Berkshire Healthcare
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

2018/19

Berkshire Healthcare NHS Foundation Trust
Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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CHAIR AND CHIEF EXECUTIVE'S REPORT

This year, the Trust has delivered a strong performance, managing the delivery of high quality care whilst maintaining an excellent financial result. This performance is all the more commendable due to the ever increasing demand for our services. We are proud of the commitment of all our staff to delivering high standards of care, whilst maintaining prudent financial management in spite of these challenges.

This year we received a full Care Quality Commission inspection of our services. We received another very pleasing result, with the Trust rated as GOOD across all our services and OUTSTANDING in Older Adult, Learning Disability services and Well Led. We are, however, not complacent and we recognise the importance of developing our delivery to ensure everyone receives the same high quality care, irrespective of the service or geography. Our financial performance has been excellent, with the Trust being ranked in the highest category by NHS Improvement. Financial excellence is not, of course, an end in itself, but by ensuring we spend our funding wisely and efficiently enables us to invest in delivering ever better care.

Staff satisfaction is good with the NHS staff survey results showing we are highly ranked compared to other Trusts. We have made good progress addressing concerns about equality and diversity with determined efforts to address staff concerns. We are seeing improved proportions of Black, Asian and Minority Ethnic (BAME) staff filling senior posts. Our staff networks for BAME, LGBT and staff with disabilities are active and helping shape our plans. In spite of this progress, we know we have more to do, but the progress to date is pleasing. Staffing, nevertheless remains our highest risk with levels of vacancies and staff turnover too high.

In spite of the Trust's good performance, we know that we have to improve how we deliver services, both to ensure we deliver ever safer and more effective care and to respond to the ever increasing demand. The Trust has adopted the Quality Improvement methodology as the basis for developing its continuous improvement. This empowers front line staff to identify and implement improvements locally, greatly increasing speed of change and increasing staff satisfaction.

We are also committed to developing our IT systems so we can take full advantage of digital services. We are already using the connected care system to enable clinicians across the care pathway to access essential clinical information, improving patient care, and our use of social media based applications for mental health is proving highly effective. We are convinced that our commitment to developing a much more comprehensive range of digital services will help in delivering patient centred care, improve the effectiveness of our services, reduce the administrative load on front line staff and help mitigate the increased demand for our services.

The Trust is fully committed to working across the health and social care landscape to develop truly integrated services. We are leading players in two Integrated Care Systems ICS): Berkshire West and Frimley Health, both of which are recognised nationally as exemplars. Developing such integrated systems, including social and primary care, community and mental health and acute is complex. We are pleased to report that in both cases, relations are positive and there is a real commitment to integration.

This year we said farewell to our Director of Nursing and Governance, Helen Mackenzie.
Helen had been a key player in the Executive and on the Board. We would like to express the thanks of the Board for her outstanding contribution.

We are pleased to report two of our staff received Honours in the Queen's New Year's Honours List 2019: Becky Chester, Consultant Nurse for People with Learning Disabilities and Alison Durrands, Locality Director, Prospect Park Hospital - were both awarded MBEs.

The Board and the Governors continue to function well. There has been some difficulty filling all the vacancies on the Council of Governors but the indications are that that is improving.

The Trust can report a strong performance with a commitment to continuous improvement in all it does and to playing its full part in the integration of services across Berkshire. None of this would be possible without the commitment of our staff always putting the care of our service users first in spite of the challenges we face.

Julian Emms
Chief Executive

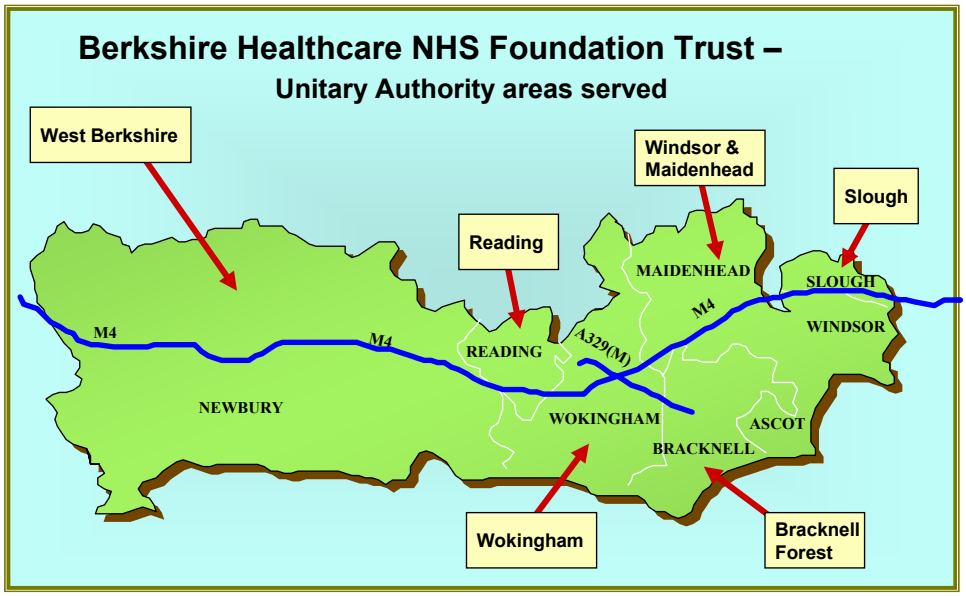
Martin Earwicker
Chairman

PERFORMANCE REPORT

Overview - Brief history and Summary Information

The purpose of this section is to provide an overview of the Trust, as well as setting out our performance in 2018-19. Berkshire Healthcare NHS Trust was set up in 2001. The Trust successfully gained NHS Foundation Trust status in May 2007. In line with the Trust's provider licence, the principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The Trust provides specialist mental health and community health services to a population of around 900,000 people in Berkshire. We operate from a number of sites across the county offering community/home based care and inpatient services – with the majority of our services being provided to people within their own homes. The Trust also provides mental health and community health inpatient services.

The Trust works with six local unitary authorities (as indicated in the map below) and seven Clinical Commissioning Groups (CCGs) which took on commissioning responsibility from April 2013. The CCGs operate as two "federations" in the East and West of Berkshire.



The Trust's turnover for 2018-19 was £257m. During 2018-19 the Trust employed approximately 4,300 staff.

The Trust was issued with its provider licence by Monitor (the Regulator – now known as NHS Improvement), on 1 April 2013.

We have continued our commitment to providing high quality services that meet the requirements of our Care Quality Commission (CQC) registration and in compliance with the conditions of our provider licence.

In June 2018, the Trust underwent a comprehensive Inspection by the CQC which resulted in the Trust retaining its overall "Good" rating. The Trust was rated "Good" across the Safety, Effectiveness, Caring and Responsiveness domains and 'Outstanding' in the Well Led domain. All of the services inspected were rated as 'Good', with the exception of our wards

for people with learning disability or autism, and our community based mental health services for older people which were rated as 'Outstanding'.

During the year, we have improved on our original financial forecast, supported by additional Provider Sustainability Funding allocated by NHS Improvement (NHSi) for delivering and exceeding the Trust's financial control total, and have ended 2018-19 with a surplus of £6.5m (versus plan of £2.3m). This has enabled us to be categorised as a Segment 1 Trust (the maximum level of autonomy) under NHS Improvement's Single Oversight Framework. We recognise the increasing financial challenge that we are facing – particularly the need to achieve recurrent and sustainable savings in light of increased demand and funding constraints of our partners.

A key role for the Trust Board and the Executive Team is to manage and mitigate risks to the delivery of our strategic objectives and we therefore operate a robust risk management process that ensures that all key risks are identified and that mitigation action is taken to address these. Our Board Assurance Framework and Corporate Risk Register are regularly reviewed by both the Trust Board and relevant Executive Groups.

Our key risks relate to the safety of and quality of care we provide to our patients, as well as to the Trust's financial sustainability. We spend considerable time ensuring that financial pressures do not compromise safety and quality. In terms of quality of care and patient safety, we are continually managing the risks that can arise from shortages of particular staff, such as nurses and from increases in demand for services beyond our commissioned activity. More information on our approach to quality can be found in the Quality Report that appears later in this document.

The Board of Directors is responsible for preparing this annual report and the annual accounts and the Directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Going concern/accounting policies

After giving due consideration to the principle risks and uncertainties contained in the Board Assurance Framework, Corporate Risk Register, including the potential risks and impacts of the United Kingdom's exit from the European Union and making additional enquiries wherever deemed appropriate, the Trust Board has a reasonable expectation that the Berkshire Healthcare NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

For this reason, the Trust continues to adopt the going concern basis in preparing the accounts.

The Trust's accounts have been prepared under a direction issued by NHS Improvement under the National Health Service Act 2006. Accounting policies for pensions and other retirement benefits (as set out in the notes to the accounts) and details of senior employees' remuneration can be found in the remuneration report.

The external auditor for Berkshire Healthcare NHS Foundation Trust, as appointed by the Council of Governors, is Deloitte LLP. The Trust's internal auditors are RSM Risk Assurance Services LLP as appointed by the Trust Board.

Performance analysis and review

The Trust Board oversees delivery against our key performance measures and achievement of strategic objectives. This ensures that the financial and governance requirements required by our provider licence are met, and that the quality and safety of care we provide meets the requirements of the Care Quality Commission.

The Trust takes an integrated approach to performance, measuring itself against targets and benchmarks in clinical care, quality, and finance. Within each are a wide variety of measures, but all are monitored and reported using established and robust system. Our performance is presented in our Integrated Performance Scorecard, which is monitored and reported monthly to the Trust Board, following detailed review and scrutiny at the Finance, Performance and Risk Committee. The key performance elements within the scorecard are:

- User Safety
- People
- NHS Improvement Non-Financial Requirements
- NHS Improvement Financial Requirements
- Service Efficiency & Effectiveness
- Contractual Performance

Our performance report is available for the public to view as part of our published Trust Board papers.

We also use benchmark information to inform our assessment of the efficiency and effectiveness of our services in comparison to other providers. We undertake regular data quality audits and Information is also triangulated with data from other sources, such as Trust Board and Governor Quality visits, complaints and patient feedback to provide additional assurance on performance quality.

During 2019-20 we will be moving to a new Performance Assurance Framework, which will replace the existing performance scorecard and will build on the principles of our Trust Quality Improvement programme changing the way we monitor, escalate and resolve instances when performance is outside of accepted thresholds.

Throughout the year, we have operated in compliance with our NHS Provider Licence issued by NHS Improvement, the foundation trust sector regulator. We continue to be in segment 1 within NHS Improvement's Single Oversight Framework. This gives NHS Provider organisations the maximum autonomy and represents the lowest level of oversight and risk assessment by the regulator.

Our strategic plans will be refreshed during 2019-20 in line with the NHS Long Term Plan requirement to submit a five-year plan in the summer of 2019. This work will be undertaken in conjunction with our Integrated Care System partners.

As the NHS continues its journey, moving toward more coherent system working, we have developed and strengthened our working relationships with our Integrated Care System partners across Berkshire West and Frimley Health and Care. This year saw all organisations in each of our Integrated Care System agree to deliver system wide financial control totals, requiring shared responsibility for effective use of our collective resources, enabling us to achieve financial balance as a whole system. The better than planned surplus achieved by the Trust this year, has helped contributed to the financial performance of both Integrated Care Systems.

Berkshire West and Frimley Health and Care Integrated Care Systems are among the ten national "exemplar" Integrated Care Systems in which commissioner and provider organisations collaborate in the use of local resources to achieve the best outcomes for local people. This includes the development of system plans which include clinical work streams, alongside potential opportunities to improve our use of our collective resources.

During 2018-19, we have provided mental health and community health services as defined by our contracts with Berkshire Clinical Commissioning Groups (CCGs), NHS England and Berkshire Unitary Authorities. Most of these are "block" contracts which mean that we receive a specified income for delivery of services in line with a commissioner specification. This funding method presents a significant challenge when referrals to our services, and activity within them increases, and we have continued to experience this across a range of services. Full details of our financial statements can be found in the Annual Accounts later in this report.

Whilst we have retained our overall "good" rating by the Care Quality Commission, we will continue to work to achieve an 'Outstanding' rating across our services and remain committed to our vision:

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

During 2018-19 we have continued to embed our Quality Improvement Programme across the whole organisation, which will help us to achieve our vision. We remain committed to our goals which are:

- **Harm-free care** – to provide safe services, prevent self-harm and harm to others
- **Supporting our staff** - to strengthen our highly skilled and engaged workforce and provide a safe working environment
- **Good patient experience** – to provide good outcomes from treatment and care
- **Money matters** – to deliver services that are efficient and financially sustainable

The above goals provide the structure for our annual "plan on a page for 2019-20", and are supported by specific measures which will enable us to focus our efforts and track our progress effectively. Our team plans also follow this structure, which informs individual objectives for all our staff.

Our Strategy Implementation Plan identifies all major initiatives being undertaken to achieve our objectives. This has now been amalgamated with our project monitoring arrangements undertaken by our Project Management Office, and progress is reported to our Executive and Trust Board throughout the year.

Our Operating Plan for 2018-19 recognised several key risks to delivery, and we also highlighted these within our system plans for 2018-19 (and 2019-20) as appropriate. These risks include:

- Inability to recruit and retain sufficient staff to provide safe, good quality services.
- Inability to meet demand in a timely way in specific services due to high referral rates – in particular, we continue to see high demand for mental health crisis and home treatment services, inpatient beds, child and adolescent mental health services and a number of community health services
- Inability to achieve prompt and timely discharge from our inpatient services due to lack of funding/availability of support.

Along with our Quality Improvement Programme, we have identified two other strategic initiatives, which are Workforce and System working – these three major areas of work are focussed on mitigating the above risks.

Our Information Management and Technology programme is a key enabler for the delivery of all our strategic goals. We achieved "Global Digital Exemplar – Mental Health" status in 2017. The coming year will be the final of a three-year programme over which time we will have invested £10m in new technology, improving services for staff and patients.

As part of the operational planning process for 2019-20, we have worked with our Commissioners to reach agreement about our contracts for the year ahead. Our plan forecasts a planned surplus of £2.3m by year end with a cash balance of £23.2m. We will continue our work with our Integrated Care System partners to achieve our "system control total".

As a public sector body, we have important obligations under the Equality Act 2010. Our work in this area is outlined in the equality and diversity section of this annual report. We have achieved good progress in achievement of a number of key objectives this year. We have also set out our areas of focus in relation to the NHS Staff Survey.

The Trust has no overseas operations.

Financial Report

The Trust ended the financial year reporting a surplus of £6.5m. This is inclusive of £0.4m non-operating fixed asset impairments and £1.0m of donations. Our financial performance was better than planned and we exceeded our agreed NHS Improvement Control Total by £1.5m. We have received £4.5m of Provider Sustainability Funding, (PSF) from NHS Improvement, including £0.9m for exceeding our regulatory target.

Our better than planned surplus has contributed positively to both our Integrated Care Systems' financial performance. This helped Frimley Integrated Care System deliver their system control total for 2018-19, but unfortunately was insufficient to mitigate financial pressures across the wider Berkshire West Integrated Care System as it failed to deliver its system control total.

The Trust's revenues, 91% are predominantly generated from other NHS organisations, and we have generated income £3.1m in excess of planned levels this year, excluding donations. Our operating costs were £2.2m higher than planned. Despite on-going workforce pressures and escalating demand for our services, we have contained rising costs within funding levels. Whilst we finished the year with pay costs £0.7m ahead of plan, we saw agency costs fall by a further £2.9m compared with 2017-18. We focussed considerable resources this year to reduce the use of out of locality placements for our mental health patients. Whilst this has benefitted the quality of care for our patients, it has also led to a £1.1m reduction in cost; still this reduction was less than assumed and overall placement spend was £2.0m higher than we had planned. Non-operating costs were £0.2m below plan, including £0.4m impairment costs.

The Trust has invested £11.0m in its Capital Programme this year, including £1.1m of donated funds. This was only £0.1m short of the level of investment that we planned for the year. We have improved the quality and safety of our Estate for both staff and patients with £2.8m of investment across our facilities. As a Global Digital Exemplar (GDE) we continue our

investment in technology, ensuring our staff have access to up to date equipment and that our systems are reliable and secure. Overall, we have invested £7.0m in technology, £2.0m of which was funded directly by the Department of Health and Social Care. Through donations, we have completed the Renal Unit at West Berkshire Community Hospital, in Newbury.

The Trust finished the year with a closing cash balance of £25.6m, which represents a net cash increase of £3.3m. In addition, a rigorous approach to the management of our working capital, the Trust has benefited from the receipt of unplanned Department of Health and Social Care IM&T funding, as well as achieving a higher than planned surplus.

The Trust delivered a Use of Resource Rating of 1 for 2018-19. This is a 1-4 rating scale used by NHS Improvement to assess the financial risk of an organisation, with 1 indicating the lowest financial risk of breaching licence conditions.

Whilst we exceeded our overall financial target, our cost improvement programme achieved £2.9m of the £4.8m savings planned. Whilst this is less than planned, it represents an 80% increase on costs saved in the prior year.

The financial outlook for 2019-20 remains challenging, despite the well published funding increases. The Trust will continue to work with partners over the coming year to develop better integrated services to Berkshire residents and patients, whilst continuing to mitigate the pressure of rising population demand and care needs.

Better Payment Practice Code

The Trust aims to pay suppliers and providers of goods and services promptly, and has a target of paying 95% of all invoices within 30 days of receipt. The Trust did not make any payments in respect of interest under the Late Payment of Commercial Debts (Interest) Act 1998 during 2018-19. The actual performance for the Trust for financial year 2018-19 was as follows:

Non-NHS Payables	**No of Invoices (count)**	**% of activity**	**Value of Invoices (£'000s)**	**% of value**
Paid within 30 days	25,207	87%	70,031	88%
Paid over 30 days	3,868	13%	9,162	12%
Total	**29,075**	**100%**	**79,193**	**100%**

NHS Payables	**No of Invoices (count)**	**% of activity**	**Value of Invoices (£'000s)**	**% of value**
Paid within 30 days	621	83%	4,155	64%
Paid over 30 days	123	17%	2,319	36%
Total	**744**	**100%**	**6,474**	**100%**

Sustainability and Climate Change

Overview

Berkshire Healthcare NHS Foundation Trust recognises that it has a responsibility to maximise its contribution to developing a real sustainable National Health Service and help combat climate change. The Trust has used national guidance to help develop and update its Sustainable Development Management Plan (SDMP). This plan sets out the strategic direction for the Trust with regards to sustainability, climate change mitigation and adaptation and how, as an organisation, we will work to achieve our Sustainable Development Policy, which is to:

> **"Provide healthcare that is sustainable, efficient, flexible and resilient; taking every reasonable opportunity to enrich the health and wellbeing of the communities we serve."**

The Sustainable Development Management Plan sets out five overarching sustainability goals that are supported by a number of key objectives. These goals are:

1. Provision of sustainable healthcare.
2. Partnerships that embrace sustainability and maximise efficiency
3. Working towards sustainable and climate ready environments
4. Enhance and optimise the estate
5. Measure, monitor and purchase sustainably

Year on Year Progress

During the 2018-19, we have continued our progress in embedding sustainability and carbon management into the operational core of the organisation. The key successes for 2018-2019 are:

- Continued to ensure that sustainability and carbon management were key considerations in all major procurement and service commissioning tenders;
- Implemented a rolling programme for LED re-lamping across the estate;
- Implemented the adopted a Trust wide Green Travel Plan;
- Continued rationalisation of the estate – to sustain and future proof service provision;
- Improved monitoring and further developed the necessary processes to ensure that none of the Trust's waste ended up in landfill;
- Continued to support the South Region Sustainable Healthcare Network through the provision of a Sustainability Ambassador;
- Highlighted the sustainable benefits of service delivery through joint work with external organisations to provide a better clinical service which was also more sustainable.
- The Therapy garden at West Berkshire Community Hospital won the NHS Employers' National Sustainable Health and Care award for Green Space; and
- Identification and initial feasibility review completed for large solar photovoltaic (PV) installation to provide renewable energy to one of the Trust's hospitals.

We have fully adopted and embedded the updated Sustainable Development Management Plan, which provides a structured plan to combat the impact of climate change, and build a positive sustainability culture across the organisation.

Summary of Performance – Non-Financial and Financial

The information presented in the table below incudes all apportioned Trust occupied sites.

Area		Non-financial data (applicable metric) 2017/18	Non-financial data (applicable metric) 2018/19		Financial data (£) 2017/18	Financial data (£) 2018/19
Waste minimisation & management	General (t)	357	294	Total cost of waste disposal	£190,587	£183,524
	Recycling (t)	67	163			
	Clinical (t)	141	81			
Finite Resources	Water (M^3)	45,142	54,321	Water	£100,817	£132,952
	Electricity (GJ)	20,676	22,888	Electricity	£677,164	£723,369
	Gas (GJ)	38,528	42,719	Gas	£307,287	£354,540

Waste data notes

- It is not possible to provide specific cost by waste stream because the Trust does not receive this information from the two Private Finance Initiative (PFI) hospital sites;
- Increase in recycling is due to inclusion of all confidential waste which is recycled;
- Reduction in the clinical waste is due to improved monitoring and apportionment of occupied floor areas; and
- Reduction in general waste is due to the removal of confidential waste stream and to an increase in recycling.

Finite resource notes

- Increase in energy costs is due partly to the increase in consumption as well as the increase in non-commodity costs;
- The increase in electricity costs is mainly due to West Berkshire Community Hospital where there have been infrastructure changes and to an increase in service provision;
- Gas increase would appear to be as a result of increase in consumption on the NHS Property Services Community Hospital sites; and
- The main increase in water consumption is on the NHS Property Services Community Hospital sites where Berkshire Healthcare provides services from.

Governance, Partnerships and Monitoring

The governance structure to support and drive forward the Sustainable Development Management Plan has been established in accordance with Department of Health and Social Care guidance and recognised best practice. We have established collaborative working relationships with key public service providers across Berkshire.

Berkshire Healthcare has a dedicated Sustainability Manager who champions and coordinates our work on sustainability and climate change. Statutory reporting operates through a number of routes, including the Estate Return Information Collection, the Care Quality Commission and NHS Improvement. We use the standard reporting template developed by the NHS Sustainable Development Unit, Department of Health and Social Care and other NHS organisations, in line with the data requirements set out in HM Treasury's Sustainability Reporting Guidance.

Future priorities and targets

Our Sustainable Development Management Plan continues to inform our activities and we have confirmed specific targets against our overarching goals. These include a number of

initiatives supported by increased use of technology to provide on-line support to patients, reduction of energy use and green travel. It also includes a number of key targets in relation to carbon emissions, waste, utility and transport.
This is the second edition of the Trust's Sustainable Development Management Plan and this will be updated during 2019-20 to continue to drive forward the agenda and ensure that the Trust becomes progressively more sustainable in all its operational and strategic activities.

Emergency Preparedness, Resilience and Response

In line with its statutory obligations under the Civil Contingencies Act 2004, the Trust has in place arrangements for Emergency Preparedness, Resilience and Response (EPRR). We undertake joint emergency planning with healthcare partners, local authorities and other emergency services. This work is undertaken through regional forums, such as the Local Health Resilience Partnership Framework and the Berkshire Resilience Group.

Development and improvement of the Trust's integrated emergency management system is overseen by the EPRR Governance group. This Group reports to the Non-Clinical Risk Group, Chaired by the Chief Financial Officer. The Chief Operating Officer is the designated Accountable Emergency Officer for the Trust, responsible for ensuring our compliance against NHS England's Core Standards for EPRR.

The Trust is assessed against the EPRR Core Standards on an annual basis. The assurance process requires provider organisations to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness, which provider organisations are required to take to a public Trust Board meeting and also publish in their Annual Report.

For 2018-19, the Trust assessed itself as fully compliant with 50 of the 54 EPRR core standards applicable to Community and Mental Health Trusts. The overall compliance rating is therefore 'Substantial'. An improvement plan has been produced which sets out actions against the 4 core standards where full compliance has yet to be achieved.

NHS England South EPRR Assurance compliance ratings

To support a standardised approach to assessing an organisation's **overall preparedness rating** NHS England have set the following criteria:

Compliance Level	Evaluation and Testing Conclusion
Full	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-Compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Diversity and Inclusion

The Trust's Equality and Inclusion Strategy 2016-2020 sets out the seven equality objectives that will support the staff and diversity networks across the organisation. The Diversity Steering Group (DSG) continues to provide leadership and scrutiny to ensure all Equality, Diversity and Inclusion work is in line with these objectives.

Public Sector Equality Duty

The Public Sector Equality Duty (PSED) requires public bodies to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities.

The Trust's Equality and Inclusion Strategy was approved by the Trust Board in June 2016 and the seven goals of the strategy support compliance under the Public Sector Equality objectives, as required by the Equality Act 2010.

1. Increase the representation of Black, Asian and Minority Ethnic (BAME) staff in (Agenda for Change) bands 7 and 8a-d, aiming for 20% representation at each of these grades. This reflects the Berkshire population.
2. Ensure there is no difference in perceptions of equal opportunity in career progression between white and BAME staff (as measured by our annual NHS Staff Survey).
3. Reduce harassment and bullying as reported by staff and in particular, BAME staff, in the annual NHS Staff Survey. We are aiming to reduce experiences of harassment and bullying to lowest quartile rankings compared with other Mental Health Trusts in the NHS Staff Survey index. We also wish to achieve equity in reporting between BAME and white staff.
4. Significantly improve the well-being of disabled staff and a reduction in the proportion of staff experiencing stress related illness.
5. Take a more robust approach to making reasonable adjustments for disabled people – in particular, implementation of the NHS Accessible Information Standard.
6. Attain Top 100 Workplace Equality Index Employer status with a ranking in the top five health and social care providers.
7. Engage with diverse groups in particular Black, Asian and Minority Ethnic, Lesbian Gay Bisexual and Transgender, and disabled people to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access in both Mental and Community Health Services.

The Trust Strategy identified three key target groups and established staff networks to address the associated inequalities with these protected characteristics. Three staff networks have been established and each has a Trust Board sponsor who is responsible for ensuring a clear pathway between the operational activity and the Trust's strategic vision. The Target groups are as follows:

- Black, Asian and Minority Ethnic people (BAME network);
- Individuals with a Disability (Purple network); and
- Lesbian, Gay, Bisexual and Transgender people (LGBT+ network).

This year we have invested in additional resource to support the networks and their leads when planning events and ensure actions are taken forward.

Divisional Equality Plans are instrumental in the delivery of the Equality and Inclusion Strategy and the Equality Leads support the implementation of the Plans. Each Region has produced a *Plan on a Page* and services aim to include Diversity and Inclusion targets in Team Plans and individual objectives. Equality plans for 2019-20 will reflect the new operational services directorate structure, enabling monitoring of progress to be embedded within the performance management system.

Diversity Road shows

Our Diversity Road shows were launched in May 2018. The objective was to communicate our equality and diversity programme in a fun and interactive way to staff who would ordinarily not engage. The format was for each locality/directorate to host their individual Road Show using local and corporate resources. Five areas held a road show. The main aims were to:

- Introduce what the Trust and the Locality were currently doing to promote Equality and Diversity in a local setting;
- Clarify what the Trust means by diversity;
- Provide an opportunity for staff to meet with staff inclusion networks and other resources, for example, wellbeing initiatives, hate crime awareness, the *Making It Right* (development programme for BAME staff) etc; and
- Provide information for staff on where to get help should this be needed for themselves, a colleague or a direct report.

The average attendance for the Road Show was 70, above our target of 60 staff. Activities were educational as well as entertaining, enabling staff to make connections and engage in good quality conversations. At one of the Road Shows, staff represented more than 20 different nationalities. Members of the Trust Board and the Senior Leadership Team were in attendance in many of the Road Shows. There is a recommendation that the Road Shows will continue in 2019, as they have proven to be a more accessible vehicle than a single organisation-wide conference. However, Equality Leads, Networks and Regional Directors are being engaged to ensure this approach is working for all, and that 2019-20 events are informed by their views.

Employment Diversity Summary

As at 31 March 2019, the Trust employed 4,341 members of staff (3,528 full time equivalents):

- 82.3% were female and 17.7% were male
- 23.3% of staff were from visible minority ethnic backgrounds, compared with 20% of the Berkshire population (2011 census); 8.8% were from non-British white backgrounds compared to 7% of the Berkshire population.
- 4.9% were disabled people compared with 7.7% of the workforce in the South East (Labour Force survey).

Table 1: Workforce Diversity

	Staff March 2018	Staff March 2019
Total	***(4304)***	***(4341)***
16 – 25 yrs	6.4% (277)	6.5% (283)
26 – 35 yrs	21.7% (913)	21.1% (915)
36 – 45 yrs	25.4% (1094)	26.2% (1138)
46 – 55 yrs	27.3% (1175)	27.6% (1200)
56 – 65 yrs	17.4% (748)	16.8% (731)
66 plus yrs	1.8% (77)	1.7% (74)
White British	64.1% (2759)	62.5% (2713)
White Other and Irish	9.0% (389)	8.8% (382)
Mixed	2.1% (92)	2.2% (97)
Asian or Asian British	10.2% (440)	10.1% (437)
Black or Black British	8.5% (364)	8.9% (386)
Other Ethnic Group	1.7% (74)	2.1% (91)
Not specified	4.3% (186)	5.4% (235)
Women	83.2% (3579)	82.3% (3576)
Men	16.8% (725)	17.7% (765)
Not specified		
Disabled staff	4.8% (207)	4.9% (217)

In addition, figures reported as at 31 March 2019 show:

- 50.7% of our workforce identify themselves as Christian, 12.8% Atheist, 3.3% Islam, 2.9% Hindu, 13.4% other religious beliefs, and 20.1 % do not declare;
- 2.1% (93) staff identify themselves as Lesbian, Gay or Bisexual, 81.3% Heterosexual, and 16.6% do not declare.

Senior Management and Leadership ethnic diversity

Senior Managers/Leaders As at 31st March 2019	Gender		Ethnicity		
	Male	Female	White	Non-White Minority ethnic	Undisclosed
Non-Executive Board (7)	57.1%	42.9%	71.4%	14.3%	14.3%
Executive Board (6)	66.7%	33.3%	83.3%	16.7%	
Directors (Locality, Clinical and other)	27.8%	72.2%	72.2%	11.1%	16.7%
Heads of service	7.5%	92.5%	87.5%	10.0%	2.5%
Senior managers (8c and above)	44.4%	55.6%	74.1%	18.5%	7.4%
Berkshire Healthcare staff (total headcount)	765	3,576	3,098	1008	235

Equality impact

The Trust publishes equality analyses with corresponding policies. Trust Board papers also include an equality impact paragraph as part of the cover sheet to ensure that equality is taken into account in all Trust Board reports.

NHS Equality Delivery System

The Trust uses the NHS Equality Delivery system (EDS2). The main purpose of the EDS2 was, and remains, to help local NHS organisations, in discussion with local partners, including local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. NHS England is currently undertaking a review of the Equality Delivery system with a plan to launch a new refined EDS3 in 2019-20.

NHS Trusts are able to determine the approach taken to grading their performance against the EDS goals, and our Diversity Steering Group is recommending that the grading happens in line with the Equality and Inclusion Strategy refresh. This would mean that the goals are formally graded every four years. Divisions have identified four goals they will be working towards and high level action plans have been developed and more detailed plans are in progress.

Goals have been identified and each division will identify four Equality goals they will be working towards from the list below:

1. To reduce the harassment and bullying reported in the annual NHS Staff Survey, in particular by BAME staff;
2. To develop a more robust approach to making reasonable adjustments for patients with a disability;
3. Engage with BAME, LGBT+ and Disabled groups to inform our understanding of their needs, with a view to ensuring good patient experience and equity of access to Sexual Health Services;
4. Improve partnership with the voluntary sector to maximise support available to improve communication for patients and carers;
5. Improved awareness and support for staff who have a disability;
6. Understand the diverse recruitment process at panel level;
7. Positively involve patients; and
8. Assess and understand the resources available across all wards to support Equality and Inclusion.

Workforce Equality, Diversity and Inclusion

As of March 2019, the Trust employed 4,341 employees or 3,528 full time equivalents. Significant work is continuing to improve equality, diversity and inclusion across the workforce. The Trust has three key networks where staff can feedback concerns, work on the activity that is required to improve equality and get support from other staff and managers who are experiencing similar issues.

Monthly, we monitor the diversity of the workforce through the new People Dashboard. We are able to track gender, ethnicity, sexual orientation, age, religious belief and disability. The 2011 census reported 20% BAME in the Berkshire population and the Trust is currently employing 23.3% but we know more works needs to be done to have this representation at all grades.

Progress of the three themes of the Trust's Equality Strategy

Race Equality - The Workforce Race Equality Standard

The Executive has approved a Workforce Race Equality Strategy (WRES) action plan which will run for two years, including a business case to support the actions. The WRES Action Plan is embedded in the Equality Employment Plan (EEP). There has been good progress in implementing both plans and the related work streams. The Equality Employment Plan is seeking to bring about a sustained change in attitudes and behaviours, using interventions that will develop and empower BAME staff, as well as increase the competence of managers. The Trust now has an action plan which is informed by best practice.

Through the *Making it Right* programme for agenda for change bands 5-7, we hope to build confidence and competence within our BAME workforce and see more successful applications for bands 7, 8a and 8b. We have completed a pilot and two cohorts of the *Making it Right* programme (43 members of staff) and the feedback has been positive. The third cohort will start in May 2019. The *Making it Right* programme is made up of four one-day workshops which are aimed at developing participants' attitude, knowledge and skills, enabling staff to:

- Compete effectively for jobs;
- Feel empowered to conduct themselves constructively when faced with discrimination or conflict at work; and
- Have access to a mentor and individual and tailored support.

The *Making It Right* programme is still in its infancy, but more than a third (8 members of staff) of the graduates have already secured promotion and others have been seconded to higher positions.

NHS England will be launching a new Workforce Equality Strategy in 2019. The strategy will support NHS organisations to increase recruitment of BAME staff and will examine ways of tackling the ethnicity and gender pay gaps.

The BAME Network has a membership of more than 300 staff and the network has co-designed the WRES action plan. In October 2018, the network hosted a Black History Month event 'Celebrating the contribution of BAME staff in Berkshire' as part of the wider NHS 70th anniversary. There were cultural performances from Asian and African artists and presentations from some distinguished speakers, including Alok Sharma MP, Roger Kline (Co-author of Snowy White Peaks) and Tracie Jolliff (NHS Leadership Academy).

In December 2018, the Trust hosted a working lunch for the Executive and members of the Network to meet with the Trust Chair. This gave the Trust Chair and Executives an insight into the first hand experiences of our BAME staff.

In 2019-2020 the Trust will continue to prioritise equality of career opportunity for BAME staff, discrimination from managers, harassment, bullying or abuse from colleagues or patients.

The National NHS Staff Survey 2018 (results were reported February 2019), highlighted the different experiences felt between white and BAME staff and illustrated the work still required to make a positive impact for BAME staff. A *Making It Right* programme is being developed for senior leaders and managers with the aim of increasing their awareness of how it feels to be a BAME member of staff and what direct actions they need to take to improve the feedback we receive from staff.

Rosemarie Ramkissoon - Reading Community Team for People with Learning Disabilities/ BAME Committee Member and Joint Reading Locality Lead shared her views of the *Making It Right* programme:

> *"The Making it Right programme is the best and the most outstanding programme for all BAME staff. It enabled me to build my confidence, in myself, my work and my outlook."*

Stephanie Wynter – Executive Assistant - BAME Network Communication Officer

"Through the Making It Right programme I have learnt the importance of articulating my expectations in my appraisal, of constructive conversations about career development; salary and goals within the Trust with my line manage. I can now see myself moving forward for the future. I appreciate all the learning outcomes from the programme and can only wish that something like this would be initiated within every organisation and society for all groups with protected characteristics and all managers – people need to hear the experiences, hear the journeys and then make it right for all".

Disability Equality

The Workforce Disability Equality Standard (WDES) came into force in April 2019 and incorporates a set of specific measures that will enable NHS organisations to compare the experiences of disabled and non-disabled staff. This standard requires an annual data submission and the first WDES reports are due to be published in August 2019, based on data from the 2018-19 financial year, and in April/May 2020 the first National WDES annual report will be published by NHS England. The Trust hosted a Disability Symposium in March 2019 to raise awareness of the WDES indicators with presentations from both NHS England and NHS Employers.

Following the launch of the Purple Network in January 2018, the Network has grown from strength to strength. Current membership stands at 100 employees. The Network has a clear set of objectives aligned to the Trust's

Equality and Inclusion Strategy. The Network has undertaken a staff survey to identify what support that is required for those with disabilities. We are aiming to launch a *Making It Right* programme for disabled staff in March 2019.

Information from our National NHS Staff Survey (2017) shows that disabled staff feel their wellbeing is poorer in a number of domains compared to non-disabled staff. There is also some disparity between the number of staff who declare themselves to be disabled with a long term condition on the electronic staff record (4.8%) compared to those who declare a disability in the Annual National NHS Staff Survey (18%).

From 1st August 2016 onwards, it became a legal requirement that all organisations providing NHS care and/or publicly-funded adult social care to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss. A fixed term post starting in April 2019, has been agreed for an Accessible information and Access lead, who will review our current status regarding this requirement, informing targeted action required. Working in conjunction with Human Resources, the role will support a specific piece of work to be completed to enable managers to have access to information that they need to make reasonable adjustments for staff with disabilities.

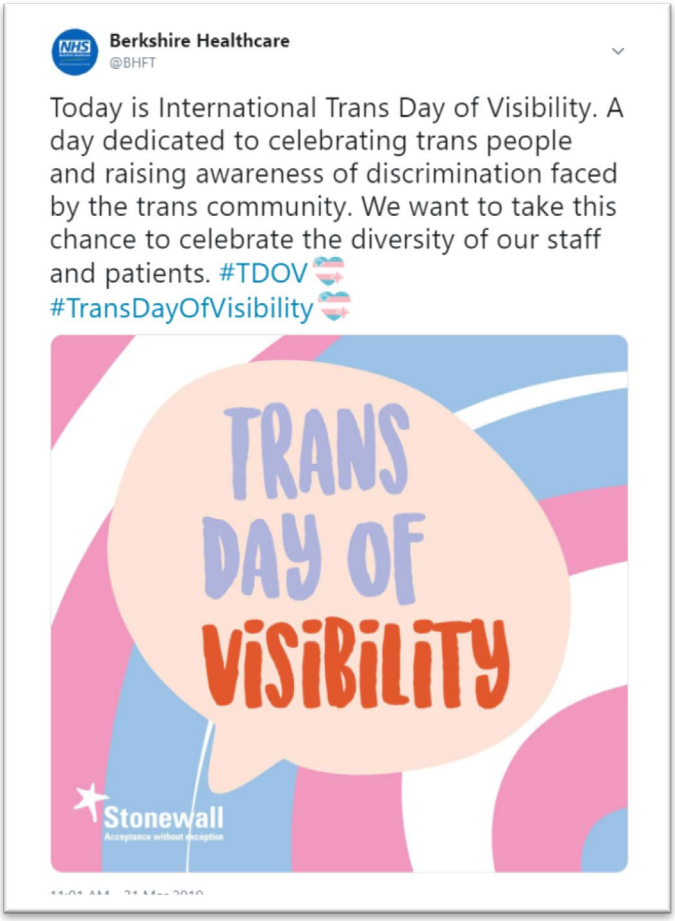
Marcella Browne, Chair of the Purple Network and a Community Nurse

"My journey over the past 7 years with Berkshire Healthcare has included pre and post diagnosis. I am now in a position where I am able to talk openly about my condition, feel like I can bring my whole self to work. By sharing our experiences, we can improve the understanding around autism, recognise our strengths and challenges, ask for support where needed and focus on achieving our goals".

Sexual Orientation and Transgender Equality

In Stonewall Workplace Equality Index 2018, the Trust was ranked 133. Although we were not successful in regaining a place in the top 100, we received positive feedback recognising our achievement in maintaining a place just outside the top 100, given the continued raising of standards by other organisations. Our submission included improvements in a number of important areas:

- Procurement
- Training
- Service Provision



A clear and proactive plan is in place to review the Stonewall submission for 2019. A working group has been established to enable us make the changes required to make this a more inclusive organisation. We have successfully engaged with employers that have achieved the top 50 within the index and we are looking to learn from their success and how to make a fundamental change this year.

Changes are being made to the electronic staff record system (ESR) to ensure that data is captured that will allow individuals to identify according to how they would describe themselves. This will support the Trust's aim to ensure that it can attract and retain staff from a diverse pool of candidates and that everyone feels welcome and has a sense of belonging. We want to create an environment where people feel able to disclose who they are and adopt the 'Do ask, Do tell' campaign, to improve disclosure rates.

There are also plans to review the data captured in RiO (electronic patient record system) and Datix (incident reporting system) to bring these in line with best practice as set out by Stonewall.

The LGBT+ staff and allies network has three new co-chairs who have developed a clear plan to promote and engage staff members across the Trust aligned to the Trust's Equality and Diversity strategy. The Network will be working with the Equality and Diversity Manager in planning for Reading pride 2019.

The Trust continues to support and actively engage with the Thames Valley LGBT+ network, which meets three times a year across the Thames Valley region. This opportunity enables the Trust to learn and engage with the good employment practice from across the region.

The Trust has committed to providing a further years funding for Support U, a local LGBT+ community group, by providing clinical supervision to their volunteer counsellors.

Nicky Augustus (Co-chair of the LGBT+ network, Personal Assistant and Estate team member)

> *"At Berkshire Healthcare we think it is important to be your authentic self as this lends to a more harmonious and productive environment. Ensuring an inclusive*

environment for all employees regardless of their sexual orientation, gender identity or expression is a key part of our belief that diversity makes us stronger. The Trust's LGBT Network meets to discuss any issues faced within the workplace and we also celebrate our uniqueness by participating in Reading Pride every year".

Register of interests

The Trust maintains a Register of Interests for all members of the Trust Board providing details of any Company Directorships and any other relevant significant business interests held that may conflict with any management responsibilities. This Register is published on the Trust's website at: https://www.berkshirehealthcare.nhs.uk/about-us/key-documents/reports-policies-and-procedures/ or may be obtained upon request to the Trust's Company Secretary.

Stakeholder relations

Berkshire Healthcare is continuing to work with our local partners to develop the Integrated Care Systems that we are part of in Berkshire West and Frimley Health and Care. Berkshire West Integrated Care System is also part of the wider Berkshire West, Oxfordshire and Buckinghamshire (BOB) Sustainability and Transformation Partnership. The purpose of these arrangements is to:

- Improve the health and wellbeing of the population served by the organisations within the Integrated Care System or Sustainability and Transformation Partnership. This includes the experience of the people who use our services, as well as improving the outcomes of care and treatment; and
- Improve the use of our collective resources as a whole system.

These arrangements include work on some key priorities that we are contributing to, and which reflect the NHS Long Term Plan that was published this year:

- Reducing the number of people that receive acute mental health inpatient care out of our area;
- Improving services for people in crisis; and enabling more children and young people to access mental health services;
- Working with groups of GP Practices to develop "Primary Care Networks" and Integrated Health and Social Care Teams, delivering care and treatment in a more joined up way;
- Continuing the development of our electronic Shared Care record – which will also include a "patient portal" so that people can view and contribute to aspects of their own record; and
- Continuing joint planning about our use of our buildings, a shared approach to workforce planning and development of our support workforce.

We work closely with our six Local Authority partners, and have links with community and voluntary sector organisations at local level. This includes our developing work to reach out to groups of people who may not readily access services, but who have specific health needs. We participate in and have constructive relationships with Health and Wellbeing Boards, Local Integration Groups and Local Authority Health Scrutiny arrangements.

We meet regularly with representatives from all six Health Watch Groups in Berkshire - which is coordinated by our Patient Experience Team. This year we are undertaking a piece

of work to enable us to measure more effectively how patients experience our services – this is part of our Quality Improvement Programme and would complement the "Friends and Family" test which asks whether patients would recommend our services to their friends and family.

The stakeholder survey that we undertook and reported on in last year's Annual Report will be repeated in the coming year. This asks the leaders of some of our key stakeholder organisations about:

- how effectively we have engaged with them
- how they view our working relationship
- how they see us as System Leaders and how confident they are that we would act on feedback about our services

We were extremely pleased with the results of this survey – which showed 89% of ratings were very good or fairly good, and our aim is to maintain a rating of 85% or more.

Julian Emms
Chief Executive
22 May 2019

OPERATING REVIEW AND SERVICE DEVELOPMENTS

Operational goals and priorities

The operational goals in 2018-19 were to support the delivery of the Trust's Strategic Plan by maintaining and improving service delivery, supporting strategic projects and working with partners to improve patient experience and outcomes.

Operational priorities for 2018-19 for each clinical service and locality are produced using a *Plan on a Page* which determines operational and service goals. These have been used to determine the key priorities and for cascade to Front Line staff and inclusion in Operational Managers' objectives.

In addition, the following key service improvement programmes were prioritised:

- Roll out of the Quality Improvement programme
- Reduction in the use of Out of Area Placements
- Workforce Strategy
- Delivery of improved clinical space and buildings
- Delivery of improved technology solutions for staff and patients
- Delivery of the Equality and Inclusion Strategy priorities and action plans

Service Review and Developments

Children, Young People and Families (CYPF) Developments

During 2018-19, we have continued to develop our Children, Young People and Families service offer. The Trust is committed to providing integrated, holistic health care to children, young people and their families. Having a county wide approach to CYPF has enabled the development of consistent service delivery within professions and services. Close working relationships with the Local Authorities continues to be important, not only for commissioning reasons, but also for work around Special Education Needs, Disability and Safeguarding.

CYPF have been involved in two multi-agency inspections in 2018-19. An inspection of the Special Educational Needs and Disability processes was undertaken within the West Berkshire Local Authority area system in July 2018 and the feedback was very positive. More recently, in January 2019, a Joint Targeted Area Inspection of the multi-agency response to sexual abuse in the family was undertaken in Bracknell Forest. Both inspections involved relevant regulatory bodies such as the Care Quality Commission, Ofsted and Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services.

Child and Adolescent Mental Health service (CAMHS)

Child and Adolescent emotional wellbeing and mental health remains an area of strong local and national focus. Our service leads have continued to work collaboratively with local partners to progress the development and implementation of plans to transform local services and achieve the targets set out in NHS England's *Five Year Forward View for Mental Health*.

Following the publication of the Government's Green paper on *Transforming Children and Young People's Mental Health Provision* in July 2018, the service worked alongside Berkshire

West Clinical Commissioning Group to develop a bid for the system to be a trail blazer site for Mental Health Support Teams to work in Schools. There will be two trail blazer sites in Berkshire West, one in Reading and one in West Berkshire and the CAMHS service will be involved in support and development of these sites. Berkshire Healthcare is also the host for the new posts of Mental Health Support Staff whilst they are training at Reading University and CAMHS have been involved in the recruitment and support of these staff.

Reading School Nursing – Development of a new service delivery model

Reading School Nursing service worked together to develop a new model of delivery. By separating the roles of School Nurses within the team into two areas of focus: Safeguarding and Public Health, they hoped that their safeguarding commitments would be managed effectively whilst allowing half of the School Nurses in the team to focus on their Public Health and early intervention role. A recent service evaluation has evidenced the following:

- A significant increase in face to face and telephone contacts with families
- Health information is now available much earlier in the safeguarding process; those families with health needs receive support more quickly (health assessments now routinely completed within 10 working days)
- A significant reduction in the amount of safeguarding meetings which needed to be attended due to the early effectiveness of the Safeguarding School Nursing team.
- An increased amount of health promotion was delivered
- Co-creation and increased service user involvement in service developments.
- The School Nursing service was more visible and accessible in the schools

Berkshire School-Aged Immunisation Team

The Immunisation team for school-aged children continues to go from strength to strength. In addition to their core work of delivering immunisations in Primary and Secondary Schools across Berkshire, the team have also embraced additional work to deliver timely responses to outbreaks of disease amongst children and adults within Berkshire.

In the spring, the team responded to a small outbreak of Hepatitis B at a School in Theale. This required the service to mobilise a small team of Nurses, engage with Health Protection Agency and Public Health Teams and provide a rapid response to an outbreak, usually within 48 hours. The team was called upon again in the summer to provide a rapid response to an outbreak of Meningitis B at a Nursery School. The children were aged between 3 and 4 years old. The outbreak occurred at the height of the summer holidays so this meant some staff coming in from their summer break to deliver prophylactic antibiotics and injections to 100 children and about 30 staff.

The autumn term saw the return of business as usual and preparation for delivery of the annual Childhood Flu Programme. The team deliver this in over 350 Schools during a seven week timetable, and each year an additional cohort is added to the timetable. In 2018-2019 the team have exceeded the upper average uptake target (65%) so far with an average uptake of 66.25%. Between September and December 2018 the team have vaccinated just over 49,000 children (around 800 vaccines per day).

The response to the Childhood Flu Programme has been mixed amongst parents and school staff. It is particularly challenging in areas with a high Muslim population, as the vaccine contains porcine gelatine, and despite assurances from the Imams that it is safe and appropriate for children to receive it, the uptake in Slough and some areas of Maidenhead and Reading has been lower.

The service utilised the Fire and Rescue's outreach truck as a Mobile Clinic. This truck became in essence become our Flu catch up Mobile Immunisation Clinic and was able to reach Slough residents direct. Much organisation was done behind the scenes as well as a huge amount of promotional work (including Press, Radio, Berkshire Healthcare, Slough Schools and GPs, Solutions4Health, Slough Borough Council, Facebook, twitter, social media etc) and the putting together of marketing material to raise the awareness and take up of the Flu vaccine in Slough.

The service held two catch up Clinics on a Saturday in December 2018 just before Christmas to capture remaining unvaccinated children. Despite challenges on the day, which included no power on the vehicle until the end of the first Clinic and appalling cold and wet weather conditions, the team of Nurses managed to vaccinate 93 children.

Health Visiting Services - Patient Participation App

The Patient Participation App was deployed to all Health Visitors' iPhones during October and November 2018. Normally the service expects approximately 5 patient participation responses per month via the online survey. In November 2018, after deployment of the App, the service had a total of 119 responses, a significant improvement and a source of valuable feedback that can be used to learn and improve where appropriate.

Children and Young People's Integrated Therapy Service (CYPIT)

The service has been involved in tender processes this year. The Trust has retained the Speech and Language Therapy contract in Bracknell and have been awarded a new contract to provide the service for school aged children in Slough.

East and West Berkshire Health Teams for Looked after Children

The East and West Berkshire teams for looked after children have united into one service providing a consistent service for the six Berkshire Local Authorities, children and their carers. Patient engagement continues to be an integral part of service improvement within the team and this year looked after children and young people have been instrumental in the team's redesign of service user feedback forms.

Mental Health In-Patient Services

All the wards in the Mental Health Unit at Prospect Park Hospital have now all completed the Quality Improvement training and have worked hard over the year on supporting the priority objectives of:

- Reducing falls;
- Reducing self-harm; and
- Reducing patient assaults on staff.

The whole Hospital has also worked using the Quality Improvement methodology in reducing the use of prone restraint. This led to the successful development of a suitable beanbag with the patient sitting on the beanbag and it has now been developed and is in use in other Trusts.

Peer Volunteers on Snowdrop ward, Prospect Park Hospital have also been introduced and become established in leading a weekly session with patients who have a Personality Disorder diagnosis. We are working hard to consider how this can be rolled out across the

other three acute wards. A team of eight Volunteers are about to start working in the early evening with patients as Activity Co-ordinators, as this is a time identified by patients when they can be most distressed.

Further positive environmental changes have also been completed including the replacement of 80 beds, the installation of new anti-ligature and anti-climb fences in all acute wards and the replacement of all taps, shower controls and baths to a push button action.

New staff roles were introduced over the year including the Modern Matron role as part of the Senior Leadership Team. These posts are all recruited to and are the pivotal link between the wards and the Leadership Team. The Chaplain has taken on the role of staff Well-Being Lead and is supportive to the staff as well as the patients.

The "Prospect Park Hospital Bake Off" competition, won by Rowan ward, raised over £100 for a local charity as well as raising staff morale and competitive spirit.

Berkshire West Inpatient Community Wards

The Inpatient Community Wards have participated in a joint project to improve patient flow through the health and social care system by working closely with Royal Berkshire Hospital and respective Unitary Authorities. Working in partnership with a diverse range of clinicians, the objective was to optimise processes underpinned by best practice and the available data. All wards have introduced a number of initiatives, including developing standard work for discharge planning and embedding trusted assessor principles.

During 2018, an exercise was completed to review the bed base at West Berkshire Community Hospital. The proposal was agreed to reduce the overall number of available beds to from 59 to 49. The review recommended an expansion of specialist neurological rehabilitation beds and to increase the general Therapy staff on the Inpatient Unit to help reduce the length of stay on the Unit.

Wokingham Community Hospital introduced *Step Up* beds during 2018. The purpose of these beds are for people who are experiencing a sudden change in health, and who need a period of intensive support and rehabilitation in order to avoid the need for a Hospital admission or permanent placement in a Residential or Nursing Home.

Berkshire West Community Nursing teams

As part of the Trust's Quality Improvement Programme, the Community Nursing Teams have embraced the Quality Management Improvement System (QMIS) training. Using quality improvement methodology, the teams have been learning tools to deliver sustainable gains working from the front line of service delivery. QMIS quality driven processes are continuing to be embedded into day to day operations, including Daily Status Exchange and Improvement Huddles from October 2018.

To address recruitment and retention challenges across the Community Nursing Teams, a suite of measures have been implemented, including recruitment hubs, piloting of new mobile technology, development and implementation of new clinical roles to support new recruits and manage high demand for specific interventions. The results of a Staff Survey in 2018 exploring how to improve retention has been completed and actions will be taken forward in 2019 with the respective Community Nursing leads.

Rehabilitation Division

Neurological Rehabilitation Services

The demand for Neurological Rehabilitation Services is growing. The service has used a Quality Improvement approach to review pathways and the triage of patients, to ensure that we are maximising the offering we can make within existing resources. This work will continue, alongside discussions with the Commissioners regarding an expansion of the service across Berkshire. Initiatives have included:

- Working with Intermediate Care teams to up skill them in Neurological Rehabilitation skills – enabling them to support patients with low level neurological needs
- Development of the 'Stroke Network' across the Acute and the Community across medicine and rehabilitation
- Implementation of the Neurological Rehabilitation bed expansion at West Berkshire Community Hospital
- Successful recruitment to a full Neurological Multi-Disciplinary Team on the ward to offer high quality Neurological Rehabilitation in a Community Hospital setting
- The increased use and development of the Therapy Garden at West Berkshire Community Hospital

West Berkshire Community Hospital Inpatient Unit

Key developments for the service during 2018-19 included:

- The introduction of daily bed board rounds resulting in a decrease in the length of stay for patients, enabling them to return to their agreed destination in a timely manner
- Increase in Neurological Rehabilitation beds and subsequent increase in Therapy staff. (also referenced above)
- Creation of Staff Development Lead role – to aid the recruitment and retention of staff, in particular, newly qualified band 5 Nurse roles

Integrated Care Home Service

During 2018, the Rapid Response and Treatment Teams (RRAT) and Care Home Support Team (CHST) across Reading, Wokingham and West Berkshire localities merged to become the Integrated Care Home Service with one Service Manager. The team now functions in an integrated way, working across boundaries, blending the approach of providing proactive and reactive services to the Care Home residents which enhances the quality of service delivered.

The Integrated Care Home Services' (ICHS) Occupational Therapist and Physiotherapist have worked with Care Homes and the Ambulance Trust to review Care Homes' Falls Policies. By training "Falls Champions", implementing Telecare and analysing falls incident data, the following outcomes were achieved:

- A 55% reduction in falls over 6 months in one Care Home through a change in the way care is delivered to residents who fall regularly
- A 90% reduction in 999 calls by a Home through a change in approach to the management of falls, with an associated 41% reduction in falls

- A 66% reduction in falls in a Home that now has Falls Champions: staff have received falls prevention training and the Home are engaged in the audit process.

The ICHS Specialist Nurse Practitioners delivered the 'Six Steps Programme' to the Care Homes, with the aim of enhancing end of life care, through facilitating organisational change and supporting staff to develop their roles around end of life care.

Integrated Community Services

Key developments for the service during 2018-19 included:

- The development of an integrated Health and Social Care team for the management of rehabilitation following a Hospital stay (Joint Care provider service)
- The integration of Therapists and Therapy Assistants working across pathways including Community Nursing
- Review of the Community Therapy pathways in West Berkshire, including Domiciliary Physiotherapy and Falls Pathways, with a resultant reduction in the waiting time for services
- The development of a revised Multi-Disciplinary Team approach to managing complex patients following on from the Community Health and Social Care Multi-Disciplinary Team model in Wokingham
- Introducing Quality Management Information System to the Community Nursing Teams as part of the Trust's Quality Improvement programme work.

Urgent Care Division

WestCall

WestCall is the Out of Hours Primary Care Service in West Berkshire. In addition to providing Out of Hours Primary Care to some 85,000 patients per year, the WestCall team also provides Out of Hours staffing to the Berkshire Integrated Hub, Out of Hours medical cover for Community Wards, 'in hours cover' for training in practice days held by Community based GPs, medical cover for patients receiving Reablement treatment at the Willows Residential Home in Reading and the Thames Valley Integrated Urgent Care 111 Clinical Advisory service.

Following a comprehensive review of the position and challenges facing the WestCall service, new 'Non-Medical' Practitioner posts were introduced into the service to work alongside GPs. This allows multidisciplinary working within the service to provide greater capacity to meet demand and allow the service to be more robust and will allow the team to spend more time focussing on the quality impact of our care delivery.

2018-19 saw WestCall receive a 'Requires Improvement' rating following a Care Quality Commission inspection. Whilst this was disappointing, it did reflect some of the known issues the team have been working very hard to mitigate. Since the inspection, a robust action plan has been implemented. The service is now back on track and we have a high level of confidence that a future Care Quality Commission inspection will find the service to be 'good'.

Emergency Department GP Streaming

Towards the end of 2017-18, the Trust was asked to provide Primary Care Services at the Royal Berkshire Hospital's Emergency Department. This service was well embedded during 2018-19 and has been reviewed several times throughout the period. It is acknowledged to be a high quality service that undoubtedly relieves some pressure from the Emergency Department team. It has however, also been suggested that it is possibly not a financially sustainable model for the future. The service is now approaching the end of its initial pilot period and a process of review is underway.

Thames Valley Integrated Urgent Care 111 Clinical Advisory Service (TVIUC - CAS)

The service operates 10 hours a day, 7 days a week and sees an Urgent Care GP working remotely within our office location in Wokingham to support the 111 operation in Bicester. The role of the GP is to provide senior clinical support to the large team of 111 operatives and Health Care Professionals working for South Central Ambulance Service.

