Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(Conducted electronically via Microsoft Team)

10:00am on Tuesday 13 July 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 11 May 2021	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Three Patient Stories – Community Nursing	Debbie Fulton, Director of Nursing and Therapies • Melissa James • Samantha Mcendoo • Saiyad Allymamod	Verbal
6.1	Freedom to Speak Up Guardian's Report	Mike Craissati, Freedom to Speak Up Guardian	Enc.
6.2	Freedom to Speak Up Self-Assessment Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Annual Complaints Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.4	Research and Development Annual Report	Dr Minoo Irani, Medical Director	Enc.
6.5	Annual Medical Revalidation Report	Dr Minoo Irani, Medical Director	Enc.
6.6	Infection Prevention and Control Board Assurance Framework Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.7	Quality Assurance Committee a) Minutes of the meeting held on 01 June 2021 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Chair of the Quality Assurance Committee	Enc.

No	Item	Presenter	Enc.
6.8	Quality Improvement Programme Update Report	David Townsend, Chief Operating Officer	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 02 2021/22 Finance Report	Paul Gray, Acting Chief Financial Officer	Enc.
8.1	Month 02 2021/22 Performance Report	Paul Gray, Acting Chief Financial Officer	Enc.
8.2	Vision Metrics Report	Paul Gray, Acting Chief Financial Officer	Enc.
STRATEGY			
9.0	COVID-19 Recovery Plan Report	Alex Gild, Deputy Chief Executive	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting held on 26 May 2021	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – *(10 August 2021 if required)* 14 September 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 11 May 2021

(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
	Mehmuda Mian	Non-Executive Director
	David Townsend	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Rachel Morgan	Specialist Speech and Language Therapist *(present for agenda item 6.0)*
	Amanda Mollett	Head of Clinical Effectiveness and Audit *present for agenda item 6.3)*
	Jason Hibbert	Quality Account and NICE Lead (*present for agenda item 6.3)*
	Jane Nicholson	Director of People *(present for agenda item 7.1)*

21/077	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
21/078	**Apologies** (agenda item 2)
	There were no apologies.

21/079	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
21/080	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
21/081	**Minutes of the previous meeting – 13 April 2021** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 13 April 2021 were approved as a correct record.
21/082	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
21/083	**Patient Story – A Children's Speech and Language Therapy Story (**agenda item 6.0)
	The Chair welcomed Rachel Morgan Specialist Speech and Language Therapist to the meeting. Rachel Morgan presented the patient story which concerned a baby with "N" syndrome who had a history of feeding difficulty, faltering growth, low tone, heart issues, pulmonary stenosis, tongue tie, reflux with vomiting and a possible cow's milk allergy (further information about the case study is attached to the minutes). Ms Morgan said that the baby was referred to the Trust's Speech and Language Therapy Paediatric Dysphagia Service and Feeding Team because of the baby's difficulties with feeding. It was noted that a multidisciplinary team were involved in supporting the baby and parents because of the baby's complex healthcare needs. This included: Speech and Language Therapy, Health Visiting, Dietitian, Occupational Therapy, Community Nursing and the Royal Berkshire Hospital's Paediatrics service. Ms Morgan reported that the Speech and Language service had made a link with another local family who had a child with "N" syndrome who also had early feeding difficulties and reported that the mother had exchanged texts with the other mother and had found the peer support helpful. Ms Morgan reported that Speech and Language service recommended that the baby had alternate nasogastric tube and oral feeds. The baby made good progress and was now able to feed orally. It was noted that the baby had a date for key-hole heart surgery at the end of May 2021.

	Mark Day, Non-Executive Director referred to the last slide of the presentation which listed the different services which were supporting the baby and family and pointed out that peer support was not included on the list and asked whether peer support was standard in such cases. Ms Morgan reported that it was case specific and pointed out that there were other ways to access peer support, for example, Wokingham ran a scheme for any child referred for early intervention. Aileen Feeney, Non-Executive Director said that she was not aware of the Speech and Language Therapy service's role in addressing problems with a baby's eating and drinking and asked how common it was for a baby to be referred into the service because of feeding problems. Ms Morgan responded that it was relatively common but pointed out that it was rare for a baby to have such complex health needs. David Buckle, Non-Executive Director asked Ms Morgan whether there was anything she would like to change about the service. Ms Morgan said that in an ideal world she would like babies and children to be referred into the Speech and Language Therapy service at an earlier stage. The Chief Executive said that he was interested in the range of work the Speech and Language Therapy service provided and asked whether it was a rewarding role. Ms Morgan said that it was a rewarding role and reported that nationally there was a piece of work to include feeding and drinking difficulties as part of the Speech and Language Therapy pre-registration training which would put the service on a par with other countries. The Chair thanked Ms Morgan for a fascinating presentation and commented that it must be very reassuring for parents of babies who had difficulties with feeding to be supported by the service.
21/084	**Patient Experience Report – Quarter 4** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • 56 complaints were received in quarter 4: of these 2 related specifically to COVID-19/COVID-19 pandemic. • Prospect Park Hospital saw an increase in complaints (11 in total this quarter compared to only 1 in quarter 3); however the total for the year overall was the same as in 2019/20. Prospect Park Hospital complaints would continue to be reviewed to ensure that there was not an increasing trend with any particular themes emerging. • There were 1,319 compliments recorded on our system (compared with 1,010 in quarter 3). This remained significantly lower than last year, however given many of our planned services for routine care had been in a phase of restoration/followed by some reduction in services during the second wave of the COVID-19 pandemic this was perhaps not surprising. • The ombudsman had advised that due to the impact of the pandemic they had a significant backlog of complaints waiting review and therefore they would be focusing on those that were more serious and/or had resulted in significant impact.

	• A contract has been awarded to I Want Great Care to develop a new patient experience measure tool with us. The project started in April 2021 and would take approximately 9 months. The Trust was planning co-production workshops with all our services, their patients and carers between May and June 2021 to hear what questions they thought would be important to ask, building on the themes identified in phase one of the project last year. The survey would then be designed over the summer and tested for a month in all services at the end of October 2021. Rollout of the new survey would start in January 2022. David Buckle, Non-Executive Director commented that it was detailed and helpful report but referred to the benchmarking data in the report and pointed out that it was difficult to make any meaningful comparisons with other similar organisations. The Director of Nursing and Therapies agreed but suggested that the new patient experience tool may make it possible to make meaningful comparisons with those Trusts who were also using the I Want Great Care patient experience measure tool. Chris Fisher, Non-Executive Director referred to the breakdown of complaints by age on page of 38 of the agenda pack and suggested that the data would be more meaningful if it highlighted those age groups which submitted a disproportionate number of complaints. **Action: Director of Nursing and Therapies** The Chair commented that he found the summary and outcome of the formal complaints set out in the appendix to the report very useful in helping the Board to understand the concerns raised by patients and service users. **The Trust Board**: noted the paper.
21/085	**Staff Staffing Six-Monthly Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and reported that the COVID-19 pandemic had impacted on all the Trust's inpatient wards during the last six months. This included increased staff sickness absence, the requirement for more staff to shield and the need to redeploy staff to support the wards. In addition, there was an increase in the acuity of patients and the need to take action to reduce the transmission of COVID-19 including cohorting of patients, flexing bed numbers and some closure of wards. The Director of Nursing and Therapies reported that over the reporting period, there was an increase in the number of shifts with less than two registered nurses and confirmed that senior staff and managers had continued to deploy the available staff resource to maintain safety, with all areas having mitigation and processes in place for when there were staff shortages. David Buckle, Non-Executive Director pointed out that prior to the COVID-19 pandemic, the Trust had been improving its safe staffing performance. Dr Buckle acknowledged the mitigations that were put in place to support wards when there were staffing shortages and asked what action the Trust would take if the mitigations were not sufficient to maintain safe staffing. The Director of Nursing and Therapies said that it was relatively easy to move staff from one ward to another and in addition, the Trust's non-registered Nursing Associates were not included in the safe staffing figures but could be deployed to support wards.

	The Chief Operating Officer reported that the Trust had business continuity plans which included closing less critical services and deploying those staff to support critical services. Dr Buckle thanked the Director of Nursing and Therapies and the Chief Operating Officer for their responses and said that he was assured that the Trust would do everything it could to maintain safe services and had plans in place to respond to short term surges together with longer term business continuity plans. The Director of Nursing and Therapies reported that the Trust was talking to Solent NHS Trust to find out how they had reduced their average length of stay and as a result the Trust was reviewing the skills mix with a view to using more Therapy staff on the wards. Chris Fisher, Non-Executive Director referred to the national benchmarking skill mix table on page 68 of the agenda pack which highlighted that the Campion Unit's recommended establishment based on an average of 4 patients was 12.45 members of staff compared with the Trust's establishment of 37.11 members of staff. The Director of Nursing and Therapies reported that the benchmarking tools were useful but did not provide the whole picture and pointed out that the Campion Unit needed more staff because the Unit was on two levels. In addition, the benchmarking data did not take account of the need to have two members of staff to one patient. The Director of Nursing and Therapies said that it was important that the Trust used the available staffing tools but staffing requirements needed to be considered in the round in order to make a clinical judgement. The Chair said that it was sensible to talk to Solent NHS Trust to find out how they had reduced their average length of stay. The Chair said that it would be helpful if future reports could draw together and summarise the information from the different safe staffing tools. **Action: Director of Nursing and Therapies** On behalf of the Trust Board, the Chair thanked staff for their work during the COVID-19 pandemic. **The Trust Board**: noted the report.
21/086	**Quality Accounts 2020-21** (agenda item 6.3)
	The Quality Accounts 2020-21 had been circulated. It was noted that the Quality Assurance Committee had reviewed the draft Quality Accounts during quarters 1, 2 and 3 and that the quarter 4 version had been shared electronically with the Quality Assurance Committee at the end of April 2021 for comment. The Medical Director presented the Quality Accounts and reported that for the second year running, NHS Improvement did not require the Quality Accounts to be submitted as part of the Trust's Annual Report and Accounts and the Trust was not required to commission an external audit on the Quality Accounts 2020-21. It was noted that the current version of the Quality Accounts did not contain details of the following information which had not yet been published: • Full-year incident data from the national reporting and learning system (NRLS)

	• 2021/22 CQUIN details This information would be added as soon as it was available and prior to the publication of the Quality Accounts on the Trust's website. Chris Fisher, Non-Executive Director commented that the Trust's Annual Report included a "going concern" declaration and asked whether the Quality Accounts should highlight any material changes which could affect quality, for example, the impact of the COVID-19 pandemic on waiting lists etc. The Medical Director said that the Quality Accounts was a retrospective report and that if during the course of the year there were issues which impacted on quality, the Trust Board would be informed at the time. Naomi Coxwell, Non-Executive Director commented that the Quality Accounts document was an excellent way to capture and summarise performance over the last twelve months. Ms Coxwell said that the inclusion of the views of external stakeholders, for example, local authorities, clinical commissioning groups and the governors also provided assurance about the Trust's performance during a very challenging and volatile year. **The Trust Board:** a) Considered the Statement of Directors' Responsibilities in Respect of the Quality Account 2020-21 and ensured that they were satisfied with the Quality Account in relation to the requirements detailed in the statement. b) Confirmed to the best of their knowledge and belief that they had complied with the requirements detailed in the statement in preparing the Quality Report c) Authorised the Chair and Chief Executive to sign the Statement of Responsibilities.
21/087	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following issues were discussed further: **a) CAMHS Tier 4 Service Changes** The Chief Executive reported that Willow House (Child and Adolescent In-Patient Unit) had closed on 30 April 2021. It was noted that this was a phased closure programme so that patients could be safely transitioned or discharged from the services. The Chief Executive paid tribute to the leadership of the Chief Operating Officer for ensuring the smooth transition of an inpatient facility to a new community based service model. The Chief Operating Officer in turn thanked everyone involved and in particular, the clinicians who had worked hard to develop the new out of hospital service model. Chris Fisher, Non-Executive Director noted that a provider collaborative led by Oxford Health NHS Foundation Trust together with the Trust and other local providers took responsibility for the commissioning of CAMHS Tier 4 services from NHS England and asked how the provider collaborative would deal with any future increases in demand for the service.

	The Chief Operating Officer explained that there were joint agreements in place with all the provider organisations around how the service would operate and there was an agreement between the provider collaborative and NHS England. The Deputy Chief Executive and Chief Financial Officer reported that the risk share agreement was currently being developed and would be presented to a future Trust Board meeting for approval. **Action: Deputy Chief Executive and Chief Financial Officer** Mark Day, Non-Executive Director and Staff Health and Wellbeing Champion said that service changes often caused anxiety for staff and he was pleased that Willow House staff had been successfully deployed into other Trust services. Mr Day suggested that the Trust publicise the positive outcome for staff other staff across the Trust. The Chief Operating Officer thanked Mr Day for his suggestion and agreed to give some thought to how best to inform staff. **Action: Chief Operating Officer** Naomi Coxwell, Non-Executive Director asked about service users' reaction to the closure of Willow House. The Chief Operating Officer confirmed that the Trust had worked very closely with existing Willow House patients about plans for their on-going care and they had been heavily engaged in the conversations about the new service model. The Chief Operating Officer confirmed that existing patients had been very supportive of the new service model. The Chair thanked the Chief Operating Officer and his team for ensuring a smooth transition from the closure of the Willow House to the new community based service model. **The Trust Board**: noted the paper.
21/088	**Gender Pay Gap Report** (agenda item 7.1)
	The Chair welcomed the Director of People to the meeting. The Deputy Chief Executive and Chief Financial Officer reminded the meeting that Gender Pay Gap Reporting was a requirement for all NHS provider organisations. It was noted that there had been a slight improvement to the Trust's Gender Pay Gap from 20% in 2019-20 to 19% in 2020-21. The Director of People presented the report and highlighted the following points: • Like other NHS Trusts, the female workforce made up most of our staffing (82.6%) – the male cohort was 17.4%. • There had been a slight dip in the number of women in the lowest quartile of pay (Quarter 1) and in the highest quartile of pay (Quarter 4). • Whilst the gender pay gap had reduced slightly, the number of females in the senior bands had also reduced. • The number of females in the lowest quartile of pay (Quarter 1) remained higher than the proportion of females employed in the Trust. • For different reasons, the majority number of staff employed on a part time basis were female – a factor that contributed to the gender pay gap.

	• The majority number of staff who used the childcare salary scheme were female – this had a disproportionate impact on the hourly rate of female staff. • The average bonus pay gap relating to the Consultants Clinical Excellence Awards had been reduced, but the difference remained substantial. The Deputy Chief Executive and Chief Financial Officer reported that the Trust's actions to address the Gender Pay Gap would be considered and agreed as part of the Trust's refreshed Equality, Diversity and Inclusion Strategy. The following actions are proposed: • The Trust needed to increase the focused work to attract more males to work for the Trust. Adverts and social media included an increased number of photographs of our male workforce, but over the coming 12 months the Trust needed to identify more ways of making Berkshire Healthcare an attractive employer for men. • Continue to support the development of female staff through mentoring, leadership development and talent management. The Trust needed to focus on ensuring that our female staff at lower bands had the confidence, skills and were supported to apply for our more senior posts at band 8A and above, including Very Senior Management posts. • Further work needed to be done to understand the gender variances in the Consultants Clinical Excellence Awards to build on the number of female Consultants who were awarded Clinical Excellence Awards. This in turn would reduce the average pay gap in the value of the bonus when compared to male Consultants. • Share our Gender Pay Gap position (as reported) with all our staff, including the actions we will take to improve our position. Aileen Feeney, Non-Executive Director asked about the reasons why female consultants were less likely to apply for Clinical Excellence Awards compared with their male colleagues. The Medical Director reported that the Trust had undertaken a lot of work to encourage female consultants to apply for Clinical Excellence Awards and reported that some female consultants had not applied for an award because they were part time and were not aware that they could still apply and/or they did not consider that they had worked over and above their role. In addition, female consultants were also less likely to volunteer to be members of the Clinical Excellence Awards panel. The Medical Director reported that the Trust had made progress on both issues but pointed out that due to the COVID-19 pandemic, there had been a national directive to proportion the current Clinical Excellence Awards across all consultants. **The Trust Board**: a) noted the report. b) Agreed the proposed actions as set out above.
21/089	**Month 12 2120-21 Finance Report** (agenda item 8.0)
	The Deputy Chief Executive and Chief Financial Officer presented the paper and highlighted the following points:

	• The Trust's Annual Accounts 2020-21 were currently being audited by the External Auditors and would be approved at the special Audit Committee meeting on 26 May 2021 • The Trust had closed 2020/21 with a reportable surplus of £0.1m. This was £3.3m better than was original forecast. After accounting for allowable impairment costs, the Trust had closed the year £1.3m in surplus, and better than the system expectation of breakeven. • During the year, the Trust had incurred marginal cost increases responding to the COVID-19 pandemic of £10.5m. These costs were offset with £9.4m of central COVID-19 funding, which included an additional £2.0m secured from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System in March 2021 • The closing year end cash balance for March 2021 was £39.1m. This was significantly higher than originally envisioned at the beginning of the year and reflected the financial backing received during the year through the financial regime. Chris Fisher, Non-Executive Director and Chair of the Audit Committee congratulated the finance team for the accuracy of their forecasting and for delivering the Trust's financial plan during a very volatile and challenging year. The Chair also expressed his thanks to the finance team. The Chair referred to page 196 of the agenda pack and pointed out that the number of management and administrative staff continued to increase. The Deputy Chief Executive and Chief Financial Officer pointed out that these posts related to support for clinical services rather than an increase in the number of back office staff. The Deputy Chief Executive and Chief Financial Officer proposed providing an analysis of these posts to the Finance, Investment and Performance Committee to provide assurance. **Action: Deputy Chief Executive and Chief Financial Officer** Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Committee had last reviewed increase in the number of management and administrative posts in July 2020, the analysis had highlighted that these posts were broadly due to planned or funded changes to services. Ms Coxwell agreed that this was an area which the Committee would continue to keep under review. **The Trust Board noted:** • The Trust had closed 2020/21 with a reportable surplus of £0.1m. This was £3.3m better than was original forecast. • After accounting for allowable impairment costs, the Trust had closed the year with a £1.3m in surplus, better than the system expectation of breakeven. • The better than planned surplus had given rise to a materially higher cash balance than planned of £39.1m. • Overall capital expenditure was £7.8m versus the financial plan of £8.2m, with a further £0.6m of spend funded centrally in year by the Department of Health and Social Care.

21/090	**Month 12 2120-21 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 12 "True North" Performance Scorecard had been circulated. The Deputy Chief Executive and Chief Financial Officer highlighted that in March 2021 there was an increase in the incidence of self-harm (177 incidents against a target of 42). It was also noted that there was a spike in the number of Out of Area Placements and the number of falls was above target (34 falls in March 2021 compared with the target of 20 falls per month). The Director of Nursing and Therapies reported that she was confident that performance would improve now that the COVID-19 second wave was over. The Director of Nursing and Therapies said that the Community Wards were developing new countermeasures to reduce the incidence of falls and pointed out that 3 patients had contributed to 69 of the self-harm incidents. The Chair asked whether the areas of under-performance all related the COVID-19 pandemic. The Director of Nursing and Therapies confirmed that responding the COVID-19 pandemic had been challenging but also pointed out that length of inpatient stays had also increased over recent months and that this was also a contributory factor to the Trust's recent underperformance in some of the harm free metrics. Chris Fisher, Non-Executive Director suggested that the increased length of stay may be because the Trust had developed community-based models aimed at supporting people at home rather than in hospital and that had increased the acuity of the patients requiring an inpatient bed. The Chief Executive said that it was important that the Trust retained its objectivity and did not seek to attribute the COVID-19 pandemic for all areas of under-performance. **The Trust Board:** noted the report.
21/091	**Finance, Investment and Performance Committee Meeting on 25 March 2021** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that the Trust had succeeded in delivering an ambitious capital programme whilst responding to the COVID-19 pandemic. Ms Coxwell reported that the Committee had acknowledged that the challenges around responding to the COVID-19 pandemic had negatively impacted on some of the Trust's key performance indicators around reducing falls and the reducing the incidence of self-harm. The Chair thanked Naomi Coxwell for her update.

21/092	**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 Restauration Programme of work was rated GREEN. All services were operational. The Acting Executive Director of Strategy reminded the meeting that the April 2021 Trust Board had requested a breakdown of the recovery timescale for different types of services. It was noted that concurrently the Recovery Programme Board had been considering how we incorporated recovery into business as usual and embed the transformational changes made as part of the Trust's response to the COVID-19 pandemic into the implementation of the Trust's three-year strategy. The Acting Executive Director of Strategy confirmed that a summary narrative of the extreme and high-risk services including cause, trend, actions underway, support needed would be presented to the June 2021 Trust Board Discursive meeting. **Action: Acting Executive Director of Strategy** Mark Day, Non-Executive Director reported that during the Non-Executive Director and Governors break out meeting at last week's Joint Trust Board and Council of Governors meeting, the staff governors had mentioned concerns about the Trust's service recovery plans because staff were exhausted post-COVID-19. The Acting Executive Director of Strategy thanked Mr Day for his feedback and reported that the Trust also had a People Recovery Plan which took account of the impact of the COVID-19 pandemic both on a professional and personal level. The Deputy Chief Executive and Chief Financial Officer reported that the People Recovery Plan was due to be launched at the Trust Leadership and Management Forum on 14 June 2021. The Deputy Chief Executive and Chief Financial Officer agreed to update the Governors about the Trust's Health and Wellbeing programme. **Action: Deputy Chief Executive and Chief Financial Officer** The Deputy Chief Executive and Chief Financial Officer thanked Mr Day for his feedback. **The Trust Board**: noted the report.
21/093	**Strategy Implementation Plan Update Report**
	The Acting Executive Director of Strategy presented the paper which set out a status update on the Trust's combined programme, project and strategy implementation. The Acting Executive Director of Strategy reported that the Executive Team was reviewing the format and context of the report. The Chair said that he would forward his suggestions on the format of the report. **Action: Chair and Acting Executive Director of Strategy** **The Trust Board**: noted the report.

21/094	**Audit Committee Meeting Held on 21 April 2021**
	Chris Fisher, Chair of the Audit Committee reported that the Trust's Annual Report and Accounts 2020-21 would be approved at a special meeting of the Audit Committee on 26 May 2021 and extended an invitation to non-members of the Audit Committee to attend the meeting. Mr Fisher reported that in addition to the standard items on the agenda, the Committee had discussed the following: • **Quality Improvement Programme** – the Committee agreed that an external review of the Quality Improvement Programme was not required and that the Committee would receive a report which set out the findings of an internal review • **Aged Debt** – the Committee received a report on aged debt. • **Single Waiver Tenders** – the Committee noted a spike in the number of single waiver tenders partly due to the COVID-19 pandemic and partly due to a vacancy in the Procurement Team. The vacancy had now been filled. • **Counter Fraud** – the Committee had discussed the new Counter Fraud standards which came into effect from 1 April 2021 and had noted that the Trust was not currently compliant with the standards but the Committee was confident that the Trust had plans in place to address any gaps. The Chair thanked Chris Fisher for his update. **The Trust Board:** noted the minutes of the Audit Committee held on 21 April 2021.
21/095	**Annual Report 2020-21**
	It was noted that the Draft Annual Report 2020-21 was not included with the published meeting paper pack and was circulated to members of the Board only because legislation required that the Annual Report could not be published until the final version was laid before Parliament in July 2021. The Company Secretary reported that the Trust's External Auditors had still to undertake their audit of the draft Annual Report. The Company Secretary agreed to inform the Board of any changes between the draft circulated and the final document. **Action: Company Secretary** The Chief Executive invited members of the Board to forward any comments to the Company Secretary. The Company Secretary agreed to circulate any amendments to the Board prior to the special Audit Committee meeting convened to approve the Annual Report and Accounts on 26 May 2021. **The Trust Board**: approved the draft Annual Report 2020-21 subject to any amendments made in response to the Trust's External Auditors and the correction of any typological and formatting errors.

21/096	**Council of Governors Update** (agenda item 10.0)
	The Chair reported that he would be discussing with the Governors about which meetings would continue to be conducted online and those which would revert to face to face meetings once the COIVD-19 social distancing requirements had been lifted. The Chair reported that the virtual Non-Executive Director breakout sessions with Governors had worked very well at last week's Joint Board and Council of Governors meeting. The Chair reported that the Council of Governors had three new Governors: • Younger People with Dementia (Partnership Governor) – Richard Noakes • Public Governor, Slough – Natasha Afful • Public Governor, Wokingham – John Jarvis It was noted that the elections for public governors were currently underway in: • Reading • Rest of England • Bracknell • Berkshire West • Staff - Non-Clinical
21/097	**Any Other Business** (agenda item 11)
	There was no other business.
21/098	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 13 July 2021
21/099	**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 11 May 2021.

Signed…….. Date 13 July 2121

(Martin Earwicker, Chair)

NHS
Berkshire Healthcare
NHS Foundation Trust

CYPIT Case study

Speech and Language Therapy Paediatric Dysphagia Service & Feeding Team

CareQuality Commission Inspected and rated Outstanding

Diversity and Inclusion Bringing us together

GDE Digital solutions for outstanding healthcare

SLT dysphagia service for babies/children with eating and drinking difficulties

- Provided by CYPIT SLT as part of the services within Dingley CDC (contracted with RBH)
- SLT role is to assess physical safety and development of the baby/child's ability to eat and drink, taking into account the many factors involved and advise, working collaboratively with other members of the team involved.
- This can involve alternative feeding alongside continued oral feeding, or advice regarding positioning, developmental stage of feeding and oral motor skills, appropriate bottles/ teats, strategies for pacing feeds, and/or consideration of early weaning etc with the aim to promote safe oral feeding where possible to enable a child's growth and development.
- Videofluoroscopy assessment (moving X-ray of a baby/ child's swallow) clinics are run by SLTs jointly with Radiology at RBH to assess the pharyngeal stage of swallowing in more detail following clinical assessment as required.

Referral

- Baby with N syndrome referred by Acute Paediatrician at 16 weeks
- Baby referred to OT for specialist seating due to low tone
- History of feeding difficulty and faltering growth. Key factors: low tone, heart issue, pulmonary stenosis, tongue tie, reflux with vomiting, possible cows milk allergy. HV support at home with feeding to date liaising with medical team at RBH.
- SLT visits baby (17 weeks) at home with parents and assessed as safe with swallowing in terms of aspiration risk but that tongue tie could be exacerbating reflux, cause issues for weaning and that low tone is affecting feeding. (Mainly anecdotal evidence that tongue tie can worsen reflux through aerophagia and inefficiency of peristaltic tongue movements for suck) Advice given on pacing and positioning for feeds.
- SLT feeds back to acute medical team that feeding safe but that tongue tie release would be advised. Issue with clotting in N syndrome due to low platelets means further medical advice needed before proceeding with a release.
- Baby continues to be ‘fussy’ around feeding, vomiting, issues with winding him and is not taking enough milk

Admission

- Reflux medication (Omeprazole) and alternative milks trialled
- Baby not gaining weight, fussing around oral feeds, so re-admitted to ward. NG tube passed.
- SLT sees baby on the ward, and advises alternate NG and oral feeds as baby very fatigued.
- Baby discharged with NG in situ. High calorie milk prescribed.
- CCN and Paediatric Dietitian become involved to support family alongside HV. NG and oral feeding continues.
- Tongue tie release discussed again between wider medical team and ENT, and agreed this can go ahead
- Anterior and posterior tongue tie release successfully performed by ENT (22 weeks)

Joint appointment

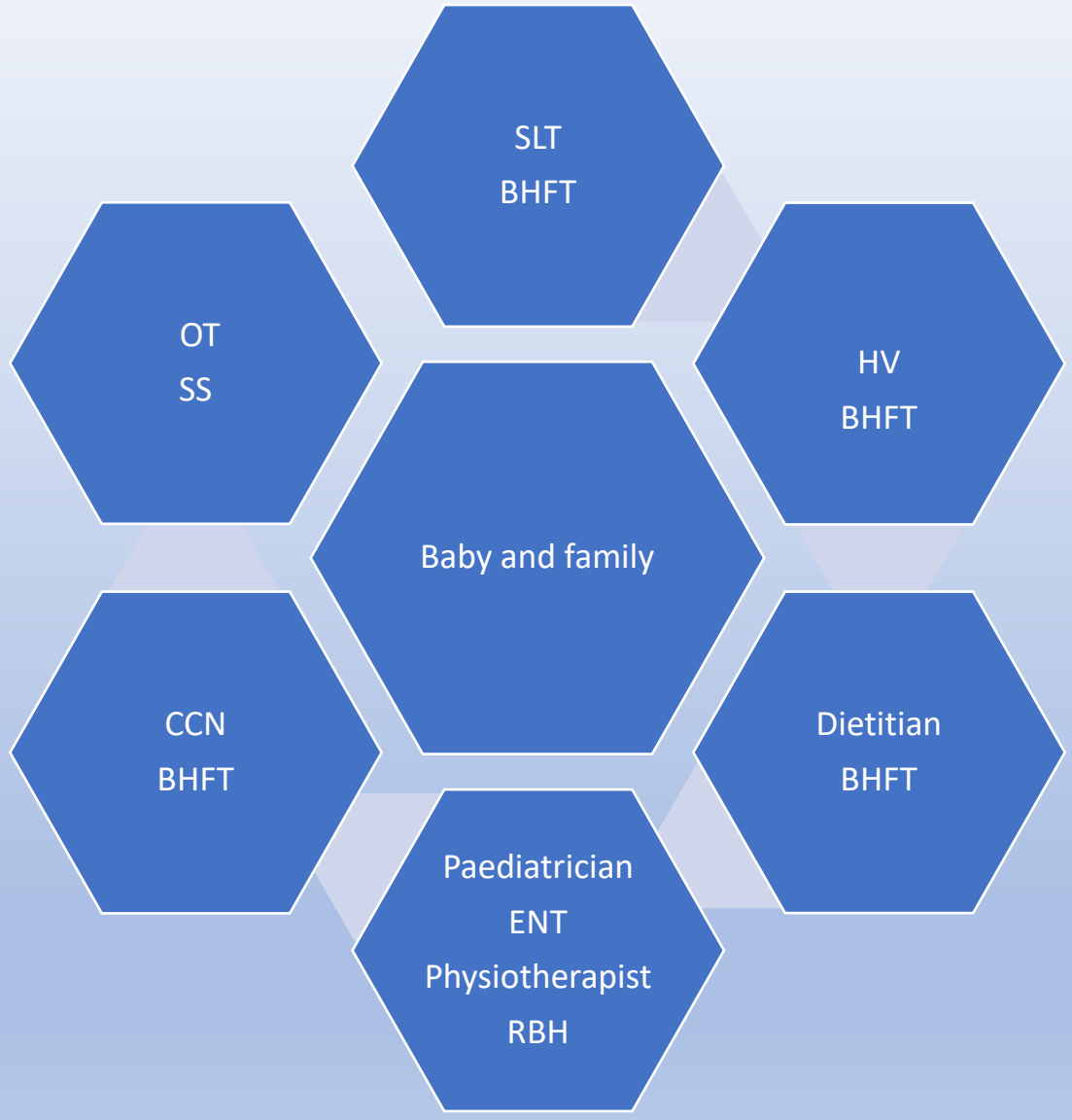
- SLT visits family with Dietitian at home 5 days post frenectomy (tongue tie release) Baby feeding better. No longer taking reflux medication.
- SLT had liaised with Mum regarding teats by text prior to the appointment as parent still trying to use and sterilise single use teats from hospital. Took appropriate Medulla slow flow teat (similar shape to ward teat). Bottle and teat left for use by family, Mum to purchase the same and next teat size up.
- SLT looked at chair/seating available due to low tone and support needed, family awaiting specialist chair. Looking to wean early to aid weight gain. Consultant had previously given go ahead to wean post 17 weeks.
- Dietitian makes a feed plan at the visit with parents, taking into account what he is managing orally, to wean off the NG tube. Scales left with family for weighing baby.

Support for family

- SLT had made a link to another local family who have a child with N syndrome who had early feeding difficulties. Mum has spoken to and exchanged some texts with this Mum which she found helpful.
- HV and CCN continue to make regular checks in with parents to support use of NG tube alongside oral feeding and provide support for maternal wellbeing/family support
- Dietitian continues to check in with family for weight information and progress onto full oral feeding

Joint appointments

- Dietitian updated team (CCN/ HV/ SLT) that baby taking milk by bottle much better but issues with moving to solids
- Baby has been able to feed orally with NG tube not replaced when it came out due to the good progress. Now on 0.4th centile for first time (syndrome associated with restricted growth)
- Joint SLT and Dietitian visit to assess physical skills for solids and positioning to offer further advice (26 weeks)
- Oral milk feeds going well, Mum able to move him to medium teat. Positioning for solids still an issue as baby has low tone, specialist chair still not available. SLT to review once chair in place, Mum to move to low volumes of twice daily solids in the interim. Seeing Physiotherapist for core strengthening exercises/advice.
- Liaison with RBH team following visit re: re-trial of Omeprazole as vomiting occurring again, possible cont/d reflux due to low tone
- Baby has a date for key hole heart surgery end May 2021
- Further joint appointment with CCN and HV planned after the Dietetic/SLT visit


SLT
BHFT
OT
SS
HV
BHFT
Baby and family
CCN
BHFT
Dietitian
BHFT
Paediatrician
ENT
Physiotherapist
RBH

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 13/07/21

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 to present options for linking True North and the Vision Metrics to the Finance, Investment and Performance Committee.	October 2021	**AG**	Carry forward to autumn strategy Trust Board Away Day – ICS System Oversight Framework has just been published the Trust needs to consider its impact.	
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit	September 2021	**DF**	15 Step Visits were paused because of COVID-19. 15 Step	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Reports as part of the Patient Experience Report.			Visits have now resumed. More detail will be included about 15 Step Visits as part of future Patient Experience Reports.	
13.04.21	21/044	Patient Story	The Quality Assurance Committee to review the Tissue Viability Service at a future meeting.	November 2021	**DF**	The Quality Assurance Committee Forward Planner has been updated to include a review of the Tissue Viability Service. The item will be on the November 2021 QAC agenda.	
13.04.21	21/050	Finance Report	The Trust to undertake work to understand the impact of the new ways of working so it would be in a position to develop its post-COVID-19 funding financial plan for the second half of 2021-22.	July 2021	**AG**	First half year planning still in progress, completing by beginning of June 2021. The Trust will then have time to develop second half year plan and into 22/23, supported by continuing transformation	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						benefits from new ways of working. Three-year strategy implementation plan and digital strategy will define further transformation opportunities in due course.	
13.04.21	21/054	COVID-19 Pandemic Recovery Plan Update Report	Reducing Health Inequalities to be added to the agenda of the June 2021 Trust Board Discursive meeting.	July 2021	**KM**	On the agenda for the July 2021 Trust Board meeting.	
13.04.21	21/054	COVID-19 Pandemic Recovery Plan Update Report	The Trust Board to receive a breakdown of the recovery timescale for different types of services.	June 2021	**KM**	Discussed at the June 2021 Trust Board Discursive meeting.	
11.05.21	21/084	Patient Experience	The breakdown of complaints by age data to be amended to highlight those age groups which submitted a disproportionate number of complaints.	September 2021	**DF**	To be included in the September 2021 Patient Experience Report	
11.05.21	21/085	Safe Staffing	Future reports to draw together and summarise the information from the different safe staffing tools.	November 2021	**DF**	To be included in the next Six-Monthly Safe Staffing Report	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
11.05.21	21/087	Executive Report – CAMHs Tier 4 Service Changes	The risk share agreement for the CAMHs Tier 4 service model to be presented to a future Trust Board meeting for approval.	July 2021	**AG**	Provider collaborative risk share not proceeding at this stage due to partner review. The Trust is satisfactorily commissioned under block contract to deliver Tier 4 community model for Berkshire with transitional cost support from NHSE. The Board will be updated on risk share proposals as and when appropriate.	
11.05.21	21/087	Executive Report – CAMHs Tier 4 Service Changes	The Chief Operating Officer to publicise that staff were redeployed into other Trust services following the decision to change the CAMHs Tier Service model.	September 2021	**DT**	The action is being progressed with the service and Marcomms currently.	
11.05.21	21/089	Finance Report	An analysis of the management and admin posts to be presented to the Finance, Investment and Performance Committee to provide	July 2021	**PG**	A paper will be presented to the July 2021 Finance, Investment and	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			assurance.			Performance Committee.	
11.05.21	21/092	COVID-19 Pandemic Recovery Plan Report	a summary narrative of the extreme and high-risk services including cause, trend, actions underway, support needed to presented to the June 2021 Trust Board Discursive meeting.	June 2021	**KM**	Discussed at the June 2021 Trust Board Discursive meeting.	
11.05.21	21/092	COVID-19 Pandemic Recovery Plan Report	The Governors to be updated about the Trust's Health and Wellbeing Programme	June 2021	**AG**	The June 2021 Council of Governors meeting received a presentation on the Trust's Health and Wellbeing Offer.	
11.05.21	21/093	Strategy Implementation Plan Update Report	The Chair to forward his suggestions for changing format and the context of the report.	July 2021	**ME/KM**	The Chair has forwarded his comments on strategy and the performance report.	
11.05.21	21/095	Annual Report 2020-21	The Company Secretary to inform members of the Board via email of any changes to the draft Annual Report.	June 2021	**JH**	Completed	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Tuesday 13th July 2021
Title	**Freedom to Speak Up Report**
Purpose	To update the Trust Board on the work of the Freedom to Speak Up Guardian over the last 6 months.
Business Area	Corporate
Author	Freedom to Speak Up Guardian – Mike Craissati
Relevant Strategic Objectives	To strengthen our highly skilled and engaged workforce and provide a safe working environment
CQC Registration/Patient Care Impacts	The Care Quality Commission assesses Trust's Speaking Up Culture as part of its Well-Led Inspection
Resource Impacts	None
Legal Implications	All UK NHS Provider organisations are required to appoint a Freedom to Speak Up Guardian
Equality and Diversity Implications	Good links have been maintained during the period with the 3 Staff Networks, the Freedom to Speak Up Guardian has promoted the concept of Freedom to Speak Up and has supported network members for any concerns they may have had around EDI issues. The Guardian has forged close ties with EDI Leads and is a member of various EDI Groups or Committees. Guardian involvement in specific EDI related workstreams: • Joint Lead, BAME Transformation Taskforce – Bullying & Harassment, Microaggressions. • Tackling racial abuse towards staff at Prospect Park Hospital, QI workstream and Rapid Improvement Event
SUMMARY	The post of Freedom to Speak up Guardian was a recommendation of the Freedom to Speak up Review by Sir Robert Francis published in 2015. The Freedom to Speak up Guardian (FTSUG) came into post in this Trust in March 2017. This is a report directly to the Trust Board for December 2020 – July 2021 and contains data for FY 2020-21 The paper includes: • a summary of communication activity being undertaken by the FTSUG • data from the most recent reports to the National Guardians Office • Feedback received from those who have raised concerns during the period • key points about improving FTSU culture • action taken to address the FTSU internal audit report

	• recommendations from the Freedom to Speak Up Guardian who will be attending the Trust Board meeting to present the report.
Impact of Covid-19	Throughout the period, December 2020 to July 2021, all FTSU activity has continued as much as possible including • Promotion of Freedom to Speak Up and a "Speak Up" culture • Responding to concerns raised • Feeding back to the Organisation on lessons learnt/trends etc.
ACTION REQUIRED	The Trust Board is asked: a) to note the contents of this report by the Freedom to Speak Up Guardian; and b) to provide support for the Guardian's recommendations detailed in this report

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

Freedom to Speak up Guardian - Report for December 2020 – July 2021

Background

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

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

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

The Role of the Freedom to Speak Up Guardian

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

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

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

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

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

Communication

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

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

- Raising Concerns presence on Nexus
- Presentations and attendance at management/team meetings (ongoing)
- Production and dissemination of posters, leaflets and cards etc (ongoing)
- Virtual F2F presence at Corporate Induction, Junior Doctor's Induction & Student's Induction via MS Teams
- Presence at Essential Knowledge for New Managers training (content to be reviewed Q 1&2 2021-22)
- Supporting all EDI/Staff Network Events as an Ally.
- Membership of the Safety Culture Steering Group, OD Steering Group, Diversity Steering Group amongst others
- Lead for Microaggressions and Bullying & Harassment workstreams for the BAME Transformation Group

Contribution to the Regional and National Agenda

The Guardian is Chair of the Thames Valley and Wessex Regional FTSU Guardian Network consisting of all NHS Trusts and private providers (including Primary Care) within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System (ICS), Frimley ICS, Hampshire & Isle of Wight (approx. 55 Guardians).

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

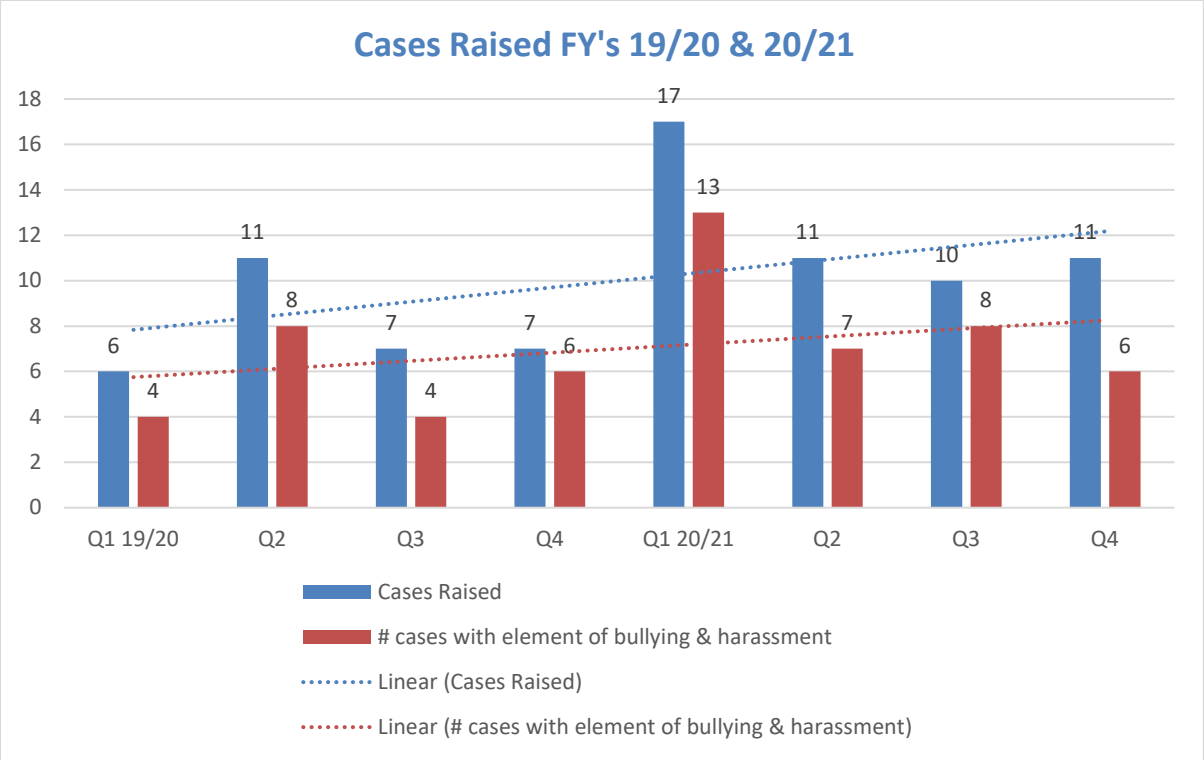
The NGO requests and publishes quarterly speaking up data.
Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

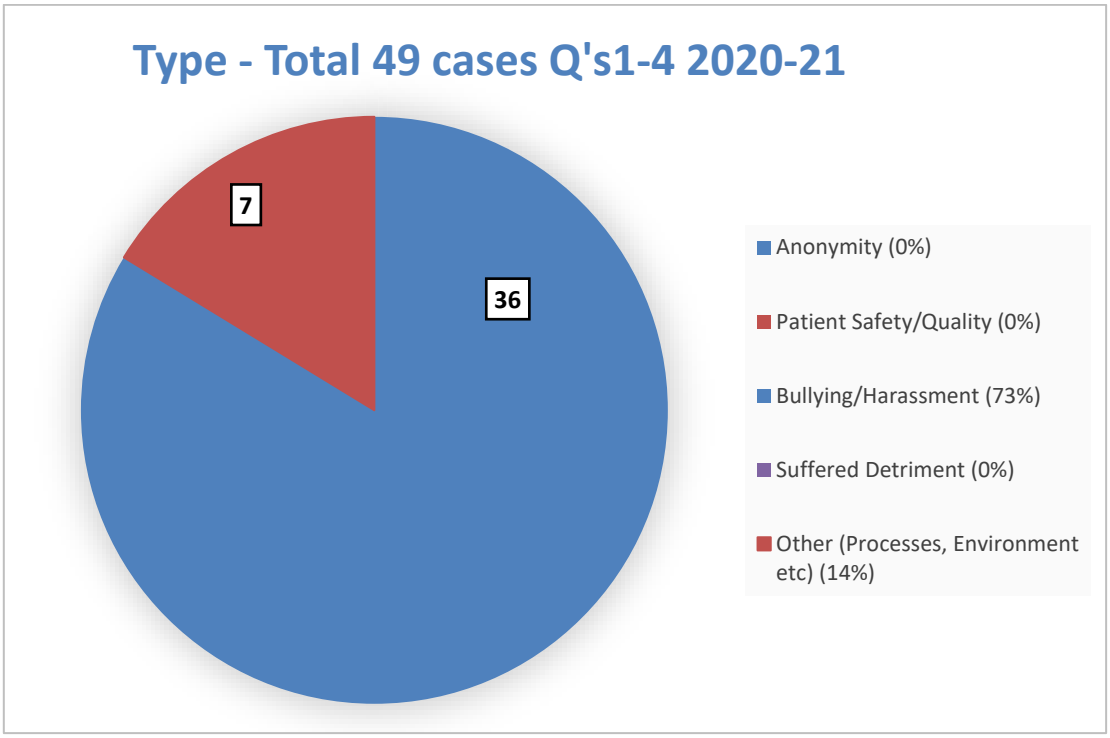
Cases are described as "those concerns raised which require action from the FTSUG".

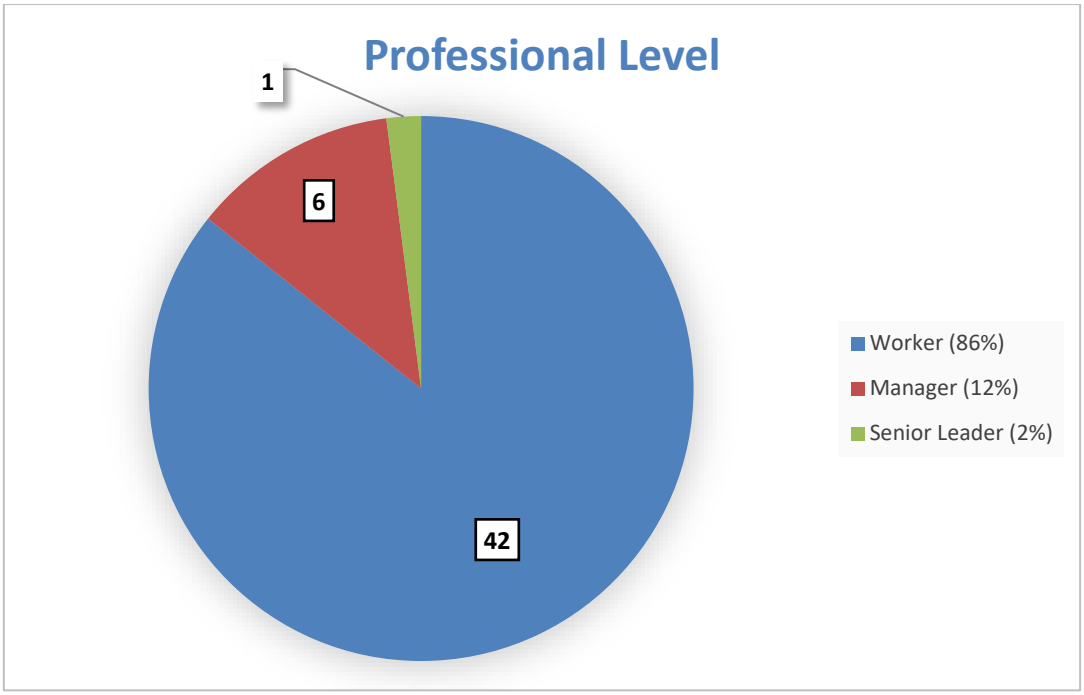
Outlined below are BHFT submissions for Q1 – Q4 FY 2020/21.

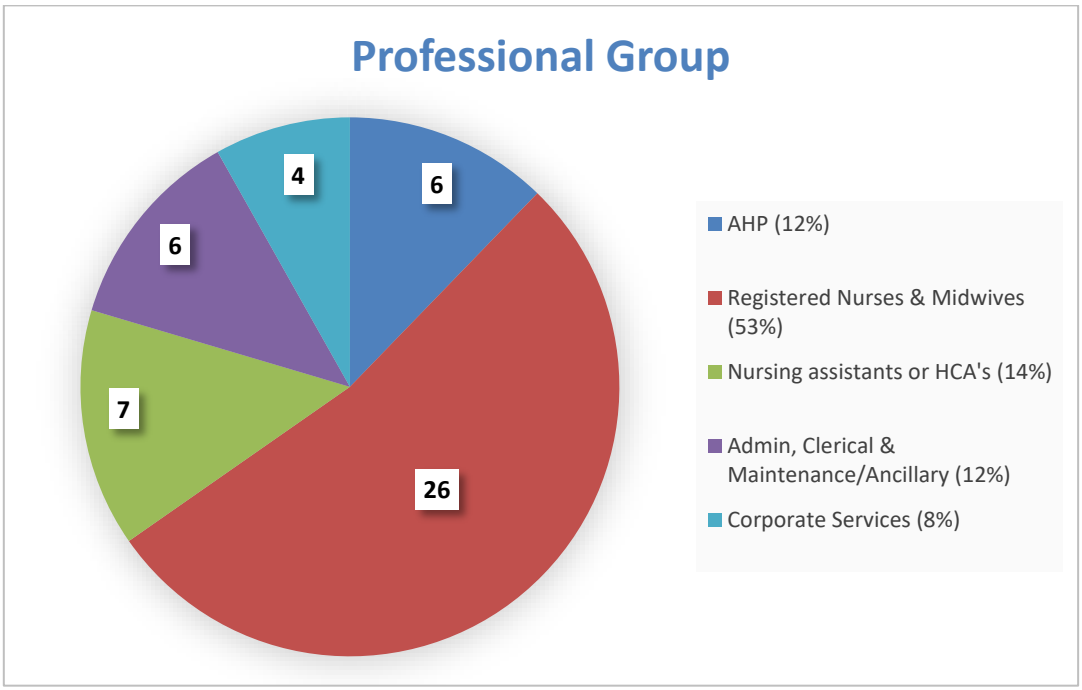
It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts. All cases and contacts at Berkshire Healthcare are reported.

The total number of cases raised for FY 2020/21 = 49









Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- The significant increase in the number of cases raised for the last 3 FY's can partly be attributed to an increased awareness of the Guardian and associated process, an increase in cases raised can be considered a good thing (a better Speak Up culture)
- Returns show zero cases are raised via FTSU around patient safety, the Board can be assured that any patient safety issues are raised via other routes, handovers etc.

- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity or confidentiality having spoken to the Guardian.
- During the period the Guardian received no anonymous concerns.
- A significantly high proportion of cases are around the “staff experience” and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients of the public at large – this would normally be highlighted via Datix).
- Of the total number of “staff experience” concerns raised, it’s estimated that, during the period, 8% come from staff of a BAME background and approx. 12% of those concerns relate to BAME issues such as exclusion or perceived racial prejudice or bullying.
- There is no data on concerns raised by members of other staff networks that may relate to membership of that network.

Impact of Covid-19

From December 2020 – July 2021, FTSU activities have continued as before (wherever possible) to ensure “business as usual”.

- **Promotional work** – Awareness has continued via Social Media, Corporate Induction, Intranet, Covid-19 weekly emails, direct meetings with services, use of MS Teams etc
- **Response to concerns –** As per usual, it has been easier for staff to communicate with the Guardian in confidence as many staff are working from home and there is no requirement to meet off site.
- During this time the Guardian supported the wellbeing hub and HR function to ensure staff were aware of FTSU support available.
- Feedback to the Organisation on cases, lessons learnt, and any trends continued as normal.

Improving FTSU Culture

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

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

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

Learning and Improvement

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

The Guardian now also meets on a six-monthly basis with the nominated Non-Executive Director lead.

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

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

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

The National Guardian's Office are planning to release a series of E-Learning packages, there will be 3 packages aimed at various levels within the Organisation.

The first two modules, Speak Up and Listen Up, have recently been released and are available for staff on the Trust Nexus e-learning platform

- **Speak Up** – Core training for all workers, volunteers, students and trainees, aimed at giving all staff an understanding what speaking up is, how to do so and what to expect when they do so.
- **Listen Up** – Aimed at all line managers, raising awareness of the barriers that can exist when staff wish to speak up and how to minimise them.
- **Follow Up** – For Senior Management groups and Trust Executives, ensuring the Organisation acts on concerns raised, learns from them and uses feedback to help

create an open & just culture where all workers are actively encouraged to use their voices to suggest improvements or raise concerns.

FTSU Index Report 2020

The National Guardian's Office have published their 3rd annual report on NHS Trusts and how they may be compared or ranked according to their mean responses to 4 questions from the 2020 NHS staff survey, essentially it is a metric to monitor the effectiveness of the "Speak up, Listen up" culture within an Organisation.

The FTSU index is calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

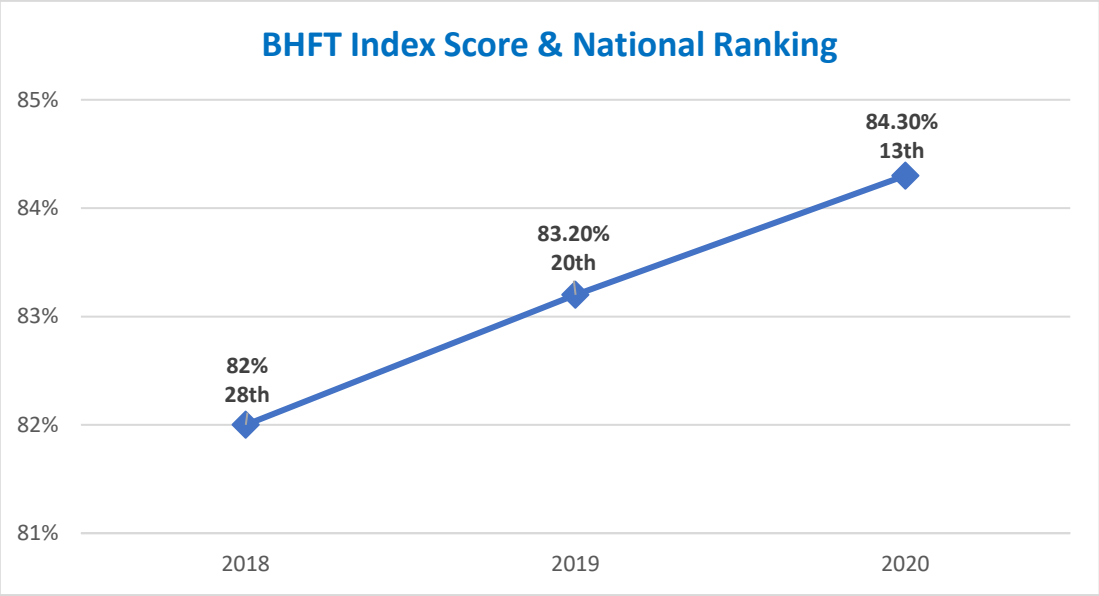
- % of staff "agreeing" or "strongly agreeing ":

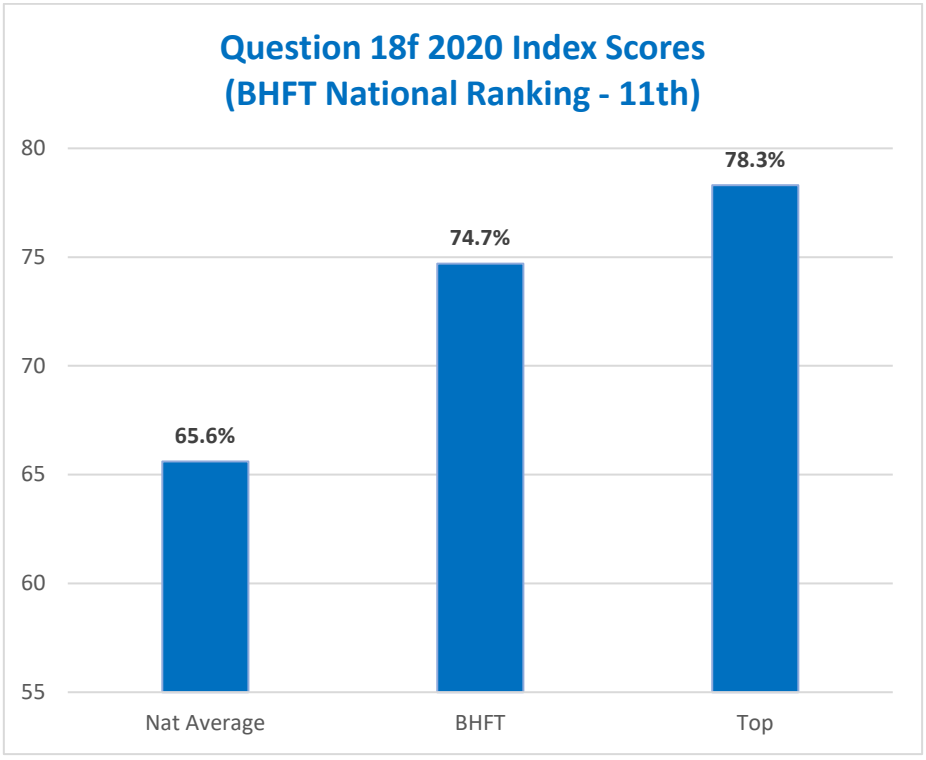
  that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
  that their organisation encourages them to report errors, near misses or incidents (question 16b)
  that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
  that they would feel secure raising concerns about unsafe clinical practice (question 17b)

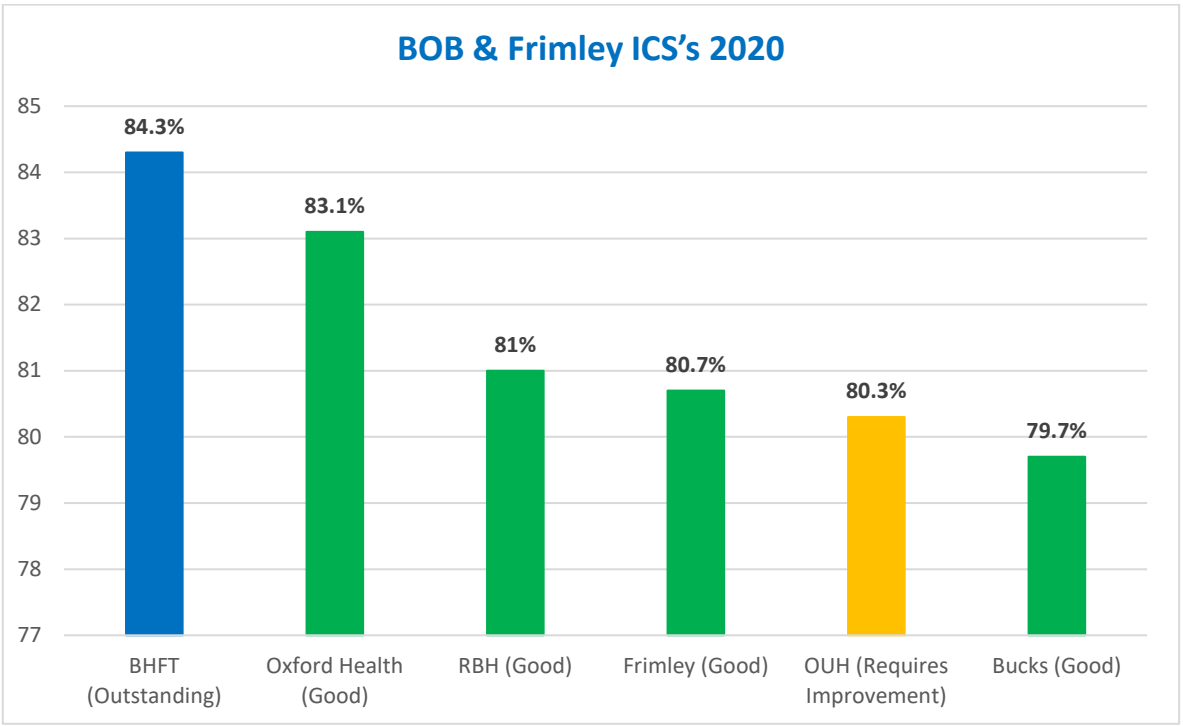
The four questions used in the FTSU Index are clinical- and incident-centric and may not have the same applicability to all staff groups and trust types. Moreover, while they give an indication of FTSU culture, a healthy speaking up culture is about more than these issues and includes making improvement suggestions.

