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 13 April 2021

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 09 February 2021	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – Tissue Viability	Debbie Fulton, Director of Nursing and Therapies/Stacey Evans-Charles, Tissue Viability Specialist Service Lead	Verbal
6.1	Quality Assurance Committee a) Minutes of the meeting held on 02 March 2021 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Chair of the Quality Assurance Committee	Enc.
6.2	Infection, Prevention and Control Board Assurance Framework	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Proposed Changes to How the Care Quality Commission Inspects	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	National NHS Staff Survey Results Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
PERFORMANCE			
8.0	Month 11 2020/21 Finance Report	Alex Gild, Deputy Chief Executive and	Enc.

No	Item	Presenter	Enc.
		Chief Financial Officer	
8.1	Month 11 2020/21 Performance Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.2	Board Vision Metrics Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
8.3	Finance, Investment & Performance Committee meeting on 25 March 2021	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	COVID-19 Recovery Plan Report	Kathryn MacDermott, Acting Executive Director of Strategy	Enc.
CORPORATE GOVERNANCE			
10.0	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.1	Trust Seal Report	Alex Gild, Deputy Chief Executive and Chief Financial Officer	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting –11 May 2021	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 09 February 2121

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

Present:	Martin Earwicker	Chair
	Chris Fisher	Non-Executive Director
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Deputy Chief Executive and Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Dr Minoo Irani	Medical Director
	Kathryn MacDermott	Acting Executive Director of Strategy
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Jane Nicholson	Director of People
	Nathalie Zacharias	Director of Equalities
	Alison Salvadori	Head of Talking Therapies Service *(present for agenda item 6.0)*

21/001	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
21/002	**Apologies** (agenda item 2)
	Apologies for absence were received from: Mehmuda Mian, Non-Executive Director.
21/003	**Declaration of Any Other Business** (agenda item 3)

	There was no other business.
21/004	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
21/005	**Minutes of the previous meeting – 08 December 2020** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 08 December 2020 were approved as a correct record.
21/006	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
21/007	**Patient Story – Recovering from "Long COVID" Case Study (**agenda item 6.0)
	The Chair welcomed Dr Alison Salvadori, Head of the Talking Therapies Service. Dr Salvadori presented the patient story (the slides presented to the Board Meeting are attached as an appendix to the minutes) and made the following points: • The Trust's Talking Therapies Services had continued to operate remotely throughout the COVID-19 pandemic and took around 2,000 referrals per month • The Talking Therapies Service had a role in treating those with Long COVID • The case study concerned Peter, (not his real name) aged 35 who worked in a non-clinical senior management. role in the NHS (not at the Trust). Peter was a family man with two young children Peter contracted COVID-19 early on in the pandemic and received in-patient hospital treatment but was not ventilated • After leaving hospital, Peter experienced feelings of hopelessness and had suicidal thoughts. He became extremely anxious about his health and was concerned that he had early onset dementia. Peter felt vulnerable and broken and pictured himself as needing a wheelchair for the rest of his life. Peter also focused on a series of negative "what if" scenarios • The Talking Therapies Service used Cognitive Behavioural Therapy (CBT) techniques. During his treatment, it became clear that issues in Peter's childhood, for example, being bullied at school were also negatively impacting on Peter's physiological wellbeing • Over the course of 17 sessions (one hour per week), Peter's anxiety level fell to within normal bounds and he no longer felt suicidal. Peter was able to return to work, resumed exercise and his role in the family was restored. Peter was also helped to develop a "staying well" plan • Peter had agreed to support others suffering from the psychological impact of COVID-19 by agreeing to become an Expert by Experience

	The Chair asked whether the Trust needed to do more early intervention for staff and the wider public suffering from the impact of Long COVID. Dr Salvadori reported that there were now two Long COVID clinics in Berkshire and said that the Talking Therapies were linked into both of these clinics. Talking Therapies practitioners were exploring options such as group interventions supported by Talking Therapies staff to enable people suffering from Long COVID to support each other. Naomi Coxwell, Non-Executive Director said that it was a very compelling case study and commented that it was reassuring that traditional CBT techniques and other tried and tested interventions were also effective in treating the psychological impact of having COVID-19. Dr Salvadori pointed out that health was a mixture of biological, social, and psychological factors and that this was the case whether the individual had cancer or Long COVID. Ms Coxwell asked how the lessons from treating Peter could be shared more broadly across the profession. Dr Salvadori reported that the Talking Therapies Services participated in a serious of national webinars and that this enabled practitioners to share learning and best practice. The Chief Operating Officer shared that he had spoken to three members of staff who were experiencing Long COVID and asked how staff accessed the Long COVIC clinic services. Dr Salvadori explained that she was working closely with the Head of Psychological Services who was leading the work around the Staff Support Service to publicise the service. It was noted that the Service was advertising its services by handing out leaflets at the COVID-19 vaccination centre, information on the Trust's intranet and posters on Trust noticeboards to ensure that staff were aware of the support that was available. Aileen Feeney, Non-Executive Director asked whether the Talking Therapies Service was considering setting up a group to support carers of people with Long COVID. Dr Salvadori reported that the Talking Therapies Service was not currently planning to set up a group for carers. Chris Fisher, Non-Executive Director said that post COVID-19, there was likely to be significantly more demand for mental health services and asked how the Talking Therapies Service was preparing to meet this increased demand. Dr Salvadori explained that the national Increasing Access to Psychological Therapies team had undertaken a modelling exercise which suggested that there may be a 30% increase in referrals for Talking Therapy services and said that it was likely that there would be some additional funding. Dr Salvadori also reported that the service had undertaken a lot of work with GPs to help them understand the psychological impact of the COVID-19 pandemic. David Buckle, Non-Executive Director commented that as a retired GP he recognised the importance of taking a holistic view of illness and echoed Dr Salvadori's observation that the mental health impact of COVID-19 was the same as for many other chronic illnesses.

	The Chair asked whether the service could do more to help people to self-manage their mental health issues. Dr Salvadori said that the Trust used SilverCloud (an online course to help people manage stress, anxiety and depression) and online CBT systems for people with mild to moderate levels of anxiety. It was noted that the SilverCloud system was now available for all Berkshire residents. The Chief Executive said that the case study showcased the support that was available for NHS staff who were negatively impacted by the psychological impact of having contracted COVID-19 and commented that it was very reassuring to hear how the Talking Therapies Service was able to support Peter. On behalf of the Board, the Chair thanked Dr Salvadori for sharing the Peter's story and thanked her and her colleagues for the work they were doing to support both staff and patients.
21/008	**Annual Community Mental Health Survey Report 2020** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and pointed out that this gave a retrospective view of Community Mental Health Services. It was noted that the survey was based on 17,601 patients who received care between September and November 2020. The Director of Nursing and Therapies commented that it was nationally acknowledged that due to the impact of the COVID-19 pandemic, it was not be appropriate to compare the results with previous years. It was noted that the overall response rate of 27% was achieved (compared to a national response rate of 26%) which was an increase of 24% in 2019, although this was still a decrease from 33% in 2018. The survey results demonstrated that our results were the same as most other trusts for all section scores. The Chair commented that it was likely that the COVID-19 pandemic would lead to an increase in people needing mental health services. **The Trust Board**: noted the paper.
21/009	**Patient Experience Quarterly Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • The Trust had received 51 complaints during quarter 3. Of these only 3 related specifically to COVID-19/COVID-19 pandemic • The services with the highest number formal complaints during the quarter were the Community Mental Health Team (total 7 a reduction on 11 in previous quarter and a small percentage of the 12,988 contacts that occurred) and Community Nursing (total 5 - 3 east and 2 west services with no emerging themes identified) . the 5 complaints in Community Nursing was a tiny percentage of the 76,442 contacts that occurred during the quarter and by comparison 152 compliments were received. • Across both Physical and Mental Health Inpatient wards there was a reduction in complaints this quarter

	• 1 of the 3 formal CAMHS complaints received during the quarter related to service wait times and 4 MP complaints were also received related to wait times for CAMHS during the quarter. The service continued to explore alternative ways to reduce wait lists for ASD/ADHD pathways. • Of the 42 complaints closed in the quarter 48% were partially or fully upheld which was below both Q1 (71%) and Q2 (60%) • There were 1,010 compliments recorded. • For 27% of our complaints, the ethnicity of the complainant was unknown and therefore it was not possible to draw any comparisons with local population demographics; work was still required to improve the capture of ethnicity data for all complainants. • There were 6 open Ombudsman complaints at present, for 2 of these investigations were underway and for the remaining 4 further information had been requested by the Ombudsman in order to decide on progressing to investigation. For 3 additional complaints referred, the Ombudsman had advised attempting to seek local resolution in the first instance. • After a decrease in MP enquires to 5 in Q1, there was an increase to 8 in Q2 and a further increase to 10 this quarter. 50% of these related to CAMHS services. • There were 10 postings on NHS Choices during quarter 3 (8 were positive and 2 were negative) • NHS England and Improvement l Friends and Family Test reporting process had re-started with the new friends and family test question (rating care rather than a recommendation to others) David Buckle, Non-Executive Director asked whether the Trust encouraged service users to post comments on NHS Choices. The Director of Nursing and Therapies confirmed that the Trust encouraged patients to use the friends and family test process but did not have a strategy of encouraging the use of NHS Choices. The Chair commented that it was important that the Trust continued to improve the recording of ethnicity data in relation to complaints. **The Trust Board**: noted the report.
21/010	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) Staff Flu Vaccination Campaign** Mark Day, Non-Executive Director asked whether those staff who did not take up the offer to have a flu vaccination had also declined the COVID-19 vaccination. The Director of Nursing and Therapies said that there was some commonality. The Director of Nursing and Therapies reported that the COVID-19 vaccination booking system would also be used for staff booking flu vaccinations. This system enabled ethnicity monitoring which would help the Trust to better target its communications.

	b) Royal College of Psychiatrists Serious Incident Process Accreditation The Chief Executive reported that the Trust was one of only two who had achieved the Royal College of Psychiatrists Serious Incident Accreditation. On behalf of the Trust Board, the Chair congratulated the Director of Nursing and Therapies and her team for their work in achieving the accreditation. **c) Staff Wellbeing Guardian** It was noted that Mark Day, Non-Executive Director had been appointed as the Trust's Wellbeing Guardian. The Chair thanked Mr Day for agreeing to undertake the role. **The Trust Board**: noted the paper.
21/011	**Month 09 2120-21 Finance Report** (agenda item 8.0)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points: • Pre-COVID-19 and deficit support, the reported deficit was £0.9m, increasing the year to date deficit to £1.5m. This was £0.8m better than forecasted and continued to be driven by higher income and associated pace of recruitment against Clinical Commissioner Group investment • In contrast, COVID-19 costs had continued to increase and were £0.4m higher than the forecast. The most notable pressure being the on-going demand for Mental Health beds, resulting in a high level of Out of Area Placements. • As the Trust responded to the latest wave of the pandemic, Out of Area Placement usage remained high into early January. Sickness cover was also increasing, and additional Community beds were being opened. • COVID-19 costs would therefore continue to increase and would remain in excess of the forecast until the current pressures had eased. • Overall, the Trust was reporting a £0.8m deficit in December 2020 moving the Trust into a £0.5m deficit year to date. The current deficit was £0.4m less than forecast. The Deputy Chief Executive and Chief Financial Officer reported that the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System was in surplus and would support the Trust's year end deficit. The Chair requested that the graph which showed staff numbers broken down by staff group be re-instated in future financial reports. **Action: Deputy Chief Executive and Chief Financial Officer** **The Trust Board noted:** ***Year to date:*** • Excluding COVID-19 and deficit funding support, the Month 9 2020/21 (December 2020) year to date deficit had increased by £0.9m to -£1.5m. This was £0.8m better than planned • COVID-19 costs had increased and were £0.4m higher than planned in month and year to date • Overall, the year to date net deficit was -£0.5m, £0.4m better than planned.

	Forecast: • The Year End Forecast was currently -£1.4m deficit (compared with the financial plan of £1.8m) before "allowable" annual leave provision change and impairment risk • Pre COVID-19 costs – the forecast was £1.9m better than planned due to additional income received and underlying recruitment profile • COVID-19 costs – the forecast was £1.9m higher than planned, due to Mental Health bed demand (placements), system flow capacity, staff bank rates and sickness cover all driven by the impact of the COVID-19 surge • The Forecast also included £0.4m of additional COVID reserve funding from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System.
21/012	**Month 09 2120-21 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 09 "True North" Performance Scorecard had been circulated. The Deputy Chief Executive and Chief Financial Officer presented the paper and reported that falls incidents in Community and Older Adult Mental Health Inpatient wards had been RAG rated "red" for the last two months. The Director of Nursing and Therapies said that the Trust was treating more COVID-19 positive patients than in the first COVID-19 wave and pointed out that older COVID-19 positive patients often experienced delirium and confusion which increased the likelihood of falls. The Chair noted that the average length of stay for Mental Health inpatients was 46 days compared with the target of 30 days. The Chief Operating Officer explained that Prospect Park Hospital staff were continuing to use Quality Improvement Programme Methodology to reduce length of stay but reducing the length of stay was complex and had been impacted by the COVID-19 pandemic which had also resulted in Social Care teams being stretched. The Chair asked whether the volume of Out of Area Placements was likely to continue over the next few months. The Chief Operating Officer said that he was hoping that the number of Out of Area Placements would come down and said the pressure on mental health beds was a national issue and reflected the increased acuity of patients during the COVID-19 pandemic. **The Trust Board:** noted the report.
21/013	**Finance, Investment and Performance Committee Meeting on 28 January 2021** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the meeting held on 28 January 2021 had discussed the forecasted financial year end position which included a relatively small deficit which would be addressed by the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and paid tribute to the work of the finance department.

	Ms Coxwell reported that the Trust was beginning its work to identify Cost Improvement Programme schemes for 2021-22. It was noted that the central financial planning cycle had been delayed because of the COVID-19 pandemic. Ms Coxwell reported that the Committee had received a lessons learnt report about the Veterans High Intensity service contract which had been awarded to Solent NHS Trust. The Committee had also discussed Mark Day, Non-Executive Director's appointment as the Trust's Health and Wellbeing Guardian. Ms Coxwell said that the Committee had fully supported Mr Day's intention to focus on preventative measures as well as reflecting and learning from existing practices. The Chair thanked Naomi Coxwell for her update.
21/014	**COVID-19 Pandemic Recovery Plan Update Report** (agenda item 9.0)
	The Acting Executive Director of Strategy presented the paper and reported that the Recovery and Restoration programme of work had been paused because of the pressures of the second wave of the COVID-19 pandemic. It was envisaged that the Recovery and Restauration process may be able to start again in March 2021. The Acting Executive Director of Strategy reported that all urgent and crisis services continued and where routine appointments could be completed remotely this continued. Whilst the impact on some services included an increase in the size of the waiting list, other services had been able to continue to work through their referrals and were reducing their waiting lists. Mark Day, Non-Executive Director asked whether patients and service users had been kept informed about changes to service provision during the second COVID-19 wave. Mr Day pointed out that at last week's Joint Non-Executive Directors and Council of Governors meeting, it was clear that some of the Governors were not aware of the current situation. The Acting Executive Director thanked Mr Day for his feedback and agreed to find out what information about changes to services during the second wave of the COVID-19 pandemic had been communicated to patients and service users. **Action: Acting Executive Director of Strategy** Chris Fisher, Non-Executive Director commented that it was possible that there would be subsequent COVID-19 waves and asked about the impact on both staff and services. The Acting Executive Director of Strategy said that the Recovery and Restoration Board would be reviewing how best to re-start services after the second COVID-19 wave and said that some services would need a break before they were able to resume normal services. It was noted that it was likely that national guidance would be issued on the recovery and restoration of services. **The Trust Board:** noted the report.

21/015	**Strategy Implementation Plan Report (**agenda item 9.1)
	The Acting Executive Director of Strategy presented the paper and reported that despite the challenges posed the COVID-19 pandemic, the Trust had progressed all the "mission critical" and "important" rated projects. **The Trust Board**: noted the paper.
21/016	**People Strategy and Equalities, Diversity, and Inclusion Strategy** (agenda item 10.0)
	The Chair welcomed the Director of People and Director of Equalities to the meeting. The Deputy Chief Executive and Chief Financial Officer reported that the People Strategy and Equalities, Diversity and Inclusion Strategy had been amended to reflect the Board's comments made at the last meeting and were presented to the Trust Board for final approval. **a) People Strategy** The Director of People reported that the People Strategy and Equalities, Diversity and Inclusion Strategy would be launched alongside the Trust's refreshed Three-Year Strategy at one of the Executive's All Staff Briefings and would be published on the Trust's website. The Director of People proposed that the Trust Board receive six monthly updates on the implementation of both the People and Equalities, Diversity, and Inclusion Strategies. **Action: Deputy Chief Executive and Chief Financial Officer/Director of People/ Director of Equalities** Chris Fisher, Non-Executive Director commented that the People Strategy was well presented and clearly articulated the Trust's ambition and included deliverables and a very challenging timetable. Naomi Coxwell, Non-Executive Director echoed Mr Fisher's comments and asked whether the implementation of the People Strategy would be aligned with the Trust's overall performance management reporting and Quality Improvement methodology. The Director of People reported that the People Strategy would be monitored as part of the Trust's normal governance mechanisms and would be integrated with the Trust's performance management reporting. The People Strategy implementation would be monitored by the Strategic People Group and would report to the Finance, Investment and Performance Committee quarterly and to Board every six months. It was noted that some of the metrics related to data, which was reported annually, for example, the Annual NHS Staff Survey etc. The Chair commented that he really liked the strapline: "Outstanding for All" and was pleased to see the inclusion of quantitative targets. The Chair referred to the section on reducing the number of disciplinary cases that involve Black, Asian, and Minority Ethnic staff (page 142 of the agenda pack) and suggested that the ambition could be made clearer. The Director of People agreed to review and re-word the section. **Action: Director of People**

The Chair thanked the Director of People for her leadership in developing the People Strategy. The Director of People in turn thanked the Trust Board for their thoughtful and helpful comments which had helped to refine the People Strategy.

b) Equality, Diversity, and Inclusion Strategy

The Director of Equalities reported that the Equality, Diversity, and Inclusion Strategy covered both staff and patients.

For staff this included:

- Addressing and reducing inequalities and differentials in experience, focusing on bullying and harassment, aligned to workforce retention in the People Strategy
- Embedding inclusive and compassionate leadership approaches
- Developing workforce career progression and talent management
- Strengthening and developing the staff networks including making them more inclusive for allies
- Developing and delivering the inclusive “ready for change” programme which build on the Making it Right programme and would address the culture change required based on allyship and a greater appreciation of the different cultural norms that can cause misunderstandings and miscommunication. This was known as “cultural intelligence”.

For patients this included:

- Embedding the Accessible Information Standard for disabled patients across all services
- Embedding reasons for and recording of patient demographics to improve health outcomes
- Identifying actions and resources needed to identify health inequalities through community engagement
- Continuing to promote LGBT+ engagement and support through Stonewall and Reading Pride
- Developing strengths-based inclusive recruitment with services
- Co-producing actions and resources needed for Trans patient’s pathways

Aileen Feeney, Non-Executive Director commented that she liked the Equality, Diversity and Inclusion Plan on a Page which included clear targets.

Naomi Coxwell, Non-Executive Director referred to the section on bullying and harassment from patients and the public and asked whether there was any learning from other institutions, for example, the Police on how to tackle this issue.

The Director of Equalities shared Ms Coxwell’s concern and said that the Trust would take account of learning from other organisations and was committed to reducing bullying and harassment.

The Chair asked whether the Trust published data around other people with protected characteristics.

The Director of Equalities said that there was a national requirement to publish the results of the Workplace Race Equality Standard and Workforce Disability Standard and the Gender Pay Gap. The Director of Equalities said that in the past the Trust had not been

	proactive in informing local communities about how their feedback and comments had been used to influence the Trust's Equalities, Diversity and Inclusion work which will be addressed through this strategy. The Chair thanked the Director of Equalities for her leadership in developing the Equalities, Diversity and Inclusion Strategy. **The Trust Board Approved**: a) The People Strategy b) The Equalities, Diversity, and Inclusion Strategy c) The outline communications and launch plan; and d) The proposed governance arrangements
21/017	**Council of Governors Update** (agenda item 10.0)
	The Chair reported that the Joint Non-Executive Directors and Council of Governors meeting held on 3 February 2021 had received two excellent presentations on the Trust's Quality Improvement Programme and on the new West Berkshire MSK pathway. The Chair reported that he was discussing the arrangements for the Trust's Annual General Meeting with the Governors. The Chair said that he was also discussing with the Governors how the Trust could increase the diversity of the membership and Council of Governors to ensure that the Council was representative of Berkshire's population.
21/018	**Annual Health and Safety Report** (agenda item 10.1)
	The Chief Operating Officer presented the Annual Health and Safety Report 2020 and highlighted the following points: • The Trust had not received any Enforcement Notices from the Health and Safety Executive or the Local Authority in 2020 • There were 9 incidents reported under the RIDDOR regulations in the year 2020, (no false reports) showing a decrease of four incidents compared to 2019. Manual Handling, Assaults and Slips, Trips and Falls were the main incident types, there had been 4 COVID-19 RIDDOR reports under the criteria Case of Disease, RIDDOR reportable incidents • During 2020 the Trust reported 578 physical assaults against staff. This was a decrease of 48 (7.6%) compared to 2019. There were 426 Non-Physical Assaults against staff reported, an increase of 113 (36%) over the previous year • During 2020, the Royal Berkshire Fire and Rescue Service undertook zero fire safety visits to ensure the Trust was compliant with the Regulatory Reform (Fire Safety) Order 2005 • Four fires were reported during 2020. One was accidental and three were arson. This was a reduction of 33% on the previous year • Compliancy in statutory training: Fire Awareness – the number of staff trained throughout 2020 had averaged 90.75% over the year. This fell short of the Trust's target of 95% compliance.

	• Compliancy in statutory training: Health and Safety - the number of staff trained throughout 2020 had averaged 95.87%. This was above the Trust's target of 90% compliance • The overall sickness rate for 2020 was 4.05%, and the main reason for absence continued to be anxiety/stress/depression which accounted for 27.8% of the sickness in the 12-month period. COVID-19 related sickness accounted for 18.7% of all sickness absence in 2020 and back/musculoskeletal problems accounted for 15.5% of sickness • The total number of FTE days lost to sickness in 2020 had decreased by 0.75% when compared to 2019. If COVID-19 related sickness was excluded from the figures, the overall sickness rate for 2020 was 3.29% and in the six-month period April–September, the sickness rate was consistently below the Trust target of 3%, which was the lowest sickness rate seen in over 7 years. Mark Day, Non-Executive Director commented that three out of four of the fires were due to arson and asked what more could be done to increase fire safety training. The Chief Operating Officer said that fire safety training compliance remained a high priority for the Trust. **The Trust Board**: noted the report.
21/019	**Audit Committee Minutes – 20 January 2021** (agenda item 10.2)
	Chris Fisher, Chair of the Audit Committee reported that the Audit Committee meeting held on 20 January 2021 had received a presentation on the Trust's new Emotionally Unstable Personality Disorder pathway. Mr Fisher reminded the meeting, that over the last two years, the Trust's Bed Optimisation Programme had focused on admission avoidance, reducing length of stay and timely discharging rather than increasing its bed capacity. The development of the new pathway for Emotionally Unstable Personality Disorder patients was a key component of the Bed Optimisation Programme work. It was noted that the Trust had used Quality Improvement Programme methodology to develop the Emotionally Unstable Personality Disorder. Mr Fisher said that the presentation to the Audit Committee provided assurance about the progress of the new pathway as well as broader assurance around the value of the Quality Improvement Programme. Mr Fisher reported that the meeting had also received the Annual Information Governance and Caldicott Guardian Report. It was noted that this report had hitherto been submitted to the Trust Board but was now presented to the Audit Committee which already received the Annual Cyber Security Report. Mr Fisher reported that the meeting had reviewed the Charitable Accounts and Annual Report 2019-20 which were formally approved by the Corporate Trustees which met immediately following the Audit Committee. The Chair thanked Chris Fisher for his report back.

21/020	**Annual Declarations of Interest and Fit and Proper Persons Test** (agenda item 10.3)
	The Company Secretary presented the paper and reported that its purpose was to provide assurance to the Trust Board that individual members of the Trust Board continued to meet the Fit and Proper Person Requirements. Naomi Coxwell, Non-Executive Director asked about the frequency of the Disclosure and Barring Service checks for Non-Executive Directors. The Company Secretary reported that Disclosure and Barring Service checks were undertaken when Non-Executive Directors were appointed. **The Trust Board**: noted the report.
21/021	**Annual Trust Board Meeting Planner** (agenda item 10.4)
	The Annual Trust Board Meeting Planner had been circulated. Mark Day, Non-Executive Director and the Trust's Health and Wellbeing Guardian proposed adding a six monthly Health and Wellbeing Report to the Meeting Planner rather than an annual report. The Company Secretary agreed to update the meeting planner. **Action: Company Secretary** **The Trust Board**: noted the report.
21/022	**Any Other Business** (agenda item 11)
	There was no other business.
21/023	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 13 April 2021.
21/024	**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 09 February 2121.

Signed…….. Date 13 April 2121

(Martin Earwicker, Chair)

NHS
Berkshire Healthcare
NHS Foundation Trust

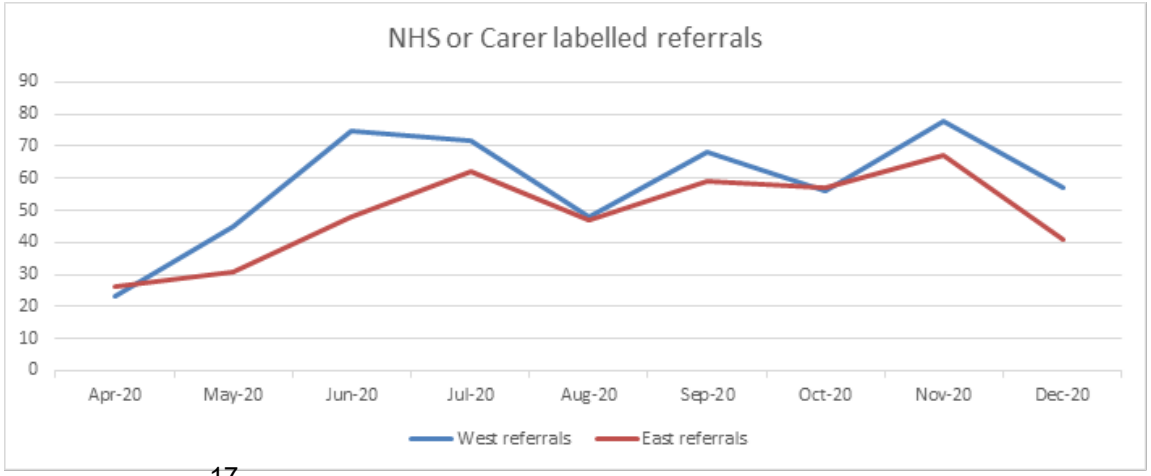
Recovering from ‘Long Covid’

A case study

Dr Alison Salvadori, Head of Service IAPT
Consultant Clinical Psychologist

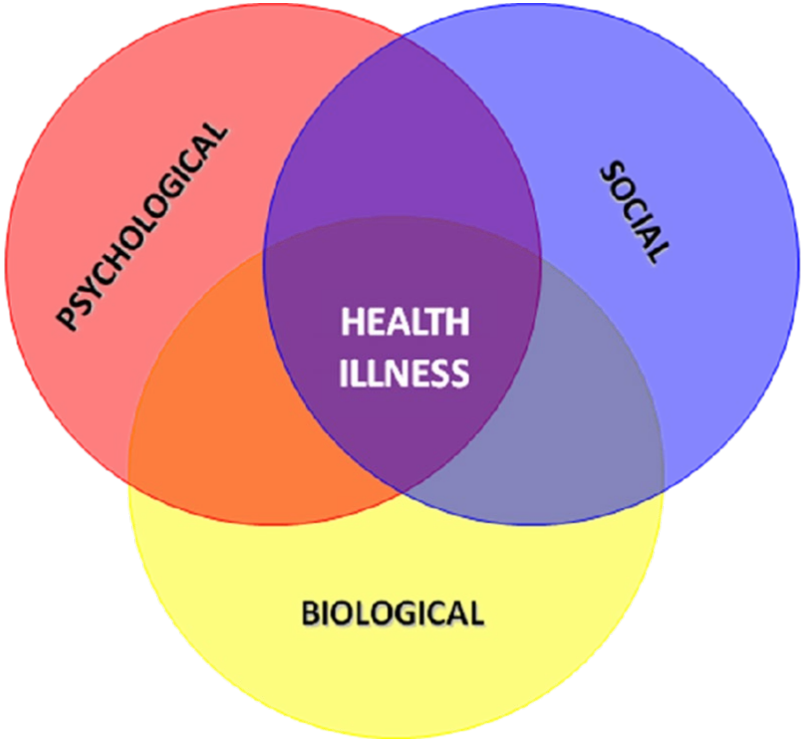
Setting the scene

- Service delivery **uninterrupted –** approaching **2000 referrals** per month
- Role in treating those with **LTCs**
- Key role in treating **NHS/Care staff**



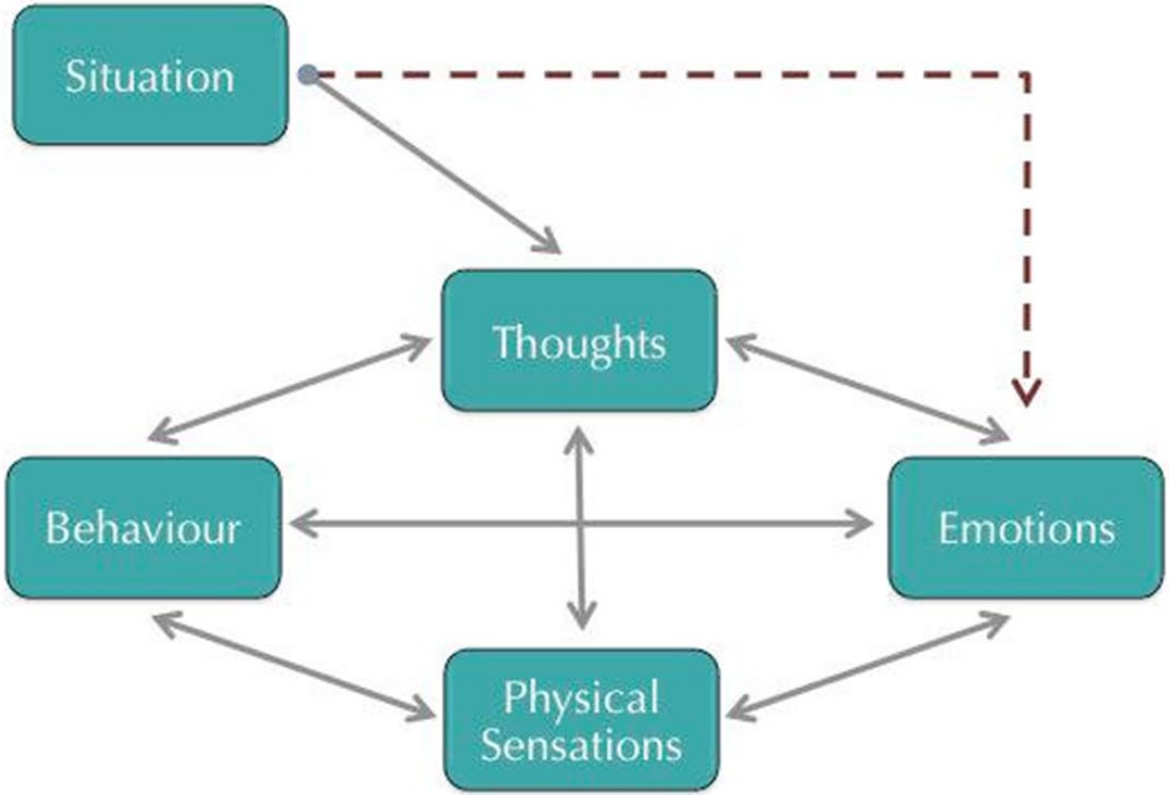
‘Peter’ – 35 year old NHS employee with ‘long Covid’

Berkshire Healthcare NHS Foundation Trust

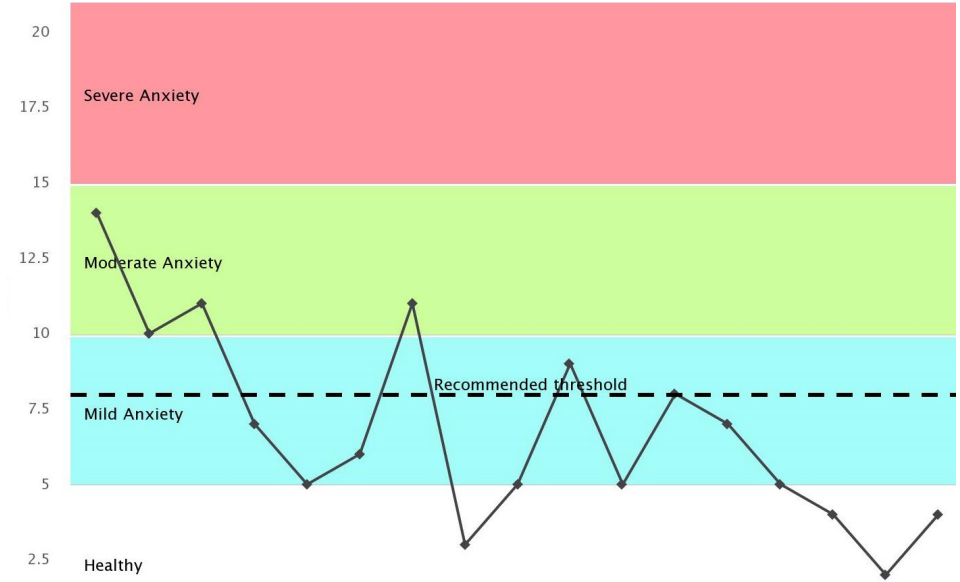


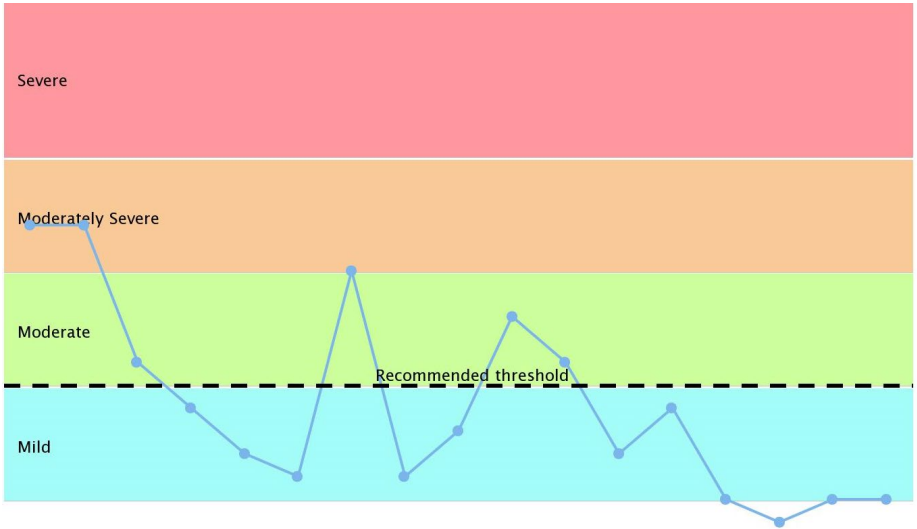
‘Peter’ is a pseudonym – he has kindly given permission for me to present his case

CBT the basics



Outcome





20 Healthy

Outcome

- 17 x 1 hour sessions
- **Working**, exercising, **role in family** restored
- **Cycling** 8 miles
- Keys to recovery ‘what ifs’, **‘sensations’ vs ‘symptoms’, jargon,** being ‘good enough’
- Staying-well plan
- Agreeing to be **Expert by Experience**

Thank you

questions…

Dr Alison Salvadori, Head of Service IAPT
Consultant Clinical Psychologist

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 13/04/21

Board Meeting Matters Arising Log – 2021 – 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.	TBC	**AG**	The Vision Metrics review will flow once we have agreed Three Year Strategy/ Longer Term True North Delivery Goals/metrics, so not ready to prepare options for revised vision metrics at this stage.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit Reports as part of the Patient Experience Report.	Paused due to Covid-19	**DF**	15 Step Visits are currently paused because of COVID-19. The action will be completed when 15 Step Visits resume.	
09.02.21	21/011	Finance Report	The graph showing staff numbers broken down by staff group to be re-instated in future financial reports.	April 2021	**AG**	The staff numbers chart has been re-instated in the Finance Report.	
09.02.21	21/014	COVID-19 Pandemic Recovery Plan	The Acting Executive Director of Strategy to confirm what information about changes to services during the second wave of the COVID-19 pandemic had been communicated to patients and service users.	April 2021	**KM**	Services largely took responsibility for managing their own communications out to patients about their services including any changes to opening hours, appointment types, rescheduled appointments. The Marcomms team kept our three main websites (Berkshire Healthcare, CYPF and Talking	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						Therapies) up to date with information as it was received.	
09.02.21	21/016	People Strategy and EDI Strategy	The Trust Board to receive six monthly updates on both the People Strategy and the EDI Strategy.	September 2021	**AG/JN/ NZ**	The Trust Board meeting planner has been updated.	
09.02.21	21/016	People Strategy and EDI Strategy	The ambition around reducing the number of disciplinaries that involve BAME staff to be made clearer.	April 2021	**AG/JN**	Completed	
09.02.21	21/021	Annual Trust Board Meeting Planner	The planner to be updated to include six monthly Wellbeing Guardian Reports.	April 2021	**JH**	The meeting planner has been updated.	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 April 2021
Title	**Quality Assurance Committee – 2 March 2021**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 2 March 2021
Business Area	Corporate
Author	Julie Hill, Company Secretary for David Buckle, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 2 March 2021 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to: a) receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 02 March 2021

(the meeting was conducted via MS Teams because of COVID-19 social distancing requirements)

Present:	David Buckle, Non-Executive Director (Chair) Aileen Feeney, Non-Executive Director Mehmuda Mian, Non-Executive Director Julian Emms, Chief Executive David Townsend, Chief Operating Officer Dr Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Guy Northover, Lead Clinical Director Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Kerry Harrison, Clinical Director, Adult Mental Health Services, East *(present for item 5.0)* Jason Hibbitt, Quality Account and NICE Lead *(present for item 6.0)* Raja Natarajan, Clinical Director *(present for item 6.1)* Nav Sodhi, Associate Medical Director *(present for item 6.1)* Maria Nogueira, Cardiac and Pulmonary Rehabilitation Lead, Intermediate Care *(present for 6.1)* Janet Sear, Medication Safety Officer *(present for item 6.1)*

1 Apologies for absence and welcome

There were no apologies.

The Chair welcomed everyone to the meeting.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 17 November 2020

The minutes of the meeting held on 17 November 2020 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising from the Minutes and Matters Arising Log

The Matters Arising Log had been circulated.

The following action was discussed further:

a) MSK Presentation

The Chair reported that the Joint Non-Executive Directors and Council of Governors meeting on 3 February 2021 had received a presentation on the MSK Pathway. The Chair said that he had invited the MSK Director and the Head of Scheduled Care to attend the next meeting to enable the Committee to have a better understanding about the significant changes to the MSK Pathway.

The Committee noted the schedule of actions.

5. Patient Safety and Experience

5.0 Physical Health Monitoring Initiative Presentation

The Chair welcomed Kerry Harrison, Clinical Director, Adult Mental Health Services, East and the Trust's Lead for Physical Health in Serious Mental Health.