As well as being a senior clinical point of contact, the GP focusses on the re-triaging of calls/patients that would otherwise be told to attend an Emergency Department or even receive a 999 ambulance response. In the previous 12 months, it is estimated that this function has prevented several thousand people from receiving an inappropriate response which not only ensures people receive care closer to home, but the ensures system wide resources are used wisely.

Minor Injury Unit (MIU)

The Non–Medical Practitioner led Minor Injury Unit at West Berkshire Hospital continues to be a success. It offers a walk-in service to residents in West Berkshire and consistently provides a high level of care, with a low level of incidents and complaints. The Minor Injury Unit achieved a 4 hour target for waiting time 98% of the time.

The Minor Injuries Unit has now been identified as a site for expansion and the Urgent Care Leadership Team have been working hard, as part of a wider Steering Group, to prepare the service for a transition into a Urgent Treatment Centre as part of the NHS Plan. This is likely to be implemented during 2019-20.

Scheduled Care Division

Podiatry Service

The Podiatry Service Berkshire-wide has continued under an Any Qualified Provider contract for 2018-19. Since beginning of 2017, there were significant vacancies in clinical posts and the majority of these have been filled successfully. We maintain links with Universities to encourage graduates to apply to Berkshire Healthcare posts, in a landscape of reduced graduates in Podiatry across the United Kingdom. The Service was visited in the 2018 Care Quality Commission inspection and helped maintain a 'Good' rating for Community Adult Services.

The service has undertaken Quality Improvement work to look at capacity and demand within our specialist service. One of the changes made has been caseloads and data collection in RiO (electronic patient record system) and will enable interrogation of this data to help us further understand the demand and help us to deliver timely care to our patients.

Musculoskeletal (MSK) Physiotherapy

Berkshire West MSK Physiotherapy provides Physiotherapy services to patients with musculoskeletal issues in the west of Berkshire. During 2018-19 we have achieved consistently high numbers of patient feedback and now have a year of robust data to support the excellent service we are providing.

We have also expanded our network within Berkshire and now have closer working relationships with our counterparts in the East, the Integrated Pain and Spinal Team, Royal Berkshire Hospital and the Minor Injuries Unit at West Berkshire Community Hospital. This has enabled us to provide consistent high quality and efficient patient care and offer further opportunities for staff to develop knowledge and skills. MSK Physiotherapy are committed to on-going service review and development and already have exciting projects planned for 2019-20, including the expansion of the Oncology service, further opportunities for staff and the exploration of further extended practice roles within Physiotherapy.

Adult Community Speech and Language Therapy

In addition to continuing to deliver our core role of assessing and treating people with swallowing and communication difficulties, the service has also been developing a number of specific projects, including:

- Using a Therapy outcome measure tool which has been integrated into RiO (electronic patient record system). This will enable the service to evaluate clinical effectiveness;
- On the Community wards, work has been completed to introduce 'soaking solutions' for puree snacks for patients on a modified diet. This has led to increased nutritional intake and patient choice, alongside an increased sense of dignity and inclusion at snack time; and
- The service continues to replicate models of service delivery across Berkshire to provide an equitable service for all care groups wherever possible and in line with the requirements of the Clinical Commissioning Groups.

The International Dysphagia Descriptors Standardisation Initiative has been an extensive piece of work has involved delivering training and changing leaflets, ward signage, ward menus and notation used in record keeping etc. This has been a collaborative effort with the Dietetics service and ensures that all patient settings in Berkshire will be using the same language when describing food and fluid consistencies and will understand how to achieve the different levels of food consistency.

Continence

The Continence service is a Berkshire-wide service for children and adults with a bladder or bowel dysfunction. Our team run Nurse-led Clinics across the county, to treat bladder and bowel issues thereby improving the patient's quality of life. Where symptoms cannot be improved, the service ensures that symptoms are effectively managed.

We also undertake the prescribing of continence aids and appliances when required. During 2018-2019 we ran a programme of continence related education for clinicians within the organisation as well as providing education for the nursing home sector. Initiatives this year have been to develop parent workshops for children with constipation issues. This model of care will be developed further in 2019-20.

Phlebotomy Service

During the year we looked at how we can make the service even more efficient for patients, staff, GPs and Consultants. We have now been given access to the Royal Berkshire Hospital's online Pathology System (ICE). This enables the Phlebotomy staff to print the blood test request forms that the GP has requested. Having access to this has a positive impact on time efficiency for all that use, or work in the Phlebotomy Service. Patients will also benefit as they do not have to bring their form to the department, so there is no risk of losing it.

We have also been liaising with the Royal Berkshire Hospital regarding access to their Electronic Patient Record system which would allow us to be able to print patient detail labels to put onto the relevant blood bottles that are taken. This will also have an impact of increased efficiency when we have the label printers installed and when we are given access.

We have been looking to install a telephone queue system, which will have a positive impact on the patients and Phlebotomy staff, as patients will only have to make one phone call and queue rather than leaving a voicemail, which will enable staff to give more time to the patients and other duties, rather than having to take high number of voicemail messages from the phone, then calling patients back, when it is often not convenient for the patient or they do not have their diary with them.

Long Term Conditions and Frailty Division

Wokingham Community Nursing

The integration work within Wokingham Community Health and Social Care Service, CHASC, has been progressing at pace. Within CHASC, the developments have been aligned to three Health Hubs/Local GP Alliances. Wokingham Community Nursing team now operates from 3 sites aligned to Local Hub/Neighbourhoods; this is aligned with future models of Community Care, and has resulted in creating more robust teams with a diverse skill mix and resilience.

The service has successfully established three Multi-Disciplinary Teams to reflect the Local Hubs. The scheme brings professionals from Health and Social Care Services to provide joined up long term health and social care support for of the top 10% of system users who are high risk or high intensity users from Wokingham. We have been able to review the needs of high intensity users within the new structure of the Multi-Disciplinary Team and the scheme has demonstrated the system benefits realised and the scheme is identified as national benchmark scheme.

Talking Therapies – Talking Health (Improved Access to Psychological Therapies)

Our Space Café launched across all localities to support discharged clients to stay well. The Café came about following service user suggestions at our quarterly Patient Forum. Some service users felt they needed a degree of support following treatment in order to stay well and prevent relapse. It was taken forward as a quality improvement and service user initiative. The first Café commenced in May 2017 at St Mark's Hospital in Maidenhead and a group of 15-30 service users meet once a month on a Thursday evening.

Those attending the Café decided on naming the group Talking Therapies 'Our Space' Café. Every month, there is a different theme based on the feedback received from the attendees of the Café. We show a TED talk at the beginning of the session that reflects the theme of the evening and sometimes we will do a mindfulness or relaxation exercise. Refreshments

are served throughout the evening. As the group has developed there is a good sense of peer support.

Further Cafés have started at Reading University, Wokingham Hospital, Upton Hospital, West Berkshire Community Hospital and Bracknell Open Learning Centre. The Cafés are proving a valuable source of support for service users, enabling them to stay well, to monitor their mental health, prevent isolation and to give support to each other.

An article about the Talking Therapies 'Our Space Café' has been published in the Accreditation Programme for Psychological Therapies Services as an example of Good Practice. The Café was also shortlisted for a Trust staff award in 2018.

The Slough Black, Asian and Minority Ethnic (BAME) Access and Recovery project was set up in with two main goals:

- To increase referrals from BAME service users GPs and other key stakeholders
- To develop excellent relationships with GPs, key stakeholders, faith and community groups to increase the profile of the service

Heading the list of anticipated benefits was the receipt of appropriate evidence-based Psychological Therapies according to the stepped care model by service users with common mental health problems. Other expected benefits were:

- an increased knowledge and understanding of the service by Slough residents
- improved relationships between the Talking Therapies Service and Clinical Commissioning Groups and GPs
- liaison with Community Groups, the Third Sector and Local Authority Service increased involvement of the Talking Therapies team in the local community and a better understanding of service users' needs

Significant progress had been made in achieving the project main goals. Project team members continue to meet monthly to review outreach activities and plan for the coming quarter. Regular outreach events continue, including Stress Less Taster Sessions for school and college students, visits to Children's Centres and Hospital Post-Natal wards, along with stands in Libraries and Shop Centres. Talks are delivered to community and health groups including Age Concern, Macmillan Cancer Volunteers and Patient Participation Groups.

In the quarterly Slough GP newsletter, the project team feedback referral rates from all GP Surgeries are 'RAG' (red, amber and green) rated them to show which Surgeries to focus on if referral rates drop. At these Practices, the project team sets up a slot to speak at the Practice meeting to update them about the Talking Therapies service and encourage the Practice to meet their referral targets.

The project team has also set up Welcome and Drop in Clinics to help clients who may struggle with accessing the Talking Therapies service in the usual way. This may be due to language barriers, cultural barriers of stigma around Mental Health difficulties, physical disabilities or poor previous experience of accessing Mental Health services. These clinics have been rolled out from local Community Hospitals into GP Surgeries. Clinicians set aside 30 to 60 minutes at the start or end of their booked clinic to see drop-in clients and welcome them to the service. GP practices who host drop in clinics have given excellent feedback to Therapists which enhances the development and strengthening of relationships between Talking Therapies and Practice staff.

Extension of the Talking Therapies Post Traumatic Stress Disorder (PTSD) pathway to create a Talking Therapies enhanced Post Traumatic Stress Disorder pathway in order to treat more patients with a single complex trauma. This has enabled 30 patients to be treated waiting on the Trauma waiting list involving a weekly referrals discussion and supervision with the Trauma service to create a seamless pathway.

We have increased access to patients with co-morbidity presentations as part of our Talking Therapies Long Term Conditions pathway for patients with an Anxiety and Depression and a Long Term Condition. We have 15 Therapists working integrating within GP surgeries and also Therapists attached to the Respiratory and Diabetes Physical Health pathways.

Learning Disability – Inpatient Services

Building on our earlier success of achieving accreditation from the Royal College of Psychiatry as part of the Quality Network for Inpatient Learning Disability Services, the Campion Unit staff team were shortlisted for Team of the Year in the Trust Awards. There was also another inspection of the Campion Unit by the Care Quality Commission during 2018-19 and as a result of this, the service was rated as "Outstanding". Areas of particular good practice included:

- The Clinical team's engagement with STOMP (Stopping Over Medication of People with a Learning Disability) with a particular focus on antipsychotic medication, patients were not on any high dose antipsychotic or multiple medication for psychosis – and the team worked to reduce the use of medication alongside other interventions
- The use of Positive Behaviour Support plans in line with recommendations by the Department of Health and Social Care
- Care plans were in an accessible format and were produced directly from RiO (electronic patient record) to ensure consistency

The Care Quality Commission report noted that the Learning Disability service benchmarks performance and outcomes for patients compares well with other Trusts. The model of care was identified as reflecting best practice outlined in the report *Building the Right Support* (NHS England 2015).

The service has also adopted the Trust's Quality Management Improvement System (QMIS) with this approach being embedded as a regular way of working on the ward. The service now holds daily Huddles and shares Status updates to help identify areas for improvement, identify local solutions, monitor performance and share learning.

Learning Disability – Community Services

Following on from the establishment of our new Learning Disability Intensive Support Team, this multi-disciplinary team was awarded the inaugural Excellence in Practice staff award from the Trust. The Intensive Support Team work in close collaboration with the Inpatient Service and the Community Teams for People with Learning Disabilities with the intention to support people most at risk of admission into inpatient services, by supporting people in their community, seeking to avoid all but the essential inpatient admissions. The Intensive Support Team works across Berkshire with the Community Teams for People with Learning Disabilities and also reaches into the inpatient services to provide support with people who need to be admitted and then enable quicker discharges. The effectiveness of this way of working was identified by the Care Quality Commission in their inspection.

The Community Teams for People with Learning Disabilities have continued to work with people in the community. The demand for this specialist input remains high and the teams triage their referrals to manage this demand. Staff are supporting people with their individual health needs as well as working at a wider system level to seek to tackle the discrimination and inequity that leads to poorer outcomes and shorter life expectancy for people with learning disabilities supporting the learning from the Learning Disability Mortality Review Programme (LeDeR).

East Berkshire Psychological Service (based at Wexham Park Hospital)

We are an established team offering Biopsychosocial assessments to patients on a 24/7 basis. Referrals are received either from the Emergency Department or the wards at Wexham Park Hospital. The team employs Nurses, Social Workers and Psychologists so we are able to offer a multidisciplinary approach to all assessments undertaken.

With the introduction of a dedicated Frequent Attenders Lead, we have worked closely with Frimley Health NHS Foundation Trust in order to address the patients' problems by putting care plans in place to meet their needs. By doing this, we have successfully reduced the number of patients attending the Emergency Department on a frequent basis. We also have a dedicated Drug and Alcohol Lead who works closely with the Emergency Department. By giving advice and teaching to the Emergency Department staff, we are able to address the patients' needs more effectively.

We are in the process of applying for Accreditation. We are also in the process of negotiating office space at Wexham Park Hospital so that we can offer brief Outpatient appointments for follow up. This approach should reduce the number of requests for inpatient beds at Prospect Park Hospital.

Research and Development

The Research and Development team have continued to deliver high quality research across the Trust. Historically, research has been delivered within Mental Health Services, but the delivery of studies across Community sites is growing to include Sexual Health and Respiratory services. During 2018, we reviewed our Research Strategy and have developed a new Strategy which aims to offer every service user the opportunity to engage in research should they wish to. A Head of Research post has been identified to support the team in delivering the Research Strategy and build upon the strong collaborations developed in recent years with our external partners and stakeholders.

Patient experience

The Trust actively promotes feedback as part of 'Learning from Experience', this includes gathering feedback from compliments, complaints, services' informal concerns, Members of Parliament enquires, our internal surveys and the Family and Friends Test.

Since quarter four 2012-13, compliments have been routinely reported directly by services through the web based Datix system. This is a way of sharing good practice and praise through our localities and across the organisation. The system continues to be developed following feedback from our staff to capture a variety of compliments. This include people verbally saying "thank you", as well as gestures, such as flowers and cards, and with implementation of a batch upload option for multiple compliments. 5,965 compliments were reported during 2018-19; an increase from 4,784 in 2017-18

Our online web system to log concerns that have been dealt with at a local level (referred to as local resolution) continues to be supported by the Patient Experience Team, with information provided to our Clinical Directors via a real time dashboard. This is an additional tool for measuring quality, before the escalation to a more formal complaint and is driven by our front line services resolving concerns effectively, with support and training available from the Complaints Office and wider Learning and Development department.

The number of formal complaints received about the Trust in 2018-19 has increased to 230 compared with 209 received in 2017-18. Throughout 2018-19, our Patient Experience team have continued to support people investigating complaints to maintain contact with complainants and we have consistently achieved response rates of 100% as shown in the table below which is a fantastic achievement:

Q1 Cumulative	Q2 Cumulative	Q3 Cumulative	Q4 Cumulative
100%	100%	100%	100%

Our complaint handling and response writing training which is available to staff has continued to be offered on a bi-annual basis across the different localities. This is in addition to bespoke, tailored training for specific teams which has taken place to staff groups and teams.

The NHS Friends and Family Test (would you recommend us) gives an opportunity for patients and the people who care for them to share their views in a consistent way across the Health Service. We have embraced this further as part our Quality Improvement programme targets (known as the Trust's *True North*) aiming to achieve a 95% satisfaction rate.

We continue to offer the Friends and Family Test to carers as we recognise that the experience of people in our services may be very different to the experience of those who care for them. We are committed to ensuring that this is as positive as possible.

An overview of our Friends and Family Test activity for 2018-19 is set out below:

Timeframe	Response Rate
Q1	11.64%
Q2	14.82%
Q3	12.82%
Q4	22.00%

Year	% Recommendation
2018/19	93
2017/18	98
2016/17	95
2015/16	91

	Year	%
Community Hospital Inpatients	2018/19	96
	2017/18	97
	2016/17	95
	2015/16	94

	Year	%
Mental Health Inpatients	2018/19	70
	2017/18	67
	2016/17	74
	2015/16	70

	Year	%
Community Mental Health and Physical Health combined	2018/19	90
	2017/18	96
	2016/17	97
	2015/16	95

Our quarterly Patient Experience Report includes benchmarking information on how we compare to other local Trusts, on both the response rate to the Friends and Family Test and the percentage recommendation to a friend. In January 2019, Berkshire Healthcare had the highest response rate nationally for both community and mental health services.

In addition to the Friends and Family Test, many of our services participate in our internal Patient Survey which had 9,087 responses in 2018-19.

Our complaints process works alongside our Serious Incident and Mortality Review processes to ensure that any complaint involving a patient death is reviewed.

The Trust has taken part in the NHS England's *Always Events* programme. WestCall, the GP Out of Hours Service, was the first service to go through this programme, supported by the Patient Experience team. NHS England's Patient Experience Team have asked for a case study to be collated to share across their Patient Experience Network. The aim is to use staff and patient feedback to inform service improvements and developments

We continue to promote Patient Leaders within the Trust and we are working with the Royal Berkshire Hospital NHS Foundation Trust to share opportunities for engagement and co-creation with the Trust. Our current Patient Leaders are engaging with the Quality Improvement team and supporting a Reablement project within Community Health Services across West Berkshire.

There are two volunteers as part of the Patient Experience Team. One is based at St Marks Hospital, and has received further training to be able to support activities and patients on the ward and in services, in addition to collecting feedback. The other volunteer is based at Prospect Park Hospital in Reading and primarily collects patient feedback from the wards.

Patient and Public Involvement Champions are fully established and embedded within the Children, Young People and Families locality. Participation Services with a Champion are seeing an increase in the response rates for the Friends and Family Test and wider

participation. There are plans to implement the Patient and Public Involvement Champions across the Mental Health West and Community Health West localities during 2019-20.

Looking ahead

As part of our annual *Plan on a Page* 2019-20, we will continue to promote the use of all patient feedback to inform service improvement and development.

We will continue to review the way we manage complaints, and look outwards at how we can efficiently facilitate and learn from multi-agency working and share learning both within and outside our organisation.

We will continue to support the NHS England *Always Events* programme, which works by actively seeking understanding and feedback from patients and carers to identify and implement behaviours and experiences that should always happen.

ACCOUNTABILITY REPORT

Directors' Report

The Board of Directors comprises five Executive Directors and six Non-Executive Directors, plus the Chair and Chief Executive of the Trust. The Chair and the Non-Executive Directors are appointed for three year terms of office by the Council of Governors. At the end of the three year term of office, the Council of Governors can re-appoint the Chair and the Non-Executive Directors for a further three year term of office.

Up until December 2016, formal meetings of the Board of Directors were held every month (except August). Following the Board's evaluation of its effectiveness in October 2016, it was agreed that the Board needed more time to discuss strategic issues and therefore from January 2017, the formal public Board of Directors meets seven times a year and holds four private discursive meetings. At the formal public Board meetings no business can be conducted unless at least one third of Directors are present, including at least one Executive Director and one Non-Executive Director. Board meetings are held in public.

The Board is responsible for:

- the exercise of the powers and the performance of the NHS Foundation Trust
- setting strategy, following discussion with the Council of Governors
- ensuring the provision of safe, high quality services
- ensuring the highest level of corporate governance
- ensuring that the Trust operates an effective process for the management and mitigation of risk.

The Non-Executive Directors are 'held to account' for the performance of the Board by the Council of Governors. The Board meets formally with the Council twice a year and Governors normally meet Non-Executive Directors on a further two occasions each year. Executive Directors routinely attend Council of Governor meetings and the Chief Executive presents to Council a quarterly performance report covering key aspects of the Trust's performance, both financial and service related.

The Council of Governors approved the re-appointment of two of our Non-Executive Directors: Mehmuda Mian and David Buckle. During the year, there were no new Non-Executive Directors appointed.

Helen Mackenzie, Director of Nursing and Governance retired from the Trust on 13 January 2019. Debbie Fulton, Deputy Director of Nursing was seconded to the role pending the recruitment of a permanent Director of Nursing and Governance in 2019-20.

Directors in post during 2018-19 are shown in the following table:

Name	Position	From	To
Martin Earwicker	Chair (Non-Executive Director)	01.12.16	30.11.19
Naomi Coxwell	Non-Executive Director	13.12.17	12.12.20
David Buckle	Non-Executive Director	01.06.15	31.05.21
Mark Day	Non-Executive Director	01.09.16	31.08.19
Chris Fisher	Non-Executive Director	01.10.14	30.09.20
Ruth Lysons	Non-Executive Director	01.11.13	31.10.19
Mehmuda Mian	Non-Executive Director	01.06.15	31.05.21

Name	Position	From	To
Julian Emms	Chief Executive	01.03.05	N/A
Debbie Fulton	Acting Director of Nursing and Governance	01.12.18	N/A
Alex Gild	Chief Financial Officer	01.04.11	N/A
Minoo Irani	Medical Director	14.07.16	N/A
Helen Mackenzie	Director of Nursing and Governance	23.04.12	13.01.19
Bev Searle	Director of Corporate Affairs	01.10.12	N/A
David Townsend	Chief Operating Officer	01.01.13	N/A

Board assessment and review

The Board commissioned an independent consultancy firm, Ernst and Young Global Ltd (EY) to conduct an external Governance review during 2015-16. Ernst and Young had no other connection with the Trust. The Board was satisfied that this review and other audit activity demonstrated it had an effective system of internal controls. Ernst and Young made a number of recommendations to further enhance the Trust's governance arrangements. The Trust developed an action plan to address each of the recommendations and the September 2016 Board meeting agreed that the actions had been implemented and approved the closure of the action plan.

The Trust Board undertook its annual review of effectiveness in October 2018. Overall the results were very positive, but the Chair and the Non-Executive Directors agreed that it would be helpful to meet as a Group without Executive Directors more often. From January 2019, the Chair and Non-Executive Directors meet prior to each public Trust Board meeting. In addition, the Non-Executive Directors hold an annual meeting without the Chair present, chaired by the Senior Independent Director.

Members of the Board undertook a self-assessment Board effectiveness survey in September 2016. The results of the exercise were discussed at the Board's Strategic Planning Away Day in October 2016. The key area identified for improvement was that more time needed to be allocated to discuss strategic developments. As mentioned earlier, this resulted in reducing the number of public Board meetings by four and using these meetings as private discursive meetings. The Board reviewed the meeting arrangements as part of its annual review of effectiveness in October 2017 and confirmed that the discursive meetings provided a useful opportunity to discuss strategic issues in more depth.

In January 2018, the Trust conducted an internal self-assessment against NHS Improvement's Well-Led Development Framework. The Trust identified a number of areas for further development, including developing a three year strategy document, presenting the quarterly Quality Concerns paper to the Trust Board as well as to the Quality Assurance Committee and developing visual performance management as part of the Trust's Quality Improvement Programme work. An action plan was developed to address the gaps identified and was approved at the February 2018 Trust Board meeting. The completed action plan was signed off by the Trust Board at its February 2019 meeting.

The Care Quality Commission undertook a Well-Led Inspection of the Trust in July 2018. The Care Quality Commission rated the Trust as "Outstanding" for the Well-Led Domain and rated the Trust overall as "Good".

Focus on quality

In April 2017, the Trust launched its Quality Improvement Programme which will enable the organisation to apply a consistent approach to continuous improvement by developing the ability of each and every staff member to become problem solvers and make improvements to the way we deliver care for our patients.

Quality of service and patient experience remain top priorities for the Board with quality being set at the top of the Trust Board's agenda each month. Directors continue to make Board visits to services and continue to be involved in the 15 Steps Challenge programme. The Board agenda either includes a patient story video or a Director's report of their visit to a service area.

The Quality Executive Committee, chaired by the Chief Executive meets monthly to review quality related issues, such as serious incidents, quality concerns and the minutes of the locality and service monthly Patient, Safety and Quality meetings. The Quality Assurance Committee, which meets quarterly, continues to provide an opportunity for Non-Executive and Executive Directors to debate and scrutinise the Trust's quality strategy, processes and performance in greater depth and to provide a forward-looking perspective on the quality agenda.

The Trust's latest comprehensive inspection by the Care Quality Commission took place in July 2018. The Trust received an overall rating of "Good" with a rating of "Outstanding" for the Well-Led domain.

The Care Quality Commission inspected WestCall GP Out of Hours Service in July 2018 and rated the service overall as "requires improvement". The Safe, Effective and Well Led domains were rated "requires improvement" with Caring and Responsive domains rated as "good". The Trust developed an action plan which is overseen by the Quality Assurance Committee to address the Care Quality Commission's concerns.

More information about the Trust's quality objectives and achievements can be found in the separate Quality Accounts Report.

NHS Foundation Trust Code of Governance compliance

Berkshire Healthcare NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the United Kingdom Corporate Governance Code issued in 2012.

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2019.

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

Our Policies on Slavery and Human Trafficking

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

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

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

- **Recruitment policy** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- **Equal Opportunities** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities
- **Safeguarding policies** - We adhere to the principles inherent within both our safeguarding children and adults policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.
- **Whistleblowing policy** - We operate a whistleblowing policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials
- Randomly request that the main contractor provide details of its supply chain
- Ensuring invitation to tender documents contain a clause on human rights issues

- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws
- Using the standard Supplier Selection Questionnaire that has been introduced (which includes a section on Modern Day Slavery)
- Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training

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

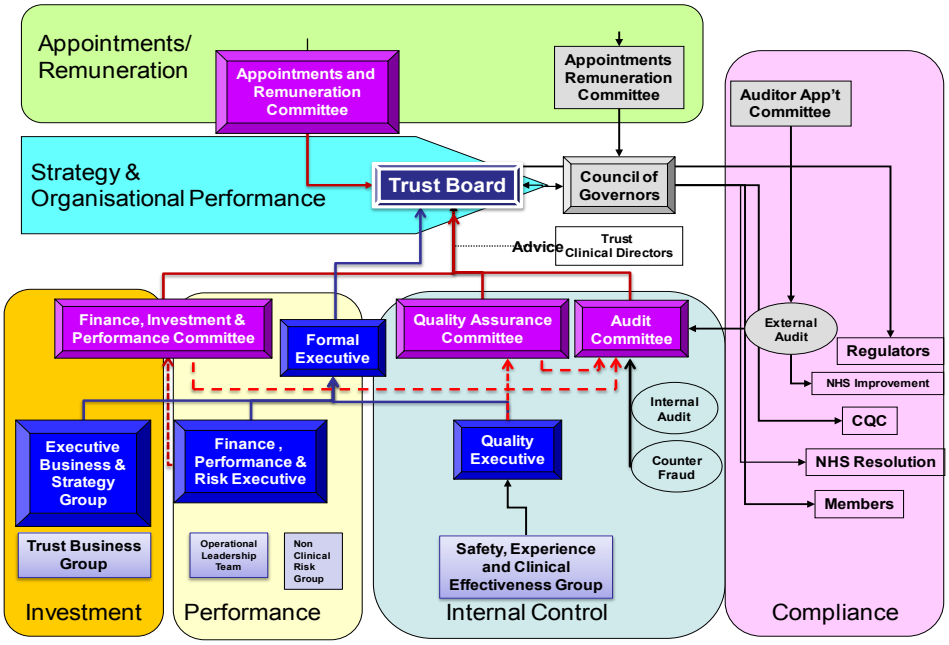
Our Performance Indicators

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

Governance framework

The Trust operates a comprehensive structure and reporting arrangements which facilitate robust governance throughout the organisation involving the Council of Governors, the Board of Directors and various committees.

The diagram overleaf provides a view of the high level governance and reporting arrangements that were in place during 2018-19 to provide appropriate governance and assurance.



The effectiveness of the Trust's governance arrangements is regularly assessed, including through internal and external audit. The Board places great emphasis on the achievement of high quality services and uses a number of sources of information to monitor and triangulate performance and to provide robust assurance. The Board receives a detailed performance assurance report at each meeting which presents information across the whole spectrum of the Trust's activity with particular reference to quality measures. This report is scrutinised further on behalf of the Board by the Finance, Investment and Performance Committee.

Streams of assurance on quality include internal and external audit activity, patient and staff satisfaction surveys, quarterly patient experience reports to the Trust Board, visits to clinical services conducted by Board Directors and by Governors via their Quality Assurance Group work programme. Reports are also received on subjects such as compliments and complaints, learning from deaths, serious incidents requiring investigations (including details of any lessons learned), infection prevention and control and compliance with Care Quality Commission regulations. These and other information sources are used to provide assurance to the Board in relation to its duty to provide regular declarations on quality to NHS Improvement.

Each locality area within the Trust has a nominated Clinical Director who is responsible for maintaining a focus on local quality issues and for ensuring that best practice is identified and shared across the organisation. This is supported by the corporate governance arrangements in place and by the patient safety function which undertakes activity to monitor the Trust's compliance with the Care Quality Commission's regulations.

Quality thrives within a culture of openness and trust and during 2018-19 the Trust continued its major staff engagement initiative *Listening into Action* aimed at stimulating a more engaged dialogue between staff and managers and leading to greater empowerment of frontline staff. In addition, the Trust has successfully introduced an organisational Quality Improvement Programme which will enable us to apply a consistent approach to continuous improvement by developing the ability of each and every staff member to make improvements to the way we deliver care for our patients.

There is more information about the Trust's approach to quality in the detailed Quality Report which features as part of this document.

The Trust operates fully in compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 5: Fit & Proper Persons and all Directors are required to meet these requirements and to declare such annually. In addition, in the case of all new Directors, appropriate checks are made in accordance with the fit and proper person regulations before an appointment can be confirmed. In addition, members of the Trust Board are required to abide by the Board's Code of Conduct which reflects the high standards of probity and responsibility which is required of all Board members.

In line with constitutional requirements, the Trust maintains a register of interests for Directors which is available on the Trust's website or from the Company Secretary. The Company Secretary attends the Trust Board and its Sub-Committee meetings and produces detailed minutes of the discussions. Any individual concerns about a proposed course of action would be recorded in the minutes in line with requirements of the NHS Foundation Trust Code of Governance.

The attendance of Directors at Board and Board Committee meetings is shown on pages 45-46 and biographical information for all Directors in post during the year is also provided.

Trust Board Committees

During 2018-19 the Trust Board had five standing committees that helped it discharge its duties.

Audit Committee

The Audit Committee, comprising only Non–Executive Directors is responsible for making sure the Trust governs itself well by concluding on the adequacy of the Trust's systems of internal control and its assurance framework. The main role and responsibilities are set out in the terms of reference approved by the full Trust Board, which are consistent with national guidance.

These responsibilities include:

- monitoring the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them;
- reviewing the Trust's internal financial controls and the internal control and risk-management systems;
- monitoring and reviewing the effectiveness of the Trust's internal audit function;
- reviewing and monitoring the external auditor's independence and objectivity, and the effectiveness of the audit process, taking into consideration relevant requirements;
- monitoring progress and output from the Trust's clinical audit activity.
- Reviewing the annual clinical audit plan.

The Audit Committee has met these responsibilities by:

- Overseeing internal audit, counter fraud and external audit services by:
    - reviewing the audit and counter fraud strategies and annual plans;
    - receiving progress reports;
    - considering the major audit findings and management's responses;
    - holding discussions with internal and external audit;

    - ensuring co-ordination between external and internal auditors;
    - reviewing the external audit management letter;
    - reviewing clinical audit summary reports.
- Reviewing and monitoring compliance with standing orders and standing financial instructions;
- Monitoring and advising the Trust Board on the Trust's Board Assurance Framework and Corporate Risk Register;
- Reviewing schedules of losses and special payments;
- Reviewing the annual accounts of the Trust before submission to the Trust Board and Charitable Funds Trustees, focusing particularly on:
    - changes in and compliance with accounting policies and practices
    - major judgmental areas
    - significant adjustments resulting from the audit
- Receiving and reviewing minutes from the Finance, Investment and Performance Committee and the Quality Assurance Committee;
- Ensuring that both internal and external auditors have full, unrestricted access to all the Trust's records, personnel and the Audit Committee members.

The Audit Committee reviewed financial and operating performance and compliance against national and regulatory standards. The Committee's review was supported by reporting from the Chair of the Finance, Investment and Performance Committee.

In depth reviews of strategic and operational risks have further supported the Committee's understanding and review of the key issues facing the Trust.

During 2018-19, there were no significant issues considered by the Committee in relation to the Trust's financial statements. The continuing effectiveness of both the internal and external auditors is monitored by the Committee, as is the Committee's own effectiveness through self-assessment against best practice standards.

The Audit Committee also considers the key risks identified by the External Auditor and uses its resources and the internal audit programme to provide assurance around the following key areas: management override, property valuations and completeness of accruals.

Auditor's Independence

The Trust requires its Auditors to demonstrate the policies and procedures they use to ensure they remain independent while carrying out their duty. During 2018-19 Deloitte's remit was to undertake external audit work and provided assurance on the Quality Accounts.

Finance, Investment and Performance Committee

The Finance, Investment and Performance Committee, comprising both Non-Executive and Executive Directors is responsible for reviewing financial and operational performance and for reviewing and providing expert comment on all significant financial investment and disinvestment decisions. They also scrutinise reporting on safe staffing and business development activity.

Quality Assurance Committee

This Committee provides a forum for detailed scrutiny and consideration of the Trust's quality agenda. Comprising both Non-Executive and Executive Director membership, the Committee obtains assurance on behalf of the Board on the quality of clinical services. This includes reviewing the quarterly reports on the Learning from Deaths and receiving the Guardians of Safe Working Hours of Doctors and Dentists in Training reports.

Appointments and Remuneration Committee

In September 2018, the Trust Board agreed to extend the membership of the Remuneration Committee to all Non-Executive Directors. Prior to this, the Committee comprised of the Trust Chair and two other Non-Executive Directors.

The November 2018, the Trust Board meeting agreed to broaden the terms of reference of the Committee from considering the terms of conditions of appointment of the Chief Executive and Executive Directors to include the Committee's role in ensuring that the Trust had robust succession plans and that there was a formal, rigorous and transparent procedure in place to identify suitable candidates to fill Executive Director and Very Senior Manager vacancies as they arise. The Trust Board also agreed that the Committee's name should be changed to the Appointments and Remuneration (rather than the Remuneration Committee). More information about Non-Executive and Executive Director remuneration can be found in the Remuneration Report later in this report.

The Appointments and Remuneration Committee should not be confused with the Council of Governors Appointments and Remuneration Committee, which considers the appointment and conditions of Non-Executive Directors.

Attendance at Board meetings and Committees 2018-19

Board Meetings

Name	Position	Meetings attended/possible*
Martin Earwicker	Chair	11/11
David Buckle	Non-Executive Director	08/11
Naomi Coxwell	Non-Executive Director	10/11
Mark Day	Non-Executive Director	10/11
Chris Fisher	Non-Executive Director	11/11
Ruth Lysons	Non-Executive Director *(Senior Independent Director and Vice Chair)*	11/11
Mehmuda Mian	Non-Executive Director	11/11
Julian Emms	Chief Executive	11/11
Debbie Fulton	Acting Director of Nursing and Governance *(from 1 December 2018)*	04/04
Alex Gild	Chief Financial Officer	10/11
Minoo Irani	Medical Director	11/11
Helen Mackenzie	Director of Nursing & Governance *(until 13 January 2019)*	07/07
Bev Searle	Director of Corporate Affairs	11/11
David Townsend	Chief Operating Officer	10/11

**Includes attendance at both the Public Trust Board meetings and four private discursive meetings.*

Audit Committee Meetings

Name	Position	Meetings attended/possible
Chris Fisher (Chair)	Non-Executive Director	05/05
Naomi Coxwell	Non-Executive Director	04/05
Mehmuda Mian	Non-Executive Director	04/05

Finance, Investment and Performance Committee Meetings

Name	Position	Meetings attended/possible
Naomi Coxwell (Chair)	Non-Executive Director	08/08
Mark Day	Non-Executive Director	08/08
Ruth Lysons	Non-Executive Director	07/08
Julian Emms	Chief Executive	04/08
Alex Gild	Chief Financial Officer	07/08
David Townsend	Chief Operating Officer	07/08
Debbie Fulton	Deputy Director of Nursing *until 30 November 2018* and Acting Director of Nursing and Governance *from 1 December 2018*	06/07

Appointments and Remuneration Committee Meetings*

**the Committees membership was extended to include all Non-Executive Directors from September 2018*

Name	Position	Meetings attended/possible
Mark Day (Chair)	Non-Executive Director	03/03
Martin Earwicker	Trust Chair	03/03
David Buckle	Non-Executive Director	03/03
Naomi Coxwell	Non-Executive Director	02/02
Chris Fisher	Non-Executive Director	02/02
Ruth Lysons	Non-Executive Director	02/02
Mehmuda Mian	Non-Executive Director	02/02
Julian Emms	Chief Executive	03/03

Quality Assurance Committee

Name	Position	Meetings attended/possible
Ruth Lysons (Chair)	Non-Executive Director	04/04
David Buckle	Non-Executive Director	02/04
Mehmuda Mian	Non-Executive Director	02/04
Julian Emms	Chief Executive	03/04
Minoo Irani	Medical Director	03/04
Helen Mackenzie	Director of Nursing and Governance (until 13 January 2019)	03/03
Debbie Fulton	Acting Director of Nursing and Governance (from 1 December 2018)	01/01
David Townsend	Chief Operating Officer	04/04

All Board Committees are supported by the Company Secretary and such other senior personnel as required.

Board members

Martin Earwicker – Chair

Martin Earwicker became Chair of Berkshire Healthcare NHS Foundation Trust in December 2016, prior to this he was Vice Chair of Dorset County Hospital NHS Foundation Trust. He retired from being Vice Chancellor of London South Bank University in 2013. Before this he was Director and Chief Executive of the Science Museum Group. However, his main career was in scientific research working for the Ministry of Defence interspersed with senior appointments in Whitehall; for the last five years of which he was Chief Executive of the Ministry of Defence's Research Laboratories, the Defence Science and Technology Laboratory.

In addition to his interest in health, he is a keen supporter of Further Education colleges, and has been chair for more than six years each of two Further Education colleges: Tower Hamlets College in the east end of London serving a particularly disadvantaged community, and Farnborough College of Technology, which he still chairs. He is also a Trustee of his local Citizens Advice Bureau.

He read Physics at Surrey University graduating in 1970. He was appointed a Fellow of the Royal Academy of Engineering in 2000 and has been a vice president of the Academy, and was awarded an Honorary Doctorate of Surrey University in 2009. He is an Emeritus Professor of London South Bank University.

Naomi Coxwell – Non-Executive Director and Chair of the Finance, Investment and Performance Committee

Naomi Coxwell joined Berkshire Healthcare as a Non-Executive Director on 13 December 2017. She lives in Farnham, Surrey and is also a Non-Executive Director for James Walker Group Ltd, a global manufacturing and engineering company, and Non-Executive Director and Trustee for Citizens Advice, Hart - providing free, impartial and confidential advice for the benefit of the Hart community.

Naomi is a former Vice President of BP and has worked in the oil and gas industry for over 30 years. She is a graduate of Exeter University where she received a Bachelor's Degree in Geology in 1984, and has studied at The Warton School, University of Pennsylvania, where she received BP's Chief Financial Officer Excellence certificate in 2012.

Naomi started her career in 1984 with Petrofina, and was one of the first women to work as a Geologist on offshore rigs in the United Kingdom. She joined BP in 2000 and spent the following 16 years working overseas in increasingly senior positions. She has led diverse, multicultural teams in the development of strategy, management of risk, and in driving continuous improvement across six continents.

Naomi believes that that the physical and psychological health of individuals is the single biggest contributor to societal strength and productivity, and sees Berkshire Healthcare as being a major contributor to that cause.

Dr David Buckle – Non-Executive Director

David worked as a GP in Woodley, Berkshire for 30 years. In 1995 he was awarded Fellowship of the Royal College of General Practitioners. He later became senior partner and was a GP trainer for many years. In 2000 he joined the local Primary Care Trust (PCT) Board and later became the clinical chair for Berkshire PCT. That decision started a long career of clinical leadership and then medical management.

Having been a Medical Director for an NHS Primary Care Trust and then a Commissioning Support Unit, David was appointed Medical Director to Herts Valleys Clinical Commissioning Group in spring 2015.

David was appointed a Non-Executive Director for Berkshire Healthcare Foundation NHS Trust in 2015. Having enjoyed this role, it encouraged David to expand his non-executive roles and in September 2018 he became an Associate Non-Executive Director for East and North NHS Hertfordshire Hospital Trust.

David has been a member of the Society for the Assistance of Medical Families for nearly 30 years and early this year he was voted president of the charity. He has also been appointed a trustee for the Stroke Association which is a large national charity.

David believes that his clinical knowledge his understanding of primary care and the wider NHS will help strengthen BHFT for the benefit of patients.

Mark Day – Non-Executive Director and Chair of the Appointments and Remuneration Committee

Mark Day joined Berkshire Healthcare as a Non-Executive Director on 1 September 2016. He lives just outside Newbury. Mark is a member of the Professional Council of the Global Executive Network and is currently the Chairman of Haven West Berkshire Homeless Charity. Haven operates a Soup Kitchen in Newbury for the homeless and vulnerable in West Berkshire.

Mark started his career with Crookes Healthcare (subsequently Boots Pharmaceuticals) and then moved to the Automobile Association where he embarked on his Human Resources career path. A number of different Human Resources related roles were undertaken until the organisation was acquired by the Centrica Group. Feeling that the time was right for a move into a different industry sector mark joined the Board of the Hospital Saving Association as Director of Human Resources.

Shortly after joining the Hospital Saving Association (subsequently becoming Simplyhealth) Mark assumed Director responsibility for the customer service operation and focussed on improving the personal service provided by the organisation. In addition to achieving consistent years of being in the Sunday Times 100 Best Companies to Work For, many industry awards were achieved for the exceptional service provided to both corporate clients and individual customers.

Until recently Mark was a Trustee of the Society of St James, a charity based in Southampton, which supports the homeless together with alcohol and drug dependant people. During his six years working for the charity Mark chaired the Personnel Committee and latterly became the Vice Chairman of the Society.

Mark firmly believes that people can be the only true differentiator in organisations and is keen to see Berkshire Healthcare continue to provide support across our communities based on this principle.

Chris Fisher – Non-Executive Director and Chair of the Audit Committee

Chris Fisher took up the role as Non-Executive Director on 1 October 2014. He lives with his family in Maidenhead and most of his career has been spent in the area.

He trained as an accountant locally and qualified in 1983 whilst working for the Avis Europe group of companies where he held a number of senior positions in financial, commercial and operational roles over a period of almost 22 years.

He completed an MBA at Henley in 2001 and joined the NHS the same year as Finance and Performance Director for a local Primary Care Trust. He went on to lead on commercial matters for the regional Strategic Health Authority in Newbury before taking planned partial early retirement in 2009.

Most recently, he led the project on behalf of Heatherwood and Wexham Park Hospital NHS Foundation Trust for its acquisition by Frimley Park Hospital and previously he was project director for Berkshire Healthcare's acquisition of the east and west Berkshire community health services provider organisations.

Chris chairs Health Education Thames Valley's (HETV) Assurance Committee – HETV is the organisation responsible for developing the future clinical and medical staffing required in the area. He is also a member of the Assurance Board for the Southern Region of Health Education England, taking the lead on Assurance work.

Other interests include golf, walking his dogs and supporting his beloved Watford football club.

Ruth Lysons – Non-Executive Director, Chair of the Quality Assurance Committee, Deputy Chair and Senior Independent Director

Ruth Lysons is a veterinary surgeon who graduated from Cambridge University in 1982. She worked in two private veterinary practices, specialising in farm animal medicine. She joined the Veterinary Laboratories Agency, progressing through a number of roles to become Head of its national network of veterinary diagnostic laboratories.

From 2002 until 2011, Ruth was Deputy Director, at the Department for Environment, Food and Rural Affairs (Defra).She advised Defra Ministers on animal health policy, led a team of 40 staff, and was accountable for a budget of £50 million per annum. She was also a member of various Government committees assessing the risks posed to human health from animal diseases, and was a senior veterinary decision-maker on actions to be taken to control major animal disease outbreaks, including Foot and Mouth Disease, Avian Influenza and Swine Influenza.

Since leaving Defra, Ruth worked for Waitrose on food safety surveillance, and subsequently became an independent veterinary consultant. She is a Non-Executive Director of the British Veterinary Association, and a Trustee of the charity My Cancer My Choices (Registered Charity 1162165), which provides complementary therapies to support cancer patients in Berkshire.

Born and brought up in Reading, Ruth has lived in West Berkshire with her husband for the last 35 years. They have two grown up children, two dogs and a cat.

Mehmuda Mian – Non-Executive Director

Mehmuda Mian practised as a solicitor specialising in commercial and professional indemnity litigation. Her commitment to rigorous, high standards in public life led her to take on a regulatory function at the Law Society, investigating complaints against solicitors, and also chairing independent review panels for the NHS. She left to take up an appointment at the Police Complaints Authority. Mehmuda was subsequently appointed as one of the first Commissioners to the Independent Police Complaints Commission and is a former BBC Trustee, Non-Executive Director of the Independent Safeguarding Authority, and of the Disclosure and Barring Service.

Mehmuda is currently a Non-Executive Director on the Independent Press Standards Organisation and a member of the Disciplinary Committee of the Royal College of Veterinary Surgeons.

Julian Emms – Chief Executive

Julian was appointed Chief Executive in July 2012, following a nine-month period during which he was the acting Chief Executive. Julian started his career in the Probation Service as a Support Worker and went on to undertake a variety of roles in the service over a 10 year period before joining the NHS in 1997.

An NHS Executive Director since 2004 Julian has wide ranging experience in organisational leadership and service improvement. Julian was part of the Trust's successful NHS foundation trust application in 2007 and was the project director who oversaw the integration of community health services into the Trust in 2011.

Julian's senior management roles prior to becoming a director were all joint posts with social care and focused on providing better integrated care for local people.

Julian is also the chair of the NHS Benchmarking mental Health Reference Group, a position he has held since January 2016.

Debbie Fulton - Acting Director Nursing and Governance (from 1 December 2018)

Debbie qualified as a nurse in 1989. She has enjoyed a varied career having held a variety of nursing as well as clinical and operational management positions across Berkshire since 1998 and prior to that as a nurse and ward manager at Frimley Park Hospital. Before commencing her current post in December 2018, Debbie has worked within Berkshire Healthcare since the merger with East and West Community organisations in 2011.

During her time with the Trust, Debbie has held both Clinical and Locality Director positions and from July 2015 was the deputy director of nursing for patient safety and quality. Debbie is very much looking forward to fulfilling this new role and being able to champion the improvement quality across the organisation.

Debbie lives locally in Berkshire she has 2 grown up children and became a grandmother in 2017, a role which she very much enjoys.

Alex Gild – Chief Financial Officer

Alex joined the Trust in September 2006. A business graduate and a qualified accountant he started his NHS finance career as a trainee finance assistant in 1996 and had spells working in the acute trusts in Oxford (Radcliffe Infirmary, Oxford Radcliffe and Nuffield Orthopaedic) before latterly joining South Central Strategic Health Authority.

Alex was deputy Director of Finance at Berkshire Healthcare NHS Foundation Trust and was appointed Director of Finance, Performance & Information in April 2011 (his title changed to Chief Financial Officer in March 2017). Alex has since become a member of the Board of Trustees of the Healthcare Financial Management Association and was President of the Association in 2018.

Dr Minoo Irani – Medical Director

Minoo has been working in Berkshire as Consultant Paediatrician (Community Child Health) since 2001 and has held positions as Lead Paediatrician, Locality Clinical Director and Lead Clinical Director in the Trust before being appointed as Acting Medical Director in November 2015 and was appointed as Medical Director in July 2016.

Minoo has experience of working on projects and committees within the Royal College of Paediatrics and Child Health, General Medical Council, Department of Health and Social Care and Berkshire Research Ethics Committee. He founded and led the NHS Alliance Specialists Network where he championed integrated working practices for professionals across primary and secondary healthcare services, authored health policy reports on integration of healthcare services and has published and presented on this topic at national meetings.

Helen Mackenzie – Director of Nursing and Governance (until 13 January 2019)

Helen qualified as a registered nurse in 1979. She has enjoyed a varied career having held a variety of nursing positions across the South East. In the 1990's she was employed by Berkshire Community Services as a Community Staff Nurse and School Nurse before getting her first management position covering South Oxfordshire. Helen held her first director appointment in 2003 and has experience from many of the sectors in the NHS including commissioning having been Deputy Chief Executive of NHS Berkshire West. She joined Berkshire Healthcare Trust in April 2012 and has found it to be one of the most rewarding positions of her career, being able to champion the improvement quality across the organisation.

In the last two years Helen has worked with the CQC as a chair of comprehensive inspections. She lives locally in Berkshire and in 2016 became a grandmother, a role she is relishing.

Bev Searle – Director of Strategy and Corporate Affairs

Originally trained as an Occupational Therapist, Bev worked within Child and Adolescent Mental Health Services, inpatient and integrated community Mental Health and Substance Misuse Services, both in Berkshire and in Devon. She then worked as a general manager in NHS Services and continued into clinical, lecturing and managerial roles across a broad range of services in health, social care and housing.

Bev has been working in Berkshire since 1997, in a number of joint health and social care roles and prior to her current role, Bev was Director of Joint Commissioning with NHS

Berkshire. She joined the Trust as Director of Corporate Affairs in October 2012 and has subsequently become a member of the Board of the Social Care Institute for Excellence since 2013.

David Townsend – Chief Operating Officer

David started working for the NHS in 2004 having worked in senior roles for leading private sector, customer focused businesses. These included BP, MacDonalds, Initial and major international food producer Geest Plc. In addition to his commercial responsibilities, he led a number of transformational projects and spent 10 years in senior leadership positions.

His first role with the NHS was to set up a new collaborative organisation for the South Central region to which he was appointed Managing Director. In 2010, David was appointed Director of Operations for Berkshire Healthcare and Chief Operating Officer in 2013.

None of the Directors have any declared political activities and all are considered independent.

Board composition

Board composition is determined to be appropriate for purpose. Non-Executive Directors with specific skills have been appointed to ensure good balance. These include skills in finance, commercial operations and strategy and clinical practice and quality. The Executive Director membership is as set out within statute, Chief Executive, Finance, Medical and Nursing Directors plus the Chief Operating Officer and the Director of Strategy and Corporate Affairs.

Directors Expenses

Directors are entitled to claim expenses in accordance with their terms and conditions of appointment. Expenses primarily relate to travel and car parking charges and for 2018-19, 8 Directors (out of 13) claimed expenses with an aggregate value of £12,327.31.

Remuneration report

The remuneration and expenses of the Chair and Non-Executive Directors are determined by the Council of Governors, taking account of relevant market data, including the NHS Providers' Remuneration Survey. The remuneration of Non-Executive Directors is comprised solely of their annual fee as set out in the table on page 54.

Senior Managers Remuneration Policy

Remuneration of the Trust's 'senior managers' (the Chief Executive, Executive Directors and Very Senior Managers (VSM) is determined by the Trust's Appointments and Remuneration Committee. From September 2018, the membership of the Committee comprises of all the Non-Executive Directors (one of whom chairs the meeting), including the Trust Chair. Prior to September 2018, the Committee comprised of three Non-Executive Directors. The Chief Executive is in attendance at meetings, but is not present for discussions relating to his own remuneration or terms and conditions. The Committee is supported by the Director of People and the Company Secretary.

The Committee does not routinely apply inflationary uplifts or increases and only applies uplifts of any kind where this is thought justified by the context. The primary aim of the

Committee is to ensure that Executive and Very Senior Manager remuneration is set at an appropriate level to ensure good value for money, whilst enabling the Trust to attract and retain high quality Directors. Executive Directors and Very Senior Manager remuneration does not currently include a specific performance related element. The Committee is reviewing the remuneration policy for Executive Directors and Very Senior Managers during 2019-20.

Where any senior manager is paid above the Prime Minister's salary (currently £150,000 per annum), the Appointments and Remuneration Committee will have satisfied itself that the actual level of remuneration paid is reflective of the individual post holders level of responsibility and performance and that the remuneration has been considered against appropriate benchmark information, local recruitment market conditions and the need to provide a reward package that ensure the recruitment and retention of high calibre senior executives.

Executive and Very senior manager contracts provide for a period of notice of six months on the part of the Trust as agreed by the Appointments and Remuneration Committee. A senior manager may suffer loss of office in a number of situations and in such cases the six month notice period normally applies, however, the Trust can, at its discretion, choose to make payment in lieu of all or part of the notice period. Where loss of office is due to circumstances where summary dismissal applies, such as gross misconduct or serious performance failure for example, no notice period would apply. If loss of office was due to redundancy then the notice period would apply, as would any redundancy provisions applying generally in the NHS at the point in time; the principle being that very senior managers would be treated neither no less nor no more favourably than other Trust staff.

Annual Statement on Remuneration

The Appointments and Remuneration Committee uses benchmarking information from available sources to set the level of remuneration of Executive Directors and Very Senior Managers. This includes NHS Improvement's remuneration benchmark data and the annual NHS Providers Pay Review survey and a market analysis through reviewing contemporary recruitment. Affordability together with an assessment of both individual and collective performance is also taken into account. The Committee considers the pay and conditions of other employees, for example, the agenda for change pay settlement and the current pay settlement for senior civil servants when considering remuneration policy, but does not actively consult with employees.

In November 2018, the Trust commissioned Hays Executive to undertake a review of Executive pay and rewards to provide an independent external view of the current relevant market pay and reward data, taking into consideration of the health sector and direct peer organisations. The review concluded that the remuneration of Executives and Very Senior Managers was broadly in line with other comparable organisations.

The Trust was also keen to identify any gender pay gap issues. The review identified a small gender pay gap in relation to the Director of Nursing role which was traditionally a female role and therefore there was a risk that any national benchmarking data perpetuated the gender pay gap. The Committee agreed to address the gender pay gap as part of the Director of Nursing recruitment process which will start in June 2019.

Taking into account NHS Improvement's guidance on very senior managers' pay, the Appointments and Remuneration Committee agreed that for executive directors whose remuneration was above the Prime Minister's salary, those individuals would receive a

consolidated pay award of £2,075 (in line with the Senior Salaries Review Body's recommended uplift for senior civil servants) and to award a non-consolidated pay award of between 1.2% to 1.5% (the salary uplift for the three individuals equated to 2.6%). Other Executive Directors and Very Senior Managers received a consolidated pay award of 2.6% in line with the pay award for staff on Agenda for Change contracts. The individual salary uplifts are set out below:

- Chief Executive: £2,075 consolidated and 1.5% non-consolidated (overall pay award 2.6%)
- Chief Financial Officer: £2,075 consolidated and 1.2% non-consolidated (overall pay award 2.6%)
- Director of Nursing and Governance*: 2.6% consolidated
- Director of Corporate Affairs: 2.6% consolidated
- Chief Operating Officer: 2.6% consolidated
- Medical Director: £2,075 consolidated and 1.2% non-consolidated (overall pay award 2.6%)

**The Director of Nursing and Governance retired from the Trust on 13 January 2019.*

All other Trust staff are covered by national NHS Agenda for Change and Medical and Dental pay and conditions.

The Trust Board sets the organisation's corporate objectives annually and these are used as the basis for developing personal objectives for the Chief Executive and Executive Directors. Performance is closely monitored through the year and in the context of annual appraisal.

Mark Day, Chair, Appointments and Remuneration Committee
Details of remuneration for Directors and senior managers are set out in the tables below:

Salaries and allowances (*the following information is subject to audit*)

2018-19

				2018/19						
Name	Title	From	To	Salary and fees (in bands of £5,000) *	Taxable benefits (total to the nearest £100)	Annual performance related bonuses (in bands of £5,000)	Long-term performance related bonuses (in bands of £5,000)	Pension related benefits (in bands of £2,500)**	Expenses - Travel and Subsistance (total to the nearest £100)	Total (in bands of £5,000)
				£000s	£00s	£000s	£000s	£000s	£00s	£000s
Executive Directors										
Julian Emms	Chief Executive	01/04/2018	31/03/2019	195 - 200	0	0	0	17.5 - 20.0	20	215 - 220
Deborah Fulton	Acting Director of Nursing	01/12/2018	31/03/2019	40 - 45	0	0	0	125.0 - 127.5	0	165 - 170
Alex Gild	Chief Financial Officer	01/04/2018	31/03/2019	150 - 155	0	0	0	72.5 - 75.0	0	225 - 230
Dr Minocher Irani	Medical Director	01/04/2018	31/03/2019	175 - 180	0	0	0	122.5 - 125.0	24	300 - 305
Helen Mackenzie	Director of Nursing	01/04/2018	13/01/2019	85 - 90	0	0	0	47.5 - 50.0	8	135 - 140
Beverly Searle	Director of Corporate Affairs	01/04/2018	31/03/2019	130 - 135	0	0	0	70.0 - 72.50	0	205 - 210
David Townsend	Chief Operating Officer	01/04/2018	31/03/2019	140 - 145	0	0	0	52.5 - 55.0	5	195 - 200
Non Executive Directors										
David Buckle	Non Executive Director	01/04/2017	31/03/2019	10 - 15	0	0	0	0	0	10 - 15
Naomi Coxwell	Non Executive Director	13/12/2017	31/03/2019	10 - 15	0	0	0	0	12	10 - 15
Mark Day	Non Executive Director	01/04/2017	31/03/2019	10 - 15	0	0	0	0	33	10 - 15
Martin Earwicker	Chair	01/04/2017	31/03/2019	45 - 50	0	0	0	0	7	45 - 50
Christopher Fisher	Non Executive Director	01/04/2017	31/03/2019	15 - 20	0	0	0	0	0	15 - 20
Mark Lejman**	Non Executive Director	01/04/2015	13/12/2017	-	-	-	-	-	-	-
Ruth Lysons	Non Executive Director	01/04/2015	31/03/2019	15 - 20	0	0	0	0	20	15 - 20
Mehmuda Mian	Non Executive Director	01/06/2015	31/03/2019	10 - 15	0	0	0	0	0	10 - 15

2017-18

		2017/18						
Name	Title	Salary and fees (in bands of £5,000) * £000s	Taxable benefits (total to the nearest £100) £000s	Annual performancerelated bonuses (in bands of £5,000) £000s	Long-term performance related bonuses (in bands of £5,000) £000s	Pension related benefits (in bands of £2,500)** £000s	Expenses - Travel and Subsistance (total to the nearest £100) £000s	Total £000s
Executive Directors								
Julian Emms	Chief Executive	190 - 195	0	0	0	100.0 - 102.5	15	295 - 300
Deborah Fulton	Acting Director of Nursing	-	-	-	-	-	-	-
Alex Gild	Chief Financial Officer	145 - 150	0	0	0	82.5 - 85.0	3	230 - 235
Dr Minocher Irani	Medical Director	175 - 180	0	0	0	137.5 - 140.0	2	310 - 315
Helen Mackenzie	Director of Nursing	105 - 110	0	0	0	50.0 - 52.5	13	155 - 160
Beverly Searle	Director of Corporate Affairs	125 - 130	0	0	0	60.0 - 62.5	2	185 - 190
David Townsend	Chief Operating Officer	135 - 140	0	0	0	47.5 - 50.0	11	185 - 190
Non Executive Directors								
David Buckle	Non Executive Director	10 - 15	0	0	0	0	0	10 - 15
Naomi Coxwell	Non Executive Director	00 - 05	0	0	0	0	0	00 - 05
Mark Day	Non Executive Director	10 - 15	0	0	0	0	0	10 - 15
Martin Earwicker	Chair	45 - 50	0	0	0	0	0	45 - 50
Christopher Fisher	Non Executive Director	15 - 20	0	0	0	0	2	15 - 20
Mark Lejman**	Non Executive Director	10 - 15	0	0	0	0	0	10 - 15
Ruth Lysons	Non Executive Director	10 - 15	0	0	0	0	1	10 - 15
Mehmuda Mian	Non Executive Director	10 - 15	0	0	0	0	0	10 - 15

Notes:

- *Helen Mackenzie terminated her appointment as Director of Nursing and Governance on 13 January 2019
- **Mark Lejman terminated from his appointment as Non-Executive Director on 13 December 2017
- No members of the Trust Board received an annual or long-term performance related bonus in 2017-18 or 2018-19
- Pension Related Benefits are calculated in accordance with the Finance Act 2004. This is commonly referred to as the "HMRC method". The account included is based on the increase in the director's accrued pension in the year. This will generally take into account an additional year of service together with any increases in pensionable pay. This amount is then multiplied by 20 to calculate the amount to be included in the Remuneration Report.

