts include the reduced capacity of our services due to COVID-19 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	Uptake in digital technologies across services has been significant with staff engaging with technology in a way many thought not possible pre COVID-19. Staff Survey indicates that working from home significantly enabled by Microsoft Teams. Trust Remote Working Toolkit and Homeworking Policy currently in development following staff listening events and staff reference group engagements.
Agree capacity and demand modelling required to clear	Approval end Sept, modelling completed end	SRO / Divisional Directors	Yes	Task and Finish group established, and work completed. Recommendations on the model to the October Recovery Programme Board and Exec. Agreed to include Capacity and Demand modelling in

waiting list backlogs and implementation plans agreed.	October/ November 2020			the Access and Flow A3 Strategic Initiative.
Capacity and demand modelling completed for prioritised services	January 2021	SRO / Divisional Directors	In progress	To be included in the Access and Flow A3 Strategic Initiative.
Restored services provide equality of access	December 2020	Divisional Directors	In progress	Equality Impact Assessments to be completed on key areas including digitally enabled services, patient experience, and patient outcomes.
Phase 3 Recovery requirements	November 2020	SRO	In Progress	Allocation of phase 3 Recovery requirements with agreed timescales and associated leads to be included in the Recovery Workbook.

Risks to highlight

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment
Board Assurance Framework – Risk 8B		• There is a risk that the Trust may be unable to maintain the standards of safe and high-quality care for patients we aspire to as an organisation because standing services back up during the recovery phase of COVID-19 whist also responding to system and regional pressures for information and support. • There is a risk that there may be insufficient staff to provide safe care due to staff to staff transmission/impact of test and trace on need for staff to self-isolate. • The impact of COVID-19 and the service response, upon staff and their ability to remain resilient and at work needs to be a continued focus.	Various sub task dates	For the purpose of this report this risk provides a summary of that included within the Board Assurance Framework 2020-21 (received 22092020)
COVID-19 – Risk of second wave de-railing the recovery process – leading to delay in recovery programme progress		Work closely with Wave 2 Lead, Divisional Directors and Project Managers to understand current state and implications on progress	March 21	Second wave planning commenced and will inform the Recovery Programme Board to by exception should Wave 2 impact on Recovery.
Capacity and Demand Planning - to support Recovery		Capacity and Demand modelling to determine capacity required to return to pre COVID near normal state and manage backlog within new service models/ covid constraints with consideration of Estates, Workforce and Finance implications for inform discussions with commissioners and clear plans moving forward. It is recognised that any plan will need to be implemented as such timings should consider this.	December 2020	This work will now be included within the Flow and Access Strategic Initiative. Discussions are currently taking place regarding prioritisation of services to be modelled.

Current Milestones Report

Milestone	Due date	Current Status (RAG)	Actions / Comments
Stakeholder Engagement and Communications Plan in place.	June 2020		To work with colleagues to determine requirements and best way forward regarding the Recovery Comms Group identified messages.
QIA and EFM Complete for all services	June 2020 [Revised to Oct 20]		All CHS have completed and approved QIA and EFM templates. Prioritisation Group will now consider remaining two Mental Health services via chairs action. CYPF have challenges in securing alternative venues for face to face sessions in the West where children centres have been closed.
Plan for Corporate Services new ways of working developed	July 2020 [Revised to Nov 20]		Plan developed. Remote Working Policy and Home Working Toolkit currently in development.
Use of the Capacity and Demand modelling tool to assess future capacity of services and resources required to clear waiting list backlogs.	June 2020 [Revised to Dec 20]		Immediate Recovery requirements have been worked up, to ensure that there is no delay in meeting requirements. Assessment of current position on services utilising the BHFT In House tool to be undertaken and resources identified to take work forward within timescales are now a priority.
Review all Phase 3 requirements and build necessary action plans.	End Sept 20 [Revised to Oct 20]		Identify organisational actions from Phase 3 for Recovery and ensure these are owned and tracked.