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation
  (question 18f)




Question 18f 2020 Index Scores
(BHFT National Ranking - 11th)
80
75
70
65
60
55
65.6%
74.7%
78.3%
Nat Average
BHFT
Top


BOB & Frimley ICS's 2020
85
84
83
82
81
80
79
78
77
84.3%
83.1%
81%
80.7%
80.3%
79.7%
BHFT (Outstanding)
Oxford Health (Good)
RBH (Good)
Frimley (Good)
OUH (Requires Improvement)
Bucks (Good)

FTSU Review

The National Guardian's Office require all Organisations to review speaking up arrangements on a biennial basis. This is the responsibility of the Trust Board and is lead by the Executive lead for FTSU and the Non-Executive Director.

This Organisation undertook a review in Q1 2021/22, results of which have been presented to the Board and recommendations coming from the review will form part of the FTSU workstream during the next 6 months or so. This will include a review of the FTSU strategy, Raising Concerns policy and a gap analysis. The intention is for the National Guardian to attend the October Board. As the current Guardian is stepping down from her post, the BHFT Guardian is waiting for confirmation of any new Guardian or an alternative attendee.

Feedback

All of those who contact the Guardian are asked to complete a feedback form outlining their experience of the FTSU process and how they felt they were supported (or otherwise), a selection of free text responses is shown below.

Q11. Should you wish to, please expand or comment on any of your answers above (Q's 1-10)

"I believe the involvement of the Guardian may have caused my Service to take my concerns more seriously than they might have done; a document I produced was certainly used as the basis for what might prove to be helpful liaison"

"I feel that it was only after approaching the guardian and then the issue being taken to a much higher level that things were finally sorted. I think that up until this point the issue was being kept quiet and was being dealt with by a select few that were keeping it from being exposed in the correct way."

"My contact with the Freedom to speak guardian was easy, respectful. He clearly stated options available to me and I didn't feel under any pressure or pushed in any direction. It was very valuable to have this reflection space. Nonetheless, speaking is a very difficult process, it means accepting the fact we have been bullied/harassed/mistreated, it is facing the fear of consequences when we raise issues with senior managers. Going through the evidence we have and the experience takes its toll on the individuals, emotionally and physically. Colleagues who have known me for a long time have shared the change, my need for reassurance, my reluctance to take creative risks when designing projects, etc. I also had to face how my career had stalled and gone down since all this happened, face HR decision to step back. In the end, because several of us reported issues, an investigation is happening. We hope there will be some positive changes, however I must confess I am slowly losing the faith. But if it had been just me... I would have been left bitter, not at the freedom to speak guardian but at BHFT response to staff struggling. I would like to see more actions happening after someone had contacts with the freedom to speak guardian."

Q21. Should you wish to, please expand or comment on any of your answers above around Equality, Diversity or Inclusion.

"I feel that the pressure I was put under in the role I am raising concerns about was unfair and took advantage of my situation as a single mother, with no family or my son's father in the country, during COVID, where I was completely isolated. I felt it was unfair to say that (amongst others) remaining at a band 7 level to feed my son was not a good enough reason.

"I wish managers understood, had more awareness around supporting staff with learning disabilities and dealing with these types of situations. Not to penalise them especially as this is protected factor and working for the NHS."

Q22. If you have any further comments around the Freedom to Speak Up process, please add them here.

"Very grateful for the input and support."

"I personally would recommend anyone who is unsure or experiences unfair treatments at work to speak to the Guardian. He is a great resource to guide us, signpost to the right resource and help us clarify where we are at, which can be confusing at times."

"Mike has been fantastic and very supportive, but the trust needs to take more action from the very top to make those who are prejudiced accountable for their actions and to promote equality and diversity."

Recommendations from the Freedom to Speak Up Guardian

The Trust Board is asked to support the following:

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

Author and Title:

Mike Craissati - Freedom to Speak Up Guardian

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Meeting Date	13th July 2021
Title	Freedom to Speak Up review tool for NHS Trusts and Foundation Trusts
Purpose	The completed self -assessment tool highlights the Boards reflection and assessment on its current position and any identified improvements and actions to ensure a culture of openness and transparency in relation to speaking up across the organisation.
Business Area	Board
Author	Debbie Fulton, Director Nursing and Therapies (Executive FTSU lead) Mark Day, Non-Executive Director (Non -Executive FTSU Board lead)
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff and Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equalities, Diversity and Inclusion Implications	N/A
SUMMARY	The Freedom to Speak up tool (attached) is designed to assist Boards in undertaking a self- assessment of the Trust Freedom to speak up processes and to ensure that these are in line with NHS England and Improvement and the National Guardians Office requirements as detailed in ''Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts'' This is the final version of the self-assessment tool presented today for approval following review and comments by all Board members in June 2021. Good practice is for this self-assessment to be undertaken on a regular basis and as a collaborative process involving all Board members. A review using this tool was last undertaken in 2018. There are several assurances that can be taken regarding our organisational FTSU culture these include: • CQC report published in March 2020 states that ''We were impressed with the further work the trust had achieved with Freedom to Speak Up (FTSU) since our last inspection. The trust fostered a positive culture of speaking up and ensured that issues raised were seen as opportunity to learn and make improvement. Staff told us they felt able to raise concerns and that senior leadership took action''

	• The 2020 FTSU index recently published demonstrates Berkshire Healthcare to have 13th best score across all NHS Trusts; with a newly reviewed questions from the staff survey (% of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation) analysed and placing us 11th • Safety culture themes from the 2020 staff survey shows a statistically significant improvement and with a score of 7.3 places us above the national average for Mental Health and Learning Disability/Mental Health and Learning Disability and Community Trusts (6.9) The review details any actions to further enhance processes/ ensure that the Board remains compliant. Whilst no significant gaps have been identified, there is one area we have rated as amber due to planned review of our Champions network; there are also some further actions detailed in the review. Actions include: • Inviting the National Guardian's Office to a discursive or Board development session this year • A refresh of our FTSU strategy • A Review of our current champions network/structure considering the recently released NGO guidance on 'Developing Champion and Ambassador Networks' and reinstating learning events for champions that were on hold during the COVID-19 pandemic. • Adding to staff voice at the board through anonymised vignettes of concerns A review of our policy will also be due later this year, however the NGO have advised that they are likely to be updating their policy this year and as a consequence NHSE have suggested that if this is confirmed organisations should wait until after consultation and publication of national policy before updating organisational policy.
ACTION REQUIRED	Board is asked to: • Approve the self-assessment and proposed actions

Freedom to Speak Up review tool for NHS trusts and foundation trusts

July 2019

NHS England and NHS Improvement

How to use this tool

This is a tool for the boards of NHS trusts and foundation trusts to accompany the *Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with page numbers in the tool) *and the* *Supplementary information on Freedom to Speak Up in NHS trusts and NHS foundation trusts* (cross referred with section numbers).

We expect the executive lead for Freedom to Speak Up (FTSU) to use the guidance and this tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

We hope boards will use this tool thoughtfully and not just as a tick box exercise. We also hope that it is done collaboratively among the board and also with key staff groups – why not ask people you know have spoken up in your organisation to share their thoughts on your assessment? Or your support staff who move around the trust most but can often be overlooked?

Ideally, the board should repeat this self-reflection exercise at regular intervals and in the spirit of transparency the review and any accompanying action plan should be discussed in the public part of the board meeting. The executive lead should take updates to the board at least every six months.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But getting the FTSU Guardian's views would be a useful way of testing the board's perception of itself. The board may also want to share the review and its accompanying action plan with wider interested stakeholders like its FTSU focus group (if it has one) or its various staff network groups.

We would love to see examples of FTSU strategies, communication plans, executive engagement plans, leadership programme content, innovative publicity ideas, board papers to add them to our Improvement Hub so that others can learn from them. Please send anything you would specifically like to flag to nhsi.ftsulearning@nhs.net

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
Behave in a way that encourages workers to speak up					
Individual executive and Non-Executive directors can evidence that they behave in a way that encourages workers to speak up. Evidence should demonstrate that they: • understand the impact their behaviour can have on a trust's culture • know what behaviours encourage and inhibit workers from speaking up • test their beliefs about their behaviours using a wide range of feedback • reflect on the feedback and make changes as necessary • constructively and compassionately challenge each other when appropriate behaviour is not displayed	Section 1 p5	**June 2021**		Staff survey results Model policy adopted CQC report published March 2020 *We were impressed with the further work the trust had achieved with Freedom to Speak Up (FTSU) since our last inspection. The trust fostered a positive culture of speaking up and ensured that issues raised were seen as opportunity to learn and make improvement. Staff told us they felt able to raise concerns and that senior leadership took action.* *The trust Freedom to Speak Up Guardian (FTSUG) was very active in their role, visible to staff and approachable. Events were publicised well and had good attendance by staff. There were eleven Freedom to speak up champions. They supported the FTSUG in marketing and promoting the service. The FTSUG met with the champions three times per year, to go through training cascaded from national guardian's office, look at national and local data, and review learning from events.*	Rated as compliant - actions below opportunity for further improvement / learning: Service feedback from non-exec board visits to be sought, this provides opportunity for reflection Invite of NGO to development session/ board discursive as further, learning opportunity for Board members - Invite has been sent to the NGO *Policy due for review October 2021 - advice from NGO received April 2021 that NGO are likely to be updating their policy this year - NHSE advise wait to see once confirmed and if national policy update is confirmed to wait until after consultation and publication national policy before updating organisational policy*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				FTSU Board reports FTSU index -overall index score for combined Mental Health / Learning Disability and Community Trusts for 2020 was 83.2% - BHFT score was 84.3% placing us 13th of all NHS Trusts In addition, an addition question was also analysed alongside the index as below *% of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)* For this question BHFT scored 74.7% ranking us 11th out of all organisations Executive lead/FTSU guardian one to one meetings and status exchange with CEO / Exec lead / FTSU and Head of Operational HR include Regular discussions on plans for FTSU in the organisation. FTSU Guardian has direct access to the Wider Executive Team and Board Values and behaviours form part of appraisal process for executive directors	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Gemba visits undertaken by executive teams with purpose of listening up / providing opportunity to speak up Board visits to teams and services undertaken by Non-Executive with purpose of listening up/ providing opportunity for staff to speak up All staff events that occur fortnightly provide opportunity for staff to pose any questions/ concerns / positive comments to the executive with Q&A session as part of the event enabling the executive to respond to these, responses to pithy challenging issues are not shied away from. Non-Exec Board members have access to attend Governor meetings are a listening up opportunity for Non-Executive	
Demonstrate commitment to FTSU					
The board can evidence their commitment to creating an open and honest culture by demonstrating: • there are a named executive and Non-Executive leads responsible for speaking up	p6 Section 1 Section 2 Section 3	June 2021		Executive and Non-Executive leads for FTSU (Debbie Fulton -Director Nursing and Therapies and Mark Day) are named in FTSU policy All staff events that occur fortnightly provide opportunity for staff to pose any questions/ concerns / positive comments to the executive with Q&A session as part of the event enabling the executive to	Rated as compliant - actions below opportunity for further improvement / learning: Invite of NGO to development session/ board discursive as further, learning opportunity for Board members - Invite has been sent to the NGO

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• speaking up and other cultural issues are included in the board development programme • they welcome workers to speak about their experiences in person at board meetings • the trust has a sustained and ongoing focus on the reduction of bullying, harassment, and incivility • there is a plan to monitor possible detriment to those who have spoken up and a robust process to review claims of detriment if they are made • the trust continually invests in leadership development • the trust regularly evaluates how effective its FTSU Guardian and champion model is • the trust invests in a sustained, creative, and engaging communication strategy to tell positive stories about speaking up.				respond to these, responses to pithy challenging issues are not shied away from. Non-Exec Board members have access to attend Bullying and Harassment key focus of work as part of EDI and People strategy Annual plan on a page includes goal in supporting our staff - *We will have a zero tolerance to bullying and harassment, and racism, taking action wherever we see or hear poor experience for our people* Safety culture workstream as part of the national patient safety strategy has focus on civility. Trust event on civility 23.3.21. FTSU guardian is part of the core membership of the group Leadership development programmes in place * Feedback from staff involved in speaking up process is sought , this is reflected in 6 monthly Board report National staff Survey results indicate positive safety culture	Bringing staff voice to Board in a meaningful way – we have had preceptees there and staff presenting patient stories • anonymised vignettes of concerns raised through FTSU to be shared with Board • Experience with EDI focus to Board Positive stories about speaking up to be considered into 6 monthly FTSU Board report Evaluation of the effectiveness of Guardian and champion roles to include review of champion structure within the organisation in line with recently published NGO guidance on developing champion and ambassador networks

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				Regular messages via teambrief, on Nexus for staff Dedicated space on Nexus Feedback is obtained from staff involved in process and included in 6 monthly report. Executive and Non-Executive Board members participate in reverse mentorship	
Have a strategy to improve your FTSU culture					
The board can evidence it has a comprehensive and up-to-date strategy to improve its FTSU culture. Evidence should demonstrate: • as a minimum – the draft strategy was shared with key stakeholders • the strategy has been discussed and agreed by the board • the strategy is linked to or embedded within other relevant strategies • the board is regularly updated by the executive lead on the progress against the strategy as a whole • the executive lead oversees the regular evaluation of what the strategy has achieved using a range of qualitative and quantitative measures.	P7 Section 4	June 2021		Strategy was presented to Board and endorsed in November 2019 Trust wide focus on safety culture with Workplan and actions in place (FTSUG is a member of the steering group).This is embedded in trust 3-year strategy Board receives 6 monthly reports from the Guardian Executive lead/FTSU guardian one to one meetings include regular discussions on plans for FTSU in the organisation Trust 3-year Strategy 2021-2024 includes: - *Improving patient safety*	Review of FTSU strategy to be undertaken as part of October Board discursive/ away-day

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
				We'll continue to build on our culture across our organisation that encourages staff to report incidents and raise concerns. Annual plan on a page includes a goal in Harm free care - *We will strengthen our safety culture to empower our people and patients to raise* *safety concerns without fear, and to facilitate learning from incidents*	
Support your FTSU Guardian					
The executive team can evidence they actively support their FTSU Guardian. Evidence should demonstrate: • they have carefully evaluated whether their Guardian/champions have enough ringfenced time to carry out all aspects of their role effectively • the Guardian has been given time and resource to complete training and development • there is support available to enable the Guardian to reflect on the emotional aspects of their role	p7 Section 1 Section 2 Section 5	June 2021		Time is ringfenced at 0.4 WTE Guardian has access to CIC & NGO support services FTSU guardian supported to attend National Guardian Office (NGO) training, workshops and regional and local FTSU networks. Monthly meeting between CEO/ FTSU Guardian/ Exec lead (DoN) and Head of Operational HR	Regular meetings between non-exec lead and guardian to be commenced Review of current ring-fenced time to be undertaken considering increase in reactive work and desire to undertake more proactive work around speaking and listening up in line with organisational safety culture improvement work

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
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• there are regular meetings between the Guardian and key executives as well as the Non-Executive lead. • individual executives have enabled the Guardian to escalate patient safety matters and to ensure that speaking up cases are progressed in a timely manner • they have enabled the Guardian to have access to anonymised patient safety and employee relations data for triangulation purposes • the Guardian is enabled to develop external relationships and attend National Guardian related events				Training needs analysis for FTSU guardian reviewed at appraisal Meetings set up to meet between Guardian and Deputy Director Nursing patient safety and quality on a bi-monthly basis, but any patient safety issues are automatically raised to Director Nursing. Patient safety data and HR data available on request and through meetings with HR (monthly) & Patient safety lead – dashboard to monitor safety culture in place Guardian is Chair of regional Guardian network and engages with NGO on a regular basis FTSU guardian discusses cases with Service Directors, if required.	
Be assured your FTSU culture is healthy and effective					
Evidence that you have a speaking up policy that reflects the minimum standards set out by NHS Improvement. Evidence should demonstrate:	P8 Section 8 National policy	June 2021		FTSU Policy approved October 2019; review is due this year and will consider any recommendations and feedback	*Policy due for review October 2021 - advice from NGO issued April 2021 that NGO are likely to be updating their policy this year - NHSE advise wait to see once confirmed and if national policy update is*

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• that the policy is up to date and has been reviewed at least every two years • reviews have been informed by feedback from workers who have spoken up, audits, quality assurance findings and gap analysis against recommendations from the National Guardian.				Internal Audit undertaken in 2019/20 used to inform current policy Process in place for receiving feedback from those who have used FTSU process, feedback form includes ability to provide feedback directly to Executive/ Non-Executive FTSU leads as an alternative to providing feedback to the Guardian. Feedback will be used to inform next policy update.	*confirmed to wait until after consultation and publication national policy before updating organisational policy* When updating policy, the national policy review framework will be used
Evidence that you receive assurance to demonstrate that the speaking up culture is healthy and effective. Evidence should demonstrate: • you receive a variety of assurance • assurance in relation to FTSU is appropriately triangulated with assurance in relation to patient experience/safety and worker experience. • you map and assess your assurance to ensure there are no gaps and you flex the amount of assurance you require to suit your current circumstances. • you have gathered further assurance during times of change or when there	P8 Section 6	June 2021		FTSU index -overall index score for combined Mental Health / Learning Disability and Community Trusts for 2020 was 83.2% - BHFT score was 84.3% placing us 13th of all NHS Trusts In addition, an addition question was also analysed alongside the index as below % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f) For this question BHFT scored 74.7% ranking us 11th out of all organisations CQC report published March 2020 *We were impressed with the further work the trust had achieved with Freedom to Speak Up (FTSU) since our last*	To introduce a more structured approach for gap analysis and ensure there is triangulation with assurance in relation to patient experience and worker experience. Reinstate learning events for Champions (these have been on hold during Covid due to champion capacity) Review of champion structure within the organisation in line with recently published NGO guidance on developing champion and ambassador networks

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
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has been a negative outcome of an investigation or inspection • you evaluate gaps in assurance and manage any risks identified, adding them to the trust's risk register where appropriate.				*inspection. The trust fostered a positive culture of speaking up and ensured that issues raised were seen as opportunity to learn and make improvement. Staff told us they felt able to raise concerns and that senior leadership took action.* *The trust Freedom to Speak Up Guardian (FTSUG) was very active in their role, visible to staff and approachable. Events were publicised well and had good attendance by staff. There were eleven Freedom to speak up champions. They supported the FTSUG in marketing and promoting the service. The FTSUG met with the champions three times per year, to go through training cascaded from national guardian's office, look at national and local data, and review learning from events.* Annual staff survey results Staff survey included Covid specific questions around what went well and not so well , these will be analysed for learning FTSU Board reports Triangulation meetings between HR lead, Director of Nursing and FTSUG	

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
The board can evidence the Guardian attends board meetings, at least every six months, and presents a comprehensive report.	P8 Section 7	June 2021		Trust Board paper written and presented to Board every 6 months by FTSU in person	
The board can evidence the FTSU Guardian role has been implemented using a fair recruitment process in accordance with the example job description (JD) and other guidance published by the National Guardian.	Section 1 NGO JD	June 2021		FTSU job description matched to national FTSU Job description. Fair recruitment process followed	
The board can evidence they receive gap analysis in relation to guidance and reports from the National Guardian.	Section 7	June 2021		6-monthly board report Reports and reviews from the NGO are presented by FTSUG to CEO, Director Nursing & Therapies and Head of HR at monthly meetings 6-monthly report includes reference to guidance and reports and any gaps in recommendations/ plans to address these	
Be open and transparent					
The trust can evidence how it has been open and transparent in relation to concerns raised by its workers. Evidence should demonstrate: • discussion with relevant oversight organisation • discussion within relevant peer networks • content in the trust's annual report	P9	June 2021		FTSU Guardian is a member of the Diversity and Safety Culture Groups 6 monthly FTSU report presented at public Board Guardian is Chair of regional Guardian network and engages with NGO on a regular basis	Invite of NGO to development session/ board discursive as further, learning opportunity for Board members- Invite has been sent to the NGO Gain feedback from FTSU guardian that the board are receptive to and engaged

Summary of the expectation	Reference for complete detail Pages refer to the guidance and sections to supplementary information	How fully do we meet this now?		Evidence to support a 'full' rating	Principal actions needed in relation to a 'not' or 'partial' rating
		Insert review date	Insert review date		
• content on the trust's website • discussion at the public board • welcoming engagement with the National Guardian and her staff				Access to FTSUG on Trust website	with subject and supported of areas of concern to be addressed
Individual responsibilities					
The chair, chief executive, executive lead for FTSU, Non-Executive lead for FTSU, HR/OD director, medical director and director of nursing should evidence that they have considered how they meet the various responsibilities associated with their role as part of their appraisal.	Section 1	June 2021		Evidence in all sections above indicates the organisations commitment to FTSU	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	13th July 2021
Title	Berkshire Healthcare NHS Foundation Trust Annual Complaints Report. April 2020 - March 2021
Purpose	The purpose of this report is to provide the Board with Annual complaint information in line with The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
Business Area	Nursing & Governance
Author	Elizabeth Chapman – Head of Service Engagement and Experience Heidi Ilsley - Deputy Director Nursing
Presented by	Debbie Fulton, Director Nursing and Therapies
Relevant Strategic Objectives	True North goal of Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC
Resource Impacts	N/A
Legal Implications	N/A
Equality, Diversity and Inclusion Implications	N/A
SUMMARY	The report looks at the application of the formal complaints process in the Trust and is for noting at the Board The information contained within this annual complaint report has been presented as part of the quarterly patient experience reports throughout the year. Over the last year complaint processes have been flexed at times due to the impact of the pandemic, however the trust has continued ensure that processes are robust for both receiving and responding to complaints in a timely manner. During 2020 /21 there were 213 formal complaints received, this is less than the 231 received in 2019/20 and equates to 0.038% of recorded contacts that occurred within Berkshire Healthcare across the year.
ACTION REQUIRED	This report is for noting at the Board

Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Annual Complaints Report

April 2020 to March 2021

Contents

1. Introduction and executive Summary

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

This report looks at the application of the Complaints Process within the Trust from 1st April 2020 to 31st March 2021 and uses data captured from the Datix incident reporting system.

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

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

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

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

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

There was a national pause on the complaint handling, driven nationally through NHSE/I and for the Parliamentary and Health Service Ombudsman (PHSO) in March 2020 for several months.
While some Trusts took this as a complete stop of the complaints function, our Complaints Service adapted; they reviewed existing formal complaints received up to the point of the pause and spoke with IOs and Service Leads on their capacity to continue to investigate and respond to these in a thorough way. A letter was drafted and approved by Senior Leaders within the Nursing Directorate (where the Patient Experience Team are based), which was sent to complainants where it was identified that we could not adequately continue with the complaint investigation.

As at the start of the pause (April 2020) there were 31 open Formal Complaints of which 7 were paused by the Trust, 2 were paused at the request of the complainant and the remaining cases remained open, investigated and were responded to. The Complaints Office supported the IO's in a number of these cases to ensure that a letter of response was received based on the completed IO Report.

The weekly SITREP report was paused at the beginning of the pandemic response, however, was reintroduced and reportedly used more effectively by Directorate leaders and the Complaints Office. From mid-June, the Complaints Office spoke with IOs about the lift of the pause in terms of their capacity to pick up complaints that had been on hold, and these were all progressed to a response in the usual way.
The Complaints Office adapted to homeworking well, and complaint responses have been signed off at Executive level electronically with only a small number of complainants not wanting or unable to receive correspondence by email.
Answerphone messages are picked up from the main Complaints Office telephone daily, and there have been no concerns about a lack of an on-site service.

The Parliamentary and Health Service Ombudsman (PHSO) has reported a backlog of 3000 cases to be reviewed and are responding to cases where they can have the most impact. Over the past year there have not been any cases taken forward for investigation by the PHSO (we have received 5 requests for further information and two requests to further attempt local resolution at a Trust Level).

The number of formal complaints received about the Trust has decreased slightly to 213 in 2020/21 compared to 231 in 2019/20, 230 in 2018/19 and 209 in 2017/18. The Trust actively promotes feedback as part of 'Learning from Experience', which within the complaints office includes activity such as enquiries, services resolving concerns informally, working with other Trusts on joint complaints, and responding to the office of Members of Parliament who raise concerns on behalf of their constituents.

In addition to complaints, there were 34 enquiries and concerns raised by MPs on behalf of their constituents in 2020/21.

Our complaint handling and response writing training which is available to staff has been adapted to be provided over Teams and continues to take place on a regular basis across the different localities, in addition to bespoke, tailored training for specific teams which has taken place to staff groups and teams.

The Trust had one breach in responding to a complaint within agreed timescale. The service carried out a review of the circumstances around the breach and have put actions in place locally to prevent this from happening again. The Trust continues to monitor the number of locally resolved and informal complaints through the quarterly Patient Experience Report. Complaint files are managed in real time and information is available on a dashboard that is accessible to the Divisional and Clinical Directors.

We have been unable to use the Model Hospital programme data as the data was not collated during 2020/21.

2. Complaints received – activity

2.1 Overview

During 2020/21, 213 formal complaints were received into the organisation**.** Table 1 evidences the number of formal complaints by service and compares them to the previous financial year.
The information in this report excludes complaints which are led by an alternative organisation, unless specified.

Table 1: Formal complaints received

	2019-20						2020-21						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Change (Annual)**
CMHT/Care Pathways	8	10	6	13	**37**	**16.02**	4	11	7	12	**34**	**15.96**	↓
CAMHS - Child and Adolescent Mental Health Services	10	8	8	4	**30**	**12.99**	2	3	3	6	**14**	**6.57**	↓
Crisis Resolution & Home Treatment Team (CRHTT)	2	2	4	6	**14**	**6.06**	4	2	3	4	**13**	**6.1**	↓
Acute Inpatient Admissions – Prospect Park Hospital	5	3	7	6	**21**	**9.09**	7	4	1	9	**21**	**9.86**	=
Community Nursing	4	3	6	2	**15**	**6.49**	2	1	5	2	**10**	**4.69**	↓
Community Hospital Inpatient	6	1	5	3	**15**	**6.49**	5	6	3	4	**18**	**8.45**	↑
Common Point of Entry	2	6	2	2	**12**	**5.19**	1	1	3	1	**6**	**2.82**	↓
Out of Hours GP Services	0	1	7	1	**9**	**3.9**	4	0	3	1	**8**	**3.76**	↓
PICU - Psychiatric Intensive Care Unit	0	0	1	0	**1**	**0.43**	2	0	0	2	**4**	**1.88**	↑
Urgent Treatment Centre	1	1	1	0	**3**	**1.3**	1	0	1	0	**2**	**0.94**	↓
Older Adults Community Mental Health Team	1	0	0	0	**1**	**0.43**	1	1	1	2	**5**	**2.35**	↑
13 other services in Q4	11	19	21	22	**73**	**31.6**	11	33	21	13	**78**	**36.62**	↑
Grand Total	**50**	**54**	**68**	**59**	**231**		**44**	**62**	**51**	**56**	**213**		

Of the 213 formal complaints received, 14 were secondary complaints.

The table above demonstrates that the number of formal complaints for Crisis Resolution/Home Treatment Team (CRHTT), Acute adult inpatient wards, Out of Hours GP and Urgent treatment Centre remained similar compared to last year. Whilst recognising the numbers are small there was an increase in complaints received in relation to Community Hospital Inpatients, PICU - Psychiatric Intensive Care Unit and Older Adults Community Mental Health Team compared with the previous year.
Community Nursing, Common Point of Entry (CPE), CAMHS and CMHT experienced decreases in the number of formal complaints received, with the most significant decrease being seen in complaints received in relation to CAMHS.

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

Table 2: Themes of Complaints received

Main subject of complaints	Number of complaints	% of total complaints
Care and Treatment	100	46.95
Communication	48	22.54
Attitude of Staff	28	13.15
Confidentiality	7	3.29
Medical Records	6	2.82
Medication	5	2.35
Access to Services	5	2.35
Discharge Arrangements	4	1.88
Waiting Times for Treatment	3	1.41
Abuse, Bullying, Physical, Sexual, Verbal	3	1.41
Other	2	0.94
Support Needs (Including Equipment, Benefits, Social Care)	1	0.47
Admission	1	0.47

The main theme of complaints received during 2020/21 was care and treatment with 46.95%, communication with 22.54% and attitude of staff with 13.15%. This is compared to care and treatment accounting for 46.75% of formal complaints and 19.48% attitude of staff and 11.69% for communication received during 2019/20. In 2018/19 care and treatment was 51.74% and attitude of staff was 16.75%.

Complaints received in relation to care and treatment are wide ranging and focus very much on individual circumstances and therefore it has not been possible to pick up themes or areas for specific action by services in relation to these. There were minimal complaints received in relation to Covid, which was helped by targeted communication from our inpatient wards (both in mental health and physical health) and communication around community based virtual appointments.

Of the 47% in relation to care and treatment:

- 66% were about the clinical care received
- 11% were about either delaying, or not making on onward specialist referral
- 7% involved delays or not being visited

- 5% were about mot been examined, or the examination not being thorough enough
- 3% were about either not making a diagnosis, or making one that was incorrect

23% of formal complaints were about communication, of these:

- 29% was about communication with other organisations
- 10% was about verbal communication (these were split across Adult Acute Admissions, CMHT, Community Nursing and CAMHS)
- 17% was about written communication (the majority of these (63%) of these complaints were from the same person)

There has been a decrease in complaints relating to the attitude of staff, down from 19.48% (n45) in 2019/20 to 13.15% (n28).

In 2020/21, 17 of the 28 (61%) complaints related to staff attitude were in relation to mental health services, 4 (14%) were about physical health services and 7 (25%) were about CYPF (the remaining complaints were about corporate services).

In 2019/20 of the 45 complaints related to staff attitude, 33 (73.33%) complaints were in relation to mental health services, 10 (22%) were about physical health services and the remaining complaints were about corporate services).

There had been a notable decrease in complaints received about access and waiting times for CAMHS compared with previous years.

The following tables show a breakdown for 2020/21 of the formal complaints that have been received and where the service is based.

2.2 Mental Health service complaints

Table 3 below details the mental health service complaints received, this shows that the main services where formal complaints are attributed to are CMHT and Adult acute Admissions wards. 43% of the complaints were about care and treatment (which is around the same as in 2019/20 and 2018/19 and an increase from 29.54% of mental health service complaints in 2017/18). Complaints about adult mental health services accounted for 52% of the total complaints received in 2020/21 compared to 64% in 2019/20.

Table 3: Mental Health Service complaints

Service	Number of complaints
A Place of Safety	2
Adult Acute Admissions - Bluebell Ward	10
Adult Acute Admissions - Daisy Ward	7
Adult Acute Admissions - Rose Ward	2
Adult Acute Admissions - Snowdrop Ward	2
CMHT/Care Pathways	34
CMHTOA/COAMHS - Older Adults Community Mental Health Team	5
Common Point of Entry	6
Complex Treatment for Veterans	1

Criminal Justice Liaison and Diversion Service - (CJLD)	2
Crisis Resolution and Home Treatment Team (CRHTT)	13
Eating Disorders Service	1
IMPACTT	3
Older Adults Inpatient Service - Rowan Ward	1
PICU - Psychiatric Intensive Care - Sorrel Ward	4
Psychological Medicine Service	2
Talking Therapies	1
Talking Therapies - Admin/Ops Team	4
Talking Therapies - PWP Team	1
Traumatic Stress Service	2
Veterans TILS Service	7
Grand Total	110

2.2.1 Mental Health Complaints by service

The adult mental health services receiving higher numbers of formal complaints in 2020/21 are detailed further below.

Veterans TILS Service

All 7 of the formal complaints received about the Veterans Transition, Intervention and Liaison (TIL) Service were from the same person. These complaints were about communication and the information contained within medical records.

Community Mental Health teams (CMHT)

As detailed in table 4, within CMHT services most complaints were received regarding the services in West Berkshire (26%) and Slough (21%). In both service areas there were multiple complaints from the same patients.

Reading has seen an increase with 18% from 8% last year and compared to 27% in 2018/19.

Wokingham CMHT also saw a sustained reduction to 12%, from 14% last year and 22% in 2018/19.

Table 4: CMHT complaints

	Geographical Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Access to Services				1		1	2
Attitude of Staff	1	2		1			4
Care and Treatment	1	2	4	5	1	3	16
Communication	3		1		1		5
Confidentiality		2			1		3
Discharge Arrangements				2			2
Medication			2				2
Grand Total	5	6	7	9	3	4	34

Adult mental health inpatients

As detailed in table 5, 36% of complaints received by the acute adult admission wards were about clinical care/ care and treatment (compared to 57% last year); these were individual to specific patient circumstances.

This includes four complaints received in relation to Sorrel ward (compared to one in 2019/20).

There was one complaint received about our Older Adult Mental Health Wards, which was for Rowan Ward, there were no complaints about Orchid Ward.

Table 5: Adult mental health inpatient ward complaints

	Ward					
Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	PICU - Psychiatric Intensive Care - Sorrel Ward	Grand Total
Alleged Abuse, Bullying, Physical, Sexual, Verbal		1	1		1	3
Attitude of Staff	8					8
Care and Treatment	2	3	1	1	2	9
Communication		3		1	1	5
Grand Total	10	7	2	2	4	25

Bluebell Ward and Daisy Ward received the highest number of formal complaints.

5 out of the 8 complaints received about attitude of staff on Bluebell Ward were from 2 patients – and these were about different staff.

The 7 complaints received about Daisy Ward were from different patients and there were no themes to note.

CRHTT

Table 6 below demonstrates that there were 13 complaints received about CRHTT in 2020/21; similar number to the 14 received in both 2019/20 and 2018/19 and a reduction on 20 received in 2017/18.

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

Table: 6 CRHTT complaints

	Geographical Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Attitude of Staff	2		2			4
Care and Treatment		5			2	7
Communication		1				1
Confidentiality				1		1
Grand Total	2	6	2	1	2	13

Table 7: Older Adults Community Mental Health Service Complaints

Older adult services

There were 5 formal complaints about the Older Adults Community Mental Health Team received in 2020/21. This is compared with 1 in 2019/20 and 3 in 2018/19 (all of the complaints received in the three previous years have been about the Wokingham based service).

	Geographic Locality			
Main subject of complaint	Slough	West Berks	Wokingham	Grand Total
Communication		2		2
Medical Records			2	2
Medication	1			1
Grand Total	1	2	2	5

2.3 Community Health Service Complaints

24% of formal complaints received into the organisation in 2020/21 a reduction from 29% in both 2019/20 and 2018/19.

Table 8 below details the community health service complaints received, this shows that the main services where formal complaints are attributed to are Community Inpatient services (35%, from 21%), WestCall out of hours services (15% from 13%) and Community Nursing (District Nursing 19% from 22%). 67% (compared to 56% last year) of the total community health service complaints were about care and treatment. There were no themes with complaints raised around specifics of care delivery and patient's individual circumstances.

Table 8: Community Health Service Complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Community Dental Services				1			1
Community Hospital Inpatient Service - Donnington Ward				1			1
Community Hospital Inpatient Service - Henry Tudor Ward					6		6
Community Hospital Inpatient Service - Jubilee Ward			3				3
Community Hospital Inpatient Service - Oakwood Ward		6					6
Community Hospital Inpatient Service - Windsor Ward						2	2
Community Physiotherapy		1					1
Community Respiratory Service		1					1
Continence				1			1
District Nursing	2	4	1	2		1	10

	Geographical Locality						
Service	Bracknell	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Integrated Pain and Spinal Service - IPASS						2	2
Out of Hours GP Services		7		1			8
Phlebotomy				1			1
Podiatry		2			1		3
Rapid Response				1		1	2
Sexual Health			1				1
Tissue Viability					1		1
Urgent Treatment Centre				2			2
Grand Total	2	21	5	10	8	6	52

2.3.1 Community Health Complaints by service

The top 3 community services receiving formal complaints in 2020/21 are detailed further below.

Community Nursing

As detailed in Table 9; 7 of the 10 complaints were regarding care and treatment, review of these has not identified any themes.

Table 9: Community Nursing Service complaints

	Geographical Locality					
Main subject of complaint	Bracknell	Reading	Slough	West Berks	Wokingham	Grand Total
Attitude of Staff	2					2
Care and Treatment		3	1	2	1	7
Communication		1				1
Grand Total	2	4	1	2	1	10

Community Health Inpatient Wards

Table 10: Community Health Inpatient Ward Complaints

	Ward					
Main subject of complaint	Donnington Ward	Henry Tudor Ward	Jubilee Ward	Oakwood Ward	Windsor Ward	Grand Total
Attitude of Staff			1			1
Care and Treatment		4	2	4		10
Communication	1			2	2	5
Discharge Arrangements		1				1
Medication		1				1
Grand Total	1	6	3	6	2	18

The number of formal complaints for Community Inpatient Wards has increased from 15 last year, 17 in 2018/19 and 11 in 2017/18.
Care and treatment continue as the main subject for complaints received about Community Inpatient wards. Henry Tudor Ward and Oakwood Wards received the highest number of complaints with 33% of all inpatient formal complaints received each. There were no themes for the complaints about these wards.
There were no formal complaints received about Ascot Ward and Highclere Ward in 2020/21.

WestCall Out of Hours GP Service

As shown in Table 11 WestCall received 8 complaints in 2020/21, a reduction from 9 complaints in 2019/20 and 17 in 2018/19.
The complaints for the out of hours GP service were found to be about care and treatment, confidentiality, and medication.

Table 11: WestCall Out of Hours GP Service complaints

	Geographical Locality		
Main subject of complaint	Reading	West Berks	Grand Total
Care and Treatment	5	1	6
Confidentiality	1		1
Medication	1		1
Grand Total	7	1	8

2.4 Children, Young People and Families

Table 12 below details the children, young people and families' complaints received, with 21% of all complaints received attributable to these services. The main services where formal complaints are attributed to our Health Visiting service (it is worth noting that 14 complaints were from the same person).

Table 12: Children, Young People and Family Service Complaints

	Geographical Locality							
Service	Bracknell	Other	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
Adolescent Mental Health Inpatients - Willow House							3	3
CAMHS - AAT			1		1	1		3
CAMHS - ADHD					2			2
CAMHS - Anxiety and Depression Pathway	1		1					2
CAMHS - Child and Adolescent Mental Health Services	1							1

	Geographical Locality							
Service	Bracknell	Other	Reading	Slough	West Berks	Windsor, Ascot and Maidenhead	Wokingham	Grand Total
CAMHS - Rapid Response						1		1
CAMHS - Specialist Community Teams			2		2			4
Children's Speech and Language Therapy - CYPIT			3					3
Common Point of Entry (Children)		1			1		1	3
Community Paediatrics				1				1
Health Visiting	3		5		11		2	21
Grand Total	5	1	12	1	17	2	6	44

CAMHS

Child and Adolescent Mental Health Services received 14 complaints in 2020/21 compared to 30 in 2019/20, 25 in 2018/19 and 26 received in 2017/18. There has been a reduction in complaints about access and waiting times. CAMHS have worked hard over the past three years to improve the support offered to 'waiters', with the aim of improving communication with the young people who are waiting to be seen and their cares. In addition to this, there is more signposting to services such as the Emotional Health Academy and parent support services.

Access to CAMHS services was the main subject of 1 complaint compared to 7 2019/20 and 3 formal complaints in 2018/19. There were no formal complaints about the attitude of staff in 2020/21 compared to 2 in each of the previous 2 years and there was a reduction in complaints about communication with 3 compared with 4 in the previous year.

The community CAMH Services have been separated out on the reporting system Datix (AAT, ADHD, Anxiety and Depression Pathway, Rapid Response and Specialist Community Teams), and the table below shows the activity for these services combined.

Table 13: Community CAMHS Complaints

	Geographical Locality				
Main subject of complaint	Bracknell	Reading	West Berks	Windsor, Ascot and Maidenhead	Grand Total
Access to Services				1	1
Care and Treatment	2	2	2	1	7
Communication		1	2		3
Discharge Arrangements		1			1
Waiting Times for Treatment			2		2
Grand Total	2	4	6	2	14

3 Complaints closed – activity

As part of the process of closing a formal complaint, a decision is made around whether the complaint is found to have been upheld, or well-founded (referred to as an outcome). Table 14 shows the outcome of complaints.

Table 14: Outcome of closed formal complaints

	2019-20						2020-21						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 19/20**	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% 20/21**	**Change (Annual)**
Case not pursued by complainant	0	0	0	0	0	0	1	1	0	0	2	1.83	↑
Consent not granted	1	0	0	0	1	0.45	0	0	2	0	2	0.45	-
Local Resolution	1	1	0	0	2	1.92	0	0	0	0	0	0	↓
Managed through SI process	0	0	0	0	0	0	0	1	1	0	2	0	-
Referred to another organisation	1	0	0	0	1	0.45	0	0	0	0	0	0	↓
Not Upheld	16	20	23	24	83	37.56	9	25	19	18	71	33.51	↓
Partially Upheld	17	22	28	23	90	40.72	13	34	20	28	95	46.33	↑
Upheld	11	13	10	9	43	19.46	12	6	0	7	25	17.88	↓
Disciplinary Action required	0	1	0	0	1	0.45	0	0	0	0	0	0	↓
Grand Total	**47**	**57**	**61**	**56**	**221**		**35**	**67**	**42**	**53**	**197**		

The national reporting statistics for 2020-21 have not yet been published (delayed due to the pandemic).

Weekly open complaints situation reports (SITREP) are sent to Clinical Directors, as well as on-going communication with the Complaints Office throughout the span of open complaints to ensure that complaints are responded to in a timely manner.

Table 15 – Response rate within timescale negotiated with complainant

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

During quarter two the Trust had one instance of not responding to a complainant in the agreed timescale. The service has put actions in place locally to stop this from recurring.

4 Complaints as a mechanism for change – learning

The complaint process was part of the Trust internal audit programme during 2020/21 and an audit took place during Quarter 4, this demonstrated the complaints function to be responsive and offering a high-quality service. A management action has been taken forward to triangulate patient experience information with other quality and performance data to further improve the quality and safety of patient care.

The Divisions monitor the outcomes and learning from complaints within their Patient Safety and Quality Meetings. From Quarter one 2021/22 a Patient Safety, Experience and Learning Group has commenced take place on a weekly basis, further learning will be shared and disseminated in a Trust wide learning newsletter.

5 Parliamentary and Health Service Ombudsman

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

Table 16: PHSO activity

Month open	Service	Month closed	Current Stage
Dec-18	Psychological Medicines Service	Open	Investigation Underway
Nov-19	CAMHS	Open	PHSO have requested information to aid their decision on whether they will investigate
Mar-20	CMHT/Care Pathways	Open	Underway
Sept 20	CPE	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	Community Inpatient Services	Open	PHSO have requested we have a final meeting with family
Nov 20	CMHT/Care Pathways	Open	PHSO have requested we attempt to reach resolution with mother of patient who has not given consent to share
Jan 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate
Feb 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate

The PHSO have advised that the COVID-19 pandemic has had a significant impact on their workforce, along with delays by Trusts in responding to enquiries. At the end of March 2021, there was a queue of over 3,000 complaints waiting to be reviewed so they have decided to focus on the more serious complaints about health services in which people may have faced a more significant impact and where they can make the biggest difference. For other complaints (where someone has faced less of an impact) they will consider whether there is anything they can do to help resolve things quickly, but if not, they will close the complaint.

6 Multi-agency working

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

There were 16 multiagency complaints responded to in 2020/21, which primarily involved our physical health services (n9).

Table 17: Formal complaints led by other organisations

Lead organisation	Number of complaints
Frimley Health	6
CCG - West	3
CCG - East	3
SCAS	2
NHS England	2
Grand Total	16

7 Complaints training

The Complaints Office has continued to offer a programme of complaint handling training, which is accessible through the Learning and Development Department. Over the last year, the Complaints Office has delivered the training virtually over MS Teams and has adapted the training to have smaller, interactive groups more frequently.

8 Mortality Review Group

The Trust Mortality Review Group (TMRG) meets monthly and the Complaints Office feeds information into this group. There were 18 formal complaints forwarded to the MRG during 2020/21, compared with 13 in 2019/20.

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

Table 17: Complaints forwarded to TMRG

Service	Number of cases
Community Hospital Inpatients	6
Community Nursing	5
Rapid Response	2
Crisis Resolution and Home Treatment Team (CRHTT)	2
Community Physiotherapy	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Community Respiratory Service	1
Grand Total	18

Trust Board Meeting	July 2021
Title	Research and Development Annual Report 2020/21
Purpose	This report presents a summary of research and related activity for the year 2020/21
Business Area	Corporate (Medical Directorate)
Author	Katie Warner, Head of Research and Development
Relevant Strategic Objectives	Our People, Our Patients, Our population
CQC Registration/Patient Care Impacts	The CQC have now included key research questions with the 'well-led' domain of their inspection framework.
Resource Impacts	The Research and Development department are predominantly funded by the National Institute for Healthcare Research (NIHR). Funding is allocated annually, and a number of team members hold short term contracts as funding is based on previous years' research activity.
Legal Implications	Operating according to the UK Policy Framework for Health and Social Care Research.
Equality & Diversity Implications	The Research and Development (R&D) department's long-term vision is to offer research participant opportunities to all Trust patients.
SUMMARY	In 2020/21 Berkshire Healthcare ranked 4th out of the 48 benchmarked mental health and community trusts for the number of research projects that we recruited to. We ranked 11th in the same benchmarked group for the number of individuals who participated in research projects. In the financial year 2020/21 we delivered 96 research projects; this compares with 79 in 2019/20. Our research efforts this year were dominated by COVID-19. This was in terms of the requirement to assist with or directly deliver Urgent Public Health/COVID-19 research projects as well as to pause, close and restart existing non-COVID-19 research. This reflects the national picture. We look forward to refocussing on BHFT core priorities in 2021/22 via our plan on a page and in particular offering research opportunities in the areas of physical health in SMI, self-harm, suicidality, pressure ulcers, falls, digital interventions and supportive technology COVID-19. This will be guided by our new R&D strategy which will be launched in 2021.
Action required	The Board is asked to note the contents of the report, progress made during the year and future direction for the coming year.

Research and Development Annual Report Template

Contents Page

1. Executive Summary

Berkshire Healthcare NHS Foundation Trust (BHFT) is a research active organisation. Our aim is for all patients to have access to research opportunities which are relevant to them.

In 2020/21 Berkshire Healthcare ranked 4th out of the 48 benchmarked mental health and community trusts for the number of research projects that we recruited to. We ranked 11th in the same benchmarked group for the number of individuals who participated in research projects.
This means that individuals interacting with Berkshire Healthcare receive more opportunities to access research across a broader range of projects, than those interacting with similar Trusts.

In the financial year 2020/21 we delivered 96 research projects; this compares with 79 in 2019/20. This includes a range of research from smaller scale student projects involving a subsection of our patients to national multi-centre clinical trials involving numerous NHS sites. In addition, we supported other NHS Acute, Mental Health and Community and Primary Care colleagues in the region to deliver two COVID-19 vaccine studies and one other Urgent Public Health COVID-19 study.

The majority of our research in the last financial year was observational, led by another non-commercial entity such as an NHS Trust or University and focuses on mental health. We had 4 research projects which were led by Berkshire Healthcare for which we acted as sponsor. Medical staff and Psychologists provided leadership in roughly equal measure to the research projects which take place with either BHFT patient, staff, carers or data. They are closely followed by Nurses. Local smaller scale research projects involved mainly PhD students and Clinical Psychology Doctoral trainees placed at local/regional universities.

By Berkshire Healthcare participating in research, our patients are provided with access to assessment, treatment and intervention which they would not otherwise receive as part of routine care. Staff, patients and carers are also able to contribute to the evidence base for conditions which are most of interest to them. 94% of our research participants in 2020/21 strongly agreed or agreed that they would consider taking part in research again.

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

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

During 2020/21 we employed 37 full or part time; permanent, fixed term or NHSP Research Nurses, Allied Health Professionals, Medics and Clinical Research Practitioners and assistants who were either based in clinical services or with the R&D department core team. The majority of our funding is provided by the NIHR Local Clinical Research Network (LCRN): Thames Valley and South Midlands.

We have continued to review our governance arrangements including research activity oversight, standard operating procedures, policies, monitoring and data management. All but one of our policies have now been updated and our new rolling audit programme has been implemented.

Our research efforts this year were dominated by COVID-19. This was in terms of the requirement to assist with or directly deliver Urgent Public Health/COVID-19 research projects as well as to pause,

close and restart existing non-COVID-19 research. This reflects the national picture. The R&D department are proud to have played such a significant role in the national COVID-19 research efforts. Specifically, helping to test vaccines, identify treatments and interventions and to monitor the impact of COVID-19.

We have continued to work with services to support the CQC clinical research requirements which feature in the well-led framework, focussing on equity, facilitation and awareness.

We look forward to refocussing on BHFT core priorities in 2021/22 via our plan on a page in particular offering research opportunities in the areas of physical health in severe mental illness, self-harm, suicidality, pressure ulcers, falls, digital interventions, supportive technology and COVID-19. This will be guided by our new R&D strategy which will be launched in 2021. The strategy will include national research strategy and policy updates which have significantly increased since the start of the pandemic.

2. Introduction

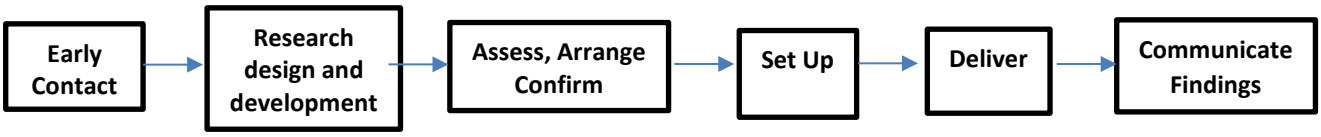
Berkshire Healthcare is one of the most research active Mental Health and Community Trusts in England. By participating in clinical research, we provide our patients and carers the opportunity to receive assessment, intervention and treatment that they would not otherwise receive as part of standard care. Our staff members and the general public are also invited to participate where possible, providing them with the opportunity to contribute their opinions and experiences to inform the evidence base on conditions and topics of interest to them.

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

Our aim is for all patients to have access to research opportunities which are relevant to them. During the course of 2020/21 our patients were able to access research relating COVID-19, anxiety, depression, psychosis, panic disorder, Downs Syndrome, vaccines, sleep, eating disorders, dementia, data consent, mindfulness, voice hearing, Post Traumatic Stress Disorder in young people, virtual reality therapy, efficiency costs and quality of mental health provision, memory problems, diabetes, autism and preventative medications for HIV.

3. Research and Development Activity at Berkshire Healthcare

3.1 Research Activity Overview



Research projects, as they relate to our Research and Development Department, progress through a number of stages, see above. In 2020/2021 Berkshire Healthcare conducted 96 research projects, compared to 79 in 2019/20. However, we reviewed and supported many other research projects at various stages which did not progress through to delivery. Our activity is detailed in the sections that follow. The full list of research projects conducted in 2020/21, can be found in Appendix 1.

3.2 Early Contact

Records are kept within the Research and Development department from the point at which an individual makes contact with us to indicate that they are thinking of developing or delivering research within Berkshire Healthcare. These contacts are followed up regularly to ascertain progress. The majority of individuals are from external organisations wishing to use Berkshire Healthcare as a research site, whilst others are internal to Berkshire Healthcare requiring support to design, develop, fund and deliver their own 'home-grown' research ideas.

3.3 Research design and development

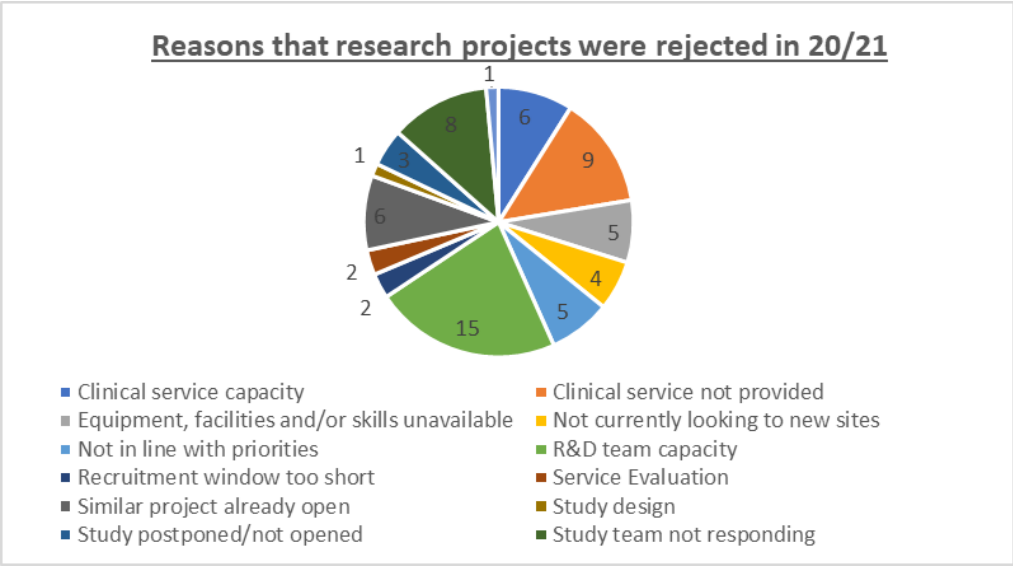
More than 20 individuals contacted our 'In-House Research Service' for support to develop their own research projects in 20/21. We have seen increasing numbers of home-grown research ideas as we have become more visible and accessible as a department. We have not formally advertised the support available as we are in the process of developing and agreeing our service offer with the R&D Committee, in line with our available capacity.

3.4 Assess, Arrange and Confirm

Once we have a formal request to deliver a research project or have identified a research project on the national portfolio database that we would like to deliver, we work through a robust process to check if it is feasible and desirable to undertake the study within Berkshire Healthcare. In addition to working on 96 research studies in 2020/21 we also assessed and rejected a further 67.

The reasons for study rejection are shown in the graph below. The top four reasons were R&D team capacity as we were requested by our funders to prioritise Urgent Public Health and COVID-19 studies; clinical service not provided; study team not responding and clinical service capacity.

With hundreds of potential studies on the national portfolio we will never be able to deliver all that we want to. This means we need to continue to work with our clinical services to understand their priorities so that we allocate resource in the most appropriate and impactful manner.

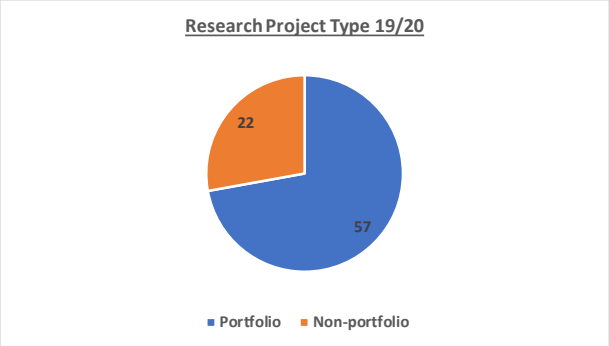


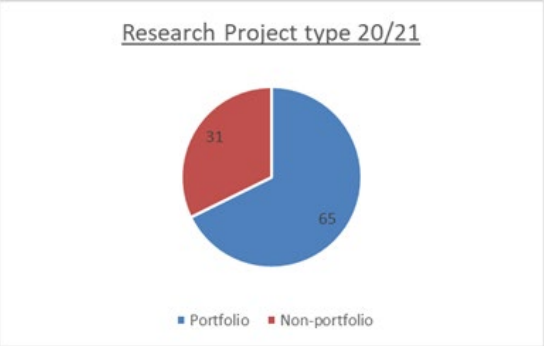
3.5 Types of Research/Research Activity Breakdown (Set up and Deliver)

NIHR portfolio v non-portfolio

Most of the research studies that we participate in are National Institute of Health Research (NIHR) portfolio studies. The NIHR portfolio is a national list of high-quality studies which have received competitive funding. We receive external funding to deliver NIHR portfolio projects. Our other high-quality research studies (non-portfolio projects) are conducted in part fulfilment of qualifications e.g. Clinical Psychology doctorates and PhD's or by a member of staff or external academic but will not have received competitive funding to make them eligible for national portfolio adoption.

