Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 13 September 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 12 July 2022	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – Children's Specialist Services	Debbie Fulton, Director of Nursing and Therapies/Hannah Lyman, Head of Specialist Children's Services	Verbal
6.1	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Infection Prevention and Control Board Assurance Framework	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Quality Assurance Committee a) Minutes of the meeting held on 30 August 2022 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Report	Sally Glen, Chair of the Quality Assurance Committee	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 04 2022/23 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 04 2022/23 Performance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.2	a) Finance, Investment and Performance Committee Meeting held on 19 July 2022 b) Finance, Investment and Performance Committee – Minor Changes to the Terms of Reference	Naomi Coxwell, Chair, Finance, Investment and Performance Committee	Enc.
STRATEGY			
9.0	Workforce Race Equality Standard Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
9.1	Workforce Disability Equality Standard Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
9.2	Quarterly Status Report on Key Trust Initiatives	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting held 20 July 2022 a) Minutes b) Minor Changes to the Terms of Reference	Rajiv Gatha, Chair, Audit Committee	Enc.
10.1	Schedule of Meetings	Martin Earwicker, Trust Chair	Enc.
10.2	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 08 November 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, 12 July 2022

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Chair
	Naomi Coxwell	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Sally Glen	Non-Executive Director
	Mehmuda Mian	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Tehmeena Ajmal	Chief Operating Officer
	Dr Minoo Irani	Medical Director
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
In attendance:	Julie Hill	Company Secretary
	Major Dan Brooks	Armed Forces Lead
	Adele Stevens	Principal Clinical Psychologist and Veterans Strategic Development Lead
	Mike Craissati	Freedom to Speak up Guardian *(present for agenda item 6.1)*
	Jane Nicolson	Director of People *(present for agenda item 9.0)*
Observers:	Zoe Fenwick	Member of the Public
	Steven Gillingwater	Public Governor

22/115	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. The Chair particularly welcomed the observers to the meeting. There were no public questions.
22/116	**Apologies** (agenda item 2)
	Apologies were received from: Rajiv Gatha, Non-Executive Director and Mark Day, Non-Executive Director.

22/117	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
22/118	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
22/119	**Minutes of the previous meeting – 10 May 2022** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 10 May 2022 were approved as a correct record.
22/120	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. The Chief Financial Officer referred to action relating to minute no 22/094 and agreed to circulate the number of staff who left the Trust within the first year. **Action: Chief Financial Officer** **The Trust Board:** noted the action log.
22/121	**Board Story – OpCourage Story (**agenda item 6.0)
	The Chair welcomed Dr Adele Stevens, Principal Clinical Psychologist and Veterans Strategic Development Lead and Major Daniel Brooks, Armed Forces Lead. Dr Stevens gave a presentation and highlighted the following points: • The Trust provided a significant amount of support to veterans and to the armed forces community. • The Trust's work had been recognised nationally and the Trust had been awarded the Ministry of Defence's Gold Employer Recognition Award. • The Trust had set up the Courage Staff Network aimed at providing those staff who were part of the wider Armed Forces Community a chance for meeting others with a similar background • The Trust's specialist Veterans Support service dated back to 2012. Veterans were fully involved in shaping the Trust's Veterans service. This included peer support workers, cutting edge clinical innovation and collaboration, being compassion focussed, expertise in dealing with combat stress, a dedicated substance misuse practitioner and a dedicated family worker. Having staff who were committed to support Veterans and who understood their military background was an essential component of the Trust's service • NHS England was responsible for commissioning specialist services for Veterans. The new OpCourage service was currently out for tender.

	Dr Stevens played a video in which Gemma, a Veteran shared her positive experience of using the Trust's Veteran service. The presentation slides are attached to the Trust Board minutes. Sally Glen, Non-Executive Director said that she had not come across this type of service and asked whether there any research which underpinned the service. Dr Stevens said that the Trust took account of evidence based research and also any feedback from the national provision of Veteran services. Major Daniel Brooks, Veterans Lead and a Reservist joined the meeting from the Falkland Islands. Major Brooks explained about his current role which was to command the British Forces joint sea and land forces to provide reassurance to the Falkland Island inhabitants and to act as a deterrent. Major Brook praised the work of the Veterans service and thanked the Trust for its commitment to supporting Veterans. Major Brooks reported that the Berkshire Veterans Service had presented to Parliament and the Minister of Defence, People and Veterans, Leo Docherty had visited the OpCourage service in April 2022. The Chair thanked Dr Stevens and Major Brooks for their presentation and for attending the meeting.
22/122	**Freedom to Speak Up Guardian Report** (agenda item 6.1)
	The Chair welcomed Mike Craissati, the Trust's Freedom to Speak Up Guardian. The Freedom to Speak Up Guardian presented the report and which also included the results of the national Freedom to Speak Up Guardian Survey 2021. It was noted that the national survey had highlighted that In 2020, 80% of Freedom to Speak Up Guardians who responded to the survey said that senior leaders supported staff to speak up. But in 2021, this fell to 71%. The Freedom to Speak Up Guardian reported that Board and senior management's support for speaking up in the Trust had continued to increase and reported that he was also heavily involved in the Trust's patient safety culture work. The Chief Operating Officer commented that it was useful to have the national picture from the Freedom to Speak Up Guardian Survey 2021. As a new Board member, the Chief Operating Officer asked whether there was more she could do with her senior leadership team to promote a Speak Up culture and to respond to concerns raised. The Freedom to Speak Up Guardian said that the National Guardian's Office had produced guidance on promoting a Freedom to Speak Up culture which was relevant to all leaders and managers. The Chief Executive reported that he held regular meetings with the Freedom to Speak Up Guardian, Director of Nursing and Therapies and the Deputy Director of People to discuss the Freedom to Speak Up cases and to triangulate this information with other intelligence. The Chief Executive said that these meetings sometimes highlighted persistent poor leadership behaviours within individual teams/services. The Chief Executive said that in

	these cases, additional support was provided to these services from a multi-disciplinary organisational development team. The Chief Operating Officer noted that the National NHS Staff Survey results for the Trust had highlighted the that a disproportionately high number of Black, Asian and Minority Ethnic (BAME) staff had reported that they had experienced bullying and harassment and asked whether there was more that could be done to encourage BAME staff to speak up. The Freedom to Speak Up Guardian reported that he worked closely with the Staff Network Chairs and said that he also attended the fortnightly BAME Network's informal "Let's Talk" meetings. It was noted that the Freedom to Speak Up Guardian was also supported by Freedom to Speak Up Champions which included people from BAME backgrounds. Sally Glen, Non-Executive Director reported that she had been the Non-Executive Director lead for Freedom to Speak Up in another Trust and commented that in that organisation some staff raised their concerns directly with the Care Quality Commission rather than using the Trust's internal Speak Up routes and asked whether this was an issue for the Trust. Director of Nursing and Therapies confirmed that the Trust received very few concerns from staff which were raised directly with the Care Quality Commission. The Chair thanked the Freedom to Speak Up Guardian for his report and for the work he did and said that it was important that the Trust did not become complacent. **The Trust Board**: a) noted the report; and b) supported for the Guardian's recommendations as set out below: o 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. o 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. o Supported assisting in minimising those barriers to communication that may prevent those wishing to speak up (in any way) from doing so. o Approved a proposal for a case review on leadership and culture change o Agreed to address the challenges from the National Guardian o Agreed to Implement and promote the guide for leaders produced by the National Guardian's Office. o Agreed to note, learn and consider appropriate changes from feedback given.
22/123	**Annual Complaints Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and reported that producing an annual complaints report was a statutory requirement but pointed out that all the

	information had been previously shared with the Trust Board as part of the quarterly Patient Experience Report. **The Trust Board:** noted the report
22/124	**Medical Appraisal and Revalidation: Annual Board Report** (agenda item 6.3)
	The Medical Director reported that the Annual Board Report and Statement of Compliance for 2021-22 was presented in the format prescribed by NHS England. The Medical Director reported that the Trust had completed 136 out of 139 doctors who had a connection with the Trust medical appraisals during 2021-22. It was noted that the three outstanding appraisals were completed between April to May 2022. **The Trust Board:** **a)** Noted the assurance provided by the Responsible Officer (Medical Director) that the Trust's medical appraisal and revalidation process was compliant with the regulations and was operating effectively within the Trust **b)** Authorised the Chair to sign the Statement of Compliance (as set out at page 158 of the agenda pack).
22/125	**Quality Assurance Committee** (agenda item 6.4)
	The minutes of the Quality Assurance Committee meeting held on 7 June 2022 had been circulated. Sally Glen, Chair of the Quality Assurance Committee reported that the minutes of the meeting were comprehensive and covered the key issues discussed at the meeting. Ms Glen reported that the Trust's learning from deaths process had identified one lapse in care. Ms Glen reported that the Trust's Guardian of Safe Working Hours had only identified one incidence of a junior doctor working an additional hour and confirmed that the Guardian of Safe Working Hours had not identified any other breaches or patient safety issues. The Chair thanked Ms Glen for her update. **The Trust Board noted**: a) The minutes of the Quality Assurance Committee held on 7 June 2022 b) The Learning from Deaths Quarterly Report and c) The Guardian of Safe Working Practices Quarterly Report.
22/126	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. **The Trust Board**: noted the paper.

22/127	**Month 02 2122-23 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust had submitted a plan for a £2.7m deficit for the year. The Trust was on plan and was reporting a £0.9m deficit as at the end of May 2022. • Following revisions to the national planning guidance and an agreement on additional funding to cover inflationary pressure, a revised plan was submitted to move to a £0.9m deficit position for 2022/23. This would be incorporated into reports from Month 3. • The national agenda for change pay award was expected soon. • Permanent staff recruitment was lower than forecasted. Expenditure on non-permanent staff had decreased since April 2022 but remained above plan. This was driven in part by sickness absence levels due to COVID-19 which were above target • The Trust had a requirement to deliver £9.7m of cost improvements. The achievement of savings was expected to increase over the year. The Trust was currently £0.1m ahead of plan. • Capital expenditure year to date was £0.2m behind plan. The Trust was seeing price inflation and supply chain issues impacting tender prices and were keeping the capital programme under review to ensure that it remained in budget. • Cash balances remained strong at £51.9m The Chair referred to the slippage in permanent workforce recruitment and asked whether the Trust had a plan to get back on track in relation to recruitment. Naomi Coxwell, Non-Executive Director added that the financial plan had assumed a net increase of 400 permanent members of staff and said that the Finance, Investment and Performance Committee would be keeping a close eye on the Trust's recruitment and the use of bank and agency staff. The Chief Operating Officer reported that she started a discussion with the Operational Leadership team about what more could be done this year to enable the Trust to do things differently next year in order to reduce some of the burden staff were feeling at the moment. This included suggestions about working differently and changing the skill mix. The Chair that said that he looked forward to hearing more about the outcome of the Operational Leadership's discussions. **The Trust Board**: noted the report.
22/128	**Month 02 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and reported that and highlighted the following points: • The incidence of falls in community and older adult mental health inpatient wards was RAG rated red at 31 falls compared with the target of 26 falls. However, it should be borne in mind that the Trust's number of falls was below the national average

	• The Trust had held a Falls Reduction Rapid Improvement event attended by a cross section of staff and had identified a number of countermeasures aimed at reducing the number of falls • Self-harm incidents on mental health wards (excluding learning disability unit) was 74 against a target of 67. Snowdrop and Bluebell wards were the highest contributors this month • Physical health checks for people with severe mental illness performance was 78% against a revised stretch target of 90% • I Want Great Care compliance (replacing Friends and Family Test) response rate was 0.6% for April 2022 against a 10% target. The new system was being embedded and would take time to see improvements in the response rate. The Chair referred to the staff turnover rate which was showing a steady increase month on month and asked whether the increased turnover related to staff in low paid roles. The Director of People agreed to provide the Trust Board with a breakdown of the staff turnover data. **Action: Director of People** Sally Glen, Non-Executive Director asked whether the Trust was seeing an increase in the number of people retiring post-COVID. The Director of People reported that the Trust operated a successful retire and return policy. The Director of People reported that the Trust would be piloting a reservist scheme on behalf of the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System where retired staff agreed to come back and work for the Trust for a minimum 30 days per year. Naomi Coxwell, Non-Executive Director referred to the I Want Great Care response rate and asked whether the Trust had a projection around when the 10% target would be met. The Director of Nursing and Therapies reported that the I Want Great Care response rate was increasing month on month and said that switching on the SMS functionality would improve the response rate. The Chief Executive suggested that Board members asked frontline staff about the I Want Great Care tool as part of their visits to services. **The Trust Board**: noted the report.
22/129	**Equalities, Diversity and Inclusion Strategy Update Report** (agenda item 9.0)
	The Chair welcomed Jane Nicholson, Director of People to the meeting. The Director of People presented the paper and reported that Trust was currently focusing on reducing bullying and harassment particularly in relation to Black, Asian and Minority Ethnic staff and people with disabilities who reported significantly higher levels of bullying and harassment than white and non-disabled staff. This included developing a formal conflict resolution process using external facilitators to try and resolve conflicts. The Director of People reported that during the pandemic, the Trust had paused leadership training and this had meant that inexperienced staff appointed into leadership

	roles had not received the training around inclusive and compassionate leadership to support them in these roles. It was noted that the Trust was currently refreshing its leadership training modules. The Director of People reported that the Trust was aware that Black, Asian and Minority Ethnic staff were under-represented in leadership roles. To address this, the Trust was considering developing a sponsorship programme whereby senior leaders supported individual Black, Asian and Minority Ethnic staff to apply for more senior roles. The Director of People reported that as part of the neurodiversity work, the Trust would be piloting a scheme whereby all applicants for a particular job would be given the interview questions in advance so that they could prepare their responses. The Deputy Chief Executive reported that the Trust had identified that Black, Asian and Minority Ethnic staff working at Prospect Park Hospital experienced high levels of racial abuse from patients and had taken action to address this by introducing a zero tolerance of racial abuse policy. The Deputy Chief Executive said that this initiative had resulted in higher levels of staff confidence around the Trust's commitment to racial equality. The Chair welcomed the zero tolerance of racial abuse at Prospect Park Hospital and said that the Trust needed to maintain a strong focus on identifying issues of concern and developing interventions to address those issue. The Chair commented that management and leadership training was important but acknowledged that some people may not have the necessary skills set to be able to manage staff and therefore the Trust may need to think through the selection process for management/leadership roles. **The Trust Board**: noted the report.
22/130	**Audit Committee Meeting – 08 June 2022** (agenda item 10.0)
	The minutes of the Extraordinary Audit Committee meeting held on 8 June 2022 had been circulated. Naomi Coxwell, Non-Executive Director and member of the Audit Committee reported that the meeting had been scheduled to approve the Annual Accounts 2021-22 but the External Auditors had raised an issue regarding the valuation of the Trust's PFI hospitals. It was noted that the Trust's valuation was provided by the District Valuer but the External Auditors' own property valuers had used a different method of calculating the value of the properties and had reached a significantly different valuation. The Chief Financial Officer reported that until an agreement could be reached between the District Valuer and the External Auditors, the Trust's Annual Accounts 2021-22 could not be submitted to NHS England. It was noted that the Trust had informed NHS England about the issue. The Chief Financial Officer reported that the Trust had also engaged the services of a second property valuer. Ms Coxwell said that she was supportive of the actions the Trust was making to try and resolve the issue. The Chair thanked Ms Coxwell for her update.

	The Trust Board: noted the minutes of the Audit Committee meeting held on 08 June 2022.
22/131	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that he had run induction sessions for new governors. The Chair reported that the Governors were engaged and positive and thanked the Governors for their contribution to the work of the Trust. The Chair reported that following the retirement of John Barrett, he was discussing with the Lead Governor whether the focus of the Living Life to the Full Governor Working Group should be around taking a system view of services provided outside of the Trust.
22/132	**Any Other Business** (agenda item 11)
	There was no other business.
22/133	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on (09 August 2022 if required) 13 September 2022.
22/134	**CONFIDENTIAL ISSUES:** (agenda item 12)
	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 12 July 2022.

Signed…….. Date 13 September 2022

(Martin Earwicker, Chair)

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

Op COURAGE delivered by Berkshire Healthcare

Dr Adele Stevens, Principal Clinical Psychologist & Strategic Lead

Berkshire Healthcare Armed Forces Commitment

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

Legislation / Scheme
UNDERPINNING LEGISLATION The Armed Forces Covenant
The MOD Employee Recognition Scheme
NHS Step Into Health
Career Transition Partnership
NHS I Veterans Covenant Healthcare Alliance
Army Families Federation

Berkshire Healthcare Armed Forces Commitment

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

ARMED FORCES COVENANT
EMPLOYER RECOGNITION SCHEME
GOLD AWARD

Awarded July 2022

VETERAN AWARE

Accredited Oct 2021

Launched Nov 2021

Berkshire Healthcare

2012: South Central Veteran Service

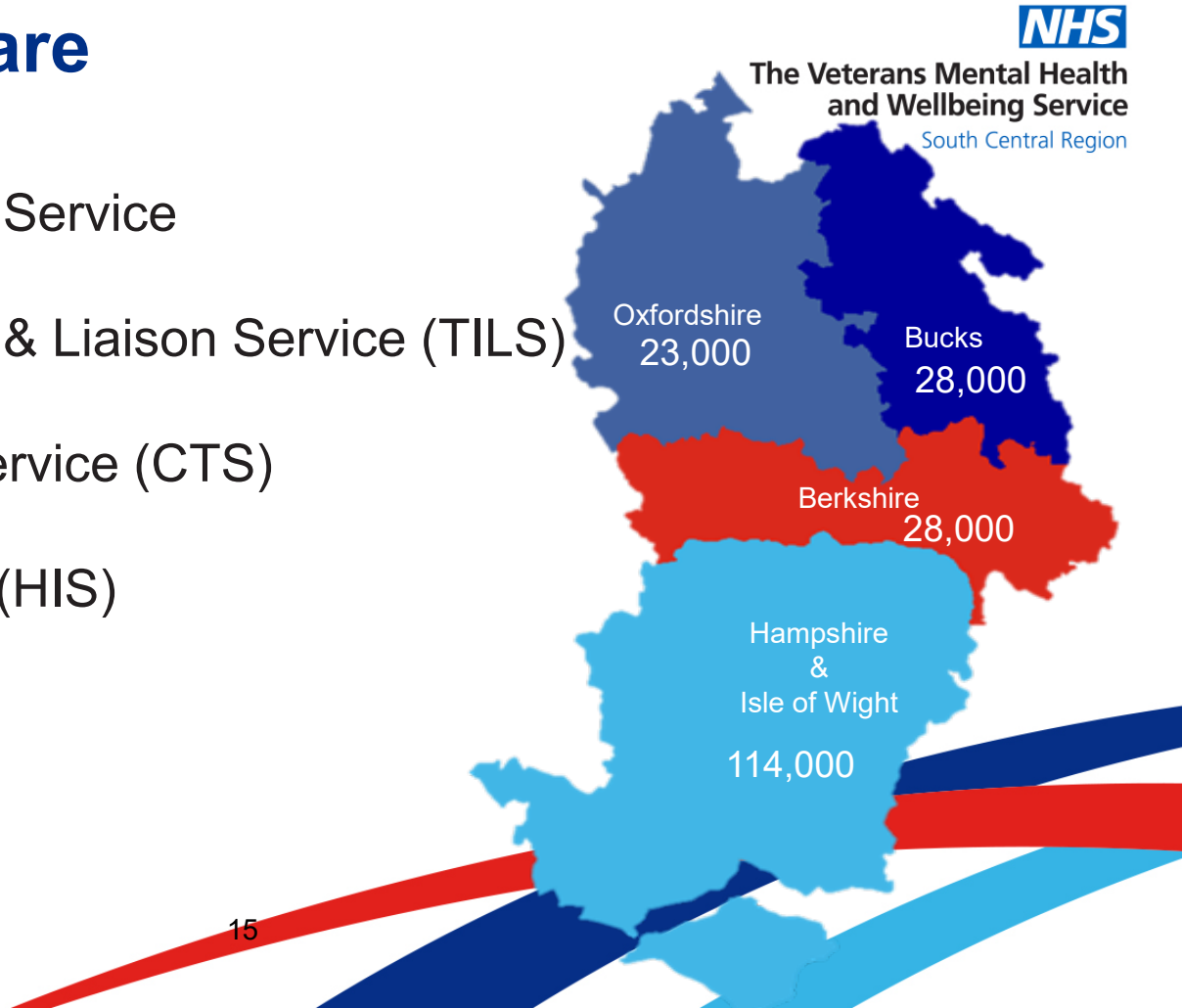
2017: Transition Intervention & Liaison Service (TILS)

2018: Complex Treatment Service (CTS)

2021: High Intensity Service (HIS)

2021: OpCOURAGE

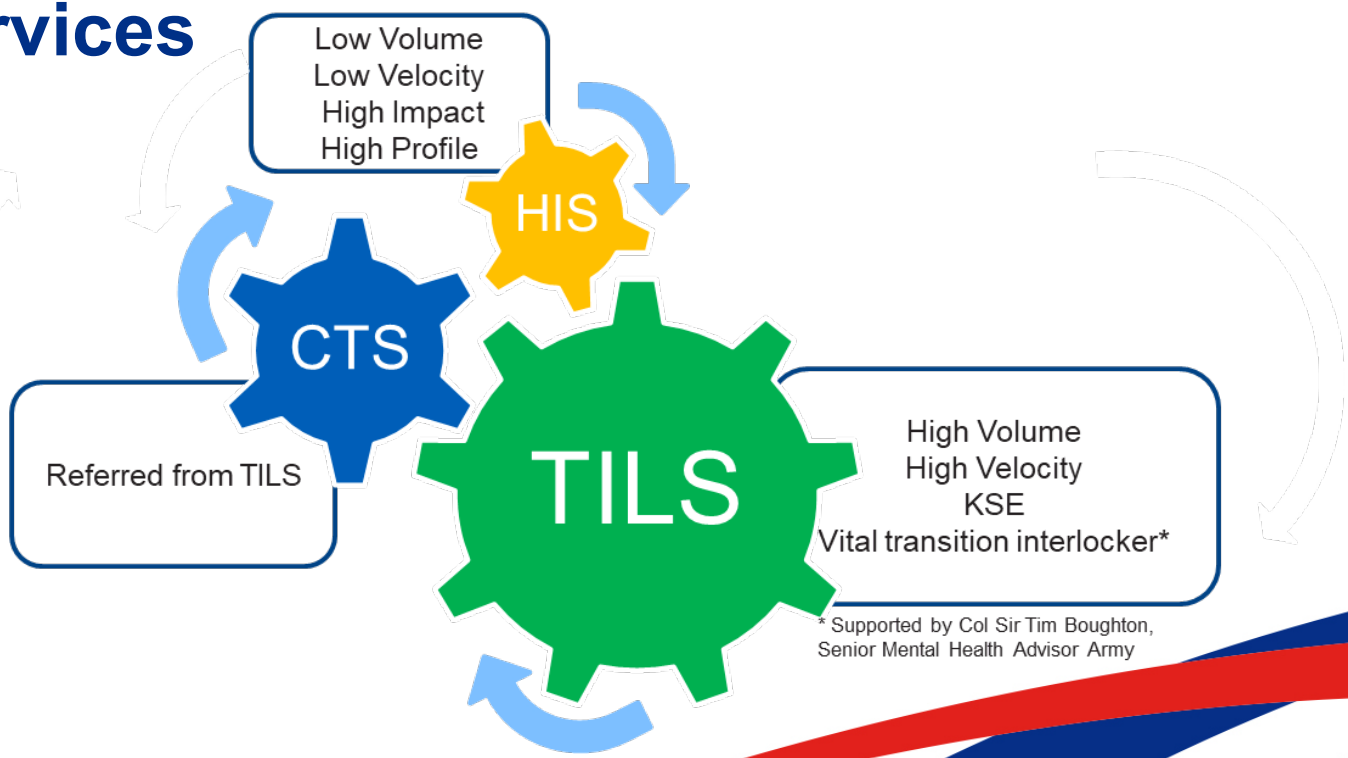
2023: Re-tender



OpCOURAGE

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

The Services



* Source NHSE AF

Needs of Veterans

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

- Transition
- Substance Misuse
- Mental Illness
- Physical Injury
- Criminal Justice
- Relationship Breakdown
- Employment
- Family Needs
- Homelessness

Making a difference to veterans' lives

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

- Veteran informed service
- Peer support workers
- Cutting edge clinical innovation & collaboration

  Compassion focussed

  Be Your Best Ally (with Combat Stress)

  True Strength Group OpCOURAGE
- Dedicated substance misuse practitioner
- Dedicated family worker

Veteran informed care

The Veterans Mental Health and Wellbeing Service
South Central Region

Language

Engagement

Clinical intervention

Gemma’s story

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

Thank you

NHS
The Veterans Mental Health and Wellbeing Service
South Central Region

'I have a brand-new foundation. I am far more secure and sure of myself. When I have a down day or a blip, the bounce back is quick – and the biggest difference is that I am so much kinder to myself when I have them'.

'Most of us end up on a scrap heap after we leave the military and its you who come in, pick us up and help us live again. Everyone's doing an amazing job, a job that doesn't often get a lot of praise. What you do is more than important. You deserve a pat on the back because you are the real heroes.'

'Thank you for your fantastic support you have given me.'

Berkshire Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS MEETING 13.09.22

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
12.07.22	22/120	Action Log	The Chief Financial Officer to circulate the number of staff who left the Trust within the first year.	September 2022	**PG**	219 members of staff left the Trust within the first year to working for the Trust over the course of the last year	
12.07.22	22/128	Performance Report	A breakdown of the staff turnover figures to be shared with the Trust Board.	September 2022	**JN**	Included at appendix 1.	

HR Dashboard: Summary (June 2022)

NHS Berkshire Healthcare NHS Foundation Trust

Sickness	Turnover	Leavers	Starters	IG Training	Fire Training	Headcount
Trust level (June 2022) Trust target 3.5%	Trust level (June 2022) Trust target 12%	Trust level (June 2022) Total & FTE	Trust level (June 2022) Total & FTE	Trust level (June 2022) Target 95%	Trust level (June 2022) Target 95%	Trust level (June 2022) Total & FTE
4.41%	16.84%	75 / 65.98	76 / 66.07	95.8%	91.8%	4,814 / 4,178 FTE

Sickness by Service	Turnover	Leavers	Starters	IG Training	Fire Training	Headcount
371 Children, Young People, Families & Learning Disabilities Services	4.16%	19.07%	14 / 11.26	16 / 14.22	97.9%	94.3%	874 / 723.3
371 Community Health East Services	4.92%	19.99%	10 / 8.18	10 / 8.70	98.4%	94.2%	612 / 523.2
371 Community Health West Services	4.71%	18.07%	17 / 15.26	19 / 16.44	95.9%	93.8%	1,027 / 847.3
371 Corporate Services	2.37%	11.65%	7 / 5.68	9 / 7.88	93.6%	85.4%	606 / 550.9
371 Head of Inpatient (MH) Services	8.77%	16.69%	4 / 4.00	3 / 3.00	94.3%	80.0%	312 / 297.1
371 Mental Health East Services	5.16%	17.39%	7 / 7.00	5 / 4.43	94.9%	91.1%	363 / 325.7
371 Mental Health West Services	4.23%	16.57%	13 / 12.00	12 / 10.20	95.7%	93.1%	835 / 746.9
371 Other Health Services Service	0.60%	9.55%	3 / 2.60	2 / 1.20	89.1%	80.7%	185 / 163.3

Berkshire Healthcare NHS Foundation Trust

Trust Board Meeting Paper

Meeting Date	13th September 2022
Title	Patient Experience Report Quarter 1 (April -June 2022)
	Item for Noting
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 1
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience Debbie Fulton , Director Nursing and Therapies
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, Diversity and Inclusion Implications	Tables 8, 9 and 10 of the report includes ethnicity, age and gender data in respect of complaints
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 1 (April – June 2022). The 'I want Great Care' patient experience tool is now being used as our primary patient survey programme and was introduced in December 2021; this is available to patients through online, SMS, paper, and electronic tablet; it is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge. As services start to embed the use of this tool, we are seeing an increase in the numbers of responses received which will support areas for improvement alongside hearing the patent voice both where the experience is good and where improvements could be made With the new patient survey now being used across the organisation the patient experience report has been restructured to enable triangulation of data from complaints, compliments and the survey by Division. 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. We are seeing that wait times especially for CAMHS services are featuring across both formal and informal complaints, local resolution and MP enquires. This is not a new theme and there are a number of initiatives in place to support reduced waiting times particularly for neurodiversity pathways.

	Involvement and information came out across the divisions as being the areas for most improvement whilst this was not true of all individual services it is an area of focus for some; this included understanding of why visits were occurring. There were also several services where ease of access including venue, type of appointment and appointment time came across as areas for improvement, although these were all in small numbers: with the vast majority of patients being very satisfied with all aspects of their care and treatment. The positive compliments and feedback received continues to far outweigh the concerns and complaints raised with the overall trust positive satisfaction score from the patient survey being 94% resulting in a 4.75 5-star rating. That said every concern / complaint is reviewed with feedback provided and consideration given to learning from the persons experience. There were a number of 15 steps visits undertaken during quarter 1, and Appendix 1 of the report provides a short summary of these.
ACTION REQUIRED	The Trust Board is asked to: Note the report.

Patient Experience Report; Quarter One 2022/23

Introduction

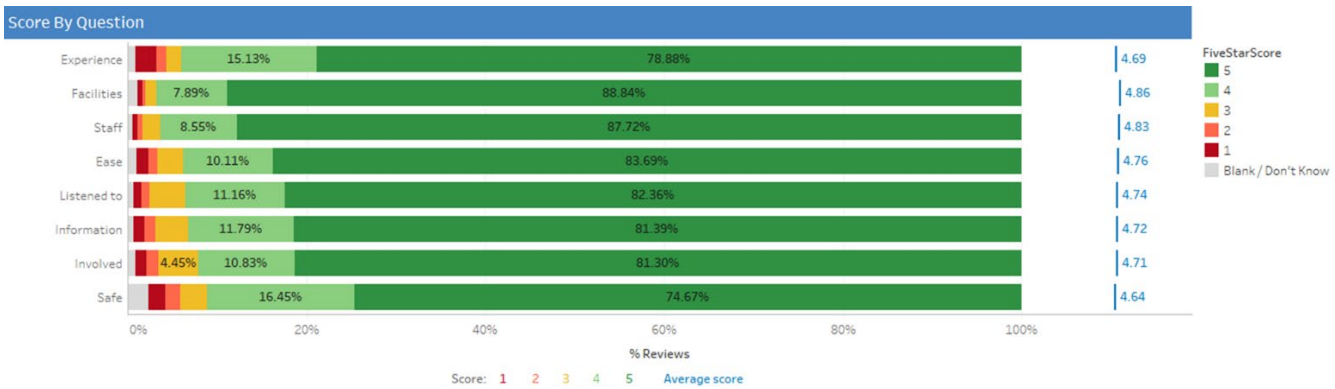
This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, PALS, and our patient survey programme. The report usually also includes any feedback received via NHS Choices however the NHS choices platform merged onto the nhs.uk website, and feedback relating to the Trust was not available at the time of writing this report.

This report is written in the context of there being 113,817 reported patient contacts and discharges from our inpatient wards with around 2990 pieces of feedback provided through compliments, complaints and the patient experience survey equating to around 2.7% feedback. The total amount of feedback received is expected to rise as more services utilise the patient feedback survey.

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

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

Below is the trust overall scoring which is based on the **2,069** responses received during the quarter; a **94% positive score** was achieved with an average **4.75-star** rating. We are seeing a month on month increase in the number of patient surveys completed (April 449, May 710 and June 910). It is worth noting that not all questions are scored by everyone, for example facilities related questions only apply where patients are seen in a building / are on a ward/ outpatient appointment and are therefore not asked in all surveys. Our surveys are also available in easy read and differing languages.



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

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

Service	Star Rating	Number of Responses	% Positive Score
District Nursing & Community Matrons West Berks	4.93	118	99.2
CRHTT East	4.40	111	93.7
Talking Therapies	4.56	80	87.5
Henry Tudor Ward	4.64	72	93.1
Jubilee Ward	4.51	72	88.9
CRHTT West	4.19	69	78.3
Sexual health Upton and Skimped Hill	4.90	68	97.1
MSK Physio - Wokingham	4.89	63	98.4
Intermediate care West Berks	4.69	55	89.1
Intermediate care Wokingham	4.73	53	96.2
Community Nursing Wokingham	4.84	49	100
Hi-tech care community	4.89	48	95.8
Community Paediatrics	4.87	42	90.5

The patient survey also includes a free text section for a review and any suggested improvements.

During the quarter, there were a total of 113,817 contacts (including discharges from wards), the Trust received a total of **61 formal complaints** (14 of these were secondary complaints) this equates to 0.05%, and a further **25 concerns that were locally resolved** / responded to as informal complaints. **57 formal complaints were closed** during the quarter with a **98% response within agreed timescale** achieved. We also received **837 compliments** in addition to the patient survey feedback and **26 MP enquiries.** The number of formal complaints received is comparable with previous quarters and the number of concerns locally resolved or responded to as informal complaints has reduced. The number of MP enquires has risen every quarter since Q1 2021/22, this is predominantly due to enquiries around CAMHS waiting times in the West of Berkshire.

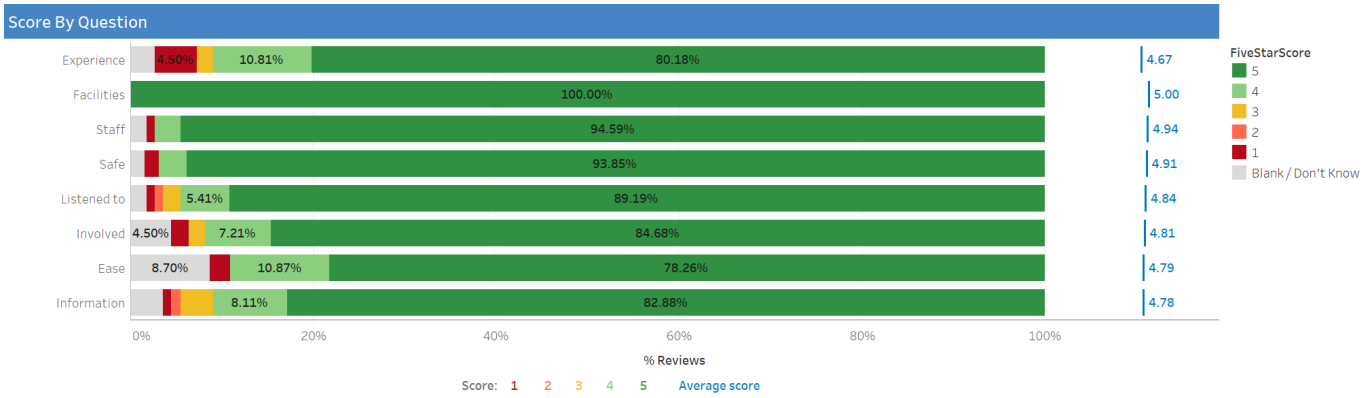
What the data is telling us

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

Children and Young Peoples division including learning disability services

Table 2: Summary of patient experience data

Patient Experience - Division CYPF and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	111			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	0.5%			
iWGC 5-star score	Number	4.81			
iWGC Experience score – FFT	%	91%			
Compliments received directly by services	Number	47			
Formal Complaints Rec	Number	11			
Formal Complaints Closed	Number	15			
Formal Complaints Upheld/Partially Upheld	%	60			
Local resolution concerns/ informal complaints Rec	Number	11			
MP Enquiries Rec	Number	21			



Children and Young People

For children's services the question regarding 'information' (was the information you were given easy to understand?) received lowest score with 6 of the 111 surveys responding with a score of 3 or below, this was followed by the question regarding 'involvement' (were you involved as much as you wanted to be in your care or therapy?) and the question regarding if the patient felt 'listened to' (Were you listened to?) which both had 4 of the responses receiving a score of 3 or below. Although 'ease' scored second to bottom in the chart above this is skewed by the number not completing that question (the number of negative scores were 2).

Children's Physical Health Services

For children's physical health services there were a total 7 formal complaints received, 3 of these were for the immunisation team and 3 were in relation to children's speech and language therapy, there were also 2 children's speech and language therapy concerns relating to waiting times responded to informally. There were 4 formal complaints that were closed as either partially upheld or upheld during the quarter (3 for the immunisation team

and 1 for occupational therapy), of these 3 related to communication and one was about the vaccine. To provide some context the school immunisation team administered 27,663 immunisations during quarter 1.

82 of the 111 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Immunisation teams and the East Community Paediatric team; the Immunisation team received 38 of these responses all of which scored positively receiving a five-star rating of 4.92. The Community Paediatric team in the East received 42, all of which were positive with a five-star score of 4.87. The services received many free text comments related to kindness, friendly staff, professionalism and being clear about treatment plans.

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were four complaints received for CAMHS services (these were in relation to wait times, attitude of staff and care/ treatment received). In addition to this, 21 of the organisation's total of 26 MP enquires related to CAMHS services with 16 relating to waiting times.

There have only been 14 responses for CAMHS services received through our patient survey for this quarter, with the majority (10) being received for the family safeguarding model service and therefore it has not been possible to use the data to support triangulation this quarter. It is worth noting that the 2 responses received in relation to the neurodiversity team were positive about the service received. Currently the survey is accessed through paper forms or configured tablets in the departments, from end of quarter 2 it will also be possible for young people to provide their feedback online which is anticipated to support an improved uptake.

The CAMHS service have been undertaking an experience questionnaire internally and this received a total of 105 responses (44 from young people and 61 from parents/ carers). This provides an opportunity for free text comments alongside some key questions including feeling listened to, gaining help needed and appointment times . Convenience of time and place of appointments received the least favourable responses with 50-60% answering this as 'certainly true'. For the question around feeling listened to 98% parents / carers and 84% young people answered 'certainly true', with similar scoring for both 'being treated well', 'being taken seriously'. For understanding of help available the 'certainly true' scores were 90% for parents and around 70% for young people themselves. With overall help received given 93% by parents and carers and 86% by the young people . There were lots of free text comments around feeling listened to, and positive comments about staff. With comments around long wait times and flexibility of appointment featuring as some of the suggestions for improvement.

The services have also received some compliments including '*''CAMHS autism assessment team I have to say, I was so impressed with your manner and impact with xxx. You clearly have a rare talent for engaging young people and I can't thank you enough for how you have shared this with our family. You are one in a million!''.*

Learning disability

There were 3 complaints received this quarter for the Campion unit (from 2 differing patients) and 1 concern in relation to community learning disability services that was locally resolved. 3 complaints were closed this quarter, 2 were in relation to staff attitude and 1 was around concern of not being able to see a pet, all 3 were partially upheld.

10 responses from the patient survey have been received (7 were in relation to the Wokingham based team). These received 80% positive score which was skewed due to 2 service users providing only a 1-star score which the remaining 8 providing positive scores.