Top to Median Staff Pay Multiple (Ratio) (*the following information is subject to audit*)

The NHS Foundation Trust now provides information on the ratio between the highest paid director compared to the median total remuneration for all employees, including agency, bank and other staff of the NHS Foundation Trust. In calculating the median total remuneration, all payments to employees that constitute salary are included, such as basic pay, and enhancements for unsocial, night time or weekend working. Overtime is not included as that is not regarded as salary. Employer pension contributions and cash equivalent transfer value of pensions are also excluded.

Comparative for 2017-18 has been provided.

	2018/19	2017/18
Band of Highest Paid Directors Remuneration (£'000)	**195-200**	**190-195**
Median Total Remuneration	**£29,523**	**£29,750**
Remuneration Ratio	**6.72**	**6.50**

Pension Benefits *(the following information is subject to audit)*

Name	Title	From	To	Real increase in pensionable age (bands of £2,500) £000s	Real increase in pension lump sun at aged 60 (bands of £2,500 £000s	Total accrued pensionable age at 31 March 2019 (bands of £5,000) £000s	Lump sum at pensionable age related to accrued pension at 31 March 2019 (bands of £5,000) £000s	Cash Equivalent Transfer Value at 1 April 2018 £000s	Real increase in Cash Equivalent Transfer Value £000s	Cash Equivalent Transfer Value at 31 March 2019 £000
Julian Emms	Chief Executive	01/04/ 2018	31/03/ 2019	0.0 - 2.5	0.0 - 2.5	60 – 65	150 -155	1,070	139	1,209
Deborah Fulton	Acting Director of Nursing & Governance	01/12/ 2018	31/03/ 2019	5.0 - 7.5	10.0 - 12.5	25 - 30	60 – 65	369	222	591
Alex Gild	Chief Financial Officer	01/04/ 2018	31/03/ 2019	2.5 - 5.0	0.0 - 2.5	45 - 50	105 - 110	618	139	757
Dr Minoo Irani	Medical Director	01/04/ 2018	31/03/ 2019	5.0 - 7.5	5.0 - 7.5	60 - 65	145 - 150	1,005	237	1,242
Helen Mackenzie	Director of Nursing & Governance	01/04/ 2018	13/01/ 2019	0 0 - 2.5	5.0 - 7.5	50 – 55	150- 155	0	0	0
Bev Searle	Director of Strategy & Corporate Affairs	01/04/ 2018	31/03/ 2019	2.5 - 5.0	7.5 - 10.0	50 - 55	150- 155	1,079	170	1,249
David Townsend	Chief Operating Officer	01/04/ 2018	31/03/ 2019	0 0 - 2.5	5.0 - 7.5	25 - 30	75 - 80	526	104	630

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from

another scheme or arrangement) and uses common market valuation factors for the start and end of the period. Where a member has a CETV of £0 the member has reached Normal Retirement Age.

During 2018-19, the Trust did not operate a performance related element to very senior managers' remuneration. The remuneration of the Chief Executive, Medical Director and Chief Operating Officer included a non-consolidated pay award of between 1.2% and 1.5% (the overall salary uplift equated to 2.6%). Other very senior manager's received a 2.6% consolidated pay award. The only non-cash element of the most senior managers' remuneration packages is pension related benefits accrued under the NHS Pension Scheme. Contributions are made by both the employer and employee in accordance with the rules of the Scheme.

All of the senior managers are employed on contracts of service and are substantive employees of the Trust. Their contracts are open ended employment contracts which can be terminated by the Trust by six months' notice. Other Trust staff are covered by the terms and conditions of the national NHS 'Agenda for Change' provisions.

Julian Emms
Chief Executive
22 May 2019

Statement as to Disclosure to Auditors

So far as the Directors are aware, there is no relevant audit information of which the Auditors are unaware, and the Directors have taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the Auditors are aware of that information.

Staff report

For the last seven years, staff engagement has been a strategic organisational development objective for Berkshire Healthcare and we recognise the importance of high levels of staff engagement as a direct contributor to not only patient care, the patient experience and high quality outcomes, but also to the ability to recruit and retain our workforce.

We are really pleased that our overall rating for staff engagement has increased year on year (until 2017) and this year we have achieved the same outcome as 2017 (3.93) despite an impressive 7% or around 300 additional members of our workforce providing feedback.

The main initiatives helping us to achieve high staff engagement during 2018-2019 were:

- Our *Listening into Action* programme, now in its seventh year, which is aimed at improving patient care by listening to staff, acting on their ideas and empowering them to take their suggestions forward
- Our Brighter Together initiative – entering its fifth year - which supports staff innovation, and which was a direct response to staff on how they could take forward creative ideas for patient care.
- Our leadership development programmes, starting in 2013 with our Excellent Manager Programme, Essential Skills for managers, and followed by our Senior Clinical Leadership and Compassionate Leadership programmes
- The Quality Improvement Programme launched in 2017. The programme provides groups of staff and services with the training and tools to take ownership for developing and implementing the improvements to their patient care, service delivery and areas of working.

The national NHS Staff Survey continues to be a key source of evidence of our performance and progress. This is supplemented by the Staff Friends and Family Tests (which tell us how many of our staff would recommend the Trust as a place to work or receive treatment) which are run online three times per year and are open to all permanent Berkshire Healthcare staff.

The NHS staff survey is conducted annually and supplied to all staff by Picker. They provide a confidential mechanism for staff to complete the survey online. This year we took the decision to allow some staff at Prospect Park Hospital and in the Estates and Facilities team to complete a paper survey. This allowed managers the opportunity to talk to people face to face about the importance of the feedback and schedule time away from front line services to have their say.

Response rates:

This year we set up a working group to discuss ideas for improving the response rates. The group came up with ideas to boost responses, including sending out a communication to the senior leadership team with a number of actions they could take, sending individual emails to managers where a number of staff were not responding and sharing the league tables of response rates. Importantly, we ran a communication programme with staff sharing updates on what feedback we have heard and the action we have taken over the years as a direct consequence of the national NHS Staff Survey feedback.

NHS National Staff Survey response rates 2013-2018:

	2014	2015	2016	2017	2018
BHFT	45%	38%	46%	44%	51%
Average	44%	44%	44%	45%	45%

NHS National Staff Survey feedback

The NHS Staff Survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The employee engagement level remained the same year on year, a score of 3.93 out of 5.

The table below compares the data for the last three years.

	2018/19		**2017/18**		**2016/17**	
	Trust	Benchmarking Group	**Trust**	Benchmarking Group	**Trust**	Benchmarking Group
Equality, diversity and inclusion	9.0	9.2	9.1	9.2	9.1	**9.2**
Health and wellbeing	6.1	6.1	6.2	6.1	6.4	**6.2**
Immediate managers	7.2	7.2	7.2	7.1	7.1	**7.1**
Morale	6.3	6.2	NA	NA	NA	**NA**
Quality of appraisal	5.8	5.5	5.9	5.4	5.9	**5.4**
Quality of care	7.4	7.4	7.5	7.4	7.6	**7.5**
Safe environment – bullying and harassment	8.2	8.2	8.4	8.3	8.4	**8.2**
Safe environment – violence	9.5	9.5	9.6	9.5	9.6	**9.5**
Safety culture	7	6.8	7.1	6.7	7	**6.7**
Staff engagement	**7.3**	**7**	**7.3**	*Data not available**	*Data not available**	*Data not available**

**The NHS Staff Survey was scored out of 5 in those years. NHS Employers have not provided the alternative scores.*

The results enable us to review whether the actions we take have an impact the following year.

The True North vision unites the workforce around a set of Trust wide objectives. Teams work on producing a *Plan on Page* which will set local objectives and link this to their personal appraisal. Question 4h asks staff about whether the team they work in has shared objectives. 80% of our staff report back that they have shared objectives, in comparison to 75% of the benchmark average.

The Trust has started rolling out the Quality Improvement programme and it is pleasing to report that 81% of staff feel that they are able to make suggestions for improvements at work in comparison to 78% of the benchmark average. 64% of our staff say that they are able to make improvements happen at work in comparison to 60% of the average.

The results vary from team to team and between individuals depending on ethnicity, gender,

sexual orientation and whether people identify as having a disability or not. What is clear is that we have more work to do to make everyone feel that the Trust is a great place to work.

There were many things to be encouraged about in the survey:

82% said that **'care of service users'** is the organisation's top priority, which is well above the NHS average of 70%

80% said that **'my organisation acts on concerns raised by service users'** - the NHS average is 76%

94% said that they' **had an appraisal'** in the last 12 months - the NHS average is 90%

76% said '**training, learning or development'** needs were identified during the appraisal (up 4% from last year)

60% said '**my line manager supported me'** to receive this training, learning or development (up from 55% last year)

But there is always more to do.

Over the coming year, we will focus on making sure our health and wellbeing offer is known about by all staff, used by staff who need more support and care, and improved for consistency across the Trust. We are investing in a Health, Wellbeing and Engagement lead to ensure we adopt best practice and are able to share it with all teams and managers. We will implement a Health and Wellbeing week and introduce Champions across the teams to remind people to care for themselves and remind the 1,000 staff who have completed the Compassionate Leadership course that they have permission to care for themselves and how they can do this.

We have changed the appraisal documentation this year. We listened to the feedback from staff and managers last year and took action. Following focus sessions and consultation with staff we have produced new forms which will make it easier for people to have good conversations, recognise individual contribution and give honest and helpful feedback. We have updated the management development training to improve the competence of managers to offer good appraisals.

We know that how it feels to work here (employee morale) needs to improve. We are able to review data about turnover, vacancy levels, sickness, training and the national NHS Staff Survey results. As a result of this we can support managers to have a conversation about the actions that need to happen locally to improve the culture despite the workforce challenges. We are developing a series of actions to improve retention and have started engaging managers and staff in a conversation about 'making this a great place to work – for everyone'.

We have shared the data with our staff networks and will take action to make changes because this is the right thing to do, so everyone can bring their whole self to work. The feedback in the survey is clear; we have to improve how it feels to work for Berkshire Healthcare if you have a protected characteristic. We are currently developing a programme for all managers called *Making It Right* for managers whereby people will be able to go through the data, the themes and the actions and behaviours we all need to adopt to make this a fair and engaging place to work for everyone.

Top and bottom scores when Berkshire Healthcare is compared to similar Trusts:

	Top 5 scores (compared to average)
47%	Q19e. Appraisal/performance review: organisational values definitely discussed
44%	Q9d. Senior managers act on staff feedback
45%	Q9c. Senior managers try to involve staff in important decisions
68%	Q21c. Would recommend organisation as place to work
63%	Q4f. Have adequate materials, supplies and equipment to do my work

	Bottom 5 scores (compared to average)
31%	Q10c. Don't work any additional unpaid hours per week for this organisation, over and above contracted hours
71%	Q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities
35%	Q5g. Satisfied with level of pay
80%	Q11f. Not felt pressure from colleagues to come to work when not feeling well enough
20%	Q6a. I have realistic time pressures

Key areas for improvement:

- Support managers to have the skills to engage staff effectively and offer the right support
- Build a better health and wellbeing offer
- Roll out *Making It Right* for managers
- Produce a 'flexible working statement' making clear our expectations and offer
- Continue to build our digital infrastructure and capability
- Build career paths and offer the necessary learning and development
- Support managers to have really good conversations during appraisals and mid-year reviews

The national NHS Staff Survey working group will review the list of actions and lessons learnt this year to improve the NHS Staff Survey response even further next year.

The Strategic Workforce Steering Group will receive monthly updates on the actions we have agreed and will ensure that the solutions are fit for purpose and have the desired impact.

The Business and Strategy Executive Committee received updates each month on actions taken on the recruitment and retention project, the health and wellbeing project and the induction and training project, ensuring work was progressing on time and was prioritised throughout the year.

The True North statement (goal 2) sets the following targets for the year ahead; notably the ambition to achieve a national NHS Staff Survey engagement score of 4 or more across all services.

- To achieve an engagement score of 4 or more across all services
- For 70% of our staff to feel that they can make improvements at work
- For 85% of our staff to recommend Berkshire Healthcare as a place to work
- To promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduced assaults on staff by 20%

Staff numbers (*the following information is subject to audit*)

Average number of employees (whole time equivalent basis)

					2018/19		2017/18
	Permanent		Other		Total		Total
	Number		Number		Number		Number*
Medical and dental	166		14		181		175
Ambulance staff	4		-		4		2
Administration and estates	530		37		567		552
Healthcare assistants and other support staff	250		2		252		252
Nursing, midwifery and health visiting staff	969		137		1,107		1,132
Nursing, midwifery and health visiting learners	914		157		1,071		1,077
Scientific, therapeutic and technical staff	688		32		721		691
Healthcare science staff	14		1		16		16
Total average numbers	**3,537**		**381**		**3,917**		**3,897**

* The prior year staff numbers for 2017/18 have been re-analysed following a review of staffing posts during 2018/19 to align them to operational community and mental health services.

Staff gender split at end of year 2018-19

The following table provides information on the gender split for Trust staff at the end of the year:

	Male	Female	Total
Non-Executive Directors	4	3	7
Executive Directors	4	2	6
Senior Managers	99	347	446
Other staff	658	3,224	3,882

The following information is subject to audit

Compensation Schemes – Exit Packages 2018-19

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	1	1	**2**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**1**	**4**
Total resource cost (£)	177,000	19,000	**196,000**

Reporting of compensation schemes - exit packages 2017-18

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,001 - £25,000	1	-	**1**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	1	-	**1**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
Total number of exit packages by type	**4**	**-**	**4**
Total resource cost (£)	149,000	-	**149,000**

Exit packages: other (non-compulsory) departure payments

	2018-19		2017-18	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	19	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**1**	**19**	**-**	**-**

Off Payroll Arrangements Disclosure

The NHS Foundation Trust reports arrangements whereby individuals are paid through their own companies (and so are responsible for their own tax and national insurance arrangements, not being classed as Trust employees). The costs of these off payroll engagements are recorded in the expenditure of the Trust, within consultancy costs. The Trust made no "off payroll" payments from 1 April 2018 to 31 March 2019.

Other staff related matters

In accordance with the requirements of the Companies Act 2006 and the Large and Medium-sized Companies Regulations 2008, the Trust makes these additional declarations:

- The Trust addresses the employment, training and career development needs of all disabled persons through use of the following key policies and procedures:
    - Equality and Inclusion Strategy 2016-20;
    - The Department of Work and Pensions 'Two Ticks' scheme;
    - 'Time to Change' – anti-stigma campaign on mental illness;
    - Equal Opportunities and Diversity policy;
    - Workforce Development policy.

The above are co-ordinated by the work of the Human Resources team including the Head of Human Resources, the Equality and Diversity Manager and the Equality Human Resources Manager.

- The Trust actively seeks to provide employees systematically with information of concern to them through the following:

- Regular publication of our electronic newsletter;
- Regular meetings with representatives of recognised staff unions;
- Regular meetings with staff representatives of our three staff networks:
  - Lesbian Gay Bisexual and Transgender
  - Disability
  - Black Asian and Minority Ethnic
- Elected staff representatives forming part of the NHS Foundation Trust's Council of Governors.

The Trust has a broad range of staff engagement and communications arrangements. Executive responsibility for communications rests with the Director of Strategy and Corporate Affairs. There are regular staff briefings using newsletters, intranet resources, podcasts and team briefings and considerable use is made of web based survey applications to obtain staff views and feedback. During the year, the Trust continued to implement and benefit from the national NHS programme called 'Listening into Action'. The programme provides a structured methodology for embedding a listening, engaging and empowering style of leadership across the organisation.

Regular meetings with senior managers and clinical leaders provide a forum for setting out and discussing key issues facing the Trust, including financial, economic and quality considerations. Information from these meetings is used in staff briefings to ensure all employees understand key factors influencing performance and can be encouraged to get involved in managing performance relative to their position in the organisation. This is reinforced through the application of the Trust's annual staff review process covering objective setting, personal development and performance appraisal. The Trust has a formal succession planning and talent management framework for senior managers to assure the flow of suitably qualified and capable staff to meet organisational need.

The Trust has appointed a Freedom to Speak Up (FTSU) Guardian. The FTSU Guardian is an important role and acts as an independent and impartial source of advice to any member of staff who may wish to raise a concern. Information for staff on how to contact the FTSU is contained on the Trust's internal Intranet and made aware to all new starters at induction. The FTSU Guardian is supported by both the Regional Guardian network and by the National Guardian's Office.

The Trust has developed Anti-Bribery and Conflicts of Interests Policies to line with the requirements of the Anti-Bribery 2010 Act and Guidance from NHS England on Managing Conflicts of Interests.

The Trust's Standards of Business Conduct (incorporating declarations of hospitality, gifts, business interests and commercial sponsorship and conflicts of interest) Policy sets out the high standards of probity which the Trust requires of all staff.

Sickness Absence Figures – January to December 2018

Figures Converted by Department of Health and Social Care to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
3,641.67	32,878.11	1,329,208	53,336	9.03

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the Electronic Staff Record (ERS) Data Warehouse

Data items: ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Trade Union Disclosure

Table 1 - Relevant union officials

Total number of employees who were relevant Trade Union officials during 2018-19

Number of employees who were relevant Trade Union officials during 2018-19	*Full-time equivalent employee number*
19	16.25

Table 2 - Percentage of time spent on facility time

Percentage of time relevant Trade Union officials employed by the Trust during 2018-19 spent on working on facility time:

Percentage of time	Number of employees
0%	13
1-50%	6
51-99%	0
100%	0

Table 3 - Percentage of pay bill spent on facility time

The percentage of the total pay bill spent on paying employees who were relevant Trade Union officials for facility time during 2018 -19:

First Column in Table 2 above	Figures
Total cost of facility time	£17,594 (per annum)
Total pay bill	£175,026M (per annum)
The percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

The Trust does not allow Trade Union representatives to attend meetings during work time which are defined by ACAS as: "time for which there is no specific right to be paid including meeting full-time officers, attending regional or branch meetings".

Counter fraud activity

The Trust operates a robust arrangement for minimising the risk of fraud and meets the requirements of the Secretary of State that each health body nominate an officer to act as its Local Counter Fraud Specialist. As well as handling suspected cases of fraud, the service provides awareness and education support to help embed an 'anti-fraud' culture throughout the organisation. There is a clear policy on counter fraud together with other provisions to support staff in raising concerns about possible fraudulent activity.

Health and Safety

The Trust's arrangements for the health and safety of staff, patients, visitors and others are set out in a clear organisational policy that emphasises the organisation's commitment to providing a safe place to work and a healthy environment for all. A comprehensive suite of policies and procedures are in place to ensure that risks to the health and safety of all are minimised and these policies and procedures are reviewed regularly to ensure the effectiveness of the Trust's health and safety management system.

The Trust produces an annual Health and Safety report, which reviews the Trust's performance on a range of categories, comparing results to the previous year and national figures. Key points of note include:

- There were 14 incidents reported under the RIDDOR regulations in the year 2018, showing an increase on the 7 incidents for the 2017 annual period. As in the previous year, most related to slips, trips and falls. There were two incidents where 3 people (each one reported separately) were struck by a moving object. Every incident is investigated; route causes identified and remedial actions implemented.

- During 2018, the Trust reported 641 physical assaults against staff. This is an increase of 131 (26%) compared to 2017. This is a major focus of Trust's Quality Improvement programme work to reduce patient assaults on staff.

- Compliancy in statutory training has been above target for Health and Safety and Manual Handling (92.9% and 91.2% annual average). The target for Fire Awareness Training was increased in April 2018 from >90% to >95% and has been below target (annual average 90.4%).

- 12 fires were reported during 2018, seven of which were at Prospect Park Hospital. Six were minor incidents and one required ward evacuation.

- The Trust received one Enforcement Notice from Royal Berkshire Fire and Rescue Service following a fire at Prospect Park Hospital. The Trust had a fire on Daisy Ward on 1 April 2018 in which a patient set fire to their bedding requiring the ward to be evacuated and the attendance of the Fire Service. The ward was safely evacuated, the fire was extinguished and there were no injuries.

- The Royal Berkshire Fire Service undertook a fire safety audit on 3 April 2018 which found that whilst training records were compliant, the actions on the ground were not consistent with the training and procedures for locating the fire and evacuation and liaison with the Fire Service were inadequate.

- As a result of the Regulatory Notice, we undertook a comprehensive and complete review of all our fire safety measures and produced a response for the Fire Service which included all measures in place and actions already being addressed to provide the assurances required. These were independently reviewed by a leading national fire safety expert who confirmed they provided comprehensive assurance.

- We provided our response to the Royal Berkshire Fire Service and had confirmation that the enforcement notice has been withdrawn.

- During 2018, the Royal Berkshire Fire and Rescue Service undertook four fire safety visits and several site specific risk assessment visits at Prospect Park Hospital for the purpose of updating their own records.

NHS Improvement Single Oversight Framework Ratings

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial Sustainability	Capital service capacity	2	2	2	2	2	2	2	2
	Liquidity	1	1	1	1	1	1	1	1
Financial Efficiency	I&E Margin	1	1	1	1	1	2	2	2
Financial Controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	1	1	1	1	1	1	1	1
Overall Scoring		**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**

Julian Emms
Chief Executive

22 May 2019

COUNCIL OF GOVERNORS

The Trust's Council of Governors plays a crucial role in the governance of the Trust providing a forum through which the Board of Directors is accountable to the local community. The Council discharge a number of key responsibilities including:

- Representing the interests of the Trust's members and stakeholder organisations in the governance of the Trust;
- Appointing or removing the Chair and other Non-Executive Directors;
- Approving the appointment (by the Non-Executive Directors) of the Chief Executive;
- Deciding the remuneration, allowances and other terms and conditions of office of the Non-Executive Directors;
- Holding the Non-Executive Directors to account for the performance of the Board;
- Considering the annual accounts, plus any report of the external auditor on them, and the annual report;
- Appointing the External Auditors;
- Developing and approving the Trust's membership strategy;
- Providing views to the Board of Directors on the Trust's forward planning;
- Undertaking functions requested from time to time by the Board of Directors;
- Attending events in order to engage with members and the public;
- Attendance at the Annual Members Meeting.

Membership of Council

During 2018/19 there were 32 positions on the Council of Governors:

- 23 elected from the public and staff constituencies
- 9 appointed from local authorities, universities and voluntary organisations

The elected governors were drawn from the following constituencies:

- Public constituency – total of 19
- Staff constituency – total of 4

The following table shows the attendance record of Governors at Council meetings during the year:

Name	Constituency	Meetings attended/possible
Linda Berry	Public - Bracknell	1/4
Pat Rodgers	Public - Bracknell	3/4
Raymond Fox	Public – West Berkshire	3/4
Verity Murricane	Public – West Berkshire	4/4
Susana Carvalho	Public – West Berkshire	1/2
John Barrett	Public – Windsor, Ascot & Maidenhead	4/4
Tom O'Kane	Public – Windsor, Ascot & Maidenhead	3/4
Nick Prentice-Harrison	Public – Windsor, Ascot & Maidenhead	0/1
Ruffat Ali-Noor	Public – Slough	4/4
Amrik Banse	Public – Slough	4/4
Nigel Oliver	Public – Slough	2/4
Andrew Horne	Public – Wokingham	3/4

Name	Constituency	Meetings attended/possible
Krupa Patel	Public – Wokingham	2/4
Gary Stevens	Public – Wokingham	2/4
Keith Asser	Public - Reading	1/2
Tom Wedd	Public Reading	1/1
Paul Myerscough	Public – Reading	4/4
Tom Lake	Public – Reading	4/4
Paul Sahota	Public – Rest of England	1/3
Julia Prince	Staff – Clinical	4/4
Guy Dakin	Staff – Non-Clinical	4/4
June Carmichael	Staff - Non-Clinical	1/4
Natasha Berthollier	Staff – Clinical	4/4
Isabel Mattick	LA – Bracknell	4/4
Munawar Sohail	LA – Slough	0/4
Graeme Hoskins	LA - Reading	0/3
Adrian Edwards	LA – West Berkshire	4/4
Shamsul Shelim	LA – Windsor and Maidenhead	1/3
Jenny Cheng	LA – Wokingham	2/3
Craig Steel	Thames Valley University	0/3
Suzanna Rose	British Red Cross	3/4
Marion Child	Alzheimer's Society	1/3

LA = Local Authority

During 2018-19 there were four formal meetings of the Council held in public with publicity given through the Trust's website.

In September 2018, the Trust held a public Annual Members Meeting where the Trust's Annual Report and Accounts were presented.

The annual election of Lead and deputy Lead Governor also took place in September 2018 with Governors appointing Paul Myerscough as Lead Governor and appointing Krupa Patel as Deputy Lead Governor.

The Council has also put in place a structure of committees and steering groups to help fulfil its duties and each Committee reports back to the full Council at each Council meeting. The Committees/Groups are:

- Membership and Engagement Group
- Living Life to the Full Group
- Appointments and Remuneration Committee
- Quality Assurance Group

Strong working relationships continue between the Council and Board of Directors with regular engagement, involving Executive and Non-Executive Director attendance at Council meetings, joint meetings between Council and the Board, including two meetings a year specifically with Non-Executive Directors, and regular attendance of Governors at Board meetings. The Chief Executive attends all meetings of the full Council and other Executive Directors attend as and when required. The meetings held with Non-Executive Directors have been useful in supporting Governors to discharge their duty to hold the Non-Executive

Directors to account for the performance of the Board and for seeking assurance on service quality and financial sustainability.

For new Governors joining the Trust during the year induction training was provided involving the Trust Chair and Company Secretary.

A number of Governors were actively involved in membership recruitment during the year attending a variety of events, including World Mental Health day and at local community events. The Membership Strategy is overseen by the Council's Membership and Engagement Group, supported by the Trust's Marketing and Communications team. The Group continued to explore ways in which Governors can become more engaged with members and the public.

Governors have an opportunity to submit written questions in advance of the informal Joint meetings with the Trust Board and Council of Governors. The Chief Executive and other Executive Directors provide answers to the questions at the meetings which are recorded in the minutes. The Chair holds monthly meetings with the Lead Governor to discuss governor related issues and concerns.

The Trust's Constitution sets out the process for the Council of Governors to remove the Trust's Chair and Non-Executive Directors in the event that all other means of engaging with the Trust Board have been exhausted.

Farewell and welcome

In 2018-19 a number of Governors left and we welcomed others. Whilst it is always disappointing to lose enthusiastic and experienced Governors, Council benefits immensely from the injection of different perspectives and ideas that new Governors bring.

Our thanks go to departing Governors: Keith Asser, Public Governor, Paul Sahota, Public Governor and Cllr Richard Dolinski, Partnership Governor

We warmly welcomed: Thomas Wedd, Public Governor, Susana Carvalho, Public Governor, Nick Prentice-Harrison, Public Governor, Cllr Jenny Cheng, Partnership Governor, Graeme Hoskin, Partnership Governor and Cllr Natasa Pentalic, Partnership Governor.

Governor Expenses

The role of Governor is unpaid; however, they are entitled to claim reimbursement of expenses, such as travel and subsistence costs. During 2018-19, thirteen Governors (out of 32) claimed an aggregate total of £2,002.55 in expenses (£2,190 in 2017-18). The majority of expenses relate to travel costs and the quantum of this is primarily a function of distance from home to meeting locations.

Elections

Public and Staff Governors are elected by the membership of the relevant constituency and they serve for a period of three years. They can be re-elected and can serve for a maximum of nine consecutive years. The following table provides information on the results of Governor Elections held during the year:

Date of Election	Constituency	Election turnout %
November 2018	Reading	6.5%
November 2018	WAM	Uncontested
November 2018	West Berkshire	Uncontested
November 2018	Bracknell	1 seat uncontested 1 seat no nominations

All elections were completed and supervised by Electoral Reform Services Ltd and were conducted in accordance with the Trust's Constitution.

Partnership Governors are appointed by the relevant organisation.

Register of interests

A register of interests is maintained for Governors. It is available by contacting the Trust's Company Secretary.

Membership

Berkshire Healthcare became an NHS foundation trust in 2007. This status allows us to make a range of decisions independently from direct government control. NHS foundation trusts are accountable to their staff, patients and local communities through their members and governors. All NHS foundation trusts have a duty to engage with their local communities and encourage local people to become members of their organisations.

NHS foundation trusts are required to maintain a membership which is representative of the communities they serve. Our members and governors help us shape our plans for the future and make sure that the services we provide reflect what is needed locally.

Anyone can become a member of our Trust; however the minimum age is 12 years. The Marketing and Communications team is responsible for recruiting and engaging with our membership.

During 2018-19 we grew our membership by 212 from 11,723 to 11,935.

We have worked towards maintaining membership numbers rather than growing them over the last year, as we are comfortably over our target number of 10,000.

Over the past year we attended Reading Pride and other community events, mainly across the summer months to recruit new members. As member numbers are strong, we will focus less on general events for the coming year and more on the demographics of our members, thinking of ways we can directly encourage those who are under-represented to join up. We will also promote our new way of joining – an online membership form accessed via the Trust's website.

Our staff automatically become members of Berkshire Healthcare, but can 'opt out' if they choose to do so.

Engagement with Members

Over the last year engagement with our members has included an invitation to attend our Annual General Meeting, information about voting for governors and digital newsletters covering key health topics and information. Our membership database means we can produce reports for our digital communications, and generate improved data reports (including areas such as demographics, health and involvement interests).

Our current membership numbers in each local authority are shown below.

Current public membership by local authority area (on 1 April 2019)

Locality	Public	% of Membership	Base	% of Locality
Bracknell	937	12.3	121,592	13.4
Reading	1,932	25.3	164,374	18.1
Slough	753	9.9	149,765	16.5
West Berkshire	744	9.8	157,655	17.4
Windsor and Maidenhead	669	8.8	150,520	16.6

Locality	Public	% of Membership	Base	% of Locality
Wokingham	1,007	13.2	164,311	18.1
Rest of England	1,332	17.5	N/A	N/A
Out of Trust Area	257	3.4	N/A	N/A
Total	**7,631**	**100.00**	**908,217**	**100.00**

Most of our members live in Berkshire; however a few live further away and have an interest in our organisation. They may be

- carers who look after, or are responsible for, someone who uses our services
- members of staff
- someone who has moved away from the county and wishes to maintain links with us

These members are part of our 'Rest of England' constituency. The 'Out of Trust Area' category refers to members whose postcode is not recognised or who live overseas.

The table below shows the size of our current membership, and the movement in numbers of members compared to 2017-18.

Membership size and movements (on 1 April 2019)

Public constituency	2017/2018	2018/2019	Percentage change
At year start (April 1)	7,277	7,419	1.95%
New members	317	273	-13.88%
Members leaving	175	230	31.42%
At year end (31 March)	7,419	7,631	2.85%
Staff constituency	**2017/2018**	**2018/2019**	**Percentage change**
At year start (April 1)	4,262	4304	0.98%
New members	822	879	5.52
Members leaving	864	769	-10.99
At year end (31 March)	4304	4342	0.88%

Regular cleanses of the database and the daily updating of members means there is a small difference in numbers every day.

Differences in total numbers of public members compared to other analysis tables are due to report generation on different dates.

The following table provides analysis of our public membership by age, ethnicity, socio-economic group and gender. Eligible membership (population) figures have been provided by Membership Engagement Services (MES), our database provider, and are taken from the 2011 census.

The 'Index' column refers to how 'on target' we are with representing the communities we serve. A score under 100 shows an under representation and a score above indicates an over representation. The minimum age to be a member is 12 years.

Analysis of public membership (on 1 April 2019)

RED *indicates under-representation in the particular membership category*
GREEN *indicates over representation in the particular membership category*

Age	**No of public members**	**Population**	**Index**
0-16	35	208,700	2
17-21	176	49,943	42
22+	6,016	651,147	110
Not stated	1,404*	0	0
Gender	**No of public members**	**Population**	**Index**
Unspecified	711	0	0
Male	2,535	452,448	67
Female	4,380	455,769	114
Transgender	5	0	0
Ethnicity	**Number of public members**	**Population**	**Index**
Asian	622	111,616	63
Black	238	29,968	90
Mixed	144	22,158	73
Other	1,194*	8,250	1,635
White	5,433	689,878	89
ONS/Monitor Classifications	**Number of public members**	**Population**	**Index**
AB	2,129	86,677	85
C1	2,199	82,933	92
C2	1,399	48,349	101
DE	1,571	47,624	115
Total membership	**7,422**	**904,324**	

** Not all members have provided full details for classification.*

Plans for 2019-20

Due to strong membership numbers we will not organise any dedicated membership recruitment events during 2019-20. However other teams, such as Talking Therapies, run regular events and they will still encourage the people they talk to, to sign up. We will also once again be attending the Reading Pride event in September 2019.

Our membership strategic goals for the coming year are:

1. To make the membership more representative of our local communities
2. To maintain our current membership levels between 10,000 and 12,000
3. To promote opportunities for members to become a governor and highlight elections to the Council of Governors.

We will use analysis of our database to inform where our main areas of focus should be. Our action plan aims to improve the alignment of our membership to the demographics of the population of Berkshire. This year we hope to recruit more Asian, mixed race and male members.

We will also encourage patients, carers and other interested people to become members by working with Patient Participation Groups and local Healthwatch organisations.

To promote opportunities and maintain engagement of our members, we will issue twice yearly newsletters, as well as providing additional correspondence about elections and becoming a governor.

PUBLIC INTEREST DISCLOSURES

Accounts note

The NHS Foundation Trust Annual Reporting Manual 2018-19 sets out the requirements for foundation trusts' annual reports. The NHS Foundation Trust Annual Reporting Manual contains the formal accounts direction for foundation trusts and the requirements for the basic structure. The Trust's financial statements have also been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2018-19.

Cost allocation

Berkshire Healthcare NHS Foundation Trust has complied with the cost allocation and charging requirements set out in Her Majesty's Treasury and Office of Public Sector Information guidance.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust

Quality Account 2018/19

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

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

What is a Quality Account?

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

About the Trust

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

We are rated as 'Good' by the Care Quality Commission and our ambition is to achieve a CQC rating of 'Outstanding'. We are currently rated as 'outstanding' in the Well-Led domain.

We are also a digital pioneer, having been named by NHS England as a 'Global Digital Exemplar'. This will allow us to transform patient care through new technologies.

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

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

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

Table of Contents for Quality Account 2018/19

Quality Account Positive Highlights and Overall Summary 2018/19

Highlights

Patient Experience Priorities

- 95% or more of patients responding to the Friends and Family Test (FFT) stated they were likely or extremely likely to recommend many of our services. 71% of respondents stated they would recommend our mental health inpatient services.
- 96% of carers responding to the FFT stated that they were likely or extremely likely to recommend our services.
- The Trust worked with its health and social care partners to improve system-wide patient satisfaction and outcomes, as part of Integrated Care Systems (ICS).

Patient Safety Priorities

We have continued to implement our Quality Improvement and Zero Suicide programmes which have had specific impact on the following.

- Preventing patient falls on our community inpatient wards.
- Self-harm incidents continue to reduce and were below the target threshold.

Clinical Effectiveness Priorities

- We have participated in all applicable national clinical audits and ensured that appropriate actions are taken and improvements made.
- We have a robust system for reviewing NICE guidance to ensure that care is delivered in line with national standards.
- Ensuring patients can access care locally is a high priority and we remain below the local threshold for patients having to be treated elsewhere due to availability of beds.
- The Trust continues reviewing, reporting and learning from deaths in line with national guidance.

Supporting our Staff Priorities

We have met our target to reduce staff vacancies to below 10% in the year to date and to train an additional 24 services in our Quality Improvement System.

Care Quality Commission (CQC) Rating

The Trust continues to be rated as 'Good' overall and is rated as 'Outstanding' in the Well-Led Domain.

2019/20 Trust Priorities

Patient Safety Priorities

1. We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia. Specific targets are detailed in main body of report
2. At least 95% of our reported incidents will be low or no harm to patients.
3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20. All our support services will work with patient facing services to identify ways that they can support safety of patients.
4. With our health and social care partners, we will work to achieve reduced urgent admissions and delayed transfers of care.

Clinical Effectiveness Priorities

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities in this report.
2. We will continue to review, report and learn from deaths in line with new national guidance as published

Patient Experience Priorities

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

Supporting our Staff Priorities

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

Figure 1- Summary of Trust achievement against 2018/19 Quality Account

Priority, Indicator and target (Click on links to access related main sections of report)		Results 2017/18	Results 2018/19	Comment & Change from 17/18- 18/19
Patient Experience				
Patient Friends and Family Test (FFT) - % of patients stating they are likely or extremely likely to recommend the service to a friend or family member. (Target ≥95% of respondents)	Community Services (Mental health and physical health combined).	96%	**94%**	**Target Not Met**
	Mental Health Inpatients.	67%	**71%**	**Target Not Met**
	Community Hospital Inpatients.	97%	**96%**	**Target Met**
	Minor Injury Unit.	98%	**98%**	**Target Met**
Trust Patient Satisfaction Survey- % of Patients rating the service they received as good or very good	Community Mental Health.	85%	**85%**	**No Change**
	Community Physical Health.	93%	**89%**	**Change -4%**
	Mental Health Inpatients.	72%	**66%**	**Change -6%**
	Patients in Community Hospitals.	97%	**98%**	**Change +1%**
Carer Friends and Family Test (FFT) - % of carers likely or extremely likely to recommend the service to a friend or family member.		97%	**96%**	**Change -1%**
Staff report using service user feedback to make informed decisions in their department. (Target- ≥60% of staff, Source- National NHS Staff Survey).		57%	**61%**	**Target Met**
Reduce use of prone restraint by 90% (Target ≤2 cases by end of March 2019).		N/A	**3** in March 19	**Target Not Met**
The Trust will contribute to Integrated Care Systems (ICS) to improve patient experience and outcomes.		N/A	**Met**	**Target Met**
Reduce Delayed Transfers of Care across inpatient services. (Target <7.5%).		11.3%	**9.0%**	**Target Not Met**
National Community Mental Health Survey- Overall result (score out of 10).		7.3	**7.2**	**Change -0.1**
Patient Safety				
Continue Trust Quality Improvement (QI) Programme.		N/A	**Met**	**Target Met**
Continue Trust Zero Suicide Programme.		Met	**Met**	**Target Met**
Reduce patient falls on wards for older people (Target 50% reduction).		345	**468**	**Target Not Met**
Reduce the Rate of inpatient falls on wards for older people (Target ≤8 per 1000 bed days).	Older Peoples Mental Health Wards	9.66	**16.59**	**Target Not Met**
	Community Health Wards	4.65	**6.02**	**Target Met**
Reduce patient self-harm incidents by 30% (Target ≤87 per month)		N/A	**78**	**Target Met**
Achieve an 'Outstanding' overall Care Quality Commission (CQC) Rating		Good	**Good**	**Target Not Met**
Urgent Admissions- Reduce the total number of bed days patients spend in an Inappropriate Out of Area Mental Health Placement (OAP). (Targets set by Berkshire East CCG and Berkshire West CCG- see main report)		N/A	**Met**	**Target Met**
Clinical Effectiveness				
Compliance with NICE Guideline on long term management of Self Harm		N/A	**96%**	**Target Met**
Continue to review, report and learn from deaths in line with new national guidance as it is published		Met	**Met**	**Target Met**
Supporting our Staff (previously titled 'Organisational Culture)				
Staff report feeling they can make improvements at work (Target- ≥66% of staff, Source- National NHS Staff Survey)		N/A	**64.4%**	**Target Not Met**
Staff agree or strongly agree they would recommend the Trust as a place to receive treatment (Target- ≥75% of staff, Source- National NHS Staff Survey)		75%	**73.6%**	**Target Not Met**
Reduce assaults on staff by 20% (Target <36 per month)		N/A	**45**	**Target Not Met**
Reduce Staff Vacancies (Reduce to below 10%)		N/A	**Met**	**Target Met**
Train an additional 24 services in the Trust Quality Improvement System		N/A	**Met**	**Target Met**
Achieve objectives set out in equality plans for each area		N/A	**Met**	**Target Met**
Participate in Integrated Care System ICS) work streams to enhance job satisfaction and career development opportunities		N/A	**Met**	**Target Met**

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

Berkshire Healthcare NHS Foundation Trust has continued to deliver effective, safe and efficient care for its patients through 2018/19. We have a Trust-wide vision to be recognised as the leading community and mental health provider by our patients, staff and partners.

The Trust continues to be rated as 'Good' by the Care Quality Commission (CQC) and has been awarded an 'Outstanding' rating in the Well-Led Domain. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities has also been rated as 'Outstanding' following assessment this year.

We continue to implement our Quality Improvement (QI) programme across the Trust, with more staff being trained in its methodology. This allows us to apply a consistent approach to continuous improvement, resulting in a better experience and outcome for patients and staff. Several of the improvements arising from this programme are included in this Quality Report.

We are committed to ensuring that patients have a positive experience of the care we provide and we continue to prioritise learning from patient experience surveys, complaints and compliments. Feedback from patient surveys has been largely positive this year and we aim to improve on and learn from this feedback.

Patient safety will always be of paramount importance to us, and our Trust board monitors performance in this area through scrutiny of a variety of patient safety metrics, several of which are shared in this report. We maintain robust governance, patient safety, incident and mortality reporting systems which are able to highlight areas for improvement in a timely manner allowing for learning. This year, we have focused on improving safety in a number of areas, including reducing prone restraint and self-harm, and we will continue striving to improve in these areas.

Our clinical effectiveness agenda helps to ensure that we are providing the right care to the right patient at the right time and in the right place. Our clinical audit and NICE programmes allow us to measure our care against current best practice leading to improvement. This report details the work undertaken in this area.

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

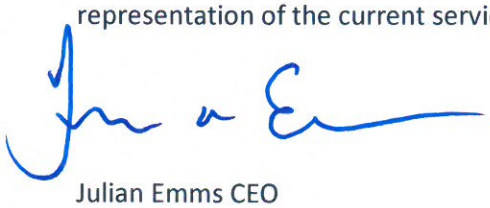
Following the publication of the report into the deaths at Gosport War Memorial Hospital, it is increasingly important that Trusts have robust systems in place that enable staff to 'speak up' about potential patient safety issues without fear of repercussions. This report outlines how we enable our staff to do this.

Our Trust is committed to the principles of system working and is actively involved with the Berkshire West and Frimley Integrated Care Systems in finding sustainable population based solutions for meeting the physical and mental health needs of our patients and service users. This report details some of our activity to achieve this with our partners during the year.

This Quality Report demonstrates the breadth of improvement work that is being undertaken, as well as the commitment of Trust staff to improve services for patients across the county.

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

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



Julian Emms CEO

"My elderly relative was admitted to the care of Rowan Ward at the end of 2018. At which point she had hit crisis point and we were really shocked and distressed at her behaviour! She was diagnosed with dementia with Lewy bodies and was extremely poorly! The staff on Rowan Ward were unbelievably supportive and caring not only to her but to us as a family. They remained positive and provided endless encouragement, even though at times we found the situation extremely difficult! After nearly six weeks through their care, support and professionalism, my relative returned home with a support package! As a family we cannot thank these wonderful people enough, from the bottom of hearts we thank them all for giving us our relative back! Each and every one of them are an absolute credit to the NHS and they all went above and beyond the call of duty. It just goes to show with the right support and care miracles do happen!!"

From a relative of a patient- Rowan Ward, Prospect Park Hospital, Reading

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

2.1. Achievement of Priorities for Improvement for 2018/19

ⓘ This section details the Trust's achievements against its quality account priorities for 2018/19. These priorities were identified, agreed and published as part of the Trust's 2017/18 quality account.

These quality account priorities support the goals detailed in the Trust's 2018/19 True North Annual Plan (see Appendix A). The Trust's Clinical Effectiveness Strategy also supports this through the following six elements:

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

2.1.1 Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2018/19.

Our 2018/19 Patient Experience Priorities:

1. To achieve a 95% satisfaction rate in our Friends and Family Test (FFT) and 60% of staff reporting use of service user feedback to make informed decisions in their department
2. To reduce our use of prone restraint by 90% by the end of 2018/19 (Target: ≤2 cases by the end of March 2019)
3. All our services will focus on understanding and supporting outcomes of care that are important to patients
4. At a system level, to contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes and reduce delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

Trust performance in relation to complaints, compliments and the 2018 National Community Mental Health Survey is also detailed in this sub-section.

Patient Friends and Family Test (FFT)

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

Response Rate

The Trust aims to achieve a response rate of at least 15%. It should be noted that in 2018/19 the Trust changed its methodology on how it reports the Friends and Family Test and therefore this year's performance should not be compared with that of last year. Figure 2 below demonstrates the response rate each quarter. During the whole of 2018/19 the overall response rate was above the 15% target at 15.2%.

Satisfaction Rate- Target 95%

One of the trust's targets for 2018/19 is to achieve a 95% satisfaction rate in the FFT. Figures 3 and 4 below demonstrate the Trust's achievement in relation to this target by showing the percentage of respondents stating they were extremely likely or likely to recommend services.

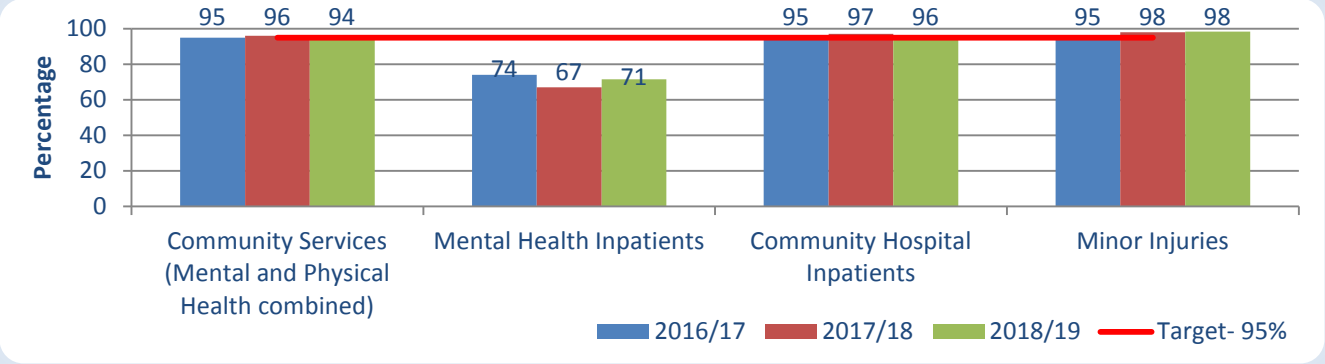
The figures show that the Trust's community inpatient services and minor Injury services met the target during 2018/19. Community services (mental health and physical health combined) were close to meeting the target with a rating of 94%. Mental Health inpatients were below target at 71%, but this is above the 2017/18 figure.

Figure 2- Response Rate for Patient FFT

2018/19 Quarter	Q1	Q2	Q3	Q4	2018/19 Full Year
% Response Rate	11.8	14.8	12.8	22.0	15.2

Source: Trust Patient Experience Reports

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



Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk-In Centre prior to its transfer to another organisation in September 2017

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

Survey and Service	2017/18			2018/19		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
Community Services- Mental Health & Physical Health Combined	15399	14718	96	**30078**	**28321**	**94**
Mental Health Inpatients	87	58	67	**480**	**343**	**71**
Community Hospital Inpatients	1057	1028	97	**930**	**894**	**96**
Minor Injuries Unit	3094	3035	98	**2245**	**2209**	**98**

Source: Trust Patient Experience Reports. Please note that the figure for Minor Injuries previously also included data for Slough Walk In Centre prior to its transfer to another organisation in September 2017

Carer Friends and Family Test (FFT)

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

Figures 5 and 6 below demonstrate the Trust's achievement in relation to the Carer Friends and Family Test and detail the percentage of respondents that stated they were extremely likely or likely to recommend Trust services. The figures show that the 2018/19 score (96%) is just below that of the 2017/18 full year finding, and is based on a greater number of respondents.

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

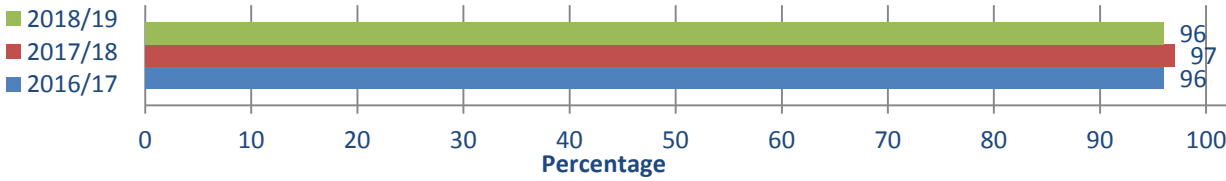


Figure 6- Carer Friends and Family Test- total number of responses

Survey and Service	2017/18			2018/19		
	Total no. of respondents	Respondents likely or extremely likely to recommend service		Total no. of respondents	Respondents likely or extremely likely to recommend service	
		No.	%		No.	%
All carers	269	261	97	**849**	**815**	**96**

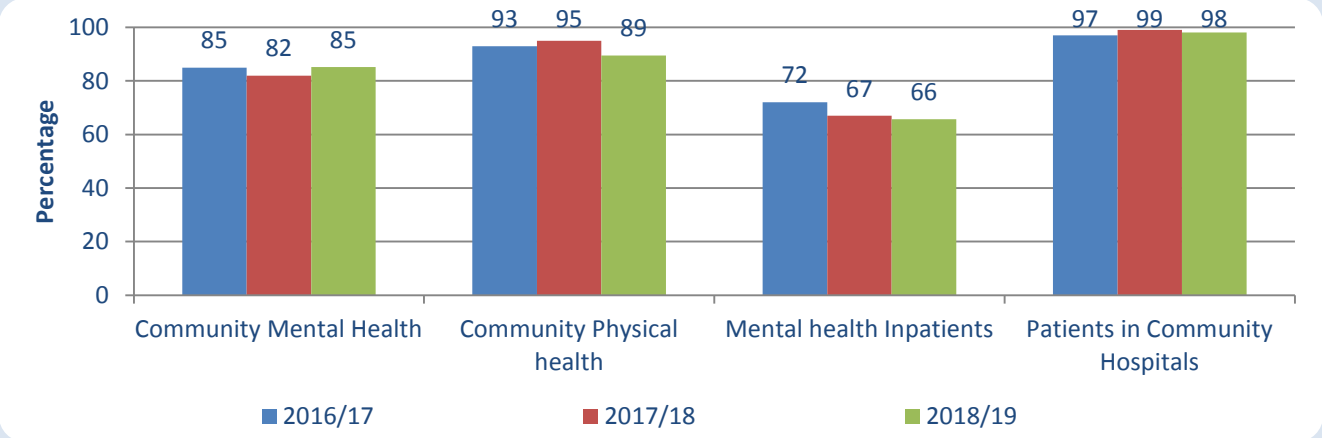
Source: Trust Patient Experience Reports Please note that the Trust does not have a response rate for this survey.

Trust Patient Satisfaction Survey

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

Figures 7 and 8 below demonstrate the Trust's performance in relation to this survey. The figures show that in 2018/19, 98% of respondents rated the care they received in community hospitals as good or very good, but this figure is based on a smaller number of respondents than in 2017/18. Community mental health and community physical health services were also highly rated. 66% of mental health inpatient respondents rated the service as good or very good in 2018/19, and this is based on a greater number of respondents when compared with the 2017/18 figures.

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



Source: Trust Patient Experience Report

Figure 8- Trust Patient Survey- total number of responses

Survey and Service	2017/18			2018/19		
	Total number of respondents	Total rating service as good or very good	% rating service as good or very good	Total number of respondents	Total rating service as good or very good	% rating service as good or very good
Community Mental Health	1203	985	82	**3197**	**2722**	**85**
Community Physical Health	12193	11559	95	**7896**	**7062**	**89**
Mental Health Inpatients	6	4	67	**417**	**274**	**66**
Patients in Comm. Hospitals	341	336	99	**53**	**52**	**98**

Source: Trust Patient Experience Reports

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

ⓘ One of the Trust's targets for 2018/19 is that 60% of staff will report that they use service user feedback to make informed decisions about their department.

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question and so this target has been met.

Learning from Complaints and Compliments

The Trust has continued to respond to and learn from complaints and compliments during the year. Figures 9 and 10 below show the number of complaints and compliments received by the Trust.

There were a total of 230 formal complaints received during 2018/19 compared with 209 in 2017/18.

During Quarter 4 of 2018/19, the trust received 50 formal complaints- a decrease compared with all other quarters during the year (60 in Q1, 63 in Q2 and 57 in Q3).

Of the 50 complaints reported in Q4 of 2018/19:

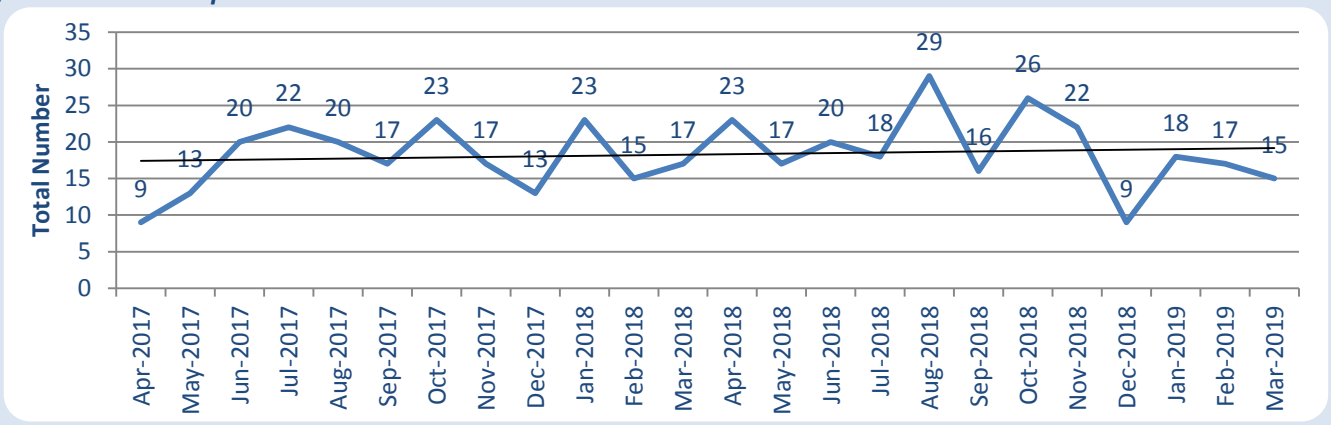
- 27 (54%) related to adult mental health service provision, of which:
  - 9 (18%) related to Community Mental Health Teams (CMHT), a reduction compared with Q1 (16), Q2 (11) and Q3 (10).
  - 5 (10%) related to Mental Health Inpatient services, a reduction compared with Q1 (9), Q2 (12) and Q3 (8).
  - 4 (8%) related to Crisis Resolution and Home Treatment Teams (CRHTT)- a similar number to those received in previous quarters.
- 14 (28%) related to community health service provision
- 6 (12%) related to Child and Adolescent Mental Health services (CAMHS) compared with 5 (Q1), 6 (Q2) and 8 (Q3).

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

100% of complaints were acknowledged within three working days during 2018/19, with 100% being resolved within the timescale agreed with the complainant.

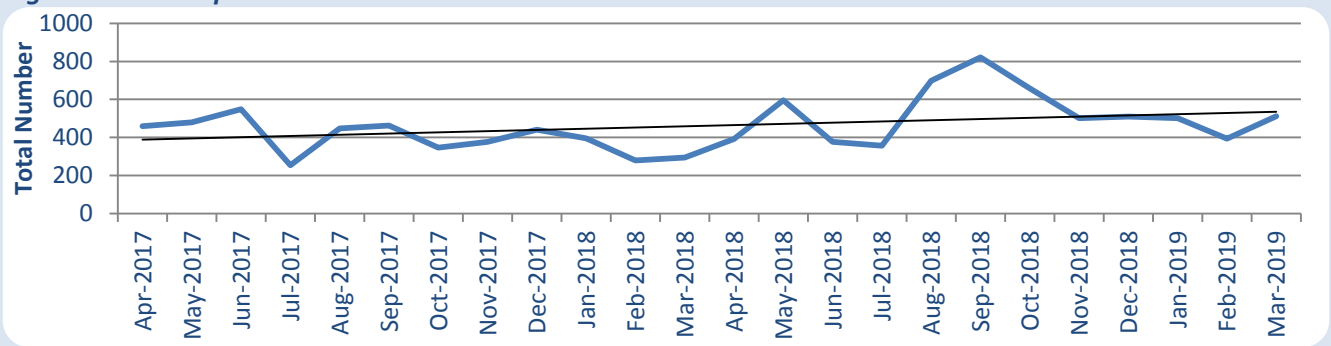
Please also note that the number of complaints, together with response and resolution times is included within section 3 of this report as they are indicators of quality.

Figure 9- Complaints received



Source: Trust Complaints Report

Figure 10- Compliments received



Source: Trust Compliments Report- this is based on compliments being submitted voluntarily by service

Use of Prone (Face-Down) Restraint

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

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

One of the Trust's targets for 2018/19 is to reduce the use of prone restraint by 90% by the end of 2018/19. This means that there should be ≤2 cases reported by the end of March 2019.

A project group has been established at Prospect Park Hospital to address this target using Quality Improvement (QI) methodology. Following a rapid improvement event, the following measures were initiated in July 2018 and are being tested using the plan, do, study, act (PDSA) approach:

- Safety Huddle on Snowdrop Ward – this is still being tested
- A response/debrief role on Sorrel Ward- the hospital Psychiatric Intensive Care Unit (PICU). – this is still being tested
- Early warning signs forms on Sorrel Ward (PICU) – this is still being tested
- Use of a bean bag for seclusion exits- this has been tested and now implemented
- Training in the use of supine (face-up) restraint and how to administer Intramuscular (IM) medication in this position- This has also been tested and now implemented across all wards.