Kerry Harrison gave a presentation and highlighted the following points:

- Life expectancy for people with serious mental illness was up to 20 years less than for the general population. This included a higher rate of physical conditions such as cardiovascular disease
- Many medications used to treat serious mental illness caused obesity which in turn increased cardiovascular risk
- People with depression had up to a 10-year reduction in life expectancy
- People with serious mental illness also had higher levels of smoking, drug and alcohol misuse
- There was a real opportunity in the Trust through cultural change, role modelling and education to address the physical health needs of people with serious mental illness
- The Trust had developed a Physical Health in Serious Mental Illness Strategy and was committed to reducing unwarranted variation in health care access for all patients, across all age groups and to bring the life expectancy of those with serious mental illness in line with the rest of the population
- Physical health reviews were now being undertaken for every inpatient during their admission involving all members of the Multi-Disciplinary Team
- There was a focus on annual physical health checks for patients with serious mental illness. There will be physical health and wellbeing clinics across all six Berkshire localities
- There was collaborative working with physical health leads and care co-ordinators with improved RiO physical health observations recording.
- Communications with GP practices was being improved to ensure coding and registers were correct
- There was also a programme of educational meetings for all clinicians which included topics such as depression and physical health and addressing smoking and alcohol abuse

The Chair thanked Kerry Harrison for an excellent presentation and commented that he was pleased that there continued to be a focus on smoking cessation.

Aileen Feeney, Non-Executive Director said that she was surprised about the statistic around people with depression having a ten-year reduction in life expectancy.

Ms Harrison confirmed that the ten-year reduction in life expectancy related to people with severe depression.

The Chief Executive asked whether there was a role for IT in supporting physical health monitoring of people with serious mental illness

Ms Harrison said that the service was using a system used by the Early Intervention in Psychosis service which used Tableau which enabled Care Co-ordinators to drill down and access their patients' physical health status which was colour coded to highlight any outstanding checks.

The Chair thanked Kerry Harrison for attending the meeting.

5.1 Quality Concerns Report

The Director of Nursing and Therapies presented the paper and reported that where relevant, the individual Quality Concerns had been updated.

The Director of Nursing and Therapies highlighted that two new services had been added to the waiting list concern around the Trust's outpatient services due to increased wait lists and potential clinical impact: Dental Treatment under general Anaesthetic and consultant appointments for East Diabetes services. It was noted that it was likely that Podiatry services would also be added to the outpatient services concern.

The Committee noted the report.

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

The Director of Nursing and Therapies presented the paper and reminded the meeting that the Care Quality Commission's Report, Sexual Safety on Mental Health Wards, published in September 2018 had set out recommendations on how sexual safety could be improved.

The Director of Nursing and Therapies reported that the Trust had developed an action plan to address the Care Quality Commission's recommendations. The Director of Nursing and Therapies explained that the initial actions identified within the action plan had been completed, however the action plan had been updated to reflect new learning from incidents over time. This included extending CCTV to communal areas.

The Committee noted the report.

5.3 Serious Incidents Report – Quarterly Report

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

- During Quarter 3 there were a total of 17 serious incidents reported

- 8 of the incidents were suspected suicides and a further 1 was an attempted suicide. This was a similar number to previous years, but the Trust was closely monitoring the learning in relation to the COVID-19 pandemic to ensure that the Trust could respond and adapt its practice in a timely way
- 2 of the reported incidents related to the COVID-19 pandemic. Both incidents were reported due to the potential for significant service disruption as they involved closure of mental health wards due to COVID-19 outbreaks
- The Trust had started to record ethnicity alongside serious incident reporting to help understand if any ethnic groups were disproportionately impacted. There was no evidence of this occurring during Quarter 3, but data would need to be reviewed over time in order to gain better insight around this issue

Mehmuda Mian, Non-Executive Director congratulated the Trust on achieving Royal College of Psychiatrists accreditation for its Serious Incident review systems and processes.

Aileen Feeney, Non-Executive Director suggested that the Committee receive a briefing about the support for staff involved in a serious incident.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.4 Learning from Deaths Quarterly Report

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

- In Quarter 3 of 2020/21, 892 deaths were recorded on the clinical information system (RiO) where a patient had been in contact with a Trust service in the year before they died
- Of the deaths, 98 met the criteria to be reviewed further. All 98 deaths were reviewed by the Executive Mortality Review Group. 49 deaths were closed with no further action; 47 deaths required “second stage” review (using an initial findings review/structured judgement review methodology)
- Of the 49 deaths, 9 were classed as “Serious Incidents” requiring investigation. Two deaths remained open for further information to support the outcome decision
- During Quarter 3 the Mortality Review Group had reviewed the findings of 41 second line review reports of which 5 related to patients with a learning disability
- 7 deaths (4 in-patient and 3 transfers) were reported where COVID-19 was stated on the medical certificate as the cause of death and/or had a positive COVID-19 swab within 28 days of their death.
- Of the 41 case reviews received by the Mortality Review Group none identified a lapse in care.

The Chair commented that the report provided a high level of assurance especially in the context of responding to the COVID-19 pandemic.

The Committee noted the report.

5.5 Well-Led Care Quality Commission Inspection Must Do and Should Do Action Plans

The Director of Nursing and Therapies presented the paper and reported that following the November-December 2019 inspection, the Care Quality Commission had rated the Trust as “Outstanding”. As part of the inspection, the Care Quality Commission had assessed two core services (Specialist Community Mental Health

Services for Children and Young People and Acute Wards for Adults of Working Age and Psychiatric Intensive Care Wards) where the Trust must take action.

The Director of Nursing and Therapies reported that the Care Quality Commission had also identified some “should do” actions. It was noted that action plans had been developed to implement both “Must Do” and “Should Do” actions.

The Director of Nursing and Therapies explained that all actions were being progressed, however some were taking longer than anticipated because of the COVID-19 pandemic. It was noted that the internal fire door replacement on wards to remove a ligature risk had commenced and was due for completion in March 2021. Replacement of bedroom doors to enable patients to lock their own doors had been piloted on one ward and a business case had been developed to roll this out across all areas. The Trust was now looking to install a fixed call bell system following an unsuccessful pilot of portable call bells.

Aileen Feeney, Non-Executive Director asked whether the pilot into enabling patients to lock their own doors had included patients using wrist bands

The Director of Nursing and Therapies confirmed that this was case and said that the Trust had sourced a wrist band which did not pose a ligature risk.

Mehmuda Mian, Non-Executive Director asked whether there was any indication that the Trust’s business case for increased funding to reduce the wait times for young people with AHSD/ASD had been approved by the Commissioners.

The Chief Executive reported that one of the Care Quality Commission’s “must do” actions following the last Well-Led inspection was for the Trust to continue to work with Commissioners to ensure that waiting times for young people with AHSD/ASD were not excessive. The Chief Executive reported that there were ongoing meetings with Commissioners to review demand and capacity and the Trust had submitted a business case to both the East and West Commissioners for additional resources to reduce waiting times. It was noted that the Trust was awaiting confirmation of increased funding from the Commissioners in order to progress the initiatives set out in the business case.

The Committee noted the report.

5.6 Reducing Restrictive Practice Action Plan

The Director of Nursing and Therapies presented the paper and reminded the meeting that the Care Quality Commission’s “Out of Sight – Who Cares? A Review of Restraint, Seclusion and Segregation for Autistic People and People with a Learning Disability and/or Health Condition” was published in October 2020.

It was noted that prior to the Care Quality Commission’s report. The Trust had already had an action plan in place to review and reduce restrictive practice. The Trust’s action plan had been updated to reflect the guidance in the Care Quality Commission’s report.

The Committee noted the report.

5.7 Duty of Candour Process Report

The Director of Nursing and Therapies presented the paper which provided an overview of the Duty of Candour regulation and requirements and how these duties were fulfilled in the Trust.

The Director of Nursing and Therapies confirmed that the Trust had robust duty of candour systems and processes in place and pointed out that the Care Quality Commission had reviewed the process and had provided positive feedback.

The Chair thanked the Director of Nursing and Therapies for the report and commented that it provided a high level of assurance.

Aileen Feeney, Non-Executive Director referred to the letter template and commented that the tone was compassionate and caring. Mehmuda Mian, Non-Executive Director echoed Ms Feeney's positive comments about the tone and language used in the template letters.

The Chair asked about the process for assessing whether an incident was "mild to moderate" and did not fall within the parameter of the Duty of Candour process.

The Director of Nursing and Therapies explained that it would be a joint decision between the Patient Safety Team and the relevant service. The Director of Nursing and Therapies confirmed that if there was any doubt as to whether an incident fell within the Duty of Candour criteria, the Trust would always err on the side of caution an include it.

The Committee noted the report.

5.8 Governance Assurance Around Formal Complaints Report

The Director of Nursing and Therapies presented the paper which provided assurance in relation to the Trust's internal complaints processes.

The Chair thanked the Director of Nursing and Therapies for her report.

The Committee noted the report.

5.9 COVID-19 Pandemic Response Update

The Director of Nursing and Therapies gave a verbal update to the latest COVID-19 situation and reported that there had been no COVID-19 positive patients at Prospect Park Hospital for three weeks and there were currently no active COVID-19 outbreaks on the Community Wards.

The Director of Nursing and Therapies reported that the number of staff off sick due to COVID-19 had also reduced although around 15-20 additional staff had received letters informing them that they needed to shield until the end of March 2021.

The Director of Nursing and Therapies reported that 78.5% of Trust staff had received their first COVID-19 vaccination and the Trust was now giving second doses of the COVID-19 vaccination to staff.. It was noted that the Trust had also vaccinated eligible people on its inpatient wards.

The Medical Director reported that since November 2020, there had been 11 deaths due to COVID-19. It was noted that the Trust continued to receive and respond to Central Reporting System (CAS) alerts in relation to changes in COVID-19 related treatments etc.

The Chair thanked the Director of Nursing and Therapies and Medical Director for updating the Committee.

5.10 COVID-19 Board Assurance Framework and Corporate Risk Register Risks

The COVID-19 Board Assurance Framework and Nosocomial Infection Corporate Risk Register Risks had been circulated.

Aileen Feeney, Non-Executive Director asked whether the COVID-19 related risks on the Board Assurance Framework should be updated to reflect that winter planning and planning for the second wave of COVID-19 has passed and the staff COVID-19 vaccination programme has begun. Ms Feeney also suggested that the risk score may also need to be lowered.

The Medical Director reported that since the report had been produced, he had updated the section on the winter planning and planning for the second COVID-19 wave referred to in risk 8A. It was noted that the COVID-19 related risks were reviewed monthly by the Quality and Performance Executive Committee. The Medical Director said that it was too soon to include the impact of the staff vaccination at this point.

Ms Feeney asked whether the updated COVID-19 Board Assurance Framework risks would make reference to the service pressures over the next year.

The Medical Director confirmed that the next version of the COVID-19 related risks would reflect how the Trust was going to recover from the backlog of unmet needs and how the lessons learnt from the first and second waves of COVID-19 would be included in the planning for any subsequent waves of COVID-19.

Action: Medical Director

The Committee noted the report.

5.11 True North Patient Safety Indicators Verbal Update

The Medical Director reported the Executive Team had discussed the True North Patient Safety Indicators and had agreed to add a new indicator in relation to the identification of the deteriorating patient.

The True North indicators for 2021/2 would be as follows:

We will reduce:

- Falls
- Self-harm
- Avoidable deaths due to physical health deterioration on all inpatient wards

The Chair thanked the Medical Director for his update.

5.12 Devon Partnership NHS Trust and Secretary of State for Health and Social Care: implications of the judgement for the Trust

The Medical Director presented paper and explained that Devon Partnership NHS Trust had sought a declaration from the Court as to whether remote assessments could be used to lawfully detained someone under the Mental Health Act (MHA).

The Medical Director said that the Court's ruling was restricted to its interpretation of the phrases "personally seen" (section 11 (5) of the MHA) and "personally examined" (section 12(1) of the MHA). The Court concluded that the physical attendance of the person in question (the Approved Mental Health Professional and doctors) was required when assessing a person for detention under the MHA.

The Medical Director reported that following the judgement, the Trust had identified a small number of cases involving remote assessments and interviews. Each of the individual cases had been reviewed.

The Chair thanked the Medical Director for bringing the judgement to the Committee's attention.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Quality Accounts 2020-21

The third quarter Quality Accounts 2020-21 had been circulated. The Chair welcomed Jason Hibbitt, Quality Account and NICE Lead

The Chair commented that the Committee had not spend much time reviewing quarters 1 and 2 of the draft Quality Accounts 2020-21 and that there was an opportunity at this meeting to comment on the quarter 3 version which was complete.

The Chair said that the Quality Accounts was an important document as it pulled together quality related data from several different sources.

It was noted that changes from the quarter 2 draft Quality Accounts were highlighted in green.

The Head of Clinical Audit and Effectiveness reported that NHS England and Improvement had mandated there was no requirement for the Trust to include the Quality Accounts as part of the Trust's Annual Report 2020-21 or to commission at external audit on the Quality Account. In addition, the deadline for the completion of the Quality Accounts had been extended to 30 June. It was noted that the national changes to the reporting structure were in recognition of the additional pressures of responding to the COVID-19 pandemic.

The Head of Clinical Audit and Effectiveness said that the final version of the Quality Accounts 2020-21 would be shared with members of the Committee electronically to enable to report to be approved at the May 2021 Trust Board meeting. It was noted that the Quality Accounts quarter three report would also be shared with the Council of Governors meeting on 10 March 2021 and would be circulated for comment to other stakeholders.

Aileen Feeney, Non-Executive Director asked whether it would be possible to publicise the service improvement section of the Quality Accounts more widely.

The Medical Director said that the Quality Accounts were circulated to Health Overview and Scrutiny Committees, Commissioners and other stakeholders for comment and the final report was published on the Trust's website.

The Chair thanked the Head of Clinical Effectiveness and Audit and the Quality Accounts and NICE Lead for their work in producing the Quality Accounts.

The Committee noted the report.

6.2 Clinical Audit Report

The Medical Director reported that since the last meeting, two national audits had been received by the Clinical Effectiveness Group:

- The National Audit of Chronic Obstructive Pulmonary Disease (COPD) and Asthma Programme (NACAP) pulmonary Rehabilitation report
- The National Diabetes Audit (NDA) report 2019/20

The Medical director reported that the report also included the results of the Trust's internal clinical audit into the prescribing of Valproate for women of childbearing age.

a) The National Audit of Chronic Obstructive Pulmonary Disease (COPD) and Asthma Programme (NACAP) pulmonary Rehabilitation report

The Chair welcomed Raja Natarajan, Clinical Director, Community Health Services West and Maria Nogueira, Cardiac and Pulmonary Rehabilitation Lead, Intermediate Care.

Dr Natarajan reported that the 137 patients diagnosed with COPD were included in the audit.

The Chair asked for assurance that the service would address the areas highlighted for improvement. Dr Natarajan reported that the service had developed an action plan to address the domains which did not meet full compliance and required improvement.

Maria Nogueira confirmed that the service had already address two of the areas for improvement and were closely monitoring the implementation of the action in respect of the remaining areas. It was noted that recruitment of staff remained the biggest challenge for the service.

Aileen Feeney, Non-Executive Director noted that the audit had been completed during the COVID-19 pandemic and commented that this must have prevented challenges for the service.
The Chair noted that the patients were drawn from West Berkshire and asked whether there was a similar service in East Berkshire.

The Medical Director pointed out that in East Berkshire, Frimley Health NHS Foundation Trust was commissioned to provide the service.

The Chair asked whether the service would be re-audited next year. Maria Nogueira confirmed that this would be the case.

The Chair thanked Raja Natarajan and Maria Nogueira for attending the meeting.

b) The National Diabetes Audit (NDA) report 2019/20

The Lead Clinical Director explained that Sara Fantham, Interim Clinical Director and Lead Nurse East Adult Physical Health Division was on annual leave, but she had briefed him on the audit. The Chair said that he'd also spoken to the Clinical Director about the audit.

The Chair said that previous national Diabetes Audits had highlighted issues around data collection and commented that the Trust had made significant changes in the past 18-24 months in terms of data collection and recording including a new assessment form for clinical data entry on the RiO patient record system.

The Chair noted that the audit highlighted that 94% of people with both Type 1 and Type 2 diabetes (HbA1c of 58 or below) who had been seen by the service have had

at least one HbA1c recorded in the period. This was above the national average and the service had shown continued improvement since 2017 for this metric.

It was also noted that the service was identified as a national outlier and notified as 'Alert Status' against the Treatment target for patients with Type 1 diabetes.

It was noted that the service performance was below average for Type 2 diabetics achieving the treatment target of HbA1c of 58 or below. The Chair noted that these targets were directly linked to health outcomes and although performance had improved to 44%, he felt there were some doubts as to how much this would be further improved due to the restraints on the service.

The Chair agreed to discuss the targets with the service leads.

Action: Chair

The Lead Clinical Director pointed out that Diabetes UK has recognised that the treatment target for patients with Type 1 diabetes was a national issue and together with NHS digital had designed a national collaborative quality improvement programme (QIC).

Mehmuda Mian, Non-Executive Director asked whether the timescales in the action plan were realistic given the current pressure on services because of the COVID-19 pandemic.

The Lead Clinical Director agreed to contact the service for a confirmation of the action plan timescales.

Action: Lead Clinical Director

The Chair asked whether the Trust had discussed with the Commissioners whether the diabetes service model needed to be changed.

The Medical Director confirmed that the service had ongoing discussions with the Commissioners and the service had developed a business case to support a request for more staff.

c) **POMH Prescribing of Valproate – Women of Child-Bearing Age Prevent Programme preliminary report**

The Chair welcomed Dr Nav Sodhi, Associate Medical Director and Janet Sear, Medication Safety Officer.

The Chair said that he was pleased that the Trust had included all women of childbearing age as part of the local clinical audit of the prescribing of Valproate. The Chair said that he was very assured by the outcome of the audit and thanked everyone involved.

The Committee noted the report.

Update Items for Information

7.0 Guardians of Safe Working Hours Quarterly Report

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

It was noted that during the reporting period (31 October 2020 to 2 February 2021 there were three "hours and rest" exception reports totally an extra 14.5 hours worked over and above the Trainees' work schedules and no "education" reports.

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

The Committee noted the report.

7.1 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held in November 2020, December 2020 and January 2021 were received and noted.

Closing Business

8.0 Standing Item – Horizon Scanning

The items on the Committee's forward plan are:

- Trust's compliance with the new CPA Guidance
- Single room and therapeutic environment at Prospect Park Hospital
- Eating Disorder Service and the Wider System
- Review of the MSK Pathway
- Post COVID-19 Lock Down and its impact on the Trust's demand for services (particularly mental health services)

8.1. Any Other Business

There was no other business.

8.2. Date of the Next Meeting

01 June 2021

These minutes are an accurate record of the Quality Assurance Committee meeting held on 2 March 2021.

Signed:-

Date: - 01 June 2021

QPEG / QAC/ Trust Board	February 2020
Title	**Learning from Deaths Quarter 3 Report 2020/21**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	The trust mortality review and Learning from Deaths process has operated without any additional resource allocation since it was launched in 2016. Additional resource will be required to progress further quality improvements.
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
Summary	892 deaths were recorded on the clinical information system (RiO) during Q3 (Q2 915) where a patient had been in contact with a trust service in the year before they died. Of these 98 (Q2 101) met the criteria to be reviewed further. All 98 were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 49 were closed with no further action • 47 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 49, 9 were classed as Serious Incident Requiring Investigation (SI) • 2 remained open for further information to support the outcome decision. During Q3, the trust mortality review group (TMRG) received the findings of 41 2nd stage review reports, of which 5 related to patients with a learning disability (these are cases reviewed in Q3 and will include cases reported in previous quarters). **COVID 19 reported deaths.** 7 deaths (4 Inpatient and 3 transfers) were reported where Covid 19 was stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death. 3 were closed at 1st stage review, 3 moved to 2nd stage review and 1 was confirmed as a serious incident. The 2nd stage reviews were received at the January TMRG where 1 was closed and 2 were escalated for further review through the patient safety team as potential serious incidents. **Lapse in Care** Of the 41 reviews received by the TMRG in Q3, none were identified a lapse in care **Learning from Serious Incidents (Source: Q2 SI Report)** Specific activity that has occurred in Q3 relating to themes previously identified from serious incident reviews. • The process for transferring patients between community mental health teams (CMHT's) has been reviewed and updated after working with front line clinicians. This workstream

involved a review of the current existing documents that refer to transfer between CMHTs; exploring and understanding the barriers to implementation.

- West and East mental health services are working together to provide a common point of access (CPA) Transition & Risk Safety Learning Event which will take place in Q4. The learning event will be facilitated by experienced clinicians, a short film clip captures learning from serious incidents, serious case reviews and mortality reviews.

Learning from the mortality review process (first and second stage review of deaths).
There has been some significant learning across several services which is detailed within the report, the following key areas and points should be noted:

Learning disability Service
Following several national publications, the learning disability service conducted a review to ensure that the recommendations and learning in the national reports is embedded in the service. This report details the significant learning that has already been embedded in practice with some areas for further development; to support this the team have updated their plan on a page to incorporate the national learning and recommendations. The key areas are:

- Equality and Diversity
- Respiratory Conditions
- Annual Health checks
- Acute liaison

Physical Health
Community health service (West) has conducted a 6-month review of all their 2nd stage reviews, identifying common themes and actions they are taking to improve quality and safety of patient care. Both East and West physical health services ensure that the learning is shared via their governance groups and through specific learning events to embed the actions which are identified in the reports. The Key areas are:

- Palliative Care
- Sepsis Management
- Falls Management
- Management of the Deteriorating Patient
- Communication with Families

Mental Health
The findings from a serious case review identified learning for Mental Health Inpatients around out of area placements a joint learning event for all teams involved to be facilitated to focus on the learning from this case.

It was identified in Q3 that the talking therapies (TT) service potentially had a cluster of deaths related to the TT service. The Clinical Director for the service has requested a deep dive into the service, the outcome of this will be reported in Q4.

Conclusion
Activity levels remain similar to previous quarters (with the exception of Q1).

Of the 41 2nd stage reviews completed, several significant learning points were identified by the services and have been taken forward as action plans and improvement actions using the trust QI methodology.

4 inpatient deaths were reported where Covid 19 was stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death. These were

	reported to the CPNS in line with national guidance. 3 deaths occurred due to Covid 19 following a patient transfer to an acute provider, 2nd stage reviews were requested for all. In the January TMRG these were reviewed where one review was closed and 2 were escalated for further review, the outcomes of which will be reported in Q4. No lapse in care were identified in Q3.
ACTION REQUIRED	The committee is asked to receive and note the Q3 learning from deaths report to provide assurance to the Trust Board that the Trust is complying with CQC and NHS Improvement requirements in respect of learning from deaths.

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1.0 Purpose

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

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

2.0 Scope

This report supports the Trust learning from deaths policy which was published in August 2017 and updated in March 2019.

3.0 Introduction

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

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

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

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

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

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

Definitions:

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

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

4. Summary of Deaths and Reviews completed in 2020/21.

Figure 1	17/18 total	18/19 total	19/20 total	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	YTD 20/21
Number of deaths seen by a service within 365 days of death	4381	3961	3884	1478	915	**892**		**3285**
Total deaths screened (Datix) 1st stage review	307	320	406	170	101	**98**		**369**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	198	72	48	**47**		**167**
Total number of deaths investigated as serious incidents	32	40	43	7	9	**9**		**25**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	3	1	0	**0**		**1**
Number of Community Hospital Inpatient deaths reviewed (Including patients at the end of life)	123	144	124	56	42	**33**		**131**
Total number of deaths of patients with a Learning Disability	35	28	47	18	8	**5**		**31**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	0	0	**0**		**0**

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

4.1 Total Number of deaths in Q3

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 2 identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death.

Figure 2:

Specialty last seen	October 2020	November 2020	December 2020	Grand Total
Nursing Episode	126	142	127	**395**
Community Health Services Medical	42	24	13	**79**
Dietetics	23	22	19	**64**
Old Age Psychiatry	27	18	13	**58**
Rehabilitation	19	13	17	**49**
Palliative Medicine	11	19	14	**44**
Podiatry	18	10	13	**41**
Adult mental Illness	12	11	6	**29**
Physiotherapy	10	9	5	**24**
Respiratory Medicine	10	5	6	**21**
Speech and Language Therapy	8	3	9	**20**
Cardiology	3	6	7	**16**
General Medicine	7	4	5	**16**
Intermediate Care	6	8	1	**15**
Geriatric Medicine	1	3	2	**6**
Genito-urinary Medicine		5		**5**
Occupational Therapy	1	1	1	**3**
Clinical Psychology		3		**3**
Paediatrics	2			**2**
Learning Disability			2	**2**
Grand Total	**326**	**306**	**260**	**892**

Figure 3 below details the age of the patients; this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority. The highest number of deaths is in the over 75 age group with the majority of these in receipt of community nursing services in their homes/ care homes/ receiving care at the end of life.

Figure 3	October to December 2020				
	A:0-17	B:18-65	C:66-75	D: Over 75	Grand Total
Grand Total	**5**	**109**	**154**	**642**	**892**

4.2 Total Deaths Screened (1st stage review)

The Trust learning from deaths policy identifies several criteria which if met require the service to submit a Datix form for review on the Trust incident management system following the notification of a death.

First stage reviews occur weekly by the Executive Mortality Review Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

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

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

98 (Q2 101) deaths were submitted for 1st stage (Datix)review in Q3, the average per quarter last year was 102 with a range of 90 to 108. Of the 98 deaths undergoing first stage review, the EMRG closed 49 cases with no further action required, 47 were referred for 2nd stage review and of these 9 were classed as serious incidents for RCA investigation.

5. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death which relates to an individual with a learning disability and these are detailed with regards to the level of involvement for those deaths reported in Q3. In addition, for all expected inpatient end of life deaths or deaths where a 2nd stage review (SJR) is undertaken, the family will receive a letter of condolence and the bereavement booklet, with the opportunity to raise any concerns about the care provided to the patient.

6. 2nd Stage Reviews Completed

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

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 41 (58 in Q2 of 2020/21) reviews have been received and considered by the group in Q2. Figure 5 details the service where the review was conducted.

Figure 5: Reviews Conducted in Q3

	Total Number	Divisions
October 2020	15	Learning Disabilities: 3 East Physical Health: 3 West Physical Health: 6 West Mental Health:2 East Mental Health:1
November 2020	14	West Physical Health: 4 East Physical Health:3 East Mental Health:1 West Mental Health:6
December 2020	12	Learning Disabilities: 2

		West Physical Health:6 East physical health: 2 West Mental Health:2

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

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

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

7. Concerns or Complaints

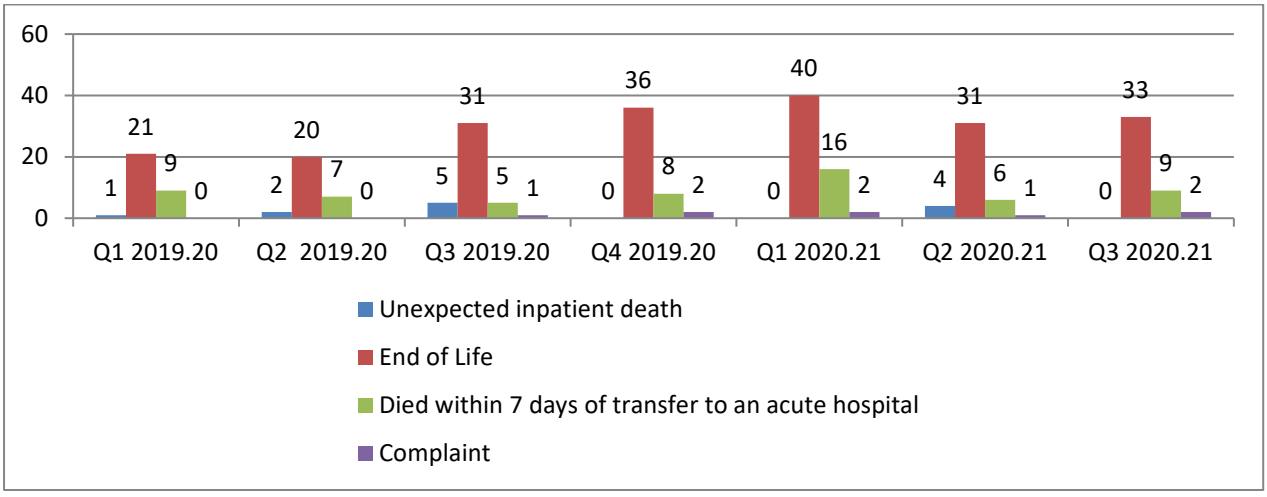
In Q3 2 complaints in total were received from families following the death of a relative, 2nd stage reviews were requested both and reviewed and closed in Q4.

8. Deaths of patients (including palliative care) on community health inpatient wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 6 details these.

In addition, we are required to complete a national submission to the Covid Patient Notification System (CPNS) on inpatient deaths where the patient had a positive Covid result within 28 days of death or had Covid 19 stated on the medical certificate of cause of death (MCCD).

Figure 6: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q3 44 (Compared to 42 in Q2 of 2020/21) deaths in total were reported, 33 inpatient deaths of which all occurred on our Community Inpatient Wards. 9 deaths were reported where the patient was transferred to an acute hospital and died within 7 days, and 2 complaints were received where the patient had received hospital care.

Of the 44 reported deaths, 33 were expected deaths and related to patients who were specifically receiving end of life care. These were reviewed by the EMRG, 28 were closed where enough information had been provided to give assurance that appropriate end of life care had been given. 5 cases were reviewed as 2nd stage reviews.

9 deaths were unexpected (10 in Q2) following transfer to an acute provider, 2nd Stage reviews were requested for 8 cases and 1 was closed at first stage review.

2 complaints were received relating to deaths following an inpatient stay, 2nd Stage reviews were requested for both.

8.1 Covid-19 related deaths on inpatient wards between October and December 2020
4 deaths which occurred on our community health inpatient wards had Covid 19 stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death.

2 deaths following transfer of a patient to an acute provider from our community health inpatient wards, stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death.

In addition deaths over 7 days of transfer which are directly related to Covid 19 are reviewed and for Q3 we had 1 death after 7 days following transfer from our community health inpatient ward to an acute provider stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death.

Of the 7 deaths 3 were closed at 1st stage review, 3 moved to 2nd stage review and 1 was confirmed as a serious incident. The 2nd Stage reviews were received at the January TMRG where 1 was closed and 2 were escalated for further review through the patient safety team as potential serious incidents.

There were no mental health inpatients with Covid 19 infection who died on our inpatient wards or following transfer to an acute provider.

In conclusion, for all deaths of inpatients where either Covid 19 was mentioned on their MCCD or if they had a positive Covid 19 swab within 28 days of their death and irrespective of where they died, a first or second stage review of the death was carried out.

9. Deaths of Children and Young People
In Q3 9 (Q2 7) deaths were submitted as a Datix for 1st stage review. All 9 cases were closed at EMRG following 1st stage review. Cause of death was either extreme prematurity or complex disability in most cases. All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel.

10. Deaths of adults with a learning disability
In Q3 the Trust Mortality Review Group (TMRG) reviewed a total of 5 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death.

Of these 5 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Respiratory System	1
Heart & Circulatory System	3
Cancer	1

Number of COVID related deaths:
COVID suspected but unconfirmed for 1 of the heart and circulatory deaths detailed above.

Demographics:
Gender:

Female	2
Male	3

The age at time of death ranged from 45 to 68 years of age (median age: 61yrs)

Severity of Learning Disability:

Mild	1

Severe	2
Not Known	2

Ethnicity:

White British	3
White Other	1
Not Known	1

Engagement and feedback with family members
The Learning Disability Service contacts the family and/or staff team following the reported death of a person with a learning disability - there has been no specific feedback or concerns raised through this contact.

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

In Q3, 9 deaths (9 in Q2) have been reported as serious incidents; figure 5 details the service where the SI occurred.

Figure 5. Service (Source Q3 Serious Incident Report)	**Number**
Slough Community Mental Health	4
Windsor Ascot and Maidenhead Community Mental Health	1
Wokingham Community Mental Health Team	1
Talking Therapies	1
Common Point of Entry (CPE)	1
Crisis Resolution and Home Treatment Team West	1
Total	**9**

11.1 For all deaths which are categorised as an SI
The family is contacted in line with our duty of candour (DoC) policy and advised of the process of investigation. Someone from the service (usually a senior clinician or manager) contacts the family as soon as it is known that an incident causing death has occurred. At this time, they offer a face to face meeting which will include:

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

Duty of Candour (DoC) applied to 9 deaths in Q3 all of which are currently under SI investigation, 8 were reported as suspected suicides and 1 reported as an unexpected death.

Phone contact has been attempted with all families or nominated next of kin (NoK). 7 of the phone contacts were successful in speaking with the family. The 2 contacts that were unanswered were followed up with written correspondence. 8 of families / NoK have received written correspondence providing condolences, an apology, an explanation of the review process and provision of offers of support. Written correspondence did not occur for 1 family as there was no known address for them.

None of the families in Q3 took up the offer of a further meeting with the service after the initial phone call. Some families may not take up the offer of an initial meeting with the service but have met later or spoken with a member of the review team as part of the review process. In addition, further opportunities to meet or talk, should they wish, are always offered at the point of sharing any outcomes in written format from the review or investigation.

11.2 Lapse in Care
Of the 41 reviews received by the TMRG in Q3 none identified a lapse in care.

12.Learning from Deaths

The aim of the trust policy and process is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details areas of quality improvement identified in Q3.

12.1 Learning from Serious Incidents (Source: Q3 SI Report)

Specific activity that has occurred in Q3 relating to themes previously identified from serious incident reviews.

Following a recent serious incident and in recognition that the identified concerns were not an isolated issue, the process for transferring patients between community mental health teams (CMHT's) has been reviewed and updated after working with front line clinicians. This workstream involved a review of the current existing documents that refer to transfer between CMHTs; exploring and understanding the barriers to implementation; unpicking what is missing, agreeing what should be included; and discussing how best to share and where the guidance should be accessed from. This process is being finalised and will be included in the Risk standard operating procedure (SOP) and the CMHT SOP.

West and East mental health services are working together to provide a common point of access (CPA) Transition & Risk Safety Learning Event which will take place in Q4. The learning event will be facilitated by experienced clinicians, a short film clip captures learning from serious incidents, serious case reviews and mortality reviews. It focuses on a patient's journey through child and adolescent mental health (CAMHs) to secondary care and supported housing. It highlights good practice where staff have made a connection and provokes reflection on system issues for example disjointed formulations, fragmented and unclear pathways, handoffs and also staff burnout. It portrays the perspectives of patient, family and staff and the ripple effects when a suicide occurs. The objectives of the session are met by providing authentic experiences in a safe space for learning and innovation to be explored, staff support is also highlighted.

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

The Learning Disabilities Mortality Review (LeDeR) Programme has recently published its 2019 'Annual Report' (LeDeR 2020). In addition to this NHS England NHS Improvement (NHSE/I) have published the 'Improvement Action from Learning report describing progress to address premature mortality and health inequalities of people with a learning disability' (NHSE/I 2020). There has also been a review undertaken as part of the LeDeR programme 'Deaths from COVID19 reviewed as part of the LeDeR programme' which has reviewed 50 deaths of people with learning disabilities whose death has been attributed to COVID19 (LeDeR 2020b).

The following provides a summary of the key learning identified from these reports and identify local learning and actions being undertaken to address health inequalities experienced by people with learning disabilities.

Summary of the Findings of the LeDeR Report 2019 (LeDeR 2020):

From 1st July 2016 - 31st December 2019, 7,145 deaths were notified to the programme (6,629 were adults and 516 were children aged 4-17 years).

Of the deaths notified to LeDeR, 58% were males, 42% were females; 30% had mild learning disabilities, 33% had moderate learning disabilities, 27% severe learning disabilities and 10% profound and multiple learning disabilities.

90% were white British. People from BAME groups died disproportionately at younger ages than white British people. Of those who died in childhood (ages 4-17 years), 43% were from BAME groups.

In 2018, the majority (85%) of people in the UK population died aged 65 and over. The corresponding proportion of people with learning disabilities was 37%. For deaths notified in 2019, the median (average) age at death was 61 for males and 59 for females. People with profound and multiple learning disabilities died at younger ages.

There was a higher proportion of deaths of people with learning disabilities between October – December than people without learning disabilities.

People with learning disabilities were more likely to die in hospital than people without learning disabilities. They were also less likely to be referred to the coroner.

The most frequent causes of death by ICD-10 were diseases of the respiratory system, diseases of the circulatory system and congenital and chromosomal abnormalities. Pneumonia and aspiration pneumonia were the most cited cause of death in Part 1 MCCD.

DNACPR decisions were in place for 72% of reviews. Of this 78% were considered by reviewers as appropriate, correctly completed and followed.

A third (34%) of deaths of people with learning disabilities were identified as being from treatable causes (compared to 8% in the general population).

1 in 10 reviews identified one or more of the following problems in care delivery:

- Delays in diagnosing and treating illness.
- An apparent lack of care.
- Unsafe discharges from hospital.
- The quality of health or social care received by the person.
- Assumptions made about the person.

Respiratory Conditions:

Respiratory conditions have remained the highest cause of premature mortality for people with learning disabilities, the risks increased with severity of learning disability (24% of adults and 20% of children died from bacterial pneumonia and 17% of adults and 3% of children died from aspiration pneumonia). NHSE/I is working with the British Thoracic Society to develop national guidance on an 'Ideal Pathway of Care' for people with learning disabilities presenting with Pneumonia.

Within the learning disability services in Berkshire Healthcare, we are undertaking the following actions to promote and support respiratory health:

- Launch of the respiratory health care pathway, to promote respiratory health and wellbeing and to develop respiratory health care plans for people at risk from poor respiratory health. The pathway includes initial triage to identify people at increased risk from poor respiratory health, detailed respiratory assessment with measurement for targeting individual physiological variables, MDT review and specialist interventions and training to promote good respiratory health and physiological variables and development of multi-agency care plans/guidelines.
- The Community Teams for People with Learning Disabilities (CTPLDs), Intensive Support Team (IST) and learning Disability Inpatient Service (Campion) are all promoting the uptake of Flu Vaccines for people with learning disabilities. The Protect yourself from flu Easy Read leaflet is being shared with teams to share with people with learning disabilities, their families and carers and is also being shared on the Learning Disability SHaRON platform.

In addition to respiratory health and the flu campaign this year, there are also the concerns regarding the risk and impact of Covid-19 for people with learning disabilities. The LeDeR Covid-19 Rapid Review report investigating 50 Covid-19 related deaths identified the following themes:

- Mobility impairment or mental illness may be proxy indicators for increased risk from Covid-19.
- People with Epilepsy may also be at an increased risk and attention should be paid to protecting them.

- Key symptoms of Covid-19 may not be as evident in people with learning disabilities.
- There is a need to monitor DNACPR decisions and decisions relating to palliative care and end of life.
- Close attention should be given to safe discharge planning (1 in 5 reviews had previously been discharged from hospital and then readmitted).
- Recommendation to increase the provision of acute and primary care liaison.

Early in the Covid-19 pandemic BHFT learning disability service identified the potential increased risk of Covid-19 to people with learning disabilities. To mitigate against the risks of Covid-19 the learning disability services developed the Covid-19 symptom checker for people with learning disabilities. The aim of this is to identify the signs and symptoms of Covid-19 and to ensure that people, families, and carers can access the right care and treatment in a timely way, but also to reduce potential risks of diagnostic overshadowing. A copy of this is available electronically via the link below:

https://www.berkshirehealthcare.nhs.uk/our-services/mental-health-and-wellbeing/learning-disabilities-ctpld/

Annual Health Checks:

Annual Health Checks are part of the Direct Enhanced Scheme (DES). They were developed as a reasonable adjustment to support with assessment and identification of health needs of people with learning disabilities. Annual Health Checks are undertaken in Primary Care. The CTPLDs promote Annual Health Checks and in the West of Berkshire there is also a primary care liaison nurse. The CTPLDs and Primary care Liaison Nurse provide training via different routes to primary care on the annual health check and supporting people with learning disabilities. Within the West of Berkshire Annual Health Check uptake for 2019-2020 Q4 was 74%. Transition work will also support promotion of the annual health check for the 14+ age group. Residents in care homes, will be offered health checks as part of the plan for delivery of the Primary Care Network Directly Enhanced Service (DES) care homes specification from 1st October and practices will also be expected to make health checks a key focus for delivery of the QOF QI module for learning disability.

