Berkshire Healthcare
NHS Foundation Trust

COUNCIL OF GOVERNORS

The next meeting will be held on Wednesday, 6 December 2023 starting at 10.30am

(Conducted via MS Teams)

There will be a governor pre-meeting at 9.45.

AGENDA

ITEM	DESCRIPTION	PRESENTER	TIME
1.	**Welcome & introductions**	Chair	1
2.	**Apologies for Absence**	Julie Hill, Company Secretary	1
3.	**Declarations of Interest**	All	1
4.1	**Minutes of Last Formal Meeting of the Council of Governors and Matters Arising**	Chair	1
5.	**"Bright Ideas" Programme Presentation**	Alex Gild, Deputy Chief Executive/Kendra Ainley, Head of Innovation	25
6.	**Annual Audit Committee Report to the Governors**	Rajiv Gatha, Chair, Audit Committee	10
7.	**Role of Allied Health Professionals Presentation**	Jodie Holtham, Deputy Director of Allied Health Professionals	15
8.	**Committee/Steering Groups** Reports: *a)* Membership & Public Engagement (*Enclosure)* *b)* Quality Assurance meeting *(Enclosure)* *c)* Living Life to the Full *(Enclosure)*	Committee Group Chairs and Members	5
9.	**Executive Reports from the Trust** 1. Patient Experience Quarter 2 Report *(Enclosure)* **2.** Performance Report *(Enclosure)*	Liz Chapman, Head of Service Engagement and Experience Julian Emms, Chief Executive	10
10.	**Governor Feedback Session** *This is an opportunity for governors to feedback relevant information from any (virtual) external*	Martin Earwicker, Chair	2

ITEM	DESCRIPTION	PRESENTER	TIME
	meetings/events they have attended		
11.	**Any Other Business**	Martin Earwicker, Chair	2
12.	**Dates of Next Meetings** • *Joint NEDs and CoGs meeting – 7 February 2024 – hybrid meeting* • *6 March 2024 – Formal Council of Governors Meeting*	Martin Earwicker, Chair	1
13.	**CONFIDENTIAL ISSUE:** **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	1
14.	**External Auditors Contract Extension**	Paul Gray, Chief Financial Officer	10

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Council of Governors Meeting held on

Wednesday, 27 September 2023 at 10.30am

(Conducted via MS Teams)

	Present:	Martin Earwicker, Chair
	Public Governors:	Tom Lake Brian Wilson Jon Wellum Madeline Diver Baldev Sian Ros Crowder Graham Bridgman Ian Germer Sarah Croxford Debra Allcock Tyler John Jarvis James Cuggy Charlie Draper
	Staff Governors:	Guy Dakin Anne Jumba
	Appointed Governors:	Cllr Deborah Edwards Cllr George Shaw Cllr Anna Wright Elaine Williams
	In attendance:	Julian Emms, Chief Executive Paul Gray, Chief Financial Officer Sally Glen, Non-Executive Director Mark Day, Non-Executive Director Rajiv Gatha, Non-Executive Director Julie Hill, Company Secretary Jenni Knowles, Executive Office Manager & Assistant Company Secretary Linda Jacobs, Executive Business Assistant
	Guests:	Maria Grindley, Ernst & Young External Auditors Alison Kennett, Ernst & Young External Auditors Katie Humphrey, Carers Lead Sue McLaughlin, Clinical Director Liz Chapman, Head of Service Engagement and Experience
1.	**Welcome and Introductions**	
	Martin Earwicker, Chair welcomed everyone to the meeting.	
2.	**Apologies for Absence**	

	Alun Griffiths, Janine Lewis, Tom O'Kane, Tim Dee-McCullough, Aileen Feeney, Non-Executive Director and Rebecca Burford, Non-Executive Director.
3.	**Declarations of Interest**
	None declared.
4.1	**Minutes of Last Formal Meeting of the Council of Governors and Matters Arising - 14 June 2023**
	The minutes the meeting held on 14 June 2023 were approved as a correct record of the meeting.
5.	**Election Results Paper**
	The results of the public governor elections in Reading and Slough and the Clinical and Non-Clinical Staff Governors had been circulated. The Chair welcomed James Cuggy who had been elected as a Public Governor for Reading and welcomed back Jon Wellum (Public Governor, Reading) and Nigel Oliver, Public Governor for Slough. The Chair also welcomed Alun Griffiths, Non-Clinical Staff Governor and Anne Jumba, Clinical Staff Governor. Tom Lake requested that the updated list of Governors be circulated to all Governors. **(Post meeting note**: The Company Secretary emailed the list of governors after the meeting.) The Council of Governors noted that the outcome of the Elections.
6.	**External Auditors Report to the Council of Governors**
	The External Auditors Report to the Governors had been circulated. The Chair welcomed Maria Grindley and Alison Kennett, Ernst & Young External Auditors to the meeting. Maria Grindley reported that the External Auditors' opinion on the Trust's Annual Report and Accounts 2022-23 was unqualified. Maria reported that the audit had gone smoothly and thanked the Trust for all their help and support. The Chair thanked Maria Grindley and her team for their work on the Audit. Tom Lake congratulated Paul Gray, the Finance Team and the Ernst & Young for a clear and helpful presentation.
7.	**Trust's Annual Report and Accounts 2022-23 Presentation**
	Trust Annual Report The Chair welcomed Julian Emms, Chief Executive to the meeting. Julian said that the same presentation on the Trust's Annual Report and Accounts 2022-23 would be given at the Annual General Meeting later today. Julian said that in consultation with stakeholders (public, patients, carers, staff), the Trust had a new mission and vision which was patient focussed as set out below:

The Trust's "mission is to maximise independence and quality of life"
The Trust's "vision is to be a great place to get care, a great place to give care"

Julian highlighted the Trust's commitment to being an anti-racist organisation and service wide developments over the course of the year including Virtual Wards and the Mental Health Integrated Community Services. Julian also presented the key results from the Trust's NHS Staff Survey and in particular positive results in relation to staff feeling confident to raise concerns and for the Trust to address those concerns.

Julian reminded the meeting that over the last year, David Townsend had retired from the Trust as Chief Operating Officer and had been replaced by Tehmeena Ajmal. Dr David Buckle had also stepped down as a Non-Executive Director and had been replaced by Sally Glen, Non-Executive Director. Julian thanked the departing Board members and also played tribute to Paul Myerscough in his role as Lead Governor and thanked Brian Wilson for taking over the Lead Governor role.

The Chair expressed his strong commitment to the Trust's Anti-Racism work and informed that Governors that there would be an Equality, Diversity and Inclusion Awareness session for governors after the Joint Trust Board and Council of Governors meeting in November 2023.

Ian Germer welcomed the new mission and vision statement which was patient and staff focussed and congratulated the Trust on a positive year. Ian Germer referred to the Trust's Equality, Diversity and Inclusion work and asked if the Trust knew why BAME patients waited longer than other patients.

Julian reported this was not fully known and the Trust was doing work around access and take up of services to identify and address any barriers.

Jon Wellum asked for an overview of how the Integrated Care System was affecting the work of the Trust.

Julian reported that the introduction of the Integrated Care Systems had been a positive move but more work was needed to get the health, social care and the voluntary community sector to work together to deliver integrated care to patients.. The challenge for the Trust was being in two Integrated Care Systems which was time consuming and could lead to Partners in the two Integrated Care Systems having conflicting priorities.

Trust's Annual Accounts 2022-23
The report was taken as read.

The Chair welcomed Paul Gray, Chief Financial Officer to the meeting.

Paul provided an overview of the Financial Review 2022/23.

Paul reported that overall, the Trust's financial performance was better than anticipated and the Trust had delivered a breakeven position.

Looking forward for 2023/24

- Trust had submitted a £1.2m surplus financial plan for 2023/24
- Efficiencies of £14.1m of which £11.1m recurrent and £3.0m non-recurrent
- Plans to invest £12.5m capital expenditure had been agreed with the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System
- A planned decrease in cash of £8.6m

Graham Bridgman asked if the Trust had earmarked reserves and general reserves and if so, how this was split.

Paul Gray advised that the Trust did not split earmarked and general reserves in term of the amount of cash that was in the bank. There was a financial threshold the Trust would

	not want to go below which was reviewed annually. The level of Capital Investment was agreed by partners across Buckinghamshire, Oxford and Berkshire West Integrated Care Board dependant on cash and available allocations. John Jarvis asked if the breakdown on the total expenditure could be broken down to show the changes this year from last year. Paul Gray reported this information was available and detailed in the Trust's Annual Report and Accounts 2022-23 which could be downloaded via the Trust's website. Tom Lake asked for more information about the Trust's plans for efficiencies and capital. Paul Gray reported that a key Estate programme was the planned move from The Old Forge to Resource House in Wokingham and some staff were being re-located to Wokingham Community Hospital. With the increase in workforce, there was more IT investment in equipment. Other efficiencies included a reduction of estate costs as increased numbers of staff working from home, Out of Area Placements and a new telephony system. The Chair thanked Julian and Paul on behalf of the Governors for a good year for the Trust which was continuing to perform at a very high standard, delivering the best care efficiently.
8.	**Quality Improvement Programme - Reducing Assaults on Staff Presentation**
	The Chair welcomed Sue McLaughlin, Clinical Director to the meeting. Sue shared a presentation on Reducing Staff Assaults at Prospect Park Hospital using Quality Improvement Methodology. Sue said that violence towards healthcare workers was a huge problem nationally, particularly in mental health settings. The Trust had introduced a number of actions to reduce patient assaults including: <u>Countermeasures in place</u> - A consistent care planning process based on induvial risk and needs assessment - Use of seclusion review planning template after every seclusion review - Daily Safety Huddles (these were part of the Quality Improvement Methodology and involved staff coming together very quickly every day to focus on changes) to update all staff about new risks and changes to care plans - Safe Wards Modules - Mutual expectations, de-escalation, bad news mitigation - **Zero tolerance** - Incident reporting focus on reinforcing the message, letter from Chief Executive, Police presence and involvement if applicable <u>Over the next 12 months</u> Nurse Consultant Network Supporting staff in managing patients with complex behaviours There would be a focus on Rose Ward which had the highest number of patient assaults on staff **Gaining an understanding of the data** - Staff had access to a real time dashboard - There was a greater understanding about some of the triggers for patient assaults on staff, example, vaping, medication refusal, leave refusal, bad news communication from Ward rounds, prevented interaction with other patient etc **Gaining an understanding around:** - Staff factors: gender, ethnicity, age, job role, agency verses regular. Length of service/training - Autism and self-harm overlaps

	- Flow through the system and bed occupancy - Perpetrator's gender, age, ethnicity - Impact of restrictive practices, diagnosis, risk, care plan/risk assessment **ZERO Tolerance - making sure this has teeth including incident reporting, Police, action, feedback** - Standard work regarding capacity recording, information sharing for prosecution - Advanced care plans - Staff support to ensure that there was an open culture - restorative supervision, leadership roles, review of existing support Jon Wellum asked if staff can be proactive around anticipating a staff assault by a patient especially after having contact with a patient multiple times in order to reduce the risk of an assault. Sue McLaughlin said that when reviewing the CCTV footage after an assaults in order learn more about incidents, it was sometimes possible to identify changes in a patient's mental state prior to an assaults, for example, if they were becoming more agitated or were pacing etc and these can be signs where proactive intervention could be made in order to prevent an assault. Sue said that it was important that the Trust made it clear to patients on admission about any restrictions etc. Ros Crowder asked if there was similar work being done to look at patient on patient assaults. Sue McLaughlin reported work was being done to look at patient on patient assaults as staff can sometimes be assaulted whilst preventing patient on patient incidents. The Chair thanked Sue for her presentation and continued work on reducing staff assaults.
9.	**Carers Strategy Update Presentation**
	The Chair welcomed Katie Humphrey, Carers Lead to the meeting. Katie provided an update on the continued work of the Carers Strategy, based on Triangle of Care (TOC), NICE principles, national guidance and best practice. Working towards Six Standards of Care 1: Staff will be 'carer aware' 2: Services will identify carers and involve them in the planning of care } Tier 1 3: Staff will refer or signpost carers to relevant support 4: Services will have allocated staff responsible for carers 5: Services will provide and introduction to the service and relevant information across there care pathway } Tier 2 6: Services will provide a range of carers support and obtain carers feedback *All services should achieve Standards 1-3* Carers Activities and Improvements <u>Engagement</u> - Internally with Heads of Services, managers and staff; Attendance at meetings; specific projects ie. One Team - Carer Event (July) - Externally with NHS England; ICS partners; voluntary sector, local authorities. - Attendance on Carer Strategy Groups - Input into revised/updated Carers Strategies for Bracknell, Reading and West Berkshire Councils

Friends, Family & Carers Awareness Training

- Yellow belt project to review completion rates

Website/Nexus

- Additional pages and content including our Charter, video and updated resources information leaflets

Mind the Gap Project

- NHS England funding to identify carer voice of those supporting Veterans
- Report published Carers Week
- Specific OpCourage Family & Carers webpage
- Bitesize educational videos
- Embedding Family Liaison & Support Lead role

Friends, Family & Carers Charter

- Launched Carers Rights Day (November 2022)
- Co-produced with Carers following Carer Events
- Four pillars reflect strategy standards
- Circulated to services to be displayed
- Promoted at Trust Leadership meeting (December 2022)
- Available on Nexus for services to download and print

Next Steps

- Analyse Self-assessment Review responses (September 2023)
- Review action plans and work with teams to target areas for improvement
- Refine/review the Self-assessment process
- Promote and recruit Friends, Family & Carers Champions (September 2023 onwards)
- Work towards identifying a champion for each team to make incremental changes to culture and behaviours to influence our on-going engagement and involvement with Carers
- Continuing Professional Development (September 2023 onwards)
- Working with Clinical Education teams to included Friends, Family & Carer sessions as part of student nurse; preceptorship; HCA Development programmes etc.
- Working Carers - Wellbeing workshops for staff (September & November 2023)
- SilverCloud - Plans for a specific Carere Programme - project launch October 2023
- Refresh Carers Strategy (originally created for 2023 to 2023)

The Chair thanked Katie for her presentation.

Ros Crowder asked if there were plans for Carer Peer Support Worker roles.

Katie Humphrey confirmed that the Carers work was informed by people with lived experience, including carers.

Brian Wilson asked how the carers would be progressed with those services that have not responded to the Self-Assessment Reviews.

Katie Humphrey reported she will be attending meetings in all the three new Divisions to engage with services and to promote the Carer Strategy work.

Katie invited Governors to join the Friends, Family & Carers Steering Group.

The Chair thanked Katie for her presentation.

10.	**Committee/Steering Groups**

Reports:

a) Membership and Public Engagement
The report was taken as read.

It was noted that the Membership and Public Engagement Group had reviewed the Trust's Excluded Member Review Process. The revised Excluded Member Review Process was presented to the Council of Governors meeting for approval.

Graham Bridgman said that he would contact the Company Secretary outside of the meeting with a few minor punctuation and formatting suggestions.

The Council of Governors **approved** the Excluded Member Review Process subject to the changes suggested by Graham Bridgman.

b) Quality Assurance Group
The report was taken as read.

c) Living Life to the Full Group
The report taken as read.

Tom Lake reported Sport in Mind attended the last meeting and gave a presentation on their work with the Trust's Research Department to assess how charities and other organisations supported the Trust with workloads, reduced readmission rates etc.

It was noted that the next meeting would include a talk by Lorna McArdle, Chief Executive of Support U an LGBTQ+ Charity based in Reading speaking about how they link with the Trust. All Governors and the Executive Board are welcome to attend.

11.	**Executive Reports from the Trust**

1. Patient Experience Quarter 1 Report
   The report was taken as read.

   Tom Lake commented on the report layout and made some suggested improvements.

   Graham Bridgman pointed out the discrepancy in wording and percentages on Table 8: Ethnicity:
   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.

   This indicated complaints from Black/British but not complaints received from White patients.

   Tom Lake noted out the patient survey response rate percentage was not being Captured consistently.

   Liz Chapman noted all comments for reviewing the Report.

   The Chair reminded the Governors that the Patient Experience Report was a Board report and therefore the format and information contained within the report was a matter for the Board.

2. Performance Report
   The Council of Governors noted the report.

   Guy Dakin thanked the Executive for the change to the Performance Report Metrics.

	Tom Lake commented that the Trust should be aware of the indicators that are doing well, are reducing and noted this could indicate stress within the workforce. Sarah Croxford asked for an update on the number of staff that have completed the mandatory Oliver McGowan Autism Training Levels 1 and Level 2. Julian Emms reported that Level 1 training was mandatory to be completed by the end of March 2024. Julian said that there had been mixed feedback from staff about the training with some staff feeling it was too long and repetitive. Level 2 was not available to the NHS staff yet. The Chair noted the topic was very important and that the Oliver McGowan training would benefit from being shorter and clearer. Anne Jumba advised that she had completed the training and although lengthy and some staff had struggled to compete it, she had found it useful. Anne added that the training had enabled staff to gain to gain knowledge and how to provide support when dealing with families. Jon Wellum advised as a tutor for online courses he had provided an overview before staff started the online training which gave people an opportunity to ask questions first.
12.	**Appointment of Lead and Deputy Lead Governors –** to approve the re-appointment of Brian Wilson as Lead Governor and Jon Wellum as Deputy Lead Governor for another year
	Brian Wilson and Jon Wellum were re-appointed by Governors as Lead and Deputy Lead Governor for another year. The Chair thanked Brian and Jon on their service.
13.	**Governor Feedback Session** *This is an opportunity for governors to feedback relevant information from any (virtual) external meetings/events they have attended*
	None.
14.	**Any Other Business**
	Graham Bridgman asked how the decision was made to hold the Annual General Meeting as a virtual and not a hybrid meeting. The Chair advised holding a virtual meeting provides a wider range of people to attend and this will be looked into and discussed for next year's meeting.
15.	**Dates of Next Meetings and Annual Schedule of Meetings for 2023**
	• 01 November 2023 - Joint Trust Board and Council of Governors Meeting - Hybrid - MS Teams/In person • 06 December 2023 - Formal Council Meeting - MS Teams

Berkshire Healthcare
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Annual Report of the Trust's Audit Committee to the Council of Governors
January 2023 to December 2023

SUMMARY

It is good practice for the Audit Committee to provide a report annually to the Council of Governors to:

- Highlight any relevant audit issues identified during the year in respect of which the Committee considers action or improvement is required and setting out the steps to be taken.
- Comment on the quality of the auditors' work and on the reasonableness of the fees (if appropriate).

Introduction

The Audit Committee's chief function is to advise the Trust Board on the adequacy and effectiveness of the Trust's systems of internal control, risk management and governance and also its arrangements for securing economy, efficiency and effectiveness. The Committee's terms of reference are attached at appendix 1.

As requested by the Council of Governors, this annual report has been expanded to provide more detail about the work of the Committee. It should be noted that the full minutes of the Audit Committee are presented to the next meeting of the Public Trust Board (the Trust Board's meeting papers are available from the Trust's website at https://www.berkshirehealthcare.nhs.uk/about-us/key-documents/board-meetings

Committee Membership

The members of the Committee during 2023 (all of whom are Non-Executive Directors) were as follows:

- Rajiv Gatha, Non-Executive Director and Audit Committee Chair
- Naomi Coxwell, Non-Executive Director
- Mehmuda Mian, Non-Executive Director (until 30 June 2023)
- Mark Day, Non-Executive Director (from 1 July 2023)

Executive support to the Committee included regular attendance by the Chief Financial Officer, Director of Finance, Director of Nursing and Therapies, Medical Director and Head of Clinical Effectiveness and Audit. The Company Secretary supports the Committee.

External representation included representatives Ernst and Young, External Auditors, RSM Risk Assurance Services, Internal Auditors and TIAA, Anti-Crime Services.

During 2023, the Committee met on five occasions, including June 2023 when the Annual Accounts were presented.

All meetings were quorate.

The minutes of each Committee meeting are received at the next available Trust Board meeting. The Audit Committee Chair presents the minutes and highlights any key areas of the Committee's discussions.

Audit Committee Seminars

The Audit Committee's external representatives (internal and external auditors and anti-crime specialists are invited to facilitate seminars prior to the Audit Committee meeting. The seminars were conducted virtually and covered the following topics:

- Cyber Security facilitated by the Internal Auditors
- UK Protect Duty Legislation facilitated by the Anti-Crime Specialist
- Whistleblowing facilitated by the Anti-Crime Specialist

Committee Self-Assessment of Effectiveness

The Committee undertakes an annual self-assessment of effectiveness. Members and regular attendees are requested to rate the performance of the Committee and to make suggestions for improvement. The results are then considered to determine what action, if any, may be necessary.

The results of the latest self-assessment exercise were reported to the July 2023 Audit Committee meeting. Overall, the results were positive.

The Committee also reviewed compliance with the updated NHS Provider Code of Governance which included a section on audit committees. The Company Secretary and the Chief Financial Officer conducted a self-assessment exercise and provided sources of assurance to the Committee that the Trust complied with the Code's requirements.

Summary of Work Undertaken

During 2023 key activity included:

A) Board Assurance Framework and Corporate Risk Register

The Committee reviews the Board Assurance Framework and the Corporate Risk Register at each meeting to maintain scrutiny on the management of risks to strategic and corporate objectives.

B) Cyber Security Annual Report 2022-23

The Chief Information Officer presented the Trust's Cyber Security Annual Report 2022-23 to the Committee and highlighted the following points:

- The Trust had 10 Information Security incidents logged in 2022, down from 23 in 2021. Four of the incidents were classified as critical as clinical systems were taken offline because of issues with the suppliers. The longest outage (5 weeks) was for the Adastra clinical records system which was because of a cyber security breach. On 4 August 2022, Advanced, providers of Adastra and Carenotes clinical systems took all their systems offline following the identification of a cyber-attack on their systems. Adastra is used by WestCall,

the Minor Injuries Unit, Urgent Care and the 111 Services. Carenotes is an Oxford Health NHS Foundation Trust system used by Trust's Criminal Justice Court Liaison and Diversion and Veterans services when accessing Oxfordshire patients' historic records
- This was a national, not localised incident and as a large number of NHS organisations were affected, the incident was managed at a national level. Local business continuity plans were activated and a manual process was quickly put in place
- Advanced worked with Microsoft, the National Cyber Security Centre and a third-party security supplier to recover their systems and to ensure that their systems were secure
- Following the incident, the Trust's assurance process for new clinical systems has been changed to add more onus on suppliers to prove that they have adequate measures in place to protect their environment and the capability to recover them quickly from incidents
- The Trust had implemented multi factorial authentication which should reduce the incidence of phishing

The report included details of the Trust's Mock Phishing Exercise in July 2022 which included 8% of staff clicking on the link in an email. The Chair asked whether the results of the mock phishing exercise were better or worse for similar exercises in the in the past.

The Chief Information Officer said that the results were better than in the past and showed that there was greater awareness amongst staff about the dangers of phishing. The Chief Information Officer added that there was a function on Outlook where staff could report a suspected phishing email to the IT Department and said that the number of staff reporting phishing emails had increased.

C) Information Governance Annual Report 2022-23

The Chief Information Officer presented the report and highlighted the following points:

- The 2022 Data Security and Protection Toolkit (DSPT) return of Standards was exceeded
- Of the 1,250 Subject Access Requests, the Trust received, only 5 exceeded the 30-day timeframe for response
- Of the 356 reported Information Governance incidents, 2 met the threshold of a reportable breach to the Information Commissioner's Office (ICO)
- Key areas of development in 2023 included supporting delivery of the Trust's Digital Strategy and working with system partners to ensure that data protection considerations and obligations had been met for Integrated Care System initiatives
- There was an increase in the number of staff accessing clinical records inappropriately and the Trust was reviewing its communications to ensure that all staff, including Temporary and Bank staff understood the requirements around accessing clinical records

The Chair referred to the breakdown of information governance incidents set out in the report and noted that the biggest area related to data sent by email to the incorrect recipient and asked for more information.

The Chief Information Officer said that this was usually down to human error and was sometimes because the patient's email was not up to date.

Naomi Coxwell, Non-Executive Director asked about the processes in place to protect patient information when dealing with third party organisations.

The Chief Information Officer explained that every NHS organisation had to complete the annual Data Security and Protection Toolkit submission and to meet the minimum standards.

The Chief Information Officer said that issues can arise when third party organisations profess to meet all the NHS standards but upon further scrutiny, it transpired that they did not meet the requirements of the Data Security and Protection Toolkit. It was noted that there was a balance of risk around whether or not to contract with these third sector organisations and pointed out that in some cases, a decision was made to contract with these organisations whilst they got their appropriate certification in place.

The Chief Information Officer also pointed out the staff working in the acute sector had unfettered access to patient records whilst patients were on the wards but said that this was very different for staff working in the community. It was noted that the Trust needed to ensure that staff working in the community understood when it was appropriate to access patient records.

The Anti-Crime Specialist, TIAA welcomed the Trust's focus on raising awareness around the importance of accessing patient records appropriately and commented that the abuse of records and inappropriate sharing data was an element in one of TIAA's investigations.

Naomi Coxwell, Non-Executive Director congratulated the Chief Information Officer and his team for providing high levels of assurance on information governance, data protection and cyber security.

D) HFMA Checklist on Grip and Control – Action Plan

In April 2022, the Healthcare Financial Management Association (HFMA) issued a publication called "Improving NHS financial sustainability: are you getting the basics right?" This publication focused on a self-assessment to be undertaken by all NHS provider organisations to help them consider the core elements of financial governance to support the organisation's financial sustainability.

There were 2 areas (cost improvement programme and culture, training and development) where the Trust scored less well and where action was required. In both areas, there were a number of questions where a score of 3 was assigned, meaning "the statement holds about half of the time". For both areas, these lower scores were linked in part to recovery action required following the pandemic.