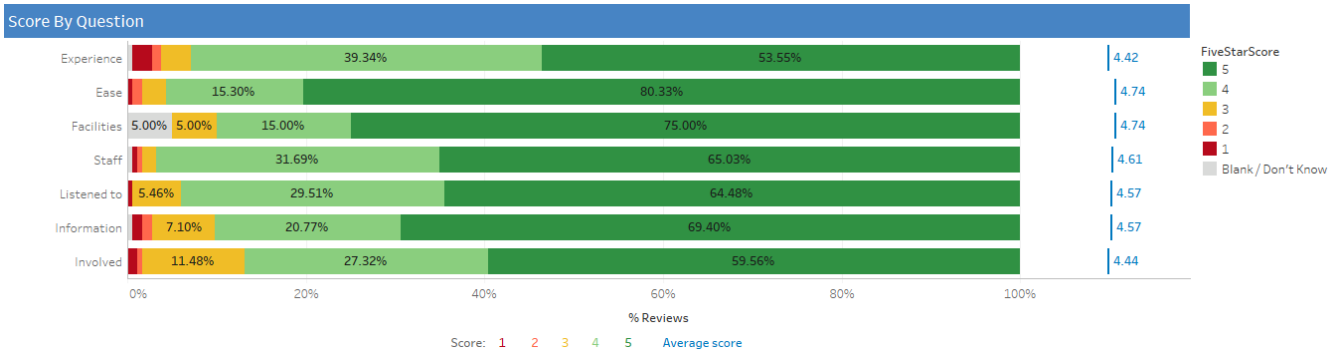
Neither of those who scored 1 provided feedback to understand their concerns further, the positive responses included free text narrative speaking positively about staff for example;

''*Because this place feels like a family home style environment than a hospital and because all of the staff and patients at this hospital have treated me better than my own parents family members and care staff in all of my previous care homes ever have done''* and ''*If I need any advice no matter how big or small I can always contact x and Salt team and she will always come back to me with appropriate advice and will also come out to see the person I am concerned about''.*

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

Table 3: Summary of patient experience data

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	183			
Response rate (calculated on number contacts)	**%**	1.5			
iWGC score	**Number**	4.56			
iWGC Experience score - FFT	**%**	93%			
Compliments received directly by services	**Number**	43			
Formal Complaints Rec	**Number**	9			
Formal Complaints Closed	**Number**	7			
Formal Complaints Upheld/Partially Upheld	**%**	71			
Local resolution concerns/ informal complaints Rec	**Number**	5			
MP Enquiries Rec	**Number**	0			



Two of the services within Mental Health East division received the majority of the patient survey responses (CRHTT 102 and Slough Memory Clinic 28) of the CRHTT survey responses the average 5-star score was 4.4 with 93.69% positive feedback, this was in line with the overall divisional scores achieved.

Questions relating to feeling involved and information were least likely to be positive and some suggestions for improvement included lack of support on discharge from CRHTT, and some areas around communication including clarity around reason for calling and notice before a home visit all were noted in the feedback; however there was a significant amount of positive feedback including that they found the staff/ service to be very supportive, kind, caring, compassionate, interested and responsive.

Some examples of compliments received by the division are detailed below:

''Called the crises team line on Thurs 7th Jul, lady I spoke to was great I felt listened too and not rushed or like a nuisance. Crises Home Treatment Team came out later that evening. [name removed] I connected with and felt at ease about opening up, specially as she was honest about her past struggles too. [name removed] had a calming presence and took action on one of my housing issues by contacting my housing association, which was greatly appreciated. Few days after [name

removed] and another male social worker came and were both great. I was doing a lot better that day so enjoyed having more of a not in crises chat. Thank you for providing such great support and despite passing my care back to GP you still left the door open to contacting again. I know you guys will continue to inspire others, thank you for making such a difference''. (CRHTT)

''Staff were extremely professional and treated me like a human being. They were non-judgemental. Could not fault the team. Valuable service''. (CRHTT)

"x is the best!! She is so kind and very lovely and helps me so much". (CMHT)

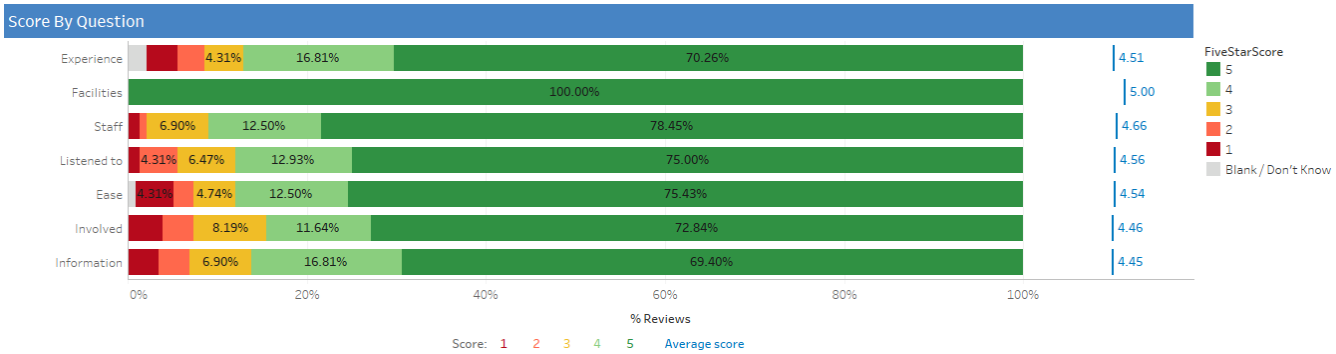
''Simply that it was clear that to the staff my condition was of very great importance to them''. (Older adult MH)

7 complaints were received into the division during this quarter; in addition there were 5 informal/ locally resolved complaints. 7 complaints were closed during the quarter of these 5 were partially upheld and 2 were not upheld. Of those partially upheld 3 were relating to Slough CMHT, there were no themes in relation to any of the complaints.

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

Table 4: Summary of patient experience data

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	232			
Response rate (calculated on number contacts)	**%**	0.5%			
iWGC score	**Number**	4.53			
iWGC Experience score - FFT	**%**	87%			
Compliments received directly by services	**Number**	434			
Formal Complaints Rec	**Number**	14			
Formal Complaints Closed	**Number**	11			
Formal Complaints Upheld/Partially Upheld	**%**	55			
Local resolution concerns/ informal complaints Rec	**Number**	2			
MP Enquiries Rec	**Number**	2			



The Mental Health West division has a wide variety of services reporting into it, including Talking Therapy services and Court Liaison as well as secondary mental health services. The 2 services with the most feedback through the patient survey were Talking Therapies with 80 responses and CRHTT with 69 responses.

As with Mental Health East division feeling involved and informed received the most negative reviews in the patient survey.

CRHTT received 2 complaints during the quarter and 3 complaints were closed, 2 of these were partially upheld, one in relation to staff attitude and one to confidentiality; in addition to

the patient survey feedback 4 compliments were received directly into the service. Feedback from the survey was varied and whilst a large proportion was positive with comments such as '*'best experience I've had they were helpful and supportive got a good relationship with the staff open up and communicate with them honestly''*; along with comments about feeling listened to there were some comments from patients who didn't feel they needed the help of the service and also around call/ visit times not always being kept to as well as some finding the service didn't help them. CRHTT use all comments provided to help shape provision along with a dedicated lived experience worker who supports the whole team to improve on service user and carer experience.

There were 7 complaints for West CMHT's during the quarter and 3 complaints closed during the quarter (none of these were upheld). Very little feedback was received through the patient survey during the quarter to enable triangulation of patient experience data. There was 1 older adult complaint closed which was not upheld during the quarter. Older adult and memory clinic combined have received 44 patient survey responses during the quarter with a 97.73% positivity rating (4.84-star rating) some of the feedback included *''Wonderfully helpful and sympathetic team, and one which communicated really well between themselves''; ''The location flexibility certainly helped Dad with his thought process and was far less formal than an unfamiliar surrounding. x was fantastic!. She was empathetic to my fathers needs and made it seem like he was in control of his situation. The information shared was relevant and useful''* and '*'I was really impressed with x's listening skills and the follow up was very fast. By a very long way the most advanced assistance that I have received (during 60 years of varied and intermittent problems)''.*

For Talking Therapies their patient survey responses gave a positivity score of 87.5% (4.56 star rating), they are also the service who receive the most compliments back to the service with 364 received this quarter. There were no complaints opened and one complaint closed which was partially upheld and in relation to consent prior to speaking with another agency.

The vast majority of comments were very positive about the staff, finding them kind, supportive and empathetic. A number of the comments /areas for improvement demonstrated need for flexibility and differing approaches preferred for example *'My first sessions with the counsellor were face to face, I was extremely uncomfortable with this approach…….I later asked for a telephone consultation, this was approved. From then on I felt much happier''; ''Shouldn't be on video call. Should be in person'', ''Was also annoyed that it was very inflexible in terms of appointment times''; 'have more options than the app'', ''I would have preferred to have had face to face appointments, I hope that this is something that will be reinstated for people that would prefer it to phone calls''.*

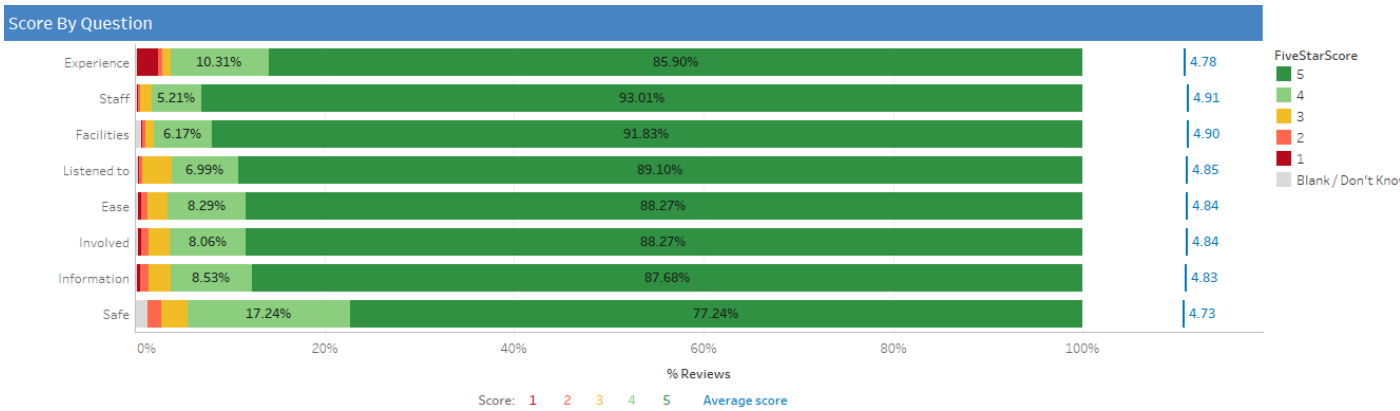
There were 6 reviews that scored very low (1 or 2 star) where patients did not feel that the service had been at all helpful to them. To provide some context there were 28,053 contacts for the service during the quarter.

There is currently one complaint being investigated by PHSO (Psychological Medicine Service).

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

Table 5: Summary of patient experience data

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	755			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3.4%			
iWGC score	Number	4.83			
iWGC Experience score - FFT	%	96%			
Compliments received directly into the service	Number	174			
Formal Complaints Rec	Number	5			
Formal Complaints Closed	Number	2			
Formal Complaints Upheld/Partially Upheld	%	100			
Local resolution concerns/ informal complaints Rec	Number	6			
MP Enquiries Rec	Number	0			



During this quarter there were 5 complaints received into the division and 6 locally resolved/ informal, 3 of the formal complaints were for community nursing; 2 complaints were closed for community nursing; both of the closed complaints were from the same person and were partially upheld.

To provide some context across our East and West District Nursing teams combined there are 71,561 contacts this quarter. East Community Nursing / Community Matrons received 89 patient survey responses during the quarter with a 100% positive scoring and comments including, *''i received T/c from nurse, was very caring and she has given me plenty of time to express my concerns in regarding to my mother's health'', ''you lot are doing really good and I'm grateful for your hard work'', ''Everybody is really kind and friendly, nothing is too much trouble'* and *''nurse was helpful, caring and allowed time for me answer/ques''.* District nursing services (East and West) also receive the second highest number of compliments directly into the service this quarter (95)

The other complaints received were for Jubilee ward and the assessment and treatment centre. Jubilee ward has also received 72 patient survey during the quarter with an 89% positive scoring, it would appear that the 2 scores giving 1 star each which impacted overall rating may have read the questionnaire wrongly as their comments were both very positive. Comments included '*I like the staff and the happiness around the ward', 'I felt that I received the best treatment in the hospital all the staff and as were very nice and looked after me well* and *'because staff are excellent'.* There were some mixed reviews regarding the food. The scoring was mirrored across Henry Tudor ward with 93% positive rating, the improvements for the ward included some desire for increased therapy.

The Community Dental service received 41 responses to the patient survey during the quarter with a positive score of 95% and all but 1 score receiving 5 stars, there were lots of comments about kindness and friendliness of staff including ‘*’Because the dentist was very kind and it got me over my fear of x-rays. He explained everything to me as well”* and ‘*’very friendly, very approachable, very clear and we’re very good with speaking and communicating with my 6 year old. Highly recommended”.*

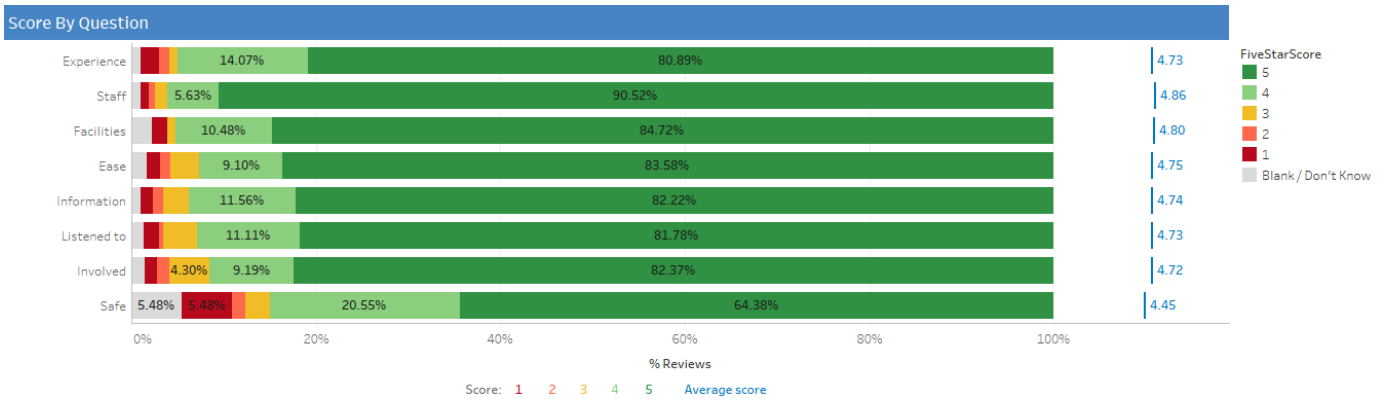
As with MSK physio in the West, there was a high number of responses to the patient survey and a high positivity score of 97% (4.93 stars), comments were very complimentary about staff and included ‘*All the Physiotherapy team that I have seen have been extremely professional and supportive of my issues. I have also been attending a 4 week online course with x. I have also seen X face to face and feel the course very much helped me strengthen my injury with the 45 minute session. It worked very well and x is very good at explaining the steps as we go through the course.’* There were no themes emerging from the improvement suggestions.

All of the outpatient services within the locality received equally positive scores for example hearing and balance received a 100% positivity score (4.98 stars) from the 42 responses received including ‘*’When people attend a hospital they don’t want fuss , they want a calm environment with things explained clearly by staff that know what they are talking about in an easy to understand manner . This was my experience today”.* There were no themes across areas for improvement detailed within the survey feedback and patients were generally all very satisfied with services provided across the division, where patients were less satisfied these were down to specific individual reasons.

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

Table 6: Summary of patient experience data

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	675			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	0.9%			
iWGC score	Number	4.76			
iWGC Experience score - FFT	%	95%			
Compliments (received directly into service)	Number	126			
Formal Complaints Rec	Number	7			
Formal Complaints Closed	Number	11			
Formal Complaints Upheld/Partially Upheld	%	55			
Local resolution concerns/ informal complaints Rec	Number	16			
MP Enquiries Rec	Number	3			



There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 95% positive satisfaction and 4.76 star rating and the question on staff (were you treated kindly?) receiving a 96% positive scoring from the 675 responses received.

There were 7 complaints received during the quarter, 3 of these related to community wards. There was 1 relating to Westcall (to provide context they had18,834 reported attendances), this was regarding the process of having to go through NHS 111 and waiting times. There was also one complaint for the Urgent Care Centre, which had 4,679 attendances, this was regarding attitude of staff. The services received 27 patient survey responses during the quarter, most were very positive receiving 5 stars across both services receiving for example ‘*’We are really grateful for the care we received. The staff were kind and calm and did a great job caring for my son”* and *‘ I’m not sure the name of the nurse who helped us, who was obviously under pressure from lack of other staff available, but she seemed unflappable, kind and patient. Really great care’* .Less positive comments were about wait and call back times.

There were no complaints for Community Nursing and Community Nursing have received some of the highest numbers of feedback (195 across the 3 localities in the quarter, with a 99% overall satisfaction score), Community Nursing also received amongst the highest number of compliments; there were a significant number of positive comments about the staff and very little around areas for improvement. The service also received several compliments including ‘’*Daughter wants to thank the community nursing team after the peaceful passing of her mother. She had high praise for staff and asked for a special thank you to be given as she was her mother's main nurse and she always appeared professional and caring and this put the daughter and her mother at ease and she also said that she just fitted in with the furnishings like she was one of their own”.*

There were 9 complaints closed for the division during the quarter with 6 being upheld or partially upheld all of these were in relation to the community wards (Oakwood and Wokingham wards), 4 of these related to patients who had died (3 Oakwood, with 2 being same patient, 1 Windsor ward). All 4 included an element of communication with some concerns around care and treatment specific to each individual case. During this quarter the wards have received 70 responses through the patient survey receiving a 88.57% positive score (7 responses scored 3 and below overall) feeling listened to and information questions received the most results of 3 and below; there were a mix of views with comments around kindness of staff and care provided including ‘*’Wokingham community hospital has regained my faith in British hospital. Most staff friendly and caring and gave the impression they really genuinely did care for my welfare.*’’ There were also a number of suggestions for improvement relating to communication and staffing levels in relation to care and treatment including therapy as well as some comments around improvements that could be made in relation to food.

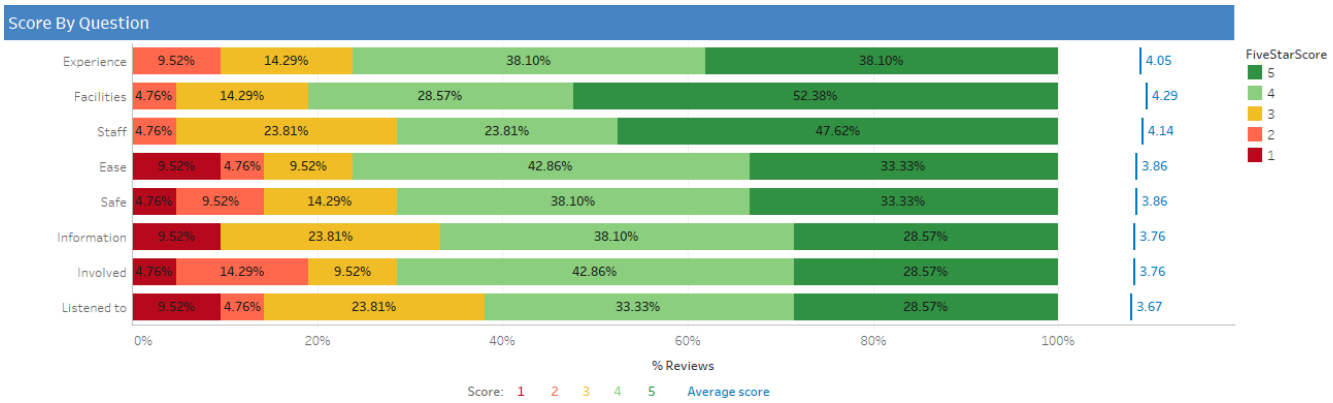
MSK Physio has not received any complaints in the quarter, it has received, 56 compliments and 101 patient survey scores with a 97% positive score , very few areas for improvement were included in feedback with just a few related to wait times/ gaining and appointment and some challenges with booking an appointment, but overall feedback was extremely positive. The positivity along with areas for improvement were also reflected in responses to podiatry, both physio and podiatry also receive some of the highest numbers of compliments directly into the service this quarter.

There are 2 PHSO complaints currently under investigation (1 for Podiatry and 1 Oakwood)

Mental Health Inpatient Division

Table 7: Summary of patient experience data

Patient Experience - Division MH Inpatients		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	21			
Response rate	**%**	10.3%			
iWGC score – 5 star score	**Number**	3.92			
iWGC Experience score - FFT	**%**	76%			
Compliments	**Number**	12			
Formal Complaints Rec	**Number**	14			
Formal Complaints Closed	**Number**	11			
Formal Complaints Upheld/Partially upheld	**%**	45			
Local resolution concerns/ informal complaints Rec	**Number**	2			
MP Enquiries Rec	**Number**	0			



There were 203 reported discharges from mental health inpatient wards (including Sorrel Ward). All the acute wards and older adult mental health wards have started receiving feedback through the iWGC tool, 21 were received this quarter equating to 10.3% response rate. The satisfaction rate at 76% is possibly skewed by 6 of the 21 completed questionnaires giving scores of 1-3 and the low number of returns. There were only 6 questionnaires completed in relation to the older adult mental health ward however all 6 gave positive scores. The individual question themes would indicate that feeling listened to receives the least positive scores with overall 5-star rating being 3.67; with 8 of the 21 giving a score of 3 or less to this set of questions. There was also one review which detailed a concern regarding staff communication. This would triangulate with partially upheld/ upheld complaints during the quarter , which were spread across all 4 acute wards and where 3 of the 6 included an element of communication / staff attitude within the complaint.

However, there were many positive comments received in the feedback including comments such as treated with dignity, compassion and kindness, lovely staff, very friendly staff coming through many of the responses and some suggestions for improvement included more therapy. The wards have also received direct compliments including '' *A very big thank you for saving my life- you will get a thank you card from XXX soon too".*

There were 2 upheld complaints relating to clinical care, one complaint was moved to being reviewed as a serious clinical incident (medication) and one about their experience of PMVA.

Demographic profile of people providing feedback

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendances
Asian/Asian British	18.03	6.9	9.67
Black/Black British	3.28	1.2	2.67
Mixed	8.2	1.9	3.49
Not stated	9.84	9.3	15.89
Other Ethnic Group	0	5.4	1.62
White	60.66	74.2	66.66

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

Table 9: Gender

Gender	% Complaints received	% patient survey responses	% Breakdown of Q4 attendance
Female	68.85%	47.90%	53%
Male	31.15%	30.90%	46.98%
Non-binary/ other	0	2.6%	
Not stated	0	18.7%	0.009

This would indicate that whilst the breakdown by attendance is fairly equally split, it would appear that we are more likely to hear the voice of the patient either as a complaint or patient survey if they are female

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
0 to 4	1.64%	6.50%	18.41
5 to 9	11.48%		4.14
10 to 14	4.92%		4.34
15 to 19	4.92%		4.52
20 to 24	9.84%	7.10%	2.87
25 to 29	8.20%		3.14
30 to 34	11.48%	8.80%	3.56
35 to 39	3.56%		
40 to 44	3.28%	8.80%	3.58
45 to 49	8.20%		3.52
50 to 54	8.20%	11.90%	3.73
55 to 59	6.56%		4.32
60 to 64	1.64%	13.40%	4.46
65 to 69	4.92%		4.63
70 to 74	1.64%	14.90%	4.53
75 to 79	3.28%		5.56
80 to 84	3.28%	20.20%	6.16
85 +	3.28%		6.55
Not known	3.28%	8.50%	11.98

Ongoing improvement

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

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

There is ongoing work to improve uptake of the patient survey and during quarter 2 work will be completed to enable young people to access the iWGC online platform (for young people currently access to the survey is via enabled tablets held in the service or paper).

During quarter 1 a number of services shared their experience of implementing and embedding the iWGC system within their areas, through the ‘all staff briefing’ and the trust leaders and managers forum. Both of these presentations were well received, and the teams were able to demonstrate how they are using the system, working through any early implementation issues and then acting upon the feedback. For example, the results are displayed on some of the wards for staff and visitors to see, in CRHTT their lived experience lead and peer support worker support encouragement of feedback and staff receive regular emails detailing the feedback as well as it being shared and discussed as part of the quality improvement work in the services and at their huddles and staff meetings.

From Quarter 2 the report will include some examples for each division of you said, we did to demonstrate how the feedback is being used to improve services, as many divisions are only starting this quarter to see a good amount of data it has not been possible to include this within this report.

15 Steps

Appendix 1 contains the 15 Steps visits that took place during quarter one, with the programme fully recommencing in April 2022. There were 2 visits to community physical health inpatient wards, 5 for mental health inpatient wards (including the Campion Unit) and 3 to community based physical healthcare services.

Summary

The largest single concern raised through all data sources is that of waits in children’s services where this features within formal, informal and MP concerns as well as being identified within patient surveys. There is work being undertaken currently within the children’s division and with support of some external resource to ensure that there is clarity on wait time data , the reasons behind our longest waits are understood and that the services are operating in the most efficient way possible in the context of increasing demand and staffing resource. Some of our other services also received some comments around wait times.

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

Involvement and information came out across the divisions as being the areas for most improvement whilst this was not true of all individual services it is an area of focus for some, this included understanding of why visits were occurring. There were also a number of services where ease of access including venue, type of appointment and appointment time came across as areas for improvement, although these were in small numbers.

It is very positive to see increased volumes of patient feedback through our patient survey month on month and all managers and divisional leaders have access to the live tableau dashboard to view this. As the available data is now readily available, we will be asking for examples of how this data is being used to inform service improvements to provide within this report from quarter 2.

Appendix 1. 15 Steps Challenge

Quarter 1 2022/23

- 15 Steps fully restarted from April 2022.

Orchid Ward

Positives observed during the visit:

- Staff members were easy to identify as most staff had their ID badges on.
- The Fire doors were shut and free of any clutter.
- There was clear information for visitors presented at the main entrance.
- Hand hygiene posters where present by every sink.
- Staff interacted positively with patients.
- The ward had their designated mealtimes and visiting times clearly displayed.

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

- Patient information only appeared to be in English - Manager indicated this was something they were looking into.
- Female bathtub had not been working since 07/03/22- Manager informed that they were waiting for delivery of the parts needed and has since been fixed.
- Notice boards had some out-of-date information- Manager reported that they were looking at updating all the boards and the work has started.

Rose Ward

Positives observed during the visit:

- Staff interacted positively with patients.
- Information was presented clearly at the main entrance for visitors.
- Toilets and bathrooms were clean, and signage was visible.
- Equipment was stored appropriately in allocated areas.
- Staff members were easy to identify as most staff had their ID badges on.

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

- The larger of the three gardens had uneven flooring and gradient- this had already been reported and is awaiting work to be undertaken to resolve.
- Main lounge hardly had any appropriate furniture- Manager reported that the furniture that was there had been taken for repair and due to social distancing, they could not add more furniture into that space. This has been addressed with senior managers and chairs have also been returned from repair.

- Some staff pictures were missing on the information board- Manager informed that this would be updated.

Windsor Ward

Positives observed during the visit:

- Staff were very welcoming to the team.
- Signage to the ward was very clear.
- Corridors were clear of trip hazards.
- Staff spoke to patients in appropriate tones.
- Patients spoke very highly about care provided.

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

- One patient reported that she got her leg caught on the bad railing- bed bumpers were provided to the patient to prevent this.
- There were two beds and two hoists at the end of the corridor- Deputy Manager informed that the two beds were broken, these have been fixed; unfortunately, there is no specific space on the unit for equipment waiting collection for repair.
- The QMIS Board and Nursing Board were out of date- both have been updated.

Podiatry Wokingham

Positives observed during the visit:

- Staff were welcoming.
- Patients walk into the clinic with a smile and left with a smile.
- Clinic space was clean and looked well maintained.
- Leaflet and boards were up to date.
- Surgery rooms were neat, tidy, and free of clutter.

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

- The team did not notice signage in different languages- Staff informed that they used interpreting services.
- The corridor had a chest of drawers and stools in the corridors- Staff informed that the stools were constantly in use and did not present a hazard and they were neatly tucked away when not in use.
- Staff reported that they were having issues with Rio- Due to a recent upgrade staff struggled to find vital patient information but the transformation team were fully aware of this and helping with the system.

Physiotherapy Dellwood

Positives observed during the visit:

- The main areas were uncluttered and clean smelling.
- The team were very supportive and embraced the wellbeing ethos of the trust.
- Waiting lists were being actively addressed.
- All information about appointment is sent to patients prior.

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

- Evidence on active feedback needed to be updated- The team lead was addressing this issue.
- The was limited storage for the equipment needed which resulted in staff areas appearing cluttered- This did not affect patients as their areas were uncluttered.

Podiatry Tilehurst

Positives observed during the visit:

- The clinic was easy to find with parking in a close proximity.
- The clinic was bright, clean, and airy.
- The notice boards were well kept and up to date.
- Staff were welcoming and accommodating.
- Clinic were running on time.

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

- The disabled access button was not working on the main door- Podiatry manager said this was reported and waiting on repair.
- The patient toilet door lock was not working- Manager was unaware of this as it hadn't been reported but would report it to maintenance to get it fixed.
- There were no photographs of staff working in podiatry- Manager said that this was being addressed and would be in place by the end of the month.

Campion Ward

Positives observed during the visit:

- Staff Photo Board is up to date.
- There was clear signage to the bathrooms.
- The furniture on the ward was bulky and designed for safety.
- The ward felt calm, safe, and organised.
- Staff were appropriately dressed.

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

- The visiting times were not displayed- Ward manager explained that all visits were booked via phone which worked efficiently.
- One corridor did not smell fresh- Manger explained that they would investigate the source of the smell.
- Activities were not taking place at the time of visit - Manager indicated that activities form an important role in recovery and that there is a schedule of activities for patients.

Snowdrop Ward

Positives observed during the visit:

- The ward felt homely and inviting.
- Visiting times were clearly displayed along with the career information.
- Staff looked calm and relaxed.
- All staff wore their staff IDs.
- The team felt safe throughout the visit.

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

- Some notice boards were out of date- Ward manager indicated that the boards would be updated.
- Some doors did not sit well around the hinges- this had been waiting repair and has since been resolved.
- One of the window near the manager office opened too wide, this has been resolved.

Bluebell Ward

Positives observed during the visit:

- Ward felt welcoming but secure.
- All staff wore ID badges.
- Notice boards were up to date.
- Evidence of ward activities taking place.
- The Ward felt light and airy.

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

- Staff board on ward needed updating and is in process of being updated.
- The dimmer switch in de-escalation room did not appear to work, this has been fixed.
- The artwork on entrance to the ward appeared untidy and some on the floor. Would benefit from regular monitoring, this is monitored daily through managers walk arounds

Oakwood Unit

Positives observed during the visit:

- The ward felt calm and organised.
- Staff Information was very clear.
- Safety Huddles were undertaken daily to help communication.
- Ward entrance was light and airy.
- QMIS board was up to date and current.
- Health & Wellbeing board evident for staff.

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

- There was no information about mealtime or routine.
- The garden area looked very uninviting and bare.
- Limited evidence of signs or literature in other languages.

Friends & family team discussion:

Members of all the teams said that, should a family member or friend be admitted to any of the services visited they would feel confident in the care that they would receive.

Linda Nelson & Pauline Engola
Professional Development Nurses
June 2022

Appendix 2: complaint and PALS activity

All formal complaints received

	2021-22						2022-23			
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Higher or lower than previous quarter**	**Q1**	**Total for year**	**% of Total**
CMHT/Care Pathways	5	8	10	9	32	**13.85**	↑	11	11	**18**
CAMHS - Child and Adolescent Mental Health Services	5	10	6	10	31	**13.42**	↓	4	4	**6**
Crisis Resolution & Home Treatment Team (CRHTT)	5	4	2	4	15	**6.49**	↓	3	3	**5**
Acute Inpatient Admissions – Prospect Park Hospital	11	8	7	6	30	**12.99**	↑	13	13	**21**
Community Nursing	4	5	2	1	12	**5.19**	↓	3	3	**5**
Community Hospital Inpatient	6	8	6	5	25	**10.82**	↓	4	4	**6**
Common Point of Entry	0	1	1	0	2	**0.87**	-	0	0	**0**
Out of Hours GP Services	1	1	5	2	9	**3.9**	↓	1	1	**2**
PICU - Psychiatric Intensive Care Unit	3	1	2	1	7	**3.03**	-	1	1	**2**
Urgent Treatment Centre	1	1	0	0	2	**0.87**	↑	1	1	**2**
Older Adults Community Mental Health Team	0	0	0	2	2	**0.87**	↓	1	1	**2**
Other services in Q3	18	14	14	16	64	**27.71**	↑	19	19	**31**
Grand Total	59	61	55	56	231	100		61	61	100

Locally resolved concerns received

Division	**Apr-22**	**May-22**	**Jun-22**	**Qtr 1**
MH IP	0	0	0	**0**
CHS East	3	0	2	**5**
CHS West	8	1	5	**14**
MH East	0	0	0	**0**
MH West	1	0	1	**2**
CYPF and LD	4	0	3	**7**
Total	**16**	**1**	**11**	**28**

Informal Complaints received

Division	**Apr-22**	**May-22**	**Jun-22**	**Qtr 1**
MH IP	1	1	0	**2**
CHS East	1	0	0	**1**

CHS West	1	0	1	**2**
MH East	3	2	0	**5**
MH West	0	0	0	**0**
CYPF and LD	3	1	0	**4**
Total	**9**	**4**	**1**	**14**

KO41A Return

	2020-21				2021-22			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mental Health complaints - nationally reported	**2,058**	**3,049**	**2,753**	**2,854**	**3,312**	**3,227**	**3,132**	**3,152**
2Gether NHS Foundation Trust	..	..	..	..	..	..	..	..
Avon and Wiltshire Mental Health Partnership NHS Trust	42	67	48	65	74	68	63	64
Berkshire Healthcare NHS Foundation Trust	**40**	**47**	**37**	**51**	**48**	**46**	**42**	**46**
Cornwall Partnership NHS Foundation Trust	12	27	15	8	94	27	61	60
Devon Partnership NHS Trust	15	31	49	40	46	50	61	54
Dorset Healthcare University NHS Foundation Trust	60	109	98	95	97	119	124	116
Kent and Medway NHS and Social Care Partnership Trust	70	111	78	80	115	95	107	104
Oxford Health NHS Foundation Trust	44	54	54	55	51	56	63	53
Southern Health NHS Foundation Trust	29	51	40	31	28	32	31	21
Surrey and Borders Partnership NHS Foundation Trust	9	27	24	17	20	20	53	N/A
Sussex Partnership NHS Foundation Trust	99	164	154	198	267	286	216	286

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

Formal complaints closed

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

Outcome of closed formal complaints

Outcome of formal complaints closed

	2021-2022						2022-2023	
Outcome	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Q4**	**% Of 21/22**	**Q1**	**% of 22/23**
Not Upheld	27	36	34	↓	21	51.00%	23	40.00%
Partially Upheld	19	18	22	-	22	35.00%	21	37.00%
Upheld	9	11	6	-	6	14.00%	12	21.00%
SI	0	0	0	-	0	0	1	2%
Grand Total	**55**	**65**	**62**		**49**		**57**	

57% of complaints closed were either partly or fully upheld in the quarter (compared to 49% last quarter), these were spread across several differing services.

Table 13: Complaints upheld and partially upheld

	Main subject of complaint								
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Confidentiality**	**Discharge arrangements**	**Medication**	**Waiting Times for Treatment**	**Grand Total**
SUN				**1**	**1**				**2**
Adult Acute Admissions - Bluebell	1								**1**
Adult Acute Admissions - Daisy	1	1							**2**
Adult Acute Admissions - Rose		1							**1**
Adult Acute Admissions - Snowdrop			1						**1**
CAMHS - ADHD								1	**1**
CAMHS - Rapid Response		2							**2**
CAMHS - Specialist Community Teams			1						**1**
Children's Occupational Therapy - CYPIT				1					**1**
CMHT/Care Pathways			1	1				1	**3**

	Main subject of complaint								
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Confidentiality**	**Discharge arrangements**	**Medication**	**Waiting Times for Treatment**	**Grand Total**
Community Hospital Inpatient Service - Ascot Ward						1			**1**
Community Hospital Inpatient Service - Oakwood Ward			3						**3**
Community Hospital Inpatient Service - Windsor Ward			2						**2**
Crisis Resolution and Home Treatment Team (CRHTT)		1			1				**2**
District Nursing			2						**2**
Immunisation				2			1		**3**
Learning Disability Service Inpatients - Campion Unit - Ward	1	2							**3**
Psychological Medicine Service			1						**1**
Talking Therapies - PWP Team					1				**1**
Grand Total	**3**	**7**	**11**	**5**	**3**	**1**	**1**	**2**	**33**

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 415 queries recorded during Quarter one. An increase 139 since Quarter 4. PALS has engaged a volunteer on a part time basis, and this has improved direct access to the service. In addition, there were 232 non-BHFT queries recorded. Work is ongoing as part of the QMIS process in order to reduce this number.

