Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 12 March 2024

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 9 January 2024	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Patient Story - CAMHs Mental Health Support Getting Help Team	Debbie Fulton, Director of Nursing and Therapies/Jade Hens, Getting Help and Mental Health Support Team	Verbal
6.1	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Freedom to Speak Up Self-Reflection Tool	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Quality Assurance Committee a) Minutes of the meeting held on 27 February 2024 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	Sally Glen, Chair of the Quality Assurance Committee/ Dr Minoo Irani, Medical Director	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	National NHS Staff Survey Results Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
PERFORMANCE			

No	Item	Presenter	Enc.
8.0	Month 10 2023/24 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 10 2023/24 Performance Report	Paul Gray, Chief Financial Officer	Enc.
8.2	Finance, Investment and Performance Committee meeting on 17 January 2024	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
CORPORATE GOVERNANCE			
9.0	Fit and Proper Person Test Policy	Julie Hill, Company Secretary	Enc.
9.1	Annual Health and Safety Report	Paul Gray, Chief Financial Officer	Enc.
9.2	Audit Committee Meeting - 17 January 2024	Rajiv Gatha, Chair of the Audit Committee	Enc.
9.3	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
9.4	Use of the Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
Closing Business			
10.	Any Other Business	Martin Earwicker, Chair	Verbal
11.	Date of the Next Public Trust Board Meeting – 14 May 2024	Martin Earwicker, Chair	Verbal
12.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 09 January 2024

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	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
	Allen Johnston	Podiatry Service Manager *(present for agenda item 6.0)*
	Tim Tilling	Podiatry Clinical Lead *(present for agenda item 6.0)*
	Justine Alford	Sustainability Lead *(present for agenda item 9.0)*
Observers:	None	

24/001	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting.
24/002	**Apologies** (agenda item 2)
	Apologies were received from: Rebecca Burford, Non-Executive Director and Sally Glen, Non-Executive Director.
24/003	**Declaration of Any Other Business** (agenda item 3)

	There was no other business.
24/004	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
24/005	**Minutes of the previous meeting – 12 December 2023** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 12 December 2023 were approved as a correct record.
24/006	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
24/007	**Board Story – A Podiatry Story (**agenda item 6.0)
	The Chair welcomed Allen Johnston, Podiatry Service Manager and Tim Tilling, Podiatry Clinical Lead to the meeting. Allen Johnston gave a presentation and highlighted the following points: • A quarter of the population would be aged over 65 by 2033, and this patient cohort were likely to have more than one long-term health condition, along with increasing frailty. The challenge of meeting these demands for Podiatrists was complex and required changes to working practices. • The loss of the NHS Student Bursary in 2017 had significantly reduced the demand for University Podiatry Degrees and therefore was a significant shortage of Podiatrists entering the profession. • In 2019, the Trust employed 24 (whole time equivalents) Podiatrists but currently there were 13 (whole time equivalents) Podiatrists at the Trust. Due to the shortage of Podiatry staff both at the Trust and nationally, the Podiatry Services' Routine Waiting List increased to a wait of approximately 35 weeks by the end of 2022 with around 5,000 people on the waiting list. • In order to meet increasing demand and to reduce waiting times for Podiatry Services, coupled with significant workforce shortages, the Trust worked with two local private Podiatry providers and with the agreement of patients who were triaged as having a routine Podiatric problem, were outsourced for an initial assessment to these private providers. • Work was undertaken in 2022 to alter the Trust's treatment criteria to enable the Podiatry Service to see patients with the highest Podiatric need. Tm Tilling shared Mr X's story who was an 86-year-old with a past medical history which included Kidney Disease, Polymyalgia Rheumatica and Hypertension. Mr X's GP referred him to the Podiatry Service because Mr X was unable to attend to his own foot health and had dystrophic nails which were causing a risk of skin breakdown and future ulceration.