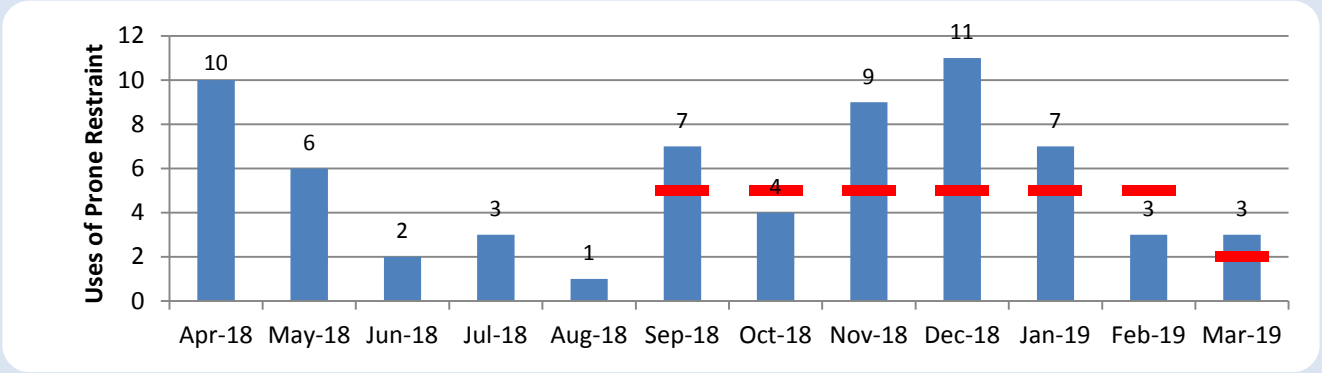
In addition to these measures, a number of other 'quick- win' measures have been implemented to address this target. These include:

- Public Health Model (PHM) management planning
- Introduction of post incident review meetings to support the PHM process of risk formulation and management.
- Detailed focus on and assessment of non-physical skills in Prevention Management of Violence and Aggression (PMVA).
- A poster highlighting the risks of prone restraint has been developed and now displayed in staff areas on the ward.
- Each episode of prone restraint is thoroughly reviewed by the nurse consultant to pick up themes and reasons for any use of prone restraint.
- Changes have been made to the Datix incident database structure to ensure accurate reporting and better understanding of the incidents.

The monthly number of cases of prone restraint in Trust mental health care is detailed in Figure 11 below and shows that the target of having no more than two cases of prone restraint in March 2019 was just missed, with three cases of prone restraint in this month.

The Trust will continue to prioritise reducing prone restraint in 2019/20.

Figure 11- Monthly uses of prone restraint in Trust mental health services Target- 5 per month by September 2018 then 2 per month by March 2019



Source- Trust Tableau Dashboard

Understanding and Supporting Outcomes of Care that are Important to Patients

ⓘ One of the trusts priorities for 2018/19 is to ensure that all services focus on understanding and supporting outcomes of care that are important to patients

Performance against this target has been measured with reference to Question 22c in the 2018 National NHS Staff Survey, which asks whether ""Feedback from patients / service users is used to make informed decisions within my directorate / department". 60.6% of staff respondents answered "Yes" to this question.

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

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

The Trust is a member of two ICS:

- Berkshire West ICS- covering covers a population of approx. 528,000 residents in Reading, West Berkshire and Wokingham. Berkshire West CCG and The Royal Berkshire NHS Foundation Trust are also part of this ICS, which is now aiming to align its work with the "Berkshire West 10 Integration Partnership", including Local Authority partners.
- Frimley Health and Care ICS cover a population of approx.726,000 residents in East Berkshire, North East Hampshire and Farnham and Surrey Heath. Berkshire East CCG, Frimley Health NHS Foundation Trust (including Wexham Park Hospital) and our Local Authority partners in Bracknell, Slough, Windsor and Maidenhead and Bracknell Forest County Council.

During 2018/19, the Trust has participated in the following workstreams to improve patient experience and outcomes:

- The ongoing development of the Berkshire-wide Connected Care programme which will deliver joined up care planning and delivery across health and social care through shared electronic records.
- The mental health priorities in Frimley Health and Care ICS are Out of Area Placements, Crisis Care, Perinatal Mental Health and access to Child and Adolescent Mental Health Services. A reference group, made up of service user and carer representatives, has been set up to inform our planning of services.
- Integrated Care Decision Making Hubs in Frimley Health and Care ICS are being developed to enable patients to receive more joined up out of hospital care, minimising non-elective admissions and delayed transfers of care.
- A Musculoskeletal (MSK) pathway in Berkshire West ICS is being developed to provide more treatment in community based services. This involves joint working between the Trust, Royal Berkshire Hospital Foundation NHS Trust, GPs and Physiotherapy Alliances

Reducing Mental Health Delayed Transfers of Care

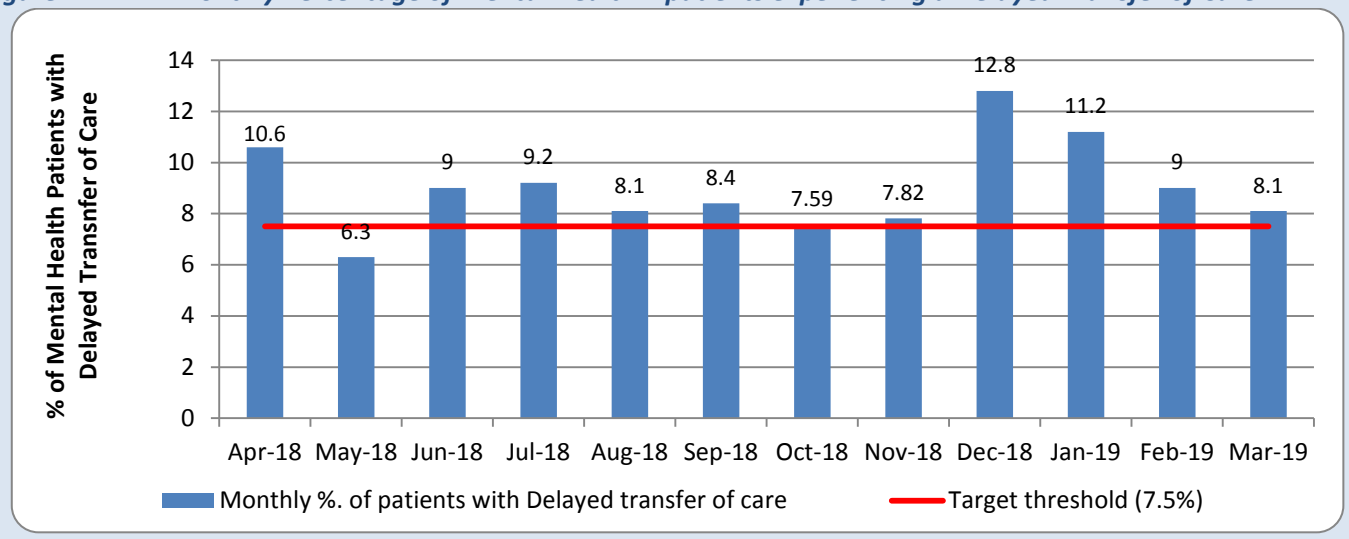
A mental health delayed transfer of care occurs when a patient is ready for discharge and is still occupying a bed.

One of the Trust priorities for 2018/19 is to reduce the number of mental health delayed transfers of care. This is achieved through:

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

Figure 12 below demonstrates performance against this priority. The chart shows that performance in this is in breach of the 7.5% target threshold, with a monthly average of 9.0% of mental health inpatients experiencing a delayed transfer of care in 2018/19.

Figure 12- Monthly Percentage of Mental Health inpatients experiencing a Delayed Transfer of Care



Source- Trust Tableau Dashboard

"My relative was rushed in for assessment - staff were amazing. The staff in the minor injuries department were exceptional at looking after my relative and I. We were advised to head straight there following a call with a 111 doctor. Once we arrived they saw my relative immediately, supported us both emotionally and looked after my relative's deteriorating physical health. They contacted the emergency ambulance service very quickly and did everything they could to make our experience as easy as possible. I was and am very impressed by the staff that we saw that evening. A huge thank you!

From a relative of a patient- Minor Injuries Unit, West Berkshire Community Hospital, Newbury

National NHS Community Mental Health Survey 2018

The National Community Mental Health Survey is an annual exercise that aims to ascertain the experiences of people that receive specialist care or treatment for a mental health condition. Feedback from people about their experiences of our community mental health services is crucial in helping us highlight good care and to identify potential risks to the quality of services.

The Survey Sample

People aged 18 and over were eligible for the survey if they were receiving specialist care or treatment for a mental health condition and had been seen by the Trust between 1 September 2017 and 30 November 2017. Responses were received from 270 people meeting these criteria, representing a 33% response rate. This is a 4% increase from the Trust response rate in 2017 and 5% above the 2018 national response rate.

About the Survey and how it is scored

The 2018 survey contained 37 questions organised across 11 sections. Individual survey responses were converted into scores on a scale from 0 to 10, with 10 representing the best and 0 the worst possible response. Each Trust score was then graded according to where it ranked against all participating trusts.

Summary of Trust results

The Trust scored about the same as other Trusts across all sections of the 2018 survey- the same as in the 2017 survey. The Trust also scored about the same as other Trusts across all questions in the 2018 survey, with the exception of two questions where the trust scored amongst the best performing trusts:

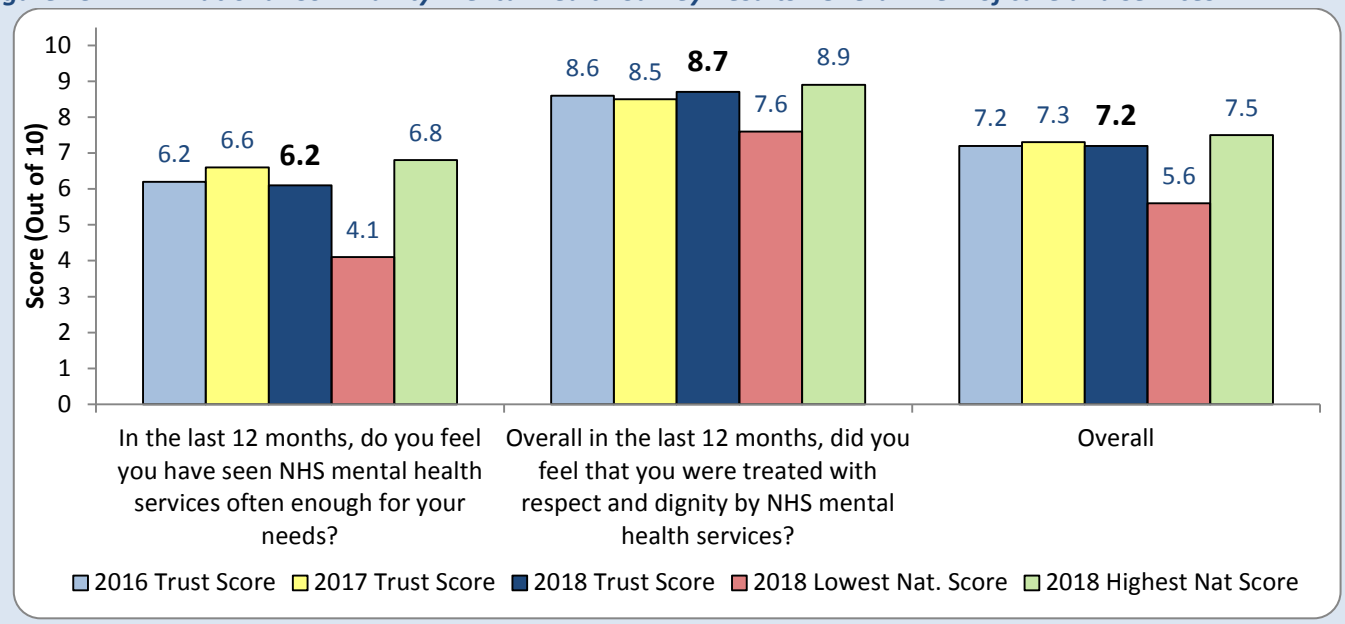
- Support and Wellbeing- Q36. Have you been given information by NHS mental health services about getting support from people who have experience of the same mental health needs as you?
- Overall views of care and services- Q38: Overall, in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Respondents' overall view of care and experience

Figure 13 below gives an overview of scores for the Trust in relation to respondents' overall views of the care and service they received and their overall experience. The 2018 Trust scores (shown by the dark blue bar in the middle of the chart) are compared with the highest and lowest scores achieved by other Trusts in 2018 (the red and green bars), and with the comparable Trust score in both 2016 and 2017 (the light blue and yellow bars).

The overall Community Mental health score for the Trust is also included within section 2.4 of this report as it is a core indicator.

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



Source: National Community Mental Health Survey

2.1.2 Patient Safety

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

Our 2018/19 Patient Safety Priorities:

1. To drive quality improvement through the continued delivery of the Trust Quality Improvement Programme
2. To align our efforts and work to deliver the following harm-free objectives:
   - Reducing patient falls incidents on Older People's Inpatient Wards by 50%
   - Reducing patient self-harm incidents by 30%
   - Reducing rates of suicide of people under our care by 10% by 2021
3. All our services will contribute towards achieving an "Outstanding" overall Care Quality Commission (CQC) rating. Please note that this priority is reported on in the CQC sub-section of the "Statements of Assurance from the Board" section later in this report
4. At a system level, to achieve reductions in urgent admissions (Inappropriate Out of Area Mental Health Placements).

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

The Trust is signed up to the 'Sign up to Safety' pledges and through this has committed to put safety first, continually learn, be honest and transparent, collaborate in learning and support staff, to help them understand and improve on when things go wrong.

Learning occurs across the organisation with respect to errors, incidents, near misses and complaints. The Trust has continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaborative.

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

The Trust Quality Improvement Programme

ⓘ The Trust introduced an organisational Quality Improvement (QI) Programme in 2017/18. This programme enables a consistent approach to continuous improvement across the whole Trust. This is achieved by introducing new techniques, education, tools and training that focus on reducing waste and adding value for patients and staff.

The Trust ultimately wants to provide all staff with the right support, knowledge and skills to give them the confidence to make changes and take away the frustrations that stop them focusing on the important parts of their job which really make a difference to patient care and experience. The Trust also wants to empower staff to solve problems rather than wait for the managers to do so.

The QI programme has four workstreams and a brief summary of progress with each is given below.

1. **The Quality Improvement (QI) Office-** *Ensuring structured accountability, support and dedicated resources are in place for improvement activity. Developing capabilities for improvement across the Organisation.*

The QI team and the Trust have been accredited as a Lean Organisation with the Lean Competency System (LCS) - the first NHS Trust in the UK to do so. This is a great achievement for both the Trust and the QI team and allows training to be run in-house, rather than relying on external consultancies. This will mean that bespoke Lean training can be delivered to meet specific Trust needs. 42 members of staff have been accredited by the Trust as Yellow Belt practitioners, with 20 members of staff due to qualify as Green Belt practitioners soon.

2. **Quality Management and Improvement System (QMIS)-** *A management system that aligns performance and daily improvement to the Trust's strategic goals*

Waves 6 and 7 of QMIS training (with 7 teams in each wave) are now underway. Out of a total of 160 teams, 40 teams will have been trained once Wave 7 has been completed

3. **Strategy Deployment-** *Identifying a small number of strategic priorities and cascading these through the organisation*

True North is now well established in the Trust. The Annual Plan on a Page, showing the goals and metrics for each element of the Trust's True North, has been disseminated throughout the organisation.

4. **Improvement Projects:-** *Making improvements in areas that are too complex to be resolved through daily continuous improvement techniques*

The Emotionally Unstable Personality Disorder Pathway Project (EUPD) continues in its Implementation phase. This project aims to develop an end-to-end pathway for some of our most challenging mental health patients, including those with non-psychotic personality disorder. Roll out of implementation is taking place in Bracknell and Wokingham localities.

Reducing Falls on Older People's Inpatient Wards

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

The Trust has set a priority to reduce falls on its older people's inpatient wards by 50% during 2018/19 compared with 2017/18.

Trust clinicians have worked closely with the Oxford Academic Health Science Network (OAHSN) across the Thames Valley to implement evidence-based ways of reducing falls in services. This has included implementing the Royal College of Physicians FallSafe care bundles, which involves the analysis of falls data on each ward, completing a gap analysis and then identifying suitable care bundles to implement on each ward to reduce falls.

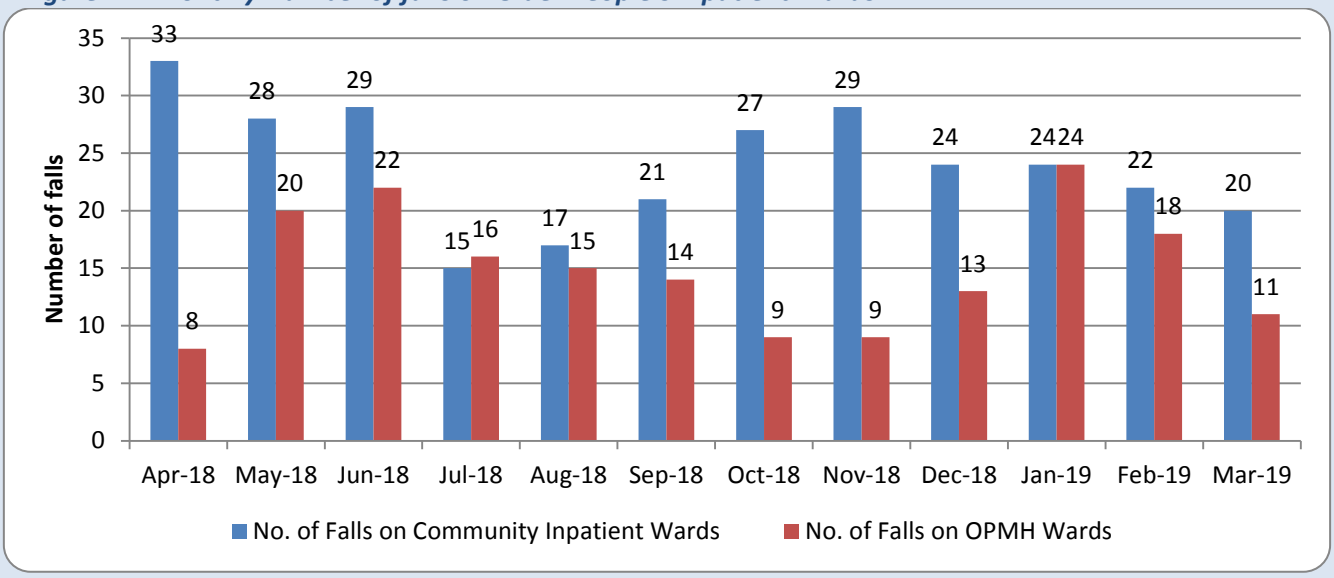
In order to address the target, both of the Trust's Older Peoples Mental Health (OPMH) wards at Prospect Park Hospital are working to reduce the number of falls as part of a Quality Improvement initiative during 2018/19. They will be analysing their falls data to understand why the falls occurred and then implement preventative measures using the Plan Do Study Act (PDSA) methodology. We continue to explore options for assistive technologies to help staff monitor patients at risk of falls. The risk of a patient falling and mitigation is recorded on the patients clinical record (RiO) used on the OPMH wards.

Progress against this priority will also be monitored against a target of no more than 8 falls per 1000 bed

days (taken from a National Patient Safety Agency target developed in 2007). Figures 14 and 15 below detail the number of falls and achievement against the target rate.

The figures show that Community Hospital inpatients have maintained achieved a rate of below 8 during the year, at 6.02 falls per 1000 bed days. Falls on OPMH wards were above the threshold at 16.59 falls per 1000 bed days for the year. OPMH wards cared for a number of patients who fell numerous times during the year. As a result, the falls assessment has been reviewed and is due to be incorporated in the risk summary on RIO. Patient specific care plans relating to falls management are also being reviewed together with the process that is carried out following a patient falling on one the older adult wards.

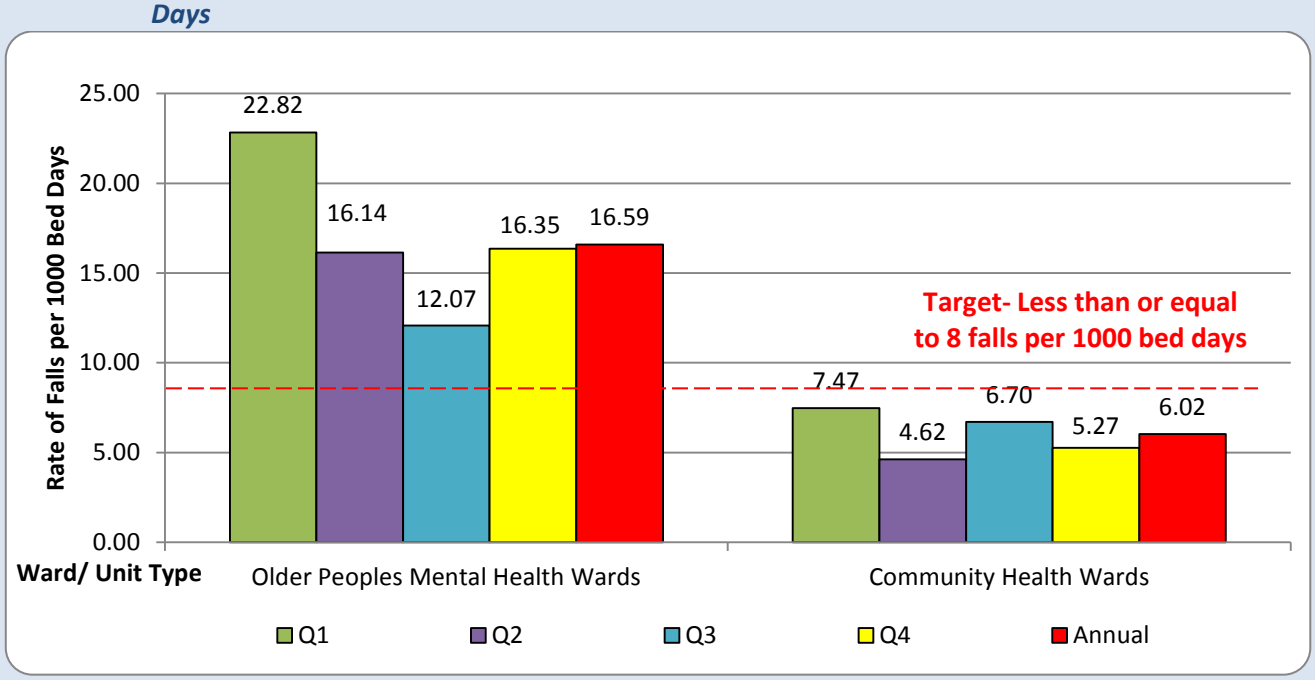
Figure 14- Monthly Number of falls on Older People's Inpatient Wards



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

Source- Trust Tableau Dashboard

Figure 15- Rate of falls per 1000 bed days- Split by Ward Type (Target- less than or equal to 8 per 1000 bed Days



Sources- Trust Falls and Occupied Bed Days data provided on Tableau

Reducing Self-Harm Incidents

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

The Trust has set a priority to reduce patient self-harm incidents reported for patients under trust care by 30%. The target is to have ≤87 such incidents each month.

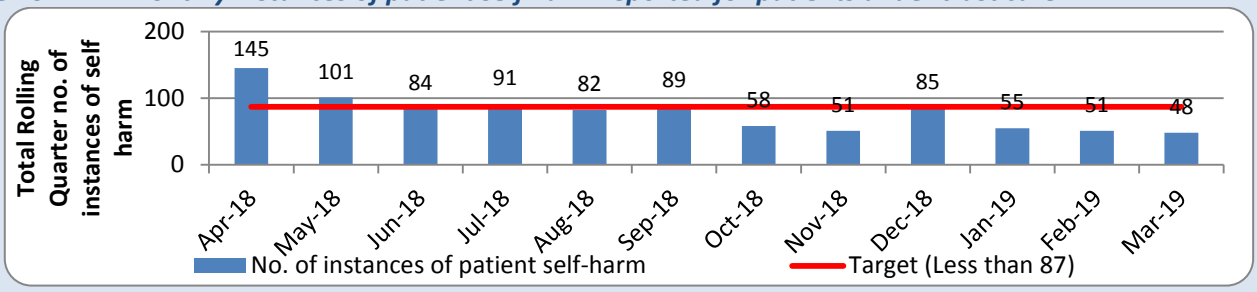
Using Quality Improvement methodology (QMIS), four of the adult mental health wards at Prospect Park Hospital and Willow House Adolescent Unit have identified the reduction of self-harm incidents as a priority. Each ward has developed actions in an attempt to reduce the number of such incidents on their units. Progress against this is reported.

The following factors have been identified as contributing to self-harm:

- Boredom in the evening (18.00-20.00)
  We are trialling an activity room approach in the early evening.
- Communication of distress in the early hours of the morning (01.00-02.00)
  We are investigating the case data on communication of distress and bad news mitigation with psychology colleagues to understand if this is a theme.
- Searches unable to detect contraband items
  Use of therapeutic searching.

Figure 16 below shows trust performance during 2018/19. As can be seen, the monthly number of self harm incidents reported was below target for 8 of the 12 months in the year, with an average number of 78 self-harm incidents reported per month which is below the threshold of 87.

Figure 16- Monthly instances of patient self harm reported for patients under trust care



Source- Trust Tableau Dashboard

Suicide Prevention- Zero Suicide

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

The Trust has set a target to maintain a 10% reduction from the 2015/16 baseline rate of suicides of people under Trust mental healthcare by 2020/21.

The 2018 "Zero Suicide" programme of work has focused on 4 main areas, with the following achieved in 2018/19:

1. Despite the increase in the numbers of suicide compared to 2017/18, the Trust is on target to see a reduction of 10% in the overall suicide rate compared to the 2016 baseline (9.2 deaths per 10,000 people under MH care) by April 2021. It has been repeatedly highlighted that suicide rates should be viewed over a 5-10 year period and we must be mindful that changes based on year-on-year data could be natural fluctuations rather than the beginning of a longer-term trend.
2. We have seen a decrease in the number of staff reporting they feel blamed when a suicide occurs compared to baseline data down to 8% from 16% (Zero Suicide Workforce Survey)
3. Leadership around communicating the key messages and expectations across the organization about suicide prevention being a priority for the Trust has been an important element of the project this year. 86% of staff reported that Leaders have explicitly communicated that suicide prevention is a priority.

4. Training - significant resource has been dedicated to the 3 day bespoke training, e- learning, ad-hoc training, workshops and a conference in December 2018 has seen staff reporting an increase in the skills and confidence compared to baseline (80% of staff admin and clinical compared to 62%).

Figures 17 and 18 below show the monthly number and yearly rate of suicides per 10,000 people under Trust mental healthcare. Figure 16a shows that the trust rate has again fallen to below the 10% reduction target rate (compared to the baseline 15/16 rate of 9.2 per 10,000 people under mental healthcare). However, it is important to continue to monitor the rate to determine if this can be sustained.

Figure 17- Number of suicides per 10,000 people under Berkshire Healthcare NHS Foundation Trust Mental Healthcare

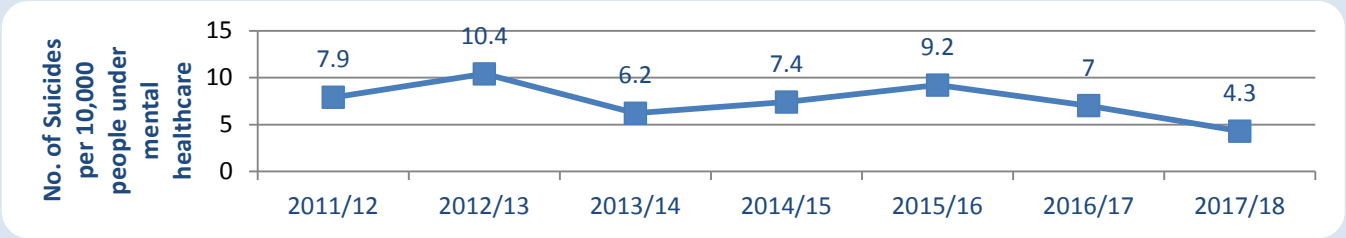
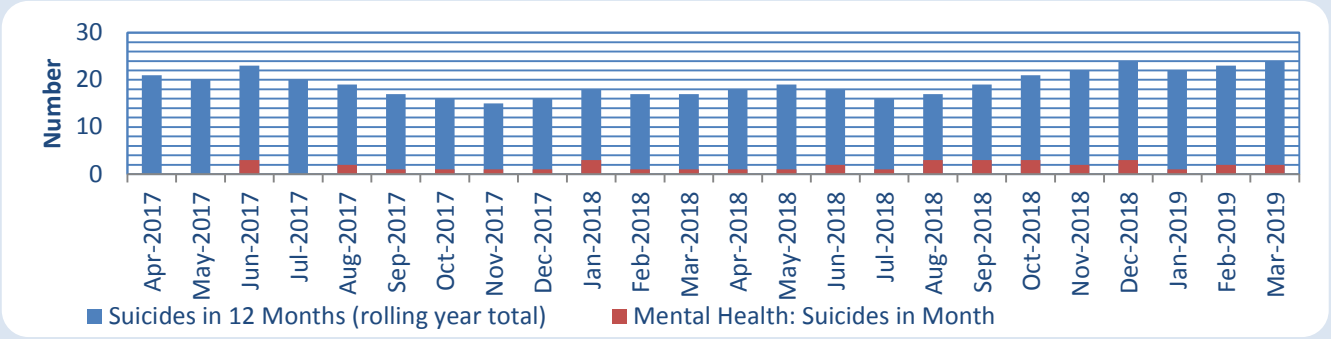


Figure 18- Suicides of patients under Berkshire Healthcare NHS Foundation Trust mental healthcare Number per month and rolling year total per month



Source- Trust Tableau Dashboard

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

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

In order to achieve this, the Trust is focused on reducing the length of stay for inpatients and ensuring alternatives to admissions have been fully considered. The approach to bed management has been changed, gatekeeping functionality has been enhanced and discharge planning improved to support patient flow and the experience.

Achievement against this target is measured with reference to the total number of occupied bed days that patients spend in Out of Area placements.
Figure 19 below demonstrates performance against this priority. The figure shows that the trust has achieved its target overall during 2018/19, with an average of 185 bed days spent as an OAP each month during the year. It should be noted that the number of OAPs was above the target set by NHS Berkshire West CCG in Q3 of 2018/19 and above the target set by NHS Berkshire East CCG in Q4. In line with the national demand on Mental Health services, the Trust continues to experience variation in Inpatient Mental Health bed occupancy leading to the use of Inappropriate Beds in alternative providers. The

ongoing programme of work has resulted in a reduction of patients being treated away from home in the last financial year, as well as reduced associated costs, however further improvement is required to eliminate this practice. The programme aims to achieve this by a reset of the programme which will look at the Prospect Park offer; local ownership of the initiatives to improve the use of inpatient beds; alongside an increased focus on Length of Stay to look to achieve a reduction in bed occupancy with the ideal being 85%, in order to offer the right care, in the right place, at the right time.

The OAPs indicator has been a challenging process to develop as there are a number of complex steps in the process. Significant progress has been made since the last audit of this indicator, but we still need to address the use of a spreadsheet to control part of the process and a programme of work is in place to address this. The trust is performing well against the Single Oversight Framework indicator and has achieved it quarterly target of reducing inappropriate OAPs throughout the year.

Figure 19- Quarterly and annual number of Inappropriate Out of Area Placements

CCG of patient	Out of Area Placement Occupied Bed Days in 2018/19									
	Q1		Q2		Q3		Q4		2018/19	
	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)	No. of occupied bed days	Target (Less than)
NHS Berkshire West	**299**	436	**366**	396	**397**	356	**167**	316	**1229**	1504
NHS East Berkshire	**324**	418	**116**	380	**196**	342	**356**	304	**992**	1444
Grand Total	**623**	854	**482**	776	**593**	698	**523**	620	**2221**	2948
Average Per Month	**208**		**161**		**198**		**174**		**185**	

Source: Trust Out of Area Placement Report

Quality Concerns

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

The Trust was inspected by the Care Quality Commission (CQC) during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

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

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

Shortage of permanent nursing and therapy staff

Mental and physical health inpatient and West Berkshire community services are now affected by shortages of permanent nursing and therapy staff. This has a potential impact on the quality of patient care and experience, and increases our costs. Community nursing services are experiencing significant staff shortages alongside increased demand for care. We have reduced the bed base by ten beds in West Berkshire Community Hospital and have invested in therapy and specialist roles. This will support an additional 3 dedicated neuro beds and provide additional therapy input to improve patient outcomes so that patients return back to their usual place of residence in a timely manner Prospect Park Hospital continues to have qualified nursing pressures. A recruitment and retention programme is being developed by the Director of People and further details of this and its achievements to date are included in the 'Reducing Staff vacancies' section of this report.

Duty of Candour

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

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

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

The Trust process for formal Duty of Candour include meeting with patients and families, apologising for their experience, explaining the investigation process, inviting them to be involved in the investigation and then sharing the report and findings when the investigation is complete. We also ensure that support is offered to patients, family and carers as appropriate. The Duty of Candour supports the Trust learning from deaths programme detailed in Section 2.3.6. Figure 20 below details the total number of incidents requiring formal duty of candour during the year. The trust considers that the Duty of Candour was met in all cases.

Figure 20- Incidents requiring formal duty of candour (DOC)

Month	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Incidents with formal DOC	26	44	28	31	25	28	26	36	30	25	37	21

2.1.3 Clinical Effectiveness

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

Our 2018/19 Clinical Effectiveness Priorities are as follows:

1. To demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. To review report and learn from deaths in line with new national guidance as it is published. Information on learning from deaths is included is included within the 'Statements of assurance from the board' in Section 2.3.6 of this report

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

Implementing National Institute for Health and Care Excellence (NICE) Guidance related to Trust priorities identified in this Quality Account

ⓘ Since 1999, NICE have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective healthcare. NICE guidelines, technology appraisals and quality standards provide valuable evidenced-based information on clinically effective and cost-effective services.

It had been intended to evaluate compliance against four pieces of NICE Guidance. However it was decided at the Trust Clinical effectiveness Group to concentrate on the self-harm NICE Guidance only.

To support the Trust's suicide prevention and self-harm priorities, an assessment of compliance against NICE Clinical Guideline 133 on self harm in over 8's has been undertaken. This exercise has been undertaken with the Clinical Directors for the Trust Adult Mental Health services and senior representatives of the Trust Child and Adolescent Mental Health Service (CAMHS).

An assessment of compliance has been produced and approved by the Trust Clinical Effectiveness Group in March 2019. The assessment concluded that the trust is meeting 53 (96%) of the 55 relevant recommendations in the NICE Guideline. The two unmet recommendations relate to:

1. Prompting clinicians to ask patients as part of a risk assessment whether they have access to family members', carers' or significant others' medications. Action is in place to add this.
2. If stopping self harm is unrealistic in the short term, advising the patient of less destructive techniques. This is not met as in all cases clinicians will try to stop the patient from self harming rather than advising them of a less destructive method. This would be undertaken as part of a risk assessment.

NHS Doctors in Training- Rota Gaps and Plans for Improvement

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

The Trust appointed two 'Guardians of Safe Working' in February 2017. These guardians work within the Trust as Consultant Psychiatrists and have a duty to advocate for safe working hours for junior doctors and to hold the board to account for ensuring this. As part of this duty, the Guardians of Safe Working report to the Board on activity relating to Junior Doctor working hours, including rota gaps.

Figure 21 below details the Psychiatry rota gaps for NHS Doctors in training in the Trust between 1st April 2018 and 31st March 2019. The table shows that all but one of the requested gaps in shifts were covered and worked.

The gaps are the result of core training vacancies. To reduce rota gaps, the Trust has participated in the Medical Training Initiative (MTI) scheme. This brings experienced doctors from outside the European Union into the Trust for two years and, after an initial introduction to the NHS, they are then able to participate in the junior doctor's Out of Hours rota. This is the first year the Trust has participated in the scheme, and has received one doctor. Following the very positive feedback, the Trust will be looking to increase its number of MTI Drs and will always try and recruit doctors into the gaps.

The Trust has also increased, and continues to increase, its number of bank doctors to ensure that the rota is always covered and patient safety is not compromised.

Figure 21- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st April 2018 – 31st March 2019

Rota Gaps	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	258	257	206	51	0	2561	2548.5	2087	461.5	0

Source- Trust Guardians of Safe Working Board Reports

2.1.4. Supporting our Staff

ⓘ The Trust is committed to acting in line with our values, with a strong focus on delivering services which provide good outcomes for patients and their families. We will listen and respond to our staff and provide opportunities for training and development. This section was titled 'Organisational Culture' in previous Trust Quality Reports

Our 2018/19 Supporting our Staff Priorities are as follows:

1. To achieve improvements in the following key areas:
   - 66% of our staff feeling they can make improvements at work
   - 75% of our staff recommending our Trust as a place to receive treatment
   - A 20% reduction in assaults on staff
2. Our recruitment and retention plans will reduce vacancies to below 10%.

* Please note that the original target set by the Trust had been to reduce vacancies by 10% against the previous year's levels. However, following further analysis and establishment of the Trust People Dashboard this year a clearer ambition was set to reduce vacancies to below 10% overall.

3. An additional 24 services will be trained in our Quality Improvement System
4. To achieve the objectives set out in the Equality Plans for each area
5. At a system level, to participate in Integrated Care System work streams, enhancing job satisfaction and career development opportunities.

2018 National NHS Staff Survey

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

The Trust participated in the 2018 NHS National Staff Survey between September and November 2018.

Differences between the 2017 and 2018 Survey

For the 2018 survey, the 32 Key Findings seen in the 2017 survey have been replaced by 10 themes. These themes cover ten areas of staff experience and present results in these areas in a clear and consistent way. All of the ten themes are scored on a 0-10 scale, where a higher score is more positive than a lower score. These theme scores are created by scoring question results and grouping these results together.

The Survey Sample.

The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees, 2,067 (51%) of whom responded. This is higher than the Trust's 2017 response rate of 44% and the 2018 national response rate of 45% for similar Trusts (31 combined mental health, learning disability and community health services Trusts).

Summary of Trust Results.

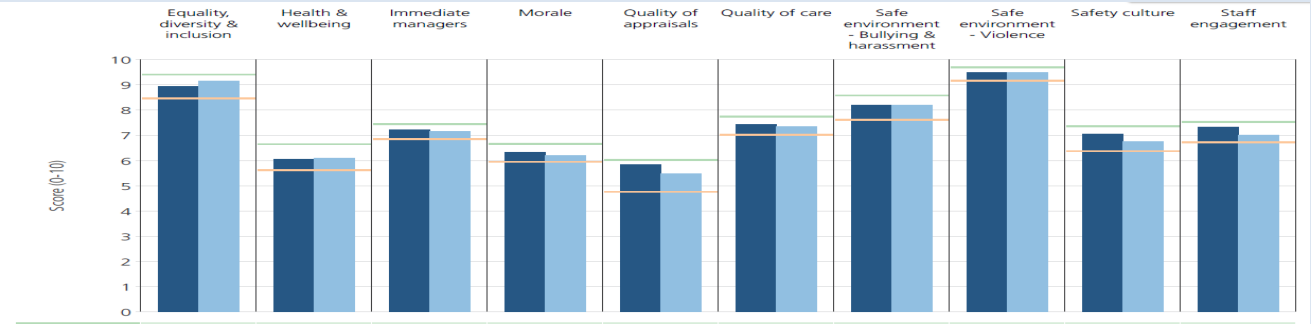
The Trust results were benchmarked against the other 31 similar Trusts and showed:

- Better than average scores for 4 of the 10 themes
- Equal to the average scores for 5 of the 10 themes
- Worse than average scores for 1 of the 10 themes

Figure 22 below details the Trust results by theme and shows that there is more work to do in areas such as health and wellbeing, and in creating an environment free from discrimination and bullying. An analysis of individual questions shows that 82% of responding staff said that 'care of service users is the organisation's top priority', which is well above the NHS average of 70%. In addition, 80% of responding staff said that 'my organisation acts on concerns raised by service users' (NHS average 76%).

The staff engagement score for the Trust in the 2018 survey was 7.3 out of 10 which is the third highest engagement score for all mental health, community and learning disability trusts and puts us in the top 20% of all trusts. This is important due to the link between staff engagement and the provision of good quality, safe services.

Figure 22- 2018 Trust NHS Staff Survey Results by theme



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.4	6.7	6.0	7.7	8.6	9.7	7.4	7.5
Your org	9.0	6.1	7.2	6.3	5.8	7.4	8.2	9.5	7.0	7.3
Average	9.2	6.1	7.2	6.2	5.5	7.4	8.2	9.5	6.8	7.0
Worst	8.5	5.6	6.9	6.0	4.8	7.0	7.6	9.2	6.4	6.7
Responses	1,970	1,998	2,005	1,951	1,804	1,771	1,963	1,954	1,981	2,056

Source- 2018 NHS Staff Survey- Trust benchmark Report

Staff feeling they can make improvements at work

One of the Trust targets for 2018/19 was that at least 66% of staff responding to the staff survey state 'yes' to Question 4d, 'I am able to make improvements happen in my area of work'. The survey results show that 64.4% of responding staff answered yes to this question, and so the target was just missed.

Staff recommending the trust as a place to receive treatment

One of the Trust targets for 2018/19 was that at least 75% of staff responding to the staff survey state 'yes' to Question 21d of the survey, 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation. The survey results show that 73.6% of responding staff answered yes to this question, and so the target was just missed.

The Workforce Race Equality Standard (WRES) requires organisations to demonstrate progress against a number of indicators of workforce equality, with some of these indicators based on the Trust's National Staff Survey results. Figure 23 below details these findings for the Trust, separated into scores for white and black and minority ethnic (BME) staff. The Trust recognise there are concerns here that need addressing, and work is underway to build on some of the things that are already have in place, such as the Making it Right programme. The Trust will make a consistent and sustained commitment over time to make progress in this area, and have in place a programme of work to achieve this.

Figure 23- Staff survey results relating to the Workforce Race Equality Standard

Indicator and Description	Race	Trust Scores (%) 2015 (%)	2016 (%)	2017 (%)	2018 (%)	2018 Average (median) for combined MH/LD and community Trusts (32 Trusts)
Ind.5- Percentage of staff experiencing harassment or bullying from patients / public in the last 12 months	White	23	22	22	23	26
	BME	25	27	27	31	31
Ind.6- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	19	18	18	20	21
	BME	27	26	21	26	26
Ind.7- Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	White	91	90	89	89	88
	BME	74	68	74	68	76
Ind.8- In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues	White	5	5	7	7	6
	BME	14	17	11	17	13

Source- 2018 National Staff Survey

Reducing Mental Health Patient Physical Assaults on Staff

ⓘ The NHS has had a 'zero tolerance' attitude towards violence since 1999, and NHS staff should be able to come to work without fear of violence, abuse or harassment from patients or their relatives.

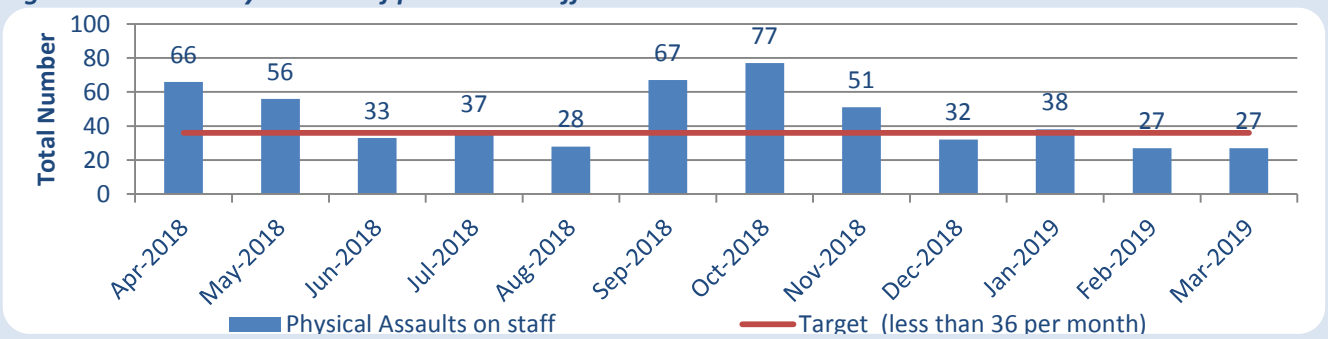
The trust has set a target of reducing the number of assaults on staff by 20% in 2018/19.

Figure 24 below details the number of patient to staff assaults. The figure shows that the number of patient physical assaults on staff was above the threshold of 36 in 7 of the 12 months in 2018/19 with an average number of 45 assaults per month during the year.

Sorrel Ward, the Psychiatric Intensive Care Unit (PICU) at Prospect Park Hospital is focusing on completing Datix incidents reports accurately to help them fully understand the situation. They are also using a key worker board so that patients can clearly see who their allocated person is for that shift to avoid any communication breakdowns. Work is also being undertaken on Sorrel Ward to standardise the level 4 (general) observations. These actions have been reviewed in light of the Q3 findings and will be further reviewed at the end of March 2019 to ensure they are meeting objectives.

Information on patient to patient assaults is included in part 3 of this report.

Figure 24- Monthly number of patient to staff assaults



Source- Trust Tableau Dashboard

Reducing Staff Vacancies

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

The trust set a target of reducing its staff vacancies to below 10% through its recruitment and retention action plan. The original target set by the Trust had been to reduce vacancies by 10% against the previous year's levels. However, following further analysis and establishment of the Trust People Dashboard this year a clearer ambition was set to reduce vacancies to below 10% overall.

From April to November 2018 the Trust recruited 516 new starters and 450 staff left the organisation, a positive variance of 66 Full Time Equivalent (FTE).

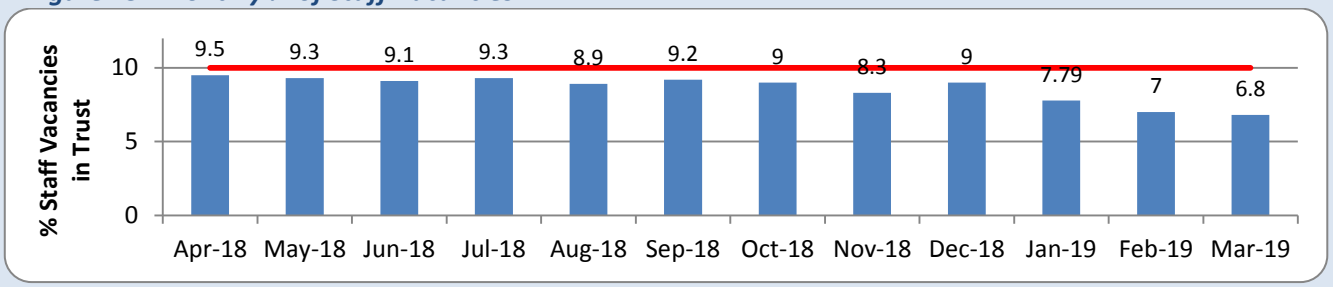
The Trust has a Recruitment and Retention working group which meets once per month to deliver the action plan. In addition we have developed action plans for District Nursing, Prospect Park Hospital and West Berkshire Community Hospital. One significant action is an advertising campaign to attract new recruits to vacancies now and planned for the months ahead. This campaign covers radio, buses, newspapers and social media advertising, plus open days and school and university fair attendance.

West Berkshire Community Hospital held a recruitment open day in April 2019 attended by 90 potential applicants. The trust will hold another open day in May 2019 at Prospect Park Hospital with the aim of recruiting band 5 nurses.

The Trust has decided to fund a three year project to improve the health and wellbeing offer and improve employee engagement with the aim of making this a great place to work. Over the longer term it is anticipated that this work will have a positive impact on recruitment and retention.
The operational, clinical education team and HR are working together to build better data for workforce planning and a new People Hub has been set up with an increased focus on recruitment and retention. The People Hub allows the recruitment team to review the data for all teams, professions and priorities the recruitment and retention activity. The team have, developed the use of social media to target applicants, redrafted job descriptions and adverts, streamlined elements of the recruitment process, designed new advertising material, improved the school and university fair offer and set up a contract with an agency to recruit community nurses.

Figure 25 below details monthly achievement against this target and shows that a staff vacancy rate of below 10% was met throughout 2018/19. The trust continues to focus on strategies to reduce the vacancy rate for substantive band 5 nurses, which was at nearly 35% (full time equivalent) as at 1 January 2019. This vacancy factor is managed through use of temporary nursing staff in addition to staff from a different nursing band.

Figure 25- Monthly % of Staff Vacancies



Source- Trust Tableau Dashboard

Training Staff in Quality Improvement

ⓘ The Trust wants to provide all staff with the right support, knowledge and skills to give them the confidence to make changes and take away the frustrations that stop them focusing on the important parts of their job which really make a difference to patient care and experience.

The Trust set a target to train 24 teams in its Quality Improvement System (QMIS) in 2018/19. 26 teams have been trained in QMIS during this period and so the target has been met.

Achieving Objectives in Trust Equality Plans

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

Examples of work undertaken so far this year to meet objectives include the following:

As of the end of December 2018 the first and second cohort of staff have successfully completed the 'Making it Right' (MIR) Programme for BAME staff. The third cohort is due to begin in May 2019. A MIR mentor's workshop was conducted in November 2018 to up-skill mentors with the knowledge and requirement of being a MIR mentor.

In the last quarter we have employed a new member of the equality team to help support the staff networks. This role is able to publicise events, share

information, and ensure that there is administration support for all the activity we try to deliver.

The Learning and Development team in collaboration with staff, managers and the networks, have developed a new course called 'Making it Right for Managers'. The aim is to share the data about our workforce (national staff survey, recruitment, turnover, sickness) and provide a forum for discussion about the actions that are required by all managers to improve how it feels to be a member of staff with a protected characteristic.

In March 2019 the Trust's Purple Network hosted a disability symposium, entitled 'Maximising our Ability,' with guest speakers and attendance by more than 100 members of staff. The event allowed attendees to be involved in finding solutions to some of the challenges our staff, managers and carers face. As a result of this a number of the actions will be taken forward during 2019, specifically developing our managers and improving how we support staff needing a reasonable adjustment.

The NHS national staff survey took place in October 2018 and the results were published in February 2019. A team of managers have reviewed the data to look at themes and priority areas of focus. The results were shared at the Diversity Steering Group and the Director of People took an action to review the feedback in detail with the lead for each staff network and the Executive sponsor for that network. The aim is to have an agreed understanding of the key messages, next steps and to ensure actions are in place to make a significant improvement over the coming months.

Following the submission of the Workforce Race Equality Standard report and the accompanying action the board agreed the following actions:

- Review local population data and consider whether a target above our current level of 20% BAME staff in bands 8a-d is achievable
- Review the actions set out in the current action plan and determine how we engage white managers in the conversation about why there is an over-representation of BAME staff in disciplines and grievance
- Develop talent pools and improve our external advertising and ensure all band 8a and above roles are advertised
- Set up focus groups with non-BAME managers, unions, black and minority staff and develop learning and development interventions, communication tools and new ways of working that create a new Berkshire Healthcare way of working to shift from 'Making It Right' to 'It Being Right'

The finance team are ensuring that all staff members have a work place assessment and that wellbeing is asked about and explored as part of the appraisal process. The team have also been openly discussing types of disabilities to help people declare a disability if they so wish.

Staff Networks

The Trust has three staff inclusion networks that play a vital role in delivering workplace equality and advising on service inclusion issues. They are open to interested members of staff from any background.

The Black, Asian and Minority Ethnic (BAME) Network was formed in 2016 to help the trust meet its statutory duty to promote racial equality and eliminate discrimination in line with the Workforce Race Equality Standard (WRES). The network's mission is "to create equal career prospects and advancement opportunities for BAME staff by enriching their working lives through caring for the individual, being committed to providing quality patient care and working together to develop innovative solutions". During the year 2018/19, the network continued to support the delivery of the Making It Right (MIR) Programme and hosted a high profile conference to celebrate Black History month. Additionally, members of the network organised road shows and local networking events to foster dialogue, advance cohesion and raise awareness of issues that may affect BAME staff members. The network has identified key priorities for 2019/20 which include continued support for the MIR Programme, Reverse Mentoring, Working with Equality and Diversity lead on inclusion strategies, supporting the Freedom To Speak Up initiative and celebrating events and achievements.

The LGB&T and Friends Network provide focused advice and assistance to the Trust to ensure sexual orientation equality in employment and service delivery. The network has three new co-chairs who have agreed the 10 priority areas to work on including improving membership, building the allies network, taking actions on the feedback from Stonewall, and ensuring the staff survey feedback is reviewed and actions taken. The network also engages with the

local LGB&T community and is a supportive network for LGB&T staff, providing personal support and mentoring where required. The LGB&T network is open to LGBT staff as well as heterosexual staff as there are a great many heterosexual staff members who are very supportive of this work. The network aims to make issues of sexual orientation and transgender open and visible within the organisation ensuring all members of staff feel able to bring their whole self to work.

The Purple Network was formed in 2018 to support trust staff with disabilities, impairments, physical disabilities, neuro-diverse conditions, mental health conditions and caring responsibilities. The network supports the trust to increase its disability confidence, address barriers and promote a culture of openness in line with the new Workforce Disability Equality Standard (WDES). During the year 2018/19, the network celebrated and raised awareness of a number of national events including; persons with disability day, purple light-up day, and Time to Talk. In addition, the network undertook a survey of 'purple staff'. This activity culminated in a successful and well-attended conference in March 2019 entitled 'Maximising our Ability'. The network has identified key priorities for 2019/20 which include; producing blogs to raise awareness of the experiences of purple staff, promoting the voices of purple staff, celebrating equality days both in the trust and on social media, attending the 2019 disability summit, supporting the introduction in the trust of the WDES and implementing suggestions from the 'Maximising our Ability' conference.

Participating in Integrated Care System Work Streams to enhance job satisfaction and career development opportunities

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

The Trust is a member of both West Berkshire ICS and Frimley Health and Care ICS, the make-up of which is described in the Patient Experience Section earlier in this report. The Trust is involved in activity that covers the following areas with the aim of delivering best practice:

- Occupational health
- Medical staffing
- Statutory and Mandatory training
- Recruitment

The outcomes should ensure that NHS staff who move between trusts are able to do so more easily, at pace and more efficiently.
In addition, organisations are working together to improve the capability of the workforce to ensure that enough staff are trained to undertake roles following remodelling of services. For example we offer advanced history taking and prescribing courses. The ICS are also working together to improve workforce modelling data and capability.

All Human Resources Directors of Trusts in the Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership (BOB STP) have met and drafted a new People Strategy with the aim of having a single agreed document and joint working teams finding solutions aligned to priorities. The development process included a day with local authorities, social care providers and the CCG to ensure the People Strategy covers all providers' concerns and to build consensus on priorities and focus areas. The strategy will then work at ICS and individual trust level too. The group now meets weekly to progress this work on behalf of the Local Workforce Action Board.

The Trust are currently looking at good practice in statutory and mandatory training across the country with the aim of finding a better solution for the Strategic Transformation Partnership (STP) that also works for our staff. The recruitment streamline project is progressing and changes have been made by us to align to other STP providers, which will speed up our recruitment processes. There are issues with Electronic Staff Record usage and functionality as all providers use the system differently and therefore ICS or STP data is difficult to produce.

Freedom to Speak Up

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

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

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

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

How can staff speak up?
Staff are encouraged to raise concerns in a number of ways:

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

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

The role of the Freedom to Speak Up Guardian
The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers and promote learning and improvement. This is achieved by ensuring that; workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and Issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between April 2018 and March 2019 44 cases where brought to the Trust's Freedom to Speak up Guardian.

Whistleblowing Cases
A total of 14 concerns were raised using the Trust whistleblowing process during 2018/19. All of these whistleblowing cases have been fully investigated and closed. All parties have received feedback and the appropriate action has been taken and is on-going. Four of the concerns raised included a patient safety element.

2.1.5. Other Service Improvement Highlights in 2018/19

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

The Trust also participates in quality improvement programmes and accreditation schemes that are facilitated by the Royal College of Psychiatrists. These are a key part of the Trust annual plan. A table detailing the projects that the Trust is participating in, including the accreditation status of Trust services, is included in Appendix G

2.1.6. Improvements in Community Health Services for Adults

West Berkshire Community Hospital Inpatient Unit in Newbury has implemented daily board rounds involving trust and social care staff. These occur around each ward base PSAG board (Patient Status at a Glance). All members of the Multi-Disciplinary Team (MDT) are present and the meetings on each ward last approx. 30 minutes. Only patients designated as medically fit have their discharge plan reviewed and tasks are assigned daily and reviewed daily. As a result, the average length of stay on the wards is below the trust target. Patient discharge plans are discussed on a daily basis to facilitate this and a Development Lead role has also been introduced to the Unit. The unit plan to increase therapist input this further.

Oakwood Community Inpatient Unit at Prospect Park Hospital in Reading has achieved a falls target of less than three falls per months for three consecutive months. They have also introduced board rounds to improve patient flow and introduced a weekly staff support group.

Wokingham Community Hospital Inpatient Wards have introduced a number of improvements including; board rounds (see above), focusing on improvements in early warning system escalation (NEWS), induction and pressure ulcer prevention.

Wokingham Intermediate Care Service achieved a 'Good' rating in their recent CQC inspection and has introduced a Units based system which has enabled to them to better manage their demand. A robust Lone working procedure has been introduced for Therapists with better monitoring systems. Service provision has been expanded to include mobility visits (rehab visits) at the weekend and the team also raised funds in Wokingham as part of the NHS70 celebrations.

West Berkshire Intermediate Care Service undertook a green belt project to produce a single pathway for all community therapy patients so that patients are seen at the right time by the right clinician. This involved; merging three existing pathways into one, clearing a backlog of patients, re-designing patient triage and developing a standard work process for all staff to follow. After eight months of intensive work, the new pathway became operational resulting in the waiting list reducing from 11 months to 1 week. The new pathway is allowing more focused, quality time with patients on visits.

The Community Podiatry Service participated in a Rapid improvement Event (RIE) to address their capacity and demand. The event identified quick wins and longer term action which focused around collecting and using data to improve capacity. This work is still ongoing. The service has also implemented a new 0300 telephone number for East Berkshire (St Marks, King Edward and Upton sites). This new system includes a call queuing system and informs patients that their calls will be answered within a certain time.