Acute Liaison:

BHFT have links with the learning disability liaison nurses in Frimley Park Hospital Trust and Royal Berkshire Hospital. With new ways of working and increased use of technology to enable people to attend meetings virtually teams have been able to invite the learning disability acute liaison nurses from Royal Berkshire Hospital to the Reading, Wokingham and West Berkshire CTPLD Multi-Disciplinary Team meetings. This has enabled more effective joint working across the acute hospital and the community-based services and has supported with teams being able to joint work and co-ordinate meetings for discharge planning more effectively.

The report has highlighted a couple of new key pieces of work that the learning disability service is undertaking to reduce health inequality. In addition to this, the services have been raising awareness of Sepsis and sharing information packs with people with learning disabilities and their families and carers and many other projects to support the physical and mental health wellbeing of people with learning disabilities. A copy of the plan on a page is available below, to provide a visual representation of the ongoing work that the services are undertaking.

12.3 Community Physical Health

District nursing services in East and West shared learning for end of life cases which included:

- To Set up Palliative Care supervision/Reflective sessions to enable discussions of current EOL patients and promote and educate open conversations with patients and their families in relation to disease and end of life trajectory.
- To add the current Palliative Care Portfolio to the competence requirements of all staff, ensuring that they are discussed as part of their development during 1:1's
- To create an end of life checklist to ensure that each patient is getting the same standard of care.
- To make available the "where to obtain medication/which pharmacies stock end of life medication" document on Teams for staff access.
- To send out communication to all staff regarding local analgesia
- Record keeping recording for Teams; to include the aspect of timely completion and validating.

A 6-month review of the learning and themes identified in west physical health has been completed with the following learning, actions and assurance provided.

Issue	Learning	Actions	Assurance
Sepsis tool was not completed in a timely manner	Recognition of sepsis and appropriate actions taken following detection of sepsis	Learning shared with the team Inpatient governance lead to discuss with all 3 teams and monitor treat, escalate appropriately	Update on action at the West CHS governance monthly meeting and feedback at the PPSQ

Issue	Learning	Actions	Assurance
Falls care plan not in place, falls policy not followed	Falls care plans to be completed in a timely manner as per policy	Similar themes amongst other CHS west wards. Raised at the ward managers and matrons meeting	Update on action at the West CHS governance monthly meeting and feedback at the PPSQ
Management of a deteriorating patient	Identifying deteriorating patients and escalating appropriately	- Daily status exchanges in the wards to identify deteriorating patients and their management - Weekly internal Gemba to review deteriorating patients - IPU governance lead to share the learning with all IPUs	Update on action at the West CHS governance monthly meeting and feedback at the PPSQ
Communication with family members regarding care plans	To inform family members/carers about the patient's health condition and treatment plans	- identifying staff to perform the function of liaising with families. - ANPs and medics to involve family members in care planning and treatment - SBARC included in Rio	CHS West governance lead to monitor any themes around this issue and triangulate it with complaints arising about this issue
Timely interventions for End of life care patients	To ensure that interventions like catheterisation and pain management are done in a timely manner for EOL patients	- Action plan to address these issues were developed by the service and shared at MRG - Staff training and supervision sessions in place	CHS West governance lead to monitor any themes around this issue and triangulate it with complaints arising about this issue
Ceiling of treatment and escalation plans	To ensure that clear ceilings of treatment are in place and escalation plans included in treatment plans	- Discussions in the clinical supervision sessions - Assessing clinicians to document clear ceilings of care and escalation plans in RRAT service - Similar themes in inpatient units	CHS West governance lead to monitor any themes around this issue

12.4 Mental Health Learning

The findings from a serious case review identified the following learning for Mental Health Inpatients around out of area placements a joint learning event for all teams involved to be facilitated to focus on the learning from this case. The case will be anonymised, a training session/learning event will be devised to highlight the issues raised.:

- to ensure all aspects of funded services are specified and checked by Care Coordinators as necessary

- to liaise with host Authority to ascertain the quality and safety of the placement
- Host references should be made prior to placements commencing.
- If an acceptable reference is not received and/or it is not received within the necessary timescales, then the funding authority must undertake a robust quality assurance process in advance of commissioning the placement.
- A QI project with regards to clinical documentation in the psychiatric in-patient services. Berkshire Healthcare to ensure this project identifies how improvements can be made to the clinical documentation process and practice Berkshire Healthcare to ensure this learning is implemented and shared with partner agencies

It was identified in Q3 that the talking therapies (TT) service had had several 2nd reviews which they had completed, it was noted there is a potential cluster of deaths related to the TT service. The Clinical Director for the service has requested a deep dive into the service, the outcome of this will be reported in Q4.

13 Conclusion

Number of deaths reported in Q3 remain similar to previous quarters (except for Q1 of 2020/21).

Of the 41 2nd stage reviews completed, significant learning were identified by the services and have been shared and implemented through action plans, learning events and using the trust QI methodology.

4 inpatient deaths were reported where Covid 19 was stated on their medical certificate of cause of death (MCCD) and/or had a positive Covid 19 swab within 28 days of their death. These were reported to the CPNS in line with national guidance. 3 deaths occurred due to Covid 19 following a patient transfer to an acute provider, 2nd stage reviews were requested for all. At the January TMRG, these were reviewed where one was closed and 2 were escalated for further review, the outcomes of which will be reported in Q4.

No lapse in care were identified in Q3.

QAC Meeting Date	2 March 2021
Title	Guardian of Safe Working Hours Quarterly Report (October 2020 to February 2021)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Matthew Lowe, Dr James Jeffs, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time shared by the 2 Guardians
Legal Implications	Statutory role
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 31st October 2020 to the 2nd February 2021. Since the last report to the Trust Board we have received three *'hours & rest'* exception reports and no '*education*' reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

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

This report covers the period 31st October 2020 to 2nd February 2021

Executive summary

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

This report focusses on the period 31st October 2020 to the 2nd February 2021. Since the last report to the Trust Board we have received three *'hours & rest'* exception reports and no '*education*' reports.

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

Introduction

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

High level data

Number of doctors in training (total): 39 (FY2 – ST6)

Included in the above figure are 2 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 39

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

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

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

a) **Exception reports (with regard to '*hours & rest*')**

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	3	3	0
Sexual Health	0	0	0	0
Total	0	3	3	0

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

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

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

In this period, we have received three '*hours and rest*' exception reports where the trainees worked hours in excess of their work schedule, totaling an extra 14.5 hours worked over and above the trainees' work schedules. 6.5hours of this was straightforwardly unpredicted additional hours. 8 hours was for a more unusual situation making up time already taken off unexpectedly (see detail below). Exception reporting is a neutral action and is encouraged by the Guardians and Director of Medical Education (DME). We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

Of the three reports, none related to work on the out-of-hours rota. Two related to a trainee's leadership responsibilities towards the trust junior doctors committee. The third, more unusual situation, related to a travel issue leading to a trainee unavoidably missing a working day, and therefore working additional hours over three remaining days in post to complete patient work. This is arguably TOIL taken in advance and not what the exception reporting system is designed for, but the Guardians of Safe Working have taken an inclusive position here and counted it.

It has been the opinion of Medical Staffing and the Guardians of Safe Working that in most cases "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work, however during the COVID crisis we agreed to change the emphasis such that payment for the extra hours worked was an equally valid outcome. At the beginning of August, we reverted to TOIL as the default option. If the pandemic again leads to individual problems with TOIL, the Guardians are happy to review this again.

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

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardians at induction and at every Junior Doctor Forum.

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 31st October 2020 to the 2nd February 2021)

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	81	81	39	42	0					0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	28	28	19	9	0	258	258	208.5	49.5	0
Sickness	17	17	11	6	0	176.5	176.5	124.5	52	0
Covid-19	36	36	9	27	0	355	355	94.5	260.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	81	81	39	42	0	789.5	789.5	427.5	362	0

d) **Fines**

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

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

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

Qualitative information

Currently the OOH rota is still operating at 1:12 and our system for cover continues to work as normal, with gaps being quickly filled.

Covid-19 remains the main cause of gaps for this period. We have seen a slight rise from the last report (we had 24 gaps from August to the end of October from Covid-19), but they are still down compared to the 59 we saw from May to August.

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

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there is under-reporting of small excess hours worked.

The current GOSW will have fulfilled the role for 5 years this year. We have started the recruitment process. We will also prepare a brief summary report for the board of those 5 years.

Actions taken to resolve issues

Next report to be submitted May 2021.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No trainee has breached the key mandated working limits of the new contract.

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

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

Questions for consideration

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

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

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

The below table highlights the changes to the safety limits and rest provisions between the 2016 terms and conditions and the 2018 contract refresh. For full details please refer to schedule 3 of the terms and conditions of service (TCS).

2016 terms and conditions	2018 contract refresh
Maximum of 72 hours work in any 7 consecutive day period.	Maximum of 72 hours work in any 168-hour consecutive period.
46-hours rest required after 3-4 consecutive night shifts.	46-hours rest required after any number of rostered nights.
Doctors paid at nodal point 2 are exempt from the requirements that no doctor shall be rostered for work at the weekends greater than 1 week in 2 for one placement during their foundation year.	No doctor shall be rostered for work at the weekend at a frequency of more than 1 week in 2.
No doctor shall be rostered for work at the weekend at a frequency of greater than 1 week in 2.	All reasonable steps should be taken to avoid rostering trainees at a frequency of greater than 1 in 3 weekends.
Where 8 shifts of any length are rostered or worked on 8 consecutive days, there must be a minimum 48-hours rest rostered immediately following the conclusion of the eighth and final shift.	Maximum of 7 shifts of any length can be rostered or worked on 7 consecutive days. Where a shift contains hours of work across more than one day, the work on each day will be counted independently toward the total number of consecutive days*.
No more than 5 long shifts shall be rostered or worked on consecutive days. Where 5 long shifts are rostered on consecutive days, there must be a minimum 48-hour rest period rostered immediately following the conclusion of the fifth long shift.	No more than 4 long shifts shall be rostered or worked on consecutive days. There must be a minimum 48-hour rest period rostered immediately following the conclusion of the final long shift*.
A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours, and • a second 30 minute paid break for a shift rostered to last more than 9 hours.	A doctor must receive: • at least one 30 minute paid break for a shift rostered to last more than 5 hours • a second 30 minute paid break for a shift rostered to last more than 9 hours • A third 30-minute paid break for a night shift as described in paragraph 15 of Schedule 2, rostered to last 12 hours or more.

*As soon as reasonably practicable from August 2019, and in any event as soon as possible before 5 August 2020, the employer will consult with doctors and agree to alter existing rotas.

Trust Board

Date of Board meeting	13th April 2021
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
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. Attached is the latest version(V1.6) released in February 2021. 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 Review of our current processes against the framework does not demonstrate any significant 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. Previous versions of the assurance framework have been reviewed by CQC and NHSE/I; with no concerns raised 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

February 12th, 2021. V1.6

Berkshire Healthcare

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 (V7 09/02/2021) (V7Updated to include information on management of SARS COV-2 variant of concern and guidance for transfer to care/nursing home) 22.12.2020- assessment/ decision regarding xmas leave for adult and YP inpatient units agreed 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. Audit of admission screens undertaken by IPCT with results of audit feedback to wards. Screening compliance records now available on tableau, linked to recording of screening on Rio patient notes. Checklist for OPD/ Clinic services implemented including Rio and paper version introduced September 2020 in line with remobilisation guidance. Instructions disseminated to clinical teams	MH wards achieving 85 % compliance with swabbing (due to MH patient compliance). Community Health wards achieving 95% compliance A tool has been built into RIO to enable audit of swabbing compliance. Recording of swab in RIO tool is inconsistent across wards and this means that it is difficult to have easy oversight of swabbing activity for individual patients or obtain % compliance of 3-day, 5-7 day and ongoing swabbing	All Mental Health patients isolated until post 5-7 screen is completed and result available 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

	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		21.12.20 - all wards now undertaking admission, day 3, day 5-7 and weekly routine screening of all covid negative inpatients
• that on occasions when it is necessary to cohort COVID or non- COVID patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per guidance	Covid-19 inpatient isolation and cohorting SOP IPC compliance tools		
• patients with possible or confirmed COVID-19 are not moved unless this is essential to their care or reduces the risk of transmission • there are pathways in place which support minimal or avoid patient bed/ward transfers for duration of admission unless clinically imperative	Patients with confirmed or positive COVID are isolated / cohorted in line with Covid-19 inpatient isolation and cohorting SOP (V5 27/11/2020). Individual ward guidelines for management of patient pathways aligned to inpatient isolation & cohorting SOP developed. Risk assessment document developed, completed, and reviewed by all wards Review of positive cases by Infection prevention and control Team with advice on management provided Screening at admission, day 3 and day 5-7 alongside routine weekly screening of covid negative patients to assist in mitigating transmission risk Isolation monitoring included in IPC annual monitoring programme. To be undertaken in Q4 by IPCT.		

• compliance with the national guidance around discharge or transfer of COVID-19 positive patients	All patients being transferred to care homes are swabbed 48 hours 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. Updated guidance 16/12/20 re discharge to care homes followed . Further update to guidance for discharge received 24.3.21 - this has been shared with wards and included in revised SOP	No designated homes within Berkshire identified	New guidance issued 16/12/20 being followed.
• monitoring of IPC practices, ensuring resources are in place to enable compliance with IPC practice ➢ staff adherence to hand hygiene? ➢ staff social distancing across the workplace ➢ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in: a) clinical b) non-clinical setting	IPC resource pack available and disseminated to all wards / services IPC Compliance tool completed monthly for inpatient and community services (frequency increased if non-compliance identified or higher incidence) and provided to divisional PSQ PPE competence tool for all staff (both inpatient and community teams)– check at beginning each shift that all on duty have completed; Spreadsheet of all competed assessments held by ward or service/department. Posters and signage to support compliance NHSE - Every action counts resourced have been reviewed and videos shared in newsletter and directly with wards 18th and 25th March 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

	PPE guardians at prospect Park Hospital Senior leadership and IPC visits to wards Outbreak meetings held for all outbreaks (2 or more cases potentially linked) includes review of practices, daily compliance tool completion and sharing of any learning. shared learning disseminated through management cascade/ all staff team briefing and COVID newsletters as well as through PPE senior oversight group Infection control mandatory training includes quiz to ensure understanding and compliance		
• monitoring of compliance with wearing appropriate PPE, within the clinical setting • consider implementing the role of PPE guardians/safety champions to embed and encourage best practice	PPE competence document for all patient facing staff (includes donning and doffing) – 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 community clinical services PPE Guardians introduced at PPH Senior leadership and IPC visits to wards Where learning identified this is shared through meetings/ forums/ COVID newsletter and all staff team briefings		

• staff testing and self-isolation strategies are in place and a process to respond if transmission rates of COVID-19 increase • implementation of twice weekly lateral flow antigen testing for NHS patient facing staff, which include organisational systems in place to monitor results and staff test and trace • additional targeted testing of all NHS staff, if your trust has a high nosocomial rate, as recommended by your local and regional infection prevention and control/Public Health team.	Information available to staff Around Access to both Pillar 1 and 2 testing. Pillar 1 testing available for all symptomatic staff seeing patients face to face and their households. Process in place to source whole service/ ward 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 - updates and changes to isolation communicated to staff Lateral flow testing introduced for 1000 patient facing staff. December 20 -2000 further LFT kits received and distributed to services including EFM staff COVID testing email for all testing queries monitored through day to support timely response Outbreak meetings instigated for all outbreaks - this includes ensuring LFT and ease of access to PSR testing Additional targeted testing to be implemented as required		Review being undertaken to ensure that all 1000 front line staff issued initially with kits are reporting results as required
• 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 and quiz for individuals & teams to undertake.	Ensuring that all non-clinical staff use resources and training opportunities available	

	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 for medium and high risk pathways in patient facing services Every action counts videos circulated for use through weekly newsletter and ward managers March 2021 compliance 90% for annual training		All clinical and divisional directors aware of need to continue to promote annual IPC training On-line resource/ presentation with quiz available as alternative to F2F Training – links shared All staff have PPE competency and compliance document being completed at least monthly by services to ensure staff adhering to IPC guidance (outbreak areas completing daily)
• 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 individuals and teams to undertake. This presentation is used for mandatory training and induction training. All patient facing staff undertake PPE competence assessment. Monthly service compliance tool is undertaken to ensure compliance with IPC measures IPC resource pack updated	As above	As above

• all staff are regularly reminded of the importance of wearing face masks, hand hygiene and maintaining physical distance both in and out of work	Weekly COVID Newsletter/ alternate week teams live events/ posters/ intranet / screen savers and floor / wall stickers all used to promote mask- hand hygiene and social distancing. PPE guardians at Prospect Park Hospital to support compliance and reminders Visits by senior staff to sites to support continued compliance Local / divisional meetings used to remind staff NHSE - Every action counts Videos circulated through weekly newsletter and direct to ward managers		
• all staff (clinical and non-clinical) are trained in putting on and removing PPE; know what PPE they should wear for each setting and context; and have access to the PPE that protects them for the appropriate setting and context as per national guidance	COVID -19 PPE page on Nexus links to updated guidelines Posters demonstrating how to Don and Doff mask and other PPE available and displayed for all staff. this was disseminated through newsletters as well as being available on Nexus 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 patient facing 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		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

	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, IPC link practitioners and direct with Clinical Directors for dissemination	Ongoing challenges with individual compliance in non-clinical and clinical settings	Frequent reinforcement of messages through newsletters/ teams live/ service visits/ posters and local processes
• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace	Posters available and displayed in both inpatient and community staff areas: • PPE Visual guide for medium/high risk pathways • How to wear a facemask • Social distancing at work • Hand hygiene • Putting on and removing facemask • Safety at work		

• 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 Nexus 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 / updated as guidance changes Covid clinical review 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 Director Nursing and Therapies attends weekly system DIPC meetings and regional/ national calls		
• 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/ December/ March QPEG and November Board. Also provided to Board discursive 12th January 2021 and formal Board in April 2021Trust Corporate Risk Register includes nosocomial infection and Board assurance framework includes COVID - both documents have executive / Senior leadership and Board oversight		
• risks are reflected in risk registers and the board assurance framework where appropriate	March 2020 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/ October 2020, QAC received		

	August and November 2020; September/ December 2020 - COVID-19 BAF and CRR updated. V1.6 to March 2021 QPEG and April Board		
• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	IPC policies IPC routine surveillance/ dissemination of any actions following identification Post infection reviews IPC monthly report presented to QPEG Quarterly shared learning reports Quarterly Datix review of IPC incidents Policy review programme		
• that Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all data submissions via the daily nosocomial sitrep. This will ensure the correct and accurate measurement and testing of patient protocols are activated in a timely manner.	Process in place for Medical / Nursing Director sign- off daily submissions in relation to healthcare acquired (post 8 day) cases following review by IPC teams		
• 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		

	Director Nursing provides updates to Board and Executive committees including Quality Assurance and Audit Committee on current covid situation and any outbreaks		
• This Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board	BAF is reviewed by clinical reference group fortnightly and at least alternate monthly at Quality and Performance group. In addition, presented to trust Board as changes occur last presented Jan 2021, to be presented again April 2021		
• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas	Gemba visits to services undertaken by exec and senior leadership team		
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 completed and reviewed - 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	Risk assessment document to be considered for community teams	Ward risk assessment being adapted for use

	PPE videos for donning & Doffing disseminated to teams and available on intranet PPE posters on team net and printed copies made available to services Support visits by IPCT, DN & DDN as well as local managers and clinical leads. Sampling guidelines include swabbing technique 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 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 Ongoing FIT testing in place for staff that may undertake AGP as part of their clinical work Additional FIT tester training sessions to increase number of FIT testers available		
• designated cleaning teams with appropriate training in required techniques and use of PPE, are	In -patient wards have designated cleaning teams Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE/I		

assigned to COVID-19 isolation or cohort areas	• 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 PPE competence for domestic staff		
• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance	IPC compliance tool for all patient facing areas 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 IPC compliance tool includes check against decontamination and use of cleaning products (including reconstitution of chlorclean). posters available to support correct chlorclean reconstitution for clinical areas.		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ Further reminders provided around chlorclean and ensuring correct reconstitution following reporting at an outbreak meeting that a member of staff was unclear.

• 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 for all clinical sites and wards – checks undertaken to ensure compliance and monitored as part of compliance tool Wipes and cleaning products available for staff to use on desks / workstations in non-clinical areas EFM attend any outbreak meetings		
• cleaning is carried out with neutral detergent, a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses	E&F cleaning and environmental SOP EFM monitoring of wards has continued throughout this period Chlorclean used Monitored as part of IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy		Additional checks regarding correct dilution of chlorclean undertaken with both clinical and EFM staff
• Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfectant	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		Additional checks regarding correct dilution of chlorclean undertaken with

solutions/products as per national guidance	Guidance for safe use including storage of Chlorclean included in IPC mandatory training and information posters available in clinical areas/ Nexus.		both clinical and EFM staff
• '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 decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily)	Monitored as part of 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 at least 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.		
• 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		Action plans developed following annual monitoring to be monitored by ward managers/ matrons.

	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		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	Included as part of IPC compliance tool Patient equipment monitoring included in IPC annual monitoring programme. Monitoring undertaken by the IPCT during December 2020 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 and community services equipment cleaning schedules Included as part of 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 by IPCT 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; this is more challenging in cold winter months	Draft national ventilation guidelines reviewed by EFM Completion of ventilation policy in progress by EFM
• there is evidence organisations have reviewed the low risk COVID-19 pathway, before choosing and decision made to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants	Review undertaken and No patient facing clinical areas within BHFT have been assessed as being in low risk pathway except for Dental planned surgery are using low risk pathway in local acute trusts in line with elective surgery pathway		
• monitor adherence environmental decontamination with actions in place to mitigate any identified risk	IPC compliance tool EFM monitoring IPC spot checks		

• monitor adherence to the decontamination of shared equipment with actions in place to mitigate any identified risk	IPC compliance tool IPC spot checks Equipment cleaning monitoring part of IPC annual monitoring programme and undertaken for inpatient units in Q3 by IPCT. Report and action plan disseminated to services		
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 05 March 2021 – visitor guidance updated to commence 08 March to reflect planned visiting arrangements.	New guidance received 17/3/21 – consideration re how to implement LFT for visitors to end of life patients	Review/ SOP being considered to enable visitor LFT
• 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 December - visitor guidance, change in isolation periods and link to safety netting when self -isolating added to website		
• 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 Infection Control Isolation, Cohort 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	Signage available in clinical areas		

staff to comply with hands, face and space advice.	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 have reviewed and implemented updated guidelines for recommencing planned surgery/ treatment. All clinic setting have checklist for use to screen patients just prior to on arrival – December the electronic RIO version of this is being updated to reflect the change in isolation period from 14 days to 10. Inpatients are tested on admission, day 3 day 5-7 and then weekly as routine (also tested if become symptomatic) unless known to be positive to enable quick detection and appropriate action to mitigate transmission		
• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms	Trust does not have an A&E admission are generally planned unless admission through Place of safety. Admission screening of all patients (unless known positive).		

and to segregate from Non COVID- 19 cases to minimise the risk of cross-infection as per national guidance	Triaging tool used for outpatient services and UTC. 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. Transfers known to have had exposure to covid prior to transfer isolated for 14 days		
• 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. (December being updated to reflect change in isolation periods form 14 days to 10)		
• 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 all outpatients and visitors	Signage at entrances Masks, hand gel and bins available at entrances Visitors including outpatient attendees reminded of need to wear face coverings		
• face masks are available for patients and they are always advised to wear them	Masks available Individual risk assessment undertaken for inpatients Mask wearing included in ward risk assessment tool Wearing facemasks for patients on inpatient wards poster displayed on inpatient units Patients attending outpatient settings advised to wear masks & posters at entrances.	Not all patients are able to tolerate wearing face masks/ for some patients masks are ligature risk	Individual risk assessment undertaken

• 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	risk assessment included in ward risk assessment template Individual risk assessments also undertaken; masks worn where tolerated/ don't introduce additional risk Patients attending outpatient settings advised to wear masks & posters at entrances.	As above	Risk assessment carried out on individual basis and worn if tolerated
• monitoring of Inpatients compliance with wearing face masks particularly when moving around the ward (if clinically ok to do so)	included in ward risk assessment and individually risk assessed dynamically depending on patients condition and ability to tolerate	As above	As above
• 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		

tracing is achieved until proven negative	Information to wards to remind them of prompt isolation and testing Included as part of handover/ standard work Contact tracing for any staff/ patient contacts undertaken as part of IPC and any outbreak management - flow chart in place to support managers with contact tracing		
• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document	Admission screening compliance Rio forms for compliance with admission, day 3, day 5-7 & weekly screening. Report available on tableau	Compliance with use of RIO tool to enable audit of compliance	discussion at clinical review group and reminder and instructions resent out 5.3.21
• 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 Any patients who develop symptoms are tested and isolated in line with 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 COVID status 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		

	Community teams including phlebotomy, UTC, 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 clinical and divisional directors continue to promote annual IPC compliance. On-line resource/ presentation with quiz available as alternative to F2F Training – links shared

	PPE guardians to act as reminders PPE competence completed for all patient facing staff Ward compliance/ hand hygiene tools in use Compliance with annual IPC training - 90%		All staff have PPE competency and compliance document being completed at least monthly by services to ensure staff adhering to IPC guidance (outbreak wards completing daily. Compliance tool monitored through divisional PSQ meetings
• all staff providing patient care and working within the clinical environment 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 PPE posters on Nexus and printed copies made available to services Mandatory IPC training covers PPE, includes induction		Donning and Doffing lanyard card reminders in progress for donning & doffing
• 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		March 2021 - annual training compliance 90% 2 yearly 89%
• 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 with actions in place to mitigate any identified risk	Monthly IPC service compliance tool (stepped up to daily for all outbreaks or increased incidence) IPCT and senior staff visits to monitor PPE compliance PPE Guardians reintroduced at PPH Senior staff visibility to promote		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 including instructional posters • good respiratory hygiene measures • maintaining physical distancing of 2 metres wherever possible unless wearing PPE as part of direct care • staff maintain social distancing (2m+) when travelling to work (including	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 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		

avoiding car sharing) and remind staff to follow public health guidance outside of the workplace • frequent decontamination of equipment and environment in both clinical and non-clinical areas • clear visibly displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Patient equipment monitoring included in IPC annual monitoring programme Enhanced cleaning in place Social distancing in non-clinical areas poster Safety at work poster Wearing a facemask for patients poster displayed in inpatient units Staff reminders in weekly newsletters and on Nexus to not car share		
• 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 within the local population and for hospital/organisation onset	DoN participation in Frimley and BOB ICS IPC meetings to discuss local intelligence and learning from any local outbreaks Attendance at regional Webinar for IPC		

cases (staff and patients/individuals)	Feedback from ICS DoN from local PH chaired outbreak meetings Attendance at local and regional IPC meetings by Head of IPC Daily review cases by IPC Outbreak meetings instigated where there are 2 or more potentially linked cases -any learning is shared across inpatient areas. This includes monitoring of staff and patient cases Staff absence related to covid captured on ESR Operational calls to monitor staff absence impact		
• 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 72-hour reports completed for any post 8-day covid positive cases and outbreak meetings implemented for any situation where 2 or more cases are potentially linked; this is chaired by DoN or deputy, with attendance by IPC; EFM, clinical team; services managers, clinical director and COO Where there is service disruption due to outbreak or an individual case meeting threshold for Serious incident reporting this is undertaken.		

• 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) Outbreak meetings undertaken for 2 or more potentially linked cases chaired by Director Nursing and Therapies, these include actions and learning. Learning shared at system DIPC meetings as well as internally. IPC daily surveillance of lab reports to identify positive cases and any potential outbreaks. Clear guidance sent to relevant ward when outbreak identified, along with notification to key senior staff and on-call, this is reviewed daily. Daily update on number of cases on each ward sent to wards and relevant managers includes any actions / restrictions to admissions Serious incident policy in place and followed for individual cases that meet threshold or significant service disruption		
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 size of the facility, prevalence/ incidence rate	On PPH site wards segregated to provide cohorting with restrictive access between		

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 and regularly reviewed by all wards Where possible staff are allocated to Covid / non-covid pathways where there are positive patients on the wards		
• areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas	Cohort wards /areas are in place at Prospect Park Hospital - this is detailed in SOP and risk assessment/ physical barriers of closed doors with clear signage Community wards have cohort bays -posters / signage but not all have physical barriers. Ward staff aware of differing risk areas on their wards and are able to assist patients in understanding, 1:1 / increased observations where patients are not able to understand / comply with segregation	Posters and signage in cohorting areas but physical barriers not possible on Community Wards	
• patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate	Isolation policy Isolation and cohorting SOP; oversight by IPC and senior managers to ensure understanding and appropriate actions Wards at PPH agreed as designated isolation wards/ areas; community wards cohort in bays / parts of ward depending on number of suspected on known COVID patients at any time		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	Isolation Policy Isolation and cohorting SOP	23rd December - system ask due to bed pressures to reduce bed spacing below 2 metres - agreement to reduce	bays with known positive / recovering patients only to mitigate risk of increased

national guidance	Risk assessment tool completed and regularly reviewed for all wards Reduced number beds on wards to ensure compliance with 2m distancing as able depending on system capacity Compliance tool undertaken to ensure compliance	31st December - system bed capacity and pressures have meant need to increase bed capacity to pre-covid levels therefore reducing 2 metre bed spacing April 2021 - bed spacing to 2 metre bed spacing	transmission amongst negative patients mitigation to minimise / reduce transmission / COVID outbreaks; **Placement of patients:** Negative known contact with positive COVID case to be prioritised for single rooms to complete 14-day isolation Patients from acute trusts to have samba test prior to transfer and to continue with routine screening following admission (local data has shown identification of positive cases 7-14 days following transfer from acute trusts) Minimal movement of patients following transfer

			Means of physical segregation: Curtains partial closure between bed spaces Trial of use of plastic curtains – 14.1.21 – now being installed across all wards with bay areas - curtains up in all ward areas where 2bed-bed gap is not quite 2 metres Bed – chair- locker configuration Overview of actual space (i.e. minimal reduction of 2 metres) Patient screening: Screening undertaken on admission, at day 3, day 5-7 and then every 7 days for negative patients **Cohorting of staff** Where possible between high and medium risk areas

			Staff undertaking lateral flow 2x weekly
• patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	Isolation policy ICC001 communicable disease and outbreak management policy for inpatient and community services. IPC surveillance and support for decision making as required / Director on call out of hours Isolation and cohorting SOP; oversight by IPC and senior managers to ensure understanding and appropriate actions. Review and circulation of required actions by IPC as reminder to both relevant ward and managers 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 (unless known positive), at day3, 5-7, every 7 days during stay and 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 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 3 and at 5-7, weekly for all negative patients thereafter through their stay and if symptomatic and prior to discharge to Nursing /care homes Lateral flow testing introduced for patient facing staff (further kits received December to enable all patient facing staff to receive a kit)	Process for the ward to review / audit compliance with 3 and 5-7-day screening in progress initial screening compliance audit undertaken	PPH Senior leadership team developing action plan for improved compliance with admission, 3 a and 5-7 days screening Work to produce alert in RIO to assist / remind staff of need for 3 and 5-7-day screen and for wards to be able to monitor ongoing compliance via tableau completed
• regular monitoring and reporting that identified cases have been tested and reported in line with the	IPC monitor admission screening IPCT receive daily COVID 19 testing reports provided by BSPS		

testing protocols (correctly recorded data)	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		
• that all emergency patients are tested for COVID-19 on admission.	All patients are tested on admission (unless already known to be covid + or recently recovered)		
• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	All patients negative on admission are tested on day 3, day 5-7 and then weekly during admission as well as if symptoms arise.		
• that those emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	All admissions who test negative on admission are tested on day , 3, day 5-7 and then weekly during their inpatient stay		
• that sites with high nosocomial rates should consider testing COVID negative patients daily.	Would be considered if high nosocomial rates – currently no wards with nosocomial transmission		
• that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is	Included in inpatient SOP		

communicated to receiving organisation prior to discharge			
• that those being discharged to a care facility within their 14 day isolation period should be discharged to a designated care setting, where they should complete their remaining isolation.	Included in inpatient SOP		
• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission.	No elective patients admitted		
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure 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 Dedicated COIVD in box for 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, outbreaks and post incident reviews		

	Monthly IPC report shared through Divisional patient safety and quality processes as well as QPEG IPC champions/ Link Practitioners in place across the Trust IPC surveillance with IPC guidance provided PPE guardians introduced at PPH PPE Guardians at PPH Signage, posters and reminders on all staff briefings and newsletters Monthly compliance tool		
• 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 Weekly COVID-19 newsletters and alternate week all staff briefings used to highlight changes (additional newsletters as required) 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		

10.Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure: staff in 'at-risk' groups are identified using an appropriate risk assessment	Risk assessment undertaken for all staff, process also in place to ensure risk assessment undertaken as part of recruitment process to capture all new starters. All staff		

tool and managed appropriately including ensuring their physical and wellbeing is supported that risk assessment(s) is (are) undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic (BAME) and pregnant staff staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and a record of this training is maintained and held centrally staff who carry out fit test training are trained and competent to do so all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used	that are CEV of CV have agreed and documented management plan to mitigate risk. This includes working from home/ redeployment and other actions as appropriate and on an individual assessed basis. HR support available. Clinical staff assessed as high risk moved off wards with positive patients/ do not provide care to positive/ symptomatic patients. Wellbeing hub in place to support all staff with a variety of wellbeing offers/ psychological support packages available. All staff required/ may be required to wear FFP3 are FIT tested and trained by staff who have undertaken FIT test training Ongoing fit testing Programme in place Only staff who have undergone FIT tester training undertake staff FIT testing and a record is centrally maintained of all staff who have undergone FIT tester training Staff are tested for the masks that they are using and where supply changes staff are retested for available masks		March 2021; risk assessment review undertaken for all CEV staff members prior to any decision around working arrangements at end of national shielding directive. Review all staff risk assessments to be undertaken over April/ May as part of well-being conversations

a record of the fit test and result is given to and kept by the trainee and centrally within the organization	The IPC/ EFM hold a list of all staff who have been trained as fit testers and those who have been fit tested/ mask they have been fit tested for. when a member of staff is fit tested, they are given a certificate detailing the result of the fit test and which mask. These results are then forwarded to IPCT who add to the register. Departments also keep a local record for staff who have been fit tested.		
for those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods for members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health following consideration of reasonable adjustments e.g. respiratory hoods,	Where a member of staff fails a FIT test of a certain mask alternative FFP3 masks are tried and hoods are available for those that require FFP3 as part of their regular clinical work but no FFP3 fit adequately (there are only a very small number services that routinely require FFP3 due to their work within the Trust as AGP are not performed in the fast majority of Community and Mental Health Services); for services where there is occasional need to undertake and AGP procedure someone who is not FIT tested / able to acquire adequate FIT of any available mask would not be asked to perform the procedure Any decision on redeployment due to staff member risk is documented		

personal re- usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record boards have a system in place that demonstrates how, regarding fit testing, the organization maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance all staff should adhere to national guidance on social distancing (2 metres) if not wearing a facemask and in non-clinical areas health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are	Staff are where possible allocated to specific wards including cohort wards and where community wards have cohort bays due to only 1 or 2 wards at a location staff are allocated to either covid or non-covid bays As detailed in this assurance framework every effort is made to ensure that staff are aware of and adhere to guidance. All staff in clinical and non-clinical areas are expected to wear masks even when able to be 2 meter socially distanced (except for whist eating and drinking) Additional spaces have been provided for staff break times to support social distancing. Staff are advised not to	process not currently in place for Board to review FIT test records. DoN has access to records and raises any issues or concerns; Current exploration of records being able to be held on ESR	Agreed at Board on 12.1.21 that updates would be provided to the Board to include numbers of staff FIT tested and any concerns in regard to FIT testing Process in place for recording of all FIT testers and staff fit tested this is currently held centrally by IPC and locally by services

mitigated maximally for everyone staff are aware of the need to wear facemask when moving through COVID-19 secure areas.	car share and if this is essential to wear masks. Posters / media platforms and alternate week briefings are used to remind staff of need to wear masks and social distancing guidance. IPC and senior staff visiting support compliance		
staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	Staff absence is monitored through ESR; in line with usual processes and policy any staff absent are kept in touch with to ensure support available. Pillar one testing is available for staff to access, how to access testing is publicised through NEXUS, team briefings and newsletters; staff are also, provided info by managers. All staff also have access to covid email box for help and support. Each division has HR support alongside occupational health also available for advice.		
staff who test positive have adequate information and support to aid their recovery and return to work	Regular contact with line manager to ensure adequate support and advice/ signposting to occupational health as required; safety netting advice shared in newsletter and available on Nexus. Trust Wellbeing hub also available		

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

Updated to COVID-19: Guidance for maintaining services within health and care settings
Infection prevention and control recommendations issued January 2021
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/954690/Infection_Prevention_and_Control_Guidance_January_2021.pdf

https://future.nhs.uk/Estates_and_Facilities_Hub/view?objectID=19747856

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Meeting Date	13 April 2021
Title	CQC - Consultation on Changes for more Flexible and Responsive Regulation
Purpose	The purpose of this paper is to update Trust Board on CQC's proposed changes to achieve more flexible and responsive regulation
Business Area	Nursing & Governance
Author	Debbie Fulton, Director Nursing and Therapies
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
Equality and Diversity Implications	N/A
SUMMARY	The CQC are currently out to consultation around some specific changes to the way they regulate; this is following recognition, during the pandemic that current processes prevent the ability to assess and rate services flexibility. The aim of the changes is to enable increased flexibility with the ability to rate services more often in a more accessible, responsive, timely and proportional way and to make ratings easier to understand for everyone. In summary the document covers: • How quality and service provision will be assessed • How ratings will be reviewed and updated • Rating changes **1. Assessing quality** ➢ A move away from comprehensive inspection as the main way of updating ratings and instead use wider sources of evidence, tools, and techniques ➢ On-site/ targeted inspections will continue when information suggests there is significant risk to safety and to ensure rights of vulnerable people are protected. ➢ Increased use of available information to inform decisions ➢ Reduction of information requested ahead of an inspection with requests being much more targeted and proportionate **2. Review and update ratings** ➢ Ability to update ratings more often when there are changes in quality; this will no longer require on -site inspection but will use a variety of sources

	and available data including peoples feedback and experience of care, smaller targeted inspections, available national and local data , insight from other organisations, CQC relationships and accreditation alongside expertise/judgement of inspectors. **3. How NHS trusts are rated** ➢ It is proposed that at Trust level there will just one single rating given, this will be based on the well-led key questions of culture and leadership, thus removing the complex aggregation of rating that currently occurs in relation to the safe, responsive, effective and caring domains. ➢ Ratings for each domain will continue to be published for core service lines Although the changes are currently at consultation phase the document recognises that there will not be a return to using current inspection approach in place. Further work is being undertaken to develop assessment frameworks and publish how ratings will be updated.
ACTION REQUIRED	The Trust Board is asked to: Note the document and provide any feedback for consideration as part of Trust response.

Strategy

Consultation on changes for more flexible and responsive regulation

The world of health and social care is changing.

So are we.

The COVID-19 pandemic has made health and social care services think differently. We are no exception.

The pandemic has made clear that some of the ways we currently work prevent us from being flexible and responding to situations as they happen. Following on from the consultation on our new strategy and ambitions launched earlier in January, we're now proposing some specific changes that will enable us to deal with ongoing challenges from the pandemic and move us towards our ambition to be a more dynamic, proportionate and flexible regulator.

Our inspection reports and ratings give a view of quality that's vital for the public, service providers and stakeholders. We want to introduce changes to allow us to assess and rate services more flexibly, so we can update our ratings more often in a more accessible, responsive and proportionate way. The changes will make ratings easier to understand for everyone.

The proposals we're consulting on in **part 1** apply to all health and care sectors that we regulate (including those that we don't have the powers to rate).

In part 2, we set out how we'll be engaging with you in the future when we make changes to the way we regulate.

Part 1: Our proposals for change

Assessing and rating quality

What we do now

Our site visits are an important part of how we assess the quality of services. They enable us to observe care and the culture in a service (particularly services at risk of developing a closed culture[1]). They can also help us to check whether the information we have reflects people's experience of care. Under our current ways of working, we must always carry out a site visit in order to assess quality and rate a service.