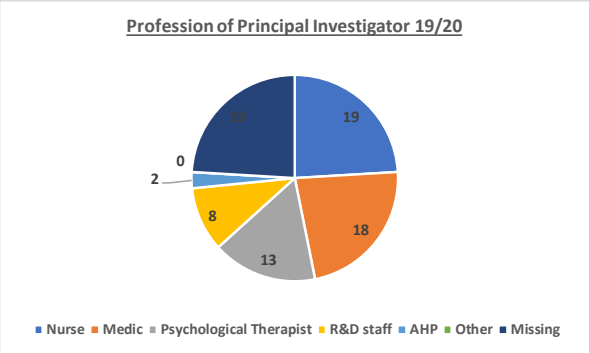
All research has a sponsoring organisation. By sponsoring the research the organisation is accepting overall responsibility for proportionate, effective arrangements being in place to set up, run and report a research project. Historically do not act in the role of sponsor very frequently. There were 4 occasions in the last year where we acted in the role of sponsor. The numbers of portfolio compared with non-portfolio projects are shown below:

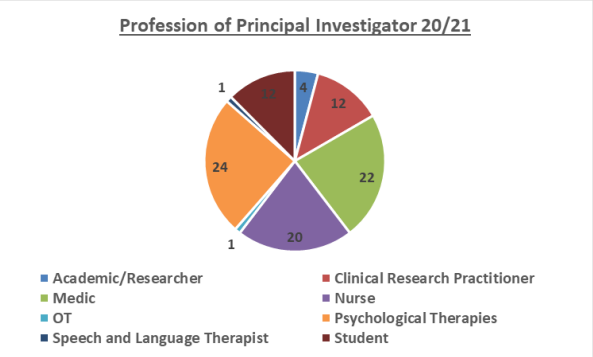




3.6 Professional Group of the Principal Investigators

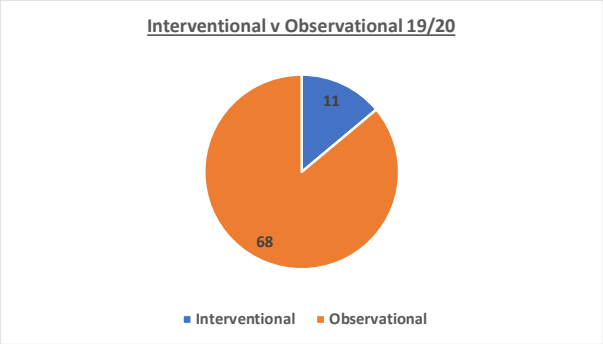
All research projects should have a Chief Investigator and if operating at multiple sites (e.g. different NHS Trusts), a Principal Investigator (PI) should be in place at each research site. At Berkshire Healthcare the number of trained and experienced Principal Investigators is increasing year on year. The professional backgrounds of our Principal Investigators in 20219/20 and 2020/2021 are below:

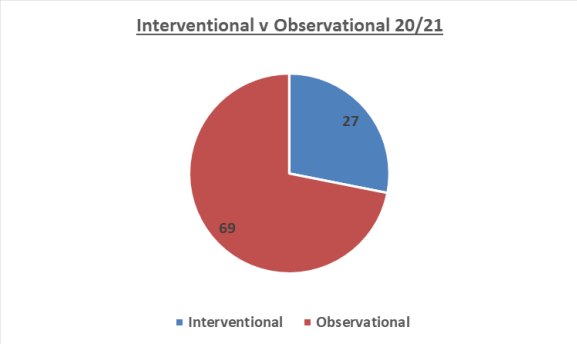




3.7 Interventional v Observational research

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

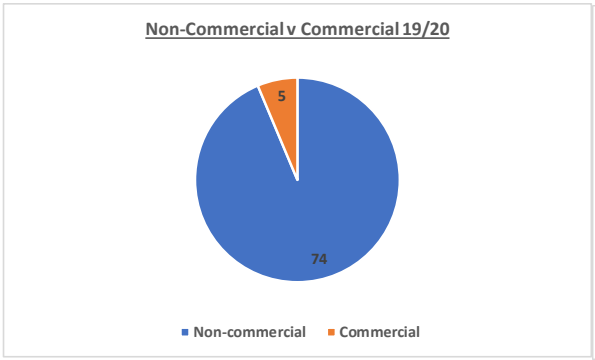


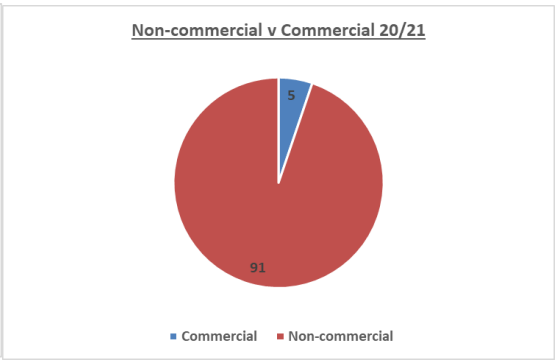


3.8 Commercial v Non-Commercial

The majority of the research that we undertake is non-commercial research. Neighbouring Trusts are better established with enhanced facilities, skills, expertise and experience in commercial trials. This makes it difficult to compete when submitting expressions of interest for commercial research. Of the 5 commercial research projects undertaken last year, we were a Patient Identification Centre (PIC) rather than a full site in one case. This means we explain the study to potential participants and with their permission forward their contact details to the study team to undertake the detailed consent procedure and deliver the research. We would act as a PIC site where we have the patient population but not necessarily the expertise, experience and/or facilities to deliver the research.

The breakdown of commercial compared with non-commercial research is shown below:

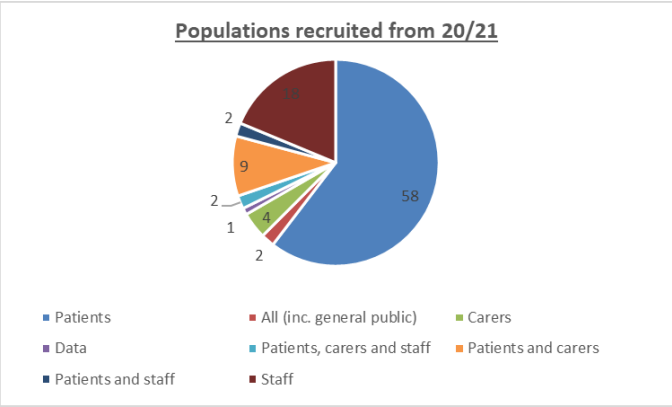




The department expressed an interest in five Commercial NIHR Portfolio trials in 2020/21. We were successful in all cases. Three related to pharmaceutical and two to digital technology companies.

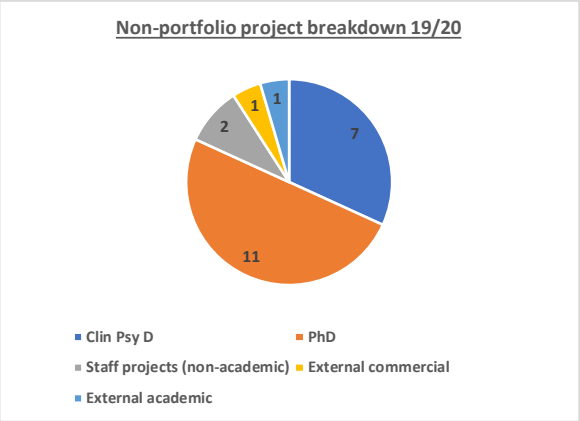
3.9 Populations recruited from

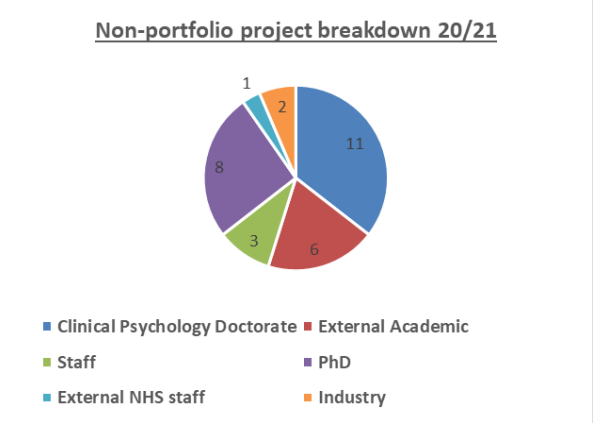
In 20/21 the majority (73 out of 96) of research projects recruited patients from Berkshire Healthcare. 18 projects recruited staff members only.



3.10 Non-portfolio project breakdown

In 20/21 our non-portfolio studies mainly comprised Clinical Psychology Doctorates, External Academics and PhD's. A full breakdown can be found below:

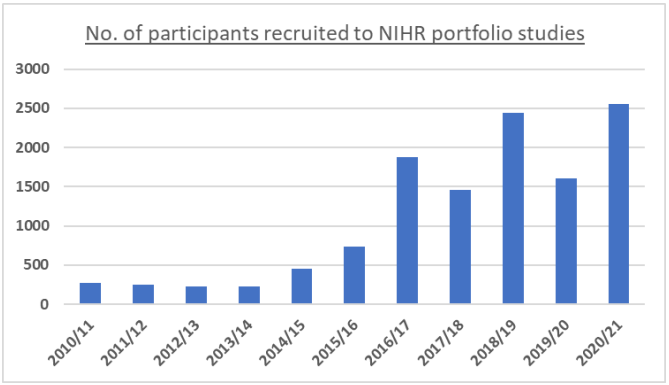


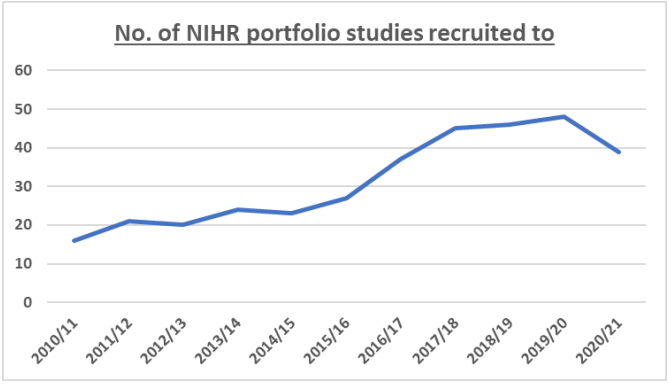


3.11 NIHR Portfolio project breakdown

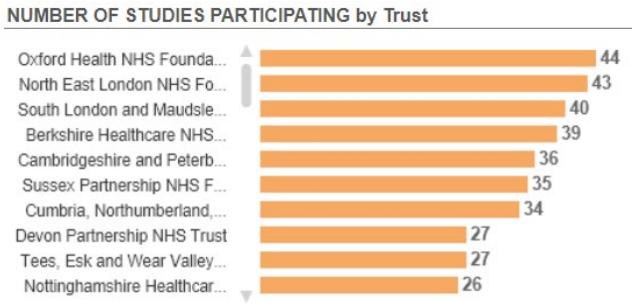
The graphs below show i) our performance year on year; ii) our performance against the 48 benchmarked Mental Health and Community Trusts and iii) the clinical areas researched.

Please note that the number of portfolio projects captured on the national databases for benchmarking purposes and reflected in the graphs below is lower than that recorded as part of our own systems (pg 6 above). Specifically, in 2020/21 as an organisation we participated in 65 NIHR portfolio studies, however this is recorded in the graphs below as 39 studies. This is because only studies which were recruited to are counted nationally, by contrast, we count all NIHR portfolio projects which were open to ensure the total volume of research activity is understood within Berkshire Healthcare. This includes projects open but not recruited to, in follow up and where we acted as Patient Identification Centres as opposed to a full research site.

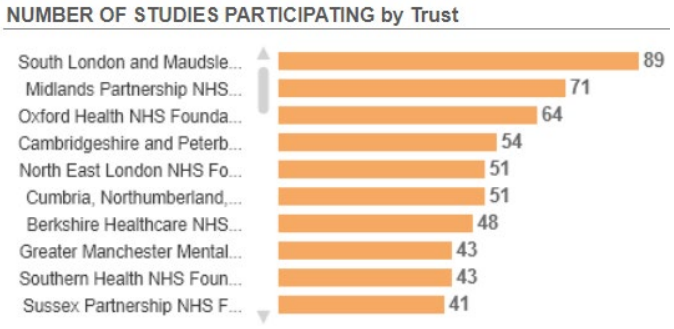


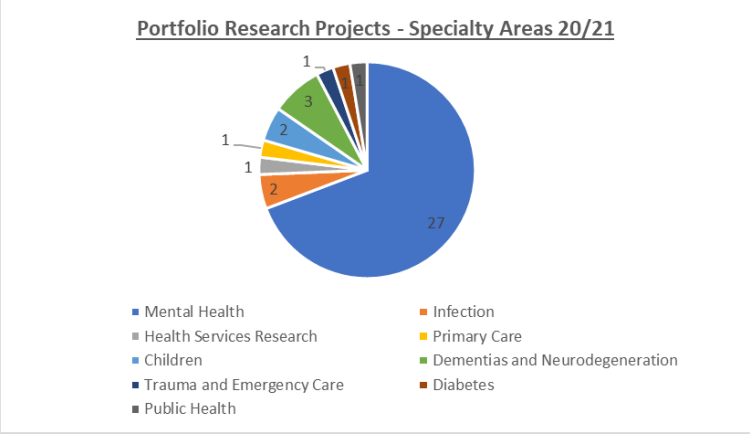


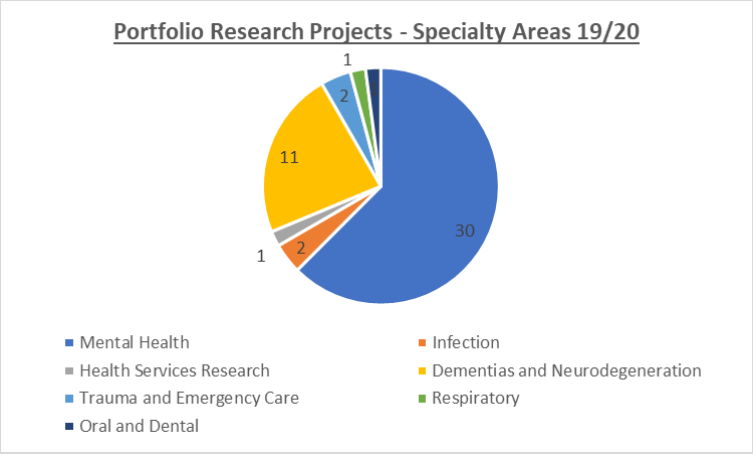
Top 10 Mental Health and Community Trusts for number of NIHR Portfolio Research Projects recruited to 2020/21:



Top 10 Mental Health and Community Trusts for number of NIHR Portfolio Research Projects recruited to 2019/20:







4. Impacts and Benefits- What difference did research that we participated in really make?

Clinically research active hospitals have better patient care outcomes (Boaz et al, 2015; Jonker & Fisher, 2018; Jonker et al, 2019). In Berkshire Healthcare we make a significant contribution to the research evidence base for the populations we serve. Six examples from last year are listed below:

VACCINE STUDIES- Our contribution to COVID-19 vaccine development studies was acknowledged by the National Institute for Healthcare Research in a national article see appendix 2 or link below:

Working together to deliver COVID-19 vaccines studies (nihr.ac.uk)

UK-REACH- "Analysis of interim questionnaire data has found nearly a quarter of healthcare workers were hesitant about COVID-19 vaccines. Hesitancy was greater in some ethnic groups; in women - especially pregnant women; in younger healthcare workers; and in those who had previously tested positive for COVID-19. Being less positive about vaccines in general, having lower trust in employers, and greater belief in COVID conspiracies were also predictors of hesitancy".

VIRUS WATCH- Interim findings indicate that this study is helping to build the evidence base around where people perceived COVID-19 is caught, their changes in mobility after receiving a COVID-19 vaccine, prevalence of persistent COVID symptoms in children.

TRIANGLE- Patients were selected from the TRIANGLE trial which is testing a novel intervention for Anorexia Nervosa. They had "reduced access to Eating Disorder (ED) services, loss of routine and heightened anxieties and ED symptoms resulting from COVID-19 and lockdown measures presented challenges for patients and carers. Increased remote support by ED services enabled the continuation of treatment and self-management resources and strategies promoted self-efficacy".

PrEP (HIV Pre-exposure Prophylaxistrial)- PrEP can greatly reduce the risk of HIV infection. To plan the PrEP programme, NHS England and Local Authorities use results from this study to ascertain how many people attending sexual health clinics need PrEP, numbers started on PrEP and duration.

ESCAPE- Improving Access to Psychological Therapy services appear to be a natural environment for smoking cessation treatment, but this needs to be further tested with a pilot and feasibility study.

We continue to collate and share the results of research that we participate in with those who participated and relevant clinical services.

Research that we are currently involved in aims to:

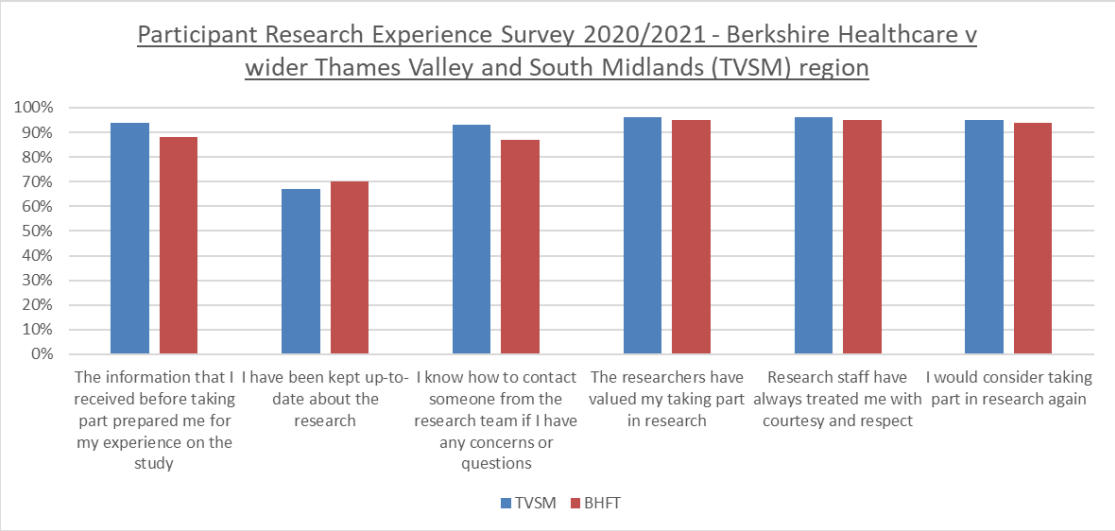
- Test a brief prototype of automated Virtual Reality treatment for patients with psychosis.
- Test an online parent-led cognitive behavioural treatment that parents/carers of children with anxiety disorder work through with remote support from a CAMHS therapist.
- Trial an intervention aimed at preventing and mitigating the onset of depression and loneliness in older people and those with long-term conditions as a result of the COVID-19 lockdown.
- Testing evidence-based training and support programmes to help family and paid carers to provide high quality care to people living with dementia.
- Explore experiences of psychologists working with people with intellectual disability online during COVID-19.
- Test the feasibility of treating sleep problems in young people at ultra-high risk of psychosis.
- Learn about patients' experiences with a diagnosis of psychosis from different ethnic backgrounds who have experienced psychosis.
- Evaluate internet cognitive therapy for young people with PTSD using a randomised control trial to compare this against waiting list condition and face to face cognitive therapy.

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

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

Berkshire Healthcare Research and Development staff work to promote the survey amongst the research participants that we engage with. It should be noted that where studies are accessed online or anonymously it is more difficult to contact the research participants to promote the survey.

The key findings for Berkshire Healthcare as compared to the wider Thames Valley and South Midlands Clinical Research Network region are as follows. Please note these are the percentage of individuals who responded to agree or strongly agree to the questions posed:



Examples of narrative feedback received are as follows:

Very friendly professionals; very reassured about biosecurity measures taken. Very appreciative that we were able to have a home visit because of my mobility problems. (Virus Watch)

It felt like someone was finally listening to me . Not being judged about my symptoms. It was nice to be asked (Hearing nasty voices)

It all seemed very professional but also compassionate and considerate of the topic of the research. (Psychological Impacts)

It was very professional and courteous which made the questioning (even though delicate sometimes) that much easier. (TANDEM)

Just their friendliness - they were so grateful that we were doing the study, they went out of their way to help us (Virus Watch)

What we need to improve?

- Improving experience survey response rates.
- Ensuring good communication of study requirement prior to enrolling participant
- Ensuring feedback of study progress at regular intervals.
- Feedback to study teams where research participants found research questionnaires too onerous.
- Improve signage to research unit.

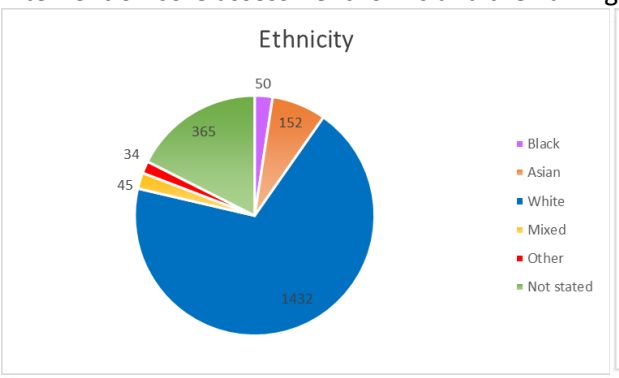
6. Equity of Access- What we know about equity of access to research opportunities at BHFT

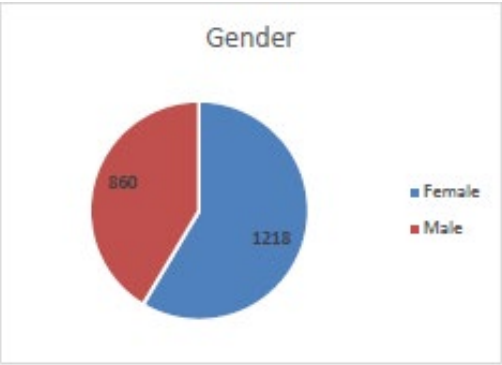
The Future of UK Clinical Research Delivery published in March 2021 by the Department for Health and Social Care re-emphasised the need for patient centred research which ensures that access to and participation in research is as easy for all, including rural, diverse and under-served populations.

Locally, Berkshire Healthcare has launched a new Equality, Diversity and Inclusion strategy with a clear intention to address differentials of experience for patients and staff. The Research and Development department aim to provide as many people as possible with research opportunities i.e. access to treatments, interventions and assessments which are not available as standard care.

Progress:

- We are one of the most research active Mental Health and Community Trusts in the country. This means that patients, staff and carers have more research opportunities than if they received their care in/worked for a similar organisation.
- We invest our funding in a diverse range of staff members to ensure that research is delivered to the highest standards and that local access to research can be facilitated. In addition to our core Research and Development department staff members, in 2020/21 clinicians were funded to undertake research in Older Adults, CAMHS, Talking Therapies, Sexual Health, Urgent Care, Diabetes Services and Pharmacy. These clinical staff were located across Berkshire and worked in hospitals, clinics, community bases, universities and people's homes.
- It is not possible at the current time to provide accurate demographic data on the people who access the research that we provide. This is because data is submitted directly to study teams who analyse the data and it is not accepted practice to provide this information back to those who facilitated the delivery of the research. We continue to challenge this at national level.
- We hold a Research Interest List locally which patients can sign up to be contacted about research opportunities. Numbers of the list have approximately doubled in the last year to 2700 by the end of March 2021. This has been partly due to increased research interest due to COVID but mainly due to the work of the Trust Digital Transformation team and Talking Therapies who have built a standard 'consent to contact about research' question into diabetes and Early Intervention core assessment forms and the Talking Therapies service self-referral form.

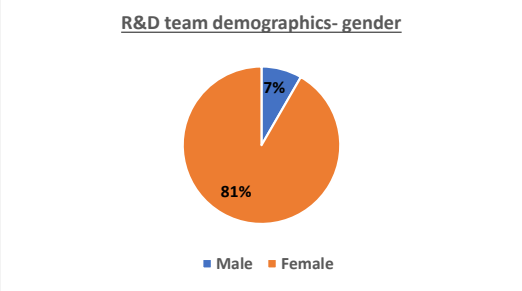


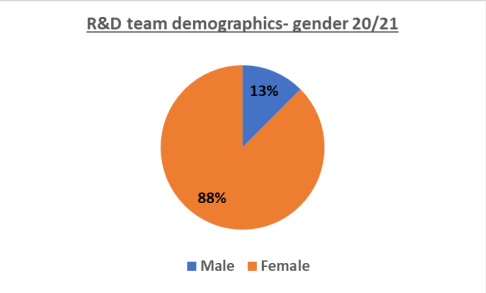


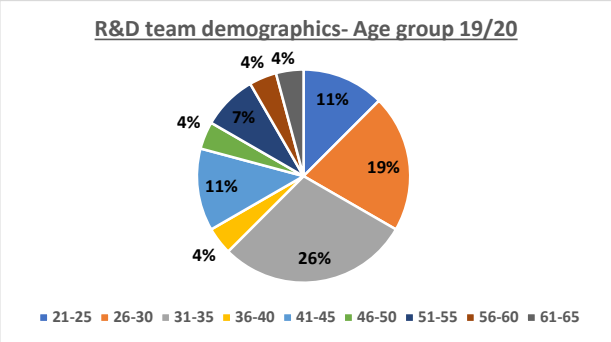
- We continue to engage services in research who have had limited or no access to research opportunities previously.

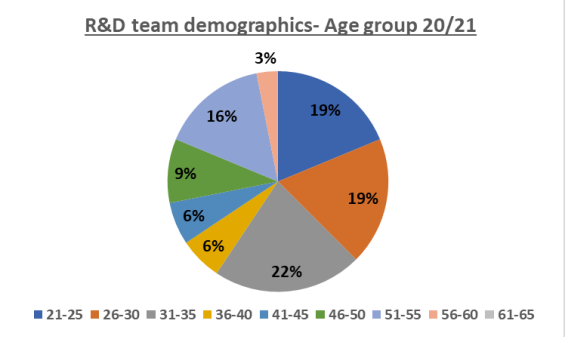
Our staff demographic profile:32 Berkshire Healthcare individuals were funded by the R&D department either full or part time, permanent, fixed term or NHSP in 2020/21, compared to 27 in 2019/20.

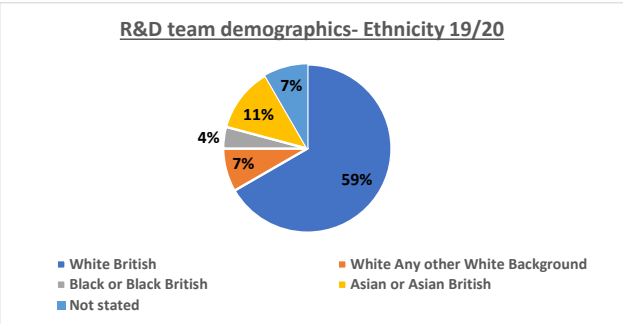
2019/20 **2020/21**

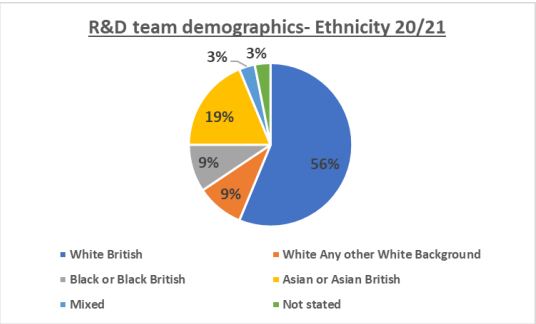


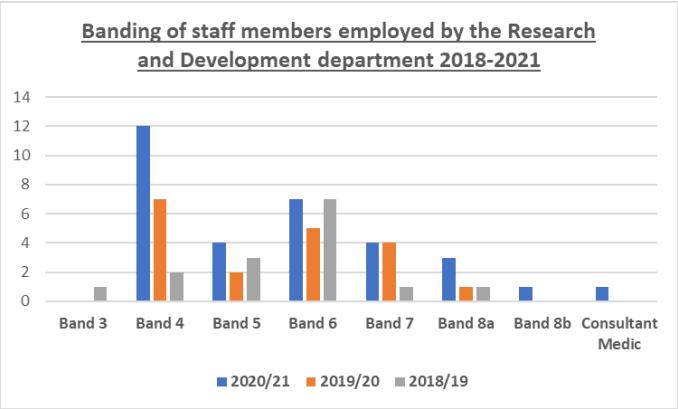












7. Communication and Promotion- How do we promote and communicate research at BHFT?

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

Website –our website content and structure was significantly updated in 2020/21.

Intranet- we have developed a Nexus page to better support staff members to do research.

Media coverage-

Berkshire Healthcare COVID-19 vaccines article
https://local.nihr.ac.uk/news/working-together-to-deliver-covid-19-vaccines-studies/27285

Virus Watch, BBC Radio Berkshire, Dr Sanjoo Chengappa
https://drive.google.com/file/d/1VC7Gv3ka7sFeTvCxCCUYEq2F3Bd4FMXM/view?usp=sharing

Vaccine registry, call for BAME volunteers, Stephen Zingwe
https://drive.google.com/file/d/1wTt6KN72VvoECFi1YsDRVcC_A_D8oYYo/view?usp=sharing

100 Berkshire Healthcare responses to Participant in Research Experience Survey
https://sites.google.com/nihr.ac.uk/tvsmpres/results?authuser=0

Social media: We are increasingly using social media platforms to promote research and specific research participation opportunities.

Team brief and COVID news: We have used existing Trust communication mediums on at least 12 occasions to promote our research studies in 2020/21. Particularly those where staff had the opportunity to take part such as UK-REACH study which investigated the differing impact of COVID on healthcare workers of different ethnicities; the PRINCIPLE studies which provides access to COVID treatments in the community; vaccine studies and the Psychological Impact of COVID-19 study.

CAMHS research event: Open to all CAMHS staff members to inform and promote the research support available in Berkshire Healthcare.

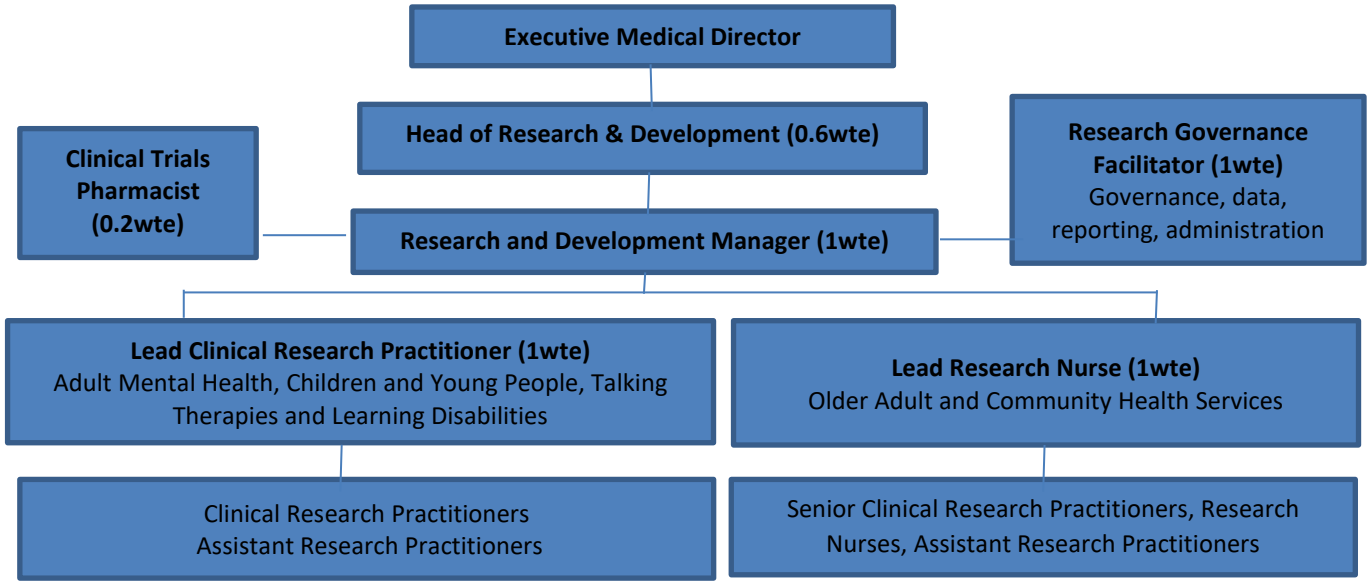
Partner presentations: We presented at the University of Reading, School of Psychology and Clinical Language Sciences to help to build relationships, stimulate collaborations and enhance awareness.

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

8.1 R&D department structure and staffing

The core BHFT R&D team are based at the University of Reading in the School of Psychology and Clinical Language Sciences although we operate home and/or remote working where possible.

The structure of the R&D department varies slightly depending on the studies we are delivering. At the end of March 2021 our core team comprised:



8.2 Research and Development External Funding

Source	2017/18	2018/19	2019/20	2020/21
NIHR CRN	392,792	400,000	420, 000	445,000
CRN contingency funding	12,432	39, 413	5, 000	0
CRN Greenshoots funding	0	0	13, 358	0
ETC Funding re qtr 4 2018/19	0	0	3, 106	352
Research Capability Funding (RCF)	25,016	20,000	20, 000	52,960
Commercial Income	13,247	10,453	2, 414	3,457
Other Funding				
PoMeT Research project	11,056	0	0	0
IBER Study	0	5,258	150, 353	63,279
STADIA	0	0	7,003	11,554
ASCEND	0	0	2,755	151,125
NIHR Fellowship	0	0	0	3,171
Totals	**454,543**	**475,124**	**623,990**	**730,898**

We receive Trust funding for our Head of R&D (three days) and in part for the Research Governance Facilitator and R&D Manager.

9. Governance

Research governance refers to the broad range of regulations, principles and standards of good practice that ensure high quality research. The R&D department is responsible for ensuring BHFT comply with the UK Policy Framework for Health and Social Care Research and related regulations. In order to ensure compliance in 2020/21 we have:

- Continued to maintain a register of all research activity that takes place involving BHFT staff, patients, carers or data.
- Continued to ensure all relevant approvals have been obtained and that the required contracts and key documentation is in place before the research begins.
- Reviewed and updated all but one of our research policies. The Intellectual Property policy will be updated in 2021/22.
- Reviewed and updated a quarter of our Standard Operating Procedures. A plan is in place to complete all remaining reviews in 2021/22.
- Developed a comprehensive audit programme to ensure we are adhering to our policies and procedures.
- Introduced a new Standard Operating Procedure to ensure that key aspects of information governance are understood and managed appropriately.
- Improved our databases to capture our early engagement and in-house research service activity.
- Continued to support local researchers and NHS staff members to undertake research at Berkshire Healthcare by arranging research passports, honorary research contracts and letters of access.
- Relaunched the R&D Committee, chaired by the Head of R&D, with Clinical Director, R&D Senior Leadership team membership and University of Reading representation.
- Continued reporting every two months to the Clinical Effectiveness Group.

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

10.1 Overview

The R&D Department monitors performance against two sets of objectives. Firstly, specific objectives set by our main funders the National Institute for Healthcare Research (NIHR) Local Clinical Research Network (LCRN) and secondly, Berkshire Healthcare plan on a page team objectives. In addition, we are required to report our Clinical Trials Performance on our website.

10.2 Objectives allocated by NIHR LCRN 2020/21

We did not receive specific objectives from our main funders the Local Clinical Research Network in this financial year due to the pandemic. Instead all NHS R&D department were asked to prioritise COVID-19 vaccine studies, platform trials which tested multiple treatments and other COVID studies.

10.3 The R&D department objectives 2020/21 and progress

In line with the objectives that we set in our plan on a page last year we:

- Increased the proportion of research projects which relate to COVID-19. (Harm-free care)
- Increased visibility for clinical and service leads of all current research and proposed future research. (Harm-free care)
- Improved our research development capacity and support offering for individuals who would like to develop and/or deliver research studies (Supporting our staff)
- Improved the career development pathways for R&D staff members by reviewing our job descriptions and providing further job role clarity at bands 4-7. This work has made it clearer to understand what is needed to progress to the next level. (Supporting our staff)

- Improved retention by understanding and better supporting staff wellbeing. We have a wellbeing champion who highlights trust support and initiatives in an engaging way. (Supporting our staff)
- We supported staff to embed working remotely for a significant part of their role and to develop the necessary skills to operate safely and effectively. (Supporting our staff)
- We used the patient research experience survey feedback to make necessary improvements to our service (good patient experience)
- We worked with our partners to significantly increase the proportion of interventional v observational research (good patient experience)
- We increased access to research opportunities in service areas where there are no current active research projects. This included West Call Urgent Care services, CAMHS getting help services, SHaRON and district nursing and Estates and Facilities (patient experience)
- We have reviewed our approval, screening and delivery processes to increase efficient and effective as possible (money matters)
- We have identified an increased number of research projects that focus on technologies with a view to reducing clinical time for Berkshire Healthcare services.
- We have continued to move to electronic systems and eliminate paper where possible.

Our Plan on a page for 2021/22 can be found in Appendix 3

10.4 Clinical Trials Performance (CTP)

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

To access our 2020/21 CTP reports please visit the link https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development/. Three of these studies did not recruit the first participant in 30 days because no patient consented and fourth experienced sponsor delays.

11. Partnership Working and Collaborations

11.1 Portfolio delivery

Partnership working is of paramount importance to the research we deliver in Berkshire Healthcare. We have worked with 29 universities and 11 NHS organisations over the past year to bring research opportunities to patients, staff and carers (see appendix 4 for details). The relationship with these institutions was in their role as sponsor or employer of the Chief Investigator.

11.2 National networks

Berkshire Healthcare are also members of the UK Research and Development (UKRD) which is a community of Research and Development leaders with responsibilities to Board for the R&D function in their organisation. Our involvement in this group is via the Head of R&D and we have contributed to multiple conversations and senior government discussions throughout 2020/21. In addition, a number of staff members in the R&D department link into the NHS R&D Forum (RDF) which is a UK–wide community of practice and professional network for the health and care research management, support and leadership workforce.

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

The NIHR Clinical Research Network comprises 15 LCRN's that cover England. They coordinate and support the delivery of research in the NHS and wider care landscape. Our LCRN is Thames Valley and South Midlands which covers Berkshire, Buckinghamshire, Milton Keynes and Oxfordshire.

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

11.4 University of Reading

Our main research collaborations with the University of Reading are with the School of Psychology and Clinical Language Sciences. In the last year we have supported at least a dozen academics with developing research proposals, research grants, linked academics with clinicians to work on research ideas, funded staff to support NIHR portfolio delivery, acted as lead NHS organisation or participating site for University of Reading led NIHR portfolio studies and met regularly with the Research Division leads to ensure we are prioritising areas of mutual interest.

11.5 Oxford Health NHS Foundation Trust

Our collaboration and partnership working has continued throughout 20/21. During COVID-19 vaccine trials we arranged Letters of Access for our staff and released their time to support these important studies. In return Oxford Health provided paediatric blood support to one of our COVID-19 Urgent Public Health studies. We continue to share knowledge and learning in relation to governance; national, regional and local initiatives and potential research opportunities.

11.6 Royal Berkshire Hospitals NHS Foundation Trust

We continued to identify opportunities to collaborate throughout 2020/21. We loaned three staff members during wave 1 of the COVID-19 pandemic to support a particularly labour-intensive study.

We also worked together to identify potential locations and staff members who could support COVID-19 vaccine trials. We were unsuccessful in our expression of interest to host a Berkshire hub for vaccine research trials. This would have been led by Royal Berkshire Hospitals.

Moving forward, it is felt that collaborations relating to Dementia and Neurodegeneration studies might bring the most benefit to Berkshire residents. Royal Berkshire Hospitals open relatively few NIHR portfolio studies in this area and it is a national priority area. Meanwhile Berkshire Healthcare have expertise to deliver these studies but not the equipment or medical back up required.

11.7 Oxford Academic Health Science Network (AHSN)

Berkshire Healthcare are represented at the Oxford AHSN Research & Development group by the Head of R&D. This group comprises representatives from universities, NHS trusts and related bodies in the Oxford AHSN region and provides opportunities for collaboration between the NHS and university partners within the region. Key national and regional updates are also received.

11.8 Frimley Health Foundation Trust

We have worked with the R&D department at Frimley Health to identify areas of mutual interest. Diabetes and long COVID are of particular interest at present and we are reviewing current NIHR portfolio opportunities that might benefit from joint working.

12. Future Direction- DRAFT R&D strategy outline

In recent months we have seen several documents at national level which indicate the increasing importance which has been attached to research development and delivery. They also signal a coordination of focus and effort across policy areas and strategies for example National Institute of Health Research, NHS England and NHS Improvement, Department for Health and Social Care, Care Quality Commission, National Institute for Health and Care Excellence and the upcoming NHSX digital strategy. Our draft R&D strategy outline is consistent with the national direction:

	VISION- where do we want to be in 2024	**PLAN**			**ALIGNMENT WITH STRATEGY**		
		YR 1	**YR 2**	**YR 3**	**TRUST**	**ICS**	**NATIONAL**
PRIORITISED	100% of research carried out at Berkshire Healthcare aligns with a Patient and Public Involvement, clinical service, Trust, Integrated Care System or National Priority	X			X	X	X
EMBEDDED	All our people in clinical services can articulate the role they play in research	X					X
ACCESSIBLE	Our patients know how to access research opportunities	X			PE		X
EQUITABLE	All our patients are able to access research opportunities which are of interest to them.	X			PE		X
SUPPORTED	Our people who want to develop or deliver research have the guidance, support and time to do so.		X		SOP		
VISIBLE AND IMPACTFUL	Our staff, patients, carers and partners know the benefits and impacts of the research we are involved in		X				X
COLLABORATIVE	We work with a range of partners to design, support and deliver research		X		MM	X	
VALUED	Our people are supported to develop and practice the skills they need to carry out research		X		SOP		
INCOME GENERATING	We have a minimum of three NIHR grant funded projects hosted by Berkshire Healthcare at any one time			X	MM		
INNOVATIVE	We will double our commercial research, providing patients with the access to more cutting-edge treatments, interventions and technologies.			X	MM		
EVIDENCE-BASED	Our people will have access to and be aware of the latest evidence for the clinical area/speciality in which they work			X	HFC		
RECRUITED AND RETAINED	We will attract and keep research interested, skilled and experienced staff because they feel able to progress their research interests and careers at Berkshire Healthcare			X	SOP		

Appendix 1: Summary of Open Studies and Studies in Set Up by Service Area in Berkshire Healthcare for FY2020/21

COVID-19 – 2020/21 projects				
Study title and lead	Summary	Reference	Portfolio status	Study end date
Psychological impact of COVID-19 **(LC – Emma Donaldson)**	This study aims to explore the psychological impact of COVID-19 outbreak and the resultant restrictions in terms of behavioural, emotional and social factors. Questions will be asked of the data collected to see what factors may be supportive or more detrimental to wellbeing. The general public including health professionals and those with pre-existing mental health conditions will be invited to complete the survey.	2020-14	Portfolio	25/09/2021
Enforced social isolation and mental health **(LC – Daisy Fancourt)**	This will be an online survey of people's experiences of social isolation due to Covid-19.	2020-16	Non Portfolio	18/05/2021
PRINCIPLE **(PI – Dr Sandeep Sandhu)**	As yet, there are currently no known treatments for COVID-19 that have been proven to be effective. Our trial aims to evaluate potential treatments as they are identified. To be able to do this, we aim to test one or more suitable, potential treatments for COVID-19, as soon as they become available. We will evaluate drugs that are well known and have been used for many years around the world. We aim to find out whether selected treatments given to those at higher risk of becoming more ill when they are infected with COVID-19 helps reduce the need for hospitalisation and the length of stay required, helps people recover quicker and get fewer complications.	2020-17	Portfolio	25/03/2022
SOLITUDE **(PI – Pramod Kumar)**	This study will invite people with dementia and their carers to complete three interviews over the phone, during the course of 6 months. This study will identify individuals who may be more deeply affected by social isolation. It will also help us describe the relationship between social isolation and worsening of dementia symptoms. Such findings will allow us to improve care delivery and inform prevention.	2020-27	Non Portfolio	30/09/2021
Virus Watch **(PI – Dr Sanjoo Chengappa)**	The Virus Watch study will recruit a community cohort of 25,000 across England. In this population we will measure the frequency of respiratory infection syndromes and related behaviours. Through linkage with NHS Digital, we will measure the impact of infections on hospitalisations and deaths. In a nested sub-cohort of 10,000, we will measure the incidence of PCR confirmable COVID-19, its clinical symptom profiles, the proportion of the population infected after each wave of the pandemic and the protective effect of antibodies acquired through natural infection. In a subset of people, we will conduct a household contact follow up survey & PCR to measure the extent of pre-symptomatic and asymptomatic viral shedding in household contacts. We will also monitor population movement and assess the extent to which public contact increases the risk of infection.	2020-30	Portfolio	30/09/2021 (In follow up)

Child Anxiety Treatment in the Context of COVID-19 (CO-CAT) **(LC – Emma Donaldson)**	This study worked with children, parents, and NHS clinicians to develop a brief online parent-led cognitive behavioural treatment (CBT) delivered by the OSI platform that parents/carers of children with anxiety disorders work through with remote support from a CAMHS therapist. We will now test whether access to the OSI platform together with therapist support works as well as what CAMHS are otherwise offering to help children with anxiety problems (whatever this might be while social distancing measures are in place and in the post COVID-19 recovery phase), and whether OSI as delivered with therapist support brings economic benefits. We will also provide an understanding of parents' and therapists' experiences of digital treatments in CAMHS in the context of COVID-19.	2020-38	Portfolio	30/08/2021
BASIL-C19 **(PI – Nick Woodthorpe)**	URGENT PUBLIC HEALTH. This COVID study looks at social isolation in older adults.	2021-01	Portfolio	03/10/2022
UK REACH **(PI – Stephen Zingwe)**	URGENT PUBLIC HEALTH. Study looking at existing data held by national healthcare organisations to understand what the risk of having, and dying from, COVID-19 is for ethnic minority healthcare workers (HWCs). We will also follow a group of ethnic minority HCWs over 12 months to see what changes occur in their physical/mental health.	2021-04	Portfolio	31/03/2021

Dementia – 2020/21 projects				
Study title and lead	Summary	Reference	Portfolio Status	Study end date
Alzheimer's Dementia Genetics **(PI- Nick Woodthorpe)**	ADG is a study run by Cardiff University looking for DNA bio-markers specifically related to Alzheimer's disease. This involves a blood test preferably but samples of saliva can be collected where bloods are not available. Cognitive measures, a quality of life questionnaire and family history are collected in addition to the samples. (Study on hold)	2014-31b	Portfolio	31/03/2021
BDR3 **(LC – Shani McCoy)**	Brains for Dementia Research is a study whereby participants have donated their brains to the research project following their death. In a longitudinal approach participants are reviewed on an annual basis to understand their cognitive function, physical health and other specified markers which are then paired with brain tissue analysis following harvest of the brain.	2018-14	Portfolio	31/03/2026 (In follow up)
Living well and enhancing active life: The IDEAL-2 study **(PI- Nick Woodthorpe)**	IDEAL-2 is a longitudinal study utilising questionnaire approach to understand the lived experience of individuals living with dementia and that of their carers. This is a multi-site multi-organisation study that is aiming to build a database of information that can be accessed by researchers in the future. This study is currently in its fourth year coming into the fifth and has produced several research papers from the data collected to date.	2018-17	Portfolio	26/05/2021
Current practice relating to Assistive Technology within Memory Services **(PI – Gwen Bonner)**	This project aims to determine current practice of professionals working in memory services in the provision of information on, and access to, Assistive Technology for families living with dementia.	2018-28	Portfolio	31/05/2020

Dementia with Lewy Bodies Genetic study **(PI- Nick Woodthorpe)**	DLB Genetic study is a study run by Cardiff University looking for DNA bio-markers specifically related to dementia with Lewy bodies. This is a branch of the original Alzheimer's Dementia Genetics study and has the same samples to be collected including blood test (or saliva where this is not possible), cognitive measures, quality of life questionnaire and family history.	2019-05	Portfolio	01/06/2020
Nutrition, hydration and care for people with dementia at the end of life: How can we best support family carers? **(PI- Adebayo Anjorin)**	The aims of this University College London study are to explore carers' understanding of how best to manage eating and drinking at the end of life for someone with dementia; establishing if there are gaps in their knowledge and also identifying what information Practitioners provide to carers. We will set the scene for developing a carer resource if this appears desirable.	2019-20	Portfolio	31/07/2020
Exploring and managing dementia in black African and Caribbean Elders - EMBRACE **(PI- Stephen Zingwe)**	Our Older adult services will collaborate with University College London to conduct a qualitative study with semi-structured interviews and participant observations to explore how people from the UK's Black ethnic groups and their families and friend carers conceptualise and manage memory problems and dementia, their expectations of and attitudes towards treatment and care, and the lived experience of the individuals with dementia who continue to live independently at home or move to a care home, and their family carers. (2019-19)	2019-19	Portfolio	17/06/2020
PriDem: Primary care led support in dementia: Developing best practice **(PI – Nick Woodthorpe)**	New recommendations have been made about the types of help needed by people with dementia. We want to find out what you think about these recommendations and how to put them into practice. This will help us to develop a new model for support people after a diagnosis of dementia. PriDem are looking to interview you and/or a family member or friend about your experiences. They are looking for people with a diagnosis of any type of dementia. They would also like to talk to family members or friends of people with dementia. You can participate together or separately.	2019-08	Portfolio	03/06/2020
Clarity-AD **(LC - Sarra Blackman)**	This is a multinational, multicenter, double-blind, placebo-controlled, parallel-group study using a Bayesian design with response adaptive randomization across placebo or 5 active arms of BAN2401 to determine clinical efficacy and to explore the dose response of BAN2401 using a composite clinical score (ADCOMS)	2019-27	Portfolio	31/03/2021
NIDUS-Family **(PI – Leena Reddy)**	The study will recruit 297 family/friend carers and people with dementia (dyads) who live at home through memory services, GP practices, home care agencies and Join Dementia Research. 198 participant dyads will be randomly chosen to receive the intervention (NIDUS-family) alongside usual care, and 99 participant dyads will be randomly chosen to receive usual care without NIDUS-family. We will compare if participants who receive NIDUS-family have better outcomes (goal attainment, quality of life, activities of daily living, symptoms and service use) than those who do not receive it at 6 and 12-months.	2020-22	Portfolio	28/02/2023
Measuring the social care outcomes of people with dementia and carers **(PI – Gaurav Chakrabarti)**	This study will test the ASCOT-Proxy and the ASCOT-Carer with 300 carers of people with dementia living in their own home. People will be invited to complete a paper questionnaire or online survey with an optional brief follow-up questionnaire one week later. The study will be advertised with the help of local authority adult social care departments, carers' organisations and care providers. We will also advertise the study on social media. The information collected will be used to assess whether the questionnaires are easy to complete and measure what they are intended to measure – that is, aspects of people's lives that might be affected by social care services – in a way that is stable over time.	2020-34	Portfolio	31/08/2021 (In follow up)

ADePT **(LC – Stephen Zingwe)**	This study involves interviews with NHS personnel involved in Dementia Diagnostic Pathway nationwide in order to gain insight into how the pathway operates in practice. The pathway processes will be mapped and analysed across multiple NHS Trusts in order to identify issues and opportunities that may be addressed via digital health technologies. The aim of this study is to understand the needs of users, enabling an effective and successful deployment and adoption of a digital technology for cognitive assessment in the NHS.	2020-42	Non Portfolio	01/04/2021

Mental Health – 2020/21 projects				
Study title and lead	**Summary**	**Reference**	**Portfolio Status**	**Study end date**
ADHD				
PROUD **(PI - Dr James Jeffs)**	Aims to evaluate the effectiveness of a new intervention to prevent comorbid depression and obesity in ADHD	2017-34	Portfolio	30/07/2020
Autism				
ASC-UK: Learning about the lives of adults on the autistic spectrum **(PI – Trevor Powell)**	In this project, we will undertake the first stage of a programme of research into the life-course experiences of people with ASD. Experts in ageing and life-course, experienced ASD researchers, and people with ASD and relatives will undertake this project. We will engage with people with ASD, their parents, siblings and partners, and meet and discuss with them to understand much more about how ASD affects people's daily lives as they age.	2015-15	Portfolio	31/12/2021 (In follow up)
Females with Autism Spectrum Disorder and Borderline Personality disorder – the overlap **(PI- Trevor Powell)**	Using Interpretative Phenomenological Analysis, explore and identify themes around how females with both ASD and BPD perceive self-harm, abandonment and their diagnosis, in order to learn more about the overlapping features of ASD and BPD.	2019-17	Non Portfolio	31/12/2021
Elucidating the relationship and co-development of sensory reactivity and mental health symptoms in autism **(PI -Teresa Tavassoli)**	This project will explore if sensory reactivity, such as being oversensitive to sounds, is associated with anxiety and related mental health symptoms. To do so we will follow 100 3-4 year old autistic children and 100 5-6 year old autistic children for 5 years.	2019-23	Non Portfolio	01/05/2023

SPRINT: The Prevalence of Social Communication PRoblems in Adult Psychiatric INpaTients **(PI – Mary Waight)**	Aims: 1) To estimate the prevalence of Autism Spectrum Disorders (ASD's) amongst adults who have been admitted to psychiatric hospitals (including those with intellectual disabilities) population of adult psychiatric inpatients. 2) To examine the association between other mental and physical health conditions in adults who meet diagnostic criteria for ASD's with those who do not meet such criteria (all of whom have been admitted to a psychiatric hospital).	2020-06	Portfolio	01/06/2021
Investigating differences in social cognition in women with diagnoses of Autism Spectrum Conditions and Emotionally Unstable Personality Disorder (Clinical Psychology Doctorate – Bryony Summerhayes)	This study is looking to understand differences in the thinking styles between women with diagnoses of Emotionally Unstable Personality Disorder (EUPD), compared to women with Autism. It is hoped the findings from the study will contribute to understanding of the difference between EUPD and autism in women, helping to improve the process of diagnosis.	2020-19	Non Portfolio	31/12/2020
Music-assisted programmes (MAP): Developing communication in autism spectrum disorder through music making **(LC – Emma Donaldson)**	The proposed research aims to develop a set of music-assisted intervention programmes to increase spoken language ability in 24-60-month-old, nonverbal or minimally verbal children with autism spectrum disorder (ASD)	2020-11	Portfolio	30/06/2021
UK National Autism Diagnostic Services survey 2020 **(LC – Emma Donaldson)**	The survey aims to collect data relating to the way diagnostic services function, the challenges they face, and adaptations that they have made to meet challenges.	2020-26	Portfolio	31/10/2020
Speech and Language access for preschool children with Autism (Academic Project, PhD - Iona Wood)	This qualitative study aims to provide an in-depth understanding of the individual, service, organisational and structural factors impacting on access to Speech and Language Therapy for preschool children with Autism from the perspective of a range of stakeholders.	2021-03	Non Portfolio	02/06/2023
Borderline Personality Disorder				
A questionnaire study examining the link between experiences of betrayal and Borderline Personality Disorder (BPD) (Clinical Psychology Doctorate - Stephanie Barningham)	This study will investigate whether experiences of betrayal (betrayal sensitivity and betrayal of others) are a key feature of BPD and will compare betrayal responses across the three groups (BPD, OCD clinical control and non-clinical control group). Student project	2019-30	Non Portfolio	25/09/2020

Bipolar				
Imagery Based Emotion Regulation (IBER) **(PI - Craig Steel)**	BHFT have collaborated with the University of Reading to do a study to test whether a psychological therapy, called Imagery Based Emotion Regulation (IBER), can help with the symptoms of anxiety within people already diagnosed with bipolar disorder. Recent research suggests that most people diagnosed with bipolar disorder may also suffer from anxiety, but they rarely get assessed, diagnosed or treated for this part of their mental health.	2018-06	Portfolio	30/09/2020
Depression				
Genetic Links to Anxiety and Depression (GLAD) **(PI - Dr Amir Zamani)**	Kings College London will explore genetic and environmental factors associated with risk for depression and anxiety disorders in the UK, to understand these common disorders and help develop better treatments. The participants will be recruited into an existing biobank, the NIHR BioResource for Translational Research in Common and Rare Diseases, a re-contactable biobank. Our recruitment will help towards forming the largest re-contactable biobank of participants diagnosed with or suffering from two very common disorders, depression and anxiety, who will be primarily recruited through an online platform.	2019-13	Portfolio	01/09/2028
Maladaptive sleep-related beliefs and attitudes in co-morbid depression and sleep disturbance in older adults(Clinical Psychology Doctorate – Elizabeth Templeman)	We are interested in looking at the relationship between depression and sleep difficulties in older adults. We know there is a link between depression and insomnia, with poor sleep being a risk factor for developing depression and vice versa. Despite this knowledge it is still unclear what is underlying this relationship. A large number of people who have treatment and recover from depression still have sleep difficulties and this can impact the likelihood of the reoccurrence of depressive symptoms.	2019-36	Non Portfolio	30/09/2020
Eating Disorders				
TRIANGLE **(PI - Dr Elma Ramly)**	Our Eating Disorder service is collaborating with King's College London on a project involving patients with anorexia nervosa and their carers. The project investigates whether providing extra information on how to cope with the illness to both patients and carers improves their wellbeing up to 18 months post-admission. The aim is to ensure a smooth transition between inpatient treatment and integration in the community. The project also entails measuring symptom burden with questionnaires at different time points. Patients will be reimbursed for completing the questionnaires.	2017-01	Portfolio	01/06/2021
The influence of social communication styles and cognitive profiles on restrictive eating disorders in women (Academic Project, PhD - Janina Brede)	This current study aims to assess the role of autism-specific factors for the development and maintenance of restrictive eating disorders (REDs) in autistic individuals, via a comparison of autistic women with AN, women with AN who are not on the autism spectrum, and autistic women who do not have an eating disorder.	2020-02	Non Portfolio	31/12/2020

An exploration of the relationships between attachment, expressed emotion and early symptom change in family therapy for adolescent anorexia nervosa **(Clinical Psychology Doctorate – Francesca Glover)**	The study is trying to find out more about why family therapy for Anorexia Nervosa might be more helpful for certain people and less helpful for others. In order to investigate this, we are going to use questionnaire measures to explore the effect of two things on the outcome of treatment: 1) Adolescents' emotional bond (or 'attachment') to their main caregiver. 2) The ways in which emotions are communicated ('expressed emotion') between adolescents and their parents.	2020-03	Non Portfolio	16/04/2021
Eating Disorders and Social Media **(Clinical Psychology Doctorate – Zahra Khaki)**	The aim of this study is to understand how people with eating disorders experience social media. There is a lot of talk about social media in the press and we are particularly interested in what the effects of using social media might be. Participants will be asked to complete three questionnaires, then will be asked to scroll through an Instagram feed for 15 minutes, where they will be able to like photos as they wish. Participants will be randomised as to which of the two Instagram feeds they will look at and then will be asked to complete four more questionnaires.	2020-24	Non Portfolio	01/06/2021
Learning Disabilities				
An evaluation of the psychometric properties of the adapted PHQ-9 and GAD-7 outcome measures for use with adults with intellectual disabilities. **(Clinical Psychology Doctorate – Hannah Jenkins)**	People with Intellectual Disabilities (ID) have more mental health problems than the general population. They face many barriers to getting help for problems such as depression and anxiety. One barrier is the lack of adapted materials, like questionnaires, to help assess mental health problems in people with ID. Questionnaires are often used in mental health services to assess if people have problems with feeling anxious or depressed and the questionnaires help to check if people are getting better. Some of these questionnaires have been adapted so they are suitable to be used with people with ID. Making adaptations to the questionnaires was part of a previous research project. It is now important to make sure these adapted questionnaires measure what they are supposed to measure (they need to be valid and reliable).	2020-28	Non Portfolio	30/06/2021
Online Support Group Use and Wellbeing of Carers of People with ID **(PI – Dr Jon Codd)**	The research aims to explore the importance of carer networks and peer support as an adjunct to existing service support in health care. The Support Hope and Resources Online Network (SHaRON) is an online support network used across services in Berkshire Healthcare. SHaRON will be implemented with learning disabilities services with a platform for relatives and paid carers initially and then a separate platform for people with an intellectual disability.	2020-20	Non Portfolio	03/02/2023
Psychosis				
The SlowMo Trial **(PI – Gwen Bonner)**	This study aims to test the clinical efficacy of SlowMo, a new therapy, and determine the mechanism through which it reduces paranoia severity, over 24 weeks, and to identify participant characteristics that moderate its effectiveness (either by moderating the degree of change in the mechanism, or by influencing adherence to the intervention).	2016-77	Portfolio	01/09/2020
EFFIP **(PI – Jacqueline Sin)**	Randomised controlled trial commencing with an internal pilot RCT to evaluate the effectiveness of an online intervention to promote carers' wellbeing.	2017-41	Portfolio	31/12/2020