The Nutrition and Dietetics Service has been involved in the development of a new Irritable Bowel Syndrome (IBS) service within Frimley Integrated Care System (ICS). In addition, the service continues to work with the Daisy Garland charity to provide a full time dietician that supports the Paediatric team at the Royal Berkshire Hospital in running a Ketogenic Diet service. This is a service for children with a confirmed diagnosis of epilepsy who have been identified by a Paediatrician as suitable to move to a ketogenic diet. Such a change in diet can reduce the number of seizures the child has and the impact of them on the child's quality of life. In addition, the dietetics service at The Royal Berkshire Hospital (RBH) undertook a

pilot of the Low Calorie Liquid Diet (LCLD) approach for diabetes remission using a group model, the first known of its kind in the UK. The outcomes were highly successful resulting in a remission in diabetes of 46% and a mean weight loss of 10kg after 1 year. Discussions are being held with commissioners as a result of these findings.

The Musculoskeletal (MSK) Physiotherapy Service has introduced a GP helpline so that advice can be sought from the service via e-mail on a daily basis.

The Integrated Pain and Spinal Service (IPASS) have introduced an 'opt in' system that has helped reduce their waiting list for initial assessment of pain management to within target. The 'Did Not Attend' (DNA) rate for spinal assessment has also reduced from between 7-11.5% to 5%. Pain clinicians have introduced a detailed pathway to ensure consistency in practice and more effective triaging of patients into the correct part of the service. In addition, 'Cauda Equina' cards have been developed and distributed. These are small cards with essential advice for patients who are at risk of having a spinal medical emergency.

The Community Speech and Language Therapy (SLT) Service have introduced 'soaking solutions' for puree snacks on community inpatient wards. Patients on these wards that require a modified diet now have improved access to suitably appropriate snacks and this has led to increased nutritional intake, greater patient choice and an increased sense of dignity and inclusion at snack time. The team have also been working collaboratively Berkshire wide to produce a 'feeding with acknowledged risk' policy. When finalised and adopted, this policy will ensure clear communication and continuity of care across settings for clients with identified eating and drinking issues. In collaboration with the Dietetics Service, the team have also started the International Dysphagia Diet Standardisation Initiative (IDDSI). This extensive piece of work has involved delivering training and changing leaflets, ward signage, ward menus and notation used in record keeping etc. The team will be fully compliant with this initiative by April 2019.

The Adult Acute Speech and Language Therapy (SLT) Service completed a service review in October 2018 that resulted in the development of a new team structure and new SLT posts. The team have worked with other hospital staff at the Royal Berkshire Hospital (RBH) to introduce the International Dysphagia Diet Standardisation Initiative (IDDSI) fluid descriptors. These descriptors are global and provide a standard framework for everyone to work from. A full time head and neck cancer post has also been created which allows the RBH to provide an outreach service/satellite service to head and neck cancer patients at Wexham Park Hospital in Slough so they do not need to travel to Reading. Finally, a Quality improvement project was undertaken with the aim of improving the SLT service for patients with Parkinson's disease. The poster for this work won First Prize in the Royal Berkshire Hospital NHS Foundation Trust Audit Competition.

The Continence Advisory Service has started paediatric group sessions for parents of children with underlying constipation**.** This has empowered parents to help manage their children's constipation, as well as reducing waiting times for input from continence services for families. In addition, a pilot specialist catheter clinic was instigated to re-catheterise mobile patients within the Wokingham community, rather than being added to the District Nursing caseloads.

The Phlebotomy Service now have access to the Royal Berkshire Hospital Pathology (ICE) system, allowing staff to print blood request forms for patients that have been referred for a blood tests by their GP.

The Berkshire Integrated Hub has reduced their process time for routine referrals from 7 days to 3 days. A revised training programme has been introduced for new staff, and staff and user surveys have been introduced.

East Berkshire Community Nursing Services have been involved in developing standard work processes to improve consistency across the service. Catheter clinics have commenced in Bracknell and Maidenhead, and are planned for Slough. Staffing-skill mix has been reviewed, with a phlebotomy role introduced and extension of the health carer role**.** The use of I-pads is being trialled to support mobile working and a community nursing video has been filmed for sharing with patients.

Wokingham Community Nursing Services have consolidated their community teams into larger, more effective teams located within GP surgeries. A restructure of team resources has been undertaken to take account of the skill mix of staff and the need to provide a better visible governance and support structure for the teams.

Nurse Led Do Not Attempt Cardio–Pulmonary Resuscitation (DNACPR). A training and competency programme has been developed for senior nurses, Advanced Nurse Practitioners and specialist nurses relating to DNACPR conversations and the completion of the relevant paperwork to record the DNACPR decision. Previously, these senior experienced nurses may have had DNACPR conversations with patients where this was appropriate, but would then need to request that a GP or senior medic have a further conversation to complete the paperwork. The new DNACPR programme is facilitated by Trust Geriatricians, a Hospice consultant and a senior Trust nurse. To date, the training has been well evaluated, with 60 nurses completing the programme.

Community Cardiac and Respiratory Specialist Service (CARSS). The Cardiac Rehabilitation team has been certified as an accredited service, have improved their home exercise programme and updated their education sessions. The Heart Function Team has established a cardio-renal Multidisciplinary Team (MDT) with a consultant at the Royal Berkshire Hospital. They have also strengthened their relationship with The Great Western Hospital in Swindon allowing better sharing of information for patients who have a GP in Berkshire West**.** The Respiratory Team have introduced phone-call assessments for patients with sickle cell anaemia requiring home oxygen review. These assessments have saved patient time and travelling. The Pulmonary Rehabilitation Team have updated their education sessions and introduced coffee mornings/afternoons where specific topics can be discussed. In 2019/20, the team plan to further integrate the various teams to ensure a streamlined approach for service delivery and less repetition for patients (e.g. by initiating joint visits).

Integrated Care Home Service (ICHS). The Rapid Response and Treatment Teams (RRAT) and Care Home Support Team (CHST) across Reading, Wokingham and West Berkshire localities have now merged to become the Integrated Care Home Service (ICHS) with one service manager. The team now functions in an integrated way which enhances the quality of service delivered. The ICHS Occupational Therapist and Physiotherapist have worked with the care homes and the ambulance trust to; review care home falls policies, train falls champions, implement telecare and analyse falls incident data. This has resulted in; a 55% reduction in falls over 6 months in one care home, a 90% reduction in 999 calls with an associated 41% reduction in falls in another care home, and a 66% reduction in another care home that now has falls champions. The ICHS Specialist Nurse Practitioners have delivered the 'Six Steps' programme to the care homes with the aim of enhancing end of life care through facilitating organisational change and supporting staff to develop their roles around end of life care. The ICHS Speech and Language Therapist set a challenge for care home staff to help residents enjoy their puree meals and snacks and stop residents losing weight. The chefs in the care homes rose to the challenge and designed some very appetising dishes which they have shared with each other. The winner went on to win a national competition 'Care Dine with Me'.

The Home First Rapid Response Service participated in in the first Green Belt project to be completed by the Trust QI team. The Length of Stay (LoS) on their caseload was in a breach of the service specification which stated that patients should be on the pathway for up to 14 days. The project group designed a new patient pathway and standard work for staff to follow, which they rolled out and continuously reviewed over a 6 month period. The outcomes have been positive for the service and patients and have seen the Length of Stay (LoS) on caseload reduced to 1-15 days.

The High Tech Care Service has sourced a venue for a new Peripherally Inserted Central Catheter (PICC) clinic in Reading to support District Nursing. The team are also working with The Rosemary Appeal, a Dialysis and Cancer care Charity in West Berkshire, to ensure the team have suitable treatment rooms when they move to their new premises based at West Berkshire Community Hospital (WBCH). This move has the potential to realise other benefits such as increasing the number of patients that can be seen at the WBCH IV clinic.

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

Urgent Care Services, including Westcall GP Out- of-Hours Service, Emergency Department (ED) Streaming and the Thames Valley 111 (TV111) Clinical Advisory Service

A new process for management of controlled drugs (CDs) has been put in place. Previously CDs were issued to individual GPs for them to use and record in their own registration books and on the Adastra patient system. When a doctor had used all their CDs they would return to WestCall to collect more or return expired medications. Under the new system CDs are much more tightly controlled with clear Standard Operating Procedures issued to doctors, nurses and drivers. The ordering, stock control, management and reconciliation of these medicines are tightly audited and controlled in order to reduce incidents and waste.

A new and improved process for non-answered calls to patients has been put in place and this has resulted in increased safety-netting and visibility of cases that are not answered upon call back.
Pathology results are now checked by a named GP on a daily basis at 1900hrs. This improves care by ensuring that all pathology requests made by WestCall GPs are both audited and followed up in a timely way

The Urgent Care administration team has been restructured to ensure named individuals have delegated responsibilities. A team leader has also been introduced to the team.

Nurse and paramedic practitioners have been introduced onto the clinical rotas. This has improved the skill mix of the team, enabling it to be more responsive and effective.

An experienced Urgent Care Matron specialising in out of hours care has been added to the senior leadership team. This ensures that non-medical practitioners and clinical support staff are well led.

A Clinical Governance Lead post has been introduced, and the service governance structure improved. This was undertaken in response to CQC feedback and ensures that clinical governance and quality standards remain robust, well embedded and audited.

The WestCall GP out-of-hours service has introduced the ability for 111 call centres to book patients directly into the service if appropriate to do so. This represents an improvement in the patient journey as, prior to this change, patients had to await call back from the service before being given an appointment. WestCall GP out of hours also now accepts patient self-referrals through 111 online.

The GPs in the TV111 Clinical Advisory Service are focusing on re-triaging patients who would otherwise have been told to attend the Emergency Department (ED) or be sent a 999 ambulance. This has resulted in less ambulances being dispatched and less patients attending ED which improves the whole system.
The Westcall GP out-of-hours service has introduced a new home triage role. This role supports clinicians to manage patients remotely using equipment provided by the service.

The service have introduced a FastTrack GP recruitment procedure and can now move a GP from enquiry to employed in the space of only a few hours if required.

Minor Injuries Unit (MIU), West Berkshire Community Hospital, Newbury
The service have trained two of their reception staff as Healthcare Assistants (HCAs) to support the practitioners doing initial assessments on patients as they arrive, as well as other tasks.

An office has been converted into a treatment room, allowing staff to do observations on patients there rather than in the waiting room. A new treatment room has been equipped with a Bariatric trolley with pressure relieving mattress. In addition, the staff toilet has been converted into a specimen toilet which allows patients to do their specimen in the toilet and leave it there to be tested rather than it being tested in a clinical room.

An appointment system has been introduced via 111, which allows patients to be seen at a suitable time, with the team endeavouring to see these patients within 30mins of this set time regardless of the wait time for walk-in patients. It is hoped this will become more popular with patients and allow workload to be spread throughout the day. In addition, a direct referral pathway has been set up with Podiatry

The service has developed a working relationship with a local GP Surgery to allow their staff to work with the duty GP and the Nurse Practitioners to develop their

minor illness skills. The Service has made a reciprocal offer to the GP Surgery.

Three members of staff are attending a Masters level course on Minor Illness to allow the service to see more patients that present with medical problems. In addition, a member of staff is attending a Non-Medical prescribing course to enhance patient treatment plans.

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

Participation Champions. Service users are crucial to the development of feedback mechanisms to ensure services meet needs. CYPF services have a vibrant network of participation champions who promote participation and the collection and analysis of service user feedback within the service. They meet on a quarterly basis to share ideas and good practice.

The Looked after Children Nursing Teams have been working with children and young people in care in order to develop their young person's feedback form. Team members have linked in with children in Care Youth Councils across Berkshire, where young people who are in Local Authority care or who are care leavers are able to meet and discuss their views. Having the involvement of young people at the earliest opportunity ensures the team are able to ask the right questions about the service they deliver and how it can be improved.

Child and Adolescent Mental Health Services (CAMHS) have produced a mini report on the findings of recent service user feedback. This is available for children, young people and their families to read when accessing our services. Whilst there are multiple ways to collect feedback and involve young people and families in participation activities, reporting back the outcomes of their input is essential. This helps ensure service users know that their contribution has been heard, that it is valued and that changes have been made as a result.

The Children and Young People Integrated Therapies (CYPIT) Service have developed a form that captures feedback gathered at parent groups. The form enables the facilitator to detail actions that are needed in response to parent feedback, who is responsible and when this will happen. This not only ensures that the service is collecting qualitative feedback, but makes sure that SMART actions are put in place and assigns responsibility.

Reading School Nursing Team is commissioned to deliver health promotion within the Reading locality, with one of the areas of focus being substance misuse. Following a scoping exercise and consultation with children and teachers, it was agreed that the best way to address this would be through a film made by the young people in Reading, for the young people of Reading. As a result, the team have been working in partnership with schools in Reading to develop a film called 'Taylors' Story'. The film will form the centrepiece of a health promotion session and contains three scenarios that are designed to be paused to allow for discussion about what Taylor's choices are and what the consequences might be. Filming has now taken place and the team are awaiting the edited version.

A new model of delivery has also been developed by Reading School Nursing Team. By separating the roles of School Nurses within the team into two areas of focus, Safeguarding and Public Health, they hoped that their safeguarding commitments would be managed effectively whilst allowing half of the School Nurses in the team to focus on their Public Health/early intervention role, which had historically received less attention. The pilot of this new approach commenced on 5th September 2017 and completed in August 2018. Evaluation of the pilot found a number of benefits including; a significant increase in face-to-face and telephone contact with families, a significant reduction in the number of safeguarding meetings which needed to be attended and an increased amount of health promotion being delivered.

The Berkshire School-Aged Immunisation Team continues to successfully carry out their core work of delivering immunisations in primary and secondary schools across Berkshire. In addition, the team have embraced additional work to deliver timely responses to outbreaks of disease amongst children and adults within Berkshire. In the spring of 2018/19 the team responded to a small outbreak of Hepatitis B at a school. This required the service to mobilise a small team of nurses, engage with the Health Protection Agency and Public Health Teams and provide a rapid

response to an outbreak, usually within 48 hours. The team was called upon again in the summer to provide a rapid response to an outbreak of Meningitis B at a nursery school of 3 – 4 year old children during the height of the summer holiday. The service rose to the challenge, with staff coming in from their summer break to deliver prophylactic antibiotics and injections to children and staff.

Reading Health Visiting (HV) Team and Reading Community Nursery Nurse (CNN) Team are trialling two innovative solutions to improve uptake of the Healthy Child Programme scheduled development reviews. Firstly, the CNN team are working in partnership with a number of local nurseries to improve uptake of the 27 month development review. When a nursery identifies a child that has not had their 27 month review then, with the consent of the parent, this review can be arranged to be undertaken with a CNN at a convenient date. This has resulted in 60 reviews to date within a Nursery setting. Secondly, the team have started a number of health promotion sessions in local supermarkets in an attempt to identify children that have either missed a scheduled development review or are due one soon, and also to identify expectant mothers/parents to be that have not accessed an Antenatal contact.

Transition from Child to Adult Mental Health Services- Commissioning for Quality and Innovation (CQUIN) This relates to improving the quality of transition from children's mental health services to adult mental health services and requires the audit of four aspects:

1. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider
2. The percentage of young people who've undergone Joint Agency Transition Planning if transitioning into a receiving provider: Young people are meant to have a discharge plan and this must be shared with the young person
3. The percentage of young people who in their pre-transition survey reported feeling prepared at point of discharge
4. The percentage of young people who in their post-transition survey reported that they met their transition goals

An audit has found that all four of these aspects have been met by the Trust for the year April 2018 to end of March 2019.

2.1.9. Improvements in Services for Adults with Learning Disabilities

Campion Unit Learning Disability Inpatient Unit at Prospect Park Hospital in Reading has undertaken several service improvements during the year. These include training all staff on the ward on the use of active communication and active support to ensure that patients have adequate social and emotional stimulation during their stay on the ward. Work has been undertaken looking at the skill mix on the ward, with staff feeling more confident and up-skilled to undertake their new roles. This in turn has resulted in reduced delayed transfers of care and improved quality of care for our patients. Work has also been undertaken to reduce the numbers of people in out-of-area placements and this has also resulted in reduced rates of admission to the ward. The unit are currently using Quality Management Information System (QMIS) methodology to focus on reducing the number of assaults on their staff.

Community Teams for People with Learning Disabilities (CTPLD)

CTPLD Team Slough. Over the past 18 months the team have developed some innovative quality improvements. This has included translating an epilepsy care plan into the persons preferred language and translating hospital passports into three languages; Urdu, Punjabi and Polish. This enables the team to address the needs of the local community and promotes diversity and inclusion.

The team have also worked closely with Public Health to run a successful 16 week weight loss programme in line with national obesity targets. There is little evidence of implemented programmes which include reasonable adjustments to address the needs of people with LD and obesity, and encouraging people with a learning disability to attend and commit can be challenging. Individual easy read diaries were also developed by the team to enable people with LD and their carers to record tips during the session, to use when they return home to maintain their weight loss. All educational material was also developed by the team, and at the end of the 16 weeks 6 out of 9 attendees lost weight.

A pilot screening tool has also been developed due to the number of inappropriate referrals received by the CTPLD Slough team. This project is ongoing and has

the aim of using the psychologists time more effectively.

Alongside the CTPLD in Bracknell, the Slough team have started a Postural Management Clinic for people with Profound and Multiple Learning Disability (PMLD). People with PMLD are highly vulnerable to the adverse effects of poor positioning, and are often unable to communicate their concerns. The physiotherapist is able to carry out a full assessment of their multiple and complex needs at this clinic with the aim of maintaining, protecting and restoring body shape, maximising comfort and promoting health and wellbeing in addition to other benefits.

CTPLD Team Bracknell. There is a national drive to promote annual health checks by GPs for people with LD and the Bracknell and Slough Health Lead has worked hard to build relationships with the GP's in those localities. There is still some distance to go with this, but improvement has been seen over the years. Initiatives have included the development of GP LD registers and LD training being delivered to some GPs and practice staff by the LD Lead. This has resulted in improved healthcare and preventative healthcare for people with LD.

The team have recently delivered LD training to the Parapet Breast Screening Unit staff at King Edward VII Hospital in Windsor. This has raised awareness of LD and the required reasonable adjustments amongst the Parapet team and it is intended that this will be delivered every year.

The Occupational Therapists have been working with the 'Dogs for Good' charity to introduce a community dog as an aid to improve independent life skills for people with LD. A pilot of 8 clients for 8 sessions ran from March 2017 to November 2018. Due to the success of the pilot, a new branch in the service was created with a full time dog handler with a dog and a full time Occupational Therapy Assistant to meet the needs of people with a LD. The new service has developed a waiting list and a second dog should be allocated to a dog handler in the next 6 months to address this.

The team have also facilitated a Relationship/Sexual Health programme for final year students at a school over a period of 4 weeks. The feedback was extremely positive from the school and the students.

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

Talking Therapies- Improving Access to Psychological Therapies (IAPT). The service has introduced the 'Our Space' cafés to offer support to patients following treatment in order to stay well and prevent relapse. These cafes take place at St Mark's hospital in Maidenhead, Reading University, Wokingham Hospital, Upton Hospital, West Berkshire Community Hospital and Bracknell Open Learning Centre. The service also initiated a Black, Asian and Minority Ethnic (BAME) access and recovery project in slough that has led to an increase in BAME referrals from 2014/15 to 2017/18. The IAPT Post Traumatic Stress Disorder (PTSD) pathway has been extended to treat more patients with a single complex trauma. Access to the service has also been increased for patients with anxiety and depression alongside other long term conditions (LTC) as part of the service's IAPT-LTC pathway.

East Berkshire: Admiral Nurse for Young People with Dementia. Admiral Nurses are registered nurses with specific knowledge of dementia care. They provide support to individuals and families living with dementia as well as education, leadership, development and support to other colleagues and service providers. The Trust was commissioned by East Berkshire CCG to provide a part time (3 days per week) Admiral Nurse for younger people with dementia. This represents a new partnership in east Berks between BHFT and the national charity Dementia UK. The nurse has worked with approximately 30 families this year, as well as signposting others to appropriate sources of support. Satisfaction and impact has been high with reported reductions in visits to other services such as GPs, and delayed need for more intensive care and support.

Trust Memory Clinic Services successfully in achieved reaccreditation for the next two years and, as part of this, have been awarded a sustainable Mental Health Service Commendation by the Royal College of Psychiatrists Sustainability Committee.

Individual Placement and Support Employment Service (IPS). Following a successful bid for funding

from NHS England, the Trust has increased the size of its IPS Employment Service team from five staff to eleven, so that the service now covers the whole of Berkshire. This service provides one to one support to active clients of secondary mental health services helping clients into work. The focus is on competitive paid work and works closely to ensure the job matches with the client's preferences, skills and ambitions. Employment Specialists are now integrated into all Community Mental Health Teams (CMHTs) and Early Intervention in Psychosis clinical teams and use a person centred, strengths based approach to identify work goals. Collectively, the service has worked with approximately 100 service users this year, and is beginning to show promising job outcomes for people under the care of CMHTs.

Improving the physical health of people with severe mental illness. People with severe mental illness have significantly poorer physical health than the general population and can have a reduced life expectancy of up to 20 years. The Trust has been working with their local Clinical Commissioning Groups, Public Health teams and voluntary sector partners to address this issue in Berkshire. In East Berkshire, the Trust introduced a physical health lead in mental health services to oversee the initiatives**.** Physical Health CQUIN targets for 2017/18 were met and work is progressing to support achievement for 18/19.

Recovery Colleges in East Berkshire. The Trust is commissioned to provide Recovery Colleges in Windsor, Ascot and Maidenhead (WAM), and in Slough. In WAM, Opportunity Recovery College is in its second year of operation, and in Slough Hope College has been operating for 4 years. One of the key principles of these colleges is to offer an education based route to recovery, with peer-led education and training programmes as a partnership within mental health services. The colleges continue to offer wide range of courses, including courses aimed at promoting wellbeing, physical health, employment related initiatives, and leisure.

Family Safeguarding Service. The Trust is a partner in the Family Safeguarding model which is being implemented in the Bracknell and West Berkshire localities. This model adopts a whole system approach to Child Protection Services, focusing on risk due to Domestic Abuse, Mental Health and Substance Misuse. The Trust provides six expert adult mental health practitioners to work in a multi-agency service, alongside child protection social workers, domestic abuse workers and drug and alcohol specialists. The mental health interventions provided to parents, together with the formulations and insights provided to colleagues are beginning to show a positive impact.

Community Mental Health Team (CMHT) accreditation. Bracknell CMHT is one of the first teams to undertake accreditation with the Royal College of Psychiatrists. This programme works with staff to assure and improve the quality of community mental health services. A final accreditation decision is due in March 2019.

Structured Clinical Management. The Trust is introducing Structured Clinical Management as part of the newly emerging pathway for people with personality disorder. This is a new evidence based intervention which can be delivered to trained practitioners working within CMHTs. Training has now been provided to 90 practitioners across all Trust CMHTs, and implementation is now in the early stages across all teams.

Reading Community Mental Health Team (CMHT) has started a project to build its resilience following its uncoupling from Reading Adult Social Care Team. This focused on four areas that the team found challenging; supervision, team culture, team organisation and team development. Each identified area has team members allocated to it and priorities identified. This work is ongoing, but some actions have already been undertaken and the team are presenting as stronger and more resilient as a result.

Wokingham Community Mental Health Team recruited a psychology lead in October 2018 which has led to reductions in waiting lists and waiting time for therapy.

East Berkshire Crisis Resolution and Home Treatment Team (CRHTT) identified their response time as their main area of improvement. There is a national expectation that by 2020/21 all areas within the UK will offer a 24 hour crisis service which will be truly responsive. The team aspiration is to see all referrals within 4 hours or even faster and develop a rapid response element within the service. However, historically such "4 hour crisis referrals" were only available to GPs making a referral to the service via the Common Point of Entry (CPE). The service has now opened up these "4 hour crisis referrals" to all referrers, resulting in an increase in assessments being completed within 4 hours.

East Berkshire Psychological Medicine Service formed in January 2018 and comprises a specialist dedicated team of Nurses, Social Workers and Psychologists delivering a 'Core 24' service to the A&E Department and wards at Wexham Park Hospital (WPH). The team work with WPH staff to ensure patients with mental health needs receive the best possible care in the acute hospital setting. The service is consistently meeting their performance targets

The Early Intervention in Psychosis Service (EiP) has implemented an online support forum called 'SHARON for EiP' for carers. This forum has received good uptake and information is being developed to increase the resources available. SHARON for EiP Service users is due to go live in February 2019.

Hillcroft House shares a site with West Berkshire Community Hospital in Thatcham and houses multiple teams, including primary and secondary mental health services, Community Health Services and partners such as Adult Social care. Work began on the building in November 2018 to better meet the needs of service users and staff. These include significant changes to the reception and waiting room areas, increasing the usable clinical space and improving the safety of the building. Office space has also been upgraded to include more breakout and meeting space, a more comfortable climate and upgrade of staff rest areas.

Thames Valley Criminal Justice Liaison and Diversion (CJLD) Service were awarded a commendation for Service of the Year at the Howard League for Penal Reform Awards in October 2018. The service was also awarded the tender for the Hampshire and Isle of Wight Liaison & Diversion Service from 1st April 2019.

Intensive Management of Personality Disorders and Clinical Therapies Team (IMPACTT). IMPACTT is a specialist service which provides comprehensive assessment and evidence-based treatments for individuals aged 18 and over with a diagnosed personality disorder, primarily Borderline Personality Disorder/Emotionally Unstable Personality Disorder (BPD/EUPD). The service offers two evidence-based treatments: Dialectical Behavioural Therapy (DBT) and Mentalization-Based Treatment (MBT), as recommended by the NICE guidelines. The service has been rolling out training events across the organisation on working with personality disorder and these have been very well received. A new initiative known as Psychologically Informed Consultation and Training (PICT) is currently in development. This which will continue to grow the consultation and training arm of IMPACTT and further support the organisation in working with patients with personality disorder.

Adult Mental Health Inpatient Services at Prospect Park Hospital have been involved in numerous quality improvement projects during the year, many of which are listed in earlier sections of this quality report. In addition a Green Belt Project has been undertaken to increase the number of Friends and Family Test (FFT) responses received for this service. This has resulted in 140 responses to the FFT in the 7 months since the start of the project compared to 22 responses in previous 7 months. The Project is ongoing with work concentrating on sustaining changes and reporting back to service users.

2.1.11. Improvements in Medicines Management

Patient safety

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

Our Medication Safety Officer is a member of the National Medication Safety Network and ensures that good practice is shared and embedded across the Trust.

Our Pharmacists ensure that we respond to, and take appropriate action, on national medication safety alerts. This includes sharing medication safety information through publication of regular Medication Safety Bulletins (shared trust-wide), and producing posters, for example, on the safe supply of valproate to females of child bearing potential.

The Pharmacists provide training to doctors to improve their knowledge of medicines safety. Pharmacists provide in-house teaching to doctors on a number of medication related topics, including Medication Safety and Rapid Tranquillisation Medicines.

The Deputy Chief Pharmacist has developed a Pharmacy Improvement and Innovation Programme to facilitate the embedding of a rolling, annual programme of medicines-related audits, and timely follow up of actions arising out of the findings of these audits. This shall improve patient safety and ensure compliance with national standards.

Patient experience

Our Pharmacists shall continue to review all medicines for effectiveness and adverse effects, and provide support to service users. Pharmacists continue to offer 1:1 sessions for inpatients, facilitate patient education sessions in inpatient units, support inpatient carer sessions, and contribute to patient and carer Recovery College workshops.

Pharmacy has continued to invest in staff development to ensure, that staff have the skills required to work effectively and efficiently.

In line with the Carter Report (NHS Operational Productivity: unwarranted variations: Mental Health Services, Community Health Services, 2018), our Pharmacy Department ensures pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation. We are committed to increasing specialist pharmacy professionals including ACP qualified pharmacists and pharmacist prescribers to add capacity, expertise and value to patient care.

Electronic Prescribing and Medicines Administration (ePMA)

The Trust is a Mental Health Global Digital Exemplar site. We have implemented Electronic Prescribing and Medicines Administration (ePMA) at all our mental health inpatient wards, and in November 2018, ePMA was rolled out to the first mental health outpatient service, namely Windsor, Ascot and Maidenhead Depot Clinic. The introduction of ePMA in the outpatient clinic has enabled depot antipsychotic injections to be prescribed and ordered electronically, facilitating a seamless link to the dispensing and supply system within Pharmacy.

Our Specialist Informatics Pharmacist supports all aspects of technical configuration, and clinical content relating to medicines management within the ePMA system. ePMA has been effectively used to support the national valproate Pregnancy Prevention Programme for women and girls of child bearing potential

2.2. Setting Priorities for Improvement for 2019/2020

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2019/20 (see Appendix A). Specific priorities have been set in the areas of patient experience, patient safety, clinical effectiveness and organisational culture. They have been shared for comment with Trust governors, local Clinical Commissioning Groups (CCGs), Healthwatch Organisations and Health Overview and Scrutiny Committees. Responses to this consultation are included in Appendix H, together with the Trust response to each comment made by the stakeholders. Several of the priorities from 2018/19 have been rolled forward to 2019/20.

2.2.1. Patient Safety Priorities

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

1. We will reduce harm to our patients by reducing:
   - Self harm incidents by 30%. Target: no more than 61 per month.
   - Suicides of people under trust mental health care by 10% by 2021
   - Falls on our community inpatient wards and older adult inpatient wards by 50%. Target: no more than 4 per 1000 bed days
   - Medication errors graded moderate and above by 20%. Target: fewer than 4 per year
   - Category 3 and 4 pressure ulcers due to a lapse in care by trust staff. Target: At least 180 days between the development of these ulcers. In areas where this target is already being met, a 10% improvement against current baseline is to be applied.
   - Gram negative bacteraemia due to a lapse in care on our inpatient community wards by 50%. Target: No more than 1 per ward.
2. At least 95% of our reported incidents will be low or no harm to patients

3. All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
4. All our support services will work with patient facing services to identify ways that they can support safety of patients
5. With our health and social care partners: We will work to achieve reduced urgent admissions and delayed transfers of care.

2.2.2. Clinical Effectiveness Priorities

1. We will demonstrate our delivery of evidence-based services by reporting on the implementation of NICE guidance related to Trust priorities identified in this Quality Account
2. We will continue to review, report and learn from deaths in line with new national guidance as it is published

2.2.3. Patient Experience Priorities

To provide good outcomes from treatment and care

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

2.2.4. Supporting our Staff Priorities

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

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

2.2.5. Monitoring of Priorities for Improvement

All priorities detailed above will be monitored on a quarterly basis by the Trust Quality Assurance Committee as part of the Quality Report and the Board of Directors will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2019/20.

2.3. Statements of Assurance from the Board

During 2018/19 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 relevant health services.

Berkshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2018/19.

The data reviewed aims to cover the three dimensions of quality – patient safety, clinical effectiveness and patient experience. Details of a selection of the measures monitored monthly by the Board which are considered to be most important for quality accounting purposes are included in Part 3. These incorporate more than three indicators in each to the key areas of quality.

2.3.1. Clinical Audit

ⓘ Clinical audit is undertaken to systematically review the care that the Trust provides to patients against best practice standards. Based upon audit findings, the Trust makes improvements to practice to improve patient care. Such audits are undertaken at both national and local level.

National Clinical Audits and Confidential Enquiries

During 2018/19, 16 national clinical audits and 0 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=16/16) national clinical audits of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2018/19 are shown in the first column of Figure 26 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2018/19.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2018-19 are also listed below in Figure 26 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of fig. 26).

Figure 26- National Clinical Audits and Confidential Enquiries Undertaken by the Trust

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=16)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP)	
National audit of Anxiety and Depression 2017	Data Collection: June 2018 – September 2018. 73 (100%) patient's submitted across, 1 service. Report due: August 2019
National audit of Anxiety and Depression 2017 - Spotlight 1 - Psychological Therapies	Data Collection: October 2018 – January 2018. 150 (100%) patient's submitted across, 5 services. Report due: TBC 2019
National Sentinel Stroke Audit (2018/19)	Data Collection: 1st April 2018 – 31st March 2019 (Continuous). 571 (99%) patients submitted for 2018/19, across 3 services, 185 6-month follow-ups. Report due: TBC 2020
National Audit of Care at the End of Life (2018/19)	Data Collection: June 2018 – October 2018 33 (100%) patient's submitted, across 1 service. Report due: May 2019
National Diabetes Audit - Secondary care 2018	Data Collection: May 2018 (data 2017/18). 1747 (100%) patients submitted, across 1 service. Report due: June 2019. Insulin Pump Report Due: July 19
Learning Disability Mortality Review Programme (LeDeR) (2018/19)	Data collection: 1st April 2018 – 31st March 2019 Report due: Annually
National Diabetes Footcare (Community Podiatry care) (2018/19)	Data Collection: 1st Jul 18 – 31st Mar 19 (Continuous). 64 patients submitted across 1 service (Final figure not yet available). Report due: TBC 2020
The National Clinical Audit of Psychosis - EIP spotlight audit	Data Collection: October 2018 – November 2018. 86 (100%) patient's submitted, across 1 service. Report due: August 2019
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: 1st Mar 19 – 31st Mar 20 Continuous. xx patient's submitted, across 1 service (Final figure not yet available) Report due: TBC 2021
National Audit of Inpatient Falls	Data Collection: Continuous, starts 1st Jan 19. Organisational audit completed Jan 19. No Submissions required for core data collection during 2018/19. Report due: TBC
Non- NCAPOP Audits	
POMH Topic 16b - Rapid Tranquilisation re-audit (May 2018)	Data Collection: March 2018 – May 2018. 41 (100%) patient's submitted, across 5 services. Report published: November 2018

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2018/19	Data collection status, number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
POMH Topic 18a Prescribing clozapine (June 2018)	Data Collection: June 2018 – July 2018. 106 (100%) patient's submitted, across 3 services. Report published: February 2019
POMH - Topic 6d - Assessment of the side effects of depot antipsychotics- Sept-Oct 18	Data Collection: September 2018 – November 2018. 151 (100%) patient's submitted, across 6 services. Report due: June 2019
POMH Topic 7f – Monitoring of patients prescribed Lithium	Data Collection: February 2019 – March 2019. 108 (100%) patient's submitted, across 10 services. Report due: July 2019
National Audit of Cardiac Rehabilitation (2018/19)	Data Collection: Continuous, 1st April 2018 – 31st March 2019 Number of patients submitted (100%) 314 event records; 376 initial assessments; 313 post assessments. Report due: January 2020
National Audit of Intermediate Care (2018)	Data Collection: 21st May 2018 – 31st August 2018 Data submitted across 4 Intermediate care service types. Crisis response, home based intermediate care, bed based intermediate care and re-ablement services. Benchmarking Project. Reported: Jan 2019
National Confidential Enquiries (N=0)	

Source: Trust Clinical Effectiveness Department

The reports of 9 (100%) national clinical audits were reviewed by the Trust in 2018-19. This included national audits for which data was collected in earlier years with the resultant report being published in 2018/19. Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare provided as detailed in Appendix B.

Local Clinical Audits

The reports of 48 local clinical audits were reviewed by the Trust in 2018/19 and Berkshire Healthcare NHS Foundation Trust intends to take actions to improve the quality of healthcare which are detailed in Appendix C.

2.3.2. Research and Development (R&D)

ⓘ The Trust participates in research activity to help provide new knowledge that has the potential to be valuable in managing and treating patients. It is important that such research is open to critical examination and open to all that would benefit from it

The number of patients receiving relevant health services provided or sub-contracted by Berkshire Healthcare NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by Health Research Authority was 1209 from 45 active NIHR Portfolio studies.

As part of the Clinical Research Network Trust Patient Research Ambassador initiative, we now recruited 6 research ambassadors in 2018/19. These are patients who have taken part in research and help us promote research by, for example, presenting at our various research events telling their story about how and why they got involved in research and giving their thoughts about research participation.

Our research activity reflects that we are now a mental health and community Trust; our portfolio of research whilst dominated by mental health research also incorporates research in other non-mental health services such as Diabetes Centre at King Edward VII Hospital in Windsor, the Community Cardiac and Respiratory Specialist Service (CARSS) and Health Visiting service.

The trust held its inaugural research conference in May 2018. This provided the opportunity to celebrate the Trust's contribution to research and to raise awareness locally. Entitled 'Research Collaborations for Better Patient Care' – guest speakers included, amongst others, Keynote speaker Dr Jonathan Sheffield, Chief Executive Officer, NIHR Clinical Research Network (CRN), Professor Belinda Lennox, Clinical Senior Lecturer, Honorary Consultant Psychiatrist, Clinical Director NIHR CRN, Oxford University Hospitals, Professor Adrian Williams, Research Dean, University of Reading and Jennifer Harrison, HRA Approval Change Manager, Health Research Authority. Everyone who completed an evaluation form on the day gave positive

feedback about the event and for a first event it was a fantastic to have 121 delegates attend.

The Trust also publishes the Department of Health mandated "Performance in Initiating and Delivering" (PID) research data on a quarterly basis. This allows the trust to benchmark its performance nationally with some of this data also published on the R&D pages of the Trust's Internet site; the data is available on the following link.
https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development

The Care Quality Commission (CQC) has now included key research related questions in its inspection framework as part of the "well-led" domain. Further information is available at https://www.nihr.ac.uk/news/support-for-clinical-research-further-recognised-in-the-cqc-inspection-framework/9497?diaryentryid=36923

The Trust Research and Development department registered 19 publications by Trust Staff during 2018/19. Publications of Trust Staff research indicate a growing number and diversity of clinician involvement in health research in the Trust. This helps demonstrate the growth of research awareness.

2.3.3. CQUIN Framework

ⓘ The Commissioning for Quality and Innovation (CQUINs) payments framework was set up from 2009/2010 to encourage NHS providers to continually improve the quality of care provided to patients and to achieve transparency. CQUINs enable commissioners (such as the Clinical Commissioning Groups) to reward excellence, by linking a proportion of service providers' income to the achievement of national and local quality improvement goals.

A proportion of Berkshire Healthcare NHS Foundation Trust's income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2018/19 and for the following 12 month period can be found in Appendix E & F.

The income in 2018/19 conditional upon achieving quality improvement and innovation goals is £4,398,604. This is the expected value at 100% achievement, and is to be confirmed in June 2019. The associated payment received for 2017/18 was £2,135,032 against named CQUINs with a further £1,708.000 against STP conditions.

2.3.4. Care Quality Commission (CQC)

ⓘ The Care Quality Commission (CQC) is the independent regulator for health and social care in England. It ensures that services such as hospitals, care homes, dentists and GP surgeries provide people with safe, effective, compassionate and high-quality care, and encourages these services to improve. The CQC monitors and inspects these services, and then publishes its findings and ratings to help people make choices about their care.

Berkshire Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered with no conditions attached to registration.
The Care Quality Commission has not taken enforcement action against Berkshire Healthcare NHS Foundation Trust during 2018/19.

Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. The Trust was inspected by the Care Quality Commission during June and July 2018. The Campion Unit, the trust's assessment and treatment unit for people with learning disabilities was rated 'outstanding' as a service. The trust was rated 'outstanding' for the well-led domain and continues to be rated overall 'good'.

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018/19:

1. How older people move through the health and social care system in Reading, with a focus on how services work together. The reviews looked at how hospitals, community health services, GP practices, care homes and home care agencies work together to provide seamless care for people aged 65 and over living in a local area. Review dates- 29th October 2018- 2nd November 2018
2. Joint targeted area inspection of the multi-agency response to sexual abuse in the family in Bracknell Forest. Review Dates 21-25 January 2019.

Berkshire Healthcare NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

1. An action plan has been developed as a system response through the Berkshire West Integrated Care System. Leads have been identified for each of the actions.
2. A multi-agency response including actions is to be produced by the Director of Children's Services in the Local Authority by 20th June 2019.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2019 in taking such action:

1. Actions have been developed and progressed as a system response through the Berkshire West Integrated Care System
2. Progress to be detailed following production of action plan.

By law, the Care Quality Commission (CQC) is also required to monitor the use of the Mental Health Act 1983 (MHA), to provide a safeguard for individual patients whose rights are restricted under the Act.

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2018/19 financial year at Prospect Park Hospital

- 17th October 2018- Bluebell Ward
- 23rd January 2019- Rose Ward
- 5th February 2019- Rowan Ward

2.3.5. Data Quality and Information Governance

ⓘ It is important that data used by NHS services is of a high quality so that it can be best used to inform decisions on the management of patients. In addition, data must be of a high quality to help inform organisational decision-making and planning.

The Secondary Uses Service (SUS)

Berkshire Healthcare NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data:

— Which included the patient's valid NHS number was:
99.7% for admitted patient care
99.9% for outpatient care and
100% for accident and emergency care.

— Which included the patient's valid General Medical Practice Code was:
100% for admitted patient care;
100% for outpatient care; and
100% for accident and emergency care.

Information Governance

Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance

Berkshire Healthcare NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 'Standards Met'

The Information Governance Group is responsible for maintaining and improving standards in this area with the aim of being satisfactory across all aspects.

Data Quality

Berkshire Healthcare NHS Foundation Trust will be taking the following actions to improve data quality.
The Trust is using the latest Commissioning Data Set (CDS) version to send data. Data will continue to be monitored and improvements made where required.

The Trust continues to monitor the improvement of data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information line and action plans.

Data Quality and Data Assurance audits are carried out throughout the year as part of the Information Assurance Framework (IAF) and where data issues are identified internal action plans are put in place. The data is monitored until assurance is gained that the Trust can have a high confidence level in the data being reported. The assurance reports are included in the monthly Finance, Performance and Risk Executive committee alongside the Performance Assessment Framework (PAF) and reviewed in monthly and quarterly Locality meetings. External Data Quality reports published on the NHS Digital website are analysed to ensure consistency in reporting both internally and externally.

The clinical coding team continue to review and improve the Trust's diagnostic data. As part of our continuous improvement programme, a full detailed audit took place in November 2018, which showed that 90% of primary and 92.8% of secondary diagnoses were coded correctly

Indicators chosen for external testing

The key measures selected for data quality scrutiny by external auditors, as mandated by the Foundation Trust regulator, NHS Improvement, and agreed by the Trust Governors are:

1. Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral- *Mandated indicator*
2. Inappropriate out-of-area placements for adult mental health services- *Mandated indicator*
3. 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital- *Governors' Choice*

In March and April 2019 Deloitte LLP carried out testing on these areas. For each indicator Deloitte met with a relevant staff member of staff to understand how the data is used and collected to calculate the indicator. A sample of items was selected from the data set for the auditor to carry out the testing with the designated clinician for each indicator.

"Absolutely delighted with the care and respect that was shown to my relative at an ENT Consultant Outpatients appointment - lovely staff, professional, courteous and an outstanding service, thank you.

From a relative of a patient- Hearing and Balance Service, King Edward VII Hospital, Windsor

2.3.6. Learning from Deaths

ⓘ For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However, some patients experience poor quality care resulting from multiple contributory factors. The purpose of mortality review is to identify whether problems in care might have contributed to the death and to learn in order to prevent recurrence.

In March 2017, the National Quality Board published Guidance on Learning from Deaths for all NHS Trusts to implement. The Trust has fully implemented this guidance, and a new Trust policy and procedures for learning from deaths was approved in August 2017.

An audit of this was undertaken by internal auditors as part of the approved internal audit plan for 2017/18. The audit reviewed the Trust's adherence to the National Guidance on Learning from Deaths and found that the Trust is effectively identifying, reporting, investigating, monitoring and learning from deaths of patients in their care. Substantial assurance was given that the controls upon which the organisation relies to manage the identified risk are suitably designed, consistently applied and operating effectively.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death. In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further.

The level of review required will depend on whether certain criteria are met, and we review the care provided for all patients who had a learning disability and died.

Figure 27 below details the number of deaths of trust patients in 2018/19. This is presented alongside the number of case record reviews and investigations of these deaths that were undertaken over the same period, as well as an assessment of the number of deaths that were more likely than not to have been due to problems in care provided. Please note that the table contains statements that are mandated by NHS Improvement for inclusion.

Figure 27- Deaths of trust patients in 2018/19- case reviews and investigations carried out in 2018/19

	1. Total number of Deaths	2. Total number of reviews and investigations carried out			3.Deaths more likely than not due to problems in care
Mandated Statement	During 2018/19 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2019, the following number of case record reviews and investigations have been carried out in relation to 3474 of the deaths included above.			The number and percentage of the patient deaths during the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient are detailed below. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)
		1st Line Case Record Reviews (Datix)	2nd Line Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 18/19	**3474** ↓	**320**	**134** ↓	**40**	**3, representing 0.08%*** ↓
Mandated Statement	This comprised the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 18/19	**812**	**73**	**42**	**6**	**1, representing 0.12%**
Q2 18/19	**788**	**77**	**25**	**14**	**0**
Q3 18/19	**983**	**95**	**28**	**14**	**1, representing 0.10%**
Q4 18/19	**891**	**75**	**39**	**6**	**1, representing 0.11%**

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

A number of learning points were identified from the review and actions arising from the learning points have been completed and monitored through the trust mortality review group. The impact of actions is monitored through the Serious Incident process.

Figure 28 below details the number of deaths of trust patients in 2017/18 that had case note reviews and investigations carried out in 2018/19. This is presented alongside an assessment of the number of these deaths that were more likely than not to have been due to problems in care provided and, as a result, a revised estimate of the number of deaths that were more likely than not due to problems in care in 2017/18 Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 28- Deaths of trust patients in 2017/18- case reviews and investigations carried out in 2018/19

	1. Reviews and investigations carried out		**2.Deaths more likely than not due to problems in care**	**3. Revised estimate of deaths in 2017/18 that were more likely than not due to problems in care**
Mandated Statement	The number of case record reviews and investigations completed after 1st April 2018 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2018)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been estimated using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2017/18 that are judged to be more likely than not to have been due to problems in the care provided to the patient.
	Case Record Reviews	Investigations		
Total	**34**	**9**	1 (representing 0.03%) lapse of care has been identified and reported subsequently as an SI in May 2018 following review of the report by the Trust Mortality Review Group: The death occurred in 2017/18. Included in Table 27 above. *	**2, representing 0.05%***

Source- Trust Learning from Deaths Reports

**** Please note that 1 death judged more likely than not due to a problem in care has been reported in both the figures in Fig 27 and Fig 28. This is because the death of the patient occurred in 2017/18, but the investigation was completed in 2018/19***

2.4. Reporting against core indicators

ⓘ Since 2012/13, all NHS Foundation Trusts have been required to report performance against a core set of indicators. This section details the Trust's performance against these core indicators.

Where available, the national averages for each indicator, together with the highest and lowest scores nationally have also been included.

It is important to note, as in previous years, that there are a number of inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from a large number of different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Data is collected by a large number of teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.
- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years.

Figure 29	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period	97.8%	97.7%	**98.7% (Average Monthly %)**	**95.8%**	**83.5%-100%**
Data relates to all patients discharged from psychiatric inpatient care on Care Programme Approach (CPA)					
Note: The acceptable exclusions for these indicators are as follows: (i) patient dies within 7 days of discharge, (ii) where legal precedence has forced the removal of the patient from the country (iii) patients discharged to another inpatient psychiatric ward (iv) CAMHs patients are not included.					
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: In line with national policy to reduce risk and social exclusion and improve care pathways we aim to ensure that all patients discharged from mental health inpatient care are followed up (either face to face or by telephone) within 7 days of discharge. This is agreed and arranged with patients before discharge and this facilitates our high compliance level					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust meets the minimum requirement set by NHS Improvement of 95% follow up through the implementation of its Transfer and Discharge from Mental Health and Learning Disability Inpatient Care Policy.					

Source- Trust Tableau Dashboard

Figure 30	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	99.1%	99.2%	**99.1% (12M Average Percentage)**	**98.1%**	**88.2%-100%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: Crisis resolution and home treatment (CRHT) teams were introduced in England from 2000/01 with a view to providing intensive home-based care for individuals in crisis as an alternative to hospital treatment, acting as gatekeepers within the mental healthcare pathway, and allowing for a reduction in bed use and inappropriate in-patient admissions. An admission has been gate kept by the crisis resolution team if they have assessed the patient before admission and if the crisis resolution team was involved in the decision- making process					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: The Trust Admissions policy and procedures provides a clear framework to ensure that no admissions are accepted unless via the urgent care service					

Source- Trust Tableau Dashboard

Figure 31	2016/17	2017/18	2018/19	National Average 2018/19	Highest and Lowest
The percentage of Mental Health patients aged— (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period	6.2%	7.9%	**6.9% (Average Monthly %)**	**Not Available** (National Indicator last updated 2013)	**Not Available** (National Indicator last updated 2013)
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust focusses on managing patients at home wherever possible and has fewer mental health beds for the population than in most areas. Sometimes the judgement to send a patient home may be made prematurely or there may be deterioration in the patient's presentation at home due to unexpected events					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Work being undertaken around gatekeeping for admission to the hospital should start to ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. A Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 32	2016/17	2017/18	2018/19	National Average 2018/19 For combined MH/LD and community Trusts	Highest and Lowest For combined MH/LD and community Trusts
The indicator score of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends *This finding has been taken from the % of staff respondents answering 'yes' to Question 21d of the National NHS Staff Survey: If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*	74.8%	75.1%	**73.6%**	**66.2%**	**55.9%-79.1%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average and this is maintained.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a five year Organisational Development strategy which has at its heart the achievement of high levels of staff engagement and through that high quality care and service delivery. The specific objectives of the strategy, to be implemented in stages over five years are: To enable every member of staff to see how their job counts, to listen and involve staff in decisions that impact their areas of work, to provide support for their development, and to develop our clinical and managerial leaders. In this, Berkshire Healthcare Trust has signed up to the national Pioneer initiative – Listening into Action – aimed at engaging and empowering staff in achieving better outcomes for patient safety and care. In addition, the Trust runs a compassionate Leadership course and excellent manager programme which are well attended with positive feedback. Several interventions are also in place to help make it a better place to work despite the challenges around recruiting and retaining staff.					

Source- National Staff Survey

Figure 33	2016/17	2017/18	2018/19	National Figures 2018/19	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.2	7.3	7.2	**6.8** (median figure for all participating trusts)	**5.6- 7.5**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trusts score is in line with other similar Trusts					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from a number of sources to show how our users feel about the service they have received. Actions are put in place through a number of initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 34	2016/17	2017/18	2018/19	National Figures 2018/19	Highest and Lowest
The number of patient safety incidents reported	3195 *	4824 *	4518 *	169,041 **	16-9,204 **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	29.1 *	45.9 *	46.2 *	48.8 ** (Median)	24.9-114.3 **
The number and percentage of such patient safety incidents that resulted in severe harm or death	35 (1.1%) *	44 (1.1%) *	40 (0.9%) *	1834 (1%) **	1-239 **
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The above data shows the reported incidents per 1,000 bed days based on Trust data reported to the NRLS. In the NRLS/ NHSI most recent organisational report published in March 2019, the median reporting rate for the Trust is given as 75.2 incidents per 1000 bed days (but please note this covers the 6-month period April 2018-Sept 2018). High levels of incident reporting are encouraged as learning from low level incidents is thought to reduce the likelihood of more serious incidents.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Bolstering the internal governance and scrutiny of serious incident reports, their recommendations and action plans. Implementation of strategies to address common findings in serious incident reports, including clinical record keeping and triangulation of patient risk information.					

Sources: ** Trust Figures reported to the NRLS. Please note that these figures are representative of the number of incidents reported at the time the report is sent and are subject to change over time.*

*** NRLS/ NHSI Organisation Patient Safety Incident Report covering 6 months between April 18- Sept 2018 relating to 50 Mental Health Organisations Only*

Part 3. Review of Quality Performance in 2018/19

In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly Performance Assurance Framework reports related to key areas of quality. The metrics in these reports are closely monitored through the Trust Quality Governance systems including the Quality Executive Group, the Quality Assurance Committee and the Board Audit Committee. They provide assurance against the key national priorities from the Department of Health's Operating Framework and include performance against relevant indicators and performance thresholds set out in the Compliance Framework. Information relating to specific areas of Trust quality and safety performance in 2018/19 is detailed below.

Incidents and Serious incidents (SIs)

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

The Trust aims to maximise reporting of incidents whilst reducing their severity level through early intervention and organisational learning. Organisations that report more incidents usually have a better and more effective safety culture. The annual number of patient safety incidents reported by the Trust is detailed section 2.4 above.

Never Events

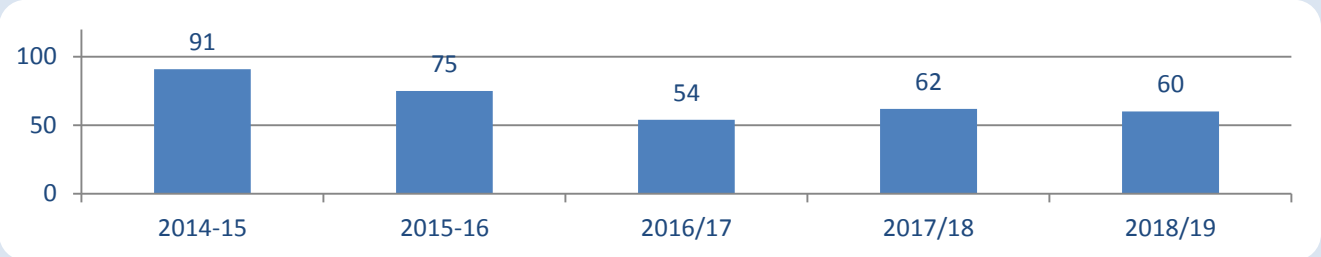
Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust has reported 0 never events in 2018/19.

Figure 35 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

It should be noted that from 2015/16 Admission of Minors was no longer reported as an SI.

Figure 35- Number of SIs- Year on Year Comparison (excluding pressure ulcers)



Source: Trust Serious Incident Report

Summary of findings from Serious Incident (SI) reporting

During Q4 there were a total of 13 serious incidents originally reported. At the time of writing, 2 have been downgraded and therefore 11 serious incidents have been included. This is a reduction on the number reported in the previous quarters (18 in both Q3 and Q2 of 2018/19). All 11 of the serious incidents reported were related to mental health services; 5 to Community Mental Health West, 3 to Community

Mental Health East and 3 to Mental Health Inpatient Services. There were no serious incidents reported for Community Physical Health or Children's Services.

The serious incidents reported during Q4 were:

- **Suspected Suicide Cases:** 5 cases were reported in Q4- 3 fewer than in Q3 of 2018/19.
- **Unexpected Deaths:** 1 case was reported- significantly fewer than the 6 reported in Q3.
- **Falls:** 1 fall resulting in moderate harm met the SI reporting threshold as it required surgical repair.
- **Patient on Staff Assault:** 1 case was reported in Q4 of a serious assault by a patient on a doctor during an inpatient Mental Health Managers meeting.
- **Patient on Family Member Assault:** 1 case was reported in Q4 of a patient attempting to murder a family member who was critically injured.
- **Allegation of Sexual Assault by a Member of Staff:** During Q2 of 2018/19, a female patient made an allegation of sexual assault against a member of staff on one of the Trust's mental health inpatient wards. The patient was appropriately safeguarded and the police were contacted at the time who informed the Trust that there would be no further investigation. The Police subsequently contacted the Trust again in March 2019 to inform them that the investigation was active and that additional evidence had been established. This was logged by the Trust as a Serious Incident at this point.
- **Other:** 1 reported serious incident in Q4 related to a serious alleged non-accidental injury to a baby whose mother was in receipt of a targeted health visiting service.
- **Pressure Ulcers:** In Q4 no pressure ulcers were reported as serious incidents. There were 6 learning events held for incidents of category 2, 3 and 4 pressure damage that developed in our care and where there was a potential lapse in that care that may have contributed to the development. Following the learning events, 4 pressure ulcers were agreed to be as a result of a lapse in care in community settings. There were no learning events for Inpatient Units for developed pressure ulcers where a lapse in care was concluded.
- **Preventing Future Death reports (Reg. 28):** The Trust had input into 17 inquests during Q4- 10 more than in Q3. No Regulation 28s were issued but the Trust did receive criticism at two inquests in which a narrative outcome was delivered. Both of these were for deaths which occurred in Prospect Park Hospital and were in relation to a death by natural causes and also a suicide of a person detained under the Mental Health Act. Action plans were already in place to address concerns raised by Coroner.

Comparison to 2017/18: There have been 60 SIs reported in 2018/19 compared with 62 reported in 2017/18 (excluding downgrades). 18 of the SIs reported in 2017/18 were information governance (IG) breaches, whereas only 1 IG SI has been reported in 2018/19 due to a change in reporting requirements. SIs for unexpected deaths have increased from 13 in 2017/18 to 16 in 2018/19 whilst SIs for suspected suicides have increased from 13 to 24. At the time of writing the Trust do not know what percentage this is of secondary care contacts. Falls with harm SIs have decreased from 7 in 2017/18 to 6 in 2018/19. The 3 top reporting categories in 2017/18 were information governance breaches, suspected suicides, and unexpected deaths. The top 3 reported categories in 2018/19 were suspected suicides, unexpected deaths and falls.

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

- **Communications with family / carers:** Failings in communication with families and carers and the documentation of such communication are a common finding in serious incident investigations.
- **Management of hydration**: This has been raised as an issue in some investigations with regards to the assessment and management for signs and symptoms of dehydration on Inpatient Units (both physical and mental health). It is important to intervene early and act on this information. At times the tools available to staff are not being robustly completed and monitoring is not being effectively carried out.
- **Multidisciplinary Team (MDT) Meetings**: The robustness and completeness of documenting what is discussed and planned in MDT meetings has been highlighted as a theme in a previous quarterly report but continues to be identified as an issue in relation to mental health MDTs.
- **Lack of robust safety** planning – whilst safety plans are now in place ongoing work is required to ensure that the quality of interventions, particularly to mitigate the likelihood of suicide, are always explored and documented clearly.

Actions are being undertaken to address these main themes.

