Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 08 February 2022

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 14 December 2021	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Board Story – Talking Therapies	Debbie Fulton, Director of Nursing and Therapies/ James Momoh and Rani Griffiths, Talking Therapies	Verbal
6.1	NHS Community Mental Health Benchmarking Report 2021	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Infection Prevention and Control Board Assurance Framework	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 09 2021/22 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 09 2021/22 Performance Report	Paul Gray, Chief Financial Officer	Enc.
8.2	Finance, Investment and Performance Committee meeting on 27 January 2022	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Enc.
STRATEGY			

No	Item	Presenter	Enc.
9.0	Health and Wellbeing Update Report	Alex Gild, Deputy Chief Executive/Director of People	Enc.
9.1	Trust's Green Plan 2022-25	David Townsend, Chief Operating Officer/Jayne Reynolds, Regional Director (East)	Enc.
9.2	Strategy Implementation Plan Summary Report	Alex Gild, Deputy Chief Executive	
CORPORATE GOVERNANCE			
10.0	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.1	Annual Health and Safety Report	David Townsend, Chief Financial Officer	Enc.
10.2	Audit Committee Minutes – 19 January 2022	Rajiv Gatha, Chair of the Audit Committee	Enc.
10.3	Annual Declarations of Interest and Fit and Proper Persons Test Report	Julie Hill, Company Secretary	Enc.
10.4	Annual Trust Board Meeting Planner	Julie Hill, Company Secretary	Enc.
10.5	Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 12 April 2022	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday 14 December 2021

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Chair
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Debbie Fulton	Director of Nursing and Therapies
	David Townsend	Chief Operating Officer
	Paul Gray	Chief Financial Officer
In attendance:	Julie Hill	Company Secretary
	Joanne Cocksey	Principal Clinical Psychologist, Phoenix Unit *(present for agenda item 6)*
	Natasha Maseya	Social Worker, Phoenix Unit *(present for agenda)*
	Jane Nicholson	Director of People *(present for agenda item 7)*
	Mike Craissati	Freedom to Speak Up Guardian

21/226	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
21/227	**Apologies** (agenda item 2)
	There were no apologies.

21/228	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
21/229	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
21/230	**Minutes of the previous meeting – 09 November 2021** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 09 November 2021 were approved as a correct record.
21/231	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
21/232	**Case Study – Child and Adolescent Mental Health Services (CAMHS) Phoenix Unit – Tier 4 Hospital at Home Service (**agenda item 6.0)
	The Chair welcomed Joanne Cocksey, Principal Clinical Psychologist and Natasha Maseya, Social Worker, Phoenix House Unit, Child and Adolescent Mental Health Services. Dr Cocksey and Ms Maseya gave a presentation and highlighted the following points: • Following the closure of the CAMHS in-patient unit at Willow House, the Trust had developed a day hospital and home treatment service known as the Phoenix Unit for young people aged 12-18 with moderate to severe and complex mental health disorders whose needs could not be adequately met within community and outpatient settings (Tier 4 CAMHS). • The new service was developed in collaboration with NHS England and Oxford Health NHS Foundation Trust in line with national evidence of hospital at home and intensive community treatment models. • The Unit was opened on 1 May 2021 and operated from 8am to 8pm including weekends and bank holidays. • The Unit had a multidisciplinary team which included: consultant psychiatrists, clinical psychologists, occupational therapist, social worker, nursing staff, teachers and education staff. This enabled the service to provide a holistic approach to managing each of the young people. • The average length of stay was 12 weeks. The service also provided support for the family. • For young people who may struggle to attend the day programme, the service would shortly offer a home treatment service. Dr Cocksey presented a case study of a young person with severe emetophobia (Vomit phobia) and obsessive-compulsive disorder whose life became so restrictive that they

	were not able to leave the house. The young person was referred to CAMHS following admission to hospital with stomach pains, reduced food intake and weight loss. The CAMHS Anxiety and Depression Team referred the young person to the Phoenix Unit for more intensive support. The young person attended the day programme, engaged in individual, group and family therapy, started medication and was starting to make good progress. Ms Maseya gave another example of a young person with high levels of anxiety, perceptual disturbances (seeing figures, hearing voices), had strong suicidal thoughts and impulses, was struggling to remain adequately functioning in the community and who had an unclear diagnosis. Ms Maseya reported the young person had been referred to CAMHS because of their high levels of anxiety and agitation. Following crisis calls from the family, the young person was assessed by the CAMHS Getting Help Team who referred to young person to the Phoenix Unit for specialist CAMHS intervention. The Unit worked closely with the family and also worked with the family's community social worker. The young person and their family engaged well with the programme and the young person was making progress. Dr Cocksey gave two examples of positive feedback from young people who had used the service. The presentation slides are circulated with the minutes of the meeting. The Chair asked how many young people had used the service since it opened in May 2021. Dr Cocksey reported that there were up to 10 young people accessing the day programme and moving forward there would be capacity for around 8 young people to be supported by the home treatment service. David Buckle, Non-Executive Director asked whether there was scope for young people to attend the Unit on a part time basis if they did not require intensive support. Dr Coaksey said that currently there were no young people attending seven days a week although they may have additional telephone support over the weekends. Dr Coaksey said that wherever possible, the service made sure that young people maintained links with their school, friends and continued with any community therapy/support and this approach helped to ensure that they did not become overly reliant on the service when discharged. The Chief Operating Officer asked whether the young people were able to socialise with each other and had access to exercise equipment. Dr Coaksey said that there were wellbeing activities and there were opportunities for young people to mix socially but many of the young people were under weight and were not well enough to undertake strenuous physical activity. It was noted that the service was looking into providing gentle exercise such as yoga. Naomi Coxwell, Non-Executive Director asked about the importance of working with the family. Ms Maseya said that family therapy was really helpful and confirmed that parents were involved in all meetings and there was daily feedback provided to parents by the nursing staff and parents were also encouraged to give feedback on the young people when they returned home in the evening.

	The Chair thanked Dr Coaksey and Ms Maseya for an excellent presentation and also thanked them for the work they did.
21/233	**People Strategy Update Report** (agenda item 7.0)
	The Chair welcomed the Director of People. The Director of People presented the paper and highlighted the following points: • Nationally and locally, the NHS continued to face chronic workforce challenges. The Trust's turnover was rising and was now at 14.7%. Staff sickness had also increased and was now at 4.9%. • Workforce shortages meant that the Trust was unable to fill many vacancies, despite additional funding being made available. • The Trust had welcomed its first international nurse with other international nurses planned to arrive in the new year. The Trust had agreed to expand the programme to recruit an additional 20 international nurses during 2022. • 58.5% of the Trust's staff had completed the national NHS Staff Survey which was the highest response rate within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. • The Trust was launching a new Digital Strategy which included looking at Human Resources business processes with the aim of reducing the administrative burden of recruiting staff. • In response to staff feedback at an Executive All Staff Briefing, the Trust was fixing the date staff received their salary from March 2022 rather than paying staff on the last Thursday of the month. • The Trust had run a virtual workshop session which was attended by over 200 staff to try and dispel myths around the COVID-19 vaccination with the aim of encouraging more staff to take up the vaccination before it was mandated for NHS staff. The Chair referred the slide headed "Is there anything that Trust/your manager could have done to support you to remain with the Trust?" (page 31 of the agenda pack) and commented that the highest number of staff had sighted "flexible working" and asked for more information. The Chief Executive reported that the results of the NHS National Staff Survey showed that on the whole, staff viewed the Trust as being good at offering flexible working where this was operationally feasible but reiterated that for some roles it was more difficult to provide opportunities for flexible working. . The Director of People said that managers were encouraged wherever possible to resolve requests for flexible working at the local level. The Chief Executive said that Health and Care organisations were not only competing with each other for staff but were also losing staff to other areas where there were staff shortages, such as hospitality. The Chair commented that the workforce pressures would not easily be solved and therefore the Trust needed to be innovative in its thinking. The Chair commented that staff were working in very challenging circumstances with both staff shortages and meeting the demands of the COVID-19 pandemic and asked whether the Trust was doing all it could to support staff.

	The Director of People said that the Trust could potentially do more to support staff wellbeing but the increased demands of services meant that many staff were too busy to be able to take time out to support their wellbeing. The Director of People said that she would be happy to brief the Board on the Trust's staff wellbeing work at a future meeting. **Action: Deputy Chief Executive/Director of People** Mark Day, Non-Executive Director and Non-Executive Director Lead for Staff Wellbeing commented that he was impressed by the flexible approach the Trust was taking to its Staff Wellbeing offer which was tailored to meet the needs of individuals and teams. The Chair commented that it was important that the Trust did everything it could to reduce the bureaucratic burden on staff to enable them to focus their efforts on patient care. Naomi Coxwell, Non-Executive Director asked about the likely impact on the Trust of mandated staff COVID-19 vaccinations. The Director of Nursing and Therapies reported that the Trust had robust plans in place to prepare for mandated staff COVID-19 vaccinations. Rajiv Gatha, Non-Executive Director noted that the main reason staff gave for leaving the Trust was relocation and asked whether this was because staff were moving to areas where the cost of living was lower. The Director of People said that for some staff this was around moving to a less expensive area but other staff ticked the relocation box when they were moving to another clinical site. The Director of People reported that the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System had commissioned some research into retention and the impact of the cost of living to see if there was more that could be done to address key issues such as the affordability of housing. The Chair reported that he had attended the Trust's new Ready for Change Programme and he said that as well as being an excellent training course, it also provided a useful opportunity to meet a cross section of front line staff and to hear about their experiences of working at the Trust. The Chair suggested that other Non-Executive Directors may like to attend the programme. **Action: Company Secretary** The Chair thanked the Director of People for her update. **The Trust:** noted the report.
21/234	**Freedom to Speak Up Guardian's Six Monthly Report** (agenda item 8.1)
	The Chair welcomed Mike Craissati, Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian presented the paper and highlighted the following points: • It was important that the Freedom to Speak Up role was visible and accessible to staff. The Freedom to Speak Up Communications Plan outlined how this would be achieved. The Communications Plan included: information on the Trust's Intranet (called NEXUS); presentations at management/team meetings; posters, leaflets etc.; Freedom to Speak Up slots at corporate, junior doctors and student's

induction programmes; and there was a Freedom to Speak Up slot at the Essential Knowledge of New Managers training programme
- The Freedom to Speak Up Guardian supported all the Staff Networks as an Ally
- The Freedom to Speak Up Guardian was a member of the Safety Culture Steering Group, Organisational Development Steering Group, Diversity Steering Group and was the Co-Lead for the Microaggressions and Bullying and Harassment workstreams for the Black and Asian Minority Ethnic Minority Transformation Group
- The Freedom to Speak Up Guardian was also the Chair of the South East Regional Freedom to Speak Up Guardian Network
- The total number of Freedom to Speak Up cases raised for full year 2020-21 to date was 31. Of the 31 cases, 70% were from staff within the Nursing Directorate.
- There were only five cases which had an element of patient safety.
- A key focus of the Freedom to Speak Up Guardian was around creating a culture where all staff felt able speak up and felt valued for doing so. This aspiration was dependent upon the Trust showing that it was listening and taking staff concerns seriously. Giving feedback was one important way the Trust could demonstrate that it valued staff speaking up.
- The All Staff Executive Briefings which were introduced at the start of the COVID-19 pandemic had provided a useful mechanism for two-way communication between staff and the Executive but there was still more that could be done to improve communication.
- Further work was needed to develop a Listening Up culture and to improve communication and feedback to those who raised concerns, including timescales and expectations around outcomes.
- All those who contacted the Freedom to Speak Up Guardian were asked to complete a feedback form outlining their experience of the process and how they felt they were supported (or otherwise). A selection of the feedback responses was included in the report
- As requested by the Board, the report also included some anonymised examples of follow up actions from the cases raised. This included two services which now had additional support from a multi-disciplinary team/organisational development team to assist the Heads of Service with improving morale, behaviours and efficiency of the service.

The Freedom to Speak Up Guardian reported that he had attended the Making It Right training event yesterday and one of the delegates had expressed frustration that the actions in response to them raising a concern with the Guardian had not been implemented.

David Buckle, Non-Executive Director commented that the Trust's small number of cases which had an element of patient safety was reflected nationally. Dr Buckle said that he had a slight worry that the national Freedom to Speak Up Guardian role had been introduced to make it easier for staff to raise patient safety concerns following the inquiry into Mid Staffordshire NHS Foundation Trust but the focus was now on bullying and harassment issues. Dr Buckle asked whether the Freedom to Speak Up Guardian linked into the Trust's Patient Safety and Safety Culture work.

The Director of Nursing and Therapies said that the Freedom to Speak Up Guardian was a member of the Patient Safety Steering Group very involved in the Trust's Civility and Safety Culture work.

The Freedom to Speak Up Guardian said that there were alternative routes in the Trust for staff to raise patient safety concerns. The Director of Nursing and Therapies said that staff

	could raise clinical concerns directly with the Medical Director, Chief Executive and with herself. Rajiv Gatha, Non-Executive Director referred to the feedback form (page 49 of the agenda pack) and noted that out of 9 responses, 5 staff had indicated that their concern had only been partially addressed and asked for an explanation. The Freedom to Speak Up Guardian explained that this was often down to the individual having a higher expectation about the outcome of them raising a concern Mark Day, Non-Executive Director Lead for Freedom to Speak Up said that Non-Executive Directors were very keen to support the work of the Freedom to Speak Up Guardian and suggested that it would be helpful if future reports provided more targeted examples of where the learning was not necessarily taken on board. **Action: Freedom to Speak Up Guardian** The Chief Executive pointed out that he attended the Corporate Induction sessions and encouraged staff to speak up. It was also noted that the Chief Executive, Director of Nursing and Therapies and Deputy Director of People met with the Freedom to Speak Up Guardian to discuss the issues raised with him. Mr Day commended the Freedom to Speak Up Guardian for his work both within the Trust and in his role Chair of the South East Regional Freedom to Speak Up Guardian Network. On behalf of the Board, the Chair endorsed Mr Day's comments and thanked the Freedom to Speak Up Guardian. The Chair also commented that the more he met with staff the more he was aware that sometimes it was relatively small issues which were easily resolved which had a big impact on staff. **The Trust Board**: a) Noted the report. b) Supported the Freedom to Speak Up Guardian's recommendations: • Supported and encouraged initiatives to address "Staff Experience" concerns, specifically those that included an element of bullying and harassment and those concerns that may affect Network members. • Supported and encouraged initiatives to improve a Listening Up culture, so that all staff would feel more able to challenge in a positive way, to encourage positive suggestions that may improve ways of working, the patient experience or efficiencies. In turn this would make raising more traditional Freedom to Speak Up concerns easier and more a part of the culture. • Assist in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so. • Noted, learn, and consider appropriate changes from any feedback given.
21/234	**Quality Assurance Committee – 16 November 2021** (agenda item 8.2)
	a) Minutes of the Quality Assurance Committee held on 16 November 2021 David Buckle, Chair of the Quality Assurance Committee reported that in addition to the standing items, the Committee had received two informative presentations on Single Room and Therapeutic Environment at Prospect Park Hospital and on the Getting It Right

	First Time Programme. It was noted that the Committee had also received an update on the Trust's work on the National Safety Programme, Mental Health Act Function: Governance and Assurance and the Trust's response to the Pascoe Report (stage 2 independent investigation into five deaths from 2011-2015 at Southern Health NHS Foundation Trust). Naomi Coxwell, Non-Executive Director referred to the presentation on single beds at Prospect Park Hospital and asked about the reduction in the number of beds at Prospect Park Hospital as a result of moving to single room accommodation. The Chief Operating Officer confirmed that the bed base at Prospect Park Hospital had been reduced by three beds. **b) Learning from Deaths Quarterly Report** The Medical Director presented the paper and reported that there had been no lapses in care during quarter 2. It was noted that there had been one death due to COVID-19 during the quarter but confirmed that the patient had not acquired COVID-19 whilst in the care of the Trust. The Chair asked whether diversity data was reviewed as part of the Trust's Mortality Review process and if it was, whether there were any Equality, Diversity and Inclusion issues. The Medical Director reported that diversity data was not routinely collected as part of the mortality review process as this was not part of the national guidance on the mortality review processes. The Chair suggested that the Executive consider whether it would be helpful to review diversity data as part of the mortality review systems and processes. **Action: Medical Director** **c) Guardian of Safe Working Practices** The Medical Director confirmed that there were no exception reports during the reporting period. The Chair thanked Dr Buckle and the Medical Director for their updates. **The Trust Board noted**: a) The minutes of the Quality Assurance Committee held on 16 November 2021 b) The Learning from Deaths Quarterly Report and c) The Guardian of Safe Working Practices Quarterly Report.
21/235	**Executive Report** (agenda item 9.0)
	The Executive Report had been circulated. The following issues were discussed further: **a) Staff Vaccination Programme 2021 – December 2021 Update** The Chair apologised that the Staff Vaccination Programme December 2021 Update had inadvertently been omitted from the Executive Report. The Company Secretary had updated the Executive and had re-circulated the agenda pack.

	The Director of Nursing and Therapies reported that as at 3 December 2021, 58.7% of staff had received a flu vaccination and 42.1% had received their COVID-19 booster (not all staff were eligible for a COVID-19 booster if they had received their second COVID-19 vaccination less than three months ago). Aileen Feeney, Non-Executive Director asked how the uptake of the flu vaccination compared with the position last year. The Director of Nursing and Therapies reported that around 70% of staff had their flu vaccination in 2020. It was noted that the staff flu vaccination campaign would run until the end of December 2021. The Chief Executive reported that NHS England had declared a level 4 national incident in response to the rapidly rising number of Omicron cases and the Trust had been asked to contribute to the national COVID-19 booster campaign by running a public vaccination centre at Wokingham Hospital. **b) New Patient Experience Measure** Mark Day, Non-Executive Director commented that he was pleased that the Trust's new Patient Experience Measure was now up and running from 1 December 2021 and requested that an update in the next Patient Experience Report on how it was operating and what insights and changes it was bringing. **Action: Director of Nursing and Therapies** **The Trust Board**: noted the paper.
21/236	**Month 07 2121-22 Finance Report** (agenda item 10.0)
	The Chief Financial Officer presented the paper and highlighted the following points: • The Trust had submitted its financial plan for the remainder of 2021/22. The forecast was for a breakeven position for the year overall. Income and expenditure plans for the remainder of H2 (second half of the financial year) had been adjusted to reflect run rates from H1 (first half of the financial year), resulting in the lowering of anticipated workforce growth and recognised investment income. • The Trust was reporting a surplus of £0.6m to the end of October 2021. This was £1.1m better than planned. The financial performance in October 2021 was a £0.4m deficit. • The October 2021 workforce charts in the financial report reflected the transfer of the Trust's Estates and Facilities staff to NHS Property Services from the 1st October 2021. • The Trust continued to defer investment income due to workforce availability. • Planned capital expenditure year to date was £2.6m. This was £2.4m less than planned. £1.0m of this related to delayed IM&T procurement which had since occurred. • Cash balances remained strong at £47.4m • NHS England/Improvement had indicated that the profit on the sale of 3-5 Craven Road, Reading would not count towards the Trust's System control total, but the Trust was still planning for a break-even position at year end. • The Trust continued to experience financial pressure in relation to an increase in the number of out of area placements • The national planning guidance for 2022-23 was expected to be published on or around 24 December 2021. It was expected that the planning cycle would revert

	back to a full year financial planning. An update the planning guidance would be presented to the next Trust Board meeting. **Action: Chief Financial Officer** The Chair referred to the workforce slide on page 103 of the agenda pack which showed a reduction in the forecasted number of staff and asked for more information. The Chief Financial Officer explained that the forecasted number of staff had been revised to bring it in line with the actual number of staff. It was noted that the Trust was discussing how to manage the deferred income from not being able to recruit staff with the Commissioners. Naomi Coxwell, Non-Executive Director noted that back in July 2021, the Trust had purchased an additional 8 acute beds and 5 psychiatric intensive care unit beds and were now looking to purchase an additional 6 beds and asked about the timescale for these beds. The Chief Financial Officer explained that the additional beds were being paid for from central COVID-19 funding and were contracted until the end of the financial year. The Chief Financial Officer said that given the current pressure on beds, the Trust needed to model the out of area placement requirement trajectory as part of the development of the financial plan for 2022-23. The Chief Operating Officer reported that the Trust's Bed Optimisation Group met weekly and had developed a number of actions to improve flow. The Trust was also working with Oxford Health NHS Foundation Trust and Surrey and Borders NHS Foundation Trust to see if there was anything further that could be done collectively to manage the increased demands on beds. **The Trust Board:** noted the report.
21/237	**Month 07 2121-22 "True North" Performance Scorecard Report** (agenda item 10.1)
	The Month 07 "True North" Performance Scorecard had been circulated. The Chair referred to page 135 of the agenda pack and noted that the regulatory compliance – system oversight framework indicators were greyed out. The Chief Financial Officer explained that these would be defined nationally and would be received in time for the next financial year. **The Trust Board:** noted the report.
21/238	**Board Vision Metrics Report** (agenda item 8.2)
	The Chief Financial Officer presented the paper and reported that the Finance, Investment and Performance Committee would be reviewing the Board Vision Metrics at their meeting in January 2022. The Chair commented that the Board Vision Metrics enabled the Board to have a step back and have an overview of the Trust's performance. The Chair said that it was positive that so many of the metrics were RAG rated green.

	The Trust Board: noted the report.
21/239	**Strategy Implementation Plan Update Report** (agenda item 11.1)
	The Strategy Implementation Plan Update Report had been circulated. The Chair commented that the small font of the tabular format of the report was difficult to read. The Deputy Chief Executive reported that the report would revert back to a narrative format. The Deputy Chief Executive said that the key points were highlighted in the cover sheet. **Action: Deputy Chief Executive** **The Trust Board**: noted the report.
21/240	**Council of Governors Update** (agenda item 12.0)
	The Chair reported that he continued to hold informal "coffee morning" sessions with the governors and said that the governors were very supportive of the Trust. The Chair reported that the Council of Governors meeting on 1 December 2021 had received two excellent service presentations about Neurodiversity and on the Trust's work to ensure that people with severe mental illness received physical health checks The Chair reported that the Director of Nursing and Therapies had provided some helpful guidance for Governors in relation to their visits to services. The Chief Executive said that NHS England/Improvement had declared a level 4 incident due to the rapidly rising number of Omicron cases and therefore in person service visits by governors would need to be paused. The Chief Executive proposed that Executive and Non-Executive Director in person service visits would continue.
21/241	**Trust Seal Report** (agenda item 12.1)
	The Chief Financial Officer reported that the Trust's seal had been affixed to a document transferring a small parcel of land (40m2) from Royal Berkshire NHS Foundation Trust to BHFT at nil cost, which lies within the planning application and sale site of 3-5 Craven Road, Reading. The Chief Financial Officer reported that unfortunately the original buyer for the 3-5 Craven Road building had pulled out of the sale. It was noted that the Trust was now reviewing an alternative bid. The Chief Executive asked whether there were any advantages in delaying the sale until the next financial year. The Chief Financial Officer said that it was unlikely that any profit on the disposal would count towards the system control total for the next financial year. The only benefit would be an increase in the capital allocation that would be available to the system. The Chief

	Financial Officer reported that the Trust was in discussions with NHS England/Improvement about the accounting arrangements for the disposal. **The Trust Board**: noted the report.
21/242	**Any Other Business** (agenda item 13)
	There was no other business. The Chair wished everyone a merry Christmas and a happy new year.
21/243	**Date of Next Public Meeting** (agenda item 14)
	The next Public Trust Board meeting would take place on 08 February 2022.
21/234	**CONFIDENTIAL ISSUES:** (agenda item 15)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 14 December 2021.

Signed……. Date 08 February 2022

(Martin Earwicker, Chair)

Berkshire Healthcare NHS
NHS Foundation Trust

CAMHS PHOENIX UNIT - TIER 4 HOSPITAL AT HOME SERVICE

Dr Joanne Cocksey, Principal Clinical Psychologist
Natasha Maseya, Social Worker

Healthcare from the heart of your community

What is Phoenix Unit?

- Day hospital and home treatment service for young people aged 12-18 years of age with moderate to severe and complex mental health disorders whose needs can not be adequately met within community and outpatients settings ("tier 4 CAMHS").

- New service developed in collaboration with NHS England and Oxford Health NHS Foundation Trust in line with national evidence of hospital at home and intensive community treatment models.

- Open 8am – 8pm Monday to Friday; 9am – 5pm weekends and bank holidays.

- Opened 1st May 2021.

The multidisciplinary team

- Service manager
- Consultant psychiatrists
- Clinical psychologists and assistant psychologists
- Family and systemic psychotherapist
- Occupational therapist
- Social worker
- Dietician
- Nursing team (qualified nurses and clinical support workers)
- Activities co-ordinator
- Teachers and education staff

What do we offer?

- Average length of stay is 12 weeks
- Multidisciplinary assessment, formulation of difficulties and diagnosis
- Evidence-based individual, group and family therapies
- Medication initiation and monitoring
- Nursing support
- Meal planning, meal supervision, dietetic advice
- Social care advice, support and liaison
- Education support and onsite school
- Joint work and liaison with other professionals, including community CAMHS care teams, particularly around discharge planning

Patient Timetable CAMHS Tier 4 Hospital at Home Service – Aug 2021

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15	ARRIVAL 08:15
	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15	BREAKFAST 08:30 – 09:15
	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30	POST MEAL SUPPORT 09:15 – 09:30
	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30	SCHOOL 09:30 -10:30
	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00	BREAK /SNACK 10:30 – 11:00
	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15	SCHOOL 11:00 – 12:15
	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30	LUNCH PREP 12:15 – 12:30
	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15
	POST MEAL SUPPORT / 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT / 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00	POST MEAL SUPPORT/ 1-2-1 SESSIONS SLOTS 13:15- 14:00
	SCHOOL 14:00 – 15:00	MANAGING MOODS (10.08.2021) 14:00 – 15:00	SCHOOL 14:00 – 15:00	MANAGING MOODS 14:00 – 15:00	Wellbeing Activity 14:00 – 15:00
	BREAK /SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30	BREAK / SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30	BREAK /SNACK 15:00-15:30
	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45
	Motivation and Resilience Group (Start: 16/09/2021) 15:45-17:00	Food and Nutrition Group (ED)/ other (Start 10.08.2021) 15:45-17:00 1-2-1 SESSIONS SLOTS	Parents Group Non-ED / OT Related Group (TBC mid sept) 15:45-17:00	Advocacy/ Community Meeting (Alternate Fortnightly) 15:45-17:00 1-2-1 SESSIONS SLOTS	The Weekend Group 15:45-17:00
	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 -18:00	Wellbeing Activity 17:00 – 18:00	Wellbeing Activity 17:00 – 18:00
	1-2-1 FT SESSIONS SLOTS	Parents Group ED 18:00-19:30 (07/09/2021)	1-2-1 FT SESSIONS SLOTS	1-2-1 FT SESSIONS SLOTS	
	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00	DINNER 18:00- 17:00
18:45	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT	POST MEAL SUPPORT

WEEKEND	SUPPORT-	HOME/DIGITAL
	BREAKFAST 09:15-09:45	BREAKFAST 09:15-09:45
	POST MEAL SUPPORT/ 1-2-1 09:45-10:15	POST MEAL SUPPORT/ 1-2-1 09:45-10:15
	WELLBEING ACTIVITY / COPING SKILLS & STRATERGIES 10:15 – 12:30	WELLBEING ACTIVITY/ COPING SKILLS & STRATERGIES 10:15 – 12:30
	LUNCH 12:30 – 13:15	LUNCH 12:30 – 13:15
	POST MEAL SUPPORT/ 1-2-1 13:15 – 14:00	POST MEAL SUPPORT/ 1-2-1 13:15 – 14:00
	WELLBEING ACTIVITY 14:00 -15:00	WELLBEING ACTIVITY 14:00 – 15:00
	BREAK / SNACK 15:00-15:30	BREAK / SNACK 15:00-15:30
	POST MEAL SUPPORT 15:30 -15:45	POST MEAL SUPPORT 15:30 -15:45
	COPING STRATERGIES & EVENING MEAL PREP 15:45 – 16:45	COPING STRATERGIES & EVENING MEAL 15:45 – 17:00
	HOME 16:45	HOME 16:45

Key: Groups highlighted in yellow

1-2-1 SLOTS ARE Bookable For Nursing / Psychology/ OT / FT/ Doctor via the 1-2-1 booking sheet

Examples of young people attending

- Young person with anorexia, significantly underweight and losing weight in the community despite regular support
- Young person with severe emetophobia (vomit phobia) and obsessive-compulsive disorder whose life became so restrictive that they were not able to leave the house
- Young person with high levels of anxiety, perceptual disturbances (seeing figures, hearing voices), strong suicidal thoughts and impulses, struggling to maintain adequate functioning in the community; diagnosis unclear
- Young person with severe depression, spending all of their time in their bedroom, not socialising or attending school, possible autism

Such young people would usually be referred to a 24/7 inpatient unit

Example journey through the service

Young person with severe emetophobia (vomit phobia) and obsessive-compulsive disorder whose life became so restrictive that they were not able to leave the house

- Referral to CAMHS following admission to general hospital with stomach pains, reduced food intake and weight loss
- Assessment with CAMHS Rapid Response Team – referred to CAMHS Anxiety and Depression (A&D) Team for treatment of emetophobia and OCD symptoms
- Young person struggles to engage with individual cognitive-behavioural therapy but family attend family therapy. Weight increases to healthy range but anxiety and symptoms remain high and impairing.
- OCD symptoms start to worsen, young person out of education for two years, not leaving the house, simple tasks taking hours, food restriction returns
- A&D Team refer to CAMHS Phoenix for more intensive support. Young person engaged in individual, group and family therapy, starts medication and starts to make progress.

Example journey through the service

Young person with high levels of anxiety, perceptual disturbances (seeing figures, hearing voices), strong suicidal thoughts and impulses, struggling to maintain adequate functioning in the community; diagnosis unclear

- GP referral to CAMHS for high levels of anxiety and agitation
- Crisis calls from family into CAMHS. Young person assessed by CAMHS Getting Help Team but needs deemed more significant so young person referred to specialist CAMHS for intervention.
- Perceptual disturbances reported, increased agitation, functional symptoms, crisis calls and presentations to A&E due to high levels of agitation and confusion and young person reporting suicidal ideation. Seen by Early Intervention in Psychosis Service but assessment concluded not psychotic.
- Referral to CAMHS Phoenix to support with stabilising presentation, assessing and improving mental state and decreasing risk to self. Young person engages well and makes improvements.

Feedback from young people

When I first arrived at CAMHS Phoenix, I was very anxious and scared. Though it was a lot to get used to, the staff and patients were really friendly and supportive. The more I spent time at CAMHS Phoenix, the easier it was for me to fit in and feel safe. Since coming to CAMHS Phoenix, I have learnt to grow in myself and look past my anxiety. The group sessions and activities have really helped me know how to use strategies that can be life changing. Overall, my experience here has given me hope and a fulfilling future.

*Safia, age 17y
*pseudonym

Feedback from young people

Before I arrived at Willow House, I was really nervous, with no idea of what to expect and I was dreading coming. My first day was pretty daunting, it was a bit like being at a new school, but I was surprised how quickly I made friends.

The best thing about Willow House is the staff. From the nurses to the psychologists to the therapists, they are all so kind and do everything they can to help you settle in.

Whilst I miss my normal school and friends, I know I'm in the right place to help me get better.

*Emma, aged 15y

*pseudonym

Thank you

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 08/02/2022

Board Meeting Matters Arising Log – 2022 – Public Meetings

Key:

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

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit Reports as part of the Patient Experience Report.	February 2022	**DF**	Included as part of the Patient Experience Report which is on the agenda for the meeting.	
13.07.21	21/130	Vision Metrics	The Vision Metrics to be expanded to include System performance.	March 2022	**PG**	To be reviewed by the Finance, Investment and Performance Committee.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
14.12.21	21/233	People Strategy	The Trust Board to receive an update on the Trust's staff wellbeing work.	February 2022	**AG/JN**	On the agenda for the meeting.	
14.12.21	21/233	People Strategy Update Report	The Company Secretary to find out dates of future Read for Change Programme training sessions and inform Non-Executive Directors.	February 2022	**JH**	The Company Secretary has emailed the booking enrolment link to the Ready for Change Programme.	
14.12.21	21/234	Freedom to Speak Up Guardian Report	Future reports to provide more targeted examples of where the learning from concerns raised had not been fully implemented.	July 2022	**MC**		
14.12.21	21/235	Quality Assurance Committee	The Executive to consider whether it would be helpful to review diversity data as part of the mortality review process.	February 2022	**MI**	The current national guidance on Learning from Deaths does not require trusts to collect EDI data for the deaths which are scrutinised locally. In the context of BHFT, majority of deaths are for the elderly and end of life care patients and EDI analysis of these may not contribute to	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						additional learning. At the same time, some of the national reviews/ reports on deaths have EDI characteristics included and these are available to our Trust Mortality Review Group for learning. Specifically, for deaths of people with a Learning Disability (which are all reviewed by LeDeR), all people from an ethnic minority background will receive a focussed review and this will also be extended to deaths of people with autism. The national confidential inquiry into suicide looks at	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						EDI in its national reports . Child Death Overview Panel national reports also report on EDI.	
14.12.21	21/235	Executive Report	The Patient Experience Report to include an update on the new Patient Experience Measure	February 2022	**DF**	Included as part of the Patient Experience Report.	
14.12.21	21/236	Finance Report	An update on the new national planning guidance to be presented to the Trust Board.	February 2022	**PG**	On the agenda for the In Committee meeting.	
14.12.21	21/240	Strategy Implementation Plan	Future reports to revert back to a narrative rather than a tabular format.	February 2022	**AG**	On the agenda for the meeting	

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Meeting

Board Meeting date	8th February 2022
Title	NHS Community Mental Health Benchmarking report 2021
	ITEM FOR NOTING
Purpose	To provide information collated through the annual mental health survey in relation to patient experience of mental health services.
	For Noting
Business Area	Nursing and Governance
Author	CQC
Relevant Strategic Objectives	True North goals of Harm free care, Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equalities, Diversity and Inclusion Implications	N/A
SUMMARY	The Community Mental Health Survey is part of the NHS Patient Survey Programme (NPSP) which is commissioned by the Care Quality Commission (CQC). The CQC use the results from the survey in its assessment of mental health trusts in England. The survey which was completed by 27% of eligible patients (national average response rate 26%) showed that when compared with other trusts one of the responses was better than others (Q38. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?) whilst the remaining 27 questions received responses about the same compared with others. We had no scores worse of significantly worse than others. Against our own scores from last year, 1 score was significantly worse (Q17. In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?) with remaining scores being about the same. It should be noted that Q7. 'Were you given enough time to discuss your needs and treatment?' Scored above the national average; it would therefore appear that whilst patients had not always had a specific meeting to discuss their care many more did feel that there was time during their contacts to discuss their needs and treatment. Page 10 of the report details the 5 areas we scored best in against national average and the 5 areas where we scored worst and would want to focus our attention. The areas for focus are: 1. Thinking about the last time you tried to contact this person or team, did you get the help you needed?

	2. Have you had a specific meeting with someone from NHS mental health services to discuss how your care is working? 3. Were these NHS talking therapies explained to you in a way you could understand? 4. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use? 5. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc.)? In relation to the 5th bullet point above, our quality improvement programme of work has supported and continues to support significant improvements in physical health checks for patients with a serious mental health illness within our services. The report has been shared with all relevant services, the Clinical Directors are meeting with their teams to review the results alongside the monthly mental health benchmarking and other available data to agree any areas for incorporating into improvement work.
ACTION REQUIRED	The Board is asked to note the report.

NHS Community Mental Health Survey Benchmark Report 2021

Berkshire Healthcare NHS Foundation Trust

NHS
Care Quality Commission
Survey Coordination Centre

Contents

This work was carried out in accordance with the requirements of the international standard for organisations conducting social research (accreditation to ISO27001:2013; certificate number GB10/80275).

Background and methodology

This section includes:

- an explanation of the NHS Patient Survey Programme
- information on the Community Mental Health Survey
- a description of key terms used in this report
- navigating the report

Background and methodology

The NHS Patient Survey Programme

The NHS Patient Survey Programme (NPSP) collects feedback on adult inpatient care, maternity care, children and young people's inpatient and day services, urgent and emergency care, and community mental health services.

The NPSP is commissioned by the Care Quality Commission (CQC); the independent regulator of health and adult social care in England.

As part of the NPSP, the Community Mental Health Survey has been conducted almost every year since 2004. The CQC use the results from the survey in its assessment of mental health trusts in England.

To find out more about the survey programme and to see the results from previous surveys, please refer to the section on further information on this page.

Community Mental Health Survey

The survey was administered by the Survey Coordination Centre for Existing Methods (SCCEM) at Picker Institute.

The 2021 survey of people who use community mental health services involved 54 providers of NHS community mental health services in England. We received responses from 17,322 people, a response rate of 26.5%.

People aged 18 and over were eligible for the survey if they were receiving care or treatment for a mental health condition and were seen face-to-face at the trust, via video conference or telephone between 1 September 2020 and 30 November 2020. For more information on the sampling criteria for the survey, please refer to the sampling instructions detailed in the 'Further information' section. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between February and June 2021.

Trend data

The Community Mental Health Survey is comparable back to the 2014 survey. Trend data is presented in this report for questions that have been asked in previous survey years.

Further information about the survey

- For published results for other surveys in the NPSP, and for information to help trusts implement the surveys across the NPSP, please visit the NHS Surveys website.
- To learn more about the CQC's survey programme, please visit the CQC website.

Key terms used in this report

The 'expected range' technique

This report shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part. It uses an analysis technique called the 'expected range' to determine if your trust is performing about the same, better or worse compared with most other trusts. This is designed to help understand the performance of individual trusts and identify areas for improvement. More information can be found in the Appendix.

Standardisation

Demographic characteristics, such as age and sex, can influence service users' experience of care and the way they report it. For example, research shows that older people report more positive experiences of care than younger people. Since trusts have differing profiles of service users, this could make fair trust comparisons difficult. To account for this, we 'standardise' the results, which means we apply a weight to individual service user responses to account for differences in demographic profile between trusts. For each trust, results have been standardised by the age and sex of respondents to reflect the 'national' age-sex type distribution (based on all respondents to the survey).

This helps ensure that no trust will appear better or worse than another because of its profile, and enables a fairer and more useful comparison of results across trusts. In most cases this standardisation will not have a large impact on trust results.

Scoring

For each question in the survey, the individual (standardised) responses are converted into scores on a scale of 0 to 10. A score of 10 represents the best possible result and a score of 0 the worst. The higher the score for each question, the better the trust is performing. Only evaluative questions in the questionnaire are scored. Some questions are descriptive (for example Q1) and others are 'routing questions', which are designed to filter out respondents to whom the following questions do not apply (for example Q25). These questions are not scored. Section scoring is computed as the arithmetic mean of question scores for the section after weighting is applied.

National average

The 'national average' mentioned in this report is the arithmetic mean of all trusts' scores after weighting is applied.

Suppressed data

If fewer than 30 respondents have answered a question, no score will be displayed for that question (or the corresponding section the question contributes to).

Further information about the methods

For further information about the statistical methods used in this report, please refer to the survey technical document.

Using the survey results

Navigating this report

This report is split into five sections:

- **Background and methodology** – provides information about the survey programme, how the survey is run, and how to interpret the data.
- **Headline results** – includes key trust-level findings relating to the service users who took part in the survey, benchmarking, and top and bottom scores. This section provides an overview of results for your trust, identifying areas where your organisation performs better than the average and where you may wish to focus improvement activities.
- **Benchmarking** – shows how your trust scored for each evaluative question in the survey, compared with other trusts that took part; using the 'expected range' analysis technique. This allows you to see the range of scores achieved and compare yourself with the other organisations that took part in the survey. Benchmarking can provide you with an indication of where you perform better than the average, and what you should aim for in areas where you may wish to improve.
- **Change over time** – displays your trust score for each survey year. Where available, trend data will be shown from 2014 to 2021. Questions are displayed in a line chart with the trust mean plotted alongside the national average. Statistical significance testing is also shown between survey years (2021 vs 2020 and 2021 vs 2019). This section highlights areas your trust has improved on or declined in over time.
- **Appendix** – includes additional data for your trust; further information on the survey methodology; and interpretation of graphs in this report.

How to interpret the graphs in this report

There are several types of graphs in this report which show how the score for your trust compares to the scores achieved by all trusts that took part in the survey. Additionally, line charts show your trust's trend data over time.

The two chart types used in the section 'Benchmarking' use the 'expected range' technique to show results. For information on how to interpret these graphs, please refer to the Appendix.

Other data sources

More information is available about the following topics at their respective websites, listed below:

- Full national results; A-Z list to view the results for each trust; technical document: http://www.cqc.org.uk/cmhsurvey
- National and trust-level data for all trusts who took part in the Community Mental Health Survey 2021 https://nhssurveys.org/surveys/survey/05-community-mental-health/year/2021/. Full details of the methodology for the survey, instructions for trusts and contractors to carry out the survey, and the survey development report can also be found on the NHS Surveys website.
- Information on the NHS Patient Survey Programme, including results from other surveys: www.cqc.org.uk/content/surveys
- Information about how the CQC monitors hospitals: https://www.cqc.org.uk/what-we-do/how-we-use-information/using-data-monitor-services

Headline results

This section includes:

- information about your trust population
- an overview of benchmarking for your trust
- the best and worst scores for your trust

Who took part in the survey?

This slide is included to help you interpret responses and to provide information about the population of service users who took part in the survey.

1250 invited to take part

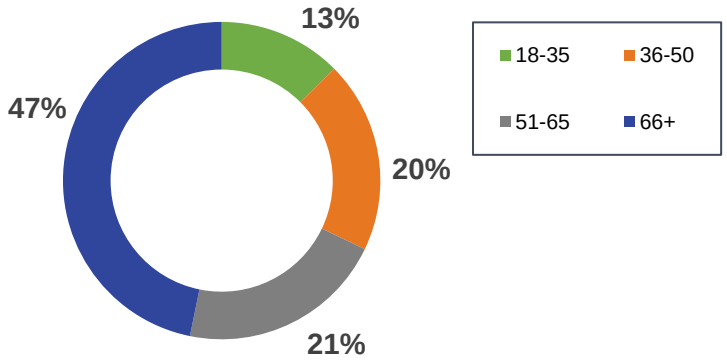
327 completed

27% response rate

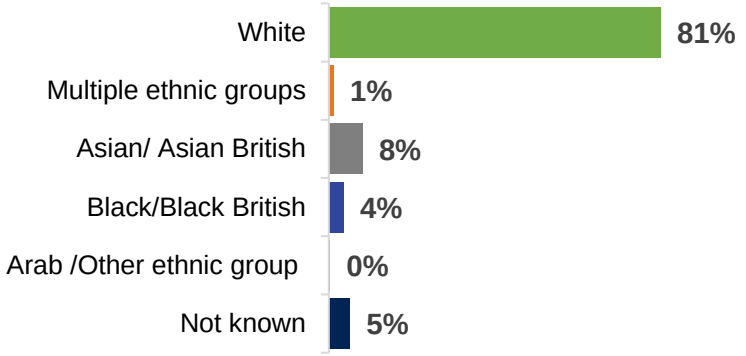
26% average response rate for all trusts

27% response rate for your trust last year

AGE



ETHNICITY



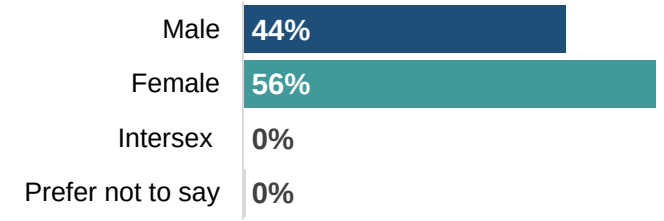
LONG-TERM CONDITIONS

90% of service users have a **physical or mental health condition or illness that has lasted or is expected to last for 12 months or more.**

Number of long-term conditions reported:

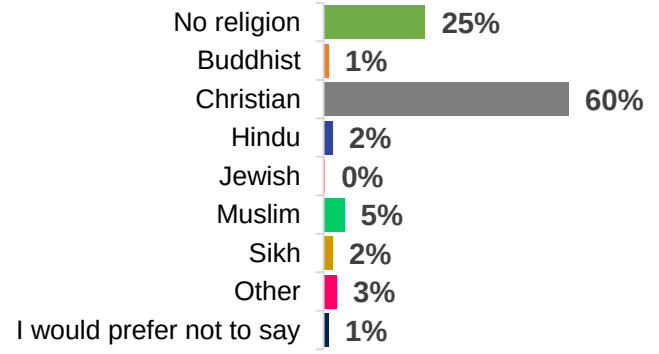
SEX

At birth were you registered as…



1% of service users said their **gender is different from the sex they were registered with at birth**.

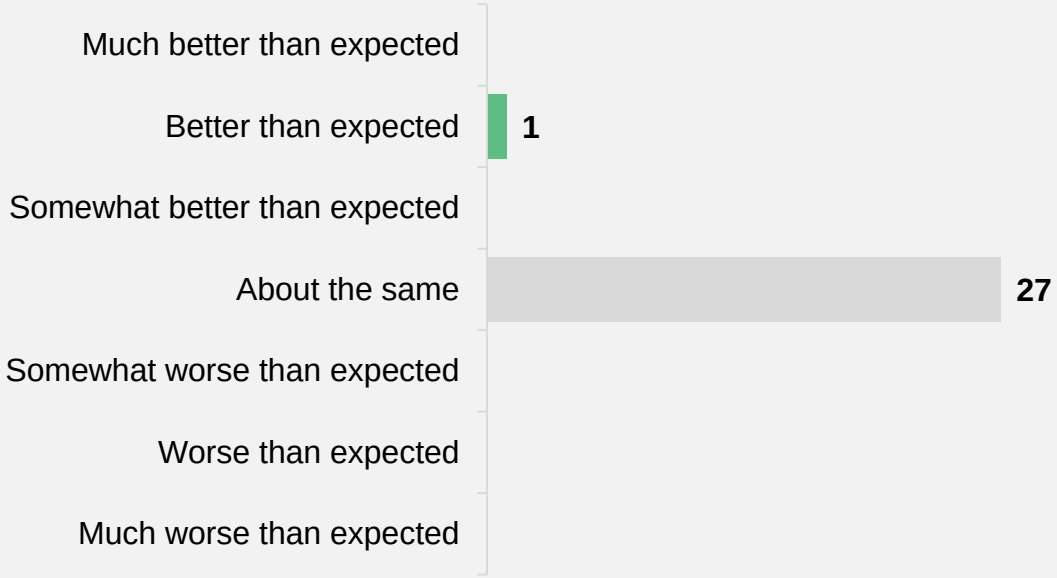
RELIGION



Summary of findings for your trust

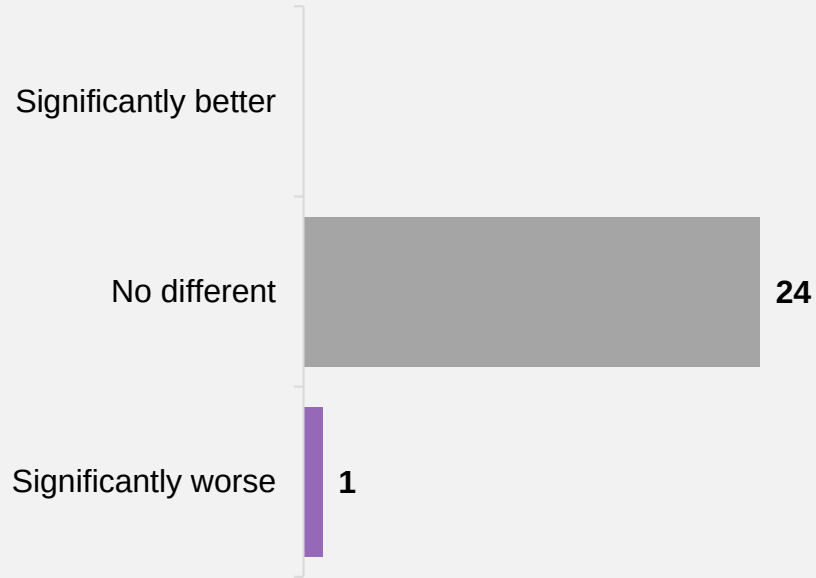
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2021 vs 2020.



For a breakdown of the questions where your trust has performed better or worse compared with all other trusts, please refer to the appendix section "your trust has performed much worse" , "your trust has performed worse" , "your trust has performed somewhat worse", "your trust has performed somewhat better", "your trust has performed better", "your trust has performed much better" .

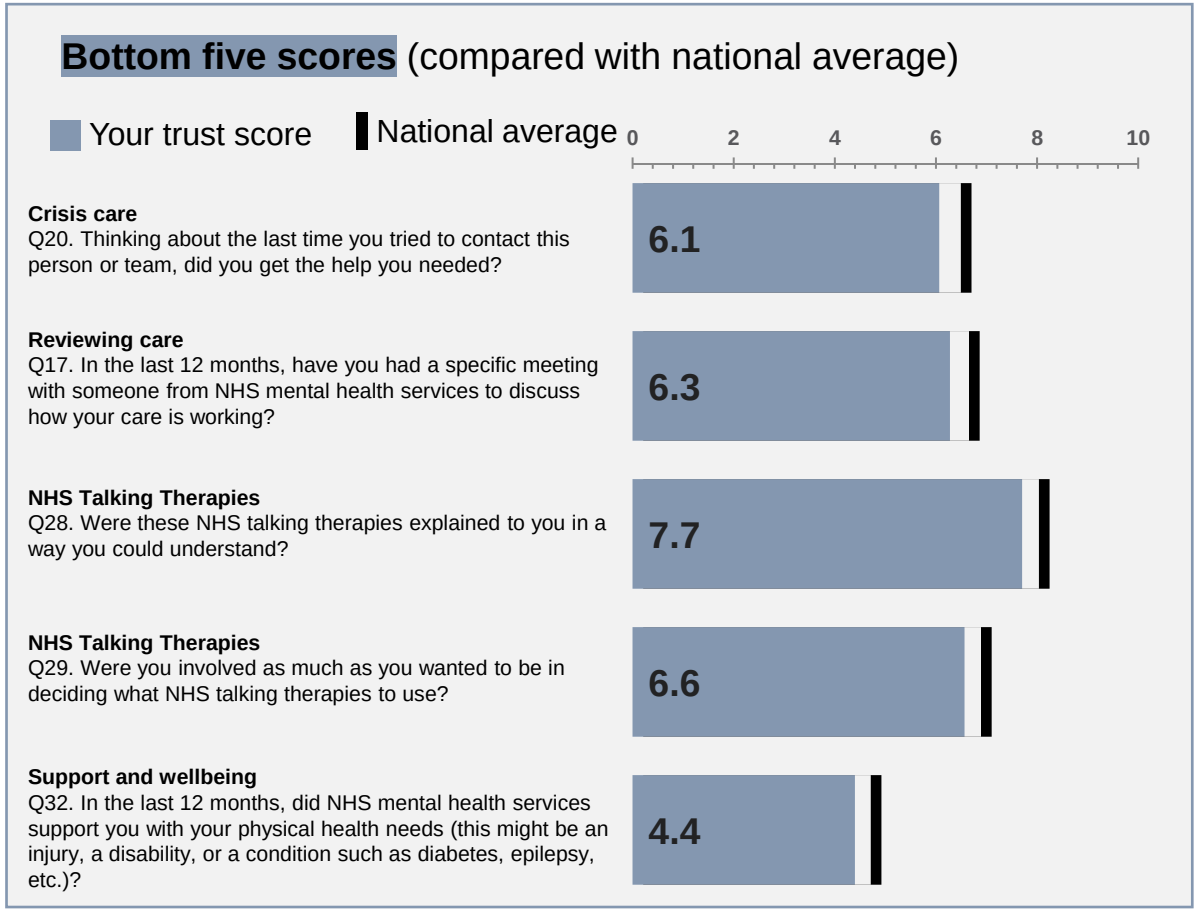
Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the national average.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.

Top five scores (compared with national average)

Bottom five scores (compared with national average)



Benchmarking

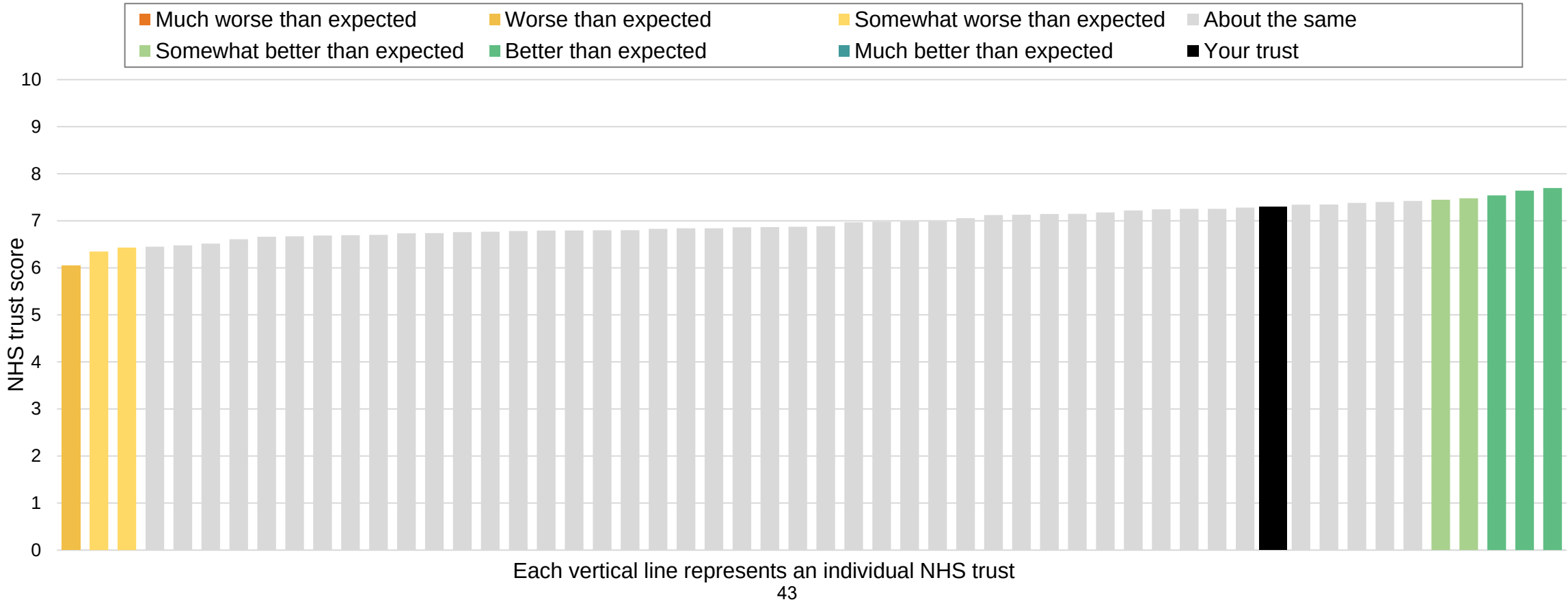
This section includes:

- how your trust scored for each evaluative question in the survey, compared with other trusts that took part.
- an analysis technique called the ‘expected range’ to determine if your trust is performing about the same, better or worse compared with most other trusts.

Section 1. Health and social care workers

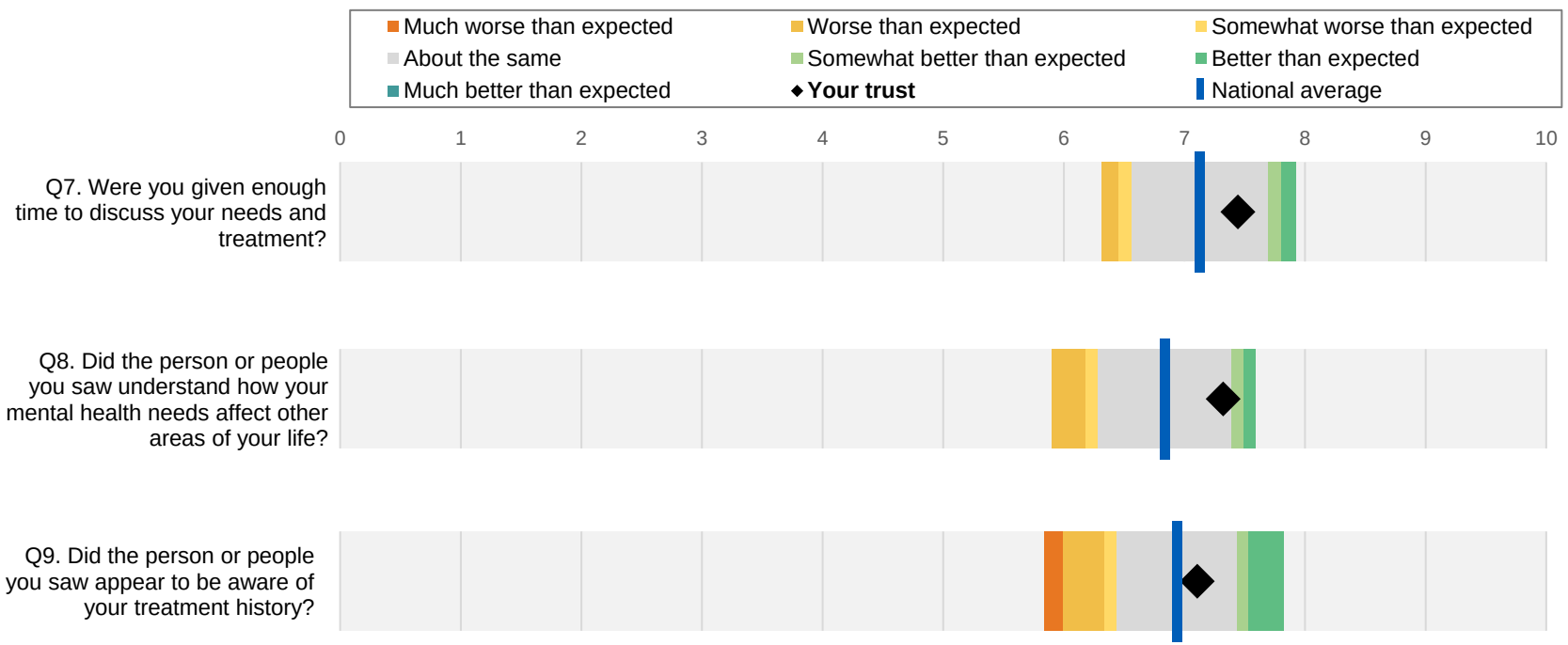
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.3 About the same



Section 1. Health and social care workers (continued)

Question scores



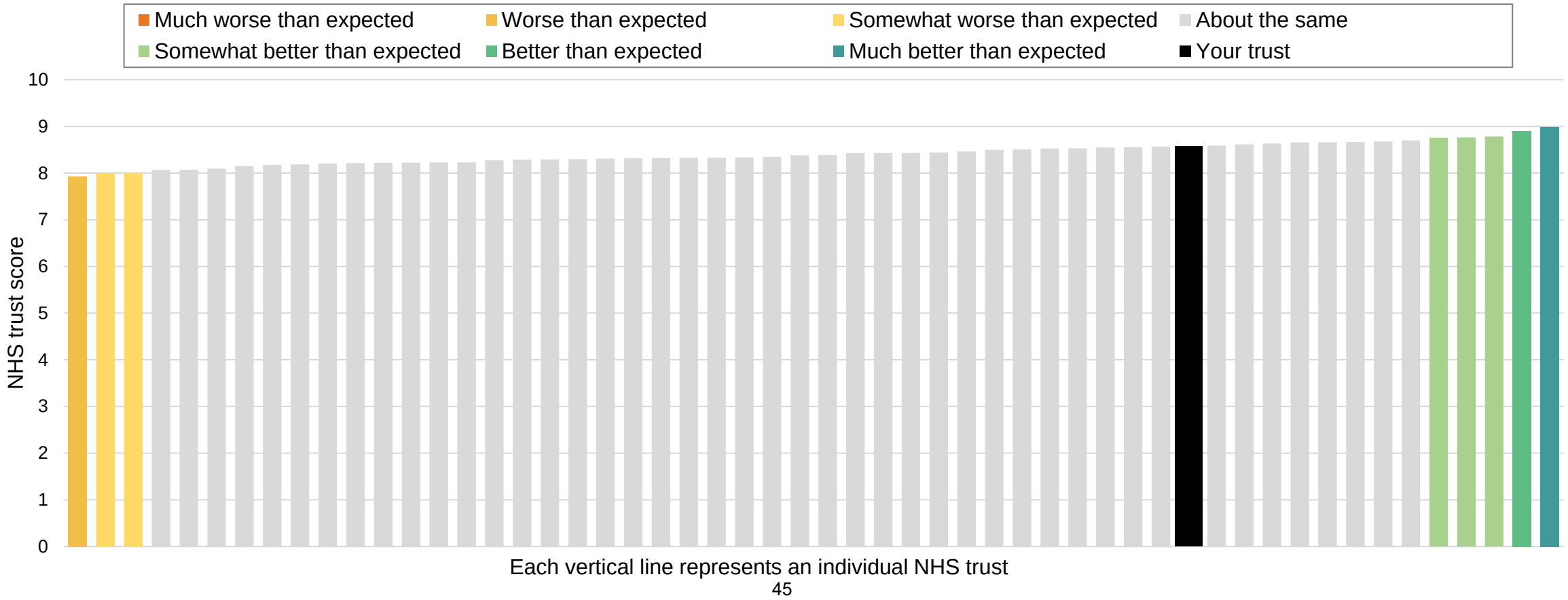
			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q7. Were you given enough time to discuss your needs and treatment?	301	7.4	7.1	6.3	7.9
Q8. Did the person or people you saw understand how your mental health needs affect other areas of your life?	299	7.3	6.8	5.9	7.6
Q9. Did the person or people you saw appear to be aware of your treatment history?	290	7.1	6.9	5.8	7.8

About the same

Section 2. Organising care

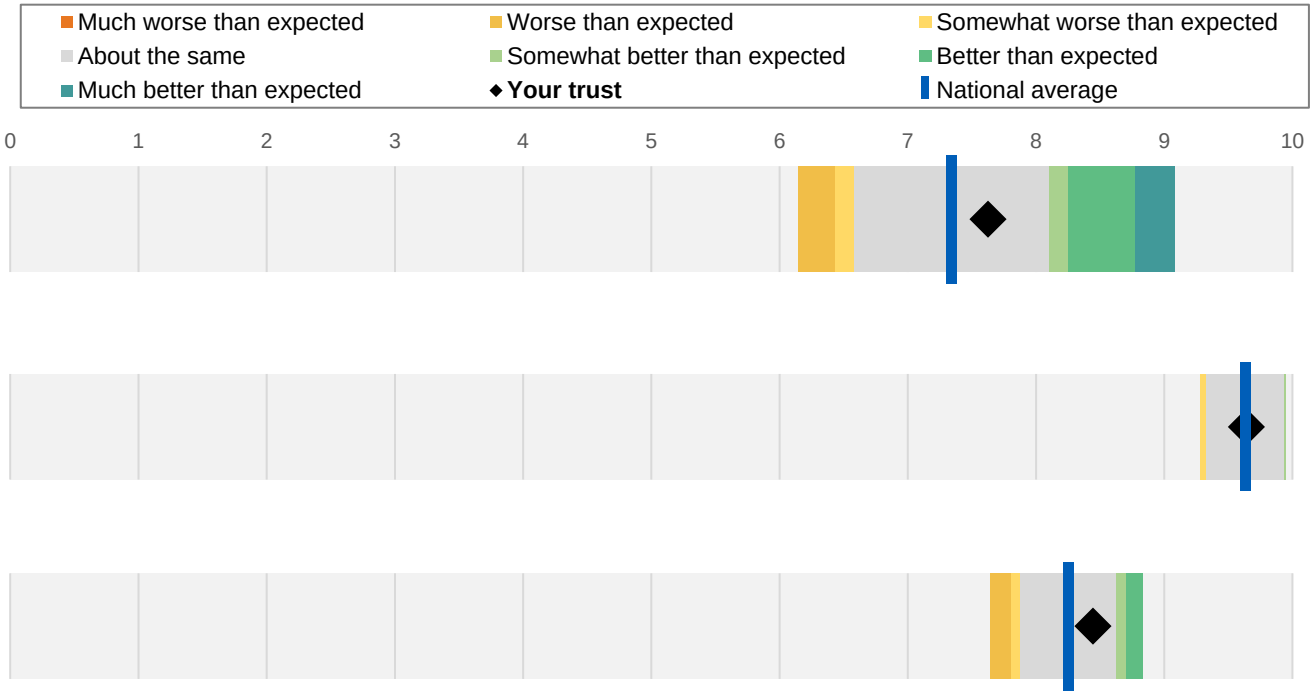
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 8.6 About the same



Section 2. Organising care (continued)

Question scores



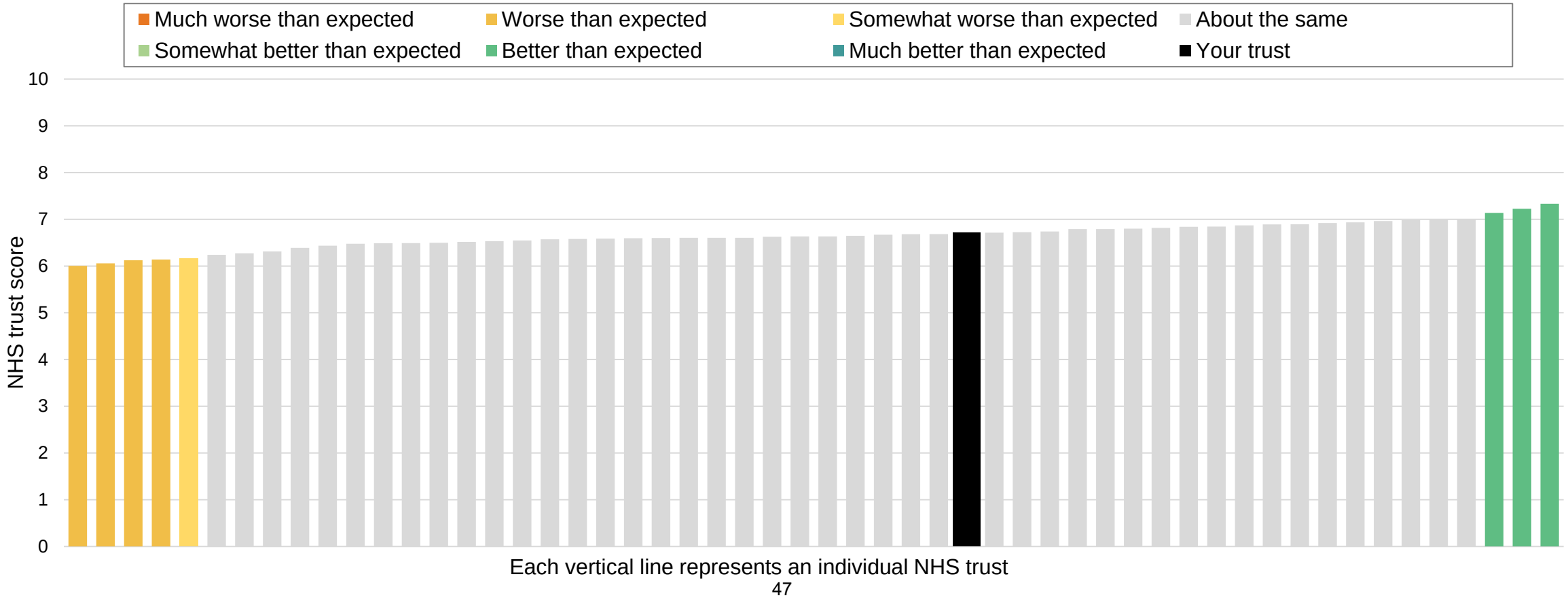
		All trusts in England			
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q10. Have you been told who is in charge of organising your care and services? (This person can be anyone providing your care, and may be called a "care coordinator" or "lead professional").	258	7.6	7.3	6.1	9.1
Q12. Do you know how to contact this person if you have a concern about your care?	139	9.6	9.6	9.3	9.9
Q13. How well does this person organise the care and services you need?	140	8.4	8.3	7.6	8.8

About the same

Section 3. Planning care

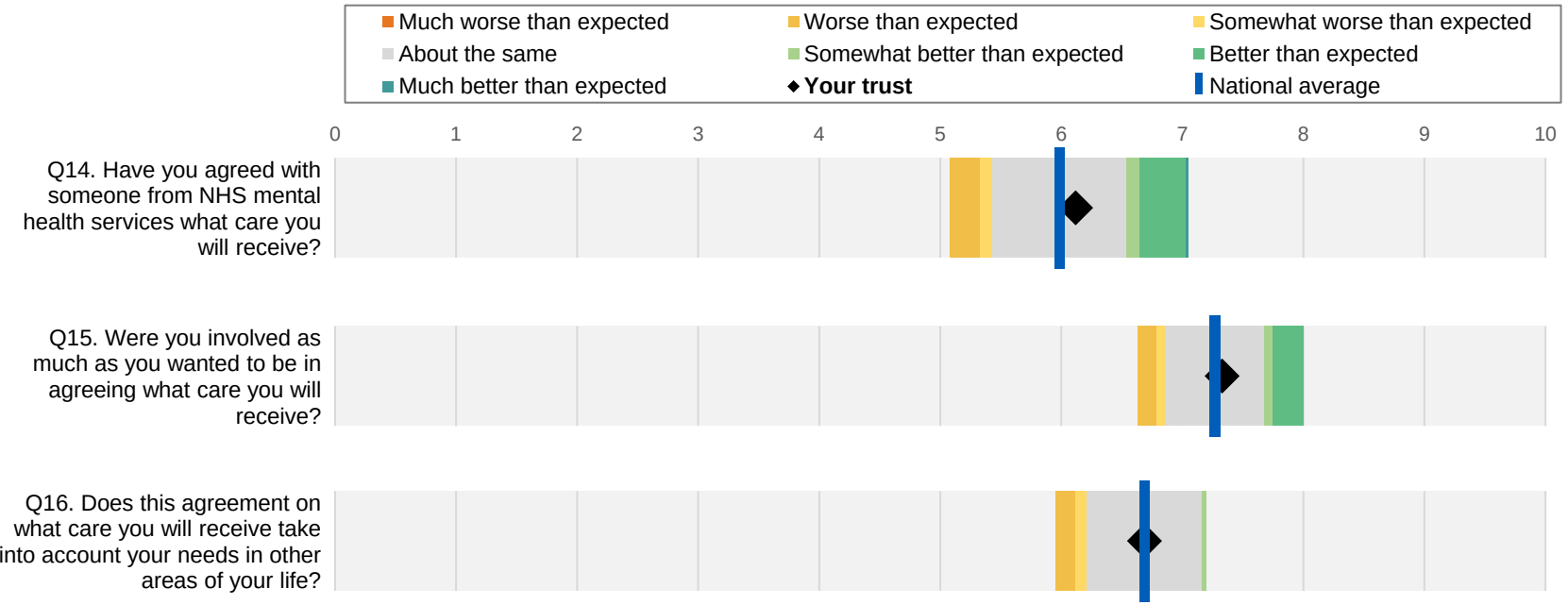
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.7 About the same



Section 3. Planning care (continued)

Question scores



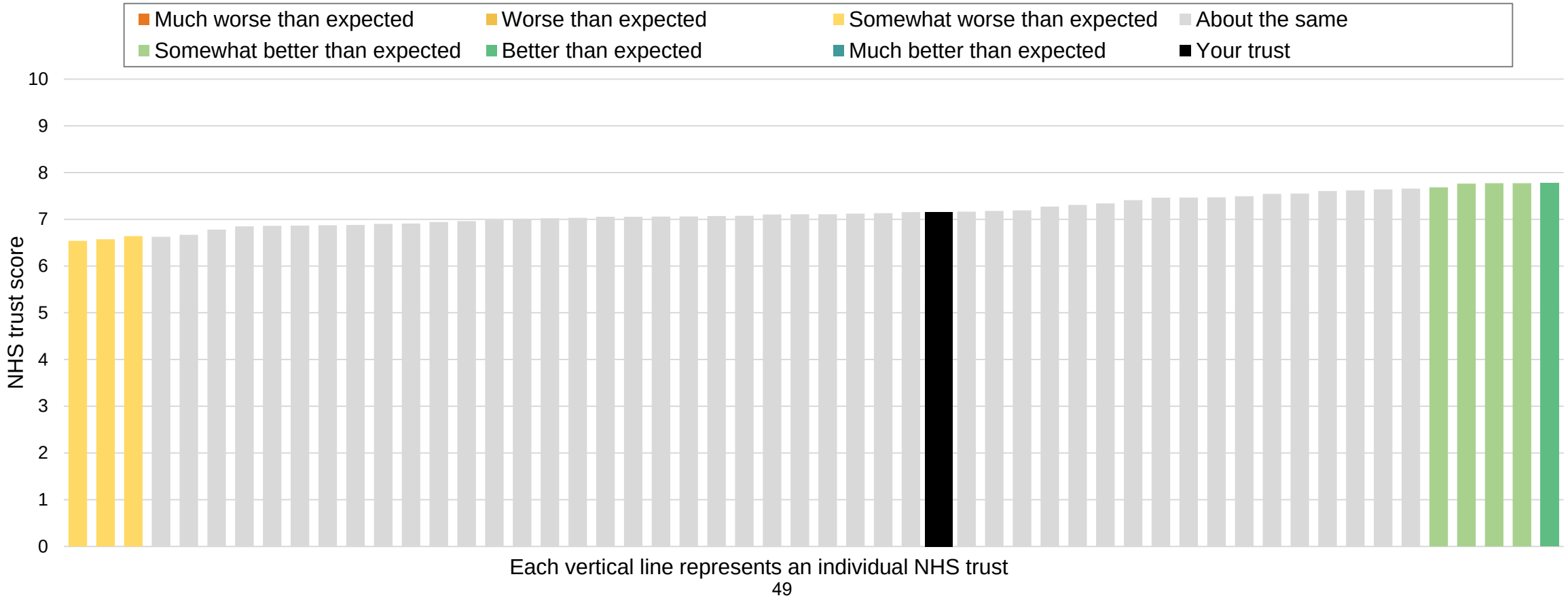
			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
Q14. Have you agreed with someone from NHS mental health services what care you will receive?	319	6.1	6.0	5.1	7.0
Q15. Were you involved as much as you wanted to be in agreeing what care you will receive?	240	7.3	7.3	6.6	8.0
Q16. Does this agreement on what care you will receive take into account your needs in other areas of your life?	227	6.7	6.7	6.0	7.2

About the same

Section 4. Reviewing care

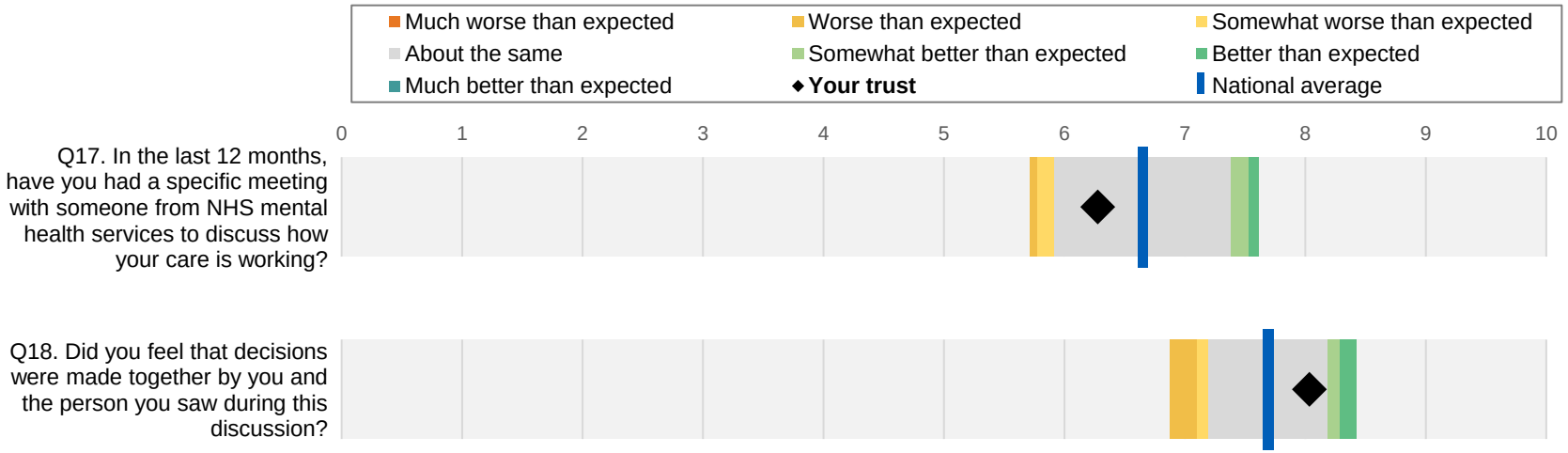
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.2 About the same



Section 4. Reviewing care (continued)