EYE-2 **(PI - Katherine Mckinnon)**	A randomised controlled trial that aims to evaluate the effectiveness of a team based intervention in Early Intervention Psychosis teams.	2018-31	Portfolio	31/01/2022 (In follow up)
THRIVE **(PI – Gwen Bonner)**	A randomised controlled trial comparing Virtual Reality Confidence Building with VR Mental Relaxation for people with fears about others	2018-19	Portfolio	30/12/2021 (In follow up)
Molecular Genetics of Adverse Drug Reactions (MolGen) **(PI- Dr Sharif Ghali)**	A biomarker study that aims to define the genetic and non-genetic risk factors predisposing to adverse drug reactions to clozapine.	2013-04	Portfolio	30/04/2023
PPiP2 **(PI- Dr Sanjoo Chengappa)**	A study that aims to establish the prevalence of pathogenic antibodies in patients with first episode psychosis.	2017-44	Portfolio	30/11/2022
The Game Change Trial **(LC – Emma Donaldson)**	A randomised controlled trial testing automated virtual reality cognitive therapy for patients with fears in everyday social situations.	2019-22	Portfolio	31/12/2021 (In follow up)
Exploring Unusual Feelings **(PI – Emma Cernis)**	This study is a questionnaire study where 1000 patients with non-affective psychosis will answer a pack of 10 questionnaires (approx. 30 minutes), and some brief demographic details (age, gender, ethnicity). They will answer the questionnaires once only (a “cross-sectional” design). We will then use the latest statistical methods (network analyses based on probability estimations) to understand the likely causal relationships between the psychological factors measured. Specifically, the aim of the study is to better understand what factors cause dissociation, and whether dissociation might cause psychotic symptoms	2019-32	Portfolio	30/04/2020
Hearing Nasty Voices **(PI – Sanjoo Chengappa)**	A questionnaire study to better understand the problem of hearing derogatory or threatening voices	2020-09	Portfolio	29/10/2021
Does being more satisfied with romantic relationship status increase wellbeing in people who experience psychosis? **(LC – Emma Donaldson)**	Questionnaire study to measure if increased satisfaction with romantic relationship status is associated with better wellbeing outcomes in people who experience psychosis	2020-04	Portfolio	31/03/2021
PREFER: Patient preferences for voice hearing therapies **(LC – Emma Donaldson)**	This study aims to explore patient preferences for psychological therapies for the experience of hearing distressing voices	2019-44	Portfolio	30/11/2021

The SleepWell Trial **(LC – Emma Donaldson)**	The SleepWell trial will now work with forty young people (aged 14-25 years) to test the feasibility of treating sleep problems in young people at high risk of psychosis. The results of this study will determine whether a larger and more conclusive trial of our psychological intervention can take place.	2020-32	Portfolio	01/11/2022
Inpatient CBTp Delphi Study **(PI – Catherine Evans Jones)**	A Delphi study examining key competencies for the delivery cognitive behavioural therapies for psychosis in acute psychiatric inpatient settings.	2020-39	Non Portfolio	31/12/2021
What are the experiences of people from black and minority ethnic groups with a diagnosis of psychosis leading up to their recovery? **(Staff project – Ranjan Baruah)**	The intent of the proposed study is to learn about patients experiences with a diagnosis of psychosis from different ethnic backgrounds who has attained recovery.	2019-18	Non Portfolio	31/01/2022
PTSD				
Stop-PTSD **(PI - Anke Ehler)**	The design is a single blind (assessors of treatment outcome blinded) randomised controlled trial comparing two therapist-assisted internet-based psychological treatments for posttraumatic stress disorder and a wait-list condition, with an embedded process study	2017-39	Portfolio	30/09/2020
OPTYC Online PTSD Treatment for Young People and Carers **(LC – Dorothy King)**	Post Traumatic Stress Disorder (PTSD) is prevalent and impairing in children and young people. Effective face to face treatments exist, including Cognitive Therapy for PTSD (CT-PTSD), developed by our group. However, few young people access effective treatments. We are therefore developing a website and smart-phone App that will improve accessibility of this treatment by allowing trained therapists to deliver CT-PTSD over the internet (iCT) to young people (12-17 years old) with PTSD. In this study we want to evaluate iCT. We propose to do this by running a 3-arm randomised controlled trial to compare iCT to face-to-face CT to a Wait List condition.	2020-23	Portfolio	26/02/2022
Internet treatment for PTSD in IAPT (OVERCOME-PTSD) **(Anke Ehlers)**	This study is primarily auditing the effectiveness of iCT-PTSD (an internet-based version of trauma-focused cognitive therapy) in routine clinical practice.	2021-05	Non Portfolio	31/08/2022
Self Harm				
Exploring Mental Imagery and Self-Harm in Young People **(Clinical Psychology Doctorate – Karima Susi)**	The current project aims to investigate the amount and nature of any mental imagery related to self-harm and whether mental imagery strengthens the link between negative feelings before self-harm and completing self-harm primarily using a 20 minute questionnaire but also a 30-60 minute in-depth interview. The findings of the study could help assessment and treatment for young people who self-harm	2020-18	Non Portfolio	30/07/2021

Suicide				
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) **(PI – Louis Appleby)**	Establishing and regulating working practices for safeguarding the receipt, disclosure and holding of identifiable patient information	2018-38	Portfolio	04/01/2022
Qualitative study with Mental Health Practitioners' **(Academic Project, PhD - Zaid Hosany)**	The purpose of this study is to understand the views and preferences of staff working in the CRHTT (Mental Health Practitioners, Senior Mental Health Practitioners, Advanced Mental Health Practitioners, Managers, Psychologists and Assistant Psychologists and Psychiatrists) regarding the use of Brief Suicide-specific Psychological Interventions (BSPI) within a Crisis Resolution and Home Treatment Team (CRHTT) service.	2018-36a	Non Portfolio	06/01/2021
Quantitative study with Mental Health Practitioners **(Academic Project, PhD - Zaid Hosany)**	The purpose of this study is to evaluate whether a training in brief suicide-specific psychological interventions (BSPI) with Mental Health Practitioners (MHPs) within a Crisis Resolution and Home Treatment Team (CRHTT) service to support suicidal patients produces measurable changes in nursing practice and patient care.	2018-36b	Non Portfolio	30/04/2021
Suicide by middle aged men **(PI - Louis Appleby)**	This study will combine multiple sources of information to examine factors related to suicide in this hard-to-reach group, including barriers to accessing services.	2019-28	Portfolio	31/03/2021
Does feeling connected and valued affect the way people feel about themselves and their lives in people aged 50 years and older from different cultures **(Clinical Psychology Doctorate - Iman Hassan)**	The study aims to see if feeling connected and valued affect the way people feel about themselves and their lives in people aged 50 years old and above. We are particularly interested in thoughts related to suicide. We are also interested in seeing if there are any differences in people from cultures that place more importance on being part of a group, such as a close family or community network, compared to people from cultures that place more emphasis on the individual. Student project	2019-31	Non Portfolio	31/07/2020
	IAPT (Talking Therapies)			
Internet-delivered CBT intervention (Space for Sleep) for sleep disorder: a pilot trial **(PI – Sarah Sollesse)**	The current study seeks to investigate the feasibility of an internet-delivered CBT-based intervention for sleep disorder. CBT for Insomnia is evidence based and recommended as first line treatment in NICE clinical guidelines in the UK and the evidence based intervention for the management of sleep problems (Schutte-Rodin, et al., 2008). The findings will be used to understand the feasibility of an online intervention for sleep disorder/difficulties and to improve the programme in accordance with user needs.	2019-14	Portfolio	01/07/2020

Understanding SilverCloud Supporter Information Practices & Data Needs **(PI- Sue Scuphum)**	A brief 35 minute interview with Psychological Wellbeing Practitioners, who are currently using the SilverCloud service as 'supporters' to look at their experiences of working with SilverCloud	2019-33	Non Portfolio	30/06/2020
The Bigger Picture – IAPT **(LC – Emma Donaldson)**	This research aims to find out how we can make "psychological therapy" more helpful for people living in more deprived areas.	2019-38	Non Portfolio	01/06/2021
PIPS **(PI – Sarah Sollesse)**	COMMERCIAL STUDY. We need to develop tools that can improve the precision with which we allocate treatments in psychiatry. Current psychiatric disease classifications (DSM-5, ICD-10) ensure reliable diagnoses across clinicians, but their diagnostic categories do not allow for individual treatment predictions – for example, most patients with major depression do not recover after their first treatment. This project aims to remedy this by using machine learning to develop an algorithm that can quantify how likely an individual is to respond to a range of mental health treatments, specifically in this case, online cognitive behavioural therapy (iCBT)	2020-07	Portfolio	31/12/2021
Improving Access to Psychological Therapy **(PI – Sarah Sollesse)**	This study will look at 4 years' worth of data from an IAPT service to take a deep dive into how iCBT has impacted depression and anxiety, firstly by comparing outcomes to GSH and group wellbeing, and secondly by analysing sociodemographic and clinical covariates associated with these different interventions and their outcomes. This will help understand the effects of iCBT as compared to other similar treatments and in different populations and subgroups, and would help to improve the content and delivery of this innovative form of therapy in future.	2020-21	Non Portfolio	01/06/2022
The Implementation of Digital Interventions in Healthcare Services **(PI – Sarah Sollesse)**	The current research seeks to qualitatively explore the experiences of groups involved with the implementation of iCBT interventions in Improving Access to Psychological Therapies Services in the NHS. These groups will consist of psychological healthcare professionals (psychological wellbeing practitioners, service managers, clinicians), patients and individuals associated with the provision and development of an iCBT intervention (commercial/sales people, customer success managers, product developers). This research aims to investigate the lived experience of implementing internet-delivered interventions in modern healthcare services, as well as the factors that are of most importance to the relevant stakeholder groups involved.	2020-29	Portfolio	29/01/2021
The Watch Study **(PI – Sarah Sollesse)**	COMMERCIAL STUDY. The current study seeks to investigate the acceptance of the use of a smartwatch in an internet-delivered Cognitive Behavioural Therapy (CBT) based intervention for depression. CBT for depression is evidence-based and recommended as first-line treatment in NICE clinical guidelines in the UK.	2020-35	Portfolio	30/04/2021
Internet cognitive therapy for social anxiety disorder (iCT-SAD) **(PI – Alison Salvadori)**	This study is primarily auditing the effectiveness of iCT-SAD in routine clinical practice.	2020-40	Non Portfolio	31/03/2022

	Non-specific mental health			
Cause and Prevalence of Memory Problems (CAP-MEM) **(LC- Stephen Zingwe)**	A questionnaire study that aims to explore the cause and prevalence of memory problems in people with mental health, neurodevelopmental and neurodegenerative disorders.	2018-23	Portfolio	31/03/2021
The influence of changes in self-concept after brain injury **(Clinical Psychology Doctorate - Christina Cusack)**	Aims and Objectives of the study: 1. Is carer burden influenced by brain injury survivors' perceptions of self-concept? 2. Is carer burden influenced by their perceptions of changes in self-concept of the brain injury survivor? 3. Is perceived social support influenced by brain injury survivors' and relatives' perceptions of self-concept changes in the brain injury survivor? Are the factorial and psychometric properties of the HISD-III-R equivalent to those of the patient's version of the HISD-III? (exploratory)	2019-10	Non Portfolio	01/05/2020
Peer Support in Mental Health Services **(Academic Project, PhD – Tishna Uttamlal)**	Aims: 1) To understand the identity of a PSW and how this is constructed. 2) To examine how and why PSWs may construct or be implicated in a liminal space based on their identity construction. 3) Use this to understand organisationally, how PSWs fit into the current workforce and make recommendations for future steps in developing and sustaining the PSW role. 4) To see what factors contribute to the notion of liminality in peer support workers Which of these are seen as positive and which of these are seen as negative and how this influences a PSWs identity	2019-41	Non Portfolio	01/09/2021
ESCAPE – Views about smoking cessation and mental health **(LC – Emma Donaldson)**	This study is inviting health care professionals working with patients with mental health difficulties in *any* context to take part in an online survey to help us understand current attitudes, practices, training needs, and perceived barriers and facilitators to address and implement smoking cessation treatments.	2020-15	Portfolio	31/08/2020
The PROMISE Study **(LC – Emma Donaldson)**	This study will take two prominent social psychological theories on habit formation and sustained human behaviour change (the theory of planned behaviour and the transtheoretical model), to investigate engagement with the digital mindfulness intervention, Headspace (www.headspace.com). The study sample will consist of NHS employees, a population whom are exposed to high levels of workplace stress. Recent research has shown Headspace to be beneficial in lowering NHS staff stress levels, when compared to another digital health intervention. Staff will be offered one year's free subscription to Headspace and asked to complete two online surveys. The surveys will include questions on different components that make up the theory of planned behaviour and the transtheoretical model.	2020-33	Portfolio	31/10/2020
Traumatic childbirth, wellbeing and social identity on new mothers **(Clinical Psychology Doctorate – Shama El-Salahi)**	This study looks to recruit new mothers who have had a traumatic childbirth and new mothers who have not had a traumatic childbirth to compare their levels of wellbeing and their strength of identity as a new mother. Each participant will be asked to fill in a few online questionnaires at one time point so that we can learn more about the relationship between traumatic childbirth, social identity and psychological wellbeing.	2020-36	Non Portfolio	16/04/2021

Children and Young People (CYP) – 2020/21 projects				
Study title and lead	Summary	Reference	Portfolio Status	Study end date
STAndardised DIagnostic Assessment for children and adolescents with emotional difficulties (STADIA): **(PI- Tamsin Marshall)**	Population: Children and young people (age 5-17 years) presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS). The aim of the study is to evaluate the clinical and cost effectiveness of a standardised diagnostic assessment (SDA) tool as an adjunct to usual clinical care in children and adolescents presenting with emotional difficulties referred to Child and Adolescent Mental Health Services (CAMHS).	2018-20b	Portfolio	30/04/2022
ASCEND - Evaluating an early social communication interaction for young children with Down Syndrome **(PI - Vesna Stojanovik)**	SPONSORED STUDY. A new parent-led intervention programme for children with Down Syndrome. The goal is to improve language and communication skills in children with Down syndrome. Preliminary work by our research team has shown that children who had an intervention on improving shared attention understood and produced twice as many words compared to children who did not have the intervention. We want to find out whether delivering the intervention programme and assessing the effect it has are feasible for a larger trial	2019-11	Portfolio	01/08/2021
Treatment of Panic Disorder in Adolescents (PANDA Study) **(PI – Polly Waite)**	A research project to compare two talking therapies, that involve working with a therapist one-to-one, for the treatment of panic disorder in young people aged 11-17½ years	2019-34	Portfolio	30/09/2021
Parents' experiences of parenting a child with Obsessive Compulsive Symptoms/Disorder **(Academic Project, PhD - Chloe Chessell)**	This study aims to explore parents' experiences of parenting a child (aged 7 to 12 years) with OCD, their views and preferences towards different levels of parent involvement in CBT for OCD. Student project	2019-07	Non Portfolio	29/08/2020

Physical Health Service – 2020/21 projects				
Study title and lead	Summary	Reference	Portfolio Status	Study end date
Sexual Health Services				
PrEP Impact Trial Study **(PI - Dr Nisha Pal)**	The PrEP Impact Trial aims to address outstanding questions about PrEP, eligibility, uptake and duration of use of PrEP though expanding the assessment to the scale required to obtain sufficient data. In addition the trial will assess under real world conditions the impact of PrEP on new HIV diagnoses and on sexually transmitted infections, compared to historical controls.	2017-30	Portfolio	01/09/2020

Re-Evaluation of Annual Cytology using HPV testing to Upgrade Prevention (REACH UP): a feasibility study in Women Living With HIV **(PI - Nisha Pal)**	To estimate HPV prevalence in women living with HIV to calculate sample size of the main study	2019-16	Portfolio	31/01/2021
All Long-Term Conditions (LTC)				
Psychological risk factors for fatigue in Rheumatoid Arthritis **(PI – Cathy Beresford)**	The study investigates a number of factors which may influence levels of fatigue, distress and disability in patients with long-term conditions. It specifically focusses on behavioural and psychological factors including quality of sleep, anxiety and depression, beliefs about fatigue and coping strategies.	2018-37	Portfolio	01/04/2021
Diabetes service				
Startright (Getting the right classification and treatment from diagnosis in adults with diabetes) **(PI- Dr Mohammadi Alizera)**	Our Diabetes at King Edwards VII are teaming up with University of Exeter Medical school to support recruitment into this study aiming to achieve more accurate early classification of diabetes and identification of which patients will rapidly require insulin treatment. The clinicians will record clinical features and biomarkers that may help to determine diabetes type at diagnosis and follow participants for 3 years to assess the development of severe insulin deficiency (measured using C-peptide) and insulin requirement. Findings will be integrated into a freely available clinical prediction model.	2018-02	Portfolio	30/06/2023 (In follow up)
Embedding Diabetes Education RCT **(PI- Alison Marie Jones)**	As part of the Embedding Diabetes Education study (an NIHR funded PGfAR) Leicester diabetes centre are going to be working with the Diabetes Education provider team at Berkshire Healthcare NHS Foundation Trust to assess whether the embedding Package reduces HbA1C in patients with type 2 Diabetes Mellitus compared to usual care	2019-04	Portfolio	31/01/2021
Exploring patient and healthcare-professional perspectives on barriers and facilitators towards foot self-care practices in diabetes **(Academic Project, PhD – Andrew Hill)**	This study primarily seeks to explore patient and healthcare-professional perspectives on perceived barriers and facilitators to foot self-care practices in diabetes. In addition, this study will explore whether similarities and/or differences between patient and healthcare-professional perspectives in this context contribute to these barriers and/or facilitators	2020-08	Non Portfolio	31/12/2021

ADDRESS II **(PI – Cathy Beresford)**	The project aims to establish a support system to facilitate future research into type 1 diabetes. The system will consist of a database of individuals with new−onset type 1 diabetes and their siblings who will have consented to be contacted by the study team about future diabetes research. Some participants will have agreed to provide in addition a blood sample for DNA and specific antibody tests.	2020-37	Portfolio	31/12/2022
	Cardiac and Respiratory Specialist Services (CARSS)			
TANDEM (Tailored intervention for ANxiety and DEpression Management in COPD) **(PI- Cath Darby)**	Our Cardiac and Respiratory Specialist Service is collaborating with Queen Mary University of London Research study for patients with Chronic Obstructive Pulmonary Disease (COPD); also known as chronic bronchitis or emphysema. To investigate the benefits of offering people with moderate to very severe Chronic Obstructive Pulmonary Disease (COPD) and mild or moderate anxiety or depression, the opportunity to receive structured, one to one support and advice delivered by a trained respiratory health care professional (nurse, physio or occupational therapist). The sessions are based on a Cognitive Behavioural approach. COPD can affect many aspects of such patients; breathing difficulties can limit their day-to-day activities and can make them feel worried (anxious) or feel low (depressed).	2018-29	Portfolio	30/06/2021
	Digestion			
Assessing the ecological role of yeast in the gut **(Academic Project, PhD - Grace Ward)**	The University of Reading are conducting research on people who suffer from gut disorders, with a focus on yeasts in the gut. It has been proposed that yeasts found in the human gut cause the symptoms experienced with gut disorders, such as Irritable Bowel Syndrome and Inflammatory Bowel Disease (Crohn's disease and ulcerative colitis). Understanding the cause of such disorders could lead to the development of treatments to relieve the pain of sufferers.	2019-24	Non Portfolio	30/09/2021
	Cellulitis			
NEXCEL **(LC – Sarra Blackman)**	Nurses' experiences of preventing lower limb cellulitis: a qualitative interview study. The aim of this study is to explore nurses' views and experiences of managing patients who are at risk of recurrent lower limb cellulitis.	2021-06	Portfolio	31/03/2021
	Vaccinations			
Fluenz Tetra Enhanced Safety Surveillance Programme 2020-2021 **(LC – Charlotte Church)**	Children (or their parents/guardians) are eligible to participate in this surveillance if they have received the nasal seasonal flu vaccine, Fluenz Tetra, as part of their routine care in accordance with guidance from the Department of Health.	2020-31	Portfolio	02/03/2021

Non-health related studies – 2020/21 projects				
Study title and lead	Summary	Reference	Portfolio Status	Study end date
Data				
Infrastructuring Data Integration between Multiple Socio-Technical Contexts of Care **(Academic Project, PhD - Andrey Elizondo)**	How is the integration of data across care settings negotiated between different actors? What –intended and unintended- early consequences arise as a result of data integration? Student project	2019-29	Non Portfolio	30/04/2020
CLIMB: University of Cambridge NHS/HSC Health Data Consent Survey **(LC – Sarra Blackman)**	To establish patient and public views on the sharing of identified NHS/HSC health data (for clinical purposes) and de-identified health data (for research) within the UK.	2020-10	Portfolio	30/09/2020
Staff				
Culture and difference within the supervisory relationship. **(Clinical Psychology Doctorate – Charlotte McCann)**	How are issues of culture and difference in clinical psychology training and practice perceived and explored within the supervisory relationship?	2019-39	Portfolio	01/10/2020
EMHEP 3: Efficiency, cost and quality of mental healthcare provision **(LC – Emma Donaldson)**	This research will analyse the efficiency, cost and quality of mental healthcare provision in the English NHS.	2020-05	Portfolio	30/04/2021
The lived experiences of career progression of NHS BME Very/Senior Managers/ Executives in South West of England and Greater London **(Academic Project, PhD – Stephen Zingwe)**	The researcher wishes to examine the experiences of career progression of NHS BME staff working in senior/very senior management positions that are in the South West of England Region and Greater London.	2020-12	Non Portfolio	31/01/2021

Appendix 2- Berkshire Healthcare Vaccine contribution – national media coverage

National Institute for Health Research March 2021

In this article, staff at Berkshire Healthcare NHS Foundation Trust reflect on the role they played in support studies into COVID-19 vaccines.

Our research team are playing a critical role in supporting the National Institute for Health Research in delivering research into COVID-19 urgent public health issues. A big part of this research agenda is supporting vaccine studies to help secure a range of vaccines to help tackle coronavirus. In order to make this possible, the NIHR have funded national training packages to train as many research staff as possible.

Over the last six months, a team of Berkshire Healthcare staff have been travelling to and from Oxford to support two trials, developed by Novavax and The Janssen Pharmaceutical Companies of Johnson & Johnson. These are trials of more than 800 participants, with staff working robustly and vigorously to get the results through.

Novavax

In February, the Novavax vaccine became the first COVID-19 vaccine to show robust clinical efficacy against the new predominant UK variant and also to the South African variant of COVID-19.

Between October and November, trust Lead Research Nurse Sarra Blackman (right) contributed 103 hours to the Novavax study, working with NHS professionals from across the Thames Valley and South Midlands Clinical Research Network. This involved working mainly evening and weekend shifts, which required travel from Berkshire to Oxford, sometimes at short notice.

Sarra said: “Working on the vaccine trials has been an amazing opportunity. To contribute to research that is so important globally because of the pandemic has given me a strong sense of pride and hope.”

One of the most surprising rewards from taking part in the trials has been the chance to work with colleagues who she would not normally meet. “These are all people that I now consider friends.

“We have leaned on each other when times have been tough and when we have been overwhelmed with the sheer volume of work. We have learned skills from each other and laughed together.

“Most importantly, we have succeeded together, to develop treatments for this illness that has shaken our world.”

Janssen

A group of 10 Berkshire Healthcare staff have been working on the Janssen trial at two GP practices in West Oxfordshire since November. Roles have included shift co-ordinators, lab technicians, to analyse blood work, and vaccinating nurses. These nurses are separated into either unblinded or blinded control groups, with “blinded” nurses not knowing if they’re giving a vaccine or placebo.

Some of the staff working on study have not been involved in these types of trials before. Research Nurse, Susan Dhliwayo (left), has given more hours to the study than anyone else. She said: “I have been enjoying working on the vaccine trials and feel honoured to have been part of the process in the innovation for such an essential cause."

Katie Warner, Head of Research and Development at Berkshire Healthcare said: “I’m so proud of the huge collaborative effort across the region, which we hope will mark the start of a new era of closer partnership working. Thanks to the commitment, energy and determination of our research team to the vaccine trials and other projects, we’re now third in the country compared with similar Trusts for number of research opportunities we offer.”

To find out how you can get involved in existing and future research studies, either as staff or a participant, contact the trust’s Research and Development Team

Appendix 3

Team name: Research and Development Department

Berkshire Healthcare NHS Foundation Trust

TEAMS Plan on a page 2021/22 (Team Objectives)

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

True North goal 1: Harm-free care

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

We will do this by:

1. Proactively identifying and offering research projects to services relating to COVID-19, self-harm, suicide, pressure ulcers, physical health in SMI including sleep, diet, exercise, smoking and cardiovascular disease.
2. Disseminating the findings of research projects and evidence reviews relating to the above topic areas via the research club.

True North goal 2: Supporting our staff

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

We will do this by:

1. Supporting staff with the continuing transition to remote working including physical and mental wellbeing.
2. Providing opportunities for staff to make improvements through QI and bright ideas via team engagement days to ensure all staff have a voice.
3. Improving the research training and development offer for Trust staff.

True North goal 3: Good patient experience

✓ To provide good outcomes from treatment and care

We will do this by:

1. Offering a wider range of studies in a wider range of health/disease areas increasing our visibility and access to patients & carers.
2. Circulating customer service surveys and make improvements based on feedback.
3. Developing, consulting and implementing an R&D strategy that helps us to deliver an efficient, high quality and sustainable R&D function

True North goal 4: Money matters

✓ To deliver services that are efficient and financially sustainable

We will do this by:

1. Reviewing all processes involving paper and changing them to digital wherever possible.
2. Streamlining our processes wherever possible using QI principles.
3. Proactively identifying and offering research projects to services which trial digital interventions.

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

Appendix 4- Academic institutions and NHS Trusts we worked with to deliver research in 2020/21

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

Cardiff University	University of Liverpool
Imperial College London	University of Manchester
King's College London	University of Northampton
Newcastle University	University of Nottingham
Queen Mary, University of London	University of Oxford
St George's, University of London	University of Reading
Trinity College Dublin	University of Sheffield
University College London	University of Southampton
University of Bath	University of Surrey
University of Bristol	University of Sussex
University Cambridge	University of Warwick
University of Edinburgh	University of West London
University of Exeter	University of Wolverhampton
University of Kent	University of York
University of Leicester	

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

Cambridgeshire & Peterborough NHS Foundation Trust	Southern Health NHS Foundation Trust
North East London NHS Foundation Trust	Sussex Community NHS Foundation Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	Sussex Partnership NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust	Chelsea and Westminster Hospital NHS Foundation Trust
Nottinghamshire Healthcare NHS Foundation Trust	Royal Devon and Exeter NHS Foundation Trust
Oxford Health NHS Foundation Trust	

Appendix 5- List of Staff Publications

ASHFIELD, E., CHAN, C. & LEE, *D*. 2020. Building 'a compassionate armour': The journey to develop strength and self-compassion in a group treatment for complex post-traumatic stress disorder. *Psychology and psychotherapy*.

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Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Trust Board Meeting Date	13 July 2021
Title	Revalidation—Annual Board Report and Statement of Compliance for 2020/21
Purpose	To assure the Trust Board that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.
Business Area	Medical Director
Author	Dr Minoo Irani, Medical Director & Responsible Officer
Relevant Strategic Objectives	1 – To provide accessible, safe and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports CQC 'well led' inspection and safe patient care
Resource Impacts	Currently 0.5 wte Band 4 administrator and 1 Additional Programmed Activity for Appraisal Lead.
Legal Implications	Statutory role
SUMMARY	The annual board report for revalidation (2020/21) is presented in the standard format prescribed by NHS England and Improvement. The appraisal process in the Trust was not suspended/paused during any of the surge periods related to the pandemic in 2020/21. Appraisers and doctors follow the Principles of 'Appraisal 2020' for appraisals in the Trust, although everything else remains unchanged in terms of process and documentation.
	138 completed appraisals were confirmed for 2020/21, for 143 doctors with connection to the trust. 3 Consultant appraisals and 1 Specialty Doctor appraisal were approved as missed because the doctors were on long term sick/maternity leave. 1 Specialty Doctor appraisal was approved as delayed where workload was cited as reason for delay.
ACTION REQUIRED	Trust Board to note assurance provided by the RO that medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust. Trust Chair is requested to sign the Statement of Compliance on page 13 of the report following receipt of this assurance.

A Framework of Quality Assurance for Responsible Officers and Revalidation

Annex D – Annual Board Report and Statement of Compliance.

NHS England and NHS Improvement

Contents

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – Berkshire Healthcare NHS Foundation trust can confirm that:

1. The Annual Organisational Audit (AOA) for this year has been submitted.

The AOA submission was suspended nationally during the Covid pandemic. Hence an AOA was not submitted during 2020/21. The AOA submission is followed by the comparator report which compares the trust appraisal figures with other trusts. Berkshire Healthcare has compared very favourably with other similar trusts in previous years, with consistently high medical appraisal rates. No comparator report was available for 2020/21. 138 completed appraisals were confirmed for 2020/21, for 143 doctors with connection to the trust. 3 Consultant appraisals and 1 Specialty Doctor appraisal were approved as missed because the doctors were on long term sick/maternity leave. 1 Specialty Doctor appraisal was approved as delayed where workload was cited as reason for delay. There are no adverse trends noted from the appraisal figures that would require specific action for 2021/22.

2. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Dr Minoo Irani was appointed as interim Medical Director and RO for Berkshire Healthcare and started in this role on 2 November 2015. Dr Irani has completed the required RO training, regularly attends the NHSE (South) RO Network meetings and is member of the GMC RO Reference Group since November 2015. There are no additional training needs currently identified for Dr Irani in his medical appraisal or PDP related to his RO role. The Trust appraisal lead attends annual refresher training events in the region and attends NHSE (South) RO and Appraisal Leads network meetings when possible.

3. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

The RO is supported by a band 4, 0.5 wte appraisal and revalidation administrator and a Consultant Psychiatrist who is appraisal lead for the trust and has one Additional Programmed Activity per week allocated for this role.

There are no pending actions from last year; additional actions potentially required in 2021/22 relate to strengthening the long term capacity of the band 4 administrator and exploring a digital/ e- appraisal platform.

4. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The appraisal and revalidation administrator maintains an up to date record of all doctors with a prescribed connection to the trust (database on secure shared drive).

The RO and Revalidation administrator have access to GMC connect and the RO regularly refers to this at the monthly Decision Making Group meetings attended by the Medical Workforce Manager, Appraisal and Revalidation administrator, Medical Appraisal Lead, Associate Medical Director and Medical Director.

The RO receives notification from the GMC when a doctor has either added the trust as their designated body or if a doctor's designated body has changed. In case of any doubt, the RO triangulates this information with the medical staffing office and with the revalidation administrator.

There are no pending actions from last year or additional actions required in 2021/22 in this regard.

5. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

The Appraisal Policy for Medical Staff was reviewed and re-issued in May 2021. It will be reviewed again in January 2023.

Re-skilling, Rehabilitation, Remediation and Targeted Support for Medical Staff Policy was reviewed and is due for a re-write, following which it will be published in 2021.

There are no pending actions from last year or additional actions required in 2021/22 in this regard.

6. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

The Revalidation Team from NHS England (South) visited the trust on 12 May 2015 for a peer based Quality Assurance of the medical appraisal process in the Trust. The visiting panel made recommendations for improvement which were all implemented by the RO in 2016/17. These improvements were detailed in previous annual revalidation reports to the trust Board.

The RO provided a detailed report of all improvements to the Higher Level Responsible Officer (letter of 6 September 2018). An interim report about the improvements made following the 'Independent Verification Visit' was provided by the RO to NHS England South on 24 November 2016.

The RO commissioned the trust internal auditors to review the medical appraisal process in July 2016 and this was reported in August 2016. The auditors identified one 'Medium' priority issue-- 'The Appraisal Policy for Medical Staff (ORG084) and relevant guidance is outdated and does not reflect current operating practice'. The RO accepted this recommendation and acknowledged that the wide-ranging improvements made in the medical appraisal process were not part of the policy which existed at that time. The policy was re-written and published by December 2016. There are no further actions identified for 2021/22.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All NHS locum or short-term placement doctors appointed to the trust under trust employment contracts are provided with the full range of support with governance data, CPD, appraisal and revalidation like any other substantive doctor in the trust.

For the very small number of doctors employed through locum agencies from time to time (who do not have prescribed connection to the trust), appraisal is not offered through the trust panel of approved appraisers. Their appraisal and revalidation requirements are met through the locum agencies. Agency locum doctors are managed through the same governance processes as all other doctors in the trust and can obtain advice for appraisal and revalidation from the appraisal lead. If a training need is identified which would support the locum agency doctor to provide better quality and safer care, the trust would support this.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

Whole practice appraisals on annual basis are the norm in Berkshire Healthcare and doctors and appraisers have had frequent updates about this during internal training. As part of Quality Assurance of appraisals, the appraisal lead assesses the quality of a sample of completed appraisal MAG forms using a standardised tool (PROGRESS) and presents a summary of the quality reviews to the appraiser forum to facilitate improvement in practice and

standardisation of the appraisal content and output. This process also confirms that whole practice appraisals are the standard in the trust.

The revalidation administrator provides the appraiser and doctor with information about incidents, complaints and compliments recorded on Datix and specific to the doctor, approximately 2 months in advance of the allocated appraisal date.

Appraisers and doctors follow the principles of 'Appraisal 2020', although everything else in terms of process and documentation remains unchanged. The Medical Appraisal Guide (MAG) remains the current method of documentation of appraisals.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

The trust medical appraisal policy is up to date and in line with national policy, has approval from medical and BMA representative from the Local Negotiating Committee.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

The trust has 24 trained appraisers for 143 connected doctors. Additionally, 10 doctors have expressed interest in becoming medical appraisers and are in the process of going through the required training. This should allow adequate trained appraisers to be available to replace those who retire/ leave this role.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

The appraisal forum meeting (chaired by the RO/ appraisal lead) occurs three times a year to provide peer support and updates to appraisers with respect to revalidation and appraisal requirements. The RO provides updates from NHSE RO & Appraisal Leads forum which he attends. The appraisal lead

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

presents data (appropriately anonymised) from MAG forms in the previous quarter with respect to content of the MAG forms and appraiser narrative and judgements. This is in the context of training for improving the quality of documentation and discussion at appraisal meetings.

All appraisers are encouraged to attend regional appraiser refresher training events.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

A sample of MAG forms is subject to Quality Assurance by the appraisal lead using the PROGRESS tool. The RO receives this information (approximately 20 MAG forms are Quality Assured by the appraisal lead every year). Additionally, the RO Quality Assures a sample of the completed MAG and PROGRESS forms (the RO Quality assures the QA of the appraisal lead by reviewing the MAG forms and corresponding 5 PROGRESS). The Responsible Officer scrutinises a sample of Medical appraisal forms in detail to monitor quality and consistency and liaises with the appraisal lead for calibration, if necessary.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

All revalidation recommendations to the GMC have been timely and in line with GMC requirements. There have been no delayed recommendations made by the RO to the GMC.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

When the RO makes a positive recommendation to the GMC for revalidation, the doctor receives a message from the GMC confirming this. There have been no non-engagement referrals to the GMC.

The RO or appraisal lead will always discuss any deferral recommendations with the doctor, in advance of the recommendation being submitted to the GMC.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Berkshire Healthcare has an effective clinical governance system for all clinical staff including doctors and this has been reviewed by the CQC

through their well-led inspections of the trust. In addition, doctors are supported through governance processes involving medical leads in all services, Clinical Directors and the Medical director. The Clinical Effectiveness and audit department also support doctors through implementation of NICE Guidelines and participation in national and local clinical audits.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Any concern about the conduct/ performance of doctors is managed through an established process involving the service manager, Associate Medical Director/medical leads, Lead Clinical Director/ clinical director and RO (Medical Director).

The performance of doctors is monitored through a system of line management coupled with professional accountability to the Medical Director. The quality governance systems for the Trust, including with respect to incidents and complaints, support the monitoring of doctors' performance. PDP groups and peer groups also act to provide feedback to the psychiatrists on their performance and professional expectations. Doctors engage with clinical audit activities, including national audits to assess their/ team performance in comparison with others. The process of enhanced medical appraisal has fostered improved engagement from doctors with respect to monitoring performance with improved visibility for appraisers and the Responsible Officer / Medical Director. This includes reflection on patient and colleague feedback.

The revalidation administrator provides the appraiser and doctor with information about incidents, complaints and compliments recorded on Datix and specific to the doctor, approximately 2 months in advance of the allocated appraisal date. Reflection/ discussion of governance issues raised is monitored through the Quality Assurance of MAG forms by appraisal lead.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Trust Policy on Disciplinary Procedure for Medical and Dental Staff is up to date and based upon the Maintaining High Professional Standards national policy.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and

outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Trust Chairman and CEO are kept informed if any doctor is subject to the Trust Policy on Disciplinary Procedure for Medical and Dental Staff. There were no investigations of doctors commissioned by the Medical Director in 2020/21.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

The standard Medical Practice Information Transfer form is used to request information about new connections to the trust. The RO also promptly responds to MPIT information request from other trusts. Although GPs who work in the out of hours service are employed by Berkshire Healthcare, they do not have a prescribed connection to the trust and do not get appraised within the Trust. The Medical Lead of Westcall (the GP Out of Hours service) has provided assurance to the RO that the scope of GP practice in Westcall feeds into their appraisal process in primary care through a summary review that is carried out. Additionally, since 2016, the revalidation administrator provides Westcall GPs who have an employment contract with the trust, with a Datix summary of their governance data for use in their appraisal documentation and discussion. There are also doctors employed by the acute Trust who work within the services delivered by Berkshire Healthcare (Geriatricians employed and connected to the Royal Berkshire Hospital who work on elderly care wards in Berkshire West); an established RO to RO communication process is used if there were any concerns about this very small group of doctors.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Clinical Governance arrangements for doctors including processes for responding to concerns about a doctor's practice are transparent and information about how decisions are made are communicated to doctors in a timely manner. All relevant trust policies have mechanisms to enable doctors to appeal a decision. The medical director will invite doctors subject to concern or investigation for a meeting to explain the process and obtain assurance about the doctor's feedback and reflection.

[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

All medical staff recruited by the Trust are done so by following NHS Employers six safer recruitment standards. Before making an unconditional offer of employment medical staffing check:

1. Identity
2. Employment history & reference checks
3. Work health assessment
4. Professional registration & qualifications
5. Right to work
6. Criminal records check

Candidates must satisfy these pre-employment checks prior to employment.

As part of the medical appointments interview process, we have introduced a duty on the chair of the interview panel to obtain the panel's consensus that they are satisfied with the language competency of the doctor being offered the post. This assessment is based upon the interview panel noting the doctor's spoken language and written application skills as part of the interview.

Locums are only sourced from framework agencies that follow the 6 checks above; Medical Staffing also double check professional registration and the Alerts Register.

Section 6 – Summary of comments, and overall conclusion

Overall conclusion:

The Board is asked to receive the annual revalidation report for 2020/21. This will be made available to the higher level Responsible Officer from NHS England South. The Board can be assured that the medical appraisal and revalidation process is compliant with the regulations and is operating effectively within the trust.

Section 7 – Statement of Compliance:

The Board of Berkshire Healthcare NHS Foundation trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

Official name of designated body: Berkshire Healthcare NHS Foundation Trust

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Date of Board meeting	13th July 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
Equalities, Diversity and Inclusion 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 30 June 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. V1.5

June 30th , 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 Local risk assessments should be based on the measures as prioritised in the hierarchy of

controls 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: • local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff; • the documented risk assessment includes: • a review of the effectiveness of the ventilation in the area; • operational capacity; • prevalence of infection/variants of concern in the local area. • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways; • when an unacceptable risk of	Wards and services have individual risk assessments in place ; these are reviewed at services level Wards all have a up to date SOP in place for management of COVID patients including screening / cohorting etc Any results for in-patients that return as positive are monitored through IPCT with advice and guidance/ risk assessment given in real time and with daily review this would include consideration for use of enhanced PPE in certain situations and other actions required to minimise any transmission Where there is high incidence / variant of concern in local areas staff avhe been encouraged to present for PCR testing in addition to undertaking twice weekly lateral flow testing	July 2021 - Local overarching Trust wide risk assessment to be recorded to include all points detailed	All points are covered in local documents and / or service risk assessments with staff aware of actions to be taken

transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;			
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) 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	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 %	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.

	with remobilisation guidance. Instructions disseminated to clinical teams Identification of risk category for services in high, medium, or low pathways undertaken. All patient facing services in medium risk pathway, moving to high risk pathway of symptomatic or confirmed cases identified. Low risk pathways assigned to virtual consultations	compliance of 3-day, 5-7 day and ongoing swabbing	Guidelines and competence for swab taking recirculated to all wards 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.
resources are in place to enable compliance and monitoring of IPC practice including: ➢ staff adherence to hand hygiene? ➢ patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE. ➢ ➢ staff adherence to wearing fluid resistant surgical facemasks	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 All MH wards across the Trust are single occupancy, community wards have been laid out to achieve at least 2 metre bed spacing as far as is practicable with additional measures and guidance in place where this is not possible due to significant bed pressures causing greater patient risk		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ clear advice for staff in place regarding where to place patients depending on where admitted from and their covid testing history/

(FRSM) in: a) clinical b) non-clinical setting	Social distancing is maintained in all clinic / outpatient setting unless providing hands on care Visual reminders in place 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 count resourced have been reviewed and videos shared in newsletter and directly with wards 18th and 25th March -detailed plan in place for which resources are being used Patient equipment monitoring being undertaken by IPCT for inpatient units. 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		vulnerability; adequate ventilation and use of curtains to divide bed spacing if 2 metres spacing is not quite achieved, with expectation that patients are placed at least 2 metres apart unless bed pressures cause greater risk to patients

	Infection control mandatory training includes quiz to ensure understanding and compliance		
• monitoring of compliance with wearing appropriate PPE, within the clinical setting • that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;	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	PPE fatigue and continued compliance in some areas	Unannounced supportive visits, includes IPCT and senior staff Continued supportive conversations / messaging / use of safety huddles guardian style role is currently being considered
• 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	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	Compliance with LFT recording	

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.	Use of intranet/ staff briefings and newsletters to support staff knowledge of self -isolation requirements - updates and changes to isolation communicated to staff All staff have access to LFT kits and there is a local reporting system with alerts to managers as staff record - this allows managers to be aware 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 Staff encouraged to undertake PCR tests as part of surge testing where they live or working local area – this has included information in weekly newsletter and information provided at all staff briefings	The process for ordering test kits and for staff to report results has changed from 5 July 2021. The Medical director is working with the LFT steering group to implement these changes in the trust and strengthen data reporting systems to maintain oversight of staff compliance with self-testing.	Use of Lateral Flow Test (LFT) for asymptomatic staff testing has been implemented in the trust since November 2020 and although the twice weekly reporting figures by our staff suggest that not all staff are reporting their test results, our reporting numbers are significantly better than the national reporting data.
• 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. 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	Ensuring that all non-clinical staff use resources and training opportunities available	All clinical and divisional directors aware of need to continue to promote annual IPC training On-line resource/ presentation with quiz

	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 Every Acton counts materials reviewed and relevant tools in use with clear plan around what has been implemented		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	Weekly COVID Newsletter/ monthly teams live events/ posters/ intranet / screen savers and floor / wall stickers all used to promote mask- hand hygiene and social distancing.		

both in and out of work	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 Deputy Director Nursing & Head IPC supportive meetings with community services to aid infection prevention and control & PPE understanding	Ongoing challenges with individual compliance/ PPE	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ Frequent reinforcement of messages through newsletters/ teams live/

	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	fatigue in non-clinical and clinical settings	service visits/ posters and local processes Unannounced supportive visits being undertaken by IPCT
• 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 Every action counts resources reviewed, detailed plan for which elements are relevant and in use		

	Review of posters to ensure all teams have most up to date versions undertaken		
• 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 week East system DIPC meetings(BOB system meetings paused end April 2021 due to current covid position locally) and regional/ national calls		
• changes to national 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 and July 2021; Trust 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 presented Jan 2021; April 2021 and July 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 Unannounced supportive visits undertaken by IPCT/ corporate staff from nursing and governance directorate		

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 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	Risk assessment document to be considered for community teams	Ward risk assessment being adapted for use

	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 assigned to COVID-19 isolation or cohort areas	In -patient wards have designated cleaning teams Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE/I • 01 Cleaning Process COVID 19 within 1 metre of patient • 02 Cleaning process COVID 19 High risk units where AGPs being conducted • 03 Cleaning Process COVID 19 cohort no patient contact • NHS Cleaning and Decontamination Training - Covid-19 (Coronavirus) These documents are available electronically and in a printed format to all relevant teams 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 solutions/products as per national guidance	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Staff have all been trained in the use of Chlorclean as per National standards of cleanliness and the Healthcare cleaning manual Guidance for safe use including storage of Chlorclean included in IPC mandatory training and information posters available in clinical areas/ Nexus.		Additional checks regarding correct dilution of chlorclean undertaken with both clinical and EFM staff
a minimum of twice daily cleaning of: • areas that have higher environmental contamination rates as set out in the PHE and other national guidance. • 'frequently touched' surfaces e.g. door/toilet handles, patient call	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		

bells, over bed tables and bed rails; • electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; • rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff;	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.		
• reusable non-invasive care equipment is decontaminated: o between each use o after blood and/or body fluid contamination o at regular predefined intervals as part of an equipment cleaning protocol o before inspection, servicing or repair equipment	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Ward and community services equipment cleaning schedules Included as part of IPC compliance tool		
• 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		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

	Patient equipment monitoring (inpatient units) part of IPC annual monitoring programme being undertaken by IPCT in Q3		
• 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 All staff advised through newsletter/intranet and staff briefings regarding need for good natural ventilation June 2021 - allowed in single occupancy clinical and non-clinical areas	Natural ventilation adherence 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	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		

opposed to widespread use of disinfectants			
• monitor adherence environmental decontamination with actions in place to mitigate any identified risk	IPC compliance tool EFM monitoring IPC spot checks		
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) 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:			
• national guidance on visiting patients in a care setting is implemented;	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. 08 April 2021 - Visitor Guidance updated and circulated to include wards requesting any ward visitors to access and record LFT twice weekly via national system now		

	nationally available for all. Information added to Trust website 14 May 21- visitor guidance updated to reflect 2 visitors per patient allowed from 17.5.21 with same booking in process and request for LFT by visitors		
• 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 April /May 2021 Updated visitor guidance to include LFT and 2 visitors		

• 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 staff to comply with hands, face and space advice.	Signage available in clinical areas Signage available in public areas including waiting rooms and toilets and at entrances Written information to patients who receive written OPD letters		
• Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Every Action counts plan in place to include information within the supporting excellence document - shared with Clinical Reference Group for dissemination within their directorates Clear plan in place for which elements are in use and disseminated		

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 and to segregate from Non COVID- 19 cases to minimise the risk of cross-infection as per national guidance	Trust does not have an A&E admission are generally planned unless admission through Place of safety. Admission screening of all patients (unless known positive). 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		
• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;	Admission screening to ensure vulnerability and covid vaccine status known to ensure appropriate actions taken	Inpatient SOP to be updated to ensure that this is adequately reflected	
• 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	Not all patients are able to tolerate wearing face masks/ for some patient's masks are ligature risk	Individual risk assessment undertaken

	Wearing facemasks for patients on inpatient wards poster displayed on inpatient units Patients attending outpatient settings advised to wear masks & posters at entrances.		
• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	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) providing it is tolerated and is not detrimental to their (physical or mental) care needs;	included in ward risk assessment and individually risk assessed dynamically depending on patients' condition and ability to tolerate	As above	As above
• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; 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 All MH wards across the Trust are single occupancy, community wards have been laid out to achieve at least 2 metre bed spacing as far as is practicable with additional measures and guidance in place where this is not possible due to significant bed pressures causing greater patient risk Social distancing is maintained in all clinic / outpatient setting unless providing hands on care Visual reminders in place		clear advice for staff in place regarding where to place patients depending on where admitted from and their covid testing history/ vulnerability good ventilation maintained and clear curtain used to separate bed spacing where 2 metres is not quite achieved with expectation that patients are placed at least 2 metres apart unless bed pressures cause greater risk to patients
• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;	Inpatient SOP details need 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
• 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 Staff have ability to enter covid vaccination status on RIO tool		
• 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:			
• patient pathways and staff flow are separated 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. PPE guardians to act as reminders		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 All staff have PPE competency and compliance document

	PPE competence completed for all patient facing staff Ward compliance/ hand hygiene tools in use IPC training annually was 85% and 92% for those required to update biannually as at the end of May 2021.		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 safely put it on and remove it;	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		
• 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		IPC training annually was 85% and 92% for those required to update biannually as at the end of May 2021.
• 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		Clinical Directors to have process for assuring compliance from services within their Directorates and through already

	Senior staff visibility to promote		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 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	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 Patient equipment monitoring included in IPC annual monitoring programme Enhanced cleaning in place Social distancing in non-clinical areas poster Safety at work poster		

• clear visibly displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas	Wearing a facemask for patient's poster displayed in inpatient units Staff reminders in weekly newsletters and on Nexus to not car share		
• staff regularly undertake hand hygiene and observe standard infection control precautions;	Monthly compliance audit Visual reminders		
• 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 guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas;	Paper towels are available in all clinical areas Posters displayed to remind staff and are also in public areas		
• staff understand the requirements for uniform laundering where this is not provided for onsite;	Guidance provided to staff on laundering of uniform provided on trust intranet		

• all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms	Regular reminders via newsletters/ ward huddles/ team communications		
• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)	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 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 low/high) by other patients/individuals, visitors, or staff	On PPH site wards segregated to provide cohorting with restrictive access between 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.	Posters and signage in cohorting areas but physical barriers not possible on Community Wards	

	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		
• 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 national guidance	Isolation Policy Isolation and cohorting SOP 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 May 21 – 2 metre bed spacing across both East wards with 2 metre bed spacing being re-introduced in West wards were possible and bed pressures allow - all wards have some beds at more than 2 metres and clear		bays with known positive / recovering patients only to mitigate risk of increased 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

	guidance for how to place patients when admitted/ as they progress through inpatient journey Compliance tool undertaken to ensure compliance		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 use of plastic curtains – 14.1.21 – now being installed across all wards with bay areas - curtains up in all ward areas where bed-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:			
• 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	Consistency of use of RIO tool to enable audit of compliance with 3- and 5-7-day screening	PPH Senior leadership team developing action plan for improved compliance with admission, 3 a and 5-7 days screening Increasing use of tool support from

	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). Managers receive notification when staff have recorded their LFT to enable managers to know who is testing and who to follow up	The process for ordering test kits and for staff to report results has changed from 5 July 2021. The Medical director is working with the LFT steering group to implement these changes in the trust and strengthen data reporting systems to maintain oversight of staff compliance with self-testing.	transformation team and sharing of current tableau data to support continual improvement Use of Lateral Flow Test (LFT) for asymptomatic staff testing has been implemented in the trust since November 2020 and although the twice weekly reporting figures by our staff suggest that not all staff are reporting their test results, our reporting numbers are significantly better than the national reporting data.
• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data)	IPC monitor admission screening IPCT receive daily COVID 19 testing reports provided by BSPS Liaison with Acute Trusts and laboratory services/ BSPS leads		
• regular monitoring and reporting that identified cases have been tested and reported in line with the	RIO tool for reporting of all screening and results in place	ensuring recording is captured within the tool to allow for ease of audit	Ongoing support to staff

testing protocols (correctly recorded data);			
• 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 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 Every Action Counts action plan with use of tools assessed to be relevant		
• 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)		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

	Posters to support waste and linen segregation		
• 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 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	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 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. June 21 – Risk assessments including wellbeing conversations for all staff reviewed with covid vaccine status included 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		March 2021; risk assessment review undertaken for all CEV staff members prior to any decision around working arrangements at end of national shielding directive. June 21 - Approx. 80% staff have reviewed risk assessments

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 a record of the fit test and result is given to and kept by the trainee and centrally within the organization 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	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 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. 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		June 21 - 72 FIT testers currently trained with more FIT trainer sessions being planned 890 staff across the organization are FIT tested for FFP3 covering all areas of the organization who have been required to wear FFP3 during the pandemic 154 of these currently FIT tested for UK masks with ongoing testing to increase this - stocks of masks staff are tested for currently available in our stocks

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, 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	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	process not currently in place for Board to review FIT test records. DoN has access to records and raises any issues or concerns; current numbers added	

pathways and urgent/emergency care pathways as per national guidance all staff should adhere to national guidance on social distancing (2 meters) 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 mitigated maximally for everyone staff are aware of the need to wear facemask when moving through COVID-19 secure areas. staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing	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 meters 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 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 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	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 regarding 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 Further date to train staff to FIT test occurred in May 2021 Ongoing FIT clinics in place alongside service undertaking testing themselves using trained testers in the teams - Monitoring centrally of staff numbers tested and tested for UK manufactured masks

staff who test positive have adequate information and support to aid their recovery and return to work	for help and support. Each division has HR support alongside occupational health also available for advice. 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

Board Meeting Date	13 July 2021
Title	**Quality Assurance Committee – 1 June 2021**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 1 June 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 1 June 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, 01 June 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 David Townsend, Chief Operating Officer Dr Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Guy Northover, Lead Clinical Director
In attendance:	Julie Hill, Company Secretary Carl Davies, MSK Director *(present for agenda item 5.0)* Lesley Holmes, Head of Scheduled Care *(present for agenda item 5.0)* Sue McLaughlin, Clinical Director

1 Apologies for absence and welcome

Apologies were received from: Julian Emms, Chief Executive and Amanda Mollett, Head of Clinical Effectiveness and Audit.

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 02 March 2021

The minutes of the meeting held on 02 March 2021 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 Committee noted the report.

5. Patient Safety and Experience

5.0 MSK Pathway Development and Provider Collaboration in Berkshire West

The Chair welcomed Carl Davies, MSK Director and Lesley Holmes, Head of Scheduled Care

Carl Davies and Lesley Holmes gave a presentation and highlighted the following points:

- The MSK Pathway was developed following feedback from both clinicians and patients
- Patients often felt that they were bounced between services and there was a lack of a coherent joined up system and model
- The new MSK Pathway was patient centred, outcome focussed, supported patients to self-manage their own health, used technology to support patients and outcomes and invested in support for clinicians to deliver the pathway
- The MSK Community Specialist Service started in February 2020 but had to close on 31 March 2020 because of the COVID-19 pandemic. The service resumed in July 2020. There was currently a pilot project on knees.
- The average wait time was four weeks. Around 40% of patients with knee conditions were referred onto secondary care. Following an assessment, around 40% of patients were referred onto secondary care, other patients were referred for physiotherapy and/or pain services etc.
- Feedback from both patients and clinicians was very positive
- Work was underway to integrate the model into wider systems and develop more seamless patient flow whilst at the same time reducing the amount of paperwork clinicians had to complete
- A key aim of the MSK Pathway was to provide wrap around care to make sure patients were supported at all stages, including pre- and post-surgery rehabilitation support.

The Chair asked for clarification about the geographical, financial and clinical boundaries of the MSK Pathway.

Mr Davies confirmed that the MSK Pathway covered the West Berkshire area within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System and consisted of a number of clinical services, for example Physiotherapy, Community based MSK Intermediate services, secondary care including Orthopaedics, but then interfaced with Primary Care, imaging, pain services etc. Other services, such as those provided by local authorities had a role to play but these were not included as part of the commissioning model.

The Chair commented that there had been other initiatives in the past aimed at driving better value and improving the patient experience, but which had not been successful and asked why this pathway was different.

Mr Davies reported that the MSK Pathway had been informed by other successful models, for example, Gloucestershire and Surrey. It was noted that the key learning from others was around the importance of engagement and partnership. Mr Davies said that what was different between the MSK Pathway and previous models was that working within the Integrated Care System framework, there were the tools and levers available to be able to overcome barriers.

Lesley Holmes pointed out that the MSK Pathway had also built upon the success of the Integrated Pain and Spinal Service.

Aileen Feeney, Non-Executive Director asked why knees had been selected for the pilot project.

Ms Holmes explained that knee problems formed around a third of peripheral joint issues and therefore would involve a large enough cohort of patients to be able to test the model.

Ms Feeney asked about the use of technology to support remote monitoring etc.

Mr Davies reported that the focus was to ensure that any work involving processes work within the currently embedded I.T. system where needed, and no specific work was underway regarding these systems.

Ms Feeney asked whether there was support from process improvement experts to remap processes and improve them.

Mr Davies said that he was experienced in project management and process improvement and therefore had not brought in any additional expertise in this area.

Mehmuda Mian, Non-Executive Director asked whether there were plans to introduce a similar MSK Pathway in East Berkshire.

Mr Davies reported that at present that was beyond the remit of his work. Although conversations may be taking place across boundaries and that his understanding was that there was some work being undertaken in East Berkshire, he did not know the detail.

The Chair thanked Carl Davies and Lesley Holmes for attending the meeting and said that the development of the new MSK Pathway had the Board's full support.

5.1 Suicide Prevention Strategy

The Chair welcomed Sue McLaughlin, Clinical Director to the meeting.

Ms McLaughlin presented the paper and the Trust had exceeded the National Suicide Prevention target to reduce the suicide rate by April 2021 by 10% against the 2015/16 baseline. The Trust rate had reduced by 39% compared to the baseline rate of 9.2.

Ms McLaughlin said however, that there had been an increase in the suicide rate amongst women and reported that a deep dive review into 33 cases of women who had taken their own lives had identified a previous episode of self-harm as a key theme amongst women who had taken their own lives. Another theme identified was that women had denied that they were suicidal. It was noted that the Suicide Prevention Strategy had been updated to reflect the findings of the deep dive.

Aileen Feeney, Non-Executive Director asked whether the increase in the number of women who had taken their own lives was reflected nationally.

Ms McLaughlin confirmed that this was reflect nationally but cautioned that it was too soon to know whether this was a trend.

Ms Feeney asked whether women were more likely than men to self-harm. Ms McLaughlin confirmed that this was case.

The Chief Operating Officer said that couple of years ago, there were a higher number of men who had taken their own lives and further analysis had identified loss of employment, breakdown of relationships and alcoholism as risk factors.

Ms McLaughlin said that in addition to self-harm, for women, adverse childhood experience, for example, sexual abuse was a key risk factor.