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

Service	Number of contacts
CMHT/Care Pathways	41
Operational HR	32
Admin teams and office based staff	32
CAMHS - ADHD	21
CAMHS - Common Point of Entry (Children)	18
CAMHS - AAT	14
Adult Acute Admissions - Rose Ward	11
CAMHS - Specialist Community Teams	10
Integrated Pain and Spinal Service - IPASS	9

Formal Complaints closed during Quarter one 2022-23

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
8405	West Berks	CMHT/Care Pathways	Low	Family dispute appt's have happened and wish a referral to UCL Queen Sq Institue of Neurology ORIGINAL - Poor transition from CAMHS to adults. Complainant feels they have to keep chasing in order to get any form of service and states the complaint is that there is NO treatment for the patient	Not Upheld	consent not recieved	Care and Treatment
8400	Reading	Adult Acute Admissions - Snowdrop Ward	Moderate	Pt states this admission is very distressing, no help at all with mental health or general health as I am vulnerable pt with diabetes and covid on the ward. Disinhibited pt has triggered traumatic memories and staff did nothing	Partially Upheld	Culture awareness and differences to be discussed on the ward Weekly 1:1 with named nurse to be completed and Psychological Therapies support via Teams to be offered if there is any further restriction due to Covid on the ward. The team to promote Person Centre Care. Weekly Communal meeting via Teams if there is any further restriction due to Covid. Staff on the ward to ensure that patients are made aware of their rights and being involve in their own care. All rules to be clarified on the ward and shared immediately with the team if there is any restrictions or changes.	Care and Treatment
8459	Slough	CMHT/Care Pathways	Moderate	Family unhappy with the lack of support from SCMHT for the pt, in particular with the Social worker	Partially Upheld	Discussion with duty team about conduct while speaking with vulnerable patients Discussion with team that patients can record calls OT assessment and care co-ordination needs assessment arranged List of services available in Slough communicated to complainant Discussion with Juliet Montague about her conduct during discussions with service users Safeguarding concerns around harassment and trauma, to be discussed during OT and Care co-ordination needs assessment	Waiting Times for Treatment
8450	Wokingham	Integrated Pain and Spinal Service - IPASS	Low	Pt unhappy with the response ORIGINAL COMPLAINT pt believes they were told they could expect 2 years of twice weekly physio, at an hour a session, unhappy this is not being delivered.	Not Upheld	To review criteria for referral into IPASS Pain and ensure that all team members are aware that patients should not be referred into both Musculo-skeletal physiotherapy and Pain Physiotherapy. Where patients are attending both musculoskeletal and pain physiotherapy by their own choice due to self-funding the differences in approach must be discussed at the earliest opportunity. This will be fed back to the team and reflected in the clinical pathway. Seek team training on how to end appointments which are over-running	Communication
8442	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt felt uncomfortable and judged when meeting f2f. Expressed it was hard to get through on the telephone and when they did felt the staff were rude and unprofessional.	Partially Upheld	Individual & group reflective sessions with individual Duty team staff 1:1 supervision with staff member to reflect on the meeting/assessment with complainant highlighting the expressed ethical issues and subsequent subjectively reported impact on complainant's mental health. Group supervision for CRHTT west to reflect on anonymised case to enhance understanding and skills for supporting distressed and highly anxious patients engaging in risky and self-harming behaviour.	Attitude of Staff
8410	Reading	CAMHS - ADHD	Minor	Father has complained about CAMHS letting them down. Daughter had private diagnosis in November as CAMHS have let them down 4 times and now they have to wait a further 3 years.	Partially Upheld	CAMHS CPE reviewing signposting advice/language in letters/calls. CAMHS services to offer review appointment. ADHD services to identify a future date for review	Waiting Times for Treatment
8419	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	pt believes staff are abusing them with objects. Believes they are not unwell and should not be in hospital	Not Upheld		Attitude of Staff
8430	Reading	Adult Acute Admissions - Bluebell Ward	High	Family believe the Pt sustained extensive bruising whilst being restrained	Upheld	All staff involved to receive further training in restraint techniques	Abuse, Bullying, Physical, Sexual, Verbal
8404	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Minor	lack of support and diagnosis from CAMHS, parent feels CAMHS do not look at the pt as a whole person just as a patient to a process. 28 points to address and 15 outcomes required	Partially Upheld	Cases should be given a named clinician who acts as the co-ordinator for CAMHS, when it is evident that MDT involvement will be required from a number of CAMHS teams and wider agencies, and where there is risk of harm or significant deterioration. In cases where it is known that neurodiversity is a factor, consideration should be given to adapting the assessment approach where possible. All CAMHS teams could benefit from guidance, and sharing of resources/materials from the Autism Assessment and ADHD teams. This would standardise and make equitable information about what to expect from the assessment process, and incorporate tools/methodologies that would assist the assessment. Although service users receive an Evaluation of Service Questionnaire (ESQ) when their care has been completed, or at discharge from that particular team to another service for ongoing care, more regular service user feedback should be requested. Clinicians will be encouraged to do this so the information can be used to improve provision of care to patients and their families.	Care and Treatment
8439	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt disagrees with their diagnosis and believes inaccurate information has been written about them in the medical records which they wish to be deleted	Not Upheld		Medical Records
8340	West Berks	Children's Speech and Language Therapy - CYPIT	Moderate	Historic concerns regarding a delayed referral from CYPIT to CAMHS in relation to autism	Not Upheld		Care and Treatment
8431	Reading	Older Adults Inpatient Service - Rowan Ward	Low	pt allegedly advised they were entitled to Sc117 aftercare, family expected to care for the pt but have numerous health issues	Not Upheld		Discharge Arrangements

8445	Reading	CAMHS - Rapid Response	Minor	Family unhappy the clinicians have not written and apologised directly to the patient ORIGINAL BELOW Family unhappy with the use of incorrect pronouns with the pt by the visiting RRT person. Family feel no help was offered. general poor communication from CAMHS. Unhappy with the attitude of 2 staff members	Upheld	Clinicians to attend pronoun workshop Team Lead to shadow clinicians while assessing Processes and Procedures to be discussed at Team Meeting Ongoing professional conduct discussions to continue in supervision	Attitude of Staff
8458	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	lack of support from CRHTT on 3 occassions. Pt is also angry that CRHTT arrived at family home on the weekend despite being advised pt did not live there anymore and did not want family know about their MH issues	Partially Upheld	Direct Supervision with clinician mainly involved with case re: managing appointments and ethical issues (consent to sharing information, visiting at parents' house and understanding case prior to contact). J will cascade the learning to the whole team and continue as part of reflective practice. M will continue to work with the whole team to improve on Service user experience as she is Advanced Professional as well as CRHTT Lived Experience worker.	Confidentiality
8490	Slough	CMHT/Care Pathways	Minor	Pt met with psychiatrist to discuss recent attackwhich they are pressing charges on. Court asked for the psychiatrist to write how the attack had affected the pt but the letter contains all information about the pt's history, which the pt does not want read out in court. On asking the Dr to re-written the letter for court they have refused and pt does not know how this is allowed to happen.	Partially Upheld	resolved locally by service amending letter and sending out	Communication
8531	Reading	Adult Acute Admissions - Bluebell Ward	Moderate	Pt's allegedly not transferred without medication or notes from Sorrel to Bluebell blamed on a computer error. Bluebell ward have now increased the dose and the pt is constantly drowsy resulting in a wrist injury when on leave	Serious Untoward Incident Investigation	moved to SI process	Medication
8421	Reading	Community Hospital Inpatient Service - Oakwood Ward	Moderate	Complainant feels the response falls short of actions to be taken and would like a response based on comments to each section ORIGINAL COMPLAINT Deceased Pt: Discharged from RBH to Oakwood. Lack of communication left the pt frustrated, distressed and embarrassed causing great distress to the family. Family concerned about nurses knowledge of PU care especially in a type 2 Diabetic pt. Family unhappy at cognitive tests being carried out without taking pt terminal brain tumor into consideration. Family unhappy at the obstructive attitude of staff when wanting to take pt to visit dying spouse in RBH, also unhappy at attitude of allowing support when telling the pt their spouse had passed away	Partially Upheld	Communication course (Customer services) and Conflict resolution for all attended by All admin MCA's – Refresher training has been booked for all qualified therapy staff to attend All therapy staff are also to attend communication training to improve their skill and confidence in difficult and sensitive conversations. Rio Transformation to be made aware that MCA document on RIO does not give an option to suggest an inconclusive result or prompt for next steps should that be the case Work to be done to rectify this.	Care and Treatment
8422	Reading	Community Hospital Inpatient Service - Oakwood Ward	Moderate	Deceased pt - discharged to RBH from Oakwood. Blood pressure taken from broken arm causing excess pain, inhaler denied for COPD, unacceptable attitude of staff around food.	Partially Upheld	Communication course (Customer services) and Conflict resolution for all attended by All admin MCA's – Refresher training has been booked for all qualified therapy staff to attend All therapy staff are also to attend communication training to improve their skill and confidence in difficult and sensitive conversations. Rio Transformation to be made aware that MCA document on RIO does not give an option to suggest an inconclusive result or prompt for next steps should that be the case Work to be done to rectify this.	Care and Treatment
8503	Bracknell	District Nursing	Minor	Complainant feels we have missed the point as cannot cope with adhoc visits and no physio ORIGINAL COMPLAINT Patient unhappy with DN visiting arrangements. Wants to know if referrals have been made and is experiencing problems with patient transport.	Partially Upheld	Shared learning with Team and wider DN services re importance of keeping patients informed re planned visits and any changes to date, times, standard work for deferred visits to be recirculated. Alert put on RIO, re advance notification of visit in order for arrangements with neighbour to give access. Planned visits and liaising with WCN to establish if Doppler can be done at home, if oedema reduced. Need for Lymphoedema referral and MDT management. Unable to facilitate alternative Community Nursing Team. To be communicated as part of investigation and complaint response.	Care and Treatment
8494	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	Pt was allegedly denied a knife and folk to eat their lunch by a nurse. Advocate says the pt does not feel safe on the ward	Not Upheld		Abuse, Bullying, Physical, Sexual, Verbal
8487	Reading	Adult Acute Admissions - Daisy Ward	Minor	Pt feels there is a lack of support on the ward also believes the Covid vaccination has caused the latest MH trauma. She was not given her phone charger.	Partially Upheld	Doctors, including the ward doctors during working hours and duty doctors, need to be contacted when a patient raises issues around medication	Attitude of Staff
8473	Reading	Learning Disability Service Inpatients - Campion Unit - Ward	Minor	Pt unhappy at being intimidated, states they have a recording of 2 staff members taking the mickey out of them	Partially Upheld	Key nurse to draw care plans care plan re behaviours and use of energy drinks Care plan re requests for energy drinks and caffeine (i note that there is already info about caffeine intake in the physical health care plan but it is quite generic and doesn't state actions required of staff to ensure consistency of approach. I also wonder if it would be more easily identified by staff if in a specifically titled care plan for intake of caffeine and energy drinks staff being supported to carry on consistent approach and practice towards supporting needs of pt with clear care plan support needs in place Medication Review Ward manager to facilitate meeting between alleged staff and pt	Attitude of Staff
8500	Reading	Adult Acute Admissions - Snowdrop Ward	Low	Complainant wants to know how the pt 'escaped' on the 21st April and was able to travel to Birmingham. Complainant feels vulnerable pt life is in danger and their young children too.	Not Upheld	No consent granted	Care and Treatment

8449	Windsor, Ascot and Maidenhead	Children's Occupational Therapy - CYPIT	Minor	Complainant unhappy at the delay in OT assessment and report to enable EHCP	Upheld	OT Action Plan in place to reduce numbers of CYP breaching EHCP deadline OT recruitment being carried out to address demand/capacity issues	Communication
8489	Reading	Adult Acute Admissions - Daisy Ward	Minor	Unhappy with response, wants to air his concerns in person ORIGINAL COMPLAINT BELOW Complainant says pt has been injured by members of staff and pt is not being offered any support. Believes staff are winding pt up about their condition	Partially Upheld	Staff to ensure there are clear communication lines between carers and the ward. The information being shared with carers concerned about the welfare of their loved once need to accurate and timely.	Abuse, Bullying, Physical, Sexual, Verbal
8486	Reading	Learning Disability Service Inpatients - Campion Unit - Ward	Low	Complainant raising concerns regarding who is looking after pt's dogs and belongings whilst they are in hospital. Pt told they have not earnt enough time to be allowed to receive a visit. Feels pt is being kept like a caged animal. Complainant also believes inappropriate comments have been made by staff to the pt.	Partially Upheld	Reward chart to be continually reviewed. Clear implementation guidelines to be shared again as a reminder for support staff and others who are part of the plan i.e. partner. To ensure adequate recording and organisation of CPA meetings/other important meetings with clear chairing, attendance list and introductions. Request for admin support for CPA meetings to allow for accurate recording of information	Abuse, Bullying, Physical, Sexual, Verbal
8477	Wokingham	Community Hospital Inpatient Service - Ascot Ward	Low	Family confused over the wards protocols for ESBL. Unhappy with some of the care and support the pt received on the award. Pt's belonging were missing when they returned from RBH and whilst on Ascot, staff did not raise this. Lack of clarity over discharge. Family wish compensation for the loss of property	Upheld	Communication to relatives about PPE use when visiting patients – to be raised as a quality improvement ticket. Improvement in ward tidiness/cleanliness (plates left in Pt room) – reminder to all staff to be sent and at next unit meeting. Staff response to relatives – raise as huddle ticket, discuss with staff on duty, further review if individuals need further training. Property care, documentation and reporting when patients are transferred – Currently being worked on as part of the ward's length of stay (LOS) driver project. Communication confusion when coming up to discharge especially relating to nursing home discharge – Escalated within LOS project Lack of information on our Website - Escalated within LOS project	Discharge Arrangements
8470	Reading	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Minor	Complainant feels there have been shortfalls in professional competence regarding the patients care . following the completion of a national survey on MH, the family feel the care provided was not fast enough resulting in rapid on set dementia in a 57 yr old.	Not Upheld		Care and Treatment
8491	West Berks	Urgent Treatment Centre	Low	Patient unhappy with the attitude of staff and feels that she was assaulted.	Not Upheld		Abuse, Bullying, Physical, Sexual, Verbal
8493	Slough	CMHT/Care Pathways	Minor	Pt providing feedback to service did not get a response. Pt unhappy with the blanket approach from the service, Pt concerned if they will be helped if they contact services in the future.	Not Upheld		Care and Treatment
8492	Reading	Immunisation	Low	Complainant has not received a call back from the Immunisation nurse who said they would call back in November	Upheld		Communication
8484	Reading	Children's Speech and Language Therapy - CYPIT	Low	Staff failed to refer the pt to SLT	Not Upheld		Care and Treatment
8481	Bracknell	Talking Therapies - PWP Team	Minor	pt unhappy that a statement made in a therapy session has been disclosed 2 years after the fact to outside agencies without consent or pt knowledge	Partially Upheld	When a Talking Therapies clinician makes a referral to Social Services they should take a copy of the referral form and put this on IAPTUS in the documents section. When a Talking Therapies clinician is going to make a referral to Social Services they should explain clearly to the client, unless there are clinical or safeguarding reasons not to do, why they are doing so. The rationale for the referral and that the client has been informed should be documented in the notes.	Confidentiality
8508	Reading	Adult Acute Admissions - Rose Ward	Low	complainant feels the staff are rude, lack of concern and lack of professionalism, they are very upset with the care. Pt's property has gone missing as the complainant says no property list has been completed, they feel there is a complete disregard for pt's belongings	Partially Upheld	Care was appropriate, however there could have been improved communication with the family once consent was gained.	Attitude of Staff
8555	Slough	SUN	Moderate	complainant feels facilitators pick and chose what they want to respond to	Partially Upheld	An apology to pt for the situation and the distress she has experienced as a result. SUN Facilitators to continue to fully use weekly clinical supervision and reflective practice to ensure supportive practice in all SUN groups. This will include the discussion and practise of support, containment and turn taking skills. SUN Facilitators to always aim for all groups to end with a collaborative taking of minutes so there is a shared understanding of the themes raised during the group and to ensure any concerns raised are logged. Facilitators to routinely allocate time at the end of each group for this practice. SUN Team to consider taking more immediate action regarding time away decisions as appropriate. Not needing to necessarily wait until clinical supervision if the behaviour of member/s is clearly unsupportive. An invitation for pt to return to SUN groups as soon as she feels ready to. Pt to be reminded she remains a SUN member and is welcome to return to SUN at any point in the future as long as she does so sober. Signpost to substance misuse services if pt would like help in reducing her alcohol use.	Communication
8550	Wokingham	CMHT/Care Pathways	Low	Complainant unhappy that the care coordinator told the patient they had spoken to the family about their needs to look after the pt. Complainant feels the cc broke their confidentiality	Not Upheld	Not upheld	

8510	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Minor	Deceased Pt:- NOK unhappy with care of the pt whilst on Windsor ward before being discharged	Upheld	Improving general nursing care – workshops with staff (understanding the patient's position)– standard works being created for how to care for patients – Dress for dignity audit and improvement (aspects being led by Huddle tickets) Ward information – leaflet for patients about the ward and how to raise concerns while an inpatient. Refresh on medicine management for nursing staff – Case presentation to medical and nursing staff and how this could be managed better – better communication etc (take to all unit meetings) Weekend physio – prevention of 'nursing in bed' over the weekends – Raise at meetings again and work with Physio and nursing teams to increase mobility practice at weekends. Improve medical team conversations/availability for relatives - currently part of work on the ward – create process and be visible and available to relatives so works for both parties.	Care and Treatment
8495	Reading	Learning Disability Service Inpatients - Campion Unit - Ward	Low	Pt unhappy staff would not take then out. Unhappy at being told not to shout	Partially Upheld	The Ward Manager will ensure that staff have a discussion during periods of inclement weather to agree times to escort patients out for Section 17 leave. The Ward Manager will ensure the agreed measures for a care plan review to manage risk behaviours are in place for this patient.	Attitude of Staff
8511	Slough	Immunisation	Minor	Family believe their child was vaccinated for a second time with the same vaccination despite the child saying they had already had it and without parent consent	Upheld	Refresher training to all staff to demonstrate how to correctly search for a completed consent form, by several different search terms including: •First name •Surname •DOB •NHS number Team learning event to be held at our annual training day 5th September 2022 in addition to shared learning being disseminated to the team via email and Teams Further scrutiny of the Lead Nurse role, in conjunction with the service improvement group to ensure all staff know what is expected of them prior to a session e.g., triage, communication with school, communication with the wider team Further discussion with Cinnamon e-consent system to share learning from incidents and look to implement further safety measures to prevent duplicate consent forms being completed and picked up on.	Medication
8545	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Minor	Feedback and concerned raised regarding the day to day running of the ward and the negative impact some actions had	Upheld	DNR conversations to be held in private if possible – fed back to clinical teams on unit Patient information required about DNR conversations – Patient leaflet to include details around this. Escalate the possibility or voice progress notes for staff – take to digital transformation Review curtain tracks – with estates	Care and Treatment
8461	Reading	Psychological Medicine Service	Minor	complainant feels pt was discharged without listening to pt and family regarding their state of mind. Complainant states the same staff member discharge in the same way in December without listening. Pt in RBH ICU due to suicide attempt. family feel this is a safeguarding issue	Upheld	Reflective supervision for staff member involved	Care and Treatment
8501	Bracknell	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	complainant believes medication changes made by OPAMHT are the result of pt being back in PPH. Complainant not invited to MDT meetings	Not Upheld	Not upheld	Medication
8509	Windsor, Ascot and Maidenhead	CAMHS - Specialist Community Teams	Low	Complainant feels many elements of the previous response need to be re-looked at or gone into in more depth. Issues with current family therapy due to GCSE time. Feels the pts issues are not being addressed. Complainant also feels too much of the concerns are swept away under Autism	Not Upheld	Complaint not upheld.	Care and Treatment
8523	Reading	SUN	Moderate	Pt states facilitator accidentally shared their text chat on their screen which mentioned the patient and then allegedly lied about it	Upheld	as a result. All SUN facilitators trained in how to safely share and unshare their screens during group. Where possible, SUN facilitators are to close all other unnecessary open windows during group time and are to use the "do not disturb" status update to block notifications of new chat messages during group time. All new SUN facilitators to practise using Teams including sharing screens prior to running groups. All SUN facilitators to be discouraged from sending chat messages to each other whilst facilitating groups and to instead bring any concerns into the group, particularly if they are concerning a member's risk. Such discussions to be linked to a member's Crisis And Support Plan (CASP). If this is not possible or appropriate at the time, facilitators to use the group break or the debrief time post group to discuss over the telephone with their co-facilitator (i.e. when not in the online group). SUN facilitators to use clinical supervision and reflective practice to ensure honest, open and transparent practice. To discuss and role play in supervision how to take responsibility for mistakes and discuss within the group. SUN facilitators to ensure their Information Governance mandatory training is complete and in date. An invitation for pt to return to SUN groups as soon as he feels ready to. Pt to be reminded he remains a SUN member and is welcome to return to SUN at any point in the future.	Confidentiality
8512	Wokingham	CMHT/Care Pathways	Low	Complainant feels they are working against CMHT to get a diagnosis for then pt, Complainant is suffering with the stress of their responsibilities to the family and the pt feels the Dr has not read any of the letter sent.	Not Upheld	consent not obtained	Care and Treatment
8327	Slough	CMHT/Care Pathways	Low	Complainant unhappy with the response ORIGINAL COMPLAINT BELOW pt feels they have not received any form of therapy from services relating to their OCD. Previously service lead has allegedly not followed through with promises made	Partially Upheld		Care and Treatment
8450	Wokingham	Integrated Pain and Spinal Service - IPASS	Low	Pt unhappy with the response ORIGINAL COMPLAINT pt believes they were told they could expect 2 years of twice weekly physio, at an hour a session, unhappy this is not being delivered.	Not Upheld	To review criteria for referral into IPASS Pain and ensure that all team members are aware that patients should not be referred into both Musculo-skeletal physiotherapy and Pain Physiotherapy. Where patients are attending both musculoskeletal and pain physiotherapy by their own choice due to self-funding the differences in approach must be discussed at the earliest opportunity. This will be fed back to the team and reflected in the clinical pathway.	Communication

8421	Reading	Community Hospital Inpatient Service - Oakwood Ward	Moderate	Complainant feels the response falls short of actions to be taken and would like a response based on comments to each section ORIGINAL COMPLAINT Deceased Pt: Discharged from RBH to Oakwood. Lack of communication left the pt frustrated, distressed and embarrassed causing great distress to the family. Family concerned about nurses knowledge of PU care especially in a type 2 Diabetic pt. Family unhappy at cognitive tests being carried out without taking pt terminal brain tumor into consideration. Family unhappy at the obstructive attitude of staff when wanting to take pt to visit dying spouse in RBH, also unhappy at attitude of allowing support when telling the pt their spouse had passed away	Partially Upheld	attended by All admin MCA's – Refresher training has been booked for all qualified therapy staff to attend All therapy staff are also to attend communication training to improve their skill and confidence in difficult and sensitive conversations. Rio Transformation to be made aware that MCA document on RIO does not give an option to suggest an inconclusive result or prompt for next steps should that be the case Work to be done to rectify this.	Care and Treatment
8503	Bracknell	District Nursing	Minor	Complainant feels we have missed the point as cannot cope with adhoc visits and no physio ORIGINAL COMPLAINT Patient unhappy with DN visiting arrangements. Wants to know if referrals have been made and is experiencing problems with patient transport.	Partially Upheld	Shared learning with Team and wider DN services re importance of keeping patients informed re planned visits and any changes to date, times, standard work for deferred visits to be recirculated. Alert put on RIO, re advance notification of visit in order for arrangements with neighbour to give access.	Care and Treatment
8484	Reading	Children's Speech and Language Therapy - CYPIT	Low	Staff failed to refer the pt to SLT	Not Upheld		Care and Treatment
8492	Reading	Immunisation	Low	Complainant has not received a call back from the Immunisation nurse who said they would call back in November	Upheld		Communication
8289	Wokingham	Health Visiting	Low	Info sent in showing false, misleading and incomplete information following a DSA request ORIGINAL COMPLAINT 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	Not Upheld	Communication
8445	Reading	CAMHS - Rapid Response	Minor	Family unhappy the clinicians have not written and apologised directly to the patient ORIGINAL BELOW Family unhappy with the use of incorrect pronouns with the pt by the visiting RRT person. Family feel no help was offered. general poor communication from CAMHS. Unhappy with the attitude of 2 staff members	Upheld	Clinicians to attend pronoun workshop Team Lead to shadow clinicians while assessing Processes and Procedures to be discussed at Team Meeting Ongoing professional conduct discussions to continue in supervision	Attitude of Staff
8431	Reading	Older Adults Inpatient Service - Rowan Ward	Low	21 Points raised, some in response to our response letter some new all relating to her stay at PPH ORIGINAL COMPLAINT BELOW 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	Not Upheld		Care and Treatment

Trust Board Paper

Board Meeting Date	13th September 2022
Title	**Infection Prevention and Control Board Assurance framework**
	Item for Noting
Purpose	To provide the Board with assurance that our organisational practices in relation to standard and transmission-based Infection Prevention and Control are reviewed, monitored and managed in line with national guidance.
Business Area	Nursing and Governance
Author	Debbie Fulton, Director nursing and Therapies
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	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. Over the last few months there has been some guidance changes in relation to the management of Covid-19, with a greater emphasis on local risk assessment to inform local processes rather than blanket national rules, as an example local risk assessments factor in local prevalence and types of services provided. In July 2022, an update of the National Infection Prevention and Control Manual was also released, this provides guidance on standard precautions as well as precautions for any transmissible infection including Covid-19 rather than there being lots of Covid -19 specific guidance. The UKHSA will continue to advice on specific precautions for any transmissible infection including Covid-19 as the need arises. In light of the changes, it was anticipated that a revised Board Assurance Framework would be released, currently this is still awaited and therefore the current available version has been updated to reflect changes. For ease any changes are detailed in red within the framework. Where there are gaps, there is mitigation and actions in place and no causes for concern identified.

ACTION	The Trust Board is requested to note the report.

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 winter plan.	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 and patient pathway in place for management of respiratory and other infection/ symptomatic patients including screening / cohorting etc. This includes cohorting, admission , and symptomatic testing Where there is increased incidence or outbreak contact patients are monitored for symptoms and swabbing undertaken as required. PCR 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. All ward use LFD testing for asymptomatic covid admission screening	Admission and symptomatic patient testing in place

	Inpatient patient pathway includes plan for use and prioritisation of single rooms/ segregation areas. Respiratory infection pathways include prioritisation of single rooms. staff are encouraged to undertake 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 continue to be held as required and 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.	Change in national guidance in relation to social distancing and other workplace measures however Relevant IPC measures remain in place including ventilation, hand hygiene and mask wearing (personal choice in all non-clinical areas) as well as clinical areas where PPE appropriate to the patient must be worn. Signage , information on Nexus and reminders/ notification of changes through all staff covid newsletter / all staff briefings		

	All IPC resources updated to reflect use of standard and transmission based precautions. Posters and resources updated and available on Nexus		
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 Hierarchy of Controls resource updated June 2022		
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	Reduced transparency in reporting following transfer of EFM services from BHFT to NHSPS	Ongoing meetings and escalation in place to support improvement
if the organisation has adopted practices that differ from those	National guidance is followed ; Any deviations from national guidance this would be agreed at Gold/	Verbally EFM are being told that NHSPS are adhering to the new	.ongoing follow up and escalation

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.	Executive level internally and through relevant system meetings	guidance. No written confirmation other than what was circulated by NHSPS.	
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 We have a schedule of FIT testing clinics and have undertaken additional sessions for FIT testers as well as continued assessment of stock to ensure multiplicity of brands		
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/ Patient pathway.		
the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight	Process in place for Medical / Nursing Director sign- off daily submissions of daily sitrep		

of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases			
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 at Quality and Performance Executive 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 Any outbreaks and identified learning are detailed in the monthly IPC report that is received by QPEG		
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 (NSoHC) and this plan is monitored at board level	EFM leading implementation of National Standards. Actions completed by November 1st 2021 in line with implementation of NSoHC implemented. Plan to be issued by February 1st 2022 IPCT involved with review and planning.	Final transparent assurance on all details awaited from NHS Property Services in relation to their services	Weekly and monthly operational meetings as well as a dedicated task and finish NSoHC group are auditing progress and compliance

the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms	completed and implemented by May 1st 2022 with ongoing review by Head of Facilities (EFM)		
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. Star ratings are publicly displayed		
increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.	Estates and facilities cleaning SOPs – cleaning and disinfection process as determined by NHSE/I • 01 Cleaning Process COVID 19 within 1 metre of patient • 02 Cleaning process COVID 19 High risk units where AGPs being conducted • 03 Cleaning Process COVID 19 cohort no patient contact • NHS Cleaning and Decontamination Training - Covid-19 (Coronavirus) These documents are available electronically and in a printed format to all relevant teams 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 meetings		
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 team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses	E&F cleaning and environmental SOP EFM monitoring of wards has continued throughout this period Chlorclean used Monitored as part of IPC compliance tool ICC026 Environmental/Equipment Cleaning and Disinfection Policy		
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.	Inpatient SOP E&F cleaning and environmental SOP		

• 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.	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.	ICC026 Environmental/Equipment Cleaning and Disinfection Policy Ward and community services equipment cleaning schedules		

• after blood and/or body fluid contamination • at regular predefined intervals as part of an equipment cleaning protocol • before inspection, servicing, or repair equipment.	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 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	Review of all aircon on trust sites undertaken with risk assessment and guidance issued - 22.6.20 guidance circulated through service management including list of air con for use; also circulated through all staff email with reminders through COVID newsletters including heatwave advice for staff. Guidance regularly recirculated as part of summer planning information dissemination Ventilation policy has been amended to reflect the new HTM 0-01		

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 cool rooms have been created using appropriate air handling in areas where we cannot provide natural ventilation? 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
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure:			
arrangements around antimicrobial stewardship is maintained	Pharmacy antimicrobial stewardship strategy Antimicrobial Stewardship Group programme of work that encompasses the requirements of Criterion 3 of the H&SC Act (2008) to demonstrate compliance. Antimicrobial stewardship group meeting minutes Antimicrobial stewardship annual audit		

previous antimicrobial history is considered	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 , this follows current national visitor guidance. Implementation of all guidance around visiting with guidance circulated to wards. checking for any COVID/ Infection related symptoms and other restrictions such as those needing to self-isolate prior to visiting . masks, hand rub and bins available at entrances for visitors not wearing face coverings. Posters to remind visitors to wear face, 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 Update to visitor posters available on Nexus. Local implementation of IPC precautions for visitors (such as mask wearing) introduced based on Covid activity/ surveillance/ high incidence.		
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.	Visitors to general hospital sites and outpatient areas providing IPC triage has taken place) are no longer required to wear masks, these are available for any patients, visitors or staff who want to wear them. (Subject to change in high incidence) 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 (e.g., 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	Visitors would not be present during AGP unless considered essential		

considered essential following a risk assessment e.g., carer/parent/guardian			
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 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.		
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, and if they become symptomatic or following risk assessment of symptoms if considered as a close contact of a positive case and 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).Use of LFD on admission to any inpatient environment including Place of Safety Triaging tool used for outpatient services and Minor Injury Unit . MIU 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 Rio forms for compliance with admission, symptomatic, close contact following risk assessment screening for SARS CoV -2 and symptomatic testing for influenza. Report available on tableau	Compliance with use of RIO tool to enable audit of compliance	discussion at clinical review group and reminder and instructions resent
patients 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.	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 screened using LFD , any patient with symptoms are admitted to single room 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.	Following national change of guidance masks are currently worn in all wards and areas where patients are not triaged prior to attending the healthcare setting or clinicians visiting patients in their own home. for all other areas mask wearing is assessed based in symptoms/ infection status of patient and personal choice with masks available. 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 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 symptomatic patients treated as potentially positive with appropriate PPE worn in accordance with standard and transmission based precautions Community teams including phlebotomy, UTC, CMHT's are triaging ahead of appt IPC mandatory training & resource pack cover management of symptomatic patients		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			
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 where this is required		

	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 Signage is actively being removed where this no longer reflects guidance (for example 2m distance signs on the floor and walls of corridors)		
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 For financial year 2021/22 - the organisation compliance with infection control mandatory training stood at 82% 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 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) Glove improvement project and involvement in national pilot commenced, update to be provided at IPCLP event in October 2022		
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	Paper towels are available in all clinical areas		

dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.	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	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 LFD 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 onset cases (staff and patients/individuals).	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 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 when required, for example when high incidence identified, patient has respiratory/ infectious symptoms.	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	**For outpatient services** Berkshire healthcare does not have separate spaces for most services, patients known or suspected to be positive		

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 patients/individuals. patients are appropriately placed ie, infectious patients in isolation or cohorts.	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 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 and patient pathway; 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		
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) Patient pathway for managing infection/ symptomatic patients		
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), 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/ Influenza/ RSV testing of patients on admission, and if symptomatic/ and prior to discharge to Nursing /care homes Testing for flu and other respiratory illness where patient is symptomatic alongside testing for covid -19	Consistency of use of RIO tool to enable audit of compliance with admission, screening	Increasing use of tool support from transformation team and sharing of current 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 LFD 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 / LFD is required , available on NEXUS, disseminated through all staff newsletter How to gain LFD disseminated to staff and on Nexus		Trust dashboard for wards with email out to each ward manager showing compliance for their staff with twice weekly LFD testing Some kits available for ward staff with support to ensure their results are logged

	Dedicated LFD mail box and covid mail box for staff queries		
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 where PCR is undertaken provided by BSPS Wards escalate positive patient LFD results to IPC inbox as detailed in SOP 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	All patients negative on admission are tested if symptoms arise. This is written in ward SOPs		

are retested at the point symptoms arise.			
that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission	All admissions who test negative on admission re tested if symptoms arise 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 isolation period 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 for 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 COVID in box for advice Guidance for keeping safe at work 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 wards have spaces for staff breaks		
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 Dedicated team used to deliver PPE to services with support from redeployed staff where necessary		

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 guidance)	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 LFD available on nexus and through all staff newsletter 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	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		

programme for the healthcare workforce • lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 • encourage staff vaccine uptake.	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 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	Annual risk assessment undertaken for all staff, additional risk assessments for individuals if their circumstances		

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; • 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.	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 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/ 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	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

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 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	maintained of all staff who have undergone FIT tester training Staff are tested for the masks that they are using and where supply changes staff are retested for available masks The IPC/ EFM hold a list of all staff who have been trained as fit testers and those who have been fit tested/ mask they have been fit tested for. when a member of staff is fit tested, they are given a certificate detailing the result of the fit test and which mask. These results are 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		Monitoring of ESR records monthly - we now have over 800 of the 1000 staff FIT tested with their mask type recorded on ESR

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.	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. staff who test positive have adequate information and support to aid their recovery and return to work	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 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	13 September 2022
Title	**Quality Assurance Committee – 30 August 2022**
	ITEM FOR NOTING and RATIFICATION OF THE MINOR CHANGES TO THE COMMITTEE'S TERMS OF REFERENCE
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 30 August 2022
Business Area	Corporate
Author	Julie Hill, Company Secretary for Sally Glen, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 30 August 2022 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to: a) receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 30 August 2022

(the meeting was conducted via MS Teams)

Present:	Sally Glen, Non-Executive Director (Chair) Mehmuda Mian, Non-Executive Director Aileen Feeney, Non-Executive Director Julian Emms, Chief Executive Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Tehmeena Ajmal, Chief Operating Officer Guy Northover, Lead Clinical Director Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Dr Raja Natarajan, Clinical Director Dr Garyfallia Fountoulaki, Clinical Director Sara Fantham, Clinical Director Katie Humphrey, Carers' Lead (present for agenda item 5.0) Sue McLaughlin, Clinical Director (present for agenda item 5.1)

Opening Business

1 Apologies for absence and welcome

There were no apologies.

The Chair welcomed everyone to the meeting.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 07 June 2022

The minutes of the meeting held on 07 June 2022 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated.

The Chair thanked the Director of People for providing information about the Trust's process when staff were coming to the end of their fixed term contracts.

The action log was noted.

Patient Safety and Experience

5.0 Carers' Strategy Update Report

The Chair welcomed Katie Humphrey, Carers' Lead to the meeting.

Katie Humphrey gave a presentation and highlighted the following issues:

- The Carers Strategy consisted of six standards:
  - Staff will be 'carer aware'
  - Services will identify carers and involve them in the planning of care
  - Staff will refer or signpost carers to relevant support
  - Services will have allocated staff responsible for carers
  - Services will provide an introduction to the service and relevant information across the care pathway
  - Services will provide a range of carer support and obtain carers' feedback
- Over the last year, the Trust had undertaken a significant amount of engagement and relationship building work with NHS England's Triangle of Care, Carers UK, local authority partners, integrated care system partners and with local voluntary sector organisations
- Internally, the Trust's Friends, Family and Carers Steering Group had representation across all divisions and services and included carer and governor representatives.
- A Baseline Evaluation Form was created to gather data on services current carers related activities. The data was used to inform future workstreams, including revisions to the self-assessment review process and the development of a managers' toolkit.
- A new e-learning training package had been developed designed to raise awareness of unpaid carers and good practice around engaging with friends, family and carers
- The Trust's website had been updated to ensure accurate information to help signpost carers to support. Additional resources had been added, for example, carer frequently asked questions. The staff intranet (NEXUS) had also been updated and included the Carers Strategy and helpful resources and information on the carer feedback process
- A video of a carer's story supporting a partner with dementia was available on NEXUS for teams to share at learning events and similar sessions.
- A new Friends, Family and Carer Feedback Form had been created.
- The Trust had received funding from NHS England as part of the "Mind the Gap" programme which aimed to help localities to identify and support carers from vulnerable communities. The Trust's work focussed on carers supporting veterans and engaging with carers. The Trust had also received NHS England funding for project on engaging with carers as part of the discharge process.
- The Trust recognised that many staff were carers and has set up a network for staff under the Purple (disability) Staff Network to support staff who had caring responsibilities.

- The Trust was developing standard operating procedure around recording carers on the RiO (electronic patient record) system.
- The Trust was co-producing a Friends, Family and Carers Charter which would be launched on Carers Rights Day in November 2022.

The Chair reported that she had recently visited the Children, Young People and Families service at Phoenix House and the Hazelwood Memory Clinic and had seen excellent examples of friends, family and carer engagement in these services.

The Chair commented that one of the key challenges was around engaging with carers from “hard to reach” communities.

Ms Humphrey acknowledged that this was more difficult and pointed out that NHS England’s “Mind the Gap” programme was focussed on developing and disseminating best practice around engaging with carers from vulnerable communities.

The Chair asked from a governance perspective where the Friends, Family and Carers Steering Group work reported to. Ms Humphrey reported that the Quality and Performance Executive Group received a six monthly update on the implementation of the Carers Strategy.

The Chair congratulated the Trust on retaining its two star accreditation for the Triangle of Care and asked what further work the Trust would need to do in order to achieve the maximum three star accreditation.

Ms Humphrey reported that in order to achieve three star accreditation, the Trust would need to embed its Carers Strategy across all services and pointed out that the Triangle of Care accreditation process was currently being reviewed.

The Chair thanked Katie Humphrey for her report and presentation.

The Committee would receive an update on the implementation of the Carers Strategy in one year’s time.

Action: Chief Operating Officer

The Committee noted the report.

5.1 Suicide Prevention Strategy Group Update Report

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

Sue McLaughlin presented the report and highlighted the following points:

- The prevention of suicide remained a priority for the Trust. The Suicide Prevention Strategy sought to prevent suicides by identifying where the key areas for learning and development and embedding the learning within the Trust.
- The Trust continued to participate in the system wide review of the Berkshire Suicide Prevention Strategy. A Berkshire wide suicide survey was underway to get feedback from staff about the suicide prevention work.
- In light of the current cost of living crisis, Public Health colleagues were focussing on providing support and advice on debt management, substance and alcohol abuse and gambling
- Learning from deaths during quarter 1 had highlighted inconsistencies around the grading of suicidal risk and the Trust was keen to move away from a system of risk assessment grading to a more descriptive categorisation of risk

- The Trust was developing bespoke workshops for staff on risk.

Aileen Feeney, Non-Executive Director commented that she found the Berkshire Suicide Surveillance Dashboard (figure 4 of the report) very helpful as it provided a good level of detail across a range of indicators.

The Chair asked for more information about the issue around inconsistency and culture of down grading level of need to fit service thresholds.

Sue McLaughlin gave the example of the Talking Therapies service and said that there was a lack of constituency around the assessment of service users care requirements when making referrals for secondary mental health services because the service mainly dealt with lower risk service users. Sue McLaughlin said that the Trust was considering holding joint training sessions so that primary and secondary care mental health staff could gain a shared understanding about the criteria for requiring secondary mental health services.

The Chair thanked Sue McLaughlin for attending the meeting and requested that the Committee continue to receive updates on the Suicide Prevention work.

Action: Director of Nursing and Therapies

5.2 Quality Concerns Status Report

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

- **Quality Concern No 12: WestCall** – this concern was re-added to the Quality Concerns Register in July 2022 because the period of stability had not been maintained as a result of continued increase in demand and staffing challenges
- The following Quality Concerns had been re-written since the Register was last presented to the Committee to provide clarity of the current position and mitigations:
    - Quality Concern No 10: Outpatient Services: Pulmonary Rehabilitation
    - Quality Concern No 10: Podiatry
    - Quality Concern No 10: Speech and Language Therapy
- There had been no concerns removed since the Register was last submitted to the Committee. It had been agreed that both Speech and Language Therapy and Community Dental would be monitored over the coming three months and if the improved/stabilised positions remained for these services, that they would be removed from the Register and continue to be monitored through the Divisional Patient Safety and Quality with concerns escalated to the Quality and Performance Executive Group meeting.

The Chair commented that the Quality Concerns Register was very helpful and said that by reading this in conjunction with the monthly Quality and Performance Executive Group meeting minutes, she was able to get an overview of the scale of the current challenges faced by individual services as well as being informed about the mitigation strategies put in place to address those challenges.

The Committee noted the report.

5.3 Serious Incidents Report

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

- During quarter 1, there were a total of 20 serious incidents initially reported, with none downgraded during the quarter. There were also 21 incidents investigated through the internal learning review process.
- There was a COVID-19 related death reported as a serious incident during the quarter. This was a 90 year old woman who sadly contracted COVID-19 during her stay on one of the Trust's inpatient wards.
- The Trust had been involved in 19 inquests during the quarter. There were no "Preventing Future Death" reports issued to the Trust following the outcome of these inquests.
- Learning from incidents continued to be taken forward.
- Staff support post incident continued with excellent feedback being received from staff. 51 members of staff were supported during the quarter.
- Moving forward, the format of the Serious Incident Quarterly Report would need to be changed and aligned to the Patient Safety Incident Review Framework when this came into force.

The Chair noted that Dysphagia training was being delivered to the Trust's Community Wards in response to learning from serious incidents and commented that people with learning disabilities were often at increased risk of swallowing issues.

The Director of Nursing and Therapies pointed out that the Learning Disabilities service and the acute Mental Health wards had access to Speech and Language Therapies to provide support to patients with dysphagia but said that learning from serious incidents had identified the need for dysphagia training for Community wards for older adults who had some form of dysphagia due to illness.

Mehmuda Mian, Non-Executive Director referred to page 68 of the agenda pack and asked for more information about the medication error concerning an inpatient who did not receive any medication for 14 days following his inpatient transfer between Sorrell and Bluebell wards.