Question scores

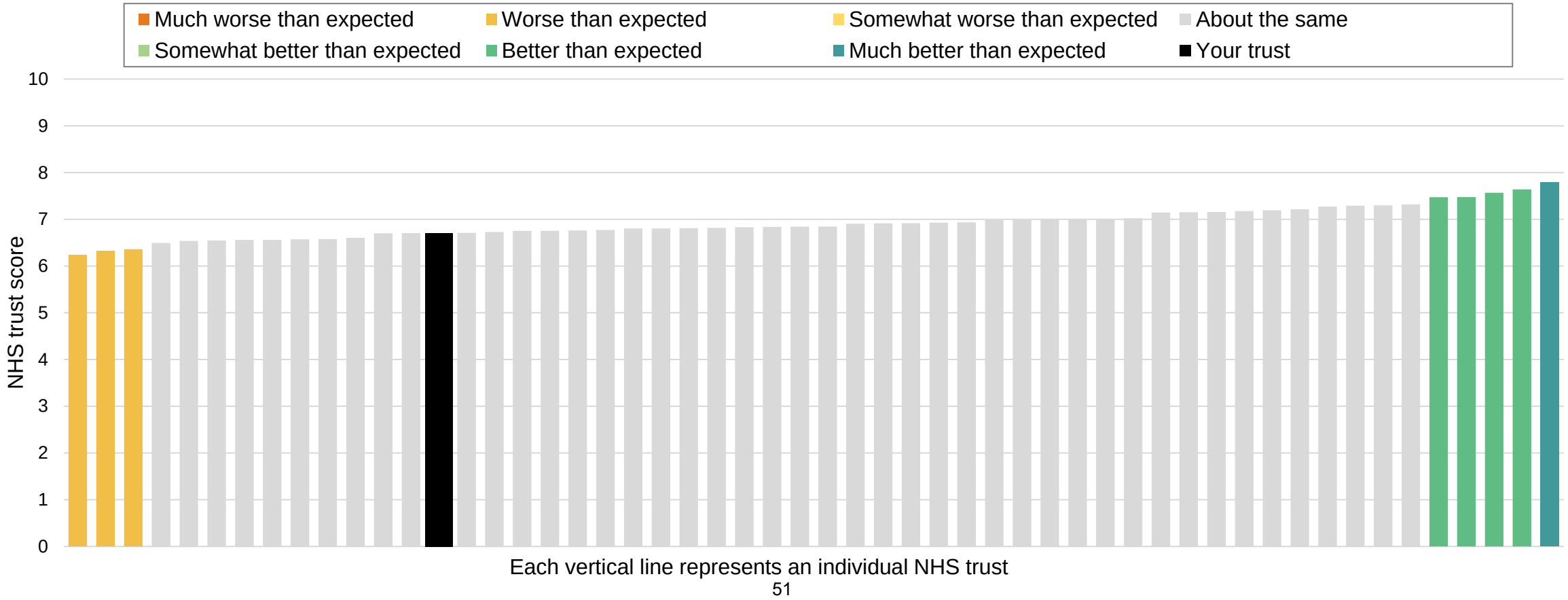


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	233	6.3	6.7	5.7	7.6
About the same	145	8.0	7.7	6.9	8.4

Section 5. Crisis care

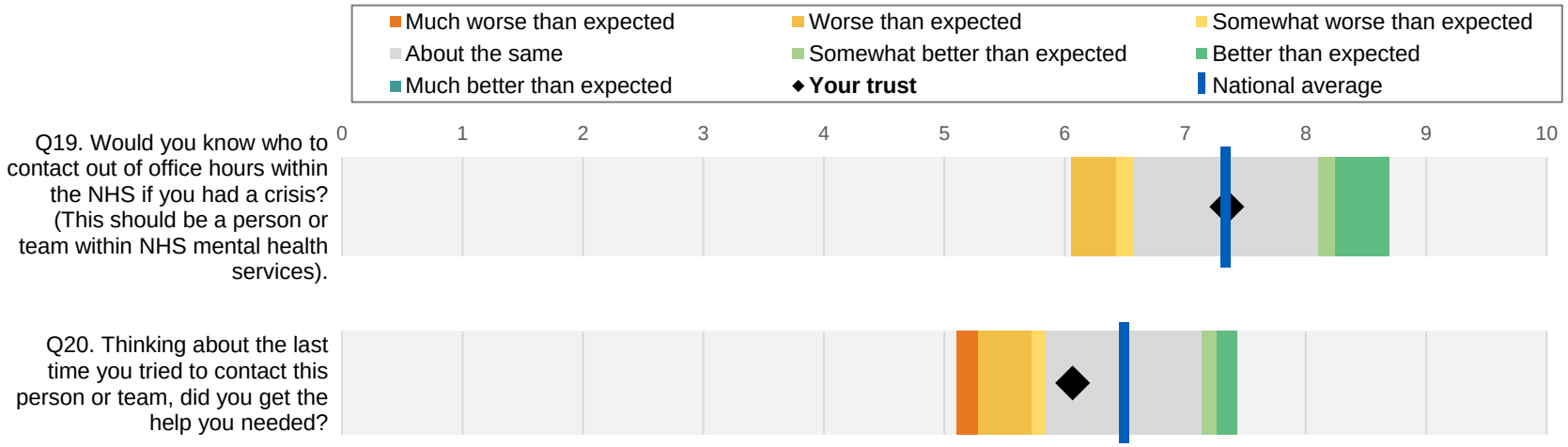
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.7 About the same



Section 5. Crisis care (continued)

Question scores

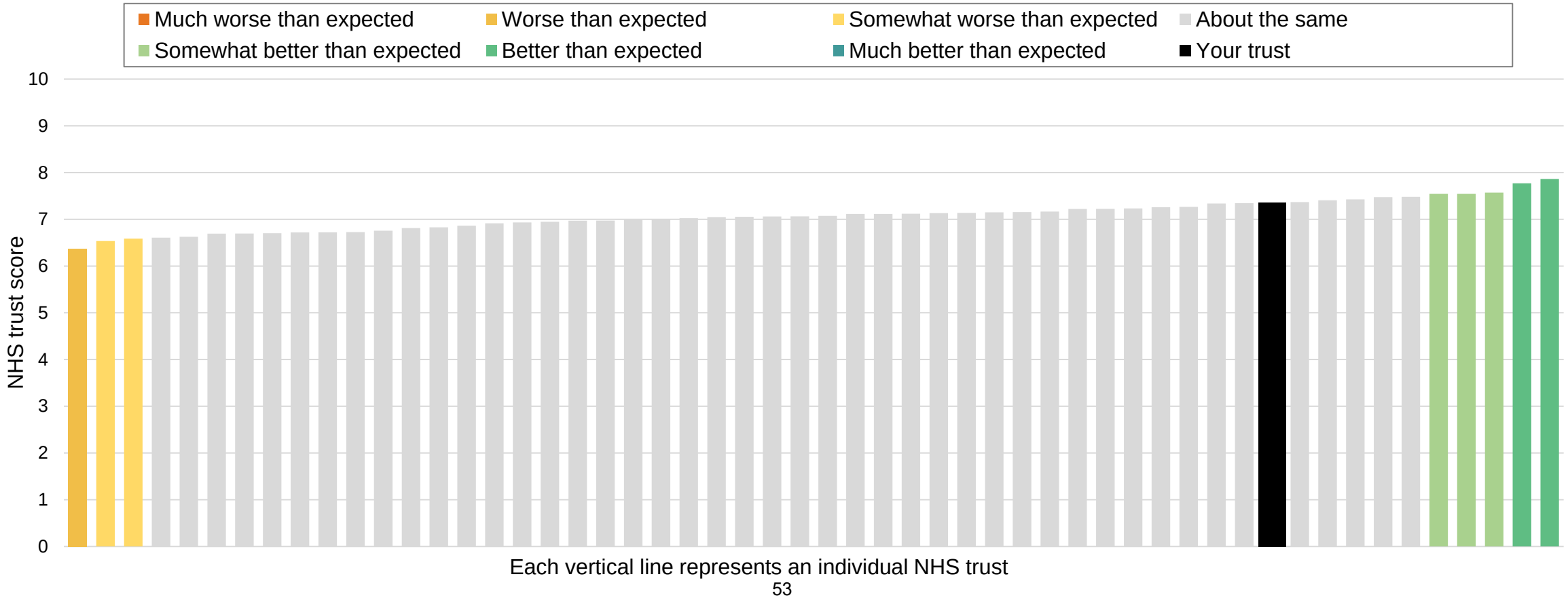


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	285	7.3	7.3	6.1	8.7
About the same	145	6.1	6.5	5.1	7.4

Section 6. Medicines

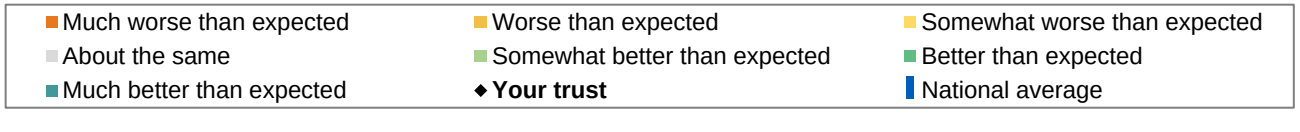
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.4 About the same



Section 6. Medicines (continued)

Question scores

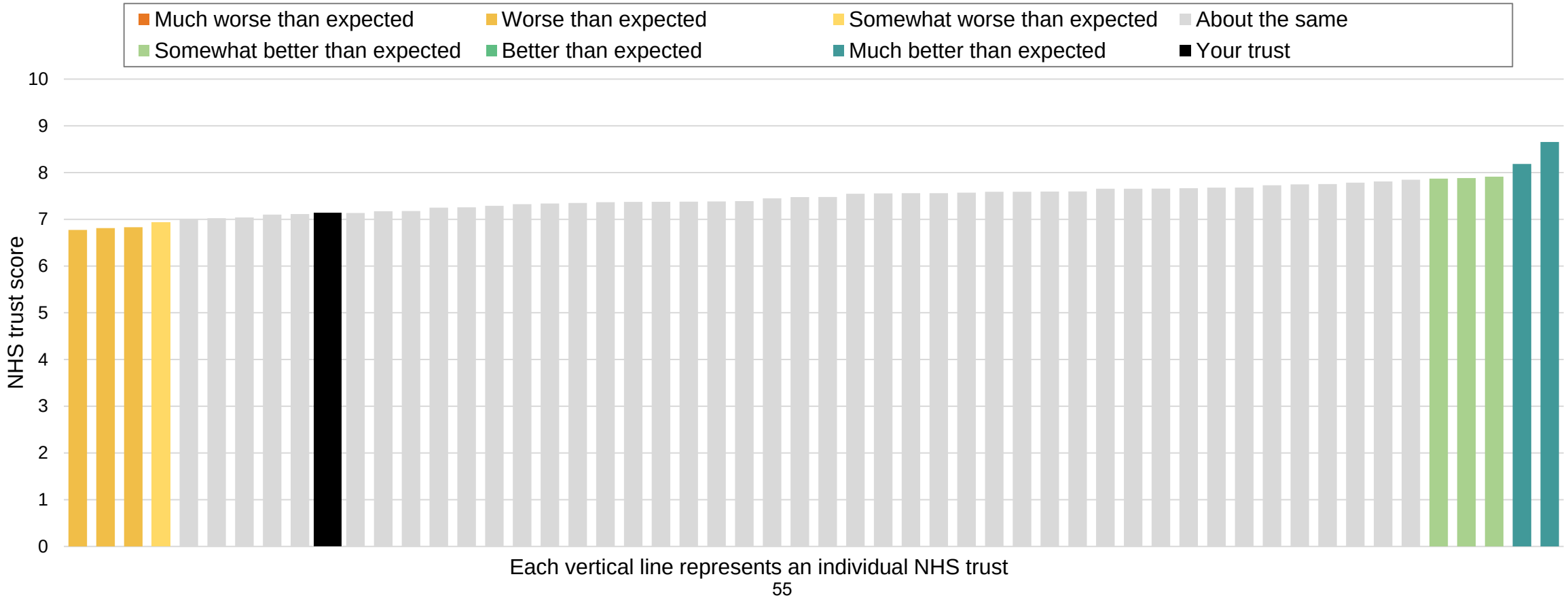


		All trusts in England				
	Number of respondents	Your trust	National average	Lowest score	Highest score	
Q22. Has the purpose of your medicines ever been discussed with you?	231	8.0	7.8	7.2	8.3	About the same
Q23. Have the possible side effects of your medicines ever been discussed with you?	232	6.3	5.9	5.2	6.8	About the same
Q26. In the last 12 months, has an NHS mental health worker checked with you about how you are getting on with your medicines? (That is, have your medicines been reviewed?).	185	7.8	7.5	6.6	8.6	About the same

Section 7. NHS Talking Therapies

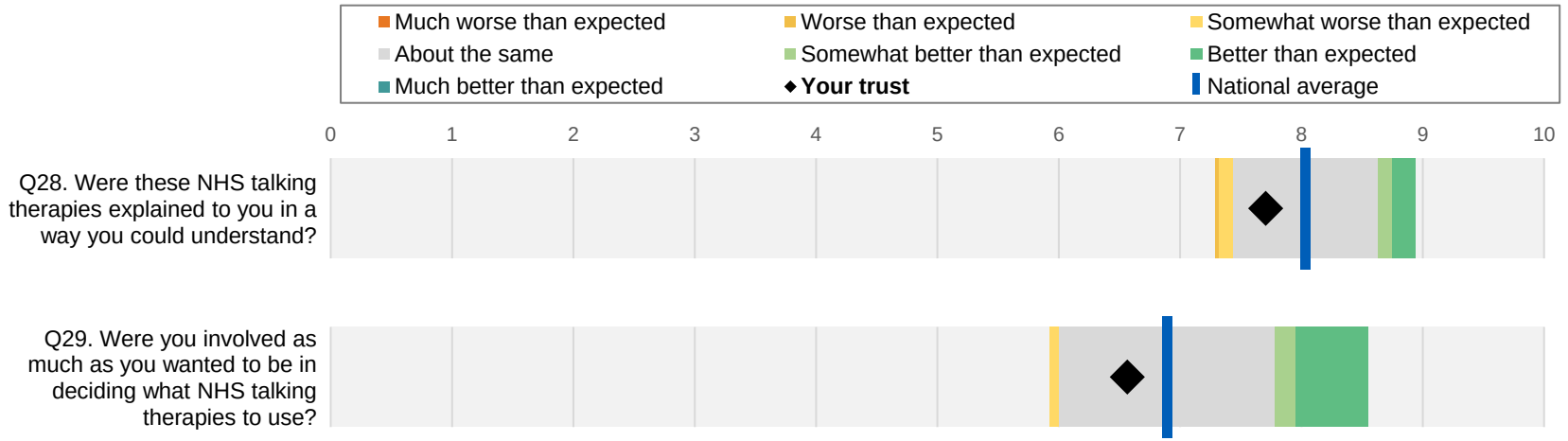
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.1 About the same



Section 7. NHS Talking Therapies (continued)

Question scores

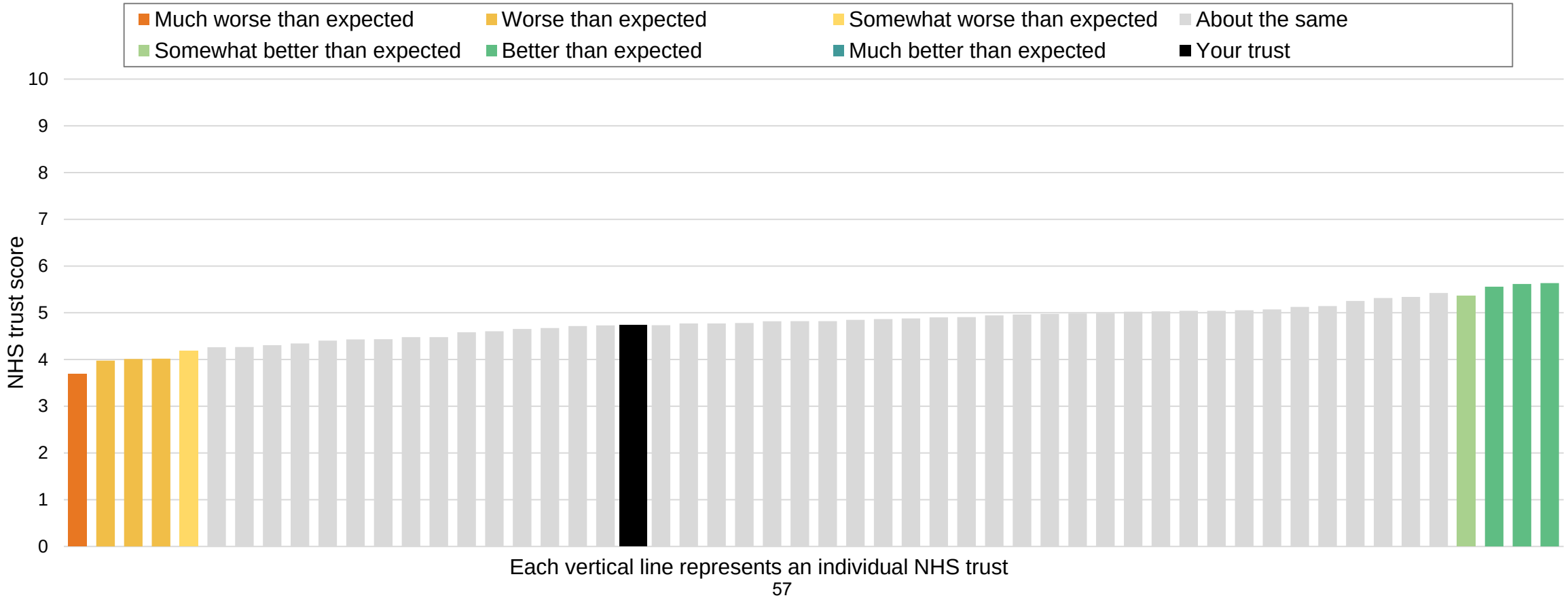


			All trusts in England		
	Number of respondents	Your trust	National average	Lowest score	Highest score
About the same	72	7.7	8.0	7.3	8.9
About the same	66	6.6	6.9	5.9	8.5

Section 8. Support and wellbeing

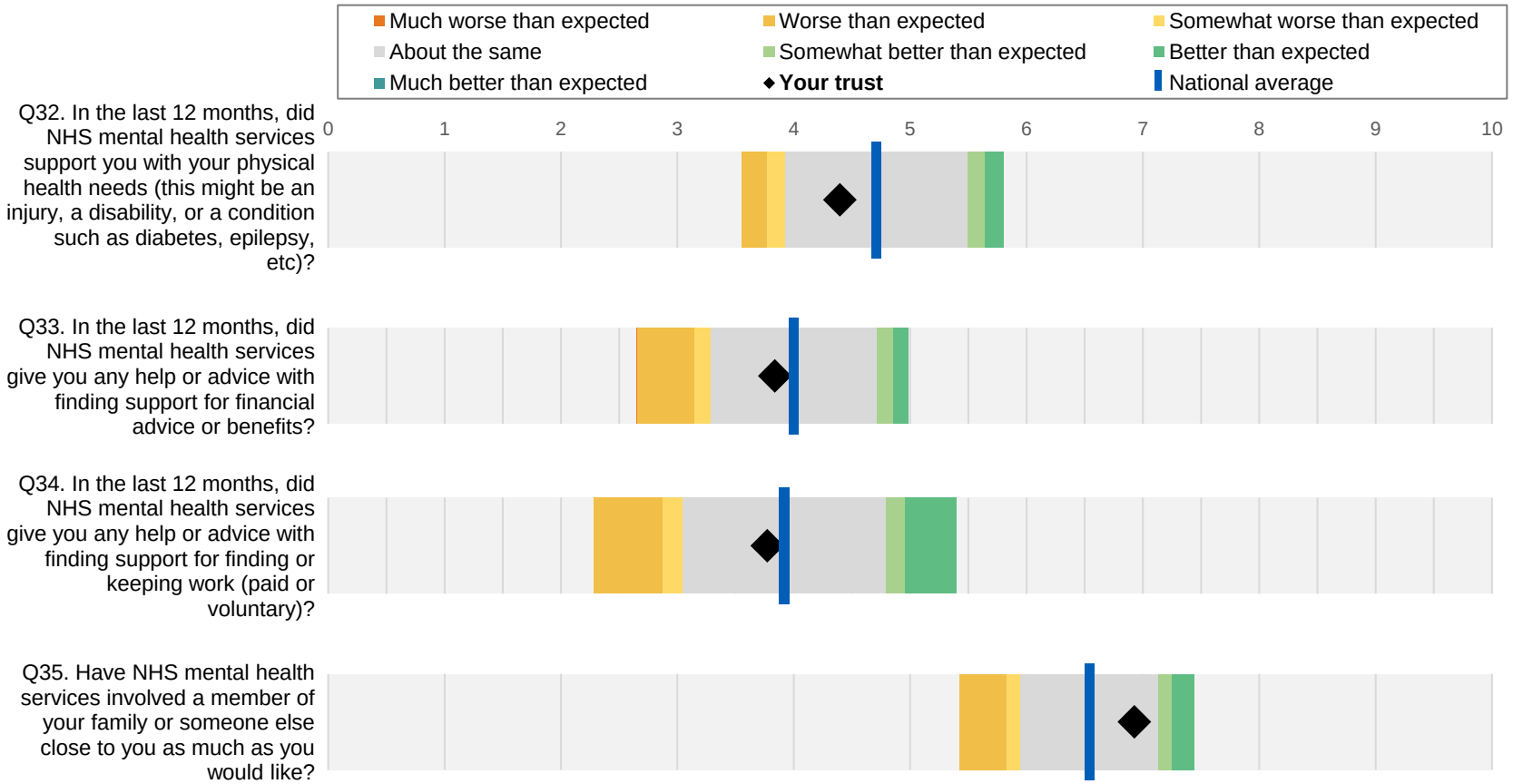
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 4.7 About the same



Section 8. Support and wellbeing (continued)

Question scores

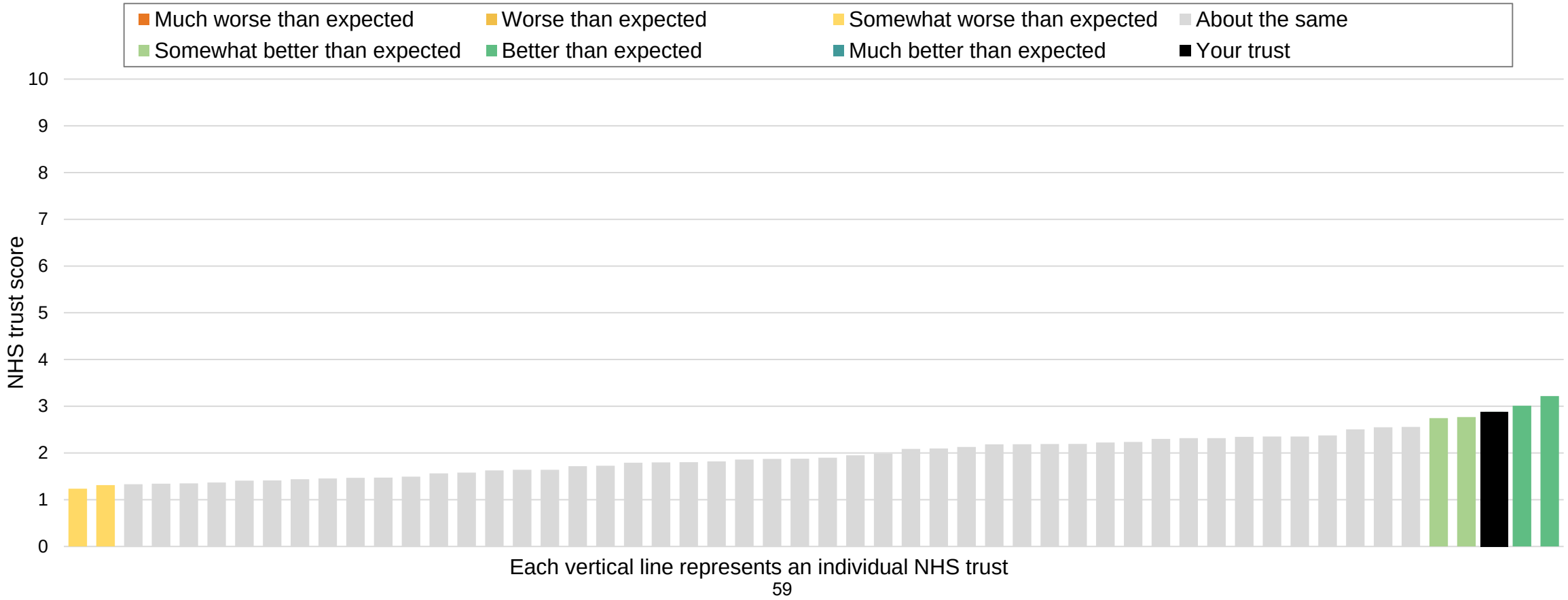


		All trusts in England				
		Number of respondents	Your trust	National average	Lowest score	Highest score
Q32. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?	About the same	150	4.4	4.7	3.6	5.8
Q33. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?	About the same	150	3.8	4.0	2.6	5.0
Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?	About the same	74	3.8	3.9	2.3	5.4
Q35. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?	About the same	227	6.9	6.5	5.4	7.4

Section 9. Feedback

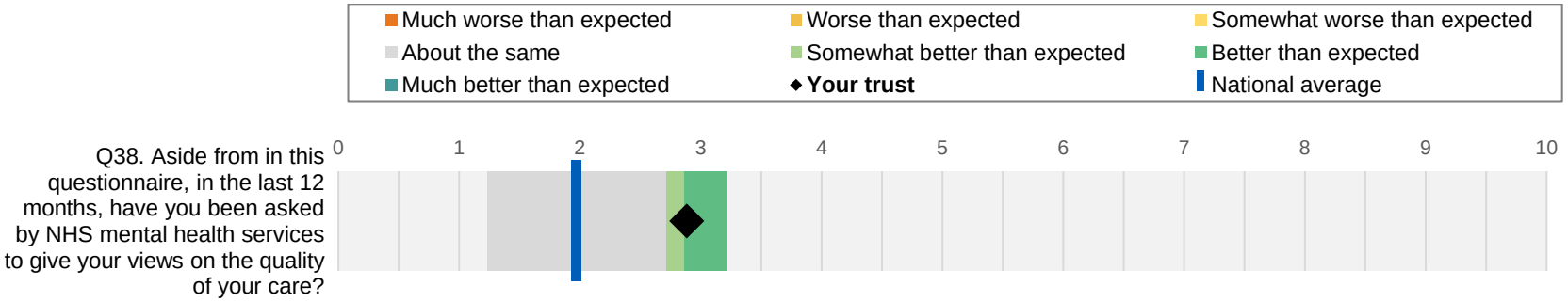
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 2.9 Better than expected



Section 9. Feedback (continued)

Question scores

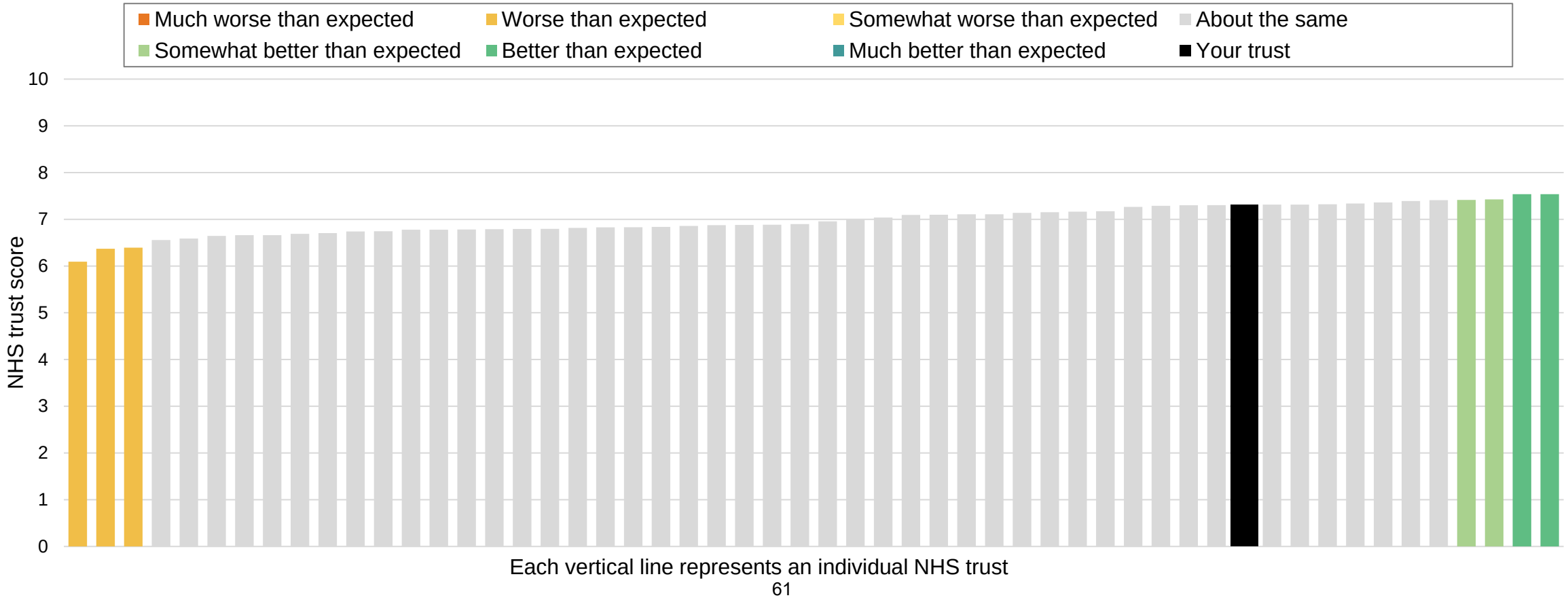


		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
272	2.9	2.0	1.2	3.2

Section 10. Overall views of care and services

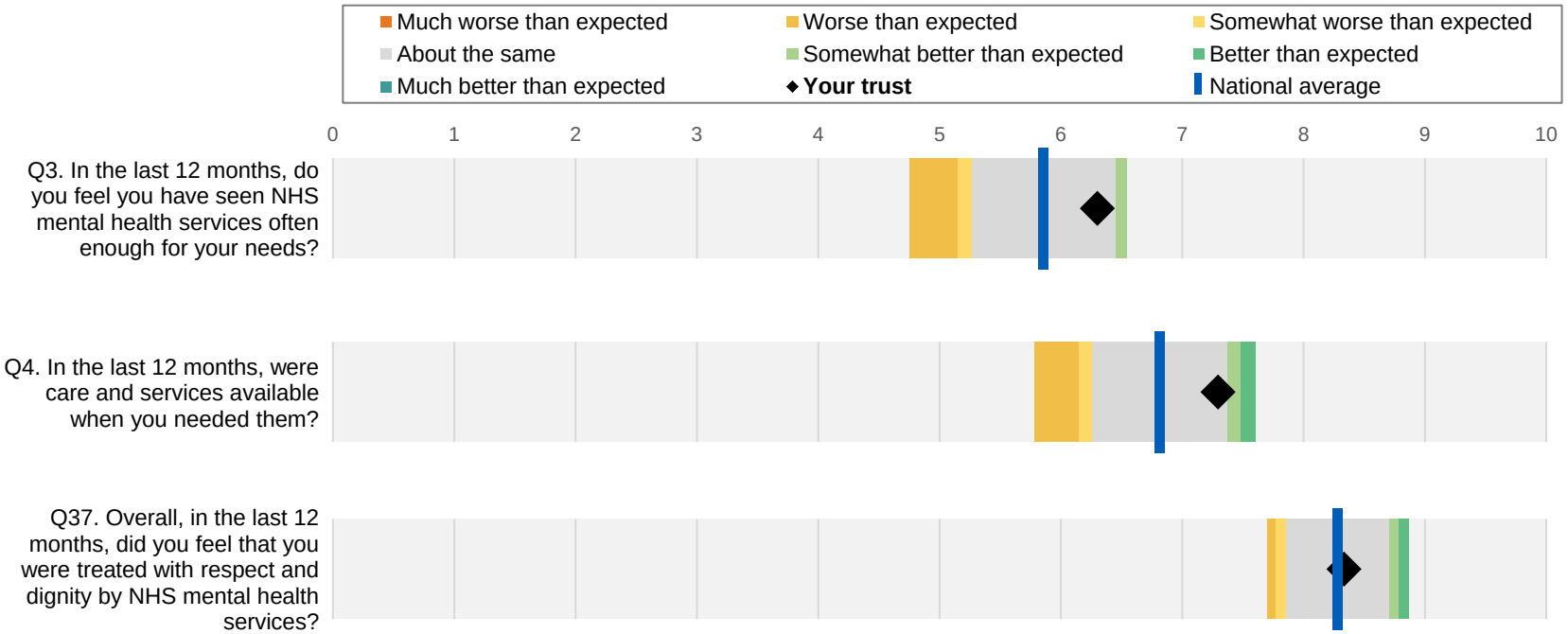
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.3 About the same



Section 10. Overall views of care and services (continued)

Question scores



		All trusts in England		
Number of respondents	Your trust	National average	Lowest score	Highest score
308	6.3	5.9	4.7	6.5
283	7.3	6.8	5.8	7.6
312	8.3	8.3	7.7	8.9

About the same

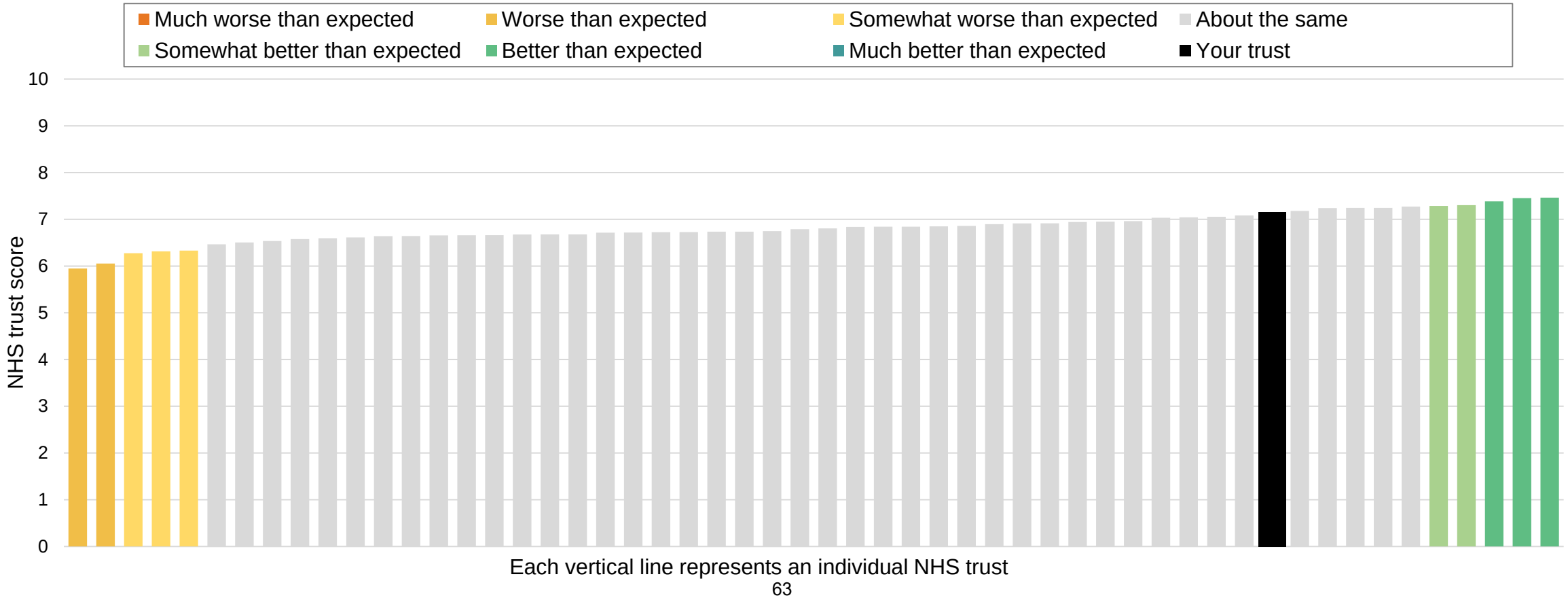
About the same

About the same

Section 11. Overall experience

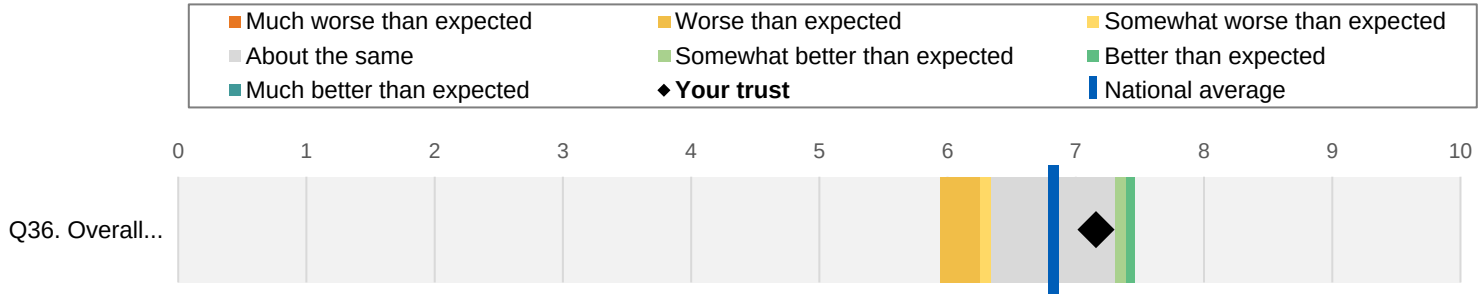
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the 'expected range' analysis technique used, a trust could be categorised as 'about the same' whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 7.2 About the same



Section 11. Overall experience (continued)

Question scores



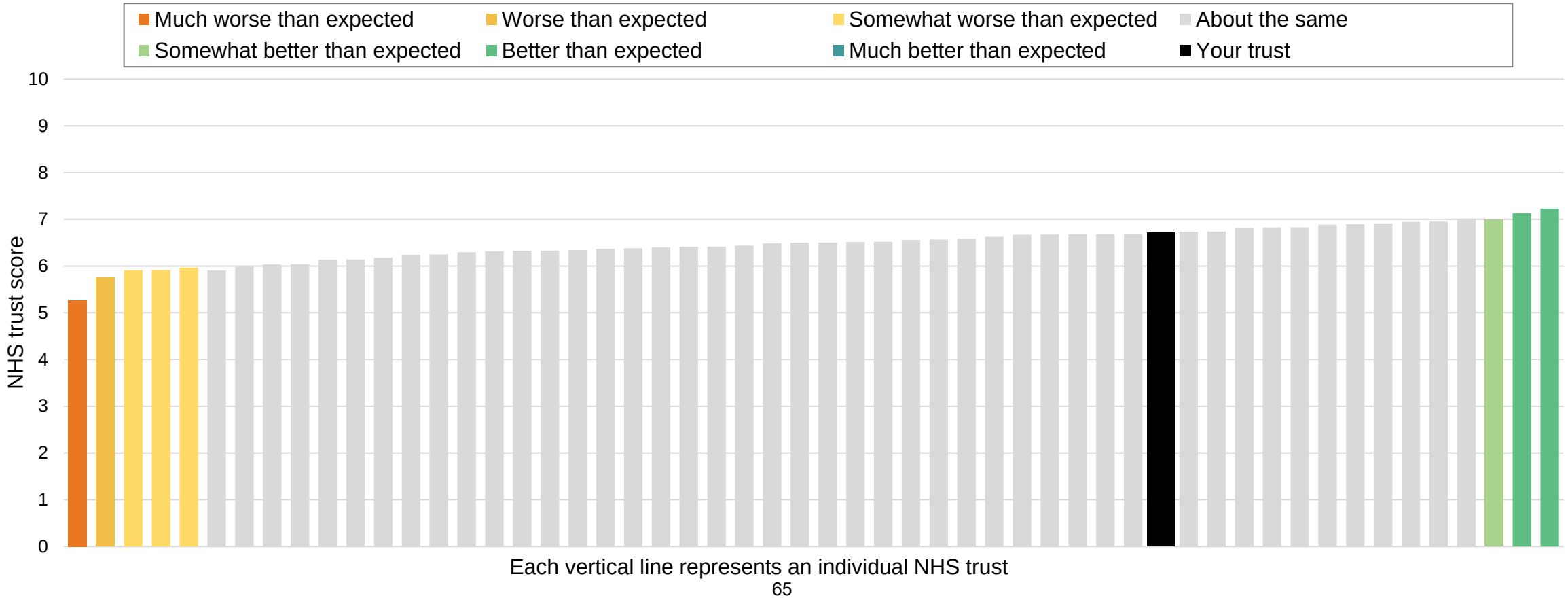
About the same

	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
303	7.2	6.8	5.9	7.5

Section 12. Care during the Covid-19 pandemic

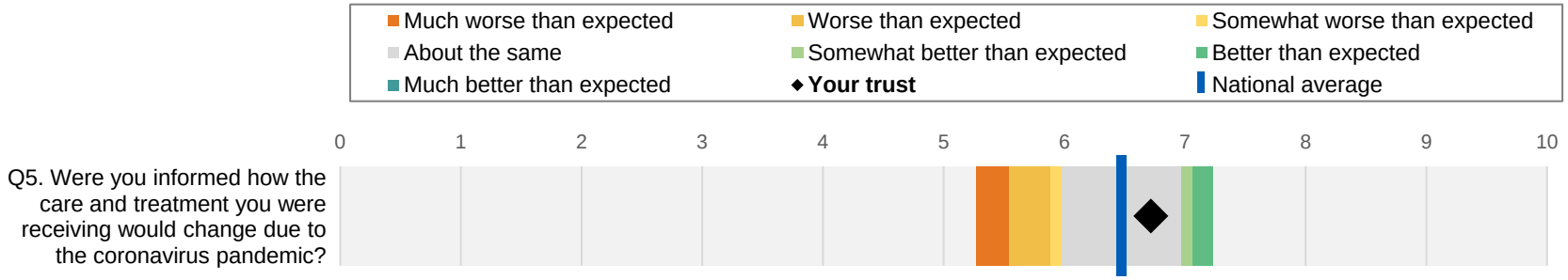
This shows the range of section scores for all NHS trusts. The colour of the line denotes whether a trust has performed better, worse, or about the same compared with all other trusts (as detailed in the legend). The result for your trust is shown in black. Please note, as a result of the ‘expected range’ analysis technique used, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

Your trust section score = 6.7 About the same



Section 12. Care during the Covid-19 pandemic (continued)

Question scores



About the same

	All trusts in England			
Number of respondents	Your trust	National average	Lowest score	Highest score
273	6.7	6.5	5.3	7.2

Change over time

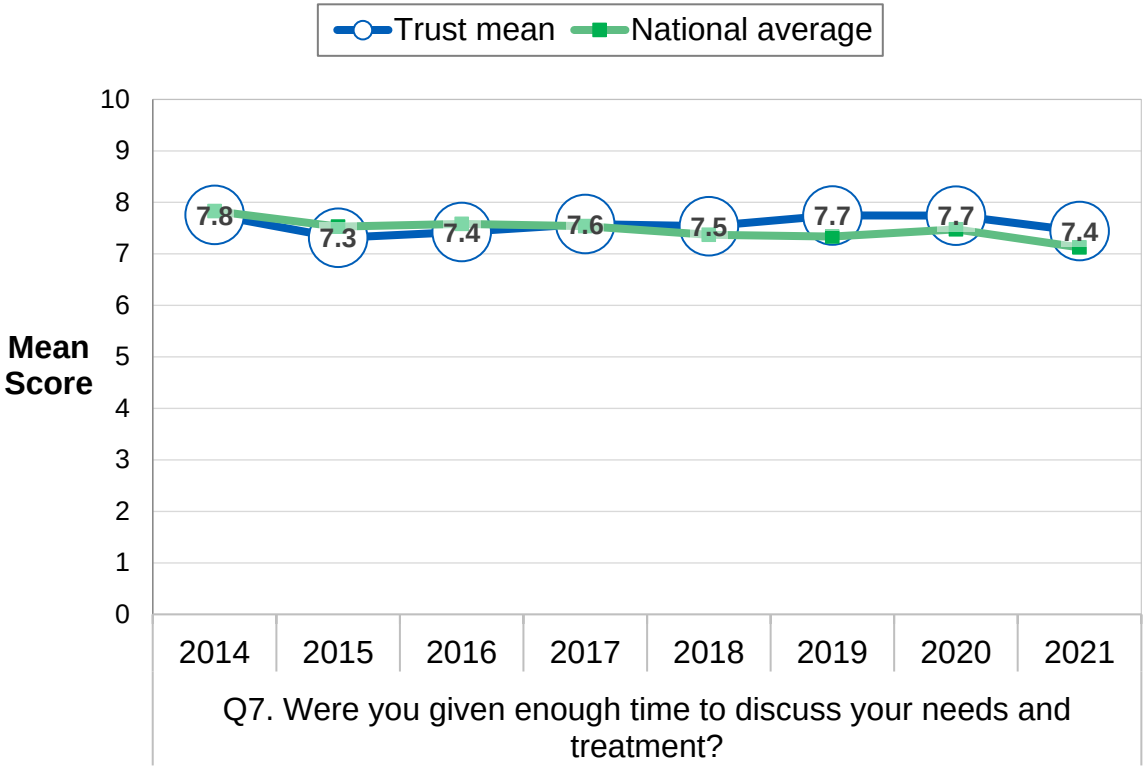
This section includes:

- a comparison to previous survey years scores for your trust for each question, including:
  - your trust's 2021 score compared with its scores from 2014 to 2020

Please note, if data is missing for a survey year, this is due to a low number of responses, or because the trust data was not included in the survey that year, due to sampling errors or ineligibility.

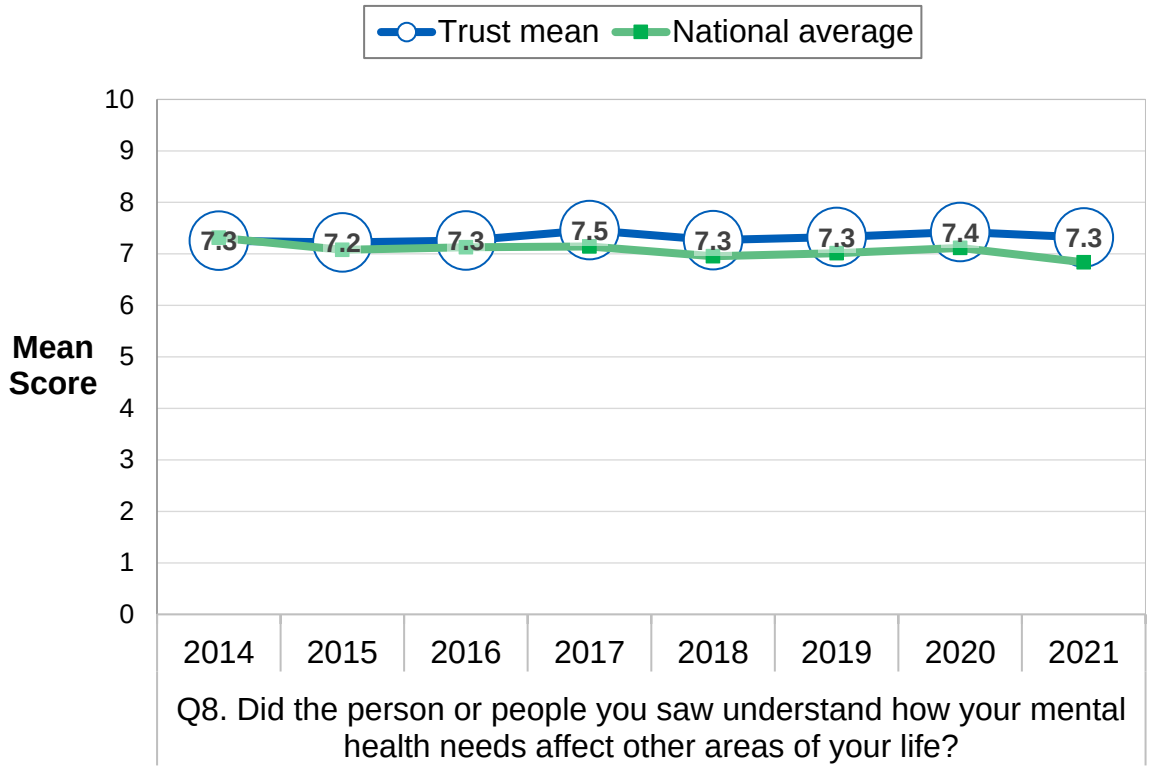
Section 1. Health and social care workers

Question scores



Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 226; 2015: 226; 2016: 221; 2017: 229; 2018: 254; 2019: 190; 2020: 310; 2021: 301

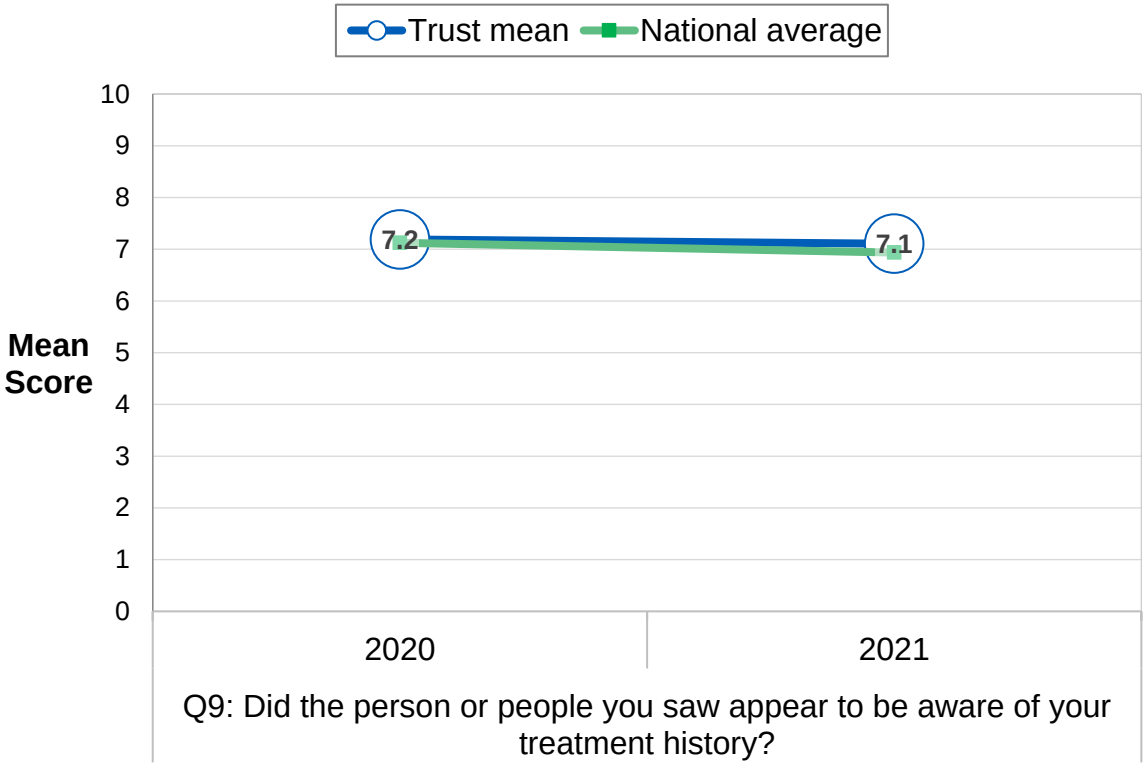


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2014: 211; 2015: 224; 2016: 221; 2017: 220; 2018: 249; 2019: 183; 2020: 299; 2021: 299

Section 1. Health and social care workers

Question scores

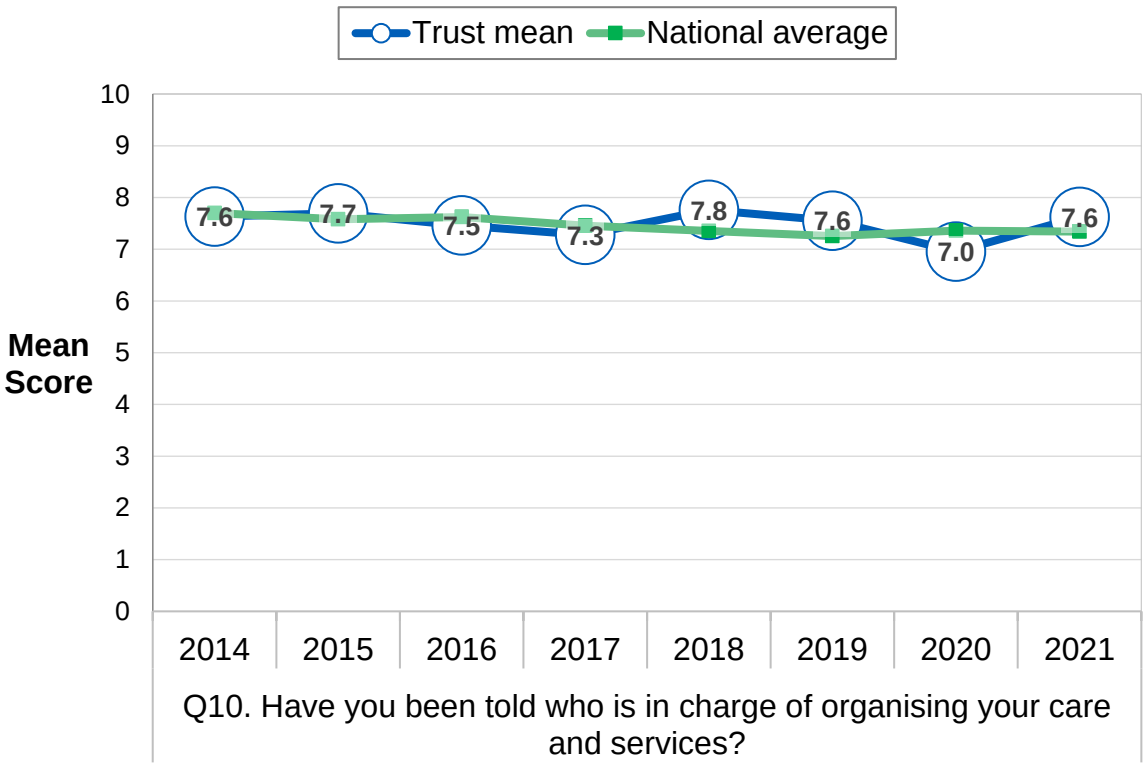


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by all.
Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2020: 291; 2021: 290

Section 2. Organising care

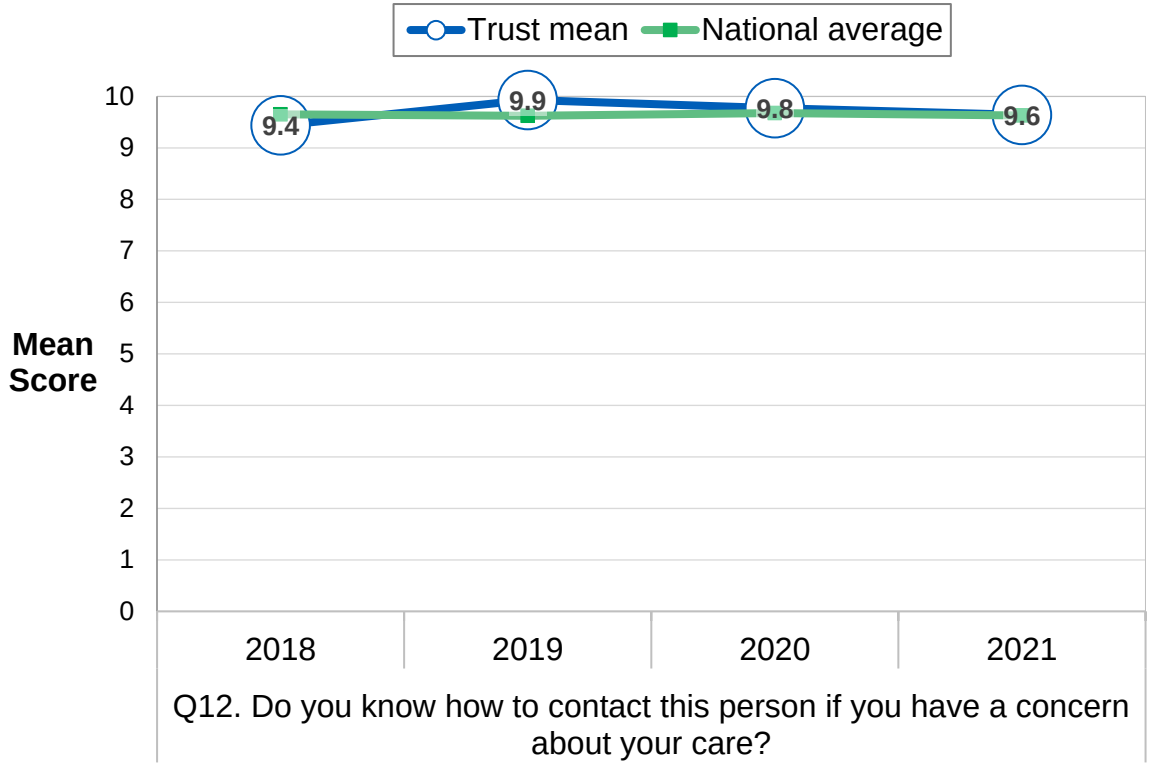
Question scores



Q10. Have you been told who is in charge of organising your care and services?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2014: 198; 2015: 198; 2016: 189; 2017: 195; 2018: 215; 2019: 164; 2020: 264; 2021: 258



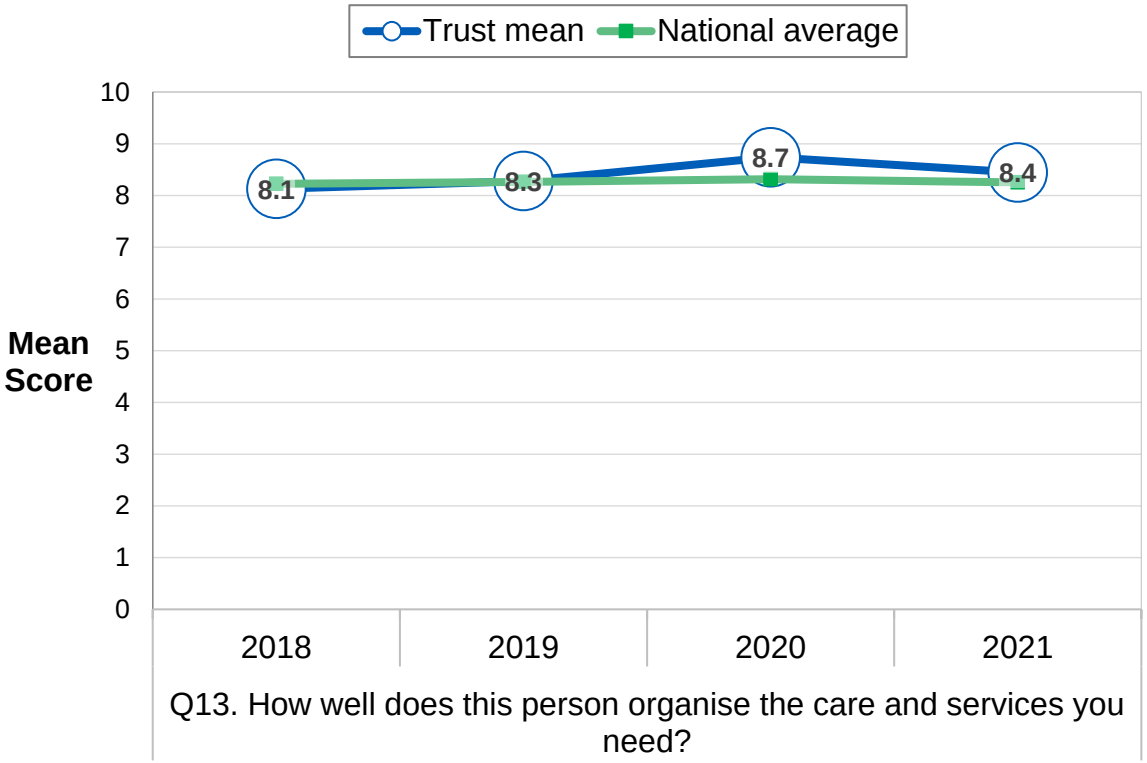
Q12. Do you know how to contact this person if you have a concern about your care?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2018: 102; 2019: 81; 2020: 134; 2021: 139

Section 2. Organising care

Question scores

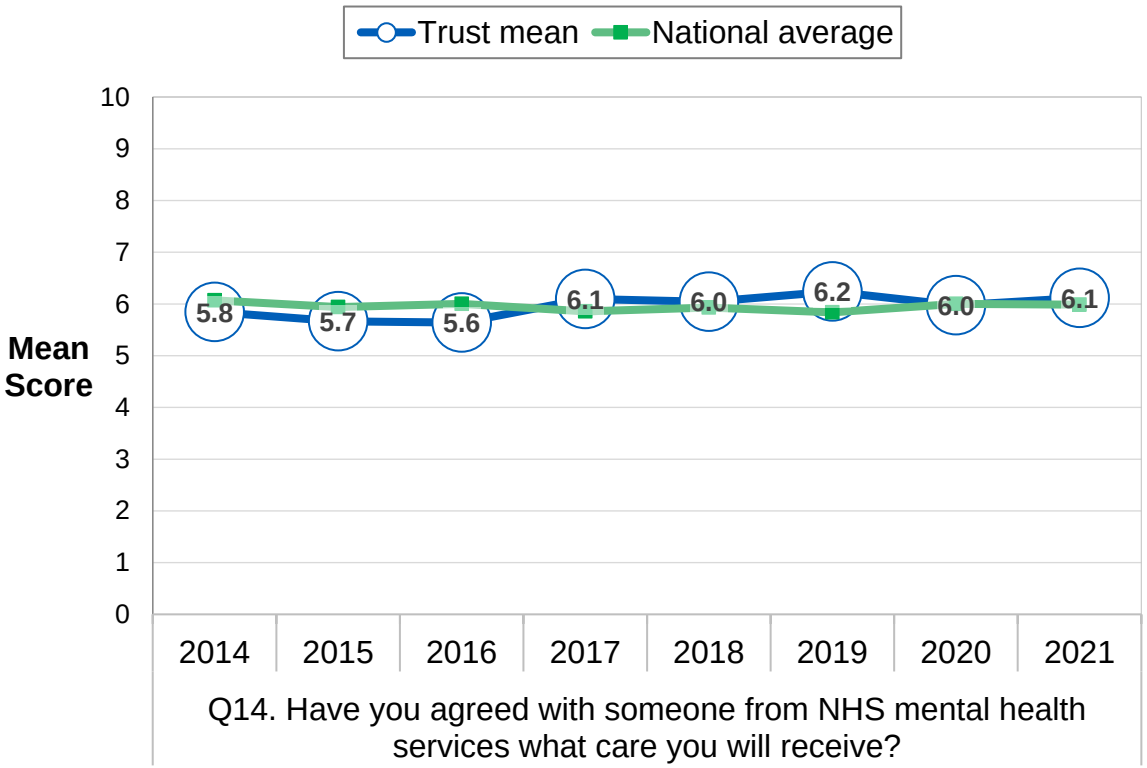


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have been told who is in charge of organising their care and services, and the person in charge is not a GP.
Number of respondents: 2018: 106; 2019: 86; 2020: 139; 2021: 140

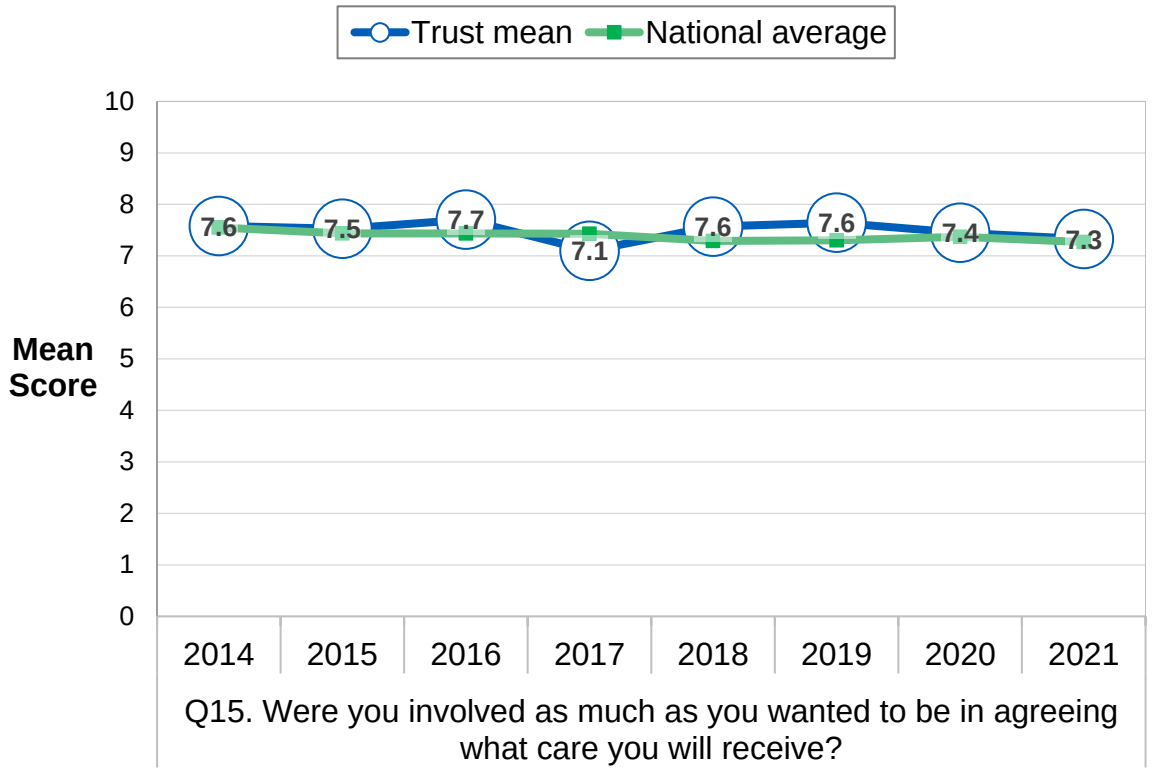
Section 3. Planning care

Question scores



Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Number of respondents: 2014: 223; 2015: 232; 2016: 225; 2017: 226; 2018: 260; 2019: 192; 2020: 317; 2021: 319

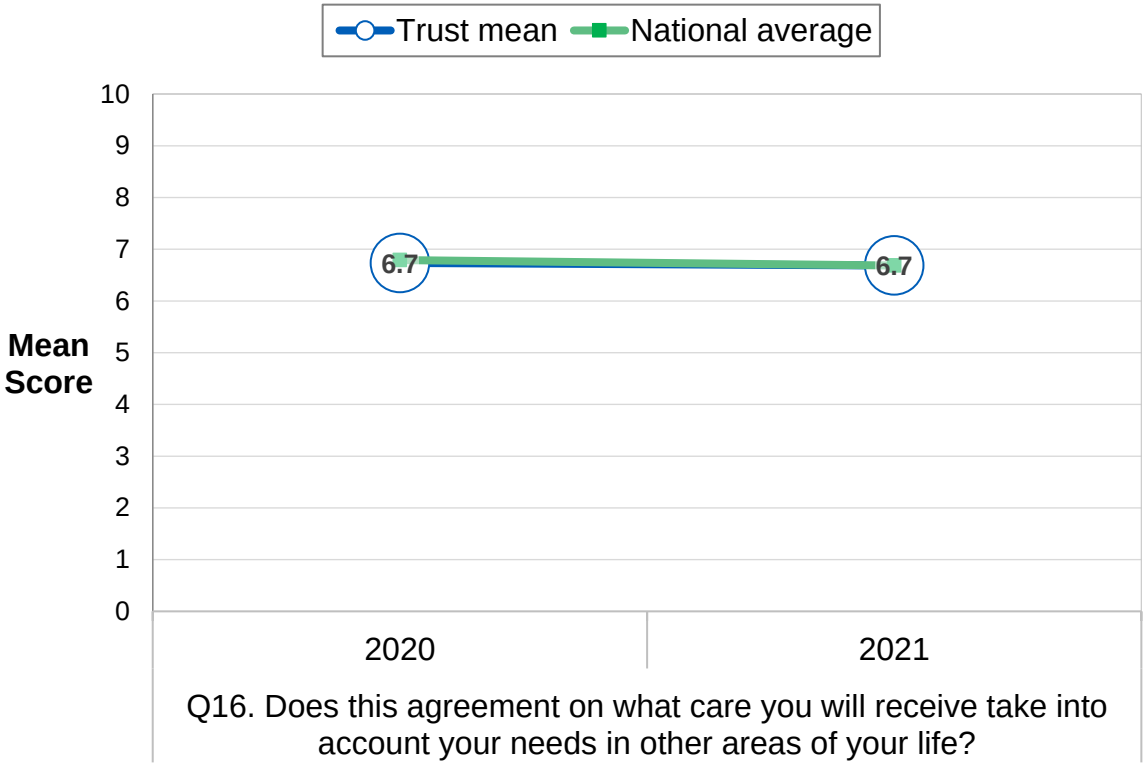


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have agreed with someone from NHS mental health services what care they will receive. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2014: 161; 2015: 155; 2016: 160; 2017: 175; 2018: 194; 2019: 153; 2020: 241; 2021: 240

Section 3. Planning care

Question scores

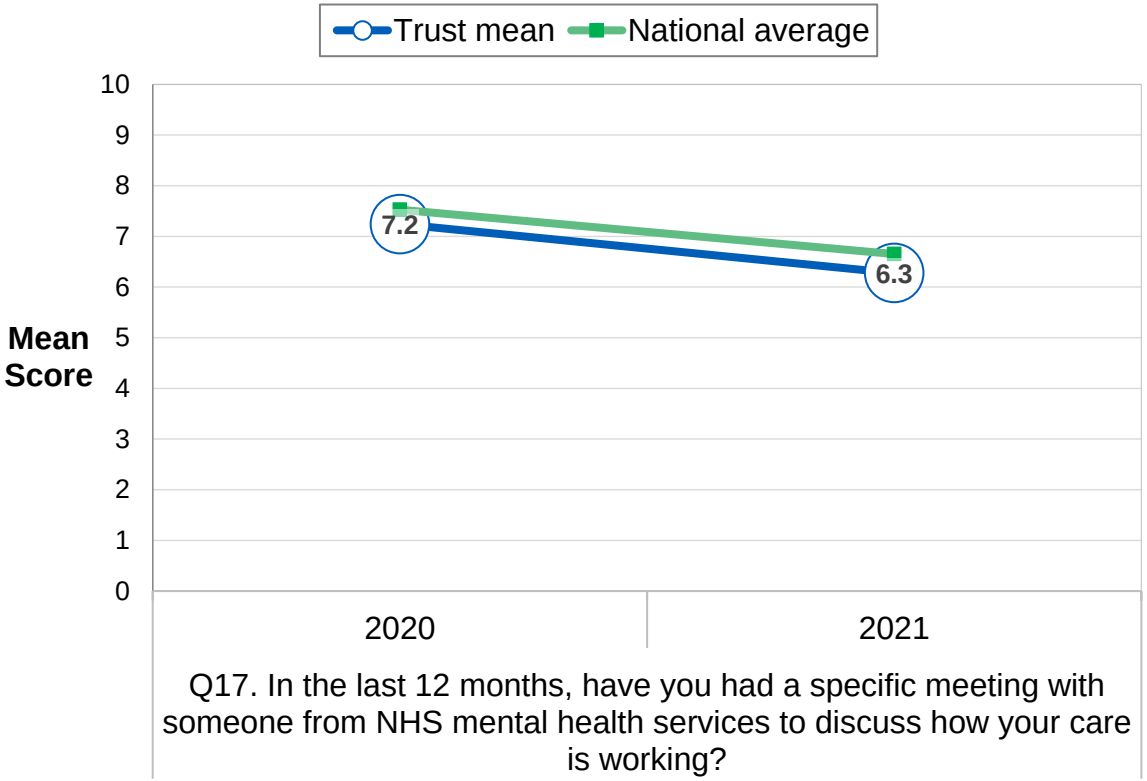


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by those who have agreed with someone from NHS mental health services what care they will receive. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2020: 229; 2021: 227

Section 4. Reviewing care

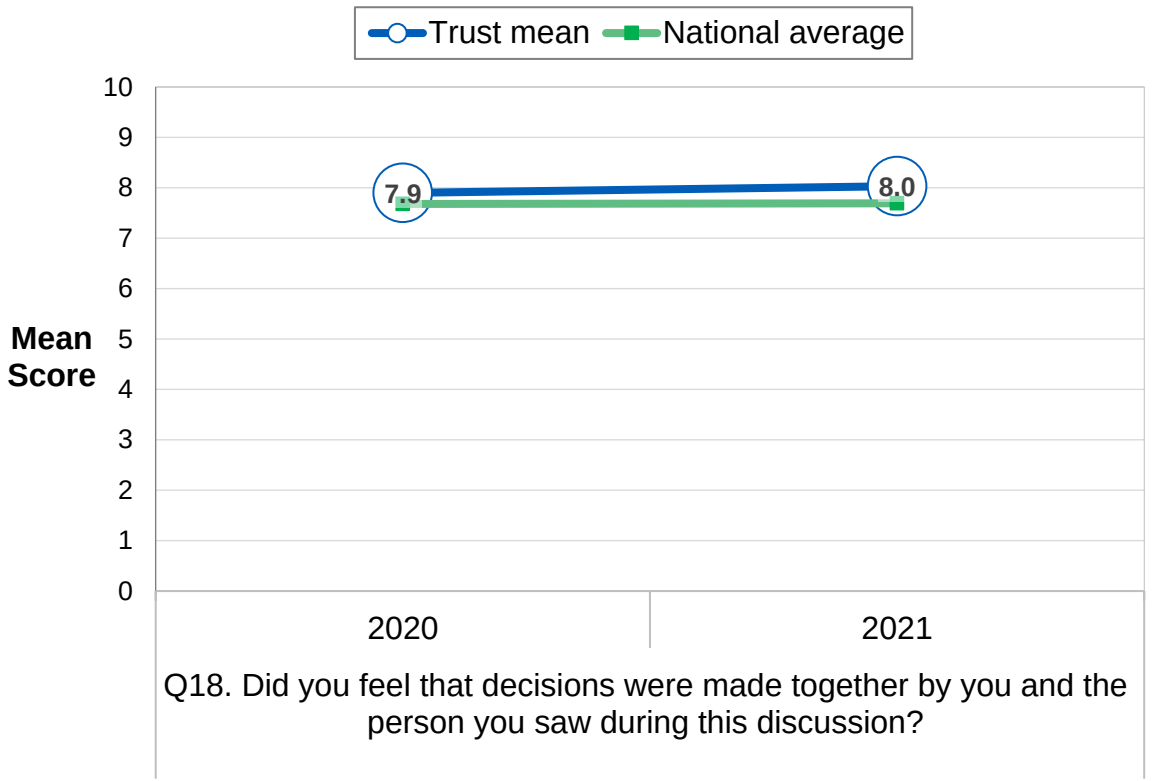
Question scores



Q17. In the last 12 months, have you had a specific meeting with someone from NHS mental health services to discuss how your care is working?

Significant change 2021 vs 2020	Decrease
Significant change 2021 vs 2019	-

Answered by those who have been in contact with mental health services for one or more years. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2020: 245; 2021: 233



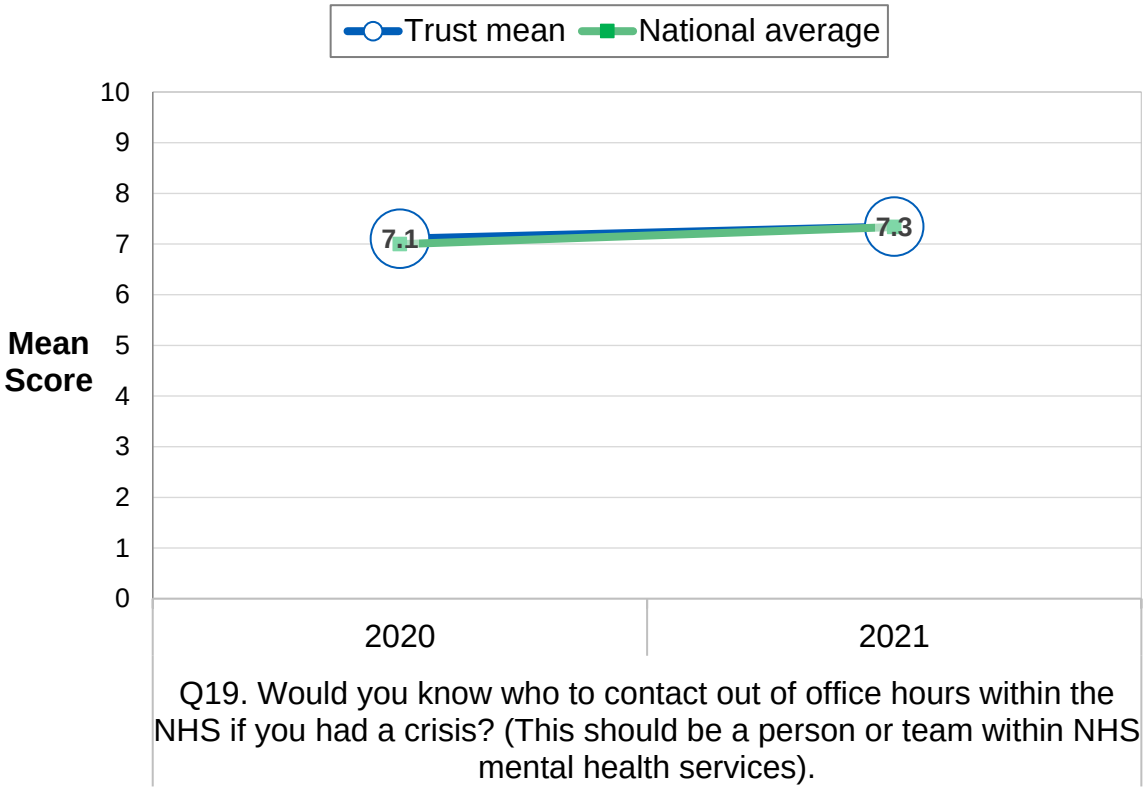
Q18. Did you feel that decisions were made together by you and the person you saw during this discussion?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by those who have been in contact with mental health services for one or more years, and have had a specific meeting with someone from NHS mental health services in the last 12 months to discuss how their care is working. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2020: 173; 2021: 145

Section 5. Crisis Care

Question scores



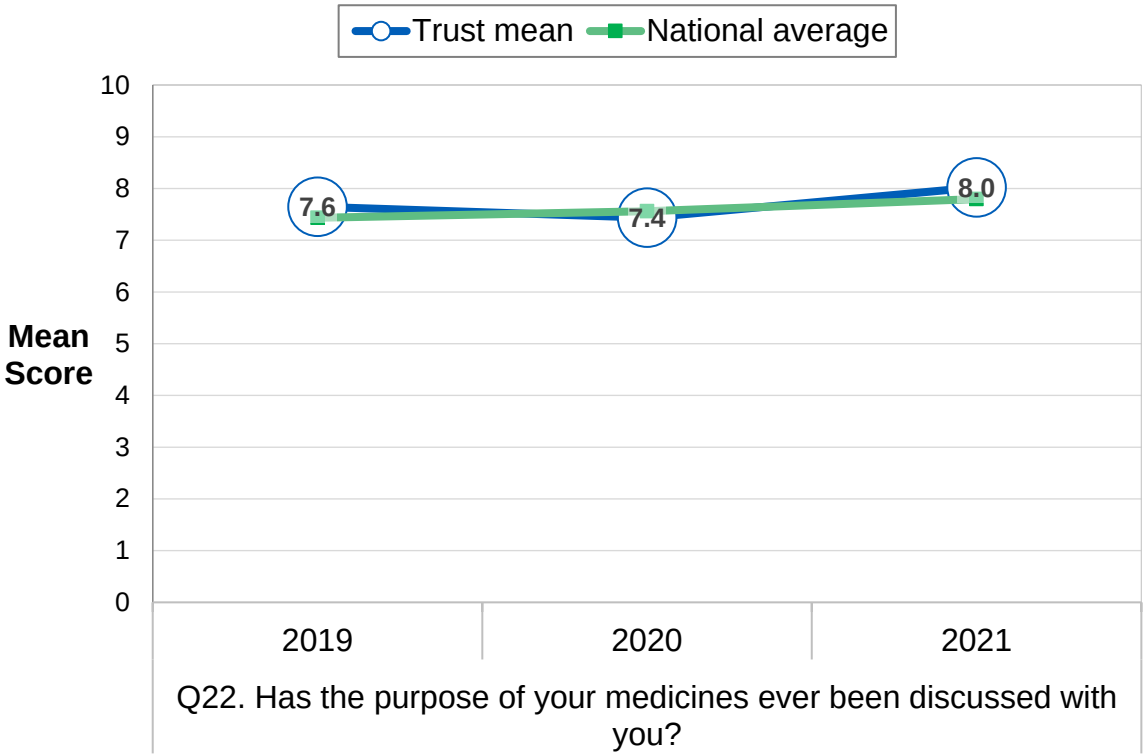
Q19. Would you know who to contact out of office hours within the NHS if you had a crisis? (This should be a person or team within NHS mental health services).