F) Clinical Audit Programme

The Audit Committee's role is to ensure that there is an effective Clinical Audit process. This included reviewing the annual clinical audit plan and receiving regular reports on both progress against plan and status of relevant action plans. The results of the individual clinical audits together with action plans to address any areas identified for further improvements are reviewed by the Quality Assurance Committee.

G) Data Quality Assurance

The Trust recognises that all its decisions, whether clinical, managerial, or financial need to be based on sound information that is of the highest quality. Information is derived from individual data items that are collected from numerous manual and digital sources. Use of information to support:

- effective patient care
- clinical governance
- management and service agreements for healthcare planning

This means that data quality is a crucial element in providing assurance that decisions made are the correct ones. The Committee received a quarterly Data Quality Assurance Report which sets out the results of the Trust's data quality audits.

H) Single Waiver Report

The Committee receives a quarterly report setting out details of any contracts awarded to a provider without going through the usual procurement process. There are several reasons for single waiver contracts, for example, if the provider is the sole source of supply or an existing contract is extended pending a full procurement exercise.

I) Losses and Special Payments Report

The Committee receives a quarterly report on any losses or special payments made during the reporting period.

J) Clinical Claims and Litigation Report

The Committee receives a quarterly report on clinical negligence and employers' liability claims together with any learning and on-going work in relation to any themes identified as part of the claims process. Learning from the analysis of the claims (both clinical and employee detailed within this paper will be shared with the wider organisation through learning newsletters and patient safety and quality forums.

K) Approval of the Trust's Annual Accounts on behalf of the Trust Board

We convened a special meeting in June 2023 to approve the Trust's Annual Accounts on behalf of the Trust Board.

I) Other Matters

The Committee also received:

- Reports from the Internal Auditors, External Auditors and Anti-Crime Specialist.
- The Internal and External Auditors and the Anti-Crime Specialist share national good practice and help the Audit Committee to be kept up to date with any new policy developments.
- Minutes of assurance related Committees, including the Finance, Investment and Performance and Quality Assurance Committees

There are no substantial issues or concerns that the Audit Committee needs to draw to the Council's attention from its work in 2022-23.

External Audit Matters

The Trust's External Auditors, Ernst and Young attended the September 2023 Council of Governors meeting to present their audit report to the Governors. NHS England has removed the requirement for the Trust's Quality Accounts 2022-23 to be subject to external assurance, so the External Auditors' report only included their comments on their audit of the Trust's annual accounts and the value for money commentary.

The External Auditors' Report on the Trust's Annual Accounts 2022-23 was "unqualified" which meant that the Trust's financial statements gave a true and fair view of the financial position of the Trust as at 31 March 2023 and of its expenditure and income for 2022-23.

Internal Audit Reports

A copy of the Internal Auditor's 2022/23 annual report to the Audit Committee is provided at Appendix 2 for fuller information and assurance purposes.

The Trust's Head of Internal Audit opinion for the year was "The organisation has an adequate and effective framework for risk management, governance and internal control. However, work identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

In reaching their opinion, the Internal Auditors had taken into effect the positive assurance ratings in respect of the individual audit reviews over the course of the last year and management's response to addressing any areas for improvement when assigning an internal audit opinion.

A summary of the audit reviews completed since the last Annual Audit Committee Report to the Governors is set out below:

2022-23

a) Green Plan – Sustainability (reasonable assurance)

The following areas were considered as part of the review:

- Implementation of the Green Plan and progress against delivery of Trust priorities and whether there was evidence of improved outcomes.
- Extent to which the Trust had developed targets and performance measures and extent to which these were documented in the Plan.
- Adequacy of the Trust delivery plans in place to meet NHS Standards such as the Greener NHS programme including an assessment of whether these were realistic and in line with expectation.
- Review of sustainability reports outlining environmental issues the Trust was addressing i.e., greenhouse gas emissions, waste, water, transport etc and whether this reflected the Green Plan.
- Compliance and best practice seen elsewhere for the Trust to learn from. This involved assessing the metrics/frameworks being used by the Trust, and how they compared with peer reporting/similar organisations.
- Action plans and contingency plans in place for areas that were not delivering or expected to deliver according to Plans.
- How the Trust was supporting staff to adopt more green practices and how staff were encouraged to participate in a wide range of events to raise awareness of sustainability issues.

- Educational resources provided to support staff to make changes in the workplace, as well as at home.
- Extent of Board oversight including responsibilities for overseeing the plan's delivery.
- Survey staff where relevant to assess the effectiveness of plans.

The Auditors gave a rating of "reasonable assurance." The Auditors' "medium" priority recommendations were:

- To ensure that the Green Plan Action Tracker was regularly reviewed and where appropriate, actions were updated.
- To undertake more work to promote the Green Plan to increase staff awareness

b) IT Application Review (reasonable assurance

The following areas were considered as part of the review:

- Unit4 Agresso (an enterprise software suite, including finance management, accounting)
- The audit focussed on the following key scope areas and a number of associated controls only:
    - Authentication, identity, and access management and remote access
    - Patching and system updates
    - Vulnerability management (penetration testing/vulnerability scans and phishing testing)
    - Logging and monitoring
    - Website and database security
    - Data storage and security
    - Hosting environment and resilience
    - Backup and disaster recovery
    - Third/fourth party management

The Auditors gave a rating of "reasonable assurance". The Auditors' "medium priority" recommendations were:

- The Unit4 Agresso system is a third-party product. Operating system patches are deployed monthly and critical patchers can be implemented outside the planned maintenance window if required. However, critical security patches are not deployed within 14 days of release. The Trust's Management was asked to note the associated risks around delays to the implementation of patches on the risk register.
- The test environment of Agresso should be anonymised. However, given the volume of data, it was not feasible. Transactions entered by the finance team do not contain patient information. Invoices from suppliers contain patient initials only.

c) New Models of Care (reasonable assurance)

This review focussed on the tier 4 services that the Trust provided and considered the following:

- Review of governance model and arrangements, data flows, accountability and reporting arrangements within the Trust and then out into the provider collaborative.
- Processes for strategic planning, service development and working with partners to maximise the greatest impact and value for patients.

- Processes for clinical oversight of patients and quality assurance of services, and continuously improving outcomes and experience for Service Users, carers and families.
- The arrangements in place for contract management including contract review meetings and provision of information to support contract management.
- The performance framework and escalation processes in place for responding to emerging issues and urgent quality and safety concerns and ensuring improvement.
- Processes for managing conflicts of interest in line with protocols/agreements and ensuring transparency in decision making.
- Review of financial governance arrangements

The Auditors gave a rating of “reasonable assurance”. The Auditors’ “medium priority” recommendations were:

- Management to ensure regular quality audits were undertaken of the safety plans that were developed and completed for patients to ensure that an adequate service was provided. Where audits were not being completed, or completed to a satisfactory level, management would investigate this further and identify learning in order to improve the service
- Management to agree the frequency of the CAMHS (Child and Adolescent Mental Health Services) risk audits, the purpose of which was to identify whether the needs of individuals had been accurately captured through engagement and documented appropriately to ensure that a regular assessment was undertaken in relation to the engagement with service users
- An item on declaration of interests to be added as a standing agenda item on the Contract Review meetings in relation to CAMHS Tier 4 services

d) Bed Management (reasonable assurance)

The following areas were considered as part of the review:

- The arrangements in place to manage bed occupancy including out of area placements for mental health hospital beds.
- Relevant policies, procedures and guidance for bed management have been authorised, and communicated to relevant personnel.
- How the Trust collaborated with its Integrated Care System partners to more effectively coordinate bed management to reduce patient bed days.
- Action plans developed by the Trust to address potential blockages for patients ready to be discharged.
- Understanding the discharge plans in place for patients in an in-patient setting.
- Governance and reporting arrangements.

The Auditors gave a rating of “reasonable assurance”. The Auditors’ “medium priority” recommendations were:

- The Trust to consider involving more staff to monitor, challenge and advise on out of county placements using a placement framework that supported quality oversight and anticipated outcomes
- The Trust to consider having a Quality Framework for Out of Area Placements which should guide staff on the quality measures including key performance indicators
- The Trust should consider increasing the administrative support for the Bed Management Office to ensure that there is sufficient capacity within the team to manage the bed management flow.

e) Health and Safety and Staff Wellbeing (reasonable assurance)

The following areas were considered as part of the review:

- Appropriate policies in place that are inclusive and support staff wellbeing.
- The processes in place to ensure the wellbeing of staff and support provided to employees including line management and engaging with the workforce.
- The pace of delivery of the staff wellbeing initiatives.
- Demonstration of oversight of the staff wellbeing initiatives at senior/board level.
- Action plans in place to address mental health and wellbeing concerns.
- Provision of training support available to managers on mental health and wellbeing.
- The structure of staff wellbeing initiatives and how they link with other areas, i.e. reconnecting events and the impact of these events and whether they made a difference.
- Whether the measures put in place were effective and how employees perceived this and whether they were seeing the benefits which were positively impacting on their health and wellbeing, with the use of a questionnaire sent to staff.

The Auditors gave a rating of “reasonable assurance”. The Auditors’ “medium priority” recommendations were:

- Health and Wellbeing Project plans needed to be updated regularly so that progress in any given area could be truly assessed. These should have target completion dates added in order to keep projects on track and in line with wider plans.
- The process of raising concerns about wellbeing issues needed to be clearer so that staff were signposted towards the relevant people who could help.
- Health and Wellbeing action plans needed to be linked to wider human resources processes, for example, appraisals, one to one supervision meetings, new leadership training and how the role of line managers may be incorporated into this. In addition, alternative escalation points needed to be signposted and accessible when employees felt that they could not raise issues with their immediate manager.
- More engagement and focus groups should be encouraged between staff and leadership so that the Trust was informed from a diverse perspective of what employees actually thought.
- The Trust should review the current training in place and consider whether there was enough provision in place covering wellbeing and what elements should be mandatory.
- The Trust should ensure consistent communications and regular updates on all live initiatives

f) Risk Management (reasonable assurance)

The following areas were considered as part of the review:

- The Risk Management Framework in place for identifying, managing, monitoring and reporting risks.
- Process for undertaking risk assessments for identification of new risks and how risks are aligned with the organisation’s strategic objectives. Whether a consistent approach is used for the identification and scoring of risks across the BAF, corporate, directorate and operational risk registers, and the number of risks in place across all registers.

- How well the organisation monitors inherent and residual risk scores and takes into account changes in likelihood and impact. How risk scores have changed for a sample of risks over the last 12 months and if there is a clear rationale for the changes.
- The risk appetite, methodology, categorising and scoring criteria. How risks are aligned to the organisation's risk appetite and what actions are taken to bring risks in line with the desired appetite level.
- The effectiveness of the risk management processes below the Board Assurance Framework and Corporate Risk Register and the systems used to capture this data. A sample of areas to focus on was selected to test the use and maintenance of risks registers within these locations.
- A review of whether the risk register has adequate content, with specific review of the design pertaining to risks, controls, mitigation of risks and, where appropriate, assurance identified. As part of the review a sample of risks to focus on will be selected to consider the clarity of the controls, assurances and mitigating actions. This will include one clinical, one financial and one operational risk.
- The effectiveness, timeliness and relevance of assurances identified on the registers to mitigate risks over a period of 12 months for a sample of risks
- Review of the timeliness of the delivery of actions on the Board Assurance Framework and Corporate Risk Register and the impact these have on residual risk scores.
- Review of a sample of actions over a 12-month period.
- How risk management informs and steers governance agendas and meetings.
- Level of scrutiny and focus on the Risk Register during governance meetings.
- The adequacy of training programmes in place at the organisation relating to risk management; and
- Risk management culture and will undertake a series of interviews/questionnaire with a range of stakeholders to gauge their perceptions of the organisation's approach to risk management and the extent to which there is a clear and embedded risk management culture at all levels within the organisation. Interviews will also be held with a number of Executive Director's together with a range of Non-Executive Directors.

The Auditors gave a rating of "reasonable assurance." The Auditors' "medium priority" recommendations were:

- Owners of the Divisional Risk Registers will undergo a cleansing exercise to ensure only timely and relevant risks are kept on the register. Where a risk review date has surpassed, owners of the risk will be contacted by the respective register owner to provide a current update on the risk.
- The Trust will continue to implement the newly planned induction for Clinical and Operational Risk Management training. The Trust will also develop refresher training courses in Clinical and Operational Risk Management, with consideration of including training on how to identify risks, differentiation between risks, controls, assurances and gaps in controls/assurances, the process for raising risks to management, and the functions of risk registers pertaining to Clinical and Operational Risk.
- The Trust will maintain records of attendance for Risk Management training in order to provide assurance that a sufficient number of staff have been trained and to ensure that there is adequate risk awareness across the organisation.

g) HFMA Checklist – Financial Sustainability (advisory)

In April 2022, the Healthcare Financial Management Association (HFMA) issued Improving NHS financial sustainability: are you getting the basics right? The self-

assessment is made up of two parts: an initial self-assessment and a detailed checklist.

Of the 72 questions in the self-assessment, the Trust scored itself 4 (there are areas where there was room for improvement) or 5 (that statement holds true for the whole organisation or whole process all the time). The auditors concluded that there was evidence in place to support these scores with the exception of question B3:

- Have financial budgets been agreed and signed off by all budget holders/ managers? Does sign-off also include confirmation that the budget accurately reflects: •
    - agreed operational targets
    - the underlying resources, in terms of staff as well as supplies and services, needed to deliver those targets?

The Trust re-visited the evidence and it was not possible to provide sufficient evidence to support the score. Action plans are in place for the questions where the Trust scored 3 (statement holds true about half of the time) or 2 (often the arrangement is not in place). There were no 1 scores (the statement never holds true).

h) Data Security and Protection (DSP) Toolkit (advisory – moderate assurance)

This review produced the following outputs:

- The confidence level in the veracity of the Trust's self-assessment/DSP Toolkit submission and how the submission aligns to the Trust's assessment of the risk and controls.
- The overall risk rating as regards the Trust's data security and data protection control environment i.e., the level of risk associated with controls failing and data security and protection objectives not being achieved.

The Auditors identified that five employees who had left the Trust remained on the "Active Directory Users List" and could potentially access the Trust's systems. Following the review, all leavers' user accounts are now reviewed on a bi-monthly basis and removed in a timely manner in line with Trust policy.

The Auditors also identified that Recovery Time Objectives and Recovery Point Objectives had not been agreed for the Trust's key systems within the IT disaster recovery plan. The Trust has plans in place to address the issue.

2023-24

i) Patient Experience

The following areas were considered as part of the review:

- Mechanisms and procedures in place that capture and utilise patient experience.
- Assessment of how the organisation triangulated this information with other quality and performance data to improve the quality and safety of patient care.
- Review of the service that is in place to investigate complaints including those that involve serious incident investigations.
- How the Trust learnt from patient experience data including investigating complaints and listening to patients to understand the patient journey and make improvements where required.

- How the organisation listened and worked with patient led groups who speak on behalf of patients.
- How the organisation shared feedback and let patients know they had been listened to.

The Auditors gave a rating of “reasonable assurance”.

The Auditors’ “medium priority” recommendation was around ensuring that patient and service user feedback was discussed at the divisional Patient Safety and Quality meetings, there was a risk that the patient service user perspective was not being taken into account which could lead to poorer patient experience.

Patient experience and service user feedback will be discussed within the divisions. Complaints, learning/improvement actions, trends and iWGC should form part of this, as well as "You Said, We Did" updates, compliments, and updates on how services are exploring and developing other feedback mechanisms, such as focus groups. Services should be encouraged to include patient feedback into their individual service updates.

The Patient Experience team will draw out best practice from divisional Patient Safety and Quality meetings and share this with the Trust's other divisions.

j) Sickness Absence

The review was to ensure that there are robust processes for managing staff absences and that the reporting of absences to the Trust Board was accurate.

The Internal Auditor gave a rating of “partial assurance”.

The Internal Auditors made three high priority recommendations:

- Management to undertake regular spot checks to ensure that absences have the relevant medical certificate covering the duration of absence for employees off sock and that this is documented on the system. Management will remind staff of the requirement to obtain medical certificates.
- Management will undertake spot checks to ensure regular contact is made with employees during the period of sickness absence. Management will ensure evidence of contact can be provided
- Electronic systems to be reviewed to see how they can be more supportive, effective, proactive and prompt line managers when a return to work

The Trust has developed plans in place to address the Internal Auditors' recommendations.

k) Data Quality

The review looked at the processes in place for the generation of key performance data to ensure that the processes enable the accurate reporting of performance.

The Internal Auditors gave a rating of “reasonable assurance.”

The Internal Auditors made two medium recommendations:

- The Prospect Park Hospital Bed Management Team will be responsible for ensuring the RiO (electronic patient record system) forms are completed in a timely manner and with all required information (including admission and discharge dates).

- The Training and Compliance Team will ensure that the data which is collated for the inpatient fire safety key performance indicator is validated and reviewed prior to being entered onto the Tableau (performance management system) to ensure that the data collated is accurate

The Trust has developed plans in place to address the Internal Auditors' recommendations.

Overall Internal Audit Programme Progress

The table below sets out the ratings of the audit reviews conducted in 2022-23 which were not finalised when the Council of Governors received last year's annual audit committee report.

The table also sets out the ratings of the audit reviews conducted so far during 2023-24.

Audit Area	***Risk Rating***
2022-23	
Green Plan - Sustainability	Reasonable Assurance
Financial Governance (HFMA Review)	Advisory – no rating
Health and Safety and Staff Wellbeing	Reasonable Assurance
Risk Management	Reasonable Assurance
Data Security and Protection Toolkit	Moderate Assurance (Advisory)
New Models of Care	Reasonable Assurance
Bed Management/Out of Area Placements	Reasonable Assurance
IT Application Review	Reasonable Assurance

Audit Area	***Risk Rating***
2023-24	
Sickness Absence	Partial Assurance
Patient Experience	Reasonable Assurance
Data Quality	*Reasonable Assurance*
Temporary Staffing	*TBC*
Key Financial Controls	*TBC*
Transformational Plan/Cost Improvement Plans	*TBC*
Board Assurance Framework and Risk Management	*TBC*
Bed Management and Discharge Processes	*TBC*
Long Term Placements	*TBC*

ACKNOWLEDGEMENTS

The Audit Committee also commends the sterling work carried out by the Trust's finance team on the annual accounts this year.

ANTI-CRIME SPECIALIST AND AUDITORS' CONTRIBUTION:

Throughout the year, the Audit Committee has been supported fully by the Trust's internal and external auditors and by the Anti-Crime Service.

The Committee is fully satisfied with the quality of the work undertaken by the Anti-Crime Service, TIAA, the Internal Auditors, RSM and the former External Auditors, Deloitte and current External Auditors, Ernst and Young.

ACTION:

The Council of Governors is invited to note the report and to seek any clarification.

Prepared by Julie Hill
Company Secretary

Presented by Rajiv Gatha,
Chair of Audit Committee

Berkshire Healthcare
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

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

Document Control

Version	Date	Author	Comments
1.0	12 Mar 08	Garry Nixon	Initial Draft for Committee Chair
2.0	14 Mar 08	Garry Nixon	Updated following Committee Chair comments
3.0	1 May 08	Garry Nixon	Updated following Audit Committee consideration
4.0	22 May 09	John Tonkin	Revised per Internal Audit Report Recommendations on Integrated Governance –
5.0	28 May 09	Clive Field	Minor amendments
6.0	12 August 2010	John Tonkin	Revision following Audit Committee review July 2010
7.0	14 Sept 2010	John Tonkin	Revision following Board consideration 14 Sept 2010
8.0	8 May 2012	John Tonkin	Revision following Board consideration 8 May 2012
9.0	12 April 2013	John Tonkin	General revision to reflect changes in past year
10.0	23 May 2013	John Tonkin	Revision following Board discussion on 14 May 2013
11.0	11 June 2013	John Tonkin	Board approved – 11 June 2013
12.0	13 May 2014	John Tonkin	Board approved - 13 May 2014
13.0	27 July 2016	Julie Hill	Revision following Audit Committee review – October 2016
14.0	08 November 2016	Julie Hill	Board approved – 08 November 2016
15.0	July 2018	Julie Hill	Revision following Audit Committee review – July 2018 – Board approved September 2018
16.0	July 2019	Julie Hill	Revision following Audit Committee review – July 2019 – Board approved September 2019
17.0	October 2020	Julie Hill	Revision following Audit Committee review – October 2020
18.0	July 2022	Julie Hill	Revision following Audit Committee review – July 2022

Document References

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

Authority

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

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

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

Purpose

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

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

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

b. Annual Plan declarations relating to the Assurance Framework.

Membership

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

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

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

3.4 A quorum shall be two members.

In attendance at meetings

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

- Chief Financial Officer
- Director of Finance
- Medical Director
- Head of Clinical Effectiveness and Audit
- Director of Nursing and Therapies (or deputy)

- The Company Secretary

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

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

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

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

Frequency and Administration of Meetings

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

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

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

Duties

Governance Risk Management and Internal Control

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

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

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

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

b. The underlying assurance processes that indicate the following:

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

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

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

Audit & Counter Fraud

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

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

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

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

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

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

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

6.6 Clinical Audit

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

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

Financial Reporting

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

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

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

Reporting

6.11 The Committee will routinely review the minutes of:

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

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

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

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

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

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

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

Other functions

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

6.16 It will review the following:

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

b. Any decision to suspend Standing Orders

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

d. The Trust's Litigation activity

e. Information Governance and Caldicott Guardian Annual Report

6.17 It will approve changes in accounting policies.

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

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

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

6.21 The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality.

Amended: July 2022

Board approved: September 2022

Next review: July 2024

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Annual internal audit report (1 April 2022 to 31 March 2023)

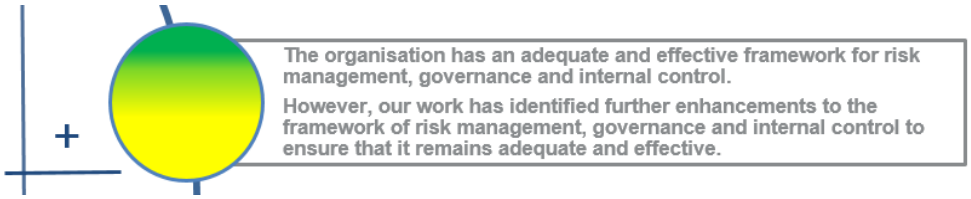
15 June 2023

THE ANNUAL INTERNAL AUDIT OPINION

This report provides an annual internal audit opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance reporting.

The opinion

For the 12 months ended 31 March 2023, the head of internal audit opinion for Berkshire Healthcare NHS Foundation Trust is as follows:



Please see appendix A for the full range of annual opinions available to us in preparing this report and opinion.

It remains management's responsibility to develop and maintain a sound system of risk management, internal control and governance, and for the prevention and detection of material errors, loss or fraud. The work of internal audit should not be a substitute for management responsibility around the design and effective operation of these systems.

Scope and limitations of our work

The formation of our opinion is achieved through a risk-based plan of work, agreed with management and approved by the audit committee, our opinion is subject to inherent limitations, as detailed below:

- internal audit has not reviewed all risks and assurances relating to the organisation;
- the opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led assurance framework. The assurance framework is one component that the board takes into account in making its annual governance statement (AGS);
- the opinion is based on the findings and conclusions from the work undertaken, the scope of which has been agreed with management;
- where strong levels of control have been identified, there are still instances where these may not always be effective. This may be due to human error, incorrect management judgement, management override, controls being by-passed or a reduction in compliance; and
- due to the limited scope of our audits, there may be weaknesses in the control system which we are not aware of, or which were not brought to our attention.

FACTORS AND FINDINGS WHICH HAVE INFORMED OUR OPINION

We issued the following positive assurance opinions in 2022/23:

- Health & Safety and Staff Wellbeing – Reasonable Assurance.
- IT Application review – Reasonable Assurance.
- New Models of Care – Reasonable Assurance.
- Risk Management – Reasonable Assurance.
- Bed Management – Reasonable Assurance.
- Green Plan – Reasonable Assurance.

In the audits above, we have identified some areas where enhancements are required and in each of these cases management actions have been agreed, the implementation of which will improve the control environment.

We issued the following Advisory report in 2022/23:

- Financial Sustainability HFMA – Advisory.

A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

Topics judged relevant for consideration as part of the annual governance statement

We would advise the Trust to consider whether there are any other areas based on any other information received or reviews undertaken that the Trust should consider for inclusion in the Annual Governance Statement.

Service Auditor report

Electronic Staff Record Programme (ESR)
Nine exceptions were highlighted under the seven main control objectives. We do not consider this sufficient to impact on our overall Head of Internal Audit Opinion.

Remaining internal audit work for 2022/23

The following assignment is yet to be completed and reported in final.

- Data Security and Protection toolkit – in progress (fieldwork stage).

