Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 09 May 2023

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 11 April 2023	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – CAMHS Rapid Response Service	Debbie Fulton, Director of Nursing and Therapies/Marie Duffield, Service Manager, CAMHS Rapid Response Service and Nadine daCal, Clinical Psychologist, CAMHS Rapid Response Service	Verbal
6.1	Patient Experience Report – Quarter 4	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Safe Staffing Six Monthly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Quality Accounts Report 2022-23	Dr Minoo Irani, Medical Director	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	Health and Wellbeing Update Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
7.2	Ethnicity Pay Gap Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
PERFORMANCE			
8.0	Month 12 2022/23 Finance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.1	Month 12 2022/23 Performance Report	Paul Gray, Chief Financial Officer	Enc.
8.2	Finance, Investment and Performance Committee meeting on 27 April 2023	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
CORPORATE GOVERNANCE			
9.0	Audit Committee Meeting on 27 April 2023	Rajiv Gatha, Chair, Audit Committee	Enc.
9.1	Annual Report 2022-23*	Julian Emms, Chief Executive	Enc.
9.2	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
10.	Any Other Business	Martin Earwicker, Chair	Verbal
11.	Date of the Next Public Trust Board Meeting –11 July 2023	Martin Earwicker, Chair	Verbal
12.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

**It is a legal requirement that an NHS Foundation Trust's Annual Report is not published until the Report has been laid before Parliament. The draft Annual Report is therefore excluded from the Public Trust Board papers on the Trust's website.*

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 11 April 2023

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Naomi Coxwell	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Tehmeena Ajmal	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Jane Nicholson	Director of People (*present for agenda items 7.1 and 7.2)*
Patient Story:	Alison Jones	Diabetes Specialist Dietitian

23/038	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. The Chair thanked Naomi Coxwell, Senior Independent Director for chairing the February 2023 Trust Board meeting at short notice.
23/039	**Apologies** (agenda item 2)
	There were no apologies.
23/040	**Declaration of Any Other Business** (agenda item 3)

	There was no other business.
23/041	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
23/042	**Minutes of the previous meeting – 14 February 2023** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 14 February 2023 were approved as a correct record.
23/043	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
23/044	**Board Story – Community Diabetes Services (**agenda item 6.0)
	The Chair welcomed Alison Jones, Specialist Diabetes Dietician to the meeting. The Director of Nursing and Therapies reported that unfortunately the Head of the Community Diabetes Service was not able to attend the meeting. The Director of Nursing and Therapies thanked Alison Jones for stepping in and giving the presentation. Alison Jones gave a presentation and highlighted the following points: • In 2020, the National Diabetes Clinical Audit (NDA) reported that the Diabetes Specialist Service for patients with Type 1 Diabetes in Berkshire Healthcare Foundation Trust was significantly different from other trusts for the proportion of people with an HbA1c <=58 mmol/mol and recommended that the Trust should consider what might have caused the outlying rate in the 2019/2020 data. • The Trust used Quality Improvement Methodology to develop a Diabetes Improvement Project to reduce the HbA1c levels in people with type 1 Diabetes under the care of the Trust's Diabetes Specialist Service • Previously all people with Diabetes referrals into the service were coded either as a new patient or a follow up patient. The Trust recoded the referral codes for all people with Diabetes referred to the Diabetes Specialist Service in order to identify those patients with Type 1 Diabetes, under 25s, those who used an insulin pump, used continuous glucose monitoring system, used Flash Technology and those patients with Type 2 Diabetes • The new codes made it easier to book patients to the most appropriate specialised clinic • The Trust joined the National Diabetes Audit Type 1 Collaborative which was focussed on improving Diabetes outcomes nationally • The Trust had employed a dedicated Diabetes Consultant from January 2022 to support service development and to increase clinic capacity.

	• The Trust was working with the Integrated Care System's Informatics Team to find the location of approximately 700 people with Type 1 Diabetes who were not under the care of the Diabetes Specialist Service. • The Trust had increased the percentage of patients with a HbA1c <=58 mmol/mol in people with Type 1 Diabetes under the care of the Trust's Diabetes Specialist Service from 30% to 38% which was in line with the national average • The National Diabetes Audit Collaborative Quality Improvement Lead had congratulated the Trust on its work to increase the use of insulin pumps and for the improvements in performance it had achieved. Alison Jones presented two patient case stories to illustrate how the Diabetes Specialist Centre worked with patients to help them control their condition (the presentation slides are attached to the minutes) Mark Day, Non-Executive Director said that he was aware that nationally it was more challenging to engage with younger people with Diabetes and asked whether this was an issue for the Trust. Alison Jones acknowledged that it was more challenging to engage with younger people with Diabetes but said that as more technologies had been developed, more younger people were engaging with the service and were using remote monitoring systems to help them manage their condition. It was noted that the Trust also had a designated under 25s clinic Mehmuda Mian, Non-Executive Director asked whether the service covered Type 2 Diabetes and whether it was involved in Type 2 preventative work Alison Jones said that the service was involved in a patient education programme for people newly diagnosed with Type 2 Diabetes. Ms Jones reported that there was a national Diabetes Prevention Programme which people could join. Sally Glen, Non-Executive Director said that one of the issues raised at the Quality Assurance Committee when the results of the last National Diabetes Clinical Audit were discussed was a lack of expertise about the use of insulin pumps amongst the nursing team, Alison Jones said that the Diabetes Specialist Service included two dedicated Diabetes Specialist Nurses and two dedicated Specialist Diabetes Dietitians and the service was also upskilling all Diabetes Centre staff around the use and management of insulin pumps. Ms Glen asked whether patients could telephone the service for advice about managing their insulin pump. Alison Jones confirmed that all patients with an insulin pump under the care of the Diabetes Specialist Service could telephone or email the service for help and support. Naomi Coxwell, Non-Executive Director commented that the Diabetes Specialist Service was a good example of where national benchmarking had identified that the Trust was an outlier and the steps the Trust had taken to address the issues and to improve its performance. Ms Coxwell asked whether the service would have improved if the benchmarking data had not been available. Alison Jones said that individual patients with Type 1 Diabetes monitor their blood sugars all the time in order to manage their condition but the difference now was that greater

	emphasis was placed on improving their blood sugar long term. The changes in clinical coding also enabled the service to identify those patients who required more support. The Chief Executive said that the presentation had highlighted the benefit of the national clinical audit programme as a tool for service improvement. The Chair thanked Alison Jones for her presentation. **The Trust Board:** noted the presentation.
23/045	**Quality Assurance Committee Meeting – 28 February 2023 (agenda item 6.1)**
	a) Unconfirmed Minutes of the Quality Assurance Committee Meeting held on 28 February 2023 The unconfirmed minutes of the Quality Assurance Committee meeting held on 28 February 2023 had been circulated together with the quarterly Learning from Deaths Report and the quarterly Guardian of Safe Working Practices Report. Sally Glen, Chair of the Quality Assurance Committee and highlighted the following issues from the February 2023 meeting: • Three risks on the Quality Concerns Register (Quality Concerns No 4: Common Point of Entry, Crisis Resolution at Home Team and Community Mental Health Team interfaces; No 9: Record Keeping in Mental Health Services, particularly in relation to risk and safety planning and No 15: Community Mental Health Teams had been combined into the Quality Concern No 15: Community Mental Health Team concern • The Committee had noted that the Community Nursing Review was progressing well and that the Project Manager was working with the Primary Care Network Leads to get the views from GPs regarding the Trust's community nursing model. • The Committee had agreed to invite the Family Liaison Officer (who provided support to families following an unexpected bereavement) to a future meeting so the Committee could find out more about their role • The Committee had received an update on the Trust's work around implementing the National Patient Safety Strategy and had received assurance that the work was progressing well Ms Glen reported that she had been interviewed in her role as Chair of the Quality Assurance Committee about the data the Board received in relation to mental health services and about how helpful she thought the data was in identifying any issues as part of the Government's Rapid Review of Mental Health Inpatient Services. **b) Learning from Deaths Quarterly Report** The Medical Director reported that there had been no deaths as a result of a lapse of care in quarter three. It was noted that a "lapse in care" was defined as greater than a 50% likelihood that problems in the care of a patient could have contributed to the death of the patient. The Medical Director reported that from April 2023, the Trust was using the death avoidability score system which was regularly used by acute trusts which would provide

	more granular information than the current system for determining whether or not there had been a lapse in care. The Chair asked how the Trust guarded against "group think" in relation to reaching a judgement about whether or not there was more than a 50% likelihood that problems in care had contributed to the death of the patient. The Medical Director explained that determining whether there had been a lapse in care involved a rigorous process including the relevant clinical director checking the outcome of the structured judgement review process, a review by both the Medical Director and the Director of Nursing and Therapies and finally, approval by the Mortality Review Group. If there were any concerns, the Medical Examiner could also review the death. **c) Guardian of Safe Working Practices Quarterly Report** The Medical Director reported that there had only been one minor exception report in the quarter. The Chief Executive reported that it was the first day of the junior doctors' industrial action. The Medical Director explained that being a mental health and community trust, the Trust employed relatively few junior doctors and therefore the impact of the industrial action was less than it would be for an acute hospital. The Medical Director confirmed that the Trust had been planning for the industrial action for several months and was able to deploy other clinical staff to maintain patient safety. The Medical Director said that the Trust would be monitoring the situation on a shift by shift basis during the course of the industrial action. The Chair thanked the Medical Director for his updates. **The Trust Board**: a) The unconfirmed minutes of the Quality Assurance Committee held on 28 February 2023 b) The Learning from Deaths Quarterly Report and c) The Guardian of Safe Working Practices Quarterly Report.
23/046	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) Public Satisfaction with the NHS and Social Care** The Chair noted that overall satisfaction with the NHS had fallen to 29% - a 7% decrease from 2021 which was the lowest level of satisfaction recorded since the survey began in 1983. The Chair commented that the NHS had a significant challenge to re-build the public's confidence about its services. The Chief Executive agreed and said that understandably, politicians were concerned about productivity given the additional funding allocated to the NHS. The Chief Executive added that the Trust needed to get its "own house in order" in terms of being able to demonstrate how the additional Mental Health Standard investment funding was being deployed to reduce waiting times for services with the longest waits etc and how investment in community services initiatives such as Virtual Wards were cost effective.

	The Chair suggested that the Trust should do more to publicise its improvements to services so the public had a more rounded view about the Trust and the wider NHS. **Action: Deputy Chief Executive** The Chief Executive agreed that it was important that the messages the public received about the NHS were not all "doom and gloom" and gave the example of the Community Dental Service who had managed to address their long waits and waits were now at the pre-COVID-19 pandemic level. Aileen Feeney, Non-Executive Director asked whether it was possible to have a breakdown of the results by region in order to identify any significant variances. The Chief Executive said that the results were published at a national level. Naomi Coxwell, Non-Executive Director asked about the audience for the Public Satisfaction with the NHS and Social Care Report. The Chief Executive said that politicians were a key audience for the survey as it provided them with an insight into how the public perceived the NHS. The Chief Executive said that NHS England, the Integrated Care Boards and individual NHS and Social Care provider organisations were all key audiences for the survey. **b) Delegating to Three New Services to Integrated Care Systems** Naomi Coxwell, Non-Executive Director asked how responsibility for commissioning Pharmaceutical, General Ophthalmic Services and Dentistry to Integrated Care Systems would impact the Trust. The Chief Executive explained that there were no direct impacts for the Trust but pointed out that indirectly it would affect the Trust's patients were used those services. The Chief Executive added that it was also a new responsibility for the Integrated Care Boards to get to grips with and would inevitably take up a lot of senior staff time on top of the Integrated Care Board's other responsibilities. **The Trust Board**: a) Noted the report b) Requested that the Trust do more to publicise and showcase improvements to services
23/047	**Gender Pay Gap Report** (agenda item 7.1)
	The Chair welcomed the Director of People to the meeting. The Director of People presented the report and highlighted the following points: • The Gender Pay Gap was the difference between the average pay of men and women in an organisation. Gender Pay Gap reporting was a requirement under the Equality Act 2010 and was based on the data from the previous year • Organisations were required to report both the median and mean Gender Pay Gap. The Trust's median Gender Pay Gap in 2022-23 was 16.46%. This represented a decrease of 0.55% from 17.01% from 2021-22 moving in the right direction. The

	Trust's mean Gender Pay Gap in 2022-23 was 16.96%. This represented a 3.49% decrease from 2021-22, again moving in the right direction • The reasons for the Gender Pay Gap were varied and complex, some of which were within the Trust's control and some which were more systemic within society. One of the major reasons for the pay gap was that there was a higher proportion of males in more senior bands within the Trust. Female staff represented 83.25% of the Trust's workforce yet only represented 74.19% of the workforce in the upper quartile. Male employees represented 16.75% of the workforce but were overrepresented in the upper quartile (25.81%). • The Trust was committed to continuously reviewing systems, practices and processes to ensure that the Gender Pay Gap was reduced, where practically possible to do so. • Before developing a more detailed action plan in collaboration with our stakeholders, the Trust was asked to perform a detailed statistical analysis to gain a better understanding of the drivers for the pay gap and to ascertain what more the Trust could do to reduce the Gender Pay Gap • In 2022-23, the Trust had proposed equal bonus payments (Clinical Excellence Awards) for all eligible male and female consultants irrespective of whether they were full time or part time without any pro rata calculations. This would have helped to eliminate the gender pay gap in the year in relation to Clinical Excellence Awards, since female consultants were more likely to work part time. However, this proposal was rejected by the Local Negotiating Committee and BMA Guidance for pro rata calculations was required to be implemented. The Chair asked what more the Trust could do to reduce the Gender Pay Gap. The Director of People said that attracting more men into entry level jobs, for example, apprenticeships and increasing the number of women in senior roles would help to reduce the Gender Pay Gap. The Deputy Chief Executive referred to the table setting out the percentage difference in hourly pay compared with our local Trusts and commented that the Trust appeared to be an outlier. The Director of People said that the Trust had a disproportionately high number of female who were predominantly in lower level roles compared with other local trusts. The Chair requested that the Board receive further information about the reasons for the difference in the Trust's mean/median hourly rate compared with our neighbouring Mental Health and Community trusts. **Action: Director of People** The Chief Executive said that whilst it was helpful for the Board to get more information and to gain a better understanding about the drivers for the Gender Pay Gap, it was also important to ensure that there were no unintended consequences. For example, providing opportunities for part time/flexible working when practicable was important for staff retention but inevitably contributed to the Gender Pay Gap. Naomi Coxwell, Non-Executive Director referred to the Gender Profile by Band table (page 72 of the agenda pack) and asked whether more could be done to support women in bands 8A to move into band 8B and above roles and said that the data also needed to be broken down into staff with other protected characteristics.

	The Chair agreed that it would be helpful to understand why women were under-represented at bands 8B and above. The Director of People reported that the Trust had also conducted an Ethnicity Pay Gap exercise which she would present to a future Board meeting. It was noted that a Disability Pay Gap exercise would be conducted next year. **Action: Director of People** **The Trust Board**: a) Noted the report b) Requested further information about the reasons for the difference in Trust's mean/median hourly rate compared with neighbouring Mental Health and Community Trusts c) Agreed that the Ethnicity Pay Gap Report would be presented to a future Trust Board meeting d) Agreed that the Trust would undertake a Disability Pay Gap exercise in 2024
23/048	**National NHS Staff Survey Report Results** 2022 (agenda item 7.2)
	The Director of people presented the report and highlighted the following points: • The Trust's National NHS Staff Survey Results 2022 remained high with above average scores in all elements and themes. The Trust's Staff Engagement Score of 7.4 remained at the top of the Trust's peer group. • The Trust scored top in its peer group for the "we are always learning" element. The Trust also had top scores for compassionate culture, appraisals and motivation. The percentage of staff who would recommend the Trust as a place to work had increased from 62.8% last year to 73% this year. The percentage of staff who felt confident that the Trust would address unsafe clinical practice had also increased from 67.3% last year to 73.3% this year. Similarly, the percentage of staff who felt that the Trust took positive action on health and wellbeing had increased from 63.7% last year to 74.3% this year • The Trust's response rate had increased by 5% to 65%. The Trust's response rate was now 15% above the average response rate for 51 Mental Health/Learning Disability and Community Combined Trusts. • The results showed that the Trust was making minimal progress in areas such as work pressures and unwarranted differential experiences of staff with protected characteristics • The Trust had started a piece of work using Quality Improvement Methodology to gain a better understanding of the underlying causes of staff working excessive hours. The Trust was also continuing its work around reducing violence and aggression against staff. • The Workforce Race Equality Standard (WRES) results highlighted that the experience of black and ethnic minority colleagues was considerably poorer than those who were white and this was not acceptable. The Trust was now scoring better than average across all indicators but despite this, the gap in experience remained and was not closing as much as it should, either locally or nationally • Similarly, the Workforce Disability Equality Standard (WDES) results also highlighted that the experience of staff with disabilities was considerably poorer than those without and this was not acceptable. The Trust scored better than average in most indicators but as with ethnicity, the gap in experience remained

- The National NHS Staff Survey Results indicated that staff who identify as gay/lesbian/other also had a poorer experience compared to their heterosexual/straight colleagues and again this was not acceptable.
- The National NHS Staff Survey Results broken down for each division and corporate services highlighted areas where there had been shifts both in deterioration and in improvement
- The Human Resources Business Partners were now working with divisional leads to look at the results and were having discussions about the next steps. This included reviewing the information at a lower level and planning listening and feedback events. The results would also be shared with the Staff Networks

The Chair referred to the chart showing broken down by division/corporate services (on page 102 of the agenda pack) and commented that it was a concern that Prospect Park Hospital's results had deteriorated.

Mark Day, Non-Executive Director congratulated the Executive Team for managing to sustain performance despite all the operational pressures over the last year. Mr Day suggested using social media to publicise the Trust's National Staff Survey Results to provide a more positive picture of the NHS to that which is often portrayed by the media. Mr Day added that the Trust's positive score in relation to the percentage of staff who think the Trust was a good place to work may help to attract staff.

The Director of People reported that the Trust was using social media to publicise the Staff Survey Results and also made reference to the Staff Survey results in job advertisements. The Director of People pointed out that a number of others trusts in the Southeast also had relatively high engagement scores and that this may reflect the fact that high cost of living areas found it more difficult to attract and retain staff and therefore focussed on staff retention activities.

Rajiv Gatha, Non-Executive Director referred to the divisional breakdown slide and asked about the scale.

The Director of People explained that the slide showed whether there had been a percentage up or down compared with the previous staff survey results.

The Chief Executive added that the slide was in relation to the number of questions where there had been a shift compared with the previous year and therefore the percentage movement was quite small. The Director of People agreed to circulate a separate slide which provided the information more clearly.

Action: Director of People

Sally Glen, Non-Executive Director said that it was very pleasing that the staff engagement score was so high and that staff felt confident that the Trust would address patient safety concerns. Ms Glen added that it was useful to triangulate the Staff Survey results with other data to gain a more holistic picture at the local level.

The Director of People confirmed that work was underway to develop tailored action plans for each division/corporate services. The Director of People added that it was important that the Trust was able to pick up early signals where a particular team and/or service was under pressure rather than focusing too much of the overall positive scores as this could hide areas of underperformance when aggregated across the Trust.

	Aileen Feeney, Non-Executive Director asked whether there had been any response about the Staff Survey results from the teams and also asked whether there was an opportunity to share good practice. The Director of People said that the Human Resources Business Partners were going through the detailed results with each division/corporate services and confirmed that areas of good practice would be shared across the Trust. Ms Feeney said that the overall staff engagement score was impressive but said that it was really disappointing that so many staff had reported experiencing harassment, bullying or abuse. The Director of People said that the Staff Survey results had not identified any hidden areas of underperformance and said that the teams where bullying and harassment and violence at work were a particular concern, additional resources had been put in place to support those teams and individuals to improve. On behalf of the Board, the Chair thanked the Director of People and colleagues for the positive Staff Survey Results but acknowledged that there were areas where further improvement was needed. The Director of People thanked the Board for their support and for setting the culture of the Trust. **The Trust Board**: a) Noted the report b) Requested that the Director of People circulate a slide showing the improvement or deterioration in scores compared with the previous year's scores broken down by divisions and corporate services
23/049	**Month 11 2122-23 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust was reporting a £1m surplus against a year to date deficit plan of £1m. • In February 2023, the Trust was reporting a £0.5m surplus against a £0.1m deficit plan. The increased surplus was in line with the agreement for the Trust to move to a surplus forecast outturn as part of the work to bring the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System forecast deficit in line with NHS England's expectations. • The Trust's revised forecast outturn was a surplus of £1.89m. The Trust was planning to release the balance of the Elective Recovery Funding over the final months of the year and was assuming no claw back of funding which was in line with NHS England's Guidance • The Trust's cash balances remained strong with a closing balance of £58.5m as of 28 February 2023 • The Trust had planned to deliver £10.1m of cost improvements in order to achieve the planned deficit position. The Trust's Cost Improvement Programme delivery was £4.3m less than the financial plan and there remained £2.5m of unidentified schemes, plus some schemes at risk and which would not deliver as planned, furthering the requirement for new initiatives

	• Pay costs in month were £20m which was lower than plan and lower than in previous months. The underspend in month was in part the result of the payment of the Clinical Excellence Awards happening in October 2022 rather than in February 2023 as planned. There was an increase of 13 contracted whole time equivalents which was mainly in the Children and Young People Division against specific investment funding. • The Trust was continuing to offset in part, substantive vacancies with higher levels of temporary staffing. Bank expenditure had reduced since the previous month but agency spend had remained the same despite a shorter month with no bank holidays • Expenditure on Out of Area Placements continued to be higher than planned although the average number of placements had decreased from 19 in January 2023 to 14 in February 2023 with the monthly costs decreasing from £0.5m to £0.4m • The Trust was reporting £5.3m of capital expenditure against a year to date plan of £9.6m. There was a £2.6m year to date underspend against the limit set by the Integrated Care Board but it was expected that the Trust would fully recover the slippage by year end The Chair referred to the Trust's Cost Improvement Programme delivery which was £4.3m less than planned and asked whether this represented a risk in terms of the Trust delivering its financial plan at year end. The Chief Financial Officer explained that the Cost Improvement Programme delivery had been taken into account when the Trust's forecasted year end position had been revised. It was also noted that the Cost Improvement Programme requirement was less than planned because it had been assumed that Elective Recovery Funding would be clawed back if targets were not met. **The Trust Board**: noted the report.
23/050	**Month 11 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and highlighted the following points: • The new falls technology had now been rolled out across all Community and Older Adult Mental Health Inpatient wards. The number of falls in month was 19 against a target of 26 per month. In view of the reduction in the number of falls, falls would be retired as a driver metric in the True North Performance Scorecard 2023-24 • There was a significant increase in the number of self-harm incidents in month (145 against a target of 42). Around 95% of the incidents related to two patients. • Performance in relation to physical health checks for people with severe mental illness was 84% against a target of 85%. • Performance in relation to the number of Out of Area Placements was RAG rated green in month but this was expected to be RAG rated red by the end of the quarter. • Mental Health and Community Inpatient occupancy retained high. The number of delayed discharges of care had reduced from 21.7% in January 2023 to 16.6% in February 2023. • Performance in relation to the proportion of patients referred for diagnostic Audiology tests who had been waiting for less than 6 weeks was at 72.4% against a target of 95%. The Trust expected to be compliant with the target by the end of the first quarter of 2023-24

	Sally Glen, Non-Executive Director noted that the incidence of mental health prone (face down) restraint had increased from 2 incidents in January 2023 to 13 incidents in February 2023 and asked for further information about the increase. The Director of Nursing and Therapies explained that some patients preferred choice of restraint was prone restraint and that this was the case for one particular patient in February. **The Trust Board**: noted the report.
23/051	**Finance, Investment and Performance Committee Meeting 23 February 2023** (agenda item 8.2)
	Naomi Coxwell, Chair, Finance, Investment and Performance Committee reported that the March 2023 meeting had been held in person for the first time since the COVID-19 pandemic. Ms Coxwell paid tribute to the work of the Chief Financial Officer and his team for ensuring the delivery of the financial plan 2022-23 and for the work in developing the draft financial plan 2023-24. **The Trust Board**: noted the update from the Chair of the Finance, Investment and Performance Committee.
23/052	**Trust's Green Plan Update Report** (agenda item 9.0)

	The Chief Financial Officer gave a presentation and highlighted the following points:
	
	• The Climate Change Act 2008 had a national statutory target to being all greenhouse gas emissions to net zero by 2050.
	• The NHS had set a target to become net zero emitter of carbon emissions by 2045. NHS England had set out two commitments:
	  o For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an **80% reduction by 2028 to 2032**
	  o For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an **80% reduction by 2036 to 2039**
	• The Trust's Green Plan 2022-25 sets out 38 initial actions over the three year period and sets out initial targets:
	  o All staff to receive training and or have access to net zero/green hero network by 2023/24
	  o To reduce by 50% staff commuting and business travel by 2025/26
	  o To decarbonise utilities consumed by the Trust and to reduce CO2 emission by 50% by 2025/26
	  o To reduce the amount of waste generated by the Trust by 10% by 2023/24
	• In the course of the first year of the Green Plan, a significant amount of work had been done to build the governance infrastructure to deliver the plan, for example, establishing the Trust Green Group with cross divisional representation supported by internal groups and collaboration with key estates partners, PFI, NHS Property Services, Estates Green Group and Waste Management Group. In addition, the

Trust worked with the NHS England South East Regional Estates Group, Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board's Net Zero Programme Board, South Est Sustainable Procurement Group and with the South East Medicines Working Group.

- Updates and news relating to sustainability were communicated to staff via Team Brief, Nexus (staff intranet) and the Trust's Bright Ideas programme encouraged staff to present sustainability ideas. The Trust was planning to use social media to publicise the Trust's sustainability work
- All the Trust's leased/purchases vehicles, including the Health Bus were ultra-low emissions vehicles or zero emissions vehicles. The Trust was continuing its expansion of electric vehicle charging points.
- The Trust had reduced its gas and electricity consumption and was continuing its work to roll out LED lighting. The Trust had stopped the single use of catering plastics and had also increased the volume of recycled waste.
- Sustainability questions were now included on all Invitations to Tender documents to prospective supply chain partners. Sustainability Impact Assessment had been introduced and included in all business cases.
- The Trust's water consumption had increased by 28% and further work was being undertaken to understand what was driving increased water consumption. There was also an increase in business mileage as staff moved back to offices and the number of face to face meetings increased.
- The Trust was in the process of recruiting a substantive Sustainability Manager to oversee the delivery of the Trust's Green Plan.

The Chief Operating Officer said that the Trust had clearly undertaken a significant amount of work but commented that it was important to get the balance right between sustainability and staff efficiency, for example, staff travelling to attend face to face meetings etc.

The Chief Operating Officer added that it was important to work with teams to develop local sustainability opportunities.

The Chief Financial Officer agreed and said that there was scope to develop the role of the Green Network Champions. The Chief Financial Officer added that the Internal Audit Sustainability Review had highlighted that there was lots of communication internally amongst those who were involved in the Green agenda but there was further work to be done to engage with staff across the Trust.

The Chair asked whether the Trust's work was impacted because some of its buildings were owned and run by NHS Property Services.

The Chief Financial Officer commented NHS Property Services had the same national and NHS England sustainability targets as the Trust and were also rolling out things like LED lighting and electric vehicle charging points but pointed out that much of the NHS Property Services estate was old and inefficient compared with newer buildings.

Naomi Coxwell, Non-Executive Director asked about the governance of the Trust's Green Plan.

The Chief Financial Officer explained that he was the Executive Lead for Sustainability and when the new substantive Sustainability Manager was in post, they would be responsible for leading the Green Group and developing and overseeing the implementation of the objectives and actions.

	Ms Coxwell suggested that the new Sustainability Manager be invited to attend a future Trust Board meeting to share their perspectives with the Board. The Chair agreed and commented that it also be helpful for the Board to understand which actions were likely to deliver the most benefit in terms of the Green Agenda. **Action: Chief Financial Officer** The Deputy Chief Executive pointed out that the Green Agenda was included as part of the Trust's Strategy and therefore would form part of the Strategic Implementation Plan which would be presented to the Trust Board in May 2023. **Action: Deputy Chief Executive** The Chief Executive reported that new staff attending the Trust's Corporate Induction Programme often asked about what the Trust was doing to contribute to the Green Agenda. The Chief Executive agreed with the Chair about the importance of identifying areas where there was likely to be the biggest impact. The Chief Executive said that it was important that the Green Plan was aligned with the Trust's Strategy and gave the example of Virtual Wards which would result in Community Response staff travelling to people's homes. The Chief Executive said that ideally, staff would be driving electric vehicles but the reality was that the cost of electric vehicles and the practicalities around charging vehicles especially for people living in flats etc meant that for many staff this was not an option. The Chair agreed about the importance of ensuring that there was alignment between the Trust's Green Plan, Digital Strategy and Trust Strategy. **The Trust Board**: a) Noted the presentation b) Agreed that the new Sustainability Manager would be invited to attend a future Trust Board meeting to share their perspectives with the Board and to identify which actions were likely to deliver the most benefit in terms of the Trust's Green Plan c) Noted that the Green Agenda was included in the Trust's Strategy and would form part of the Trust's Strategic Implementation Plan
23/053	**Council of Governors Update** (agenda item 10.0)
	The Chair reported that the Council of Governors' Appointments and Remuneration Committee had started the recruitment process to appoint a new Non-Executive Director to replace Mehmuda Mian whose term of office ended in June 2023. The Chair said that there was a very strong and diverse list of candidates and reported that he was confident that the Governors would be able to make an appointment.
23/054	**Any Other Business** (agenda item 11)
	There was no other business.
23/055	**Date of Next Public Meeting** (agenda item 12)

	The next Public Trust Board meeting would take place on 09 May 2023.
23/056	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 11 April 2023.

Signed……. Date 09 May 2023

(Martin Earwicker, Chair)

NHS
Berkshire Healthcare
NHS Foundation Trust

Quality Improvement

Diabetes Specialist Service

Patient Stories

Jan Durrant
Alison Jones
Dr Emma Bingham
April 2023

Background:

National Diabetes Audit Data 2019/2020

NHS
Berkshire Healthcare
NHS Foundation Trust

			HbA1c ≤ 58 mmol/mol										
Audit Year	Organisation Code	Organisation Name	HbA1c ≤ 58 Numerator	HbA1c ≤ 58 Denominator	HbA1c ≤ 58 Percentage	Observed	Expected	Standardised Ratio	Lower Limit 2SD	Upper Limit 2SD	Lower Limit 3SD	Upper Limit 3SD	Banding
2019_20	RWX5G	DIABETES CENTRE – WAM NMP5G	225	750	30.0	225	255.6	0.88	0.88	1.13	0.82	1.21	Lower than expected - alert

Treatment Target	BHFT % (2017/18)	BHFT % (2018/19)	BHFT % (2019/20)	National % (2019/20)
Type 1 diabetes				
HbA1c <= 58 mmol/mol (7.5%)	31.7	28.7	**30.0**	31.6

In 2020, the National Diabetes Audit (NDA) reported that the diabetes specialist service for patients with type 1 diabetes in Berkshire Healthcare Foundation Trust was significantly different from other trusts for the proportion of people with an HbA1c <=58 mmol/mol and was recommended that BHFT should consider what might have caused the outlying rate in 2019/2020 data.

The data (2019/2020) shows that 30% of people with Type 1 Diabetes under BHFT care have an HbA1c <=58mmol/l, which is 1.6% below the National average and was deemed to be significantly different by 3 standard deviations

Title of Improvement Project / Problem Solving Item:

Mother A3 for Improving HbA1c for People with Type 1 Diabetes Under the Care of the Diabetes Centre

Members of Project Team:

All Diabetes Centre Staff

NHS
Berkshire Healthcare
NHS Foundation Trust

Step 1 - Problem Statement:

In 2020, the National Diabetes Audit (NDA) reported that the diabetes specialist service for patients with type 1 diabetes in Berkshire Healthcare Foundation Trust was significantly different from other trusts for the proportion of people with an HbA1c <=58 mmol/mol and was recommended that BHFT should consider what might have caused the outlying rate in 2019/2020 data.

The data (2019/2020) shows that 30% of people with Type 1 Diabetes under BHFT care have an HbA1c <=58mmol/l, which is 1.6% below the National average and was deemed to be significantly different by 3 standard deviations

Step 2 - Data:

The following data has been collated to understand the current situation:

- NDA report for people with Type 1 Diabetes
- HbA1c results of people with Type 1 Diabetes on Diabetes Centre caseload
- Type 1 Diabetes caseload
- Type 1 Diabetes on insulin pump caseload
- Type 1 Diabetes under 25s caseload
- Type 1 Diabetes Freestyle Libre / CGMS caseload
- Frequency of consultant appointments
- Overdue follow up appointments
- Current Pathways & Processes

Step 3 - Vision and Goals:

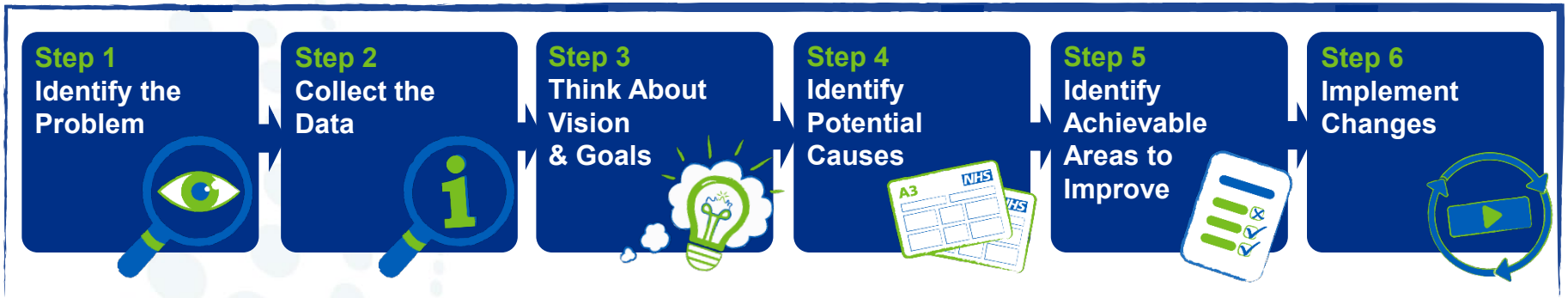
Our vision is to reduce the HbA1c levels in people with Type 1 Diabetes under the care of the BHFT Diabetes Centre improving their long-term health outcomes.

The goal of this project is to increase the percentage of patients with an HbA1c <=58 mmol/mol in people with Type 1 Diabetes under the care of the BHFT Diabetes Centre by 3%, initially focusing on quality and frequency of their education and Healthcare Professional appointment time.

Process:

Identifying Where to Start and Avoid Assumptions

Berkshire Healthcare NHS Foundation Trust



Identifying People with Type 1 Diabetes

Identification:

Berkshire Healthcare NHS Foundation Trust

- Previously, all people with diabetes referrals into the service were coded either as a new patient or a follow up patient
- Recoded the referral ‘Team Codes’ for all people with diabetes referred to the Diabetes Specialist Service:
  - Type 1 Diabetes
  - Under 25 Team
  - Pump Team
  - Tech: Continuous Glucose Monitoring System
  - Tech: Flash Technology
  - Type 2 & Other Diabetes
- Recoding allowed us to book the correct patient in the correct specialised clinic:
  - Type 1 Diabetes (General) Clinic
  - Under 25s Clinic
  - Insulin Pump Clinic
  - Technology Clinic
  - Type 2 & Other Diabetes Clinic
- Number of people in each caseload can be easily identified

Reports:

Berkshire Healthcare NHS Foundation Trust

- The Diabetes Assessment Form on RiO which has been developed over the past 2 years by the service is a clinical assessment tool that allows any data entered to be pulled into a tableau report.

- This Diabetes Assessment Form is in the process of being updated to improve the detail of the information collected and to be able to identify areas to target more easily. This will now include:

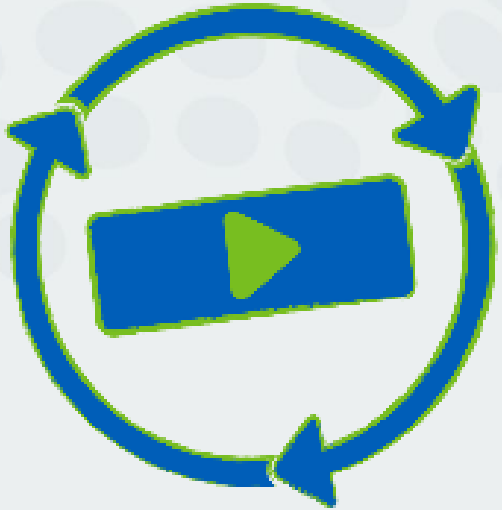
  - Type of insulin pump
  - Continuous Glucose Monitoring System / Flash Technology data
  - Blood Test data
  - Demographics

- This information can now be used to help reduce variation in care for example using patient demographics to review

  - Uptake of technology

  - Focus on groups that are not achieving optimal glycaemic control

Implementation of Change



Changes made:

Berkshire Healthcare NHS Foundation Trust

- Changed the Consultant Clinics:
  - Increased length of clinic appointments
  - Created dedicated Type 1 and Technology Clinics
  - Specific clinics assigned dependant on need/activity

- Developed and implemented Virtual and Face to Face Flash Technology education to ensure on-going support to aid self management
- Joined NDA Type 1 Collaborative looking to improve diabetes outcomes nationally.
- Internal business case submitted and funding agreed to recruit to a dedicated 1.0 WTE Diabetes Consultant to support service development and increase clinic capacity. New Consultant took up post in January 2022.
- Working with the ICS informatics team to find location of approximately 700 people with Type 1 not under the care of the Diabetes Specialist Service.

Achievement:

Berkshire Healthcare NHS Foundation Trust

The goal of the project was to increase the percentage of patients with an HbA1c <=58 mmol/mol in people with Type 1 Diabetes under the care of the BHFT Diabetes Centre by 3%, initially focusing on quality and frequency of their education and Healthcare Professional appointment time.

NDA Results 2020/2021

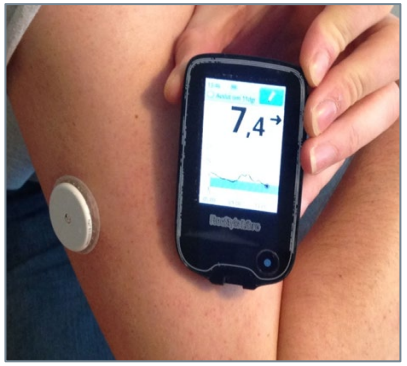
BHFT achieved 36.5 % which was above national average of 34.8 %

Previous Result	Target	Current Result
30%	33%	38%

What Does This Mean for People with Diabetes ?

Patient Stories:

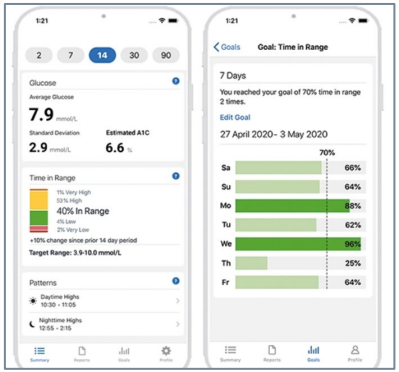
Case Study 1



- Age 18
- Type 1 Diabetes
- Date of Diagnosis 2010
- Basal Bolus Regimen
- HbA1c in June 2022- **62mmol/mol**

Management

- Seen In Consultant Clinic in June 2022 followed by Consultation with Senior Diabetes Specialist Dietitian (DSD)
  - Dietary Advice Provided
  - Consider use of Flash Technology as met NICE criteria and to start 14 day trial
  - Attend Freestyle Libre Education (Flash)
  - Food diary to be completed
  - Consider attending CHOICE Type 1 Carbohydrate Counting and Diabetes Education Programme



Patient Stories:

Case Study 1

Berkshire Healthcare NHS Foundation Trust

- DSD July and August 2022
  - Review of food diary
  - 121 carbohydrate counting education
  - Change of basal insulin
  - Mylife bolus calculator to support carbohydrate counting
  - Some episodes of hypoglycaemia related to change of insulin regimen
- Attended Flash Structured Group Education in September 2022
- Consultations with Diabetes Specialist Nurses for support with dose titration and injection sites in October 2022
  - Experienced some loss of hypoglycaemic awareness
  - Flash Technology and use of alarm function supported reduction in hypoglycaemic episodes
  - October Results from Flash Technology
    - 83% Target
    - 14% High
    - 1% Very High
    - 2% Low
- Attended CHOICE Education Programme
- **HbA1c - 52mmols/mol December 2022**

CHOICE

Patient Stories: CSII

Case Study 2

- Age 40
- Type 1 Diabetes
- Date of Diagnosis 1995
- Basal Bolus Regimen
- HbA1c in June 2021- **70 mmol/mol**
- Flash Technology – not getting on well with it
- Reports Dawn Phenomenon
- Gastrointestinal Issues
- Frustrated with diabetes control

Management

- Consultation with Senior DSD in March 2021
  - Not accurately carbohydrate counting
  - Booked to attend CHOICE Type 1 Education in May 2021
  - Consider change to Continuous Glucose Monitoring System
  - To consider Insulin Pump Therapy

Patient Stories: CSII

Case Study 2

- Reviewed 2 weekly by DSD plus support from DSN
  - Change of Flash Technology
  - Pre Insulin Pump Education on 26th August 2021
- **MDT 27th August 2021**
  - Would benefit from fully closed loop insulin pump system using Tandem and Dexcom
- **October 12th 2021**
  - Dexcom Start
- **October 19th 2021**
  - Insulin pump start
- **October 21st 2021**
  - Patient reports ‘best control in a very long time’
  - Followed up closely by DSD
- **Less than 2 weeks later control improved**
  - 76 % Target -Only achieved **60%** on basal bolus regimen
  - 18% High
  - 5 % Very High
  - 1% Low
  - 0 % v. low

Patient Stories: CSII

Case Study 2

Berkshire Healthcare NHS Foundation Trust

- November 23rd 2021 attended education for Control IQ Technology
- December 15th 2021 reviewed in Consultant Clinic
  - Benefited greatly
  - 82% time in range
  - Patient reports that the pump adjustments are
    'allowing him the best nights sleep since his diagnosis of diabetes'
- **HbA1c - 46 mmols/mol June 2022**

NDA Collaborative Feedback:

Berkshire Healthcare NHS Foundation Trust

Michael Sykes:
NDA Quality Improvement Lead:

'Please accept my immense thanks to you both for taking the time to share your impressive work with the 40 specialists' teams taking part in the national Diabetes Audit Quality Improvement Collaborative. I very much hope you will provide similar input to the second wave of 40 teams in 2024.

The aim of the Collaborative is to increase the use of insulin pumps, addressing the gap nationally that about 60,000 people have an HbA1c above 69mmol/mol but do not use a pump. For teams to do this, they first need to identify how many people on their caseloads and/or in their geography have a high HbA1c. The work you have undertaken provides a pathway for them to follow.

You illustrated not only how they might do this but why: For example, at the patient level, identifying patients who scan less frequently provides the opportunity to provide additional support and give feedback about the link between scanning and 'time in range'. At the organisational level, your work demonstrates the importance of data at identifying and exploring variation and gaps between intended and actual delivery. It is great that you have subsequently been able to use the data to generate organisational commitment for business cases. Congratulations that this, alongside specialising clinics, training and increases to clinic time has translated into an impressive increase in the number of patients with an HbA1c <58mmol/mol, a marker of reduced risk of retinopathy, nephropathy, neuropathy, cardiovascular disease, sexual health problems and foot disease.

It was clear from the workshops that there are Trusts keen to learn even more from your work, and I hope it will be possible to arrange a longer session with these sites.

Once again, please accept my sincere thanks and congratulations for the improvements made to date'

Thank you

any questions?

Berkshire Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS MEETING 09.05.23

Board Meeting Matters Arising Log – 2023 – Public Meetings

Key:

Purple - completed
Green – In progress
Unshaded – not due yet
Red – overdue

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
13.09.22	22/150	Performance Report	The Performance Report to re-introduce the information about the number of individuals who made up the self-harm incidents.	June 2023	**PG**	The True North Performance Scorecard will include the number of individuals who make up the self-harm incidents from June 2023.	
13.09.22	22/150	Performance Report	The Finance, Investment and Performance Committee to receive an update on the project on reducing	June 2023	**TA**	The March 2023 Trust Board Discursive meeting discussed the	

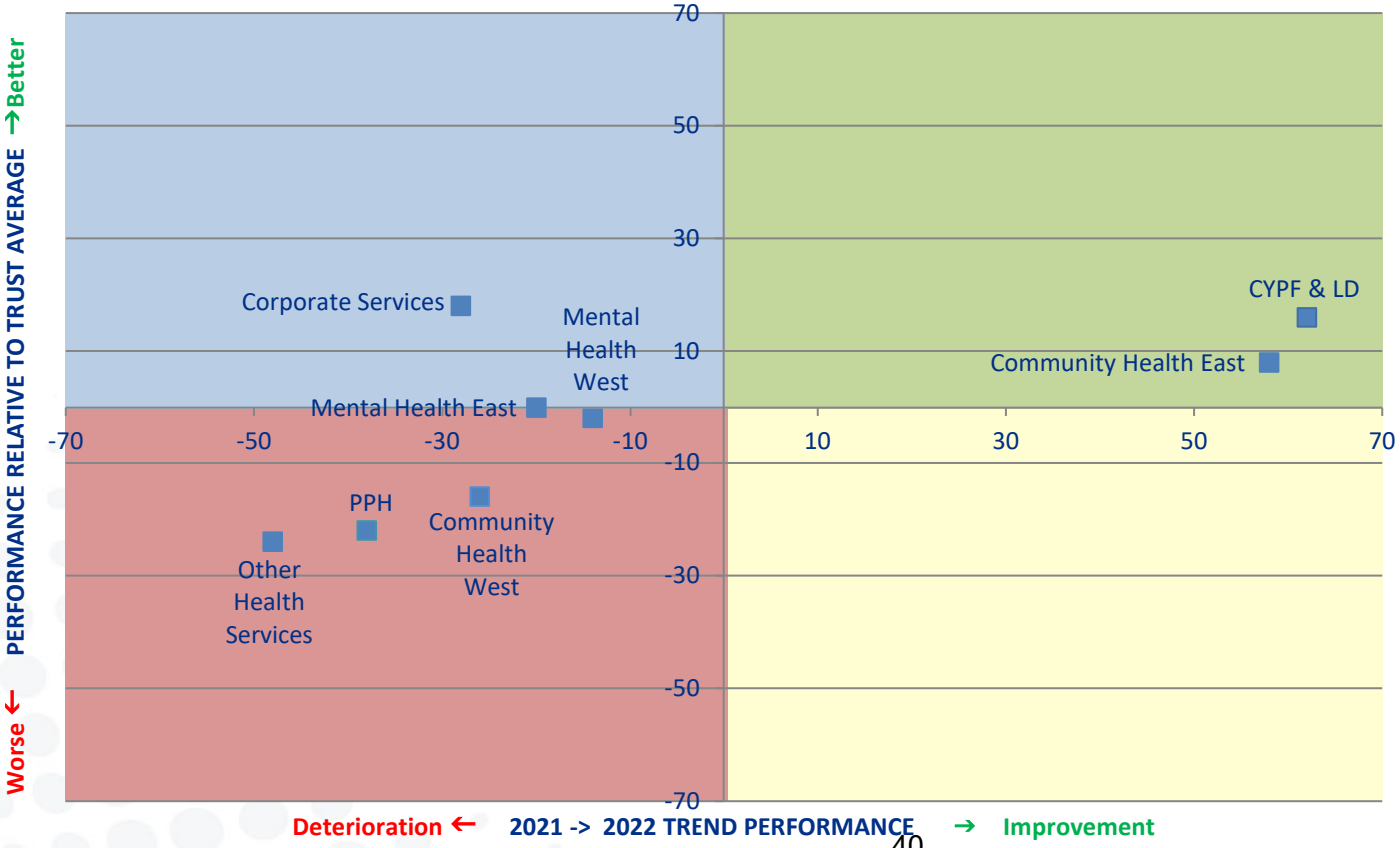
Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			the average length of stay for mental health patients			Trust's commitment to reducing the average length of stay as part of the bed modelling item. An update will be presented to the Trust Board in due course.	
13.12.22	22/218	Freedom to Speak Up Guardian Report	The Freedom to Speak Up Guardian to include some anonymised examples of instances where staff have used the Speak Up function and positive changes had been made as a result in the next report.	July 2023	**MC**		
13.12.22	22/224	People and EDI Strategies Update Report	A paper on which options were most success in terms of addressing the Trust's workforce challenges to be presented to a future FIP Committee meeting.	July 2023	**JN**		
13.12.22	22/228	Trust's Constitutional Changes	The changes to the Trust's Constitution to be ratified at the next Annual Members' Meeting in September.	September 2023	**JH**		
14/02/23	23/013	Quarterly Status Report	An update on the East Community Hospitals Project to be presented to	April 2023	**PG**	An update was presented to the April	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		on Key Initiatives	the March 2023 Finance, Investment and Performance Committee meeting.			2023 FIP Committee meeting.	
11/04/23	23/046	Executive Report	The Trust to consider publicising improvements to services so that public had a more rounded view about the Trust and the wider NHS	May 2023	**AG**	The Trust's Annual Report includes a wide range of material on Trust service improvements and developments. The new Trust strategy and implementation plan highlights are being developed for publication on the website.	
11/04/23	23/047	Gender Pay Gap Report	The Board to receive further information about the reasons for the difference in the Trust's mean/median hourly rate compared with our neighbouring Mental Health and Community trusts.	May 2023	**JN**	The difference is likely to be in the way others have reported this (using hourly pay rather than total pay as we do), as we also reported this way in previous years. We will clarify this with system colleagues.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
11/04/23	23/047	Gender Pay Gap Report	The Ethnicity Pay Gap Report to be presented to a future meeting of the Trust Board.	May 2023	**JN**	On the agenda for the meeting.	
11/04/23	23/047	Gender Pay Gap Report	The Disability Pay Gap Report to be presented to a future meeting of the Trust Board	April 2024	**JN**		
11/04/23	23/048	National NHS Staff Survey Reports	The Director of People to circulate a slide which provided a breakdown by division and corporate services of improvements or deterioration in questions in the NHS Staff Survey	May 2023	**JN**	Attached at appendix 1	
11/04/23	23/052	Trust's Green Plan	The new Sustainability Manager to be invited to attend a future Trust Board meeting to share their perspectives and to help the Board to understand which actions were likely to deliver the most benefit in terms of the Green Agenda.	September 2023	**PG**	The Sustainability Manager has not yet started with the Trust.	
11/04/23	23/052	Trust's Green Plan	The Green Agenda actions to be included in the Strategy Implementation Plan	May 2023	**AG**	Sustainability is included as part of the Strategy Implementation Plan.	

Divisional Movement

Berkshire Healthcare NHS Foundation Trust



Based on questions

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board

Meeting Date	9th May 2023
Title	Patient Experience Report Quarter 4 (January - March 2023)
	Item for Noting
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 4
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience
Relevant Strategic Objectives	True North goals of harm free care, supporting our people and good patient Experience
CQC Registration	Supports maintenance of CQC registration
Resource Impacts	N/A
Legal Implications	N/A
SUMMARY	During this quarter there were a reported 125,927 patient contacts this includes patient hospital discharges and around 6,694 pieces of feedback received, this equates to around 5.31% feedback. The feedback includes 88 formal and locally resolved complaints, 924 compliments, 24 MP enquires received and 5,658 responses to our patient experience tool. All of this data is used to provide the triangulation summary within the attached report. The 'I want Great Care' patient experience tool is, since December 2021 our primary patient survey programme, it is available to patients through online, SMS, paper, and electronic tablet; it is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge. As services start to embed the use of this tool, we are continuing to see an increase in the numbers of responses received, the 5,658 this quarter is up from 4,580 in quarter three and 4,024 in quarter two. The increased feedback will support areas for improvement alongside hearing the patient voice both where the experience is good and where improvements could be made. We are also seeing services using the information to make improvements and displaying/promoting where they have done this (examples are detailed on page 16). The overall positivity score was 93.6% this quarter around the same as quarter three (93.3%) slightly lower than 95% in Q2 and 94% in Q1 however the star rating has not materially changed at 4.74 compared with 4.77 in Q2 and 4.75 in Q1 &3. It is the view of the Director of Nursing that there are no new themes or trends identified from the patient experience data within the report. Opportunities for improvement have included involvement of families and carers, wait times/access to services, continuity of care, along with more service specific ideas/ areas for improvement. Thematic analysis demonstrates that the most positive themes were in relation to emotional support, empathy and respect (93% respondents reporting that staff are kind, friendly and understanding and that they are treated with respect, compassion and empathy). Whilst positive compliments and feedback continues to far outweigh the concerns and complaints raised, we strive to continue to ensure that the experience is improved for everyone, and every concern / complaint is reviewed with feedback provided and consideration given to learning from the persons experience.
ACTION REQUIRED	The Board is asked to: Note the report.

Patient Experience Report Quarter 4

Introduction

This report is written for the board and contains patient experience information for Berkshire Healthcare (The Trust) incorporating feedback from complaints, compliments, PALS, our patient survey programme, and feedback collated from other sources during the quarter.

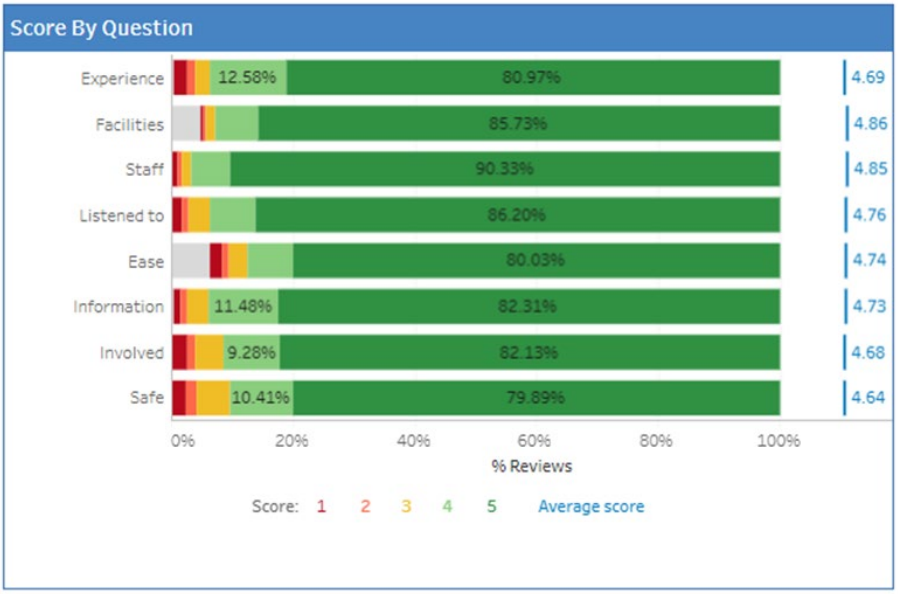
This report is written in the context of there being 125,927 reported patient contacts (from data supplied by our Informatics team) and discharges from our inpatient wards, with around 6,694 pieces of feedback collated through compliments, complaints, the patient experience survey, and MPs equating to around 5.31% service user feedback from contacts this quarter (an increase from 3.8% in Q3). The total amount of feedback received is expected to rise as more services utilise the patient feedback survey.

The 'I want Great Care' patient experience tool is now used as our primary patient survey programme and was introduced in December 2021, this is available to patients through online, SMS, paper, and electronic tablet; it is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge. As services start to embed the use of this tool, we are seeing an increase in the numbers of responses received which will support areas for improvement alongside hearing the patient voice both where the experience is good and where improvements could be made.

The tool uses a 5-star rating which is comparable across all services within the organisation and is based on questions in relation to experience, facilities, staff, ease, safety, information, involvement and whether the person felt listened to.

Thematic analysis demonstrates that the most positive themes were in relation to emotional support, empathy and respect (93% respondents reporting that staff are kind, friendly and understanding and that they are treated with respect, compassion and empathy); involvement in decision and respect for preference (with most staff involving patients in key decision regarding their care and considering patient wishes); Clear information, communication and support for self-care (with most patients feeling listened to and given opportunity to ask questions and given clear helpful advice and information and effective treatment delivered by trusted professionals (84% respondents describing their treatment as excellent or good and delivered by caring and professional staff).

Below is the trust overall scoring which is based on the 5658 responses received during the quarter; a 93.6% positivity rating was achieved with an average 4.74-star rating. It is worth noting that not all questions are scored by everyone, for example facilities related questions only apply where patients are seen in a building/are on a ward/outpatient appointment and are therefore not asked in all surveys. Our surveys are also available in easy read and differing languages.



For this quarter, 2 of the divisions that are proactively using the tool achieved an overall positivity scoring of over 95% (this is the threshold that we are aspiring to achieve at trust, divisional and service level scoring), these were Community Health East and Community Health West divisions, this is the same as Quarter 1, Quarter 2 and Quarter 3.

Other highlights from the quarter are that the total number of responses received via the patient experience tool has continued to increase with a further 19% increase in responses compared to Q3 and that 65% of enabled services received feedback, an increase of 4% from the previous quarter; whilst the percentage increase may seem small, this shows that services are consistently collecting feedback.

The thematic analysis and high-level findings are provided in an 'I Want Great Care' quarterly report, these are shared with the Clinical Directors for further sharing, learning and service improvements; this is alongside the live dashboard that all services have access to enabling them to see individual and collated scores and feedback.

Table 1: The services with the largest numbers of feedback through the patient survey

Service	Star Rating	Number of Responses	% Positive Score
Talking Therapies	4.46	603	83.6
District Nursing & Community Matrons Wokingham	4.94	214	99.1
District & Community Matrons West Berkshire	4.94	203	98.5
CRHTT East	4.24	198	85.4
St Marks Assessment & Rehab Centre	4.92	163	96.9
MSK Physiotherapy - WBCH	4.90	140	97.1
District Nursing & Community Matrons Reading	4.679	137	97.1
Upton Assessment & Rehab Centre	4.96	125	100
Community Respiratory Services - Community	4.87	120	97.5
Musculoskeletal (MSK) Physiotherapy East – Church Hill House	4.84	108	96.3

During the quarter, there were a total of 125,927 contacts (including discharges from wards), the Trust received a total of **58 formal complaints** (8 of these were secondary complaints, 50 were new complaints) there were a further **30 concerns that were locally resolved** / responded to as informal complaints. We also received **924 compliments** in addition to the

patient survey feedback and **24 MP enquiries.** The number of formal complaints received is slightly lower than Quarter three where 61 were received.

72 formal complaints were closed during the quarter with a 100% response within agreed timescale achieved.

Appendices 2 and 3 contain our PALS and Complaints information for Quarter four.

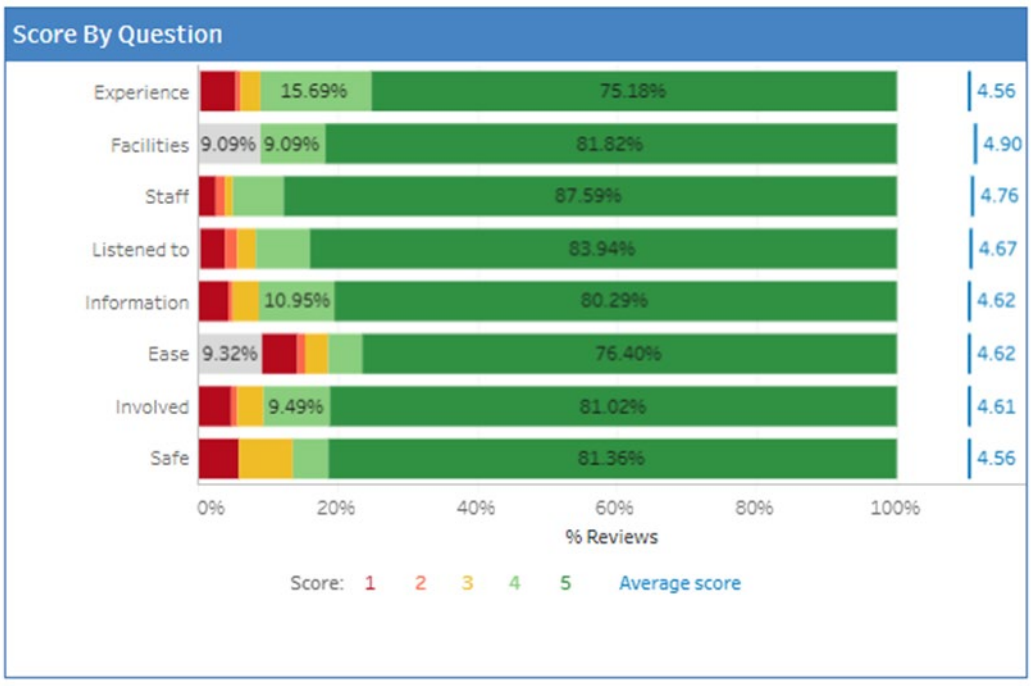
What the data is telling us

Below is a summary and triangulation of the patient feedback we have received for each of our 6 divisions.

Children and Young Peoples division including learning disability services.

Table 2: Summary of patient experience data

Patient Experience - Division CYPF and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	111	92	169	274
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	0.5%	0.4%	0.8%	1.15%
iWGC 5-star score	Number	4.81	4.80	4.86	4.64
iWGC Experience score – FFT	%	91%	95.6%	94.7%	90.9%
Compliments received directly by services	Number	47	80	82	72
Formal Complaints Rec	Number	11	11	15	14
Formal Complaints Closed	Number	15	12	13	16
Formal Complaints Upheld/Partially Upheld	%	60	67	54	56
Local resolution concerns/ informal complaints Rec	Number	11	6	9	5
MP Enquiries Rec	Number	21	10	13	16



For children's services the iWGC feedback form is not currently being well used and therefore it is less easy to draw conclusions; young people and parents/carers have been assisting in the ways to promote the new patient experience tool to other service users, including the design and layout of the new posters that will now be used across CYPF services.

Of the 274 responses, 224 responses related to the children's services within the division; these received 91.5% positivity score, with positive comments about staff and services and a few suggestions for further improvement, this included 3 reviews for Phoenix House our T4 adolescent day unit were comments about support and safety was very positive and there were some suggestions for further improvement regarding being listened to and crisis prevention. 41 of the responses related to learning disability services as detailed below and 9 to eating disorder services.

From the feedback that was received, ease and information were most frequent reasons for individual questions being scored below 4. Although 20% of respondents gave a score of 3 (satisfactory) to facilities and it therefore appears to be lowest star rating, it was only scored by 20 people with the responses from Phoenix House and Woodland respite centre where young people spend the longest periods of time all scoring 5 for that question.

Children's Physical Health Services

There were 3 formal complaints for children's physical health services received this quarter. There were 2 formal complaints about the immunisation service, which both related to the concerns from parents about consent being obtained. The Head of Service is looking into how consent is obtained and documented. There was also a formal complaint about a delay in a family receiving an assessment report from an Occupational Therapist.

There was one locally resolved complaint received for the Immunisations team.

172 of the 224 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Immunisation services –East and Immunisation West; the Immunisation East received 86 of these responses all of which scored positively receiving a five-star rating of 4.59 and feedback included *"[name removed] was amazingly calm, patient, encouraging & understanding with my son. She made his experience exceptional given his needle phobia." "The lady was very kind to me and helpful" and "The nurse was nice and she explained why we were getting the vaccines and what it meant for the future.."*

Children's services have continued to undertake their feedback surveys this quarter for school nursing 3 young people completed the survey with all stating the service was good or better, responses included that they were listened to, understanding and feels like talking to a friend. Health Visiting are waiting for some changes to be made on their age range by iWGC but are keen to start using their surveys as soon as possible. There are also some responses that are associated with Health Visiting incorrectly which affects the overall rating for CYPF negatively. We are, along with iWGC looking into this to ensure it is rectified.

Children's services have continued to gain feedback via other methods during this quarter including an online focus group to learn from the experiences of parents/carers and nursery staff who have attended early years Speech and Language Therapy [SLT] drop-in surgeries in the past. This provided valuable learning detailed in the you said , we did section of this report. The CYPIT East team also attended the "Special Voices" parent group in Slough in February to hold a focus group. Areas of discussion generated included parental involvement, the voice of the child, and a lack of knowledge/understanding about how the CYPIT team operates.

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were 11 complaints received (these were in relation to care and treatment received, waiting times and communication; themes around these included concerns about a lack of communication following referrals being accepted, and inaccuracies being recorded in letters from the service). In addition to this, the service received 16 enquiries via MPs, and most of these again related to waiting times.

There have only been 9 responses for CAMHS services received through our patient survey for this quarter. Currently the survey is accessed through online or configured tablets in the departments.

The admin team for CAMHS Getting Help collated feedback from young people who received a service. Experience of Being Referred to a Getting Help Service in the East of Berkshire. They have received 46 responses for this quarter with 38 of the responses describing being satisfied or very satisfied with the referral process (4 of the 46 were dissatisfied / very dissatisfied). As a result of the survey a focus group is planned to gain more detailed understanding of people's experience.

In addition to the current feedback tools, the anxiety and depression pathway have set up a question on the whiteboard in waiting rooms, asking for feedback and suggestions for young people and their families, there will be a differing question each month.

Compliments for our CAMHS services included that *Parents of a YP were extremely complimentary about the care and treatment received by CAMHS Phoenix for their daughter. They reported feeling very well supported and said many thank yous to the team. They reported that they feel the service has helped their daughter transition from an inpatient unit to the community with a smooth transition.* And ''*I can't express my gratitude & support for the CAMHS team in the most critical day of my life and personally to ****. He was the person who was helping my family to get through from the first day in the hospital where my son was taken with suicidal attempt to the moment we were assigned to the specialist to take further care of him now. **** was very supportive, respectable and open to the needs. He was very sensitive talking to my son at his worst times showing all his professionalism and care, very attentive to the details''*.

Learning disability

There was one complaint received this quarter for the Campion Ward.

28 responses from the patient survey have been received. These received 85.7% positive score, this was skewed by 2 responses not having a score; 1 person scored the services as a 1 however there are no comments to understand the reason for this; feedback included that staff were nice, "Communication was good as well as presentation.", "I got help I needed to make my life easier." and "We explained well with what is going to happen", there was a comment for improvement which was that meetings at patients home would be preferred.

41 responses from the patient survey have been received (9 in relation to the Wokingham based team), an increase from 24 responses last quarter. These received 90.2% positive score, 1 person scored the services as a 2 and comments were left regarding focus not being on their needs. Feedback included "*Couldn't have asked for better care and understanding for my son's needs.," "I had the pleasure of working with [name removed]. Very professional, knowledgeable, and kind." And "[name removed] was compassionate and caring, she understood our situation and really helped us at our lowest.."* There were a couple comments for improvement which included timing, follow up and wanting to be seen under the service for a longer time.

Eating disorders

There were no complaints for eating disorders.

Of the 8 feedback responses received 7 scored a 5 with comments such as 'I feel I've been listened to', 'staff are friendly', 'I couldn't have asked for more help and 'x has made a positive impact on my life and really helped me'.

The services also have other methods of collating feedback to support service improvement including that The Berkshire PEACE team (Pathway for Eating Disorders and Autism Developed from Clinical Experience) have been running the parent participation groups, with parents invited from Berkshire, Buckinghamshire, and Oxfordshire. The February group took place online via MS Teams and 8 parents attended. Within Adult BEDs [Berkshire Eating Disorder service] have a good system in place of feeding back from the individual groups from day programme, individual first steps group, as well as continuing to regularly review day programme every 3 months. The service users have identified areas for improvement; including more information/ transparency of services and treatments at the point of assessment/ first steps group.

Mental Health East division (Slough, Windsor, Ascot & Maidenhead, Bracknell)

Table 3: Summary of patient experience data

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	183	309	349	400
Response rate (calculated on number contacts)	**%**	1.5%	2.2%	3.7%	2.4%
iWGC 5-star score	**Number**	4.56	4.57	4.58	4.52
iWGC Experience score - FFT	**%**	93%	92.9%	94.6%	90.8%
Compliments received directly by services	**Number**	43	201	43	37
Formal Complaints Rec	**Number**	9	13	12	12
Formal Complaints Closed	**Number**	7	12	9	12
Formal Complaints Upheld/Partially Upheld	**%**	71	50	66	33
Local resolution concerns/ informal complaints Rec	**Number**	5	2	3	2
MP Enquiries Rec	**Number**	0	1	0	2

12 complaints were received into the division during this quarter; in addition, there were 2 informal/ locally resolved complaints. 12 complaints were closed during the quarter of these 8 were upheld, 4 were partially upheld and 0 were not upheld. Five of the complaints related to care and treatment,

The services receiving the majority of iWGC responses were CRHTT East 198 responses, Memory Clinic – Bracknell 26 responses, CMHT Slough 23 responses and CMHT Bracknell 22 responses. CRHTT East received two formal complaints this quarter, one relating to communication, the other to care and treatment. They received one informal concern relating to attitude of staff. They closed two formal complaints, and both were upheld.

Across the CRHTT East survey responses the average 5-star score was 4.80 with 95.5% positive feedback, an increase from last quarter. 169 of the (overall number of responses received) scored a 4 or 5-star rating with many comments about staff understanding, being helpful, listening and being empathetic; "*They were really empathetic towards me. Great teamwork. Listened to what I had to say. Make me feel comfortable*." This quarter, questions relating to feeling involved and ease were least likely to be positive with areas for improvement and dissatisfaction with the service about the support being limited and staff not listening.