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by all. Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2020: 285; 2021: 285
Q20 is not shown, as this question was not historically comparable.

Section 6. Medicines

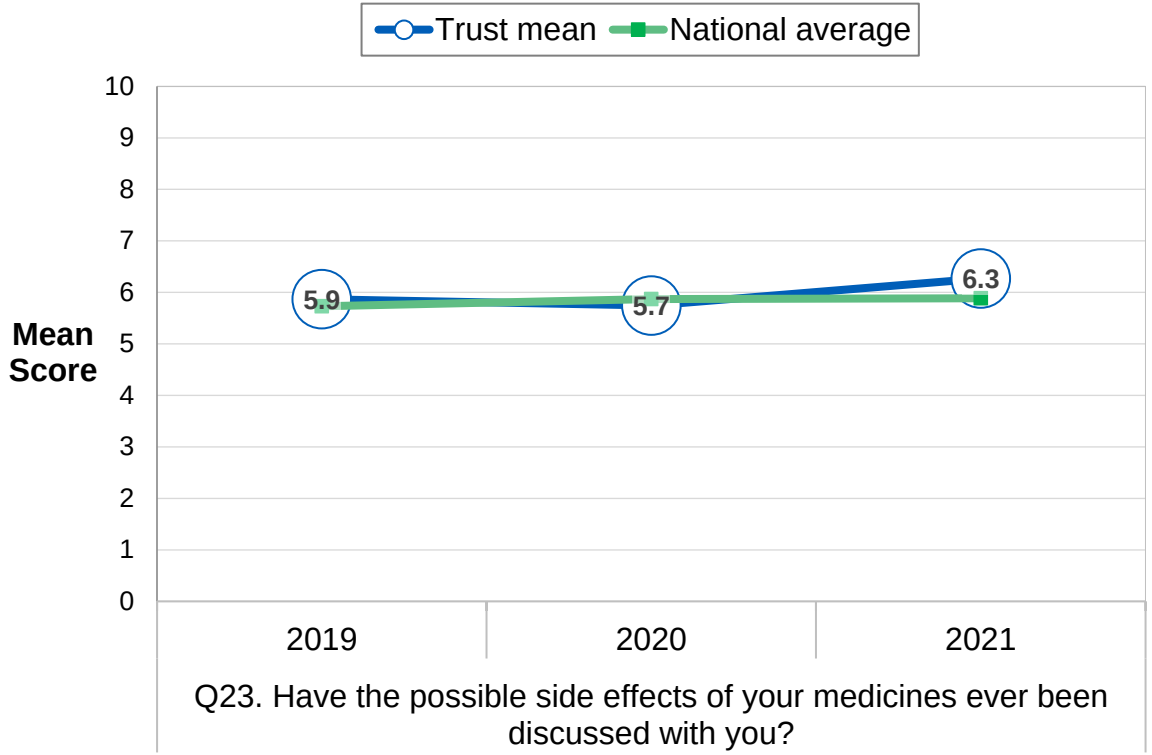
Question scores



Q22. Has the purpose of your medicines ever been discussed with you?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 159; 2020: 249; 2021: 231



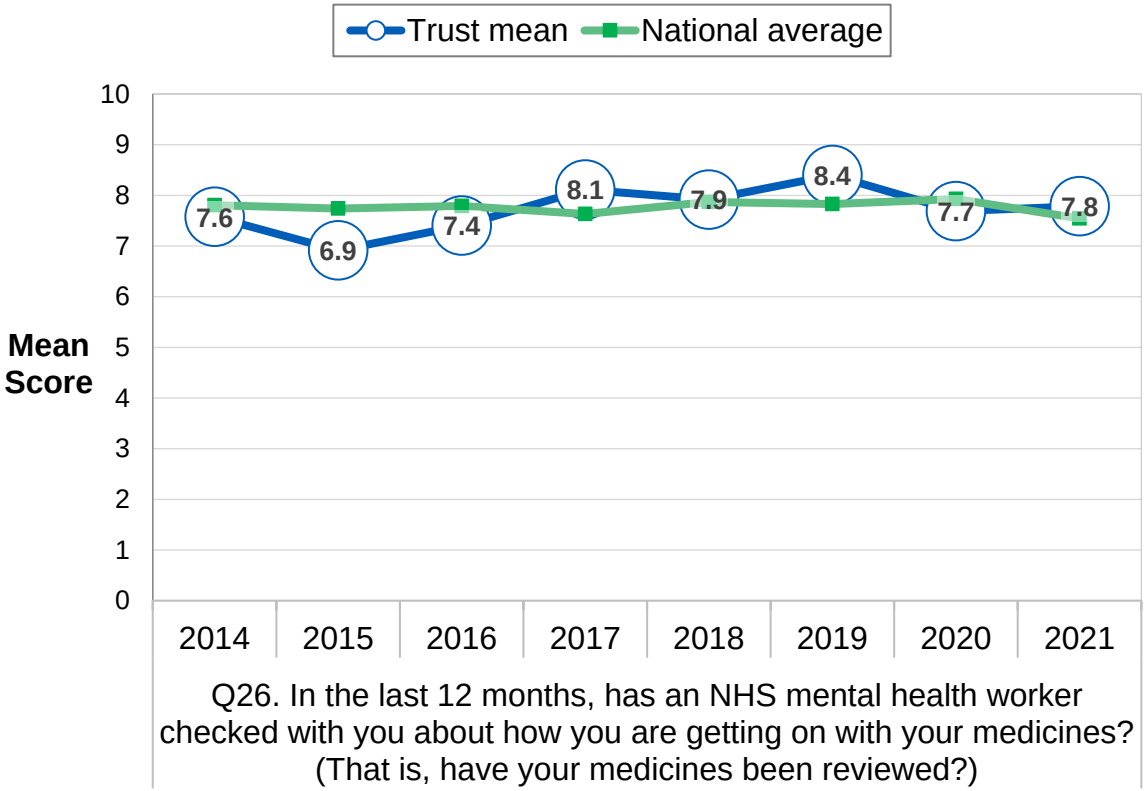
Q23. Have the possible side effects of your medicines ever been discussed with you?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have been receiving any medicines in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded.
Number of respondents: 2019: 153; 2020: 240; 2021: 232

Section 6. Medicines

Question scores

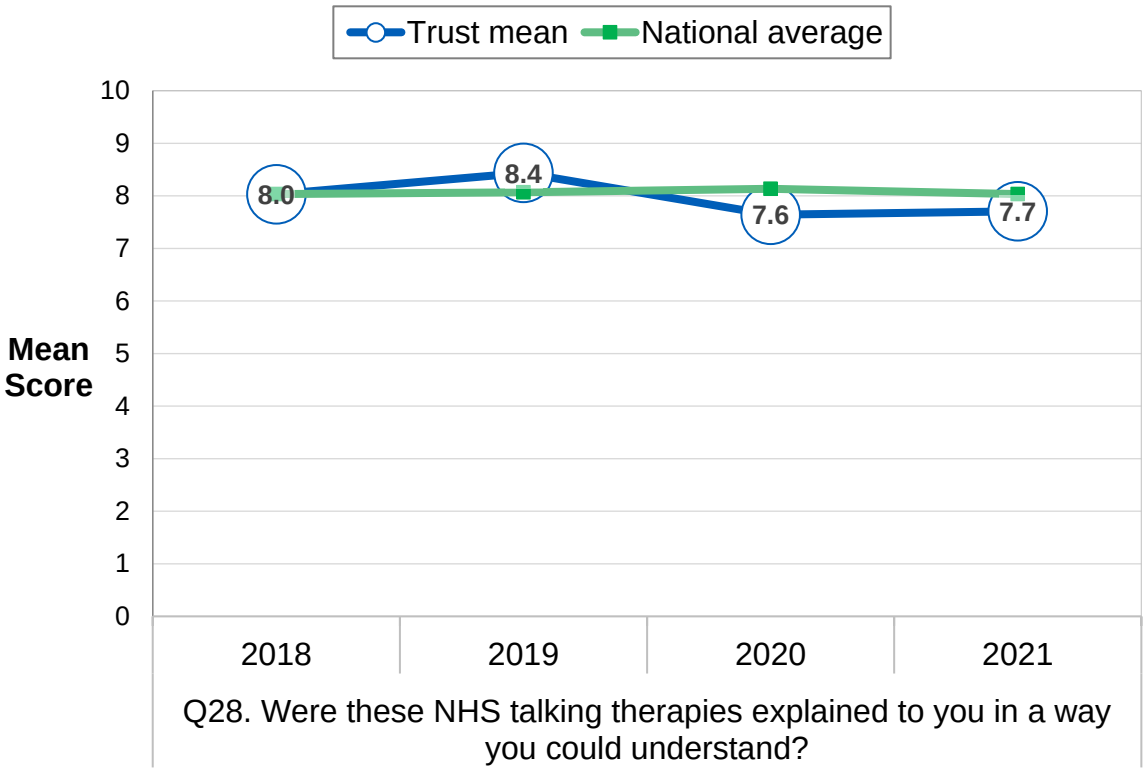


Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have been receiving any medicines for 12 months or longer for their mental health needs. Respondents who stated that they didn't know / couldn't remember have been excluded. Number of respondents: 2014: 135; 2015: 150; 2016: 128; 2017: 153; 2018: 160; 2019: 129; 2020: 184; 2021: 185

Section 7. NHS Talking Therapies

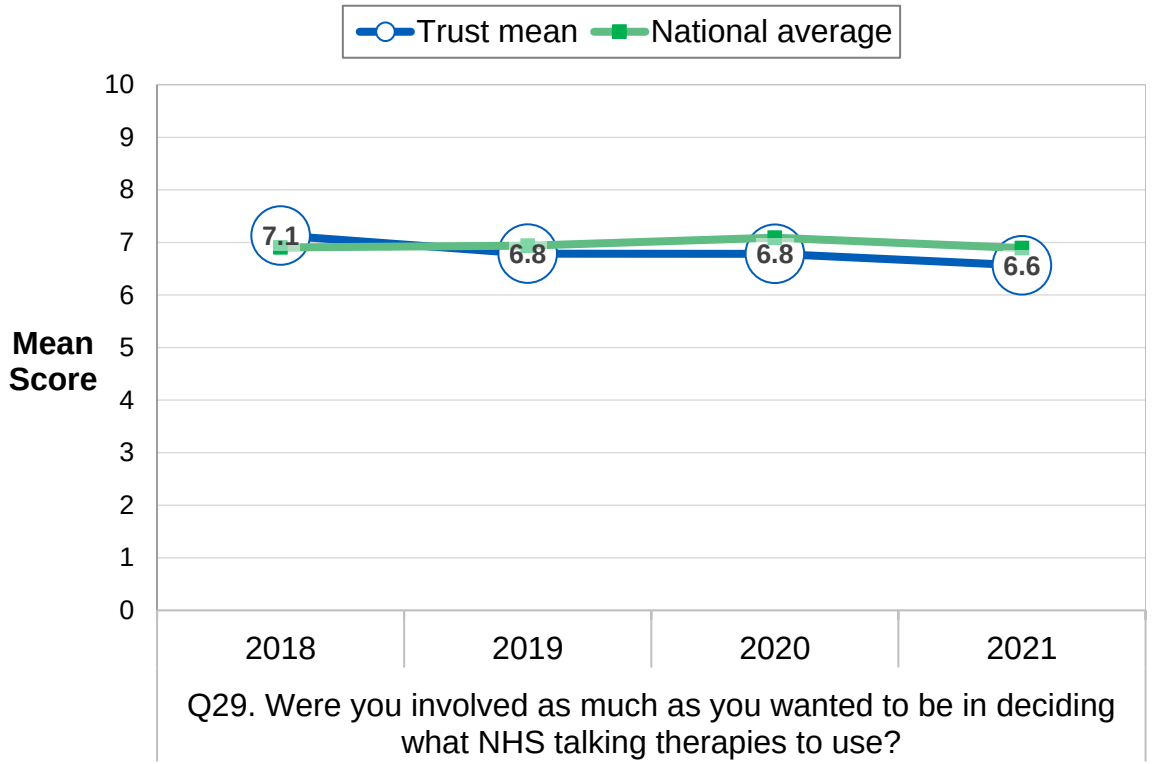
Question scores



Q28. Were these NHS talking therapies explained to you in a way you could understand?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that no explanation was needed have been excluded.
Number of respondents: 2018: 92; 2019: 79; 2020: 132; 2021: 72



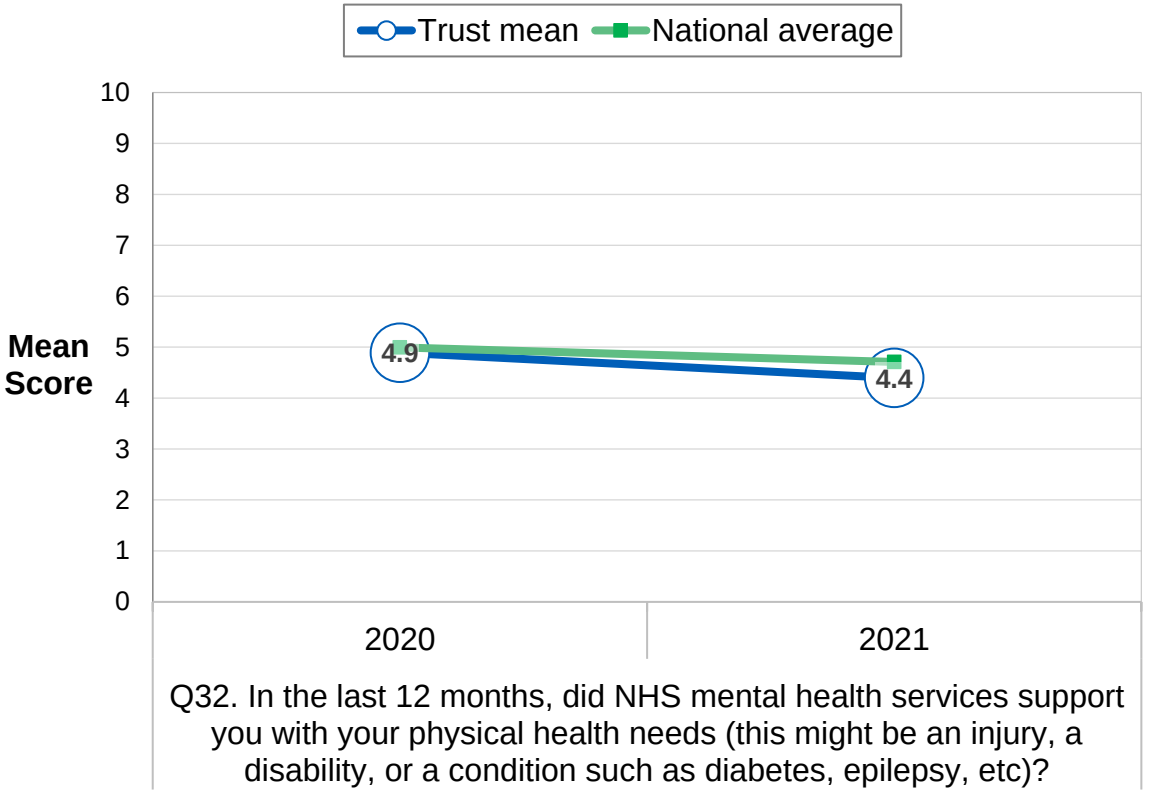
Q29. Were you involved as much as you wanted to be in deciding what NHS talking therapies to use?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by those who have received any NHS talking therapies in the last 12 months for their mental health needs. Respondents who stated that they didn't know / couldn't remember or did not want to be involved have been excluded.
Number of respondents: 2018: 85; 2019: 76; 2020: 129; 2021: 66

Section 8. Support and wellbeing

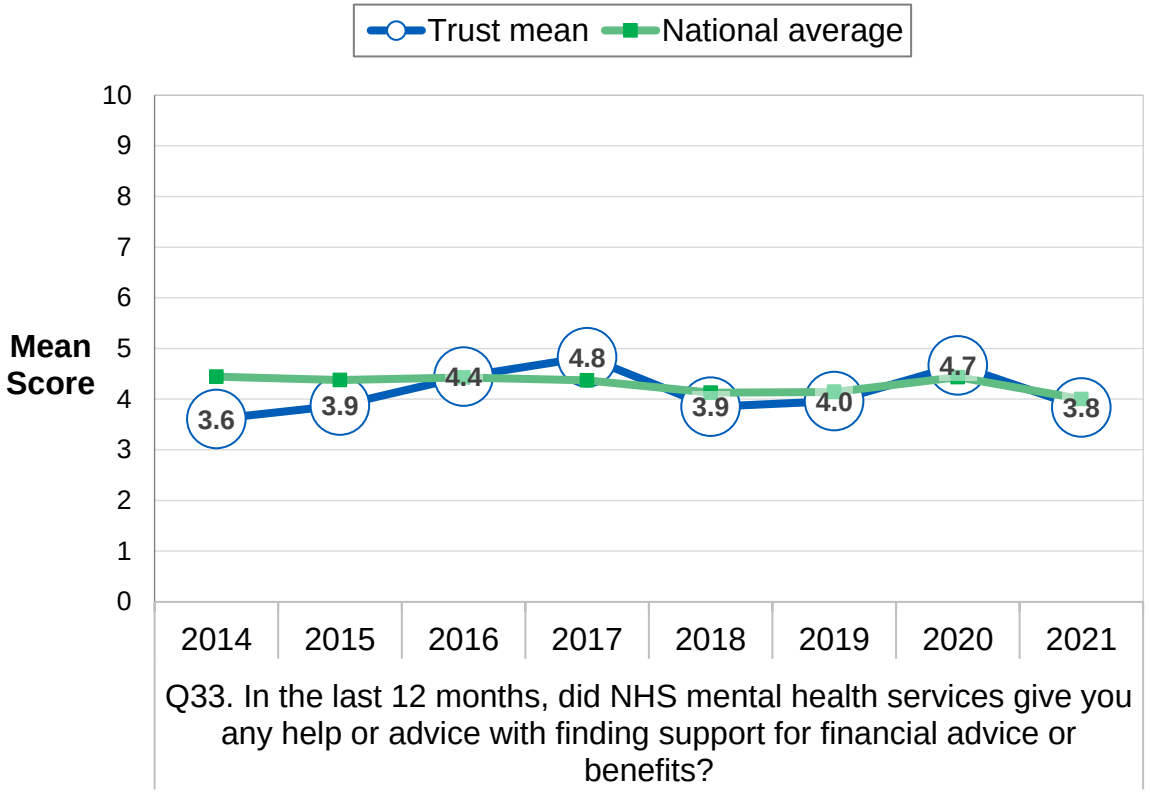
Question scores



Q32. In the last 12 months, did NHS mental health services support you with your physical health needs (this might be an injury, a disability, or a condition such as diabetes, epilepsy, etc)?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by all. Respondents who stated that they have support and did not need NHS mental health services to provide it, do not need support for this, or do not have physical health needs have been excluded. Number of respondents: 2020: 147; 2021: 150



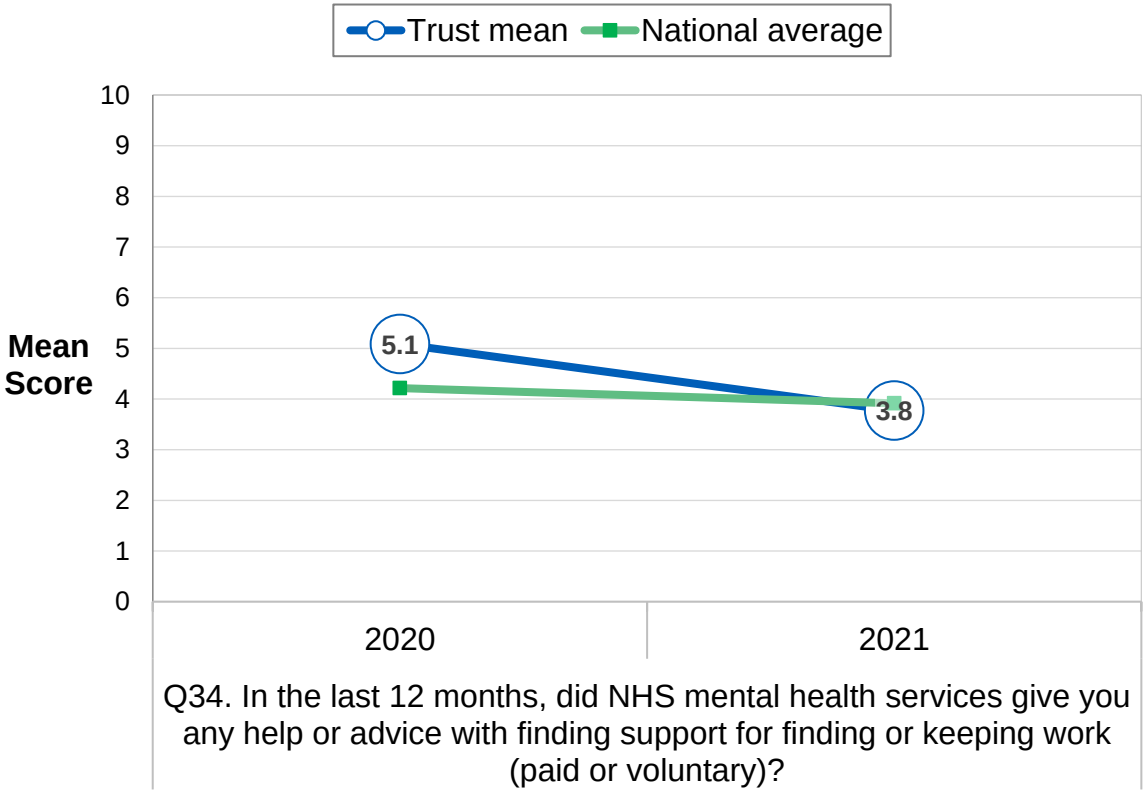
Q33. In the last 12 months, did NHS mental health services give you any help or advice with finding support for financial advice or benefits?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, or do not need support for this have been excluded.
Number of respondents: 2014: 106; 2015: 123; 2016: 104; 2017: 119; 2018: 129; 2019: 102; 2020: 171; 2021: 150

Section 8. Support and wellbeing

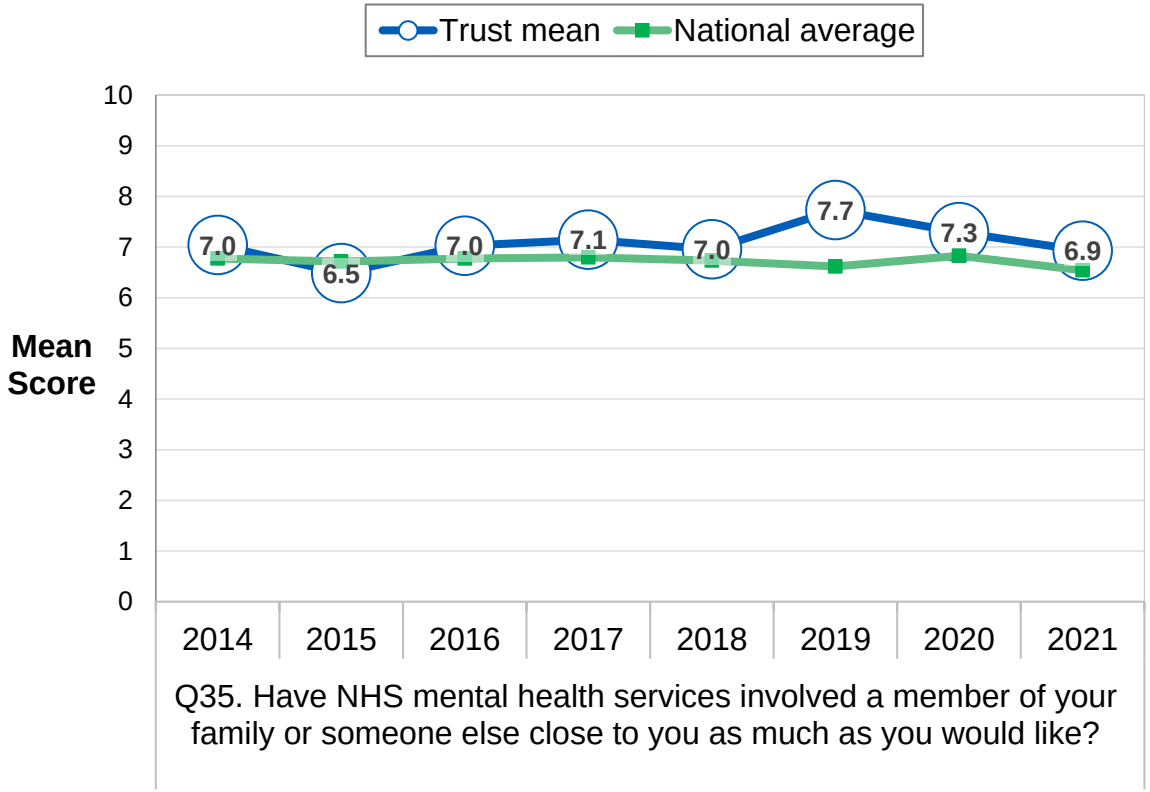
Question scores



Q34. In the last 12 months, did NHS mental health services give you any help or advice with finding support for finding or keeping work (paid or voluntary)?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	-

Answered by all. Respondents who stated that they have support and did not need help / advice to find it, do not need support for this, or are not currently in or seeking work have been excluded. Number of respondents: 2020: 76; 2021: 74



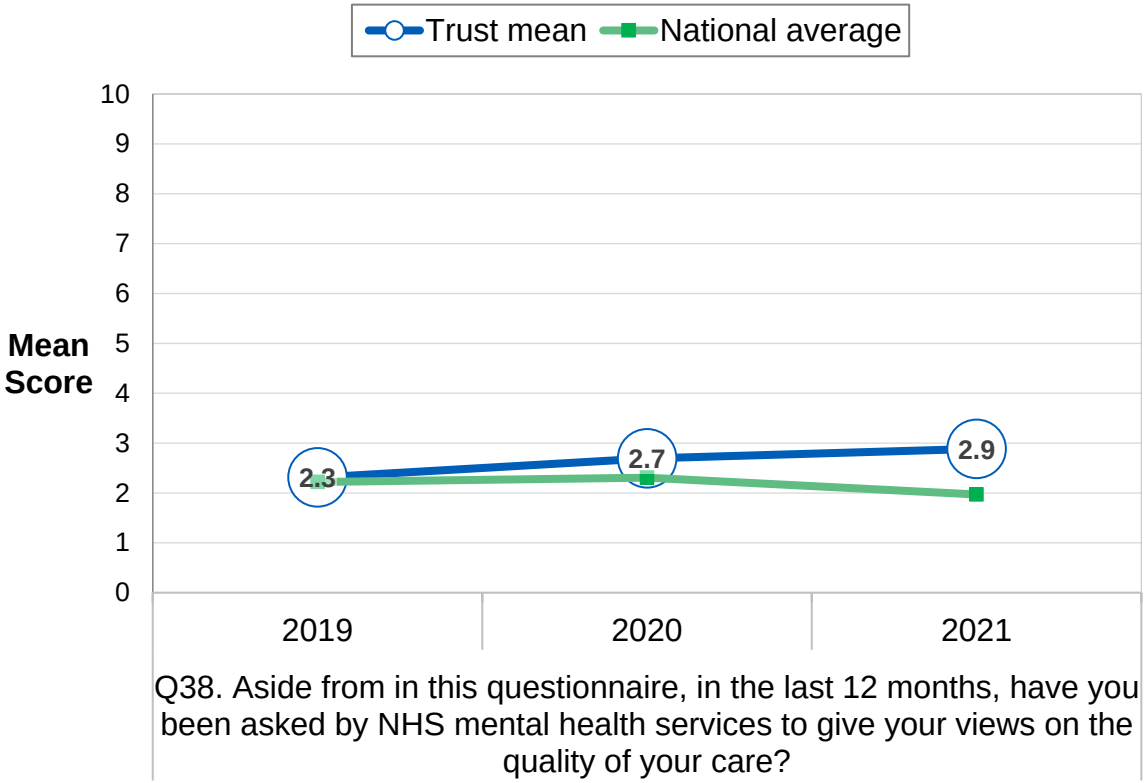
Q35. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all. Respondents who stated that their friends or family did not want to be involved, did not want their friends or family to be involved, or that this does not apply to them have been excluded. Number of respondents: 2014: 148; 2015: 158; 2016: 160; 2017: 173; 2018: 177; 2019: 142; 2020: 214; 2021: 227

Section 9. Feedback

Question scores



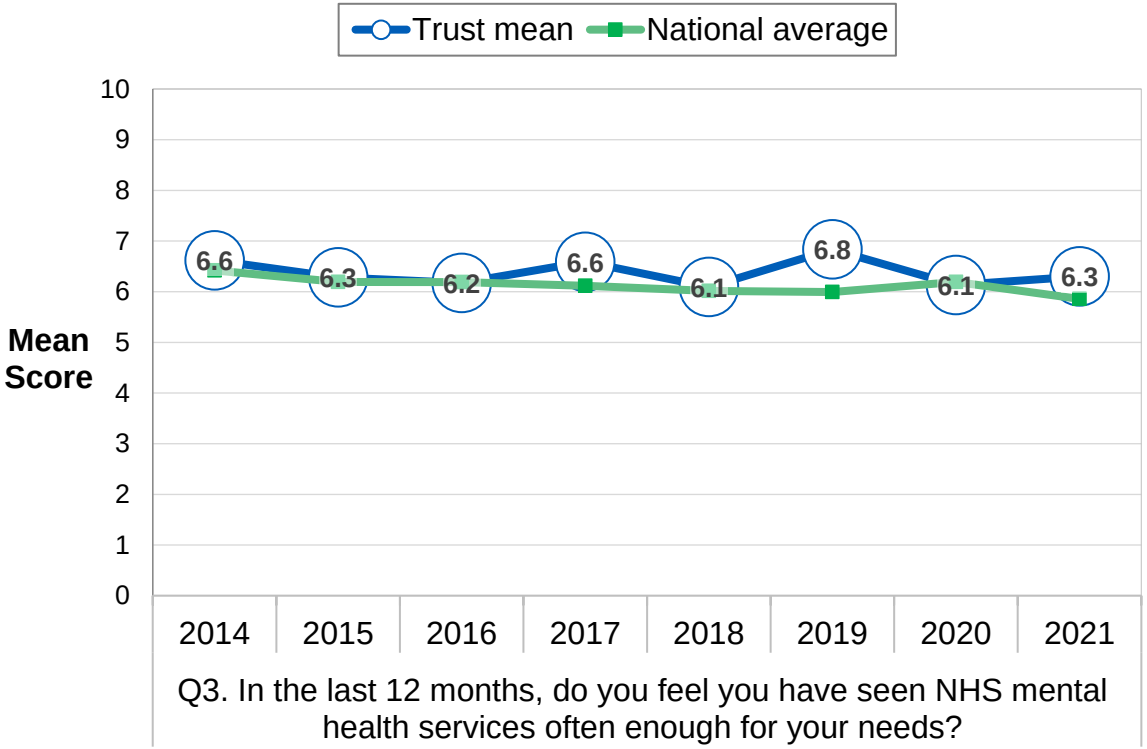
Q38. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Respondents who stated that they weren't sure have been excluded.
Number of respondents: 2019: 167; 2020: 288; 2021: 272

Section 10. Overall views of care and services

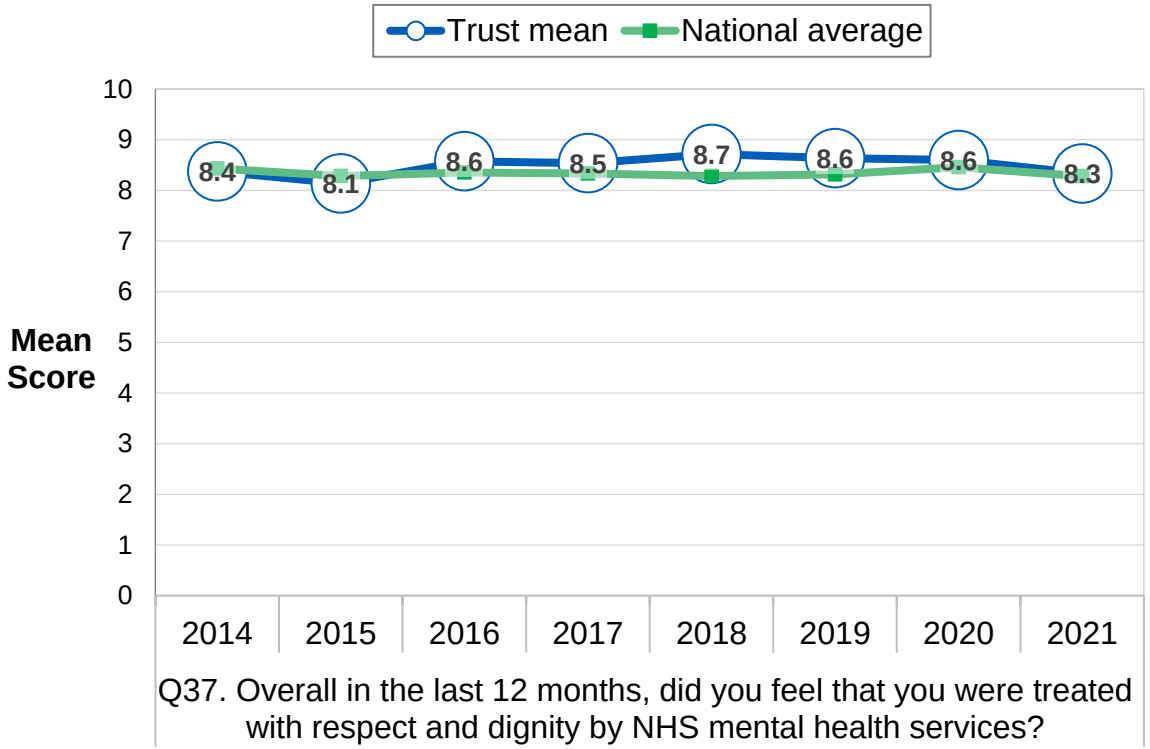
Question scores



Q3. In the last 12 months, do you feel you have seen NHS mental health services often enough for your needs?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Respondents who stated that they didn't know have been excluded.
Number of respondents: 2014: 222; 2015: 232; 2016: 216; 2017: 229; 2018: 256; 2019: 187; 2020: 312; 2021: 308



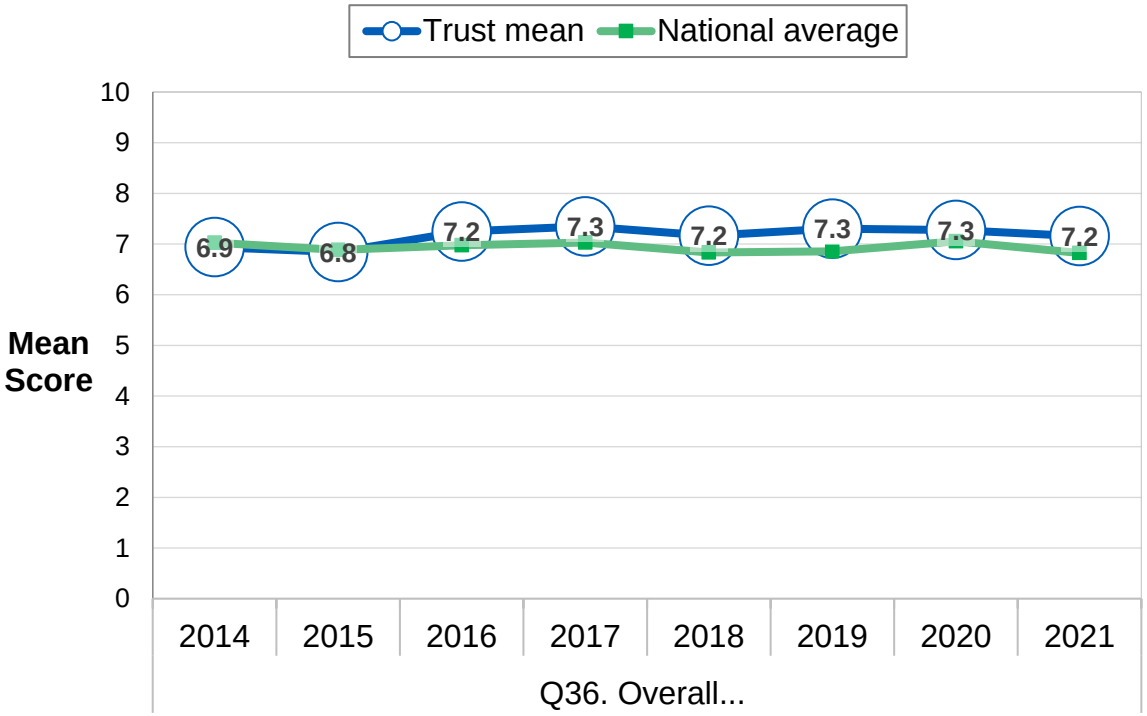
Q37. Overall in the last 12 months, did you feel that you were treated with respect and dignity by NHS mental health services?

Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Respondents who stated that they have support and did not need help / advice to find it, or do not need support for this have been excluded.
Number of respondents: 2014: 226; 2015: 239; 2016: 222; 2017: 232; 2018: 258; 2019: 193; 2020: 313; 2021: 312

Section 11. Overall…

Question scores



Significant change 2021 vs 2020	No change
Significant change 2021 vs 2019	No change

Answered by all.
Number of respondents: 2014: 214; 2015: 228; 2016: 215; 2017: 225; 2018: 245; 2019: 191; 2020: 301; 2021: 303

Appendix

Comparison to other trusts: where your trust has performed much better

The questions at which your trust has performed much better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed better

The questions at which your trust has performed better than compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Better than expected

- Q38. Aside from in this questionnaire, in the last 12 months, have you been asked by NHS mental health services to give your views on the quality of your care?

Comparison to other trusts: where your trust has performed somewhat better

The questions at which your trust has performed somewhat better when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat better than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed somewhat worse

The questions at which your trust has performed somewhat worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed worse

The questions at which your trust has performed worse compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Worse than expected

- No questions for your trust fall within this banding.

Comparison to other trusts: where your trust has performed much worse

The questions at which your trust has performed much worse when compared with all other trusts are listed below.
The questions where your trust has performed about the same compared with all other trusts have not been listed.

Much worse than expected

- No questions for your trust fall within this banding.

NHS Community Mental Health Survey

Results for Berkshire Healthcare NHS Foundation Trust

Where service user experience is best

- ✓ **Views on quality of care:** NHS mental health services asking service users for their views on the quality of their care
- ✓ **Mental health needs:** staff understanding how service user mental health needs affect other areas of their life
- ✓ **Access to care:** care and services available when service users needed them
- ✓ **Seen often enough:** service users being seen by NHS mental health services often enough for their needs
- ✓ **Friends/Family involvement:** service user's family/someone close to them is involved in their care as much as they like

Where service user experience could improve

- **Crisis care help:** services users getting the help needed when they last contacted the crisis team
- **Review of care:** service users meeting with NHS mental health services to discuss how their care is working
- **NHS Talking Therapies:** staff explaining NHS talking therapies in a way service users can understand
- **NHS Talking Therapies:** service users being involved in deciding what NHS talking therapies to use
- **Support with physical health needs:** service users being given support with their physical health needs

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

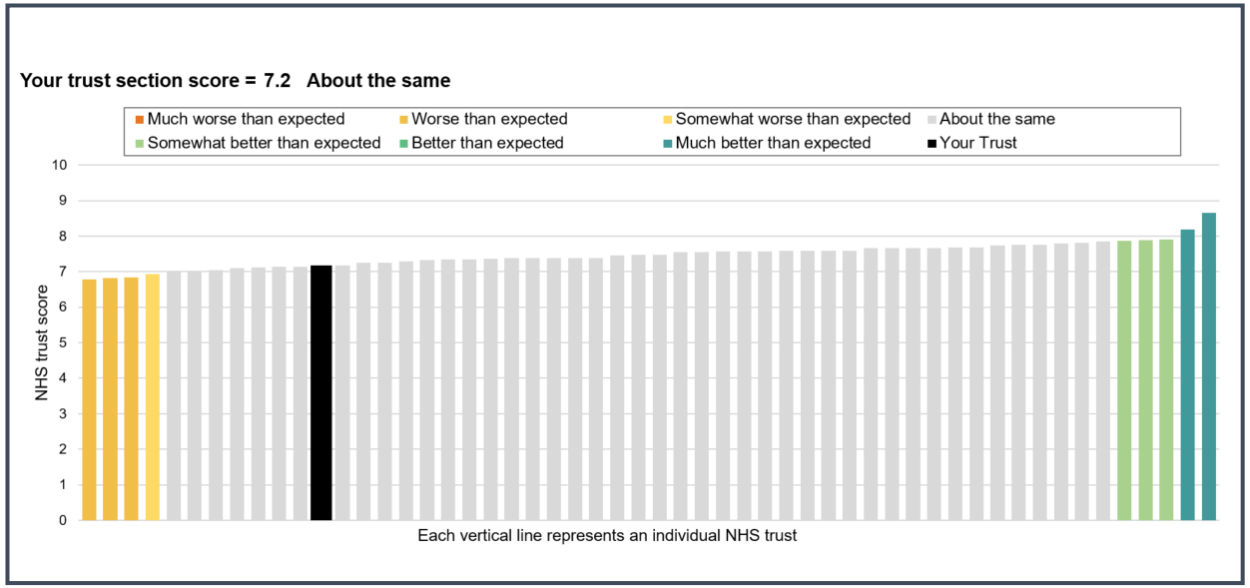
This survey looked at the experiences of people who were receiving care or treatment for a mental health condition and had been treated by the trust between 1 September 2020 and 30 November 2020. Between February and June 2021 a questionnaire was sent to 1250 recent service users. Responses were received from 327 service users at this trust. If you have any questions about the survey and our results, please contact [INSERT TRUST CONTACT DETAILS].

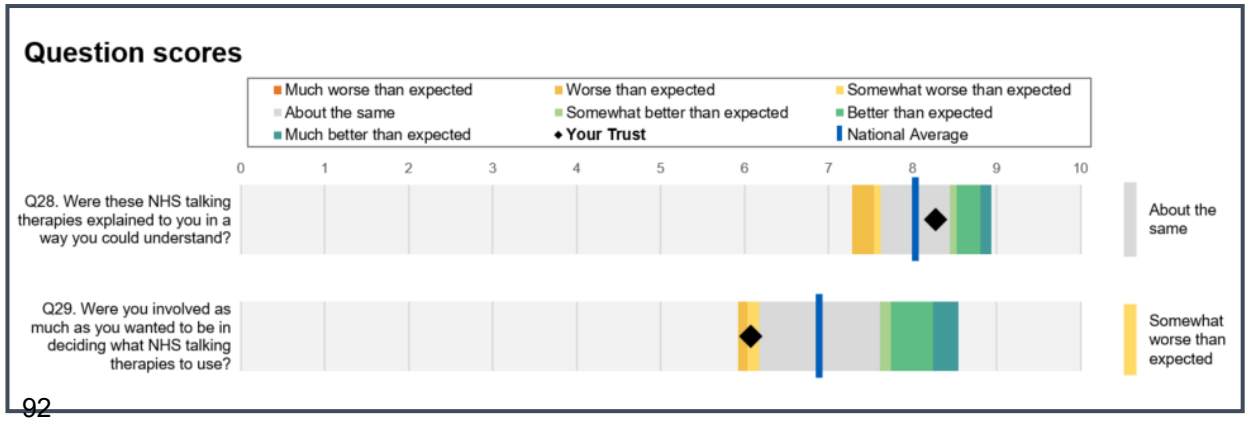
How to interpret benchmarking in this report

The charts in the 'benchmarking' section show how the score for your trust compares to the range of scores achieved by all trusts taking part in the survey. The black line shows the score for your trust. The graphs are divided into seven sections, comparing the score for your trust to most other trusts in the survey:

- If your trust's score lies in the **dark green section** of the graph, its result is 'Much better than expected'.
- If your trust's score lies in the **mid-green section** of the graph, its result is 'Better than expected'.
- If your trust's score lies in the **light green section** of the graph, its result is 'Somewhat better than expected'.
- If your trust's score lies in the **grey section** of the graph, its result is 'About the same'.
- If your trust's score lies in the **yellow section** of the graph, its result is 'Somewhat worse than expected'.
- If your trust's score lies in the **light orange** section of the graph, its result is 'Worse than expected'.
- If your trust's score lies in the **dark orange** section of the graph, its result is 'Much worse than expected'.

These groupings are based on a rigorous statistical analysis of the data termed the 'expected range' technique.





How to interpret benchmarking in this report (continued)

The ‘much better than expected,’ ‘better than expected’, ‘somewhat better than expected’, ‘about the same’, ‘somewhat worse than expected’, ‘worse than expected’ and ‘much worse than expected’ categories are based on an analysis technique called the ‘expected range’. Expected range determines the range within which a trust’s score could fall without differing significantly from the average, taking into account the number of respondents for each trust, to indicate whether the trust has performed significantly above or below what would be expected.

If it is within this expected range, we say that the trust’s performance is ‘about the same’ as other trusts. Where a trust is identified as performing ‘better’ or ‘worse’ than the majority of other trusts, the result is unlikely to have occurred by chance.

In some cases, there will be no shades of orange and/or green area in the graph. This happens when the expected range for your trust is so broad that it encompasses either the highest possible score for all trusts (no green section) or the lowest possible score for all trusts (no orange section). This could be because there were few respondents and/or a lot of variation in their answers.

In some cases, a trust could be categorised as ‘about the same’ whilst having a lower score than a 'worse than expected' trust, or categorised as 'about the same' whilst having a higher score than a 'better than expected' trust.

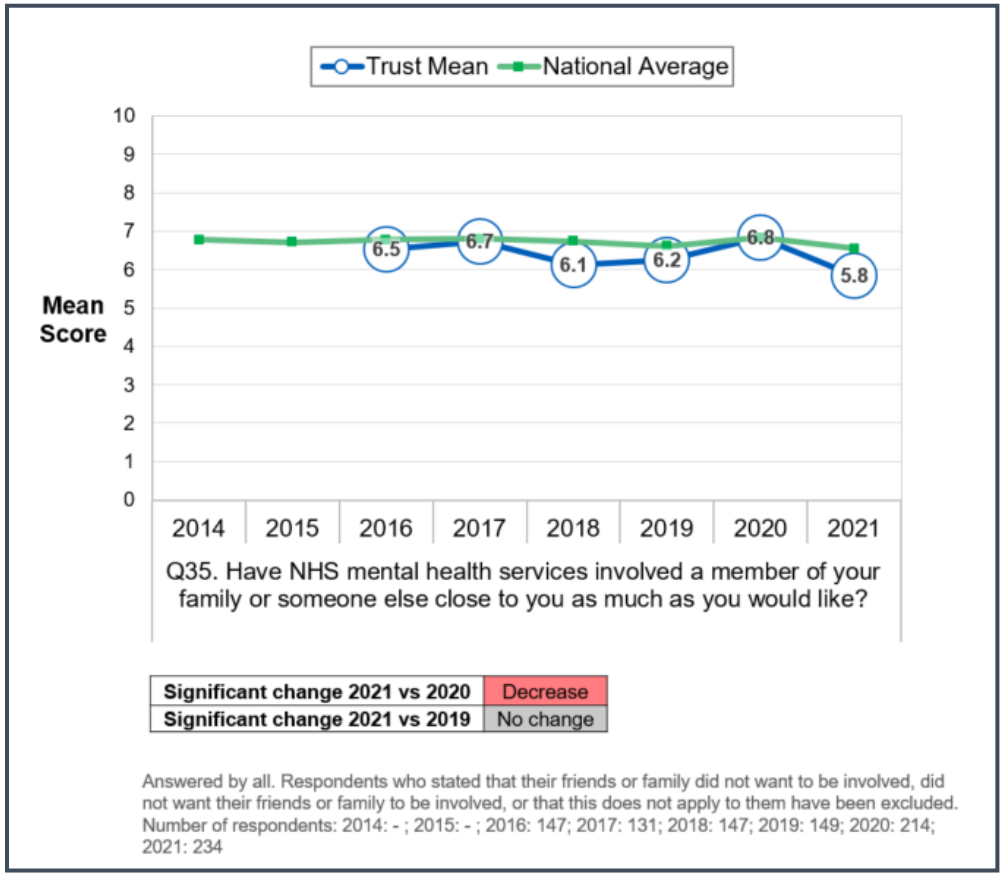
Additional information on the ‘expected range’ analysis technique can be found in the survey technical report on the NHS Surveys website.

How to interpret change over time in this report

The charts in the ‘change over time’ section show how your trust scored in each Community Mental Health survey iteration. Where available, trend data from 2014 to 2021 is shown. If a question only has one data point, this question is not shown. Questions that are not historically comparable, are also not shown.

Each question is displayed in a line chart. These charts show your trust mean score for each survey year (blue line). The national average is also shown across survey years, this is the average score for that question across all community mental health trusts in England (green line). This enables you to see how your trust compares to the national average. If there is data missing for a survey year, this is may be due to either a low number of responses, because the trust was not included in the survey that year, sampling errors or ineligibility.

Statistically significant changes are also displayed in tables underneath the charts, showing significant differences between this year (2021) and the two previous years (2020 and 2019). Z-tests set to 95% significance were used to compare data between the two years (2021 vs 2020 and 2021 vs 2019). A statistically significant difference means it is unlikely we would have obtained this result if there was no real difference.



An example of scoring

Each evaluative question is scored on a scale from 0 to 10. The scores represent the extent to which the service user's experience could be improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas a score of 10 refers to the most positive service user experience possible. Where a number of options lay between the negative and positive responses, they are placed at equal intervals along the scale. Where options were provided that did not have any bearing on the trust's performance in terms of service user experience, the responses are classified as "not applicable" and a score is not given. Similarly, where respondents stated they could not remember or did not know the answer to a question, a score is not given.

Calculating an individual respondent's score

The following provides an example for the scoring system applied for each respondent. For question 7 "Were you given enough time to discuss your needs and treatment?":

- The answer code "Yes, definitely" would be given a score of 10, as this refers to the most positive service user experience possible.
- The answer code "Yes, to some extent" would be given a score of 5, as it is placed at an equal interval along the scale.
- The answer code "No" would be given a score of 0, as this response reflects considerable scope for improvement.
- The answer code "Don't know / can't remember" would not be scored, as they do not have a clear bearing on the trust's performance in terms of service user's experience.

Calculating the trust score for each question

The weighted mean score for each trust, for each question, is calculated by dividing the sum of the weighted scores for a question by the weighted sum of all eligible respondents to the question for each trust. An example of this is provided in the survey technical document.

Calculating the section score

An arithmetic mean of each trust's question scores is taken to provide a score for each section.

Thank you.

For further information please contact the Survey Coordination Centre for Existing Methods:

mentalhealth@surveycoordination.com

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8th February 2022
Title	Patient Experience Report Quarter 3 (October– December 2021)
Purpose	The purpose of this report is to provide the Board with an overview of patient experience information and activity for Quarter 3
	Item For Noting
Business Area	Nursing and Governance
Author	Elizabeth Chapman, Head of Patient Experience
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff and Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	n/a
Legal Implications	n/a
Equality and Diversity Implications	n/a
SUMMARY	This report is for information and provides detail of patient experience data and feedback including complaints and compliments collected across the Trust during quarter 3 (October – December 2021). It is the view of the Director of Nursing that there are no new themes or trends identified from the patient experience data within the report. The total number of complaints are comparable with the previous quarter and there is also a similar percentage of closed complaints that are either partially or fully upheld with these generally being spread across services. The highest numbers of upheld/ partially upheld complaints relate to care and treatment (19) with these being very specific to the individual with no obvious themes emerging.

	The demographic data shows that for ethnicity and gender there is correlation between percentage of attendances and percentage of complaints received. The positive compliments and feedback received continues to far outweigh the concerns and complaints raised; that said every concern / complaint is reviewed with feedback provided and consideration given to learning from the persons experience. The new patient experience tool which has been developed in partnership with 'I WantGreatCare' launched toward the end of quarter 3, it is recognised that the new tool and optimum use of the information received through it will take time to embed. A sample of the free text feedback has been provided in the report alongside the overall percentage satisfaction of those who have responded using the new tool during December. Appendix 3 of the report shows some examples of how feedback is provided back to teams / services and the wider organisation. The PHSO continues to catch up with complaints raised to them and as a result we have a large number that we have provided information to assist their decision making and are awaiting a decision around whether the PHSO will progress to an investigation. Some 15- steps visits have recommenced, and Appendix 2 of the report provides a short summary of these.
ACTION	The Board is asked to note the report

Quarter Three – Patient Experience Report (October 2021 to December 2021)

1. Introduction

This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, PALS, and our patient survey programme (which is collected using paper, online, text, kiosks, and tablets).

2. Complaints received

2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2020-21 and 2021-22 by service, enabling a comparison. During Quarter three 2021-22 there were 55 complaints received (including re-opened complaints). This is comparable with the same period for 2020-21 where there were 51.

There were 115,195 reported contacts and discharges from our inpatient wards, giving a sustained complaint rate of 0.05%.

Table 1: Formal complaints received

	2020-2021						2021-22					
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% Of Total**	**Q1**	**Q2**	**Higher or lower than previous quarter**	**Q3**	**Total for year**	**% Of Total**
CMHT/Care Pathways	4	11	7	12	34	**15.96**	5	8	↑	10	23	**13.14**
CAMHS - Child and Adolescent Mental Health Services	2	3	3	6	14	**6.57**	5	10	↓	6	21	**12.00**
Crisis Resolution & Home Treatment Team (CRHTT)	4	2	3	4	13	**6.1**	5	4	↓	2	11	**6.29**
Acute Inpatient Admissions – Prospect Park Hospital	7	4	1	9	21	**9.86**	11	8	↓	7	26	**14.86**
Community Nursing	2	1	5	2	10	**4.69**	4	5	↓	2	11	**6.29**
Community Hospital Inpatient	5	6	3	4	18	**8.45**	6	8	↓	6	20	**11.43**
Common Point of Entry	1	1	3	1	6	**2.82**	0	1	-	1	2	**1.14**
Out of Hours GP Services	4	0	3	1	8	**3.76**	1	1	↑	5	7	**4.00**

	2020-2021						2021-22					
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% Of Total**	**Q1**	**Q2**	**Higher or lower than previous quarter**	**Q3**	**Total for year**	**% Of Total**
PICU - Psychiatric Intensive Care Unit	2	0	0	2	4	**1.88**	3	1	↑	2	6	**3.43**
Urgent Treatment Centre	1	0	1	0	2	**0.94**	1	1	↓	0	2	**1.14**
Older Adults Community Mental Health Team	1	1	1	2	5	**2.35**	0	0	-	0	0	**0.00**
Other services in Q3	11	33	21	13	78	**36.62**	18	14	-	14	46	**26.29**
Grand Total	**44**	**62**	**51**	**56**	**213**		**59**	**61**		**55**	**175**	

The ‘other services’ complaints were split over 8 different services, and there is nothing of note to report as these services only saw numbers of 1 or 2 complaints.

3 of the 55 formal complaints received were about, or mentioned, Covid, these were:

- Two complaints about the vaccine given to school aged children
- Family remained unhappy with SI report and still have concerns around the fact their father contracted Covid and died

Complaints are reported against the geographical locality where the care was received which is the most meaningful way of recording. The following tables show a breakdown of the formal complaints that have been received during Quarter three and where the service is based. Complaints relating to end-of-life care are considered as part of the Trust mortality review processes.

2.2 Adult mental health service complaints received in Quarter three

28 of the 55 (51%) complaints received during Quarter three were related to adult mental health service provision.

Table 2: Adult mental health service complaints

	Geographical Locality						
Service	**Bracknell**	**Ports-mouth**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Adult Acute Admissions - Bluebell Ward			2				**2**
Adult Acute Admissions - Daisy Ward			3				**3**
Adult Acute Admissions - Snowdrop Ward			2				**2**
CMHT/Care Pathways			3	3	2	2	**10**
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1				1		**2**
Common Point of Entry			1				**1**
Criminal Justice Liaison and Diversion Service - (CJLD)		3					**3**
Crisis Resolution and Home Treatment Team (CRHTT)			2				**2**

	Geographical Locality						
Service	**Bracknell**	**Ports-mouth**	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Learning Disability Service Inpatients - Campion Unit - Ward			1				**1**
PICU - Psychiatric Intensive Care - Sorrel Ward			2				**2**
Grand Total	**1**	**3**	**16**	**3**	**3**	**2**	**28**

2.2.1 Number and type of complaints made about a CMHT

10 of the 55 complaints (18%) received during Quarter three related to the CMHT service provision, detail below. There were 9,971 reported attendances for CMHT and the ASSiST service during Quarter three, giving a complaint rate of 0.10%, compared 0.07% in Quarter two and 0.04% in Quarter one.

There were no formal complaints for the Talking Therapies service in Quarter three.

Table 3: CMHT complaints

	Geographical Locality				
Main subject of complaint	**Reading**	**Slough**	**West Berks**	**Wokingham**	**Grand Total**
Attitude of Staff				1	**1**
Care and Treatment	2	3	1		**6**
Clinical Care Received	1				**1**
Discharge Arrangements				1	**1**
Confidentiality			1		**1**
Grand Total	**3**	**3**	**2**	**2**	**10**

6 of the complaints about the CMHT related to care and treatment, these included.

- Concerns from families about the level of care being offered
- Access to the service
- A concern about a misdiagnosis and medication

2.2.2 Number and type of complaints made about CPE

There was 1 complaint received about CPE in Quarter three out of 1,510 contacts. The 1 complaint was about being discharged.

2.2.3 Number and type of complaints made about Mental Health Inpatient Services

During Quarter three, 9 of the 55 complaints (16%) related to Adult Acute mental health inpatient services (including APOS) and Sorrel Ward. This is a decrease in the numbers received in Quarter two (20%) and Quarter one (24%).

There were 199 reported discharges from mental health inpatient wards (including Sorrel Ward) during Quarter three giving a complaint rate of 4.5%.

Table 4: Mental Health Inpatient Complaints

	Ward				
Main subject of complaint	**Bluebell Ward**	**Daisy Ward**	**Snowdrop Ward**	**Sorrel Ward**	**Grand Total**
Abuse, Bullying, Physical, Sexual, Verbal	1				**1**
Care and Treatment		2	2	1	**5**
Clinical Care Received	1				**1**
Failure/incorrect diagnosis				1	**1**
Management and Administration		1			**1**
Grand Total	**2**	**3**	**2**	**2**	**9**

2.2.4 Number and type of complaints made about Crisis Resolution/ Home Treatment Team (CRHTT)

In Quarter three, 2 of the 55 complaints (4%) were attributed to CRHTT, a continued decrease from 4 in Quarter two and 5 in Quarter one.

There were 14,459 reported contacts for CRHTT during Quarter three giving a complaint rate of 0.01% compared to 0.02% in Quarter two and 0.03% in Quarter one.

Table 5: CRHTT complaints

	Geographical Locality	
Main subject of complaint	**Reading**	**Grand Total**
Attitude of Staff	1	**1**
Care and Treatment	1	**1**
Grand Total	**2**	**2**

2.3 Community Health Service Complaints received in Quarter three

During Quarter three, 16 of the 55 complaints (29%) related to community health service provision. The table below shows further details.

Table 6: Community Health service complaints

	Geographical Locality						
Service	**Bracknell**	**Reading**	**Slough**	**West Berks**	**Windsor, Ascot, and Maidenhead**	**Wokingham**	**Grand Total**
Community Hospital Inpatient Service - Ascot Ward						1	**1**
Community Hospital Inpatient Service - Donnington Ward				1			**1**
Community Hospital Inpatient Service - Highclere Ward				1			**1**
Community Hospital Inpatient Service - Jubilee Ward			1				**1**
Community Hospital Inpatient Service - Oakwood Ward		2					**2**
District Nursing	1				1		**2**
Integrated Pain and Spinal Service - IPASS		1					**1**
Out of Hours GP Services		2		1		2	**5**
Rapid Response		1				1	**2**
Grand Total	**1**	**6**	**1**	**3**	**1**	**4**	**16**

2.3.1 Community Health Inpatient Ward Complaints

During Quarter three, 6 of the 55 complaints (11%) received related to inpatient wards. This is compared to 8 in Quarter two and 6 in Quarter one.

There were 504 reported discharges from community health inpatient wards during Quarter three giving a complaint rate of 1.2%, compared to 1.3% in Quarter two and 1% Quarter one.

Table 7: Community Health Inpatient complaints

	Ward					
Main subject of complaint	**Ascot Ward**	**Donnington Ward**	**Highclere Ward**	**Jubilee Ward**	**Oakwood Ward**	**Grand Total**
Care and Treatment			1	1	1	**3**
Clinical Care Received		1			1	**2**
Discharge Arrangements	1					**1**
Grand Total	**1**	**1**	**1**	**1**	**2**	**6**

From the eight community health inpatient wards, 6 complaints were received for five wards. The top theme was care and treatment.

There has been a reduction in complaints received about the Oakwood Unit who received 5 of the 8 complaints for Community Health Inpatients in Quarter two, The Ward Manager and Governance Lead continue to closely review and monitor complaints on the unit.

2.3.2 Community Nursing Service Complaints

District Nursing received 2 complaints in Quarter three, compared to 5 in Quarter two and 6 in Quarter one.

There were 72,195 reported attendances for the Community Nursing Service during Quarter three giving a complaint rate of 0.002%. Complaints against the Community Nursing Service continues to be a very small complaint rate, which is well below the Trust overall rate of complaints per contact.

Table 8: Community Nursing Service complaints

	Geographical Locality		
Main subject of complaint	**Bracknell**	**Windsor, Ascot, and Maidenhead**	**Grand Total**
Care and Treatment	1	1	**2**
Grand Total	**1**	**1**	**2**

2.3.3 GP Out of Hours Service (WestCall) Complaints and Urgent Care Centre

There were 5 complaints in Quarter three for WestCall, out of 18,708 reported attendances, giving a complaint rate of 0.027%, compared to 0.006% in Quarter two, 0.005% for Quarter one and 0.01% for Quarter four, whilst an increase this remains a very small percentage of total contacts for the service and the total number of complaints for the year to date remains the same as the number received in the first three quarters of 2020/21.

These included delays in call backs from the service (which was due to unprecedented demand), diagnosis and communication.

There were no complaints for the Urgent Care Centre, which had 4,160 attendances.

2.4 Children, Young People and Family service Complaints

2.4.1 Physical Health services for children

There were five complaints for Children's physical health services, three complaints were regarding the immunisation service. 1 was about the content of the nasal flu spray, and 2 were about the access and administration of vaccinations.

Table 9: Children and Young People service physical health service complaints

	Geographical Locality			
Service	**Bracknell**	**West Berks**	**Wokingham**	**Grand Total**
Children's Speech and Language Therapy - CYPIT		1		**1**
Health Visiting			1	**1**
Immunisation	1	1	1	**3**
Grand Total	**1**	**2**	**2**	**5**

2.4.2 CAMHS complaints

During Quarter three, 6 of the 55 complaints (11%) were about CAMHS services (compared to 11 in Quarter two), including the Adolescent Mental Health Inpatient Unit, which has now changed to a Hospital at Home model. There were 7,671 reported attendances for CAMHS during Quarter three giving a complaint rate of 0.07%, compared to 0.14% in Quarter two and 0.06% for Quarter one.

Table 10: CAMHS Complaints

	Main subject of complaint				
Service	**Care and Treatment**	**Healthcare Professional**	**Long Wait for an appointment**	**Written to Patients**	**Grand Total**
CAMHS - ADHD			1		**1**
CAMHS - Common Point of Entry (Children)	1				**1**
CAMHS - Getting Help East				1	**1**
CAMHS - Specialist Community Teams	1	1	1		**3**
Grand Total	**2**	**1**	**2**	**1**	**6**

2.5 Learning Disabilities

There were no complaints about the community-based team for people with a Learning Disability and there was 1 complaint for our Learning Disability Inpatient Ward (Campion Unit) during Quarter three.

3. KO41A return

Each quarter the complaints office submits a quarterly return, called the KO41A.

The return looks at the number of new formal complaints that have been received by profession, category, age, and outcome. The information is usually published a quarter behind, but it can be three quarters behind. Information for Quarters one and two for 2021/22 were only requested to be submitted

in October 2021, however the publication has been delayed. The table below shows the information for Mental Health Trusts, up to and including Quarter four 2020-21.

Table 11: KO41A Return

	2018-19				2019-20				2020-21			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mental Health complaints - nationally reported	**3,598**	**3,651**	**3,391**	**3,450**	**3,507**	**3,502**	**3,335**	**3,303**	**2,058**	**3,049**	**2,753**	**2,854**
2Gether NHS Foundation Trust	17	14	21	20	24	16	..	..	..	..	..	..
Avon and Wiltshire Mental Health Partnership NHS Trust	78	72	77	51	56	67	59	63	42	67	48	65
Berkshire Healthcare NHS Foundation Trust	**49**	**45**	**38**	**51**	**47**	**52**	**56**	**51**	**40**	**47**	**37**	**51**
Cornwall Partnership NHS Foundation Trust	31	28	20	30	24	22	23	19	12	27	15	8
Devon Partnership NHS Trust	44	56	33	45	52	46	56	49	15	31	49	40
Dorset Healthcare University NHS Foundation Trust	91	90	92	54	61	60	64	88	60	109	98	95
Kent and Medway NHS and Social Care Partnership Trust	87	115	121	118	121	128	124	90	70	111	78	80
Oxford Health NHS Foundation Trust	50	56	58	56	52	61	72	68	44	54	54	55
Somerset Partnership NHS Foundation Trust	17	14	24	18	24	24	17	19	45	90	NA	NA
Southern Health NHS Foundation Trust	91	95	82	68	73	51	52	51	29	51	40	31
Surrey and Borders Partnership NHS Foundation Trust	26	36	16	26	22	28	32	27	9	27	24	17
Sussex Partnership NHS Foundation Trust	209	192	181	173	178	217	219	194	99	164	154	198

The Head of Service Engagement and Experience has contacted colleagues in a number of the local Trusts to better understand the vast contrast in some of the reported activity.

In summary, when looking at this data is important to do so with the following in mind:

- The numbers do not reflect the complexity of the complaints
- It does not give an indication of the quality of the responses e.g. how many of these are re-opened complaints
- Some Trusts with low levels of reported formal complaints and combined PALS and Complaints offices have a rigorous process of informal resolution before accepting a complaint as formal (this approach needs to be managed carefully as the regulations do not give the instruction to do this)
- Some Trusts with high levels of reported formal complaints treat every complaint contact as formal
- One Trust with low levels of reported formal complaints has an average response time of over 120 days

4. 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). During Quarter three there were 62 complaints closed.

Appendix one contains a listing of the formal complaints **closed** during Quarter three.

4.1 Outcome of closed formal complaints

Table 12: Outcome of formal complaints closed

	2020-2021						2021-2022				
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% Of 20/21**	**Q1**	**Q2**	**Higher or lower than previous quarter**	**Q3**	**% Of 21/22**
Not Upheld	9	25	19	18	71	36%	27	36	↓	34	53.3%
Partially Upheld	13	34	20	28	95	48%	19	18	↑	22	32.4%
Upheld	12	6	0	7	25	12.50%	9	11	↓	6	14.3%
Disciplinary Action required	0	0	0	0	0	0	0	0	-	0	0
Grand Total	**34**	**65**	**39**	**53**	**191**		**55**	**65**		**62**	

47% of complaints closed were either partly or fully upheld in the quarter (compared to 45% last quarter), these were spread across several differing services. Of these, 3 were about staff attitude (down from 9), 2 were in relation to communication (down from 3) and 19 related to care and treatment received (up from 12). This equates to 11% for staff attitude (down from 27%), 7% for communication (down from 10%) and 68% for care and treatment (an increase from 41%) in Quarter three.

Table 13: Complaints upheld and partially upheld

	Main subject of complaint						
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Medication**	**Waiting Times for Treatment**	**Grand Total**
Adult Acute Admissions - Bluebell Ward	1		1				**2**
Adult Acute Admissions - Daisy Ward			1				**1**
Adult Acute Admissions - Snowdrop Ward			1				**1**
Assessment and Rehabilitation Centre (ARC)			1				**1**
CAMHS - AAT		1				1	**2**
CAMHS - ADHD						1	**1**
CAMHS - Getting Help East				1			**1**
CAMHS - Specialist Community Teams			1				**1**
CMHT/Care Pathways		1	3				**4**
Community Hospital Inpatient Service - Donnington Ward			2				**2**

	Main subject of complaint						
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Medication**	**Waiting Times for Treatment**	**Grand Total**
Community Hospital Inpatient Service - Jubilee Ward			1				**1**
Community Hospital Inpatient Service - Oakwood Ward			3				**3**
Crisis Resolution and Home Treatment Team (CRHTT)			1				**1**
District Nursing			1				**1**
Older Adults Inpatient Service - Orchid ward			1				**1**
Older Adults Inpatient Service - Rowan Ward			1				**1**
Corporate Services				1			**1**
Out of Hours GP Services		1	1				**2**
Pharmacy					1		**1**
Grand Total	**1**	**3**	**19**	**2**	**1**	**2**	**28**

4.2 Response Rate

The table below shows the response rate within a negotiated timescale, as a percentage total.

Weekly open complaints situation reports (SITREP) are sent to Clinical Directors, as well as on-going communication with the Complaints Office throughout the span of open complaints to keep them on track as much as possible.

Table 14: Percentage response rate within timescale negotiated with complainant

2021-22			2020-21				2019-20			
Q3	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**	**Q2**	**Q1**
100	100	100	100	100	99	100	100	98	100	100

All complaints closed in Quarter three were closed within an agreed timescale.

5. Characteristic data

5.1 Ethnicity

One of the ways that the Trust can monitor the quality of its services is by seeking assurance through the complaints process, that people are not treated negatively as a result of their ethnicity or other protected characteristic.

The tables below show the characteristics of patients who have had complaints raised about their care between 1 October and 31 December 2021. This does not include where a different organisation was leading the investigation but does include re-opened complaints. The population data has been aligned to the information provided by the Trust Business Intelligence Team and is based on the characteristics of attendances during Quarter 4 2020/21.

Table 15: Ethnicity

Ethnicity	Number of patients	% Complaints received	% Breakdown of Q4 attendances
Asian/Asian British	6	9.84	9.67
Black/Black British	3	4.92	2.67

Mixed	2	3.28	3.49
Not stated	12	19.67	15.89
Other Ethnic Group	2	3.28	1.62
White	36	59.02	66.66
Grand Total	**61**		

As a way of improving ethnicity recording, information is sent back to services where this is not documented on RiO. The Complaints Office also discuss the importance of capturing this information when delivering the Complaint Handling Training.

5.2 Gender

There were no patient complaints where the person identified as anything other than male or female during Quarter three.

Table 16: Gender

Gender	Number of patients	% Complaints received	% Breakdown of Q4 attendance
Female	28	53	53
Male	25	47	46.98
Not stated	0	0	0.009
Grand Total	**53**		

5.3 Age

Table 17: Age

	Number of patients	% Complaints received	% Breakdown of Q4 attendance
0 to 4	3	5.66%	18.41%
5 to 9	1	1.89%	4.14%
10 to 14	2	3.77%	4.34%
15 to 19	5	9.43%	4.52%
20 to 24	3	5.66%	2.87%
25 to 29	3	5.66%	3.14%
30 to 34	2	3.77%	3.56%
40 to 44	4	7.55%	3.58%
45 to 49	1	1.89%	3.52%
50 to 54	3	5.66%	3.73%
55 to 59	3	5.66%	4.32%
60 to 64	5	9.43%	4.46%
65 to 69	1	1.89%	4.63%
70 to 74	2	3.77%	4.53
75 to 79	4	7.55%	5.56
80 to 84	1	1.89%	6.16
85 +	8	15.09%	6.55
Not known	2	3.77%	11.98
Grand Total	**53**	**100%**	**0**

6. Parliamentary and Health Service Ombudsman

6.1 The Parliamentary and Health Service Ombudsman (PHSO) activity related to the Trust

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process.

There has been one new formal investigation taken on by the PHSO in Quarter three and we have received 1 enquiry where they have asked for further information. There are currently 3 cases that are open for investigation. The table below shows each case against the service.

There has been a notable increase in the number of requests for information from the PHSO over the two quarters. This is due to a backlog in cases being reviewed and taken forward for further exploration by the PHSO as a result of the pandemic. All of the information has been provided.

Table 18: PHSO

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

Month open	Service	Month closed	Current Stage
May-21	Talking Therapies	n/a	PHSO have requested information to aid their decision on whether they will investigate
Jun-21	Community Nursing	n/a	PHSO have requested information to aid their decision on whether they will investigate
Jul-21	District Nursing	n/a	PHSO have requested information to aid their decision on whether they will investigate
Jul-21	Talking Therapies - Admin/Ops Team	n/a	PHSO have requested information to aid their decision on whether they will investigate
Aug-21	Health Visiting	n/a	PHSO have requested information to aid their decision on whether they will investigate
Aug-21	Podiatry	n/a	PHSO have requested information to aid their decision on whether they will investigate
Sep-21	Children's Speech and Language Therapy - CYPIT	n/a	PHSO have requested information to aid their decision on whether they will investigate
Sep-21	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Sep-21	Veterans TILS Service	n/a	PHSO have requested information to aid their decision on whether they will investigate
Nov-21	Oakwood Ward	n/a	Investigation Underway
Dec-21	Corporate	n/a	PHSO have requested information to aid their decision on whether they will investigate

7. Multi-agency working

In addition to the complaints detailed in this report, the Trust monitors the number of multi-agency complaints they are involved in but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There were nine complaints received that were led by another organisation during Quarter three; one led by NHSE, one by Frimley Health, two by the RBH and five by SCAS.

8. MP enquiries, locally resolved complaints and PALS

8.1 MP enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust.

Table 19: MP Enquiries

	Main subject of complaint			
Service	**Care and Treatment**	**Management and Administration**	**Waiting Times for Treatment**	**Grand Total**
CAMHS - AAT			1	**1**
CAMHS - ADHD			1	**1**
CAMHS - Anxiety and Depression Pathway	2			**2**
CMHT/Care Pathways	2			**2**
Community Hospital Inpatient Service - Ascot Ward	1			**1**
District Nursing Out of Hours Service	1			**1**
Early Intervention in Psychosis - (EIP)		1		**1**
PICU - Psychiatric Intensive Care - Sorrel Ward	1			**1**
Grand Total	**7**	**1**	**2**	**10**

There were 10 enquiries raised by constituents to their MPs in Quarter three. This compares to 15 in Quarter two and 17 in Quarter one.

7 of the MP enquiries related to care and treatment and 2 were regarding waiting times. The enquiries for waiting times were all related to CAMHS services. Overall 4 of the enquiries were for CAMHS (down from 8) and two were for the CMHT (down from 3).

8.2 Local resolution complaints

Complaints can be raised directly with the service, where the service will discuss the options for complaint management with those raising the complaint to give them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint locally, without involvement of the Complaints Office. These are called Local Resolutions and services log these so that we can see how services are doing at a local level.

Table 20: Concerns managed by services – Local Resolution complaints

Service	**Number of complaints**
CAMHS - Anxiety and Depression Pathway	**1**
Children's Speech and Language Therapy - CYPIT	**2**
Community Dietetics	**1**
Community Hospital Inpatient Service - Oakwood Ward	**1**
Community Team for People with Learning Disabilities (CTPLD)	**1**
District Nursing	**2**
Health Visiting	**1**
Physiotherapy Musculoskeletal	**2**
Podiatry	**5**
School Nursing	**1**
Grand Total	**17**

There were 17 local resolution complaints logged in Quarter three, up from 16 in Quarter two and down from 35 in Quarter one. This decline in recording is being picked up and discussed in the regular Complaint Handling Training course delivered by the Complaints Office.

Communication was the most common theme for the local resolutions that were logged with 4 relating to this subject. 1 related to CAMHS (down from 7), none to adult mental health services and 10 to community based physical health services continuing the theme that more concerns are resolved through local resolution within physical health services compared with mental health services.

Of the 5 concerns logged by the Podiatry, 2 were about care and treatment, with the remaining concerns being about access to the service, communication and waiting times.