THE BASIS OF OUR INTERNAL AUDIT OPINION

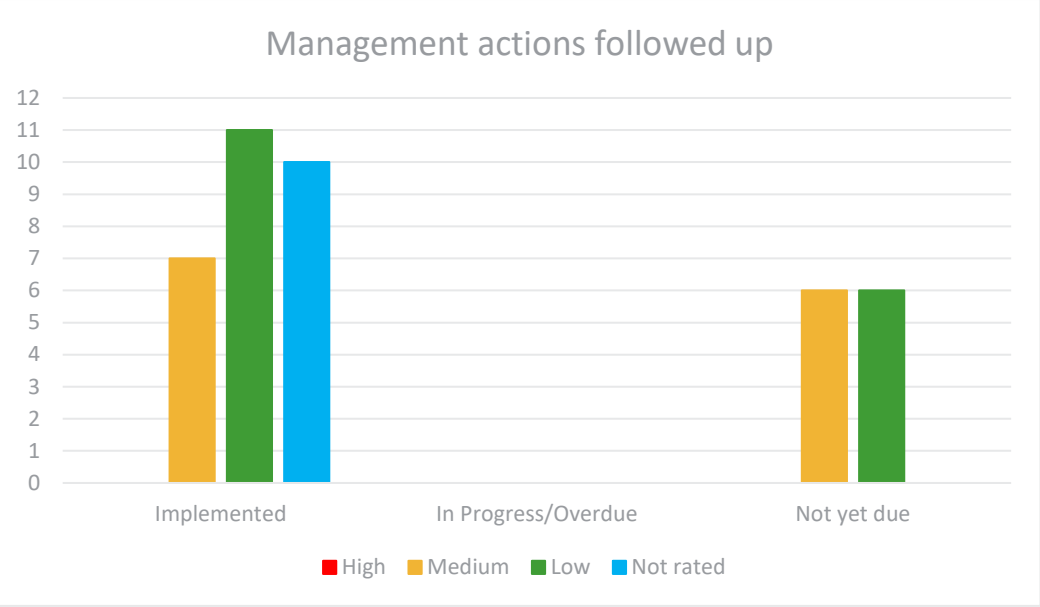
As well as those headlines previously discussed, the following areas have helped to inform our opinion. A summary of internal audit work undertaken, and the resulting conclusions, is provided at appendix B.

Acceptance of internal audit management actions

Management have agreed actions to address all of the findings reported by the internal audit service during 1 April 2022 to 31 March 2023.

Implementation of internal audit management actions

Where actions have been agreed by management, these have been monitored by Internal Audit through the action tracking process in place. During the year progress has been reported to the audit committee, with the validation of the action status confirmed by internal audit on a rolling basis. Our follow up of the actions agreed to address previous years' internal audit findings shows that the organisation had made good progress in implementing the agreed actions.



As reported throughout our progress reports to the Audit Committee during 2022/23, there were a total of 28 actions (7 medium, 11 low and 10 advisory) which were followed up in 2022/23.

28 actions (7 medium, 11 low and 10 advisory) were implemented during the year.

12 actions, including six medium and six low priority actions, relating to IT Application Audit, New Models of Care and Risk Management were not yet due for implementation and will be followed up accordingly when due.

Working with other assurance providers

In forming our opinion, we have not placed any direct reliance on other assurance providers.

OUR PERFORMANCE

Wider value adding delivery

Area of work	How has this added value?
Healthcare Benchmarking	We have shared benchmarking information with the Trust including our annual report on the outcomes of Internal Audit opinions and actions across our NHS client base.
Webinars, Conferences, Training, Newsletters and Workshops.	We have invited the Trust to various webinars, newsletters, workshops and conferences including the following: • Employment Matters, which focused on considerations of hybrid working from a people management, employment tax, legal and global mobility perspective. • RSM & CIPFA Public Procurement and Contract Management conference, webinars, training and newsletters covering topical and current issues offering expert advice on EU and UK public sector procurement and contract management. • Health Matters workshop which focused on flexible workers and processes around recruitment, rostering and retention. • Health Matters newsletter featuring insights from our private healthcare, NHS and life sciences specialists. We explored the importance of ICSs developing analytics capabilities that support and enable place-based and local action on inequalities, as well as improving the availability of data at a granular and local level for analytics to be effective. • Partnership working through digital transformation**.** We partnered with The King's Fund on an online panel session on digital transformation in the healthcare sector. A paper on learning and key themes from the workshop was shared with the Trust.
Analysis of High Priority Findings	We undertook analysis of previous High priority findings across our healthcare clients and shared this with the Trust.
Benchmarking	We have shared the following benchmarking with the Trust: **NHS Financial Sustainability Benchmarking** In this benchmarking paper we looked across our 50 NHS clients and compared average scores and summarised our findings under themes for the Trust to consider. **Data Security and Protection Toolkit Benchmarking** In 2021/22 we undertook 34 independent assessments of DSPT submissions across healthcare bodies. In this paper we compared our DSPT review outcomes across organisations for the Trust to consider.
Specialists	Where relevant we continue to use Specialists to support our work. For example, the review of Health & Safety and Staff Wellbeing was supported by a HR specialist to ensure the right people are looking at the right areas and

Area of work	How has this added value?
	allows the Trust to learn from best practice seen and shared by our specialists. The reviews of IT Application and Apprenticeships were also supported by specialists.
Client Briefings	As part of our client service commitment, during 2022/23 we issued news briefings to each Audit Committee meeting.
Progress Meetings	We continue to hold regular progress meetings with the Chief Finance Officer to discuss internal audit progress and follow up of internal audit actions.
Audit Committee	We contributed to the discussions at each audit committee on various items on the agenda in order to ensure that the Trust benefits from wider input in further developing its governance arrangements.

Conflicts of interest

RSM has not undertaken any work or activity during 1 April 2022 to 31 March 2023 that would lead us to declare any conflict of interest.

Conformance with internal auditing standards

RSM affirms that our internal audit services are designed to conform to the Public Sector Internal Audit Standards (PSIAS).

Under PSIAS, internal audit services are required to have an external quality assessment every five years. Our risk assurance service line commissioned an external independent review of our internal audit services in 2021 to provide assurance whether our approach meets the requirements of the International Professional Practices Framework (IPPF), and the Internal Audit Code of Practice, as published by the Global Institute of Internal Auditors (IIA) and the Chartered IIA, on which PSIAS is based.

The external review concluded that RSM 'generally conforms* to the requirements of the IIA Standards' and that 'RSM IA also generally conforms with the other Professional Standards and the IIA Code of Ethics. There were no instances of non-conformance with any of the Professional Standards'.

* The rating of 'generally conforms' is the highest rating that can be achieved, in line with the IIA's EQA assessment model.

Quality assurance and continual improvement

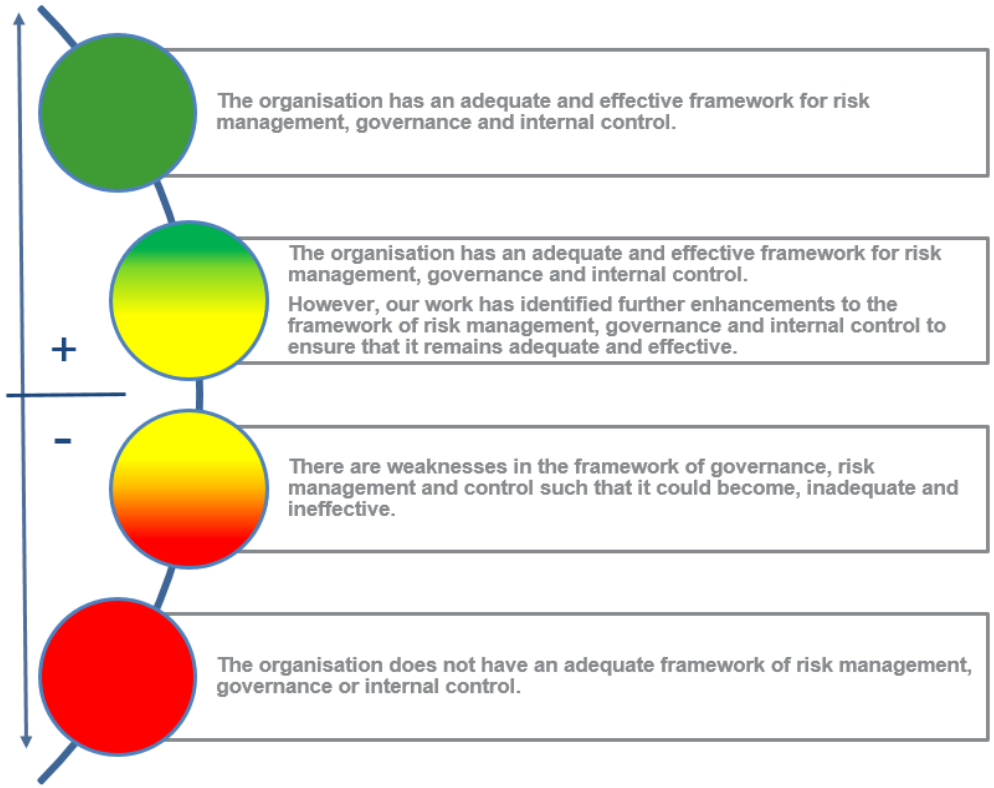
To ensure that RSM remains compliant with the PSIAS framework we have a dedicated internal Quality Assurance Team who undertake a programme of reviews to ensure the quality of our audit assignments. This is applicable to all Heads of Internal Audit, where a sample of their clients will be reviewed. Any findings from these reviews are used to inform the training needs of our audit teams.

Resulting from the programme between 1 April 2022 to 31 March 2023, there are no areas which we believe warrant flagging to your attention as impacting on the quality of the service we provide to you.

In addition to this, any feedback we receive from our post assignment surveys, client feedback, appraisal processes and training needs assessments is also taken into consideration to continually improve the service we provide and inform any training requirements.

APPENDIX A: ANNUAL OPINIONS

The following shows the full range of opinions available to us within our internal audit methodology to provide you with context regarding your annual internal audit opinion.

Annual opinions	Factors influencing our opinion
	The factors which are considered when influencing our opinion are: • inherent risk in the area being audited; • limitations in the individual audit assignments; • the adequacy and effectiveness of the risk management and / or governance control framework; • the impact of weakness identified; • the level of risk exposure; and • the response to management actions raised and timeliness of actions taken.

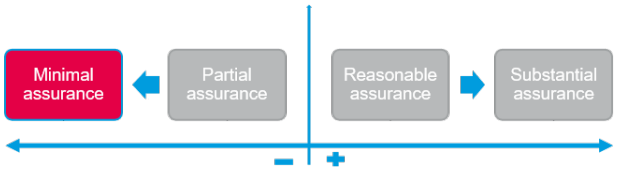
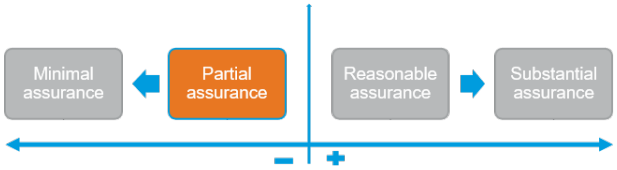
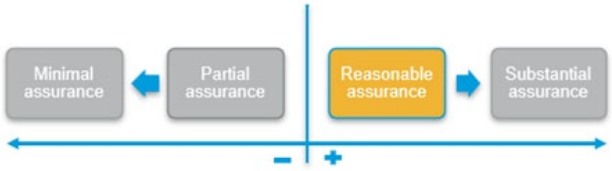
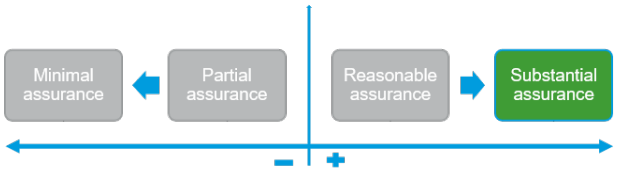
APPENDIX B: SUMMARY OF INTERNAL AUDIT WORK COMPLETED DURING APRIL 2022 TO MARCH 2023

All of the assurance levels and outcomes provided above should be considered in the context of the scope, and the limitation of scope, set out in the individual assignment report.

Assignment	Executive lead	Assurance level	Actions agreed			
			L	M	H	NR
Risk Management	Julie Hill, Corporate Secretary	Reasonable Assurance [●]	3	2	-	-
Application review	Alex Gild, Deputy Chief Executive	Reasonable Assurance [●]	3	2	-	-
Financial Governance (HFMA review)	Paul Gray, Chief Financial Officer	Advisory [●]	-	-	-	1
Health and Safety and Staff Wellbeing	Jane Nicholson, Director of People	Reasonable Assurance [●]	-	5	-	-
New Models of Care	Tehmeena Ajmal, Chief Operating Officer	Reasonable Assurance [●]	1	3	-	-
Green Plan	Paul Gray, Chief Financial Officer	Reasonable Assurance [●]	3	2	-	-
Bed Management / Out of Area Placements	Tehmeena Ajmal, Chief Operating Officer	Reasonable Assurance [●]	1	3	-	-
Data Security and Protection Toolkit	Paul Gray, Chief Financial Officer	TBC	TBC			

APPENDIX C: OPINION CLASSIFICATION

We use the following levels of opinion classification within our internal audit reports, reflecting the level of assurance the board can take:

	Taking account of the issues identified, the board cannot take assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Urgent action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take partial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied or effective. Action is needed to strengthen the control framework to manage the identified risk(s).
	Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective. However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).
	Taking account of the issues identified, the board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

YOUR INTERNAL AUDIT TEAM

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The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Actions for improvements should be assessed by you for their full impact. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

Our report is prepared solely for the confidential use of Berkshire Healthcare NHS Foundation Trust, and solely for the purposes set out herein. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM UK Risk Assurance Services LLP for any purpose or in any context. Any third party which obtains access to this report or a copy and chooses to rely on it (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM UK Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

RSM UK Risk Assurance Services LLP is a limited liability partnership registered in England and Wales no. OC389499 at 6th floor, 25 Farringdon Street, London EC4A 4AB.

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Bed Management/ Out of Area Placements

Internal audit report 6.22/23

Final

15 May 2023

1. EXECUTIVE SUMMARY

With the use of secure portals for the transfer of information, and through electronic communication means, a proportion of our audit assignment has been conducted remotely. Remote working has meant that we have been able to complete our audit assignment and provide you with the assurances you require. Based on the information provided by you, we have been able to sample test, or undertake full population testing using data analytics tools, to complete the work in line with the agreed scope.

Why we completed this audit

An internal audit review of Bed Management / Out of Area Placements (OAPs) was undertaken at Berkshire Healthcare NHS Foundation Trust as part of the agreed internal audit plan for 2022/23. This review specifically reviewed the Mental Health Inpatients bed management and OAP's.

The bed management team consists of three bed managers and a part time administrator. The bed management team fall under the inpatient management which ensures a closer working relationship across all parts of the Trust. The bed management team have the sole responsibility for sourcing mental health beds for Berkshire patients, whether those patients are living in Berkshire or not. The remit of the role is to work across Mental Health Inpatient Services, community teams and with colleagues in social services, and any other relevant professionals; to provide leadership and advice on bed availability to ensure patients have when critical, access to beds within in Berkshire.

The role of the Bed Manager is to liaise with the wards on a daily basis, using the information gathered within the day and during the updates received from the ward. Daily bed meetings ensure the bed state information is accurate and up to date.

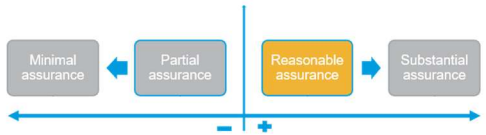
Monthly reports are in place which details OAP's for Berkshire Hospital East and West teams.

Conclusion

Internal audit opinion:

Taking account of the issues identified, the board can take reasonable assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective.

However, we have identified issues that need to be addressed in order to ensure that the control framework is effective in managing the identified risk(s).



Key findings

Effectiveness

Out of Area Placements Summary

The chart below details the number of OAP's for the period of 01 December 21 to 30 November 2022. We found that there were 218 inappropriate OAP's for November 2022. We noted that the number of the inappropriate placements have increased over the recent months. An inappropriate out of area placement for acute mental health in-patient care is defined as when a person with assessed acute mental health needs who requires adult mental health acute inpatient care, is admitted to a unit that does not form part of their usual local network of services. We found that the Bed Optimisation Project Steering Group is in place which main responsibility is to seek address the continued work needed to achieve the Trust ambition of optimising the utilisation of Acute and PICU mental health inpatient beds.

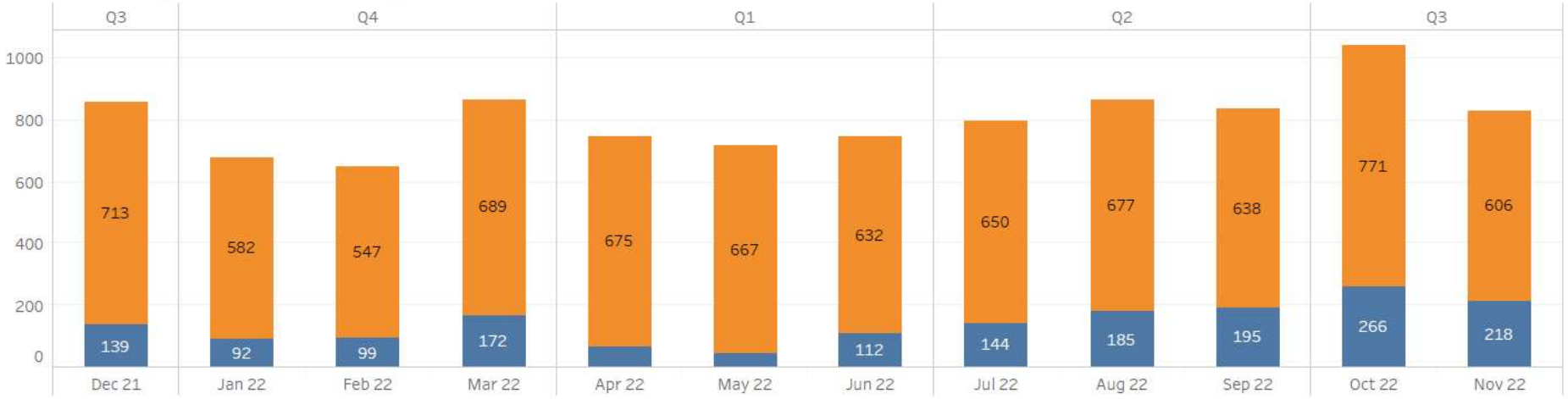
We found that PICU work is concentrating on flow through the service to ensure that the Trust can effectively step people down in a more timely manner. Since May 2022, the Trust has discharged 13 patients from Sorrell ward, however due to the continued high levels of demand, the Trust has not been to return patients of OAP PICU beds.

Please select Date Range
01/12/2021 00:00:00 to 31/12/2022 23:59:59

East/West
All

Appropriate
Inappropriate

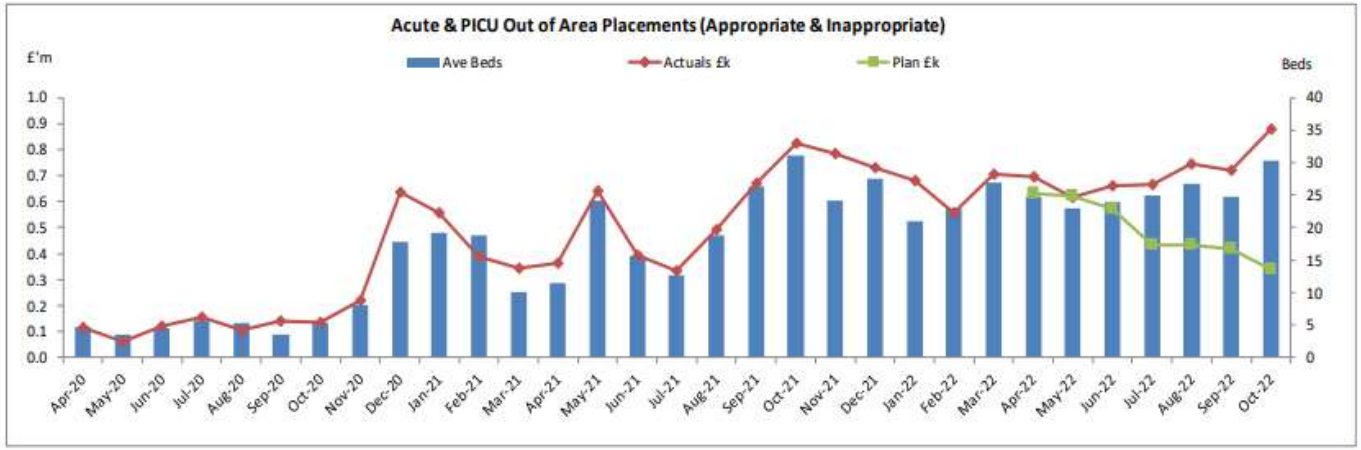
Number of Appropriate/Inappropriate Bed Days Per Month



Number of Bed Days per Month

As reported in December's Board meetings minutes, the average number of placements has increased from 25 in September 2022 to 30 in October 2022, with the monthly cost increasing from £0.72m to £0.88m

Placement Costs



OAPs

YTD	£'m
2022/23	5.0
2021/22	2.9
▲	72%

Prior Yr	£'m
Oct-22	0.9
Oct-21	0.8
▲	6%

We have raised three 'Medium' and one 'Low' priority management actions relating to the following areas. Further details can be found in section 2 of this report:

Bed Management Office

The current administrative support for the team is 4 hours per day. The Trust has set itself an ambitious plan to ensure that there are no inappropriate OAP's by 2023/2024. However, the current administrative support may not be sufficient or appropriately skilled to support the team to deliver on this important trajectory. **(please see management action 1 – Medium).**

Out of Area Placements performance framework and Inconsistencies in lengths of stay

We found that there is no performance framework for OAP's. Our review found that there is a variation in the average length of stay for patients that are placed out of county. Where a quality framework or KPIs are not in place, this poses a risk that OAP's will not be monitored effectively.

There is also an inconsistency in terms of the length of stay for patients on similar wards with similar diagnosis including PICU.

Staff members advised that sometimes one to one supervision might be overprescribed, and they also discussed that some patients with emotional unstable disorder may sometimes be admitted for longer than required.

(please see management action 2 – Medium).

We noted the following controls to be adequately designed and operating effectively:

Bed management meetings

From review of relevant Standard Operating Procedure (SOP's), we found that the following meetings are in place to discuss bed management:

- Daily Summit meeting which is held at 10am and it is chaired by a Matron covering the MH wards for the Trust
- Bed Management meeting covering inpatient wards at 2.30 pm; and
- Bed flow meeting at 3pm which discusses all patients including out of area placements. The meetings are held on a Tuesday, Wednesday, Thursday, and Friday.

We observed the meetings held and found that sufficient discussions were held and noted that during these meetings.

Post Admission Liaison Meeting (PALM) meetings

From our discussion with management, we found that PALM meeting is also in place which includes attendees from the crisis team and these meetings include discussion of treatment/care plans and forward planning.

Initiatives to reduce Out of Area Placements

We found that the following initiatives were in place at the Trust:

- The Trust has pledged by 2023/24 that there will be no more inappropriate out of area placements. This was in line with NHSE England's recommendations;
- The Trust has had a recent review and options appraisal carried out to review the bed stock and future modelling. We reviewed the Terms of References (TOR), presentations, and the most recent update. This review was carried out by the external consultant. At the time of the audit, we noted that a decision had not yet made on the model best suited for the Trust;
- The Trust appointed its first Advanced Nurse Practitioners role at Band 7 in January 2022, and they will be introducing new Associate Nurse Consultant roles which will be replacing the existing Matron roles. The aim of this is to improve patient experience, quality, and patient flow; and

- There are conversations taking place with the Berkshire, Buckinghamshire, and Oxford Integrated Care Board (ICB) to have a Mental Health Provider Collaborative. It was noted that this item was on the agenda for ICB.

Focus on Prevention of hospital admission

We found that the Trust has invested in crisis service with teams in the West and the East. The Trust has staff hosted within Royal Berkshire and Wrexham Hospitals. There are 15 nurses on each site including: 2 psychologists and consultant cover. The core provision to A&E offers 24/7 emergency provision including biopsychology assessments. The team have a key performance indicator that they must see patients within a one-hour window once a request has been made. The Trust staff report that there is a good relationship with their colleagues within the A&E departments.

We found that the following were also in place:

- The Trust has a staff member in each A&E department who will support and identify those patients that present regularly. Initially this was part of the Commissioning for Quality and Innovation (CQUIN), and the Trust has continued this service. There are two part time staff who cover each A&E dept. They support individualised care planning;

- Each patient whether referred from the Emergency Department (ED) or inpatient wards receives a comprehensive bio psychosocial assessment that includes formulation of risk and care planning. Care planning and discharge plans are agreed with each patient. Patients receive a copy of their care/discharge plan;

- The Trust practices Gatekeeping which involves assessing the patient before admission to hospital; the Crisis Team act as gate keepers. All requests for inpatient admissions are considered after a full mental health assessment has been completed;

- There are PALMs weekly liaison meetings for patients with Emotionally unstable personality disorder (EUPD) between ward, Community Mental Health Team (CMHT), Crisis Resolution and Home Treatment Team (CRHTT), Psychologist on EUPD pathway to support discharge planning;

- There is a Psychosis Quality Improvement (QI) project taking place that is looking to have a standard process for reviewing patients who have been in the Trust longer than 60 days. We found that there is a fortnightly meeting held for those patients who have stayed over 60 days to review their care and any actions that need to be taken. We confirmed that these are then added onto the Bed Management file and

- Consultation staff from the EUPD service who are linked to particular patients with EUPD continue to link with community staff about care planning regardless of whether someone is being treated in the Trust or through the OAP's.

Integrated Care Systems

From discussion with the Divisional Director Mental Health Inpatients, we found that the weekly MH System meeting takes place every Monday which includes attendance of the Local Authorities, ICB Long Term Placement Team and representatives from the Berkshire Hospital. The meeting is chaired by the Head of Service for Mental Health. Actions and updates are then circulated to the Integrated Care System partners via email. We found that this meeting is not minuted, however we were provided with email examples. We found that most recently a review has been undertaken around the Winter Operating Model.

Monthly OAP's report

We found that monthly OAP's report are in place. We obtained the latest report for December 2022 which included information for the Trust's Trajectory Inappropriate / Appropriate Bed Days Summary for the period of December 2021 to December 2022.