The Lead Clinical Director explained that the medication error was due to a system process issue. There had been a connectivity issue between the electronic prescribing system and the patient record system which had now been resolved. The Lead Clinical Director said that the learning from the incident was around making sure that clinicians did not just rely on computer systems.

The Committee noted the report.

5.4 Learning from Deaths Quarterly Report

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

- 119 deaths met the criteria to be reviewed further
- All 119 deaths were reviewed by the Executive Mortality Review Group and the outcomes were as follows:
    - 69 were closed with no further action
    - 48 required "second stage" reviews (using an initial finding review/structured judgement review methodology)
    - Of the 48 deaths requiring further review, 9 were classified as Serious Incidents requiring investigation. 2 cases were awaiting further information
- During quarter 1, the Trust Mortality Review Group had received the findings of 36 second stage review reports of which 7 related to patients with a learning disability

- There were “no lapses in care” identified from the quarter 1 reviews which were undertaken
- Learning from the reviews of death had been shared with the relevant services by the Clinical Directors through their Patient Safety and Quality Group meetings.

Mehmuda Mian, Non-Executive Director asked how the new Medical Examiner role was operating.

The Medical Director confirmed that from the Trust’s perspective, the Medical Examiner role was efficient and was working well. The Head of Clinical Effectiveness and Audit added that the Medical Examiner had completed their work in relation to the two inpatient deaths on the older adult wards within three days.

The Committee noted the report.

5.5 CQC “Must Do” and “Should Do” Action Plans

The Director of Nursing and Therapies presented the paper and reported that the Care Quality Commission’s “Must Do” actions for Prospect Park Hospital had now been completed.

It was noted that there was ongoing improvement work and a continued focus in relation to the sexual safety of patients and also in relation to restrictive practice. Progress around improvement work relating to sexual safety was monitored through the Quality and Performance Executive Group. The Restrictive Practice Group reported into the Mental Health Act Governance Board.

The Director of Nursing and Therapies reported that there continued to be over two year waiting times for some young people within our Neurodiversity pathways. The number of young people waiting over two years had increased this month as a result of the number of waiters moving from over one year waits to over two year waits. This was despite increased activity and prioritisation of those most at risk alongside those with the longest waits.

It was noted that work on ensuring that pathways and process was as efficient as possible to maximise capacity and reduce waiting times continued with project management support.

The Director of Nursing and Therapies reported that the “Should Do” actions had now been completed and that the Committee would no longer receive a report in its current format. The Director of Nursing and Therapies proposed that the Committee would receive update reports on the Neurodiversity waiting list.

The Chief Operating Officer suggested that the Committee receive an update on the Neurodiversity waiting lists at the February 2023 meeting.

Action: Chief Operating Officer

The Committee noted the report.

5.6 National Patient Safety Strategy Implementation Report

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

- The new national Patient Safety Incident Review Framework (PSIRF) was released on 16 August 2022. It was expected that organisations would start the process of transitioning from the current serious incident framework to the

new framework from September 2022 with the transition completed by Autumn 2023.

- The new framework was a significant shift in the way the NHS responded to patient safety incidents and was a major component of the national patient safety strategy which would enable and support the NHS to embed key principles of a patient safety culture. The framework promoted more proportionate and considered response to patient safety incidents focusing on how they happened rather than seeking to apportion blame on individuals which would enable more effective learning and improvement.
- The new framework made the Trust Boards of provider organisations accountable for high quality incident responses while Integrated Care Boards (ICBs) would consider their providers' overall approach rather than each individual report/responses.
- The Trust would need to implement the Learning from Patient Safety Events recording system by 1 April 2023. A number of risks had been identified associated to this including:
    - The capacity required to switch from the National Reporting and Learning Service reporting to the Learning from Patient Safety Events system
    - Changes in taxonomy affecting our existing Datix language
    - Additional compulsory fields that may lead to much longer incident reporting forms (that could affect compliance and quality of reporting)
    - Duplication of reporting
- The Trust had recruited a Neurodiversity Patient Safety Partner

The Chair acknowledged that the implementation of the new Patient Safety Strategy was a significant piece of work.

The Director of Nursing and Therapies said that one of her concerns was that if the changes to the reporting of incidents was more complex this could lead to a reluctance around reporting incidents. The Director of Nursing and Therapies reported that support would be provided to staff on changes to the incident reporting system.

The Director of Nursing and Therapies reported that an update on the implementation of the National Patient Safety Strategy would be presented to the September 2022 Trust Board meeting as part of the Executive Report.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.7 Sexual Safety Update Report

The Director of Nursing and Therapies presented the report and highlighted that there had been an increase in the number of patient on staff sexual safety incidents over the last quarter. To date, countermeasures had focussed on increasing patient safety and awareness. The next meeting of the Sexual Safety Group would start to analyse patient on staff incidents to enable the appropriate countermeasures to be developed.

The Chair asked about the frequency of the Sexual Safety Update Report.

The Director of Nursing and Therapies reported that the Committee received an update every six months.

The Committee noted the report.

5.8 Annual Infection Prevention and Control Report 2021-22

The Annual Infection Prevention and Control Report 2021-22 had been circulated.

The Chair commented that infection prevention and control was crucially important from a patient safety point of view and acknowledged the hard work of the team during the COVID-19 pandemic.

The Committee noted the report.

5.9 Infection Prevention and Control Quarterly Summary Report

The Director of Nursing and Therapies presented the paper and pointed out that historically the Infection Prevention and Control Quarterly Summary Report had not been submitted to the Committee but commented that she thought that the Committee may find it useful to have a summary of the Trust's infection control activity that had occurred during the last quarter.

The Director of Nursing and Therapies reported that since the report was written, NHS England had issued new COVID-19 guidance. The new guidance paused the routine lateral flow testing of staff and patients because of the current low COVID-19 infection rate. Healthcare staff were no longer required to wear face mask, although they could do so if they wanted to. It was noted that if the prevalence of COVID-19 started to increase, it was likely that the testing requirement would be reinstated. Staff and patients displaying symptoms would continue to be tested.

The Chair asked about the Trust's role in administering the Monkey Pox vaccination.

The Director of Nursing and Therapies reported that NHS England had paused the Monkey Pox vaccination programme due to a shortage of vaccine. The Director of Nursing and Therapies confirmed that the incidence of Monkey Pox was declining.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Medical Director presented the paper and reported that the Trust had received the Trust level data and benchmarking for one National Clinical Audit since the last meeting and two high level national reports (for which no Trust level data was provided):

- POMH: Prescribing for Depression in adult mental health services
- National Diabetes Footcare audit Interim report
- NCEPOD Report: A Picture of Health? Bridging the gap between physical and mental healthcare in adult mental health inpatient settings (2022)

a) Prescribing for Depression in adult mental health services

The Chair welcomed Dr Garyfallia Fountoulaki, Clinical Director.

Dr Fountoulaki pointed out that the Prescribing for Depression in adult mental health services was a re-audit (the first audit was in May 2019) and reported that the Trust had performed better than the national findings across nearly all standards and had improved overall since the previous audit findings. Dr Fountoulaki reported that the audit had identified areas for improvement and an action plan had been developed

which would be overseen by the Clinical Effectiveness Group and service level governance processes. The areas for further improvement included:

- Patients prescribed continuing antidepressant medication should have a care/crisis plan that identified potential triggers/precipitating factors that could lead to a worsening of their condition, including psychosocial stressors and reference should be made to strategies to manage such triggers
- For patients with depression under the care of a Community Mental Health Team prescribed continuing, long-term antidepressant medication, there should be at least annual review to consider symptoms assessed using a Formal Rating Scale; the role of use of alcohol in precipitating or maintaining depression; the role of use of other substances in precipitating or maintaining depression and the role of co-morbid physical illness in precipitating or maintaining depression

The Chair asked for more details about the care/crisis plan not including information about triggers.

Dr Fountoulaki explained that the issue was around not documenting how the triggers would be managed. It was noted that the Electronic Patient-Reported Outcomes Letter template had a heading specific to triggers and confirmed that the Trust was anticipating that the roll out of its use or adding this to all clinic letters would lead to further improvement in reporting. Clinic letters had a management plan so adding a reminder or clarifying the wording there to include managing the risk of relapse would be helpful.

The Chair thanked Dr Fountoulaki for attending the meeting and congratulated the service on achieving a positive clinical audit report.

b) National Diabetes Footcare audit Interim report and NCEPOD Report: A Picture of Health? Bridging the gap between physical and mental healthcare in adult mental health inpatient settings (2022)

The Medical Director reported that the two audits had been discussed at the Clinical Effectiveness Group meeting which had provided assurance that the relevant services had noted the audit findings and the good practice recommendations.

The Committee noted the report.

6.1 Quality Accounts 2022-23 Quarter 1 Report

The Quality Accounts 2022-23 quarter 1 report had been circulated.

The Medical Director presented the report and pointed out that the data contained in the Quality Accounts had already been reported elsewhere. The Head of Clinical Effectiveness and Audit added that submitting the Quality Accounts quarterly provided the Committee with an opportunity to make changes to the format and content of the Quality Accounts as the report developed rather than waiting to make changes when the report was almost finalised.

Aileen Feeney, Non-Executive Director commented that she found the Quality Accounts a useful reference document.

The Committee noted the report.

7.0 Annual Review of Effectiveness and Terms of Reference Review

The results of the Committee's Annual Review of Effectiveness had been circulated. The Company Secretary thanked members of the Committee for completing the survey and said that the results had been very positive.

The Committee's Terms of Reference had also been circulated and the Company Secretary invited members of the Committee to identify any changes.

The Director of Nursing and Therapies said that moving forward, the Committee's terms of reference would need to be reviewed against the national Patient Safety Strategy and that this could include extending the Committee's membership to include a patient safety partner.

Action: Director of Nursing and Therapies/Company Secretary

The Chief Executive commented that the Committee undertook a significant amount of routine work and suggested that if a patient safety partner did join the Committee, the Committee may want to consider changing the structure of the meeting to ensure that agenda items which would benefit from the patient safety partner's input were identified otherwise there was a danger that the patient safety partner may become disengaged.

The Chair thanked the Company Secretary for facilitating the annual review of the Committee's effectiveness.

The Committee noted the report.

Update Items for Information

8.0 Guardian of Safe Working Hours Quarterly Report

The Guardian of Safety Working Hours report had been circulated.

The Medical Director presented the paper and reported that during the reporting period (1 May 2022 to 2 August 2022) the Trust had received three 'hours and rest' exception reports totalling an extra four hours worked over and above the trainees' work schedules. and one 'education' report where a trainee had missed on hour of their allocated teaching session. All four exception reports related to a busy clinical workload on the inpatient wards due to medical staff being off sick or on leave.

It was noted that the Guardian of Safe Working Hours had provided assurance to the Trust Board that no unsafe working hours had been identified and there were no other patient safety issues requiring escalation.

The Committee noted the report.

8.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meeting held on 18 May 2022 had been circulated.

The Medical Director reported that the Mental Health Act Governance Board provided oversight across all aspects of the Mental Health Act. It was noted that the December 2021 Quality and Performance Executive Group meeting had approved the removal of the Mental Health Act compliance risk from the Quality Concerns Register on the basis that the risk would be monitored through the Mental Health Act Governance Board. The Mental Health Act Compliance Trust wide risk on the

Corporate Risk Register had also been closed because of the effectiveness of the mitigations that had been put in place.

The Medical Director said that the Mental Health Act Governance Board was particularly focussed on monitoring the use of the Place of Safety as a temporary additional bed and had received assurance that this was usually for no more than 24 to 48 hours. The Medical Director reported that the Trust was also undertaking work to gain a better understanding about the ethnicity aspect of people detained under the Mental Health Act. It was noted that the Director of Strategic Planning and lead for the Trust's work on Health Inequalities: Mental Health Act detentions of black individuals project had attended the August 2022 meeting to discuss the next steps for the project.

The Chair commented that the minutes were very comprehensive and supported the Mental Health Act Governance Board's focus on monitoring the use of the Place of Safety as an additional bed and the work around gaining a better understanding of the ethnicity aspect of detentions.

The Committee noted the minutes.

8.2 Annual Mental Health Act Report 2021-22

The Annual Mental Health Act Report 2021-22 had been circulated.

The Medical Director highlighted that the Trust was developing a new method to capture patients' ethnicity more accurately. It was noted that the Trust was undertaking a piece of work to gain a better understanding about the underlying reasons why patients from a BAME background were disproportionately more likely to be detained than their white counterparts.

The Chair asked whether there would be an opportunity to discuss the proposed changes to the Mental Health Act.

The Medical Director explained that the draft bill had been published but pointed out that there was significant discussions taking place within the Department of Health and Social Care about the proposals and therefore he proposed briefing Trust Board when there was more clarity around the final changes.

Action: Medical Director

The Committee noted the report.

8.3 Annual Place of Safety Report 2021-22

The Annual Place of Safety Report 2021-22 had been circulated for information.

The Committee noted the report.

8.4 Annual Safeguarding Report 2021-22

The Annual Safeguarding Report had been circulated for information.

The Chair asked whether there were any issues around staff not reporting safeguarding concerns.

The Director of Nursing and Therapies confirmed that there was a strong safeguarding reporting culture across the Trust but said that there was a gap around Adult Services reporting potential safeguarding issues concerning children.

Raja Natarajan, Clinical Director added that there this sometimes happened when multiple services were visiting in people's homes and individuals did not report a children's safeguarding issue because they had assumed that other people would have reported the issue.

The Committee noted the report.

8.5 Quality and Performance Executive Group Minutes – June 2022 and July 2022

The minutes of the Quality and Performance Executive Group minutes for June 2022 and July 2022 had been circulated.

The Chair commented that she found the content of the Quality and Performance Executive Group minutes informative and useful context for the Quality Assurance Committee's discussions.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

A copy of a Governors' visit to the Berkshire Traumatic Stress Service, Transition, Intervention and Liaison for Veterans Mental Health and Veterans' Mental Health Complex Treatment service had been circulated.

The Chair thanked the Governors for an informative report about their visit.

The Committee noted the Governors' service visit report.

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

The Chair reported that she had agreed with the Director of Nursing and Therapies that it would be useful for the Committee to receive an update on the Trust's Falls Reduction Quality Improvement Programme Breakthrough Objective at the next meeting.

Action: Director of Nursing and Therapies

9.1. Any Other Business

There was no other business.

9.2. Date of the Next Meeting

The next meeting is scheduled to take place on 29 November at 10am.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 30 August 2022.

Signed:- _____

Date: - 29 November 2022 _____

QPEG / QAC/ Trust Board	August 2022
Title	**Learning from Deaths Quarter 1 Report 2022/23**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
Summary	119 deaths met the criteria to be reviewed further and were submitted on Datix for review. All 119 were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 69 were closed with no further action • 48 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 48 deaths requiring further review, 9 were classed as Serious Incident Requiring Investigation (SI) • 2 cases were awaiting further information During Q1, the trust mortality review group (TMRG) received the findings of 36 2nd stage review reports, of which 7 related to patients with a learning disability. **Lapse in care (LIC)** A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. No lapse in care was identified from the Q1 reviews which were undertaken. **COVID 19 Inpatient Deaths.** We had 2 deaths where Covid 19 was stated as the main cause of death (part 1 of the medical certificate of cause of death, MCCD). 1 met the criteria for a full SI review as a definite healthcare acquired infection and the 2nd case was subject to second stage review (SJR) as a probable healthcare acquired infection. Learning from review of deaths is further shared with services by the Clinical Directors through their patient safety and quality groups (PPSQs).
ACTION REQUIRED	The committee is asked to receive and note the Q4 learning from deaths.

Figure 1. Summary of Deaths and Reviews completed in 2021/22.

Figure 1	20/21 total	21/22 total	Q1 22/23	Q2 22/23	Q3 22/23	Q4 22/23	Total 22/23
Total deaths screened (Datix) 1st stage review	510	**467**	119				
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	269	**209**	48				
Total number of deaths reported as serious incidents	48	**35**	9				
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	1	**4**	0				
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	185	**156**	43				
Total number of deaths of patients with a Learning Disability (1st stage reviews)	53	**51**	7				
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	**0**	0				

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

1.1 Total Deaths Screened (1st stage review)

119 deaths were submitted by services through the trust Datix reporting system for a first stage review by the EMRG. Of these 119 deaths reviewed, EMRG advised closing 69 cases, 48 were referred for a second stage review of which 9 were referred for SI investigation. 2 cases require additional information at first stage review.

1.2. 2nd Stage Reviews Completed

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 36 second stage reviews have been received and considered by the group in Q1. Figure 2 details the service where the review was conducted.

Figure 2: 2nd Stage Reviews Completed in Q1

April 2022	14 SJR 4 IFR **18 Total** New Complaints: 3	Learning Disabilities: 3 SJR West Mental Health: 1 SJR, 3 IFR East Mental Health: 1 IFR West Physical Health: 9 SJR East Physical Health: 1 SJR
May 2022	8 SJR 2 IFR **10 Total** New Complaints: 0	Learning Disabilities: 3 SJR West Mental Health: 3 SJR East Mental Health: 2 IFR West Physical Health: 1 SJR East Physical Health: 1 SJR
June 2022	3 SJR 5 IFR **8 Total** New Complaints: 2	Learning Disabilities: 1 SJR West Mental Health: 3 IFR Mental Health Inpatients: 1 SJR West Physical Health: 1 SJR East Physical Health: 1 IFR Children Young People Families: 1 IFR

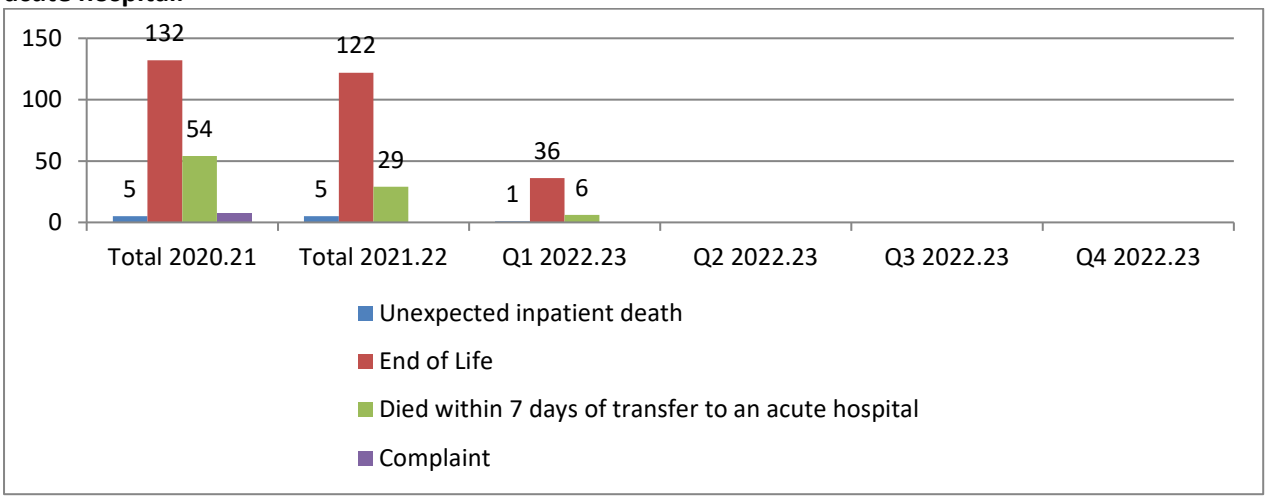
2. Concerns or Complaints

In Q1, 5 new complaints in total were received from families following the death of a relative, 2nd stage reviews were requested for all. None of the complaint related SJR reviews at TMRG raised concern which reached the threshold for a lapse in care (LIC).

3.1 Deaths of patients (including palliative care) on Community Health Inpatient Wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 3 details these.

Figure 3: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q1 there were 42 deaths reported by Community Inpatient Wards and 1 death from our Older Adults mental health wards, of which:

- 36 were expected deaths and related to patients who were receiving end of life care (EOLC) including our Older Adults Mental Health ward.
- 6 unexpected deaths due to ill health deterioration where they were transferred to an acute hospital and died within 7 days
- 1 unexpected inpatient death

Of the 36 EOLC deaths reviewed by the EMRG, 34 were closed at 1st stage review and 2 were referred for 2nd stage review (see covid 19 section below).

Of the 7 unexpected deaths, 2nd stage reviews were requested for all.

3.2 Covid-19 Inpatient deaths.

From the deaths noted above, 3 patients tested positive for Covid 19 within 28 days of death, of these:

- 1 was closed at first stage review, the patient was admitted for end-of-life care and was positive for covid 19 on or prior to admission, Covid 19 was not stated on medical certificate of cause of death (MCCD).
- 1 patient was admitted for end-of-life care and acquired a Covid 19 infection whilst in our care. Covid 19 was cited on part 1 of the MCCD and this therefore meets our criteria to be reviewed as an SI
- 1 patient was admitted for end-of-life care and tested positive within 7 days for Covid 19 infection. Covid 19 was cited on part 1 of the medical certificate of cause of death and this therefore meets our criteria to be reviewed as an SJR.

3.3 Medical Examiner

Nationally, acute trusts Medical Examiner's Offices are required to put in place measures to extend Medical Examiner scrutiny of deaths across all non- acute sectors so that all deaths are scrutinised.

RBFT provide this service for the Trust and all BHFT inpatient deaths (since December 2022) have been scrutinised through the RBFT Medical Examiner's Office.
Subject to parliamentary process this will become a statutory requirement in April 2023.

All 37 inpatient deaths have been independently scrutinised by a Medical Examiner. In 34 cases, the medical certificate of cause of death (MCCD) was agreed and processed. 2 cases were referred to the coroner, the coroner agreed the cause of death and gave permission for us to issue the MCCD (100A).

The ME process allows for the Medical Examiner to also recommend cases for structured judgement review and notify us of any family concerns, no cases were identified for review in Q1 by the ME.

4. Deaths of Children and Young People

In Q1, 11 deaths were submitted as a Datix for 1st stage review. 10 cases were closed at EMRG following 1st stage review. Cause of death was either extreme prematurity or complex disability in most cases. 1 case was escalated as a serious incident. All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP).

5. Deaths of adults with a learning disability

In Q1 the Trust Mortality Review Group (TMRG) reviewed a total of 7 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 7 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the respiratory system	5
Diseases of the circulatory system	1
Other	1

None of the deaths were attributable to COVID.

Demographics:

Gender:

Female	3
Male	4

Age:

The age at time of death ranged from 36 to 89 years of age (median age: 58 yrs)

Severity of Learning Disability:

Mild	1
Mild to Moderate	1
Severe	1
Not Known	4

Ethnicity:

White British	7

Engagement and feedback with family members

The Learning Disability Service makes contact with the family and/or staff team following the reported death of a person with a learning disability. There have been no responses received to date from those contacted in this quarter.

6. Deaths categorised as Serious Incidents

In Q1, 9 deaths were reported as serious incidents (See SI Q1 report for details).

7. Lapse in Care

A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. No lapse in care was identified from the Q1 reviews which were undertaken.

8.Learning from Deaths

The aim of the trust policy and process is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details areas of quality improvement identified in Q1.

8.1 Learning from Serious Incidents (SI)

Please refer to Q1 SI Report

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

Actions and learning identified during the previous quarter have been completed / shared. On area of learning was noted in a specific case:

- To ensure it is clearly documented in RiO the outcome of the triaging of referrals to provide a clear explanation if they cannot be actioned upon receipt. This learning was shared with the specific CTPLD and was re-iterated via the LD patient safety and quality meeting as part of mortality review feedback.

In Q1, there was ongoing evidence of:

- good MDT working, coordination of care, and of communication with families and across local services
- capacity and risks being considered and that appropriate actions were taken to meet people's needs in a holistic and personalised way
- BHFT services being responsive to people's needs and of care being delivered in a timely way

The Learning Disability Service continues to support the local LeDeR programmes by supplying the details of our SJR's in relation to those people whose death was reported to the service.

8.3 Key Learning from Mental Health Services

- A review identified areas of learning focusing on clearer documentation of assessed risk, safety planning and sharing plans with a GP. Further evidence in the documentation of clinical formulation would have supported more transparency and assurance. An action plan is in place to action the learning points identified.
- Learning has been identified with reference to substance misuse service and proactive management of risks. A learning event is planned for the specific team involved in the care.
- End of life (EOL) care management specifically around the aspect of transferring to an acute hospital when EOL care was planned and expected.

8.4 Key Learning from Community Physical Health

- Continued learning identified with regards to the escalation of care for the deteriorating patient and multidisciplinary working on the inpatient community health wards.
- Escalation of the care of deteriorating patient in community teams, specifically with regards to low oxygen saturations. The team has subsequently undertaken training regarding vital signs and competencies. Rationale of escalation has been discussed in the training and further discussion at team meetings is on-going to recognise when to refer to other services for urgent attention.
- Learning has been identified around a referral which should have been made to the adult speech and language therapists for oral fluid consistency advice.
- Learning when a patient is discharged home following a positive result of Covid with regards to ensuring that anticoagulant medication is discussed with the patient and family in the context of Covid infection being a risk factor for thrombosis/embolism.

9.Conclusion

During Q1, the trust mortality review group (TMRG) received the findings of 36 2nd stage review reports. All hospital inpatient deaths were reviewed by a medical examiner.

No lapse in care were identified.

We had 2 deaths where Covid 19 was stated as the main cause of death (part 1 of the medical certificate of cause of death MCCD). 1 met the criteria for a full SI review as a definite healthcare acquired infection and the 2nd case was subject to second stage review (SJR) as a probable healthcare acquired infection.

Learning from review of deaths is further shared with services by the Clinical Directors through their patient safety and quality groups**.**

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	August 2022
Title	Guardian of Safe Working Hours Quarterly Report (May to August 2022)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Dr Marjan Ghazirad, Ian Stephenson
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardian of Safe Working. This report focusses on the period 1st of May to 2nd of August 2022. Since the last report to the Trust Board, we have received four exception reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardian.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS IN TRAINING

This report covers the period 1st May 2022 to the 2nd of August2022

Executive summary

This is the latest quarterly report for consideration by Trust Board from the Guardian of Safe Working.

This report focusses on the period the period 1st May 2022 to 2nd August 2022. Since the last report to the Trust Board, we have received three '*hours & rest'* exception reports and one '*education*' report.

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

Introduction

The current reporting period covers the second half of a six-month CT and GPVTS rotation.

High level data

Number of doctors in training (total): 43 (FY1 – ST6)

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

Number of doctors in training on 2016 TCS (total): 43

Amount of time available in job plan for guardian to do the role: 1PA

Admin support provided to the guardian: Medical Staffing

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

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	4	4	0
Sexual Health	0	0	0	0
Total	0	4	4	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	4	4	0
CT	0	0	0	0
ST	0	0	0	0
Total	0	4	4	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	4	4	

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	4	0	0
CT1-3	0	0	0	0
ST4-6	0	0	0	0
Total	0	4	0	0

In this period, we have received three '*hours and rest*' exception reports where the trainees' worked hours in excess of their work schedule, totaling an extra four hours worked over and above the trainees' work schedules. In regard to the education report, trainee missed an hour of allocated teaching session. Exception reporting is a neutral action and is encouraged by the Guardians and DME. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.
All three *hours and rest* exception reports and an education report received related to a busy clinical workload on the inpatient wards due to medical staff being off sick or on leave meaning that the doctor stayed late by 1-2 hours to complete the work on the ward or not being able to attend the scheduled teaching.
It has been the opinion of Medical Staffing and the Guardian of Safe Working that in most cases "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work. However, the trainee has now completed their rotation with BHFT, the extra hours work was toward the last few days of trainee's rotation with BHFT, and they filed the exception reports the day after leaving, hence it was decided to pay the trainee on this occasion since they have moved to another Trust.

There have been no systemic concerns about working hours, within the definitions of the 2016 TCS.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum. In addition, a flyer about exception reporting is being mounted in junior doctors on call room and an exception report banner for virtual teams meeting has been provided by the Guardian of Safe Working to the chair of academic meetings and consultant in medical psychotherapy to use during their meetings.

b) Work schedule reviews

There have been no work schedule reviews in this period. The Medical Staffing department has created Generic Work Schedules. The DME, working with tutors, the School of Psychiatry and Clinical Supervisors, has developed Specific Work Schedules. These are both required by the contract.

Work schedule reviews by grade	
CT1-3	0
ST4-6	0

Work schedule reviews by department	
Psychiatry	0
Dentistry	0
Sexual Health	0

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 1st May 2022 to 2nd August 2022)

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	109	108	30	78	0	1110.5	1098	314	784	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	57	56	20	36	0	573.5	561	205	356	0
Sickness	52	52	10	42	0	537	537	109	428	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	109	108	30	78	0	1110.5	1098	314	784	0

d) **Fines**

Fines levied by the Guardians of Safe Working should be applied to individual departments, as is the intent of the contract. No fines have been levied in this quarter.

Fines by department		
Department	Number of fines levied	Value of fines levied
None	None	None
Total	0	0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£0	£0	£0

Qualitative information

The OOH rota continues operating at 1:11 and our system for cover continues to work as normal, with gaps generally being quickly filled. We have had 1 unfilled gap this rotation, however, patient safety was not an issue and we always had one junior doctor on duty out of hours.

Our bank doctors have continued to be an asset, and we continue to increase this pool.

No immediate patient safety concerns have been raised to the guardian in this quarter.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there may be under-reporting of small excess hours worked.

Actions taken to resolve issues

Next report to be submitted November 2022.

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No trainee has breached the key mandated working limits of the new contract.

The Guardian gives assurance to the Trust Board that no unsafe working hours have been identified, and no other patient safety issues requiring escalation have been identified.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum. Junior Doctors are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the Trust. An anonymized survey was conducted to gather Junior doctors' view about the exception reporting, and it is in the data analysis stage.

Questions for consideration

The Guardian ask the Board to note the report and the assurances given above.

The Guardian make no recommendations to the Board for escalation/further actions.

Report compiled by Dr Marjan Ghazirad, GOSW, & Ian Stephenson, Medical Workforce Manager.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 September 2022
Title	**Executive Report**
	For Noting and to Confirm the Trust Board's Support to the Staff Flu and COVID-19 Booster Campaign
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting 13 September 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. Changes to How the Care Quality Commission Will Regulate

The Care Quality Commission is changing the way it regulates health and social care provider and integrated care systems. An overview of the new approach is set out at appendix 1.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. COVID-19 Update

The prevalence of Covid-19 in the community has fallen and remains at a comparatively low level as we emerge from the current Omicron wave. We are seeing much lower Covid-19 related staff absence and the likelihood of individuals entering our healthcare services and being infectious has also reduced.

As a result of this and some changes to national guidance, we have updated our current processes in relation to both routine testing and the routine wearing of masks.

Covid-19 testing

Updated national guidance in relation to testing was released on 24th August 2022 to come into effect from 1st September; this means that:

- Routine lateral flow testing for staff will be paused. In line with local risk assessment processes, if case rates rise or if national guidance changes this will be reviewed and may be reinstated. Staff displaying any symptoms should continue to use Lateral flow testing and follow guidance in relation to staying away from the workplace.
- Routine admission screening of patients will be paused. In line with local risk assessment processes, if case rates rise or if national guidance changes this will

be reinstated. Any patient displaying symptoms will continue to be tested for Covid-19 and other respiratory infection and will also continue to be isolated/ cohorted in line with infection prevention and control transmission-based precautions.
- In line with national guidance, patients will continue to be screened prior to transfer to a care home.

Mask wearing

Updated national guidance issued on 1st June 2022 - *Next Steps on Infection Prevention and Control*, advised that: ''IPC guidance has continued to evolve throughout the pandemic, and we are now setting out further changes following updates from the UK Health Security Agency (UKHSA).''

The guidance included that: ''for healthcare workers in health and care settings, non-pharmaceutical interventions (such as mask wearing and enhanced ventilation) may be used, depending on local prevalence and risk assessment.''

The guidance also advised that:

- ''Health and care staff should continue to wear facemasks as part of personal protective equipment required for transmission-based precautions when working in COVID-19/respiratory care pathways, and when clinically caring for suspected/confirmed COVID-19 patients. This is likely to include settings where untriaged patients may present such as emergency departments or primary care, depending on local risk assessment. In all other clinical care areas, universal masking should be applied when there is known or suspected cluster transmission of SARS-CoV-2, e.g., during an outbreak, and/or if new SARS-CoV-2 VOC emerge''.
- ''Universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression e.g., oncology/haematology. This should be guided by local risk assessment''.
- ''Health and care staff are in general not required to wear facemasks in non-clinical areas e.g., offices, social settings, unless this is their personal preference or there are specific issues raised by a risk assessment. This should also be considered in community settings''.

Based on the above guidance and given the current lowercase rates we have implemented the following:

- Routine wearing of masks for all staff is being paused. If Covid-19 case rates rise or there is differing national guidance this decision will be reviewed.
- Staff will continue to follow standard and transmission-based Infection prevention and control precautions, this includes the wearing of masks (along with other required PPE) when this is indicated (for example if there are symptomatic or covid-19 positive patients on a ward, outbreak situations, where we are treating immunocompromised patients, where a patient being seen at home or in a clinic has covid-19 or respiratory symptoms and where we see patients who have not been triaged).

The above changes do not take away staff personal choice. Should staff wish to continue to wear a mask routinely, masks are readily available for them to do so.

These changes are based on the current situation and will be risk assessed/re-evaluated on a regular basis and as case rates change.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4. Staff Flu and COVID-19 Booster Vaccination Campaign 2022

Seasonal influenza and COVID-19 have the potential to add substantially to the winter pressures the NHS usually faces, particularly if infection waves from both viruses coincide.

The timing and magnitude of potential influenza and COVID-19 infection waves for winter 2022/23 are currently unknown, but mathematical modelling indicates the 2022/23 influenza season in the UK could be up higher than typically seen. The vaccine uptake ambitions for this coming season are to offer 100% frontline (clinical and non-clinical) staff the opportunity to receive the vaccines; for flu there is a national quality indicator set out within the Commissioning for Quality and Innovation (CQUIN): 2022/23 Guidance, to achieve 70-90% uptake and this should be regarded as the minimum level to achieve.

The Department of Health and Social Care have announced that the Flu and Covid-12 Booster campaign will launch nationally on 12th September 2022. The campaign asks for all frontline workers to take up the offer of a free vaccination. Last year, our flu vaccination uptake (61.7%) was lower than in other recent years where we had achieved around 70% uptake. This was directly affected by more staff working from home. This year, our campaign has been revamped to include a greater focus on staff in all areas being offered both the influenza and Covid-19 vaccination.

This year's vaccine will be Sequiris Quadrivalent cell-based vaccine and can be given to all adults 18+. A different vaccine for the over 65's is not required in this year's campaign, though over 65's can access the preferred Trivalent vaccine from their GP if preferred.

The Covid vaccine being given/that we will receive is Moderna Spikevax Bivalent

We are expecting to receive our first batches of vaccines toward the end of September/beginning October 2022 and will commence our clinics once this is received.

The guidance this year is that both vaccines can be given at the same time; whilst we will offer this, our campaign will also enable staff to have these vaccinations on separate occasions if that is what they prefer.

As in previous campaigns, we will offer clinic based sessions for covid-19/flu vaccines and alongside this. This year, we will use our new immunisation bus to enable us to travel to various sites offering vaccines and health promotion. For flu we will also continue to use peer vaccination and vouchers.

We recognise that some staff may receive their covid-19 and/or flu vaccinations via their GP and local pharmacies and we will as in previous campaigns be asking staff to let us know if they receive their vaccine somewhere other than through the Trust.

Requirements for Trust Boards

1. Record their commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated.

2. All Board members and senior managers receive their vaccinations and publicise it.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. COVID-19 National Inquiry

At the end of August 2022, the statutory Covid-19 inquiry launched its second module which will examine political and administrative decision-making of the UK and devolved governments.

Module one was launched in July 2022, focusing on the UK's resilience and preparedness for a pandemic. A third module – the most relevant to NHS leaders will be launched later in the year, examining healthcare systems and governance, the impact of Covid-19 on waiting times, vaccination programmes and Long Covid.

Executive Lead: Julian Emms, Chief Executive

6. Long COVID

Data released by the Office for National Statistics, estimates that around 430,000 Britons were still suffering from long COVID two years after first contracting the virus. One in every 32 people in the UK was estimated to have some form of long COVID at the end of July 2022, equivalent to 2 million people. Of those, around 1.5 million said their symptoms were adversely affecting their daily activities.

Executive Lead: Julian Emms, Chief Executive

7. Large Increase in NHS Vacancies

Data from NHS Digital Published on the 1 September 2022 highlighted that the number of posts vacant across the NHS in England has reached a record high of 132,139 – almost 10% of its planned workforce. Quarterly personnel figures show the number at the end of June 2022 was up sharply from three months earlier when there were 105,855 vacancies.

A jump in nearly 30,000 staff vacancies is unprecedented, with the biggest issues in nursing, which have grown by nearly 8,000.

Executive Lead: Julian Emms, Chief Executive

8. Update on the National Patient Safety Strategy and Introduction of the Patient Safety Incident Response Framework (PSIRF)

One of the major components of the National Patient Safety Strategy is the Patient Safety Incident Response framework (PSIRF). This was published on 16 August 2022 and will replace the 2015 Serious Incident Framework.

The new framework is a significant shift in the way that the NHS responds to patient safety incidents and will enable and support the NHS to embed key principles of a patient safety culture. The framework promotes more proportionate and considered response to patient safety incidents focusing on how they happened rather than seeking to apportion blame on individuals which enables more effective learning and improvement .

The framework has 4 key elements to achieving more effective learning and improvement:

- Compassionate engagement and involvement of those affected by patient safety incidents.
- Considered and proportionate response to patient safety incidents.
- Application of a range of system-based approaches to learning from patient safety incidents.
- Supportive oversight focused on strengthening response system functioning and improvement.

The new framework makes the leaders of provider organisations accountable for high quality incident responses while Integrated Care Boards (ICBs) will consider their providers' overall approach rather than each individual report/response.

It is expected that organisations will work over the next 12 months to fully implement the PSIRF; during this time there are some key pieces of work to be undertaken which will be led by the patient safety team and which will require Board sign-off before implementation including:

- Review of current systems and processes against the new patient safety incident response standards
- Development and publishing of a new incident response policy and plan

There is also a requirement to identify a PSIRF executive lead (ICB and NHSE regional teams are also required to do this)

To support the introduction of the new framework and the principles of patient safety culture, NHSE have developed a training syllabus with all staff including Board members expected to complete the L1 (essentials of patient safety) e-learning training. To date round 700 of our staff have completed this training, and we are looking at innovative ways including group sessions and use of the e-learning as part of team meetings etc. to maximise the uptake of this. There is an additional L1 learning for boards and senior leadership teams. Any staff leading on a learning response to an incident will be expected to undertake a second level of training much like our investigating officers have to date been required to undertake a level of training before undertaking investigations.

The standards required to achieve the Royal College of Psychiatry Serious Incident Review Accreditation are aligned in many ways with the ethos of the new framework

and therefore the work that we undertook to achieve this in 2021 has meant that we had already started reviewing and changing our processes around incident review, including ways of involving patients, families, and staff in the process, this will stand us in good stead now that the framework is released. That said there is still a significant amount of work to be undertaken over the coming year in terms of ensuring that all our systems and processes are aligned with the new framework.

To support this work, another key element of the National Patient Strategy has been for each organisation to identify at least one Patient Safety Specialist, their role is to provide dynamic senior patient safety leadership and support, playing a key role in the development of the patient safety culture, safety systems and improvement activity . The specialists have close links with the NHS England and NHS Improvement National Patient Safety Team who host a national network for Patient Safety Specialists, including regular meetings and information sharing through a dedicated online forum. The specialists are also expected to have direct access to their executive team, which facilitates the escalation of patient safety issues or concerns. As a Trust we have identified two patient Safety Specialists from within our Patient Safety Team.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

Presented by Julian Emms
Chief Executive
13 September 2022

NHS
Berkshire Healthcare
NHS Foundation Trust

Changes to how the CQC will regulate

Other detail (presenter)

New framework

Berkshire Healthcare NHS Foundation Trust

The new framework will cover:

- all sectors, service types and levels from registration, to how we look at individual providers, local authorities and integrated care systems

It's focus is on:

- What matters to people who use health and social care services and their families.
- It will let us provide an up-to-date view of quality.