8.3 Informal complaints received

An informal complaint is managed locally by the service through discussion with the Complaints Office. It is a concern raised through the complaints office but can be resolved without the need of a full investigation. Complainants are offered the option to resolve informally, but the option to escalate to a formal complaint remains.

There have been 13 informal complaints received in Quarter three compared to 25 in Quarter two and 32 in Quarter one.

Table 21: Informal complaints

	Main subject of complaint						
Service	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Management and Administration**	**Medication**	**Waiting Times for Treatment**	**Grand Total**
CAMHS - ADHD	1	1					**2**
CAMHS - Specialist Community Teams		1				1	**2**
CMHT/Care Pathways		1					**1**
Community Hospital Inpatient Service - Jubilee Ward					1		**1**
District Nursing		1					**1**
East Berkshire Wheelchair Service			1				**1**
Immunisation		1					**1**
Phlebotomy				1			**1**
Talking Therapies - PWP Team	2	1					**3**
Grand Total	**3**	**6**	**1**	**1**	**1**	**1**	**13**

8.4 NHS Choices

There were 3 postings on NHS Choices during Quarter three; 2 were negative and 1 was positive. PALS responded to these with contact information and the offer of a further conversation about their experience. It was also sent on to the services for their attention.

Table 22: NHS Choices

Service	No of postings	Positive	Negative
CRHTT- East Berks.	1		It has been an almighty struggle to access any sort of mental health support from Berkshire Healthcare. Attempts are made not to offer any treatment and a level of persistence is required. You can expect to be left in the dark over how long you will have to wait. When you are given estimates, expect to be disappointed as they will not be met. Months will pass without any therapeutical support given. The only immediate support is medication, and if that doesn't work for you, then tough. Should things get bad, you are encouraged to contact the crisis team. Unfortunately, one particular member of staff at East Berks out-of-hours crisis team has an arrogant, patronising attitude and will dismiss you every time.
CRHTT	1		Not a service will use anymore for my own safety, That had a crisis, phoned the crisis team. The member of staff said got to go and phone me back then put the phone down Then I waited all too early in the morning and no one phoned back. That no one had record of me phoning and seamed distant on the phone. Expressed upset would not use the service ever again, that police had pick pieces up so many times with conjunction with the ambulance service in absence of the crisis team as want to do it all on the phone at a distance lost count.
Wokingham Hospital – Windsor Ward.	1	Outstanding My mother was admitted in Oct following an admission to the RBH, she was there for 5 weeks and returned home yesterday from side room 2. In that time she received outstanding care, kindness, dignity shown at all times, the ward was so clean and fresh as was her room. The care given from start to finish and beyond was totally brilliant at all levels. Her discharged was planned out thoroughly so she was able to go back home safely with the necessary equipment and package in place. I cannot speak highly enough for the care and staff. Windsor Ward is just outstanding in every level.	

8.5 PALS Activity

PALS has continued to provide a signposting, information, and support service throughout the pandemic response. 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 was available across all inpatient areas. The PALS Manager continues in the roles of Freedom to Speak Up champion and Armed Forces Service Network champion.

There were 278 queries recorded during Quarter three. In addition, there were 337 non-BHFT queries recorded. Work is ongoing as part of the QMIS process in order to reduce this number.

The main reasons for contacting PALS were:

- Access to services (both concerns and enquiries)
- Communication (both concerns and enquiries)

Some examples of the contacts are:

Access to services. (Concern).

Patient requires dental treatment. Behavioural contract drawn up.

Disabled patient experienced difficulties accessing a building at KEV11 Hospital.

Difficulties arranging a blood test. Unhappy with booking system.

Mother concerned that daughter is putting herself at risk and concerns about partners' deteriorating condition.

Son has difficulties accessing SALT and cannot speak. Childs' needs have changed and he needs to be reassessed.

Access to services enquiries

People seeking updates on referrals to CMHT, CAMHS and IPASS. People also seeking access to services on behalf of a family member and people living out of area.

Queries relating to obtaining Covid and Flu vaccinations for children.

People seeking appointments with Hearing and Balance service and requesting adjustments to equipment.

Access to independent advocacy.

Communication concerns

Attitude and support provided by WestCall GP. Confusing communication. Prescription not sent to GP and no information on test results.

Unhappy with communication with CRHTT.

Poor communication with relatives and a lack of information. Carers Lead involved. Relatives not kept abreast of developments with regard to care.

Parents waiting for correspondence following a CAMHS referral and professionals making contact to discuss referrals.

Communication enquiries

Contact with TVP in connection with patients and offences. Queries around capacity at time of offence.

Relatives seeking feedback on referrals.

Requesting supporting evidence for benefits application.

Equipment needs collecting from their home.

Support required following discharge.

Of the 278 queries, 4 were Covid related.

- Inaccurate recording of vaccinations which affected availability of booster
- Inaccurate Covid update from school
- Wants to highlight employee rights with regard to Covid vaccine and FOI regarding Covid vaccinations in schools – Escalated to NHS E
- Visitor to St Marks Hospital unhappy with LFT monitoring

9 queries were escalated to the formal complaints process and 39 were not responded to within the 5-day response target, although this has just recently been extended from 2 working days to align with other local organisations to manage demand and capacity within the service.

9. Patient Experience Tool

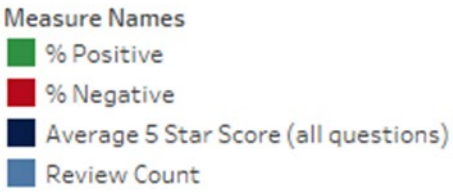
The new patient experience tool which the Trust have been working in partnership with 'i Want Great Care' (iWGC) to develop was launched during December and is being introduced across the whole organisation.

The aim of the tool is to measure patient experience in a standardised way across all teams and services within the organisation, and for this data to be available to teams and services in real time, supporting understanding of patient experience and improvement activity. The experience data collated can be viewed not only at organisational and service level but also by differing demographics meaning that we can see if there is inequality of experience by protected characteristics.

The tool uses a 5-star scoring system as an overview as well as free text to capture the patients overall experience alongside their experience around facilities, staff, information, feeling listened to, ease, involvement, and safety. Free text invites the patient to comment on both their experience and suggested improvements.

During December 162 patients provided feedback through the new tool the combined scores are detailed below:

Performance Over Filtered Date Range	
% Positive	93.83%
% Negative	3.70%
Average 5 Star Score (all questions)	4.63
Review Count	162



The tool includes the friends and Family test questions to enable continued reporting of this.

It is recognised that use of this new tool will take time to embed within services and the expectation is that over Quarter 4 the patient experience team will continue to support teams to embed the use of the tool into practice. Over quarter four, ipads alongside kiosks on our main hospital sites are being rolled out to enable feedback through an app in addition to the SMS, online and paper now available.

Examples of feedback received:

Service	Review	Improvements
Liaison and diversion	*Treated really fairly, x felt she was listened to, the practitioner helped me be really calm. I was suffering quite bad with anxiety. Sought help from your GP.*	*Maybe have STR contacts number as only had the generic office number so i could have direct contact.*

Service	Review	Improvements
	Because you felt the answers were correct. Informative conversation and helpful. *compassionate and caring and I felt listened too* *"Carly gave me all the information and helped me make an informed decision* *I found contact over the phone very helpful for me at the time rather than face to face.* *My situation was horrible which I take responsibility for but Claire and Carly were so kind and caring and my experience much easier"*	
MSK physio	*Very professional staff. Clinic building adjacent to bus stop therefore very convenient.*	*Upon entering the building, I was unsure which check in reception I should report to.*
East Heart Function	*Xx is a excellent support nurse and is a joy to visit after the year I had and many visits to different hospitals, you know a good visit from a bad one, she is very knowledgeable and is willing to help you understand what you're medicine is for. The other staff I have met are a great team and always treated me with respect and friendliness, thank you all so much*	*Better signage, when I first visited, I could not find the door also fix the door buzzer so you don't have to keep ringing a number to get help*
Podiatry	*Very warm and welcoming , very friendly very knowledgeable generally a very good experience.*	*A receptionist on the desk would have helped!*
Speech and Language Therapy	*It was so useful to have a home visit, and the person who came was excellent. I have a rare neurological disorder, and she listened to me carefully. She was kind, thoughtful and clearly very knowledgeable. I hadn't been sure if there was much more I could do to help my issues, but she gave me several strategies which have been very helpful. I was really impressed overall. The very next day my GP surgery received the prescription request too, which was fab!*	*The time I could do was not passed on, so they turned up early while in was still in bed! (I had discussed this over the phone when the appointment was booked and was told it was fine for it to be a certain time so I could get up and be ready). However, the member of staff kindly offered to wait in the car until i could get ready, but I said just come in so long as you don't mind me being in my dressing gown!*
Talking Therapies	*I have a fantastic therapist. Very understanding and supportive*	*Giving the patient their diagnosis on paper rather then them having to ask for such prove*
Family Safeguarding model	*"It was good to be able to connect remotely saving me time to move between places & work* *The information was timely for my needs - relevant* *The information help me evaluate my experiences & how I cope with stress/ challenges & also helped me use it to manage change behaviours from my children & change my parenting styles for the better*	*Have a client facilitate with staff as a volunteer , someone who has done the course/ group work as an expert in their own recovery to encourage & to build more confidence in group participation & learning .*

Service	Review	Improvements
	Staff were willing to listen & were supportive . *I did not feel judged"*	

Appendix 3 of this report shows samples of the real time data that is available through the dashboard. The free text comments are also available on the dashboard in real time.

10 . The Friends and Family Test

The tables below contain the FFT results, which is an amalgamation of data from both the new (iWGC) and old (CRT) system.

Table 23: Response rate for the FFT

		Number of responses	Response Rate
2021-22	Q4		
	Q3	5271	4.53%
	Q2	6124	6%
	Q1	5788	5.66%
2020-21	Q4	4259	4.66%
	Q3	4597	4.66%
	Q2	3018	3.33%
	Q1	3572	4.66%
2019-20	Q4	10,083	9.29%
	Q3	10,933	10.69%
	Q2	11,095	10.86%
	Q1	11,721	12.20%

Table 24: FFT split by community health and mental health services

	2021/22				2020/21			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Community Mental Health Services	93%	90%	94%		70%	90%	85%	89%
Mental Health Services	75%	84%	86%		60%	85%	81%	83%
Trust Total	87%	88.3%	90%		59%	90%	85%	89%

*Rating of good or better than good has replaced recommendation to a friend

During Quarter one 2021/22 there was a reduction in the rating for mental health services. These were mainly due to lower scores for Talking Therapies, CRHTT and CPE – all of which have seen improvements since this time.

Table 25: FFT results for Inpatient Wards, shown as a percentage

		2021/2022				2020/2021				2019/20			
Ward	**Ward type**	**Q4 %**	**Q3 %**	**Q2%**	**Q1%**	**Q4 %**	**Q3 %**	**Q2 %**	**Q1 %**	**Q4%**	**Q3%**	**Q2%**	**Q1%**
Oakwood Ward	Community Inpatient		100	100	52	100	0	0	0	100	100	100	95.83
Highclere Ward			75	100	81	0	67	50	0	100	100	100	100
Donnington Ward			-										
Henry Tudor Ward			97	88.88	70.66	100	93	100	98.3	-	85	90.48	97.44
Windsor Ward			100	85	100	100	93	0	100	-	-	91.89	-
Ascot Ward			100	100	95	100	100	90	100	-	-	100	-
Jubilee Ward			96	92.22	100	98	50	100	0	89.13	99	96.34	95.45
Bluebell Ward	Mental Health Inpatient		50	100	75	0	100	0	0	56.25	53	65.22	60
Daisy Ward			0	0	67	100	100	100	50	50	87	62.50	75
Snowdrop Ward			83	0	100	85	67	0	100	80.76	67	74.49	71.11
Orchid Ward			0	94.73	92	0	75	100	0	76.66	76	77.78	84.48
Rose Ward			0	100	100	0	100	0	100	87.50	70	76.92	62.50
Rowan Ward			100	0	100	0	0	0	0	54.16	80	86.67	93.33
Sorrel Ward			0	0	100	0	100	0	100	50	29	-	-

Table 26: Carer FFT results

	2021/22	2020/21	2019/20	2018/19
Q1	18	335	67	111
Q2	94	408	201	32
Q3	58	242	314	39
Q4		411	258	86

The Trust Carer Lead has taken on the responsibility of promoting and collecting the carer FFT, and the Patient Experience Team are continuing to report on the results.

11. Updates: Always Events and Patient Participation and Involvement Champions, Healthwatch

There is no activity to report for Always Events, Patient Participation and Involvement Champions as these were not carried out as part of the pandemic response.

The 15 Steps Programme restarted during Quarter two, the report is attached as Appendix two.

There continues to be open and regular channels of communication between the Patient Experience Team and the Healthwatch organisations across Berkshire, on individual cases and for sharing communication with our communities.

12. Compliments

There were 960 compliments reported during Quarter three. The services with the highest number of recorded compliments are in the table below.

Table 27: Compliments

Service	Number of compliments
Talking Therapies - Admin/Ops Team	290
District Nursing	191
Physiotherapy Musculoskeletal	69
Podiatry	37
CMHTOA/COAMHS - Older Adults Community Mental Health Team	36
Community Respiratory Service	31
Community Dietetics	26
Diabetes	26
Cardiac Rehab	23
Community Based Neuro Rehab - CBNRT	16

Table 28: Examples of compliments received during Quarter three

Continence *I am sending this e-mail to just reiterate what your team probably already knows – that the nurse we saw is an absolute credit to her profession and a god send to her patients. My father was diagnosed with lung fibrosis in 2017 and had really suffered through a series of negligence through his medical care. So when I was introduced to the nurse, I approached with caution but she was like a breath of fresh air – her attention to detail, her compassion and her follow through was second to none. Her consistent efforts to assist my father has renewed my faith in the NHS. Her commitment to go above and beyond in her role is truly appreciated by myself and my family.*	District Nursing (WAM) Community staff nurse went to visit a patient who was delighted to see her and thanked her for sorting all her injections out last year as she was so stressed and ill worrying. She took her to the living room and introduced her to her husband as *'the girl that saved my life'.*
Veterans TILS *Just wanted to say how great it was to meet you yesterday. My emotions were a little all over, still don't get where that comes from so it was therefore very reassuring to talk to Peer Support Worker who experienced similar when he was going through it.* *I'm not sure where I'd be if it hadn't been put onto you, I don't say that lightly. Having been dismissed a lot in the past you know I've been quite guarded about who I trust but from the start you made this so easy for me. I wanted to say this to you yesterday but wouldn't have been able to so only right I put the words down here. (wife) also says thank you, clearly you have not only helped me!!!*	Traumatic Stress Service *I was in a very low place when I reached out for help and I knew that my unhelpful coping styles were not sustainable and would lead me down a dark road if left untreated. I gave myself over wholly to xx and even though I was very sceptical that it would work, EMDR has changed my life. I will forever be grateful to xx for helping me and teaching me ways to cope going forwards. Thank you* 😊
Immunisation *I want to send this email to say a big thank you to all your staff that helped on xx.* *At xxx school, as they were there doing covid vacations.* *As my daughter had fainted and was sick.* *And she needed to go to hospital.* *She is ok now.* *Everyone was amazing to her and me.* *Thank you.*	Community Respiratory Service *The Integrated Rehabilitation Assistant is so good! They have lifted me from down to up! I look forward to seeing them each session. They boost your ego and makes you laugh. They are a star.* *This place has given me so much hope. Your Team really don't know what you do, it's wonderful. I can breathe.*
Rose Ward	

Make the right thing today to make it a better tomorrow, angels of Prospect Park Hospital.

A big thank you to the angels of Prospect Park Hospital.

I'm privileged to use the bed of Prospect Park Hospital, everyone would want to be in this bed, but they couldn't, or they can't. I thank you to all the staff of Prospect Park Hospital for allowing me to use your bed and be healed from my mental health. I thank you from the bottom of my heart.

She was surrounded with strangers who became her friends and her family. She remembered few others coming to Prospect Park Hospital, but it doesn't matter anymore as it was a dream, what matters is the present, surrounded with the angels on the earth inside Prospect Park Hospital.

They care for xx, they observe more than using their mouth, they are alert of all danger to the patients of Prospect Park Hospital, first. They know the patients individually and treat them in such a manner. They know the exact time when to save the patient's needs, they are aware of the life after Covid-19 that affected the entire universe. The new life is to observe more and listen to what the big man had installed for us. In the new life after Covid-19, care for those that are unable to care for themselves. When the alarm goes off you see how the life saviour runs off and forms a group trying to save life, that's why they are the soldiers. I salute the angels, the soldiers of Prospect Park Hospital. They fight a good simplistic, beautiful, and kind war in health.

They run around to make it a better place. There are messages in our kitchen saying to wash ourselves first, but our rooms are being cleaned every single day to go hand in hand with us washing ourselves and is being cleaned by our other angels as our helpers and not to forget about them being part of the Prospect Park Hospital as well.

Being a professional counsellor myself, it is not easy to run this place, but she is glad to see them managing it well. Well done soldiers in health!

CBNRT

In May of this year, I suffered a stroke. It was a debilitating outcome and, in hospital, I wondered how it (after effects) could be addressed from home.

I needn't have worried. The recovery group consisted of xxx. Once I'd realised what they were going to 'provide', it became apparent that every aspect of how a stroke manifests itself, was to be treated and addressed. It's hard to overstate the effectiveness of this support. Some of these people actually visited me at home several times. World-class precious resources coming to see me.

To that end, I wanted to express my thanks not only for the outstanding help I received but to acknowledge how 'joined up' the scope of treatment is. It's possibly this aspect that makes the process so much more effective. The sharing of information designed to cover all the eventualities was, quite simply, brilliant.

I was struck by the professionalism, empathy, expertise, and patience of them all. Whoever put this programme into place, gets my full admiration. The way they followed up apart from anything, was touching. In the current climate seeing them arrive with gowns and masks, sanitising gels, and spare bag, was wonderful.

I'm more than happy to discuss and or further endorse this team in any capacity that may serve to widen their impact on my life and those of others.

Table 29: Compliments, comparison by quarter

	2021/22					2020/21				
	Q1	Q2	Q3	Q4	2021/22	Q1	Q2	Q3	Q4	2020/21
Compliments	1076	986	960	-	3022	873	975	1,010	1,319	4,177

Liz Chapman

Head of Service Engagement and Experience

25 January 2021

Formal Complaints closed during Quarter three 2021/22

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
8212	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Moderate	Pt wishes clarity on several parts of the complaints response and areas of CAMHS service provision ORIGINAL COMPLAINT BELOW Pt unhappy with therapist expressing opinions on family members, not considering f2f appt when C19 restrictions were lifted, various issues occurred during therapy sessions that they wish addressed. They would like an apology for the therapists approach, behaviour and attitude	Not Upheld	Clinical care was appropriate, as was the transition from child to adult services.	Attitude of Staff
8227	Reading	Adult Acute Admissions - Snowdrop Ward	not granted	Family feel mother was coerced into getting pt discharged in her home. Family concerned for mothers welfare as they state the pt has been abusive and violent to family members	Not Upheld	Consent not received	Communication
8193	Reading	Community Hospital Inpatient Service - Oakwood Ward	Low	Dietary concerns on the ward resulting in weight loss, concerns also raised regarding the RBH	Partially Upheld	Staff reminded to follow up referrals to dieticians via the Health Hub.	Care and Treatment
8243	Reading	Adult Acute Admissions - Rose Ward		Pt unhappy that after speaking with nurse she thought she would be discharged within 2 days. Pt feels nurses should not have 1to1 conversations with pts	Not Upheld	Local resolution	Communication
8255	Reading	Adult Acute Admissions - Daisy Ward	Minor	Pt states they were verbally and physically attacked by a staff member in the medication room	Not Upheld		Abuse, Bullying, Physical, Sexual, Verbal
8232	West Berks	Community Hospital Inpatient Service - Donnington Ward	Minor	DECEASED PT: transferred from RBH to West Berks, unable to do much physio due to dialysis. family concerned about pts confusion, poor communication from the ward. Pt stated multiple times they were in pain which the family feel was ignored	Partially Upheld	Clinical care was appropriate - staff did not however inform the patient's family of their transfer to the RBH swiftly.	Care and Treatment
8252	Bracknell	Immunisation	Low	Parent with shared custody unhappy that nurse spoke to the child asking if they wish to have the COVID vaccine after the consent form had stated they are not to have it. Child also said no	Not Upheld	Now UPC Discussion with the young person about the vaccination was appropriate. The complainant has been signposted to NHSE ref his concerns about the vaccine.	Communication
8263	Wokingham	CMHT/Care Pathways	Low	Pt believes they were illegally discharged from CMHT. Has a lack of clarity regarding their diagnosis. States Crisis call handler was inappropriate. 10 points raised in total	Not Upheld		Discharge Arrangements
8249	West Berks	CMHT/Care Pathways		Complainant feeling the care and treatment from MH services over the years has been insufficient resulting in the pt not receiving the care they feel they should have received	Not Upheld	Closed locally following discussion and confirmation email	Care and Treatment
8216	Wokingham	Rapid Response	Minor	Family have raise 4 further questions following the response Original complaint - DECEASED Pt: Family wish to know what happened when the nurse from RRT went to visit the pt	Not Upheld	Clinical care was appropriate	Care and Treatment
8196	Reading	Adult Acute Admissions - Daisy Ward	Minor	Family feel cognitive function of the pt has seriously deminished since being on the ward they feel it is being ignored. Pt has lost a significant amount of weight and the family have asked for this to be looked into and feel again this has been ignored. no supervision from staff to ensure meds are taken. lack of bowl movements for pt has been ignored by staff along with personal hygiene issues. Family are being spoken to terribly during meeting which the family feel is bullying	Partially Upheld	Ward manager to form a development plan with member of staff around her way communication with others, and how this may come across to distressed relatives or patients. Visiting times and rules to be clarified for all staff. Ward staff, especially the nursing team, need further training and support around working with carers and maintaining communication, especially when dealing with strong emotions and distressed relatives	Care and Treatment
8237	West Berks	CAMHS - Specialist Community Teams	Minor	Further questions	Not Upheld		Communication
8177	Reading	CAMHS - Specialist Community Teams	Minor	Complaint is regarding alleged lack of support from Reading CAMHS, who say patient is best supported in the community. Mum doesn't agree, pt is being looked after by LA due to self harming. She feels treatment is a postcode lottery	Not Upheld		Access to Services
8206	Wokingham	Adolescent Mental Health Inpatients - Willow House - Ward	Minor	Pt wishes to complain about the overall performance of care in Willow House Adolescent Psychiatric Inpatient Unit. they feel there was a blatant neglect towards the patients from various members of the staff who they feel displayed clear incompetence.	Not Upheld	Care was appropriate. The patient was disruptive on the ward and the staff managed them and the other patients well at a time of stress.	Care and Treatment
8239	Slough	CMHT/Care Pathways	Low	Pt feels internal damage has been caused to their body by the medication given when referred to MH services, specifically injections they feel they feel they shouldn't have. Pt looking for a letter which can be sent used to obtain financial reimbursement so they can seek alternative methods of treatment	Not Upheld	Unable to get hold of complainant. Physical health care on the ward was appropriate.	Medication
8233	West Berks	Pharmacy	Minor	Clozapine posted to pt, not received on time, service required to send via taxi to arrive on time	Partially Upheld	Pharmacy SOP was followed however there was miscommunication and understanding of how the prescription will be delivered.	Medication
8238	West Berks	Other	Low	Unhappy with the Review panel for unreasonable persistent complainants	Partially Upheld	Apology sent for complainant not being updated about outcome of conversation with a member of staff. The complaint about the UPC process is to be taken to the PHSO.	Communication
8213	Slough	CMHT/Care Pathways	Minor	Pt distressed that Dr and Care coordinator continuously typed throughout the pt's entire meeting, Dr rubbished previous Dr leaving the pt feeling the experience as abusive, humiliating and insulting	Upheld	Communication should have been better and the staff have apologised - they were very busy so tying during the meeting rather than engaging and connecting with the patient.	Attitude of Staff
8142	Bracknell	CAMHS - AAT	Moderate	Waiting times for ASD assessment, family feel medication needed but GP can't do anything without intervention from CAMHS first	Partially Upheld	Communication and inaccurate placement of referral led to a delay. Clinical care was appropriate.	Waiting Times for Treatment
8230	Windsor, Ascot and Maidenhead	Assessment and Rehabilitation Centre (ARC)		Family and pt angry a diagnosis has been entered on the system for the pt which they state is not true and has impacted on other areas of care. Apology and explanation along with redaction of this from records is required	Upheld	Information was incorrectly taken by the ambulance service and passed on. This should have been checked with the patient and their family.	Care and Treatment
8159	Wokingham	CAMHS - AAT	Moderate	Family unhappy with response especially as pt is now no longer attending school, wishes response points numbered and would like a meeting ORIGINAL COMPLAINT Complainant believes staff member produced totally prejudicial and unsubstantiated CAMHS report which they were unaware of and not involved in despite having shared parental care.	Partially Upheld	•CYPF Managers to communicate to staff that at the initial contact clinicians should explicitly ask about current childcare arrangements and ensure that they have the contact details for both parents clearly documented in the young person's clinical records. •Highlight this learning via CYPF Patient Safety and Quality meeting •At the initial contact the young person and the accompanying parent should be asked if they wish the other parent to be involved in the assessment process and the opportunity should be offered in the most practical way i.e via telephone if in person is not possible and/or it would delay the process. To highlight this learning via CYPF Patient Safety and Quality meeting •The process for sharing information should be discussed with the young person at the outset and agreed. This is important when the young person is over 16 or assessed as having Gillick competency. To highlight this learning via CYPF Patient Safety and Quality meeting. •Feed back concerns about paraphrasing specific religious vocabulary and recommend that the correct vocab is used with description included and described as such.	Attitude of Staff
8192	Reading	Adult Acute Admissions - Daisy Ward	Minor	Spouse unhappy that services did not read and action any of the documentation from 3rd party organisations ORIGINAL COMPLAINT Spouse wishes pt to be moved to a MH hospital near to family home in Wimbourne	Not Upheld	Delays in transfer have been appropriate due to responding to safeguarding concerns. Communication plans put in place were not followed. Original complaint - partially upheld. Re-opened complaint - not upheld	Care and Treatment

8248	West Berks	CAMHS - ADHD		MP has come back with further points requested around justification of wait times Original concerns - Wait time	Partially Upheld	Apology given for a lack of a telephone call with a clinician. Waiting time was appropriate and the patient has been triaged for a review in light of new information.	Waiting Times for Treatment
8004	Reading	Older Adults Inpatient Service - Orchid ward	Minor	Complaint re-referred to CQC as issues remain ORIGINAL COMPLAINT Friend of pt is generally unhappy with the care, communication and compassion from the staff on the ward. Believes admission stemmed from a medication issue that the ward has exasperated.	Partially Upheld	Key nurses to review family contact and documentation. Consider weekly family contact with intent to update them on patient progress. Team to device a Standard operation for meetings PALS to improve on feed back and communication with complainants. Ward manager to liase with PALS for a discussion over strategies to enhance communication All attendees of best interest meeting to be communicated with all relevant prior to meeting. Team to device a Standard operation for meetings	Care and Treatment
8172	Slough	CAMHS - Getting Help East	Minor	Unhappy with response not reading 3rd party organisation info ORIGINAL BELOW Father is complaining that he believes a professional did not share with appropriate agencies that a child was at significant risk. He says the same professional wrote an assessment that was not impartial and he feels was extremely biased resulting in the mother now having sole care of the child	Partially Upheld	RO Forwarded to PHSO ORIGINAL BELOW Learning for member of staff on completion of S47 and communication with parents who are not together. Revised report to be sent by the service.	Communication
8106	West Berks	CMHT/Care Pathways	Low	Complainant has further questions following the response ORIGINAL COMP pt believes staff member gave incorrect info resulting in them being sectioned (135), they this is not 'best practice'	Not Upheld		Communication
8247	West Berks	CAMHS - Specialist Community Teams	Minor	Parent still unhappy that the patient is not going to be seen, and MP would like to further explanation as to why not and advice on how the wait list can be reduced ORIGINAL COMPLAINT Family extremely worried by suicidal thought, pt on wait list but they need to know if they can be seen earlier	Not Upheld	Clinical care was appropriate - nothing further to add. Explanation given on national picture and initiatives to reduce waiting lists.	Waiting Times for Treatment
8280	Reading	CMHT/Care Pathways	Low	Complainant wishes clarification on 6 points ORIGINAL COMPLAINT pt feels there has been a lack of support and a misdiagnosis, wishes to meet and discuss	Not Upheld		Care and Treatment
8220	Windsor, Ascot and Maidenhead	District Nursing	Moderate	family believe 1 point was not addressed ORIGINAL COMPLAINT - DECEASED PT: Complainant unhappy with attitude of DN who they say would not give pain relief or fit a syringe driver	Not Upheld	All staff to attend new syringe driver training that now includes holistic assessment of the patient. Initially All band 6 and above staff to attend advanced / intermediate communication skills training commissioned to be provided by the hospice then for all other qualified staff. For end-of-life training including the care of dementia patients to be commissioned. Staff to be reminded to complete end of life assessments/ care plans.	Communication
8283	Reading	Adult Acute Admissions - Snowdrop Ward	Low	13 points raised regarding MHA / attitude of Dr / coercion to make the mother write a letter / Incident investigation / phone confiscation / complaints process.	Not Upheld	Local res as situation changed	Care and Treatment
8288	Wokingham	Community Hospital Inpatient Service - Ascot Ward	low	Family state Wokingham hospital have said the pt has to be discharged to self isolate for 3 days before surgery at Nuffield, Oxford. Family feel pt would not be able to look after themselves on their own. Family also unhappy about a comment a nurse made on the ward about the patient and the general care received.	Not Upheld	Initial concerns - Local resolution	Care and Treatment
8235	Reading	Community Hospital Inpatient Service - Oakwood Ward	Minor	Pt discharged from ward with bed sores, urine infection and foot sores. pt told to use a pad for the toilet as staff too busy. pt frightened of falling in case she has to go back to the ward	Partially Upheld	Local resolution sought	Care and Treatment
8266	West Berks	Immunisation	Low	Family unhappy with informal responses into the handling of the incident for which the Child was not Covid vaccinated due to their medical history	Partially Upheld	Apology for confusion about letter being sent. Waiting time and advice ref the patient turning 17 was appropriate.	Attitude of Staff
8290	Reading	Adult Acute Admissions - Snowdrop Ward		Pt does not feel PPH is a hospital environment, they feel they have been forced there, not allowed out, no therapy, no support. Pt says they feel unsafe	Not Upheld	No consent received - a review of care showed this was appropriate and information regarding processes sent	Care and Treatment
8258	West Berks	CAMHS - Specialist Community Teams		Feedback about a pt journey, the number of services and wait lists added to, despite having seen many people they have been told they do not meet the criteria for things offered and are now no further forward but the pt still has all the symptoms	Partially Upheld	Apology to family for misunderstanding behind clinicians' words and actions which resulted in hurt feeling. Clinician has reflected on this case and given a full and frank explanation of the reasoning behind the actions he took.	Care and Treatment
8257	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)		Complainant feels the actions of HTT not visiting a vulnerable young person with an evolving psychosis is inexcusable, believes a proper assessment would have resulted in quick care and more appropriate care	Not Upheld	PPH - Partially Upheld - clinical care was appropriate. Welcome pack to be revised and staff are to ensure that it is given on admission. CRHTT - Not Upheld.	Care and Treatment
8291	Wokingham	Out of Hours GP Services	Minor	Pt seen at WestCall, family feel the Dr was very patronising and said the pt to needed drink 'Chicken Broth and full sugar orange Squash' Dr called Paediatric Dr under complainants request.	Partially Upheld	Apology to family for misunderstanding behind clinicians' words and actions which resulted in hurt feeling. Clinician has reflected on this case and given a full and frank explanation of the reasoning behind the actions he took.	Attitude of Staff
8199	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt unhappy at the way they were treated in Dec 2020 which resulted in a mis diagnosis and a sectioning which was allegedly over turned at tribunal. Pt say they spent 14 horrendous days in PPH. pt states they have also had the driving license revoked after a letter was sent to the DVLA by the Dr. Pt also states they requested their medical records sometime ago and still not received	Partially Upheld	PPH - Partially Upheld - clinical care was appropriate. Welcome pack to be revised and staff are to ensure that it is given on admission. CRHTT - Not Upheld.	Care and Treatment
8252	Bracknell	Immunisation	Low	Parent with shared custody unhappy that nurse spoke to the child asking if they wish to have the COVID vaccine after the consent form had stated they are not to have it. Child also said no	Not Upheld	Now UPC Discussion with the young person about the vaccination was appropriate. The complainant has been signposted to NHSE ref his concerns about the vaccine.	Communication
8216	Wokingham	Rapid Response	Minor	Family have raise 4 further questions following the response Original complaint - DECEASED Pt: Family wish to know what happened when the nurse from RRT went to visit the pt	Not Upheld	Clinical care was appropriate	Care and Treatment
8304	Portsmouth	Criminal Justice Liaison and Diversion Service - (CJLD)	Low	Pt extremely unhappy with the response and BHFT holding information about them, also feels there is conflicting statements between all services ORIGINAL COMPLAINT pt wishes their medical records rectified and in some cases erased, general operational questions also to be answered	Not Upheld	Apology offered for where there were errors in report and that staff member did not wear a mask	Care and Treatment
8323	West Berks	CMHT/Care Pathways		Patient has complained via telephone to the CMHT that they have received a copy of a letter sent by the CMHT to the wrong GP practice, where they have never been a patient. They previously raised this with the CMHT but it is still happening. They complain this is a breach of their confidentiality.	Upheld	Locally resolved	Care and Treatment

8301	Reading	Rapid Response		Family unhappy with the report regarding the pt's mobility	Not Upheld	The urgent community response team will receive feedback and learning from the complaint. The urgent community response team will receive further training about the frailty score and documenting their assessment of this The urgent community response team will ensure that any discharge letters are sent back to a clinician that has recently seen the patient for checking prior to sending. This has been raised within the teams clinical supervision 23rd November 2021 The urgent community response team will receive further training to ensure they are documenting a full and detailed functional assessment including functional history	Attitude of Staff
8282	Reading	Out of Hours GP Services	Minor	Pt disputing call back was made by Dr ORIGINAL COMPLAINT: Pt promised called back from SCAS within 2 hours - no call made. Family called 999, pt taken to hospital with double pneumonia, hypertensive with low oxygen levels	Partially Upheld	Apology to complainant via response letter WestCall to develop pre-emptive text alert system warning patients of delays. This will be sent on receipt of a referral from 111	Care and Treatment
8224	Reading	Older Adults Inpatient Service - Rowan Ward	Low	Complainant has concerns the pts physical medical care needs are not being met. Pt has fallen, is unable to swallow, is moved by hoist. Rapid deterioration in kidney function, pain associated to this is not being managed. Pt has food allergies which are not being taken into consideration when given to them. Poor communication, no one calls back	Partially Upheld		Care and Treatment
8265	Windsor, Ascot and Maidenhead	CAMHS - Common Point of Entry (Children)		Family unhappy the referal from GP has been closed when they state the pt needs help and services have not spent anytime to understand the issues	Not Upheld	Complainant withdrew complaint	Care and Treatment
8307	Reading	Community Hospital Inpatient Service - Oakwood Ward	Minor	Deceased pt: family feel there was a lack of care and dignity. Staff failed to assist with food as agreed, made the pt wear a pad with no underwear and transferred to RBH without personal possessions so was cold	Partially Upheld	We have apologised for breakdowns in communication and areas for improved patient care are being shared with the ward	Care and Treatment
8272	Slough	CMHT/Care Pathways		Family member concerned BHFT are taking the appropriate action to assist with pt's MH or to safeguard the family	Not Upheld	No consent received	Care and Treatment
8297	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	Not happy with the response, want another meet with Dr on the ward and still waiting for a 2nd opinion ORIGINAL COMPLAINT Family unhappy that new Dr has said pt does not have schizophrenia, family want to know why the pt has been taking meds for that for 10 yrs if doesn't have it believes PPH are refusing to help the pt and are not talking to the family	Not Upheld		Care and Treatment
8285	Reading	Adult Acute Admissions - Daisy Ward	Low	Pt wishes to raise many concern and service improvement suggestions for PPH Inpts	Not Upheld		Management and Administration
8279	West Berks	CMHT/Care Pathways	Low	Complainant believes the pt is receiving the bare minimum from service - they are raising 5 points regarding care co-ordinator contact, provision of support worker. The belief 1:1 support from the consultant is required and belief we should now be doing this face2face	Not Upheld		Care and Treatment
8319	West Berks	CMHTOA/COAMHS - Older Adults Community Mental Health Team		Family have questions around the Doctor ORIGINAL COMPLAINT Family unhappy that police came into their home following an alleged call from services and safeguarding regarding the EOL pt	Not Upheld	Outcome was recorded in first complaint	Communication
8289	Wokingham	Health Visiting		Parent believes there are inconsistencies between events and details passed on to Children's Service for a CFA by a HV following a Subject access request	Not Upheld		Communication
8295	Reading	CMHT/Care Pathways	Low	Family concerns for staff member (relative) and delays in CMHT dealing with pt. Family feel safeguarding issues and email exchange needs to be reviewed they also feel the Trust has taken inappropriate steps with pt/staff member over the Covid period	Upheld	There was confusion with the referral and communication between CMHT, the Gateway and GP.	Care and Treatment
8293	Reading	Integrated Pain and Spinal Service - IPASS	Low	Pt feels physiotherapist was unnecessarily forceful and has caused me to be in pain ever since.	Not Upheld		Care and Treatment
8299	Reading	Adult Acute Admissions - Bluebell Ward	Minor	Detained July 2020 - pt alleges being physically abused on their first night and sexually assaulted in their room. They state books and £15 in cash were stolen from their room. They feels CMHT harassed them before admission.	Partially Upheld	Better communication between nursing and medical team. Have discussion with safeguarding team to clarify any safeguarding concerns if unsure.	Abuse, Bullying, Physical, Sexual, Verbal
8278	Slough	Community Hospital Inpatient Service - Jubilee Ward	Minor	Family unhappy with our response believing there are inaccuracies ORIGINAL COMPLAINT Family unhappy they were not contacted to advise pt has a pressure sore, they believe no one has been treating this	Partially Upheld	Some areas of care were not satisfactory, such as not documenting the use of cream, no evidence of the patient being left in soiled pads.	Care and Treatment
8280	Reading	CMHT/Care Pathways	Low	Complainant wishes clarification on 6 points ORIGINAL COMPLAINT pt feels there has been a lack of support and a misdiagnosis, wishes to meet and discuss	Not Upheld		Care and Treatment
8220	Windsor, Ascot and Maidenhead	District Nursing	Moderate	family believe 1 point was not addressed ORIGINAL COMPLAINT - DECEASED PT: Complainant unhappy with attitude of DN who they say would not give pain relief or fit a syringe driver	Upheld	All staff to attend new syringe driver training that now includes holistic assessment of the patient. Initially All band 6 and above staff to attend advanced / intermediate communication skills training commissioned to be provided by the hospice then for all other qualified staff. For end-of-life training including the care of dementia patients to be commissioned. Staff to be reminded to complete end of life assessments/ care plans.	Care and Treatment
8212	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Moderate	Pt wishes clarity on several parts of the complaints response and areas of CAMHS service provision ORIGINAL COMPLAINT BELOW Pt unhappy with therapist expressing opinions on family members, not considering f2f appt when C19 restrictions were lifted, various issues occurred during therapy sessions that they wish addressed. They would like an apology for the therapists approach, behaviour and attitude	Not Upheld		Attitude of Staff
8186	West Berks	Community Hospital Inpatient Service - Donnington Ward	Low	PHSO will not pick up complaint until a LRM has taken place with palliative care-team ORIGINAL COMPLAINT family saw a daily decline in the pt since admission and noted many areas of staff behaviour that impacted on the pt. Family feel catheter and canular fitting was just to keep the pt quiet and cause less hassle, sent home with a full catheter bag. Inconsistency in nursing care. Family upset that the pt had been sedated and given antidepressants. Pt lost 2 stone in 10 days but this was not recorded on notes. Oral thrush appeared not to have been treated at all whilst in hospital	Partially Upheld	Care and communication were appropriate - learning around communication and documenting the use of a port.	Care and Treatment

8030	Reading	Adult Acute Admissions - Bluebell Ward	Low	Unhappy with response raising many questions on various points of our response letter ORIGINAL COMPLAINT: Pt feels we did not take into consideration their physical health issues and medication when prescribing and that we denied physical health meds when the pt was in PPH	Partially Upheld	Original complaint - not upheld Re-opened complaint (altered issues) - partially upheld. Physical health to be discussed on admission. S132 rights to be read and documented.	Care and Treatment

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15 Steps Challenge

Quarter 2 2021/22

The Arc, St Marks

On arrival to the area, the team found the signage to the service was not clear the service has liaised with Estates and Facilities since the visit to improve the signage. .First impressions were that there were no patients waiting in the waiting area, the area was clean and had a staff photo signage board.

Physio Department, St Marks Hospital

First impressions were of a professional and courteous service. The service appears to be well running offering a professional and courteous service. Due to the pandemic, the service is running a limited service with first appointments virtual and 60% of the follow ups face to face meetings, the rest being online consultations.

The member of staff at reception was very welcoming even when he was unsure of who we were. He was patient, welcoming and knew when the next appointment was. There were no staff except reception staff or patients available to speak to at the time of the visit.

Physiotherapy Department, WBCH

First impressions were of a professional service which the staff visiting felt they would be happy to be treated by. Evidence of good work being undertaken responding to both patient need and the pandemic. The team shared clear direction and ideas with regards to taking the service forward. The visitors observed a supportive atmosphere in the unit.

Podiatry, WBCH

First impressions were of a department that had reduced staffing and staff shared that staffing had been stretched. Since undertaking the visit, there has been some successful recruitment of staff. The team lead was covering clinically and supporting another podiatry department. There was some storage of equipment issues which are in the process of being reviewed.

Podiatry, King Edward VII Hospital

On arrival, it was noted the department work without their own receptionist on site. There is a waiting area for patients which allows for social distancing off the main corridor and clinic rooms nearby.

The podiatrist on duty spoke enthusiastically about her role and the challenges the service faced during the pandemic. She was welcoming and accommodating. **Quarter 3 2021/22**

Physio, Upton Hospital, Slough
The team found the department well organised and were responding well to the challenges that Covid restrictions were placing on them. New ways of working had been implemented to deal with the additional pressure and the team were responding well to these new practices. This involved both face to face and remote consultations.

There had been some challenges with capacity due to an increase in referrals however the department was responding well. Urgent referrals were being seen/assessed within 2-4 weeks which is similar to the other physiotherapy departments across the trust. A room was due to be transferred to a consulting area shortly to increase the ability for face-to-face consultations.

Jubilee Ward, Upton Hospital, Slough
The atmosphere on the ward was calm and friendly and the staff were open and welcoming to the team. The ward appeared to be well-run.

Ward manager spoke of the challenges during covid regarding visiting. The ward had tried to mitigate this as much as possible. One Ipad was available, the manager has requested further Ipads for the purpose of virtual visiting. The hospital had recently changed meal providers without consultation with ward staff, patients or relatives. This had resulted in a repetitive diet for patients i.e., all chicken dishes on the same day. The ward manager had fed this back to the new estates provider who were taking this forward.

Physiotherapy Department, Wokingham Hospital
A very well run, organised and efficient department, the receptionist was extremely professional and knowledgeable about all aspects of the clinic. All areas of the department were clean and uncluttered. Clinical staff were actively engaging with patients.

Ascot Ward, Wokingham Hospital
This was a positive visit, and the team were welcomed onto the ward. The ward was clean and tidy and appeared well run. The unit manager was very supportive of the visit and feedback.

The garden area was a bit untidy and unattractive, but the team were informed that there were some proposed ideas for improvement being discussed. The Flow board was very bright which could disturb some patients at night. Although there had been no specific complaints or comments. This was being reviewed by the ward manager.

Friends & family team discussion:
Members of all the teams said that, should a family member or friend be admitted to any of the areas visited they would feel confident in the care that they would receive.

Linda Nelson
Lead Nurse for Professional Practice
January 2022

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Site Name	Service Name	Hierarchy Level	Hierarchy Name	FFT Data Submission
All	All	All	All	All

Experience Score	Question	Has Reply?	Publishable?	Review Source	Review Date
All	All	All	Yes	All	12/1/2021 to 1/27/2022 and Null values

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Performance Over Filtered Date Range

% Positive	93.58%
% Negative	3.21%
Average 5 Star Score (all questions)	4.62
Review Count	187

Performance Previous Month

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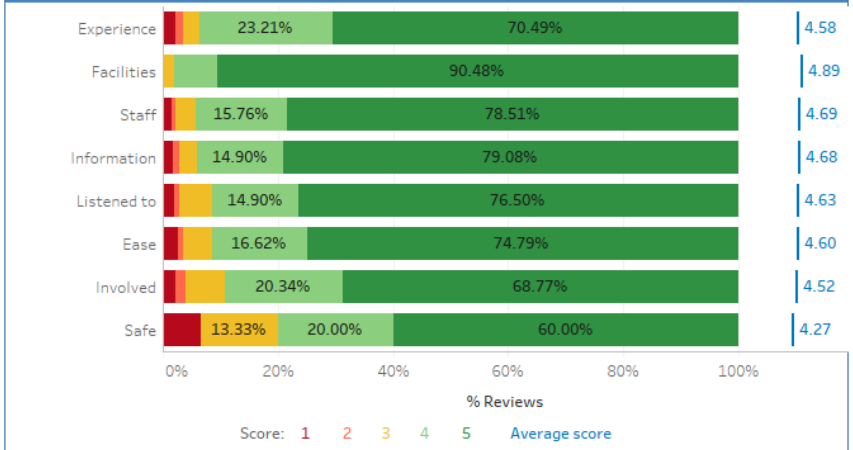
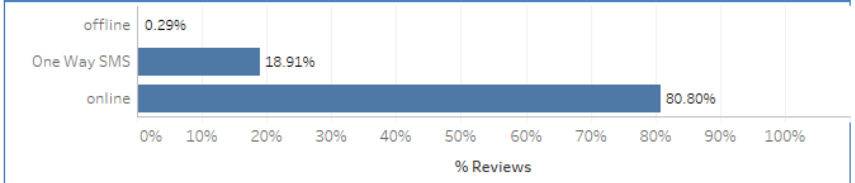
Score By Question



Reviews & Replies

Reviews with Review free text	349	100.00%
Reviews with Improvements free text	349	100.00%
Reviews with no free text	0	0.00%
Reviews replied to	0	0.00%

Review Source



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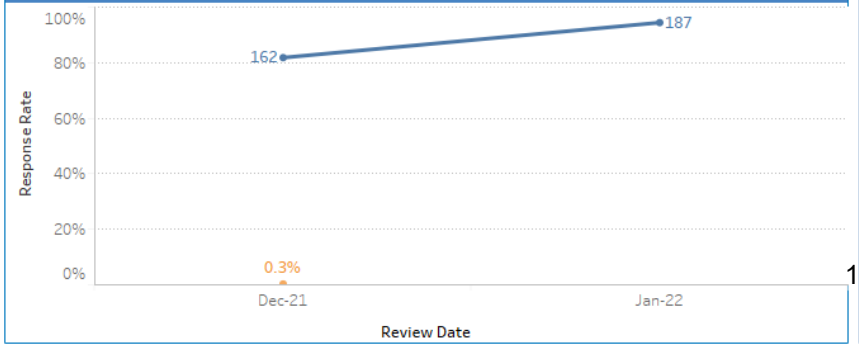

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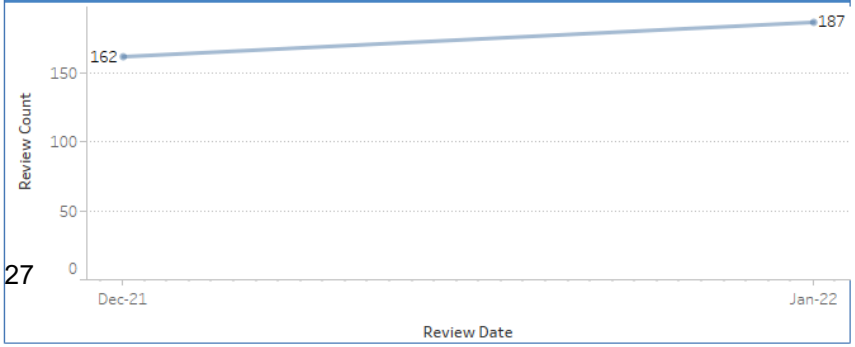

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All	All	All	All	All	Experience

Experience Score	Question	Has Reply?	Publishable?	Review Source	Review Date
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FILTERS(S) IN USE

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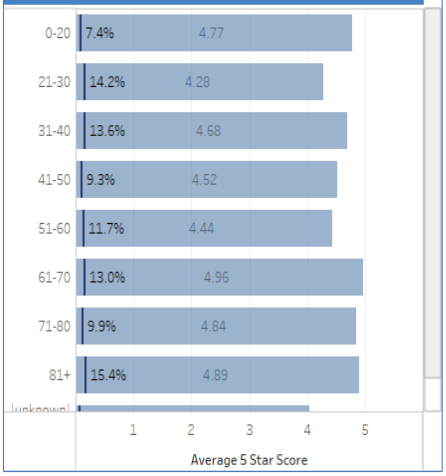
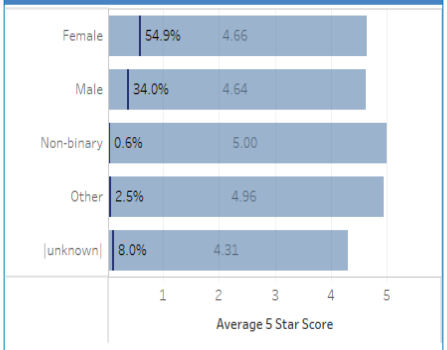
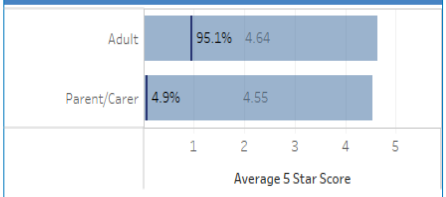
Age



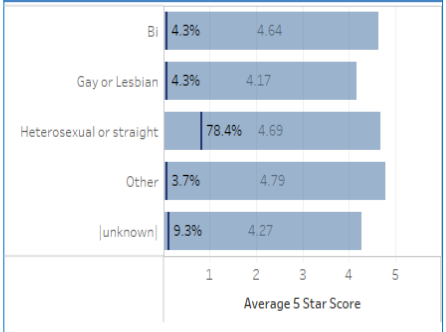
Gender Identity



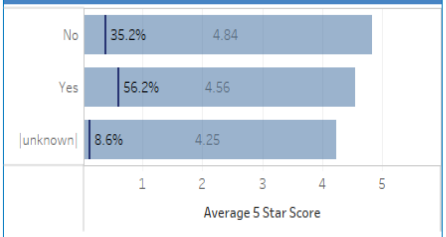
Patient Type



Sexual Orientation



Disability



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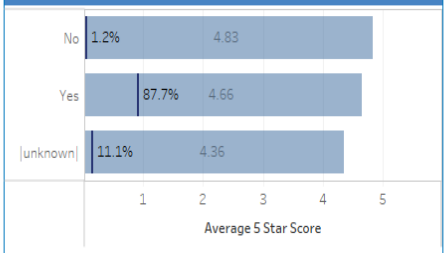
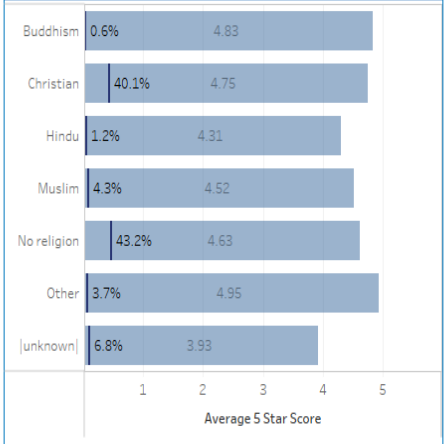


Religious Belief



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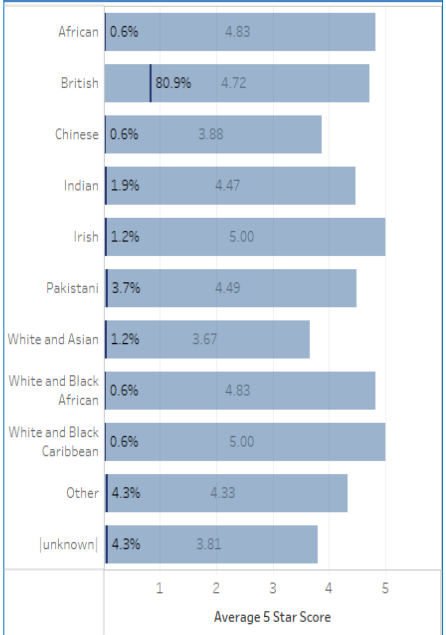
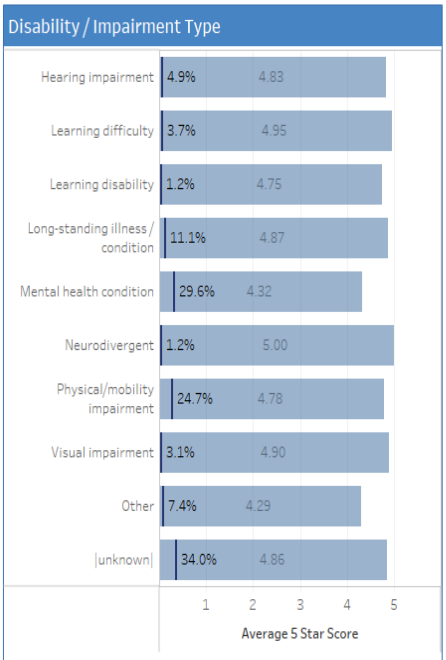
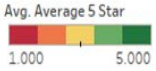


Disability / Impairment Type

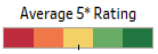


% Reviews Average Score (all questions)

Improvements Word Cloud



Review Word Cloud



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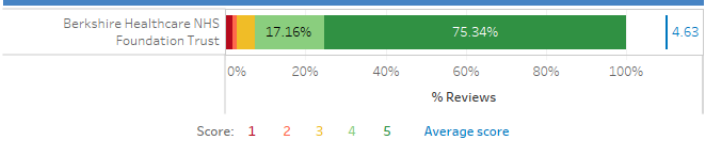
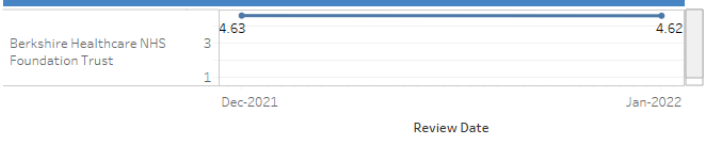
Benchmark 1
Organisation

Score by Organisation



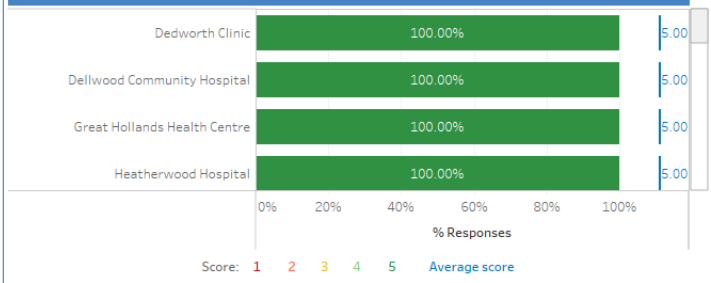
Score: 1 2 3 4 5 Average score

Organisation trend



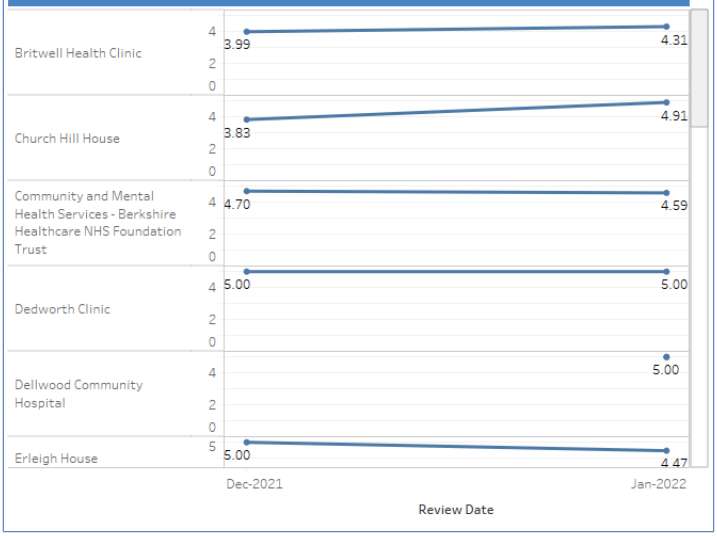
Benchmark 2
Hospital

Score by Hospital



Score: 1 2 3 4 5 Average score

Hospital trend



Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8th February 2022
Title	**Infection Prevention and Control Board Assurance framework**
Purpose	To provide the Board with assurance that our organisational practices in relation to Covid and other respiratory illnesses are reviewed, monitored and managed in line with national guidance
	Item for Noting
Business Area	Nursing and Governance
Author	Debbie Fulton
Relevant Strategic Objectives	Harm free care, supporting our staff, good patient experience.
CQC Registration/Patient Care Impacts	Requirement of CQC to be able to evidence appropriate Infection prevention and control measures in line with the provision of safe care
Resource Impacts	none
Legal Implications	none
Equality and Diversity Implications	none
SUMMARY	On 24th December 2021 the IPC board assurance framework was updated and re-issued following national updates. The attached version reflects current IPC policy, procedure and practices across the organisation. The aim of the framework is to support all healthcare providers to effectively self-assess their compliance with UKHSA and other COVID-19 related infection prevention and control guidance and to identify risks. It is also intended to assure directors and the Board that measures taken in line are in with current guidance. The Board assurance framework is reviewed regularly by the Head of Infection Prevention and Control and the

	Director of Infection Prevention and Control (Director Nursing and Therapies), where changes are made, and updated version are released the framework is taken to Quality Performance and Experience Group and Covid Clinical Reference Group as well as Board. Throughout the pandemic the organisation has followed national guidance and continues to do so. There are no significant risks identified through review of the updated framework. The main gap that continues to be addressed is: • Ensuring that the FFP3 records for all staff are transferred into ESR (this is an ongoing piece of work supported by ESR team)
ACTION	No action required of Board

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Berkshire Healthcare

Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May
Chief Nursing Officer for England

1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond inan evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This isa decision that will be taken locally although organisations must ensure they have alternativeappropriate internal assurance mechanisms in place.

2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of

patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work Local risk assessments should be based on the measures as prioritised in the hierarchy of controls In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effectively

1. **Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users**			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
A respiratory season/winter plan is in place: • that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services • to enable appropriate segregation of cases depending on the pathogen. • plan for and manage increasing case numbers where they occur. • a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts	Wards and services have individual risk assessments in place ; these are reviewed at services level Wards all have a up to date inpatient isolation and cohorting SOP in place for management of respiratory patients including screening / cohorting etc. This includes cohorting, admission ,day 3, 5-7 and then weekly screening for SARS CoV- 2. Where there is increased incidence or outbreak screening of negative patients is undertaken every 48 hours. Screening for symptomatic patients includes SARS CoV-2, Influenza and RSV. Hierarchy of controls in place at trust level and included as a guide for services/ within inpatient SOP IPC surveillance and review of local and national PHE data. Outbreak reporting.	Point of care testing is not available to community /Mental health Trusts	Day 1,3 5-7 remains in place with patients isolated or in beds that have adequate social distancing when admitted with unknown covid status

winter plan.	Inpatient SOP includes plan for use of single rooms/ segregation areas. Respiratory infection pathways include prioritisation of single rooms. Where there is high incidence / variant of concern in local areas staff have been encouraged to present for PCR testing in addition to undertaking twice weekly lateral flow testing Ventilation added as a standard agenda item on the Trust Health and Safety Group meeting Triage tool undertaken for outpatients where possible. Triage for inpatients undertaken at referral and admission screening compliance Weekly Gold calls are multi professional to support decision making NHSE visit 3rd September 2021 processes witnessed and demonstrated in practice to be in line with current guidance		
health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.	Covid secure measures remain in place including Social distancing , ventilation and mask wearing in all non-clinical areas as well as clinical areas where PPE appropriate to the patient cohorts must be worn. Signage , information on Nexus and reminders/ notification of changes through all staff covid newsletter / all staff briefings		

Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: • based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area. • applied in order and include elimination; substitution, engineering, administration and PPE/RPE. communicated to staff.	Individual ward/ service risk assessment tools are based on Hierarchy of controls		
safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.	Weekly DoN call for discussion of system working and alignment Weekly system call to share risk assessments / QIA		
if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.	National guidance is followed ; Any deviations from national guidance this would be agreed at Gold/ Executive level internally and through relevant system meetings		.

risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.	IPC related Risk assessments are undertaken by service managers with support from IPC and are reviewed by the Head of IPC and DIPC prior to implementation		
if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.	The use of FFP3 is considered as part of individual employee risk assessments as well as service and situation specific (outbreaks/ high incidence/ staff preference for example) assessments. January 2022 - currently all staff providing care to covid positive / suspected patients are advised to wear FFP3		
ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services	Patients are not transferred unless clinically necessary or in order to cohort appropriately in line with inpatient SOP		
the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases	Process in place for Medical / Nursing Director sign- off daily submissions of daily sitrep		
there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.	Gemba visits to services undertaken by exec and senior leadership team Unannounced/ announced supportive visits undertaken by IPCT/ corporate staff from nursing and governance directorate		
resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).	IPC compliance tools undertaken by services IPC resources and training materials on Nexus Local induction		

the application of IPC practices within this guidance is monitored, eg: • hand hygiene. • PPE donning and doffing training. • cleaning and decontamination.	Monthly hand hygiene audits for inpatient units and Quarterly Report for Community Services Monthly IPC compliance audits include hand hygiene , PPE, cleaning and decontamination PPE competency assessment for all staff IPC/ SLT service visits monitor compliance IPC annual monitoring programme undertaken throughout year	Ongoing challenges with individual compliance/ PPE fatigue in non-clinical and clinical settings	Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ Frequent reinforcement of messages through newsletters/ teams live/ service visits/ posters and local processes Unannounced supportive visits being undertaken by IPCT
The IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.	The IPC BAF is reviewed by clinical reference group fortnightly and at least alternate monthly at Quality and Performance group. In addition, presented to trust Board and Quality Assurance committee.		
the Trust Board has oversight of ongoing outbreaks and action plans.	COO and DoN attend all outbreak meetings with DoN chairing these. Updates are provided to Board. Weekly gold meetings attended by DoN, MD, COO and Deputy CEO. Silver role undertaken by COO		
the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required.	A range of masks are available in our central stores , all staff who might need FFP3 are encouraged to be tested for more than one mask including a UK mask. FIT testing is overseen by EFM with central records now being transferred onto ESR . Dedicated email box for FIT		

	testing requests . Ongoing programme of FIT tester training		
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level	EFM leading implementation of National Standards. Actions completed by November 1st in line with implementation of NSoHC implemented. Plan to be issued by February 1st 2022 IPCT involved with review and planning.		
the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	To be completed and implemented by May 1st 2022		
cleaning standards and frequencies are monitored in clinical and non- clinical areas with actions in place to resolve issues in maintaining a clean environment	Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE/I All areas monitored as in line with frequency - Healthcare cleaning manual. Spot checks have been increased EFM national SOPs for cleaning, catering, estates and portering circulated to all staff. Reminders sent to managers.		
increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient	Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE/I		

isolation rooms and cohort areas.	• 01 Cleaning Process COVID 19 within 1 metre of patient • 02 Cleaning process COVID 19 High risk units where AGPs being conducted • 03 Cleaning Process COVID 19 cohort no patient contact • NHS Cleaning and Decontamination Training - Covid-19 (Coronavirus) These documents are available electronically and in a printed format to all relevant teams Inpatient SOP and patient pathways Cleaning schedules in place which include enhanced twice daily cleaning requirements for all clinical sites and wards – checks undertaken to ensure compliance and monitored as part of compliance tool Wipes and cleaning products available for staff to use on desks / workstations in non-clinical areas EFM attend any outbreak meeting		
Where patients with respiratory infections are cared for : cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance if an alternative disinfectant is used, the local infection prevention and control	E&F cleaning and environmental SOP EFM monitoring of wards has continued throughout this period Chlorclean used Monitored as part of IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy		

team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses			
manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Staff have all been trained in the use of Chlorclean as per National standards of cleanliness and the Healthcare cleaning manual Guidance for safe use including storage of Chlorclean included in IPC mandatory training and information posters available in clinical areas/ Nexus.		
a minimum of twice daily cleaning of: • patient isolation rooms. • cohort areas. • Donning & doffing areas • 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails. • where there may be higher environmental contamination rates, including: • toilets/commodes particularly if patients have diarrhoea.	Inpatient SOP E&F cleaning and environmental SOP Cleaning schedules in place which include enhanced twice daily cleaning requirements for all clinical sites and wards – checks undertaken to ensure compliance and monitored as part of compliance tool These documents are available electronically and in a printed format to all relevant teams Wipes and cleaning products available for staff to use on desks / workstations in non-clinical areas EFM attend any outbreak meetings Touch points – doors/handles and handrails at least 4 times per day in patient areas.		

A terminal/deep clean of inpatient rooms is carried out: • following resolutions of symptoms and removal of precautions. • when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens) • following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).	IPC/ Out-break Policy details requirements Domestic staff on ward have been trained and issued relevant SOPs. Site coordinators also check IPC compliance tool includes check against decontamination and use of cleaning products (including reconstitution of chlorclean). posters available to support correct chlorclean reconstitution for clinical areas.		
reusable non-invasive care equipment is decontaminated: • between each use. • after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment.	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Ward and community services equipment cleaning schedules Included as part of IPC compliance tool Monitored as part of IPC monthly spot check (inpatients) SOP for cleaning of reusable goggles Patient equipment monitoring part of IPC annual monitoring programme		
Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.	IPC and EFM spot checks Ward compliance tool Patient equipment monitoring (inpatients)		
As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural	Review of all aircon on trust sites undertaken with risk assessment and guidance issued - 22.6.20 guidance circulated through service management including list of		

or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways	air con for use; also circulated through all staff email with reminders through COVID newsletters including heatwave advice for staff. Guidance regularly recirculated as part of summer planning information dissemination Ventilation policy		
where possible air is diluted by natural ventilation by opening windows and doors where appropriate where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place	All staff advised through newsletter/intranet and staff briefings regarding need for good natural ventilation Part of ward compliance tool Risk assessments and service level SOP's include natural ventilation Ventilation policy in line with HTM03-01 Any screens and partitions are installed by EFM	Natural ventilation adherence more challenging in cold winter months	Reminders regarding ventilation as part of IPC measures are part of regular reminders through staff communications , on Nexus and through visits to wards Wards have processes for ensuring windows are opened regularly for ventilation

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure:			
arrangements around antimicrobial stewardship is maintained previous antimicrobial history is considered	Pharmacy antimicrobial stewardship strategy Antimicrobial Stewardship Group programme of work that encompasses the requirements of Criterion 3 of the H&SC Act (2008) to demonstrate compliance. Antimicrobial stewardship group meeting minutes Antimicrobial stewardship annual audit The trust's antimicrobial stewardship strategic plans are aligned with the Trust goals. There is an AMS Annual Plan on a Page, as opposed to a specific AMS strategy		
the use of antimicrobials is managed and monitored: • to reduce inappropriate prescribing. • to ensure patients with infections are treated promptly with correct antibiotic	Oversight by AMSG, and AMS Lead Pharmacist.: Routine pharmacist review of all prescribing, ensuring adherence to antimicrobial formulary (Trustwide access via Microguide app) NICE guidelines for anti-infectives reviewed by the AMSG and the Microguide updated appropriately. Access to, and/or supply of, the required antibiotics or antimicrobials in a prompt and timely manner (supported 24/7 by on-call pharmacist (and associated pharmacist advice and guidance).		
mandatory reporting requirements are adhered to and boards continue to maintain oversight	The programme to be monitored by the AMS Group and progress reported to the IPCSG quarterly		

	Mandatory surveillance of reportable infections in place and reported via monthly/ QEG reports. Post infection reviews and associated learning disseminated and reviewed at PSQ		
risk assessments and mitigations are in place to avoid unintended consequences from other pathogens.	Anti-microbial advice is always sought as required		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors national guidance on visiting patients in a care setting is implemented;	Visitor guidance in place and available on Trust internet Implementation of all guidance around visiting with guidance circulated to wards. This includes ensuring ability to contact trace visitors if required and checking for any COVID related symptoms and other restrictions such as those needing to self-isolate prior to visiting . use of LFD is encouraged for all visitors prior to attendance masks, hand rub and bins available at entrances for visitors not wearing face coverings. Posters to remind visitors to wear face covering, social media and internet also issued to promote message. Each ward has process in place for monitoring visitor numbers, support to use outside spaces where possible. IPAD for promoting virtual visiting in place for all wards		

restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.	Restrictive visiting during outbreaks is included in visitor guidance		
there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing.	Signage available in clinical areas Signage available in public areas including waiting rooms and toilets and at entrances Written information to patients who receive written OPD letters Verbal communication with visitors to explain processes around PPE/ hand hygiene External webpage has relevant information and is updated		
if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.	Isolation signage used in addition to verbal conversations with visitors		
visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.	Visitor guidance details need for visitors with respiratory symptoms to not visit - all visitors asked by staff prior to visit if booking it or on entry to ward STOP Posters available in relation to not visiting if symptoms of infection (available on Nexus) Guidance provided to wards to support visitors for end-of-life patients in line with national guidance		
visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian	Visitors would not be present during AGP unless considered essential		

Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk)	Every Action counts plan in place to include information within the supporting excellence document - shared with Clinical Reference Group for dissemination within their directorates Clear plan in place for which elements are planned or in use and disseminated IPC guardians and resources included in IPC Link Practitioner programme		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.	STOP posters for visitors		
infection status of the patient is communicated to the receiving organization, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred	Completion of inter healthcare transfer form. Monitoring of IHTF part of IPC annual monitoring programme and being undertaken during Q3 ICC017 Infection Control Isolation, Cohort and Movement of Patients IPC surveillance. Flagging of positive and suspected cases on Rio Robust links with local acute providers Review of Datix if non-compliance identified Triage and Covid status on admission referral		

staff are aware of agreed template for triage questions to ask	Template triage tool circulated through email, newsletter, and PPE clinical reference group. Also available electronically on RIO. (December being updated to reflect change in isolation periods form 14 days to 10)		
screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.	All clinic settings have checklist for use to screen patients just prior to or on arrival – this is available on RIO - circulated in newsletter, through clinical reference group and email via IPC Inpatients are tested on admission, day 3 day 5-7 and then weekly as routine (also tested if become symptomatic) unless known to be positive to enable quick detection and appropriate action to mitigate transmission		
Front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.	Trust does not have an A&E admission are generally planned unless admission through Place of safety. Admission screening of all patients (unless known positive). Triaging tool used for outpatient services and UTC. UTC have a process for managing patients with respiratory symptoms/ clinical signs of infection. Covid-19 inpatient isolation and cohorting SOP – this includes cohorting of possible and confirmed cases away from patients who are asymptomatic waiting results and those with negative result. Transfers known to have had exposure to covid prior to transfer isolated for 14 days RIO tool for inpatient screening can be audited /also detailed within notes. Admission screen compliance monitored		
there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.	Admission screening compliance	Compliance with use of RIO tool to enable audit of compliance	discussion at clinical review group and reminder and instructions resent

	Rio forms for compliance with admission, day 3, day 5-7 & weekly screening for SARS CoV -2. Report available on tableau		
patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.	Patients attending outpatient settings advised to wear masks & posters at entrances. included in ward risk assessment and individually risk assessed dynamically depending on patients' condition and ability to tolerate	Not all patients are able to tolerate wearing face masks/ for some patient's masks are ligature risk	Individual risk assessment undertaken
patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result. patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.	New admissions are admitted to single room or socially distanced bed whilst waiting results of PCR – symptomatic patients prioritised form single rooms Single triage rooms in MIU and urgent treatment centre for assessing patients who present Inpatient SOP details single room prioritisation		
patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their families and carers accompanying them for treatments/procedures must be considered	Inpatient SOP details single room prioritisation		
where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes	Included in outpatient checklist		

face masks/coverings are worn by staff and patients in all health and care facilities.	Trust guidance includes need for face masks to be worn by staff , visitors and patients (where they are able to tolerate this) in all clinic areas Posters, checks on compliance through exec and SLT visits, reminders in newsletters/ all staff briefings and on NEXUS As detailed above risk assessment undertaken for patients , need for this included in ward risk assessment and SOP		
where infectious respiratory patients are cared for physical distancing remains at 2 metres distance	All wards have single rooms and / or socially distanced beds to accommodate this		
patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.	Berkshire healthcare does not have separate spaces for most services, patients known or suspected to be positive would not be attending clinics/ Trust premises other than when being admitted into wards Use of triage tool prior to or on attending appointments enabling staff to risk assess placement of patient where appointment necessary Virtual consultation to remain default where possible SOP in place for this process EFM review of all sites as part of recovery process and screens/ partitions provided where appropriate All MH wards across the Trust are single occupancy, community wards have been laid out to achieve at least 2 metre bed spacing as far as is practicable with additional mitigation measures and guidance in place where this is		

	not possible due to significant bed pressures causing greater patient risk Social distancing is maintained in all clinic / outpatient setting unless providing hands on care with screens in place to protect receptions staff Visual reminders in place		
patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re- tested and contacts traced promptly	Isolation policy Any patients who develop symptoms are tested and isolated in line with Covid-19 inpatient isolation and cohorting SOP IPCT daily review of cases Routine IPC surveillance Information to wards to remind them of prompt isolation and testing COVID status Included as part of handover/ standard work Staff have ability to enter covid vaccination status on RIO tool IPCT liaison with transferring Trusts if positive cases identified following transfer to BHFT		
isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative;	Inpatient SOP details need Information to wards to remind them of prompt isolation and testing Included as part of handover/ standard work Contact tracing for any staff/ patient contacts undertaken as part of IPC and any outbreak management - flow chart in place to support managers with contact tracing		

patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	Triage tool used on arrival or prior to attendance All patients treated as potentially positive with appropriate PPE worn Community teams including phlebotomy, UTC, CMHT's are triaging ahead of appt IPC mandatory training & resource pack cover management of symptomatic patients 2 metre distancing in waiting areas		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
appropriate infection prevention education is provided for staff, patients, and visitors.	Posters in place in clinical and non-clinical areas Monthly and quarterly hand hygiene observations submitted by inpatient and community services Hand hygiene technique included in IPC training and resource pack Social distancing signage Signage for use face coverings Catch it, Kill it, Bin it posters Regular social media use to promote need for visitors to wear face covering IPC Compliance tool for clinical areas to ensure adherence Equipment cleaning schedules in clinical areas		

	Patient equipment monitoring included in IPC annual monitoring programme Enhanced cleaning in place Social distancing in non-clinical areas poster Safety at work poster Wearing a facemask for patient's poster displayed in inpatient units Ongoing messaging to staff around how to keep themselves safe outside of the workplace Verbal communication/ education for visitors and patients provided by staff, senior staff available for support		
training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.	Mandatory IPC training for clinical staff Updated IPC training presentation including recorded version and quiz for individuals & teams to undertake. IPC mandatory training compliance reviewed monthly and included in IPC monthly reports Resource IPC resource pack available for all, this includes standard/ transmission-based precautions as well as PPE related information and guidance for medium and high-risk pathways in patient facing services Every action counts videos circulated for use through weekly newsletter and ward managers December 2021 compliance 82% for annual training and 90% for bi-annual training For financial year 2020/21 - the organisation compliance with infection control mandatory training stood at 90% against a target of 85%.		

	Every Acton counts materials reviewed and relevant tools in use with clear plan around what has been implemented rollout of IPC guardian role for all services IPCT providing bespoke training sessions for those areas identified with low training compliance.		
adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.	Monthly IPC service compliance tool (stepped up to daily for all outbreaks or increased incidence) IPCT and senior staff visits to monitor PPE compliance PPE Guardians reintroduced at PPH Senior staff visibility to promote NHSE visit 3rd September - all staff observed to be adhering to guidance		
gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's.	PolicyICC003 Standard Precautions and the use of Personal Protective Equipment (PPE)		
the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	Paper towels are available in all clinical areas Posters displayed to remind staff and are also in public areas		
staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace	All non -clinical areas are set out to provide 2 metre distancing		

	Posters and signage to promote social distancing in all areas except where providing clinical care Reminders in staff briefings and newsletters Service visits by senior staff and IPC to promote compliance		
staff understand the requirements for uniform laundering where this is not provided for onsite	Guidance provided to staff on laundering of uniform provided on trust intranet		
all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance	Flow charts and checklists provided to staff through all staff emails / available on NEXUS . Reminders re actions to be taken how to access PCR		
to monitor compliance and reporting for asymptomatic staff testing	Local BHFT system used for reporting of LFT tests, this enables tableau reporting , weekly reports to service managers for inpatients and community Nursing to enable monitoring by managers . reports available to managers on Tableau	Not all staff are remembering to report their result	Monitored weekly with reminders to staff through managers and also in newsletters and on Nexus dedicated covid testing mail box to support staff with queries. Kits at work and support to log result on inpatient wards
there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation	DoN participation in Frimley IPC meetings to discuss local intelligence and learning from any local outbreaks . COVID on agenda for BOB , Berks West and Frimley quality meetings		

onset cases (staff and patients/individuals).	Attendance at regional Webinar for IPC Feedback from ICS DoN from local PH chaired outbreak meetings Attendance at local and regional IPC meetings by Head of IPC Daily review cases by IPC Outbreak meetings instigated where there are 2 or more potentially linked cases -any learning is shared across inpatient areas. This includes monitoring of staff and patient cases Staff absence related to covid captured on ESR Operational calls to monitor staff absence impact		
positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported.	Process in place ICC011 Communicable Diseases and Outbreak Management Single case and outbreak identification and management process in place in working hours and out of working hours (including test & trace) Outbreak management and reporting in place for in and out of hours 72-hour reports completed for any post 8-day covid positive cases and outbreak meetings implemented for any situation where 2 or more cases are potentially linked; this is chaired by DoN or deputy, with attendance by IPC; EFM, clinical team; services managers, clinical director and COO Where there is service disruption due to outbreak or an individual case meeting threshold for Serious incident reporting this is undertaken.		