However, site visits are not the only way to assess quality and update ratings. We already use information from a wide range of sources to support our judgements (for example, national data sets, information from other organisations and partners, and feedback from the public). Good quality information is already available for specific types of service, such as NHS services, where it helps us to judge key questions such as the effectiveness of services – all of which can be gathered without a site visit.

[1] By a closed culture we mean a poor culture that can lead to harm, which can include breaches of human rights such as abuse.

There's also more use of digital technology in health and social care, enabling services to deliver care remotely, for example online primary care services. We've seen more services taking advantage of this during the pandemic. We now have an opportunity to think differently about how we assess quality in these types of services, as a site visit can't do this.

The pandemic has highlighted the need for our assessment activity to be more targeted and focused, which depends less on 'physical' site inspections and pre-inspection information requests (for example Provider Information Requests (PIRs) in hospitals). In the last 11 months we've been exploring and testing new ways of working, including enhanced monitoring (such as our Emergency Support Framework and Transitional Regulatory Approach), targeted inspections and gathering evidence without physically crossing the threshold. For example, we're currently testing ways of assessing home care providers and GP practices without visiting the premises.

When we've needed to visit a service during the pandemic, inspections have been targeted and focused on areas of highest concern wherever possible, which minimises the time our teams spend on site.

For services that we rate, how often we inspect is determined primarily by the current rating for the service or provider. These rules vary across the sectors that we regulate. They mean that our regulation can't be as flexible and responsive as it needs to be. The frequency rules also rely on on-site inspections as the primary way for us to carry out our work.

What we want to do differently

Assessing quality

We want to move away from using comprehensive[2], on-site inspection as the main way of updating ratings (or assessing quality in services where we don't rate). Instead, we want to use wider sources of evidence, tools, and techniques to assess quality. This includes where we've gathered appropriate evidence following focused or targeted inspections, assessments without a site visit, and if we need to take significant enforcement action to protect people. But inspection will remain an important part of how we assess quality – we'll still carry out an on-site inspection where we have information about significant risks to people's safety, and to ensure we protect the rights of vulnerable people.

Our proposed change means we'll make more use of information that we hold to update ratings, and it won't be necessary to always carry out a site visit if we want to update a rating. If we need to ask health and care providers for information before an inspection, the requests will be targeted and proportionate. We'll carry on using more targeted inspections to enable us to work in this more focused and proportionate way.

[2] On-site inspections where we assess performance against all five key questions (safe, effective, caring, responsive and well-led).

We'll carry on developing the approach to assessing home care providers and GP practices without visiting the premises, moving towards updating ratings on the basis of this activity. We'll use learning from these pilots to consider how we can apply this approach to other health and care settings.

What do you think?

1. Assessing quality

We propose to assess quality and rate services by using a wider range of regulatory approaches – not just on-site or comprehensive inspections.

Question 1a. To what extent do you support this approach?

Question 1b. What impact do you think this proposal will have?

Reviewing and updating ratings

We want a less rigid approach that allows us to update ratings more often when we recognise changes in quality and to make our on-site inspections more targeted and flexible. This will enable us to provide a more up-to-date overview of the quality of care across England. The changes that we want to make mean we won't return to using the current inspection frequencies that are published on our website and the type of large inspections associated with this approach.

We want to stop describing frequency of assessment in terms of 'inspection', and instead by how often we review quality and update ratings. So, we'll focus on reviewing, confirming and changing ratings in a variety of ways – this won't just be limited to after a physical on-site inspection or a full assessment of quality. Being able to update ratings without an on-site inspection means we'll be able to use the expertise and professional judgement of our inspectors in a more flexible way.

We'll use the best available information about quality in a service to review ratings more often. This will include a better understanding of people's feedback and experiences of care, and using a combination of targeted inspections, national and local data and insight from other organisations and partners, and from our relationships with care services and their own self-assurance and accreditation. All this will enable us to reflect changes in quality more quickly than we did before – we know this is important to the public, service providers and stakeholders.

We currently do not have the powers to rate primary care dental services, so inspection frequencies for these providers can't be linked to a previous rating. We'll continue to assess practice locations, selecting them for inspection on the basis of risk and sampling of services.

For all these changes to happen we'll need to further develop our assessment frameworks and publish information to explain how often we'll update ratings in a consistent and proportionate way. This work will sit alongside wider changes in how we assess quality to help us deliver our new strategy later in the year. We'll work with partners across health and social care on these developments and will keep you up to date with changes as soon as we can, explained in a clear way.

What do you think?

2. Reviewing and updating ratings

Rather than following a fixed schedule of inspections, we propose to move to the more flexible, risk-based approach set out in this section for how often we assess and rate services.

Question 2a. To what extent do you support this approach?

Question 2b. What impact do you think this proposal will have?

Changing how we rate GP practices and NHS trusts

In our new strategy, we have an ambition to evolve our ratings to make them easier to understand, more relevant and accessible for health and care providers and people who use services. We want to get going on this now, starting with changes to simplify how we rate GP practices and NHS trusts, and how we aggregate ratings.

At the moment, we are not proposing any changes to how we aggregate ratings in adult social care as part of this consultation.

GP practices

What we do now

As well as inspecting and rating GP practices for the five key questions, we currently also assess people's experiences of care in six population groups (older people; people with long-term conditions; families, children and young people; working age people; people whose circumstances make them vulnerable; and people experiencing poor mental health). We give a rating for each population group against the effective and responsive key questions. The two ratings are then aggregated to reach an overall rating for these population groups.

We introduced this in 2014 when we began rating GP practices, and made changes in 2018 to improve our approach to rating the population groups. The intention of rating practices in this way was to reflect the various needs of different people when they access primary medical care and to reflect any variation in the quality of care people receive from GP practices.

What we want to do differently

After evaluating this approach, and listening to feedback from GP practices, national stakeholders and our own inspectors, we propose to stop providing ratings for individual population groups because:

- There is little variation in ratings for the different population groups, as they are usually influenced by evidence and judgements about the quality of care that affects **all** the people using a GP practice.
- Our current approach to rating GP practices is too complex and we are committed to considering our regulatory impact and to keeping our approach as simple as possible.
- Providing care to specific population groups is often influenced by wider local health systems; we want to reflect this in developing our approach to primary care networks and the wider health and care system.

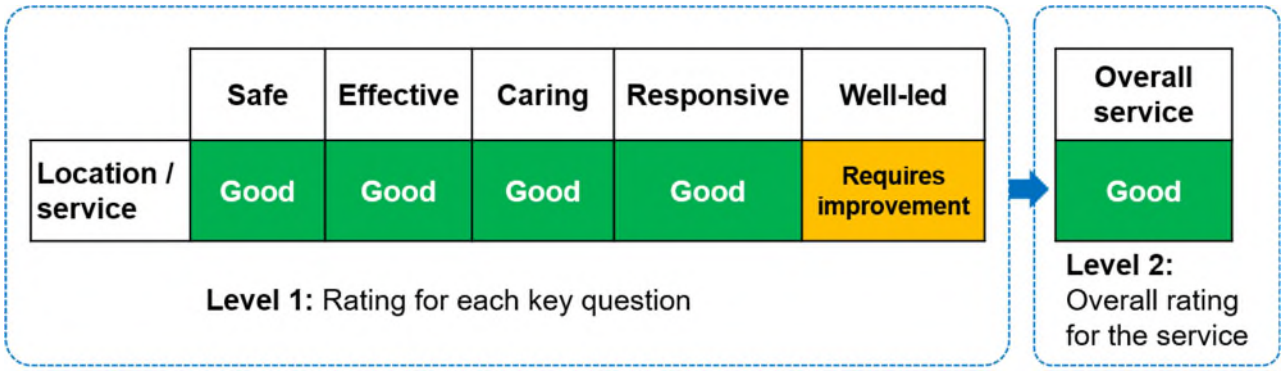
In 2021, we plan to introduce simplified ratings for GP practices at two levels:

Level 1: A rating for each key question for the location/service. This will be based on relevant evidence of how GP practices personalise people's care and provide care for different groups of people.

Level 2: An overall rating for the service. This will be an aggregated rating informed by our findings at level 1.

Figure 1 shows an example of how the simplified ratings, without aggregated ratings for population groups, could look for a GP practice.

Figure 1: Example of proposed rating of a GP practice



This change doesn't mean that we'll stop looking at how practices provide personalised and proactive care to their local populations and consider people's different needs when receiving primary medical care. This will still be a key part of our assessment activity. It means that we won't provide an additional and separate rating for different groups of people for the effective and responsive key questions.

What do you think?

3. Rating GP practices and population groups

We propose to stop providing separate and distinct ratings for the six population groups when rating GP practices.

Question 3a. To what extent do you support this approach?

Question 3b. What impact do you think this proposal will have?

NHS trusts

What we do now

As well as inspecting and rating core services in NHS trusts, we also inspect and rate the well-led key question at trust level (and the trust's use of resources, where applicable). We use our aggregation principles and the professional judgement of our inspection teams to rate the other four key questions at trust level. We then aggregate these to produce a rating of the overall quality of the trust.

We introduced our approach to rating NHS trusts in 2013 and introduced the assessment of the well-led key question at trust level in 2017. This was to support the proven link between a trust's leadership and culture with the delivery of safe, high-quality care. Along with NHS Improvement, we used an agreed updated framework to assess the well-led key question.

To evaluate this approach, we have listened to feedback from NHS trusts, the public, national stakeholders and our own inspectors, and we now propose to change how we rate NHS trusts. We want to simplify our approach to rating at the trust level because:

- The approach is too complex, and the aggregation can conceal variation in the quality of services.
- Aggregated ratings rely on inspection at a service level and can become out of date quickly.
- Aggregated ratings do not always reflect the way people experience services and care.

What we want to do differently

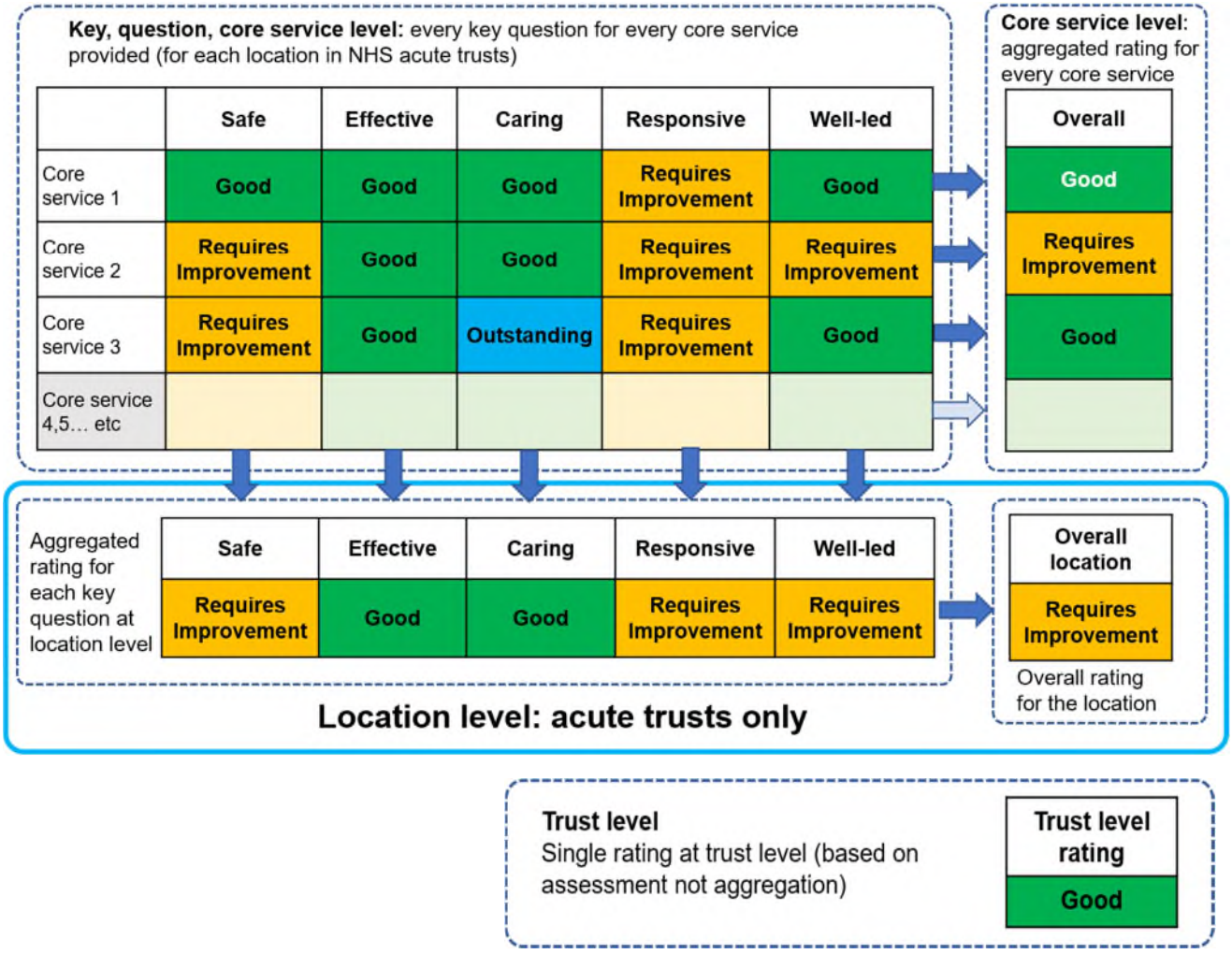
We propose to simplify ratings for NHS trusts by publishing a single rating at the overall trust level, rather than multiple levels of complex, aggregated ratings. This will enable us to focus on the culture and leadership of an organisation, as well as the services where people receive care.

This single rating will be based on our overall assessment of the organisation's performance against the well-led key question, including findings from service-level assessments. We'll continue to develop our approach to assessing the well-led key question at trust level to make sure that we look at the overall organisational performance on quality and safety effectively as part of that assessment.

Once we implement this approach, we will no longer publish separate trust-level ratings for the safe, effective, caring and responsive key questions. We will continue to publish those ratings at service and location level. This will provide a clear view of the quality of those services at the level that is relevant to people who use the service.

Figure 2 on the next page shows an example of how the simplified ratings could look with a single rating at the overall trust level for an NHS trust.

Figure 2: Example of proposed ratings for NHS trusts



Over 2021, we'll be working with partners at NHS England and Improvement to explore how to evolve the future approach to overall quality ratings for NHS trusts. We'll work with service providers and partners across the sector on this important area and will keep you up to date with developments as soon as we can explained in a clear way.

What do you think?

4. Rating NHS trusts

We propose to remove aggregation for NHS trust level ratings and replace with a single trust-level rating, based on a development of our current assessment of the well-led key question for a trust.

Question 4a. To what extent do you support this approach?

Question 4b. What impact do you think this proposal will have?

Measuring the impact on equality

We need to consider equality and human rights in all our work, so we've produced a draft **equality and human rights impact assessment**. It identifies the opportunities and risks for doing this through our proposals. Importantly, it identifies the actions we'll take to minimise the risks and make positive change happen.

What do you think?

5. Measuring the impact on equality

Question 5. We'd like to hear what you think about the opportunities and risks to improving equality and human rights in our draft equality impact assessment. For example, you can tell us your thoughts on:

- Whether the proposals will have an impact on some groups of people more than others, such as people with a protected equality characteristic.
- Whether any impact would be positive or negative.
- How we could reduce or remove any negative impacts.

The quickest and easiest way to respond to this consultation is through our online form.

Part 2: How we'll engage with you in the future

The way we currently consult and engage on any changes to our methods is a long process and means we can't implement changes and tell you about them quickly enough.

What we do now

Under section 46 of the Health and Social Care Act 2008, we must prepare, publish, and consult on a statement that explains how we'll assess the performance of health and care service providers. Historically, our approach has involved publishing and consulting on detailed information describing our entire processes for each type of service, with large public consultations usually taking place over a 12-week period.

This approach goes beyond the requirements of the Act and has limited our ability to be as dynamic and responsive as we want to be.

What will be different

We're changing the way we consult and engage with you on regulatory changes. To meet our statutory duties under the Health and Social Care Act 2008 we will still publish a statement that explains how we'll assess the performance of health and care service providers.

However, going forward, we'll be able to hear people's views constantly through a range of ways, making it easier for us to design solutions together with all our stakeholders in real time as we develop our future ways of regulating.

This means you'll see fewer large-scale formal consultations, but more on-going opportunities to contribute as we'll engage in different ways. Where we do need to consult on areas under section 46 of the Act, our consultations will be more targeted and responsive. So, rather than consultations that ask about many diverse areas of our work, we'll have more targeted conversations about things that affect you, for example through focus groups and our online CitizenLab platform. This will help us to respond more quickly to changes in health and care.

Importantly, it will mean we'll spend less time planning for formal consultations and more time listening to you.

In future, the guidance we provide about how we regulate will be more focused on the key areas that service providers and the public need to know about. Where we make changes to the way we carry out our work, we'll tell you about them as soon as we can and explain them clearly. Our engagement activity and the information we publish will be more accessible and easier to understand.

Our promise to keep you informed and involved

- **We'll always meet our statutory duties to consult under the Health and Social Care Act 2008.**
- **We'll engage with you in a proportionate, targeted and responsive way when we're making changes to the information and guidance we publish about how we assess quality.**
- **Our information will be up to date and the latest version will always be available on our website in an accessible and easy to understand format.**

How to respond to this consultation

Thank you for taking the time to tell us what you think about our proposals for more flexible and responsive regulation. It's important for us to get your views so we can work together to develop our methods.

Please respond by 5pm on **Tuesday 23 March 2021**.

The quickest and easiest way to respond is through our **online form.**

If you can't use the online form, you can respond by email to: regulatorychanges@cqc.org.uk

Or you can post your response free of charge to:

Freepost RSLS-ABTH-EUET
Regulatory Changes Consultation
Care Quality Commission
Citygate
Gallowgate
NEWCASTLE UPON TYNE
NE1 4WH

Please contact us if you would like a summary of this document in another language or format.

CQC-469-012021

Corporate member of Plain English Campaign
Committed to clearer communication
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Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 April 2021
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 13 April 2021

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. Modern Day Slavery Statement

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

Summary
The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the current financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Trust Board.

The Trust's Modern-Day Slavery Statement for 2020-21 is attached at appendix 1.

The Trust Board is requested to approve the Modern-Day Slavery Statement for 2019-20 which will be included as part of the Trust's Annual Report for 2020-21.

Executive Lead: Julian Emms, Chief Executive

3. Information Governance and Cyber security Assurance Update

In April 2020, the Trust welcomed an audit from the Information Commissioner's Office (ICO). The wide-ranging audit looked at "governance and accountability" and "cyber security". The Trust achieved high assurance ratings in both areas, demonstrating robust data protection practice at all levels as well as our commitment to continuous improvement.

Following this audit, the Trust submitted the 2020/21 Data Security and Protection Toolkit (DSPT) in March 2021, once again achieving a status of standards exceeded, giving further assurance of the Trust's approach to, and the importance given to, achieving good data protection and security practices across the Trust.

In March 2021, The Trust successfully completed the annual renewal of our Cyber Essentials Plus certification, providing third party assurance that our cyber security controls and approach meets the standards required by the NHS.

All NHS organisations are mandated by NHS England to achieve compliance with the Cyber Essentials Plus standard by June 2021 and this is our second year of being certified as compliant. Cyber Essentials Plus is a National Cyber Security Centre backed scheme to ensure that organisations have the correct controls and technical defenses to help protect themselves against cyber-crime.

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

4. 2021-22 NHS Operational Planning Guidance

A summary briefing from NHS Providers is appended to the executive report.

Of note are the six operational planning priorities for 2021/22 (with 17 sub priorities, summarised by NHSE in the table below):

Reflecting the uncertainties with which we are entering the year, and the recovery challenges we face including backlogs in primary care, mental health and elective services
Supporting our people • Looking after the health and wellbeing of the workforce and helping them recover from the impact of covid • Embedding new ways of working to improve productivity and make the NHS a better place to work • Growing for the future including locking in some of the covid-related workforce expansion
Continuing to deal with demands related to covid • Delivering phase two of the covid vaccination programme and preparing for re-vaccination • Maintain the dedicated long-COVID clinics that have been established

• Increasing the use of non-admitted pathways for covid and non-covid care, including virtual
Focusing on population health, prevention and keeping people well • Restoring access to primary care and community services including through increased digital capability • Prioritising interventions to support people to stay well, such as proactive LTC management • Addressing health inequalities through a focus on the needs of local populations, underpinned by data analytics
Restoring elective services, managing increasing mental health demand, and delivering key LTP commitments • Supporting the rapid recovery of elective services in a way that prioritises the clinically most urgent patients, supports the reduction of health inequalities, good patient communication, and transforms clinical pathways • Expanding diagnostic capacity and taking the next steps to improve cancer outcomes • Focusing on patient safety and quality, for example in maternity care • Addressing the existing care deficit and increase in demand for mental health services
Preventing inappropriate admissions to hospital and maintaining reduced length of stay • Accelerate the rollout of the 2-hour crisis community health response at home • Using NHS111 as the primary route to access urgent care • Continue to deliver timely and appropriate discharge from hospital inpatient settings
Delivering these priorities via collaboration at system level • Continuing to develop ICS infrastructure with a view to meeting the expectations set out in *Integrating Care* • Undertaking planning and financial allocations on a system basis

Within the planning guidance and of relevance to the Trust:

- Continuing commitment to the Mental Health Investment Standard, with an additional £500m announced in the recent budget to support COVID recovery action, alongside previous Long-Term Plan investment commitments including Community Mental Health Services.
- An inequalities focus, amongst others, on improving the physical health outcomes of those with a severe mental illness.

- Introduction of a two-hour Community Health Service At Home Crisis Response time by April 2022, and funding continuation to support rapid community discharge initiatives for timely discharge of patients from hospital.
- Commitment to the development of the role, function and governance of Integrated Care Systems, per the recent “Integrating Care” paper.
- Revenue and capital allocations will be managed at system level (capital plan submission April 2021, system revenue plan submission May 2021)

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

Presented by Julian Emms
Chief Executive
April 2021

Berkshire Healthcare
NHS Foundation Trust

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2021.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Berkshire Healthcare has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the Trust or our supply chain.

Our Policies on Slavery and Human Trafficking
Berkshire Healthcare is aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Standard NHS Contracts and the Trust's contract specifications contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with Berkshire Healthcare's anti-slavery policy. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate a number of internal policies which ensure that we are conducting business in an ethical and transparent manner. These include:

- **Recruitment** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- **Equal Opportunities** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and fair access to training and development opportunities
- **Safeguarding** - We adhere to the principles inherent within both our safeguarding children and adults' policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.

- **Whistleblowing** - We operate a whistleblowing/raising concerns policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials
- Randomly request that the main contractor provide details of its supply chain
- Ensuring invitation to tender documents contain a clause on human rights issues
- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws
- Using the standard Supplier Selection Questionnaire that has been introduced (which includes a section on Modern Day Slavery)
- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training
Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory for all our new starters. We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators
We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if there are no reports received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Approved by the Trust Board: 11 February 2020
Next review: February 2020

Signed: Julian Emms, Chief Executive

NHS 2021/22 priorities and operational planning guidance

NHS England and NHS Improvement (NHSE/I) published priorities and operational planning guidance for 2021/22 on 25 March 2021. This overarching document sets out six priorities for the year ahead, and asks systems to develop fully triangulated plans across activity, workforce and money for the next six months. These arrangements are supported by an additional £8.1bn of funding to reflect the ongoing impact of COVID-19. For any questions on this briefing, please contact amelia.chong@nhsproviders.org and isabel.lawicka@nhsproviders.org.

Key points

- In the context of responding to the ongoing challenges presented by COVID-19, while also restoring services, meeting new care demands and tackling health inequalities, the planning guidance sets out six priorities (and 17 sub-priorities) for the year ahead:
  1. supporting the health and wellbeing of staff, and taking action on recruitment and retention
  2. delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
  3. building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services
  4. expanding primary care capacity to improve access, local health outcomes and address health inequalities
  5. transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
  6. working collaboratively across systems to deliver on these priorities.
- The government has so far committed £8.1bn to cover COVID-19 costs in 2021/22, of which £7.4bn is available over the first half of the year. A further £1.5bn has been allocated for elective recovery, mental health and workforce development. The full settlement for months 7-12 will be agreed once there is greater certainty around the circumstances facing the NHS in the second half of the year.
- Systems are asked to develop fully triangulated plans across activity, workforce and money for the first half of the financial year. Mental health plans are expected to cover the next 12 months. Draft plans are due by 6 May 2021 and final plans are due by 3 June 2021.

Summary of priorities

Supporting the health and wellbeing of staff, and taking action on recruitment and retention

The workforce elements of the guidance note the extraordinary efforts made by trusts and frontline staff in adapting and innovating to confront COVID-19, while continuing to deliver other essential services. The emphasis on the need for staff recovery at the heart of service delivery and transformation is notable and welcome. There will naturally be activity and financial implications in supporting staff with wellbeing offers and time off to recuperate, which are considered in later sections of the guidance.

Systems are asked to review their people plans in first half of 2021/22, and give additional focus to equality, diversity and inclusion, creating compassionate and inclusive cultures, and increasing workforce supply. These areas were highlighted as part of the review of local plans in September 2020.

Looking after our people and helping them to recover

The guidance acknowledges the individualised nature of recovery and gives some suggestions as to how trusts can enable this for staff:

- Left over annual leave from 2020/21 is to be carried over and used by staff in 2021/22. To support this, system financial performance assessments will exclude higher accruals for annual leave in 2020/21.
- Individual health and wellbeing conversations (as per the People Plan 2020/21) are to become a regular aspect of staff management, resulting in annually agreed plans for staff, undertaken in the first half of this financial year. Plans should include risk assessment, flexible working options, compliance with infection prevention and control policy, and testing policy. The guidance encourages managers to draw on the range of preventative health and wellbeing support available in formulating these plans.
- Occupational health, wellbeing support, and psychological and specialist support should all be made available to staff. To facilitate this, national investment will be provided to roll out mental health hubs in each Integrated Care System (ICS).

Belonging in the NHS and addressing inequalities

This work is highlighted as an urgent priority, which is welcome and necessary but feels underdeveloped, as there are no clear actions or next steps listed. Instead, systems are asked to

develop improvement plans based on recent WRES data (with attention given to recruitment and promotion practices), and to accelerate delivery of model employer goals. NHS Providers will continue to support and share the action which trusts have been taking on this issue.

Embed new ways of working and delivering care

The guidance notes significant changes to ways of working that have been accelerated by the pandemic and gives a steer as to which changes should be embedded going forwards. NHS Providers have also published analysis of this area, which is wider reaching. The guidance focusses on:

- e-rostering, which should be utilised more widely and accompanied by providers demonstrating how they will meet the highest level of attainment in NHSE/I's meaningful use standards for e-job planning and e-rostering
- facilitating the continuation of staff movement within systems with remote working plans, technology-enhanced learning, and utilising staff digital passports.

Regarding staff movement across organisations, our view is that whilst there is a need to avoid command and control, and respect the role of leadership in systems, it would be useful for colleagues at a national level to be sighted overall on emerging risks from this approach. This would enable insight and issues to be shared at the earliest opportunity across systems through regional teams. We are aware of plans for System Quality Groups, which will have a role in identifying risks within a system, but it is not yet clear if they will be responsible for escalating insight upwards and sharing it with other systems. Further detail in this area would be useful.

Grow for the future

The NHS workforce has grown during the pandemic, due to innovative measures to increase staff numbers at pace. The guidance states that this growth needs to be made sustainable and deployed to meet measures set out in the NHS long term plan (LTP). Systems are asked to produce local workforce supply plans, though the guidance does not give a deadline for this work. The plans should cover recruitment and retention, collaboration between organisations, and wider labour participation in health and care system.

Ensuring that there are enough staff to cover existing workforce gaps and build flexibility into the system, is vital to ensure more realistic workloads and better work life balance for staff. However, the ask for systems to develop local workforce supply plans will not be effective without national funding for recruitment and retention initiatives, underpinned by a fully costed and funded national workforce plan. In addition, it is unclear how much weight will be given to the request for system workforce supply plans to support economic recovery, which could transpire to be quite a significant ask.

In addition to local workforce supply plans, the guidance sets out that:

- National investment should be utilised to increase numbers of Maternity Support Workers, and national interventions to bolster Health Care Support Workers and international nursing recruitment should also be engaged with.
- Clinical placement capacity should be planned for as a priority, to help students qualify as close to their intended dates are possible, and postgraduate training recovery plans are to be developed and implemented to integrate local training needs to service delivery. Both of these asks will require collaboration with education bodies and institutions.
- Workforce plans should cover all sectors, and support the expansion and development of integrated teams in the community. The guidance stated that primary care networks (PCNs) will be the foundation for this as they have Additional Roles Reimbursement Scheme funding, which should be utilised widely through the options of rotational or joint employment.

Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19

The COVID-19 vaccine will continue to be delivered through implementing a mixed model of vaccine delivery. This includes vaccination centres, hospital hubs, general practice and community pharmacy capacity. The model will vary depending on the needs of the local population. There will also be targeted approaches where required to drive uptake, particularly in underserved populations. Primary care will continue to play a key part in the roll out of the vaccine, with PCNs having the option to vaccinate those aged between 18 and 49 (cohorts 10-12).

Due to the lack of information about how long protection lasts once somebody has received a vaccine and given the possibility of new variants emerging, the Joint Committee on Vaccination and Immunisation (JCVI) will issue further advice in due course. Systems need to be prepared for a COVID-19 re-vaccination programme from autumn and the possibility of COVID-19 vaccination of children (should vaccines be authorised for use in under 18s and recommended by the JCVI).

PCNs will have an important, ongoing role in response to the pandemic that will involve the use of hospital-led 'virtual wards'. NHSE/I hope that COVID virtual wards may be able to support some COVID patients who would otherwise be admitted to hospital. Furthermore, NHSE/I confirm that national funding to maintain dedicated post-COVID assessment clinics will continue. NHSE/I will also conduct a stocktake of both physical critical care capacity and workforce, which will inform next steps in creating a resilient and sustainable service. This will include critical care transfer services.

NHS organisations are asked to ensure reliable application of the recommendations in the UK Infection Prevention and Control guidance.

Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services

Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services

In order to increase activity across elective inpatient, outpatient and diagnostic services, systems are asked to rapidly draw up delivery plans for the next six months that:

- maximise available physical and workforce capacity: this will range from adapting wards to segregate patients, improving elective care flow, and utilising the independent sector (IS)
- prioritise the clinically most urgent patients
- manage clinical risk by incorporating patient focused reviews and validating waiting lists
- proactively reach out to the clinically most vulnerable;
- provide analysis of waiting times by ethnicity and deprivation;
- safeguard the health and wellbeing of staff, allowing people to recover.

There should be a particular focus on restoring diagnostic activity volumes. Additional capacity and efficiencies should be delivered via community diagnostic hubs, and pathology and imaging networks. Systems should note how they will adhere to the recommendations of the Richards review.

Following the additional £1bn for elective recovery announced at the 2020 Spending Review, the Elective Recovery Fund (ERF) will be made available to systems that achieve activity levels above set thresholds (the levels funded from system envelopes). The threshold is set against a baseline value of all elective activity delivered in 2019/20 – for April 2021 it will be 70%, rising by 5% each month to 85% from July. Further information can be found in the accompanying implementation guidance.

The planning guidance makes it clear that trusts should continue to collaborate with the IS to ensure there is enough capacity across systems to deliver elective recovery plans. More work will be carried out over the next two months to explore how IS capacity can be most effectively utilised.
No specific timelines have been established for systems to restore activity to meet or exceed pre-pandemic levels. However, the guidance states that systems should identify approaches to tackle the backlog and (when feasible) to move beyond the 2019/20 baselines.

Providers are encouraged to demonstrate learning from other systems, and to take advantage of high impact changes and transformation opportunities to increase activity, in particular: clear accountability for elective recovery at system level; implementing high impact service models; implementing whole pathway transformations with support via the National Pathway Improvement Programme; and embedding outpatient transformation.

Restore full operation of cancer services

There is concern for people who have not contacted their GP with symptoms. To address this, systems should draw on advice from their Cancer Alliance to return the number of people waiting longer than 62 days to pre-pandemic levels, and to address the shortfall in the number of first treatments by March 2022.

In terms of operational performance, systems are expected to deliver against the new 28 day faster diagnosis standard from Q3 2021/22, with data being collected and published from Q1. Systems should also focus on improving performance against the existing cancer waiting time standards.

On behalf of their ICS(s), Cancer Alliances must establish delivery plans for April to September 2021 covering the following areas:

- Getting patients to come forward – the guidance recommends providers collaborate with public health commissioning teams to restore all cancer screening: an additional £50m investment has been made available for breast cancer screening, and NHSE/I will begin to extend bowel cancer screening to include 50-60 year olds.
- Investigate and diagnose – providers should extend the centralised clinical prioritisation and hub model to patients on cancer diagnostic pathways (starting with endoscopy where appropriate).
- Treat – embed the collaborative approaches of system working demonstrated throughout the pandemic (like the centralised clinical triage and surgical hubs), and agree personalised stratified follow-up pathways.

Expand and improve mental health services and services for people with a learning disability and/or autism

The guidance recognises how COVID-19 has caused a significant increase in demand for mental health services. NHSE/I has outlined how systems might expand capacity and transform mental health services, and support people with learning disabilities, autism or both.

NHS long term plan commitments on mental health

Systems are expected to meet the mental health ambitions outlined in the LTP, transforming core mental health services, and ensure services can implement the recommendations from the clinical review of standards for mental health. Key expectations include:

- increasing children and young people's access to NHS-funded community mental health services
- delivering physical health checks for people with Serious Mental Illness (SMI), particularly given that the Quality Outcomes Framework (QOF) indicators have changed
- delivering the scale of workforce growth needed to meet the LTP ambitions
- investing fully in community mental health (funding will be provided to create new integrated models for SMI, SDF funding will allow the expansion of services, and co-funding requirements across the NHS contract and GP contract will deliver additional PCN posts. New metrics will also be introduced assessing people who access community mental health services.)
- improving equalities across all programmes, noting actions and resources identified in the *Advancing mental health equalities strategy*.

Providers are also encouraged to advance the beneficial changes made throughout the pandemic, including (where clinically appropriate) 24/7 open access, staff wellbeing hubs, and crisis lines.

An additional £500m was announced at the 2020 Spending Review to address the impact of COVID-19. We welcomed the news last month that £79m will be allocated to children and young people's mental health services, but we still do not know the precise allocations of the total sum going forward.

Learning disabilities and autism

There is a recognised need to deliver the LTP commitments for those with a learning disability, autism or both. There are a range of actions outlined in the guidance, including:

- reducing reliance on inpatient care for adults and children with learning disability, autism or both, supported by improved community capacity to expand personalised care, closer to home
- improving accuracy of GP learning disability registers (with a particular focus on ensuring under-represented groups are recorded)
- continuing pilots and early adopter sites for keyworkers for children and young people with most complex needs
- implementing the actions coming out of the Learning Disability Mortality (death) Review (LeDeR) programme to tackle inequalities.

Deliver improvements in maternity care, including responding to the recommendations of the Ockenden review

This year NHSE/I are committing to improving maternity safety. Their most recent board papers detail a £95m investment to meet the immediate and essential actions from the Ockenden report. The planning guidance stated that this figure would be 'more than £80m', so the £95m amount is extremely welcome. To support this work, local maternity systems (LMSs) will be accountable to ICSs for their safety. LMSs must also oversee the implementation of the seven immediate and essential actions from the Ockenden report across their local trusts.

Systems are asked to continue to strive towards the maternity transformation measures set out in the LTP. This requires a personalised care and support plan to be offered to every woman, implementing the Saving Babies' Lives Care Bundle, and working towards implementing the continuity of carer model of midwifery.

In February, NHS Providers wrote to the Health and Social Care committee, noting that more than £400m is needed in extra annual recurrent funding in order to increase numbers of maternity service staff, in line with the Ockenden report's findings. Whilst a fully costed and funded workforce plan is vital more generally, it is particularly key to improving maternity service safety.

Expanding primary care capacity to improve access, local health outcomes and address health inequalities

Restoring and increasing access to primary care services

The commitment to a significant real-terms expenditure increase on primary and community health services will be met again in 2021/22. It is expected to support:

- restoring and increasing access to primary care services
- implementing health population management and personalised care approaches to improve health outcomes and address health inequalities
- transforming community services and avoiding unnecessary hospital admissions and improving flow, in particular on the emergency pathway.

Systems will be expected to prioritise local investment and support for PCNs to enable stronger integration with community services, helping their PCNs to:

- achieve their share of 15,000 FTE PCN roles to be in place by the end of the financial year, in line with the target of 26,000 by 2023/24
- expand the number of GPs towards the 6,000 target

- continue to make progress towards delivering 50 million more appointments in general practice by 2024.

Systems are also asked to support general practices to improve access for patients, enable all practices to deliver pre-pandemic appointment levels and offer face-to-face consultations. Systems should continue to support practices to increase online consultations, as part of embedding total triage. Systems will be expected to support their PCNs and general practices to work with local communities to address health inequalities. QOF indicators on long term condition management reviews, medication reviews and routine vaccinations will be re-introduced from April 2021.

Implementing population health management and personalised care approaches to improve health outcomes and address health inequalities

Systems are encouraged to adopt population health management techniques as part of their targeted recovery strategies. NHSE/I will work with systems to develop the data tools needed to support this work, applying lessons from the COVID-19 vaccination programme. This includes risk stratification to identify those facing the greatest health inequalities. Systems should provide multi-disciplinary support in line with the NHS comprehensive model for personalised care. More information on tackling health inequalities can be found in the accompanying implementation guidance.

NHSE/I asks systems to develop robust plans for the prevention of ill health, covering both primary and secondary prevention deliverables as outlined in the LTP. Plans should set out how ICS allocations will be deployed in support of the expansion of smoking cessation services, improved uptake of the diabetes prevention programme and cardiovascular disease prevention. Systems should continue and where possible accelerate the delivery of personal health budgets, social prescribing referrals, and personalised care and support plans. Recruitment to three additional roles will support this: social prescribing link workers, health and wellbeing coaches, and care coordinators.

Transforming community and urgent and emergency care to prevent inappropriate attendance at ED improve timely admission to hospital for ED patients and reduce length of stay

Transforming community services and improve discharge

Every system is asked to set out plans to accelerate the roll out of the two-hour crisis community health response at home to provide consistent national cover (8am-8pm, seven days a week) by April 2022.

Community services will welcome confirmation of the continuation of the discharge to assess policy, and will now work towards improving length of hospital stays, with a particular focus on stays of between 14 and 21 days. In light of this, the first six weeks of additional care after discharge from an NHS setting will continue to be funded during the first quarter, and the first four weeks from the beginning of July. This position will be reviewed with government for the second half of the year.

Ensuring the use of NHS 111 as the primary route to access urgent care and the timely admission of patients to hospital who require it from emergency departments

Systems are asked to continue to progress the work already underway through NHS 111 First and Same Day Emergency Care (SDEC) Programmes. Specifically, systems should:

- promote NHS 111 as the primary route into all urgent care
- maximise the use of booked time slots in A&E, with an expectation that at least 70% of all patients referred to an emergency department by NHS 111 receive a booked time slot to attend
- maximise the utilisation of direct referral from NHS 111 to other hospital services (including SDEC and specialty hot clinics) and implement referral pathways from NHS 111 to urgent community and mental health services
- adopt a consistent, expanded, model of SDEC provision, including associated acute frailty services, within all providers with a type 1 emergency department to avoid unnecessary hospital admissions.

To assist the transformation of the urgent and emergency care (UEC) pathway, better understand pressures and monitor recovery, trusts are asked to roll out the Emergency Care Data Set to all services and begin to collect data for a set of new measures tested as part of UEC clinical review of standards. Systems are asked to measure:

- the time to initial assessment for all patients presenting to A&E
- the proportion of patients spending more than 12 hours in A&E from time of arrival
- the proportion of patients spending more than one hour in A&E after they have been declared clinically ready to proceed.