Feedback from compliments for the service included, '' *I'd like to praise your CRHTT in East Berkshire. They have been absolutely stellar. Prior to moving to XX I'd occasionally been under the home treatment teams at xxx , xxx and xxxx at times over the last decade - your trust has shown what a CRHTT should look like and sets the benchmark for other trusts. I particularly appreciate their candour and support with getting me onto the right therapy pathway, I honestly didn't think I'd ever get such great care from an NHS mental health trust - they've proved me wrong! (And I say this as a former service user governor at XX.) I'm also very grateful for their four week programme for family members/carers - I've not come across this at other trusts. My fiancé XX and I feel supported and encouraged by the team, through what has been a very difficult couple of weeks''.*

The Memory Clinic Bracknell received 100% positive score (4.92-star rating) and received positive feedback about thorough assessments, clear explanations and staff being understanding. "*Very friendly and kind approach, very thorough assessing process and we weren't rushed at all. Conclusion and way forwards explained very clearly*."

CMHT Slough received 91.3% positive feedback (4.37-star rating), many of the comments were positive about staff being supportive, kind and understanding. "*Because I was listened to for the first time and they were patient and they were thorough and I am glad I am in safe hands."* One patient gave a score of 1 and said *'Dr XX didn't show any care for me at all and left me feeling cold and alone and not wanting to go on, just concerned with pills nothing else. A shameful experience.'*

Other areas for being worked on for improvement include that it takes a long time to get through on the phone, patients wanted to be given more information on the therapy they would receive, that it took a long time to be seen and that they were seen by a different psychiatrist at each appointment and wanted more consistency.

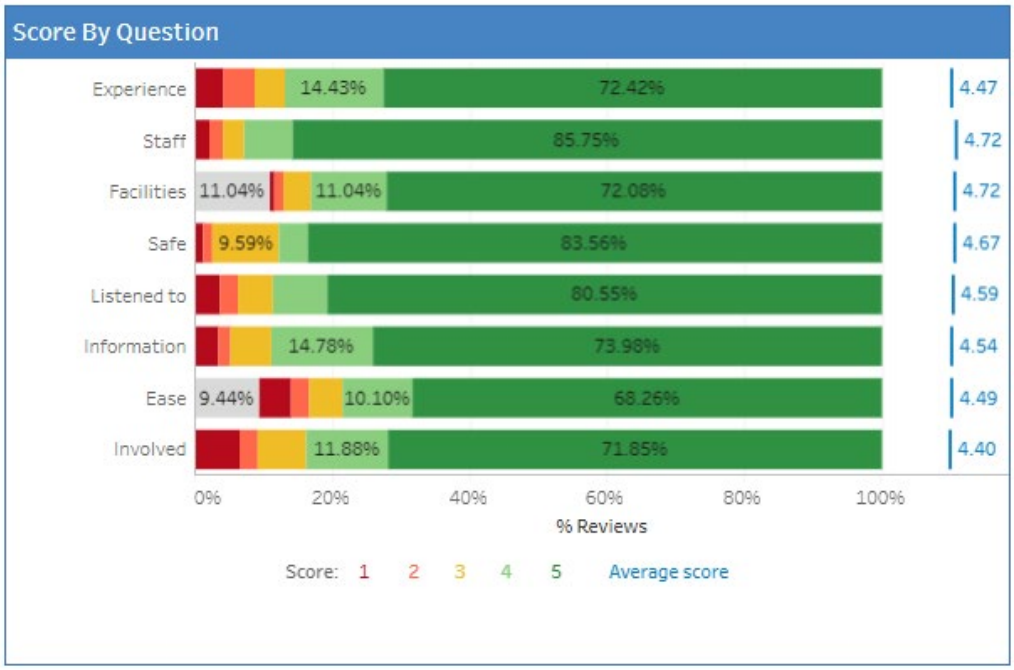
CMHT received 51 responses (Bracknell 26, WAM 17 and Slough 8) with 92.16% positive score and 4.49 star with 4 of the total responses scoring less than a rating of 4; comments included that "*Consultant was very kind and caring, and listened", "Because it was totally professional cannot think of anything better" and "The whole CMHT have been fabulous. Caring and genuinely interested in my care. I feel supported and hopeful about the future."* There were a number of positive comments about being listened to, staff being kind and helpful.

CMHT Bracknell received 22 feedback responses with a positivity score of 95.5% and 4.80-star rating. Comments included that "*[Name removed] was lovely, she listened to me and didn't rush through appointment. Very professional and kind.3 examples of positive free text comments)", "[Name removed] was very understanding and presented questions in a respectful way." and "I was very impressed with the new hospital facilities. The staff have been very professional and courteous as usual."* There were a number of positive comments about Staff being kind, listening and understanding.

Mental Health West Division (Reading, Wokingham, and West Berks)

Table 4: Summary of patient experience data

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	232	717	851	1095
Response rate (calculated on number contacts)	**%**	0.5%	1.6%	3%	2.4%
iWGC 5-star score	**Number**	4.53	4.61	4.46	4.53
iWGC Experience score - FFT	**%**	87%	90.4%	83.2%	86.9%
Compliments received directly by services	**Number**	434	589	680	320
Formal Complaints Rec	**Number**	14	10	20	10
Formal Complaints Closed	**Number**	11	13	13	17
Formal Complaints Upheld/Partially Upheld	**%**	55	85	54	41
Local resolution concerns/ informal complaints Rec	**Number**	2	4	5	3
MP Enquiries Rec	**Number**	2	3	6	5



The Mental Health West division has a wide variety of services reporting into it, including Talking Therapy services and Court Liaison as well as secondary mental health services. The division saw an increase in number of responses received this quarter, this was largely due to increase in responses from Talking Therapies. The 3 services with the most feedback through the patient survey were Talking therapies 603 responses, PMS West 73 responses and CRHTT West 58 responses.

Within Mental Health West the questions relating to ease and feeling involved had the least number of positive responses.

This division received 10 formal complaints during the quarter with CMHT receiving 5. There were 17 complaints closed with 7 being found to be upheld or partially upheld and 10 not upheld.

CRHTT West received one complaint this quarter, relating to care and treatment following a suicide attempt. They also received one informal complaint relating to care and treatment and one MP enquiry. Two complaints were closed across CRHTT West and neither of these were upheld.

For CRHTT there were 58 feedback questionnaires completed with a 70.7% positivity score and 4.19-star rating; with lots of positive comments about staff being supportive and listening, *"Very friendly, I felt listened to and understood. Fantastic support at a very hard time";* a number of the less positive reviews talked about staff needing more training and not listening.

All of the five complaints for West CMHT's during the quarter, related to care and treatment. There were 17 complaints closed, 10 being upheld, six partially upheld and one not upheld.

There were 64 responses received with 84.4% positivity score and 4.23-star rating, 54 of these were positive with comments received that staff were understanding and listened, there were 10 negative responses with reviews stating that patients felt like staff didn't listen, appointments and treatment weren't given. Older adult and memory clinic combined have received 107 patient survey responses during the quarter with a 100% positivity rating (4.87-star rating) some of the feedback included *"Both appointments went smoothly. Everyone was kind and helpful. Reception made us feel welcome and relaxed. The doctors who did the assessments were friendly, patient, and professional. One, a trainee under supervision, was just brilliant - so calm. The atmosphere in the clinic and the kindness of the staff made a somewhat daunting experience OK."*

The West Psychological medicine service received 72 responses with an 86.1% positive score and 4.58-star rating (10 responses scored less than 4) many of the comments were positive about staff being supportive, engaging and listening well although a few felt that this was not the case.

For Talking Therapies, their patient survey responses gave a positivity score of 83.6% (4.46-star rating), 98 of the reviews scored less than 4. The vast majority of comments were still very positive about the staff, including that they were understanding, kind and listened. A number of the comments/areas for improvement were requesting the support to be provided sooner and less questionnaires and more talking. Some other areas for improvement were that they were not given an appointment and never followed up with the patient. For example, *"The therapist never made an appointment with me. Never followed up for another appointment. I needed an evening appointment, and she wasn't willing to give me an appointment at that time".*

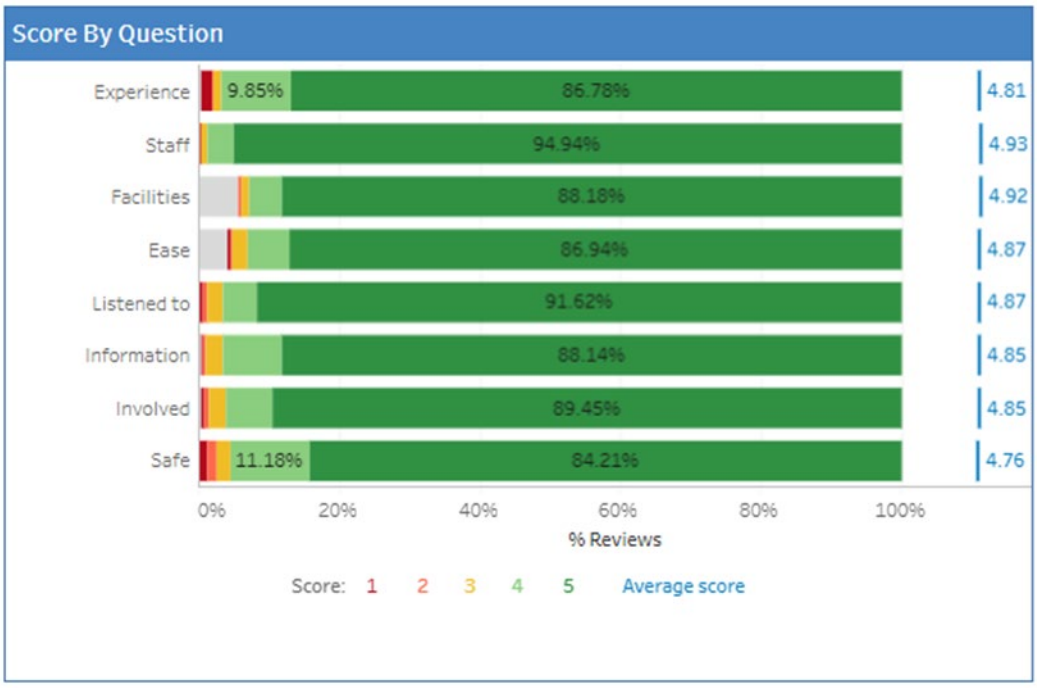
Examples of positive feedback about Talking Therapies included, *'I self-referred to Silvercloud mainly as talking therapies with someone in person daunted me a lot. I have found it useful to do things in my own time and to sit on my own and reflect on my answers and what matters to me. I feel much better and in control of my emotions and what parts of my life I need working on'*, *'I feel that sometimes people refrain from asking for help related to mental health issues in person due to social stigma and shame, hence an online platform is a wonderful way to slowly ease into receiving help. It is less intimidating than talking to someone in person or over the phone (according to me personally)'* and *'Really useful service and I really enjoyed it being online as it was easier than making face to face appointments but although it wasn't face to face, I still felt supported and listened to.'* Patients reported that they felt *'grateful to not feel abandoned,' 'enjoyed it greatly so far' and were 'very appreciative of the support while they are waiting.'*

The service identified that the referral numbers for ethnic groups was decreasing so they did some targeted work reaching out to a Community Wellbeing Hub. The service received the following feedback as a result of this engagement, *'I want to thank you for the mental health counselling that I received at ACRE (Alliance for Cohesion and Racial Equality), offered by XX (Talking Therapies CBT Therapist). I was at the cliff end, but after the first and other counselling sessions, I feel confident and sure of myself'.*

Community Health East Division (Slough, Windsor, Ascot and Maidenhead, Bracknell)

Table 5: Summary of patient experience data

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	755	1416	1427	1838
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3.4%	5.6%	9.3%	5%
iWGC 5-star score	Number	4.83	4.84	4.87	4.86
iWGC Experience score - FFT	%	96%	97.2%	96.7%	96.6%
Compliments received directly into the service	Number	174	201	298	247
Formal Complaints Rec	Number	5	1	3	4
Formal Complaints Closed	Number	2	4	2	5
Formal Complaints Upheld/Partially Upheld	%	100	50	50	60
Local resolution concerns/ informal complaints Rec	Number	6	2	2	1
MP Enquiries Rec	Number	0	0	0	0



Four complaints were received this quarter. Three for District Nursing, relating to care and treatment (two complaints about the service based in Windsor, and one for the Slough team), and one for Jubilee Ward, relating to discharge arrangements.

There were five complaints closed, one for Jubilee Ward, which was partially upheld, and four for District Nursing, which were equally split between partially upheld and not upheld.

Hearing and balance received 78 responses to the patient experience survey with a 97.4% positive score and 4.86-star rating.

East Community Nursing/Community Matrons received 175 patient survey responses during the quarter with a 98.3% positive scoring, many comments were about staff being kind and helpful, for example "*Excellent care and understanding by each and every one of the brilliant staff, can't thank them enough for being so helpful and kind", "Amazing service, not sure what we would do without them. I would like to thank each and every one of them for their kind, caring words,"* "*Lovely kind, caring people, truly thankful for the service and all they do for me. Look forward to the company"* and *"Great service. Staff are always friendly and very helpful."* There were also some comments around timing of visits and *"Good service, though timed visits would be great as the DNs sometimes turn up when I am heading down for lunch and we end up missing each other."*

The wards received 145 feedback responses (80 responses for Jubilee ward 93.8% positive score and 65 Henry Tudor ward 100% positive score). 1 of the responses giving a score of below 3 for Jubilee ward had positive comments so it appears there was confusion with the way the scoring worked, comments included "*Staff are good. Food not bad medium. Everything ok."* Most of the comments for improvement were to prioritise better (take patients to toilet rather than make beds), more staff and more food choices.

As with MSK physio in the West, there was a high number of responses to the patient survey and a high positivity score of 94.9% (4.82-stars), comments were very complimentary about staff being professional and helpful, *"Excellent care, friendly staff, clear explanation of my injury and physio exercises I need to do".* There were no themes emerging from the improvement suggestions this quarter.

Outpatient services within the locality received a positivity score of 96.8% with 4.89 stars from the 1,693 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Great service. So quick and so helpful. I couldn't have asked for more. Wonderful team. Brilliant staff."*

The diabetes service received 33 feedback responses with 97% positivity and some lovely comments including "[name removed] was amazing! She listened to my concerns and the. Worked out an insulin medication plan with follow-ups to check how I am doing. Amazing! [name removed] had provided me with an amazing diabetic analysis on what I am using now and what medications will help me bring sugar levels under control." Alongside some helpful suggestions for the service to consider such as "It would be helpful if one's partner could also attend so they too could understand the situation and therefore be more supportive."

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including ''*I was so impressed with, literally, everything that I felt it important to communicate my thoughts to you. Even more excellent communication – Dr XX phoned me on XX to give me specific details and an opportunity to discuss the findings. Later that day… I found a letter waiting for me. The communication was from ARC and gave a detailed printout of all the procedures and outcomes. It was dated Sunday XX!''.*

Community Health West Division (Reading, Wokingham, West Berks)

Table 6: Summary of patient experience data

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	675	1459	1763	2011
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	0.9%	3.1%	3.3%	2.4%
iWGC 5-star score	Number	4.76	4.84	4.81	4.81
iWGC Experience score - FFT	%	95%	96.3%	95.6%	95.7%
Compliments (received directly into service)	Number	126	167	289	217
Formal Complaints Rec	Number	7	5	7	6
Formal Complaints Closed	Number	11	4	6	8
Formal Complaints Upheld/Partially Upheld	%	55	50	50	50
Local resolution concerns/ informal complaints Rec	Number	16	16	14	16
MP Enquiries Rec	Number	3	1	2	1

Community Health West saw a significant increase in responses this quarter. There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 95.7% positive satisfaction and 4.81-star rating and the question on staff receiving a 97.7% positive scoring from the 2011 responses received.

There were 6 complaints received during the quarter, 2 of these related to District Nursing, 2 to WestCall, the Out of Hours GP service, one for phlebotomy and one for Podiatry.

There were 8 complaints closed for the division during the quarter with 2 being upheld, 3 not upheld, 2 partially upheld and one moved to a serious incident investigation. Three of the closed complaints related to waiting times with WestCall.

During this quarter the community hospital wards have received 139 responses through the patient survey receiving a 90.7% positive score and 4.47-star rating, (13 responses scored 3 and below) questions around feeling listened to and involved received the most results of 3 and below; comments include staff were friendly and helpful, “All staff were really nice.”, “Everyone was really lovely and did their best to make me understand.”, “Staff/doctors are very informative and provided great care and support.” And “Outstanding loved my stay here that’s because staff are so kind and caring,” there were some individual comments where

patients were less satisfied, with comments including food was cold, need for more physiotherapy, more staff, and more equipment for staff.

WestCall received 15 responses through the iWGC questionnaire this quarter (93.3% positive score, 4.79-star rating, 1 score received below 4. Positive comments included *("We saw [name removed] with our young daughter. I thought he was thorough, understanding, kind and very knowledgeable. I came away feeling we were listened to cared for.," "Friendly and caring staff and doctor. The nurse [name removed] had such a pleasant smile even though she was working on New Year's Day. Thank you, NHS."* and *"All the staff here were very kind and caring. Thank you!."* WestCall received around 18545 contacts during the quarter.

Podiatry services received 150 patient survey responses. Most responses were very positive receiving 5 stars (overall 95.3% positivity 4.82-star rating) with examples including "Always considerate and first-class treatment given. Friendly & engaging staff.2 examples of positive free text comments" and "Lovely clean place. The lady doing my feet was very friendly and waited till my wife came to explain how to file my nails. Very pleased with the result". There were three complaints for Community Nursing, two relating to care and treatment and one relating to attitude of staff. have received some of the highest numbers of feedback (554 across the 3 localities in the quarter, with a 98.4% overall satisfaction score and 4.90-star rating). To provide some context across our East and West District Nursing teams combined there are 35,100 contacts this quarter. Lots of comments included nurses were kind, helpful and knowledgeable, "*The triage nurse who called me back was so knowledgeable and explained everything clearly to me, I was really impressed", "So helpful, gave me all the information I needed and supported us" and "All the nurses who come are lovely but [name removed] is particularly knowledgeable and never leaves without making my husband laugh first".* There were several positive comments about nurses listening and there were very few suggestions for improvement, mainly around timing of visits and being given an allocated time for a visit.

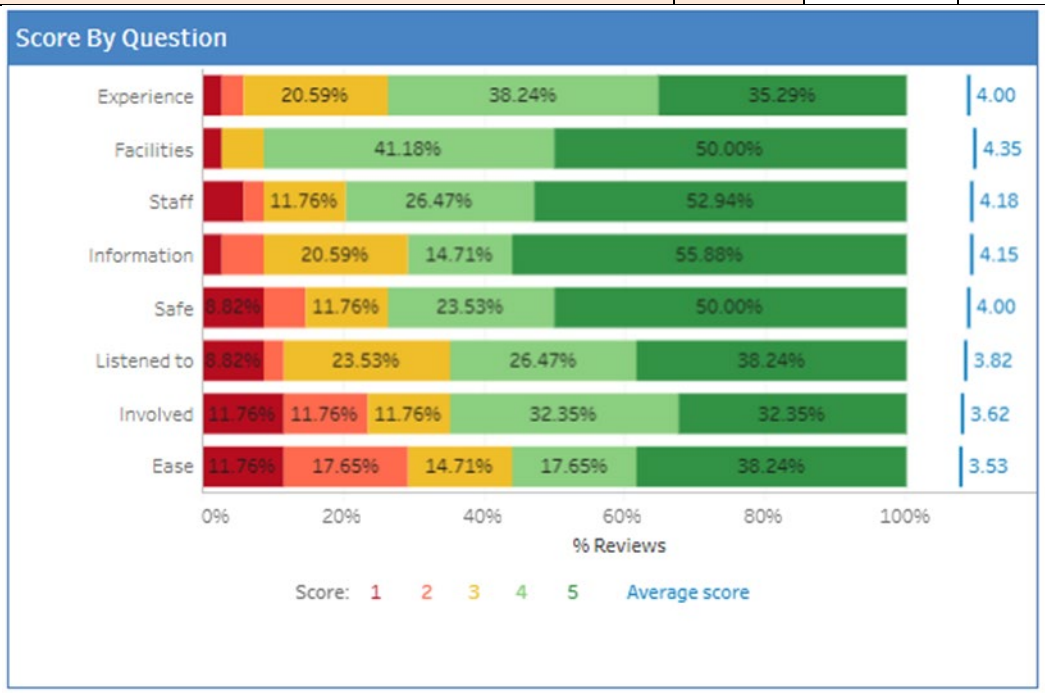
MSK Physio has received one complaint in the quarter relating to discharge arrangements. The service has received 23 compliments and 327 patient survey responses with a 96.9% positive score (4.87 star rating), very few areas for improvement were included in the feedback there were a few suggestions including that it would be helpful to have a video demonstration of exercises, waiting time for appointment and to be assessed before being discharged and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, kind and understanding.

The services across the division received many compliments including ''…….. *Throughout the months I have known XX she has been a great friend, caring and considerate and very positive about my progress. Nothing has been too much for her. Equipment she has ordered in the morning has often arrived that same afternoon always in pristine condition. I can't speak too highly of her persuasive energetic approach to the work she does that has encouraged me especially on the bad days and her lighthearted sense of humour that emerges on the good days''*

Mental Health Inpatient Division

Table 7: Summary of patient experience data

Patient Experience - Division MH Inpatients		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	21	33	21	34
Response rate	**%**	10.3%	16.5%	12.1%	27%
iWGC 5-star score	**Number**	3.92	3.77	3.44	3.96
iWGC Experience score - FFT	**%**	76%	75.8%	42.9%	73.5%
Compliments	**Number**	12	10	11	30
Formal Complaints Rec	**Number**	14	10	10	11
Formal Complaints Closed	**Number**	11	15	9	13
Formal Complaints Upheld/Partially upheld	**%**	45	67	55	46
Local resolution concerns/ informal complaints Rec	**Number**	2	1	1	1
MP Enquiries Rec	**Number**	0	0	0	0



There were 126 reported discharges from mental health inpatient wards (including Sorrel Ward). Only Bluebell, Daisy, Orchid, Snowdrop and Sorrel collected feedback from the patient experience tool this quarter, with no responses received from Oakwood, Rose, and Rowan. The satisfaction rate at 73.5% is skewed by 9 of the 25 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to ease receives the least positive scores with overall 5-star rating being 3.53; with 15 of the 34 giving a score of 3 or less to this question.

There were 11 formal complaints received for mental health inpatient wards during the quarter, with allegations / concerns around bullying/ harassment (physical and non- physical) being the main theme for 5 of the complaints. 4 of the total complaints received were about Sorrel Ward, and three of these related to care and treatment.

There were 13 complaints closed for this Division during the quarter and of these 5 were partially upheld and one was not upheld with the remaining 7 being upheld.

There were many positive comments received in the feedback including comments such as staff were helpful and caring, drug and alcohol misuse nurse was especially helpful. 7 of the 34 responses to the survey were from Sorrel Ward and of those 4 gave a positive score of 4 or 5. Most of the lower scores did not provide much additional feedback however there were

some comments about bathrooms and showers not locking properly, wanting to be more involved with their own care, feeling like care overall could be better and wanting to move on quicker. Examples of the feedback left are "*The drug and alcohol nurse were very friendly, approachable, consistent, and included me in the care plan and support in the community. Introduced me to a calendar to keep myself organised*," "*The drug and alcohol nurse Very helpful and felt looked after and listened too," "I was diagnosed with bipolar disorder at 18 years old. I have been through many psychiatric wards and rehabs over the years. Prospect Park is by far the most far advanced and ahead of their game in mental health care that I have had the pleasure of being a patient at. Everything works like clockwork and carers are helpful and the facilities are really great," "[name removed] ward Staff are lovely supportive and promote independent thinking and holistic wellbeing*." The 2 responses related to Place of Safety provided positive scores and comments.

Demographic profile of people providing feedback (Breakdown up to date as of Quarter 4 data from our Business Intelligence Team)

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendances
Asian/Asian British	8.62%	7.30%	9.67%
Black/Black British	5.17%	2.90%	2.67%
Mixed	3.45%	1.70%	3.49%
Not stated	10.34%	9.70%	15.89%
Other Ethnic Group	1.72%	6.50%	1.62%
White	70.17%	71.90%	66.66%

The above would indicate that potentially we have a higher number of complaints received compared to attendance percentage from those with Black/Black British heritage and that there is still more feedback being received from White British as a percentage of contacts than from others. It will be important to ensure as we continue to gain an increase in our patient survey responses that everyone is able to access and use the survey; the survey is provided in easy read and a number of differing languages, but it will be important to ensure that the prompts to complete this are not inhibiting feedback representative of the community and our patient attendance.

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q4 attendance
Female	46.55%	46.90%	53%
Male	48.28%	33.10%	46.98%
Non-binary/ other	0.00%	1.40%	0%
Not stated	5.17%	18.50%	0.01%

This would indicate that whilst the breakdown by attendance is fairly equally split as are complaints it would appear that we are still more likely to hear the voice of the patient through the patient survey if they are female.

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
0 to 4	3.45%	5.70%	18.41
5 to 9	5.17%		4.14
10 to 14	8.62%		4.34
15 to 19	8.62%		4.52
20 to 24	5.17%	4.50%	2.87
25 to 29	10.34%		3.14
30 to 34	5.17%	6.90%	3.56
35 to 39	8.62%		
40 to 44	6.90%	9.30%	3.58
45 to 49	3.45%		3.52
50 to 54	8.62%	13%	3.73
55 to 59	5.17%		4.32
60 to 64	1.72%	15.30%	4.46
65 to 69	3.45%		4.63
70 to 74	1.72%	17.20%	4.53
75 to 79	0.00%		5.56
80 to 84	0.00%	18.90%	6.16
85 +	6.90%		6.55
Not known	6.90%	8.80%	11.98

Ongoing improvement

Complaint Handling Training continues to be delivered by the Complaints Office to support ensuring robust investigation and response to any complaints (formal or informal) that are received.

All services have access to a tableau dashboard detailing response to our patient survey including free text comments and this is refreshed daily to enable live data to be used by services alongside improvement work being undertaken.

Many of the teams are starting to use the feedback and improvement suggestions received through the iWGC tool, services like wards and outpatient departments are also starting to display these for services users and their loved ones to see.

Some examples of services changes and improvements are detailed below.

Service	You said	We did
Talking Therapies	It can feel daunting making contact with a service for the first time and some people would prefer not to speak to directly to a therapist initially and ease themselves into therapy	Developed a direct to digital pathway. Direct to Digital launched in May 2022 and provides an innovative solution, allowing Talking Therapies clients immediate access to online support for depression and anxiety. Referral information is collected from patients electronically and they get quick and easy access to our SilverCloud programmes. A clinician then supports them

Service	You said	We did
		through the programme. Over 1300 patients have accessed this service so far.
	The waiting times for Step 3 therapy was too long and patients can feel abandoned from assessment or when stepped up from step 2 treatment with no contact or support whilst waiting	Offered Silvercloud to patients on our waiting lists. Patients on the waitlist for Talking Therapies are offered access to online treatment using the Silvercloud programme under the guidance of a support worker. Early results show that this has resulted in mood improvement in a number of cases and feedback from staff and patients is very encouraging.
	Our referral numbers told us that our engagement with ethnic minority groups needed improving	Targeted outreach by offering therapy clinics at ACRE Community Wellbeing Hub, Reading. Talking Therapies has committed to addressing ethnic health inequalities with the establishment of permanent Cultural and Ethnic Diversity Lead roles. The leads have already made great strides towards building, developing, and maintaining relationships with local communities, grassroots organisations, faith leaders and faith-based organisations. The team have also conducted targeted outreach to specific community locations, such as the ACRE community wellbeing hub (CWH) in Reading, to break down cultural barriers to accessing mental health treatment for groups including asylum seekers and refugees.
Community Inpatient Wards in the East (Slough and Maidenhead)	There are some language barriers (patients who did not have English as a first language) are finding it difficult to communicate their needs with the staff in the wards.	The admin lead created some communication leaflets using the 4 most common languages in this area (Hindi, Punjabi, Urdu and Polish) utilising words and pictures.
	There is a lack of activities/therapy.	We have now employed an activities co-ordinator across the wards and the therapy team have created some innovative groups on Henry Tudor Ward; gardening therapy, boccia and other 1:1 activities including crafts, colouring and nail painting.
PMS, Reading	Complaints/feedback was received from our service users that the interview room where they had to wait in and be assessed, seemed more like a box, and not welcoming.	This feedback was shared with the ED colleagues, that room has now been converted and is well decorated, does not seem as unwelcoming as before. The current room that is being used for interviews, is not cramped with the heavy furniture as the other room was, patients

Service	You said	We did
		have fed back that there is space and it is more welcoming.
Early Years Speech and Language Therapy	To access Early years surgeries on different days/times as well as be notified when a slot had become available at the last minute due to a cancellation. Support from the SLT team when they needed it, dependent on the needs of the child.	The Early Years team are looking into changing the schedule of the surgeries to allow for settings to access them at a different time and speaking to the local authority about notifying nurseries of last-minute slots that become available. The Early Years SLT team has been working hard to ensure that settings and families can access the SLT team and improve the level of support that is given.
Feedback to CYPIT East team from Special voices parent group in Slough	parental involvement, the voice of the child, and a lack of knowledge/understanding about how the CYPIT team operates	Creating new targeted live online training packages to schools across East Berkshire. Updating our website Updating our report templates. Trialling new triage system for CYPIT SALT EY [Early years] to tackle waiting times. Creating new universal training packages for SLT to support parents whilst waiting support or before they need support in early years. Signposting families to GEMS Berkshire and Neurodiversity SHaRoN earlier in 0-5 years AAT pathway so families have access to support while they wait

15 Steps

Appendix 1 contains the 15 Steps visits that took place during Quarter 4, with the programme fully recommencing in April 2022.

There were 2 visits this quarter, one to the Hearing and Balance Service and the other to the Diabetes Service; both services are based in King Edward VII Hospital.

Summary

It is very positive to see further increased volumes of patient feedback through our patient survey month on month and all managers and divisional leaders have access to the live tableau dashboard to view this. It is also positive to see a number of services proactively using the feedback to make changes and displaying this for patients and their loved ones to see.

Responses about staff have remained overwhelmingly positive although we recognise that this is not the experience for everyone and do see some feedback and complaints relating to staff attitude for the vast majority of patient contacts their experience of our staff is a good one; we continue to foster our culture of kindness and civility across the organisation.

It has been noted that in some cases we continued to receive scores of 1 (the lowest rating) but with very positive comments alongside this rating which doesn't quite equate; this has been fed back to iWGC who have advised that this is a recognised issue with feedback

across the Trusts that they work with and that as they consider this as a minimal impact, there are no plans to amend the supporting information that is given about the rating scale.

Berkshire Healthcare
NHS Foundation Trust

15 Steps Challenge

Quarter 4 2022/23

During quarter four , 2 visits were carried out.

Hearing & Balance- King Edward VII Hospital

Positives observed during the visit:

- Clinic felt calm and well organised.
- Toilets were clean.
- Team members picture were clearly displayed and up to date.
- Noticeboards were well maintained and not overloaded with information.
- All areas of the department were clean and tidy with no clutter.

There were some observations made which were discussed at the time of the visit with the manager:

- The QMIS Board was out of date - Manager reported that as they were working on reducing waiting times, huddles had not been taking place, this will be revisited by the team.
- Some of the décor was a bit tired and peeling off in the waiting area - Manager said the children's area was being redecorated in a few weeks.
- Waiting lists is still below target - This was work in progress and had improved recently due to recruiting new staff.

Diabetes- King Edward VII Hospital

Positives observed during the visit:

- Access for wheelchair users.
- Posters and information available in alternative languages.
- Staff were very approachable and accommodating.
- Clinic was well signposted.
- Toilet areas were clean.

There were some observations made which were discussed at the time of the visit with the manager:

- Photo board was not up to date and pictures were missing - This was in progress and there had been some changes to staff.

- No receptionist was available on the day of visit - Receptionist was off on day of visit but there is usually one present during clinic times.
- The feedback board was empty in the waiting area- Lead nurses highlighted that information would be helpful to demonstrate that feedback is acted on, this will be addressed.

Linda Nelson & Pauline Engola
Professional Development Nurses
April 2023

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2021-22						2022-23						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Q4**	**Total for year**	**% of Total**
CMHT/Care Pathways	5	8	10	9	32	**13.85**	11	10	18	↓	14	53	**22.00%**
CAMHS - Child and Adolescent Mental Health Services	5	10	6	10	31	**13.42**	4	6	13	↓	10	33	**14.00%**
Crisis Resolution & Home Treatment Team (CRHTT)	5	4	2	4	15	**6.49**	3	9	6	↓	4	22	**9.00%**
Acute Inpatient Admissions – Prospect Park Hospital	11	8	7	6	30	**12.99**	13	7	9	↓	6	35	**15.00%**
Community Nursing	4	5	2	1	12	**5.19**	3	0	4	↑	5	12	**5.00%**
Community Hospital Inpatient	6	8	6	5	25	**10.82**	4	3	2	↓	1	10	**4.00%**
Common Point of Entry	0	1	1	0	2	**0.87**	0	1	3	↓	1	5	**2.00%**
Out of Hours GP Services	1	1	5	2	9	**3.9**	1	0	1	↑	2	4	**1.50%**
PICU - Psychiatric Intensive Care Unit	3	1	2	1	7	**3.03**	1	2	0	↑	4	7	**3.00%**
Urgent Treatment Centre	1	1	0	0	2	**0.87**	1	0	0	-	0	1	**0.50%**
Older Adults Community Mental Health Team	0	0	0	2	2	**0.87**	1	1	0	-	0	2	**1.00%**
Other services during quarter	18	14	14	16	64	**27.71**	19	11	15	↓	11	56	**23.00%**
Grand Total	59	61	55	56	231	100	61	50	71		58	240	100.00%

Locally resolved concerns received

Division	Jan	Feb	March	Qtr 4
CYPF	1	1		2
Community Mental Health East	1	1		2
Community Mental Health West		1		1
Community Physical Health East			1	1
Community Physical Health West	4	8	2	14
Total	**6**	**11**	**3**	**21**

Informal Complaints received

Division	Jan	Feb	March	Qtr 4
CYPF	1	1	1	3
Community Mental Health West		1	1	2
Community Physical Health West		1	1	2
Corporate	1		1	2
Mental Health Inpatients			1	1
Total	**2**	**3**	**5**	**10**

KO41a Return

We have been informed by NHS Digital that they are no longer collecting and publishing information for the KO41a return on a quarterly basis, but will now be doing so on a yearly basis. We will expect to be asked to submit our information in May 2023, so this will next be reported in the Q2 2023 report.

Formal complaints closed

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

Outcome of formal complaints closed

	2021-2022				2022-2023						
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Q4**	**Total for year**	**% of 22/23**
Not Upheld	27	36	34	21	23	22	23	↑	38	106	43.00%
Partially Upheld	19	18	22	22	21	30	26	↓	25	102	41.00%
Upheld	9	11	6	6	12	9	7	↓	8	36	15.00%
SI	0	0	0	0	1	0	1	↑	1	3	1%
Grand Total	**55**	**65**	**62**	**49**	**57**	**61**	**57**		**72**	**247**	**100.00%**

46% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 58% quarter 3), these were spread across several differing services.

Complaints upheld and partially upheld

	Main subject of complaint											
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Access to Services**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Confidentiality**	**Discharge Arrangements**	**Financial Issues/ Policy**	**Medical Records**	**Patients Property and Valuables**	**Waiting Times for Treatment**	**Grand Total**
Adult Acute Admissions - Bluebell Ward	1											1
Adult Acute Admissions - Daisy Ward									1			1
Adult Acute Admissions - Rose Ward					1							1
Adult Acute Admissions - Snowdrop Ward				1								1
CAMHS - AAT						1						1
CAMHS - ADHD				1							1	2
CAMHS - Rapid Response			1	1								2
CAMHS - Specialist Community Teams				2					1			3
Children's Occupational Therapy - CYPIT					1							1
CMHT/Care Pathways				4	1			1				6
Community Hospital Inpatient Service - Jubilee Ward							1					1
Community Hospital Inpatient Service - Windsor Ward										1		1
Crisis Resolution and Home			1	1								2

Treatment Team (CRHTT)												
District Nursing				2								2
Out of Hours GP Services											2	2
Phlebotomy		1										1
PICU - Psychiatric Intensive Care - Sorrel Ward	2											2
Psychological Medicine Service				1								1
Talking Therapies - Admin/Ops Team				1								1
Talking Therapies - PWP Team				1								1
Grand Total	**3**	**1**	**2**	**15**	**3**	**1**	**1**	**1**	**2**	**1**	**3**	**33**

PHSO

During Quarter 4, we had one new case referred to the Ombudsman, which relates to the Older Adults Mental Health Team in the west. This is being reviewed by the PHSO to see if an investigation is appropriate.

We received the outcome of a complaint that had been under investigation for a few years. The PHSO had partially upheld an element of the complaint against us, and we have complied with their recommendations.

Compliments

The chart below shows number of compliments received into services, these are in addition to any compliments received through the iWGC tool.

	2021/22					2022/23				
	Q1	Q2	Q3	Q4	Total 2021/22	Q1	Q2	Q3	Q4	Total to date 2022/23
Compliments	1076	986	960	772	3794	1076	1119	1403	924	4522

Top 10 services with the highest number of compliments

Service	Number of compliments
District Nursing	156
Diabetes	79
Intermediate Care	37
CMHTOA/COAMHS - Older Adults Community Mental Health Team	36
Community Respiratory Service	21
Children's Speech and Language Therapy - CYPIT	20
Cardiac Rehab	19
Community Hospital Inpatient Service - Oakwood Ward	19
Community Hospital Inpatient Service - Windsor Ward	19
Older Adults Inpatient Service - Orchid ward	16

PALS activity

PALS provides a signposting, information, and support service across Trust services within Berkshire. The service deals with a range of queries with an emphasis on informal resolution. PALS collaborates with the complaints team in order to triage queries which may merit a formal investigation.

PALS has continued to facilitate the 'Message to a loved one' service, which involves collating messages for patients, which are then delivered on the ward. This is available across all inpatient areas. The PALS Manager continues in the role Armed Forces Service Network champion. PALS is also responsible for responding to postings on the NHS website which refer to Trust services.

There were 310 queries recorded during Quarter four. An increase of 47 since Quarter 3. 303 queries were acknowledged within the 5 working day target but the recording of queries has fallen behind due to the volume of queries coming into the service. PALS has engaged a volunteer on a part time basis, and this has improved direct access to the service. The volunteer is also recording queries which has improved the rate of data collection.

In addition, there were 189 non-BHFT queries recorded. Work is ongoing as part of the QMIS process to reduce this number. Another member of the Patient Experience Team is consistently helping with the recording process in order to improve the rate of data collection.

The services with the highest number of contacts are in the table below:

Service	Number of contacts.
CAMHS AAT	28
Phlebotomy	27
CAMHS ADHD	20
CMHT Care Pathways	20
CAMHS CPE	17
CRHTT	15
IPASS	11

Formal Complaints closed during Quarter four 2022-23

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
8760	Wokingham	CAMHS - Rapid Response	Low	Experience of pt not being acknowledged by staff for their gender, action plan to be put in place for future cases	Upheld	Sage and Thyme training identified for staff	Attitude of Staff
8751	Reading	Community Hospital Inpatient Service - Oakwood Ward	Low	Pt discharged from Oakwood, after 2 hours of being at home an ambulance was called and he was readmitted to the RBh. Family believe it was a negligent discharge that should never of happened	Not Upheld	No consent received	Discharge Arrangements
8761	Wokingham	CAMHS - Anxiety and Depression Pathway	Low	lack of neurodiverse inclusivity within the support offered to pt. Inefficient and ineffective triaging	Not Upheld		Care and Treatment
8777	Reading	Psychological Medicine Service	Minor	emergency contact numbers not used at the time of crisis. Pt left for 21 hrs in A&E with no clear plan from MH services	Upheld	MHAA Team made aware the defer resulted in patient waiting longer in ED, the team will make sure that this does not happen again There is now a designated space for mental health service users when attending ED.	Care and Treatment
8782	Wokingham	CMHT/Care Pathways	Minor	DECEASED Pt: Family wish an investigation into how a pt with sever MH issues was allowed to come of their medication. How abuse within the house was allowed without any services being aware	Partially Upheld	Apology given for the lack of contact about the investigation taking place. The clinical care and decision making were appropriate and safe.	Care and Treatment
8743	Windsor, Ascot and Maidenhead	Common Point of Entry	Low	complainant unhappy that services would not help the patient but instead sent the information to police and safeguarding	Not Upheld		Communication
8781	Reading	Adult Acute Admissions - Rose Ward	Minor	complainant during previous admissions of pt to PPH. - Response to include: •Concerns about PPH not involving complainant during the CPA discharge meeting •Difficulties to get through to the wards in PPH, either not responding to phone or asking to call back.	Upheld	Review the Carer Lead role in the absence of Clinical Development lead and re nominate the role to another member of the Multi-Disciplinary Team Carers Clinic to be piloted, where an afternoon will be set aside for appointments with families to discuss their loved one's care and treatment with Multi-Disciplinary Team members Pilot of a monitored email for Carers and relatives to use to contact the ward and avoid frustration of being unable to access the ward via the telephone.	Communication
8786	Reading	Adult Acute Admissions - Daisy Ward	Low	Allegedly pt was previously taken off medication which led to an episode. Pt currently in PPH where they have had their items taken away due to policy	Not Upheld	pt refused consent	Care and Treatment
8795	Slough	CMHT/Care Pathways	Low	Pt feels there is a lack of respect and humanity for Dr due to their history. They feel they should be entitled to a proper MH assessment	Not Upheld	Dual diagnosis worker to engage and facilitate joint assessment	Care and Treatment
8792	Slough	CMHT/Care Pathways	minor	1. pt believes drug prescribed made them violent. 2. clinicians appeared on pt's parent's door step threatening to call police if they ever drive again 3&9. DVLA revoked license allegedly due to calls may by SCMHT, wnats to know what they are going to do about it 4. requested Christian consultant which too a year 5&6. pt fees psychiatrist won't listen about lack of Vitamin B, states it has caused MH issues 7. lack of trust hindering recovery 8. pt refusing to see psychiatrist and under DPA stating SCMHT cannot tell the GP 10. feels all bad treatment is due to complaint raised when in PPH	Partially Upheld	IO to liaise with the lead clinician for the Physical Health Clinic to request pt is offered a Physical Health check (her last one was 3rd December 2021). Pt is concerned about her physical health due to being on antipsychotic medication, and this will help assuage her concerns. IO to liaise with a Psychologist/Psychological therapist colleague to identify Psychoeducation/independent workbook materials in relation to managing stress in the context of complex trauma. IO to ensure it is reflected in pt's clinical records that she feels Promethazine makes her physically and verbally hostile, and if possible she would like to explore alternative medications should short-term anti-anxiolytics be required.	Care and Treatment
8806	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Low	tried to obtain to get help from GP/CMHT/Crisis no one would help until 1 week before admission feels this is negligence	Partially Upheld	staff to consider not withholding phone numbers when calling patient	Care and Treatment
8803	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Low	£800 Denture missing + issues with discharge and other missing items	Upheld	Claim for denture – complainant to send receipt to IO. Information and reminders to staff about care of patient's property. Information and reminders to staff about discharging patients in appropriate clothes.	Patients Property and Valuables
8747	Windsor, Ascot and Maidenhead	District Nursing	Low	Care and treatment provided to the pt. The complainant also said they were appalled at their attitude.	Not Upheld	no consent recieved	Care and Treatment
8768	Wokingham	CMHT/Care Pathways	Moderate	Sec 117 funding to support transport to and from school safely	Partially Upheld	To consider training for staff in relation to pre/post transition s117 aftercare. To review needs assessment process pre/post transition to identify and agree a single overarching needs assessment that carries forward post-18 (it is possible currently to carry out a Care Act assessment pre-18 and so it may be that this is standardised?)	Financial Issues/Policy
8848	Windsor, Ascot and Maidenhead	District Nursing	Low	Family feel the DN team is disjointed and uncoordinated, both internally and also in its relationships with other services. The District Nursing team does not appear to be providing sufficient support for the EOL patient; the level of support seems to be variable and insufficient. CHC funding was due to be applied for but then not	Not Upheld	withdrawn due to local resolution	Care and Treatment
8762	Slough	CAMHS - AAT	Minor	YP's personal data sent to the wrong address	Upheld	When receiving a completed Healios invite, ensure it is saved in the correct folder with the CYP initials, as a PDF file as soon as it is opened Process for opening / storing / labelling invitations and completed documents communicated to admin team In the event of a data breach by admin in future, admin have been instructed to escalate this to Joint Team Leads as a matter of urgency, before contacting the relevant family/families. Contact to be made with the family by telephone, not via email / voicemail / text. Ensure that we do not ask for patient identifiable information to be sent via email, due to risk of further breaches.	Confidentiality
8789	Reading	Talking Therapies - Admin/Ops Team	Minor	Lack of support from service following a fire incident December 2021	Partially Upheld	apology offered as offer of initial appointment was greater than the 5-6 months explained at outset	Care and Treatment

8797	Bracknell	CMHT/Care Pathways	Low	Unhappy with the Trust response regarding Dr ORIGINAL COMPLAINT BELOW Pt feels harassed by doctor and care co-ordinator	Not Upheld		Attitude of Staff
8798	Bracknell	CMHT/Care Pathways	Low	Pt believes clinician breached their confidentiality agreement as believes intimate details of therapy have been discussed with other clinicians, wants recordings of conversations to be destroyed	Not Upheld		Confidentiality
8858	Bracknell	Admin teams and office based staff	Low	Patient say he has not been sent information requested in SAR	Not Upheld	No breach in timescales for SAR, apology offered for not ack'ing.	Communication
8823	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Family feel a number of opportunities to help the pt have been missed by services, feel Crisis could have done more but praise what was done	Not Upheld	not pursued as no consent granted	Care and Treatment
8842	Bracknell	Immunisation	Low	YP immunised without parent consent form being completed	Not Upheld	Imms service to review non responder process for year 9 children receiving dose 1 to ensure that the same information about HPV being a two-dose vaccination is included/provided. Imms service to review information sent to families re HPV to ensure that it is explicitly stated that the consent form covers BOTH doses of the HPV and that by signing the form parents are consenting to two doses. Imms service to review questions asked prior to vaccination to decide whether question relating to previous vaccinations should be made even more explicit for HPV dose 2 – i.e. to ask the young person 'Did you have any adverse reactions or feel unwell following dose 1 of your HPV?'	Communication
8815	Wokingham	District Nursing	Low	Deceased pt: Family believe the OT lied about their status within the NHS, entered the property without permission, broke furniture and stole a wedding ring	Not Upheld	Staff could have recorded that furniture was broken and broke further when attempted to move. An incident that occurred should be recorded.	Attitude of Staff
8831	Slough	Talking Therapies - PWP Team	Minor	family unhappy with the care provided by TT, questioning what they can do next to help the pt	Not Upheld		Care and Treatment
8833	Windsor, Ascot and Maidenhead	CAMHS - ADHD	Low	lack of information provided to family until MP enquiry, records requested and yet to be sent, emails bounce back as the inbox is full	Partially Upheld	Update website	Waiting Times for Treatment
8821	Reading	Out of Hours GP Services	Moderate	Pt called to obtain antibiotics as previously prescribed with the same symptoms, complainant unhappy this took approx 18 hours	Upheld	WestCall post Bank Holiday Analysis Meeting Implementing Rota Master for shift transparency and ease	Waiting Times for Treatment
8818	Reading	Adult Acute Admissions - Daisy Ward	Low	Pt feels sectioning took place due to incorrect information documented in their medical records from July 2018	Partially Upheld	Learning identified around documentation of nearest relative	Medical Records
8829	Bracknell	Talking Therapies - PWP Team	Minor	Pt unhappy with the way the therapist managed them and their sessions	Partially Upheld	Reflection undertaken by Therapist	Care and Treatment
8689	Slough	CAMHS - Rapid Response	Moderate	Mother complaining about care for daughter. Multiple calls to RRT and ended with hospital admission.	Partially Upheld	Breakdown in referral process between Trusts. Feedback given to both.	Care and Treatment
8838	West Berks	Out of Hours GP Services	Moderate	SCAS referred for 1 hour call back, chased 1hr 17 mins later. Family took pt to hospital themselves where they later died	Serious Untoward Incident Investigation	escalated to SI	Waiting Times for Treatment
8822	Reading	CAMHS - ADHD	Low	Family unhappy they have yet to receive any help from services despite completing all the forms	Not Upheld		Waiting Times for Treatment
8807	West Berks	CMHT/Care Pathways	Minor	Why do services wish to place the pt on CTO when discharged from unit? Issues around S117 funding need to be sorted. Pt would prefer a new CC. Feels being detained is a violation of their rights	Not Upheld	awaiting IO confirmation of outcome	Care and Treatment
8824	Reading	Adult Acute Admissions - Snowdrop Ward	Low	Pt feels he is being lied to, states the Dr is hostile and they are being detained longer than necessary	Not Upheld		Care and Treatment
8830	Reading	Adult Acute Admissions - Snowdrop Ward	Minor	Complaint is re snowdrop ward professionalism, confiscation of phone, apparent double dose of meds and lack of section 17 leave.	Not Upheld	There is some evidence of planning around removing property but is of poor quality.	Care and Treatment
8845	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Very unhappy with members of the Crisis team, from being hung up on and not understood	Partially Upheld	Apology offered by staff as appropriate. Offer made to pt to work to find a way he finds therapeutic	Attitude of Staff
8791	Wokingham	CMHT/Care Pathways	Minor	Pt appalled at the level of care provided and the rudeness of staff within the service	Partially Upheld	Pt request for support with Mental health and medication to be discussed with MCHIS Pt offered an apology for feeling dismissed and not listened to by CMHT staff Refer pt to previous letter dated 7th of February from service manager regarding the barter option If required, provide guidance to GP on how to restart medication	Care and Treatment
8837	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	pt unhappy with staff's verbal and physical conduct on the ward as well as allegedly denying the pt basic human rights	Not Upheld		Attitude of Staff
8801	Reading	CMHT/Care Pathways	Low	Pt does not understand how MH treatment can be given without a firm diagnosis. Wishes to know diagnosis with evidence behind it. Also wishes to know what the MH team meant by 'we've got it wrong'	Not Upheld		Care and Treatment
8814	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Minor	request for complaint investigation to be reviewed ORIGINAL COMPLAINT BELOW lack of support available to the YP	Not Upheld	Feedback, mums concern regarding gap in service provision for under 12s and alternative therapy for anxiety.	Care and Treatment
8840	West Berks	CAMHS - Specialist Community Teams	Minor	Complainant feels there are several inaccuracies that they find damaging and caused the complainant to feel depressed and suicial in the recently received assessment report. They would like it rewritten	Partially Upheld	Letter/report to be amended	Medical Records
8835	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Minor	Unhappy with response, wishes to see CCTV ORIGINAL COMPLAINT BELOW Unprofessional behaviour from a staff member on the ward	Partially Upheld	Staff member to undertake supervision and reflective sessions	Abuse, Bullying, Physical, Sexual, Verbal

8696	Reading	CAMHS - Specialist Community Teams	Low	BHFT Clinicians not turning up to appts. Regular appts seem to have stopped. Handover not actioned between clinicians. Lack of concern for pt's suicidal thoughts	Partially Upheld	Clearer information be provided to service users stating that unconfirmed appointments will be cancelled automatically by the service.	Care and Treatment
8749	Slough	CMHT/Care Pathways	Low	Pt going through a custody battle which maybe lost due to stay in PPH and CMHT diagnosis which wasn't there before	Not Upheld	If patient wishes; following receipt of complaint response, then IO has offered to forward complaint to Children, Young People and Families services.	Communication
8876	Bracknell	CMHT/Care Pathways	Low	Complainant wishes the historical element of their complaint to be investigated ORIGINAL COMPLAINT BELOW Complainant unhappy that the patient may need to do shared accommodation despite all multi agencies saying otherwise	Not Upheld		Care and Treatment
8839	Slough	District Nursing	Minor	DECEASED PT: family feels UTI with the patient was missed	Partially Upheld	Importance of confirming that emails sent to GP surgeries have gone, and need to follow up that actioned Importance of following care plan for individual patient including Ketone monitoring if BM high. Staff now have Ketone meters and have completed Diabetic update training. IDENTIFYING OBS THAT ARE AND TAKING APPROPRIATE ACTION TO RULE OF SEPSIS PROCEDURE FOR TAKING CLEAN URINE SAMPLE FROM PATIENTS WITH INDWELLING URETHRAL CATHETERS Explore NMPs within Community Nursing as alternative to GP PROCESS FOR TEAMS TO RAISE CLINCAL CONCERNS WHEN TIMELY RESPONSE NOT RECEIVED FROM GP	Care and Treatment
8885	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Minor	Family wish to know when SCT will commence as coming to the end of ITT they feel there should be no brake in therapy. Family extremely concerned about the escalating behaviour of the YP further concerns added 27.2.23	Partially Upheld	There needs to be a process in place for the retrieval of emails in a teams general email inbox and the message bei g relayed to the individual clinician Care plans and decisions around the formulation of care and treatment should be given out during the sessions.	Care and Treatment
8856	Reading	Podiatry	Low	1. Pt feels the nurse who attended to the wound should not have handed over to, what they felt was an unskilled, untrained person to do the dressing. 2. Pt feels the reception staff for the clinic was extremely rude to them on the phone following their appt.	Not Upheld		Care and Treatment
8863	Slough	Common Point of Entry	Low	Attitude of the call handler	Not Upheld		Attitude of Staff
8873	Windsor, Ascot and Maidenhead	District Nursing	Minor	DN's attended stating they were not trained to use the hoist and both had bad backs so could not lift the pt who was left in urine soaked clothes due to blocked catheter	Partially Upheld	Reflection and learning with staff members OH and Physiotherapy support offered for back pain CC to complete High Risk M&H when booked later in 2023	Care and Treatment
8904	Reading	Neuropsychology	Low	Issues with communication from the service, no medication renewal	Not Upheld		Communication
8879	West Berks	Phlebotomy	Low	Pt feels the booking system is not fit for purpose	Partially Upheld	points 1-3 not upheld point 4 partially. Options have now been removed to simplify the process	Access to Services
8869	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	pt unhappy about the conditions they are being kept in, the attitude of the staff and other pts. States the Dr should visit every 2 hrs in seclusion but only comes once a day. Feels they are medicating out of spite. Want to appeal against Sec 3	Not Upheld		Care and Treatment
8859	Reading	Adult Acute Admissions - Bluebell Ward	Minor	Pt feels the ward did not display effective and engaging care, several allegations of bullying from staff. Letters sent to ward manager were not acknowledged or responded to. Pt wishes to know what ongoing training is being provided to staff re communication with pts.	Partially Upheld	The trust is will continue to work with all staff as part of the objectives in supporting them to provide the best care to our patients.	Abuse, Bullying, Physical, Sexual, Verbal
8841	Windsor, Ascot and Maidenhead	CAMHS - ADHD	Minor	No follow up call provided since initial medication despite being advised there would be. Complainant concerned as repeat prescriptions of controlled medication are given without YP being seen	Upheld	Reminder to all clinicians about care during titration: process, responsibilities and importance of following and documenting this Reminder to all staff regarding the expectations and the importance of entering updates into the records for the records to have a clear care plan and be a full record of care provided	Care and Treatment
8854	West Berks	CMHT/Care Pathways	Minor	Pt wishes a plan to be put in place for future support	Not Upheld		Care and Treatment
8820	Reading	Adult Acute Admissions - Bluebell Ward	Low	Complainant wishes to know pt's treatment plan in the community, feels the pt is not fir enough to attend appts etc. Complainant wishes for pt to be able to obtain residential treatment	Not Upheld		Care and Treatment
8897	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Discharged from A&E after 2 days following a suicide attempt. Pt feels they should have been admitted. Also unhappy with Care Coordinator	Not Upheld	CMHT Care Coordinator to be notified of pt's request for support to raise awareness of her condition with family and friends chosen.	Care and Treatment
8853	Slough	Community Hospital Inpatient Service - Jubilee Ward	Minor	Family unhappy the pt was discharged home from the ward. Pt fell within 24 hrs, taken to A&E with pneumonia.	Partially Upheld	A local resolution is now in place to manage the way the initial assessments are completed with a check list for essential equipment for discharge. This will be added to the daily handover. In service training on discharge processes and communication with patient and families will be arranged Clear communication process for referral to be implemented between the ward and social services regarding the installation and assessment for pendent/falls alarms All staff will be invited to training on record keeping and a regular review of this will be implemented	Discharge Arrangements
8884	Reading	Out of Hours GP Services	Low	Long delay in being seen despite having an appt. Qu's why a prescription was not forth coming from the triage nurse	Partially Upheld	TB Service Manager emailed Locum Agency to ensure staff rostered do fulfil shifts by double checking WestCall Action Plan to use Notice Boards to update patients at PCC (Westcall meeting 21/2/23 action 11.5)	Waiting Times for Treatment
8836	Reading	Adult Acute Admissions - Rose Ward	Low	Complainant is concerned for the safety of the pt due to physical abuse from other patients, issues surrounding when food is served on the ward and the Dr not attending a scheduled appt	Not Upheld	Complaint withdrawn	Abuse, Bullying, Physical, Sexual, Verbal
8868	West Berks	Immunisation	Low	Vaccine received without consent being given from parent	Not Upheld		Communication

8857	Reading	CMHT/Care Pathways	Moderate	Bad communication for the ward to the family. family feel current presentation of the could have been avoided and would like to understand what went wrong	Partially Upheld	review of policies to be undertaken	Care and Treatment

Berkshire Healthcare
NHS Foundation Trust

Board Meeting Date	9th May 2023
Title	Six Monthly Safe Staffing Review, October 2022 – March 2023
	Item for Noting
Purpose	The purpose of this report is to provide the Board with information and assurance of safe staffing
Business Area	Nursing and Governance
Author	Linda Nelson - Professional Development Nurse Heidi Ilsley - Deputy Director Nursing
Relevant Strategic Objectives	Harm free care, Good Patient Experience, supporting our Staff, Money Matters
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience and Harm Free Care.
Resource Impacts	N/A
Legal Implications	N/A
Summary	This report aims to provide the Board with information and assurance on the assessment of safe staffing across our wards both in terms of a retrospective view over the last 6-month period (October 22 – March 2023) and a prospective assessment of whether our staffing levels are sufficient to provide safe care over the coming months. The report is structured to support the requirements within the 2016 National Quality Board and the October 2018 NHSI Developing Workforce safeguards in relation to Board oversight of staffing on the wards. The report includes an executive summary and the required safe staffing declaration can be found on page 18 of the report. In summary, there are no predicted changes to any of the wards in terms of capacity meaning that current retrospective assessment also provides likely prospective requirements. Triangulation of available data including the safecare tool indicates that the number of staff being used at PPH are broadly in line with meeting the needs of the acuity of patients, whilst vacancy amongst permanent positions means that a high number of temporary staff are used, many know the hospital well and staff are moved around the hospital/ deployed to ensure that staffing is in the right place to best meet patient need. Additional temporary staffing is brought in to meet additional patient 1:1 observations. For the community wards in the West a review of establishment is in progress to ensure that we can provide optimal care for the current cohort of patients being admitted to the wards. The safer care tool is showing that staffing may not be optimal on all of these wards and the Care Hours Per Patient Day

	(CHPPD) tool is showing variation across the wards and in general lower than the East wards. There are several therapy staff on each of the wards who contribute to daily patient care and who are not factored into the safecare tool od CHPPD data and therefore the wards have been assessed as safe although not always optimal. For the East wards staffing over last 6 months has been largely in line with suggested staffing when using the daily safecare tool, although in this report the 20-day snapshot indicated Jubilee ward to be less than optimal at that time; like the West wards there are therapy staff not captured in the safer care tool, staffing will therefore continue to be monitored over the coming months to ensure that it remains adequate to meet current patient need; both wards were assessed as being safe although there were times within the reporting period where they were sub-optimal. Campion unit appears to have the right level of staffing establishment to meet desired rota and patient acuity from safecare tool data. The number of unfilled shifts across all wards has reduced in the last 6 months to 11% compared to 26% this time last year and 14% in the previous 6 months. The number of shifts with less than 2 registered staff are monitored each month, the highest percentage of shifts with less than 2 registered staff continues to be across our mental health wards with 21.66% shifts although this is a slight improvement on the last 6 months were there were 26% and the same reporting period last year where there were 27% shifts. The west wards although much smaller numbers had 5.3% total shifts with less than 2 registered staff which is also an improvement on the previous 6 months (8.5%) whilst the East wards have maintained a position of no shifts with less than 2 registered staff. Whilst there has been no correlated link between staffing levels and patient safety incidents, we recognise that workforce remains one of our most significant risks and although there is significant work in place to support increased recruitment and retention, including staff well-being, there is currently limited assurance that care was always of a high quality. It also possible that patient experience may have been compromised due to high temporary staffing on some shifts and some gaps in staffing that were unable to be filled. There continues to be much higher levels of sickness absence on the wards (around 8%) compared to overall trust sickness absence at 4.7%. Top reasons in terms of number days absent is stress and anxiety related, MSK and respiratory illness. There is a significant amount of work being undertaken to provide differing sources of recruitment such as apprenticeships and international recruitment and quality improvement work supporting assessment and actions in terms of retention. The community wards currently have only small amounts of vacancy compared with Prospect Park Wards that have current vacancy of around 22% overall with 40% registered nursing vacancy; this is largely unchanged since last 6 monthly report.

ACTION REQUIRED	The Board is asked to note the report and the declaration provided by the Director of Nursing and Medical Director

Berkshire Healthcare NHS Foundation Trust

Six Monthly Safe Staffing Review. October 2022 – March 2023.

1.0 Executive Summary

The purpose of this report is to provide the board with an assessment and assurance in relation to safe staffing on our wards, as required in the NHS Improvement, Developing Working Safeguards document published in 2018. This report is in addition to the monthly safe staffing report provided to the Finance Committee and made publicly available, it provides detail on metrics and information used to assess both retrospective staffing safety and prospective staffing requirements.

As part of the safe staffing review, it is a requirement that both the Director of Nursing and Therapies and the Medical Director confirm in a statement that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This statement can be found on page 17.

The report highlights the ongoing challenges, particularly in relation to registered nursing recruitment and retention, with registered nursing vacancy across the mental health wards currently around 40%. (There is some restructuring in progress which is envisaged will help with leadership and support to more junior staff including introducing band 7 Mental Health Practitioners instead of Band 6 Clinical Development Leads and the introduction of Advanced Nurse Practitioners). For the community wards the registered nursing vacancy rate is much lower at around 5%, although absence due to sickness and authorised leave such as maternity leave still impacts on ward staffing.

In line with national reporting, shifts with less than two registered nurses are monitored each month (table 7). 21.66% of the shifts across the mental health wards had less than 2 registered staff (26% in previous 6 months), whilst the West community wards had 5.53% of their shifts and the East wards had no shifts with less than 2 registered nurses. Although very high in some areas, these figures do show a small improvement across all areas from the last 6 monthly report; the peak of shifts with less than 2 registered staff was over October/November 2022. Across the mental health wards, the improvement seen is due to better temporary staffing fill rates rather than a decrease in vacancy, there has been an increase in total vacancy over this 6-month period at PPH from 21.7% in October to 24.89% in March with the main areas of concern being Rose ward (47.9% vacancy) and Snowdrop ward (48.73% vacancy).

Across the wards we use the e-roster tool to support with rota completion, temporary staffing, primarily through NHSP (and agency where this is not possible) provides support to fill any gaps in the rota or additional need. During the last 6 months 11.13% of our temporary staffing requests were unfilled (total temporary staffing shifts requested 33,655). This is a slight reduction on the previous 6 months where 14% requests were unfilled (total requests in previous 6 months 29,763).

During this reporting period we have continued to see challenges which have impacted staffing due to sickness absence amongst both our permanent and temporary workforce and at times ward capacity has also been affected. Sickness absence in general is high across our inpatient wards with all but 4 of the wards currently above 5% (average absence 7.25% March 23); the top three sickness absence reasons in terms of number of working days lost due to illness are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems and cold, cough, flu. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness. As is a requirement when building agreed

establishments for wards, a 24% uplift is included to factor in absence such as training , annual leave and some sickness.

The main ways used to review safe staffing establishments are:

1. Professional judgement (this is what staff and managers believe to be staffing needed)
2. Staffing review tool -Safecare / MH tool (this is a national recognised tool that calculates staffing needed to meet the care of the patients factoring in their acuity and dependency.

Care Hours Per Patient Day (CHPPD) is also calculated, this looks at an average number of hours each patient has of care provision each day, this allows us to benchmark across wards. CHPPD data can be skewed, particularly on the mental health wards where extra staff are brought in to provide one to one care to a patient. Across our wards CHPPD does not include supernumerary staff such as the Ward Managers, Doctors, or Allied Health Professionals / Psychologists and therefore the actual hours of total care received from all professionals is slightly more than the CHPPD indicates.

In summary across the mental health wards (as can be seen in table 1 of this report), the whole-time equivalent establishment except for Rose Ward is possibly less than the establishment required to achieve the rota patterns currently being used (professional judgement), however this is based on standard shifts of 7.5 hours and some staff work long days which will It is demonstrated through the safe staffing tool review (Table 2) that the rota pattern/ the staffing numbers used across the mental health wards are needed to meet acuity of patients, however the resource is not always in the right place and staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need at any given time. Completion of beyond budgeting work with finance continues to support, ensuring that the ward establishments are reflective of patient acuity and need and reduce ad-hoc temporary staffing requests. A deep dive exercise involving workforce planning and the Mental Health Inpatient wards was completed in late 2022 and identified short, medium, and long-term workforce transformation opportunities to help address the current staffing challenges. These recommendations are in the process of being implemented . The regrading of Ward Manager positions from band 7 to 8a and clinical lead posts being rebranded as advanced MH practitioners and regraded to reflect the levels of responsibility has led to some successful recruitment both internally and externally.

For the West community wards, the staffing establishment is sufficient to provide the agreed rota (Table 1) however, the safer nursing care tool data (Table 2) indicates that there was a shortfall of actual staffing against patient need to achieve optimal care. The primary function of these wards is rehabilitation and therefore there are several additional therapy staff on each of the wards that contribute to daily patient care, these staff are not factored into the safecare tool data and therefore the wards were not seen as unsafe over the previous 6 months. Ascot, Windsor, and Donnington wards also have the lowest CHPPD (Table 4) compared to the other community wards in this reporting period. A review of staffing is underway and it is advised that the safercare tool is proactively used to identify when acuity is higher than expected and therefore additional temporary staff are needed.

For the East wards, staffing over last 6 months has been largely in line with suggested staffing when using the safecare tool daily, although in this report the 20-day snapshot indicated Jubilee ward to be less than optimal, unlike the West wards this has not been consistently the case. As with the wards in the West there are also therapy staff not factored into the SafeCare tool assessment that support the wards daily. The SafeCare tool will continue to be used to monitor staffing over the coming months, to ensure that establishment alongside temporary additional staffing continues to be adequate to meet the needs of the patients being cared for.

From all available data, Campion unit appears to have the right level of staffing establishment to meet the desired rota and patient acuity, both retrospectively and prospectively.

There are no predicted changes to any of the wards in terms of capacity over the coming months that require factoring into a prospective view of staffing.

NHS 2022/23 priorities and operational planning guidance highlights the need to invest in our workforce both in terms of more people but also new ways of working and by strengthening the compassionate and inclusive culture needed to deliver outstanding care. The guidance details a focus on looking after our people (improving retention through flexible working, career conversations and enabling staff to understand their pension, support for staff wellbeing and improving of attendance by addressing sickness absence); improve belonging in the NHS (implementation of plans to improve equity); working differently (establishing new roles) and growing for the future (expanding ethical international recruitment, and apprenticeships and making the most effective use of temporary staffing).

Within the trust we have a strategic initiative related to workforce and several workstreams in place that are supported by Quality Improvement methodology to focus on identified areas including staff retention. We also have ongoing work in relation to improving equity for all staff following review of our WRES and WDES data and an active programme supporting international recruitment and apprenticeships as a route into healthcare and career progression. Detail of these initiatives and quality improvement programmes is covered within workforce reporting to the Board and are therefore not covered in detail within this report although are pertinent to achieving safe staffing and the safe staffing data that is detailed within this report.

There are several initiatives in place to grow our workforce, this includes Nurse Associate posts that have now been successfully embedded in several services across the organisation, the Trust currently has 23 employed and further 7 in training. We have recruited into some international posts across our community and mental health wards (32 nursing and AHP staff from October 2021 to April 2023) and are developing a competency-based approach to promotions where we assess that staff have the right skills and behaviours to progress to permanent and higher banded roles which includes a temporary to permanent initiative at PPH for healthcare support workers which has proved to be successful.

Most of the newly recruited staff, particularly those across our mental health wards continue to be newly registered nurses who have been on placement with us. There is an onboarding, preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. Alongside this, ward managers and a senior leadership structure of Associate Nurse Consultants (replacing matrons), Advanced Mental Health Practitioners(replacing Clinical Development Leads) and specialists such as the Nurse Consultant, Physical Health and Drug & Alcohol leads and Allied Health Professionals who are supernumerary to the ward establishment, are able to support when the ward is short staffed as well as where less experienced staff are on duty, there is also a Duty Senior Nurse available 24/7. In addition, there is a programme called ‘Reaching my potential’ which is open to all band 5 staff and aimed at supporting improved resilience and confidence.

To improve staff resilience and support in all areas of the trust the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021 and we currently have 60 qualified PNAs. The PNA role involves providing restorative supervision which is aimed at improving wellbeing as staff feel supported and listened to, this in turn supports staff retention. The PNA programme is a Health Education England initiative supported by Ruth May and has been a requirement in midwifery for some years and is now being rolled out nationally across healthcare. At Berkshire Healthcare the current PNA focus is to assist with supporting post incident reviews and ensuring the availability of SPACE groups for physical health clinical staff. Work is currently underway and is being undertaken in collaboration with our psychological support teams.