7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs	Masks available included in ward risk assessment and individually risk assessed dynamically depending on patients' condition and ability to tolerate Individual risk assessment undertaken for inpatients and documented Mask wearing included in ward risk assessment tool Wearing facemasks for patients on inpatient wards poster displayed on inpatient units Patients attending outpatient settings advised to wear masks & posters at entrances.	Not all patients are able to tolerate wearing face masks/ for some patient's masks are ligature risk	Individual risk assessment and maintaining social distancing as much as possible
separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients. patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other	**For outpatient services** Berkshire healthcare does not have separate spaces for most services, patients known or suspected to be positive would not be attending clinics/ Trust premises other than when being admitted into wards Use of triage tool prior to or on attending appointments enabling staff to risk assess placement of patient where appointment necessary and defer appointment where it can be safely postponed Virtual consultation to remain default where possible SOP in place for this process		

patients/individuals. patients are appropriately placed ie, infectious patients in isolation or cohorts.	EFM review of all sites as part of recovery process and screens/ partitions provided where appropriate F2F visits to patients homes as an alternative option to attending a clinic where clinically required **For the wards** Isolation policy Isolation and cohorting SOP; oversight by IPC and senior managers to ensure understanding and appropriate actions Cohort wards /areas are identified for Prospect Park Hospital should they be required - this is detailed in SOP and risk assessment/ physical barriers of closed doors with clear signage Community wards have cohort bays -posters / signage IPC advice where there are potential / known respiratory infections IPC surveillance to identify new cases and ensure appropriate actions taken to minimise spread		
ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).	Daily staffing review with access to temporary workforce to increase staffing where this is needed / available Use of Business continuity plans to ensure safe staffing in critical services MH beds are all single occupancy rooms For community wards there is a mix of single rooms/ socially distanced beds with risk assessment escalation process in place for when / how this would be reduced to		

	meet system bed capacity requirements - this includes agreement through senior leaders and DIPC Inpatient SOPs / ward risk assessments		
standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result	Posters, Information on Nexus, IPC training and supportive IPC visits all reinforce standard precautions alongside FRSM masks wearing		
the principles of SICPs and TBPs continued to be applied when caring for the deceased	ICC003 Standard Precautions and the use of Personal Protective Equipment (PPE) IPC Respiratory guidelines (linked in inpatient SOP)		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure:			
testing is undertaken by competent and trained individuals	Guidance and competency assessment provided to all inpatient and swabbing teams. Support from physical health lead at PPH to support training		
patient testing for all respiratory viruses testing is undertaken promptly and inline with national guidance;	Covid Screening undertaken on admission (unless known positive), at day3, 5-7, every 7 days during stay and if appropriate on discharge and if symptomatic Guidance for staff regarding requirements and process for staff testing on Nexus/ in newsletters/ screen savers. Dedicated COVID testing email Inpatient SOP includes Covid 19 testing of patients on admission, at day 3 and at 5-7, weekly for all negative patients thereafter through their stay and if symptomatic and prior to discharge to Nursing /care homes	Consistency of use of RIO tool to enable audit of compliance with admission, day 3- and 5-7-day screening	PPH Senior leadership team developing action plan for improved compliance with admission, 3 a and 5-7 days screening Increasing use of tool support from transformation team and sharing of current

	Testing for flu and other respiratory illness where patient is symptomatic alongside testing for covid -19		tableau data to support continual improvement
staff testing protocols are in place	Lateral flow testing introduced for patient facing staff Managers receive notification when staff have recorded their LFT to enable managers to know who is testing and who to follow up Flow charts and checklists to support staff with understanding when PCR testing / LFT is required , available on NEXUS, disseminated through all staff newsletter How to gain LFT and PCR disseminated to staff and on Nexus Dedicated LFT mail box and covid mail box for staff queries Tableau dashboards available for managers to monitor staff compliance with Lateral flow testing and weekly email sent to wards, community nursing.	The process for ordering test kits changed in July meaning that staff must order their own kits using national gov site, this has been challenging over December due to national ability to meet demand On-going challenge of ensuring all staff report their results	Some kits available for ward staff with support to ensure their results are logged During times of shortage kits have been obtained through mutual aid and a clear prioritisation process in place for provision Managers emailed when tests undertaken , weekly email to managers of key services (wards and community nursing) Tableau dashboards
there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.	Monitored through IPC and escalated to DIPC and Head of commissioning if issues arise IPCT receive daily COVID 19 testing reports provided by BSPS		

	Liaison with Acute Trusts and laboratory services/ BSPS leads		
There is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);	RIO tool for reporting of all screening and results in place IPC receive daily COVID testing reports provided by BSPS	ensuring recording is captured within the tool to allow for ease of audit	Ongoing support to staff
screening for other potential infections takes place	IPC mandatory surveillance processes in place Daily, weekly & monthly mandatory surveillance data provided by laboratory/ acute trusts Deteriorating patient procedures in place to include being alert to potential sepsis and transfer of unwell patients to acute providers as appropriate		
that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission	All patients are tested on admission (unless already known to be covid + or recently recovered) Testing for other respiratory illness undertaken where patient is showing respiratory symptoms		
that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise.	All patients negative on admission are tested on day 3, day 5-7 and then weekly during admission as well as if symptoms arise. This is increased to every 48 hours where there is a known positive case/ close contacts on a ward This is written in ward SOPs		
that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	All admissions who test negative on admission are tested on day , 3, day 5-7 and then weekly during their inpatient stay This is written in ward SOPs		

that sites with high nosocomial rates should consider testing COVID negative patients daily.	Would be considered if high nosocomial rates Increased from routine weekly to every 48 hours for contacts if positive case detected on a ward		
that those being discharged to a care home are being tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge	Included in inpatient SOP		
those patients being discharged to a care facility within their 14-day isolationperiod are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance	All patients being transferred to care homes are swabbed 48 hours prior to discharge Included in inpatient SOP		
there is an assessment of the need for a negative PCR and 3 days self- isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance.	No elective procedures undertaken except form Dental where this is in place		

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that:			
the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors). staff are supported in adhering to all IPC policies, including those for other alert organisms	IPC training recorded on ESR and monitored Dedicated IPC email for support and advice Dedicated COIVD in box for advice Guidance for keeping safe at work including social distancing produced and disseminated. Support / visits from managers, Clinical Directors and IPCT to check compliance Annual IPC monitoring programme in place Sharing of learning from incidents, outbreaks, and post incident reviews Monthly IPC report shared through Divisional patient safety and quality processes as well as QPEG IPC champions/ Link Practitioners in place across the Trust IPC surveillance with IPC guidance provided Signage, posters and reminders on all staff briefings and newsletters Monthly compliance tool Every Action Counts action plan with use of tools and resources assessed to be relevant EFM monitoring of cleaning schedules / practice		

safe spaces for staff break areas/changing facilities are provided.	All staff spaces have agreed maximum capacity with additional space provided where this is needed for example at PPH there are 2 additional rest areas away from ward in place		
Robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.	Process in place Single case and outbreak identification and management process in place in working hours and out of working hours (including test & trace) Outbreak management in on call Director pack Outbreak management and reporting in place 72-hour reports completed for any post 8-day covid positive cases Outbreak meetings implemented for any situation where 2 or more cases are potentially linked; this is chaired by DoN or deputy, with attendance by IPC; EFM, clinical team; services managers, clinical director and COO Where there is service disruption due to outbreak or an individual case meeting threshold for Serious incident reporting this is undertaken. Hierarchy of Control for single case and outbreak management tool for review at outbreak meetings. Standard checklist used for outbreaks		
all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored, and managed in accordance with current nationalguidance.	IPC compliance tool Waste management included in Trust guidance documents and posters including flyer for community patients Policy on waste management		Clinical Directors to have process for assuring compliance from services within their Directorates and through already established meetings such as PSQ

	https://www.england.nhs.uk/coronavirus/publication/covid-19-waste-management-standard-operating-procedure/ Waste management SOP Feedback from waste suppliers regarding non-compliance Linen and laundry monitoring part of IPC annual monitoring programme (undertaken July 2020) Posters to support waste and linen segregation		
• PPE stock is appropriately stored and accessible to staff who require it	PPE held at central locations with dedicated team responsible for managing and distributing Over £50,000 was invested to bring a designed for purpose storage facility into operation All items have at least 14 days of current stock Separate arrangements made for winter / adverse weather contingency plans to reduce change of disruption in supply Stock control and distribution arrangements in place as well as process for estimating burn rate Trust is an active user of the national Palantir system PPE stock catalogue PPE supply and stock review meetings are held twice a week involving nursing, procurement, PMO and the PPE team PPE included in daily Sit reps ICS-wide Process in place for mutual aid should stock levels become an issue and shared warehouse with additional stock beginning to operate		

	Email for all staff to request PPE in place Redeployed staff used to deliver PPE to services		

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

Key lines of enquiry	Evidence	Gaps in Assurance	Mitigating Actions
Appropriate systems and processes are in place to ensure:			
staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.	Dedicated infection control in box for advice Occupation health service Individual risk assessment undertaken annually and if staff member situation changes with individual advice given where risk is deemed high Wellbeing hub for staff in place offering a range of wellbeing offers		
bank, agency, and locum staff follow the same deployment advice as permanent staff.	All bank and agency have induction NHSP are informed when there is a ward with covid positive patients to enable high risk staff to be aware Same PPE available to all staff IPC advice/ nexus to staff including temporary workers		
staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (Staff isolation: approach following updated government	Flow chart and checklists in place for staff and managers that is in line with current national guidance -these are disseminated through newsletter and available on Nexus Staff advice re accessing LFT and PCR testing available on nexus and through all staff newsletter		

guidance)	Covid inbox is available for all queries		
staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.	PPE videos for donning & Doffing included within IPC resource pack PPE competency for all clinical staff providing face to face patient care – wards check at start of shift that all staff on duty have undertaken PPE competency training PPE posters on Nexus and printed copies made available to services Mandatory IPC training covers PPE, includes induction		
a fit testing programme is in place for those who may need to wear respiratory protection.	In place, dedicated fit testing email and ongoing fit testing train the trainer sessions arranged as required.		
where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and absence. • facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19	Datix completed for all staff contracting covid as possible work exposure, these are reviewed by risk team and RIDDOR reporting supported Absence is monitored and supported by managers with HR support All staff have been offered covid and flu vaccine through staff Immunisation Programme, Individual conversations with those staff who are not as yet vaccinated with advice and resources available on Nexus ; Q&A / webinar provided ; Q&A and all staff briefings Promotion of how to gain both flu and covid through regular communications		

• encourage staff vaccine uptake.	Flu campaign includes voucher schemes as well as peer vaccinators and clinics to support maximum uptake Advice from IPC / microbiology / HCSAUK as required Staff sickens absence including reason is monitored		
staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.	All staff have access to information on nexus, through regular all staff newsletter and all staff briefings of the continued need to take all appropriate precautions regardless of vaccine status or having had respiratory illness. Spot check and supportive visits by IPC/ senior leaders to enforce this alongside IPC training, champions networks IPC and covid mail boxes available for advice where staff are not clear on PPE/ national guidance		
a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19. • A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;	Annual risk assessment undertaken for all staff, additional risk assessments for individuals if their circumstances change; this includes individual conversations for those at risk with advice from occupational health , IPC , medical Director for those most at risk . Deployment of high risk staff away from wards with covid positive patients. Pages on nexus providing information		

• that advice is available to all health and social care staff, including specific advice to those at risk from complications. • Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff . • A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.	All temporary staff have local induction , access to NEXUS and same info as available to permanent staff High risk temporary staff are to deployed to covid positive cohort areas All pregnant staff have risk assessment revisited and advice provided with support from HR / occupational health, IPC as required		
staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records. staff who carry out fit test training are trained and competent to do so. all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used. all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks	All staff required/ may be required to wear FFP3 are FIT tested and trained by staff who have undertaken FIT test training Ongoing fit testing Programme in place Only staff who have undergone FIT tester training undertake staff FIT testing and a record is centrally maintained of all staff who have undergone FIT tester training Staff are tested for the masks that they are using and where supply changes staff are retested for available masks The IPC/ EFM hold a list of all staff who have been trained as fit testers and those who have been fit tested/ mask they have been fit tested for.	Transfer and upload of local records to ESR is an ongoing piece of work with not all records as yet held in ESR	**R**eminder in all staff email, information out to managers to explain how to upload to ESR. Offer of support from ESR team Monitoring of ESR records monthly

a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods. that where fit testing fails, suitable alternative equipment is provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions. members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm. a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.	when a member of staff is fit tested, they are given a certificate detailing the result of the fit test and which mask. These results are added to ESR and Departments also keep a local record for staff who have been fit tested. Where a member of staff fails a FIT test of a certain mask alternative FFP3 masks are tried and hoods are available for those that require FFP3 as part of their regular clinical work but no FFP3 fit adequately (there are only a very small number services that routinely require FFP3 due to their work within the Trust as AGP are not performed in the fast majority of Community and Mental Health Services); for services where there is occasional need to undertake and AGP procedure someone who is not FIT tested / able to acquire adequate FIT of any available mask would not be asked to perform the procedure Any decision on redeployment due to staff member risk is documented FIT testing programme includes EFM staff		

boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board	Agreement with the Board that the DoN will highlight any concerns regarding FIT testing to the Board as part of executive updates Monthly report provided to DoN from the FIT testing coordinator		
consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.	Services minimize the movement of staff as much as is practicable whilst balancing safe service delivery BCP planning includes cross cover and support for critical services with staff allocated to specific areas to again minimize movement		
health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone	All services clinical / nonclinical comply with mask wearing, social distancing, good ventilation, and hand hygiene. There is regular communication through all staff newsletters, on NEXUS , all staff briefings of the importance . Posters/ signage in all areas to remind staff Supportive visits by IPC and senior leaders to both clinical and non clinical sites Work form home where this is possible guidance in place		
staff absence and well-being are monitored and staff who are self - isolating are supported and able to access testing.	Sickness absence policy includes keeping in contact HR support to managers where required Wellbeing hub available for all staff Covid inbox for staff queries around access to testing		

staff who test positive have adequate information and support to aid their recovery and return to work	Guidance available on Nexus regarding options for access to testing Managers checklist / flow chart		

Links to guidance referenced in framework:

https://www.gov.uk/government/publications/coronavirus-covid-19-hospital-discharge-service-requirements

https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=103031

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0030_Visitor-Guidance_8-April-2020.pdf

https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/

Minimising_Nosocomial Infection_-letter of 9th June 2020

FAQ on use of masks and coverings in hospital settings

Healthcare associated COVID-19 infections – further action – 24th June 2020

Covid -19: Guidance for the remobilisation of services within health and care settings. Infection prevention and control recommendations issued August 2020
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 February 2022
Title	**Executive Report**
	For Noting
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 8 February 2022

EXECUTIVE REPORT

1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Director of Finance Appointment

Becky Clegg has been appointed as our permanent Director of Finance, following a 6 month secondment as Interim Director of Finance. Becky's previous role was Chief Financial Officer at Berkshire West Clinical Commissioning Group.

Executive Lead: Paul Gray, Chief Financial Officer

3. COVID-19 Vaccination as a Condition of Employment

On 6 January 2022, the Government made new legislation approved by Parliament, which amended the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the 2014 Regulations"). This extended the scope of mandatory vaccination requirements for staff beyond registered care homes to health and wider social care settings in England.

The vaccination as a condition of deployment (VCOD) requirements include front-line workers, as well as non-clinical workers not directly involved in patient care but who may have face to face contact with patients, including ancillary staff such as porters, cleaners or receptionists. It also includes staff entering areas which are utilised for the provision of a CQC-regulated activity which may result in incidental face to face contact with patients or service users and therefore we have assessed that most of our staff are within scope of these regulations.

The VCOD regulations allow a grace period for compliance and the requirement will come into force on 1 April 2022. This means that staff must have had their 1st vaccination by 3rd February to have their 2nd before 1st April.

As of 31st January 2022, we had 129 staff who were still to receive a first dose of the vaccine, of these 27 have either booked to receive their first dose by 3rd February or

are likely to be out of scope. There are a further 81 staff who have received a first vaccine but not as yet their second.

On 31st January the secretary of state announced that the legislation is now being reconsidered. The Government's decision is subject to the Parliamentary process and will require further consultation and a vote to be passed into legislation.

As a result of this NHS England have requested that employers do not serve notice of termination to employees affected by the VCOD regulations. They do however remain clear that vaccination is the best way to protect yourself, your family, your colleagues and, of course, your patients from the virus and that staff have a professional duty to do so. Reporting on organisational position regarding vaccines therefore remains a requirement and we continue to do all that we can to encourage as many of our staff yet to take up the vaccine offer to do so.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Modern Day Slavery Statement

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

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

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

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

The Trust Board is requested to approve the Modern-Day Slavery Statement which will be included as part of the Trust's Annual Report for 2021-22.

Executive Lead: Paul Gray, Chief Financial Officer

Presented by Julian Emms
Chief Executive
February 2022

Appendix 1

Modern Day Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2022.

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

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

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

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

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

within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.

- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

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

Training

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

Our Performance Indicators

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 February 2022
Title	Financial Summary Report December 2021
	ITEM FOR NOTING
Purpose	To provide the Trust Board the financial position for the period ending 31 December 2021.
Business Area	Finance
Author	**Chief Financial Officer**
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities / Diversity Implications	N/A
SUMMARY	The Trust is reporting a surplus of £0.7m to the end of December 2021, which is £1.5m better than planned. The Trust is in a strong position going into the final quarter of the year and has improved its forecast to breakeven for the second half of the year against a £1m deficit plan, taking the FY forecast to a £1m surplus. Overall workforce growth is lower than planned, with elements of investment income deferred as a result. It is anticipated that unused Spending Review and Service Development Funding will be returned to NHSE&I rather than deferred at year end. Marginal COVID costs continue to be at a lower level than funded. Capital expenditure year to date is £4m, £2.1m behind plan. There is currently an underspend against the Trust's share of the ICS capital control total but it is expected that the underspend will be minimal by the end of the year. Cash balances remain strong at £56.2m.

ACTION REQUIRED	The Board is invited to note the report.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year Ending 2021/22

December 2021

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 December 2021.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	17/01/2022	Rebecca Clegg	Draft
2.0	18/01/2022	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Contents

1.0 Income & Expenditure

Dec-21	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	21/22 Plan £'m
Operating Income	24.6	24.0	0.6	216.1	217.2	(1.1)	291.2
Elective Recovery Fund	(0.0)	0.0	(0.0)	1.7	1.7	(0.0)	1.7
Top Up Funding	0.4	0.4	0.0	4.4	4.4	0.0	5.7
COVID Funding	0.8	0.8	0.0	7.1	7.1	0.0	9.3
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	***25.8***	***25.2***	***0.6***	***229.3***	***230.3***	***(1.1)***	***307.9***
Staff In Post	16.1	16.9	(0.8)	145.2	149.1	(3.8)	200.0
Bank Spend	1.7	1.4	0.3	14.6	12.9	1.7	17.1
Agency Spend	0.5	0.4	0.2	4.1	3.0	1.1	3.9
Total Pay	***18.3***	***18.6***	***(0.3)***	***163.9***	***165.0***	***(1.0)***	***221.0***
Purchase of Healthcare	1.9	1.9	(0.0)	15.8	15.9	(0.1)	21.2
Drugs	0.4	0.5	(0.1)	4.1	4.2	(0.1)	5.6
Premises	1.3	1.3	0.0	13.5	14.6	(1.1)	18.4
Other Non Pay	1.8	1.7	0.1	16.2	16.7	(0.5)	21.8
PFI Lease	0.5	0.5	(0.0)	4.8	4.8	(0.0)	6.4
Total Non Pay	***5.9***	***5.9***	***0.0***	***54.3***	***56.1***	***(1.8)***	***73.4***
Total Operating Costs	***24.2***	***24.5***	***(0.3)***	***218.2***	***221.1***	***(2.9)***	***294.4***
EBITDA	***1.6***	***0.7***	***0.9***	***11.0***	***9.2***	***1.8***	***13.5***
Interest (Net)	0.3	0.3	(0.0)	2.9	2.9	0.0	3.9
Depreciation	0.7	0.7	0.0	6.2	6.1	0.1	8.2
Impairments	0.0	0.0	0.0	0.2	0.0	0.2	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.1	0.1	0.0	1.1	1.1	0.0	1.4
Total Financing	***1.2***	***1.1***	***0.0***	***10.3***	***10.1***	***0.2***	***13.5***
Reported Surplus/(Deficit)	***0.4***	***(0.4)***	***0.9***	***0.7***	***(0.9)***	***1.5***	***(0.0)***

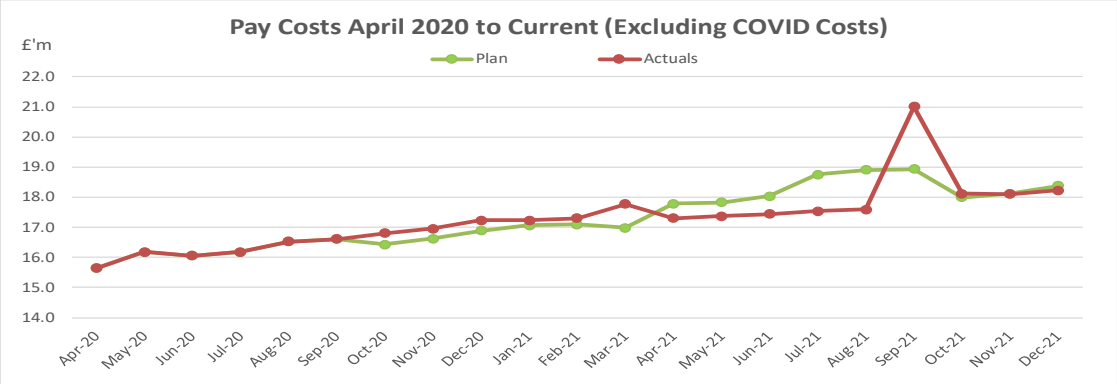
Key Messages

The table above gives the financial performance against the Trust's plan as at 31 December 2021. In December there was a £0.4m surplus against a £0.4m deficit. Our YTD surplus is £0.7m and we are forecasting a YE surplus of £1.0m which is an improvement on our plan for breakeven.

As in the first half of the year the plan assumed that Service Development and Spending Review Funding would be recognised, matching planned increases in expenditure but costs, in particular staff costs, have not materialised as planned and this has resulted in further deferral of in-year income, which is now at £3.3m year to date. NHSE/I have indicated that unspent mental health allocations will be clawed back by before year end, and we are working with system partners to minimise this risk.

In the second half of the year the Trust will not receive any additional Elective Recovery Fund due to changes in the way this funding is earned. COVID and Top up funding has been reduced and an efficiency target of 0.78% has been applied to the commissioner block contracts.

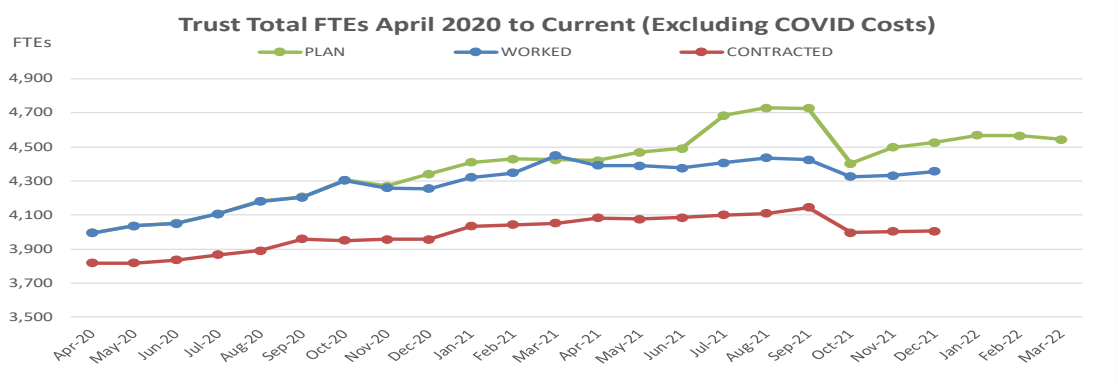
Workforce



Staff Costs

YTD	£'m
2021/22	162.7
2020/21	148.2
▲	10%

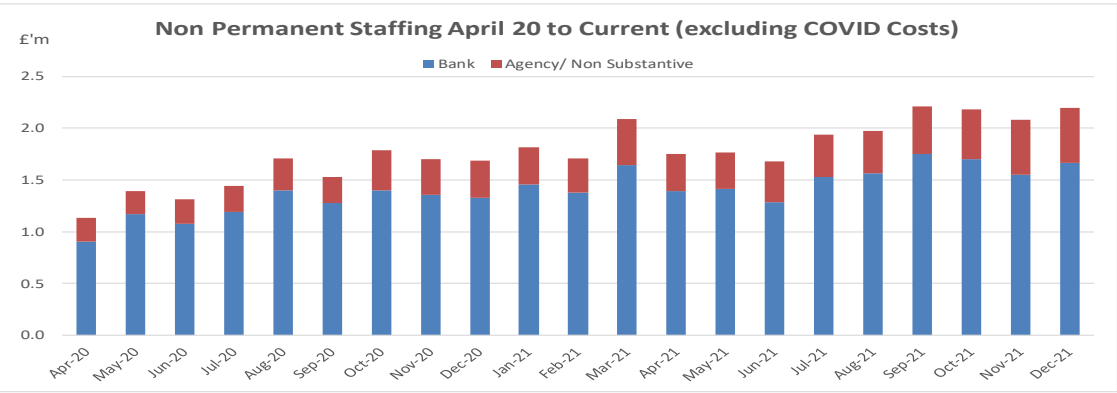
Prior Yr	£'m
Dec-21	18.2
Dec-20	17.2
▲	6%



FTEs

Prior Mth	CFTE	WFTE
Dec-21	4,006	4,356
Nov-21	4,002	4,331
	0% ▲	1% ▲

Prior Yr	CFTE	WFTE
Dec-21	4,006	4,356
Dec-20	3,956	4,255
	1% ▲	2% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2021/22	13.9	3.9
2020/21	11.1	2.6
	25% ▲	52% ▲

Prior Yr	Bank £'m	Agency £'m
Dec-21	1.7	0.5
Dec-20	1.3	0.4
	25% ▲	48% ▲

Key Messages

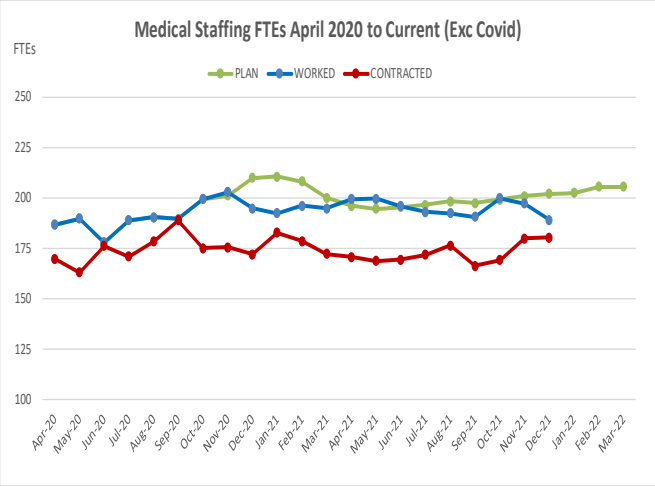
Pay costs in December were £18.2m (excluding COVID costs). Underlying pay excluding COVID costs have risen since the start of the year with costs in December £0.9m higher than April and an increase between November and December of £0.1m.

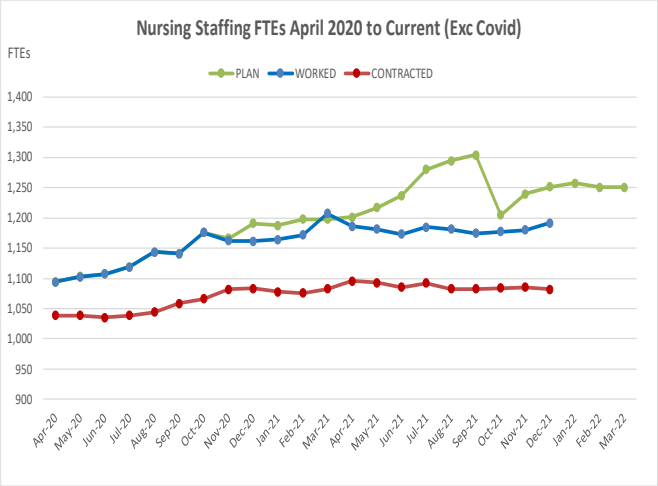
Expenditure on non-permanent staff rose this month and spend in the Q3 is the highest seen in recent years. This is being driven by staff vacancies, sickness and pressure to increase rates. We have agency price cap breaches in several areas but are working on this issue with ICS partners who are all experiencing the same pressures.

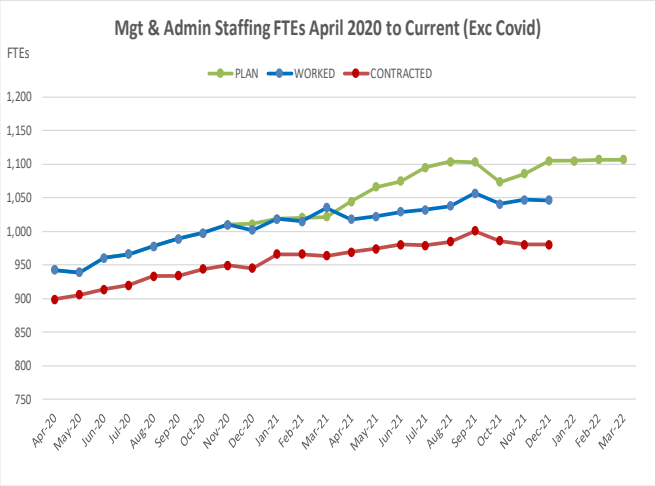
Contracted WTEs increased by 4 and worked WTEs increased by 25 in December with most of the increase being on agency staff. There were increased in other nursing (12 WTEs) and support to clinical (21 WTEs) offset by a decrease of 8 WTEs on medics and minimal changes elsewhere.

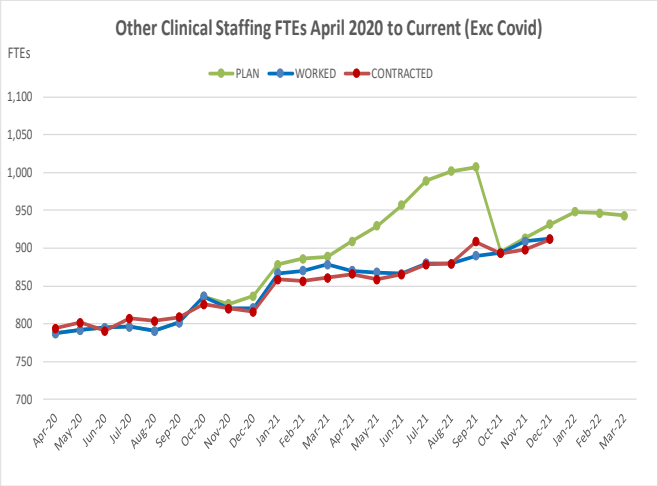
The level of staffing costs attributable to COVID was below £0.1m in December, which is similar to the position reported in November.

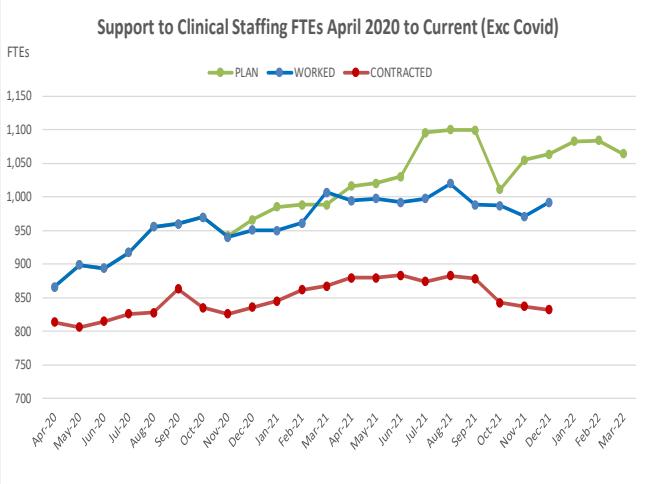
Staffing Detail

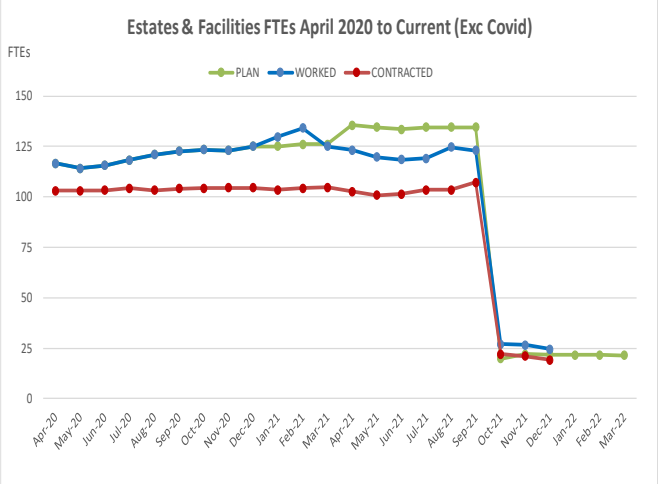










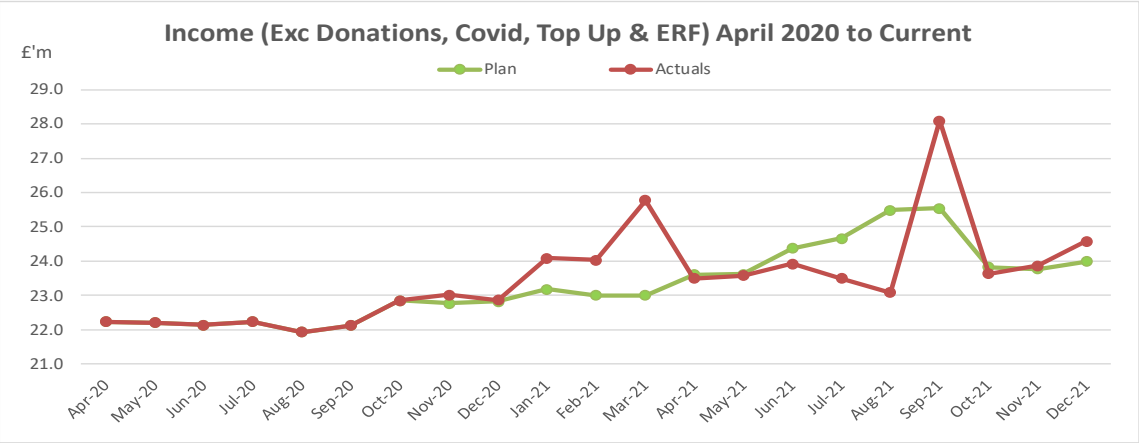


Key Messages

The tables above provide current staffing numbers broken down into core staffing groups. The planned levels reflect assumptions on underlying recruitment, as well as an expectation of staffing increases funded through commissioner investment.

As the plan has been developed for the second half of the year, actuals have been closer to plan in the first few months of H2, however, the gap is now starting to widen across most staffing groups. Changes to WTEs are summarised on the previous page.

Income & Non Pay



Income

YTD	£'m
2021/22	216.1
2020/21	201.6
▲	7%

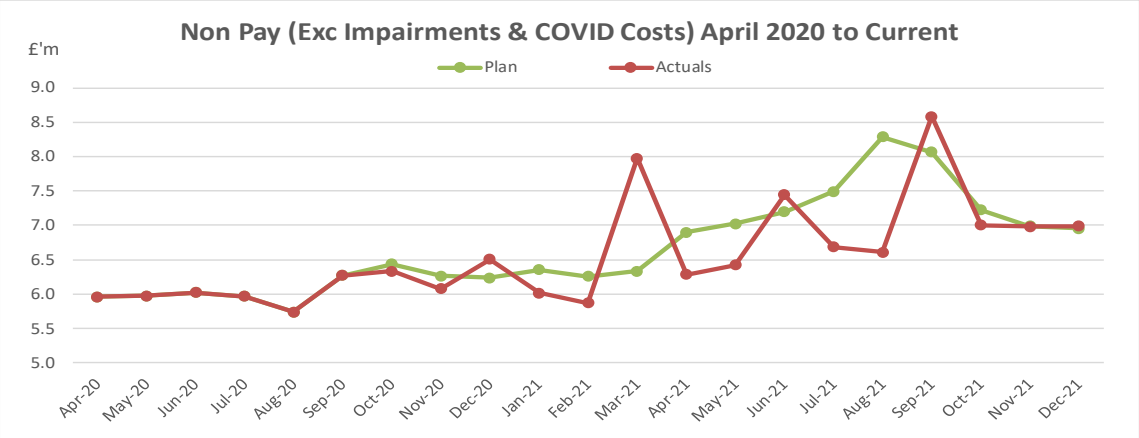
Prior Yr	£'m
Dec-21	24.6
Dec-20	22.9
▲	8%

Key Messages

The graph above reflects the Trust's planned and actual income excluding COVID, top up and Elective Recovery Funding for the year to date. In the second half of the year, the Trust is not planning to earn any Elective Recovery Fund income due to changes in the way the scheme works with a focus on completed pathways.

The in-month variance was due to higher than planned income from NHSE&I in respect of Liaison and Diversion.

The Trust continues to defer income into later months of the year as a result of recruitment against the investments funded from Service Development and Spending Review Funding being below plan. Discussions are ongoing with commissioners regarding the extent of the deferred income, levels of clawback and the potential impact on outturn and year end reporting.



Non Pay

YTD	£'m
2021/22	63.0
2020/21	54.9
▲	15%

Prior Yr	£'m
Dec-21	7.0
Dec-20	6.5
▲	7%

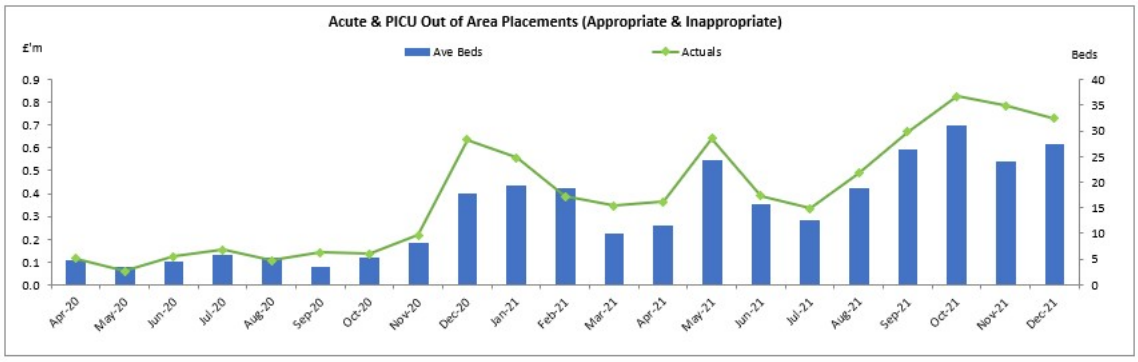
Key Messages

Non Pay spend was £7m in month, which was in line with the plan. Variances in month were low, which is to be expected given the recent H2 planning exercise. The main non-pay pressure in-month is due to expenditure on Out of Area Placements. The average number of placements has increased from 24 in November to 28 in December but the monthly cost has reduced from £0.78m to £0.73m. Further analysis and narrative can be found on the next page.

Negotiations are ongoing with NHS Property Services regarding the recharging of costs related to the estates and facilities management services which the Trust continues to provide. Negotiations are continuing to secure efficiencies for the contract and recovery of retained services, which will improve the financial contract in the coming year.

COVID related costs, excluding OAPs were £50k in month, a slight decrease from the £65k incurred during the previous month.

Non Pay Expenditure: Placement Costs



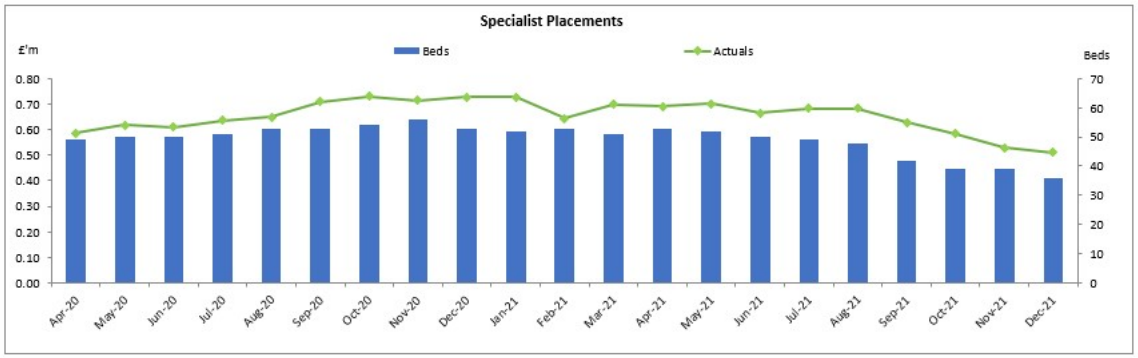
OAPs

YTD	£'m
2021/22	5.2
2020/21	1.7

▲ *210%*

Prior Yr	£'m
Dec-21	0.7
Dec-20	0.6

▲ *15%*



Specialist Placements

YTD	£'m
2021/22	5.7
2020/21	6.0

▼ *-5%*

Prior Yr	£'m
Dec-21	0.5
Dec-20	0.7

▼ *-30%*

Key Messages

Specialist Placements. The number of placements has reduced from 39 in November to 36 in December with a reduction in costs from £0.53m in November to £0.51m in December. This is in line with improved review processes and step down of patients to less restrictive options.

Out of Area Placements. The average number of placements has increased from 24 in November to 28 in December but the monthly cost has reduced from £0.78m to £0.73m.

Since July 2021 we have seen a substantial increase in demand on our Prospect Park Hospital (PPH) bed base alongside a reduction in availability due to COVID related closures. These two occurrences have resulted in an increased need for out of area placements. We have purchased 14 additional extra-contractual Acute beds and 5 PICU beds and these have been in place since July. This means that we are able to meet the continuity principle set by NHSE&I and therefore these beds are not recorded as inappropriate OAPs, but whilst this helps with our trajectory to zero it still leaves us with a financial cost pressure. Furthermore, with a worsening position in September 2021 and a lack of out of area provision we have purchased an additional 6 beds.

We have reset a programme board and this is looking at 4 areas that are felt to have the biggest potential to address the continued pressure. In the first instance we are concentrating efforts on bringing the numbers back into line with PPH bed base and the additional 13 beds. Weekly status exchanges are continuing and although the workstreams under bed optimisation have largely been paused during January some background data work and project support to understand next steps has continued. Three of the six localities are in escalation (this is an increased scrutiny position), but we are now seeing a decrease in the number of inpatients across five of the six localities.

2.0 Balance Sheet and Cash

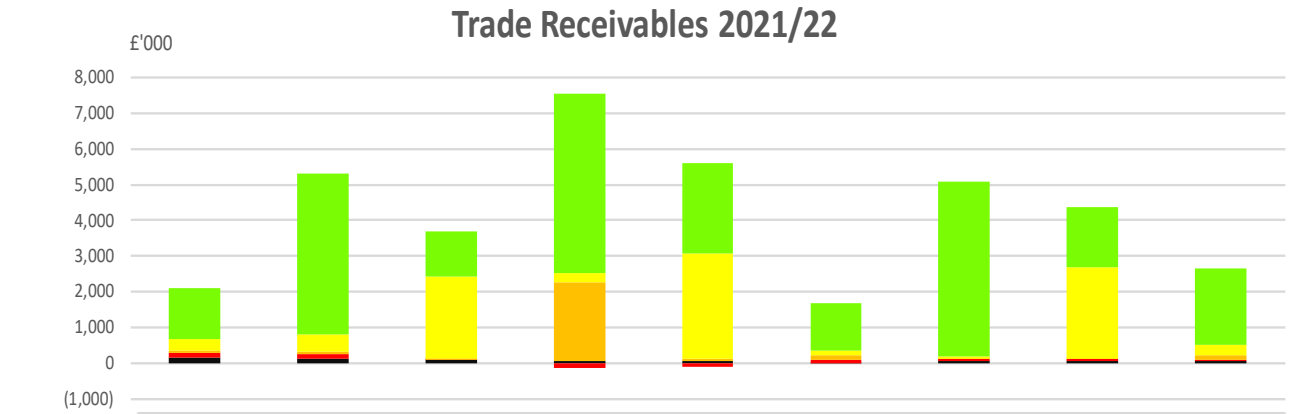
Balance Sheet	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	5.4	3.7	3.8	(0.1)	3.7	3.8	(0.1)
Property, Plant & Equipment (non PFI)	38.4	37.9	38.1	(0.2)	37.9	38.1	(0.2)
Property, Plant & Equipment (PFI)	55.5	55.3	54.8	0.5	55.3	54.8	0.5
Total Non Current Assets	**99.3**	**97.0**	**96.8**	**0.2**	**97.0**	**96.8**	**0.2**
Trade Receivables & Accruals	9.4	8.6	14.8	(6.2)	8.6	14.8	(6.2)
Other Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Cash	39.1	56.2	47.4	8.8	56.2	47.4	8.8
Trade Payables & Accruals	(30.1)	(34.8)	(33.3)	(1.5)	(34.8)	(33.3)	(1.5)
Current PFI Finance Lease	(1.6)	(1.7)	(1.7)	(0.0)	(1.7)	(1.7)	(0.0)
Other Current Payables	(6.2)	(15.1)	(13.8)	(1.2)	(15.1)	(13.8)	(1.2)
Total Net Current Assets / (Liabilities)	**10.9**	**13.4**	**13.6**	**(0.2)**	**13.4**	**13.6**	**(0.2)**
Non Current PFI Finance Lease	(25.5)	(24.2)	(24.2)	(0.0)	(24.2)	(24.2)	(0.0)
Other Non Current Payables	(2.5)	(3.5)	(3.5)	0.0	(3.5)	(3.5)	0.0
Total Net Assets	***82.0***	***82.7***	***82.7***	***0.0***	***82.7***	***82.7***	***0.0***
Income & Expenditure Reserve	30.0	30.8	30.6	0.2	30.8	30.6	0.2
Public Dividend Capital Reserve	20.0	20.0	20.1	(0.1)	20.0	20.1	(0.1)
Revaluation Reserve	32.0	32.0	32.0	0.0	32.0	32.0	0.0
Total Taxpayers Equity	***82.0***	***82.7***	***82.7***	***0.0***	***82.7***	***82.7***	***0.0***

Cashflow	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Operating Surplus/(Deficit)	5.8	0.9	0.4	0.5	4.7	4.3	0.5
Depreciation and Impairments	9.4	0.6	0.7	(0.1)	6.2	6.2	0.0
Operating Cashflow	***15.2***	***1.5***	***1.1***	***0.4***	***10.9***	***10.4***	***0.5***
Net Working Capital Movements	***11.0***	***3.2***	***(0.1)***	***3.3***	***15.4***	***6.8***	***8.5***
Proceeds from Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	(0.0)	0.0	0.0	0.0	(0.0)	0.0	(0.0)
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(7.9)	(0.8)	(0.5)	(0.3)	(4.9)	(4.8)	(0.2)
Investments	***(7.9)***	***(0.8)***	***(0.5)***	***(0.3)***	***(5.0)***	***(4.8)***	***(0.2)***
PFI Finance Lease Repayment	(1.5)	(0.1)	(0.1)	(0.0)	(1.2)	(1.2)	(0.0)
Net Interest	(4.0)	(0.3)	(0.3)	(0.0)	(2.9)	(2.9)	(0.0)
PDC Received	0.8	0.0	0.1	(0.1)	0.0	0.1	(0.1)
PDC Dividends Paid	(1.0)	(0.0)	0.0	(0.0)	(0.2)	(0.2)	(0.0)
Financing Costs	***(5.7)***	***(0.5)***	***(0.3)***	***(0.1)***	***(4.3)***	***(4.2)***	***(0.1)***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***12.7***	***3.4***	***0.1***	***3.3***	***17.0***	***8.3***	***8.7***
Opening Cash	26.4	52.7	47.2	5.4	39.1	39.1	0.0
Closing Cash	***39.1***	***56.2***	***47.4***	***8.8***	***56.2***	***47.4***	***8.8***

Key Messages

The Trust's closing cash balance for December 2021 was £56.2m, which is £8.8m above revised plan and £3.5m higher than at the end of the previous month. Contributing to the cash position is a net inflow of cash related to income received in advance of anticipated activity and a net increase in working capital balances. We have also received £1m income from NHSE in error and this will be repaid in January. The first half surplus of £1m and slippage against capital expenditure of £1.9m are both adding to the current cash surplus. It is anticipated that the capital underspend will continue to reduce in Q4. The cash forecast for the end of the year is £43m but we continue to keep this under review.

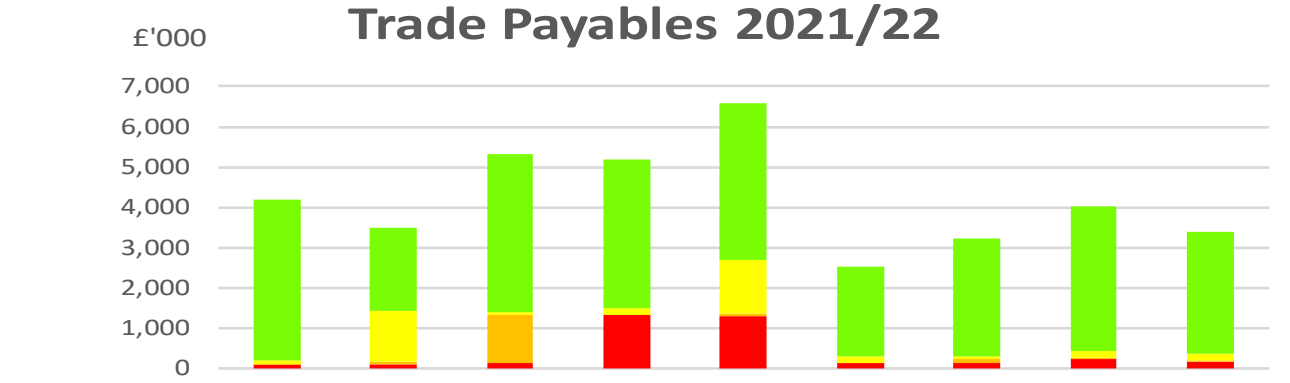
Cash Management



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
<30 Days	1,413	4,488	1,270	5,029	2,507	1,329	4,868	1,690	2,127
>30 <60 Days	316	472	2,289	262	2,966	121	72	2,530	297
>60 <90 Days	73	77	22	2,193	62	139	6	28	118
>90 < 180 Days	131	124	22	(139)	(84)	70	73	60	38
>180 Days	163	139	90	69	64	13	55	59	66

Key Messages

Overall debtors balances decreased by £1.7m due to a decrease in over 30 days balances of £2.2m relating to payment by Health Education England, offset by increase in current balances of £0.4m. Balances over 60 days remained at a similar low level to prior months, with the largest balances relating to Local Authorities, NHS Property Services, Oxford Health FT and Buckinghamshire Healthcare FT. We continue to engage with these organisations to clear the balances.



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
<30 Days	3,976	2,070	3,920	3,697	3,890	2,223	2,948	3,592	3,044
>30 <60 Days	88	1,266	63	152	1,311	143	59	173	156
>60 <90 Days	12	54	1,187	21	60	23	96	31	29
>90 days	109	111	136	1,322	1,309	126	140	235	175

Key Messages

Overall Creditors decreased by £0.6m, mainly due to a decrease in current balances. The queries on the older balance continue to be reviewed and we are hoping these will be cleared during this quarter.

3.0 Capital Expenditure

Schemes	Current Month			Year to Date			FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000
Estates Maintenance & Replacement Expenditure							
Erlegh Road (LD etc works)	4	13	(9)	4	86	(82)	135
Other Trust Owned Properties	(1)	0	(1)	36	0	36	0
Leased Non Commercial (NHSPS)	32	39	(7)	211	225	(14)	370
Head Office Relocation	0	88	(88)	0	472	(472)	800
Leased Commercial - Erlegh House Atrium	27	14	13	35	81	(46)	135
Wokingham Willow House Projects	20	0	20	776	950	(174)	950
Environment & Sustainability	3	5	(2)	20	34	(14)	49
Various All Sites	64	12	52	101	93	8	130
Statutory Compliance	3	21	(18)	3	165	(162)	240
Subtotal Estates Maintenance & Replacement	**152**	**192**	**(40)**	**1,186**	**2,106**	**(920)**	**2,809**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	(0)	0	(0)	0
IM&T Refresh & Replacement	450	37	413	1,787	1,963	(177)	2,102
IM&T System & Network Developments	44	44	0	227	302	(75)	466
IM&T GDE & Community Projects	15	36	(21)	232	334	(102)	465
Subtotal IM&T Expenditure	**509**	**117**	**393**	**2,246**	**2,599**	**(354)**	**3,033**
Subtotal CapEx Within Control Total	**661**	**309**	**352**	**3,431**	**4,705**	**(1,274)**	**5,842**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	0	0	0	144	131	13	131
PPH Fire Doors	0	0	0	117	116	1	116
PPH Place of Safety	0	16	(16)	0	137	(137)	200
PPH Zonal Heating Controls	0	36	(36)	0	201	(201)	350
PPH Ward Bedroom Door Mechanisms (Swipe Access)	24	22	2	163	229	(66)	320
Service change/redesign (not included in ICH)	0	20	(20)	0	101	(101)	200
Other PFI projects	106	63	43	143	388	(245)	631
PPH Elimination of Dormitories - PDC Funded	0	13	(13)	0	69	(69)	120
Donated Assets	0	0	0	8	0	8	0
Subtotal Capex Outside of Control Totals	**130**	**170**	**(40)**	**574**	**1,372**	**(798)**	**2,068**
Total Capital Expenditure	**791**	**479**	**313**	**4,005**	**6,077**	**(2,072)**	**7,910**

Key Messages

The Trust has a capital control total of £5.8m, in addition to the £2.1m of spend outside of system control total, with the overall plan being £7.9m. Year to date spend is £2.1m behind plan, of which £1.3m relates to the control total.

Estates, Maintenance and Replacement is £0.9m behind plan, year to date with £0.6m relating to the profiling of expenditure on the Willow House and Head Office Relocation schemes. There is a delay in the Head Office Relocation project, which means that the planned £0.8m spend will slip into next year and some of the in-year underspend will be utilised by other projects approved in year including Erlegh House Atrium works (£0.4m), BMS Installation at Church Hill House (£0.1m) and Gosbrook Rd and Kings Rd Upgrades (£0.1m).

IM&T is underspent by £0.4m year to date and this relates to the IT Infrastructure Refresh Projects (£0.2m), locality schemes (£0.1m) and GDE & Community projects (£0.1m).

Prospect Park Hospital schemes are underspent by £0.8m year to date. The Ward Bedroom Door Mechanism is now expected to complete by the end of Q4 as is the PPH & WBCH Air Conditioning project. The underspend against PFI schemes is in part due to Zonal Heating Controls (£0.2m) and a number of other projects being in the feasibility phase.

We continue to work with partners in BOB ICS to ensure that the ICS capital resource limit is utilised in full.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	8th February 2022
Title	**True North Performance Scorecard** **Month 9 (December 2021) 2021/22**
	FOR NOTING
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2021/22.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 9 2021/22 (December 2021) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. The business rules apply to three different categories of metric:

	• **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention. • **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month. • **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity. **Note** - several indicators have been temporarily suspended nationally or locally due to the COVID-19 pandemic. These are highlighted in grey to indicate this status. **Month 9** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Falls incidents in Community & Older Adult Mental Health Inpatient Wards **(Harm Free Care) –** red at 27 against a target of 20. Red for 7 months against a stretch target. Ascot (7), Oakwood (5), Donnington (4) and Windsor Ward (4) were the highest contributors. Existing countermeasures are in place, but additional activities are being implemented: ○ Celebrate success – Oakwood have achieved below their median for the second month. Donnington have achieved their target and are below their median for 5 months. Community East and Prospect Park Older Adults also achieved their targets. ○ 82% of falls were unwitnessed. ○ 82% of falls happened on wards with occupancy over 80%. ○ Severity of harm – 0 falls resulted in moderate or more severe harm. 6 falls (21%) resulted in low or minor harm. ○ Counter measures are additional staffing placement, therapy lead, additional health care assistants and the use volunteers.

	○ There remain issues with falls sensor alarms and the team are meeting with another local provider to assist in developing an action plan. • Self-harm incidents on mental health wards (excluding LD) **(Harm Free Care)** – 82 incidents against a target of 42. Bluebell (38), Rose (17), Daisy (14) and Snowdrop (10) wards were the highest contributors this month. The 38 incidents on Bluebell ward were attributed to 2 patients. Ligatures has been the lowest number of incidents for over 15 months at 5%. Countermeasures remain the same; 'Safe wards' interventions are being used such as the 'Zen den', a 'getting to know you folder' and self-soothing bag on admission, patient held safety crosses to achieve 'harm free days'. Safety huddles continue. The team has introduced a support pack for patients that self-harm. Individual patient countermeasures have also been implemented. • Patient Friends and Family Test (FFT) recommend rate: **(Patient Experience)** - at 90% against a 95% target. There is a project underway to implement a new system, so this measure will be reviewed in Q4. • Patient Friends and Family Test (FFT) response rate: **(Patient Experience)** - at 7% against a 15% target. There is a project underway to implement a new system, so this measure will be reviewed in Q4. • Mental Health Clustering **(Patient Experience)** - at 78.7% against an 80% target. Services are operating in a challenging environment which is impacting their ability to achieve the target. There has been a significant improvement in performance but remains below target. Action plans are in place to improve this metric. • Fire Evacuation training for Inpatient staff **(Supporting our Staff)** – a recent review of the fire metric has split inpatient staff training from other staff. Currently at 92.5% against a 95% target. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters)** – at 58 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is also underway. • Staff turnover (including fixed-term posts **(Money Matters)** – 16.3% against a 16% target. A challenging area which remains a focus for the organization. • Inappropriate Out of Area Placements **(Money Matters)** – at 405 days against a quarter 3 target of 220 days. Pressures continue but there is an improvement project underway. Pre-commissioned beds should mitigate some of the pressures.

	Tracker Metrics (where red for 4 months or more) • Sickness rate **(Regulatory Compliance)** – red at 4.92% against a target of 3.5%. This is not a "hard" compliance focus with NHSI but is tracked. Six months red, but within the seasonally higher period. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <1 week (Urgent) **(Regulatory Compliance)** – red at 75% against a 95% target by 2021 and show an improved performance. This is a newly introduced target. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <4 weeks (Routine) **(Regulatory Compliance)** – red at 87.5% against a 95% target by 2021 and show an improved performance. This is a newly introduced target. • Community Health Services: 2 Hour Urgent Community Response. **(Regulatory Compliance – System Oversight Framework)** – red at 68.3% against an 80% target. This is a newly introduced target as part of the Aging Well programme.
Action	The Board is asked to note the new True North Scorecard.

True North Performance Scorecard – Business Rules & Definitions

The following metrics are defined as and associated business rules applied to the True North Performance Scorecard:

Driver - True North / break through objective that has been prioritised by the organisation as its area of focus	**Tracker Level 1-** metrics that have an impact due to regulatory compliance	**Tracker -** important metrics that require oversight but not focus at this stage in our performance methodology

Rule #	Metric	Business Rule	Meeting Action
1	**Driver** is **Green** in current reporting period	Share success and move on	**No action** required
2	**Driver** is **Red** in current reporting period	Share top **contributing reason**, the amount this contributor impacts the metric, and **summary of initial action(s)** being taken	Standard structured **verbal** update
3	**Driver** is **Red** for **2+** reporting periods	Produce full structured **countermeasure summary**	Present full written **countermeasure analysis and summary**
4	**Driver** is **Green** for **6** reporting periods	Retire to **Tracker** level status	Standard structured **verbal** update and retire to **Tracker**
5	**Tracker 1 (or Tracker)** is **Green** in current reporting period	**No action** required	**No action** required
6	**Tracker** is **Red** in current reporting period	Note metric performance and move on unless they are a **Tracker Level 1**	If **Tracker Level 1,** then structured **verbal** update
7	**Tracker** is **Red** for **4** reporting periods	Switch to **Driver** metric	Switch and replace to **Driver** metric (decide on how to make capacity i.e. which **Driver** can be a **Tracker**)

Harm Free Care

Metric	Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	46	26	25	37	17	23	27	33	36	33	21	27
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	110	127	177	76	42	128	124	56	51	132	130	82
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	1	1	0	0	0	0	0	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	1	4	3	2	1	4	0	2	1	0	4	2
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	50% by 30th September 2021, then 60%					19%	31%	43%	52%	68%	67%	71%	74%
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

Patient Experience

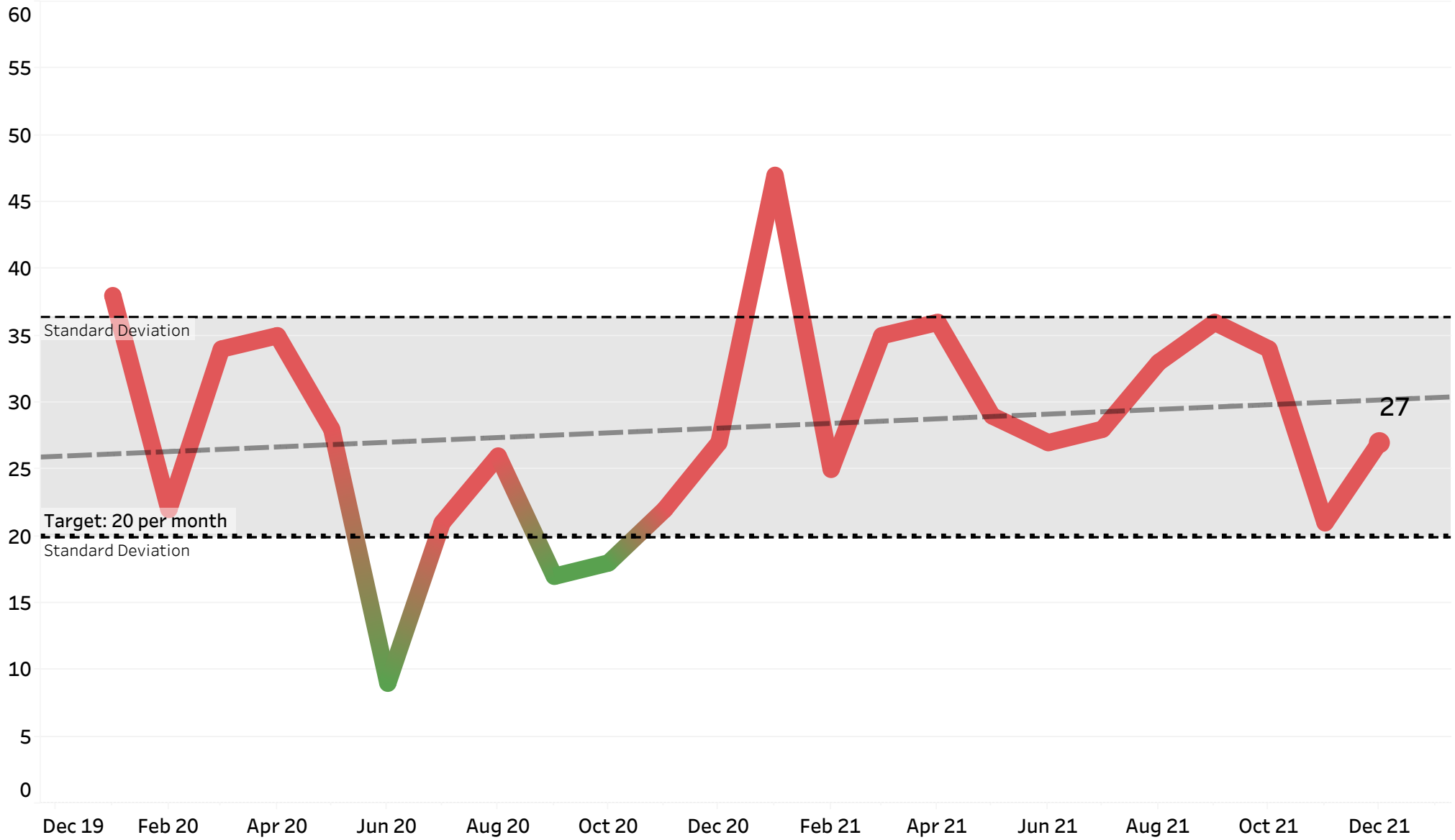
Patient FFT Recommend Rate: %	95% compliance	85%	88%	93%	90%	92%	79%	89%	85%	89%	92%	90%	
Patient FTT response rate: %	15% compliance	3%	6%	5%	5%	5%	6%	6%	6%	6%	5%	7%	
Mental Health Clustering within target: %	80% compliance	75.7%	76.2%	74.9%	73.9%	73.5%	71.5%	77.2%	80.4%	78.7%	79.4%	79.5%	78.7%

Performance Scorecard - True North Drivers (December 2021)

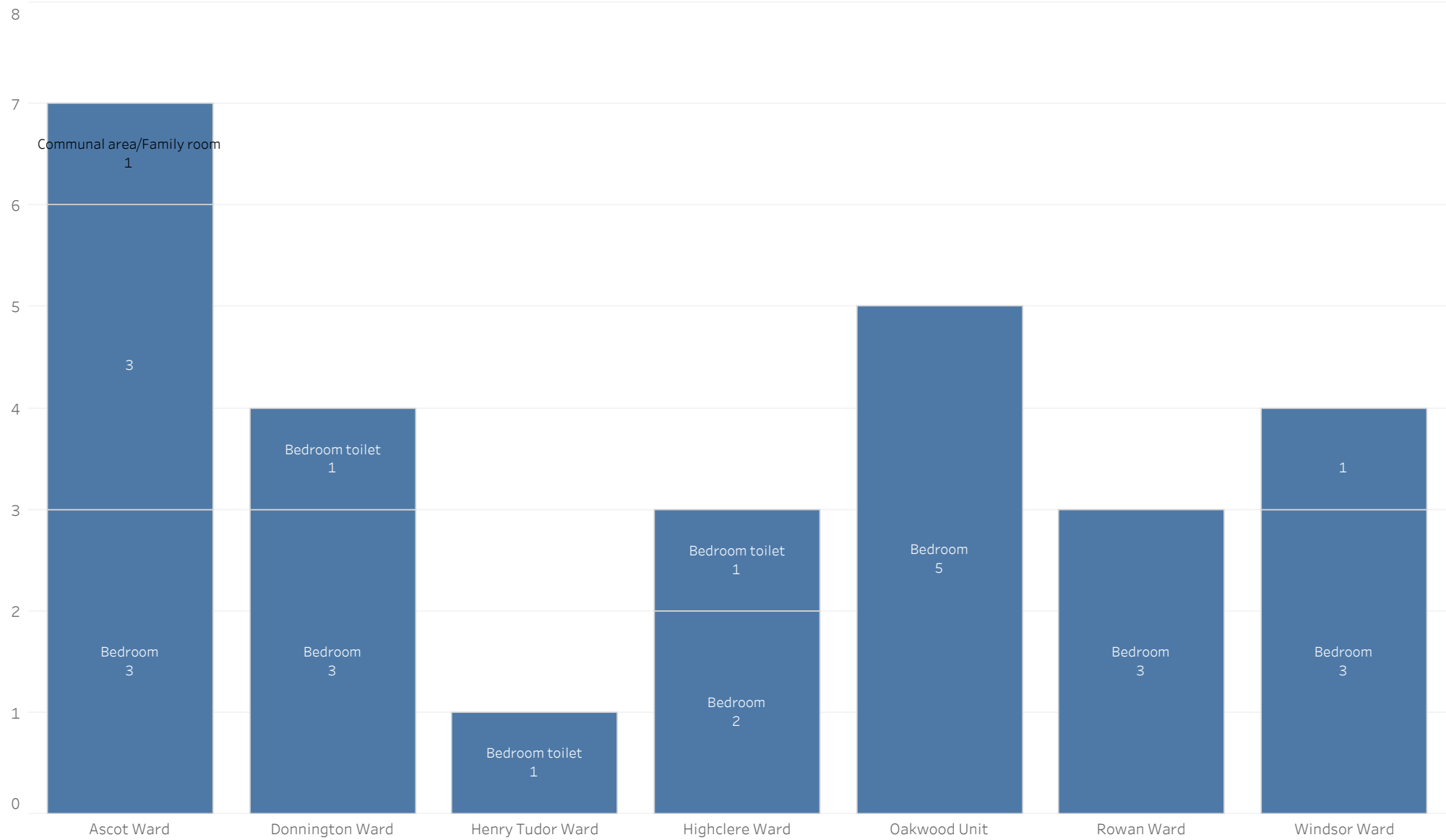
Metric	Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Supporting our Staff													
Physical Assaults on Staff	44 per month	58	52	55	54	42	50	66	75	80	85	60	33
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due t..	Score of 10	7.40	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5
WRES and WDES outcome improvement	TBC												
Fire Evacuation training for inpatient staff	95% compliance									87.9%	89.9%	92%	92.5%
Money Matters													
CIP target (£k): (Cumulative YTD)													
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]													
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	83.3%	86.1%	91.9%	97.4%	97.5%	96.0%	96.0%	90.6%	93.1%	91.2%	92.2%	87.2%
Control total target (£k): (Cumulative YTD)	TBC												
Mental Health: Acute Average Length of Stay (bed days)	30 days	45	42	46	47	50	50	49	50	52	53	58	58
Staff turnover (excluding fixed term posts)	<16% per month	13.1%	13.0%	12.4%	12.5%	12.5%	13.1%	13.8%	14.2%	14.6%	15.4%	15.4%	15.3%
Staff turnover (including fixed-term posts)	<16% per month	15.4%	15.3%	14.7%	14.7%	14.6%	15.3%	15.8%	15.1%	15.6%	16.4%	16.5%	16.3%
Inappropriate Out of Area Placements	220 Cumulative Total Q3	379	766	957	160	587	856	168	418	636	195	266	405

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

Any incident (all approval statuses) where sub-category excluding Sat or lowered to floor & near miss, Location exact excluding Patient/staff home and incident type = patient

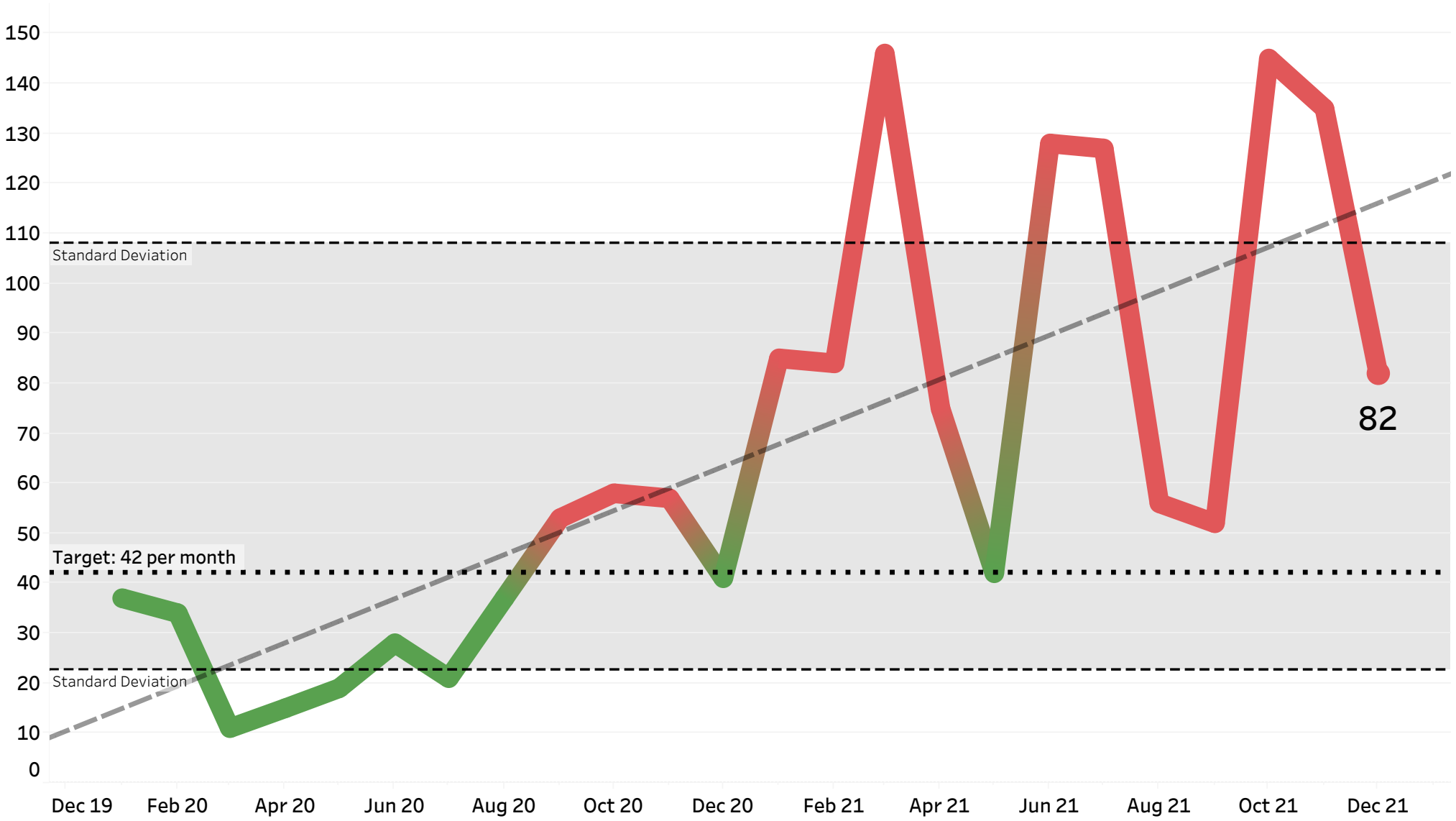


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (December 21)

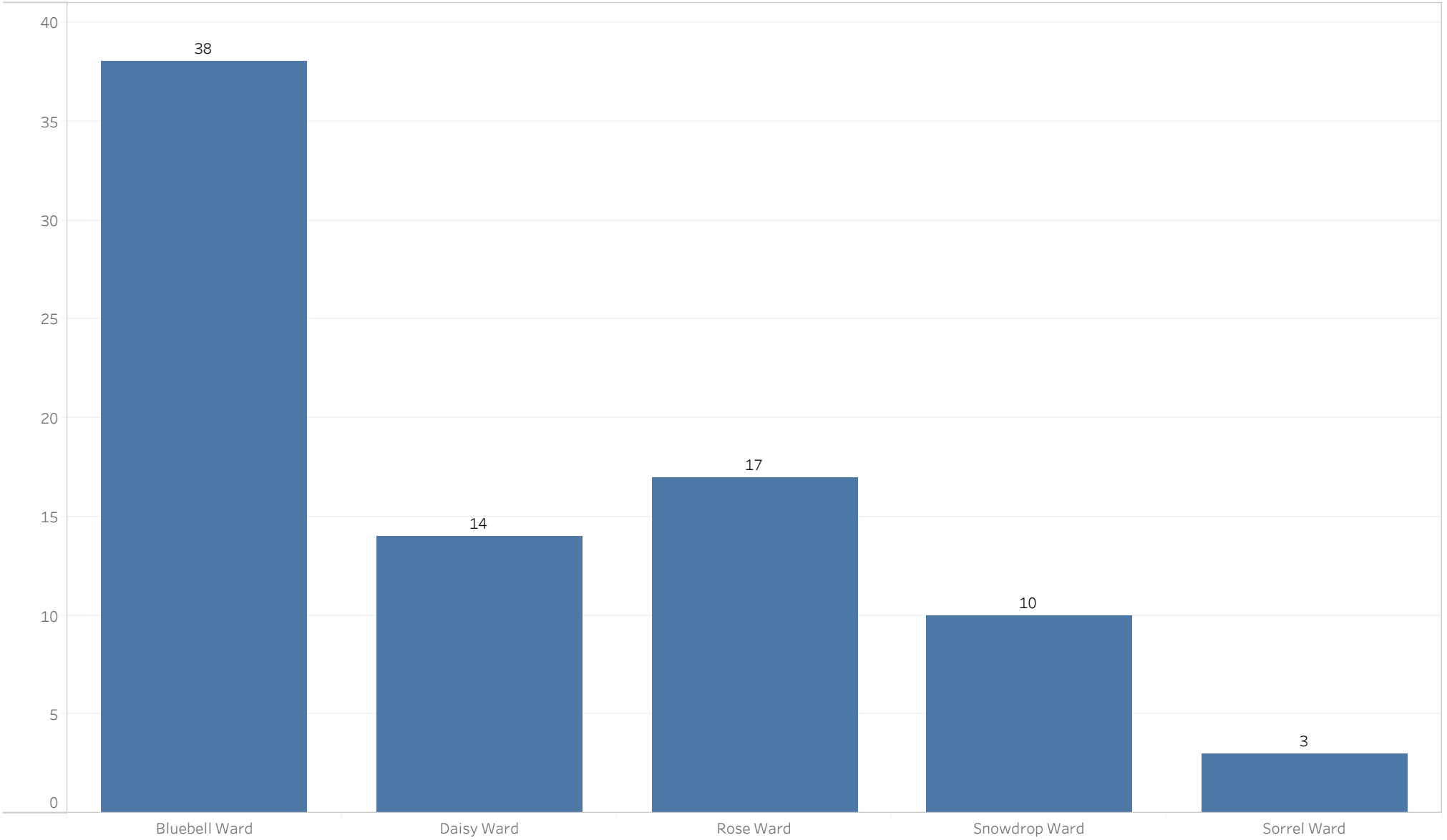


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Jan 20 to Dec 21)