The Committee noted the report.

5.2 Action Plan in Response to the Regulation 28 Notice Update Report

The Director of Nursing and Therapies reminded the meeting that on 2 March 2020, following the inquest of Sophie Booth, the Coroner had issued a Section 28 report in relation to four areas of concern:

- Ensuring salient information was best captured by referrers when completing and sending referral forms to the Trust's Common Point of Entry service;
- The importance of effective due diligence when triaging referrals where the potential client had experienced an episode of mental health crisis abroad;
- Assurance that downgrading referrals from red to amber was consistently conducted in a rational and proportionate manner, including seeking further information from the referrer or potential client as required; and
- Ensuring that mental health services communicate effectively – particularly in relation to information sharing where someone was referred into more than one service.

The Chair asked whether the action plan had been fully implemented.

Sue McLaughlin, Clinical Director confirmed that the action plan had been completed.

The Committee noted the completion of the actions in response to the Regulation 28 Notice issued to the Trust in March 2020.

5.3 Staff Support Post Incident Report

The Director of Nursing and Therapies presented the paper which outlined the Trust's Staff Support Post-Incident Offer. The Director of Nursing and Therapies explained that the Trust had formalised the process to ensure that there was consistency across the Trust. This included being proactive in ensuring that staff and teams involved in a significant incident knew how to access the support.

Aileen Feeney, Non-Executive Director asked whether there was any feedback from staff who had accessed the support.

The Director of Nursing and Therapies confirmed that so far the only feedback that had been received had been positive.

Sue McLaughlin, Clinical Director reported that staff had welcomed the introduction of a consistent offer across the Trust. Ms McLaughlin pointed out that the post-incident support offer provided a stepped approach which recognised that one size did not fit all and that some staff only needed a post incident chat with their line managers whilst others may require more support.

Mehmuda Mian, Non-Executive Director asked whether the Trust had the data about how many staff had accessed the service.

The Director of Nursing and Therapies agreed to find out and inform the Committee.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.4 Quality Concerns Status Report

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

- Since the last meeting, no new concerns had been added to the Quality Concerns Register, although some concerns had been redrafted to provide more clarity around the particular concern. This was particularly relevant to Quality Concern No 1 around workforce and Quality Concern No 10 around Wait Times.
- Quality Concern No 12 (Willow House) had been removed following the closure of the Unit as a 24/7 in-patient unit
- The Quality and Performance Executive Group meeting in May 2021 had agreed that Diabetes waits could be removed as a Quality Concern due to a Locum Consultant starting in February 2021 and a GP with a special interest in Diabetes starting in April 2021. This had resulted in waiting times for medical review reducing to one month. The Division would continue to monitor Diabetes waiting times to ensure the positive impact on waiting times was maintained.

The Committee noted the report.

5.5 Serious Incidents Report – Quarterly Report

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

- During quarter 4, there were a total of 29 Serious Incidents, bringing the total for the year to 80. Of these, 5 had been downgraded, bringing the total for 2020-21 to 75.
- All deaths with COVID-19 cited on part 1.A of the death certificate and which met the NHS England definition of a probable or definite hospital acquired infection had been investigated as Serious Incidents. There had been 10 incidents during quarter 4 that were related to the COVID-19 pandemic which met NHS England's definition.

The Chair asked whether there was any learning in relation to the 10 COIVD-19 Serious Incidents.

The Director of Nursing and Therapies said that there was always learning from any serious incident but confirmed that in each of the incidents, there was no evidence that staff were not following the correct infection prevention and control procedures.

The Committee noted the report.

5.6 Learning from Deaths Quarterly Report

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

- In Quarter 4 of 2020/21, 1,257 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, 141 met the criteria to be reviewed further. All 141 deaths were reviewed by the Executive Mortality Review Group. 39 deaths were closed with no further action; 102 deaths required “second stage” review (using an initial findings review/structured judgement review methodology)
- Of the 102 deaths, 23 were classed as “Serious Incidents” requiring investigation.
- During Quarter 4 the Mortality Review Group had reviewed the findings of 57 second line review reports of which 13 related to patients with a learning disability
- 27 deaths (7 in-patient and 20 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.
- All COVID-19 related deaths had second stage reviews except for two cases which were closed after the first stage review; both patients were admitted specifically for end of life care and had a documented COVID-19 infection prior to admission.
- Three patient deaths were confirmed as due to COVID-19 and the infection was acquired (definite or probable) whilst being an inpatient under the care of the Trust.
    - In two cases, COVID-19 was acquired whilst in the Trust’s care (1 definite and 1 probable)
    - In one case, there was some uncertainty as to where the COVID-19 infection was acquired (although it was definitely healthcare acquired infection, there was potential for the transmission to have occurred during brief visits from Trust’s community ward to the acute hospital).

The Medical Director pointed out that the report covered the period of the COVID-19 second wave. The Medical Director explained that the Trust Executive Mortality Review Group had debated whether if there were no errors in infection prevention and control, healthcare acquired COVID-19 infections should be considered as “a lapse of care”. It was noted that no national guidance had been issued.

The Medical Director reported that he had sight of the Quarter 4 mortality reports from the local acute trusts and neither hospital had declared a single “lapse in care” due to hospital acquired COVID-19 infections during this period.

The Medical Director reported that the Mortality Review Group had agreed that until there was a national definition of what would constitute a “lapse in care” in relation to COVID-19 healthcare acquired infections, it was agreed that these deaths would not be reported as “a lapse in care”, unless there were any omissions or errors in infection control which led to the patient acquiring the infection while in our care.

The Chair thanked the Medical Director of his paper which provided the Committee with significant assurance about the Trust’s robust mortality review systems and processes.

The Committee noted the report.

5.7 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 reported that there had been some slippage in the implementation of the action plan due to the COVID-19 pandemic. It was noted that work to change the closure mechanism of the fire doors at Prospect Park Hospital so as to remove a potential ligature point had now been completed.

It was noted that work would now commence on the bedroom doors and fixed call bells. It was also noted that additional funding had been agreed with the Commissioners to reduce the waiting times for access to services for those referred to the Attention Deficit Hyperactivity Disorder Pathway and Autism Assessment.

The Chair asked for assurance that the delay in implementing the action plan was due to supply issues.

The Director of Nursing and Therapies confirmed that the slippage was due supply issues (both in terms of materials and the availability of people) but also pointed out that there were logistical challenges around completing works on in-patient settings when it was not feasibly to close a ward whilst the works were being undertaken.

The Committee noted the report.

5.8 National Patient Safety Strategy Implementation Plan

The Director of Nursing and Therapies presented the paper and reported the National Patient Safety Strategy was published in April 2019, but the new national reporting system was yet to be released and the new Patient Safety Incident Response Framework was still under development. Similarly, the implementation plan for the National Patient Safety Syllabus had not yet gone live. At the national level, progress with each of these had been hindered by the Covid-19 Pandemic.

The Director of Nursing and Therapies reported that internally, the Trust had made significant progress over the last quarter, including:

- Statistically significant improvement in the safety culture theme within the NHS National Staff Survey
- Revision of Human Resources and Serious Incident policies and procedures to support the “Just Culture” work
- A ‘Power of Kindness and Civility in Healthcare’ event was held in March 2021 followed by a session at an all staff briefing on safety culture
- Accreditation achieved with the Royal College of Psychiatrists for our Serious Incident Investigation Processes, with a key element being our team approach
- Establishment of post incident staff support
- Safety Culture Charter developed
- The Trust now had two allocated National Patient Safety Specialists; one for Mental Health and one for Physical Health; additional recruitment to the team, following the successful business case, would enable these roles to focus on the national set priorities released at the beginning of April 2021.

The Chair commented that it was difficult to measure changes to culture.

The Director of Nursing and Therapies agreed but pointed out that the NHS National Staff Survey included questions around the safety culture and that this provided a helpful proxy measure in which to measure cultural change.

The Lead Clinical Director confirmed that the Clinical Directors were all engaged with the Trust's patient safety work.

The Committee noted the report.

5.9 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 about the timescale for the Trust continuing to monitor the COVID-19 risks.

The Chair confirmed that she expected to continue to monitoring the COVID-19 risks beyond the Government's road map to end restrictions on 21 June 2021. The Director of Nursing and Therapies reported that it was difficult to give a timescale but pointed out that the Trust would continue to receive national supplies of personal protective equipment until at least March 2022.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.1 Clinical Audit Report

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

- NACR National Audit of Cardiac Rehabilitation Annual Report 2020
- POMH Improving the Quality of Valproate Prescribing in Adult Mental Health Services

a) NACR National Audit of Cardiac Rehabilitation Annual Report 2020

The Medical Director pointed out that the Cardiac Rehabilitation service was a joint service with the Royal Berkshire NHS Foundation Trust and that the Trust would have provided data to the Royal Berkshire who would then submit the data along with their own data for the audit.

It was noted that the joint service had continued to achieve all seven key performance indicators and had retained their accreditation certification.

b) POMH Improving the Quality of Valproate Prescribing in Adult Mental Health Services

The Medical Director reminded the Committee that the Trust had undertaken its own internal review of Valproate prescribing in women of childbearing age, the results of which were reported at the last meeting.

The Medical Director reported that the audit had identified the following areas for improvement:

- Standard 6 – women of childbearing age – the Trust had implemented actions following the local analysis to ensure that Standard 6 was met
- Ensure 'off label 'prescribing was explained to patients and documented within RiO.
- Patients to have a 3-month review following valproate initiation with documentation of any side effects

The Medical Director pointed out that NICE guidance did not mention the requirement for a three-month review.

Mehmuda Mian, Non-Executive Director asked whether there were other drugs that were potentially dangerous to take during pregnancy.

The Medical Director reported that he was not aware of any drugs which the Trust prescribed, other than Valproate which posed a significant risk to unborn children.

The Chair explained that Valproate was a historic drug and was not prescribed very often. The Chair agreed with the Medical Director that he was not aware of any other drugs which posed a serious risk to unborn children.

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 (3 February 2021 to 4 May 2021 there were six "hours and rest" exception reports totally an extra 20.5 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.

IT was noted that this was the last report completed by Dr Lowe and Dr Jeffs and that Dr Ghazirad had been confirmed as the Trust's new Guardian of Safe Working Hours following interviews at the end of April 2021.

On behalf of the Trust, the Chair thanked Dr Lowe and Dr Jeffs for their work as the Trust's Guardians of Safe Working Hours.

The Committee noted the report.

7.1 Quality Executive Committee Minutes

The minutes of the Quality Executive Committee meetings held in February 2021, March 2021 and April 2021 were received and noted.

Mehmuda Mian, Non-Executive Director asked for an update on whether staff had received their second COVID-19 vaccination.

The Director of Nursing and Therapies confirmed that overall 84% of staff had received the COVID-19 vaccination and that of these staff, 95% of staff had received both doses. It was noted that clinical staff had been asked to let the Trust know if they had received their second vaccination outside of the Trust. It was also noted that there may be legitimate reasons why some staff had not received their second dose, for example if they were pregnant.

Mehmuda Mian, Non-Executive Director noted that the February 2021 minutes had made reference to staff being exhausted and stressed.

The Chief Operating Officer acknowledged that a number of teams were under pressure because of the COVID-19 pandemic and reported that the Trust continued to have Silver Control meetings to review the current status of service which also looked at colour coded “heat maps” which included issues around staffing.

Ms Mian noted that the incidence of prone restraint and patient assaults on staff had increased.

The Director of Nursing and Therapies confirmed that there had been an issue of double counting in relation to the incidence of prone restraint.

The Director of Nursing and Therapies acknowledged that there had been a spike in the number of patient assaults on staff and that this reflected the high level of acuity of patients. It was noted work was going on identify what further countermeasures needed to be put in place in order to reduce assaults.

Closing Business

8.0 Standing Item – Horizon Scanning

The items on the Committee’s current forward plan are:

- Carers Strategy
- Single room and therapeutic environment at Prospect Park Hospital
- Eating Disorder Service and the Wider System
- Post COVID-19 Lock Down and its impact on the Trust’s demand for services (particularly mental health services)

The Chair proposed adding the following items to the Committee’s forward plan:

- Governance around the application of the Mental Health Act
- An update on the Trust’s work on the “Getting It Right First Time” (GIRFT) programme

a) Mental Health Act

The Medical Director requested clarification on the scope of the Mental Health Act item.

The Chair explained that the Trust Chair chaired the Mental Health Act (MHA) Governance Board and had suggested that the Committee reviewed the functioning of the MHA Board in terms of providing scrutiny and assurance to the Trust Board on the application of the MHA.

Mehmuda Mian, Non-Executive Director said that it would be helpful to expand the review of the MHA to include the systems and processes around the application of the Mental Capacity Act.

The Medical Director reported that he was reviewing the Trust's systems and processes around the application of the Mental Health Act and therefore suggested that it would be premature to provide an assurance report to the Committee until his review was completed. The Medical Director said that he had a meeting with the Trust Chair later today to discuss the MHA Governance Board.

The Chair said that he would have a conversation with the Medical Director outside of the meeting to discuss the remit of the paper.

Action: Chair and Medical Director

b) "Getting It Right First Time Programme"

The Chair said that it would be helpful to the Committee to receive a paper on the Trust's role in the "Getting It Right First Time" programme. It was noted that the Lead Clinical Director was the national GIRFT lead for Child and Adolescent Mental Health Services.

The Lead Clinical Director pointed out that there were only three GIRFT pathways relevant to the Trust: Child and Adolescent Mental Health Services, Adult Crisis and Acute Mental Health Services and Mental Health Rehabilitation Services.

The Lead Clinical Director agreed to produce a paper for the Committee in six months' time setting out the findings of the GIRFT review of the Trust's Adult Crisis and Acute Mental Health Services. The paper would also set out the Trust's governance processes around the GIRFT Programme.

Action: Lead Clinical Director

8.1. Any Other Business

Fire at Prospect Park Hospital on 13 May 2021

The Chair reported that the Chief Operating Officer had already briefed the Non-Executive Directors about particular circumstances of the fire in the Place of Safety at Prosect Park Hospital on 13 May 2021 but invited the Chief Operating Officer to give a verbal update to the Committee.

The Chief Operating Officer confirmed that there were no serious injuries as a result of the fire and reported that the Place of Safety had been redecorated and was now back in use. The Chief Operating Officer reported that the Fire Brigade had not yet issued their investigation report but said the Trust's Fire Officer had undertaken an internal review and had identified some areas of learning and had developed an action plan.

It was noted that following a fire on Snowdrop Ward, Prospect Park Hospital in January 2021, the Trust had identified a number of actions and confirmed that those actions had been implemented.

The Chief Operating Officer said that as a result of the most recent fire, the Trust had had agreed that all mattresses in the Place of Safety would have a flame-retardant rating of level 7 (which was over and above what was recommended for a Place of Safety).

The Chair thanked the Chief Operating Officer for his update.

8.2. Date of the Next Meeting

The Chair reported that he had a commitment on 31 August 2021. The next meeting was therefore re-scheduled to take place on 24 August 2021

These minutes are an accurate record of the Quality Assurance Committee meeting held on 01 June 2021.

Signed:-

Date: - 24 August 2021

Berkshire Healthcare
NHS Foundation Trust

QPEG / QAC/ Trust Board	1 June 2021
Title	**Learning from Deaths Quarter 4 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	1257 deaths were recorded on the clinical information system (RiO) during Q4 (Q3 1109) where a patient had been in contact with a trust service in the year before they died. Of these 141 (Q3 98) met the criteria to be reviewed further. All 141 were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 39 were closed with no further action • 102 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 102, 23 were classed as Serious Incident Requiring Investigation (SI) During Q4, the trust mortality review group (TMRG) received the findings of 57 2nd stage review reports, of which 13 related to patients with a learning disability (these are cases reviewed in Q4 and will include cases reported in previous quarters). **COVID 19 reported deaths.** 27 inpatient deaths (7 BHFT Inpatient deaths and 20 deaths following transfer to acute hospital) 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. All Covid 19 related deaths had 2nd stage reviews except for 2 cases which were closed after first stage review; both patients were admitted specifically for end of life care and had a documented Covid 19 infection prior to admission.

Three patient deaths were confirmed as due to Covid 19 and the infection was acquired (definite or probable) while an inpatient under our care.

- In 2 cases Covid-19 was acquired in our care (1 definite and 1 probable BHFT healthcare acquired infection).
- In 1 case there is some uncertainty as to where the Covid 19 infection was acquired (although definite healthcare acquired infection but potential for the transmission to have happened during brief visits from BHFT Community ward to acute hospital).

Learning from these 3 cases is identified in the learning section 12.3.

Learning from Serious Incidents (Source: Q4 SI Report)
Specific activity that has occurred in Q4 relating to themes previously identified from serious incident reviews.

- Documenting and completing MDT agreed decisions
- Provision of carers support
- Transition between Child and Adolescent Mental Health (CAMHS) and CMHT
- Safety planning and consideration of safety contacts
- Challenges presented to mental health staff in relation to providing required services for patients with autism.

Learning from the mortality review process (first and second stage review of deaths).
Significant learning has been identified by the services and shared and implemented/being implemented through action plans, learning events and using the trust QI methodology. The following key areas and points should be noted:

Learning disability Service

- The importance of consideration of vascular dementia and associated risk factors for vascular dementia has been identified, as well as considering Alzheimer's and other types of dementia. Awareness of these risks have been shared via the Learning Disability Patient Safety Quality meeting and with the Dementia Workstream lead
- The service has also been sharing information with social care providers regarding the Restore2-mini tool to help with early identification if a person's health is deteriorating
- The learning disability service has also produced and shared 'Covid-19 Vaccination Consent and Best Interest Guidance'. This guidance provides a step by step process to support GP's and staff working with people with learning disabilities to prepare them to receive the vaccine
- Alongside this the Community Teams for People with a Learning Disability (CTPLD's) have completed proactive work to accelerate the inclusion of people with a learning disability in the high priority groups for Covid-19 Vaccination in order to address the related health inequalities and premature mortality experienced by this vulnerable population.

Learning from Healthcare Acquired Covid Infections.

There were no deficits in infection control measures, errors or omissions during the care of patients who acquired Covid 19 infection while an inpatient within our services. Following detailed review of all aspects of care provided for the patients, learning was identified and improvement actions are being implemented:

- Limited recording in the electronic progress notes of pertinent Covid-19 information on admission. Teams to improve the use of the alerts to identify positive, suspected and recovered patients.
- Taking of swabs and recording of results is inconsistently recorded on eObs swabbing tool. To support both of the actions, ensure staff are familiar with the process for using the alert system and the swabbing tool as outlined in the trust guidance by sharing findings in team meetings to discuss how to improve use of the RiO swabbing tool (in eObs) for recording Covid-19 information. Wards will then review their compliance with the RiO swabbing tool using the tableau report.
- Handover sheets will be used to encourage a daily conversation about the Covid-19 status of patients on the ward.
- Staff to be aware of the guidance contained within the standard operating procedure for visiting and regarding discharge criteria to ensure consistent and correct advice is given.
- Wards to document patient risk assessments for face masks in the RiO progress notes.

Physical Health

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 which include previously identified themes are:

- Palliative Care
- Administration of Medication
- Care of person with mental health (MH) and physical health needs
- Understanding and recognising pain in patients with complex mental health needs
- Sepsis Management
- Falls Management
- Management of the Deteriorating Patient
- Communication with Families

Conclusion

The number of 2nd stage reviews requested in Q4 (102) and the number of SI declared (23) were significantly higher (more than double the numbers) than reported in Q3 and Q4. We note an increase in inpatient deaths and learning disability deaths, linked to the surge in Covid 19 infections during Q4.

57 2nd stage reviews were completed in Q4, significant learning has been identified by the services and shared and implemented/being implemented through action plans, learning events and using the trust QI methodology.

	3 2nd stage reviews were escalated by the TMRG for a more detailed review using root cause analysis (RCA) to ascertain if there was any potential lapse in care (one Covid 19 case and 2 deaths unrelated to Covid). Although some second stage reviews and actions arising from reviews noted at TMRG in Q4 are in progress, the majority of SJRs have been completed within 30 days of the request. SI and root cause analysis reviews can take considerably more time and the outcomes/ learning or any LIC will be reported in the next quarter when they are concluded. A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. Of the 57 second stage reviews/SI investigation reports received by the TMRG in Q4, no deaths were identified as being directly resulting from a lapse in the care provided to our patients. 3 deaths were identified as following a definite or probable healthcare acquired Covid 19 infection. We note the need for national guidance for determining how healthcare acquired Covid 19 infections where no infection control lapses have been identified, should be classed in relation to learning from deaths.
ACTION REQUIRED	The committee is asked to receive and note the Q4 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	Total 20/21
Number of deaths seen by a service within 365 days of death	4381	3961	3884	1478	915	1109	**1257**	**4859**
Total deaths screened (Datix) 1st stage review	307	320	406	170	101	98	**141**	**510**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	153	134	198	72	48	47	**102**	**269**
Total number of deaths investigated as serious incidents	32	40	43	7	9	9	**23**	**48**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	3	3	1	0	0	**0**	**1**
Number of Community Hospital Inpatient deaths reviewed (Including patients at the end of life)	123	144	124	56	42	33	**54**	**185**
Total number of deaths of patients with a Learning Disability	35	28	47	18	8	5	**22**	**53**
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**	**0**

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

4.1 Total Number of deaths in Q4

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 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	January 2021	February 2021	March 2021	Grand Total
Nursing episode	218	171	133	**522**
Community health services medical	49	37	35	**121**
Dietetics	45	31	34	**110**
Podiatry	45	18	23	**86**
Old age psychiatry	34	25	11	**70**
Rehabilitation	32	20	15	**67**
Palliative medicine	14	21	25	**60**
Adult mental illness	16	19	7	**42**
General medicine	18	8	11	**37**
Cardiology	19	5	4	**28**
Intermediate care	11	10	7	**28**
Physiotherapy	13	5	8	**26**
Speech and language therapy	11	5	2	**18**
Respiratory medicine	5	4	6	**15**
Genito-urinary medicine	4	3	1	**8**
Geriatric medicine	3	2	1	**6**
Learning disability	1	1	2	**4**
Clinical psychology	3	1		**4**
Occupational therapy	1	2		**3**
Paediatrics	1			**1**
Psychotherapy		1		**1**
Total	**543**	**389**	**325**	**1257**

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.

Figure 3	January 2021 to March 2021				
	A:0-17	B:18-65	C:66-75	D: Over 75	Grand Total
Grand Total	**2**	**154**	**182**	**919**	**1257**

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

141 (Q3 98) deaths were submitted by services through the trust Datix reporting system for a first stage review by the EMRG. Of these 141 deaths reviewed, EMRG advised closing 39 cases, 23 were referred for SI investigation from EMRG and 79 were referred for a second stage review.

5. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death which relates to an individual with a learning disability and these are detailed with regards to the level of involvement for those deaths reported in Q4. In addition, for all expected inpatient end of life deaths or deaths where a 2nd stage review (SJR) is undertaken, the family will receive a letter of condolence and the bereavement booklet, with the opportunity to raise any concerns about the care provided to the patient.

6. 2nd Stage Reviews Completed

The purpose of the 2nd stage review of deaths is to determine if any potential problem or lapse in care may have contributed to the person's death, to identify learning and to utilise the learning to guide necessary changes in services in order to improve the quality of patient care. It is expected that, over a period, 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; 57 second stage reviews have been received and considered by the group in Q4 Figure 4 details the service where the review was conducted.

Figure 4: 2nd Stage Reviews Completed in Q4

	Total Number	Divisions
January 2021	15	Learning Disabilities: 3 East Physical Health: 1 West Physical Health: 5 West Mental Health: 2 Joint N&D and EDS: 1 Joint West MH and East PH:1 Complaint: 2
February 2021	13	Learning Disabilities: 2 MH inpatients: 1 East Physical Health: 1 West Physical Health: 3 East Mental Health:2 West Mental Health: 3 Complaint: 1
March 2021	29	Learning Disabilities: 8 East Mental Health: 2 West Physical Health: 7 East physical health: 4 West Mental Health: 5 Complaint: 3

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.

Of the 57 completed second stage reviews the TMRG identified 3 cases which required further scrutiny through the internal RCA process for a potential lapse in care. Of these 3 cases, 1 was a Covid related death.

7. Concerns or Complaints

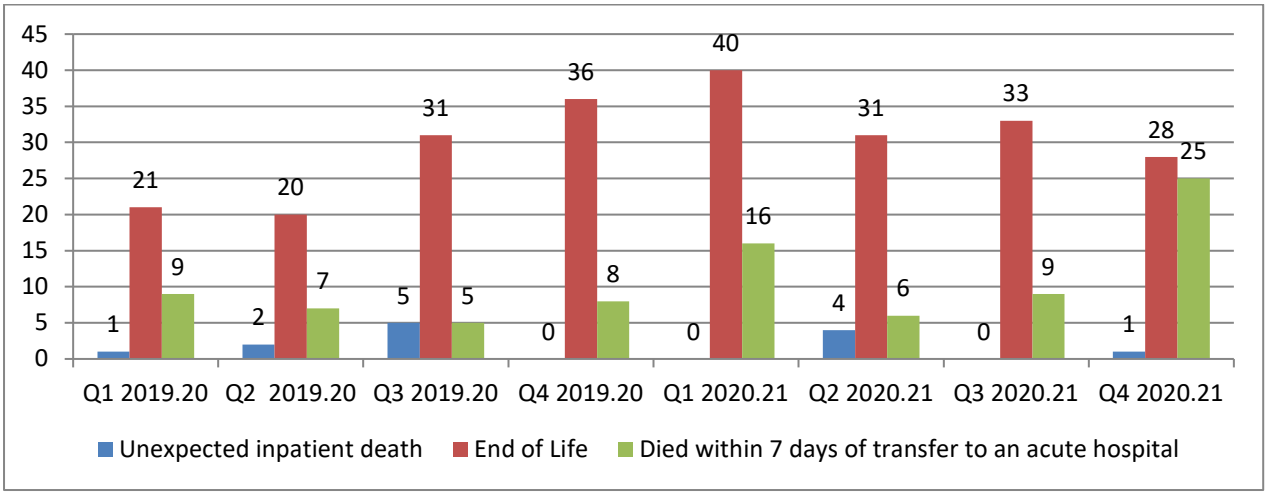
In Q4 6 (Q3 2) complaints in total were received from families following the death of a relative, 2nd stage reviews were requested for all. None of the complaint related SJR reviews at TMRG raised concern about a lapse in care (LIC).

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



In Q4 there were 54 deaths of which 53 deaths were reported by Community Inpatient Wards and 1 death was reported by a mental health ward, of which:

- 28 were expected deaths and related to patients who were receiving end of life care (EOLC). 7 of these patients had Covid 19 recorded on their medical certificate of cause of death, these are reviewed further in the section 8.1 below.

- 26 out of 54 were unexpected deaths
  - For One unexpected death, the cause of death is still to be determined by the coroner.
  - 24 patients were transferred to an acute hospital and died within 7 days,
  - 1 patient transferred to the Nursing Home and died within 7 days
  - Of these 25 transfers above, 20 were related to a deterioration of a patient with Covid 19 infection (see Covid 19 section 8.1 below).

Of the 21 EOLC deaths (excluding the 7 Covid 19 cases, detailed in section below) reviewed by the EMRG, 16 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.

8.1 Covid-19 related deaths in Q4 (January to March 2021)

7 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.

The table below details the total number of Covid 19 inpatient deaths which occurred in Q4 together with whether the infection was healthcare acquired and the level of review undertaken.

Figure 6.

Healthcare acquired infection	Total number of patients (n=7)	2 stage review undertaken
No: patient positive pre admission to hospital	3	2 closed at 1st stage review; patients admitted for palliative care. 1 SJR
Indeterminate: patient positive 3-7 days post admission	1	1 SJR
Probable: patient positive 8-14 days post admission	1	1 SI
Definite: patient positive 15 days or more post admission	2	1 SI 1 SJR

Figure 7 below details the total number of transfers to an acute trust following the deterioration of a patient with Covid 19 infection in Q4 together with whether the infection was healthcare acquired and the level of review undertaken.

19 deaths occurred following transfer of a Covid 19 positive patient to an acute provider from our community health inpatient wards and 1 patient from a mental health ward, who then 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.

Figure 7.

Healthcare acquired infection (HAI)	**Total number of patients (n=20)**	**2 stage review undertaken**
No: patient positive pre admission to hospital	8	8 SJR
No: patient positive less than 2 days	1	1 SJR
Indeterminate: patient positive 3-7 days post admission	4	3 SJR 1 IFR
Probable: patient positive 8-14 days post admission	3	2 SI 1 SJR
Definite: patient positive 15 days or more post admission	4 including one MH transfer	4 SI

Outcome of reviews completed

16 of the 17 SJR/IFR which were requested inQ4 were reviewed by the TMRG in March and April and closed with two cases requiring further information.

1 SI (definite HAI) which was requested in Q4 was reviewed and confirmed as due to a definite healthcare acquired infection.

7 SI reviews and 1 SJR for Q4 remain in progress at the time of writing this report, once concluded any LIC will be reported in future reports.

2 SI relating to Q3 deaths were concluded in Q4 and confirmed as due to a definite or probable healthcare acquired infection.

In conclusion, all Covid 19 related deaths had 2nd stage reviews except for 2 cases which were closed after first stage review; both patients were admitted specifically for end of life care and had a documented Covid 19 infection prior to admission.

Three deaths are attributed to Covid 19 where the infection was acquired (definite or probable healthcare acquired) while an inpatient under our care.

- 2 cases Covid-19 was acquired in our care (1 definite and 1 probable BHFT healthcare acquired infection).
- 1 case there is some uncertainty as to where the Covid 19 infection was acquired (although definite healthcare acquired infection but potential for the transmission to have happened during brief visits from BHFT Community ward to acute hospital).

Learning from these 3 cases is identified in the learning section 12.3.

9. Deaths of Children and Young People

In Q4 8 deaths were submitted as a Datix for 1st stage review. 7 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.

1 case was referred by EMRG for a 2nd stage review; at TMRG following second stage review, this was escalated for an internal learning review to enable robust initial reflections and learning by the service, which will then be shared as part of a joint agency review which is being conducted into this case.

10. Deaths of adults with a learning disability

In Q4 the Trust Mortality Review Group (TMRG) reviewed a total of 13 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 13 deaths there were no identified lapses in care provided by Berkshire Healthcare.

Figure 8. The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the respiratory system	7
Diseases of the heart & circulatory System	2
Diseases of the digestive System	1
Diseases of the nervous system	1
Diseases of the genitourinary system	1
Specific cause not established through post-mortem (currently awaiting results of toxicology and histology swabs)	1

Work undertaken to mitigate risks/impact of Covid-19:

There were 6 deaths reported where the person had been identified as having Covid-19. Of these deaths 4 people were over the age of 60. Of the other 2 people 1 was 49 and the other 32. 4 of the deaths were male and 2 were female. 1 death was of a person of Asian or Asian British – Pakistani ethnicity, the remaining deaths were people of White British ethnicity. Each of the Covid-19 related deaths had either comorbid physical health or mental health conditions and for some they had both comorbid physical health and mental health conditions.

There was 1 death identified during the reporting period where it was suspected that the person had Covid-19 (but this suspicion was unconfirmed). This person was 58, female and of White British ethnicity who had comorbid physical and mental health conditions alongside their learning disability

It is difficult to identify wider themes relating to comorbidity at this point in time, but the learning disability service will continue to review emerging themes and trends alongside the wider national work involving the rapid review of a sample 50 people with a learning disability, whose death was Covid-19 related.

Demographics:

Gender:

Female	4
Male	9

Age: The age at time of death ranged from 21 to 80 years of age (median age: 62yrs)

Severity of Learning Disability:

Mild	1
Severe	5
Not Known	7

Ethnicity:

White British	10
Asian / Asian British	2
Asian or Asian British - Pakistani	1

Engagement and feedback with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability. There have been 2 responses received to date from those contacted in this quarter and neither raised any concerns.

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

In Q4, 23 deaths (9 Q2 9 Q3) have been reported as serious incidents; figure 5 details the service where the SI occurred. Of these 23 incidents 10 are related to the Covid-19 Pandemic as a probable or definite health acquired infection.

Figure 9. Service (Source Q4 Serious Incident Report)	**Number**
Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT)	1
Slough Community Mental Health	1
Windsor Ascot and Maidenhead Community Mental Health	1
Bracknell Community Mental Health	1
Reading Community Mental Health	2
West Berkshire Community Mental Health	1
Psychological Medicines Services (PMS)	2
Talking Therapies	1
Crisis Resolution and Home Treatment Team West	2
Community Health Inpatient Ward	9
Mental Health Inpatient Ward	1
Community Physical Health	1
Total	**23**

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 26 deaths in Q4, 23 of which are currently under or have completed SI investigation. Of these 23, 8 were reported as suspected suicides, 5 were reported as unexpected deaths and 10 were a healthcare acquired infection control incident (C19) meeting SI criteria. In addition, there were 3 deaths which have been investigated as an ILR following review by TMRG for which DoC applied.

If phone numbers are available, phone contact has been attempted with all families or nominated next of kin (NoK). However, if there has been no phone number in the patient's clinical record and other sources also do not have one (e.g the GP) then letters have been sent (if the address is known). Of the phone contacts made, 15 of the phone contacts were successful in speaking with the family. The remaining families / NoK were sent written correspondence

apart from two families for which details are currently unknown and two families who had already received a condolence letter so will be followed up following the completion of the subsequent investigation.

2 of the families in Q4 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 57 reviews received by the TMRG in Q4 and using the current definition for lapse in care, no deaths were identified as a lapse in care. 3 deaths were noted to be due to a definite or probable healthcare acquired Covid 19 infection.

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 Q4.

12.1 Learning from Serious Incidents (Source: Q4 SI Report)

Specific activity that has occurred in Q4 relating to themes previously identified from serious incident reviews.

Documenting and completing MDT agreed decisions:

- Work has commenced between Community Mental Health (CMHT) Clinical Directors in conjunction with clinical staff to revisit the multi disciplinary team (MDT) template. Once it has been agreed, it will be added to the electronic patient record. Support is being provided to work on a tracking tool to go alongside this template. CMHTs are also working to improve documentation following referrals and allocations meetings to include rationale for decisions made. In addition, Prospect park hospital have created a standard work for the MDT meeting to follow including reviewing actions agreed from the previous meeting and allocating who will complete each action.

Provision of carers support

- A leaflet for families post suicide has nearly been completed. Along with providing information about our serious incident process, it also includes details of our support offer. In addition, the psychoeducation support offer is being revisited and will be advertised soon so all Divisions are aware of the availability. There is a new carers strategy and lead role for the Trust Carers | Nexus (berkshirehealthcare.nhs.uk)

Transition between Child and Adolescent Mental Health (CAMHS) and CMHT

- An interactive session using online Forum Theatre has been devised and delivered throughout March/April to all Mental Health Divisions. 127 staff have now attended this workshop that drew from a number of serious incidents to pull themes together to track a patient journey from CAMHS into adult mental health services. The story demonstrated how various professionals were involved and highlighted need to be proactive, take ownership, communicate and share information. It also highlighted risk of making assumptions, defensive practice and how the patient and carers voices/needs get lost. Lack of a care programme approach (CPA) process and clear safety planning were also highlighted.
- Alongside the improved awareness being provided through the workshop, guidance for staff on best practice during transition has been updated in the standard operating procedure which has been re-circulated and work continues on a system protocol. CAMHS are embedding transition within their pathway project. This involves collecting data from the CAMHS Specialist Community Teams (SCT) monthly to understand the transition needs of the young people open to Specialist CAMHS teams and to monitor the transition process and what happens when young people are unable to be transitioned

to adult services. The transition policy is due to be reviewed in June 2021, and there is agreement to review the SOPs /Standard Work and develop a checklist which both SCT and CMHT sign up to.

- Adherence to CPA policy especially in relation to communications and liaison between the hospital staff and community colleagues during discharge planning. The training mentioned above focuses on CPA and the importance of communications. In addition to this we have developed a resource for staff.

Safety planning and consideration of safety contacts

- An example of how to include safety contacts has been circulated and trainers will also use this in training. We have also commenced work on the review of the safety plan as we move towards a National template. There is focus on the quality of safety plans through internal audit.

Challenges presented to mental health staff in relation to providing required services for patients with autism.

- This is an area of learning that has been identified from a number of serious incidents as well as a theme from complaints. Therefore, a number of workstreams are currently underway including a focus on a Trust Neurodiversity Strategy with dedicated Clinical Director input. This strategy is looking at Autism and ADHD across child and adult services, mental health and physical health and our workforce. Early aims are to improve knowledge and awareness about, and confidence in working with, patients with autism and/or ADHD and their families with an aim to improve access to services and the work will involve engagement with practitioners, charity groups and third sector organisations, participation and engaging the workforce. We are also part of the Oliver McGowan autism and learning disability training pilot which will eventually provide training for all staff on working with patients with autism and/or learning disability. The aim is to have neurodiversity proactively considered as an integral part of all that we do and across everything that we do and not to be viewed as an add on.
- In addition, guidance has been provided for staff (in the form of an alert) on safety planning adaptations when patients are presenting with autism. It is also a focus in mental health governance meetings using shared data from a deep dive and this will be followed up again next month to provide staff with an opportunity for further discussion with a view to helping staff feel more confident when working with those with autism. Training has been provided and this will be recorded to enable it to be accessible more widely across all the teams.

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

Actions and learning identified during the previous quarter have been completed / shared. In Q4, there were no new identified actions for the LD service to take forward, however there was ongoing evidence of good team working and communication with families, support staff and across local services. There was also ongoing evidence to show the trust services were responsive to people's needs and that care was delivered in a timely way, despite a period of national lockdown due to the Covid-19 pandemic.

The importance of consideration of vascular dementia and associated risk factors for vascular dementia has been identified, as well as considering Alzheimer's and other types of dementia. Awareness of these risks have been shared via the Learning Disability Patient Safety Quality meeting and with the Dementia Workstream lead. Consideration of any further review of our dementia pathways or around the identification of different types of dementia will be undertaken through the dementia workstream. The Consultant Nurse has also built links with the Senior Consultant Admiral Nurse at Dementia UK.

The service has also been sharing information with social care providers regarding the Restore2-mini tool to help with early identification if a person's health is deteriorating.

Following the roll out of the Respiratory Health Care Pathway and the training sessions for staff, virtual 'clinics' have been set up from Jan 2021 in order to provide LD Service staff with additional support where needed with using the pathway. There are also plans to identify pathway Champions within each locality.

The learning disability service has also produced and shared 'Covid-19 Vaccination Consent and Best Interest Guidance'. This guidance provides a step by step process to support GP's and staff working with people with learning disabilities to prepare them to receive the vaccine. It also provides useful links on where to access key information and forms to help with this as well as information on Reasonable Adjustments, in addition to a dedicated email address to enable staff to seek additional supports in relation to complex decision making in this area.

Alongside this the Community Teams for People with a Learning Disability (CTPLD's) have completed proactive work to accelerate the inclusion of people with a learning disability in the high priority groups for Covid-19 Vaccination in order to address the related health inequalities and premature mortality experienced by this vulnerable population. The Consultant Nurse and Primary Care Liaison Nurse have been invited to work with the Queens Nursing Institute (QNI) as part of an NHSE/I funded programme/Community of Practice looking at long covid from a learning disability perspective. This work will further inform the respiratory health and wellbeing of people with learning disabilities.

12.3 Learning from Healthcare Acquired Covid infections.

Three cases reviewed as serious incidents in Q4 were due to the patient either probably or definitely acquiring the infection whilst in our care. Although there was no deficit in care identified, the following learning was identified and actions are being implemented:

- Limited recording in the electronic progress notes of pertinent Covid-19 information on admission teams to improve the use of the alerts to identify positive, suspected and recovered patients.
- Taking of swabs and recording of results is inconsistently recorded on eObs swabbing tool. To support both of the actions, ensure staff are familiar with the process for using the alert system and the swabbing tool as outlined in the trust guidance by sharing findings in team meetings to discuss how to improve use of the RiO swabbing tool (in eObs) for recording Covid-19 information. Wards will then review their compliance with the RiO swabbing tool using the tableau report.
- Handover sheets will be used to encourage a daily conversation about the Covid-19 status of patients on the ward.
- Staff to be aware of the guidance contained within the standard operating procedure for visiting and regarding discharge criteria to ensure consistent and correct advice is given.
- Wards to document patient risk assessments for face masks in the RiO progress notes.

12.4 Learning from Community Physical Health

Figure 10.

Concern	Cause	Countermeasure (Action)
Confidentiality Issue	Handover sheet and patient identifiable information left in communal area breaching IG.	All teams that work on the ward to be updated regarding breach and how to ensure documentation remains safe. To check all staff in date with IG training
Administration of Medication	Medication taken from 2 separate supplies making it appears that does had been omitted	All nursing staff to be briefed regarding this incident and correct process highlighted.
Administration of Medication	Omission of regular medication on admission to ward	Process to be developed to safely and effectively manage medication omissions due to no stock on admission
Communication with wider teams and any agencies working on the wards to assist patients with individualised needs	Healthcare Assistant worked on the ward with patient, no record of handovers, communication between this staff member and ward staff, Little interaction with ward and mental health team, no	Standard work to be devised to share with any visiting teams regarding expectations, clear handover and communication process, including correct way to raise concerns

Lack of robust induction/expectations for external staff	process regarding how to raise concerns	
Care of person with mental health (MH) and physical health needs	Concerns raised during investigation by the MH team that MH needs had not been met and the team lacked understanding of how MH conditions can impact on physical health conditions	Training for all the team regarding how to care for a patient with complex mental health needs on a physical health inpatient unit. To include staff attitudes and empathy towards MH patients (MH team have offered training)
Understanding and recognising pain in patients with complex mental health needs	Unclear from records if fear and anxiety was considered as a contributory factor towards the pain experienced.	Training regarding pain and understanding the impact this can have on those with complex mental health and physical health needs
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
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 wards. Raised at the ward managers and matrons meeting
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 - Inpatient governance lead to share the learning with all inpatient units
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. - Advance nurse practitioners and medics to involve family members in care planning and treatment
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 this issues were developed by the service and shared at TMRG - Staff training and supervision sessions in place
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

12 Conclusion

The number of 2nd stage reviews requested in Q4 (102) and the number of SI declared (23) were significantly higher (more than double the numbers) than reported in previous quarters of 2020/21. We note an increase in inpatient deaths and learning disability deaths, linked to the surge in Covid 19 infections during Q4.

57 2nd stage reviews were completed in Q4, significant learning has been identified by the services and shared and implemented/being implemented through action plans, learning events and using the trust QI methodology.

3 2nd stage reviews were escalated by the TMRG for a more detailed review using root cause analysis (RCA) to ascertain if there was any potential lapse in care (one Covid 19 case and 2 deaths unrelated to Covid).

Although some second stage reviews and actions arising from reviews noted at TMRG in Q4 are in progress, the majority of SJRs have been completed within 30 days of the request. SI and root cause analysis reviews can take considerably more time and the outcomes/ learning or any LIC will be reported in the next quarter when they are concluded.

A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. Of the 57 second stage reviews/SI investigation reports received by the TMRG in Q4 and using the current definition for declaring a lapse in care, no deaths were identified as being directly resulting from a lapse in the care provided to our patients.

Three deaths have been confirmed to be directly a result of definite or probable Covid 19 infection

- 2 cases Covid-19 was acquired in our care (1 definite and 1 probable BHFT healthcare acquired infection).
- 1 case there is some uncertainty as to where the Covid 19 infection was acquired (although a definite healthcare acquired infection, but potential for the transmission to have happened during brief visits from BHFT Community ward to acute hospital).

We note the need for national guidance for determining how healthcare acquired Covid 19 infections where no infection control lapses have been identified, should be classed in relation to learning from deaths.

Berkshire Healthcare NHS Foundation Trust

QAC Meeting Date	1 June 2021
Title	Guardian of Safe Working Hours Quarterly Report (February to April 2021) and summary report of the 5 years of the current Guardians of Safe Working Hours
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 and a report summarising the last 5 years of work of the Guardians Of Safe Working which forms part of the handover to the new Guardian who will take on the role from July 2021. This report focusses on the period 3rd February to the 4th May 2021. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

Berkshire Healthcare
NHS Foundation Trust

SUMMARY REPORT COVERING FIVE YEARS OF THE GOVERNOR OF SAFE WORKING HOURS FOR DOCTORS IN TRAINING

Executive summary

This is a report to summarize the work of the Guardians of Safe Working (GOSW) during the five years of their role for BHFT. At the end of June 2021 Dr Lowe and Dr Jeffs will be stepping down from the role. Their successor has been chosen after a highly competitive interview process. Dr Marjan Ghazirad, Consultant in Learning Disability Psychiatry has been appointed to take over the role from July 2021.

BHFT has had a low level of exception reports relative to other local trusts and this has continued to be true over the past five years. Trainees have used the processes well and have used the exception reporting system and the ability to claim time off in lieu to ensure that their working hours have not become unsafe.

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. We wish Dr Ghazirad all the best in her new role.

Exception Reporting

Figure 1 and Table 1 show the exception reporting data over time as collected by the BHFT Guardians of Safe Working Hours. Although the Guardians were appointed in July 2016 alongside the creation of the new contract the exception reporting systems did not come into effect for trainees in BHFT until February 2017. Therefore, the first report and the first data we have available dates from May 2017.

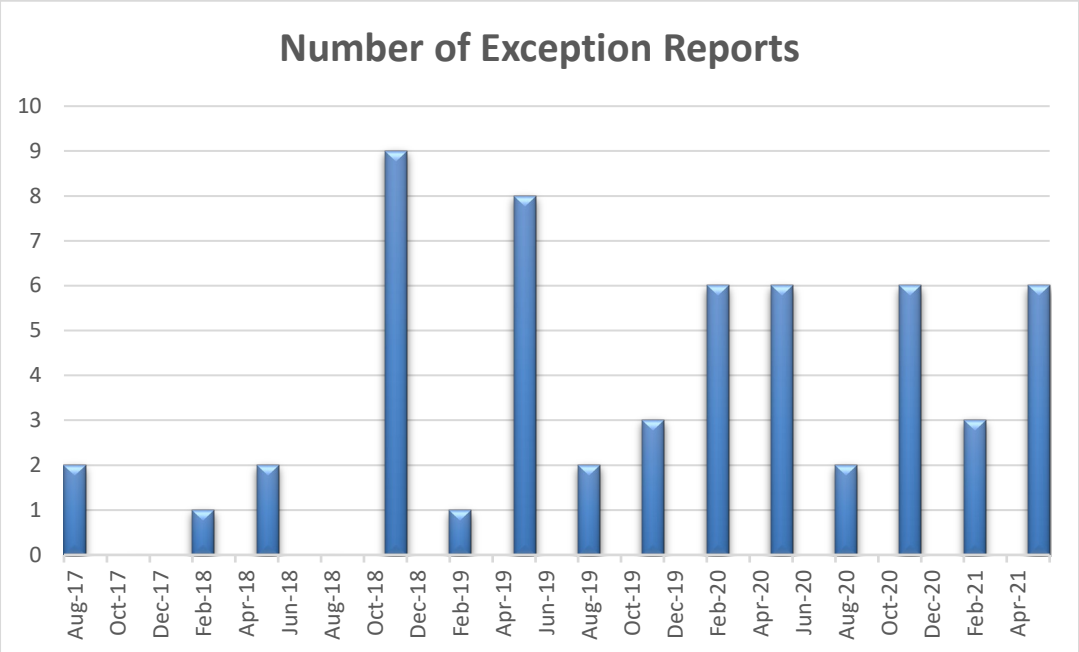


Figure 1 – Number of exception reports in each quarter – the date relates to the date of the report to the trust board and covers the three-month period prior to that date.

Quarter	Feb-April	May-July	Aug-Oct	Nov-Jan	Feb-April	May-July	Aug-Oct	Nov-Jan	Feb-April	May-July	Aug-Oct	Nov-Jan	Feb-April	May-July	Aug-Oct	Nov-Jan	Feb-April
Year	2017	2017	2017	2018	2018	2018	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021
Number Exception Reports	1	2	0	1	2	0	9	1	8	2	3	6	6	2	6	3	6

Table 1 - Number of exception reports per quarter

The exception reports we have received defy easy categorization. However, the majority relate to trainees staying late on either their normal working days or on call shifts to complete urgent work. Often these have related to medical emergencies, urgent psychiatric work or the completion of long pieces of work that cannot be easily handed over to the next doctor on shift. There have also been a small number of exception reports were trainees have attended semi-planned clinical or managerial work outside their usual work pattern (e.g. on an annual leave day).

On average there were less than 4 reports per quarter. The number of exception reports is low compared to our neighboring trusts and the purposes of the exception reports are in line with the original intent of the exception reporting system, allowing the junior doctors to complete urgent or necessary work outside of their usual working hours and being able to claim back the time to ensure that they are not overtired or overworked.

The exception reports are placed through the "DRS4" computer program designed for the purpose. It is an imperfect system and doesn't prompt supervisors or guardians when trainees place reports. As most supervisors will only to complete an exception report less frequently than once per year this often leads to delays in the completion of the report, but thankfully from feedback from the trainees is that it does not delay the meeting with supervisors or the agreement of TOIL (Time Off In Lieu).

Fines

Since the new contract has been in place there have not been any exceptions that have required the Guardians to raise a fine.

Engagement with Trust, Local and National systems

The Guardians of Safe Working Hours attended the 2 national conferences on the New Contract in London in 2016 and Leeds in 2018. The Guardians have been active members of the Regional Guardians Network that has provided an opportunity for peer support, information sharing, dissemination of best practice and benchmarking. The Guardians have regularly attended the LNC and the MEM for BHFT. We have completed the Exception Reporting Guidance for the trust. The new contract required a Junior Doctor's Forum (JDF) to be set up within the trust. It was important to us that the trainees felt they had ownership of this so we facilitated the trainees to elect their own committee and then encouraged their autonomy while offering supervision as requested. The trainees drew up their own terms of reference in 2017 for this and then completed a quality improvement project in late 2018 to improve the format and structure of the forum. The forum has been well attended and has particularly proved its worth in being a voice for the trainees in COVID 19.

Covid-19

Covid-19 has changed the working lives of junior doctors dramatically. In the first wave some doctors were asked to redeploy to other services to ensure continuity of service provision, particularly around the inpatient wards. The Junior Doctor Forum was keenly involved in the discussions around this and there was a high level of good will from both sides. Covid-19 did not result in an increase of Junior Doctors working in excess of their work schedules as is demonstrated by the steady level of exception reports and feedback from the JDF. We had agreed for the duration

of the acute Covid-19 situation to change our default action from only giving TOIL, to giving trainees the choice of payment for extra hours worked or TOIL. This is because it was felt that trainees should have the flexibility to continue to support their services. In the end only one exception report resulted in payment.

Rotations, rotas and gaps

Junior doctor rotations occur on a six-monthly cycle running August to February to August. With the main rotation being in August. The quarterly GOSW reports therefore cover half a rotation per report. Table 2 pulls together all of the data from these GOSW reports concerning rota gaps.

Report Period	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:		Rota Pattern
			Bank	Trainee	Agency			Bank	Trainee	Agency	
1st November 2016 – 31st January 2017	22	21	20	0	1	192	188	184	0	4	1:9
1st February – 2nd May 2017	20	20	18	2	0	176	176	160	16	0	1:9
3rd May – 1st August 2017	47	45.5	40.5	4	1	476	456	416	40	12	1:9
2nd August – 31st October 2017	60	60	59	1	0	584	584	580	4	0	1:9
1st November 2017 – 6th February 2018	20	20	16	4	0	184	184	152	32	0	1:9
7th February – 30th April 2018	39	39	34	3	2	364	364	328	12	24	1:9
1st May – 31st July 2018	100	99	83	16	0	968	956	828	128	0	1:9
1st August – 31st October 2018	52	52	45	7	0	376	376	324	52	0	1:9
1st November 2018 – 5th February 2019	100	100	86	14	0	912	912	800	112	0	1:9
6th February – 5th May 2019	65	65	48	17	0	628.5	628.5	464	164.5	0	1:9
6th May – 6th August 2019	87	87	55	32	0	839.5	839.5	575.5	264	0	1:9
7th August – 31st October 2019	41	41	16	25	0	293.5	293.5	138	155.5	0	1:10
1st November 2019 – 4th February 2020	71	71	25	46	0	614.5	614.5	198.5	416	0	1:10
5th February – 30th April 2020	48	47	17	30	0	486	473.5	190.5	283	0	1:12
1st May – 4th August 2020	108	107	24	83	0	1064	1051.5	234	817.5	0	1:12
5th August – 30th October 2020	51	51	21	30	0	484.5	484.5	217.5	267	0	1:12
31st October 2020 – 2nd February 2021	81	81	39	42	0	789.5	789.5	427.5	362	0	1:12
3rd February – 4th May 2021	82	82	58	24	0	844	844	643	201	0	1:11
Total numbers	1094	1088.5	704.5	380	4	10276	10215	6860.5	3326.5	40	
Total as %	100	99.5	64.4	34.7	0.4	100	99.5	66.7	32.4	0.4	

Table 2 – Details of out of hours shifts on the Junior Doctors rota at Prospect Park Hospital that have needed to be covered according to each of the quarters covered by the Guardian of Safe Working hours reports to the board.

Shift gaps, and leaving aside Covid-19 for the moment, arise for a number of reasons. Primarily because we did not receive the doctors from HEETV but still have to run the rota at a certain frequency (see below). On top of which gaps are created by short- and long-term sickness, pregnancy and maternity leave, occasionally resignations, and more latterly Covid-19. High numbers of shifts correspond to a combination of these factors and not to a single factor.

We started to report Covid-19 in the February-April 2020 report and the largest number of gaps caused by the disease were in the period May-August 2020. Since August 2020 Covid-19 has continued to have an impact on the rota being the main cause of shift gaps in that rotation, as it was in the previous rotation. Since February 2021 Covid-19 continues to cause shift gaps but is no longer the main cause. During the whole of the pandemic we have only had one shift we were unable to cover and that was as a result of normal sickness, not Covid-19.

In terms of fill rate, Medical Staffing covered 99.5% of gaps, with unfilled shifts amounting to no more than 5.5 shifts or 61 hours. Overall, of the filled shifts our bank doctors covered two thirds, with the remaining third being covered by trainees. Agency was negligible and is no longer used. The reasons behind our ability to cover are on a mundane level due to our conscious policy of constantly looking to increase bank numbers, they have gone up from single

figures in 2015 to the current level of 36 bank doctors, and by offering a very good bank rate. Beyond this, and more importantly, our support, help and flexibility regarding and for our trainees, and many of our bank doctors are former trainees, has paid dividends in their willingness to cover gaps and cover them quickly.

Rota frequency at the start of this period was 1:9, which was viewed as a heavy rota and not popular with trainees across the Deanery, Medical Staffing therefore started working with the to improve not only the rota frequency, but also the pattern and length of shifts. This meant that when the refresh of the Junior Doctors contract came in July 2019, in terms of rota rules changes we were well prepared for these changes and had anticipated and were already implementing them. We were thus able to lighten the rota to 1:10 and subsequently 1:12, alongside reducing the numbers of hours the trainees worked, thereby improving their work/life balance. The current 1:11 is a result of the fluctuation of trainee numbers from HEETV and is not materially heavier than 1:12. Going forward we are looking to keep the rota at 1:11/1:12 dependent upon trainee numbers.

Summary

This is a report to summarize the work of the Guardians of Safe Working during the five years of their role for BHFT. At the end of June 2021 Dr Lowe and Dr Jeffs will be stepping down from the role. Their successor has been chosen after a highly competitive interview process. Dr Marjan Ghazirad, Consultant in Learning Disability Psychiatry has been appointed to take over the role from July 2021.

BHFT has had a low level of exception reports relative to other local trusts and this has continued to be true over the past five years. Trainees have used the processes well and have used the exception reporting system and the ability to claim time off in lieu to ensure that their working hours have not become unsafe.

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. We wish Dr Ghazirad all the best in her new role.

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

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Berkshire Healthcare
NHS Foundation Trust

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

This report covers the period 3rd February to 4th May 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 the period 3rd February to 4th May 2021. Since the last report to the Trust Board we have received six *'hours & rest'* exception reports and no '*education*' reports.

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

This is the last report to be completed by Drs Lowe and Jeffs who will be handing over to Dr Ghazirad who has been confirmed as the new Guardian of Safe Working Hours following interviews at the end of April.

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): 37 (FY1 – ST6)

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

Number of doctors in training on 2016 TCS (total): 37

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

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

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

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	6	0
Sexual Health	0	0	0	0
Total	0	6	6	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	0	0	0
CT	0	6	6	0
ST	0	0	0	0
Total	0	6	6	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	6	6	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	2	2	2	0
ST4-6	0	0	0	0
Total	2	2	2	0

In this period, we have received six '*hours and rest'* exception reports where the trainees worked hours in excess of their work schedule, totaling an extra 20.5 hours worked over and above the trainees' work schedules. 3 reports (totaling 16.5 hours) relate to less than full time trainees working on non-working days. 7 hours relates to a less than full time trainee attending induction on their non-working day. 4.5 hours relating to clinical work needing to be completed on a non-working day and 5 hours relating to management activities relating to the Junior Doctors Committee needing to take place on a non-working day. 3 reports (totaling 4 hours) relate to trainees finishing late on on-call shifts. 2 of these reports relate to trainees responding to urgent situations towards the end of shifts and 1 relates to an unusually busy shift. These are all within the scope of the purpose of exception reporting, allowing trainees to complete important work outside of their standard working hours on rare occasions and providing a system whereby taking TOIL so that they do not become overworked because of it.

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. 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 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 3rd February to 4th May 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
	82	82	58	24	0	844	844	643	201	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	50	50	38	12	0	533	533	424	109	0
Sickness	15	15	8	7	0	146.5	146.5	82	64.5	0
Covid-19	17	17	12	5	0	164.5	164.5	137	27.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	82	82	58	24	0	844	844	643	201	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

The OOH rota is now operating at 1:11 and our system for cover continues to work as normal, with gaps being quickly filled. Our bank doctors in particular have continued to be an asset, and we continue to increase this pool.

We had to increase the rota frequency as we had an increased in gaps resulting from HEETV trainee numbers being slightly reduced, along with the loss of our FY2 for part of this period and one of our existing MTIs leaving and going into higher training. Even so we still have a number of gaps as the new contract rules do not allow for too heavy a rota pattern.

Covid-19 remains but has had far less of an impact, normal sickness has also been quite low.

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 as of July this year. Interviews were held on the 28th April 2021 and the successful candidate was Dr Marjan Ghazirad. Dr Ghazirad will gradually take over from the current guardians after a handover period. The outgoing guardians will also prepare a brief summary report for the board of those 5 years.

Actions taken to resolve issues

Next report to be submitted August 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.