Working collaboratively across systems to deliver on these priorities

Effective collaboration and partnership working across systems

ICSs will be asked to confirm, by the end of Q1, delivery and governance arrangements to support delivery of the 2021/22 priorities. These must be set out in a memorandum of understanding (MoU), agreed with NHSE/I regional teams, and in line with the proposed new NHS system oversight framework. MoUs should also set out the oversight mechanisms and structures that reflect those delivery and governance arrangements, including the respective roles of the ICS and NHSE/I regional team. NHSE/I is currently consulting on the NHS system oversight framework.

Develop local priorities that reflect local circumstances and health inequalities

ICSs are expected to develop their own set of local health and care priorities in recognition of the varying range of circumstances and population health needs, and the challenges systems face in recovering services. These priorities must be aligned to the four primary purposes of an ICS: improving outcomes in population health and healthcare; tackling inequalities in outcomes, experience and access; enhancing productivity and value for money; and helping the NHS support broader social and economic development.

Develop the underpinning digital and data capability to support population-based approaches

The guidance highlights the importance of digital innovation in meeting population needs, including joined-up person-level data across health and care partners, and analytical capability aligned across system partners. More detail will be contained in the forthcoming NHSX what good looks like framework. Systems are asked to commence procurement of a shared care record for a minimum viable product to be live by September, developing further to include wider data sources and use for population health by April 2022.

Develop ICSs as organisations to meet the expectations set out in integrating care

ICSs are expected to take steps during 2021/22 to deliver their four core purposes, and are asked to set out how they will organise themselves to support this through updating their system development plans (detailing how they will ensure their system has the necessary functions, leadership, capabilities and governance), as well as preparing to move to a statutory footing from April 2022, subject to legislation.

Implement ICS-level financial arrangements

NHSE/I will shortly issue system funding envelopes for the next six months. These will be based on the H2 2020/21 envelopes, including a continuation of the system top-up and COVID-19 fixed allocation arrangements. Envelopes will be adjusted to reflect a general efficiency requirement of 0.28%, with an increased requirement for systems that had deficits compared to 2019/20 financial trajectories at the end of 2019/20. The current block contract payments approach will continue for NHS providers. More information can be found in the accompanying finance and contracting guidance.

In addition, systems are asked to continue taking actions to strengthen their system financial governance arrangements and build collaborative plans to optimise system resources.

Process and timetable

ICSs are expected to work across their partner organisations to produce plans that consider alignment between Clinical Commissioning Groups (CCGs) and providers, and between activity, workforce and finances.

Key tasks	Deadline
Templates issued • Non-functional activity, workforce • Narrative	Friday 26 March 2021
System financial planning template and SDF schedules issued	Monday 29 March 2021
Organisation (provider) capital and cash plan submission	Monday 12 April 2021
Finance plan submission • System finance plan submission • Mental health finance submission Draft plan submission deadline • Draft activity, workforce (primary and secondary care) and mental health workforce numerical submission • Draft narrative plan submission	Thursday 6 May 2021
Non-mandated provider organisation finance plan submission	w/b 24 May 2021
Final plan submission deadline • Final activity, workforce and mental health workforce numerical submission • Final narrative plan submission	Thursday 3 June 2021

NHS Providers view

After an incredibly turbulent year, the planning guidance sets out a framework for trusts – and their system partners – to plan for the months ahead with confidence.

Overall, the guidance strikes a balance between ambition and pragmatism. It is absolutely right that supporting staff health and wellbeing is a top priority, and that a realistic approach is being taken to elective recovery, with a clear focus on prioritising the most clinically urgent patients. Trusts will welcome the continued emphasis on collaborative working across primary and secondary care. The extension of COVID-19 finance and contracting arrangements until at least the end of September provides stability, and will give trusts breathing space to focus on the task at hand.

We also welcome acknowledgement of the unique challenges facing different parts of the provider sector. For example, the accelerated roll out of the two-hour crisis community health response standard will help measure progress and provide consistency of care across the country, and the continuation of discharge funding for the first half of the year is vital to reducing length of stay in hospital. The guidance recognises the increasing and new demands on mental health services, stresses the importance of this being adequately prioritised by systems and helpfully emphasises that meeting the Mental Health Investment Standard (MHIS) is a minimum requirement – not a cap. It is, however, disappointing not to see greater recognition of the role that ambulance services have played throughout the pandemic. Patient transport needs to be factored into the overall recovery strategy and ongoing pressure on the acute sector could impact on ambulance handover times. We will continue working with NHSE/I to understand and shape the implications of system working for specialised services.

However, with 17 sub-priorities sitting beneath the six headline priorities, the scale of the task facing trusts and their system partners should not be underestimated. On top of managing pressing operational demands, there is a renewed emphasis on service transformation, in line with the ambitions of the LTP. ICSs are asked to continue strengthening their approach to system finances, confirm delivery and governance arrangements to drive forward the 2021/22 priorities by the end of Q1, and take additional steps to prepare for the possibility of becoming statutory bodies from April 2022 – this has the potential to take up considerable leadership time, particularly for systems still in their infancy. Making meaningful progress on health inequalities is going to require action far above and beyond the next steps set out in the guidance, which focus on data collection and pre-existing prevention programmes.

There are also areas where it is difficult to see how significant progress can be made without additional support and investment. It looks increasingly likely that there will be a COVID-19 re-vaccination programme from the autumn, which needs to be resourced and staffed on a sustainable basis. We are still waiting for a fully costed and funded national workforce plan. The £1.5bn allocated for elective recovery, mental health and workforce development is welcome, but it is only an initial down payment and it will not be effective if it does not reach the frontline quickly. While out of the scope of the guidance, it is impossible to ignore the detrimental impact of prolonged government inaction on public health and social care, which directly affects the NHS.

We support the flexible and iterative approach to planning that NHSE/I is taking this year. This is entirely appropriate given that the full financial settlement for months 7-12 will not be confirmed until

there is greater certainty around the challenges and opportunities going into the second half of 2021/22. What we must avoid is a repeat of the situation seen earlier this month, when the NHS budget was only confirmed 13 days in advance of the new financial year. This kind of uncertainty risks compromising patient care, puts unnecessary pressure on staff and is entirely avoidable.

NHSE/I has maintained an ongoing dialogue with trusts throughout the pandemic. It is imperative that this continues across acute, community, mental health and ambulance services: no one knows exactly what COVID-19 will bring over the next 12 months and additional preparation will be needed heading into winter. There is a real opportunity for NHS to emerge from the pandemic stronger than it was before, if services are restored in a sustainable way.

NHS Providers press release

Planning guidance provides much needed clarity for the year ahead

Responding to the publication of the planning guidance, the deputy chief executive of NHS Providers, Saffron Cordery said:

"The planning guidance provides welcome and much needed clarity for the year ahead. It rightly acknowledges the extraordinary efforts made by trusts and frontline staff in dealing with the pandemic, adapting and innovating to confront COVID-19 while continuing to deliver other essential services.

"It is good to see the approach will place staff wellbeing at the centre of service recovery and transformation. Trusts and their partners are already looking at how they can help staff recover from an unprecedented period of sustained pressure, and will welcome the roll out of 40 mental health hubs.

"Ensuring that we have enough staff not only to cover existing workforce gaps, but to build flexibility into the system, is vital to ensure more realistic workloads and better work life balance. The calls for systems to develop local workforce supply plans will not be effective without national funding for recruitment and retention initiatives, underpinned by a fully costed and funded national workforce plan.

"Trust leaders agree on the need for further progress on equality, diversity and inclusion. However the planning guidance has not listed clear actions or next steps which are fundamental if we are serious about tackling health inequalities nationally and locally.

"We have also welcomed additional funding for elective activity to address the backlog of care created during the pandemic and will work closely with NHS England and NHS Improvement to ensure the funding flows effectively for trusts and patients. We also welcome the additional £95m made available for maternity services.

"We welcome the focus on clinical prioritisation in the guidance to ensure those patients most in need receive timely care, and recognise the need for sustained focus on cancer care and other services. The thresholds set do, to some extent, reflect the difficulties involved in scaling up this work as the threat from COVID-19 persists.

"The guidance highlights the importance of the vaccination programme. It is sensible to plan now for a possible booster campaign and extension of vaccines to children. However the extraordinary success of the programme so far should not disguise the fact that this is a huge logistical commitment which will need to be resourced and staffed on a sustainable basis.

"Similarly it is right to acknowledge the growing impact of long-COVID. The true impact of this is not yet clear, but it is already evident that it will be a major concern for years to come.

"We support the work to avoid unnecessary hospital admissions, which is an important element in steps to ensure a sustainable service. We welcome continued funding for discharges, but would like to see this made permanent to improve capacity for long term planning and to reduce uncertainty.

"We welcome plans to move forward with the roll out of two-hour crisis community health response standards, but it is crucial that funding reaches these services to help with the roll out.

"The additional £500m for mental health services secured last year is of course very welcome, but there is a risk that it is spread too thinly to make the difference people in need of mental health care and support really need, and deserve, to see. While a welcome £79m was allocated to children and young people's mental health services last month, we still do not have complete clarity on exactly where the rest is going to be targeted.

"The planning guidance provides much needed clarity for trusts and their partners for the year ahead. However it is important to remember that funding has only been allocated for the additional costs of COVID-19 for the first half of the year. This will need to be kept under close review as the true costs of the pandemic become clear.

"The operational burden that trusts and local systems are still bearing is huge. The planning guidance rightly seeks to establish priorities, but given the immediate pressures and the big task of recovery, the health and care sector will continue to face considerable challenges for the year to come."

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13th April 2021
Title	2020 National Staff Survey Results
Purpose	To provide the Board with a summary of the results of the 2020 National Staff Survey
Business Area	Workforce
Author	Deputy Chief Executive and Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	The 2020 National Staff Survey results are summarised in the paper. These are the best results the Trust has achieved and puts us at the top of our peer group for Staff Engagement (7.5 score). Alongside a much higher than average response rate of 60% (like 2019), we have achieved statistically significant improvements in themes including health and wellbeing, safety culture, morale, and staff engagement. Considering this was the year of the Covid pandemic, to see above average results in all ten themes of the staff survey is pleasing and positive. As well as top scoring for Staff Engagement, we are strongest in our peer group for Team Working. This is a testament to the collective work of our staff during very difficult times.

	The staff survey results also help us triangulate where we need to improve the experience of our staff, to truly be “Outstanding for Everyone”. Our new People and EDI strategies are focused to the areas that need improving, including and particularly the unwarranted differential experiences of our staff with protected characteristics.
ACTION REQUIRED	The Board is asked to note the update.

NHS
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NHS Foundation Trust

Making Berkshire Healthcare…

Outstanding for everyone

National staff survey results: 2020

CareQuality Commission Inspected and rated Outstanding

Diversity and Inclusion bringing us together

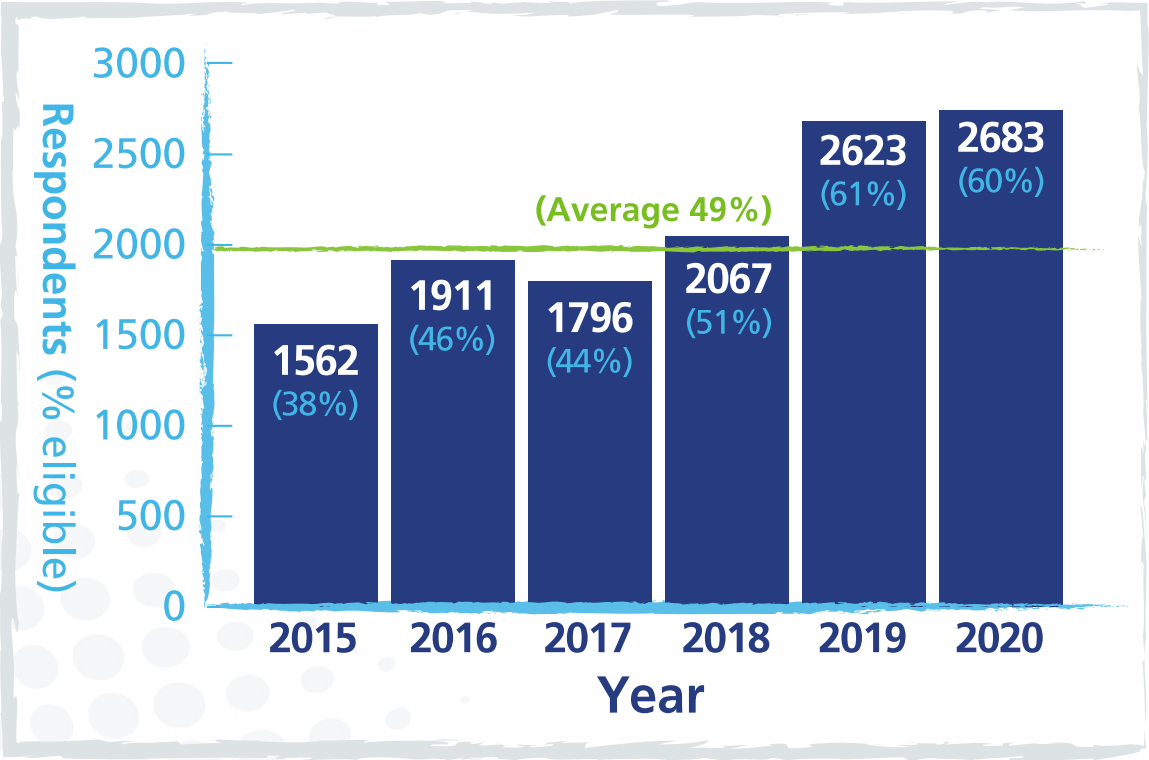
GDE Digital solutions for outstanding healthcare

Alex Gild and Jane Nicholson

National staff survey response rates

- year on year

Berkshire Healthcare NHS Foundation Trust



In 2020 60% of you took the time to tell us what it feels like to work here.

The average response rate for 32 Mental Health / Learning Disability and Community combined Trusts is **49%.**

Although **more staff responded to the survey in 2020,** the total number of staff has increased which means the overall % is slightly lower.

Overall engagement score

Our overall engagement score is 7.5. No other combined Trust has scored higher than this.

*10 being the highest score available.

Overall engagement score
- how it's calculated

Berkshire Healthcare NHS Foundation Trust

The overall staff engagement score is calculated as an average of the three grouped scores on **"Motivation"**, **"Advocacy"** and **"Involvement"**

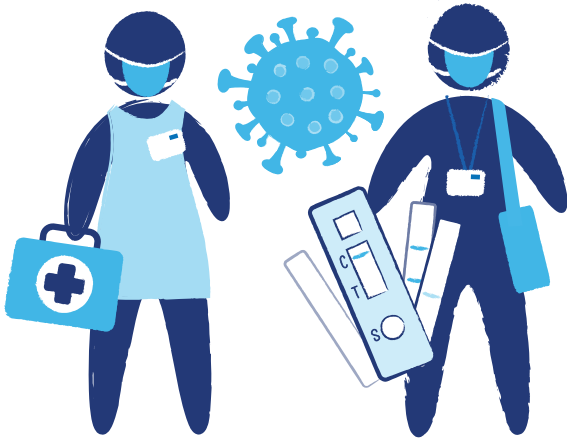
NHS national staff survey			Berkshire Healthcare		
EEI	Qs	Statement	2018	2019	2020
Motivation	2a	Often/always look forward to going to work	63.2	65.8	66
	2b	Often/always enthusiastic about my job	77.8	78.6	78.3
	2c	Time often/always passes quickly when I am working	83.9	82	82.8
Advocacy	18a	Care of patients/service users is organisations top priority	82	83.9	87.7
	18c	Would recommend organisation as a place to work	68	70.4	77.8
	18d	If friends or relatives needed treatment would be happy with the standard of care provided by organisation	73.1	74.4	80.1
Involvement	4a	Opportunities to show initiative in my role	78.1	76.7	78.6
	4b	Able to make suggestions to improve the work of my team/dept	80.6	81.6	81.9
	4d	Able to make improvements happen in my area of work	64.3	65.7	66.5
Response rate	%		51	61	60

2020…
Working with COVID-19

NHS
Berkshire Healthcare
NHS Foundation Trust

2020 was the start of a very difficult year as we faced the COVID-19 pandemic. To better understand how you have felt through the experience we asked two specific questions…

1) **Thinking about your experience of working through the COVID-19 pandemic,** what lessons should be learned from this time?
2) **What worked well during COVID-19** and should be continued?



We've added in a few of your thoughts but more detailed work to analyse the responses will follow.

Working with COVID-19…
your responses

NHS
Berkshire Healthcare
NHS Foundation Trust

Regular Trust briefings by senior management

Working from home can be very **isolating**, particularly for those who **live alone**.

The initial response to the lockdown was one of camaraderie

Multiagency meetings work well online and make better use of time and resources

Having video appointments as part of the offer to families

Working from home and flexibility in working hours

Online meetings instead of asking staff to travel all over the place to attend these in person.

Maintaining regular contact with team members

That we are able to offer our services **remotely** in a lot of cases and that we should be open to such **flexible working**

To be more kind to each other and look after our Mental health

Staff survey results - themes

Survey Coordination Centre

2020 NHS Staff Survey Results > Theme results > Overview

NHS England

NHS Berkshire Healthcare NHS Foundation Trust

	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.1	6.5	7.5	6.7	7.6	8.4	9.6	7.3	7.5	7.4
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	2,615	2,624	2,631	2,598	2,306	2,522	2,615	2,609	2,651	2,633

The **ten themes** from the survey give a high level overview of the results. This year our scores have improved and are **above average** for combined Trusts in **all ten themes** and the **best** for two themes out of the ten.

Our **highest scoring themes** of **2020**

Berkshire Healthcare NHS Foundation Trust

The chart below shows us which themes scored significantly higher in 2020 in comparison to 2019, indicating that there is some great work being done with **health & wellbeing**, **morale, safety culture** and staff **engagement.**

Theme	2019 score	2020 score
Equality, diversity and inclusion	9.0	9.1
Health and wellbeing	6.2	6.5 ↑
Immediate managers	7.4	7.5
Morale	6.4	6.7 ↑
Quality of care	7.5	7.6
Safe environment - Bullying and harassment	8.3	8.4
Safe environment - Violence	9.6	9.6
Safety culture	7.2	7.3 ↑
Staff engagement	7.4	7.5 ↑
Team working	7.3	7.4

The ↑ indicates which theme has scored significantly higher in 2020 in comparison to 2019.

There's plenty to feel proud about…

		Average	Our Score
NSS Questions	Do you feel trusted to do your job?	90%	91%
	Do you feel that your immediate manager values your work?	79%	81%
	Do you feel that communication between senior management and staff is effective?	47.9%	60%
	Do you feel that you are involved in deciding on changes introduced that affect your work area / team / department	54%	61%
	Do you feel that the organisation acts fairly regarding career progression?	83%	89%
	Do of you feel that when errors, near misses or incidents are reported, Berkshire Healthcare takes action to ensure that they do not happen again?	73%	82%
	Would you recommend Berkshire Healthcare as a place to work?	66%	78%
Picker	Opportunities to show initiative frequently	75%	79%
	Able to make suggestions to improve the work of my team	78%	82%
	Involved in deciding changes that effect work	54%	61%
	Able to make improvements happen in my area of work	60%	67%

NHS
Berkshire Healthcare
NHS Foundation Trust

We scored above the national average on all of these questions.

The QI Programme is making a big difference…
four of our results reported as the **best experience** in comparison to **all** mental health & learning disability trusts working with **Picker,** our survey provider this year.

Picker

Quality Improvement programme

There's still work to do…

When we look at the data from the survey, and look at how we're doing compared to other combined Trusts, and others in our region, we can see that the key areas for improvement are:

- **Equality, diversity and inclusion / Safe working environment**
- **Health and wellbeing of our people**
  - **30% have experienced MSK problems as a result of work activities**
- **Work pressures and workload**
  - **66% of people work additional unpaid hours per week for this organisation, over and above contracted hours**

Focus on… Equality, diversity and inclusion

NHS
Berkshire Healthcare
Diversity and Inclusion

It's great to see we're still making progress with equality, diversity and inclusion, but this doesn't mean we can become complacent.

Our WRES and WDES data continues to show that our BAME and disabled staff have a **disproportionate experience of bullying and harassment** in comparison to their white and non-disabled colleagues.

It's important we retain our diverse workforce and **eliminate the differentials** that some of our people experience. This will continue to be the focus of our work as there are still pockets of inequalities affecting our people with protected characteristics.

Sexual orientation

NHS
Berkshire Healthcare
Diversity and Inclusion

In 2020 we relaunched our Pride network, and we're delighted that membership of this network has continued to grow. **Our aim is to ensure that the voices of the whole LGBT community are represented, and feel able to bring their whole self to work and feel accepted.**

We know there's some work to do to understand why **not everyone feels comfortable and willing** to disclose their sexual orientation.

	ESR	NSS
Staff that identified as heterosexual	**84.25%**	**89.3%**
Staff that identified as LGBT+ (On ESR staff could select LGBT+ compared to the NSS where staff selected Lesbian, Gay, Bisexual)	**2.88%**	**4.5%**
Other / prefer not to say / not stated	**12.88%**	**7.7%**

Workforce Race Equality Standard (WRES)

NHS
Berkshire Healthcare
Diversity and Inclusion

The experience of our BAME colleagues is not always positive, and this is not acceptable.

Question		2019	2020
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	White	22%	20%
	BAME	30%	**31%**
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	15%	18%
	BAME	20%	**23%**
Percentage believing that the trust provides equal opportunities for career progression or promotion	White	91%	92%
	BAME	76%	**78%**
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager / team leader or other colleagues	White	6%	5%
	BAME	13%	**12%**

BAME Network
Together we can be the change

In 2020, our BAME network went from strength-to-strength, supporting its members regarding COVID and sharing concerns raised regarding the vaccination programme and contributing to the **BAME transformation project.**

Workforce Disability Equality Standard (WDES)

NHS
Berkshire Healthcare
Diversity and Inclusion

The experience of our disabled colleagues is not always positive, and this is not acceptable.

Question		2019	2020
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Non-disabled	23.1%	20.3%
	Disabled	**30.2%**	**30%**
Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	Non-disabled	14.4%	13.3%
	Disabled	**23.2%**	**21.2%**
Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion	Non-disabled	87.7%	84.1%
	Disabled	**85.8%**	**90%**
Percentage of staff satisfied with the extent to which their organisation values their work	Non-disabled	61.1%	66.5%
	Disabled	**53.8%**	**55.2%**
Percentage of disabled staff saying their employer has made adequate adjustment(s) to enable them to carry out their work	**Disabled**	**74.6%**	**77%**

PURPLE Network

In 2020 our Purple network continued to support staff with disabilities and those with caring responsibilities.

Together with our Purple network we launched a new **Reasonable Adjustments Policy** to support colleagues with disabilities.

Equality, diversity and inclusion -

NHS
Berkshire Healthcare
Diversity and Inclusion

So what are we doing?

Our **new EDI strategy** addresses the differentials of experience seen in the survey.

Some of the workstreams to achieve the ambitions in our strategy include:

- ✓ **BAME transformation programme** (3 workstreams) to reduce bullying, harassment and micro-aggressions, career progression and disciplinaries and grievances
- ✓ Joint work between colleagues to improve the experience of our staff at PPH where there is the highest reported incidence of race related abuse and hate crimes
- ✓ Developing programme to support better understanding of **reasonable adjustments** and the implementation of the new policy for our disabled people which will reduce their experience of bullying and harassment
- ✓ Roll out of our **'ready for change' programme** to support leaders and managers to create a culture of inclusion and belonging

Diversity and Inclusion
Bringing us together

Our strategy will address the **differentials in experience** at all levels of the organisation and **support the development** of allies of this culture change over the next three years.

This will lead to:

- Improved staff and patient satisfaction
- Good health outcomes
- Everyone feeling they are valued and have a voice

Focus on… health and wellbeing and making this a safe place to work

Berkshire Healthcare NHS Foundation Trust

We've made great progress since 2019 supporting our people but we want to further improve health & wellbeing and making this a safe environment for our people to work in.

Question	Average	Our Score
In the last three months have you come to work despite feeling not well enough to perform your duties?	45.6%	43.6%
Have you experienced musculoskeletal (MSK) problems as a result of work related activities?	26.9%	30%
Have you experienced harassment, bullying or abuse from other colleagues?	15.5%	15.6%

Focus on… work pressures

Berkshire Healthcare NHS Foundation Trust

Some of our lowest scores were related to workplace pressures experienced by staff. These scores tell us we need to continue focus on recruitment and retention, as well as looking at how we can balance operational pressures.

We want to work with you to identify ways that we can improve this, so will be supporting teams to make **reducing work pressures** a priority.

Question	Average	Our Score
Do you work additional unpaid hours over and above your contracted hours?	60.6%	65.9%
Have you felt pressure from colleagues to come to work when unwell?	18.3%	18.2%
Do you experience unrealistic time pressures?	26.9%	25.4%

Health and wellbeing and work pressures -

So what are we doing?

Berkshire Healthcare NHS Foundation Trust

Our **new people strategy** keeps the wellbeing of our people firmly at the centre of our organisational culture.

We've made huge improvements, but there's still work to be done. Some of the workstreams to achieve the ambitions in our strategy include:

- ✓ Continuing to focus on **improving staff experience** to ensure our new starters want to stay
- ✓ A detailed review of the number of people working additional unpaid hours and how we can **reduce those work pressures.** One of our key areas will be reducing gaps in our workplace by **retaining our people**
- ✓ Developing extra support for our people, including introducing **annual wellbeing assessments** and **wellbeing check in's** as part of our appraisals
- ✓ **Wellbeing hubs** that focus on building resilience and providing rapid **psychological support** for our people
- ✓ Offering training and better support to line managers so that they know how to make **reasonable adjustments** that enable colleagues to perform at their best

Next steps…

NHS
Berkshire Healthcare
NHS Foundation Trust

Over the next few weeks, we're going to be looking at the results alongside our **new People** and **Equality and Diversity Strategies** and having discussions and workshops about what they mean and what improvements we need to make as a result.

We want to involve you in these discussions, there'll be opportunities for some of you to take part in focus groups.

We're also going to be talking to the **staff networks** and having discussions with the **Board**.

Review the results with your team:

A link to our results page on **nhsstaffsurveyresults.com** will become available on **Thursday 11 March 2021** – we will update this presentation on Nexus and provide a reminder in Team Brief the following week.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13th April 2021
Title	Financial Summary Report – M11 2020/21
Purpose	To provide the Trust Board, the Month 11 2020/21 financial position and latest YE forecast.
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 / Diversity Implications	N/A
SUMMARY	To provide the Trust Board, the Month 11 2020/21 financial position and latest Year End forecast.

ACTION REQUIRED

The Board is invited to note the following:

The Trust is reporting a £0.3m surplus YTD, £1.9m better than planned.

The latest YE forecast is below, including assessment of the allowable items omitted from system targets:

	£'000 Actual	£'000 Plan	£'000 Var
YE Forecast			
YTD Operational Surplus M11	(544)		
M12 Forecast Run Rate Surplus	156		
Bank Annual Leave Increase	(250)		
Asset Impairment	(2,100)		
NHSE CAMHS Transitional Funding	750		
ERS Pensions Cost Increase	8,461		
ERS Pensions Cost Increase Funding	(8,461)		
Impact of PPE Stock Accounting	0		
BOB Sytem Allocation	0		
Planned Balance Sheet Movement	(653)		
YE Forecast (Deficit) ex-COVID/Support	**(2,641)**	**(6,494)**	**3,852**
Deficit Support Funding	3,374		
M12 Support Funding	469		
YE Forecast Deficit Support	**3,843**	**3,842**	**1**
YTD COVID Deficit M11	(2,538)		
M12 COVID Costs	(835)		
M12 Covid Funding	509		
Additional COVID Funding BOB ICS	2,000		
YE Forecast COVID Surplus / (Deficit)	**(865)**	**(582)**	**(282)**
YE Forecast Reportable Surplus / (Deficit)	**337**	**(3,234)**	**3,571**
Allowable Items for Control Total			
Annual Leave Provision	1,700		
Annual Leave Provision Funding	(1,700)		
Other Income Loss Funding	180		
ERS Pensions Cost Increase	(8,461)		
ERS Pensions Cost Increase Funding	8,461		
Impairments (AME)	1,287		
Other Allowables	59		
Surplus after Allowable Items	**1,863**	**(3,234)**	**5,097**

This has given rise to a materially higher cash balance that planned of £39m, with the key movements from originally anticipated below:

Initial Closing Cash Forecast	25.40
- I&E movement	3.00
- Annual Leave Accrual Funding	2.30
- Capital Expenditure Underspend	0.80
- PDC Funding	0.60
- Working Balance Movement	2.00
- Deferred income	4.80
Adjusted Cash Forecast	**38.90**

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2020/21

February 2021

Purpose

To provide the Board & Executive with a summary of the Trusts financial performance for the period ending 31st January 2021.

Version	*Date*	*Author*	*Comments*
1.0	15/03/2021	Paul Gray	Final
2.0	01/04/21	Paul Gray	Revised Cash and I&E Forecasts

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Income & Expenditure

M11 Feb 2020	In Month Act £'m	In Month Plan £'m	In Month Var £'m	M7 - M11 YTD Act £'m	M7 - M11 YTD Plan £'m	M7 - M11 YTD Var £'m	PY Plan £'m
Operating Income	20.8	21.3	(0.5)	108.7	106.5	2.2	122.1
Other Income	3.1	1.4	1.7	7.9	6.9	1.0	13.9
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	***23.9***	***22.7***	***1.2***	***116.6***	***113.3***	***3.3***	***136.1***
Staff In Post	15.6	15.6	(0.0)	76.9	77.8	(0.9)	93.3
Annual Leave Provision	0.0	0.0	0.0	0.0	0.0	0.0	1.4
Bank Spend	1.4	1.2	0.2	6.9	6.2	0.7	7.6
Agency Spend	0.3	0.3	0.0	1.8	1.4	0.3	1.7
Total Pay	***17.3***	***17.1***	***0.2***	***85.6***	***85.4***	***0.2***	***104.0***
Purchase of Healthcare	1.1	1.2	(0.1)	6.5	5.9	0.6	7.1
Drugs	0.5	0.5	(0.0)	2.2	2.4	(0.3)	2.9
Premises	1.3	1.5	(0.2)	6.7	7.2	(0.5)	8.7
Other Non Pay	1.5	1.6	(0.1)	8.0	7.8	0.2	9.2
PFI Lease	0.4	0.6	(0.1)	2.5	2.8	(0.3)	3.4
Total Non Pay	***4.8***	***5.3***	***(0.5)***	***26.0***	***26.3***	***(0.3)***	***31.3***
Total Operating Costs	***22.1***	***22.4***	***(0.3)***	***111.5***	***111.7***	***(0.1)***	***135.3***
EBITDA	***1.8***	***0.3***	***1.5***	***5.1***	***1.7***	***3.4***	***0.7***
Interest (Net)	0.3	0.3	(0.0)	1.6	1.6	(0.0)	1.9
Depreciation	0.7	0.7	(0.0)	3.3	3.4	(0.1)	4.1
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairments	0.0	0.0	0.0	0.3	0.0	0.3	0.0
PDC	0.1	0.1	(0.0)	(0.1)	0.6	(0.7)	0.7
Total Finanacing	***1.1***	***1.1***	***(0.0)***	***5.1***	***5.6***	***(0.5)***	***6.7***
(Deficit) Pre COVID & Support	***0.7***	***(0.8)***	***1.5***	***(0.0)***	***(3.9)***	***3.9***	***(6.0)***
COVID Income	0.1	0.0	0.1	0.3	0.0	0.3	0.0
COVID Pay Costs	0.8	0.4	0.4	2.5	1.8	0.7	2.0
COVID Non Pay Costs	0.6	0.1	0.5	2.0	0.5	1.6	0.8
Total COVID Costs	***1.2***	***0.5***	***0.8***	***4.3***	***2.3***	***2.0***	***2.8***
System COVID Funding	0.5	0.5	0.0	2.3	2.3	0.0	2.8
System Top Up Funding	0.5	0.5	0.0	2.3	2.3	0.0	2.8
Total Revenue Support	***0.9***	***0.9***	***0.0***	***4.6***	***4.6***	***0.0***	***5.6***
Reported Surplus/ (Deficit)	***0.4***	***(0.3)***	***0.7***	***0.3***	***(1.6)***	***1.9***	***(3.2)***

Key Messages

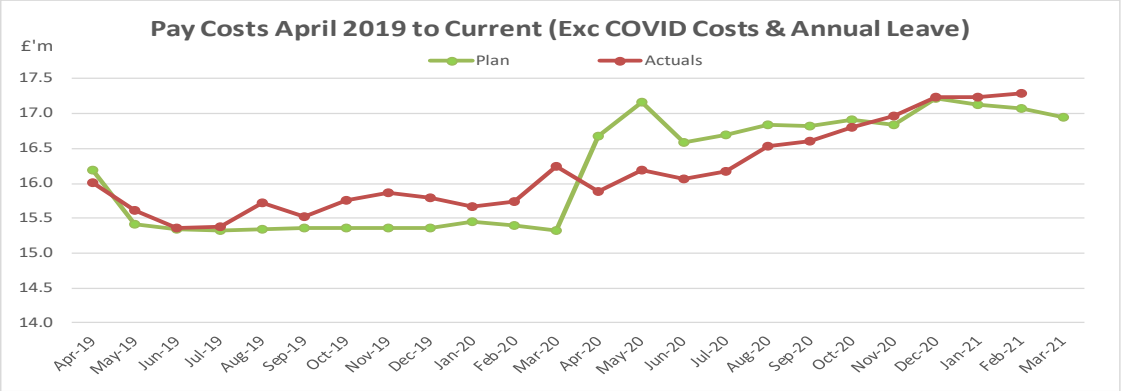
The table above illustrates financial performance against the forecast submitted to NHSI for Q3 and Q4. A consolidated YTD Income Statement can be found on Page 7.

Pre COVID and deficit support, the reported a surplus of £0.7m, moving the finances to breakeven YTD and £3.9m better than forecast.

Monthly COVID costs held at £1.2m taking net costs in the second half of the year to £4.3m, £2.0m higher than planned. Costs remain focused in the following areas; OAPs usage above our historic baseline, sickness and shielding cover, NHSP enhanced rates, enhances service models within WestCall, Phlebotomy and 7 day working in the East. Given the system and patient benefits, some of these initiative are expected to continue into the new year, for which on-going COVID support funding will need to be identified.

Overall the Trust posted a monthly surplus of £0.4m surplus, taking the Trust into surplus YTD at £0.3m. This is £1.9m better than forecast YTD.

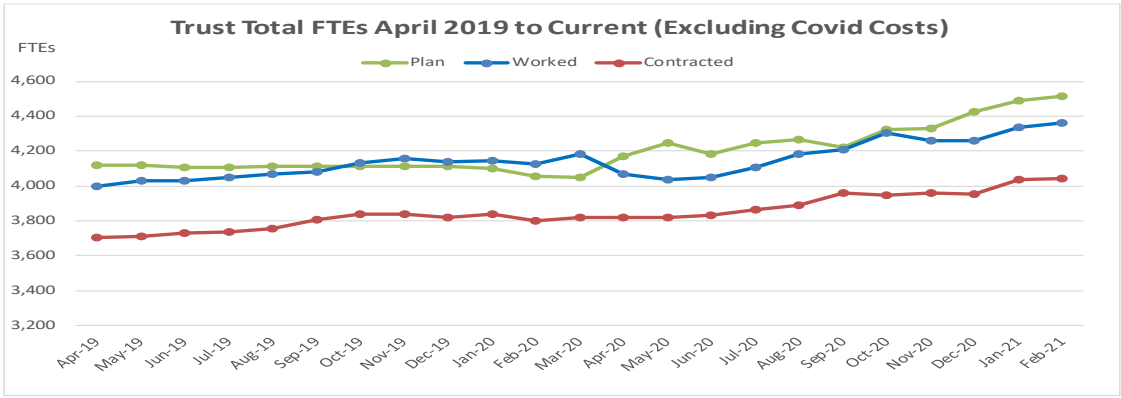
Workforce



Staff Costs

YTD	£'m
2020/21	183.0
2019/20	172.4
▲	6%

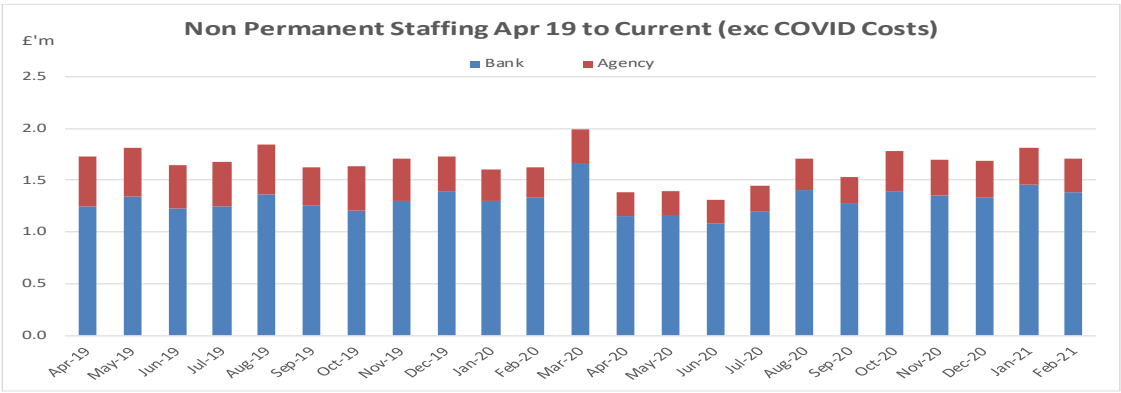
Prior Yr	£'m
Feb-21	17.3
Feb-20	15.7
▲	10%



FTEs

Prior Mth	CFTE	WFTE
Feb-21	4,043	4,362
Jan-21	4,034	4,338
	0% ▲	1% ▼

Prior Yr	CFTE	WFTE
Feb-21	4,043	4,362
Feb-20	3,802	4,124
	6% ▲	6% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2020/21	14.2	3.3
2019/20	14.2	4.4
	0% ▼	-26% ▼

Prior Yr	Bank £'m	Agency £'m
Feb-21	1.4	0.3
Feb-20	1.3	0.3
	3% ▲	15% ▲

Key Messages

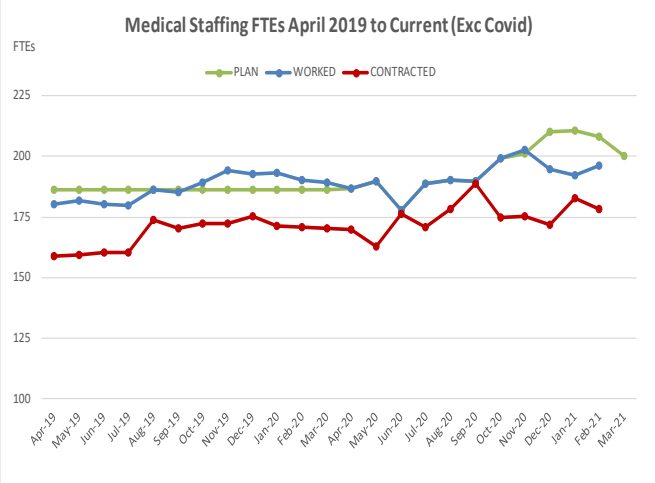
Overall Pay costs rose £0.1m with COVID related costs holding at January's level. The increase this month is attributed to backdated pay award for salaried GP within the WestCall service amounting to £0.2m. Excluding this underlying pay costs reduced by £0.1m.