Mental Health Prospect Park Hospital (MHPPH) Driver Metrics Divisional Scorecard

A monthly scorecard is in place for the MH Inpatients which is reported to the Patient Safety and Quality Executive meeting. We obtained the latest scorecards for the period of August to October 2022, and found that they included the following metrics:

- MH Acute Average Length of Stay;
- MH Older Adult Average Length of Stay (days);

We found that the average target stay for the MH Acute wards was 30 days. We found that for the period of November 2021 to October 2022, the average stays varied from 34.2 to 84.6 days.

For the MH Older Adult wards, the average length of stay is 79 days. We found that for the period of November 2021 to October 2022, it varied from 53.2 to 156.8 days.

We found that Bed Optimisation Project is in place.

Quality and Performance Executive

We found that TOR dated June 2022 was in place for the Quality and Performance Executive. We noted that the purpose of this group is to lead on quality assurance and drive improvements for quality of care for patients/ users of their services. The group provides an executive function of scrutiny and management of the operational performance of the organisation assuring regulatory compliance, delivery of plans and mitigating actions.

We found that MH Inpatients summary is presented to the meeting which includes details on the items of concern, patient experience/good practice, and support for staff. CQC domains are reviewed around, safe, caring, responsive, effective, well led including KPIs.

As noted in the October's 2022 report, we found that an update on the patient / bed flow was also provided.

The Bed Optimisation Programme

The Bed Optimisation Programme is in place and the project group meets monthly with a status exchange every month, this therefore equates to a fortnightly discussion on the prevailing issues. Each of the workstreams has project support and clinical leadership and a QI approach is being applied to the work. The number of extra-contractual beds has been amended based on what has worked over the prior 6 months.

2. DETAILED FINDINGS AND ACTIONS

This report has been prepared by exception. Therefore, we have included in this section, only those areas of weakness in control or examples of lapses in control identified from our testing and not the outcome of all internal audit testing undertaken.

1. Bed Management Office				
Control	The Bed Management Office is in place which includes the three Bed Managers and part time administrative support (4 hours).		**Assessment:** **Design** ✓ **Compliance** ×	
Findings / Implications	Whilst present in the bed management office we noted the intensity of the setting and workload. There was a significant number of calls being received by the team. The current administrative support for the team is 4 hours per day. The Trust has set itself and ambitious plan to ensure that there are inappropriate OAP's by 2023/2024. The current administrative may not be sufficient or appropriately skilled or senior to support the team to deliver on this important trajectory, especially in terms of logistics, chasing information and challenging late and inappropriate responses to requests for data/information/action.			
Management Action 1	*The Administrative support for the Bed Management Office will be increased to ensure that there is a sufficient capacity within the team to manage the bed management flow.*	**Responsible Owner: Theresa Wyles**	**Date: Completed**	**Priority: Medium**

2. Oversight and quality assurance of OAP's and Inconsistencies in the lengths of stay for patients			
Control	Missing control: a quality schedule is not in place or performance framework for OAP. Inconsistencies were noted in the lengths of stay for patients. Missing control: Eviction policy was not in place.	**Assessment:** **Design** × **Compliance** N/A	
Findings / Implications	Oversight and quality assurance of OAP's From discussion with management, we found that there is not a quality schedule in place or performance framework for OAP. There is a dedicated individual who is responsible for liaising and following up patients who are placed out of area. There is a variation in the average length of stay for patients that are placed out of country. The bed management and OAP team lead liaises with numerous providers to discuss care and treatment planning. At present for those patients who are placed under spot purchasing the governance around these placements is not robust. The Trust should consider some KPIs, Quality Metrics, and escalation points. The staff are passionate about patient outcomes and have articulated that some providers are slow in focusing on ensuring that patients treatment plans are followed to ensure improved patient outcomes and reduced lengths of stay. Where a quality framework or KPIs are not in place, this poses a risk that OAP's will not be monitored effectively. Support and involvement with OAP's and PICU From our interviews we found that an oversight to support the OAP's is dedicated to one key person. The Trust has an ambition to improve the quality of placements and to reduced inappropriate placement. Other staff members have expressed that they would be willing to support this and be involved of reducing OAP's. Inconsistencies in the lengths of stay for patients From our discussion with staff members, we found that some staff have articulated that there is inconsistency in terms of the length of stay for patients on similar wards with similar diagnosis including PICU. Staff members advised that sometimes one to one supervision might be overprescribed, and they also discussed that some patients with emotional unstable disorder may sometimes be admitted for longer than required. We found no evidence that steps have been taken to review these inconsistencies. Where inconsistencies with lengths of stay exists, this poses a risk that the Trust is keeping some patients for longer than required and therefore this increase the risk that OAP's will be needed. We further found that the Trust does not have an eviction policy for those patients who refuse to leave the wards.		
Management Action 2	*The Trust will draft a Quality Framework for the OAP's which should guide staff on the quality measures including the key performance indicators.*	**Responsible Owner: Theresa Wyles**	**Date: July 2023**	**Priority: Medium**

2. Oversight and quality assurance of OAP's and Inconsistencies in the lengths of stay for patients				
	Additionally, the Trust will consider involving more staff to monitor, challenge and advise on out of county placements using a placement framework that supports quality oversight and anticipated outcomes.			
Management Action 3	*The MH Inpatient will consider auditing these areas or some targeted workshops to discuss the differences and to addresses unwarranted variation in practice.* *Eviction policy will be drafted and circulated to all relevant staff members.*	**Responsible Owner: Sue McLaughlin**	**Date: September 2023**	**Priority: Medium**

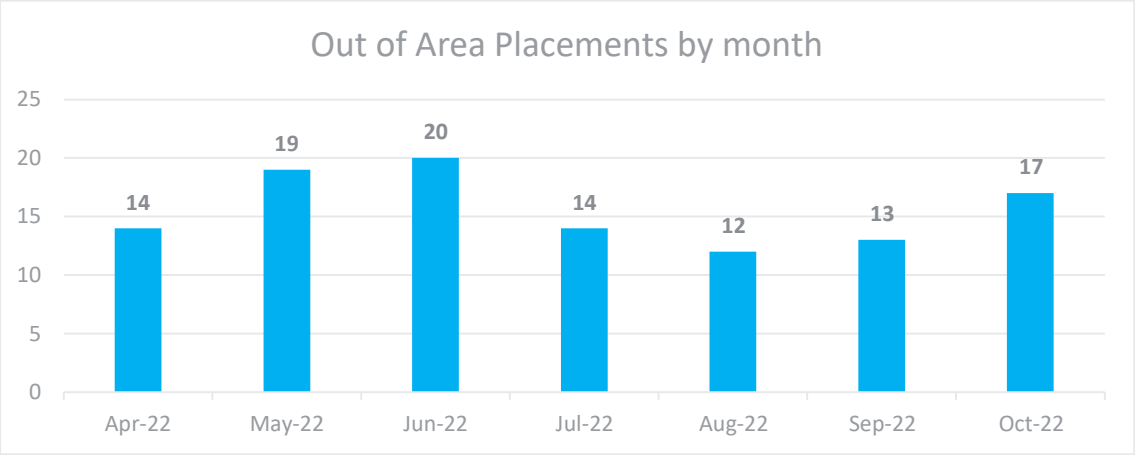
4. An Advanced Nurse Practitioner role			
Control	The Trust has introduced an Advanced Nurse Practitioner role.	**Assessment:**	
		Design	✓
		Compliance	×
Findings / Implications	The Trust has introduced an Advanced Nurse Practitioner (AHP) role and will be introducing new roles soon to improve patient care and outcomes. The impact of the AHP role has not formally been evaluated yet. From our discussion we found that the Trust does not routinely discharge patients at the weekends or advocate for nurse led discharge. This poses a risk that more OAP's will be needed.		
Management Action 4	*The MH Inpatient will consider the impact of the new roles and how they could enhance discharge especially at weekends.*	**Responsible Owner: Helen Robson**	**Date: May 2023**	**Priority: Low**

APPENDIX A: DATA ANALYTICS

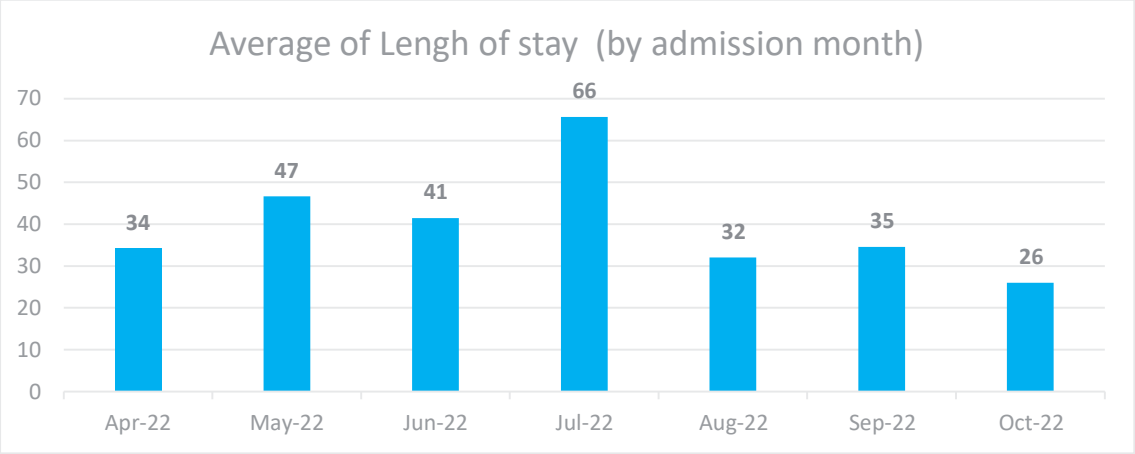
Out of Area Placements (OAP's)

We obtained the report from the Bedrock system which included the OAP's for the period of April to October 2022.

Our findings are summarised below:



The highest number of the OAP's were in the months of June 2022 (20 cases), May 2022 (19 cases) and October 2022 (17 cases).



* Length of stay as of 24 November 2022

Admissions by month

We found that the Bed Manager has undertaken an analysis on the admission for the Mental Health Inpatients for the period of April to November 2022. Please note that the figures included below for the November 2022 do not include the full months' figures.

The admissions are correlated to the Out of Area placements. There were in total 82 admissions for August 2022, and there was a lowest number of OAP's reported for that period (12 cases).

	APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMEBER
ACUTE ADMISSIONS								
Bluebell	24	16	15	16	17	14	7	8
Daisy	13	17	12	13	9	10	10	8
Rose	14	15	10	13	16	23	22	15
Snowdrop	15	12	17	17	20	20	19	7
TOTAL	**66**	**60**	**54**	**59**	**62**	**67**	**58**	**38**
PICU								
Sorrel	3	7	5	8	10	9	11	4
TOTAL	**3**	**7**	**5**	**8**	**10**	**9**	**11**	**4**
OLDER ADULT ADMISSION								
Rowan	3	1	7	6	5	5	4	1
Orchid	7	5	5	6	5	2	6	1
TOTAL	**10**	**6**	**12**	**12**	**10**	**7**	**10**	**2**

APPENDIX B: CATEGORISATION OF FINDINGS

Categorisation of internal audit findings	
Priority	**Definition**
Low	There is scope for enhancing control or improving efficiency and quality.
Medium	Timely management attention is necessary. This is an internal control risk management issue that could lead to: Financial losses which could affect the effective function of a department, loss of controls or process being audited or possible reputational damage, negative publicity in local or regional media.
High	Immediate management attention is necessary. This is a serious internal control or risk management issue that may lead to: Substantial losses, violation of corporate strategies, policies or values, reputational damage, negative publicity in national or international media or adverse regulatory impact, such as loss of operating licences or material fines.

The following table highlights the number and categories of management actions made as a result of this audit.

Objective	Control design not effective*		Non Compliance with controls*		Agreed actions		
					Low	Medium	High
Assurance will be provided over the robustness of the bed management processes at the Trust which in turn facilitate patient flow.	1	(10)	3	(10)	1	3	0
Total					**1**	**3**	**0**

* Shows the number of controls not adequately designed or not complied with. The number in brackets represents the total number of controls reviewed in this area.

APPENDIX C: SCOPE

The scope below is a copy of the original document issued.

Scope of the review

The scope was planned to provide assurance on the controls and mitigations in place relating to the following risks:

Objective of the area under review	Risks relevant to the scope of the review
Assurance will be provided over the robustness of the bed management processes at the Trust which in turn facilitate patient flow.	BAF RISK REF 8A: There is a risk that the Trust may be unable to maintain the standards of safe and high-quality care for patients we aspire to as an organisation because of the challenges of responding during the active phase of COVID-19 and also responding to further waves of COVID-19 with winter pressures. There is a risk that there may be insufficient staff to provide safe care due to staff to staff transmission and the impact of test and trace on the need for staff to self-isolate.

This review will consider the following:

- We will review arrangements in place to manage bed occupancy including out of area placements for mental health hospital beds.
- Relevant policies, procedures and guidance for bed management have been authorised, and communicated to relevant personnel.
- We will consider how the Trust collaborates with its ICS partners to more effectively coordinate bed management to reduce patient bed days.
- We will also consider action plans developed by the Trust to address potential blockages for patients ready to be discharged.
- There may also be a focus on understanding the discharge plans in place for patients in an in-patient setting.
- Governance and reporting arrangements.
- We will use data analytics to consider the following:

- Undertake data profiling to identify any trends or unusual patterns, identify incomplete data and reconcile bed occupancy to patient admissions and discharge data.
- Review areas of high bed utility and focus on the bed management and discharge processes in those areas to identify any themes/trends.
- Identify the wards / divisions where the Trust is demonstrating a higher or lower level of performance than others.
- Days difference between expected discharge date (EDD) and actual date and percentage of patients with EDD recorded. *

*has been excluded from the scope, as this is not relevant for the MH Inpatient.

The following limitations apply to the scope of our work:

- The audit will be limited to the areas of consideration stated above.
- Any testing undertaken as part of this audit will be on a sample basis from April 2022 only.
- Our review may involve interviews with a sample of staff, and as such, conclusions will be drawn from our discussions.
- The review should not be considered as a comprehensive review of all aspects of non-compliance that may exist now or in the future.
- The results of our work are reliant on the quality and completeness of the information provided to us.
- In addition, our work does not provide any guarantee against material errors, loss or fraud or provide an absolute assurance that material error, loss or fraud does not exist.

The full scope of the audit can only be completed within the audit budget if all the requested information is made available at the start of the audit, and the necessary key staff are available to assist the audit process during the audit. If the requested information and staff are not available we will need to reduce the scope of our work and/or increase the audit budget. If this is necessary we will agree this with the client sponsor.

Debrief held	14 December 2022
Draft report issued	27 January 2023
Responses received	15 May 2023
Final report issued	15 May 2023

Internal audit Contacts	Clive Makombera, Partner Sharon Kaur, Manager Mohammed Naeem, Assistant Manager Angela Dempsey, Associate Consultant Loreta Valskyte, Lead Auditor
Client sponsor	Tehmeena Ajmal, Chief Operating Officer
Distribution	Tehmeena Ajmal, Chief Operating Officer Theresa Wyles, Divisional Director Mental Health Inpatients (Prospect Park Hospital)

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The matters raised in this report are only those which came to our attention during the course of our review and are not necessarily a comprehensive statement of all the weaknesses that exist or all improvements that might be made. Actions for improvements should be assessed by you for their full impact. This report, or our work, should not be taken as a substitute for management's responsibilities for the application of sound commercial practices. We emphasise that the responsibility for a sound system of internal controls rests with management and our work should not be relied upon to identify all strengths and weaknesses that may exist. Neither should our work be relied upon to identify all circumstances of fraud and irregularity should there be any.

Our report is prepared solely for the confidential use of Berkshire Healthcare NHS Foundation Trust, and solely for the purposes set out herein. This report should not therefore be regarded as suitable to be used or relied on by any other party wishing to acquire any rights from RSM UK Risk Assurance Services LLP for any purpose or in any context. Any third party which obtains access to this report or a copy and chooses to rely on it (or any part of it) will do so at its own risk. To the fullest extent permitted by law, RSM UK Risk Assurance Services LLP will accept no responsibility or liability in respect of this report to any other party and shall not be liable for any loss, damage or expense of whatsoever nature which is caused by any person's reliance on representations in this report.

This report is released to you on the basis that it shall not be copied, referred to or disclosed, in whole or in part (save as otherwise permitted by agreed written terms), without our prior written consent.

We have no responsibility to update this report for events and circumstances occurring after the date of this report.

RSM UK Risk Assurance Services LLP is a limited liability partnership registered in England and Wales no. OC389499 at 6th floor, 25 Farringdon Street, London EC4A 4AB.

GOVERNORS' SUBCOMMITTEE – MEMBERSHIP & PUBLIC ENGAGEMENT

Meeting Date: 21st November 2023

Thank you to the Governors and other attendees at the last meeting for a lively and comprehensive discussion of the agenda items and other matters raised at the meeting. Good to see the 'turnout' increasing too. Both at this M&PE meeting and an earlier QAG meeting we discussed not just attendance at the three subcommittee meetings but the notion of all Governors being notified and invited to all three, receiving the Meeting Papers, and attendance being by choice and availability, of course. Our Chair, Martin Earwicker has confirmed via the last QAG that there is no need for a limit to Governor attendance at the subcommittees and they should indeed be open to all.

Our continued thanks go to Marcomms for the Membership Report and answering Governor questions at the meeting. The next Member Newsletter is due out after New Year and we have asked for the upcoming next round of Governor Elections to be featured. Next year, in total, there will be 8 Governor re-elections and 2 vacancies to fill.

A small reduction in Member numbers resulted from the post cards sent out in the run up to the AGM is September and the consequent returns for no longer at an address, a useful form of data cleansing. Membership categories that are a little light in numbers include:

Age groups 17-21, 22-29 and 40-49 Male Members
Asian and Mixed Ethnicity
Overall Membership numbers in Slough, W. Berks, Windsor and Maidenhead and Wokingham

The Trust has made it quite clear that their staff and Marcomms are 'busy' and that there are no further resources and finances available for this area. In recognising this, we also acknowledge that any kind of general Membership Drive is not the way forward and not what we explored in our discussions in the meeting.

My view is that we can make a contribution in this area, particularly constituency-based Governors in looking to 'top up' Membership numbers in key areas, such as the category shortfalls mentioned above. In the coming months, I will endeavour to put more substance into this "idea" and engage with Governors to explore how to approach this. A very important point, made by Ian Germer was that the "message" had to be carefully and appropriately formulated so that prospective new Members would be fully clear on what Membership entails and "what's in it for them". Marcomms will be checking on the current use in service units of the Membership Cards.

Trust Membership Strategy – we had hoped this would have been available for the meeting to discuss. A final review is being undertaken and the document should be available to the Governors quite soon.

Brian Wilson, Chair, M&PE Subcommittee

GOVERNORS' WORKING GROUP – QUALITY ASSURANCE GROUP

REPORT TO COUNCIL OF GOVERNORS FOR 6TH DECEMBER 2023

Unfortunately, Tim Dee who was expected to take over as Chair of the Quality Assurance Group had resigned as both a Governor and the Chair of the Quality Assurance Group. We all wish him well and hopefully look forward to his return as a Governor in the future. As Co-Chair I have stepped up to the role of Chair and I would like to thank Sarah Croxford for taking over the role of Co-Chair.

This meeting is the first meeting that I have taken the Chair and I would ask for your allowance should I make any mistakes or errors until I am fully up to speed with all the requirements for a Chair. This was a Hybrid Meeting with Governors being both present and connected via a Teams Meeting. As mentioned in the last Report this Governors' Working Group has the most papers and requires a great deal of reading of both the current Agenda Items and the previous Agenda Items to understand all the nuances and expected outcomes in order to make sense of the reported waiting times and patient experience. Sarah and I expect to work together before the next meeting to go through the Agenda and reported schedules to see if there is a way to both precis and expand critical areas to make the reading more easily understood. I note that we may have some problems as many of the schedules are decided at national level and do not easily admit to any small changes. We will however try.

We had a very interesting talk from Dan Badman, Deputy Director of Patient Safety and Quality, about the significant change next year on the way incidents would be reported and their effect on the investment of resources in terms of doing investigations and the use of this intelligence to determine where best to invest and the greatest opportunities for learning. This system, The Patient Safety Incident Response Framework (PSIRF) will be going live in January 2024. This will hopefully lead to incidents being looked at in a slightly less complex way.

DB was asked how the new reporting system was working from his perspective and he noted that the ultimate aim was for the Learning From Patient safety Events, LFPSE, to be used nationally to pick up themes across the NHS and other bodies to improve the way the NHS works. There is still a lot of consultation needed to improve the system and Governors could be involved around patient safety.

It was noted that the Waiting Lists Report contained many areas awaiting targets from which the waiting lists can be assessed. It was noted that these targets are being set at a national level and are currently being worked on. There should be more information at our next meeting.

I would finally encourage both new and experienced Governors to make as many visits as they are able to as this will broaden their knowledge of the BHFT and their role in helping the Trust carry out its obligations. I would suggest that in the first instance Governors look at areas of the NHS in which they have a particular interest and/or in their local area.

John L Jarvis
Chair, QAG

Governors "Living Life to the Full" Group – Report to Council
Tom Lake 6 December 2023

In our continuing familiarisation with organisations that work with mental health care, we heard a talk and presentation from Lorna McCardle, founder and CEO of SupportU, a charity supporting LGBT people across Berkshire. Like "Sport in Mind", this is a local organisation that has grown rapidly in recent years.

SupportU will refer on where it finds clients needs cannot be met by themselves and so it is an important navigator for LGBT people as well as offering services in its own right.

SupportU now receives 6,500 enquiries a year for services, sees 100 people a week with 200 group attendees a month and has a turnover of around £250K pa. A current project is to increase representation of and engagement with black and asian LGBT people.

Startlingly, Lorna told us that 50% of LGBT people and 90% of their clients are autistic. They are in contact with Autism Berkshire. Does this have any implications for the Trust? They are looking for engagement with research in this area.

SupportU offers a wide range of outreach services, and Lorna suggested that the Trust board might want to take a "Lunch and Learn" from them at a future date.

Governors responded very positively to the presentation.

On other matters Tom and Brian had both attended events where the new approach of Police to engaging with people with mental health problems or crises was discussed and found the approach careful with good inter-service relations and cooperation, on the model of the Humberside pilot.

In discussion at the Council/NEDs meeting governors expressed a wish for a formal link of this group with the Carers Strategy – Katie Humphreys has agreed to attend for an update twice a year, starting on 17th April.

We will next hear from youth counselling service No5 on 21st Feb and from Community Mental Health East on 17th April. Katie Humprey will lead a full discussion on Carers Strategy at the October meeting following her update to Council in September. All governors are invited to attend this group which hopes to inform and educate about the wider environment in which our Trust operates.

Berkshire Healthcare
NHS Foundation Trust

Patient Experience

Quarter Two 2023-24 Report

Presented by: Liz Chapman, Head of Service Engagement and Experience

Highlight Patient Experience Report
Quarter two 2023/24

1. Why is this coming to the Board?

This report is written to provide information and assurance to the Board in relation to the Trust's handling of formal complaints and also to provide information and learning around broader patient experience data available to us.

Both the CQC and Parliamentary Health Service Ombudsman (PHSO) set out expectations in relation to the handling of complaints; these are based on the principles that complaints are a valuable insight for organisations and should be seen as a learning opportunity to improve services. There is a requirement for complaints to be reviewed robustly in a timely manner that is fair, open, and honest.

Complaints are only one element of understanding the overall experience of those accessing our services, we therefore analyse data gathered through a variety of means including the 'I want great care' (iWGC) tool now used as our primary patient experience tool, to support understanding of patient experience and areas for improvement.

2. What are the key points?

The iWGC tool enables patients to provide a review of their experience using a 5-star rating for several areas(facilities, staff, ease, safety, information, involvement and whether the person felt listened to) as well as making suggested improvements. The trust has an ambition as part of the Trust strategy to increase the volume of feedback received over the next 3 years to 10% and also to increase the use of the information received to support improvement. All divisions have a performance metric that they are monitoring to improve levels of feedback. For our Mental health wards there is also work in progress to identify alternative ways of capturing patient experience.

The table below provides the overall Trust metrics complied in relation to patient experience. The full report provides more detailed information by division. A target is added where there is one. There is not a metric for number of complaints/ MP enquiries, all feedback should be viewed as an opportunity for learning, however where there are not metrics per say last years total are included to provide some context.

