Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 14 November 2023

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 12 September 2023	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story – Building Resilience and Valuing Emotions (BRAVE) Project	Debbie Fulton, Director of Nursing and Therapies/Natasha Berthollier, Consultant Counselling Psychologist	Verbal
6.1	Staff Health and Wellbeing Update Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
6.2	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Six Monthly Safe Staffing Report *(NB the Finance, Investment and Performance Committee reviews the monthly Safe Staffing Reports)*	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.4	Research and Development Annual Report	Dr Minoo Irani, Medical Director	Enc.
6.5	Patient Safety Incident Response Policy and Plan Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 06 2023/24 Finance Report	Paul Gray, Chief Financial Officer	Enc.

No	Item	Presenter	Enc.
8.1	Month 06 2023/24 Performance Report	Paul Gray, Chief Financial Officer	Enc.
8.2	Finance, Investment and Performance Committee Meeting held on 26 October 2023	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	National Six Equality, Diversity and Inclusion Actions Progress Report	Alex Gild, Deputy Chief Executive/Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting on 25 October 2023	Rajiv Gatha, Chair, Audit Committee	Enc.
10.1	Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
10.2	Council of Governors Update	Martin Earwicker, Trust Chair/Mark Day, Vice-Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting –12 December 2023	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 September 2023

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Naomi Coxwell	Non-Executive Director
	Rebecca Burford	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Tehmeena Ajmal	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Jane Nicholson	Director of People (*present for agenda items 9.0, 9.1 and 9.2)*
	Ash Ellis	Deputy Director for Leadership, Inclusion & Organisational Development (*present for agenda items 9.0 and 9.1)*
Observers:	Tom Lake	Public Governor
	Guy Dakin	Staff Governor

23/154	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting.
23/155	**Apologies** (agenda item 2)
	There were no apologies.

23/156	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
23/157	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
23/158	**Minutes of the previous meeting – 11 July 2023** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 11 July 2023 were approved as a correct record.
23/159	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
23/160	**Board Story – Older Adult Mental Health (**agenda item 6.0)
	The Clinician scheduled to present the Board Story had to tend to an urgent clinical matter and was therefore unable to attend the Board meeting.
23/161	**Patient Experience Quarterly Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented the paper and highlighted the following points: • Following feedback from the Chair, the format of the report had changed. The report now included a summary report. The agenda for Board members included links to the full patient experience report and its appendices (the public Trust Board meeting pack contained the full report). • The Patient Experience Summary Report included a new table which provided the overall Trust metrics complied in relation to patient experience together with arrows to indicate changes in the Trust's performance in comparison with quarter 4 (2022-2023) • The Patient Experience Team was working hard with the Divisions where there were large footfalls, but low patient feedback (for example, Children's Services) received via the I Want Great Care tool • As requested by the Trust Board, the full Patient Experience Report included examples of changes which had been made because of patient feedback ("You Said, We Did") Sally Glen, Non-Executive Director said that it was positive to read about the examples of patient feedback resulting to improvements to services. Ms Glen asked for more

	information about the alternative ways the Trust was developing to capture feedback from patients at Prospect Park Hospital. The Director of Nursing and Therapies explained that Prospect Park Hospital was starting to use Community Groups facilitated by either peer support workers or psychological therapies staff. The Director of Nursing and Therapies said that further work was needed before the feedback from these informal discussions was in a suitable format to be included in the report. Mark Day, Non-Executive Director referred to page 55 of the full agenda back and noted that the Trust continued to receive I Want Great Care scores of 1 (the lowest rating) but the very positive comments alongside the rating did not equate to a low score and pointed out that I Want Great Care was aware of the issue but had no plans to amend the supporting information that was provided about the rating scale. The Director of Nursing and Therapies said that as this was down to human error, it was unlikely that a technological fix could be found. The Chair commented that the "You Said, We Did" improvements were at the very local level and asked whether there was a process for capturing common themes and/or ideas that could be implemented in other areas. The Director of Nursing and Therapies said that the three Divisions discussed patient feedback at their respective divisional meetings and the minutes of the divisional meetings were reported to the Quality and Performance Executive Group meetings so there was visibility around what each Division was doing. Naomi Coxwell, Non-Executive Director asked whether the Trust could anticipate some complaints before they were submitted. The Director of Nursing and Therapies confirmed that in some cases, the Trust had already tried to locally resolve an issue before a formal complaint was submitted. It was noted that around 50% of formal complaints were not upheld. The Chair asked whether Board members liked the new format of the report. There was agreement that the new format was helpful. **The Trust Board**: noted the report.
23/162	**Quality Assurance Committee** (agenda item 6.2)
	The minutes of the Quality Assurance Committee meeting held on 29 August 2023 together with the Learning from Deaths and Guardian of Safe Working Hours Quarterly Reports had been circulated. Sally Glen, Non-Executive Director reported that the Committee had discussed the Sexual Safety Six Monthly Report, the Trust's progress on the implementation of the National Patient Safety Strategy and had received an update on the Trust's Suicide Prevention work as well as the standard agenda items. Ms Glen reported that the Committee had also received the results of its annual review of effectiveness which were positive and had made minor changes to its terms of reference.

	The Learning from Deaths Quality Report and the Guardian of Safe Working Hours Quality Report had been circulated. Ms Glen reported that following the Lucy Letby conviction there was a national focus on mortality review systems and processes across all trusts. The Chair referred to page 101 of the agenda pack and noted that the number of deaths had declined year on year. The Medical Director cautioned against drawing any conclusions about the number of deaths as most of the deaths related to elderly people and/or people nearing the end of life and therefore there would be year on year variations. Mark Day, Non-Executive Directors noted that of the deaths requiring further review, five were classified as serious incidents requiring investigation and asked for more information. The Medical Director explained that the first stage of the process involved a review of all reported deaths without differentiating between suicides, unexpected deaths and end of life deaths. The next step involved filtering out those deaths which would be reported as serious incidents, and these deaths would be included in the Serious Incident Reports presented to the Quality and Performance Executive Group and the Quality Assurance Committee meetings. The much larger proportion of reported deaths would then be subject to a second stage review with learning themes identified for services. It was noted that there were zero exception reports in the Guardian of Safe Working Hours Report. T**he Trust Board:** a) Noted the minutes of the Quality Assurance Committee held on 29 August 2023 b) Ratified minor changes to the Committee's Terms of Reference c) Noted the Learning from Deaths Quarterly Report d) Noted the Guardian of Safe Working Hours Quarterly Report.
	Executive Report (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) NHS England's Letter Following the Lucy Letby Trial Verdict** A copy of NHS England's Letter to Trusts following the Lucy Letby trial verdict together with a summary of relevant national initiatives and the Trust's patient safety work had been circulated. The Chair commented that the summary of the Trust's patient safety work provided the Trust Board with assurance that the Trust was focused on developing and maintaining open cultures where staff felt able to speak up. The Chair reported that in the wake of the Lucy Letby trial conviction, the Medical Director and hehad attended an event for Chairs and Chief Executives (or their nominees) to meet with members of NHS England's Board. The Chair said that one of the key issues discussed was around the importance of not regarding the Lucy Letby case as a one-off

but looking at the underlying issues within the context of the common themes across other national inquiries into NHS failures.

b) Right Care, Right Person

The Chief Executive reported that the Government had recently published the National Partnership Agreement limiting the police response to mental health crises which will see the Right Care, Right Person approach being implemented.

The Chief Executive said that the way this had been described in the media had caused some concern, particularly when it was reported in May 2023 that the Metropolitan Police would no longer attend 999 calls linked to mental health incidents from September 2023. Due to stakeholder concern, the date of implementation across London had now been delayed by two months to allow for greater engagement with partners and patient groups.

The Chief Executive reported that he had discussed the changes with the Thames Valley Chief Constable who was clear that Thames Valley police would continue to provide a response where there was a clear policing purpose, that is, an immediate threat to life and/ or an immediate threat of serious injury.

It was noted that section 136 of the Mental Health Act provided the power for police to remove a person believed to be suffering from a mental health disorder and to be in need of immediate care and control to a Place of Safety. The Chief Executive said that if the Trust's Place of Safety at Prospect Park Hospital was full, the police would have to wait with the patient in their car until a place was available. The Chief Executive said that under a pilot scheme in Humberside, NHS staff rather than the police waited with patients until they could access the Place of Safety.

The Chief Executive said that the Trust had an excellent relationship with the Thames Valley Police and would work together to ensure that the move to the new Right Care, Right Person approach went smoothly.

Sally Glen, Non-Executive Director commented that the Humberside pilot involved additional NHS funding.

The Chief Executive said that the mental health trusts would need to work with their commissioners to agree additional funding.

c) National Cost Collection Submission

It was noted that the Trust was required to complete a National Cost Collection submission each year. The Trust Board agreed to delegate responsibility for approval of the National Cost Collection submission to the Finance, Investment and Performance Committee.

d) Staff Flu and COVID-19 Booster Vaccination Campaign 2023

The Trust Board recorded their commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated against flu and COVID-19. The Trust Board also agreed that members of the Trust Board and Senior Managers should receive their vaccinations and publicise that they had done so to staff across the Trust.

e) Institute for Fiscal Studies' Analysis of the NHS Long Term Workforce Plan

The Chief Executive commented that the Institute for Fiscal Studies' analysis of the NHS Long Term Workforce Plan had highlighted that a significant amount of additional

	investment would need to be allocated to deliver the NHS Workforce Plan – the equivalent of an extra 6p on income tax. The Chair said that the analysis demonstrated that it was imperative that the Trust and other NHS provider organisations maximised the potential of digital systems and developed new service models so that services were delivered in the most efficient and cost-effective way. Naomi Coxwell, Non-Executive Director asked whether the Integrated Care Boards were considering the financial impact of the NHS Long Term Workforce Plan. The Chief Executive said that the Integrated Care Boards would look to NHS provider organisations to help shape the debate about workforce. The Chief Executive also pointed out that at a national level there would be significant pressure on capital budgets given the scale of the RAAC (Reinforced Autoclaved Aerated Concrete) issue affecting many schools. **The Trust Board**: a) Noted the report b) Noted the assurance provided in response to NHS England's Letter following the Lucy Letby trial conviction c) Agreed to delegate responsibility for the approval of the Trust's National Cost Collection submission to the Finance, Investment and Performance Committee d) Agreed to record their commitment to achieving the ambition of 100% of frontline healthcare workers being vaccinated. e) Agreed that all Trust Board members and senior managers should receive their vaccinations and publicise it throughout the organisation.
23/164	**Month 04 2122-23 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust had a plan for a £1.3m surplus as part of the agreed plan for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. • The Trust was reporting a £0.1m surplus against a year-to-date deficit plan of £1.0m. • The Trust was continuing to forecast delivery of the planned £1.3m surplus. • Delivery against the cost improvement plan was on track linked to control total compliance • The 2023/24 pay award, including back pay to April 2023, and the 2022/23 bonus elements were paid in June 2023. After accounting for additional funding, the Trust had estimated a c£1m full year pressure due to the way the NHS tariff uplift was calculated. However, this was currently being offset by delays to recruitment against core allocations • The Trust was operating below NHS England's system agency ceiling of 3.7% (currently running at 2.9% of overall pay costs year to date) • The Trust's cash balance was below plan at £50.1m but this was expected to recover once Integrated Care Board contract payment values were updated for 2023/24. • Expenditure on Out of Area Placements had increased noticeably this month, driven by demand with costs now above plan.

	• The Trust was reporting £0.7m capital spend year to date. Sally Glen, Non-Executive Director asked whether patients requiring a forensic facility counted towards the number of Out of Area Placements. The Chief Operating Officer said that the Out of Area Placements in the report were for adult acute mental health or psychiatric intensive area unit beds. The Chief Operating Officer said that the Trust was managing an increasing number of patients with complex presentations and it was sometimes difficult to find a suitable placement for these patients, some of whom may require a forensic bed. The Deputy Chief Executive said that it would be helpful if the Chief Financial Officer could explain the current financial challenges faced by both local Integrated Care Systems. The Chief Financial Officer explained that the national financial position was extremely difficult and there was a sizable financial deficit year to date. Neither local Integrated Care System was currently on track to deliver their financial plans, mainly driven by the acute hospitals. It was noted that NHS England had issued a number of financial and process controls that they expected all NHS organisations to have in place. The Chief Financial Officer said that the Trust had reviewed NHS England's list of requirements and was compliant with most of them but some of them would require working with the Integrated Care Systems in terms of how they were implemented. The Chief Financial Officer reported that the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System had asked whether that was any scope for the Trust to further improve its financial performance. The Chief Financial Officer said that at the current time it was difficult to take a view of this given the pressure on beds and workforce costs. The Deputy Chief Executive added that the Frimley Integrated Care Board was also reviewing its financial sustainability and controls environment. **The Trust Board**: noted the report.
23/165	**Month 04 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and highlighted the following points: • There were 47 Self-harm incidents on Mental Health Inpatient wards (excluding the Learning Disability Unit) against a target of 42. CCTV footage had been used to review incidents for learning opportunities and a number of actions had been highlighted, including staff needing to be more proactive and incidents relating to leave and also vaping. Counter measures included: involving patients in decision making and staff listening to patients • A new line of enquiry was underway looking at patients with autism or attention deficit hyperactivity disorder and their higher prevalence for self-harm and use of restraint. Countermeasures were being reviewed with the Neuro-diversity team but included sensory bags, noise cancelling headphones and focused work to make the environment more sensitive. • Performance against the new Clinically Ready for Discharge by Wards breakthrough objective was 712 lost bed days against a target of 250 lost bed

	days. The Trust's current focus was on the discharges of longer stay patients which was driving up the number of lost bed days and this would remain RAG rated red for a few months until the longer stay patients were discharged safely • The staff turnover figure had reduced from 17.02% in August 2022 to 14.35% in July 2023. • Audiology waiting time performance had dropped to 92.09% in June 2023 but had performance had recovered in July 2023 with performance at 97.79% of patients referred for audiology diagnostic tests being seen within six weeks of referral • Bed occupancy (mental and community health) and mental health average length of stay remained high and reflected the increased demand for services. The Chief Operating Officer reported that the Trust was working with the Integrated Care Systems to develop their winter plans. The Chair noted that performance in relation to Health Visiting (new birth visits within 14 days) was at 86.8% against a target of 90% and had been RAG rated red for the last year. The Chief Operating Officer reported that the caseload for Health Visiting services had significantly increased over the last two years. The Chair said that it was important that the Trust did everything it could to ensure that Health Visitors' caseloads were manageable to reduce the risk staff taking time off with stress etc. **The Trust Board**: noted the report.
23/166	**Finance, Investment and Performance Committee Meeting (agenda item 8.2)**
	Naomi Coxwell, Chair, Finance, Investment and Performance Committee confirmed that there were no issues to highlight from the meeting which had not already been raised as part of the Finance and Performance Reports.
23/167	**Workforce Race Equality Report** (agenda item 9.0)
	The Chair welcomed the Director of People and the Deputy Director for Leadership, Inclusion and Organisational Development to the meeting. The Deputy Director for Leadership, Inclusion and Organisational Development presented the report and highlighted the following points: • The paper provided an overview of the Trust's annual performance against the Workforce Race Equality Standard (WRES) metrics for 2021-22. The data would be published on the Trust's website along with the action plan in line with regulatory requirements • The number of black and minority ethnic (BME) staff had increased by 99 to 1,411 from 1,312 in the previous year. 28.40% of staff were represented in the black minority ethnic category compared with 27.4% last year. The Trust' workforce was more representative of the Berkshire population in terms of ethnicity • Based on the data there were clear areas where the Trust needed to improve. However, 7 out of 9 indicators had seen an improvement over from the previous year. One indicator had declined over the last year: "relative likelihood of white staff

	accessing non-mandatory training and continuous professional development compared to BME staff." The bullying and harassment indicator had stayed the same over the last year • The Trust's race disparity ratio showed that white colleagues were 1.93 (clinical roles) and 1.13 (non-clinical roles) times more likely to progress through the organisation than BME colleagues with regards to their career progression • Actions to further improve the Trust's WRES performance aligned with the Trust's strategic ambitions and priorities, in particular, making Berkshire Healthcare a great place to work for our people. To meet this goal, the Trust had refreshed its strategy and had committed to becoming an anti-racist organisation to address unwarranted differences in staff experience. The Deputy Chief Executive said that although the Trust had acknowledged that there was further work to do, the Trust's Race Disparity Ratio was fairly near the top when compared with other NHS provider organisations within the Trust's two integrated care systems. The Chief Operating Officer said that it was important to understand what the data was telling us. For example, a disproportionate number of BME staff experienced harassment, bullying or abuse from patients, relatives, or the public. Most of these incidents were at Prospect Park Hospital which had a high BME workforce and therefore more work was required to understand how many of these incidents had a racial element. The Deputy Chief Executive said that the point was well made and commented that caution was always needed when reviewing aggregate data. The Deputy Chief Executive said that it was important that the Trust understood where this poor staff experience was taking place. The Deputy Chief Executive said that the anti-racism work would involve engaging and connecting with divisions to highlight and understand where there were hot spots. It was noted that the Trust had initiated a zero-tolerance approach to racial abuse at Prospect Park Hospital. Sally Glen, Non-Executive Director asked whether individual services got the granular detail for their areas to help them develop action plans. The Director of People confirmed that the People Directorate's Business Partners worked with individual areas to develop action plans as part of the business planning process. Naomi Coxwell, Non-Executive Director said that she would be interested to hear about how the Trust was planning to improve performance in relation to BME staff accessing non-mandatory training and continuous professional development indicator. The Deputy Chief Executive said that the Trust had recently launched its new Leadership and Management Development Programme which would be a key driver to unlocking opportunity and would help with staff retention and talent management. The Chief Executive reported that he had discussed the issue of violence towards staff with the Chief Constable. The Chief Executive said that the Trust needed to be clear when an assault had taken place and provide the police with prompt information to help the police who had traditionally found it challenging to deal with assaults occurring within a mental health facility. It was noted that most patients who assaulted staff did have mental capacity. **The Trust Board**: a) Noted the report

	b) Supported the next steps as outlined in the report.
23/168	**Workforce Disability Equality Standard Report** (agenda item 9.1)
	The Deputy Director for Leadership, Inclusion and Organisational Development presented the report and highlighted the following points: • The Workforce Disability Equality Standard (WDES) was the national framework through which trusts were required to measure their performance against thirteen key metrics for staff representation and experience with regard to disability. • The number of Disabled colleagues had increased by 63 to 318 from 255 last year. • 6.41% of the Trust's workforce was represented in the Disabled category, compared to 5% last year. The data shows that the Trust's Disabled workforce was underrepresented by 6.99% compared to overall Berkshire population (13.4%). • A large number (413) of the overall workforce (8.18%) had not declared their disability status. • Overall, there had been positive change and improvement across most of the indicators. However, performance against one indicator had declined this year. Disabled staff were more likely to have felt pressure from their manager to come to work despite not feeling well. This was 6.5% more than non-disabled staff (an increase of 2.5% from the previous year). • An action plan co-created by the Purple (Disabled) Staff Network and Diversity Steering Group was being developed to further improve the Trust's performance. Rebecca Burford, Non-Executive Director noted that some Non-Executive Directors had not declared whether they had a disability and commented that the Non-Executive Directors should lead by example. The Chair thanked Ms Burford for raising the issue and encouraged those Non-Executive Directors who had not already done so to update their entry in the Electronic Staff Record (ESR) system. **Action: Non-Executive Directors** Aileen Feeney, Non-Executive Director asked whether there was any feedback from disabled staff around the Trust making reasonable adjustments. The Deputy Director for Leadership, Inclusion and Organisational Development said that around 80% of staff felt that the Trust was making reasonable adjustments. It was noted that the Trust's requirement to make reasonable adjustments for disabled staff was covered at the Corporate Induction Programme and was built into the Trust's Leadership and Development programmes to ensure that managers understood their responsibilities around supporting disabled staff. **The Trust Board**: a) Noted the report. b) Supported the next steps as outlined in the report.

23/169	**Leadership Strategy Report** (agenda item 9.2)
	The Deputy Chief Executive said that it was mission critical that the Trust invested in leaders and managers development training. It was noted that during the COVID-19 pandemic, the Trust had paused its leaders and managers development programmes. The Deputy Chief Executive reported that the Trust had refreshed its approach and had developed a new Leadership and Management Strategy which was focused around ensuring inclusive and compassionate leadership and management capacity and capability. Sally Glen, Non-Executive Director asked whether the Trust would be developing a bespoke training programme for BME staff (agenda for change bands 8A and above) to help them to progress to more senior positions within the Trust. The Deputy Chief Executive explained that the Trust used to run a programme for BME staff called *Making It Right*, but there was mixed feedback with some BME staff not wanting to be singled out for special treatment because of their ethnicity. Rebecca Burford, Non-Executive Director said that as a Black woman, she sympathised with BME staff who did not want to be singled out for a BME only development programme but suggested that a more subtle approach may be required whereby managers could proactively encouraging BME to put themselves forward for a Leaders and Managers development programme on a case by case basis. Ms Burford said that the Trust also needed to be mindful about intersectionality whereby staff with more than one protected characteristic and/or from a lower socio-economic group may find it even harder to put themselves forward for training and development. The Chair thanked Ms Burford for her helpful comments and said that there would be an opportunity to discuss the Trust's Talent Management and Succession Planning during the In Committee meeting after the Public Board meeting. Mark Day, Non-Executive Director commented that he was pleased that equality, diversity and inclusion was woven into the Leadership Strategy. Mr Day noted that 360-degree feedback would be included in the leader and management development programme and asked about the timescales. The Deputy Director for Leadership, Inclusion and Organisational Development explained that the Trust was already using the National Leadership Academy 360-degree feedback model but was also in the process of developing a bespoke Trust 360-degree feedback tool over the coming month. Naomi Coxwell, Non-Executive Director asked whether the Trust had considered using external experts to develop its Leadership and Management Strategy. The Director of People said that the Leadership and Management Strategy was developed in line with current best practice and built upon the Compassionate Leadership Programme developed in-house by Deborah Lee, Consultant Clinical Psychologist who was an expert in this field. Rajiv Gatha, Non-Executive Director and said that in his view, the Trust's Leadership Strategy reflected current best practice. Mr Gatha said that it would be helpful if the Board

	could have an update about how the Trust was planning to measure the impact on performance. **Action: Director of People** Mr Gatha also pointed out that there was a lot of research around the usefulness of 360-degree feedback models. The Chief Operating Officer said she encouraged staff to work tactically and consider sidewards career moves so that they gained more experience of different roles which would help them when they went for more senior roles. The Chair said that he looked forward to receiving updates about the implementation of the Leadership Development Strategy. **The Trust Board**: noted the report.
23/170	**Audit Committee Meeting Held on 26 July 2023** (agenda item 10.0)
	The Audit Committee minutes of the meeting held on 26 July 2023 had been circulated. **The Trust Board**: noted the minutes of the Audit Committee meeting held on 26 July 2023.
23/171	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that there were a number of new governors, including five out of six new local authority appointed governors following the recent local elections. The Chair commented that Brian Wilson, Lead Governor, was doing an excellent job in encouraging governors to play a full role in the Trust's activities.
23/172	**Schedule of Meetings for 2024** (agenda item 10.2)
	The Chair reminded everyone that the Board had agreed to change the pattern of meetings from 2024. The new meeting scheduled included six formal Trust Board meetings and five Trust Board Discursive meetings. **The Trust Board**: noted the report.
23/173	**Any Other Business** (agenda item 11)
	There was no other business.
23/174	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 14 November 2023.
23/175	**CONFIDENTIAL ISSUES:** (agenda item 13)

	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 12 September 2023.

Signed……. Date 14 November 2023

(Martin Earwicker, Chair)

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 14.11.23

Board Meeting Matters Arising Log – 2023 – Public Meetings

Key:

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

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
13.09.22	22/150	Performance Report	The Finance, Investment and Performance Committee to receive an update on the project on reducing the average length of stay for mental health patients	October 2023	**TA**	An update was presented to the Finance, Investment and Performance Committee in October 2023.	
13.12.22	22/228	Trust's Constitutional Changes	The changes to the Trust's Constitution to be ratified at the next Annual Members' Meeting in September.	September 2023	**JH**	Completed – the changes were ratified at the Annual Members Meeting on	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						27 September 2023,	
11/04/23	23/052	Trust's Green Plan	The new Sustainability Manager to be invited to attend a future Trust Board meeting to share their perspectives and to help the Board to understand which actions were likely to deliver the most benefit in terms of the Green Agenda.	December 2023	**PG**	Scheduled for December 2023	
11.07.23	23/117	Freedom to Speak Up Guardian Report	future Freedom to Speak Up Guardian Reports to include anonymised case study reports.	December 2023	**MC**		
11.07.23	23/120	Annual Complaints Report	The Director of Nursing and Therapies to consider adding an additional column in Table 2 in the report which set out the complaint themes to indicate the number of complaints which were upheld, partially upheld and not upheld.	July 2024	**DF**		
11.07.23	23/133	External Well Led Report and Action Plan	The Company Secretary to update the progress in implementing the Well-Led Review Action Plan in six months' time.	December 2023	**JH**	On the agenda for the December 2023 Trust Board meeting.	
12.09.23	23/168	Workforce Disability Equality Standard	Non-Executive Directors to update the ESR (employee staff record	November	**NEDs**	The Company Secretary emailed	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		Report	system) to declare whether or not they have a disability.	2023		Non-Executive Directors about updating their information on the ERS system.	
12.09.23	23/169	Leadership Development Strategy	The Trust Board to be updated around how the Trust was going to measure the impact on performance of the new Leaders and Managers Development training programme.	November 2023	**JN**	There are several measures we will be looking at for impact of leadership programme, as well as using a variation on Kirkpatrick's evaluation model to monitor impact and behaviour change in attendees (Pre & Post questionnaires – please see appendix 1.) These measures are open to discussion if Board members have any other suggestions for measuring the impact of the leadership	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						programme.	

Appendix 1

Measure	Target
NHS Staff Survey – compassion, inclusion score. *(compassionate culture, compassionate leadership, inclusion, diversity and equality)* NHS Staff Survey – we are a team score. *(team working, line management)*	8 (currently 7.7) 7.5 (currently 7.3)
Number of current / new managers recruited/promoted attending programme (%)	95% (currently no target group)
Workforce Race Equality Standard Workforce Disability Equality Standard Stonewall Pay Gaps	The disparity reducing and inequality of experience being removed.
Workforce retention figures – Stability	Above 90% (currently 84.2%)
CQC – particularly 'well led' domain.	Performance and evidence against the 'we target's'
Trust cultural barometer/heat map – triangulation of data from different sources that show overall performance of team/service area	Cultural improvement across collective measures of barometer/heat map
Outcomes for patients /Patient experience (iWantGreatCare)	+experience 95% (currently 93.42%)

Trust Board Paper

Board Meeting Date	14TH November 2023
Title	**Health & Wellbeing Update**
Purpose	To provide a six-monthly update to Trust Board on health and wellbeing activity
Business Area	Corporate
Author	Jane Nicholson/Steph Moakes
Relevant Strategic Objectives	True North Goal 2: Supporting our staff
CQC Registration/Patient Care Impacts	Deliver safe, compassionate, high-quality care and a good patient experience through a skilled and engaged workforce
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	EDI implications considered
SUMMARY	This paper provides an update on health and wellbeing activity over the last 6 – 12 months and give an indication of the planned milestones ahead.
ACTION	For information and discussion

Report to Trust Board – November 2023

Health, Wellbeing, Engagement & Rewards Update

Introduction

In line with the trust People Strategy, national People Promise and new NHS Health & Wellbeing Framework, health, wellbeing, and rewards continues to be a high priority and profile activity. Our ambitions in this space are to support the trust strategy of being a great place to give care. Some of the measures of this are the scores within the staff survey for recommending the organisation as a place to work, feeling that the organisation takes positive action on health and wellbeing and the extent that the organisation values work. The health, wellbeing and rewards activity is a contributing factor to our high scores in this area.

This paper looks to update on the work that has happened since the last update and give an indication of the planned milestones ahead.

Review:

The last six months have been challenging, particularly from a staffing perspective that has impacted on the team's ability to drive progress on existing and new projects. Two consultations have been conducted with the Wellbeing Matters team following the removal of NHS E/I funding and transfer into a Berkshire Healthcare only service. Another team member has been on secondment with the HR team to support with staffing gaps there and there is a staffing gap in the ergonomics team following retirement and difficulties in recruiting.

Despite the staffing challenges, the Health and Wellbeing team have continued to deliver and since the last board update in May, the following outcomes have been achieved:

Activity	**Target staff group**	**Benefit** (including feedback and uptake where appropriate)

Currently working with HR and operational leads to give all staff an opportunity to share their voice and feedback in the **2023 NHS Staff Survey**. Our response rate is **57%** (as of 2nd Nov) – this is **7% higher** on this date last year and there are over three weeks to go. We are currently **top of our comparator group** trusts who use Picker.	All staff	Increased responses mean that the results are more reliable from within the organisation.
Wellbeing Matters have now finished the transition into a **staff psychological support service only for Berkshire Healthcare staff** (since May 2023) and are fully integrated with the wider Health & Wellbeing team. This is following the consultations with our team. During this period, support to individual staff members and teams has continued as shown by the usage data in the right hand column. Usage has grown in the last 6 months, particularly team support proving popular. The team have also upskilled to enable evidence based provision across the staff support field. This includes Compassion Focused and Acceptance and Commitment approaches, as well as Tree of Life and kindness training. The team has worked closely with other parts of the Trust to improve staff support, including the development of reflective SPACE groups in collaboration with PNA leads for example. New recruitment will embed support to PPH staff. There have been a number of challenges over the past six months which has impacted on some delivery. Some of this relates to the reduced team and therefore bigger impact of sickness/maternity etc., as well as difficulties in recruitment. There are also ongoing system issues which impact on our	All staff	User data since May 2023: **Individual support requests – 374** (includes emails, calls, anonymous contact log forms, silvercloud engagement and NHS self-assessment tool) **Team support requests – 46** (Wellbeing hubs, SSPI's, referral or information forms) **Hubs and workshops delivered – 43** **Mental Health First Aider Training – 61** **Staff Support Post Incident (SSPI):** Team – 13 Individual – 19 **Feedback** Hubs are on average rated 4.25 out of 5 for how valuable staff found them One attendee said *"It was useful to set time aside specifically to discuss our wellbeing and what was going on within the team wellbeing wise. Having the opportunity to have more than one session was useful to be able to reflect back on what had changed through the time between sessions."*

ability to capture and analyse data but also our ability to respond to incidents across the trust.		
Work has continued for our two **NHS Charities Together funded projects** and updates are provided in the next two rows.		
Project 1: Recruit a **Wellbeing activities facilitator** (1 year fixed term contract) to deliver virtual and face-to-face exercise sessions for staff as well as coordinate additional sessions such as mindfulness and nutrition. We have continued to build the schedule of activities available for staff with a minimum of two classes running Tuesday – Friday. There are also three walking groups at different sites and ongoing face to face classes. We were also able to commission two 6 week blocks of running coaching for staff at 3 locations across the trust and as a result two running groups are continuing to run. Michelle, our Wellbeing Facilitator, also attends away days for teams delivering taster sessions and to encourage further sign ups	All staff	Since February 2023: Classes run: 261 Attendees: 1239 Workshops: 3 Attendees: 357 Team/trust events e.g. away days: 20 Site visits: 22 **Feedback** Rating of enjoyment of the class (out of 5) - 4.74 Whether the class will help improve health and wellbeing (out of 5) - 4.73
Project 2: Update 5 rest areas and staff kitchens across the trust. The main work is complete in all rest rooms, with just furniture and finishing touches like décor to complete.	Staff in teams who received the grant funding	Improved working environment. We have sought feedback from the teams to gain an understanding of the impact the improvements have had. Photos and write up from one team attached as an appendix. We continue to chase feedback from other teams although this has been delayed by the staffing gap due to secondment.
Our staff benefits provider contract expired in July 2023. We had hoped to include a home & electronics scheme as part of the offer but have come up against insurmountable IG issues.	All staff	From Jan 23 – Nov 23, we have received 21 Cycle to work orders.

As such, the contracting process for only the cycle to work scheme and lifestyle discounts has been delayed. Access to the scheme has been continued by Vivup while the contract is sorted.		
In July, we launched access to **Salary Finance,** a financial wellbeing provider who offer a range of benefits, designed to help staff take control of their finances and reduce money worries. This includes a learning platform, savings through salary, accessing earning pay in advance and loans through salary. The loan rates may not be the best deal/option for everyone or every situation, they're here for those who may need to access it.	All staff, particularly those impacted by cost of living increases.	Access to services to have greater control over finances such as accessing earned pay ahead of pay day. Improved financial support and subsequent wellbeing. In the first six weeks of the launch, the following user data was captured. **Borrow:** 28 applications 10 full loan offered 2 starter loan offered 10 rejected and debt advice signposted Of the 12 loans issued. 8 – debt consolidation 1 – car 3 – other **Advance:** 20 registered users 9 active users 18 advances @ average £155 **Save:** 3 active save accounts £50 saved

		Our first quarterly report and MI figures are due in November.
Due to both the Wellbeing Matters external site being shut and the internal wellbeing pages needing work following the Nexus update, we have undertaken a huge project with Marcomms colleagues to update and refresh the Health & Wellbeing section on Nexus. We involved stakeholders in the design, particularly our Wellbeing Champions who gave us feedback. The page now brings together all of our wellbeing support, in one place. Some of our popular pages are at the top: Assess your wellbeing, Employee Assistance Programme (Health Assured), Wellbeing Matters, Free Wellbeing Apps, Health and Wellbeing Calendar. Below that, there are new sections including Support for your mental health, support for your physical health, support for your financial health, support at work, support for your team and training and workshops. There are more updates to do, particularly around the visuals and use of icon.	All staff	Easier to navigate and improved search terms to help pages appear when searching. We need to collect some user data and continue to adjust as needed.
We have been supported the HR policy & transformation team to create a Workplace Stress Indicator tool, which replaced our old stress risk assessment. The tool is based on a version by the HSE and aims to help staff identify and address factors known to cause workplace stress. We are promoting the tool in our communications to encourage use and will embed it within support provided, particularly through Wellbeing Matters	All staff	Improving stress management at work

The HR policy & transformation team have also created a menstruation policy and we are actively supporting and publishing this across our Wellbeing Comms	Staff who are menstruating and managers	Creating a culture where those who are experiencing menstrual symptoms feel able to discuss the impact it may be having on them at work or the support they might need in the workplace.
We continue to offer and administrate various wellbeing support and benefits as part of business as usual. This includes Peppy App for menopause and men's health support, Health Assured for in the moment emotional support and counselling, access to eye test vouchers and our early access physio service. We have highlighted some key data from these services on the right	All staff	**Peppy** 314 Menopause users, 73 Men's Health users. Over 80 consultations and 500 live events booked. NPS score of 78. **Health Assured** (Aug 22 – Jul 23) Calls – 514 468 for emotional support/counselling (top themes - anxiety, low mood and bereavement) 46 for advice (top themes - childcare, employment and divorce/separation (legal)) For those who went on to (and have finished) counselling (84), 71% returned to work.
Our milestone awards, including Long Service continues and we have received mostly excellent initial feedback.	All staff	Feeling of recognition and value of our people by the organisation Since April, we have issued: Welcome cards: 429 BHFT service milestone (1-40 years): 898 NHS Milestones (5-40 years): 351 Retirement: 32 We will look to evaluate the awards after the first year
The last Wellbeing Newsletter was distributed in July via post. Unfortunately, we could not go on our normal tour due to staffing levels and sickness in the team.	All staff on sites that are visited	Immediate feedback while we are out on visits is positive and enables proactive conversations about support available, what's missing etc.

The next tour will restart in November/December along with the next version of the newsletter. Our next steps are to work to include our teams who are further afield such as Hampshire.		We need to do some work this year evaluating the reach and usage.

Future Roadmap:

Upcoming project delivery and likely timescales are captured below.

Activity	Target staff group	Intended benefit
As part of the ongoing recognition and reward work, we are currently executing the organisations request to distribute a £50 festive voucher to all staff. As with last year, it was agreed that this would be sent out in November, earlier than normal, to support individuals during what can often be a more costly month.	All permanent staff employed on 1st Nov	Feeling of recognition and value of our people by the organisation Support with cost-of-living pressures
Within Wellbeing Matters, the next six months will be primarily focused on three areas: **Staffing and recruitment** Our immediate priority is to stabilise our staffing post consultation and to build as much cover as possible, including full integration with the wider Health and Wellbeing Team. **Overcoming data issues** Continuing to work with colleagues to overcome issues with Datix reporting so that we can proactively contact staff who have been experienced assault or harm at work.	All staff	Creating the foundations for a stable service who can provide compassionate confidential support for our staff and our teams.

Procuring a data system for the Wellbeing Matters team to enable better record keeping and data insights to inform evaluation **Increasing engagement** Once staffing stabilised post consultations, we will be looking to use our data to target certain areas/teams that may need more support. We also need to continue to build connections with other teams to increase opportunities for collaboration and avoid duplication. Alongside this, the team will continue to deliver the existing service and other projects such as SPACE group facilitator training		
We are due to undertake a organisational diagnostic aligned to the new NHS health and wellbeing framework. This work had been paused while the Wellbeing & Reward Manager is on secondment and is now due to start in December. This will include a focus on better use of data and evaluation of wellbeing interventions.	Teams across the People Directorate and operational colleagues	By undertaking the diagnostic, we will be able to self-asses our current wellbeing offer and prioritise our health and wellbeing work within the context of our organisation and diversity of our people
We are working to produce a full communications plan and wellbeing calendar for 2024. This will give us a planned and sustainable approach to ensure we are using all possible channels to engage with our staff. This will include the Wellbeing Newsletter and tour.	All staff	Improved communications and opportunity for us to gather feedback Planned approach to promoting current and new services (such as Wellbeing Matters, Peppy, Health Assured, Vivup etc) to build engagement by linking with existing awareness days and considering best channels.
Our scope of the estates has had to pause due to the secondment of our Wellbeing & Rewards Manager. This will	All staff using BHFT sites	Creating a healthier workplace and improving equity of access where possible

restart in January, working with our estates and sustainability teams to understand the facilities that our staff have access, what the gaps are and how to improve. This includes multi-faith spaces. We will continue to link in the estates team to ensure that there is no duplication in work.		
We are linking closely with both the sustainability team and BHFT charity team to look at projects that span either some or all of our teams and taking a proactive approach to working together. This includes looking at climate cafes (supporting mental health), litter picks or tree planting (supporting physical health) as well as looking at opportunities for charitable funding.	All staff	Linking our work to create a healthier workplace with the organisations sustainability goals
We will be reviewing and analysing the results of the 2023 Staff Survey when it is published early next year. We will then, along with the EDI team, look to support the HR Business Partners to further develop their action plans in the new divisional structure	All staff	The Staff Survey results are an important data metric to inform internal action and also to use as a recruitment tool. Enables staff to see changes that are made as a result of the staff survey (either directly or indirectly) on their day to day activity
As our two NHS Charities Together funded projects (described earlier) come to an end, we are focusing on the evaluation of the work, communicating this and looking at options for sustainability. This means the projects, particularly the wellbeing activities may not continue after March 2024.	All staff	Uncertain of benefits until we explore some options that may be sustainable after the charitable funding has ceased.
When the Wellbeing and Rewards manager returns to post, we are going to put an enhanced focus on the Wellbeing Champions next year. This will include looking at communications, training and links with other champion networks.	Wellbeing Champions	By creating a bigger, more effective community, we hope to create more positive local team cultures who feel able to keep wellbeing a key focus and are better able to signpost staff to appropriate support

Berkshire Healthcare NHS Foundation Trust

Trust Board Meeting Paper

Meeting Date	14th November 2023
Title	Patient Experience Highlight Report Quarter 2 (July– September 2023)
	Item for Noting
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 2
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience
Relevant Strategic Objectives	True North goals of harm free care, supporting our people and good patient Experience
CQC Registration	Supports maintenance of CQC registration
Resource Impacts	N/A
Legal Implications	N/A
Equality, Diversity and Inclusion Implications	The full report contains a section on demographic profile of people providing feedback.
SUMMARY	The attached report highlights the key facts from the quarterly patient experience report. The Board agenda includes links to the full patient experience report and appendices of that detailing complaint and PALS information, 15-steps visits undertaken during the quarter and detail of formal complaints closed during the quarter.
ACTION REQUIRED	The Board is asked to: Note the report.

Highlight Patient Experience Report
Quarter two 2023/24

1. Why is this coming to the Board?

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

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

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

2. What are the key points?

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

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

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

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

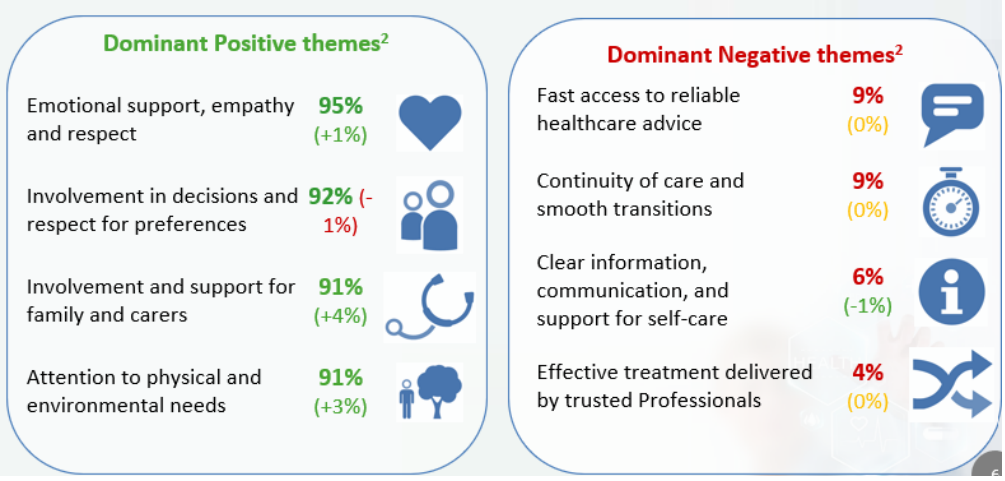
1*Increased from Q4 but within quarterly control limits based on previous quarters over last year
2* Lower than Q4 but less complaints opened in Q4 will result in less to close in Q1, more complaints received in Q1 therefore number closed has increased for Q2.
3* increased from Q4 but within quarterly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

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

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

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

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



*Number in brackets shows change form previous quarter

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

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

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

4. Conclusions and Recommendations for consideration by the Board

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

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

Berkshire Healthcare
NHS Foundation Trust

Patient Experience Report Quarter 2 2023/24

Introduction

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

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

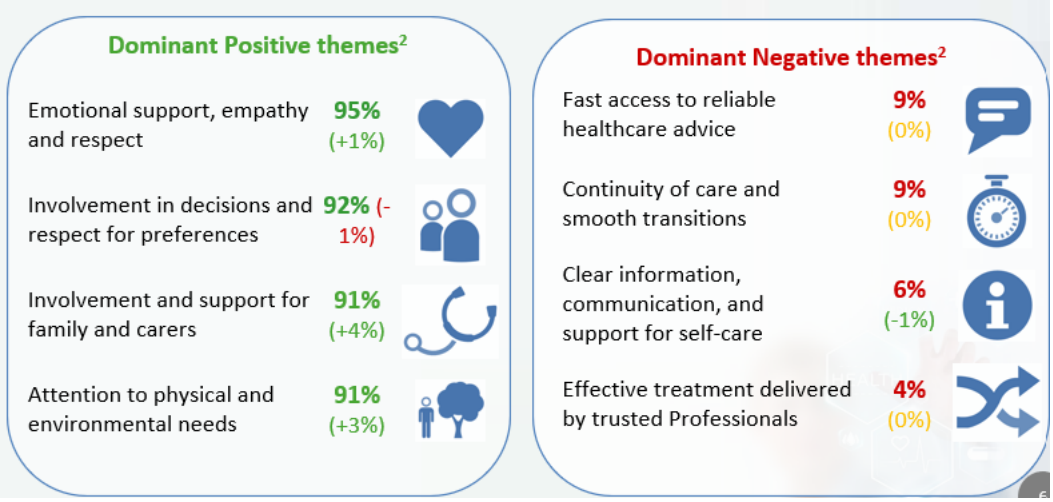
The iWCG tool is used as our primary patient survey programme and is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge via a variety of platforms. The tool uses a 5-star rating which is comparable across all services within the organisation and is based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

Table 1: Overall Trust Summary

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

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

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



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

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

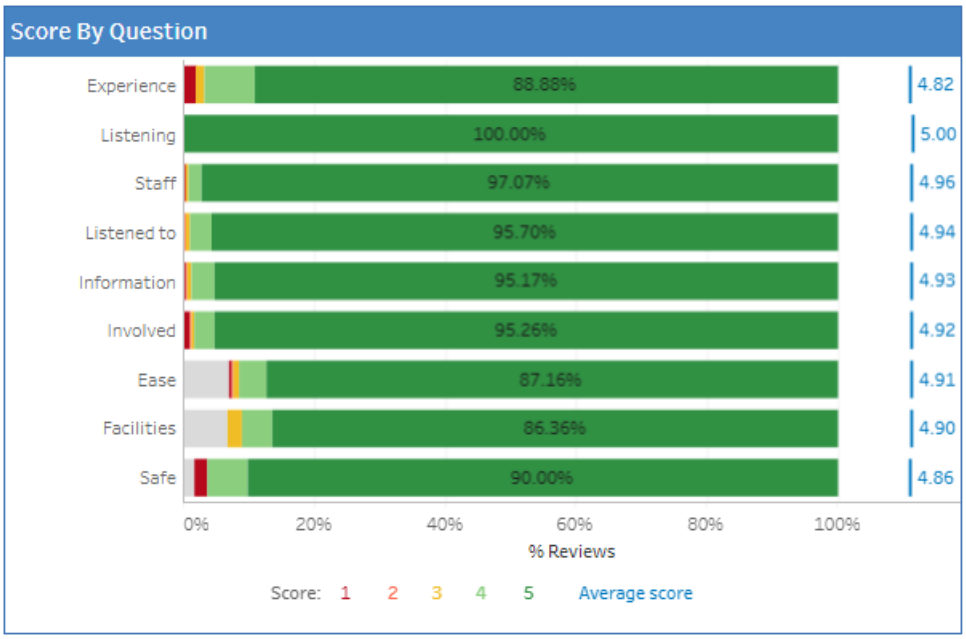
What the data is telling us

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

Children and Young Peoples division including learning disability services.