2.0 Main Report.

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

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

Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and executive leaders. The board should discuss the workforce plan in a public meeting. An effective workforce plan should be multidisciplinary, evidence-based, integrated with finance, activity and performance plans, and directly involve leaders and managers of the service. The Director of People for the Trust leads on this piece of work.

The publication states that establishment setting must be done annually, with a mid-year review, and should take account of:

- Patient acuity and dependency using an evidence-based tool (as designed and where available).
- Activity levels.
- Seasonal variation in demand.
- Service developments.
- Contract commissioning.
- Service changes.
- Staff supply and experience issues.
- Where temporary staff have been required above the set planned establishment.
- Patient and staff outcome measures.

The minimum staffing expectation of at least two registered staff on each ward for every shift remains a requirement. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of one registered with three support workers was best able to meet with patient need at night.

2.1 Current Situation.
Berkshire Healthcare NHS Foundation Trust has the following wards:
1 Learning disability unit.
7 Community hospital wards (5 units).
7 Mental health wards.

All the wards have a staffing establishment that includes an allowance of 24% for planned and unplanned leave (training, annual leave, sickness absence). Table 1 demonstrates the ward establishments, alongside shift patterns agreed with wards and senior leaders (professional judgement) and the establishment required to achieve that shift pattern.

Table 1: Current Staffing establishment, bed numbers and shift patterns October 2022 to March 2023:

Ward	Beds	FTE Establishment in budget 2022/23	Professional judgement FTE	Planned shift pattern. (Early-late-night)
Bluebell	**22**	39.95	40.6wte + 1 ward manager + 0.5 DSN + 1 MHP = 43.1wte	7-8-6 activity coordinator inc on the late shift
Daisy	**20**	39.95	40.6wte + 1 ward manager + 0.5 DSN + 1 MHP =43.1wte	7-8-6 activity coordinator inc on the late shift
Rose	**22**	44.15	40.6wte + 1 ward manager + 0.5 DSN + 1 MHP = 43.1wte	7-8-6 activity coordinator inc on the late shift
Snowdrop	**22**	38.31	40.6wte + 1 ward manager + 0.5 DSN + 1 MHP = 43.1wte	7-8-6 activity coordinator inc on the late shift
Orchid	**20**	46.8	41.3wte + 1 ward manager + 0.5 DSN + 1 MHP = 43.9 wte	7-7-7
Rowan	**20**	48.60	44.8 + 1 ward manager + 0.5 DSN + 1 MHP = 47.3 wte	8-8-7
Sorrel	**11**	37.00	41.3 + 1 ward manager + 0.5 DSN + 1 MHP = 43.8wte	7-7-7
Campion	**9**	37.11	37+ 1 ward manager = 38	7-7--5
WBCH	44	63.46	**DONNINGTON** 40.6wte+ 1 ward matron + 0.3 staff development lead = 41.9wte	9-6-6
			HIGHCLERE 30.8wte + 1 ward matron + 0.3 staff development lead = 32.1wte	6-5-4
Oakwood	**24**	46.67	38 + 1 ward manager and 1 dep. ward manager/ matron = 40	9-7-4
Wokingham	**46**	61.31	57.8+ 1 ward manager + 0.8 matron = 59.6	13-10-7
Henry Tudor	**24**	32.80	32.7+ 1 ward manager = 33.7	7-6-4
Jubilee	**22**	30.23	33.5 + 1 ward manager = 34.5	7-5-5

The table above shows that 3 of the acute mental health wards as well as Orchid, Rowan, Sorrel, West Berks Community Hospital and Jubilee ward do not appear to have the establishment required to meet the shift pattern being used; however, some of the staff on these wards work long days which effectively means a 37.5 hour week covers 6 shifts rather than the traditional 7.5 hour shifts covering 5 shifts per week; with some staff working long days these establishments are sufficient. Beyond budgeting work being undertaken with the mental health wards continues to help confirm that the establishments are sufficient for the current mix of standard and long days being undertaken.

At times across a month, wards may require additional staff above what is planned within the establishment to meet patient acuity and one to one observation.

3.0 Review of staffing establishment.

When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling tools are used to assist in the triangulation of data, alongside benchmarking and professional judgement. For Mental Health wards the modelling tool used is the Mental Health Optimal Staffing Tool (MHOST); the SafeCare tool (which uses the SNCT for the dependency calculations) is used for other wards. It is recognised that these modelling tools use a snapshot of dependency of patients on a given day and that dependency can fluctuate. Therefore, reviews using the tools utilises the collation of daily data over a period of 20 days to understand the average dependency for each ward.

The SafeCare tool is a software module within the Allocate E- Roster system, it provides information on actual staff levels together with the acuity/ dependency of patients, this has been implemented across the community health wards. The implementation for the Mental Health wards is now embedded although there continues to be some gaps on occasion which can skew figures. Due to delays in embedding the SafeCare tool on the MH wards Campion ward have yet to complete the module.

3.1 Review using workforce modelling tool.

Tables 2 and 3 below show the current establishments compared to the recommended establishment from the 20-day review undertaken in March 2023 using the current available Keith Hurst tools**.**

Table 2: Prospect Park Hospital Wards:

Ward	Bed Number	Current establishment (WTEs)	Average additional staff requested above establishment (WTE per day)	Recommended establishment from March 2023 review (WTEs)	Total actual establishment (including unfilled shifts requested)
Sorrel	11	37	4.95	27.7	41.95
Rose	22	44.15	5.78	44.07	49.93
Snowdrop	22	38.31	6.40	43.84	44.71
Bluebell	22	39.95	4.0	42.07	43.95
Daisy	20	39.95	4.75	36.7	44.7
Rowan	20	48.60	9.67	43.49	58.27
Orchid	20	46.8	7.63	41.65	54.43
Total	137	294.76	43.18	279.92	337.94

The review was undertaken over a 20-day period in line with the Developing Workforce Safeguards recommendations and offers a guide. The recommended establishment compared to actual establishment demonstrates that the current staffing establishment is sufficient for the needs of the wards. It is recognised that the resource is not always in the right place and that staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need at any given time. Financial support services will assist in ensuring that the ward establishments are reflective of patient acuity and need and reduce ad-hoc temporary staffing requests. It should be noted that Sorrel ward was closed to admissions for a period of time during the data collection period and this is likely to have skewed their recommended establishment figures. A deep dive exercise involving workforce planning and the Mental Health Inpatient wards was completed in late 2022 and assisted in identifying short, medium, and long-term workforce transformation opportunities to help address the current staffing challenges. These are currently being implemented and some improvement in recruitment and retention to more senior roles has been evident in the last 2 months (upgrading both ward manager and clinical lead posts has led to some internal promotions and external recruitment).

Patients on Rowan and Orchid wards most frequently required extra staff to support the high level of patients requiring observations and high levels of acuity.

All acute wards now have Activity Co-ordinators who work on the wards during the 4pm-10pm period, 7 days per week. This supports both safe staffing and the therapeutic environment. There will always be a requirement for some flexibility to meet increased observations and demand.

Ward Managers and Advanced Mental Health Practitioners are not included in the numbers although are able to contribute a combined 10-15 hours per day per ward of registered nursing time if required. All wards have Allied Health professionals and Psychology who support the wards who are also not included in the numbers but support the ward throughout the day with patient care and treatment, including some weekends. These additional roles have supported the safe staffing of the wards during this period as well as the role of activity coordinator which aims to improve the therapeutic environment.

Table 3: Community Wards and Campion:

Ward	Bed Numbers	Current establishment	Recommended establishment from March 2023 review	Average additional staff requested above establishment (WTE per day	Total actual establishment (including unfilled shifts requested)
Oakwood	24	46.67	51	2.11	48.78
Wokingham (Ascot /Windsor)	46	61.31	75.34	3.38	64.69
WBCH (Highclere/ Donnington)	49	63.46	77.16	3.95	67.41
Henry Tudor	24	32.8	37.7	1.91	34.71
Jubilee	22	30.23	42.88	1.47	31.7
Campion	9	37.11	27.19	5.58	42.69

The review of staffing in March occurred when bed availability was at optimal levels with no closures.
Across the wards West Berks Community Hospital and Campion were most likely to request additional staffing.
Across the West community wards, the safer nursing care tool data in the table above indicates that there was a shortfall of actual staffing against patient need to achieve optimal care most notable is Wokingham, West Berkshire. The primary function of these wards is rehabilitation and therefore there are several additional therapy staff on each of the wards (for example 7 WTE on Oakwood) that contribute to daily patient care, these staff are not factored into the SafeCare tool data and therefore the wards were not seen as unsafe over the previous 6 months.

Data is reviewed and monitored via the monthly staffing reports to ensure that total staffing establishments are sufficient to meet the acuity and complexity of patients now being cared for in these settings. Work is currently being undertaken using Quality Improvement (QI) initiatives to review staffing levels and develop initiatives on how best to utilise staff. There are various workstreams which have members from both nursing and allied health professional groups looking at areas of improvement. The aim is to maximise the patient's rehabilitation potential leading to decreased lengths of stay and improved quality of experience and care. It is advised that the SafeCare tool is proactively used to identify when acuity is higher than expected and therefore additional temporary staff are needed.

For the East wards, staffing over last 6 months has been largely in line with suggested staffing when using the safecare tool on a daily basis which feeds into the monthly staffing report. In this report the 20-day snapshot indicated Jubilee ward to be less than optimal but this has not been consistently the case over the last 6 month period. During the time frame of the 20 day dependency Jubilee ward had a patient under DOLs who required constant one to one supervision which affected the data collection figures; however they deemed that they had sufficient staff to manage this over the period; on East CHS wards like the wards in the West there are also therapy staff not factored into the safecare tool assessment that support the wards on a daily basis, the SafeCare tool will continue to be used to monitor staffing over the coming months to ensure that it continues to be adequate to meet the needs of the patients being cared for. There will be some QI work undertaken in the next few months to align all the community CHS wards across the trust following the higher-level restructuring. It is envisaged that this will enable a more consistent and uniform approach to care on all the CHS wards.

From all available data, Campion unit appears to have the right level of staffing establishment to meet the desired rota and patient acuity, both retrospectively and prospectively. Temporary staffing is frequently used to help support the high acuity and challenging patients as well as cover shortages on the unit hence the high level of requests.

3.2 Care Hour per Patient Day (CHPPD) Data Collection**.**
Lord Carter's review: 'Operational Productivity and Performance in English Acute Hospitals: Unwarranted Variations' (2016); highlighted the importance of the non-acute sectors in ensuring efficiency and quality across the whole NHS health economy. One obstacle identified to eliminate unwarranted variation in clinical staff distribution across and within the NHS provider sector has been the absence of a single means of consistently recording, reporting and monitoring staff deployment. CHPPD provides this measure. The CHPPD is calculated by taking the actual hours worked (split into registered nurses and healthcare support workers) divided by the number of patients occupying beds on the ward at midnight and is fed into the national data collections team each month.

CHPPD does not consider patient acuity, ward environmental issues, patient turnover or movement of staff for short periods only staffing levels in relation to patient numbers on individual in patient wards. The table below shows the CHPPD for each of the wards over this six-month period. The SafeCare tool is used to demonstrate actual and required staffing levels for the Inpatient wards for both physical and mental health patients. Across the Trust CHPPD does not include allied health professionals or clinicians other than nursing and health care support workers, working on the wards.

Across our wards CHPPD does not include supernumerary staff such as the Ward Managers, Doctors, or Allied Health Professionals / Psychologists that work with the patients and therefore the actual hours of total care received from all professionals is slightly more than the CHPPD indicates.

Table 4: BHFT CHPPD:

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Bluebell	8.1	7.6	9.00	8.4	10.9	11.4
Daisy	9.8	9.9	11.6	10.8	11.5	10.9
Rose	8.9	10.5	11.0	11.3	11.0	10.6
Snowdrop	10.4	10.5	9.8	10.3	11.3	10.6
Orchid	15.6	15.0	14.5	15.3	15.2	16.3
Rowan	10.1	20.2	23.9	18.7	18.3	21.5

Sorrel	18.9	22.7	21.8	21.9	23.2	25.4
Campion	43.3	41.1	42.3	42.6	41.9	41.6
Donnington	6.7	6.60	6.9	6.6	6.7	6.8
Highclere	8.7	8.1	8.0	8.2	8.1	8.6
Oakwood	6.7	7.20	8.0	7.0	7.4	7.4
Ascot	6.4	7.7	7.2	7.0	6.6	6.6
Windsor	5.6	5.80	6.1	5.2	5.3	4.7
Henry Tudor	6.8	7.00	7.30	7.5	7.8	6.9
Jubilee	7.2	7.80	9.4	7.6	7.7	8.0

Campion Unit CHPPD data figures have remained consistently high during this 6-month period and are due to the high amount of level 2 observation patients who required 2 on 1 supervision for safety/safeguarding reasons and challenging behaviour. The data is skewed by number of patients requiring 1:1 observation and therefore explains some of the variation particularly on the mental health wards making it more difficult to make direct comparisons. Windsor, Ascot and Donnington wards have lower CHPPD than the other community wards and this should be monitored given that the community health wards all have a very similar function and therefore similar CHPPD would be expected.

3.3 Bed occupancy.

Table 5 below details monthly bed occupancy over the reporting period, the data highlighted in red is where bed occupancy has exceeded 90%. The areas that have frequently experienced bed occupancy in excess of 90% are the Acute Adult Mental Health Wards. In addition, the West CHS wards (West Berkshire wards, Wokingham wards and Oakwood Unit) also demonstrated periods of high occupancy and the average for Highclere ward, Oakwood Unit and Windsor ward was 90% and over. During this reporting period there were some periods of time where beds needed to be closed to ensure appropriate cohorting and management of patients to minimise the risk of transmission of infection in line with national guidance.

Table 5: Bed Occupancy:

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Average
Bluebell	99.40%	98.00%	96.80%	97.70%	93.00%	94.10%	97%
Daisy	96.60%	97.50%	93.90%	100.50%	98.70%	95.50%	97%
Rose	94.00%	95.30%	81.10%	92.50%	94.80%	92.50%	92%
Snowdrop	95.30%	94.50%	87.70%	98.70%	95.30%	97.40%	95%
Orchid	86.10%	86.30%	85.00%	89.70%	88.00%	79.00%	86%
Rowan	83.50%	84.50%	70.80%	88.70%	88.40%	79.00%	82%
Sorrel	97.70%	87.00%	88.60%	90.90%	81.80%	75.70%	87%
Campion	88.50%	88.10%	78.10%	76.30%	83.30%	86.70%	84%
Donnington	86.50%	89.30%	85.80%	91.40%	89.30%	88.80%	89%
Highclere	85.30%	91.10%	90.30%	90.90%	95.20%	88.80%	90%
Oakwood	86.80%	89.60%	84.90%	93.40%	93.30%	93.50%	90%
Ascot	90.80%	71.90%	81.70%	95.00%	93.90%	77.50%	85%
Windsor	87.00%	93.50%	86.50%	97.00%	94.40%	98.90%	93%
Henry Tudor	91.50%	87.20%	84.10%	79.10%	79.10%	85.50%	84%
Jubilee	89.70%	87.70%	80.20%	88.60%	82.00%	89.20%	86%

All the acute mental health wards demonstrate that occupancy was almost always above 90% each month and averaged over 90% over the last 6 months. Other areas have seen a similar occupancy rates to the previous 6 months apart from Jubilee ward whose bed occupancy has increased from 81% to 86%. Campion Unit's occupancy rate has increased over the six-month period from 75% to 84%.

4.0 Workforce data

Several factors have the potential to impact on the wards ability to achieve the agreed staffing levels on every shift; these include vacancies, maternity leave and sickness absence.

4.1. Vacancies.

Table 6 below shows the combined whole-time equivalent (wte) vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. Across the mental health wards registered nurse vacancies has varied during the last six months, with recruitment remaining challenging, vacancies have varied between 41.64 wte and 47.92 wte. Unregistered vacancies have varied but the overall trend shows a small decrease in vacancy levels within the last 6 months. Campion unit has consistently had low vacancy rates but has challenges filling specialist RN positions and support workers long term. Graph 2 shows vacancy per ward over the reporting period.

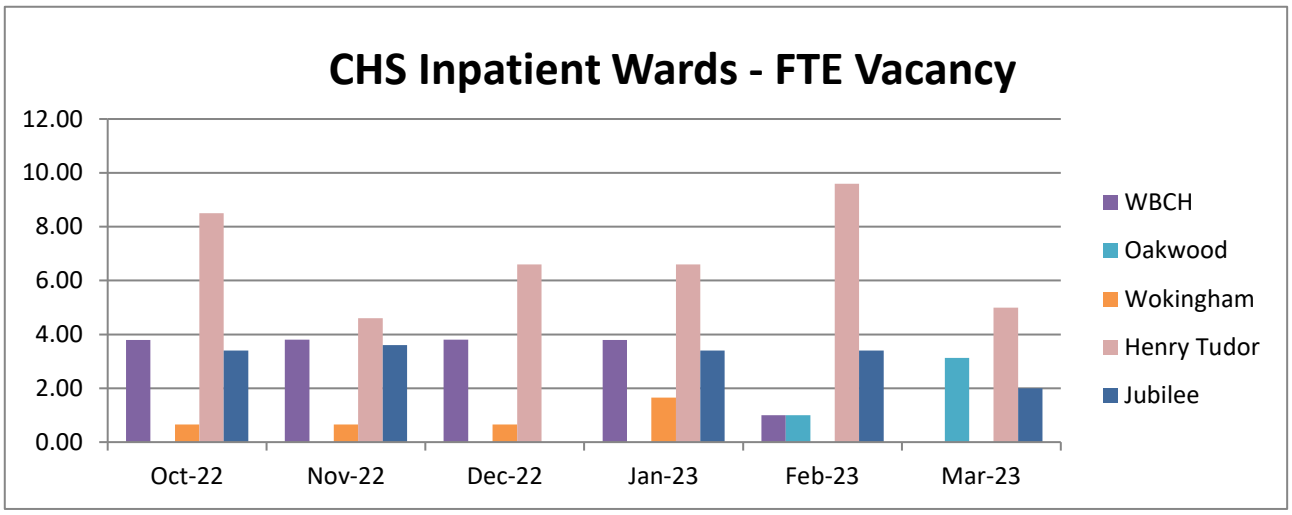
An 18-month rotational Mental Health band 5 role between inpatient and community services is being tried and is ongoing, leading to a possibility of a band 6 position on completion. Currently 3 individuals are in post with one recently obtaining a band 6 role internally. There is also significant vacancy across the unregistered posts, and the initiative continues whereby people can join NHSP as a way of trialling working on our wards, are guaranteed at least 30 hours per week and they then move to a permanent position if they would like to, this has proved popular with 12 people currently working under this scheme. There are regular HCA open days held with the March event recruiting 6 band 2 staff. The next open day is scheduled for May.
The CHS wards, especially the East CHS wards, have had some staffing challenges but there have been some benefits from some successful international recruitment appointments to the West CHS wards.

Table 6: Whole Time Equivalent (WTE) vacancy of registered nursing and healthcare worker combined:

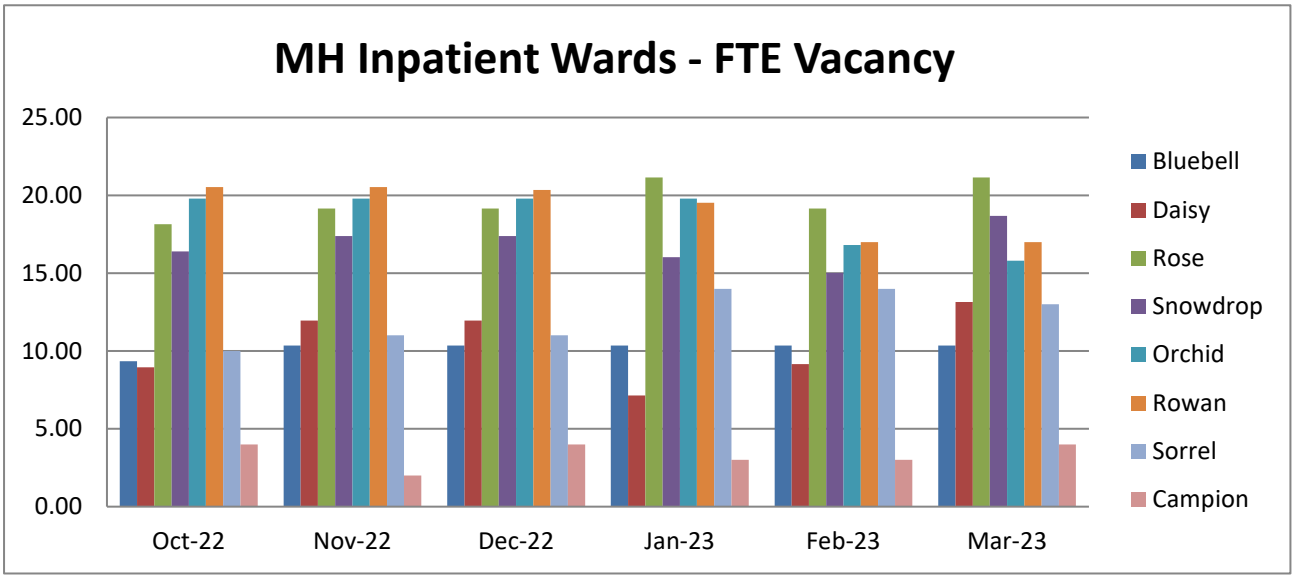
Ward	Grade of Staff	October 22	November 2022	December 2022	January 2023	February 2023	March 2023
MH Wards	Registered	45.64	47.64	43.64	45.64	41.64	47.92
	Unregistered	50.76	55.56	55.2	52.4	47.87	49.87
CHS Wards	Registered	4.6	4.8	3.6	4.6	6.6	2.0
	Unregistered	11.84	4.4	3.0	5.4	8.4	8.13
Campion	Registered	2.00	1.00	1.00	0.00	0.00	1.00
	Unregistered	2.00	3.00	3.00	3.00	3.00	3.00

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing. Across the mental health wards there is some work on restructuring some posts which it is envisaged will have a positive impact on vacancy longer term (the upgrading of ward manager and clinical lead posts to reflect the level of responsibility).

Graph 1: WTE on the Community Wards by Month:



Graph 2: WTE on the Mental Health Wards by Month:



4.2 Sickness absence.

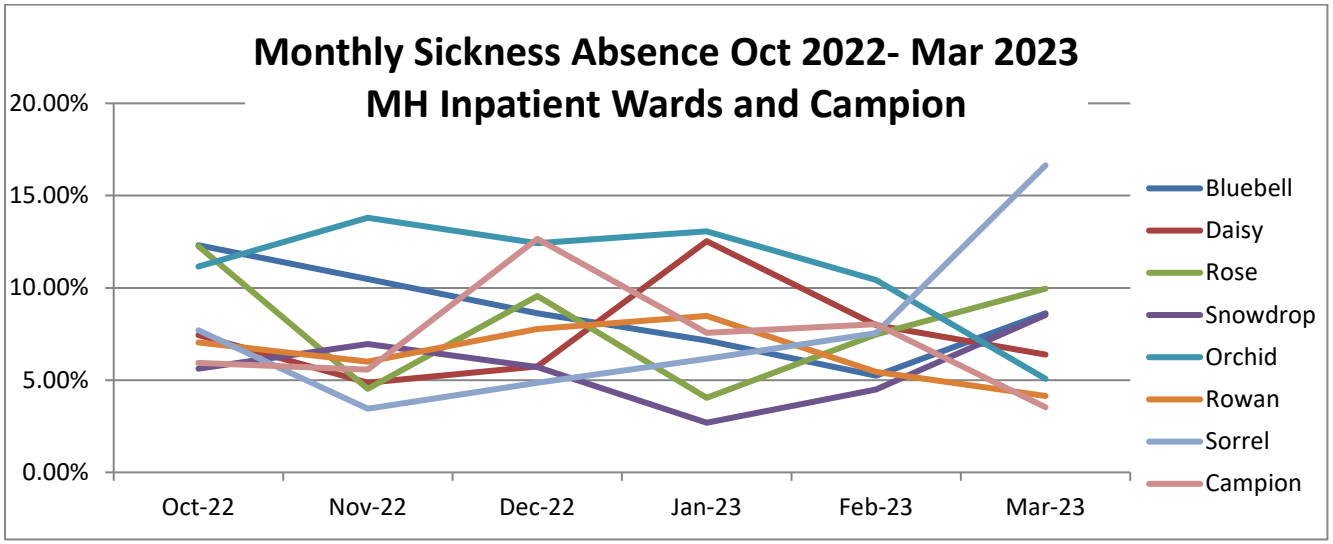
Graphs 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short-term sickness.

During this reporting period we have continued to see challenges which has impacted staffing due to sickness absence amongst both our permanent and temporary workforce and at times ward capacity. Sickness absence in general is high across our inpatient wards, with most of the wards consistently exceeding the trust target of 3.5% and the organisational average of 4.7% (apart from Sorrel ward in November 2022; Snowdrop ward January 2023; Henry Tudor ward October and November 2022; and Jubilee ward January, February and March 2023), the top three sickness absence reasons in terms of number of working days lost due to illness are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems, and cold, cough, and flu.

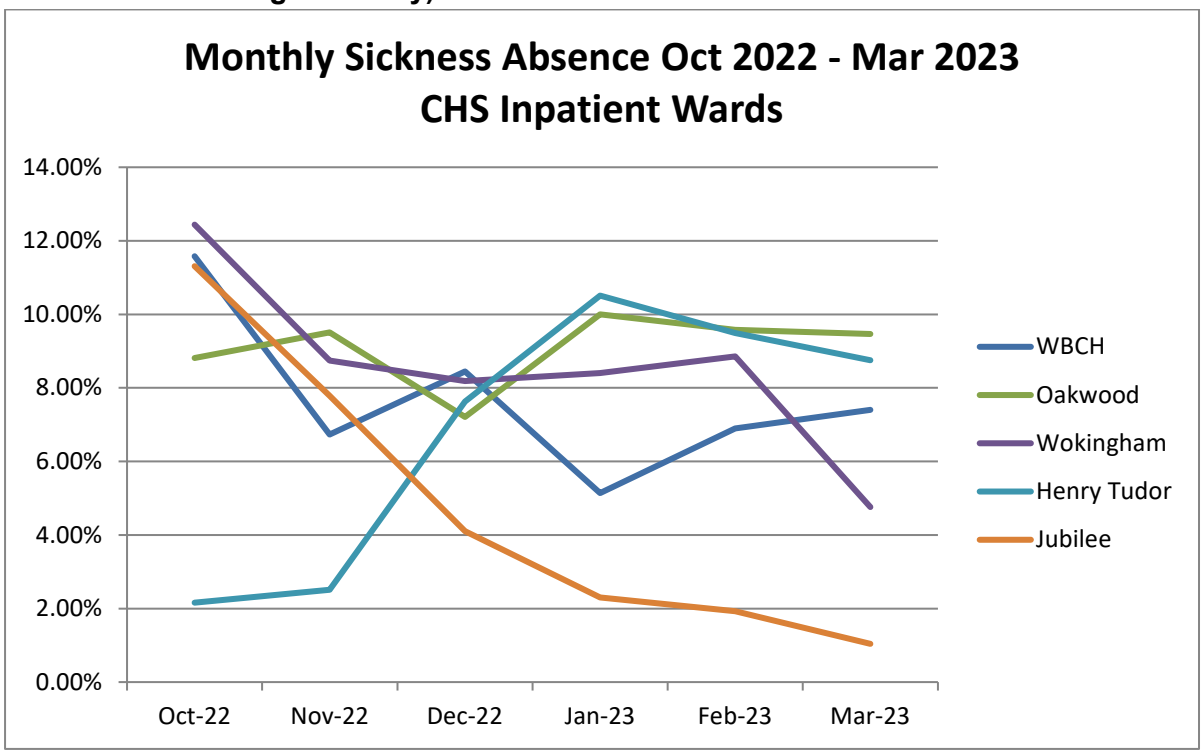
The Trust has a sickness absence policy which with support from the Human Resources department, ensures that appropriate action is taken to support staff and managers with sickness

related absenteeism. There are several wards with a high sickness absence due to a combination of both long and short-term sickness factors. These wards are working closely with Human Resources and Occupational Health providers to ensure that appropriate support is offered, and action being taken. The Trust also has a Health, Wellbeing and Engagement Manager and team. In addition, there are several initiatives which are widely advertised to address both physical and mental health care needs of staff including a health and wellbeing hub for staff and the PNA programme. These can be accessed by all staff via Nexus the Trust internet site or via Occupational Health referral if appropriate.

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

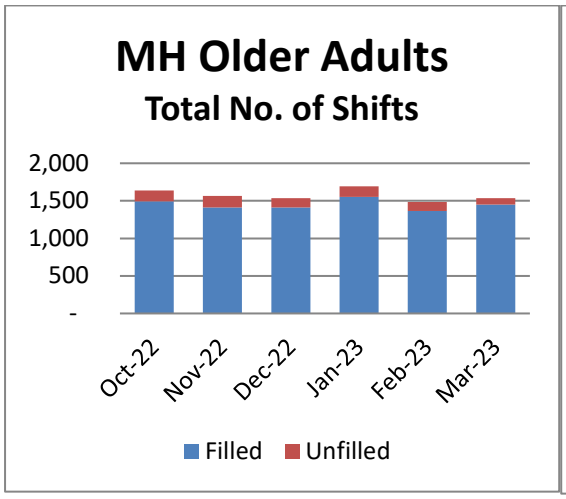


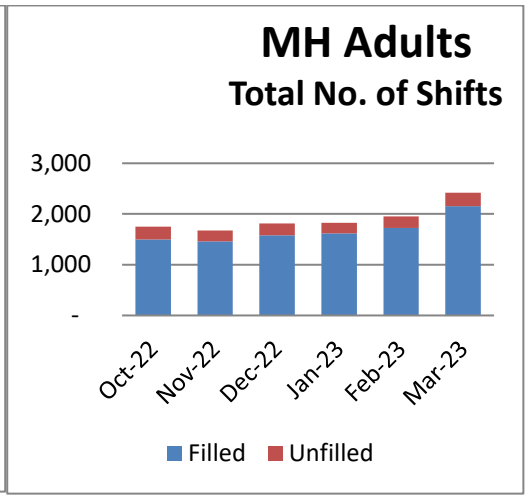
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Mental Health, Wards and Learning Disability):

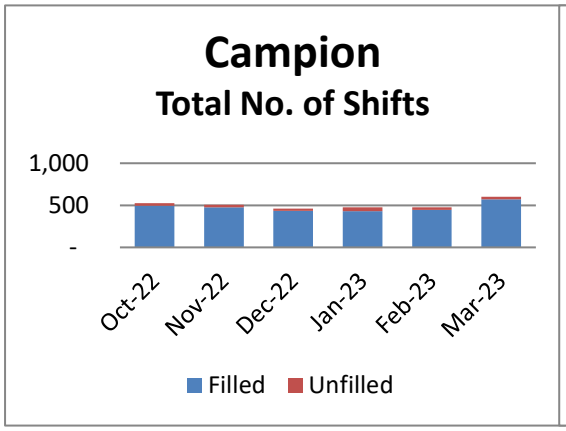


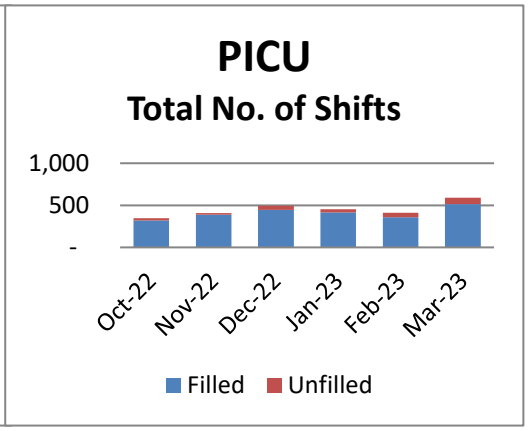
4.3 Temporary staffing.
When the wards have vacancies and sickness within their nursing staff establishment, they use temporary staffing (agency / bank, or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff are required. It is recognised that increased numbers of agency and bank staff have the potential to impact on quality of care. Therefore, the wards continue to work hard with the support of the recruitment team to fill vacancies with the aim to reduce the reliance on temporary staffing.

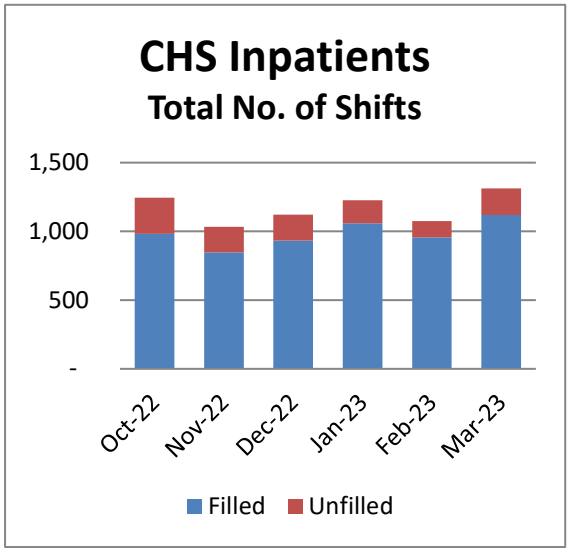
The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled.











5.0 Displaying planned and actual registered and care staff on the wards.
All the wards within the trust have a display board which shows the number of staff that the ward had planned to have on shift and the number of staff on shift. This is clear to visitors to the ward as to the number of registered nurses and care staff on the ward at the time. The nurse in charge of the shift portrayed so that visitors can identify who to contact if they have a concern or want to speak to them. These boards are monitored during quality visits to individual wards throughout the year by senior managers and 15 steps visits to ensure they are current.

6.0 Safety on our wards.
The NHSE/I in its workforce safeguarding recommendations recommends organisations need to demonstrate effective governance and commitment to safety so boards can be assured that their workforce decisions, promote patient safety and comply with the Care Quality Commission's (CQC) fundamental standards. Therefore, it is just as important to have the appropriate staff capability alongside the number of staff to ensure that they can deliver a safe and quality service to all patients.

6.1 Quality indicators.
To monitor safety of care delivered on the wards the Director of Nursing and Therapies and the board reviews a range of quality indicators on a monthly basis alongside the daily staffing levels.

These indicators are:
Community Wards:
- Falls where the patient is found on the floor (an unobserved fall).
- Developed pressure ulcers.
- Patient on staff assaults.
- Moderate and above medication related incidents.

Mental Health Wards:
- AWOL (Absent without leave) and absconsion.
- Self-harm.
- Falls where the patient is found on the floor (an unobserved fall).
- Patient on patient physical assaults.
- Seclusion of patients.
- Use of prone restraint on patients.
- Patient on staff assaults.

Monthly discussions are held with senior staff from each ward area to discuss staffing data along with the listed indicators. Any concerns are highlighted in the monthly safer staffing board report and inform the safe staffing declaration provided by the Director of Nursing and Therapies.

Table 5: Quality metric for mental health inpatient wards (October 2022 to March 2023):

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	15	4	10	19	1	7	157
Daisy	11	2	25	20	0	1	100
Rose	19	4	25	54	0	9	13
Snowdrop	5	7	9	10	0	10	90
Orchid	0	8	6	25	0	2	0
Rowan	0	17	22	44	0	13	1
Sorrel	5	3	17	27	0	33	6

Campion	2	1	11	61	0	9	10
Total	**57**	**46**	**125**	**260**	**1**	**84**	**377**

* Correct at time of report

There has been an overall decrease in incidents reported during this period compared to the previous six months from 1001 to 950. The figures for self-harm have decreased (from 462 to 377) with the most noticeable reduction in numbers being in prone restraints (from 19 to1). Other priorities such as reducing falls have seen some reductions and continue to be key priorities for the trust. There are a number of Quality Improvement programmes of work and initiatives being undertaken across the Trust including reducing restrictive practice. Self harm, falls and assaults are also Breakthrough objectives for the trust receiving specific focus and also have staff training packages alongside quality improvement work to support staff competence in these areas.

Table 6: Quality metric for community physical health inpatient wards (October 2022 to March 2023):

Ward	Drugs	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	24	15	12	1
Highclere	21	15	12	2
Oakwood	17	10	16	0
Wokingham	69	15	11	5
Henry Tudor	11	6	11	0
Jubilee	13	4	3	1
Total	**155**	**65**	**65**	**9**

* Correct at time of report

Incidents reported during this six-month period have increased during the last 6 months (243 to 294). The number of falls is the same at 65; but an increase in alleged patient on staff assaults (4 to 9), drug errors (123 to 155) and pressure ulcers (51 to 65). Pressure ulcer reviews and learning events are undertaken to ensure learning is shared within teams across the Trust and ensures information is disseminated to relevant staff. A Pressure Ulcer Improvement Oversight group led by the Deputy Director of Nursing was set up in April 2022 with an aim to improve the pressure ulcer figures for the trust and is focussed on the prevention of new pressure ulcers and a reduction in the number of developed inherited pressure ulcers. Further work is currently underway on improving staff training and awareness of pressure damage to reduce incident numbers led by the Lead Nurse for Professional Practice and the Tissue Viability Service Lead.
Reducing falls is a key focus for the Trust and is part of the harm free care driver metrics using a quality improvement approach to support reduction.
All medication incidents have been reported as being low or causing no harm.

6.2 Red flags.
The ability to achieve a position of at least two registered staff on duty is also perceived as a metric of quality (NICE; 2014 and 2018). It has been well documented that a shift with less than two registered staff on duty should be perceived as a red flag incident.

Table 7 demonstrates the number of occasions by ward and month where there were less than two registered nursing staff on a shift.
For all the wards where there are less than two registered nurses, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as

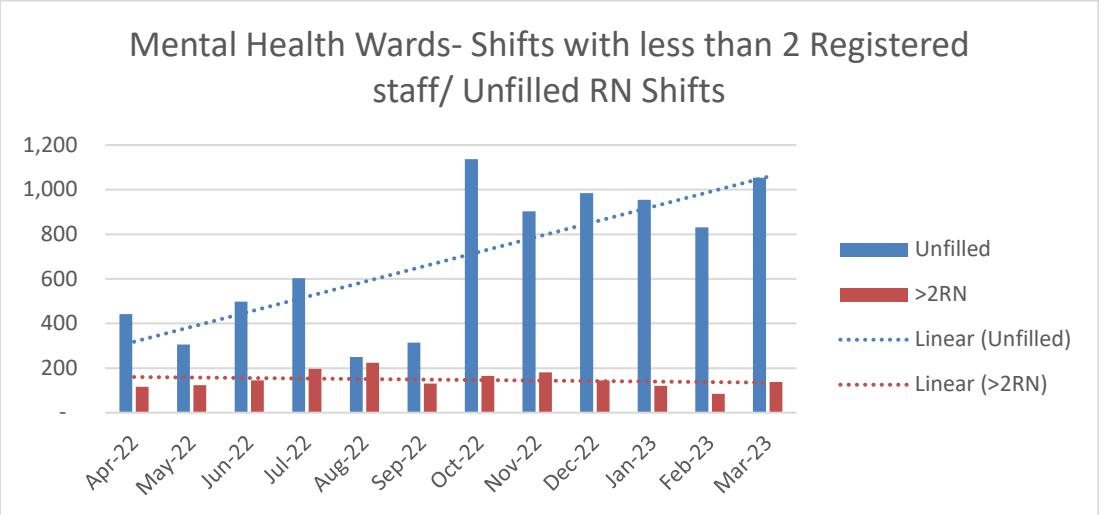
Physiotherapy and Occupational Therapy provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and able to take an overview of the wards and redeploy staff to areas of most need, as necessary.

Table 7: wards and number of occasions where there were less than two registered nursing staff on duty*

	Oct-22		Nov-22		Dec-22		Jan-23		Feb-23		Mar-23		Total for ward
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Bluebell	22	10	29	10	18	7	9	9	18	9	17	14	**172**
Daisy	23	5	22	2	29	7	9	5	1	3	14	3	**123**
Rose	22	12	19	5	19	5	9	3	9	1	22	2	**128**
Snowdrop	15	2	12	7	8	5	18	4	12	0	17	3	**103**
Orchid	20	7	41	18	21	4	27	11	13	7	10	7	**186**
Rowan	10	12	0	9	5	9	5	2	3	1	3	2	**61**
Sorrel	4	1	6	1	4	2	6	1	3	4	10	13	**55**
Campion	0	0	0	0	2	0	2	0	0	0	0	0	**4**
Donnington	13	13	1	0	0	0	0	0	0	0	0	1	**28**
Highclere	0	2	4	1	2	6	5	0	5	4	8	3	**40**
Oakwood	0	0	0	0	1	0	0	1	0	1	0	0	**3**
Ascot	4	9	5	6	7	6	2	2	2	6	8	14	**71**
Windsor	1	0	0	4	0	3	0	0	0	0	0	1	**9**
Henry Tudor	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Jubilee	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total for month	**207**		**202**		**170**		**130**		**102**		**172**		**983**

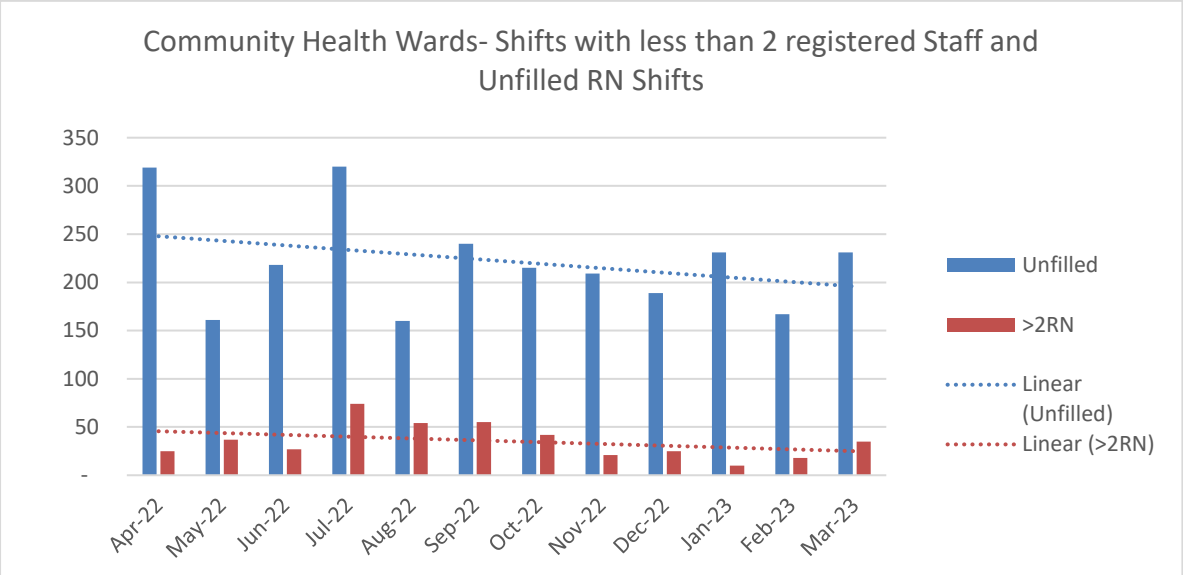
*Supernumerary staff are not factored into our number of shifts with less than 2 registered staff therefore deployment of the supernumerary staff to the wards will have reduced these numbers

Registered Nursing temporary fill rate and shifts with less than 2 registered staff for Prospect Park Hospital:



The graph indicates that the shifts with less than 2 registered staff each shift is fairly stable month on month, the wards have attempted to increase the numbers of registered staff on a shift but that this has not always been successful with these shifts being unfilled and showing as increased unfilled RN shifts in each month.

Registered Nursing temporary fill rate and shifts with less than 2 registered staff for the Community Health Wards.



7.0 Safe Staffing Declaration.

Each month the Director of Nursing and Therapies is required to make a declaration regarding safe staffing based on the available information.

Following the publication of Developing Workforce Safeguards (NHSI, 2018) there is a requirement as part of the safe staffing review for the Director of Nursing and Therapies and the Medical Director to confirm in a statement to their board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.

Declaration by Director of Nursing and Therapies and Medical Director.

Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels; supernumerary staff and managers , allied health professionals and temporary staffing have been used to achieve that. It is however recognised that during the period there were, due to inability to fill all rota gaps as a result of vacancy, absence and temporary staffing availability, shifts when staffing was sub-optimal and as a consequence there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised. Proactive work continues to support increased recruitment and improve retention and therefore sustainability of our permanent workforce. Alongside this a review of permanent ward establishments against actual staffing (including additional temporary staffing) being used to meet patient acuity is currently being undertaken for the mental health wards and a review of nurse staff establishments on our community wards will be undertaken to ensure that permanent staffing establishments are optimal to meet patient acuity prospectively.

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

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

Out of hours medical cover is provided by junior doctors for the mental health wards with Consultant Psychiatrists providing on-call cover from home.

8.0 Nursing Associates.

The Nursing Associate (NA) role is a nursing role which has been created due to the inability to recruit enough registered nurses. In addition, it will bridge the skills gap between healthcare support workers and registered nursing professionals. It is seen as offering a range of benefits: working alongside more senior regulated professionals, helping to improve patient care and a career pathway development opportunity. This role is an important part of workforce development within the Trust. Qualified NAs are registered with the Nursing and Midwifery Council (NMC).

There are 23 qualified NAs working in a range of services (community nursing, community mental health teams, community health wards) across the trust. 7 trainee NAs are at different stages of their training across all services. Work is being undertaken within the trust to continue to encourage suitable applicants for future cohorts and numbers of trainees have increased dramatically especially those in training during the last 6 months (3- April-September 2022; 7- October 2022-March 2023).

9.0 Conclusion and next steps.

- Support the deep dive work recommendations on the mental health wards as required, including the development pathway for bands 2's, 3's and 4's with aim to reduce agency use.
- Continue with focused recruitment plans which have achieved some positive results in securing new staff. Support the international recruitment programme. Support the preceptorship programme to ensure preceptee feel confident to fulfil their role on the wards.
- Continue to use the SafeCare tool to give an accurate picture of staffing needs across the wards.
- Support the Nurse Associate pathway and recruitment post qualifying. Support with any work streams associated with increasing the Nurse Associate programme take up.
- Commence the implementation of the newly developed community nursing dependency tool.
- Participate in the work experience review and recruitment initiatives.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	9th May 2023
Title	Quality Account 2022/23
	ITEM FOR APPROVAL
Purpose	NHS Trusts must publish a quality account each year, as required by the NHS Act 2009, and in the terms set out in the NHS (Quality Accounts) Regulations 2010.
Executive Lead	Medical Director
Authors	Head of Clinical Effectiveness and Quality Account & NICE Lead
Relevant Strategic Objectives	All: The priorities reported within the Quality Account align to the Trust Annual Plan on a Page.
CQC Registration	Data and evidence to support CQC inspections and improvements in patient care.
Legal Implications	The Board of Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year
SUMMARY	This is the 2022/23 Quality Account for final approval by the Trust Board. The Quality Assurance Committee (QAC) have reviewed the draft report in committee during Q1, Q2 and Q3. The Q4 version was shared for virtual approval by the QAC in April 2023. National guidance has been published by NHS England and we are required to publish our Quality Account on the Trust website by 30th June 2023. The requirements for submission of the QA as part of the Annual Report and external audit were removed in 2020. We share our Quality Account with specified stakeholders. The Q3 version of the account was shared at the beginning of March 2023 with NHS Frimley and Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Boards (ICB), Bracknell Forest Council Health and Care Overview and Scrutiny Panel, our Council of Governors and local Healthwatch organisations. All stakeholder comments and our response will be included in final published version of the account. Trust Priorities (Plan on a Page 2022-23) which have been met are: Patient Experience (Section 2.1.1) • We are meeting five of our mandated access targets at the end of 2022/23 and have put actions in place to meet the unmet target relating to audiology diagnostics waiting time. Patient Safety (Section 2.1.2) • We continue to adhere to recommended infection control measures to protect both patients and staff from COVID-19. • The number of falls on older adult inpatient wards was below the target threshold of 26 in eight of the twelve months during 2022/23 • The number of category 2, 3 or 4 pressure ulcers due to a lapse in care by trust staff were below the target threshold. • The target for physical health monitoring of patients with severe mental illness (SMI) was met at the end of the year. • No lapse in care provided was identified as a contributory factor for patients who died unexpectedly either as an inpatient in our care, or within 7 days of transfer to an acute hospital. Clinical Effectiveness (Section 2.1.3) • We are participating in all mandated national clinical audits and confidential enquiries.

	• We continue to progress several initiatives to support local Trust and/or University of Reading led research. • We continue to report on and learn from deaths of patients. Supporting our staff (Section 2.1.4) • We continue to implement our People Strategy 2021-24 with the aim of making the Trust a great place to work for everyone. All objectives related to supporting our staff are progressing. Areas where trust targets are not currently being met are as follows: Patient Experience (Section 2.1.1) • A 94% positive score was achieved in the 'I Want Great Care' patient experience tool during 2022/23, with an average 4.75 out of 5-star rating. The target is 95%. Patient Safety (Section 2.1.2) • The number of self-harm incidents on mental health inpatient wards exceeded the target threshold of 42 in 9 of the 12 months in 2022/23. Quality improvement work is being undertaken to address this. Supporting our staff (Section 2.1.4) • The overall staff sickness rate is above the 3.5% threshold. The rate was 4.17% in March 2023. Information on how we are supporting our staff and their wellbeing is detailed within the 'Supporting our Staff' section of the report. Board members are asked to note that this version of the Quality Account does not contain full-year incident data from the national reporting and learning system (NRLS) as we are awaiting its national publication. These will be added as soon as they are released and prior to publication on the website in June 2023.
ACTION REQUIRED	The Board is asked to seek any clarification required and approve the 2022/23 Quality Account. Directors are asked to consider the Statement of Directors' Responsibilities in Respect of the Quality Account (page 71), and ensure they are satisfied with the quality account in relation to the requirements detailed in this statement. Directors must confirm to the best of their knowledge and belief they have complied with the requirements detailed on page 71 in preparing the Quality Account, and the statement must then be signed by the Chair and Chief Executive following approval by the Trust Board to confirm this. Once approved, the final Quality Account will be published on our Trust Website by the deadline 30th June 2023, thus fulfilling our Statutory duties in this area.

Berkshire Healthcare
NHS Foundation Trust

Quality Account 2022/23

Our mission is to maximise independence and quality of life
Our vision is to be a great place to get care, a great place to give care

caring for and about you is our top priority

committed to providing good quality, safe services

working together with you to develop innovative solutions

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 approximately 4,500 staff who operate from our many sites as well as out in people's homes and in various community settings.

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 also run several 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. We work in partnership with Berkshire's two acute hospital trusts, Royal Berkshire Hospital NHS Foundation Trust and Frimley Health NHS Foundation Trust. We also work closely with Berkshire's six local authorities and a diverse range of community and charitable organisations.

The Care Quality Commission (CQC) oversee patient quality and safety and we are rated overall as 'Outstanding' by them. This award supports our wider aim to be a leading provider of mental and physical health services.

As a Foundation Trust we are accountable to the community we support. NHS Improvement regulate our financial stability and have given us a financial sustainability risk rating of 4, which is the best rating we could have (they rate from 1 to 4, with 1 being at most risk and 4 being the least risk).

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

Contents

Quality Account Summary and Highlights 2022/23

Figure 1- Trust Summary for 2022/23

Indicator (Click on links to access the related main sections of the report)		2022/23 Target	Results		Comment
			2021/22	2022/23	
Patient Experience					
I Want Great Care- % of patient respondents giving a positive rating (a score of 4 or 5 out of 5)		95%	N/A	**94%**	Target not met
Carer Experience - % of carers rating their experience as good or very good		No target set	96%	**89%**	
Harm-Free Care					
Number of falls on Older People's Inpatient Wards (Community Inpatient Wards and Older People's Mental Health Wards)		<26 per month	Target Met in 0/12 months	**Target Met in 8/12 months**	
Pressure ulcers (PUs) due to lapse in care by Trust staff	Number of category 2 PUs due to lapse in care by Trust staff	<19 per year	18	**1**	Target Met
	Number of category 3, 4 unstageable or deep tissue injury PUs due to lapse in care by Trust staff	<18 per year	2	**0**	Target Met
Self-harm incidents by mental health inpatients		≤42 per month	Target met in 1/12 months	**Target met in 3/12 months**	
Patients with Severe Mental Illness (SMI) referred to Community Mental Health Teams (CMHT) will have all parameters of the annual physical health check completed within one year of referral to the CMHT		85% by end of year	79% at end of year	**85% at end of year**	Target Met
Clinical Effectiveness					
Compliance with NICE Guideline on Supporting Adult Carers		≥80%	N/A	**97%**	Target Met
Supporting our People					
Staff sickness level		<3.5% per month	Target met in 2/12 months	**Target met in 0/12 months**	

The figure below gives an overview of highlights for this year. We strive to provide a positive experience for all our patients and staff and, where this is not the case, will continue to learn from these to make improvements.

Patient Experience Priorities

- We are meeting five of our mandated access targets and have put actions in place to meet the unmet target relating to audiology diagnostics.
- A 94% positive score (target 95%) was achieved in the 'I Want Great Care' patient experience tool, with an average 4.75 out of 5-star rating.

Patient Safety Priorities

We have met the following targets:

- <33 falls per month on our older people's inpatient wards (target met in 8/12 months)
- <19 category 2 and fewer than 18 category 3 or 4 pressure ulcers (PUs) due to a lapse in care by trust staff
- On 1st April 2023, 85% of patients with severe mental illness referred to our Community Mental Health Teams (CMHTs) had all seven parameters of the annual physical health check completed within a year of referral to CMHT.

Clinical Effectiveness Priorities

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

Supporting our Staff Priorities

- We continue to implement our People Strategy 2021-24 with the aim of making the Trust a great place to work for everyone. All objectives related to supporting our staff are progressing.

Care Quality Commission (CQC) Rating

We are rated as "Outstanding" overall by the CQC and all our services are individually rated as either "Outstanding" or "Good".

2022/23 Trust Priorities

Patient Experience Priorities. We will: · Reduce the time patients wait for our services. Offer advice on healthy choices. Address inequality of access to services. Gain feedback from at least 10% of patients and make improvements based on this.

Patient Safety Priorities. We will: Protect patients and staff from infection. Prioritise patients at risk of harm from waiting times. Ensure face-to-face care where clinically indicated. Reduce falls, pressure ulcers, inpatient self-harm and suicides. Respond to physical health deterioration on inpatient wards. Improve the physical health of those with serious mental illness. Strengthen our safety culture.

Clinical Effectiveness Priorities. We will: Participate in relevant national audits and implement and report on NICE guidance. Review, report, and learn from deaths.

Supporting our People Priorities. We will: Ensure our teams have access to effective health and wellbeing support. Promote a culture of respect, compassion, and kindness. Not tolerate bullying, harassment, or abuse. Support staff to work flexibly and connect with their teams. Act on feedback from staff to improve satisfaction and identify inequalities. Provide opportunities for staff to show initiative and make improvements. Support staff to achieve their career aspirations. Welcome leavers, apprentices, students and international recruits to help close workforce gaps.

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

This Quality Account details our achievement against our key quality priorities for 2022/23. It highlights some of the service improvements our staff are proud to share and areas where we continue to strive to do better.

Our key priority is to provide safe, high-quality care to our patients, in addition to providing a great place to work for all our staff. Our achievements and strengths include:

- A positive value driven culture, fostering listening, learning and driving safer care.
- Our national staff survey results demonstrate a highly engaged and motivated workforce.
- We encourage innovation and every day continuous improvement led by our frontline staff.
- We are a financially stable, well led organisation with an Outstanding CQC rating.
- We have been at the forefront of leading digital care and been invited to support the shaping of the national NHS digital strategy.

In 2019 we developed a three-year strategy; this was updated in 2020 to address our response and learning to the global pandemic. The extraordinary circumstance of the pandemic accelerated significant change and improvements to the way we work.

Delivery of healthcare continues to change at pace, and we have been working on developing a new mission and vision to enable us to meet the many challenges healthcare faces.

Our new vision for 2023 is for high quality patient care which will be directly supported by making Berkshire Healthcare a great place to work, for all staff. We know that building inclusive, motivated, and engaged teams working to shared goals translates to great care for patients.

Our mission and vision purposefully focus us to our patients. We will take a patient centred view of everything we do, actively listening to carers, families and patients ensuring we sustain our focus.

We want to support people to live independent and full lives, within their individual circumstances. We'll be involved in people's care when needed, at all stages of life, and support them to achieve the best possible quality of life.

We're an outstanding organisation, with much to be proud of. However, we know that not all our patients experience the best possible care and not all colleagues have the best possible experience at work.

We will continue to work with our system partners to improve the health and wellbeing of the populations we serve and to reduce health inequalities through collaboration and integrated working.

With a focus on safe, high quality patient care, supported by continuous improvement and excellent teamwork, we'll deliver our vision to provide great care for all patients.

Our mission and vision are underpinned by our values – 'Caring, Committed and Working together' - and our True North goals, setting out how we'll achieve our vision are detailed in the plan on a page for 2023 /24 and form the key priorities for the 2023/24 Quality Account.

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

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

2.1. Achievement of Priorities for Improvement for 2022/23

ⓘ This section details the Trust's achievements against its quality account priorities for 2022/23. These priorities were identified, agreed, and published as part of our 2021/22 quality account.

These quality account priorities support the goals detailed in the Trust's 2022/23 Annual Plan on a Page (see Appendix A). The Trust's Quality Strategy also supports this through the following six elements:

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

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

2.1.1. Patient Experience and Involvement

ⓘ One of the Trust's priorities is ensuring that patients have a positive experience of our services and receive respectful, responsive personal care. This sub-section details our performance against our patient experience priorities for 2022/23.

Our 2022/23 Patient Experience Priorities:

Improving outcomes

1. We will reduce the number of patients waiting for our services.

2. We will identify and address inequality of access to services and improve outcomes.

3. We will collect more patient and carer feedback and use this to deliver improvements in our services.

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

Reducing the number of patients waiting for our services. Prioritising patients at risk of harm resulting from waiting times. Ensuring face to face care where clinically indicated. Identifying and addressing inequality of access to services

ⓘ It is important that patients are seen as quickly as possible following referral to one of our services. This helps to provide the best outcome and experience for the patient. The NHS has set several ambitious waiting time targets to manage this, including those relating to mental health and planned hospital care.

It is important that waiting times for our patients to see our services are kept as short as possible. It is also important that we prioritise those patients that are at risk of harm due to waiting. This section of the report details our performance against mandated access targets and gives examples of other work being carried out in this area. Further examples are included in the 'Other Service Improvements' sections (parts 2.1.5- 2.1.11 of this report).

Figure 2- Overview of Trust performance against national mandated access targets for patients

		Target wait time	Met by trust?
Community Paediatrics*		95% within 18 weeks	Yes
Diabetes Outpatients*		95% within 18 weeks	Yes
Audiology diagnostics		95% within 6 weeks	No
Accident and Emergency (Minor Injuries Unit)		95% within 4 hours	Yes
Improving access to Psychological Therapies (IAPT)	Assessment	75% within 6 weeks	Yes
	Treatment	95% within 18 weeks	Yes

* Relates to 'incomplete pathways'- those patients that are waiting for their treatment to begin

Audiology Diagnostics.
Due to high turnover of staff and sickness rates, performance against the audiology diagnostics target (see above table) dropped down to 41% in September 2022. Currently, 68% of patients are seen within 6 weeks from the referral. To regain our performance, several key strategies have been implemented such as expediting recruitment processes, reviewing of administration systems and creation of a new data collection dashboard.

The service is fully staffed as of April 2023 and all new staff are currently being trained. We are expecting to reach optimal clinical capacity in May 2023, and this will help us to clear the backlog from 2022/23 and move towards achieving the 95% target. We are also booking additional hours with current staff and using more efficient data collection tools to better track the waits.

Longer term strategies are also in place. These include caseload review, focus on staff retention and in-service training for current staff.

Impact on waiting times of additional investment into the Children and Young People Integrated Therapy (CYPIT) Occupational Therapy (OT) Team.
In April 2022 additional (non-recurrent) investment was provided to this team to support improvements in waiting times. This investment resulted in an increase in the number of qualified whole time equivalent (WTE) OT staff in the team (from 5.8 WTE to 8.8 WTE staff). The investment also allowed the team to introduce a wider skill mix through the recruitment of more OT assistants (from 0.64 WTE staff to 3.0 WTE staff).

This has led to the following improvements during this year:

- A substantial reduction in both:
  - the number of children and young people awaiting triage- down from 239 patients in Q1 to 3 patients at the end of Q3
  - the waiting time for the triage process to commence- down from 32 weeks in Q1 to 4 weeks at the end of Q3.
    The service should reach the target of patients waiting no more than 2 weeks for triage by the end of the year. In addition, as there are fewer patients awaiting triage, OT clinicians can make a quicker informed decision about the next step for each patient.
- A reduction in the number of children and young people waiting longer that 53 weeks for a full OT assessment- down from 50% waiting this long in April 2022 to 25% at the end of December 2022. The aim is to have no patient waiting this long by the end of March 2023.
- A reduction in the waiting time for sensory processing workshops to 21 weeks, and we expect to reduce this further. The initial target was to have no one waiting more than a year for this.

The service has also improved its compliance with Education Healthcare Needs Assessment (EHCNA) requests. At the end of Q3:

- All children who are previously known to the service and are on the OT caseload receive input into their EHCNA within the 6-week deadline.
- This target is also being met for all children who are on the OT waiting list.

However, the 6-week deadline is not always being met for children that are not previously known to the OT service. Dedicated time has now been allocated to address this backlog.

Using patient and carer feedback to deliver improvements in our services.

One of the Trust's priorities is to use patient and carer feedback to drive improvements in our services. We use several methods to achieve this, including the "I Want Great Care" patient experience measurement tool, learning from complaints and the national community mental health survey. The sections below detail how we have performed during the year in this area.

I Want Great Care (iWGC)

ⓘ The 'I want Great Care' patient experience tool was introduced in December 2021 and is our primary patient survey programme. It is used to hear the patient voice and support areas for improvement. It is available to patients in a variety of ways including online SMS, paper and electronic tablet. It is also available in a variety of languages and in easy read format and includes the Friends and Family Test (FFT) questions.

The iWGC tool uses a 5-star scoring system (with 5 being the best score) which is comparable across all services within the organisation. Questions are asked about experience, facilities, staff, ease, safety, information, involvement and whether the person felt listened to. Respondents are also invited to use free text to comment on their experience and to suggest improvements. Not all questions are relevant to every patient. For example, only patients seen in a building, on a ward or at an outpatient appointment will be asked facilities-related questions.

Response Rate

Figure 3 below demonstrates the response rate to the iWGC tool.

Satisfaction Rate

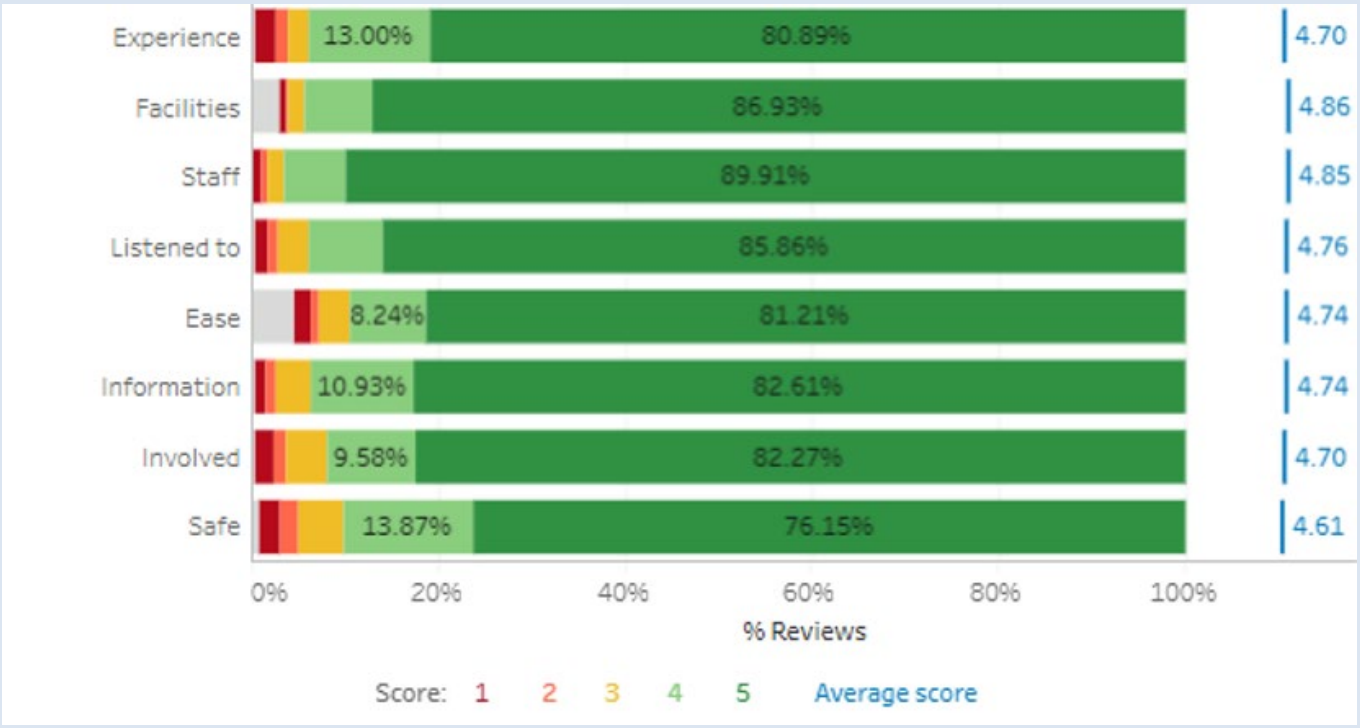
Figure 4 below demonstrates how patients rated their experience overall (the top bar) and

then broken down into themes. This is based on 16,311 responses during 2022/23. A 93.9% positive experience score was achieved for 2022/23 with an average 4.75-star rating.

Figure 3- I Want Great Care- Response Rate

2022/23 Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% Response Rate	0.8	1.1	1.3	2.5	2.3	1.9	2.3	2.6	2.7	2.8	2.3	3.1

Figure 4- I Want Great Care: How respondents from all trust services rated their experience of our services on a scale of 1 to 5 (with 5 being the best score)- 2022-23



Source: Trust Patient Experience Report

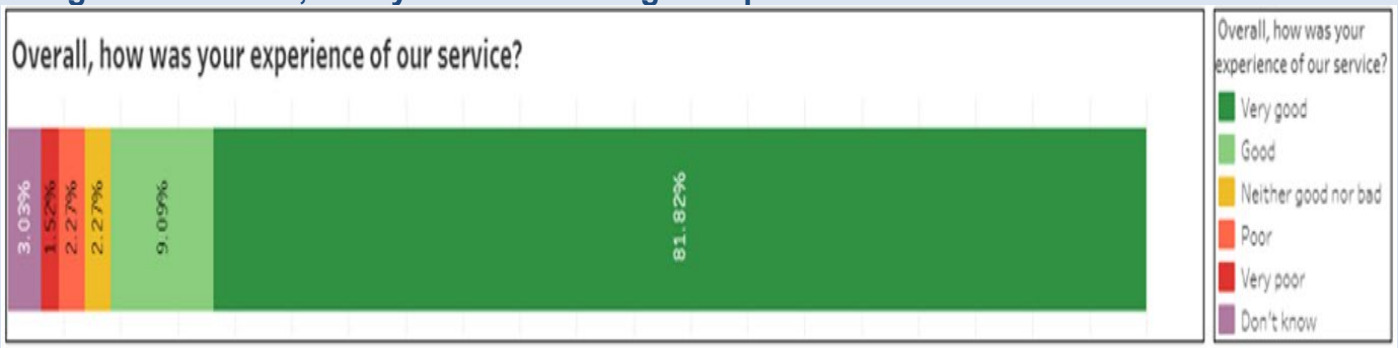
Friends, Family and Carer Feedback

ⓘ We recognise the valuable role unpaid carers play in supporting our patients/ service users and have established a bespoke process to gather unpaid carer feedback to help us learn from their experience.

The Friends and Family test was introduced nationally to gather patient experience and was not mandated nationally for carer feedback. Therefore, our I Want Great Care (IWGC) patient experience tool does not capture friends, family or carer feedback on their experience. However, we value carer input and have established a bespoke process to gather unpaid carer feedback using a Microsoft form. Results are collated and published in a Tableau dashboard. Figure 5 below demonstrates how carers rated their overall experience during 2022/23.

Response rates are low but increasing. Based on 132 responses, 92% of respondents rated their experience as good or very good. Services can access and review data regarding their service and use the feedback to support quality improvement activities.

Figure 5- Friends, family and carer rating of experience overall- 2022/23



Source: Carers Experience Dashboard on Tableau

Complaints and Compliments

We continue to respond to and learn from complaints and compliments. Figures 6 and 7 below show the monthly number of complaints and compliments received by the Trust.