Ratings and the five key questions remain:

Safe - Effective - Caring - Responsive - Well-led

Quality Statements & Assessments

Berkshire Healthcare NHS Foundation Trust

- Quality statements will replace our key lines of enquiry (KLOEs), prompts and ratings characteristics.
- They will set clear expectations of providers, based on people's experiences and the standards of care they expect.
- There will be six new evidence categories under the statements

Assessment is not tied to set dates or driven by a previous rating

- The CQC will collect evidence on an ongoing basis and can update ratings at any time. To help us respond more flexibly to changes in risk
- Assessment will be tailored to different types of providers and services

Evidence Categories

Berkshire Healthcare NHS Foundation Trust

People's experience of health and care services

Feedback from staff and leaders

Feedback from partners

Observation

Processes

Outcomes

- Which evidence categories and the sources of evidence collected will vary according to service type/ model, as well as if the assessment is for an existing service or at registration.
- Evidence will be scored to make our judgements more structured and consistent

Inspections

Berkshire Healthcare NHS Foundation Trust

- Inspections (site visits) will be a vital tool to gather evidence to assess quality
- Data and insight will be used to decide which services to visit.
- When on site, The CQC will observe care and talk to staff and people who use services
- Shorter and simpler reports will be issued

Quality Statements for Each of the Key Questions

Safe

Berkshire Healthcare NHS Foundation Trust

- **Learning Culture** – A proactive & positive culture of safety based openness & honesty
- **Safe Systems, Pathways & Transitions** – Maintain safe system of care by working with our people & partners.
- **Safeguarding** – work with our people & partners to understand what safe means and the best way to achieve this.
- **Involving people to manage risks** – work with our people to understand & manage risks by thinking holistically.
- **Safe Environments –** detect and control potential risks in the care environment.
- **Safe & Effective Staffing** – Make sure there are enough Qualified, skilled and experienced people who receive effective support, supervision and development.
- **Infection Prevention & Control** – Assess & manage the risk of infection.
- **Medicines Optimisation** – We make sure medicines and treatments are safe and meet peoples needs, capacities and preferences.

Effective

Berkshire Healthcare NHS Foundation Trust

- **Assessing Needs** – Maximise the effectiveness of people's care and treatment
- **Delivering Evidence-based Care & Treatment**– We plan and deliver people's care with them considering what is important to them.
- **How staff, teams and services work together** – work effectively across teams and services to support people and ensure they only need to tell their story once.
- **Supporting people to live healthier lives**– Supporting people to manage their health & wellbeing so they can maximise their independence, choice & control.
- **Monitoring and Improving Outcomes–** Routinely monitor people's care and treatment to continuously improve it.
- **Consent to Care & Treatment** – we tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Caring

Berkshire Healthcare NHS Foundation Trust

- **Kindness, Compassion and Dignity** – We always treat people with kindness, empathy and compassion and we respect their privacy and dignity.
- **Treating People as Individuals** – We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.
- **Independence, Choice & Control** – We promote people's independence, so they know their rights and have choice and control over their own care, treatment and wellbeing.
- **Responding to People's Immediate Needs** – We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.
- **Workforce Wellbeing and Enablement –** We care about and promote the wellbeing of our staff, and we support and enable them to always deliver

Responsive

Berkshire Healthcare NHS Foundation Trust

- **Person-centred Care** – We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs..
- **Care provision, Integration, and Continuity**– We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.
- **Providing Information**– We provide appropriate, accurate and up-to-date information in formats that we tailor to individual needs.
- **Listening to and involving people -** We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.
- **Equity in Access–** We make sure that everyone can access the care, support and treatment they need when they need it.

Responsive contd.

Berkshire Healthcare NHS Foundation Trust

- **Equity in Experiences and Outcomes-** We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.
- **Planning for the Future**– We support people to plan for important life changes, so they can have enough time to make informed decisions about their future, including at the end of their life.

Well-Led

Berkshire Healthcare NHS Foundation Trust

- **Shared Direction & Culture**– We have a shared vision , strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement.
- **Capable, Compassionate & Inclusive Leaders**– We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation.
- **Freedom to Speak up** – We foster a positive culture where people feel that they can speak up and that their voice will be heard.
- **Governance, Management & Sustainability**– We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support.
- **Partnerships & Communities–** We understand our duty to collaborate and work in partnership, so our services work seamlessly for people.

Well-Led contd.

Berkshire Healthcare NHS Foundation Trust

- **Learning, Improvement and Innovation** - We focus on continuous learning, innovation and improvement across our organisation and the local system.
- **Environmental sustainability** – Sustainable development: We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it.
- **Workforce equality, diversity and inclusion**– We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 September 2022
Title	Financial Summary Report July 2022
	Item for Noting
Purpose	To provide the Trust Board the financial position for the period ending 31 July 2022.
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 has submitted a revised plan for £0.9m following the receipt of additional funding from BOB ICB and the requirement to deliver a further £0.4m of cost improvements. The Trust is slightly ahead of plan, reporting a £0.2m deficit against a £0.6m deficit plan year to date. The Trust has a requirement to deliver £10.1m of cost improvements. The achievement of savings is expected to increase over the year, and currently we are £0.5m ahead of plan. Capital expenditure year to date is £0.4m, £1m behind plan. We are seeing price inflation and supply chain issues impacting tender prices and have therefore slipped several schemes from 2022/23 to 2023/24. Cash balances remain strong at £55.2m
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 2022/23

July 2022

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 July 2022.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	15/08/22	Nikola Pollard	Draft
2.0	16/08/22	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Contents

Dashboard & Summary Narrative

Target		Year to Date Actual £m	Year to Date Plan £m	Year to Date Achieved	Forecast Outturn Forecast £m	Forecast Outturn Plan £m	Forecast Outturn Achieved
1a	Income and Expenditure Plan	-0.16	-0.60	Yes	-0.93	-0.93	Yes
2a	CIP - Identification of Schemes	7.50	10.10	No	7.50	10.10	No
2b	CIP - Delivery of Identified Schemes	1.74	1.20	Yes	n/a	10.10	n/a
3a	Cash Balance	55.2	51.5	Yes	46.7	46.7	Yes
3c	Aged Receivables > 90 days	0.2	n/a	n/a	n/a	n/a	n/a
3d	Aged Payables > 90 days	0.4	n/a	n/a	n/a	n/a	n/a
3e	Better Payment Practice Code Value NHS	58%	95%	No	95%	95%	Yes
3f	Better Payment Practice Code Volume NHS	83%	95%	No	95%	95%	Yes
3g	Better Payment Practice Code Value non-NHS	92%	95%	No	95%	95%	Yes
3h	Better Payment Practice Code Volume non-NHS	93%	95%	No	95%	95%	Yes
4a	Capital Expenditure not exceeding CDEL	0.41	1.37	Yes	8.70	8.70	Yes

Key Messages

The table above provides a high level summary of the Trust's performance against key financial duties and other financial indicators. The key points to note are:

- We are performing slightly better than plan on Income and Expenditure.
- Overall pay costs were £0.4m below plan in July, with the substantive workforce contracting offset by an increase in temporary staffing cover.
- The national pay award has been communicated and will be paid in September. This is being funded via a 1.7% increase in national tariff. Our specific funding and costs have yet to be worked through, but given the tariff funding route, it is likely that the award will increase the financial pressure on the Trust.
- The Trust needs to deliver £10.1m of cost improvements in order to achieve the planned deficit. While the in-month performance is good, it is against a low expectation which continues for the early months of the year and therefore focus needs to continue to be on the identification of further in year cost reduction or slippage against plans.
- CIP delivery is £0.5m greater than planned, but there remains a £2.5m of unidentified schemes, plus identified schemes at risk and which will not deliver as planned, furthering the requirement for new initiatives.
- The underperformance on Better Payment Practice code non-NHS invoices by value relates to a single invoice from the PFI provider received in advance and which was settled in early August. The underperformance on NHS invoices relates to NHSPS invoices which have required additional validation.

System View

ICSs were established on a legal basis on the 1st July. Given the delays to this years planning round and the incorporation of ICSs, we have yet to sign contracts this year. We are not flagging any major risks in relation to core funding allocations and we expect contracts to be signed following ICS board meetings in September.

2.0 Income & Expenditure

Jul-22	In Month			YTD			22/23
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	26.2	26.5	(0.3)	104.2	105.1	(0.9)	318.8
Elective Recovery Fund	0.2	0.2	0.0	0.2	0.2	0.0	2.0
Donated Income	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0
Total Income	**26.4**	**26.7**	**(0.3)**	**104.4**	**105.3**	**(0.9)**	**320.8**
Staff In Post	17.0	18.2	(1.2)	68.1	71.6	(3.5)	221.2
Bank Spend	1.8	1.3	0.5	7.1	5.4	1.7	16.2
Agency Spend	0.7	0.4	0.3	2.4	1.8	0.6	4.5
Total Pay	**19.5**	**19.9**	**(0.4)**	**77.6**	**78.7**	**(1.2)**	**241.9**
Purchase of Healthcare	1.7	1.4	0.2	6.9	6.3	0.6	16.7
Drugs	0.4	0.4	(0.0)	1.8	1.7	0.1	5.3
Premises	1.2	1.2	0.0	5.0	4.9	0.2	14.7
Other Non Pay	1.5	1.7	(0.2)	5.7	6.3	(0.6)	20.1
PFI Lease	0.6	0.6	0.0	2.4	2.4	0.1	7.0
Total Non Pay	**5.5**	**5.4**	**0.0**	**21.9**	**21.6**	**0.3**	**63.7**
Total Operating Costs	**24.9**	**25.4**	**(0.4)**	**99.5**	**100.4**	**(0.9)**	**305.6**
EBITDA	**1.5**	**1.3**	**0.2**	**5.0**	**4.9**	**0.0**	**15.1**
Interest (Net)	0.3	0.3	(0.1)	1.1	1.3	(0.2)	4.0
Depreciation	0.9	0.9	(0.0)	3.6	3.7	(0.2)	10.8
Impairments	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.1	0.1	(0.0)	0.4	0.4	(0.0)	1.3
Total Financing	**1.3**	**1.4**	**(0.1)**	**5.2**	**5.5**	**(0.4)**	**16.2**
Reported Surplus/ (Deficit)	**0.2**	**(0.0)**	**0.3**	**(0.2)**	**(0.6)**	**0.4**	**(1.0)**
Adjusted Surplus/ (Deficit)	**0.2**	**(0.0)**	**0.3**	**(0.2)**	**(0.6)**	**0.4**	**(0.9)**

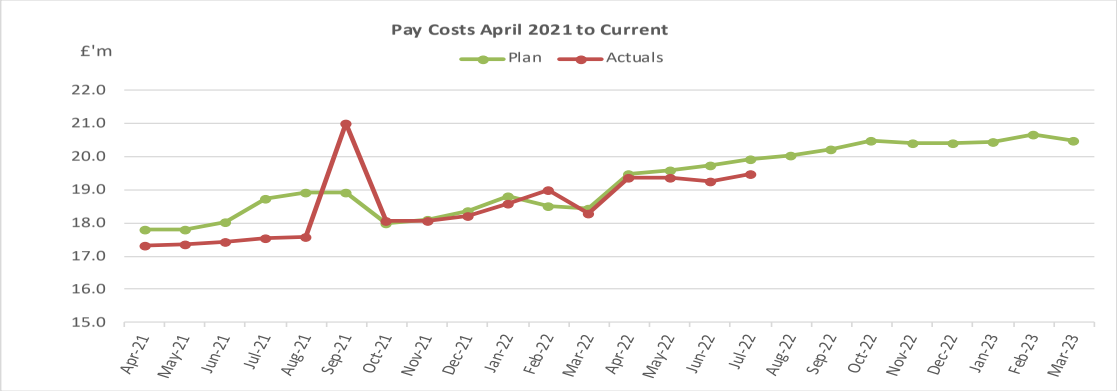
Key Messages

The table above gives the financial performance against the Trust's income and expenditure plan as at 31st July 2022. Our COVID costs remain very low and in the main part are business as usual costs, therefore we are now reporting these within the main graphs and tables.

In July the Trust is reporting a £0.2m surplus, which has decreased our YTD deficit to a £0.2m, £0.4m better than planned.

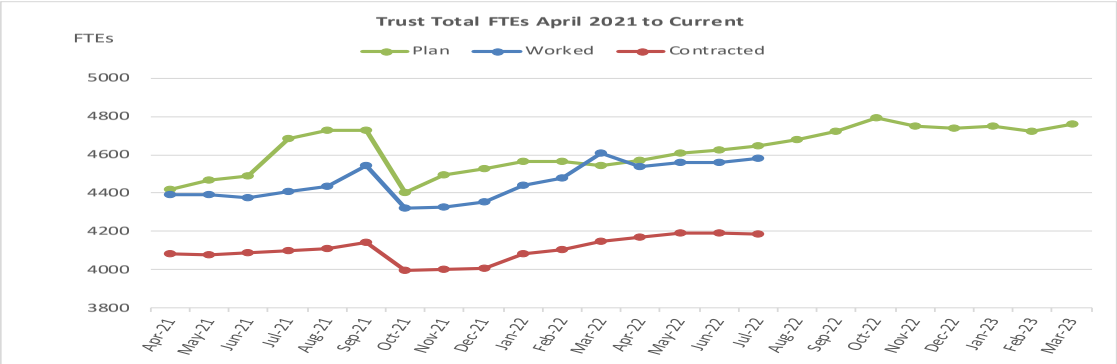
Pay costs reflect the 2% pay award assumed in planning. The recent pay award will be paid in September and will therefore will be reflected in the M06 finance report. DHSC have committed to fully funding the pay award and will issue additional funding to ICSs reflecting a 1.7% increase to tariff income. The allocation of income through tariff represents a risk that income will be insufficient to cover costs given typically mental health and community providers pay costs represent a great proportion of cost that average. Once we have received our funding allocations we will be able to confirm the net impact.

Workforce



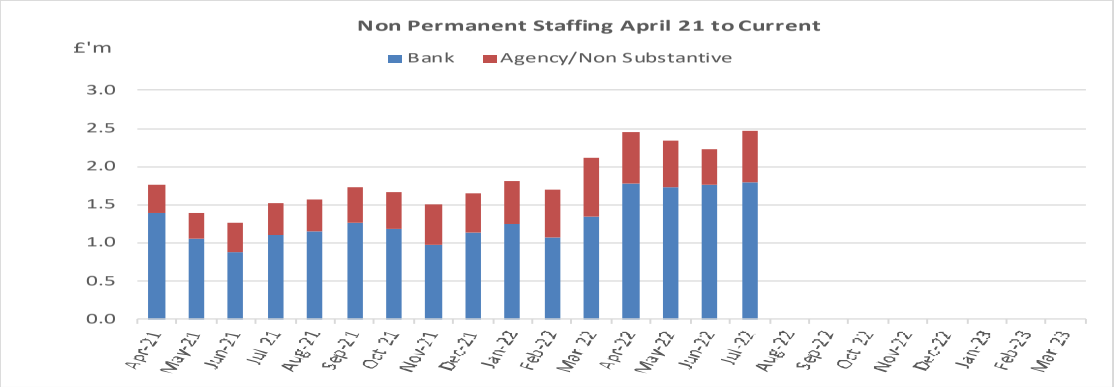
Staff Costs

YTD	£'m
2022/23	77.5
2021/22	69.7
▲	11%
Prior Yr	**£'m**
Jul-22	19.5
Jul-21	17.5
▲	11%



FTEs

Prior Mth	CFTE	WFTE
Jul-22	4,186	4,582
Jun-22	4,190	4,559
	0% ▼	1% ▲
Prior Yr	**CFTE**	**WFTE**
Jul-22	4,186	4,582
Jul-21	4,099	4,408
	2% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2022/23	3.5	2.4
2021/22	2.4	1.5
	44% ▲	57% ▲
Prior Yr	**£'m**	**£'m**
Jul-22	1.8	0.7
Jul-21	1.1	0.4
	63% ▲	61% ▲

Key Messages

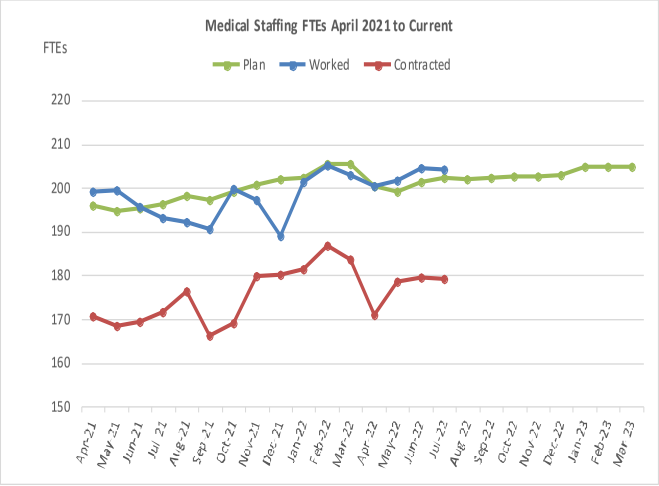
Pay costs in month were £19.5m. This is £0.4m below plan in month and £1.2m behind plan year to date.

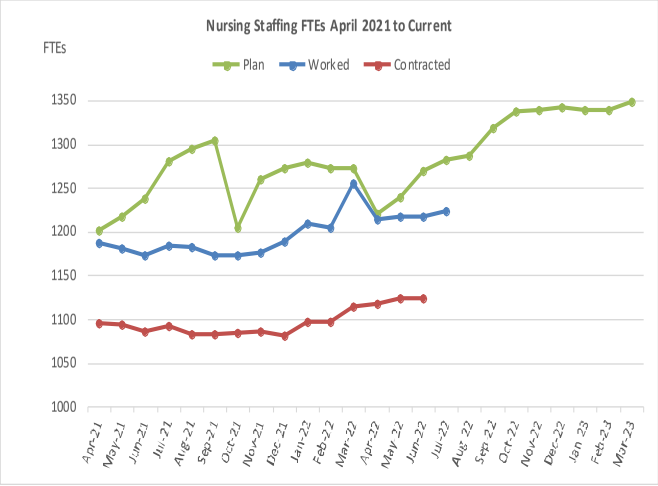
Underlying pay cost has remained consistent in recent months. We continue to see increasing turnover rates in the Trust and there was a small reduction in our contracted workforce of 4 FTE and a small increased in worked WTEs in month.

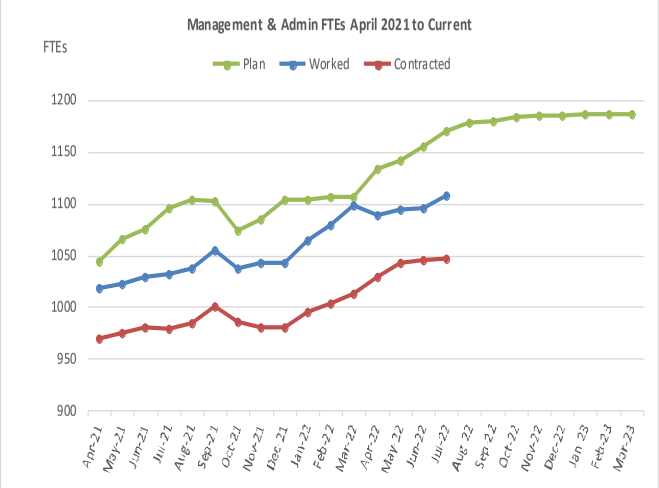
We are continuing to offset substantive vacancies with higher levels of temporary staffing, with bank spend showing the greatest increase since the start of the year. Temporary staffing spend is £2.3m higher than planned offsetting in part the £3.5m YTD underspend on substantive recruitment.

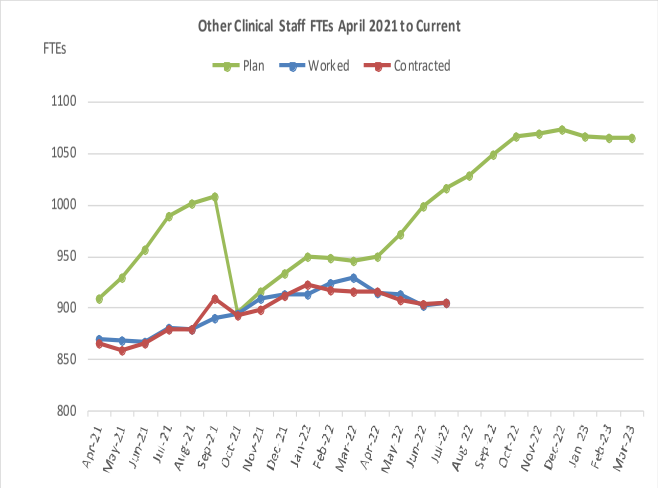
NHSE/I have reintroduced Agency ceiling, but applied them at a system level, with the sum of all partners costs contributing to the target. There is an expectation that costs will be a minimum of 10% lower than in 21/22. Our agency costs grew gradually during 21/22 due in part to the need to cover medical vacancies and continued pressures filling rotas in WestCall. This run rate has continued into the current year and unchanged will result in costs c20% higher than last year.

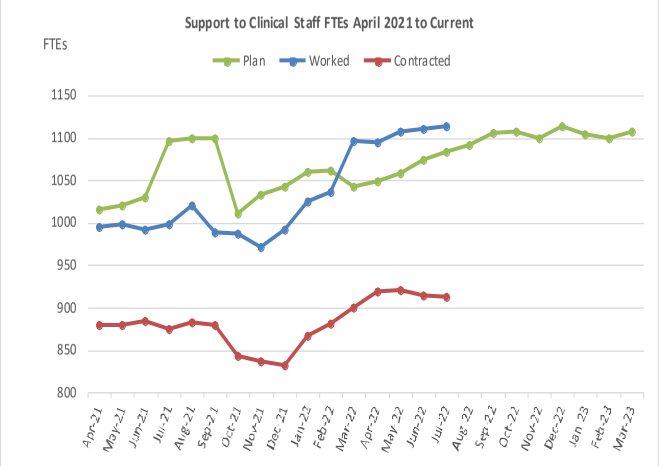
Staffing Detail

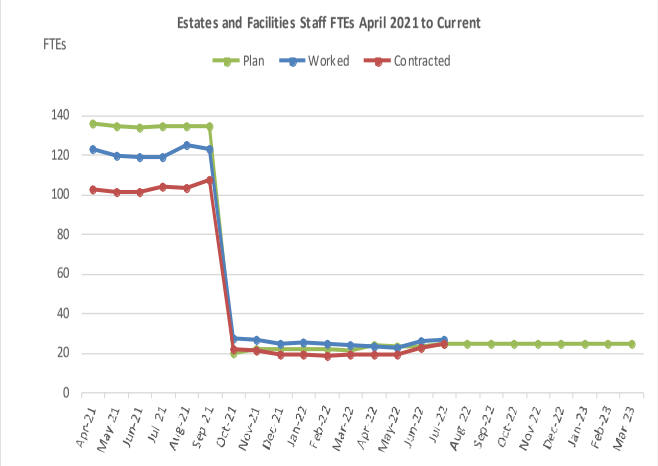












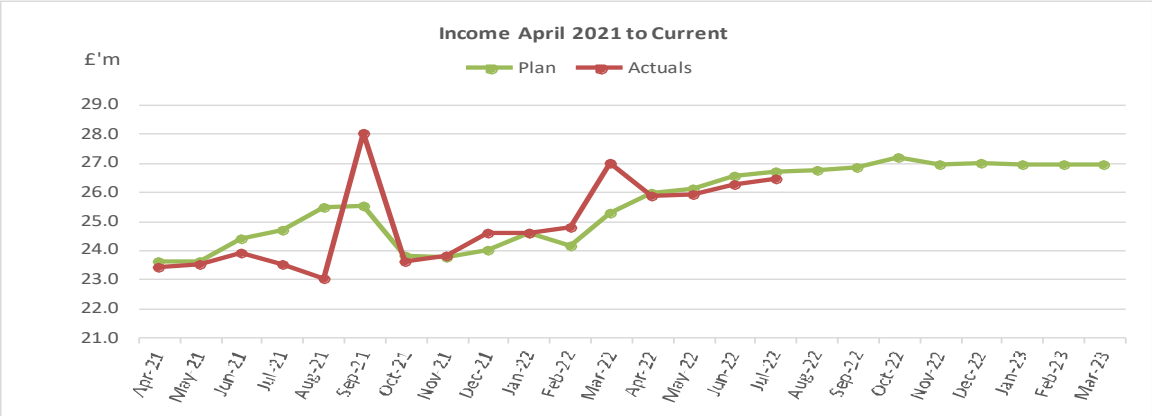
Key Messages

The tables above provide current staffing numbers broken down into core staffing groups.

There was minimal change in total contracted or worked WTEs in month. Worked WTEs are below plan in all areas apart from Medical Staffing and Support to Clinical Staff where the sharp increase seen in March has been maintained.

MHI is overspent against plan but all other areas are now underspent against plan with the biggest variances see in community services.

Income & Non Pay

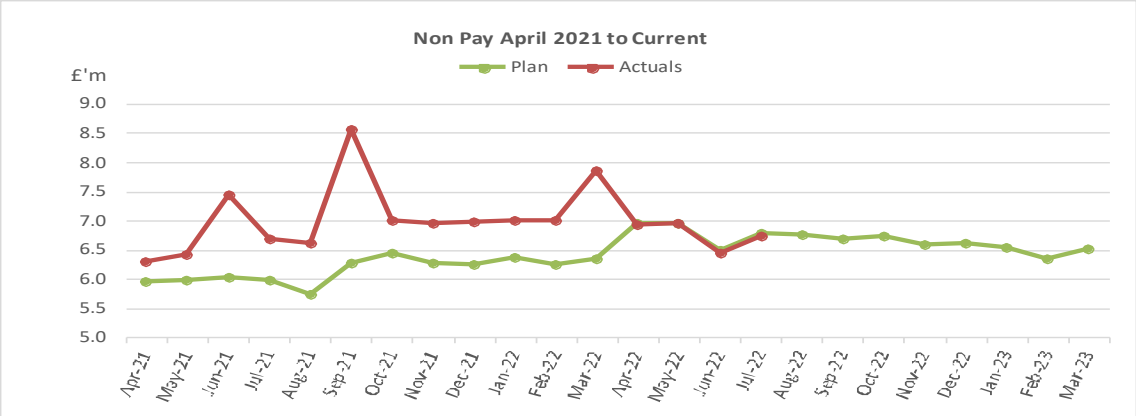


Income	
YTD	**£'m**
2022/23	104.4
2021/22	94.3
▲	**11%**
Prior Yr	**£'m**
Jul-22	26.4
Jul-21	23.5
▲	**12%**

Key Messages

The graph above reflects the Trust's planned and actual income. Income was £0.3m behind plan in July, and overall the Trust is reporting £0.9m less than planned YTD. The principle reason for the shortfall is slippage on investments due to lower than expected recruitment. This income is being deferred and is being monitored closely by both ICBs, who will be looking to close residual system gaps with unspent funding.

The YTD position includes £0.23m of ERF income which at this stage assumed no clawback despite the Trust not delivering the additional levels of activity required. This assumption is being made in line with system partners.



Non Pay	
YTD	**£'m**
2022/23	27.1
2021/22	26.8
▲	**1%**
Prior Yr	**£'m**
Jul-22	6.7
Jul-21	6.7
▲	**1%**

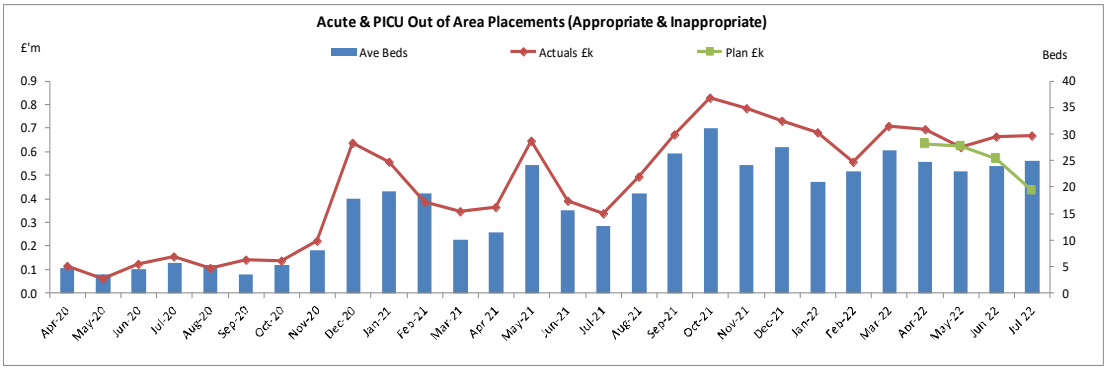
Key Messages

Non Pay spend was £6.7m in month, which was on plan with limited variances to report. Overall Non Pay is £0.3m higher than plan YTD.

The average number of out of areas placements has increased from 24 June to 25 in July, although costs remain in line with June. The Further detail can be found on the next page.

We are continuing to see suppliers pushing for significant price increases given the current rates of inflation and supply chain issues. Whilst the contractual arrangement with NHSPS mitigates our, although not the systems exposure to utility increases, we are closely monitoring utility costs where we are exposed. Procurement are expending significant effort negotiate on rates in order to minimise the financial pressure.

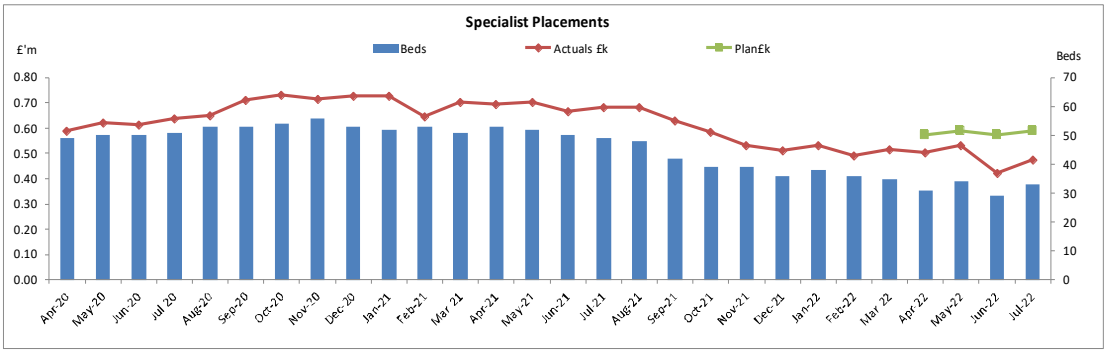
Placement Costs



OAPs

YTD	£'m
2022/23	2.6
2021/22	1.7
▲	*53%*

Prior Yr	£'m
Jul-22	0.7
Jul-21	0.3
▲	*99%*



Specialist Placements

YTD	£'m
2022/23	1.9
2021/22	2.7
▼	*-30%*

Prior Yr	£'m
Jul-22	0.5
Jul-21	0.7
▼	*-31%*

Key Messages

Specialist Placements. The number of placements has increased from 29 in June to 33 in July with costs increasing from £0.42m in June to £0.47m in July. The increase in the number of placements continues is expected to be temporary as improved review processes and step down of patients to less restrictive options continues to be developed. However, the average price has increased as we have unoccupied beds for some of our block contracts as part of the process of withdrawing.

Out of Area Placements. The average number of placements has increased 24 in June to 25 in July, although the monthly cost has remained static at £0.7m.

We have identified an issue with the reporting function, therefore we will need to submit a revised position against the OAP's trajectory in September.

The Bed Optimisation Programme has now been reset and the project group meets monthly with a status exchange every month, this therefore equates to a fortnightly discussion on the prevailing issues. Each of the workstreams has project support and clinical leadership and a QI approach is being applied to the work. The number of extra-contractual beds has been amended based on what has worked over the prior 6 months. We now contract for 11 Acute beds only and have a plan to taper the usage of these as the financial year progresses, to effectively achieve the zero OAPs trajectory. The position remains tight as we continue to see Covid outbreaks and resulting bed closures. Dr Sodhi is leading a review of all patients with a psychotic illness who have a LOS of 65+ days.

The Community Enhance Rehabilitation Service business case has now been approved and this will support the work on the psychosis pathway, providing an alternative to bed based provision and both a step up/step down offer.

PICU work is concentrating on flow through the service to ensure that we can effectively step people down in a more timely manner. Since May 2022 we have discharge 13 patients from Sorrell ward, however due to the continued high levels of demand and acuity we have not been able to return patients of OAP PICU beds. We have ceased the purchase of ECA PICU beds because they were not a cost effective use of resource as they could not always be accessed when required. We will continue to SPOT purchase PICU beds where they are clinically required. We continue to have significant demand for PICU beds including prison transfers, which whilst do not count as an inappropriate out of area bed against the OAP's trajectory we are seeing the financial impact.

We are planning a targeted flow fortnight commencing the 19th September with the aim of creating capacity at PPH and reducing the number of acute overspill beds.

2. Cost Improvement Programme

Cost Improvement (Cash releasing) Scheme	In Month Act £'k	In Month Plan £'k	In Month Var £'k	YTD Act £'k	YTD Plan £'k	YTD Var £'k	Plan £'k
Trust Wide Schemes							
Out of Area Placements - Volume	0.0	0.0	0.0	0.0	0.0	0.0	1,821.4
Out of Area Placements - Price	0.0	0.0	0.0	0.0	0.0	0.0	354.0
Opt to Tax (Historic)	125.0	125.0	0.0	500.0	375.0	125.0	1,500.0
Opt to Tax (Recurrent)	37.0	37.0	0.0	148.0	111.0	37.0	444.0
Contribution from New Investments	12.1	8.0	4.1	14.1	24.0	(9.9)	96.0
EFM Recharge to NHSPS	0.0	41.0	(41.0)	0.0	123.0	(123.0)	732.0
Procurement / ICS Procurement	16.0	36.0	(20.0)	16.0	60.0	(44.0)	300.0
Medicines Optimisation	0.0	4.0	(4.0)	0.0	12.0	(12.0)	50.0
Interest Receivable	55.0	0.0	55.0	212.5	0.0	212.5	0.0
Long Term Placements	111.0	0.0	111.0	308.0	0.0	308.0	0.0
Recruitment Slippage	0.0	0.0	0.0	400.0	400.0	0.0	400.0
Division/Corp Schemes Local Delivery							
Total smaller value schemes	36.0	10.0	26.0	144.0	30.0	114.0	845.0
Corporate Schemes Trust Decision							
Corporate Schemes - FWH Vacating Early	0.0	0.0	0.0	0.0	0.0	0.0	105.0
Review of Management Structures	0.0	0.0	0.0	0.0	0.0	0.0	550.0
System Supported Schemes							
Agency - Price Cap Compliance (ICS Temporary Staffing Project)	0.0	0.0	0.0	0.0	0.0	0.0	150.0
Agency - Improved Procurement (ICS Temporary Staffing Project)	0.0	0.0	0.0	0.0	0.0	0.0	150.0
Unidentified	**0.0**	**207.7**	(207.7)	**0.0**	**68.2**	(68.2)	**2,597**
Total Cost Improvement	**392.1**	**468.7**	**(76.7)**	**1,742.5**	**1,203.2**	**539.4**	**10,094.0**

Key Messages

The Trust's initial financial plan for 22/23 included a requirement to deliver £9.7m of cost improvements in order to achieve the deficit plan that has been submitted. The requirement was increased by £0.4m in June when the Trust agreed to take a share of the BOB system deficit to bring the overall system plan back to breakeven.

There remains a £2.6m unallocated target reflects the gap between our plan submission and the identified savings schemes. We continue to work to identify schemes in excess of this value to take account of slippage and to contribute to recurrent financial sustainability.

The EFM "recharge" to NHSPS saving remains at risk, in part due to the construct of the agreement with NHSPS governing the transfer of services under the original business transfer agreement. The Trust is engaged in Exec level conversations with NHSPS over this in respect of retained costs from the transfer of services in October 22.

The additional £0.4m CIP required from the ICS has been delivered through recruitment slippage from Q1.

The number of long term placement placements continue at a lower than planned level, and despite the an increase in cost this month, savings of £0.3m are reported.

The review of management structures is underway, although given its complexities, the majority of savings are likely to impact later in to year and into the following year.

Given the historically low levels of usage and rates paid, there has been little identified through the ICS Temporary Staffing Programme in respect of in year benefit. However NHSI's recently issued system agency ceiling will require us to look again at agency costs with a view to reducing costs in year.

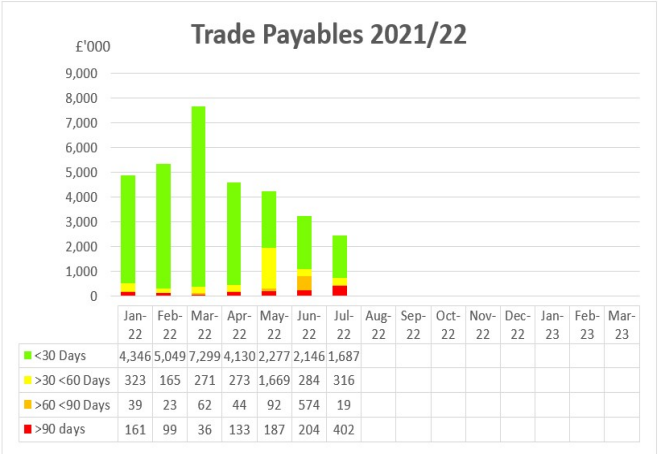
3.0 Balance Sheet

Balance Sheet	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	4.2	3.5	3.6	(0.1)	3.5	3.6	(0.1)
Property, Plant & Equipment (non PFI)	35.2	34.0	35.0	(1.0)	34.0	35.0	(1.0)
Property, Plant & Equipment (PFI)	58.0	57.5	57.6	(0.1)	57.5	57.6	(0.1)
Property, Plant & Equipment (RoU Asset)	0.0	13.2	13.2	(0.0)	13.2	13.2	(0.0)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**97.6**	**108.4**	**109.7**	**(1.2)**	**108.4**	**109.7**	**(1.2)**
Trade Receivables & Accruals	8.9	15.6	8.8	6.8	15.6	8.8	6.8
Other Receivables	0.2	0.2	0.2	(0.1)	0.2	0.2	0.0
Cash	53.9	55.2	51.5	3.6	55.2	51.5	3.6
Trade Payables & Accruals	(35.3)	(37.1)	(30.7)	(6.4)	(37.1)	(30.7)	(6.4)
Current PFI Finance Lease	(1.7)	(1.7)	(1.7)	0.0	(1.7)	(1.7)	0.0
Current RoU Asset Finance Lease	0.0	(2.5)	(2.4)	(0.1)	(2.5)	(2.4)	(0.1)
Other Current Payables	(12.8)	(16.8)	(12.8)	(4.0)	(16.8)	(12.8)	(4.0)
Total Net Current Assets / (Liabilities)	**13.2**	**12.8**	**12.9**	**(0.1)**	**12.7**	**12.9**	**(0.1)**
Non Current PFI Finance Lease	(23.8)	(23.2)	(24.9)	1.7	(23.2)	(24.9)	1.7
Non Current RoU Finance Lease	0.0	(11.2)	(11.2)	0.0	(11.2)	(11.2)	0.0
Other Non Current Payables	(1.6)	(1.6)	(1.6)	0.0	(1.6)	(1.6)	0.0
Total Net Assets	***85.4***	***85.2***	***84.8***	***0.3***	***85.1***	***84.8***	***0.3***
Income & Expenditure Reserve	32.5	32.3	31.9	0.4	32.3	31.9	0.4
Public Dividend Capital Reserve	20.7	20.7	20.7	0.0	20.7	20.7	0.0
Revaluation Reserve	32.2	32.2	32.2	0.0	32.2	32.2	0.0
Total Taxpayers Equity	***85.4***	***85.2***	***84.8***	***0.3***	***85.2***	***84.8***	***0.3***

Key Messages

From 1 April 2022, the NHS has adopted International Financial Reporting Standard 16: Leases, which removes the distinction between operating leases and finance leases. Most operating lease arrangements now result in an asset going on balance sheet offset by a lease liability. The asset and liability will be respectively depreciated and repaid over the term of the lease.