	Following the triage process based on the GP's referral, MR X was assessed as requiring routine Podiatry treatment and was referred to one of the private providers. The private provider discovered puss and a lesion underneath the toenail and as per the outsourcing process, Mr X was referred back to the Trust as he had developed an urgent podiatric problem. The Trust's Podiatrist became concerned that the lesion was increasing in size and Mr X was referred to the Dermatology Service for investigation. A biopsy of the lesion showed that it was malignant, and Mr X remains under the care of Oncology. Mr X's family complained to the Trust expressing concerns around Mr X's initially being referred to a private provider who dealt only routine/low risk problems and around the length of time spent waiting for an appointment with the Trust's Podiatry Service during which time, Mr X's toe had deteriorated. Tim Tilling said that Mr X's experience had highlighted a number of areas for improvement, including a review of the referral form so that referrers understood what constituted a podiatric high-risk foot; a need for Podiatry staff to understand how to manage non-Podiatry related test results that can be accessed on the ICE system (electronic pathology results system); and a better understanding about the potential risk associated when referring a patient for outsourced treatment in terms of the time delay if they required further treatment. The Chief Executive commented that there tended to be a flat staffing structure in the Podiatry Service. The Chief Executive asked given the national shortage of Podiatrists and the reduction in the number of people being trained as Podiatrists, whether apprenticeships was one way for the Trust to "grow its own." Allen Johnston confirmed that the Podiatry Service had two Podiatry Apprenticeships and had successfully recruited Podiatrists from overseas. Tim Tilling reported that the Podiatry Service had done a lot of work on career progression and had created a new Band 7 clinical role. Aileen Feeney, Non-Executive Director asked whether the private providers used qualified Podiatrists. Tim Tilling confirmed that the private providers employed Podiatrists who had the same qualifications as the Trust's Podiatrists but pointed out that if patients like Mr X were found to require more complex treatment, there was a delay around being referred back to the Trust for treatment. Allan Johnston reported that the Trust was planning to bring the outsourced routine Podiatry Service back in house from summer 2024. The Chair thanked Allen Johnston, Podiatry Service Manager and Tim Tilling, Podiatry Clinical Lead for their presentation. The presentation slides are attached to the minutes. Naomi Coxwell said that it would be helpful for the Board to have a discussion about the Trust's approach to outsourcing to private and voluntary sector healthcare providers. The Chair agreed and suggested having a discussion at a future Trust Board Discursive meeting. **Action: Deputy Chief Executive** The Chief Operating Officer reported that working with third party providers had been added as a risk on the Trust's Corporate Risk Register.

24/008	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following items were discussed further: **a) Junior Doctors Industrial Action Update** The Medical Director reported that Junior Doctors had taken industrial action for six days which was the longest period of strike action in the NHS. The Medical Director said that the industrial action had ended at 7am this morning. It was noted that the Trust had secured cover at night for Prospect Park Hospital and confirmed that the Trust had not cancelled any appointments because of the Junior Doctors strike. The Medical Director paid tribute to the professionalism of the Trust's Junior Doctors during the period of industrial action. **b) Staff Flu and COVID-19 Booster Vaccination Campaign** The Director of Nursing and Therapies reported that as of 18 December 2023, 49.8% of staff had received the Flu vaccination and 45.1% of staff had received a COVID-19 booster vaccination. It was noted that the Trust's performance compared favourably with other Trusts in the Southeast Region. The Director of Nursing and Therapies said that nationally there was a lower than hoped take-up of the vaccines by health workers. Aileen Feeney, Non-Executive Director noted that the Executive Report mentioned that all Board members had received their Flu vaccination, but the report did not mention the COVID-19 booster vaccination. The Director of Nursing and Therapies explained that NHS England required NHS provider trusts to report on the Board's take up of the Flu vaccination, but there was no requirement to report on the take-up of the COVID-19 vaccination. The Director of Nursing and Therapies confirmed that all Board members had received both the Flu and COVID-19 vaccinations. **c) National Planning Guidance 2024-25** The Chief Executive said that there was a delay to the publication of NHS England's Planning Guidance 2024-25. It was noted that this meant that the Finance team would be making assumptions in terms of developing its draft financial plan for 2024-25 which was not helpful in terms of long-term financial strategic planning. **The Trust Board**: noted the report.
24/009	**Month 08 2122-23 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The Trust was reporting a £0.6m surplus year-to-date which was £1.5m better than planned. The year-to-date position included £550k of additional income which was