Figure 6- Complaints received (excluding re-opened complaints)

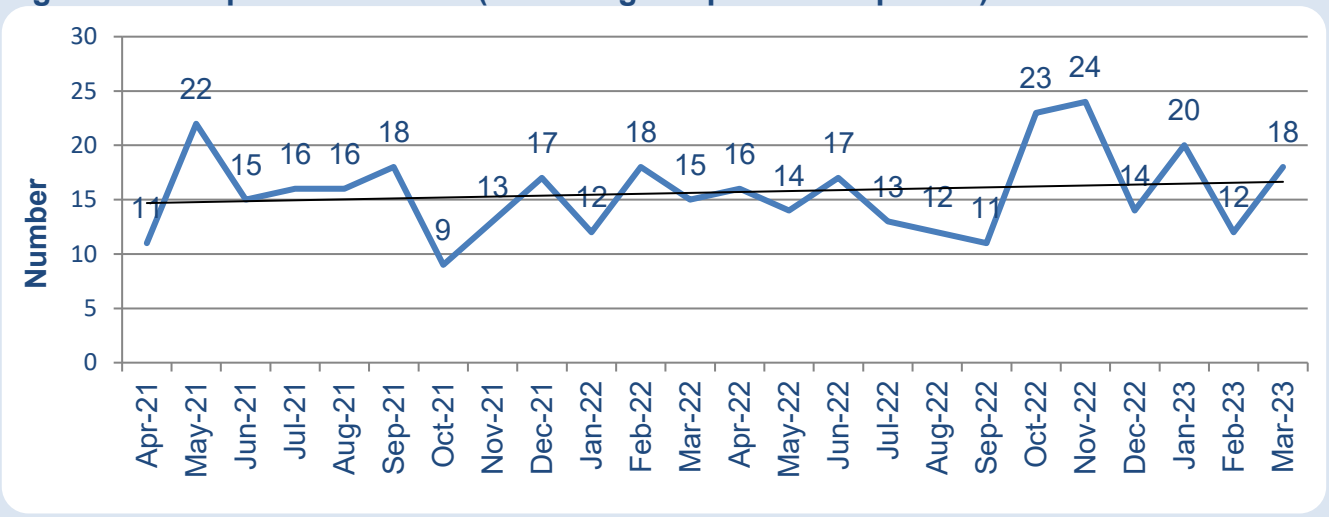
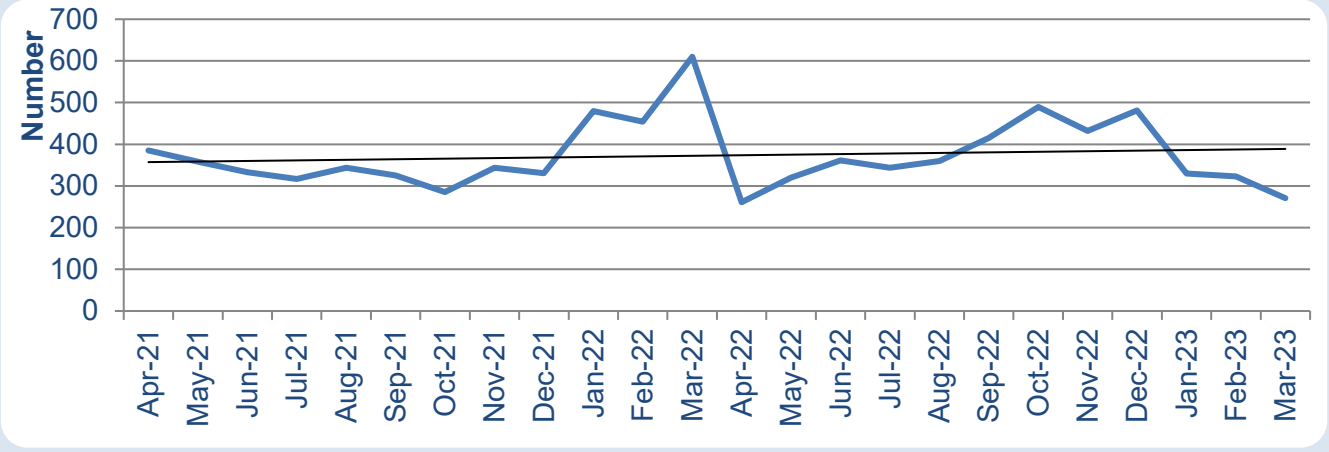


Figure 7- Compliments received.



Source: Trust Complaints and Compliments Reports- based on compliments being submitted voluntarily by service. We also receive compliments through the IWGC patient experience tool, but these are not included in the figure above.

240 complaints were received during 2022/23 (both new complaints and re-opened complaints), compared with 231 in 2021/22. Figure 8 below details these complaints by service.

Figure 8- Formal complaints received by service.

Service	2021-22 Total	2022-23				
		Q1	Q2	Q3	Q4	Total
Community Mental Health Teams (CMHT) /Care Pathways	32	11	10	18	14	53
Child and Adolescent Mental Health Services (CAMHS)	31	4	6	13	10	33
Crisis Resolution & Home Treatment Team (CRHTT)	15	3	9	6	4	22
Acute Inpatient Admissions – Prospect Park Hospital	30	13	7	9	6	35
Community Nursing	12	3	0	4	5	12
Community Hospital Inpatient	25	4	3	2	1	10
Common Point of Entry (CPE)	2	0	1	3	1	5
Out of Hours GP Services	9	1	0	1	2	4
Psychiatric Intensive Care Unit (PICU)	7	1	2	0	4	7
Urgent Treatment Centre	2	1	0	0	0	1
Older Adults CMHT	2	1	1	0	0	2
Other services	64	19	11	15	11	56
Grand Total	**231**	**61**	**50**	**71**	**58**	**240**

Source: Trust Complaints and Compliments Reports

Learning from Patient Experience and Involvement

Each service takes patient feedback seriously and staff directly involved in complaints are asked to reflect on the issues raised and consider how they will change practice. Many teams are using our feedback tools to make improvements to their services, and some examples of these improvements are detailed below in a 'you said, we did' format.

Service	You said	We did
Children in care	You would like to have a choice of face-to-face or online health checks	We now offer to see you face-to-face or virtually for your health checks
Crisis Resolution and Home Treatment Team (CRHTT)	Concerns raised about navigating Mental health services	We have built on an existing Directory of Services and raised a Bright Idea with hopes of creating a user-friendly app or webpage to support Carers, patients, and staff with this. We plan to include service information, such as remit, inclusion/ exclusion criteria, opening hours, and contact details for all our Mental Health Services and guide users through the various pathways
Community Physiotherapy	You said you would prefer later opening times	We have increased our opening times to include early evening appointments

Service	You said	We did
Health Visiting	Families fed back they were getting their Ages and Stages Questionnaire development checks later and problems had been dealt with by other services.	We devised a catch-up process to ensure these families had a timelier appointment and children approaching their developmental review is now at the correct time.
Hearing and Balance	Feedback from a patient who was urgently trying to rebook appointment. Patient did not answer call and so wasted attendance.	We now text patients as well as calling if we have been unable to talk to someone. We have also changed the outgoing phone number on our calls as our previous one showed as an unknown number. It now shows our 0300 number in case patients are wary of answering unsolicited calls.
Mental Health Inpatient Wards	Carers reported poor communication and involvement in decision making and care.	We have set up carers' clinics on each ward where the ward manager has a half-day slot allocated once a week where carers can be booked in or call up to speak to the ward manager. This is included on the information sent to carers on admission
	Patients reported not being involved in care, having regular 1-1s or knowing who their key nurse is.	Each ward is setting up 'Who's caring for me' boards. These identify who is looking after them that shift. There is a role descriptor for this so that the person looking after you is responsible for key parts of your care that day– i.e. 1-1, physical observations, review of risk summary/safety plan.
Talking Therapies	The waiting time for Step 3 therapy was too long and patients can feel abandoned from assessment or when stepped up from step 2 treatment with no contact or support whilst waiting	Patients on the waitlist for Talking Therapies are now offered access to online treatment using the Silvercloud programme under the guidance of a support worker. Early results show that this has resulted in mood improvement in several cases and feedback from both staff and patients is very encouraging.

National NHS Community Mental Health Survey

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

The survey sample. People aged 18 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen face to face at the trust, via video conference or telephone between 1 September 2021 and 30 November 2021. Responses were received from 265 (22%) respondents, compared to a national response rate of 21%. The Trust response rate was lower than the previous year (27%).

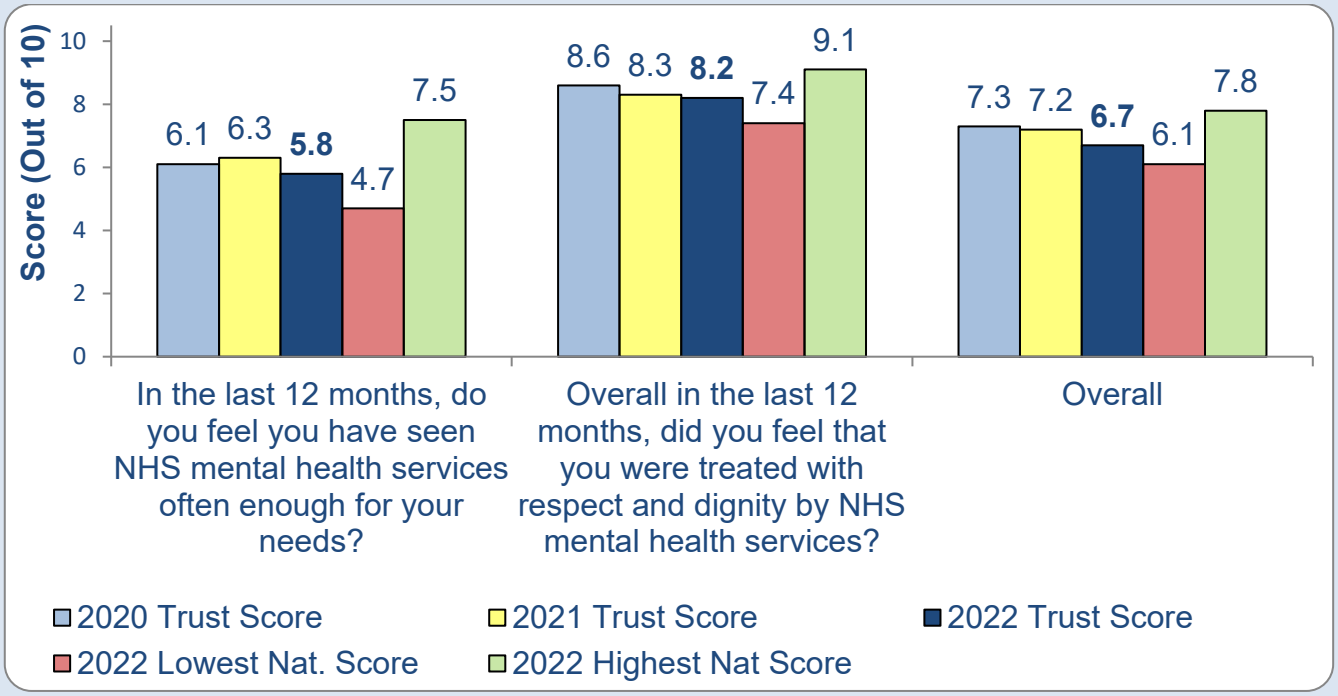
About the survey and how it is scored. The survey contained several questions organised across 12 sections. Responses to each

question and section were converted into scores from 0 to 10 (10 representing the best response). Each score was then benchmarked against 52 other English providers of NHS mental health services, resulting in the Trust being given a rating for each question and section on a five-point scale ranging from "much better" to "much worse" than expected.

Summary of Trust results. In the 2022 survey, the Trust was rated "about the same" as the 52 other Trusts in all 12 sections.

Respondents' overall view of care and experience. Figure 9 gives an overview of Trust scores for overall experience. The 2022 Trust scores (shown by the dark blue bar in the middle of each question) are compared with the highest and lowest scores achieved by all Trusts (the red and green bars to the right of the dark blue bar), and with the Trust scores in 2020 and 2021 (the light blue and yellow bars to the left).These survey results have been shared with clinical leads to share with their teams and to identify any further actions that would have a positive impact.

Figure 9- National Community Mental Health Survey Results - Overall view of care and services



Source: Data from National Community Mental Health Survey Reports

2.1.2. Harm-Free Care

ⓘ We aim 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 2022/23 Harm-Free Care Priorities:
Providing safe services

1. We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures.
2. We will identify and prioritise patients at risk of risk of harm resulting from waiting times, and always ensure face-to-face care where clinically indicated.
   Please note that this area is covered within the section on reducing waiting times in the Patient Experience section above.
3. We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all our services.
4. We will recognise and respond promptly to physical health deterioration on our in-patient wards.
5. We will improve the physical health of people with severe mental illness.
6. We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents.

The Trust's aim throughout the year has been to continue to foster an environment that has the patient at the heart, where all staff take accountability for their actions, senior leaders are visible in clinical areas, challenge, role model and create safe environments for people to speak up about poor care and to learn when things go wrong. In support of an open culture there is a 'Freedom to Speak Up' policy which has been in place for several years, and this is described further in Section 2.1.4- Supporting our staff. There is also a Safety Culture Charter, and several initiatives are in place to help ensure that staff feel psychologically safe to raise concerns and learn from errors to provide safe care. The implementation of the national patient safety strategy alongside quality improvement supports this ambition to continuously improve patient safety by building on the foundations of a safer culture and safer systems. This enables learning from incidents, errors and patient feedback. The Trust has also continued to engage with and contribute to cross organisational initiatives such as the regional patient safety collaboratives and national improvement programmes.

Protecting our patients and our people from COVID-19

ⓘ It is vitally important that our patients and staff are protected from COVID-19. The trust has stringent infection control practices in place, and these have been enhanced to manage the coronavirus risk.

Examples of additional resources and guidelines that have been put in place to protect patients and staff from COVID-19 include the following:

- Patient pathways are in place for placement of COVID-19 Inpatients. This includes advice on management of isolation, cohorting and stepdown of isolation.

Guidance on screening, in line with national guidance, is in place. National guidelines and updates are reviewed and implemented.

- Management of Covid -19 is incorporated in Infection Prevention and Control (IPC) guidance which supports management and prevention of other infections based on standard and transmission-based precautions.
- Guidance for community and outpatient settings.
- Resources for staff are available on the trust COVID intranet page and are disseminated to clinical teams and via newsletters. Resources are regularly reviewed and updated. Links to information include:
  - Staff testing, actions if a positive result, and guidance for contacts of a positive case.
  - Staying safe at work
  - Staff risk assessments in place for all staff
  - Staff wellbeing programme and support
  - PPE videos for donning and doffing
  - Staff vaccination
- Review and overview of stock levels and supply of Personal Protective Equipment (PPE) is undertaken by the Deputy Director of Nursing and by the Estates and Facilities Management team.
- All-staff briefings. This is a live broadcast which is also published on Teams and includes a live question and answer aspect to support practical application of guidance.
- Service visits are carried out by the IPC team, Director of Nursing, clinical directors, and divisional managers to support implementation of guidance.
- Visiting guidelines have been updated.
- Supporting guidelines are available for managers.
- Guidance on the use of face masks is available and updated based on national guidance and surveillance of increase in cases locally.

The Trust is monitoring these measures in several ways:

Trust Wide assessment. At an organisational level, the Trust has completed and updated a Trust-wide Infection Prevention and Control Board Assurance Framework (BAF). This framework has been produced and is regularly updated by NHS England to support all healthcare providers to effectively self-assess their compliance with United Kingdom Health Security Agency (UKHSA) and other infection prevention and control guidance and to identify risks leading to improvement. It is a live document and is reviewed by the trust Board and several forums within the Trust. Risk assessments support review and application of Hierarchy of Controls.

Scoping for the implementation of the national IPC manual (England) by 2024 has been undertaken and forms part of the IPC annual programme. Mandatory IPC training and resources have been updated and aligned with the manual. As part of our policy review programme, IPC policies will be replaced with the IPC manual where appropriate, with local supporting guidance as required. Once this has been completed, most policies will be linked to the IPC manual as a stand-alone document. The web- based manual is available on our Nexus IPC and policy pages.

Service-level assessment. To help individual services meet the required guidelines, we have developed service specific risk assessments and Infection Prevention and Control COVID-19 compliance tools. These tools are completed monthly on every ward and service, with the frequency of completion increased during outbreaks and in areas of high incidence. The tools cover the areas of hand hygiene, environmental decontamination, decontamination of patient equipment and Personal Protective Equipment (PPE). Action plans are completed and implemented based on the outcome of these assessments which are reviewed by service leads and clinical directors. Learning is

shared from incidents and services use handovers and team meetings to update.

Individual Staff PPE Competence Tools are completed for every member of staff that is required to wear PPE. The results of these are held at service level and ensure that all staff can wear PPE correctly to reduce the risk of infection. Staff are undertaking individual sign-off within services.

Hand Hygiene audits are completed by all inpatient services monthly and all community services on a quarterly basis. This audit is designed to ascertain whether, over a designated period, healthcare workers have adequately decontaminated their hands. The audit is undertaken opportunistically without the staff members knowing that the observation is being undertaken. Specific observations are made; before patient contact, before aseptic task/ clean task, after body fluid exposure risk, after patient contact, after contact with the patient's surroundings and ensuring staff are bare below the elbow. Where scores are below 80% staff are required to ensure action is taken within their areas to improve compliance prior to the next report. Figure 10 below details the findings from this audit during the year.

Figure 10- Hand Hygiene Audit Results

Area	April	May	June	July	August	September	October	November	December	January	February	March
Jubilee	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Henry Tudor	98%	98%	77%	98%	98%	98%		96%	59%	89%	100%	
Phoenix Unit	100%	91%	100%	100%	100%	95%	95%	100%	92%	100%	100%	100%
Woodlands Childrens Respite	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Ascot	100%	94%%	98%	100%	98%	100%	100%	92%	92%	100%	100%	100%
Windsor	80%	100%	100%	100%	100%	94%	96%	100%	93%	100%	100%	100%
Donnington	100%			100%	100%	100%	100%	100%	100%	100%	100%	100%
Highclere	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Oakwood	100%	100%	100%	100%	100%	100%	95%	96%	98%	85%	100%	98%
Campion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
ECT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Bluebell	100%	100%	100%	100%		93%	96%	97%	97%	81%	81%	85%
Daisy	100%	100%	100%		98%	100%		100%	100%	100%	100%	100%
Orchid	100%	100%		100%	100%	100%	100%	100%	100%	100%		
Rose	89%			97%	100%			69%	94%	81%	86%	91%
Rowan	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Sorrel	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Snowdrop	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	97%	98%
Place of safety	100%	100%	100%	100%	100%			100%	100%	100%	100%	100%

Source- Infection Prevention and Control Monthly Reports

Reducing Falls on Older People's Inpatient Wards

ⓘ The Trust considers prevention of falls a high priority. Although most people falling in hospital experience no or low physical harm, others suffer severe consequences, such as hip fracture, head injury or, on rarer occasions, a fall will be fatal. The personal consequences of a fall for the individual can be significant and even 'minor' falls can be very debilitating.

The total number of reportable inpatient falls for the community health and older adult inpatient wards in 2022/23 was 295. This is compared to 380 in 2021/22 and represents a 15% reduction in falls. This means that the breakthrough objective for this year has been achieved thanks to the commitment and ongoing work by teams.

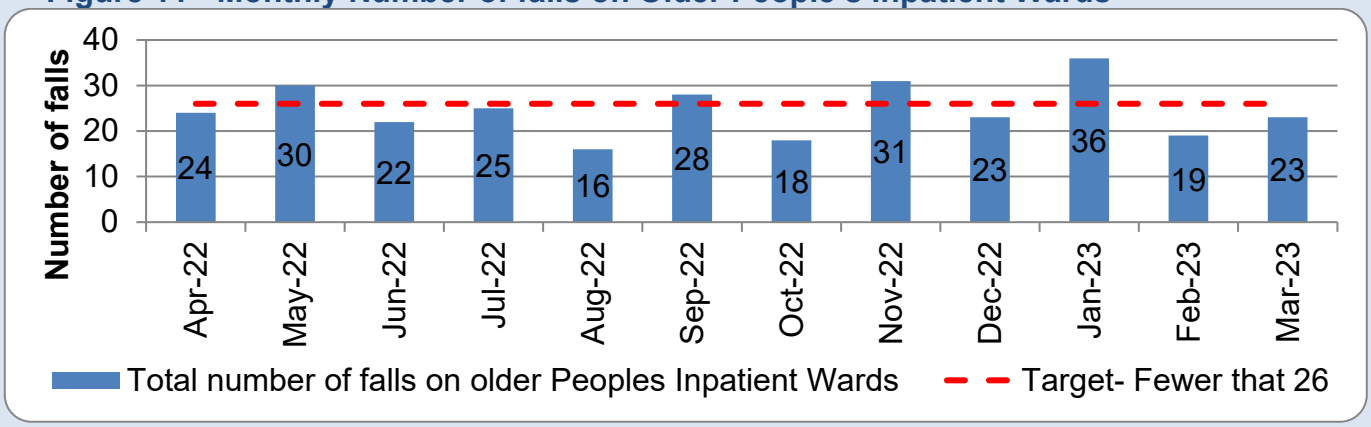
The monthly average number of falls was 25 and the median has reduced to 24 meaning both are below the overall trust target of 26. This will remain the target for 2023/24. We remain below the national benchmark rate of falls per 1000 bed days for community hospitals and injurious falls.

Given the reduction in the number of falls, the trust has agreed that this is no longer a breakthrough objective. However, the ward

teams will continue to use the established Quality Improvement methodology to continue with their continuous improvement approach to falls reduction, reviewing root causes and implementing countermeasures accordingly. The number of falls will also continue to be monitored monthly, with work continuing to be supported by the Trust's strategic Falls Group and the QI team. This will help ensure best practice is shared and that recommendations from the national audit of inpatient falls are implemented. This will be further supported by our membership of the national and local falls reduction networks.

A new falls technology has been installed on all the community health wards, with positive feedback from staff using it. A trial is planned on older adult mental health wards in April 23.

Figure 11- Monthly Number of falls on Older People's Inpatient Wards



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

Preventing Pressure Ulcers

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

We have set two targets in 2022/23:

1. To have no more than 19 grade 2 pressure ulcers due to a lapse in care by trust staff.
2. To have no more than 18 grade 3 or 4, unstageable or deep tissue injury pressure ulcers due to a lapse in care by trust staff.

We ensure that all clinical staff have had relevant training in pressure ulcer prevention and management. All developed pressure ulcers of category 3 and 4 that are potentially due to a lapse in care are discussed at a learning event following a desktop review. This is to see whether there is anything that could have been done differently to help prevent the skin damage, or to identify where improvements can be made. All category 2 pressure damage are reviewed by the handler and finalised by the patient safety team. Thematic reviews are held on a quarterly basis to enable learning opportunities.

Figures 12 and 13 below show that targets are being met.

Figure 12- Developed Category 2 Pressure Ulcers due to a Lapse in Care by trust staff.

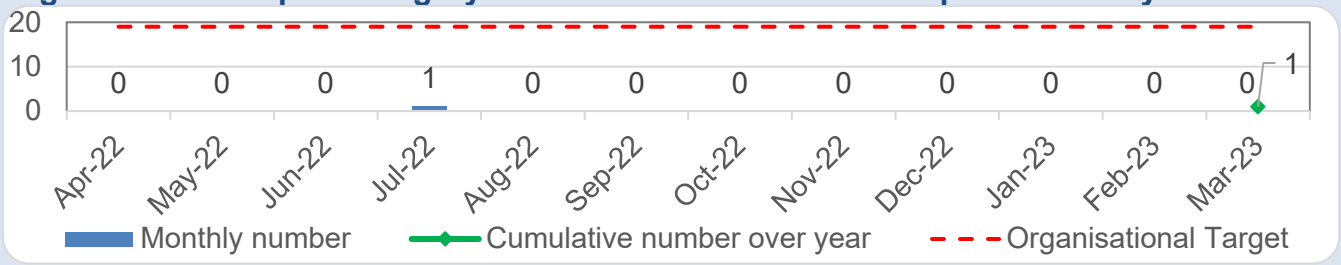
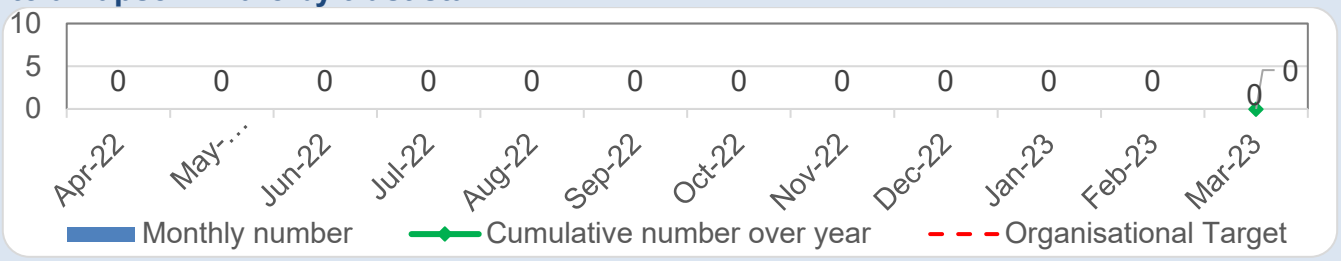


Figure 13- Developed Category 3, 4 unstageable or deep tissue injury Pressure Ulcers due to a Lapse in Care by trust staff.



Source: Trust Quarterly Pressure Ulcer Reports

Reducing Self-Harm Incidents on Trust Mental Health Inpatient Wards

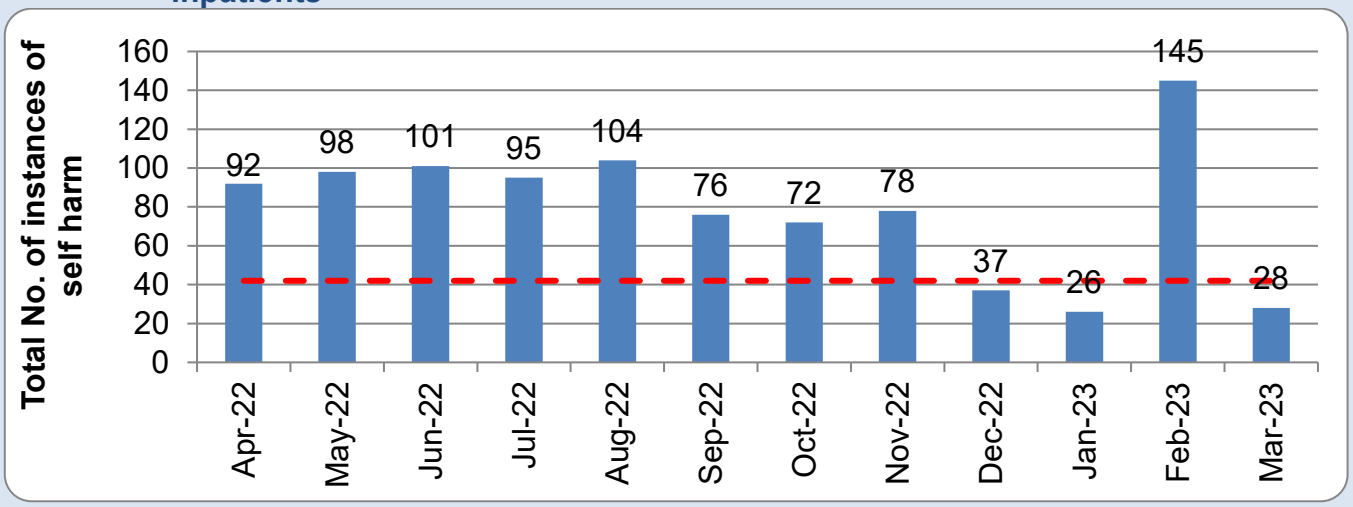
ⓘ Self-harm is when an individual intentionally injures themselves as a way of dealing with or expressing overwhelming emotional distress. It is sometimes carried out when individuals feel they have no other option.

Figure 14 below shows monthly performance during 2022/23 and shows that the target of having no more than 42 was met in 3 of the 12 months in 2022/23.

It is recognised that looking at the numbers of self-harm alone is not a helpful measure as many of our patients use self-harm as a way of coping with difficult feelings and to keep themselves safe. It is also well recognised that the more restrictive we are in stopping self-harm, the higher the level of harm can become as more extreme methods are used when usual means are not available.

Two of the adult mental health wards that are showing as highest contributors to these areas have decided that, given the complexity of reducing self-harm, focusing on the use of restraint may be more beneficial whilst still impacting on the incidents of self-harm. Both wards have now made reducing the use of restraint or increasing the use of de-escalation their driver and have countermeasures to encourage the more robust use of de-escalation before resorting to the use of physical restraint. We continue to see some encouraging data in the reduction in the use of restraint and self-harm, particularly on one ward where the quality improvement work is more established. There was a spike in self-harm in February 2023 due to 2 patients on one ward who were encouraging each other in their efforts to self-harm, causing a large data point rather than a trend in the data. This has been managed and March 2023 shows the number has reduced again. We will continue to review this progress and are working with the other ward that has restraint/self-harm as a driver metric to continue to implement their countermeasures.

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



Source- Trust Tableau Dashboard

Suicide Prevention

ⓘ The trust is focusing 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 suicide prevention strategy group monitors the progress of actions set out in our Suicide Prevention Plan. This plan, together with the plan-on-a page has been updated to reflect progress made in key areas. The suicide rate currently remains static over the longer term, although we are expecting to see a slight increase in this rate when new data has been confirmed. We have convened groups to work on areas that have been identified for improvement. Work that is being undertaken in this area is detailed below.

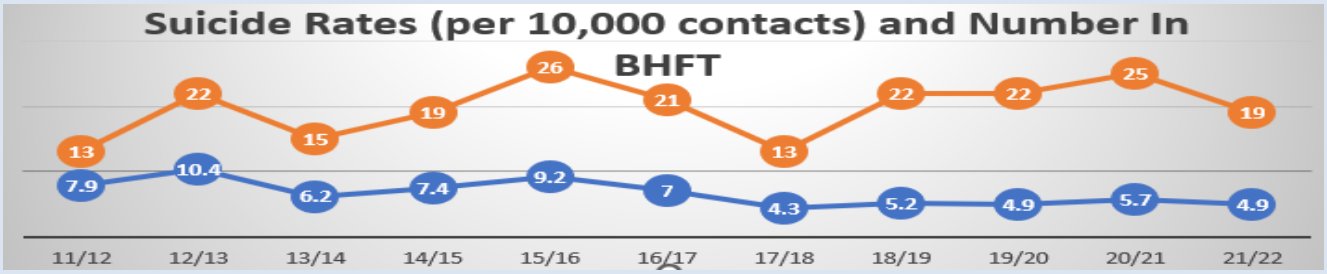
Focus on Deaths in Windsor and Maidenhead. A deep-dive review is underway with public health in response to local surveillance highlighting an increase in 2022/23.

Learning From Suicide Deaths

The following actions have been taken in response to suicide deaths:

- Update and accreditation of training (1 day and 3 day).
- A review of the Community Mental Health Team (CMHT) model continues as part of the wider transformation programme (One Team).
- Guidance for staff and patients on the alternative framework to Care Programme Approach (CPA) is part of the One Team programme.
- System wide review of the Berkshire Suicide Prevention Strategy.
- A Berkshire wide suicide audit is underway.
- Suicide surveillance has highlighted that the increase in female deaths has subsided, scrutiny continues.
- New guidance for psychosocial assessment following self-harm shared and being implemented (NICE guidance)
- Involvement in National work focusing on Risk assessment .

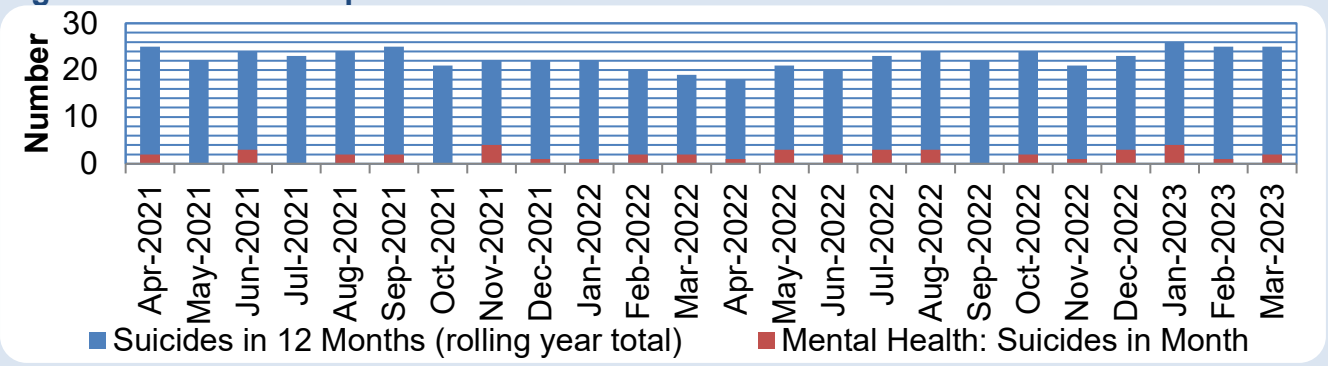
Figure 15- Number of suicides and rate per 10,000 people under Berkshire Healthcare Trust Mental Healthcare



Key: Blue- Rate per 10,000 contacts Orange- Number of suicides

The rate per 10,000 contacts for 2022/23 will be available in November 2023.

Figure 16- Suicides of patients under Berkshire Healthcare Trust mental healthcare



Source- Trust Tableau Dashboard. This includes suicide deaths of those patients open to Berkshire Healthcare secondary Mental Health services, and those discharged from these services in the last year. These are also investigated as serious incidents.

Recognising and responding promptly to physical health deterioration on in-patient wards

ⓘ Wards are required to recognise and respond promptly to physical health deterioration by following the National Early Warning Score (NEWS) Trust policy. All inpatient deaths, and deaths within seven days of transfer from our wards to an acute hospital are reviewed in line with the Trust Learning from Deaths policy.

Figure 17 below shows the number of unexpected inpatient deaths and deaths within 7 days of transfer from one of our inpatient wards to an acute hospital. The figure shows that there were no lapses in care confirmed during 2022/23.

Figure 17- Unexpected inpatient deaths and deaths within 7 days of transfer to an acute hospital 2022-23

Quarter	Q1	Q2	Q3	Q4	Annual Total
Total unexpected inpatient deaths and deaths within 7 days of transfer to an acute hospital reported during quarter	7	7	7	12	33
Total lapses in care agreed (will relate to deaths in previous quarters)	0	0	0	0	0

Source- Trust Learning from Deaths Reports

Improving the physical health of people with severe mental illness (SMI)

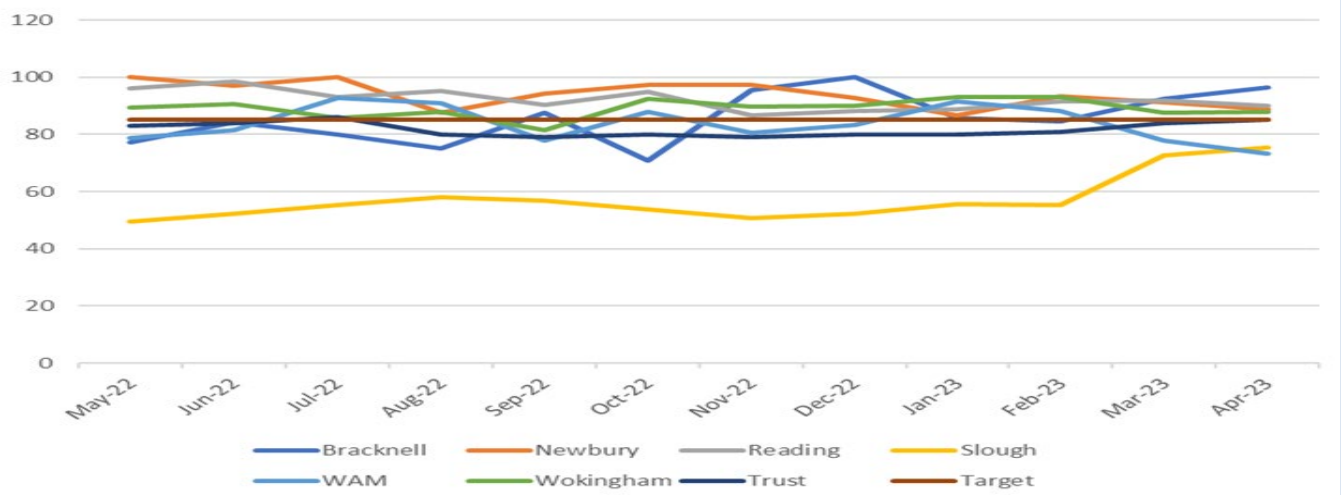
ⓘ National statistics show that people with serious mental illness (SMI) are at a greater risk of poor physical health and have a higher premature mortality than the general population, often dying 20 years sooner from conditions like cardiovascular disease or cancers.

We aim to ensure that physical health checks are completed for all new patients with severe mental illness to help bring their life expectancy in-line with the general population.

On 1st April 2023 we achieved the trust goal of 85% of patients with Severe Mental Illness (SMI) that are referred to our Community Mental Health Teams (CMHTs) having all seven parameters of the annual physical health check completed within a year of referral to CMHT.

A significant improvement has been seen in Slough locality, where the percentage of patients having a health check as per the criteria stated increased from 55% in February 2023 to 75% in April. This is due to improvements in engagement with the team and increased resource (filled a vacant physical health post) allowing implementation of countermeasures to raise compliance. However, there is still some local variation ranging from 73% to 96% cross the county and work continues to achieve our 85% goal in all six areas of Berkshire.

Figure 18- Percentage of patients with Severe Mental Illness (SMI) that are referred to CMHT and have had all parameters of the annual physical health check completed within a year of referral to CMHT.



Strengthening our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents.

Strengthening our Safety Culture.

The safety culture steering group continues to oversee developments to further enhance the Trust safety culture. This has included actions to improve hearing the voice of our staff and patients and ensuring that concerns are acted upon alongside fostering compassionate leadership at every level. Actions have included a review of all HR policies and procedures to ensure that they all align with

just culture principles, training and development opportunities for staff to support a kind and compassionate workforce, new approaches to learning from incidents, Making Families Count Training on how to work with bereaved families and support for staff post-incident.

Never Events

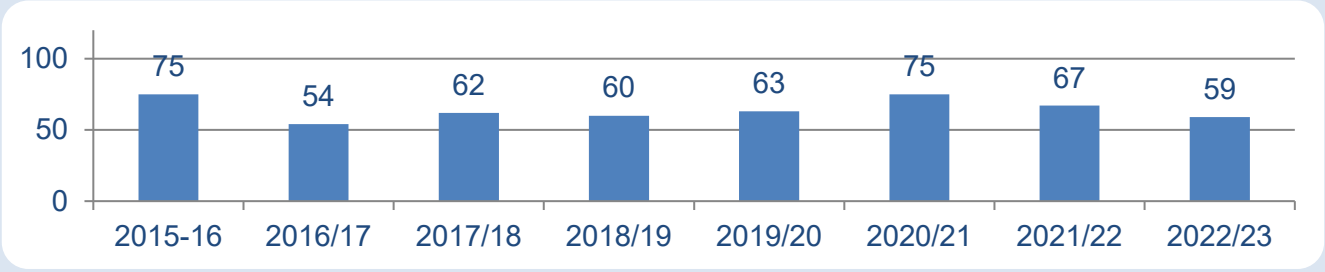
ⓘ Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

The Trust reported one never event in 2022/23. This event occurred at Prospect Park Hospital and involved a patient tying a ligature to a shower curtain rail hook(s). This is under investigation and learning will be shared in future reports.

Serious Incidents (SIs)

Figure 19 below shows the annual number of serious incidents reported by the Trust in comparison with the previous financial years.

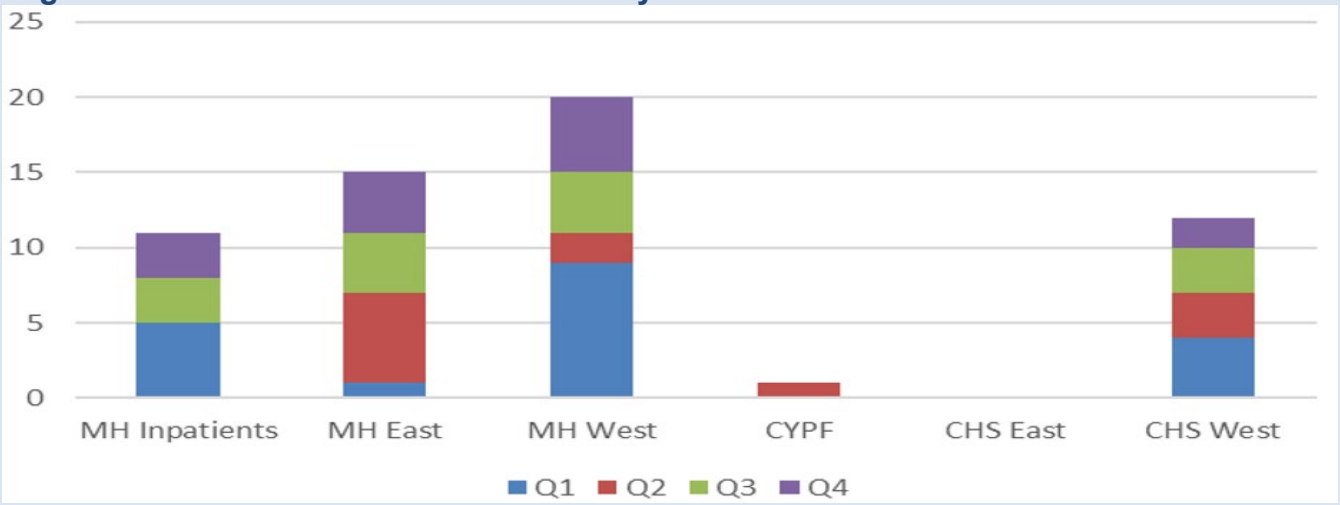
Figure 19- Number of Serious Incidents reported by the Trust- Year on Year Comparison



Source: Trust Serious Incident Quarterly Reports

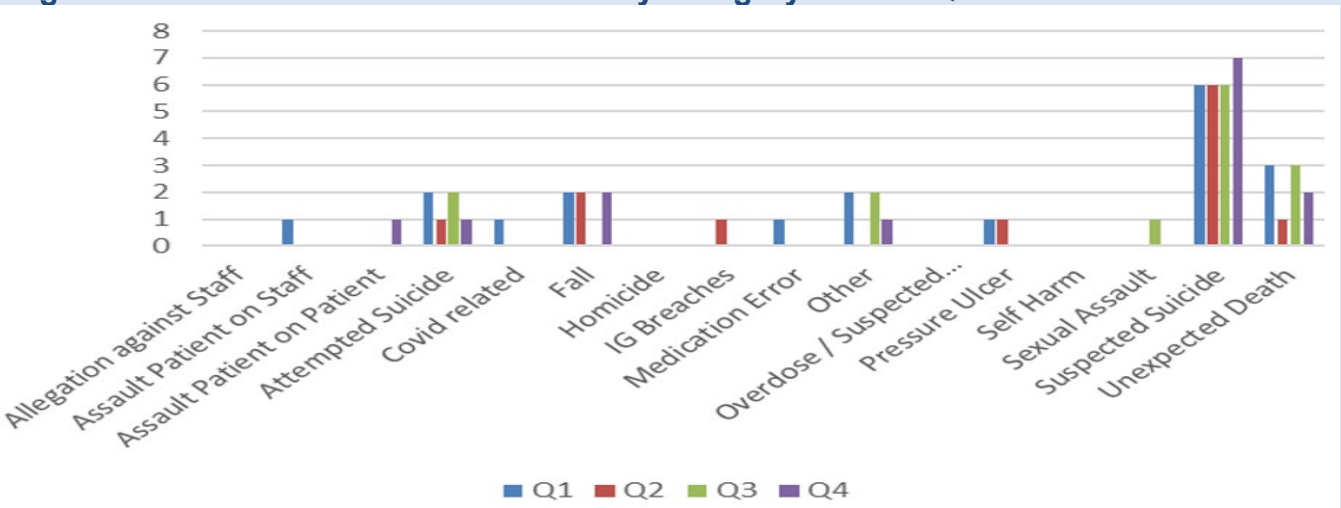
A total of 59 serious incidents were reported in 2022/23. This is 8 fewer than in 2021/22. Figure 20 below details the number of serious incidents reported quarterly by each Division, with Figure 21 detailing these serious incidents by category.

Figure 20- Number of Serious Incidents by Division in 2022-23



Source: Trust Serious Incident Quarterly Reports

Figure 21- Number of Serious Incidents by Category in each Quarter of 2022-23



Source- Trust Serious Incident Quarterly Reports

65 inquests took place in 2022/23. 33 of these inquests had been declared by the Trust as serious incidents. No Preventing Future Deaths (PFD) reports have been issued but the coroner did reserve the ability to issue a PFD report following an inquest in September 2022.

According to the ethnicity recorded on RiO for serious incidents reported during 2022/23:
17 patients were White British
25 patients were White-English/ Welsh/ Scottish/ Northern Irish/ British,
2 patients were white- any other background.
1 patient was Black or Black British
1 patient was Black or Black British- African
1 patient was Asian or Asian British
2 patients were Asian or Asian British- Pakistani,
2 patients were Asian or Asian British- Indian
1 patient was Asian or Asian British- Chinese
1 patient was Mixed White & Black Caribbean
6 patients were not stated.

In response to thematic analysis, learning and requirements for improvement that have been identified from serious incident investigations, there continues to be significant patient safety activity across the Trust during the year.

For our mental health services, the following actions have been taken:

- A focus on responsibilities and accountability within Multidisciplinary Teams (MDTs) at Prospect Park Hospital.
- Training tools to improve understanding about the relationship between capacity and positive risk for patients presenting with suicidal ideation.
- Improved safety planning process
- Progress has been made with the Co-Occurring Mental Health, Alcohol and Drug Disorders (COMHAD) Improvement Project.
- Training offers across mental health services continue to be developed and delivered. Across mental health services, training is based on specific themes including high suicide risk and withheld intent, domestic abuse, and family involvement in safety planning.
- Trust-wide roll-out of training on neurodiversity focusing on autism and safety planning.

For our physical health services, the following actions have been taken:

- Learning has been identified in relation to management of patients with dysphagia and the risk of aspiration pneumonia. This is being addressed across the community health wards.

- The supportive observation guidelines for the reduction of physical harm (falls) have been agreed.
- Learning and actions in relation to ensuring our patients have observations when they are admitted to our community wards so that if they deteriorate, staff have a baseline for comparison.
- Embedded learning regarding pressure management for some of the wards
- New falls technology is being rolled out to all physical health wards. So far, the teams have reported that it is much more user friendly, and compliance has therefore increased. We are now also trialing the technology on the mental health older adult wards.
- Work has begun to develop a new documentation process for falls risk assessments. Discussions have also been had to include an alert for weekly review of the falls risk assessments.

Quality Concerns

ⓘ The Trust Quality and Performance and Executive Group review and identify the top-quality concerns at each meeting and these are also reviewed at the Trust Quality Assurance Committee (QAC) to ensure that appropriate actions are in place to mitigate them. Quality concerns are identified through some of the information sources provided in this account, together with intelligence received from performance reports, our staff, and stakeholders.

Acute adult mental health inpatient bed occupancy continues to be consistently above 90% at Prospect Park Hospital. This means that patients might not receive a good experience all the time. Delayed discharges have increased over the last year. There are programmes of work in place to support reduction in occupancy and out-of-area placements. Out of areas placements have remained high and the pressure remains on local beds.

Shortage of permanent nursing and therapy staff. Mental and physical health inpatient services as well as several of our community-based adult and young people's services for mental and physical health are now affected by shortages of permanent nursing and therapy staff and increased demand. This has a potential impact on the quality of patient care and experience and increases our costs. A programme of work has been commenced to revise pathways and models of care across our community Mental Health services. Our new workforce strategy will focus on how to retain and grow staff to meet our demand. A new workforce forecasting model has been developed to support understanding of gaps so that appropriate, cost-effective interventions can be agreed.

Wait times. Wait lists in some services are rising due to a combination of service capacity and increased demand. This increases risk to patients and means that we are not meeting national or local targets in all services. A long wait for an outpatient appointment does not provide a good experience for patients, families, and carers. Some services have had long waits for several years, and these are due to several reasons, including limited funding from commissioners and staff vacancies. Wait lists are monitored monthly at the Quality Performance and Experience meeting. Action plans and programmes of work are being taken forward with system partners to reduce some of these wait times.

Duty of Candour (DOC)

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

The Trust has an 'Open Communication (Being Open) a Duty to be Candid' policy that supports our culture of openness when things go wrong. Face to face training has been provided alongside a trust intranet page where staff can access information and advice. The Patient Safety Team monitors incidents to ensure that formal Duty of Candour is undertaken.

The Trust process for formal Duty of Candour includes 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 later in this report.

Figure 22 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 22- Number of Incidents requiring formal Duty of Candour (DOC)

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
(22/23)	29	29	49	50	32	26	31	43	47	46	45	40

Source- Trust Serious Incident Monthly Reports

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 2022/23 Clinical Effectiveness Priorities are as follows:

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

This section also includes a statement on rota gaps for NHS Doctors in Training, and the plan for improvement to reduce such gaps. Trust performance against the Learning Disability Improvement Standards is also included in this section.

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

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

We have produced a policy that describes how we identify, assess, implement and monitor implementation of NICE Guidance. The paragraphs below detail some of guidance that we have progressed during this financial year.

Supporting Adult Carers- NICE Guideline-NG150. A reassessment of compliance with this guideline showed that 88/91 (97%) of recommendations were now being met. This is on the basis that information and guidance is in place for services and carers to use. A self-assessment review will be undertaken with services during the next financial year to ascertain the level of uptake of this guideline in practice.

Mental Wellbeing at Work- NG212. An initial baseline assessment of the Guideline showed that we were meeting almost all recommendations due to our focus on improving the wellbeing of our staff. More information on actions being taken to improve staff wellbeing can be seen in the 'Supporting our People' section of this report.

Medicines Optimisation- NG5. A re-assessment of compliance with this guideline was undertaken which showed that 44/48 (92%) of recommendations are being met. Unmet recommendations were addressed by t outlining best practice for staff and signposting to useful resources.

Controlled Drugs: Safe Use and Management- NG46. Our Pharmacy Team have updated our Standard Operating Procedures on Controlled Drugs to bring them in line with the recommendations in this Guideline.

Venous thromboembolic diseases: diagnosis, management and thrombophilia testing- NG158. A baseline assessment showed that our wards, Westcall GP Out of Hours Service and Pharmacy team have the relevant procedures in place to follow this guideline**.**

Vaccine Uptake in the General Population-NG218 A baseline assessment with our showed that our immunisation team the team are meeting 67/68 (98%) recommendations in the guideline.

Mental Health of Adults in Contact With the Criminal Justice System- NG66. Our mental health services, and in particular our Liaison and Diversion Service were assessed to be compliant with 41/43 (95%) of recommendations in this Guideline. Unmet recommendations are being addressed.

Social, Emotional and Mental Wellbeing in primary and secondary education- NG223. Although primarily relevant to the education sector, some of the recommendations in this guideline were relevant to our East Mental Health Support Team and West Primary Health Teams that work with schools. The recommendations are being met.

Reducing Sexually Transmitted Infections-NG221. This Guideline is relevant to our Sexual Health Service at the Garden Clinic in Slough, and most of the recommendations are being met. The team are progressing a was recommendation relating to sending reminders for second and third dose vaccinations.

Ongoing work. Several other guidelines are in the process of being assessed and implemented. These include guidelines relating to depression in adults, bipolar, self-harm, epilepsy and disabled children and young people with complex needs. Work is ongoing in these areas and is reported to the Trust Clinical Governance Group.

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.

We now have a new 'Guardian of Safe Working' (GOSW) in place who is a consultant psychiatrist. The GOSW continues their 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, they report quarterly to the Board on activity relating to Junior Doctor working hours and rota gaps.

Figure 23 below details the Psychiatry rota gaps for NHS Doctors in training during the year. Our system of cover continues to work as normal, and gaps are generally covered quickly. We have had six unfilled gaps during the year, however patient safety was not an issue and we always had one junior doctor on duty out of hours.

Figure 23- Rota Gaps for NHS Doctors in Training – Psychiatry – 1st Apr 22- 31st March 23

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
	365	359	102	257	0	3646.5	3593.5	1038	2555.5	0

Source- Trust Medical Staffing Team

The Learning Disability Improvement Standard

ⓘ The Learning Disability Improvement Standards have been developed to help NHS trusts measure the quality of care they provide to people with learning disabilities, autism, or both. They contain several measurable outcomes which clearly state what is expected from the NHS in this area.

Increasing awareness of health inequalities experienced by people with learning disabilities and autistic people across the Trust; and improving our ability to segment outcome data and patient experience feedback to help target future areas for prioritisation and actions (respecting and protecting rights). Work remains ongoing, overseen by the Connected Care supplier, to develop a tool to help flag important information for other NHS and social care providers. Once this is operational it will give us another way to explore how we segment our outcome data and patient feedback.

Increasing awareness and use of reasonable adjustments (inclusion and engagement). The roll out of the Oliver McGowan Mandatory Training in Learning Disability and Autism is being undertaken by the Integrated Care Boards. The e-learning for all Berkshire Healthcare staff has recently been introduced as part of the mandatory training within the Trust. This first tier of the training will provide all staff with a baseline knowledge and increased awareness of the needs and adjustments for people with a learning disability and autistic people.

Supporting a cohort of staff to undertake the Advanced Practice Credential in Learning Disability and Autism (ACP LD/A) with support from Health Education England to further develop specialist skills (workforce). Two team members have successfully completed the ACP LD/A. They are continuing to be supported to complete the MSc in Advanced Clinical Practice and this continues over the next 12 months.

Work with Commissioners to support the development of local Dynamic Support Registers (DSR) which seek to identify those people at risk of admission to inpatient services and provide intervention in the community to avoid all but essential admission (learning disability services standard). We continue to work with Commissioners in East Berkshire with the Dynamic Support Register implemented by the Integrated Care Board (ICB). In Berkshire West, following the introduction of a pilot of a basic internal Dynamic Support Register supported by the Intensive Support Team, we have now been asked to implement this more widely with partners locally. Work is underway for implementation across Berkshire West in May 2023.

2.1.4. Supporting our People

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

Our 2022/23 Supporting our People Priorities are as follows:

1. We will develop our four pillars of workforce growth to attract new and existing talent to reduce workforce gaps and deliver our service, providing the best possible patient care.
2. We will ensure our teams have access to effective health and wellbeing support.
3. We will promote a culture of respect, compassion and kindness.
4. We will not tolerate bullying, harassment or abuse of any kind.
5. We will support staff to work flexibly and connect with their teams.
6. We will act on feedback from staff to further improve satisfaction and address any identified inequalities.
7. We will support staff to achieve their career aspirations.
8. We will provide opportunities for our people to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas.

Details on Freedom to Speak Up are also included in this section.

The priorities detailed above have been translated into our People Strategy 2021-24. This strategy has the aim of making the Trust Outstanding for Everyone. The key priorities of this strategy are detailed in the graphic below.

People Strategy Key Priorities

Developing four pillars of workforce growth to attract new and existing talent to reduce workforce gaps and deliver our services.

ⓘ Our people are our greatest asset and are key to consistently delivering high quality care to our patients. It is therefore important that we keep our existing talent and attract new people to help deliver our services.

While we make strides forward with our continued improvement and expansion plans, the current state of readily available clinical workforce for both substantive and affordable temporary staff does not match all our ambitions and has sharpened our focus to create a future proofed workforce.

We introduced integrated operational planning, alongside colleagues from finance, Human Resources and operations. This allowed us to meet the challenge of delivering safe, high-quality care within the boundaries of contractual obligations and the constraints of available resource (both workforce and financial). We have also invested in a series of workforce deep-dives in key areas to better articulate risks, identify mitigations and look at service and workforce changes which expanded in scope where needed to include demand and capacity activity to support current implementation plans and inform priorities.

Whilst we continue to have significant workforce vacancies, we have invested in candidate attraction strategies which are starting to pay dividends. This has resulted in a higher proportion of clinical starters than we have seen in the recent past, including in some of our hard-to-fill vacancies. Historically, we have been reliant on ad-hoc and student recruitment to fill our vacancies, but clinical recruitment has become increasingly challenging with fewer students in training and more staff retiring/leaving. To help address this, we have now invested £1.5million in a clear, well-supported apprenticeship strategy to grow and develop our own clinical workforce pipeline. This is linked to our needs, targeting existing and emerging gaps in roles and skills. This targeted approach allows us to invest in diverse local talent from the populations we serve and is a key component of our plans.

We continue to focus our apprenticeship programme on our hard to fill roles, targeting groups that traditionally would have been excluded from such training due to the costs of university education or those under-represented in certain professions.

Given the time required to train new clinicians, we have invested in an international recruitment campaign. We ensure their safe arrival, induction and embedding into our workforce to promote the NHS and to benefit from their significant expertise. Our next step is to implement an international Allied Healthcare Professional (AHP) recruitment campaign.

To support the pipeline coming into these opportunities, we have introduced a development programme with our bank provider, NHS Professionals, for those wishing to embark on a career in healthcare. This provides them with all the training, support and supervision needed to become a Healthcare Assistant before progressing to substantive employment or joining us on one of our career pathways. Twenty health care assistants have joined us on this journey with almost all now having received their care certificate on successful completion and having been offered a substantive post where they wish to remain in the Trust.

Looking After our People

Ensuring our teams have effective health and wellbeing support

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

Improving the mental and physical health and wellbeing of our people

Throughout 2022/23, we have continued to prioritise supporting the mental and physical health and wellbeing of our people. We can see the impact that this is having through the numbers of staff who report that the organisation takes positive action on health and wellbeing. In 2022, we achieved the top scoring trust in our comparator group.

We launched our new Employee Assistance Programme (EAP) from Health Assured in August 2022. Staff can use this programme to access more counselling sessions (up to 6 sessions per issue per year) as well as an impressive app which includes live chat, breathing exercises, steps leader boards and 4-week programmes in a variety of topics. Usage remains good with over 230 calls in the first 6 months.

Our staff and teams continued to receive support from Wellbeing Matters; a mental health and wellbeing hub for all health and social care stuff across the Berkshire region which is hosted by Berkshire Healthcare. As well as providing individual support, team wellbeing hubs and manager consultations, Wellbeing Matters have also run Mental Health First Aider training and Mental Health conversation training for managers of our staff. They have supported over 200 trust staff, 85 teams and trained 176 staff.

We gave access to menopause support through the Peppy Health app to all our staff in October 2022. Peppy provides instant messaging support from expert practitioners, one-to-one video appointments and access to vetted resources and events. The feedback has been overwhelmingly positive, and we now have 280 users. A trial of other support services available through Peppy (Fertility, Pregnancy & Baby and Men's Health) led to the submission of a business case for ongoing funding, and we will be launching Men's Health access for all staff by May 23.

With sustained increases in the cost of living, we have consolidated and enhanced the financial support available for staff through 22/23. Fuel reimbursement rates have been temporarily increased alongside a one-off back payment. A nexus intranet page has also been improved to detail all the existing support offers available and to signpost to external support. We are also a referring organisation for local foodbanks to support those staff who may find themselves at a crisis point and need more immediate support.

We have created a more comprehensive benefits package for our staff over the last year. This now includes the ability to buy/sell annual leave and a new long-service and recognition scheme, expanding the current NHS only scheme to include Berkshire Healthcare service, new joiners and retirees.

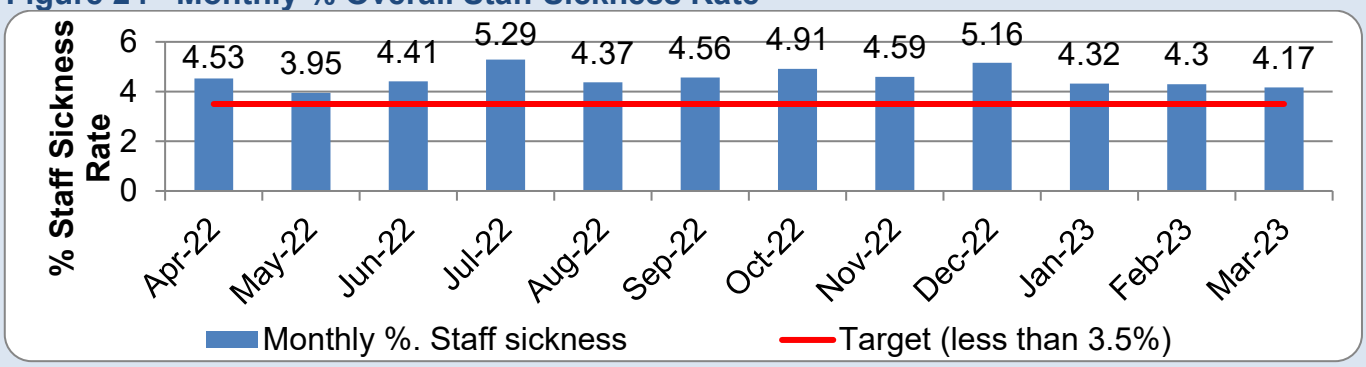
A big focus in 22/23 was how to improve our communication with frontline staff who rarely access emails/intranet. We have introduced a Wellbeing at Work physical newsletter which is distributed three times a year by members of the Wellbeing team, who also visit sites with the newsletters and some goodies.

We received funding from NHS Charities Together over the last year for two projects. The first was to update some of the rest rooms across the trust and these will be completed soon. The second was to recruit a Wellbeing Facilitator to run wellbeing and exercise classes for staff. The classes are going well with over 150 staff having accessed the sessions to date.

Reducing staff sickness

Figure 24 below details the monthly percentage of staff sickness absence and shows that the target rate was not achieved in 2022/23 .

Figure 24- Monthly % Overall Staff Sickness Rate



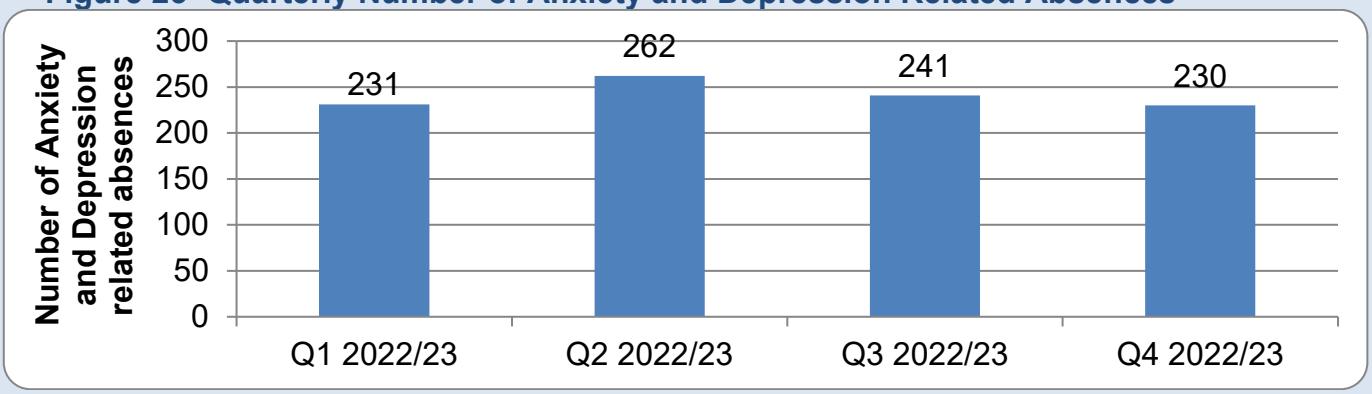
Source- Trust Tableau Dashboard

Reducing stress, anxiety and depression.

The Health and Safety Executive (HSE) define work-related stress as "The adverse reaction people have to excessive pressures or other types of demand placed on them at work". Stress itself is not an illness, but if it becomes excessive and prolonged then mental or physical illness may develop. We have initiated a project to look at the causes of excess work pressures on our staff.

Figure 25 below details the quarterly number of anxiety and depression related absences. Rates remain high although are slowly trending down from the high experienced immediately after Covid in August 2020. Alongside the work detailed above, we are increasing the focus on wellbeing conversations through the risk assessment and appraisal processes as well as re-establishing Mental Health First Aider training.

Figure 25- Quarterly Number of Anxiety and Depression Related Absences



Source- Trust HR Department

Reducing musculoskeletal (MSK) disorders

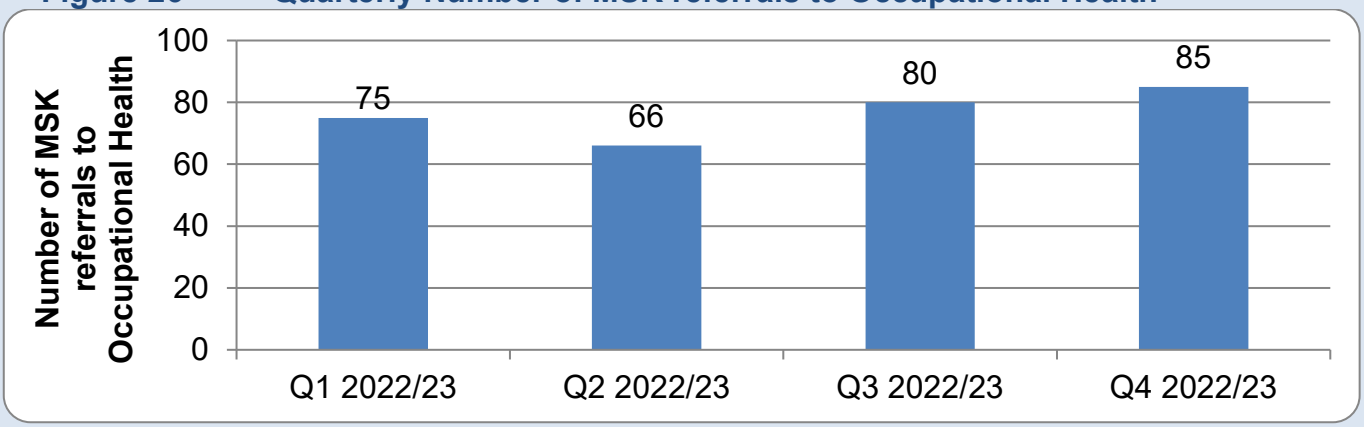
Musculoskeletal disorders can affect muscles, joints, and tendons. It is important that our staff do not sustain work-related musculoskeletal disorders, and we aim to reduce the occurrence of these injuries during the year. We have put in place actions to try and prevent these injuries from occurring.

As well as the well-established fast- track referrals to physiotherapy, we also have an in-house ergonomics team who work with individuals and teams to risk assess their working areas and provide advice and guidance as well as deliver manual handling training for the trust.

Figure 26 below details the monthly number of musculoskeletal referrals made to occupational health for our Trust staff. MSK referrals have been more prominent from ward

areas, rather than from those working from home, as staff are managing patients with greater physical health needs and are required to do more lifting.

Figure 26- Quarterly Number of MSK referrals to Occupational Health



Source- Trust HR Department

Acting on feedback from the staff to further improve satisfaction and address any identified inequalities

ⓘ 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.

A monthly all-staff briefing gives our staff an opportunity to feedback suggestions and comments about current ways of working. We address these and are now including monthly "you said, we did" updates. As a result, we have changed the pay date and have allowed people to buy and sell annual leave.

A quarterly Pulse survey has been launched which allows us to track progress throughout the year. Response rates are often lower and so comparison with the staff survey is difficult.

Both the Trust People Strategy and Equality Diversity and Inclusion Strategy have been informed and designed based on learning from; the staff survey; data from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES); and engagement workshops with staff and staff networks.

We are also launching and anti-racism strategy as part of our commitment to address the inequalities that our workforce and patients face.

National Staff Survey Trust Results.
The Trust participated in the 2022 NHS National Staff Survey between October and November 2022. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise. This sets out, in the words of NHS staff, the things that would most improve their working experience.

The Survey Sample.
The survey was conducted online, resulting in it being open to over 4000 of the Trust's employees. 3046 staff responded to the 2022 survey and our response rate was 65%. This is 5 percentage points higher than in 2021 (60%), and 15 percentage points higher than the median response rate for similar Trusts to ours (50%)

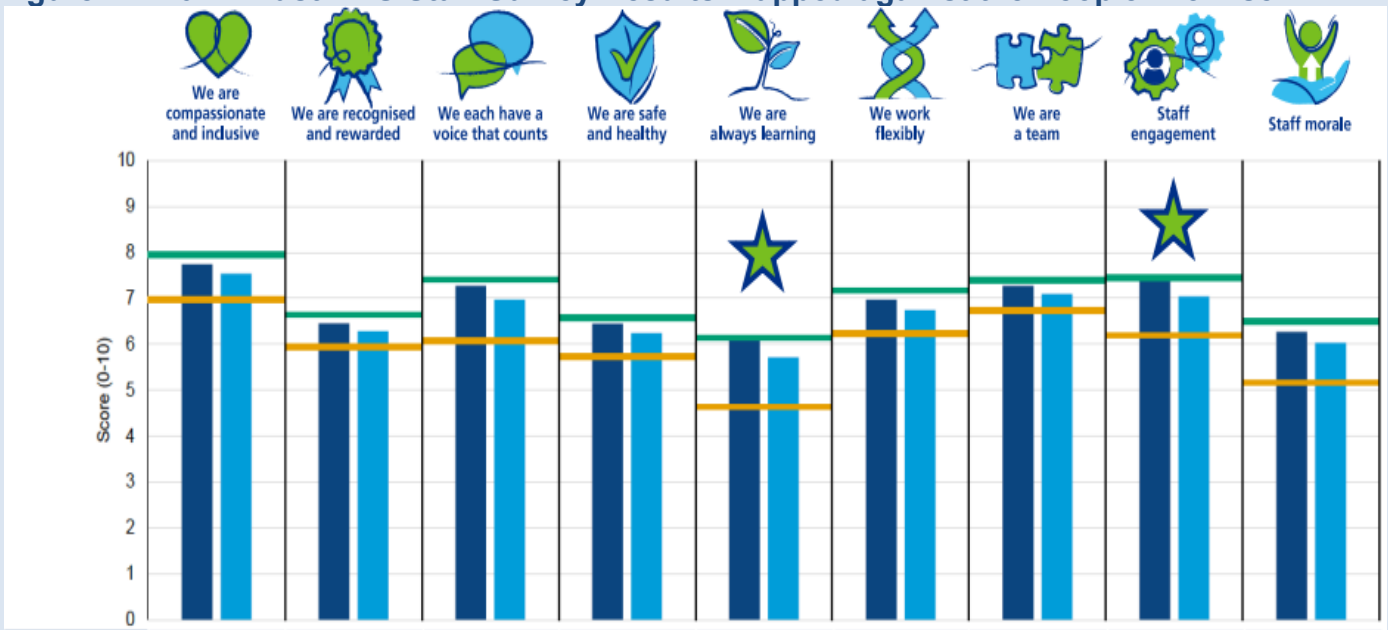
Summary of Trust Results.
When we look at the results, there's plenty to feel proud about. As the figure below shows, our scores are above average for similar Trusts in all ten themes and the best for two themes out of the ten. Our engagement score remains the top score for trusts in our group-

something we have achieved for the past three years.