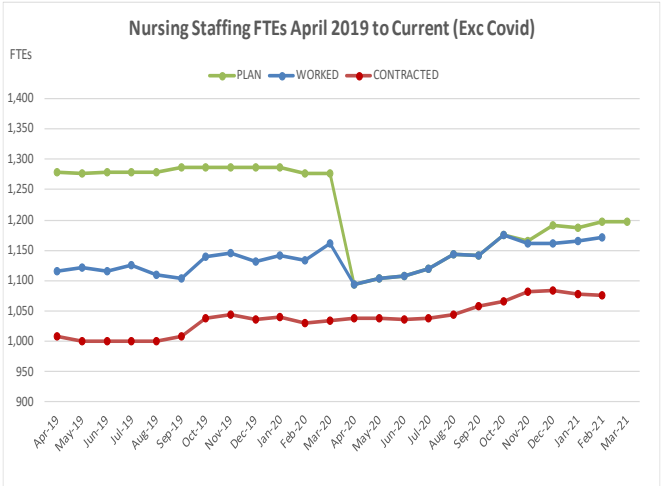
Non COVID related Costs were £0.2m higher than planned and take YTD costs £0.2m above forecast. Substantive recruitment is £0.9m below expectation, although offset by £1.1m of temporary staffing costs. This is due in part to temporary staffing being employed against non recurrent funding allocations for MH Discharge and Winter pressures amongst other. Overall contract numbers rose by 9.

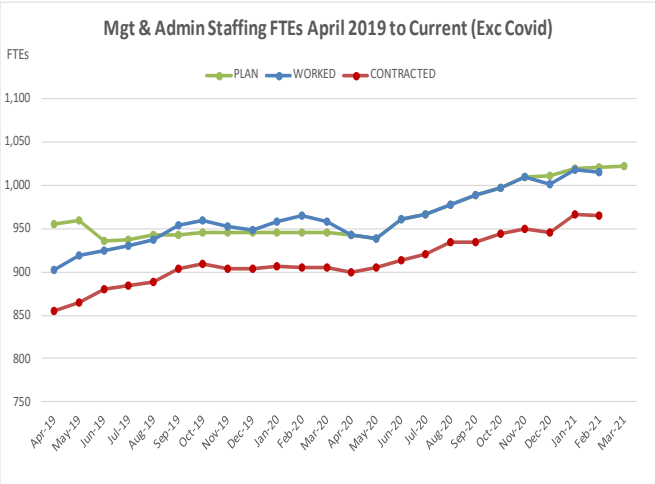
Aside from COVID usage, non permanent staffing costs fell with a £0.1m in bank usage across PPH. All other areas reporting usage in line with previous months.

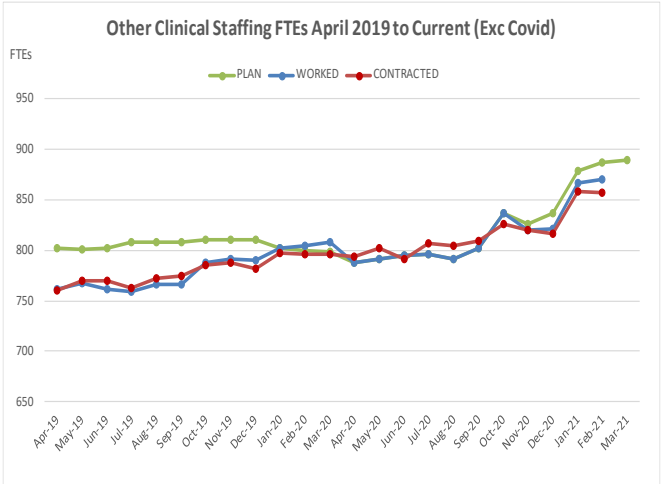
Marginal COVID costs were £0.8m. Whilst the cost of sickness and shielding cover reduced, February include a full month of NHSP shifts being paid at previously increased rates which added £0.3m to shift prices and offset other reductions.

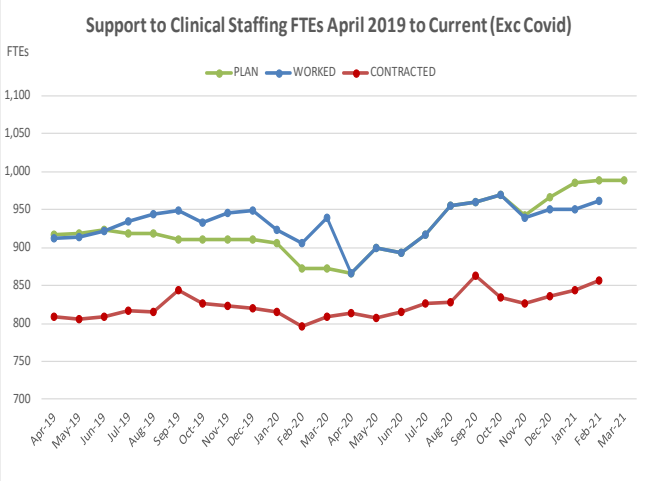
Staffing Detailed

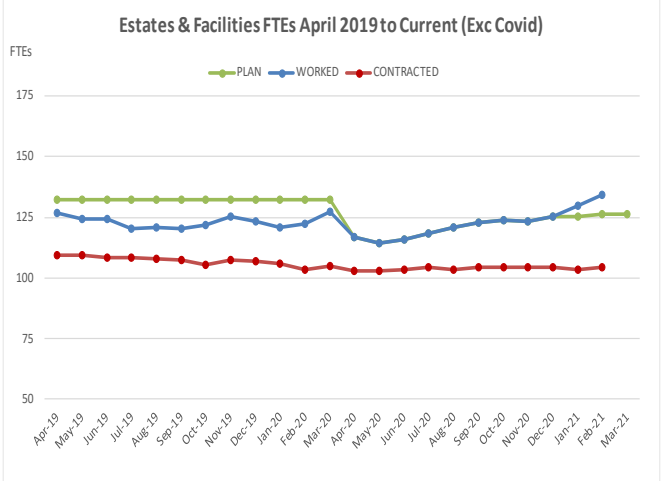










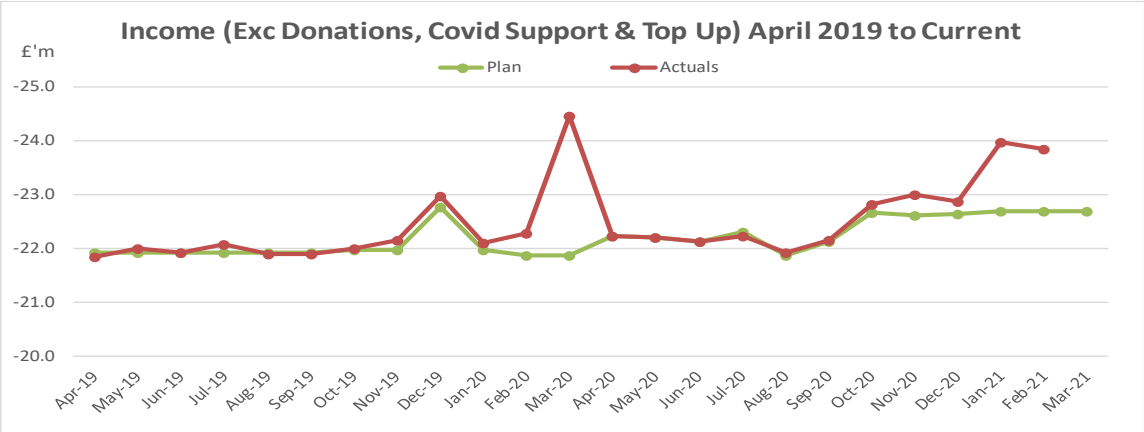


Key Messages

The tables below provide a current staffing number broken down by major staffing groups. The planned levels reflects the revised planning assumptions for this year emphasises plans based on forecast actuals.

With the exception of Estates and Facilities staffing, and despite the pandemic, all staff groups have seen an increase in contracted number s during the year. Increases have been higher in the final two quarters following the agreement of revised block contracts with commissioners unlocking MH investments, as well as continued recruitment to investments such as Ageing Well and Frimley MHICs development.

Income & Non Pay



Income

YTD	£'m
2020/21	249.5
2019/20	243.2
▲	3%

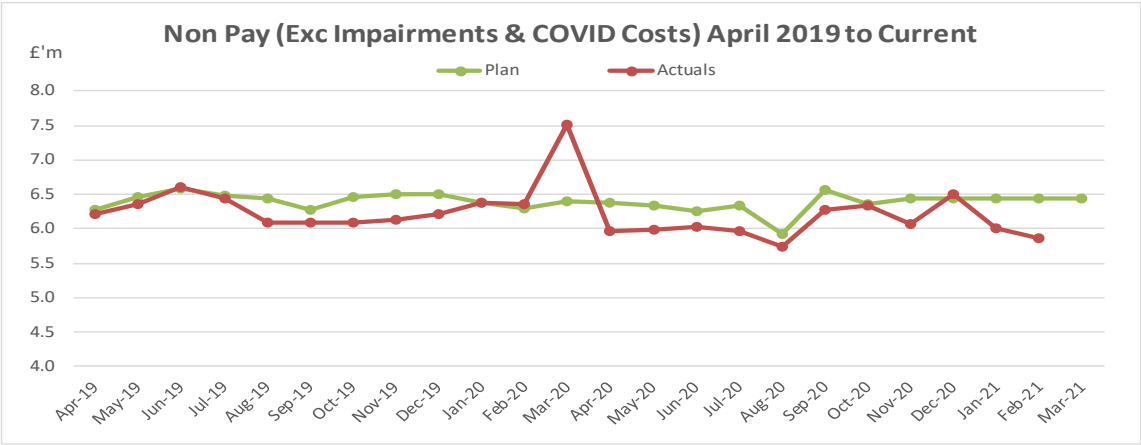
Prior Yr	£'m
Feb-21	23.8
Feb-20	22.3
▲	7%

Key Messages

Although income reduced in February, it remained at a significantly higher rate than originally forecast. Monthly income was £1.3m higher than on forecast, increased the YTD variance to £3.3m.

The Trust continuing to benefit from Ageing Well and other allocations notified after the submission of the mid-year plan. The £0.7m reduction in income resulting from last months reconciliation of Ageing Well, MH Discharge and prior year CCG income, was partially offset by £0.3m from NHSE aligning to revised block allocations, and £0.2m from DHSC to offset non-NHS income losses during the pandemic.

Income is expected to increase next month with addition system allocations and NHSE funding for CAMHS Tier 4 transition.



Non Pay

YTD	£'m
2020/21	67.0
2019/20	69.0
▼	-3%

Prior Yr	£'m
Feb-21	5.9
Feb-20	6.4
▼	-8%

Key Messages

Spend YTD is £0.8m below forecast, with PDC benefit accounting for £0.7m and £0.3m underspend on operational expenditure, being reduced by impairments costs of £0.3m.

After adjusting for £0.4m of PDC benefit and impairment costs booked last month and a £0.2m YTD reduction to accrued placement costs, Non Pay costs were in line with the average over the past quarter.

In recent weeks the number of OAPs has reduced and this is expected to drive a reduction in COVID spend in March. The number and longevity of placements into the new year will continue to be underlying financial pressure which the Trust must remain vigilant of given the reliance of COVID funding to absorb these costs.

Despite the increase in placement costs over the year and planned investments, YTD Non Pay costs are £2.0m below those incurred in 19/20, highlighting the impact of our current operating model and its financial benefits.

Consolidated YTD Financial Performance

	M01 - M06 YTD			M7 - M11 YTD			Consolidated YTD			FY
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	126.4	124.5	1.8	108.7	106.5	2.2	235.0	231.0	4.1	246.7
Other Income	6.5	8.4	(1.9)	7.9	6.9	1.0	14.4	15.3	(0.8)	22.3
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**132.9**	**132.9**	***(0.0)***	**116.6**	**113.3**	***3.3***	**249.5**	**246.3**	***3.3***	**269.0**
Staff In Post	88.7	90.1	(1.4)	76.9	77.8	(0.9)	165.5	167.8	(2.3)	183.4
Annual Leave Provision	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4
Bank Spend	7.3	5.5	1.7	6.9	6.2	0.7	14.2	11.8	2.4	13.1
Agency Spend	1.5	1.8	(0.3)	1.8	1.4	0.3	3.3	3.2	0.1	3.5
Total Pay	***97.4***	***97.4***	***0.1***	***85.6***	***85.4***	***0.2***	***183.0***	***182.8***	***0.2***	***201.4***
Purchase of Healthcare	6.9	7.1	(0.2)	6.5	5.9	0.6	13.4	13.1	0.4	14.3
Drugs	2.5	2.5	0.0	2.2	2.4	(0.3)	4.7	5.0	(0.3)	5.4
Premises	8.0	8.5	(0.6)	6.7	7.2	(0.5)	14.7	15.8	(1.1)	17.2
Other Non Pay	8.5	7.7	0.7	8.0	7.8	0.2	16.5	15.6	0.9	16.9
PFI Lease	3.3	3.3	0.0	2.5	2.8	(0.3)	5.8	6.2	(0.3)	6.7
Total Non Pay	***29.2***	***29.3***	***(0.1)***	***26.0***	***26.3***	***(0.3)***	***55.2***	***55.5***	***(0.4)***	***60.6***
Total Operating Costs	***126.6***	***126.6***	***(0.0)***	***111.5***	***111.7***	***(0.1)***	***238.2***	***238.3***	***(0.1)***	***262.0***
EBITDA	***6.3***	***6.3***	***(0.0)***	***5.1***	***1.7***	***3.4***	***11.4***	***8.0***	***3.4***	***7.0***
Interest (Net)	1.9	1.9	0.0	1.6	1.6	(0.0)	3.5	3.5	0.0	3.9
Depreciation	3.9	3.9	(0.0)	3.3	3.4	(0.1)	7.2	7.4	(0.1)	8.1
Disposals	(0.0)	0.0	(0.0)	0.0	0.0	0.0	(0.0)	0.0	(0.0)	0.0
Impairments	0.0	0.0	0.0	0.3	0.0	0.3	0.3	0.0	0.3	0.0
PDC	0.9	0.9	0.0	(0.1)	0.6	(0.7)	0.8	1.5	(0.7)	1.6
Total Finanacing	***6.7***	***6.8***	***(0.0)***	***5.1***	***5.6***	***(0.5)***	***11.9***	***12.4***	***(0.5)***	***13.5***
(Deficit) Pre COVID & Support	***(0.5)***	***(0.5)***	***0.0***	***(0.0)***	***(3.9)***	***3.9***	***(0.5)***	***(4.4)***	***3.9***	***(6.5)***
COVID Income	0.0	0.0	0.0	0.3	0.0	0.3	0.3	0.0	0.3	0.0
COVID Pay Costs	3.4	3.4	0.0	2.5	1.8	0.7	5.9	5.2	0.7	5.4
COVID Non Pay Costs	1.8	1.8	0.0	2.0	0.5	1.6	3.8	2.2	1.6	2.6
Total COVID Costs	***5.2***	***5.2***	***0.0***	***4.3***	***2.3***	***2.3***	***9.4***	***7.4***	***2.0***	***7.9***
COVID Funding	4.6	4.6	0.0	2.3	2.3	0.0	6.9	6.9	0.0	7.4
Top Up Funding	1.0	1.0	0.0	2.3	2.3	0.0	3.4	3.4	0.0	3.8
Total Revenue Support	***5.6***	***5.6***	***0.0***	***4.6***	***4.6***	***0.0***	***10.2***	***10.2***	***0.0***	***11.2***
Reported Surplus/ (Deficit)	***(0.0)***	***(0.0)***	***(0.0)***	***0.3***	***(1.6)***	***1.6***	***0.3***	***(1.6)***	***1.9***	***(3.2)***

Key Messages

The table above represents financial performance against the revised forecast submitted to NHSE/I.

The table illustrates performance under the two separate financial regimes that have operated this year. Q1 and Q2 being the original interim financial regime under which support was provided to ensure financial breakeven. Q3 and Q4 which reflects the current regime, where the plan is based upon our recent forecast submission.

To note the plan present in the table for Q1 and Q2, reflects a revised plan from NHSI with the plan aligning breakeven and not the original £1.1m surplus assumed in the first iteration in April. This allows greater transparency over the £6.5m pre support deficit, excluding the impact of COVID.

Update on 20/21 YE Forecast

YE Forecast	£'000 Actual	£'000 Plan	£'000 Var
YTD Operational Surplus M11	(544)		
M12 Forecast Run Rate Surplus	156		
Bank Annual Leave Increase	(250)		
Asset Impairment	(2,100)		
NHSE CAMHS Transitional Funding	750		
ERS Pensions Cost Increase	8,461		
ERS Pensions Cost Increase Funding	(8,461)		
Impact of PPE Stock Accounting	0		
BOB Sytem Allocation	0		
Planned Balance Sheet Movement	(653)		
YE Forecast (Deficit) ex-COVID/Support	**(2,641)**	**(6,494)**	**3,852**
Deficit Support Funding	3,374		
M12 Support Funding	469		
YE Forecast Deficit Support	**3,843**	**3,842**	**1**
YTD COVID Deficit M11	(2,538)		
M12 COVID Costs	(835)		
M12 Covid Funding	509		
Additional COVID Funding BOB ICS	2,000		
YE Forecast COVID Surplus / (Deficit)	**(865)**	**(582)**	**(282)**
YE Forecast Reportable Surplus / (Deficit)	**337**	**(3,234)**	**3,571**
Allowable Items for Control Total			
Annual Leave Provision	1,700		
Annual Leave Provision Funding	(1,700)		
Other Income Loss Funding	180		
ERS Pensions Cost Increase	(8,461)		
ERS Pensions Cost Increase Funding	8,461		
Impairments (AME)	1,287		
Other Allowables	59		
Surplus after Allowable Items	**1,863**	**(3,234)**	**5,097**

Key Messages

The table above represent our latest view of the forecast for 20/21 YE.

Even given the proximity to the YE, there remains a number of unknowns for which guidance is anticipated, and which could yet still alter our forecast. Our financial performance will be better than planned and previously communicate to the Board. It is expected that results in March will continue to deliver an underlying surplus and that the Covid costs are expected to reduce.

The forecast is further expected to move for the following reasons:

- BOB ICS allocating an additional £2.0m in COVID funding above planned levels.
- Underlying costs continuing to be lower than anticipated in our forecast.
- NHSE providing £0.75m Implementation funding for the new CAMHS Tier 4 Community model.

There remains further items where national guidance is awaiting in respect of accounting treatments which could further impact the forecast. The key items being:

- Flowers Provisions, arising from legal challenge around overtime not being used in the calculation of holiday payments, is the subject of ongoing discussions as to the value and whether it is to be included in provider accounts.
- PPE where there is an expectation providers will include all 'PPE Push Stock' within their accounts.

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	5.0	5.7	(0.7)	5.0	5.7	(0.7)	5.7
Property, Plant & Equipment (non PFI)	37.5	38.0	38.2	(0.2)	38.0	38.2	(0.2)	38.2
Property, Plant & Equipment (PFI)	57.3	57.3	57.5	(0.2)	57.3	57.5	(0.2)	57.7
Total Non Current Assets	**102.7**	**100.4**	**101.5**	**(1.1)**	**100.4**	**101.5**	**(1.1)**	**101.7**
Trade Receivables & Accruals	11.3	14.9	13.4	1.5	14.9	13.4	1.5	13.4
Other Receivables	0.1	0.2	0.2	0.0	0.2	0.2	0.0	0.2
Cash	26.4	55.9	46.6	9.2	55.9	46.6	9.2	22.7
Trade Payables & Accruals	(24.8)	(33.5)	(27.6)	(5.9)	(33.5)	(27.6)	(5.9)	(27.6)
Current PFI Finance Lease	(1.5)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)
Other Current Payables	(2.5)	(26.6)	(24.9)	(1.7)	(26.6)	(24.9)	(1.7)	(2.8)
Total Net Current Assets / (Liabilities)	**9.6**	**9.4**	**6.2**	**3.2**	**9.4**	**6.2**	**3.2**	**4.3**
Non Current PFI Finance Lease	(27.0)	(25.6)	(25.6)	(0.0)	(25.6)	(25.6)	(0.0)	(25.5)
Other Non Current Payables	(1.9)	(1.9)	(1.9)	(0.0)	(1.9)	(1.9)	(0.0)	(1.9)
Total Net Assets	***82.4***	***82.2***	***80.1***	***2.0***	***82.2***	***80.1***	***2.0***	***78.5***
Income & Expenditure Reserve	29.1	29.4	27.4	1.9	29.4	27.4	1.9	25.8
Public Dividend Capital Reserve	19.2	19.4	19.3	0.1	19.4	19.3	0.1	19.3
Revaluation Reserve	33.4	33.4	33.4	(0.0)	33.4	33.4	(0.0)	33.4
Total Taxpayers Equity	***82.4***	***82.2***	***80.1***	***2.0***	***82.2***	***80.1***	***2.0***	***78.5***

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	0.8	0.1	0.7	4.6	3.4	1.2	2.2
Depreciation and Impairments	+	8.5	0.7	0.7	(0.0)	7.5	7.4	0.2	8.1
Operating Cashflow		***14.9***	***1.5***	***0.8***	***0.7***	***12.2***	***10.8***	***1.4***	***10.3***
Net Working Capital Movements	+/-	***1.4***	***1.5***	***(0.1)***	***1.7***	***29.2***	***22.1***	***7.1***	***0.4***
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)	(0.4)	(0.9)	0.5	(6.9)	(7.7)	0.8	(8.5)
Investments		***(9.8)***	***(0.4)***	***(0.9)***	***0.5***	***(6.9)***	***(7.7)***	***0.8***	***(8.5)***
PFI Finance Lease Repayment	-	(1.2)	(0.1)	(0.1)	(0.0)	(1.3)	(1.3)	(0.0)	(1.5)
Net Interest	+/-	(3.6)	(0.3)	(0.3)	(0.0)	(3.5)	(3.5)	(0.0)	(3.9)
PDC Received	+	1.2	0.2	0.0	0.2	0.2	0.1	0.1	0.1
PDC Dividends Paid	-	(2.1)	0.0	0.0	0.0	(0.4)	(0.1)	(0.2)	(0.6)
Financing Costs		***(5.7)***	***(0.2)***	***(0.4)***	***0.2***	***(5.0)***	***(4.9)***	***(0.1)***	***(5.8)***
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***	***2.4***	***(0.5)***	***3.0***	***29.5***	***20.2***	***9.2***	***(3.7)***
Opening Cash		25.6	53.5	47.3	6.3	26.4	26.4	0.0	26.4
Closing Cash		***26.4***	***55.9***	***46.7***	***9.2***	***55.9***	***46.7***	***9.2***	***22.7***

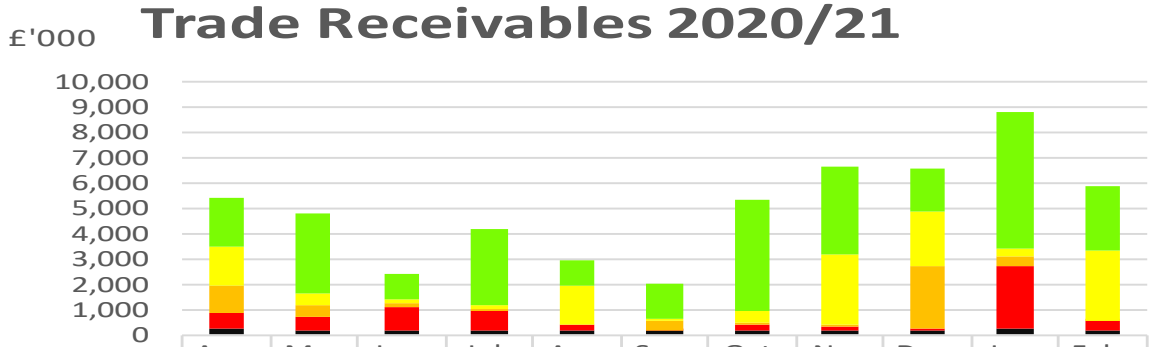
Key Messages

Closing cash balance for February was £55.9m, which is £9.2m above the plan, due to capital slippage and better than expected I&E performance.

Even after allowing for no contract payments in March, making goods on the double payment in April, the Trust is forecasting closing cash of c£38m. This will represent a net increase of c£9m over the year, substantially higher than originally forecast, with a number of payments only confirmed in recent weeks.

The increase includes a number of non recurrent allocations, some of which will be deferred with associated spent in 21/22. Some of the recent larger receipts include central capital funding £0.6m, HEE allocations £0.3m, NHSE transitional funding £0.8m, additional system COVID funding £2.0m and Annual Leave Provision backing of £2.3m.

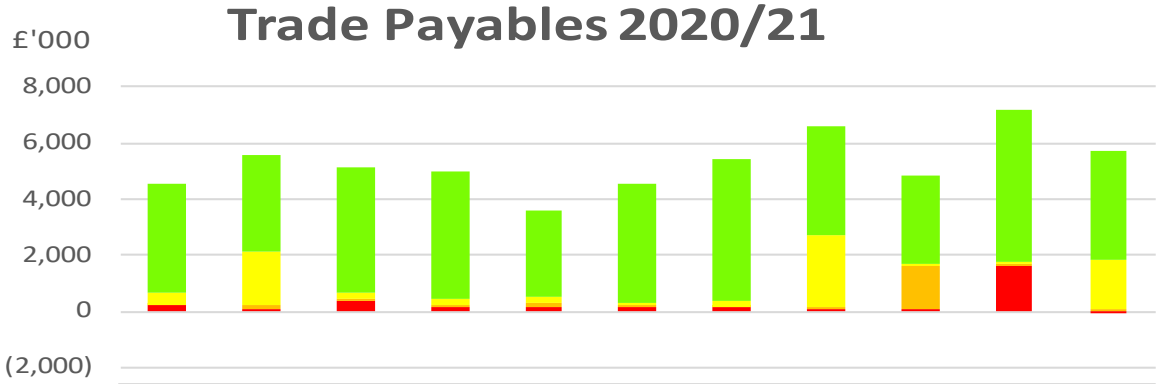
Cash Management



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
<30 Days	1,870	3,230	973	3,032	1,000	1,377	4,337	3,482	1,701	5,432	2,597
>30 <60 Days	1,573	388	225	180	1,535	136	518	2,789	2,143	315	2,752
>60 <90 Days	1,063	500	154	34	0	327	59	70	2,489	378	29
>90 < 180 Days	673	538	864	802	251	25	204	132	80	2,492	333
>180 Days	241	197	220	182	186	200	219	217	191	247	218

Key Messages

Debtors balances decreased by £2.9m, mainly due to settlement of aged NHS PS invoices. Debtors > 30 days increased £2.1m due to the final tranche of this years NHSPS charges. The largest balances remaining over 60 days are with Wokingham Borough Council, £0.2m and smaller values with both RBH, Frimley Health and NHS England.



	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
<30 Days	3,924	3,486	4,438	4,531	3,117	4,245	5,030	3,907	3,106	5,450	3,902
>30 <60 Days	391	1,858	207	227	159	99	236	2,576	64	95	1,710
>60 <90 Days	51	182	63	27	205	74	42	77	1,563	61	97
>90 days	196	77	403	194	126	153	124	51	95	1,622	(13)

Key Messages

Creditors decreased by £1.5m, due to the settlement of NHSPS invoices, which reduced balances over 90 days. This was offset by increase in 30 to 60 days balances, which includes £1.6m of NHSPS invoices subject to reciprocal payment. Balances over 60 days remain low with very few transactions accounting for the overdue balances.

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	58	28	30	1,100	993	107	1,021
Erleigh Road (LD etc works)	0	33	(33)	0	120	(120)	153
Wokingham Willow House Projects	38	0	38	134	197	(63)	197
Trust Owned Properties Other	43	0	43	98	111	(13)	111
Leased Non Commercial (NHSPS)	74	33	41	254	302	(47)	335
Leased Commercial	0	7	(7)	0	44	(44)	50
Various All Sites	0	71	(71)	0	340	(340)	410
Medical Devices	10	8	1	73	92	(19)	100
Statutory Compliance	35	22	13	73	323	(250)	347
Subtotal Estates Maintenance & Replacement	**257**	**203**	**54**	**1,732**	**2,520**	**(788)**	**2,724**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	61	(61)	31	307	(276)	368
IM&T System & Network Developments	7	112	(105)	737	1,429	(692)	1,541
IM&T Other	(281)	0	(281)	384	395	(11)	445
GDE & Community Trust Funded	32	94	(62)	155	864	(709)	958
IM&T HSLI	0	0	0	19	0	19	0
Subtotal IM&T Expenditure	**(242)**	**267**	**(509)**	**1,326**	**2,995**	**(1,669)**	**3,312**
Subtotal CapEx Within Control Total	**15**	**470**	**(455)**	**3,058**	**5,515**	**(2,457)**	**6,036**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	175	311	(136)	1,963	1,336	627	1,647
Other PFI Projects	0	0	0	137	285	(148)	295
HSLI Projects	0	17	(17)	174	158	16	174
Subtotal Capex Outside of Control Totals	**499**	**328**	**171**	**2,596**	**1,779**	**817**	**2,116**
Total Capital Expenditure	**514**	**798**	**(284)**	**5,654**	**7,294**	**(1,640)**	**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
Centrally Funded							
Pandemic Storage Facility	0	0	0	44	0	44	0
Point of Care Testing Bids (NHSPS sites)	8	0	8	46	0	46	0
Laptops COVID-19	0	0	0	64	0	64	0
Point of Care Testing Bids (PFI - £57K)	0	0	0	24	0	24	0
National Attend Anywhere Product	20	0	20	20	0	20	0
Mental Health Remote Working	286	0	286	286	0	286	0
Total CapEx excluded from Annual Plan	**314**	**0**	**314**	**484**	**0**	**484**	**0**

Key Messages

Capital spend was £0.5m, £0.3m less than planned, increasing the YTD underspend to £1.6m. This is the net of a £2.5m underspend against Control Total and a £0.8m overspend on other Capital.

Estates spend was £0.8m below plan but expect the remaining allocation to be spend by YE, except for statutory compliance which will result in a £0.1m shortfall. Spend on schemes outside of control total are £0.8m higher than planned due to the early completion of LD to Jasmine and PPH Fire doors scheme. IM&T spend was £1.7m below plan and overall spend is expected to be £0.9m below plan by YE.

Despite the approval of additional capital bids and pulling forward planned IT spend from 21/22, it is expected that the Trust will underspend against its Control Total by £1.0m in 20/21. This has been further impacted by additional Capital awards for IT investment, received late in the year, which have been utilised to fund existing costs.

There was also £0.3m spend on IM&T remote working and Covid-19 projects, which have been funded by PDC

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	13th April 2021
Title	**True North Performance Scorecard** **Month 11 (February 2021) 2020/21**
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) 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 11, 2020/21 (February 2021) 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 11** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Falls incidents in Community & Older Adult Mental Health Inpatient Wards **(Harm Free Care) –** red at 26 against a target of 20. Red for 4 months. Some wards have increased patients with cognitive impairment, increased acuity, and fatigue. Existing countermeasures are in place, but not sufficient for additional contributing factors, such as challenges filling shifts to offer 1:1 support for patients, visibility of all patients in 'high risk' beds and PPE donning and doffing affecting timeliness of response to alarms. Additional countermeasures are being considered. • Self-harm Incidents on Mental Health Inpatients Wards (excluding LD) **(Harm Free Care)** – red at 127 incidents against a target of 42. Willow House, Bluebell and Rose ward were the highest contributors. Individual safety planning measures are in place. Ligatures are an increasing risk on mental health wards, not just fixed ligature points. National work on ligature management has begun. Additional

	countermeasures include exploring proactive digital surveillance, self-management, alternatives to admission and a focus on trauma. • Mental Health Prone (Face Down) Restraint **(Patient Experience)** - at 7 against a target of 2. Additional countermeasures include new bean bags ordered that can be used for de-escalation as well as restraint and seclusion exit. Benchmarking for 2019/20 places the Trust in the lowest quartile nationally due to the improvement activities completed to date. • Mental Health Clustering **(Patient Experience)** - at 76.2% against an 80% target. Services are operating in a challenging environment during this phase of the pandemic, which is impacting their ability to keep this above target. • Physical assaults on staff **(Supporting our Staff)** – at 52 incidents against a target of 44. Campion was the highest contributor this month with 25 incidents. Sorrel have introduced a second safety huddle at midday for planning and communications. Staff are exploring a ticket to reduce patient restrictions and patients have identified turning the TV area into a chill out space. Snowdrop are implementing safe wards intervention regarding bad news mitigation and restarted a debrief for patients. Campion continue to use individual countermeasures for patients. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** at 42 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. The Trust is participating in a project across the South about Length of Stay in Mental Health acute wards of patients with a stay of 90 days plus. • Inappropriate Out of Area Placements **(Money Matters)** – at 934 days for the quarter against a 0-bed day target. Pressures within our inpatient units have resulted in more out of area placements. **Tracker Level 1 Metrics** • Mental Health 7 day follow up **(Regulatory Compliance)** – 4 patients not followed up within the timeframe resulted in this breach of target. • Sickness **(Regulatory Compliance)** is at 4.73% (for January 2021) against a 3.5%

	target. There has historically been a seasonal increase; 2019/20 – 4.75%, 2018/19 – 4.10%. **Tracker Metrics (where red for 4 months or more)** • Statutory Training: Fire **(Supporting our Staff)** Dropped to 85% – focusing assurance on ward environments. A few wards are not at target. All Mental Health wards are above 90% and one Community below target. The introduction of a new eLearning solution is expected to improve training rates.
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**)

Harm Free Care

Metric	Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	21	29	27	20	8	16	25	17	17	22	24	46	26
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	42	25	15	58	37	41	40	57	67	76	46	110	127
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	21	22	1	0	1	0	0	1	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	1	2	3	3	1	1	1	1	4	3	1	1	4
Gram Negative Bacteraemia	1 per ward per year	0	0	3	0	0	0	0	0	0	0	0	0	0

Patient Experience

Mental Health: Prone (Face Down) Restraint	2 per month	7	3	3	8	3	6	2	3	1	5	1	6	7
Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance	87.4%	91.9%								87%	78%	85%	
Patient FTT response rate: % [Suspended centrally due to COVID]	15% compliance	11.7%	5.51%								87%	4%	3%	
Mental Health Clustering within target: %	80% compliance	81.5%	80.6%	81.2%	78.7%	83.8%	83.7%	82.7%	81.5%	81.7%	80.9%	78.5%	75.7%	76.2%

Performance Scorecard - True North Drivers (February 2021)

Supporting our Staff

Metric	Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Physical Assaults on Staff	44 per month	41	57	36	27	34	53	51	26	34	44	73	58	52
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.29	7.29	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.5

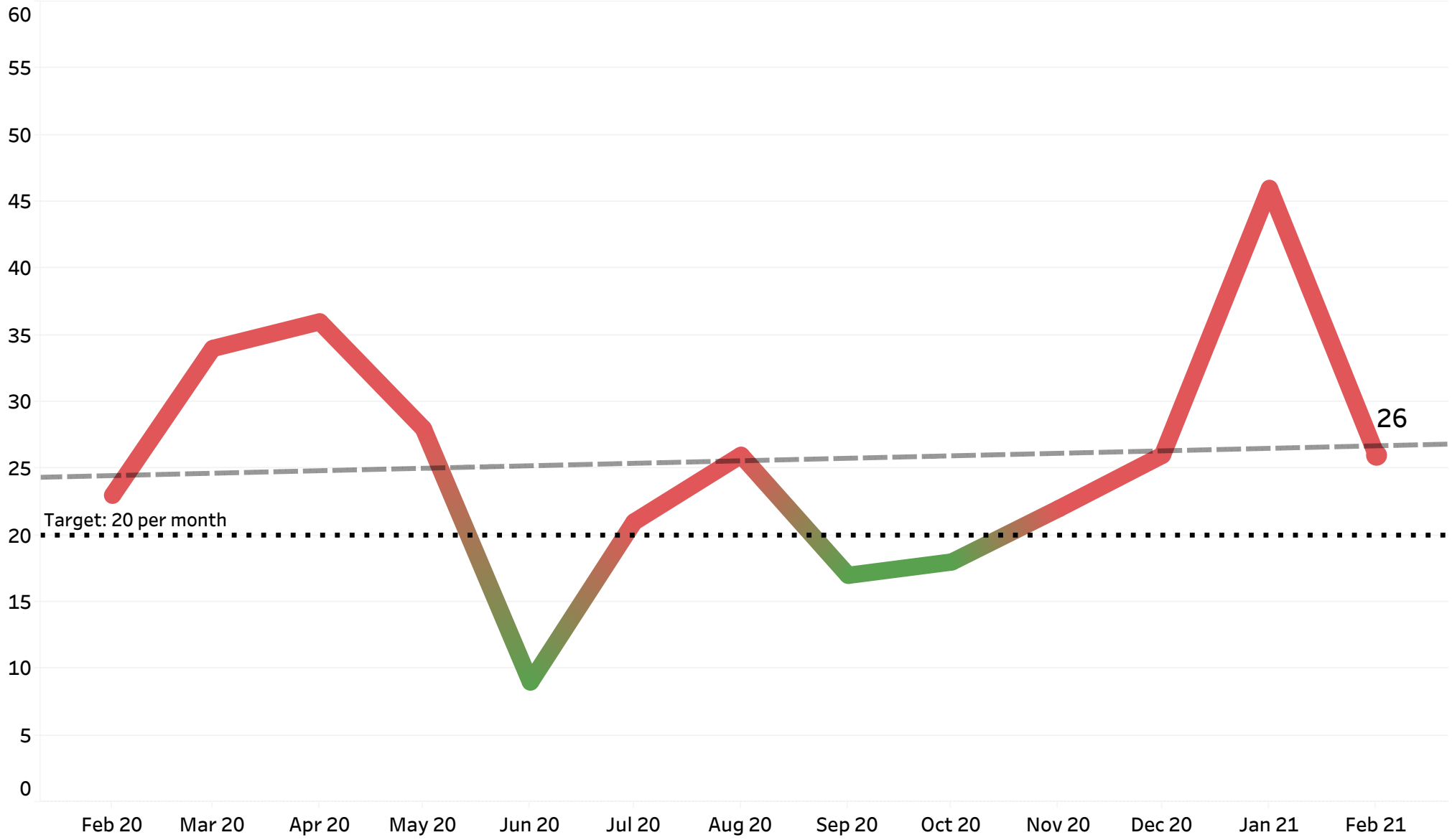
Money Matters

CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)	£4.24M	£4.60M											
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]	-£0.4m	-£0.28M	£0.26M											