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Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 July 2021
Title	Quality Improvement Update
Purpose	To provide the Board with an update on the roll out and development of a Quality Improvement system across the Trust.
Business Area	Trust wide
Author	Chief Operating Officer
Relevant Strategic Objectives	To provide a way to support the improvement of patient safety, support to our staff, good patient experience and cost effectiveness.
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and the delivery of safe and responsive care
Resource Impacts	None
Legal Implications	None
Equalities, Diversity and Inclusion Implications	N/A
SUMMARY	The attached paper provides the Board with an update on the development of the Quality Improvement (QI) system which continues to be rolled out across the Trust. The paper covers why Trusts use a QI approach, what we set out to achieve, the building blocks of our QI approach, the progress and benefits to date, next steps, QI leadership and the contribution of the board to the QI system.
ACTION REQUIRED	To note the report, seek any clarification, discuss the role of the board and recommendations. To confirm any actions arising from the discussions.

Why use Quality Improvement Approach?

Berkshire Healthcare NHS
NHS Foundation Trust

"Improvements in the quality of care do not occur by chance. They come from the intentional actions of staff equipped with the skills needed to bring about changes in care, directly and constantly supported by leaders at all levels.
They do not come free and will require a substantial and sustained commitment of time and resources."

Source: Ham, C., Berwick, D., and Dixon, J. *Improving Quality in the English NHS: A Strategy for Action.* The King's Fund. February 2016.

How do we solve a nagging, persistent patient care delivery problem?

A. Call the improvement specialists
B. Gather more data
C. Ask frontline staff to solve it
D. All of the above
E. Identify what type of problem it is first

Catalysis

Improving the patient experience is a complex problem

What is our management philosophy?
What is the management philosophy based on?
What type of problems are we trying to solve?
What is the process for understanding our patient's unmet needs and therefore the problems they struggle with?
How do we gather new knowledge about our patients?
What do we do with this new knowledge?
How do we develop our strategy with this new knowledge?
How do we know if what we did worked?
How do we scale it?

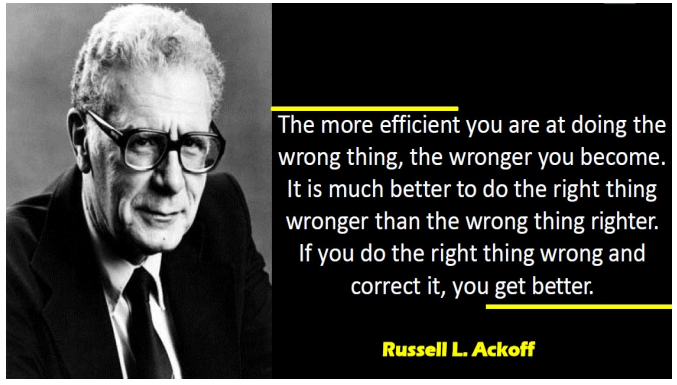
Catalysis

The impact of Lean principles in industry

Validated Industry Averages*	
Direct Labour / Productivity Improved	45–75%
Cost Reduced	25–55%
Throughput/Flow Increased	60–90%
Quality (Defects/Scrap) Reduced	50–90%
Inventory Reduced	60–90%
Space Reduced	35–50%
Lead Time Reduced	50–90%

*Summarised results, subsequent to a five-year evaluation, from numerous companies (more than 15 aerospace-related).
Companies ranged from 1 to >7 years in lean principles application / execution

Source: IHI Innovation Series: Going Lean in Health Care



"We have learnt from our inspections and ongoing relationships that high-quality organisations delivering outstanding care have embedded systematic improvement cultures. QI should not be an optional extra for hospitals, but considered essential to providing sustainable high-quality care"

Source: Care Quality Commission. *Quality Improvement in Hospital Trusts: Sharing Learning from Trusts on a Journey of QI*. Care Quality Commission, 2018.

According to Professor Ted Baker, the Chief Inspector of Hospitals, 'QI has been shown to deliver better patient outcomes, and improved operational, organisational and financial performance when led effectively, embedded through an organisation and supported by systems and training. When QI is used well, it gives us confidence about the long-term sustainability of the quality of care. More informally, when we visit trusts that have an established QI culture, they feel different. Staff are engaged, they are focused on the quality of patient care, and they are confident in their ability to improve. This is also reflected in surveys of staff and patient satisfaction.'

Source: Care Quality Commission. *Quality Improvement in Hospital Trusts: Sharing Learning from Trusts on a Journey of QI*. Care Quality Commission, 2018.

What is the alternative and how is it a better approach?

What we set out to achieve

1. Enable leaders to understand and run the Trust using a management method based in QI tools.
2. To create a culture that supports and enables continuous quality improvement and innovation.
3. To develop our people to solve problems and improve performance.
4. Develop internal experts to lead QI, to teach and coach others.
5. Develop leaders who will personally champion and apply QI methods and tools.
6. Deliver a mature, sustainable and visible quality improvement organisation.

7. Delivery of increased patient quality, patient experience, support for staff and lower costs.
8. Improvement to delivery of Trust strategy, vision metrics and external performance rating.
9. The application of QI tools and disciplines by teams will improve their day-to-day operations.
10. Alignment across organisation to reduce over burdening and improve productivity.
11. Prioritisation of projects and work to deliver substantial and lasting changes in performance.

Building blocks of our QI System

Berkshire Healthcare NHS
NHS Foundation Trust

01
Strategy Deployment

Identifying a small number of strategic priorities and cascading these through the organisation.

02
Quality Management and Improvement System

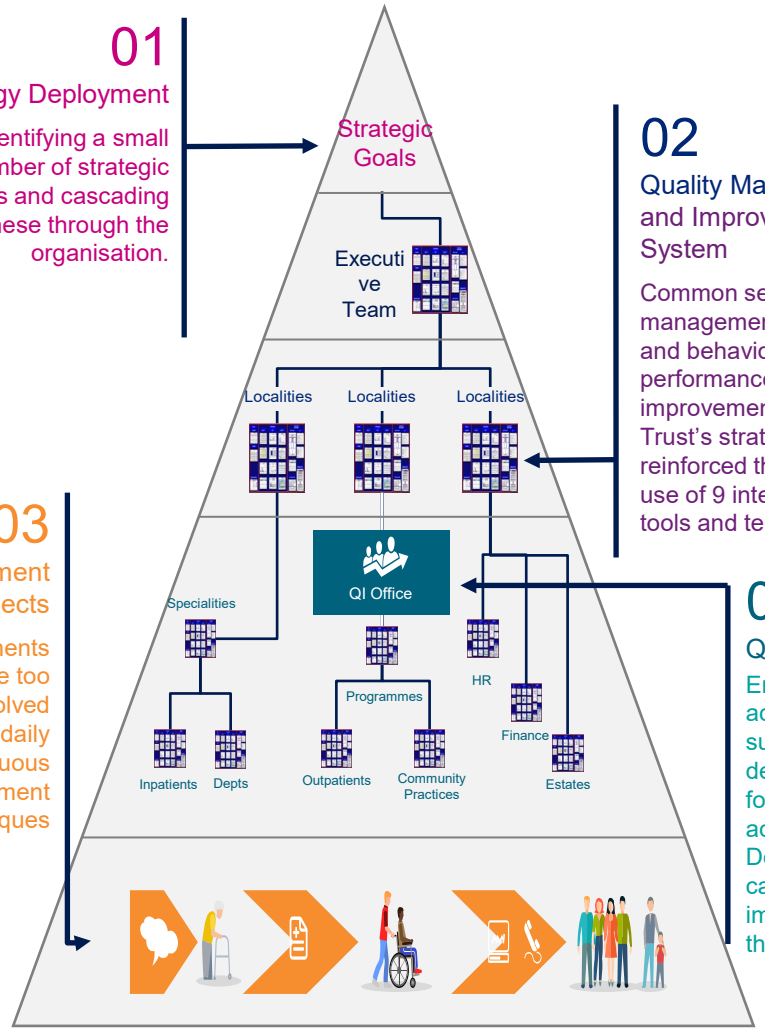
Common set of management routines and behaviours to align performance and daily improvement the Trust's strategic goals, reinforced through the use of 9 integrated tools and techniques

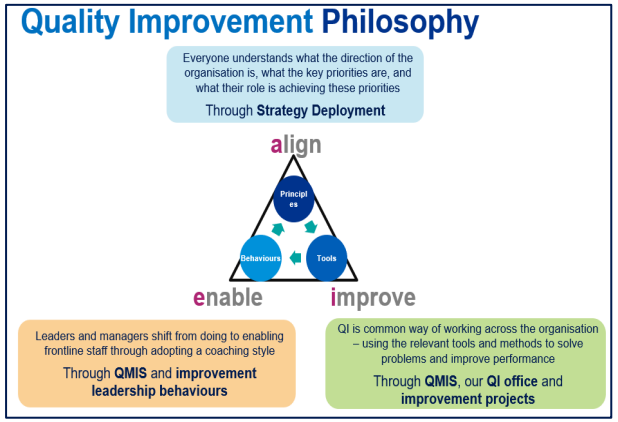
03
Quality Improvement Projects

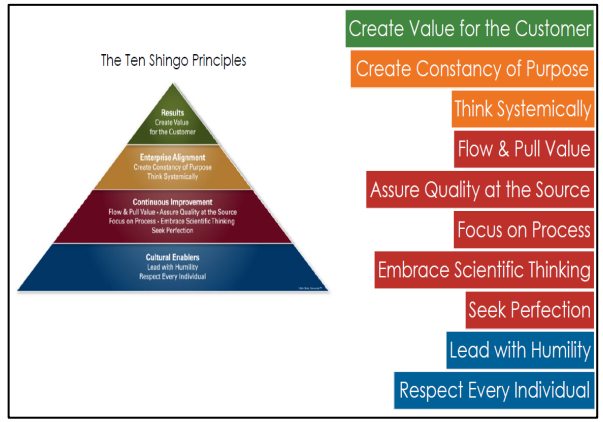
Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques

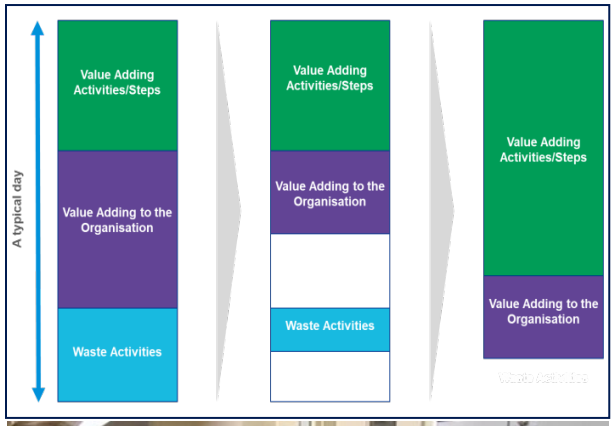
04
QI Office

Ensuring structured accountability, support and dedicated resources for improvement activities. Developing capabilities for improvement across the organisation.









Continually striving to achieve perfection
Constantly seeking new ways
Substantial & lasting changes in performance
Maximising Customer Value
Eliminating Waste
Process improvement
A3 Problem solving
Inch Wide Mile Deep
PDSA approach
Standard work
Visual Management
Leadership Behaviours

Real experts:
- Those who perform the job everyday

Respect:
- Listening
- Involvement
- Empowerment
- Providing tools
- Building capability

Engage:
- Involve those who perform the job everyday
- Make the organisation's goals 'real' to the frontline
- Provide opportunity

Outcome:
- An organisation full of 'problem solvers' who are making small scale improvements on a daily basis

Healthcare from the heart of your community

How are we progressing?

Berkshire Healthcare NHS
NHS Foundation Trust

True North Delivery

QI project delivery

Daily performance improvement

Visual Management

Leadership development

Roll out & Maturity

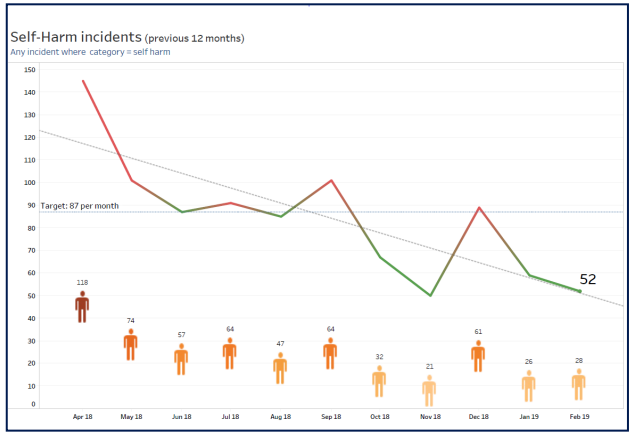
Feedback from QI experts worldwide

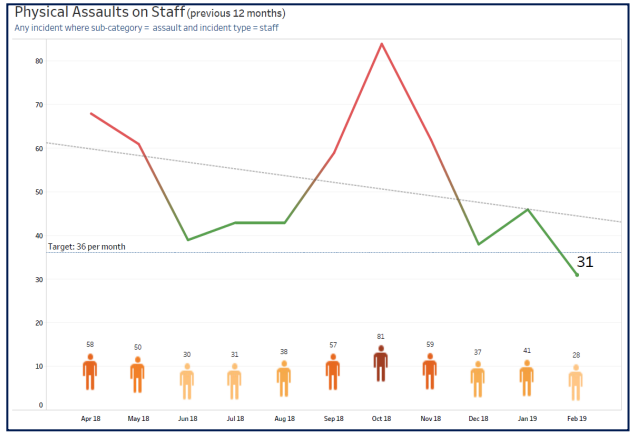
QI Launch:	**2018**
QMIS roll out:	**5 years 2018 - 2022**
Years 1 – 3:	**on track. 54% teams trained**
Year 4:	**pandemic, pause in roll out**
Years 5 – 6:	**2021 – 2023 complete roll out**

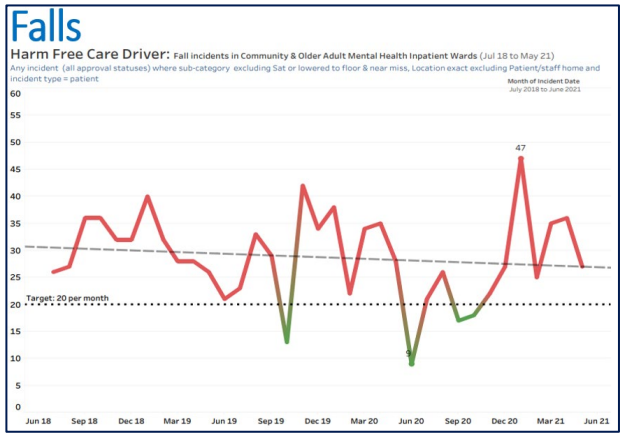
Healthcare from the heart of your community

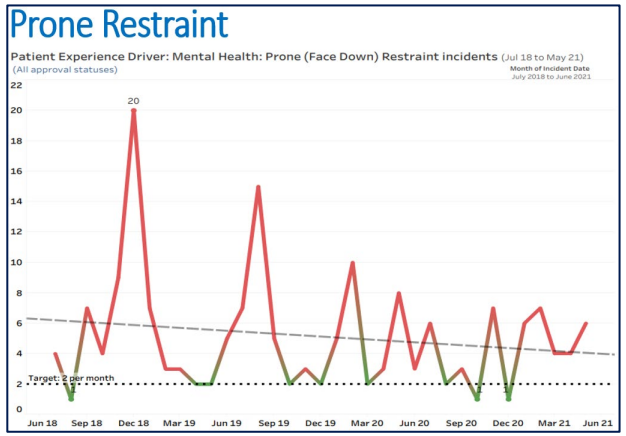
Quality Improvement Benefits

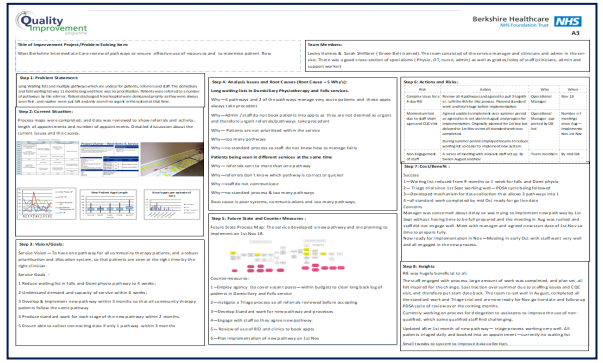
Berkshire Healthcare NHS
NHS Foundation Trust

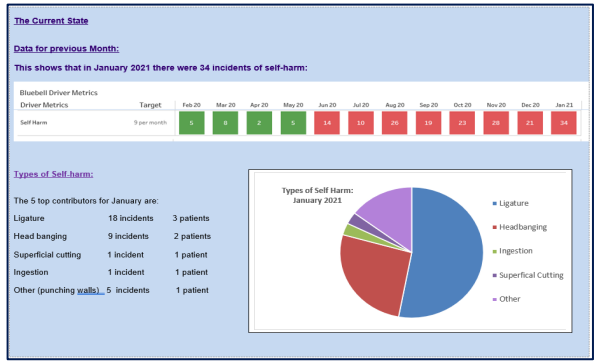












Healthcare from the heart of your community

What next?

Berkshire Healthcare NHS
NHS Foundation Trust

QI Programme Leadership and Delivery

1 Strategy Deployment
True North
Trust Driver metrics
Corporate Projects
Project Priorities
Strategic Initiatives
Objective Dialogue – projects
Objective Dialogue – performance
Corporate QMIS

2 QMIS
Teams Trained
Maturity
Improvement tickets
Divisional Driver
Service Drivers
Performance improvement
Operational projects
Countermeasures
Objective Dialogue – projects
Objective Dialogue – performance

3 QI Team
QI Resources
Training
Coaching
QMIS Maturity
Roadmap
Project support
Green Belt projects
Yellow Belt projects

4 QI Governance
Assurance report
Programme effectiveness criteria
Performance reporting
Value for money review

Links
Trust Strategy
People Strategy
E&D Strategy
Digital Strategy
Estates Strategy
Board vision metrics
System developments
Recovery
Compliance
Staff survey
Benchmarking
Strategic projects

- ✓ Programme has 4 workstreams & an Executive allocated lead
- ✓ Programme plan with prioritised activities for each workstream in place
- ✓ Exec Team dedicated QI meeting every month using standard work to review plan progress, priorities still right, support needed and update QI skills
- ✓ Transformation & QI Director appointed to take over programme & QI Team leadership
- ✓ QI Team restructured and fully recruited

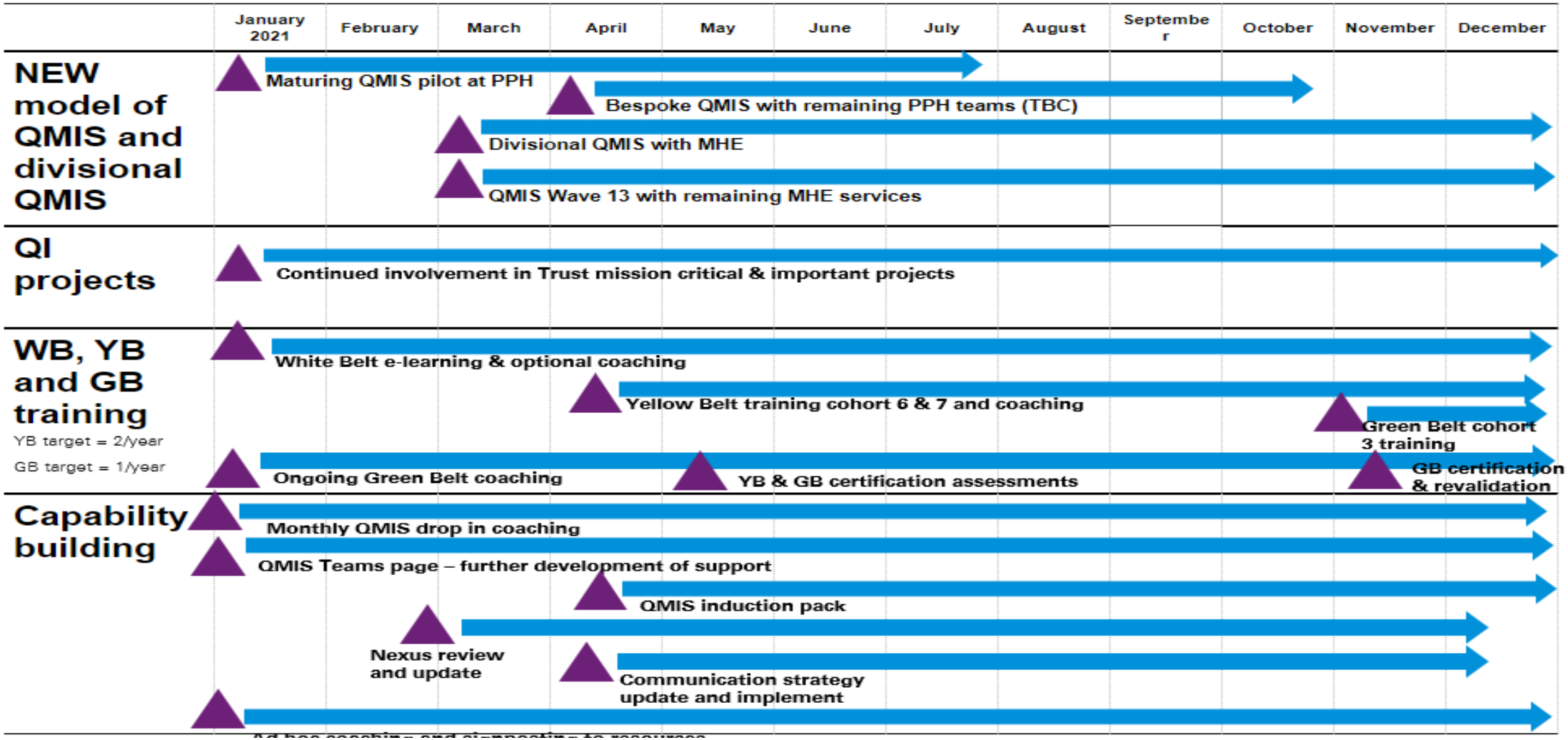
What would you need to see each month to know if we're winning or losing?

Mind set : listening, continuous improvement, inch wide mile deep, leader standard work
Tool set : A3s, status exchange, countermeasure summaries, huddles, gemba
Skill set : coaching, teaching, listening, standard work, process improvement
Reliability of system overtime (improvement in driver metrics)

QI Plan Workstream Priorities

	QI Leadership	David				09-Apr
	Challenge & Opportunity	Owner	Priority	Action	When	Status
1	Programme leadership & workstream ownership	DT	A	Plan produced, discussed & allocated	Mar-21	complete
2	How do 4 QI workstreams fit together	DT	A	Standard work produced & shared	Mar-21	complete
3	Board, Exec & SLT alignment & visibility of QI programme	DT	A	Updates being planned for board & SLT	May-21	in progress
4	Support transfer of QI leadership and Team to Transformation lead role	DT	A	Interviews on 16 April	Sep-21	in progress
5						
6						
7						
8						
9						
10						
	Strategy Deployment	Kathryn				
	Challenge & Opportunity developments	Owner	Priority	Action	When	Status
11	Exec ownership & development of strategy deployment	KM	A	Named Execs agreed	Mar-21	complete
12	True north Driver metrics 2021-22	KM	A	Draft list being confirmed	Apr-21	in progress
13	True North Driver metrics cascade from Board to Teams	KM	A		Apr-21	in progress
14	Driver metric ownership at Exec level (corporate owners)	KM	A	Agreed at Exec meeting	Apr-21	complete
15	Link of Trust Strategy, True north, Board vision metrics & plan on a page	KM	A	Plan on a page issued	May-21	in progress
16	Link of True North, Strategic initiatives, Corporate & breakthrough projects	KM	A		Sep-21	
17						
18						
19						
20						
	QI Projects	Kathryn				
	Challenge & Opportunity	Owner	Priority	Action	When	Status
21	Process for project selection and leadership	KM	A	Project process reviewed at Exec	Apr-21	complete
22	Alignment, progression & reporting of Strategic initiatives	KM	A		Jun-21	in progress
23	Alignment of projects to strategy and priorities	KM	B		Jun-21	
24	Maturity and development of project prioritisation process	KM	B		Jun-21	
25	Alignment of project prioritisation at Trust, Corporate, Division and system	DT/KM	B		Sep-21	
26						
27						
28						
29						
30						
	QI Management System	David				09-Apr
	Challenge & Opportunity	Owner	Priority	Action	When	Status
31	Production of road map for next 2 years	CA	A	Being updated	Apr-21	in progress
32	Corporate QMIS ownership & delivery	DT	A		Apr-21	
33	Divisional performance link to Exec & Services - objective dialogue	DT	A	Divisional meetings arranged for April	May-21	in progress
34	Maturity & Sustainability of QMIS in teams & Divisions variable	DT	A	Maturity model developed.	Sep-21	in progress
35	Identify and address gaps in management system	CA	B		Sep-21	in progress
36	Lack of visibility of improvement delivery & performance in Divisions & teams	CA/DT	B		Sep-21	
37	Divisional projects link to Exec & Services - objective dialogue	DT/KM	B		Sep-21	
38						
39						
40						

What next – Roadmap 2021/22



Leadership in QI Systems

Berkshire Healthcare NHS
NHS Foundation Trust

Boards and executive teams need to:

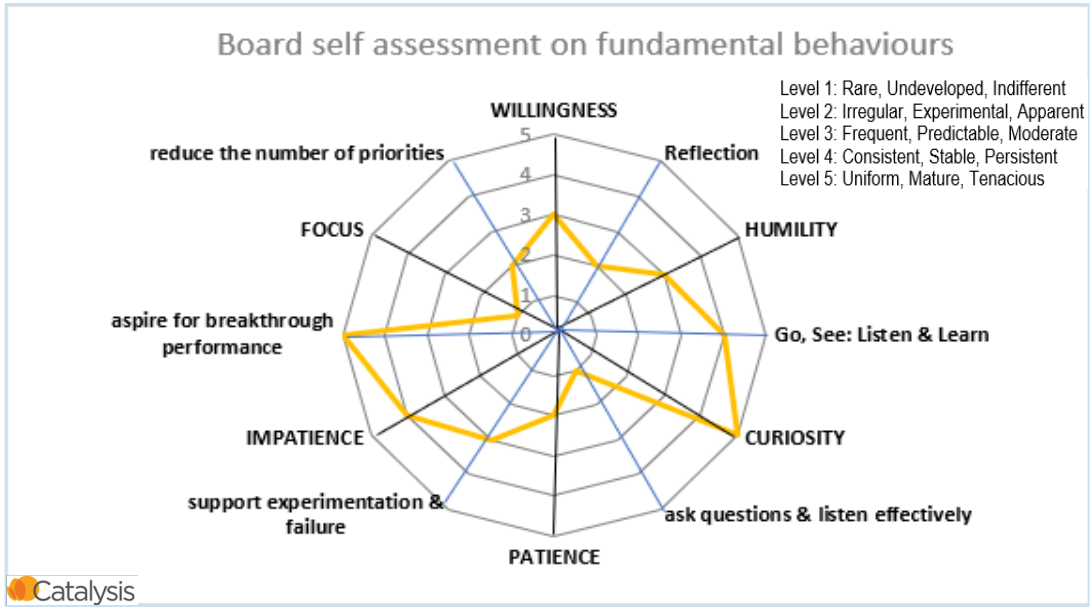
- ✓ provide visible and focused leadership for improvement drive the development of a compelling mission, purpose and way of working
- ✓ reconcile short-term external demands with long-term organisational improvement objectives
- ✓ show constancy of purpose and give front-line teams time, space and permission to plan, develop and refine improvement interventions
- ✓ make available sufficient resources to identify, plan and deliver improvement
- ✓ promote a culture of distributed leadership throughout the organisation
- ✓ have access to reliable, timely and relevant data about organisational performance and the ability to analyse the data and act appropriately
- ✓ ensure that the views of staff and patients help shape organisational strategy and improvement priorities
- ✓ build on previous improvement work and ensure that existing improvement expertise in the organisation is valued and maximised
- ✓ seek out relevant knowledge, expertise and innovation from outside bodies and use it to inform improvement strategy and practice
- ✓ create a governance climate geared to 'problem sensing' within the organisation, rather than 'comfort seeking'
- ✓ ensure alignment between improvement activities, workforce functions and organisational strategy.

Health Foundation. Bryan Jones, Tim Horton, Will Warburton. The Improvement Journey. Why organisation- wide improvement in healthcare matters, and how to get started. 2019

10 lessons for NHS leaders

1. Make quality improvement a leadership priority for boards.
2. Share responsibility for quality improvement with leaders at all levels.
3. Don't look for magic bullets or quick fixes.
4. Develop the skills and capabilities for improvement.
5. Have a consistent and coherent approach to quality improvement.
6. Use data effectively.
7. Focus on relationships and culture.
8. Enable and support frontline staff to engage in quality improvement.
9. Involve patients, service users and carers.
10. Work as a system.

Kings Fund, "Making the case for quality improvement: Lessons for NHS boards and Leaders". October 2017



Healthcare from the heart of your community

Our contribution to QI System delivery

1. Sustainability of QI system and long term benefits

Biggest threat to the benefits of a QI system is lack of leadership support and changes to Executive and board positions resulting in loss of understanding and changes to organisational ways of working.

Recommendation 1: QI Induction programme for new board members

Recommendation 2: QI refresher training for board members

2. Maximise value rather than question value

Focus on continuous improvement and maximising benefits delivery – how can we improve this system to make us even better and gain greater value?

Recommendation 3: Review link between Vision metrics, True North, Strategic initiatives, Corporate projects & breakthrough projects.

Recommendation 4: Support reduction of overburdening and waste from system.

3. Use QI principles, behaviours and tools

Leading by example, gaining benefits of QI methodology to our work, supporting our colleagues.

Recommendation 5: Introduce Gemba visits for board members to go see, learn, support QI maturity and help prioritisation

Recommendation 6: Board members to complete leadership fundamental behaviours self assessment

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 July 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 July 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. Integrated Care Systems

On 16 June 2021, NHS England and NHS Improvement (NHSE/I) published the Integrated Care Systems (ICS) Design Framework.

This framework builds on NHSE/I's renewed vision for ICSs in the Integrating Care paper (November 2020) and the two-part statutory Integrated Care System model proposed in the Government's White Paper, Integration and Innovation: working together to improve health and social care for all (February 2021). It sets out the operating model for Integrated Care Systems from April 2022 (subject to legislation and its parliamentary process) and acts as interim guidance for how Integrated Care Systems need to continue developing and preparing for new statutory arrangements over the next ten months. A summary of the framework published by NHS Providers is included in the attached appendix.

Executive Lead: Julian Emms, Chief Executive

3. Summary of the NHS System Oversight Framework

The new 'NHS System Oversight Framework' was released on the 25th June 2021, replacing the existing 'Single Oversight Framework'. It provides the framework for 2021/22, with amendments expected for 2022/23 to reflect planned legislative changes affecting ICSs and their future role in formal oversight.

The framework reinforces the approach of system-led delivery of care and the importance of provider collaboration, with failure to engage in system collaboration ultimately resulting in potential enforcement action.

The framework acknowledges that Integrated Care Systems (ICSs) are at differing stages of development and governance, and the framework recognises the approach to oversight is linked to ICS progression. This will lead ultimately to ICSs taking the lead on organisational oversight, and NHS England/Improvement (NHSE/I) intervention in only exceptional circumstances.

The NHS System Oversight Framework:

a) sets out how NHSE/I will monitor performance; sets expectations on working together to maintain and improve the quality of care; and describes how identified support needs to improve standards and outcomes will be co-ordinated and delivered

b) will be used by NHSE/I to guide oversight of ICSs at system, place-based and organisation level as well as decisions about the level and nature of delivery support they may require

c) describes how NHSE/I will work with the Care Quality Commission (CQC) and other partners at national, regional, and local level to ensure activities are aligned

d) introduces system focused Recovery Support Programme (RSP) replacing the current 'special measures' regimes.

Characterised Approach to Oversight:

a) working **with and through ICSs**, wherever possible, to tackle problems

b) a greater emphasis on **system performance and quality of care outcomes**

c) matching **accountability for results** with improvement support, as appropriate

d) **greater autonomy** for ICSs and NHS organisations with evidence of collective working and a track record of successful delivery of NHS priorities, including tackling inequality, health outcomes and access

e) **compassionate leadership behaviours** that underpin all oversight interactions.

Approach to Oversight

The framework is built around the following national key themes that reflect the ambitions of the NHS Long Term Plan, as well as the inclusion of local priorities recognising ICSs individual circumstances and challenges.

1. Quality of care, access and outcomes
2. Preventing ill health and reducing inequalities
3. Finance and use of resources
4. People
5. Leadership and capability
6. Local strategic priorities

ICSs are required to agree a memorandum of understanding with regional teams that sets out the delivery and governance arrangements across the ICS. This must include financial and quality governance arrangements, the role place-based partnerships and provider collaboratives will play in delivery of NHS priorities, agreed

oversight mechanisms, and the local strategic priorities that the ICS has committed to deliver in 2021/22 as a partnership.

Monitoring

The oversight process follows an ongoing three step cycle of monitoring ICS and NHS organisation performance and capability under the six key themes, identifying the scale and nature of support needed, and co-ordinating support activity (and where necessary formal intervention) so that it is targeted where it is most needed.

The oversight process will include review meetings with ICSs or where relevant, place-level groups of providers and commissioners, and by exception with individual organisations. The frequency and leads being open to discussion and agreement linked to ICS maturity. These will be complemented by focused engagement with the ICS and the relevant organisations where specific issues emerge outside these meetings.

To support ongoing monitoring of ICS and organisational performance NHSE/I will continue to gather information relating to the key themes through the collection of annual and in-year submissions, as well as additional requests as required.

Segmentation and Identifying the scale and nature of support needs

NHSE/I will allocate each ICSs, trusts and CCGs to one of four 'segments', (segment 1, no support required, to segment 4, requirement for mandated intensive support). The default for all ICSs, trusts and CCGs is segment 2. The segment descriptions and nature of support needs are illustrated below:

	Segment description			Scale and nature of support needs
	ICS	CCG	Trust	
1	Consistently high performing across the six oversight themes Capability and capacity required to deliver the ICS four fundamental purposes is well developed	Consistently high performing across the six oversight themes Streamlined commissioning arrangements are in place or on track to be achieved	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities	No specific support needs identified. Trusts encouraged to offer peer support Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations
2	On a development journey, but demonstrate many of the characteristics of an effective, self-standing ICS Plans that have the support of system partners in place to address areas of challenge	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Plans that have the support of system partners in place to address areas of challenge Targeted support may be required to address specific identified issues	Flexible support delivered through peer support, clinical networks, the NHS England and NHS Improvement universal support offer (eg GIRFT, RightCare, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the six oversight themes Significant gaps in building the capability and capacity required to deliver on the ICS four fundamental purposes	Significant support needs against one or more of the six oversight themes No agreed plans to achieve streamlined commissioning arrangements by April 2022	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)	Bespoke mandated support through a regional improvement hub, drawing on system and national expertise as required (see Annex A)
4	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme (see Annex A)

Segmentation decisions will be determined by assessing the level of support required segmentation decisions will be taken having regard to the views of system leaders.

The criteria and consideration for each segment are detailed below.

	Eligibility criteria	Additional considerations
1	• Performance against the oversight themes typically in the top quartile nationally based on the relevant oversight metrics *and* • On agreed financial plan and forecasting delivery against full year envelope *and* • CQC 'Good' or 'Outstanding' overall and for well-led (trusts)	*For ICSs and/or CCGs:* • Success in tackling variation across the system and reducing health inequalities • Whether the ICS consistently demonstrates that it has built the capability and capacity required to deliver on the four fundamental purposes of an ICS • Whether the CCG has achieved streamlined commissioning arrangements aligned to the ICS boundary, or is on track to fully achieve these against an agreed plan. *For trusts:* • Evidence of established improvement capability and capacity • The degree to which the trust plays a strong, active leadership role in supporting and driving place-based priorities, provider collaboration and overall ICS priorities.
2	This is the default segment that all ICSs, trusts and CCGs will be allocated to unless the criteria for moving into another segment are met	
3	• Performance against multiple oversight themes in the bottom quartile nationally based on the relevant oversight metrics *or* • A dramatic drop in performance, or sustained very poor (bottom decile) performance against one or more areas *or* • An underlying deficit that is in the bottom quartile nationally and/or a negative variance against the financial plan and/or not forecasting to meet plan at year end *or*	*For all:* • Existence of other material concerns about a system's and/or organisation's governance, leadership, performance and improvement capability arising from intelligence gathered by or provided to NHS England and NHS Improvement (eg delivery against the national and local transformation agenda) • Evidence of capability and capacity to address the issues without additional support, eg where there is clarity on key issues with an existing improvement plan and a recent track record of delivery against plan and/or of agreed recovery actions • There are other exceptional mitigating circumstances *For ICSs:* • Evidence of collaborative and inclusive system leadership across the ICS, eg where the system is not in financial balance, whether it has been able to collectively agree credible plans for meeting the system envelope
	• A CQC rating of 'Requires Improvement' overall and for well-led (trusts) *or* • No agreed plans to achieve streamlined commissioning arrangements aligned to ICS boundaries by April 2022 (CCGs)	• Clarity and coherence of system ways of working and governance arrangements *For trusts:* • Whether the trust is working effectively with system partners to address the problems
4	In addition to the segment 3 criteria: • Longstanding and/or complex issues that are preventing agreed levels of improvement for ICSs, trusts or CCGs in SOF segment 3 *or* • A catastrophic failure in leadership or governance that risks damaging the reputation of the NHS *or* • A significant underlying deficit and/or significant actual or forecast gap to the financial plan *or* • CQC recommendation (trust)	

ICSs trusts and CCGs in segment 1 will benefit from the lightest oversight arrangements and greater autonomy. This will include being able to request devolution of programme funding and greater control over the deployment of improvement resources available through regional improvement hubs. Also being able to request funding to provide peer support to other organisations, be exempt from consultancy controls, relevant running cost limits and streamlined business case approval.

ICSs, trusts and CCGs with significant support needs that may require formal intervention and mandated support, will be placed in segment 3 or 4 and will be subject to enhanced direct oversight by NHS England and NHS Improvement (in the case of individual organisations this will happen in partnership with the ICS) and,

depending on the nature of the problem(s) identified, additional reporting requirements and financial controls.

Mandated support will consist of a set of interventions designed to remedy problems within a reasonable time frame. Depending on the severity and complexity of the issues, mandated support may be led by either NHSE/I regional teams with input from the national intensive support team, or mandated intensive support delivered through the nationally coordinated Recovery Support Programme.

There may also be additional scrutiny of plans, additional reporting requirements, and financial controls such as lower capital approval limits. While the eligibility criteria for mandated support will be assessed at ICS and individual organisation level, packages will be designed and delivered with the relevant system context in mind, including place and provider collaboratives.

Local system partners will be expected to play their role in addressing system-related causes and solutions to the problem.

Recovery Support Programme

For systems, trusts and CCGs allocated to segment 4, the new national Recovery Support Programme (RSP) will provide focused and integrated support. This replaces the separate quality and finance special measures programmes that have been in place since 2013.

The RSP will differ from the special measures programme in that it is system oriented, while providing focused support to organisations, will focus on the underlying drivers of the problems that need to be addressed. The programme will be led nationally by a System Improvement Director (SID) jointly appointed by the system, region and national intensive support team.

NHSE/I will review the capability of the ICS, trust or CCG's leadership, and may lead to changes to the management of the system or organisation to ensure the board and executive team can make the required improvements.

Relevant Metrics

The framework included an extensive list of metrics that will be monitored at ICS, Trust and CCG level. Overall, the metrics continue to be physical health focussed, with Mental Health metrics consolidated into CCGs requirement to fulfil the Mental Health Investment Standard and Trusts required to deliver on the Long-Term plan metrics. A full list of the metric relevant to the Trust can be found in Appendix 2.

Executive Lead: Paul Gray, Acting Chief Financial Officer

Presented by Julian Emms
Chief Executive
July 2021

Integrated Care System Design Framework

NHS England and NHS Improvement (NHSE/I) published the Integrated Care System (ICS) Design Framework on 16th June 2021. This briefing sets out the operating model for ICSs from April 2022, after the enactment of the Health and Care Bill which will place ICSs on a statutory footing. It also acts as interim guidance for how ICSs need to continue developing and preparing for new statutory arrangements over the next ten months. The design framework will be supplemented by further information and guidance later this year to support detailed planning. For any questions on this briefing, please contact georgia.butterworth@nhsproviders.org.

Key points

- The ICS design framework sets out the next steps for how NHSE/I expects NHS organisations, working with system partners, to continue developing ICSs during 2021/22, in anticipation of establishing statutory ICS NHS bodies from April 2022. The framework sets out the core arrangements that NHSE/I will expect to see in each system, as well as some key elements of good practice. We expect further information and guidance to be issued later this year.
- As set out in the government's *Integration and Innovation* white paper in February, ICSs will be made up of two parts: the ICS partnership, and the statutory ICS NHS body. NHSE/I expects the ICS partnership to be a committee, rather than a corporate body. Its role will be to align the ambitions, purpose and strategies of partners across each system. It will be established by the relevant local authorities in collaboration with the ICS NHS body, and have a specific responsibility to develop an "integrated care strategy".
- The ICS NHS body will be a statutory body, whose functions will include planning to meet population health needs, allocating resources, and overseeing delivery. ICS NHS bodies will have a unitary board. The statutory minimum membership of the board will be confirmed in forthcoming legislation but is expected to be comprised of: a chair and at least two independent non-executive directors; a chief executive and three executive directors; and a minimum of three "partner" members, representing trusts, primary care and local authorities. Partner members will be expected to bring a perspective from their specific sectors, but not act as delegates of those sectors.
- The ICS NHS body will be expected to agree with local partners the membership and form of governance at place level. The design framework sets out five potential place-based governance arrangements: a consultative forum; a committee of the ICS NHS body; a joint committee of the ICS NHS body and one or more statutory provider; an ICS NHS body director with delegated authority; or a lead provider contracted to manage resources at place level.

- The design framework reiterates that all trusts providing acute and mental health services are expected to be part of one or more provider collaborative. Community and ambulance trusts and non-NHS providers should participate in these where it makes sense to do so.
- Providers will continue to be accountable for quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions delegated to them by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible.
- The final 2021/22 System Oversight Framework (SOF), which is expected to be published in the coming weeks, is expected to confirm ICSs' formal role in the oversight of organisations and partnership arrangements within their system. NHSE/I will retain its statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE/I.
- NHSE/I also sets out the key features of the financial framework that will support system working, including some further detail on how resources will be managed at system level. It is envisaged that ICS NHS bodies will be given a duty to act with a view to ensuring system financial balance, and meet other financial objectives set by NHSE. This duty would also apply to trusts.
- The framework includes a roadmap to implement new arrangements for ICS NHS bodies by April 2022, including appointing leadership teams and ensuring a smooth transition of staff from CCGs.

Summary of the framework

Context

This framework builds on NHSE/I's renewed vision for ICSs in the Integrating care paper published in November 2020, which set out their four core purposes: improving outcomes; tackling inequalities; enhancing productivity; and supporting social and economic development. It also builds on the two-part statutory ICS model proposed in the government's white paper, Integration and Innovation: working together to improve health and social care for all, which stated that ICSs will be comprised of an ICS partnership – bringing together a broad alliance of organisations related to improving health and care – and an ICS NHS body – bringing together organisations that plan and deliver NHS services to improve population health and care.

The ICS partnership

Under the two-part statutory ICS model, each ICS will have a partnership, established by the NHS and local government "as equal partners". NHSE/I expects the ICS partnership to bring partners from local government, the NHS and wider organisations within the ICS together to align purpose and ambitions, and improve the health and wellbeing for their population, including influencing the wider

determinants of health. NHSE/I expects the ICS partnership to have a specific responsibility to develop an "integrated care strategy" covering health and social care for the whole population. NHSE/I indicates that the legislation for how partnerships should operate will not be prescriptive.

Membership of the ICS partnership will vary between systems, and may be drawn widely from health, care and other partners such as housing providers. They will be established by the relevant local authorities and the ICS NHS body. Partnerships will be able to use sub-groups, networks and other methods to convene parties to deliver the priorities set out in its shared strategy.

The ICS partnership chair will be jointly selected by the ICS NHS body and local authorities, who will also define the chair's role and accountabilities. NHSE/I provides some flexibility in this arrangement, by acknowledging that some systems may prefer the partnership and the ICS NHS body to have different chairs while others may choose to appoint one chair to sit across both. NHSE/I describes ten principles for ICS partnerships to consider, which include: distributed leadership; collective decision-making that seeks to find consensus; and a collective model for accountability.

The Department of Health and Social Care, NHSE/I and the Local Government Association will jointly develop guidance on the partnership, including on the role and accountabilities of the chair of the ICS partnership. This guidance will be consulted on before implementation.

The ICS NHS body

ICS NHS bodies will be statutory organisations that bring together all organisations involved in planning and providing NHS services within their footprint, to take a collaborative approach to agreeing and delivering ambitions for the health of their population.

NHSE/I outlines the specific functions that the ICS NHS body will be responsible for delivering:

- Developing a plan to meet the health needs of their population, having regard to the partnership's strategy. NHSE/I highlights a focus on recovery following COVID-19.
- Allocating resources to deliver the plan across the system, including setting principles for how resource (revenue and capital) should be allocated across services and providers. This will be a balance between enabling local decision-making and harnessing the benefits of scale.
- Establishing joint working arrangements with partners to deliver priorities, including joint commissioning (possibly at place) with local authorities under section 75 of the 2006 NHS Act.
- Establishing governance arrangements to support collective accountability. This will be underpinned by the statutory and contractual accountabilities of individual organisations.

- Arranging for the provision of health services in line with the allocated resources across the ICS. This will be delivered in several ways including: through contracts and agreements with providers; convening and supporting providers (working across the ICS and at place) to lead major service transformation programmes; and working with local authority and voluntary, community and social enterprise (VCSE) partners to put in place personalised care.
- Leading implementation of the NHS People Plan and people priorities in the planning guidance, with specific responsibilities from April 2022. NHSE/I also expects ICS NHS bodies to adopt a "one workforce" approach, developing shared principles across the NHS, local authorities, the VCSE sector and other partners.
- Leading system-wide action on data and digital.
- Working alongside councils to invest in local community organisations and infrastructure, ensuring the NHS contributes to social and economic development and sustainability.
- Driving joint work on estates, procurement, supply chain and commercial strategies.
- Planning for, responding to and leading recovery from incidents.
- Take on functions NHSE will be delegating including commissioning of primary care and appropriate specialised services. Specific public health functions may also be delegated.

Once an ICS NHS body has been established, NHSE/I expects that all CCG functions and duties will transfer over, including CCG assets and liabilities, such as commissioning responsibilities and contracts. NHSE/I is reviewing its own operating model, including how its functions and resources will be deployed in the context of the creation of statutory ICS NHS bodies.

NHSE/I expects the ICS NHS body's duties to include: supporting achievement of the triple aim, improving quality of service, reducing inequalities, ensuring public involvement, obtaining clinical and public health advice, promoting innovation and research, and other duties that may be defined in law.

NHSE/I will clarify in separate guidance how the statutory duties of CCGs will transition to ICS NHS bodies. NHSE/I will work with Health Education England to produce supplementary guidance and implementation support resources for ICSs on developing their strategic people capabilities.

Governance and management arrangements

This section sets out NHSE/I's expectations for ICS governance and management arrangements, with further resources to follow throughout this year. The final composition of the board and the process of appointing partner members (as described below) is subject to the parliamentary process.

The ICS NHS board

The ICS NHS body will have a unitary board, with all board members having shared corporate accountability for delivery of the functions and duties of the ICS and its performance. The board will be the senior decision-making structure for the ICS NHS body, and will be expected to facilitate finding consensus and manage areas of disagreement. The ICS NHS body should foster constructive challenge, debate and the expression of different views. If consensus cannot be agreed, the chair may make decisions on behalf of the board, and where necessary third-party intervention from NHSE/I or peer review may be needed.

The statutory minimum membership of the board will be confirmed in the legislation, but NHSE/I expects it to be comprised at least by the following roles:

- Independent non-executive directors (NEDs): This will include the chair plus a minimum of two other independent NEDs. These individuals will normally not hold positions or offices in other health and care organisations within the ICS footprint.
- Executive roles (employed by the body) This will include the chief executive, who will be the accountable officer for the funding allocations of the ICS NHS body, as well as a director of finance, director of nursing and medical director. These individuals will normally be full-time ICS employees.
- Partner members: a minimum of three additional board members, including at least:
    - One member from trusts and foundation trusts which provide services within the ICS;
    - One member from primary care providers within the ICS footprint; and
    - One member from the local authority, or authorities, with statutory social care responsibility whose area falls wholly or partly within the ICS footprint.

Partner members will be expected to bring knowledge and a perspective from their specific sectors, but not act as delegates of those sectors. NHSE/I expects the partner member(s) from trusts and local authorities will often be the chief executive of their organisation. The appointment process of partner members and rules for qualification will be set out in the constitution of the ICS NHS body. The constitution, which may also include the appointment of additional members, will need to be agreed with NHSE/I.

The framework highlights the need for the board and its committees to ensure it considers the perspectives and expertise of all relevant partners, including those across the local health and care system covering physical and mental health, primary care, community and acute services, patient and carer representatives, social care and public health, with directors of public health having an official role in the ICS NHS bodies and the ICS partnership.

NHSE/I will provide further guidance on the composition and operation of the board, which will include a draft model constitution. Additional guidance on the management of conflicting roles and interests to enable effective joint working will also be published.

Committees and decision making

NHSE/I expects ICS NHS bodies to put in place arrangements for committees and groups to advise and feed into the board and to exercise functions delegated by the board. These arrangements should also enable the involvement of clinical and professional leaders, leaders of place-based partnerships and providers, including relevant provider collaboratives.

Each board will be required to establish an audit committee and a remuneration committee. Other decision-making or advisory committees may be established by the board if they decide. It is expected that the legislation will give ICS NHS bodies flexibility in how committees are established, including how members are appointed and responsibilities delegated.

Place-based partnerships

The framework positions 'place' as central to the coordination and improvement of service planning and delivery, as well as addressing the wider determinants of health. The ICS NHS body will be expected to agree with local partners the membership and form of governance at this level, building on/complementing existing arrangements. The ICS NHS body will remain accountable for NHS resources deployed at place-level. At a minimum NHSE/I proposes that place-based partnerships should cover leadership from primary care, local authorities including directors of public health, providers across acute, community and mental health services, and representation from communities.

The framework sets out the following potential place-based governance arrangements:

- Consultative forum, informing decisions by the ICS NHS body, local authorities and others;
- Committee of the ICS NHS body with delegated authority to take decisions about the use of ICS NHS body resources;
- Joint committee of the ICS NHS body and one or more statutory provider;
- Individual directors of the ICS NHS body having delegated authority; and
- Lead provider managing resources and delivery at place under a contract with the ICS NHS body.

Supra-ICS arrangements

This section outlines functions where multiple ICS NHS bodies will need to work together to develop a shared plan across these systems. This includes, for example, the commissioning of specialised services and ambulance services. The governance arrangements to support this should be co-designed between the related providers and the ICS NHS bodies' clinical networks or alliances, and, where relevant, NHSE/I's regional teams.

Quality governance

NHSE/I sets the expectation for ICSs to build on existing quality oversight arrangements and work collaboratively with system partners to maintain and improve the quality of care. The ICS NHS body will have statutory duties to act with a view to securing continuous improvement in quality and will lead System Quality Groups (previously Quality Surveillance Groups). NHSE/I will provide support in line with the National Quality Board's guidance.

The role of providers

NHSE/I states that each ICS partnership and ICS NHS body must draw on the expertise and ambition of providers, given their critical role in the delivery, transformation, and improvement of services and outcomes within places and across and beyond systems. Trusts will be expected to work alongside system partners at place level to tailor their services to local needs and integrate pathways. They will have a role in agreeing how resources should be used and how they can best contribute to population health improvement as both service providers and as local "anchor institutions". There is flexibility in what this will look like locally and ICS NHS bodies will be expected to work with all providers to agree arrangements at different levels. In future, the ICS NHS body may delegate "commissioning" functions to providers for certain populations, which builds on the NHS-led provider collaboratives model for specialised mental health, learning disability and autism services. Trusts will increasingly be judged against their contribution to the objectives of the ICS alongside their existing duties, including delivering their agreed contribution to system financial balance.

NHSE/I also sets out the important role of primary care (including Primary Care Networks), independent sector providers and the VCSE sector in ICSs. NHSE/I expects primary care to be represented in all levels of ICS decision-making and by April 2022, the ICS will need to have a formal agreement for embedding the VCSE sector in system level governance arrangements.

Provider collaboratives

From April 2022, all trusts providing acute and/or mental health services are expected to be part of one or more provider collaborative. NHSE/I now states that community trusts, ambulance trusts and non-NHS providers should participate in these collaboratives where it makes sense for patients/the system. Provider collaboratives will be expected to agree specific objectives in line with the ICS's strategic priorities and help facilitate the work of alliances and clinical networks. The ICS NHS body and provider collaboratives will be expected to define their working relationships and governance arrangements, which will include their participation in committees through partner members as well as other local arrangements.

NHSE/I will publish additional guidance on provider collaboratives this summer.

Clinical and professional leadership

NHSE/I states that all ICSs should develop a model of distributed clinical and care professional leadership. This should build on clinical leadership within clinical commissioning groups, although the specific model will be determined by ICSs locally. Such leadership should be fully involved in decision-making, supported with sufficient resources and reflect the health, social care and VCSE sectors. ICSs will be expected to use forthcoming guidance to support a self-assessment of their clinical and professional leadership model, and implement mechanisms to measure progress and performance. The ICS NHS board will be expected to sign off a model and improvement plan.

NHSE/I will provide best practice guidance describing features of an effective professional leadership model for ICSs in due course.

Working with people and communities

The ICS will be expected to agree how to involve people and communities in developing plans and priorities. The framework reiterates seven principles for how ICSs should work with people and communities, including working with Healthwatch and the VCSE sector as key partners. The ICS NHS body should use these principles as a basis for developing a system-wide strategy for engaging with people and communities. As part of this, ICSs should develop arrangements for:

- representation on the ICS partnership and in place-based partnerships; and
- gathering intelligence about the community's experience of, and aspirations for, health and care.

NHSE/I expects there will be a legal duty for ICS NHS bodies to make arrangements to involve patients, unpaid carers and the public in planning and commissioning services.

NHSE/I will provide more information in guidance on the membership and governance of ICS NHS bodies and in the implementation support resources for how ICSs work with people and communities.

Accountability and oversight

As set out in the planning guidance for the first half of 2021/22, NHSE/I regional teams will agree the constitutions and plans of ICS NHS bodies and hold them to account for delivery through the chair and chief executive. NHSE/I clarifies that providers will continue to be accountable for the quality, safety, use of resources and compliance with standards, as well as the delivery of any services or functions commissioned from or delegated to them, including by an ICS NHS body. Executives of providers will remain accountable to their boards for the performance of functions for which their organisation is responsible. If a provider executive sits on the board of the ICS NHS body, they will also be accountable for the ICS NHS body and ensuring its functions are discharged. When acting as an ICS body board member, they must act in the interests of the ICS NHS body and the wider system, not that of their employing provider.

Approach to NHS oversight within ICSs

NHSE/I confirms that the oversight arrangements for 2022/23 will build on the final SOF, which was consulted on earlier this year and is expected to be published in the coming weeks. NHSE/I expects these arrangements to confirm ICSs' formal role in oversight, including leading oversight and support of organisations and partnership arrangements within their system. The newly formed NHSE will retain NHSE/I's statutory regulatory responsibilities, so any formal regulatory action with providers will be taken by NHSE. NHSE will work with each ICS NHS body to ensure "effective and proportionate oversight of organisations" that avoid duplication. However, the framework does not set out what the role of NHSE/I regional teams will look like or whether any functions/resources will be transferred to ICSs. NHSE/I envisages that ICS NHS bodies may over time decide to take the role of provider collaboratives and place-based partnerships into account when determining how to address issues through system oversight. CQC, NHSE/I and DHSC are working together to agree the process and roles for reviewing and assessing systems, which will aim to avoid duplication and overlap.

Financial allocations and funding flows

ICS allocations

In line with the current direction of travel, NHSE will allocate funding to each ICS NHS body, which will decide how such funds should be spent. This will include budgets for CCG-commissioned primary and secondary care, as well as running cost allowances. This may also include the allocations for NHSE functions, including primary care budgets, specialised services, national transformation funding, the Financial Recovery Fund, and funding for digital and data services. Full capital allocations will be made to the ICS NHS body, based on the outcome of the 2022/23 settlement.

Increasingly, funding will be linked to population need. Allocations will be based on supporting equal opportunity of access and contributing to the reduction of health inequalities. NHSE/I's approach will continue to be informed by the independent Advisory Committee on Resource Allocation. Allocations will be set in a way that avoids large swings in funding that would risk destabilising local health economies.

NHSE will allocate funding to ICSs taking into account the needs of their population and how quickly they move towards their target allocations. NHSE will not set allocations to place within the ICS. The ICS NHS body will have the freedom to set a delegated budget to place-based partnerships to spend ICS NHS resources, but it must focus on equal access for equal need and reduce health inequalities. The ICS NHS body should explain any variation from previous CCG budgets and enable pooling with local authority budgets.

Distribution of funds by the ICS NHS body

The ICS NHS body will agree how the allocation will be used to perform its functions, in line with its priorities. Money will flow from the ICS NHS body to providers largely through contracts for "services/outcomes", which may be managed by place-based partnerships or provider collaboratives.

In conjunction with ICS leaders, NHSE will consider supporting provider collaboratives to take on further responsibility for use of resources to deliver population health outcomes.

The ICS NHS board and chief executive will be ultimately responsible for services under delegation arrangements with place-based partnerships or through lead provider contracts.

Each ICS will have an agreed framework for collectively managing and distributing financial resources within the system's financial envelope to address the greatest need and tackle inequalities in line with

the NHS system plan, having regard to the strategies of the ICS partnership and the health and wellbeing board(s). Every ICS will be required to meet the mental health investment standard and the primary and community health services funding guarantee.

Financial and regulatory mechanisms to support collaboration

These measures build on existing financial and regulatory mechanisms to support collaboration, including system financial envelopes and changes to the SOF. NHSE/I envisages that further policy and legislative enablers will support these developments, including: a duty to collaborate; a duty on the ICS NHS body to act with a view to ensuring system financial balance and meet other financial objectives set by NHSE (this would also apply to trusts); and powers to ensure organisational spending is in line with the system capital plan.

The legislation will enable NHSE direct commissioning functions to be jointly commissioned, delegated or transferred to ICS NHS bodies as soon as they are ready to do so. Commissioning of primary medical services is currently delegated to CCGs, so will transition immediately into ICS NHS bodies when they are established.

NHSE/I will review the NHS provider licence in light of the new legislation and policy developments.

Data and digital standards and requirements

NHSE/I expects digital and data experts to have a pivotal role in ICSs. The What Good Looks Like framework is due to be published in the first quarter of 2021/22. This will set out a common vision to support ICS leaders to accelerate digital and data transformation with their partner organisations. From April 2022, ICSs will need to have smart digital and data foundations in place. ICS NHS bodies are expected to: have a named SRO with the appropriate expertise; implement a shared care record; and agree a plan for embedding population health management capabilities, among other things.