	the Trust's share of the additional £800m made available nationally to help bridge the financial gap caused by industrial action. • The Trust's forecasted surplus had increased to £3.1m following confirmation of the £550k funding and agreement that the Trust's forecast elective activity over performance of £1.3m would be funded in full. • Delivery against the cost improvement plan was on track linked to control total compliance. However, there were significant variances relating to Out of Area Placements and Mental Health inpatient staffing for which remedial action would be required in Quarter 4. • Non-pay spend was £7.6m in month and was above plan year to date due to expenditure on Out of Area Placements linked to high demand. • The 2023/24 Agenda for Change and Doctors pay awards had been made. After accounting for the additional cost and funding, we estimated a £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 Agency Ceiling of 3.7% (currently running at 3.2% of overall pay costs year to date) but with costs running close to the ceiling in recent months. • The Trust had recognised £0.1m over performance against our Elective Recovery Fund (ERF) target for the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System year to date as final agreement had not been reached on full payment of overperformance during month 8. • Capital was under plan year to date, but this was mainly due to the phasing of estates projects and was offset in part by a high volume of IT kit purchases linked to new investments. Our forecast remained in excess of our Capital Departmental Expenditure Level capital allocation with the expectation that this would be covered by underspending elsewhere in Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System. The Chair asked whether it was likely that the Trust's capital allocation for the next financial year would be reduced. The Chief Financial Officer said that systems had received a three-year capital allocation so at a system level, the available capital would be broadly in line with the current year's capital allocation, but pointed out that he expected it to be challenging to agree capital allocations at the NHS provider organisation level. **The Trust Board**: noted the report.
24/010	**Month 08 2122-23 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the paper and highlighted the following points: • Physical Assaults on Staff performance was at 59 against a target of 44. Work was ongoing to encourage staff to report all incidents and there was greater involvement with Thames Valley Police in ward status exchanges. • Clinically Ready for Discharge by Wards (including Out of Area Placements) Mental Health performance was at 364 against a 250-bed day target. • Bed Days Occupied by Patients who were Ready for Discharge (community physical health) performance was at 767 against a 500-bed day target. The number of lost bed days remained high but had decreased since the higher level in October 2023. The primary reason for delays was arranging local authority packages of care.

	• I Want Great Care compliance rating performance was at 3.5% against a 10% target. • Inappropriate Out of Area Placements performance was at 844 against a 120 quarterly bed day target. • Mental Health Non-Acute Occupancy rate performance was at 87.18% against an 80% target. Mental Health Acute Occupancy rate performance was at 93.6% • Staff Sickness rate was at 4.6% against a target of less than 3.5% Mark Day, Non-Executive Director highlighted that staff turnover was at 13.02% against a 14% target and paid tribute to the Director of People and her team for their work in reducing staff turnover. **The Trust Board**: noted the report.
24/011	**"Green Plan" – Sustainability Strategy Update Report (**agenda item 9.0)

	The Chair welcomed Justine Alford, Sustainability Lead Manager to the meeting:
	
	The Chief Financial Officer reminded the meeting that the Trust Board received an annual update on the implementation of the Trust's three-year Green Plan. It was noted that the Green Plan would be refreshed next year.
	
	The Sustainability Lead Manager gave a presentation and highlighted the following points:
	