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

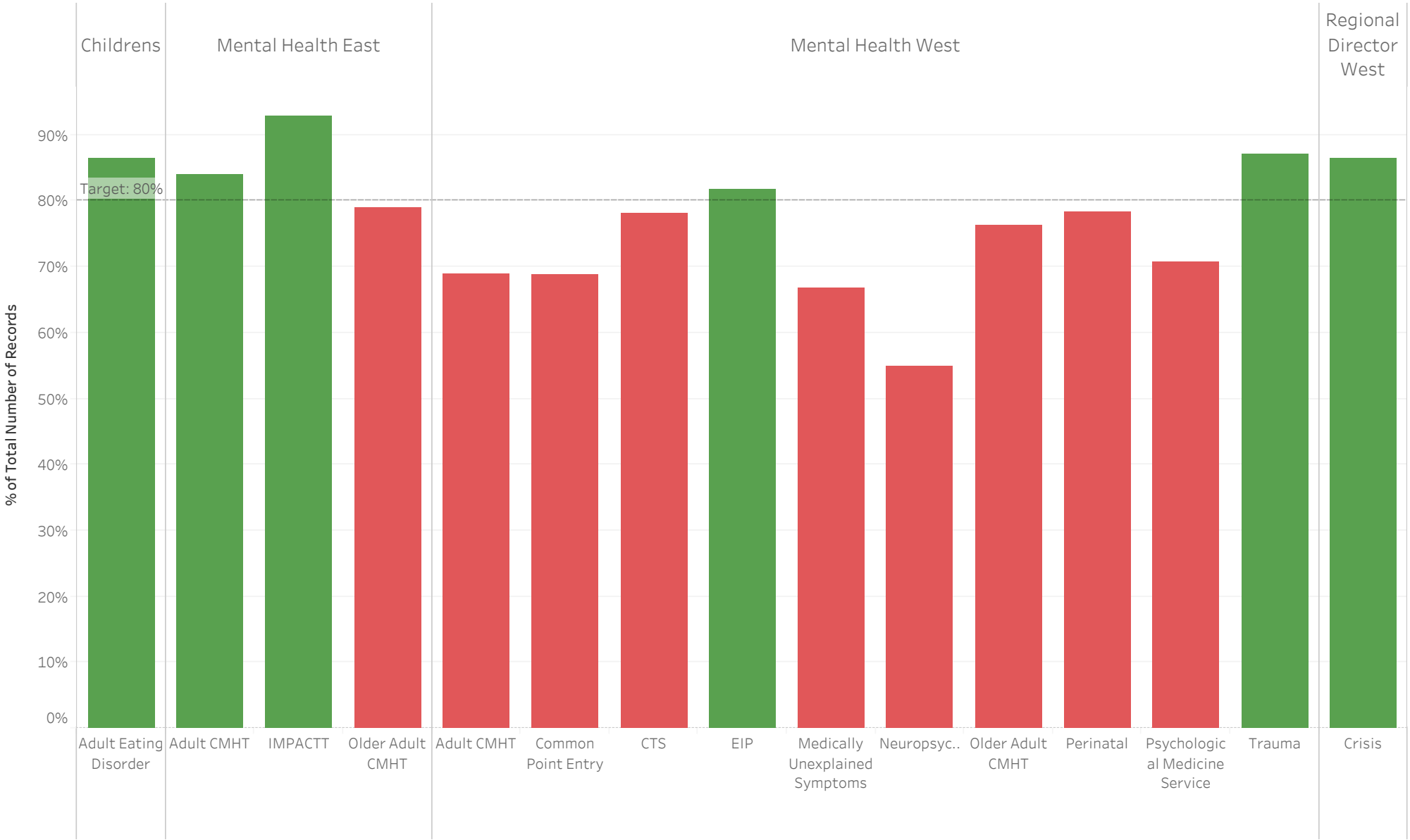


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (December 21)



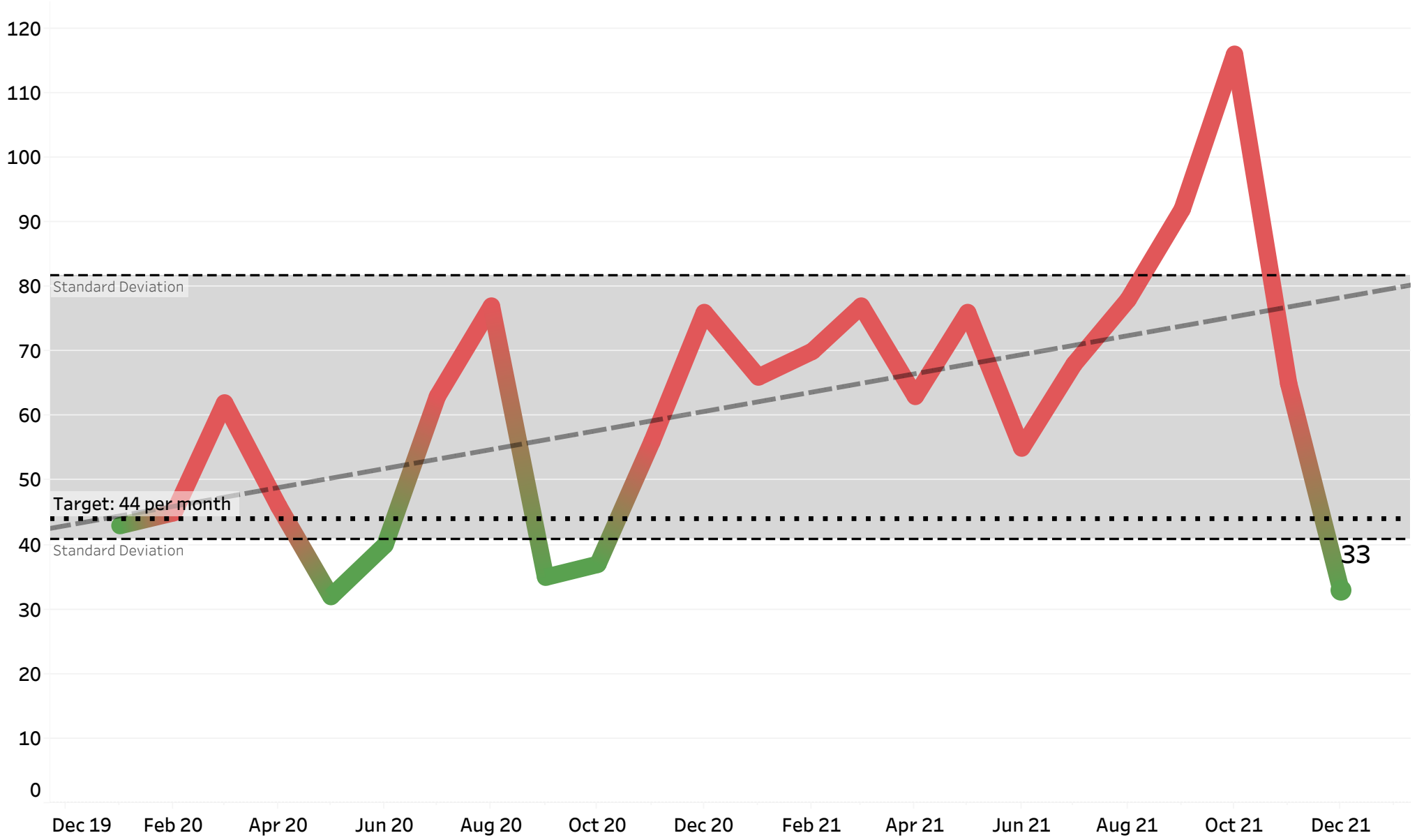
Patient Experience: Clustering breakdown (December 2021)

Outpatient Cluster Status (by Service)

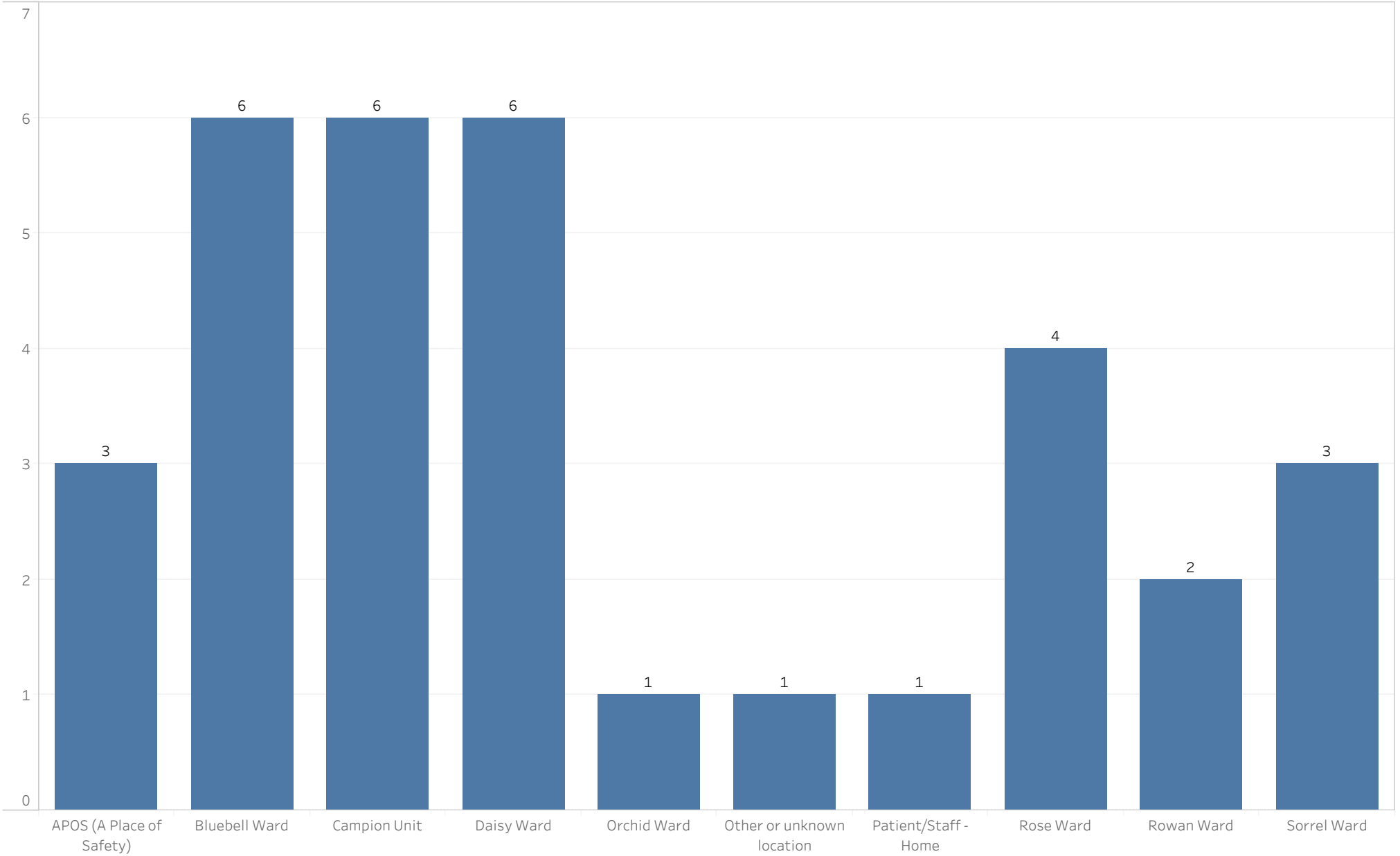


Supporting Our Staff Driver: Physical Assaults on Staff (Jan 20 to Dec 21)

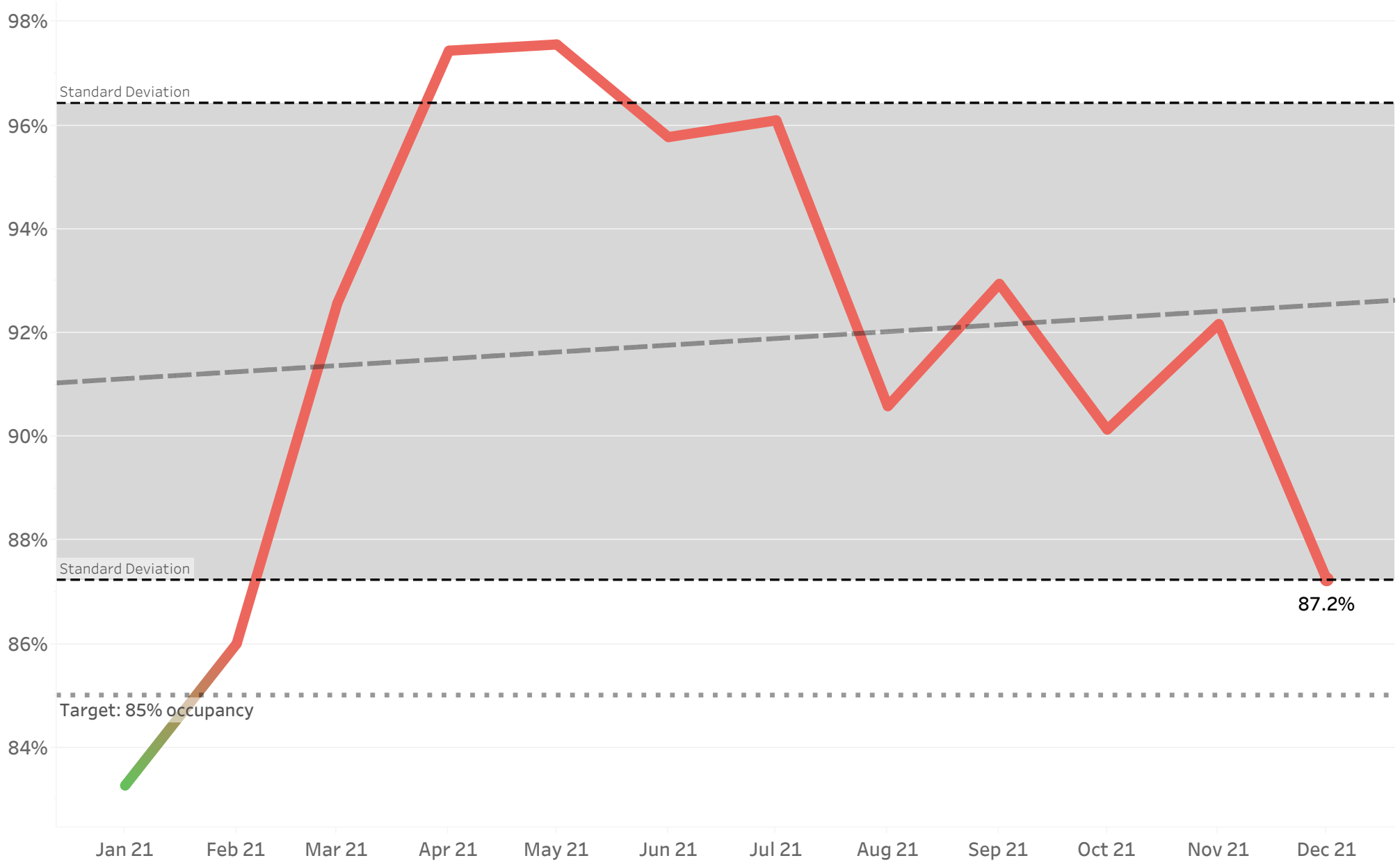
Any incident where sub-category = assault by patient and incident type = staff



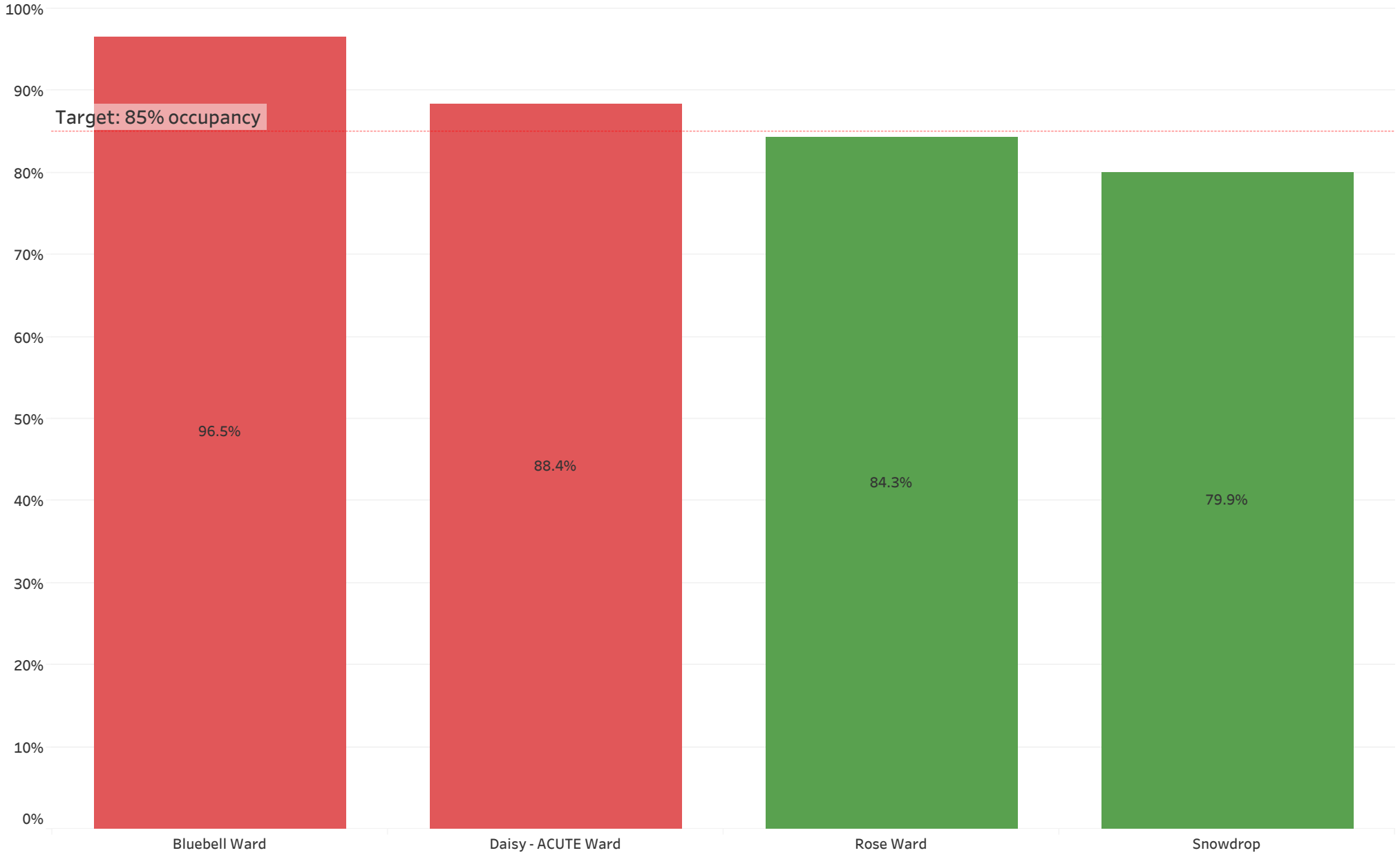
Supporting Our Staff Driver: Physical Assaults on Staff by Location (December 2021)



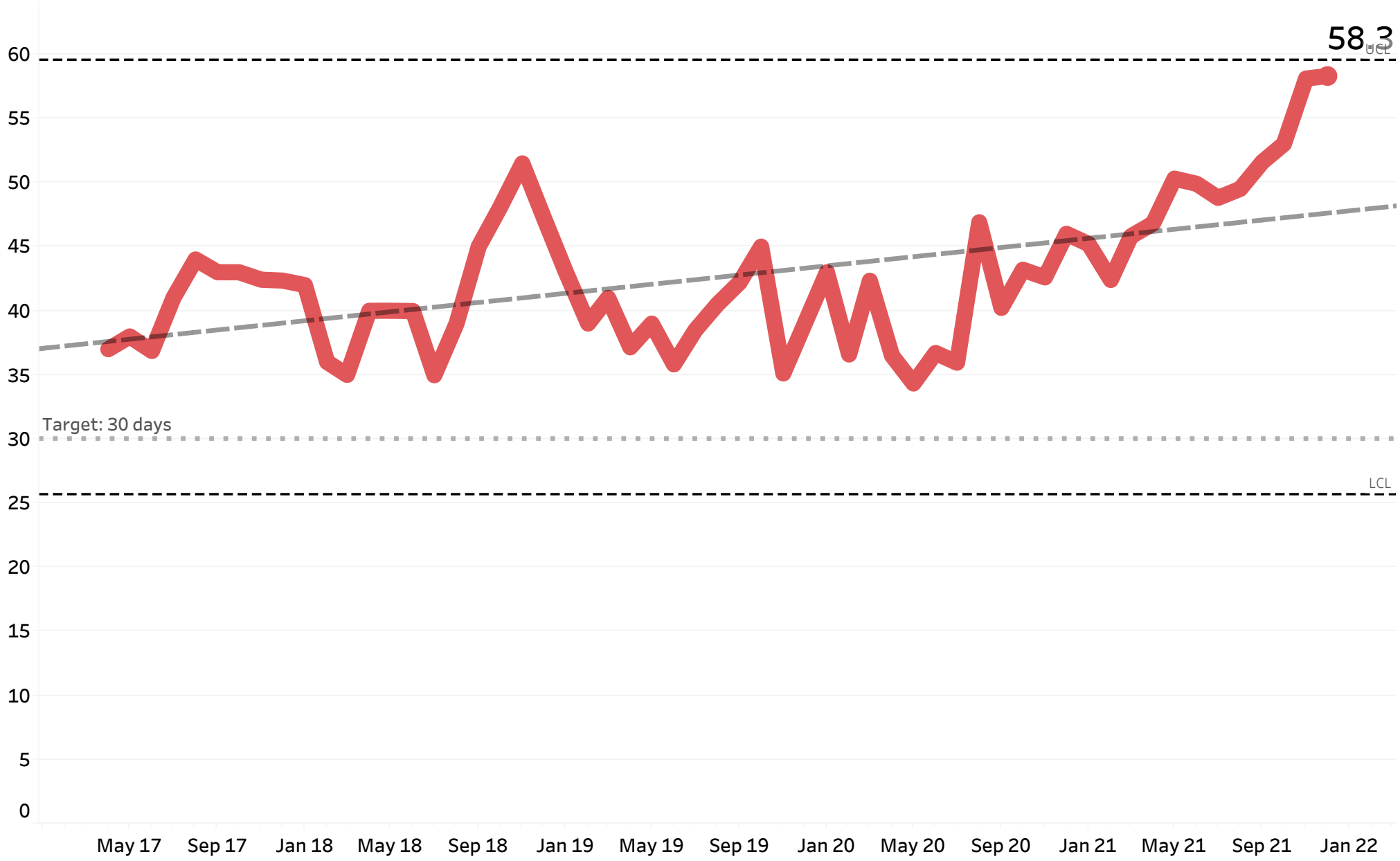
Money Matters: Mental Health Acute Bed Occupancy Rate (Jan 21 to Dec 21)



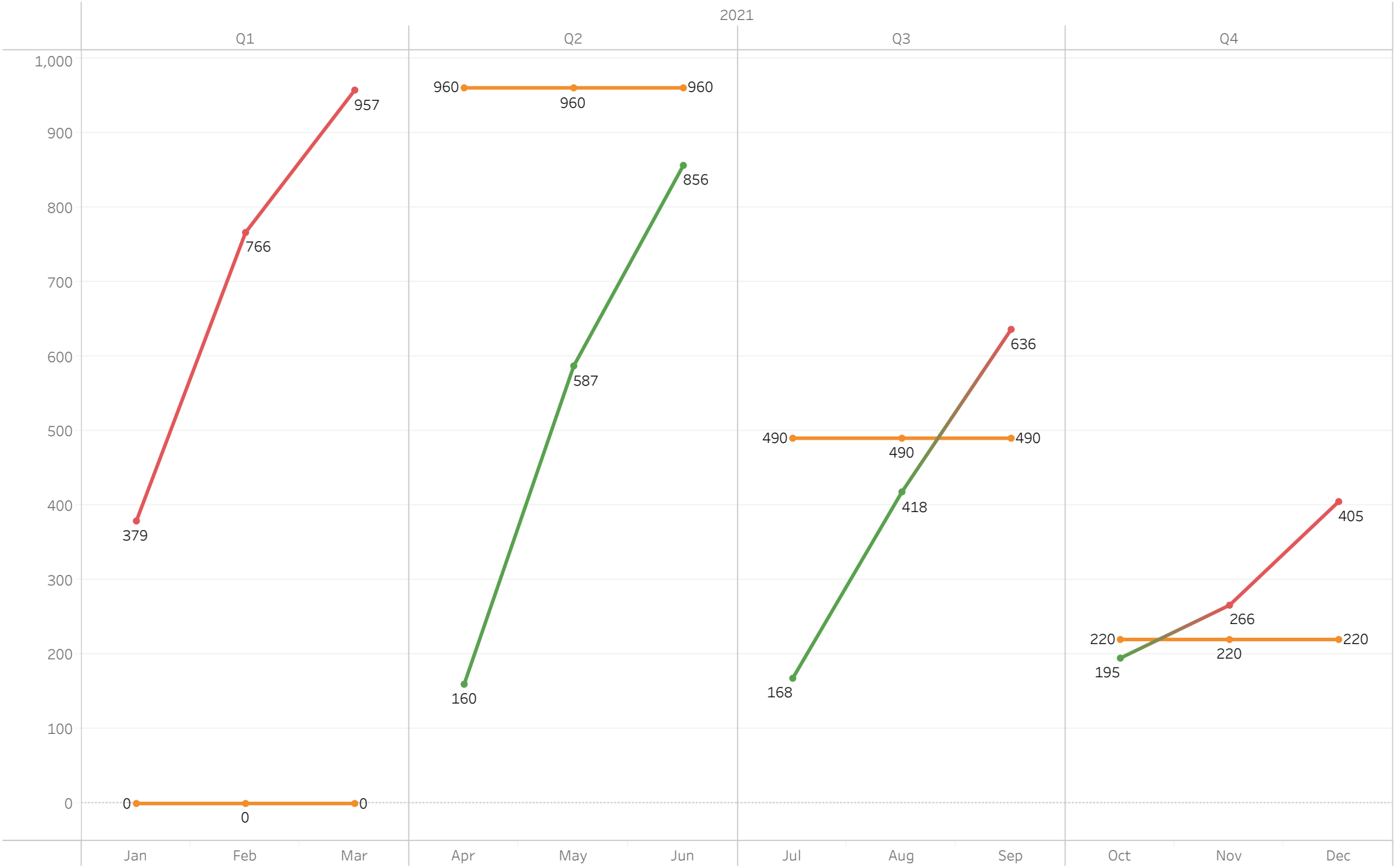
Money Matters Driver: MH Acute Bed Occupancy by Unit (December 2021)



Money Matters: Mental Health: Acute Average Length of Stay (bed days) (Sept)



Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	1	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	2	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	3	3	2	10	5	3	4	8	5	9	7	8	2
Mental Health: Absconsions on MHA section(Excl: Failure to return)	8 per month	0	9	10	4	5	11	13	9	7	17	7	3	5
Mental Health: Readmission Rate within 28 days: %	<8% per month	5.89	7.09	8.59	8	6.60	7.29	8.40	8.30	6.70	5.09	4.29	5.20	5.5
Patient on Patient Assaults (LD)	4 per month	0	3	1	1	0	0	1	1	0	2	0	1	2
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019[Suspended c..	15% by March 2020; 20% by June 2021	12.9%	13%	12.9%	13.9%	14.4%	14.2%	13.1%	13.8%	13.6%	14.0%	13.7%	14.0%	13.5%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000	5.2	5.2	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.9	5.7	5.7
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	0	1	0	1	2	2	0	0	0	13	12	0	0
Smoking Status Recorded	55% until Sept 2021						48%	60.1%	65.4%	73.0%	74.5%	69.9%	71.1%	65.2%

True North Patient Experience Summary

Tracker Metrics

		Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Mental Health: Prone (Face Down) Restraint	4 per month	1	6	7	9	4	3	9	5	3	2	4	3	2
Patient on Patient Assaults (MH)	38 per month	11	9	25	8	18	17	15	16	23	21	15	17	14
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	91.2%	94.5%	95.0%	91.2%	88.2%	94.3%	94.1%	96.7%	93.7%	90.6%	91.3%	96.7%	89.1%
Mental Health: Uses of Seclusion	13 in month	9	4	12	4	11	15	13	15	11	15	10	2	0

True North Supporting Our Staff Summary

Tracker Metrics

		Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Gross vacancies: % [Suspended centrally due to COVID]	<10%													
Statutory Training: Fire: %	90% compliance	92.3%	91.5%	85.0%	83.7%	90.2%	91.5%	91.5%	90.8%	90.7%	90.9%	91.2%	91.8%	92.3%
Statutory Training: Health & Safety: %	90% compliance	95.9%	95.7%	92.5%	92.5%	95.1%	95.1%	95.1%	95.0%	95.0%	95.3%	95.5%	95.8%	95.6%
Statutory Training: Manual Handling: %	90% compliance	94.0%	93.8%	86.0%	95.0%	87.8%	88.6%	88.9%	90.0%	90.0%	91.2%	91.2%	91.3%	91.4%
Mandatory Training: Information Governance: %	95% compliance	95.2%	93.8%	89.0%	88.4%	92.0%	91.9%	94.7%	92.0%	94.6%	94.8%	91.6%	95.2%	94.8%
PDP (% of staff compliant) Appraisal: %	95% compliance 'by 30th June 2021'	91.9%	88.9%	88.1%	86.1%	10.0%	74.4%	90.7%	95.4%	93.6%	92.6%	90.7%	91.4%	91.4%

True North Money Matters Summary

Tracker 1

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	3.30	2	3.50	3.10	3	4	5.09	4.39	1.89	1.40	2.60	1.60

Tracker Metrics

CHS Inpatient Occupancy	80-85% Occupancy	83.5%	75.0%	70%	82.0%	83.5%	86%	85%	83%	88.2%	85.5%	81.5%	83.5%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	73.42%	73.04%	69.89%	74.37%	77.48%	78.36%	86.46%	86.46%	88.89%	92.09%	86.72%	73.56%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.29%	4%	4.29%	4.5%	4.29%	7.5%	4.90%	4.70%	4.79%	4.59%	2.90%	4.79%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	10.6%	6.70%	10.6%	7.79%	7.19%	5.60%	9.70%	7.79%	3.59%	5%	4.39%	6.20%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	0	0	0	0	0	2	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	1	2	0	1	1	2	0	0	0	0	1	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	1	0	0	0	1	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	1	0	0	0	0	0
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	88.9	75	88.9	90.9	75	80	50	100	100	60	100	71.3
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98.9	98.0	99.2	98.4	99.3	99.3	98.9	98.8	99.2	99.8	99.5	99.1
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	98	98	99	98	98	98	98	98	98	98	97	97
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	54.9	52.7	53.8	54	55.0	54	54	55.9	52	55.0	54	53
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to C..	99% seen	99.6	99.1	99.6	99.3	99.2	99.7	100	99.7	99.1	98.2		99.7
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	98.6	100	98.0	100	94.6	96.7	98.9	98	100
Sickness Rate: %	<3.5%	4.73	3.50	3.04	3.46	3.43	3.83	4.17	4.47	4.87	4.75	4.92	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95% (by 2021)	66.7%	44.4%	64.7%	0%	0%	33.3%	50%	60%	50%	50%	46.4%	75%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95% (by 2021)	45.5%	45.8%	48.5%	8.33%	50%	50%	54.5%	34.7%	38.7%	53.3%	68%	87.5%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

Metric	Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Community Health Services: 2 Hour Urgent Community Response %.	TBC				63.2%	66.7%	72.7%	72.5%	73.5%	74.2%	74.5%	72.0%	68.3%
Community Health Services: Inpatient Number of Discharges by 5pm	TBC				397	499	474	566	514	199	124	332	283
E-Coli Number of Cases identified	TBC				1	1	2	0	0	2	0	1	1
CHS: VTE Risk Assessment	TBC												
A&E - % Face to Face Assessment within 1 hour	TBC				90.2%	90.4%	88.5%	92%	96%	98.5%	98%	94%	93.5%
Crisis Response Times % 1 hour	TBC								18%	35.5%	17.8%	23.6%	14.4%
Crisis Response Times % 4 hours	TBC								44%	26.9%	23%	43%	22.2%
Crisis Response Times % 24 hours	TBC												
4 Week Access Target for Children's Mental Health Services	TBC												
4 Week Access Target for Adults' mental health services	TBC												
4 Week Access Target for Older Person's mental health services	TBC												
Personality Disorder Services	TBC												
Adult Eating Disorder Services	TBC												
Community Rehabilitation Pathways	TBC												
Expand Early Intervention in Psychosis	TBC												
Individual Placement Support - Access Target	TBC												
Number of people with SMI having an annual physical health check	TBC								22%	31%	67%	72%	74%
Potential under reporting of NRLS Safety Incidents	TBC												
Ethnicity and most deprived quintile proportions across service restoration and NHS Long Term Plan metrics	TBC												
From Data Sets - Proportions of patient activities with an ethnicity code	TBC												
Proportion of staff who say they have a positive experience of engagement	TBC								7.5%	7.5%	7.5%	7.5%	7.5%

Regulatory Compliance - System Oversight Framework

Metric	Target	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Number of people working in the NHS who have had a flu vaccination	TBC												
Proportion of staff in senior leadership roles who are from a BME background	TBC												
Proportion of staff in senior leadership roles who are women	TBC												
CQC - Quality of Leadership	TBC												
Aggregate score for NHS Staff Survey questions that measure perception of leadership culture	TBC												
People promise index	TBC												
Health and wellbeing index	TBC												
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (a) managers	TBC								6.70%	6.70%	6.70%	6.70%	6.70%
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues,	TBC								6.70%	6.70%	6.70%	6.70%	6.70%
Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from (c) patients/ service users, their relatives or other members of the public in the last 12 months	TBC								7.90%	7.90%	7.90%	7.90%	7.90%
Proportion of people who report that in the last three months they have come to work despite not feeling well enough to perform their duties	TBC								43%	43%	43%	43%	43%
Percentage of staff who say they are satisfied or very satisfied with the opportunities for flexible working patterns	TBC								70.1%	70.1%	70.1%	70.1%	70.1%
% of jobs advertised as flexible	TBC												
Staff retention rate (all staff)	TBC	86.7%	86.7%	87.5%	87.4%	86.5%							
Performance against Financial Plan	TBC												
Underlying Financial Position	TBC												
Run Rate Expenditure	TBC												
Overall trend in reported financial position	TBC												
Mental Health 72 Hour Follow Up	TBC			86%	84%	84%	87%	85%	86.2%	88.5%	98.1%	90.5%	92%

Trust Board Paper

Board Meeting Date	8th February 2022
Title	**Health and Wellbeing Update Report**
	ITEM FOR NOTING
Purpose	To provide a six-monthly update to Trust Board on health and wellbeing activity
Business Area	Corporate
Author	Steph Moakes – Health and Wellbeing Lead
Relevant Strategic Objectives	True North Goal 2: Supporting our staff
CQC Registration/Patient Care Impacts	Deliver safe, compassionate, high-quality care and a good patient experience through a skilled and engaged workforce
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	EDI implications considered
SUMMARY	This paper provides an update on health and wellbeing activity over the last 6 – 12 months and gives an indication of the planned milestones ahead.
ACTION	For information and discussion

Report to Trust Board – February 2022

Health & Wellbeing Update

Introduction

In line with the trust People Strategy, national People Promise and new NHS Health & Wellbeing Framework, Wellbeing continues to be a high priority and profile activity. This paper updates on the work that has happened over the last 6 – 12 months and gives an indication of the planned milestones ahead.

Review:

The journey to proactive staff wellbeing support in Berkshire Healthcare started in earnest in August 2019 with the appointment of a Wellbeing Lead. With only 6 months until the pandemic took over most of business as usual, a substantial proportion of the time has been spent reacting to immediate needs and pressures from across the system. This included creating a psychological staff support service with redeployed Psychological Therapists for Berkshire Healthcare and Royal Berkshire Hospital staff. Staff Wellbeing has continued to grow both in remit and importance for our people, having indirect impact on recruitment, retention, and sickness absence, as well as overlapping with our EDI, Leadership and HR functions.

Over the last six months, the following projects have been delivered:

- **Refresh & Reframe Wellbeing Plan** launched in July 2021. Work on delivering this plan is almost complete with many of the deliverables moving into business as usual going forward.
- **Staff Survey 2021** completed with a **60% response rate** (maintained from 2021). National results are expected by mid-March.
- **Reconnect Events**: Teams were given a budget to bring people together, reconnect and recharge between August and October
- **A £25 voucher** was sent to all staff in December as a **thank you** for their hard work over the year.
- The **Wellbeing Champions Network** was launched in Jan with the aim of bringing together people who are focused on wellbeing in their teams, giving them extra support and knowledge.
- Launched the **Peppy menopause app** in October which is specifically designed to support staff through the perimenopausal and menopausal stages of life. We currently have **117 users** registered on the app with an additional 29 interested (next user registration figures due on 31 Jan). Funding has been secured for a one-year pilot with an evaluation at the midpoint to determine a business case for any future funding.

- Successful recruitment to a **band 7 Wellbeing & Rewards Manager** position which will support the Health & Wellbeing Lead

Alongside the trust level health and wellbeing work, two ICS projects have also been running:

Wellbeing Matters, the ICS Mental Health Hub which is hosted by Berkshire Healthcare has received funding for another year of delivery. The aim is to increase engagement in the service from all health and social care partners throughout the next year.

The **Enhanced Occupation Health & Wellbeing (EOHW) Project** in BOB ICS has continued its project delivery after the successful bid for £800k to support Health and Wellbeing initiatives in the area. Key impact areas for Berkshire have been REACTMH training now available to leaders and Champions, additional Mental Health First Aider spaces available and support in launching our Wellbeing Champions network.

2022 Roadmap:

As we move into a new year and our Covid recovery wellbeing plan comes to an end, we want to transition to a proactive, agile health and wellbeing plan.

The Health and Wellbeing Plan will encompass:
- Health & Wellbeing
- Engagement (including Staff Survey)
- Rewards & Recognition

This will be directly linked to the trust People Strategy, new NHS Health & Wellbeing Framework and the NHS People Promise. The new NHS Health & Wellbeing Framework includes a new diagnostic which will inform priority areas going forward.

While the new plan is developed in collaboration with networks, we will continue to deliver health and wellbeing projects on the existing roadmap. This will include the following key milestones:

February
- Gaining feedback on the proposal to introduce a policy/guidance around buying and selling annual leave. This follows ongoing requests from staff over several years.

March
- Health Kiosks to be delivered to main sites (details tbc) for staff to get a health MOT/check (funded through the BOB Enhanced Occupational Health & Wellbeing Project)
- Completed Health & Wellbeing Framework Diagnostic and creation of updated wellbeing plan for 2022-2023
- National Staff Survey results published, organisational action plan created, and divisions supported to incorporate actions into existing plans.

April

- Target date for recommendations from the current review into staff rest areas
- Evaluation of Peppy menopause app undertaken to determine business case for future funding. Exploration of other services offered by Peppy including men's health, fertility, and pregnancy.
- Wellbeing Matters moves into the second full year of funding with plans to bring own independent reporting system, AI chat box and an ambitious recruitment plan to support engagement throughout ICS partners in Berkshire.

May

- The Enhanced Occupational Health & Wellbeing project in BOB ICS will end and various evaluations will be made as to its success.

August

- The new Employee Assistance Programme provider will begin their contract following the current tender process.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 February 2022
Title	Trust Green Plan 2022-25
	Item for Noting
Purpose	To provide the Board with the strategy and planned actions to tackle environmental sustainability
Business Area	Operations & Estates
Author	Paul Harrison – Sustainability Manager Jayne Reynolds – Regional Director
Relevant Strategic Objectives	To provide accessible and safe environments which keep patients safe, supports our staff, provides good patient experience and is cost effective.
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and the delivery of safe and responsive care
Resource Impacts	Financial investment and staff time
Legal Implications	The UK legislation – Climate Change Act (2008) has a national statutory target to bring all greenhouse gas emissions to net zero by 2050. The NHS has a target to become net zero emitter of carbon emissions by 2045. The 2021/22 NHS Standard Contract requires every Trust to ensure a Board member is responsible for their net zero targets and Green Plan.
SUMMARY	The attached paper provides the Board with the Trust's Green Plan 2022 -25. It provides information on 1. the drivers for change 2. What we have done to date 3. What we need to do, and 4. Our plan to achieve the Trust green sustainability strategy and targets

ACTION REQUIRED	To note the report and seek any clarification.

NHS
Berkshire Healthcare
NHS Foundation Trust

Net Zero‘n’Green

Inspected and rated Good
Care Quality Commission

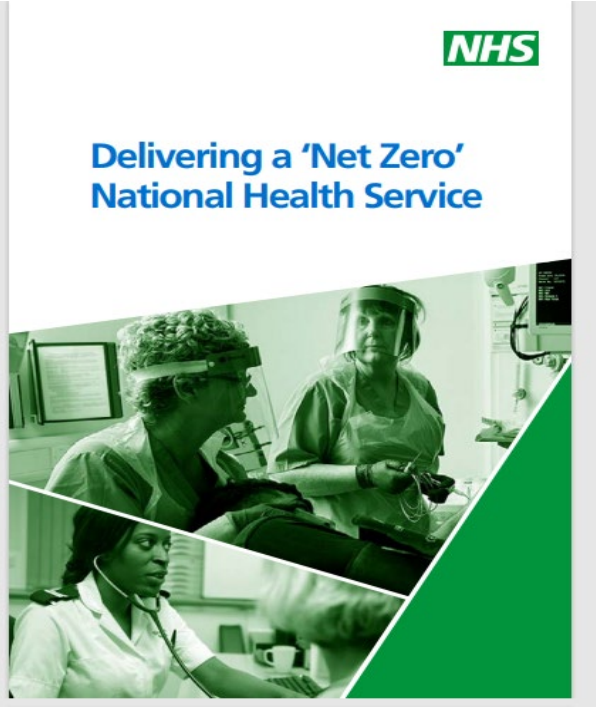
Diversity and Inclusion
Bringing us together

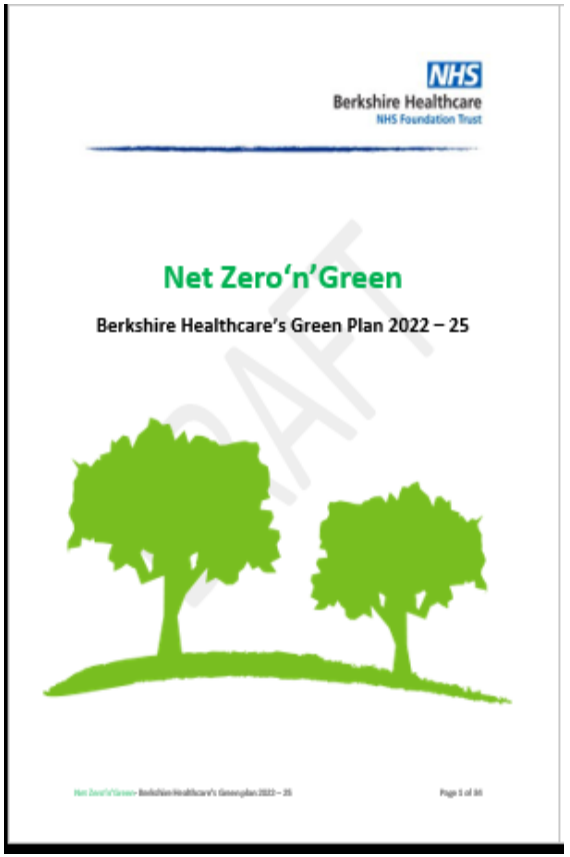
Our Journey To Green 2022 – 25

1. Why Green and Why Now?

NHS
Berkshire Healthcare
NHS Foundation Trust

"The nature and the scale of our business in the NHS means we have a responsibility - as well as a unique opportunity – to play a leading role in the climate change agenda for the benefit of patients and the public."





2 Drivers for change – legislation.

Berkshire Healthcare NHS Foundation Trust

- The UK legislation – Climate Change Act (2008) has a national statutory target to bring all greenhouse gas emissions to net zero by **2050.**
- The NHS has set a net zero carbon emissions target by **2045.**
- Two key targets dates -

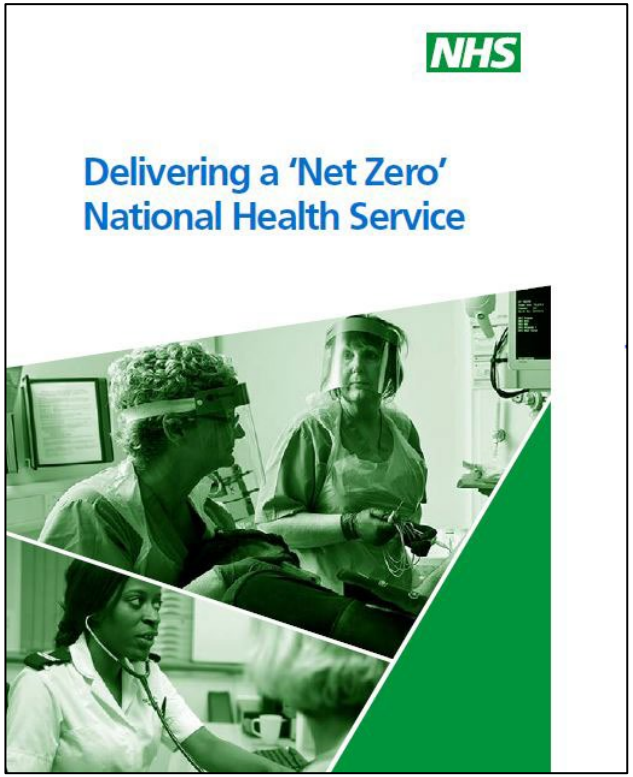
  for the emissions directly controlled, net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

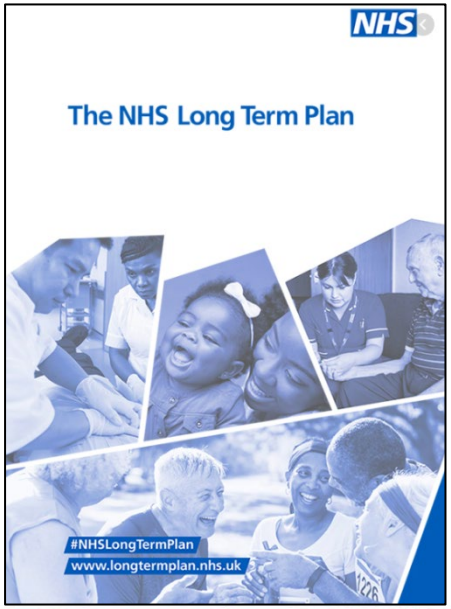
  for the emissions we do not directly control, but can influence, we need to achieve net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039
- The sale of new petrol and diesel-powered vehicles stops in **2030.**

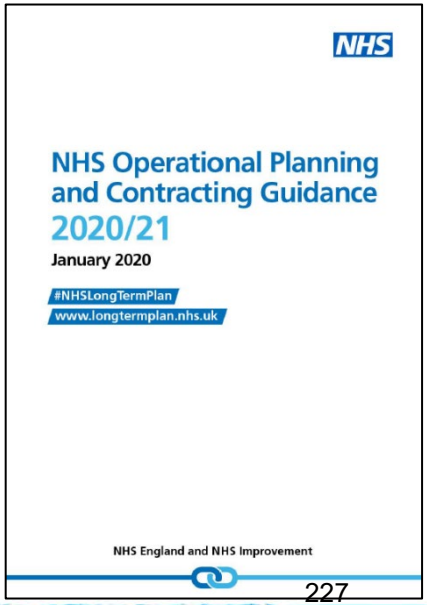
2. Drivers for Change – NHS.

Berkshire Healthcare NHS Foundation Trust

FOR A GREENER NHS







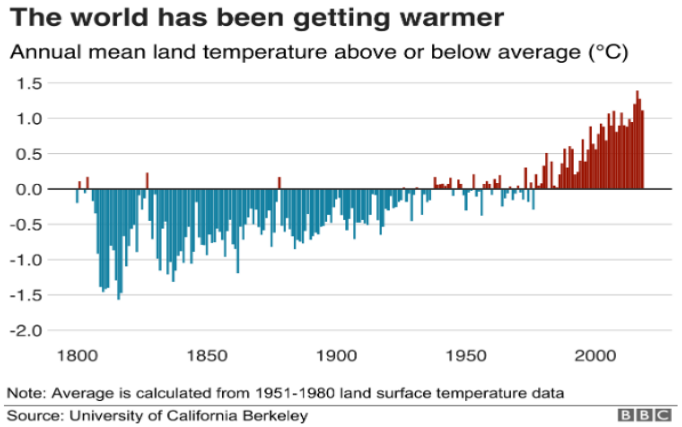
The NHS organisations sign up to reduce the use of plastic in hospital canteens

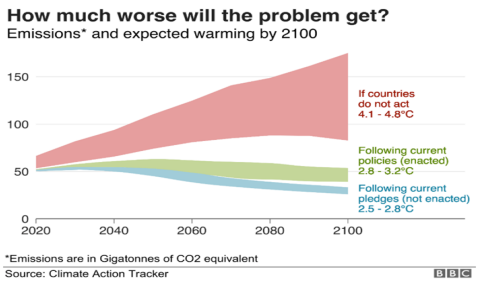
2. Drivers for change – C02/Climate change.

Berkshire Healthcare NHS Foundation Trust

UN CLIMATE CHANGE CONFERENCE UK 2021

IN PARTNERSHIP WITH ITALY





COP26

2. Drivers for change – impacts.

Berkshire Healthcare NHS Foundation Trust

"When you look at climate change from a human mortality perspective, it will be the equivalent of a coronavirus crisis every year from the middle of this century, and every year, not just a one-off event. So it is an issue that needs to be addressed now."

Mr Mark Carney, United Nations envoy for climate action and finance,

https://www.bbc.co.uk/news/business-55944570 **viewed, 10th February 2021**

Health impacts of climate change

Summary of health impacts from 2012 UK climate change risk assessment	Risk level (2020s)	Risk level (2050s)	Confidence
Positive			
Decline in winter mortality/morbidity (1,300–12,000 fewer deaths pa)	High	High	Medium
Negative			
Mental health effects of floods/storms (twice as many people affected by 2020)	High	High	Medium
Summer mortality/morbidity due to higher temperatures (130–1,700 more deaths pa)	Medium	High	High
Extreme weather event mortality	Medium	Medium	Medium
Extreme weather event injuries	Low	Medium	Medium
Sunlight/UV exposure	Low	Medium	Low
Mortality and morbidity due to summer air pollution (ozone)	Unknown	Unknown	

Source: Department for Energy, Food and Rural Affairs (2012). Report. UK Climate Change Risk Assessment

3. What have we done – plastic & Waste.

Berkshire Healthcare NHS Foundation Trust

- Where possible we've eliminated the use of single use plastic
- Directly managed contracts - zero waste to landfill.
- Improved recycling rates across the Trust
- Increased clinical waste segregation
- Established challenging targets going forward.

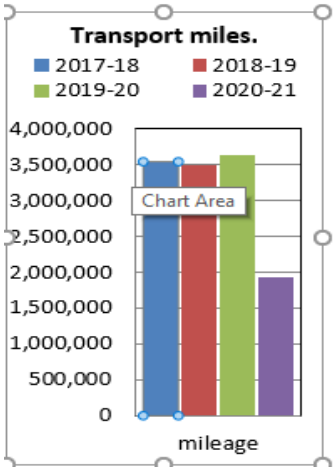
3. What have we done – green sites.

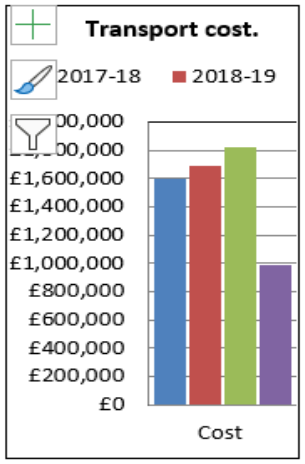
Berkshire Healthcare NHS Foundation Trust

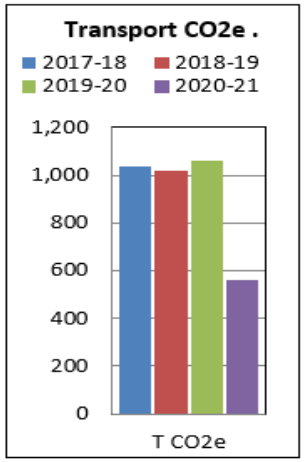
- Hugely successful therapy garden project at WBCH
- Provides clinical therapy space
- Provides food which is used by onsite catering
- Provides outside space for staff
- Won the national sustainability health and care award for green space 2018.
- Planted a tiny Forest at WBCH through DEFRA funding

3. What have we done – Vehicles & Remote Working.

- Electric Vehicle charging points installed at Erlegh House, Church Hill House, Wokingham and St Marks.
- More scheduled for 2022/23 to be installed at PPH, WBCH and Hillcroft House.
- Trust wide policy on Electric Vehicle use being developed. Remote working has reduced business travel by half.
- Saving 500 tonnes of CO2e and £835,000 in costs
- Big increase in non-face to face consultations saving further CO2e emissions

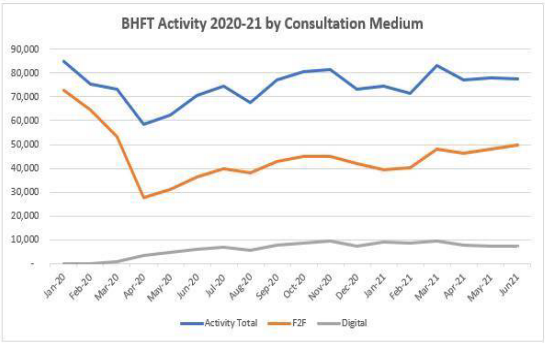






BHFT Activity Summary by Consultation Medium - 2020 & 2021

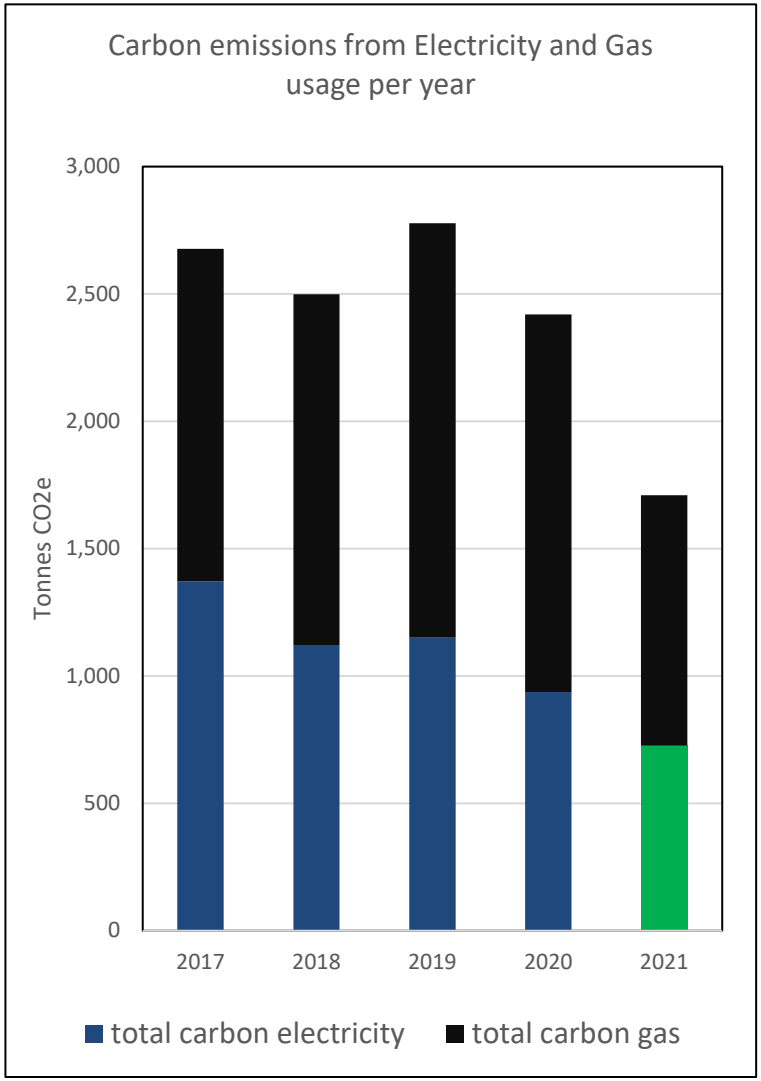
Month	Activity Total	F2F	Digital
Jan-20	84,793	72,731	101
Feb-20	75,236	64,568	89
Mar-20	73,179	53,247	634
Apr-20	58,422	27,780	3,309
May-20	62,305	31,360	4,544
Jun-20	70,742	36,566	5,879
Jul-20	74,675	39,959	6,797
Aug-20	67,483	38,187	5,555
Sep-20	77,241	42,713	7,616
Oct-20	80,379	45,143	8,677
Nov-20	81,267	45,159	9,303
Dec-20	73,256	42,148	7,468
Jan-21	74,377	39,482	9,023
Feb-21	71,614	40,214	8,773
Mar-21	83,084	48,232	9,557
Apr-21	77,264	46,491	7,826
May-21	77,839	48,251	7,459
Jun21	77,628	49,710	7,263



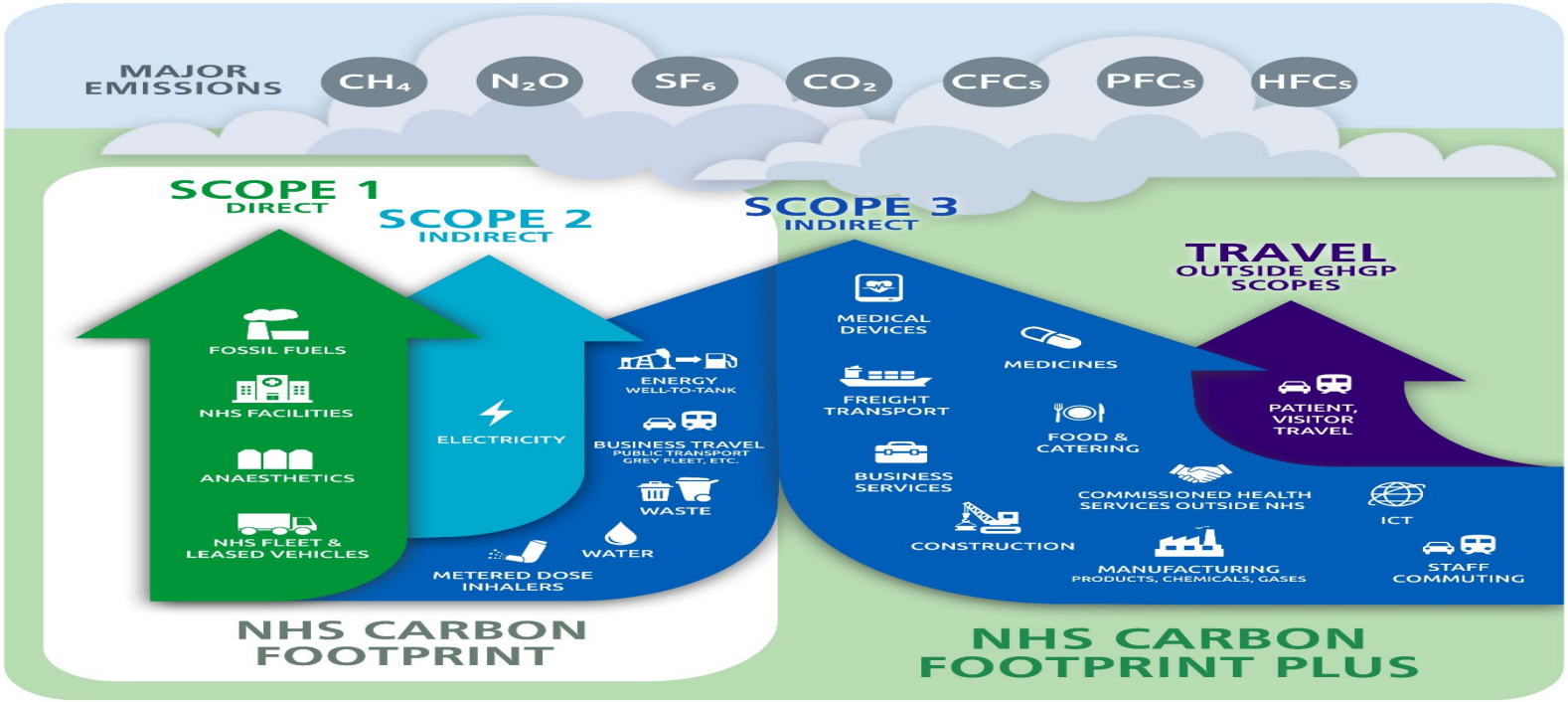
Note The remaing activity = Telephone, Email, Other and SMS Text

3. What have we done – Energy.

- Lighting – LED light upgrade rolled out across the Trust.
- April 2020 all electricity supply the Trust controls is from renewable sources. Saving 727 tonnes of CO2e
- Energy efficiency equipment installed across larger sites.



4. What we Need to do.



In general, for Berkshire Healthcare, the scope 1 and 2 sources of emissions are the ones it has more direct control over and are identified as the NHS Carbon footprint. Scope 3 and Travel are the areas the NHS needs to influence.

24% control = carbon footprint 76% influence = carbon footprint plus

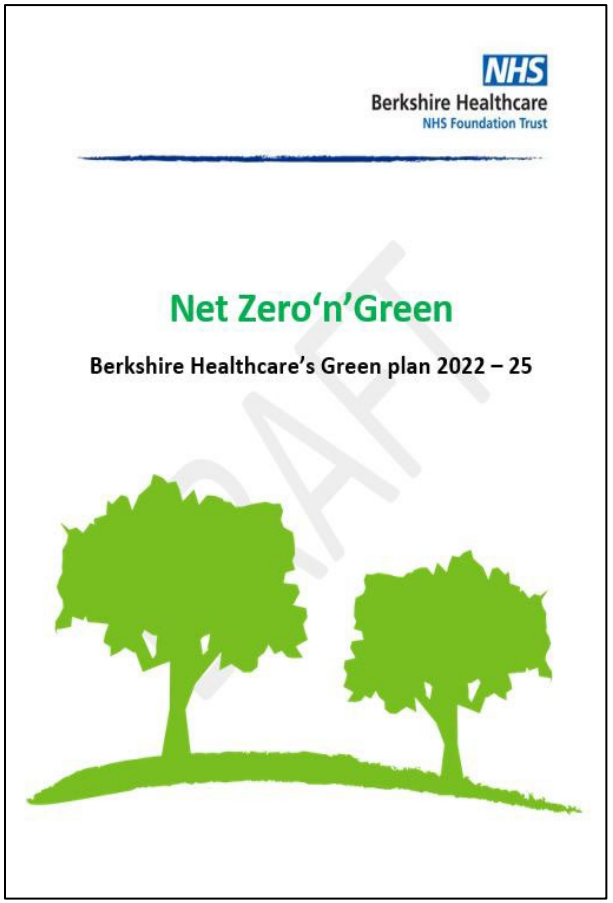
5. Our Plan for Journeying to Green.

Berkshire Healthcare NHS Foundation Trust

"This plan will help shape healthcare delivery to ensure services become sustainable and meet net zero target".

Strategic goals are to;

- **Cut carbon to net zero**
- **Stop polluting our environment**
- **Improve health and wellbeing**
- **Improve financial efficiency**
- **Enhance reputation**



5.Action Planning.

Berkshire Healthcare NHS Foundation Trust

The Action Plan

Please not the Capex figures identified below are indicative and are a clear indication of the type of investment potentially needed to complete a specific action.

Responsibility Key

SM – Sustainability Manager, Mar – Marcoms, L&D-Learning and Development, E – Estates, FM – Facilities, 3rd Party FM – NHSPS, ISS, Bellrock, private landlords, F – Finance, CSM – Clinical Service Managers, P – Procurement, CE - Clinical engagement / input, EP – EPRR Manager, PM – Property Manager

Area of Action	People						Strategic Goals				
Objective	Increase the resources to ensure full staff engagement and support.		Target	All staff to receive training and or have access to net zero n green hero network by 2023			Cut carbon emission	Stop polluting	Health and wellbeing	Financial efficiency	Reputation
	Action	Responsibility	Resource	Capex	By	Outcome					
1.	Develop and support network of net Zero'n'Green hero's	SM,	Staff time Admin support	£20K pa	2022	• A support team of likeminded staff helping to deliver the trust wide changes that endorse net zero and embrace sustainable healthcare	✓	✓	✓		✓
2.	Invest and maintain high quality website / intranet information and guidance for all staff, patients, public and other stakeholders to access	SM, Mar	Staff time consultant	£25k pa	2022	• Provide information to all to empower and enable individuals to make change to achieve net zero and implementing	✓				✓
3.	Actively engage and use social media and sustainability activities	SM, Mar	Staff time		2022	• Utilise this form of communication to inform and promote what the organisation is doing to meet its			✓		✓
4.	Increase training to all staff - make it mandatory and include at induction	SM, L&D	Staff time		2023	• Raise awareness and encourage action by all staff • Ensure all staff engaged in decarbonising BHFT	✓				✓

Area of action	Travel						Strategic Goals				
Objective	To boost and facilitate the decarbonisation of all trust activities		Target	To reduce by 50% staff commuting and business travel using ICE 2025			Cut carbon emission	Stop polluting	Health and wellbeing	Financial efficiency	Reputation
	Action	Responsibility	Resource	Capex	By	Outcome					
5.	Measure and monitor all travel data from service delivery and commuting.	SM, F,	Staff time Consultant Software	£5k pa	2022	• Identify change and demonstrate success. Also focus activity where failings are identified. • Promote success.	✓	✓	✓	✓	
6	Review and implement Trust-wide Green Travel Plan and site-specific plans	SM, FM, E	Staff time Link to Act.7,9,10		2023	• Provide clear alternatives to petrol- or diesel-powered vehicles. • Reclassify parking spaces to support alternatives to petrol / diesel powered vehicles.					
7.	Provide site specific information on all travel opportunities via intranet and website(s)	SM, M, FM 3rd Party FM	Staff time Link to Action 2	£10k pa	2022	• Actively encourage commuting and busine travel away from ICE powered vehicles.		✓	✓		

Other action areas are:-

- Estate – Utilities, Waste, Buildings and sites
- Procurement
- Adaptation

NHS
Berkshire Healthcare
NHS Foundation Trust

Thank you

questions…

Paul Harrison/Jayne Reynolds

Berkshire Healthcare
NHS Foundation Trust

Net Zero'n'Green

Berkshire Healthcare's Green Plan 2022 – 25

Contents

Foreword

"The climate emergency is a health emergency. Climate change threatens the foundations of good health, with direct and immediate consequences for our patients, the public and the NHS"

Costello A, Abbas M, Allen A, Ball S, Bell S, Bellamy R, et al. Managing the health effects of climate change. *Lancet* 2009; 373(9676): 1693–1733.

"When you look at climate change from a human mortality perspective, it will be the equivalent of a coronavirus crisis every year from the middle of this century, and every year, not just a one-off event. So, it is an issue that needs to be addressed now."

Mr Mark Carney, United Nations envoy for climate action and finance,

https://www.bbc.co.uk/news/business-55944570 viewed, 10th February 2021

There is irrefutable evidence that the planet's temperature has increased by over 1 degree centigrade since pre-industrial levels. If a dramatic reduction in greenhouse gas emissions does not take place this is predicted to increase by a further 3 degrees centigrade by 2100.

There is universally consensus that keeping a global temperature increase to 1.5 degree centigrade is required to minimise the devastating impacts of a warming planet. This can only be achieved by cutting greenhouse gas emissions and implementing actions that that will absorb carbon dioxide from the atmosphere.

This has led to net zero carbon emission commitments being made by nations, states, local government, the public sector and commercial organisations across the planet, including NHS England, which has a net zero target by 2045.

The Greener NHS programme was launched in 2020 to support and implement the changes required to address climate change and ensure that the NHS is a provider of sustainable healthcare.

For NHS England to meet this target all Trusts need to make the necessary changes to reach their own net zero target. Taking actions to achieve this will also contribute to ensuring the provision of a sustainable healthcare service now and for future generations.

To facilitate the change all NHS Trusts have been tasked with preparing and implementing a Green Plan, which will set out the organisations direction and actions to progressively decarbonise the provision of healthcare.

This is Berkshire Healthcare's first Green Plan and sets the foundations to progressively remove carbon emissions from all its operational activities and strategic decision making. It focuses on the areas that, firstly the Trust has control over, secondly are clearly defined sources of greenhouse gas emissions and finally will create a position for successful long-term change.

The Green Plan will also ensure that the Trust is taking direct action to enable it to be an organisation that is taking a lead in becoming a provider of sustainable healthcare and will achieve its overarching vison in relation the climate change and sustainability which is.

To be a provider of healthcare that is efficient, flexible and resilient by applying the overarching principles of sustainability.

Introduction

Berkshire Healthcare's Green Plan (2022-25) is about making change. Change that is both for the good of all who use and rely on our services and those who provide these healthcare services.

It is a pathway strategy and starts our drive to decarbonise all of our operational activities and strategic decision making. Its implementation will affect all aspect of clinical and non-clinical activities, ensuring that we're providing healthcare services that are sustainable and that are not contributing to environmental damage.

The climate emergency and sustainability requirements will need to be taken into account and addressed at every operational level throughout the Trust. This subject area is intrinsically linked to everything each and every staff member does, and every decision made. It is a 'must do', not a 'nice to have'.

https://www.visitsoutheastengland.com/places-to-visit/berkshire/map

We're in the relatively unique position of operating across a geographical area that is covered by two different Integrated Care Systems. These are Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System and partnerships and Frimley Integrated
Care System (for East Berkshire).

We need to address the climate emergency and provide healthcare services that don't damage the environment, are socially responsible and financially efficient.

The net zero carbon emissions target and sustainable healthcare agenda are fundamentally aligned so that working towards one will also support meeting the other.

The greener NHS programme and the delivering a net zero National Health Service commitments increases the impetus and clarifies the need to address climate change, ensuring that the NHS delivers the required actions to enable its realisation of its ambition to be a sustainable healthcare provider.

To achieve this all trusts are now required to have a Board-approved Green Plan. This strategic document outlines the organisation's aims, objectives, and delivery plans for achieving net zero and sustainable healthcare. It is valid for 3 years and reviewed at least once in the interim period and reported on to the Board or Governing Body on an annual basis.

This, being our first Green Plan, will focus on reducing the carbon emissions that we have direct control over (NHS carbon footprint) as well as setting the foundation to manage the reduction of carbon emissions that it can influence (NHS carbon footprint plus).

By taking direct action the Trust will be moving towards its overarching 'Green' vision,

To be a provider of healthcare that is efficient, flexible and resilient by applying the overarching principles of sustainability.

This Green Plan sets out a number of strategic goals which support and ensure that our overarching green vision is achieved . These strategic goals are.

- **Cut carbon** to be net zero

- **Stop polluting** of the environment
- **Improve health and wellbeing**
- Improve **financial efficiency**
- Enhance **reputation**

These goals shape the specific actions that this Green Plan will target and address. It focuses on areas of action that we have more control over as well as being responsible for carbon emissions that are clearly defined. It also set the foundations for future actions in areas that we can influence but not directly control.

The 2022-25 Green Plan is the start of a process to facilitate huge change to ensure that Berkshire Healthcare is contributing and leading in its ambition to achieve net zero and provide sustainable healthcare to all of the communities it serves.

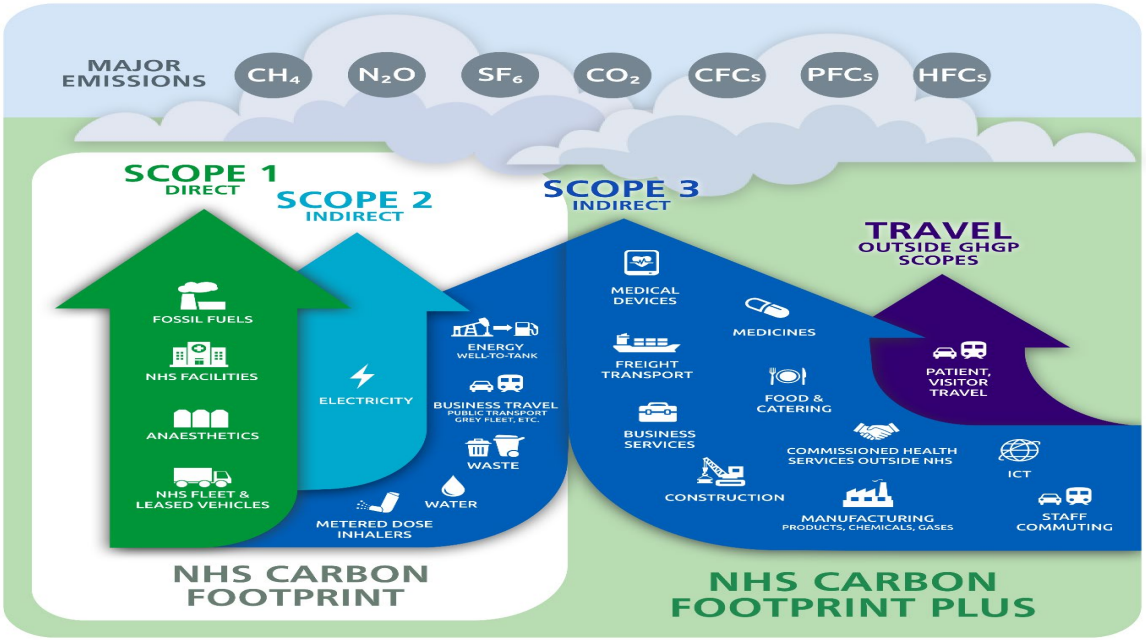
The foundation of the Net Zero'n'Green plan.

Becoming Net Zero is an underlying, must achieve, necessity for the Trust. It means that we need to take actions that will balance the amount of emitted greenhouse gases with the equivalent emissions that are either offset or stored.

To achieve this, we will firstly need to rapidly reduce our carbon emissions. Where we cannot remove all carbon, we will need to find a means to capture and store carbon or offset the equivalent emissions. We will need to effectively balance the impact of the remining greenhouse gas emissions with a way of removing the same amount from the atmosphere.

The sources of carbon are diverse and intricate in detail. Some are easy to identify and measure whereas other are not only difficult to measure but also beyond the direct control of the Trust. Many of these more challenging sources are related to the purchase of goods and services and this is where we can influence and guide change by third party organisations through procurement processes and Trust policy.

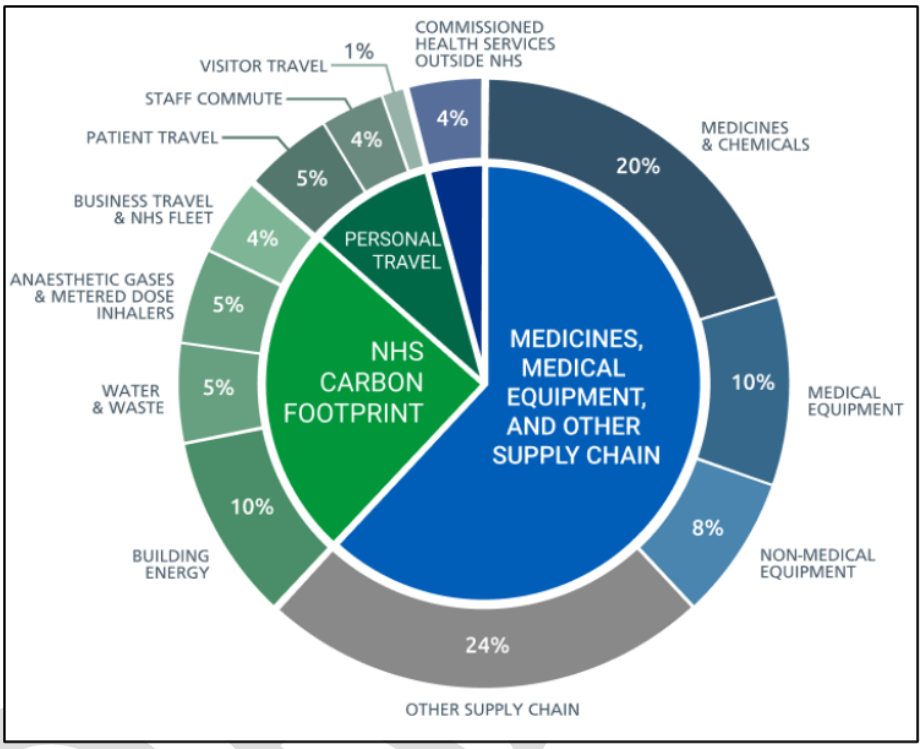
The diagram below demonstrates the complex number of identified sources of carbon emission, direct and indirect that all NHS Trusts will need to address to reach the net zero by **20??.**



Delivering a 'Net Zero' National Health Service, NHS England and NHS Improvement, 2020

In general, for Berkshire Healthcare, the scope 1 and 2 sources of emissions are the ones it has more direct control over and are identified as the NHS Carbon footprint. The NHS carbon footprint plus is the more challenging goal where influence and guidance will be needed to assist in the management and reduction in these sources of carbon that we need to remove from our operational activities and strategic decision making , in order to achieve net zero.

The diagram below highlights which activities and by what proportion contribute to the NHS carbon footprint. It also demonstrates the part that is under direct control as opposed to the part which can be influenced.