	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	1,750	2,402	2,741	1,554	1,956	2,296	1,462								
>30 <60 Days	143	301	95	582	0	32	67								
>60 <90 Days	79	30	22	53	546	0	0								
>90 < 180 Days	49	83	18	27	48	77	110								
>180 Days	66	62	61	60	60	62	68								



	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
<30 Days	4,346	5,049	7,299	4,130	2,277	2,146	1,687								
>30 <60 Days	323	165	271	273	1,669	284	316								
>60 <90 Days	39	23	62	44	92	574	19								
>90 days	161	99	36	133	187	204	402								

Key Messages

Receivables balances decreased by £0.8m. The small amount of over 90 days debt relates to Slough BC and NHS Property Services. Creditors decreased by £0.8m. The increase in >30<60 days and >90 days is NHSPS invoices from Q1 and Q2, that were settled on the 1st August.

3.0 Cash

Cashflow	21/22 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Reported Surplus / (Deficit)	1.9	0.2	0.0	0.2	(0.2)	(0.6)	0.4
Remove Finance Charges through SoCI	2.6	0.2	0.3	(0.1)	1.1	1.3	(0.2)
Remove PDC Dividend accrual through SoCI	0.9	0.1	0.1	0.0	0.4	0.4	0.0
Operating Surplus/(Deficit)	**5.4**	**0.6**	**0.4**	**0.2**	**1.4**	**1.2**	**0.2**
Depreciation and Impairments	9.2	0.9	0.9	(0.0)	3.6	3.7	(0.2)
Operating Cashflow	***15.2***	***1.5***	***1.3***	***0.2***	***5.0***	***4.9***	***0.0***
Net Working Capital Movements	***11.6***	***2.9***	***(0.1)***	***3.0***	***0.0***	***(4.1)***	***4.1***
Proceeds from Disposals	2.2	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(8.1)	(0.1)	(0.3)	0.2	(1.3)	(2.0)	0.7
Investments	***(5.9)***	***(0.1)***	***(0.3)***	***0.2***	***(1.3)***	***(2.0)***	***0.7***
PFI Finance Lease Repayment	(1.6)	(0.1)	(0.1)	0.0	(0.6)	(0.6)	(0.0)
RoU Asset Finance Lease Repayment	0.0	(0.2)	(0.2)	0.0	(0.7)	(0.8)	0.1
Net Interest	3.9	(0.2)	(0.3)	0.1	(1.1)	(1.3)	0.2
PDC Received	0.7	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends Paid	0.8	0.0	0.0	0.0	0.0	0.0	0.0
Financing Costs	***3.8***	***(0.5)***	***(0.7)***	***0.1***	***(2.5)***	***(2.7)***	***0.2***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***12.7***	***3.7***	***0.2***	***3.5***	***1.2***	***(3.9)***	***5.1***
Opening Cash	39.1	51.5	51.3	0.2	53.9	55.4	(1.5)
Closing Cash	***53.9***	***55.2***	***51.5***	***3.6***	***55.2***	***51.5***	***3.6***

Key Messages

The Trust continue to have a strong cash position with a closing cash balance for July of £55.2m, which is £3.6m above the revised plan. The majority of this increase is due favourable working capital balances driven by increased deferred income, and the timing of payment of NHSPS invoices, in addition to capital slippage.

4.0 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							
Erleigh road Change of Service - Phase 2	0	0	0	42	0	42	150
Extension for Clinical Space - CHH	0	2	(2)	0	2	(2)	450
Other Trust Owned Properties	(6)	0	(6)	(5)	0	(5)	70
Leased Non Commercial (NHSPS)	(2)	40	(42)	(0)	50	(50)	240
Head Office Relocation	0	217	(217)	0	217	(217)	1,300
MSK Relocation	0	67	(67)	0	67	(67)	335
Leased Commercial Other	(1)	17	(17)	(0)	17	(17)	140
Leased Non Commercial (NHSPS)	(4)	0	(4)	0	0	0	20
Environment & Sustainability	5	5	0	7	5	2	50
Windsor Consolidation (Dedworth)	0	117	(117)	0	167	(167)	500
Various All Sites	(0)	39	(39)	(0)	44	(44)	616
Statutory Compliance	(2)	12	(14)	4	12	(8)	150
Subtotal Estates Maintenance & Replacement	**(10)**	**515**	**(524)**	**49**	**580**	**(531)**	**4,021**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	0	0	0	0	0	0	120
IM&T Refresh & Replacement	(1)	171	(172)	1	171	(170)	2,782
IM&T System & Network Developments	62	19	43	259	75	185	260
IM&T GDE & Community Projects	24	21	3	67	117	(50)	242
IM&T Digitial Strategy	33	106	(74)	33	425	(392)	1,275
Subtotal IM&T Expenditure	**118**	**317**	**(199)**	**360**	**788**	**(428)**	**4,679**
Subtotal CapEx Within Control Total	**108**	**831**	**(723)**	**408**	**1,367**	**(959)**	**8,700**
CapEx Expenditure Outside of Control Total							
PPH 'Place of Safety	0	0	0	1	0	1	1,600
PPH Zonal Heating Controls	0	42	(42)	0	42	(42)	250
Statuory Compliance	0	8	(8)	0	8	(8)	100
Environment & Sustainability / Zero Carbon	0	0	0	0	0	0	200
Other PFI projects	(18)	45	(63)	3	45	(42)	185
Health Bus	0	0	0	0	0	0	0
Subtotal Capex Outside of Control Totals	**(18)**	**95**	**(113)**	**4**	**95**	**(91)**	**2,335**
Total Capital Expenditure	**90**	**926**	**(836)**	**412**	**1,462**	**(1,049)**	**11,035**

Key Messages

The capital plan for 2022/23 is £11m, £8.7m of which is within the BOB ICS capital control total (CDEL) and £2.3m outside of the control total for PFI projects.

Expenditure year to date is an underspend of £1.0m against the plan due to delays and reprofiling of spend across IM&T Digital Strategy and Estates schemes.

Head Office Relocation is in the design stage and tender to be completed by late August, the delivery timescale for December 22 remains unchanged.

We are continuing to see price fluctuations and increases in material costs driven by pressure on supply chains and inflation. This is materialising in tender price submissions as well increased IT equipment costs. In order to mitigate these increases we have reviewed the original capital programme and have rephased and prioritised our plans in order that we can hold costs within our agreed ICS Capital Allocation.

In total our key estates programmes are forecast to cost £1.1m in excess of our original estimates, subject to final tender submissions. In order to fund these, the timeline on works to Churchill House, Reading Estates Consolidation and bariatric facilities in Wokingham Hospital have been reviewed and will now run into 23/24, with slippage in the current year being utilised.

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	13th September 2022
Title	**True North Performance Scorecard** **Month 4 (July 2022) 2022/23**
	ITEM FOR NOTNG
Purpose	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2022/23.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 4 2022/23 (July 2022) 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. **Month 4** **Performance business rule exceptions, red rated with the True North domain in brackets:** **Breakthrough and Driver Metrics** Context and update to driver performance to be provided in discussion of counter measure action and development: • Self-harm incidents on mental health wards (excluding LD) **(Harm Free Care)** – 73 incidents against a revised target of 67. Snowdrop (27) and Bluebell (21) wards were the highest contributors this month. • Physical Health Checks – 7 Parameters for People with Severe Mental Illness (SMI) **(Harm Free Care)** at 80% against a revised stretch target of 90% by the end of September 2022. • I Want Great Care Compliance Rate **(Patient Experience)** (replacing the Patient Friends and Family Test (FFT) response rate) at 2.3% against a 10% target. The new system is being embedded, so will take time to see improvements. • Staff turnover (including fixed-term posts) **(Supporting Our Staff)** – 16.83% against a 16% target. A challenging area which remains a focus for the organisation. **Tracker 1 Metrics (where red for 1 month or more)** • Meticillin-resistant Staphylococcus Aureus (MSSA) bacteraemias (Cumulative year to date) **(Regulatory Compliance)** – there is 1 incident year to date, which was reported in May 2022. The way this is reported has changed, so showing as red due to a target of 0 for the year. • Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 –

	Audiology) **(Regulatory Compliance)** – at 47.1% a large drop from last month against a 90% target. Significant staffing issues are contributing to this breach. There are process reviews and an audit scheduled to support a recovery position. • Sickness rate **(Regulatory Compliance)** – red at 4.41% against a target of 3.5%. This is not a "hard" compliance focus with NHSI but is tracked. Six months red, but we are in 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 85.7% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <4 week (Routine) **(Regulatory Compliance)** – red at 87.5% against a 95% target. This is a newly introduced national target that is challenging to achieve for trusts as evidenced by regional and national benchmarking. **Tracker Metrics (where red for 4 months or more)** • Mental Health: Absent Without Leave (AWOL) on Mental Health Act (MHA) Section **(Harm Free Care)** at 15 against a target of 10. This is being reviewed by the Prospect Park team. • Mental Health Delayed Transfers of Care **(Money Matters)** at 8.73% against a target of 7.5%. A positive reporting shift is placing a focus on mental health delays in the systems. • Increase in Elective Care Activity from 2019/20 baseline (physical health only) – follow up appointment **(Money Matters)** at -7.5% against a target of 4%. Red for 4 months for challenging recovery target, with limited service inclusion for the Trust. • Mental Health Acute Occupancy rate **(Money Matters)** at 95.9% against an 85% target. Red for 12 months. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters)** – at 47 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is underway.

Action	The Board is asked to note the 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	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month increased from 20 in Feb 22	34	37	39	22	31	43	36	32	26	31	24	24
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	67 per month	56	50	145	141	86	170	88	112	98	95	109	73
Number of suicides (per month)	SI =<3	2	2	0	4	1	1	2	2	1	3	2	3

		Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90% until Sept 22, then 95%	52%	68%	67%	71%	74%	78%	81%	80%	78%	78%	79%	80%

Patient Experience

IWGC Positive Score %	95% compliance from April 22	85%	89%	92%	90%	92%	92%	79%	93.2%	94%	92.7%	95.2%	95.1%
IWGC Compliance %	10% compliance	6%	6%	5%	7.0%	1.7%	0.3%	0.4%	0.8%	0.6%	1.0%	1.3%	2.3%

Performance Scorecard - True North Drivers (July 2022)

Supporting our Staff

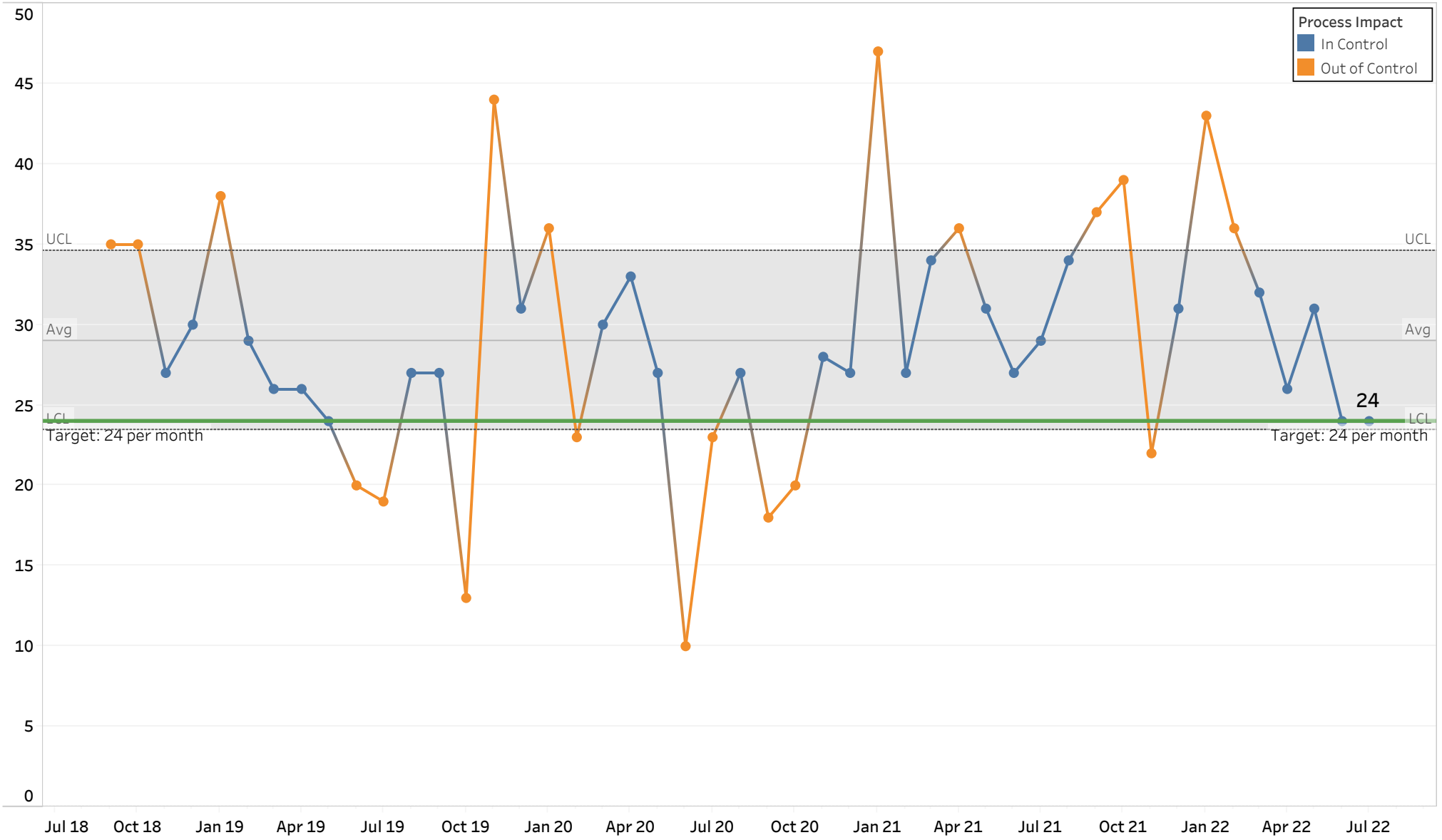
Metric	Target	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Physical Assaults on Staff	44 per month	77	94	117	65	55	57	115	92	136	61	61	38
Staff turnover (excluding fixed term posts)	<=16% per month	14.25%	14.60%	15.46%	15.44%	15.31%	15.32%	15.37%	15.93%	16.19%	16.71%	16.76%	16.83%

Money Matters

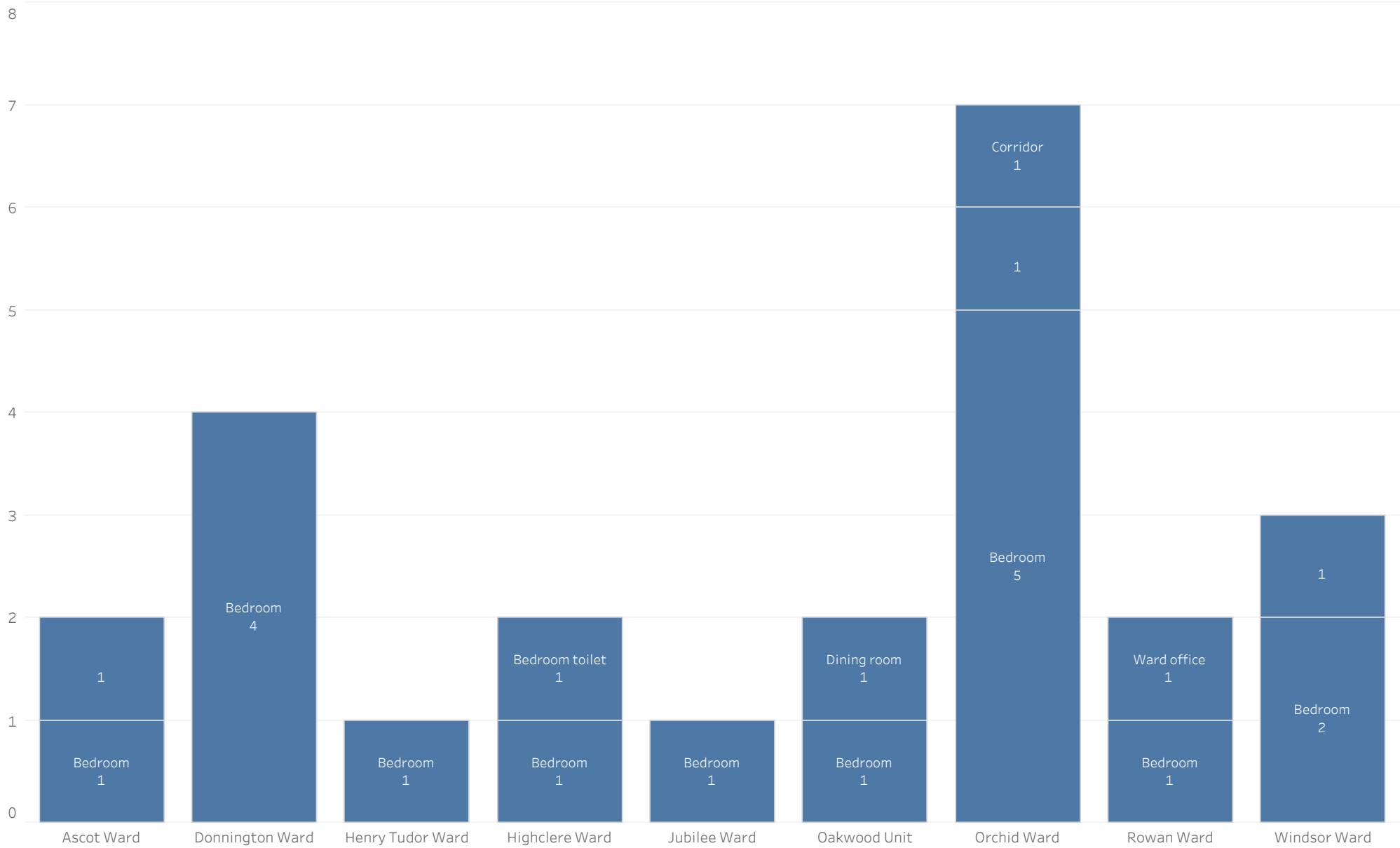
Variance from YTD NHSE financial control total (£'k)	<£0k									-3000	32000	-149000	-400000
Variance from YTD NHSE efficiency plan (£'k)	>£0k									112000	134000	490000	183000
Inappropriate Out of Area Placements	276 Cumulative Total Q2 2022/23	168	418	636	195	266	405	92	191	363	69	114	228	175

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Sep 18 to Jul 22)

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

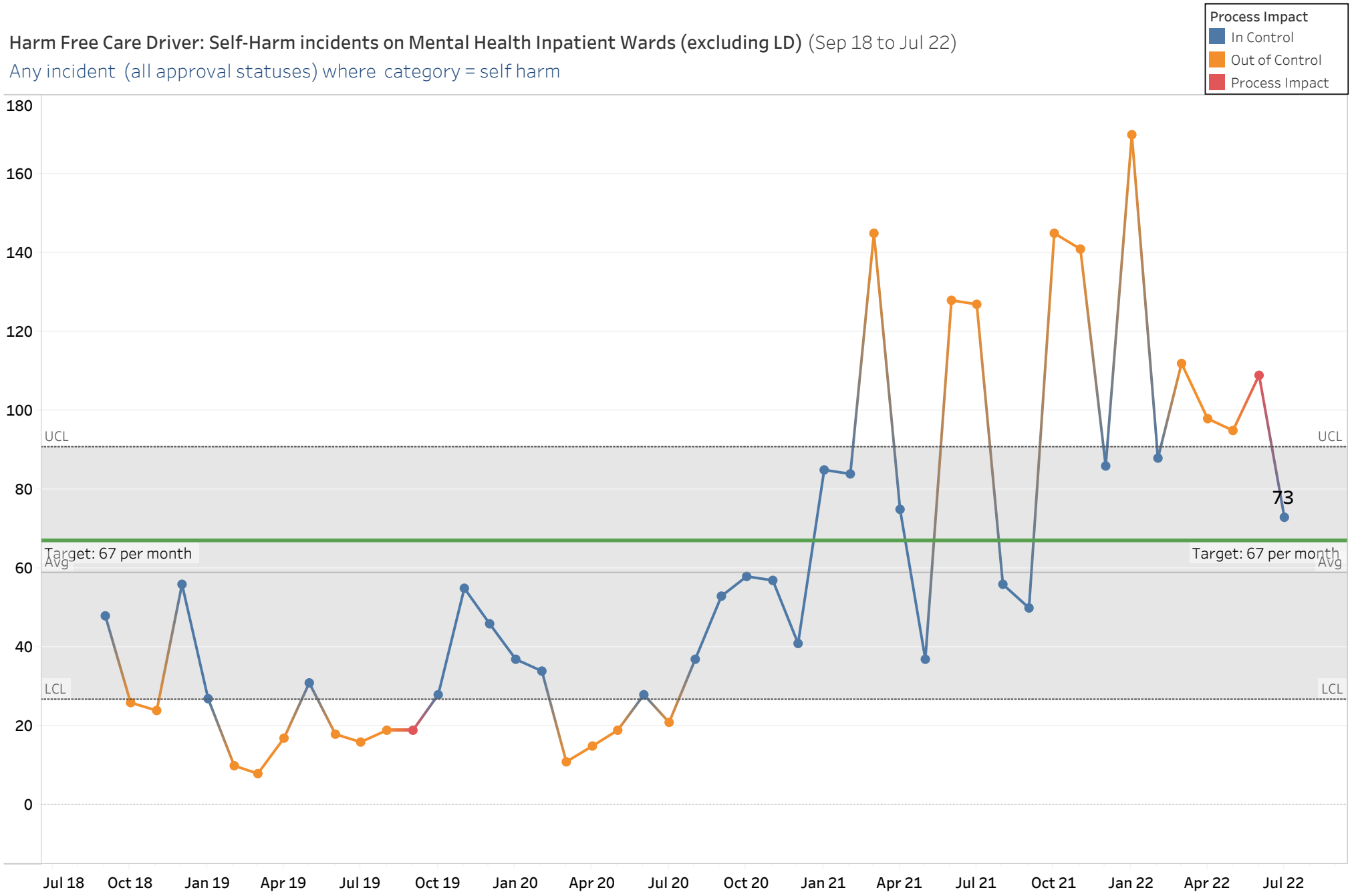


Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (July 2022)

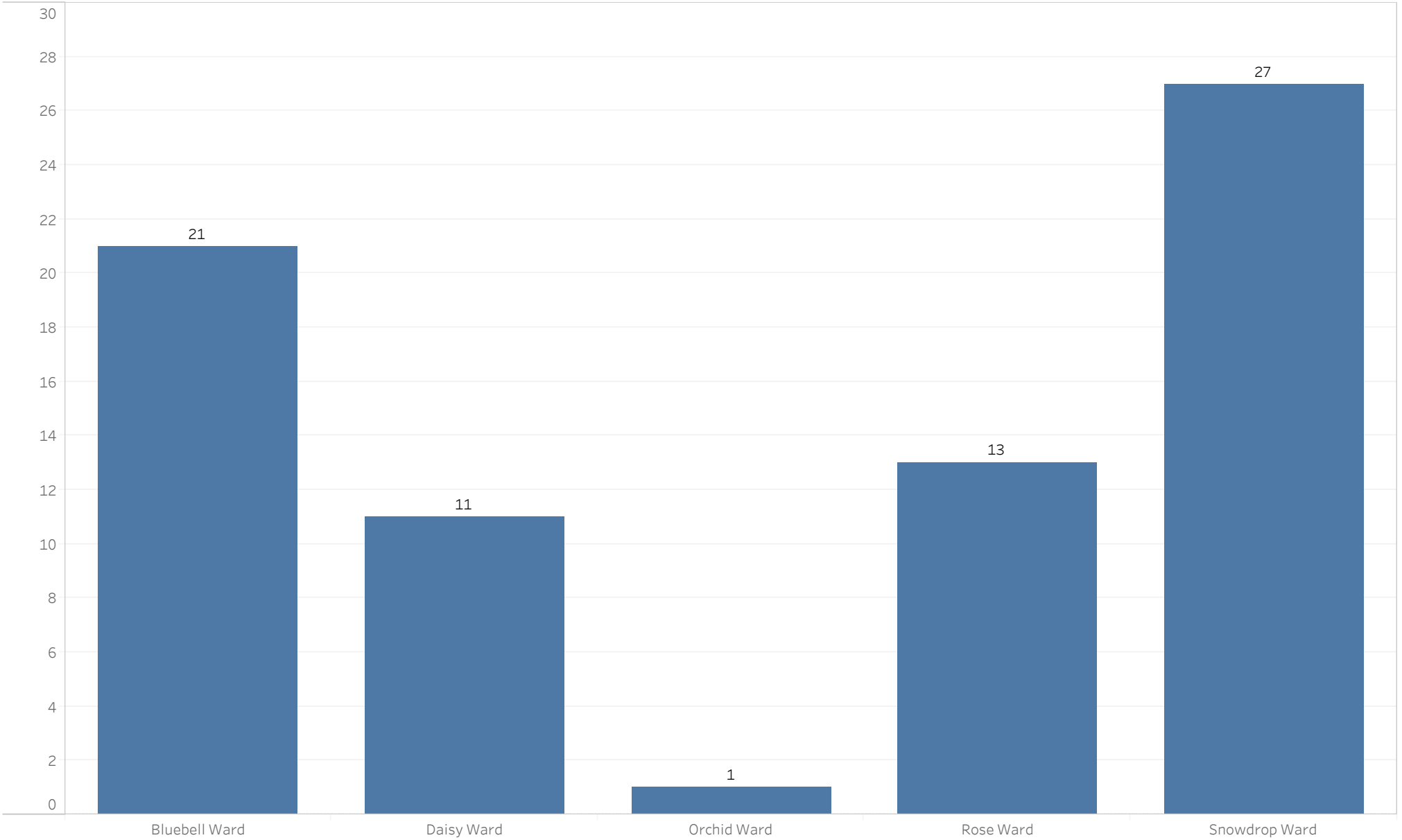


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Sep 18 to Jul 22)

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

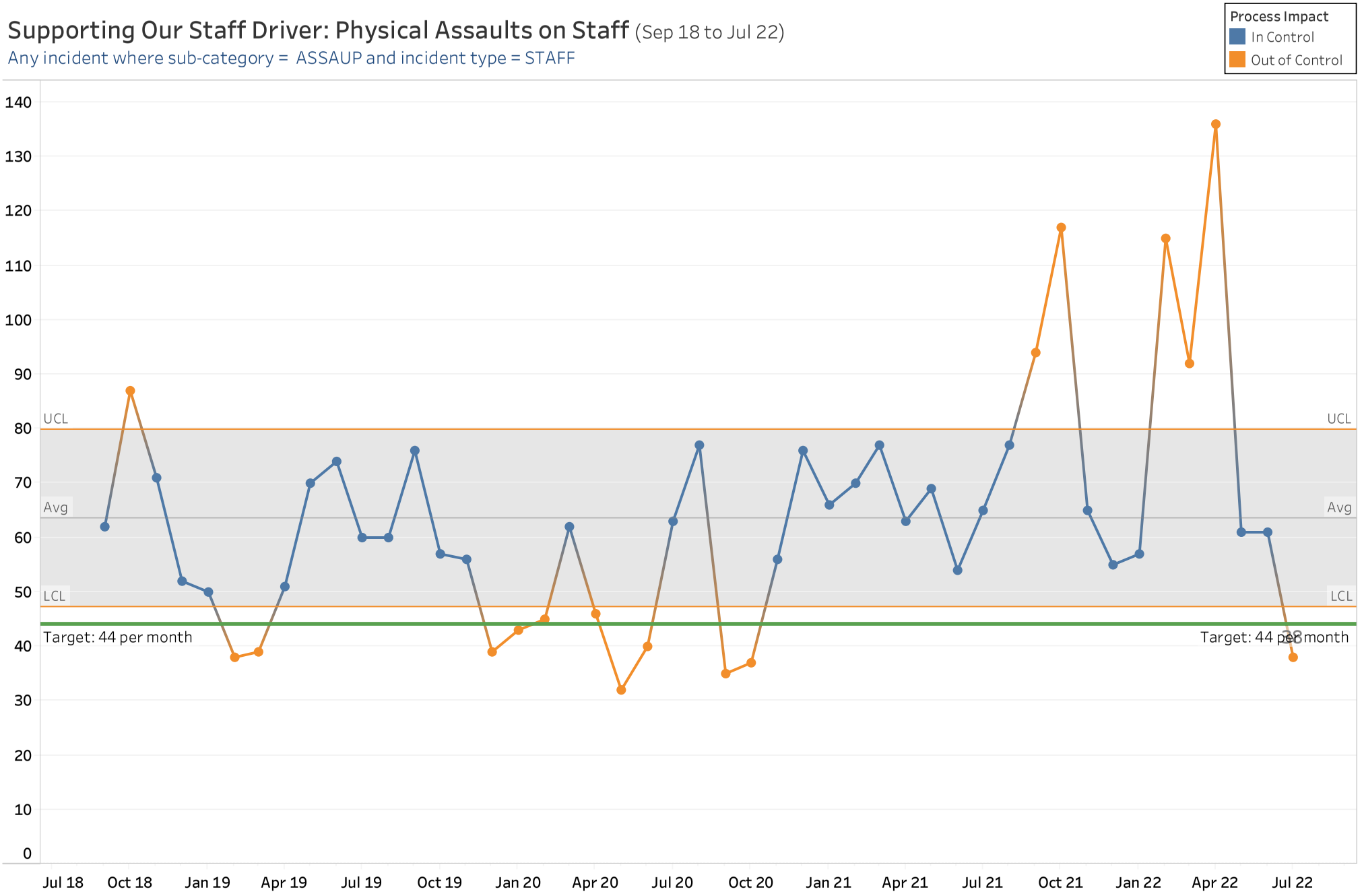


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (July 2022)

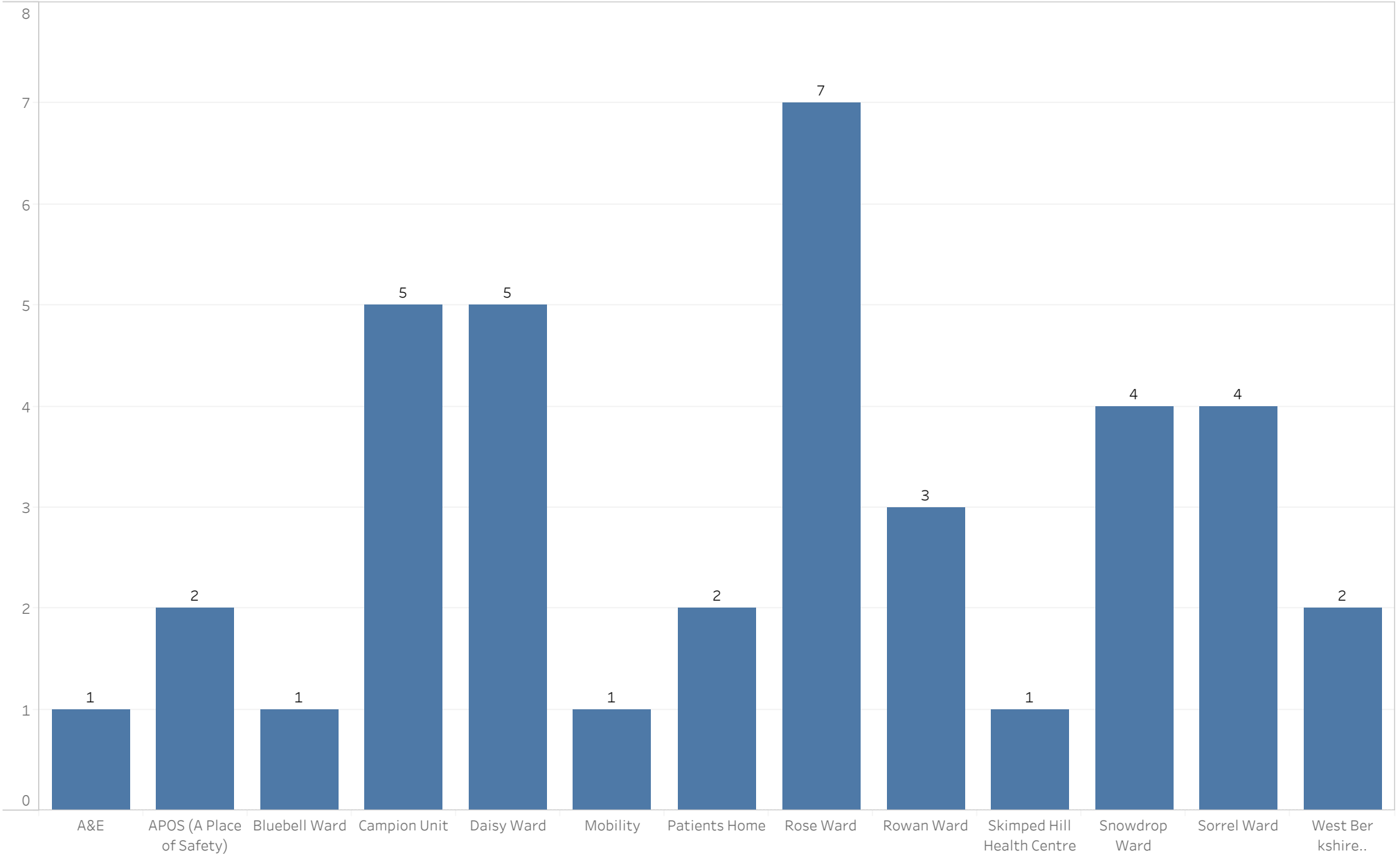


Supporting Our Staff Driver: Physical Assaults on Staff (Sep 18 to Jul 22)

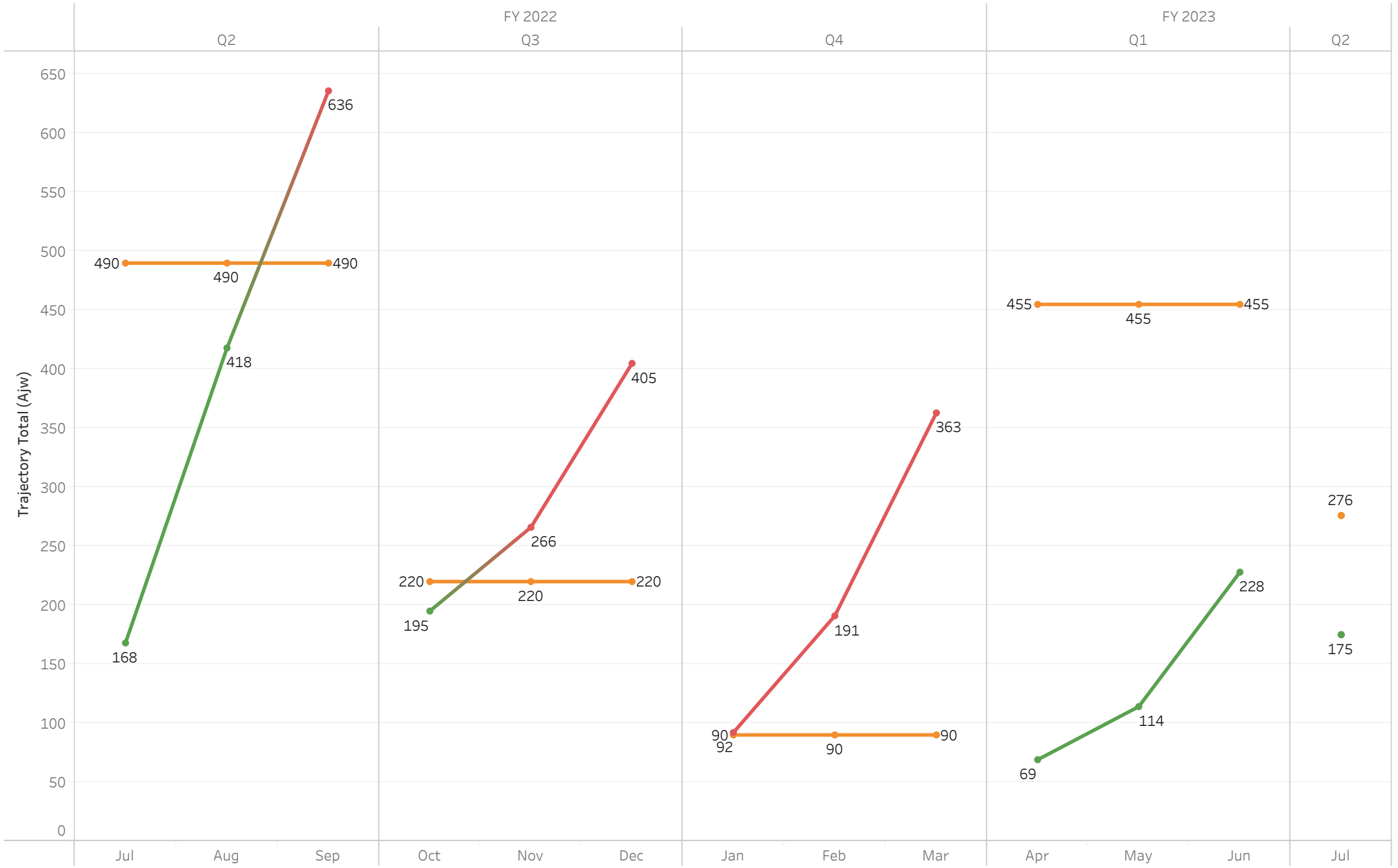
Any incident where sub-category = ASSAUP and incident type = STAFF



Supporting Our Staff Driver: Physical Assaults on Staff by Location (July 2022)



Money Matters Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

True North Patient Experience Summary

Tracker Metrics

		Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Mental Health: Prone (Face Down) Restraint	4 per month	3	2	4	3	2	3	2	0	7	4	2	0
Patient on Patient Assaults (MH)	25 per month	23	21	15	17	14	10	25	7	15	20	12	17
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	93.7%	90.6%	91.3%	96.7%	89.1%	77.4%	87.4%	93.0%	95.0%	100%	85.1%	86.5%
Mental Health: Uses of Seclusion	13 in month	11	15	10	2	0	19	10	11	6	6	5	9

		Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Mental Health Clustering within target: %	80% compliance	80.4%	78.7%	79.4%	79.5%	78.7%	77.2%	77%	78%	79%	80%	81%	87%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	1	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	1	0	0	0	0
Mental Health: AWOLs on MHA Section	10 per month from April 2022	5	9	7	8	2	4	3	12	13	13	11	15
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	7	17	7	3	5	7	1	7	14	7	3	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	6.70	5.09	4.29	5.20	5.5	5.55	4.90	6.32	9.83	4	5.79	7.92
Patient on Patient Assaults (LD)	4 per month	0	2	0	1	2	1	18	1	9	1	1	0
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019	20% from June 2021	13.6%	14.0%	13.7%	14.0%	13.5%	14.0%	14.3%	15.1%	14.6%	15%	14.6%	14.1%
Suicides per 10,000 population in Mental Health Care (annual)	7.4 per 10,000	4.9	4.9	4.9	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community	31 per month	0	13	12	0	0	15	19	3	2	12	25	32
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

True North Money Matters Summary

Tracker Metrics

		Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly)	7.50%	4.39%	1.89%	1.40%	2.60%	1.60%	3.40%	4.01%	8.95%	10.8%	10.2%	9.49%	8.73%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - First Appointment	4.00%									1.26%	5.75%	0.27%	-4.1%
Increase in Elective Care Activity from 19/20 Baseline (Physical Health only) - Follow Up Appointment	4.00%									-6.9%	-4.9%	-4.0%	-7.5%
Community Inpatient Occupancy	80-85% Occupancy	85%	83%	88.2%	85.5%	81.5%	83.5%	83.4%	74.7%	85%	86.5%	86.0%	82.5%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	86.46%	86.46%	88.89%	92.09%	86.72%	73.56%	80.90%	73.04%	81.02%	73.04%	88%	90.51%
DNA Rate: %	5% DNAs	4.90%	4.70%	4.79%	4.59%	2.90%	4.79%	4.73%	4.56%	4.71%	4.90%	5%	4.92%
Community: Delayed transfers of care Monthly and Quarterly: %	7.5% Delays	9.70%	7.79%	3.59%	5%	4.39%	6.20%	8.64%	11.7%	18.4%	12.6%	11.3%	2.91%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	96.0%	90.6%	93.1%	91.2%	92.2%	87.2%	91.1%	86%	93.3%	86%	94.4%	95.9%
Mental Health: Acute Average Length of Stay (bed days)	30 days	49	50	52	53	58	58	37	45	49	50	38	47

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
C.Diff due to lapse in care (Cumulative YTD)	6	0	0	0	2	2	3	3	3	0	0	2	2
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	0	0	0	1	0	0	0	0	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	1	1	1	1	1	1	1	1	0	1	1	1
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	100	100	60	100	71.3	85.7	66.7	100	100	80	100	86
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98.8	99.2	99.8	99.5	99.1	99.5	98.8	99.1	98	98.9	99.0	
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	98	97	97	97	98	97	97	96	96	95
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	55.9	52	55.0	54	53	52	52	52.5	52	52	56.0	51.8
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% to March 2025	99.7	99.1	98.2	99.7	99.7	99.7	100	98.8	99.2	98.2	71.7	47.1
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	94.6	96.7	98.9	98	100	100	98.3	98	99.5	99.5	100	100
Sickness Rate: %	<3.5%	4.47	4.87	4.75	4.92	5.46	5.33	4.59	4.30	4.53	3.95	4.41	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	60%	50%	50%	46.4%	75%	50%	50%	75%	83.3%	78%	50%	85.7%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	34.7%	38.7%	53.3%	68%	87.5%	46%	50%	87.5%	80%	100%	100%	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	Threshold / T..	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22
Community Health Services: 2 Hour Urgent Community Response %.	80%	86.0%	84.5%	89.4%	88.5%	84%	80.4%	83.2%	81.3%	88.4%	88.2%	89.2%	90.2%
E-Coli Number of Cases identified	Tbc	0	2	0	1	1	1	1	0	0	0	1	0
Mental Health 72 Hour Follow Up	80%	86.2%	88.5%	98.1%	90.5%	92%	90.1%	87.5%	86.4%	96.4%	95.5%	98.4%	95.1%

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 September 2022
Title	**Finance, Investment and Performance Committee – Terms of Reference**
	ITEM FOR RATIFICATION
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Mark Day, Committee Chair
Relevant Strategic Objectives	True North Goal – Finance
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The Finance, Investment and Performance Committee has reviewed its terms of reference. The Committee agreed to make minor changes (proposed changes are highlighted in red tracked changes).
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference.