Table 2: Summary of patient experience data

Patient Experience - Division CYPF and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	556	1169		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.1%	3.4%		
iWGC 5-star score	Number	4.59	4.7		
iWGC Experience score – FFT	%	89.3%	96.6%		
Compliments received directly by services	Number	72	55		
Formal Complaints Rec	Number	14	15		
Formal Complaints Closed	Number	14	14		
Formal Complaints Upheld/Partially Upheld	%	93%	57%		
Local resolution concerns/ informal complaints Rec	Number	6	14		
MP Enquiries Rec	Number	15	7		



For children's services the iWGC feedback has seen the responses double from last quarter, this has been seen across physical health services and further work needs to continue to ensure that we receive responses from those accessing our children and young people's MH services; young people and parents/carers have been assisting in the ways to promote the new patient experience tool to other service users, including the design and layout of the new posters that will now be used across CYPF services.

Of the 1159 responses, 1128 responses related to the children's services within the division; these received 96.6% positivity score, with positive comments about staff being helpful and friendly and a few suggestions for further improvement, this included 3 reviews for Phoenix House where comments about staff being supportive and understanding was very positive and there were some suggestions for further improvement regarding clarity over the extent of the care that will be provided and improvement in communication. 32 of the responses related to learning disability services as detailed below and 20 to eating disorder services.

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

Children's Physical Health Services

There were 3 formal complaints for children's physical health services received this quarter. There were 2 formal complaints about the Speech and Language service. The third complaint was relating to children's OT service.

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

Child and Adolescent Mental Health Services (CAMHS)

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

There have only been 27 responses for CAMHS services received through our patient survey for this quarter. Currently the survey is accessed through paper surveys, online or configured tablets in the departments.

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

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

Compliments for Children and Young Peoples division included *'Thank you for today, it is the first time we have felt truly listened to. X was so relaxed in the appointment and enabled him to be so open and share his views. Thank you for all you have done and going the extra mile.'*

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

Learning disability

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

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

Eating disorders

There were no complaints for eating disorders.

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

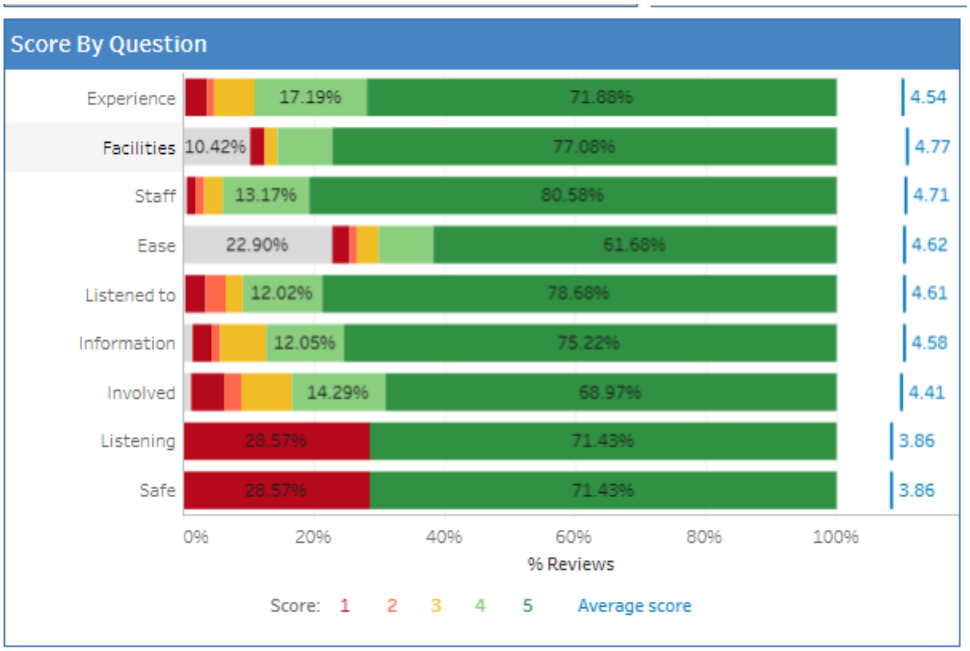
respond quickly to emails or calls. We are so grateful to have this service at our disposal and so very lucky that it is local and easy to get to. Thank you for everything.", "*[name removed], [name removed] and [name removed] are the most amazing team! Their gentle but firm approach led my daughter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

Mental health Division

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

Table 3: Summary of patient experience data

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	449	448		
Response rate (calculated on number contacts)	**%**	2.7%	2.2%		
iWGC 5-star score	**Number**	4.64	4.58		
iWGC Experience score - FFT	**%**	92.7%	89.1%		
Compliments received directly by services	**Number**	37	26		
Formal Complaints Rec	**Number**	16	12		
Formal Complaints Closed	**Number**	16	13		
Formal Complaints Upheld/Partially Upheld	**%**	37%	23%		
Local resolution concerns/ informal complaints Rec	**Number**	4	2		
MP Enquiries Rec	**Number**	1	2		



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

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

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

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

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

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

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

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

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

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

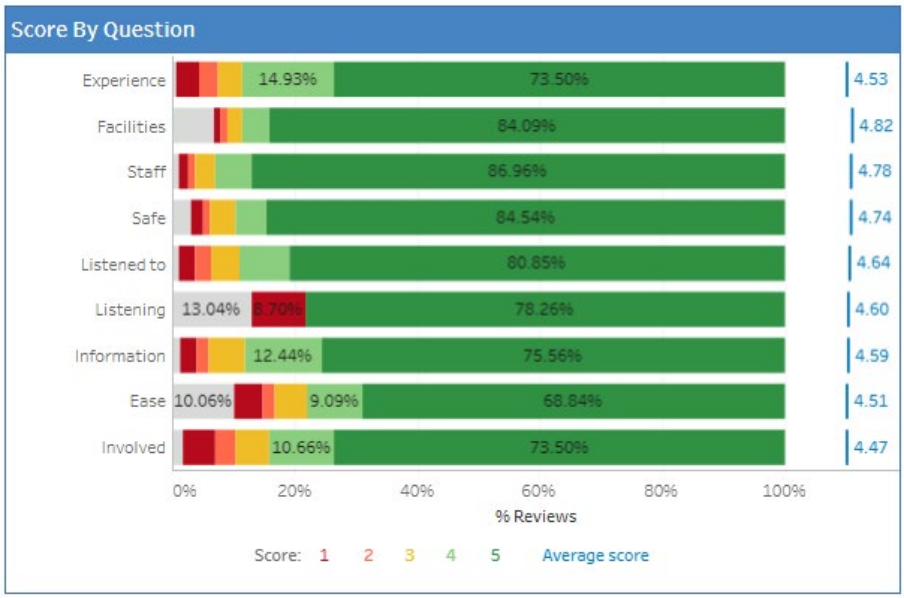
I'm listened to at all. Had an assessment from another service and they were so much more empathetic, caring and listened." There were a number of positive comments about being listened to, staff being understanding, helpful and kind including ''x *has been amazing and helped me alot (sic) and has been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

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

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

Table 4: Summary of patient experience data

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	1246	1219		
Response rate (calculated on number contacts)	**%**	2.5%	2.3%		
iWGC 5-star score	**Number**	4.61	4.58		
iWGC Experience score - FFT	**%**	89.3%	88.4%		
Compliments received directly by services	**Number**	557	403		
Formal Complaints Rec	**Number**	12	15		
Formal Complaints Closed	**Number**	7	13		
Formal Complaints Upheld/Partially Upheld	**%**	43%	54%		
Local resolution concerns/ informal complaints Rec	**Number**	7	5		
MP Enquiries Rec	**Number**	4	0		



The Mental Health West division has a wide variety of services reporting into it, including Talking Therapy services and Court Liaison as well as secondary mental health services. The 3 services with the most feedback through the patient survey were Talking therapies 740 responses, PMS West 83 responses and CRHTT West 81 responses.

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

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

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

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

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

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

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

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

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

Op Courage

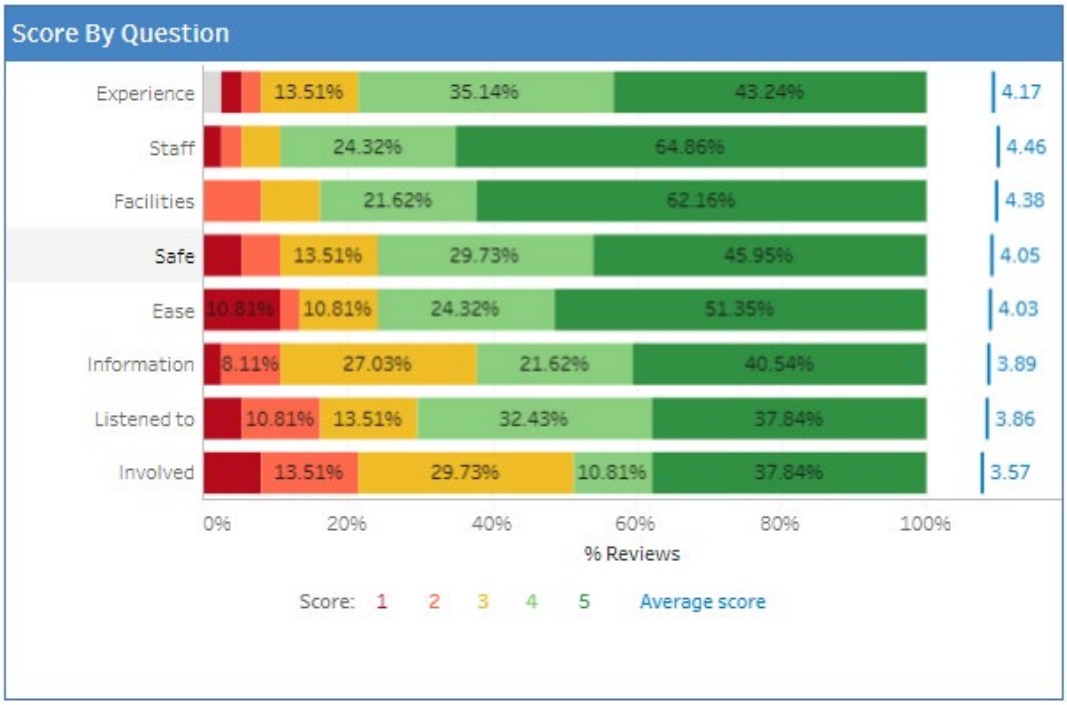
Op COURAGE is an NHS mental health specialist service designed to help serving personnel due to leave the military, reservists, armed forces veterans and their families. During this quarter, the Trust did not receive any complaints about this service.

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

Mental Health Inpatient Division

Table 7: Summary of patient experience data

Patient Experience - Division MH Inpatients		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	43	37		
Response rate	**%**	28.3%	28.5%		
iWGC 5-star score	**Number**	4.30	4.05		
iWGC Experience score – FFT	**%**	88.4%	78.4%		
Compliments	**Number**	12	11		
Formal Complaints Rec	**Number**	10	4		
Formal Complaints Closed	**Number**	5	5		
Formal Complaints Upheld/Partially upheld	**%**	80%	60%		
Local resolution concerns/ informal complaints Rec	**Number**	0	0		
MP Enquiries Rec	**Number**	0	0		



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

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

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

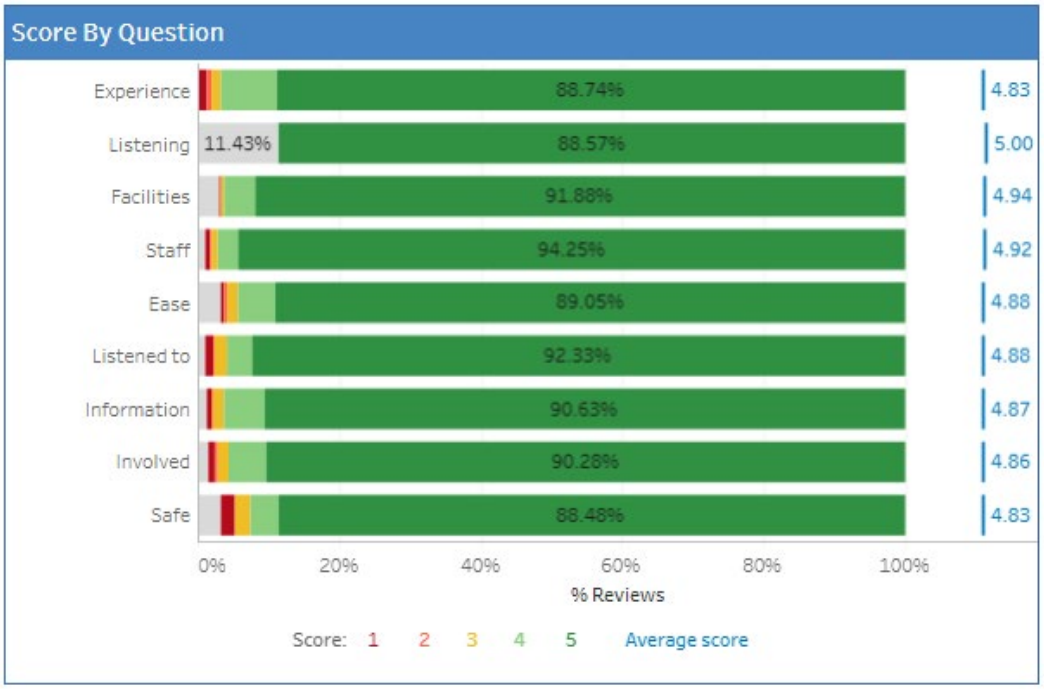
There is ongoing work at Prospect Park to increase feedback including work within the Therapy department.

Community Health Services Division

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

Table 5: Summary of patient experience data

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2044	2016		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.5%	7.1%		
iWGC 5-star score	Number	4.86	4.88		
iWGC Experience score - FFT	%	97%	96.7%		
Compliments received directly into the service	Number	217	401		
Formal Complaints Rec	Number	2	6		
Formal Complaints Closed	Number	2	5		
Formal Complaints Upheld/Partially Upheld	%	50%	40%		
Local resolution concerns/ informal complaints Rec	Number	1	8		
MP Enquiries Rec	Number	1	1		



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

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

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

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

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

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

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

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

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

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

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

Table 6: Summary of patient experience data

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2056	2239		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.5%	2.8%		
iWGC 5-star score	Number	4.81	4.82		
iWGC Experience score - FFT	%	95.1%	96.3%		
Compliments (received directly into service)	Number	196	298		
Formal Complaints Rec	Number	12	10		
Formal Complaints Closed	Number	7	14		
Formal Complaints Upheld/Partially Upheld	%	86%	86%		
Local resolution concerns/ informal complaints Rec	Number	18	25		
MP Enquiries Rec	Number	3	2		

Community Health West saw an increase in responses this quarter. There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 96.3% positive satisfaction and 4.82-star rating and the question on staff receiving a 97.1% positive scoring from the 2239 responses received.

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

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

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

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

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

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

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

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

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

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

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

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

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendances
Asian/Asian British	3.64	8.7	9.67%
Black/Black British	0	3.2	2.67%
Mixed	3.64	2.1	3.49%
Not stated	7.27	12.9	15.89%
Other Ethnic Group	1.82	6.8	1.62%
White	83.65	66.3	66.66%

It will be important to ensure as we continue to gain an increase in our patient survey responses that everyone is able to access and use the survey; the survey is provided in easy read and a number of differing languages, but it will be important to ensure that the prompts to complete this are not inhibiting feedback representative of the community and our patient attendance.

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q4 attendance
Female	39.1	39.5	53%
Male	61.9	27.5	46.98%
Non-binary/ other	0	4.2	0%
Not stated	0	28.7	0%

This would indicate that whilst the breakdown by attendance is fairly equally split as are complaints it would appear that we are still more likely to hear the voice of the patient through the patient survey if they are female. There has been a marked increase in the number of patients who have not completed their age on the survey (this is not a mandatory field).

Table 10: Age

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

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q4 attendance
45 to 49	10.91%		3.52
50 to 54	9.09%	11.113.18	3.73
55 to 59	3.64%		4.32
60 to 64	9.09%	12.9	4.46
65 to 69	3.64%		4.63
70 to 74	1.82%	15.0	4.53
75 to 79	1.82%		5.56
80 to 84	5.45%	13.6	6.16
85 +	3.64%		6.55
Not known	7.27%	26.0	11.98

Ongoing improvement

Complaint Handling Training continues to be delivered by the Complaints Office to support ensuring robust investigation and response to any complaints (formal or informal) that are received. The Complaints Office encourages all those who may be asked to investigate a complaint, to attend the training to ensure a clear they have a clear understanding of the process.

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

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

Some examples of services changes and improvements are detailed below.

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

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

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

15 Steps

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

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

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

Summary

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

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

Appendix 1: complaint, compliment and PALS activity

All formal complaints received

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

Locally resolved concerns received

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

Informal complaints received

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

KO41a Return

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

Formal complaints closed

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

Outcome of formal complaints closed

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

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

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

Complaints upheld and partially upheld

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

Care and Treatment complaint outcomes

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

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

PHSO

The table below shows the PHSO activity since April 2023:

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

CQC

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

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

PALS activity

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

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

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

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

There were 315 queries recorded during Quarter two. A decrease of 68 since Quarter 1. 311 queries were acknowledged within the 5 working day target, but the recording of queries has fallen behind due to the volume of queries coming into the service.

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

PALS has engaged a volunteer on a part time basis, and this has improved direct access to the service. The volunteer is also recording queries which has improved the rate of data collection. Our volunteer has also represented us at Reading Pride and has taken part in a PLACE visit.

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

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

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

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

Formal Complaints closed during Quarter Two 2023.24

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

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

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

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

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

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

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

Appendix 3

15 Steps; Quarter Two 2023/24

During quarter two, there were two visits:

Orchid Ward – Prospect Park Hospital

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

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

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

Rose Ward – Prospect Park Hospital

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

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

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	14th November 2023
Title	6 monthly Safe staffing Board Report
	Item for Noting the report and safe staffing declaration made by the Nursing and Medical Directors.
Purpose	The purpose of this report is to provide the Board with an overview of staffing across our wards both retrospectively over the last 6 months and prospectively
Business Area	Nursing & Governance
Author	Linda Nelson, Lead Nurse Professional Practice
Relevant Strategic Objectives	True North goals of harm free care, supporting our people and good patient Experience
CQC Registration	Supports maintenance of CQC registration
Resource Impacts	N/A
Legal Implications	N/A
Equality, Diversity and Inclusion Implications	N/A
SUMMARY	The attached report highlights the key facts from the 6 monthly safe staffing report including a declaration by the Medical and Nursing Director in relation to safety of our staffing as required by the NHS Developing Workforce Safeguards, published in 2018. The Board agenda includes links to the full safe staffing paper.
ACTION REQUIRED	The Board is asked to: Note the report and the staffing declaration within it.

Highlight Report

Six monthly safe staffing report for Board

1. Why is this coming to the Board?

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

There is a requirement within the NHS Improvement, Developing Working Safeguards document for a declaration / statement to be made by both the medical and Nursing Director to the Board that they are satisfied with the outcome of the assessment that staffing is safe, effective and sustainable. This statement is detailed below in the Summary.

2. What are the key points?

We continue to use a number of ways to assess staffing need across our wards; Safer Nursing Care Tools (SNCT) and the Mental Health Optimal Staffing Tool (MHOST) are NICE endorsed, evidence based tools currently used in the NHS to calculate clinical staffing requirements based on patients' needs (acuity and dependency) which, together with professional judgement, guides chief nurses in their safe staffing decisions.

Use of these tools and professional judgement demonstrates that we currently have broadly appropriate establishments on our wards; we do however have vacancy, this is particularly significant on our mental health wards and remains our greatest challenge. Alongside this there is a need for additional staff to meet patient acuity at times meaning that we continue to utilise a high level of temporary staffing use.

Temporary staffing is primarily sourced for NHS Professionals, many of the staff also hold substantive contracts with us and / or work for us on a regular basis meaning that they are familiar with our patients, wards and processes. We are able to fill the majority of our vacant shifts with temporary staff and any unfilled temporary staffing shifts are showing a decreasing trend over the 6 month period.

In line with national expectation Ward Managers are supernumerary to our safe staffing numbers on our wards. All of the wards have therapy input which is additional to safe staffing numbers, these staff also work on the wards to contribute to overall care, ensuring a therapeutic environment and safety for our patients.

There are a number of initiatives in place to improve our registered nursing and healthcare worker position, including apprenticeship programmes, international recruitment, rotational posts and the temp to perm healthcare support worker scheme. These initiatives are all reported to the board as part of the recruitment and retention work programme.

Having less than 2 registered staff on a shift is seen nationally as a red flag and something that we monitor. Over the last 6 months across the Mental Health wards 12.67% shifts started with less than 2 staff; this is a significant improvement on the previous 6 months where this was 21.66% shifts. When this occurs we are able to move staff around at Prospect Park Hospital and we also have clinical nursing staff not included in the rota both on the wards (ward manager and mental health practitioner) and in leadership roles such as the Associate Nurse Consultant, Advanced Practitioners who are able to step in and support the wards. Separate to this the hospital also has a physical health lead and a drug and alcohol lead able to offer specialist advice. For the community health wards the number of shifts with less than 2 registered staff is much lower (West wards 3% shifts and East ward 0.27% shifts), when this does occur like the mental health wards we are able to support the wards by moving staff around, providing support from ward managers and leaders not included in the ward safe staffing numbers.

Sickness absence remains a challenge across all the wards with an average sickness level of 7.63% across the time period, this ranges across the time period and by ward quite significantly from Bluebell as highest in a month at 19.6% to Daisy ward at lowest in a month with 0.99%. Chest and respiratory problems including coughs, colds remain the most common reason for absence with anxiety/ depression, musculoskeletal and chest and respiratory problems causing the most days of absence .

Staff wellbeing plays a significant role in managing sickness absence, our wellbeing services provide a wide range of support alongside this staff have access to physiotherapy to assist with early intervention for Musculoskeletal problems.

There have been no changes to the wards or their purpose over the last 6 months. Over the coming 6 months our wards are not anticipated to change except for the acute mental health wards for working age adults, where there is a plan to reduce the bed numbers on each ward to 20 (reduction of6 beds). This will not alter the staffing requirements for the wards.

The national community nursing staffing tool was released earlier this year. This is the first time that there has been a national tool enabling a more objective view of staffing needs for community nursing based on acuity of patients and activity undertaken.
To date 2 of the localities (Slough and West Berkshire) have piloted the tool with the initial findings showed that if fully staffed West Berkshire team would have sufficient staffing to meet patient need, whilst for Slough there would be a slight shortfall for patients on the caseload at the time of the data collection. It is recognised that there is significant vacancy across community nursing services, with, for this collection West Berkshire carrying a high level of vacancy and therefore despite having temporary staffing to support, both localities were 5-6 FTE below the staffing suggested by the tool to adequately meet patient need. The other localities will be using the tool over the coming months. National guidance is that 2 full data collection should be undertaken before using the tool to inform staffing levels.

The full report also details quality indicators as a means of assessing safety across the wards, there is nothing of significance to highlight in relation to these over this 6 month period.

3. Ongoing Improvement Work

- Continued recruitment effort as detailed within recruitment and retention workstream of the People plan, including the development pathway for bands 2's, 3's and 4's; rotational posts, nurse associate roles and apprenticeships with aim to reduce agency use.

- Continued support to improve retention rates of those with less than 2 years services including preceptorship programme to ensure preceptees feel confident and supported to fulfil their role on the wards.

- Encourage consistent use of the Safecare tool to give an accurate picture of staffing needs across the wards and use it to inform monthly board reports.

- Complete data collation and analysis of the newly developed community nursing dependency tool.

- Review of ward function and layout across the acute mental health wards as the work is completed to reduce the bed numbers and provide a more optimal therapeutic environment.

4. Summary

The Safe staffing declaration provides the opinion of the medial and Nursing Directors in relation to the position of our staffing across our wards over the last 6 months. This is detailed on page 18 of the full report.

Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels; supernumerary staff and managers, allied health professionals and temporary staffing have been used to achieve that. It is however recognised that during the period there were, due to inability to fill all rota gaps as a result of vacancy, absence and temporary staffing availability, shifts when staffing was sub-optimal and as a consequence there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised. Proactive work continues to support increased recruitment and improve retention and therefore sustainability of our permanent workforce.

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

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

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

Safe medical cover was maintained over the Junior Doctors and Consultant Industrial Action days.

Berkshire Healthcare
NHS Foundation Trust

Six Monthly Safe Staffing Review.
April 2023 – September 2023.

1.0 Executive Summary

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

As part of the safe staffing review, it is a requirement that both the Director of Nursing and Therapies and the Medical Director confirm in a statement that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. This statement can be found on page 18.

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

In line with national reporting, shifts with less than two registered nurses are monitored each month (table 7). 12.67% of the shifts across the mental health wards had less than 2 registered staff (21.66% in previous 6 months), whilst the West community wards had 3.09% of their shifts and the East wards had 0.27% of shifts with less than 2 registered nurses. Although very high in some areas, the figures do show some improvement across all areas from the last 6 monthly report; the peak of shifts with less than 2 registered staff was over July/August 2023 (usually the peak holiday season). Across the mental health wards, the improvement seen is due to better temporary staffing fill rates rather than a decrease in vacancy.

Across the wards the e-roster tool is used to support with rota completion. Temporary staffing, primarily through NHSP (and agency where this is not possible) provides support to fill any gaps in the rota or additional need. During the last 6 months 7.85% of our temporary staffing requests were unfilled (total temporary staffing shifts requested 32,191). This is a reduction on the previous 6 months where 11.13% requests were unfilled (total requests in previous 6 months 33,655).

During this reporting period we have continued to see challenges which have impacted staffing due to sickness absence amongst both our permanent and temporary workforce. Sickness absence in general is higher than Trust average across our inpatient wards, all but 2 of the wards are currently above 5% (average absence 7.63% September 23); However there have been some improved levels especially on Daisy ward where levels were below 4.55% for the whole 6 months, WBCH below 5% for 5 months and Snowdrop, Campion and Rowan wards had 3 months below 5%. The top three sickness absence reasons in terms of number of working days lost due to illness are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems and cold, cough, flu. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness. As is a requirement when building

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

The main ways used to review safe staffing establishments are:

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

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

In summary across the mental health wards (as can be seen in table 1 of this report), the whole-time equivalent establishment is possibly less than the establishment required to achieve the rota patterns currently being used (professional judgement), however this is based on standard shifts of 7.5 hours and some staff work long days of 12 hours, this will have a positive impact on full time equivalent needed to staff the wards. It is demonstrated through the safe staffing tool review (Table 2) that with the addition of temporary staffing the staffing is sufficient across the mental health wards to meet acuity of patients, however the resource is not always in the right place and staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need at any given time.
A deep dive exercise involving workforce planning and the Mental Health Inpatient wards completed in late 2022 identified short, medium, and long-term workforce transformation opportunities to help address the current staffing challenges. These recommendations have been or are in the process of being implemented. The regrading of the Ward Manager positions from band 7 to 8a and clinical lead posts being rebranded as advanced MH practitioners and regraded to reflect the levels of responsibility has led to some successful recruitment both internally and externally. Consequently, all the ward manager roles at PPH are currently filled.

For the West community wards, the staffing establishment is sufficient to provide the agreed rota (Table 1) whilst the safer nursing care tool data (Table 2) indicates that there was a shortfall of actual staffing against patient need to achieve optimal care the wards do believe that they are sufficiently staffed. The primary function of these wards is rehabilitation and therefore there are several additional therapy staff on each of the wards that contribute to daily patient care, these staff are not factored into the Safecare tool data and therefore the wards were not seen as unsafe over the previous 6 months. Windsor and Donnington wards have the lowest CHPPD (Table 4) compared to the other community wards in this reporting period. A review of community ward staffing is ongoing and the wards are able to bring in additional staff where acuity exceeds planned staffing levels. Currently both Wokingham and WBCH use an additional RN to support at night where this is needed.
For the East wards, staffing over last 6 months has been largely in line with suggested staffing when using the Safecare tool daily, although in this report the 20-day snapshot indicated both the East CHS wards to be less than optimal. As with the wards in the West there are also therapy staff not factored into the SafeCare tool assessment that support the wards daily. The SafeCare tool will continue to be used to monitor staffing, to ensure that establishment alongside temporary additional staffing continues to be adequate to meet the needs of the patients being cared for.

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

Over the next 3 months, the acute working age adult mental health wards will see a reduction in beds from 86 to 80 across the four wards, this will not affect the prospective view of staffing. There are no other planned changes across any of the wards.

The first NHS Long Term Workforce Plan was published in June 2023 and highlights the need to invest in our workforce both in terms of more people but also new ways of working and by strengthening the compassionate and inclusive culture needed to deliver outstanding care. The guidance details a focus on looking after our people (improving retention through flexible working, career conversations and enabling staff to understand their pension, support for staff wellbeing and improving of attendance by addressing sickness absence); improve belonging in the NHS (implementation of plans to improve equity); working differently (establishing new roles) and growing for the future (expanding ethical international recruitment, and apprenticeships and making the most effective use of temporary staffing).

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

There are several initiatives in place to grow our workforce, this includes Nurse Associate posts that have now been successfully embedded in several services across the organisation, the Trust currently has 17 employed and further 7 in training. Other apprenticeships nursing and AHP apprenticeships are also being undertaken by our staff and have recruited into some international posts across our community and mental health wards (23 Adult nurses, 8 Mental Health nurses since we commenced international recruitment in 2021, with a further 3 Mental Health nurses in the pipeline). A competency-based approach to development is also being developed where we assess that staff have the right skills and behaviours to progress to permanent and higher banded roles which includes a temporary to permanent initiative at PPH for healthcare support workers which has proved to be successful.

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

To improve staff resilience and support in all areas of the trust the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021 and we currently have over 60 qualified PNAs and around 10 staff currently in training across the trust. The PNA role involves providing restorative supervision which is aimed at improving wellbeing as staff feel supported and listened to, this in turn supports staff retention. The PNA programme is a Health Education England initiative which has been a requirement in midwifery for some years. It is now being rolled out nationally across healthcare. At Berkshire Healthcare the current PNA focus is to assist with ensuring the availability of SPACE groups for physical health clinical staff which is established in the mental health clinical staff teams. Work is currently underway and is being undertaken in collaboration with our psychological support and mental health teams. Training is due to commence in November 2023 following some scoping earlier in the year.

In Community Nursing, The Community Nursing Safer Staffing Tool (CNSST) commenced a pilot roll out in June 2023 with 2 localities. The remaining localities will be undertaking the data collection in November 2023 following training.

2.0 Main Report.

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

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

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

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

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

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

2.1 Current Situation.

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

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

Table 1: Current Staffing establishment, bed numbers and shift patterns April 2023 to September 2023

Ward	Beds	FTE Establishment in budget 2023/24	Professional judgement FTE	Planned shift pattern. (Early-late-night)
Bluebell	**22**	41.87	40.6FTE + 1 ward manager + 0.5 DSN + 1 MHP = 43.1FTE (WM, DSN and MHP not in figures)	7-8-6 activity coordinator inc on the late shift
Daisy	**20**	41.87	40.6FTE + 1 ward manager + 0.5 DSN + 1 MHP =43.1FTE(WM, DSN and MHP not in figures)	7-8-6 activity coordinator inc on the late shift
Rose	**22**	41.87	40.6FTE + 1 ward manager + 0.5 DSN + 1 MHP = 43.1FTE(WM, DSN and MHP not in figures)	7-8-6 activity coordinator inc on the late shift
Snowdrop	**22**	41.87	40.6FTE + 1 ward manager + 0.5 DSN + 1 MHP = 43.1FTE(WM, DSN and MHP not in figures)	7-8-6 activity coordinator inc on the late shift
Orchid	**20**	41.87	41.3FTE + 1 ward manager + 0.5 DSN + 1 MHP = 43.9 FTE(WM, DSN and MHP not in figures)	7-7-7
Rowan	**20**	41.87	44.8 + 1 ward manager + 0.5 DSN + 1 MHP = 47.3 FTE(WM, DSN and MHP not in figures)	8-8-7
Sorrel	**11**	41.87	41.3 + 1 ward manager + 0.5 DSN + 1 MHP = 43.8FTE(WM, DSN and MHP not in figures)	7-7-7
Campion	**9**	37.11	37+ 1 ward manager = 38	7-7--5
WBCH	44	63.46	**DONNINGTON** 40.6FTE+ 1 ward matron + 0.3 staff development lead = 41.9FTE	9-6-6
			HIGHCLERE 30.8FTE + 1 ward matron + 0.3 staff development lead = 32.1FTE	6-5-4
Oakwood	**24**	46.67	38 + 1 ward manager and 1 dep. ward manager/ matron = 40	9-7-4
Wokingham	**46**	61.31	57.8+ 1 ward manager + 0.8 matron = 59.6	13-10-7
Henry Tudor	**24**	32.80	32.7+ 1 ward manager = 33.7	7-6-4
Jubilee	**22**	30.23	31.55 + 1 ward manager = 33.55 * currently 33.55 needed to provide the additional nurse at night (This is sourced via NHSP)	Current 7-5-5 (usual pattern is 7-5-4) the additional staff member on nights as a precautionary measure)

The table above shows that the budget full time equivalent (FTE) for all of the mental health wards is the same. This is following the introduction of the control total scheme for budgeting. The acute mental health wards as well as Orchid, Rowan, Sorrel, West Berks Community Hospital do not appear to have the establishment required to meet the shift pattern being used; however, some staff on these wards work long days which effectively means a 37.5-hour week covers 6 shifts rather than the traditional 7.5-hour shifts covering 5 shifts per week; with some staff working long days these establishments are sufficient. Jubilee have an extra staff member on duty at night to manage any need to evacuate due to fire, which is needed due to the ward design, and could also contribute to the figure totals, this is being provided through NHSP. Current workforce development work being undertaken continues to help confirm that the establishments are

sufficient for the current mix of standard and long days being undertaken on the mental health wards.

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

3.0 Review of staffing establishment.

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

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

3.1 Review using workforce modelling tool.

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

Table 2: Prospect Park Hospital Wards

Ward	Bed Number	Current establishment (FTEs)	Average additional staff requested above establishment (FTE per day)	Recommended establishment from October 2023 review (FTEs)	Total actual establishment (including unfilled shifts requested)
Sorrel	11	41.87	4.94	47.04	46.81
Rose	22	41.87	5.99	54.47	47.86
Snowdrop	22	41.87	6.04	50.0	47.91
Bluebell	22	41.87	5.15	46.35	47.02
Daisy	20	41.87	3.82	42.03	45.69
Rowan	20	41.87	9.36	55.88	51.23
Orchid	20	41.87	6.80	37.12	48.67
Total	137	293.09	42.1	278.42	335.19

The review was undertaken over a 20-day period in line with the Developing Workforce Safeguards recommendations and offers a guide. The recommended establishment compared to actual establishment demonstrates that the current staffing establishment is sufficient for the needs of the wards. It is recognised that the resource is not always in the right place and that staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need at any given time. Financial support services will assist in ensuring that the ward establishments are reflective of patient acuity and the need to reduce ad-hoc temporary staffing requests. A deep dive exercise involving workforce planning and the Mental Health Inpatient wards was completed in late 2022 and assisted in identifying short, medium, and long-term workforce transformation opportunities to help address the current staffing challenges. There has been some recruitment

and retention into more senior roles including the upgrading of some ward manager and clinical lead posts. Consequently, at the time of the report all the ward manager posts are filled which has not been the case for several months.

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

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

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

Table 3: Community Wards and Campion

Ward	Bed Numbers	Current establishment	Recommended establishment from September 2023 review	Average additional staff requested above establishment (FTE per day	Total actual establishment (including unfilled shifts requested)
Oakwood	24	46.67	50.45	1.69	48.36
Wokingham (Ascot /Windsor)	46	61.31	70.41	2.77	64.08
WBCH (Highclere/ Donnington)	49	63.46	73.80	4.09	67.55
Henry Tudor	24	32.8	40.43	1.75	34.55
Jubilee	22	30.23	37.26	1.06	31.29
Campion	9	37.11	23.58	5.11	42.22

The review of staffing in September occurred when bed availability was at optimal levels with no closures although there was some cohorting of patients, as necessary.
Across the wards West Berks Community Hospital and Campion were most likely to request additional staffing. The tool does not account for those patients needing 2:1 care which will contribute to the high level of requests for Campion.
Across the West community wards, the safer nursing care tool data in the table above indicates that there was a small shortfall of actual staffing against patient need to achieve optimal care the wards do believe that they are sufficiently staffed. The primary function of these wards is rehabilitation and therefore there are several additional therapy staff on each of the wards (for example 7 FTE on Oakwood) that contribute to daily patient care, these staff are not factored into the SafeCare tool data and therefore the wards were not seen as unsafe over the previous 6 months. Both Wokingham wards and West Berkshire wards have commenced having an extra staff member on at night to manage the acuity of the patients when required. In addition, there is work underway to examine the staffing and recording of patient dependency to ensure the data collected is robust.

Data is reviewed and monitored via the monthly staffing reports to ensure that total staffing establishments are sufficient to meet the acuity and complexity of patients now being cared for in these settings. Work was undertaken using Quality Improvement (QI) initiatives to review staffing

levels and develop initiatives on how best to utilise staff. Since the change in senior management structures across the trust other work is being undertaken on staff numbers and data collection processes to ensure data is robust before making permanent changes to establishments. It is advised that the SafeCare tool is proactively used to identify when acuity is higher than expected and therefore additional temporary staff are needed.

For the East wards, staffing over last 6 months has been largely in line with suggested staffing when using the Safecare tool on a daily basis which feeds into the monthly staffing report. In this report the 20-day snapshot indicated both the East wards to be less than optimal but this has not been consistently the case over the last 6-month period. In addition, they deemed that they had sufficient staff to manage the acuity of the patients over this time period. On the East CHS wards like the wards in the West there are also therapy staff not factored into the Safecare tool assessment that support the wards on a daily basis, the Safecare tool will continue to be used to monitor staffing over the coming months to ensure that it continues to be adequate to meet the needs of the patients being cared for. There is some QI work being undertaken to align all the community CHS wards across the trust following the higher-level restructuring. It is envisaged that this will enable a more consistent and uniform approach to care on all the CHS wards.

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

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

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

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

Table 4: BHFT CHPPD

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Bluebell	11.50	10.80	8.40	10.10	10.90	9.30
Daisy	9.80	10.60	10.90	11.30	9.90	9.80
Rose	12.90	13.10	9.80	8.60	10.30	11.30
Snowdrop	10.40	9.90	11.20	10.10	10.90	11.50
Orchid	13.40	14.10	14.50	15.60	15.60	14.50
Rowan	22.30	18.10	19.90	19.10	19.60	19.90
Sorrel	19.60	22.00	19.90	21.90	23.30	22.20
Campion	39.60	38.70	35.00	38.90	38.50	37.20
Donnington	7.00	8.30	6.60	7.70	7.00	7.60
Highclere	8.80	9.60	8.90	10.30	9.40	9.10
Oakwood	7.40	7.70	7.20	8.50	7.40	7.00
Ascot	6.70	7.80	8.30	8.50	10.10	8.50
Windsor	5.20	6.20	6.20	6.50	7.10	7.00
Henry Tudor	6.90	7.10	6.60	7.50	8.20	7.70
Jubilee	7.80	6.60	7.30	7.00	8.10	8.00

Campion Unit CHPPD data figures have remained consistently high during this 6-month period and are due to the high amount of observation patients including patients requiring 2 on 1 supervision for safety/safeguarding reasons and challenging behaviour.

The data is skewed by number of patients requiring 1:1 observation and therefore explains some of the variation particularly on the mental health wards making it more difficult to make direct comparisons. Windsor and Donnington wards have lower CHPPD than the other community wards however, staff are able to move between Donnington and Highclere and also Ascot and Windsor wards and when looking at combined CHPPD on a site then all are comparable.

3.3 Bed occupancy.

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

Table 5: Bed Occupancy

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Average
Bluebell	93.80%	94.00%	97.00%	93.80%	89.90%	97.70%	94%
Daisy	98.70%	97.60%	96.80%	99.50%	94.00%	92.80%	97%
Rose	84.40%	96.50%	96.70%	95.60%	91.50%	93.60%	93%
Snowdrop	97.30%	95.20%	95.50%	98.80%	97.90%	94.50%	97%
Orchid	95.70%	94.50%	91.50%	83.20%	94.70%	91.70%	92%
Rowan	82.80%	93.70%	90.70%	90.80%	83.90%	86.30%	88%
Sorrel	98.20%	87.10%	99.40%	89.70%	90.10%	93.90%	93%
Campion	90.00%	89.20%	93.70%	88.50%	91.80%	87.00%	90%
Donnington	90.00%	77.50%	83.30%	72.40%	84.70%	82.00%	82%
Highclere	85.60%	79.80%	83.60%	72.00%	90.00%	83.80%	82%
Oakwood	93.30%	89.20%	93.60%	76.60%	91.80%	95.40%	90%
Ascot	83.70%	81.00%	75.70%	68.90%	53.40%	65.60%	71%
Windsor	94.20%	78.50%	87.30%	79.50%	72.30%	87.50%	83%
Henry Tudor	83.30%	86.80%	90.60%	87.30%	75.90%	85.10%	85%
Jubilee	80.60%	93.50%	90.20%	92.60%	79.90%	80.50%	86%

All of the mental health wards demonstrate high levels of occupancy over the last 6 months. For the community wards there was more fluctuation and Oakwood showing highest occupancy over the period for the community wards.

4.0 Workforce data

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

4.1. Vacancies.

Table 6 below shows the combined Full-time equivalent (FTE) vacancy rate of registered nursing and healthcare support staff for each ward according to finance data over the last six months. Across the mental health wards registered nurse vacancies have remained fairly static, with recruitment remaining challenging, although a slight improvement on the last 6 months has been seen. Unregistered vacancies look to have increased significantly between May and June, this is because of the work that has been undertaken to look at ward establishments including conversion of some full time equivalent temporary staffing being switched to substantive staffing in ward budgets..

An 18-month rotational Mental Health band 5 role between inpatient and community services is being tried and is ongoing, leading to a possibility of a band 6 position on completion. Currently 2 individuals are in post.

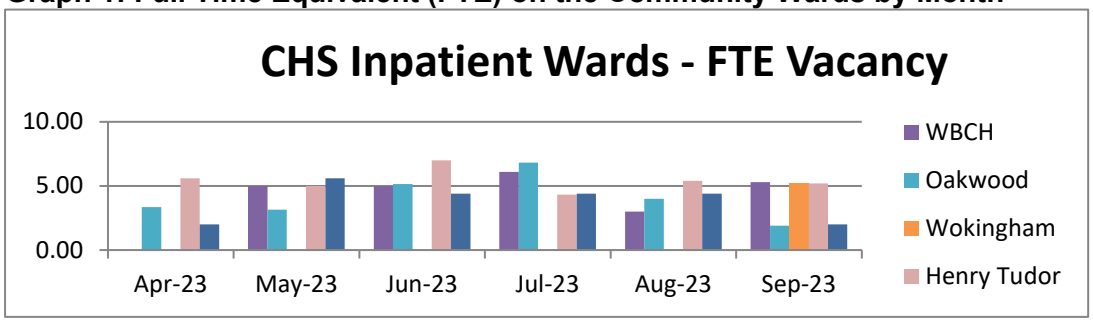
Regular open days are held alongside other recruitment initiatives including social media campaigns. There is also a temporary to permanent trial in place whereby staff are able to join NHSP, are guaranteed 30 hours a week and can then switch to a permanent position (this accounts for 12 of the 82FTE vacancies at present.

Table 6: Full Time Equivalent (FTE) vacancy of registered nursing and healthcare worker combined

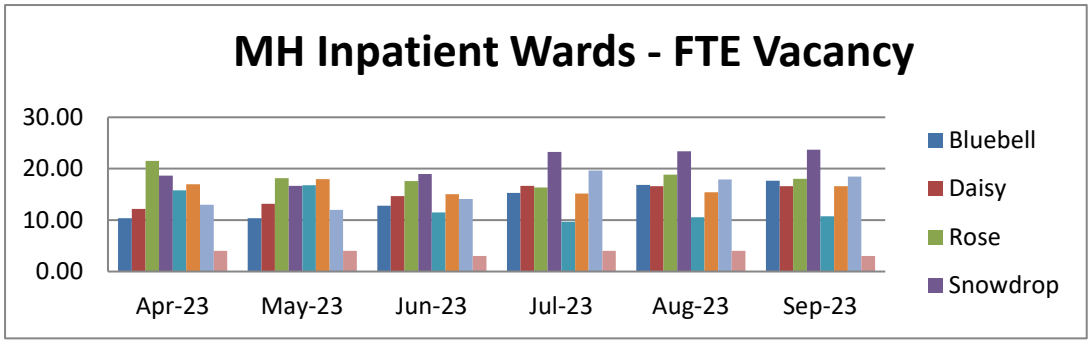
Ward	Grade of Staff	April 2023	May 2023	June 2023	July 2023	August 2023	Sept 2023
MH Wards	Registered	40.64	38.64	38.02	36.11	37.53	39.46
	Unregistered	46.87	45.4	85.37	79.98	81.98	82.37
CHS Wards	Registered	2	2	4	5.57	7.4	7.94
	Unregistered	5.6	8.6	12.18	16.94	9.4	12.46
Campion	Registered	1.00	1.00	1.00	1.00	1.00	1.00
	Unregistered	3.00	3.00	3.00	3.00	3.00	2.00

Graphs 1 and 2 below detail the split of vacancy across the wards and demonstrate variation in level of vacancy that each ward is experiencing. Across the mental health wards there has been some restructuring and regrading of posts and currently all the ward manager posts currently are filled which it is envisaged will have a positive impact on the wards as a whole due to a stable leadership.