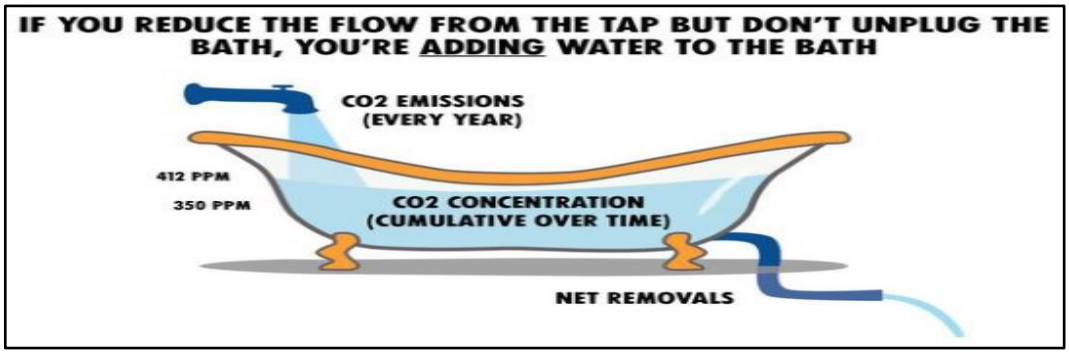
Delivering a 'Net Zero' National Health Service, NHS England and NHS Improvement, 2020

24% control = carbon footprint 76% influence = carbon footprint plus

This needs to be achieved through the removal, as far as is possible, of all carbon emissions. Where all opportunities to achieve this have been utilised then the residual emissions need to be offset. This means utilising carbon credits or sequestration through rewilding or carbon capture and storage

The diagram below indicates the specific activities that cause the most greenhouse gases for Community and Mental Health Trusts and highlights where this strategy needs to focus for our first Green Plan.

Using a bath to explain this means that the water from a tap increase the level of the water in the bath. Similarly, burning fossil fuels is the open tap putting more and more greenhouse gasses into the atmosphere. If we shut the tap, then we stop the water, and the bath stops filling. If we stop burning fossil fuel, then we stop filling the atmosphere with greenhouse gases and the water level does not rise.



(https://www.sheffieldtelegraph.co.uk/news/environment/think-of-the-bath-as-an-analogy-for-co2-emissions-3406587 , viewed 10th November 2021)

If we pull the plug, then the water level drops as the water drains away. From a net zero perspective this is where we remove greenhouse gasses from the atmosphere to reduce the global warming effect. This includes carbon storage or planting trees which take carbon out of the atmosphere and drop the levels of greenhouse gases.

Addressing the climate emergency is imperative and not a nice to have or do. We have no choice but to act. Legally, morally, financially and from a service continuity perspective the Trust will need to become a net zero emitter of Greenhouse gases.

The legislation, national targets and NHS plans and business requirements all require commitment and investment to facilitate direct action that will cut environmental damage and contributions to global warming and are the foundations of the Net Zero Green Plan.

Legislation

There are key pieces of national legislation that we have to comply with, and the application of this net zero green plan will ensure that the organisation is meeting the legal obligations set out in the following Acts.

- **Climate Change Act (2008**)

UK legislation – long term legally binding framework to reduce carbon emissions, mitigate and adapt to climate change. It sets CO2e reduction targets (compared to 1990 baseline) of; 34% by 2020, 50% by 2025, 80% by 2050. This was updated in 2019 to net zero by 2050.

- **Civil Contingencies Act (2004)**

This Act requires certain organisations to prepare for adverse events/ incidents. Heatwaves, flooding and cold weather can disrupt the operation of the health and care system and have direct impacts on health.

- **Public Services (Social Value) Act (2012)**

This Act places a requirement on commissioners to consider economic, social and environmental benefits, taking a value for money approach -. not lowest cost - to assessing contracts, when buying goods and services

- **Health Sector Report on Adaptation (2015)**

Under the Adaptation Reporting Power provisions outlined in the Climate Change Act (2008) the government has nominated the Sustainable Development Unit with support from NHS England and Public Health England as the reporting authority for the health sector.

National targets

There are also a number of national targets that will have fundamental impacts upon the way we deliver our healthcare services.

- The UK has a national statutory target which requires the country to bring all greenhouse gas emissions to net zero by 2050.
- The NHS has a target to become net zero emitter of carbon emissions by 2045.
  The NHS target consists of a number of stage targets to achieve net zero. These are,
  - for the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
  - for the emissions we can influence (our NHS Carbon Footprint Plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039
- The sale of new petrol and diesel powered vehicles are to be banned by 2030.

Other NHS requirements and plans

The NHS Long-Term Plan - sets out the following deliverables for environmental sustainability in the NHS.

- Reduce carbon, waste and water: including phasing out coal and oil fuel as primary source of heating, switching to lower carbon asthma inhalers, Reducing the carbon footprint from anaesthetic gases
- Improve air quality: Cutting business mileages and fleet air pollutant emissions by 20%
- Reduce the use of avoidable single-use plastics

The 2021/22 NHS Standard Contract:

- Every trust to ensure a Board member is responsible for their net zero targets and their Green Plan.
- Every trust to purchase 100% renewable electricity from April 2021.
- Every trust to reduce its use of desflurane in surgery to less than 10% of its total volatile anaesthetic gas use, by volume.

Delivering a net zero National Health Service

- Ensure that, for new purchases and lease arrangements, systems and trusts solely purchase and lease cars that are ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).
- Develop a green travel plan to support active travel and public transport for staff, patients and visitors.

The 2021/22 NHS planning guidance

- Where outpatient attendances are clinically necessary, at least 25% of outpatient activity should be delivered remotely, resulting in direct and tangible carbon reductions

Trust Plans, Policies and Programmes

Three Year Strategic Plan 2021/22 – 2024/25

Reducing environmental impact

Our response to COVID-19 included a substantial shift in the number of patients that no longer have to travel to clinics. This created a significant drop in our carbon footprint through reduced travel and reduced paper and office waste. We'll continue to keep our impact on the environment as low as possible by using digital opportunities where possible and appropriate.

Delivering sustainable services
We'll make the best use of our resources to ensure sustainability. Working with our ICS and ICP colleagues, we'll develop and maintain a sustainable health and care system. We'll make the best uses of our financial resources, making investment decisions aligned to our strategic priorities.

We'll secure new appropriate business and make the most of our assets and estates. At service level, we'll ensure we continue to focus on delivering best value for patients by improving our efficiency and productivity

True North Goals
The four True North goals set the direction of travel for us and are underpinned by a set of outcome measures to enable us to demonstrate our progress.

Goal 1 Harm free care – To provide safe services by eliminating avoidable harm
Goal 2 supporting our staff – To support our people and be a great place to work
Goal 3 Good Patient Experience – To provide good outcomes from treatments and care
Goal 4 Money Matters – To deliver services that are efficient and financially sustainable

The matrix below demonstrates how this strategy will contribute to achieving the True North goals.

	Green Plan Strategic Goals				
True North Goals	Cut carbon to net zero	Stop polluting the environment	Improve health and wellbeing	Improve financial efficiency	Enhance reputation
Harm free care - To provide safe services by elimination avoidable harm	X	X	X		X
Supporting our staff – To support our people and be a great place to work	X	X	X		X
Good Patient Experience – To provide good outcomes from treatments and care			X	X	X
Money Matters – To deliver services that are efficient and financially sustainable	X			X	X

There are a number of existing policy documents that the green plan will endorse, support and increase their effectiveness. These include,

- Remote Working Policy
- Sustainable Procurement policy
- Energy and water management policy
- Sustainable Development policy
- Green travel Plan

Green Plan - Governance

We have a designated Board-level Executive, the Chief Operating Officer, who is responsible for net zero and sustainability agendas.

We also have an established Green Group that provides guidance and direction across a broad range of subject areas, from both clinical and non-clinical perspective. It is made up of senior managers

from across the Trust who provide guidance and influence our wider net zero and sustainability agendas.

The Green Group is responsible for the review and update of the Green Plan on a quarterly basis and will consider.

- the progress made and the ability to increase or accelerate agreed actions.
- new initiatives generated by staff or partner organisations.
- advancements in technology and other enablers.
- the likely increase in ambition and breadth of national carbon reduction initiatives and targets.

The Green Plan's progress will be reported on annually to the Trust Board with regard to how we are meeting all reporting requirements as specified by NHS England, the south-east region and the two Integrated Care systems, Frimley and BOB.

To support and ensure that we're able to provide the most accurate and informative reporting we will need to enhance the data we collect. This being an NHS E/I requirement which is directly supported and recognised by their Net Zero strategy, which states.

- Evidence-based targets and data underpin the analysis, commitments and success.
- Need to increase and improve the monitoring and data collection capacity of the whole system and all Trusts.
- Trusts will be required to include these indicators in their annual report, which will be used to inform a regular update of the NHS emissions profile.

Organisational 'Green' Vision

Our overarching vison in relation to climate change and sustainability is.

To be a provider of healthcare that is efficient, flexible and resilient by applying the overarching principles of sustainability.

This three-year Green Plan will focus on a number of strategic objectives that set out our immediate priorities, which will establish the necessary foundations for decarbonising our strategic and operational activities to achieve net zero by 2045.

The strategic goals that will support and enable our vision is set out below along with the necessary objectives;

Cut carbon emission

- Reducing gas, electricity and water usage to reduce carbon emissions
- Ensuring 100% green electricity supply to all sites
- Actively support and invest in travel that does not use petrol-or-diesel-powered vehicles
- Decarbonise heating systems
- All suppliers of goods and services to be aligned to net zero target

Stop polluting the environment

- Reduce waste to protect the environment
- Eliminate single use plastics
- Reduce causes of air pollution from healthcare provision
- Purchase harm free products whenever possible

Improve health and wellbeing

- Support on site health and wellbeing opportunities
- Invest in green site enhancement
- Support and encourage active travel i.e., walking and cycling to work.

Increase financial efficiency

- Reduce gas, electricity and water consumption to save money
- Reduce grey fleet mileage
- Reduce waste to cut costs

Enhance reputation

- Improve standing amongst peers
- Support and encourage staff green groups
- Provide information and promote action

By focusing on these specific areas, we will be able to make huge inroads in to cutting our carbon emissions and working towards the net zero target.

It will also mean that our operational activities will be increasingly more sustainable and enable us to operate in a way that will not damage the environment, is socially responsible and financially prudent.

NHS England Areas of focus

Becoming net zero and providing a sustainable healthcare service can only be achieved with all aspects of the Trust's operational and strategic activities embracing, engaging and endorsing the necessary far-reaching changes required.

The following subject areas have been identified by NHS England as overarching areas of focus when considering a green plan and take into account the areas that directly and indirectly impact upon carbon emissions and achieving sustainable healthcare.

Workforce and system leadership
Engaging, providing information and guidance is an integral part in achieving change that embraces sustainability and taking actions that reduce greenhouse gas emissions.

For us to successfully implement the necessary action to work towards a net zero outcome it is reliant on every member of staff making decisions and taking actions in support of this overarching strategic goal. Every member of staff will have their part to play in helping us achieve our net zero and sustainable healthcare goal.

Sustainable models of care
Working towards net zero will need to be embedded across all our clinical services now and into the future.

Ensuring that net zero and sustainability are considered and implemented in all the clinical services we provide is critical. This area of work will focus on what we can do, with this section considering carbon reduction opportunities in the way care is delivered.

Digital transformation
The use of technology clearly has a place in streamlining service delivery and supporting functions whilst improving the associated use of resources and reducing carbon emissions.

Travel and transport
Travel is one of the main causes of carbon emissions that Trusts are able to directly influence.

To address this source of Greenhouse Gas (GHG) there needs to be a huge cultural shift away from the reliance on the internal combustion engine (ICE). This means disincentivising the use of petrol- and diesel-powered cars for commuting, for service provision and by patients and visitors to any of our sites.

This can be achieved by providing alternatives; to try to reduce journeys, to increase the use of public transport, support and facilitate active travel and provide the necessary infrastructure to support non-ICE powered vehicles.

The Estate and facilities
The estate and how it is utilised has a huge impact on our carbon emissions. It is also an area that we have direct control on the associated greenhouse gases emitted as a result of using these buildings.

Whether it's the energy and water consumed, or the waste produced, the use of the estate currently results in carbon emissions that need to be addressed. This area of focus is broken down into a number of subject matters

- **Buildings**

We occupy a large number of buildings across the county, and beyond which differ in size, age and tenure. The building fabric has a huge impact upon the amount of energy that is utilised to run these buildings.

- **Energy and water usage**

The cheapest and most environmentally friendly energy we use is the energy we don't use. Ensuring that all viable energy efficiency measure have and are being taken is critical not only to reduce carbon emissions but also to reduce cost.

- **Waste reduction**

The less waste we produce the less environmental damage and less cost in disposal we incur.

Medicines
We need to examine the key opportunities to reduce the carbon emissions related to our prescribing and use of medicines and medical products. This includes reducing pharmaceutical waste and identifying opportunities to utilise lower carbon alternatives medicines.

The 2021/22 NHS Standard Contract set out inhalers and anaesthetic gases as two key areas for early action. For us these are both specific causes of carbon emissions that are not significant in our carbon emission inventory.

Supply chain and procurement
The supply of goods and services to the Trust has a huge impact on the associated carbon emission that we are responsible for - approximately 62%. Therefore, it is quite clear that procurement activities and decision making has a huge part to play in achieve net zero.

The procurement process can also allow us to influence our goods and service providers to address their own carbon emissions and set a net zero target. Procurement can also shape the internal goods purchased and selected by encouraging reuse and green alternative products.

Food and nutrition
The food we produce, serve and dispose of all contribute to the global warming. The consideration that needs to be taken into account are:

- The provision of healthier meal options
- The increased use of locally sourced food to minimise associated food miles and subsequent carbon emissions
- Shaping menus that maximise the opportunity of seasonal available food as well as minimising heavily processed foods. This is not only good for the environment, but also good for the consumers of such products.

Adaptation
Ensuring that we're ready and able to meet the future challenges presented by a changing climate as a direct result in the increase in greenhouse gas emissions. This is resulting in more extreme weather events and will include two fundamental changes which are longer periods of hot weather and more extreme storms and intense levels of rainfall.

Offsetting
Offsetting all opportunities for carbon reduction have been exhausted. This is seen as very much a last resort and currently there appears to be consensus that it should not be considered at this stage of the journey to net zero.

Areas of Action

The areas of action that NHS England have set out are a vast range of interconnected subjects and actions. All of which must be embraced and actioned if net zero is to be achieved. But to achieve success entails certain actions and subject matters being initially prioritised.

This is the first of a number of Green Plans to take us to net zero, and it focuses on the key causes of carbon emissions that we can address now.

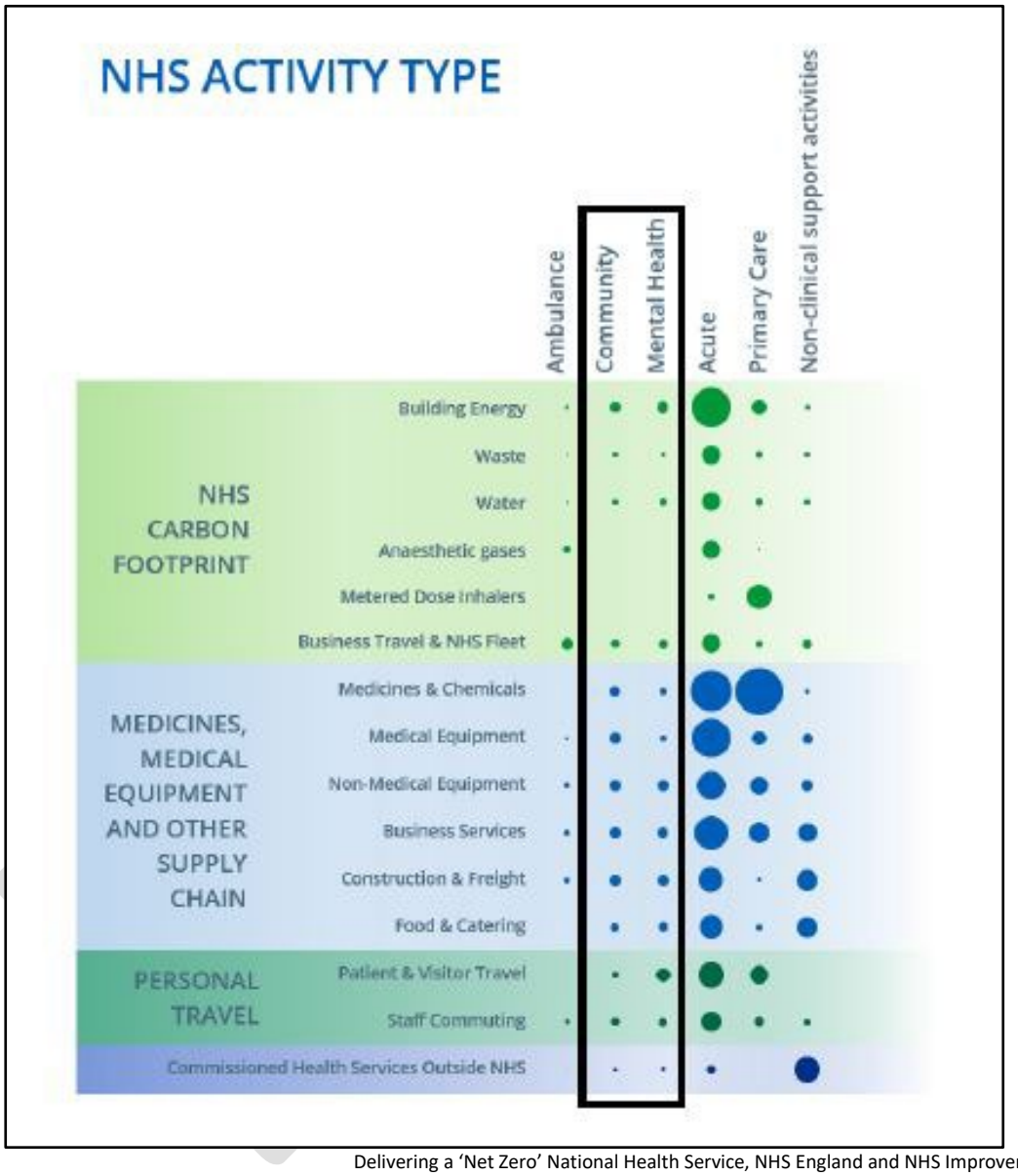
The table below highlights the areas that this green plan will focus on in relation to the NHS England wider set of areas of action.

	BHFT Strategic Goals				
NHS England Areas of action	cut carbon emissions	Stop polluting the environment	Improve health and wellbeing	Improve financial efficiency	enhance reputation
Workforce and system leadership			✓		✓
Sustainable models of care	✓	✓			
Digital transformation	✓			✓	
Travel and transport	✓	✓	✓		
The estate and facilities	✓	✓			
Medicines					
Supply chain and procurement	✓	✓			
Food and nutrition					
Offsetting					

It should be noted that the reason that medicines are not currently included in our strategic goals is because this NHS England area of action is focused on antithetic gases and metered dose inhalers. Neither of which are a major consideration for us.

Food and nutrition are a huge consideration in the decarbonisation of healthcare services. However, for us it makes up a relatively small proportion of our overall carbon emissions because of the small number of inpatient facilities.

The diagram below supports and helps to identify the areas that we need to focus on with this Green Plan to have the greatest impact upon carbon emissions.



Delivering a 'Net Zero' National Health Service, NHS England and NHS Improvement, 2020

To achieve the strategic goals there are number of subject areas which will combine to ensure that the vision and supporting goals are embraced and met by the Trust. These subject areas are

- People
- Travel
- The Estate – utilities, waste, building / site
- Procurement
- Adaptation

The table below demonstrates the positive impact that each area of action will have on our strategic goals. It also highlights how a specific activity can have a contributing impact upon multiple goals.

		Our Strategic Goals				
		Cut carbon emissions	Stop polluting the environment	Improve health and wellbeing	Improve financial efficiency	Enhance reputation
Areas of Action	People	✓	✓	✓	✓	✓
	Travel	✓	✓	✓	✓	
	The estate •Utilities •Waste •Buildings /site	✓	✓	✓	✓	✓
	Procurement	✓			✓	
	Adaptation			✓	✓	✓

The one supporting universal factor is data and how this is vital in identifying and focusing action as well as measuring and monitoring progress and success in achieving a net zero organisation that delivers sustainable healthcare.

The indicative carbon emissions percentage figures, as a result of specific activities, is taken from NHS England guidance (see diagram on page 7 of this Plan). There are two areas that have been omitted from this plan, which are antithetic gases and metered dose inhalers (5%) and commissioned health services outside of the NHS (4%).

People - engage, invest, empower

In order for us to cut our carbon emissions and meet the net zero target we needs all staff to embrace, support and implement the necessary changes that have to take place.

To achieve this requires support, learning and easily found information. This will then allow an individual to make decision and take actions on a daily basis that will combine to create real change.

This also requires a string positive network facilitation to encourage and guide how staff can engage and put forward ideas and identify issues that need addressing.

What we will do

- Develop and support a network of net Zero'n'Green heroes
- Invest and maintain high quality intranet information and guidance for all staff to access
- Actively engage and use social media and sustainability activities
- Maintain high quality information on our website(s) for patients, public and other stakeholders
- Increase training for all staff - make it mandatory and include at induction

Travel – 14% of our carbon emissions

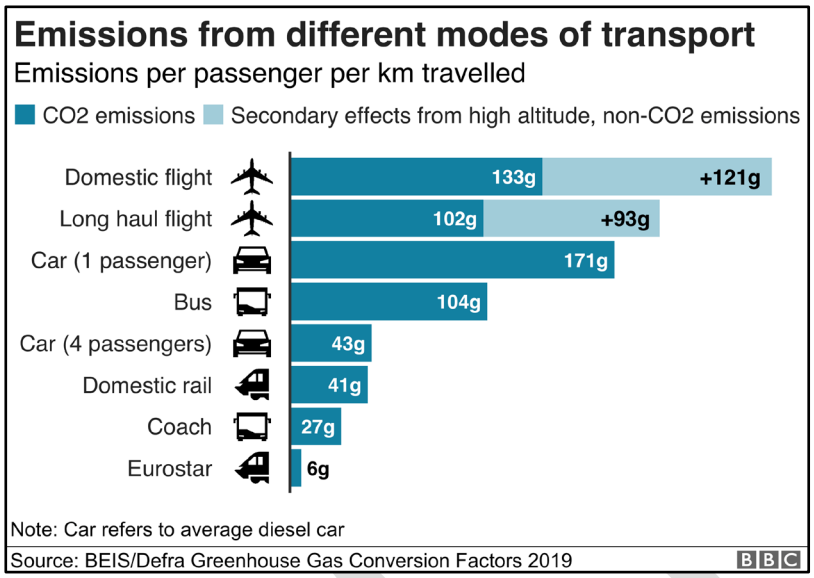
Travel and transport accounts for approximal 14% of our carbon footprint. This is made up of three distinct activity groups, which are.

- staff commuting - 4%
- healthcare delivery / business travel – 4%
- patient / visitor travel – 6%

This Green Plan will focus on the healthcare delivery activities requiring business travel and commuter travel.

The key for heading towards net zero is to reduce the amount of travel that relies on vehicles that are powered by the internal combustion engine (ICE). We have to actively encourage other forms of transport whilst actively discouraging the use of road vehicles which run on petrol or diesel.

As the diagram below demonstrates switching away from using an ICE powered car can have a dramatic impact upon the amount of carbon that is emitted.



https://www.bbc.co.uk/news/science-environment-49349566 viewed 1st Dec 2021

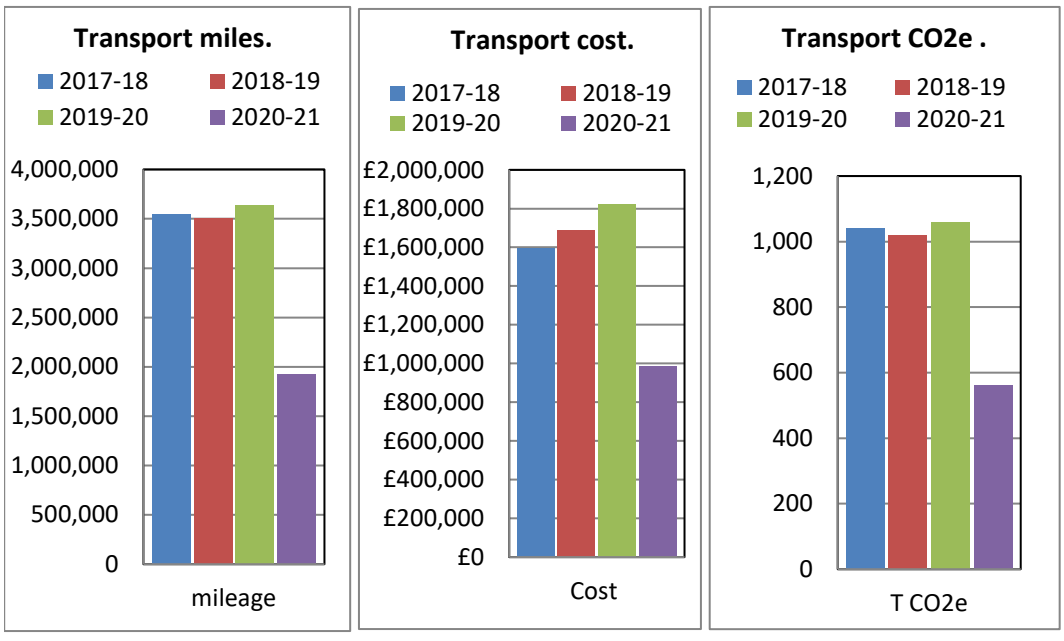
Noting that walking and cycling, which are not included in this diagram are zero grammes of CO2e/km travelled.

Business travel fact box

This demonstrates that switching how we get to our workplaces and then deliver the healthcare services can have a huge impact upon reducing this particular source of greenhouse gases.

On average we cause 1,000 tonnes of carbon emissions from driving 3,500,000 direct business miles at a cost to the Trust of over £1,800,000.

But looking at 2020-21 figures below (although it was an exceptional year due to the pandemic), they illustrate that working practises can make major changes to carbon emissions, as well as to operating costs.



What we will do

To provide the necessary encouragement and facilities to decarbonise travel

- Measure and monitor all travel data from service delivery and commuting
- Review and implement the Trust-wide Green Travel Plan – including site specific plans
- Produce and implement Green Fleet Vehicle Strategy.
- Provide site specific information on all travel opportunities via our intranet and website(s)
- Roll out an electric vehicle charging network across all the larger sites
- Reclassify parking spaces to support alternatives to petrol / diesel powered vehicles.
- Actively develop and encourage active travel to get to and from our sites
- Commit to all leased vehicles to be ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).

Support policy / strategy (existing and proposed)

- Trust wide Green Travel Plan
- Electric Vehicle policy
- Active Travel strategy

The Estate – 15% of our carbon emissions

The estate area of action includes the utility management and consumption, waste impacts as well as the buildings and sites that the Trust uses to provide its healthcare service. We provide a range of healthcare services from a large number of buildings and sites. These vary considerably by condition, age, size, tenure, energy management and energy efficiency.

From a carbon perspective there are two major sources of greenhouse gas that we must address, which are the electricity we consume and the gas we burn for heating.

To address the above we will need to apply all current best practise to improve energy efficiency, from improved awareness and better housekeeping to investing in the building fabric and improved energy efficient equipment and technology.

Utilities

The consumption of electricity, gas and to a lesser degree water result in a major contribution to our directly controllable carbon emissions. These sources of carbon are ones that we can and will reduce.

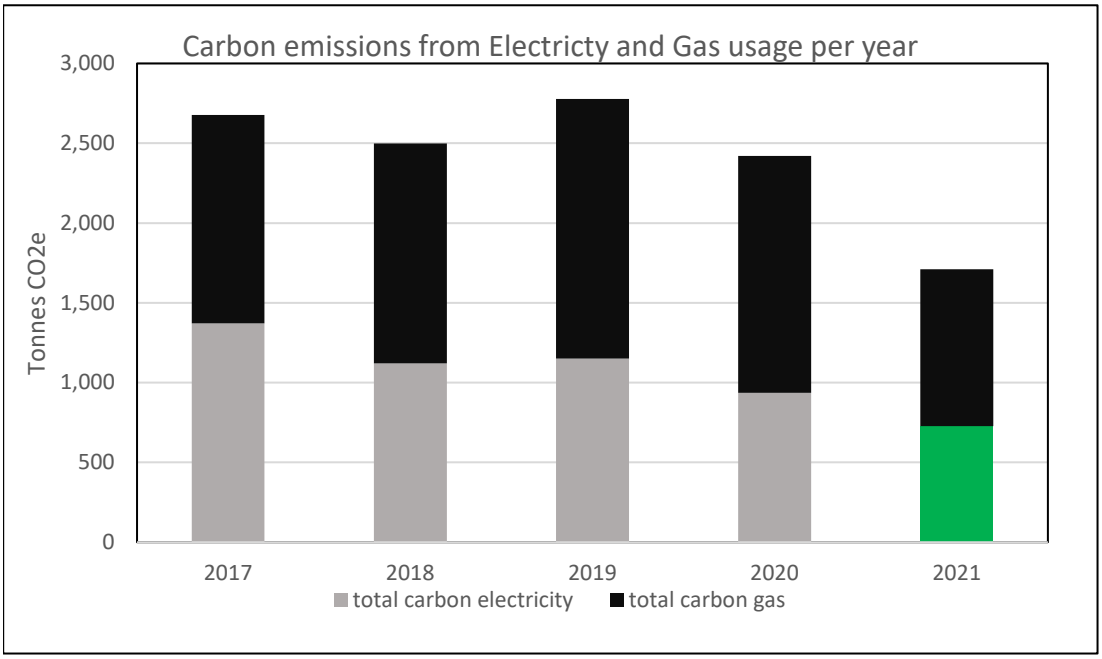
The graphs below highlight the challenge we face, and this is just for the sites where we have direct control of the utilities.

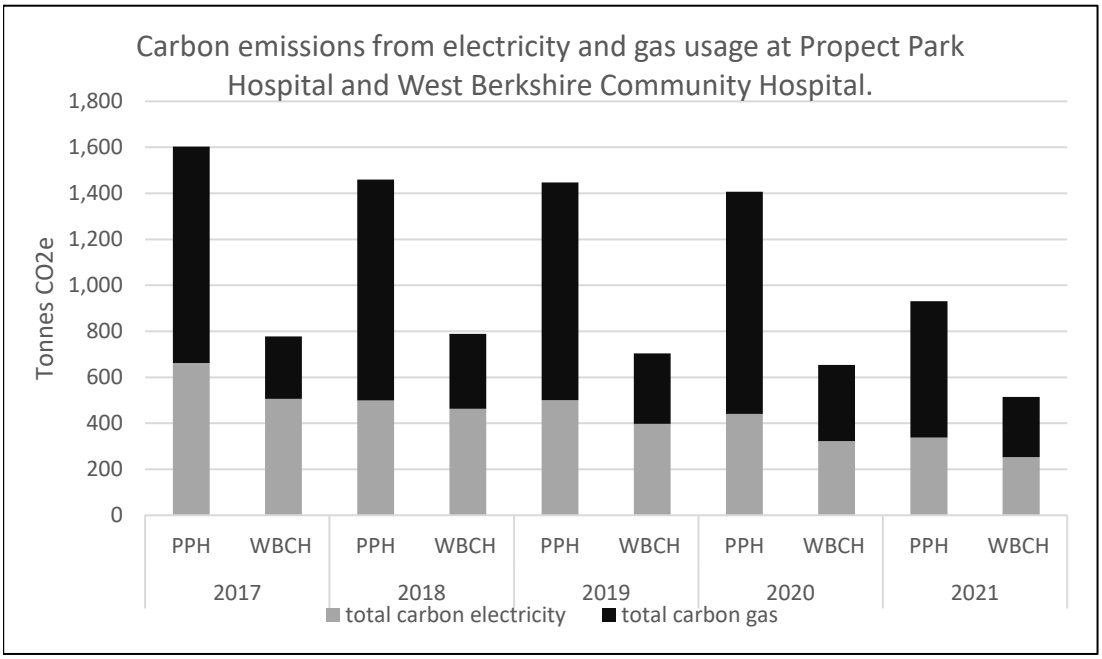
The 2021 figure for carbon emissions as a result of electricity consumption is shaded green to emphasise that this was the first year that we received electricity from renewable sources, which are backed by Renewable Energy Guarantees of Origin (REGO) so assisting the drive to net zero.

The graphs also demonstrate the challenge that we face to decarbonise our carbon emissions from gas consumed primarily for heating and hot water.

Carbon from utilities fact box

This graph shows the associated carbon emissions for the electricity and gas consumed on the sites where the Trust has direct control of the utilities.





What we will do

To decarbonise the utilities, we consume

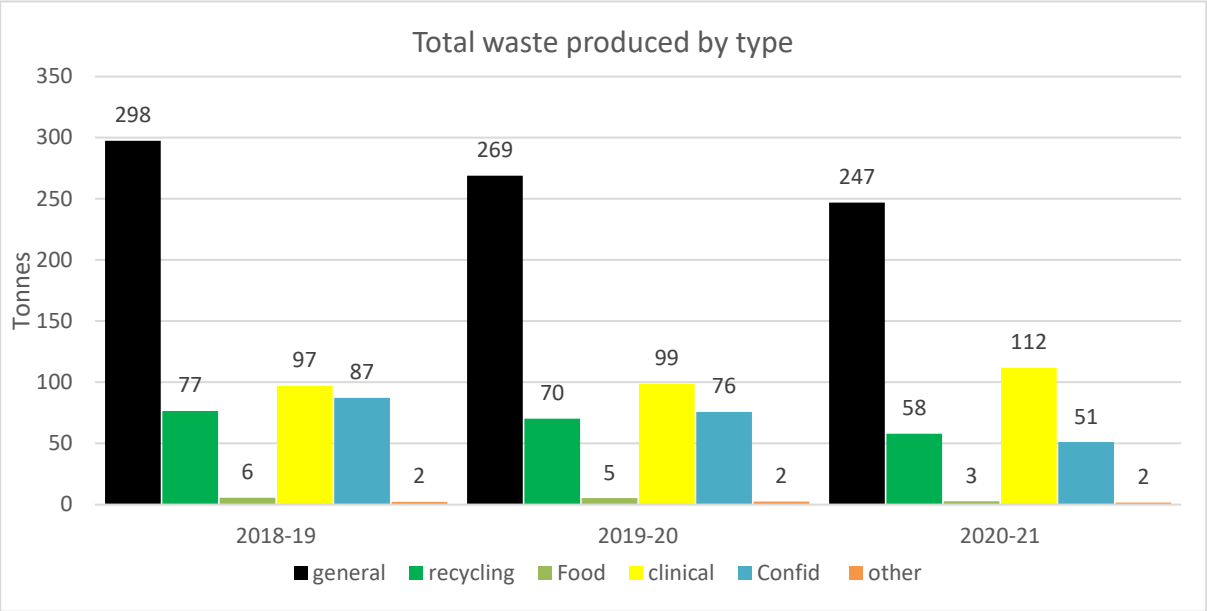
- Increase and improve utility management, measuring and monitoring across for the whole Trust.
- All leased property owners / management to be aligned and committed to net zero (PFI's, NHSPS and private landlords).
- Reduce overall utility consumption
- Ensure all electricity consumed by us is from renewable generation (REGO certification)
- Decarbonise heating across all sites
- Instal renewable energy technology

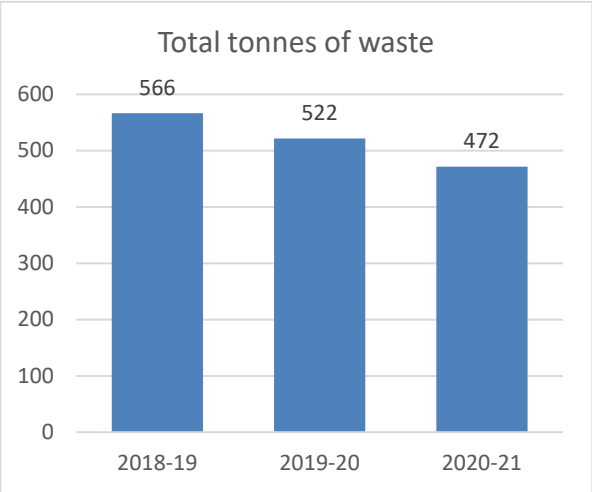
Waste

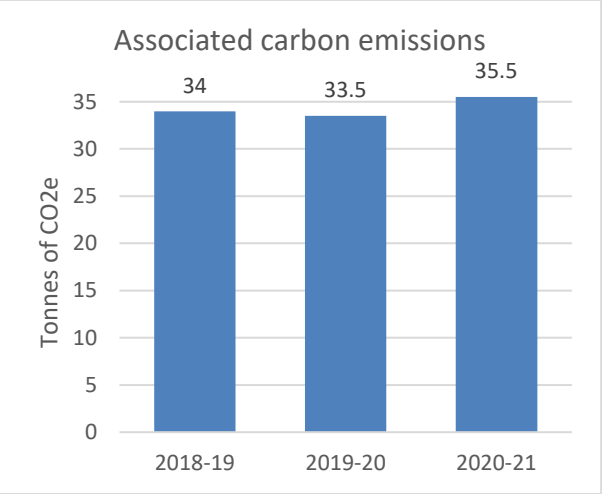
We need to reduce the amount of waste we produce and are responsible for. Doing this will mean fewer resources are consumed. It will reduce the number of materials that need to be removed from site and it will reduce the associated carbon that is directly caused by waste and how it is processed.

Waste fact box

Waste is just a waste of money and resources. Over the last the three years we have seen a marginal drop in total waste







What we will do

To reduce the total waste generated by us

- Increase and improve the measuring and monitor of all waste arising
- Introduce medical equipment and office furniture reuse scheme
- Cut confidential waste – stop printing
- Stop using single use plastic items across all of our activities
- Increase trust-wide recycling
- Increase collection of food waste

Buildings and sites
The buildings we use need to be of a suitable condition to ensure the best levels of energy efficiency, that they are fit to cope with a changing climate and are enhanced to support health and wellbeing of all who work for and visit us.

We also need to enhance our estate from a biodiversity perspective, which includes maximising every available opportunity to plant more trees.

What we need to do
To improve and invest in our estate so it is fit for purpose and supports net zero target
- All capital projects reviewed and assessed to ensure contribution to net zero and sustainability is adequately assessed.
- All future building selection to have net zero as a key consideration
- Set an energy certification threshold level – EPC / DEC / BREEAM rating for building selection.
- Invest in the decarbonisation of building heating and hot water
- Formulate a Trust-wide biodiversity strategy
- Increase planting and tree cover on all sites.

Procurement – 62% of our carbon emissions
The purchase of goods and services accounts for nearly two thirds of our total carbon footprint. Therefore, there needs to be clear focus and consideration in tackling this part of our total greenhouse gas emissions.

This source of carbon emissions is grouped by NHS England as being a part of the NHS's carbon footprint plus or sources that are indirectly controlled by the Trust.

The key and fundamental objective for us is to influence all our goods and service providers to ensure that they are net zero aligned and are taking actions to remove carbon for their operation activities.

What we will do
To make net zero a key consideration for all procurement activities and no longer purchase from suppliers that do not meet or exceed a commitment to be net zero.
- Increase and improve the measuring and monitoring of associate carbon emissions from all goods and service providers
- increase the scope and weight given to contracts and product selection that support and directly reduce associated carbon emissions.
- To only purchase products or services from suppliers that are aligned with net zero commitments
- All contract meetings to be carbon neutral
- Review and select only procurement frameworks that have committed to a net zero target

Adaptation
The is a clear need to adjust and prepare for the change in weather patterns that we will experience as a result of climate change. There will be an increase in extreme weather events which will result in increasing periods of hot weather and more intense storms and rainfall.

The impacts of flooding can be split into two distinct areas, which are direct and indirect.

Direct impact - includes localised flooding on, near or around our estate and includes building fabric failure, drainage systems being overwhelmed

Indirect impact - includes flooding that affects transport infrastructure failures and wider services disruption, for example waste collection and pharmaceutics deliveries. There is also the potential increase in service demand as a result of social care and other NHS Trust facilities being flooded, which would increase pressure on our own sites and services.

What we will do

Ensure that we are prepared and ready for a changing climate

- Implement Climate Change Adaptation strategy
- Require all third-party organisations to include extreme weather impacts in their business continuity plans
- Increase the ability to maintain appropriate temperatures and across patient areas
- Focus on Investing and installing non mechanical cooling infrastructure - shading, insulation, natural ventilation
- Increase tree coverage to provide shading and flood prevention
- Review direct (local) and indirect (region) flood risks and mitigate

The way forward

Now the action needs to begin. The implementation of this Green Plan will allow us to make considerable inroads into reducing our carbon emissions. It will also ensure that change is introduced that will increase our sustainability credentials and reputation.

The Green Plan is very much an umbrella strategy and as such will result in a number of subject-specific strategies which will be focussed, targeted actions. These will include,

- Trust-wide Green Travel Plan
- Site specific Green Travel Plans
- Green Fleet Vehicle Strategy
- Waste Reduction Strategy
- Biodiversity Strategy
- Climate Change Adaptation Strategy

This Green Plan (2022-25) is the start of the Greener NHS programme and will set the foundation for future green plans.

The Action Plan

Please not the Capex figures identified below are indicative and are a clear indication of the type of investment potentially needed to complete a specific action.

Responsibility Key

SM – Sustainability Manager, Mar – Marcoms, L&D-Learning and Development, E – Estates, FM – Facilities, 3rd Party FM – NHSPS, ISS, Bellrock, private landlords, F – Finance, CSM – Clinical Service Managers, P – Procurement, CE - Clinical engagement / input, EP – EPRR Manager, PM – Property Manager

Area of Action	**People**						**Strategic Goals**				
Objective	**Increase the resources to ensure full staff engagement and support.**		**Target**	**All staff to receive training and or have access to net zero n green hero network by 2023**			**Cut carbon emission**	**Stop polluting**	**Health and wellbeing**	**Financial efficiency**	**Reputation**
	Action	**Responsibility**	**Resource**	**Capex**	**By**	**Outcome**					
1.	Develop and support network of net Zero'n'Green hero's	SM,	Staff time Admin support	£20K pa	2022	• A support team of likeminded staff helping to deliver the trust wide changes that endorse net zero and embrace sustainable healthcare	✓	✓	✓		✓
2.	Invest and maintain high quality website / intranet information and guidance for all staff, patients, public and other stakeholders to access	SM, Mar	Staff time consultant	£25k pa	2022	• Provide information to all to empower and enable individuals to make change to achieve net zero and implementing	✓				✓
3.	Actively engage and use social media and sustainability activities	SM, Mar	Staff time		2022	• Utilise this form of communication to inform and promote what the organisation is doing to meet its			✓		✓
4.	Increase training to all staff - make it mandatory and include at induction	SM, L&D	Staff time		2023	• Raise awareness and encourage action by all staff • Ensure all staff engaged in decarbonising BHFT	✓				✓

Area of action	Travel						Strategic Goals				
Objective	**To boost and facilitate the decarbonisation of all trust activities**		**Target**	**To reduce by 50% staff commuting and business travel using ICE 2025**			Cut carbon emission	Stop polluting	Health and	Financial efficiency	Reputation
	Action	**Responsibility**	**Resource**	**Capex**	**By**	**Outcome**					
5.	Measure and monitor all travel data from service delivery and commuting.	SM, F,	Staff time Consultant Software	£5k pa	2022	• Identify change and demonstrate success. Also focus activity where failings are identified. • Promote success.	✓	✓	✓	✓	
6.	Review and implement Trust-wide Green Travel Plan and site-specific plans	SM, FM, E	Staff time Link to Act.7,9,10		2023	• Provide clear alternatives to petrol or diesel powered vehicles. • Reclassify parking spaces to support alternatives to petrol / diesel powered vehicles.					
7.	Provide site specific information on all travel opportunities via intranet and website(s)	SM, M, FM 3rd Party FM	Staff time Link to Action 2	£10k pa	2022	• Actively encourage commuting and busine travel away from ICE powered vehicles.		✓	✓		
8.	Produce and implement Green Fleet Vehicle Strategy.	SM, FM, E, F, Ser M	Staff time Link to Act. 11		2023	• A strategy setting out clear direction regarding Trust owned / leased road vehicles. • Implementation will reduce associated carbon emissions				✓	✓
9.	Roll out an electric vehicle charging network across all the larger sites	E, FM, 3rd Party FM	Link to Act.6, 7,10	£50k pa	On going	• The more chargers there are the more confidence there will be in make the switch to EV's	✓	✓			✓
10.	Promote, develop and encourage active travel	SM, E, FM, M, Mar	Link to Act.6, 7,9	£50k pa	On going	• Benefit health and wellbeing of staff • Enhance Trust reputation • Cut carbon from commuting and business travel • Cut air pollution caused by petrol and diesel powered vehicles	✓	✓	✓		✓
11.	Commit to all leased vehicles to be ultra-low emissions vehicles (ULEVs) or zero emissions vehicles (ZEVs).	SM, F, Finance, CSM	Staff time Link to Action 8		2022	• Decarbonise trust lease / owned fleet • Set a clear example and commitment to remove petrol and diesel powered vehicles from the Trust	✓	✓			✓

Area of Action	Estate – Utilities						Strategic Goals				
Objective	**To decarbonise the utilities consumed by the Trust**		**Target**	**To reduce carbon emission by from 50% gas and electricity usage by 2025**							
	Action	Responsibility	Resource	**Capex**	**By**	Outcome	**Cut carbon emission**	**Stop polluting**	**Health and wellbeing**	**Financial efficiency**	**Reputation**
12.	Increase and improve utility management, measuring and monitoring across for the whole Trust.	SM, PM 3rd party FM	Staff Time		2022	• Clear and detailed understanding of consumption, cost and carbon. • Use to inform and target direct actions • Meet all external reporting requirements	✓			✓	✓
13.	All leased property owners / management to be aligned and committed to net zero (PFI's, NHSPS and private landlords).	SM, PM	Staff time		2022	• Will ensure indirect emissions are being reduced • Will ensure direct emissions are being reduced	✓				✓
14.	Reduce overall utility consumption	All staff	Staff time Link to action 1,2,3,4	£10k	On going	• By cutting consumption the Trust will save money and reduce its directly controlled carbon emissions.	✓			✓	
15.	Ensure **All** electricity consumed by the Trust is from renewable generation (REGO certification)	SM, PM	Staff Time	Policy decision	2022	• This will mean that the Trust has removed via a purchasing decision this source of carbon emissions that it directly controls from its total carbon inventory.	✓			✓	✓
16.	Decarbonise heating across all sites	SM, E, 3rd party FM	Staff time, Consultant, Contractors	Depend on project size	2023	• Reduce and remove a directly controlled source of carbon. • Contribute to meeting net zero target • Reduce operational costs	✓			✓	✓
17.	Instal renewable energy technology (Solar PV is the primary option)	SM, E	Staff time, Consultant, Contractors	Depend on project size	2025	• Energy supply security • Energy cost security • Generate income	✓			✓	✓

						• Enhanced reputation • Maximising trust assets to improve financial position						
Area of Action	**Estate – Waste**											
Objective	**To reduce the total waste generated by the Trust**		**Target**	**To reduce the amount of waste generated by the Trust by 10% by 2023.**								
	Action	**Responsibility**	**resource**	**Capex**	**By**	**Outcome**						
18.	Increase and improve the measuring and monitor of all waste arisings.	SM, FM, 3rd Party FM	Staff time	£10k pa	2022	• Provide improved data on the Trust waste arisings to inform and identify targeted actions . • Meet all mandated reporting.	✓			✓	✓	
19.	Introduce medical equipment and office furniture reuse scheme	SM, FM, E, CE	Staff time	£15k pa	2024	• Save money by not buying new equipment and diverting equipment from waste stream	✓			✓	✓	
20.	Cut confidential waste	All staff	Staff time Training – link to Action 2, 4		2022	• Reduce consumption of paper usage, reduce printer consumable, reduce confidential waste. • Reduce operational costs. • Printer and paper cost = £400k pa creates 134 tonnes of paper waste.	✓			✓	✓	
21.	Stop using single use plastic items wherever possible.	All staff P, CE	Staff time Policy decision		2022	• Stop using oil based resource • Reduce waste generation • Enhance trust reputation	✓	✓			✓	
22.	Increase Trust wide recycling	SM, FM, E All staff	Policy decision		2022	• Reduce general waste tonnage • Enhance trust reputation		✓			✓	
23.	Increase collection of food waste	FM, 3rd Party FM P	Policy decision	£5k pa	2023	• Reduce contribution to carbon emissions • Reduce general waste	✓	✓			✓	
Area of Action	**Estate – Buildings and Site**											
Objective	**Improve the estate to achieve net zero target and enable sustainable healthcare**		**Target**	**All Trust buildings to have met a minimum energy rating by 2025 and all sites to have at least one tree pant project by 2023**								
	Action	**Responsibility**	**resource**	**Capex**	**By**	**Outcome**						

24.	All capital projects to contribution to net zero and sustainability.	SM, E,	Staff time Consultants Contractors	Link to act. 16	2022	• Net zero and sustainability are inclusive and considered at project inception. •	✓				✓
25.	Net zero to be a key consideration for all building and site selection.	SM, E,	Policy decision		2022	• Save utility running cost • Increase trust reputation • Reduce direct controlled carbon emissions	✓			✓	✓
26.	Set energy rating threshold for EPC / DEC / BREEAM certification.	E, PM	Policy decision		2022	• Ensure all buildings that the Trust use meet a minimum energy rating • Reduce utility expenditure	✓			✓	✓
27.	Inform and guide all on energy efficiency actions	SM, E,	link to action2 consultant	£20k	2022	• Reduce utility expenditure • Enhance reputation • Staff engagement and support					
28.	Formulate and implement Trust wide biodiversity strategy	SM, E, 3rd Party FM	Staff time, Consultant Contractor	£15k	2023	• Will ensure that the trust is meeting future environmental legislation • Improve health and wellbeing provision for staff and patients. • Support the rewilding and greening of all sites •	✓		✓		✓
29.	Increase planting and tree cover on all sites.	SM, E, 3rd Party FM	Staff time, Consultant Contractor	£20k pa	2023	• Trees will absorb and store carbon • The enhance the environment – air quality, reduce flooding, screen noise, • Enhance health and wellbeing for staff and patients • Enhance Trust reputation	✓	✓	✓	✓	✓

Area of Action	Procurement							Strategic Goals				
Objective	**To make Net Zero a key consideration for all procurement activities.**		**Target**	**All procurement activities to consider and promote net zero and sustainable products and service by 2025**				Cut carbon emission	Stop polluting	Health and wellbeing	Financial efficiency	Reputation
	Action	**Responsibility**	**resource**	**Capex**	**By**	**outcome**						
30.	Increase and improve the measuring and monitoring of associate carbon emissions from all good and service providers	SM, P	Staff time		2022	• Provide detailed information on the actual carbon associated to the services / products provided to the trust		✓				✓
31.	Increase the scope and weight given to contracts and product selection that are aligned with net zero commitments and sustainability.	SM, P	Staff Time	Policy decision	2022	• Support and encourage all product and service providers to address their carbon emissions. • Enhance Trust reputation and leadership in relation to net zero and sustainability healthcare provision		✓	✓			✓
32.	Apply and develop Sustainable Procurement Policy to ensure the Trust uses frameworks and purchases products or services from suppliers that are aligned with net zero commitments and sustainability	SM, P	Staff time	Policy decision	2022	• Support and encourage all product and service providers to address their carbon emissions. • Enhance Trust reputation and leadership in relation to net zero and sustainability healthcare provision		✓	✓			✓

Area of Action	Adaptation						Strategic Goals				
Objective	**Ensure that the Trust is prepared a changing climate**		**Target**	**Proactive and planning in place to manage extreme weather events by 2023**			Cut carbon emission	Stop polluting	Health and wellbeing	Financial efficiency	Reputation
	Action	**Responsibility**	**resource**	**Capex**	**By**	**Outcome**					
33.	Implement Climate Change Adaptation Strategy	SM, E, FM, CE	Staff time		2023	• The trust is prepared for changing weather patterns and the impact upon healthcare demands and delivery. • Implementation will reduce financial impacts as a result of extreme weather conditions			✓	✓	✓
34.	Require all third-party organisations to include extreme weather impacts in their business continuity plans.	SM, P, EP	Staff Time		2023	• Receive assurance that third party service providers have planned for extreme weather condition to ensure service continuity.				✓	✓
35.	Increase the ability to maintain appropriate temperatures and across patient areas.	E, FM, CE	Staff time, Consultants	£20k pa	2023	• Improved monitoring of temperatures allowing focused actions	✓		✓	✓	✓
36.	Invest and instal nonmechanical cooling infrastructure - shading, insulation, natural ventilation	E, CE	Staff time, Consultants	£50k pa	2023	• Improved internal conditions for patients and staff. • Reduce the need for retrofit AC installations – save Capex • More energy efficient and so save money	✓		✓	✓	
37.	Increase tree coverage to provide shading and flood prevention	SM, E, 3rd Party FM	Staff time, Contractor	Link to Action 28	2023	• Improve site biodiversity and rewilding • support carbon sequestration – imperative for net zero • support health and wellbeing for patients and staff • Increase reputation by enhancing site appears	✓		✓	✓	✓
38.	Review direct (local) and indirect (region) flood risks and mitigate.	SM, EP, E	Staff time, consultants	£20k	2022	• Link into all EPBC activities • Identify potential site specific flood risks • Raise awareness and indirect impacts upon the trust form wider reginal flooding.				✓	✓

Trust Board Paper

Meeting Date	8th February 2022
Paper Title	Quarterly Status Report on Key Trust Initiatives
	Item for Noting
Purpose	This document updates Board members on the current status of the Trust's key programmes and projects
Business Area	Corporate
Author	Director of Projects
Presented by	Alex Gild, Deputy Chief Executive
Relevant Strategic Objectives	The portfolio of initiatives addresses all the Trust's True North goals
CQC Registration/Patient Care Impacts	The portfolio of programmes and projects includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience.
Budget/Resource Impacts	As per individual projects
Equalities, Diversity and Inclusion Implications	n/a
Brief Executive Summary	Paper to provide assurance and oversight of the Trusts Strategic initiatives and the projects that will deliver True North and strategic priorities. The report provides a status update on the Trust's combined programme, projects, and strategy implementation.
Recommendation/ Action Required	The Board is asked to note the status of the Trust's key initiatives.

Quarterly Status Report on Key Trust Initiatives

Author: Karen Watkins & Neil Murton, Director of Projects

Director: Alex Gild, Deputy Chief Executive

Date: 1st February 2022

Purpose

This document has been prepared to update the Trust Board at its February 2022 meeting regarding the current status of the organisation's portfolio of key programmes and projects prioritised as Mission Critical and Important, together with other priorities and initiatives to deliver the Trust's vision and Trust North Goals.

Members of the Trust Board are asked to review and note the report.

Document Control

Version	Date	Author	Comments
1	25.01.2022	Karen Watkins & Neil Murton	The document includes an updated version of the Combined Projects/SIP Report submitted to the Business & Finance Executive on 24th January 2021

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Combined Programme/Project & Strategy Implementation Plan Status Reporting	Jan 2022	Karen Watkins Director of Projects
Status Report on Trust Strategic Initiatives	Sept 2021	Karen Watkins Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	May 2021	Karen Watkins, Director of Projects
Status Report of Trust Strategic Initiatives as impact by the COVID-19 Pandemic	Feb 2021	Neil Murton Director of Projects

CONTENTS

Purpose of Paper

To provide an update, assurance and oversight of the Trusts Strategic initiatives and the projects that will deliver True North and strategic priorities.

Introduction

The Trust identifies its significant strategic projects and programmes through a strategic prioritisation process which references a Strategic Filter. This process was established as part of the Trust's Quality Improvement (QI)Programme and provides the Trust with control over its programme and project portfolio, including assurance that it is focusing on the right priorities ("True North") and that there is best use of resource in the organisation.

Strategic prioritisation is designed to:

• identify emerging key schemes (both within and external to the Trust)
• facilitate their consideration against the Trust's priorities
• decide if they should proceed and if so, how they will be resourced, managed and monitored.

New schemes are considered following Standard Work and referencing a Strategic Filter which informs decisions regarding their priority status, which may be:

- Mission Critical
- Important
- Important – wait
- Important - pause
- Managed locally
- Rejected

Mission Critical and Important schemes require Executive oversight and as the status indicates, Mission Critical schemes are those that must proceed and be resourced. "Important" schemes may be paused to release resources to support those of higher priority.

Prioritised projects are included on the Trust's Strategic Prioritisation Board and progress of those projects is monitored at Executive level through a monthly Report to the Executive Business & Finance Group. That report has been provided to Board Members in May and September 2021 and again in December 2021 to provide an update on the Trust's key schemes. On this occasion, it has been requested that an overview be provided for members, rather than the full report. An overview is provided of the projects and programmes on the Strategic Prioritisation Board, including the highlighting of newly established initiatives; those moving to business as usual; those recently closed together with any initiatives currently reporting an Amber or Red RAG status.

A review of the above arrangements is currently underway, in line with the QI approach of continuous improvement. A key factor in future strategic prioritisation arrangement is the role of he newly established Transformation Delivery Group, through which the Trust is seeking to achieve enhanced visibility and oversight of current and emerging change activities (particularly those forming part of the implementation of strategies and also system initiatives) and the resources they consume.

Projects currently included on the Corporate Strategic Prioritisation Board

The current portfolio of prioritised programmes and project included on the Strategic Prioritisation Board are listed below, against the True North goals they support. Larger scale projects will inevitably support more than one True North Goal and therefore the groupings below reflect the main True North goal the project supports.

Supporting True North Goal 1 – Harm Free Care (Providing safe services) • Quality Improvement Programme • CMH Framework Programme (trusted assessment, formulation and safety plan) • CHS ePMA • Safety Strategy • CYPF Referral Management System	**Supporting True North Goal 3 – Good Patient Experience (improving outcomes)** • Berkshire West Ageing Well Accelerator Site • Berkshire East Ageing Well • CAMHS Clinical Pathways • EDI Strategy • East Children's Therapies • CAMHS Tier 4 Service Transformation • Information Technology Architecture Strategy • Frimley CMH Transformation (Phase2) • BOB CHS Transformation • Connected Care (BOB and Frimley STP areas) • Patient Experience Measure • Neurodiversity Strategy • Reading Estates – Reading Review
Supporting True North Goal 2 – Supporting Our People (A great place to work) • People Strategy • Transfer of EFM Services to NHS Property Services	**Supporting True North Goal 4 – Money matters (A financially sustainable organisation)** • PPH Bed Optimisation • Green Plan • Redevelopment of east community Hospitals (Frimley Integrated Care Hub Programme) • Replacement of Fitzwilliam House

Recent changes to the portfolio of Programmes and Projects

Detailed below, are programmes and projects that have recently been established and added to our Strategic Prioritisation Board; established schemes now moving to business usual, together with initiatives that are now closed.

New Key Initiatives

Supporting Trust North Goal 1: Harm-free care - Providing safe services

CYPF Referral Management System – This was considered and prioritised as Important in October. This initiative is to improve the quality of information received to triage and improve the efficiency of CYPF triage systems and processes.

Supporting True North Goal 4: Money Matters - a financially sustainable organisation

Prospect Park Bed Optimisation – This was considered and prioritised as Mission Critical in October. Theis project will build on the work previously undertaken in eliminating the avoidable use of Out of Area (OAP) beds and reducing length of stay locally due to current pressures. There is an NHSE/I trajectory to achieve zero inappropriate acute OAPs by 31st March 2022.

The following initiatives are now moving to business as usual

Supporting True North Goal 1 – Harm Free Care (Providing safe services)

Quality Improvement Programme (including QMIS) – Moving to business as usual, although transition to a business partnering model has been delayed until Summer 2022, due to senior staffing changes.

CAMHS Tier4 Service Transformation - An out of hospital service has been established, enabling the closure of the Willow House Tier 4 inpatient service on 30th April. The Tier 4 team is now based in upgraded accommodation in Wokingham and offering day care and some home treatment. The Closure Report for the project is due to be presented in April 2022.

Supporting True North Goal 3 – Good Patient Experience (improving outcomes)

Patient Experience Measure – The new Patient Experience Surveys went live in December 2021. The first two phases are now concluded (Phase 3 being a three-year contract with “I Want Great Care”. There will be on-going oversight from the Quality Exec.

Connected Care – This IT initiative within both BOB and Frimley is finally moving to business as usual in Quarter 4 of 2001/22.

The following initiatives have been closed:

Supporting True North Goal 3 – Good Patient Experience (improving outcomes)

EUPD pathway – The establishment of an operational end to end pathway for people with emotionally unstable personality disorder. This was successfully completed, with a Closure Report submitted and approved in September and a presentation to the Audit Committee in October.

Information Technology Architecture Strategy (ITAS*)* – The Closure Report was presented and approved in January bringing to a conclusion a major programme delivering several foundational technology projects in support of the Trust's 2016-2021 IM&T Strategy. The programme's benefits were particularly demonstrated during the 1st Wave of Covid lockdown in March 2020 when most of the Trust moved to home/remote working and the IT infrastructure was in place to support this.

Move of Learning Disability Assessment & Treatment facilities from the Campion Unit to Jasmine Ward, Prospect Park Hospital – The completion of this scheme was delayed as a direct consequence of Covid restrictions. The project was closed in October with good feedback received both regarding the new environment and also regarding the conduct of the project and building contract.

Gateway to all mental health services – Transformation of entry arrangements into adult mental health services, including CPE, talking therapies and the third sector. The Closure Report was presented and approved in October with the understanding that some residual matters will be addressed through Mental Health Transformation and also the Community Mental Health Framework Programme (Trusted Assessment, Formulation and Safety Plan).

Other programmes and projects concluded during 2021/22 have been:

- COVID Recovery Programme
- Berkshire Healthcare Induction
- Reading Estates Phase 1
- Global Digital Exemplar (GDE)

Summary of Progress to end of January 2022 – based on RAG ratings

Mission Critical Projects

There are currently nine mission critical projects on the Trusts Strategic Prioritisation Board. Of these six are on track and rated as Green.

Two projects are rated at Amber:

Supporting Trust North Goal 2: Supporting Our Staff – A Great Place to Work

- The **People Strategy** which includes a number of workstreams - Overall status is Amber - Attracting & retaining staff now Red due to turnover continuing to increase.
  Training & Clinical Education, Just Culture and the Talent & Leadership workstreams are rated at amber rated at Amber. All other work steams within the strategy are Green.

Supporting True North Goal 3 – Good Patient Experience (improving outcomes)

- The EDI Strategy is currently rated amber due to the impending loss of two key members of the EDI Team. Recruitment is underway but posts are not likely to be filled prior to the departure of the current members.

The East Children's Therapies initiative (supporting True North Goal 3) is rated Red due to a number of risks including:

- project posts not being appointed to. An external company has now been appointed by the CCG to support and a project manager is now in place, but the project has been delayed.
- commitment across the system is not fully embedded.
- the impact of COVID and long wait times resulting in clinicians being overwhelmed.

Important Projects

There are currently five important projects on the strategic prioritisation board. Two are rated green.

Two projects are rated as amber:

Supporting Trust North Goal 1: Harm-free care - Providing safe services

- **ePMA** rated at amber due to the project start being delayed by recruitment of project staff and two changes of project manager, but most significantly by a) Pharmacy service vacancies impacting ability to support the project team, and b) a maintenance release/update of the EPMA software programme. The project board agreed that the go-Live date to be moved by 6 months, from March to September 2022.

Supporting Trust North Goal 4: Money Matters (A Financially Sustainable Organisation)

- **Green Plan** – the project is rated at amber due to unknowns around the impact of changes as a result of COP 26 and the letter to all Trust CEO's from the Secretary of state for health and social care (dated the 8th Nov 2021). These are currently being reviewed and will impact on delivery of the project along with further announcements that are expected. The climate emergency declaration and net zero target date still need to be determined and are dependent on the Trust agreeing.

The **CYPF Referral Management System** project has yet to commence reporting. Arrangements for resourcing this requires clarification and if this cannot be resolved in the next month, the initiative will be paused.

CONCLUSION

The Trust has successfully concluded a number of major programmes and projects this year in pursuit of its True North Goals and continues to achieve good progress with its current portfolio of initiatives to that end. With the establishment of a Transformation Delivery Group, the Trust is seeking to achieve even better visibility of current and emerging change activities (particularly those forming part of the implementation of strategies and also system initiatives) and the resources they consume.

ACTION

The Committee is asked to note the progress of the strategic projects and initiatives.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	8 February 2022
Title	Health & Safety Annual Report 2021
	ITEM FOR NOTING
Purpose	To provide the Board with the annual Health & Safety report for 2021
Business Area	Operations & Estates
Author	Chief Operating Officer
Relevant Strategic Objectives	To provide accessible and safe environments which keep patients safe, supports our staff, provides good patient experience and is cost effective.
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and the delivery of safe and responsive care
Resource Impacts	None
Legal Implications	Report seeks to provide assurance of Trust's adherence to relevant legislation
Equalities, Diversity and Inclusion Implications	N/A
SUMMARY	The attached paper provides the Board with the Trust's annual Health & Safety report, highlighting key areas of performance and providing assurance on relevant internal processes.

ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
Health & Safety - Annual Report 2021

Executive Summary

This report provides an update to the Board on Berkshire Healthcare's Health and Safety performance statistics for the calendar year 2021

The report reviews Trust performance on a range of categories, comparing results to the previous year and national figures. Key points of note include:

- The Trust received no Enforcement Notices from the HSE or the Local Authority in 2021.

- There were eight incidents reported under the RIDDOR regulations in the year 2021, (no false reports) showing a decrease of one incident compared to 2020. Manual Handling, Assaults and Slips, Trips & Falls are the main incident types reported under RIDDOR.

- During 2021 the Trust reported 861 physical assaults against staff. This is an increase of 283 (49%) compared to 2020. The Trust also reported 938 Non-Physical Assaults against staff, an increase of 512 (120.2%) over the previous year.

- During 2021 the Royal Berkshire Fire and Rescue Service undertook three fire safety visits to ensure the Trust is compliant with the Regulatory Reform (Fire Safety) Order 2005.

- Seven fires were reported during 2021. All seven were arson, with one being in the community at a patient's home, and six at Prospect Park Hopsital. This is an increase of 133% on the previous year's arson figure.

- Compliancy in statutory training: Fire Awareness – The number of staff trained throughout 2021 has averaged 89.15% over the year. This falls short of the Trust's target of 95% compliance.

- Compliancy in statutory training: Health & Safety - The number of staff trained throughout 2021 has averaged 94.53%. This is above the Trust's target of 90% compliance.

- The overall sickness rate for 2021 was 4.26%, an increase from 4.05% in 2020. The most common reason for absence remains anxiety/stress/depression, accounting for 28% of all sickness in the 12-month period. Covid related sickness accounted for 16.5% of all sickness in 2021, a reduction from 18.7% in 2020. Absences attributed to musculoskeletal/back problems remained consistent with last year, at 15.7%.

- The number of FTE days lost to sickness in 2021 has increased by 9.5% when compared to 2020. The overall sickness rate for Covid related sickness for the year was 0.70%. If Covid related sickness is excluded from the figures, the overall sickness rate for 2021 was 3.56%, an increase from 3.29% in 2020.

1. Key National Annual Figures

The most recent data from the Health and Safety Executive highlights the following issues:

- **1.7 million** working people were suffering from a work-related illness (up from previous year).
- **0.8 million** workers suffering from work-related stress, depression or anxiety
- **142** workers were killed at work (up from 111 in 2020).
- **51,211** injuries to employees reported under RIDDOR (down from **65,427).**
- **441,000** injuries occurred at work according to the Labour Force Survey (down from **693,000**).

The coronavirus (COVID-19) pandemic has impacted health and safety statistics in 2020/21. No new data on working days lost and economic costs is available. However, two new measures have been developed to explore the impact of coronavirus on work-related ill health in 2020/21:

- **93,000** workers suffering from COVID-19 in 2020/21 which they believe may have been from exposure to coronavirus at work (new or long-standing).
- **645,00*** workers suffering from a work-related illness caused or made worse by the effects of the coronavirus pandemic (new or long-standing) in 2020/21. Around 20% of those suffering were in human health and social work activities. (*Excludes the 93,000 workers in the first statistic).

2. Enforcement

There have been no enforcement actions from Royal Berkshire Fire & Rescue Authority or the Health & Safety Executive during 2021.

3. The Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

During 2021 there were 8 RIDDOR incidents which fell into the following categories:

RIDDOR Incident Type	2020	2021
Manual Handling	2	2
Assault	-	4
Injured during physical restraint	1	-
Slip, Trip or Fall	2	2
Sharps Injury	-	-
Collision Struck by moving object	-	-
Case of disease	4	-
Total	9	8

RIDDOR incident reports, including root cause analysis and remedial actions taken, are included in quarterly Trust performance reports at NCRM Committee and tabled at the Joint Staff Consultative Committee.

Health & Safety Training Compliancy 2021

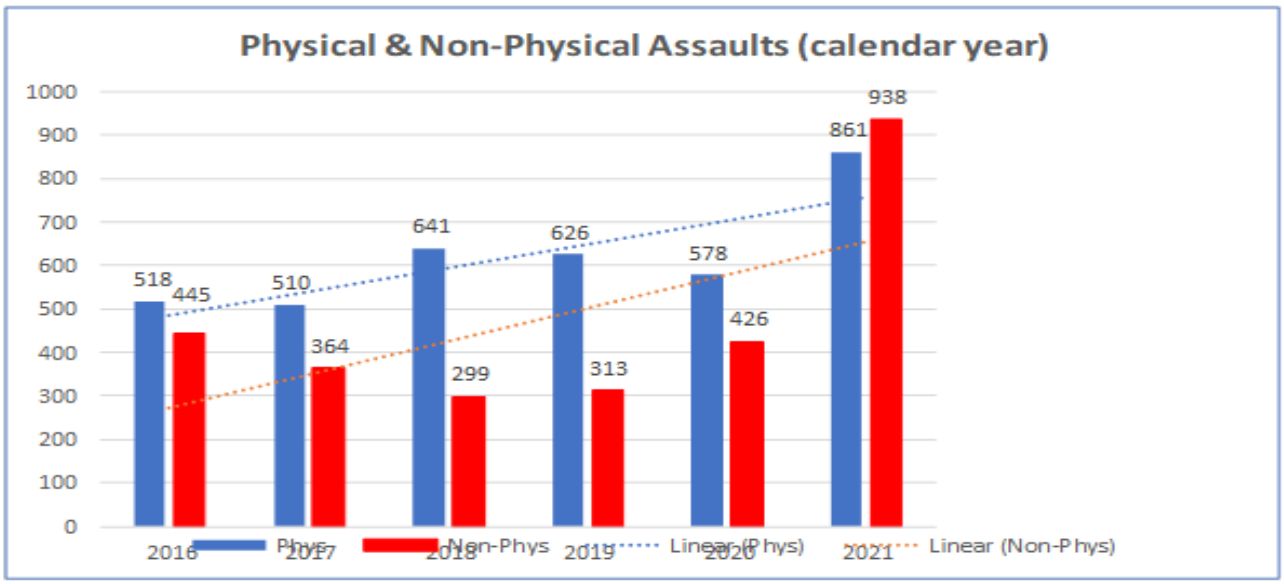
All staff under-take statutory and mandatory training in Health & Safety every 5 years.

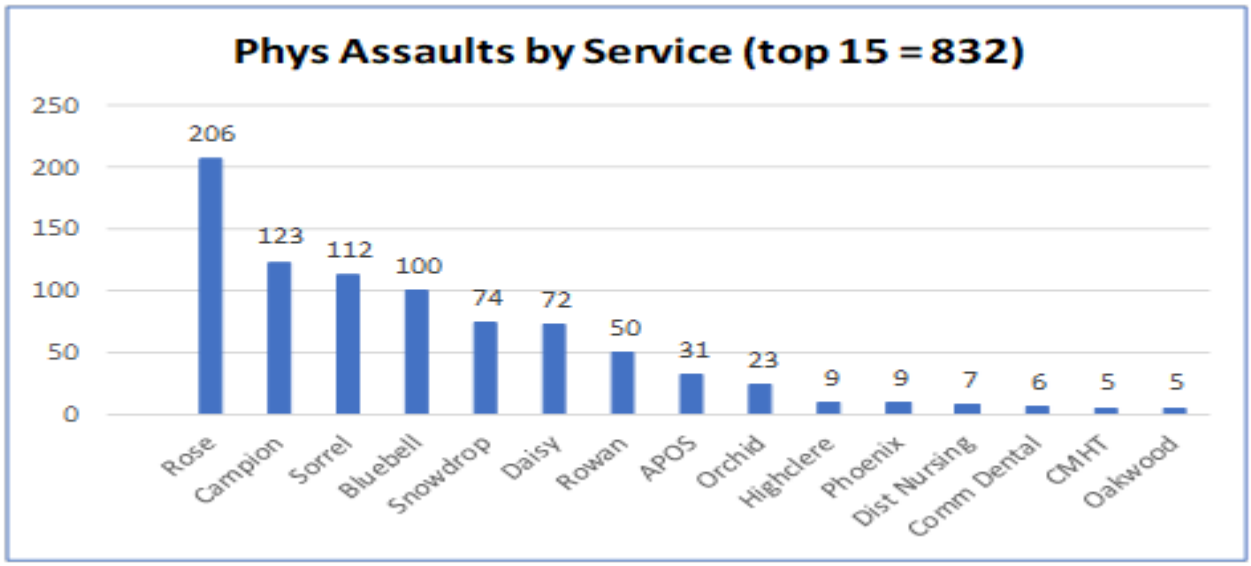
The number of staff trained through out 2021 has averaged 94.53%. This is above the health and safety training target of 90%. Manual Handling training has been marginally below the compliancy training target of 90% with 89.69% of staff trained on average throughout the year.

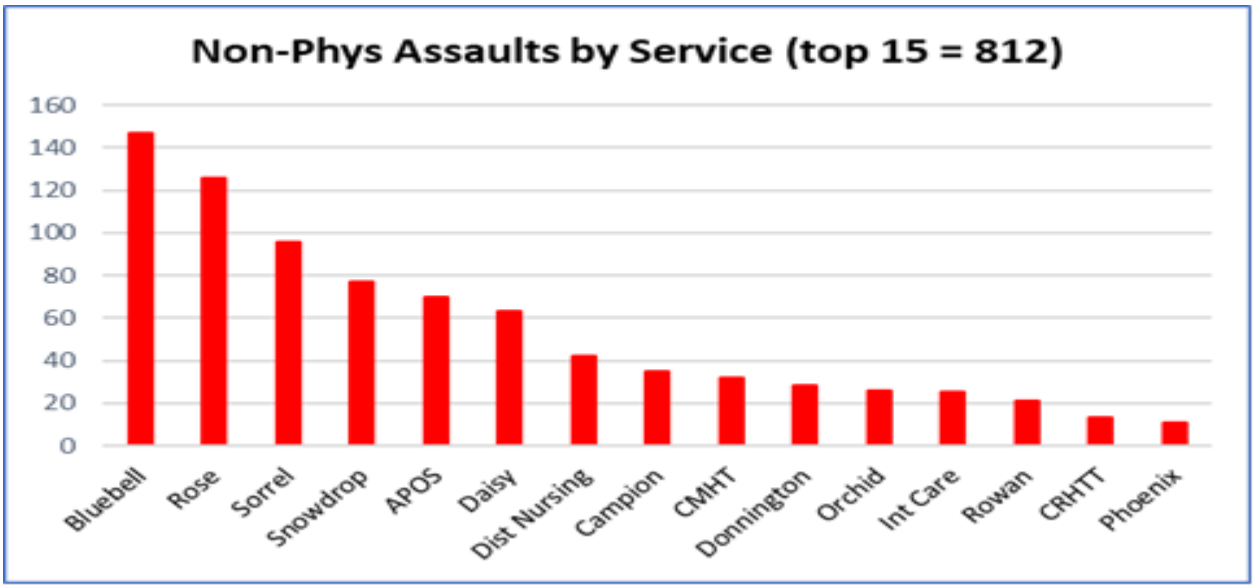
Health & Safety Training Compliancy 2021 (Statistics provided by Learning & Development)												
Statutory Training	**Jan 2021 %**	**Feb 2021 %**	**Mar 2021 %**	**Apr 2021 %**	**May 2021 %**	**Jun 2021 %**	**Jul 2021 %**	**Aug 2021 %**	**Sep 2021 %**	**Oct 2021 %**	**Nov 2021 %**	**Dec 2021 %**
Health & Safety	**95.78**	**90.07**	**91.99**	**95.13**	**95.11**	**95.13**	**95.08**	**95.02**	**95.39**	**95.51**	**95.81**	**94.36**
Moving & Handling	**93.82**	**86.08**	**86.41**	**87.81**	**88.64**	**88.93**	**90.02**	**90.08**	**91.22**	**91.29**	**91.37**	**90.70**

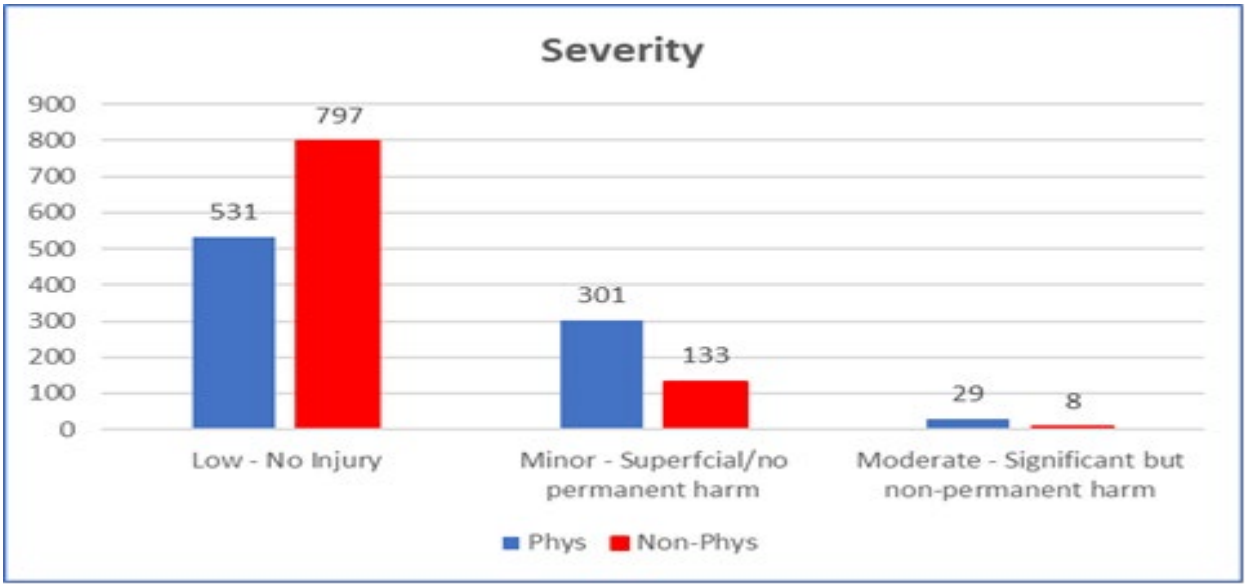
4. Violence and Aggression

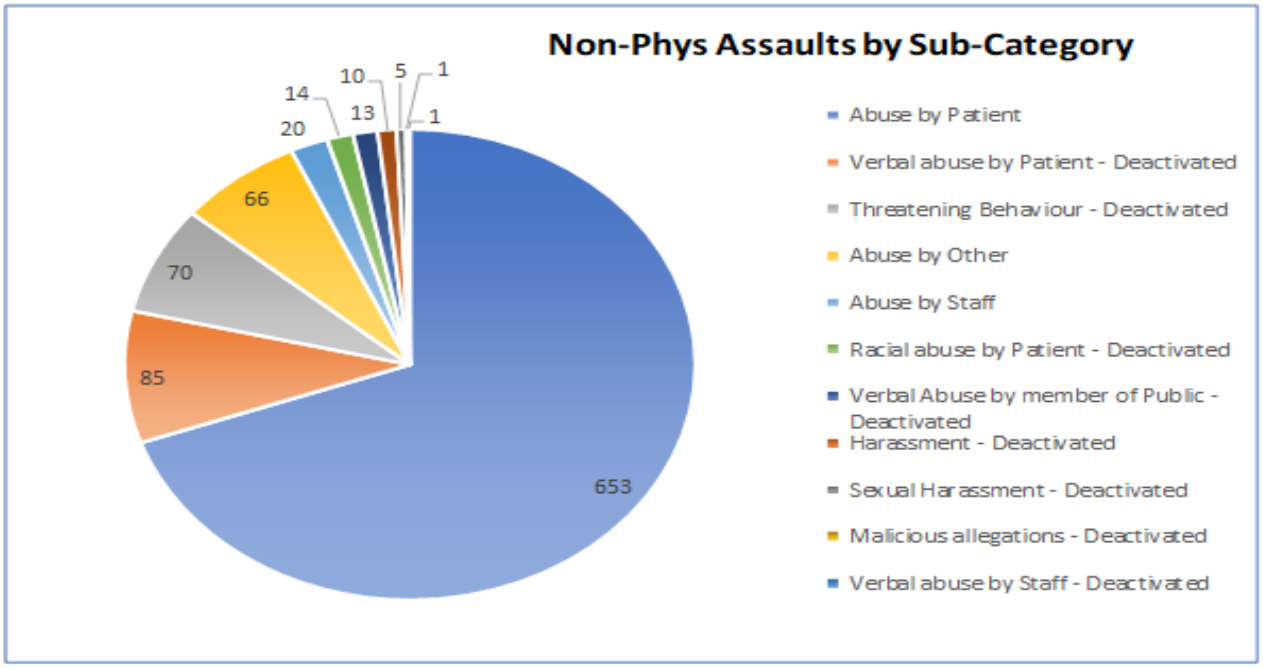
- 861 physical assaults against staff were reported during the period, which is an increase of 283 (49%) compared to 2020.
- 791 (95%) of the assaults took place on the mental health adult admission wards, PICU and older persons MH wards compared to 402 in 2020 which is an increase of 389 (97%) assaults.
- The number of reported Non-Physical Assaults has increased from 426 in 2020 to 938 in 2021 (120.2%). 832 of these incidents were carried out by patients.
- Despite the rise in numbers of both Physical & Non-Physical Assaults against staff compared to 2020, 1,328 (73.8%) were categorized as “Low – No Injury”.