	Complete		On Track		On Track / Known risks being managed		Off Track

Key Activity during Next Period

Activity/Product to be delivered	Action/notes	By when
Roadmaps to future state	Complete Roadmaps for all divisions and identify impact of Wave 2.	November 2020
Highlight reports for all divisions	Recovery team to work with Divisional and Corporate leads to ensure completion.	November 2020

Completed Milestones

Milestone	Due date	Current Status (RAG)	Actions / Comments
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
Second Wave Planning Group established	Sep 2020		JR will lead this work. A planning group is in place if significant risks are identified with regards to progress of recovery should Wave 2 occur depending on the severity.
Recovery milestones and activity included in the two system refreshed plans.	21st Sep 20		KM coordinating this work, combination of recovery and phase 3 milestones and activity.
Template for patient letters	July 20		Comms to provide template, letters now being used by operational teams– services to use as appropriate and save in Teams folders.
Prioritisation and approval of community health services for recovery complete with start dates or phasing identified.	Aug 2020		Prioritisation group now meeting weekly with approvals being made at every meeting. Near 100% of CHS restored.
Prioritisation and approval of health services for recovery complete with start dates or phasing identified.	Aug 2020		Remaining will be approved by Chairs Actions
Capacity & Demand Task and Finish Group recommendations to Recovery programme board	October 2020		Recommendation to Exec that this be included in the A3 on Access and Flow.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 November 2020
Title	**Audit Committee – 28 October 2020**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 28 October 2020 and to ratify minor changes to the Committee's Terms of Reference
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached. The Audit Committee meeting approved minor changes to its terms of reference. The changes are highlighted in red type.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered b) To ratify minor changes to the Audit Committee's Terms of Reference

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 28 October 2020, Fitzwilliam House, Bracknell

Present:	Chris Fisher, Non-Executive Director, Committee Chair Naomi Coxwell, Non-Executive Director Mehmuda Mian, Non-Executive Director *(present from 3pm)*
In attendance:	Paul Gray, Director of Finance Debbie Fulton, Director of Nursing and Therapies Minoo Irani, Medical Director *(present for agenda items 10 and 11)* Clive Makombera, Internal Auditors, RSM Ben Sheriff, Deloitte, External Auditors Kim Hampson, Counter Fraud, TIAA Melanie Alflatt, Counter Fraud, TIAA *(present from 3pm)* Julie Hill, Company Secretary Martin Brabin, Financial Management Trainee

The meeting was conducted via Microsoft Teams because of COVID-19 social distancing requirements.

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Alex Gild, Deputy Chief Executive and Chief Financial Officer and Amanda Mollett, Head of Clinical Effectiveness and Audit. Apologies for lateness due to other commitments were received from Mehmuda Mian, Non-Executive Director and Melanie Alflatt, Counter Fraud Service.	
2.	**Declaration of Interests,**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 22 July 2020**	
	The Minutes of the meeting held on 22 July 2020 were confirmed as a true record of the proceedings.	

4.	**Action Log and Matters Arising**	
	Action Log The Action Log had been circulated. The following matters arising, and action updates were discussed further: **a) Patient Level Costing System** The Director of Finance reported that the initial output of the Patient Level Costing System was being reviewed and would be presented to the Finance, Investment and Performance Committee by the end of the financial year which would then be shared with the Trust Board and/or with the Audit Committee as appropriate. **b) Annual Work Programme – Prospect Park Hospital Estate** The Chair reported that the Chief Operating Officer had confirmed that there were no estates issues relating to Prospect Park Hospital which needed to be brought to the Committee's attention. The item had therefore removed from the Committee's Work Programme. The action log was noted.	
5.A	**Board Assurance Framework**	
	The Board Assurance Framework had been circulated. The Company Secretary reported that the COVID-19 risk (risk 8) had been split into two separate risks – risk 8A – responding to the COVID-19 pandemic and risk 8 B – COVID-19 service recovery and winter planning. The Chair reported that the full Board Assurance Framework and Corporate Risk Registers would be presented to the November 2020 Trust Board meeting for their annual review. The Chair also reported that the risks on the Board Assurance Framework would be reviewed and aligned with the Trust's refreshed Three-Year Strategy 2021-24. The Committee reviewed the Board Assurance Framework and made the following points in respect of the risks below: **Risk 6 – Demand Risk** The Chair asked for an update on inappropriate Out of Area Placements. The Director of Nursing and Therapies reported that the majority of inappropriate Out of Area placements related to patients requiring Psychiatric Intensive Care Unit beds. The Director of Finance confirmed that there were currently four inappropriate Out of Area Placements. The Chair asked whether the additional costs associated with inappropriate Out of Area Placements would be funded nationally as part of the COVID-19 funding regime so would be cost neutral.	**AG/JH**