Our results are broadly showing positive trends over the past five years. We continue to receive top marks for 'I would recommend my organisation as a place to work' and, 'the team I work in has a set of shared objectives' as well as top scores in the sub-sections on compassionate culture, appraisals and motivation. There are also significant increases in other areas since 2021, including, 'I feel a strong personal attachment to my team' and, 'I have frequent opportunities to show initiative in my role'.

However, there's more to do. The main areas where we can do better reflect our organisational focus and ongoing work, particularly diversity, inclusion, negative experiences such as bullying and harassment, as well as workplace pressures and stressors, all of which impact on our retention. We will continue to work on these areas and the survey results will help us to reflect on progress and consider next steps.

Figure 27- 2022 Trust NHS Staff Survey Results mapped against the People Promise



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Staff morale
Your org	7.7	6.5	7.3	6.4	6.1	7.0	7.3	7.4	6.3
Best	7.9	6.6	7.4	6.6	6.1	7.2	7.4	7.4	6.5
Average	7.5	6.3	7.0	6.2	5.7	6.7	7.1	7.0	6.0
Worst	7.0	5.9	6.1	5.7	4.6	6.2	6.7	6.2	5.2
Responses	3039	3042	3022	3027	2947	3036	3038	3043	3045

Source- 2022 NHS Staff Survey- Trust Benchmark Report

The Workforce Race Equality Standard (WRES) and the Workforce Disability Equality Standard (WDES)

The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations, mandated by the NHS Standard Contract in 2015. It is a mirror that allows NHS Trusts to visualise workplace inequalities through 9 measures (metrics) that compare the working and career experiences of Black, Asian, and Minority Ethnic (BAME) and White staff in the NHS.

We continue making incremental progress in unmasking and tackling workplace inequalities between BAME and White staff that are captured through nine WRES indicators. Four of these indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey questions, and one indicator focuses on BAME representation at Board level. The WRES is underpinned by a desire to equalise experience between staff who come from

BAME backgrounds and their White counterparts. It aims to facilitate an inclusive, supportive, and fair culture in organisations to ensure that every member of the NHS diverse workforce has a sense of belonging and a positive working experience.

The WRES enables organisations to compare their performance with others in their region and those providing similar services, with the aim of encouraging improvement by learning and sharing good practice.

During 2022/23 we also launched our anti-racism work to address longstanding inequalities highlighted within our staff survey

Overall we have seen positive trends across the WRES indicators over the past 5 years and improvements in our scores this last year, with one staying the same. We are now scoring better than average in all indicators. Despite this, the gap in experience remains and is not closing as much as it should, either locally or nationally.

Figure 28- Staff survey results relating to the Workforce Race Equality Standard (WRES)

WRES Indicator	Metric Descriptor		BAME 2022	White 2022
5. Staff Survey Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	29.4%	18.5%
		NHS Trusts	31.5%	25.4%
6. Staff Survey Q14b&c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Berkshire Healthcare	20.8%	15.4%
		NHS Trusts	22.8%	17.3%
7. Staff Survey Q15	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	Berkshire Healthcare	51.7%	68.1%
		NHS Trusts	49.6%	62.3%
8. Staff Survey Q16b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Berkshire Healthcare	13.2%	5.2%
		NHS Trusts	13.6%	5.7%

Source- 2022 National Staff Survey

The Workforce Disability Equality Standard (WDES) is a requirement for all NHS organisations and was mandated by the NHS Standard Contract in 2018. It comprises of 10 measures (metrics) that compare the working and career experiences of Disabled and Non-Disabled staff in the NHS. The 10 metrics cover the workforce profile, recruitment and capability processes, experiences of disabled staff, board make up, and the opportunity that disabled staff have to voice and air their concerns and to be heard.

It is underpinned by the Social Model of Disability which argues that people are disabled because of societal barriers, rather than long-term health conditions. With the Social Model of Disability in mind, the WDES seeks to help unmask barriers that have a negative impact on the experiences and career opportunities of Disabled staff in the NHS or disabled applicants seeking employment in the NHS, and thus facilitates transparency and inform year on year improvement.

Overall we have seen positive trends across the WDES indicators over the past 5 years and improvements in our scores over the last year with one staying the same. We are scoring better than average in most indicators. However, as with ethnicity, the gap in experience sadly remains.

Figure 29- Staff survey results relating to the Workforce Disability Equality Standard

WDES Indicator	Metric Descriptor		Disabled 2022	Non-Disabled 2022
4 Staff Survey Q14a-d	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying or abuse in the last 12 months from:	(a) Patients/Service users, their relatives or other members of the public	26.8%	19.7%
		(b) Managers	12.3%	5.4%
		(c) Other Colleagues	18.1%	11.5%
		(d) Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	59.8%	57.3%
5 Staff Survey Q15	Equal opportunities for career progression or promotion	Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	60.6%	64.5%
6 Staff Survey Q9e	Presenteeism	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	22.5%	16.0%
7 Staff Survey Q4b	Disabled staff's views / satisfaction with the extent to which their organisation values their work.	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	51.9%	61.4%
8 Staff Survey Q30b	Reasonable adjustments for disabled staff	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	80.9%	N/A
9. National Survey staff engagement score	NHS Staff Survey and the engagement of Disabled staff	(a) The staff engagement scores for Disabled and Non-Disabled staff	7.2	7.5
		(b) Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard?	Yes*	

Source- 2022 National Staff Survey * There is active engagement with our staff networks to ensure that we are listening to our staff. Our Equality Diversity and Inclusion teams meet monthly with the network chairs and these chairs also have regular access to the Director of People

Promoting a culture of respect, compassion and kindness

ⓘ The Trust is committed to strengthening our Safety Culture to empower staff and patients to raise safety concerns without fear and to facilitate learning from incidents.

We remain committed to embedding the principles of a Safety Culture, where everyone feels safe to raise concerns with a focus on learning from incidents. Our aim is to remove unwarranted disciplinary action for staff as we work towards our objective of making Berkshire Healthcare an 'outstanding place to work for everyone'.

There is encouraging evidence of the progress we are making in this respect. We have seen a 50% reduction in the number of formal disciplinary investigations when compared with the previous year. There was also a significant improvement in the number of disciplinary cases involving BAME staff being more representative of the BAME staff profile (28% of or workforce staff are BAME). This year, 33% of formal disciplinary investigations involved BAME staff, compared to 65% and 44% in the previous two years.

We have also continued embedding the role of the dedicated Investigating Officers (IOs). These IOs worked on a total of 39 closed cases in 2022/23- a combination of full investigations and fact-finds for both disciplinary and early resolution cases. This accounted for 48% of all the casework in the year, and they worked on 93% of the full disciplinary investigations, which are the more complex cases that would otherwise take up a significant amount of service managers' time. The dedicated IOs have spent a total of approximately 1600 hours working on cases in the last year, with an average of approximately 41 hours per case. We have recently increased our number of dedicated IOs with two new investigators ready to start working on cases and a further two joining in the coming months. This will take our pool of investigators to six and will mean that they can work on a higher percentage of our cases, without impacting on the resolution times.

Belonging to the Trust
Not Tolerating bullying, harassment or abuse of any kind

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

Assaults in the Trust, as well as nationally, continue to rise year on year, with the number of physical and non-physical assaults increasing. Thames Valley Police have provided a Community Support Officer into Prospect Park Hospital to support our staff.

Nationally, NHS England, NHS Improvement and the Social Partnerships Forum, have published a new national Violence Prevention and Reduction (VPR) standard, which complements existing Health and Safety Legislation. This delivers a risk-based framework that supports a safe and secure working environment for NHS staff, safeguarding them against abuse, aggression, and violence. The Deputy Director for Leadership, Inclusion & OD has oversight for the implementation of the VPR standard in Berkshire Healthcare, working collaboratively with other internal support services as well as our local Integrated Care Systems (ICS) and with Buckinghamshire, Oxfordshire and Berkshire West Safer Workplaces working group. We are also working with Frimley Health and Care ICB (one of 6 pilot ICB's

working with NHS England to implement the standards across the system). Current training provision is also being reviewed in line with research. Our Prevention and Management of Violence and Aggression policy has been reviewed and is due for publication.

Our Staff Experience, Support and Improvement offer is now led by Psychological Services who continue to contact staff who are identified on our Datix incident system as being assaulted at work. They offer practical support, escalate concerns, resolve issues and signpost to specialist support. They are also supporting various projects and workstreams relating to aggression.

The Personal Safety Team received their annual re-certification by BILD, ensuring their training is in line with the Restraint Reduction Network's Training standards. They continue to provide support for clinical teams regarding personal safety and aggression. Figure 30 below details incidents of violence against staff for the current and previous financial year.

Figure 30- Incidents of violence against staff 2021-22 and 2022-23

Incidents by Sub-Category	Q1	Q2	Q3	Q4	TOTAL 22-23	TOTAL 21-22
Alleged Sexual Assault	12	2	1	3	**18**	**23**
Attitude	8	13	12	25	**58**	**52**
Dirty Protest	0	0	1	0	**1**	**0**
Patient refusing treatment	1	0	0	1	**2**	**3**
Damaging Property/Criminal Damage	3	3	4	2	**12**	**4**
Physical Assault by Patient	249	198	200	168	**815**	**859**
Physical Assault by Staff	1	1	1	1	**4**	**5**
Abuse by Patient	313	212	184	152	**861**	**806**
Physical Assault by Other	4	2	3	0	**9**	**6**
Abuse by Staff	5	5	4	5	**19**	**30**
Abuse by Other	26	24	30	14	**94**	**79**
Total	**622**	**460**	**440**	**371**	**1893**	**1867**

New Ways of Working
Recruitment Business Process Improvement (BPI) Project

ⓘ The purpose of the HR Business Process Improvement project is to improve the experience of our candidates, reduce duplication and waste in our recruitment processes and look at ways to make it inclusive and accessible for all.

We are automating our recruitment processes using robotic technology. In 2022, we automated interview invitations, so that candidates have the flexibility to choose their own interview slots. More recently, instead of staff having to complete a manual process of moving candidate data following appointment, the robot now takes care of this behind the scenes. This has resulted in reducing the time this takes from approximately 20 minutes per candidate to around 4 minutes.

Reducing the 'time to hire' through our pre-employment checks is a key metric for us. We have introduced a monthly scorecard which allows us to understand the average time taken for each stage of the recruitment journey, which provides us with clear areas to focus on. We are making changes as a result and will continue to measure the outcomes.

We want to make sure our candidates have a great experience as they join our trust. We have launched an online portal 'Nexus for new starters' to provide candidates with information available on our intranet and the capability to start their statutory and mandatory training before they join us, should they wish to do so.

We have also launched a welcome email from the Director of People to all new joiners.

To showcase the opportunities that are available to our staff once they join us, we have introduced a 'jobs of the week' in our weekly digital bulletin 'Team Brief'. We are currently monitoring the interest and levels of applications coming in from this.

Our focus on candidate attraction continues to grow. We continue building relationships with local schools and universities, with opportunities for final year clinical students on over 80 job boards across the country and we have delivered over 50 events promoting apprenticeships, reservists, work experience, and volunteering opportunities. This is supported by over 20 school ambassadors who support school visits.

Our recruitment marketing audience is growing across our platforms - LinkedIn, Twitter, Facebook, Instagram and TikTok and we are now compiling a quarterly report to understand the campaigns that have yield the best results. We are also improving our external website so that our candidates better understand our recruitment processes.

As part of our new neurodiversity strategy, we continue to find a university partner to conduct a research project on fair and inclusive recruitment interview processes.

Supporting our staff to achieve their career aspirations

ⓘ It is important that all staff are supported to grow and develop in their roles with the Trust. This can be achieved by ensuring they have high quality appraisal, supervision, and training to help support patient and staff satisfaction, safety, and effectiveness.

We are piloting a refreshed leadership offer, reviewing all training and devising a portfolio of learning. This will include our commitment to compassionate leadership, anti-discrimination and violence reduction.

We have worked with Berkshire Oxfordshire and Buckinghamshire Integrated Care System to launch a culture transformation programme called 'A Kind Life' which aims to build kinder, more effective organisational cultures.

We are also simplifying the appraisal process by ensuring all appraisal documents are in one place and that appraisees and appraisers can enter one system to share information.

Clinical Education

We work closely with patient facing services and professional leads to plan and deliver clinical skills training and to support the continuing professional development of our clinical workforce to keep them competent and enable safety and autonomy in practice.

Clinical Skills Project. This project aims to develop and maintain staff competence and professional development to enhance patient safety. In-house clinical skills programmes have been reviewed and updated. An essential skills training matrix is being launched and implemented in 2022/23. A competency project has commenced, and we will prioritise the review and standardisation of band 5 and 6 competencies to support our career progression work.

Preceptorship project. This project aims to review the current preceptorship offer and align the programme with new national guidelines for Allied Health Professional preceptorship. We are progressing an application for the quality mark accreditation which we expect to gain by summer 2023. The preceptorship programme has been reviewed with input from Allied Health Professional (AHP) leads, international recruitment leads and a social worker programme lead.

Mental Health (MH) training project. This project aims to identify gaps in the current Mental Health training provision and develop new training and professional competencies as needed. This project ends in August 2023, and we have achieved several project

objectives. New roles are being created within the MH services including a physical health training lead and a nurse consultant to promote clinically based training provision for our staff. We will also dedicate additional resources to deliver the new MH training programmes and have negotiated with the local Higher Education Institute to deliver a bespoke prescribing programme for our MH staff. We are also working with the Head of Psychological Therapies to pilot a specialist educator role in psychology to coordinate educational activities within psychology services.

Healthcare Support Worker (HCSW) programme. This is a workforce pipeline development programme that helps to develop the skills and confidence of HCSWs to achieve their career aspirations. It is supported by Health Education England (HEE) and aims to ensure learning starts and continues throughout their onboarding period. The programme was piloted at Prospect Park Hospital last year and is now being rolled out to all new HCSW joining us. We are also partnering with the Integrated Care System to implement the Bedside Emergency Assessment Course for Healthcare Staff (BEACH), enabling our HCSWs to identify and escalate signs of clinical deterioration. Our Allied Health Professional (AHP) project lead is working with the national AHP faculty to develop several pathways for HCSWs to pursue a career in AHP professions. There have been no staff leavers in the trial group since the introduction of this programme. Programme roll out is progressing as expected and an update on its implementation was provided in an all-staff executive meeting on the 20th of April 2023. We have also organised a HCSW Education event on the 29th of March 2023.

Pre-registration Programme. This is a workforce pipeline development programme that aims to maximise our pre-registration placement capacity and develop newly qualified pre-registration nurses and AHPs to fill vacancy gaps within the organisation. It prepares up to 100 eligible newly qualified registrants for recruitment across several professions per year. The Programme is up and running as expected and placement capacity expansion project work will finish in August 2023. Berkshire Healthcare will also support a new adult MSC nursing programme that is starting in September 2023. We have participated in joint career events with the University of West London and Royal Berkshire Hospital to help to boost the nursing programme applications for the current academic year. We have also developed a new system to share our student experience survey results with the wider Trust.

International Nurses Objective Structured Clinical Examination (OSCE) Recruitment. We are pleased to have exceeded our adult nurse target for 2022, with 15 nurses having joined us this year. All 15 have now completed our in-house OSCE programme. We aim to support two OSCE cohorts in 2023. This is progressing as expected and achieved a 100% pass rate.

Apprenticeship and T-Level Programme. This is a workforce pipeline development programme that aims to create opportunities for career progression of all staff and development of new nurse and AHP registrants to fill vacancy gap. Centralised trust funding has been approved to support the salary of clinical apprentices to backfill their placements and protected learning time. We have enrolled 7 nursing associates and 1 audiology apprentice in Dec 2022 with an OT candidate scheduled to start. We took on 36 new apprentices in the last 12 months, making a total of 118 apprentices in the Trust currently. We are generating income through apprenticeship partnerships with HEE and Higher Education Institutes which support our fixed term projects roles. There are 12; T-level students in the Trust and they are all first year. A new process has been agreed between our candidate attraction team, workforce lead and apprenticeship team to facilitate the candidate selection process for our clinical apprenticeship programmes. We have several candidates in the pipeline for courses in September 2023. We are also developing a new system to analyse apprenticeship finance

and activity data on a quarterly basis and have developed a new system to report apprenticeship AHP candidate engagement data to AHP director every month.

Equality, Diversity and Inclusion (EDI). We have identified EDI as a service priority and have started reviewing our training data to establish a format for meaningful reporting.

Providing opportunities for our people to show initiative and make improvement for their colleagues and patients through great team working, Quality Improvement and Bright Ideas

ⓘ We have a Quality Improvement (QI) Programme that provides opportunities for staff to make improvements using QI methodology. We also encourage Bright Ideas to be submitted by staff to improve services.

The term 'Quality Improvement' (QI) refers to the systematic use of methods and tools to continuously improve quality of care and outcomes for patients. It gives the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. QI involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement. It can deliver sustained improvements not only in the quality, experience, productivity and outcomes of care, but also in the lives of the people working in health care.

Our Trust QI Team are responsible for:

- Training our front line and divisional colleagues in the Trust's Quality Management Improvement System (QMIS)
- Supporting colleagues to become further accredited in lean training by delivering yellow belt and green belt QI training and assessing staff competence.
- Leading and supporting Trust wide high priority projects and programmes with the use of lean methodology.

The core QI team also support the Trust strategic objectives and breakthrough objectives.

Progress with the Quality Management Improvement System (QMIS).

- Face to face training was restarted at the request of staff and wave 17 of the training was successfully completed. This wave included bespoke training for our Research and development team. Wave 18 commences in May 2023.
- Monthly quality support sessions introduced.
- QMIS refresher sessions introduced across the Trust, with over 120 people have attending. These will be continued as they were so successfully received.
- The team are focussing themselves and bringing into all their training the necessity of involving service users/ the community in all QI work.
- The Criminal Justice Liaison and Diversion team have been collecting data for one of the tracker metrics around management supervision since August 2022. The target was set to 95% and for 6 months they did not meet this. However, after raising this as an area of concern at their Unit leadership team (ULT) meeting, the admin team have really driven this and are now achieving 100% on a regular basis.
- Three members of the Talking Therapies senior leadership team have been meeting weekly for peer support to implement QMIS practices. They noticed that they were overwhelmed with emails and, inspired by a piece of email standard work shared by the QMIS coach, they set about freeing up their time by taking a systematic approach to email management.
- Reading Mental Health Integrated Care Services (MHICS) tested three countermeasures to reduce their Did not Attend (DNA) rate. This resulted in the DNA

rate dropping from 37 % to 15% and they are now setting a new target to further reduce this rate.

Quality Improvement training.

- The QI team completed a 2-day face to face yellow belt course for 15 members of staff. All trainees also undertake an improvement project in their local area as part of their assessment. The assessment takes the form of presenting an improvement project that must meet the Lean Competency Scheme (LCS) criteria to pass.
- Bespoke yellow belt training, specifically for the children's and young people all age services, will also start in May 2023. This will include a total of 5 cohorts planned for 2023 (approx. 70 staff).
- Green belt training. This is a 4-day face-to-face course that deepens the learning and understanding of the QI/ lean tools, coupled with completion of a more complex project. This is planned for the Autumn 2023 for approximately 10 staff.

QI projects and programmes. The table below details some of the Green Belt and Yellow Belt projects happening in the Trust

Project Title	Summary of Project
Digital transformation – duration of complex changes	Complex changes were taking too long to be completed – the average duration of a completed change was approx. 43 months. The vision was to change this to under 8 months. Main contributors to this length of time where the request for change step and the wait list step. Countermeasures and new slicker processes have been tested and introduced and the waitlist has gone down from 166 to 59 days. The request for change step time has gone down from 314 to 0 days. Other areas are still needing work to be conducted, but the yellow belt trainee commented that even though this can be difficult to do by using the QI tools she was able to dig deeper and find out the actual root cause of the problem. It felt a structured and helpful approach.
To provide resources to participants after training sessions, improve feedback forms received and reduce DNAs	The trainee tried 4 PDSA (plan, do, study, act) cycles – the first three had negligible impact and caused more work for all staff but the 4th cycle, introducing power automate (including a QR code) into the process helped and has been adopted into the wider organisation successfully.
Reducing the waiting for Child and Adolescent Mental Health Services (CAMHs) Common Point of Entry (CPE) service users needing signposting support.	Waiting times had increased to over 16 weeks for signposting. Standard work was developed, new editable letters were developed in RIO, a specific member of staff was allocated to tackle this problem and the number of weeks patients were waiting was significantly reduced to an average of 4 weeks and less than 5 referrals waiting, compared to over 200 at the start of the project.
Current projects in train from recent yellow belt cohort and supported by the QI team are:	• Reducing assaults on Rose ward, Prospect Park Hospital. • Improving compliance in recording annual Electrocardiogram (ECG) • Improving shared learning from unsafe discharges • Improve induction period and content for new starters. • Standardisation of Common Point of Entry (CPE) documents • Improving renal patient experience (dietetic) and supporting patients to self-manage • Improve and increase how unpaid carers are recorded on RIO • Using digital photography for measuring wounds for carers and families.

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

How does the Trust ensure that staff do not suffer detriment from speaking up?

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

How can staff speak up?

Staff are encouraged to raise concerns in several ways:

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

How is feedback given to staff raising a concern?

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

The role of the Freedom to Speak Up Guardian. The Trust Freedom to Speak Up Guardian helps to protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement. This is achieved by ensuring that: workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered and issues raised are used as opportunities for learning and improvement. This role is now fully embedded in the Trust and awareness of this facility is very well publicised Trust-wide. Between 1st April 2022 and 31st March 2023, 67 cases were brought to the Trust's Freedom to Speak up Guardian

2.1.5. Other Service Improvement Highlights in 2022/23

ⓘ 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 in the sections below.

2.1.6. Improvements in Community Physical Health Services for Adults

The Nutrition and Dietetics Service host the dietetics team in the Royal Berkshire Hospital (RBH), which is funded by the RBH. They have secured funding for an Intensive Care Unit (ICU) at the RBH. This dietitian is a critical part of the ICU Multidisciplinary Team (MDT), and they help facilitate optimal and faster recovery. An abstract outlining the benefits of this role has subsequently been published in the British Journal of Gastroenterology. In addition one of the Ketogenic Dietitians (who aim to reduce epileptic seizures in children by means of a ketogenic diet) had a poster presentation displayed at the Global Keto Conference outlining how a tertiary specialist service can be developed in a District General Hospital.

Our Community Dietitians have addressed recruitment challenges by introducing Band 4 Dietetic Assistant Practitioners into their team. They have also created a new model of working with care homes in West Berkshire.

Berkshire Community Dental Service (CDS) received additional funding from NHS England in 2021 to reduce waiting lists. By appointing additional staff on a fixed term basis, they have reduced the waiting list from referral to consultation from 1206 to 489 with a reduction in waiting times from 40 to 16 weeks. Introducing additional General Anaesthetic (GA) sessions on Saturdays at the Royal Berkshire and Wexham Park hospitals has reduced the paediatric extraction GA waiting list from 491 to 101 with the maximum waiting time reducing from 115 to 18 weeks. The comprehensive treatment GA waiting list has reduced from 171 to 60 with only 5 patients waiting more than 18 weeks.

The Diabetes Service has been working to increase the number of people with type 1 diabetes whose HbA1c is equal to or less than 58 mmol/mols. Nationally around 30% of people with type 1 diabetes meet this target. The team used quality improvement methodology to address this, resulting in several improvements being made and resulting in an increase, above the national average, of people with Type 1 diabetes managed under the specialist service. Waiting times for follow up appointments have also been reduced and a pilot project is being carried out with Community Nursing using new diabetes technology to help support people with diabetes who are housebound. A dedicated Diabetes Consultant has now been employed directly by the Trust to provide strong clinical leadership.

The Podiatry Service host the team at the Royal Berkshire Hospital (RBH), which is funded by the RBH. They have used transformation funding to send a community podiatrist to work with the RBH Foot Multi-disciplinary Team (MDT) for 2 days per week for 6 months. This rotational post has allowed the community podiatrists to participate in an educational role within the acute podiatry team and allowed them to expand and develop their practical clinical skills.

Adult Speech and Language Therapy (SLT) have developed a dysphagia training programme with the SLT team at the RBH. Both teams can now train Band 5 staff in their dysphagia competencies internally, thus saving the time and funding required in taking external courses. Staff become dysphagia competent and can manage a dysphagia caseload earlier, thus reducing waiting. The team are also part of the Parkinson's Plus outpatients MDT team hosted by Frimley Health at Heatherwood Hospital. Clients

attend this “one-stop” clinic for assessment which, in most cases, reduces the need for further referral to our SLT service.

Integrated Services in East Berkshire. A duty triage role has been introduced for the Assessment and Rehabilitation Centre (ARC) and Community Physiotherapy to ensure that referrals are appropriate and assigned to the correct service. ‘Check calls’ have also been introduced to ensure patients waiting are kept informed, and any changes in circumstances are reflected. Urgent referral waiting times in this area have reduced from 24 to 0-1 weeks, with routine waits down from 48 to 8 weeks. Inpatient therapies now provide a 7-day service.

The East Berkshire Lower Limb Service are following the National Wound Care Strategy guidelines for lower limb management and consistently exceed their target of having a healing rate of 70% or more within 12 weeks for non-complex lower limb ulcers.

The Specialist Wheelchair Service has found a 3rd party supplier to recondition their wheelchairs and improve timely access to reconditioned wheelchairs for patients. They have also invested in reconditioning Motor Neurone Disease (MND) specification power wheelchairs in-house. This allows a quicker response to the needs of MND patients whose condition can deteriorate quickly.

The East Berkshire Heart Function Service. Some staff have completed courses on advanced assessment, cardiology and leadership. They have also held three competency workshops for all Heart Function Nurses in their Integrated Care Board area to help them get their Heart Function nurse competencies signed off. One of the staff members has also co-authored a Heart Failure nurse competency framework that has been published in the British Medical Journal. The Berkshire East Heart Failure team are currently an NHS England accelerator site to pilot Heart Failure patients on remote monitoring. This will help to reduce hospital admissions, recognise early signs of deterioration and promote self-management of heart failure. An Intravenous diuretic community lounge has also been put in place to treat patients with decompensating heart failure closer to home and reduce hospital admissions.

The Musculoskeletal Physiotherapy West Service have re-designed and re-launched 7 types of face-to-face patient exercise classes. They have also launched pathways that provide more seamless care for patients with Osteoarthritis and Low back pain who are referred from the Integrated Pain and Spinal Service / Community Specialist Services. The team have started a review the service to identify positive changes for the future.

Community Nursing Teams in East Berkshire have introduced a community nursing forum to allow for clear messaging, better information sharing and to facilitate cross-cover of resources and staff. A triage administrative role has been introduced in each locality. Clinical leads have introduced support drop-in sessions to support staff wellbeing, and a rolling programme of bite-sized training has been introduced to provide support for less experienced staff.

Urgent Community Response (UCR) /Virtual Wards (VW) in West Berkshire. All South-Central Ambulance Service (SCAS) referrals to the UCR Service are now directed to the appropriate UCR/VW Team Coordinator by the Integrated Health Hub. This has improved the referral process and the quality of information gained at the point of referral.

The Care Home Support Team in West Berkshire have introduced multidisciplinary clinical meetings with care home managers, to review patients with complex needs and/or showing signs of deterioration in their health.

Newbury and the West Berkshire Community Nursing Services have introduced a Community Matron Coordinator role to support to the Community Nursing teams. This has resulted in a reduction in Community Nurses’ waiting time for prescriptions and authorisations, a more integrated approach to caring for patients in

the community and an increase in referrals to the Community Matron service. The team hold fortnightly Complex Case review meetings to discuss the patients they are concerned about.

Reading Community Nursing Service have introduced an Allocation Standard Work Process to support the daily allocation of work and ensure that it is safe and effective. A prioritisation capacity tool was also introduced to support with the decision making and reduce the risk of harm to patients. The service also works with the other localities in the West to introduce development workshops for Band 6 Community Nursing Sisters.

Wokingham Community Nursing Service has reviewed its process for reporting missed visits and a caseload management tool was also updated to make it less time-consuming. They have employed a Clinical Development and Quality for the Wokingham District Nursing teams and a Wound Care Nurse Specialist has also been appointed.

Cardiac and Respiratory Specialist Services (CARRS) in West Berkshire. The Respiratory Service have introduced new processes which have led to a reduction in errors and removed duplication of work. They are automating the process of referrals for the oxygen service and a virtual diary has been developed to allocate appointments to healthcare staff in the same postcode. The Heart Function service has implemented a Rapid Titration Clinic for patients that are prescribed Entresto (a treatment for heart failure) in the community.

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

WestCall GP Out of Hours Service has enhanced their IT access during the year. They now have increased access to daytime GP EMIS clinical systems and to the Royal Berkshire Hospital electronic patient records. This allows them to visualise the whole patient journey from daytime primary care to acute secondary care, thus giving them greater oversight. A remote laptop upgrade has also enabled clinicians to utilise electronic prescribing on home visits remotely for the first time. It also allows clinicians to access ICE (test results) on home visits.

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

Work carried out across the CYPF Division. Band 5 rotational therapy posts have been introduced, as well as developmental band 6 roles to give opportunities to staff who are thinking of promotion. A system has been created to collate all staff supervision to aid recording and performance management.

SEND (Special Education Needs and Disability). All CYPF services are involved in the provision of care for children with SEND according to the Children and Families Act 2014. Teams have seen an increase in the number of requests for Education and Health Care Needs Assessments (EHCNA). Work undertaken in this area to reduce Occupational Therapy times for this is described in part 2.1.1. above. We have also worked with Local Authorities to promote the "universal offer", which is available for schools to access. This helps to support the child and parents.

The Children in Care Team has seen an increase in the number of unaccompanied asylum-seeking children referred to the team. They have started a series of engagement sessions to support these young people.

The Children and Young People's Integrated Therapy Service (CYPIT). The three Local Authorities in the east of the county have worked with Frimley Integrated Care System on a joint review of children's therapy services. We anticipate that new arrangements will be rolled out from April 2023. Additional investment has been given to

the Occupational Therapy (OT) team to increase the number of qualified staff and introduce a wider skill mix through the recruitment of OT assistants. CYPIT have also been awarded a contract to deliver their service to patients in the west of Berkshire. Early years training courses are being run virtually for parents and professionals across Berkshire, and the Speech and Language Therapy (SLT) team has developed a training programme for early years settings in partnership with a West Berkshire education practitioner. CYPIT has also continued to strengthen its support for school-aged children. The SLT team continue delivering training across the 3 west Berkshire localities and the physiotherapy team have started developing a series of training videos for school staff. The Occupational Therapy (OT) team have started advice clinics in schools.

The Health Visiting (HV) and School Nursing (SN) 0-19 years services. Health Visiting services have introduced a 'Chat health' service for parents/carers of children 0-5 living in Bracknell, Wokingham, Reading or West Berkshire. This allows Parents/ carers to contact the Health Visiting team more easily for confidential advice and information. Saturday working has been introduced in Reading as well as a vulnerable holding caseload. Three specialist HV roles have also been introduced for perinatal mental health, SEND and complex Needs and Health Inequalities. In Bracknell, the team have started integrated 2-2.5yrs of age development reviews.

Across Berkshire the school nursing service have launched 'Chat health' for 11- 19-year-olds and parents of 5–19-year-olds. They receive positive feedback for the delivery if their medical awareness sessions for school staff. New weight management and anxiety pathway have also been developed.

The School Aged Immunisation Service received a letter of recognition from NHS England for achieving the highest uptake of the in-schedule Human papillomavirus (HPV) and school leaver booster vaccines within the NHS England Hampshire & Thames Valley Commissioned area during the 21/22 academic year. The Health Bus was also launched to offer catch up clinics and opportunistic appointments. The first offer of flu vaccinations to all children in Reception to year 9 was completed before the end of the Autumn Term 2022. The team also supported the evergreen offer of Covid Vaccinations to children educated within Special Educational Needs schools. A specialist immunisation nurse team has been developed to improve uptake of immunisations in specific areas. A targeted Pregnancy Disclosure pathway has also been developed in case a young person discloses that they are pregnant during an immunisation session. Finally, a process has been developed to maximise opportunities for parents and young people to consent to and receive immunisations.

Specialist Children's Services. Improvement has continued across the service, including development of a new East Berkshire Special School Nursing service.

The Community Children's Nursing (CCN) team. The West CCNs have introduced a Rapid Response Service to provide support and advice to the Police in the event of an unexpected child death. They have also finished introducing their commissioned 8-8 service, with the longer hours helping to prevent children being admitted to hospital. Both the East and West CCN teams continue to develop End of Life care and have supported a significant number of children and families in the community. Training has also been developed focusing on mental health for Children and Young People. The Paediatric Early Warning System has also been implemented.

The Special Schools Nursing Team. The West SSN team have reviewed their role across the Special Educational Needs schools to ensure appropriate cover. Clinical competencies have been re-assessed and a training plan in place. The East Berkshire Service continues to develop with the appointment of an SSN at each of the SEN Schools in East Berkshire.

The Community Paediatrician Service have reduced both wait numbers and wait time for autism assessments and have completed a Quality Improvement project to progress a paper lite system.

The CYPF Dietetic Service care for children who have complex health needs and require enteral feeding support at home. They have been working with Royal Berkshire Hospital dietetic team, catering and an external provider to develop ambient temperature blended diet pouches for use at ward level. The service is also involved in the Buckinghamshire Oxfordshire and Berkshire Integrated work on Avoidant restrictive food intake disorder (ARFID).

The CYPF Neurodiversity- Autism Assessment Team and Attention Deficit Hyperactivity Disorder (ADHD) Team. The service received significant new investment enabling a service expansion and service transformation. This included implementing service efficiencies, outsourcing of some routine assessments and medication initiation and titration to reduce waiting times to below 2 years. The service has also received recruitment support to help address staff turnover and recruit hard-to-fill Clinical Psychology posts. A project on autism assessment is also being carried out in Berkshire, Oxfordshire, Buckinghamshire and Surrey to help improve the autism assessment process.

Two qualified and three trainee Children's Wellbeing Practitioners are now in place to provide support to families whilst they are waiting for autism and/or ADHD assessments via the Neurodiversity Helpline. These practitioners can also provide evidence-based low intensity Cognitive Behavioural Therapy (CBT) informed interventions to children on the autism or ADHD pathways, who are experiencing mild-moderate low mood, anxiety or behavioural difficulties. Quality Improvement (QMIS) methodology is well-embedded across the neurodiversity service. Within the autism assessment team, there have been various initiatives to improve efficiency, resulting in more assessments being concluded in a timely manner. Finally, there are now 3 non-medical prescribers in place in the ADHD team.

Child and Adolescent Mental Health Services (CAMHS) and the Berkshire Eating Disorders Service (BEDS) have historically had long waiting times, with demand and acuity continuing to grow. Several projects are underway to address this. Two new posts have been created to lead on quality improvement and Transformation work across the teams. The CAMHS leadership team are developing and implementing updated, evidence-based clinical care pathways across the service.

The CAMHS Common Point of Entry (CPE) team have been using QI methodology to reduce waiting times for initial contact and initial assessment. Several countermeasures were implemented, resulting in a 42% reduction in people waiting and a 56% reduction in those waiting for routine support.

A QI project was also undertaken to look at retention of staff in the CAMHS Rapid Response team- a challenging area with a high risk of burn-out and high staff turnover. The impact of this project is being evaluated.

The CAMHS Getting Help Team, who support care through schools-based mental health support, wanted to understand why there had not been the anticipated reduction in the number of referrals to the Common Point of Entry (CPE). Using QI methodology alongside the CPE team and transformation colleagues from the Frimley ICB, they identified waste and inefficiencies in the process and developed a set of countermeasures. The team are hopeful these actions will result in a reduction in the time taken from referral to treatment, a reduction in referrals to CPE, and an increase in referrals to the Getting Help team.

Buckinghamshire Oxfordshire and Berkshire Integrated Care Board secured funding to become an early adopter pilot site for the new Key Working Programme. This is a national initiative to support children and young people with a learning disability and/or autism, who

are at risk of admission to a Tier 4 mental health unit/hospital. Berkshire Healthcare CAMHS has been commissioned to provide this service in Berkshire West. Core staff have been recruited to the service, which went live in January 2023 and the service will expand through 2023/24 .

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

Caring for People with a Personality Disorder and an Intellectual Disability (CaPDID) training – Inpatient & Community Services. Many people with learning disabilities have experienced adverse childhood experiences and/or trauma in their lives. This means that as adults they may have difficulties forming and sustaining relationships and can behave in ways which can be challenging for others. CaPDID training is a three-session training course run over several weeks, which brings professionals and paid carers together to enable discussion of experiences of supporting people who can present in this way. The training shares some key psychological concepts which can help staff formulate and better understand people's experiences and presentations. To date CaPDID training has been run for one group of staff within the Learning Disabilities Service, which has been well received with positive feedback. Two further groups are being run early in 2023, with plans for it to be offered to local care providers, and the possibility of Berkshire being a pilot site for a national research study looking into the outcomes of CaPDID training.

Reducing Inpatient Admissions – Dynamic Support Register pilot. To help support the aim to reduce the use of inpatient services, our Intensive Support Team have been working to develop a local Dynamic Support Register. This has involved researching good practice and piloting tools to help assess the risk of inpatient admission. The outcome from the project will be fed back to our Commissioners to help inform the future development of a system wide Dynamic Support Register.

Community Teams for People with Learning Disabilities have had their work developing an end-of-life care pathway for people with learning disabilities published in the Learning Disability Practice journal. This demonstrated their approach to partnership working and sharing the pathway with others in the wider LD arena. Following on from the publication, the team were invited to apply for the Royal College of Nursing awards and were shortlisted with other finalists.

The team have also held various "Meet the Team" events including an event at a local day centre where the team role-played to demonstrate the roles of different team members. A session on healthy eating and positive mental health was also carried out.

Team members have also introduced an epilepsy clinic at Ravenswood with a Community Nurse and Neurologist attending. This has proven to be an efficient approach for all involved and helped to ensure the person, their carers and health professionals all contribute to updated epilepsy care plans.

Administration & Medical Secretary Support. EPRO has now been implemented in the LD specialist service to make digital dictation processes easy and more efficient for both the clinicians and the Medical Secretaries who support them.

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

Talking Therapies

Direct to Digital was launched in May 2022. This provides an innovative solution, allowing Talking Therapies clients immediate access to online support for depression and anxiety. The client is then contacted by a clinician to support them through the programmes and ensure they get the right support at the right

time. This has also resulted in a reduction in the time required to process new referrals and has provided a new route into our service.

Offering SilverCloud online treatment to patients on our waiting lists. The service is now offering clients waiting for Cognitive Behavioural Therapy (CBT) access to online treatment (SilverCloud).

Cultural and Ethnic Diversity work. Talking Therapies are committed to addressing ethnic health inequalities and have established permanent Cultural and Ethnic Diversity Lead roles. These leads build, develop and maintaining relationships with local communities, grassroots organisations, faith leaders and faith-based organisations. They have also conducted targeted outreach to specific community locations and have provided training to staff around working therapeutically with diverse client groups. The team are also working with GPs and Primary Care Nurses to address specific locality needs.

The Reading Waitlist Project aimed to reduce the Reading Step 3 waitlist and identified several inefficiencies causing delays. The project also identified that post-traumatic stress disorder (PTSD) was over identified as a presenting problem. Countermeasures were put in place to address this.

Wellbeing Strategy and Wellbeing Strategy Action Plan. A joint Improving Access to Psychological Therapies (IAPT) Staff Wellbeing Project has been funded by NHS England for implementation across Thames Valley IAPT Services. It aimed to develop an approach to strategically support good wellbeing of IAPT staff and resulted in the development of a 'Model IAPT Staff Wellbeing Strategy'. Using this strategy as a baseline, our Talking Therapies service held local engagement events and ran a service wide survey to identify areas of potential development and to gather feedback from staff on actionable changes that would result in greater wellbeing. Actions are being implemented, the outcomes of which will be monitored and reviewed regularly over a 2-year period.

Community-Based Mental Health Services for Adults

'One Team' will transform Berkshire's Mental Health offer, in line with the NHS Long Term Plan, to create a brand-new model for Berkshire. This new model will feature improvements to the way we deliver the collaborative, integrated and equitable services that the modern population of Berkshire need.

Supporting people with their mental health is rarely straightforward. Sometimes people need help from a range of services and organisations. This can be a challenge when our ways of working aren't set up to allow this easy flow between services. People can end up on long waiting lists, being bounced around between services that aren't quite right for their needs, or not ever receiving the right treatment for them. While waiting for the right treatment, a person's mental health may deteriorate further. These barriers to working collaboratively are also frustrating for staff. Who want to offer the best personalised care for their patients.

The OneTeam project will improve this for our patients by doing the following:

- Bring together East and West Berkshire's Community Mental Health Services in to one clear service offer, eliminating any unwarranted variation between localities.
- Provide consistency and equity of service provision across Berkshire.
- Move towards a more holistic approach that considers physical and social determinants of mental health.
- Better utilise community assets and voluntary sector organisations
- Reduce or eliminate unnecessary barriers to accessing services.
- Work across multi-agency boundaries
- Allow earlier intervention, improve access and interfaces between Primary and 'Secondary' or specialist care.

The Common Point of Entry (CPE) service have reduced their waiting time for new planned assessments from 12 to 4 weeks.

The Out of Area Placements (OAPs) Team have had success in improving the outcomes for patients placed in independent hospitals. This has included a reduction in numbers.

The Community Rehabilitation Enhanced Support Team (CREST) helps support those with complex mental health needs in the community. The team has been in the initial stage of operation since November 2022 and further recruitment is in progress.

Thames Valley Liaison and Diversion (L&D) Services have started carrying out Speech and Language Therapy assessments in Berkshire for those requiring this. They have also carried out a Listening into Action event to reduce duplication of work and administration around screenings and assessments. A more clinical and restorative approach to providing supervision to staff was also put in place. A new Prison Healthcare Single Point of Contact process has been developed that allows the L&D Team to make one referral directly to prison healthcare to alert them of a defendant's vulnerabilities or needs. Hampshire L&D team have also implemented fortnightly Restorative Clinical Supervision sessions, facilitated by a Professional Nurse Advocate.

The Psychological Medicine Service maintain a strong relationship with Royal Berkshire and Wexham Park Hospitals. They consistently meet their performance targets with an excellent one-hour response time for patients in Accident and Emergency. They have re-introduced face to face teaching in both hospital sites and both services have been re-accredited by the Royal College of Psychiatrists.

The Individual Placement and Support employment team supports clients with significant or severe mental health issues to gain, sustain and retain paid employment. The team underwent an extremely thorough external fidelity review towards the end of 2022 and scored the highest possible marks on areas which are vital to the service, including their integration with the clinical teams they work alongside. Monthly peer support groups have also been established.

The Building Resilience and Valuing Emotions after Domestic Abuse (BRAVE) Team have been offering psychological input to East Berkshire residents for the last three years. They have now secured a commissioning contract from The Thames Valley Police and Crime Commissioner to expand their service into west Berkshire localities. An additional service called 'BRAVE Too' has also been developed to focus on supporting male victims of domestic abuse.

Emotional Minds Bring Reasons and Choices Every day (EMBRACE) is an East Berkshire Therapeutic Community that is part of our recovery services. They offer numerous opportunities to their members for recovery growth, engagement and co-production on a weekly basis. EMBRACE has been nationally recognised as an example of good practice in co-production and is accredited by The Royal College of Psychiatrists.

Slough Co-Production Pathway enables service users and carers in slough to contribute to service developments and evaluations, whilst some choose to train as peer mentors, becoming volunteers for our Trust. They also have opportunities to work in an expanding choice of paid roles as lived experience practitioners. They have recently contributed to the Safe Haven, East Berkshire out-of-hours mental health support project.

The 'SPINE' Slough Primary Care Network Mental Health Integrated Community Service (MHICS) was launched in November 2022, with plans for the whole Primary Care Network to be served by the end of Feb 2023.

Alternative Resource Reimbursement Scheme (ARRS) for asylum seekers. ARRS clinicians and their primary care colleagues have seen unprecedented demand in some areas due to the increased asylum seeker population in Slough. Feedback from primary

care partners as well as objective measures of output, have been very positive.

The Intensive Management of Personality - Disorder and Clinical Therapies Team (IMPACTT). The Psychologically Informed Consultation and Training (PICT) team is a part of the IMPACTT service. It is a collection of senior psychologists and psychotherapists with specialist knowledge of working with patients with personality disorders. This year they have widened their 'primary care' offer to the West Berkshire/ Buckinghamshire, Oxfordshire and Berkshire (BOB) system. They have also developed and delivered more bite-sized training packages for professionals to help dispel some of the stigma of this diagnosis and improve confidence and skills in working with these difficulties.

The SUN (Service User Network) provides community-based, open access peer support groups across Berkshire to those with personality disorder difficulties who may have found it difficult to engage with other therapy services or are waiting to access these. Members have given very positive feedback about their experiences, and more than 50% of members starting in SUN return to a group on more than 3 occasions.

The Managing Emotions Programme (MEP) has been co-produced in partnership with Surrey and Borders Foundation Trust to meet the needs of people at the mild to moderate end of the continuum of personality disorder. It will be integrated within the wider Mental Health Integrated Community Service (MHICS) team to boost its development and ensure a more robust staffing structure.

The Assertive Interventions and Stabilisation Team (ASSIST) service was initially developed in Slough then adapted and extended across Berkshire. They provide support to people diagnosed with Emotionally Unstable Personality Disorder (EUPD) who may be experiencing such increased levels of distress that they may have been admitted for inpatient care.

The Dialectical Behaviour Therapy (DBT) and Mentalization Based Treatment (MBT) therapy teams now have a 'blended' offer of in-person and remote/ online therapy, depending on clinical need and patient preference.

Carers Awareness Tools and Support (CATS). The team have piloted a new Carers group to support the family and friends of people with EUPD who are using services.

The Crisis Resolution and Home Treatment Team (CRHTT) in Berkshire West have trained five Professional Nurse Advocates (PNAs) to provide wellbeing support, restorative supervision, education and career advice. The PNAs also facilitate Space Group reflective sessions which give staff the opportunity to share key messages/learning and talk about challenges in an honest and open space. A wellbeing event has also held this year where incident data was considered. The event also included education workshops on the impact of suicide on health workers. Counter measures have been put in place to increase staff wellbeing and mitigate trauma, moral injury and burn out. A Dual Diagnosis Coordinator has also been introduced to support the team with clinical reasoning and decision making for those with Co-occurring Mental Health, Alcohol and Drugs. The service now has six Non-Medical Prescribers in place and a nurse led non-medical prescribing clinic has been started. Lived experience practitioners have also been introduced to provide advice and support to our teams and to advocate for service users and carers.

Mental Health Inpatient Services at Prospect Park Hospital

A targeted piece of work to improve the communication system between inpatients and community services has been undertaken. A Bed Flow project has led to an improved communication system which provides real-time workflow information to all staff involved in inpatient admissions. A Mental Health Liaison Role has also been introduced to support patient flow between inpatients and community teams.

There is also currently a wide-ranging piece of work being completed at Prospect Park Hospital in relation to reducing restrictive practice. We know that this is a widespread issue, and this needs to be changed in a manner that will be longstanding. Our main focus is around reducing the use of Prevention and Management of Violence and Aggression (PMVA) restrictive measures and increasing the use of other helpful measures. Our data suggests that over the years, the reason for which PMVA is used has changed, with self-harm being a top contributor in comparison to some years ago.

To help reduce restrictive practice we have looked at reducing 'blanket restrictions' such as having kitchens locked during certain times, and restrictions on visiting times and access to gardens. We know that such blanket restrictions can be challenging for patients and can be unhelpful when planning and providing holistic and person-centred care. Two wards in particular, Snowdrop and Bluebell have started using countermeasures to reduce the use of PMVA and increase the use of personalised care plans whilst measuring the impact this has on self-harm. The first countermeasure involves 'who's looking after me today,' which provides patients with access to one key person that will be specifically supporting their needs through the day, rather than having to go to several different people. The second countermeasure is the use of safety huddles. These happen every day following the ward handover, to highlight any patients that might become distressed during the day and how the teams will approach, support and engage with that patient to avoid restrictive measures like PMVA. There is also ongoing work around the hospital in trying to understand why a person may self-harm. This understanding will allow teams to develop a care plan that supports the patient and develops their coping strategies.

Work has also been undertaken to improve services for patients admitted with drug or alcohol misuse. This has included:

- Improving the care pathway for patients who are admitted in a Mental Health crisis but also require a detox from alcohol.
- Improving identification of drug use on admission.
- Improving access to support for patients who have used substances or alcohol.
- Establishing a Tobacco Dependence service within the hospital- Since June 2022
- Improving pre-admission conversations re Smokefree hospital
- Essential training for all staff to improve confidence in having Smokefree conversations.
- Staff Focus group to support staff who smoke and work in the hospital.

2.1.11. Improvements in Medicines Management

Safer use of clonazepam. This is a powerful benzodiazepine widely used in acute mental health episodes but not recommended for wider use, especially on discharge from hospital, due to the common confusion over its potency. Trust use was audited, and then followed up with clearer guidelines and education sessions with prescribers.

Working with Estates to tackle high ambient temperatures in wards medicines storage areas. This includes the selective installation of air conditioning, to prevent medicines being exposed to temperatures of 25°C or higher. This programme has reduced the number of medicines having to be destroyed because of exposure to high temperatures.

2.2. Setting Priorities for Improvement for 2023/2024

ⓘ This section details the Trust's priorities which reflect the Trust Annual Plan on a Page for 2023/24 (see Appendix A). Specific priorities have been set in the areas of patient experience, harm free care, clinical effectiveness, and supporting our people. They have been shared for comment with Trust governors, Integrated Care Boards, 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.

2.2.1. Harm-Free Care Priorities

Providing Safe Services

- We will protect our patients and staff by using appropriate infection control measures.
- We will identify and prioritise patients at risk of harm resulting from waiting times.
- We will ensure face to face care where clinically indicated.
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services.
- We will recognise and respond promptly to physical health deterioration on all our wards.
- We will improve the physical health of people with serious mental illness.
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and ensure learning from incidents.

2.2.2. Clinical Effectiveness Priorities

- We will participate in applicable national clinical audits and operate a robust system for reviewing NICE guidance to ensure that care is delivered in line with national best practice standards.
- We will continue to review, report, and learn from deaths in line with new national guidance.

2.2.3. Patient Experience Priorities

Improving Outcomes

- We will reduce length of time patients wait for our services, year on year (compared to 2022 waits
- We will make every contact count by offering advice in making healthy choices.
- We will identify and address inequality in access to services.
- We will gain feedback from at least 10% of our patients in each service and demonstrate service improvement based on feedback.

2.2.4. Supporting our People Priorities

A great place to work.

- We will ensure our teams have access to effective health and wellbeing support.
- We will promote a culture of respect, compassion and kindness.
- We will not tolerate bullying, harassment or abuse of any kind.
- We will support staff to work flexibly and connect with their teams.
- We will act on feedback from staff to improve satisfaction and address identified inequalities.
- We will provide opportunities for staff to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas
- We will support staff to achieve their career aspirations.
- We will attract and welcome school leavers, apprentices, students and international recruits to help close our workforce gaps.

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 Trust Board will be informed of performance against agreed targets. The Trust will report on our progress against these priorities in our Quality Account for 2023/24.

2.3. Statements of Assurance from the Board

During 2022/23 Berkshire Healthcare NHS Foundation Trust provided and/or sub-contracted 49 relevant health services.

Berkshire Healthcare NHS Foundation Trust has reviewed all the data available to them on the quality of care in all these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Berkshire Healthcare NHS Foundation Trust for 2022/23.

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 we provide to patients against best practice standards. We make improvements to patient care based on audit findings. Such audits are undertaken at both national and local level.

National Clinical Audits and Confidential Enquiries

During 2022/23, 12 national clinical audits and 3 national confidential enquiries covered relevant healthcare services which Berkshire Healthcare NHS Foundation Trust provides.

During that period Berkshire Healthcare NHS Foundation Trust participated in 100% (n=12/12) of national clinical audits and 100% (n=3/3) of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust was eligible to participate in during 2022/23 are shown in the first column of Figure 31 below. This column also details the national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in during 2022/23.

The national clinical audits and national confidential enquiries that Berkshire Healthcare NHS Foundation Trust participated in and for which data collection was completed during 2022/23 are also listed below in Figure 31 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (detailed in the second column of Figure 31).

Figure 31- National Clinical Audits and Confidential Enquiries

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2022/23	Data collection status and number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
1. National Clinical Audits (N=12)	
National Clinical Audit and Patient Outcomes Programme (NCAPOP) Audits	
National Sentinel Stroke Audit	Data Collection: Apr 2022 to March 2023. 371 patients submitted, across 3 services, 61 six-month follow-ups. Report due: Annually November 2023
National Diabetes Footcare (Community Podiatry care)	Data Collection: Apr 2022 to March 2023. 287 patients submitted, across 1 service). Report due: 2024
National Asthma and COPD Audit Programme (NACAP): pulmonary rehabilitation	Data Collection: Apr 2022 to March 2023. 61 patients submitted, across 1 service. Report due: Annually 2023/24
National Audit of Inpatient Falls	Data Collection: Apr 2022-March 2023. 3 patients submitted, across 2 services. Report due: Annually- November 2023
National Diabetes Audit - Secondary care	Data Collection: Apr 2022 to March 2023. 1915 patients HbAc1, 199 Structured Education and 84 Insulin pump patients submitted, across 1 service Report due: Annually- July 2024
National audit of care at end of life	Data collection July 2022 to Oct 2022. 26 patients submitted, across 1 service. Report due: July 2023
National Clinical Audit of Psychosis	Data Collection: Feb 2023 to March 2023. 100 patients submitted, across 1 service. Report due: 2023/24 tbc
Non- NCAPOP Audits	
National Audit of Cardiac Rehabilitation	Data Collection: Apr 2022 to March 2023. 171 patient assessment 1's & 111 assessment 2's submitted across 1 service. Report due: 2023/24
Prescribing Observatory for Mental Health (POMH) – 1h&3e: Prescribing high dose and combined Antipsychotics	Data Collection: March 2022 to April 2022. 71 patients submitted, across 1 service. Report released: Dec 2022
POMH – 21a: The use of Melatonin	Data Collection: June 2022 – July 2022. 158 patients submitted, across 3 services. Report released: Feb 23
POMH – 20b: Valproate Prescribing in adult mental health	Data collection: Oct 2022 – Nov 2022. 163 patients submitted, across 3 services. Report due: May 2023
POMH - 7g: Monitoring of patients prescribed Lithium	Data Collection: March 2023 to April 2023. 140 patients submitted, across 3 services Report due: August 2023
2. National Confidential Enquiries (N=3)	
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Child Health Clinical Outcome Review Programme. Transition from Child Health to adult services	Data Collection: July 2021 to October 2022. 7 patients submitted. Report due: June 2023

National Clinical Audits and Confidential Enquiries that the Trust was eligible to participate in and did participate in during 2022/23	Data collection status and number of cases submitted as a percentage of the number of cases required by the terms of each audit and other comments
National Confidential Enquiry into Suicide and Homicide (NCISH) - Mental Health Clinical Outcome Review Programme Suicide and Homicide 2022/23	Data Collection: Apr 2022 to March 23. 43 (100%) patients submitted. Report due: 23/24 (tbc)
Learning Disability Mortality Review Programme (LeDeR)	Data Collection: April 2022 to March 2023. 100% patients submitted. Report due: 2024

The reports of 12 (100%) national clinical audits and 1 (100%) Board Level audit were reviewed by the Trust in 2022-23. This included national audits for which data was collected in earlier years with the resulting report being published in 22/23. 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 20 local clinical audits and 16 service evaluations were reviewed by the Trust in 2022/23 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)

ⓘ Clinical Research activity is crucial to ensure the quality of care we provide and to discover new treatments and interventions. Our research activity and outcomes contribute to evidence-based practice by enabling skill development for staff.

Evidence demonstrates that hospitals active in clinical research have better patient care outcomes. Berkshire Healthcare is committed to clinical research and to providing research that is patient centred. Our Research portfolio is aligned with the needs and priorities of our population and services.

The overall number of patients receiving health services provided or sub-contracted by Berkshire Healthcare up to end of Q4 2022/23 that were recruited to participate in research approved by a Research Ethics Committee was 653 into 29 studies. All 29 of these studies are included on the National Institute for Health Research (NIHR) portfolio.

We are delivering on our strategic objectives to embed Research into clinical care, to build on and create new collaborations and ensure access to Research.

Patient experience

In 2022/2023 6,978 participants were recruited into NIHR portfolio studies within Berkshire of which 156 completed the national Participant in Research Experience Survey (PRES). 149 out of the 156 participants would consider taking part in Research again with all stating that the Research staff always treated them with courtesy and respect. A third of participants had been on a Research study for 1 year or more. The lead research nurse for the Trust contributes to the regional Patient Public Involvement Engagement group where strategies for increasing the participation in the national PRES survey are discussed.

Supporting our staff priorities

The Research culture at Berkshire Healthcare demonstrates clear benefits for the development of staff skills. Clinical Research increases staff engagement and retention by ensuring external clinical innovations and advancements of clinical practice can be

implemented into departmental practices, whilst also contributing to evidence-based practice by enabling skill and knowledge development for staff.

This financial year saw the Berkshire Healthcare Research Delivery team named as joint winners of the All-round High performing team award. Several AHPs within Berkshire Healthcare have also provided input into a Buckinghamshire, Oxfordshire and Berkshire West (BOB) Allied Health Professions (AHP) Faculty website. Together with the R&D senior leadership team, the input ensured that Research featured in the profiles of AHPs and, as one of the pillars of advanced clinical practice, there were examples on the website of Research, Quality Improvement, and Innovation opportunities/news.

A registered Clinical Research Practitioner (CRP) within the Berkshire Healthcare R&D team has been appointed to the Thames Valley and South Midlands regional CRP role. The post will support other CRPs across the region and assist in education and support by creating, developing and sustaining supportive networks for those who attain registration status and others who are working towards registration status. The role also provides Berkshire Healthcare with an opportunity to work closely with the national Engagement Manager for CRP Registration, ensuring that regionally focused approaches align with overarching NIHR strategy.

Patient safety priorities and clinical effectiveness

100% of our research portfolio in 2022/23 was aligned with, Patient and Public Involvement and Engagement, a clinical service, Trust priority, Integrated Care System, or a national priority. This helps ensure we improve the quality of our service.

Research representatives sit on the Trust's Reducing Health Inequalities steering group. The Applied Research Collaboration awarded research funding to the Trust for a project focusing on tackling health inequalities in black individuals who have been detained under the Mental Health Act. The Clinical Research Network awarded the Trust funding to develop; a research strategy for Learning and Disabilities services, a patient public engagement event, and to implement data quality processes to ensure data can be collected to evaluate the service and identify priorities. All projects are on-going and will be taken forwards as part of the delivery plan of 2023/24.

Berkshire Healthcare is a partner in the Oxford Health Biomedical Research Centre (OHBRC), which is one of only two centres in the country wholly dedicated to research into mental and brain health. There are 11 themes of research, and we are involved in the 'Psychological' and the 'Mental Health in Development' themes. The Berkshire Traumatic Stress Service is hosting the Complex Post-Traumatic Stress Disorder (PTSD) project entitled 'Does a Phased Approach Enhance Outcomes for Trauma-Focused Cognitive Therapy for Complex Post-Traumatic Stress Disorder (CPTSD)?' This is a collaborative project involving several stakeholders and delivers on the Psychological theme of the OHBRC.

2.3.3. CQUIN Framework

ⓘ The Commissioning for Quality and Innovation (CQUIN) 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 2022/23 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 2022/23 and for the following 12-month period can be found in the appendices.

The income in 2022/23 conditional upon achieving quality improvement and innovation goals is X (TBC when finalised). The associated payment received for 2021/22 was N/A as there was no CQUIN in that year.

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 2022/23.
Berkshire Healthcare NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission. Following our CQC inspection of our core services in November 2019, and a "Well Led" inspection in December 2019 the Trust is now rated as Outstanding overall. Both our Community Physical Health services for adults and our End-of-Life service have been recognised as Outstanding. They join our Learning Disability In-Patients and our Older Peoples Community Mental Health services who also hold an outstanding rating. All our services are now either outstanding or good.

The CQC detailed the following actions that the Trust must take to improve:
Acute wards for adults of working age and psychiatric intensive care wards. The Trust must:

- Ensure that ligature risks are managed appropriately, ensure that patients are kept safe- for example promoting the sexual safety of people using the service, and ensure an alarm system is easily accessible to patients and visitors and that they are made aware of how to use them (Regulation 12)
- Ensure that the ward environment is always adequately furnished and maintained. (Regulation 15)
- Ensure restrictions are necessary and proportionate responses to risks identified for particular individuals (Regulation 13)

Specialist community mental health services for children and young people. The Trust must:

- Continue to work with commissioners to ensure waiting times are not excessive, thereby putting young people waiting to receive treatment at increased risk. Particular attention needs to be paid to ensuring timely access to services for those referred to the attention deficit hyperactivity disorder (ADHD) pathway and autism assessment pathway.

An action plan was submitted to the CQC outlining how we planned to respond to these highlighted areas and the majority of these actions are now complete. All estates related works are now complete, including fitting of a call bell system across the mental health wards. An extensive piece of work is being undertaken to address ADHD and autism waiting times and further information on this is detailed in the 'Other Service Improvements' section (part 2.1.8 above).

Berkshire Healthcare NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2022/23:

1. Joint targeted area inspection of Royal Borough of Windsor and Maidenhead- 9th -13th May 2022

Berkshire Healthcare NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

1. The action plans are held and monitored by the Local Authority, and the Trust will feed into these, and action as required.

Berkshire Healthcare NHS Foundation Trust has made the following progress by 31 March 2022 in taking such action:

1. Actions are being progressed as per the action plans noted above.

The CQC has carried out the following unannounced Mental Health Act (MHA) visits during the 2022/23 financial year:

- Sorrel ward , Rose ward and Bluebell ward- 29th June 2022
- Sorrel ward and Campion ward- 26th September 2022
- Orchid ward and Rowan ward- 15th November 2022

Reports from these MHA visits are reviewed, and action plans produced and monitored.

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 2022/23 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:
99.8% for admitted patient care.
99.9% for outpatient care, and
* 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
* for accident and emergency care

* This data is now being collected through the ECDS and we do not have any concerns in this area as we have consistently achieved >99%.

Information Governance

ⓘ Information Governance requires the Trust to set a high standard for the handling of information. The aim is to demonstrate that it can be trusted to maintain the confidentiality and security of personal information, by helping individuals to practice good information governance.

Berkshire Healthcare NHS Foundation Trust Data Security and Protection Toolkit (DSPT) overall score for 2021/22 was 'Standards Exceeded'. The Score for 2022/23 will be available in June 2023.

The Information Governance Group is responsible for maintaining and improving standards in this area.

Data Quality

Berkshire Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

Berkshire Healthcare NHS Foundation Trust are taking the following actions to improve data quality:

The Trust is using the latest Commissioning Data Set version to send data. Data is continuously monitored, and improvements made where required.

The Trust continues to track the improvement of data quality. An overarching Information Assurance Framework (IAF) provides a consolidated summary of every performance information indicator and action plans. The key messages are shared at all data quality forums and quarterly super user presentations. The six-weekly data quality forum also shares the priorities and audit results with services. A separate In-Patient Data Quality meeting is held bi-monthly. A data quality intranet page, containing all data quality related policies, procedures, training and guides, is available for all staff to access.

Data Quality and Data Assurance audits are carried out throughout the year as part of the IAF, where data issues are identified, and internal action plans are put in place. The data is monitored until assurance is gained so that the Trust can have a high confidence level in the data being reported. The assurance reports and the Performance Scorecard are 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 2022, which showed that 88% of primary and 90.2% of secondary diagnoses were coded correctly. The audit recommendation was to disseminate information amongst all junior doctors, consultants and administrative staff on each ward to ensure timely discharge summaries as per Trust guidelines; and put a strategy in place for areas of non-compliance. The audit report stated that the clinical coding team is undertaking a remarkable role in support of data quality. The next audit is scheduled for November 2023.

2.3.6. Learning from Deaths

ⓘ Many people 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 to prevent recurrence.

The Trust learning from deaths process includes all patients identified on our electronic patient records who have accessed one of our services in the year before death. In most cases these are expected deaths but where a specific trigger is noted (as identified in our policy) we then review these deaths further. The level of review required will depend on whether certain criteria are met, and we review the care provided for all patients who had a learning disability and died.

Figure 32 below details the number of deaths of Trust patients in 2022/23. 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 32- Deaths of Trust patients in 2022/23- case reviews and investigations carried out in 2022/23

	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 2022/23 the following number of Berkshire Healthcare NHS Foundation Trust patients died	By 31st March 2023, the following number of case record reviews and investigations have been carried out in relation to the deaths.			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. *
		1st Stage Case Record Reviews (Datix)	2nd Stage Review (IFR/ SJR)	Case Record Review & Investigation (SI)	
Total 22/23	**456**	**456**	**192**	**31**	**0**
	↓	↓			↓
Mandated Statement	This comprised of the following number of deaths which occurred in each quarter of that reporting period:	The number of deaths in each quarter for which a case record review or an investigation was carried out was:			In relation to each quarter, this consisted of:
Q1 22/23	**119**	**119**	**48**	**9**	**0**
Q2 22/23	**98**	**98**	**37**	**4**	**0**
Q3 22/23	**113**	**113**	**42**	**8**	**0**
Q4 22/23	**126**	**126**	**65**	**10**	**0**

Source- Trust Learning from Deaths Reports *These numbers have been obtained using either Initial Findings Report or Root Cause Analysis methodology.

Immediate learning from all deaths is shared by Clinical Directors and Governance Leads through locality governance and quality meetings. Where the need for more

substantial learning is identified from initial review, actions are taken, and an Internal Learning Review is facilitated by the Patient Safety Team.

Thematic learning from mortality reviews is summarised and circulated to all staff via a trust briefing. The impact of this results in staff being made aware of learning across the Trust.

Figure 33 below details the number of deaths of Trust patients in 2021/22 that had case note reviews and investigations carried out in 2022/23. 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 2021/22. Please note that the table contains statements that are mandated by NHS Improvement for inclusion in the Quality Account.

Figure 33- Deaths of Trust patients in 2021/22 with case reviews and investigations carried out in 2022/23

	1. Reviews and investigations carried out		2. Deaths more likely than not due to problems in care	3. Revised estimate of deaths in 2021/22 that were more likely than not due to problems in care
Mandated Statement	The number of case record reviews and investigations completed after 31st March 2022 which related to deaths which took place before the start of the reporting period (deaths before 1st April 2022)		The number and percentage of patient deaths before the reporting period that are judged to be more likely than not to have been due to problems in the care provided to the patient. (These numbers have been ascertained using either Initial Findings Report or Root Cause Analysis methodology)	The number and % of the patient deaths during 2021/22 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 (SIs)		
Total	**0**	**0**	**0**	**4 (0.1%)**

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 several inherent limitations in the preparation of quality reports which may impact the reliability or accuracy of the data reported.

- Data is derived from many different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Data is collected by many teams across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted.
- In many cases, data reported reflects clinical judgement about individual cases, where another clinician might have reasonably classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years.

Figure 34	2020/21	2021/22	2022/23	National Average 2022/23	Highest and Lowest
The percentage of adult mental health inpatients receiving a follow-up within 72 Hours of Discharge *	N/A	88.3%	**94%**	**Data not yet available**	**Data not yet available**
* Please note that we have replaced the older indicator, relating to 7-day follow up of mental health patients discharged with a CPA, as it is no longer being reported as part of the NHS Oversight Framework. Measurement against this new indicator, which requires mental health inpatients to be followed up within 72 hours (3 days) of discharge, is a key part of the work to support the suicide prevention agenda within the NHS Long Term Plan. The National Confidential Inquiry into Suicide and Safety in Mental Health (2018) found that the highest number of deaths occurred on day 3 post discharge, and this new indicator helps to address this.					
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 72 hours of discharge.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services: The Trust has a good level of compliance with this indicator through the implementation of our policies and procedures relating to discharge.					

Source- Trust Tableau Dashboard

The indicator "The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period" is no longer included as it is no longer required to be reported on as part of the NHS Oversight Framework.

Figure 35	2020/21	2021/22	2022/23	National Average 2022/23	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	6.3%	6.2%	**4.3%**	**Data Not Available**	
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 ensure all admissions are appropriate and/or have greater consideration of their benefits and risks. Review is in place and embedded which takes place within 72 hours (wherever possible) and produces an intended discharge date. This is monitored at the daily bed management team so that plans are checked, and any concerns escalated.					

Source- Trust Tableau Dashboard

Figure 36	2020/21	2021/22	2022/23	National Average 2022/23	Highest and Lowest
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 percentage of staff respondents answering 'yes' to Question 23d 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."	80.1%	77.0%	**76.5%**	**63.6%**	**40.01%-79.6%**
Berkshire Healthcare NHS Foundation Trust considers that this percentage is as described for the following reasons: The Trust's score is better than average, and this is maintained.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of services, by: Implementing a People Strategy that has the overall aim of making the trust a great place to work for everyone.					