Graph 1: Full Time Equivalent (FTE) on the Community Wards by Month



Graph 2: Full Time Equivalent (FTE) on the Mental Health Wards by Month



4.2 Sickness absence.

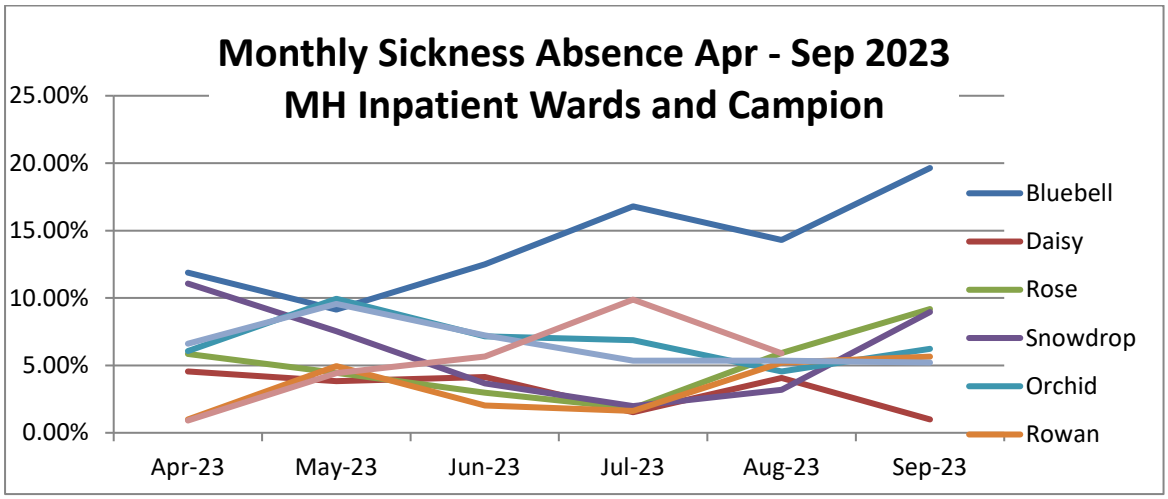
Graphs 3 and 4 detail the sickness absence as a percentage of the total registered nursing and care staff workforce for each ward. The sickness absence includes long and short-term sickness.

During this reporting period we have continued to see challenges which has impacted staffing due to sickness absence amongst both our permanent and temporary workforce and at times ward capacity. Sickness absence in general is high across our inpatient wards, with most of the wards consistently exceeding the trust target of 3.5% and the organisational average of 4.7% (apart from Daisy ward who were below 4.55% for the whole 6 month period; ;Snowdrop ward June, July and August 2023; Rose ward June and July 2023 ; Rowan ward April, June and July; Campion April to

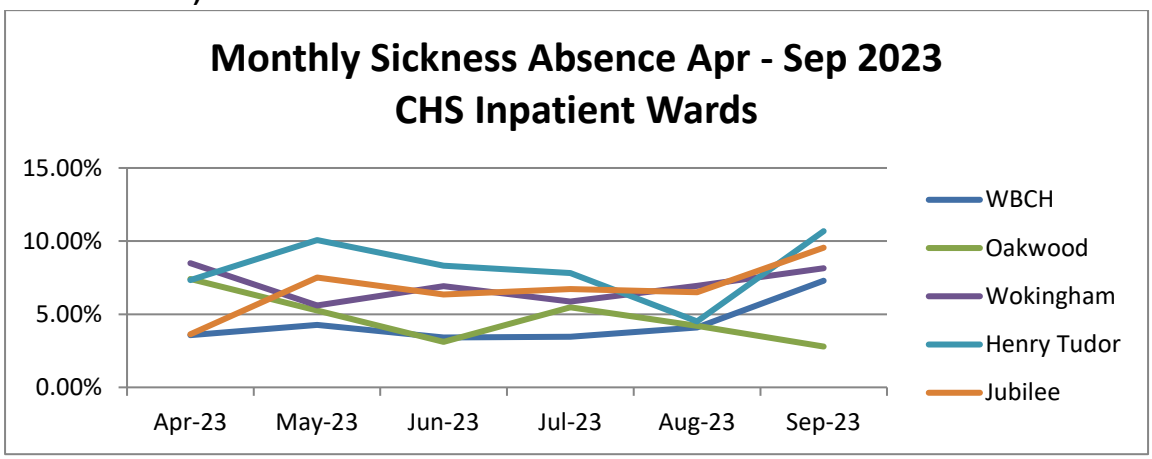
June 2023; West Berkshire Community hospital April-August 2023; Oakwood June, August and September 2023; Jubilee April 2023 and Henry Tudor August 2023). Bluebell ward had consistently high rates of over 9% for the 6-month period and is currently at 19.64% resulting from 4 staff being on long term sick in combination with 5 staff having short term recurring sickness. This is being managed via the appropriate HR methods. The top three sickness absence reasons in terms of number of working days lost due to illness are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems, and cold, cough, and flu.

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

Graph 3: Sickness absence for wards as a percentage of total ward staffing (Mental Health Wards and Campion)



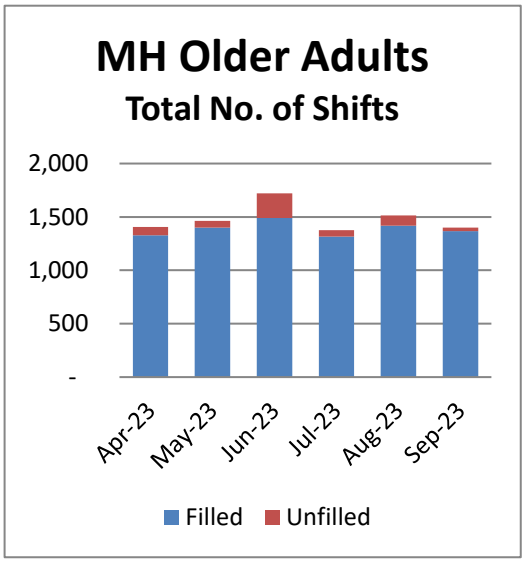
Graph 4: Sickness absence for wards as a percentage of total ward staffing (Community Health Wards)

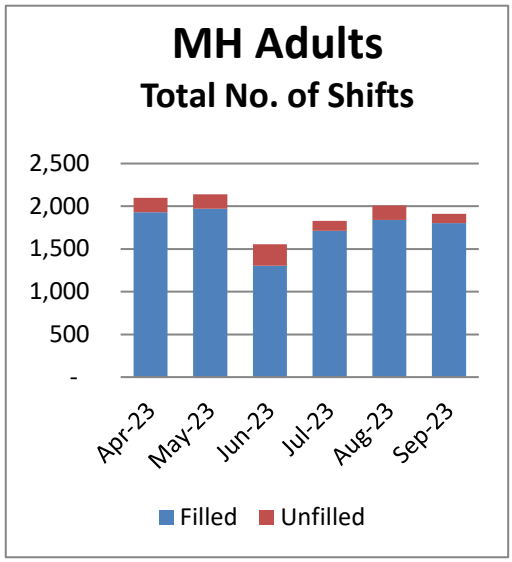


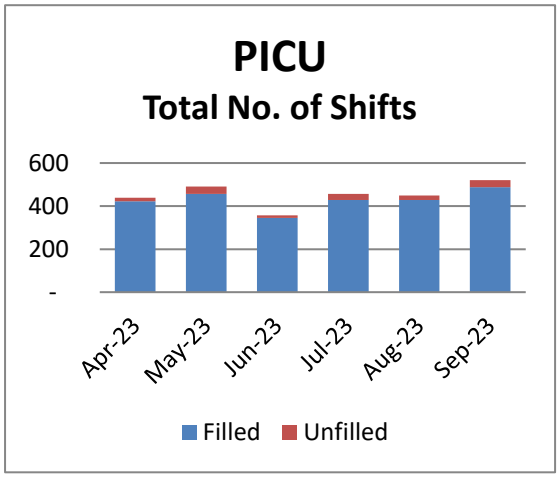
4.3 Temporary staffing.

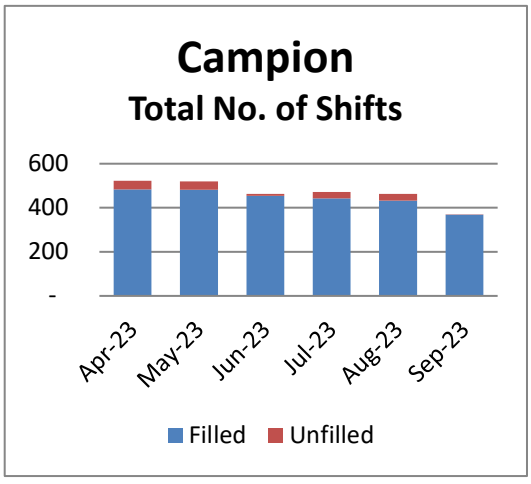
When the wards have vacancies and sickness within their nursing staff establishment, they use temporary staffing (agency / bank, or additional shifts by their own staff) to ensure that safe staffing levels are maintained. Temporary staffing is also used where patient need means that additional staff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

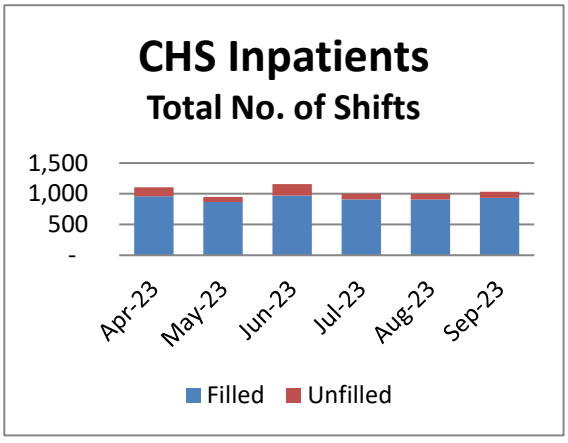
The graphs below show the total number of shifts required to be filled for each area as well as number of these that were filled/ unfilled.











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

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

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

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

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

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

Table 5: Quality metric for mental health inpatient wards and Campion (April 2023 to September 2023):

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	17	1	19	18	1	11	51
Daisy	9	1	7	32	3	2	24
Rose	11	1	25	49	3	9	62
Snowdrop	16	1	11	20	1	2	22
Orchid	2	14	3	15	0	0	1
Rowan	2	20	9	18	0	0	4
Sorrel	6	1	13	14	5	33	1
Campion	13	0	7	40	0	6	4
Total	**76**	**39**	**94**	**206**	**0**	**63**	**169**

* Correct at time of report

There has been an overall decrease in incidents reported during this period compared to the previous six months from 950 to 647. The number of AWOL have increased (from 57 to 76). Self-harm figures have decreased (from 377 to 169) with prone restraints being at 13.Other priorities such as reducing falls have seen some reductions (from 46-39) and continue to be key priorities for the Trust. There are a number of Quality Improvement programmes and initiatives being undertaken across the Trust including reducing restrictive practice. Self-harm and assaults are also Breakthrough objectives for the trust receiving specific focus. Staff have training packages alongside quality improvement work to support competence in these areas.

Table 6: Quality metric for community physical health inpatient wards (April 2023 to September 2023):

Ward	Medication	Falls	Pressure Ulcers	Patient on Staff Assaults
Donnington	10	13	17	1
Highclere	14	3	9	5
Oakwood	16	14	12	0
Wokingham	42	18	21	4
Henry Tudor	27	14	0	1
Jubilee	11	2	0	0
Total	**120**	**64**	**59**	**11**

* Correct at time of report

Incidents reported during this six-month period have decreased during the last 6 months (294 to 254). The number of falls is the similar at 64 (65 last 6 months); and an increase in alleged patient on staff assaults (9 to 11); There has been a decrease in drug errors (155 to 120) and pressure ulcers (65 to 59). A quality improvement approach is being used to support reduction in both pressure ulcer management and falls with reviews and learning events undertaken to ensure learning is shared within teams across the Trust and ensures information is disseminated to relevant staff.

All medication incidents have been reported as being low or causing no harm.

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

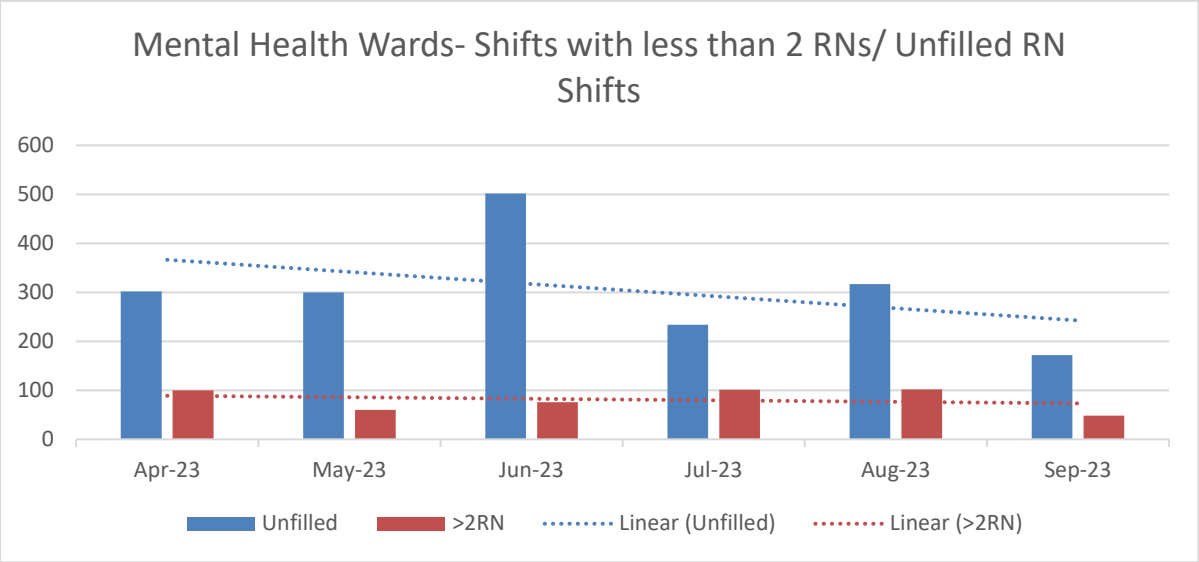
Table 7 demonstrates the number of occasions by ward and month where there were less than two registered nursing staff on a shift.
For all the wards where there are less than two registered nurses, senior staff and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and able to take an overview of the wards and redeploy staff to areas of most need, as necessary.

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

	Apr-23		May-23		Jun-23		Jul-23		Aug-23		Sep-23		Total for ward
	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	Day	Night	
Bluebell	19	5	9	2	21	6	27	5	31	9	15	3	**152**
Daisy	7	2	11	0	1	1	1	1	3	0	0	0	**27**
Rose	31	4	12	0	4	2	26	4	21	3	5	1	**113**
Snowdrop	13	3	10	0	9	3	12	2	9	1	2	2	**66**
Orchid	8	2	5	3	15	5	13	1	10	2	8	1	**73**
Rowan	1	2	1	4	3	5	2	2	4	4	1	1	**30**
Sorrel	3	0	3	0	1	0	3	2	4	1	8	1	**26**
Campion	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Donnington	2	2	0	0	0	0	0	0	0	0	0	0	**4**
Highclere	4	7	3	0	0	1	2	2	3	6	6	9	**43**
Oakwood	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Ascot	2	8	3	2	1	1	4	3	6	0	0	1	**31**
Windsor	2	2	0	2	0	1	0	0	0	0	0	0	**7**
Henry Tudor	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Jubilee	0	0	0	0	0	0	0	0	1	0	0	2	**3**
Total for month	**129**		**70**		**80**		**112**		**118**		**66**		**575**

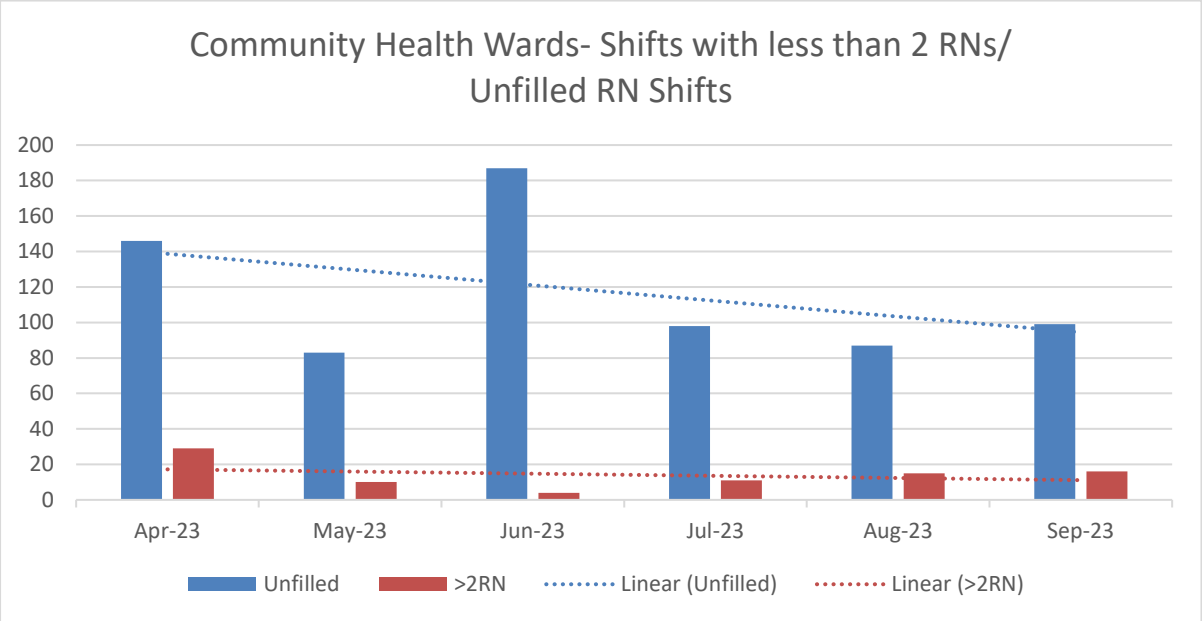
*Supernumerary staff are not factored into our number of shifts with less than 2 registered staff therefore deployment of the supernumerary staff to the wards will have reduced these numbers

Graph 5: Registered Nursing temporary fill rate and shifts with less than 2 registered staff for Prospect Park Hospital:



The graph above indicates that the shifts with less than 2 registered staff on each shift has fluctuated between 101 June to 48 in September and is showing a small downward trend. The wards have attempted to increase the numbers of registered staff on a shift and whilst there has been some month on month fluctuation there has been an overall downward trend in the number of unfilled RN shifts in each month over the 6 month period.

Graph 6: Registered Nursing temporary fill rate and shifts with less than 2 registered staff for the Community Health Wards.



The graph indicates that the shifts with less than 2 RNs vaires from 29 in April to 4 in September and sows a downward trend. The number of unfilled shifts also shows a downward trend over the period with some month on month fluctuation, June being particularly high at 187.

7.0 Safe Staffing Declaration.

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

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

Declaration by Director of Nursing and Therapies and Medical Director.

Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels; supernumerary staff and managers, allied health professionals and temporary staffing have been used to achieve that. It is however recognised that during the period there were, due to inability to fill all rota gaps as a result of vacancy, absence and temporary staffing availability, shifts when staffing was sub-optimal and as a consequence there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised. Proactive work continues to support increased recruitment and improve retention and therefore sustainability of our permanent workforce.

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

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

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

Safe medical cover was maintained over the Junior Doctors and Consultant Industrial Action days.

8.0 Nursing Associates.

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

There are currently 17 qualified NAs working in a range of services (community nursing, community mental health teams, community and mental health wards) across the trust. 7 trainee NAs are at different stages of their training across all services. Work is being undertaken within the trust to continue to encourage suitable applicants for future cohorts in line with national drivers.

9.0 Community Nursing.

There has not been an accredited tool for community nursing which has made staffing establishments challenging. The Community Nursing Safer Staffing Tool (CNSST) was introduced in late 2022. Due to other commitments and bouts of industrial action Berkshire Healthcare commenced roll out in May 2023. There were 2 pilot sites which undertook the data collection in June 2023; Slough and West Berkshire.
West Berkshire undertook their data collection period between Monday 5th and Sunday 11th June inclusive. Slough undertook their data collection between Monday 12th June and Sunday 18th June inclusive.

West Berkshire

Local staffing	FTE (Full Time Equivalent)
Team funded FTE (budgeted)	49.56
Team Actual FTE (rostered)	32.77
Team Temporary FTE (bank/agency/overtime)	3.85
Roster total	**36.62**

Recommended staffing	FTE
Registered practitioners and band 4 nurse associates.	37.12
Healthcare support workers	4.20
Total (headroom included)	**41.32**

Slough.

Local staffing	FTE
Team funded FTE (budgeted)	36.98
Team Actual FTE (rostered)	32.48
Team Temporary FTE (bank/agency/overtime)	0.00
Roster total	**32.48**

Recommended staffing	FTE
Registered practitioners and band 4 nurse associates.	28.65
Healthcare support workers	9.63
Total (headroom included)	**38.28**

The initial findings form use of the tool showed that if fully staffed West Berkshire team would have sufficient staffing to meet patient need, whilst for Slough there would be a slight shortfall for patients on the caseload at the time of the data collection. It is recognised that there is significant vacancy across community nursing services, with, for this collection West Berkshire carrying a high level of vacancy and therefore despite having temporary staffing to support, both localities were 5-6 FTE below the staffing recommended by the tool to adequately meet patient need. The other localities will be using the tool over the coming months.

The tool is being rolled out currently to the four remaining localities with the data collection being undertaken at the end of November 2023. It is envisaged a clearer picture of staffing and patient acuity will be obtained which can be used to future plan. Guidance is that 2 full data collections need to be undertaken before it can be used to fully inform staffing levels.

10.0 Next steps.

- Continued recruitment effort as detailed within recruitment and retention workstream of the People plan, including the development pathway for bands 2's, 3's and 4's; rotational posts, nurse associate roles and apprenticeships with aim to reduce agency use.

- Continued support to improve retention rates of those with less than 2 years services including preceptorship programme to ensure preceptees feel confident and supported to fulfil their role on the wards.

- Encourage consistent use of the Safecare tool to give an accurate picture of staffing needs across the wards and use it to inform monthly board reports.

- Complete data collation and analysis of the newly developed community nursing dependency tool.

- Review of ward function and layout across the acute mental health wards as the work is completed to reduce the bed numbers and provide a more optimal therapeutic environment.

Trust Board Paper

Board Meeting Date	14th November 2023
Title	Research and Development Annual Report 2022/2023
	Item for Noting
Purpose	This report presents a summary of research and related activity for the year 2022/2023
Format of the Report	The format of the report is not nationally prescribed
Business Area	Corporate (Medical Directorate)
Author	Kate Penhaligon, Head of Research and Development
Relevant Strategic Objectives	**Patient safety** The report highlights the processes in place to ensure compliance to relevant frameworks and examples of hosted research projects aimed at addressing harm risk for our patients. Two studies are highlighted as examples of how research is being used to address patient safety in Self-Harm (the SafePIT study) and eating disorders (Panorexia). **Patient experience and voice** This report highlights the on-going programmes of work to ensure our patients' views are met in the design, conduct and output of the research process. An example of using coproduction with Kids charity is provided with a summary of information from the Patient Research Experience Survey (PRES) feedback and how carers have got involved in Research. Examples of hosted research projects are also noted. **Health inequalities** Research has been used as a tool within the Mental Health Act detentions project and for delivery aspects of the neurodiversity strategy, all projects aiming to reduce health inequalities across Berkshire. This report highlights some examples of home-grown and hosted research projects. **Workforce** The R&D department collaborate with several external partners who are research active. Our Research also supports several MSc placements, internships, apprentices, and studentships. **Efficient use of resources** Berkshire Research is predominantly funded by the National Institute for Health and Care Research (NIHR) to support delivery of Research. The core team also work to attract additional income based on research activity through industry (commercial research), grant funding opportunities, charitable funding, and education funding to sustain and grow capacity for research across the Trust.
CQC Registration/Patient Care Impacts	Data and evidence is available to support key research questions arising from CQC inspections.
Resource Impacts	Research capacity is managing 1.8 whole time equivalent vacancies within the clinical research team
Legal Implications	Operating according to the UK Policy Framework for Health and Social Care Research Compliance to statuary obligations: • Medicines for Human Use (Clinical Trials) Regulations 2004 • Mental Capacity Act • Human Tissue Act 2004 • Section 111(7) of the Care Act 2014 • General Data Protection Regulation and Data Protection Act 2018 • International Conference on Harmonisation for Good Clinical Practice
Equalities and Diversity Implications	Equity of access to research studies has been a focus of the trust research strategy. This is well aligned with the trust strategy and values and also a national objective from the National Institute for Health and care Research (NIHR).
ACTION	The Board is asked to receive this report and note the content, progress made during the year, projected recruitment for 2023/2024.

Executive Summary

This paper presents the Research and Development Governance and Performance report for 2022-2023. The Research portfolio at Berkshire Healthcare NHS Foundation Trust is predominantly hosted research projects of both observational and interventional research. The Trust sponsored 3 research projects across 3 services.

In March 2022, in readiness for the new financial year, the Department of Health and Social Care (DHSC) Chief scientific advisor issued a call to action to address the current clinical research delivery challenges in the NHS. The UK Clinical Research Recovery Resilience and Growth (RRG) programme, led by DHSC and NHSE to ensure restoration and delivery of a full portfolio of clinical research. The programmes aim was to recover the UK's capacity to deliver research by discontinuing poorly performing research, encouraging NHS sites to expedite commercial research, and introducing performance related payments to Trust's where more than 80% of commercial research is 'on-track'. Research sponsors were requested to take action to get studies that were not progressing back on track or, if this was not possible, close them to recruitment or close them completely.

The reset process was unable to recover commercial contract research at the same rate as non-commercial research and in May 2023, the DHSC instructed sites to 'expedite the setup and delivery of commercial contract studies' to clear the back log of commercial studies in setup and to achieve the globally competitive timelines. The DHSC recognise that the availability of both Research funded staff, including those supported through the National Institute for Health and Care Research, the Clinical Research Networks, and the wider NHS, is a major factor in the practicability of studies. Pressures on NHS R&D Departments remain high as they support large portfolios of studies and follow-up activities.

The findings and recommendations in the recent O'Shaughnessy review are welcomed as a national focus on how to improve performance for commercial trials. Commercial research within Community Mental Health and Physical Health remains low in numbers compared to acute-focused industry research. Berkshire Healthcare are working with NHSE on a demand signalling programme initiated in August 2023 which seeks to identify the gaps in mental health research and to identify the research priorities for funders and sponsors.

Our aim through this work has been to make delivery of our Research portfolio achievable and sustainable within the resource and capability we currently have across the Trust. Delivering on the Research and Development strategy, we continue to work to ensure a balanced research portfolio across the divisions. In the FY 2022/2023 year the Tissue Viability service hosted 2 commercial trials. This is a welcome addition of a research active service within our Community Physical Health division, given our research activity is predominantly within mental health.

In 2022/2023 we delivered **73** research projects; this compares to 94 research projects in 2021/2022. This includes **43** National Institute of Health Research (NIHR) Portfolio studies and **30** non-NIHR Portfolio studies. Most participants recruited to the NIHR Portfolio projects were recruited into non-commercial observational studies. We were ranked joint **16th** out of **48** similar Trusts (Mental Health and Community Trusts) for the number of national studies and were **22nd** out of **48** similar Trusts for the number of participants that we have recruited. We recruited **690** participants (**654** recruited into non-commercial trials and **36** into commercial trials) to Portfolio and non-portfolio studies.

The Research and Development strategy was approved by the board in October 2021. The strategy was aligned to the government's policy: The Future of UK Clinical Research Delivery. Owing to the national changes and changes to the way the NHS works and delivers its services, the Research and Development strategy will be refreshed accordingly to reflect the updates within the national strategies such as Making Research Matter (Chief Nursing Officer for England's strategic plan for Research), The Royal College of Physicians (making Research everybody's business) and the programmes of work that support Lord O'Shaughnessy's review of commercial clinical trials.
Dr Minoo Irani – Medical Director and Executive Lead for Research

Patient safety

Providing Safe Services

This report covers the period from 1 April 2022 to 31 March 2023 and examines data and activity in relation to the Clinical Research activity across the Trust, compliance to the UK Policy for Health and Social Care Research and how the Trust discharges its statutory duties and responsibilities applicable to Clinical Research.

Research and Development (R&D) is part of the Corporate Division of Berkshire Healthcare NHS Foundation Trust, reporting via the Medical Director, who is an Executive member of the Board. The Research and Development Committee is accountable to the Trust Board through the Clinical Effectiveness Group (CEG). It is chaired by the Head of Research and Development; it meets every 2 months and was quorate for 2022/2023. R&D is also represented as an invited member of the Quality & Performance Executive Group (QPEG).

Research governance refers to the framework to manage the research process from end to end. The Health Research Authority provides assurance to the NHS that study complies with required standards and criteria. They assess the governance, legal compliance and the ethics review and will issue approval once all other regulatory approvals, i.e.Research Ethics Committee Medicine Health Regulatory Agency, Confidentiality Advisory Group, are in place.

The Health Research Authority approval provides assurance to the NHS that study complies with required standards and criteria to free up NHS sites to concentrate on putting arrangements in place to deliver the study.

We have robust processes which are in line with the Health Research Authority guidance of assessing, arranging, and confirming capacity to deliver research. Assessment is captured within our quality management system and workflows are used to capture processes and evidence/information for in-depth reporting. We are responsible for assuring the framework is adhered to and the roles and responsibilities of individuals at the site, and any collaborating parties, are agreed and documented.

In 2022/23 the R&D department undertook a review of the governance processes to ensure compliance with the UK Policy Framework for Health and Social Care and to maximise efficiency.

The national HR Good Practice Resource Pack provides the expectations for the study and the pre-engagement checks that should and should not be undertaken. To ensure appropriate access for research purposes to our patients, staff and/or Trust premises, all researchers must have the relevant access, either a substantive/Honorary research contract (HRC) or be issued with a letter of access (LoA) accompanied by a complete Research Passport. The level of access is determined by the activity the Researcher is undertaking. In 2022/23 the department issued **30** LoAs and **1** HRCs to non-BHFT researchers. Local services have oversight and operational management for the individuals requesting the access.

All research falling under the remit of the Secretary of State for Health must have a formal Sponsor. This includes all research in health and social care that involve NHS patients, their tissue or information. The Trust sponsors home-grown research projects and hosts national projects and student research projects. No Trust sponsored applications were received in the financial year 2022/2023 however support was given to conceptual ideas which led to future sponsorship applications for FY 2023/2024. Three Trust sponsored studies were active in 2022/2023. We have governance processes in place that evidences our compliance to sponsorship activity. The Research & Development committee have oversight of all sponsored studies and are involved in assessing the risk for interventional clinical research projects prior to Trust sponsorship approval.

Reducing harm risk for our patients

We have two hosted research trials highlighted below to demonstrate how research can be used to reduce the potential for harm to patients in higher risk services and provide a positive experience to patients accessing our services.

Self Harm

SafePIT study: The Self-harm, Assessment, Formulation, Engagement Trial of Psychodynamic Interpersonal Therapy (SAFE-PIT). This study sponsored by the University of Leeds aims to find out whether a type of brief therapy, psychodynamic interpersonal therapy (PIT), helps people who attend an emergency department (ED) after an episode of self-harm (SH). With a focus on whether PIT helps people reduce future SH, ED attendance and improve their mental health and quality of life. This study also measure costs and potential cost-savings as this is important for the NHS. PIT therapy involves 4 weekly sessions and is intended for people who have 3 or fewer SH episodes.

Eating disorders

PANOREXIA – This study provides opportunities for our patients who have been suffering from a DSM-V diagnosis of anorexia nervosa for 3 years or more, and who have found other forms of treatment ineffective. Over a period of 6 weeks, participants who are deemed eligible at screening will partake in 8 study visits, including three psilocybin dosing sessions with varying doses. The maximum dose of psilocybin a participant will receive in a single session is 25 mg. Across these 8 visits, there will also be 2 MRI scans, 5 EEG recordings and a range of psychological measures (questionnaires and interviews). There will be a follow-up period of 12 months following the final study visit. This is a collaborative study with Oxford Health and Oxford Universities.

For further examples please refer to studies captured under disease/condition area

Patient experience and voice

Using patient experience and voice, we continue work to establish strong links with our local communities by gaining patient and carer feedback. Co-production and Co-design for research projects has been a national research focus since 2016 with the National Institute for Health and care Research mandating evidence of Patient Public Involvement in all funding applications.

Carers

Research active staff are members of the Carers Hub – Friends, Family and Carer network (Teams channel). Opportunities to participate in research projects or research design work and to and understand what kind of support they would want are posted on this forum. In the FY 2022/2023, we opened the **'Continuing Compassion in Care (CCiC**): Caring for someone living with dementia' research project which is particularly focussed on self-compassion and how compassion for others starts with ourselves through an online support package. This study gathers the experiences of compassion, emotions, thinking styles and how carers feel about their relationships. We have continued to recruit to this study in FY 23/24.

We completed a study looking at the online support group use and wellbeing of carers of people with intellectual disability. This research aimed to explore the importance of carer networks and peer support as an adjunct to existing service support in health care. The Support Hope and Resources Online Network (SHaRON) was implemented within the learning disabilities services with a platform for relatives and paid carers and then a separate platform for people with an intellectual disability. The findings are being analysed.

Patient and staff experience

The Digital Health Tools in Psychosis study was hosted by the Early Intervention in Psychosis team. This survey was formed to understand what service users and staff think about using digital devices like a smartphone (e.g. Android phone or iPhone) or wearable device (e.g. Fitbit or smart watch) to help manage mental health. This study is looking to recruit 300 service users and 300 healthcare professionals (HCPs) nationally. Our site target is 20 and we have recruited 10 to date which is a mix of both service users and HCPs. It remains active and is open to recruitment until March 2024.

Patient experience

Improving Peer Online Forums (iPOF) trial. Berkshire Healthcare are the lead (and only) NHS site and hold the grant for this research study. As the host trust we are responsible for various outputs, the first one being an animation videohttps://www.sharon.nhs.uk/research/ which looks at the opportunity and potential benefits of using a digital community to support well-being and positive mental health. This animation video which highlights the benefits of using an online forum like SHaRON was co-designed by the service-users and patients who use SHaRON and who are participating in the main research trial.

Staff voice

The open-door project was hosted by the perinatal mental health team. This project aims to develop recommendations for how services can increase and improve access to evidence-based psychological support perinatal parents. It is estimated that between 2-22% of parents in the perinatal period experience perinatal obsessive-compulsive disorder (POCD), with an increased amount experiencing sub-threshold symptoms. This project sought the professional's views of healthcare staff in answering these three Research questions:

1. What barriers, from a healthcare professional perspective, are a priority to focus on to increase access to psychological treatment for perinatal obsessive-compulsive disorder?
2. What are potential solutions to overcome the prioritised barriers, from a healthcare professional perspective?
3. How could solutions be implemented most effectively to improve access to psychological treatment for perinatal obsessive-compulsive disorder, including format, delivery and distribution?

Patient Research Experience Survey (PRES)

PRES is an annual nationally standardised survey used to collect participants' views and experiences of participating in NIHR supported research. In 2022/2023, Berkshire Healthcare received **19** returns from participants. Berkshire Healthcare utilise this feedback to improve our service provision.

In the financial year 2021/2022, a review of community and mental health Trusts within the South-East Central Network showed that Berkshire Healthcare is the only Trust which does not have an 'opt-out' approach to research. The Trust supported the move to an 'opt-out' approach which has significant advantages for both patients and researchers. Patients consider research to be important and that they want to be made aware of opportunities to participate in research. Research evidence has shown that an 'opt-out' approach to research recruitment could benefit both clinical research and patient care.
This is an organisational change and as such we are working with support and advice from Information Governance to engage with all clinical services to implement the changes. An action-plan is being utilised to ensure a smooth implementation and to populate a Data Protection Impact Assessment Form.

Health inequalities

The research team continue to support the Trust in their focus on health inequalities through planning and delivery of research studies

Learning and Disability team

We were successful in obtaining contingency funding to develop a Learning Disability Research Strategy which aims to ensure that research opportunities are provided to this patient population. This work is continuing in 2023/2024 in partnership with the learning disability service and the KIDS charity. Co-production is at the core of this work, the patient population are being consulted to ensure their voice is heard ensuring that we are inclusive in the outputs developed from this strategy. This work provides input and support to the neurodiversity strategy.

Mental Health Act Detention work

The core Research team have been integral in supporting the Trust with workstreams linked to health inequalities. In 2022/2023, we were successful in obtaining funding to support the Mental Health Act Detentions work and provided resource from the service to complete a literature review which has helped shaped the direction of this work in 2023/2024.

Link to Highlighted study:

Why are black people overrepresented in Mental Health Act detention data

Sensory App

The University of Reading collaborated with us to host this NHS England funded project. The project provided the healthcare community with an easily accessible open resource sensory App which was used to identify sensory reactivity differences in autistic adults, and provide specific recommendations for healthcare providers.

Workforce

Aligning with the Trusts strategy to make the Trust a great place to work for everyone **supporting our people** and **encouraging partnership working** is of paramount importance to the research that we deliver in Berkshire Healthcare.

We **collaborate with health and social care partners,** including Integrated Care Boards (ICBs); these partnerships allowed us to work with **23** universities, **6** NHS organisations and several commercial and small technology companies. This brought research opportunities to patients, staff, and carers aiming to **address Health Inequalities and provide better, more efficient care.** Through collaboration **our local communities** strengthen the opportunities and deliver research projects **that respond to local community needs.**

Our aim is to attract and retain research interested, skilled and experienced staff who feel that their skillsets are valued. That they are empowered to progress research interests and careers at Berkshire Healthcare. **Recruiting and retaining a consistent workforce continues to be one of the biggest challenges we face at Berkshire Healthcare**. In September 2022 the Trust hosted a recruitment and retention rapid improvement event backed by research. This has resulted in a programme of intended work supported by the R&D Team. This programme includes consistent competency sets across the workforce based on the four pillars of practice, one of which is research. These programmes have been initiated in 2023/2024.

Berkshire Healthcare enabled and empowered our most senior Clinical Research Practitioner to complete the new **Clinical Research Practitioner registration**. Given their wealth of experience and knowledge this work was completed. They were appointed as the Clinical Research Practitioner Engagement Lead for Thames Valley, South Midlands Clinical Research Network in February 2023.

Embedded

Berkshire Healthcare's research culture demonstrates **clear benefits for the development of staff skills**. It is our vision to ensure **all staff can articulate the role they play in research**. Clinical research increases staff engagement and retention by ensuring that innovations and advancements of clinical practice can be adopted into departmental practices, whilst also contributing to evidence-based practice and enabling skill and knowledge development for staff. The ambition is to support research development opportunities akin to the internship/clinical academic role, across several disciplines.

Evidence demonstrates that Trusts active in clinical research have better patient care outcomes. Delivering **innovative ways of working and care initiatives** aids the development of research skills and supports **development of staff** across the organisation ensuring that **we can build and sustain teams fit for the future**. Wherever possible externally research generated funds have enabled us to **invest in clinicians** based within clinical services. They support the **development and delivery of research** rather than this sitting within the core R&D team. This helps to provide embedded access to opportunities which are relevant to local populations and develops research knowledge and skills within the clinical services.

Team Structure, Plan on a Page and CQC Single Assessment Framework

Efficient use of resources

The R&D department are predominantly funded by the National Institute for Health and Care Research (NIHR). The majority of this is Activity Based Funding (ABF) and is received via the Local Clinical Research Network (CRN) Thames Valley and South Midlands.

Funding is supplemented by NIHR Research Capability Funding (RCF), a small commercial and non-commercial stream of income and some trust finance. Funding is allocated annually; several team members hold short term contracts as funding is based on previous years' research activity.

Income 2018-2023 and **Finance dashboard**

Research External Income Sources					
Source	**2018/19**	**2019/20**	**2020/21**	**2021/22**	**2022/23**
Clinical Research Network Core Funding	400,000	420,000	445,000	463,000	477,000
Clinical Research Network Contingency Funding	39,413	5,000	0	35,424	52,158
Greenshoots Funding	0	13,358	0	0	0
Excess Treatment Costs Payments	0	3,106	352	9,293	3,807
Research Capability Funding	20,000	20,000	52,960	48,054	29,073
Commercial and non-commercial research Income	10,453	2,414	3,457	35,123	46,964
Other Funding					
Hosted NIHR Grant (IBER)	5,258	150,353	63,279	26,555	0
Non-commercial funding via a NIHR grant (STADIA)	0	7,003	11,554	6,420	15,338
Hosted NIHR Grant (ASCEND)	0	2,755	151,125	117,133	0
Doctoral Research Fellowship	0	0	3,171	109,273	0
Hosted NIHR Grant (iPOF Online Mental Health Communities)	0	0	0	0	337,801
MSK Physio Internship funding	0	0	0	0	9,219
Totals	**475,124**	**623,989**	**730,898**	**850,276**	**971,360**

Ensuring we are a **financially sustainable organisation**, the aim is to have a minimum of three National Institute for Health and Care Research (NIHR) grant funded projects hosted by Berkshire Healthcare at any time. In 2022/23 we were successful in securing the National Institute for Health and Care Research Grant with the University of Lancaster for the delivery of the iPOF study "Realist evaluation of online mental health communities to improve policy and practice". We hosted a welcome grant award through the NIHR for a Doctoral Research Fellowship award. This award is to facilitate the educational award through the study "Developing a novel, co-produced, mental imagery intervention with people with mild to moderate intellectual disability". We continue to build and support collaborations with university partners to develop NIHR grant applications. 6 grant applications were submitted in the financial year of 2022/2023.

Research funded posts

Funded Posts		
Service	**Posts Funded**	**Funding Source**
OPMH - Wokingham, Newbury, Reading, Slough and Bracknell	0.2 wte funded in each (1 wte in total)	Clinical Research Network
Sexual Health	0.21 wte funded (0.1 wte of consultant)	Clinical Research Network & Capacity Funding
Psychology Trauma	0.2 wte funded	Oxford Health PTSD & BRC projects
Web Services SHaRON	0.55 wte funded	Clinical Research Network/ iPOF project
Physiotherapy WAM MSK	Salary backfill for Internship £9.2k	ARC-OxTV and Oxford Brookes University
LD Psychology	0.8 wte funded (maternity leave in 2022/23)	NIHR Fellowship
LD Management	0.3 wte band 6 for 4 months funded	Clinical Research Network
Administration	0.2 wte band 5 for 4 months funded	Clinical Research Network
Locality Management Childrens Services	0.06 wte band 8C for 4 months funded	Clinical Research Network

The focus for the next 6 months is to ensure that we are aligned with Trust priorities and maximise grant funding opportunities, increase the capacity and capability for industry (commercially sponsored research) and to continue to support Internship applications

Conclusion

Clinical research within the NHS has nationally reduced since 2020/2021 with Mental Health Research remaining low. Our participant recruitment for the financial year 2022/2023 is notably reduced. This reflects the national recruitment uptake and this trend has carried forward to 2023/2024. The recruitment pledge for 2023/2024 is 940. The government's current commitments to mental health are set out in the NHS long term plan. This serves to provide the foundation for future clinical research.

We have proactively responded to the Demand Signalling programme which is a process used by NHS England to identify, prioritise, and articulate important health research priorities. It generates research questions in high-level priority areas for research funders and policy makers and involves practitioners, researchers, NHS England policy leads, charities and people with lived experience. Previous workshops determined seven priority topics as part of the demand signalling for mental health nursing research.

Research Demand Signalling for Mental Health Nursing

Our aim is to build the capacity and capability for Research across Berkshire Healthcare to support research projects developed to answer 7 priorities and to facilitate increased industry studies which will generate income to sustain and grow our research capability. Our Research strategy will be refreshed to reflect national strategies and a strategic implementation plan will be created to ensure delivery to the updated strategy.

Actions that support the recommendations in the recent O'Shaughnessy review will be carried through to the FY 2023/2024 and into FY 2024/2025 ensuring an increase of commercial/industry led research projects. These projects will provide opportunities to the population we serve and income to grow the capacity and capability for research.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Meeting Date	14th November 2023
Title	Patient Safety Incident Response Plan and Policy
	Item for Approval
Purpose	This highlight report sets out the context and key facts of the national patient safety framework, plan and Policy. The local Plan and Policy are attached
Business Area	Nursing & Governance
Author	Daniel Badman, Deputy Director Nursing Patient safety and Quality Helen DeGruchy and Tiziana Ansell, Patient Safety Specialists
Relevant Strategic Objectives	True North goals of harm free care, supporting our people and good patient Experience
CQC Registration	Supports maintenance of CQC registration
Legal Implications	National Requirement of NHS contract
Equality, Diversity and Inclusion Implications	N/A
SUMMARY	The attached report highlights the key facts in relation to implementation of the patient Safety and Incident Response Plan. The plan and policy are attached as links into the agenda. These documents require Board approval prior to progression to final approval by the Integrated Care Board and subsequent internal progression to the implementation phase of the patient safety incident response framework. The Director of Nursing and Therapies recommends approval of the plan and Policy which have been through relevant consultation and are in line with national requirements.
ACTION REQUIRED	The Board is asked to Approve the plan and Policy

Highlight Report

Patient Safety Incident Response Plan and Policy

1. Context

The National Patient Safety Strategy (NPSS) which was published in July 2019, sets out what the NHS will do to achieve its vision to continuously improve patient safety through the development of the foundations of a safety culture and a safety system and in line with three strategic aims:

- Improving understanding of safety (insight),
- Equipping patients, staff and partners with the skills and opportunities to improve patient safety (involvement)
- Designing and supporting programmes that deliver effective and sustainable change (improvement).

One of the key elements of the strategy is the change from current practice of serious incident investigation including retirement of the 2015 serious incident Framework and replacement with the Patient Safety Incident Response Framework (PSIRF), which includes a broader range of investigative processes and a focus on learning. This represents a significant shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

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

The move to implementing the PSIRF is a contractual requirement under the NHS Standard Contract and as such is mandatory for services provided under that contract, including acute, ambulance, mental health, and community healthcare providers.