	• Through the Climate Change Act (2008), the United Kingdom had a legal duty to achieve net zero emissions by 2050. There was also a moral imperative to achieve net zero.
	• On 1 July 2022, the NHS became the first health system in the world to embed net zero legislation through the Health and Care Act 2022
	• Healthy environments led to healthier, happier people with a higher quality of life. The climate crisis was therefore a health crisis. 13 million people died globally every year due to avoidable environmental causes.
	• The NHS Standard Contract required trusts to reduce greenhouse gas emissions in line with the targets set out in *Delivering a 'Net Zero' National Health Service*; phasing out of fossil fuel heating and replacing them with less polluting alternatives; reducing waste and water and reducing air pollution from fleet vehicles, transitioning to zero and ultra-low emission vehicles and ensuring vehicle leasing schemes excluded high emission vehicles.
	• The Trust had been tracking its carbon emissions since 2018 and had made progress in reducing its carbon intensity, but in order to meet NHS Targets, the Trust would need to achieve an 80% reduction by 2032 which would require the Trust to triple the rate of carbon reduction to 15% a year.
	• Some of the reductions in carbon emissions were not directly due to the Trust's policies but reflected changes in working patterns, with more staff working from home etc.
	• The Trust's Green Plan included:
	  ○ **installation of renewable energy technology**, for example, solar panels had been installed at two sites and feasibility studies were being done for a major solar farm.
	  ○ **decarbonising heating across all sites** - the Trust had made a £2m grant application for heat pumps at West Berkshire Community Hospital

	○ **reducing overall utility consumption** – energy consumption intensity had fallen, but water consumption and intensity had risen. ○ **increasing and improving utility management, measuring and monitoring** – energy audits were being introduced from March 2024 including a metering strategy. ○ **travel and transport** – rolling out an electric vehicle charging network across the Trust's larger sites; implementing a Trust wide Green Travel Plan; measuring and monitoring all travel data from service delivery and community; and promoting and encouraging active travel. ○ **increasing and improving the measuring of waste** – a waste audit was being undertaken and would inform future strategy. ○ **introducing medical equipment and office furniture reuse scheme** ○ **increasing Trust wide recycling –** since 2017, the Trust had increased the amount of recycled waste by 25% but general waste had only reduced by 7% ○ **confidential waste reduction –** confidential waste was increasing and remained high. ○ **develop and support a network of Net Zero Heroes across the Trust** – 27 Net Heroes had been recruited across 13 sites. ○ **staff training and information** – sustainability was included as part of the Trust's corporate induction programme along with an expanded e-learning offer for staff and information and resources on the NEXUS (staff intranet) site. ○ **increased planting tree cover** – the Trust had planted 15 trees at two sites with a further 50 ordered; a new sensory garden at Wokingham Hospital had been opened. ○ **net zero to be a key consideration for all building and site selection** – a sustainability checklist for new properties had been developed. ○ **All capital projects to contribute to net zero and sustainability** – all capital projects included an environmental impact assessment. ○ **Biodiversity strategy** – a pilot survey had been commissioned at West Berkshire Community Hospital The Deputy Chief Executive asked about the options for incentivising staff to switch to electronic vehicles. The Sustainability Lead Manager said that the Trust's Travel Review would help to identify areas of high non-electric car use and potential mitigations included the use of pool vehicles and all new leased vehicles being electric from 2027. The Sustainability Lead Manager pointed out that there were concerns around whether the national grid would be able to sustain a significant increase in the use of electric vehicles. Naomi Coxwell, Non-Executive Director commented that it was an informative presentation and asked for more information about the availability of national funding to support the Trust's Green Plan. The Sustainability Lead Manager explained that NHS England had set NHS provider organisations ambitious targets and goals but there was no national funding to support trusts. It was noted that there was funding available to install heat pumps, but trusts were only allowed to bid for funding for one site at a time. Ms Coxwell suggested that the Finance, Investment and Performance Committee have a discussion about the sources of available funding in order to take a longer-term strategic perspective. **Action: Chief Financial Officer**