	The Director of Finance confirmed that this was not the case and reported that the Trust had made provision for a level of inappropriate Out of Area Placements in the Trust's end of year financial forecast. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee would be reviewing the Trust's bed optimisation "Just to Zero" Project Closure Report at its meeting on 29 October 2020. The Chair noted that the Trust's Emotionally Unstable Personality Disorder Pathway was now due to be rolled out in January to February 2021 and asked whether this would have an impact on the Trust's bed capacity at Prospect Park Hospital. The Director of Nursing and Therapies reported that currently there were only a few Emotionally Unstable Personality Disorder patients at Prospect Park Hospital and therefore the new pathway would not free up a lot of bed capacity. The Chair said that it would be helpful for the Committee to receive an update on the Emotionally Unstable Personality Disorder Pathway at the next meeting. The Chair referred to the roll out of the Trust's Quality Management Information System training and said that given the Trust's level of investment in the Quality Improvement Programme, it may be helpful to commission an independent review to identify the patient safety, outcomes, patient experience benefits and any cost savings. The Director of Nursing and Therapies pointed out that there were clear qualitative patient safety benefits to patients in terms of reducing the number of falls and reducing the use of prone restraint. Naomi Coxwell, Non-Executive Director said that it would be helpful if any review went back to the Quality Improvement Business Case to ascertain whether the Trust had succeeded in delivering the Programme's original objectives. **Risk 8B – COVID-19 Service Recovery** The Chair asked for an update about the Trust's recovery of services. The Director of Nursing and Therapies reported that all the Trust's services were now up and running. It was noted that some services were operating at reduced capacity because of COVID-19 social distancing requirements. The Director of Nursing and Therapies reported that online consultations had replaced many face to face interactions. The Committee: noted a) The Board Assurance Framework b) The COVID-19 Risk which had been split into two separate risks – responding to the COVID-19 pandemic and COVID-19 service recovery/winter planning	**DT/MI** **DT/MI**

5.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Committee noted the Corporate Risk Register updates since the last meeting.	
6.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from July 2020 to September 2020 had been circulated. The Director of Finance highlighted that due to urgency during the COVID-19 pandemic, two tender awards did not go through the usual process and were retrospectively reviewed and approved. The Director of Finance confirmed that the post-approval review did not identify any issues of concern. The Committee noted the paper.	
7.	**Information Assurance Framework Update Report**	
	The Director of Finance presented the paper and reported that a total of five indicators were audited during Quarter 2: • Mental Health Re-Admission rate within 28 days – rated amber, moderate assurance • Mental Health 7-Day Follow Up (audited monthly) – rated amber, moderate assurance • Pressure Ulcers acquired at BHFT due to a Lapse in Care – rated green, high assurance • Falls Incidents on Inpatient Wards – rated amber, moderate assurance • Mental Health Acute Average Length of Stay – rated amber, moderate assurance It was noted that action plans had been put in place to address any issues. The Chair referred to page 89 of the agenda pack relating to falls incidents on Inpatient wards and noted that one incident was missed as a fall because it was recorded as an "unwitnessed fall – last seen on bed" which had been recently added to the DATIX online recording system and was not included in the filter for the performance scorecard. The Chair asked whether performance scorecard would be retrospectively updated to reflect the additional fall. The Director of Finance agreed to update the Committee. The Chair referred to page 90 of the agenda pack and asked what was meant by a patient being "discharged in error". The Director of Nursing and Therapies explained that this was when someone had incorrectly inputted onto the RiO electronic patient record system that a patient had been discharged and had then immediately recognised their error and rectified the patient's record.	**PG/IH**

	The Chair said that it was heartening that the amount of amber (moderate confidence) and red (limited confidence) on the report was going down and was being replaced by green (high confidence). The Committee noted the report.	
8.	**Losses and Special Payments Report**	
	The Losses and Special Payments Report covering April to September 2020 had been circulated. The Chair referred to page 96 of the agenda pack and asked for more information about a claim paid to the Compensation Recovery Unit of the Department of Work and Pensions. The Director of Finance agreed to find out and update the Committee. The Committee noted the report.	**PG**
9.	**Clinical Claims and Litigation Report and Claims Management Policy**	
	The Director of Nursing and Therapies presented the paper and reported that during quarter 2 there were two new claims both relating to employer liability claims and there were two claims closed. The Director of Nursing and Therapies reported that the Trust's updated Claims Management Policy had been circulated to the Committee for information. The Committee noted that report.	
10.	**Clinical Audit Report**	