Source: National Staff Survey

Figure 37	2020/21	2021/22	2022/23	National Figures 2022/23	Highest and Lowest
Patient experience of community mental health services indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period	7.3	7.2	**6.7**	**6.1**	**7.8**
Berkshire Healthcare NHS Foundation Trust considers that this score is as described for the following reasons: The Trusts score is in line with other similar Trusts.					
Berkshire Healthcare NHS Foundation Trust has taken the following actions to improve this score, and so the quality of services, by: Being committed to improving the experience of all users of their services. Data is collected from several sources to show how our users feel about the service they have received. Actions are put in place through several initiatives to improve both an individual's experience and if required to change the service provision.					

Source: National Community Mental Health Survey

Figure 38	2020/21	2021/22	2022/23	National Figures 2022/22	Highest and Lowest
The number of patient safety incidents reported	**5510** *	**7790** *	**Data not yet available** *	**Data not yet available** **	**Data not yet available** **
Rate of patient safety incidents reported within the Trust during the reporting period per 1000 bed days	**62.7** *	**84.7** *	**Data not yet available** *	**Data not yet available** ** (Median)	**Data not yet available** **
The number and percentage of such patient safety incidents that resulted in severe harm or death	**37 0.7%** *	**36 0.5%** *	**Data not yet available %***	**Data not yet available** **	**Data not yet available** **
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. 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.					

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 Organisation Patient Safety Incident Report covering 3 months between X-X relating to 50 Mental Health Organisations Only

Part 3. Review of Quality Performance in 2022/23

ⓘ In addition to the key priorities detailed in Part 2 of this report, the Trust Board receives monthly performance 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 and include performance against relevant indicators and performance thresholds. Information relating to specific areas of Trust quality and safety performance is detailed below.

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).

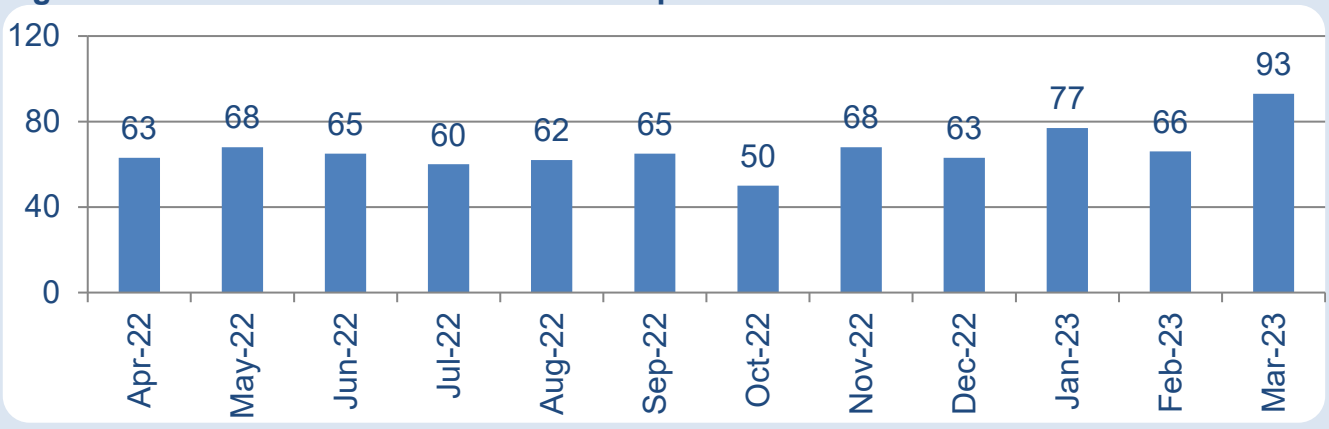
Figure 39 below details the total number of medication errors reported per month. When interpreting this figure, it should be noted that a high and increasing rate of medication error reporting is a sign of a healthy learning culture in the organisation and that reporting of such errors is being encouraged as the first step in ensuring that a robust safety culture exists.

The data reported also includes all the near misses and documentation errors, so they are not all actual incidents. There is also evidence to suggest that not all incidents and near misses that staff acted upon were reported, so any increase may be due to better reporting culture rather than a less safe organisation.

There were five medication errors during 2022/23 that led to moderate patient harm, and a summary of the learning points from these is given below:

- Drug chart will be reviewed in full at every Multidisciplinary Team meeting.
- Training on monitoring and escalating issues relating to diabetes is being delivered by the diabetes nurses.
- Physical health monitoring of clozapine patients.
- Face- to- face presentation and training on lamotrigine and a lamotrigine template added to the trusts electronic prescribing system (ePMA).
-

Figure 39: Number of Medication Errors Reported Each Month



Source: Medicines Safety Quarterly Report

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 can leave the ward without permission.

Figures 40 and 41 below detail the number of absconsions on a Mental Health Act Section and the number of patients absent without leave on a Mental Health section.

Figure 40- Absent without leave (AWOL) on a Mental Health Section- (Rolling quarters)

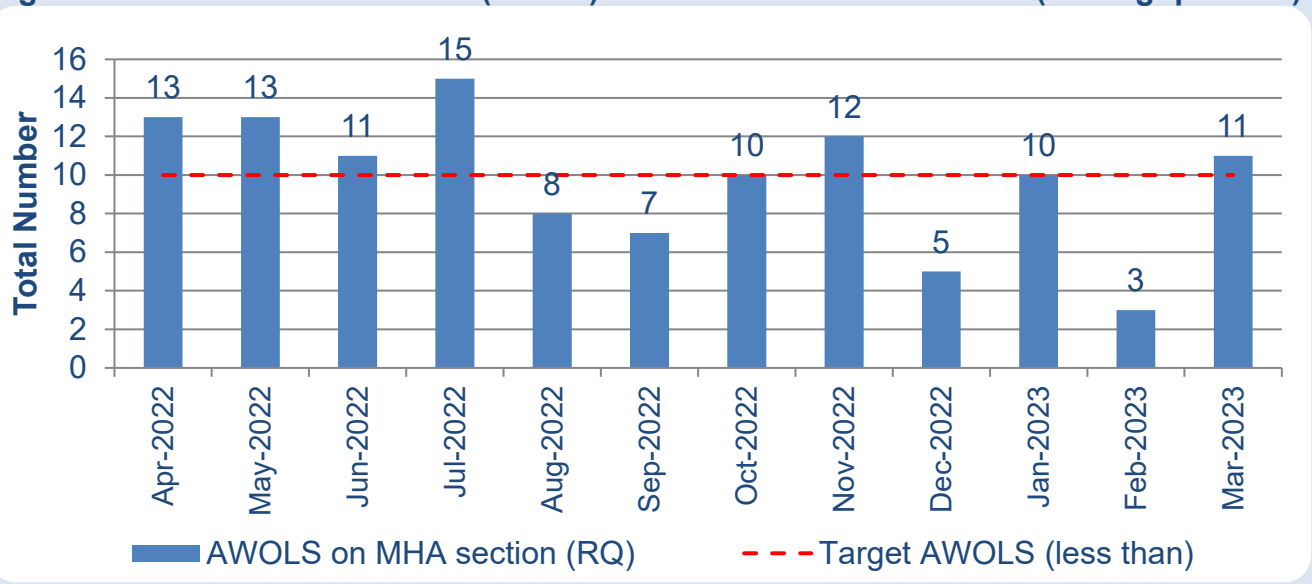
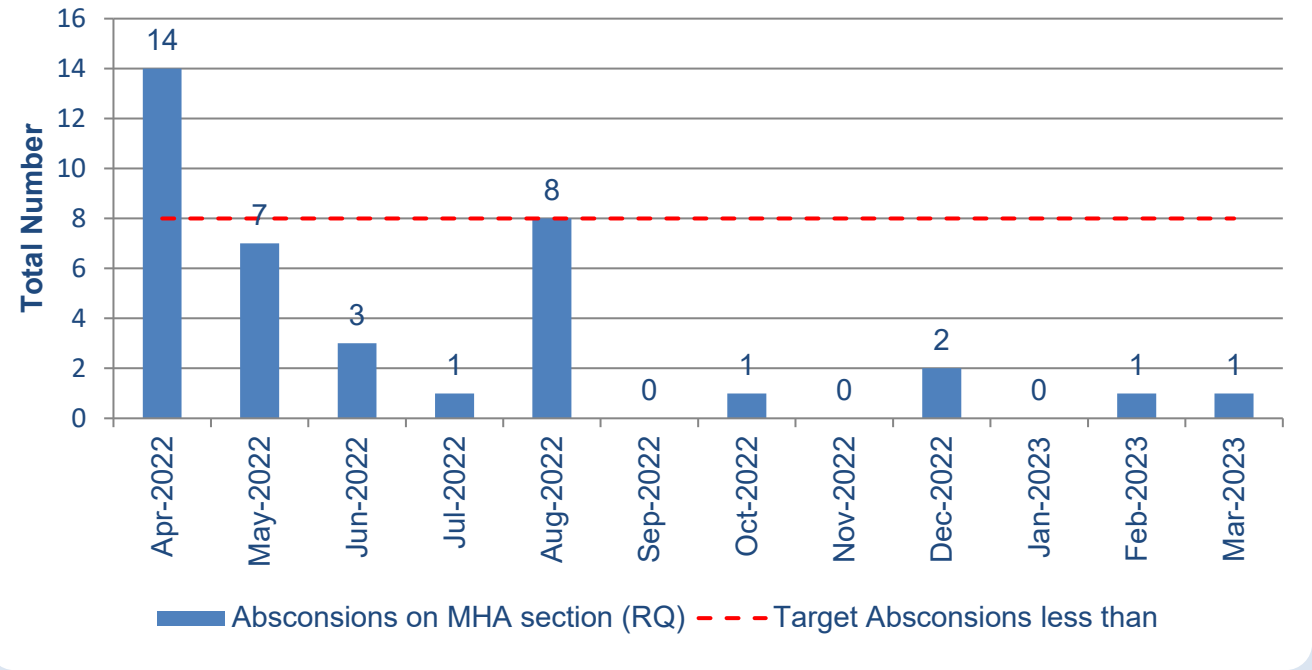


Figure 41- Absconsions on a Mental Health Act (MHA) Section- (Rolling Quarters)



Source- Trust Tableau Dashboard

Other Quality Indicators

Figure 42- Other Quality Indicators	Annual Target	2020/21	2021/22	2022/23	Commentary
Patient Safety					
Never Events	0	0	0	**1**	Total number of never events
Infection Control- MRSA bacteraemia	0	0	1 (No Lapse in care)	**0**	Total number of MRSA Cases Source- Trust Infection Control. Report.
Infection Control- C. difficile due to lapses in care	<6	1	3	**2 (0.020 per 1000 bed days)**	Total number & rate per 1000 occupied bed days of C. Diff due to lapse in care by Trust. Source- Trust Infection Control Report
Medication errors	N/A	761	691	**800**	Total number of medication errors reported. Source- Trust Medicines Management Report
Inappropriate out-of-area placements (OAP) for adult mental health services (Occupied Bed days as OAP)	Reduce as per Target	211 (Target not met)	194 (Target not met)	**129** (Target not met)	Average monthly total bed days spent out of area
Mental Health minimising delayed transfers of care (Relates to Mental Health delays only- Health & Social Care).	<7.5%	4.5%	3.6%	**9.3%**	Average monthly %. Calculation = number of days delayed in month divided by Occupied Bed Days in month.
Clinical Effectiveness					
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	60%	93.9%	81.6%	**91.4%**	Average monthly %

Figure 42- Other Quality Indicators	Annual Target	2020/21	2021/22	2022/23	Commentary
Improving access to psychological therapies (IAPT): proportion of people completing treatment who move to recovery	50%	55.5%	53.6%	**49.6%**	Average Monthly %
People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral	75%	96.9%	97.7%	**94.8%**	Average monthly %
People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral	95%	100%	100%	**100%**	Average monthly %
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	97.7%	99.1%	**99.3%**	Average monthly %
Patient Experience					
Community Paediatric Service- Referral to Treatment waiting times (RTT)- Incomplete pathways	95% <18 weeks	99.5%	98.4%	**99.6%**	Average monthly %
Diabetes Service- RTT- Incomplete pathways	95% <18 weeks	99.7%	100%	**100%**	Average monthly %
Complaints received		213	231	**240**	Total number of complaints
Complaints acknowledged within 3 working days	100%	99.6%	99.0%	**99.2%**	% meeting requirement
Complaint resolved within timescale of complainant	90%	99.7%	100%	**99.6%**	% meeting requirement

Source- Trust Tableau Dashboard except if indicated in commentary.
*Please note that metrics relating to admissions to adult facilities for patients under 16 years old and the Data Quality Maturity Index are not detailed as they are no longer part of the NHS oversight framework

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 2022/23 and supporting guidance detailed requirements for quality reports 2022/23
- 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 2022 to May 2023
  - papers relating to quality reported to the Board over the period April 2022 to May 2023
  - feedback from commissioners dated April 2023
  - feedback from governors dated April 2023
  - feedback from local Healthwatch organisations dated April 2023
  - feedback from Overview and Scrutiny Committees dated April 2023
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2023
  - the 2022 national patient survey, November 2022
  - the 2022 national staff survey, March 2023
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated May 2023
  - CQC inspection report dated March 2020
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- the performance information reported in the Quality Report is reliable and accurate.
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review, and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

[DATE] **Martin Earwicker, Chairman**

[DATE] **Julian Emms, Chief Executive**

Appendix A- Annual Plan on a Page

Annual Plan on a Page- 2022-23

Annual Plan on a Page 2022/23

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

Harm-free care

Providing safe services

- We will protect our patients and staff from getting COVID-19 by using appropriate infection control measures
- We will identify and prioritise patients at risk of harm resulting from waiting times, and always ensure face to face care where clinically indicated
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on our in-patient wards
- We will improve the physical health of people with serious mental illnesses
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and to facilitate learning from incidents

Supporting our people

A great place to work

- We will ensure our teams have access to effective health and wellbeing support
- We will promote a culture of respect, compassion and kindness
- We will not tolerate bullying, harassment or abuse of any kind
- We will support staff to work flexibly and connect with their teams
- We will act on feedback from staff in order to further improve satisfaction and address any identified inequalities
- We will provide opportunities for staff to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas
- We will support staff to achieve their career aspirations

Good patient experience

Improving outcomes

- We will reduce the number of patients waiting for our services
- We will identify and address inequality of access to services and improve outcomes
- We will collect more patient and carer feedback and use this to deliver improvements in our services

Money matters

A financially sustainable organisation

- We will work as a team to manage within the financial plan for our service
- We will work as a team to identify and deliver improved productivity

With our health and care partners: We will work in partnership with **our health and social care partners to address Health Inequalities and to collaborate on the redesign of services to provide better and more efficient care.**

Annual Plan on a Page- 2023-24

Annual Plan on a Page 2023/24

NHS
Berkshire Healthcare
NHS Foundation Trust

Our mission is to maximise independence and quality of life
Our vision is to be a great place to get care, a great place to give care

Harm-free care
Providing safe services

- We will protect our patients and staff by using appropriate infection control measures
- We will identify and prioritise patients at risk of harm resulting from waiting times
- We will ensure face to face care where clinically indicated
- We will continue to reduce falls, pressure ulcers, self-harm in in-patient services and suicide across all of our services
- We will recognise and respond promptly to physical health deterioration on all our wards
- We will improve the physical health of people with serious mental illnesses
- We will strengthen our safety culture to empower staff and patients to raise safety concerns without fear, and ensure learning from incidents

Good patient experience
Improving outcomes

- We will reduce length of time patients wait for our services, year on year (compared to 2022 waits)
- We will make every contact count by offering advice in making healthy choices
- We will identify and address inequality of access to services
- We will gain feedback from at least 10% of our patients in each service and demonstrate service improvements based on the feedback

Supporting our people
A great place to work

- We will ensure our teams have access to effective health and wellbeing support
- We will promote a culture of respect, compassion and kindness
- We will not tolerate bullying, harassment or abuse of any kind
- We will support staff to work flexibly and connect with their teams
- We will act on feedback from staff to improve satisfaction and address identified inequalities
- We will provide opportunities for staff to show initiative and make improvements through great team working, Quality Improvement and Bright Ideas
- We will support staff to achieve their career aspirations
- We will attract and welcome school leavers, apprentices, students and international recruits to help close our workforce gaps

Efficient use of resources
A financially and environmentally sustainable organisation

- We will achieve our financial plan
- We will improve our productivity, returning to pre-pandemic activity levels or better
- We will take action to reduce our environmental impact

With our health and care partners: We will work with our health and social care partners to provide **better and more efficient care.**

Appendix B- National Clinical Audits- Actions to Improve Quality

National Clinical Audits Reported in 2022/23 and results received that were applicable to Berkshire Healthcare NHS Foundation Trust

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
National Clinical Audit and Patient Outcomes Programme (NCAPOP) Audits			
1	National Audit of Care at End-of-Life audit (NACEL)	This is the third year of the audit which is open to all acute and community organisations providing inpatient services. It focuses on patients who were expected to die in hospital. It is based upon best practice defined in the following documents:- One Chance to get it Right, Leadership Alliance for Care of Dying People, 2014.- NICE Quality Standards 13 &144 -Care of Dying Adults in the Last Days of Life, 2017.	Agree and formalise a rapid discharge home procedure within an appropriate guidance.- Inpatient lead to cross-reference the End-of-Life care plan to see if references Gold Standard Framework for End-of-Life.- Managers to inform all staff that the care plans link to End-of-Life to improve understanding of the Governance section of the audit.- Inpatient lead to liaise with Chaplain lead to discuss how and when to seek support for religious preferences.- Review staff survey key areas at team level with staff to understand the true picture and if there really are any issues that need further action.
2	National Clinical Audit of Psychosis – Early Intervention in Psychosis	The NHS Long Term Plan and the NHS Mental Health Implementation Plan 2019/20 - 2023/24 set new targets for access to a NICE-approved care package within 2 weeks of referral for people experiencing first episode psychosis and achievement of NICE concordant treatment by EIP services. It built on the requirements of the original Early Intervention in Psychosis Access and Waiting Time Standard (NHS England, NICE & NCCMH, 2016).The audit standards are based on the NICE quality standards in relation to treating and managing psychosis (NICE QS80, 2015; NICE QS102, 2015), and the Early Intervention in Psychosis.	Additional training for point of care machines, and venepuncture training for identified staff.- A Standard Operating Procedure will be in place to ensure that all staff know how to complete the Rio Physical Health and Lifestyle Form.- The tableau report for physical health data will be reviewed monthly- Clinical Governance Leads will work with the service leads to develop the supervision tableau system to ensure Family Intervention (FI) is visible and can be embedded through monitoring in monthly clinical supervision.- Clinical Director to attend Business meeting to raise FI requirements- Undertake a Review of the FI training.- Put in place Monthly Scrutiny review of FI outcomes from Tableau through clinical supervision.- Undertake an audit in six months' time (data collect October 2022) on these standards to ensure that implementation of actions has improved practice.

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
3	National Diabetes Footcare audit (NDFA) Interim report	The National Diabetes Team published an interim report in June 2022 about diabetic foot ulcers in England and Wales that occurred between 14 July 2014 and 31 March 2021. No local reports were released for local services to review. Ulceration of the foot in diabetes presents significant challenges to people with diabetes and the overall aim of the NDFA is to measure factors associated with increased risk of ulcer onset and adverse ulcer outcomes. It aims to share information relating to best clinical practice, and to enable the highest quality of care of diabetic foot ulcers in England and Wales.	The two key recommendations from the National report were applicable to Berkshire Healthcare's Podiatry community service: 1. Ensure that Healthcare Professionals (HCPs) arrange early expert assessment of all new foot ulcer episodes- Our podiatry team has early expert assessment of new foot wounds and can evidence this by our urgent wait list data (9 days currently) and we promote to other HCP's that foot wounds are referred as an urgent referral to Podiatry service. 2. Ensure that healthcare providers and HCPs review NDFA measures for their organisations, including time to First Expert Assessment (FEA), ulcer severity at FEA and 12-week outcomes- A dashboard is being developed by the National Team so that services can access their local data and these outcomes. In the meantime, this area is being reviewed between the podiatry service and the clinical audit department. National team to report in 2023
4	NCEPOD Report: A Picture of Health? Bridging the gap between physical and mental healthcare in adult mental health inpatient settings	National Report published in May 2022. The criteria for inclusion were patients aged 18 years and older who were admitted to a mental health inpatient setting for a period of more than one week from 1st Nov '18 to 31st Oct '19, and who had one or more of the following physical health conditions recorded on discharge: • Chronic obstructive pulmonary disease/asthma • Cardiovascular disease • Diabetes. Five key messages were reported which aim to improve the care of people admitted to a mental health inpatient setting who are also physically unwell.	Review physical health admission protocols for medical and nursing staff to identify care planning step within this process. Explore development of existing electronic systems that can support clinicians in access to up-to-date accurate information re a patient's physical health on admission. Develop a comprehensive standard work for transfers to and from and readmissions from an acute hospital to include the recommendations from this audit. Include in carers contact standard work sharing information re the persons physical health assessment, healthy lifestyles and how to support good physical health.

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
5	National Asthma and COPD audit programme – Pulmonary Rehab organisational report – July 2022	One in five people in the UK have a long-term respiratory illness, and one of the most common is chronic obstructive pulmonary disease (COPD). For people living with COPD, pulmonary rehabilitation (PR) can be a crucial part of their treatment, with 90% of people who complete a PR programme reporting an improved quality of life.	This report aims to show how PR services are currently organised and help to identify variation. Data was collected between 1 Nov and 3 Dec 2021 on the resourcing and organisation of services delivering pulmonary rehabilitation to people with COPD. No Actions were required against the reported organisational outcomes
6	National Diabetes Core audit – Care Process & Treatment Targets annual report – July 2022	The National Diabetes Audit (NDA) measures the effectiveness of diabetes healthcare against NICE Clinical Guidelines and NICE Quality Standards. It collects and analyses data for use by a range of stakeholders to drive changes and improvements in the quality of services and health outcomes for people with diabetes.	Set up service audit to track change in patients' HbA1c between first visit within the last year to specialist diabetes service and 6-12 months later (Tracker metric)- Identify demographics of patients who are not progressing to direct strategies to support any groups identified, e.g., obesity, mental health, ethnicity, locality.- Increase the appropriate use of technology as per NICE Guidance.- Audit HbA1c of patients with Type 2 diabetes in East Berkshire.- Diabetes Service to set up practice visits to all GP practices in East Berkshire.
7	National Audit of Dementia Memory Services Spotlight Audit Report 2022	This spotlight audit is aimed at community-based memory services. It included a patient level audit of case notes that focussed on waiting times, access to assessments, treatment and post diagnostic support for people with dementia. There was also an organisational checklist which provided contextual data about the service.	Re-introduce a letter to patients and carers acknowledging receipt of referral and indicating the expected wait for an initial assessment.- Older Peoples Mental Health (OPMH) special assessment form to be updated to include prompt on falls history & rolled out across localities. A further prompt added to ask about confidence in mobility.- Review specialist assessment form and options to include a tick-boxes to indicate where there are problems with eyesight or hearing.- Fully implement new dementia pathway.- Wokingham & Newbury services to put in place more consultant time.- Slough service to utilise NHS Professional shifts to offer additional evening and weekend clinics.

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
Non- NCAPOP Audits			
8	Prescribing Observatory for Mental Health (POMH): Prescribing for Depression in adult mental health services	This is a re-audit with practice standards derived from NICE guideline CG90 depression in adults: recognition and management (2009) and the British Association for Psychopharmacology guideline for treating depressive disorders with antidepressants. NICE guidelines for the management of depression propose a 'stepped-care' approach to the treatment of depression based on clinical criteria and treatment needs.	- Audit results to be shared at East and West Performance Meetings and through the academic meeting - Introduce EPRO use across localities if not already in use and adhere to agreed headings - Audit results to be shared at medical staffing committee- Email reminder to be circulated to support this message - Audit results to be shared at Mental Health Localities Meeting and Service Managers to remind staff to complete the proforma - Add substances as a heading on the Follow Up template with smoking - Staff to be reminded, through Mental health Localities meeting and team meetings to use rating scales, including a demonstration of where these scales are stored on RIO - To ensure that the new CPA form has a direct link to the appropriate rating scales.
9	National audit of Inpatient Falls annual report 2022	The National Audit of Inpatient Falls (NAIF) is part of the Falls and Fragility Fracture Audit Programme (FFFAP). It aims to improve falls prevention and post-fall management across the NHS.	All eight national recommendations have been reviewed by the Falls Lead who is also the Deputy Director of Allied Health Professionals. One recommendation, relating to post-falls checks, requires further review to ensure that we are meeting it, and this will be progressed by the Lead. We have a robust policy in place for post-fall injury checks using the I-STUMBLE falls assessment tool and will prioritise this recommendation for review, to ensure this happens. The facilities audit will need to be checked when completing the post-fall check as competency training is not mandatory but is essential on the new matrix.

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
10	Board request- Re-audit of NCAP Early Intervention in Psychosis (EIP) national audit 2022	This audit relates to the National Clinical Audit of Psychosis - EIP spotlight audit. The EIP service has been re-audited annually for the last 4 years. The last round of this audit in 2021/22 identified two standards where the trust was performing as a potential outlier nationally. These areas required improvement.	Family Intervention: All actions relating to this area on the action plan have now been completed. Four staff are receiving systemic family intervention training with a further 14 staff booked to complete in-house behavioural family intervention training. The re- audit has shown an improvement which would enable the service to return to the "performing well" category for this standard in the next national audit. Family Intervention is a tracker metric for the team, and barriers to the offer and its uptake are being monitored. Physical health checks: All actions relating to this area on the action plan have now been completed. The tableau dashboard shows the current state and identifies clients who are due for their annual check. Physical health checks are the driver metric for the EIP team and are discussed weekly as part of the QMIS huddle.
11	POMH: 1h&3e: Prescribing High-dose and Combine Antipsychotics audit report 2022	The audit aims to benchmark the prescribing behaviour of antipsychotic medication in acute adult, complex needs and forensic inpatient wards. The definition of "high dose" includes when a single antipsychotic medication dosage is above the licensed daily maximum prescribed. "Combined dose" refers to instances where two or more antipsychotic medications are prescribed to be taken, instead of a single antipsychotic medication dosage. "PRN" antipsychotic prescriptions were for people with psychosis who take medication as required to manage acute clinical presentations, such as disturbed behaviour and agitation.	To review trust guidance for the Prescribing of High Dose Antipsychotics and include these standards within this. To be clearer within the guidance re the taking of plasma prolactin levels on admission and include in admission protocol. To share learning from this audit with consultant group. To explore with electronic prescribing (EPMA) team the possibility of making reason for PRN mandatory. To ensure the Multi-disciplinary Team (MDT) template prompts a discussion re PRN medication and this is documented in patient's clinical record as part of the meeting. To share learning from this audit with consultant group, Pharmacists and nursing staff.

National Audits Reported in 22/23		National Audit Aim/ Objectives	Actions to be Taken
12	NACAP – 'Drawing Breath' – National Asthma and COPD National report - Local Summary report against National recommendations (no Berkshire Healthcare local data)	NACAP's key goal is to improve care for people with asthma and COPD. The audit aims to improve provision of early and accurate diagnosis; improve provision of timely care; improve provision of care received from the right people; empower people with asthma and COPD and their carers by providing joined-up care pathways and high-quality information; and minimise variation in care contributing to health inequalities	- Increase the community venue hire for pulmonary rehabilitation (PR) sessions per locality by 6 hours per week and increase class size from 4 to 6 patients. This will allow the programme size to increase by 6 patients per cohort and further reduce the waiting list. In addition, to have an "Initial Assessment Day" in each area to increase the total number of Initial Assessments by 9 patients per week. Improve the quality of the Initial Assessment - Be able to invite patients from the waiting list to attend if there is a cancellation at short notice. Allow for an assessment slot to be saved for patients who have had an acute exacerbation of COPD (AECOPD) to access Pulmonary Rehab within 30 days. - Recruitment of: 1WTE Respiratory Physiotherapist and 1WTE Integrated Rehabilitation Assistant. - Fast track process for patients with AECOPD. Immediate contact from Respiratory Physio following triage of referral. 1 initial assessment slot per locality reserved each week for these patients. Update Standard Operating Procedures. - Provide a virtual option of PR for those patients that are unable to attend a group session. - Develop the aerobic exercise component of PR: Initiate walking programme for patients to follow independently at home during their time on the programme. Prioritise the Endurance Shuttle Walk Test (ESWT) during the class time. Create a rota of patients that will need to prioritise the ESWT during the class. Utilise the exercise bikes present at venues with suitable patients.

Appendix C- Local Clinical Audits- Actions to Improve Quality

	Audit Title	Aim/Actions
1	(7015/CA) - Wound Care Audit	There has been a recent rise in the risk of pressure ulcers being reported by Berkshire Healthcare staff, for which classifications are incorrect. Documentation, as per root cause analysis, has also highlighted that there are inconsistencies in paperwork and record keeping. The aim of this audit to provide harm free care to patients in Berkshire Healthcare Objectives: - To standardize wound care and pressure ulcer assessment - To standardize documentation - To provide evidence-based practice to staff - To ensure the Trust is working to National Targets and providing basic care to patients - To ensure timely intervention - To reduce wound deterioration through early identification and intervention of assessment. Areas for improvement include implementation of wound care plans once a wound is identified, with supporting photographs to be taken on admission and discharge. Staff will be encouraged to complete when required as a standard of care for all patients admitted as an inpatient. These areas can now be targeted as part of training which is available for all staff. Staff on Jubilee ward will be encouraged to attend to improve knowledge and awareness. Tissue Viability Nurse presence on the ward to complete face to face assessment, provide recommendations for patients referred to the service, and prompt completion of accurate documentation. There will also be a discussion with Ward Managers to improve standards.
2	(7088/CA) – Review of local procedures for young people accessing sexual health services	The 2019 CQC inspection identified that sexual health was not collecting data to evidence practice. Our commissioners asked the sexual health service to compile and audit all young and vulnerable patients to ensure best practice and safeguarding for anyone attending the service. The aim of the project was to keep the young people of East Berkshire as safe as possible whilst navigating the world of sex and relationships. Objectives: - To ensure all clinicians are adequately trained to ask questions and assess the needs of our young population - To ensure all clinicians are and are adhering to the national guidelines for safeguarding in sexual health. Action Plan- To continue monitoring all young people coming through the service using the data collection sheet on an ongoing basis - To update any questions on the data collection sheet as the guidance changes - To continue providing monthly safeguarding supervision and continually work on improving the training and understanding of safeguarding.

	Audit Title	Aim/Actions
3	(7525/CA) - Deep Vein Thrombosis (DVT) Protocol Audit	National and local policy utilised by the WestCall GP Out of Hours Service specifies that a Wells score should be performed before a d-dimer blood test and that the Wells score should always be performed after a physical examination excluding patients with leg swelling or pain. The aim of the project was to ascertain the current level of WestCall performance for DVT management against national guidelines. Objectives:1. To determine the rate clinicians utilise the Wells score before performing a d-dimer in patients with suspected Deep Vein Thrombosis (DVT). 2. To determine the rate of starting on an anticoagulation therapy and appropriate onward referral. 3. A review of the current paperwork that knowledge in the area is up-to-date and utilised appropriately in the clinical setting. Action plan -To share the findings and discuss with primary care. Liaise with AdAstra to add this as a drop-down menu option, ensure all clinicians are aware once it has been added- Audit findings circulated to all staff and staff informed of the standards to be maintained. Review of the current paperwork and adaption/design of new paperwork. All staff across WestCall informed of the new procedure to ensure this is adhered to. Leaflet agreed for use and distributed to PCC's. Staff made aware of leaflets. Ensure front of house staff are trained to teach patients and relatives technique.
4	(7724/CA) - Audit of Ages and Stages Developmental Reviews in Health Visiting Services 2021	The Ages and Stages Developmental Reviews (ASQ's) are a necessary and mandated component of the Healthy Child Programme (2009) and are completed by the health visiting service at 9-12 months and 2-2.5 years. It is necessary for assurance that the reviews are delivered in a meaningful and thorough way, ensuring record keeping, scoring and onward referrals/plans of support are carried out. The aim of the audit is to establish through a large-scale audit whether the ASQ developmental reviews are being conducted and completed in a consistent manner and will identify any current areas of concern or celebration. There is expected to be an action plan and training as part of the recommendations. The key actions from the audit were: 1. Length of appointment to be standardised. 2. Include completion of the SE questionnaire as part of the universal 2-year review and wherever else it is appropriate. The changes to the embedded form available on RiO, which are being carried out as part of the service transformation, will continue to include this information, and will be reported on. 3. RiO progress note template will reiterate the importance of documenting whether additional support or onward referrals are required. Further support and training for staff to ensure this is discussed. 4. Ensure weight and height (at 2-year reviews) are captured for each contact. Further support and training for staff to ensure this is carried out as standard as part of the developmental review.

	Audit Title	Aim/Actions
5	(8165/CA) - BASHH SAS Doctors' Group National Clinical Audit: Impact of COVID on Syphilis	This clinical audit is based on the British Association for Sexual Health & HIV (BASHH) Staff, Associate Specialist & Specialty (SAS) Doctors group who conducted a national audit focusing on the management of syphilis following a previous National Audit Group (NAG) audit in 2017. Aims: 1. To assess performance against auditable outcomes specified in 2015 guidelines 2. To assess the impact of the covid-19 pandemic Objectives: 1. A survey comparing clinic policy and practice pre- and during the pandemic 2. A case-note review of the last 30 adults (≥16) per clinical service diagnosed with syphilis. No Actions required against key outcomes
6	(8645/CA) - BASHH National Audit of HIV Post-Exposure Prophylaxis (PEP) pathways (2021)	This audit is intended as a baseline to inform future guidance about Post-Exposure Prophylaxis for HIV (PEP) provision, especially whether and in what circumstances to use “starter packs”. Aim: to improve the completion of PEP among individuals Objectives - To assess the completion of PEP among individuals initially dispensed with full courses or starter packs - To determine whether any cases not completed were clinically appropriate. Action Plan 1. Reminder on the proforma in electronic patient record for new version of Lille to ensure baseline HIV test is performed on all patients being prescribed PEP. 2. Teaching session on revised BASHH guidelines. 3. Add patients to the recall list for follow up at 4 months of initial presentation. Health advisors will then contact/text patients to ensure testing either by attending clinic or online testing. 4. Teach clinicians to add reminder on recall list.
7	(9154/CA) Audit of pulse assessment prior to AChEI initiation at Windsor Memory Clinic	This audit aimed to evaluate current prescribing practice against Maudsley’s recommendations under NICE guidelines (NG97) to see whether routine baseline pulse checks had been carried out and documented for patients started on acetylcholinesterase inhibitors (AChEI) in the Windsor locality. Key Recommendations/ actions: The pulse should be recorded and documented on the RiO patient record for all patients commenced on AChEIs to ensure the patient’s safety and to keep up with the good clinical practice. All new staff involved in patient care must be made aware of the protocols and the guidelines at the time of induction.

	Audit Title	Aim/Actions
8	(7062/SE) - Outcomes of a compassion and resilience-based staff support groups during the COVID-19 pandemic	This project reviewed healthcare professionals stress during the COVID-19 outbreak and provided recommendations to create opportunities for staff support in the organisation to help prevent mental health concerns among healthcare professionals using problem- based peer support groups to help reduce work- related stress. - Aim: To explore if the compassionate peer support groups (with a focus on COVID-19) improves staff coping and resilience and to find out their experience of the groups. Recommendations/Actions. 1. Groups carry on 2. Include mindfulness 3. Permission to take a break- encouraging breaks and time for yourself (taking the breaks you are entitled to) 4. Support staff to structuring breaks 5. Future research- looking at burnout, fatigue for staff working with people with learning disabilities 6. Share with service managers and at best practice forum
9	(7223/SE) - Experiences of online video meetings of service providers working with BHFT to support people with learning disabilities	The global pandemic resulted in adaptations in the way people work, including those who provide care for others. This project aims to explore the experiences of online video meetings held on Microsoft Teams and One Consultation of service providers working with Berkshire Healthcare NHS Foundation Trust to support people with learning disabilities. Key Recommendations/Actions: • A re-audit would be useful once restrictions are eased or the COVID-19 pandemic ends. • Continue to limit face-to-face meetings where there is a significant risk of COVID-19 or there is an infection control risk • Using a hybrid approach between both face-to-face and online meetings may be useful where clinical practise allows for it, as there have been identified benefits and drawbacks. • The development of a set of questions may be useful to support deciding if a meeting is more useful to take place online or in person. This could be used service-wide to assist clinicians in ensuring they have identified if there may be overlooked barriers to a meeting taking place in either medium.

	Audit Title	Aim/Actions
10	(7366/SE) - Young peoples' experiences of transitioning from child to adult mental health services	This service evaluation explores the transition process for young people going into adult services, to determine the extent to which it is patient-centred and empowers patients to take part in the formulation of their needs. Aim: to explore the experience of young people transitioning from children to adult mental health services Objectives: - To determine patient satisfaction with the transition care pathway - To identify ways which can improve the transition process for future patients Recommendations/Actions. 1. Child and Adolescent Mental Health Services (CAMHS) and Adult Mental Health Services (AMHS) should collaboratively develop transition care plans, including discharge arrangements, medical reviews, and coordination of any ongoing therapeutic interventions to avoid gaps in transition. 2. AMHS should assign a key worker in advance who can be involved in the transition process to ensure key information is shared and work with the young person and family to clarify any concerns about the process. 3. Staff should ensure they offer patient-centred care that respects young people's experience, values, needs and preferences in the planning, coordination, and delivery of care. Managers must use case management supervision sessions for auditing and ensuring that staff involve patients in transition discussions. 4. Young people who require long-term care must be identified one year in advance and no less than six months before AMHS transition. Key information should be shared, including patient history, formulation, medication needs, engagement, and progress within CAMHS. CAMHS and AMHS should offer joint reviews with the young person and their family within the agreed time before the transition to AMHS including a jointly produced guide to transition for the young people and their parents and carers. 5. AMHS should identify a key worker in advance who can attend the transition care plan meetings with CAMHS and the young person and their careers. 6. There should be a shared protocol between CAMHS and AMHS, and CAMHS should consider the possibility of adopting a mentoring scheme where young people who have transitioned to adult services may offer help and support to new arrivals.
11	(8612/SE) - Paediatric repeat GA procedures for dental extractions in Community Dental Services	This service evaluation will determine whether repeat General Anaesthetic (GA) was performed following the Royal College of Surgeons clinical guidelines within Berkshire Community Dental Service (BCDS), at Wexham Park Hospital (WPH) and the Royal Berkshire Hospital (RBH).Aim: To assess the rates of repeat GA within our service and determine whether any changes are required to reduce these numbers. Objectives:- To assess total numbers of children seen on BCDS GA lists between 2015-2020, including numbers of teeth, average age ranges and further overall analysis of data- To identify all children for whom there was a repeat GA procedure for dental care and potential reasons or themes that may have led to this No Action required

	Audit Title	Aim/Actions
12	(9164/CA) - Referrals for FPMs to Orthodontists by Community Dental Services (CDS)	A clinical audit to establish the quality and appropriateness of referrals regarding First Permanent Molars (FPMs) by Community Dental Services (CDS) based on two guidelines: The Royal College of Surgeons and the Thames Valley Orthodontic Network. Aim: To ensure that only appropriate, high-quality referrals are made to reduce waiting lists. Objectives: 1. Assess quality of referrals made based on the guidelines above 2. Assess appropriateness of referral based on the guidelines above 3. Ensure all factors are considered and written down in the patient notes before referrals are made. 4. To make dental officers more confident with their knowledge of FPM extraction guidelines Action Plan 1. Presentation at quarterly staff meeting as a refresher of local and Royal College of Surgeons guidelines. 2. Compliance section to be added on to the proforma for dentists to tick. 3. Reason for referral section to be added on to the proforma for dentists. 4. Presentation at quarterly staff meeting as a refresher of what to include in the radiographic report. 5. FPM section to be added on proforma for all dentists to complete at the time of referring.
13	(9283/CA) - Re-Audit of The Quality of Review Health Assessments (RHA's) for Children and Young People in Care 2021/22	This is a re-audit of review health assessments for children and young people in care audit 20/21 (ID 8413). It is a requirement under the Looked after children and safeguarding reporting schedule for the Children and Young People in Care Team. Recommendations/actions: • All staff completing RHAs will be reminded to use the most up to date RHA form and this can be accessed via the service shared drive. • The following will be incorporated into the level 3 children in care training provided for all staff undertaking review health assessments. The following should be recorded on the RHA. o The Social Worker should be contacted for an update prior to the RHA. If the Social Worker does not respond, then the practitioner should email the relevant Local Authority's contact email. o Information from other health professionals should be gathered and recorded on the RHA. If the child is in receipt of one of these services and it is provided by BHFT then the information will be available on RiO. If not, then the practitioner will be required to obtain this information from the relevant health professional. o The Strengths and Difficulties Questionnaire should be available and if not, the reason recorded. This should be requested from the Social Worker if it is not available. o If the child has an Education and Health Care Plan (EHCP) and it is not available on RiO then the EHCP coordinator should be contacted and asked to obtain the most recent versions. o All recommendations should have a timescale scale for completion and a named person. "Ongoing" should not be recorded for a timeframe for completion. o Substance use should be included on all RHAs for over 11s unless this is inappropriate to ask e.g. special education needs. • The service manual for completing RHAs will be updated. • Further advice on the use of the Drug Use Screening Tool will be discussed with the Alcohol and Drug Usage services to ascertain if any improvements need to be made.

	Audit Title	Aim/Actions
14	(7011/SE) - Evaluating the efficacy of CBT for Health Anxiety (HA) and OCD adapted for online delivery in the context of Covid-19	There are concerns regarding the potential effects of the Covid-19 pandemic on the population's mental health. Given the high levels of uncertainty that people have had to live with it is unsurprising that there has been an increase in worries related to cleanliness / contamination and the possibility of falling ill. This is particularly the case for individuals experiencing Health Anxiety (HA) and Obsessive-Compulsive Disorder (OCD). During this time there has also been a significant change to the way that traditional psychological therapies have been delivered, with most services delivering therapy remotely, either through telephone or video consultations. This study therefore aimed to find out how well Cognitive Behavioural Therapy (CBT) for HA and OCD, delivered through a combination of video consultations and additional self-study booklets, performed at helping to reduce HA and OCD symptoms in patients. The study also wanted to assess the helpfulness of training workshops that were provided to therapists. Recommendations/Actions: The findings provide support for the effectiveness of the online delivery of treatment with the inclusion of additional self-study booklets. This is important as whilst there is currently a trend towards resuming face-to-face therapy, it is likely that there will continue to be a blend of consultation mediums used by services. Whilst this study was designed to evaluate the effectiveness of online CBT with self-study booklets it would be beneficial to examine how these materials could be incorporated into face-to-face therapy. A comparison study of face-to-face therapy with either the inclusion or exclusion of the booklets would be able to provide this.
15	(8620/SE) - Reasons for engagement and drop out from Talking Therapies: A Service Evaluation	Only 35% of all new referrals to Talking Therapies are later coded as "Completed Treatment" upon discharge. A service evaluation aimed to look at why clients disengage from the service and to provide suggestions for improving the service and to promote ways to better engage clients so that they can receive the treatment they need. This links in with the Trust strategies and priorities of patient experience and improving care. Actions: To conduct a further deep dive looking specifically at early disengagement ('Did not Opt Ins'). Talking Therapies service to continue their offering of wait list review calls. To build "What to Expect" section on the Talking Therapies website / consider the design of a video infographic to be shared.

	Audit Title	Aim/Actions
16	(9157/CA) – JD- Assessing the need for screening for ADHD in PICU	This audit considers the need for providing services for screening and assessing Attention Deficit Hyperactivity Disorder (ADHD) in the Psychiatric Intensive Care Unit (PICU) setting to reduce levels of aggression in patients. The aim is to reduce the levels of aggression, inadequate care, increased burden on staff and length of stay in patients with ADHD in the PICU. Objectives: To identify the typical profile of a patient that may require ADHD screening Actions: Implementing the recommendations in all the wards. Similar audit to be done on different wards, and re-audit after 3 months. Circulate this audit to Drugs and Therapeutics Committee.
17	(9288/CA - JD) Anti-Psychotic ECG Monitoring on Older Adult Wards	This audit and re-audit will assess whether Electrocardiograms (ECGs) have been performed within four hours of admission and after antipsychotic dose increases as per NICE and local guidelines, when working with older adult inpatients at Prospect Park Hospital. The aim is to improve the physical health of older adult inpatients and reduce their risk of cardiac arrhythmias Objectives: To determine whether NICE and local guidelines regarding ECG monitoring are being followed. To implement actions for improvement as required Actions: Create an Excel spreadsheet to enable close monitoring of antipsychotic prescribing and admission ECGs, which will be updated when a new patient is admitted and during Multi-disciplinary team meetings . When admission ECGs have not been performed, it would be recorded and set as a job. The spreadsheet will also note dates of medication changes and for repeat ECGs.
18	(6653/SE) Improving Patient Information within the Birth Trauma Pathway	The Berkshire Traumatic Stress Service's Birth Trauma Pathway does not have written information for Postnatal Post Traumatic Stress Disorder (PTSD); and women were given either no information or a booklet about Complex PTSD when joining the service. This has led to the Service Lead identifying the need for specialised information on Postnatal PTSD. Aim: To create a service user experience baseline for people on the birth trauma pathway Objectives: To determine service user satisfaction, drop-out rates, missed sessions and qualitative reports. To improve patient experience by creating a new information guide for service users. Actions: Produce information for booklet and send to Berkshire Healthcare Studio to design. Deliver booklet routinely to service users after assessment. Pilot booklet for service users. Compare data after 18 months. Talk to women with different birth experiences or different backgrounds/ encourage them to fill out the questionnaire. Adapt the booklet as required.

	Audit Title	Aim/Actions
19	(8324/SE) Evaluation of the Effectiveness of the modular STEPPS programme in Reading IPT, Berkshire	This service evaluation investigates the effectiveness of the STEPPS (Systems Training for Emotional Predictability and Problem Solving) programme delivered under the Reading Integrated Psychological Therapies (IPT) service. Aim: To ensure adaptations and modifications made to the Reading IPT service STEPPS programme have been effective. Objectives: To evaluate whether the modular format of the STEPPS programme is effective and leads to reliable and clinically significant change on pre and post therapy measures. To investigate whether completing the STEPPS programme leads to decreased frequency of patients' contact with secondary mental health services, such as the Psychological Medicine Service and Crisis Resolution and Home Treatment Team (CRHTT). To investigate whether there is any difference in outcome measures depending on which module patients start their treatment at. In other words, whether joining the STEPPS programme at any one module would lead to similar outcomes. Actions: To introduce an individual screening appointment to ensure patients are aware of the commitment and their therapy goals are in line with the STEPPS programme.- To follow up on patients who drop out of treatment to understand the barriers to engaging with the therapy.- To introduce a more efficient way of collecting end of therapy outcome measures through either: an electronic system of collecting data, e.g. Microsoft Forms or offering support in completing measures with the patient (e.g. via telephone call or a brief appointment).- To work closely with other localities to collect more male participants joining the programme at the same time.- A Reading STEPPS representative to attend STEPPS cross-locality meetings to gather information about any potential males awaiting treatment in other localities.- Reaching out to other teams within Reading e.g. CRHTT/CMHT to encourage referrals for males.
20	(8434/SE) Improving Support for Parents Who Are Accessing Treatment in BTSS	The Berkshire Traumatic Stress Service (BTSS) supports adults with Post Traumatic Stress Disorder (PTSD) and complex PTSD. Several clients have requested information about how they can explain PTSD to their children. Aim: to involve parents in considering what additional resources may be beneficial to support parents in the BTSS and their children. Objectives: How many patients in the BTSS are parents to children under the age of 18?- What information and support would parents receiving treatment from BTSS value for their children?- What information and support do clinicians working in the BTSS believe would be feasible to deliver for children of their patients? Recommendations/actions: Develop links with child services, including CAMHS and social services, to consider how the services may work together to provide support for the whole family.- Work with commissioners to provide joint-up service provision for parents and their children.- Develop links with external agencies, such as Recovery College, charities (e.g., Young Carers and Cruse bereavement care), that could work together with BTSS to facilitate support for the whole family.

	Audit Title	Aim/Actions
21	(8573/SE) Evaluating Teaching on Learning Disabilities to High Intensity IAPT Trainees	This is an evaluation of teaching delivered to High Intensity Improving Access to Psychological Therapy (IAPT) trainees at the University of Reading, on working with people with Learning Disabilities (LD). It focuses on whether teaching impacted on the trainees' general self-efficacy and confidence in working with and attitudes towards this client group. Aim: to increase the confidence, self-efficacy and attitudes of High Intensity IAPT trainees through training at the University of Reading. Objectives: To determine the confidence of therapists in working with people with LD.- To evaluate the self-efficacy of therapists in working with people with LD.- To establish the attitudes of therapists to treating people with LD Recommendations/actions: Training needs to be carried out with mainstream practitioners to enable them to have more confidence, self-efficacy and positive attitudes towards people with LD.- Training should be made as interactive as possible by including case histories and role play.- Teaching can be carried out virtually whilst maintaining a positive impact.
22	(9292/CA) - Re-Audit of Antimicrobial Prescribing on all Trust Inpatient Wards 2021/22	The aim of this audit is to ensure there is safe and effective prescribing of antimicrobials in Berkshire Healthcare's inpatient wards, both Mental Health Services and Community Health Services. Objectives: 1. To determine whether antimicrobials are being prescribed in accordance with Trust policy and prescribing guidelines 2. To evaluate the clinical appropriateness of antimicrobial inpatient prescriptions Actions: 1. Disseminate the information on documentation requirements through Trust newsletter, meetings and email to Community service managers and Mental Health Inpatient ward managers to disseminate to prescribers. 2. Consider collaborative working with primary care to ensure Summary Care Record for patients has more information e.g. severity of penicillin allergy.3. Submit to Drugs and Therapeutic Committee, eLearning module is a standalone requirement for all Trust prescribers
23	(8643/CA) - Re-audit of the use of the Dementia Intervention Care Pathway in LD Services	The aim of this project is to ensure the Dementia Intervention Care Pathway tool is being implemented when required. Objectives: To measure the use of the Dementia Intervention Care Pathway tool, or the information provided by this tool, across the six health teams providing services to people with Learning Disabilities (LD) in Berkshire. To determine whether the Dementia Intervention Care Pathway tool needs to be publicised further within the health teams providing support for people with Learning Disabilities. Actions: Dementia workstream meeting to be held. Meeting with chairs of relevant local dementia planning meetings. Service wide dementia training to be arranged. Regular Dementia workstream meetings taking place.

	Audit Title	Aim/Actions
24	(9434/CA) - Re-audit of Local Procedures for Young People in Sexual Health	The aim of this project is to keep the young people of East Berkshire as safe as possible whilst navigating the world of sex and relationships. Objectives: To ensure all clinicians are adequately trained to ask questions and assess the needs of our young population. To ensure all clinicians are and are adhering to the national guidelines for safeguarding in sexual health. Actions: To continue to monitor our safeguarding practice by doing a yearly audit of young people seen in our service.- To set up 2 new spreadsheets with the details of the vulnerable patients entering our service with regular monitor & update - To update any questions on the data collection tool as the guidance changes.- To continue monthly safeguarding supervision as an MDT and learn from each other's practice (facilitated by safeguarding team and lead by the service safeguarding lead). The safeguarding lead will continue to monitor the training of individual members of the clinical team and arrange group training, tailored to sexual health, where appropriate.- To discuss with the sexual health team the importance of filling in the CSE proforma at every consultation with a person under the age of 18 and to offer and document screening for infections to all patients in the service.
25	(9601/CA) - Re-audit of Referrals for First Permanent Molars to Orthodontists by Community Dental Services (CDS)	A re-audit to establish the quality and appropriateness of referrals regarding First Permanent Molars (FPMs) by Community Dental Services (CDS) based on two guidelines: The Royal College of Surgeons and the Thames Valley Orthodontic Network. previous audit ID: 9164. The aim of the project is to ensure that only appropriate, high-quality referrals are made to reduce waiting lists for CDS patients. Objectives: Assess quality of referrals made based on the guidelines above. Assess appropriateness of referral based on the guidelines above. Ensure all factors are considered and written down in the patient notes before referrals are made. To make dental officers more confident with their knowledge of FPM extraction guidelines Actions: Dentist to include fissure sealants and fillings in treatment plan where possible and relevant or to include the patient's compliance in the referral.

	Audit Title	Aim/Actions
26	(7594/SE) Patient experience review of vocational rehabilitation intervention from CBNRT	A service evaluation looking into the experience of patients who have received vocational rehabilitation from the Community Based Neuro Rehab Team (CBNRT), including East Berks Earlier Supported Discharge Team (ESD). Aim: To establish a service baseline to direct future service improvement and a more tailored approach to vocational rehabilitation for ESD patients. Objectives: Gather patient feedback of current vocational rehab interventions delivered within our 6-week ESD remit at point of discharge. Provide insight into when and how many of our patients receiving vocational rehab intervention have returned to work. Enable greater understanding of the demand for a specialist vocational rehab services within East Berks. Actions: To share results of service evaluation with CBNRT/ESD staff in team meetings and in-service training. Seek opportunity to have training from Employment Officer. Network with local specialist services. Author and line manager to meet with audit team and seek external support for further exploration/ auditing of service demand across Berkshire.
27	(9529/CA) - Anti-psychotic and Prolactin Monitoring Inpatient Unit Rose Ward	This audit looks at local Trust standards of care relating to inpatients admitted onto Rose Ward who should have baseline prolactin, which needs to be repeated at 3 months if they are on antipsychotic medication. Aim: to improve prolactin monitoring of inpatients on Rose Ward who are taking antipsychotic medication Objectives: To determine to what extent Trust guidelines are being followed. To create an action plan for improvements as required. Actions: Serum prolactin should be taken for all inpatients admitted to the ward and guidance will be circulated to all the medical staff of this.- If for any reason, serum prolactin is not taken, it should be clearly documented, and re-attempted as soon as possible.
28	(7401/SE) - Evaluation of online STEPPS groups in comparison to face to face groups across Berks Integrated Psychological Therapies	Systems Training for Emotional Predictability and Problem Solving (STEPPS) is a 20-week manual-based group treatment programme for outpatients with Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (EUPD) that combines cognitive behavioural elements and skills training with a systems component. STEPPS is in keeping with NICE Guidelines for BPD (NICE, 2009) in that it has a theoretical basis and is structured and has an intervention longer than 3 months. During the pandemic, this group was adapted and offered online. The aims of this service evaluation were to- Evaluate whether the STEPPS groups are effective in terms of reliable and clinically significant change on the pre and post treatment questionnaires- Determine if running STEPPS groups online are an effective and/or comparable alternative to face-to-face groups in terms of similar outcomes on the pre and post therapy questionnaires and retention/drop-out rate. Recommendations/Actions- STEPPS to continue online- Improved availability of devices in order to enable access for those who do not have access to smart technology- Assertively contacting service users to complete measures if not already returned.- Collection of data on reasons for non-completion of programmes.

	Audit Title	Aim/Actions
29	(9316/CA) - BHIVA National Audit 2022: Routine monitoring of HIV positive patients through the pandemic	This is a service evaluation, which is part of a wider British Human Immunodeficiency Virus Association (BHIVA) non-NCAPOP national audit that reviews Human Immunodeficiency Virus (HIV) patients who were monitored and managed through Berkshire Healthcare's Garden Clinic during the COVID-19 pandemic. Aim: To gain a UK-wide picture of how much routine HIV monitoring was disrupted, how HIV clinical services worked to maintain care standards, and current care delivery. Objectives: How much routine HIV monitoring was disrupted by the pandemic. How HIV clinical services worked to maintain care standards. Current care delivery at the time of data collection, in May-August 2022. Recommendations: Patients not living alone should have a recorded enquiry about intimate partner/domestic abuse.
30	(9386/CA) - Re-Audit on quality of Social Care referrals across BHFT (2021-2022)	In 2014, a referral audit (ID 1632) was completed by the Trust safeguarding team. This current audit aims to review these standards and assess if any further recommendations may be required. The purpose was to ensure that the children's social care referrals produced by Berkshire Healthcare are of an appropriate standard and quality to meet Berkshire Wide Safeguarding Children Procedures. Also:- To ensure that internal trust record keeping standards are being upheld- To review the quality of the current referrals that have been completed. Actions:- A review of the RIO training.- A quick reference guide to be constructed.- Safeguarding training presentations to be reviewed / changed.- A RIO transformation bid to be completed to look to streamline the process.- Departments to review / update their standard operating procedures regarding record keeping.- Discussion with RIO team regarding changes to the wording on the safeguarding risk page.
31	(9969/CA) - The quality of referrals to audiology from the school hearing screening programme	A clinical audit with Community Health East's Hearing & Balance Services to establish whether there are ways to reduce the number of inappropriate school screening referrals as the is evidence of unnecessary referrals. Aim: To reduce the number of inappropriate referrals to audiology. Objectives: To determine if there is a significant difference between the number of referrals from the school hearing screening programme and the number that have normal hearing in the audiology clinic. To determine the percentage of patients that did not attend their appointment. Actions: Re-introduce partial booking system. Continue with text reminders. Arrange visit of audiologist to school screening and discuss referral protocol and testing conditions. Arrange visit of school screener to audiology clinic and have discussions.

	Audit Title	Aim/Actions
32	(10001/CA-JD) - Pulse assmt prior to AChEIs initiation at Windsor memory clinic	This was a re-audit of that previously undertaken in 2021 (ID 9154) to evaluate current prescribing practice against Maudsley's recommendations under NICE guidelines (NG97) to see whether routine baseline pulse checks had been carried out and documented for patients started on acetylcholinesterase inhibitors in the Windsor locality. Recommendations/Actions: The pulse should continue to be recorded and documented on RiO for all patients commenced on AChEIs to ensure patient's safety and to keep up with the good clinical practice. All new staff involved in patient care must be made aware of the protocols and the guidelines at the time of induction.
33	(8621/SE) - Identifying inter-agency barriers & facilitators to providing integrated MH provision for people who are homeless	People experiencing homelessness are at significant risk of mental health difficulties. If they don't receive intervention, their coping strategies and subsequent engagement with services may reduce, thereby perpetuating homelessness. This project was developed in response to several concerns regarding the lack of uptake of mental health care provision in Berkshire by people experiencing homelessness, as identified by the local commissioning group. Recommendations/Actions: Training and supervision, with emphasis on trauma and attachment-informed care. Formal agreements, to establish clarity regarding the responsibilities of each service. Promotion of communication/continuity between services. Integrated commissioning between services with development of an integrated care pathway. Lowered threshold of acceptance to services. Flexibility regarding engagement/attendance protocols. Outreach working.
34	(9058/SE) - Evaluation of Integrated Referrals Meetings at the Gateway (2021/2022)	The Integrated Referrals Meeting (IRM) was developed as an online clinical case discussion and decision-making forum to aid the process of referral into a variety of mental health services and facilitate joint working between services. The two main aims of this service evaluation are: 1. To evaluate the process of the IRM from the perspective of multiple stakeholders. 2. To evaluate the outcomes of the IRM in terms of meeting its original goals for: a. aiding clinical decision making and b. streamlining the client journey of referral into/between services. Recommendations/Actions:- Develop guidance/information- Ensure there is not a more appropriate alternative available, potentially using fewer resources- To agree roles in advance.- To represent the client voice- To ensure that all attendees have appropriate and realistic expectations- Provide on-going support and skills development.- Enable longer discussion slots.- Improve processes to support preparation and cancellations.

	Audit Title	Aim/Actions
35	(9330/SE) – 6 Week Group Rehab for Long COVID with BLIS	Aim: To determine the effectiveness of the Berkshire Long COVID Service's (BLIS) outcomes of their six-week rehabilitation groups for people with Long COVID, which is part of the Integrated Pain & Spinal Service (IPASS) in Finchampstead, Berkshire. Objectives: - Evaluate formal outcome measures by analysing pre and post treatment COVID screening tool responses.- Analyse the feedback forms from the patients that were gathered by the service.- Conduct telephone interviews and/or focus groups with people who have completed treatment, dropped out of treatment, or did not attend the treatment programme. Recommendations/Actions: Patient recommendations for improvements at each stage of the pathway (before, during and after the group) have been detailed in a chart
36	(9598/SE) - Improving Referral Rates to the Learning Disabilities (LD) - SHaRON Service	SHaRON is an online peer-support platform designed to connect individuals using NHS Services. LD-SHaRON is a platform aiming to support carers and family members of people with LD, and users can interact with each other in several ways, including posting on the main platform, commenting on other's posts, and through writing and sharing blogs. There is also a range of resources to support carers that are free to access. Having access to LD-SHaRON is likely to allow carers to connect to others in similar situations, share resources and ideas, and have further access to NHS support. The LD Service has received funding for SHaRON since June 2019. However, the SHaRON usage within the LD Service has been consistently low. Commissioners have stated that due to the low levels of engagement in LD-SHaRON, the service is at risk of being retracted. The aims of this evaluations were to determine how referral rates to LD-SHaRON can be increased, to ensure that the service continues to be commissioned, so that carers can benefit from digital peer support. Recommendations/Actions:1. Determine that teams have adequate information about the SHaRON website. 2. SHaRON training to be made mandatory for all staff and to take place as part of events such as nurses forums and OT forums. 3. Make referral process less time-intensive for staff. 4. Develop an app that can be pre-installed in staff members phones or iPads, for easy logging on. 5. LD-SHaRON to include more specific resources for less common physical health problems. 6. All staff to receive a SHaRON login on joining the Service. 7. SHaRON website to include resources in other languages. 8. An option for carers to express interest to be referred to SHaRON to be included on the LD referral form. 9. A staff member to call everyone on the waiting list and determine whether their carers would benefit from a SHaRON referral. Staff members to call everyone who has not activated their account following a referral and determine whether they need further support. 10. Pre-printed SHaRON leaflets to be distributed to all staff teams. Digital versions to be developed.

Appendix D- CQUIN 2022/23

The national 2022/23 CQUIN is available at the following Link:
https://www.england.nhs.uk/publication/combined-ccg-icb-and-pss-commissioning-for-quality-and-innovation-cquin-guidance/

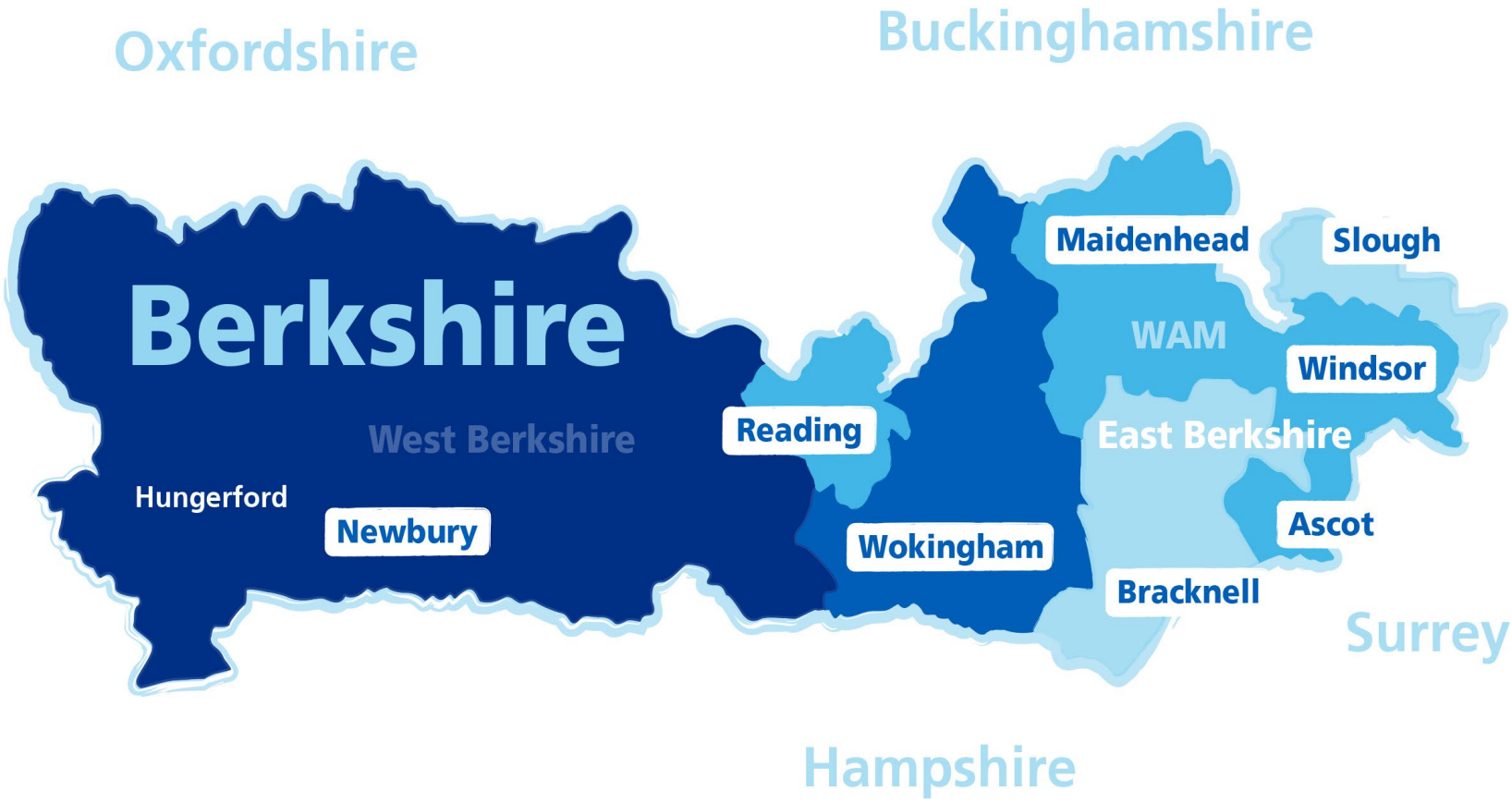
Appendix E- CQUIN 2023/24

To be added when finalised.

Appendix F- Statements from Stakeholders

None yet received. To be added when received.

Appendix G- Map of Berkshire Localities



Glossary of acronyms used in this report.

Acronym	Full Name
AchEI	Acetylcholinesterase inhibitors
A&E	Accident and Emergency
ACP LD/A	Advanced Practice Credential in Learning Disability and Autism
ADHD	Attention Deficit/ Hyperactivity Disorder
AHP	Allied Healthcare Professional
AMHS	Adult Mental Health Services
ARC	Assessment and Rehabilitation Centre
ARFID	Avoidant/restrictive food intake disorder
ARRS	Alternative Resource Reimbursement Scheme
ASQ	Ages and Stages Questionnaire
ASSIST	Assertive Intervention Stabilisation Team
AWOL	Absent Without Leave
BAF	Board Assurance Framework
BAME	Black Asian and Minority Ethnic
BASHH	British Association for Sexual Health and HIV
BEACH	Bedside Emergency Assessment Course for Healthcare Staff
BEDS	Berkshire Eating Disorder Service
BMI	Body Mass Index
BOB	Buckinghamshire, Oxfordshire and Berkshire
BPI	Business Process Improvement
BRAVE	Building Resilience and Valuing Emotions
BTSS	Berkshire Traumatic Stress Service
CAMHS	Child and Adolescent Mental Health Service
CaPDID	Caring for People with a Personality Disorder and an Intellectual Disability
CARRS	Cardiac and Respiratory Rehabilitation Service
CATS	Carers Awareness Tools and Support
CBNRT	Community-Based Neuro-Rehabilitation Team
CBT	Cognitive Behavioural Therapy
CCN	Community Children's Nursing
CDiff	Clostridium Difficile
CDS	Commissioning Data Set or Community Dental Service
CMHT	Community Mental Health Team
COMHAD	Co-occurring Mental Health, Alcohol and Drug Disorders
COPD	Chronic Obstructive Pulmonary Disease
COVID-19	Coronavirus disease 2019
CPA	Care Programme Approach
CPE	Common Point of Entry
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CREST	Community Rehabilitation Enhanced Support Team

Acronym	Full Name
CRHTT	Crisis Resolution and Home Treatment Team
CYPF	Children, Young People and Families
CYPIT	Children and Young People's Integrated Therapy Service
DBT	Dialectical Behavioural Therapy
DOC	Duty of Candour
DSPT	Data Security and Protection Toolkit
DSR	Dynamic Support Register
DVT	Deep Vein Thrombosis
EAP	Employee Assistance Programme
ECG	Electrocardiogram
EHCNA	Education and Health Care Needs Assessment
EHCP	Education Health and Care Plan
EIP	Early Intervention in Psychosis
EMBRACE	Emotional Minds Bring Reasons and Choices Every day
ESD	Earlier Supported Discharge
EUPD	Emotionally Unstable Personality Disorder
FEA	First Expert Evaluation
FFT	Friends and Family Test
FI	Family Intervention
FPM	First Permanent Molars
FTSU	Freedom to Speak Up
GA	General Anaesthetic
GOSW	Guardian of Safe Working
HA	Health Anxiety
HCP	Healthcare professionals
HCSW	Healthcare Support Worker
HEE	Health Education England
HPV	Human papillomavirus
HSE	Health and Safety Executive
HV	Health Visitor, Health Visiting
IAF	Information Assurance Framework
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
ICU	Intensive Care Unit
IFR	Initial Findings Report
IMPACTT	Intensive Management of Personality Disorders and Clinical Therapies Team
IPC	Infection Prevention and Control
IPS	Individual Placement and support (Employment Service)
IPT	Integrated Psychological Therapies
IV	Intravenous
iWGC	I Want Great Care (patient experience monitoring)

Acronym	Full Name
LCS	Lean Competency System
LD	Learning Disability
L&D	Liaison and Diversion
LeDeR	Learning Disability Mortality Review Programme
LIC	Lapse in Care
LoS	Length of Stay
MBT	Mentalization-Based Treatment
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MEP	Managing Emotions Programme
MH	Mental Health
MHA	Mental Health Act
MHICS	Mental Health Integrated Community Health Service
MND	Motor Neurone Disease
MOFD	Medically Optimised for Discharge
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSK	Musculoskeletal
NACAP	National Asthma and COPD Audit Programme
NCAP	National Clinical Audit of Psychosis
NCAPOP	National Clinical Audit and Patient Outcomes Programme
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Enquiry into Suicide and Homicide
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NEWS	National Early Warning System
NG	NICE Guideline
NHS	National Health Service
NHSE	NHS England
NICE	The National Institute of Health and Care Excellence
NIHR	National Institute of Health Research
NRLS	National Reporting and Learning System
OAP	Out of Area Placement
OCD	Obsessive Compulsive Disorder
OH	Occupational Health
OPMH	Older Peoples Mental Health
OSCE	Objective Structured Clinical Examination
OT	Occupational Therapy/ Occupational Therapist
PALS	Patient Advice and Liaison Service
PDSA	Plan, Do, Study, Act
PEP	Post-Exposure Prophylaxis
PFD	Preventing Future Deaths
PICT	Psychologically Informed Consultation and Training

Acronym	Full Name
PICU	Psychiatric Intensive Care Unit
PMS	Psychological Medicine Service
PNA	Professional Nursing Advocate
POMH	Prescribing Observatory for Mental Health
PPE	Personal Protective Equipment
PPI	Patient and Public Involvement
PPH	Prospect Park Hospital
PR	Pulmonary Rehabilitation
PRES	Participant Research Experience Survey
PTSD	Post-Traumatic Stress Disorder
PU	Pressure Ulcer
QAC	Quality Assurance Committee
QI	Quality Improvement
QMIS	Quality Management and Improvement System
RBH	Royal Berkshire Hospital
R&D	Research and Development
RHA	Review Health Assessment
RiO	Not an acronym- the name of the Trust patient record system
RTT	Referral to Treatment Time
SE	Service Evaluation
SEND	Special Educational Needs and Disability
SI	Serious Incident
SJR	Structured Judgement Review
SLT	Speech and Language Therapy/ Therapist
SMI	Severe Mental Illness
SN	School Nurse/ School Nursing
SSN	Special Schools Nursing
STEPPS	Systems Training from Emotional Predictability and Problem Solving
SUN	Service User Network
SUS	Secondary Users Service
TILS	Transition, Intervention and Liaison Service for Veterans.
TT	Talking Therapies
UCR	Urgent Community Response
UKHSA	United Kingdom Health Security Agency
VPR	Violence Prevention and Reduction
VW	Virtual Ward
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
WTE	Whole Time Equivalent

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 May 2023
Title	**Executive Report**
	Item for Noting
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	The Trust Board is requested to: a) To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 09 May 2023

EXECUTIVE REPORT – Public

1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Industrial Action Update

On the day of writing (2 May 2023), the NHS Staff Council comprising 14 unions representing all NHS staff apart from doctors and dentists, accepted the Government's headline pay rise offer of 5% for 2023/24 and a one off sum of at least £1,655.