Patient Experience – overall Trust Summary		Target	Qtr. 1		Qtr. 2		Qtr. 3	Qtr. 4
Total patient contacts recorded (inc discharges from wards)	Number		216,579		219,999			
Number of iWGC responses received	Number	**16,000** (based on Q1 contact)	6,450	↑	7,156	↑		
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**7.5%** by Mar '24	3%	↔	3.3%	↑		
iWGC 5-star score	Number	**4.75**	4.71	↑	4.79	↑		
iWGC Experience score – FFT (good or very good experience)	%	**95%**	93.8%	↑	94.5%	↑		
Compliments received directly by services	Number	Total 22.23 **4522**	1091	↑	1229	↑		
Formal Complaints received	Number	Total 22/23 **240**	68	↑ **1***	64	↓		
Formal Complaints Closed	Number	Total 22/23 **247**	53	2*	64	2*		

Formal complaints responded to within agreed timescale	%	**100%**	100%	↔	100%	↔		
Formal Complaints Upheld/Partially Upheld	%	Total 2022/23 **56%** total complaint	62%	↑	55%	↓		
Local resolution concerns/ informal complaints Rec	Number	Total 2022/23 **134**	36	↑ 3*	50	↑		
MP Enquiries Rec	Number	2022/23 total **88**	24	↔	11	↓		
Complaints upheld/ partially by PHSO	Number	Total 2022/23 **0**	0	↔	0	↔		

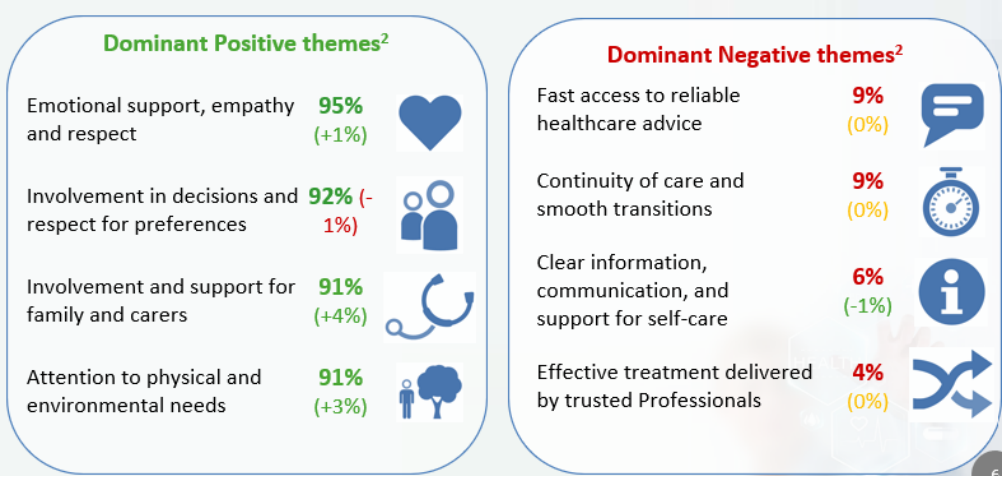
1*Increased from Q4 but within quarterly control limits based on previous quarters over last year
2* Lower than Q4 but less complaints opened in Q4 will result in less to close in Q1, more complaints received in Q1 therefore number closed has increased for Q2.
3* increased from Q4 but within quarterly control limits based on previous quarters over last year

There are no significant changes identified in most of the analysis of data that differs from previous reports, the highest number of complaints related to specific care and treatment concerns and the largest volume of MP enquires (7) relates to wait times within CAMHS services (Neurodiversity pathway), although the number has dropped by more than 50% since Q1 and there is internal work to maximise efficiency and also external conversations in terms of resourcing.

The one notable difference is the increase in dissatisfaction with feeling listened to from iWGC survey results relating to East of the counties Mental Health services, this is not reflected in increased formal/ informal complaints and should be reviewed by the teams and monitored trough Q3; review of individual feedback demonstrates many compliments about being listened to and staff being kind and patient with very few free text comments in relation to feeling unheard/ not listened to, where these comments are made they are in relation to a number of differing services.

There is work being undertaken across all divisions in relation to highlighted learning and improvements; examples of feedback alongside 'you said, we did' improvements can be found in the full report accessed through the hyperlink. There continues to be disparity across the organisation in how services are utilising the tool and there is ongoing work and support being provided to increase both volume and use of the information received.

Overall feedback remains overwhelmingly positive; the below show the most positive and negative themes based on free text responses within the iWGC experience tool that patients have documented to explain their experience.



*Number in brackets shows change form previous quarter

3. What are the implications for EDI and the Environment?

We aim to receive feedback that is representative of the diversity across the population. The below table shows the split of both complaint and survey responses by ethnicity. We continue to see a higher number of white British making formal complaints in comparison to % split of attendances and a more representative sample of survey completion against attendance by ethnicity. In terms of gender, we have seen a higher number of complaints made by males this quarter in relation to attendances and a lower percentage of men completing the survey, recognising that we have 29% of those completing the survey not providing gender to enable total confidence in gender split.

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of attendances
Asian/Asian British	3.64	8.7	9.67%
Black/Black British	0	3.2	2.67%
Mixed	3.64	2.1	3.49%
Not stated	7.27	12.9	15.89%
Other Ethnic Group	1.82	6.8	1.62%
White British	83.65	66.3	66.66%

4. Conclusions and Recommendations for consideration by the Board

It is the view of the Director of Nursing and Therapies that, with the exception of feeling listened to for East Mental Health Services, as mentioned above and which should be reviewed by the teams receiving this feedback and monitored through Q3, that there are no new themes or trends identified within the quarter two patient Experience report. For areas of concern such as wait times for Neurodiversity assessments there are service and quality improvement programmes of work in place. There is also an on-going programme of work involving staff, service users and those with lived experience that is reviewing the service delivery model of our community mental health services, this aims to provide clarity around care and treatment as well as improved access to the right services and therefore a better patient experience.

There has been a small increase in the number of responses received through the patient experience tool and work is ongoing to support further increases; the use of this information for improvement across services does continue to increase. Board members should continue, as part of their contact with services to explore how patient feedback is being used for improvement.

Berkshire Healthcare
NHS Foundation Trust

Patient Experience Report Quarter 2 2023/24

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.

The below table shows information related to the overall Trust position in terms of patient experience feedback.

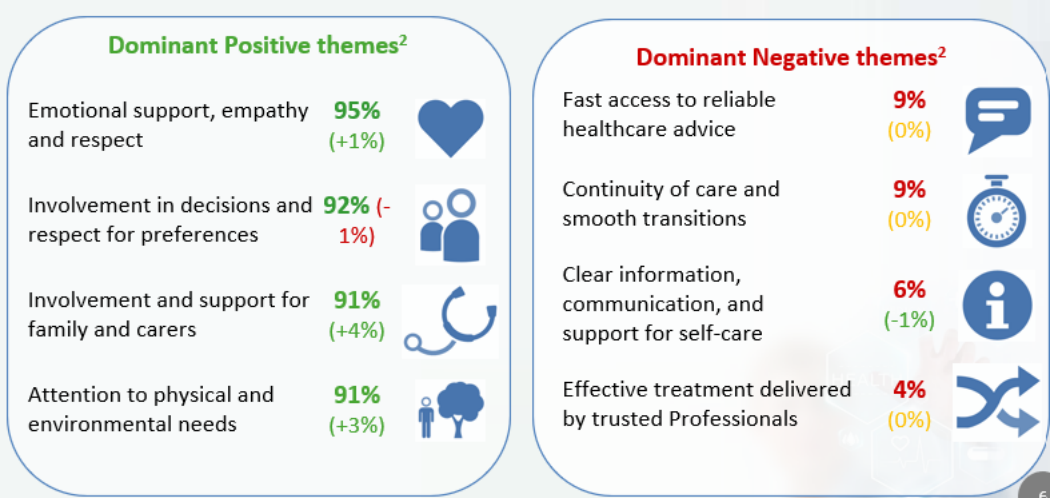
The iWCG tool is used as our primary patient survey programme and is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge via a variety of platforms. The tool uses a 5-star rating which is comparable across all services within the organisation and is based on questions in relation to experience, facilities, staff, ease, safety, information, involvement and whether the person felt listened to.

Table 1: Overall Trust Summary

Patient Experience – overall Trust Summary		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Total patient contacts recorded (inc discharges from wards)		216,579	219,999		
Number of iWGC responses received	Number	6,450	7,156		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3%	3.3%		
iWGC 5-star score	Number	4.71	4.79		
iWGC Experience score – FFT	%	93.8%	94.5%		
Compliments received directly by services	Number	1091	1229		
Formal Complaints Rec	Number	68	64		
Number of the total formal complaints above that were secondary (not resolved with first response)		11	10		
Formal Complaints Closed	Number	53	64		
Formal complaints responded to within agreed timescale	%	100%	100%		
Formal Complaints Upheld/Partially Upheld	%	62%	55%		
Local resolution concerns/ informal complaints Rec	Number	36	50		
MP Enquiries Rec	Number	24	11		
Complaints open to PHSO	Number	3	3		

There are no significant changes identified in analysis of data that differs from previous reports, the highest number of complaints related to specific care and treatment concerns. The number of MP enquiries received has dropped from 24 to 11. CAMHS and children's services continued to receive the highest number of MP enquiries.

Overall feedback remains overwhelmingly positive; the below show the most positive and negative themes based on free text responses within the iWGC experience tool that patients have documented to explain their experience.



The number in the brackets in the picture above shows the comparison to the report for quarter one. This demonstrates that there has been no change in 3 of the 4 dominant negative themes, with a slight improvement in 1 and an improvement in 3 of the 4 dominant positive themes, with a slight reduction in 1.

Appendices 1 and 2 contain our PALS and Complaints information for Quarter two.

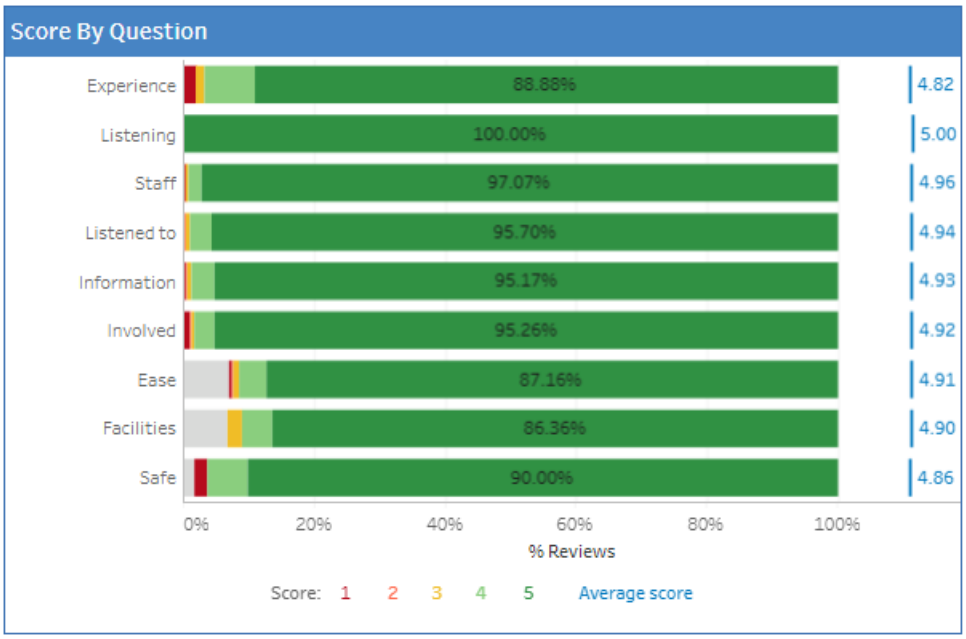
What the data is telling us

Below is a summary and triangulation of the patient feedback we have received for each of our 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	556	1169		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.1%	3.4%		
iWGC 5-star score	Number	4.59	4.7		
iWGC Experience score – FFT	%	89.3%	96.6%		
Compliments received directly by services	Number	72	55		
Formal Complaints Rec	Number	14	15		
Formal Complaints Closed	Number	14	14		
Formal Complaints Upheld/Partially Upheld	%	93%	57%		
Local resolution concerns/ informal complaints Rec	Number	6	14		
MP Enquiries Rec	Number	15	7		



For children's services the iWGC feedback has seen the responses double from last quarter, this has been seen across physical health services and further work needs to continue to ensure that we receive responses from those accessing our children and young people's MH services; 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 1159 responses, 1128 responses related to the children's services within the division; these received 96.6% positivity score, with positive comments about staff being helpful and friendly and a few suggestions for further improvement, this included 3 reviews for Phoenix House where comments about staff being supportive and understanding was very positive and there were some suggestions for further improvement regarding clarity over the extent of the care that will be provided and improvement in communication. 32 of the responses related to learning disability services as detailed below and 20 to eating disorder services.

From the feedback that was received, ease and facilities were most frequent reasons for individual questions being scored below 4.

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 Speech and Language service. The third complaint was relating to children's OT service.

1080 of the 1128 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Health visiting team, Bracknell and Health Visiting, Wokingham; the Health Visiting team in Bracknell received 265 of these responses which scored positively receiving a five-star rating of 4.71 and feedback included "*Information provided was very helpful made me feel comfortable about my breast feeding journey also it helped to make me feel that what I am doing is suitable for me and baby and I no longer feel tempted to give up my journey." "Really friendly staff, helpful, reassuring, explained information well & attentive & patient." and "Very kind and helpful staff, she answered us to all our concerns and she gave us a lot of nice advice. Thank you for this wonderful meeting."*

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were 12 complaints received, these were primarily in relation to care, and treatment received and waiting times. Themes around this included clinical care received and long wait for treatment. In addition to this, the service received 7 enquiries via MPs, and most of these again related to waiting times.

There have only been 27 responses for CAMHS services received through our patient survey for this quarter. Currently the survey is accessed through paper surveys, 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 Children and Young Peoples division included *'Thank you for today, it is the first time we have felt truly listened to. X was so relaxed in the appointment and enabled him to be so open and share his views. Thank you for all you have done and going the extra mile.'*

Further work is being carried out with CAMHS to improve uptake as part of the wider patient experience improvement plan.

Learning disability

There were no complaints received this quarter for the Campion Ward regarding care and treatment on the ward.

Overall there were 32 responses for all Learning Disability services from the patient survey received, responses were for the Community Teams for People with a Learning Disability and the Learning Disability Intensive Support Team. These received a 93.8% positive score, this was skewed by 4 responses not having a score; other feedback included that staff listened, "*It was fantastic and I was happy with everything.*", "*Treated with respect and kindness.*" and "*Felt listened to. Things were explained well and didn't feel judged.*", there were comments for improvements including would have preferred to be seen face to face and to have visits more often.

Eating disorders

There were no complaints for eating disorders.

Of the 20 feedback responses received, 14 scored a 5 with comments such as "*Amazing, dedicated staff members and clinicians who have a genuine and deep care for their patients. A pro-recovery environment within the patient group itself (most of the time). Support offered even during times I was not at the programme or the block had ended. Individualised plans that encompassed professional and also patient opinion. A good balance of kindness and directness / professionalism.*", "*The BEDs team have saved [name removed]'s life. And rescued us. They reacted very quickly to a self-referral and were weeks ahead of the GP. We were given help and advice over the phone and an urgent appt to look forward to at a time when everything felt frightening and hopeless. The triage team were gentle kind and sensible, I felt immediately in safe hands. They continue to support and empower us,*

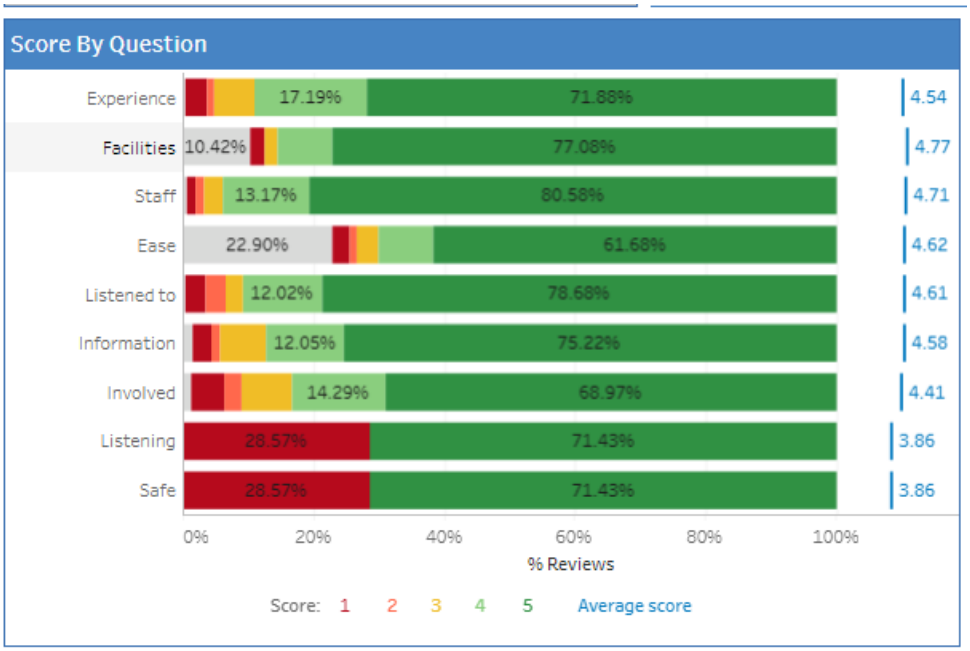
respond quickly to emails or calls. We are so grateful to have this service at our disposal and so very lucky that it is local and easy to get to. Thank you for everything.", "[name removed], [name removed] and [name removed] are the most amazing team! Their gentle but firm approach led my daughter to trust them and gradually learn to work with them on her recovery, something she had never achieved in her teenage encounters with CAMHS. What was even more important is that they listened to her needs and in the later months, as she started to improve, they adapted their approach to suit her and best support her. We could not have been more grateful for their understanding, kindness and professionalism. They are a truly skilled, dedicated and committed team. In our view this team should be seen as a best practice template for all other ED services to replicate. I'm just so grateful that my daughter had the good fortune to be sent to Maidenhead ED services. THANK YOU. X.".

Mental health Division

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**	449	448		
Response rate (calculated on number contacts)	**%**	2.7%	2.2%		
iWGC 5-star score	**Number**	4.64	4.58		
iWGC Experience score - FFT	**%**	92.7%	89.1%		
Compliments received directly by services	**Number**	37	26		
Formal Complaints Rec	**Number**	16	12		
Formal Complaints Closed	**Number**	16	13		
Formal Complaints Upheld/Partially Upheld	**%**	37%	23%		
Local resolution concerns/ informal complaints Rec	**Number**	4	2		
MP Enquiries Rec	**Number**	1	2		



There has been an increase in less positive scoring in relation to feeling listened to. Whilst there continued to be many positive comments about being heard and listened to some of

the comments included "*Be confidential and actually listen and help", The staff did not listen to me.", "I was not listened to'' a*nd *"A staff with listening ears would have been great''.* The comments about not feeling heard were spread across a number of services rather than relating to one particular service.

13 complaints were closed during the quarter, 3 of these were either fully or partially upheld and 8 were not upheld, with 2 being resolved locally. Four of the complaints related to communication or care and treatment, and three related to an alleged breach in confidentiality (two of these were from the same patient).

The services receiving the majority of iWGC responses were CRHTT East 156 responses, Psychological Medicine Service East, 56 responses, Memory Clinic Bracknell 47 responses and CMHT Bracknell 29 responses.

Across the CRHTT East survey responses the average 5-star score was 4.34 with 85.3% positive feedback, a decrease from last quarter. 133 of the (overall number of responses received) scored a 4 or 5-star rating with many comments about staff understanding, being helpful, listening and kind; "*They took time to listen & understand my problems & say they will follow up things for me. Gave me a good feeling of being supported.*" 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 feeling it was unhelpful, discharged without being informed, were not through and did not help.

Feedback from compliments for the service included, ‘*'Our hearts were aligned in group today, we really had each other's backs. Aligned and connected together. I certainly feel less alone and I'm glad I came.'*

The Psychological Medicine Service - East received 83.9% positive score (4.42-star rating) and received positive feedback about staff being helpful, listening, supportive and friendly. "*[name removed] and [name removed] who assessed me in A&E were so kind caring and understanding. They took the time to listen and had my best interests at heart. I'm so glad there are people like this working within mental health as they made me feel at ease considering I was going through a difficult time.*"

Memory Clinic Bracknell received 97.9% positive feedback (4.85-star rating), many of the comments were positive about staff being helpful, supportive and Friendly. "*We were both listened to and any questions we wanted to ask was fully explained. No issue was brushed aside. At the end of our consultation we were asked again. Did we have any other problems. The doctor and apprentice were kind considerate & reassured us where and whom to contact if we needed any further help. Excellent consultation throughout the appointment. Thank you."* One patient gave a score of 1 and said, *"Pharmacist tried her best to arrange weekly prescriptions for my aunt's medication but was refused because of 'practice policy'. My Aunt was a nurse for 43 years and now she needs some help with her medication which the Practice won't provide, very disappointing and sad that the care has been taken out of the service she gave her life to. No alternative way to arrange her medication so she'll struggle on and deteriorate quicker."*

Other areas being worked on for improvement include a chance to discuss concerns with the doctor without the patient to avoid worrying them, change the wording of questions to make patient feel more comfortable, reduce time between appointments and offer help between appointments in case their conditions worsen.

CMHT received 60 responses (Bracknell 29, WAM 15 and Slough 16) with 88.3% positive score and 4.60 star with 7 of the total responses scoring less than a rating of 4; comments included "*The MH nurse, who I've been seeing, whenever I look up doesn't look interested in what I am saying and I have to keep repeating myself. She seems to be looking in to space and couldn't look less interested if she tried. Doesn't make me want to engage.", "I don't feel*

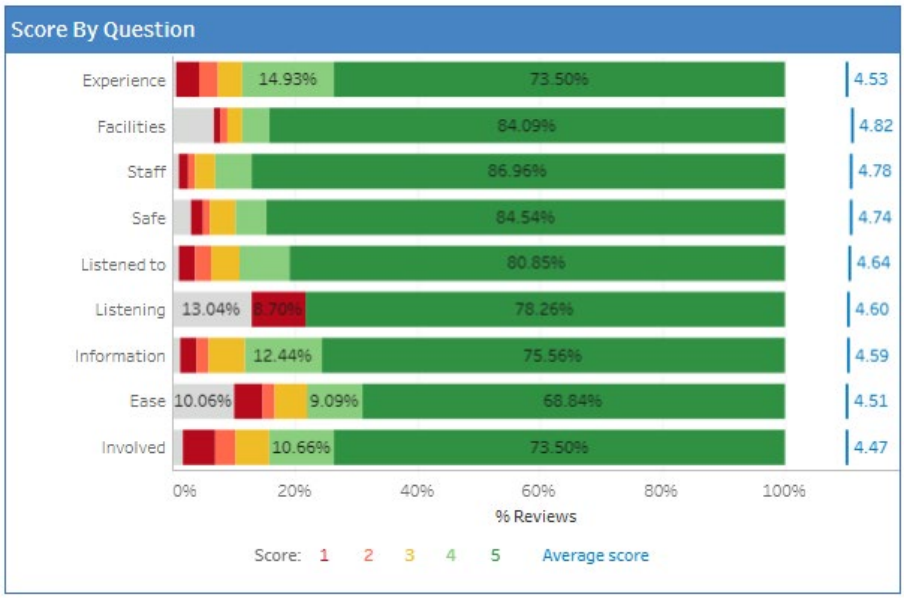
I'm listened to at all. Had an assessment from another service and they were so much more empathetic, caring and listened." There were a number of positive comments about being listened to, staff being understanding, helpful and kind including ''x *has been amazing and helped me alot (sic) and has been there when I needed someone she also taught me a lot''* and '' *All the facilitators were extremely helpful and professional during the 18 week course. I loved that I was part of a group too, so we could share all our experiences together as one''.*

Further work is being carried out with Mental Health services to improve uptake as part of the wider patient experience improvement plan.

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**	1246	1219		
Response rate (calculated on number contacts)	**%**	2.5%	2.3%		
iWGC 5-star score	**Number**	4.61	4.58		
iWGC Experience score - FFT	**%**	89.3%	88.4%		
Compliments received directly by services	**Number**	557	403		
Formal Complaints Rec	**Number**	12	15		
Formal Complaints Closed	**Number**	7	13		
Formal Complaints Upheld/Partially Upheld	**%**	43%	54%		
Local resolution concerns/ informal complaints Rec	**Number**	7	5		
MP Enquiries Rec	**Number**	4	0		



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 3 services with the most feedback through the patient survey were Talking therapies 740 responses, PMS West 83 responses and CRHTT West 81 responses.

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

This division received 15 formal complaints during the quarter with CRHTT receiving 5 and CPE receiving 3. There were 13 formal complaints closed with 7 being found to be upheld or partially upheld and 4 not upheld. Two were resolved locally.

Mental Health West also received 7 informal complaint/locally resolved complaints and 4 MP enquiries.

For CRHTT there were 81 feedback questionnaires completed with an 84% positivity score and 4.30-star rating; with lots of positive comments about staff being helpful, kind and listening, *"Being referred to the crisis team was a scary thing for me, but every member of staff involved in my care has been so incredibly empathetic and caring and has made a difficult time in my life a whole lot easier. I really do want to thank everyone for their help and their kind and caring approach as it really has made a huge difference to me and how I'm feeling.";* a number of the less positive reviews talked about lack of communication, not informed about planned discharge and wanting the staff members who they are being seen by to be consistent.

There were 231 responses received for West CMHT teams with 82.3% positivity score and 4.34-star rating, 190 of these were positive with comments received that staff were kind and listened, there were 40 negative responses with reviews included that patients felt the service with unhelpful and felt staff didn't understand or always listen.

Older adult and memory clinic combined have received 94 patient survey responses during the quarter with a 96.8% positivity rating (4.91-star rating) some of the feedback included *"The staff at the Wokingham Memory Clinic are very friendly and welcoming. The treatment suggested, and the longer-term future for someone with mental health issues, can be frightening but everything was well explained and the ongoing support has been excellent. We were given ample opportunity to discuss the options available and all concerns were addressed."*

The West Psychological medicine service received 83 responses with an 89.2% positive score and 4.57-star rating (9 responses scored less than 4) many of the comments were positive about staff listening, helpful and reassuring.