Managing the transition to statutory ICSs

In this section, NHSE/I sets out how CCG staff and functions will transfer into the ICS NHS body. This change process will be guided by NHSE/I's Employment Commitment[1] and a set of core principles, and will be managed by current ICS and CCG leadership, with increasing involvement of the new leaders who may be appointed on a shadow or designate basis, pending the legislation. Plans will be agreed with NHSE/I regional teams. NHSE/I sets out indicative outputs expected in every ICS during 2021/22, subject to legislation and other factors (including pending any potential changes to ICS boundaries).

NHSE/I will issue a set of guidance and resources to support this transition, including:

- Change and transition approach (core principles)
- Employment Commitment Guidance, including national support offer

After the legislation is introduced, NHSE/I will publish the following resources and guidance:

- HR framework (technical guidance)
- Appointments guidance for the statutory roles
- FAQs for staff
- Leadership competencies, job descriptions and proposed pay structure for ICS statutory roles.

NHS Providers view

Context

Overall, the ICS design framework begins to set out a clearer vision for how the two-part statutory ICS model – with the ICS partnership and the ICS NHS body – will operate after the enactment of the legislation. Trust leaders are fully supportive of NHSE/I's ambition to set out a coherent and flexible operating model for ICSs from April 2022. They are clear that an enabling policy and legislative framework is required for systems to design what works best for their local communities and circumstances. We will continue to engage with trust leaders to determine whether the right balance between permissiveness and clarity has been struck here, considering the implications for all trust types ranging across acute, community, mental health, ambulance and specialised.

[1] The Employment Commitment does not apply to those in senior/board level roles who may be affected by the new ICS board structure.

The framework also builds on the steps outlined in the 2021/22 implementation guidance, which set out how ICS leaders and their constituent organisations, including trusts, should prepare for new statutory arrangements in this "transition period" up to March 2022. The complexity of this endeavour should not be underestimated, as systems must prepare for legislative change without pre-empting the outcome of the Bill. The collective leadership of ICSs and their constituent organisations will also need to navigate a complex new array of policy frameworks, including adjusting to a new financial regime and oversight framework. We welcome NHSE/I's commitment to supporting the system through this coming year.

It is worth remembering that these imminent changes are taking place whilst providers remain under significant operational pressure to restore routine services affected by the pandemic, tackle the backlogs of care, and meet deferred demand across urgent and emergency care, mental health and community health services. We would strongly encourage NHSE/I to keep this context top of mind, especially in light of the expectation that ICSs will maintain momentum on improving outcomes and supporting recovery at the same time as embedding significant new planning and accountability arrangements.

Principles

We fully support NHSE/I's ambition to accelerate the current direction of system working and collaboration, and welcome the recognition of providers playing a central, leadership role in ICSs. Providers are the engine for transformation and delivery. They are responsible for employing the vast majority of NHS staff and spending the vast majority of NHS funding. However, we are increasingly concerned that the language around ICSs describes them as a separate entity to providers, rather than as genuine partnerships of all the organisations that contribute to health and care services and outcomes within the system. The model risks moving away from the founding spirit of partnership and ambitions of population health, to becoming a separate body managing those within it. This leaves the proposals vulnerable to the perception that the ICS NHS body will simply act as a larger commissioner divorced from providers, when the ICS should in fact remain a sum of its parts.

Similarly, we are also concerned that collective confidence in the ICS as currently structured could be undermined in several ways, which could hinder the opportunity and ambition of system working. For example, the founding principle of local ownership that has been central to driving improvements in collaboration and outcomes thus far could be undermined if the 'partner' members are not appointed in consultation *and agreement with* the relevant constituency. There also needs to be

parity between NHS and local authority representation. For example, if all relevant local authorities, who are already represented on the ICS NHS body by a 'partner' member, are involved in setting up the ICS partnership and selecting the chair, but no additional providers are, the ICS partnership composition could be a majority local authority decision which undermines the principle of equal partnership.

Governance

Well-functioning health and care systems need good governance and clear accountabilities. We continue to have some concerns about the proposed ICS governance arrangements:

- While we agree the board of the ICS NHS body will need to be formally accountable to NHSE/I and parliament, they should also see themselves as accountable to the communities they serve and the organisations within their footprint. NHSE/I should set this out explicitly in future guidance.
- In our view, it is crucial that non-executive directors form a majority on the board of the ICS NHS body in line with best practice drawn from all types of organisations led by unitary boards, including NHS trusts and foundation trusts. This will ensure effective challenge, risk management and assurance, which in turn will ensure the board can answer for the decisions it makes. We recommend this is explicitly defined in future guidance, rather than being locally determined as currently proposed.
- We would recommend that 'partner' members be referred to as non-executive directors drawn from the system as this would provide clarity around their status in decision making.

Given the nature of the ICS task, especially in taking decisions around contract values and funding allocations, there will likely be different views within its membership and it may legitimately be difficult to reach consensus. We welcome NHSE/I's recognition of this potential for disagreement, which we have been calling for to ensure the framework is not designed on the basis that system partners will always agree. Legitimate challenge is a sign of a healthy system. One of the core ICS tasks, as the framework acknowledges, is to manage reasoned dissent well, reconcile differences and build consensus.

Involvement of all provider types

We continue to emphasise the need for NHSE/I to ensure the views of the full range of provider types have sufficient access and input to the ICS NHS body decision-making process. We welcome the framework's statement that the board of the ICS NHS body must ensure it takes into account the perspectives and expertise of all relevant partners. We would urge NHSE/I to take this further and ensure that each ICS has a mechanism which enables the views of trusts to feed into the decision-

making process, and ensures trusts agree with the way the board of the ICS NHS body is set up and comprised, with recourse to a challenge function if they are unhappy. This parity in decision-making is absolutely critical if a collaborative approach to planning and delivering more integrated care, is to be implemented as intended.

Missed opportunities

Finally, there are a few missed opportunities in this guidance. While NHSE/I references its intention to develop its own new operating model, it remains unclear how the role of NHSE/I regional teams will change and how resources and responsibilities will be transferred to ICSs over time. This leaves the framework open to the charge that it is adding to rather than reducing bureaucracy as intended, especially in the context of the renewed emphasis on place-based partnerships and provider collaboratives.

In addition, the framework states that trusts will need to meet system financial objectives set by NHSE under the new legislation; providers will need clarity on what this will look like in practice. For example, it will be vital to know what these requirements will be, who is responsible for judging whether a provider or system is compliant, and the consequences for providers and systems for not meeting these objectives. Finally, while we understand this is an NHS-only framework, it will be important to keep wider system partners involved in this process and ensure they have buy-in within the plans and priorities of their ICS(s). This is not only important in the context of improving wider determinants of health and tackling health inequalities, but also in ensuring wider public services are fully involved at system and/or place level.

We look forward to continuing to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. We will continue to engage with our members on key proposals outlined within this new framework and ensure their views are fed back to NHSE/I.

NHS Providers press release

New ICS design framework offers clarity ahead of major reforms to health service but questions remain

Responding to the publication of a new Integrated Care System (ICS) design framework by NHSE/I, the deputy chief executive of NHS Providers, Saffron Cordery said:

"Today's ICS design framework sets out a much needed, clearer vision for how ICSs will develop further this year and how these new statutory bodies will operate when the health and care bill becomes law. We welcome the dialogue with NHSE/I throughout its development.

"The framework addresses many of the concerns outlined by our members, who fully support NHSE/I's ambition to set out a coherent, yet flexible operating model for ICSs from April 2022. Providers will particularly welcome recognition within the framework of their central, leadership role in ICSs and their commitment to delivering the best possible care for their local communities.

"But there are big challenges ahead as ICS leaders and their constituent organisations adjust to the complexities of system working.

"A key concern is that these NHS reforms- the most far reaching for nearly a decade- will take place against a challenging backdrop as trusts work to clear backlogs of care, restore routine services, and tackle pent up demand across urgent and emergency care, mental health and community health services.

"It is vital NHSE/I acknowledges the pressures and expectations trusts face as ICSs take a greater role in efforts to improve outcomes and support recovery while simultaneously embedding significant new planning and accountability arrangements.

"Trust leaders are keen to ensure ICSs remain a genuine partnership of all the organisations that contribute to local health and care services and outcomes within the system. They are increasingly concerned that the ICS model risks moving away from being a sum of its parts to a separate body managing those within it. There must be appropriate governance measures to ensure ICSs are accountable not only to NHSE/I and parliament, but also to the communities they serve and the organisations within their footprint.

"In the coming weeks and months, we will continue to work closely with senior leaders and colleagues at NHSE/I as the framework is implemented and further guidance is produced. Alongside this, we will continue to regularly consult our members on key proposals to ensure their views are reflected as this framework progresses".

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Oversight theme	NHS Long Term Plan/People Plan headline area	2021/22 Planning guidance deliverable	Measure name (metric)	CCG	Trust	ICS
Quality, access and outcomes	Restoration of elective and cancer services consultant-led treatment	Maximise elective activity, taking full advantage of the opportunities to transform the delivery of services Elective activity levels	Elective activity levels	✓	✓	✓
			Overall size of the waiting list	✓	✓	✓
			Patients waiting more than 52 weeks to start consultant-led treatment	✓	✓	✓
	Mental health	Meet the MHIS and use the investment to grow the workforce and deliver transformation of care	Delivery of the mental health investment standard	✓		✓
		Deliver the mental health ambitions outlined in the NHS Long Term Plan, expanding and transforming core mental health services	NHS Long Term Plan metrics for mental health	✓	✓	✓
	Delivering safe, high quality care overall		Summary hospital-level mortality indicator		✓	
			Overall CQC rating (provision of high-quality care)		✓	
			Acting to improve safety (safety culture theme in NHS Staff survey)		✓	
			Potential under-reporting of patient safety incidents		✓	
			National Patient Safety Alerts not completed by deadline		✓	
			Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate		✓	
			Clostridium difficile infection rate		✓	
			E. coli bloodstream infections		✓	
			Venous thromboembolism (VTE) risk assessment		✓	
Preventing ill health and reducing inequalities	Screening and vaccination programmes meet base levels in the public health agreement or national goals	Flu vaccination	Number of people receiving flu vaccination		✓	
	Reducing inequalities	Restoring NHS services inclusively	Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	✓	✓	✓
		Ensuring datasets are complete and timely	Proportions of patient activities with an ethnicity code	✓	✓	✓
Leadership and capability	Leadership	Quality of leadership†	Quality of leadership†	✓	✓	✓
		Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	Aggregate score for NHS Staff Survey questions that measure perception of leadership culture††	✓	✓	✓
People	People promise index	Supporting the health and wellbeing of staff and taking action on recruitment and retention	People promise index	✓	✓	✓
	Looking after our people		Health and wellbeing index††	✓	✓	✓
			Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers, (b) other colleagues, (c) patients/ service users, their relatives or other members of the public in the last 12 months	✓	✓	✓
			Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	✓	✓	✓
			Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	✓	✓	✓
			% of jobs advertised as flexible	✓	✓	✓
			Staff retention rate (all staff)	✓	✓	✓
			Sickness absence (working days lost to sickness)	✓	✓	✓
			Proportion of staff who say they have a positive experience of engagement	✓	✓	✓
			Number of people working in the NHS who have had a 'flu vaccination	✓	✓	✓
	Belonging in the NHS		Proportion of staff in senior leadership roles who are (a) from a BME background, (b) women	✓	✓	✓
			Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age	✓	✓	✓
	Growing for the future		Number of registered nurses employed by the NHS (WTE)			✓
			Additional primary care WTE through ARRS	✓		✓
			Number of healthcare support workers employed by the NHS			✓
			Mental health workforce growth	✓		✓
Finance and use of resources	The NHS will return to financial balance: NHS in overall financial balance each year	Systems to manage within financial envelopes	Performance against financial plan	✓	✓	✓
			Underlying financial position	✓	✓	✓
			Run rate expenditure	✓	✓	✓
			Overall trend in reported financial position	✓	✓	✓

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 July 2021
Title	Financial Summary Report May 2021
Purpose	To provide the Trust Board the financial position for the period ending 31 May 2021
Business Area	Finance
Author	**Paul Gray, Acting 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	The Trust is reporting a surplus of £1m to the end of May 2021, £0.6m better than planned. The financial plan for H1 (April – September) has been amended to reflect the final plan submission to NHSE/I on the 22nd June, with the Trust planning for breakeven during this period. The amended plan reflects assumed system allocated Elective Recovery Income and increased revenue costs following the review of planned capital spend. Cash balances remains strong at £39.7m Planned capital expenditure has been reduced in line with the agreed Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System allocation. Spend overall is £0.2m, £0.6m behind plan.
ACTION REQUIRED	The Board is invited to note the report.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year Ending 2021/22

May 2021

Purpose

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

Version	*Date*	*Author*	*Comments*
1.0	22/06/2021	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Contents

1.0 Income & Expenditure

M2 May 2020	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	H1 Plan £'m
Operating Income	23.6	23.5	0.0	47.1	47.1	(0.0)	143.8
Elective Recovery Funding	0.0	0.0	0.0	0.0	0.0	0.0	3.4
Deficit Support	0.5	0.5	0.0	1.0	1.0	0.0	3.1
COVID Funding	0.8	0.8	0.0	1.6	1.6	0.0	4.8
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	***24.9***	***24.9***	***0.1***	***49.7***	***49.7***	***(0.0)***	***155.2***
Staff In Post	15.7	16.2	(0.5)	31.3	32.0	(0.7)	100.2
Bank Spend	1.5	1.4	0.1	3.1	3.1	0.0	8.7
Agency Spend	0.4	0.2	0.1	0.8	0.5	0.3	1.4
Total Pay	***17.6***	***17.8***	***(0.2)***	***35.2***	***35.6***	***(0.4)***	***110.3***
Purchase of Healthcare	1.8	1.7	0.1	3.3	3.2	0.2	9.7
Drugs	0.5	0.3	0.1	0.9	0.7	0.3	2.0
Premises	1.4	1.5	(0.0)	2.8	2.9	(0.2)	10.8
Other Non Pay	1.6	1.8	(0.3)	3.2	3.7	(0.5)	12.4
PFI Lease	0.5	0.5	(0.0)	1.1	1.1	0.0	3.2
Total Non Pay	***5.8***	***5.8***	***(0.0)***	***11.3***	***11.6***	***(0.2)***	***38.1***
Total Operating Costs	***23.4***	***23.7***	***(0.3)***	***46.5***	***47.2***	***(0.6)***	***148.4***
EBITDA	***1.5***	***1.2***	***0.3***	***3.2***	***2.6***	***0.6***	***6.8***
Interest (Net)	0.3	0.3	0.0	0.7	0.7	0.0	2.0
Depreciation	0.7	0.7	(0.0)	1.4	1.4	(0.0)	4.1
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.1	0.1	0.0	0.2	0.2	0.0	0.7
Total Financing	***1.1***	***1.1***	***(0.0)***	***2.2***	***2.2***	***(0.0)***	***6.7***
Reported Surplus/ (Deficit)	***0.4***	***0.1***	***0.3***	***1.0***	***0.3***	***0.6***	***0.0***

Key Messages

The table above illustrates financial performance against our plan for H1 (Q1 and Q2) 21/22.

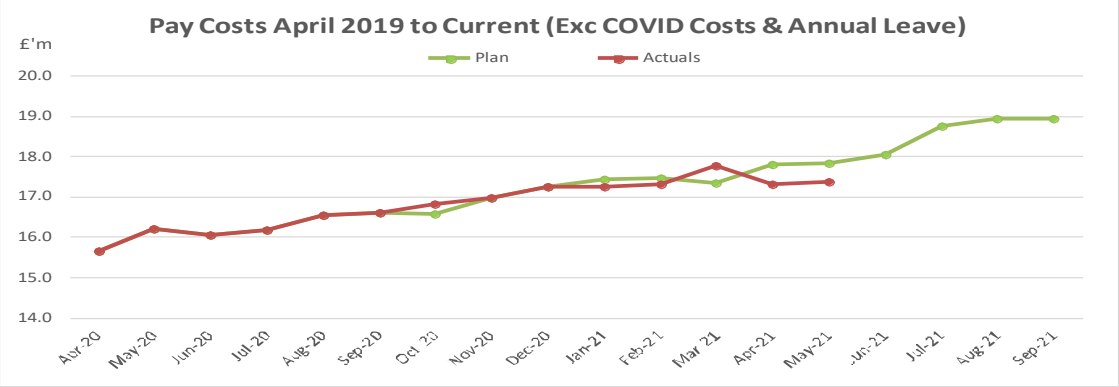
The plan reflects our agreed System Contribution for the period. The plan has been updated to reflect the latest submission to NHSE/I on the 22nd June and the final BOB ICS system financial submission. The changes include assumptions on additional system Elective Recovery Income to be allocated and offsetting increases in expenditure.

Elective Recovery Income has not been reported YTD due to NHSE revising our activity baseline at the end of May. This is been validated and the resultant benefit earned will feed into system ERF funding allocations from June.

The Trust reported a surplus in May of £0.4m, increasing the YTD surplus to £1.0m. This is £0.3m higher than anticipated and predominantly reflects pace of staff growth being slower that assumed in our plan and reducing COVID costs.

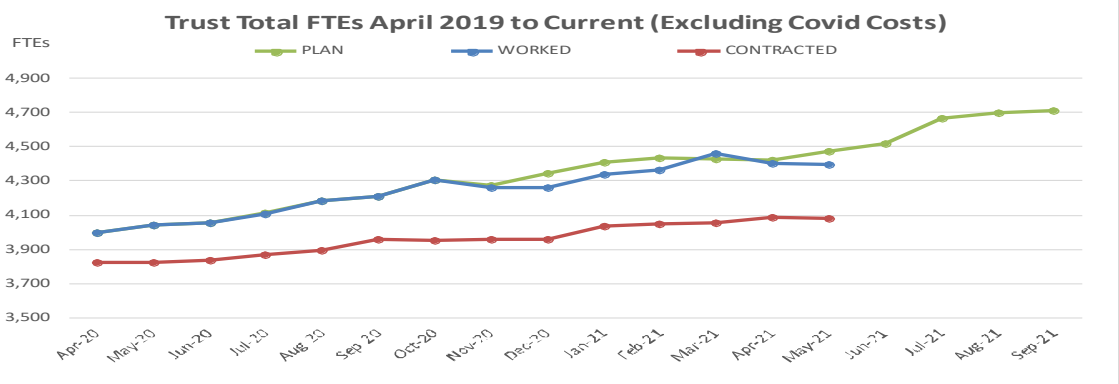
Although there has been a small increase in staffing costs, contracted and worked hours fell in May. It is crucial that we increase recruitment over the coming months in order to keep pace with the level of investment reflected in this years settlement into both Community and Mental Health Services.

Workforce



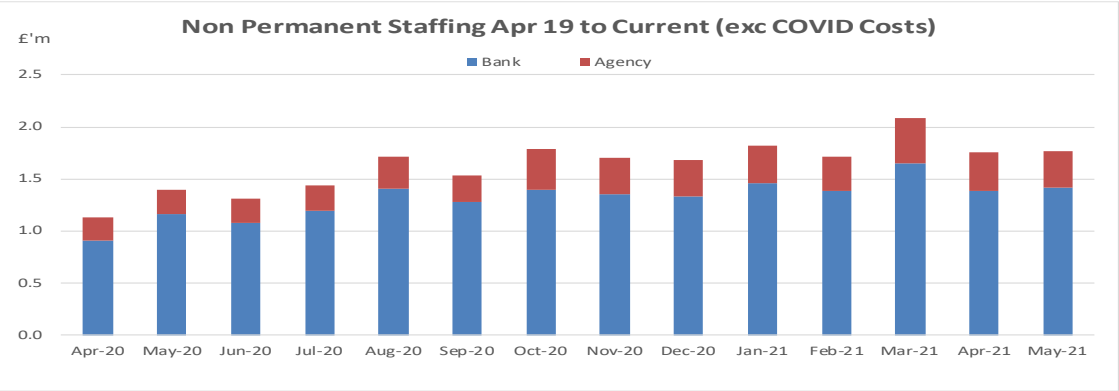
Staff Costs

YTD	£'m
2021/22	34.7
2020/21	31.8
▲	9%
Prior Yr	**£'m**
May-21	17.4
May-20	16.2
▲	7%



FTEs

Prior Mth	CFTE	WFTE
May-21	4,075	4,393
Apr-21	4,083	4,401
	0% ▲	0% ▼
Prior Yr	**CFTE**	**WFTE**
May-21	4,075	4,393
May-20	3,818	4,036
	7% ▲	9% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2021/22	1.4	0.4
2020/21	0.9	0.2
	53% ▲	61% ▲
Prior Yr	**Bank £'m**	**Agency £'m**
May-21	1.4	0.4
May-20	1.2	0.2
	21% ▲	57% ▲

Key Messages

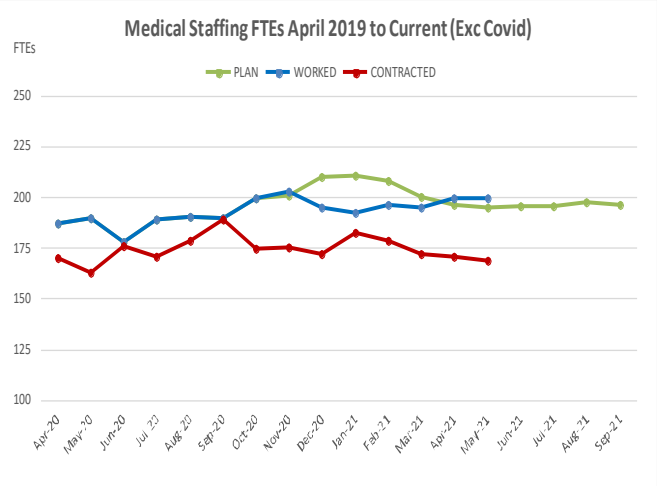
Overall Pay costs were £17.6m, comparable to costs incurred in April.

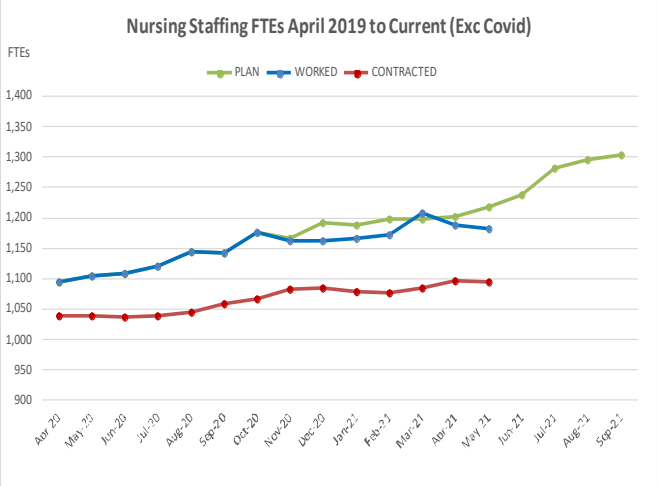
Substantive Pay costs rose by £50k overall, with the increase being attributable to bank holiday enhancements. Contracted staffing numbers fell by 8 FTE with a corresponding reduction in worked hours. Recruitment has commenced into services where investment has been planned, however it remains unclear if the increase in staffing will match the level of investment and align to plan phasing. This in part will be impacted by the level of internal appointments in these new roles.

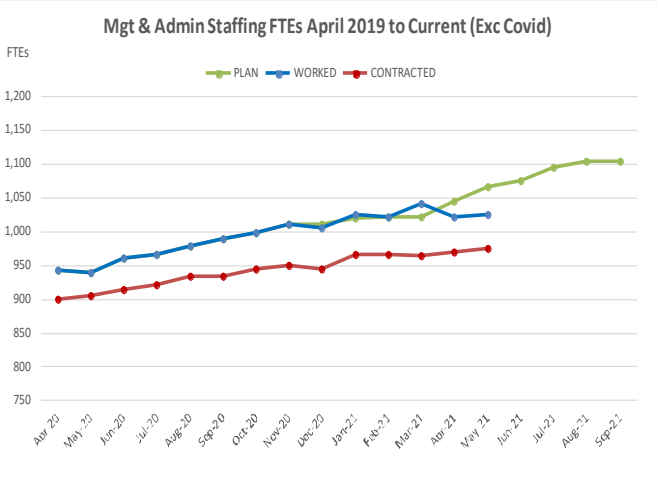
The level of staffing costs attributable to COVID has decreased to £0.2m with funding focused on new service requirements and enhancements arising from the pandemic. Sickness and shielding's costs were <£25k in the May and at their lowest levels since the start of the pandemic.

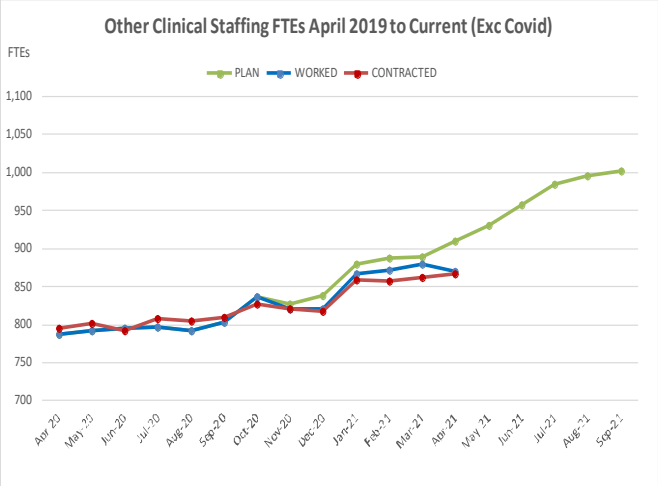
Non Permanent staffing cost fell by £0.1m, with fewer agency shifts being worked in May. Reductions were seen across all staffing groups. Although bank costs remained on par with April, reduction in Nursing usages was offset by increase Medical staffing costs in WestCall.

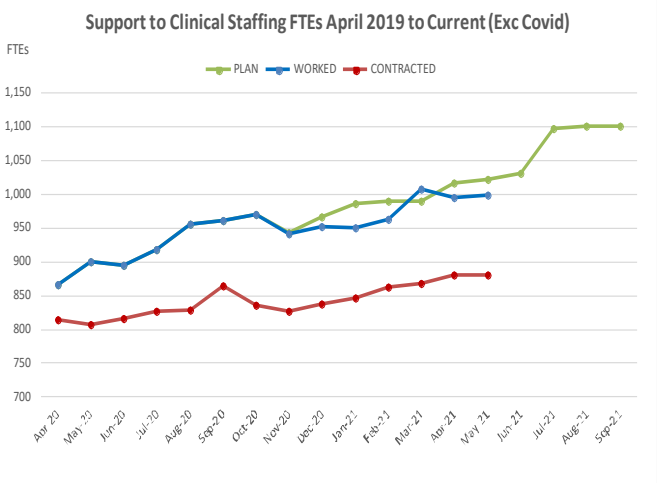
Staffing Detailed

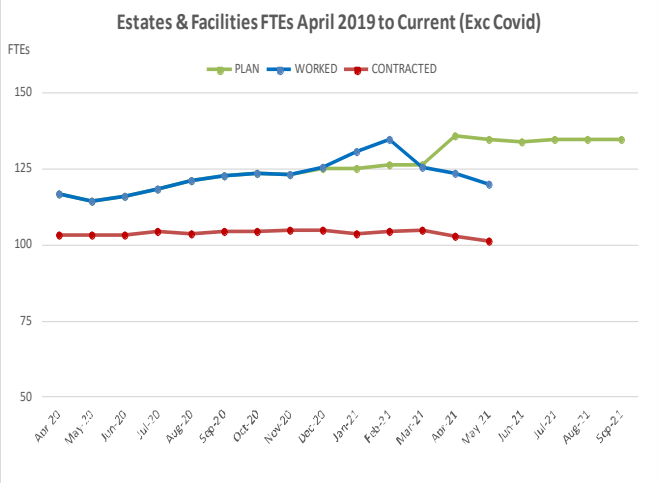










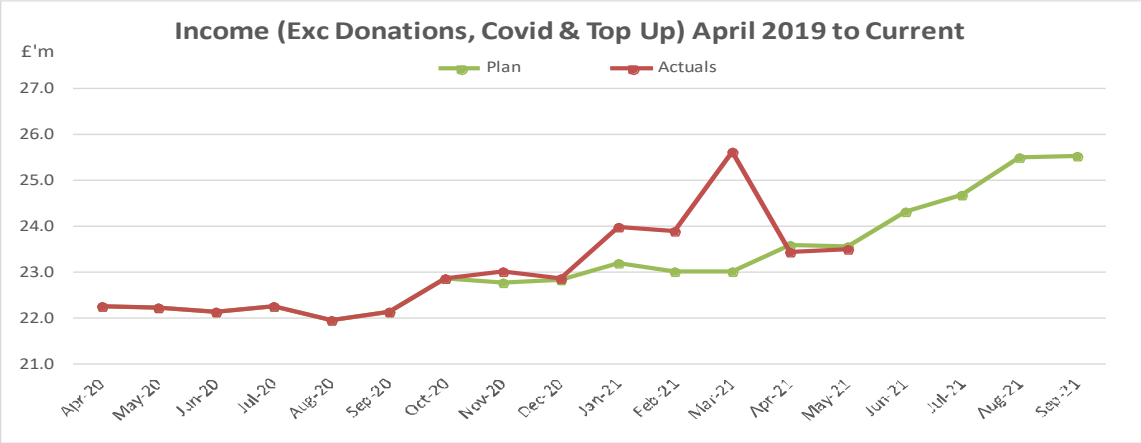


Key Messages

The tables above provide illustrate current staffing number broken down into core staffing groups. The planned levels reflects assumptions on underlying recruitment, as well as expectation of staffing increases funded through commissioner investment. Some CCG investments are still to be agreed and actual staff groups recruited may differ to plan.

There were small decreases in Medical contracted numbers, although additional hours worked in WestCall maintained the overall level of hours worked. Estates and Facilities staffing numbers have fallen for the second month, which will continued to be monitored given the planned transfer of services to NHSPS in October.

Income & Non Pay



Income

YTD	£'m
2021/22	47.1
2020/21	44.4
▲	6%

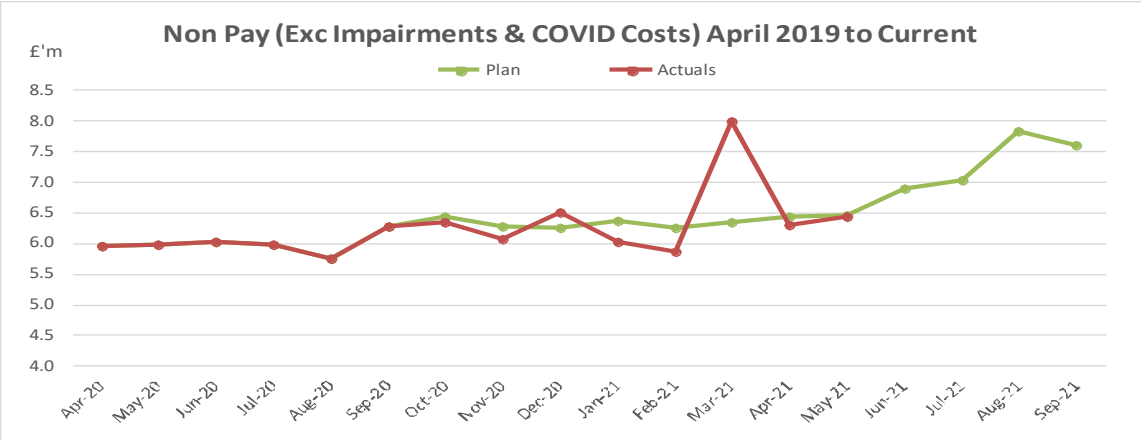
Prior Yr	£'m
May-21	23.6
May-20	22.2
▲	6%

Key Messages

The income plan, above, reflect the latest view of agreed block contracts for H1, but excludes our agreed £4.8m COVID allocation and £3.1m deficit support. Key investment income, including Service Development Funding and Spending Review Funding is assumed to be release from Q2 to offset planned increased in cost.

Across BOB, we are working to agree the mechanism and prioritisation for distribution of Elective Recovery Funding (ERF) earned by the system. The plan has been adjusted to reflect assumed allocations at this stage.

The income YTD remains inline with plan based on agreed block values with commissioners.



Non Pay

YTD	£'m
2021/22	12.7
2020/21	11.9
▲	6%

Prior Yr	£'m
May-21	6.4
May-20	6.0
▲	7%

Key Messages

Non Pay spend overall was £6.8m, £0.3m below plan in month. This includes £0.4m of costs which continues to be funded via COVID allocations. This month's underspend increases the YTD underspend to £0.6m.

Average OAP usage increased in May, with average usage over the month at 24 beds, a 110% increase on April. This increased costs by £0.2m to £0.6m, with total costs YTD now standing at £1.0m. Whilst we are utilising COVID funding to mitigate the impact of this cost, we are also working to reduce the usage in line with agreed trajectories.

2.0 Balance Sheet and Cash

Balance Sheet	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	5.4	5.0	5.0	0.0	5.0	5.0	0.0
Property, Plant & Equipment (non PFI)	38.4	37.8	37.8	0.0	37.8	37.8	0.0
Property, Plant & Equipment (PFI)	55.5	55.3	55.3	0.0	55.3	55.3	0.0
Total Non Current Assets	**99.3**	**98.1**	**98.1**	**0.0**	**98.1**	**98.1**	**0.0**
Trade Receivables & Accruals	13.9	12.8	12.8	0.0	12.8	12.8	0.0
Other Receivables	0.2	0.1	0.1	0.0	0.1	0.1	0.0
Cash	39.1	39.7	39.7	0.0	39.7	39.7	0.0
Trade Payables & Accruals	(34.5)	(29.9)	(29.9)	0.0	(29.9)	(29.9)	0.0
Current PFI Finance Lease	(1.6)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0
Other Current Payables	(6.1)	(8.5)	(8.5)	0.0	(8.5)	(8.5)	0.0
Total Net Current Assets / (Liabilities)	**10.9**	**12.6**	**12.6**	**0.0**	**12.6**	**12.6**	**0.0**
Non Current PFI Finance Lease	(25.5)	(25.2)	(25.2)	0.0	(25.2)	(25.2)	0.0
Other Non Current Payables	(2.8)	(2.5)	(2.5)	0.0	(2.5)	(2.5)	0.0
Total Net Assets	***82.0***	***83.0***	***83.0***	***0.0***	***83.0***	***83.0***	***0.0***
Income & Expenditure Reserve	30.6	31.0	31.0	0.0	31.0	31.0	0.0
Public Dividend Capital Reserve	20.0	20.0	20.0	0.0	20.0	20.0	0.0
Revaluation Reserve	31.4	32.0	32.0	0.0	32.0	32.0	0.0
Total Taxpayers Equity	***82.0***	***83.0***	***83.0***	***0.0***	***83.0***	***83.0***	***0.0***

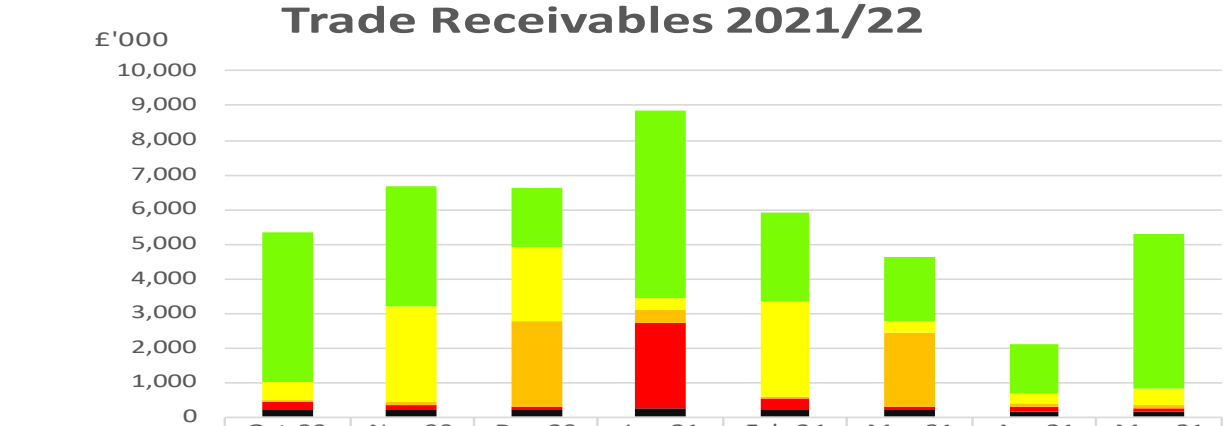
Cashflow	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Operating Surplus/(Deficit)	4.9	0.9	0.9	0.0	1.9	1.9	0.0
Depreciation and Impairments	10.3	0.7	0.7	0.0	1.4	1.4	0.0
Operating Cashflow	***15.2***	***1.5***	***1.5***	***0.0***	***3.2***	***3.2***	***0.0***
Net Working Capital Movements	***11.0***	***(1.6)***	***(1.6)***	***0.0***	***(0.3)***	***(0.3)***	***0.0***
Proceeds from Disposals	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)
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(7.9)	(0.2)	(0.2)	0.0	(1.4)	(1.4)	0.0
Investments	***(7.9)***	***(0.2)***	***(0.2)***	***0.0***	***(1.5)***	***(1.4)***	***(0.0)***
PFI Finance Lease Repayment	(1.5)	(0.1)	(0.1)	0.0	(0.3)	(0.3)	0.0
Net Interest	(4.0)	(0.3)	(0.3)	0.0	(0.7)	(0.7)	0.0
PDC Received	0.8	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends Paid	(1.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0
Financing Costs	***(5.7)***	***(0.5)***	***(0.5)***	***0.0***	***(0.9)***	***(0.9)***	***0.0***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***12.7***	***(0.7)***	***(0.7)***	***0.0***	***0.6***	***0.6***	***(0.0)***
Opening Cash	26.4	40.3	40.3	0.0	39.1	39.1	0.0
Closing Cash	***39.1***	***39.7***	***39.7***	***0.0***	***39.7***	***39.7***	***(0.0)***

Key Messages

The closing cash balance for May was £39.7m. The Trust continues to report a strong cash balance and expects to retain this over the first two quarters of the year, given we are planning for revenue breakeven and revised capital spend is planned to be inline with depreciation funding.

With the final plan submission made and capital allocations agreed, the balance sheet and cashflow plans will be final-ised for H1 and reported back to committees in July.

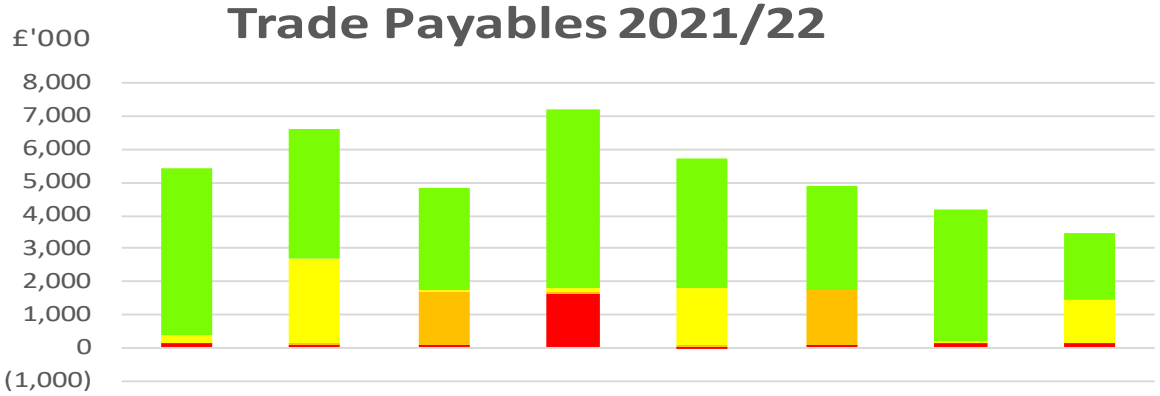
Cash Management



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
<30 Days	4,337	3,482	1,701	5,432	2,597	1,845	1,413	4,488
>30 <60 Days	518	2,789	2,143	315	2,752	327	316	472
>60 <90 Days	59	70	2,489	378	29	2,159	73	77
>90 < 180 Days	204	132	80	2,492	333	112	131	124
>180 Days	219	217	191	247	218	184	163	139

Key Messages

Overall debtors balances increased by £3.2m, with £2.2m relates to the most recent NHS Property Services charge. Balances over 60 days remained at the similar low level to prior month. The largest balances remaining over 60 days are with NHS Property Services (£0.1m), Royal Berkshire (£0.06m) and Wokingham Borough Council (£0.06m) and combined remaining CCG debt of £0.04m. We continue to pursue for settlement and do not consider the balances to be at risk.



	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
<30 Days	5,030	3,907	3,106	5,450	3,902	3,133	3,976	2,070
>30 <60 Days	236	2,576	64	95	1,710	29	88	1,266
>60 <90 Days	42	77	1,563	61	97	1,632	12	54
>90 days	124	51	95	1,622	(13)	90	109	111

Key Messages

Overall Creditors decreased by £0.7m, mainly due to decrease in current balances by £1.9m. This was offset by increase in 30 to 60 days balances by £1.2m, which includes reciprocal payment with NHS Property Services of £1.2m.

The remaining main balance over 60 days remain at historically low levels.

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							
Trusr Owned Properties	8	5	3	1	10	(9)	135
Leased Non Commercial (NHSPS)	6	20	(14)	3	40	(37)	370
Head Office Relocation	0	0	0	0	0	0	800
Erlegh House Leasehold Improvement - Atrium Works	0	2	(2)	1	4	(3)	135
Wokingham Willow House Projects	11	0	11	16	0	16	950
Environment & Sustainability	0	6	(6)	0	12	(12)	49
Various All Sites	0	11	(11)	0	22	(22)	130
Statutory Compliance	0	55	(55)	3	110	(107)	240
Subtotal Estates Maintenance & Replacement	**26**	**99**	**(73)**	**24**	**198**	**(174)**	**2,809**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	13	0	13	(0)	0	(0)	0
IM&T Refresh & Replacement	6	0	6	11	0	11	2,015
IM&T System & Network Developments	67	33	34	68	76	(8)	556
IM&T GDE & Community Projects	42	71	(29)	57	143	(86)	465
Subtotal IM&T Expenditure	**128**	**104**	**24**	**135**	**219**	**(83)**	**3,036**
Subtotal CapEx Within Control Total	**154**	**203**	**(49)**	**159**	**417**	**(258)**	**5,845**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	72	44	28	76	88	(12)	131
PPH Fire Doors	(0)	39	(39)	0	78	(78)	116
PPH Place of Safety	0	25	(25)	0	50	(50)	200
PPH Zonal Heating Controls	0	0	0	0	0	0	350
PPH Ward Bedroom Door Mechanisms	0	53	(53)	0	106	(106)	320
Service change/redesign (not included in ICH)	0	3	(3)	0	6	(6)	200
Other PFI projects	(0)	54	(54)	(0)	108	(108)	751
Subtotal Capex Outside of Control Totals	**72**	**218**	**(146)**	**76**	**436**	**(360)**	**2,068**
Total Capital Expenditure	**226**	**421**	**(195)**	**235**	**853**	**(618)**	**7,913**

Key Messages

The capital plan presented in the table reflects the final plan submitted on the 22nd June. All providers across BOB have now submitted plans which collectively align to the system capital allocation. The Trust has agreed to a capital allocation of £5.9m, in addition to the £2.0m of spend outside of system control total, with the overall plan being £7.9m.

The delay in agreeing the 21/22 capital plan has contributed to slippage, with the funding uncertainty delaying the commencement of some projects. Overall YTD spend is £0.6m behind our original plan.

IM&T is underspend by £0.1m YTD with spend on GDE related projects delayed, including Community Electronic Prescribing , which has been impacted by resources allocated to Covid testing.

Spend against PFI schemes is £0.4m behind plan,. The Fire Door replacement programme is now expected to be completed in June. The new door locking mechanisms, flagged as a requirement by CQC, have now been approved so expect spend to commence imminently.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	13th July 2021
Title	**True North Performance Scorecard** **Month 2 (May 2021) 2021/22**
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2021/22.
Business Area	Trust-wide Performance
Author	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 Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 2, 2021/22 (May 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 2** **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 28 against a target of 20. Red for 7 months. Donnington (7) and Oakwood (8) wards were the highest contributors. Existing countermeasures are in place, but additional measures are being implemented: o Donnington – 6 out of the 7 falls occurred overnight. Guardian sentry system planned for installation in July. o Oakwood – specific falls reduction for staff, considering ward layout and optimizing time to respond to an alarm. o Wokingham – reviewing data from guardian sentry system including looking at targeted interventions and patient specific countermeasures. Sharing joint assessment work completed. o Other areas – shared learning with RBH. Falls reduction and management

	policy for patients updated. Standard work being developed for community inpatients. • Mental Health Clustering **(Patient Experience)** - at 73.5% 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. Action plans are in place to improve this metric. • Physical assaults on staff **(Supporting our Staff)** – at 66 incidents against a target of 44. Sorrell (14), Daisy (12), Snowdrop (9) and Rose (9) wards were the highest contributors this month. There were a higher number of incidents in non-Mental Health wards with challenging patients on Highclere ward and confused patients on Donnington ward. Existing countermeasures remain in place. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** at 50 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 with the Benchmarking network about Length of Stay in Mental Health acute wards of patients with a stay of over 90 days. An improvement project is underway. **Tracker Metrics (where red for 4 months or more)** • Statutory Training: Fire **(Supporting our Staff)** Increased to 91.5% – focusing assurance on ward environments. The scores for all wards was at 94.1% against a 95% target. Daisy (74.2%) and Snowdrop (75%) wards have the lowest figures. The introduction of a new eLearning solution is expected to improve compliance. • Mental Health: 7-Day Follow-up (Quality Domain) **(Regulatory Compliance)** – red at 91.2% against a target of 95%. Five breaches took this below target with the majority in the west. Processes are being reviewed.
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	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	8	16	25	17	17	22	24	46	26	34	37	28
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	37	41	40	57	67	76	46	110	127	177	76	39
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	1	0	0	1	0	0	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	1	1	1	1	4	3	1	1	4	3	2	1
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	1

Patient Experience

Patient FFT Recommend Rate: % [Suspended centrally due to COVID]	95% compliance						87%	78%	85%	88%	93%	90%	92%
Patient FTT response rate: % [Suspended centrally due to COVID]	15% compliance						87%	4%	3%	6%	5%	5%	5%
Mental Health Clustering within target: %	80% compliance	83.8%	83.7%	82.7%	81.5%	81.7%	80.9%	78.5%	75.7%	76.2%	74.9%	73.9%	73.5%

Performance Scorecard - True North Drivers (May 2021)

Supporting our Staff

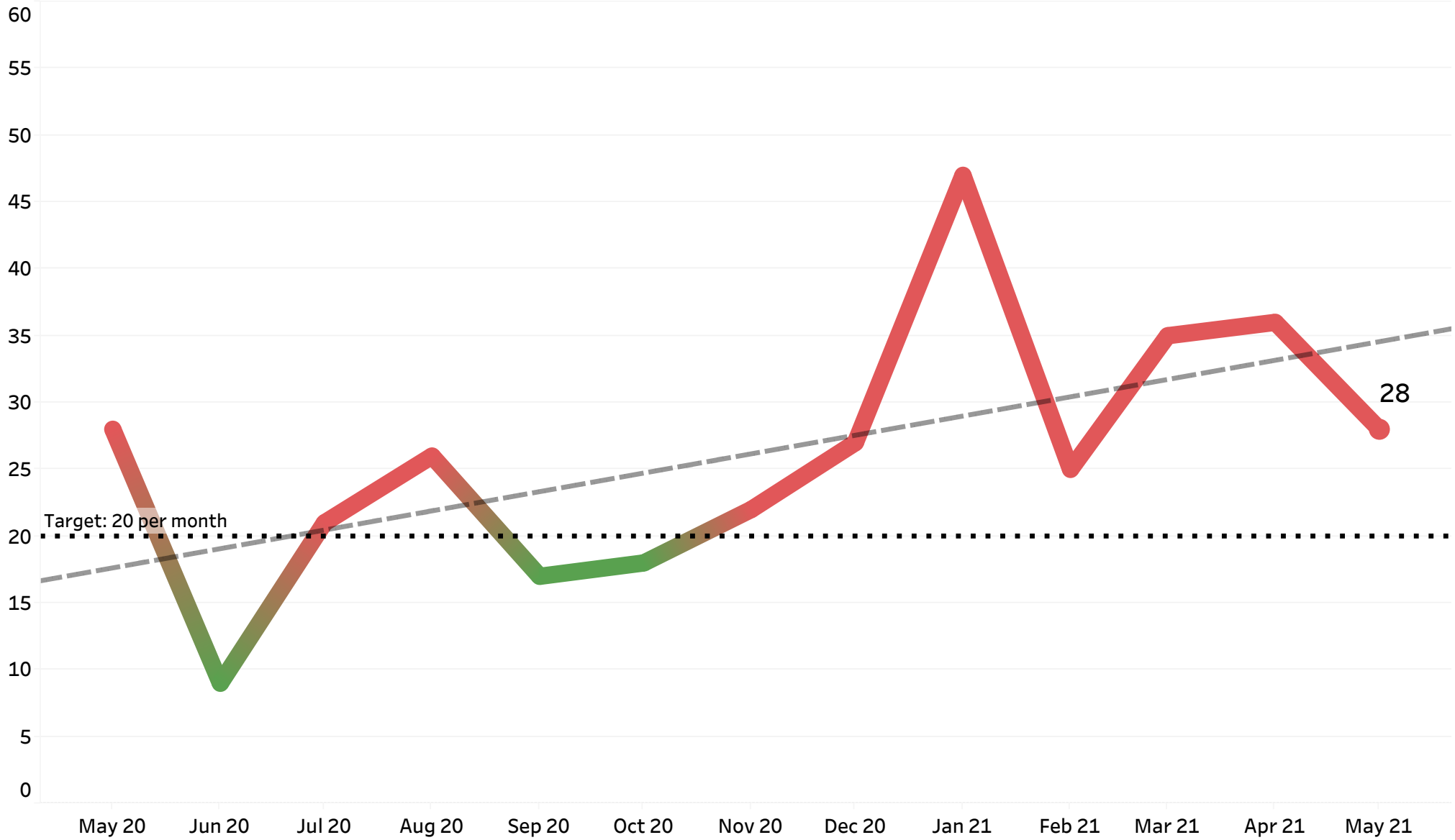
Metric	Target	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Physical Assaults on Staff	44 per month	34	53	51	26	34	44	73	58	52	54	54	66
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.40	7.5	7.5	7.5	7.5

Money Matters

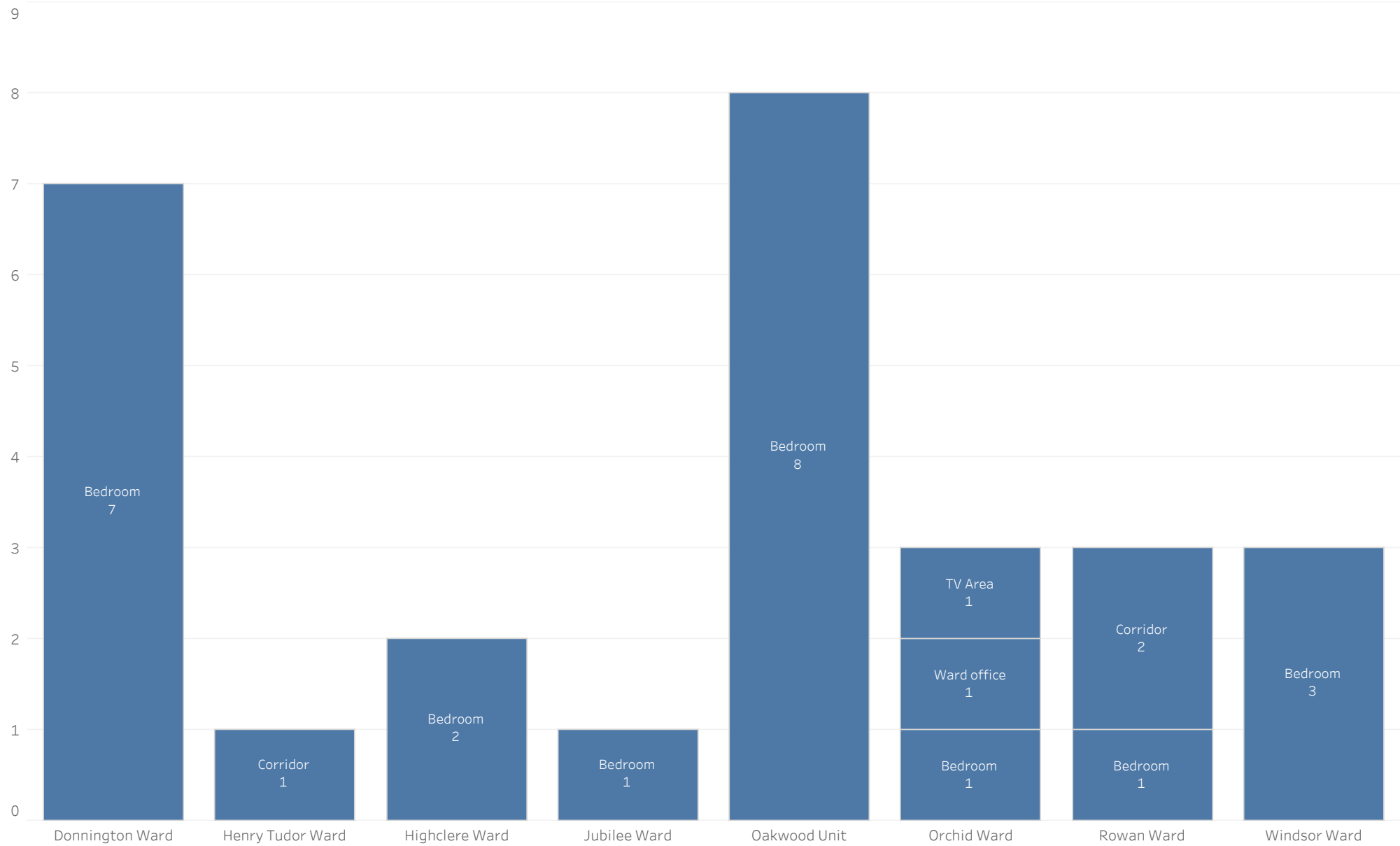
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)												
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]	-£0.4m												
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	92.1%	92.2%	97.2%	92.6%	90.6%	90.5%	91.8%	83.3%	86.1%	91.9%	97.4%	97.6%
Mental Health: Acute Average Length of Stay (bed days)	30 days	37	36	47	40	43	43	46	45	42	46	47	50
Staff turnover (excluding fixed term posts)	<16% per month	13.9%	13.4%	13.3%	13.9%	13.8%	13.7%	13.1%	13.1%	13.1%	12.4%	12.5%	12.4%
Staff turnover (including fixed-term posts)	<16% per month	15.6%	15.3%	15.9%	17.1%	16.9%	16.9%	16.4%	15.4%	15.4%	14.7%	14.7%	14.6%
Inappropriate Out of Area Placements	960 Cumulative Total Q1 400 Month 1, 320 Month 2..	77	148	312	418	164	338	681	421	844	1,045	180	607

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

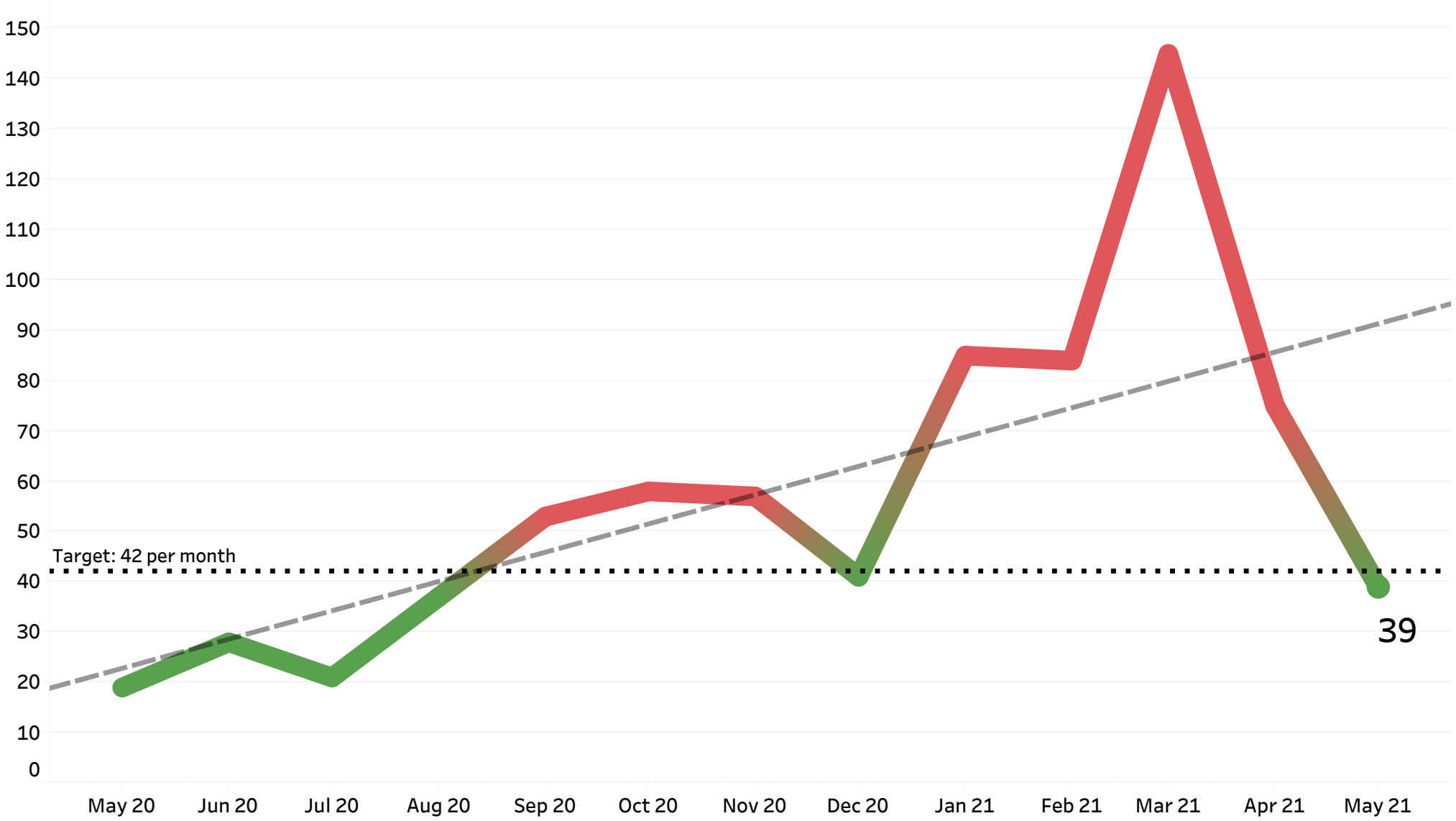


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (May 21)