Some unions may choose to remain in dispute and re-ballot their members for further strike action.

The junior doctors strike earlier in April 2023 passed without incident or impact on the operation of Trust services. The end of April 2023, the RCN strike also passed with no impact on Trust services.

The Trust is hopeful that the pay agreement will be enacted via national NHS instructions as quickly as possible to support staff with their pay and cost of living.

Executive Lead: Alex Gild, Deputy Chief Executive

3. Social Care Workforce Funding Reduced

The Government has confirmed that funding promised to develop the Social Care workforce in England has been halved. In 2021, the Government pledged "at least" £500m for reforms, to be spent on training places and technology over three years. However, according to a recent statement by the Department of Health and Social Care that figure is now £250m.

Executive Lead: Julian Emms, Chief Executive

4. The Economic Cost of Poor Health

The Institute for Public Policy Research (IPPR) recently published findings which showed Britain's poor record on health is costing the economy £43bn a year and cutting the annual incomes of individuals affected by long-term sickness by up to £2,200 a year on average.

It is calculated that a 1 per cent decrease in the proportion of workers off due to long-term sickness is associated with an additional 180,000 workers joining the workforce, and every pound invested in the NHS results in around £4 back to the economy. The IPPR said improving the country's health was vital both for the economy and to boost the incomes of disadvantaged groups.

Executive Lead: Julian Emms, Chief Executive

5. NHS Impact

At the end of April 2023, NHS England published the findings of its review of delivery and continuous improvement in the NHS, and launched its new approach to improvement, NHS Impact.

The review was carried out by Anne Eden, NHS South-East Regional Director and was commissioned to consider how the NHS can continue to deliver against its immediate priorities while also continually improving services over the long-term.

The review's findings were:

- NHS England's structures do not currently enable a focus on a small number of shared priorities for improvement.
- NHS England needs to engage differently with clinicians and operational managers to enable improvement-led delivery.
- Improvement approaches are embedded in many NHS organisations, but some providers and systems need more support.
- Improvement methodologies are an important element of building improvement approaches but their deployment should be based on priorities for improvement.
- There is more scope for NHS England to provide tailored support to organisations and systems facing greater challenges.
- NHS England can do more to provide practice support to enable organisations to focus on improvement, including aligning regulatory incentives.

In response, NHS England has agreed three actions:

- To establish a national improvement board, which will agree national priorities for improvement-led delivery.
- To launch a single, shared 'NHS improvement approach' – which will be developed through NHS Impact.
- To co-design and establish a Leadership for Improvement programme.

For now, trusts are not being asked to take any specific action. However, as the review states, as NHS England develops an improvement approach through NHS Impact, trusts will soon be asked to introduce an organisational improvement approach aligned with NHS Impact. The five principles of NHS Impact are:

- Building a shared purpose and vision of improvement.
- Investing in people and culture.
- Developing leadership behaviours that support improvement.
- Building improvement capability and capacity.
- Embedding improvement into management systems and processes.

The Board will recognise the above principles as they align with the improvement approach we established in 2016. It was also pleasing to note that case studies from Berkshire Healthcare were cited as examples of good practice, alongside 3 other Trusts that are also mature in their approach to Continuous Improvement.

Executive Lead: Julian Emms, Chief Executive

6. Hewitt Review

The Hewitt review into the oversight, governance and accountability of Integrated Care Systems (ICSs) was published at the beginning of April 2023 to a somewhat muted reception. Launched in November 2022, it is both comprehensive in its breadth and draws on extensive engagement with the sector and key partners. Reflecting this, the final document which many had hoped would be a punchy outline of the key issues weighs in at 89 pages. With that in mind, I would identify the following as the key take home messages:

- **The central premise is to shift away from a culture of top-down performance management to one of learning and improvement.** The ambition is for national and regional bodies to support ICSs to become 'self-improving' systems. One of the proposals is to vastly reduce the number of national targets and priorities, with Hewitt suggesting these should be limited to no more than ten. That is not to say that systems would be left unchecked. The review advocates stronger local and mutual accountability within systems, underpinned by timely, transparent data (streamlined to address excessive and duplicative reporting), a national peer review offer (building on established approaches in local government), Care Quality Commission (CQC) assessments looking at how systems are creating cultures of learning and improvement, and

an explicit role for overview and scrutiny committees (made up of local councillors) in scrutinising the work of ICSs.

- **The review calls for a reset in national/local relationships.** In particular it envisages a shift from the current hierarchical approach towards a partnership of equals. As well as reducing the number of targets and streamlining reporting requirements, it suggests ICSs should co-develop local priorities, with these being given equal weight to national targets. Other steps to support the reset include largely ending the use of small, in-year funding pots and giving systems more flexibility to determine budget allocations within their boundaries, as well as rebalancing resources across central and regional bodies and ICSs, shifting a greater share into systems themselves. These ambitions however were not accompanied by recommendations of concrete changes to the powers of the Department of Health and Social Care and NHS England that could help bake this in. Furthermore, there is minimal focus on how to support the cultural and behavioural changes on which these ambitions would ultimately stand or fall.
- **Local variation is baked into the proposals when it comes to ICS development and ways of working.** The development of ICSs so far has been marked by local flexibility, reflected in significant variation in their size, complexity and maturity. The review does not seek to change this. Indeed, it restates ambitions around subsidiarity (the idea that decisions should be taken as close to local communities as possible) and suggests systems could strengthen this by ensuring there is visible and accountable leadership at place and supporting places to define their own priorities and initiatives within their overarching ICS strategies. In this model, Berkshire Healthcare which sits in two ICSs and many places could have a bewildering of array of differing priorities across its geography. The review also proposes most advanced ICSs would be supported to go further, with around ten systems selected as 'high accountability and responsibility partnerships' to take on greater local autonomy and trial new ways of working with regional and national bodies.
- **A commitment to prevention is at the heart of the review.** Although not central to its original terms of reference, the review makes a strong case for a greater focus on prevention, calling for a shift in resources to support this (specifically, recommending the share of ICS budgets going towards prevention should increase by at least 1 per cent over the next 5 years, as well as an increase in the public health grant allocation). It also calls for cross-government collaboration on prevention with formal arrangements to underpin this, and the establishment of a national integrated care partnership forum and new health, wellbeing and care assembly to support engagement. It is not however immediately apparent what these additional bodies would be able to achieve in terms of impact.
- **The review stops short of giving firm answers on the respective roles and responsibilities of providers and ICBs.** There have for some time been differing views about how providers and ICBs should relate to one another, particularly the question of whether providers 'report into' ICBs. At points it seemed the review would offer direction on this, however, perhaps unsurprisingly given the wide range of stakeholders consulted, the final draft reaches no such position. Local ICBs and providers will have to continue to live with and work through the complexities of how they relate to one another.
- **The impact of the proposals is by no means certain.** The Hewitt Review also makes an array of hugely ambitious proposals from a strategy for the social care workforce, to new GP contracts, and a review of the NHS capital funding regime. However it must be remembered this is not government policy; indeed, a month on since its publication the only response so far is a commitment that ministers will review the recommendations 'in due course'. On balance and in the

current operating environment it feels unlikely that those ministers would be willing to relinquish central control to give ICSs the freedoms Hewitt suggests. It therefore remains to be seen whether her work will translate into any real changes in the environment ICSs find themselves in.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
09 May 2023

Trust Board Paper

Board Meeting Date	9th May 2023
Title	**Health & Wellbeing Update**
	ITEM FOR NOTING
Purpose	To provide a six-monthly update to Trust Board on health and wellbeing activity
Business Area	Corporate
Author	Jane Nicholson/Steph Moakes
Relevant Strategic Objectives	True North Goal 2: Supporting our staff
CQC Registration/Patient Care Impacts	Deliver safe, compassionate, high-quality care and a good patient experience through a skilled and engaged workforce
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	EDI implications considered
SUMMARY	This paper provides an update on health and wellbeing activity over the last 6 – 12 months and give an indication of the planned milestones ahead.
ACTION	For information and discussion

Report to Trust Board – May 2023

Health, Wellbeing, Engagement & Rewards Update

Introduction

In line with the trust People Strategy, national People Promise and new NHS Health & Wellbeing Framework, Wellbeing continues to be a high priority and profile activity. This paper looks to update on the work that has happened since the last update and give an indication of the planned milestones ahead.

Current staff survey scores show that wellbeing is positively viewed within the organisation and contributes to general organisational experience. We have the top score in our comparator group (Combined Mental/Community/LD Trusts) for staff believing that the organisation takes positive action on health and well-being at work (74.3%) as well as the top engagement score (7.4) and top score for staff recommending the organisation as a place to work (73%).

Review:

The last six months have largely been focused on moving forward existing projects, driving the response rate for the staff survey and the introduction of the Berkshire Healthcare Milestone awards, including long service.

Since the last board update in November, the following projects have been delivered:

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)
Working with HR and Operational leads to give all staff an opportunity to share their voice and feedback in the **2022 NHS Staff Survey**. This resulted in the **response rate going up by 5% to 65%** - 15% above the average within our comparator group	All staff	Increased responses mean that the results are more reliable from within the organisation.

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)
In February, we received the **results of the Staff Survey** which showed we had the **top engagement score** across all Mental/Community/LD Trusts. It also showed that 74.3% of staff believe that Berkshire Healthcare takes **positive action on health and well-being**, which was the **top score** in our comparator group	All staff	The Staff Survey results are an important data metric to inform internal action and also to use as a recruitment tool.
The HR People Partners, with our support, are working with their new divisional leads to look at gathering more information and then create a **Staff Survey Action Plan**, exploring existing and new changes to make a difference.	All staff	Enables staff to see changes that are made as a result of the staff survey (either directly or indirectly) on their day to day activity
Work has continued for our two **NHS Charities Together funded projects** and updates are provided in the next two rows.	All staff	As below
Project 1: Recruit a **Wellbeing activities facilitator** (1 year fixed term contract) to deliver virtual and face-to-face exercise sessions for staff as well as coordinate additional sessions such as mindfulness and nutrition. We have launched our schedule of activities which are currently primarily virtual, in order to enable a quick launch but are slowly increasing the number of face-to-face events/sessions. This has included bringing local gyms on to sites to run competitions and give access to free health checks. Additional instructors have been bought on to deliver additional sessions such as dance blast or nutrition	All staff	Classes launched properly in January so in the first 4 months, there have been over 450 sign ups to virtual classes and received over 70 feedback forms. Participants were asked how much they felt the class would help improve their health and wellbeing and the average score is 4.81 out of 5.
Project 2: Update 5 rest areas and staff kitchens across the trust.	Staff in teams who received the grant funding	Improved working environment.

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)
The main work is complete in all rest rooms, with just furniture and finishing touches like décor to complete.		We will be seeking immediate and delayed feedback from teams to gain an understanding of the impact the improvements have had.
After a small trial of support from **Peppy** for Men's Health, Pregnancy & Baby and Fertility, we delivered a business case for ongoing funding. This had partial success and we are now able to fund **Menopause and Men's Health support on a recurrent basis.** Those currently using the other support functions will receive signposting to other options for support. When the contracts are signed, we will be looking to increase the registered users for the app, particularly for Men's Health.	Staff or their partners who need support with menopause or men's health.	Registered users: 269 – Menopause 43 – Men's Health 83 Net Promoter score
Linking to the Peppy update above, **World Menopause Day** was celebrated with comms including: - Launch of the new **Menopause Policy**, which has just been approved. - Launch of the unlimited licences for **Peppy menopause** support app	Staff impacted by the menopause and managers	This aims to continue challenging the stigma around menopause, increase awareness and ensure staff can have conversations around what support is needed and access expert health advice. Currently no concerns received on the menopause policy after launch. Will review at the 12 month mark
2023 Wellbeing Calendar created and published for use within teams	All staff	The calendar gives us a planned way to pick up on key health and wellbeing themes throughout the year. We need to do some work this year evaluating the reach and usage.
Introduced two years of **funding of Blue Light Cards** for all staff	All staff	Support for our people during cost of living. We need to do some work this year evaluating the usage and perceived value.

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)
In April, we launched the new **Berkshire Healthcare milestone recognition awards**. This considerably widens the previous recognition of 25 and 40 year NHS service to include the following: - A card on joining with an offer to expense a Blue Light Card - Congratulatory email celebrating 1 year work anniversary at BHFT with a £10 voucher. - Letter, pin badge and voucher (£20 - £200) for reaching 5, 10, 15, 20, 30 and 40 years continuous BHFT service. In March, we issued all eligible staff with backdated pin badge and voucher for their most recently achieved BHFT service. - Email at 5 and 10 years NHS service with notification of annual leave change - Continued recognition of 25 and 40 year NHS service with voucher for 40 years. - Letter and £50 voucher for all retirees (regardless of service) - Annual afternoon tea celebration for those who have reached 20, 30 or 40 years BHFT service. We have also appointed an administrator who will be leading on this work.	All staff	Feeling of recognition and value of our people by the organisation So far, we have issued: Mar: 2,194 backdated awards Apr: 167 BHFT milestones for 1 – 40 years. Initial feedback has been very positive with some constructive feedback about how to improve the process. We will look to evaluate the awards after the initial period.
Mental Health First Aid and REACTMH Wellbeing Conversations training were restarted with delivery moving to the Wellbeing Matters team. A high number of staff have received training since then and MHFAiders have also joined a network of regular catch ups.	All BHFT staff and managers as well as all health & social care staff in Berkshire	Since September: MHFA: 100 REACTMH: 72 Both training courses have formal evaluation processes which are regularly reviewed

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)
We have increased the **Wellbeing Champion Network** to over **90 members**. We are designing and delivering regular information and update sessions. The next steps are to increase engagement in the network and work towards the goal of having a champion in every team	All teams	Wellbeing champions create a focus on wellbeing within a team and also enable improved two-way communication throughout the organisation. Over the last six months we have conducted 4 champion meetings with guest speakers on baby loss, mental health and weight management.
We have completed another two Wellbeing Tours to distribute physical newsletters. Each time, we visit over 20 sites within 3-4 days. Our next steps are to work to include our teams who are further afield such as Hampshire.	All staff on sites that are visited	Immediate feedback while we are out on visits is positive and enables proactive conversations about support available, what's missing etc. We need to do some work this year evaluating the reach and usage.
As part of the ongoing recognition and reward work, we implemented the organisation request to distribute a £50 festive voucher to all staff. It was agreed that this would be sent out in November, earlier than normal, to support individuals during what can often be a more costly month.	All permanent staff employed on 1st Nov	Immediate feedback through emails and on executive briefing showed that this is well received and appreciated by staff.
Wellbeing Matters have had their NHSE funding removed. We have spent the last 6 months applying for funding from the ICB's which was not supported, before switching to an internal only business case. This has just been agreed at TBG and will fall into our plan for the coming year	All staff	An internal psychological support service will support with the trust ethos of compassionate leadership. There is a growing body of literature that shows the impact on patient safety, as well as contributing to sickness and turnover.

Future Roadmap:

Upcoming project delivery and likely timescales are captured below.

Activity	Target staff group	Intended benefit
Consulting with Wellbeing Matters team and moving to an **internal only psychological staff support service** that will form part of the existing wellbeing structure. The initial focus will be to ensure a smooth transition and manage the communications to our staff, whilst closing down the service to the rest of the system.	All staff	An internal only service will give us greater opportunity to use local data to drive interventions in areas of most need, improve communications and outreach within our teams and implement a stronger focus on evaluation/outcomes across all our wellbeing provision.
Continue to grow our Wellbeing classes including virtual and face to face classes, events and guest instructors. Focus on outreach and monitoring uptake/feedback to inform any business case/charitable funding requests for future funding.	All staff	To continue to create a healthier workplace with access to physical and health-based activities.
Finalise rest room refresh project and share with colleagues.	Staff in teams who received the grant funding	Improved rest areas which are a basic need
We are continuing the scope of the estates to understand the facilities that our staff have access, what the gaps are and how to improve. This includes multi-faith spaces. We will continue to link in the estates team to ensure that there is no duplication in work.	All staff using BHFT sites	Creating a healthier workplace and improving equity of access where possible
The contract for our staff benefits provider is due to finish in July 2023 so we will be starting a tender process for a new provider and this will include the launch of a home & electronics scheme as requested by our colleagues	All staff	Access to services such as cycle to work and home & electronics salary sacrifice schemes. Improved financial support and subsequent wellbeing.

Activity	Target staff group	Intended benefit
We have had a number of barriers to introducing financial support packages such as Salary Finance, to give employees greater control over their finances but we are continuing to work with trust colleagues to overcome this.	All staff, particularly those impacted by cost of living increases.	Access to services to have greater control over finances such as accessing earned pay ahead of pay day. Improved financial support and subsequent wellbeing.
Extension of the trial food bank donation points at Upton Hospital. We have struggled to evaluate the use of the donation points so we are reaching out to champions to support us with this.	All staff, particularly those struggling financially	This responds to feedback from operational teams about staff who are not at crisis point yet (therefore not suitable for Trussell Trust) but are in need of a little support.
The next Wellbeing at Work newsletter and tour is planned for June 2023	Frontline staff	Improved communications and opportunity for us to gather feedback

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	May 2023
Title	**Ethnicity Pay Gap Report**
For Noting	
Purpose	**This report sets out an analysis of the Trust's first Ethnicity Pay Gap Report for 2022-2023**
Business Area	**People Directorate**
Author	**Ash Ellis, Deputy Director for Leadership, Inclusion, OD**
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Anti-racism commitment in addressing staff experience differential.
CQC Registration/Patient Care Impacts	The relevance of this paper supports all CQC KLOEs and patient experience.
Resource Impacts	The paper references work that needs to be undertaken across the Trust.
Legal Implications	This supports our public sector equality duty, although is not a mandated report required by Trusts.
Equality and Diversity Implications	This paper helps us to recognize, explore and take action against any differential in pay gap for our workforce.
SUMMARY	This paper provides the Board with an overview of the pay equality in BHFT, the balance of BAME and white colleagues at different paygrades, and how effective we are at nurturing and rewarding talent. All through our anti-racism lens.
ACTION REQUIRED	To note the report, next steps and seek any clarification.

Ethnicity Pay Gap Reporting (EPG) for the year 2022-2023

Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This report sets out an analysis of the Trust's Ethnicity Pay Gap Report for 2022-2023

Executive Summary

- Ethnicity Pay Gap reporting is not a specified requirement under the Equality Act 2010 like the Gender Pay Gap.
- The Ethnicity Pay Gap is not the same as unequal pay. The Ethnicity Pay Gap is the difference between the average pay of BME and white employees in an organisation.
- BHFT's Median Ethnicity Pay Gap in 2022-2023 was 3.59%**.** This means that on average our white colleagues earn £0.65p more than our colleagues who identify as being from a Black, Asian or other ethnic minority (BME) group.
- 2.76% (137) of our workforce are 'Not Stated' which needs more exploration to understand how this could influence the pay gap further.
- There is a contrast between higher number of BME staff and lower number of white staff particularly more evident in the lower middle quartile, it needs further exploration. Our BME staff population decreases through higher pay quartiles 8a – 8d.
- The Ethnicity Pay Gap data will be published on the Trust's website. In line with the Gender pay gap the information should remain on the Trust website for a period of at least three years, beginning with the date of publication.
- The reasons for the Ethnicity Pay Gap can be varied and complex, some of which are within our control and some will be more systemic within society. One of the major reasons for the pay gap is that there is a higher proportion of white colleagues across all quartiles of the workforce than BME colleagues.
- The overall aim of this ethnicity pay gap exercise is to assess the pay equality in BHFT, the balance of BME and white colleagues at different paygrades, and how effective we are at nurturing and rewarding talent. All through our anti-racism lens.
- The Trust is committed to continuously reviewing our systems, practices and processes to ensure we are reducing our Ethnicity Pay Gap where practically possible and will work closely with our Diversity Steering Group, staff networks, Race Equality Network, Trade Unions and other stakeholders to develop an effective action plan. This action plan will sit within the Trust's overall EDI action plan and agreed priorities.
- Before we develop a more dedicated and detailed action plan in collaboration with our stakeholders, we would like to engage a statistician to enable the Trust to better understand the drivers for the pay gap so we can know what is within our control and what is systemic and what actions will be effective to reduce the pay gap.

Recommendation	The Board is asked to acknowledge the report and subsequent approach to develop actions.

1. Background

Although not yet mandated to do so, BHFT will publish its first Ethnicity Pay Gap report alongside its mandated Gender Pay Gap report. We believe this is an important step on our journey towards greater equality, diversity and inclusion and effective anti-racism.

As this is the first year we are reporting on this we cannot compare the figures with the previous year. But this does give us a basis on which to build and ensure that we have equality in pay when it comes to ethnicity.

2. Our Ethnicity Pay Gap Report in BHFT

Our Ethnicity Pay Gap report for 2022/2023 contains a number of elements:

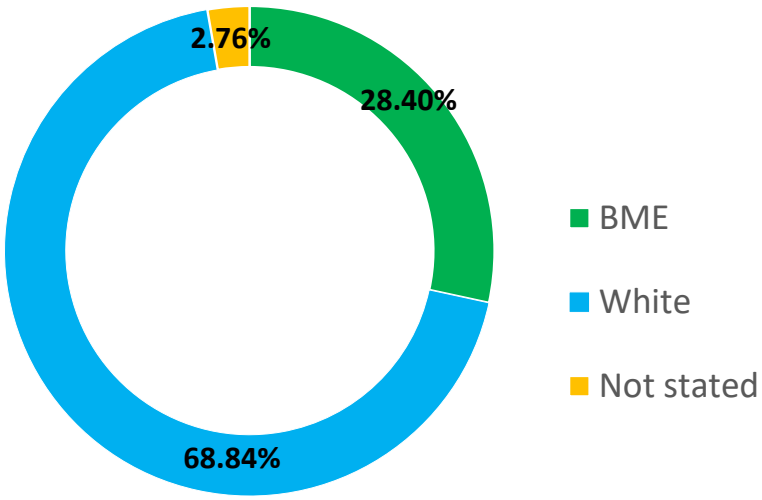
- The mean basic pay gap
- The median basic pay gap
- An analysis of the pay gap across specific staff bands and quartiles within BHFT.
- Recommendation as to any future action to reduce any inequality

The mean pay gap is the difference between the pay of all white and BME (Black, Asian or other ethnic minority) employees when added up separately and divided by the total number of white and BME employees in the workforce.
The median pay gap is the difference between the pay of the middle white employee and the middle BME employee, when all of the employees are listed from the highest to the lowest paid.

3. Our Ethnicity Profile in BHFT – 2022/23

Data collected shows that our workforce consists of 4,968 people, 1,411 are BME and 3,420 are White and 137 have not stated. Figure 1 below shows our ethnicity profile.

Figure 1: BHFT Ethnicity Profile 2022/23



4. Median and Mean Hourly Rate in BHFT

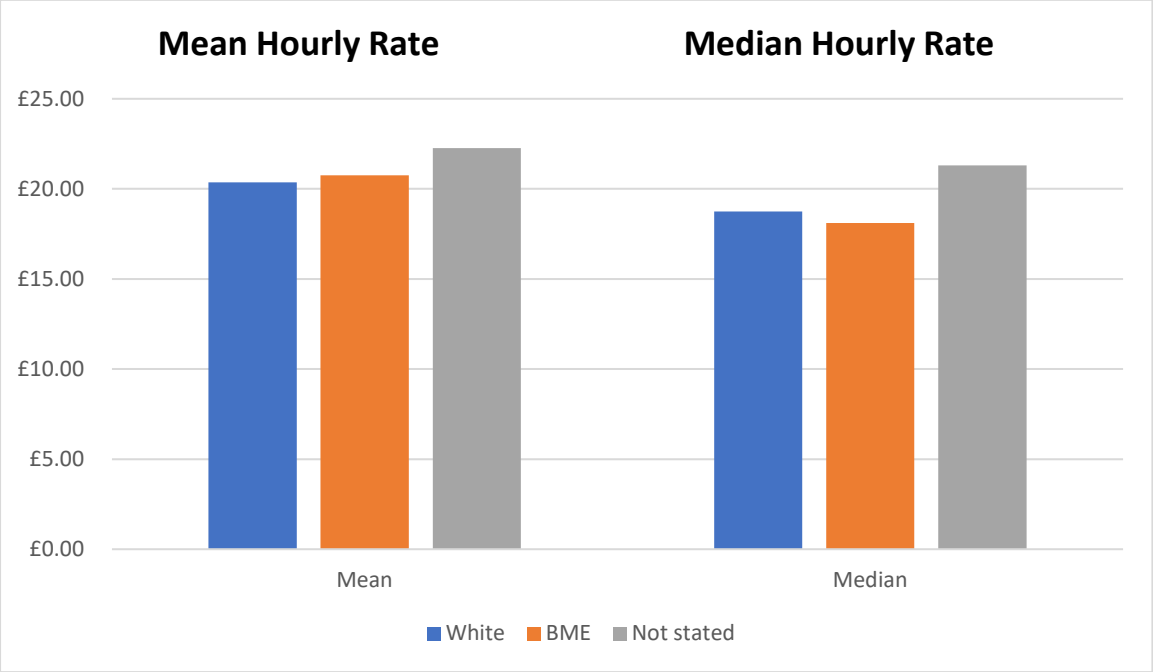
Ethnicity	Mean Hourly Rate	Median Hourly Rate
BME	20.76	18.10
White	20.36	18.75
Not Stated	22.26	21.30
Difference	0.40	0.65
Pay Gap %	-1.93%	3.59%

The mean hourly pay for white employees is £0.40p less than of BME employees, which is gap of -1.93% in favour of BME employees. This needs further exploration to understand the reasoning behind this.

The median pay for white employees is £0.65p higher than BME employees, which is a gap of 3.59% in favour of white employees. This means that, on average, white colleagues earn slightly more than those colleagues who identify as being from a Black, Asian or other ethnic minority (BME) group.

More exploration is needed to understand the 'not stated' population as this is 2.76% (137) of the workforce, and this group on average earns up to £3 more an hour than our BME stated grouping.

From a purely statistical standpoint, the median is considered to be a more accurate measure as it is not skewed by very low hourly pay or very high hourly pay i.e. such as medical staff who are on much higher salaries than other professional groups. However, we know in the gender pay gap for example the very high paid people tend to be men, and the very low paid people tend to be women, and the mean paints an important picture of the pay gap because it reflects this issue. It is therefore good practice to use both the mean and the median when analysing or reporting on the pay gap.



5. Ethnicity Profile by pay band and quartiles in BHFT 2022-2023

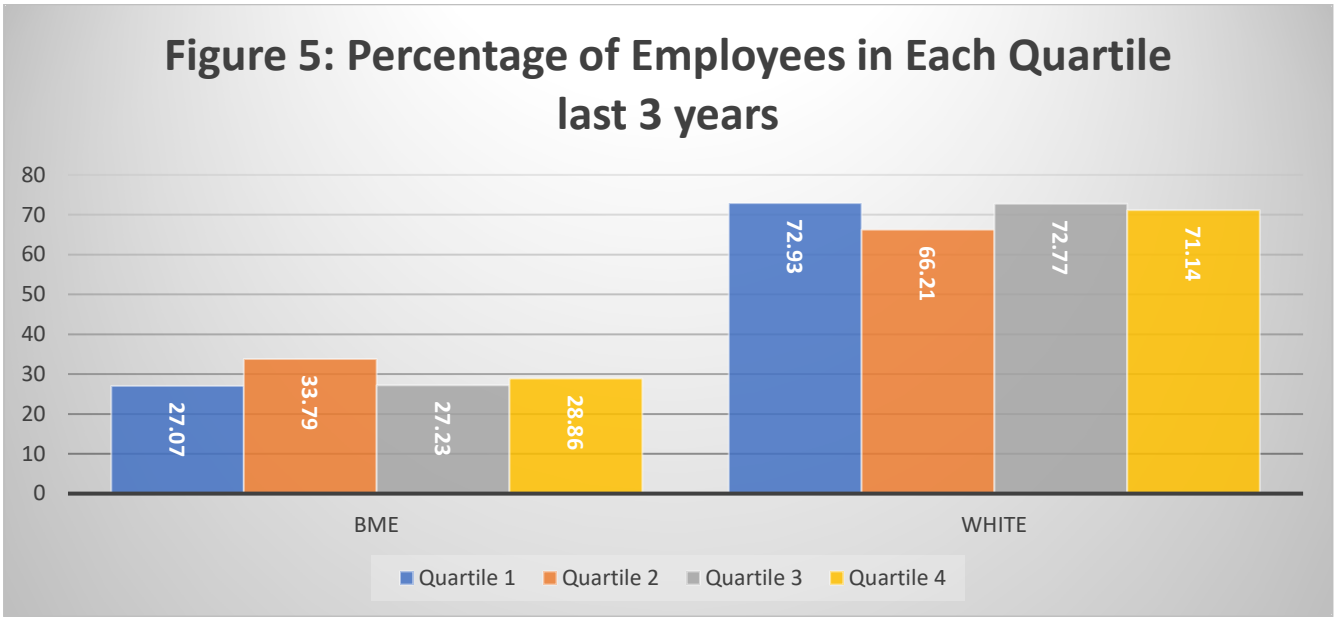
All BHFT staff, except for medical staff, executive (6) and very senior managers (3) are paid on the National Agenda for Change (AfC) pay, terms and conditions of service. The terms and conditions set out band structures and pay for all employees to ensure transparency, fairness and equal treatment for all.

Figure 4 below details the number and percentage of BME and white staff within each pay band. A majority of the pay bands are broadly representative of the organisations ethnicity ratio, however this does show more white staff as percentages increase in bands 8b, 8c and 8d and less BME staff in bands 8b, 8c, and 8d as BME percentages decrease. Pay band 8d is representative of just 1 BME individual.

Figure 4: Ethnicity Profile by Pay Band and pay quartile

	BME		White		Not Stated		Total
Grouped Pay Scale	Headcount	%	Headcount	%	Headcount	%	Headcount
Ad-Hoc	1	20.00%	2	40.00%	2	40.00%	5
Apprentice	3	27.27%	8	72.73%	0	0.00%	11
Band 2	95	42.04%	126	55.75%	5	2.21%	226
Band 3	172	27.17%	450	71.09%	11	1.74%	633
Band 4	189	24.02%	574	72.94%	24	3.05%	787
Band 5	234	38.30%	361	59.08%	16	2.62%	611
Band 6	249	25.83%	687	71.27%	28	2.90%	964
Band 7	222	25.14%	637	72.14%	24	2.72%	883
Band 8a	86	23.56%	268	73.42%	11	3.01%	365
Band 8b	28	17.07%	133	81.10%	3	1.83%	164
Band 8c	10	16.95%	48	81.36%	1	1.69%	59
Band 8d	1	2.94%	31	91.18%	2	5.88%	34
Band 9	3	27.27%	8	72.73%		0.00%	11
Board	4	30.77%	7	53.85%	2	15.38%	13
Medical & Dental	114	56.44%	80	39.60%	8	3.96%	202
Grand Total	1411	28.40%	3420	68.84%	137	2.76%	4968

Figure 5 below demonstrates that one of the major reasons for the pay gap is that there is a higher proportion of white staff in more senior bands within the Trust. As highlighted in Figure 1, BME staff represent 16.75% of our workforce yet only 2.94% of the workforce are in Band 8d.; white staff represent 83.25% of our workforce but are overrepresented in band 8d (91.18%). This means that BME staff are underrepresented by 13.81%% in 8d and white staff overrepresented by 7.93%.



Across the quartiles for BME staff, It is relatively similar with 1% or so between them with the exception of the lower middle quartile having the majority of BME staff by around 5% more than any other quartile.

Across the quartiles for white staff, it's relatively similar with 1% or so between them with the exception of the lower middle quartile have the least majority of white staff by around 6% less than any other quartile.

With 28.40% of our workforce being BME and 68.84% of our workforce being white, we have to remember that 2.76% of the workforce are 'not stated'. This needs more exploration as does the contrast between higher number of BME staff and lower number of white staff in the lower middle quartile.

It's also useful to look at our workforce compared to the communities we support (Figure 6) to see how representative our workforce is of our local population. The data shows that BHFT BME workforce is overrepresented by 0.7% compared to overall Berkshire population.

The data also shows that BHFT white workforce is overrepresented by 5.94% compared to overall Berkshire population. Like within BHFT there is a large population of the overall Berkshire population where we do not know their ethnicity (9.4%).

Figure 6: BHFT Workforce compared to Berkshire Population

(from Insights population health data)

	BME	White	Not stated	Total
BHFT Workforce	1,411 (28.40%)	3,420 (68.84%)	137 (2.76%)	4,968
Berkshire Population	279,170 (27.7%)	632,934 (62.9%)	94,280 (9.4%)	1,006,384

6. Ethnicity breakdown of staff who have receive bonus pay

Figure 7: Ethnicity breakdown of bonus payments in BHFT

	Count of Ethnicity	%
BME	38	53.52%
White	32	45.07%
Not Stated	1	1.41%
Grand Total	71	

Bonus Pay, the data presented in Figure 7 shows that 8.45% of our BME colleagues received bonus pay compared to our white colleagues. The bonus data relates only to Clinical Excellence Awards (CEA) paid to all eligible substantive Consultant Medical Staff who have been in post for at least a year. However, it is important to note the context and challenges associated with the bonus pay system:

- CEA's are not a one-off annual performance payment. Instead, it relates to a nationally agreed contractual payment which forms part of the salary package for Consultant Medical Staff.
- This system is prescribed by the British Medical Association (BMA) and NHS Employers – the Trust adopts a nationally agreed system.
- Third, many of the CEA's that are still being paid out are historic and will be maintained until the recipient's retirement.

In 2022-23 the Trust proposed equal bonus payments for all eligible Consultants in the Trust, irrespective of whether they were full-time or part-time without any pro-rata calculations. This would have helped eliminate any pay gap in the year. However, this proposal was rejected by the Local Negotiating Committee and BMA guidance (for pro-rata payment) was required to be implemented. Additionally, as stated above, there is an on-going annual legacy bonus payments made in relation to CEA points awarded prior to 2018 that some of the Consultants will continue to benefit from until retirement.

7. Conclusion and recommendations

Actions to further improve the Trust's ethnicity pay gap align with the Trust's strategic ambitions and priorities, in particular making Berkshire Healthcare a great place to work for our people. To meet this goal the Trust has refreshed its strategy and has committed to:

- Scale workforce gap closing action including international recruitment, apprenticeships and streamline student placement employment offer. Attraction focus widens into schools, T levels, NHS Reservists and underrepresented groups including veterans – *this will support our aim to try and increase the diversity of our workforce at all levels in all pay quartiles.*
- Internal matching to place staff into roles prior to external recruitment – *in time this could help our BME workforce with progression and carer development.*
- Recruitment and onboarding process improvement supported by automation and customer focused recruit/candidate connection prior to start – *will be developed*

alongside our review of inclusive recruitment to ensure this is anti-racist and removes any bias.

- Anti-racism commitment and action key area of ambition to address staff experience differential – *we will start with our vision and action scope.*
- Talent management cycle/pooling and leadership programme development. Service management skills set development – *this will support our BME staff to progress and develop their careers within BHFT.*
- Streamline internal progression path (competency based) with smooth upward grade movement – *will provide more opportunity for BME workforce to progress up the bands.*

As part of our EDI priorities work we will have key areas of focus which are designed to reduce any ethnicity Pay Gap. Within our EDI Priorities outlined in the EDI and People Strategies, our ethnicity Pay Gap actions will focus on 5 key areas:

- Inclusive Recruitment – *consider as to how we might increase underrepresented groups in all quartiles.*
- Pay and Reward - *Although the NHS Terms and Conditions do not allow the legacy Consultant bonus payments to be changed, we will explore further to ensure that ethnicity is looked at against this.* Also exploring the ethnicity pay gap through an intersectional lens is vital to understanding the different dimensions of historically marginalised groups. Looking at the ethnicity pay gap through regions, departments and job role which will also provide useful insight collectively but also for managers and leaders.
- Learning and Development – *We need to ensure our BME staff at lower bands have the confidence, skills and are supported to apply for posts at band 8A and above.*
- Culture and Engagement – *we need to share our ethnicity pay gap position with our staff, and include them in the co-production of any action plan. We will continue to publish ethnicity pay gap every year from now on, and we hope this will encourage others to do the same. We also need to encourage and support people to self declare on ESR, as 2.76% (137) of our workforce have not stated their ethnicity, and this could have further bearing on the pay gap.*
- Ways of working – *continue to embed flexible working and ensuring our people policies are supportive and enabling of greater flexibility in the way we deliver our services.*

Before we develop dedicated and detailed actions in collaboration with our Diversity Steering Group, Race Equality Network, Trade Unions and other stakeholders, we would like to engage the support of a statistician to enable the Trust to better understand any statistical significance in the pay gap within BHFT.

Contact for further information:
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Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	09 May 2023
Title	**March 2023 Finance Report**
	ITEM FOR NOTING
Purpose	To provide an update to the Committee on the Trust's Financial Performance to 31January 2023.
Business Area	Finance
Author	Rebecca Clegg, Director of Finance
Relevant Strategic Objectives	Strategic Objective 2: Work with partners to deliver integrated and sustainable services to improve health outcomes for our populations. True North Goal 4: Money Matters – to deliver services that are efficient and financially sustainable.
CQC Registration/Patient Care Impacts	Achievement of CQC Well Led standard.
Resource Impacts	n/a
Legal Implications	Compliance with statutory Financial Duties.
Equality and Diversity Implications	n/a
SUMMARY	The Trust is reporting a £2.2m adjusted surplus against a year to date deficit plan of £0.9m. The Trust's cash balance as at 31 March 2023 was £55.2m. The Trust is reporting £9.6m capital expenditure against a year to date plan of £11m.
ACTION	The Trust Board is asked to note the Trust's financial performance.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2022/23

March 2023

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 March 2023.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	20/04/23	Rebecca Clegg	Draft
2.0	21/04/23	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Contents

Dashboard & Summary Narrative

Target		Year to Date Actual £m	Plan £m	Achieved
1a	Income and Expenditure Plan	2.2	-0.9	Yes
2a	CIP - Identification of Schemes	7.5	10.1	No
2b	CIP - Delivery of Identified Schemes	5.2	10.1	No
3a	Cash Balance	55.2	46.7	Yes
3c	Aged Receivables > 90 days	0.2	n/a	n/a
3d	Aged Payables > 90 days	0.3	n/a	n/a
3e	Better Payment Practice Code Value NHS	78%	95%	No
3f	Better Payment Practice Code Volume NHS	90%	95%	No
3g	Better Payment Practice Code Value non-NHS	91%	95%	No
3h	Better Payment Practice Code Volume non-NHS	93%	95%	No
4a	Capital Expenditure not exceeding CDEL	9.0	8.7	Yes

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The key points to note are:

- In December, the Board agreed to move the forecast outturn to a £1.1m surplus. In recognition of the Trust's contribution to improving the system position, we will receive an additional £0.8m of funding from BOB ICB, bringing our overall revised target to a £1.9m surplus. The final outturn for assessment of our performance is a £2.2m surplus. This is now subject to external audit.

- The Trust planned to deliver £10.1m of cost improvements in order to achieve the planned deficit in part. Our CIP delivery is £5.2m.

- The underperformance on Better Payment Practice code non-NHS invoices by value relates to a single invoice from the PFI provider received in advance and which was settled in early August. The underperformance on NHS invoices relates to NHSPS invoices which have required additional validation.

- Although the Trust has exceed its capital expenditure limit, this was agreed with the ICS and is being covered by underspends elsewhere in the system.

System View

The contract hosted by Frimley ICB for services across Frimley and BOB IBCs is now signed. Agreement has been reached on the carry forward of SDF with both ICBs.

2.0 Income & Expenditure

Mar-23	In Month			YTD			22/23
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	49.1	26.7	22.4	343.5	318.8	24.7	318.8
Elective Recovery Fund	0.3	0.2	0.1	4.1	2.0	2.0	2.0
Donated Income	(0.2)	0.0	(0.2)	(0.2)	0.0	(0.2)	0.0
Total Income	**49.2**	**26.9**	**22.3**	**347.3**	**320.8**	**26.6**	**320.8**
Staff In Post	37.2	18.8	18.4	230.0	221.2	8.7	221.2
Bank Spend	2.4	1.4	1.0	23.2	16.2	7.0	16.2
Agency Spend	0.8	0.3	0.5	7.9	4.5	3.5	4.5
Total Pay	**40.5**	**20.5**	**20.0**	**261.0**	**241.9**	**19.1**	**241.9**
Purchase of Healthcare	3.5	1.2	2.3	22.3	17.3	5.0	16.7
Drugs	0.4	0.4	(0.0)	5.3	5.3	0.0	5.3
Premises	2.3	1.3	1.0	15.9	14.7	1.2	14.7
Other Non Pay	0.7	1.7	(1.0)	18.8	19.4	(0.6)	20.1
PFI Lease	0.6	0.6	(0.0)	7.5	7.0	0.4	7.0
Total Non Pay	**7.4**	**5.2**	**2.2**	**69.7**	**63.7**	**6.0**	**63.7**
Total Operating Costs	**47.9**	**25.7**	**22.2**	**330.8**	**305.6**	**25.1**	**305.6**
EBITDA	**1.3**	**1.2**	**0.1**	**16.6**	**15.1**	**1.4**	**15.1**
Interest (Net)	0.2	0.3	(0.1)	2.7	4.0	(1.3)	4.0
Depreciation	0.8	0.8	0.0	10.8	10.8	0.1	10.8
Impairments	1.7	0.0	1.7	1.7	0.0	1.7	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	(0.5)	0.1	(0.6)	1.4	1.3	0.0	1.3
Total Financing	**2.3**	**1.3**	**1.0**	**16.6**	**16.1**	**0.5**	**16.1**
Reported Surplus/ (Deficit)	**(1.0)**	**(0.1)**	**(0.9)**	**(0.1)**	**(1.0)**	**0.9**	**(1.0)**
Adjusted Surplus/ (Deficit)	**(1.0)**	**(0.1)**	**(0.9)**	**2.2**	**(0.9)**	**3.1**	**(0.9)**

Key Messages

The table above gives the financial performance against the Trust's income and expenditure plan as at 31 March 2023.

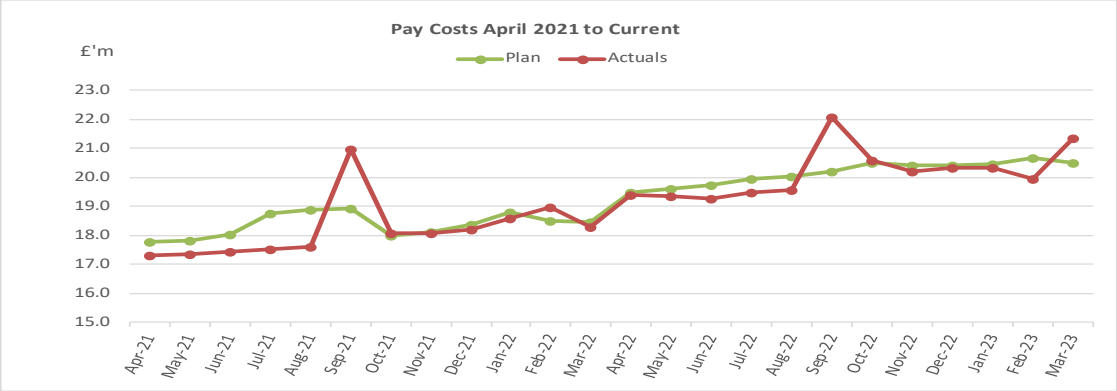
In March, the Trust's reported position is a deficit of £0.1m which includes £2.2m of impairments following the revaluation of our assets. The impairments are excluded when calculating our adjusted surplus, the measure by which our performance in assessed. The adjusted surplus is £3.2m better than plan and £0.3m better than the revised plan agreed with the ICB.

The Trust has also had a reversal of an impairment which happened in 2021/22, which as it related to an enhancement to an existing property, does not count towards the adjusted position.

Income and expenditure variances in month relate to the centrally funded pension costs £9.8m and the non-consolidated pay offer £9.7m cost (£9.3m funded) .

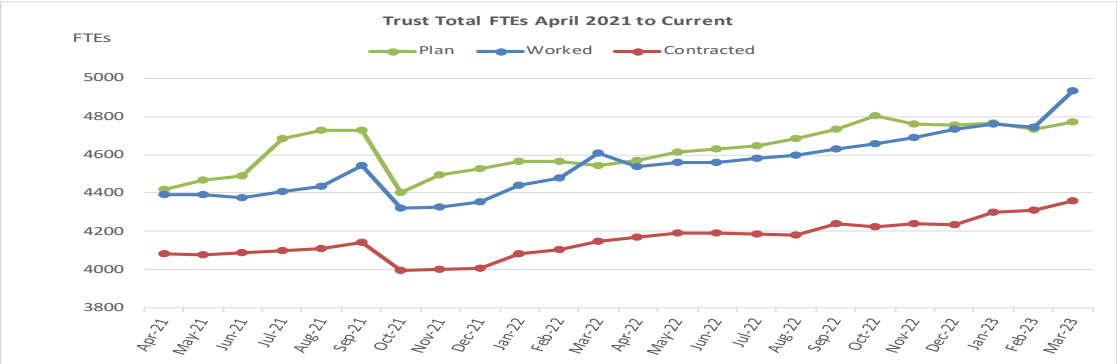
We exit the year with a c£80k per month run rate deficit against the forecast used for 2023/24 planning.

Workforce



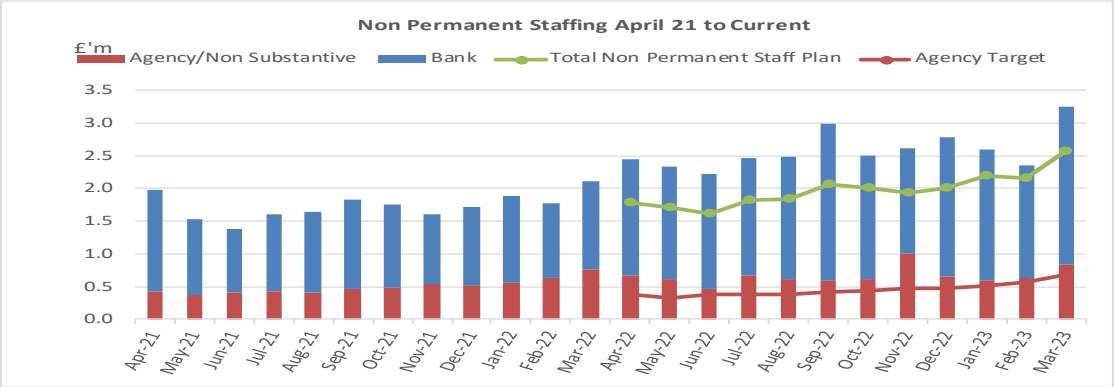
Staff Costs

YTD	£'m
2022/23	241.9
2021/22	218.4
▲	11%
Prior Yr	**£'m**
Mar-23	21.4
Mar-22	18.3
▲	17%



FTEs

Prior Mth	CFTE	WFTE
Mar-23	4,358	4,933
Feb-23	4,310	4,741
	1% ▲	4% ▲
Prior Yr	**CFTE**	**WFTE**
Mar-23	4,358	4,933
Mar-22	4,145	4,608
	2% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2022/23	23.2	7.9
2021/22	14.8	6.0
	56% ▲	33% ▲
Prior Yr	**£'m**	**£'m**
Mar-23	2.4	0.8
Mar-22	2.1	0.8
	14% ▲	10% ▲

Key Messages

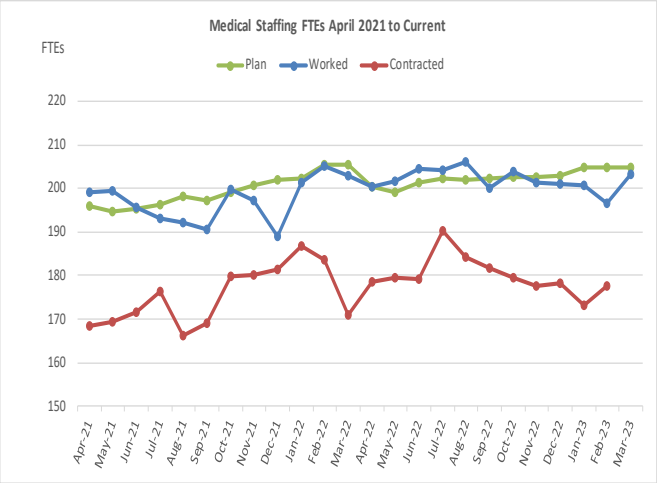
Pay costs in month were £21.4m, which is higher than plan due to an increase in bank staff costs (£790k) and an accrual made for the unfunded element of pay award offer (£352k). The centrally funded pension costs £9.8m and the funded elements of non-consolidated pay offer £9.3m have been excluded to aid comparison with previous years and the plan.

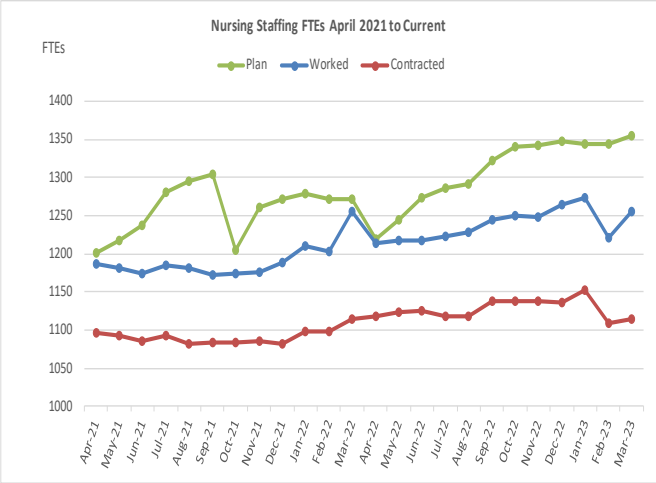
In month, we have seen an increase in contracted WTEs (49) and an increase in worked WTEs (191).

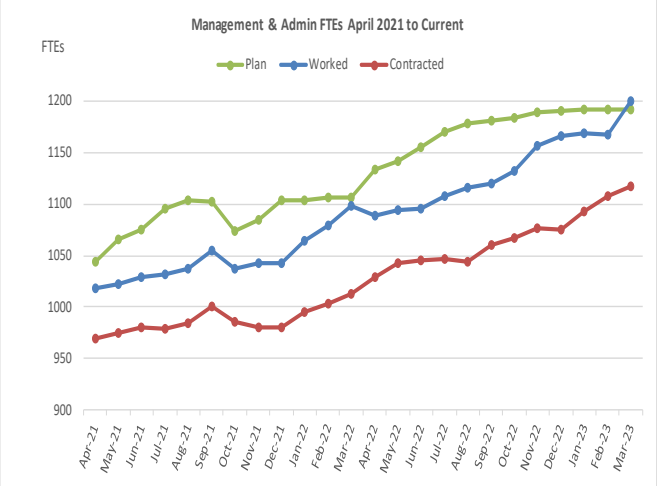
We are continuing to offset in part, substantive vacancies with higher levels of temporary staffing (£10.5m higher than plan for the year). In February the bank was understated by £300k because of an incorrect YTD adjustment (circa 50wte), in March the actual increase compared to February was £490k (circa 90WTE), which will be in part due to difference in number of days but mainly cover for annual leave.

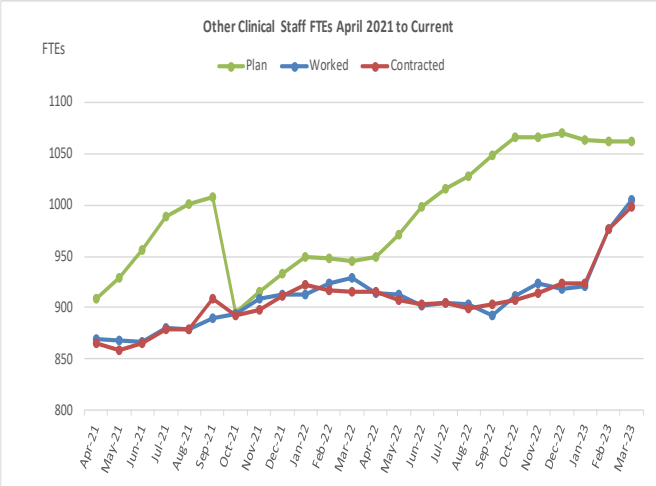
NHSE has reintroduced an agency ceiling, which applies at a system level. There is an expectation that costs will be a minimum of 10% lower than in 21/22. Our agency costs grew gradually during 21/22 due in part to the need to cover medical staffing vacancies and continued pressures filling rotas in West Call. This run rate has continued into the current year and unchanged will result in costs c20% higher than last year despite a plan to reduce agency usage significantly. A representation of a 10% reduction in spend (compared with 2021/22) has been added to the chart.

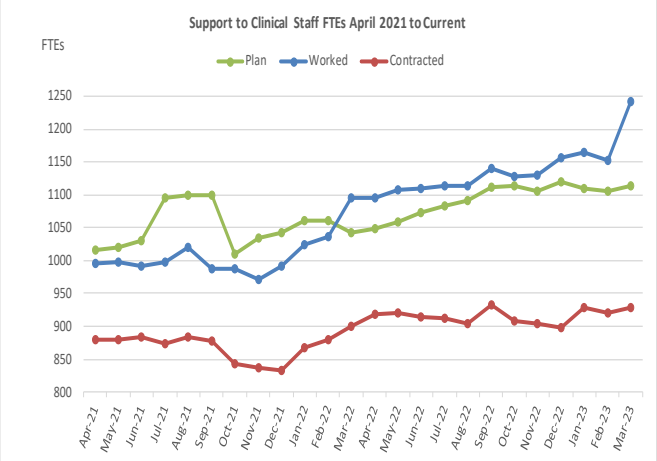
Staffing Detail

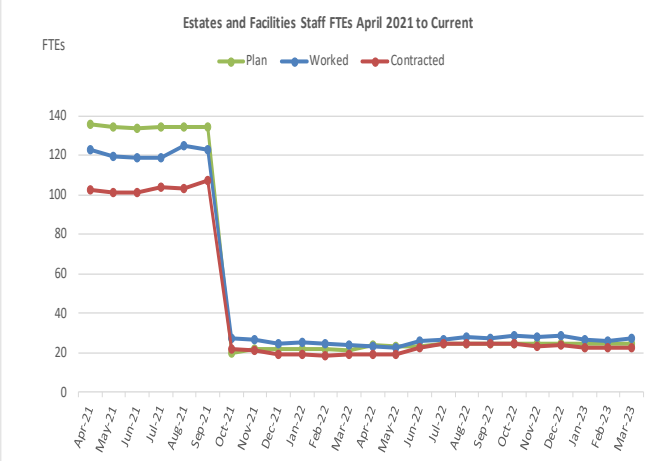










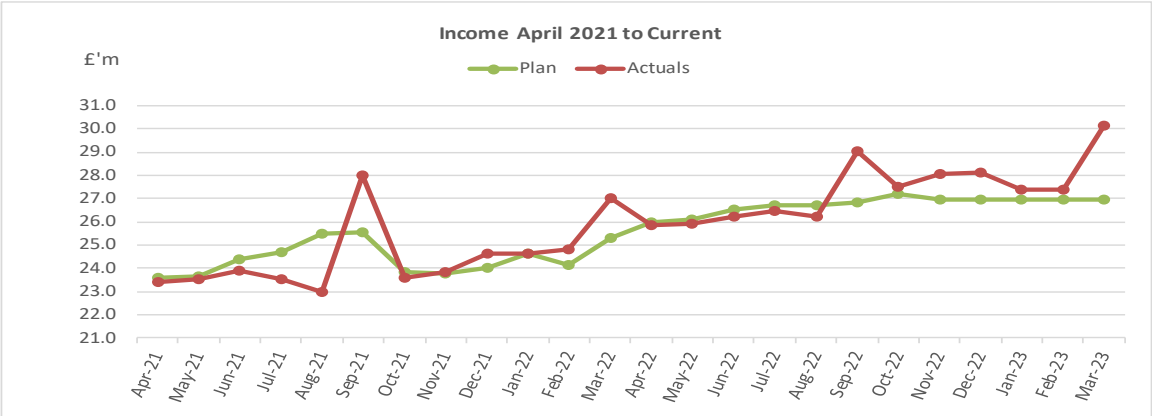


Key Messages

The tables above provides current staffing numbers broken down into core staffing groups.

In month, we have seen an increase in contracted WTEs (49). Increases have been across all directorates and include Community Nursing (3), Physio/MSK (5), Pharmacy (4), Estates and Facilities (2), CAMHS (6), CYPIT (3), LD (2), CMHT (5), CRHTT (3) and IAPT (10). Many of the increases are funded from SDF.

Income & Non Pay

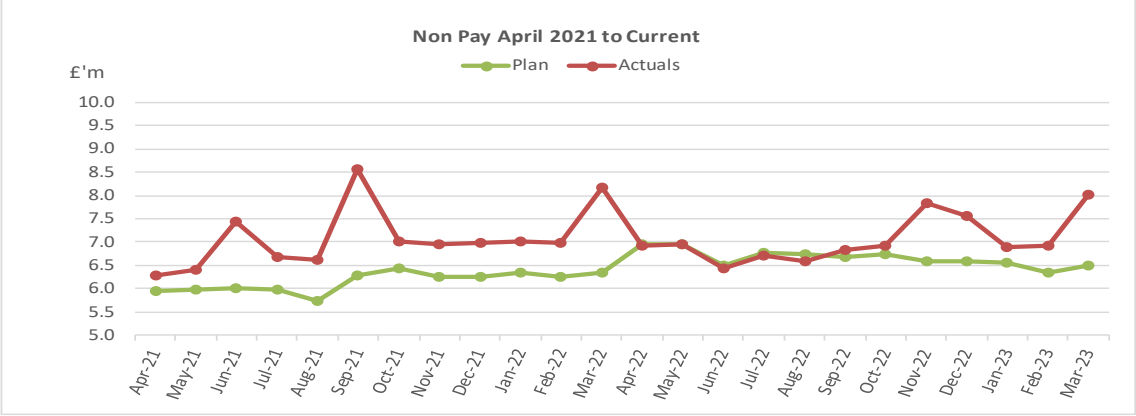


Income	
YTD	£'m
2022/23	328.2
2021/22	293.7
▲	12%
Prior Yr	£'m
Mar-23	30.1
Mar-22	27.0
▲	12%

Key Messages

Throughout the year, core income has been higher than planned due to the pay award which was higher than the 2% in the original planning assumptions. Offsetting the funding for the pay award has been the clawback in funding for the reduction in employer's NICs from November. In March, we have accrued for an additional £0.8m income from BOB ICB. Income assumed for the accounting treatment of centrally funded pension costs £9.8m and the non-consolidated pay offer £9.3m has been excluded from the graph. We continue to defer income/slippage on investments linked to lower than expected recruitment but have released some of the income in month 12.

NHSE confirmed that there is no clawback of ERF income this year.



Non Pay	
YTD	£'m
2022/23	84.6
2021/22	85.2
▼	-1%
Prior Yr	£'m
Mar-23	8.0
Mar-22	8.2
▼	-2%

Key Messages

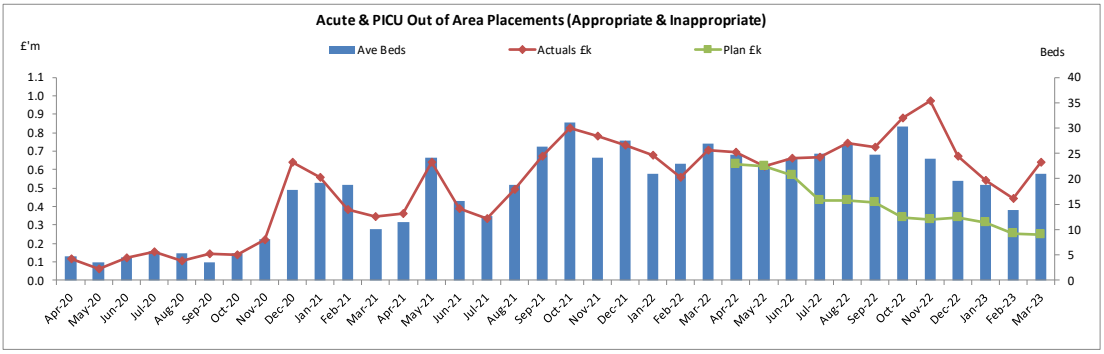
Non Pay spend was £8m in month.

Expenditure on Out of Area Placements continues to be higher than planned with the average number of placements increasing from 14 in February to 21 in March. The monthly costs increased from £0.4m to £0.6m.

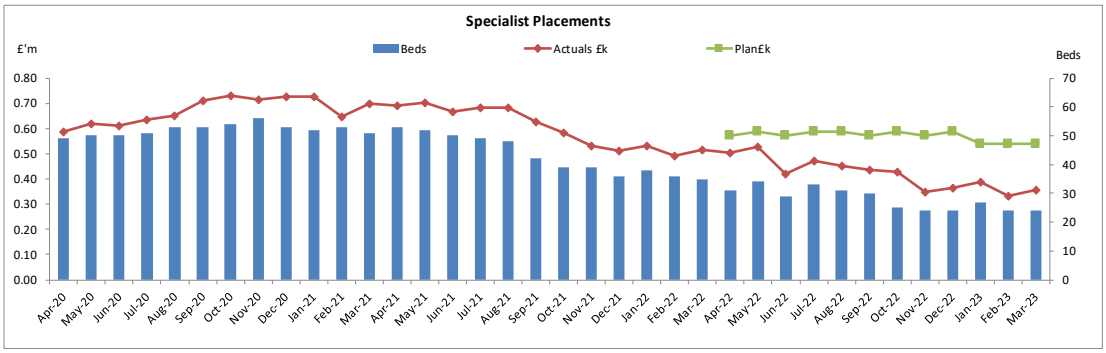
We have increased energy costs linked to inflation. The contractual arrangement with NHSPS mitigates our risk on price increases for NHSPS properties, with costs passed through to ICBs under the historical arrangement.

The Trust is benefiting from an increase in bank interest rates and has generated £1.5m YTD in interest.

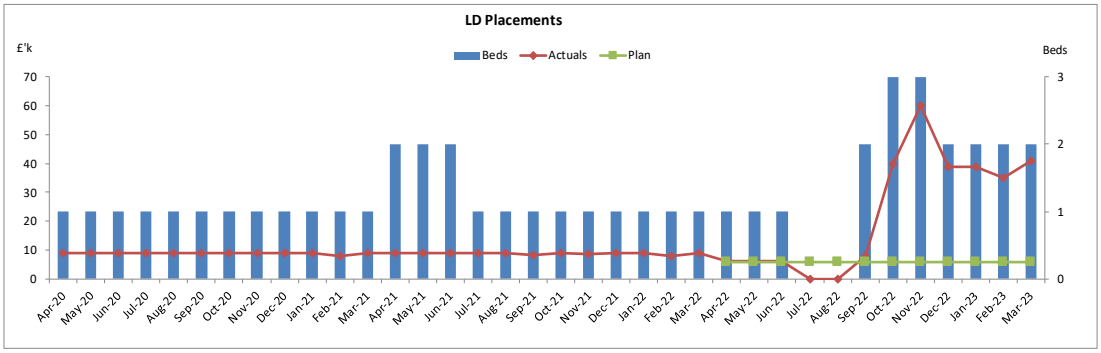
Placement Costs



OAPs	
YTD	£'m
2022/23	8.2
2021/22	7.2
▲	*15%*
Prior Yr	£'m
Mar-23	0.6
Mar-22	0.7
▼	*-10%*



Specialist Placements	
YTD	£'m
2022/23	5.0
2021/22	7.2
▼	*-30%*
Prior Yr	£'m
Mar-23	0.4
Mar-22	0.5
▼	*-31%*



LD OAPs	
YTD	£'k
2022/23	280.0
2021/22	104.7
▼	*-63%*
Prior Yr	£'k
Mar-23	41.0
Mar-22	8.8
▲	*366%*

Key Messages

Out of Area Placements. Expenditure on Out of Area Placements continues to be higher than planned with the average number of placements increasing from 14 in February to 21 in March. The monthly costs increased from £0.4m to £0.6m. Some of the variance between February and March relates to working days.

We now have a dedicated clinical lead for the delivery of the bed optimisation programme, and this post has supported daily bed flow meetings, development of a new bed flow dashboard which has provided improved visibility and locality oversight of admission numbers and LOS and also improved identification and escalation of MOFD/CRFD patients.

We will continue to spot purchase PICU beds where they are clinically required. We continue to have significant demand for PICU beds especially for patients with forensic backgrounds, which do not count as an inappropriate out of area bed against the OAPs trajectory but which do have a financial impact. From the 1st January we have reduced our OAP acute overspill beds to 9 and will have an escalation to Director on Call if there is a request to admit to an additional bed.

Specialist Placements. The average number of placements was 24 which is the same as in the previous month. The cost increased from £0.33m to £0.36m mainly due to the number of days in the month.

LD Placements: We have had an increase in LD placements in September and are monitoring this closely with the position expected to improve from Q1 of 23/24.

Cost Improvement Programme

Cost Improvement (Cash releasing) Scheme	In Month Act £'k	In Month Plan £'k	In Month Var £'k	YTD Act £'k	YTD Plan £'k	YTD Var £'k	Plan £'k
Trust Wide Schemes							
Out of Area Placements - Volume	0.0	314.6	(314.6)	0.0	1,821.4	(1,821.4)	1,821.4
Out of Area Placements - Price	0.0	54.9	(54.9)	0.0	354.0	(354.0)	354.0
Opt to Tax (Historic)	125.0	125.0	0.0	1,500.0	1,500.0	0.0	1,500.0
Opt to Tax (Recurrent)	37.0	37.0	0.0	444.0	444.0	0.0	444.0
Contribution from New Investments	12.0	8.0	4.0	110.1	96.0	14.1	96.0
EFM Recharge to NHSPS	0.0	41.0	(41.0)	0.0	732.0	(732.0)	732.0
Procurement / ICS Procurement	2.0	26.0	(24.0)	9.7	300.0	(290.3)	300.0
Medicines Optimisation	0.0	5.0	(5.0)	0.0	50.0	(50.0)	50.0
Interest Receivable	235.0	0.0	235.0	1,501.5	0.0	1,501.5	0.0
Long Term Placements	74.0	0.0	74.0	883.0	0.0	883.0	0.0
Recruitment Slippage	0.0	0.0	0.0	400.0	400.0	0.0	400.0
Division/Corp Schemes Local Delivery							
Total smaller value schemes	36.0	90.5	(54.5)	366.0	845.0	(479.0)	845.0
Corporate Schemes Trust Decision							
Corporate Schemes - FWH Vacating Early	0.0	21.0	(21.0)	0.0	105.0	(105.0)	105.0
Review of Management Structures	0.0	100.0	(100.0)	0.0	550.0	(550.0)	550.0
System Supported Schemes							
Agency - Price Cap Compliance (ICS Temporary Staffing Project)	0.0	25.0	(25.0)	0.0	150.0	(150.0)	150.0
Agency - Improved Procurement (ICS Temporary Staffing Project)	0.0	25.0	(25.0)	0.0	150.0	(150.0)	150.0
Unidentified	**0.0**	**239.9**	(239.9)	**0.0**	**2,596.2**	(2,596.2)	**2,597**
Total Cost Improvement	**521**	**1,113**	**(592)**	**5,214**	**10,094**	**(4,879)**	**10,094**

Key Messages

The Trust's initial financial plan for 22/23 included a requirement to deliver £9.7m of cost improvements in order to achieve the deficit plan submitted. The requirement was increased by £0.4m in June when the Trust agreed to take a share of the BOB system deficit to bring the overall system plan back to breakeven.