Berkshire Healthcare
NHS Foundation Trust

Finance, Investment & Performance Committee

Terms of Reference

Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10	June 2019	Julie Hill	Amended following review by F,I&P Committee – for board approval September 2019
11	August 2020	Julie Hill	Updated in August 2020
12	July 2021	Julie Hill	Updated in August 2021 following review by F,I &P Committee approval August 2021 –Board approved September 2021

1. Authority

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

1.2 The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from within and outside the Trust if it considers this necessary to discharge its duties.

2. Purpose

2.1. To conduct independent and objective review of financial and investment policy and to review financial and operational performance information and issues. To discharge this duty the Committee will:

2.1.1 scrutinise and review current financial performance, ensuring that there are robust plans in place to correct any material adverse variances from financial plan.

2.1.2 scrutinise and review organisational performance as reported within the Trust's True North Performance Scorecard in accordance with the agreed business rules ensuring that there are robust plans in place to correct any material adverse variances from target.

2.1.3 Identify areas of organisational performance for more in-depth review and scrutiny

2.1.4 review the Trust's Investment Strategy and Policies and maintain scrutiny and oversight of investments and significant transactions ensuring compliance with the regulator and Trust Policy.

2.1.5 examine the Trust's medium-term financial strategy and provide assurance that the Trust's future strategic service plans support continued compliance with NHS Improvement's Provider Licence and the Single Oversight Framework.

2.1.6 review the progress against national requirements for maintaining safe staffing on the Trust's inpatient wards

2.1.7 review the relevant risks on the Board Assurance Framework.

2.1.8 Oversee the Trust's People Strategy's ~~People Strategy~~ recruitment and retention work on behalf of the Trust Board

2.1.9 Review the Trust's Employee Casework

2.10 Review any ad hoc areas delegated by the Trust Board

3. Membership

3.1 The members of the Committee shall be as follows:

- Three Non-Executive Directors
- Chief Executive
- Chief Financial Officer (Lead Executive Director)
- Chief Operating Officer
- Director of Nursing & Therapies or Deputy Director of Nursing

Director of Finance will be in attendance at the meetings

3.2 The Chair of the Audit Committee shall not be a member.

3.3 The Chair of the Committee will be a Non-Executive Director.

3.4 A quorum shall be three members, including at least two Non-Executive Directors.

4. Frequency and Administration of Meetings

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

4.2 The Committee will be supported by the Company Secretary who will agree the Agenda for the meetings and the papers required, directly with the Chair.

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

5. Remit

5.1 Financial Policy and Performance

5.1.1 To review and scrutinise current financial performance and assess adequacy of proposed rectification to bring performance in line with plan (where necessary).

5.1.2 To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity.

5.1.3 To examine the Trust's annual financial plan and maintain an oversight of Trust's income sources and contractual safeguards.

5.1.4 To initiate in-depth investigations and receive reports on key financial, investment and performance issues affecting the Trust.

5.1.5 The committee will review long term financial projections, those overarching the more detailed review of annual budget proposals.

5.2 Investment Policy and Performance

5.2.1 To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions.

5.2.2 To scrutinise all investment proposals for financial implications and consistency with strategic plans prior to submission to the Board when required.

5.2.3 To receive and scrutinise future service and business development proposals, including enhancements to existing contracts, acquisitions, etc to ensure proper financial evaluation, including impact on future risk ratings.

5.2.4 To ensure adequate safeguards on investment of funds.

5.2.5 To receive reports as appropriate on actual or potential breaches of the Prudential Borrowing Code.

5.2.6 To review, at least annually, credit ratings, report on benchmarking of investments and borrowing activities since the date of the last review.

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

5.3.1 To review and scrutinise organisational performance as reported within the Trust's True North Performance Scorecard report in accordance with the business rules

5.3.2 To assess the appropriateness of remedial action to address material variances from target and to monitor progress.

5.3.3 To consider the overall adequacy of the True North performance Scorecard and the monitoring metrics and to recommend changes as necessary to maintain appropriate levels of Board assurance.

5.4 Other areas delegated to the Committee by the Trust Board

5.4.1 To oversee the Trust's People Strategy's recruitment and retention work

5.5 To review any other ad hoc areas as delegated by the Trust Board

Amended: ~~August 2021~~July 2022

Approved by Trust Board:

For review ~~August~~ July 2023~~2~~

Formatted: List Paragraph, Outline numbered + Level: 2 + Numbering Style: 1, 2, 3, … + Start at: 3 + Alignment: Left + Aligned at: 1.01 cm + Tab after: 2.3 cm + Indent at: 2.3 cm

Formatted: List Paragraph, Outline numbered + Level: 3 + Numbering Style: 1, 2, 3, … + Start at: 1 + Alignment: Left + Aligned at: 2.01 cm + Tab after: 3.31 cm + Indent at: 3.31 cm

Berkshire Healthcare NHS Foundation Trust

TRUST BOARD PAPER

Board Meeting Date	13th September 2022
Title	Workforce Race Equality Standard (WRES)
	Item for Noting and to Approve the Publication of the WRES Report
Purpose	To update the Board on the Workforce Race Equality Standard (WRES) and the progress made over the past 12 months as well as areas of focus over the next 12 months in our action plan.
Business Area	Corporate
Author	Gold Egele (Head of Inclusion, OD, and Organisational Experience) Amit Popat (Deputy Director Leadership, Inclusion and Organisational Experience)
Relevant Strategic Objectives	The Trust Equality Diversity and Inclusion strategy and People strategies 2021-2024: • Continue to build a culture of belonging and ensure Berkshire Healthcare is 'Outstanding for everyone' • Have a duty of care for our Black, Asian, and Minority Ethnic (BAME) staff. • To facilitate an inclusive, supportive, and fair organisational culture that is underpinned by allyship where every member of our diverse workforce has a sense of belonging and a positive working experience. • Recognise the added value that a diverse workforce brings.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes. The WRES forms part of the CQC well-led inspections.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty
Equality and Diversity Implications	The WRES was mandated by the NHS Standard Contract in 2015; 2021 is its sixth year. The WRES is underpinned by a desire to equalise experience between staff who come from BAME backgrounds and their White counterparts. It aims to facilitate an inclusive, supportive, and fair culture in organisations to ensure that all racial groups of the NHS' workforce have a sense of belonging and a positive working experience.

EXECUTIVE SUMMARY	The WRES allows NHS Trusts to measure workplace racial inequalities through nine metrics that compare the working and career experiences of BAME and White staff in the NHS. Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BAME representation at Board level. Berkshire Healthcare continues to make progress against previous years with notable improvements made in four out of the nine indicators of race equality. Our BAME staff however continue to have a poorer experience than their White colleagues in all areas.
ACTION REQUIRED	To note the WRES results and consequent action plan and approve their publication.

Berkshire Healthcare NHS Foundation Trust

Equality Diversity & Inclusion

Workforce Race Equality Standard (WRES) Annual Report 2022

To find out more about what Berkshire Healthcare NHS Foundation Trust is doing to be an 'Outstanding and Equal Employer and Care Provider for Everyone', please contact: EDITeam@berkshire.nhs.uk

Executive Summary

The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations to publish data and action plans against nine indicators of workforce race equality.

This report presents Berkshire Healthcare's latest workforce race equality data (as of 31st March 2022) and identifies where improvements have been made and where data has stagnated and/or deteriorated.

The key findings from the 2022 report

Berkshire Healthcare continues to make incremental progress in unmasking and tackling workplace inequalities between Black, Asian, and Minority Ethnic (BAME) and White staff that are captured through nine WRES indicators. Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BAME representation at Board level. It is pleasing to note that progress was made in 4 of the indicators, however there is stagnation and/or regression in 5 of the metrices. Overall, BAME staff have a poorer work experience than White staff – this has been the trend since the WRES was mandated in 2015:

- As of 31st March 2022, the Trust grew by 72 employees (from 4,708 in 2021) to 4,780 members of staff: 3,318 (69.4%) were White and 1312 (27.4%) were from a BAME background. This represents an increase of 1% in the BAME staff population since 2021. The BAME staff population at Berkshire Healthcare has continued to rise gradually annually and currently sits at 5% above national average in the NHS - see the snapshot in Table 13 (Appendix 1).

However:

- There is underrepresentation of BAME staff with voting membership on the Board
- BAME staff are 1.53 less likely to be appointed from shortlisting than White staff
- BAME staff are 4.59 more likely to enter the formal disciplinary process than White staff
- BAME staff are 1.28 less likely to access non-mandatory training and continued professional development compared to White staff
- 29% of BAME staff experienced harassment, bullying or abuse from patients, relatives and the public than White staff
- 23% of BAME staff experienced harassment, bullying or abuse from staff
- 14% of BAME staff experienced discrimination at work from either their manager, team leader or colleagues than White staff
- 46% of BAME staff are less that likely to believe the Trust provides equal opportunities for career progression or promotion than White staff

WRES – Introduction

The Workforce Race Equality Standard (WRES) was mandated by the NHS Standard Contract in 2015; 2022 is its seventh year. It is a mirror that allows NHS Trusts to visualise workplace inequalities through 9 measures (metrics) that compare the working and career experiences of Black, Asian and Minority Ethnic (BAME) and White staff in the NHS. The WRES is underpinned by a desire to equalise experience between staff who come from BAME backgrounds and their White counterparts. It aims to facilitate an inclusive, supportive, and fair culture in organisations to ensure that every member of the NHS' diverse workforce has a sense of belonging and a positive working experience.

With that ethos in mind, the WRES seeks to help unmask barriers that have a negative impact on the experiences and career opportunities of BAME staff in the NHS or applicants from BAME backgrounds seeking employment in the NHS, and thus facilitates transparency and informs strategies for the amelioration of the challenges that are reviewed annually.

Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BAME representation at Board level.

Through providing comparative data between BAME and White staff, the WRES illuminates where key differences lie, and thus provides the foundation for the development of Action Plans to enable the tracking of year-on-year progress. This year's Action Plan was built around the Race Disparity Ratio (RDR): the difference in proportion of BAME staff in AfC Band 8 and above vs AfC Band 5 and below in the Trust compared to the proportion of White staff at those Bands. It looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM.

Drawing on the Race Disparity Ratio, this year, 2022, NHS England and NHS Improvement South-East proposed a South-East Approach where Trusts in the region were tasked with coming up with Six National Actions to address the Race Disparity Ratio in their organisations.

Correspondingly, the aim of this report is to present Berkshire Healthcare's latest WRES data, identify where improvements have been made and where there has been stagnation and/or regression and embed the Trust's Six National Actions that were perceived central to facilitating improvement.

Workforce Race Equality Standard Progress in 2021/22

It is encouraging to note improvements in 4 out of the 9 indicators of race equality:

- Increase in the percentage of the BAME workforce
- A slight reduction in the percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives, or the public
- A slight improvement in the percentage difference between Board voting membership and its overall workforce
- A slight improvement in the relative likelihood of staff accessing non-mandatory training and continued professional development

Several actions have been taken in the last WRES reporting year that will have attributed to the above improvements, these include:

- Supporting our BAME Network to achieve their objectives: operationalisation of the role of the network Chair (4 hours protected time a week).
- Launch of a new Equality Diversity and Inclusion training programme on Allyship and Cultural Intelligence.
- Organisational focus on Bullying and Harassment and focused work on the reduction of abuse against our staff including the introduction of a dedicated Violence Reduction Lead.
- All Divisions provided with granular data on Equality, Diversity, and Inclusion to facilitate targeted interventions.
- Launch of Just and Learning Culture approach to casework which is aimed at reducing the disparity in experience between BAME and White Staff in investigations and disciplinaries
- Launch of our international nurse recruitment programme
- Working towards embedding an Anti-Racism approach with the leadership team and organisation as a whole

Indicator 1: Percentage of staff in each AfC Bands 1 to 9 and VSM compared with the percentage of Black and Ethnic staff in the overall workforce.

Table 1: Workforce Profile - Non-Clinical Cohort 2020-22

Pay Band	2020 Non-Clinical Workforce Data				2021 Non-Clinical Workforce Data				2022 Non-Clinical Workforce Data			
	Total Non-Clinical Staff	White	BAME	Ethnicity Unknown	Total Non-Clinical Staff	White	BAME	Ethnicity Unknown	Total Non-Clinical Staff	White	BAME	Ethnicity Unknown
Under Band 1	9	5 (56%)	3 (33%)	1 (11%)	3	2 (67%)	1 (33%)	0 (0%)	5	2 (40%)	3 (60%)	0 (0%)
Band 1	19	12 (63%)	6 (32%)	1 (5%)	13	9 (69%)	3 (23%)	1 (8%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	144	116 (81%)	25 (17%)	3 (0%)	144	113 (78%)	28 (19%)	3 (2%)	70	56 (80%)	14 (20%)	0 (0%)
Band 3	261	203 (78%)	52 (20%)	6 (0%)	276	217 (79%)	56 (20%)	3 (1%)	274	216 (79%	55 (20%)	3 (1%)
Band 4	255	191 (75%)	54 (21%)	10 (4%)	266	193 (73%)	63 (24%)	10 (4%)	272	199 (73%)	64 (24%)	9 (3%)
Band 5	121	90 (74%)	24 (20%)	7 (6%)	129	97 (75%)	28 (22%)	4 (3%)	130	99 (76%)	30 (23%)	1 (1%)
Band 6	129	96 (74%)	30 (23%)	3 (2%)	135	95 (70%)	34 (25%)	6 (4%)	134	95 (71%)	36 (27%)	3 (2%)
Band 7	92	60 (65%)	32 (35%)	3 (3%)	87	56 (64%)	28 (32%)	3 (3%)	103	65 (63%)	34 (33%)	4 (4%)
Band 8a	74	58 (78%)	15 (20%)	1 (1%)	88	68 (77%)	19 (22%)	1 (1%)	84	58 (69%)	24 (29%)	2 (2%)
Band 8b	41	37 (90%)	2 (5%)	2 (5%)	39	35 (90%)	3 (8%)	1 (3%)	58	51 (88%)	6 (10%)	1 (2%)
Band 8c	32	26 (81%)	5 (16%)	1 (3%)	32	27 (84%)	4 (13%)	1 (4%)	36	28 (78%)	7 (19%)	1 (3%)
Band 8d	12	8 (67%)	1 (8%)	3 (25%)	14	9 (64%)	2 (14%)	3 (21%)	15	11 (73%)	1 (7%)	3 (20%)
Band 9	4	1	1	2	4	1 (25%)	1 (25%)	2 (50%)	7	3 (43%)	1 (14%)	3 (43%)
VSM	3	2	0	1	4	1 (25%)	0 (0%)	3 (75%)	4	1 (25%)	0 (0%)	3 (75%)
Total	1119	905	250	44	1234	923	270	41	1192	884	275	33

The data in Table 1 above (non-clinical workforce) and Table 2 below (clinical workforce) indicates that overall, there is an increase in the workforce from a BAME background since 2020.

Non-Clinical Workforce (Table 1): The most significant increases are at Band 8a (29%), which represents 5 additional recruitments/promotion. There were 3 additional recruitments at Band 8b, hence an increase from 8% to 10%. There was also 3 more additional recruitment/promotion at Band 8c which resulted in an improvement of 6% from 4 (13%) to 7 (19%). However, Band 8d shrunk by 7% (1 member of staff).

Clinical Workforce (Table 2): The most notable increases are at Band 7 (33%), 8a (29%), 8b (10%) and 8c (19%) which equates to 6 additional recruits and/or promotions at Band 7, 5 at Band 8a, 6 at Band 8b and 3 at Band 8c. However, Band 8d shrank by 1 member of staff.

One would note here that the issue of staff opting to withhold their ethnicity is prevalent across the AfC Pay Bands: this significantly compromises both the accuracy and integrity of the data, particularly where the respective cohorts have low numbers. For instance, the total number of non-clinical VSM staff is 3 which represents 75% of that cohort yet have not declared their ethnicity. This shows the sensitivity of the data to small changes in staff numbers at higher levels.

Overall, whilst the improvements are encouraging, the Trust recognises that there is still significant work to be done to achieve race equality within the workforce. In line with the Model Employer strategy and NHS People Plan the Trust is currently setting targets to increase representation of BAME staff at Bands 8a to VSM - a concern that has resulted in the launch of a new indicator: the Race Disparity Ratio (RDR).

Table 2: Workforce Profile - Clinical Cohort 2020-22

	2020 Clinical Workforce Data				2021 Clinical Workforce Data				2022 Clinical Workforce Data			
Pay Band	**Total Clinical Staff**	**White**	**BAME**	**Ethnicity Unknown**	**Total Clinical Staff**	**White**	**BAME**	**Ethnicity Unknown**	**Total Clinical Staff**	**White**	**BAME**	**Ethnicity Unknown**
Under Band 1	8	5 (63%)	2 (25%)	1 (135)	7	5 (71%)	1 (14%)	1 (14%)	7	2 (29%)	4 (57%)	1 (14%)
Band 1	0	0	0	0	1	1 (100%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	162	71 (44%)	84 (51%)	7 (1%)	171	80 (48%)	83 (49%)	8 (5%)	180	83 (46%)	88 (49%)	9 (5%)
Band 3	371	266 (72%)	98 (26%)	7 (2%)	406	279 (69%)	118 (29%)	9 (2%)	368	242 (66%)	119 (32%)	7 (2%)
Band 4	344	264 (77%)	68 (20%)	12 (3%)	387	295 (76%)	82 (21%)	10 (3%)	439	340 (77%)	91 (21%)	8 (2%)
Band 5	428	266 (62%)	138 (32%)	24 (6%)	438	261 (60%)	162 (37%)	15 (3%)	462	260 (56%)	183 (40%)	19 (4%)
Band 6	838	601 (69%)	199 (24%)	38 (5%)	876	653 (75%)	193 (22%)	30 (3%)	862	628 (73%)	205 (24%)	29 (3%)
Band 7	591	448 (76%)	126 (21%)	17 (3%)	652	472 (72%)	160 (25%)	20 (3%)	682	504 (74%)	158 (23%)	20 (3%)
Band 8a	207	163 (79%)	42 (20%)	2 (1%)	215	166 (77%)	47 (22%)	2 (1%)	243	182 (75%)	59 (24%)	2 (1%)
Band 8b	63	57 (90%)	6 (10%)	0 (0%)	70	59 (84%)	11 (16%)	0 (0%)	81	68 (84%)	12 (15%)	1 (1%)
Band 8c	22	16 (73%)	6 (27%)	0 (0%)	21	16 (76%)	5 (24%)	0 (0%)	23	17 (74%)	6 (26%)	0 (0%)
Band 8d	18	16 (89%)	2 (11%)	0 (0%)	20	19 (95%)	1 (5%)	0 (0%)	18	17 (94%)	1 (6%)	0 (0%)
Band 9	5	5 (100%)	0 (0%)	0 (0%)	4	4 (100%)	0 (0%)	0 (0%)	3	3 (100%)	0 (0%)	0 (0%)
VSM	0	0	0	0	0	0	0	0	0	0	0	0
Total	3057	2178	771	108	3268	2310	863	95	3368	2346	926	96

Table 3: Clinical (Medical & Dental) Workforce Data 2020-2022

Pay Band	2020 Clinical (Medical & Dental) Workforce Data				2021 Clinical (Medical & Dental) Workforce Data				2022 Clinical (Medical & Dental) Workforce Data			
	Total Medical & Dental Staff	White	BAME	Ethnicity Unknown	Total Medical & Dental Staff	White	BAME	Ethnicity Unknown	Total Medical & Dental Staff	White	BAME	Ethnicity Unknown
Consultants	82	29 (35%)	38 (46%)	15 (18%)	98	31 (32%)	43 (44%)	24 (24%)	100	37 (37%)	51 (51%)	12 (12%)
Snr Medical Manager	0	0	0	0	0	0	0	0	0	0	0	0
Non-consultant Career Grade	94	35 (37%)	43 (46%)	16 (17%)	87	33 (38%)	38 (44%)	16 (18%)	82	33 (40%)	43 (53%)	6 (7%)
Trainee Grade	28	2 (7%)	4 (14%)	22 (79%)	21	2 (10%)	2 (10%)	17 (81%)	25	9 (36%)	15 (60%)	1 (4%)
Other	0	0	0	0	0	0	0	0	0	0	0	0
Total	204	66	85	53	206	66	83	57	207	79	109	19

According to the Clinical (Medical & Dental) Workforce Data in Table 3, the highest percentage of Ethnic Minority staff are Consultants (51%) and Non-Consultant Career Grade (53%). This is in line with the greater numbers of BAME graduates entering medical degrees 60% of entrants to medical profession are from BAME backgrounds with 87% of the 60% from Asian backgrounds. On the surface, there is underrepresentation at Trainee Grade, however this grade with a non-declaration rate of 4% have clearly improved in declaring ethnicity.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

The following indicators are taken from Berkshire Healthcare data and will be used as a benchmark for the future.

Table 4:Relative likelihood of appointment from shortlisting

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BAME applicants	Berkshire Healthcare	**1.46**	**1.46**	**1.53**
		NHS Trusts	**1.46**	**1.61**	

From a BAME perspective, the data in Table 4 shows a concerning disparity in comparison with White staff. The likelihood of BAME staff being appointed from shortlisting has not improved since 2021 – White staff are 1.53 times more likely to be appointed from shortlisting than BAME applicants. According to Table 4, our recruitment practice is worse than it was 3 years ago. The Trust has adopted the WRES' Six National Actions to address disparities that exist in our recruitment practice – see Appendix 2 for more detail.

Indicator 3: Relative likelihood of staff entering the formal disciplinary process

Table 5: Relative likelihood of entering formal capability process

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff	Berkshire Healthcare	1.76	1.81	4.59
		NHS Trusts	1.22	1.16	

The data in Table 5 indicates that the disparity in the likelihood of BAME staff and White staff entering the formal disciplinary process has significantly increased from what it was 3 years ago. Our new Just Culture Approach has significantly reduced the number of staff entering a disciplinary process (both White and BAME), however, BAME staff continue to be more likely to be involved in a disciplinary as they are concentrated in roles where they are more likely to be open to accusations which lead to investigations. In order to better understand the reasons behind this data, we are working with ICB colleagues to commission some in-depth EDI expert analysis of our data – our intention is that this expertise will help us to understand why we did not meet our 21/22 target, and despite full and successful implementation of our just culture principles which have overall had a positive impact on our staff, we continue to experience a disproportionate number of BAME staff involved in disciplinary investigations.

Indicator 4: Relative likelihood of staff accessing non-mandatory training and continued professional development

Table 6: Relative likelihood of staff accessing non-mandatory training and CPD

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22
4		Berkshire Healthcare	1.59	1.51	1.28

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22
	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff	NHS Trusts	**1.15**	**1.14**	

This data in Table 6 Illustrates that White staff are 1.28 times more likely to access non mandatory training and continued professional development than BAME staff. This disparity is rather disappointing because national data suggests that most Trust now fall within the non-adverse range of 0.80 to 1.25, based on the four-fifths rule. We now monitor the diversity of all applicants for training and professional development to assess for any bias in our processes.

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public

Table 7: Harassment, bullying or abuse in the last 12 months (patients, relatives & public)

WRES Indicator	Metric Descriptor		BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21	BAME 2021/22	White 2021/22
5 Staff Survey Q13a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	30%	22%	31%	20%	29%	20%
		NHS Trusts	36%	28%	32%	25%	32%	26%

This data in Table 7 indicates that BAME staff are 29% more likely to experience harassment, bullying or abuse from patients, relatives and the public than White staff. This represents a slight improvement from the previous year's data and is almost consistent with the national average score. There has been no consistent progress since 2019. The Trust has prioritised tackling harassment, bullying and/or abuse of staff in its new Equality, Diversity and Inclusion Strategy and has launched several initiatives such as the BAME Transformation Project, training programme on Allyship, and a three-day Rapid Improvement Event that targeted racial abuse of staff where several short term and long-term projects were agreed supported by our Comms team. There is a commitment to facilitating change.

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff

Table 8: Harassment, bullying or abuse in the last 12 months (staff)

WRES Indicator	Metric Descriptor		BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21	BAME 2021/22	White 2021/22
6. Staff Survey Q13c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Berkshire Healthcare	25%	20%	23%	18%	23%	14%
		NHS Trusts	25%	21%	25%	20%	23%	18%

The data in Table 8 indicates that there has been no improvement in the harassment, bullying or abuse of BAME staff by their colleagues. However, staff from BAME backgrounds are still 9% more likely to experience harassment, bullying or abuse from staff than their White counterparts. This is unacceptable – the Trust has prioritised tackling harassment, bullying and/or abuse of staff in its new Equality, Diversity and Inclusion Strategy and has facilitated several initiatives this year such as the BAME Transformation Project, a new training programme on Allyship and Cultural Intelligence, and a three-day Rapid Improvement Event that targeted racial abuse of staff where several short terms and long-term projects were launched. BAME staff have also been given opportunities to share their lived experiences with the Board to raise awareness.

Indicator 7: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

Table 9: Opportunities for career progression or promotion

WRES Indicator	Metric Descriptor		BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21	BAME 2021/22	White 2021/22
7. Staff Survey Q14	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	Berkshire Healthcare	50%	68%	50%	70%	46% The way of calculating these results has changed this year, so we have updated all previous results to be in line for this scoring	68%
		NHS Trusts	46%	59%	46%	61%	47%	61%

This data in Table 9 indicates that 46% of BAME staff believe that the Trust provides equal opportunities for career progression or promotion compared to 68% of White staff. This represents a regression from the previous year's data and is almost consistent with the national average score. There has been no consistent progress since 2019. The Trust has commissioned a BAME Transformation project that aims to look at career progression and or internal promotion processes to equalise experience. This has also been put at the centre of the Trust's new Equality, Diversity and Inclusion Strategy as well as the People Strategy. Career progression is also one of the drivers of the Trust's Six WRES National Actions.

Indicator 8: Percentage of staff personally experiencing discrimination at work from their manager/team leader or colleagues

Table 10: Experience of discrimination at work from manager/team leader or colleagues

WRES Indicator	Metric Descriptor		BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21	BAME 2021/22	White 2021/22
8. Staff Survey Q13b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Berkshire Healthcare	13%	6%	12%	5%	14%	5%
		NHS Trusts	13%	6%	15%	6%	14%	6%

The data in Table 10 demonstrates that 14% of BAME staff have personally experienced discrimination at work from either their manager, team leader or colleagues in comparison to 5% of White staff. The Trust is committed to tackling harassment, bullying and/or abuse of staff. It continues to deliver a suite of Leadership and Management programmes that aim to foster inclusive and compassionate leadership behaviours in management teams across the Trust and this team now reports to the Assistant Director of Leadership, Inclusion and Organisational Experience, working collaboratively with the EDI team. Also, there is a new Equality, Diversity and Inclusion Strategy, several initiatives such as the BAME Transformation Project, a new training programme on Allyship and Cultural Intelligence, and a range of project targeted at raising awareness as well as changing a culture that still has pockets of discrimination. BAME staff have been given opportunities to share their lived experiences with the Board to raise awareness and profile of the scale of the challenge.

Indicator 9: Percentage difference between Board voting membership and its overall workforce

Table 11: Board Representation

WRES Indicator	Metric Descriptor		2019/20	2020/21	2021/22
9 Board Representation	Percentage difference between Board voting membership and its overall workforce	Berkshire Healthcare	**15%**	**-15%**	**-4.4%**
		NHS Trusts	**8%**	**10%**	

The data presented in Table 11 indicates that as of 31st March 2022, BAME Board Membership has improved at -4.4% as there is now a change at Board level with 1 voting member.

Berkshire Healthcare Race Disparity Ratio

Table 12: BOB ICS Race Disparity Ratio Heat Map

Trust Name	% BAME Staff	Disparity Ratio		
		Lower to Middle	Middle to Upper	Lower to Upper
Berkshire Healthcare NHS Foundation Trust	25.8%	1.24	1.42	1.75
Buckinghamshire Healthcare NHS Trust	26.0%	1.50	1.04	1.56
Oxford Health NHS Foundation Trust	18.4%	1.70	1.47	2.50
Oxford University Hospitals NHS Foundation Trust	25.5%	1.73	2.32	4.01
Royal Berkshire NHS Foundation Trust	29.2%	1.76	2.08	3.67
South Central Ambulance Service NHS Foundation Trust	5.2%	0.92	1.37	1.26

Building on the challenges highlighted by the 9 WRES indicators presented in this report, Table 12 above presents Berkshire Healthcare's Race Disparity Ratio (RDR) and juxtaposes it with the Trust's partners in the BOB ICS. It is worth noting that the above RDR is based on the previous year's data.

The RDR is underpinned by the principle that once recruited into an organisation progression/promotion chance should be equally accessible to everyone – an issue that is highlighted as problematic by our WRES' data. Table 12 suggests that across the ICS, there is a disparity in proportion of BAME staff in AfC Band 8 and above vs AfC Band 5 and below compared to the proportion of White staff at those Bands.

With the understanding that the RDR looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM these are the implications of the Berkshire Healthcare's RDR presented in Table 12:

- Lower to Middle: White staff are 1.24 times more likely to progress through the organisation than BAME staff.
- Middle to Upper: White staff are 1.42 times more likely to progress through the organisation than BAME staff.
- Lower to Upper: White staff are 1. 75 times more likely to progress through the organisation than BAME staff.

Both BOB and Frimley ICS have appointed EDI leads that will support and oversee the action plans submitted to address the six national key actions.

Conclusion and Next Steps

Based on the 2021-22 data the following have been identified as areas of concern that the Trust must focus on for improvement:

- Underrepresentation of BAME staff in senior posts (bands 8a and above)
- Likelihood of BAME staff being appointed from shortlisting
- Likelihood of BAME staff accessing non-mandatory training and continued professional development
- Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives, or the public
- Percentage of BAME staff experiencing harassment, bullying or abuse from staff
- Percentage of BAME staff experiencing discrimination at work from their manager, team leader or colleagues
- Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion
- Underrepresentation of BAME on the Board with voting membership

With these areas for improvement in mind, the Trust's EDI Improvement Plan (see Appendix 2) outlines actions the Trust will take to respond to the WRES and achieve improvements against the following themes:

- ‘De-biasing’ and ‘inclusivisation’ of the recruitment and selection processes (this will be integrated with the Six National Actions): the aim is to increase representation of Black, Asian, and Ethnic Minority staff in Bands 8a to VSM
- Eradication of discrimination, bullying and harassment in the workplace
- Inclusive practise for equalisation of career opportunities for development
- Compassionate and Inclusive Leadership (with cultural intelligence)
- Talent approach and Sponsorship programme
- Allyship
- Continuation of the Just Culture work

Appendix 1: BAME Staff Population

Table 13: BAME staff population at Berkshire Healthcare

Overall Percentage of BAME Staff		2019/20	2020/21	2021/22
Percentage of BAME staff in overall Berkshire Healthcare workforce compared with other NHS Trusts in England	Berkshire Healthcare	**25%**	**26%**	**27.4%**
	NHS Trusts	**20%**	**21%**	**22.4%**

Appendix 2: EDI Improvement Plan

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
Increase the likelihood of BAME staff being appointed from shortlisting through improved and inclusive recruitment processes	*Recruitment Processes*	**National Action 1**: Set specific recruitment targets **National Action 2:** Introduce a system of ‘comply or explain’ to ensure fairness during interviews **National Action 3:** mandate new policy where all hiring managers include evidence of EDI work /	• Work with BAME Network and review recruitment process (including job adverts) • Deliver inclusive recruitment training (including unconscious bias)	December 2022 October 2022

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
		understanding as essential criteria for Bands 8a and above roles.		
Continue to address the poorer experience of BAME staff reported through the NSS for Bullying and Harassment	*Inequalities and differentials in experience:* • *Just Culture* • *Bullying and Harassment*	• Promote Trust's Zero-Tolerance Policy about bullying and harassment. • Work with the BAME Network to improve use of soft intelligence about people's experience, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes. • **National Action 4:** Adapt and adopt resources, guides and tools to help leaders and individuals have productive conversations about race (normalise conversations about race).	• Reduction of Bullying and Harassment to be a key deliverable of the newly formed EDI Team. • Embed conversations about race into Leadership Training for managers and through Respect and Civility training • Continue to promote the inclusion through the internal communication channels for staff and managers. • We are working with ICB colleagues to commission some in-depth EDI expert analysis of our data – our intention is that this expertise will help us to understand why we did not meet our 21/22 target, and despite full and successful implementation of our just culture principles which have overall had a positive impact on our staff, we continue to experience a disproportionate number of BAME staff involved in disciplinary investigations.	January 2023 January 2023 December 2022 December 2022
Continue to invest in developing compassionate and inclusive leadership	*Leadership and Management*	• Continue to thread EDI into Leadership and Management Training • **National Action 4:** Adapt and adopt resources, guides, and tools to help leaders and individuals have productive conversations about race (normalise conversations about race).	• Review all Leadership and Management Training through EDI lenses. • Embed EDI in Leadership and Management Training, including Sponsorship programme aimed at improving the diversity of our talent pipeline • Inclusive Leadership Competency Framework (with Cultural Intelligence) training, aimed at supporting senior managers to adopt values and behaviours that support an inclusive culture and promotes career progression for all.	January 2023 January 2023 January 2023

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
Provide inclusive career progression opportunities for development	*Inequalities and differentials in experience:*	• Use of reliable and robust data – to understand the experiences of our staff and proactively use data to address areas of concern. Work with the BAME Network to improve our use of soft intelligence about people's experiences, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes. **National Action 5:** Organise talent panels or internal promotion panels: • Create a 'database' of individuals eligible for promotion and development opportunities • Design a transparent promotion system/criterion **National Action 6:** Overhaul interview processes to incorporate: • Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. • Enhance EDI support available to train organisation and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies	• Career conversations embedded into the annual appraisal process • Implement and fully embed an inclusive talent management system, to support the development of a talent pipeline • Promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, • Identify any specific gaps requiring some targeted or bespoke • Working with ICS colleagues to adapt script for a 7-minute Just-In-Time video on Top Tips on Fair Recruitment and promoting this with hiring managers to ensure fair and inclusive practices are used.	January 2023 January 2023 January 2023 December 2022 December 2022

Berkshire Healthcare NHS Foundation Trust

TRUST BOARD PAPER

Board Meeting Date	13th September 2022
Title	Workforce Disability Equality Standard (WDES)
	Item for Noting and to Approve the publication of the WDES Report
Purpose	To update the Board on the Workforce Disability Equality Standard (WDES) and the progress made over the past 12 months as well as areas of focus over the next 12 months in our action plan.
Business Area	Corporate
Author	Gold Egele (Head of Inclusion, OD, and Organisational Experience) Amit Popat (Deputy Director Leadership, Inclusion and Organisational Experience)
Relevant Strategic Objectives	The Trust Equality Diversity and Inclusion strategy and People strategies 2021-2024: • Continue to build a culture of belonging and ensure Berkshire Healthcare is 'Outstanding for everyone' • Have a duty of care for staff with existing disabilities and members of staff who may develop a disability whilst employed by the Trust. • To facilitate an inclusive, supportive, and fair organisational culture that is underpinned by allyship where every member of our diverse workforce has a sense of belonging and a positive working experience. • Recognise the added value that a diverse workforce brings.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes. The WDES forms part of the CQC well-led inspections.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty
Equality and Diversity Implications	The NHS WDES became a requirement as of 1st April 2019 to enable NHS organisations to capture and compare the experiences of disabled staff with those of non-disabled staff. The WDES is underpinned by the Social Model of Disability which argues that people are disabled because of societal barriers, rather than long-term health conditions.
EXECUTIVE SUMMARY	The WDES is underpinned by ten metrics that cover the workforce profile, recruitment and capability processes, experiences of disabled

	staff, board make up, and the opportunity for disabled staff to voice and air their concerns and to be heard. Berkshire Healthcare continues to make progress against previous years with notable improvements made in four out of the ten indicators of disability equality. Our disabled staff however continue to have a poorer experience than their non- disabled colleagues in all areas.
ACTION REQUIRED	To note the WDES results and consequent action plan and approve their publication.

Berkshire Healthcare NHS Foundation Trust

Equality Diversity & Inclusion

Workforce Disability Equality Standard (WDES) Annual Report 2022

To find out more about what Berkshire Healthcare NHS Foundation Trust is doing to be an 'Outstanding and Equal Employer and Care Provider for Everyone', please contact: EDITeam@berkshire.nhs.uk

Executive Summary

The Workforce Disability Equality Standard (WDES) is a requirement for all NHS organisations to publish data and action plans against 10 indicators of workforce disability equality.

This report shows Berkshire Healthcare's latest workforce disability equality data (as at 31st March 2022) and identifies where improvements have been made and where data has stagnated or deteriorated.

The key findings from the 2022 report

Berkshire Healthcare continues to make incremental progress in tackling and removing barriers faced by staff with a Disability and individuals seeking employment with the Trust. Notable improvements were made in 6 out of the 10 WDES indicators of disability equality. However, Disabled staff have a poorer work experience than Non-Disabled staff overall - there is stagnation and/or regression in some of the metrics.