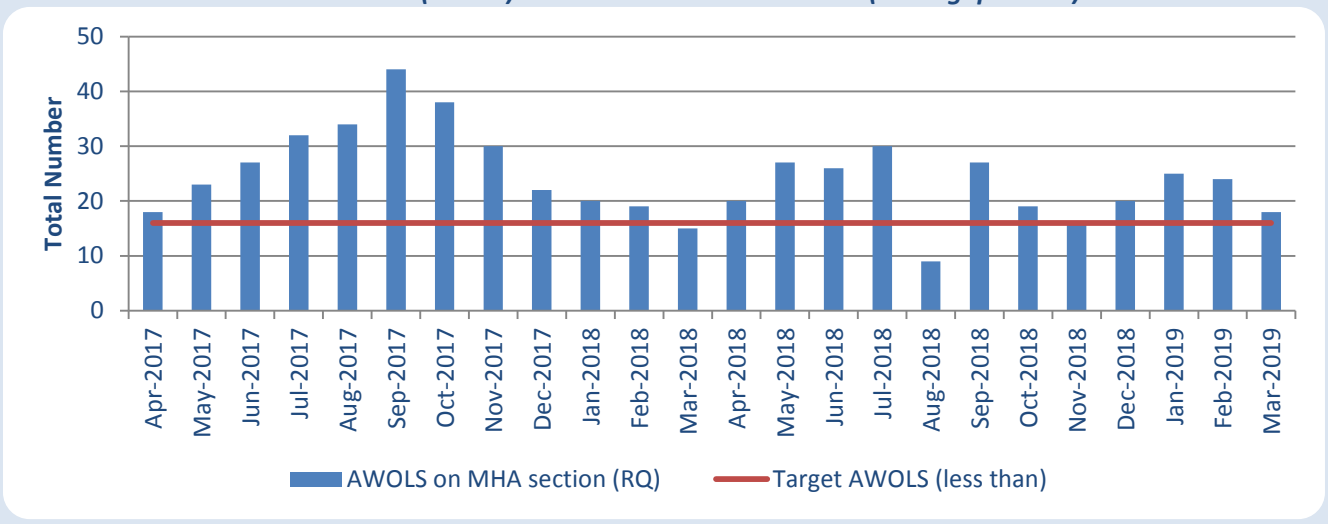
Absent without leave (AWOL) and absconsions

ⓘ The definition of absconding used in the Trust is different than AWOL. Absconsion refers to patients who are usually within a ward environment and are able to leave the ward without permission.

Figures 36 and 37 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

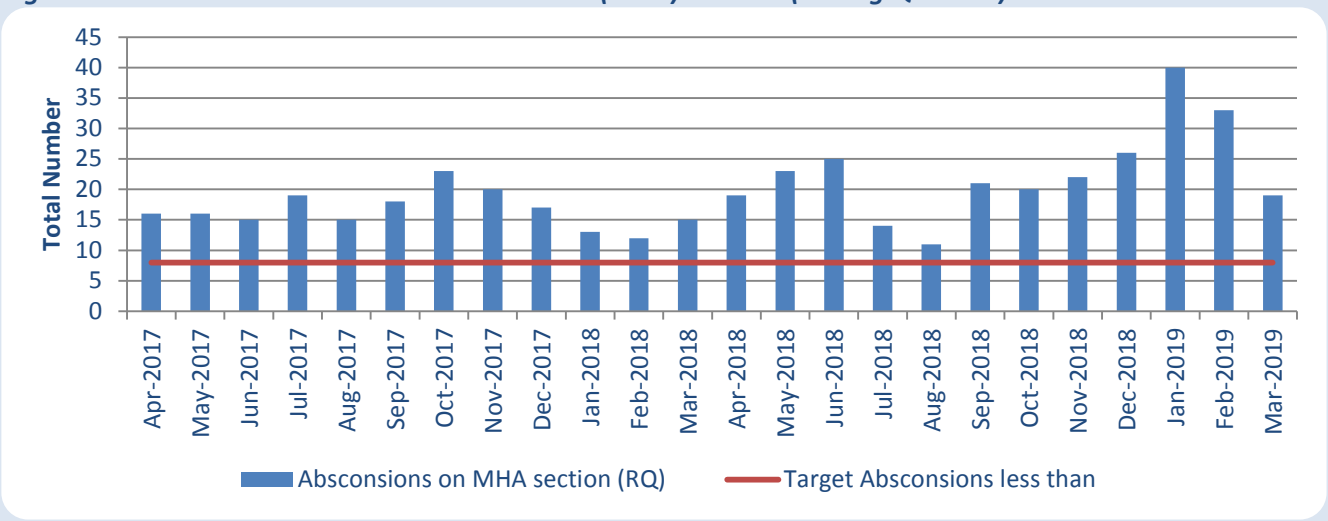
To address this target, the wards are Prospect Park Hospital are running a 'failure to return' project which aims to reduce the number of AWOLs and absconsions.

Figure 36- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)



Source- Trust Tableau Dashboard

Figure 37- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source- Trust Tableau Dashboard

Medication errors

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

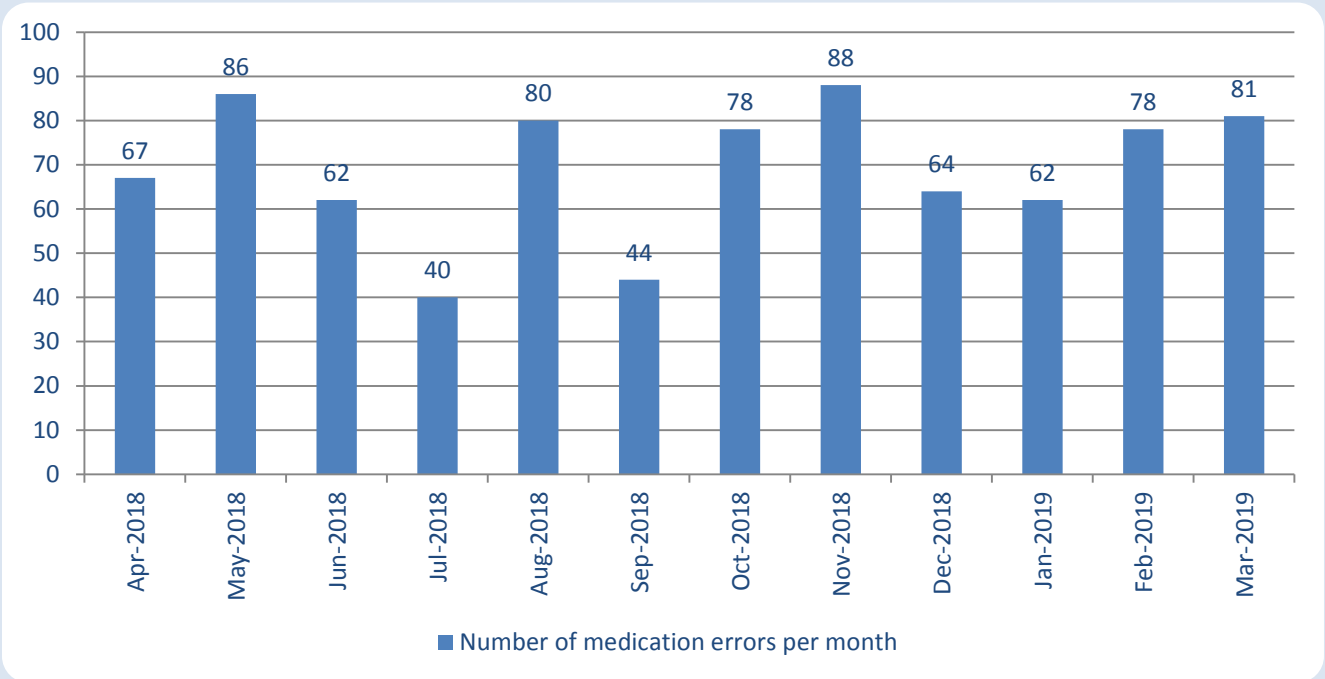
Figure 38 below details the total number of medication errors reported per month. There were a total of 830 medication errors reported in 2018/19. When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring a robust safety culture exists. The data reported also includes all the near misses and documentation errors, so they are not all actual incidents. There is also evidence to suggest that not all incidents and near misses that staff acted upon were reported so any increase may be due to better reporting culture rather than a less safe organisation.

Local processes in this area are being updated by line managers. Trust-wide, there is much activity in overseeing this area including; sharing learning from incidents with summaries sent to locality Patient Quality and Safety Groups, Standardising practices around insulin doses in the community, Treatment to Take Out (TTO) tracking stickers, review of medicines management training, resolving EPMA system errors and standardising and streamlining technology to support medicines management.

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

One moderate medication error was reported during the year (during Quarter 1). This error related to Insulin and other medicines being given to an incorrect patient on a Community Health Ward. There was no harm reported for the patient.

Figure 38: Number of Medication Errors Reported Each Month



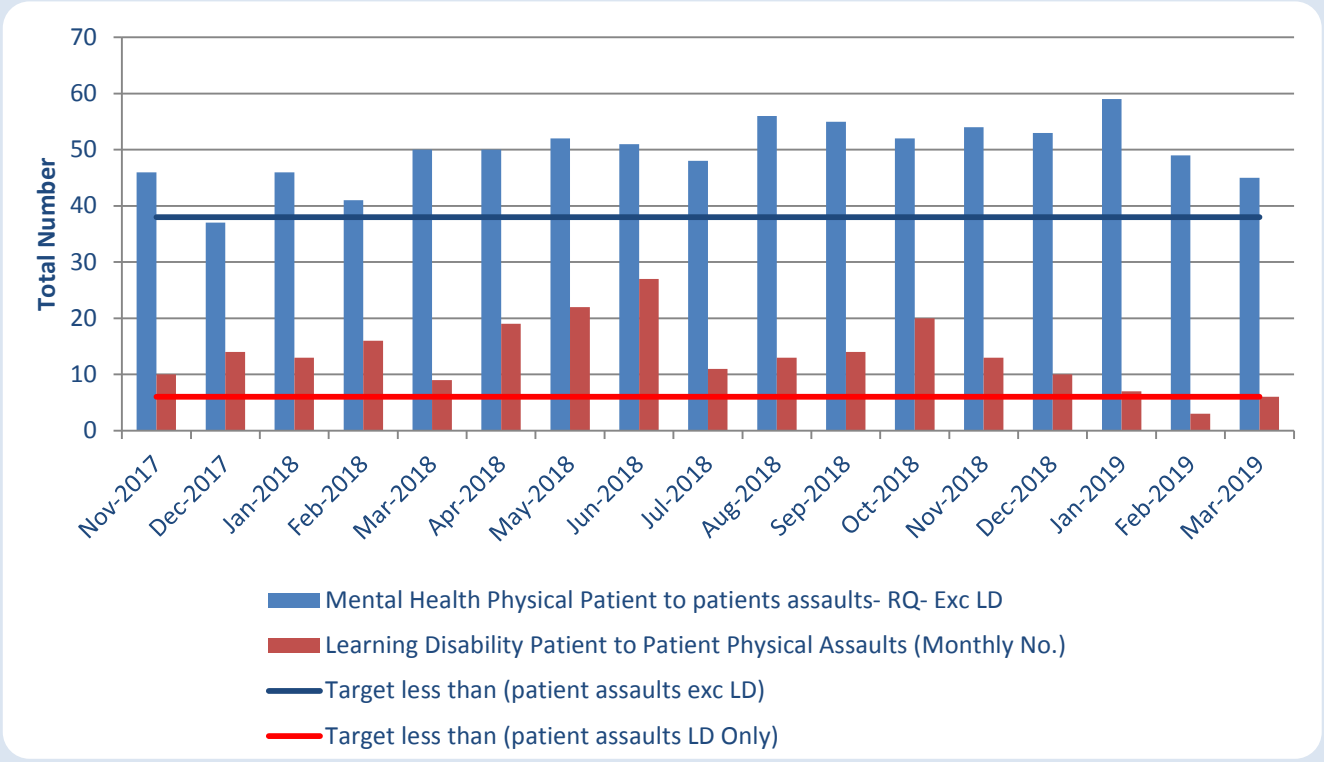
Source: Medicines Management Quarterly Report

Mental Health and Learning Disability Patient to Patient Physical Assaults

Figure 39 below details the number of patient to patient physical assaults. This data has been separated to show assaults by patients with and without learning disabilities (LD). As can be seen, the level of patient on patient assaults appears to fluctuate.

Information on patient assaults on staff is included in part 1 of this report.

Figure 39- Patient to Patient Physical Assaults- Rolling Quarters (RQ)



Source- Trust Tableau Dashboard

"Excellent emergency care. My relative was visited on a daily basis by the team when he became suicidal. They were diligent and persistent, even when he was reluctant to engage, and when he needed to see the team psychiatrists the appointments were given promptly and he was seen on time. I cannot fault the follow up, and we couldn't have managed without their support and advice."

From a relative of a patient- Crisis Resolution and Home Treatment Team (CRHTT), West Berkshire

Other Quality Indicators

Please note that the following indicators have been removed from this section of the Quality Account as they are not in the Single Oversight Framework:

- CPA review within 12 months
- Completeness of Community service data
- Referral to treatment (RTT) waiting times – non-admitted –community.
- Access to healthcare score for people with a learning disability

Figure 40	Annual Target	2016/17	2017/18	2018/19	Commentary
Patient Safety					
Never Events	0	0	0	**0**	Total number of never events in year
Infection Control- MRSA bacteraemia	0	0	0	**0**	Total number of MRSA Cases in year *Source- Trust Inf. Control. Rept.*
Infection Control- C. difficile due to lapses in care	<6	2	3	**1 (0.01 per 1000 occupied bed days)**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust in year. *Source- Trust Infection Control Reports*
Developed Category 2 Pressure Ulcers due to Lapse in Care by Trust Staff	<19	N/A	14	**16**	Total number of Cat 2 pressure ulcers due to lapse in care by Trust in year. *Source- Trust Pressure Ulcer Reports*
Developed Category 3 and 4 Pressure Ulcers due to Lapse in Care by Trust Staff	<18	N/A	18	**17**	Total number of Cat 3 and 4 pressure ulcers due to lapse in care by Trust in year. *Source- Trust Pressure Ulcer Reports*
Medication errors	Increase Report.	N/A	N/A	**830**	Total number of medication errors reported in year. *Source- Trust Medicines Management Report*
Ensuring that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards b) early intervention in psychosis services c) community mental health services (people on care programme approach)	a) 90% b) 90% c) 65%	N/A	a) 87.5% b) 88.5% c) 100%	**TBC when data available**	Percentage of patients with psychosis where cardio-metabolic assessment requirements were met. *Source- Trust CQUIN Report*
Admissions to adult facilities of patients under 16 yrs. old	0	N/A	0	**0**	Total number of patients <16 years of age admitted to adult MH Inpatient Facilities in year

Figure 40	Annual Target	2016/17	2017/ 18	2018/19	Commentary
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per CCG Targets	N/A	247	**185 (Target met)**	Average monthly total bed days spent out of area in year
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only-Health & Social Care).	<7.5%	12.38%	11.3%	**9.0%**	Average monthly % in year. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	53%	85.8%	84.5%	**82.6%**	Annual Percentage
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	N/A	58.8%	**57.4%**	Average Monthly % in Year
Improving access to psychological therapies (IAPT):People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	98.4%	98.9%	**98.3%**	Average monthly % in year
Improving access to psychological therapies (IAPT): People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	99.9%	100%	**100%**	Average monthly % in year
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ disch.	95%	99.5%	99.3%	**99.8%**	Average monthly % in year
Data Quality Maturity Index (DQMI) – MHSDS dataset score (Revised Indicator)	95%	N/A	N/A	**97.8%**	Average monthly % in year
Patient Experience					
RTT waiting times Community: Incomplete pathways	92% <18 weeks	99.9%	99.8%	**99.4%**	Average monthly % in year
Complaints received		209	209	**230**	Total number of complaints in year
1. Complaint acknowledged within 3 working days 2. Complaint resolved within timescale of complainant	100% 90%	100% 100%	100% 100%	**100%** **100%**	Total % in year.

Source- Trust Tableau Dashboard except where indicated in commentary

Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation Trust annual reporting manual 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to May 2019
  - papers relating to quality reported to the board over the period April 2018 to May 2019
  - feedback from commissioners dated April 2019
  - feedback from governors dated April 2019
  - feedback from local Healthwatch organisations dated April 2019
  - feedback from Overview and Scrutiny Committees dated April 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019
  - the 2018 national patient survey November 2018
  - the 2018 national staff survey March 2019
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2019
  - CQC inspection report dated October 2018
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

14th May 2019 **Martin Earwicker** **Chairman**

14th May 2019 **Julian Emms** **Chief Executive**

Appendix A:
Annual Plan on a Page- 2018-19

True North: Annual plan on a page 2018-2019

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

NHS
Berkshire Healthcare
NHS Foundation Trust

True North: goal 1 - Harm-free care

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

- We will align our efforts and work to deliver our harm-free objectives
  - Reducing patient falls incidents by 50%
  - Reducing patient self-harm incidents by 30%
  - Reducing rates of suicide of people under our care by 10% by 2021
- All our services will contribute to an Outstanding Care Quality Commission rating

At a system level: We will achieve reductions in urgent admissions and delayed transfers of care across our inpatient services, working in collaboration with provider partners and commissioners.

True North: goal 2 - Supporting our staff

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

- We will achieve improvements in key areas:
  - 66% of our staff feeling they can make improvements at work
  - 75% of our staff recommending Berkshire Healthcare as a place to receive treatment
  - 20% reduction in assaults on staff
- Our recruitment and retention plans will reduce vacancies by 10%
- An additional 24 services will be trained in our Quality Improvement System
- We will achieve the objectives set out in the Equality Plans for each area

At a system level: We will participate in Integrated Care System work streams, enhancing job satisfaction and career development opportunities.

True North: goal 3 - Good patient experience

✓ To provide good outcomes from treatment and care

- We will achieve a 95% satisfaction rate in our Friends and Family Test and 60% of staff reporting use of service user feedback to make informed decisions in their department
- We will reduce our use of prone restraint by 90% by the end of 2018/19
- All our services will focus on understanding and supporting outcomes of care that are important to patients

At a system level: We will contribute to Integrated Care System work streams to improve patient experience and outcomes.

True North: goal 4 - Money matters

✓ To deliver services that are efficient and financially sustainable

- We will deliver our financial plan for the year and achieve £5m internal savings
- We will continue to improve our efficiency in the way we buy goods and services and further reducing our use of agency staff
- People needing acute mental health inpatient care will be able to access it locally, eliminating the need for acute out of area treatment by 2021
- We will achieve our environmental targets, reducing our use of fuel and water

At a system level: We will contribute to the achievement of the financial targets in 'Berkshire West' and 'Frimley Health and Care' Integrated Care Systems.

Quality Improvement programme

Annual Plan on a Page- 2019-20

Annual plan on a page 2019/20

NHS
Berkshire Healthcare
NHS Foundation Trust

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

True North goal 1: Harm-free care

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

- We will reduce harm to our patients by reducing: self harm and suicide, falls, medication errors, pressure ulcers and preventable deaths from septicaemia
- At least 95% of our reported incidents will be low or no harm to patients
- All patient facing teams will have evidence based objectives for reducing patient harm in their plans for 2019/20
- All our support services will work with patient facing services to identify ways that they can support safety of patients

With our health and social care partners:
We will work to achieve reduced urgent admissions and delayed transfers of care.

True North goal 2: Supporting our staff

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

- We will achieve high levels of staff engagement across all our services - scoring four or more in our staff survey. We will increase the numbers of our staff feeling they can make improvements at work to more than 70%, and aim to achieve more than 85% of staff recommending our Trust as a place to receive treatment
- We will aim to achieve a vacancy level of less than 10%, a staff turnover rate of less than 16% and a sickness level of less than 3.5%
- We will promote an inclusive and compassionate culture, with zero tolerance of aggression, bullying and exclusion, and reduce assaults on staff by 20%
- We will achieve our objectives for equality of opportunity and staff wellbeing

With our health and social care partners: We will enhance career development opportunities and improve our workforce planning.

True North goal 3: Good patient experience

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

- We will achieve a 95% satisfaction rate in our Friends and Family Test (FFT) and 60% of staff reporting use of patient feedback to make informed decisions in their department
- All our services will focus on delivery of outcomes of care that are important to our patients, based on a good understanding of our diverse population

With our health and social care partners: We will contribute to Integrated Care System (ICS) work streams to improve patient experience and outcomes.

True North goal 4: Money matters

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

- We will achieve our financial target of a £1.9m surplus so that we can continue to invest in improving our services, buildings and equipment
- All our teams will work on achieving a 2% efficiency or productivity improvement to benefit patients and staff
- We will continue to achieve reduced use of agency staff and deliver an additional 1% reduction in corporate costs

With our health and social care partners: We will play our part to achieve the financial targets in Berkshire West and Frimley Health and Care Integrated Care Systems.

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2018/19 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National audit		Description	Actions to be taken to meet recommendations
NCAPOP Audits			
1	National Clinical Audit of Psychosis (3582) (including MH CQUIN3 for community & Inpatients)	National Clinical Audit of Psychosis (NCAP) was previously known as the National Audit of Schizophrenia (NAS) from which two reports were previously published: NAS1 in December 2012 and NAS2 in November 2014. The audit has focused on four issues relating to the quality of care provided for people with psychotic disorders: management of physical health, prescribing practice, access to psychological therapies and outcomes. Twelve audit standards and two outcome measures were developed to address these issues which were measured using 29 individual metrics	The audit highlighted that we have the lowest proportion of patients on CPA when benchmarked with other The proportion of patients on CPA is wider than the NCAP and has been highlighted previously in other benchmarking reports. This is being addressed across BHFT, each locality led by the locality directors has an operational action plan in place, to ensure appropriate review of patients who should be on CPA and that specific actions required are implemented within that locality to support the compliance with the CPA policy. Assessments of carers needs: The audit identifies that we have the lowest number of patients with carers identified and that assessment of their needs is not completed when benchmarked against other similar organisations. There is a specific focus on Carers within the trust which the Clinical Director for Children's Services leads on, all mental health services have an action plan in place to specifically address the needs of carers which is being monitored through this programme of work. In addition for those patients on CPA the crisis plan specifically reviews carer's involvement. Locality risk audits are completed and reviewed quarterly by the locality through the patient safety and quality meetings. The audit looks at the service user view, carer view and safety plan (in addition to other areas), any areas of concern are raised to the Quality Executive Group (QEG), and actions are taken within the specific localities to improve compliance. The August risk assessments give assurance that appropriate carer involvement is being completed for patients on CPA. Interventions for when glucose and lipid results which are outside of the Lester tool parameters are often lifestyle and diet advice and in some cases onward referral to an appropriate specialist. In previous audits we have identified that documentation of this is not always easy to find on RiO and this can lead to inaccurate audit data submissions. There is a significant focus on physical health of mental health patients within the trust and documentation of interventions is an area they are aware of and reviewing.
2	National Diabetes Footcare audit (3586)	The National Diabetes Footcare audit (NDFA) is a measurement system of care structures, patient management and the outcomes of care for people with active diabetic foot ulcers. The NDFA is a continuous data collection audit and is part of the National Diabetes Audit (NDA) portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP)	There has been an increase year on year of the proportion of patients who are being seen more than 2 months after initial presentation, increasing from 12.8% to 24.6% To improve time from first being assessed by any Healthcare Professional (HCP) to referral into the MDfT the part time Foot Protection Lead role (community role) continues to support community Podiatry woundcare clinics in this process along with changing referral guidelines to the MDfT. Podiatry local investigation to be carried out for all major amputations from April 2018. From July 18 the community Podiatry service will be collecting data which will give more comparable data across the CCGs.

National audit		Description	Actions to be taken to meet recommendations
3	National Diabetes Secondary Care & Insulin Pump audit (3751)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. GP Practices and secondary care services were also involved in the audit to give a full picture of the diabetes care pathway. The NDA is part of the National Diabetes Audit portfolio within the National Clinical Audit and Patient Outcomes Programme (NCAPOP), commissioned by the Healthcare Quality Improvement Partnership (HQIP).	Significant work has been done since 2016/17 the timeframe in which these audits review, and detailed below is the improvements and actions which have been taken and are in progress. The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Board was set up in April 2017 to help support the transformational bids across the whole Frimley ICS. The Diabetes Service is also a key member of the Berkshire East Clinical Leads Group where local needs are reviewed and addressed. The service is also represented at the Thames Valley Diabetes Clinical Reference Group which looks to improve diabetes services across Thames Valley. The service is currently working as part of the Frimley ICS and is looking to redesign by moving to a more integrated diabetes service. This will include Consultant support in Primary Care and an increase in WTE of Diabetes Specialist Nurses based in the Community to up-skill Primary Care. The Diabetes service is working with the supplier of their Diabetes Database, HICOM so that that more functionality can be utilised to obtain more accurate data. The system may be able to link with RIO and ICE (the pathology system) to ensure that relevant data is entered onto the system automatically. The Specialist Service is in discussion with East Berkshire CCG in respect of commissioning more dietary interventions for people with diabetes as healthy eating and associated weight loss plus physical activity still remains the best treatment for people diagnosed with type-2 diabetes. Structured education Provide more education session including evening and weekend sessions. Sessions in other languages to meet the needs of the local population. Working in partnership with a local GP practice by piloting a locally developed type 2 education programme in Punjabi. An on-line offering of structured education for those people who do not want to attend a face to face course. The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative. The ICS is reviewing how to engage this group of people in their care and how to improve uptake to the services available. Slough are currently recruiting Diabetes Community Champions supported by Diabetes UK to work in the local community to provide support and signposting to Diabetes Care as well as highlighting the risk factors and complications related to the condition Insulin Pump All people with Type 1 Diabetes who are referred for an insulin pump and meet NICE criteria for Insulin Pump Therapy are offered Insulin Pump Therapy. A pathway is in place and agreed with East Berkshire CCG.
4	National Audit of Care at the End of Life (3588)	The National Audit of Care at the End of Life (NACEL) is a nationally-facilitated project that is mandated for Trust participation by our trust community inpatient wards and mental health inpatient wards as part of the National Clinical Audit and Patient Outcome	Review and update the Trust Individualised End of Life Care Plan template to ensure that it meets all of the current best practice requirements, and ensure all patients that require them have an end of life care plan. Ensure that all patients that require them have an End of Life Care Plan. Ensure patients have their capacity to be involved in their end of life care decisions both assessed and documented. Where mental incapacity is not suspected, ensure that this is also documented. Ensure that a senior clinician (a senior doctor or recognised competent nurse) carries out a documented

National audit		Description	Actions to be taken to meet recommendations
		Programme (NCAPOP). The audit focuses on expected hospital deaths and comprises three main aspects; an organisational audit, a patient case note audit and a 'Nominated Person' quality survey. All three parts of the audit were analysed against best practice as defined in "One Chance to get it Right (2014) and NICE Quality Standard 144 -Care of Dying Adults in the Last Days of Life (2017). This is the first time that this audit has been open to services that the Trust provides. In February 2019, the national team running the project (The NHS Benchmarking Network) released a Trust Bespoke Dashboard detailing trust findings benchmarked against all Trusts. It is the findings from this Bespoke Dashboard that are presented in this report.	discussion about CPR with both the patient and the nominated person (unless the patient does not consent to this, in which case this should also be documented). Ensure that the possibility that the patient may die is discussed and documented with the patient. Ensure that the need for routine tests (such as vital signs and blood tests) and non-routine tests is reviewed and documented in light of the patients deteriorating condition. Ensure that the recorded contact details for the nominated person include their address. Ensure that the potential side effects of medications are discussed and documented with both the patient (where possible) and the nominated person. Ensure that the patient's hydration and nutrition status are reviewed regularly (daily in the case of hydration) and that conversations are held and documented with both the patient and nominated person about the risks and benefits of hydration and nutrition options. Review the processes, support and information available immediately prior to, at the time and immediately after the patient's death. Review this interim analysis once the national report for the project is published in May 2019. Implement standardised process for sending condolence letters including BHFT Information for families following a bereavement leaflet Update trust end-of-life guidelines to include a guideline for viewing the body in the immediate time after death and a guideline for enabling rapid discharge home to die if that is the person's preference Investigate whether it would be possible to have an adult and child psychologist available to be consulted by patients, relatives and carers for trust community inpatient wards Investigate the possibility of including End-Of-Life care on trust induction & mandatory training programme
5	National Diabetes Secondary care – Care Process and Treatment Targets report (4330)	The National Diabetes Audit (NDA) provides a comprehensive view of Diabetes Care in England and Wales, measuring the effectiveness of diabetes healthcare against NICE Clinical Guidelines & Quality Standards. It reviews both Primary & Secondary Care services to give a full picture of care provided across the whole diabetes care pathway. It is a requirement of the NDA for secondary care services to participate. In East Berks we are commissioned to provide a Specialist Secondary Care Diabetes Service which supports both people with diabetes primary care in the management of the condition.	The Diabetes Service is a core member of the Frimley Health and Care Diabetes Programme Board who make recommendations for improvement in diabetes care across the whole Frimley ICS. The Service has received extra non –recurrent funding in 2018 in respect of structured education to provide more education session including evening and weekend sessions, sessions in other languages as well as an on-line offering. The service is also working with a local GP practice by piloting an Asian type 2 education programme The service is working in partnership with Talking Therapies to help support uptake of structured education as part of an education hub initiative . Over 70% of people who did not respond to an invitation to attend structured education when questioned felt that they did not need to attend as they had sufficient education and or another family member with type 2 diabetes.

National audit		Description	Actions to be taken to meet recommendations
Non-NCAPOP audits			
6	POMH Topic 15b: Prescribing valproate for bipolar disorder (2017) (3583)	The Prescribing Observatory for Mental Health (POMH-UK) runs clinical audit based quality improvement programmes that focus on discrete areas of prescribing practice. This report focuses on the first re-audit for POMH 15b: Prescribing valproate for bipolar disorder. The standards are derived from NICE Clinical Guideline CG185: Bipolar disorder (update): the management of bipolar disorder in adults, children and adolescents in primary and secondary care, September 2014.	Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the MHRA drug safety alert, that valproate should no longer be used in women of child bearing age unless a pregnancy prevention plan is in place. Medical Director to further communicate advice to doctors at the medical staff committee (MSC) Medication Safety update to be sent to all Patient Safety and Quality Meetings across the Trust The consultant checklist to be replaced by the Annual Risk Acknowledgement Form which is required to be completed by the specialist prescriber and the patient. This form must be completed at initiation and yearly thereafter with copies sent to the GP. Valproate Screensaver 'Stop' 'think' detailing link to pharmacy resources on all Trust computers A prompt has been added to the new CPA template and also the risk aide memoir to provide a further reminder to staff. EPMA text reminder to appear when sodium valproate is clicked on. A request has been put into EMIS for EPMA as currently there is no "alerting" functionality within EPMA unlike other systems that could remind staff at point of prescribing. Audits of prescribing for this cohort both 6 monthly and annually through FP10 and electronic systems to be undertaken and reviewed at the MSG. Trust Medical Director to email all psychiatrists including trainees in the trust advising them of the trust audit results, reminding them of their responsibilities when prescribing valproate to patients. A programme of work is already underway to improve physical health screening for those with SMI. This will be extended to include all patients with a bipolar diagnosis prescribed valproate. Physical health leads will ensure education and information provided captures the findings from this audit and the areas to improve on in terms of physical health monitoring. This group should also be included in the shared care protocols for physical health monitoring that are underway
7	Review of the Early Intervention in Psychosis Network's (EIPN) self-assessment report on Berkshire Healthcare's EIP Service 2017/18 (3589): May 2018	The Early Intervention in Psychosis Network (EIPN), an initiative of the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI), provides supportive quality improvement reviews for EIP services. Services are reviewed against EIPN quality standards through a process of self-review and a peer-review visit. The aim of the self-assessment tool was to provide services with the opportunity to review their practice against a core set of	EIP Service to link in with the Physical Health monitoring work to identify how baseline data can be identified easier at start of being prescribed antipsychotic medication To add documenting baseline measures to the risk register To link in with Cardio-metabolic Assessment QI work. To meet with Inpatient Physical Health Leads to plan raising awareness of the need to document baseline physical health measures at start of antipsychotic medication whenever antipsychotic medication is initiated during an admission. The outcome measure forms are to be accessed online via electronic means such as RiO, iPhones, tablets and available through SHARON if possible A meeting with IT to establish what is possible electronically around forms on RiO, tablets and whether e-forms can be incorporated electronically onto clinician devices and accessed via SHARON.

National audit		Description	Actions to be taken to meet recommendations
		standards which included an assessment of their ability to offer NICE recommended interventions, deliver timely assessment and collect appropriate outcome measures. This is the second time the EIP self-assessment has been undertaken and included data relating to expectations laid out in the 'Implementing the Early Intervention in Psychosis Access and Waiting Time Standard'. The previous EIPN self-assessment was conducted in 2016/17. This National audit also included the CQUIN EIP 2017/18	To have forms created electronically. To meet with IT again to make a plan for developing the electronic forms by the end of October as part of the GDE project
8	POMH Topic 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour (3975)	This report focuses on the first re-audit for POMH 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour. The standards are derived from NICE Guideline NG10: Violence and aggression: short-term management in mental health, health and community settings.	Three standards have been highlighted as areas which require improvement: A prompt debrief is completed and recorded on the patients RiO record within 24 hours (Trust policy requirement) Physical health monitoring and recording in the hour post rapid tranquilisation Physical health monitoring for at risk patients (15 minute observations). In addition to the actions which have been completed since September 2018 there are a number of other actions which have been implemented or are in the progress of being implemented. Staff training continues to be a focus of development and in the last 6 months we have introduced e-Observations which allows' staff to directly input physical observations onto an i-pad and this information goes directly into the patient management system. One of its functions is to be able to set the frequency of physical observations and this is able to serve as a reminder to staff that observations are due.
9	POMH Topic 18a Prescribing clozapine (June 2018) (3996)	This baseline audit aimed to review clinical practice against national standards for prescribing clozapine. Wherever current practice diverges from best practice, as outlined in NICE Clinical Guideline CG178, Berkshire Healthcare aims to take action to make improvements and reduce risks related to prescribing clozapine. There were seven standards and a treatment target based on the NICE guidance.	Comprehensive standardised approach to physical health monitoring. Review alongside physical health monitoring for BHFT patients through physical health group and agree standards Trust wide. Defined Clozapine pathway in line with other care pathways with consistent approach to record interventions on RIO system. Develop pathway through BHFT pathway project team and transformation team. Evidence based agreed standards for prescribing and monitoring of Clozapine within BHFT. Review of guidance and consideration of side effect monitoring tool (GASS).

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Conclusion/Actions
1	High dose or multiple antipsychotic medication use in Wokingham CMHT 4170)	This audit aimed to review whether Wokingham CMHT was meeting national NICE Guidance (NICE Schizophrenia Guideline: Clinical Guideline CG178, 2014, Psychosis and schizophrenia in adults. Although majority of the data documented in their notes CPA, clinic letters, or Clozapine clinic follow up charts it would be ideal to have an agreement to document those in one place on the system so it can be easily checked when required. Also, although it is documented somewhere on case notes that the patient is on high or multiple dose of medication, it would be ideal if it is written as a separate statement in clinic letters, therefore they can be monitored more carefully in primary care settings with given advice. Capacity and consent to treatment is also documented in all of their notes, however, a statement about patients being informed about risks of multiple or high dose of antipsychotic medication, about the risks of combining those with other medications when applicable and obtaining informed consent specifically for that can be considered and would be a better practice.
2	Audit of PGD use by Peer Vaccinators for the 2017 staff influenza vaccination campaign (4227)	The purpose of this audit was to examine the use of the influenza vaccination PGD used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff, working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. It focussed on whether the PGD for the administration of flu vaccine to staff has been used in accordance with agreed inclusion criteria and whether documentation was in line with the national recommendations. An action plan has been devised and includes: PGD to be updated and to include people who work in trust clinical areas on a voluntary basis in the inclusion criteria. Issues identified with standards: 5, 8, 11 & 15 to be clarified and re-enforced. Consent form to be updated and the questions re-ordered in order to avoid staff missing questions. Only the most up to date consent forms to be used and available on Teamnet.
3	East Berkshire audit of assessment and investigation of newly diagnosed HIV patients (3649): December 2017	BHIVA has produced extensive guidance on the initial assessment and baseline investigations for newly diagnosed HIV patients. Each patient should have a full medical history and examination plus documentation of 14 factors. Recommended investigations cover a broad range of tests. Slough Sexual Health Clinic serves East Berkshire and cares for approximately 600 people living with HIV. The audit highlighted several areas requiring improvement including the need to include DA, travel, vaccination and mental health history in the clinic proforma. Patients may not report mental health issues unless asked and, as it could affect engagement with services, medication choice and adherence, it should be recorded. Improved recording of travel histories will facilitate targeted TB and parasite testing. MSM patients should be offered the vaccine if non-immune. PHI-testing is not currently available at our local laboratory but would be useful for targeted partner notification. The findings from this audit have been reported back to the clinic and plans to update the proforma should act as an aide memoire and improve documentation. An action plan was fully completed in 2017, which involved updating proformas and presenting the findings to staff to improve compliance with physical examinations.
4	Health Visitor New Birth Assessment Audit (3855): February 2018	This re-audit had two main aims. Firstly, to identify good practice in recording of HV assessments and to establish if the RIO version of the Family Health Needs Assessment (FHNA) New Birth, had been safely embedded in practice and secondly to identify any possible areas for improvement and actions required. The template for the FHNA had been developed within RiO as recommended in the previous audits action plan. Health Visitors need to continue using the RiO CYPF New Birth FHNA template, need to improve on the recording of the outcome of the new birth FHNA in the mother's progress notes, the recording of fathers details using the personal contacts link, to improve on the synchronising of RiO details with the National Spine and need to complete their records within 24 hours, in keeping with the trust business rules. Reminders to be given at all team meetings and followed up via review of records during management supervision, All localities/managers to confirm actions completed at service improvement group. Audit tool needs to be adapt for next audit to fit with the 24hr standard not 48hr.

	Audit Title	Conclusion/Actions
5	Consent to ECT Audit (4092): January 2018	The aim of this re-audit is to ensure that Berkshire Healthcare ECT Department comply with national guidelines for consent to ECT and, in order to ensure that consent is valid, for all patients to have a robust capacity assessment with relevant documentation prior to ECT. Standards were developed from the ECT Care Pathway and the Berkshire Healthcare ECT Policy and Guidelines (CCRO). The re-audit included one additional standard when compared to the baseline: the mental capacity form is completed on RiO. Clear documentation is the best way of evidencing that the trust is meeting the standards set by its policy and the ECTAS guidelines. Therefore, we must aim to improve and reach the previous 100% compliance with re-checking capacity on the day of the ECT and recording it in the patient's notes. In addition, although lack of the RiO form being completed, does not mean that capacity was not checked on the day prior to ECT, it should be utilised more to ensure clear and detailed documentation of a capacity assessment does take place prior to each ECT treatment. Raise awareness with ward doctors about the importance of completing the capacity forms on the day prior to each ECT treatment – this can be emphasised at the junior doctor induction. To provide immediate feedback to ward doctors on the day of ECT if they have failed to complete the capacity form prior to treatment. Raise awareness with posters about the consenting process for ECT. These can be placed in office areas on the wards.
6	Blood Transfusion Audit 2018 West Infusion Clinics (4177): March 2018	There is an MHRA requirement for all clinical areas where blood transfusion occurs to undertake the British Society of Haematology national bed side audit. The audit was undertaken in the High Tech Care Team to comply with BHFT's transfusion policy (CCR133) requirement to undertake an annual audit of transfusion practice. An action plan has been developed and action has already been taken to inform blood banks that the service works alongside, about the audit results. Further action is being taken to ensure that prescribers are aware of the need to document special requirements.
7	Lurasidone (Latuda®) Evaluation within BHFT (2715)	Purpose: To evaluate the prescribing of Lurasidone to patients referred to inpatient ward Psychiatrists (BHFT) where one of the treatment goals is to manage schizophrenia and psychoses with minimal risk of weight gain and metabolic side effects. Consider treatment with Lurasidone for Berkshire patients admitted as inpatients, experiencing relapse for the following reasons: Non-adherence of current treatment due to side effects and/or weight gain or other metabolic adverse effects from current treatment. Lack of efficacy of one antipsychotic. -The formulary position of Lurasidone should be reviewed as a result of this audit within CCGs - BHFT has added this drug to its formulary but this will not be taken over by GP's.
8	10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital (3863)	For all children and young people who present to an acute hospital in a mental health crisis, our standard operating procedure recommends a "7-10 day follow up either by a telephone or face to face contact". This project aimed to measure the 10 day follow up rates by Berkshire CAMHS Rapid Response Team following discharge of a CYP from acute hospital and an evaluation of the reasons where this has not been possible. Community 7-10 FU appointment is determined before the patient is seen in acute hospitals and offered to the patient at the crisis appointment in acute hospital. Review operational process for handovers of CYP who have out of hour assessments by engagement with PMS services and with PPH/APOS – Protocols in practice meeting. The handover protocol to be incorporated in standard work/SOP for CAMHS RR. Review operational process for handovers of CYP out of hour assessments in out of area hospitals (Basingstoke and FPH) Induction protocol embedded in standard operational procedures for new starters. Operational causes will be evaluated and we expect to implement actions to improve the compliance rate for re-audit in one year.
9	Prescribing psychotropic medication in individuals with intellectual disability (4054)	The aim of this audit is to determine the level of compliance with the current standards of practice for the prescribing of psychotropic medication in patients with intellectual disability as outlined by the report of the Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists, alongside the NICE guidelines for challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. Make the admitting and ward doctors aware of current standards for prescribing psychotropic medication in intellectual disability, with focus on the recording of off-label medication. Inform admitting and ward doctors of the off-label use of antipsychotics for challenging behaviour and the NICE conditions. Push for clear documentation in patient notes for the rationale behind changes in medication.

	Audit Title	Conclusion/Actions
10	Re-Audit of Antimicrobial Prescribing on all Berkshire Healthcare Inpatient Wards (3574)	This audit is a re-audit of Project 3494. The audit aimed to determine how compliant the Trust was with nationally recognised standards of good antimicrobial stewardship (AMS) and practice, and whether local Trust prescribing guidelines for antimicrobial prescribing is followed by prescribers. Recommendations will be managed through the BHFTs AMS Group who will have overall responsibility for taking these actions forward. Continue the wide spread use and regular update via AMSG of Trust guidelines through The Microguide app. Doctor's induction pack. Inpatient bulletin. Continue staff engagement through continued staff training and awareness of AMS principles. Annual AMx Guardian campaign. Review e-learning to incorporate ongoing pertinent AMS points. Raise staff awareness for full completion of allergy box on EPMA charts across all healthcare professionals. Inpatient bulletin. Continue system working. Joint collaboration to streamline Trusts and CCG guidelines within the County It is expected that further improvements will be observed as EPMA is embedded. The AMS group are due to discuss the action plan at their next meeting on 16th July 2018; they will lead on this going forwards.
11	Re-Audit of compliance with sepsis early recognition tool in community health inpatient units (3713): April 2018	The NICE sepsis guidelines were published in July 2016 and a quality standard published in September 2017. An initial audit was undertaken in 2016-17 to establish baseline compliance in inpatient units following the implementation of the sepsis early recognition tool. Targeted training to continue including eLearning. HIPC to continue to provide support for staff in compliance with the sepsis early recognition tool. The sepsis page on Teamnet is to be regularly reviewed and updated, new resources and guidelines to be communicated to clinical staff. Infection Prevention and Control post infection reviews to be monitored for compliance with the early recognition of sepsis tool. Learning is to be disseminated to clinical teams via relevant post infection review reports and quarterly shared learning reports disseminated by the IPCT. Involvement with individual QMIS projects to review the use of the early sepsis recognition tool.
12	Fragility Fractures Audit Programme (FFFAP) - CSP Hip Sprint Audit 2017 (3630)	Although this was a national audit, it is not mandated (quality account reportable) or on the NCAPOP Programme. Following a review of the national report's recommendations, the following actions were devised for BHFT: Evidence based exercise programme including strength, balance, mobility and endurance in place for all hip fracture patients on Jubilee. Health coaching and goal setting used to increase adherence to programme. Continuity post discharge by referral to other ARC services – ICR, Community Physio, ARC
13	School Nursing Nocturnal Enuresis Service Audit (4118): December 2017	The school nursing service undertakes the record keeping audit on an annual basis in order to measure compliance against the CCR153 'School Nursing: Nocturnal Enuresis Policy. Compliance against this policy is required to be monitored via the annual audit using the national enuresis service monitoring tool. An action plan was developed which includes key actions for all localities to ensure that the enuresis assessment tool is used in all cases. Further education and development of staff through pan-Berkshire staff nurse meeting and the use of the school nursing letter to distribute, findings, recommendations and further information. New automatic waiting list set up on RIO with an alert after 42days if client not yet seen, which will prompt review of clinic availability
14	Safeguarding Record Keeping Audit, School Nursing 2017 (4119): December 2017	An in-depth audit of child protection records and health assessment was conducted by the school nursing service. Spot checks will be conducted half termly via management supervision, to include reviewing whether safeguarding children's risk forms are fully completed and whether the progress notes summaries the key information including risk to the child. IT training has been provided in uploading documents and the Health assessment form is being Built into RIO.

	Audit Title	Conclusion/Actions
15	Audit of Risk Summary Documentation for all Patients in the Slough Pathways Outreach Team (4318)	The purpose of the audit was to establish if all eligible patients under the care of the Slough Pathways Outreach Team (SPOT) have had risk summaries completed. In particular, whether their last risk summary update was in line with the time frame required (either 6-monthly or 12-monthly depending on necessity to have CPA meetings). There is nowhere on RiO which prompts staff that a risk summary is overdue; it is possible that this would improve compliance. Team to be made aware that risk summaries can be updated despite not having seen the patient in the case (as one of ours) when they are in a different region of the country. If there has been any contact with the patient, family or other healthcare professionals this can be documented and as long as clearly stated that the patient has not been seen and assessed, this is valid. Discussion with the MDT surrounding adding a column on the MDT handover sheet. The current form includes patient details, their last CPA, next CPA, cluster number, details of outpatients appointments and CTOs. Two columns could easily be added to include date of last risk summary and date next risk summary is due.
16	Lithium use in Wokingham CMHT: Audit of safety and quality of monitoring in the last year (4349)	Wokingham CMHT previously participated in the national POMH Lithium re-audit in June 2016. This audit measures using NICE Clinical Guideline (CG185) for Bipolar disorder: assessment and management (published September 2014). Whilst compliance with all standards prior to starting Lithium are excellent, some measures conducted during maintenance treatment could be improved upon, particularly serum calcium 6 monthly. It should not be assumed that requests for U&E's will also mean that calcium would be checked as an electrolyte; it should be requested separately.
17	Audit on use of hypnotics for insomnia in West CRHTTs in comparison with NICE guidelines (4331)	The aim of the audit was to identify patients under West CRHTT who were started hypnotics (Zopiclone, Zolpidem and Zaleplon) and to assess whether NICE guidance was followed. Patient's literature on sleep hygiene should be readily available to clinicians. Patients should be provided with information and followed up on sleep hygiene plan. MDT collaboration to review ongoing hypnotic's use. Improve awareness of NICE guidance of management of insomnia.
18	ADHD Shared Care Clinic Annual Review Audit (4094)	Adult ADHD is treated with medication and managed locally by the Adult ADHD Shared Care Clinic. Both the new and previous NICE Guidelines recommend an annual review of the condition and treatment: NICE CG 72 (2008) and NICE NG 87 (2018) respectively. . The aim of this audit was to demonstrate whether we are meeting the standards. All annual reviews should lead to communication to GP's on the pro forma. Where there is no available previous weight, a BMI should be calculated, anyway. We need to ask about sexual side effects on atomoxetine and record the outcome. We should ensure that we record comments on mental wellbeing, physical health and substance misuse at every annual review.
19	A direct observation study of medication administration errors in a community and mental health setting (2733)	In response to a 2010 NPSA alert on omitted and delayed medicines, repeated audits of 'blank boxes' on medication administration charts have been completed; however action plans have had either a temporary or little effect (blank boxes are unsigned administration records when a medication was due, leading to uncertainty whether the medication was administered or not). In response, we completed this wide scale audit of all medication administration errors across BHFT. This aimed to document the rate of medication administration errors (MAE's) across all inpatient wards in a community and mental-health Trust, and to investigate the interrelationship between error rates and possible contributing factors. Additional information to be added to the mandatory medicines management training. Medication administration processes to be discussed at Medicines Safety Group with actions to be identified.
20	Evaluation of a Transdiagnostic Cognitive Behavioural Therapy Group in a Secondary Care Adult Mental Health Service (4088): May-18	The aim of this project was to evaluate the effectiveness and acceptability of the tCBT group. No issues were raised as a result of completing this service-evaluation and therefore no action is necessary. The evaluation demonstrated that running the tCBT group is effective and acceptable.

	Audit Title	Conclusion/Actions
21	Audit of Care Pathway: People Whose Behaviour Challenges - Pre and Post Outcomes (4206)	This audit is completed every year to ensure that the LD service delivers an excellent quality of care to people following the People Whose Behaviour Challenges Care Pathway. The audit is based upon good practice standards set out in two documents: Challenging Behaviour: a unified approach (2007); and Challenging Behaviour and Learning Disabilities: Prevention and Interventions for People with Learning Disabilities Whose Behaviour Challenges (NICE 2015). Present findings to the Learning Disability Governance meeting (November 23rd, 2018). Re-audit in April 2019 to ensure progress is maintained and improved. The Intensive Support Team (IST), Occupational and Speech and Language therapists will be asked to contribute specialist assessments as pre and post outcome measures. A three monthly follow up, repeating outcomes measures used, will be completed as per guidelines, to enable measurement of whether the gains have been maintained following closure. This guideline will be added to the care pathway.
22	Re-audit Berkshire Perinatal Community Mental Health Service Discharge Summaries (4458): 09/08/2018	This re-audit aims to measure improvements since last years' audit. One standard relating to timeliness of reporting to the GP was added to the 2018 re-audit, while all other standards remained the same as in 2017. To discuss with the team the importance of documenting a plan for future pregnancies. Standardised Discharge Summary to be used by all perinatal clinicians
23	Better understanding of the interplay between hyperactivity, inattention and impulsiveness in the clinical assessment of ADHD (2732)	The standard assessment of ADHD in BHFT CAMHS includes the use of screening questionnaires (Conners rating scales) and neurocognitive testing combined with infrared motion analysis (QBTest). This project tried to assess whether distinct neurocognitive profiles can also be distinguished in the scoring of the Conners rating scales & what the degree of correlation will be. In order to improve the interpretation of clinical data and investigations for the benefit of making more reliable diagnoses and raising the standard of the diagnostic assessment, thus leading to better treatment plans, the following have been implemented: Results were presented at the Specialist CAMHS ADHD Team Meeting on 10.10.2017. Attention was drawn towards the careful analysis of activity levels in relation to neurocognitive profiles. Clinical advice was given with regards to the integration of investigations, i.e. clinical observation, screening questionnaires and objective measurements when assessing for a diagnosis of ADHD. Standard Assessment was introduced with aids as to how to analyse neurocognitive profiles and how to complete an ADHD assessment that will meet Bolam/Bolitho criteria.
24	Improving Multidisciplinary Rounds on an acute Psychiatry inpatient ward (4211)	Multidisciplinary ward rounds (MDR) are an important forum wherein patients, carers and inpatient teams share information about patient's care. The outcomes were expected to aid enhanced patient engagement, service user safety, improve communication between inpatient team, carers and community mental health teams and to reduce unnecessary delays in discharges. A further review is needed to assess the views of carers and community staff, to gain a full understanding of how MDR rounds can be improved on an inpatient ward, but this is likely to be part of a separate piece of work.
25	Audit on the documentation and appropriate review of blood investigations in the inpatient services (4249)	The audit aimed to review the proportion of new admissions that had blood tests taken, whether these were documented in RiO, if documentation was timely, and if an appropriate plan was documented. Phlebotomy to be consulted as to how they can best/most easily communicate with clinicians. Mention the need to document bloods on RiO to new trainees at induction. Consultants to be made aware by email of findings of audit in order to pass the message on to the team.

	Audit Title	Conclusion/Actions
26	Covert Administration Audit on Rowan Ward (4362): May 2018	. The main aim of the audit was to measure the level of adherence that healthcare professionals on Rowan Ward had to Berkshire Healthcare's SOP on covert administration. Training on where to specifically store and how to use the MRSOP; 4009 Covert Administration of Medicines forms. Nurses to be given additional training on covert administration and the importance of signing the covert administration form with their agreement. Training for pharmacists on how to use ePMA to input specific endorsements for the method of administration. Improve the covert administration process by ensuring that covert administration forms are all uploaded to RiO, to make accessible to all. Reduce the maximum official review date for covert medication from 3 months to 2 months and ensure review includes looking at if medications are still essential. Repeat audit using a regular member of the team to complete the audit prospectively over a longer period when recommendations have been implemented.
27	Parkinson's Audit (3656)	The objective of the Parkinson's patient management audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson's complies with national guidelines including the Parkinson's NICE guideline and the National Service Framework for Long Term Neurological Conditions (NSF LTNC).
28	Frequent attenders at the emergency department (2839)	The CCG asked the Psychological Medicine Service (PMS) to create a system to address the problems for individuals and services associated with people who repeatedly present to A&E at the RBH. The aim of this project was to identify the 'top 20' repeat attenders aged 16+ to RBH A&E each quarter and to implement appropriate indirect / direct interventions with the aim of reducing attendances in the following quarter(s). No specific actions are required as part of this project, though further related work will include: Continuing with CQUIN until 2020, Increasing frequent attenders pathway (requires resources). Continuing to develop the work regionally – benchmarking and networking with other Emergency Departments
29	Audit of transition practice for young persons with ADHD (3803): June 2018	Berkshire Healthcare Trust implemented a policy on the ADHD Transition Pathway from CAMHS to Adult Services in 2015 based on NICE guidelines and recommendations. Effective and thorough transition from CAMHS to adult services in patients with ADHD is crucial to minimise the impact to patients in what can be a challenging and anxiety-provoking period for both the patients and their families. The audit sought to assess, whether the transition process was being followed by services across Berkshire in line with BHFTs transitioning tool, and to make changes where required improving the service provision for patients. The audit demonstrated that the current policy is in line with national standards and guidance. However, there are some gaps within the service based on the recommendations made: • ADHD Transition from CAMHS to Adult Services Policy should be made more widely available on the intranet by discussing with IT and appropriate professionals involved in these services. • Results of the audit to be presented at the CAMHS academic seminar, ensuring relevant professionals are informed & made aware of change. • Results of the audit presented during team meetings in each area of BHFT e.g. Maidenhead / Wokingham / Reading etc. • The ADHD transition from CAMHS to Adult Services Policy to be presented at team meetings in each area locality in order for people to become more familiar with the standards and expectations of the transition process. • Whilst this audit primarily highlights changes which can be made by CAMHS, this audit needs to be passed to the adult ADHD team in order for them to be made aware of areas for improvement including them sending receipt of referrals and sending appointments. • A proposed checklist to be created outlining in brief what needs to be completed prior to transition and during the transition process including deadlines; to be distributed amongst the teams. • In the longer-term, to consider having a prompt on RiO to ask whether clinicians are considering referral may be a helpful as a reminder.

	Audit Title	Conclusion/Actions
30	An audit of current practice of Partner Notification for patients with a new diagnosis of HIV presenting 2016-17 at the Garden Clinic (4184): July 2018	Partner Notification (PN) is an important outcome to be evaluated in the commissioning of sexual health services and is also important from a public health perspective as it enables services to identify those at risk of HIV infection, particularly those at risk of primary HIV infection, who will be most at risk of transmitting the virus to new sexual partners. The HIV Partner Notification for Adults: Definitions, Outcomes and Standards published by BASHH/BHIVA in 2014 define the process whereby contacts of those with HIV are identified and offered HIV testing. The aim of this audit was to compare performance at the Garden Clinic in Slough with national results and with results of the 2012/13 PN audit. This audit highlights the need for local review of the PN process as PN information was often difficult to access and information was documented differently depending on the clinician who saw the patient. Following the audit, it became apparent that Health Advisors in the team could input PN information that was not available to other members of staff. The action plan tackles the issues of access and, through training, will ensure a consistent process if followed using the sexual contacts tab on Lille.
31	Re-Audit on the Management of Gonorrhoea in the Sexual Health Service (4186): September 2018	Antimicrobial resistance is on the rise worldwide, GRASP surveillance has issued warning regarding resistance to the currently used Cephalosporin antibiotics. Though the incidence of Gonorrhoea infection is on the rise especially in high risk individuals, is also an indication of HIV transmission. The purpose of this audit is to audit the investigation and treatment of gonorrhoea positive patients. Standards were taken from the UK National Guideline for the Management of Gonorrhoea in Adults (2011; BASHH). An audit against the same standards was conducted a year prior to the re-audit. Recommendations include: Improving attendance rates of men, such as by having clinics for men or online testing. NAATS and culture plates should be taken from all appropriate sites. Full sexual history must be taken from both men and women. If first line of treatment is not given, continue to document reasons. Written information to be given out to patients and documented on Lille. An action has been developed to set up a texting system on Lille to provide a link with patient information leaflets.
32	Audit of the Safeguarding Children Risk Form on the RIO record (4375): April 2018	The safeguarding children at risk form was designed to enable practitioners to see at a glance the safeguarding issues for the child, whilst at the same time holding important information about the contact details for the social worker and details of the next safeguarding meetings. The form allows for all of this important information to be accessed from one place and be viewed at a glance. The purpose of this audit was to review if the safeguarding children risk forms were being used since their introduction two years ago. The initial reason for developing the form was so that the information around safeguarding was instantly accessible. The audit sought to highlight if the forms were being completed correctly. Overall, the findings of the audit were positive, the children risk forms are being used as designed for their intended purpose. Therefore, no further actions required
33	A QIP on the Physical Health Monitoring of Inpatients on Bluebell Ward (4024): June 2018	This project was carried out as it was identified that although, there was a robust monitoring system in place to assess the physical healthcare of patients on admission, there was no process where a patient's physical health examination, bloods, ECGs or other general physical health was discussed as part of the weekly MDT meetings whilst they were an inpatient. The audit sought to address the impact of this and improve this with the objective of being able to review the processes involved and identify gaps in care. The key recommendations proposed are: The physical examination, results of blood tests and ECG should be documented in the patient's electronic records. Medical aspects of the patient's clinical presentation should be adequately documented during weekly MDT discussions summarising the physical health status of the patients during the review and their treatment. The monitoring of NEWS should be consistent with the Trusts NEWS monitoring policy CCR 116 in terms of the frequency of the monitoring and contacting relevant medical professionals. 24-hour physical monitoring forms on RIO should be completed to include all parameters such as hearing, sight, dentition, bowel problems and fluid balance. The nutrition monitoring forms on RIO should be completed with eating and swallowing problems being recorded. Propose to re-audit in a years' time. All doctors on the inpatient wards will use the check list during the MDT meetings and the use of the check list will be periodically reviewed.