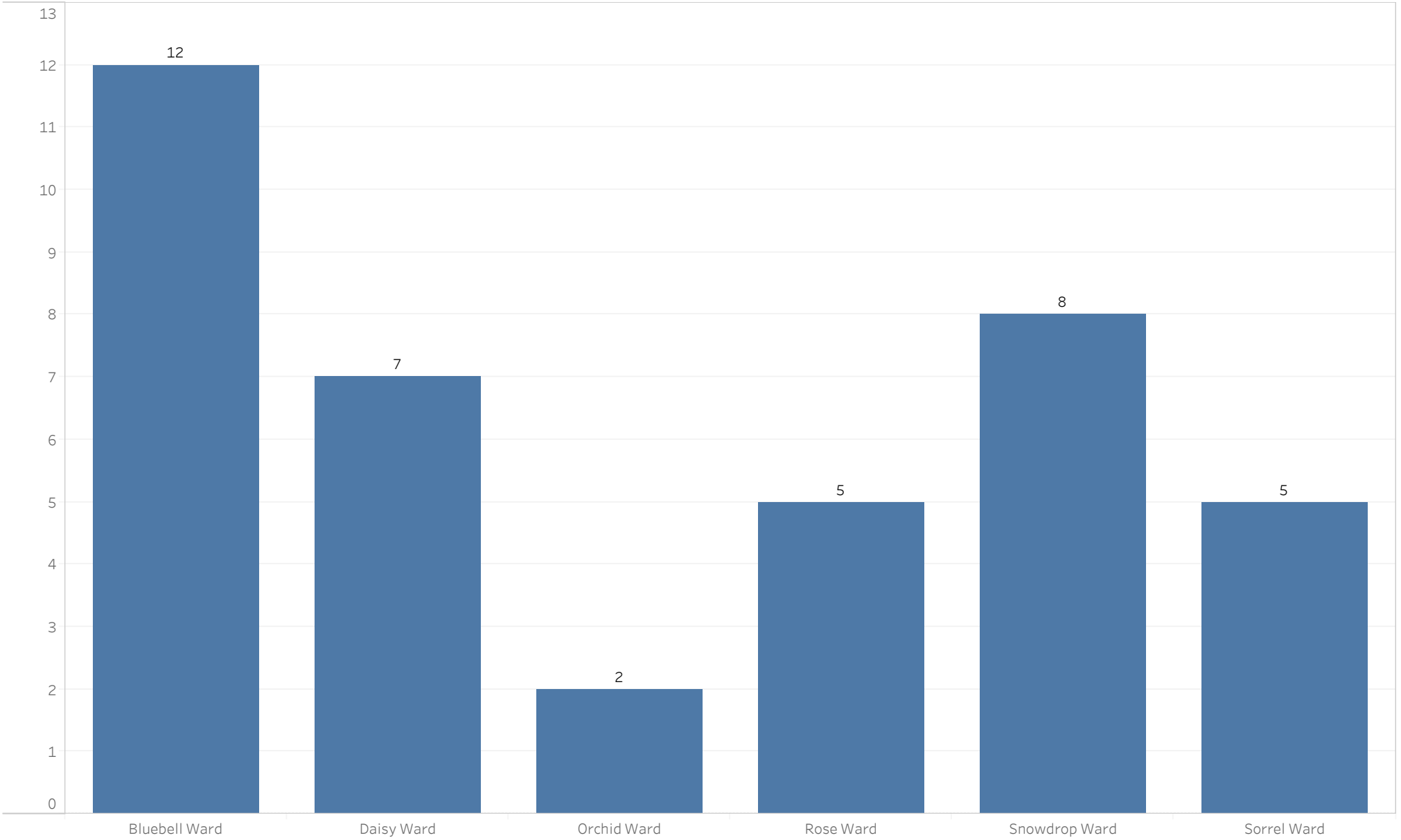


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (May 20 to May 21)

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

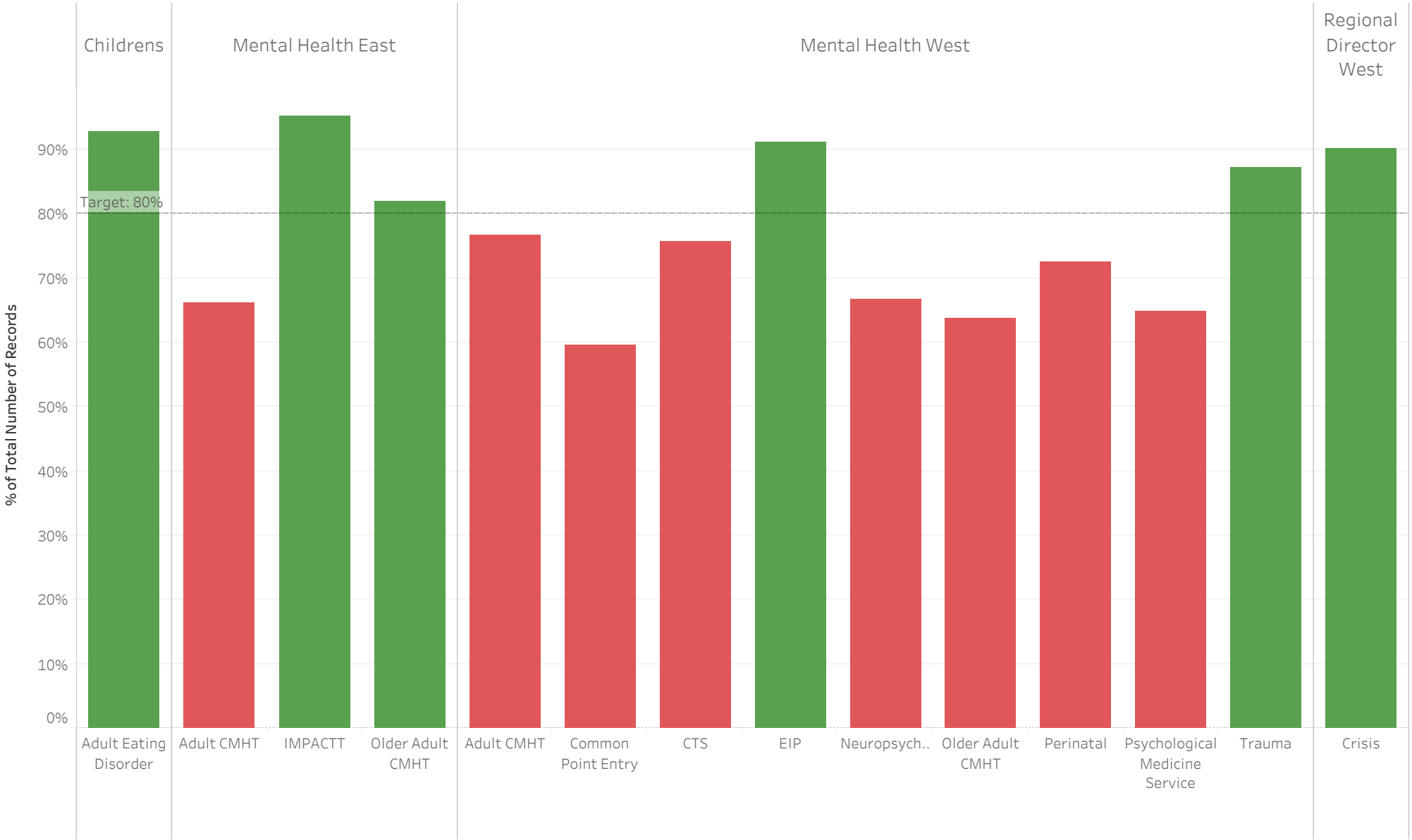


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (May 21)



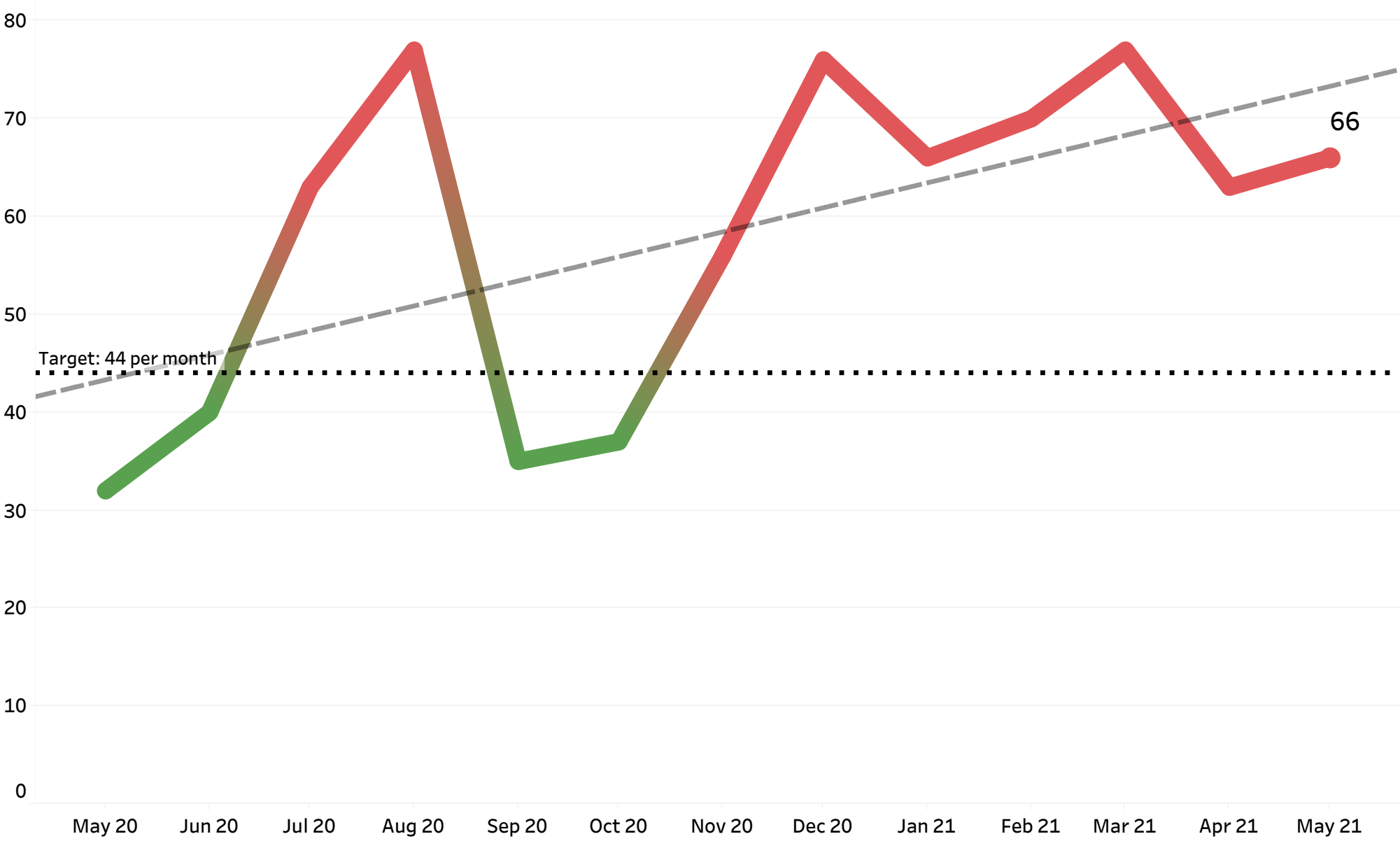
Patient Experience: Clustering breakdown (May 2021)

Outpatient Cluster Status (by Service)

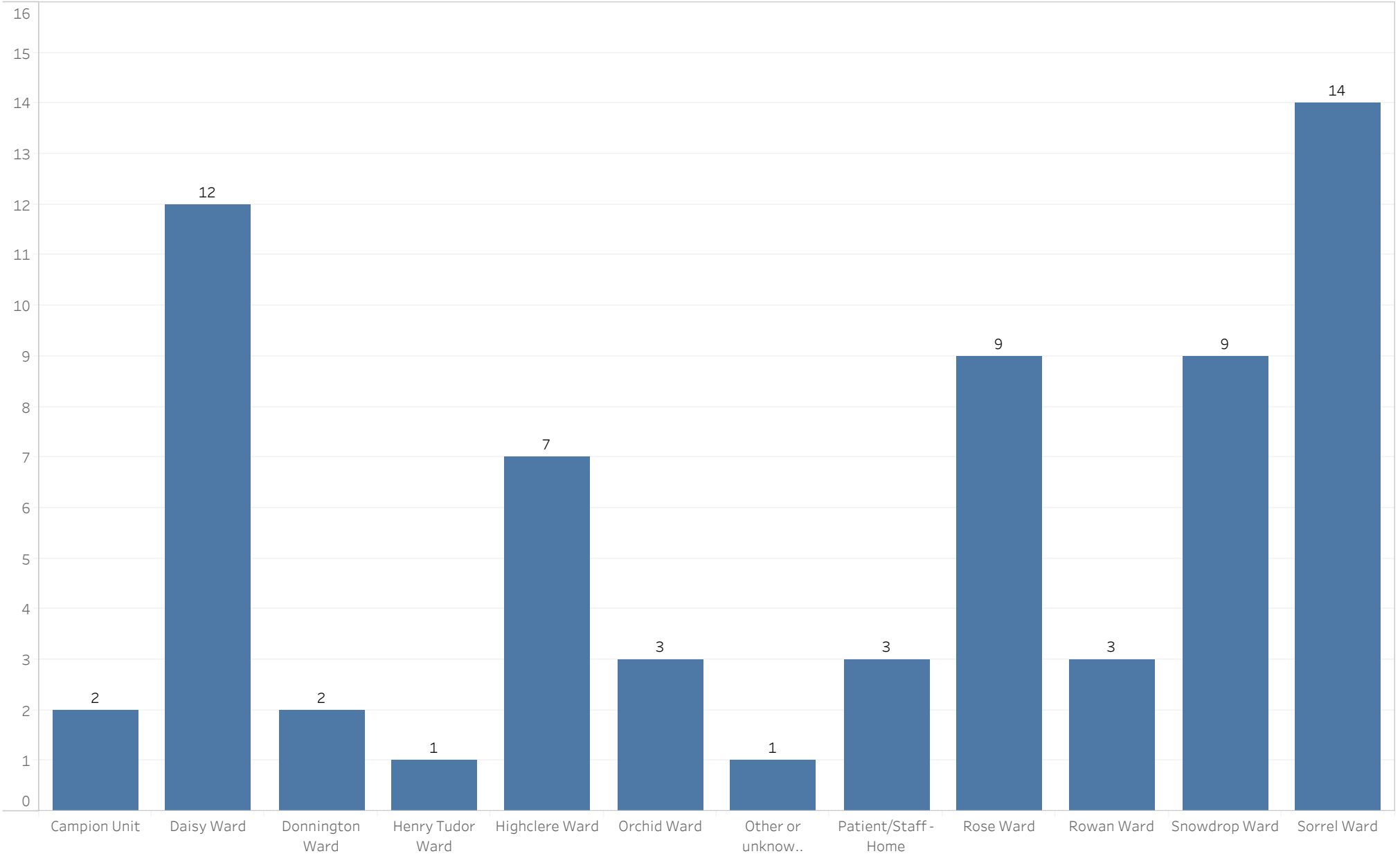


Supporting Our Staff Driver: Physical Assaults on Staff (May 20 to May 21)

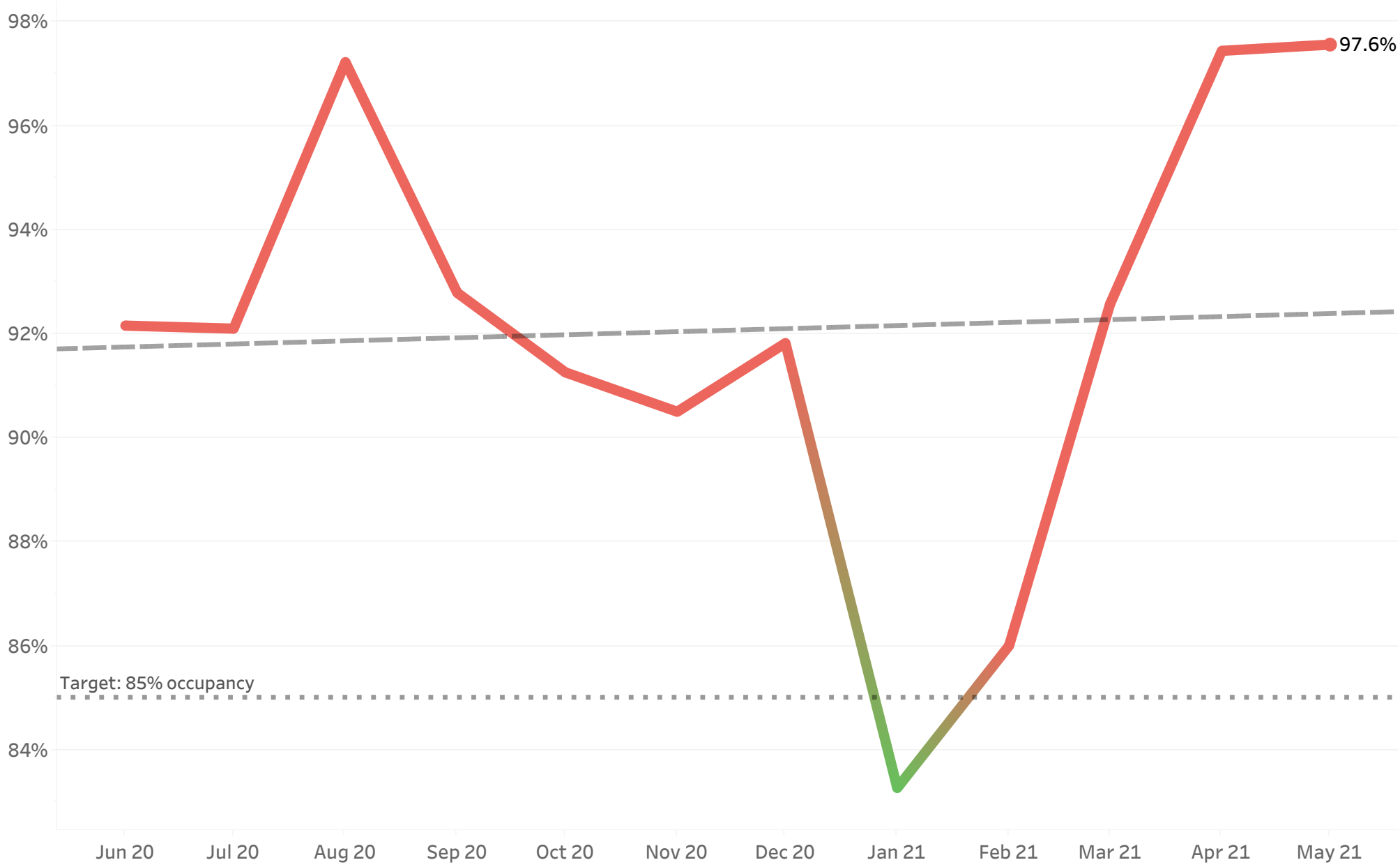
Any incident where sub-category = assault by patient and incident type = staff



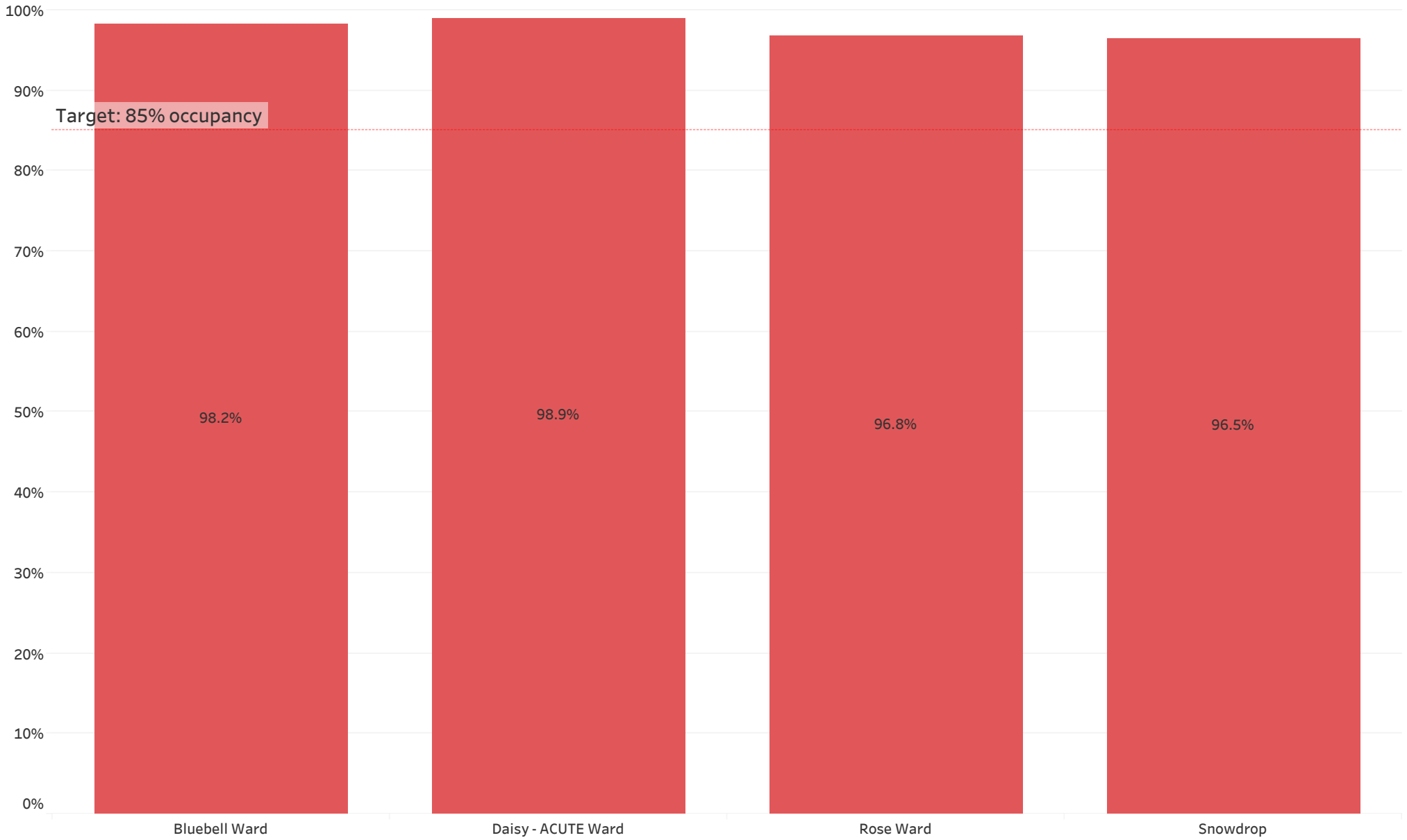
Supporting Our Staff Driver: Physical Assaults on Staff by Location (May 2021)



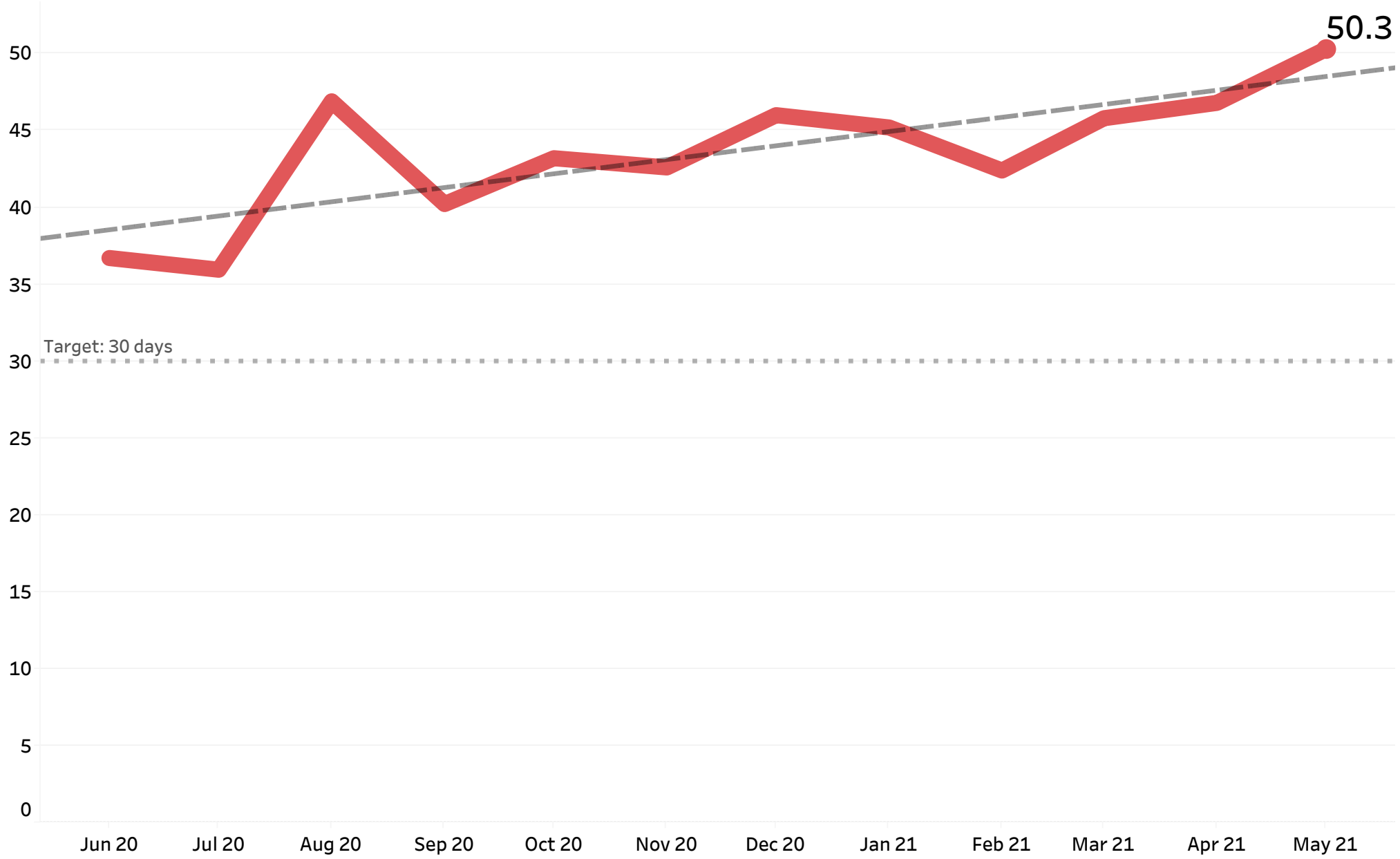
Money Matters: Mental Health Acute Bed Occupancy Rate (Jun 20 to May 21)



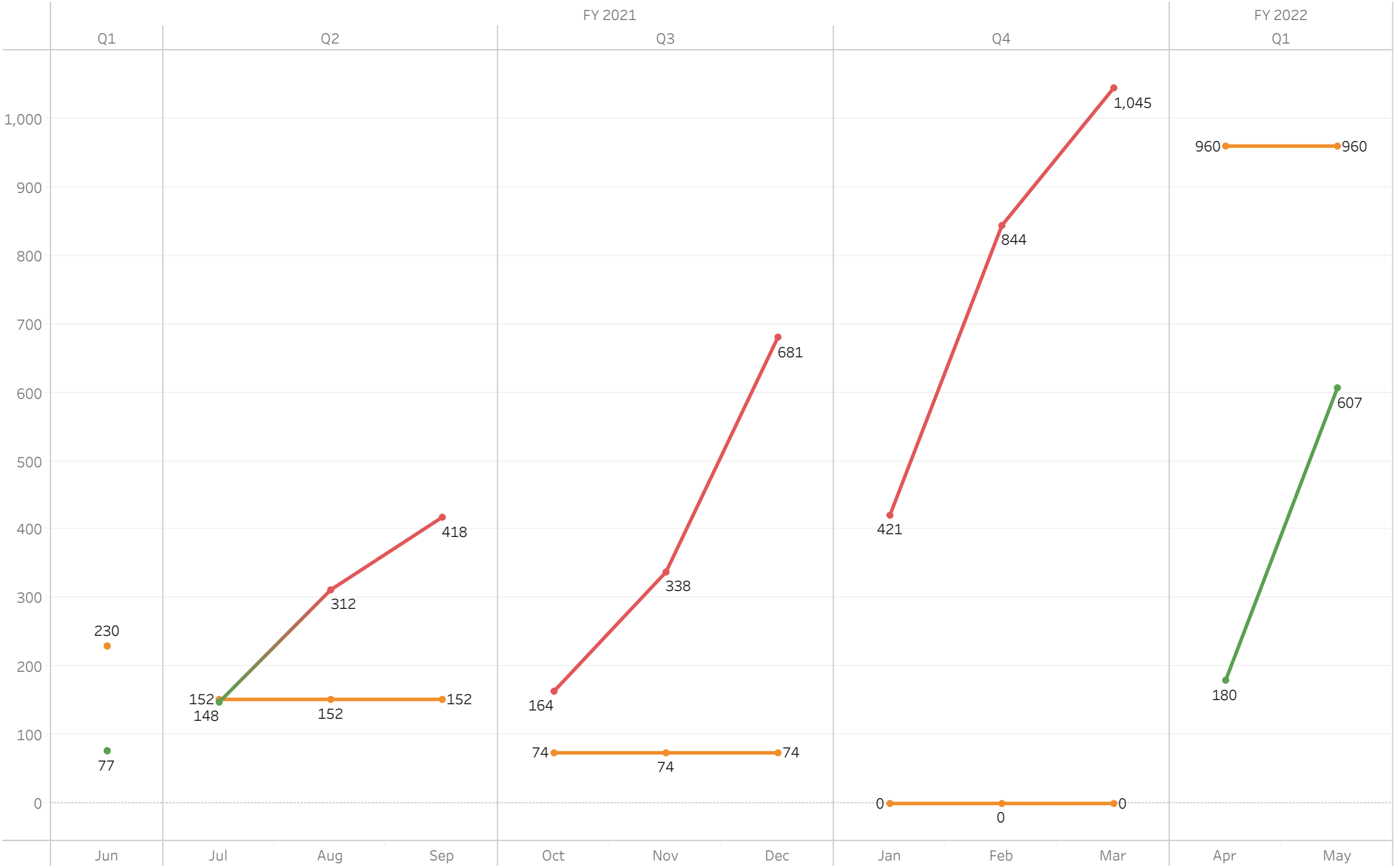
Money Matters Driver: MH Acute Bed Occupancy by Unit (May 2021)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (May)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	1	0	0	1	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	3	9	2	2	3	9	3	3	2	10	5	3
Mental Health: Absconsions on MHA section(Excl: Failure to return)	8 per month	4	6	3	4	4	3	0	9	10	4	5	11
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.86	5.22	4.95	6.33	7.43	6.65	5.89	7.09	8.59	8	6.60	7.29
Patient on Patient Assaults (LD)	4 per month	4	4	4	2	0	3	0	3	1	1	0	0
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019[Suspended centrally due to COVID]	15% by March 2020; 20% by June 2021	13.8%	13.5%	13.6%	13.7%	13.4%	12.6%	12.9%	13%	12.9%	13.9%	14.4%	14.2%
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	4.9	4.9	4.9	4.9
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	3	3	0	2	1	1	0	1	0	1	2	4

True North Patient Experience Summary

Tracker Metrics

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Mental Health: Prone (Face Down) Restraint	4 per month	3	6	2	3	1	5	1	6	7	5	4	6
Patient on Patient Assaults (MH)	38 per month	20	24	12	21	7	14	11	9	25	8	18	17
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	92.6%	93.4%	91.1%	91.1%	92.7%	92.0%	91.2%	94.5%	95.0%	91.2%	88.2%	94.3%
Mental Health: Uses of Seclusion	13 in month	17	15	16	8	15	11	9	4	12	4	11	15

True North Supporting Our Staff Summary

Tracker Metrics

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Gross vacancies: % [Suspended centrally due to COVID]	<10%												
Statutory Training: Fire: %	95% compliance	87.3%	90.1%	91.3%	92.9%	92.4%	91.1%	92.3%	91.5%	85.0%	83.7%	90.2%	91.5%
Statutory Training: Health & Safety: %	90% compliance	95.5%	95.3%	95.6%	95.9%	96.0%	95.0%	95.9%	95.7%	92.5%	92.5%	95.1%	95.1%
Statutory Training: Manual Handling: %	90% compliance	90.3%	90.1%	91.1%	92.3%	92.5%	93.1%	94.0%	93.8%	86.0%	95.0%	87.8%	88.6%
Mandatory Training: Information Governance: % [Suspended centrally due to COVID]	95% compliance	92.1%	92.6%	92.2%	94.7%	94.0%	94.8%	95.2%	93.8%	89.0%	88.4%	92.0%	91.9%
PDP (% of staff compliant) Appraisal: %	95% compliance 'by 30th June 2021'	42.1%	88.6%	87.3%	95.5%	95.3%	94.4%	91.9%	88.9%	88.1%	86.1%	10.0%	74.4%

Mental Health Inpatient Services – Fire training compliance

Competence (group)	Target	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Fire Safety Training - Whole Service	95%	89.4%	92.2%	94.8%	96.5%	96.6%	94.4%	96.6%	95.6%	88.4%	90.5%	92.7%	94.1%

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
371 Bluebell Ward PPH	95%	77.8%	95.5%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%	84.8%	93.5%	92.9%	83.3%
371 Daisy Ward PPH	95%	88.5%	92.3%	96.2%	93.8%	100.0%	96.3%	100.0%	93.3%	84.4%	86.7%	88.9%	74.1%
371 Orchid Ward PPH	95%	84.6%	92.3%	92.0%	96.2%	82.8%	92.6%	93.1%	96.4%	87.5%	93.3%	93.5%	96.7%
371 Rose Ward PPH	95%	91.3%	96.2%	96.3%	100.0%	100.0%	96.4%	100.0%	96.0%	76.7%	87.1%	90.0%	90.3%
371 Rowan Ward PPH	95%	77.4%	92.9%	100.0%	100.0%	94.1%	91.7%	94.1%	91.4%	80.6%	91.7%	100.0%	100.0%
371 Snowdrop Ward PPH	95%	100.0%	96.7%	96.9%	100.0%	96.6%	96.0%	96.2%	92.0%	67.7%	75.0%	81.5%	75.0%
371 Sorrell Ward PPH	95%	96.2%	96.3%	93.3%	100.0%	100.0%	100.0%	97.1%	96.8%	87.9%	90.6%	90.6%	90.3%

Community Health – Fire training compliance

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
371 Community Health East Services	Fire Safety Training - Whole Service 95%	93.1%	94.8%	96.4%	97.8%	96.0%	93.1%	96.3%	94.9%	89.0%	91.7%	92.1%	94.1%
371 Community Health West Services	Fire Safety Training - Whole Service 95%	86.9%	90.5%	93.8%	95.6%	97.0%	95.2%	96.7%	96.0%	87.9%	89.8%	93.1%	94.1%

CH IP Fire Safety Breakdown

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
371 Henry Tudor Ward	95%	96.7%	93.1%	89.7%	100.0%	92.9%	92.9%	100.0%	86.7%	87.5%	97.0%	97.0%	97.0%
371 Jubilee Ward	95%	81.3%	96.8%	93.5%	100.0%	100.0%	96.8%	96.6%	96.9%	87.9%	96.9%	100.0%	100.0%
371 Oakwood Ward	95%	94.9%	100.0%	95.2%	95.7%	95.5%	97.9%	100.0%	97.7%	79.6%	80.4%	88.2%	96.2%
371 WBCH Inpatient Wards	95%	93.7%	93.9%	96.3%	96.2%	96.1%	91.5%	96.1%	96.2%	90.6%	90.0%	95.3%	95.3%
371 Wokingham InPatient Unit	95%	64.8%	86.7%	93.5%	96.7%	98.4%	98.4%	98.3%	95.2%	86.7%	90.8%	100.0%	100.0%

Campion & Willow House – Fire training compliance

True North Money Matters Summary

Tracker 1

		Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	5.29	4.29	2.60	4.29	9	4.29	3.59	3.30	2	3.50	3.10	3

Tracker Metrics

Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	49%	57.3%	73.5%	72.8%	74.7%	72.7%	79%	83.5%	75.0%	70%	82.0%	83.5%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	64.04%	84.74%	67.06%	75.68%	75.68%	65.10%	66.21%	73.42%	73.04%	69.89%	74.37%	77.48%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	3.79%	4.39%	4.29%	4.59%	4.29%	4.39%	4.20%	4.29%	4%	4.29%	4.5%	4.29%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	2.10%	7.5%	6.5%	5.29%	10.1%	2.5%	7.29%	10.6%	6.70%	10.6%	7.79%	7.19%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
Mental Health: 7 day follow up (Quality Domain): %	95% seen	96.2	94.5	94.1	97.7	98.6	97.2	100	96.2	93.7	96.5	96.6	91.2
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	0	0	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP: %	90% treated	88	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
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	0	0	0	0	0	0	1	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed-sex accommodation breaches [Suspended centrally due to COVID]	Zero tolerance	0	0	0	0	0	1	0	0	0	0	0	0
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of children and young persons under 16 who are admitted to adult wards (Safe Domain)	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	56% treated	100	90.9	100	100	91.7	100	100	88.9	75	88.9	90.9	75
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	97.9	96.0	98.2	98.7	97.8	98.6	98.0	98.9	98.0	99.2	98.4	99.3
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	96	95	96	98	98	98	98	98	98	99	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

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	55.4	56.6	56.1	57.4	58.5	60.5	53.3	54.9	52.7	53.8	54	55.0
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	59	59	59	69	69	69	69	69	69	68	68	71
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	12	12	12	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	15
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	97.8	98.2	100	100	99.5	99.6	99.1	99.6	99.3	99.2
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	98.6	100
Sickness Rate: %	<3.5%	3.40	3.49	3.23	3.25	3.60	4.29	4.08	4.73	3.50	3.04	3.46	
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
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												
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	98.4	98.2	98.9	98.7	98.9	99.0	99	97.0	97.5	97.5	99	97.3
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13th July 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	Paul Gray Acting 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 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 awarded and project underway.

	• 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 May 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 (now retired as a driver metric due to sustained performance).
ACTION REQUIRED	The Board is asked to note the update.

Board Vision Metrics: Performance Update to end May 2021

Supporting delivery of the Trust's Vision

Trust Board – public meeting

Paul Gray, Chief Financial Officer

30th June 2021

BHFT staff only

Purpose

Update the Finance Performance and Risk Executive and Trust Board on Vision Metrics.

Document control

Version	*Date*	*Author*	*Comments*
1.0	31/03/2021	I Hayward & C Magee	

This document is *BHFT staff only* and is therefore restricted to current BHFT employees only.

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 in order to assure the Trust on its progress towards the vision.

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

1.5. The national benchmarking network has expanded participants in the Mental Health project to include providers from Wales, Northern Ireland, the Channel Islands and Scotland. The data here shows the rankings against the 57 English providers and the 32 Combined Mental Health and Community Trust respondents in the latest available report.

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 and the first performance report provided to the April 2017 in committee Board meeting. Supporting vision transparency and accountability, this paper is the first-time vision delivery performance is reported to the Board in public, alongside the usual 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 for 2019/20 and above the median 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 were ranked 44th out of 57 English Mental Health respondents. In 2019/20 the Trust is ranked 28th out of 32 combined mental health and community Trusts which is 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 and mental health Trusts and is a worsening of our position where the Trust was ranked 22nd out of 32.

- **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 English benchmarking respondents. The Trust ranks 5th out of 32 joint Community and Mental Health Trusts. This is an improvement of our performance from 2018/19 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 Quality Improvement (QI) and the Harm Free Care priorities set out in the Annual Plan.

- The next update on this section will be Quarter 4 2021/22.

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 in April 2017. One incident has been identified on Daisy Ward in April 2021. There were no incidents in 2020/21 or 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 May 2021 and was 98% against a target of 85%. This is an increase from 86% in February 2021.

- **Never Events –** This covers all never events that occur within 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 people under mental health care in 2019/20 from 5.2 per 10,000 in 2018/29. This local target was based on a 10% reduction on the 2015/16 suicide level of 9.2 per 10,000 people under mental health care and the Trust has achieved a 46.7% reduction on this rate. The next update will be in Quarter 4 2021/22. Our zero-suicide initiative and QI programme around 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 2021/22 the Trust has agreed investment with commissioners across all expected priorities including mental health (national investment standard and Long-Term Plan (LTP)), COVID response, Ageing Well and community transformation programmes.

- **Stakeholder Satisfaction - Survey of System Partners –** the last survey was completed pre-COVID pandemic (December 2019) and there was positive stakeholder satisfaction results across all partners. Next survey to be completed during 2021/22.

- **Patient Friends & Family Test Response Rate –** This was suspended at the start of the pandemic and formal reporting restarted in December 2020. This is below target at 5% and has been marked red in Appendix 1. This is a deterioration since last reported in February 2021 at 6%. This is a QI driver metric.

- **Staff Survey Engagement Rating –** the latest available performance ranking was published on 11th March 2021. Our position remains unchanged from last year but Trust Staff Engagement Score of 7.5 is an increase from 7.4 in 2019/20. The next update will be in Quarter 4 2021/22. The Trust has the highest score amongst peers.

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 -** maintained segment 1 of the Oversight Framework in the latest assessment. Segment 1 is the 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. This was suspended as a consequence of the pandemic.

- **Number of CQC Compliance Actions –** There remain 6 compliance actions from the most recent CQC inspection, which are as follows:
  1. **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 ensure timely access to services for those referred to the Attention Deficit Hyperactivity Disorder (ADHD) pathway and autism assessment pathway.
  2. **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*
  3. The trust must ensure that the ward environment is always adequately furnished and maintained. (Regulation 15).
  4. The trust must ensure that patients are kept safe. For example, promoting the sexual safety of people using the service (Regulation 12).
  5. The trust must ensure restrictions are necessary and proportionate responses to risks identified for individuals (Regulation 13).
  6. 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).

3. Quality Improvement Programme: supporting delivery of our vision

3.1. The QI programme aims to improve the services we provide to our patients and their families, and will help us achieve our vision, which is to be recognised as the leading provider of community and mental health services.

3.2. The QI programme will implement sustainable changes to the way we work. QI is about empowering and enabling staff to make improvements and feel they can make a difference at work; it is a bottom up process which equips people with the tools and techniques they need, making sure the Trust is aligned in its work and focused on achieving key objectives.

3.3. The QI programme consists of four work streams:

- Strategy deployment – making all staff aware of our key priorities

- Quality Management and Improvement System (QMIS) (phased approach) – daily changes in the way we work, reinforced by nine integrated tools and techniques

- Quality improvement projects (on-going) – significant and complex change projects
- QI Office – a team dedicated to the sustainability of the programme

All four work streams will link in to the four Trust priorities that we have identified (known as 'True North'), these will translate into the four primary goals of our annual plan. The True North domains are:

- To provide 'harm free care' with a focus on reducing self-harm and physical harm
- To improve our 'staff experience' by focusing on staff engagement and reducing violence and aggression from patients
- To improve the 'patient experience', evidenced by an increase in the number of returned Friends and Family Tests and improve results
- To support financial sustainability across the organisation 'money matters', by improving net surplus performance.

3.4. As the QI programme develops during 2021/22, the underpinning driver and tracker metrics aggregating to the performance view of True North delivery will be integrated into the Trust Board's summary performance reporting, supported by review at Finance Investment and Performance (FIP) committee.

3.5. It is not surprising that a number of our QI / True North metrics align with the Trust's vison metrics in Appendix 1, given True North's purpose is to align quality improvement activity to delivery of our vision. It is anticipated there will be iterations to the True North Performance Scorecard as the process is refined.

3.6. One new driver and one tracker metric has been developed and will included from month 3 reporting (June 2021) to the Harm Free care domain for 2021/22:

- The number of mental health service users with a Serious Mental Illness (SMI) on the Trust's caseload for less than a year who have had a physical health check with all 7 measures recorded. The 7 measures are Body Mass Index, Blood Pressure (Systolic and Diastolic), Blood Glucose levels (Hb1Ac), total cholesterol, smoking status, and harmful alcohol consumption.
- A tracker metric related to the above focussing on Smoking status.

Appendix 1 – Board Vision Metrics

Trust Board Vision Metrics

As at: May 2021

		Quality			Safety					
Target		Mental Health Patient on Patient Assaults Top 3	Mental Health Patient on Staff Assaults Top 3	Mental Health Use of Restraint Top 3	Falls Due to Lapse in Care 0	Mental Health Inpatient Deaths from Self Harm 0	Mental Health Bed Occupancy 85%	Never Events 0	Pressure Ulcers 10% Reduction	Suicide Rate per 10,000 under Mental Health care 10% Reduction Target 8.2
	Performance trend since last report	↓	↓	↑	↓	↔	↓	↔	↑	↑
Actual	All English NHS Mental Health Providers (out of 57)	52nd	50th	18th	1	0	98%	0	0	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		
Target		CCG Net Investment Green	CCG Satisfaction Survey To be defined	Patient FFT Response Rate 15%	Staff Survey Engagement Rating (out of 32) 3rd	CQC Rating Outstanding	CQC Compliance Actions 0	NHSI Segment 1
		↔	-	↓	↑	↔	↔	↔
Actual		✓	✓	5%	1st	Outstanding	6	✓
		-	-	Patient Experience - Driver Metric	Supporting our staff Drive Metric	-	-	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	July 2021
Title	COVID 19 Recovery Programme Highlight Report
Purpose	The purpose of this report is to provide the Board with an update on the Closure and transition of Recovery and Restoration process for BHFT to operations.
Business Area	All
Author	Kathryn MacDermott, Director of Strategic Planning
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 plan
SUMMARY	The Recovery and Restoration programme of work has completed its task and is now closed. The continuation of recovery and restoration of services is incorporated into the operational planning of services and implementation of the new 3-year strategy.

ACTION REQUIRED	The Board is asked to: Note the report and progress.

COVID-19 Recovery Programme Highlight Report	Month: July 2021

Programme Title	COVID-19 Recovery Programme

Summary Description

The scope of the COVID-19 Recovery 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 Recovery programme was established in May 2020. Its 1st priority was to oversee the re-opening and extension of services following the urgent response BHFT put in place to manage the response to the COVID-19 pandemic. The Service Prioritisation Steering Group had responsibility to ensure a coordinated approach which included the services completing and submitting a Quality Impact Assessment, an Estates Facilities Management (EFM) Recovery form and an Equality Impact Assessment that included the impact on staff and patients. The Service Prioritisation Steering Group completed this work in September 2020 and the focus moved to the Recovery Programme Board providing oversight over the impact that COVID has had on the operating model for services and on waiting times.

The Recovery programme was established as a task & finish programme of work to meet the specific and additional demands that the immediate response to COVID-19 required. It is acknowledged that the 'recovery and restoration' of services will take time. The operational response to the challenges thrown up by COVID will be part of how services deliver their respective elements of the three-year strategy and it is therefore appropriate that the Recovery programme board is stood down as a separate workstream. Recovery is now embedded in the operational delivery of services.

Separately the Recovery SRO and Operations SLT have met and agreed a plan to provide a regular update to the Exec and Trust Board that provides:

- Summary of the status of services including waiting pressures, safety/quality concerns, workforce pressures and complexity via a 'heatmap' visual
- Summary narrative of any higher risk services including cause, trend, actions underway, support needed

A draft of the Recovery 'heatmap' was reviewed by the May Trust Board discursive. This is a live document that will continue to be updated and improved based on feedback and usage.

Deployment Status: M/I	Mission Critical	Project Life Cycle Status:	Closed	Planned Completion Date:	July 2021

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

Author	Kathryn MacDermott, Director of Strategic Planning	Overall Project Status*:	

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

Summary Commentary re status & progress:	The Recovery programme has completed its task and is now Closed. The work of Recovery will continue through Operations and implementation of the three-year strategy. A standard work for a Three-year Strategy Oversight Implementation Group of which recovery is a subset, has been drafted and reflects the need to embed the transformational ways of working accelerated during the COVID response into business as usual. The Recovery Highlight report is replaced by the Recovery Heatmap that provides a summary of the status of services including waiting pressures, safety/quality concerns, workforce pressures and complexity via a 'heatmap' visual and a summary narrative of the higher risk services including cause, trend, actions underway, and where support is needed. **Reducing Health Inequalities** BHFT has a dedicated Reducing Health Inequalities due to the impact of COVID action plan which will continue to report quarterly to the Quality and Performance Executive via the Reducing Health Inequalities steering group. Guidance on reducing health inequalities and recovery was included in the operational planning guidance.

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
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. Capacity planning support and analysis is focused to higher risk services on the Heatmap.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 July 2021
Title	**Audit Committee – 26 May 2021**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 26 May 2021
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Audit Committee Meeting held on

Wednesday, 26 May 2021

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

Present: Chris Fisher, Non-Executive Director, Committee Chair
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

In attendance: Alex Gild, Deputy Chief Executive and Chief Financial Officer
Graham Harrison, Head of Financial Services
Monika McEwen, Financial and Capital Accountant
Paul Gray, Director of Finance
Ben Sheriff, External Auditors, Deloitte
Clive Makombera, Internal Auditors, RSM

Item	Title	Action
1.A	**Chair's Welcome and Opening Remarks**	
	The Chair welcomed everyone to the meeting.	
1.B	**Apologies for Absence**	
	There were no apologies.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Annual Accounts 2020-21, including the Annual Governance Statement**	
	The Annual Accounts 2020-21 and Annual Governance Statement had been circulated. It was noted that members of the Committee had been given the opportunity to review the draft Annual Accounts 2020-21 and Annual Governance Statement prior to the meeting. The Chair reported that his questions had been fully answered by the Finance Team. The Chair explained the questions that he had asked of the finance team and in high level the answers and assurances that he had received.	

	The Chair commented that the Annual Accounts 2020-21 were excellent and confirmed that he had no further comments. The Chair said that he was surprised that the centre did not require the Trust to include a note in the accounts on the impact of the COVID-19 pandemic. It was noted that there were additional disclosures required in the Annual Governance Statement which referred to the Board Assurance Framework for key business and operating risks related to responding to the COVID-19 pandemic. Ben Sheriff, External Auditors confirmed that Trusts had not been requested to split out any income and expenditure in the financial statements between COVID-19 and non-COVID-19 related expenditure, other than in specific areas such as income for COVID-19 top up funding or donated income for consumables for Personal Protective Equipment and the subsequent expenditure. Mr Sheriff said that it would be difficult to segregate out recurrent and non-recurrent expenditure across the sector. The Chair invited questions from Naomi Coxwell and Mehmuda Mian, Non-Executive Directors. Ms Coxwell referred to the comment which stated that the Trust was not fully compliant with the requirements of the Care Quality Commission registration and asked for an explanation. The Deputy Chief Executive and Chief Financial Officer explained that this was standard wording because the Trust had “must do” actions arising from the latest comprehensive Care Quality Commission inspection. The Deputy Chief Executive and Chief Financial Officer agreed to include an explanation in the Annual Accounts. Naomi Coxwell referred to comment that the Trust had one reportable information governance incident during 2020-21 and asked whether this had been reported to the Trust Board. The Deputy Chief Executive and Chief Financial Officer said that he would check and confirm whether information governance reportable incidents were reported to the Trust Board. Ms Coxwell commented that she would have expected that the cost of education and training would have been lower than last year because of the COVID-19 pandemic. The Deputy Chief Executive and Chief Financial Officer clarified that the training and development costs in the section on “other operating income from contracts with customers” related Health Education England funding for clinical training and education which had continued during the COVID-19 pandemic which included the salary costs of providing for back fill cover for participants. Ms Coxwell referred to the table on Operating Expenses and asked for more information about “purchase of healthcare from non-NHS bodies”. The Deputy Chief Executive and Chief Financial Officer explained that the	**AG** **AG**

	majority of costs related to out of area placements and independent long-term specialist placements. Ms Coxwell said that she was surprised that the employee expenses were as high as they were given that a large proportion of staff were working at home. The Head of Financial Management explained that during the COVID-19 pandemic, the Trust's head count had increased because more temporary and agency staff were required. The Deputy Chief Executive and Chief Financial Officer said that it would be helpful to triangulate the costs to confirm whether or not they related to the COVID-19 pandemic or to other drivers. Ms Coxwell asked about the "other employment benefits" costs. The Head of Financial Management explained that this related to annual leave accrual costs. Ms Coxwell commented that the percentage increase in directors' remuneration costs appeared high. The Head of Financial Management confirmed that the costs included an ICS Director post which the Trust hosted. The Head of Financial Management confirmed that the figures would be adjusted in the final version of the Annual Accounts. Mehmuda Mian, Non-Executive Director referred to the section on "other operating income from contracts with customers" and asked about "reimbursement and top up funding". The Chair said that he had asked the same question prior to the meeting and had received further information from the Finance Team. Ms Mian referred to the "operating expenses" table and asked for more information about the impairment costs. The Head of Financial Management explained that the impairment costs mainly related to buildings works during the year and a re-valuation of Hillcroft House. The Chair asked Ben Sheriff and Chris Randall for their feedback on this year's external audit. Mr Sheriff commented that undertaking the external audit remotely was more challenging but thanked the Head of Financial Management and his team for their support. The Committee agreed the Annual Accounts 2020-21 and agreed to delegate approval of any changes that were required following the conclusion of the External Auditors outstanding work to the Chair and to the Deputy Executive and Chief Financial Officer and Director of Finance. The Committee agreed that if the changes were material, another meeting would be convened to give final approval to the Annual Accounts 2020-21.	**PG** **GH**

4.	**External Auditors Report on the Annual Accounts 2020-21 and Independent Auditor's Report and Management Representation Letter in respect of the Financial Statements**	
	Ben Sheriff, External Auditors, Deloitte, referred to the ISA 260 Memorandum which summarised the key issues identified during Deloitte's audit of the Trust's financial statements. Mr Sherriff confirmed that the majority of the External Auditors work had been completed but there were a couple of outstanding issues. This included more work in relation to deferred income items and in addition, the National Audit Office and NHS England had issued late guidance in respect of the preparation of the Annual Accounts. The Chair asked if the Committee approved the Annual Accounts at the meeting today whether the outstanding items were likely to have a material effect on the final Accounts. Mr Sheriff confirmed that his expectation was that the outstanding items would not be material but suggested that the Committee delegate authority to the Chair and the Chief Financial Officer to approve the final version of the Annual Accounts. Mr Sheriff said that if the outstanding issues materially affected the Annual Accounts, it may be necessary to convene another meeting as stated above in section 3. Chris Randall, External Auditors, Deloitte referred to the section on significant audit risks and said that the External Auditors had identified an overall risk for the sector in respect of the completeness and validity of accruals due to the COVID-19 pandemic. Mr Randall highlighted the revised property valuation of Hillcroft House which was significantly lower because the building had been reclassified as a non-specialised asset. The Chair requested that the Deputy Chief Executive and Chief Financial Officer inform the Committee of the outcome of the External Auditors outstanding work on the Annual Accounts. The ISA 260 Audit Memorandum was received and noted.	**AG/JH**
5.	**Letter of Representation**	
	Ben Sheriff, External Auditors, Deloitte reported that the Trust was required to sign a management representation letter in respect of the Financial Statements. On behalf of the Trust Board, the Committee authorised the Chief Executive to sign the Management Representation Letter.	
6.	**Formal Approvals**	
	It was noted that the Trust Board had delegated full authority to the Audit Committee to issue all necessary approvals in respect of the 2020-2021 Annual Accounts on its behalf.	

	It was also noted that the Trust Board had approved the Annual Report. The Company Secretary reported that since the Trust Board meeting on 11 May 2021, the Annual Report had been updated to reflect comments made by the External Auditors. A copy of the changes had been circulated to all Board members for comment. The Company Secretary confirmed that she had not received any comments. The Committee noted and approved the following relating to the Annual Accounts for 2020/21: • ***Audit Memorandum*** The ISA 260 Audit Memorandum was received and noted. • ***Annual Accounts 2020/21*** The Annual Accounts for 2020/21 were approved subject to any changes required as a result of the External Auditors outstanding work (*as mentioned above, the Committee gave delegated authority to the Chair and Deputy Chief Executive and Chief Financial Officer and the Director of Finance to approve any non-material changes.)* • **Management Representations** The proposed Trust Management Representations response to Deloitte was approved: • ***Annual Governance Statement*** The Annual Governance Statement was approved.	
7.	**Internal Audit Strategy 2021-26 (including the Internal Audit Plan 2021-22**	
	Clive Makombera, RSM presented the Internal Audit Plan 2021-22. The Chair commented that it was a comprehensive and well thought out plan and asked whether the Executive Team were comfortable with the Internal Audit Plan. The Deputy Chief Executive and Chief Financial Officer reported that the Executive Team had discussed the draft Internal Audit Plan and had reviewed the draft Infernal Audit Plan and had substituted a review of the implementation of the Care Quality Commission's "must do" actions rather than a review of Population Health Management. The Chair reported that Governors were interested issues pertaining to waiting lists and asked whether a review of waiting lists could be added. Mr Makombera pointed out that the Internal Audit Plan included a review of the Trust's recovery from the COVID-19 pandemic and confirmed that the scope of this review could include waiting lists. Mr Makombera referred to appendix b of the report which set out the proposed Internal Audit Strategy 2021-26 and stressed that this was based on the Trust's current risk profile and the proposed areas of review could be changed if and when necessary during the course of five-year programme.	**CM**

	Mr Makombera reported that RSM would be working with the Company Secretary to further develop the Assurance Map by reviewing the effectiveness of the sources of assurance. Naomi Coxwell, Non-Executive Director agreed that it was a comprehensive plan but queried whether the plan should be reviewed within the context of the Trust's refreshed three-year Strategic Plan. Mr Makombera agreed to review the Internal Audit Strategy within the context of the Trust's three-year Strategy and to identify any gaps. Ms Coxwell asked whether the Internal Audit Strategy should include the Trust's response to the COVID-19 pandemic, for example, the provision of Personal Protective Equipment, patients discharged into care homes, lack of testing in the early days of the pandemic etc. Mr Makombera said that many of the issues referred to above were the responsibility of the system rather than Berkshire Healthcare and said that if this was an area the Trust wanted to review, it would be important to set the parameters of any review. The Chair thanked Ms Coxwell for raising the issue and said that it was important that the Trust embedded the positives from the new ways of working and learnt any lessons from the pandemic and not wait until the outcome of any public enquiry. Mr Makombera agreed to discuss with the Deputy Chief Executive and Chief Financial Officer and Director of Finance around how best to provide assurance. **The Committee**: approve the Internal Audit Strategy 2021-2026 (including the Internal Audit Plan 2021-22.	**CM** **CM/AG/ PG**
8.	**Any Other Business**	
	There was no other business.	
9.	**Chair's Closing Remarks**	
	The Chair congratulated Paul Gray on being appointed acting Chief Financial Officer with effect from 7 June 2021 following changes in Alex Gild's Deputy Chief Executive portfolio. On behalf of the Committee, the Chair thanked the Head of Financial Management and his team for producing an excellent set of Annual Accounts. The Chair thanked Ben Sheriff and Chris Randall, External Auditors for completing their audit online for a second year due to the COVID-19 pandemic. The Chair also thanked Clive Makombera, Internal Auditor for his considered work over the last year.	
10.	**Date of the Next Meeting**	

	The next meeting will be held on 21 July 2021.	

These minutes are an accurate record of the Audit Committee meeting held on 26 May 2021.

Signed:-

Date: - 21 July 2021