	The Medical Director presented the report and highlighted the following points:
	
	• The Trust's Clinical Audit Programme for 2020-21 remained on track during the COVID-19 pandemic, although the national Clinical Audit Programme had slowed down.
	• There are three reports due to be presented at the November 2020 Quality Assurance Committee:
	  o National Clinical Audit of Psychosis: EIP service re-audit 2019
	  o POMH – 9d Antipsychotic prescribing in people with learning disability
	  o National Clinical Audit of Anxiety & Depression: a 2nd Report from the audit featuring on the Qualitative aspects of the patient survey results.
	• The Trust was currently collecting data in respect of Prescribing for Valproate and for the national clinical audit of Psychosis: Early Intervention in Psychosis re-audit 2020
	
	The Medical Director reported that given the high priority and profile of prescribing Valproate to women of childbearing age, the Trust had agreed that the audit would include all women of childbearing age prescribed valproate rather than a sample of patients.	

	The Committee noted the report.	
11.	**Counter Fraud Report**	
	Kim Hampson presented the report which set out TIAA's activity across the generic areas of Strategic Governance, Inform and Involve and Prevent and Deter and highlighted the following points: • The Government Functional Standards for Counter Fraud would be replacing the current NHS Counter Fraud Standards for Providers from April 2021; • There was no specific action for the Trust to undertake at this stage and any changes required were not expected to be material; • The Trust was selected to contribute to the NHS Counter Fraud Authority's work to develop and promote a clear risk-based methodology to assist organisations in demonstrating and recording the effectiveness and impact of local counter fraud activity designated as "proactive work"; • November was international fraud awareness month. TIAA was liaising with the Trust's Marcomms team to promote fraud awareness across the Trust; • In line with Government guidance and NHS Counter Fraud Circulars, TIAA had developed a COVID-19 Fraud Risk Thematic Review to provide a rapid assessment of the key risks the Trust was facing across areas of the organisation – finance, workforce, procurement, IT and Corporate Governance; • The objective of the review was to identify any emerging or existing fraud threats, whilst providing assurance over the key fraud and bribery risks facing organisations during the unprecedented COVID-19 period; • TIAA had made two recommendations for the Trust: o Working whilst sick – a declaration should be added to the return to work forms to confirm that the employee had not worked whilst on sick leave; and o A review of Accounts Payable spend should be done to ensure that there were no unexpected increases in non-purchase order spend which had been processed during COVID-19 • As part of the 2020-21 Counter Fraud work-plan, the Trust had requested that TIAA undertook a review to ensure that pre-employment checks for new substantive staff were being conducted in accordance with Trust Policy. • The review concluded that pre-employment checks conducted by the Trust's Recruitment Team were of a very high standard and were fully compliant with NHS Employers Check Standards. However, there were fraud vulnerabilities in the appointment of interim/contractor appointments who were not subject to the usual pre-employment checks. TIAA had made recommendations for improvement and the Trust's management were addressing the issues; • TIAA had also conducted a proactive review of expense claims and in the sample of claims which were reviewed had identified that vehicle and driver documents were not annually checked in accordance with the Trust's policy which could result in increased safety and liability risks. TIAA had made recommendations for improvement and the Trust's management were addressing the issues; Naomi Coxwell, Non-Executive Director asked whether working whilst off sick	

	had increased due to COVID-19. Ms Hampson said that working whilst off sick was the most common referral to the Counter Fraud Specialist across all NHS provider organisations and that the overall number of referrals had not increased during the COVID-19 period. The Committee noted the report.	
12.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Clive Makombera, Internal Auditors, RSM, presented the Internal Audit Progress Report and reported that since the meeting, the Internal Auditors had finalised the following report:
	
	• There was a delay in agreeing the Internal Audit Plan and audits had been postponed due to the COVID-19 pandemic. However, revised timescales had been agreed with the Executives to ensure that the Internal Audit Plan was delivered by 31 March 2021 to inform the Head of Internal Audit Opinion and Annual Governance Statement;
	• Since the last meeting, two reports had been finalised:
	  o Key Financial Controls – Accounts Payable (substantial assurance)
	  o Board Assurance Framework and Risk Management Culture (substantial assurance for the Board Assurance Framework and Corporate Risk Management and reasonable assurance for divisional risk management and links to the Corporate Risk Register)
	• Draft reports had been issued in respect of the Workforce Race Equality Standard and Recruitment and Retention. The Quality Improvement review was in progress;
	• The Trust was currently in the development stage of the costing process and therefore in agreement with Management, the Patient Level Information and Costing System review had been postponed to the next financial year;
	• There were two overdue Management actions but both these actions were in progress and revised implementation dates had been agreed with Management.
	