	Audit Title	Conclusion/Actions
34	Effective Use of Anticoagulation Use in Atrial Fibrillation (4218): July 2018	Atrial Fibrillation is associated with increased risk of strokes; effective anticoagulation can minimize patients having strokes. The primary objective of this audit was to see whether all patients who need anticoagulation are on either warfarin or NOACs. Further also to find out the reasons, if patients have not been started on anticoagulants or if they are on Aspirin or Clopidogrel. To increase the awareness among GPs on CHA2DS2-VASc by arranging lectures, posters and sending emails. Display CHA2DS2-VAS score guidelines in clinical areas. To investigate if the system can have periodic pop ups of CHA2DS2-VASc score as reminder.
35	MIU X-ray Diagnosing, Reporting and Follow Up Audit (4279): August 2018	The purpose of this audit is to review the Minor Injuries Unit's (MIU) practice relating to diagnosing, reporting and following up on patients who have x-rays. Similar audits have been completed during 2016 and 2017; however this audit has been updated (following a SIRI 2017/19265) to include two additional standards relating to follow up processes when a patient requires referral to the Virtual Fracture Clinic (VFC). The radiology department at WBCH should be printing the RBH x-ray reports and delivering them to MIU in a timely manner. Differences in diagnosis and report should be clearly documented in the notes regardless of whether it affects treatment. Patients with fractures to the proximal and middle phalanx of the fingers should be referred to VFC as per VFC recommendations. Documentation of what the x-ray report stated should be recorded correctly in the patient notes. Delay between the time a patient has their x-ray and in the checking of the x-ray report should be reduced. Checking the VFC referral has been made needs to continue and must be documented.
36	To establish, improve and maintain a personal folder for inpatients. Audit to check items in patient folders against a checklist (June 2017 to December 2017) (3701): October 2018	Campion Unit is an acute inpatient service providing intensive multidisciplinary assessment, formulation and treatment in a controlled setting. Service users have complex needs, often with multiple diagnoses. Standards have been developed based on Transforming Care Programme, which was developed by NHS England, the Association of Adult Social Services, the CQC, Dep of Health and RPsych. Action was taken throughout the 6 month period based on the findings of the audit. Completion of these actions has resulted in improvements for patients: - Full and complete care plans and section 17 leave documentation, which evidence patient involvement, have given clarity to the patients and their families about leave opportunities for patients to maintain contact with their families as well as leisure activities. - T2 and T3 forms were not clearly understood by all of the patients and the Responsible Clinician has since developed an easy read explanation of the SOAD process and T3 certification. Including communication passports in the patient folders has helped to embed the need for all staff to individualise communication with patients. Staff have reported that this has increased their use of, and confidence in using non-verbal methods of communication including sign supported English such as Makaton. - Storage of documentation relating to healthcare appointments at Royal Berkshire Hospital (and other healthcare sites) has been a challenge. The Responsible Clinician has devised a system for copying information related to the patient into their folder to improve practice in this area. - The CTR leaflet is being given to the patient and completed during the Mental Capacity Act process. This is documented in the progress notes.
37	First Prescription of Combined Oral Contraceptive (COC) Audit (4535): October 2018	This re-audit aims to measure compliance (and any improvements since the 2011 audit) with the following auditable outcomes: - Prior to first prescription of COC, all women attending the service have a Body Mass Index (BMI) and blood pressure documented - Before first prescription of COC, all women attending the service have a documented record showing assessment of cardiovascular risk factors, including migraine. Key recommendations from this re-audit include: Filling out physical health details electronically while the patient is in the room so as not to forget to document results on the electronic system. Further development of the contraception proforma, including a banner at the top with a box for blood pressure, height and weight to be documented. The proforma and physical details tab should be linked if possible so that it can self-populate. Feed results back to staff, including issues relating to incorrect coding of prescriptions on SRHAD.

	Audit Title	Conclusion/Actions
38	Neuro-imaging in dementia patients (4570): November 2018	Neuroimaging is an essential part of investigations in dementia patients. NICE Guidelines exist for this aspect of investigation for dementia (NICE Guidelines: 1.2.13: offer structural imaging to rule out reversible causes of cognitive decline and to assist with subtype diagnosis, unless dementia is well established and the subtype). Although full compliance was found, an action plan will be considered based on the following recommendation: create a recommended time in the local policy in which a previous scan would be acceptable. Ideally this should be within one year in order to rule out reversible causes.
39	Audit on testing Vitamin D level in elderly patients admitted to Henry Tudor Ward after falls, as per NICE Guidelines in Falls and Vitamin D (4532): December 2018	The standard for this audit was: All patients presenting on admission with a clinical problem of falls will have a vitamin D test completed within 1 month. The purpose of the current audit was to evaluate how compliant Henry Tudor Ward is with NICE recommendations, specifically recommendation 7 which relates to testing vitamin D levels on patients presenting with a clinical problem of falls, with the aim of starting vitamin D treatment earlier for applicable patients. There have not been any recent audits on this topic in Berkshire Healthcare. The results were presented to the Clinical Governance Group on 19th December 2018, where the recommendations and action plan were agreed. Recommendations include: - Educating ward and rehab doctors on the Vitamin D NICE Guideline during weekly teaching meetings, clinical governance meetings and weekly multi-disciplinary team meetings about the need to add a vitamin D request in routine blood for all patients who have falls. - Designing a notice based on NICE Guidelines around falls and displaying the notice on notice boards in doctors' rooms and clinical rooms. - Adding a pop-up notice to computer desktops on vitamin D and falls. - If nurses are unable to book vitamin D blood tests, their ICE login should be updated. - Doctors' ICE login can be set to default to the endocrine panel where vitamin D is displayed. - Discussing any limitations to testing vitamin D with the biochemistry lab.
40	Review of patients on anti-dementia medication (ID 4276): January 2019	This audit set out to evaluate the current prescribing practice in the Bracknell Community Mental Health Team for Older People (CMHTOA). Based on the 2011 guidelines BHFT participated in a POMH (Prescribing Observatory for Mental Health) audit in 2013 on prescribing anti-dementia drugs. An action plan is being devised. Recommendations: - Clear recording of information: A standardised form to adequately record the review. - The results of the audit will be presented and discussed at a Bracknell memory clinic and CMHT business meeting.

	Audit Title	Conclusion/Actions
41	An Audit of the Antipsychotic Drugs prescribed for management of Behavioural and Psychological Symptoms of Dementia (BPSD) in Older Adult Community Patients (4357): June 2018	The current audit uses standards developed from NICE Guideline CG42 (2016) and NG97 (2018) to audit antipsychotic prescribing for management of BPSD in patients from Slough Older Adults Community Mental Health Team (CMHT) who have dementia, with the aim of making improvements to practice where necessary. The findings of the audit were presented to the multi-disciplinary team for further discussion and analysis. At this meeting it became apparent that not all staff were aware of the timescales for completing assessments and that another reason why the three-month follow up is not always being completed is due to patients presenting as too disturbed for cognitive re-testing. The decision was made to develop an action plan for improvement and review these standards on an annual basis as per the guidelines. The action plan includes actions relating to: - Using the pain score tool to identify the severity of pain when reviewing patients prescribed antipsychotic medication. - Using medication information and leaflets to present medication effects, risks and benefits and to improve compliance with prescribed medication. - Documenting reported effects, CVA risks & risks & benefits of antipsychotic treatment in the Psychotropic Medication section in RiO progress notes. - Using the MSE template and Physical Health section on RiO progress notes to document the Behavioural and Functional Analysis and CVA risk. - Including timescales of assessments in staff inductions and training. - Staff education via clinical supervision, appraisals and MDT meetings to highlight importance of re-assessment of cognitive function for patients' prescribed antipsychotic medication. - Identifying and recording social needs using functional tools such as Bristol Activities of Daily Living, Face Overview Assessment. - Considering referrals to Occ. Therapy / Physiotherapy / Podiatry / Falls Clinic when identifying needs and deficits with living conditions and mobility. - Discussing possible psychosis in clinical meetings and adhering to NICE guidelines for management of psychosis for patients with dementia. - Reviewing after 3m and 6 m subsequently, per CQUIN requirements & Royal College of Psychiatry Guidelines on prescribing psychotropic medication.
42	Capacity and Consent Issues (ID 4666): May 2018	Mental capacity is an important issue regarding patients with mental health problems. This is relevant for the psychiatric patients who are admitted informally or under the Mental Health Act. This audit aimed to review whether mental capacity was recorded on RIO for admission and treatment purposes for patients who were admitted on Rose Ward, PPH. An action plan is being devised. A recommendation includes: • Capacity for treatment is documented in three different places which make it a challenge and time consuming to pull out specific aspects of care. The medical team aim to assess capacity for treatment and admission at the first patient review or at the MDT.
43	Audit of Physical Activities in patients with learning disabilities (ID 4166): February 2019	People with Learning Disability (PWLD) are at higher risk of developing mental illnesses and dying prematurely due to poor physical health. Reducing premature death and increasing the general well-being of PWLD is a national and organisational priority. This audit used an adaptation of IPAQ-SF, specifically designed and tested for PWLD, to quantify the level of physical activities in PWLD. • Raise awareness amongst healthcare professionals e.g. GPs, social workers, members of MDTs and carers/relatives about the current guidelines and recommended level of physical activities. This can be achieved by designing and distributing easy-read leaflets, running educational sessions and publishing papers in journals/mass media. • Develop the current audit tool (LDPAQ) in collaboration with our physio/OT colleagues to elaborate further on different vigorous activities in people with severe learning and physical disabilities. • Undertake further studies and surveys to explore the impact of different factors such as level of learning disabilities, mental and/or physical co-morbidities and presence or absence of capacity on preferred life style and level of physical activities. • Explore the possibility of using technology to measure the intensity of physical activities in a more objective way such as recoding the heart rate. • Seek advice and recommendation from a specialist about the recommended physical activity plan for complex individuals with mental and physical health co-morbidities.

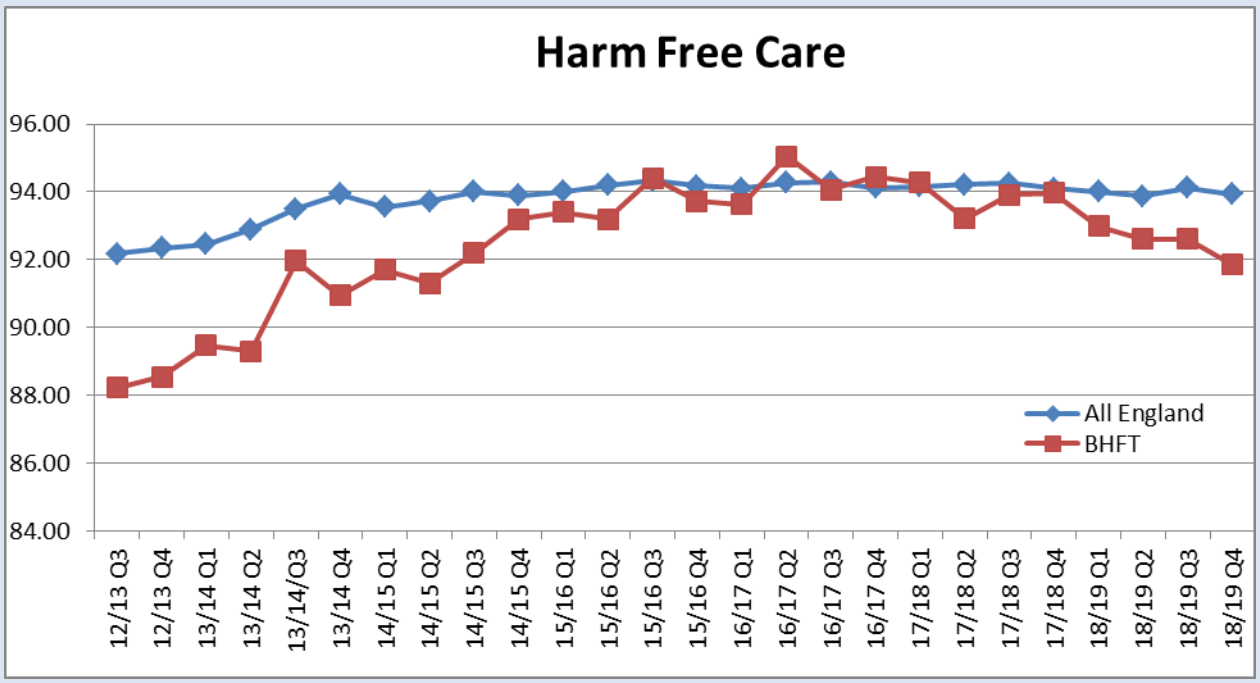
	Audit Title	Conclusion/Actions
44	Audit of use of Dementia Intervention Care Pathway in Learning Disability Services (ID 4471): January 2019	The aim of the project was to ascertain whether the Dementia Intervention Care Pathway tool or the information provided by this tool, has been used by health professionals to support PWLD who have a diagnosis of dementia. An action plan is in place and includes the following recommendations: 1. Audit findings to be fed back to the six community health teams/localities for PWLD within Berkshire. 2. The Intervention Care Pathway is to be more widely publicised within the service. 3. Health teams are to be supported to develop their Dementia Planning Meetings. 4. Liaison with the End of Life Care Pathway regarding resources and appropriate tools that may be available for use when considering Future Planning when someone has a diagnosis of dementia.
45	Waiting Time Standards for CBT Treatment in Berkshire Perinatal Community Mental Health Service (ID 4483): November 2018	This audit aimed to examine the compliance of the current service provided against Pathway 4 of the perinatal EBTP, i.e. the waiting time of women with a perinatal mental health problem who are referred for psychological interventions to our team and whether they start treatment within six weeks of referral. An action plan will be devised. Recommendations include: • To repeat this audit in 12 months' time to include a longer data collection period to identify if the results are replicated. The next audit should seek to identify reasons why clients may not be offered CBT treatment within the recommended 6 week window i.e. client not ready to engage. • To further identify reasons for clinician and client cancellation across both West and East Berkshire. To identify if this is a system or administrative error that can be resolved. • To continue to explore recovery rates through psychological tools and patient feedback. To have a larger, complete data set.
46	UNICEF Baby Friendly Initiative Annual Audit 2018 - Health Visiting Services (4531): September 2018	The UNICEF Baby Friendly Initiative aims to provide women and their families with evidence based, sound knowledge and advice to support them with their feeding choices for their baby and to promote a close and loving relationship with their child. To maintain its level 3 accreditation, the Trust has to submit annual audit figures based on staff knowledge and mothers feedback for both breastfeeding and bottle-feeding mothers to ensure that the four standards set by the Baby Friendly Initiative have been embedded into practice. To explore other ways of contact with mothers to address the issue of informing them about continued breastfeeding once they have returned to work. This could be via text messages or use of email, the inclusion of relevant information in the 'Introduction to family foods' session and the documenting of visit conversations in the Personal Child Health Record.
47	Clinical Audit of Electro-Convulsive Therapy (ECT) Outcomes: Using the Clinical Global Impression (CGI) and Hamilton Depression Scale (HAM-D) to evaluate ECT treatment (ID 4692): January 2019	Electro-convulsive therapy (ECT) is one way of treating depression, mania, schizophrenia and catatonia (NICE Guidelines, 2009). It is recommended to achieve rapid and short-term improvement of severe symptoms after inadequate trial of other treatment options has proven to be ineffective and/or the mental illness is considered to be potentially life threatening. The purpose of this project was to evaluate the ECT service provided by Prospect Park Hospital by studying who receives ECT treatment and looking at the ECT response rate. An action plan is being finalised. Recommendations: • Future audits may consider broadening the standard to include more stringent criteria for standards of patients who receive ECT treatment. • A separate audit to address the issue of increasing numbers of people having ECT and the poor post-ECT Efficacy Index rate. This could look at the quality of referrals for ECT and the appropriateness of those who receive treatment.
48	Audit of PGD use by Peer Vaccinators for the 2018 staff influenza vaccination campaign (ID: 4731): February 2019	The purpose of this audit was to examine the use of the influenza vaccination PGD (Patient Group Direction) used by peer vaccinators to administer the vaccine to Berkshire Healthcare staff and partner organisations staff working alongside Berkshire Healthcare staff, as part of the annual flu vaccination campaign. An action plan has been devised: 1. Update of PGD, including staff that are over 65 and the new egg free vaccine that will be available in 2019. 2. Quality issues identified with standards: 6, 8, 11, 13, 14 & 15 to be clarified and re-enforced at update training, prior to commencing the 2019 flu vaccination campaign. 3. Consent forms to continue to be returned to Peer Vaccinators for signing if returned unsigned. 4. Only the most up to date consent forms to be used, this will require re-iteration at training.

Appendix D Safety Thermometer Charts

ⓘ Developed for the NHS by the NHS as a point of care survey instrument, the NHS Safety Thermometer provides a 'temperature check' on harm, that can be used alongside other measures of harm to measure local and system progress in providing a care environment free of harm for our patients. It allows teams to measure harm and the proportion of patients that are 'harm free'

When interpreting the charts below, it should be noted that this Safety Thermometer data does not show the total number of each type of harm for the Trust, but only those that are recorded at a specific point in time each month.

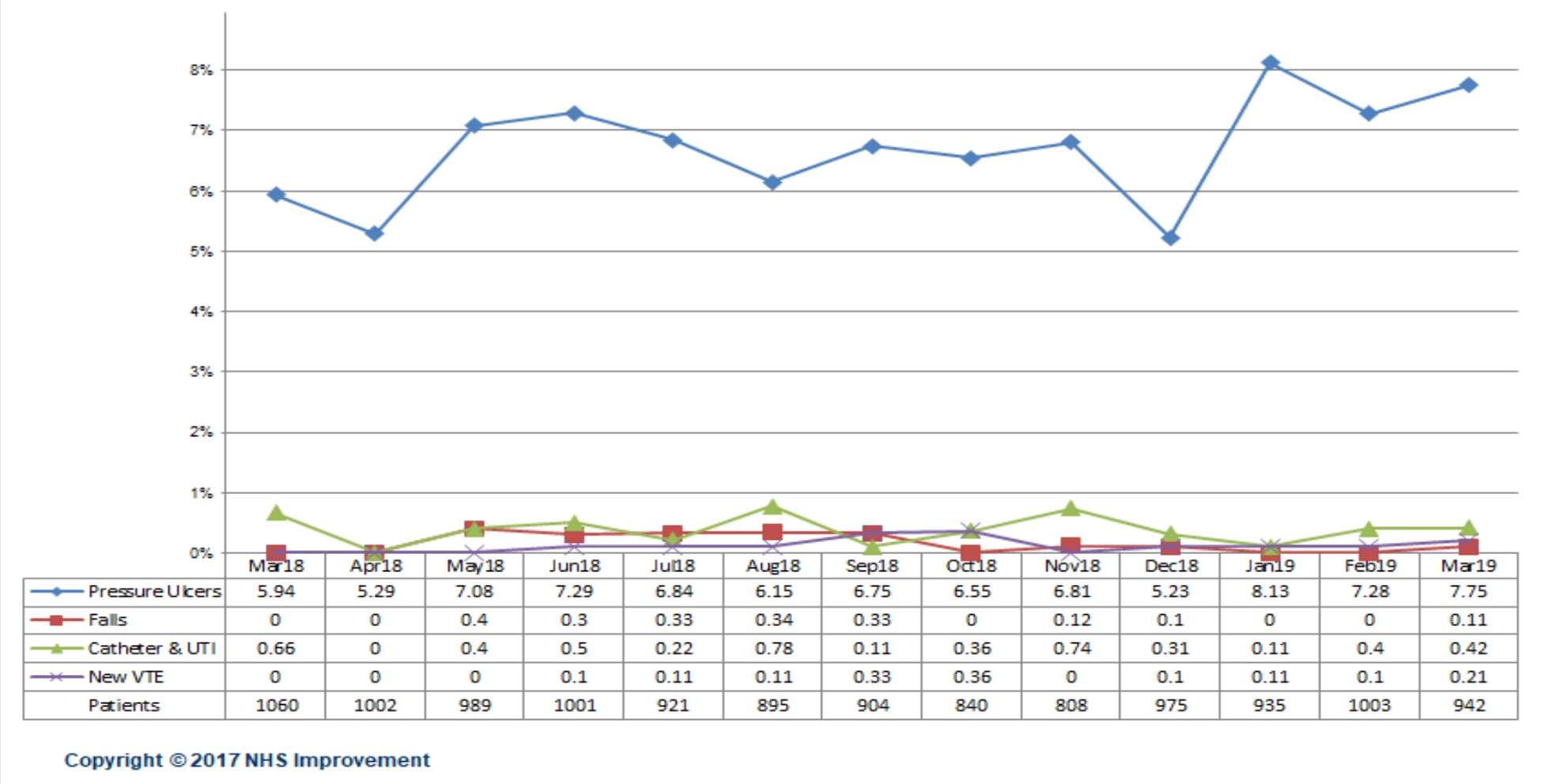
The percentage of Harm Free patients for all England in Q4 was 93.93%. The Harm Free care in Q4 for Berkshire Healthcare has dropped slightly to 91.86%. Old pressure ulcers and catheter with old UTIs, are harms which we must own despite being inherited to the Trust and therefore largely beyond our influence. In Q4 of 2018/19 these old harms made up 78.39% of our total harms.



Source: Trust Safety Thermometer Reports

Types of harm

The chart below splits the types of harms across the whole organisation. Pressure ulcers remain the highest harm based on safety thermometer data.



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
Pressure Ulcers	5.94	5.29	7.08	7.29	6.84	6.15	6.75	6.55	6.81	5.23	8.13	7.28	7.75
Falls	0	0	0.4	0.3	0.33	0.34	0.33	0	0.12	0.1	0	0	0.11
Catheter & UTI	0.66	0	0.4	0.5	0.22	0.78	0.11	0.36	0.74	0.31	0.11	0.4	0.42
New VTE	0	0	0	0.1	0.11	0.11	0.33	0.36	0	0.1	0.11	0.1	0.21
Patients	1060	1002	989	1001	921	895	904	840	808	975	935	1003	942

Source- Safety Thermometer
UTI= Urinary Tract Infection VTE = venous thromboembolism

Appendix E CQUIN 2018/19

Please note that that this is part of a 2 year contract that started in 2017/18.

CQUIN Number	CQUIN Indicator Name
CQUIN 1a	Improvement of health and wellbeing of NHS staff
CQUIN 1b	Healthy food for NHS staff, visitors and patients
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Cardio metabolic assessment and treatment for patients with psychoses
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with Severe Mental Illness: Collaborating with primary care clinicians
CQUIN 4	Improving services for people with mental health needs who present to A&E
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)
CQUIN 9a	Tobacco screening
CQUIN 9b	Tobacco brief advice
CQUIN 9c	Tobacco referral and medication offer
CQUIN 9d	Alcohol screening
CQUIN 9e	Alcohol brief advice or referral
CQUIN 10	Improving the assessment of wounds
CQUIN 11	Personalised Care and Support Planning

Appendix F- CQUIN 2019-2020

Please note that at the time of writing specific milestones and values have yet to be agreed

CQUIN Indicator Name
Staff Flu Vaccinations – All Staff
Alcohol and Tobacco – Mental Health Services and Community Health Services
72 Hours follow up following Discharge – Mental Health Services
Use of Anxiety Disorder Specific Measurements in IAPT
CCG5 MHSDS Data Quality

Appendix G- Statements from Stakeholders

Berkshire Healthcare NHS Foundation Trust – Quality Account 2018/19
Response from Council of Governors of the Trust

These comments are based on the Quality Account for the third quarter circulated to the 32 members of the Council of Governors for the Trust on the 6th March 2019. This summary is prepared by the Lead Governor, Paul Myerscough.

This report provides a good account of the Trust. The information is clearly expressed and with much of interest for all readers. The Governors feel that the results shown in the report reflect the actual performance of the Trust.

Governors are interested in trends which show year on year improvement in Trust performance. Whole year figures were not available at the time of the review. We were pleased however to see the many improvement initiatives described in section 2.1 and look forwards to seeing the evidence that new processes are effective as planned and the benefit is being felt at the frontline.

Governors continue to be concerned about the well-being of staff and the level of vacancies in some parts of the service. We are pleased that management efforts are producing results in many areas and we look forward to seeing the results from the latest staff survey which was not available at review time.

We are happy that management keeps governors up-to-date on the rare occasions when service quality concerns are raised. Governors are free to question the executive in Governor Council meetings some of which are also open to the public.

There is general scepticism among governors about the nationally mandated measure known as the 'Friends and Family Test'. We would prefer that the effort expended on the collection and collating of this data is more focused on areas of particular concern to patients and staff, where it could lead to a measurable improvement in the services delivered.

All governors were given the opportunity to comment. There were a number of requests for clarification of figures. Some concerns were expressed on understanding the significance of the statistics when throughput figures (number of patients seen in a service) are generally not available. All feedback is passed on to the team responsible for the report.

We recognise the dichotomy between a desired culture of reporting faults and problems and consequential learning and a 'blame and shame' culture which leads to suppression of information. We feel that Berkshire Healthcare have promoted a learning culture through encouraging staff to record incidents and problems in the 'Datix' system which provides useful input to Quality Improvement initiatives throughout the Trust.

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response from the Council of Governors to its 2018/19 Quality Account.

We thank Governors for the comments made in relation to the content of the report and are pleased that it is both clear and of interest. We also wish to convey our thanks to those that have taken time to help contribute to the document throughout the year.

In relation to the Friends and Family Test (FFT), we are mandated to participate in this survey and endeavour to achieve a 15% response rate. We are also working to revise our patient experience measure and will ensure that the FFT is considered with this to avoid duplication for staff.

Responses to individual queries have been included in a separate document and sent to the Chair of the Council of Governors. We look forward to working with our Council of Governors in the future.

Commissioners Response – BHFT Quality Account 2018/19

This statement has been prepared on behalf of East Berkshire CCG and Berkshire West CCG.

The Clinical Commissioning Groups (CCGs) are providing a response to the Quality Account for Quarter 3 2018/19 submitted by Berkshire Healthcare Foundation Trust (BHFT).

The Quality Account provides information and a review of the performance of the Trust against quality improvement priorities set for 2018/19 and gives an overview of the quality of care provided by the Trust during this period. The priorities for 2019/20 are also detailed in the report.
The CCGs are committed to working with the Trust to achieve further improvements and successes in the areas identified within this Quality Account.

The Trust's Quality Priorities highlighted in the 2018/19 Quality Account were Care Quality Commission (CQC) Rating; Clinical Effectiveness; Patient Experience; Patient Safety and Organisational Culture.

Care Quality Commission (CQC) Rating

The CCGs were very pleased to receive the news that the Trust maintained an overall rating of Good at the CQC inspection in June and July 2018 with the report being published in October 2018. The CCGs wish to express their congratulations to the Trust for achieving a rating of Outstanding in the Well-Led domain.
There were examples of outstanding practice in the core service inspections for; Wards for older people with mental health problems; Acute wards for adults of working age and psychiatric intensive care units; Mental health crisis services and health based places of safety and wards for people with a learning disability or autism; Urgent care and community health services for adults.
It is also very positive to see that all of the services have now received a minimum rating of Good and no areas were identified as Requiring Improvement.

Clinical Effectiveness

It is reassuring to see that the Trust has participated in all applicable national clinical audits and that improvements have been implemented from the action plans that were identified.
The CCGs are also satisfied that the Trust review NICE guidance and provide the standard of care that is line with the national standard.

Patient Experience

The Trust continues to encourage patient and carer feedback either through the Friends and Family Test, Carers Friends and Family Test and the Trust's patient satisfaction survey. Whilst the response rate is lower than both the CCGs and the Trust would like to see, there are positive results for Community Health Services with regards to the recommended rate from patients and from carers. This remains above the 95% target. The CCGs acknowledge that there is further work to be completed within the Mental Health Services to improve this.
It is disappointing to see that the Trust did not achieve the 90% reduction in the use of prone restraint but recognise the hard work that the Trust has already done and acknowledge the work that will need to be implemented in order to achieve a reduction in 2019/20. Though this is not identified in the 2019/20 priorities the CCGs will continue to monitor progress. However from the Quality Account, the CCGs can see that there are occasions when prone restraint is used because this is the choice of the patient and that other patients have been turned very quickly when it has been necessary to restrain them prone. The CCGs would like to see the instances of prone restraint used on the dementia older adult ward are as a result of necessity rather than a lack of staff training.
The Trust did not achieve the target of reducing mental health delayed transfer of care by over 2%. The commissioners can see the effort that has been put in by the staff to bring this down and can see that the Trust are not far from being able to achieve this going forward.

Patient Safety

It is very promising to see the reduction in the self-harm incidents that are being reported by the Trust and should be commended on the work that has taken place in order to achieve this.

The CCGs would like to commend BHFT on continuing to stay below the rate of 8 falls per 1000 bed days on their Community Hospital inpatient wards and although the rate has not been achieved for those patients on the older people's mental health wards, there has been a significant reduction in the rate when compared with Q1 and Q2.
A key target to reduce is the inappropriate out of area acute mental health placements and the CCGs are reassured that the Trust has met the target for the year meaning that fewer patients are being treated away from home and reducing the amount of bed days spent away from home.
The CCGs would like to acknowledge the dedication from the staff that has been involved in all of the Quality Improvement (QI) projects and whilst we recognise that further work is required to complete the objectives set out in the 2018/19 Quality Account, the QI projects have had a very powerful impact on many other areas across the Trust.

Organisational Culture
The CCGs look forward to seeing the result of the National Staff Survey, expected in Q4.
The commissioners were very pleased to see the Trust has successfully achieved the target of having less than 10% of vacancies and have been maintaining around 9% each month throughout 2018/19. The work that is being implemented is very encouraging to see and hope that the vacancy rate continues to improve.
The Trust did not meet the target for reducing the number of physical assaults against staff. The CCGs can see the work that is being done in order to ensure that this target can be reached but recognise that this is can be a very challenging target to achieve.

The Quality Account does highlight a number of other service improvements that have been undertaken in 2018/19 and that this will be continued in 2019/20.

Priorities for 2019/20
The Trust has set out the priorities for 2019/20 which are as follows:

- Patient Safety
- Clinical Effectiveness
- Patient Experience
- Organisational Culture
- Monitoring of Priorities for Improvement

The Commissioners would like to continue to be informed of any new quality concerns being identified during 2019/20 for the opportunity to support the Trust with these. The Commissioners would like to continue to work with the Trust on service redesign to improve patient outcomes.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:

The Trust welcomes this response to its 2018/19 Quality Account, prepared on behalf of East Berkshire and Berkshire West CCGs

The Trust welcomes the CCGs support of its 2019/20 priorities and is grateful for the comments made in relation to our achievement in 2018/19.

In relation to use of prone restraint on older adult mental health wards, staff on these wards have been trained in new techniques but are using them less frequently as these wards generally have fewer restraints as a whole meaning they have less opportunity to practice them. A plan is in place to address this.

We look forward to continuing to work with you to achieve further improvements and successes in the areas identified within the Quality Account, and keeping you informed of progress.

16 April 2019

West Berkshire COUNCIL

Jason Hibbitt
Clinical Effectiveness Facilitator- NICE
Clinical Audit Department,
Berkshire Healthcare NHS Foundation Trust

Adult Social Care (Communities)
West Berkshire Council
West Street House, West Street,
Newbury, Berkshire RG14 1BZ

Please ask for: Tandra Forster
Direct Line: (01635) 519736
e-mail:
tandra.forster@westberks.gov.uk

Dear Jason,

Berkshire Healthcare Foundation Trust Quality Account : West Berkshire Health and Wellbeing Board Response

Thank you for sharing the Quality Account with the West Berkshire Health Wellbeing Board and inviting comment. The Board acknowledge the broad range of priority indicators and welcome particularly the patient focus, with a clear commitment to improve service quality and safety for patients across Berkshire. Whilst the performance reporting relates to quarter 3 it is notable that the targets for a number of areas have already been met which is an indication of strong performance. However, there are number of areas where we would welcome reassurance:

- Patient safety – it is disappointing that the target to reduce falls for patients on the Older Peoples Mental wards has not been met. Whilst we appreciate that these patients will have more complex needs we would urge you to do everything possible to address this.
- Mental Health Delayed Transfers of Care – again we recognise the complexity of working with mental health patients, particularly the challenge to find appropriate ongoing support where it is required. However, we also feel that there is more that could be done to start planning discharge at an earlier point and would welcome closer working to enable this.
- Friends and Family Test – whilst the overall feedback was very positive it is notable that this is not the case for mental health in-patients and that the position has worsened compared to 2017/18. The Board feels that this needs closer attention and engagement with families so that it is clearer what actions are required to address it.

We support the priorities for 19/20 and note in particular your commitment to working with partners across the system. We feel that there are many opportunities to continue this and in particular would welcome greater progress on joint working around recruitment and retention given our shared challenge.

Yours sincerely

Tandra Forster

Tandra Forster
Acting Corporate Director (Adult Social Care)

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust Response:
The Trust welcomes this response from West Berkshire Health and Wellbeing Board to its 2018/19 Quality Account.

The Trust welcomes the Wellbeing Board's support of its 2019/20 priorities and is grateful for the comments made in relation to our patient focus and commitment to improve quality and safety.

In relation to falls, the Trust acknowledges that we have not met our target in relation to our older peoples' Mental Health Inpatient wards. As a result, the reduction of falls will again be a priority for us during 2019/20.

In relation to delayed transfers of care, a Post Admission Review (PAR) is now in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date (IDD). This is monitored at the daily bed management team so that plans are checked and any concerns escalated. The trust will continue to monitor this area.

In relation to the Friends and Family Test, the Trust acknowledges the lower satisfaction rate achieved for mental health inpatients. The satisfaction level reported for this group has historically been lower than for other groups, and is also based on smaller numbers of respondents. The trust is committed to ensuring its patients have the best possible experience of the care we provide and will strive to improve this satisfaction rating where possible.

We look forward to continuing to work with you to achieve system-wide improvements and successes during the following year.

Appendix H

Independent auditor's report to the council of governors of Berkshire Healthcare NHS Foundation Trust on the quality report

We have been engaged by the council of governors of Berkshire Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Berkshire Healthcare NHS Foundation Trust's quality report for the year ended 31 March 2019 (the 'quality report') and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Berkshire Healthcare NHS Foundation Trust as a body, to assist the council of governors in reporting Berkshire Healthcare NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Berkshire Healthcare NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter
The indicators for the year ended 31 March 2019 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- Early intervention in psychosis, and
- Inappropriate out-of-area placements for adult mental health services

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors
The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2018/19 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and the six dimensions of data quality set out in the 'Detailed guidance for external assurance on quality reports'.

We read the quality report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2018 to the date of signing of the limited assurance opinion;
- papers relating to quality reported to the board over the period April 2018 to the date of signing of the limited assurance opinion;
- feedback from Commissioners, dated April 2019;
- feedback from governors, dated April 2019;
- feedback from local Health watch organisations, dated April 2019;
- feedback from Overview and Scrutiny Committee, dated April 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2019;
- the latest national patient survey, dated November 2018;
- the latest national staff survey, dated March 2019;

- Care Quality Commission inspection report, dated October 2018; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual' to the categories reported in the quality report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the quality report is not prepared in all material respects in line with the criteria set out in the 'NHS foundation trust annual reporting manual' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in section 2.1 of the NHS Improvement 2018/19 Detailed guidance for external assurance on quality reports; and
- the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual' and supporting guidance.

Deloitte LLP

Deloitte LLP
St Albans
23 May 2019

Glossary of acronyms used in this report

Acronym	Full Name
ADHD	Attention Deficit/ Hyperactivity Disorder
AMS	Anti-Microbial Stewardship
AWOL	Absent Without Leave
BAME	Black Asian and Minority Ethnic
BHFT	Berkshire Healthcare NHS Foundation Trust
BMI	Body Mass Index
BOB STP	Buckinghamshire, Oxfordshire and Berkshire Strategic Transformation Partnership
CAMHS	Child and Adolescent Mental Health Service
CARRS	Community Cardiac and Respiratory Specialist Service
CCG	Clinical Commissioning Group
CCQI	College Centre for Quality Improvement
CD	Controlled Drug
CDS	Commissioning Data Set
CDiff	Clostridium Difficile
CHST	Care Home Support Team
CMHT	Community Mental Health Team
CNN	Community Nursery Nurse
COPD	Chronic Obstructive Pulmonary Disease
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRHTT	Crisis Resolution and Home Treatment Team
CTPLD	Community Team for People with Learning Disabilities
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
CYPMHS	Children and Young People's Mental Health Services
DBT	Dialectical Behavioural Therapy
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DOC	Duty of Candour
DQMI	Data Quality Maturity Index
DTC	Drugs and Therapeutics Committee
ECG	Electrocardiogram
ECT	Electroconvulsive Therapy
ED	Emergency Department
EIP	Early Intervention in Psychosis
EIPN	Early Intervention in Psychosis Network
EPMA	Electronic Prescribing and Medicines Administration
EUPD	Emotionally Unstable Personality Disorder
FFFAP	Falls and Fragility Fractures Audit Programme

Acronym	Full Name
FFT	Friends and Family Test
FHNA	Family Health Needs Assessment
FTE	Full Time Equivalent
GDE	Global Digital Exemplar
HCA	Healthcare Assistant
HQIP	Healthcare Quality Improvement Partnership
HR	Human Resources
HV	Health Visitor
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
IBS	Irritable Bowel Syndrome
ICHS	Integrated Care Home Service
ICS	Integrated Care System
IDDSI	International Dysphagia Diet Standardisation Initiative
IM	Intramuscular
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPCT	Infection Prevention and Control Committee
IPASS	Integrated Pain and Spinal Service
IPS	Individual Placement and support (Employment Service)
IST	Intensive Support Team
KF	Key Finding
LCLD	Low Calorie Liquid Diet
LCS	Lean Competency System
LD	Learning Disability
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse In Care
LoS	Length of Stay
LTC	Long Term Conditions
MBT	Mentalization-Based Treatment
MDT	Multi-Disciplinary Team
MDfT	Multi-Disciplinary Footcare Team
MDR	Multi-Disciplinary Round
MH	Mental Health
MHA	Mental Health Act
MHSDS	Mental Health Service Data Set
MIR	Making it Right
MIU	Minor Injuries Unit
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSG	Medication Safety Group
MSK	Musculoskeletal
MTI	Medical Training Initiative
NACAD	National Asthma and COPD Audit Programme
NAS	National Audit of Schizophrenia
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme

Acronym	Full Name
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NEWS	National Early Warning Score
NHSI	NHS Improvement
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NPSA	National Patient Safety Alert
NRLS	National Reporting and Learning System
NSF LTNC	National Service Framework on Long Term Neurological Conditions
OAHSN	Oxford Academic Health Science Network
OAP	Out of Area Placement
OPMH	Older Peoples Mental Health
PAF	Performance Assurance Framework
PDSA	Plan, Do, Study, Act (A Quality Improvement methodology)
PGD	Practice Group Direction
PHM	Public Health Model
PICC	Peripherally Inserted Central Catheter
PICT	Psychologically Informed Consultation and Training
PICU	Psychiatric Intensive Care Unit
PID	Performance in Initiating and Delivering
PMLD	Profound and Multiple Learning Disability
PMS	Psychological Medicine Service
PMVA	Prevention Management of Violence and Aggression
PN	Partner Notification
POMH	Prescribing Observatory for Mental Health
PPH	Prospect Park Hospital
PSAG	Patient Status at a Glance
PTSD	Post-Traumatic Stress Disorder
QEG	Quality Executive Group
QI	Quality Improvement
QMIS	Quality Management and Improvement System
R&D	Research and Development
RBH	Royal Berkshire Hospital
RIE	Rapid Improvement Event
RiO	Not an acronym- the name of the Trust patient record system
RTT	Referral to Treatment Time
RQ	Rolling Quarters
RRAT	Rapid Response and Treatment Team
SHARON	Support Hope & Recovery Online Network
SI	Serious Incident
SJR	Structured Judgement Review
SLT	Speech and Language Therapy
SMART	Specific, Measurable, Achievable, Relevant, Time-Bound (in relation to objectives and actions)
SMI	Severe Mental Illness

Acronym	Full Name
SOP	Standard Operating Procedure
STP	Strategic Transformation Partnership
SUS	Secondary Users Service
TCBT	Transdiagnostic Cognitive Behavioural Therapy
TV111	Thames Valley 111 Clinical Advisory Service
UTI	Urinary Tract Infection
VFC	Virtual Fracture Clinic
VTE	Venous Thromboembolism
WAM	Windsor Ascot and Maidenhead
WBCH	West Berkshire Community Hospital
WPH	Wexham Park Hospital
WRES	Workforce Race Equality Standard

Berkshire Healthcare NHS Foundation Trust

Annual accounts for the year ended 31 March 2019

Foreword to the accounts

Berkshire Healthcare NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Berkshire Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

Signed .....

Name	**Julian Emms**
Job title	**Chief Executive**
Date	**22 May 2019**

NHS
Berkshire Healthcare
NHS Foundation Trust

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the Accounting Officer of Berkshire Healthcare NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

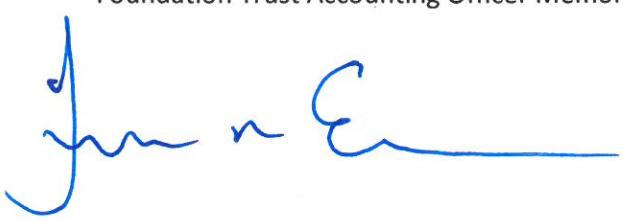
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Berkshire Healthcare NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Berkshire Healthcare NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Julian Emms
Chief Executive

Date: 22nd May 2019

Berkshire Healthcare
NHS Foundation Trust

Berkshire Healthcare NHS Foundation Trust 2018-19 Annual Governance Statement

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of Berkshire Healthcare NHS Foundation Trust,

- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Berkshire Healthcare NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The existing comprehensive Risk Management Strategy has been reviewed and approved by the Executive and the Board. It has been disseminated through the Trust. The Chief Financial Officer and Director of Nursing and Governance provide overall leadership for integrated governance at Board level. The Medical Director is the Caldecott Guardian. The Chief Financial Officer is the Senior Information Risk Owner.

The Chief Executive chairs the Executive Finance, Performance and Risk (FPR) Committee which has oversight of the Board Assurance Framework (BAF) and Corporate Risk Register (CRR). The FPR Executive Committee comprises the Chief Financial Officer in their role as Chair of the Non-Clinical Risk Management Committee, the Director of Nursing and Governance in their role as Chair of the Safety, Experience and Clinical Effectiveness Group together with the rest of the Executive Directors and senior management representatives. The Committee meets monthly and reviews the Board Assurance Framework and entire Corporate Risk Register as standing items quarterly.

The Executive routinely oversees the effectiveness of all other Committees within the governance structure through the receipt of minutes and reports via each of the three Formal Executive Committees (Finance, Performance and Risk, Quality and Business and Strategy).

The Trust operates in a complex environment with many services dispersed around the county. Each service has its own Risk Register regularly reviewed through line management arrangements. The Trust's Operational Leadership Team (chaired by Chief Operating Officer) has responsibility for ensuring that all locality Risk Registers are up to date and show a true reflection of the risks that may face that service. Directors leading corporate services have the responsibility for ensuring similar Risk Registers are in place for support services. Escalation of appropriate local service level risks to the Corporate Risk Register is undertaken if necessary following review by the relevant Executive Director.

Risk Management training is part of the corporate induction for all new staff. In addition, all existing staff are required to undertake all mandatory training in the year, to comply with the Care Quality Commission Essential Standards of Care; this training includes Fire, Lifting and Handling and Health and Safety. Clinical staff undertake additional clinical mandatory training, which includes an update on clinical risk management.

All Policies and Procedures are published on the Trust intranet and are available to all staff. Relevant Policies include, for example, Serious Untoward Incidents, Health and Safety, Infection Control, Information Governance and Freedom to Speak Up (Whistle Blowing) policy.

The Trust Audit Committee as the senior Board Sub Committee responsible for corporate governance assurance continues to review risk reporting and risk management and has done so during 2018-19. The Audit Committee continues to seek best practice guidance with which to inform it. The Audit Committee further tests the resilience of risk mitigation activity by conducting 'deep dive' reviews of individual risks through the year.

The risk and control framework

The Trust's Risk Strategy seeks to minimise risk to the Trust's stakeholders through a comprehensive system of internal controls, risk management and assurance processes, whilst maximising the potential for flexibility, innovation and best practice in the delivery of its strategic objectives. It seeks to deliver high quality, safe services for service users and secure the health, safety and welfare at work of all employees and others on the Trust premises.

The Trust uses a standardised risk assessment tool that enables risks to be graded and scored. The tool requires the individual reporting the risk to determine the risk level at the time of detection and to forecast the risk level that will be achieved following implementation of a risk mitigation plan. The risks to delivery of corporate objectives on the Board Assurance Framework and relevant risks on Corporate Risk Register have been reviewed in detail by the Board and Audit Committee during the year, with a new format Board Assurance Framework produced enhancing the oversight and review of risks for Board and Executive committees. The Board Assurance Framework risks are now routinely reviewed at Board sub-committees (quality and finance), alongside quarterly review at the Audit Committee.

The Trust recognises that it is not possible or always desirable to eliminate all risks and that systems should not stifle innovation. When all reasonable control mechanisms have been put in place some residual risk will inevitably remain in many Trust processes and this level of risk must be accepted. Risk acceptance within the Trust is systematic, explicit and transparent. Where residual risk remains

the risk will remain on the Board Assurance Framework, Corporate Risk Register or local risk register. This ensures that it is reviewed through the control systems rather than having been removed from the register and therefore out of sight.

The Safety, Experience and Clinical Effectiveness Group chaired by the Executive Director of Nursing and Governance provides service reporting oversight for quality governance arrangements within the Trust's clinical services. The Group reports to the Quality Executive Committee, chaired by the Chief Executive. The Quality Executive Committee is the lead Executive committee for assuring the quality and safety of services, through to the Board Quality Assurance Committee and the Audit Committee, with the Audit Committee providing overall governance assurance and scrutiny.

Routine assurance of compliance with Care Quality Commission registration requirements and fundamental standards of care is undertaken by the Locality Patient Safety and Quality Groups. Clinical services review their compliance with Care Quality Commission standards annually with assurance provided to the Executive (through receipt of reports at the Quality Executive Committee) and Board (through the work of the Quality Assurance Committee) of the quality of care and compliance with regulations. Where recommendations for improvement arise from the internal inspections, service level action plans are developed and followed up to ensure continuous improvement.

The Trust was subject to a Comprehensive Inspection by the Care Quality Commission in June 2018 which resulted in a "Good" overall rating for the organisation and its services. The Trust achieved "Good" ratings across inspection domains for Safety, Effectiveness, Caring and Responsiveness. The Trust was rated 'Outstanding' in the Well Led domain confirming the leadership and governance arrangements within the Trust are of a high quality and robust.

Performance information related to quality and patient safety metrics are reviewed and cross referenced with other intelligence available to the governance team prior to inclusion in Trust performance and quality reporting. The metrics are regularly reviewed with the governance and performance team. Governance of data quality in relation to quality metrics is overseen by the Audit Committee through review of the Trust's Information Assurance Framework.

The Trust completed the Data Security and Protection Toolkit supported by over 95% of staff completing annual information governance training.

Ultimate responsibility for Information Security rests with the Chief Executive of the Trust. This responsibility is delegated to the Chief Financial Officer as Senior Information Risk Owner (SIRO). Responsibility is further delegated to all staff developing, introducing, managing and using information and information technology systems through the medium of the Information Governance policy including adherence to the new General Data Protection Regulations (GDPR) introduced in May 2018.

The Trust IT Compliance and Audit Manager is responsible for the co-ordination of all aspects of computer security and for ensuring that the Trust's Information Governance Policy and practice is consistent with those defined and published by the NHS.

Service managers are responsible for the protection of all information and information technology assets within their department.

Line Managers are responsible for ensuring that their permanent and temporary staff and contractors are aware of the following:

- The information security policies applicable in their work areas.
- Their personal responsibilities for information security.
- How to access advice on information security matters.

All staff must comply with Information Governance security procedures including the maintenance of data confidentiality and data integrity. Failure to do so may result in disciplinary action. The Information Security Policy is maintained, reviewed and updated by the Trust. This review takes place annually.

Contracts with external contractors that allow access to the Trust's information systems must always be in operation before access is allowed. These contracts will ensure that the staff or sub-contractors of the external organisation will comply with all appropriate security and confidentiality policies.

The Trust is ever conscious of the cyber security risk, and it remains on the corporate risk register to ensure appropriate on-going risk oversight and delivery of enhanced software mitigating actions to protect the Trust from future cyber-attacks. The Trust is performing strongly against NHS Improvement's cyber security standards, and the Executive Committee, Audit Committee and Board receive regular updates on risks and mitigations in this area.

The Board Assurance Framework contains the following key business and operating risks (in year and future):

Key Risk	How they are managed / mitigated
Failure to recruit, retain and develop the right people in the right roles at the right time and at the right cost could impact on our ability to meet our commitment to providing safe, compassionate, high quality care and a good patient experience for our service users	• A comprehensive workforce development strategy with targeted actions has been agreed by the Board to mitigate this risk as far as possible, however workforce availability is a severe risk to the NHS not just the Trust, and is likely to take years to resolve. • Strong focus on retention and recruitment to specific service and staffing group risks including inpatient newly qualified nurses across community and mental health service lines, and community nursing.
Failure to achieve national efficiency benchmarks could impact on the Trust's future sustainability and lead to increased regulatory scrutiny	• Continuous review of efficiency opportunities using NHS Improvement and other benchmarking data. • Moving to longer term planning of efficiency supported by Lord Carter review of unwarranted variation in mental health and community services.
Failure of the Sustainability and Transformation Plans to deliver transformational change and required investment in mandated national priorities, including in the mental health five year	• As mitigating action, the Trust is working closely with health and care partners to influence and design transformation plans and system wide

Key Risk	How they are managed / mitigated
forward view, could result in the local health economy not being able to safely keep pace with the rising costs and demand for services.	governance within the two Sustainability and Transformation Partnerships that cover the Trust's service and population footprint i.e. the Frimley STP and Berkshire West Integrated Care System (part of the Buckinghamshire, Oxfordshire and Berkshire West STP). • Both the Frimley STP and the Berkshire West Integrated Care System (ICS) are part of the first cohort of eight integrated care systems being provided with funding, support and oversight to develop system transformation plans on behalf of their populations.
That other providers may acquire the Trust's Adult and Children's Community Services which would impact organisational sustainability and reduce the Trust's scope to develop new models of out of hospital care	• Robust Business Development and horizon scanning process in place • Decision making tool in place to assess tender opportunities – revised to align with prioritisation process established as part of our Quality Improvement Programme • Regular meetings with Commissioners • Participation in Clinical Networks • Member of the Buckinghamshire, Oxfordshire and Berkshire West and Frimley Health and Care STPs/ICS • Member of the Integrated Care System agreed work streams • Member of the Academic Health Science Network • Trust Board Vision Metrics
Failure to develop collaborative working relationships with key strategic partners could result in the Trust losing influence in key decisions leading to less effective services for local people	• Linked to the system transformation/STP risk above the Trust is formalising existing strong collaborative partnership relationships by influencing developing system leadership governance. • The Chief Executive and individual Executive Directors are key members of the Berkshire West ICS leadership group and management teams. • The Chief Executive is a member of the Frimley ICS Board and chairs the ICS programme delivery board. • Local authority partners are engaged through system leadership or

Key Risk	How they are managed / mitigated
	partnership governance in each STP/ICS area.
Failure of other Providers and Commissioners to deliver their services to the required standard due to financial constraints could impact on the Trust's ability to deliver high quality services	• Regular meetings with Commissioners • Integrated care system oversight of impacts and system response to mitigate risk • Trust involvement in the development of the STPs • Learning Disability Transformation Steering Group • Activity reporting and waiting time reports • Daily monitoring of Delayed Transfers of Care • Protocols in Practice (PIP) meeting with Police and Partners • Governance arrangements in place with partner organisations (e.g. A&E delivery and Children's boards etc) • Monitoring at Executive meetings and follow up actions with partners
That demand for community and mental health services outstripping supply as a result of: • demographic changes leading to increased patient need • scarcity of some professional groups • constrained commissioner, partner and/or Trust resources • rising public expectation regarding provision of NHS Services and waiting times This is a particular risk for inpatient, community nursing and Child and Adolescent Mental Health services currently.	• Systems and process are in place to identify potential areas of risk and escalate specific needs to Executive Directors for resolution. • Localities monitor service performance and coordinate resource of resources across boundaries to cover shortfalls • Monitoring and reporting activity occurs at monthly contract meeting. • Mobile working programmes have enabled teams to increase productivity and implement skill mix opportunities to maintain quality. • "Heat Map" to identify the most pressured services is discussed at Operational Leadership Team meetings. • Triaging system in place for patients on waiting lists • Deep dives, Quality Improvement Programme Reviews and Business Cases to address pressures • Operational Management and action plans

The above Board Assurance Framework risks can also be deemed to be "principal" risks to maintaining the NHS Foundation Trust licence condition 4 (FT governance). Further risk control and mitigation assurance is described throughout this Annual Governance Statement in terms of the

governance structures and processes (Board and Executive and local level) that the Trust operates to minimise risk against this operating licence condition.

The Trust prepared through 2018-19 for the potential impact of the United Kingdom's exit from the European Union, including planning for the scenario of a 'no deal' European Union Exit, following recommendations in the Department of Health and Social Care's European Union Exit Operational Guidance. The NHS's overall approach includes planning and contingency measures being taken centrally, as well as actions that are the responsibility of individual providers. The Trust raised a time-limited corporate risk up to the point of NHS national and regional preparedness action being put on hold following the European Union granting the government an extension to European Unit exit decisions to be made by October 2019.

In terms of governance, the Chief Financial Officer has been the Trust's European Union Exit Senior Responsible Officer, reporting to the Finance, Performance and Risk committee on a regular basis, with board committees considering issues as relevant through the year. The Trust's Corporate Risk Register includes a risk in respect of the United Kingdom's Exit from the European Union, which has been monitored through the year by the Audit Committee.

Risk management is embedded in the organisation through for example a locality represented environment, health and safety committee reporting into the Executive non-clinical risk committee. Local risk registers are directly managed at business unit and service level with local risks and mitigation overseen by and reported up through the Operational and Senior Leadership Teams for escalation through to an Executive Director and the Board Assurance Framework/Corporate Risk Register. Local risk registers are used as a key business planning tool supporting service delivery.

Incident reporting enables the Trust to understand and manage risks associated with patients and staff. Incidents, investigation outcomes and trends are reviewed and discussed at business unit and service level and reported to the Quality Executive Committee with Board level scrutiny undertaken by the Finance, Audit and Quality Assurance Committees. Reporting trends are monitored to ensure all services in the Trust are reporting and if concerns are raised staff are reminded of their responsibility to report. As learning outcomes are shared across the organisation staff can see the value of reporting and the resulting change.

As a Foundation Trust the Board of Directors is accountable to the Council of Governors. The Trust's Council comprises a mix of appointed and publicly elected Governors. The Board provides the Council with information on key strategic risks and performance at each Council meeting. In addition the Trust reports all Serious Incidents to the Commissioners as part of the contractual arrangements and works with Local Authority Health Overview and Scrutiny Committees and Health and Wellbeing Boards to address issues raised by the public and/or local councillors.

The Trust has mechanisms in place to assure the Trust Board that workforce issues are a focus and priority, and ensure that we respond to the recommendations made in NHS Improvement's 'Developing Workforce Safeguards' publication.

Each month key workforce data including turnover, vacancies, sickness, appraisals and training are reported to the Executive Finance, Risk and Performance committee and the reports from this meeting are reviewed at the Finance, Investment and Performance sub-committee of the Board.

Alongside these workforce metrics, the committees also review the monthly Safe Staffing report, which includes a declaration from the Director of Nursing and Governance. Our staffing levels are reviewed and any changes to staffing and skill-mix are supported by a Quality Impact Assessment.

An Incident reporting system is used to report risks from reduced staffing and processes are in place to support escalation and actions to mitigate risk.

Biannually a detailed report is submitted to the Trust Board covering all six elements of the Workforce Strategy. The Director of Corporate Affairs Director and Director of People attend the Board to present the report and take any questions, feedback and respond to concerns. The Workforce Strategy covers all aspects of the workforce and the report explains what we are doing today to resolve current issues, and what the plans are for managing longer term issues and those priority areas identified in the NHS Long term Plan.

Every six months a detailed safe staffing report is presented to the Quality Executive Committee and the Board, this report details use of evidence-based tools (where they exist), professional judgement, outcomes alongside other staff and workforce data to provide a triangulated view of safe staffing.

The Board Assurance Framework captures the risks associated with the workforce and currently identifies the recruitment and retention of the workforce as a key priority. This risk is discussed at the monthly Strategic Workforce Steering Group, attended by Divisional Directors and some Service Leads. The risks are discussed, and mitigations are agreed and reported back to the main Trust Board.

If a concern arises then a Non-Executive may lead a discussion with Executive Directors and other key individuals. After one such discussion, the Director of People has been asked to report quarterly to the Finance, Investment and Performance Board on retention actions, impact and metrics.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

The foundation trust has published an up-to-date register of interests for decision making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The foundation trust has undertaken risk assessments and has a sustainable management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Board of Directors receives a high level summary of agreed key performance indicators at its formal public meetings. These indicators cover service activity, quality, patient safety and cost as

well as the patient experience. In addition there are indicators that monitor the utilisation of the workforce and key assets.

The Finance, Investment and Performance sub-committee of the Board scrutinises this financial and performance information in detail on a monthly basis, providing further assurance to the Board of Directors.

The Finance, Performance and Risk Committee review and scrutinises monthly performance and signals where further work needs to be undertaken to understand the data and/or improve performance. The Operational Leadership Team's locality performance review meetings chaired by the Chief Operating Officer, review service performance routinely and drill down to individual service lines.

The above system ensures that the Trust performs within the agreed parameters of economy, efficiency and effectiveness and should those parameters be breached, is able to quickly identify issues and put in place plans to improve performance.

Through the audit programme internal and external audit provide further external assurance to the Board on economy, efficiency and effectiveness of use of resources.

Information governance

One information governance incident was reportable to the Information Commissioners Office in the year (2018-19), this incident was categorised under the reporting criteria in place in March 2018 and was based on the amount of data involved, the nature of the data (for example if it included sensitive personal data) and the level of risk to the data.

Incident Type	Description	Number of Incidents
Inappropriate Disclosure	This incident occurred when information about patients was sent to the correct recipient, however embedded further within this information were the details of additional patients who did not have a care relationship with the person they were sent to	1

The Information Commissioner took no further action as they were confident that the Trust had the policies and procedures in place and appropriate process had been followed to ensure a good level of data protection.

There has been a significant decrease in reportable incidents compared to the previous year due to the reportable incident assessment criteria changing in May 2018, this is now more focussed on likelihood/impact to determine the risk.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS

foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The steps which have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data are as follows:

- The production of a balanced Quality Report is the responsibility of the Executive Medical Director supported by the Head of Clinical Effectiveness.

- A Trust framework for quality reporting has been designed and agreed by the Board.

- Trust Clinical Effectiveness Group (with representation by clinical directors and through them all clinical professionals within the Trust) have been consulted and influenced the design and content of the Quality Report.

- The Quality Assurance Committee reviewed the quality report quarterly and influenced the design and content of the Quality Report.

- The Quality Report draws on a number of quality performance indicators as reported to the Board through the monthly integrated performance report. These include patient safety and service user feedback indicators.

- The integrated performance report and specific quality indicators feeding the Quality Report are underpinned by data recording and monitoring systems. The governance of data quality is overseen by the Audit Committee which reviews the Trust's Information Assurance Framework.