For Talking Therapies, their patient survey responses gave a positivity score of 87.2% (4.56-star rating), 95 of the reviews scored less than 4. The vast majority of comments were still very positive about the staff, including that they listened, were understanding and kind. A number of the comments/areas for improvement were requesting the support to be listened to, phone calls to not be rushed and questions to not be repetitive. For example, *"I felt that the questions you are asked are repetitive. I was asked from a questionnaire was I at risk of harming myself or others. I replied no to both but was still asked the same questions later."*

Examples of positive feedback about Talking Therapies included, *"The therapist were really good. She gave me tools and techniques that helped me throughout the process and which I can apply after care. She was very knowledgeable, very patient with me even when I have trouble finding my words, she didn't rush me but worked with me and helped me through it."*, "*My therapist seems to know what I am talking about, totally understands my concerns and is able to support me appropriately and in a way I can manage. She is thoughtful and extremely helpful. I can't thank her enough for all the methods she introduces to me in order for me to function. She has a bank of knowledge and is willing to talk me through things I feel. I cannot manage by myself."* and *"This was my first-time doing counselling. [name removed] was welcoming and made me feel understood. Each week I gave myself little challenges to complete based off our conversation. [name removed] helped me feel proud of the steps I did and confident for the future."* Patients reported that they felt *"I felt listened to and responses were given based on what I said rather than from a script.",* "*Was listened too and felt at ease when answering the questions."" and "Felt listened to and that therapist was prepared to work with me to achieve something beneficial to me."*

Op Courage

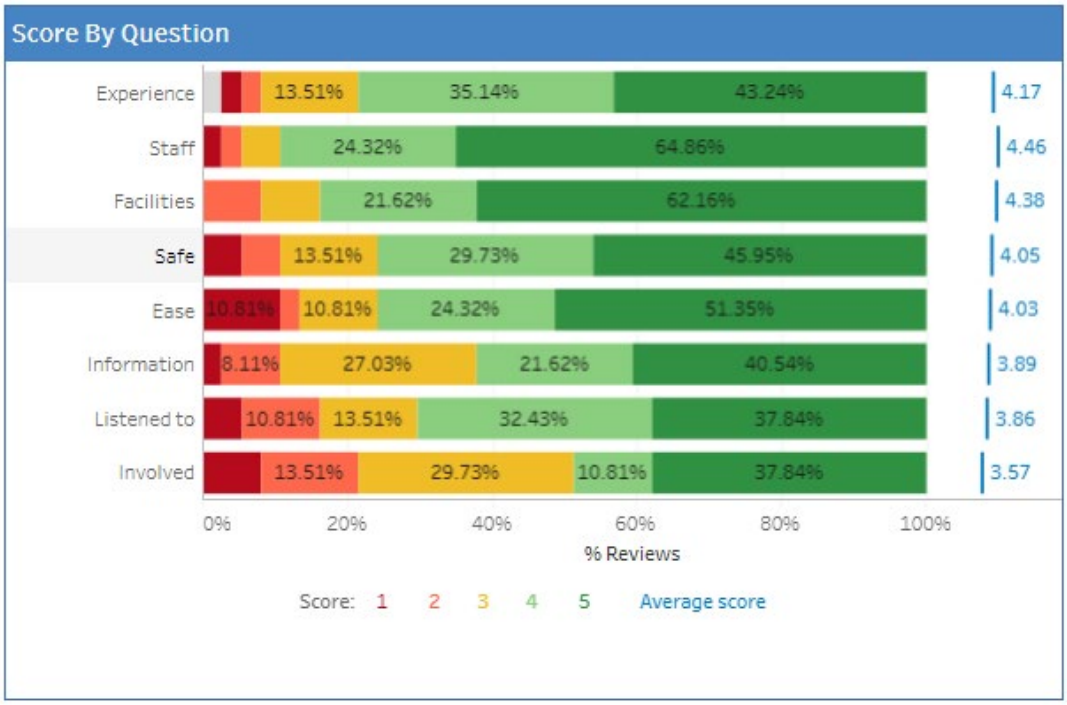
Op COURAGE is an NHS mental health specialist service designed to help serving personnel due to leave the military, reservists, armed forces veterans and their families. During this quarter, the Trust did not receive any complaints about this service.

Further work is being carried out with Mental Health West services to improve uptake as part of the wider patient experience improvement plan.

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**	43	37		
Response rate	**%**	28.3%	28.5%		
iWGC 5-star score	**Number**	4.30	4.05		
iWGC Experience score – FFT	**%**	88.4%	78.4%		
Compliments	**Number**	12	11		
Formal Complaints Rec	**Number**	10	4		
Formal Complaints Closed	**Number**	5	5		
Formal Complaints Upheld/Partially upheld	**%**	80%	60%		
Local resolution concerns/ informal complaints Rec	**Number**	0	0		
MP Enquiries Rec	**Number**	0	0		



The satisfaction rate at 88.4% is skewed by 8 of the 37 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to feeling involved received the least positive scores with overall 5-star rating being 3.57; with 19 of the 37 giving a score of 3 or less to this question.

There were 4 formal complaints received for mental health inpatient wards during the quarter, Two for Place of Safety, one for Daisy Ward and one for Rose Ward, and were mainly regarding care and treatment. There were no complaints for Sorrel Ward this quarter. There were 5 complaints closed for this division during the quarter and of these three were partially or fully upheld and two were not upheld. There has been a reduction of over 50% in the number of formal complaints received compared to last quarter, and the % of those found to be upheld and partially upheld have also reduced.

There were many positive comments received in the feedback including comments such as staff were respectful, lovely, listened and helpful. 13 of the 37 responses to the survey were from Sorrel Ward. There were some comments for improvement about having other types of therapy and seeing a psychiatrist, staff didn't listen to them and more options for food. Examples of the feedback left are "*Being in a mental health ward and Hospital is very new to me and I can honestly say the staff on Daisy ward have all been great and have treated me with respect.*" "*Very happy with the care I have in the Daisy Ward. All the staff are helpful and friendly. The whole ward is clean. All in all super star!", "Staff are lovely, Drs let you be involved in your care and listen to you when needed."* There were no responses for a Place of Safety.

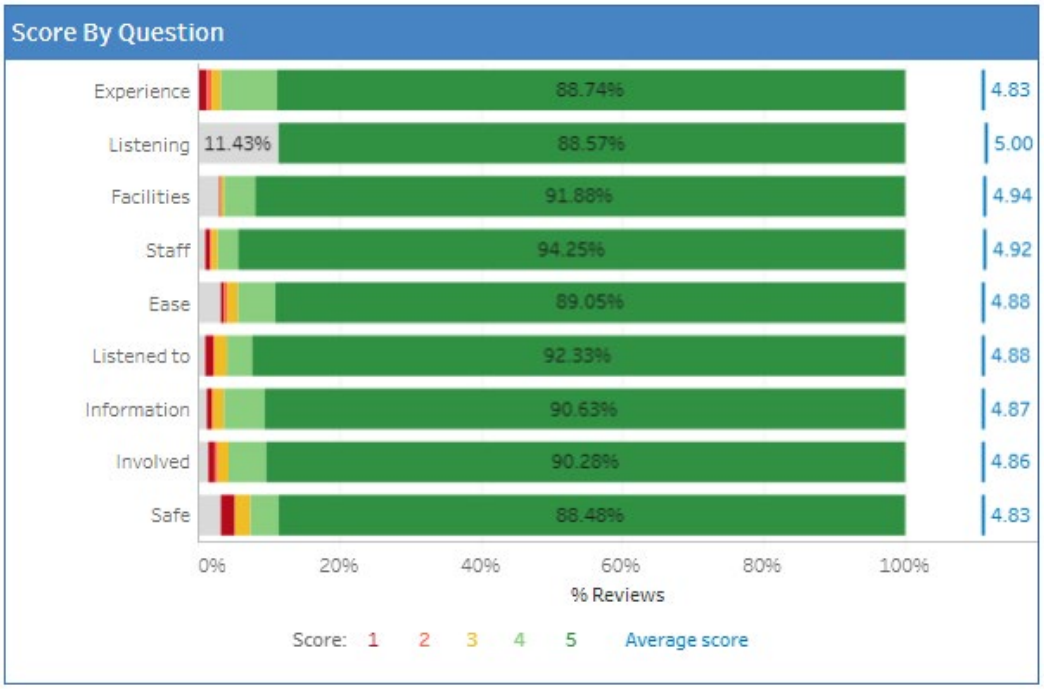
There is ongoing work at Prospect Park to increase feedback including work within the Therapy department.

Community Health Services Division

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	2044	2016		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.5%	7.1%		
iWGC 5-star score	Number	4.86	4.88		
iWGC Experience score - FFT	%	97%	96.7%		
Compliments received directly into the service	Number	217	401		
Formal Complaints Rec	Number	2	6		
Formal Complaints Closed	Number	2	5		
Formal Complaints Upheld/Partially Upheld	%	50%	40%		
Local resolution concerns/ informal complaints Rec	Number	1	8		
MP Enquiries Rec	Number	1	1		



Of the six complaints received this quarter, two were for Henry Tudor Ward (these were about care and treatment and lost property) and two for Sexual Health. One for Hearing and Balance and one for MSK Physio. Care and Treatment, and Communication were the main themes.

There were five complaints closed, two partially upheld and three not upheld.

Hearing and balance received 147 responses to the patient experience survey with a 96.6% positive score and 4.90-star rating.

East Community Nursing/Community Matrons received 275 patient survey responses during the quarter with a 98.6% positive scoring, many comments were about staff being friendly and kind, for example "*I received great care and attention from the District Nurse, explaining all of my nursing needs, and the plan going forward, always friendly and professional.", "I see the District Nurses every day they are always very kind and compassionate and listen to any concerns that I have an act on them.",* "*I see the District Nurses every day they are always very kind and compassionate and listen to any concerns, and reassure me."* and *"I have been shown great kindness, I feel listened to and I have been given time to express my concerns. The Matron has provided support and linked me to other services that have helped me to remain at home."* There were also some comments around not being notified of a scheduled visit for example *"Would like to know when nurse is visiting."*

The wards received 118 feedback responses (56 responses for Jubilee ward 91.1% positive score and 62 Henry Tudor ward 93.6% positive score). Most of the comments for improvement were staff communication including communication between staff members and understanding of discharge planning. There were a number of comments about how good the food was.

As with MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 96.5 % (4.91-stars), comments were very complimentary about staff being professional and helpful, *"I was assessed by [name removed], who was extremely helpful and explained the problem, very easily. [name removed] was professional but also friendly. We worked out a plan together which will be easy to follow. I understood I have 6 weeks to visit again or I can ring if needed.".* The reoccurring improvement suggestion for this quarter was for a sooner appointment.

Outpatient services within the locality received a positivity score of 97.8% with 4.92 stars from the 635 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"I am over the moon with the way I have been treated by this lovely team. Everyone that visited me was fantastic. THANK YOU."*

The diabetes service received 56 feedback responses with 96.4% positivity and some lovely comments including "The Consultant was thorough, she checked through each of my results and explained what they meant for me, what progress I had made and what needed further improvement - none of which felt degrading or made me feel bad, but rather from a place of care and optimism that I could get better. She allowed me time to digest the info and ask questions/take notes. Great experience." Alongside some helpful suggestions for the service to consider such as "As one person suggested, maybe partners could attend the meetings, as this could help with the support needed, especially where diet is concerned."

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "The care team could not have been better. I was treated with care and attention during the whole of the procedure. The detail examination of my balance problem extremely the rough. Many thanks- well done team."

Community Health services currently have a project group to improve feedback responses.

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	2056	2239		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.5%	2.8%		
iWGC 5-star score	Number	4.81	4.82		
iWGC Experience score - FFT	%	95.1%	96.3%		
Compliments (received directly into service)	Number	196	298		
Formal Complaints Rec	Number	12	10		
Formal Complaints Closed	Number	7	14		
Formal Complaints Upheld/Partially Upheld	%	86%	86%		
Local resolution concerns/ informal complaints Rec	Number	18	25		
MP Enquiries Rec	Number	3	2		

Community Health West saw an 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 96.3% positive satisfaction and 4.82-star rating and the question on staff receiving a 97.1% positive scoring from the 2239 responses received.

There were 10 formal complaints received during the quarter, these were split across several different services. Of these District Nursing received six complaints and Out of Hours GP service received 2

There were 14 complaints closed for the division during the quarter with 2 being upheld, 10 partially upheld, and 2 not upheld.

During this quarter the community hospital wards have received 134 responses through the patient survey receiving an 85.8% positive score and 4.47-star rating, (19 responses scored 3 and below) questions around information and feeling listened to receive the most results of

3 and below; comments include staff were friendly and kind, "*The staff were all very friendly and caring, and everyone was very helpful. It was also very nice to be able to go into the new garden, which is lovely, to enjoy fresh air*.", "*Every member of staff has been very kind and helpful could not have wished for better always cheerful I have enjoyed my stay and would recommend it to anyone. Thank you so much.*", "*Because the staff were all very friendly and caring. The food was good and it was lovely to be able to go outside occasionally*." And "*Overall everyone was really friendly, helpful and kind and made my stay as pleasant as possible.*", there were some individual comments where patients were less satisfied, with comments including better communication, better food, more staff at night and to answer the call bell quicker.

WestCall received 18 responses through the iWGC questionnaire this quarter (93.3% positive score, 4.64-star rating, 3 score received below 4. Positive comments included *("Dr [name removed] was very kind and listened my problem carefully, spent time giving advice and information. I feel valued and able to share problem I had and what should I do to get it improved. Dr [name removed] is an excellent doctor." "Lovely reception with kind staff. Given instructions, slowly and clearly. Only waited half an hour and the Dr. I saw was wonderful. (Female) afraid I didn't get her name. But she was so kind, understanding, listened to me and was very thorough, gave me a diagnosis and clear instructions, going forward. Just was to say thank you for being so fantastic!"* WestCall received around 17278 contacts during the quarter.

Podiatry services received 223 patient survey responses. Most responses were very positive receiving 5 stars (overall 96% positivity 4.86-star rating) with examples including "The podiatrist and nurse were really calm, kind, and friendly. They completely put me at ease and explained everything in an easy-to-understand way." and "The podiatrist was very experienced. She also explained everything and very reassuring. She was very patient and sympathetic concerning with my disability."

There were six complaints for Community Nursing, all relating to care and treatment. They have received some of the highest numbers of feedback (606 across the 3 localities in the quarter, with a 99.2% overall satisfaction score and 4.87-star rating).

To provide some context across our East and West District Nursing teams combined there were 56,263 contacts this quarter. Lots of comments included nurses were kind, helpful and friendly, "*District nurse [name removed] very kind and helpful, every concern we had was listened to and addressed, couldn't have asked for a better service.", "Staff are kind caring and approachable, I feel comfortable sharing thought or questions about things I am unsure with and am always greeted with a friendly and supportive response." and "[name removed], my nurse, was absolutely great!!!! She was so kind patient and caring. My weekly visit has now ceased as I am no longer housebound., and I will now receive my treatment at my GPS. Future patients will be extremely lucky to have [name removed] as their Nurse!!THANKYOU [name removed] - I shall miss you."* There were several positive comments about nurses being caring and there were very few suggestions for improvement, more frequent visits, and call patients' family to be present for visits.

MSK Physio has received one complaint in the quarter relating to the clinical care the patient received. The service has received 306 patient survey responses with a 97.7% positive score (4.92 star rating), very few areas for improvement were included in the feedback there were a few suggestions including sign posting to location, confirm next appointment at current appointment and instructions of what to do when they arrive for appointment and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, listened and helpful.

The services across the division received many compliments including "*I felt listened to and understood. Also I was given lots of information which helped my understanding of Long Covid. A huge Thankyou to the Doctor and Physio who were there at my appointment.*"

Community Health services currently have a project group to improve feedback responses.

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	3.64	8.7	9.67%
Black/Black British	0	3.2	2.67%
Mixed	3.64	2.1	3.49%
Not stated	7.27	12.9	15.89%
Other Ethnic Group	1.82	6.8	1.62%
White	83.65	66.3	66.66%

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	39.1	39.5	53%
Male	61.9	27.5	46.98%
Non-binary/ other	0	4.2	0%
Not stated	0	28.7	0%

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. There has been a marked increase in the number of patients who have not completed their age on the survey (this is not a mandatory field).

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
0 to 4	0%	3.7	18.41
5 to 9	0%		4.14
10 to 14	9.09%		4.34
15 to 19	5.45%		4.52
20 to 24	5.45%	4.3	2.87
25 to 29	7.27%		3.14
30 to 34	1.82%	6.1	3.56
35 to 39	3.64%		
40 to 44	3.64%	7.3	3.58

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
45 to 49	10.91%		3.52
50 to 54	9.09%	11.113.18	3.73
55 to 59	3.64%		4.32
60 to 64	9.09%	12.9	4.46
65 to 69	3.64%		4.63
70 to 74	1.82%	15.0	4.53
75 to 79	1.82%		5.56
80 to 84	5.45%	13.6	6.16
85 +	3.64%		6.55
Not known	7.27%	26.0	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. The Complaints Office encourages all those who may be asked to investigate a complaint, to attend the training to ensure a clear they have a clear understanding of the process.

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
Health Visiting	Service users would like the 'drop in' well baby clinics re-instated.	This has been done across all localities in West Berkshire from June. Service users also wanted the drop ins for the well-baby clinics to be opened up by making a wider number of parents/carers aware and able to access the drop in. The service is currently working on this.
CYPIT East - The SALT	To extend the number of sessions available for support. Less time waiting for assessment. Parents being involved and knowing how the service works.	SALT have new triage process, aiming to reduce time waiting for assessment and/or intervention where appropriate. SALT have introduced universal online workshops, where anyone can sign up to learn strategies and how our SALT service works.
Berkshire Eating Disorder Service (BED) - Adult	Encouraging and promoting cultural sensitivity to make the space safe for all.	Identified the need to understand what the problem is. Looking into feasibility of conducting an audit of demographics in the general population vs the client group.

Service	You said	We did
	Communication – more transparency around the treatment pathway and expected waiting time at each stage.	See where the discrepancies are e.g., at referral, at point of treatment or later? The team have put together a 'first steps' group to ensure the service quality and content is consistent to all.
	Use different gripper needles as the ones they used hurt more than normal.	We have changed the type of vascular access needles (Grippers) used so that the experience is more comfortable.
Heart Function Team	Patients have complained signage for WAM Clinic is too small.	Discussion with Estates for bigger signage – not completed as yet but working on, and map has been reviewed and re-drawn with better instructions.
	Not enough seating for relatives in the clinic.	More chairs have been ordered – awaiting delivery.
	Patients with poor mobility identified the need for a wheelchair in WAM clinic.	This has been ordered and awaiting delivery.
Nutrition and Dietetics	Patient feedback from Cow Milk Protein Allergy Group – Parents of infants diagnosed with cow's milk protein allergy stated it would have been useful to receive video/information prior to workshops.	We are now sending pre-recorded webinars prior to workshops.
MSK physio	Long waits for appointments and the length of appointments	Use of locums, ongoing recruitment to increase capacity. Review of length of appointments to increase capacity. Saturday clinics. New processes to allow direct referrals into physio from IPASS/CSS and vice versa. Reducing need for person to revisit their GP.
	Length of Journey into physio.	New self – referral process is now live.
	Comments regarding privacy due to curtained cubicles.	Access to clinic rooms for increased privacy for patients.
	Not receiving exercises.	Change in exercise prescription service more user friendly for staff and increased selection of exercises.
	Tired looking facilities.	Review of departments and work needing to be done – in progress. Review of department equipment – in progress.
	Difficult to get through on phone to book and cancel appointments.	New telephone rota for admin staff covering hours of working day. Review of admin staffing and extra recruitment.
Mental Health Inpatients	Feedback from patients who are neurodiverse that there	Posters have been reviewed and removed / relocated unless essential and up to date information for patients

Service	You said	We did
	are too many posters on the walls	
	Could there be more activities on the wards	Together for mental wellbeing charity who run the west crisis café (breathing space) have secured some winter funding money for some in-reach work. Increased sessions with one late afternoon each week in the therapy centre focusing on topics such as mindfulness and art therapy (this is in addition to activity coordinator work on the wards)
	More support preparing for discharge	drop-in sessions are being planned two evenings a week on the acute wards looking at reintegrating people back into the community linking them up with local resources etc

15 Steps

Appendix 3 contains the 15 Steps visits that took place during Quarter 2.

There were 2 visits this quarter; both of these were at Prospect Park Hospital in Reading and took place on Rose Ward and Orchid Ward.

An end-to-end review of the 15 Steps programme has been started, which will feed improvements into how these are planned, reported, and how any improvements implemented. This is feeding to NHSE/I and their national review of the 15 Steps programme. Insight from our services, Governors and Non-Executive Directors is integral to this piece of work.

Summary

All feedback we received is seen as helpful for improvement and understanding of how people using our services experience them and therefore it is very positive to see further small increases in the volume of patient feedback we are receiving through our feedback tool, all managers and divisional leaders have access to the live tableau dashboard to view this. It is also positive to see an increasing number of services proactively using the feedback to make changes and displaying this for patients and their loved ones to see. The Patient Experience Team have developed an action plan to proactively identify and support services with low or no responses to the iWGC feedback programme.

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.

Appendix 1: complaint, compliment and PALS activity

All formal complaints received

	2022/23						2023/24						
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Compared to previous quarter**	**Q2**	**Q2 no. of contacts**	**% contacts Q2**	**Total for year**	**% of Total**
CMHT/Care Pathways	11	10	18	14	53	**22.00 %**	16	↓	6	8393	0.71	22	**16.00 %**
CAMHS - Child and Adolescent Mental Health Services	4	6	13	10	33	**14.00 %**	8	↑	11	5001	0.21	19	**14.50 %**
Crisis Resolution & Home Treatment Team (CRHTT)	3	9	6	4	22	**9.00 %**	5	↑	10	13979	0.07	15	**11.50 %**
Acute Inpatient Admissions – Prospect Park Hospital	13	7	9	6	35	**15.00 %**	10	↓	2	212	0.94	12	**9.00 %**
Community Nursing	3	0	4	5	12	**5.00 %**	3	↑	6	56821	0.01	9	**7.00 %**
Community Hospital Inpatient	4	3	2	1	10	**4.00 %**	1	↑	2	479	0.41	3	**2.50 %**
Common Point of Entry	0	1	3	1	5	**2.00 %**	1	↑	3	1507	0.19	4	**3.00 %**
Out of Hours GP Services	1	0	1	2	4	**1.50 %**	1	↑	2	17278	0.01	3	**2.50 %**
PICU - Psychiatric Intensive Care Unit	1	2	0	4	7	**3.00 %**	0	-	0	3	0	0	**0.00 %**
Urgent Treatment Centre	1	0	0	0	1	**0.50 %**	1	-	1	4197	0.02	2	**1.50 %**
Older Adults Community Mental Health Team	1	1	0	0	2	**1.00 %**	1	↑	2	4421	0.04	3	**2.50 %**
Other services during quarter	19	11	15	11	56	**23.00 %**	21	↓	19	112992	0.01	40	**30.00 %**
Grand Total	61	50	71	58	240	100.00%	68		64	216579	0.02	132	100.00%

Locally resolved concerns received

Division	July	Aug	Sept	Qtr 2
CYPF	6	7	1	14
Community Mental Health East	1			1
Physical Health	10	11	5	26
Total	**17**	**18**	**6**	**41**

Informal complaints received

Division	July	Aug	Sept	Qtr 2
Community Mental Health East	2			2
Community Mental Health West	1	1	3	5
Corporate	1			1
Physical Health			1	1
Total	**4**	**1**	**4**	**9**

KO41a Return

NHS Digital are no longer collecting and publishing information for the KO41a return on a quarterly basis but are now doing so on a yearly basis. We submitted our information when requested in July 2023, but NHS Digital are not planning on publishing the results until 26 October 2023, so we will report on this in Q3.

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

	2022/23				2023/24				
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Higher or lower than previous quarter**	**Q2**	**Total for year**	**% of 22/23**
Locally resolved					**0**	↑	**4**		
Not Upheld	23	22	23	38	20	↑	25	20	38.00%

	2022/23				2023/24				
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Higher or lower than previous quarter**	**Q2**	**Total for year**	**% of 22/23**
Partially Upheld	21	30	26	25	22	↑	26	22	42.00%
Upheld	12	9	7	8	11	↓	9	11	20.00%
Grand Total	**57**	**61**	**57**	**72**	**53**		**64**	**53**	**100.00%**

55% of complaints closed last quarter were either partly or fully upheld in the quarter, compared to 62% in Quarter 1, these were spread across several differing services.

Complaints upheld and partially upheld

	Main theme for complaint						
Service	Access to services	Attitude of Staff	Care and Treatment	Communication	Discharge Arrangements	Waiting Times for Treatment	Grand Total
Adult Acute Admissions - Bluebell Ward		1					1
Adult Acute Admissions - Daisy Ward					1		1
Adult Acute Admissions - Snowdrop Ward			1				1
CAMHS - Anxiety and Depression Pathway			1				1
CAMHS Rapid Response			1				1
CAMHS - Specialist Community Teams			1				1
Children's Speech and Language Therapy - CYPIT			2				2
CMHT/Care Pathways			1	2		1	4
Common Point of Entry		1					1
Community Geriatrician Service		1					1
Community Paediatrics						1	1
Crisis Resolution and Home Treatment Team (CRHTT)		2	1				3
District Nursing			4				4
Intermediate Care			1				1
Neurodevelopmental Services		2					2
Out of Hours GP Services	1		1				2
Phlebotomy		1					1
Physiotherapy Musculoskeletal			1				1
Psychological Medicine Service		1					1
Sexual Health				2			2
Talking Therapies - PWP Team			1				1
Urgent Treatment Centre			2				2
Grand Total	1	9	18	4	1	2	35

Care and Treatment complaint outcomes

Care and Treatment complaint outcomes	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions - Snowdrop Ward	1		1
CAMHS - Anxiety and Depression Pathway	1		1
CAMHS - Rapid Response	1		1
CAMHS - Specialist Community Teams	1		1
Children's Speech and Language Therapy - CYPIT	1	1	2
CMHT/Care Pathways	1		1
Crisis Resolution and Home Treatment Team (CRHTT)		1	1
District Nursing	3	1	4
Intermediate Care	1		1
Out of Hours GP Services	1		1
Physiotherapy Musculoskeletal	1		1
Talking Therapies - PWP Team		1	1
Urgent Treatment Centre	2		2
Grand Total	**14**	**4**	**18**

31 complaints related to care and treatment. Of these 11 were not upheld, 14 were partially upheld and 4 were fully upheld.