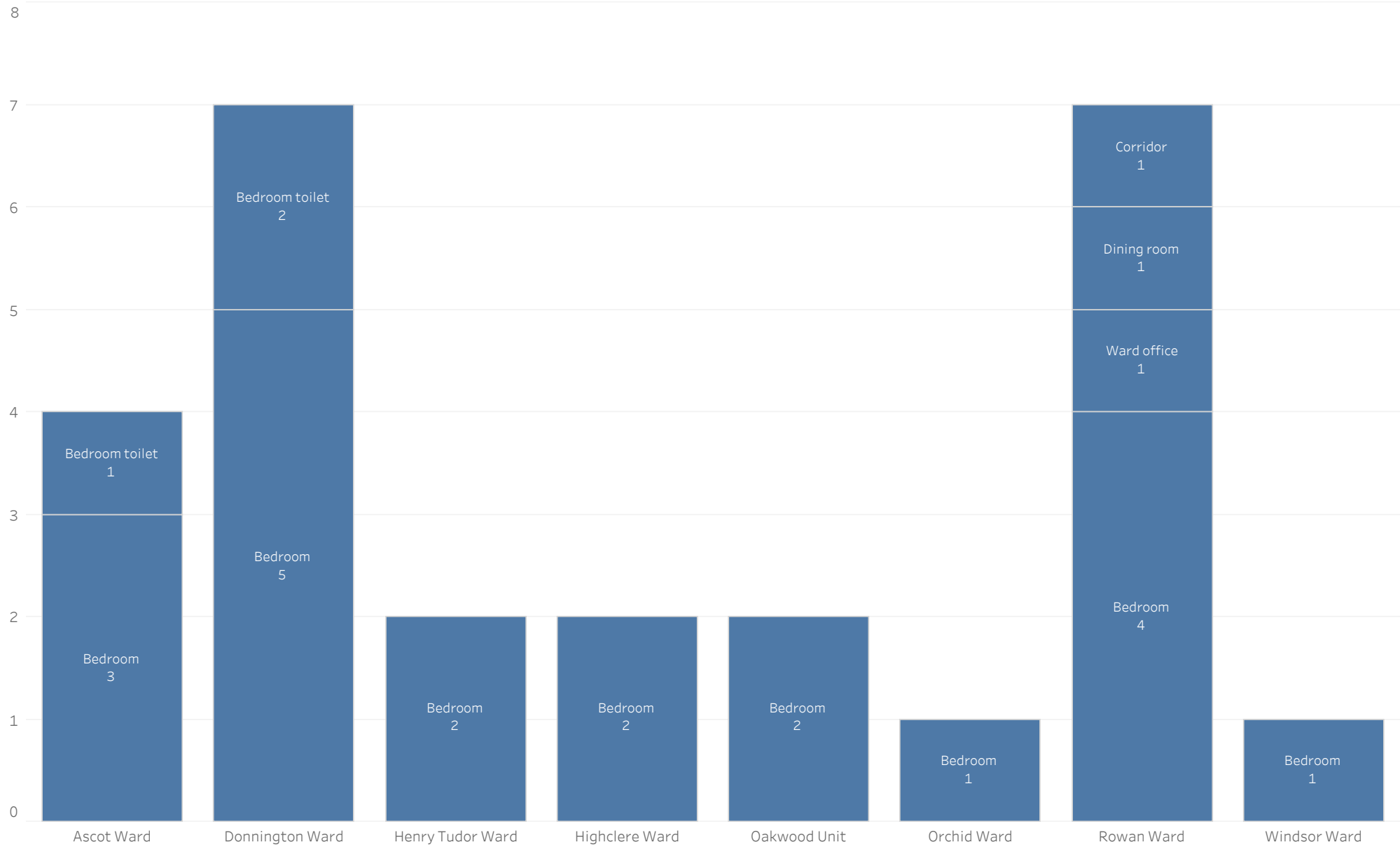
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	92.6%	89.9%		81.9%	92.1%	92.2%	97.2%	92.6%	90.6%	90.5%	91.8%	83.3%	86.1%
Mental Health: Acute Average Length of Stay (bed days)	30 days	37	42	37	34	37	36	47	40	43	43	46	45	42
Staff turnover (excluding fixed term posts)	<16% per month	14.7%	14.7%	14.6%	14.3%	13.9%	13.4%	13.3%	13.9%	13.8%	13.7%	13.1%	13.1%	13.0%
Staff turnover (including fixed-term posts)	<16% per month	16.6%	16.5%	16.5%	16.2%	15.6%	15.3%	15.9%	17.1%	16.9%	16.9%	16.4%	15.4%	15.3%
Inappropriate Out of Area Placements	0 from Jan 2021 Before 2021 - 74 bed days (cumul. Qtr)	39	58	93	170	148	312	418	164	352	726	455	934	

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Feb 20 to Feb 21)

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

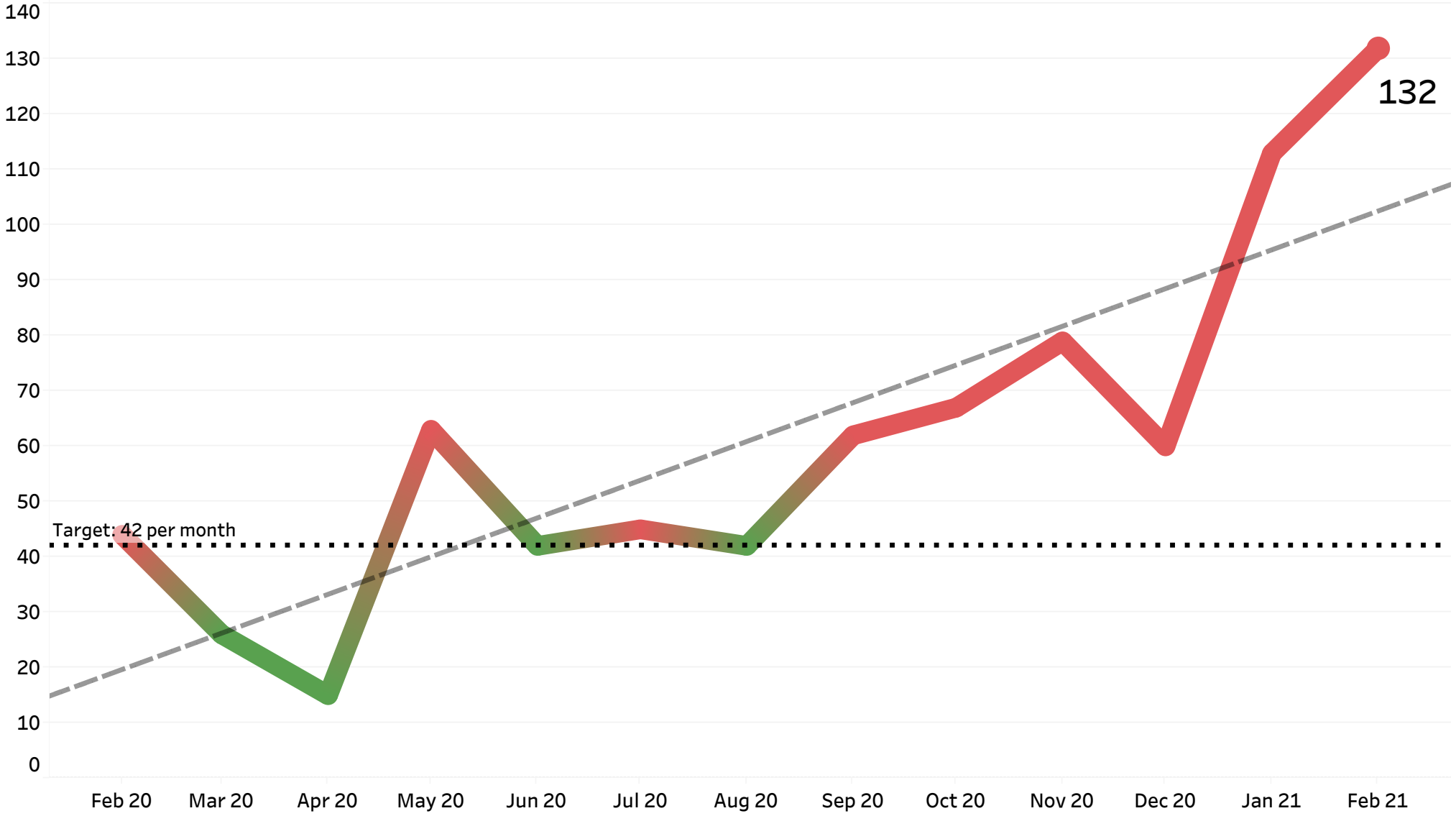


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (February)

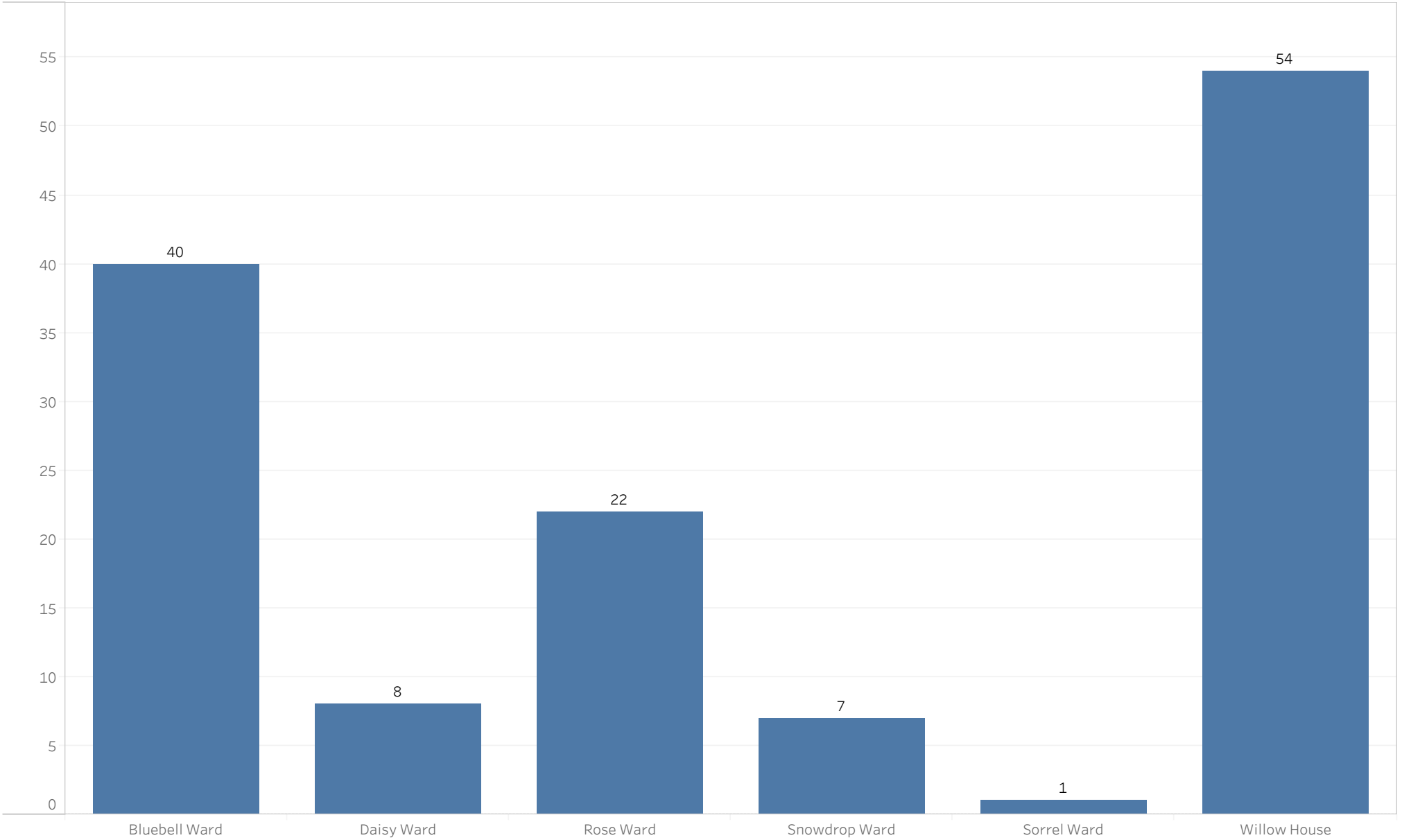


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards Inc Willow House (excluding LD) (Feb 20 to Feb 21)

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

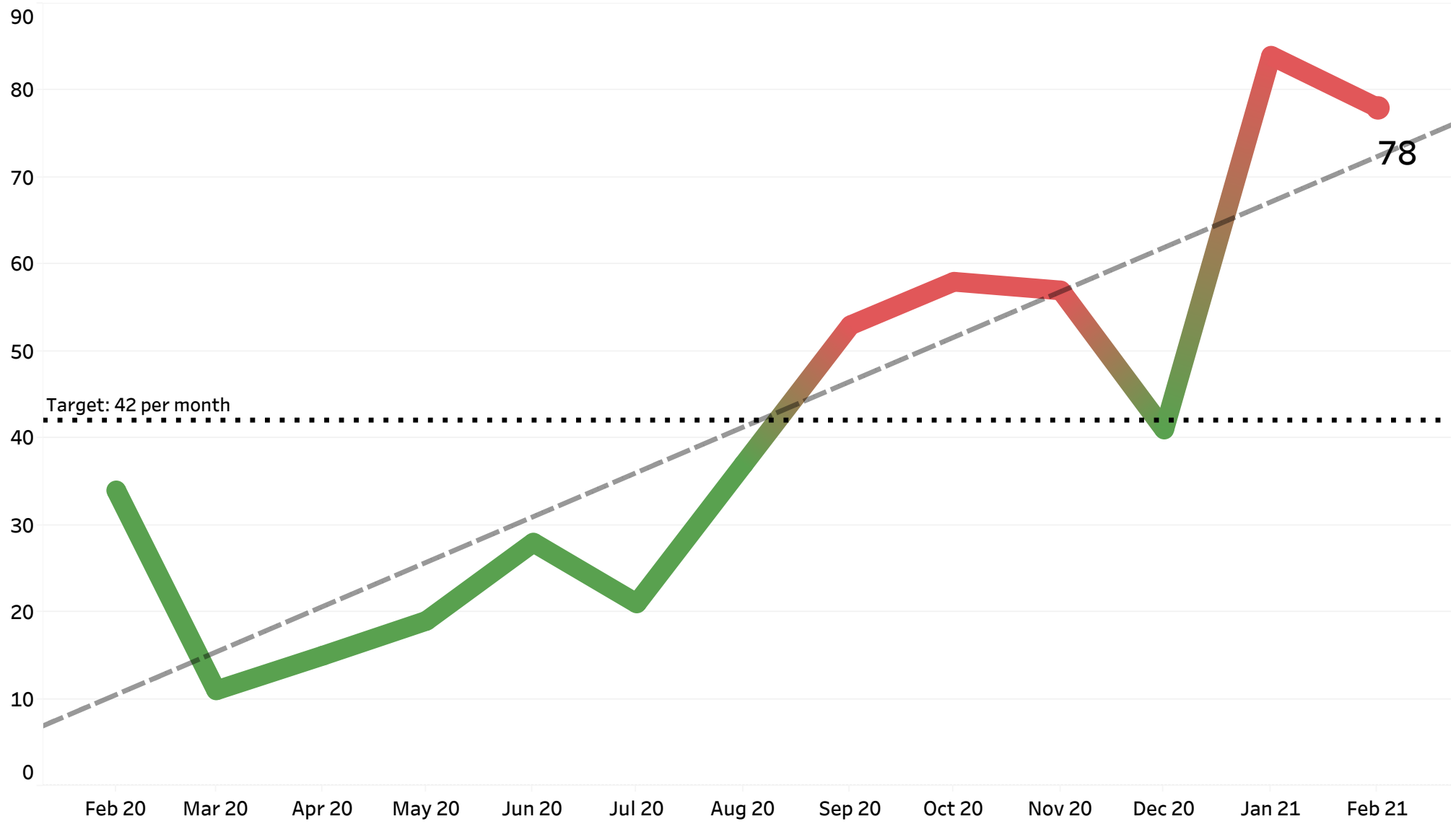


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (February)

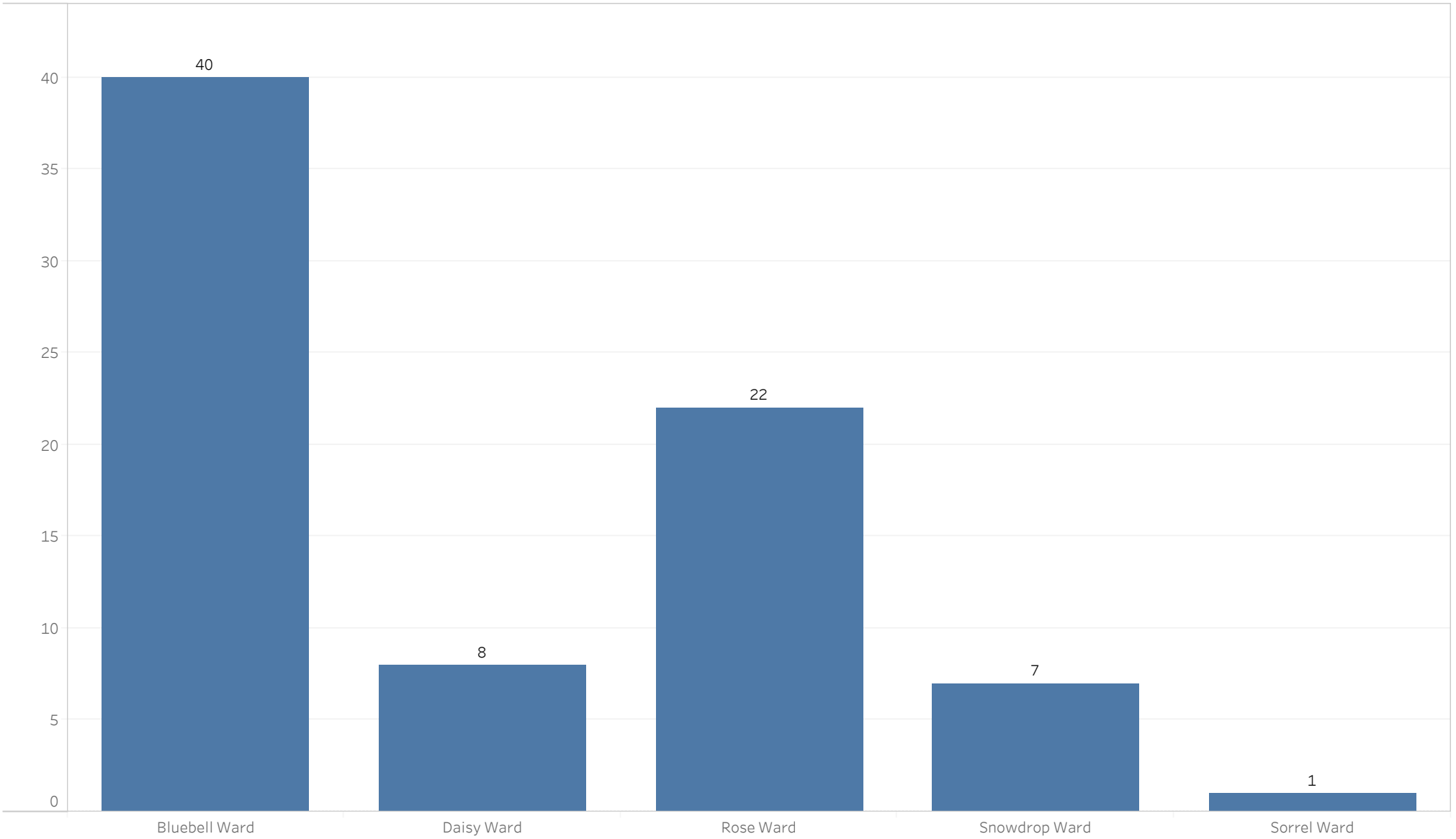


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD & Willow House) (Feb 20 to Feb 21)

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

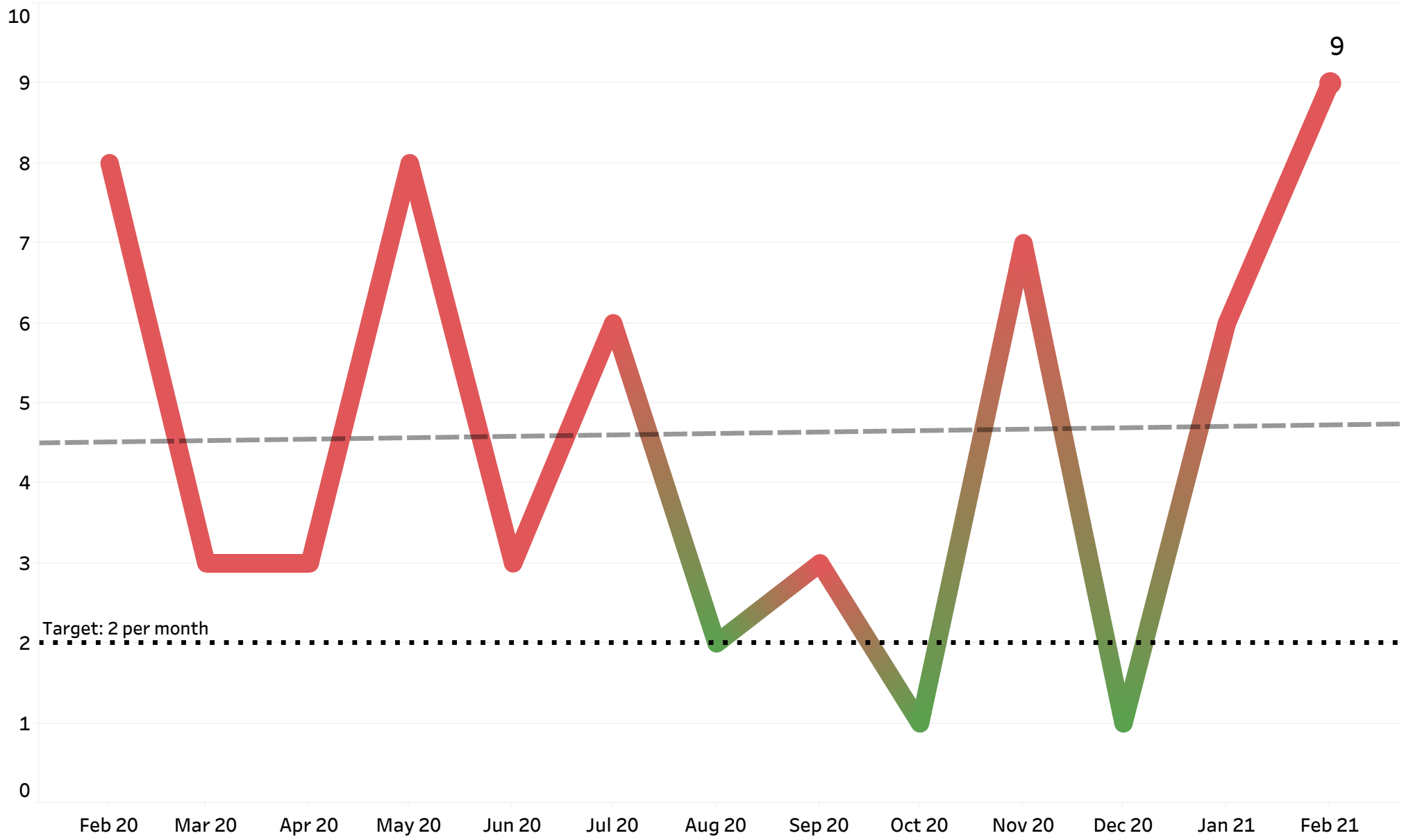


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD & Willow House) by location (February)

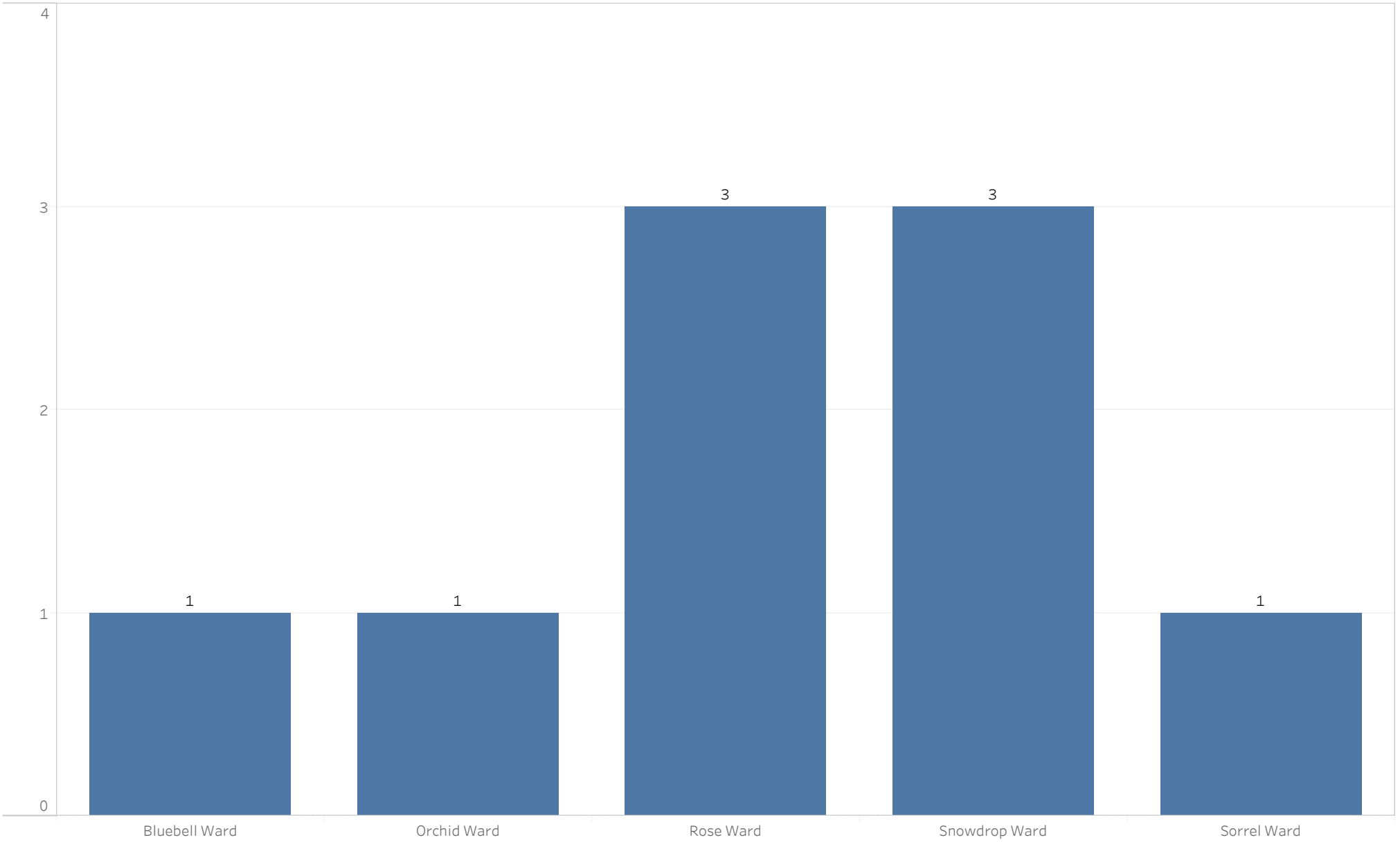


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents (Feb 20 to Feb 21)

(All approval statuses)

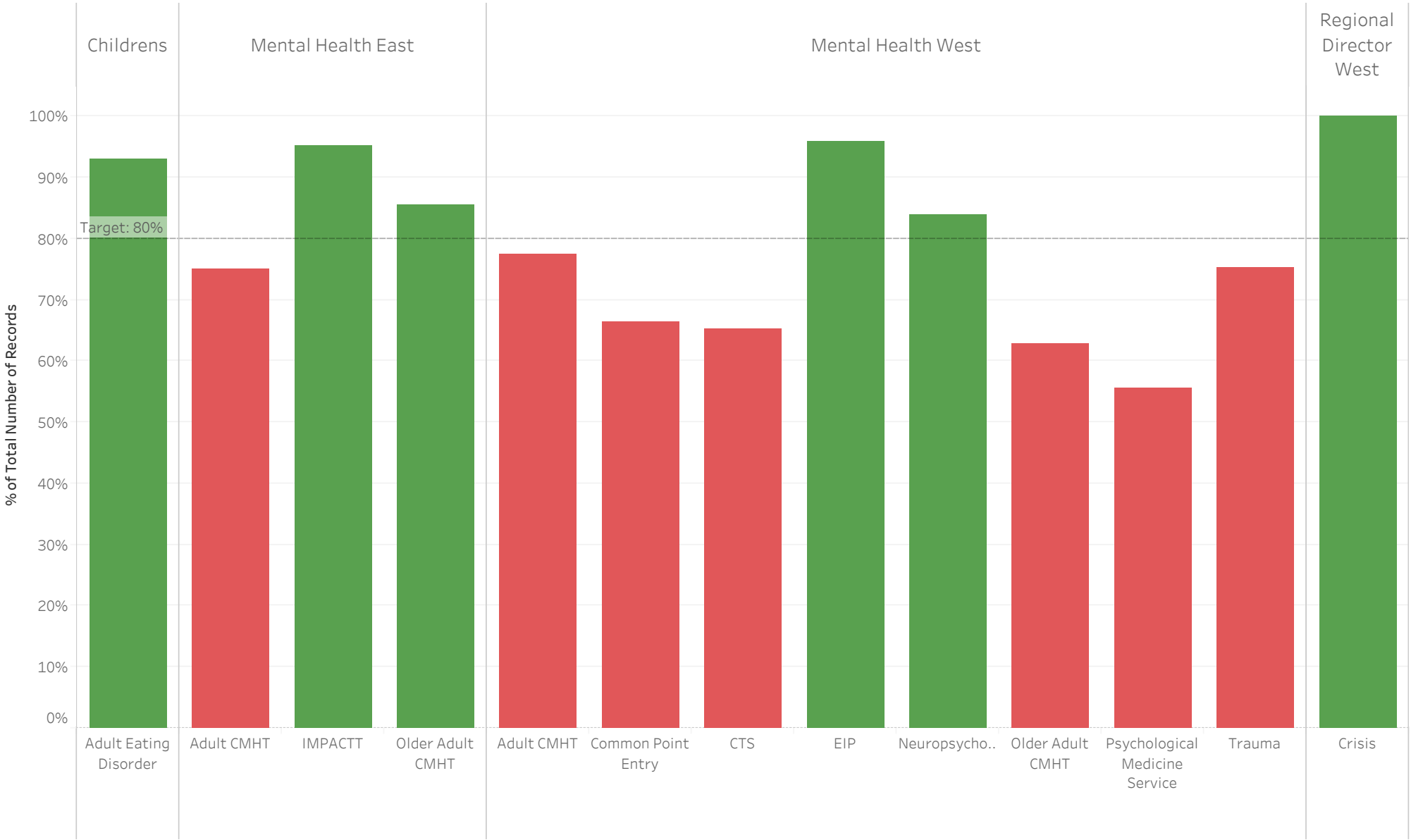


Patient Experience Driver: Mental Health: Prone (Face Down) Restraint incidents by location (February)



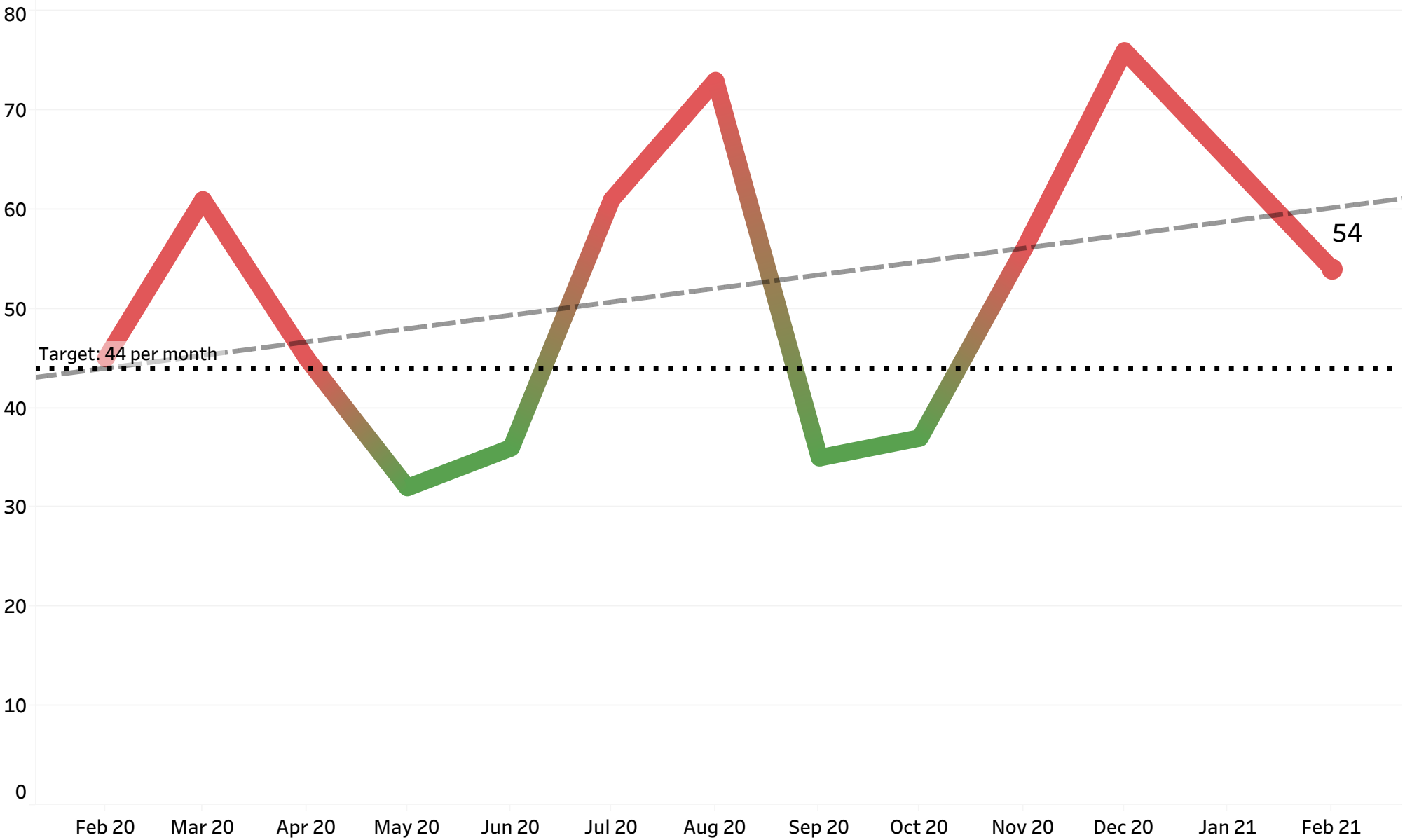
Patient Experience: Clustering breakdown (February 2021)

Outpatient Cluster Status (by Service)

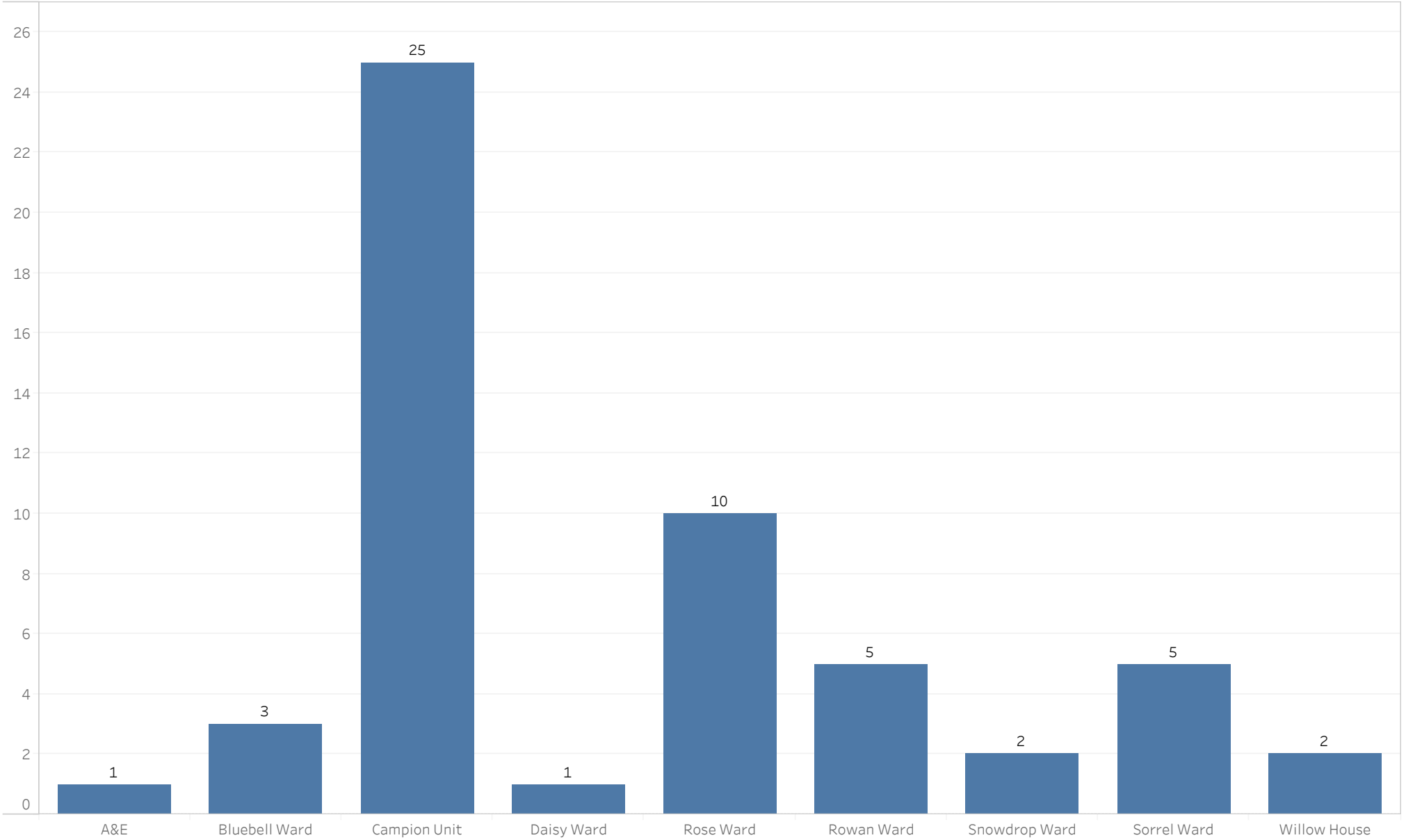


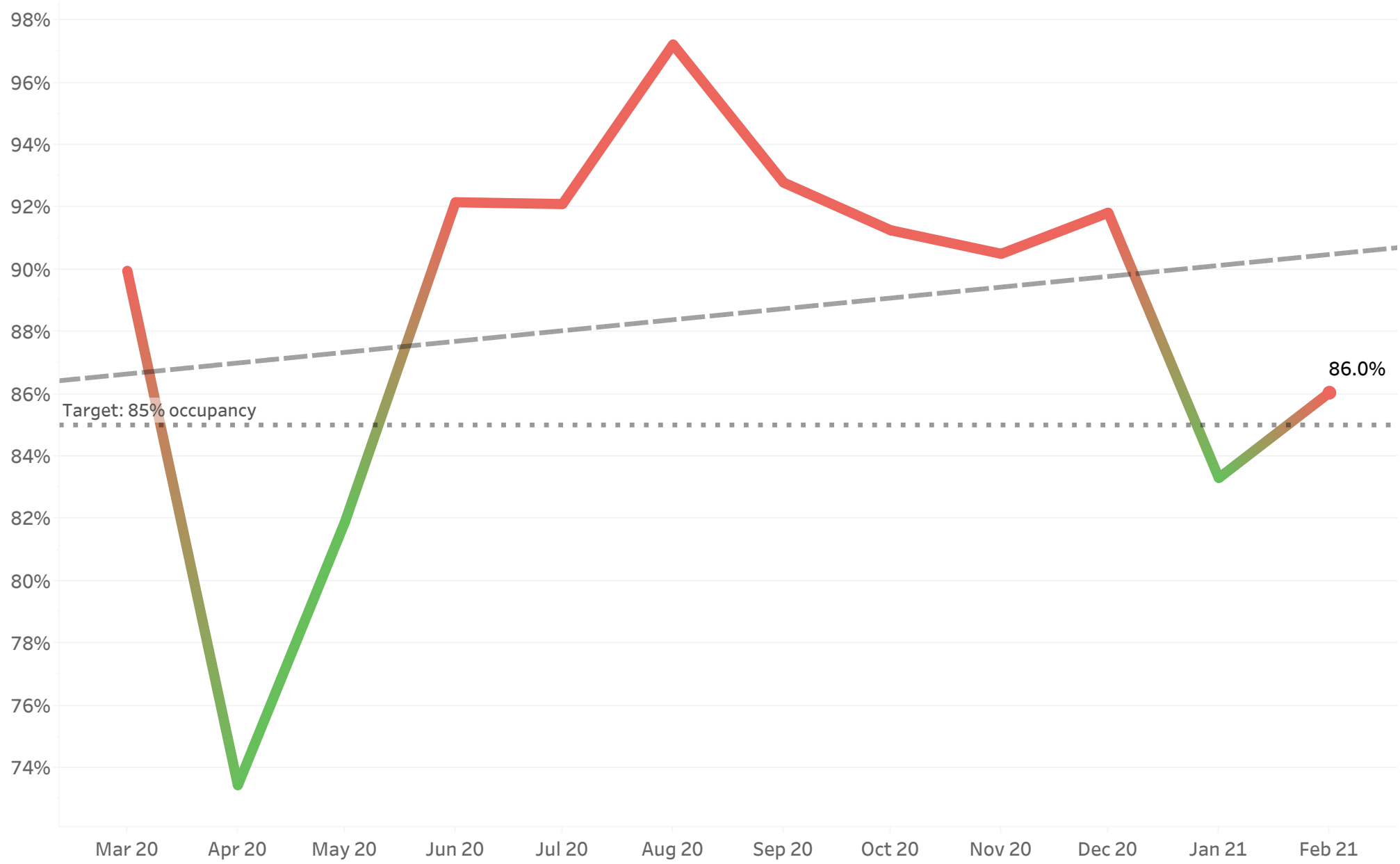
Supporting Our Staff Driver: Physical Assaults on Staff (Feb 20 to Feb 21)