- The Quality Account priorities for 2018-19 support and are in line with the Trust True North goals.

- The Trust engaged with members of the Council of Governors to select a local quality performance indicator to supplement the two nationally mandated indicators for the Quality Report.

- The integrated performance report and specific quality indicators feeding the Quality Report are underpinned by data recording and monitoring systems. The governance of data quality is overseen by the Audit Committee which reviews the Trust's Information Assurance Framework.

The Board and senior management team also gains assurance on quality via visits to divisions to review delivery of the quality agenda and reviewing feedback from patient and staff surveys, safety and outcome reports to Trust board.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the Audit Committee, Quality Executive Committee, Finance, Performance and Risk Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by:

- NHS Improvement: Single Oversight Framework Segmentation
- Regular review of strategic-level risks and the BAF by the Executive, Audit and Board sub Committees, and the Board of Directors;
- The Audit Committee in delivering its agreed Audit plan and maintaining a senior oversight of the activity of Board sub committees within the Trust's governance structure;
- The Executive Finance, Performance and Risk Committee and Executive oversight of the Governance structure;
- Executive responsibility for the delivery of effectiveness, efficiency and economy;
- Detailed processes undertaken by the Executive to verify compliance with the Care Quality Commission registration and NHS Foundation Trust Licence Conditions (positive assurance licence condition certifications provided by the Board at its meeting in May 2018).
- Attainment of 'Good' overall core services rating from the June 2018 Care Quality Commission inspections, and 'Outstanding' for Well Led.
- Review of feedback from Staff and Patient Surveys
- Significant assurance rating provided by internal audit on arrangements for risk management and BAF

The Trust's internal auditors, RSM have provided the following positive head of internal audit opinion for the 12 months ended 31st March 2019:

"The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

In providing this positive opinion RSM did not highlight any issues that needed to be reported in this governance statement.

The Trust and RSM have undertaken a range of reviews of financial, clinical and operational issues during the year including Care Quality Commission compliance assurance, assurance framework and corporate risk register and mandatory Information governance audits.

Audit recommendations are reviewed by the Audit Committee and are implemented according to an agreed timescale. Regular reviews are undertaken by the internal auditors to ensure any actions have been delivered as agreed.

Conclusion

No significant internal control issues have been identified by the Trust in 2018-19 and the Trust's Annual Governance Statement is a balanced reflection of the management position throughout the year.

Signed

Chief Executive Date: 22 May 2019

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS AND BOARD OF DIRECTORS OF BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Report on the audit of the financial statements

Opinion

In our opinion the financial statements of Berkshire Healthcare Foundation Trust (the 'foundation trust'):

- **give a true and fair view of the state of the foundation trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended;**
- **have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Taxpayers Equity;
- the Statement of Cash Flows; and
- the related notes 1 to 26.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the foundation trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Summary of our audit approach

Key audit matters	The key audit matters that we identified in the current year were: • property valuations; and • management override of controls. Within this report, any new key audit matters are identified with ⏫ and any key audit matters which are the same as the prior year identified with ⏩.
Materiality	The materiality that we used for the current year was £5.0m (2017/18: £4.9m) which was determined on the basis of 2% forecast revenue (2017/18: 2% of forecast revenue).
Significant changes in our approach	Following our first year as auditors, and accumulated understanding of the revenue processes at the Trust, we no longer identify revenue recognition as a key audit matter. This is due to the fact that as revenue for the Trust is primarily earned from block contracts, there is little judgment associated with revenue recognition.

Conclusions relating to going concern

We are required by ISAs (UK) to report in respect of the following matters where:

- the accounting officer's use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or
- the accounting officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

We have nothing to report in respect of these matters.

Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Property valuation	
Key audit matter description	The foundation trust holds property assets within Property, Plant and Equipment at a modern equivalent use valuation of £86.7m (2017/18: £81.7m), with a further £1.6m (2017/18: £1.5m) of property assets (related to leasehold improvements) held at historic cost less accumulated depreciation. The valuations are by nature significant estimates which are based on specialist and management assumptions (including the floor areas for a Modern Equivalent Asset (MEA), the basis for calculating build costs, the level of allowances for professional fees and contingency, and the remaining life of the assets) and which can be subject to material changes in value. The Trust's valuation is based on a number of judgemental assumptions including MEA space assumptions, Private Finance Initiative VAT treatment and land location. As detailed in note 1.8, the foundation trust has completed a valuation in the year. The critical assumptions are broadly consistent with those made previously. The Trust's revaluation has increased land values by £0.5m (3%), and decreased the value of buildings by £2.1m (3%) as shown in note 13.
How the scope of our audit responded to the key audit matter	We evaluated the design and implementation of relevant controls over property valuations, and tested the accuracy and completeness of data provided by the foundation trust to the valuer. We used Deloitte internal valuation specialists to review and challenge the appropriateness of the key assumptions used in the valuation of the foundation trust's properties, and have agreed the results of the valuation to the amounts disclosed in the financial statements. We have reviewed the disclosures in notes 1.3, 1.8 and 13 and evaluated whether these provide sufficient explanation of the basis of the valuation and the judgements made in preparing the valuation.

	We considered the impact of uncertainties relating to the UK's exit from the EU upon property valuations in evaluating the property valuations and related disclosures. We assessed whether the valuation was compliant with the relevant accounting standards, and in particular whether impairments should be recognised in the Income Statement or in Other Comprehensive Income.
Key observations	We are satisfied that the Trust assumptions and valuation methodology are appropriate and are not indicative of management override or manipulation to achieve a preferred outcome.

Management override of controls

Key audit matter description	We consider that in the current year there is a heightened risk across the NHS that management may override controls to fraudulently manipulate the financial statements or accounting judgements or estimates. This is due to the increasingly tight financial circumstances of the NHS and the incentives to meet or exceed control totals to receive Provider Sustainability Fund (PSF) funding. The foundation trust was originally allocated £2.4m of the PSF, contingent on achieving financial and operational targets each year, equivalent to a "control total" for the year of a surplus (adjusted for certain items) of £2.4m. The Trust's control total was adjusted mid-year to reflect an agreed £1.5m offset of control total with other organisations. NHS Improvement has allocated funding for a "bonus" to organisations that exceed their control total, including offering foundation trusts £1 of additional funding for each £1 above the control total. This creates an incentive for reporting financial results that exceed the adjusted control total of £3.9m. The foundation trust's reported results show a surplus of £6.5m (including PSF income of £4.5m), equivalent to £2.6m above the control total. Details of critical accounting judgements and key sources of estimation uncertainty are included in note 1.3.
How the scope of our audit responded to the key audit matter	**Manipulation of accounting estimates** We evaluated the design and implementation of relevant controls over accounting estimates. Our work on accounting estimates included considering each of the areas of judgement identified by NHS Improvement. In testing each of the relevant accounting estimates, we considered their findings in the context of the identified fraud risk. Where relevant, the recognition and valuation criteria used were compared to the specific requirements of IFRS. We tested accounting estimates and judgements (including NHS revenue provisions, consideration of any adjustments required for the transition to the new standards (IFRS 15 *Revenues from contracts with customers* and IFRS 9 *Financial Instruments*), property valuations (see above), useful economic lives, capitalisation and any other one-off accruals), focusing on the areas of greatest judgement and value. Our procedures included comparing amounts recorded or inputs to estimates to relevant supporting information from third party sources. We evaluated the rationale for recognising or not recognising balances in the financial statements and the estimation techniques used in calculations, and considered whether these were in accordance with accounting requirements and were appropriate in the circumstances of the foundation trust.

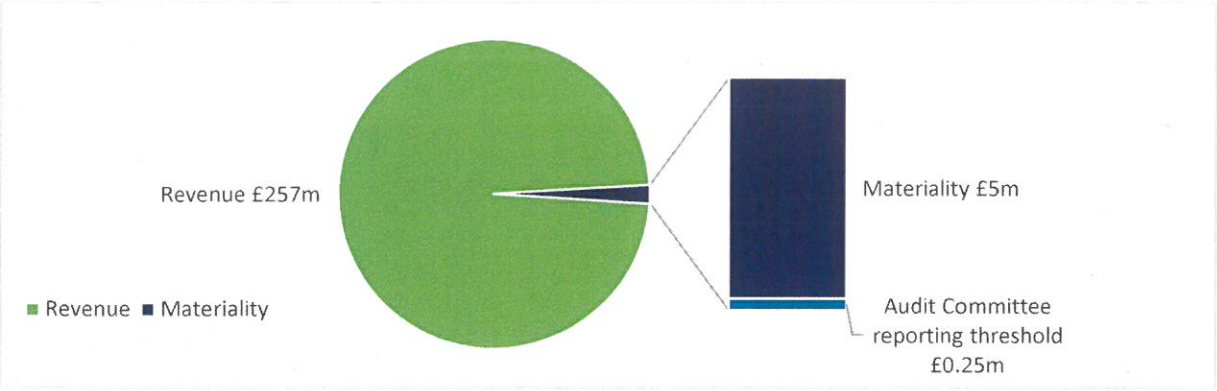
	Manipulation of journal entries We evaluated the design and implementation of relevant controls over journal entries. We used data analytic techniques to select journals for testing with characteristics indicative of potential manipulation of reporting focusing in particular upon manual journals. We traced the journals to supporting documentation, considered whether they had been appropriately approved, and evaluated the accounting rationale for the posting. We evaluated individually and in aggregate whether the journals tested were indicative of fraud or bias. We tested the year-end adjustments made outside of the accounting system between the general ledger and the financial statements. **Accounting for significant or unusual transactions** We considered whether any transactions identified in the year required specific consideration and did not identify any requiring additional procedures to address this key audit matter.
Key observations	We did not identify any significant bias in the key judgements made by management.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Materiality	£5.0m (2017/18: £4.9m)
Basis for determining materiality	2% of forecast revenue (2017/18: 2% of forecast revenue)
Rationale for the benchmark applied	Revenue was chosen as a benchmark as the foundation trust is a non-profit organisation, and revenue is a key measure of financial performance for users of the financial statements.



We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £250k, as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

An overview of the scope of our audit

Our audit was scoped by obtaining an understanding of the entity and its environment, including internal control, and assessing the risks of material misstatement. Audit work was performed at the Trust's corporate services offices in Bracknell directly by the audit engagement team, led by the senior statutory auditor.

The audit team included integrated Deloitte specialists bringing specific skills and experience in Information Technology systems and property valuations.

We used our Spotlight Data Analytics platform to identify key trends in the journals population to support our work on management override of controls and as part of our risk assessment.

Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

We have nothing to report in respect of these matters.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Directors' Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Annual Governance Statement, use of resources, and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit;
- the NHS Foundation Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- proper practices have not been observed in the compilation of the financial statements.

We have nothing to report in respect of these matters.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

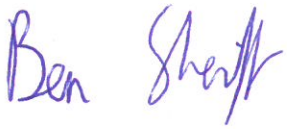
We have nothing to report in respect of these matters.

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Board of Governors and Board of Directors ("the Boards") of Berkshire Healthcare NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Ben Sheriff, ACA (Senior statutory auditor)
For and on behalf of Deloitte LLP
Statutory Auditor
St Albans, UK

23 May 2019

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	231,603	226,006
Other operating income	4	25,164	24,626
Total operating income from continuing operations		**256,767**	**250,632**
Operating expenses	5, 7	(244,942)	(239,943)
Operating surplus/(deficit) from continuing operations		**11,825**	**10,689**
Finance income	9	135	50
Finance expenses	10	(3,765)	(3,722)
PDC dividends payable		(1,682)	(1,521)
Net finance costs		**(5,312)**	**(5,193)**
Gains/(losses) of disposal of non-current assets		-	100
Surplus/(deficit) for the year from continuing operations		**6,513**	**5,596**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(2,342)	(222)
Revaluations	13	3,270	6,329
Total other comprehensive income		**928**	**6,107**
Total comprehensive income/(expense) for the period		**7,441**	**11,703**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	12	5,233	4,464
Property, plant and equipment	13	97,483	90,766
Total non-current assets		**102,716**	**95,230**
Current assets			
Inventories	14	150	274
Trade and other receivables	15	11,751	12,377
Non-current assets for sale and assets in disposal groups	16	-	1,000
Cash and cash equivalents	17	25,597	22,264
Total current assets		**37,498**	**35,915**
Current liabilities			
Trade and other payables	18	(23,939)	(23,668)
Other liabilities	18	(2,289)	(1,849)
Borrowings	19	(1,234)	(1,017)
Provisions	20	(404)	(401)
Total current liabilities		**(27,866)**	**(26,935)**
Total assets less current liabilities		**112,348**	**104,210**
Non-current liabilities			
Borrowings	19	(28,501)	(29,734)
Provisions	20	(1,470)	(1,590)
Total non-current liabilities		**(29,971)**	**(31,324)**
Total assets employed		**82,377**	**72,886**
Financed by			
Public dividend capital		18,029	15,985
Revaluation reserve		36,240	37,028
Income and expenditure reserve		28,108	19,873
Total taxpayers' equity		**82,377**	**72,886**

Name Julian Emms
Position Chief Executive
Date 22nd May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward		**15,985**	**37,028**	**19,873**	**72,886**
Comprehensive Income					
Surplus/(deficit) for the year				6,513	**6,513**
Other transfers between reserves			(1,720)	1,720	-
- Impairments	6	-	(2,342)	-	**(2,342)**
- Revaluations	13	-	3,270	-	**3,270**
Total Comprehensive Income		-	**(792)**	**8,233**	**7,441**
Public dividend capital received		2,045	-	-	**2,045**
Other reserve movements		(1)	4	2	**5**
Taxpayers' and others' equity at 31 March 2019		**18,029**	**36,240**	**28,108**	**82,377**

Statement of Changes in Equity for the year ended 31 March 2018

	Note	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward		**14,210**	**31,243**	**13,955**	**59,408**
Comprehensive Income					
Surplus/(deficit) for the year				5,596	**5,596**
- Impairments	6	-	(222)	-	**(222)**
- Revaluations	13	-	6,329	-	**6,329**
Total Comprehensive Income		-	**6,107**	**5,596**	**11,703**
Transfer to retained earnings on disposal of assets		-	(322)	322	**0**
Public dividend capital received		1,775	-	-	**1,775**
Taxpayers' and others' equity at 31 March 2018		**15,985**	**37,028**	**19,873**	**72,886**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit)		11,825	10,689
Non-cash income and expense:			
Depreciation and amortisation	5.1	5,003	4,762
Net impairments	6	448	623
Income recognised in respect of capital donations	4	(990)	(1,715)
(Increase)/decrease in receivables and other assets		(77)	400
(Increase)/decrease in inventories		124	(161)
Increase/(decrease) in payables and other liabilities		(419)	(1,976)
Increase/(decrease) in other liabilities		440	(163)
Increase/(decrease) in provisions		(245)	(239)
Other movements in operating cash flows		9	(1)
Net cash generated from/(used in) operating activities		**16,118**	**12,219**
Cash flows from investing activities			
Interest received		135	50
Purchase of intangible assets		(1,876)	(1,513)
Purchase of property, plant, equipment and investment property		(8,385)	(6,508)
Sales of property, plant, equipment and investment property*		800	-
Receipt of cash donations to purchase capital assets		1,017	1,703
Net cash generated from/(used in) investing activities		**(8,309)**	**(6,268)**
Cash flows from financing activities			
Public dividend capital received		2,045	1,775
Capital element of PFI, LIFT and other service concession payments		(1,016)	(951)
Interest paid on PFI, LIFT and other service concession obligations		(3,765)	(3,590)
PDC dividend paid		(1,740)	(1,619)
Net cash generated from/(used in) financing activities		**(4,476)**	**(4,385)**
Increase/(decrease) in cash and cash equivalents		**3,333**	**1,566**
Cash and cash equivalents at 1 April		**22,264**	**20,698**
Cash and cash equivalents at 31 March	17.1	**25,597**	**22,264**

The cash receipt of £800K relates to proceeds from a disposal that completed in 2017/18 but the funds were not received until 2018/19. See also notes 13.2 Property Plant and Equipment - 2017/18 and 15.1 Trade Receivables and Other Receivables (Capital Receivables)

NOTES TO THE ACCOUNTS

1.1 Accounting Policies and Other Information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Future changes in accounting policy

Accounting standards that have been issued but have not yet been adopted.

The Department of Health Government Accounting Manual (GAM) does not require the following Standards and Interpretations to be applied in 2018/19. These standards are still subject to HM Treasury FReM adoption, and are therefore not applicable to DH group accounts in 2018/19.

- IFRS 16 Leases - supersedes IAS 17 Leases, SIC 15 Operating Leases SIC 27 Evaluation the Substance of Transactions Involving the Legal Form of a Lease, and IFRIC 4 Determining whether an Arrangement contains a Lease. The objective of IFRS 16 is to report information that faithfully represents lease transactions and provides a better basis for users of financial statements to assess the amount, timing and uncertainty of cash flows arising from leases. The implementation of IFRS 16 has been deferred by one year and will be effective from 1st April 2020.

- IFRS 9 Financial Instruments – Amendment is made to the existing classification requirements in IFRS 9 regarding termination rights, in order to allow the recognition of financial assets measured at amortised cost or at fair value through other comprehensive income, where negative compensation payments exist.

- IFRS 3, Business Combinations and IFRS - Amendment is made to clarify that when an entity obtains joint control of a joint operation, the entity doesn't re-measure previously held interests in that business.

- IAS 12, Income Taxes - Amendments clarify requirements regarding the income tax consequences of dividends.

- IAS 23, Borrowing Costs - Amendment is made to clarify the calculation of borrowing costs on a qualifying and substantially completed asset.

- IAS 19, Employee Benefits - Amendment is made to the calculation of past and current service costs on the basis of a defined benefit plan amendment, curtailment or settlement. Clarity has also been provided on the treatment of the asset ceiling in such scenarios.

- IAS 28, Investment in Associates and Joint Ventures - The application of IFRS 9 to other financial instruments in an associate or joint venture, to which the equity method is not applied, has been clarified to include an entity's long term interest that are in substance part of the net investment in the associate or joint venture.

No new accounting standards or revisions to existing standards have been early adopted in 2018/19

The Foundation Trust will assess the impact of these standards after issue of the Annual Reporting Manual 2019/20 by NHS Improvement.

1.2.1 New standards adopted by the Trust

The following standards have been adopted for the first time for the annual reporting period commencing 1 April 2018:

• IFRS 9 Financial Instruments
• IFRS 15 Revenue from Contracts with Customers

The Trust has changed its accounting policies to take account of these changes but has not made retrospective adjustments or restatement of prior year comparatives. As a result the format of some disclosure notes may be different between the current and prior period.

1.3 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Key Sources of Estimation Uncertainty

The judgements and key sources of estimation uncertainty that have a significant effect on the material amounts recognised in the financial statements in the current or next financial year are detailed below:

- Assets valuations are provided by District Valuation office on annual basis. Valuations are subject to general price changes in the property values across the UK. Asset values might vary from the real market value when assets are disposed.

- Determination of useful lives for property, plant and equipment - estimated useful lives for Trust's assets are based on common, widely used assumptions for each asset type except where specialist information is available from professional bodies. The Trust reviews these lives on a regular basis as part of the process to assess whether assets have been impaired.

- Accruals are based on estimates and judgements of historical trends and anticipated outcomes. At the end of each accounting period, management review items that are outstanding and estimate the amount to be accrued in the closing financial statements of the foundation trust. Any variation between the estimate and the actual is recorded under the relevant heading within the accounts in the subsequent financial period.

- Provisions for pension and legal liabilities are based on the information provided from NHS Pension Agency, NHS Litigation Agency and the Trust's own sources. Pension provision is based on the life expectancy of the individual pensioner as stated in the UK Actuarial Department most recent life tables which change annually. All provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any differences between expectations and the actual future liability will be accounted for in the period when such determination is made.

1.4 Going Concern

These accounts have been prepared on a going concern basis following the definition provided in The Treasury's Financial Reporting Manual (FReM).

The directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

The Trust receives the majority of its income from customers on a block contract arrangement which means that payments against the contract are received equally in twelfths across the financial year and which is not directly linked to specific satisfaction of performance obligations.

Revenue from NHS Contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income only when it receives payment from the Department of Work and Pension's Compensation Recovery Unit. The Trust does not accrue for un-receipted income and subsequently does not provide for any specific allowance for unsuccessful compensation claims and doubtful debts for measurement of expected credit losses over the lifetime of the asset.

Other Operating Income

The Trust receives income from other sources which is not directly related to the delivery of healthcare services. This includes income to support training and development of staff; managed estates services; property rental, and crèche services. Income is also recognised in respect of donations received for the purchase of capital assets or contributions to expenditure. Other operating income is recognised on an accruals basis when the delivery of the activity has occurred.

1.6 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Annual Leave Entitlement

The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. The permitted carry forward is five days except in exceptional circumstances where an employee is on maternity or long term sickness absence.

Maternity and Paternity Leave Entitlements

The cost of the entitlement for employees on maternity or paternity at the end of the period is recognised in the financial statements. The carry forward is based on statutory maternity pay entitlement applicable at the end of the period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust ('NEST')

In 2014/15, the Trust implemented auto-enrolment for eligible employees in the National Employment Savings Trust ('NEST'), which is a scheme set up under the Pensions Act 2008. NEST is regulated by The Pensions Regulator the UK regulator of workplace pension schemes.

NEST is a defined contribution, off Statement of Financial Position scheme. The number of employees auto enrolling into NEST in 2018/19 is negligible. The value of employer contributions in 2018/19 was £24,911.50.

1.7 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.8 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

it is held for use in delivering services or for administrative purposes;
it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
it is expected to be used for more than one financial year; and
the cost of the item can be measured reliably.

In addition, for Property, Plant and Equipment to be capitalised must:

individually have a cost of at least £5,000; or

form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

form part of the initial setting-up cost of a new building or refurbishment, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any accumulated depreciation and impairment losses.

The review of valuations for Land and Buildings is performed by the District Valuer Services, which is a specialist property arm of the Valuation Office Agency. Valuations are reviewed on the 31st March of each calendar year, with a full physical inspection every five years, an interim physical verification at three years and a desktop review in all other years. The last full physical inspection was performed on 31st March 2016.

Revaluation surpluses and impairments due to changes in valuations are reflected in Other Comprehensive Income in the Statement of Comprehensive Income, the Statement of Changes in Taxpayers Equity and Notes 6 Impairments and 13.1 Property, Plant and Equipment.

Valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and existing use value for non-specialised operational property.

The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

Operational equipment is valued at depreciated historic cost as this is not considered to be materially different from fair value. Equipment surplus to requirements is valued at net recoverable amount.

Assets in the course of construction are valued at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately. Assets are revalued and depreciation commences when they are brought into use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

For all categories of non-property assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Revaluation and impairment

Land and buildings are fully revalued every five years with an interim revaluation every financial year. All revaluations are performed by a professional qualified valuer who is a member of the Royal Institute of Chartered Surveyors.

Further revaluations may be done at any other time particularly where there have been additions, dilapidation or part disposal of an asset or on the occurrence of an event likely to cause impairment.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

The standard useful life for Property, Plant and Equipment held by the NHS foundation trust is:

- Buildings (excluding dwellings): 35 years
- Furniture & Fittings: 7 years
- Transport Equipment: 7 years
- Plant & Machinery: 5 years
- Information Technology: 4 years
- Software and Licenses: 3 years

Where there is a valid and reasonable expectation of the Trust that the economic useful life of Property Plant or Equipment is different to the standard, this will be assessed on a case by case basis taking into account the materiality of the initial investment and expected timing for replacement. The useful life will then be adjusted accordingly.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

De-recognition

Assets intended for disposal is reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e. management are committed to a plan to sell the asset;
- a programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and,
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the assets on the revaluation reserve is transferred to Income and Expenditure reserve. For donated assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal amount so that no profit or loss is recognised in income and expenses. The remaining surplus or deficit in the donated asset reserve is then transferred to Income and Expenditure reserve.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.9 Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is treated as income, and is credited to the Statement of Comprehensive Income. Donated fixed assets are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations are taken though the asset revaluation reserve and, each year, a depreciation charge on the asset is to the income and expenditure account. On sale of donated assets, the net book value of the donated asset is transferred from the revaluation reserve to the Income and Expenditure Reserve.

1.10 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are treated as income and the receipt credited to the Statement of Comprehensive Income, The associated asset is treated in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the revaluation reserve and, each year, an amount equal to the depreciation charge on the asset charged to the Statement of Compressive Income.

A grant for an asset may be received subject to a condition that it is to be returned to the grantor if a specified future event does or does not occur. For example, a grant may need to be returned if the foundation trust ceases to use the asset purchased with that grant for a purpose specified by the grantor. In these cases, a return obligation does not arise until such time as it is expected that the condition will be breached and a liability is not recognised until that time. Such a condition would not therefore require the grant to be treated as deferred.

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

Payment for the fair value of services received;
Payment for the PFI asset, including finance costs; and
Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

The PFI assets are recognised as a property, plant and equipment when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacements

Components of the assets replaced by the operator during the contract are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the Trust to the operator for use in the scheme:

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

Other assets contributed by the Trust to the operator:

Assets contributed (e.g. cash payments, surplus property) by the trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets.

Expenditure on research is not capitalised.

Expenditure on internally generated assets is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

For all categories of intangible assets, the Trust considers that depreciated historical cost is an acceptable proxy for current value in existing use, as the useful economic lives used are considered to be a realistic reflection of the lives of assets and the depreciation methods used reflect the consumption of the asset.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The expected useful life for software is 3 years.

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Where a lessor retains substantially all the risks and rewards of ownership the leases are regarded as being operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.16 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 20.2.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 21 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 21, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.18 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.19 Corporation Tax

The Trust is a Health Service body within the meaning of s519A Income and Corporation Taxes Act (ICTA) 1988 and accordingly is exempt from taxation in respect of income and capital gains within the categories covered by this. There is a power for the Treasury to dis-apply the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to the provision of health care. Where trading activities are undertaken that are commercial in nature the profits per activity are below the £50,000 corporation tax threshold as per the HMRC 'Guidance on the Tax Treatment of Non-Core Healthcare Commercial Activities of NHS Foundation Trusts.

1.20 Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in note 17.2 in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.22 Financial assets and financial liabilities

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

1.22a Financial Assets

Recognition

Financial assets are recognised when the Trust becomes party to the contractual provision of the financial instrument or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or when the asset has been transferred and the Trust has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset.

Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other comprehensive income, and financial assets at fair value through profit and loss. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

For all financial assets measured at amortised cost or at fair value through other comprehensive income, lease receivables and contract assets, the Trust will recognise a loss allowance, previously classified as impairment or bad debt provisions, representing expected credit losses on the financial instrument.

Financial assets measured at amortised cost are those held whose objective is to hold financial assets in order to collect contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most financial assets at amortised costs and other simple debt instruments. After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial assets at amortised costs are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's financial assets at amortised cost comprise current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

Impairment of financial assets

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Trust recognises a loss allowance representing expected credit losses on the financial instrument.

The Trust will adopt the simplified approach to impairment, in accordance with IFRS 9, and measure the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses.

For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 1), and otherwise at an amount equal to 12-month expected credit losses (stage 2).

The Department of Health and Social Care (DHSC) provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies and the Trust will not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

1.22b Financial Liabilities

Financial liabilities are recognised when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been extinguished — that is, the obligation has been discharged or cancelled or has expired. Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value plus or minus directly attributable transaction costs for financial liabilities not measured at fair value through profit or loss.

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the amortised cost of the financial liability.

1.23 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.24 Charitable Funds

Under the provisions of IFRS 10 Consolidated Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact. As the charitable income during the financial year was £404K, compared to the Trust's revenue of £256,737K, the funds are not considered sufficiently material for consolidated account to be prepared. The position is reviewed annually, to confirm whether or not the charity's funds are material enough for consolidation to be appropriate. An outline of the charity is as follows:

> The Berkshire Health Charitable Fund is registered with the Charity Commission under reference number 1049733. Trustees of the charity are also employees of the NHS foundation trust. Details of the charity can be obtained from www.charitycommission.gov.uk.

Assets donated to the foundation trust are disclosed in Note 13 and separate accounts for the NHS charity will be produced.

Note 2 Operating Segments

IFRS 8 'Operating Segments' requires disclosure of the results of the significant operating segments. A business or operating segment is a group of assets and operations engaged in providing core or non core services that are subject to risks and returns that are different from those of other business or operating segments. In line with the standard, based on the internally reported activities, the foundation trust identifies that all activity is healthcare related and a large majority of the foundation trust's revenue is received from within UK government departments.

The Trust operates as a single operating segment. The Board of Directors, led by the Chief Executive is the Chief Operating Decision Maker within the Trust. It is only at this level that revenues are fully reported and the overall financial and operational performance of the Trust is assessed. As all decisions affecting the foundation trust's future direction and viability are made based on the overall total presented to the board, the foundation trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2018/19	2017/18
	£000	£000
Mental health services		
Block contract income	102,792	98,516
Clinical income for the secondary commissioning of mandatory services	337	542
Other clinical income from mandatory services	1,954	3,282
Community services		
Community services income from CCGs and NHS England	103,466	100,949
Community services income from other commissioners	18,666	20,638
All services		
AfC pay award central funding	2,407	-
Other clinical income	1,981	2,079
Total income from activities	**231,603**	**226,006**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
CCGs and NHS England	209,885	204,151
Local Authorities	14,416	16,489
Department of Health and Social Care	2,410	-
Other NHS foundation trusts	3,101	2,776
NHS Trusts	462	426
NHS Other	14	-
Non-NHS: overseas patients (chargeable to patient)	-	30
NHS injury scheme (was RTA)	77	157
Non NHS: other	1,238	1,977
Total income from activities	**231,603**	**226,006**
Of which:		
Related to continuing operations	231,603	226,006
Related to discontinued operations	-	-

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development	539	543
Education and training	5,438	4,951
Estates Design and Technical Services	-	110
Car Parking	257	250
Catering	146	153
IT Recharges	159	336
Sustainability and Transformation Fund income	4,505	3,549
Creche Services	1,856	1,774
Property Rental	2,360	2,216
Managed Estates Services	7,249	7,148
Other income	1,650	1,870
Other non-contract operating income		
Donations of Physical Assets	-	12
Receipt of capital grants and donations	990	1,703
Charitable and other contributions to expenditure	15	11
Total other operating income	**25,164**	**24,626**
Of which:		
Related to continuing operations	25,164	24,626
Related to discontinued operations	-	-

4.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,261
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	1,261

4.2 Transaction price allocated to remaining performance obligations

	2018/19
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000
- within one year	2,289
- after one year, not later than five years	-
- after five years	-
Total revenue allocated to remainig performance obligations	**2,289**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4.3 Income from activities arising from commissioner requested services

Under the terms of its Provider License, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	227,215	223,725
Income from services not designated as commissioner requested services	29,552	26,907
Total	**256,767**	**250,632**

Note 5.1 Operating expenses

	2018/19	2017/18
	£000	£000
Services from NHS foundation trusts	1,963	2,006
Services from NHS trusts	450	1
Services from CCGs and NHS England	20	330
Purchase of healthcare from non NHS bodies	13,141	14,825
Employee expenses - executive directors	1,157	1,135
Employee expenses - non-executive directors	130	131
Employee expenses - staff	173,869	168,499
Supplies and services - clinical	5,161	4,744
Supplies and services - general	1,093	1,152
Establishment	3,907	4,696
Research and development	125	141
Transport	2,640	3,352
Premises	15,356	15,497
Movement in credit loss allowance: contract receivables/assets	(68)	
Increase/(decrease) in provision for impairment of receivables	-	(106)
Increase/(decrease) in other provisions	(210)	-
Change in provisions discount rate(s)	17	22
Drug costs	5,897	4,769
Rentals under operating leases	3,381	2,739
Depreciation on property, plant and equipment	4,124	3,544
Amortisation on intangible assets	879	1,218
Impairments	448	623
Audit fees payable to the external auditor:	-	-
- audit services - statutory audit	74	74
- audit related assurance services	7	7
Internal Audit Fees	58	58
Clinical negligence	620	487
Legal fees	433	377
Consultancy costs	173	225
Training, courses and conferences	1,750	1,960
Service Element of PFI Unitary Payments	6,376	6,160
Redundancy	177	149
Early retirements	(4)	(77)
Hospitality	-	4
Other services (external Payroll Services)	46	45
Losses, ex gratia & special payments	72	53
Other	1,680	1,103
Total	**244,942**	**239,943**
Of which:		
Related to continuing operations	244,942	239,943
Related to discontinued operations	-	-

Note 5.2 Other auditor remuneration

The other remuneration paid to the auditor included audit related assurance services of £7K (2017/18 £7K). The fees have been disclosed VAT exclusive.

The external auditor is also appointed by the Berkshire Healthcare Charitable Fund, the results of which are not consolidated into these financial statements. Details are included in the Charitable Fund's financial statements which are available on the Charity Commission website.The audit fee paid in 2017/18 was £5,250 excluding VAT.

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £2.0m (2017/18: £2.0m).

Note 6 Impairment of assets

	2018/19	2017/18
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Over specification of assets	44	89
Unforeseen obsolescence	-	-
Changes in market price	-	-
Other*	404	534
Total net impairments charged to operating surplus / deficit	**448**	**623**
Impairments charged to the revaluation reserve	2,342	222
Total net impairments	**2,790**	**845**

*

The 'Other' impairment of £404K relates to capital expenditure on a newly constructed asset where the valuation on completion provided by the Valuation Office Agency on the 31st March 2019 provided an assessment of the building under a 'Modern Equivalent Asset' basis, which is based on the cost of re-constructing the asset using modern materials and construction methods. The total cost of capital expenditure for the newly constructed asset that was built over financial years 2016/17 to 2018/19 was £2,955K and is recorded in 'Building excluding Dwellings - Additions - Purchased from cash donations / grants' of Note 13.1 Property, Plant & Equipment. The impairment cost is shown in Note 5.1 Operating Expenses - Impairments.

Note 7 Employee benefits

	Permanent	Other	2018/19 Total	2017/18 Total
	£000	£000	£000	£000
Salaries and wages	127,445	-	**127,445**	**124,032**
Social security costs	11,841	-	**11,841**	**11,500**
Apprenticeship levy	628	-	**628**	**607**
Employer's contributions to NHS pensions	16,773	-	**16,773**	**16,166**
Pension cost - other	25	-	**25**	**12**
External Bank Staff	-	14,153	**14,153**	**8,715**
Agency/contract staff	-	6,025	**6,025**	**8,926**
Total gross staff costs	**156,712**	**20,178**	**176,890**	**169,958**
Recoveries in respect of seconded staff		-	**-**	-
Total staff costs	**156,712**	**20,178**	**176,890**	**169,958**
Included within:				
Costs capitalised as part of assets	1,816	48	**1,864**	-

Note 7.1 Average number of employees (WTE basis)

	Permanent	Other	2018/19 Total	2017/18 Total
	Number	Number	Number	Number *
Medical and dental	166	14	**181**	**175**
Ambulance staff	4	-	**4**	**2**
Administration and estates	530	37	**567**	**552**
Healthcare assistants and other support staff	250	2	**252**	**252**
Nursing, midwifery and health visiting staff	969	137	**1,107**	**1,132**
Nursing, midwifery and health visiting learners	914	157	**1,071**	**1,077**
Scientific, therapeutic and technical staff	688	32	**721**	**691**
Healthcare science staff	14	1	**16**	**16**
Social care staff	-	-	**-**	**-**
Other	-	-	**-**	**-**
Total average numbers	**3,537**	**381**	**3,917**	**3,897**
Of which:				
Number of employees (WTE) engaged on capital projects	41	1	**42**	-

* The prior year staff numbers for 2017/18 have been re-analysed following a review of staffing posts during 2018/19 to align them to operational community and mental health services.

Note 7.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (5 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £8K (£299K in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2018/19	2017/18
	£000	£000

Salary	1,054	1,014
Taxable benefits	0	0
Performance related bonuses	0	0
Employer's pension contributions	113	137
Total	**1,167**	**1,151**

Further details of directors' remuneration can be found in the Remuneration Report.

Note 8 Operating leases

Note 8.1 Berkshire Healthcare NHS Foundation Trust as a lessee

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	3,381	2,739
Contingent rents	-	-
Less sublease payments received	-	-
Total	**3,381**	**2,739**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,860	2,860
- later than one year and not later than five years;	7,585	9,934
- later than five years.	5,357	5,868
Total	**15,802**	**18,662**
Future minimum sublease payments to be received	-	-

Operating leases relate to rental of properties and lease cars. Operating leases are charged to operating expenses on a straight-line basis over the term of the lease.

Note 9 Finance income

	2018/19	2017/18
	£000	£000
Interest on bank accounts	135	50
Total	**135**	**50**

Note 10 Finance expenditure

	2018/19	2017/18
	£000	£000
Interest expense:		
Main finance costs on PFI	2,140	2,206
Contingent finance costs on PFI	1,497	1,384
Total interest expense	**3,637**	**3,590**
Other finance costs	128	132
Total	**3,765**	**3,722**

Note 10.1 The late payment of commercial debts (interest) Act 1998

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 11 Discontinued operations

	2018/19	2017/18
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Total	**-**	**-**

Note 12.1 Intangible assets - 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**9,192**	**495**	**9,687**
Additions	1,876	-	**1,876**
Reclassifications	287	(495)	**(208)**
Gross cost at 31 March 2019	**11,355**	**-**	**11,355**
Amortisation at 1 April 2018 - brought forward	**5,223**	**-**	**5,223**
Provided during the year	879	-	**879**
Amortisation at 31 March 2019	**6,102**	**-**	**6,102**
Net book value at 31 March 2019	**5,253**	**-**	**5,253**
Net book value at 1 April 2018	**3,969**	**495**	**4,464**

Note 12.2 Intangible assets - 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2017 - as previously stated	**7,579**	**595**	**8,174**
Additions	1,018	495	**1,513**
Reclassifications	595	(595)	**-**
Valuation/gross cost at 31 March 2018	**9,192**	**495**	**9,687**
Amortisation at 1 April 2017 - as previously stated	**4,005**	**-**	**4,005**
Provided during the year	1,218	-	**1,218**
Amortisation at 31 March 2018	**5,223**	**-**	**5,223**
Net book value at 31 March 2018	**3,969**	**495**	**4,464**
Net book value at 1 April 2017	**3,574**	**595**	**4,169**

Note 12.3 Intangible assets financing 2018/19

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value at 31 March 2019			
Purchased	5,253	-	**5,253**
Finance leased	-	-	**-**
Donated	-	-	**-**
NBV total at 31 March 2019	**5,253**	**-**	**5,253**

Note 12.4 Intangible assets financing 2017/18

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Net book value 31 March 2018			
Purchased	3,969	495	**4,464**
Finance leased	-	-	**-**
Donated	-	-	**-**
NBV total at 31 March 2018	**3,969**	**495**	**4,464**

Note 13.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**14,402**	**68,771**	**2,955**	**2,146**	**65**	**18,115**	**1,929**	**108,383**
Additions - purchased	-	2,020	607	72	-	4,718	726	**8,143**
Additions - assets purchased from cash donations / grants	-	990	-	-	-	-	-	**990**
Impairments	-	(2,746)	(25)	-	-	-	(2)	**(2,773)**
Reversals of impairments	-	3	-	-	-	-	-	**3**
Reclassifications	-	2,804	(2,944)	13	-	229	106	**208**
Revaluations*	475	614	-	-	-	-	-	**1,089**
Transfers to/ from assets held for sale	1,000	-	-	-	-	-	-	**1,000**
Valuation/gross cost at 31 March 2019	**15,877**	**72,456**	**593**	**2,231**	**65**	**23,062**	**2,759**	**117,043**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**0**	**-**	**1,781**	**65**	**14,377**	**1,393**	**17,616**
Provided during the year	-	2,181	-	112	-	1,683	148	**4,124**
Revaluations	-	(2,181)	-	-	-	-	-	**(2,181)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**1,893**	**65**	**16,060**	**1,541**	**19,559**
Net book value at 31 March 2019	**15,877**	**72,456**	**593**	**337**	**(0)**	**7,002**	**1,219**	**97,483**
Net book value at 1 April 2018	**14,056**	**65,741**	**534**	**455**	**2**	**3,008**	**518**	**90,766**

* Revaluations were performed on the 31st March 2019

Note 13.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - as previously stated	**14,056**	**65,742**	**534**	**2,116**	**65**	**16,316**	**1,803**	**100,631**
Additions - purchased	-	1,543	1,041	24	-	1,781	110	**4,498**
Additions - donations of physical assets (non-cash)	-	-	-	-	-	-	12	**12**
Additions - assets purchased from cash donations / grants	-	-	1,703	-	-	-	-	**1,703**
Impairments	-	(222)	(89)	-	-	-	-	**(311)**
Reclassifications	-	204	(234)	6	-	18	4	**(0)**
Revaluations**	1,550	2,000	-	-	-	-	-	**3,550**
Transfers to/ from assets held for sale	(1,000)	-	-	-	-	-	-	**(1,000)**
Disposals / derecognition	(204)	(496)	-	-	-	-	-	**(700)**
Valuation/gross cost at 31 March 2018	**14,402**	**68,771**	**2,955**	**2,146**	**65**	**18,115**	**1,929**	**108,383**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**-**	**-**	**1,662**	**62**	**13,308**	**1,285**	**16,317**
Provided during the year	-	2,245	-	120	3	1,069	108	**3,544**
Impairments	-	534	-	-	-	-	-	**534**
Revaluations	-	(2,779)	-	-	-	-	-	**(2,779)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**1,781**	**65**	**14,377**	**1,393**	**17,616**
Net book value at 31 March 2018	**14,402**	**68,771**	**2,955**	**364**	**(0)**	**3,738**	**537**	**90,767**
Net book value at 1 April 2017	**14,056**	**65,742**	**534**	**454**	**3**	**3,008**	**518**	**84,315**

** Revaluations were performed on the 31st March 2018

Note 13.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
2019								
Owned	15,877	9,677	593	329	(0)	7,002	1,209	**34,686**
other service concession arrangements	-	59,760	-	-	-	-	-	**59,760**
Donated	-	3,019	-	8	-	-	10	**3,037**
NBV total at 31 March 2019	**15,877**	**72,456**	**593**	**337**	**(0)**	**7,002**	**1,219**	**97,483**

Note 13.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
2018								
Owned	14,402	12,669	1,064	364	(0)	3,738	508	**32,744**
other service concession arrangements	-	55,640	-	-	-	-	-	**55,640**
Donated	-	462	1,891	-	-	-	29	**2,382**
NBV total at 31 March 2018	**14,402**	**68,771**	**2,955**	**364**	**(0)**	**3,738**	**537**	**90,766**

Note 14 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	150	274
Total inventories	**150**	**274**

Drug inventories recognised in expenses for the year were £1,756K (2017/18: £1,771K). Write-down of inventories recognised as expenses for the year were £0K (2017/18: £0K).

Note 15.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	8,476	-
Trade receivables*	-	4,941
Capital receivables	-	800
Accrued income*	-	3088
Allowance for other impaired receivables	-	(97)
Prepayments (non-PFI)	2,139	2,279
VAT receivable	986	1,084
Other receivables	150	282
Total current trade and other receivables	**11,751**	**12,377**

* Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 15.2 Allowances for Credit Losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**97**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	97	(97)
Reversals of allowances	(68)	
Utilisation of allowances (write offs)	(29)	
Allowances as at 31 Mar 2019	**-**	**-**

Note 15.3 Allowances for Credit Losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	2017/18
	£000
At 1 April as previously stated	**279**
Increase in provision	65
Amounts utilised	(76)
Unused amounts reversed	(171)
At 31 March	**97**

Note 16.1 Non-current assets for sale and assets in disposal groups

	2018/19		2017/18
	Property, plant & equipment	Total	Total
	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**1,000**	**1,000**	**-**
At start of period for new FTs	**-**	**-**	**-**
Plus assets classified as available for sale in the year	-	**-**	**1,000**
Plus reversal of impairment of assets held for sale	-	**-**	**-**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(1,000)	**(1,000)**	**-**
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**-**	**1,000**

Asset held for sale at the end of 2017/18 was in respect of surplus land held at West Berkshire Community Hospital in Newbury, West Berkshire. This disposal did not complete in 2018/19 as the expected arrangments that would have resulted in a disposal did not materialise with the result that the land has been transferred back into Property Plant and Equipment.

Note 17.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**22,264**	**20,698**
Net change in year	3,333	1,566
At 31 March	**25,597**	**22,264**
Broken down into:		
Cash at commercial banks and in hand	732	2,162
Cash with the Government Banking Service	24,865	20,102
Total cash and cash equivalents as in SoFP	**25,597**	**22,264**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**25,597**	**22,264**

Note 17.2 Third party assets held by the NHS foundation trust

Berkshire Healthcare NHS Foundation Trust held cash and cash equivalents which relate to monies held by the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2019	31 March 2018
	£000	£000
Bank balances	166	168
Total third party assets	**166**	**168**

Note 18.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	9,996	9,642
Capital payables	1,011	263
Social security costs	1,920	1,832
VAT payable	45	66
Other taxes payable	1,321	1,267
Other payables	337	292
Accruals	9,271	10,210
PDC dividend payable	38	96
Total current trade and other payables	**23,939**	**23,668**

Note 18.2 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	2,289	1,849
Total other current liabilities	**2,289**	**1,849**

Note 19 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,234	1,017
Total current borrowings	**1,234**	**1,017**
Non-current		
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	28,501	29,734
Total non-current borrowings	**28,501**	**29,734**

Note 20.1 Provisions for liabilities and charges analysis

	Pensions - other staff	Injury Benefits	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**1,048**	**361**	**582**	**1,991**
Change in the discount rate	(9)	(7)	33	**17**
Arising during the year	5	-	63	**68**
Utilised during the year	(106)	(20)	(25)	**(151)**
Reversed unused	(115)	(14)	(50)	**(179)**
Unwinding of discount	106	16	6	**128**
At 31 March 2019	**929**	**336**	**609**	**1,874**
Expected timing of cash flows:				
- not later than one year;	106	20	278	**404**
- later than one year and not later than five years;	424	80	127	**631**
- later than five years.	399	236	204	**839**
Total	**929**	**336**	**609**	**1,874**

Pensions - Other Staff

This relates to former NHS employees whose contract of employment was terminated prior to their normal retirement age, with the effect that the employing authority became responsible for making up any shortfall in pension contributions as a result of that termination up until the death of either the former employee or any remaining survivor. The provision is adjusted annually, taking into Government Actuarial Department changes to life expectancy for England and Wales. Where the pension is no longer payable, then this is reversed unused.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Injury Benefits

This relates to injury benefits arising to individuals as a result of an accident at work, which is paid by the NHS Pensions Agency and then reimbursed by the foundation trust.

Timing and expectation of the provision and future cashflows is based on historical payments to the NHS Pension Agency for pensions currently paid up to the end of each financial year.

Other

This relates to the following items:

Provisions in respect of Liability to Third Party ('LTPS') scheme claims against the Trust handled by NHS Litigation Authority where the foundation trusts maximum exposure is £10,000 per claim; and

Dilapidation provisions in respect of leased and rented property.

Timing of cash flows for LTPS claims are expected to occur within one year of current year end, but may be subject to on-going litigation by the claimant. Claims not upheld or not proceeded with will result in provisions being reversed.

Timing of cash flows for dilapidation provisions is based on the expected termination of the current leasehold agreement. Payment and timing of settlement for dilapidations may be subject to uncertainty due to early termination, extension of lease beyond its current expected termination date, or negotiation with leasehold provider over value of dilapidation works required.

Note 20.2 Clinical negligence liabilities

At 31 March 2019, £11,292K was included in provisions of the NHSLA in respect of clinical negligence liabilities of Berkshire Healthcare NHS Foundation Trust (31 March 2018: £9,359K).

Note 21 Contingent assets and liabilities

	31 March 2019	31 March 2018
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(34)	(60)
Gross value of contingent liabilities	**(34)**	**(60)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(34)**	**(60)**

Note 22 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	-	-
Intangible assets	-	-
Total	**-**	**-**

As at 31 March 2019 the Trust had no contractual commitments to purchase property, plant and equipment and intangible assets.

Note 23 On-SoFP PFI, LIFT or other service concession arrangements

The foundation trust operates two PFI schemes:

Prospect Park Hospital, Reading Berkshire

This PFI scheme is to design, build, maintain and operate (through facilities management and related services) a 120 bed mental health inpatient hospital facility. The hospital became operational in March 2003. At the end of the contract the hospital buildings will revert to the Trust's ownership.

The contract has a 32 year term, ending in 2033, and sees the Trust making a minimum unitary base payment that totals £4.02m annually. It is charged monthly and adjusted for RPI and according to any adverse performance against output measures describing all relevant aspects of the contract. Rates and utilities are borne separately by the Trust.

West Berkshire Community Hospital, Newbury, Berkshire

This PFI was originally managed by the former Berkshire West PCT prior to its dissolution on the 31st March 2013, when the PFI contract was transferred to the foundation trust. This facility operates services such as day case surgery and outpatient facilities. There are also a number of inpatient wards At the end of the PFI contract the hospital building will revert to the Trust's ownership.

The contract has a 32 year term, ending in 2033. The Trust makes a minimum unitary base payment that totals £1.46m annual. It is charged monthly adjusted for RPI, and according to any adverse performance against output measures describing all relevant aspects of the contracts. Rates and utilities are borne separately by the Trust.

Both PFI contracts were deemed as off-balance sheet when the Full Business Cases were approved prior to their design and construction. Following adoption of IFRS the Trust considers the contracts under IFRIC 4 Determining Whether an Arrangement Contains a Lease and IFRIC 12 Service Concession Arrangements and recognised the schemes as 'on-Statement of Financial Position'.

The substance of the two contracts is that the trust has a finance lease and annual payments comprise three elements - finance lease rental, service charges and replacements of the asset components (lifecycle replacements). The element of annual finance lease rental is further split into three components: repayment of the finance lease principal, a finance cost and contingent rental representing the inflation increases. An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period. The implicit rate of interest for Prospect Park Hospital is 7.31%, whilst for West Berkshire Community Hospital it is 6.61%.

Total obligations for on-statement of financial position PFI contracts due:

Note 23.1 Imputed finance lease obligations

	31 March 2019 £0	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**84,301**	**88,956**
Of which liabilities are due		
- not later than one year;	4,988	4,654
- later than one year and not later than five years;	22,033	21,401
- later than five years.	57,280	62,901
Finance charges allocated to future periods	(54,566)	(58,205)
Net PFI, LIFT or other service concession arrangement obligation	**29,735**	**30,751**
- not later than one year;	1,234	1,017

- later than one year and not later than five years;	6,436	5,950
- later than five years.	22,065	23,784

Note 23.2 Total On-SoFP PFI, LIFT and other service concession arrangement commitments

Total future payments committed in respect of PFI, LIFT or other service concession arrangements	**31 March 2019 £000**	**31 March 2018 £000**
	182,188	**197,433**
of which due:		
- not later than one year;	11,305	10,969
- later than one year and not later than five years;	48,116	43,874
- later than five years.	122,767	142,591
	182,188	**197,433**

Note 23.3 Payments committed in respect of the service element

	31 March 2019 £000	**31 March 2018 £000**
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	**97,886**	**113,652**
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	6,316	6,314
- later than one year and not later than five years;	26,083	25,256
- later than five years.	65,487	82,082
Total	**97,886**	**113,652**

Note 23.4 Analysis of amounts payable to service concession operator

	31 March 2019 £000	**31 March 2018 £000**
Unitary payment payable to service concession operator (total of all schemes)	**11,029**	**10,701**
Consisting of:		
- Interest charge	2,140	2,206
- Repayment of finance lease liability	1,016	951
- Service element	6,376	6,160
- Contingent rent	1,497	1,384
Total amount paid to service concession operator	**11,029**	**10,701**

Note 24 Financial instruments

Note 24.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the NHS foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to review by the Trust's internal auditors.

The Foundation Trust's financial instruments, other than those used for treasury risk management purposes, comprise cash and liquid resources and various items such as trade debtors and creditors that arise directly from its operations. The Trust does not undertake speculative treasury transactions.

Liquidity risk

The Foundation Trust's net operating costs are mainly incurred under legally binding contracts with local Clinical Commissioning Groups, NHS England and local authorities, which are financed from resources voted annually by Parliament. Under Payment by Results, the Foundation Trust is paid for activity on the basis of nationally set tariffs. For contracted activity, the Foundation Trust is paid in 12 monthly instalments throughout the year, which significantly reduces the Foundation Trust's liquidity risk. Performance in excess of contracted levels is paid in accordance with the terms of the legally binding contracts. The Foundation Trust finances its capital programme through internally generated resources and external borrowing where appropriate.

Foreign currency risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and Sterling based. The Trust has no overseas operations therefore the exposure to currency rate fluctuations is low.

Interest-Rate Risk

None of the Foundation Trust's financial assets or liabilities carries any real exposure to interest-rate risk. The Foundation Trust's owned assets are funded by public dividend capital, which is non-interest bearing and of unlimited term. The PFI assets, are funded by way of a Finance Lease which are at a fixed rate of interest over the full remaining term of the PFI contracts

Credit Risk

Due to the fact that the majority of the trust's income comes from legally binding contracts with other government departments and other NHS Bodies the trust does not believe that it is exposed to significant credit risk. The maximum exposures as at 31st March 2019 are in receivables from customers, as disclosed in the **Note 15.1 Trade and other receivables.**

Note 24.2 Carrying values of financial assets

	Loans and receivables £000	Total £000
Carrying values of financial assets 31 March 2019		
Receivables excluding non-financial assets	8,626	**8,626**
Cash and cash equivalents at bank and in hand	25,597	**25,597**
Total at 31 March 2019	**34,223**	**34,223**

	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2018		
Trade and other receivables excluding non-financial assets	9,111	**9,111**
Cash and cash equivalents at bank and in hand	22,264	**22,264**
Total at 31 March 2018	**31,375**	**31,375**

Note 24.3 Financial liabilities

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2019		
Obligations under PFI, LIFT and other service concession contracts	29,735	**29,735**
Trade and other payables excluding non-financial liabilities	20,615	**20,615**
Provisions under contract	1,874	**1,874**
Total at 31 March 2019	**52,224**	**52,224**

	Other financial liabilities £000	Total £000
Liabilities as per SoFP as at 31 March 2018		
Obligations under PFI, LIFT and other service concession contracts	30,751	**30,751**
Trade and other payables excluding non-financial liabilities	20,407	**20,407**
Provisions under contract	1,991	**1,991**
Total at 31 March 2018	**53,149**	**53,149**

Note 24.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	22,102	21,825
In more than one year but not more than two years	1,624	1,463
In more than two years but not more than five years	5,725	5,107
In more than five years	22,773	24,754
Total	**52,224**	**53,149**

Note 24.5 Fair values of financial assets at 31 March 2019

	Book value	Fair value
	£000	£000
Cash and cash equivalents at bank and in hand	25,597	25,597
Total	**25,597**	**25,597**

Note 24.6 Fair values of financial liabilities at 31 March 2019

	Book value	Fair value
	£000	£000
Provisions under contract	1,874	1,874
Obligations under PFI, LIFT and other service concession contracts	29,735	29,735
Other	20,615	20,615
Total	**52,224**	**52,224**

Note 25 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	2	-	1	-
Fruitless payments	3	5	6	2
Bad debts and claims abandoned	-	-	3	105
Stores losses and damage to property	18	17	2	2
Total losses	**23**	**22**	**12**	**109**
Special payments				
Losses of Personal Effects	3	-	11	4
Personal Injury with Advice	8	28	5	27
Other Employment	2	35	2	51
Other Ex-gratia Payments	6	22	4	30
Total special payments	**19**	**85**	**22**	**112**
Total losses and special payments	**42**	**107**	**34**	**221**

Note 26 Related parties

Berkshire Healthcare NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Berkshire Healthcare NHS

The foundation trust considers material transactions as those being where the income or expenditure is over £250,000 per annum.

The Department of Health and Social Care is regarded as a related party. During the year Berkshire Healthcare NHS Foundation Trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income		Expenditure		Receivables		Payables	
	2018/19	2017/18	2018/19	2017/18	2019	2018	2019	2018
	£000	£000	£000	£000	£000	£000	£000	£000
NHS Foundation Trusts								
Frimley Health NHS Foundation Trust	692	634	1,701	1,567	95	159	530	1,056
Oxford Health NHS Foundation Trust	0	0	357	428	0	0	75	125
Oxford University Hospitals NHS Foundation Trust	474	421	80	82	143	12	4	8
Royal Berkshire NHS Foundation Trust	4,299	3,925	2,275	1,995	604	307	290	249
South Central Ambulance Service NHS Foundation Trust	444	0	162	0	50	0	0	0
NHS Trusts								
Avon and Wiltshire Mental Health Partnership NHS Trust	212	0	317	0	78	0	99	0
Clinical Commissioning Groups								
NHS Berkshire West CCG*	113,027	109,452	31	665	402	862	799	1,767
NHS Buckingham CCG*	1,908	2,000	0	3	20	61	1	3
NHS East Berkshire CCG*	79,859	77,807	191	0	443	1,575	451	576
NHS Oxfordshire CCG	263	0	0	0	54	0	0	0
NHS England and other associated organisations	17,826	16,662	0	45	3,516	1,122	762	108
Other NHS Bodies								
Health Education England	4,189	4,596	11	37	134	40	762	912
NHS Resolution (formerly NHS Litigation Authority)	0	0	791	701	0	0	0	0
NHS Property Services	7,265	7,184	5,964	6,001	734	603	12	378
Local and Unitary Authorities								
Bracknell Forest Borough Council	3,714	8,130	194	261	104	112	130	33
Reading Borough Council	3,702	2,324	88	70	383	95	73	13
Slough Borough Council	719	611	167	244	147	155	123	284
West Berkshire Council	2,292	2,292	20	92	35	35	4	41
Windsor and Maidenhead (Royal Borough of)	381	428	145	83	79	38	26	27
Wokingham Council	3,527	2,367	200	241	217	282	73	90
Other Whole of Government Account Organisations								
HM Revenue & Customs	0	0	12,469	12,107	986	1,084	3,286	3,165
NHS Pension Scheme	14	0	16,800	16,293	14	0	2,384	2,316
Total	**244,807**	**238,833**	**41,963**	**40,915**	**8,238**	**6,542**	**9,884**	**11,151**

*** Merger of Clinical Commissioning Groups.**

The prior year comparitor for 2017/18 for the following Clinical Commissioning Groups have been consolidated following the merger of these organisations from 1st April 2018.

- NHS Berkshire West CCG was formed from the merger of NHS Newbury & District CCG, NHS North & West Reading CCG, NHS Wokingham CCG and NHS South Reading CCG
- NHS Buckingham CCG was formed from the merger of NHS Aylesbury Vale CCG and NHS Chiltern CCG
- NHS East Berkshire was formed from the merger of NHS Bracknell & Ascot CCG, NHS Windsor Ascot & Maidenhead CCG and NHS Slough CCG