The expectation around implementation of the PSIRF is that all providers must be planning and working toward this being implemented from Autum 2023 , each provider organisation must have its own patient safety incident response plan (PSIRP) and policy based on the national template detailing adoption of the PSIRF and this is subject to work with and agreement from their Integrated Care Boards

2. Why is this coming to the Board?

Prior to provider Patient Safety Incident Response Plans being agreed and signed off by the integrated Care system quality meeting, internal board sign-off is required . The plan and Policy are therefore here today following review at the September in committee Board and at the Quality Executive Committee for final approval.

It is the recommendation of the Director Nursing and Therapies that our local plan and policy be approved by the Board, the documents have been developed following relevant consultation and are in line with national requirements.

3. What are the key points?

- The document sets out how we intend to respond to incidents based on a thorough understanding of our current patient safety profile (table 2, pg. 11), ongoing improvement priorities both internally (including breakthrough objectives and key improvement activity) and nationally (deteriorating patient, national improvement focus for mental health such as restrictive practice, self harm) and available resources. A key element of PSIRF is that attention is not just focused on level of harm but also on near misses and lower level incidents where we see themes and trends to enable early learning.

- It is important to recognise that this is nationally a new way of responding to incidents and as such the attached is our local plan for the next 18-24 months, during which time we will remain flexible in our approach. We plan to commence phasing in this new approach from January 2024. This will not impact on our quarterly Learning From Deaths Report, we will however be reviewing our current quarterly Serious Incident Report that is presented to the Quality Assurance Committee to comply with this broader scope of investigative activity.

- This has been developed in collaboration with key stakeholders including both internal and external individuals and groups (table 1, pg. 9) .

- The plan is based on applying a range of system-based approaches to learning from patient safety incidents in a proportionate way that maximises learning and ensures appropriate patient , family and staff engagement. This new approach builds on the robust processes already in place and on the accreditation, we received in 2021 for the Royal college of Psychiatrists for our approach in investigating serious incidents and how we engaged with families and patients during the processes . We have already started using some of the additional methodologies such as multi-disciplinary debriefs and after action reviews over the last year to support the transition and move to the national patient safety incident review framework requirements.

- National guidance suggests that a key element of PSIRF is setting out the number of Patient Safety Incident Investigations (PSII), using full Root cause analysis approach on a par with serious incident reviews under the 2015 SI Framework that will be completed during the year to support prioritisation (set out in Table 4 page 19). However, it is the discretion of the trust to remain flexible and objective in our approach around this and therefore this is seen as a guide only. It is important to note that the type of learning response suggested will depend on key factors including the views of those affected including patient / family.

- There are a small number of incidents that must have an investigation similar to the current serious incident RCA investigation, this includes, relevant to us Never Events , deaths thought to be more likely than not to be due to problems in care, Deaths of patients detained under the Mental Health Act.

- The plan includes how we will respond to any deaths in line with our current mortality approach and policy.

4. Risk and Challenge

This is a new way of working across the NHS and as such will take time to embed and for both internal and external stakeholders to adjust.

As part of the implementation of this work, consideration is being given to the importance of providing comprehensive assurance to coroners in relation care provided by the trust and any learning that has occurred following incidents.

Berkshire Healthcare
NHS Foundation Trust

CCR

Patient Safety Incident Response Policy

Berkshire Healthcare NHS Foundation Trust

 Did you print this document yourself?
Please be advised that Berkshire Healthcare discourages the retention of hard copies of policies and can only guarantee that the policy on Nexus is the most up-to-date version.

Re-issued:	
Review Date:	
Version:	**1.0**

<table>
<tr><td>Policy Number:</td><td>CCR</td></tr>
<tr><td>Title of Policy:</td><td>Patient Safety Incident Response Policy</td></tr>
<tr><td>Category</td><td>Clinical Care and Risk.</td></tr>
<tr><td>Committee responsible for final sign off</td><td>Safety, Experience, Clinical Effectiveness Group (SECEG)</td></tr>
<tr><td>Re-issued:</td><td>New policy</td></tr>
<tr><td>Review Date:</td><td>November 2025</td></tr>
<tr><td>Designated Lead:
Policy author (authors)</td><td>Deputy Director of Nursing (Patient Safety and Quality)
Patient Safety Specialists</td></tr>
<tr><td>Version History</td><td>Version 1 of policy.
Replace ORG007 Reporting, Management, Review and Learning from Incidents (including Near Misses, Serious Incidents and Never Events)</td></tr>
<tr><td>Individuals ratified by:</td><td>Please include a minimum of 3 policy consultants who have approved the policy and the date they have confirmed approval. Must include representative of at least one member from each Division (to which the policy is relevant to)
<table>
<tr><td>Name</td><td>Date Ratified</td></tr>
<tr><td>Clinical Director Mental Health Division</td><td></td></tr>
<tr><td>Clinical Director Physical Health Division</td><td></td></tr>
<tr><td>Clinical Director CYPAA</td><td></td></tr>
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<tr><td>Relevant meetings, groups, committees ratified by</td><td>Patient Safety Review Meeting (insert date)
Trust Mortality Review Group (insert date)
Patient Safety Strategy Implementation Group (insert date)</td></tr>
<tr><td>Date endorsed by Policy Scrutiny Group:

Date endorsed by Committee responsible for final sign off:</td><td>

SECEG (insert date)</td></tr>
<tr><td>For policy information:</td><td>Policy Administration
Berkshire Healthcare NHS Foundation Trust
London House
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0300 247 3000</td></tr>
</table>

This policy has been assessed for compliance with CQC Fundamental Standards.

Contents

1 INTRODUCTION

This policy supports the best practice guidance set out in the NHS England Patient Safety Incident Response Framework (PSIRF)[1] and explains how Berkshire Healthcare NHS Foundation Trust (the Trust) will approach the development and maintenance of effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

2 PURPOSE OF POLICY

The PSIRF embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF which are:

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

These aims align to our existing Trust values which are:

- **Caring** for and about you is our top priority.
- **Committed** to providing good quality, safe services.
- **Working together** to develop innovative solutions.

This policy should be read in conjunction with our current 'Patient Safety Incident Response Plan (PSIRP), which is a separate document setting out how this policy will be implemented.

3 SCOPE OF POLICY

This policy relates to all staff working within the Trust and is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across the Trust.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by complex interactions among several components of the healthcare system and not from a single component.

Learning responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident. Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety learning response. Such processes

[1] NHS England » Patient Safety Incident Response Framework

as those listed below are therefore outside of the scope this policy:

- Claims handling,
- Human resources investigations into employment concerns,
- Professional standards investigations,
- Information governance concerns
- Estates and facilities concern
- Financial investigations and audits
- Safeguarding concerns
- Coronial inquests and criminal investigations
- Complaints (except where a significant patient safety concern is highlighted)

For clarity, the Trust considers these processes as separate from any patient safety incident response. Information from a patient safety incident response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

4 ASSOCIATED DOCUMENTS

- Fulfilling our Duty of Candour (ORG072)
- Patient Safety Incident Response Plan (PSIRP)
- Patient Advice and Liaison Services (PALS) Policy (CCR101)
- Learning from Deaths Policy (CCR157)
- Complaints Policy (ORG002)

This policy supersedes guidance related to patient safety incidents that may be included in other Trust processes/guidelines (i.e., falls, pressure ulcers). These other documents will be updated as part of a Trust-wide PSIRF implementation process.

5 DEFINITIONS OF KEY TERMS

Patient Safety Incident – NHS England national policy[2] defines it as an unplanned, unexpected or unintended event where something has happened, or failed to happen, as a result of the care or treatment provided that could have or did lead to patient harm.

Patient Safety Incident Response Plan (PSIRP) – An organisation's plan represents a proposal for how they intend to respond to patient safety incidents over a period of 24 months. PSIRP is not a permanent rule that cannot be changed. Organisations must remain flexible and consider each patient safety incident in light of the specific circumstances in which it occurred and the needs of those affected, as well as the PSIRP.

Learning Response – A response to a patient safety incident focusing on learning. The response can be delivered through a toolbox of methodologies.

Patient Safety Incident Investigation (PSII) – A patient safety incident 'review methodology' adopting an 'investigative approach' for the incident response. This leads to an in-depth review of a single patient safety incident with the formulation of a comprehensive report. The Trust's PSIRP proposes what incidents may require a PSII. The decision to carry out a PSII should be based on potential for learning, PSIRP, family concerns and bearing in mind the Trust's existing improvement plans.

[2] NHS England (2023) Policy Guidance or recording patient safety events and level of harm

(Other) Patient Safety Review (PSR) methodologies (or learning responses) – If a patient safety incient occurs, that does not require a PSII response, but there is a need for further review or potential for learning then a different review methodology should be considered. All proposed methodologies should be delivered within the context of psychological safety. Adaptations of nationally proposed methodologies will be considered to meet the specific needs of community services, physical and mental health services. These may include digital solutions such as virtual reviews using Microsoft Teams.

The toolbox of proposed methodologies may include (but are not limited to):

Swarm Huddle – The swarm huddle is designed to be initiated as soon as possible after a patient safety incident and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

Multidisciplinary (MDT) roundtable review – A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.

After Action Review (AAR) – AAR is a structured facilitated discussion of a patient safety incident, the outcome of which gives individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning? AAR may be particularly useful to review incidents involving procedures and to formally agree on improvement actions.

Desktop review – Sometimes patient safety incidents reported on our incident reporting system (Datix) may suggest that some clarifications are required to decide whether they will meet the threshold for a learning response methodology from our agreed toolkit. In these cases, consideration will be given to carrying out a desktop review of clinical records to gain further clarity on the nature of the incident. This may be supplemented with direct liaisons with the team(s) involved aimed at a prompt de-escalation (**or** if appropriate escalation) of incidents as emerging from the desktop review.

Initial Findings Review (IFR) – This is a written initial review of the incident/event, usually completed by one author. This will include a timeline of events, highlighting any immediate risks and whether there are any concerns that may require a subsequent learning response. They will usually be **requested** to determine whether a PSII response may be required (as per our PSIRP).

Learning Lead – The identified member of staff who is leading the learning response.

Engagement Lead – The identified member of staff who is leading on engagement with, and involvement of, the patient / family / carer. This member of staff could be the Family Liaison Officer and/or another member of staff who is involved in the learning process. Sometimes the two can co-exist

6 ROLES AND RESPONSIBILITIES

6.1 Principles of oversight

Working under PSIRF, organisations are advised to design oversight systems to allow an organisation to demonstrate improvement rather than compliance with centrally mandated measures.

The Trust followed the 'mindset' principles to underpin the processes we have put in place to allow us to implement PSIRF as set out in the supporting document (NHS England, 2022).

The Trust will work collaboratively with Frimley ICS and BOB ICB to ensure we have effective oversight and improvement of patient safety across our systems and to support where appropriate cross-organisational learning. This will involve participation in identified relevant forums such as Safety & Improvement Forum, regular PSIRF reviews, peer reviews and educational events.

6.2 Ensuring that PSIRF is central to overarching safety governance arrangements

The Trust Board will receive assurance regarding the implementation of PSIRF and associated standards via existing reporting mechanisms such as the Quality Performance Executive Group (QPEG) and the Quality Assurance Committee (QAC). This will come in the form of a Patient Safety and Mortality Learning Report.

The Trust will source necessary training such as the Patient Safety Syllabus (Health Education England) and other patient safety training options as appropriate to the roles and responsibilities of its staff in supporting an effective organisational learning response to incidents.

Updates will be made to this policy and associated PSIRP as part of regular oversight. A review of this policy and associated PSIRP should be undertaken at least every 3 years to comply with Trust guidance on policy development.

6.3 Quality assuring learning response outputs

The Trust will implement a Patient Safety and Mortality Learning Group (PSMLG) to ensure that PSIIs are conducted to the highest standards and to support the executive sign off process and ensure that learning is shared, and safety improvement work is adequately directed.

The PSMLG will also take oversight and provide executive sign off for PSRs relating to deaths as well as all mortality second stage reviews completed as part of the Learning from Death Policy. While the majority of mortality second stage reviews are not patient safety incidents, the Trust takes the view that reviewing these alongside PSII's and PSR's provides greater opportunity to identify themes, trends and learning.

PSRs unrelated to deaths will have oversight and sign off via the Patient Safety Incident Review Group (PSIRG) with this group escalating any higher profile, high risk reviews or those where significant opportunities for learning have been identified to the PSMLG.

7 RESPONSIBILITIES

Chief Executive: Has the overall responsibility for ensuring that there is organisational commitment to all elements of the policy within Berkshire Healthcare.

Executive Director of Nursing and Therapies: Designated Executive Director for PSIRF. The Executive Director of Nursing and Therapies will oversee the development, review and approval of the Trust's policy and PSIRP ensuring that they meet the expectations set out in the national patient safety incident response standards. The policy and PSIRP will promote the restorative just working culture that the Trust aspires to.

The Executive Medical Director: Has the lead responsibility for the Learning from Deaths process.

The Deputy Director of Nursing Patient Safety and Quality: Has delegated responsibility from the Executive Director of Nursing and Therapies for enacting the development, review and approval of the Trust's policy and PSIRP ensuring that they meet the expectations set out in the national patient safety incident response standards.

Divisional Directors, Service Directors, Clinical Directors, and other senior Managers (including senior Governance roles in Divisions): Have responsibility for ensuring divisional commitment to implement the policy as well as for putting effective governance, systems, and processes in place to enable successful implementation.

Patient Safety Specialists and Patient Safety Managers: Have responsibility for providing patient safety expertise and independence to support the implementation of the policy, as well as working alongside operational colleagues to develop effective governance, systems and processes for successful implementation of the policy.

Managers and Service Leads: Are responsible for ensuring their services and teams are provided with the right conditions to support them to engage in and practically implement the policy

All staff: Have a responsibility to behave in a way which supports an effective patient safety culture as set out in the Trust Patient Safety Culture (Our Safety Culture | Nexus (berkshirehealthcare.nhs.uk)).

8 POLICY CONTENT

8.1 Our patient safety culture

The Trust has worked over a number of years to develop its patient safety and learning culture. Significant developments have been taken forward including (but not limited to) the development of an enhanced staff wellbeing offer, a review of Human Resources to support a restorative culture, an objective 'team approach' to our PSIIs, as well as a significant commitment to 'Freedom to Speak up'. Resources relating to how we will continue to enhance our safety culture can be found here Our Safety Culture | Nexus (berkshirehealthcare.nhs.uk)

Our safety culture Charter sets out clear the key elements required for a safe culture to thrive. These are:

- Psychological safety for staff
- Diversity

- Compassionate and inclusive leadership
- Open learning

PSIRF will support the Trust in achieving these requirements creating much stronger links between a patient safety incident and learning and improvement. We aim to work in collaboration with those affected by a patient safety incident – staff, patients, families, and carers to arrive at such learning and improvement within the culture we hope to foster. This will continue to increase transparency and openness amongst our staff in reporting of incidents and engagement in establishing learning and improvements that follow. This will include insight from when things have gone well and where things have not gone as planned.

We are clear that patient safety incident responses are conducted for the sole purpose of learning and identifying system improvements to reduce risk. Specifically, they are not to apportion blame, liability or cause of death. Similarly patient safety incident responses are not designed for defining avoidability. However, as a requirement of the Learning from Deaths Policy, the PSMLG will have a process to agree avoidability scores for certain deaths.

The Trust's safety culture scores within the National Staff Survey have been positive in recent years but the Trust is committed to continuing to improve in these areas with a specific focus how we support specific groups of colleagues who scores less well in these elements of the survey compared to others. We will continue to focus on our annual staff survey results relating to safety culture with a view to sustaining and continually improving in this area.

8.2 Patient Safety Partners

The Patient Safety Partner (PSP) is a new and evolving role developed by NHS England to help improve patient safety across the NHS in the UK. As a Trust we are excited to welcome PSPs who will offer support alongside our staff, patients, families/carers to influence and improve safety across our range of services. PSPs can be patients, carers, family members or other lay people (including NHS staff from another organisation) and this offers a great opportunity to share interests, experiences, and skills to help develop the new PSP role and be a part of our team.

This exciting new role across the NHS will evolve over time and in our Trust the main purpose of the role is to be a voice for the patients and community who utilise our services and ensure that patient safety is at the forefront of all that we do.

PSPs will communicate rational and objective feedback focused on ensuring that patient safety is maintained and improved, this may include attendance at governance meetings, reviewing patient safety, risk and quality and being involved with contributing to documentation including policies, learning responses and reports. This information may be complex, and the PSPs will provide feedback to ensure that patient safety is our priority. PSPs should participate in the review of patient safety incidents, assist in the implementation of patient safety improvement initiatives and develop patient safety resources which will be underpinned by training and support specific to this new role in collaboration with the patient safety team to ensure PSPs have the essential tools and advice they need.

The Head of Patient Experience and Engagement will lead on the development of the PSP role alongside the Trust's Patient Safety Specialist(s). Information on the expectations of the role, how to enact it and how PSPs will be renumerated are available

in the Trust 'Patient Safety Partner Handbook' (available via Nexus) as well as clear mechanisms for ensuring adequate support and supervision is provided.

The Trust aim is to develop a culture whereby involvement of PSPs is embraced as the norm from a 'why should we involve a PSP' position to a 'why wouldn't we' position.

8.3 Addressing health inequalities

The Trust recognises that the NHS has a core role to play in reducing inequalities in health by improving access to services and tailoring those services around the needs of the local population in an inclusive way.

The Trust, as a public authority, is committed to delivering on its statutory obligations under the Equality Act (2010) and will use data intelligently to assess for any disproportionate patient safety risk to patients from across the range of protected characteristics. We will continue to develop the Trust incident reporting system to ensure details of patients can be directly drawn from the healthcare record and incidents can then be analysed by protected characteristics to give insight into any apparent inequalities.

When responding to a patient safety incident, we will directly address if there are any particular features of an incident which indicate health inequalities may have contributed to harm or demonstrate a risk to a particular population group, including all protected characteristics. When constructing our safety actions in response to any incident we will consider inequalities, and this will be inbuilt into our documentation and governance processes.

We will also address apparent health inequalities as part of our safety improvement work. We understand that our services provide care to significant numbers of the Core20PLUS5 population cohort identified by NHS England (2021). In establishing our policy and PSIRP we will work to identify variations that signify potential inequalities by using our population data and our patient safety data to ensure that this is considered as part of the development process for future iterations of this policy and our PSIRP. We consider this as an integral part of the future development process.

Engagement of patient, families and staff following a patient safety incident is critical to any review of patient safety incidents and their subsequent response. We will ensure that we use available tools such as easy read, translation and interpretation services and other methods as appropriate to meet the needs of those concerned and maximise their potential to be involved in our learning response.

The Trust's commitment to continually developing its safety culture has been set out in section 8.1. Further to this, the Trust is committed respecting everyone, being 'anti racist' and serving all our diverse populations equally and building an open and equitable culture within our organisation that celebrates diversity. As part of this, discrimination of any kind including racism will be proactively addressed. With explicit role modelling led by the Trust Board, we will underline this message through patient safety training and implement the system-based approach to patient safety responses which is at the heart of PSIRF best practice.

8.4 Engaging and involving patients, families and staff following a patient safety incident.

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the

development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

We are firmly committed to continuously improving the care and services we provide. We want to learn from any incident where care does not go as planned or expected by our patients, their families, or carers to prevent recurrence.

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. We also acknowledge the impact incidents have on our staff and the Trust is committed to continue working of safety culture aspects to foster an environment of psychological safety and well-being where our staff feels safe to openly review and learn from incidents,

Getting involvement right with staff, patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide.

Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

To meet our regulatory and professional requirements for Duty of Candour (see ORG072: Fulfilling our Duty of Candour), we will always be open and transparent with our patients, families, and carers because it is the right thing to do. This is regardless of the level of harm caused by an incident.

An 'engagement lead' will be allocated to each learning response to a patient safety incident. This may be the individual who is leading or supporting the actual learning response and / or this may be a dedicated Family Liaison Officer (depending on the nature of the incident).

As part of our new policy framework, we will be outlining procedures that support patients, families, and carers – based on our existing Fulfilling our Duty of Candour Policy (CR072). This will be underpinned by a network of support provided by our Family Liaison Officer, Patient Safety Team, Clinical Directors, senior Governance Leads and other senior Leaders within our Divisions who are able to guide patients, families and carers through any investigation or learning response.

PSIRF national guidance advocates the Learn Together[3] research team who have co-produced materials to support involvement in learning responses. This includes a *Patient and family information booklet: informs the patient and their family about how to get involved in learning response.* The Trust will be exploring the use of this and their other resources as part of PSIRF implementation to ensure that as much support and information as possible is provided to all those involved in a patient safety incident and subsequent learning response.

Furthermore, our staff will be supported by the '*Compassionate Communication, Meaningful Engagement*' guidance which the Trust are proud to have played a key role in co-producing with Making Families Count and other NHS organisations.

See the guide

[3] learn-together.org.uk – Serious Incident Investigation resources

In addition, in the Trust we have a Patient advice and liaison service (PALS) (PALS@berkshire.nhs.uk) and a Complaints Service. People with a concern, comment, complaint or compliment about care or any aspect of the Trust services are also encouraged to speak with a member of the care team. For more information see Patient Advice and Liaison Service (PALS) Policy (CCR101) and the Complaints Policy (ORG002).

We recognise that there might also be other forms of support that can help those affected by a patient safety incident and will work with patients, families, and carers to signpost to their preferred source for this. Detailed information regarding this can be found on Nexus or through contacting the Patient Safety Team who will maintain an up to date list of available signposting and support services.

8.5 Patient safety incident response planning and our PSIRP

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.

Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will undertake a period of planning of our use of resources for patient safety incident responses aligning this to, and informing our, safety improvement workstreams identified through our Trust quality improvement programme. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our PSIRP will then detail how this has been achieved in addition to describing how the Trust will meet both national and local focus for patient safety incident responses. PSIRP will not be a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as remembering that responses should be considered and proportionate.

Our PSIRP is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review it every 18-24 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 24 months.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with Frimley ICB (Lead Commissioner) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

A copy of our current PSIRP can be found via Nexus or through contacting the Patient Safety Team

8.6 Training requirements

The Trust has committed to ensuring that we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen.

8.6.1 Incident reporting and management training (Datix)

Incident Reporter Training- For all staff and it will include sharing principles of incident reporting and how to report using the Trust incident reporting system.

Incident Handler Training- For all staff responsible for taking on the role of handler of an incident.

8.6.2 Patient Safety Syllabus Training - Expected standards

Level 1 Patient Safety Syllabus – For All: This module is mandatory for all staff, clinical and non-clinical working in the Trust.

Level 1 Patient Safety Syllabus – For boards and senior leadership teams: This module is not mandatory however recommended to all senior management and board members.

Level 2 Access to Practice: For all clinical staff at Band 7 or above, with potential to support or lead patient safety learning responses. (i.e., Swarm Huddle post incident).

All the above are available via Nexus E-Learning.

Records of Patient Safety Syllabus training will be maintained by the Learning and Development team as part of their general education governance processes. The Patient Safety Specialist(s) will take oversight of compliance with the support of the wider patient safety and governance teams.

Level 3 and Level 4 Patient Safety Syllabus is due to be launched in Autumn 2023 and the initial expectation is that this will be completed by our Patient Safety Specialist(s).

8.6.3 Training for those leading a PSII 'team approach' or working in dedicated patient safety and clinical governance roles.

Staff working in patient safety and clinical governance roles that are expected, as part of their role, to participate in patient safety learning responses will have to meet the PSIRF training competency requirements summarised as following:

- Completion of Patient Safety Syllabus Level 1 and 2 (as above)
- Completion of a minimum of two-days 'Whole System Approach' training[4]
- Participate in 'Engagement and Involvement of those affected by a patient safety incident' (HSIB 6-hour training). Alternatively, staff can access a suitable quantity of Making Families Count webinars
- Maintain their competencies by contributing to at least two PSIIs per year

[4] This is currently provided by Healthcare Safety Investigation Branch (hsib.org.uk)

- Participate in locally arranged training on all PSR methodologies

The Patient Safety Team will maintain a record of PSIRF training compliance requirements for patient safety and governance teams until a system is introduced to ensure Learning & Development Team can monitor and if appropriate Directorates can provide ongoing monitoring of adherence to training guidance.

8.6.4 Training for those participating in a PSII 'team approach'

PSIRF suggests the use of dedicated investigating officers' (IOs) to complete PSIIs. The IOs would have to meet the competency requirements set up in the PSIRF framework.

Our Trust operate within a 'Team approach' model to complete PSII-methodology. This approach has many benefits to an individual IO approach; however, it presents with some challenges. During the first two-three years of PSIRF implementation further strategies will be identified to ensure that:

- New staff involved in specific aspects of a team-approach PSII (i.e., interviewing, writing Terms of Reference) receive an appropriate level of support through formal or informal training sessions to ensure they contribute to the investigation by applying PSIRF principles of whole system, safety culture and compassionate engagement of patient and their family.

- Staff that have already completed an IO training and that are involved in a specific aspect of a 'team-approach' PSII receive an appropriate level of support through formal or informal training sessions to ensure their previous investigating methodologies training (i.e., root cause analysis methodology) is updated to contribute to the investigation by applying PSIRF principles of whole system, safety culture and compassionate engagement of patient and their family.

Learning & Development Team will continue holding records for all those that have attended formal IO training and that currently provide support with investigations and Terms of Reference information.

The Patient Safety Team will continue supporting all directorates to ensure all incidents reviews (whether PSII or other methodology) meet PSIRF standards and to promote a cultural progression towards whole system approach and compassionate engagement of staff, patients and families.

8.6.5 Competency requirements for staff leading any type of learning response:

As a Trust we expect that staff leading learning responses are able to:

a. Apply principles of safety culture and psychological safety to all learning responses they lead
b. Apply human factors and systems thinking principles to gather qualitative and quantitative information from a wide range of sources.
c. Summarise and present complex information in a clear and logical manner and in report form.
d. Manage conflicting information from different internal and external sources.

e. Communicate highly complex matters and in difficult situations.

Support for those new to this role will be offered from the Patient Safety Team, Clinical Directors, senior Governance Lead roles and other senior Managers within Divisions.

8.6.6 Training for those involved in engagement with patients, families or carers

Staff working in patient/family engagement lead roles (i.e., Family Liaison Officer) and staff regularly engaged in supporting patients/families during a patient safety incident (i.e., to complete statutory duty of candour conversations) need to complete the 'Engagement and involvement with those affected by a patient safety incident' training. as recommended in the PSIRF.

As an alternative to the specific HSIB training, staff can access a suitable quantity of Making Families Count webinars.

Records of such training will be maintained by the Learning and Development team as part of their general education governance processes. The Family Liaison Officer will take Trust oversight of compliance with the support of the wider Patient Safety Team. Clinical Divisions will take responsibility for ensuring staff required to fulfil this role have accessed the required training and support.

8.6.7 Competency requirements for engagement leads:

As a Trust we expect that staff acting as engagement leads are able to:

a. Communicate and engage with patients, families, staff, and external agencies in a positive and compassionate way.
b. Listen and hear the distress of others in a measured and supportive way.
c. Maintain clear records of information gathered and contact those affected.
d. Identify key risks and issues that may affect the involvement of patients, staff, and families, including any measures needed to reduce inequalities of access to participation.
e. Recognise when those affected by patient safety incidents require onward signposting or referral to support services.
f. Ensure that the voice of patient and/or family is heard and their concerns and views reflected as part of the investigation review process.

8.6.8 Oversight roles training and competencies

Those in oversight roles (i.e., senior management) and responsible for Trust sign-off of PSIIs need to complete:

- Completion of Patient Safety Syllabus Level 1 and 2
- Completion of a minimum of two-days 'Whole System Approach' training[5]
- Participate in 'Engagement and Involvement of those affected by a patient safety incident' (HSIB 6-hour training). Alternatively, staff can access a suitable quantity of Making Families Count webinars.

[5] This is currently provided by Healthcare Safety Investigation Branch (hsib.org.uk)

- One day training in oversight of learning from patient safety incidents.
- All those with an oversight role in relation to PSIRF will undertake continuous professional development in incident response skills and knowledge, and network with peers at least annually to build and maintain their expertise.

Records of such training will be maintained by the Learning and Development team as part of their general education processes. The Patient Safety Specialists will take oversight of compliance.

8.6.9 Competency requirements for staff with oversight roles:

As a Trust we expect that staff with an oversight role are able to:

a. Be inquisitive with sensitivity (that is, know how and when to ask the right questions to gain insight about patient safety improvement).
b. Apply human factors and systems thinking principles.
c. Obtain through conversations and assess both qualitative and quantitative information from a wide variety of sources.
d. Constructively challenge the strength and feasibility of safety actions to improve underlying systems issues.
e. Recognise when safety actions following a patient safety incident response do not take a system-based approach (e.g., inappropriate focus on revising policies without understanding 'work as done' or self-reflection instead of reviewing wider system influences).
f. Summarise and present complex information in a clear and logical manner and in report form.

8.7 Review methodologies

8.7.1 PSII's:

The Trust will deliver PSII methodology by adopting a 'team approach' to the investigation in line with our pre-existing process which received accreditation from the Royal College of Psychiatrists.

A senior member of the Patient Safety Team will lead the completion of PSIIs and work with services and the division/s to encourage a shift towards PSIRP principles of the whole system approach, psychological safety and compassionate engagement of staff, patient and families.

The completion of the PSII investigation will be supported by a 'Review Team' made up of a Clinical Director from with the Division (and/or a delegated senior Governance Lead), a further senior Manager, ideally an additional member of the Patient Safety Team and where required a subject matter expert. All members of the Review Team should have an appropriate level of seniority, expertise and influence within the Trust.

The senior member of the Review Team who is leading on the completion of the final report should be Band 8A or above in line with PSIRF best practice guidance. However, where appropriate, there may be representation from a Band 7 - with appropriate oversight from senior staff members. This would however depend on the nature and complexity of the incident and response required and take into consideration the

professional development and career progression needs of staff.

Review Team members will not have been involved in the patient safety incident itself or be an individual who directly manages those staff. For more details on the 'Review Team' approach to PSII's please see Nexus or contact a member of the Patient Safety Team.

8.7.2 Other PSR methodologies (or learning responses):

A senior member of the relevant Division/s (i.e., Directorate Governance Lead) will be responsible to identify a designated individual to lead on the learning response. The individual should have an appropriate level of seniority, expertise and influence within the Trust; should be a Band 8A or above in line with PSIRF best practice guidance. However, where appropriate there may be some representation from a Band 7 - with appropriate oversight from senior staff members. This would however depend on the nature and complexity of the incident and response required and take into consideration the professional development and career progression needs of staff.

A senior member of the Patient Safety Team should attend learning responses to support the implementation of PSIRF values and ensure ongoing support and learning of the new review methodologies being implemented. They will also ensure a degree of objectivity is brought to the group especially where the review methodology may involve staff that provided direct care to the patient.

Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in learning responses. All Trust managers will work within our Safety Culture Charter principles and utilise other teams such as Health and Wellbeing to ensure that there is a dedicated staff resource to support such engagement and involvement. Divisions will have processes in place to ensure that managers work within this framework to ensure psychological safety.

The Trust will utilise both internal and, if required, external subject matter experts with relevant knowledge and skills, where necessary, throughout the learning response process to provide expertise (e.g., clinical, or human factors review), respond to Terms of Reference, give advice and assist with proof reading.

The Trust will have in place governance arrangements to ensure that a level of objectivity is brought to all learning responses. This will mean that some learning responses (i.e. PSII) will not be led by staff who were involved in the patient safety incident itself6 or by those who directly manage those staff.

8.8 Responding to patient safety incidents

8.8.1 Reporting arrangements

All staff are responsible for reporting any patient safety event on our Trust incident reporting system (Datix) in accordance with Datix operational procedures. New definitions of harm will apply in accordance with the new NHS England (2023) National Policy[7] (Appendix 1).

[6] This does not detract from the importance of involving staff in reviewing the incident to understand the work 'as done' at the frontline and the complex healthcare interaction that led to the incident.

[7] NHS England (2023) Policy Guidance on recording Patient Safety Events and Level of Harm

8.8.2 Response and decision making

A triage system will be implemented to ensure a prompt review of incident reporting – this will happen at multiple levels including service/divisional/corporate patient safety. This is to ensure a timely review of reported incidents and also to determine which incidents need to be further escalated. Furthermore, there will be a new focus, moving away from solely responding to the level of harm to also seeking to identify those incidents where there are the significant opportunities for learning.

The process behind this is detailed in Appendix 2 and will be subject to change as it is tested in the initial implementation phase of PSIRF. Ultimately it will lead to the identification of which incidents may require a further learning response.

Identified incidents (as outlined in PSIRP) will be reviewed and discussed at the weekly PSIRG for a collaborative decision between the Patient Safety Team and Divisional representatives.

8.8.3 Role of PSIRG

The PSIRG will have delegated responsibility for the consideration of which incidents should be PSII or require an alternative PSR. Decision making for a further learning response will depend on our PSIRP and:

- The view of those affected – including patient and family.
- Capacity to undertake a learning response.
- What is known about the factors that led to the incident.
- Whether improvement work is already underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect.
- If BHFT and its ICBs are satisfied that risks are being appropriately managed.

They will also have oversight of the outcomes of PSRs (which are not related to mortality) to ensure that recommendations are founded on a systems-based approach and safety actions are valid and contribute to existing safety improvement plans or the establishment of such plans where they are required.

The process behind this decision-making phase is detailed in Appendix 3 and will be subject to change as it is tested in the initial implementation phase of PSIRF. There will be clear records maintained regarding this decision-making process and this will be shared with relevant senior management.

Flexibility will be considered if an incident is escalated prior to weekly PSIRG and appropriate immediate actions will be taken as required to mitigate any risk.

The Patient Safety Team will have processes in place to communicate and escalate necessary incidents within NHS commissioning and regional organisations and the CQC according to accepted reporting requirements. Whilst this will include some incidents escalated as PSII, the Patient Safety team will work with the Divisions to have effective processes in place to ensure that any incidents meeting external reporting needs are appropriately escalated.

8.8.4 Responding to inherited incidents (those not attributable to our Trust)

The Patient Safety Team will forward those incidents identified as presenting potential for significant learning and improvement for another provider directly to that organisation's Patient Safety Team or equivalent. Where required, summary reporting can be used to share insight with another provider about their patient safety profile. With the introduction of LFPSE, this is likely to be operationalised through LFPSE but this will take time to implement.

8.8.5 Responding to cross-system incidents

The Trust will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate the free flow of information and minimise delays to joint working on cross-system incidents. The Patient Safety Team will act as the liaison point for such working and will have supportive operating procedures to ensure that this is effectively managed.

The Trust will defer to the ICB for co-ordination where a cross-system incident is felt to be too complex to be managed as a single provider. We anticipate that the ICB will give support with identifying a suitable reviewer in such circumstances and will agree how the learning response will be led and managed, how safety actions will be developed, and how the implemented actions will be monitored for sustainable change and improvement.

8.8.6 Trust Executive Patient Safety and Mortality Learning Group (PSMLG)

The Trust will establish and maintain an Executive-led PSMLG to oversee the operation and decision-making of the PSIRG.

PSMLG will also support the final sign off process for all PSIIs. In addition, PSRs related to mortality will be approved.

Through this mechanism the Board will be assured that it meets expected oversight standards but also understands the ongoing and dynamic patient safety and improvement profile within the organisation.

8.9 Timescales for learning responses

8.9.1 For PSIIs

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within three months of their start date. No local PSII should take longer than six months.

Most importantly, the time frame for completion of a PSII will be agreed with those affected by the incident, as part of the setting of Terms of Reference, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant.

In exceptional circumstances (e.g., when a partner organisation requests an investigation is paused, or the processes of an external body delays access to information) the Trust

can consider whether to progress the PSII and determine whether new information indicates the need for further investigative activity once this is received. This would require a decision by the Executive-led PSMLG.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the Trust and those affected.

8.9.2 For PSR's

PSRs must be started as soon as possible after the patient safety incident is identified and should ordinarily be completed within one to three months of their start date. In some circumstances this may take longer particularly when ensuring family questions are comprehensively responded to.

8.10 Safety action development and monitoring improvement

The Trust acknowledges that any form of patient safety learning response (PSII or PSR) will allow the circumstances of an incident or set of incidents to be understood, but that this is only the beginning. To reliably reduce risk, better safety actions are needed.

The Trust will have systems and processes in place to design, implement and monitor safety actions using an integrated approach to reduce risk and limit the potential for future harm. This process follows on from the initial findings of any form of learning response which might result in identification of aspects of the Trust's working systems where change could reduce risk and potential for harm – areas for improvement. The Trust will generate safety actions in relation to each of these defined areas for improvement. Following this, the Trust will have measures to monitor any safety action and set out review steps.

Learning responses should not describe recommendations as this can lead to premature attempts to devise a solution - safety actions in response to a defined area for improvement depend on factors and constraints outside of the scope of a learning response. To achieve successful improvement safety action development will be completed in a collaborative way with a flexible approach from Divisions and the support of the Quality Improvement Team with their improvement expertise.

8.10.1 Safety action development

The Trust will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

- Agree areas for improvement – specify where improvement is needed, without defining solutions
- Define the context – this will allow agreement on the approach to be taken to safety action development
- Define safety actions to address areas of improvement – focused on the system and in collaboration with teams involved
- Prioritise safety actions to decide on testing for implementation
- Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics

- Safety actions will be clearly written and follow SMART principles and have a designated owner

8.10.2 Safety action monitoring

Safety actions must continue to be monitored within the Divisional governance arrangements to ensure that any actions put in place remain impactful and sustainable. Divisional reporting on the progress with safety actions including the outcomes of any measurements will be made to the PSMLG.

For some safety actions with wider significance this may require reporting to the Trust Quality and Performance Executive Group (i.e., actions which are part of or associated to Breakthrough Objectives or Trust strategies).

8.10.3 Safety Improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. The Trust has several overarching safety improvement plans in place which are adapted to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes or CQUINs.

Our PSIRP has outlined the local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by reduction in apparent risk or harm.

The Trust will combine the outcomes from existing patient safety incident reviews (formerly SI RCA reports) where present with future learning responses conducted under PSIRF, to create related safety improvement plans.

The Divisions will work collaboratively with the Patient Safety Team and Quality Improvement Team and others to ensure there is an aligned approach to development of plans and resultant improvement efforts.

Where overarching systems issues are identified by learning responses outside of the Trust local priorities, a safety improvement plan will be developed. These will be identified through Divisional governance processes and reporting to the PSMLG who may commission a safety improvement plan. Again, the Divisions will work collaboratively with the Patient Safety Team and Quality Improvement Team and others to ensure there is an aligned approach to development of the plan and resultant improvement efforts.

9 COMPLAINTS AND APPEALS

The Trust recognises that there will be occasions when patients, service users or carers are dissatisfied with aspects of the care and services provided by the Trust. Details on how these are managed can be found in ORG002 Complaints Policy and CCR101 PALS Policy.

On occasion concerns or complaints can be raised by individuals that bring to light the occurrence of a patient safety incident. Such concerns or complaints will be brought to the weekly PSIRG to consider the best approach to responding to these. In some instances, these may meet the criteria for a PSII or PSR in which case we will liaise with

the complainant to agree the best approach to responding to their concerns.

In addition, patients, families and their carers who have been affected by a patient safety incident and involved in the subsequent learning response may have cause to raise concerns about how this was carried out. If the staff member(s) leading the learning response are not able to support resolution of their concerns then they will be directed to the complaints process in support of answering their concerns.

10 MORTALITY

This policy should be read in conjunction with CCR157: Learning from Deaths Policy

The Trust PSIRP sets out the Trust's approach to aligning patient safety activities with those required from the Learning from Deaths Policy. The Trust believes that by aligning both routes for learning, greater opportunities for triangulation of information can be promoted supporting the identification of themes and trends and minimising duplication of information requests for our staff.

11 GLOSSARY OF TERMS AND ABBREVIATIONS

Abbreviations and terms	Definition
PSIRG	Patient Safety Incident Review Group
PSMLG	Patient Safety and Mortality Learning Group
IFR	Initial Findings Report
PSII	Patient Safety Incident Investigation
PSR	Patient Safety Review
MDT	Multi-Disciplinary Team
PSELG	Patient Safety Experience and Learning Group

12 REFERENCES:

- NHS England (2023) Policy Guidance of recording patient safety events and level of harm
- NHS England (2022) NHS England » Seven interconnected principles
- NHS England (2022) Patient safety incident response standards
- B1465-5.-Patient-Safety-Incident-Response-standards-v1-FINAL.pdf (england.nhs.uk)
- NHS England (2022) Safety action development guide
- https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf
- Equality Act 2010 (legislation.gov.uk)
- NHS England (2021) NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people.

13 APPENDICES

Appendix 1: New levels of Harm definitions from NHS England LFPSE National Guidance (June 2023)

Definitions – Harm Grading

In the NHS, degree of harm recording relates to the actual impact on a patient from the particular incident being reported. Just as in NRLS, LFPSE maintains this principle. Patient safety incident harm definitions should always be applied based on the best information about the actual impact of the incident at the time of recording. The harm grading can be reviewed and updated as more information becomes available, but should not be used to speculate about, for example more severe "potential harm" if that does not appear to have been caused.

A new addition in this policy guide and in relation to patient safety incident data in the LFPSE service relates to specific capture of information on psychological harm. Previously in the NHS, harm grading included psychological harm as well as physical harm within one measure. Following feedback from staff, patients and families, physical and psychological harm have been separated out and each can now be recorded in the LFPSE service.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades	New physical harm grades	New psychological harm grades
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

The full definitions of the harm gradings are as follows:

Physical harm

No physical harm

No physical harm

Low physical harm

Low physical harm is when **all of the** following apply:

- minimal harm occurred - patient(s) required extra observation or minor treatment.
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit.
- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication.
- did not or is unlikely to affect that patient's independence.
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm

Moderate harm is when **at least one** of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention.
- has limited or is likely to limit the patient's independence, but for less than 6 months.
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe physical harm

Severe harm is when **at least one** of the following apply:

- permanent harm / permanent alteration of the physiology.
- needed immediate life-saving clinical intervention.
- is likely to have reduced the patient's life expectancy.
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment.
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions.
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm

Low psychological harm is when **at least one** of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit.
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days.
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition.

Moderate psychological harm

Moderate psychological harm is when **at least one** of the following apply:

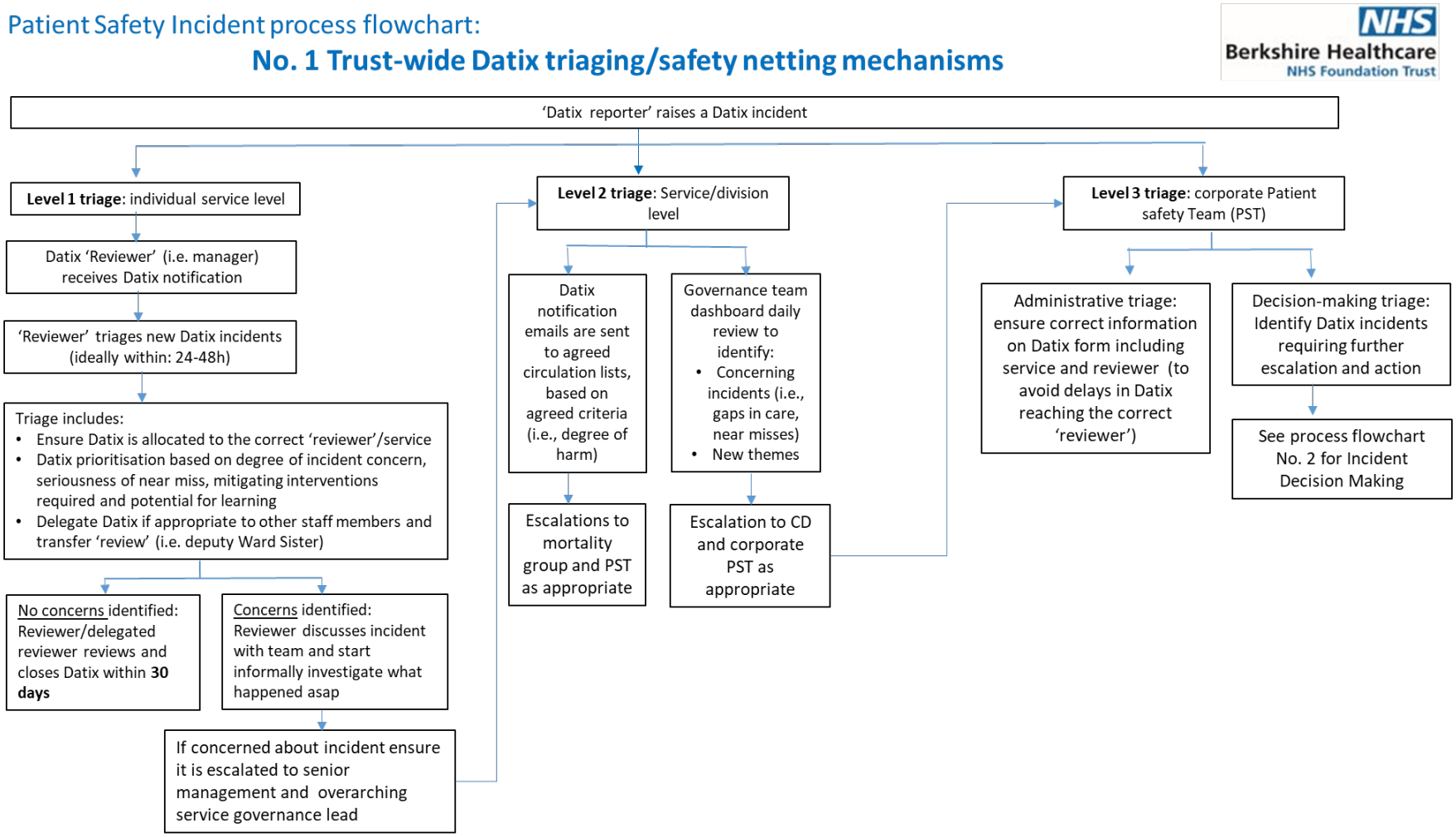
- distress that did or is likely to need a course of treatment that extends for less than six months.
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months.
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months.

Severe psychological harm

Severe psychological harm is when **at least one** of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months.
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months.
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months.