- The number of Disabled staff has remained consistent at 5% of the total workforce.
- The Trust has taken action to facilitate the voices of Disabled staff – the role of the Chair of the Purple Network has been operationalised and allocated protected time (half a day a week).
- 81% of Disabled staff report that the Trust has made adequate reasonable adjustments to enable them to carry out their work.
- Increase in the likelihood of Disabled staff being appointed from shortlisting, though still behind Non-Disabled staff.
- A reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from their manager and colleagues.
- There is 1 Disabled staff member represented on the Board with voting membership.

However:

- 9% of the workforce have not declared their disability status.
- Disabled staff are more likely to experience harassment, bullying or abuse from patients, service users, relatives, the public, their manager and colleagues than Non-Disabled staff.
- An increase in the likelihood of Disabled staff entering the formal capability process.
- A decrease in the National Staff Survey engagement score for Disabled staff for the third year running.

- Presenteeism: Disabled staff are more likely to come to work despite not feeling well enough than Non-Disabled staff.
- An increase in the percentage of Disabled staff saying that they felt pressure from their manager to come to work despite not feeling well enough to perform their duties.
- Decline in the percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion
- There is a decrease in the number of Disabled staff saying that they are satisfied with the extent to which the Trust values their work

WDES – Introduction

The Workforce Disability Equality Standard (WDES) was mandated by the NHS Standard Contract in 2018; 2022 is its fourth year. It comprises of 10 measures (metrics) that compare the working and career experiences of Disabled and Non-Disabled staff in the NHS. The WDES is underpinned by the Social Model of Disability which argues that people are disabled because of societal barriers, rather than long-term health conditions.

With the Social Model of Disability in mind, the WDES seeks to help unmask barriers that have a negative impact on the experiences and career opportunities of Disabled staff in the NHS or disabled applicants seeking employment in the NHS, and thus facilitates transparency and informs year on year improvement.

Through providing comparative data between Disabled and Non-Disabled staff, the WDES illuminates where key differences lie, and thus provides the foundation for the development of Action Plans to enable the tracking of year-on-year progress and amelioration of the challenges.

The data for indicators 1 to 3 and 10 are taken from the Trust's workforce data as at 31st March 2022 and data for indicators 4 to 9 are taken from the Trust's 2021 National Staff Survey results.

The aim of this report is to present the Trust's latest Disability Equality Data and identify where improvements have been made and where there has been stagnation and/or regression.

Workforce Disability Equality Standard Progress in 2021/22

It is pleasing to note improvements in 4 out of the 10 indicators of disability equality:

- Increase in the likelihood of Disabled staff being appointed from shortlisting.
- A reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from their manager.
- A slight reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from other colleagues.
- 81% of Disabled staff (increase by 4%) report that the Trust has made adequate reasonable adjustments to enable them to carry out their work.

A number of actions have been taken in the last WDES reporting year that will have attributed to the above improvements, these include:

- Supporting our Purple Network to achieve their objectives: operationalisation of the role of the network Chair (4 hours protected time a week).
- Launch of new Equality Diversity and Inclusion training programme on Allyship.
- Embedding of Equality, Diversity and Inclusion in Leadership and Management training programmes.
- Relaunch of the Reasonable Adjustments Policy with support/guidance given to both managers and staff.
- Work on more inclusive Adverts and Job Descriptions.
- Organisational focus on Bullying and Harassment.
- All Divisions provided with granular data on Equality, Diversity, and Inclusion to facilitate targeted interventions.
- Launch of Just and Learning Culture approach to investigations and disciplinaries
- Launch of Trust Neurodiversity Strategy and action plan

Metric 1: Percentage of staff in AfC pay-bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.

Table 1: Workforce Profile - Non-Clinical Cohort

Overall Workforce Profile - 2021				Overall Workforce Profile - 2022		
	Disabled	**Not Disabled**	**Missing or Unknown**	**Disabled**	**Not disabled**	**Missing or Unknown**
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)
Non-Clinical Cohort - 2021				**Non-Clinical Cohort - 2022**		
Cluster 1: Bands 1-4	42 (6%)	574 (82%)	86 (12%)	31 (5%)	538 (87%)	52 (8%)
Cluster 2: Bands 5-7	15 (4%)	306 (87%)	30 (9%)	22 (6%)	324 (88%)	21 (6%)
Cluster 3: Bands 8a-8b	7 (6%)	108 (85%)	12 (9%)	6 (4%)	125 (88%)	11 (8%)
Cluster 4 Bands 8c-9&VSM	0 (0%)	41 (76%)	13 (24%)	1 (1%)	45 (73%)	16 (26%)

The data presented in Table 1 indicates that 255 staff (5% of the Workforce) have declared a Disability on the Trust's ESR. The declaration rate within the Trust has been consistently at 5% with 430 (9%) members of staff withholding their disability on ESR as of 31 March 2022. However, this is an improvement of 3%: the non-declaration rate was 11% in 2021. Although high non-declaration rates are a national issue, Berkshire Healthcare continues to work on fostering a culture where employees are comfortable to declare. This year, all Divisions within the Trust were given granular data that highlighted their non-declaration rates. Rather than placing emphasis on encouraging staff to declare disabilities, Divisions were encouraged to work on facilitating a Disability Confident Culture through embracing the Trust's Reasonable Workplace Adjustments Policy to support staff. In addition as part of new starter onboarding and annually thereafter, all staff have a wellbeing assessment and are asked if they need any adjustments to help them in the workplace.

Table 1 also presents the numbers of disabled and non-disabled staff employed at Berkshire Healthcare at various Agenda for Change (AfC) pay-bands. Whilst there was a decrease of 2% at Cluster 3 (Bands 8a-8b); Cluster 4 (Bands 8c-9&VSM) increased by 1%.

Table 2: Workforce Profile - Clinical Cohort

Overall Workforce Profile 2021				Overall Workforce Profile 2022		
	Disabled	Not Disabled	Missing or Unknown	Disabled	Not Disabled	Missing or Unknown
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)
Clinical Cohort - 2021				**Clinical Cohort - 2022**		
Cluster 1: Bands 1-4	51 (5%)	845 (87%)	76 (8%)	56 (5%)	872 (88%)	66 (7%)
Cluster 2: Bands 5-7	99 (5%)	1703 (87%)	164 (8%)	115 (6%)	1747 (87%)	144 (7%)
Cluster 3: Bands 8a-8b	11 (4%)	260 (91%)	14 (5%)	14 (4%)	300 (93%)	10 (3%)
Cluster 4: Bands 8c-9&VSM	4 (9%)	37 (82%)	4 (9%)	3 (7%)	37 (84%)	4 (9%)
Cluster 5: Medical and Dental Consultants	3 (3%)	47 (48%)	48 (49%)	3 (3%)	48 (48%)	49 (49%)
Cluster 6: Medical and Dental staff, Non-Consultant Career Grade	4 (5%)	47 (54%)	36 (41%)	4 (5%)	46 (56%)	32 (39%)
Cluster 7: Medical and Dental Staff, Medical and Dental Trainee Grades	0 (0%)	0 (0%)	21 (100%)	0 (0%)	0 (0%)	25% (100%)

The clinical cohort data presented in Table 2 above indicates that there were no substantial changes in the workforce profile.

The NHS WDES Indicators: Metrics 2-4

The following indicators are taken from Berkshire Healthcare data and will be used as a benchmark for the future.

Table 3:Relative likelihood of appointment from shortlisting

Metric	Descriptor	2020/21	2021/22
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being **appointed from shortlisting** across all posts. *****A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.	**1.13**	**1.08**

The data in Table 3 indicates that whilst recruitment trends still favour Non-Disabled staff, the likelihood of Disabled staff being appointed from shortlisting has improved since 2021: Non-Disabled staff are currently 1.08 times more likely to be appointed from shortlisting. However, one would note here that Metric 2 should be used cautiously as it does not capture an accurate picture – not all shortlisted candidates will declare that they have a disability at application stage.

Table 4: Relative likelihood of entering formal capability process.

Metric	Descriptor	2020/21	2021/22
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the **formal capability process**, as measured by entry into the formal capability procedure. *****This metric will be based on data from a two-year rolling average of the current year and the previous year. * A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.	**4.30**	**5.34**

The data in Table 4 shows an increase in the relative likelihood of Disabled staff compared to Non-Disabled peers entering the formal capability process based on performance since 2021 which may reflect more work needed in the new Just Culture approach to casework. Previously, calculations were based on annual data, but from 2021 criteria will be based on data from a two-year rolling average of the current year and the previous year, thus the two figures are not directly comparable. Nonetheless, a figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.

Table 5: Harassment, bullying or abuse in the last 12 months

Metric	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying or abuse in the last 12 months from:	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22
4 Staff Survey Q13a-d	(a) Patients/Service users, their relatives or other members of the public	30%	23%	30%	20%	30%	20%
	(b) Managers	16%	9%	15%	7%	12%	5%
	(c) Other Colleagues	23%	14%	21%	13%	19%	11%
	(d) Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	53%	61%	54%	59%	56%	63%

Table 5 indicates that the percentage of Disabled staff saying they have experienced harassment, bullying or abuse at work in the last 12 months:

(a) From patients/service users, their relatives or other members of the public has remained consistent at 30%, this is 10% higher than Non-Disabled staff experience.

(b) From managers has decreased by 3%.

(c) From other colleagues has reduced by 6%, however there is still a significant gap of 8% with Non-Disabled staff.

(d) And they or a colleague have reported it has increased by 2%.

Table 6: Opportunities for career progression or promotion

Metric	Equal opportunities for career progression or promotion	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22
5 Staff Survey Q14	Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	60%	64%	59%	67%	53% The way of calculating these results has changed this year, so we have updated all previous results to be in line for this scoring	64%

Table 6 indicates that the percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion has decreased since last year by 6% and is 11% less than Non-Disabled staff.

Table 7: Presenteeism

Metric	Presenteeism	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22
6 Staff Survey Q11e	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	23%	17%	24%	15%	20%	16%

Table 7 demonstrates that Disabled staff are 4% more likely to feel pressure from their manager to come to work, despite not feeling well enough than Non-Disabled staff. This figure has improved by 4% since 2021, and may be attributed to more colleagues working from home.

Table 8: Satisfaction rate on how organisation values staff's work

Metric	Disabled staff's views / satisfaction with the extent to which their organisation values their work.	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21	Disabled 2021/22	Non-Disabled 2021/22
7 Staff Survey Q5f	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	54%	61%	55%	67%	52%	61%

Table 8 indicates that 52% of Disabled staff say they are satisfied with the extent to which their organisation values their work, however this is 9% less than Non-Disabled staff. The percentage number of Disabled staff saying this has decreased by 3% on 2021 results.

Table 9: Reasonable Adjustments

Metric	Reasonable Adjustments for Disabled staff	2019/20	2020/21	2021/22
8 Staff Survey Q26b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	75%	77%	81%

- Table 9 indicates that 81% of Disabled staff say that their employer has made adequate adjustments to enable them to carry out their work, meaning that 19% have not had the adjustments required. This improvement of 4% on 2021's results, shows an encouraging trend as our figures continue to improve year on year. We will continue to promote our reasonable adjustments policy and provide guidance and clarity for

our staff with a disability and managers. This include having a centralised budget and expert support for reasonable adjustments as well as running drop in sessions for line managers and staff to help them access the right reasonable adjustments.

Table 10: The Engagement of Disabled Staff

Metric	NHS Staff Survey and the engagement of Disabled staff	Disabled 2019/20	Disabled 2020/21	Disabled 2021/22
9 National Survey Staff Engagement Score	(a) The staff engagement scores for Disabled and Non-Disabled staff	7.0	7.2	7.1
	(b) Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard?	**Yes**		

Table 10 shows that the staff engagement score for Disabled staff has decreased marginally since last year to 7. It is worth noting that the Trust has answered 'Yes' to this question and voices of Disabled staff are heard via an active, up and running Purple Staff Network, whose Chair has protected time of half a day each week. The Purple Staff Network has Executive level sponsorship (Chief Financial Officer). The voice of disabled staff was sought in the co-production of the new People and EDI strategies and our network leads have regular meetings with both the Director of People and our EDI Leads to help support the implementation of our strategies.

Table 11: Board Representation

Metric	Board Representation: the difference for Disabled and Non-Disabled staff.	Disabled 2019/20	Disabled 2020/21	Disabled 2021/22
10 Board Representation	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	2%	-5%	2%

The data in Table 11 shows that there is now Disabled staff representation on the Board with voting membership. Staff not declaring their disability status on ESR is prevalent throughout all levels of the organisation, this is demonstrated by 9% of the workforce not reporting their disability status on ESR.

Conclusion and Next Steps

Based on the 2021-22 data the following have been identified as areas of concern that the Trust must focus on for improvement:

- Lack of parity in the recruitment and selection process
- Presenteeism
- Staff who have not declared their disability status
- Disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives or members of the public, their manager and colleagues
- Disabled staff believing the Trust provides equal opportunities for career progression or promotion
- More Disabled representation on the Board with voting membership

With these concerns in mind, the Trust's EDI Improvement Plan (see Appendix 1) outlines actions the Trust will take to respond to the WDES and achieve improvements against the following themes:

- 'De-biasing' and 'inclusivisation' of the recruitment and selection processes
- Eradication of discrimination, bullying and harassment in the workplace
- Equalisation of career opportunities for development
- Increasing disability declaration rates
- Compassionate and inclusive leadership
- Allyship

Appendix 1: EDI Improvement Plan

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
Continue to increase disability declaration rates on ESR	*Staff engagement scores for Disabled* *Declaration rates*	• Discussion of granular Divisional data with EDI Leads. • Continue to promote Reasonable Adjustments Policy – people need to see the benefits of declaring • Communication strategy to raise awareness about ESR data - people need to feel safe to declare.	• Continue to promote Reasonable Adjustment Policy • Continue to offer drop-in sessions to guide managers and staff about Reasonable Adjustment Policies. • Communicate a reminder about the importance of declaration to all staff, and how they can use ESR Self Service functionality to update their personal information.	October 2022 October 2022 October 2022
Increase the likelihood of Disabled staff being appointed from shortlisting through improved and inclusive recruitment processes	*Recruitment Processes*	• Place inclusion at the centre of candidate recruitment • Monitor candidate profiles at all stages of recruitment • Reviewing our recruitment and on-boarding process to make them more inclusive with people with disabilities.	• Work with Purple Network and review recruitment process (including job adverts) • Deliver inclusive recruitment training (including unconscious bias)	November 2022 October 2022
Continue to address the poorer experience of disabled staff reported through the NSS for Bullying and Harassment	*Inequalities and differentials in experience:* • *Just Culture* • *Bullying and Harassment*	• Promote Trust's Positive Action Policy about bullying and harassment, supported by Comms to reduce violence against our staff by patients and their families – development of a violence and prevention and reduction strategy/policy • Appointment of an OD violence reduction lead to tackle issues of violence against our staff. • Continue to promote reasonable adjustments policy and provide guidance and clarity for our staff with a disability and managers.	• Reduction of Bullying and Harassment to be a key deliverable of the newly formed EDI Team. • Continue to promote Reasonable Adjustment Policy. • Continue to offer drop-in sessions to guide managers and staff about Reasonable Adjustment Policies. • Embed Reasonable Adjustments Policy work EDI into Leadership Training for managers • Continue to promote the Reasonable Adjustments Policy through the internal communication channels for staff and managers.	January 2023 October 2022 October 2022 December 2022 December 2022

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
		• Work with the Purple Network to improve use of soft intelligence about people's experience, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes.		
Continue to invest in developing compassionate and inclusive leadership	*Leadership and Management*	• Continue to thread EDI into Leadership and Management Training	• Review all Leadership and Management Training through EDI lenses. • Embed EDI in Leadership and Management Training. • Participate in the ICS Pilot for Empowerment Passport	November 2022 December 2022 January 2023
Provide inclusive career progression opportunities for development	*Inequalities and differentials in experience:*	• Use of reliable and robust data – to understand the experiences of our staff and proactively use data to address areas of concern. Work with the Purple Network to improve our use of soft intelligence about people's experiences, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes, Well being offering	• Career conversations embedded into the annual appraisal process • Implement and fully embed an inclusive talent management system, to support the development of a talent pipeline • Promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, • Identify any specific gaps in process/opportunities requiring some targeted or bespoke training • Launch and promote a new inclusive talent management strategy	November 2022 December 2022 December 2022 November 2022 December 2022

Trust Board Committee Paper

Board Meeting Date	13th September 2022
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
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
Legal Implications	N/A
Equality and Diversity 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, highlighting new schemes, those moving to business as usual or recently closed, together with key risks of those in progress.
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: 30th August 2022

Purpose

This document has been prepared to update the Trust Board at its September 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	30.08.2022	Karen Watkins & Neil Murton	The document includes an updated version of the Combined Projects/SIP Report submitted to the Business & Finance Executive on 22nd August 2022

Distribution:

All Trust Board Members

Document References

Document Title	Date	Published By
Quarterly Status Report on Key Trust Initiatives	April 2022	Karen Watkins & Neil Murton Director of Projects
Quarterly Status Report on Key Trust Initiatives	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 Trust's 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.

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 was provided to Board Members in May, September and December 2021 to provide an update on the Trust's key schemes. It was then requested that an overview be provided for members, rather than the full report and the first of these was provided for the February 2022 Trust Board and most recently to the May 2022 meeting.

An overview is provided here 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 along with associated implications and risks.

Trust prioritised projects

The current portfolio of prioritised programmes and projects included on the Strategic Prioritisation Board is 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 (now moving to business as usual) • Community Hospitals ePMA (electronic prescribing and medicines administration) • Safety Strategy • CYPF Referral Management System	**Supporting True North Goal 3 – Good Patient Experience (improving outcomes)** • East Children's Therapies (currently paused) • Community Mental Health Transformation Programme (incorporating Frimley and BOB CMH transformation and the CPA Framework Alternative Model into one initiative reporting to a Programme Board] • Neurodiversity Strategy • Virtual Wards (Berkshire West Hospital at Home) • Community Rehabilitation Enhanced Support Team (CREST)
Supporting True North Goal 2 – Supporting Our People (A great place to work) • People Strategy • EDI Strategy	**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) * • Reading Estates Review Part 2* • Replacement of Fitzwilliam House*

* these initiatives do not feature on the Prioritisation Board but are included with reports to the Business & Strategy Executive Group.

Summary of Project progress end of August 2022

The current status of the Trust's key Programmes and Projects is summarised below:

Project	RAG Status	Comment
Children's Therapies East	Paused	Previously Red due to associated risks but due to lack of progress and the dependency on other organisations, this initiative is currently paused, awaiting developments.
Frimley Community Mental Health Transformation (Phase 2)		
People Strategy		Overall reporting Amber, but Attraction & Retention workstream reporting RED (see narrative below)
EDI Strategy		Progressing in accordance with plans but as yet, not yielding the desired impact.
Community Mental Health Transformation Programme		This programme now incorporates the Frimley and BOB CMH transformation and the CPA Framework Alternative Model.
Prospect Park Bed Optimisation		Currently behind schedule re. achieving its associated cost improvement target.
Community Rehabilitation Enhanced Support Team (CREST)		Previously CERT and renamed in line with other new services elsewhere.
ePMA (electronic prescribing)		Now working to a later timescale
Safety Strategy		
Green Plan		Progress impacted by challenges in recruiting Sustainability Manager.
Neurodiversity Strategy		
CYPF Referral Management System		Initial resourcing issues - now resolved
Virtual Wards (Berkshire West Hospital at Home)		NHSE/I initiative to improve capacity and flow.
Redevelopment of East Community Hospitals		This is a system initiative which has challenges in terms of complexity, scope and timescales (capital needing to be spent by March 2024).
Fitzwilliam House replacement		Previously Red, but now rated Green due to certainty around the future premises and associated timescales.
Reading Estates Review Part 2		Slightly behind intended timescale.

One project is rated Red:

Redevelopment of the East Berkshire Community Hospitals – a Frimley system initiative to establish Integrated Care Hubs across the ICS and include new build and refurbishments of NHS community estate. The Trust is supporting the project team (particularly regarding financials). It is rated **Red** due to the status of the work in relation to current national submission deadlines. There is a requirement for capital to be spent by March 2024, which will be challenging on basis of timescale, project scope, complexity and capital / revenue affordability.

Eight projects are rated Amber:

People Strategy - This includes several workstreams. The overall status of Amber relates to the work on attracting & retaining staff. The turnover rate for June 2022 remained high at 16.84%, reflecting continued pressures in the employment market. The pressure to replace leavers has in turn impacted on the recruitment team which is also experiences high turnover due to these pressures. In the meantime, the first cohort of international nurses has arrived and commenced employment with the Trust. A Rapid Improvement Event regarding staff retention is planned for September.

EDI Strategy - The actions to implement the Strategy are continuing to progress in accordance with our plans, but as yet these have not yielded the desired impact. In part, this may be due to delays in major programmes of work (now back on plan) around the talent development and refresh of the leadership offer.

Prospect Park Bed Optimisation project – This initiative (which comprises a number of work streams) is reporting as Amber as it is currently behind schedule with regard to achieving its associated cost improvement target.

The national target date for the eradication of inappropriate out of area placements (OAPs) is March 2024, but the Trust's target to achieve this is being retained as March 2023.

Community Rehabilitation Enhanced Support Team (CREST) - Progress on the establishment of the team has been impacted by the absence of the Service Manager and also due to the initial advertising of the key role of Team Leader failing to attract any applicants. There has since been interest in this position and short-listing is scheduled for end August. There has been good progress on the development of the service model.

Community Hospital ePMA (electronic prescribing system) - The timescale will slip (from conclusion in September 2022) due to resource issues, including staff turnover and also the legacy of competing commitments in the previous year. The first ward will go live later this year, with the others following in the New Year.

Green Plan – This initiative is reporting as Amber due to the key post of Sustainability Manager remaining vacant and proving challenging to fill (with consequent impact on progress).

CYPF Referral Management System - This project is to improve the effectiveness and efficiency of the referral process for all CYPF services, initially prioritising CAMHS and CYPIT. Currently it is reporting Amber due to uncertainty around resourcing.

Reading Estates Review Part 2 – This is a major strategic review of accommodation in Reading. It is reporting as Amber as it is slightly behind its intended timescale, but good progress has been made and a Strategic Outline Case is due to be presented in September.

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 Initiative

The following new initiative was considered in June 2022 and prioritised as Mission Critical:

Virtual Wards (Berkshire West Hospital at Home) - This is an NHSE/I initiative to improve capacity and flow. The Trust is working in partnership with Royal Berkshire Foundation Trust to develop the Berkshire West element of the BOB Virtual Ward plan. Trajectories have been set to create 17 Virtual Ward frailty beds by December 2022 (there are currently circa 13) and 40 by December 2023.

The following initiative is moving to business as usual:

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.

The following initiatives have been recently closed:

Transfer of Estates & Facilities Management Services to NHS Property Services – The relevant services transferred to NHS Property Services in October 2021, but a number of issues and risks remained and for that reason, the closure of the initiative was delayed until they had been satisfactorily addressed. The Closure Report was presented in May 2022.

CAMHS Tier 4 Service Transformation - An out of hospital service has been established, which enabled the closure of the Willow House Tier 4 inpatient service on 30th April 2021. 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 was presented in May 2022.

Connected Care – This IT initiative within both BOB and Frimley was closed in April.

Berkshire West Ageing Well – The initiative submitted its Closure Report in April.

The programme for Berkshire East Ageing Well is due to continue until March 2023. As this project is being managed with no external or corporate resource required, it has been agreed that it can be completed as a “local” project and does not feature on the Prioritisation Board.

Conclusion

There has been a significant reduction in the number of projects currently featuring on the Trust’s Prioritisation Board, following the successful completion of five significant initiatives. A number of schemes are encountering challenges as detailed above, the most significant being the efforts needed to address the conti8nuing high rate of staff turnover. However, overall, the Trust continues to achieve good progress in pursuit of the Tue North Goals.

Action

The Board is asked to note the progress of the strategic projects and initiatives.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	13 September 2022
Title	**Audit Committee – 28 April 2022**
	Item For Noting and Ratification of the Changes to the Audit Committee's Terms of Reference
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 20 July 2022 and to ratify changes to the Audit Committee's Terms of Reference
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. The Audit Committee reviewed its terms of reference and agreed to add the Committee's role in reviewing the Trust's litigation activity.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered b) To ratify the proposed change to the Audit Committee's Terms of Reference (highlighted in red tracked changes)

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 20 July 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, Director of Finance Graham Harrison, Head of Financial Services Daniel Badman, Deputy Director of Nursing Sharonjeet Kaur (deputising for Clive Makombera), RSM, Internal Auditors Amanda Mollett, Head of Clinical Effectiveness and Audit Melanie Alflatt, TIAA Jenny Loganathan, TIAA Maria Grindley, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Sarah Davaney, Ernst and Young, External Auditors Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Debbie Fulton, Director of Nursing and Therapies, Minoo Irani, Medical Director and Clive Makombera, Internal Auditors, RSM.	
2.	**Declaration of Interests,**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 28 April and 8 June 2022**	
	The Minutes of the meetings held on 28 April 2022 and 8 June 2022 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.	**Clinical Audit Report**	

	The Head of Clinical Effectiveness and Audit presented the paper and highlighted the following points:
	
	• The Clinical Audit Annual Plan 2022-23 included 24 national Quality Account reportable projects and one Board requested audit for the 2022-23 Quality Accounts.
	• In addition, there were four national audits that had previously been reported but had open action plans. There were also four national audits where data had collected during 2021-22 but the national reports were expected to be published during 2022-23.
	• The following national reports published between April 2022 and June 2022 would be presented to the August 2022 Quality Assurance Committee:
	  ○ POMH Topic 19b: Prescribing for Depression in Adult Mental Health Services
	  ○ NCEPOD Physical Health in Mental Health Report
	  ○ National Diabetes Footcare Interim Report
	
	The Committee noted the report.	

6.A	**Board Assurance Framework**	
	The latest Board Assurance Framework had been circulated. The Chief Financial Officer presented the report and highlighted the following points: • **BAF Risk 1** - (Workforce risk) – since the risk was updated, the Trust had agreed to increase the staff mileage rate by 5p per mile to help mitigate the impact of increased fuel costs in respect of work related travel. • **BAF Risk 3** – (System risk) – the Integrated Care Boards (ICBs) became legal entities on 1 July 2022. The ICBs were establishing their structures and recruiting to posts over the coming months. • **BAF Risk 7** – (Cyber security risk) – the Trust was binging forward the introduction of multi-factorial identification in response to increased cyber security threats. • **BAF Risk 8A** – (COVID-19 risk) – it was proposed to close the COVID-19 risk to reflect national infection prevention and control guidance to healthcare providers that COVID-19 should be treated in the same way as any other respiratory air borne infection. The Chair referred to Risk 1 (Workforce) and noted that it was proposed to delete the gap in assurance around apprenticeships to reflect the decision to increase investment in apprenticeships as part of the Trust's work to mitigate the shortage of qualified staff in some hard to recruit to posts. The Chair	

	queried whether the gap in assurance should remain in the light of the advisory Internal Audit review of the Apprenticeship scheme which had highlighted areas for further development. The Chief Financial Officer agreed to discuss whether the gap in assurance around apprenticeships should remain until the work further work highlighted by the Internal Auditors had been undertaken. The Chair referred to Risk 1 (Workforce) and noted that the Trust had identified that the effects of post-COIVD-19 pressures and fatigue on some teams was leading to increased staff tensions and was developing a conflict resolution framework with the help of an external expect to support and tackle these issues. The Chair commented that it was unclear from the action whether the conflict resolution framework was only now required because of the pandemic. The Chief Financial Officer agreed to review the wording around the risk action. The Chair referred to Risk 7 (Cyber Security) and noted that the implementation of the outstanding actions from the Internal Audit Report 2000-21 related to the supplier of one of the Trust's systems not co-operating with the audit recommendations. The Chair asked about the Trust's plan of action if an adequate response was not forthcoming from the supplier. The Chief Financial Officer said that the Trust would have to take a decision about whether or not to continue with the system and that this decision would take account of whether or not there was a suitable alternative system.	**PG/JN** **PG/JN**
6.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chief Financial Officer referred to the Nosocomial Risk on the Corporate Risk Register and reported that it was proposed to close this risk along with the Board Assurance Framework Risk 8A (COVID-19) because COVID-19 was now treated in the same way as any other respiratory air borne infection. The Committee: a) Noted the report b) Approved the closure of the Board Assurance Framework COVID-19 risk (Risk 8A) and the closure of the Nosocomial Risk on the Corporate Risk Register.	
7.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from April 2022 to the end of June 2022 had been circulated. The Committee noted the report.	

8.	**Information Assurance Framework Update Report**	

	The Chief Financial Officer presented the paper and highlighted the following points:
	
	• A total of 5 indicators were audited during Quarter 1:
	  ○ Mental Health 72 Hour Follow-Up (Green for Data Assurance and Red for Data Quality)
	  ○ Self-Harm Incidents on Inpatient Wards (Amber for Data Assurance and Data Quality)
	  ○ Physical Health Checks 7 Parameters for Mental Health Inpatient with a Serious Mental Illness (Green for Data Assurance and Data Quality
	  ○ Physical Assaults on Staff (Green for Data Assurance and Amber for Data Quality)
	  ○ Mental Health Gatekeeping for Admissions (Green for Data Assurance and Amber for Data Quality
	• The Mental Health 72 Hour Follow Up was a critical indicator for patient safety and therefore the Trust needed to have confidence that the process and information was accurate and up to date on this time limited measure. The audit had identified similar errors from previous audits in the data and further work was being undertaken to address these issues.
	• The Self-Harm indicator audit identified inconsistencies in the reported data with the information on the RiO system.
	• The Physical Assaults on Staff indicator audit identified that not all assaults were still not being recorded on the DATIX system
	• The Mental Health Gatekeeping for Admissions indicator audit identified that further work was required to communicate the correct process for inpatients record keeping via the Data Quality Forums
	• Action plans had been put in place to address the identified issues and previous actions were tracked in the report.
	
	The Chair commented that there had been data quality confidence issues with Mental Health 72 Hour Follow-Up indicator for some time.
	
	The Committee noted the report.	

9.	**Losses and Special Payments Report**	
	There was no Losses and Special Payments Report due to the small number of cases. The report to the October 2022 Audit Committee would cover quarters 1 and 2.	
10.	**Clinical Claims and Litigation End of Year Report**	
	The Deputy Director of Nursing presented the paper and reported that during quarter 1 there were five new claims opened all of which related to clinical negligence claims. It was noted that four out of five of the new claims had already been investigated as serious incidents. The fifth claim related to an alleged incident relating to WestCall in 2019. The Committee noted the report.	

11.	**Anti-Crime Service Progress Report**	
	Melanie Alflatt, TIAA introduced her colleague, Jenny Loganathan who was also in attendance at the meeting. Melanie Alflatt presented the report and highlighted the following points: • The Counter Fraud Functional Standard Return had been completed. The assessment made by the Trust against the NHS requirements comprised of 11 green and two amber ratings for components 3 and 11. The work required to move the amber ratings to green was set out in appendix a of the report. The provisional overall rating for the Trust was 'Green' and this would be confirmed following submission • The Fraud Risk Assessment had commenced and was almost compete. This would address the Trust's amber ratings and ensure that the Trust achieved compliance with Requirement 3 of the Counter Fraud Functional Standard Return The Chair referred to Counter Fraud Functional Standard no 11 – access to and completion of training which currently had an amber rating and asked whether there were any concerns. Jenny Loganathan said that the lifting of the COVID-19 restrictions meant that things were returning to normal, including the ability to hold face to face training sessions and confirmed that the number of training sessions would be increased during the year. The Chair referred to page 114 of the report which referred to TIAA's Fraud Alert in relation to Payment Terminal Machines and asked whether the Trust used Payment Terminal Machines. The Head of Financial Services said that the Trust did use Payment Terminal Machines, but confirmed that following a risk assessment, the Trust had identified that the fraud risk was low. The Chair referred to page 117 of the report which referred to TIAA's Fraud Alert in relation to False Invoices and asked whether there were control weaknesses around a single person being able to raise invoices. Jenny Loganathan said that there were no concerns around a single person being able to raise invoices because someone else would be responsible for approving the invoice. The Chair noted that the actions around mitigating risks around false invoices were focussed around staff and asked about any actions in relation to suppliers. Jenny Loganathan confirmed that she was in discussions with the Chief Financial Officer about taking formal action in relation to the suppliers. Mehmuda Mian, Non-Executive Director referred to page 116 of the report which concerned an individual who was working for an agency whilst off sick and also who had overlapping shifts and commented that she was surprised that it had not been possible to establish how many hours the individual had worked for each organisation.	

	Jenny Loganathan said that the investigation had highlighted weaknesses in the agency's record keeping processes. Ms Mian asked whether TIAA and the Trust would be feeding back to the agency about the importance of maintaining adequate records in relation agency workers hours worked. Jenny Loganathan confirmed that this was something that TIAA via the Trust would feedback to the agency and would share best practice in relation to record keeping. Naomi Coxwell, Non-Executive Director said that it would be helpful if TIAA's Annual Report could contain a graph of historical occurrences. Ms Coxwell commented that the test of any system was whether or not it was working in a systemic way by looking at data over a longer time frame. Jenny Loganathan agreed to include this information in future annual reports. Jenny Loganathan reported that TIAA had set up a Mental Health Forum with other mental health clients across the South East, South West and London and one of the purposes of the forum would be to share information about cases and to provide more opportunities for benchmarking. Ms Loganathan said that moving forward TIAA would be able to provide information about trends across the patch. The Committee noted the reports.	**MA/JL**
12.	**Internal Audit Progress Report**	
	a) Internal Audit Progress Report Sharonjeet Kaur presented the paper and highlighted the following points: • Since the last meeting, the Apprenticeships report had been issued. This was an advisory report and therefore no opinion rating had been assigned. RSM's Apprenticeship specialist had conducted the review and had identified a number of areas for development to support the development of the Trust's apprenticeship strategy • Recent guidance from NHS England/Improvement required the Trust to commission Internal Audit to produce a report for the Audit Committee covering the most recent HFMA publication: "Improving NHS Financial Sustainability: Are you getting the basics right?" highlighting areas of weakness in financial governance and prescribing remedial actions. The Trust's Internal Audit Plan 2022-23 had been adjusted to accommodate the review at no additional cost to the Trust • There were no overdue actions The Chair asked whether the Director of People had commented on the Apprenticeship report. Ms Kaur said that the Director of People had recognised that the Trust's apprenticeship programme was not as developed as in some other trusts and had found the Internal Auditors report very supportive and would help the Trust to develop its apprenticeship programme. Naomi Coxwell, Non-Executive Director said that historically the Trust had an ad hoc approach to apprenticeships but the additional investment would mean that the Trust would be able to develop the apprenticeship programme at scale. Ms Coxwell commented that the Internal Auditor's review was timely and	

	would help the Trust to ensure that there were the appropriate governance systems and processes in place around the apprenticeship programme. b) **Cyber Security Report** – the report had been circulated for information c) **NHS News Briefing** – the report had been circulated for information The Committee noted the reports.	
13.	**External Audit Report (Verbal)**	
	Maria Grindley, E&Y, External Auditors updated the Committee on the progress that had been made to resolve the issue over the different valuations of the Trust's PFI properties by the District Valuer who valued the Trust's buildings and E&Y's own valuation experts. Ms Grindley explained that until the property valuation issue had been resolved, the External Auditors were not able to approve the Trust's Accounts 2021-22. It was noted that NHS England/Improvement had been informed and that they were being kept up to date with any developments. Ms Grindley thanked the Finance Team for their ongoing help and support with the external audit. The Chief Financial Officer thanked Ms Grindley for her positive comments about the Finance Team and commented that the Finance team had worked hard to respond promptly to the External Auditors' queries. The Chief Financial Officer reported that the Trust had commissioned another professional Valuer to undertake an independent valuation. The Chair asked about the impact of the Trust's Annual Accounts 2021-22 if the agreed property valuation was significantly different from the figures contained in the draft accounts. The Chief Financial Officer explained that a revised valuation may impact on the depreciation figure in the accounts. Naomi Coxwell, Non-Executive Director asked whether the Committee would need to re-convene to approve the final Accounts 2021-22. The Chief Financial Officer said that the final Accounts 2021-22 could either be approved via email or a meeting of the Committee could be convened if the proposed changes were significant. The Committee thanked Ms Grindley for her verbal update.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 28 April 2022**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 28 April 2022 were received and noted.	
15.	**Minutes of the Quality Assurance Committee held on 07 June 2022**	
	The minutes of the Quality Assurance Committee meetings held on 07 June 2022 were received and noted.	

16.	**Minutes of the Quality Executive Committee Minutes –**	
	The minutes of the Quality Executive Committee meetings held on 19 April 2022, 16 May 2022 and 20 June 2022 and were received and noted.	
17.	**Audit Committee Annual Review of Effectiveness and Terms of Reference Review**	
	The Audit Committee's annual review of effectiveness and proposed changes to the Committee terms of reference had been circulated. The Company Secretary thanked all those who had competed the questionnaire and commented that the results were very positive. Maria Grindley, E&Y External Auditors pointed out that one respondent had commented negatively about the overly detailed and lengthy External Auditor Report. Ms Grindley thanked the respondent for their feedback and agreed to make the executive summaries more concise and relevant to the Trust with the more generic sector wide information contained within the body of the report. Mehmuda Main. Non-Executive Director commented that she found the sector wide information provided by the Anti-Crime Specialist, Internal and External Auditors very useful and informative. The Chair referred to section 6.21 of the Committee's Terms of Reference: "The Committee will provide assurance on the system for identifying cost improvement plans, including the process for ensuring that there are no adverse impacts on quality". The Chair queried whether it would be more appropriate for this to be included in the Quality Assurance Committee's Terms of Reference. The Chair agreed to discuss the issue with the Chair of the Quality Assurance Committee. The Committee: a) Noted the results of the annual review of the Committee's effectiveness b) Approved minor changes to the Committee's terms of reference which the Trust Board would be asked to ratify.	**MG** **RG** **JH**
18.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Charitable Funds Account sign off was changed to January 2023. The Committee's Annual Work Plan was noted.	**JH**
19.	**Any Other Business**	
	There was no other business.	
20.	**Date of Next Meeting**	

	26 October 2022	

The minutes are an accurate record of the Audit Committee meeting held on 20 July 2022.

Signed: - _____

Date: - 26 October 2022 _____

Berkshire Healthcare
NHS Foundation Trust

Terms of Reference

Audit Committee

Purpose

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

Document Control

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

Document References

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

Authority

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

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

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

Purpose

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

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

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

b. Annual Plan declarations relating to the Assurance Framework.

Membership

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

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

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

3.4 A quorum shall be two members.

In attendance at meetings

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

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

- The Company Secretary

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

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

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

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

Frequency and Administration of Meetings

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

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

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

Duties

Governance Risk Management and Internal Control

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

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

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

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

b. The underlying assurance processes that indicate the following:

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

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

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

Audit & Counter Fraud

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

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

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

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

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

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

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

6.6 Clinical Audit

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

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

Financial Reporting

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

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

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

Reporting

6.11 The Committee will routinely review the minutes of:

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

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

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

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

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

a. The fitness for purpose of the assurance framework.

b. The completeness and embeddedness of risk management.

c. The integration of Governance arrangements.

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

Other functions

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

6.16 It will review the following:

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

b. Any decision to suspend Standing Orders

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

d. The Trust's Litigation activity ~~New and existing claims~~

e. Information Governance and Caldicott Guardian Annual Report

6.17 It will approve changes in accounting policies.

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

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

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

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

Amended: July 2022

Board approved:

Next review: July 2023

Trust Board - Meeting Dates for 2023

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board	10		14			13				10		
Trust Board		14		11	9		11	8 (if required)	12		14	12
Audit Committee	26			27	17 tbc		26			25		
Finance, Information and Performance (FIP)	26		23	27			27			26		
Quality Assurance Committee (QAC)		28			30			29			28	

Council of Governors Dates 2023

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			8			14			27			6
Trust Board / Council Meeting		01 (NED)			03 (Board)		19 (NED)				01 (Board)	