	The Chair referred to Key Financial Controls – Accounts Payable review and commented that he was surprised that 65% of invoices in the sample audited were not authorised before being placed.
	
	The Director of Finance agreed but pointed out that if the Trust had a contract in place then the orders would not require a pre-authorised purchase order.
	
	The Chair referred to the Board Assurance Framework and Risk Management Culture review and said that one of the recommendations made was in respect of defining the Trust's risk appetite.
	
	The Chair reported that the Trust Board had discussed whether this would be helpful at its October 2020 Trust Board Discursive meeting and had agreed that the Trust reviewed individual risks in the round and that pre-defining the Trust's risk appetite did not add value to the Board's decisions.
	
	Clive Makombera said that when he reviewed the Trust's Board Assurance	

	Framework, the Trust's risk appetite was inherent in the risk scores. The Chair said that he would confirm in writing to Mr Makombera, the Trust's decision not to implement the audit review's recommendation in relation to defining the Trust's risk appetite. **b) Board Assurance Frameworks – Benchmarking Report** Clive Makombera presented the paper and reported that RSM had reviewed and examined the contents of 38 NHS provider organisation's Board Assurance Frameworks. Mr Makombera commented that the Trust's Board Assurance Framework was one of the best of his 20 clients and that the findings from the Benchmarking Report may help the Trust to finesse the Board Assurance Framework in order to better support the Board in its role in managing the Trust's key strategic risks. Clive Makombera reported that the Company Secretary had confirmed that the Trust was currently refreshing its Three-Year Strategic Plan and therefore this would be a good opportunity to review the risks on the Board Assurance Framework. Clive Makombera reported that the Internal Auditors were working with the Company Secretary to develop an assurance map which would help the Trust to identify any gaps in assurance. The Chair asked about the timescale for the assurance map. Mr Makombera confirmed that this would be produced by the end of the year. The Committee noted the reports.	**CF** **CM**
13.	**External Audit Verbal Report**	
	Ben Sheriff, Deloitte gave a verbal update to the Committee and reported that the External Auditors were currently finalising the Trust's Charitable Funds Accounts. It was noted that there were no material issues to report. Mr Sheriff reported that he was working with the Director of Finance to identify the impact of the new value for money external audit requirements. The Chair thanked Ben Sheriff for his verbal report.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 30 July 2020**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 30 July 2020 were received and noted. The Chair requested an update on the national financial performance regime. The Director of Finance reported that for the first half of the financial year, the national funding regime guaranteed funding to bring NHS provider organisations back to a break-even position. Under the new financial regime for the current six months, it was assumed that the Trust would make a £2.8m deficit and appropriate funding and COVID-19 costs would be covered by a central allocation to the Integrated Care System. It was noted that for the	

	purposes of the financial allocation, the Trust came under the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Finance, Investment and Performance Committee would be reviewing the Trust's year end financial forecast at its meeting tomorrow. Ben Sheriff said that there was a lack of clarify around the new financial regime.	
15.	**Minutes of the Quality Assurance Committee held on 18 August 2020**	
	The minutes of the Quality Assurance Committee meetings held on 18 August 2020 were received and noted. The Chair asked for an update on the Trust's Staff Flu Campaign. The Director of Nursing and Therapies said that the Flu Campaign was particularly challenging this year because so many staff were working at home and although the Trust provided vouchers, many pharmacies had run out of their current flu vaccination stock. It was noted that currently around 40% of staff had received a Flu Vaccination and that NHS England required that 95% of staff to be vaccinated by the end of November 2020. The Chair asked whether the Trust's leadership could do more to encourage staff to be vaccinated. The Director of Nursing and Therapies confirmed that she would be writing to the Divisional Clinical Directors later to day to ask them to make sure staff were booked to receive their Flu Vaccination. Mehmuda Mian, Non-Executive Director asked whether there were any other reasons apart from staff working at home why staff were not getting vaccinated. The Director of Nursing and Therapies said that she was not aware of any particular reasons but said that the Trust would be conducting a survey to find about why staff were not taking up the offer of a Flu Vaccination.	
16.	**Minutes of the Quality Executive Committees held on 20 July 2020, 17 August 2020 and 21 September 2020**	
	The minutes of the Quality Executive Committee meetings held on 20 July 2020, 17 August 2020 and 21 September 2020 were received and noted.	
17.	**Audit Committee Review of Effectiveness and Review of the Terms of Reference**	
	The results of the Committee's Annual Review of Effectiveness had been circulated. The Company Secretary thanked everyone for completing the survey and for ensuring that there was a 100% response rate. It was noted that the results were very positive, including complimentary comments about the Chair's skills and abilities. The Chair reviewed the comments and reminded everyone that the Committee	