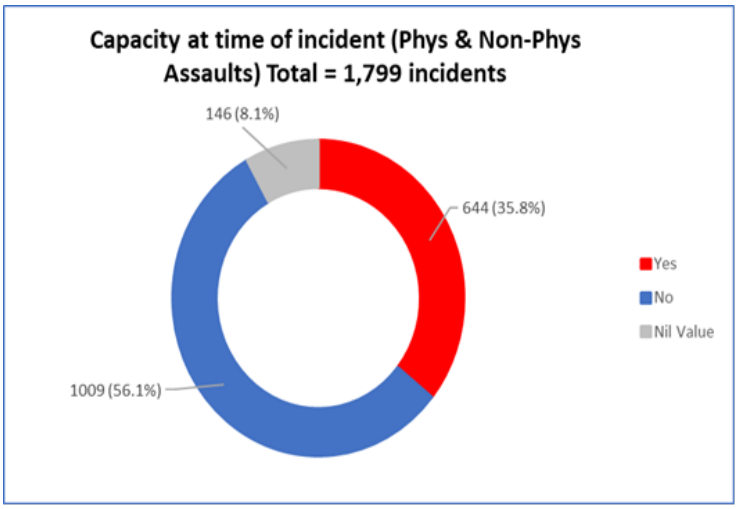



Phys Assaults by Service (top 15 = 832)
250
200
150
100
50
0
206
123
112
100
74
72
50
31
23
9
9
7
6
5
5
Rose
Campion
Sorrel
Bluebell
Snowdrop
Daisy
Rowan
APOS
Orchid
Highclere
Phoenix
Dist Nursing
Comm Dental
CMHT
Oakwood


Non-Phys Assaults by Service (top 15 = 812)
160
140
120
100
80
60
40
20
0
Bluebell
Rose
Sorrel
Snowdrop
APOS
Daisy
Dist Nursing
Campion
CMHT
Donnington
Orchid
Int Care
Rowan
CRHTT
Phoenix


Severity
900
800
700
600
500
400
300
200
100
0
531
797
301
133
29
8
Low - No Injury
Minor - Superfcial/no permanent harm
Moderate - Significant but non-permanent harm
Phys
Non-Phys





The Health, Safety & Security Management Specialists continue to raise the importance of reporting security-related incidents, particularly incidents of violence and aggression, via the Trust's incident reporting system.

It is acknowledged that the significant majority of physical and non-physical assaults are the result of a patient's mental health or medical condition, but it is important that this data continues to be captured and those affected are supported.
644 (35.8%) of all physical and non-physical assaults reported during the period were perpetrated by individuals (predominantly patients) where the indication is that they had capacity at the time of the incident. This therefore suggests that these incidents might be categorized as potentially "criminal" in nature.

Very few of these incidents reach judicial resolution with the appropriate sanctions applied. Either the victim chooses not to go down the route of reporting the incident to the police or there is lack of sufficient evidence to pursue a case or satisfy criteria required by the Crown Prosecution Service.

There is significant work underway to re-enforce the Trust's zero tolerance stance against violence & aggression towards staff, with targeted work at Prospect Park to address the high levels of Racial abuse.

The successful application of appropriate sanctions against willful and intentional violent or abusive behaviour would show:

- Greater support for victims of violent or aggressive behaviour.
- A zero tolerance stance for those who willfully abuse staff.
- Show to all perpetrators that this type of behaviour is not tolerated and should act as a deterrent.

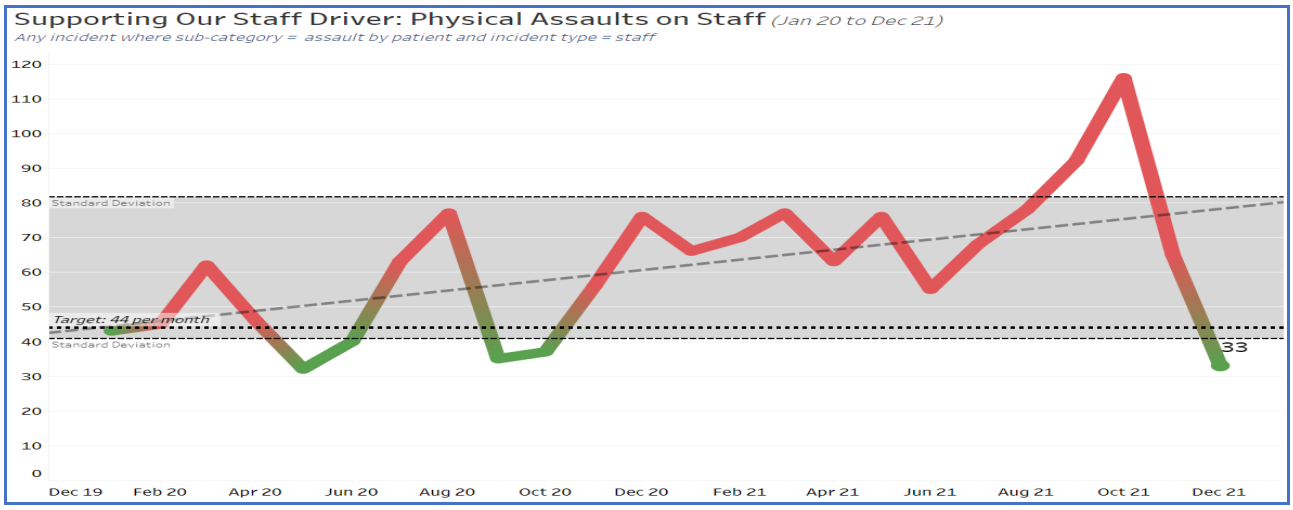
To that end the Health, Safety & Security Management Specialists will work with Services and other stakeholders to improve on the number of sanctions applied for 2022.

Impact of Covid

There is evidence to support the fact that certain types of violence and aggression have increased due to the current pandemic such as intentional spitting and coughing.

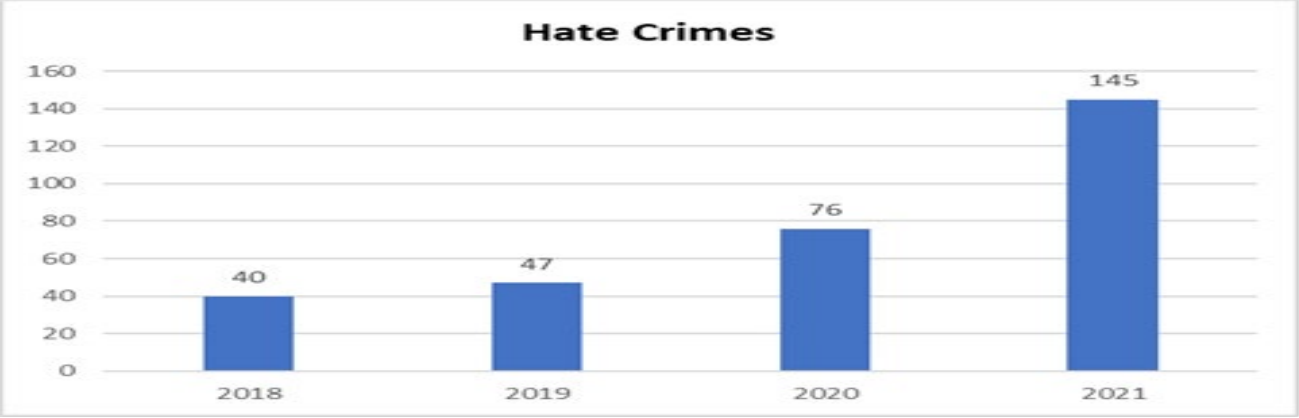
In general, the impact of Covid has meant an increase in physical violence to staff and has increased the likelihood of abusive and aggressive behaviour towards patient facing staff.

The Trust is focused on a reduction of physical assaults on staff which is a Driver metric as part of the performance improvement priorities for Supporting our Staff.

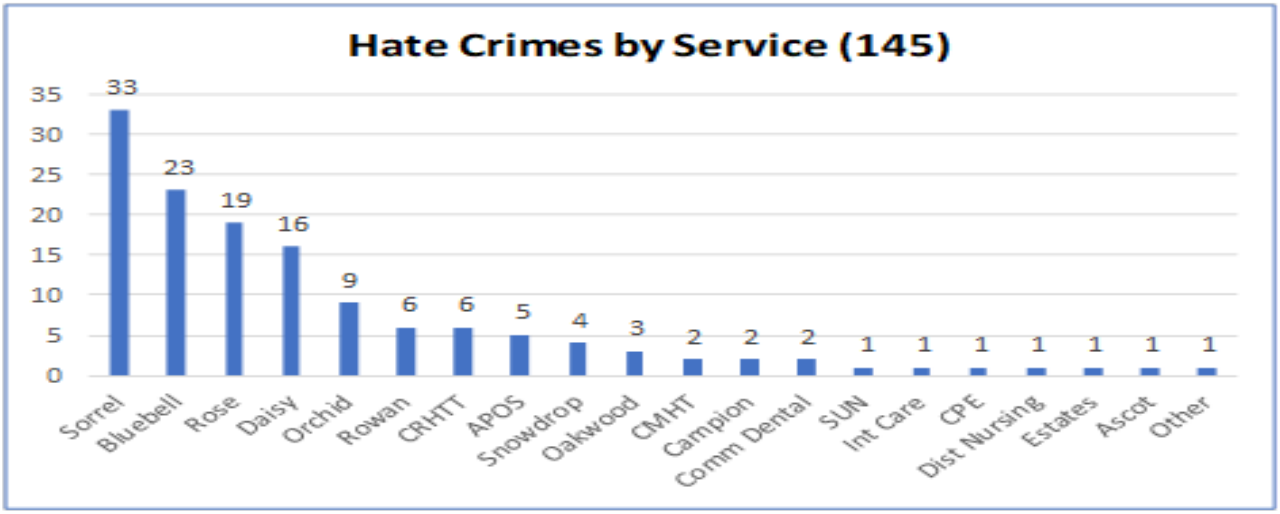


Hate Crimes

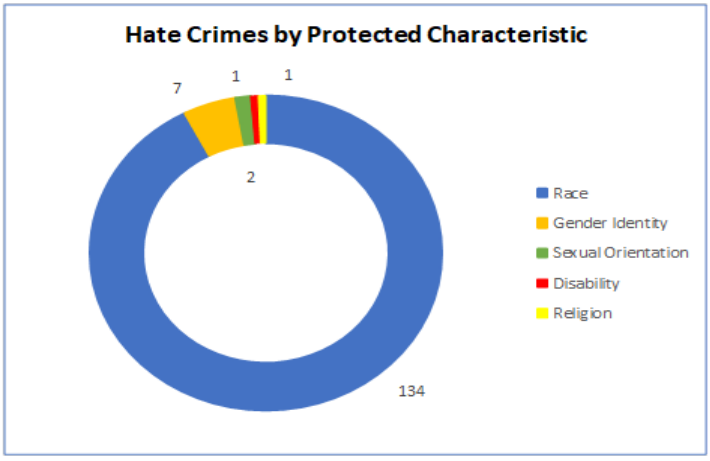
- There were 145 Hate Crimes reported during 2021. This is an increase of 69 (91%) from 2020. Hate crimes can be reported by any of the 5 protected characteristics that come under the definition, disability, race, religion, gender identity or sexual orientation (or any combination thereof). The category includes both Hate Crimes and Hate Incidents.
- They can be reported alongside another category of incident e.g. "patient breaks door and is racially abusive to attending staff member" would be categorised as Criminal Damage with the racial element "bolted" on.



- This steady increase can be seen as a positive in that ease of reporting and a better reporting culture around Hate Crimes can be seen as the cause and not a steady increase in the number of such incidents.
- Acute inpatient MH wards & PICU generated 86.2% of all hate crime incidents.



- 92.5% of the reported hate crime incidents have an element of bias against race



This is a priority for our Equality and Inclusion strategy and there are a number of actions in place to address and improve this.

5. Personal Safety and Lone Working

- During 2021 the 4 separate contracts for the lease of lone worker devices were amalgamated into one new contract ending in September 2022, this provides some cost savings and ensures a smooth end of contract into any proposed new re-tendering process.
- Reports show an average usage per month at approx. 40-50% over the year by all divisions for the 1,142 devices under contract.
- A Lone Working Risk Management Group has been setup to review all aspects of lone working including the risk assessments, associated policies and other tools to help manage lone working. The aim of the group is to increase assurances regarding lone working risk management arrangements and to advise on any improvements.

6. Fire Safety

There has been no enforcement action from Royal Berkshire Fire & Rescue Authority during 2021. Royal Berkshire Fire and Rescue Service (RBFRS) undertook three fire safety visits to ensure the Trust were compliant with the Regulatory Reform (Fire Safety) Order 2005 during 2021 -

1. 16/04/21 RBFRS visited PPH and evaluated the fire safety provided
2. 13/05/21 RBFRS visited PPH following a fire in APOS and evaluated the fire safety provided.
3. 23/11/21 RBFRS visited WBCH and evaluated the fire safety provided.

The Trust was audited by an external Authorising Fire Engineer on Fire Safety Management on 6th/7th October 2021 and a report completed on fire safety arrangements in the Trust.
Of the 26 audit questions and subsequent findings, 23 were recorded as satisfactory, 3 as medium priority with no high priority actions noted. An Action Plan has been developed to address the 3 items recommended, with expected completion date for all actions to be completed by March 2022.

7. Fire Incidents 2021

There were seven fires reported in 2021:

- Patient lit architrave; bedroom Prospect Park Hospital.
- Patient set fire; patient's own home.
- Patient lit newspaper; communal area Prospect Park Hospital.
- Patient ignited chair; communal area Prospect Park Hospoital.
- Patient ignited mattress in APOS Prospect Park Hospital.
- Patient ignited paper and dried plant; bedroom, Prospect Park Hospital.
- Patient set fire to clothing; bedroom Prospect Park Hospital.

There were ten cases of a risk of fire being identified:

- Patient smoking and ignition of paper; Prospect Park Hospital
- Threat to burn down hospital with lighters; Prospect Park Hospital
- No fire retardant linen available; Prospect Park Hospital
- Smoking - safeguarding; patients own home
- Hot iron left on adjacent to clothing, safeguarding; patients own home
- 20 lighters found outside of ward on top of lockers; Prospect Park Hospital
- 4 lighters found in patient bedroom; Prospect Park Hospital
- Faulty extension lead on ward; West Berks Community Hospital
- Smoke from Food Trolley; Oakwood Ward – Prospect Park Hospital
- Newspapers and rubbish stored close to heaters; Community hoarding

There were seven cases of fire equipment being damaged:

- Fire Alarm Call Point damaged; Prospect Park Hospital
- Fire Alarm Call Point damaged; Prospect Park Hospital
- Smoke detector damaged in bedroom; Prospect Park Hospital
- Smoke detector damaged in bedroom; Prospect Park Hospital
- Smoke detector damaged in bedroom; Prospect Park Hospital
- Smoke detector damaged in bedroom; Prospect Park Hospital
- Fire Alarm Call Point damaged; Prospect Park Hospital

There were two reports of fire equipment failure:

- St Mark's Hospital: Signal to monitoring station failed
- Orchid Ward – PPH: Fire doors faulty and were not locked

Two accidental false alarms were linked to equipment failure – both were at Wokingham Hospoital, and were due to faults on the system. There were 6 other reported false alarms, two pertaining to contractors and four due to faults on the system / accidental staff actuations.

Fire Related Incidents by Directorates:

Service	2020	2021	Total
Mental Health Inpatients	10	24	34
Corporate	17	8	25
Community Physical Health West	2	6	8
Community Mental Health West	5	2	7
Estates, Facilities and Support Services	5	0	5
Community Physical Health East	3	1	4
Children, Young persons & Families	2	1	3
Community Mental Health East	0	2	2
Total	44	44	88

Fire Related Incidents by Type:

Sub-Category	2017	2018	2019	2020	2021	Total
False Alarm Other	10	13	11	24	6	98
Risk of Fire Identified	10	14	9	5	10	49
Other Fire Incident	10	4	1	2	7	43
False Alarm Accidental Use of Call Point	2	3	2	6	2	35
Fire Arson	1	9	3	3	7	32
Fire Equipment Damaged	4	2	3	1	7	19
Fire Accidental	0	2	3	1	1	13
Fire Equipment Failure	0	4	3	2	2	11
False Alarm Malicious	5	0	1	0	2	8
Total	42	51	36	44	44	308

Fire Related Incidents by Type & Service 2021:

	Accidental	Arson	Equipment Damaged	Equipment Failure	False Alarm Accidental Use	False Alarm Malicious	False Alarm Other	Risk of Fire Identified	Other Fire Incident	Total
Mental Health Inpatients	1	6	5	1	0	2	0	5	4	**24**
Corporate	0	0	0	1	1	0	5	0	1	**8**
Community Health West	0	0	0	0	1	0	0	4	1	**6**
Mental Health East	0	1	0	0	0	0	0	0	1	**2**
Mental Health West	0	0	2	0	0	0	0	0	0	**2**
Community Health East	0	0	0	0	0	0	0	1	0	**1**
Children & Young people	0	0	0	0	0	0	1	0	0	**1**
Total	**1**	**7**	**7**	**2**	**2**	**2**	**6**	**10**	**7**	**44**

Smoking Incidents by Service & Type 2017 - 2021

	2017	2018	2019	2020	2021
Mental Health - Community or Inpatients	199	155	175	138	**241**
Berkshire Physical Healthcare West	2	6	7	13	**0**
Berkshire Physical Healthcare East	3	2	3	0	**0**
Estates, Facilities and Support Services	6	2	1	0	**0**
Total	**210**	**165**	**186**	**151**	**241**

Smoking related incidents at Prospect Park Park Hospital and in the community setting are up by 60% on the previous year 2020. 12 out of 240 (5%) of the incidents that were classified as smoking related were also subcatagorised as being a fire risk.
The e-cigarette currently being used at PPH is currently under review. There is a proposal for the Drug, Alcohol & Smoke Free Lead to trial 3 x new e-cigarettes, and support from the Risk Services Team is being provided to understand the Risk Assessment (RA) process. This process will ensure that we do not create extra sources of ignition on the wards or further health and safety risks to patients and staff.

8. Fire Safety Improvements

The following works have been completed in 2021:

Location	Action required	Actions completed
Upton Hopsital	New Fire Alarm System	New Cabling and wiring Additional smoke detector heads New Fire Alarm Panel New Fire Action Notices New Site Plans New Fire Assembly Point signage
Wokingham Hospital	Fire Alarm System Improvements	New cabling /wiring, with new fire repeater panels across the site.
Willow House Wokingham	Fire Alarm System Improvements	Full site refurbishment

9. Fire training

All members of staff undergo statutory fire safety training every 12 months. Those not on wards have Fire Awareness Training but those who work with inpatients have Inpatient Fire Evacuation Training. Whichever one they complete counts as their statutory training.

The Trust sets an overall target of 90% for Fire Training Compliance and 95% for inpatient services. The table below shows the monthly training statistics for 2021:

The Trust has consistently achieved its overall target for Fire Training compliance.
There has been an improvement through the year on inpatient wards achieving the higher target and at target in the last quarter of the year.

Through 2021, face to face training was suspended due to the Covid-19 risk. This has recovered as the year progressed with the re - introduction of face-to-face training for Inpatient Fire Evacuation Training and some basic Fire Awareness and Warden Training.

		Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Statutory Training: Fire: %	90% compliance	92.3%	91.5%	85.0%	83.7%	90.2%	91.5%	91.5%	90.8%	90.7%	90.9%	91.2%	91.8%	92.3%

Mental Health Inpatient Services – Fire Evacuation Training

Competence (group)	Target	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
Fire Safety Training - Whole Service	95%	88.4%	90.5%	92.7%	94.1%	93.5%	93.3%	92.8%	93.8%	94.9%	95.4%	95.0%

Community Health Inpatient Services – Fire Evacuation Training

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
371 Community Health East Services	Fire Safety Training - 95% Whole Service	94.9%	89.0%	91.7%	92.1%	94.1%	94.6%	93.1%	92.2%	94.5%	95.8%	95.8%	95.2%
371 Community Health West Services	Fire Safety Training - 95% Whole Service	96.0%	87.9%	89.8%	93.1%	94.1%	92.7%	93.5%	93.2%	93.4%	94.2%	95.2%	95.0%

10. Days Lost through Sickness

The total number of FTE days lost to sickness in 2021 has increased by 8.8% when compared to 2020. The most common reason for absence remains anxiety/stress/depression, accounting for 28% of all sickness in the 12-month period. However, although this reason accounts for the same proportion of sickness as in 2020, the number of FTE days lost for this reason has increased by 9.5%.

The overall sickness rate for 2021 was 4.26%, an increase from 4.05% in 2020. Analysis of the monthly sickness rates in the 12-month period shows a sharp decrease in the sickness rate in the first three months of the year, to a low of 3.06% in March. Since March there has been a consistent month-on-month increase in the sickness rate, to 5.46% in December.

The following table shows the number of days lost through sickness, by sickness reason, for the calendar year January 2021 to December 2021.

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	596	826	17,639.18	28.0
S15 Chest & respiratory problems	1046	1,361	10,408.98	16.5
S12 Other musculoskeletal problems	375	498	7,140.37	11.3
S25 Gastrointestinal problems	929	1,215	4,536.09	7.2
S13 Cold, Cough, Flu - Influenza	1259	1,649	4,533.29	7.2
S11 Back Problems	227	257	2,749.12	4.4
S17 Benign and malignant tumours, cancers	31	46	2,656.77	4.2
S16 Headache / migraine	719	983	2,326.66	3.7
S26 Genitourinary & gynaecological disorders	247	308	2,189.38	3.5
S28 Injury, fracture	127	139	1,668.63	2.6
S30 Pregnancy related disorders	84	160	1,365.64	2.2
S21 Ear, nose, throat (ENT)	270	303	1,205.35	1.9
S98 Other known causes - not elsewhere classified	89	101	808.38	1.3
S19 Heart, cardiac & circulatory problems	61	72	780.41	1.2
S29 Nervous system disorders	31	44	535.12	0.8
S23 Eye problems	64	75	478.35	0.8
S31 Skin disorders	56	67	411.49	0.7
S24 Endocrine / glandular problems	24	29	372.93	0.6
S22 Dental and oral problems	101	119	313.23	0.5
S18 Blood disorders	20	21	312.44	0.5
S27 Infectious diseases	32	33	213.56	0.3
S14 Asthma	20	22	148.90	0.2
S99 Unknown causes / Not specified	24	25	125.29	0.2
S32 Substance abuse	1	1	124.00	0.2
S20 Burns, poisoning, frostbite, hypothermia	9	11	43.91	0.1
Total	6442	8,365	63,087.45	100.0

Covid related sickness accounted for 16.5% of all sickness in 2021, a reduction from 18.7% in 2020. Absences attributed to musculoskeletal/back problems remained consistent with last year, at 15.7%.

The overall sickness rate for Covid related sickness for the year was 0.70%. Analysis of the monthly sickness due to Covid shows a sharp decline in the first three months of the year. The sickness rate for this reason remained stable at 0.3-0.4% until July when there is a gradual increase each month and then a sharp increase in December, which coincides with the significant increase seen nationally due to the new variant.

If Covid related sickness is excluded from the figures, the overall sickness rate for 2021 was 3.56%, an increase from 3.29% in 2020.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 February 2022
Title	**Audit Committee – 19 January 2022**
	Item For Noting
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 19 January 2022
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 19 January 2022

(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Mehmuda Mian, Non-Executive Director Naomi Coxwell, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Rebecca Clegg, Interim Director of Finance Debbie Fulton, Director of Nursing and Therapies Minoo Irani, Medical Director Sharonjeet Kaur, RSM, Internal Auditors *(substituting for Clive Makombera)* Amanda Mollett, Head of Clinical Effectiveness and Audit Melanie Alflatt, TIAA Maria Grindley, Ernst and Young, External Auditors Sarah Croft, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Natascha Blesing, Finance Trainee Julie Hill, Company Secretary Alison Durrands, Director of Transformation and Quality Improvement (present for agenda item 5.0)

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Clive Makombera, RSM, Internal Auditors.	
2.	**Declaration of Interests,**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 27 October 2021**	

	The Minutes of the meeting held on 27 October 2021 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the action log.	
5.	**Quality Improvement Programme Value for Money**	
	The Chair welcomed Alison Durrands, Director of Transformation and Quality Improvement. The Medical Director reminded the meeting that the Trust had embarked on its Quality Improvement journey back in 2017. It was noted that the Executive had agreed last year that it would be helpful to take stock of the effectiveness of the Quality Improvement Programme to date. The Medical Director reported that at the same time, the Audit Committee had suggested commissioning an external value for money review of Quality Improvement Programme. The Medical Director said that the Committee had agreed to wait until after the outcome of the internal review to consider whether it was necessary to commission an external review. The Chair asked for more information about the different RAG rating of the "process measures" and "outcome measures". Director of Transformation and Quality Improvement explained that "process measures" were short term actions which drove what the team were delivering and that these often moved from one RAG rated colour to another and back again. The outcome measures related to the delivery of the True North objectives or breakthrough objectives and were longer term indicators. The Chair asked whether the Trust was confident that they had all the process measures in place in order to meet the True North and/or break through objectives. The Medical Director said that the process measures did not always quickly achieve the outcomes and explained that some of the outcome measures/goals were not as refined as they should have been from the outset. For example, reducing falls had included helping patients to the floor when they had lost balance rather than focussing on reducing those falls which led to actual or potential harm to patients. Mehmuda Mian, Non-Executive Director asked how many teams had completed the Quality Management Information System (QMIS) training. The Director of Transformation and Quality Improvement reported that 38% of corporate teams and 53% of clinical teams had completed their QMIS training. Naomi Coxwell, Non-Executive Director said that she welcomed the refinement of some of the True North goals/breakthrough performance indicators. Ms Coxwell said that she hoped that the Trust would continue its work with the Integrated Care Systems in order to tackle key issues such as reducing the	

	inpatient length of stay and inappropriate out of area placements which required both an internal and external focus. Ms Coxwell referred to the direct costs to date and asked whether it was likely that moving forward, the direct costs would reduce. The Director of Transformation and Quality Improvement said that direct costs in relation to hotels, travel and refreshments had reduced because training was undertaken online because of the COVID-19 pandemic and that this was likely to continue post-pandemic. It was noted that when the QMIS training had been completed, the Quality Improvement Team would become a resource to support and coach teams in continual improvement and longer term more complex programmes of change Ms Coxwell said that the Trust had invested heavily in the Quality Improvement Programme, and it was heartening to see some significant successes but acknowledged that the True North goals and break through objectives were highly complex and it was challenging to tackle these issues. Ms Coxwell said that the COVID-19 pandemic may have stalled a few things, but it was important that the Trust remained enthusiastic and optimistic that sustained improvements could be made. The Director of Transformation and Quality Improvement thanked the Committee for their support and said that the Quality Improvement Team were passionate about continual Improvement. It was noted that the Trust had recently recruited new staff to into the Quality Improvement Team. The Chair noted that it was proposed that there was an annual review of the governance and effectiveness of the Quality Improvement Programme which would be presented to the Quality and Performance Executive Group in May 2023. The Committee noted the report.	
6.A	**Board Assurance Framework**	
	The Board Assurance Framework had been circulated. The Chief Financial Officer presented the report and highlighted that following the discussion at the Trust Board's Strategy Away Day in October 2021, the three system risks had been amalgamated into a single risk. **The Committee:** a) Noted the report; and b) Approved the amalgamation of the three system risks (risks 3, 4 and 5) into a single system risk	
6.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. Naomi Coxwell, Non-Executive Director referred to the Mental Health Act Compliance Trust-wide risk and asked whether the current and target risk	

	scores should be reduced given that there were two outstanding actions following the audit of the Mental Health Act Office. The Medical Director explained that he had agreed with the Head of Mental Health Act that the actions following the audit would only be marked as "completed" when all the changes had been implemented. The Medical Director reported that the Trust had undertaken a significant amount of work to improve the Trust's compliance with the Mental Health Act and that the decision to reduce the target and current risk scores was based on the improvements that had already been made. Sharonjeet Kaur, RSM Internal Auditors said that this was her understanding and pointed out the two outstanding actions were rated as "medium" and "low" and that the overall assessment of the Mental Health Act Office audit was "reasonable assurance" and therefore the two outstanding actions did not impact on the proposal to reduce the risk score. **The Committee:** a) Noted the report b) Approved the reduction in the current risk score in relation to the Mental Health Act Compliance Trust-wide risk from 12 (high risk) to 6 (moderate risk) and the reduction in the target risk score from 6 (moderate risk) to 4 (low risk)	
7.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from October 2021 to December 2021 had been circulated. The Chief Financial Officer presented the paper and reported that two entries related to Attention Deficit Hyperactivity Disorder services which were extensions to framework contracts rather than single waiver tenders but were included on list because of the materiality of the contract value. The Chief Financial Officer reported that the Trust had added a new process whereby high value single waiver tenders at a contract value of £300,000 or above would be discussed with the Audit Committee Chair prior to approval. The Chair confirmed that he was happy with the new process for approving high value single waiver tenders. The Chair noted that for one of the of the single waiver tenders, the contract had been approved before the single waiver had been sought and asked for more information. The Chief Financial Officer explained that this was usually when a service had engaged directly with the supply. In these cases, the Procurement Team would explain the contract rules to ensure that this would not happen again. The Interim Director of Finance said that she would provide more detail on the specifics in relation to this breach of contract regulations and inform the Committee. Naomi Coxwell, Non-Executive Director referred to the construction framework agreement which had been extended for another nine months and asked	**RC**

	whether this contract was under one contractor who then sub-contracted the work. The Chief Financial Officer explained that the framework agreement included a number of contractors. The Committee noted the report.	
8.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and reported that a total of 5 indicators were audited during the quarter. Two indicators were green rated (High Confidence), two Amber (Medium Confidence) and one red (Low confidence) for Data Quality. Action plans were put into place to address these issues. The following indicators were audited: **High assurance (Green)** • Pressure Ulcers Acquired at BHFT due to a Lapse in Care, Grade 3 and 4 • Mental Health Clustering Within Target **Moderate Assurance (Amber)** • Mental Health Readmissions within 28 days (audited quarterly) • Mental Health: Crisis Resolution/Home Treatment Team gate keeping of inpatient admissions **Low Assurance (Red)** • Mental Health 72 Hour Follow-Up (audited monthly) The Chief Financial Officer reported that there were a number of new indicators introduced as part of the updated national System Oversight Framework. Not all of the new indicators had been defined nationally and therefore there were no targets. These would be added once published. It was noted that of the indicators audited, there remained recording issues around completeness, timeliness, and accuracy. In the main these did not present material impacts on the indicators. The exception being the new 72 hour follow up (this indicator used to be 7 day follow up), which had accuracy and timeliness issues on this key safety indicator. The Chief Financial Officer reported that the new 72 hour follow up indicator would be audited monthly rather than quarterly. The Chair asked for an explanation about why an indicator was rated “red” meaning low confidence for data quality and rated “green” meaning high confidence for data assurance. The Chief Information Officer explained that low confidence for data quality meant that there were gaps in the information provided for the audit. The Chair asked whether more could be done to replace manual processes with electronic systems.	

	The Chief Financial Officer reported that the Trust was exploring technological solutions to improve the quality of data including making some data fields mandatory to complete. Naomi Coxwell, Non-Executive Director noted that the follow up actions from the data audits were all due to be completed by the end of March 2022 and asked about the Trust's evaluation processes to assess the effectiveness of the actions. The Chief Financial Officer said that the Assistant Director of Performance and Information was developing an internal tracker to monitor the implementation and effectiveness of the actions. The Committee noted the report.	
9.	**Losses and Special Payments Report**	
	The Losses and Special Payments Report quarter 3 report had been circulated. The Chair asked for more information about the case of a Community Health Nurse visiting a patient's home and accidently damaging an ornamental lamppost in their garden but who was unable to claim from their car insurance because they did not have business cover. The Chief Financial Officer reported that the Trust had not discharged its duty to verify that the employee was correctly insured whilst on Trust business and therefore had accepted liability for the claim. It was noted that following the incident, the Trust had changed its processes and from 1 April 2022, staff would not be able to claim mileage expenses if they had not uploaded and had had their motor insurance policy stating business use and other required driving documentation onto to electronic expenses system. The Committee noted the report.	
10.	**IFRS 16 Leases Update Report**	
	The Interim Director of Finance presented the paper and reported that the Trust had undertaken an impact assessment in relation to the changes in the International Financial Reporting Standards (IFRS) 16 Leases. It was noted that the implementation of IFRS 16 had been delayed for two years but would now be implemented from April 2022. It was noted that IFRS 16 would remove the distinction between an operating lease and a finance lease. In practical terms this would mean that most operating lease arrangements where there was a contract (written, oral or implied) and where there was a right of use and control of an asset would result in the asset going on the Balance Sheet offset by a lease liability. The asset and the lease liability would be respectively depreciated and repaid over the term of the lease.	

	The Interim Director of Finance reported that the Trust had concluded that the transition to IFRS 16 would not materially impact on the Trust. The Chair noted that the Trust had excluded leases operating under the Salary Sacrifice scheme, on the basis, that although the lease contract was technically in the Trust's name, the Trust did not have 'Right of Use' of the asset. The employees who sub-leased the vehicle, maintained control of the asset and retained its use consistent with a privately owned vehicle. The Chair asked whether this had been discussed the External Auditors. The Interim Director of Finance confirmed that the Trust would be discussed the detail of the transition to IFRS 16 with Ernst and Young. Naomi Coxwell, Non-Executive Director asked whether IFRS 16 only affected public sector organisations. The Interim Director of Finance confirmed that IFRS 16 would also apply to the private sector. The Chair asked whether IFRS 16 would have any impact on the Trust's capital allocation as it would mean that leases would be capitalised. The Chief Financial Officer said that further national guidance was awaited on any future adjustments in terms of capital allocations. The Committee noted that report.	**RC**
11.	**Clinical Claims and Litigation Quarterly Report**	
	The Director of Nursing and Therapies presented the paper and reported that during quarter 3 2021-22, there were four new clams opened (two related to employer liability and two related to clinical negligence) and two claims were closed. Mehmuda Mian, Non-Executive Director noted that in one of the new claims, the use of Service User Representatives on recruitment panels had been suspended and asked when Service User Representatives on recruitment panels would resume. The Director of Nursing and Therapies confirmed that suspending the use of Service User Representatives on recruitment panels had been a short-term measure to ensure everyone involved understood the process, for example, Service User Representatives would not receive copies of candidate's application forms. The Director of Nursing and Therapies confirmed that Service User Representatives on recruitment panels had resumed. The Committee noted that report.	
12.	**Clinical Audit Report**	
	The Medical Director presented the paper and reminded the meeting that the purpose of the report was to provide assurance to the Committee that the Trust was on track to deliver the annual clinical audit plan. It was noted that the	

	individual clinical audit reports were submitted to the Quality Assurance Committee for review. The Medical Director pointed out that NHS England/Improvement had issued guidance that Trusts were able to pause their clinical audit work in order to prioritise clinical work over audit work during the COVID-19 pandemic. It was noted that the Trust had decided not to pause the clinical audit programme. The Committee noted that report.	
13.	**Anti-Crime Service Progress Report**	
	a) Anti-Crime Service Progress Report Melanie Alflatt, TIAA presented the paper and highlighted the following points: • An updated Fraud Risk Assessment was in the process of being completed in accordance with NHS Counter Fraud Authority requirements and in line with the Government Counter Fraud Profession methodology; • The Trust had fully participated in the Fraud Awareness Campaign for International Fraud Awareness Week (14-21 November 2021; • TIAA had run a series of webinars during Fraud Awareness Week. Some of the webinars were being repeated. Members of the Committee were welcome to register for any of the webinars; • TIAA had undertaken a proactive review of the Trust's contract management. An interim report would be issued shortly; • A summary of the recently issued Fraud Alerts and Fraud Prevention Notices was set out at page 140 of the agenda pack; The Chair asked Melanie Alflatt whether TIAA were receiving the support they required from the Trust. Ms Alflatt confirmed that she was very happy with the support she received from the Trust particularly from the Chief Financial Officer and his team and from the MarComms team. Mehmuda Mian, Non-Executive Director referred to the National Fraud Initiative around undeclared secondary employment whilst sick and asked whether there was any learning for the Trust. Ms Alflatt said that following the review, TIAA would identify any procedural weaknesses and feedback this information to the relevant department. Ms Alflatt agreed to circulate the recommendations and action taken by the Trust following the investigation. Following on from the case study shared at the Fraud Awareness Seminar prior to the meeting, Mehmuda Mian, Non-Executive Director asked what processes were in place to check a "nil return" in respect of a member of staff's declaration of interest form. Ms Alflatt agreed to look at the substance of TIAA's report on declarations of interest and feedback any gaps.	**MA** **MA**

	Naomi Coxwell, Non-Executive Director asked Ms Alflatt if she was confident that the Trust had robust systems in place to identify instances of staff working for other organisations whilst off sick. Ms Alflatt said that the National Fraud Initiative identified individuals with secondary employment and that this could be cross checked with their declaration of secondary employment. The Committee noted the report.	
14.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Sharonjeet Kaur, Internal Auditors presented the paper and highlighted the following points:
	
	• The following final reports had been issued since the last meeting:
	  ○ Applications Review (reasonable assurance)
	  ○ Key Financial Controls – Payroll (substantial assurance)
	  ○ COVID-19 Management – Infection, Prevention and Control (reasonable assurance)
	  ○ Care Quality Commission (reasonable assurance)
	  ○ Divisional Financial Management (substantial assurance)
	• The following audits were in progress:
	  ○ Apprenticeships
	  ○ COVID-19 Recovery – Waiting List Management
	  ○ Board Assurance Framework
	  ○ Learning from COVID-19 – Service Users
	• Eight actions (three medium and five low) had been marked as implemented since the last meeting. Two actions (one medium and one low) raised from the 2019-20 Mental Health Act Office audit were overdue and/or were in progress. Revised dates had been agreed with management for those actions to be completed.
	• The Internal Auditors were continuing to work with the Company Secretary to ascertain the key assurance areas to be included in the Assurance Map.
	• The following RSM reports had been circulated for information:
	  ○ RSM Risk Deep Dive Guidance
	  ○ NHS News Briefing
	  ○ Review of NHS Internal Audit High Priority Management Actions
	
	The Chair asked Ms Kaur whether the Internal Auditors were receiving sufficient support from the Trust. Ms Kaur confirmed that the Internal Auditors were well supported by the Trust.
	
	The Chair referred to the Divisional Financial Management review action plan around concentrating efforts on bringing the numbers of out of area placements back into line with the Prospect Park Hospital Bed Base and the additional 13 beds and asked what would need to happen in order to close that action.
	
	Ms Kaur explained that the action had been discussed with the Chief Financial Officer and Interim Director of Finance and it had been agreed that the Trust would not be able to implement the action on its own and it would require a system approach. Ms Kaur said that the Internal Auditors would close down	

	the action if there was evidence that there was an improvement in performance in relation to reducing the number of out of area placements. Mehmuda Mian, Non-Executive Director referred to page 167 of the agenda pack and asked whether the number of overpayments to staff was out of line with other similar sized trusts. Ms Kaur confirmed that the Trust was not an outlier and pointed out that the Internal Auditors had given a substantial assurance rating to the Trust's Payroll financial controls. The Committee noted the reports.	
15.	**External Audit Verbal Update**	
	Maria Grindley, External Auditors reported that all three member of the Ernst and Young team were present at the meeting, and this helped the team get to know the Trust. Alison Kennett, External Auditors reported that she was liaising with the Finance Team to understand the Trust's financial systems and processes and in particular to map the general ledgers to the Trust's financial statements. Ernst and Young was also using a data analysis tool to highlight any anomalies. Ms Kennett explained that the analytics would also help the External Auditor to focus their energies on the most appropriate areas. Maria Grindley said that the analytics tool used by Ernst and Young would provide the Audit Committee with points of assurance throughout the year rather than having to rely on the outcome of the audit of the previous year's accounts. The Chair reported that he had presented the Audit Committee's Annual Report to the Governors at the Council Meeting in December 2021 and asked whether the External Auditors would be willing to explain more about the audit process to the Governors. Maria Grindley said that she would be delighted to meet with the Governors. The Chair requested that the Company Secretary set up a meeting with the Governors and the External Auditors. Sarah Croft, External Auditors reported that she would be reviewing the impact on the Trust of the new IFRS 16 as part of her preparatory external audit work. The Chair thanked the External Auditors of their update.	**JH/MG**
16.	**Minutes of the Finance, Investment and Performance Committee meeting held on 27 October 2021**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 27 October 2021 were received and noted.	
17.	**Minutes of the Quality Assurance Committee held on 29 November 2021**	
	The minutes of the Quality Assurance Committee meetings held on 29 November 2021 were received and noted.	

18.	**Minutes of the Quality Executive Committee Minutes – October 2021, November 2021 and December 2021**	
	The minutes of the Quality Executive Committee meetings held on 17 October, 21 November 2021 and 19 December 2021 were received and noted.	
19.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Committee's Annual Work Plan was noted.	
20.	**Any Other Business**	
	a) People Directorate – Workload Pressures Naomi Coxwell, Non-Executive Director reported that one of the Executive Committee minutes had made reference to workload pressures in the People Directorate and asked whether there were sufficient resources to deliver the Trust's ambitious People Strategy. The Chief Financial Officer reported that the Director of People had flagged that there were workload pressures within the People Directorate and the Trust had agreed to allocate some additional short-term funding to support the Recruitment Team. It was noted that discussions were taking place about the staffing requirements of the People Directorate as part of the development of the Trust's Financial Plan 2022-23. **b) Draft Financial Plan 2022-23** The Chair asked when the draft Financial Plan would be presented to the Trust Board. The Chief Financial Officer explained that the Trust would normally have received the national financial planning guidance by now but this year, a patchwork guidance had been issued all marked "draft". The Chief Financial Officer confirmed that an early draft of the Financial Plan 2022-23 would be presented to the Finance, Investment and Performance Committee on 27 January 2022. The draft Finance Plan would be presented to the February 2022 Trust Board meeting with the final Financial Plan submitted to the April 2022 Trust Board meeting.	
21.	**Date of Next Meeting**	
	The Committee noted the date of the next meeting had been changed to 28 April 2022.	

The minutes are an accurate record of the Audit Committee meeting held on 19 January 2022.

Signed: - _____

Date: - 28 April 2022 _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 February 2022
Title	Trust Board Declarations of Interests and Fit and Proper Persons Assurance Report
	Item for Noting
Purpose	The purpose of the agenda item is to receive the Trust Board members individual declarations of interests and to provide assurance that the Trust has taken reasonable steps to provide on-going assurance that all members of the Trust Board (and staff on Very Senior Manager contracts) meet the requirements of the Fit and Proper Persons Test.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	All strategic objectives are relevant
CQC Registration/Patient Care Impacts	Supports the Well-Led Domain
Resource Impacts	None
Legal Implications	N/A
Equalities and Diversity implications	N/A
SUMMARY	The current schedule of Directors declarations of interest is provided for review and update as appropriate.
ACTION REQUIRED	The Trust Board is asked to: a) Note the Register of Individual Directors' Interests; b) Note the assurance provided that all Directors (and staff on Very Senior Manager contracts) are and remain "Fit and Proper Persons" as defined in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) and do not meet the grounds of unfitness specified in Part 1 of Schedule 4 to the Registered Activities Regulations.

Board of Directors Register of Interests and Fit and Proper Person Assurance Report

Section A

1. Declarations of Interests

NHS England issued new guidance in February 2017 on Managing Conflicts of Interests. The Trust's Standards of Business Conduct Policy has been updated to reflect the new requirements.

NHS England defines a conflict of interest as: "a set of circumstances by which a reasonable person would consider that an individual's ability to apply judgment or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold."

Interests fall into the following categories:

Financial interests	Non-financial professional interests	Non-financial personal interests	Indirect interests
Where an individual may get direct financial benefit from the consequences of a decision they are involved in making	Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career	Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career	Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making

2. Compliance with the Regulations

Upon appointment, all Board members are required to complete a declaration of interests' form. Any declared interests are entered onto the Register of Board Member Interests maintained by the Company Secretary. In addition, there is a standing item on declarations of interest on every Board and Sub-Board meeting agendas. This provides a prompt for members to consider whether they have a potential or perceived conflict of interest in any of the matters under discussion.

The Company Secretary writes to all members of the Board in January each year with a request that individuals confirm or amend their interests on the Register. As required by NHS England, the Trust Board Register of Interests is published on the Trust's website at:

https://www.berkshirehealthcare.nhs.uk/media/109513965/board-declarations-of-interest-jan-2022-berkshire-healthcare.pdf

The current Register of Board Interests in attached at Appendix 1.

Section B

1. Fit and Proper Persons Test

Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (set out at appendix 2) was introduced as a direct response to the Francis Report into the failings at Mid Staffordshire NHS Foundation Trust. The Regulation aims to ensure that all Board level appointments of NHS provider organisations are fit and proper to carry out their roles.

It is ultimately the responsibility of the Chairman to discharge the requirement to ensure that individual members of the Board meet the fit and proper persons test and do not meet any of the "unfit" criteria.

During an inspection, the Care Quality Commission will consider compliance with the Fit and Proper Persons Regulations as part of the Well-Led domain (CQC key line of enquiry W1: Is there the leadership capacity and capability to deliver high quality, sustainable care? Specifically, one line of enquiry is to check whether leaders have the skills, knowledge, experience and integrity they need – both when they were appointed and on an going basis.

The Regulations came into force on 1 April 2015. The Trust conducted a retrospective review of all Board appointments (and directors on Very Senior Managers contracts). The then Chair confirmed that all current appointments met the requirements of the Fit and Proper Persons test.

Board level (and Very Senior Manager) appointments made after 1 April 2015 were subject to the Fit and Proper Persons Test requirements prior to appointment and were made in accordance with the Trust's Fit and Proper Persons Policy.

2. On-going Compliance with the Fit and Proper Persons Test Requirements

The purpose of this report is to provide assurance that all Board members (and staff appointed on Very Senior Manager contracts) remain fit and proper persons. The assurance is provided by:

a) The outcome of the annual appraisals process as set out below:

Appraisee	Appraiser	Fit and Proper Person Test Assurance
Chair	Senior Independent Director	The Senior Independent Director canvassed views on the Chair's performance from the Non-Executive Directors, Chief Executive, Executive Directors, the Governors, Staffside, Freedom to Speak Up Guardian and the Chairs of the two Integrated Care Systems. The Senior Independent Director confirmed that there were no Fit and Proper Person Test issues. The Senior Independent Director attended a meeting of the Council of Governors Appointments and Remuneration Committee and presented the outcome of the Chair's appraisal. The Committee in turn provided assurance to the full Council at a private meeting on 22 September 2021.
Non-Executive	Chair	The Chair conducted appraisals with each of

Appraisee	Appraiser	Fit and Proper Person Test Assurance
Directors		the Non-Executive Directors and confirmed that there were no Fit and Proper Person Test issues. The Chair presented the key points from his appraisals with each of the Non-Executive Directors to the Council of Governors' Appointments and Remuneration Committee on 7 September 2021. The Committee provided assurance to the Council of Governors at a private meeting on 22 September 2021 that all the Non-Executive Directors were performing well.
Chief Executive	Chair	The Chair conducted the Chief Executive's appraisal and has confirmed that there were no Fit and Proper Person Test issues.
Executive Directors	Chief Executive	The Chief Executive conducted appraisals with each of the Executive Directors and has confirmed that there were no Fit and Proper Person Test issues.
Very Senior Managers		
a) Director of Finance	Chief Financial Officer	The Director of Finance role is currently covered by an interim appointment.
b) Chief Information Officer	Deputy Chief Executive	The Deputy Chief Executive conducted the Chief Information Officer's appraisal and confirmed that were no Fit and Proper Person Test issues.
c) Director of People	Deputy Chief Executive	The Deputy Chief Executive conducted the Director of People's appraisal and confirmed that there were no Fit and Proper Person Test issues.

b) All Board members and staff appointed on Very Senior Manager contracts have made an annual (template attached at Appendix 3) to confirm that they continue to meet the requirements of the Fit and Proper Persons Test and do not meet any of the "unfit" criteria.

c) The Company Secretary has conducted the following on-going checks on each Board member and staff appointed on Very Senior Manager contracts:

i) Disclosure and Barring Service
ii) Individual Insolvency Register
iii) Insolvency Director Disqualification Register
iv) Bankruptcy or Debt Relief Restrictions Register
v) Company House Register of Disqualified Directors
vi) Company House Register of Directorships
vii) Charity Commission's Register of Removed Trustees

The searches did not flag any issues of concern.

d) Members of the Trust Board (and staff on Very Senior Manager Contracts) are required to conduct themselves in accordance with the Directors' Code of

Conduct (appendix 4).

Recommendations:

The Trust Board is asked to:

a) Note the Register of Individual Directors' Interests;
b) Note the assurance provided that all Directors (and staff on Very Senior Manager contracts) are and remain "Fit and Proper Persons" as defined in regulation 5 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014) and do not meet the grounds of unfitness specified in Part 1 of Schedule 4 to the Registered Activities Regulations.

Declarations of Director Interests 13 January 2022

Non-executive Directors

Date	Name	Position	Interest declared
13/12/17	Naomi Coxwell	Non-Executive Director	Trustee Hart Citizen Advice Bureau
			James Walker Group Ltd.
			Director of James Walker Pension Scheme
			Trustee of the First Walker Share Trust
			Director of James Walker Trustees Ltd.
			Director of James Walker Senior Executives Managed Pension Plan
			Arco Ltd (Arco is a safety specialist company based in Hull, UK)
01/10/2021	Rajiv Gatha	Non-Executive Director	None
01/11/19	Aileen Feeney	Non-Executive Director	Trustee of Oakleaf Enterprises (Mental Health Charity, Guildford)
			Member – Circle Trust (Wokingham Schools Trust)
			Justice of the Peace
			Lay Person for NHS Blood & Transplant Service
			Partner works for Frimley Health NHS Foundation Trust as General Manager (IT) for the Berkshire & Surrey Pathology Services
01/06/15	David Buckle	Non-Executive Director	Non-Executive Director for Salisbury Hospital NHS Foundation Trust

Date	Name	Position	Interest declared
			President of the Society for Assistance of Medical Families
			Vice President of the Stroke Association
			Non-Executive Director for East and North Hertfordshire NHS Hospital Trust
01/06/15	Mehmuda Mian	Non-Executive Director	Lay Member of the House of Commons Committee on Standards
01/09/16	Mark Day	Non-Executive Director	Director Chandlers Court (Southampton) Management Company Ltd
01/12/16	Martin Earwicker	Chair	Trustee Hart Citizen Advice Bureau
			Chair, Farnborough College of Technology

Executive Directors

Date	Name	Position	Interest declared
09/09/08	Julian Emms	Chief Executive	Brother is COO of Circassia pharmaceuticals PLC
			Wife works for Berkshire Healthcare NHS Foundation Trust
01/12/18	Debbie Fulton	Director of Nursing and Therapies	Trustee of Priors Court which is a charity run school/residential placement for young people with ASD in Newbury

Date	Name	Position	Interest declared
03/09/09	Alex Gild	Deputy Chief Executive	Member of the Board of Trustees of the Healthcare Financial Management Association
			Chair of the Southern Customer Board for NHS Procurement and Supply and Member of the National Board
01/11/15	Minoo Irani	Medical Director	Wife is employed by NHSE & NHSI (South) as Maternity Programme Manager
07/06/21	Paul Gray	Chief Financial Officer	Wife works for Berkshire Healthcare NHS Foundation Trust
26/11/12	David Townsend	Chief Operating Officer	Wife works for Compass Group

Appendix 2

Care Quality Commission's Fit and Proper Persons Test Requirements

Regulation 5 of the Regulated Activities Regulations states that the Trust must not appoint or have in place an individual as a director, or performing the functions of or equivalent or similar to the functions of, such a director, if they do not satisfy all the requirements set out in paragraph 3 of that Regulation.

The requirements of paragraph 3 of Regulation 5 of the Regulated Activities Regulations are that:

(a) the individual is of good character;

(b) The individual has the qualifications, competence, skills and experience which are necessary for the relevant office or position or the work for which they are employed;

(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;

(d) The individual has not been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and

(e) None of the grounds of unfitness specified in Part 1 of Schedule 4 apply to the individual.

The grounds of unfitness specified in Part 1 of Schedule 4 to the Registered Activities Regulations are:

(f) The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;

(g) The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;

(h) The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;

(i) The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;

(j) The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;

(k) The person is prohibited from holding the relevant office or position, or in the case of an individual carrying on the regulated

activity, by or under any enactment.

Under Schedule 4, Part 2 a director will fail the 'good character' test, if they:

1.1. Have been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in an part of the Unity Kingdom, would constitute an offence;

1.2. Have been erased, removed or struck off a register of professionals maintained by a regulator of health or social care.

Appendix 3

Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST
VERY SENIOR MANAGER / BOARD DECLARATION

The position you have been offered is subject to Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ("the Regulations") and in particular the requirement that Very Senior Manager level appointments must be "fit and proper persons."

Before you can commence employment with the Trust we need to be satisfied you are a fit and proper person pursuant to the Regulations. In order to assist us with this determination, we ask that you please complete the following declaration.

1. Are you currently bound over, or do you have any current unspent convictions or cautions, or have you ever been convicted of any offence by a Court or Court-Martial in the United Kingdom or in any other country?

   NO ☐

   YES ☐ please include details of the order binding you over and/or the nature of the offence, the penalty, sentence or order of the Court, and the date and place of the Court hearing.

   Please note: you do not need to tell us about parking offences.

2. Have you been charged with any offence in the United Kingdom or in any other country that has not yet been disposed of?

   NO ☐

YES ☐ If **YES**, please include details of the nature of the offence with which you are charged, date on which you were charged, and details of any on-going proceedings by a prosecuting body.

You are reminded that, if you are appointed, you have a continued responsibility to inform us immediately where you are charged with any new offence, criminal conviction or fitness to practise proceedings in the United Kingdom or in any other country that might arise in the future.
You do not need to tell us if you are charged with a parking offence.

3. Are you aware of any current or previous investigation being undertaken by the NHS Counter Fraud and Security Management Services (NHS CFSMS) or other body or organisation following allegations made against you in relation to matters of fraud or other financial mismanagement?

NO ☐

YES ☐ If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by NHS Counter Fraud and Security Management Services (NHS CFSMS) or other body or organisation.

4. Are you aware of any current or previous investigation that indicates that you, or an organisation for which you held responsibility, has failed to adhere to recognised best practice, guidance or processes regarding care quality?

NO ☐

YES ☐ If **YES**, please include details of the nature of the investigation made against you or the organisation, and if known to you, any action to be taken against you or the organisation by the investigatory body.

5. Have you been investigated by the Police, NHS CFSMS or any other investigatory body resulting in a current or past conviction or dismissal from your employment or volunteering position?

NO ☐

YES □ If **YES**, please include details of the nature of the allegations made against you, and if known to you, any action to be taken against you by the Investigatory Body.

6. Have you ever been dismissed or disciplined by reason of serious misconduct from any employment, volunteering, office or other position previously held by you?

NO □

YES □ If **YES**, please include details of the employment, office or position held, the date that you were dismissed or had disciplinary action taken against you, including the nature of the action or sanction, and provide details of the nature of allegations of misconduct made against you.

7. Have you been convicted of breaching any health and safety requirements or legislation on the basis of whether you or an organisation for which you have, or have had, responsibility for has organised or managed its activities?

NO □

YES □ If **YES**, please include details of the nature of the health and safety conviction against you or the organisation, and if known to you, any action to be taken.

8. Have you ever been disqualified, erased, removed or struck off from the practise of a profession, or required to practise subject to specified limitations following fitness to practise proceedings, by a regulatory or licensing body in the United Kingdom or in any other country?

NO □

YES □ If **YES**, please include details of the nature of the disqualification, erasure, removal, limitation or restriction, the date, and the name and address of the licensing or
regulatory body concerned.

The information required includes being convicted of an offence or removal from the register of a professional health or social care regulator.

9. Are you currently or have you ever been the subject of any investigation or fitness to practise proceedings by any licensing or regulatory body in the United Kingdom or in any other country?

NO ☐

YES ☐ If **YES**, please include details of the reason given for the investigation and/or proceedings undertaken, the date, details of any limitation or restriction to which you are currently subject, and the name and address of the licensing or regulatory body concerned.

10. Have you been responsible for, privy to, contributed to or facilitated any serious misconduct or mismanagement in the carrying out of any health and social care services and/or any other services that may require registration with the CQC?

NO ☐

YES ☐ If **YES**, please include details.

"Responsible for, contributed to or facilitated" means that there is evidence that you have intentionally, or through neglect, behaved in a manner (whether whilst holding a Very Senior Manager / Board appointment or otherwise) that would be considered to be, or would have led to, serious misconduct or mismanagement.

"Privy to" means that there is evidence to suggest you were aware (whether whilst holding a Very Senior Manager / Board appointment or otherwise) of serious misconduct or mismanagement but did not take appropriate action to ensure it was addressed.

"Serious misconduct or mismanagement" means behaviour that would constitute a breach of any legislation/enactment that CQC deems relevant. "Serious misconduct" might be expected to include assault, fraud and theft.

"Mismanagement" might be expected to include mismanaging funds and/or not adhering to recognised practice, guidance or processes regarding care quality within which you are required to work.

11. Are you :

- an undischarged bankrupt;
- a person who has had sequestration awarded in respect of your estate which is not discharged;
- subject to a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to the like effect make in Scotland or Northern Ireland;
- a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986; or
- a person who has made a composition arrangement with, or granted a trust deed for, creditors, and not been discharged in respect of it?

NO ☐

YES ☐ If **YES**, please include details.

12. Are you subject to any other prohibition, limitation, or restriction that means we are unable to consider you for the position for which you are applying, for example, you are prohibited from holding the post of director?

NO ☐

YES ☐ If **YES**, please include details.

13. Have you previously been employed in a position that involved work with children or vulnerable adults?

NO ☐

YES ☐ If **YES**, please include details/reasons as to why this position ended.

14. Do you know of any other matters in your background which might cause your reliability or suitability for employment to be called into question?

NO ☐

YES ☐ If **YES**, please include details.

If you have answered 'yes' to any of the questions above, please use this space to provide details. Please indicate clearly the number(s) of the question that you are answering.

You may continue on a separate sheet if necessary and may attach supplementary comments should you wish to do so.

IMPORTANT - DECLARATION

The *GDPR/DPA18* requires us to advise you that we will be processing your personal data. Processing includes holding, obtaining, recording, using, sharing and deleting information. The *GDPR/DPA18* defines 'special category data' as racial or ethnic origin, political opinions, religious or other beliefs, trade union membership, physical or mental health, sexual life, criminal offences, criminal convictions, criminal proceedings, disposal or sentence. Where you are applying for a position which involves regulated activity, this will also include any barring decisions made by the Disclosure and Barring Service (DBS) against the Children's or Adults barred

lists under the terms of the *Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012).*

The information that you provide in this declaration form will be processed in accordance with the *GDPR/DPA18*. It will be used for the purpose of determining your application for this position. It will also be used for purposes of enquiries in relation to the prevention and detection of fraud.

Once a decision has been made concerning your appointment, Berkshire Healthcare NHS Foundation Trust will not retain this declaration form any longer than necessary. This declaration will be kept securely and in confidence. Access to this information will be restricted to designated persons within the organisation who are authorised to view it as a necessary part of their work.

In signing the declaration on this form, you are explicitly consenting for the data you provide to be processed in the manner described above.

I consent to the information provided in this declaration form being used by Berkshire Healthcare NHS Foundation Trust for the purpose of assessing my suitability for employment, and for enquiries in relation to the prevention and detection of fraud. I understand that I have an ongoing duty of disclosure and must provide any further relevant information up to the date of commencement of employment.

I confirm that the information that I have provided in this declaration form is correct and complete. I understand and accept that if I knowingly withhold information, or provide false or misleading information, this may result in my offer of employment being withdrawn, or if I am appointed, in my dismissal, and I may be liable to prosecution.

Please sign and date this form.

SIGNATURE.....

NAME (in block capitals)

DATE....

Please complete and return this Declaration Form in a separate envelope marked 'Confidential'. Forms should be returned to: the Company Secretary

If you wish to withdraw your consent at any time after completing this declaration form or you have any enquiries relating to information required in this form, please contact the HR Department directly. All enquiries will be treated in strict confidence.

Appendix 4

Berkshire Healthcare NHS
NHS Foundation Trust

Board of Directors Code of Conduct

1. Introduction

High standards of corporate and personal conduct are an essential component of public service. The purpose of this Code is to provide clear guidance on the standards of conduct and behaviour expected of all directors.

This Code, with the Code of Conduct for governors and the NHS Constitution, forms part of the framework designed to promote the highest possible standards of conduct and behaviour within the Trust. The Code is intended to operate in conjunction with the Trust's Constitution, Standing Orders and Monitor's (now NHS Improvement) Code of Governance. The Code applies at all times when directors are carrying out the business of the Trust or representing the Trust.

2. Principles of public life

All directors are expected to abide by the Nolan principles of public life:

- **Selflessness -** Holders of public office should act solely in terms of the public interest: they should not do so in order to gain financial or other benefits for themselves, their family or their friends.

- **Integrity -** Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

- **Objectivity -** In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

- **Accountability -** Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

- **Openness -** Holders of public office should be as open as possible about all the decisions and actions they take: they should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

- **Honesty -** Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

- **Leadership -** Holders of public office should promote and support these principles by leadership and example.

3. General principles

Boards have a duty to conduct business with probity; to respond to staff, patients and suppliers impartially; to achieve value for money from the public

funds with which they are entrusted and to demonstrate high ethical standards of personal conduct.

The general duty of the Board, and of each director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public. The Board therefore undertakes to set an example in the conduct of its business and to promote the highest corporate standards of conduct and corporate governance.

4. Trust Vision and Values

Directors are also required to promote the Trust's Vision and to abide by the Trust's Values.

The Trust's Vision is: "to be recognised as the leading community and mental health service provider by our staff, patients and partners".

The Trust's Values are:

- **Caring** for and about you is our top priority
- **Committed** to providing good quality, safe services
- **Working together** with you to provide innovative solutions

5. Confidentiality and Access to Information

Directors must comply with the Trust's confidentiality policies and procedures. Directors must not disclose any confidential information, except in specified lawful circumstances.

Information on decisions made by the Board and information supporting those decisions should be made available in a way that is understandable. Positive responses should be given to reasonable requests for information and in accordance with the Freedom of Information Act 2000 and other applicable legislation, and directors must not seek to prevent a person from gaining access to information to which they are legally entitled.

The Trust has adopted policies and procedures to protect confidentiality of personal information and to ensure compliance with the Data Protection Act, the Freedom of Information Act and other relevant legislation which will be followed at all times by the Board of directors.

6. Media, public speaking and use of social media

Care should be taken about any invitation to speak publicly about the Trust, including speaking to journalists. Particular care must also be taken in the publication of any articles or expression of views about the Trust on social media. In any such instance, the Chairman and/or the Chief Executive should be informed in good time before such an article is proposed to be submitted or views put forward on the Trust's behalf.

Speaking publicly on the Trust's behalf about the Trust's leadership, policy, performance and regulatory relationships is a matter generally reserved to the Chief Executive and Chairman, or as delegated by them. Appropriate training should have been given to all individuals asked to speak to the media on the Trust's behalf. Speaking to, or providing written statements to the media about the Trust should be undertaken in liaison with the Trust's Marketing and Communications Team. In all cases views should not be

expressed on the Trust's behalf that are at variance from agreed Trust policy.

7. Fit and proper person

All directors are required to comply with requirements of the Fit and Proper Person Test. Directors must certify on appointment and sign an annual declaration that they are/remain a fit and proper person. If circumstances change so that a director can no longer be regarded as a fit and proper person or if it comes to light that a director is not a fit and proper person, they are suspended from being a director with immediate effect pending confirmation and any appeal. Where it is confirmed that a director is no longer a fit and proper person, their Board membership is terminated.

8. Register of interests

Directors are required to register all relevant interests in accordance with the provisions of the Constitution. It is the responsibility of each director to provide an update to their register entry if their interests change. Failure to register a relevant interest in a timely manner may constitute a breach of this Code. The Board's register of interests is published on the Trust's website.

9. Conflicts of interest

Directors have a statutory duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust. Directors have a further statutory duty not to accept a benefit from a third party by reason of being a director or doing (or not doing) anything in that capacity.

If a director has, in any way, a direct or indirect interest in a proposed transaction or arrangement with the Trust, the director must declare the nature and extent of that interest to the other directors. If such a declaration proves to be, or becomes, inaccurate or incomplete, a further declaration must be made. Any such declaration must be made at the earliest opportunity and before the Trust enters into the transaction or arrangement.

The Chair will advise directors in respect of any conflicts of interest that arise during Board meetings, including whether the interest is such that the director should withdraw from the meeting for the period of the discussion. In the event of disagreement, it is for the Board to decide whether a director must withdraw from the meeting. The Company Secretary will provide advice on any conflicts that arise between meetings.

10. Gifts and hospitality

The Board will set an example in the use of public funds and the need for good value when incurring public expenditure. The use of Trust funds for hospitality and entertainment, including hospitality at conferences or seminars, will be carefully considered. All expenditure on these items should be capable of justification as reasonable in the light of the general practice in the public sector. The Board is conscious of the fact that expenditure on hospitality or entertainment is the responsibility of management and is open to be challenged by the internal and external auditors and that ill-considered actions can damage the reputation of the Trust in the eyes of the community.

Further information about gifts and hospitality is contained in the Trust's Standards of Business Conduct Policy. Directors must not accept gifts or hospitality other than in compliance with this policy.

11. Personal conduct

Directors are expected to conduct themselves in a manner that reflects positively on the Trust and not to conduct themselves in a manner that could reasonably be regarded as bringing their office or the Trust into disrepute.

Specifically, directors must:

- act in the best interests of the Trust and adhere to its values and this Code of conduct;
- respect others and treat them with dignity and fairness;
- seek to ensure that no one is unlawfully discriminated against and promote equal opportunities and social inclusion;
- be honest and act with integrity and probity;
- contribute to the workings of the Board in order for it to fulfill its role and functions;
- recognise that the Board is collectively responsible for the exercise of its powers and the performance of the Trust;
- raise concerns and provide appropriate challenge regarding the running of the Trust or a proposed action where appropriate;
- recognise the differing roles of the Chair, Senior Independent Director, Chief Executive, executive directors and Non-Executive directors;
- make every effort to attend meetings where practicable;
- adhere to good practice in respect of the conduct of meetings and respect the views of others;
- take and consider advice on issues where appropriate;
- Be mindful of the environmental impact of Trust Board decisions;
- acknowledge the responsibility of the council of governors to hold the Non-Executive directors individually and collectively to account for the performance of the Board; represent the interests of the Trust's members, public and partner organisations in the governance and performance of the Trust; and to have regard to the views of the council of governors;
- not use their position for personal advantage or seek to gain preferential treatment; nor seek improperly to confer an advantage or disadvantage on any other person;
- accept responsibility for their performance, learning and development.

12. Compliance

The members of the Board will satisfy themselves that the actions of the Board and directors in conducting business fully reflect the values, general principles and provisions in this Code and, as far as is reasonably practicable, that concerns expressed by staff or others are fully investigated and acted upon. All directors, on appointment, will be required to give an undertaking to abide by the provisions of this Code.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 February 2022
Title	**Annual Board Planner 2022**
	ITEM FOR NOTING
Purpose	The attached sets out the non-standing items of business which will be presented to the public and in committee Trust Board meetings during 2022.
Business Area	Corporate
Author	Julie Hill, Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	The attached Board Planner sets out the forthcoming business and the frequency of reporting of the Trust Board. The planner does not include standing agenda items such as the finance report and the performance report etc. During the course of the year, other items of business are likely to occur and these items will be added to the relevant agenda.
ACTION	To note the annual Trust Board planner 2022.

Berkshire Healthcare NHS Foundation Trust

Rolling Annual Trust Board Planner for 2022– Non-Standing Agenda Items

January 2022 – Discursive Meeting	**Lead**
• National Patient Safety Specialists	Debbie Fulton
• Frimley Health and Care – Chair Designate	Julian Emms
February 2022	**Executive Lead**
• Patient Experience Report Qtr 3	Debbie Fulton
• Annual Fit and Proper Person Test and Declarations of Interest Report	Julie Hill
• Annual Health and Safety Report	David Townsend
• Annual Board Planner	Julie Hill
• Health and Wellbeing Update	Jane Nicholson/Mark Day
• Annual Community Mental Health Survey Report	Debbie Fulton
• Strategy Implementation Plan Update Report	Alex Gild
• Draft Annual Plan on a Page (In Committee)	Alex Gild
• Draft Financial Plan 2022-23 (In Committee)	Paul Gray
• West Berkshire Community Hospital – Lease to RBH (In Committee)	David Townsend
• Equality Delivery System 2 Report (n Committee)	Alex Gild
• Talent Management and Succession Planning Report (In Committee)	Alex Gild
• Health Inequalities Update Report (In Committee)	Alex Gild
March 2022 – Discursive Meeting	
• BOB ICB Chair Designate	Julian Emms
April 2022	
• Board Vision Metrics Report	Alex Gild
• Guardians of Safe Working Report Quarterly Report* • Learning from Deaths Quarterly Report* *included as part of the QAC minutes	Minoo Irani
• Annual Financial Plan	Paul Gray
• Trust Strategy – 1 One Update Report	Alex Gild
• Quality Concerns (In Committee)	Debbie Fulton
May 2022	
• Quality Accounts	Minoo Irani
• Annual Report (*circulated to members of the Board but not published until the Annual Report is laid before Parliament)*	Julian Emms
• Gender Pay Gap Report	Alex Gild/Jane Nicholson
• EDI Strategies Six monthly update	Alex Gild/Jane Nicholson
• Staff Survey Results Report	Alex Gild/Jane Nicholson
• Patient Experience – Qtr 4 Report	Debbie Fulton
• Six monthly Safe Staffing Report	Debbie Fulton
June 2022 – Discursive Meeting	
• TBC	
July 2022	
• Estates Strategy - Update Report	David Townsend
• Annual Complaints Report	Debbie Fulton

• Revalidation Annual Report	Minoo Irani
• Board Vision Metrics Report	Alex Gild
• People Strategy Update Report	Alex Gild/Jane Nicholson
• Annual Freedom to Speak Up Guardian Report	FTSU Guardian
• Guardians of Safe Working Report Quarterly Report* • Learning from Deaths Quarterly Report* *included as part of the QAC minutes	Minoo Irani
• Quality Concerns (In Committee)	Debbie Fulton
• Provider Collaboratives Update Report	Alex Gild/Kathryn MacDermott
September 2022	
• Patient Experience Report – Qtr 1	Debbie Fulton
• Strategy Implementation Plan Update Report	Alex Gild
• Workforce Disability Equality Standard Report	Alex Gild/Jane Nicholson
• Research and Development Annual Report	Minoo Irani
• Race Equality Standard Report	Alex Gild/Jane Nicholson
• Guardians of Safe Working Report Quarterly Report* • Learning from Deaths Quarterly Report* *included as part of the QAC minutes	Minoo Irani
• Well Being Guardian Report	Jane Nicholson/Mark Day
• Quality Concerns (In Committee)	Debbie Fulton
• IT Strategy Update Report (In Committee)	Alex Gild/Mark Davison
• Trust Board Away Day Agenda (In Committee)	Chair/Julie Hill
October 2022 – Annual Strategic Planning Away Day	
• Strategic Planning	Alex Gild
• Board Assurance Framework Risks	Paul Gray/Julie Hill
November 2022	
• Patient Experience – Qtr 2	Debbie Fulton
• Strategy Implementation Progress Report	Alex Gild
• EDI Strategy Update	Ale Gild/Jane Nicholson
• Six Monthly Safe Staffing Report	Debbie Fulton
• Board Assurance Framework and Corporate Risk Register Annual Review (in Committee)	Paul Gray/Julie Hill
• TB Away Day – Notes and Actions (in Committee)	Julie Hill
December 2022	
• Board Vision Metrics Report	Alex Gild
• Estates Strategy – 6 monthly Update	David Townsend
• Guardians of Safe Working Report Quarterly Report* • Learning from Deaths Quarterly Report* *included as part of the QAC minutes	Minoo Irani
• Freedom to Speak Up Six monthly Report	FTSU Guardian
• People Strategy Update Report	Alex Gild/Jane Nicholson
• Quality Concerns (In Committee)	Debbie Fulton
• Provider Collaboratives Update Report (six monthly)	Alex Gild/Kathryn MacDermott

Board Reporting Frequency

Report	Frequency
Patient Experience	4 times a year
Quality Concerns	4 times a year
Learning from Deaths Report	4 times a year
Guardians of Safe Working Practices Report	4 times a year
Strategy Implementation Programme Report	4 times year
Board Vision Metrics	3 times a year
Health and Wellbeing Report	2 times a year
Safe Staffing Report	2 times a year
Equalities, Diversity and Inclusion Strategy Update Report	2 times a year
Freedom to Speak Up Guardian's Report	2 times a year
Staff Wellbeing Report	2 times a year
People Strategy Update Report	2 times a year
Fit and Proper Persons Assurance Report	Annually
Health and Safety Report	Annually
Trust Board Report Planner	Annually
Community Mental Health Survey Report	Annually
Trust Annual Plan on a Page	Annually
Financial Plan	Annually
Quality Accounts	Annually
Trust's Annual Report and Accounts	Annually
Gender Pay Gap Report	Annually
National NHS Staff Survey Results Report	Annually
Estates Strategy Update Report	Annually
Annual Complaints Report	Annually
Medical Revalidation Report	Annually
Research and Development Annual Report	Annually
Workforce Race Equality Standard Report	Annually
Workforce Disability Standard Report	Annually
Board Assurance Framework and Corporate Risk Register Report	Annually
Digital Strategy Update Report	Annually
Equalities Delivery System 2 Report	Annually
Talent Management and Succession Planning Report	Annually

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	08 February 2022
Title	**Use of Trust Seal**
	ITEM FOR NOTING
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to: The Trust's Seal was also affixed to the sale agreement of 3-5 Craven Road, Reading. *(please note that it was reported that the Trust Seal had been affixed to the sale agreement of 305 Craven Road, Reading at the December 2021 meeting but that buyer had subsequently withdrew their offer).*
ACTION	To note the update.