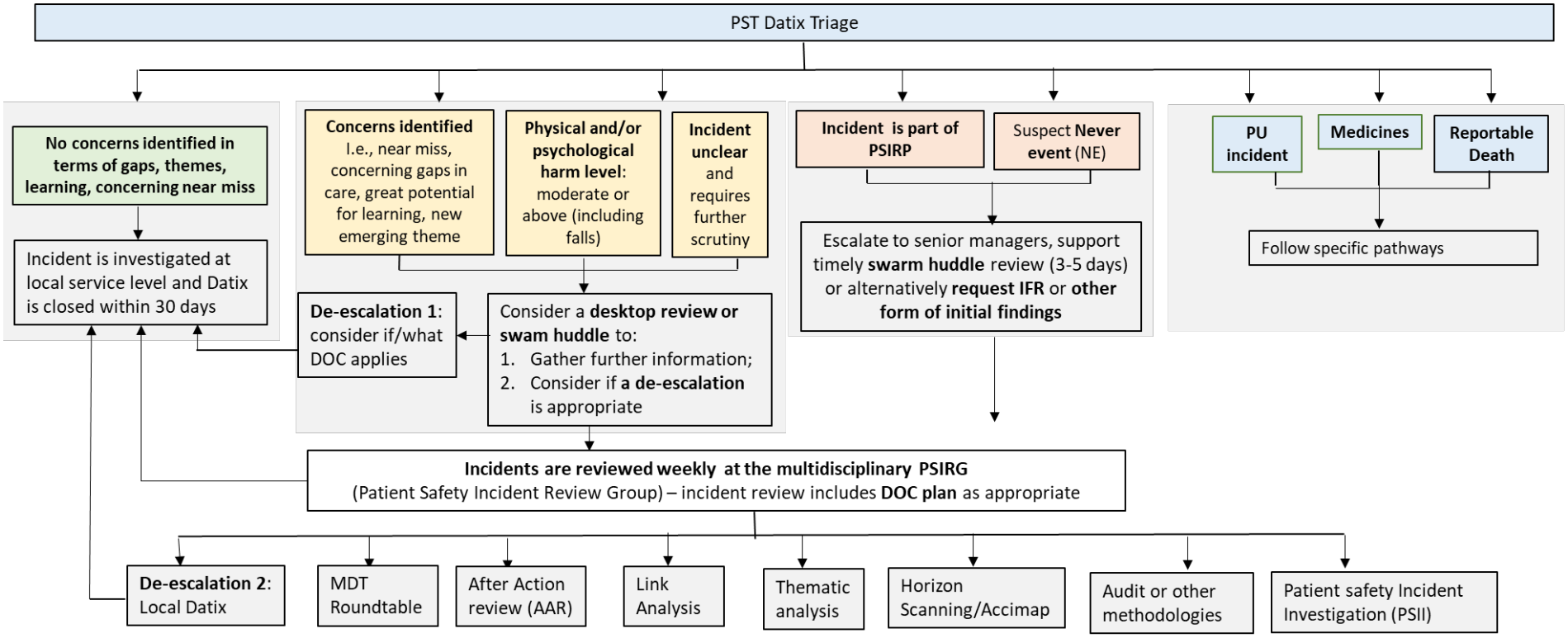
Appendix 2: Patient Safety Incidents Triage process



Appendix 3: Incident decision making process- (to determine the learning response)

Patient Safety process flowchart: **No. 3 Patient safety team (PST) – Incident Response Plan**

Berkshire Healthcare NHS Foundation Trust



Appendix 4 External Reporting Requirements

Safeguarding concerns

Staff should always record all adult safeguarding concerns on the Datix system, completing an incident form and sending a copy to the Local Authority. Any conversations with the Local Authority or updates received must be subsequently recorded on the Datix system. For children refer to the safeguarding children's policy and procedures. See Berkshire Healthcare Policy CCR089 Safeguarding Adults from Abuse or harm and CCR072 Child Protection (Safeguarding and Promoting the Welfare of Children) for further information.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013 require employers, people in control of premises and in some cases the self-employed to report certain types of injury, occupational ill-health and dangerous occurrences to their enforcing authority which occur arising out of, or in connection with work. The enforcing authorities for Healthcare Trusts are the Health & Safety Executive (hereafter referred to as the HSE) and for patient-related incidents.

- If someone dies in an accident arising out of or in connection with work it must be reported straight away on to Datix and the Deputy Director of Nursing Patient Safety and Quality/Patient Safety Managers or the On Call Director (OOH) who will report to the HSE within 24 hours via telephone on 0845 3009923.
- If any person not at work suffers an injury as a result of an accident/ incident arising out of or in connection with a Berkshire Healthcare work activity and that person is taken from the site of the accident to a hospital for treatment in respect of that injury, the Deputy Director of Nursing Patient Safety and Quality/the Patient Safety Managers or the On Call Director (OOH) should be notified as soon as possible.
- If any person suffers a specified injury as a result of an accident/ incident arising out of or in connection with their work i.e. hospital, clinic or patient's home, a Datix will be completed which will inform the Deputy Director of Nursing for Patient Safety and Quality and Patient Safety and Compliance Manager.
- The following are injuries that are to be reported:
- General Injuries:
- Any injury that restricts an employee's ability to carry out the full range of their duties, or they are absent from work for more than seven days, excluding the day of the incident. (It is important that line managers monitor the effect of work-related injuries to ensure that reporting of these incidents is not overlooked).
- Specified injuries to workers:
- Fractures, other than to fingers, thumbs and toes.
- Amputation of an arm, hand, finger, thumb, leg, foot or toe.
- Any injury likely to lead to permanent loss of sight or reduction in sight in one or both eyes.
- Any crush injury to the head or torso, causing damage to the brain or internal organs
- Any burn injury (including scalding).
- Burns which meet the above criteria are reportable, irrespective of the nature of the

agent involved, and so include burns caused by direct heat, chemical burns and radiological burns.

- Where the eyes, respiratory system or other vital organs are significantly harmed as a consequence of a burn, this is a reportable injury irrespective of the surface area covered by that burn.
- Any degree of scalping requiring hospital treatment.
- Any loss of consciousness caused by head injury or asphyxia.
- Any other injury arising from working in an enclosed space.
    - Dangerous occurrences requiring reporting will be identified by the Compliance and Risk Team following an incident report.
    - RIDDOR forms should be completed on-line at www.riddor.gov.uk/ and an electronic copy attached to the electronic incident form.
    - Additionally, the Datix incident form must be completed and include where known the following core details: -
- Date and time of incident.
- Location.
- Name, address, gender and status of persons involved/affected.
- Details of any injuries.
- Brief outline of the circumstances of the incident.
    - If the incident involves the person in charge, then the next line manager must be informed immediately. Where there is uncertainty as to whether an incident should be reported, advice must be sought from the senior manager and/or the Risk Services Team. It can be reported on-line at http://www.hse.gov.uk/riddor/. An electronic copy of the report should be attached to the adverse incident form.

Other External Agencies

Other organisations may need to be informed dependent upon the type of incident. The Patient Safety Team will be responsible for this. Organisations or parties to be reported to could include:

- Police.
- Coroner.
- NHS England.
- Commissioners.
- Health and Safety Executive.
- Medical Devices Agency.
- Care Quality Commission (CQC) (see below) *
- Berkshire Healthcare Legal Advisors.
- Local Safeguarding Children Boards/Safeguarding Adult Boards.
- The relevant head of Social Services if the incident is likely to be of particular interest to the organization
- Other Health Providers.
- University/Education Providers.

According to the processes outlined in the CQC Statutory Notifications (2012) the following must be reported directly to the CQC;

- Death of persons detained or liable to be detained under the MHA directly to the CQC.
- Applications to deprive a person of their liberty under the Mental Capacity Act 2005 and their outcomes.
- Admission on minors to Adult Mental Health Wards

Equality Analysis – Template

'Helping you deliver person-centered care and fair employment'

Title of policy/programme/service change being assessed:	
Date of Assessment:	
Assessment Author:	

1. Briefly describe the aims, objectives and purpose of the policy/programme/service change.

2. Who is likely to be affected by the policy/programme/service change?

3. Analysis of Impact - what impact will the policy/programme/service change have on protected groups. Indicate below whether the impact on each protected group will be positive, neutral or negative and give a reason for your assessment.

Protected Characteristic	Nature of any Impact			Reason for Impact Identified
	Positive	Neutral	Negative	
Sex		X		All groups will be treated equitably
Age		X		All groups will be treated equitably
Disability		X		All groups will be treated equitably
Race/Ethnicity		X		All groups will be treated equitably
Religion/Belief		X		All groups will be treated equitably
Sexual Orientation		X		All groups will be treated equitably
Gender Reassignment		X		All groups will be treated equitably
Maternity & Pregnanc		X		All groups will be treated equitably

y				
Marriage & Civil Partnership		X		All groups will be treated equitably
Carers		X		All groups will be treated equitably
Other Group(s) (please specify)		X		All groups will be treated equitably

4. Action Plan - for any negative impact(s) identified above, complete the action plan below to identify the actions needed to reduce the negative impact on specified protected groups (where no negative impact has been identified, please move to summary section 5 below)

Negative Impact	**Action needed to reduce negative impact, including changes, options and alternatives to be considered**	**Lead**	**Timescale**

5. Summary – please indicate below which of the following impact statements best describes the overall impact of the policy/programme/service change on equality

Highly likely to have an adverse effect on equality **High Risk**	May have an adverse effect of equality **Moderate Risk**	Unlikely to have an adverse effect on equality **Low Risk**
Highly likely to promote equality of opportunity and good relations **High Potential**	May promote equality of opportunity and good relations **Moderate Potential**	Unlikely to promote equality of opportunity or good relations **Low Potential**

Berkshire Healthcare
NHS Foundation Trust

Patient safety incident response plan

Effective date:

Estimated refresh date:

	NAME	TITLE	SIGNATURE	DATE
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Contents

1. Introduction

This Patient Safety Incident Response Plan (PSIRP) sets out how Berkshire Healthcare NHS Foundation Trust intends to respond to, and learn from, patient safety incidents reported by our staff, patients and their families and carers and third-parties such as the Coroner.

It is our plan for the next 18 – 24 months but we acknowledge that it is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occur and the needs of those affected.

The document should be read alongside the national Patient Safety Incident Response Framework (PSIRF) (NHSE 2022), which sets out the requirement for this plan to be developed as well as our Trust Patient Safety Incident Response Policy.

Overall, PSIRF requires a fundamental shift in how the NHS responds to patient safety incidents for the purposes of learning and improvement. It makes no distinction between 'patient safety incidents' and 'serious incidents (SI)' and as such the SI Framework will cease to exist as this plan is being introduced. Some national requirements will however continue to influence some incident responses decisions, and these are considered within this plan.

In order to develop PSIRF-compliant and effective patient safety incident response systems, we need to ensure that we[1]:

- ***Compassionately engage and involve those affected by our patient safety incidents*** – seeking patient, family and staff input into a response and developing a shared understanding of what happened using approaches that prioritises and respects the needs of those affected.

- ***Apply a range of 'system-based approaches'*** *to learning from our patient safety incidents* – PSIRF recognises the complex interactions arising from the healthcare system and the need to move away from root-cause analysis approaches to system-based investigations.

[1] How we will achieve these 4 main areas is described in more detail in our Patient Safety Incident Response Policy

- ***Decide on 'considered and proportionate responses'*** *to our patient safety incidents* – PSIRF supports organisations to respond to incidents in a way that maximises learning and improvement rather than basing responses on arbitrary and subjective definitions of harm. It promotes a range of learning responses which we can apply if an incident requires further review - meaning that an investigation is only one of a toolkit of methodologies that can be used.

- ***Have supportive oversight*** *that focuses on improvement.*

The purpose of our plan is to specify the methods we intend to use to maximise learning and improvement and how these will be applied to different patient safety incidents that occur within our services.

It has been developed based on a thorough understanding of our current patient safety profile, ongoing improvement priorities and available resources. In addition, there has been collaboration and discussion with our key stakeholders as well as assistance from, and approval by, our local Integrated Care Boards (ICB's).

This plan will be updated regularly based on new learning, our changing risk profile and ongoing improvements. In this way, 'incident response' becomes part of a wider safety management system approach across Berkshire Healthcare.

It is important to remember that we have some robust and rigorous processes already in place for reviewing our patient safety incidents and, as a result, some of these will remain as we implement our PSIRP. We received accreditation in 2021 from the Royal College of Psychiatrists for our approach to investigating 'serious incidents' which encompassed how we engage with patients and their families during the process. We use a 'team approach' to completing our investigations which has been positively received by staff and seen as factor in supporting our 'Just Culture'. Over the past 12 months, we have also been Multidisciplinary Debriefs and After Action Reviews (AAR) to introduce staff to alternative methodologies to reviewing and responding to some of our incidents.

2. Glossary

After Action Review	A structured, facilitated discussion of a patient safety incident, the outcome of which gives the individuals involved an understanding of why the outcome differed from that expected and the learning to assist improvement.
Initial Findings Review	A written initial review of the incident/event, usually completed by one author. This will include a timeline of events, highlighting any immediate risks and whether there are any concerns that may require a subsequent learning response.
Learning Response	A tool that is designed to facilitate learning in response to a patient safety incident. This is a generic term for any of the methodologies included in the toolkit which are further covered in Appendix 4.
Multidisciplinary Roundtable Review	A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.
Patient Safety Incident	An unplanned, unexpected or unintended event where something has happened, or failed to happen, as a result of the care or treatment provided that could have or did lead to patient harm.
Patient Safety Incident Investigation	A patient safety incident investigation (PSII) is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. It is an in-depth review of a single patient safety incident or cluster of events to understand what happened and how
Swarm Huddle	This is designed to be initiated as soon as possible after an event and involves an MDT discussion (could also be referred to as a hot debrief)

3. Our services

Berkshire Healthcare Foundation Trust (BHFT) is a community physical health and mental health organisation providing a wide range of services to people of all ages living within Berkshire County.

BHFT provides services to a population of approximately 915,000. Services cover mental health, physical health, and specialist services for young people.

On 01 April 2023 the organisation restructured, and its current set up includes three divisions:

- **Mental Health Services.** This includes three overarching services: Urgent Mental Health Care, Specialist Mental Health Services and Community Mental Health
- **Community Physical Health Services:** including Urgent Community Services and Scheduled Community Services
- **Children, Families and All Age Services** including CAMHS and Learning Disability and Neurodiversity and Universal Services and Perinatal, eating disorder all age

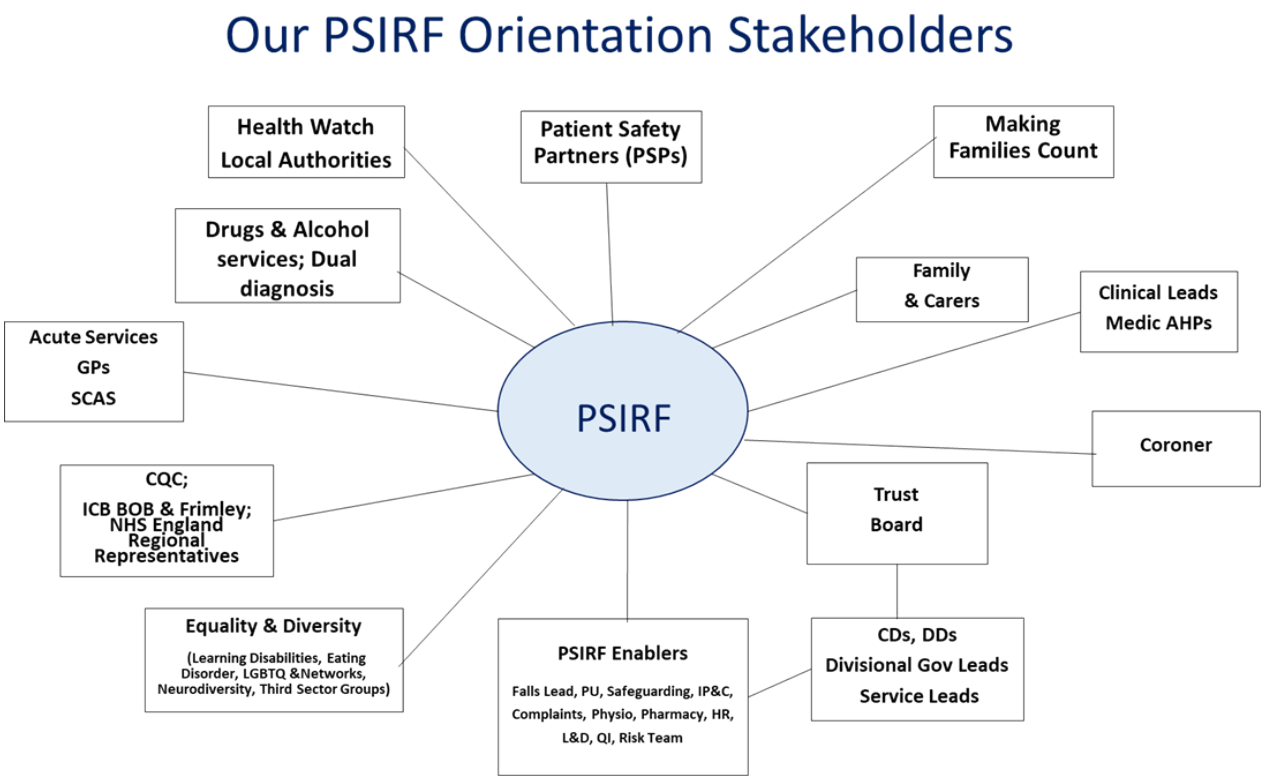
4. Defining our patient safety incident profile

In order to identify and agree the patient safety issues most pertinent to BHFT, as well as to inform and decide what our proportionate responses to patient safety incidents should be, we first had to start with a number of planning and scoping exercises.

Stakeholder engagement

A stakeholders' mapping exercise (see Fig 1) was undertaken during the PSIRF 'orientation[2]' phase and reviewed throughout our PSIRF implementation planning. This enabled the identification of key stakeholders within and outside BHFT. A range of opportunities were then offered by the Patient Safety Team to get stakeholder engagement in our planning processes and to seek their views on developing and understanding our incident profile. These opportunities included attendance at our main PSIRF event, along with completion of questionnaires and discussions at a variety of team/service/divisional meetings.

Fig. 1 – Stakeholder mapping



[2] Orientation took place between October 2022 to January 2023. During this phase Patient Safety Specialists (PSSs) met with as many internal and external stakeholders of local safety as possible to discuss PSIRF and gather views and feedback

Data sources

In addition to our stakeholder feedback, a significant amount of data was reviewed to provide us with the current intelligence to develop a robust patient safety incident profile. Data from the last 2 years was reviewed from several sources including our:

- Patient safety incidents reported on our local risk management system (Datix)
- Serious incidents
- Internal learning reviews
- Complaints
- Compliments
- Audit data
- Freedom to Speak Up reports
- Safeguarding reports and S42s
- Infection, Prevention & Control reports and post infection reviews
- Structure Judgement Reviews (Learning from Deaths)
- Prevention of Future Deaths (national recurring themes)
- Staff survey results
- Coroner feedback
- Medication reviews

Initially this data was used to develop individual local Patient Safety Incident Profiles for our divisions/services. An example of these are provided in Appendix 1. These profiles provided the focal point for discussions at our PSIRF stakeholder event.

Combining stakeholder feedback with data intelligence

Our individual local Patient Safety Incident Profiles and feedback obtained from multiple sources (see Table 1) have been used to develop:

- A collective understanding of what services/team's feel is already known about them
- What issues had already been reviewed and have associated action/improvement plans within their area
- Where energy and resources for responding to patient safety incidents should be directed in the future
- A comprehensive summary of key learning from multiple sources can be found in Appendix 2.

Table 1 – Sources of engagement and feedback

Trust-Wide PSIRF event of 30/01/23
ICB-led PSIRF events throughout 2022/2023
Trust PSIRF questionnaire
Presentation and feedback from BHFT Board
Presentation and feedback from the Patient Safety Strategy Implementation Group
Local benchmarking and network groups
Feedback from Patient Safety Partners
Feedback from our families and the Family Liaison Officer
Feedback from Making Families Count
Presentations and feedback from Divisional' Patient Safety Quality meetings (MH, PH and CYPAA)
Meetings with specialist services including infection prevention and control; mortality; pressure ulcers; falls
Meetings and feedback from local services
Conversations with other stakeholders (substances misuse services/dual diagnosis services)
BHFT QI and Transformation Leads
Suicide Prevention Strategy Group
MHICS Operational Group
Digital Clinical Leadership Group

This work has allowed us to compile the patient safety issues most pertinent to BHFT presently. It is important to acknowledge that this list is not exhaustive however it reflects what our stakeholders and data show as our current profile. As the Trust progresses with the implementation of PSIRP some changes may emerge, and these would be addressed as appropriate.

They are summarised in Table 2.

Under the PSIRF principles of "considered and proportionate" responses to patient safety incidents, how these issues will be addressed is covered in Chapter 7 and 8.

Table 2 – Summary of patient safety issues for BHFT

Patient Safety Issue	Division	Service
Absent without leave (AWOL) and welfare escalations	Mental Health	Inpatients
An issue where significant concerns about communication have affected the patient journey and subsequent care.	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Communication with our neurodivergent population	Mental Health Children, Families and All Age Services	All services Mental health services (e.g. CAMHS, BEDS)
Falls with significant harm/injury	Physical Health Mental Health	Inpatients Inpatients
Handover processes	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Incidents of attempted suicide / significant self-harm	Mental Health Children, Families and All Age Services	All services Mental health services (e.g. CAMHS, BEDS)
IT systems and infrastructure	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
Management of the deteriorating patient and escalation	Mental Health Physical Health	Inpatients Inpatients & community services
Management of mental health observations	Mental Health	Inpatients
Medication errors	Mental Health Physical Health	Inpatients Inpatients & community services
Missed visits	Physical Health Mental Health	Community services Community services
Movement between services	Physical Health Mental Health Children, Families and All Age Services	All services across all 3 divisions
New Pressure ulcers	Physical Health Mental Health	Inpatients & community services Inpatients
Restrictive interventions	Mental Health	Inpatients
Safety of patients on waiting lists	Physical Health	Community services

	Mental Health	Community services
Suicides	Mental Health	Community services
Transitioning from children's to adults mental health services	Mental Health Children, Families and All Age Services	Community services All Mental Health services (e.g. CAMHS, BEDS)

5. Defining our Patient Safety Improvement and Transformation Profile

This section is about our improvement and service transformation work that has an impact on patient safety and that is already underway or planned across BHFT. It includes relevant national and regional improvement programmes as well as locally driven service improvements.

As part of this process, consideration was given to the wider local and national picture influencing patient safety reporting and improvement plans. The following were considered within the decision-making process and in conjunction to stakeholders' feedback:

- National Patient Safety Improvement Programmes
- Nationally defined never-event incidents requiring a local Patient Safety Incident Investigation (PSII) response.
- National Learning from Death guidance and Structured Judgement Review (SJR) guidance
- Other national guidelines linked to incidents reporting and improvements (I.e., NHS England Policy Guidance on Recording Patient Safety Events)
- Existing local agreements
- BHFT True North goals.
- Strategic Prioritisation Board and other Trust Quality Improvement Programmes

5.1 National Patient Safety Improvement Programmes

The **National Patient Safety Improvement Programmes (PSIPs)** are a key part of the NHS Patient Safety Strategy (2019/2021) to ensure the delivery of safe and quality care. PSIPs are delivered locally and they are supported through a number of initiatives including support from the Oxford Academic Health Science Network (OAHSN) - Patient Safety Collaborative (PSC) team. Of significant relevance to BHFT are 5.1.3 and 5.1.5

Currently the national priorities are:

5.1.1 ***Managing Deterioration safety improvement programme*** (ManDet SIP)

ManDetSIP focuses on managing deterioration at a system-wide level across both health and social care through Managing Deterioration Networks and Care Homes Patient Safety Networks. It supports the adoption and spread of pulse oximetry[3]

5.1.2 ***Maternity and Neonatal safety improvement programme*** (ManNeo SIP)

MatNeoSIP focuses on reducing smoking in pregnancy, support spread and adoption of preterm optimisation care, improve early recognition of mother/baby deterioration; support the development of early warning scores specifically for neonatal services.

5.1.3 **Medicines safety improvement programme** (Med SIP)

MedSIP addresses causes of severe harm associated to medicines and aims at reducing administration errors, reduce harm from opioids medicines by reducing high dose prescribing; reduce harm by reducing the prescription and supply of oral methotrexate.

5.1.4 **Adoption and Spread safety improvement programme** (A&S-SIP)

A&S-SIP supports the adoption and spread of safe evidence-based interventions and practice including tracheostomy[4] interventions, Chronic-Obstructive Pulmonary Disease (COPD) care bundle; Asthma discharge care bundles; emergency laparotomy care bundles.

5.1.5 **Mental Health safety improvement programme** (MH-SIP)

MH-SIP aims at reducing variations in care and quality of care provided and focuses on reducing suicide and self-harm in both acute and non-acute mental health settings; reduce the incidence of restrictive practice, improve sexual safety for patients and staff on inpatients mental health units and within learning disabilities services.

5.2 Nationally defined incidents requiring a local PSII

5.2.1 Incidents meeting the **Never Event Criteria**

NHS England » Revised Never Events policy and framework

Of significant relevance to BHFT services are incidents including:

- Insulin overdoses due to abbreviations or incorrect device leading to ten time or greater overdose; failing to use a device (i.e., insulin syringe or pen) to measure insulin;

[3] Small medical device to measure peripheral oxygen saturation levels normally though a finger.
[4] It is an opening created in front of the neck so that a tube can be inserted in the windpipe to help breathing

withdrawing insulin from a pen or pen refill and then administering this using a syringe and needle.

- Overdoses of methotrexate for non-cancer treatment that is more than the intended weekly. dose and involving an electronic prescribing system.
- Failure to install functional collapsible shower or curtain rails in MH inpatient settings.
- Falls from poorly restricted window in all NHS settings.
- Chest or neck entrapment in bedrails in all NHS settings an patient own home where equipment has been provided by the NHS.
- Patient scalded by water used for washing/bathing

5.3 National 'Learning from Death' and 'SJR' guidance

nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

NMCRR clinical governance guide_1.pdf (rcplondon.ac.uk)

rcpsych_mortality_review_guidance.pdf

In mental health services there are significant considerations related to the review of unexpected deaths and/or suspected suicides within the principles of PSIRF that are further considered under Chapter 7 and Chapter 8.

5.4 Other National Guidelines linked to incident reporting and incident reviews

5.4.1 Guidance of reporting pressure ulcers

NHS England » Pressure ulcers: revised definition and measurement framework

5.4.2 Preventing Gram-negative bloodstream infections (GNBSI)

NHS England » Preventing healthcare associated Gram-negative bloodstream infections (GNBSI)

5.4.3 Communicable disease outbreak management (includes COVID)

Communicable Disease Outbreak Management (publishing.service.gov.uk)

5.5 Existing local agreements

There are a number of patient safety incidents that have had automatic declaration as an SI under existing arrangements and agreements with previous CCG's. All of these agreements will cease to exist as a result of PSIRF implementation, SI framework becoming redundant and the responsibility of the incident response moving from the ICB to NHS Trusts.

Amendments to local processes documented in guidelines and policies will also have to take place following the implementation of this plan.

5.5 BHFT Breakthrough Objectives

- Reducing self-harm
- Reducing physical assaults on staff
- Reducing lost bed days
- Reducing restrictive practices

5.6 Strategic Prioritisation Board and other Trust Quality Improvement Programmes

Mission-Critical Projects

Project	Key dates	Rationale for Status
Community Mental Health Transformation Programme - System projects East and West	Mar-24	Implementation of the National Community Mental Health Framework requirements
BHFT Project One Team (CMHT Transformation) and Alternative to CPA.	Sep-24	In accordance with Community MH transformation framework and NHS Long Term plan. Reduces waiting lists and unwieldy/unrealistic OPA caseload. More clarity re. CMHT offer; removal of multiple referral routes. Reducing/removing variation.
EDI Strategy (inc.BAME Transformation Plan)	Mar-24	Part of the Trusts "our people" Strategic Initiative and People Strategy but includes patient elements so presented as a separate item here.
PPH Bed Optimisation	Mar-24	National requirement NHSE/I trajectory to achieve zero inappropriate acute OAPs by 31st March 2024
Virtual Wards - East and West Berkshire	Apr-24	NHSIE initiative to improve capacity & flow. Initial ticket raised for working in partnership with RBH to deliver the Berkshire West element of the BOB VW plan. Now includes Berkshire East as well.
CREST (Community Rehabilitation Enhanced Support Team)	Apr-24	Berkshire wide initiative to adhere to National CMH guidance, NICE guidance, CQC and GIRFT to reduce number of locked rehab placements (part of 2022/23 and 2023/24 CIPs). **Soft launch in progress - potential to move to transitioning to BAU in June 23**

Important Projects

Project	Key dates	Rationale for Status
ePMA	Jul-23	Implementation of electronic prescribing and medicines administration (ePMA) integrated withTrust-Wide EPR and Pharmacy stock management and dispensing systems. **Project will move to BAU from July 23.**
Green Plan	Mar-25	Requirement for all Trusts
Neurodiversity Strategy Implementation	Mar-24	Part of the National Autism Strategy. Implementation plan approved in Nov 22.
CYPF Referral Management System	Mar-24	Involves a number of functions including the Health Hub.

6. Our patient safety incident response plan: National requirements[5]

Table 3 – National requirements for patient safety responses

Patient safety incident type	Required response	Anticipated improvement route
Never Events	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death thought more likely than not due to problems in care (>50% probability)[6]	PSII	Create local organisational actions and feed these into the quality improvement strategy
Death of patients - under MH Act 1983 or MH Capacity Act 2005 apply – where there is reason to think the death may be linked to problems in care	PSII	
Mental Health related homicides	Refer to NHS Regional Team for consideration for an independent PSII - or else a local PSII may be required	
Child death	Refer to child death overview panel and liaise with panel as to whether PSII is required	
Death of person with Learning Disability	LeDeR to review and inform if further PSII is required	
Safeguarding incident of:	Refer to Trust Safeguarding Team that will refer to Local	

[5] This list has been extracted from NHS England Patient Safety Incident Response Framework (August 2022)
[6] Also please see Chapter 8

Young individuals under child protection plan, looked after plan or victims of neglect/domestic abuse Adults >18 years in receipt of care and support needs from their Local Authority Relating to female genital mutilation, prevent, modern slavery or domestic abuse/violence	Authority, contribute to multi-agency reviews and advice further on appropriate response	
Death of person in custody	Refer to prison and probation ombudsman or the independent office for police conduct and support their investigation where required	
Domestic Homicide	Refer to Trust Safeguarding to ensure liaisons with police and community safety partnership and contribute to any required review as appropriate	

7. Our patient safety incident response plan: local focus

This section will outline the considered and proportionate response methods for the issues/incidents listed in Chapter 4 of this plan. The list is not exhaustive of all patient safety incidents in BHFT but provides guidance for what the focus of our local priorities will be over the next 18-24 months.

This plan should be read in conjunction with our Patient Safety Incident Response Policy which provides additional information regarding the processes of Datix triage, decision making and oversight responsibilities.

The type of learning response suggested will depend on:

- The view of those affected – including patient and family.
- Capacity to undertake a learning response.
- What is known about the factors that led to the incident.
- Whether improvement work is already underway to address the identified contributory factors.
- Whether there is evidence that improvement work is having the intended effect.
- If BHFT and its' ICBs are satisfied that risks are being appropriately managed.

Please note incident types described in Table 4 that are not chosen for a PSII will still be reviewed under patient safety processes to decide if:

a) a further learning response is required (from the toolkit) and/or
b) what steps are required to engage with the family and ensure their questions are answered. For those incident types that are reportable deaths this is further detailed in Chapter 8.

National Guidance suggests that a key element of PSIRF is setting out the number of PSII's that will be completed per year to support prioritisation and management of resources. However, it is at the discretion of the Trust to remain flexible and objective in our approach if this is felt necessary to support learning and meet the needs of our patient and families. Completion of PSIIs will allow us to apply a systems-based approach to learning from these incidents, exploring multiple interacting contributory factors.

Table 4

Patient safety incident type or issue	Planned learning response	Anticipated improvement route (if currently known)
An incident of suspected suicide involving individuals with neurodiverse traits and currently open to our mental health services	Consider PSII[7], up to 5 per year	Suicide Prevention and Neurodiversity workstreams
An incident of suspected suicide involving individuals that had 3 or more contacts with mental heath urgent care services but otherwise not receiving coordinated mental health interventions	Consider PSII, up to 3 per year.	Suicide Prevention and Neurodiversity workstreams
An incident of significant harm or learning occurring to a mental health inpatient (i.e., deteriorating patient, self-harm, absent without leave and welfare escalations)	Consider PSII, up to 5 per year.	MHIP improvement plans
An issue where significant concerns about communication have affected the patient journey and subsequent care (i.e., discharge/ admissions planning, children transitioning to adult services)	Consider PSII, up to 5 per year. These reviews should be conducted jointly with other involved organisations.	Project One Team, virtual wards, bed optimisation
All other suicides which are not thought to be due to problems in care (>50%) and not falling under local priority PSIIs.	Refer to Chapter 8	Suicide Prevention and Neurodiversity workstreams and Project One Team
Near miss incidents where Datix and/or initial Patient Safety Team desktop review highlight	Look at toolbox of methodologies and consider an	

[7] Statutory Duty of Candour to be applied to any incident that is a PSII

opportunities for learning, prevention of harm and improvement	appropriate learning response.	
Incidents of missed visits where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	
Incidents of medication errors where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Medication improvement plans
Safety of patients on waiting lists where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Project One team
Issues where communication with neurodivergent population where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Suicide Prevention and Neurodiversity workstreams
Falls with fractured large bones where Datix, ward debrief and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Trust improvement plan for falls
New pressure ulcers where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	Trust improvement plan for pressure ulcers

Incidents of attempted suicide / significant self-harm where Datix and/or initial Patient Safety Team desktop review highlight opportunities for learning and improvement	Look at toolbox of methodologies and consider an appropriate learning response.	
Any other patient safety incident highlighting significant concerns, learning or new emerging themes	Look at toolbox of methodologies and consider an appropriate learning response.	
Infection Prevention and Control (IPC) reportable infections whereby after initial IPC desktop review opportunities for learning are identified	Use IPC methodologies in line with national IPC guidance.	

If we cannot easily identify where an incident fits in relation to this plan i.e. whether a learning response is required, we will perform an assessment to determine whether there are any problems in care that require further exploration and potentially action. This will be a critical role of our multidisciplinary Patient Safety Incident Review Group (PSIRG) as further elaborated in the Patient Safety Incident Response Policy.

It is important to remember that under PSIRF, incident responses are not necessarily associated to the degree of harm. However, the principles of Duty of Candour and our responsibility (as per Regulation 20 of the CQC guidance) will always apply to notifiable patient safety incidents. This is further explained in the Patient Safety Incident Response Policy and our Duty of Candour Policy. In summary, if it is a PSII, professional and statutory Duty of Candour will apply; if an incident is identified as not requiring further learning response but a degree of harm is identified, plans would be considered and agreed to ensure Duty of Candour requirements are fulfilled as appropriate. An example of a letter can be seen in Appendix 3.

8. Our patient safety incident response plan: mortality

1st stage review

1st stage reviews will continue to be discussed at weekly Executive Mortality Review Group (EMRG) looking at all deaths reported via Datix.

2nd stage review - Mental Health Deaths

	Incident type	2nd stage review required	Incident Response Plan (if applicable)
1	Suspected suicides of patients open to BHFT Mental Health Services and those who were closed to BHFT Mental Health Services within 6 months of the death.	If potentially PSII / one of PSIRP priorities = IFR If not likely PSII / one of PSIRP priorities = decide most appropriate 2nd stage review i.e IFR, MDT Roundtable, Desktop Review. Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%). PSII if involving individuals with neurodiverse traits and currently open to our mental health services (max 5 PSIIs/year). PSII if involving individuals that had 3 or more contacts with MH urgent care services but otherwise not receiving coordinated MH interventions (max 3 PSIIs/year). If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 4) this will include agreeing the format of report/letter they will receive.

			If death thought less likely than not due to problems in care and no family concerns, no further learning response. However, if family wish to hear findings from 2nd stage review they will be written to with an overview of the findings (see Appendix 3 for example template).
2	Suspected suicides and unexpected deaths of patients closed more than 6 months prior to the death.	Close at first stage review Consider whether condolence letter is appropriate. Reopen at Patient Safety Incident Review Group (PSIRG) if questions come back from family or coroner.	If concerns are raised, an appropriate review of care/learning response will be considered
3	Unexpected deaths judged at 1st stage review to be more than 50% likely to be suicides. They must have been open to BHFT Mental Health Services or closed within 6 months of the death.	If potentially PSII / one of PSIRP priorities = IFR If not likely PSII / one of PSIRP priorities = decide most appropriate 2nd stage review i.e IFR, MDT Roundtable, Desktop Review. Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%) If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 4) If death thought less likely than not due to problems in care and no family concerns, no further learning response. However, if family wish to hear findings from 2nd stage review they will be written to with an overview of

			the findings (see Appendix 4 for example template)
4	Unexpected deaths judged at 1st stage review to be less than 50% likely due to suicide. Please see Physical Health Deaths below.	Structured judgement review	PSII if death thought more likely than not due to problems in care (>50%)

2nd stage - Learning Disability Deaths

	Incident type	**2nd stage review required**	**Incident Response Plan (if applicable)**
1	All deaths of patients with learning disability and/or a confirmed diagnosis of autism who received care in the last 12 months[8]	Structured judgement review	PSII if death thought more likely than not due to problems in care (>50%)

2nd stage - Physical Health Deaths

	Incident type	**2nd stage review required**	**Incident Response Plan (if applicable)**
1	Physical Health unexpected deaths where 1st stage review highlight more likely than not due to problems in care (>50%)	If potentially PSII / one of PSIRP priorities = IFR Duty of Candour to be applied (Patient Safety Team will advise whether the statutory duty applies).	PSII if death thought more likely than not due to problems in care (>50%) – (after 2nd stage review) If family concerns are raised, an appropriate review of care/learning response will be agreed with family (refer to Appendix 3)

[8] LeDer process is same for people with a learning disability and autistic people and the same level of review is conducted by ICB.

			If death thought less likely than not due to problems in care and no family concerns, no further learning response
2	Physical Health unexpected deaths highlighting new themes, potential for learning	If potentially PSII / one of PSIRP priorities = IFR	PSII if death thought more likely than not due to problems in care (>50%) – (after 2nd stage review) If highlighting new learning themes, look at toolbox of methodologies and consider an appropriate learning response.

In line with the Learning from Deaths policy the following types of deaths will all require a 2nd stage review in the form of a Structured Judgement Review. Those not covered in previous sections of this PSIRP include:

- There was an open safeguarding referral relating to the patient at the time of their death.
- Bereaved families and carers or staff have raised concern about the quality of care provision.
- Another organisation notifies us and suggests that BHFT should review the care provided to the patient but who were not under our care at the time of death.
- The patient was an inpatient on an Older Persons Mental Health Ward at the time of their death (informal and those identified as receiving end of life care).
- All mental health inpatients and those who have been discharged within a month of their death.
- They were a physical health inpatient and the death was unexpected.
- Patient was detained under Mental Health Act (MHA) – (if there is reason to think the death may be linked to problems in care then it will be a PSII).
- The death has been reported to the coroner or concerns have been raised by an individual or organisation as to the circumstances surrounding the death .
- The patient was transferred from BHFT mental health ward to an Acute Hospital and died within 7 days.

- All patients with a criteria of psychosis or eating disorder during their last episode of care who were under the care of services at the time of their death or had been discharged 6 months prior to death
- All patients under the crisis resolution and home treatment team (or equivalent) at the time of their death

Decision making following 2nd stage review

Decision regarding next steps following IFRs or MDT roundtable/desktop reviews will be made at the Patient Safety Incident Review Group (PSIRG).

Structured Judgement Reviews considered more than likely avoidable will also come to PSIRG to consider further learning response prior to coming to the Patient Safety and Mortality Learning Group

Structured Judgement Reviews considered less than likely to be avoidable will return directly to the Patient Safety and Mortality Learning Group (including deaths).

Completed PSII's and all other learning response relating to deaths (including letters to families responding to questions) will be approved at the Patient Safety and Mortality Learning Group.

Appendix 1 – Safety Profile Example – Community Mental Health

Incidents that have been reported January 2022 – December 2022

During the last calendar year, Community MH services reported 1154 incidents. The top 10 reported categories are seen below:

Category	Count in 2022
Self Harm/Self Harming Behaviour	337
Other incident	321
Confidentiality Issues	109
Drug Incident	88
Procedures not carried out	51
Assault	49
Behavioural/ Personal Conduct	30
Inappropriate Care	26
Falls, slips and trips	24
Assault - Non Physical	24

Of the 1154 incidents reported, 39 were then reported and investigated as serious incidents. They included 23 suspected suicides, 10 unexpected deaths, 1 self-harm (cutting), 1 Information Governance breach, and 4 attempted suicides.

A further 26 incidents went through an Internal Learning Review. These included 9 suspected suicides, 3 incidents of self-harm (2 from cutting and 1 from ingestion), 9 unexpected deaths, 1 attempted suicide, 1 alleged assault , 1 alleged murder, 1 road traffic accident of a patient under Community MH services and 1 IT failure.

Compliments reported January 2022 – December 2022

2210 compliments received. General themes on time spent with patients and support given.

Learning from Safeguarding Reviews

There is learning across all services from Safeguarding Adults reviews around MCA and professional curiosity. Specifically for our community MH services, there have been very few safeguarding concerns raised. Only issue has been about inappropriate staff behaviour including allegation of theft by staff.

100 Formal Complaints were received in the calendar year. Top complaint themes are:

Theme	Number of Formal Complaints
Care and Treatment	**47**
Clinical Care Received	38
Delay or failure to visit	4
Failure to examine/examination cursory	1
Failure/Delay in specialist Referral	3
Failure/incorrect diagnosis	1
Communication	**14**
Communication with Other Organisations	3
Verbal to Patients	5
Written to Patients	2
not stated	4
Attitude of Staff	**11**
Healthcare Professional	11
Confidentiality	7
Breach of Patient Confidentiality	4
Breach of third Party Confidentiality	3
Medication	**5**
Failure to prescribe/incorrect prescription	4
not stated	1
Medical Records	**5**
Inaccurate Records	4
Not stated	1

The top theme of the 100 formal complaints was **care and treatment** with the sub-theme as **clinical care received**.

Key themes from complaints: Attitude of staff features fairly highly across the community mental health services, with healthcare professionals being accused of being rude, unprofessional and/or intimidating or patients not feeling listened to.

Learning from Medicines' Datix reviews

- Omitted visit leading to omitted doses
- Omitted prescribing
- Wrong dose administered (old doses being administered)
- Administration at wrong time
- Wrong doses administered
- Duplication of administration
- Lack of response to reported constipation in patient on clozapine
- Lack of plan for long term sick cover – omitted prescribing

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Risk assessments and safety planning: frequency of completion not in line with Trust guidance; themes around quality of risk assessments/safety planning and content (variable); triangulation of risk
- Clinical plans: not being followed through (i.e. On discharge from MHIP; following MDT meetings); lack of standardisation of clinics/appointments booking; IT inadequacies to support cancellations/rebooking/administrative staff (i.e., during sickness);
- Medications: lack of consistency in documentation protocols (some paper, some electronic); unclear guidance/protocols around titrations and monitoring of adherence/non-concordance;
- Variable support to patients that may be on long waiting lists for interventions (i.e. IPT/EUPD pathways) and that are falling outside crises interventions, CHMT CCO and MHICS; local approaches, variations in approaches, variable degrees of support, commissioning and guidance unclear;
- Challenges associated with allocating CCO, cover during sickness/leave/vacancies;
- Challenges surrounding PH, MH and ASC work; silos work, capacity issues; complex patients;
- Safeguarding issues: raising Datix to inform BHFT safeguarding team, safeguarding concerns raised by various services/agencies with lack of clarity on who is leading on what; IT difficulties to access ASC information; some safeguarding, social, carer concerns not being escalated to relevant services;
- Specific patients' group (i.e., neurodiverse/ASD) suggest a higher risk of suicide. It is currently unclear if our tools/processes/approaches are 'fit for purpose' for specific groups
- Variation across the Trust in the allocation of care cluster and pathway. This is also impacted by differing thresholds for acceptance; Gaps in the outpatient review system; Lack of adaptations to the safety plan to ensure understanding
- Communication to patients who are not in the planner – maybe be missed as there is no open referral for them;
- Discrepancies between family perception of risk, expectation from services and services risk evaluation and what can be offered

Appendix 1 – Safety Profile Example – Physical Health Wards

Incidents that have been reported January 2022 – December 2022

During the last calendar year, Physical services reported 1567 incidents. The top 10 reported categories are seen below:

Category of Incident	Number in 2022
Pressure Ulcers	397
Ill Health	294
Falls, slips and trips	217
Drug Incident	160
Moisture Damage	132
Other incident	125
Skin Damage - Other	60
Procedures not carried out	55
Medical Emergency	32
Infection	17

Of the 1567 incidents reported, **9** were then reported and investigated as **serious incidents.** They included 4 falls, 3 deaths as a result of Healthcare Acquired Infection (Covid/pneumonia), 1 unexpected death and one pressure ulcer. There were no serious incidents reported during this period for East Wards

A further **29** incidents went through an **Internal Learning Review**. These included 4 Falls, 3 pressure ulcers, 1 physical assault, 1 episode of care received as a complaint from a patient and 4 unexpected deaths. There were 16 infections acquired whilst on the wards (Pseudomonas Aeruginosa x1, C. difficile x 6, E. Coli. X 6, Staphylococcus bacteraemia x 1 and MSSA x 2)

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Assessing patient's capacity and appropriate documentation in relation to this
- Medication error caused by ward team not having full details of patient's presentation - poor external communication/documentation between the acute and us as well as poor internal communication within own team
- VTE assessment was not completed and documented as per policy
- Management of dyshapgia
- Completion of accurate and consistent food and drink charts as well as fluid balance monitoring
- Review of care plans on weekly basis and lack of individualised care planning
- Management of the deteriorating patient (frequency of observations / escalation; use of correct NEWS score)
- Overall safety concerns about quality of discharge information received from acutes

Complaints reported January 2022 – December 2022

14 complaints were received. Top complaint themes are as below:

Theme	Number of Formal Complaints
Care and Treatment	**10**
Clinical Care Received	10
Discharge Arrangements	**2**
Discharge Planning	2
Patients Property and Valuables	**1**
Lost Property	1
Alleged Abuse, Bullying, Physical, Sexual, Verbal	**1**
Verbal Abuse	1

In addition, 3 complaints were taken forward to the Parliamentary and Health Service Ombudsman.