	held an annual private meeting with the Auditors. The Chair reminded the meeting that he would be stepping down as a Non-Executive Director in September 2020 and said that he was discussing succession plans with the Trust Chair. The Chair said that the Audit Committee did not need to spend time reviewing the detail of financial reports because the Finance, Investment and Performance Committee, chaired by Naomi Coxwell (also a member of the Audit Committee) undertook that role. The Committee's Terms of Reference with suggested minor amendments highlighted in tracked changes had been circulated. The Committee: a) Noted the results of the Annual Audit Committee's Review of Effectiveness; and b) Approved the minor changes to the Committee's Terms of Reference which would be ratified by the November 2020 Trust Board meeting.	
18.	**Draft Audit Committee Annual Report to the Governors**	
	The Chair reminded the meeting that the Audit Committee presented an annual report of its work to the December Council of Governors. The draft report which would be updated after the meeting had been circulated. Naomi Coxwell, Non-Executive Director suggested that the report should include a section on how the Audit Committee has supported the organisation during the COVID-19 pandemic. The Committee noted the draft report.	**CF/JH**
19.	**Standards of Business Conduct Policy Changes**	
	The Standards of Business Conduct Policy together with highlighted minor changes had been circulated. The Company Secretary reported that the Trust's Policy was closely based on NHS England's model policy. It was noted that the changes to the Business Conduct Policy would be submitted to the Policy Review Group for approval. The Chair suggested that there should be a section on staff working whilst off sick given the earlier discussion of the Counter Fraud Paper. Mehmuda Mian, Non-Executive Director suggested that the policy should also be reviewed to make sure that any learning from investigations were included, including the Counter Fraud Policy. The Committee noted the paper.	**PG** **PG/MA**

20.	**Annual Work Plan**	
	The Committee's Annual Work Plan was noted.	
21.	**Any Other Business**	
	There was no other business.	
22.	**Date of Next Meeting**	
	27 January 2021	

These minutes are an accurate record of the Audit Committee meeting held on 28 October 2020.

Signed: -

Date: - 20 January 2021

Berkshire Healthcare
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

This document contains the terms of reference for the Trust Audit Committee.

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance –
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie -Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018 – Board approved September 2018
16.0	July 2019	Julie Hhill	Revision following Audit Committee review – July 2019 – Board approved September 2019
17.0	October 2020	Julie Hill	

Document References

Document Title	Date	Published By
NHS Audit Committee Handbook	2005	Department of Health & Healthcare
The NHS Foundation Trust Code of Governance	2006	NHS Improvement, Independent Regulator of NHS Foundation Trusts

Authority

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

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary.

Purpose

2.1 To conclude upon the adequacy and effective operation of the Trust's overall internal control system and independently review the framework of risks, controls and related assurances that underpin the delivery of the Trust's objectives.

2.2 To review the disclosure statements that flow from the Trust's assurance processes ahead of its presentation to the Trust Board, including:

a. Annual Governance Statement, included in the Annual Report and Accounts and the Annual Plan together with the external and internal auditors' opinions.

b. Annual Plan declarations relating to the Assurance Framework.

Membership

3.1 The membership of the Committee shall comprise three Non-Executive Directors, at least one of whom shall have recent and relevant financial experience, plus, ex officio, the Chair of the Finance, Investment & Performance Committee. The Chair of the Quality Assurance Committee will attend as and when there are appropriate matters to discuss with the Audit Committee.

3.2 The Chair of the Trust and the Chief Executive shall **not** be members.

3.3 The Chair of the Committee will be a Non-Executive Director and will not be a member of any other standing Committee of the Board.

3.4 A quorum shall be two members.

In attendance at meetings

4.1 The Committee will be supported by the following in attendance:

- Chief Financial Officer
- Director of Finance
- Medical Director
- Head of Clinical Effectiveness and Audit
- Director of Nursing and ~~Governance~~Therapies

- The Company Secretary

4.2 The Committee can invite the Chairman and Chief Executive as well as other Trust Directors or Officers to attend to discuss specific issues as appropriate.