PHSO

The table below shows the PHSO activity since April 2023:

Month opened	Service	Month closed	Current stage
April 2023	CMHT/Care Pathways	September 2023	LGO not progressing, but now with PHSO to consider
July 2023	CMHT/Care Pathways	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
July 2023	CAMHS – Specialist Community Team	September 2023	PHSO have reviewed file and are not progressing
September 2023	CRHTT	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
September 2023	CAMHS	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate

CQC

It has been announced that from July 2023, at the point of triage, the Mental Health Act (MHA) complaints team within the CQC will consider whether any of the concerns raised could be dealt with as an early resolution by Trusts.

The Early Resolution process is designed to provide people who are detained under the MHA with a swift, person-centred response to their complaints wherever possible. It is an additional step where they will ask Trusts to respond to them within 24 hours with either the resolution or a plan of when and how the issue is to be resolved. It does not replace the MHA complaints process, and instead offers an opportunity for Trusts to quickly address concerns that can have an immediate impact.

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.

With the closure of the PALS office at Prospect Park Hospital, a programme of outreach will be developed, whereby the PALS manager will be visiting sites across Berkshire on a regular basis. Arrangements have been made to attend community meetings on wards at Prospect Park Hospital.

The service currently reports on a quarterly basis and provides a SITREP weekly, highlighting open queries and themes. PALS also reports to the Mortality Review Group monthly.

There were 315 queries recorded during Quarter two. A decrease of 68 since Quarter 1. 311 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.

The Patient Experience Team has undertaken work to standardize and streamline the PALS process, in order to make it more user friendly for the wider team and enable the service to be covered consistently during the absence of the PALS Manager. We are also refining the number of queries which need to be recorded on Datix, replacing this with a method which enables us to record more quickly and efficiently.

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. Our volunteer has also represented us at Reading Pride and has taken part in a PLACE visit.

In addition, there were 332 non-BHFT queries recorded. Another member of the Patient Experience Team is consistently helping with the recording process to improve the rate of data collection.

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

Service	Number of contacts.
CMHT/ Care Pathways.	29
CAMHS ADHD	18
CAMHS AAT	16
Phlebotomy	16

Service	Number of contacts.
Other	15
CMHTOA/COAMHS	13
Physiotherapy MSK	9

Formal Complaints closed during Quarter Two 2023.24

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
9005	Reading	Adult Acute Admissions - Daisy Ward	Moderate	Unhappy at lack of discharge in February as family feel pt was well but non compliant with medication. Discharge agreed w/c 8th May but did not happen as paperwork had not been sorted	Partially Upheld	Point 2: Poor communication of care (care perspective) •The re-establishment of the Carer clinic that managers should hold weekly with carers and friends of the patients on their ward. •This is a platform were the Carers can get an accurate picture of the progress and challenges their loved are facing and the planned interventions that are being offered. •This will be an effective way of identifying potential problematic areas before they escalate into a complaint. This will be proactive thinking and action that will be a collaborative between carers in the involvement of their loved ones care. •Named Nurse have 1:1 carers and relatives of their named patients and recording the feedback and recommendation in the MDT form in the carer input box •It is vital that the role of named nurse and who is care for me program are effectively completed on Daisy ward . •These key services that will provide for patients on the ward will help address day to day issues of care that can arise, and immediate solutions can be addressed . The effectiveness of the rolls mentioned above will be achieved using such tools as following 1.Allocation in the safety huddles who is having 1:1 and what concerns are to be addressed in the 1:1 are going to be addressed 2.The named nurse doing their 1:1 time and safety plans with their patient and feeding back the information gather in the MDT form for the weekly care review meeting. 3.Name nurse have their case load reviewed and progress of their patients in the month supervision with their line manager. •In accordance to Lester Tool it is vital to monitor regular the physical Health due to the fact that mental health clients are not well skilled in looking after their physical health. •The poor visitor health management that mental health to their bodies has a significant impact on the quality of life and their life that we physical health monitoring and management protocols on Daisy ward •Physical- pharmaceutical Education and share information with the complainant of the pharmaceutical programs that Aleksander was on. The complainant would wanted to have time with pharmacist to have better understating on the effects and impact the medication was having on pt.	Discharge Arrangements
9092	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Re-opened complaint; Patient has submitted further evidence that Trust have communicated with SaBP outside of the written agreement he had. He has been copied into an email that makes reference to a call with SaBP. ORIGINAL COMPLAINT: Pt alleging that BHFT and contacted SaBP outside of the consent he agreed to. Also incomplete medical records as pt feeling BHFT have not copied them into all correspondence with SBPFT.	Not Upheld		Confidentiality
9092	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Re-opened complaint; Patient has submitted further evidence that Trust have communicated with SaBP outside of the written agreement he had. He has been copied into an email that makes reference to a call with SaBP. ORIGINAL COMPLAINT: Pt alleging that BHFT and contacted SaBP outside of the consent he agreed to. Also incomplete medical records as pt feeling BHFT have not copied them into all correspondence with SBPFT.	Not Upheld		Confidentiality
9044	Reading	Physiotherapy Musculoskeletal	Low	Patient believes physio caused more damage than good resulting in a new foot injury	Partially Upheld	Detailed reflection on rehabilitation process for this patient with clinician Support clinician with clinical supervision from APPs / Team Lead to maximise learning and development Discussion with clinician and wider team in regards to ensuring patients feel listened to and how this is communicated Discharge / SOS criteria and process to be discussed with the wider team Confirm with clinician and wider team that documentation of exercise programmes are completed for patient and uploaded to RiO	Care and Treatment

9058	Reading	Psychological Medicine Service	Low	Pt feels Dr did not respect their needs and created trauma making them feel unsafe in the hospital. Dr asked chaperone to leave.	Upheld	Notification of Autism Diagnosis Availability of Female Psychiatrist Apology offered patient and learning for Dr identified	Attitude of Staff
9055	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Why was GP referral rejected, why does the current 'incorrect' diagnosis of paranoia stand and why can they not be reassessed	Not Upheld		Access to Services
9051	Reading	District Nursing	Minor	Upheld	Upheld	To request flow charts for staff in triage to show correct handling of referral & telephone numbers. All staff to be aware that if a patient is discharged from caseload, they need to inform patient/ family/ ward and document this conversation on RIO All outstanding continence assessments on CN Wokingham new referrals to be reviewed and processed. To review process to see if new continence assessments need to be in team planners not on team caseload until continence Nurse is in post. Closer working with inpatient unit so patients can be assessed as inpatient if indicated. Patient to be contacted if discharged from caseload to inform. Non patients facing activity to be recorded on RIO. To ensure other services know contact numbers for Community Nursing. District Nursing Vs Community Nursing	Care and Treatment
9046	West Berks	CMHT/Care Pathways	Low	Pt left Bracknell and moved to Newbury feels they have had no support since moving	Local Resolution		Care and Treatment
9064	Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Pt unhappy they were no communicated to about the allocation panel, feels the process is unfair and that they should be able partake	Local Resolution		Communication
9074	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)		Unhappy with a letter received from 2 x Psychologists and its recommendations	Local Resolution		Communication
9042	West Berks	Community Geriatrician Service	Low	Unhappy with the attitude of the consultant	Partially Upheld	Manager has discussed with staff member, who has reflected on areas where can improve communication style	Attitude of Staff
9024	Slough	Community Paediatrics	Minor	Premature child unable to stand at 2 1/2 years old. Physio appt cancelled on day of the appt, had to wait 6 weeks for another appt, which was also cancelled on the day of the appt. next one made for 21 June. Family extremely unhappy at the delays	Upheld	Appointments were cancelled for various reasons so the 18 week RTT target was missed. Patient has been seen and apologies offered. CYPIT Early Years Lead to look in to potential for cancellations to be reallocated to alternative therapist on same date/time where possible CYPIT Early Years Lead to alert CYPIT ADMIN to prioritising rebooking of cancelled appts	Waiting Times for Treatment
8986	Reading	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	Pt's presentation has changed dramatically and family believe this is due to the medication Olanzapine	Not Upheld		Medication
9015	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt called crisis at 8.20, and was asked to wait until their service opened at 9am. Follow up call pt asked why the teams do not talk to each other? why did crisis not know that MHICS do not call patients?	Upheld	MHICS Managers to discuss communication and responses to request by other teams and especially Crisis Team so that these are actioned times and respond back to emails in a timely manner. MHICS to act on CRHTT Handover sheets timely.	Care and Treatment
9082	Wokingham	CAMHS - Common Point of Entry (Children)		Discharged from waiting list due to lack of paperwork, has been on lists for 4 years (so they thought) upset they have to start again due to possible admin error	Not Upheld	Local resolution	Waiting Times for Treatment
9027	Slough	CMHT/Care Pathways	Minor	-GP referred to Gateway, reviewed - no contact with pt and medication error -referral from CRHTT - TT, 5 month wait, disharged as not appropriate. -'Safe Haven' help stopped out of the blue. -Differing views between Crisis and CMHT, generally poor communication between services. -Why was the pt left with no support and what is offered to pts discharged from CMHT with complex histories?	Partially Upheld	CPE to review medication error and processes surrounding this (including completing Datix)	Care and Treatment

9034	Bracknell	Children's Speech and Language Therapy - CYPIT	Moderate	Referred to SALT 3 years ago, only seen a handful of times. EHCP approved a year ago. staff not sticking to agreed plan of visits. Child starts school in Sept.	Upheld	Transfer to the CYPIT School Age Speech and Language Therapy Team. Share contact details of the School Age team with mum with information about timescales for responding to queries as part of the formal response to the complaint. Contact St Michael's Sandhurst school by the 22nd September to find out how XXX has settled in and book an review session before the end of October. Contact mum to inform her when the school visit will take place. Complete a review session with patient in school with a therapist. The therapist who reviewed XXX progress will contact mum within 5 working days of the visit to feedback and agree what will happen next. Agree with mum and school what the next steps will at the point of review each half term so it's clear what is happening next and when it will be.	Care and Treatment
9008	Reading	CMHT/Care Pathways	Minor	Waiting time for pathways, pt wishes support and a treatment plan	Partially Upheld	No actions identified	Waiting Times for Treatment
9079	Reading	Crisis Resolution and Home Treatment Team (CRHTT)		DECEASED PT: Care and treatment, discharge of patient as no family member have been living in the area for 5 years. Family feel the pt was failed	Not Upheld	Being handled by the SI process	Care and Treatment
9018	Reading	Neurodevelopmental Services	Low	Reception staff asking diagnosis questions and accessing pt records, then telling pt to call back for help. Pt believes receptionist was temporary	Partially Upheld	Ensure induction includes training for all non clinical staff (including temporary) on client interactions.	Attitude of Staff
8957	Wokingham	District Nursing	Minor	catheter and sores care. family feels lack of DN training resulted in the pt's hospital admission unnecessarily	Partially Upheld	Apology directly to patient regarding planned meeting. Apology already given to relatives Cambridge online training to be completed. B6 will visit when patient home to discuss trust and communication. Catheter passport to be given and staff reminded to use as soon as catheter inserted. TWOC to be planned. Policy led advice given to carers regarding catheter care Discussion to see how communication can be improved between services. Skin inspections: B6 to visit and provide up to date information to carers and family & reiterate how to escalate concerns. Regular planned skin inspection to continue	Care and Treatment
9025	Reading	Adult Acute Admissions - Snowdrop Ward	Minor	Pt felt they were not listened to and discharged too quickly. Felt uncomfortable with the whole experience, issues with the food	Partially Upheld	Review training/approach for staff in dietary preferences and management for patients Report to PPH catering feedback about food provided on the ward	Care and Treatment
8934	Bracknell	CMHT/Care Pathways	Low	11 points raised regarding the Referral form 16 points raised regarding a letter dated 20/12/2022 from the pathway team	Partially Upheld	we will ask that staff do not submit any referrals for external therapy services without the patient seeing these referrals first and agreeing to their content We will also remind staff of the importance of sharing details of suspected or confirmed neurodivergence with other services when we are making referrals We will revisit our risk training with staff and remind them that accurate, up to date information in risk and referral forms is imperative.	Communication
8949	Bracknell	CMHT/Care Pathways	Low	Pt wishes to understand how the psychiatrist was able to arrive at a ASPD diagnosis on just one meeting.	Not Upheld		Care and Treatment
9014	Bracknell	CMHT/Care Pathways	Low	5 points raised regarding clinician disclosing info to police and some allegedly false	Partially Upheld	Trust policy for sharing info was not followed. Apology offered.	Communication
8958	Reading	Adult Acute Admissions - Bluebell Ward		complainant feels staff failed to keep the pt safe on the ward, failed monitoring blood glucose levels and refused permission to see family after being attacked from another pt in their room. Pt given more medication and discharged without support	Not Upheld	No consent received	Care and Treatment
9060	West Berks	Urgent Treatment Centre		pt with broken toe, unhappy this was not spotted at the initial presentation. Following second xray, not happy with virtual fracture clinic	Partially Upheld	Service to investigate the feasibility of running a report on Adastra to compare patients sent to x-ray against entries for x-ray administration to ensure that no results are missed. MIU to keep paper x-ray reports until the above system is in place.	Care and Treatment
8950	Wokingham	CMHT/Care Pathways	Low	Further clarification required plus a LRM ORIGINAL COMPLAINT BELOW Medication ordering / delivery issues. No longer receives regular MH visits	Not Upheld	Access to alternative services in the community to seek support for their needs.	Medication

8519	Wokingham	District Nursing	Low	DECEASED PT: Care by DN's at the care home Suffolk Lodge regarding monitoring nephrostomy bag. Complainant wishes to know if DN's are able to change these	Partially Upheld	Triage to ensure that patients are discharged with a supply of dressings and devices To create a revision education session in relation to nephrostomy tubes and their function and management	Care and Treatment
8916	Reading	Adult Acute Admissions - Bluebell Ward	Minor	Unhappy with move from Bluebell to Daisy ward. Staff member derogatory to pt	Partially Upheld	Comunication Work around handover and inc the patient as appropriate Understanding care plans, where they are etc?	Attitude of Staff
8969	Reading	CAMHS - ADHD	Low	Mum unhappy with response and says it is full of lies. She wants clinician to be changed. ORIGINAL COMPLAINT Medication review required, appt booked but cancelled by service. New prescription needs to be forwarded to GP. Also advised art therapy would be 14 months, they have been waiting between 17/18 months, when will this happen	Not Upheld	Ensure all future appts are booked as face to face appts and there are 2 members of staff present	Medication
9113	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Complainant states MH patients are being prevented from choosing their own advocates and care is being withheld from them due to an advocate being present. Bad attitude from call handler as no regard to patient who has autism	Upheld		Attitude of Staff
9111	Wokingham	District Nursing	Minor	RE-OPENED - Would like clarity on communication between DN's and Suffolk house ORIGINAL (8519) DECEASED PT: Care by DN's at the care home Suffolk Lodge regarding monitoring nephrostomy bag. Complainant wishes to know if DN's are able to change these	Not Upheld		Care and Treatment
9057	Reading	Intermediate Care	Minor	Care and treatment from Intermediate care, concerns relate to the processes in place	Partially Upheld	To improve communication with Triage discussions to ensure appropriate support for medication prompting – to include communication when there is any doubt and query regarding appropriate support required. To ensure we listen to family members concerns and escalate to Team Lead for support regarding management of patient particularly regarding their concerns with care packages and appropriate review and timely response To ensure staff respect communication regarding complaints and maintain professional approach- staff training to be arranged To ensure staff action any increases in packages of care in a timely manner.	Care and Treatment
9114	West Berks	Out of Hours GP Services		DECEASED Pt:- lack of availability of local duty doctors in the area	Upheld		Access to Services
9135	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Patient unhappy with what is written in her discharge letter. She says she was persuaded to allow service to speak to her husband and now they have believed her. She said she is not paranoid and her family are being cruel to her	Local Resolution	Patient is happy for service to amend the letter and ask GP to disregard the first one.	Care and Treatment
9080	Reading	Talking Therapies - PWP Team	Minor	Advised treatment would be 1 week after initial consultation, no follow up received, despite chasing still no follow up. Pt feels their mental issues do not matter to services	Upheld	For staff member to book training on the following: Communication Skills Record Keeping Time Management Information Governance For staff member to use principles outlined in the Standard Work Document for Managing Emails	Care and Treatment

9118	Reading	CAMHS - Specialist Community Teams	Low	Family feel wait times have had a very negative impact, now discharged as they would not engage. Family feel as it has taken 8 years the YP is now at the age to just say No. Why is there no support for ADHD unless the YP is on meds?	Partially Upheld	Partially upheld due to wait.	Care and Treatment
9112	Reading	Minor	Minor	Unsupportive call handlers from Crisis. Pt wishes all staff to be trained in autism.	Partially Upheld	Staff undergoing Trust training on Autism	Attitude of Staff
9093	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	sharing personal info without pt consent to police. 12 years of misdiagnosis and mistreatment. Pt feels NHS have violated their rights	Not Upheld	Offer to patient to see different psychiatrist	Care and Treatment
9102	West Berks	CMHT/Care Pathways		Following previous complaint referral to be made to IPT and IPT to respond directly to the pt within 14 days. Nothing has been received	Not Upheld		Communication
9117	Reading	Out of Hours GP Services	Low	Dr advised pt they did not need to be seen based on a photo sent through stating it was not infected. As no improvement pt went to hospital where a nurse was able to advise it was infected just from the smell	Partially Upheld	Discuss Case at WestCall Monthly Clinical Meeting	Care and Treatment
9128	Reading	CAMHS - ADHD	Low	RO from 8969 - Complainant wishes to know if calls, dates, times and length can be tracked from a member of staff	Not Upheld	continuation of 8969	Communication
9054	Wokingham	CAMHS - Anxiety and Depression Pathway	Minor	Family feel the YP was refused help when they were in Crisis, multiple admin errors and poor communication between departments	Partially Upheld	RRT have been reminded to use the latest version of the service contact list for any further information sharing. Update induction and training for COYPW clinicians around crisis support and safety planning (including YP presenting with psychotic symptoms). Incorporate response to requests for crisis support in admin induction. Clinician involved has already had further learning via supervision around risk assessment and safety planning Complete audit of COYPW contacts and quality of safety planning	Care and Treatment
9081	Slough	Sexual Health	Low	Further concern - patient wishes info taken off their records Pt wishes to know what rules/instructions we were following ORIGINAL COMPLAINT BELOW Pt unhappy test results and diagnosis has been shared with their GP without their consent	Partially Upheld	A consent form asking for GP contact with patients' signature at registration, uploaded on Lillie as evidence. Revisit consent every attendance. Opt out rather than opt in to ensure primary care aware of input from specialist services. Disclaimer that full confidentiality is never guaranteed as patients may need to be referred to other services as part of their ongoing care. Liaise with Trust Information Governance Team to review current patient portal and what consent in this context is required if any to be recorded Consider patient information leaflet to inform all patients that a letter will be sent to their GP following any consultation. Consider posters within the clinic Learning event for all staff within the service so that they are fully aware of consent in this context	Communication
9071	Reading	A Place of Safety	Minor	Pt unhappy they were in POS for 18 hours felt no one took their autism/ADHD into consideration	Not Upheld	Learning around techniques used to move patients out of doorways to be shared with the team	Care and Treatment
9116	Bracknell	Children's Speech and Language Therapy - CYPIT	Low	Feels no acknowledgment has been given to the difficulties incurred and no responsibility for the down falls have been taken ORIGINAL COMPLAINT communication gaps during the ECHP assessment window. Prep time from the SALT assessor was not taken into consideration. family wish their private assessment to be taken into consideration. family want a formal apology and for the therapist to reflect on whether they adhered to the HCPC strict code of ethics and conduct	Partially Upheld	We will advise that SALT training/awareness sessions in schools includes the importance of information sharing between schools and the SALT team prior to assessments being undertaken to ensure that children are prepared and any adjustments made accordingly. It will be recommended that SALT teams will contact parents/carers if they are unable to complete their report within the statutory six week timeframe for EHCPs.	Care and Treatment

9095	West Berks	Phlebotomy	Low	Attitude of staff when trying to obtain a blood test for YP	Partially Upheld	Anonymised complaint to be shared at next team meeting and learning discussed Staff to undertake NHSE Handling difficult situations – Caring for yourself and others with compassion training	Attitude of Staff
9109	West Berks	Common Point of Entry	Low	GP extremely unhappy with the unprofessional letter written by a psychiatrist slating the GP to the pt resulting in further unprofessional conduct from BHFT staff to the pt re the GP	Upheld	Apology offered to GP for wording in discharge letter	Attitude of Staff
9092	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Re-opened complaint; Patient has submitted further evidence that Trust have communicated with SaBP outside of the written agreement he had. He has been copied into an email that makes reference to a call with SaBP. ORIGINAL COMPLAINT: Pt alleging that BHFT and contacted SaBP outside of the consent he agreed to. Also incomplete medical records as pt feeling BHFT have not copied them into all correspondence with SBPFT.	Not Upheld		Confidentiality
9018	Reading	Neurodevelopmental Services	Low	Patient has raised queries from response letter and had two different messages from PALS and the complaint response to the same issue. ORIGINAL COMPLAINT Reception staff asking diagnosis questions and accessing pt records, then telling pt to call back for help. Pt believes receptionist was temporary	Partially Upheld	Ensure induction includes training for all non clinical staff (including temporary) on client interactions.	Attitude of Staff
9081	Slough	Sexual Health	Low	Further concern - patient wishes info taken off their records Pt wishes to know what rules/instructions we were following ORIGINAL COMPLAINT BELOW Pt unhappy test results and diagnosis has been shared with their GP without their consent	Partially Upheld	A consent form asking for GP contact with patients' signature at registration, uploaded on Lillie as evidence. Revisit consent every attendance. Opt out rather than opt in to ensure primary care aware of input from specialist services. Disclaimer that full confidentiality is never guaranteed as patients may need to be referred to other services as part of their ongoing care. Liaise with Trust Information Governance Team to review current patient portal and what consent in this context is required if any to be recorded Consider patient information leaflet to inform all patients that a letter will be sent to their GP following any consultation. Consider posters within the clinic Learning event for all staff within the service so that they are fully aware of consent in this context	Communication
9011	Reading	IMPACTT	Minor	8 points answered locally regarding SUN facilitators, referral to Pathways, discharge and sharing of information. Pt wishes assessment from IMPACTT after allegedly waiting 7 months. 16 further points to answer, also wishes the surnames of 2 staff members	Not Upheld		Communication
9075	Bracknell	CAMHS - Rapid Response	Minor	Complainant unhappy at the content of the report written about YP. Also very unhappy this report was sent to a minor, addressed to the patient but when opened it said Dear Parent/Guardian. Felt belittled by the AMHP	Partially Upheld	Creating an expected standard template for all clinician to refer back to and highlighting the recipient part to prevent confusion for all staff. To request L&D account for all agency staff to be able to access BHFT nexus eLearning trainings. This will enable agency staff to have access to the same level and the standard of training as substantive staff	Care and Treatment
9130	Reading	CAMHS - ADHD		Unhappy with the ADHD assessment process	Not Upheld	Not upheld.	Care and Treatment
9131	Wokingham	District Nursing		DN bandaged pt's leg including their foot. Pt fell in the night as slipped on the vinyl surface. Complainant unhappy that the bandaging caused this	Not Upheld	No consent received	Care and Treatment

9141	West Berks	Urgent Treatment Centre	Minor	Patient attended UTC and was told she had sprained her shoulder, it later turned out she had fractured it. She complains she was in great pain for 5 weeks until her GP got her an xray	Partially Upheld	Practitioner to further reflect on the feedback regarding her consultation manner at next 1:1	Care and Treatment
9096	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Low	Care and treatment from the Dr on Henry Tudor ward, which the family state resulted in Sepsis	Not Upheld		Care and Treatment
9023	Bracknell	CAMHS - Specialist Community Teams		Mother unhappy as daughter is not receiving appropriate care and treatment. Diagnosis not received apart from ASD. in and out of Frimley Park with MH break downs	Not Upheld	Care was appropriate and responsive. The patient disengaged with services a number of times and they continued to try to find ways to work with her and her family. The delay in a response was due to obtaining consent.	Care and Treatment
9144	Wokingham	CAMHS - AAT		Mother has complained about waiting time for AAT and process.	Not Upheld		Waiting Times for Treatment
9068	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Low	Missing Samsung Galaxy A6 tablet on discharge	Not Upheld		Patients Property and Valuables
9152	Windsor, Ascot and Maidenhead	Physiotherapy Musculoskeletal	Low	Unhappy at the lack of reimbursement for their taxi fare being offered	Not Upheld		Management and Administration
9158	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Low	1. Was not asked if they planned to take their own life 2. Allegedly denied a video conference/Teams assessment 3. Unhappy at being discharged	Not Upheld		Care and Treatment
9129	West Berks	District Nursing	Low	Palliative pt struggling with getting DN's to resolve the blocked catheter. Family feel they have not been treated with care and dignity and do not understand why DN's won't attend when called	Partially Upheld	Discussion with GP from Hungerford surgery regarding setting expectations of the District Nursing service for palliative and end of life patient. Liaise with continence service about using RIO to document their actions. Communicating follow up plans with family and verifying their understanding of the plan, discussing with the team at locality meeting Communication between external services, in this case Sue Ryder and GP, a more collaborative approach to set out expectations of roles and joint visits	Care and Treatment

Appendix 3

15 Steps; Quarter Two 2023/24

During quarter two, there were two visits:

Orchid Ward – Prospect Park Hospital

- Positives observed during the visit:
- Nurse in charge was very enthusiastic about her job. Other staff were welcoming and positive about their work.
- Staff board visible with photographs and staff on duty that day.
- Evidence of QMIS work and improvements which benefitted both patients and staff i.e., around Falls and dehydration.
- Communal dining area was laid up for lunch which looked welcoming.
- Hydration station available for patients with choices of drinks not just water in line with QMIS feedback and evidence.
- Physiotherapist was very engaging around the importance of rehabilitation and success stories from recent patients.