Key themes from complaints: There are no themes from the data however anecdotally, call bell response times and concerns about personal care (removing beards in particular) crop up.

Compliments reported January 2022 – December 2022
345 compliments received. General themes around commitment to patients, good clinical care/service, patience, kindness and compassion shown - especially to patients who had passed away.

Freedom to Speak Up: 2 cases involving patient safety.

S42s: Very few concerns, however some concerns against staff raised for racist behaviour and assault by staff

Learning from Medicines' Datix reviews

- Failure to reconcile discharge letters and medicines handing back including PODS, previously dispensed items and TTOs particularly medicines stored in fridges and CD cupboards.
- Omitted doses
- Errors in choice of formulation MR vs plain for example
- Wrong frequency – admin boxes not crossed off / incomplete prescriptions.
- Not administering full dose when dose is made up of multiple dose units – i.e. vitamin D, methotrexate are reported but likely to be much wider range of medicines as also reported in the observation audit completed previously.
- Anticoagulant doses not modified for improving renal function or weight changes DURING stay.
- Omitted anticoagulation (prescribing particularly when courses completed and review required and administration)
- Patches omitted to be replaced or left in situ.
- Medicines put in wrong lockers leading to missed doses
- Medicines left unattended then leading to errors
- Following admin boxes and not the prescription. i.e. giving BD multiple times rather

OD when the times have changed.

What have our infection control incidents told us?

- Staff to ensure to keep the door to isolation area closed to prevent patients from other areas entering
- Potential risk of contamination injury due to one faulty needle.
- Staff to ensure to lock the sharps bin when reaches the fill line to prevent needle stick injury
- Staff to ensure to be vigilant when handling sharp items.
- Staff must assemble sharps bin in line with the policy.
- Staff must ensure to immediately dispose all used sharps into the sharps bins.
- No evidence of a sepsis tool being commenced
- Inaccuracy in documentation of urinary symptoms in patient records regarding urinary symptoms
- Delay in patients being risk assessed within 48hrs for treatment and prophylaxis of flu
- NEWS2 score not implemented as per policy

Appendix 1 – Safety Profile Example – Childrens and Young People

Incidents that have been reported January 2022 – December 2022

During the last calendar year, CYPF services reported **703** incidents. The top 10 reported categories are seen below:

Category	Number in 2022
Self Harm/Self Harming Behaviour	138
Procedures not carried out	137
Confidentiality Issues	115
Other incident	69
Drug Incident	35
Assault	22
Assault - Non Physical	21
Behavioural/ Personal Conduct	21
Ill Health	21
Privacy and Dignity Issue	20

Of the 703 incidents reported, **2** were then reported and investigated as **serious incidents.** They included 1 unexpected death and 1 confidentiality breach.

A further 4 incidents went through an Internal Learning Review. These included2 unexpected deaths, 1 pressure ulcer and 1 suspected suicide.

Opportunities for learning identified from Serious Incidents & Learning Reviews

- Poor referral (not enough information)
- Delayed referral to Tissue Viability
- Policies not in place when patient moved from RBH to BHFT, to service the needs of the patient for instance risk assessment
- Datix is adult specific and does not meet the needs of the service.
- Educational thematic learning event around Autism and Suicide took place.
- The use of Opt-In letters is very important
- Transition from CAMHS to adult community MH services

Complaints reported January 2022 – December 2022

50 complaints were received in the calendar year. The top complaint themes are:

Theme	Number of Formal Complaints
Care and Treatment	**18**
Clinical Care Received	11
Delay or failure to visit	2
Failure/Delay in specialist Referral	5
Communication	**12**
Communication with Other Organisations	4
Verbal to Patients	3
Written to Patients	4
Not stated	1
Waiting Times for Treatment	**9**
Long Wait for an appointment	9
Attitude of Staff	**4**
Healthcare Professional	4
Medication	**2**
Failure to prescribe/incorrect prescription	1
Wrong medication dispensed/wrong dose,	1

In addition to Formal Complaints, there were MP concerns/enquiries about waiting times and access to services. Key themes from complaints: Of the 50 for CYPF, 9 related to waiting times for ADHD assessments. To help with the flow of complaints and consistency of responses, they have designed a series of templates, which is easing pressure on IOs. Additionally, when assessments are written or reports for other organisations complainants sometimes say it is inaccurate.

Compliments reported January 2022 – December 2022

246 compliments received. General themes around collaborative working across teams, listening to patients and their parents, excellent clinical care was delivered – parents felt at ease, and the quality of advice/support given.

MDT

Safeguarding reviews

Learning from Safeguarding reviews across the Trust is around MCA and professional curiosity. In addition, our safeguarding team has identified a concern regarding lack of professional curiosity including not just being a passive recipient of information and having consideration of extrafamilial harm and the associated red flags

What have our medication incidents told us?

- Vaccine errors – duplication, given early or given when not consented or consent withdrawn
- Medicines not reconciled (demographics checked) when hand back.
- Confusion with MR and plain formulations
- Omitted doses

Appendix 2 - Feedback from our stakeholders

What we asked	Summary of responses
What BHFT patient safety processes already work well	*Comprehensiveness of process:* Robust; thorough; balanced; objective; in-depth focus on issues where they may be learning *Inclusivity of process:* MDT engagement and viewpoint; team-review approach; inviting the right people into our team-review process; inclusion of services; range of views; bringing all parties together *Culture:* Positive culture; safe *Patient/family:* Involving patients / family *Learning:* Provides opportunities to learn
What positive changes is PSIRF going to bring	*Impact on staff:* Opportunity to remove the blame culture; more inclusive process; understanding how staff may be feeling (conversation not an interview); learning + improvement for staff (= better engagement from staff); opportunity for clinicians to determine part of the change (bottom up); getting the right people being part of the review; decreased workload?; shared ownership- not just patient safety team *Impact on patient / family:* More patient / service user collaboration; truly placing families/patients at the centre of incidents / reviews; more focus on family being central to the process *Process:* Not having to 'find' learning; Not having to investigate everything / stopping investigations for the sake of investigating/ less investigating for investigating sake; More focus on meaningful reviews and improvement; learning from all incidents, not just moderate / severe; Looking at issues that have wider implications / learning; A more systems approach; Links with QMIS; Decreased repetition of investigations *Learning opportunities:* Shifting resources and greater potential for learning & improvement; Shared learning & better sharing to frontline staff; Learning + improvement for staff = better engagement from staff; Learning disseminated more widely – improved feedback loop
What are the concerns about PSIRF changes	*Impact on staff:* Staff capacity to deal with change; Increase workload (particularly for frontline staff); More acronyms / new acronyms / changing language; Staff training and educational needs; Cultural shift; May feel there are more 'reviews/investigations'.

	Impact on families: How we will approach family feedback without a comprehensive report; How we communicate to families about our approaches; Assurance that families wish around investigations are taken into consideration *Process:* Robust process required to decide which incidents should be reviewed; How will we know what needs an investigation vs another review approach; Will we miss something? Lack of scrutiny where scrutiny is required; More steps to the process Complacency for what were previous SIs; Understanding why we no longer investigate all serious incidents (differences between review and investigation); Not throwing baby out with bathwater. *Learning and improvement:* How to identify added value to learning; Need time to implement learning; How does this link to QI *Support for the changes:* Do we have exec backing?; Requires a big cultural shift; Will we have support at a governance level; Integration with other national processes (mortality, IPC, PU) *Coroner:* Will this lead to staff less supported for inquest; Will we be prepared enough?; Need to ensure we have enough information for coroner's report
Where we should focus future energy	*On getting the learning out there:* Sharing the learning, incident stories, case studies; Implementing the learning; Looking for immediate ways to learn *On using our staff:* Involving staff and using other resources/evidence in our investigations; Ensuring a just culture (no blame approach); Training staff to ensure a whole system approach to investigations; to understand how to find improvement areas *On our processes:* Hearing the patient / family; Near misses learning; Don't focus on small elements, take a macro approach; Look for themes; Don't focus on areas which are already QMIS trackers / QI projects; Overall both PH and MH services felt enough investigations have been done for PUs & Falls; opportunities to review COVID investigations and consider other options; Patient representatives felt that suicides have a significant impact on families and that a form of review is required (although this does not have to be a serious investigation). *Overall comments around incident reporting and Datix system*: General noise / concern about overall incident reporting process. Datix reporting form (too long, too complicated, too many questions; specifically around present on admission PUs; clarity on

	what self-harm incidents need reporting; how to learn for incidents with no harm
Where we should focus energy for Physical Health	Missed visits including forward planning; drug errors / incidents; poor discharges from acute hospitals (perhaps with a focus on hub referral)– sharing of essential information / handovers; learning from low and no harm incidents and near misses; focus on learning in smaller services and incidents with low reporting volume
Where we should focus energy for Mental Health	Non-lethal self-harm; psychiatric wait lists / times; patients on wait lists for treatment; initial engagement with services; cannot and should not ignore suicides; physical health monitoring on MH wards
Where should we focus energy for Children Families and All Ages	Transition to adult services, wait lists; neurodiversity in young adults

Appendix 3 – Example letter for patient / family who have asked for response to 2nd stage review (to be personalised for each situation)

Service Details Here
Including a key contact name, telephone number and e-mail

Private & Confidential
Family details here

Date here

Dear Mr/Mrs/Other

RE: Relationship/Patient Details - Family feedback letter

I hope this letter will not cause you unnecessary additional distress and I would like once more to express my sincere condolences for the loss of your relationship/patient name. I am writing to inform you that following on from our previous condolence's liaisons with your/your family we have completed a review into the care provided to your relationship/patient's name during the time preceding his/her unexpected death.

When unexpected, significant 'events' occur to patients/service-users under the care of Berkshire Healthcare Foundation Trust, the organisation is committed to ensuring opportunities for continuous learning and service improvement. As part of this pledge, our Trust is committed to engage with families to gather their views and feedback and ensure they have a 'voice' as part of the review process - if they wish to become involved.

Our organisation adopts a range of review methodologies that are in line with national best-practice guidance[9]. The decisions about what methodology to adopt for the review is agreed within a multi-disciplinary team approach and it is in line with Trust agreed processes[10]. Family feedback and views are considered and where appropriate an event may be escalated to a higher level of scrutiny if either family or the initial review highlight significant concerns.

From previous conversations with you/your family my understanding is that there were no concerns of significance being raised and our trust has therefore progressed with the agreed review methodology that in this case was (enter here). This consisted of (briefly explain the methodology).

I am writing this letter to you to provide assurance that we have completed our review process and that we have not identified any gaps in care or significant learning that could have substantially altered the outcome of this event. Our review indicates that the overall care provided was adequate/good/very good/excellent. We identified examples of good practice including: (add here).

[9] NHS England Patient Safety Incident Response Framework
[10] Patient Safety Policy and Patient Safety Incident Response Plan.

(Remove if not applicable) Some incidental learning was identified including: (add here). Whilst this would have not changed the outcome of this event, we have agreed to undertake the following actions to improve future services and care experience: (add actions)

Please if you would like to find out more about this review or if you have any further questions or clarifications required do not hesitate to contact me (see contact details on top of this letter).

I have included in this letter a list of local/national organisations that provide further support with bereavement/suicides. Bereavement / suicide support info may have ben sent out with the condolences letter – whether any further information is required will be decided on a case-by-case basis.

May I extend to your whole family our deepest condolences and best wishes for the future.

Yours Sincerely

Name, Surname

Signature

Title

Appendix 4 – Toolbox of methodologies

PSIRF promotes a range of system-based approaches for learning from patient safety incidents. National tools have been developed that incorporate the well-established SEIPS framework (Systems Engineering Initiative for Patient Safety).

We are encouraged to use the national system-based learning response tools and guides, or other system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.

National learning response methods	Description
Patient Safety Incident Investigation (PSII)	A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how
Multidisciplinary Roundtable Review	A multidisciplinary roundtable review supports teams to learn from patient safety incidents that may have occurred in the last few days or earlier. The aim is, through open discussion (and other approaches such as observations and walk throughs undertaken in advance of the review meeting(s)), to agree the key contributory factors and system gaps that impact on safe patient care. It may require some preparation including some focused areas for discussion/reflection and aims to bring together clinical staff with patient safety and governance support.
Swarm Huddle (could also be called a 'hot debrief')	The swarm huddle is designed to be initiated as soon as possible after an event and involves an MDT discussion. Staff 'swarm' to the site to gather information about what happened and why it happened as quickly as possible and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.
After Action Review (AAR)	AAR is a structured facilitated discussion of an event, the outcome of which gives individuals involved in the event

	understanding of why the outcome differed from that expected and the learning to assist improvement. AAR generates insight from the various perspectives of the MDT and can be used to discuss both positive outcomes as well as incidents. It is based around four questions: What was the expected outcome/expected to happen? What was the actual outcome/what actually happened? What was the difference between the expected outcome and the event? What is the learning?

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 November 2023
Title	**Executive Report**
	Item for Noting
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	The Trust Board is requested to: a) To note the report and seek any clarification.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 14 November 2023

EXECUTIVE REPORT – Public

1. Never Events

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

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Sexual Safety Charter

In June 2023, Steve Russell (Chief Delivery Officer, NHS England) wrote to all Trusts and Integrated Care Boards rightly reinforcing that the NHS should be a safe place for staff and patients in which sexual misconduct, violence, harassment or abuse will not be tolerated. The letter went on to say that a systematic zero tolerance approach to tackle this issue is required to ensure safety for both staff and patients in every part of the NHS. (The content of the letter was included in the July 2023 Trust Board Executive Report).

Further to this letter, NHS England have now launched their first Sexual Safety Charter.

The ten commitments detailed within the charter are:

1. We will actively work to eradicate sexual harassment and abuse in the workplace.
2. We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and / or inappropriate sexual behaviours.
3. We will take and intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.
4. We will provide appropriate support for those in our workforce who experience unwanted , inappropriate and / or harmful sexual behaviours.
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and / or harmful sexual behaviour.
6. We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.
7. We will ensure appropriate, specific and clear training in place.
8. We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.

9. We will take all reports seriously and appropriate and timely action will be taken in all cases.
10. We will capture and share data on prevalence and staff experience transparently.

Berkshire Healthcare are committed to ensuring that this is a safe place to work and to receive care and have signed up to the Charter demonstrating a commitment to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to ten core principles and actions to help achieve this.

There is an expectation that all organisations signing up to the Charter commit to implementing all ten commitments by July 2024.

Our approach around reviewing and ensuring implementation of the commitments within the charter is to incorporate this into current relevant programmes of work. Therefore, we will review, implement and report as below.

1. Alongside the violence reduction standards as part of our reducing violence and aggression work programme led by our Deputy Director Leadership, Inclusion and Organisational Experience.

2. Alongside the Royal College of Physicians' Sexual Safety Collaborative Standards being reviewed as part of the Sexual Safety Mental Health and Learning Disability inpatient work lead by our Consultant Practitioner, Inpatient and urgent Care.

These workstreams have input from our safeguarding and our Specialist Practitioner for Domestic Abuse.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Update on RAAC Within the Trust's Estates

NHS England wrote to all NHS provider organisations in early September 2023 outlining actions to be taken to provide assurance that as far as possible, RAAC is identified and appropriately mitigated within the NHS estate. This followed the Department for Education issuing guidance as to the presence of RAAC in the school estate, which led to heightened public interest in the presence of RAAC.

This has led to a further 18 hospitals identifying RAAC, taking the total number impacted to 42.

Following review undertaken by our Estates Department, RAAC has not been identified in any of our properties, either owned, commercially leased, our PFI facilities or properties owned by NHS Property Services.

Whilst the risk is low, we have five leased building where we await landlord confirmation of no RAAC. However, our own assessment of these buildings based on age and construction method is that RAAC is highly unlikely.

Beyond our own estate, we provide services in a number of other sites including schools and GP practices, sometimes from single rooms or offices for relatively short

periods of time. We have concluded desktop reviews, including refence to published RAAC lists for these establishments.

- Of the 42 GP surgeries, the style of buildings, age, and construction methods would suggest that no RAAC is present. Integrated Care Boards have responsibility for assurance of the GP estate, and we will continue to review information as it is shared with our local Integrated Care Boards.

- Our school occupancy was cross-referenced against the published list of RAAC from the Department of Health, with only the Avenue School identifying RAAC, but with the school remaining open for is open for face-to-face education.

The detailed report from our Estates team is included at appendix 1.

Executive Lead: Paul Gray, Chief Financial Officer

4. CQC Annual State of Care Report

In its annual State of Care Report published in October 2023, the Regulator states that the quality of Maternity Services, Mental Health and Ambulance Services has seen a “notable decline” over the last year, which is contributing to “unfair care” and worsening health inequalities.

The CQC identifies that a “turbulent” mix of operational challenges, the cost-of-living crisis and workforce pressures risked creating a ”two-tier system of health care” with people who cannot afford to pay waiting longer and getting sicker.

It also noted that the “quality of mental health services is an ongoing area of concern, with recruitment and retention of staff still one of the biggest challenges for the sector”. Staffing gaps especially in Mental Health Nursing are identified as a factor in the over-use of restraint, seclusion and segregation.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
14 November 2023

RAAC Review for BHFT Occupied Buildings

EDTS
ESTATES DESIGN & TECHNICAL SERVICES

Estates & Facilities
Berkshire Healthcare NHS Foundation Trust

Tel: 01753 638600
https://edts.berkshirehealthcare.nhs.uk/

PROJECT TITLE	Report on Reinforced Autoclaved Aerated Concrete	EDTS REF NO	N/A
PROJECT DESCRIPTION	Report on existence of RAAC on BHFT Buildings Healthcare NHS Foundation Trust.	DATE	06/10/2023 .
NHS TRUST/ CLIENT	Berkshire Healthcare NHS Foundation Trust.	LOCATION/DEPT	Various sites
SITE	Various BHFT occupied sites	Block No.	N/A

Photo of RAAC samples showing variability of the material

Photo showing bubble formation on reinforcement

Figure 1: IStructE RAAC Inspection and Assessment Guidance

Report Prepared by:
Roman Trotsyuk, Head of Estates and EDTS, BHFT
Taonga Chibaka, Senior Project Manager, BHFT

Table of Contents

1 Introduction

1.1 Background on RAAC

Reinforced Autoclaved Aerated Concrete (RAAC) is a lightweight cementitious material. It is aerated and has no coarse aggregate, meaning the material properties and structural behaviour differ significantly from 'traditional' reinforced concrete. ((IStructE, Feb22)

RAAC has been used in building structures in the UK and Europe since the late 1950's, most commonly as precast roof panels in flat roof construction but occasionally in pitched roofs, floors, and wall panels in both loadbearing and non-loadbearing arrangements. In the 1990s structural deficiencies became apparent. The panels in question were supplied, designed and installed pre-1990s. Since that time, new European Standards have been developed and published to prevent under-design and to ensure long term durability. BS EN 12602 was first published in 2008 and would cover panels supplied in the UK since that time. (IStructE, Feb22)

1.2 Why are there concerns about RAAC?

RAAC has proven to be not as durable as other concrete building materials. It generally has a lifespan of 30 years, although can last longer if the building is well maintained. There is a risk it can fail, particularly if it has been damaged by water ingress from leaking roofs which causes corrosion of the reinforcement, excessive thermal degradation, or if it was not formed correctly when originally made. Poor original installation, cutting the reinforcement bars on-site, can dramatically reduce the end bearing capacity of the planks. It can fail suddenly, hence the recent action by the UK Government.

This report is with reference to further guidance letter that was sent to all the Trusts dated 5th September 2023 (see Appendix 3.2). Adhering to the directive from NHS England that was written to all the trust to review their estate to determine if any of their various estates (RAAC) in line with the alert issued by The Standing Committee on Structural Safety (SCOSS).

1.3 What was considered?

RAAC panels have distinctive characteristics and can easily be identified if a building structure is not covered by finishes or décor.

<u>For BHFT owned buildings or those that are leased but maintained by BHFT.</u>

A desktop study and a visual inspection has been carried out to identify RAAC.

When looking for RAAC the below characteristics are considered:

- 600mm wide concrete panels (typically)
- Distinctive V-Shaped grooves at regular spacing
- Floors, walls or ceilings that are white or light grey
- Drawings and building manuals mentioning manufacturers such as Siporex, Durox, Celcon, Hebel, and Ytong

Steps Taken:

- Are any buildings constructed, or extensions to them between mid-1960s and mid-1990s? If yes, they may have RAAC. If no, unlikely to have RAAC.
- Review design drawings and O&Ms if available to see what materials were used.
- If no documentation is available carry out a visual inspection.
- If RAAC is not found, no further actions required.
- If RAAC is suspected or not sure whether the material is RAAC arrange an assessment by a structural engineer to confirm.
- If RAAC is found, implement management process.

For BHFT occupied sites that are maintained by a landlord, where access to site is limited.

- A desktop review of the building was carried considering age of the building, the type of construction (brickwork vs concrete, etc), and the type of roof.
- The desktop exercise prioritises the areas to focus on if any issues would be suspected.
- Seek confirmation from the landlords to confirm RAAC status of the premises.
- For properties that are schools, Department of Education is carrying out their own RAAC reviews. No RAAC issues have been raised with BHFT EFM from these premises.

Commission a structural engineering with further expertise in RAAC to review BHFT internal process and any areas that RAAC is suspected.

1.3 Table of BHFT Occupied Properties

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST - OWNED AND LEASED SITES

Sites	Address	Post Code	Tenure	Pitched/Flat/Both	Type of Construction Age 1950-1990	Assurance/Action
Abell Gardens	3-4 Abell Gardens, Maidenhead, Berkshire	SL6 6PS	Owned	Pitched	No RAAC-type of construction	No action requried
Adlam Villas	3 Adlam Villas 40 Greenham Road Newbury	RG14 7HX	Leased	Pitched	No RAAC-type of construction	No action requried
Allenby Road	9, Allenby Road, Maidenhead, Berkshire	SL6 5BF	Owned	Pitched	No RAAC-type of construction	No action requried
Bracknell Open Learning Centre	Bracknell Open Learning Centre, Rectory Lane, B	RG12 7GR	Bracknell Forest BC	Pitched	No RAAC-post 1990s	No action requried
Church Hill House	51-52 Turing Drive , Bracknell, Berkshire	RG12 7FR	Owned	Pitched	No RAAC-type of construction	No action requried
Coley Clinic	Carsdale Close, Reading, Berkshire	RG1 6DL	Owned	Pitched	No RAAC-type of construction	No action requried
Erleigh Road	25 Erleigh Road, Reading, Berkshire	RG1 5LR	Owned	Both	No RAAC-type of construction	No action requried
Foundation House	Units B1/B2 Fairacres Industrial Estate, Dedworth	SL4 4LE	Leased	Pitched roof	No RAAC-type of construction	No action requried
Gosbrook Road	222 Gosbrook Road Caversham Reading, Berksh	RG4 8BL	Owned	Pitched	No RAAC-type of construction	No action requried
Gosbrook Road	351 Gosbrook Road, Reading, Berkshire	RG4 8DY	Owned	Pitched	No RAAC-type of construction	No action requried
Harry Pitt Building (W056) University of Readir	Whiteknights Campus ,Earley Gate, Reading, Ber	RG6 6AH	Leased	Pitched	RAAC Unlikely	Confirm with landlord
Hillcroft House	Rookes Way, Thatcham, Berkshire	RG18 3HR	Owned	Flat	No RAAC-portacabin	No action requried
Kings Road	75 King's Road, Reading, Berkshire	RG1 3AB	Owned	Pitched	No RAAC	No action requried
Langley Health Centre	Common Road, Slough, Langley, Berkshire	SL3 8LE	GP	Pitched	RAAC Unlikely	Confirm with landlord
London House	London House, London Road, Bracknell, Berkshir	RG12 2UT	Leased	Flat	No RAAC	No action requried
London Street	81 London Street, Reading, Berkshire	RG1 5BY	Leased	Flat	RAAC Unlikely	Currently leased, unoccupied. Seek assurance from landlord.
Lower Henwick Farmhouse	Turnpike Road, Thatcham, Berkshire	RG18 3AP	Leased	Pitched	No RAAC-age/type of construction	No action requried
New Horizon Centre	Pursers Court, Slough, Berkshire	SL2 5BX	Slough BC	Pitched	RAAC Unlikely	Confirm with landlord
Nicholson's House	Nicholson's Walk, Maidenhead, Berkshire	SL6 1LD	Private	Flat	RAAC Unlikely	Confirm with landlord
Prospect Park Hospital	Honey End Lane, Tilehurst, Reading, Berkshire	RG30 4EJ	Lease	ISS/Vercity completed a review of the O&Ms confirming no RAAC was used in construction. 19/07/2023		
Resource House	20 Denmark St Wokingham Berkshire	RF402BB	Leased	Pitched	No RAAC-type of construction	No action requried
STC University of Reading	Whiteknights Campus ,Earley Gate, Reading, Ber	RG6 6BU	University of Reading	Pitched	No RAAC	No action requried
The Old Forge	45-47 Peach Street, Wokingham, Berkshire	RG40 1XJ	Leased	Pitched	RAAC Unlikely	No RAAC suspected, BHFT to move out of the building 07/10/2023
The University of Reading (Building L011)	London Road, Reading, Berkshire	RG1 5AQ	Leased	Pitched	RAAC Unlikely	Confirm with landlord
Units B1/B2 Fairacres Industrial Estate	Units B1/B2 Fairacres Industrial Estate, Dedworth	SL4 4LE	Leased	Both	No RAAC	No action requried
West Berkshire Community Hospital	London Road, Benham Hill , Thatcham, Berkshire	RG18 3AS	Sub-Underlease	Bellrock completed a review of the O&Ms confirming no RAAC was used in construction. 18/09/2023		

BERKSHIRE SITES LEASED FROM NHSPS

Sites	Address	Post Code	Tenure	Type of Roof	Age of Building	Assurance/Action
Bath Road	57-59 Bath Road, Reading, Berkshire	RG30 2BJ	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Britwell Clinic	Wentworth Avenue, Slough, Berkshire	SL2 2DH	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Cremyll Road	7-9 Cremyll Road, Reading, Reading, Berkshire	RG1 8NQ	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Dedworth Clinic	99, Smiths Lane, Windsor, Berkshire	SL4 5PE	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Dellwood Hospital	22, Liebenrood Road Reading, Berkshire	RG30 2DX	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Finchampstead Clinic	474, Finchampstead Road, Finchampstead, Wok	RG40 3RG	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Great Hollands Health Centre	Great Hollands Square, Bracknell, Berkshire	RG12 8WY	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Hungerford Clinic	Hungerford Community Health Centre, 2a, The Cr	RG17 0HY	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
King Edward VII Hospital	St. Leonards Road, Windsor, Berkshire	SL4 3DP	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Skimped Hill Health Centre	Skimped Hill Lane, Bracknell, Reading, Berkshire	RG12 1LH	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Southcote Clinic	Coronation Square, Reading, Berkshire	RG30 3QP	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
St. Marks Hospital	St Marks Road, Maidenhead, Berkshire	SL6 6DU	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Tilehurst Clinic	The Clinic, Corwen Road, Tilehurst, Reading, Be	RG30 4SU	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Upton Hospital	Albert Street, Slough, Berkshire	SL1 2BJ	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Whitley Clinic	268 Northumberland Avenue, Reading, Berkshire	RG2 7PJ	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC
Wokingham Hospital	41, Barkham Road, Wokingham, Berkshire	RG41 2RE	NHSPS-Lease			NHSPS carried out their own review confirming no RAAC

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST - OTHER MINOR SITES

Sites	Address	Post Code	Tenure	Type of Roof	Assurance/Action
Aborfield Garrison	Aborfield, Reading, Berkshire	RG2 9HN	Sec of State for Defence	Pitched	No RAAC-verified against Department of Education List
Addington School	Woodlands Ave, Woodley, Reading	RG5 3EU		Flat	No RAAC-verified against Department of Education List
Avenue Centre/School	Conwy Close, Reading	RG30 4BZ	Reading BC	Flat	RAAC present. All pupils in face to face education (URN 124525 LAESTAB 8211102)
Balmore Park Surgery	59A, Hemdean Road, Reading, Berkshire	RG4 7SS	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Battle Library Community Hub	420 Oxford Road, Reading	RG30 1EE	Reading BC	Pitched	RAAC unlikely
Binfield Surgery	Terrace Road North, Binfield, Bracknell	RG42 5JG	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Boathouse Surgery	The Boat House Surgery, Whitchurch Road, Pang	RG8 7DP	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Boundary House Surgery	Mount Lane, Bracknell	RG12 9PG	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Bridge Street	2-10, Bridge Street, Reading, Berkshire	RG1 2LU		Flat	RAAC unlikely
Brookfields School	Sage Road, Reading	RG31 6SW		Flat	No RAAC-verified against Department of Education List
Brookside Surgery	Brookside Close, Earley, Berkshire	RG6 7HG	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Burdwood Surgery	Wheelers Green Way, Thatcham, Reading, Berks	RG19 4YF	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Calcot Surgery	Royal Avenue, Calcot, Reading, Berkshire	RG31 4UR	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
CARSS Sessional Services	Greenham Community Centre, The Nightingales,	RG14 7SZ		Both	RAAC unlikely
Castle School	Love Lane, Newbury	RG14 2JG		Pitched	No RAAC-verified against Department of Education List
Caverersham Children's Centre	114 Amersham Road, Caversham, Reading	RG4 5NA	Reading BC	Pitched	No RAAC-verified against Department of Education List
Chalfont Surgery	Chalfont Close, Earley, Reading	RG6 5HZ	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Cippenham Medical Practice	261 Bath Road, Slough, Berkshire	SL1 5PP	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Claremont Surgery	2 Cookham Road, Maidenhead, Berkshire	SL6 8AN	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Compton Surgery	High Street, Compton, Berkshire	RG20 6NJ	GP		RAAC unlikely-managed on ICS/Primary care level
Cookham Medical Centre	Lower Road, Cookham, Maidenhead, Berkshire	SL6 9HX	GP	Pitched	RAAC unlikely-managed on
Crosby House Surgery	91 Stoke Poges Lane, Slough, Berksire	SL1 3NY	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Datchet Health Centre	4 Green Lane, Datchet, Slough, Berkshire	SL3 9EX	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Dedworth Medical Centre	80 Vale Road, Windsor, Berkshire	SL4 5JL	GP	Pitched roof????	RAAC unlikely-managed on ICS/Primary care level
Eastfield House Surgery (Same as Enfield Hse	6 St Johns Road, Newbury, Berkshire	RG14 7LW	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Emmer Green Surgery	4 St Barnabas Road, Emmer Green,Reading,Berk	RG4 8RA	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Falkland Surgery	Monks Lane, Newbury	RG14 7DF	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Farnham Road Surgery	301 Farnham Road, Slough, Berkshire	SL2 1HD	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Green Meadows Surgery	Winkfield Road, Ascot, Berkshire	SL5 7LS	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Green Road Surgery (known as Parkside Fami	224 Wokingham Rd, Reading, Berkshire	RG6 1JS	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Grovelands Medical Centre	701, Oxford Road Reading Berkshire	RG30 1HG	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Heatherwood Hospital	London Rd, Ascot, Berkshire	SL5 8AA	Frimley Health NHS FT	Flat-No RAAC-new	No action required
Herschel Medical Centre	45 Osbourne Street, Slough, Berkshire	SL1 1TT	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Kennel Lane School	Kennel Lane, Bracknell	RG42 2EX	Bracknell Forest BC		No RAAC-verified against Department of Education List
Kennet School	Stoney Lane, Thatcham	RG42 2EX			No RAAC-verified against Department of Education List
Lake Road Health Centre	Nutfield Place, Portsmouth	PO1 4JT	NHSPS	Pitched	NHSPS carried out their own review confirming no RAAC
Lambourne Surgery	Bockhampton Barn, Bockhampton Road, Lambou	RG17 8PS	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Linden Medical Centre	9A Linden Avenue, Maidenhead, Berkshire	SL6 6JJ	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Manor Park Medical Centre	2 Lerwick Drive, Slough, Berkshire	SL1 3XU	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Milman Road (Lister)	Milman Road, Reading, Berkshire	RG2 0AR	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
MS Therapy Centre	Bradbury House, 23A August End, Brock Gardens	RG30 2JP		Pitched	RAAC unlikely-managed on ICS/Primary care level
Reading Civic Centre	Civic Offices, Bridge Street, Reading, Berkshire	RG1 2LU	Reading BC	Pitched	RAAC unlikely-managed on ICS/Primary care level
Ringmead Medical Practice (Birch Hill)	Birch Hill Road, Leppington, Bracknell	RG12 7WW	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Royal Berkshire Hospital	Craven Road, Reading, Berkshire	RG1 5AN	Royal Berkshire NHS FT	Both	Managed by RBH
Runnymede Medical Practice	Newton Court Medical Centre, Burfiled Road, Old	SL4 2QF	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Sandhurst Group Surgery	72, Yorktown Road, Sandhurst ,Berkshire	GU47 9BT	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Speenhamland Primary School	Pelican Lane, Newbury	RG14 1NU			No RAAC-verified against Department of Education List
Strawberry Hill	Old Bath Rd, Newbury, Berkshire	RG14 1JU	GP	Both	RAAC unlikely-managed on ICS/Primary care level
Swallowfield Surgery	The Street, Swallowfield, Reading, Berkshire	RG7 1QY	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Thatcham Children's Centre	Park Lane North, Thatcham, Reading, Berkshire	RG18 3PG	West Berks BC	Pitched	RAAC unlikely
Thatcham Health Centre	The Thatcham Health Centre, 3 Bath Road, Thatc	RG18 3HD	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
The Alders and Chestnuts Children's Centre	Branksome Hill Road, Sandhurst, Bracknell	GU47 0QE	Bracknell Forest BC	Pitched	RAAC unlikely
The Avenue Medical Centre	Wentworth Avenue, Britwell Estate, Slough	SL2 2DG	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
The Bharani Medical Centre (Slough)	450 Bath Road, Cippenham, Slough, Berksire	SL1 6BB	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
The Cedars Surgery	8, Cookham Road, Maidenhead, Berkshire	SL6 8AJ	GP	Flat	RAAC unlikely-managed on ICS/Primary care level
The Croft - Hungerford (Hungerford Surgery)	The Croft, Hungerford, Berkshire	RG17 0HY	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
The Downland Practice - Chieveley	East Ln, Chieveley, Newbury, Berksire	RG20 8UY	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
The Oaks and Hollies Children's Centre	based on the site of Great Hollands Primary Scho	RG12 8QN	Bracknell Forest BC	Flat	No RAAC-verified against Department of Education List
The Rowans and Sycamores Children's Centre	based on the site of Fox Hill Primary School in Po	RG12 7JZ	Bracknell Forest BC	Flat	No RAAC-verified against Department of Education List
Tilehurst Surgery	Tylers Place, Pottery Road, Tilehurst, Reading, B	RG30 6BW	GP	Pitched roof	RAAC unlikely-managed on ICS/Primary care level
Twyford Surgery	Loddon Hall Road,Twyford, Reading, Berkshire	RG10 9JA	Lease	Flat	RAAC unlikely
Unit 8 Vickers House	Office 2 -Unit 8 Vickers House,Priestley Rd, Basir	RG24 9NP	Private	Flat	RAAC unlikely
Wargrave Surgery	Victoria Road, Wargrave, Reading, Berkshire	RG10 8BP	GP	Flat	RAAC unlikely-managed on ICS/Primary care level
West Street House	West Street, Newbury, Berkshire	RG14 1BZ	GP	Flat	RAAC unlikely-managed on ICS/Primary care level
Western Elms Surgery	317 Oxford Rd, Reading, Berkshire	RG30 1AT	GP	Pitched	RAAC unlikely-managed on ICS/Primary care level
Wexham Park Hospital	Wexham, Slough, Berkshire	SL2 4HL	Frimley Health NHS FT	Flat	To confirm locations on site
Winchcombe School	Maple Crescent, Newbury	RG14 1LN	West Berks BC	Flat	No RAAC-verified against Department of Education List

2 Conclusion and Next Steps

RAAC has not been identified in all main BHFT sites which comprise of BHFT owned properties, private leases, PFI hospitals and NHSPS owned properties.

As a community Trust we do occupy many minor sites for short periods of time or single rooms/offices within larger main buildings. For these sites only a desktop review could be carried out.

- We occupy 42 GP surgeries, this style of buildings, age, and construction methods would suggest that no RAAC is present. BHFT to gain assurance for GP surgeries/Primary Care from ICB.
- BHFT also occupy schools our school occupancy was cross-referenced against the published list of RAAC from the Department of Health (appendix 2), Addington School identified RAAC. The school is open for face-to-face education.
- Landlord response for confirmation of RAAC status is ongoing.

The risk of RAAC on BHFT occupied sites is low, but the following actions to take place.

- Pursue and collate landlord responses.
- Ensure management and remediation process is in place, if RAAC is identified or confirmed, using the advice of structural engineering consultants the Trust works with.
- All site lists are under review and being updated.

3 Appendices

Appendix 1: NHS England Letter Regarding RAAC

RAAC Letter NHS England.pdf

Appendix 2: Department of Education List of confirmed RAAC

List_of_settings_with_confirmed_RAAC_

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Meeting Date	14 November 2023
Title	**September 2023 Finance Report**
Purpose	To provide an update to the Board on the Trust's Financial Performance to 30 September 2023.
Business Area	Finance
Author	Rebecca Clegg, Director of Finance
Relevant Strategic Objectives	Strategic Objective 2: Work with partners to deliver integrated and sustainable services to improve health outcomes for our populations. True North Goal 4: Efficient Use of Resources – A financially and environmentally sustainable organisation.
CQC Registration/Patient Care Impacts	Achievement of CQC Well Led standard.
Resource Impacts	n/a
Legal Implications	Compliance with statutory Financial Duties.
Equality and Diversity Implications	n/a
SUMMARY	The Trust has a plan for a £1.3m surplus as part of the agreed plan for Buckinghamshire, Oxfordshire and Berkshire West ICS. The Trust is reporting a £0.6m surplus against a year-to-date deficit plan of £1.4m. The Trust is continuing to forecast achievement of its financial plan for the current year. The Trust is reporting £2.0m capital spend year to date, £0.6m behind plan but expects to fully untilise this years capital allocation.
ACTION	The Board is asked to note the Trust's financial performance.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2023/24

September 2023

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 30 September 2023.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	16/10/23	Rebecca Clegg	Draft
2.0		Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

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	0.6	-1.4	Yes	1.3	1.3	Yes
2a	CIP - Identification of Schemes	12.3	14.1	No	14.1	14.1	Yes
2b	CIP - Delivery of Identified Schemes	5.4	5.4	Yes	14.1	14.1	Yes
3a	Cash Balance	52.8	54.7	No	48.1	48.1	Yes
3b	Better Payment Practice Code Volume Non-NHS	95%	95%	Yes	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	91%	95%	No	95%	95%	Yes
3d	Better Payment Practice Code Volume NHS	98%	95%	Yes	95%	95%	Yes
3e	Better Payment Practice Code Value NHS	98%	95%	Yes	95%	95%	Yes
4f	Capital Expenditure not exceeding CDEL	2.0	2.6	Yes	9.5	9.2	No

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 reporting a £0.6m surplus year to date (YTD), which is £2m better than planned.
- We are continuing to forecast that we will deliver our planned £1.3m surplus. The report includes a 3 point forecast, which supports continuing to forecast in line with plan.
- Delivery against the cost improvement plan is on track linked to control total compliance.
- The 23/24 Agenda for Change and Doctors pay awards have been made for the majority of staff groups. After accounting for the additional cost and funding we estimate a £1m full year pressure due to the way the NHS tariff uplift is calculated. However, this is currently being offset by delays to recruitment against core allocations.
- We have recognised £170k over performance against our Elective Recovery Fund (ERF) target for BOB ICS.
- Cash is still being impacted by delays to finalising contract uplifts for 2023/24,but the shortfall is reducing.
- Our BPPC continues to improve with the % of non-NHS invoices paid within the deadline now above the target.
- Capital is under plan year to date mainly due to the phasing of estates projects but offset in part by a high volume of IT kit purchases linked to new investments. Our forecast remains in excess of our CDEL capital allocation but we are expecting that this will be covered by underspending elsewhere in BOB ICS.

1. Income & Expenditure

Sep-23	In Month			YTD			2023/24
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	30.1	29.9	0.2	174.5	173.8	0.6	351.0
Elective Recovery Fund	0.3	0.3	0.0	2.2	2.0	0.2	4.0
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**30.4**	**30.3**	0.2	**176.6**	**175.8**	0.8	**355.1**
Staff In Post	19.0	20.9	1.8	114.7	119.4	4.7	241.2
Bank Spend	2.1	1.6	(0.5)	12.3	10.7	(1.6)	20.3
Agency Spend	0.8	0.4	(0.4)	4.1	2.8	(1.3)	5.1
Total Pay	**22.0**	**22.9**	**0.9**	**131.1**	**132.9**	**1.8**	**266.5**
Purchase of Healthcare	2.0	1.9	(0.1)	10.8	10.9	0.2	20.6
Drugs	0.5	0.5	(0.0)	3.0	2.7	(0.2)	5.4
Premises	1.5	1.6	0.1	8.8	9.3	0.5	18.5
Other Non Pay	1.9	1.5	(0.4)	10.2	8.9	(1.3)	17.9
PFI Lease	0.8	0.7	(0.0)	5.0	4.5	(0.4)	9.0
Total Non Pay	**6.6**	**6.1**	**(0.5)**	**37.7**	**36.4**	**(1.3)**	**71.4**
Total Operating Costs	**28.6**	**29.0**	**0.4**	**168.7**	**169.3**	**0.5**	**337.9**
EBITDA	**1.9**	**1.3**	**0.6**	**7.9**	**6.6**	**1.3**	**17.1**
Interest (Net)	0.1	0.2	0.2	0.5	1.5	1.0	3.0
Depreciation	0.9	0.9	(0.0)	5.6	5.4	(0.2)	10.7
Impairments	0.2	0.0	(0.2)	0.2	0.0	(0.2)	0.0
Disposals	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0
PDC	0.2	0.2	0.0	1.0	1.1	0.1	2.2
Total Financing	**1.4**	**1.3**	**(0.0)**	**7.3**	**7.9**	**0.6**	**15.9**
Reported Surplus/ (Deficit)	**0.5**	**(0.1)**	**0.6**	**0.6**	**(1.4)**	**2.0**	**1.2**
Adjustments	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.1**
Adjusted Surplus/ (Deficit)	**0.5**	**(0.0)**	**0.6**	**0.6**	**(1.3)**	**2.0**	**1.3**

Key Messages

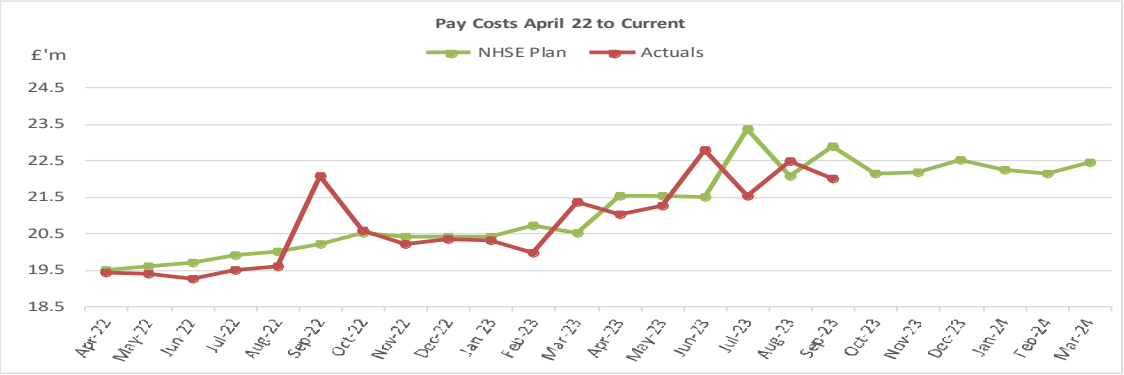
The table above gives the financial performance against the Trust's income and expenditure plan as at 30 September 2023.

The Trust has a plan for a £1.3m surplus as part of the BOB ICB plan, incorporating a £14m cost improvement programme.

At Month 6, the Trust is reporting a £0.6m surplus year to date which is, £2.0m better than plan.

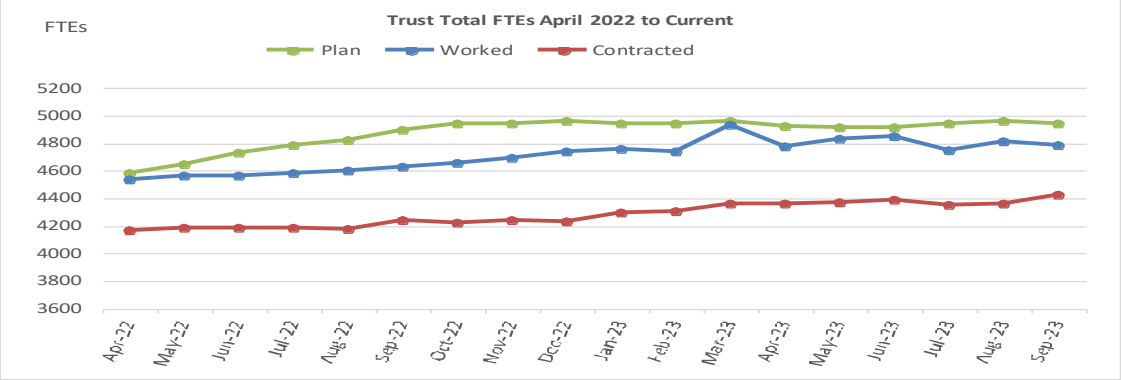
The higher than planned Agenda for Change and Doctors pay awards for 2023/24 are now reflected in the NHSE plan. The majority of payments have been made and accruals are in place for any final payments.