4.3 The Committee will be attended by representatives of the following:

- External Audit
- Internal Audit
- Counter Fraud
- Clinical Audit

4.4 The Committee will consider the need to meet privately, at least once a year, with both the internal and external auditors. The internal and external auditors may request a private meeting with the Committee at any time.

Frequency and Administration of Meetings

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

5.2 It will be supported by the Company Secretary who will agree the agenda for the meetings and the papers required, directly with the Chair.

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

Duties

Governance Risk Management and Internal Control

6.1 The Committee shall review the establishment and maintenance of an effective system of integrated Governance, risk management and internal control, across the Trust's clinical and non-clinical activities that support the achievement of its objectives.

6.2 The Committee shall ensure that the Board Assurance Framework is effective in enabling the monitoring, controlling and mitigation of risks to the Trust's strategic objectives.

6.3 In particular, the Committee will review the adequacy of the following:

a. All risk and control related disclosure statements, together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurances, prior to endorsement by the Board;

b. The underlying assurance processes that indicate the following:

- The degree of the achievement of corporate objectives
- The effectiveness of the management of principal risks
- The appropriateness of the disclosure statements

c. The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.

6.4 The Committee shall request and review reports and positive assurances from Directors and managers on the overall arrangements for governance (including clinical audit and data quality), risk management and internal control.

Audit & Counter Fraud

6.5 The Committee shall ensure that there is an effective internal audit function and clinical audit function that provide appropriate independent assurance to the Audit Committee and includes the following:

a. Review the Internal Audit Plan, operational plan and programme of work and recommend this for acceptance by the Trust Board of Directors.

b. The review of the findings of internal audits and the management response.

c. Discussion and agreement with the External Audit of the nature and scope of the External Audit annual plan.

d. The review of all external audit reports, including the agreement of the annual audit letter before submission to the Board and any work completed outside the External Audit annual plan.

e. Review and approval of the Counter Fraud Plan and operational plans.

f. The review of the findings of the Counter Fraud plan and the management response.

6.6 Clinical Audit

The Committee shall ensure that there is an effective Clinical Audit process. This includes reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans.

6.7 The Committee shall ensure that Internal Audit, External Audit and Clinical Audit recommendations are implemented promptly by management.

Financial Reporting

6.8 The Committee shall review the Annual Accounts and Financial Statements before submission to the Board.

6.9 It will ensure that the financial systems for financial reporting to the Board are subject to review as to completeness and accuracy of the information provided to the Board.

6.10 It will review the annual accounts of the Charitable Trustees prior to submission.

Reporting

6.11 The Committee will routinely review the minutes of:

- Finance, Investment & Performance Committee
- Quality Assurance Committee
- Quality and Performance Executive Committee

and will review the work of other committees within the organisation whose work can provide relevant assurance to the Committee.

6.12 The Minutes of the Audit Committee will be formally submitted to the Trust Board.

6.13 The Chair of the Committee shall report to the Board any concerns and assurances relating to the Trust and the Committee's work.

6.14 The Audit Committee Chair will produce an Annual Audit Report setting out the work of the Committee and highlighting any issues raised during the course of year by the Trust's Internal and External Auditors and the Counter Fraud Specialist. It will report annually to the Council of Governors Trust Board through an 'Audit and Governance Report' which will include the following:

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

d. The Committee's self-assessment and any action required.

Other functions

6.15 The Committee will review and monitor compliance with Standing Orders and Standing Financial instructions.

6.16 It will review the following:

a. Schedules of losses & compensations and making recommendations to the Board

b. Any decision to suspend Standing Orders

c. Decision to waive the competitive tendering rules when requested by the Board

d. New and existing claims

6.17 It will approve changes in accounting policies.

6.18 It will review the performance of the Audit Committee through self-assessment and independent review to be completed at least annually. It will also review the output from the annual self-assessment exercises conducted by other Board Committees.

6.19 It will provide oversight of the Trust's processes for ensuring robust data quality and will review periodic reports on data quality performance.

6.20 The Committee shall provide assurance on the quality checks of data used in the preparation of the Performance Assurance Framework.

6.21 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

Amended: ~~July~~ September ~~2019~~ 2020
Board approved: ~~September 2019~~

Next review: July 202~~0~~1