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

- Some of the QMIS data was not dated so it was not clear if aims were current. The nurse in charge acknowledged this but said it had been condensed from a longer document.
- It took a while to gain entry to the ward – recognising that it was a busy ward.

Rose Ward – Prospect Park Hospital

- Positives observed during the visit:
- Ward manager was very welcoming. Other staff were pleasant and greeting as appropriate. All wore ID and were dressed appropriately for the working environment.
- Lots of positive interactions observed between staff and patients.
- Excellent ward notice board which clearly depicted staff and who was looking after each patient on the shift. There was clear rationale to what care patients should expect.
- Outside areas had plenty of seating and were tidy.

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

- There were some décor issues but these had been reported and were due to be addressed by estate services.
- Signage to ward in the corridors was difficult to follow if you are unfamiliar with the building. Seems to disappear once you have gone past the main entrance. The Manager stated that this has been reported by patients and visitors previously and is under review.

NHS
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Report to Council of Governors For Quarter 2 2022/23

December 2023

Paul Gray

Chief Executive Highlights Update

Local

New diagnostic centre coming to Slough in 2025 - a £25 million state-of-the-art NHS diagnostic centre at Upton Hospital in Slough is planned for 2025. The diagnostics centre, which is being developed by Frimley Health NHS Foundation Trust will enable faster and easier diagnostic services for the local community. Construction is expected to start in 2024 (subject to necessary planning approvals) with the opening planned for spring 2025.

It will be open seven days a week, for 12 hours each day, and will provide a wide range of pre-booked diagnostic services including MRI, CT, ultrasound scans, and testing for lung and heart conditions, as well as blood tests and x-rays, for people living in Slough as well as wider communities in Windsor and East Berkshire.

Health Inequalities: Mental Health Act Detentions of Black Individuals Project - the Trust is working with MIND in Berkshire to better understand why Black people are more likely to be detained under the Mental Health Act and to help improve our mental health support for Black people. Data shows that nationally, Black individuals are five times more likely to be detained under the Mental Health Act (sometimes called 'being sectioned') than White individuals.

This engagement seeks to improve understanding about why this is, and what needs to change to make things fairer and better suited to meeting the needs of Black people. MIND will be talking to Black people in Berkshire who have been detained under the Mental Health Act in the last five years, and the family members and friends who support them, to share their lived experiences as part of this research project. Those taking part will have the opportunity to talk about how their lives, and those of their loved ones, were impacted by being sectioned. They will have their voices heard and will be able to influence positive change in how mental health services are delivered. The findings will help inform how Berkshire Healthcare can improve the support it provides and help address inequality. Learnings will also be shared with other NHS Mental Health Trusts and other organisations who may find it helpful.

Chief Executive Highlights Update

Berkshire Healthcare NHS Foundation Trust

Local Continued

Wokingham Hospital ‘bus stops’ for Dementia patients – the Trust has recently introduced two 'bus stops' on the wards at Wokingham Hospital to serve as a comforting reference point for our Dementia patients, providing them with a sense of familiarity and recognition if they start to feel confused or disorientated. For patients suffering from Dementia and other memory-related conditions, an unfamiliar hospital environment can be quite unsettling, leading to patients seeking out people and places they recognise.

Studies have shown that by creating a focal point which is universally recognised, such as a bus stop, patients will automatically be drawn towards it and take a seat. The bus stops at Wokingham Hospital are located near the nurses’ station so healthcare workers can join the patients at the bus stop, engage them in conversation, and provide the necessary reassurance and comfort as needed. This innovative approach was first pioneered in Germany back in 2008 and is designed to offer patients a sense of familiarity and recognition, while ensuring they remain in a safe and secure location within the hospital.

The inspiration for this initiative came from a member of staff who proposed the idea through our Bright Ideas initiative. Bright Ideas empowers staff within the Trust to suggest innovative ideas aimed at improving the efficiency and functionality of the organisation. The member of staff heard about the bus stop initiative being successfully introduced at other healthcare organisations where it had a positive impact on patients and decided to put the idea forward through Bright Ideas.

Chief Executive Highlights Update

Berkshire Healthcare NHS Foundation Trust

Local Continued

NHS Pastoral Care Quality Award – the Trust's International Recruitment Team have been awarded an NHS Pastoral Care Award for their outstanding support of international staff in our recruitment programme. Since 2021, we have welcomed over 36 colleagues from overseas, with 10 more due to start this year.

Winning Gold at Social Media Awards – our Social Media Team has won the esteemed 'Real Deal' category at the prestigious Golden Ele Awards. The Golden Ele awards are run by Orlo, a social media management platform and they recognise the most engaging social media campaigns in the public sector. The Real Deal award is given to those who are committed to authenticity within their social media marketing. At Berkshire Healthcare, we continuously try to weave a personal connection into the stories we tell, to truly represent who we are as an NHS Trust.

Berkshire Healthcare has profiles on Facebook, Instagram, X, LinkedIn and most recently, Tik Tok, in which the team achieved the much sought after 'viral' status to one of its videos celebrating some of our newly qualified nurses. Our presence on social media platforms has allowed us to generate awareness of our services, boost our recruitment efforts and has been a helpful tool to engage with the local communities we serve. In an age of 'fake news' and misinformation, the platforms have given us an opportunity to share accurate health information and advice.

Chief Executive Highlights Update

Berkshire Healthcare NHS Foundation Trust

Local Continued

Soldiering On Awards – Jon Giemza-Pipe, a veteran who work in the Trust's OpCourage Team and his canine companion, Baxter were crowned worthy winners in this year's Soldiering On Awards. Jon Giemza-Pipe represents the voice of military veterans in our Op Courage NHS Veterans mental health and wellbeing service across the South-East and has most recently stepped up as the acting armed forces lead at Trust. Jon draws on his experience of serving 22 years in the Royal Artillery, and being medically discharged with health difficulties in 2016, to do what he loves the most – helping veterans to overcome tough times and help them on their mental health recovery journey.

Remembrance Sunday - Jon Giemza-Pipe, Baxer, and Governor Debra Allcock Tyler represented the Trust at a Service of Remembrance at Reading Minister, honouring the memory of all those who have served in the armed forces.

Chief Executive Highlights Update

Berkshire Healthcare NHS Foundation Trust

Local Continued

The Let's Connect Community Wellbeing Network – is our social network to support wellbeing by helping people to connect with others, organisations, services and opportunities I our community. The Network offers informal, relaxed community socialising sessions for people aged 18 and over, aimed at reducing isolation and improving general well-being through connection. They also provide one-to-one support in the community for people who may need it.

The Network offers:

- Let's Connect network meetings: We have regular meetings in Newbury, Reading, and Wokingham for you to build a social network or to simply have contact with someone
- Individual meetings: We can offer up to six individual meetings to help you think about what you would like to do or connect with in your life
- Community connection: We can connect you to local community groups and organisations that can support you

To be eligible to join the network, people need to be aged over 18 and live in Newbury Reading or Wokingham and feel that more social contact and better information about your local community would boost your overall wellbeing.

Chief Executive Highlights Update

Berkshire Healthcare NHS Foundation Trust

Local Continued

RAAC within the Trust's estates - NHS England wrote to all NHS provider organisations in early September 2023 outlining actions to be taken to provide assurance that as far as possible, RAAC is identified and appropriately mitigated within the NHS estate. This followed the Department for Education issuing guidance as to the presence of RAAC in the school estate, which led to heightened public interest in the presence of RAAC. This has led to a further 18 hospitals identifying RAAC, taking the total number impacted to 42. Following review undertaken by our Estates Department, RAAC has not been identified in any of our properties, either owned, commercially leased, our PFI facilities or properties owned by NHS Property Services.

Health Service Journal Award - our **BRAVE** service (Building Resilience and Valuing Emotions after Domestic Abuse) was shortlisted for the HSJ awards in the Mental Health Innovation of the Year category. Working in partnership with the Office of the Police and Crime Commissioner for Thames Valley, BRAVE offers psychological support for people (both men and women) across Berkshire who have experienced domestic abuse. The BRAVE programme started as a 12-week programme for women which covered topics such as the function of emotions, low mood, anxiety, distress tolerance, building resilience, healthy relationships, and values.

Graduates of this programme felt they missed the connection of the group and so BRAVE EMBRACE was created, a co-produced peer group based on therapeutic community principles, where BRAVE graduates can consolidate their skills and continue to receive support for up to two years. A pathway was also created for those who completed BRAVE EMBRACE to become BRAVE Ambassadors, trained volunteers who continue to promote domestic abuse awareness. The service also found there was a great need for developing a programme for men, which led to BRAVE Too, a specialised offer for men who have been in abusive relationships and experienced psychological and emotional difficulties.

Chief Executive Highlights Update

National

Berkshire Healthcare NHS Foundation Trust

New Secretary of State for Health and Social Care – Victoria Atkins has replaced Steve Barclay as Secretary of State for Health and Social Care. Ms Atkins is a barrister and was previously Financial Secretary at the Treasury.

CQC – in its annual State of Care Report published in October 2023, the Regulator states that the quality of Maternity Services, Mental Health and Ambulance Services has seen a "notable decline" over the last year, which is contributing to "unfair care" and worsening health inequalities. The CQC identifies that a "turbulent" mix of operational challenges, the cost-of-living crisis and workforce pressures risked creating a "two-tier system of health care" with people who cannot afford to pay waiting longer and getting sicker. It also noted that the "quality of mental health services is an ongoing area of concern, with recruitment and retention of staff still one of the biggest challenges for the sector". Staffing gaps especially in Mental Health Nursing are identified as a factor in the over-use of restraint, seclusion and segregation.

NHS struggling to open extra winter beds and fill staffing gaps

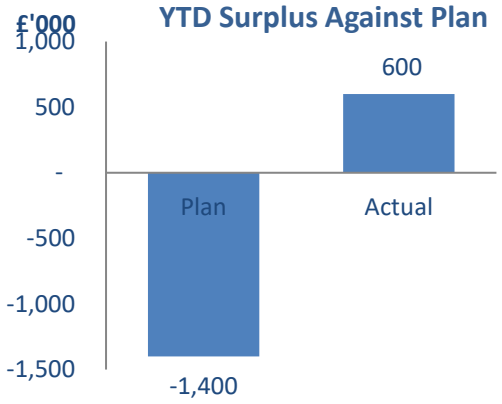
The BBC reported that NHS leaders in England are warning a lack of funds means they are having to scale back on plans to open extra beds to cope with winter. The warning, from NHS Providers came after the Treasury rejected pleas for an extra £1bn to cover the cost of strikes. NHS Providers said recruitment to plug gaps in the workforce was also having to be put on hold. Leaders at just over half of trusts responded to NHS Providers' latest *State of the provider sector* survey. Three-quarters said they were facing a worse financial situation than last year, putting patients' safety at risk.

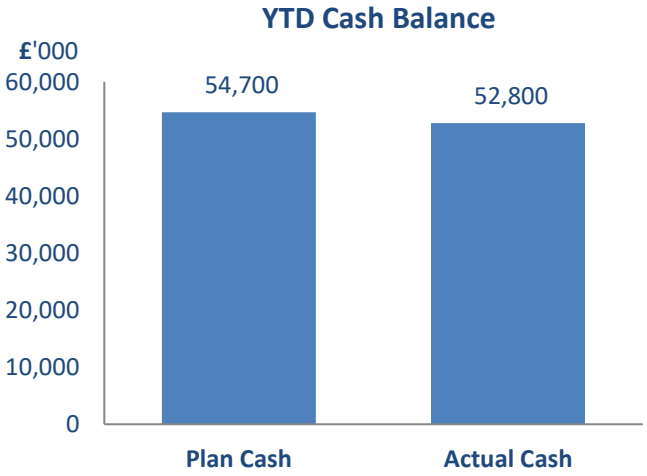
NHS under pressure - Figures from NHS Providers show that as at September 2023:

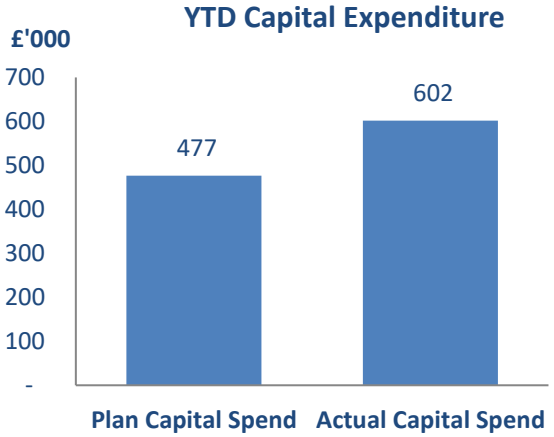
- 7.77m people were on the elective care waiting list
- 44,655 people in Accident and emergency waited 12 hours or more from the decision to admit to admission
- 1.76m people were in contact with mental health services

Financial Summary – 30th September 2023

Berkshire Healthcare NHS Foundation Trust







Year to Date

The Trust delivered a small surplus (£0.6) against a deficit plan (-£1.4m).

Bank interest in excess of plan, a reduction in utilities charges compared to plan and a small amount of recruitment slippage contribute to this better than plan position.

We were set a cost improvement target of £14.1m for the current financial year, in Q1 we reported £2.7m which is in line with plan.

Cash

Our cash balance at the end of September was £52.4m, £1.6m less than plan.

Capital Spend

The capital programme is broadly in line with plan, IM&T spend is ahead of plan driven by user demand for new and replacement kit.

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True North Driver Metrics and Oversight Performance Metrics Quarter 2 December 2023

True North: Driver Metrics

Berkshire Healthcare NHS Foundation Trust

Harm Free Care

Metric	Target	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Breakthrough Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	42 per month	74	86	37	28	162	31	22	24	19	54	37	43
Breakthrough Restrictive Interventions	TBC												

Patient Experience

IWGC Positive Score %	95% compliance from April 22	93.3%	94.8%	91.5%	94.5%	92.4%	93.7%	94.0%	94.2%	94.1%	95.2%	95.2%	94.3%
IWGC Compliance %	10% compliance	3.6%	5.4%	2.7%	2.8%	2.3%	3.1%	2.6%	3.3%	3.7%	3.5%	4.2%	3.3%

		Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Breakthrough Clinically Ready for Discharge by Wards MH(including OAPS)	250 bed days	336	317	510	414	269	300	415	468	484	565	712	460	317

True North Driver Metrics Continued

Berkshire Healthcare NHS Foundation Trust

Supporting our Staff

Metric	Target1	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Breakthrough Physical Assaults on Staff	44 per month	70	72	64	34	84	109	77	45	52	70	60	44
Staff turnover (excluding fixed term posts)	<=16% per month, 14% by March 2024, 13% by March 2025, 12% by March 26	16.5%	16.32%	16.52%	16.21%	15.69%	15.85%	15.85%	14.87%	14.54%	14.35%	14.09%	13.60%

Efficient Use of Resources

		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
YTD variance from control total (£'k)	1.3m	-774	-822	-1092	-1277	-1818	-989	-261	-441	-805	-1116	-1430	1746
Inappropriate Out of Area Placements	270 Cumulative Total Q2 2023/24	266	484	591	50	112	219	110	144	180	327	633	786

Countermeasure Summary for Driver Metrics

Berkshire Healthcare NHS Foundation Trust

Self- Harm – Analysis by ward has found that a few individual patients are responsible for the majority of incidents (in July -15, August -12 and September 10). Actions from last period

- Devised a set of principles for teams to individualise
- Focus on learning from near miss, suicide surveillance
- Focus on ligature harm minimisation and new guidance
- Big focus on service users with neurodiversity
- Big focus on visibility of the leadership team especially nurse consultants

Outcomes

- Targeting gaps identified has resulted in prompt learning
- Guiding principles rather than rigid pathways as a result of pathway testing
- Next steps
- Nurse Consultant for patients with a higher incidents of harming – working to ensure this is timely
- Peer review to take place

iWantGreatCare – there has been good take up of devices to record patient experience and work is ongoing to ensure that the correct services are aligned to correct divisions following the change in Divisional structure

Countermeasure Summary for Driver Metrics Continued

Berkshire Healthcare NHS Foundation Trust

Clinically Ready for Discharge – This is a **new driver metric from April 2023**. The measure here shows **the lost bed days** between when a client is clinically ready to be discharged and their actual discharge date for Mental Health Inpatients. Actions from the last period. Achieving target of 250 target lost bed days per month would mean a 23% reduction from the September 2023 figure. To achieve this focus areas for the next 12 months include

- Reviewing capacity and trajectory monitoring
- Focusing on the pathways for patients with psychosis
- Improving proactive anticipatory care planning
- Focusing on the PICU unit demands
- Undertaking a dashboard review for Prospect Park Hospital

Outcomes

- Bed Optimisation project will continue with key stakeholders and project management office support
- Introduction and automation of 72 hour post admission multi-disciplinary to capture key patient information and action plans developed to mitigate any factors which might cause delays.

Countermeasure Summary for Driver Metrics Continued

Berkshire Healthcare NHS Foundation Trust

Physical Assaults on Staff – 45 in September 2023 one above the target. Actions taken and impacts

- Campaign to raise reporting
- Senior Leadership availability to support staff with Datix reporting,
- Thames Valley Police colleagues' presence on wards and in status exchanges
- Clinical reviews with Nurse Consultants.

Outcomes

- Staff seeing positive impact
- Away day
- Review of staff support
- Impact of neurodiversity, self-harm, blanket rules and use of restrictive interventions

Key Performance Indicators - Oversight Framework Metrics

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Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
C.Diff due to lapse in care (Cumulative YTD)	6	2	2	2	2	2	2	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	0	1	0	0	0	0	0	0	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	2	3	3	3	3	3	0	1	1	1	1	1
Count of Never Events (Safe Domain)	0	0	0	0	1	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	83.32	92.82	85.70	91.65	87.5	90	88	75	80	87.5	100	100
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.26	99.53	99.64	99.26	99.37	99.39	99.26	99.35	99.42	99.40	99.42	99.17
People with common mental health conditions referred to Talking Therapies 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 Talking Therapies will be treated within 6 weeks from referral: %	75% treated	95	93	94	95	95	95	94	94	93	91	91	87
People with common mental health conditions referred to Talking Therapies completing a course of treatment moving to recovery: %	50% treated	47	52	48	45.5	46	46.5	46.5	48	45	49.95	46.15	46
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	35	66.49	82.84	72.48	72.42	69.06	61.26	83.45	92.09	97.79	100	99.00
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	98.70	100	100	100	100	100	100	100	100	100	99.57	99.53
Sickness Rate: %	<3.5%	4.9%	4.5%	5.1%	4.3%	4.3%	4.1%	3.7%	4.0%	3.8%	3.9%	3.7%	3.9%
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	66.7%	100%	57.1%	100%	66.6%	66.6%	50%	83.3%	66.6%	75%	75%	100%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	100%	75%	83.3%	100%	88.8%	66.6%	100%	50%	46.1%	36.3%	42.8%	62.5%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Key Performance Indicators - Oversight Framework Metrics

Berkshire Healthcare NHS Foundation Trust

Regulatory Compliance - System Oversight Framework

Metric	Threshold/T..	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Community Health Services: 2 Hour Urgent Community Response %.	80%	92.2%	88.9%	85.8%	88.5%	88.5%	89.3%	83.1%	84.2%	87.8%	87.6%	85.2%	86.3%
E-Coli Number of Cases identified	Tbc	1	1	0	0	0	0	0	1	1	0	1	0
Mental Health 72 Hour Follow Up	80%	96.5%	93.6%	87.2%	94.0%	88.6%	93.0%	96.4%	91.6%	90.7%	98.0%	87.5%	92%
Adult Acute LOS over 60 days % of total discharges	TBC			21.8%	26.5%	50%	27.3%	24.1%	25.8%	22.8%	24%	25%	24%
Older Adult Acute LOS over 90 days % of total discharges	TBC			55.5%	57.0%	40.8%	60%	66.7%	66.7%	50%	36%	32%	28.9%

Key Performance Indicators Oversight Framework: Actions for Areas of Underperformance

Berkshire Healthcare NHS Foundation Trust

MSSA This is the number of cases of the infection **Methicillin-sensitive Staphylococcus aureus** identified on our wards as occurring due to lapse in care. One case on Ascot Ward in May 2023 was defined as a lapse in care as an investigation identified that there was no evidence of commencing wound care plan during this admission for management of patient's multiple wounds.

Talking Therapies Recovery rates

- Talking Therapies recovery measures all those who come into the service (not just those who complete treatment)
- We have a clinical quality workstream working incredibly hard to improve our recovery
- This is a slow process given that therapy sessions can span 4/5 months
- Thresholds for individual therapy for depression have been adjusted so proportionally more patients with depression are receiving the top-level intervention (length of treatment means we will need to wait several months to see an impact)
- We continue to work at reducing dropouts and increasing engagement which will in turn increase recovery
- We continue to work at reducing waits (longer waits associated with poorer recovery)
- We are rolling out Bespoke Training to improve staff training
- We hope to receive funding for new senior clinical roles and business support roles to action our workstream outputs (such as maximising the quality of supervision)
- Reconfiguring of the extended trauma pathway and the treatment of those with PTSD across the Trust – likely to have a significant impact on recovery as those too complex for TTs will be better managed and moved through the pathway.

Key Performance Indicators Oversight Framework: Actions for Areas of Underperformance

Berkshire Healthcare NHS Foundation Trust

Sickness – Stress and Anxiety is the top contributing Reason for Sickness in Septmber 2023. Berkshire Healthcare has a number of well-being options including Mental Health and Physical Health Support on its intranet. Service managers meet with Human Resources to progress cases where performance management of an individuals' sickness is needed.

Children and Young Persons Eating Disorders 4 week routine waiting times target – Berkshire Healthcare have agreed a change in the clock stop definition with both ICB's. This will bring us in line with other providers in both ICB's and having reviewed the national access and waiting time standard definitions, is in line with those as well. The work needed has been agreed as a priority for the RiO transformation team and will be starting soon. We have achieved the target in the past couple of months without the change to data recording, and are confident that we will do so more consistently once the RiO work has been completed.

Board Assurance Framework Risk 2023/24 Summary

Berkshire Healthcare NHS Foundation Trust

(NB the Board Assurance Framework Risks are currently being reviewed – the red type indicated amendments and new proposed new risks. The proposed changes to the Board Assurance Framework will be discussed at the December 2023 Trust Board meeting)

Strategic Ambition	Risk Description
Workforce We will make the Trust a great place to work for everyone	**Risk 1 – Workforce** Due to national workforce shortage and increasing scarce supply **there** is a risk of failure to recruit, retain and develop a diverse workforce which could impact on our ability to meet our commitment to providing safe, compassionate, high-quality care and a good patient experience for our service users.
Patient Safety We will reduce waiting times and harm risk for our patients. **Efficient Use of Resources** We will use our resources efficiently and focus investment to increase long term value	**Risk 2 - Demand and Capacity** There is a risk that some services will fail to make the necessary performance and productivity gains to be able to keep up with increased demand leading to increased waiting times thus increasing the risk of harm to patients.
Patient Experience and Voice We will leverage our patient experience and voice to inform improvement	**Risk 3 – Patient Voice** There is a risk that that the Trust will fail to "hear the patient voice" and take account of patient experience when shaping, adapting, and designing services leading to services which do not meet the needs of all groups of patients and their families leading to inequality of access and poorer health outcomes.
Health Inequalities We will reduce health inequalities for our most vulnerable patients and communities	**Risk 4 – System Working** There is a risk that due to political, operational, workforce and funding pressures across health and care the Integrated Care Systems fail to deliver on their core aims of improving population health outcomes, reducing health inequalities, increasing system efficiency, and contributing to wider social and economic development.

Board Assurance Framework Risk 2023/24 Summary Continued

Berkshire Healthcare NHS Foundation Trust

Strategic Ambition	Risk Description
Health Inequalities We will reduce health inequalities for our most vulnerable patients and communities	**Risk 5 – Health Inequalities** Given the complexity of the determinants of health including non-health related factors, there are risks around delivering an ambitious programme of work aimed at reducing health inequalities given the long lead in time to see any improvements and outcomes impacted by factors outside of health and social care.
Efficient Use of Resources We will use our resources efficiently and focus investment to increase long term value	**Risk 6 – Finance** Failure to achieve system defined target efficiency and cost base benchmarks lead to an impact on funding flows to the Trust, and underlying cost base exceeding funding. Risk is described in the context of system funding allocations being allocated and controlled at ICS level, flowing to providers on a risk share and/or relative efficiency basis.
Efficient Use of Resources We will use our resources efficiently and focus investment to increase long term value	**Risk 7– Digital Risk** There is a risk that capital funding constraints will reduce the Trust's ability to invest in digital technology and innovation which is needed in order to maximise clinical capacity and reduce the risk of malware attack which could compromise systems leading to unavailability of clinical systems, loss of data, ransom demands for data and mass disruption.
Efficient Use of Resources We will use our resources efficiently and focus investment to increase long term value	**Risk 8 - Sustainability** There is a risk that the Trust's will not be able to deliver its Green Plan due to a lack of resources including access to capital funding and a focus on short rather than long term initiatives