Workforce



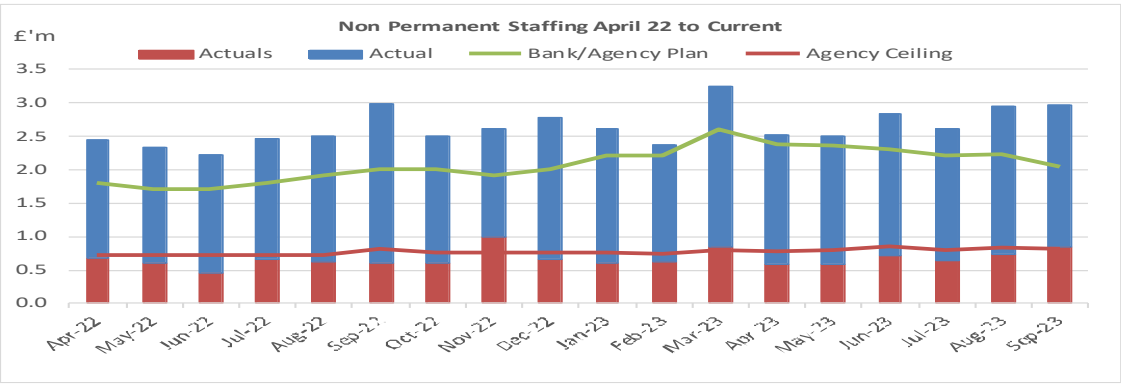
Staff Costs

YTD	£'m
2023/24	131.1
2022/23	119.2
▲	10%
Prior Yr	**£'m**
Sep-23	22.0
Sep-22	22.1
▲	0%



FTE's

Prioir Mth	CFTE	WFTE
Sep-23	4,430	4,784
Aug-23	4,360	4,818
	2% ▲	-1% ▼
Prior Yr		
Sep-23	4,430	4,784
Sep-22	4,179	4,630
	6% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2023/24	12.3	4.1
2022/23	8.9	3.6
	37% ▲	13% ▲
Prior Yr	**£'m**	**£'m**
Sep-23	2.1	0.8
Sep-22	2.4	0.6
	-11% ▼	40% ▲

Key Messages

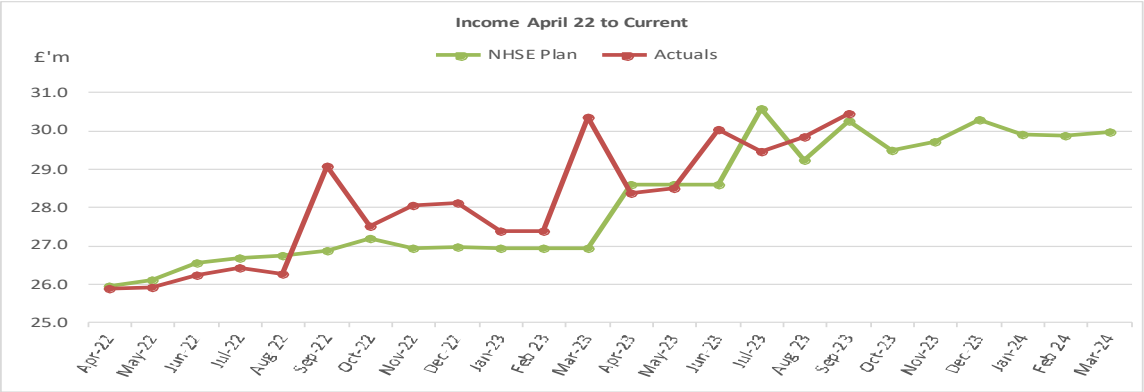
Pay costs in month were £22m. The majority of the Drs pay awards have been made in month 6 and the plan has been adjusted to reflect the additional income.

We are continuing to offset some vacancies with higher levels of temporary staffing although actuals are much closer to plan year to date than in the previous year, in part due to the work undertaken to align financial and workforce planning. The underspend on substantive staffing is also offsetting the cost pressure caused by the higher than plan pay award. The cost pressure is expected to be £1m for the year assuming that all planned posts are filled.

We are operating below the NHSE System Agency Ceiling of 3.7%, currently running at 3.1% of overall pay costs YTD but with costs running close to the ceiling in recent months. Agency price cap breaches, although low compared to other trusts, are being investigated.

In month, we have seen a slight increase in contracted WTEs (70) and a decrease in worked WTEs (-34). The increase in contracted WTEs includes c45 posts funded from new investments.

Income & Non Pay



Income

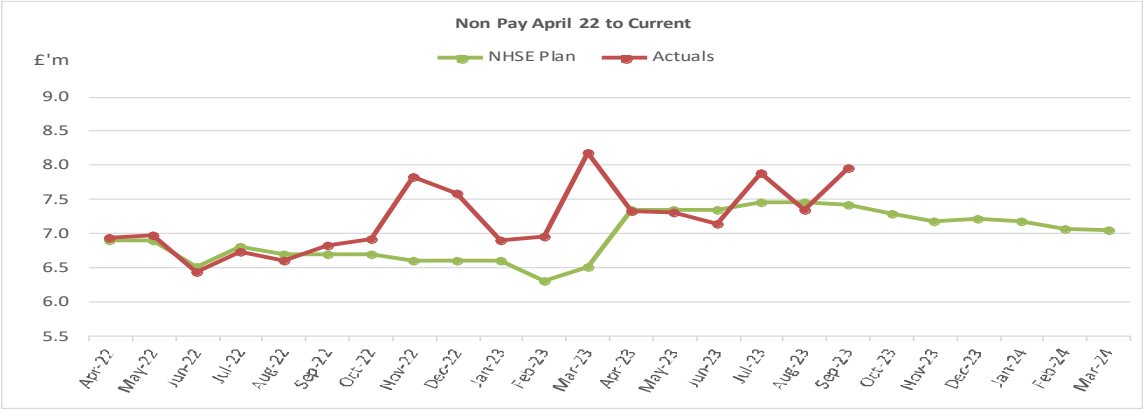
YTD	£'m
2023/24	176.6
2022/23	159.7
▲	11%
Prior Yr	**£'m**
Sep-23	30.4
Sep-22	29.1
▲	5%

Key Messages

In response to the strikes in April, NHSE have reduced the average level of activity increase required to maintain ERF payments by 2%. We are awaiting guidance regarding any further changes linked to ongoing industrial action. NHSE has capped the level of ERF clawback to 16%, which they are withholding centrally from ICBs and will release if system activity targets have been met. NHSE has released performance data for Q1 and this indicates that we are performing better than planned and our own data confirms that this has continued through Q2 for BOB ICS. We have recognised additional income of £170k based on a prudent estimate using BOB ICB's modelling which requires further work.

We continue to defer investment income as a result of slippage on new recruitment.

The Trust is continuing to benefit from an increase in bank interest rates and has generated an additional £1m year to date in interest.



Non Pay

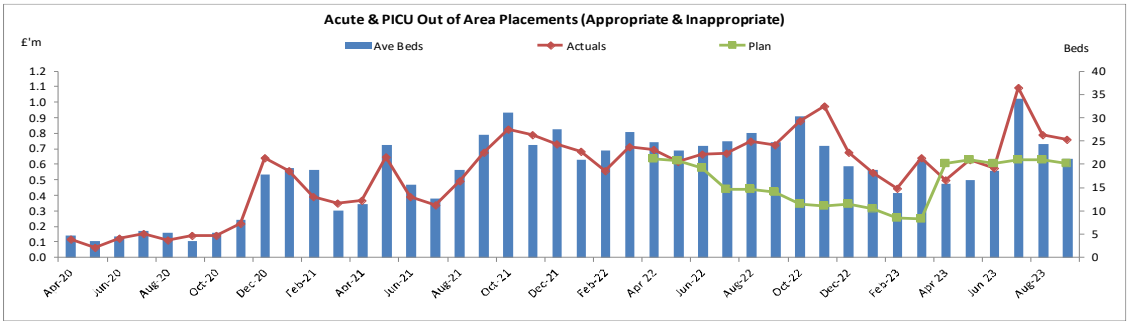
YTD	£'m
2023/24	45.0
2022/23	40.5
▲	11%
Prior Yr	**£'m**
Sep-23	8.0
Sep-22	6.8
▲	17%

Key Messages

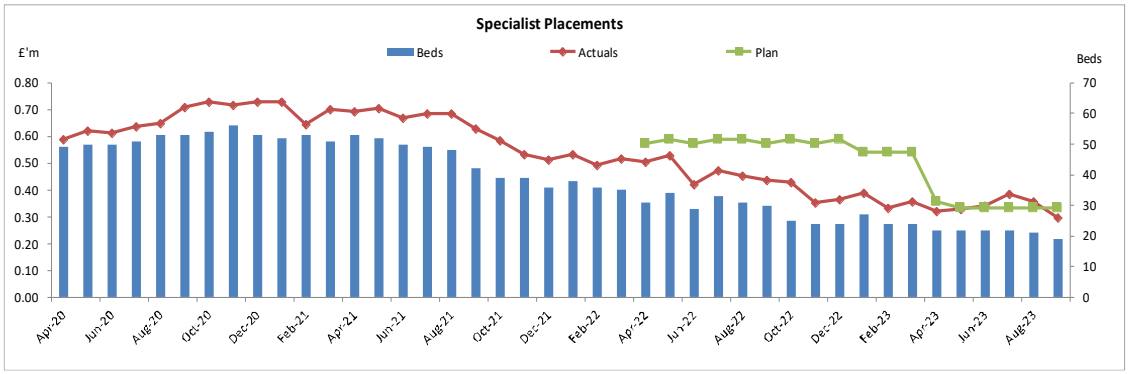
Non Pay spend was £8m in month and is above plan year to date due to expenditure on Out of Area Placements linked to high demand.

We continue to see some inflationary cost pressures coming through, including a final adjustment to PFI contract values, but these are being managed within our inflation reserve.

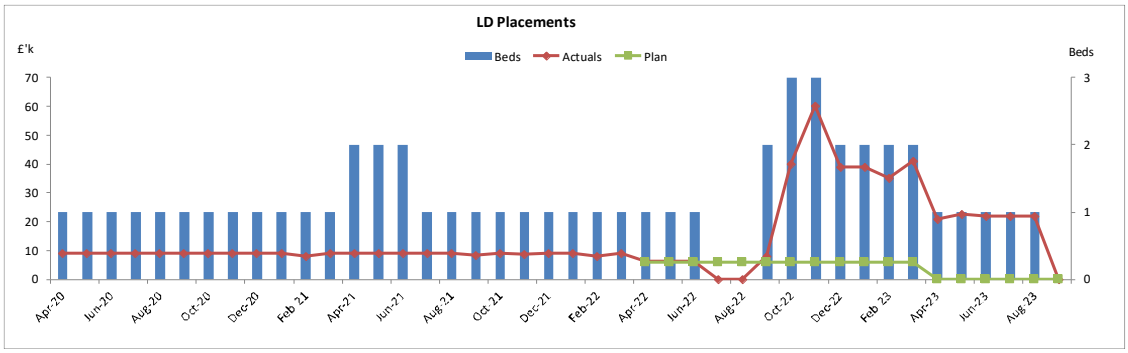
Placement Costs



OAPs	
YTD	£'m
2023/24	4.3
2022/23	4.1
▲	*6%*
Prior Yr	£'m
Sep-23	0.8
Sep-22	0.7
▲	*5%*



Specialist Placements	
YTD	£'m
2023/24	2.0
2022/23	2.8
▼	*-28%*
Prior Yr	£'m
Sep-23	0.3
Sep-22	0.4
▼	*-33%*



LD OAPs	
YTD	£'k
2023/24	108.2
2022/23	26.0
▲	*316%*
Prior Yr	£'k
Sep-23	0.0
Sep-22	8.0
▼	

Key Messages

Out of Area Placements. The average number of placements decreased from 24 in August to 21 in September. Analysis highlights that the high level of placements continues to be driven by demand, and that flow through the hospital continues to improve, with more discharges and fewer lost bed days per patient. The monthly costs were £0.8m which included a slight decrease from the previous month but is offset in part by the cost of having empty block booked beds.

We now have a dedicated clinical lead for the delivery of the bed optimisation programme, and this post has supported improving flow, including through daily bed flow meetings, development of a new bed flow dashboard which has provided improved visibility and locality oversight of admission numbers and LOS and also improved identification and escalation of MOFD/CRFD patients. We have agreed that reducing lost bed days linked to patients who are CRFD as a breakthrough objective and set a very ambitious target of 250 bed days per month. Progress against this target is monitored in QPEG.

We will continue to spot purchase PICU beds where they are clinically required. We continue to have significant demand for PICU beds especially for patients with forensic backgrounds, which do not count as an inappropriate out of area bed against the OAPs trajectory but which do have a financial impact.

A paper has been shared with the Board recommending a reduction in acute ward bed base from 86 to 80, to improve patient and staff experience of care with the 6 beds being reprovisioned through the independent sector. The planned acute ward bed reduction is due to be implemented in Q3. An additional 6 block beds have been purchased from September. The current configuration of block booked beads includes 7 female acute, 4 male acute and 3 male discharge, 2 assess beds providing acute overspill and reprovisioned beds linked to the PPH ward reduction.

Specialist Placements. The average number of placements was 19 which was a reduction from the previous month where there were 21 placements. Costs reduced from £0.4m to £0.3m. **LD Placements:** There are currently no LD placements.

Cost Improvement Programme & Elective Recovery

Cost Improvement Scheme	In Month			YTD			Full Year
	Act £000s	Plan £000s	Var £000s	Act £000s	Plan £000s	Var £000s	Plan £000s
OAPs & Specialist Placements	159	187	-28	938	1,122	-184	2,503
Contract Contribution	134	134	0	804	804	0	1,608
Additional ICB Stretch	0	0	0	0	0	0	3,055
Estates Schemes	23	23	0	138	138	0	276
Telephony Project	1	29	-28	103	174	-71	350
Divisional Control Total Alignment - CH	205	194	11	1,321	1,165	156	2,330
Divisional Control Total Alignment - MH	206	195	11	528	1,172	-644	2,344
Divisional Control Total Alignment - CFAA	70	66	4	707	398	309	796
Divisional Control Total Alignment - Central Services	46	44	2	699	264	435	528
Operational Management Team Restructure	28	28	0	168	168	0	336
Total Cost Improvement	**873**	**901**	**-28**	**5,406**	**5,406**	**0**	**14,126**

Key Messages

The Trust's initial financial plan included £12m of CIPs to get to a £2m deficit, but following further work within BOB ICB, it was agreed that the Trust would move to a breakeven position which required additional CIPs of £2m to be added to the programme. The Trust has subsequently agreed to deliver a £1.3m surplus on receipt of additional funding.

For month 6, we are reporting that we are on track with the cost improvement programme. There are some variances in divisional control totals which we are reflecting as over or under achievement of CIPs offsetting the underachievement related to OAPs and Specialist Placements.

The schemes listed as divisional control total alignment relate primarily to pay costs and are centred around new ways of working, upskilling, leadership, skill-mix, service design and recruitment and retention throughout all services.

The under-delivery within the Mental Health Division relates to staffing for inpatients services.

The telephony project is now showing an underspend linked to higher than anticipated activity.

Contract Contribution includes schemes were additional income contribution is being earned in year but is not being offset by additional costs. It also includes any smaller, generally Non-NHS contracts where action is underway to bring expenditure back in line with contract values.

ERF

As at month 6, the Trust is reporting a £170k YTD over performance in elective recovery income from BOB ICB. This is as per the table below which aligns to an initial proposal from BOB ICB regarding the treatment of performance. There are several elements that we are currently querying including the clawback of a share of the funding currently withheld from BOB ICB against the overall system position.

ERF Peformance	April		May		June		July		August		September	
	Activity	Value £	Activity	Value £	Activity	Value £	Activity	Value £	Activity	Value £	Activity	Value £
Target	5,291	1,163,274	5,991	1,312,636	6,769	1,490,422	6,309	1,398,728	6,073	1,337,877	1,776	1,294,247
Actual	5,874	1,288,159	6,521	1,439,373	6,970	1,531,131	6,420	1,409,895	6,527	1,435,242	6,883	1,511,112
Variance	**583**	**124,885**	**530**	**126,737**	**201**	**40,709**	**111**	**11,168**	**454**	**97,365**	**5,107**	**216,865**
Cumulative		124,885		251,622		292,331		303,498		400,864		617,729
Share of £11m withheld (disputed)												-448,558
Reported position Month 6												**169,171**

Elective Recovery activity includes all physical health first outpatient appointments assessed against the 2019/20 baseline with a target improvement of 12%.

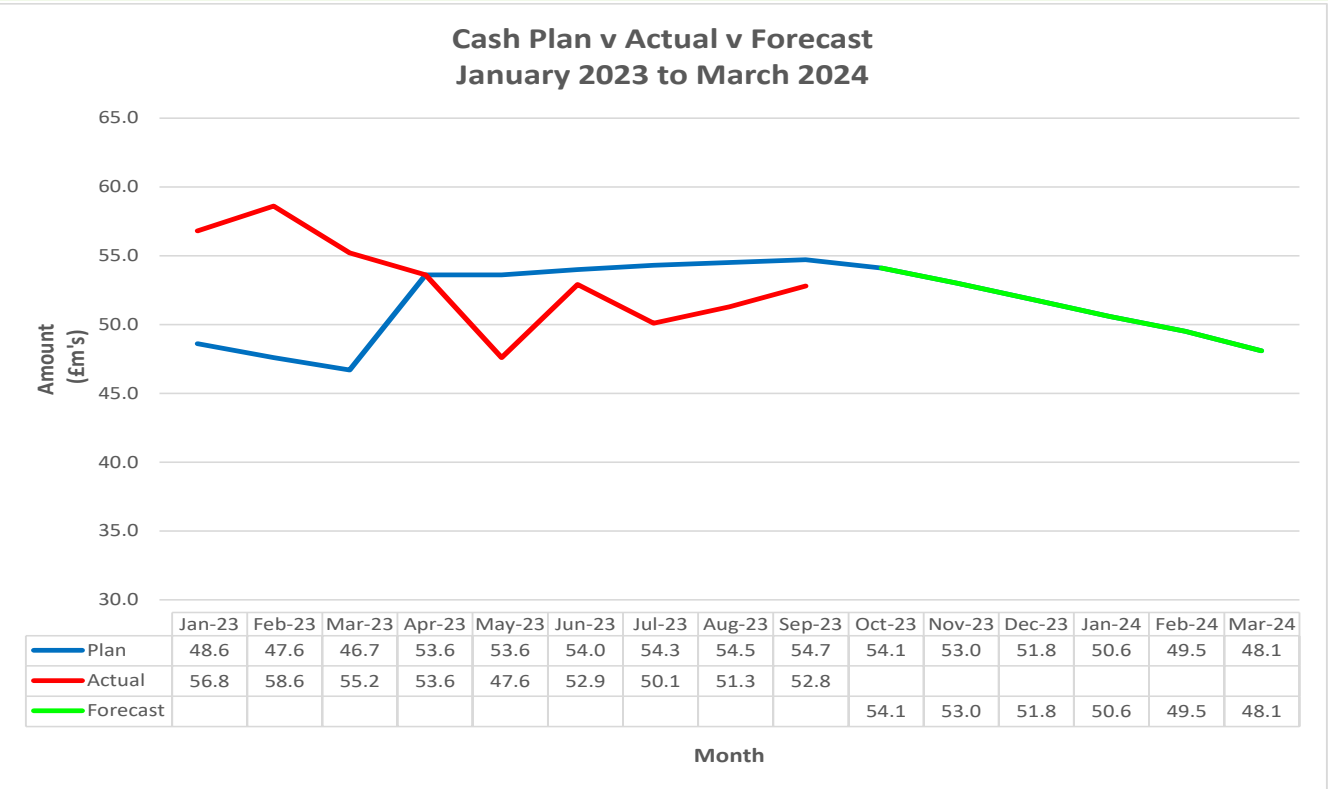
The Trust's contract with Frimley ICB does not include any funding for elective recovery.

2. Balance Sheet & Cash

Balance Sheet	22/23 Actual (Audited) £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	4.0	2.2	3.6	(1.4)	2.2	3.6	(1.4)
Property, Plant & Equipment (non PFI)	45.6	45.6	44.0	1.6	45.6	44.0	1.6
Property, Plant & Equipment (PFI)	72.1	71.6	71.3	0.3	71.6	71.3	0.3
Property, Plant & Equipment (RoU Asset)	15.5	14.2	15.5	(1.3)	14.2	15.5	(1.3)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**137.4**	**133.8**	**134.6**	**(0.8)**	**133.8**	**134.6**	**(0.8)**
Trade Receivables & Accruals	18.9	13.2	18.7	(5.5)	13.2	18.7	(5.5)
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	55.2	52.8	54.7	(1.9)	52.8	54.7	(1.9)
Trade Payables & Accruals	(48.2)	(37.1)	(46.6)	9.5	(37.1)	(46.6)	9.5
Borrowings (PFI and RoU Lease Liability)	(4.2)	(3.1)	(4.1)	1.0	(3.1)	(4.1)	1.0
Other Current Payables	(11.8)	(13.4)	(12.4)	(1.0)	(13.4)	(12.4)	(1.0)
Total Net Current Assets / (Liabilities)	**10.2**	**12.7**	**10.6**	**2.1**	**12.7**	**10.6**	**2.1**
Non Current Borrowings (PFI and RoU Lease Liability)	(34.8)	(33.9)	(34.1)	0.2	(33.9)	(34.1)	0.2
Other Non Current Payables	(2.0)	(1.4)	(2.0)	0.6	(1.4)	(2.0)	0.6
Total Net Assets	**110.8**	**111.2**	**109.1**	**2.1**	**111.2**	**109.1**	**2.1**
Income & Expenditure Reserve	31.6	32.1	30.8	1.3	32.1	30.8	1.3
Public Dividend Capital Reserve	21.1	21.1	21.1	0.0	21.1	21.1	0.0
Revaluation Reserve	58.0	58.0	57.2	0.8	58.0	57.2	0.8
Total Taxpayers Equity	**110.8**	**111.2**	**109.1**	**2.1**	**111.2**	**109.1**	**2.1**

Key Messages

The balance sheet is largely as expected year to date with the exception of cash which continues to be below plan of £2m (Month 5: £3.2m below). This is due to lower than anticipated income receipts primarily from ICBs and local authorities.



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Plan	48.6	47.6	46.7	53.6	53.6	54.0	54.3	54.5	54.7	54.1	53.0	51.8	50.6	49.5	48.1
Actual	56.8	58.6	55.2	53.6	47.6	52.9	50.1	51.3	52.8						
Forecast										54.1	53.0	51.8	50.6	49.5	48.1

3. Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Outturn £'000
Estates Maintenance & Replacement Expenditure								
25 Erleigh Road Upgrades - Internal & External	0	75	(75)	0	125	(125)	250	250
General Upgrades & Damp Issues CHH	0	50	(50)	0	50	(50)	250	200
Wokingham Reprovision - Move from Old Forge	138	75	63	283	200	83	200	335
Bariatric Facilities Wokingham	35	50	(15)	97	230	(133)	230	230
Leased Non Commercial (NHSPS) Other projects	71	25	46	122	185	(63)	235	235
HQ Relocation/MSK Relocation - AV	(2)	0	(2)	70	121	(51)	121	127
Resource House, Denmark Street	415	250	165	565	550	15	800	865
Environment & Sustainability	(1)	43	(44)	17	159	(142)	450	374
Service change/redesign	0	25	(25)	0	75	(75)	244	98
Various All Sites	1	125	(124)	37	230	(193)	515	581
Statutory Compliance	0	75	(75)	2	95	(93)	390	390
Subtotal Estates Maintenance & Replacement	**656**	**793**	**(137)**	**1,193**	**2,020**	**(827)**	**3,685**	**3,685**
IM&T Expenditure								
Business Intelligence and Reporting	0	10	(10)	0	60	(60)	120	120
Hardware Purchases	259	74	185	712	340	372	4,677	4,977
Digital Strategy incl. EMIS and ePMA re-tender	22	0	22	48	0	48	733	733
RiO Re-procurement	0	25	(25)	0	150	(150)	300	0
Subtotal IM&T Expenditure	**281**	**109**	**172**	**760**	**550**	**210**	**5,830**	**5,830**
Subtotal CapEx Within Control Total	**938**	**902**	**36**	**1,953**	**2,570**	**(617)**	**9,515**	**9,515**
CapEx Expenditure Outside of Control Total								
Low Carbon Heating System WBCH	0	0	0	0	0	0	610	610
PPH 'Place of Safety'	0	0	0	0	0	0	1,850	450
Statuory Compliance	0	20	(20)	2	30	(28)	110	100
Environment & Sustainability / Zero Carbon	0	16	(16)	0	48	(48)	150	150
Other PFI projects	19	15	4	24	45	(21)	185	195
Garden Renovation – Wokingham Hospital (Donated)	0	0	0	0	0	0	0	22
Subtotal Capex Outside of Control Totals	**19**	**51**	**(32)**	**26**	**123**	**(97)**	**2,905**	**1,527**
Central Funding								
Total Capital Expenditure	**957**	**953**	**4**	**1,979**	**2,693**	**(714)**	**12,420**	**11,042**

Key Messages

Spend YTD is £0.7m below plan. The majority of the underspend is in Estate schemes, offset by an over spend in IM&T schemes. IM&T Hardware expenditure is driven by user demand which continues to exceed allocated budget driven by higher staffing numbers and an increase in part-time staff. Further work is planned around approval for these requests.

The capital plan currently includes £0.3m of over programming which will need to be addressed in year either through slippage or securing additional CDEL allocation from BOB ICS partners. When reporting to the ICB and NHSE we have been asked to forecast in line with the £9,155k CDEL that has been allocated to the Trust.

The Place of Safety scheme which was due to commence and complete in year will now not complete until early 2024/25. This is due the additional work being undertaken in order to finalise the application for the Deed of Variation which has now been issued to the PFI funding provider and which we expect to have approval of towards the end of the calendar year. The forecast outturn for this project has now been adjusted to reflect the delay.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper - Public

Board Meeting Date	14th November 2023
Title	**True North Performance Scorecard** **Month 6 (September 2023) 2023/24**
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 2023/24.
	ITEM FOR NOTING
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 6 2023/24 (September 2023) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver

	improvement focus, and how performance will therefore be managed.
	
	The business rules apply to three categories of metric:
	
	• **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention.
	• **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month.
	• **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity.
	
	Month 6
	
	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:
	
	• **Breakthrough** – Self-harm Incidents on Mental Health Inpatient Wards (excluding Learning Disability) **(Harm Free Care)** – at 43 against a target of 42.
	  ○ There has been a steady decline in the number of incidents since March 2023.
	  ○ Rose ward was the top contributor with 23 incidents.
	  ○ Key lines of enquiry are looking at patient with neuro diversity and other conditions and there will be a further self-harm deep dive to identify patterns for further analysis / countermeasures.
	  ○ Raising awareness of suicide prevention pathway and links with self-harm behaviors. Focusing on learning from near misses and ligature harm minimisation. There is also key learning around gaps in observations which is being addressed.
	  ○ Counter measures include involving patients in decision making and that staff are listening to them. Improving concise training for bank staff (NHSP) with 'Turbo 10' course covering

	observation and safety planning. Introduction of new risk tool is being supported. • I Want Great Care Positive Score **(Patient Experience)** – at 94.3% against a 95% target. • I Want Great Care Compliance Rate **(Patient Experience)** – at 3.3% against a 10% target. • **Breakthrough** - Clinically Ready for Discharge by Wards including Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – a new indicator for 2023/24, is at 317 against a 250 bed day target. Progress for this new indicator is discharges of longer stay patients driving up the figure, which will remain high whilst these are discharged safely, so expecting red for a few months. • Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 786 against a 270 quarterly bed day target. **Tracker 1 Metrics (where red for 1 month or more)** • Meticillin-resistant Staphylococcus Aureus (MSSA) Bacteraemias (Cumulative year to date) **(Regulatory Compliance)** – there was 1 incident in May against a target for the year of 0. • People with Common Mental Health Conditions Referred to IAPT Completing a Course of Treatment Moving to Recovery - **(Regulatory Compliance)** – at 46%, below the 50% target. • Sickness rate **(Regulatory Compliance)** – red at 3.7% against a target of 3.5%. This is not a "hard" compliance focus with NHSE but is tracked. Twelve months red. • Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder (ED) will access NICE treatment <4 weeks (Routine) **(Regulatory Compliance)** – red at 62.5% 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)** • Health Visiting: New Birth Visits within 14 days **(Patient Experience)** – at 88.8% against a 90% target. • Falls incidents in Community and Older Adult Mental Health Inpatient Wards - **(Patient Experience)** – at 31 against a 26 incidents per month target.

	• Mental Health Non-Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 89.92% against an 80% target. Red for 6 months. • Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 94.6% against an 85% target. Red for 12 months. • Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 64 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. An improvement project is underway. Linked to the breakthrough objective Clinically Ready for Discharge, where longer stay patients are being prioritized where appropriate and impacting length of stay which is calculated on discharge.
Action	The Board is asked to note the True North Scorecard.

Healthcare from the heart of your community

Berkshire Healthcare NHS
NHS Foundation Trust

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**)

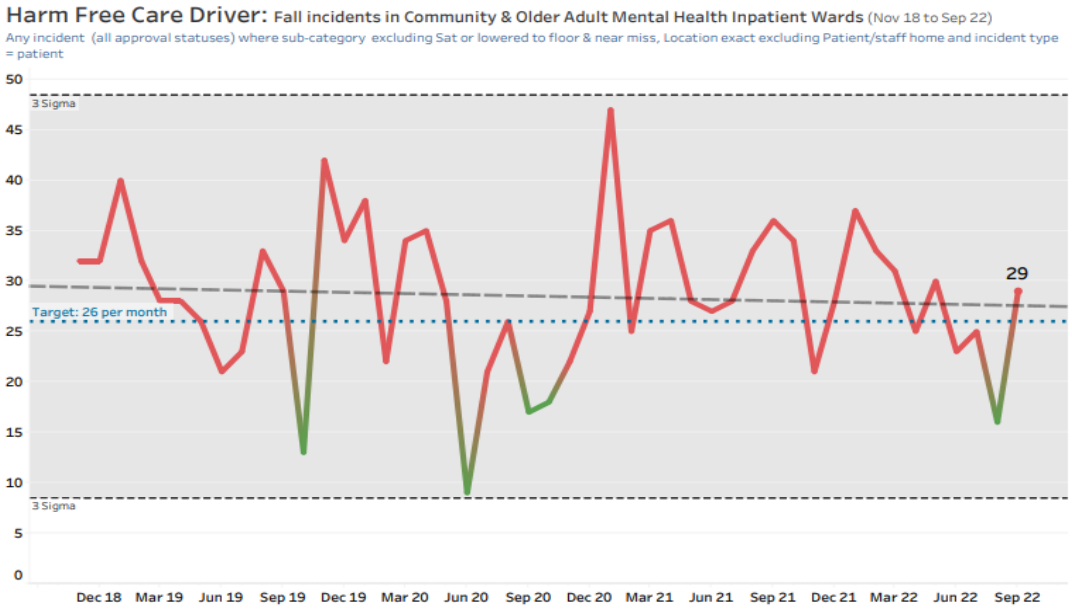
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

We intend to use SPC charts to gain a better understanding about what our data is telling us. We can use this understanding to support making improvements. It will ensure we don't overreact to normal variation within a system.

Components of an SPC Chart

The charts have the following components with an example below:



- A target line (the blue dotted line)
- A longer series of data points
- Upper Control Limit (UCL) to 3 Sigma
- Lower Control Limit (LCL) to 3 Sigma
    - These process limits (UCL & LCL) are defined by our data and calculated automatically. If nothing changes with the process, we can expect 99% of data points to be within these limits. They tell us what our system is capable of delivering. Our data will vary around these process limits. It provides a context for targeting improvement.

Variation

There are 2 types of variation:

1. Common cause variation, which is 'normal' variation (within the UCL & LCL)
2. Special cause variation (or unusual variation) which is something outside of the normal variation and outside of the process control limits (UCL & LCL)

Rules

- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data points (either up or down).
- Follow the True North Performance business rules for other metric actions.

Performance Scorecard - True North Drivers

Harm Free Care

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

Patient Experience

		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
IWGC Positive Score %	95% compliance from April 22	93.3%	94.8%	91.5%	94.5%	92.4%	93.7%	94.0%	94.2%	94.1%	95.2%	95.2%	94.3%
IWGC Compliance %	10% compliance	3.6%	5.4%	2.7%	2.8%	2.3%	3.1%	2.6%	3.3%	3.7%	3.5%	4.2%	3.3%

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

Performance Scorecard - True North Drivers

Supporting our Staff

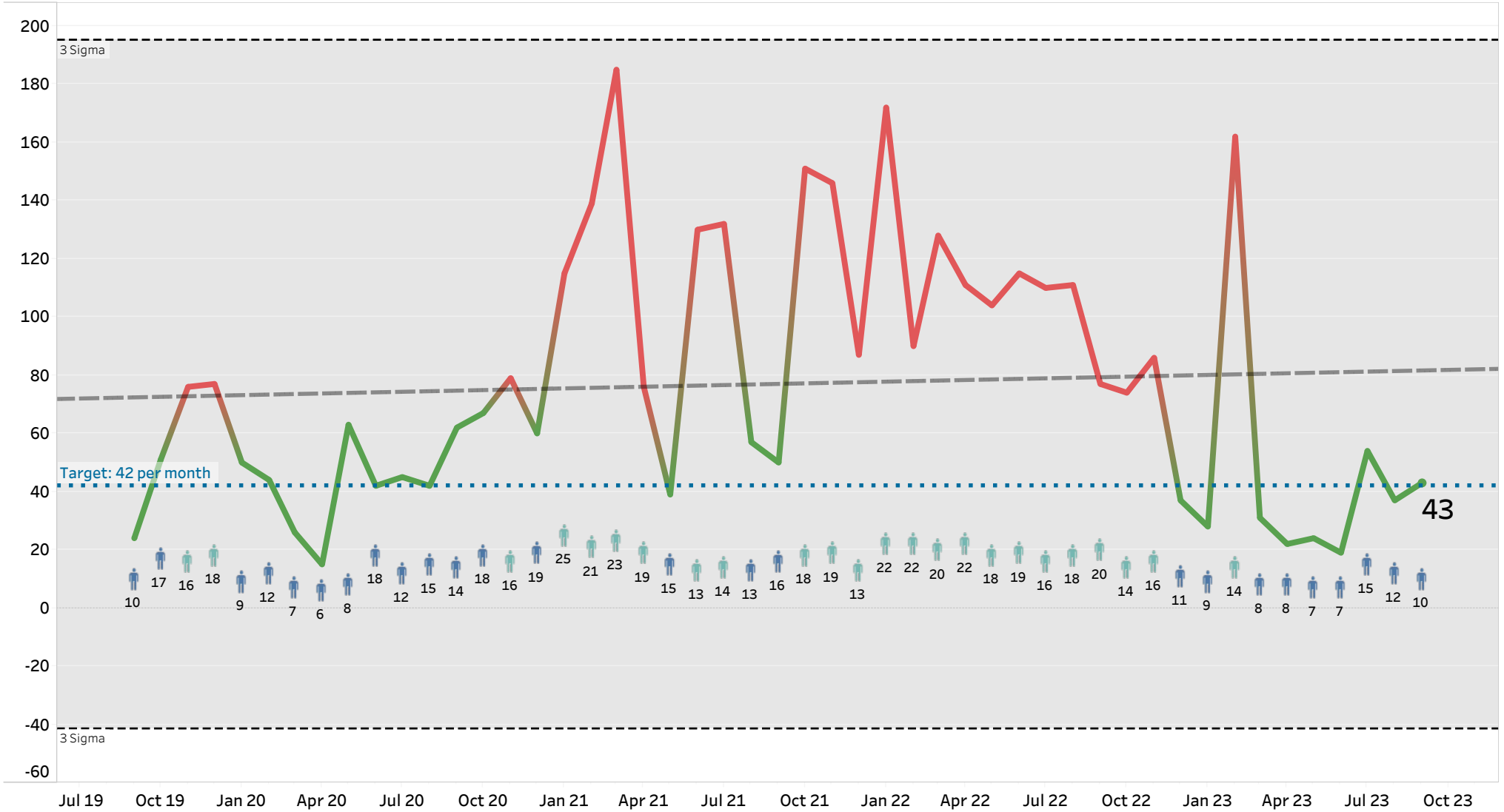
Metric	Target1	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Breakthrough Physical Assaults on Staff	44 per month	70	72	64	34	84	109	77	45	52	70	60	44
Staff turnover (excluding fixed term posts)	<=16% per month, 14% by March 2024, 13% by March 2025, 12% by March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

Efficient Use of Resources

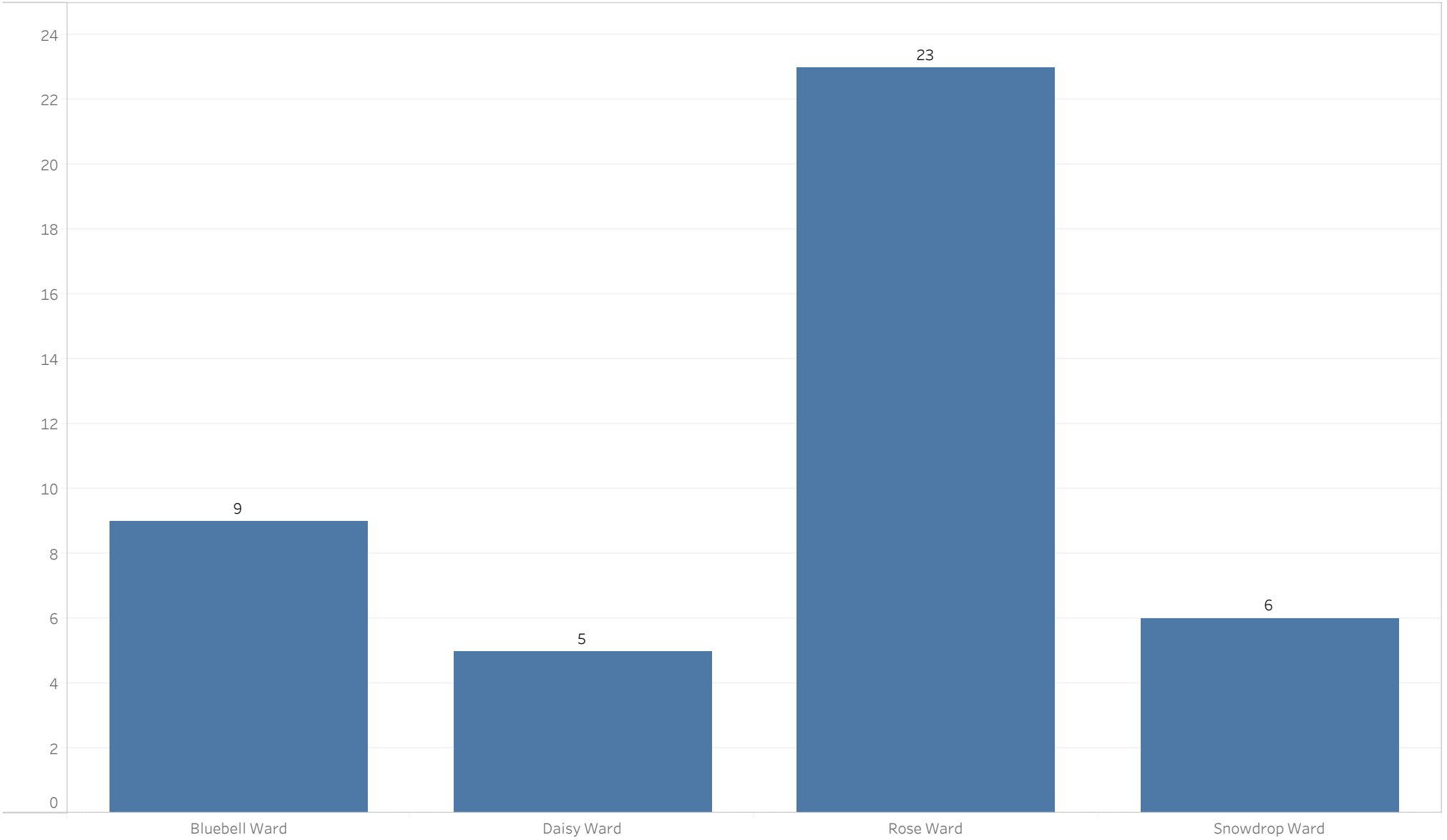
		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
YTD variance from control total (£'k)	1.3m	-774	-822	-1092	-1277	-1818	-989	-261	-441	-805	-1116	-1430	1746
Inappropriate Out of Area Placements	270 Cumulative Total Q2 2023/24	266	484	591	50	112	219	110	144	180	327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

Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Sept 19 to Sept 23)

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

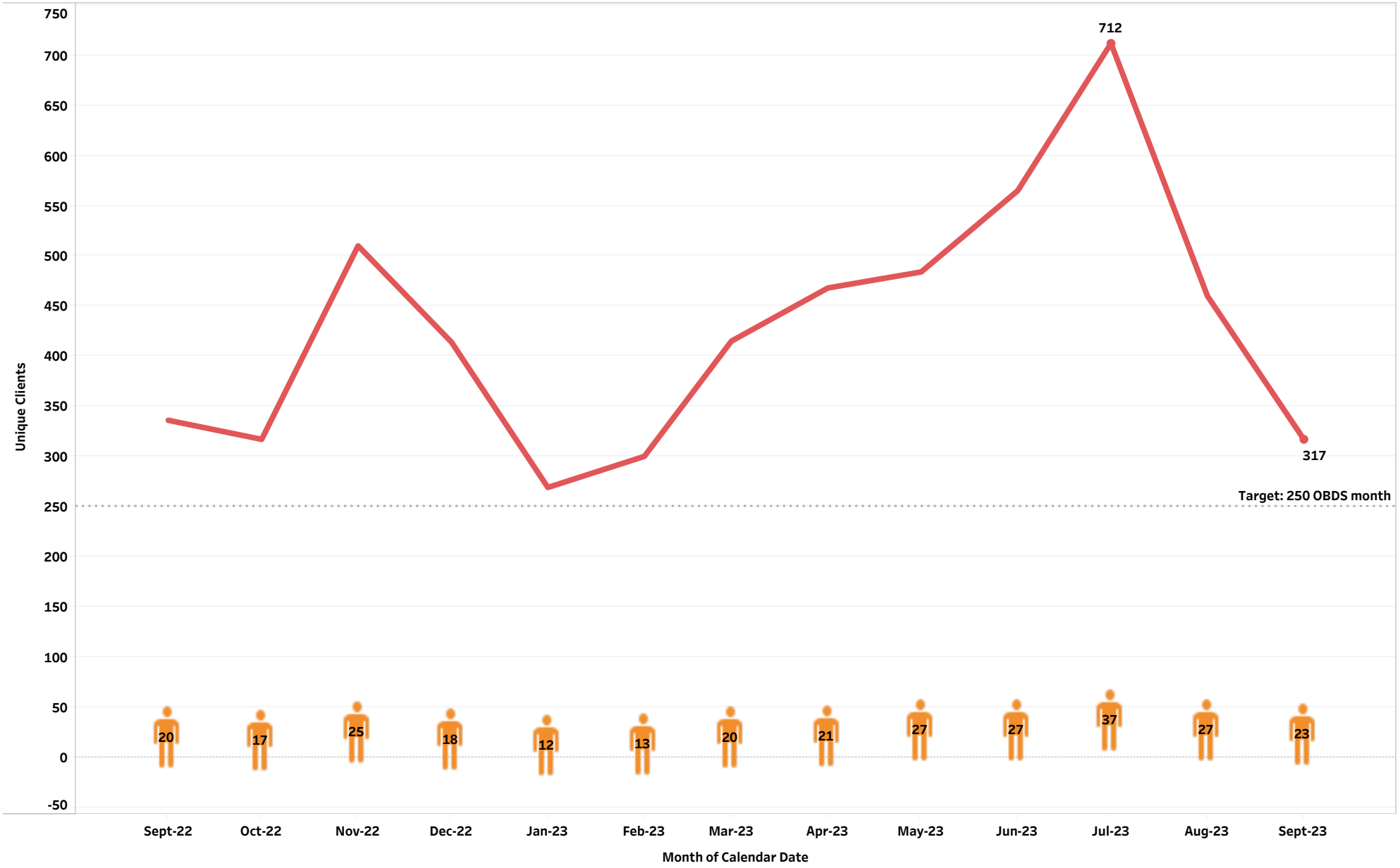


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (September 2023)