There remains a £2.6m unallocated target which reflects the gap between our plan submission and the identified savings schemes. We continue to work to identify schemes in excess of this value to take account of slippage and to contribute to recurrent financial sustainability.

The number of long term placements continues at a lower than planned level offsetting the underperformance on the OAPs CIP. This is in part due to the withdrawal from the contracted beds at Rosebank, which completed on 31/10/22 with further savings expected as a result.

The CIP related to NHSPS has not been delivered in 2022/23 due to the complications related to the original business transfer agreement for the sites, but it has been agreed a contract variation for 2023/24 for both ICBs.

The review of management structures is underway, but any savings are likely to impact into 2023/24.

Given the historically low levels of usage and rates paid, there has been little identified through the ICS Temporary Staffing Programme in respect of in year benefit.

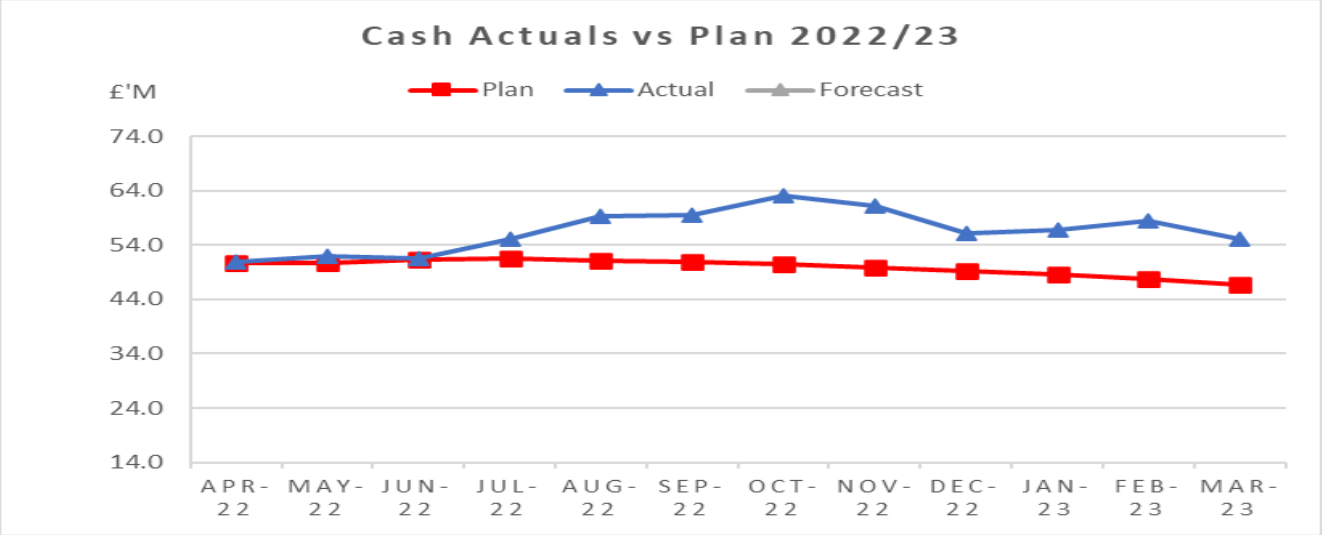
The additional £0.4m CIP required for BOB ICS has been delivered through recruitment slippage from Q1.

The under-delivery on CIPs, is being offset by the underspend on workforce and good performance on elective recovery with income not being clawed back as initially planned.

Planning for 2023/24 CIPs and cost avoidance schemes is complete.

3.0 Cash

Cashflow	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Reported Surplus / (Deficit)	1.7	(0.9)	(0.1)	(0.8)	0.0	(1.0)	1.0
Remove Finance Charges through SoCI	4.0	0.1	0.3	(0.2)	2.6	4.0	(1.4)
Remove PDC Dividend accrual through SoCI	0.9	(0.4)	0.1	(0.5)	1.4	1.3	0.1
Remove Profit on Disposal of Assets	(1.4)	(0.4)	0.1	(0.5)	1.4	1.3	0.1
Operating Surplus/(Deficit)	**5.2**	**(1.1)**	**0.4**	**(1.5)**	**4.1**	**4.4**	**(0.3)**
Depreciation and Impairments	9.4	2.5	0.8	1.7	12.5	10.8	1.7
Operating Cashflow	***14.6***	***1.4***	***1.2***	***0.2***	***16.6***	***15.2***	***1.4***
Net Working Capital Movements	***11.6***	***0.5***	***(0.1)***	***0.6***	***2.1***	***(5.0)***	***7.1***
Proceeds from Disposals	2.2	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(8.1)	(2.5)	(1.4)	(1.1)	(8.5)	(10.7)	2.2
Investments	***(5.8)***	***(2.5)***	***(1.4)***	***(1.1)***	***(8.5)***	***(10.7)***	***2.2***
PFI Finance Lease Repayment	(1.6)	(0.2)	(0.1)	(0.1)	(1.7)	(1.7)	0.0
RoU Asset Finance Lease Repayment	0.0	(1.0)	(0.2)	(0.8)	(3.3)	(2.5)	(0.8)
Net Interest	(3.9)	(0.1)	(0.3)	0.2	(2.6)	(4.0)	1.4
PDC Received	0.7	0.0	0.0	0.0	0.4	0.0	0.4
PDC Dividends Paid	(0.8)	(1.4)	0.0	(1.4)	(1.7)	0.0	(1.7)
Financing Costs	***(5.5)***	***(2.7)***	***(0.7)***	***(2.0)***	***(8.9)***	***(8.2)***	***(0.7)***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***14.8***	***(3.3)***	***(0.9)***	***(2.4)***	***1.3***	***(8.7)***	***10.0***
Opening Cash	39.1	58.5	47.6	10.9	53.9	55.4	(1.5)
Closing Cash	***53.9***	***55.2***	***46.7***	***8.5***	***55.2***	***46.7***	***8.5***



Key Messages

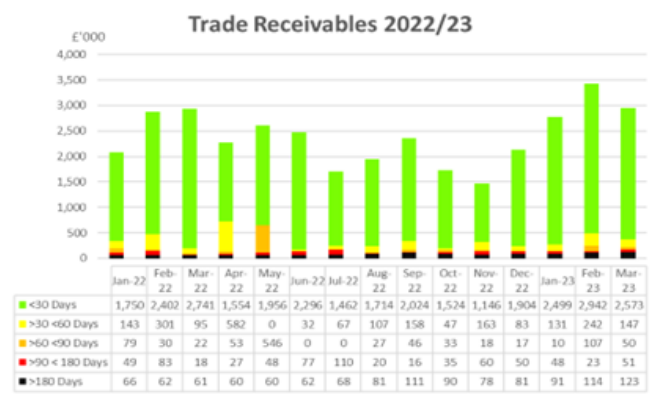
The closing cash balance for March 2023 was £55.2m, which is £8.5m above the revised plan. The year to date operating surplus is £3m above plan contributing to increase in cash. The Trust continues to carry deferred income balances linked to SDF which has not been spent in line with the plan. It is also linked to the timing of payment runs which have been realigned to facilitate working day one reporting. This means that payment runs in the final week of the month are paid in the next financial reporting period resulting in a gain in cash over the period. Average daily cash balances have increased by £1.3m as a result, which will reduce PDC Dividend risk. The variance to plan is also the result of slippage on the capital programme with some schemes not being completed until late in the month. The Trust is benefiting from an increase in bank interest rates and has generated £1.5m in interest during 2022/23.

3.0 Balance Sheet

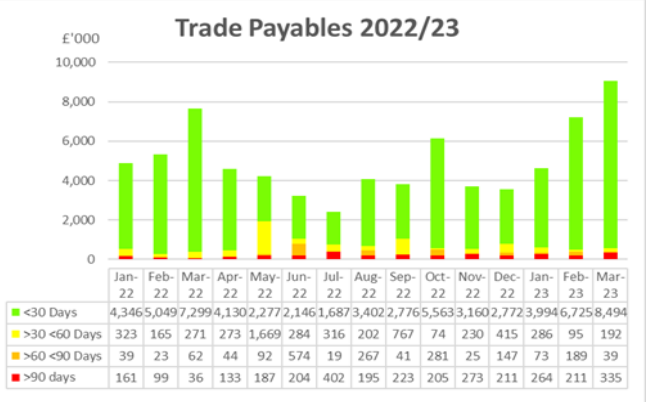
Balance Sheet	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	4.2	4.0	2.7	1.3	4.0	2.7	1.3
Property, Plant & Equipment (non PFI)	42.6	45.7	38.5	7.1	45.7	38.5	7.1
Property, Plant & Equipment (PFI)	70.2	72.1	58.8	13.3	72.1	58.8	13.3
Property, Plant & Equipment (RoU Asset)	0.0	15.5	11.6	3.9	15.5	11.6	3.9
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**117.2**	**137.5**	**111.9**	**25.6**	**137.5**	**111.9**	**25.6**
Trade Receivables & Accruals	8.9	18.5	8.8	9.7	18.5	8.8	9.7
Other Receivables	0.2	0.3	0.2	0.1	0.3	0.2	0.1
Cash	53.9	55.2	46.7	8.5	55.2	46.7	8.6
Trade Payables & Accruals	(35.4)	(47.6)	(33.0)	(14.6)	(47.6)	(33.0)	(14.6)
Current PFI Finance Lease	(1.7)	(1.7)	(1.7)	0.0	(1.7)	(1.7)	0.0
Current RoU Asset Finance Lease	0.0	(2.2)	(2.1)	(0.1)	(2.2)	(2.1)	(0.1)
Other Current Payables	(12.5)	(12.8)	(12.8)	0.0	(12.8)	(12.8)	0.0
Total Net Current Assets / (Liabilities)	**13.3**	**9.7**	**6.0**	**3.6**	**9.7**	**6.0**	**3.6**
Non Current PFI Finance Lease	(23.8)	(22.1)	(22.1)	0.0	(22.1)	(22.1)	0.0
Non Current RoU Finance Lease	0.0	(13.0)	(9.8)	(3.2)	(13.0)	(9.8)	(3.2)
Other Non Current Payables	(1.8)	(1.5)	(1.6)	0.1	(1.5)	(1.6)	0.1
Total Net Assets	***104.9***	***110.6***	***84.4***	***26.2***	***110.6***	***84.4***	***26.2***
Income & Expenditure Reserve	32.2	32.3	31.5	0.8	32.3	31.5	0.8
Public Dividend Capital Reserve	20.7	21.1	20.7	0.4	21.1	20.7	0.4
Revaluation Reserve	52.0	57.2	32.2	25.0	57.2	32.2	25.0
Total Taxpayers Equity	***104.9***	***110.6***	***84.4***	***26.2***	***110.6***	***84.4***	***26.2***

Key Messages

Following completion of year end audit for 2021/22 in October, the prior year fixed asset and revaluation reserve closing balances and subsequently in year balances have been updated to reflect the increase in Depreciated Replacement Cost valuations for the two PFIs and Greenham Trust Wing resulting in an increase in of c£20m.



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	1,750	2,402	2,741	1,554	1,956	2,296	1,462	1,714	2,024	1,524	1,146	1,904	2,499	2,942	2,573
>30 <60 Days	143	301	95	582	0	32	67	107	158	47	163	83	131	242	147
>60 <90 Days	79	30	22	53	546	0	0	27	46	33	18	17	10	107	50
>90 < 180 Days	49	83	18	27	48	77	110	20	16	35	60	50	48	23	51
>180 Days	66	62	61	60	60	62	68	81	111	90	78	81	91	114	123



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	4,346	5,049	7,299	4,130	2,277	2,146	1,687	3,402	2,776	5,563	3,160	2,772	3,994	6,725	8,494
>30 <60 Days	323	165	271	273	1,669	284	316	202	767	74	230	415	286	95	192
>60 <90 Days	39	23	62	44	92	574	19	267	41	281	25	147	73	189	39
>90 days	161	99	36	133	187	204	402	195	223	205	273	211	264	211	335

Key Messages

Overall receivables balances decreased by £0.5m mainly due decrease in current debt (<30 days). All aged debt over 30 Overall payables increased by £1.8m, primarily in current payable (<30 days). There are a small number of high value invoices for placements that are not paid as we are awaiting credit notes.

4.0 Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Outturn £'000
Estates Maintenance & Replacement Expenditure								
Erleigh road Change of Service - Phase 1 c/fwd & Phase 2	2	13	(12)	82	150	(68)	150	82
Extension for Clinical Space - CHH	0	117	(117)	0	450	(450)	450	0
Other Trust Owned Properties	46	2	44	73	70	3	70	73
Leased Non Commercial (NHSPS)	123	12	74	170	260	(90)	240	170
Head Office Relocation	167	0	167	1,461	1,300	161	1,300	1,461
MSK Relocation - AV	557	0	557	762	335	427	335	762
Leased Commercial Other	3	0	3	3	140	(137)	140	3
Environment & Sustainability	143	6	137	221	50	171	50	221
Windsor Consolidation (Dedworth)	480	0	480	1,357	500	857	500	1,357
Various All Sites	56	82	(26)	127	616	(489)	616	127
Statutory Compliance	83	16	67	90	150	(60)	150	90
Subtotal Estates Maintenance & Replacement	**1,659**	**248**	**1,375**	**4,346**	**4,021**	**325**	**4,001**	**4,346**
IM&T Expenditure								
IM&T Business Intelligence and Reporting	0	40	(40)	52	120	(68)	120	52
IM&T Refresh & Replacement	1,833	410	1,423	3,292	2,782	510	2,782	3,292
IM&T System & Network Developments	67	31	37	770	260	510	260	770
IM&T GDE & Community Projects	12	10	2	191	242	(51)	242	191
IM&T Digital Strategy	316	106	209	371	1,275	(904)	1,275	371
Subtotal IM&T Expenditure	**2,229**	**597**	**1,631**	**4,676**	**4,679**	**(3)**	**4,679**	**4,676**
Subtotal CapEx Within Control Total	**3,887**	**845**	**3,006**	**9,022**	**8,700**	**323**	**8,680**	**9,022**
CapEx Expenditure Outside of Control Total								
PPH 'Place of Safety	0	500	(500)	1	1,600	(1,599)	1,600	1
PPH Zonal Heating Controls	0	0	0	0	250	(250)	250	0
Statuory Compliance	215	10	38	54	100	(46)	100	54
Environment & Sustainability / Zero Carbon	0	23	0	0	0	0	200	0
Other PFI projects	(108)	16	21	91	385	(294)	185	92
Health Bus (Donated)	0	0	0	0	0	0	0	0
Subtotal Capex Outside of Control Totals	**108**	**549**	**(441)**	**147**	**2,335**	**(2,188)**	**2,335**	**147**
Central Funding								
Cyber Security	96	0	96	96	0	96	0	96
EOI Funding - CYPF Reading (25 Erleigh Road)	268	0	268	299	0	299	0	299
Sub Total Central Funding Outside of Control Totals	**364**	**0**	**364**	**395**	**0**	**395**	**0**	**395**
Total Capital Expenditure	**4,359**	**1,394**	**2,929**	**9,564**	**11,035**	**(1,471)**	**11,015**	**9,564**

Key Messages

Schemes within control total at the end of the year are overspent by £323k. This overspend was agreed with the ICS as an opportunity to access spare CDEL in the system to cover in year cost pressures and bring forward some activity from 2023/24.

Windsor Consolidation (Dedworth/Fairacres) Phase 1, MSK Relocation (Adlam Villas) and the Head Office Relocation all completed in year. The forecast outturn on these projects was £1.4m higher than originally planned and was funded by rephasing and prioritising capital schemes with some planned slippage into 2023/24 (Bariatric Facilities at Wokingham Hospital and the new Dental Surgery at Whitley).

IM&T Digital Strategy was underspent by £900k with the underspend being was used on IM&T Refresh & Replacement, System & Networks.

The Trust was successful in bidding for UEC capital £0.3m. The project will develop space at 25 Erleigh Road, Reading to help young people in crisis.

The Trust had five new leases starting in the financial year with Right of use Asset valued at £3.5m as per IFRS16 with CDEL cover provided by NHSE.

The Trust's bid against the Public Sector Decarbonisation Scheme (Salix) was unsuccessful so further consideration will be given to sources of funding for this work in 2023/24.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	9th May 2023
Title	**True North Performance Scorecard** **Month 12 (March 2023) 2022/23**
	ITEM FOR NOTING
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2022/23.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 12 2022/23 (March 2023) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. The business rules apply to three categories of metric:

	• **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention.
	• **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month.
	• **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity.
	
	Month 12
	
	Performance business rule exceptions, red rated with the True North domain in brackets:
	
	Breakthrough and Driver Metrics
	
	Context and update to driver performance to be provided in discussion of counter measure action and development:
	
	• Physical Health Checks – 7 Parameters for People with Severe Mental Illness (SMI) **(Harm Free Care) -** at 83% against a revised target of 85%. The metric has been consistently above the mean of 80% for more than 12 months. This has been revised from 95%, but over the national target and will take into account the ebb and flow within caseloads. The Slough team is the top contributor but has improved for the last 2 months. This is set to be retired as a breakthrough objective, as relies on improvement in an area.
	• I Want Great Care Positive Score **(Patient Experience)** - at 93.7% against a 95% target.
	• I Want Great Care Compliance Rate **(Patient Experience)** - at 3.1% against a 10% target.
	• Physical Assaults on Staff **(Supporting Our Staff)** – 67 against a target of 44.
	  ○ 53 of these incidents were on mental health wards, which is reflective of the high acuity and demand for Psychiatric Intensive Care Unit (PICU) beds and seclusion.
	  ○ Highest contributors; Rowan (16), Rose (12) and Sorrel (8) wards. Increase in incidents likely to be related to high acuity within the hospital.

	○ 1 unwell patient on Rowan ward was responsible for a number of incidents and also required restraint and seclusion. ○ The highest contributing factor for assaults on Campion was escorted leave. There are individual countermeasures for each patient. ○ Countermeasures for mental health wards remain in place, that includes daily safety huddles, robust planning and risk assessment prior to secluding patients. • Variance from YTD NHSE efficiency plan (£'k) **(Money Matters) –** at -4,875 against a target of 0. • Inappropriate Out of Area Placements **(Money Matters)** **Tracker 1 Metrics (where red for 1 month or more)** • Meticillin-resistant Staphylococcus Aureus (MSSA) Bacteraemias (Cumulative year to date) **(Regulatory Compliance)** – there were 0 incident in March, but the year-to-date total is 3 against a target of 0. • People with Common Mental Health Conditions Referred to IAPT Completing a Course of Treatment Moving to Recovery - **(Regulatory Compliance)** – at 46.5%, below the 50% target. • Proportion of Patients Referred for Diagnostic Tests who have been Waiting for Less than 6 weeks (DM01 – Audiology) **(Regulatory Compliance)** – at 69% against a target of 95%. Recovery plan in place, staff in post from recruitment which should impact the waits in the coming months. • Sickness rate **(Regulatory Compliance)** – red at 4.30% against a target of 3.5%. This is not a "hard" compliance focus with NHSE but is tracked. Twelve months red. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <1 week (Urgent) **(Regulatory Compliance)** – red at 66.6% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <4 weeks (Routine) **(Regulatory Compliance)** – red at 66.6% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking.

	Tracker Metrics (where red for 4 months or more) • Health Visiting: New Birth Visits within 14 days **(Patient Experience)** – at 85.9% against a 90% target. • Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019 **(Patient Experience)** – at 14.4% against a 20% target – 12 months red. • Self-harm Incidents within the Community **(Harm Free Care)** – at 52 incidents against a target of 31. Further work looking into this metric is being conducted. Is a driver metric for Crisis services and there is an uptake in recording. • Increase in Elective Care Activity from 2019/20 baseline (physical health only) – follow up appointment **(Money Matters)** - at -4.7% against a target of 4%. A challenging recovery target, with limited-service inclusion for the Trust. • Community Inpatient Occupancy **(Money Matters)** – at 89.4% against a target of 85%. • Community Health Delayed Transfers of Care **(Money Matters)** - at 24.3% against a target of 7.5%. A positive reporting shift is placing a focus on mental health delays in the systems. • Mental Health Acute Occupancy rate **(Money Matters)** - at 95.3% against an 85% target. Red for 12 months. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters)** – at 50 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is underway.
Action	The Board is asked to note the True North Scorecard.

Harm Free Care

Metric	Target	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	25	30	23	25	16	29	18	31	23	36	19	24
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	92	98	101	95	104	76	72	78	37	26	145	28
Number of suicides (per month)	Equal to or less than 3 per month	1	3	2	3	3	0	2	1	3	4	1	2

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	85%	78%	78%	79%	80%	79%	80%	79%	80%	80%	81%	84%	83%

Patient Experience

IWGC Positive Score %	95% compliance from April 22	94%	92.7%	95.2%	95.2%	94.1%	95.5%	93.3%	94.8%	91.5%	94.5%	92.4%	93.7%
IWGC Compliance %	10% compliance	0.6%	1.0%	1.3%	2.3%	2.2%	3.4%	3.6%	5.4%	2.7%	2.8%	2.3%	3.1%

Performance Scorecard - True North Drivers

Supporting our Staff

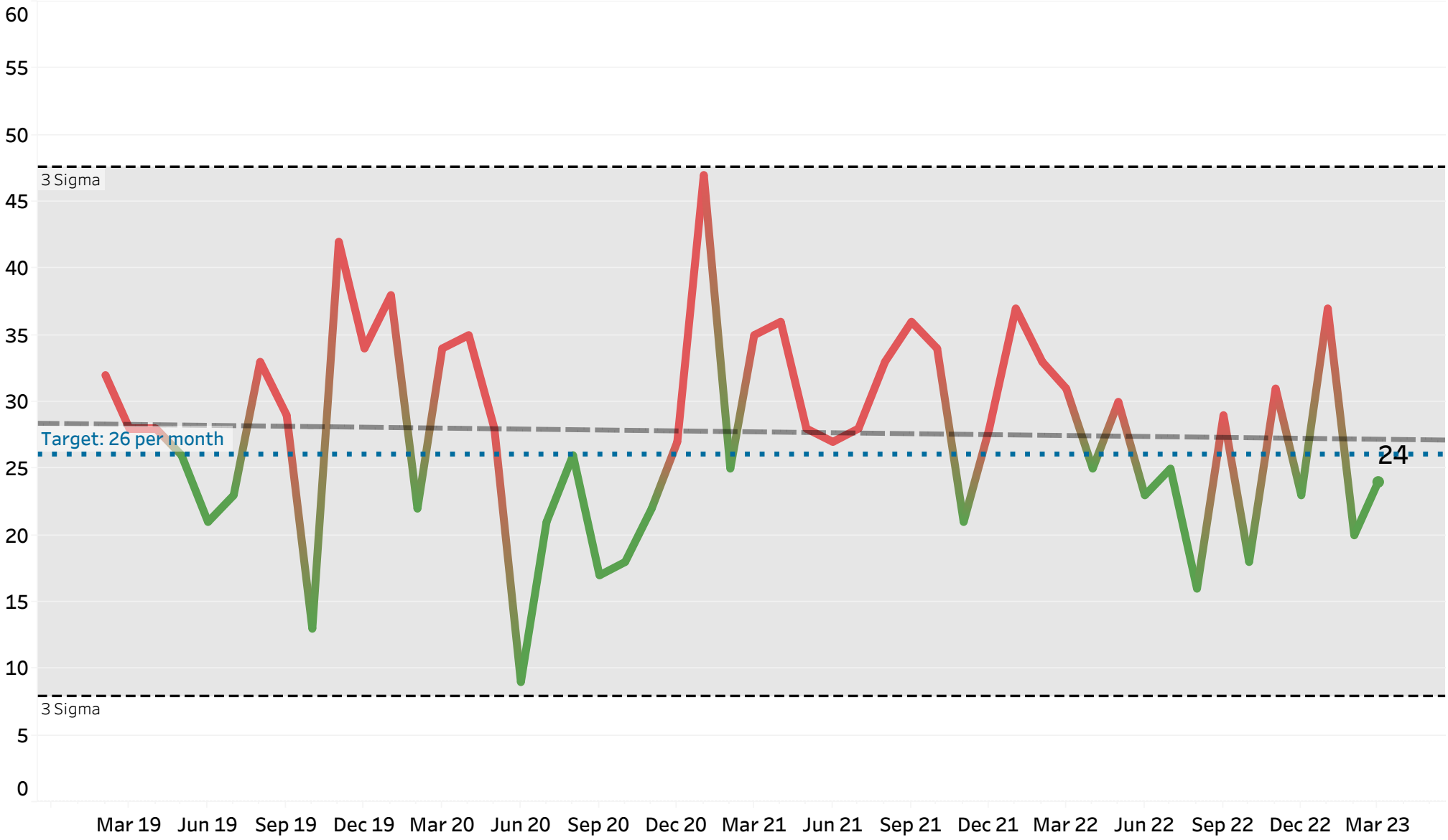
Metric	Target1	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Physical Assaults on Staff	44 per month	117	69	68	61	65	71	76	59	52	30	55	67
Staff turnover (excluding fixed term posts)	<=16% per month	16.19%	16.71%	16.76%	16.89%	17.02%	16.98%	16.5%	16.32%	16.52%	16.21%	15.69%	15.85%

Money Matters

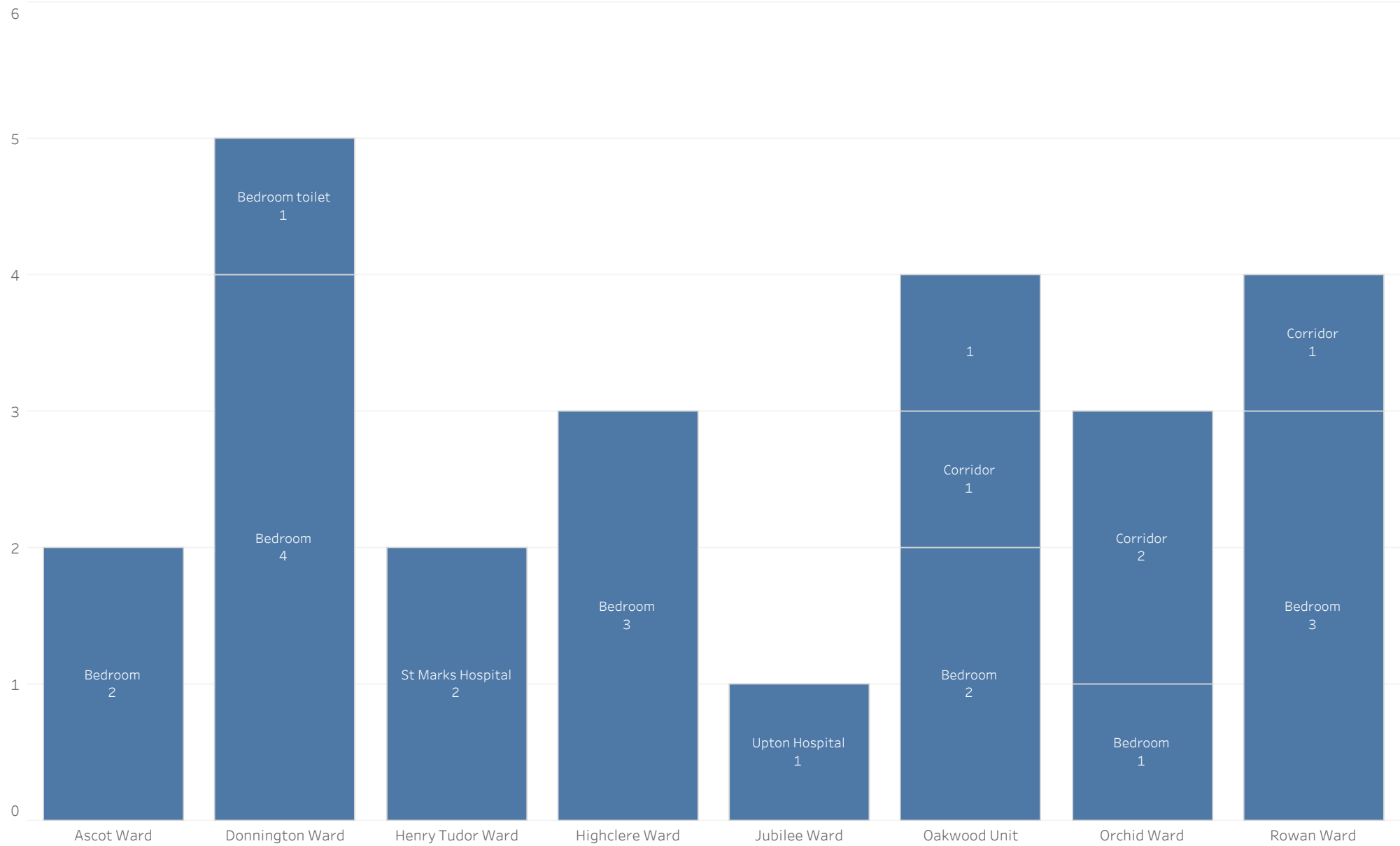
Variance from YTD NHSE financial control total (£'k)	<£0k	-3	32	-149	-400	-506	-714	-774	-822	-1092	-1277	-1818	
Variance from YTD NHSE efficiency plan (£'k)	>£0k	112	134	490	183	-571	-1141	-1803	-2357	-3003	-3583	-4283	
Inappropriate Out of Area Placements	180 Cumulative Total Q4 2022/23	69	114	226	144	329	524	266	484	591	50	112	212

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Feb 19 to Mar 23)

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

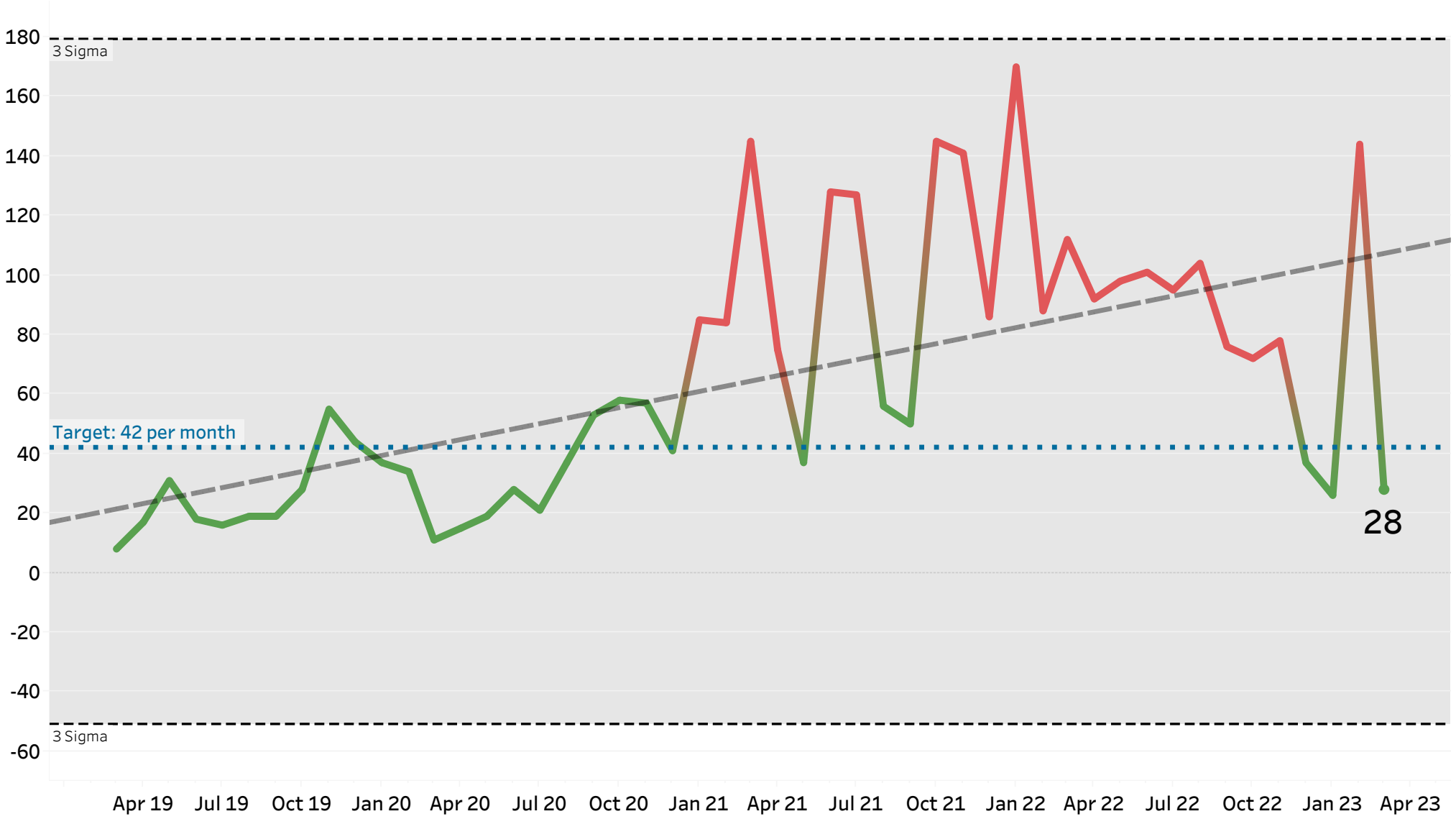


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (March 2023)

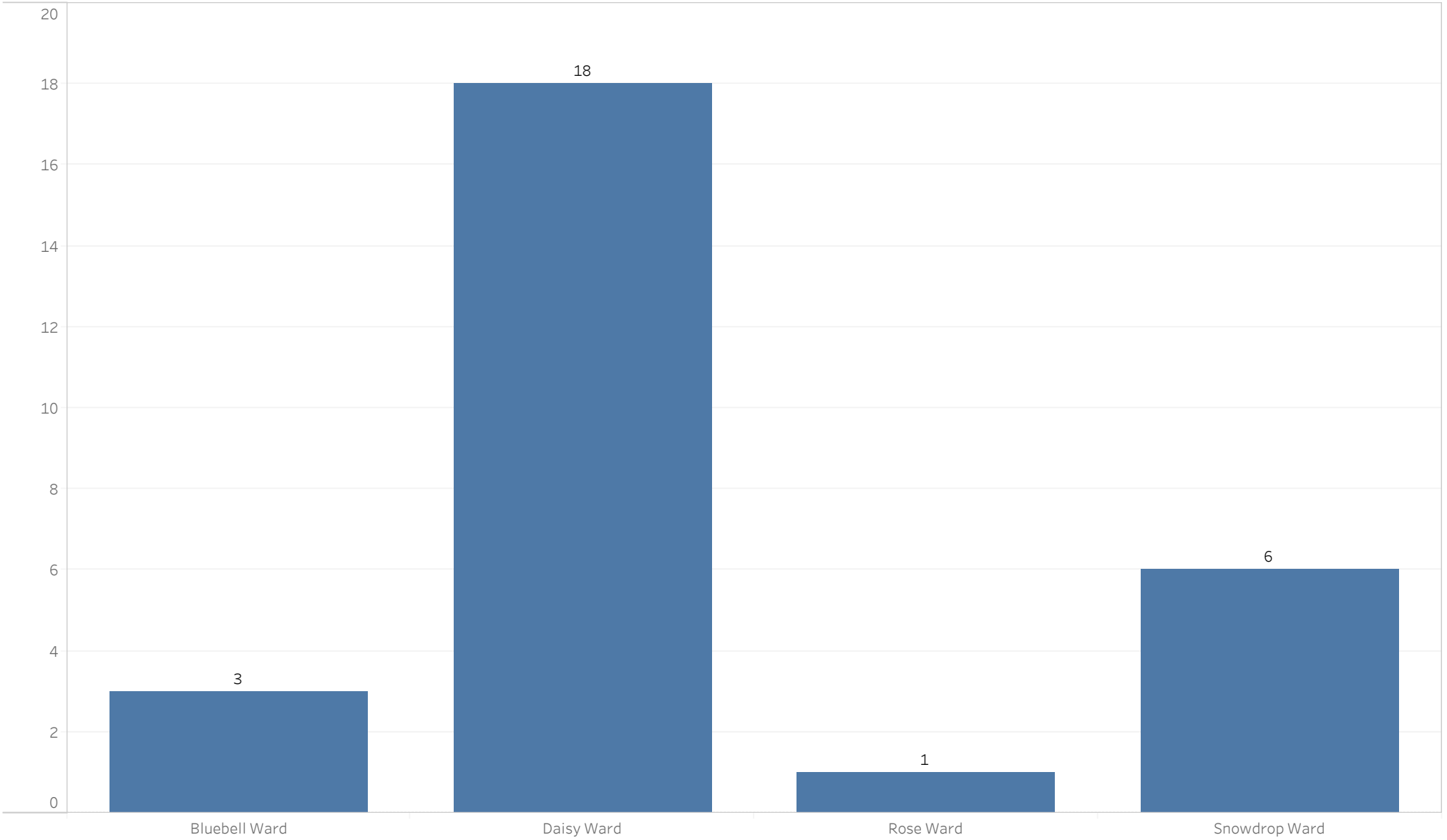


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Mar 19 to Mar 23)

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

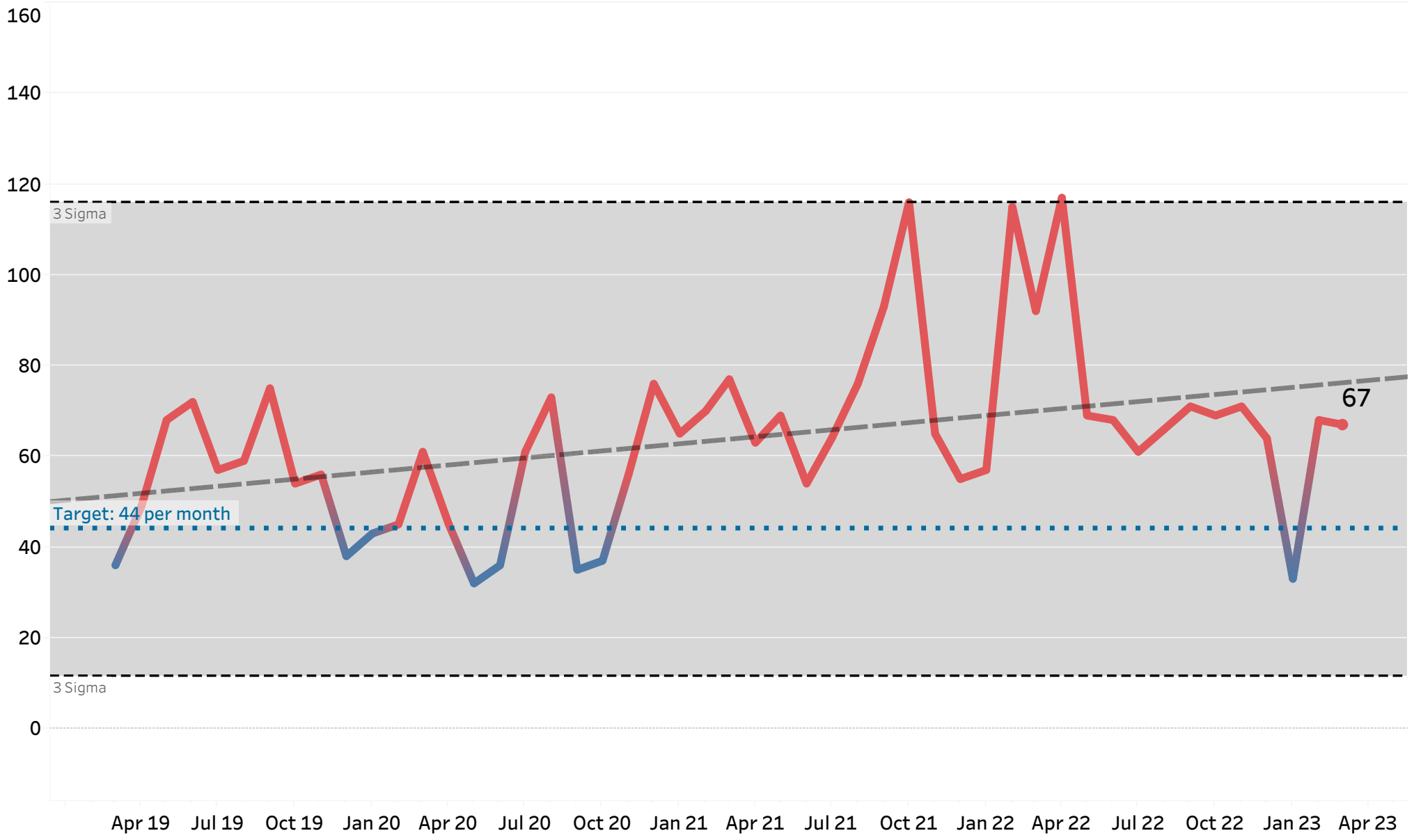


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (March 2023)

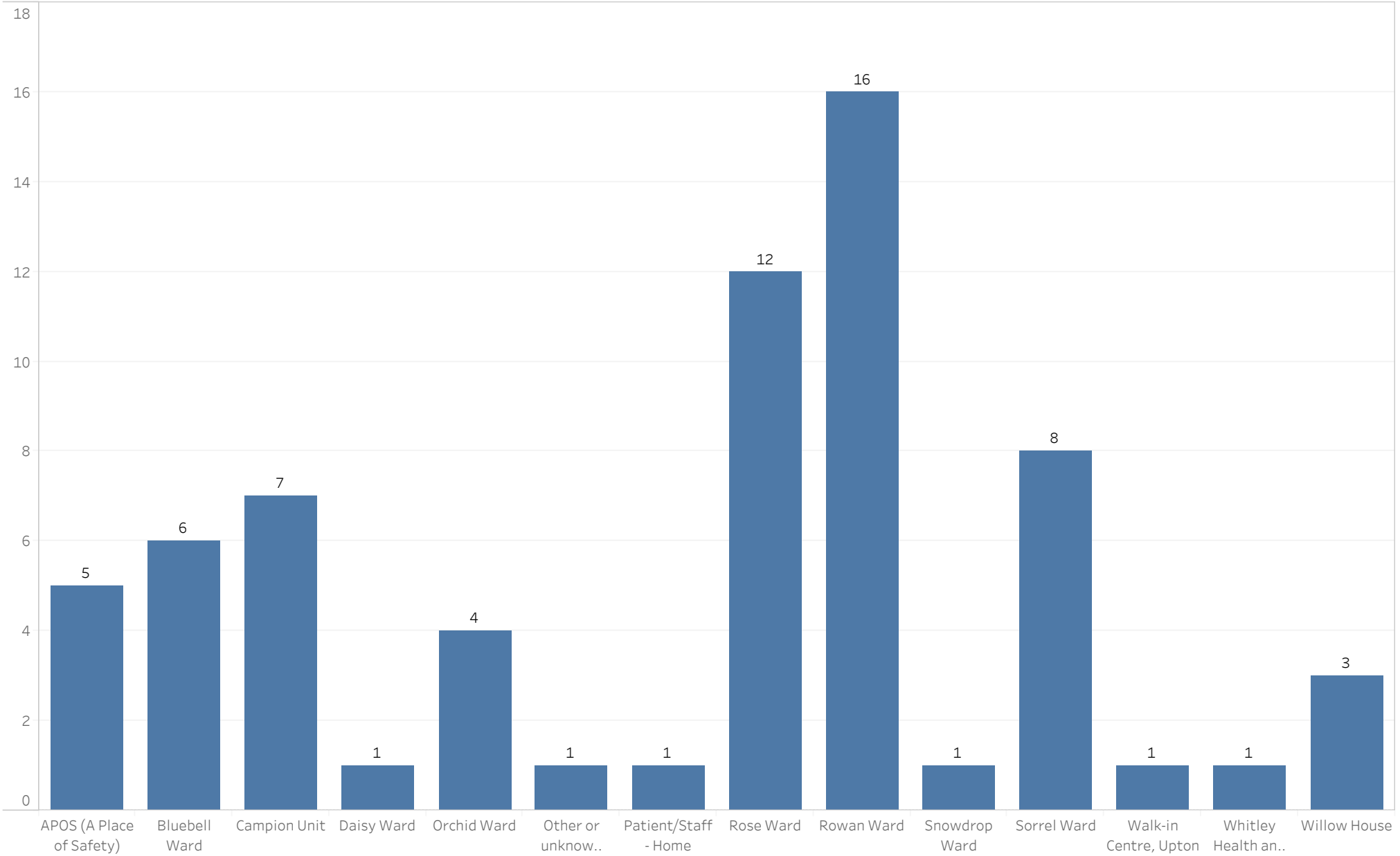


Supporting Our Staff Driver: Physical Assaults on Staff (Mar 19 to Mar 23)

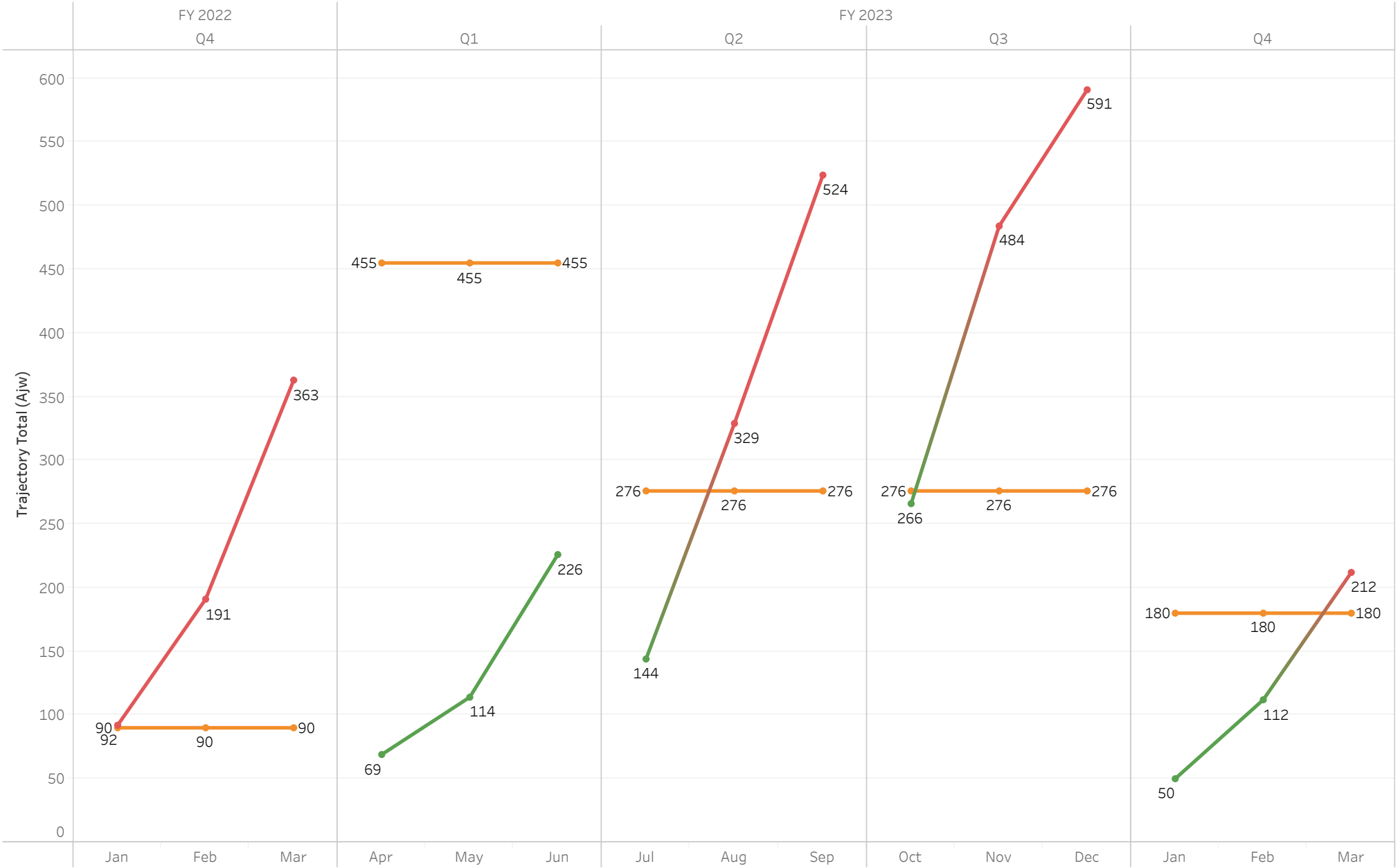
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (March 2023)



Money Matters Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Statutory Training: Fire: %	90% compliance	92.0%	91.7%	91.8%	91.8%	91.1%	90.7%	89.6%	92.0%	96.2%	92.2%	92.8%	93.2%
Statutory Training: Health & Safety: %	90% compliance	95.5%	95.3%	95.5%	95.9%	95.9%	96.0%	96.1%	96.1%	96.1%	96.1%	96.2%	95.9%
Statutory Training: Manual Handling: %	90% compliance	88.9%	88.3%	90.2%	89.2%	90.8%	90.0%	91.4%	93.1%	93.2%	92.3%	92.6%	94.3%
Mandatory Training: Information Governance: %	95% compliance from April 22	95.9%	96.2%	95.8%	96.0%	95.9%	96.9%	96.5%	98.1%	93.2%	96.0%	96.8%	97.0%
PDP (% of staff compliant) Appraisal: %	95% compliance by 31 May 2022	12.7%	86.2%	98.2%	92.3%	91.4%	89.9%	88.1%	85.0%	85.0%	85.0%	81.9%	80.4%

True North Patient Experience Summary

Tracker Metrics

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Mental Health: Prone (Face Down) Restraint	4 per month	7	4	2	0	1	3	1	1	6	2	13	9
Patient on Patient Assaults (MH)	25 per month	15	20	12	17	14	21	21	20	25	15	13	28
Health Visiting: New Birth Visits Within 14 days: %	90% com pliance	95.0%	100%	85.1%	86.5%	87.2%	82.5%	69.8%	65%	79.1%	79.2%	86.8%	85.9%
Mental Health: Uses of Seclusion	13 in month	6	6	5	9	6	7	6	6	13	6	6	6

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Mental Health Clustering within target: %	80% compliance	79%	80%	81%	79.0%	77.2%	80.4%	79.8%	78.9%	82.9%	80.2%	79.2%	78.0%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	10 per month from April 2022	13	13	11	15	8	7	10	12	5	10	3	11
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	14	7	3	1	8	0	1	0	2	0	1	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	9.83	4	5.79	7.92	2.85	5.87	6.45	1.45	1.53	1.40	1.68	2.62
Patient on Patient Assaults (LD)	4 per month	9	1	1	0	2	2	2	2	0	1	1	5
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019	20% from June 2021	14.6%	15%	14.6%	14.1%	13%	13.5%	13.3%	13.7%	13%	13.6%	13.9%	14.4%
Suicides per 10,000 population in Mental Health Care (annual)	7.4 per 10,000	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community	31 per month	2	12	25	32	36	8	21	51	37	57	51	52
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

True North Money Matters Summary

Tracker Metrics

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly)	7.50%	10.8%	10.2%	9.49%	8.73%	10.1%	8.78%	9.64%	12.4%	12.2%	6.16%	5.05%	8.11%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - First Appointment	4.00%	1.26%	5.75%	0.27%	-4.2%	-6.8%	-6.3%	-0.2%	-2.2%	3.89%	1.02%	-6.1%	7.21%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - Follow Up Appointment	4.00%	-6.9%	-4.9%	-4.0%	-7.5%	-15.%	-13.%	-13.%	-17.%	-12.%	-9%	-19.%	-4.7%
Community Inpatient Occupancy	80-85% Occupancy	86.5%	86.0%	82.5%	80.7%	83.6%	87.4%	88.1%	87.7%	86.8%	90.8%	89.3%	89.4%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	73.04%	88%	90.51%	80.82%	87.72%	87.90%	87.59%	85.75%	80.20%	89.56%	86.82%	78.12%
DNA Rate: %	5% DNAs	4.90%	5%	4.92%	1.02%	5.19%	5.24%	4.97%	5.22%	5.20%	4.85%	4.76%	4.92%
Community: Delayed transfers of care Monthly and Quarterly: %	7.5% Delays	12.6%	11.3%	2.91%	11.9%	10.3%	18.5%	17.1%	21.5%	21.7%	16.6%	19.0%	24.3%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	93.3%	86%	94.4%	95.9%	94.2%	97.2%	97.1%	96.3%	96.3%	89.7%	97.1%	95.3%
Mental Health: Acute Average Length of Stay (bed days)	30 days	49	50	38	47	43	35	50	38	62	37	43	50

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
C.Diff due to lapse in care (Cumulative YTD)	6	0	0	2	2	2	2	2	2	2	2	2	2
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	0	0	0	0	0	0	0	1	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	0	1	1	1	1	2	2	3	3	3	3	3
Count of Never Events (Safe Domain)	0	0	0	0	0	0	0	0	0	0	1	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	100	80	100	86	100	100	83.3	92.8	85.7	91.6	87.5	90
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98	98.9	99.0			99.5	99.2	99.5	99.6	99.2	99.3	99.3
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	97	96	96	95	96	94	95	93	94	95	95	95
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	52	52	56.0	51.8	49	49	47	52	48	45.5	46	46.5
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% to March 2025	99.2	98.2	71.7	47.1	55.6	40.9	35	66.4	82.8	72.4	72.4	69.0
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	99.5	99.5	100	100	99.2	97.8	98.7	100	100	100	100	100
Sickness Rate: %	<3.5%	4.53	3.95	4.41	5.29	4.37	4.56	4.91	4.59	5.16	4.32	4.30	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	83.3%	78%	50%	85.7%	50%	66.7%	66.7%	100%	57.1%	100%	66.6%	66.6%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	80%	100%	100%	87.5%	100%	100%	100%	75%	83.3%	100%	88.8%	66.6%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

Metric	Threshold / T..	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Community Health Services: 2 Hour Urgent Community Response %.	80%	88.4%	88.2%	89.2%	90.2%	90.4%	88.2%	92.2%	88.9%	85.8%	88.5%	88.5%	89.3%
E-Coli Number of Cases identified	Tbc	0	0	1	0	1	0	1	1	0	0	0	0
Mental Health 72 Hour Follow Up	80%	96.4%	95.5%	98.4%	94.7%	98.5%	98.5%	96.5%	93.6%	87.2%	94.0%	88.6%	93.0%
Adult Acute LOS over 60 days % of total discharges	TBC									21.8%	26.5%	50%	
Older Adult Acute LOS over 90 days % of total discharges	TBC									55.5%	57.0%	40.8%	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 May 2023
Title	**Audit Committee – 27 April 2023**
	Item For Noting
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 27 April 2023
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Thursday, 27 April 2023

(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Mehmuda Mian, Non-Executive Director Naomi Coxwell, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Becky Clegg, Director of Finance Graham Harrison, Head of Financial Services Minoo Irani, Medical Director Amanda Mollett, Head of Clinical Effectiveness and Audit Clive Makombera, RSM, Internal Auditors Jenny Loganathan, TIAA Maria Grindley, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors (present from 2.20pm) Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Debbie Fulton, Director of Nursing and Therapies. Apologies for lateness were received from Alison Kennett, External Auditors, Ernst and Young.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 26 January 2023**	
	The Minutes of the meeting held on 26 January 2023 were confirmed as a true record of the proceedings.	

4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework**	
	The latest Board Assurance Framework had been circulated. The Chief Financial Officer presented the report and highlighted the following points: • **Risk 3 System Working** - the risk description had been amended to reflect the current position in relation to system working • **Risk 3 System Working** – the Trust was taking the leading role in developing the system Mental Health Collaborative which was identified by NHS England as an accelerator site • **Risk 6 Capacity of our Services** – the Trust had commissioned Moorhouse Consulting to review the Trust's waiting list data and systems and processes with a view to developing a standardised approach. • **Risk 7 Cyber Security** – the update mentioned that the Trust had postponed the CyberEssentials+ annual certification audit from 22 March 2023 to 11 April 2023 to ensure that the latest MS Office patches had been applied across the Trust. Since the report had been circulated, the Trust had received confirmation that it had achieved its CyberEssentials+ certification Naomi Coxwell, Non-Executive Director referred to Risk 1 (Workforce) and noted that the update mentioned that the Trust was reducing its resources in relation to the recruitment partner pilot and asked whether there was sufficient Human Resources capacity. The Chief Financial Officer confirmed that due to a build-up of vacancies, the Trust had put in additional Human Resources staff over a nine month period to support the Trust's recruitment process and now that the position had stabilised, this additional resource was not required. The Committee noted the report.	
5.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chief Financial Officer presented the report and highlighted the following points: • **Ligature Risk** – the results of the Trust's Annual Ligature Audit would be presented to the May 2023 Quality and Performance Executive Group meeting • **Near Miss** – the national Patient Safety Incident Response Framework had been released. This replaced the Serious Incident Framework and would mean that incidents which would not have met the serious incident threshold would be reviewed as learning opportunities	

	Naomi Coxwell, Non-Executive Director referred to the Near Miss risk and the commentary about a serious incident near miss and asked whether the actions from that investigation would be embedded in the risk. The Medical Director agreed to find out from the Director of Nursing and Therapies whether there was any specific learning from the serious incident and inform the Non-Executive Directors on the Committee. The Committee: a) Noted the report	**MI**
6.	**Single Waiver Tenders Report**	
	A paper setting out the Trust's single waivers approved from January 2023 to the end of March 2023 had been circulated. The Chief Financial Officer presented the paper and reported that the single waivers in quarter 3 were a mix of extending existing contracts whilst the tender process was completed and engaging suppliers through the single tender process. The Committee noted the report.	
7.	**Information Assurance Framework Update Report**	

	The Chief Financial Officer presented the paper and highlighted the following points:
	
	• A total of 5 indicators were audited during quarter 4:
	  ○ New Birth Visits within 14 days (green - (high assurance)
	  ○ Mental Health Readmission Rate within 28 days (green - high assurance)
	  ○ Number of Suicides (green - high assurance)
	  ○ Mental Health Gatekeeping for Mental Health Admissions (amber – moderate assurance)
	  ○ Mental Health 72 Hour Follow-Up (red – low assurance)
	
	• Action plans had been put in place to address the identified issues and previous actions were tracked in the report.
	
	The Chief Financial Officer said that the Mental Health 72 Hour Follow-Up indicator had remained stubbornly red in terms of data quality. It was noted that the Mental Health 72 Hour Follow-Up metric used to be linked to the Standard Operating Oversight Framework but was not included in the current NHS Oversight Framework.
	
	The Chief Financial Officer reported that he would be reviewing the metric and the frequency of reporting with the Director of Nursing and Therapies, Director of Mental Health Services and with the Assistant Director of Performance and Information.	

	Naomi Coxwell, Non-Executive Director referred to page 67 of the agenda pack and noted that due to timings of data gathering for the Scorecard figures, data assurance for the New Birth Visits and Mental Health Readmission Rate within 28 days indicators was marked as “to be confirmed”. The Chief Financial Officer confirmed that the information would be included in the next Committee report. The Committee noted the report.	**PG**
8.	**Losses and Special Payments Report**	
	The Chief Financial Officer presented the paper which provided a list of the Trust’s losses and special payments made during quarter 4. The Director of Finance reported that the report should have included around £1,000 of interest payments in respect of the late payment of invoices, but this had come to light after the report had been submitted to the Committee. This would be included in the next report to the Committee. The Committee approved the losses and special payments made during January 2023 to the end of March 2023.	**BG**
9.	**Clinical Claims and Litigation Report**	
	The Litigation Activity Quarter 4 and End of Year Report had been circulated. It was noted that there were two new claims (both for Clinical Negligence) opened during the quarter. There were four claims during the quarter (one clinical negligence claim, two employer liability claims and one compensation under legal obligation claim. It was noted that a total of 12 claims were opened in 2022-23 (9 clinical negligence and 3 employer liability claims. The Committee noted the report.	
10.	**Clinical Audit Report**	
	The Medical Director presented the paper and highlighted the following points: • 27 clinical audit projects were listed within the report, of which, 20 met the requirements to be reported in the Quality Accounts for 2022-23 • The Quality Assurance Committee had requested one re-audit in 2022-23 due to outlier status identified in the original report for Early Intervention in Psychosis. This was reported to the Quality Assurance Committee in February 2023 • There was one open on-going action from 2021-22 which remained under review by the Clinical Effectiveness Group and related to waiting times for the community respiratory service in West Berkshire • There were five national audits where data was collected in 2021-22	

	which were due to be published in 2023-24. The reports will be presented to the Quality Assurance Committee as per usual: o POMH: 21a: Use of Melatonin o National Confidential Inquiry into Suicide and Safety in Mental Health annual report o National Audit of Cardiac Rehabilitation Annual Report. o Service Level report – Care at the End-of-Life National Audit o POMH 20b: The Quality of Valproate prescribing in adult mental health • The report provided assurance to the Audit Committee that the Clinical Audit Plan was on track. The Committee noted the report.	
11.	**Anti-Crime Services Report**	
	a) Anti-Crime Services Annual Report 2022-23 Jenny Loganathan, TIAA presented the report and highlighted the following points: • The Annual Report 2022-23 provided a summary of the work undertaken for the Trust over the last financial year and was designed to provide the Trust with assurance against the NHS Counter Fraud Authority quality assurance areas • In accordance with the Government Functional Standard 013 Counter Fraud, the Trust was required to complete a Counter Fraud Functional Standard Return. The Trust has been assessed with an overall rating of GREEN for 2022-23. The Trust's assessment included two areas where the Trust had partially met the standard in relation to policies and registers for gifts and hospitality and access to and completion of training • The number of referrals to the Anti-Crime Services was broadly the same as in the previous years, but the number of formal investigations had increased from two in the previous year to five during 2022-23 The Chair asked whether the Trust's policies around the declaration of interests and gifts were clear enough to staff. Jenny Loganathan said that the Head of Financial Services' email to staff included examples about what needed to be declared. The Head of Financial Services added that some staff had a misperception that it was only staff involved in purchasing who needed to declare interests. The Head of Financial Services agreed that the Trust needed to do more work around explaining about the need for all staff to declare interests and gifts. Mehmuda Mian, Non-Executive Director asked whether staff could telephone someone to discuss whether or not they needed to declare a particular interest/gift. Jenny Loganathan said that she was happy to provide advice to staff. The Head of Financial Services added that staff could also speak to their line managers if they were unsure about whether or not they needed to declare an interest/gift.	

	b) Indicative Risk Assessment and Strategic Work Plan 2023-24 Jenny Loganathan presented the paper and reported that the Indicative Risk Assessment and Strategic Work Plan 2023-24 was broadly similar to the previous year's work plan. It was noted that the TIAA would re-visit the Trust's risk assessment during the year depending on any emerging trends and in the light of developments within the Trust. Naomi Coxwell, Non-Executive Director asked whether the Anti-Crime Services was subject to a tender process. The Director of Finance said that the service was low value contract and therefore was not tendered. The Committee noted the report.	
14.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Clive Makombera, RSM, Internal Auditors presented the paper and highlighted the following points:
	
	• Since the last meeting, three audit reports had been finalised:
	  o New Models of Care (Reasonable Assurance)
	  o Health and Safety and Staff Wellbeing (Reasonable Assurance)
	  o Green Plan (Reasonable Assurance)
	• A draft report had been issued in relation to Bed Management – Out of Area Placements. Once that report had been finalised, the internal Audit Plan 2022-23 would be completed
	• There were no open actions
	• The report also included papers on: Emerging Risk Radar, Using Your Strategic Risk Appetite, Procurement and Contract Management Newsletter, Apprenticeships , NHS Financial Sustainability Benchmarking January 2023, Data Security and Protection Toolkit Benchmarking and an NHS New Briefing
	
	The Chair referred to the Health and Safety and Staff Wellbeing audit (agenda page 158) and asked whether the auditors felt that there was a need for more initiatives or whether there were too many initiatives.
	
	Clive Makombera explained that the Trust had a number of initiatives but needed a process for monitoring the effectiveness and impact of the various initiatives. There also needed to be better signposting so staff knew what support was available to them and how to access it.
	
	Naomi Coxwell, Non-Executive Director asked whether the Health and Safety and Staff Wellbeing Report had been shared with Mark Day, Non-Executive Director Staff Wellbeing Champion. Mr Makombera agreed forward a copy of the report to Mark Day.
	
	Clive Makombera referred to the NHS Financial Sustainability Benchmarking January 2023 which had benchmarked the Trust's performance against RSM's client base of around 50 NHS organisations and confirmed that the Trust had performed well. The areas identified for further improvement included: strengthening the processes in relation budget reporting and monitoring
		CM

	including the Cost Improvement Plan element and introducing a culture where training in financial management/financial governance was provided to all staff, not just finance staff. The Chair referred to the Using the Strategic Risk Appetite paper and asked Clive Makombera from his experience of working with other trusts, how trusts were using the risk appetite in their risk management work. Clive Makombera reported that trusts tended to review the risk appetite in relation to each risk on the Board Assurance Framework. For obvious reasons, there was a low risk appetite in areas relating to clinical safety, but there may well be a higher risk appetite in relation to areas such as cost improvement plans, innovation and digital as these were enablers for new models of care and delivering services to patients The Chair asked compared with other RSM clients, whether the Trust's risk appetite was higher or lower. Mr Makombera said that in his view, there was not much difference in the Trust's risk appetite compared with other trusts. Mr Makombera referred to the Trust's Green Plan and said that this was an area where the Board may want to take a view around its risk appetite for sustainability etc. Naomi Coxwell, Non-Executive Director added that the Trust had recently commissioned an external Well-Led Review and one of the recommendations in the report was around the Trust reviewing its risk appetite. Mr Makombera said that RSM would be happy to help the Trust review its risk appetite. **b) Draft Head of Internal Audit Opinion** Clive Makombera reported that the Trust had performed well during 2022-23 and had retained its level 2 rating in terms of the Draft Head of Internal Audit Opinion. Mr Makombera added that RSM had not awarded any level 1 opinions in 2022-23 and said that a number of trust's who received level 2 opinions last year, had received level 3 or 4 opinions this year. The Committee noted the reports	**CM**
13.	**External Audit Verbal Report**	
	Maria Grindley, Ernst and Young, External Auditors reported that last year's post-audit review meeting between the External Auditors and the Trust had been very useful in planning for the forthcoming audit. Ms Grindley said that the External Auditors had already completed a number of tasks and confirmed that at this stage in the process, she could not foresee any reasons why the audit would not be completed in time to meet NHS England's deadline for submission. Alison Kennett, Ernst and Young, External Auditors agreed and said that the audit was progressing well. It was noted that the External Auditors had started work early on areas such as directors' remuneration and property valuations which had proved to be time consuming last year. The Director of Finance reported that the Trust had met the External Auditors' deadline and had submitted the draft Accounts 2022-23 early in the day. The	

	Director of Finance said that her only concern at this stage was around understanding the requirements of the new IFRS 16 auditing standards. On behalf of the Committee, the Chair thanked both the Finance Team and the External Auditors for their work around planning for the external audit. The Committee noted the update on the external audit.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held in January 2023 and March 2023**	
	The minutes of the Finance, Investment and Performance Committee meetings held on 26 January 2023 and 23 March 2023 were received and noted.	
15.	**Minutes of the Quality Assurance Committee held on 28 February 2023**	
	The minutes of the Quality Assurance Committee meetings held on 28 February 2023 were received and noted.	
16.	**Minutes of the Quality Executive Committee Minutes – January 2023, February 2023 and March 2023**	
	The minutes of the Quality Executive Committee meetings held on 16 January 2023, 20 February 2023 and 20 March 2023 were received and noted.	
17.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Committee's Annual Work Plan was noted.	
18.	**Any Other Business**	
	There was no other business.	
19.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled for 23 June 2023 (an extraordinary meeting to approve the Annual Accounts 2022-23).	

The minutes are an accurate record of the Audit Committee meeting held on 27 April 2023.

Signed: - _____

Date: - 26 July 2023 _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	09 May 2023
Title	Draft Annual Report 2022/23
	ITEM FOR APPROVAL (subject to any final necessary additions and amendments) and approval sought to delegate to the Audit Committee, the approval of the annual accounts 2022-23
Purpose	This paper provides the Trust Board with the Draft Annual Report 2022/23 for approval
Business Area	Corporate
Author	Chief Executive Officer/Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	N/A
Legal Implications	Maintaining compliance with terms of authorisation and meeting regulatory requirements
Equalities and Diversity Implications	The Annual Report includes sections on equality, diversity and inclusion
SUMMARY	Please note that the Annual Report cannot be published until the final version has been laid before Parliament. The draft Annual Report is not included as part of the Public Trust Board papers which are published on the Trust's website. Copies of the Annual Report have been circulated to members of the Trust Board only. The financial figures contained within the draft Annual Report are subject to verification by the External Auditors. If any changes of significance arise these will be discussed with and approval sought from the Trust Chair and Chief Executive and notified to other Trust Board members as appropriate.

	An Extraordinary meeting of the Audit Committee has been arranged on 23 June 2023 to approve the Annual Accounts 2022-23 on behalf of the Trust Board. When approved, the Annual Accounts will be added to the Annual Report.
ACTION REQUIRED	The Board is invited to: 1. Consider and offer any comments on the draft Annual Report 2022/23. 2. Approve the draft for submission to NHS England subject to any final necessary additions and amendments and to delegate authority to the Chair and Chief Executive to give Board approval to the final document 3. Delegate authority to approve the Annual Accounts 2022-23 on behalf of the Trust Board to the Audit Committee