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

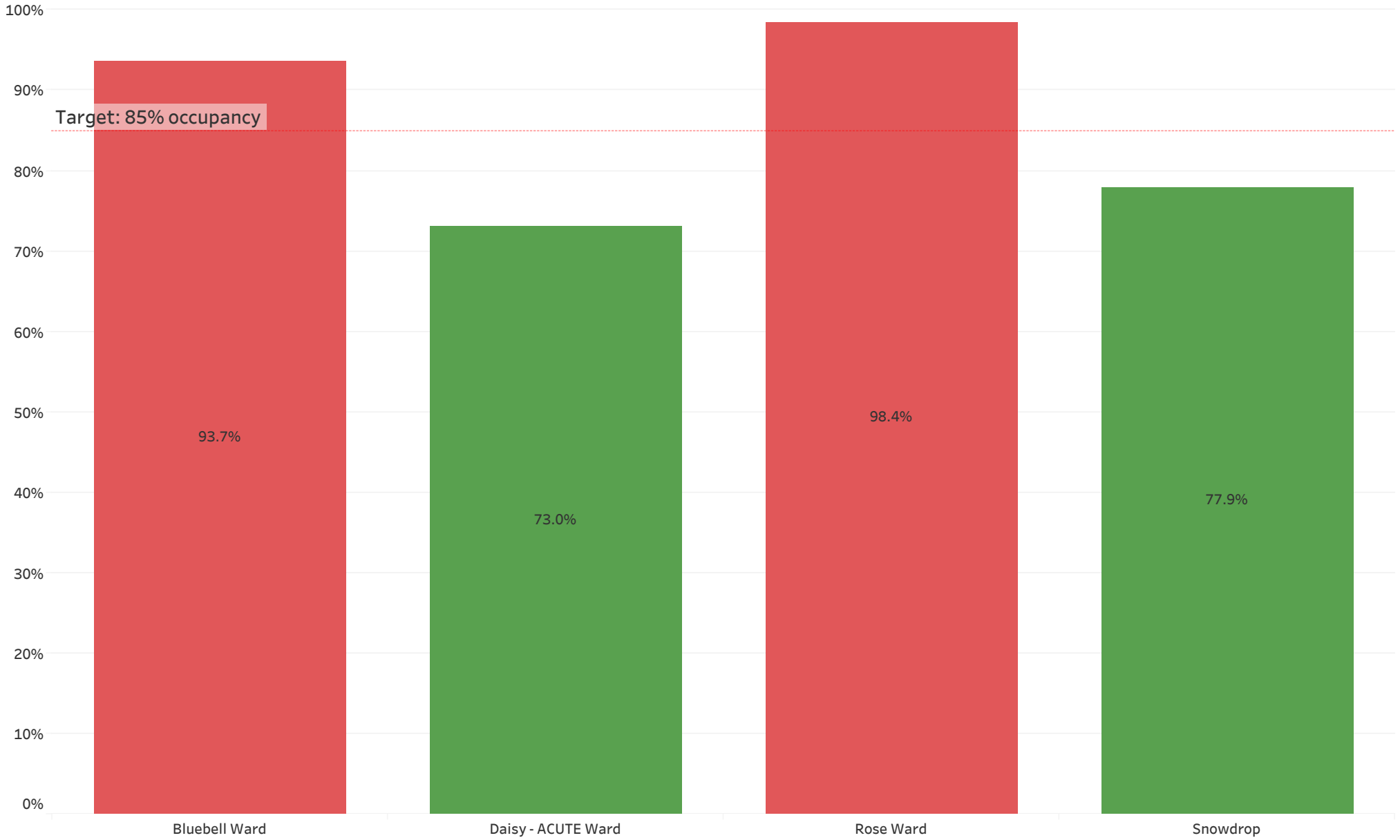


Supporting Our Staff Driver: Physical Assaults on Staff by Location (February 2021)

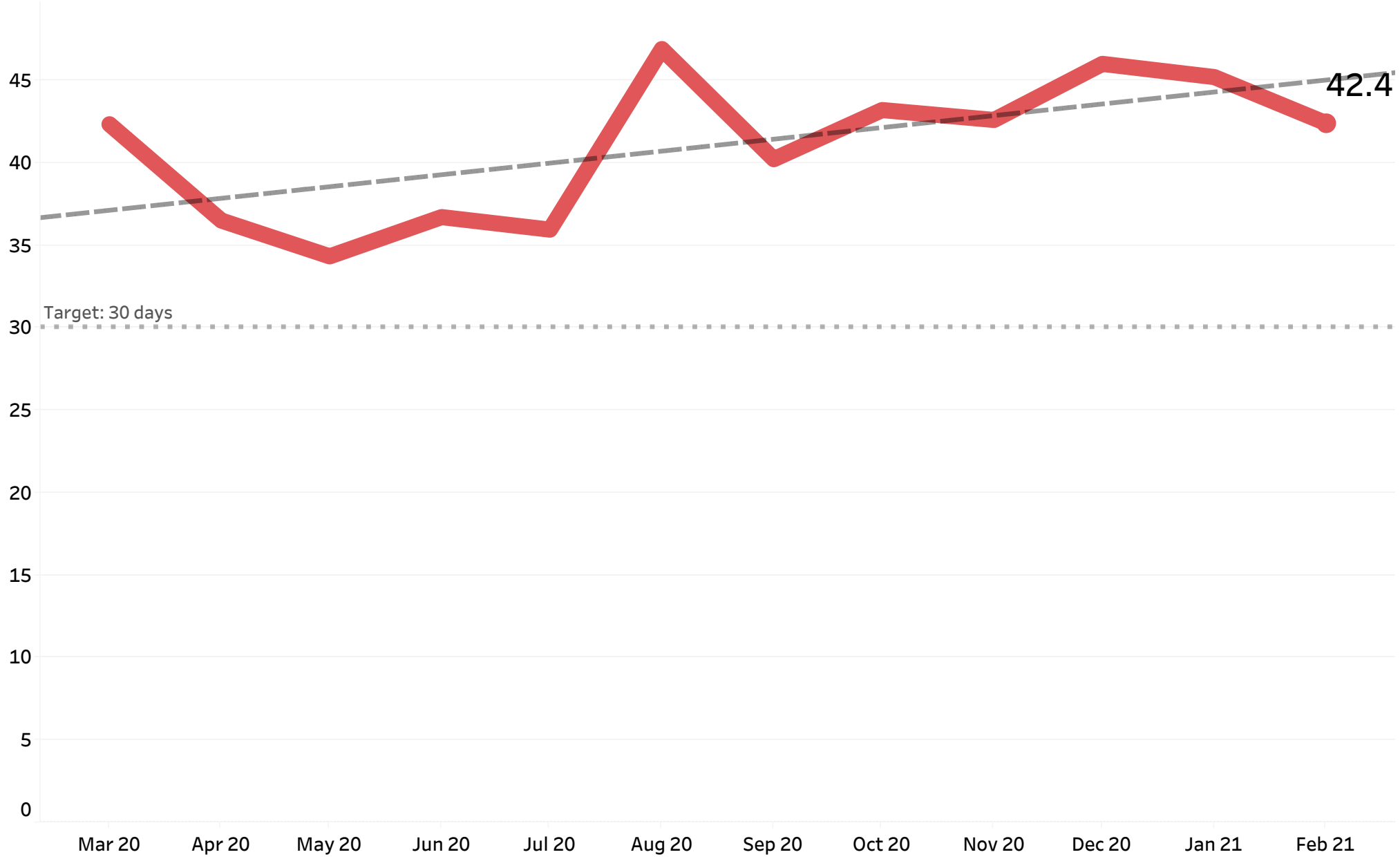



Money Matters: Mental Health Acute Bed Occupancy Rate (Mar 20 to Feb 21)
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
74%
Target: 85% occupancy
86.0%
Mar 20
Apr 20
May 20
Jun 20
Jul 20
Aug 20
Sep 20
Oct 20
Nov 20
Dec 20
Jan 21
Feb 21

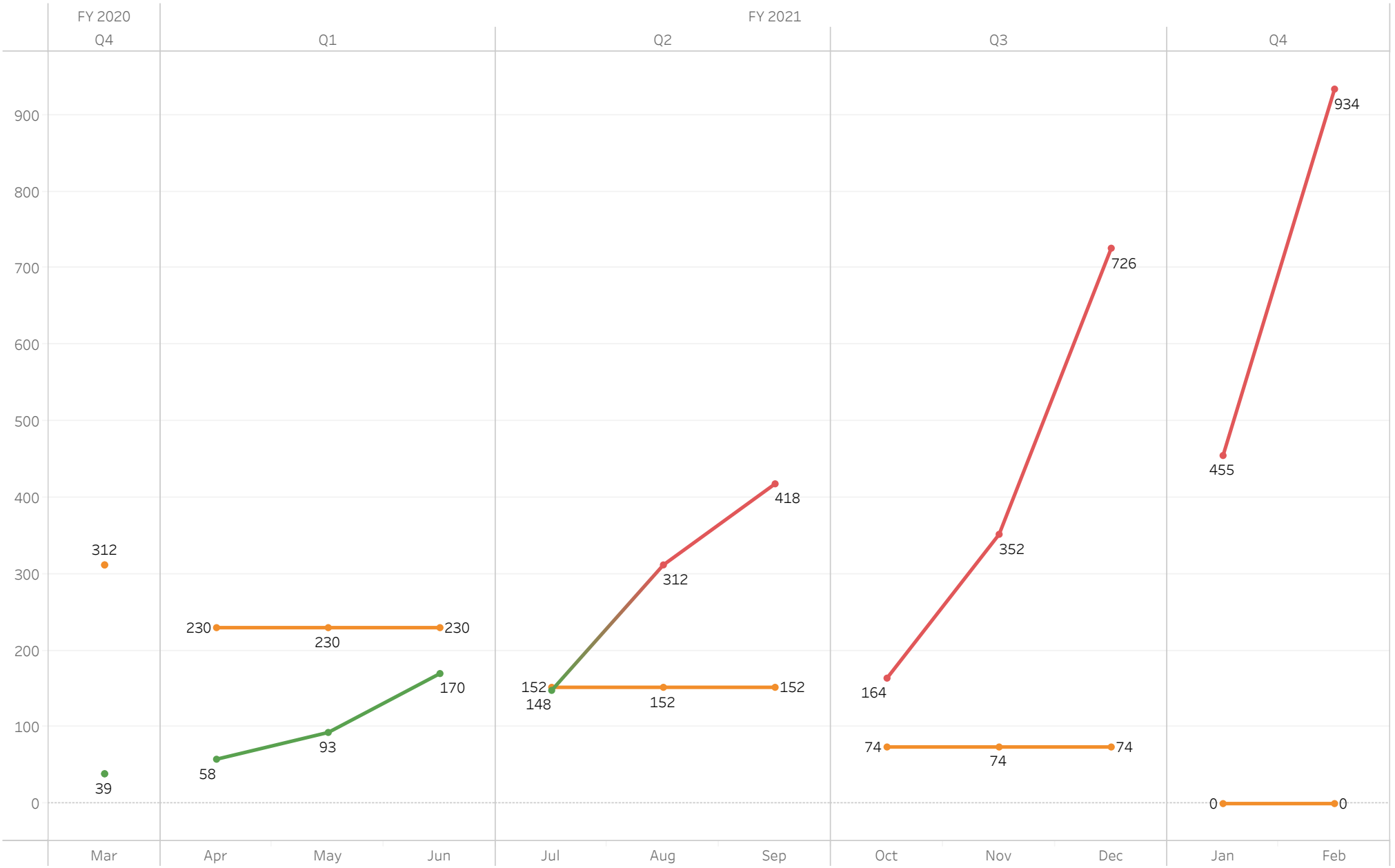
Money Matters Driver: MH Acute Bed Occupancy by Unit (February 2021)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (<February>)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	2	0	1	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	1	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	1	0	0	1	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	5	2	2	3	3	9	2	2	3	9	3	3	2
Mental Health: Absconsions on MHA section(Excl: Failure to return)	8 per month	5	6	5	3	4	6	3	4	4	3	0	9	10
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.09	4.42	4.29	5.42	5.86	5.22	4.95	6.33	7.43	6.65	5.89	7.09	8.59
Patient on Patient Assaults (LD)	4 per month	0	0	3	3	4	4	4	2	0	3	0	3	1
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	14.0%	13.6%	13.4%	13.3%	13.8%	13.5%	13.6%	13.7%	13.4%	12.6%	12.9%	13%	12.9%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	5.2	4.9
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	0	0	1	2	3	3	0	2	1	1	0	1	0

True North Patient Experience Summary

Tracker Metrics

		Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Patient on Patient Assaults (MH)	38 per month	14	15	15	15	20	24	12	21	7	14	11	9	25
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	93.9%	88.4%	89.1%	91.9%	92.6%	93.4%	91.1%	91.1%	92.7%	92.0%	91.2%	94.5%	95.0%
Mental Health: Uses of Seclusion	13 in month	18	12	4	7	17	15	16	8	15	11	9	4	12

True North Supporting Our Staff Summary

Tracker Metrics

		Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Gross vacancies: % [Suspended centrally due to COVID]	<10%	6.09%	5.89%											
Statutory Training: Fire: %	95% compliance	91.5%	90.1%	88.4%	85.9%	87.3%	90.1%	91.3%	92.9%	92.4%	91.1%	92.3%	91.5%	85.0%
Statutory Training: Health & Safety: %	90% compliance	96.4%	95.5%	96.0%	94.3%	95.5%	95.3%	95.6%	95.9%	96.0%	95.0%	95.9%	95.7%	92.5%
Statutory Training: Manual Handling: %	90% compliance	93.3%	92.5%	90.0%	88.7%	90.3%	90.1%	91.1%	92.3%	92.5%	93.1%	94.0%	93.8%	86.0%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID]	95% compliance	93.3%	93.9%	92.5%	90.0%	92.1%	92.6%	92.2%	94.7%	94.0%	94.8%	95.2%	93.8%	89.0%
PDP (% of staff compliant) Appraisal: %	95% compliance 'Extended from 19/20. Reset in June 20'	83.9%	81.7%	80.5%	80.5%	42.1%	88.6%	87.3%	95.5%	95.3%	94.4%	91.9%	88.9%	88.1%

Mental Health Inpatient Services – Fire training compliance

Org L71	Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
Fire Safety Training - Whole Service	95%	93.2%	88.3%	88.4%	84.6%	90.6%	94.8%	96.9%	98.5%	96.7%	95.7%	96.7%	94.8%
371 Bluebell Ward PPH	95%	82.6%	71.4%	75.0%	72.0%	77.8%	95.5%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%
371 Daisy Ward PPH	95%	95.8%	100.0%	92.3%	92.0%	88.5%	92.3%	96.2%	93.8%	100.0%	96.3%	100.0%	93.3%
371 Orchid Ward PPH	95%	82.8%	80.0%	76.9%	76.9%	84.6%	92.3%	92.0%	96.2%	82.8%	92.6%	93.1%	96.4%
371 Rose Ward PPH	95%	100.0%	92.0%	91.3%	83.3%	91.3%	96.2%	96.3%	100.0%	100.0%	96.4%	100.0%	96.0%
371 Rowan Ward PPH	95%	97.1%	85.3%	80.0%	70.0%	77.4%	92.9%	100.0%	100.0%	94.1%	91.7%	94.1%	91.4%
371 Snowdrop Ward PPH	95%	93.1%	90.3%	93.3%	93.3%	100.0%	96.7%	96.9%	100.0%	96.6%	96.0%	96.2%	92.0%
371 Sorrell Ward PPH	95%	100.0%	100.0%	100.0%	100.0%	96.2%	96.3%	93.3%	100.0%	100.0%	100.0%	97.1%	96.8%

Community Health – Fire training compliance

371 Community Health East Services	Fire Safety Training - Whole Service	95%	94.4%	93.1%	93.2%	92.4%	93.1%	94.8%	96.4%	97.8%	96.0%	93.1%	96.3%	94.9%
371 Community Health West Services	Fire Safety Training - Whole Service	95%	92.6%	89.2%	87.2%	86.3%	86.9%	90.5%	93.8%	95.6%	97.0%	95.2%	96.7%	96.0%

CH IP Fire Safety Breakdown

Org L71	Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21
371 Henry Tudor Ward	95%	96.4%	96.6%	96.0%	96.6%	96.7%	93.1%	89.7%	100.0%	92.9%	92.9%	100.0%	86.7%
371 Jubilee Ward	95%	100.0%	96.9%	96.8%	100.0%	81.3%	96.8%	93.5%	100.0%	100.0%	96.8%	96.6%	96.9%
371 Oakwood Ward	95%	90.5%	87.2%	88.6%	89.5%	94.9%	100.0%	95.2%	95.7%	95.5%	97.9%	100.0%	97.7%
371 WBCH Inpatient Wards	95%	89.2%	84.5%	80.7%	77.8%	93.7%	93.9%	96.3%	96.2%	96.1%	91.5%	96.1%	96.2%
371 Wokingham InPatient Unit	95%	89.1%	88.9%	87.9%	82.8%	64.8%	86.7%	93.5%	96.7%	98.4%	98.4%	98.3%	95.2%

Campion & Willow House – Fire training compliance

True North Money Matters Summary

Tracker 1

		Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	7.59			7.5	5.29	4.29	2.60	4.29	9	4.29	3.59	3.30	2

Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	90.5%	84.5%		75.4%	49%	57.3%	73.5%	72.8%	74.7%	72.7%	79%	83.5%	75.0%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	83.09%	82.79%		63.39%	64.04%	84.74%	67.06%	75.68%	75.68%	65.10%	66.21%	73.42%	73.04%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.70%	5.20%		4.20%	3.79%	4.39%	4.29%	4.59%	4.29%	4.39%	4.20%	4.29%	4%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	17.8%			4%	2.10%	7.5%	6.5%	5.29%	10.1%	2.5%	7.29%	10.6%	6.70%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
Mental Health: 7 day follow up (Quality Domain): %	95% seen	100	95.5	95.3	95.7	96.2	94.5	94.1	97.7	98.6	97.2	100	96.2	93.7
C.Diff due to lapse in care (Cumulative YTD)	0	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	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	88	88	88	88	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	21
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	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	1	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	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	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	56% treated	100	88.9	100	90.9	100	90.9	100	100	91.7	100	100	88.9	75
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	96.2	94.0	92.9	98.0	97.9	96.0	98.2	98.7	97.8	98.6	98.0	98.9	98.0
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	94	95	95	94	96	95	96	98	98	98	98	98	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	100

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	57.1	54.4	53.4	53.2	55.4	56.6	56.1	57.4	58.5	60.5	53.3	54.9	52.7
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	59	59	59	59	59	59	59	69	69	69	69	69	69
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	12	12	12	12	12	12	12	14.0	14.0	14.0	14.0	14.0	14.0
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to COVID]	99% seen	100			100	100	100	97.8	98.2	100	100	99.5	99.6	99.1
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	96.2	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	98	100	100	100	100	100	100	100	100	100
Sickness Rate: %	<3.5%	4.10	4.39	5.89	4.08	3.40	3.49	3.23	3.25	3.60	4.29	4.08	4.73	
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null	83	83	83	83	83	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											
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	98.4	98.1	98.7	98.7	98.4	98.2	98.9	98.7	98.9	99.0	99	97.0	97.5
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13th April 2021
Title	Board Vision Metrics Update
Purpose	To provide the board with a performance update on metrics agreed in measuring progress towards achieving our vision: ***"To be recognised as the leading community and mental health service provider by our staff, patients and partners"***
Business Area	Performance
Author	Deputy Chief Executive and Chief Financial Officer
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities and Diversity Implications	N/A
SUMMARY	2020/21 vision metric performance is provided at appendix 1 of the paper. Indicators are YTD February 2021 performance unless otherwise stated within the narrative. To note: • The Trust achieved the top score in its peer group for Staff Engagement in the 2020 National Staff Survey • No inpatient death from self-harm since October 2018. • Prior to suspending FFT collection due to the pandemic, response rate was inconsistent. Programme underway to design and commission new system for collecting patient experience

	information across Mental Health and Community services. Tender due to be awarded to partner. • CQC overall rating of “Outstanding” achieved in March 2020, including “Outstanding” for well led. Ratings report included six “must do” compliance actions, noted here in the vision metrics update. • Segment 1 regulatory autonomy maintained since segmentation began. Trust financial position delivering lowest financial risk rating of 1 YTD as planned to end of March 2020. Rating performance now suspended due to covid financial regimes. • Benchmark positions refreshed for 2019/20 data recently published. Ranking deterioration noted for patient on patient assaults and patient on staff assaults. Improvement in use of restraint position.
ACTION REQUIRED	The Board is asked to note the update.

Board Vision Metrics: Performance Update to end February 2021

Supporting Delivery of the Trust's Vision

Trust Board – Public Meeting

Alex Gild, Deputy CEO and Chief Financial Officer
13th April 2021

BHFT staff only

Purpose

Update the Trust Board on Vision Metrics.

Document control

Version	*Date*	*Author*	*Comments*
1.0	18/03/2021	I Hayward & C Magee	

Distribution

Trust Board

Document references

Document title	*Date*	*Published by*

Contents

1. Introduction

Background

1.1. Our vision is:

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

1.2. The Board Vision metrics monitor the Trust's progress across key indicators of vision delivery, split into the following sections:

- Quality
- Safety
- Engagement
- Regulatory Compliance

1.3. These sections cover the key indicators to assure the Trust on its progress towards the vision.

1.4. This is a performance update as per the quarterly interval (or as agreed with the Board) over the next three years. Several the indicators are annual, so updates will occur when information is available via a dashboard, see Appendix 1.

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 57 English providers and the 32 Combined Mental Health and Community Trust respondents in 2019/20 (latest available, recently published). Indicator performance has been updated to the latest available.

2. Rationale for Metric Inclusion

Sections

2.1. By dashboard section (Appendix 1) the following metrics were identified as having an impact on assessing our level of performance in delivering our vision. These metrics were agreed with the Board in 2017. Supporting vision transparency and accountability, this paper monitors delivery performance and is reported to the Board in public, alongside the standard Board summary performance report.

Quality

2.2. Key quality metrics that indicate how well we treat and care for our patients, predominantly focused on care experience metrics for mental health inpatients and uses our benchmarked scores.

2.3. A long-term stretch performance measure is maintained in the dashboard to achieve top 3 ranking of all Mental Health service providers in the national benchmarking cohort, however, where data is available we have shown how we compare to the combined community and mental health trust cohort in the descriptions below. The 2019/20 benchmarking results have been updated to the dashboard as follows:

- **Mental Health Patient on Patient Physical Assaults** – The benchmark position target shown here is a long-term stretch target. The Trust was above the mean and median for 2019/20 per 100,000 occupied bed days excluding leave and is ranked 52nd out of 57 mental health trusts; a worsening

of our 2018/19 position when we ranked 44th out of 57 English Mental Health respondents. In 2019/20 the Trust rank is ranked 28th out of 32 combined Menta Health and Community Trusts which is again a worsening of our 2018/19 position when the Trust ranked 23rd out of 32 combined Mental Health & Community Health Trust respondents.

- **Mental Health Patient on Staff Assaults** – The benchmark position target shown here is a long term stretch target. The Trust was above the mean for 2019/20 and is ranked 50th out of 57 Mental Health Trusts, which is a worsening of our 2018/19 position per 100,000 occupied bed days, excluding leave where the Trust was ranked 42nd out of 57 English Mental Health benchmarking respondents. The Trust ranked 27th out of 32 joint community mental health and is a worsening of our position where the Trust was previously ranked 22nd.

- **Mental Health Use of Restraint** – The benchmark position target shown here is a long-term stretch target. The Trust was below the mean for 2019/20 and is now ranked 18th out of 57 English Trusts, an improvement of 31 places from 2018/19 where the Trust ranked 49th out of 57. The Trust ranks 5th of 32 joint Community and Mental Health Trusts. This is an improvement of our performance in 2029/20 when the Trust was ranked 27th of 32.

- The Trust's reporting of the incidents in these categories has increased because of the focus on QI and Harm Free Care and priorities set out in the Annual Plan.

- The next update on this section will be Quarter 4 2021/22, when we expect 2020/21 benchmarking data to be published.

Safety

2.4. Key metrics that indicate how safe our services are, performance being within our control and influence:

- **Falls –** where the fall results in significant harm due to a lapse in care. The process for identifying where falls with significant harm have been the result of a lapse in care was developed and approved by the Safety Experience and Clinical Effectiveness Group. There were no incidents in 2020/21 year to date and none were identified in 2019/20. There were 2 in 2018/19. Reduction in falls is a focus for a QI programme breakthrough objective.

- **Mental Health Inpatient Deaths because of self-harm –** the metric has been updated to zero mental health inpatient deaths resulting from self-harm within a 12-month period. The last incident of an inpatient death from self-harm was in October 2018. The metric requires further consideration to confirm inclusion and definition of inpatient deaths from lapse in care, and whether this covers patients who were expected to be on a ward at the time of death. Reduction of all self-harm is a QI programme breakthrough objective.

- **Mental Health Bed occupancy** – for mental health acute beds. The figure shown here was the occupancy rate in February 2021 and shows 86% against a target of 85%. This is a decrease from 91% in October 2020.

- **Never Events –** This is all never events that occur in the Trust. None have been reported in the year to date to February 2021.

- **Suicide Rate -** By 2020/21, the Five Year Forward View (FYFV) for Mental Health set the ambition that the number of people taking their own lives will be reduced by 10% nationally compared to

2015/16 levels. The Trust's suicide rate decreased to 4.9 per 10,000 under mental health care in 2019/20 from 5.2 per 10,000 in 2018/19 for people in contact with mental health services. This local target was based on a 10% reduction from the 2015/16 suicide level of 9.2 per 10,000 people under mental health care. The Trust has achieved a 46.7% reduction of this rate. The next update will be in Quarter 4 2020/21. Our zero-suicide initiative and QI programme focus on self-harm provide complementary improvement activity in this critical safety area.

Engagement

2.5. Key metrics on how our patients, carers, staff, and stakeholders view us and our contribution to the local system and performance:

- **Commissioner Satisfaction - Net Commissioner Investment Maintained –** For 2020/21 we have agreed M7-12 investment for the part-year contract, and also bid for funding that enables satisfactory levels of funding required for the mental health investment standard and Frimley/BOB ICS Mental Health Long Term Plan transformation. We have also achieved system funding for the BOB Ageing Well programme, and rapid community discharge initiatives.

- **Stakeholder Satisfaction - Survey of System Partners –** a survey was developed in the second half of 2017/18. This was repeated in December 2019 and the results were positive with only 9.2% (11% in 2018) of the 24 respondents giving a neutral response to the Trust's leadership, quality, governance, and service delivery within the two Integrated Care Systems it operates within. Survey respondents included our six local authorities, and NHS commissioner and provider system partners. No target agreed.

- **Patient Friends & Family Test Response Rate –**This was suspended at the start of the pandemic and formal reporting restarted in December 2020, therefore this is below target at 6%. This indicator has been marked as red in Appendix 1 and is below the 9.29% when last reported in March 2020. This is a QI driver metric.

- **Staff Survey Engagement Rating –** latest available performance ranking published on 11th March 2021. The Trust Staff Engagement Score of 7.5 is an increase from 7.4 in 2019/20, and no other Trust scores higher nationally in our peer group. The next update will be in Quarter 4 2021/22.

Regulatory Compliance

2.6. Key metrics on how we are measured nationally based on external assessment:

- **Care Quality Commission Rating –** Outstanding rating achieved in March 2020.

- **NHSI Segmentation –** at last rating, maintained segment 1 of the Oversight Framework. Highest level of autonomy, with no NHSI support required. Use of Resources rating of 1 (lowest financial risk rating on scale of 1 to 4, as per plan for this year) in line with plan. Ratings have been suspended during the pandemic.

- **Number of CQC Compliance Actions –** There remains 6 compliance actions from the most recent CQC inspection, action progress is on-going and satisfactory:

  - **CAMHS** - The provider must continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk.

Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder pathway and autism assessment pathway. Business case and investment prioritisation decision making in progress with commissioners.

- **Adult Acute Wards -** The trust must ensure that ligature risks are managed appropriately (Regulation 12). This was in relation to fire doors with hinges on the wards.
- The trust must ensure that the ward environment is always adequately furnished and maintained. (Regulation 15).
- The trust must ensure that patients are kept safe. For example, promoting the sexual safety of people using the service (Regulation 12).
- The trust must ensure restrictions are necessary and proportionate responses to risks identified for individuals (Regulation 13).
- The trust must ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12).

Appendix 1 – Board Vision Metrics

Trust Board Vision Metrics

As at: February 2021

		Quality			Safety					
		Mental Health Patient on Patient Assaults	Mental Health Patient on Staff Assaults	Mental Health Use of Restraint	Falls Due to Lapse in Care	Mental Health Inpatient Deaths from Self-harm	Mental Health Bed Occupancy	Never Events	Pressure Ulcers YTD	Suicide Rate per 10,000 under Mental Health care
Target		Top 3	Top 3	Top 3	0	0	85%	0	Better than last year	10% Reduction Target 8.2
	Performance trend since last report (October 2018)	↓	↓	↑	↔	↔	↑	↔	↑	↑
Actual	All English NHS Mental Health Providers (out of 57)	52nd	50th	18th	0	0	86%	0	3	4.9
	Joint English Mental Health and Community Trusts (out of 32)	28th	27th	5th						
		Map to True North Domains	Harm-free care - Tracker metric	Supporting our staff - Driver metric	Harm-free care - Tracker metric	Harm-free care - Driver metric	Harm-free care	Money Matters - Tracker metric	Harm-free care / Regulatory Compliance	Harm-free care - Driver metric	Harm-free care - Driver metric

		Engagement				Regulatory Compliance		
		CCG Net Investment	CCG Satisfaction Survey	Patient FFT Response Rate	Staff Survey Engagement Rating (out of 32)	CQC Rating	CQC Compliance Actions	NHSI
Target		Green	To be defined	15%	3rd	Outstanding	0	Segment 1
		↔	-	↓	↑	↔	↔	↔
Actual		✓	✓	6.00%	1st	Outstanding	6	✓
		-	-	Patient Experience - Driver Metric	Supporting our staff - Drive Metric	-	-	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 April 2021
Title	COVID 19 Recovery Programme Highlight Report
Purpose	The purpose of this report is to provide the Board with an update on the Recovery and Restoration process for BHFT.
Business Area	All
Author	Kathryn MacDermott, Acting Executive Director of Strategy
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	BHFT have a dedicated Reducing Health Inequalities due to the impact of COVID
SUMMARY	The Recovery and Restoration programme of work has been amended from AMBER to GREEN. Whilst we continue to respond to the pressures of Wave 2 of COVID-19 and the Tier 1 and Tier 2 services continue to be under pressure, services have been able to continue in some form providing remote consultations in place of face to face where clinically appropriate.

	The Capacity and Demand model created in Wave 1 is being used to understand the impact of Wave 2 and any further surges on waiting list times. The learning from Wave 1 & 2 is being collated to compile a Standard Work for future 'Waves'. As we start to come out of wave 2 and the pressure eases staff that have been redeployed have returned to their substantive posts. The March Recovery Programme Board considering the Refresh and Reframe Wellbeing Plan and includes the key themes of: • Reflect – on our experiences and what we have learnt • Recuperate – help us find our own ways to rebuild our energies • Reconnect – with friends, families and colleagues • Reframe – look at new ways to work together • Respect – for each other as we continue to address the inequalities that some groups experience
ACTION REQUIRED	The Board is asked to: Note the report and progress.

COVID-19 Recovery Programme Highlight Report	Month: March 2021

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 The programme is underpinned by a Recovery Strategy approved by the Trust Board in May 2020. The existing Recovery Strategy will be updated to reflect the impact of Wave 2 of the pandemic on Recovery.

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	The March Recovery programme board recommenced and considered the learning from wave 1 & 2, the People Recovery plan and the capacity and demand modelling. The principle that operations lead on the recovery of services was reiterated and the programme board will review it's standard

re status & progress:	work to ensure maximum added benefit and minimum added workload. **Adult Community Health services** Many of the services models that were put in place in Wave 1 continued through Recovery and into the 2nd wave, such as the increase in in-reach on the frailty pathway, wrap around community services and support to intensive community rehab team (ICR). The diversion of capacity in MSK services into inpatients and community flow pathways has been instigated in wave 2 as it was in wave 1. In East Berks BHFT staff have staffed the discharge lounges and reframed the work of the ARC to assist with system pressures. In West Berks staff continue to support the Hospital Discharge Service which is now operating 7 days a week and later into the evenings. We had paused some services in Tiers 3 (medium) and 4 (low) of our priority matrix and diverting the staff and capacity into our Tier 1 (critical) and 2 (high priority) services to ensure flow/admission avoidance/Home first and capacity are maintained. As the pressure in services decreases staff are moving back to the tier 3 and 4 services. We continue to provide a virtual as well as a face to face consultation based on presentation and need. **Children's Community Health Services, including Children's and Young Persons' Mental Health** The vaccination team that was redeployed to support COVID vaccination is returning to school services as schools open up. Other services remained largely unchanged offering a virtual and face to face offer as defined by Wave 1. Most services are prioritised as critical or high priority (tier 1 and 2) and therefore we did not limit the service offer in wave 2 – this is based on the learning from wave 1. **Adult Mental Health Services** The service offer remains largely unchanged. We redeployed corporate staff into PPH to assist in ward areas to support discharge facilitation and provide support to the ward functions. We also enhanced our CPE and PMS services to support MH and Acute hospital flow and we utilised Winter pressures MH funding to increase capacity to services and the local systems. PPH remains under pressure and there continues to be staffing challenges. **Impact on Staff** Several corporate staff were redeployed to support clinical services in December and are now returning to their substantive posts. Staff redeployed from services classified as medium and low priority to support the critical and high priority services are also moving back as pressure/capacity allows. BHFT has drafted a People Recovery plan considered at the March Recovery programme board. **Digital Technology** We continue to make use of remote working across our mental health and community health services where clinically appropriate. **Equality Impact Assessments/Reducing Health Inequalities**

	BHFT has a dedicated Reducing Health Inequalities due to the impact of COVID action plan that reports quarterly to the Recovery programme board. I would also advise that there is likely to be further guidance on this area imminently.

Benefit	Timescale / date to be realised	Responsibility	Achieved Yes/No	Comment
Services restored	June 2021	Divisional Directors	Yes	All services are operational providing a blended service offer or remote and face to face were appropriate.
New ways of working embedded	June 2021	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. The original timescale of March 2021 has been extended to June 2021 to reflect the additional time operational services may need to embed new ways of working whilst responding to Wave 2. This timescale is provisional and will be reviewed by the Recovery Programme Board.
Digital technology incorporated into Business as Usual	June 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. Timescale revised to June 2021 in line with the timescale for embedding new ways of working.
Transparent modelling of capacity required to clear waiting list backlogs and implementation plans agreed.	June 2021	Divisional Directors / Assistant Director of Performance & Information	Part	The Capacity and Demand model is in place, initial trajectories have been shared with the Division and the Assistant Director of Performance & Information provides regular update to the Recovery Programme Board. Further work is needed to incorporate workforce planning which drives the potential costing model.

Restored services provide equality of access	March 2021	Divisional Directors	Part	Health East has completed and shared a framework to consider when using remote rather than face 2 face contacts. Equality of access is a priority area in the Reducing Health Inequalities due to COVID action plan.

Risks to highlight

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment
Board Assurance Framework – Risk 8B COVID-19 Recovery		• 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 the capacity required to fully open services as part of recovery whilst also responding to the 2nd wave of COVID-19 and 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 the 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
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 2021	Second wave did impact on the Recovery of services. However, all services are now operational again offering a blended model of remote and face to face were appropriate.
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	Revised to June 2021	The Capacity and Demand model was completed as part of Wave 1 Recovery. The modelling will now be updated to take account of the impact of wave 2. Timescale revised to June 2021 with a Recovery Programme Board Gateway decision on progress in March 2021.
Mass Vaccination Programme		Staff Vaccinations commenced December 2020.	December 2020	Vaccination of front-line staff has commenced and proceeding at pace. The Wokingham hub includes weekend and evening appointments.

Title / Description	Current Status (RAG)	Mitigating actions	By when	Comment
				The expectation is that all NHS staff have received their 1st vaccination by the end of January 2021. We are currently c.80% 1st vaccination coverage and 2nd vaccinations have commenced.

Current Milestones Report

Milestone	Due date	Current Status (RAG)	Actions / Comments
Plan for Corporate Services new ways of working developed	Revised to June 2021		Impacted by Wave 2.
Use of the Capacity and Demand modelling tool to assess future capacity of services and resources required to clear waiting list backlogs.	Revised to June 2021		Wave 1 Capacity and Demand modelling will need to be updated following Wave 2
Recovery process post wave 2 to be developed and agreed.	March 2021		This will build on the lessons learnt from managing Wave 1.

	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
Assessment of Wave 2 on Recovery	Wave 2 has impacted on Recovery and tier 3 and 4 face to face appointments paused or replaced with remote consultations.	March 2021
Recovery Strategy updated	Recovery Strategy previously approved. To be updated with the impact of Wave 2 and proposed Wave 2 Recovery process.	March 2021
Prioritisation checklist to be compiled	Include in the Wave 2 Recovery Strategy and delivery plan	March 2021
Wave 2 Recovery plan initiated	Learning from wave 1 & 2 considered at the March Recovery board. Standard work to be updated. Review of the recovery governance process to be completed.	April 2021
Capacity & Demand modelling trajectories completed	Timescales to be confirmed post Wave 2 surge	

Completed Milestones

Milestone	Due date	Current Status (RAG)	Actions / Comments
Capacity and Demand Prioritisation List	March 2021		Programme Board considering outcomes of In-House C&D Work, Heatmap and information already provided to other meetings to inform priority list of services (to also consider workforce, harm and patient volume). This work was completed at Divisional level.
Reducing Health Inequalities due to COVID-19 Action Plan	January 2021		Reducing Health Inequalities due to COVID-19 Action Plan (known as the Eight Point action plan) drafted and considered by the Exec in January. Updates on progress will be reported quarterly to the Recovery Programme Board.
Recovery workbook to be updated	January 2021		Recovery guidance tab created, regularly updated with the guidance related specifically to Recovery
BAF Recovery risks updated to reflect the impact of Wave 2	December 2020		Amendments to the BAF Recovery risks completed and regularly reviewed
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

Milestone	Due date	Current Status (RAG)	Actions / Comments
Phase 3 requirements	October 2020		Allocation of phase 3 requirements with associated leads and agreed timescales completed with organisational governance and reporting to provide Trust Board for assurance via the Recovery Programme Board highlight report.
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.	Sep 2020		KM coordinating this work, combination of recovery and phase 3 milestones and activity.
Template for patient letters	July 2020		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.	August 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.	August 2020		Remaining will be approved by Chairs Actions
Capacity & Demand Task and Finish Group recommendations to Recovery programme board	October 2020		Inhouse Capacity and Demand tool to be used for adult services. Berks East CCG have requested use of the Attain tool for children's services.
QIA and EFM Complete for all services post wave 1	December 2020		All Community physical and mental health services have completed and approved QIA and EFM templates for Wave 1 recovery. A revised process will need to be considered for Wave 2 Recovery.
Review all Phase 3 requirements and build necessary action plans.	Revised to October 2020		Identify organisational actions from Phase 3 and ensure these are owned and tracked. Completed and now to be transferred to Recovery Actions List.
Stakeholder Engagement and Communications Plan in place.	June 2020		Weekly / twice weekly staff bulletins circulated. DD and SRO participate in system calls.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 April 2021
Title	**Use of Trust Seal**
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to: • a 10 year agreement for the maintenance of a small area of tree planting (about the size of a tennis court) on freehold land the Trust owns at West Berkshire Community Hospital • The planting is being caried out by Earthwatch with circa £25K of funding from DEFRA. • The proposal is approved by the Trustees of the PFI and was approved at Estates Review Group on 8th February. • There are environmental and community benefits from supporting the initiative.
ACTION	To note the update.