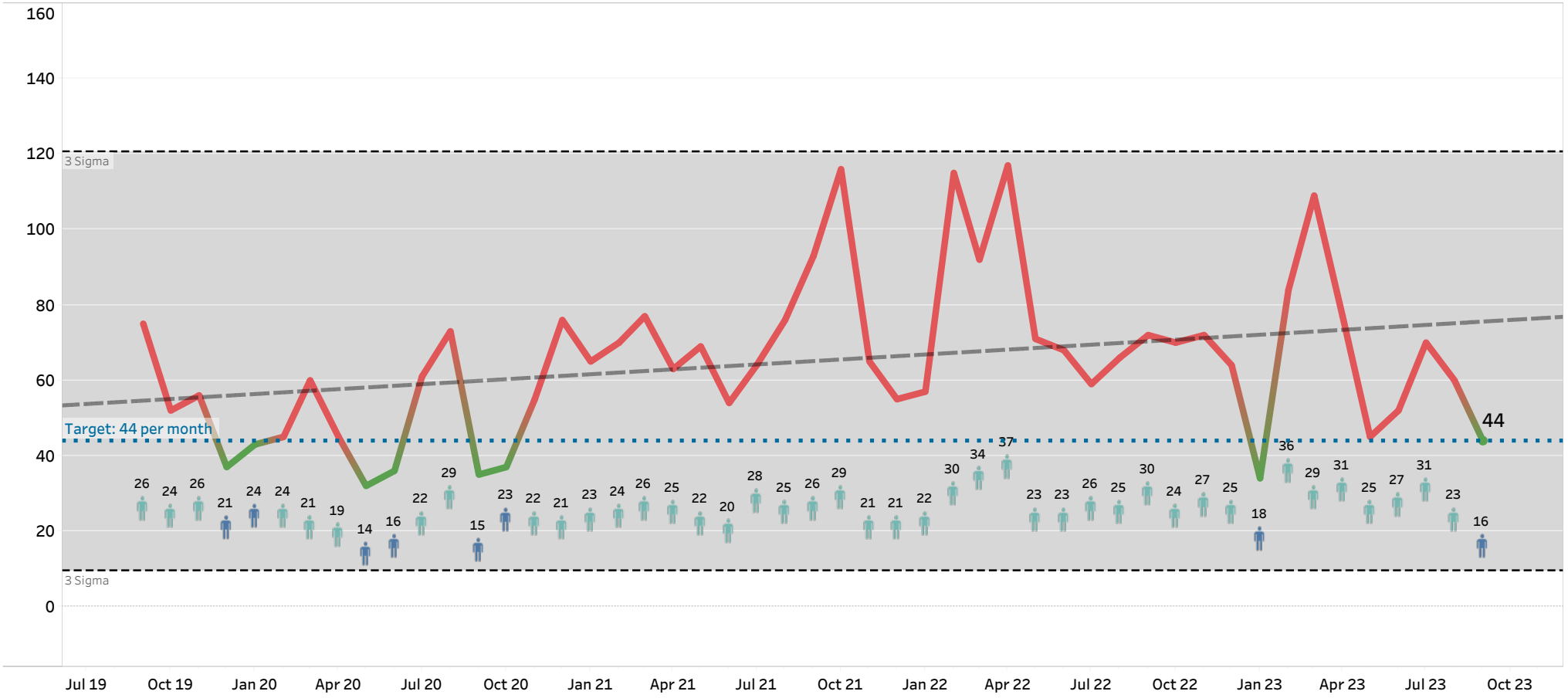
Patient Experience: Breakthrough Clinically Ready for Discharge by Wards MH (Including OAPS) (Sept 2022-Sept 2023)

All Mental Health wards excludes Campion ward (Learning Disability)

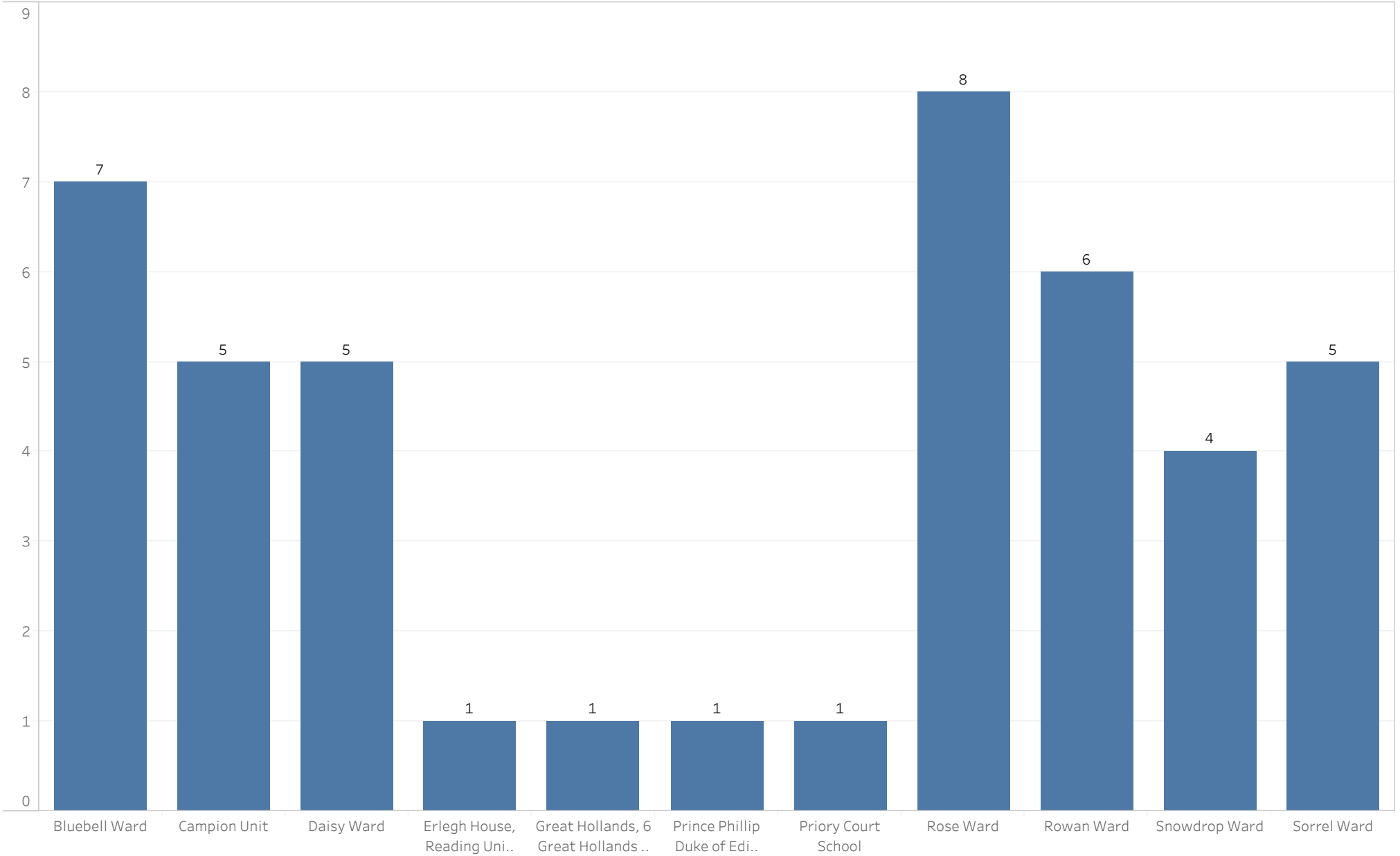


Supporting Our Staff Driver: Physical Assaults on Staff (Sept 19 to Sept 23)

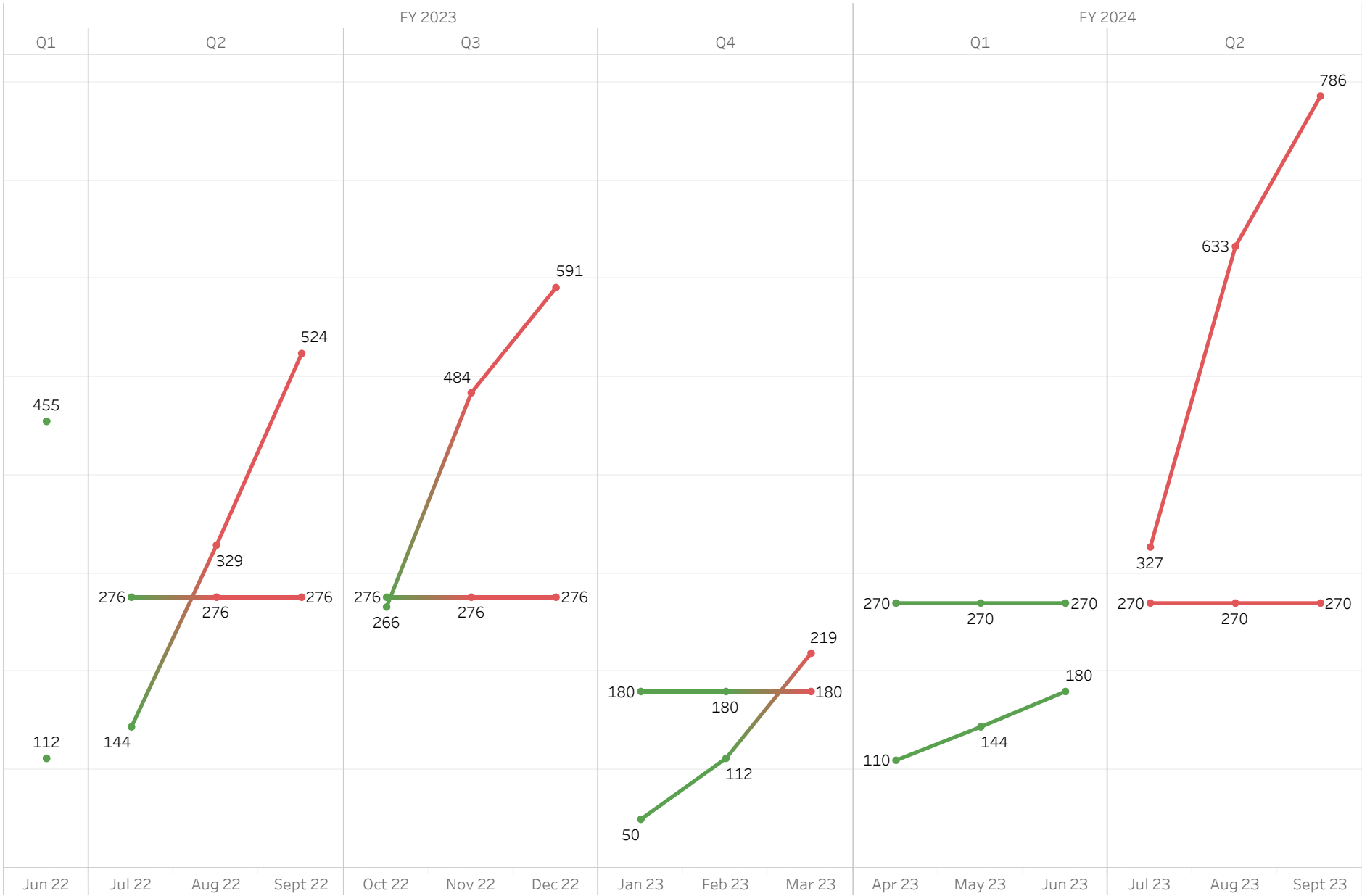
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (September 2023)



Efficient Use of Resources Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Statutory Training: Fire: %	90% compliance	89.6%	92.0%	96.2%	92.2%	92.8%	93.2%	93.0%	94.1%	94.3%	94.2%	93.5%	93.1%
Statutory Training: Health & Safety: %	90% compliance	96.1%	96.1%	96.1%	96.1%	96.2%	95.9%	95.9%	95.9%	96.4%	96.4%	96.3%	96.4%
Statutory Training: Manual Handling: %	90% compliance	91.4%	93.1%	93.2%	92.3%	92.6%	94.3%	94.5%	93.2%	94.0%	94.3%	94.3%	93.4%
Mandatory Training: Information Governance: %	95% compliance from April 22	96.5%	98.1%	93.2%	96.0%	96.8%	97.0%	97.4%	97.7%	98.0%	98.2%	97.7%	97.4%

True North Patient Experience Summary

		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Mental Health: Prone (Face Down) Restraint	4 per month	2	2	2	2	14	8	3	2	1	4	7	1
Patient on Patient Assaults (MH)	25 per month	21	20	25	15	13	28	22	15	21	10	12	11
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	69.8%	65%	79.1%	79.2%	86.8%	85.9%	77.6%	76.7%	88.4%	86.8%	90.0%	88.8%
Mental Health: Uses of Seclusion	13 in month	6	6	13	6	6	6	5	12	4	10	10	4

		Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	5	9	5	5	21	23	27	23	25	24	19	31
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	85%	79%	80%	80%	81%	84%	83%	87%	84%	85%	85%	86%	90%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	0	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	0	0	0	0	0	0	0	1	0	0	0
Mental Health: AWOLs on MHA Section	10 per month from April 2022	10	12	5	10	3	11	6	11	4	7	10	7
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	1	0	2	0	1	1	2	0	2	4	2	3
Mental Health: Readmission Rate within 28 days: %	<8% per month	6.45	1.45	1.53	1.40	1.68	2.62	2.90	5.70	4.04	3.89	1.35	3.45
Patient on Patient Assaults (LD)	4 per month	2	2	0	1	1	5	0	1	2	2	1	1
Suicides per 10,000 population in Mental Health Care (annual)	7.4 per 10,000	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7	5.7
Self-Harm Incidents within the Community	31 per month	21	51	37	57	51	52	44	44	32	32	29	23
Pressure Ulcer with Learning	Tbc							2	2	1	1	0	2
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	0	0	0

Efficient Use of Resources

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
C.Diff due to lapse in care (Cumulative YTD)	6	2	2	2	2	2	2	0	0	0	0	0	0
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI) infection rate	tbc	0	1	0	0	0	0	0	0	0	0	0	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	2	3	3	3	3	3	0	1	1	1	1	1
Count of Never Events (Safe Domain)	0	0	0	0	1	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	83.32	92.82	85.70	91.65	87.5	90	88	75	80	87.5	100	100
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.26	99.53	99.64	99.26	99.37	99.39	99.26	99.35	99.42	99.40	99.42	99.17
People with common mental health conditions referred to Talking Therapies will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100
People with common mental health conditions referred to Talking Therapies will be treated within 6 weeks from referral: %	75% treated	95	93	94	95	95	95	94	94	93	91	91	87
People with common mental health conditions referred to Talking Therapies completing a course of treatment moving to recovery: %	50% treated	47	52	48	45.5	46	46.5	46.5	48	45	49.95	46.15	46
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	35	66.49	82.84	72.48	72.42	69.06	61.26	83.45	92.09	97.79	100	99.00
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	98.70	100	100	100	100	100	100	100	100	100	99.57	99.53
Sickness Rate: %	<3.5%	4.9%	4.5%	5.1%	4.3%	4.3%	4.1%	3.7%	4.0%	3.8%	3.9%	3.7%	
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	66.7%	100%	57.1%	100%	66.6%	66.6%	50%	83.3%	66.6%	75%	75%	100%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	100%	75%	83.3%	100%	88.8%	66.6%	100%	50%	46.1%	36.3%	42.8%	62.5%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

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

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	November 2023
Title	NHS Equality Diversity and Inclusion (EDI) Improvement Plan alignment with Berkshire Healthcare EDI Activity
	Item for Noting /Item for Discussion
Purpose	To provide an update on our EDI progress and activity mapped against the NHS England EDI Improvement Plan recommendations published in June 2023.
Business Area	People Directorate
Presented by **Author**	Ash Ellis, Deputy Director for Leadership, Inclusion and Organisational Experience Stephanie Wynter, EDI Business Manager
Relevant Strategic Objectives	Make Berkshire Healthcare a financially and environmentally sustainable organisation, a great place to work, improve patient outcomes, provide safer services
CQC Registration/Patient Care Impacts	The relevance of this paper supports all key lines of enquiry, and our actions demonstrate to the CQC, the Trust's commitment to an inclusive, caring environment.
Resource Impacts	The paper references work that has happened, underway, and work planned by the EDI team and colleagues across the Trust, to co-design, co-produce and co-deliver meaningful change.
Legal Implications	This report demonstrates the Trust's commitment to advancing equality, diversity and inclusion and supports us meeting our Public Sector Equality Duty, under the Equality Act 2010.
Equality and Diversity Implications	Our data reveals disparities across race, disability, gender identity and sexual orientation. This highlights the need for employee-led action to address discrimination and create equitable access, experiences, and outcomes for all staff. Allowing unfairness across any diversity dimension brings legal, reputational, morale and retention risks.
Action	We ask the Board to note the progress and activity we have delivered when comparing against the NHS England EDI Improvement plan recommended actions.

1. Executive Summary

This paper provides an update on our EDI activities against the NHS England EDI Improvement Plan published in June 2023. It highlights how we compare against the 6 high impact actions, as well as any potential gaps in delivering against them.

Key achievements include notable improvements in WRES and WDES indicators, a commitment to becoming an anti- racist organisation, thorough analysis and publication of ethnicity, disability, and gender pay gap reports, and recognition as an accredited Stonewall Top 100 Gold Employer.
We also hold distinctions like the Bronze Rainbow Badge, Disability Confident Leader status, Gold Armed Forces, Veteran aware recognition, and Carer Charter employer.

In summary, we recognise the need for continuing focus to address plateaued indicators concerning bullying, harassment and discrimination, and inequitable access to development opportunities, as indicated by the latest WRES and WDES reports. Embedding accountability for EDI actions, addressing pay gap intersectionality (multiple protected characteristics), sustaining momentum, and promoting inclusive behaviours are vital.
Furthermore, leveraging data insights, enhancing LGBTQ+ inclusion, and prioritising intersectional analysis will be crucial steps. These efforts, supported by Board endorsements and accountability mechanisms, will be integral to our annual EDI plan and forthcoming EDI Strategy refresh in the New Year. Our commitment is to create an inclusive culture and environment, supporting the career progression of underserved groups, and addressing disparities to ensure a more equitable and diverse workplace.

Actions included are linked to those in our; Board Assurance Framework (BAF), National Staff Survey (NSS), Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), Ethnicity Pay Gap (EPG), Gender Pay Gap (GPG), Disability Pay Gap (DPG), Anti-Racism Strategy Priorities, and the Stonewall Workplace Equality Index (WEI) reports.

2. Introduction

The Trust is fully committed to advancing equality, diversity and inclusion. This aligns with our strategy objectives and vision to be a great place to get care and great place to give care.

While progress has been made, we must do more to tackle discrimination, close inequality gaps, and create a true sense of inclusion and belonging. Through collaboration, accountability, and a relentless focus on equity, we can build a Trust that is fair, compassionate, and welcoming to all.

The NHS EDI Improvement plan was published in June 2023 which sets out 6 high impact targeted actions to address the prejudice and discrimination that exists through behaviour, policies, practices and cultures across the whole NHS. These recommendations have been mapped against our existing activity to assess gaps and improve standards where we feel there are opportunities to do this.

3. Some of Our EDI Highlights

- Workforce Race Equality Standard (WRES) - Improvements seen in most indicators, but disparities persist around access to training, progression, and experiences of bullying, harassment and discrimination for ethnically diverse colleagues. Next steps focus on becoming an anti-racist organisation through systems changes, accountability, and engagement.
- Workforce Disability Equality Standard (WDES) - Mostly improvements, but issues remain around sharing of protected characteristics, bullying/harassment, feeling valued, and coming to work when feeling unwell. Next steps are increasing sharing of protected characteristics, addressing perception of managers pressuring disabled colleagues to work when unwell, and reducing harassment.
- Ethnicity Pay Gap - Actions proposed involve inclusive recruitment, pay reviews, talent development, flexible working, and engagement. Recommend exploring intersectionality (how people’s social identities overlap, i.e. gender, race, disability compounding experiences), and getting statistician input.
- Gender Pay Gap - Actions center on inclusive recruitment, progression support, flexible working, engagement, statistician input. Highlight opportunities through apprenticeships, internal promotion, development of a women's network.
- Disability Pay Gap - Actions include progression support, sharing of protected characteristics drive. Extra focus on maintaining status as a Disability Confident Leader, and progressing our reasonable adjustments and neurodiversity work.
- Anti-Racism Strategy – Action statement co-produced. Three priority areas identified around disparities in outcomes, access, experiences. Activities to be developed for each area through five separate Executive led workstreams. Emphasis on community engagement, co-production, accountability and evaluation.
- Stonewall Workforce Equality Index - Identifies gaps around visibility, policies, data collection, supply chain. Next steps detail enhancing inclusion and role models for bi, trans and non-binary staff.

4. Aligning activity against the NHS EDI Improvement Plan 2023

High-Impact Actions

The NHS EDI Improvement Plan aims to improve equality, diversity and inclusion across the NHS workforce in England.

It outlines 6 high impact actions to enhance workforce diversity, foster inclusion, and reduce discrimination.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

Success Metric

1a. Annual chair and chief executive appraisals on EDI objectives (Board Assurance Framework (BAF)).

NHS organisations and ICBs must complete the following actions:

- Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (by March 2024).
- Board members should demonstrate how organisational data and lived experience have been used to improve culture (by March 2025).
- NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by March 2024).

High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

Current progress against success metric

- 1a – Board EDI objectives are currently being discussed and agreed.
- Members of our Board have actively taken part in courses such as ‘Above Difference masterclass in Cultural Intelligence’, ‘Inclusive Leadership’ to ‘EDI Awareness’ sessions with our EDI team, for greater understanding, compassion and perspective when making strategic decisions.
- The Board reviews data which identifies areas of concern, focusing on reducing inequalities and fostering diversity. All Board papers expected to identify equality and diversity issues and impacts.
- Regular updates to committees and the appointment of a Board level Wellbeing Guardian and ensure ongoing scrutiny of diversity and inclusion strategies and work.
- We have co-produced an Organisational Anti-racism Action Statement.
- We have reviewed and updated our Board Assurance Framework.

Further actions and opportunities

- Full sharing of protected characteristics to support greater transparency of our diverse leadership.
- Ensure EDI is integrated into Board activities, such as strategy reviews. Recorded high standard of scrutiny on Equality Impact Assessments.
- Documented event attendance, shared more widely to Trust/community, to support closing the feedback loop, visible commitment to celebrating EDI.
- Share and promote EDI messaging through communication channels and social media platforms.
- Annual reflection on EDI published to wider Trust/community.
- Support an Anti-racism workstream. All Executives are leading a workstream as part of our anti-racism strategy.
- Use opportunities like staff awards to recognise EDI contributions.

NHS
Berkshire Healthcare
Equality Diversity and Inclusion

Success Metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts (WRES/WDES)

2b. Access to career progression, training and development opportunities. (NHS Staff Survey)

2c. Year-on-year improvement in race and disability representation leading to parity over the life of the plan. (WRES/WDES)

2d. Year-on- year improvement in representation of senior leadership (Band 8C and above) over the life of the plan. (WRES/WDES)

2e. Diversity in shortlisted candidates (to be developed year 2)

2f. Quality of training score (National Education and Training Survey (NETS)

NHS organisations and ICBs must complete the following actions:

- Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation (by June 2025)

High impact action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

Current progress against success metric

- 2a – The relative likelihood of white staff being appointed over ethnically diverse colleagues has improved (1.53 down to 1.51), as well as the likelihood of non-disabled colleagues to be appointed over disabled has decreased (1.08 down to 0.93) meaning disabled colleagues are more likely to be appointed.
- 2b – people's perception of fair progression / promotion opportunities increased from 61.9% to 63.3%.
- 2b – people saying they are able to access the right L&D opportunities increased from 67.4% to 69.5%.
- 2c – We saw a steady increase in representation year-on-year, in the number of disabled, and our ethnically diverse colleagues.
- 2d – Disabled and ethnically diverse representation in Bands 8C and above has increased slightly.
- We have begun a deep dive into our recruitment data and have reviewed our recruitment training.
- We are reviewing our talent pipelines and sharing vacancies within our communities. We invest in widening participation through the offering of apprenticeships, functional skills, employability programmes, work experience, reservists, and T Levels.

Further action and opportunities

- We have developed an Anti-racist Action statement, and an anti-racism workstream focused solely on recruitment, retention, conditions and progression will develop and lead actions to address the inequality experienced as outlined in our WRES/WDES and staff survey metrics.
- We are developing our Talent management approach, beyond Executives, inclusive talent boards, and competency based progression through clear career pathways.
- Co-creating a disability action plan with the PURPLE staff network, will give focus more to increasing disability disclosure, addressing pressure, and creating a safe, supportive culture.
- Neurodiversity research into staff profiling with Autistica, and sharing interview questions in advance, as well as embedding our new behaviours in interview questioning.
- We had a deep dive on our CPD usage and access within our divisions and are now sharing and promoting the Training Needs Analysis and CPD funding through our staff networks and wider.

NHS
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Equality Diversity and Inclusion

Success Metric

3a. Year-on-year reductions in the gender, race and disability pay gaps (Pay gap reporting)

NHS organisations and ICBs must complete the following actions:

- Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce. (By March 2024)
- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics. (By 2026).
- Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns. (By March 2024).

High impact action 3: develop and implement an improvement plan to eliminate pay gaps.

Current progress against success metric	Further actions and opportunities
• 3a – We already undertake the Gender pay gap reporting, the gap has reduced from 17.01% to 16.46% median and 20.45% to 16.96% mean over the past year, in favour of males. • 3a – We introduced the Disability pay gap report this year, we have a median gap of -4.95% in favour of disabled colleagues. • 3a – We introduced the Ethnicity pay gap report this year, we have a median gap of 3.59% in favour of white colleagues. • We have a flexible working policy implemented, advertise flexible working options, and we are also reviewing our remote working policy currently. • Transparency, we are sharing the pay gap reports with our workforce, directly through staff networks. They are also published on our Website, Intranet. • Implemented a new process for capturing medical education (IMG, EEA, UK), introducing equality monitoring capturing for med trainees. As well as sharing medical bonus payments • We provide nurseries, and we are reviewing our access and financial costs for colleagues, which is also a recommendation of 'Mend the Gap'.	• Collaboration with key stakeholder groups, such as the Diversity Steering Group, Trade Unions, and the staff networks. • Efforts will be made to encourage self-declaration of characteristics to obtain more comprehensive data to better inform action. • We will focus on inclusive recruitment, pay and reward structures, learning and development, culture and engagement. • We aim to continue to embed our flexible working practices and supportive people policies. This includes advertising flexible working options in recruitment campaigns to attract diverse talent. • We will be developing our talent management approach into the wider organisation, which forms a recommendation from the Mend the Gap review. • We aim to look at intersectionality in our pay gaps i.e. black females. • We have implemented most of the 'Mend the Gap' recommendations but there are some that we have not yet applied i.e. promote flexible working to appeal to men to increase the % of men that work less than full time.

NHS
Berkshire Healthcare
Equality Diversity and Inclusion

Success Metric

- 4a. Organisation action on staff health and wellbeing. (NHS Staff Survey)
- 4b. Quality of training score (National Education and Training Survey (NETS)

NHS organisations and ICBs must complete the following actions:

- Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework. (By Oct 2023).
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare. (By April 2025).

High impact action 4: Develop and implement an improvement plan to address health inequalities within the workforce.

Current progress against success metric

- 4a – 74.3% of our colleagues believe we take positive action on health and wellbeing. The wellbeing activity we deliver is a contributing factors to this score.
- 4b – 75% of our students/trainees are likely or extremely likely to recommend their training post/placement to friends and family to get care. 63% of our students/trainees are likely or extremely likely to recommend their training post/placement to friends and family as a place to work or train. We address issues collectively with our local systems and education providers, such as student hardship.
- All staff receive a wellbeing conversation within their appraisal. New starters have a wellbeing conversation and risk assessment carried out with their line manager.
- Reasonable adjustments policy in place, centralised budget, approach, ensuring equity of access.
- We have a dedicated Wellbeing Matters psychological support service for all staff, and employee assistance programme. We provide Mental Health First Aid and REACT training, and we have facilitated exercise and mindfulness/nutrition sessions for staff.
- We offer Peppy App for menopause and men's health support, Health Assured for in the moment emotional support and counselling, access to eye test vouchers and our early access physio service.

Further actions and opportunities

- Recently launched access to Salary Finance, a financial wellbeing provider, designed to help staff take control of their finances, reduce money worries.
- Developing a project to address the importance of faith in healthcare. Central to our strategic aims on health inequality, anti- racism and community engagement, this will have a positive multifaceted impact on both our communities and workforce.
- Enhancing our approach to Equality Impact Assessments within our workforce and communities.
- Promoting a new Workplace Stress Indicator tool, to help staff identify/address stress factors.
- Continue work to overcome issues with reporting so we can proactively contact and support staff who have experienced assault or harm at work.
- We are due to undertake an organisational diagnostic aligned to the new NHS health and wellbeing framework.
- Further development of our wellbeing champions i.e. communications, networking, training.
- Continue to deliver outcomes against our neurodiversity and EDI strategy, reducing

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Equality Diversity and Inclusion

Success Metric

- 5a. Sense of belonging for internationally recruited staff. (NHS Staff Survey)
- 5b. Reduction in instances of bullying and harassment from team/line manager experienced by (internationally recruited staff). (NHS Staff Survey)

NHS organisations and ICBs must complete the following actions:

- Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment; (By March 2024)
- Create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback. (By March 2024)
- Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety. (By March 2024).
- Give international recruits access to the same development opportunities as the wider workforce. (By March 2024).

High impact action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

Current progress against success metric

- We send assessment tools prior to arrival from the education lead, conduct comprehensive international recruit inductions and Welcome Meetings via Microsoft Teams. We have been awarded the NHS pastoral care quality award.
- We introduce virtual international recruits to our organisation, their line manager, Pastoral support lead and the Education Leads.
- We provide a range of valuable resources, including an International Recruitment Booklet, Cost of Living Leaflet, Buddy, SIM and Laptop allocation and practice differences information to assist international recruits in settling in.
- We offer ongoing support in finding permanent accommodation to ensure that international recruits feel secure and at home.
- We facilitate regular networking events and newsletters to foster connections among international recruits and keep them informed.
- We are proud to extend support for international recruits in navigating NMC (Nursing and Midwifery Council) processes, signposting and visa-related matters.

Further actions and opportunities

- Expanding support with targeted additional sessions for Allied Health Professionals (AHPs) to address their unique needs and challenges.
- Developing more robust talent pipelines that actively involve international staff, promoting diversity and inclusion.
- Enhancing cultural transition support by increasing the frequency of events and programs aimed at easing the transition to a new culture and workplace.
- Providing comprehensive cultural transition training to raise awareness among our teams, fostering inclusive and welcoming team cultures. Including the implementation of a ‘Manager Guide' for international recruitment to support both sides of the transition.
- Continuing to guide international recruits by actively signposting them to external groups and resources, ensuring a smoother integration into our organisation and local community.
- Our leadership and management development offer provides cultural intelligence and conscious inclusion sessions.
- There may be further opportunity in exploring developing our data in tracking our international recruits in terms of experience, effectiveness of the welcome

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Success Metric

- 6a.Improvement in staff survey results on bullying / harassment from line managers/teams (NHS Staff Survey).
- 6b. Improvement in staff survey results on discrimination from line managers or teams (NHS Staff Survey)
- 6c.NETS bullying and harassment score metric (NHS professional groups).

NHS organisations and ICBs must complete the following actions:

- Review data by protected characteristic on bullying, harassment, discrimination and violence. (By March 2024).
- Review disciplinary and employee relations processes. Where the data shows inconsistency in approach, immediate steps must be taken to improve this. (By March 2024)
- Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). (By June 2024).
- Create an environment where staff feel able to speak up and raise concerns, with steady year-on- year improvements. (By March 2024).
- Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence. (By March 2024).
- Have mechanisms to ensure staff who raise concerns are protected by their organisation.

High impact action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Current progress against success metric

- 6a – The percentage of staff experiencing harassment, bullying or abuse from managers has decreased from 10% in 2019 to 7.2% in 2022. This indicates a positive reduction in these incidents over the past 4 years.
- 6b – The percentage of staff experiencing discrimination from managers or colleagues has reduced from 8.2% in 2019 to 7.8% in 2022.
- 6c – The NETS score for never experiencing bullying and harassment has Improved from 82.9% in November 2021 to 83.4% in 2022. We welcome the Freedom to speak up guardian to all student Inductions.
- The data indicates that ethnically diverse colleagues are 10.9% more likely to experience harassment, bullying or abuse from patients, relatives and the public than white colleagues.
- Disabled colleagues are 7% more likely to experience harassment, bullying or abuse from managers than non-disabled colleagues.
- Developed a zero tolerance of racism condition of admission for patients to PPH. Launched the Prospect Park Hospital Advocacy for Racial Equity Team (PPARET) to assist staff with racial abuse and train advocates to frequently visit wards.
- Began project to improve experience of people experiencing racism in Wokingham Community Nursing and Out of Hours Services.
- Recruiting to a psychological support role to provide support to victims of abuse post-incident.
- Violence reduction policy in place, violence strategy developed, will be reviewed.

Further actions and opportunities

- In committing to become an anti-racist organisation we are developing our actions and we have an Incidents, empowerment and support workstream that will develop specific action relating to this national EDI action.
- Our new leadership development programme includes sessions on cultural intelligence, conscious inclusion, civility, conflict, behaviors, speaking up, and team dynamics. We are also developing a team development framework and conflict pathway.
- We have refreshed our Freedom to speak up policy and strategy. We have established a strong FTSU champion network which is formed of colleagues from diverse backgrounds and support from FTSUG through regular networking sessions. We've stayed above the national average in the staff survey for 'raising concerns'.
- We are also developing our Trust behaviors framework.
- We have recently relaunched our violence, prevention and reduction working group to bring more focus, and signed the organisational sexual safety charter. We will be assessing ourselves against these frameworks A workforce sexual safety policy is in development.
- We have shared our casework report on employee relations to our staff networks. Our data has been reviewed to show significant improvements in our WRES and WDES following implementing just and learning culture principles.
- We are developing an EDI data dashboard.
- More work should be focused on combatting bullying, raising awareness. 76% of FTSU cases have a bullying element.

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Trust Board Paper

Board Meeting Date	14 November 2023
Title	**Audit Committee – 25 October 2023**
	Item For Noting
Purpose	To receive the unconfirmed minutes of the meeting of the Extraordinary Audit Committee of 25 October 2023.
Format of the Report	The format of the report is not nationally prescribed
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Audit Committee Chair
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered

Berkshire Healthcare
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Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 25 October 2023

(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Mark Day, Non-Executive Director Naomi Coxwell, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Becky Clegg, Director of Finance Graham Harrison, Head of Financial Services Debbie Fulton, Director of Nursing and Therapies Minoo Irani, Medical Director Sam Abbas, RSM, Internal Auditors Melanie Alflatt, TIAA Maria Grindley, Ernst and Young, External Auditors Alison Kennett, 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: Amanda Mollett, Head of Clinical Effectiveness and Audit, Jenny Loganathan, TIAA, Clive Makombera, RSM Internal Auditors and Sharonjeet Kaur, RSM Internal Auditors.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 26 July 2023**	
	The Minutes of the meeting held on 26 July 2023 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	

	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework**	
	The latest Board Assurance Framework had been circulated. The Chief Financial Officer reported that the October 2023 Trust Board Discursive meeting had agreed that the Board Assurance Framework and Corporate Risk Registers should be reviewed to ensure alignment with the Trust's updated Strategy. Any proposed changes to the risks on the Board Assurance Framework and Corporate Risk Register would be presented to the December 2023 Trust Board meeting. The Chief Financial Officer highlighted that Risk 1 (workforce) had been updated to reflect the Trust's work on Equality, Diversity and Inclusion. It was noted that Risk 3 (System Working) had been updated to reflect the current position in relation to the development of Provider Collaboratives. The Committee noted the report.	
5.B	**Corporate Risk Register**	
	The Chief Financial Officer highlighted that the Ligature Risk had been updated to reflect a new ligature risk which had been identified by another mental health trust around toilet seats. It was noted that plans were in place to change existing fittings. It was also noted that the replacement of shower curtain tracks at Prospect Park Hospital was due to be completed in the first week of November 2023. The Chief Financial Officer reported that the Near Miss Risk had been updated to reflect the implementation of the new national Learning From Patient Safety Events Policy from September 2023. The Chief Financial Officer reported that the Prospect Park Hospital Environment Risk had been updated to reflect the Trust's work with the Prospect Park Hospital PFI Landlord. This included commissioning a full asset condition safety at Prospect Park Hospital. The Chair asked about the remaining length of the PFI Contract. The Chief Financial Officer confirmed that there was ten years remaining and pointed out that established practice was that trusts should start actively planning for the PFI contract exit when there was seven years left on the contract. The Committee noted the report.	
6.	**Single Waiver Tenders Report**	
	A paper setting out the Trust's single waivers approved from 1 July to 30 September 2023 had been circulated.	

	The Chief Financial Officer presented the paper and reported that the Thames Valley and Wessex Pharmacy Procurement Service contact waiver was to extend the current contract initially for two months followed by a further one month extension to enable the completion of a new tender exercise. It was noted that the Anxiety and Depression in Young People existing contract was transferred from the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board to the Trust but the transfer was not completed until after the existing contract had lapsed and therefore a single waiver was required. The Chief Financial Officer reported that the Physiotherapy contract waiver was to procure additional private physiotherapy capacity in order to reduced waiting list pressures. Mark Day, Non-Executive Director asked why the Physiotherapy contract had not gone out to tender given that there were private sector providers for physiotherapy services. The Chief Financial Officer explained that time limited non-recurrent funding had been made available and therefore due to time constraints, it was agreed to secure the additional private physiotherapy capacity as soon as possible. The Committee noted the report.	
7.	**Information Assurance Framework Update Report**	

	The Chief Financial Officer presented the paper and highlighted the following points:
	
	• A total of four indicators were audited during quarter 2:
	  ○ Patient on patient assaults (mental health) (green for data assurance and data quality)
	  ○ Clinically Ready for Discharge (green for data assurance and amber for data quality)
	  ○ Mental Health Readmission Rates (green for data assurance and amber for data quality)
	  ○ Mental Health Gatekeeping (amber for data quality)
	• Of the indicators audited, there remained recording issues around completeness, timeliness and accuracy
	• Action plans had been put in place to address the identified issues and previous actions were tracked in the report.
	
	The Chair commented that the response to data quality issues tended to be increased training for staff and asked whether there was ever scope to simplify systems and processes in order to reduce data recording errors.
	
	The Chief Financial Officer thanked the Chair for his suggestion and agreed to discuss if there was anything that could be done to simplify the recording processes with the Performance Team.
	
	The Committee noted the report.
		PG

8.	**Losses and Special Payments Report**	
	The Chief Financial Officer presented the paper which provided a list of the Trust's losses and special payments made during quarters 1 and 2 2023-24. The Committee approved the losses and special payments made during quarters 1 and 2 2023-24.	
9.	**Clinical Claims and Litigation Report**	

	The Director of Nursing and Therapies presented the paper and highlighted the following points:
	
	• During quarter two there were seven new claims
	  o Three clinical negligence claims
	  o Two employer liability claims
	  o Two public liability claims
	• Four claims had been closed
	
	The Committee noted the report.	

10.	**Clinical Audit Report**	

	The Medical Director presented the paper and highlighted the following points:
	
	• The report provided assurance to the Audit Committee that the Clinical Audit Plan 2023-24 was on track.
	• There was a slight delay in publishing the national Audit Reports which would mean that there would be an increase in the number of reports reported to the Quality Assurance Committee in the new year
	• The following clinical audit reports were published between July and September 2023
	  o National Audit of Care at the End of Life- Round 4 (2022-23) (Reported to the August 2023 meeting of the Quality Assurance Committee)
	  o POMH monitoring of Patients Prescribed Lithium (would be reporting to February 2024 Quality Assurance Committee)
	• The following national Clinical Audit Reports were due to be published between October 2023 and December 2023:
	  o National Diabetes Core audit report
	  o National Diabetes – Type 1 report
	  o National Diabetes – Young Type 2 report
	  o Sentinel Stroke National Audit Programme (SSNAP) – Annual Report
	  o National Falls Inpatient Audit annual report
	• All published Clinical Audit Reports and the Trust's action plans in relation to the reports were reviewed by the Clinical Effectiveness Group.
	
	The Committee noted the report.	

11.	**Anti-Crime Services Report**	
	Melanie Alflatt, Anti-Crime Specialist, TIAA presented the report and highlighted the following points: • TIAA was currently reviewing section 12 of the Mental Health Act Assessments for duplicate claims or milage claims in compliance with the Trust's policy and procedures • The current National Fraud Initiative was around payroll and creditors data • TIAA had recently conducted a client wide review of disciplinary policies to identify areas of good practice across a range of policies from a variety of NHS organisations. The Trust's policy was included as part of the review • TIAA was working with trusts to 'health check' organisational culture in respect of whistleblowing • As part of International Fraud Awareness Week in November, TIAA and the Security Team would be holding joint events to raise awareness about fraud related work The Chair referred the Audit Seminar on Whistleblowing prior to the meeting and commented that it was easy for organisations to become complacent and asked whether TIAA had identified any concerns about the Trust's speak culture. Melanie Alflatt said that TIAA would be conducting a benchmarking exercise on whistleblowing and invited the Trust to particate in the survey. Mark Day, Non-Executive Director (and Non-Executive Director Lead for Speaking Up) reported that the Trust's Freedom to Speak Up Guardian (Mike Craissati) participated in NHS England's Freedom to Speak Up Survey and suggested that TIAA liaise with the Freedom to Speak Up Guardian about the Trust's raising concerns and speaking up culture. The Committee noted the report.	**PG** **MA/JL**
14.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Sam Abbas, RSM, Internal Auditors presented the paper and highlighted the following points:
	
	• Since the last meeting, the following reports had been issued:
	  ○ Sickness Absence (partial assurance)
	  ○ Patient Experience (reasonable assurance)
	  ○ Data Quality (reasonable assurance)
	• Ten actions have been implemented and evidenced where relevant since the last meeting. There were three overdue actions which were in the process of being implemented.
	• There was a change to the Internal Audit Programme 2023-24. An additional review on the Trust's Out of Area Placements had been added.	

	Sam Abbas reported that the Sickness Absence Audit Review had received a partial assurance rating because in the sample there were cases where medical certificates did not cover the duration of the employees' absence and there was a lack of formal evidence to support that managers were making regular contact with staff members during the period of their absence. The Chair asked whether the lack of medical certificates for the whole period of sickness represented a lack of control, or the lack of a control being enforced. Sam Abbas said that Internal Auditors had identified this as an area of non-compliance with the Trust's Sickness Absence Policy and Procedures. The Chair asked what would constitute as "evidence" that managers had contacted staff during their period of sickness given that contact may be in the form of telephone calls etc. Sam Abbas explained that an example of evidence would be a follow-up email to a member of staff. Naomi Coxwell, Non-Executive Director asked whether the Trust was satisfied that the requirements for managers and staff in relation to the Trust's Sickness Absence Policy and Procedures had been adequately communicated across the Trust. Sam Abbas reported that the Internal Auditor's Sickness Absence Report had been discussed with the Director of People and she had acknowledged that there was further work to be done to improve the controls around sickness absence. Mark Day, Non-Executive Director asked whether about the sample size and whether this was sufficiently large to be able to identify pockets of high and low areas of compliance and whether areas of low compliance were teams experiencing staffing and resourcing challenges. The Director of Nursing and Therapies reported that the Sickness Absence review looked at a small sample size and therefore it was not possible to draw any wider conclusions. The Director of Nursing and Therapies also pointed out that it was sometimes challenging for staff to get sick notes due to the workload pressures experienced by GPs. The Chair referred to the Internal Audit Plan Progress section of the report and pointed out that the Data Security and Protection Toolkit review an audit rating of "moderate" which was different from RSM's usual audit ratings. Mr Abbas explained that the Internal Auditors reviewed NHS provider organisations' Data Security and Protection Toolkit reports on behalf of NHS Digital and therefore used NHS Digital's audit assurance levels. Mr Abbas confirmed that a "moderate" rating would equate with RSM's "reasonable assurance" rating. Sam Abbas reported that the following additional papers had been included in the agenda pack for information. a) NHS News Briefing b) Payroll Overpayments in the NHS Benchmarking Report c) Healthcare – Benchmarking of Internal Audit Findings 2022-23	

	d) Emerging Risk Radar Report The Committee noted the reports	
13.	**External Audit of the Berkshire Charity's Annual Report and Accounts 2022-23**	
	The Berkshire Healthcare Charity's Annual Report and Accounts 2022-23 and draft Management Representation Letter had been circulated. The Chief Financial Officer reported that the External Auditors were making the finishing touches to their report and confirmed that he was expecting the changes to be presentational in nature and would not change the numbers. It was noted that the final Berkshire Charity's Annual Report and Accounts 2022-23 would be presented to the meeting of the Trust's Corporate Trustees in November 2023 for approval before being submitted to the Charity Commission. Alison Kennett, Ernst and Young, External Auditors confirmed that the External Auditors had completed their review apart from a small number of outstanding queries. The Committee approved the Berkshire Charity's Annual Report and Accounts 2022-23 which would be submitted to the Corporate Trustees meeting on 14 November 2023 for final approval.	**JH**
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 26 July 2023**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 26 July 2023 received and noted. The Committee noted the minutes.	
15.	**Minutes of the Quality Assurance Committee held on 29 August 2023**	
	The minutes of the Quality Assurance Committee meetings held on 30 May 2023 were received and noted.	
16.	**Minutes of the Quality Executive Committee Minutes – July 2023, August 2023 and September 2023**	
	The minutes of the Quality Executive Committee meetings held on 17 July 2023, 21 August 2023 and 18 September 2023 were received and noted.	
17.	**Draft Annual Audit Committee Report to the Council of Governors**	
	The draft Annual Audit Committee Report to the Council of Governors had been circulated. The Company Secretary reported that she would update the report to include the salient points from today's meeting. The Chair confirmed that he would be presenting the report to the December 2023 meeting of the Council of Governors.	**JH** **RG**

	Maria Grindley, External Auditors, Ernst and Young said that the External Auditors would be happy to meet with Governors if requested. Naomi Coxwell, Non-Executive Director asked whether there was ever any feedback from the Governors about the content of the report. The Company Secretary reported that the Governors had provided feedback and as a result, the report had been expanded to include the Internal Auditors' medium and above recommendations and examples of Non-Executive Directors' challenges etc. The Committee noted the report.	
18.	**Board Sub-Committee's Annual Review of Effectiveness**	
	The results of the Finance, Investment and Performance Committee and Quality Assurance Committee's annual reviews of effectiveness had been circulated for assurance. The Company Secretary confirmed that the outcome of both Committee's annual reviews of effectiveness was very positive and there were no issues to highlight. The Committee noted the report.	
19.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The work programme was updated to include the External Audit Plan for the January and April 2024 meetings. The Committee's Annual Work Plan was noted.	**JH**
20.	**Any Other Business**	
	There was no other business.	
21.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled for 17 January 2024.	

The minutes are an accurate record of the Audit Committee meeting held on 25 October 2023.

Signed: - _____

Date: - 17 January 2024 _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 November 2023
Title	**Use of Trust Seal**
	ITEM FOR NOTING
Purpose	This paper notifies the Board of use of the Trust Seal
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Compliance with Standing Orders
Equalities and Diversity Implications	N/A
SUMMARY	The Trust's Seal was affixed to: • Lease of Resource House and licence for the alterations to the property • Lease of 20 Denmark Street and licence for alterations to the property
ACTION	To note the update.