	Ms Coxwell commented that there were nationally set science-based targets to measure the Trust's sustainability performance and asked how the Trust was assured that its measurements were accurate in terms of achieving net zero. The Sustainability Lead Manager reported that the Trust had starting to look at using external companies for monitoring. It was noted that at the moment, the Trust was not able to measure its indirect emissions. The Sustainability Lead Manager reported that NHS England had not developed guidance on how to measure emissions so there was variation across trusts in terms how they were measuring their emissions. Ms Coxwell asked whether there would be any penalties and/or other consequences if the Trust did not meet its legal obligations in relation to net zero. The Sustainability Lead Manager said that an organisation called Client Earth had taken the British Government to court and the High Court had ruled in its favour concluding that the Government's Net Zero Strategy was inadequate and breached the Climate Change Act and needed to be strengthened. The Sustainability Lead Manager said it was therefore unlikely that the Government would financially penalise trusts for not meeting the Net Zero target. The Deputy Chief Executive said that the Trust's Green Plan focussed on the drivers and initiatives which the Trust could deliver and asked how the Trust could get assurance about its supply chain in terms of sustainability. The Sustainability Lead Manager said that the Trust had developed a Sustainable Procurement Strategy. In addition, NHS England had issued guidelines so that any new contracts over £5m had to have a net zero plan. It was noted that for smaller contracts, the Trust asked bidders whether or not they had net zero and carbon reduction plans and tenders were scored accordingly. The Chair asked whether younger members of staff were more engaged in the sustainability agenda than older staff. The Sustainability Lead Manager said that in general that was the case but stressed that all age groups needed to be encouraged to do change their behaviour to support the sustainability agenda. The Chair thanked the Sustainability Lead Manager for her presentation. **The Trust Board**: noted the report.
24/012	**Council of Governors Update** (agenda item 10.0)
	The Chair reported that the Council of Governors was working well.
24/013	**Any Other Business** (agenda item 11)
	There was no other business.
24/014	**Date of Next Public Meeting** (agenda item 12)

	The next Public Trust Board meeting would take place on 12 March 2024.
23/247	**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 09 December 2024.

Signed……. Date 12 March 2024

(Martin Earwicker, Chair)

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Podiatry Patient Journey

Allen Johnston:
Podiatry Service Manager

Tom Tilling:
Podiatry Clinical Lead

Care Quality Commission Inspected and rated Outstanding

Diversity and Inclusion Bringing us together

GDE Digital solutions for outstanding healthcare

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Evolving

"Podiatry practice continues to evolve. High-need, high-cost patients with multiple or complex conditions. A quarter of the population will be over 65 by 2033, they are likely to have more than one long-term health condition along with increasing frailty. The challenge of meeting these demands for podiatrists is complex and requires on-going change of working practices, role flexibility, skills and underpinning knowledge - At the same time podiatrists are tasked with putting patient care at the centre of all they do. Podiatry practice has to change to support this."

(Journal of Foot and Ankle Research 2019)

Background

"In 2018-19 Health Education England (HEE) and NHS England and NHS Improvement (NHSEI) predicted that the number of podiatry vacancies in 2025 would be double that of 2018-19 – up from 7.0% to 14.8%, with the loss of the NHS bursary in 2017 only accelerating this decline. Post-Covid estimates suggest the supply/demand gap for 2025 could be even higher at 1108 vacancies – a 27.3% vacancy rate."

(The Podiatrist 2022)

Background continued

"Podiatry has been particularly affected by the 2017 reforms to healthcare education funding, which has resulted in a decline in recruitment of students to undergraduate podiatry courses. These reforms withdrew the bursary funding, which included payment of full fees for podiatry training"

(The Diabetic Foot Journal 2020)

"There was a sudden and significant drop in university applications in 2017 following the loss of training bursaries. This coincided with a significant proportion of podiatrists registered with the HCPC nearing retirement age. To make matters worse, colleagues were leaving the NHS, citing no hope of promotion and greater expectations of them for less money. Steps to address the problem nationally include apprenticeship schemes with universities and community trusts, the 'first contact practitioner' initiative within GP surgeries, and the launch of the Podiatry Career Framework"

(The Podiatrist 2022)

Outsourcing

- In 2021 the Podiatry Service commenced Outsourcing of its MSK patients to private providers
- In March 2022, the Podiatry Service commenced Outsourcing of its Routine Patients to private providers
- Due to a shortage of Podiatry staff both in BHFT and nationally, the Podiatry services routine waiting list increased to a wait of approximately 35 weeks by the end of 2022. To manage this the service has worked in partnership with two local private Podiatry providers, with an agreement that all patients who are triaged as having a routine Podiatric problem are outsourced for an initial assessment to these private providers
- Work was undertaken in 2022 to alter our treatment criteria to enable the Podiatry Service to see the patients with the Highest Podiatric need

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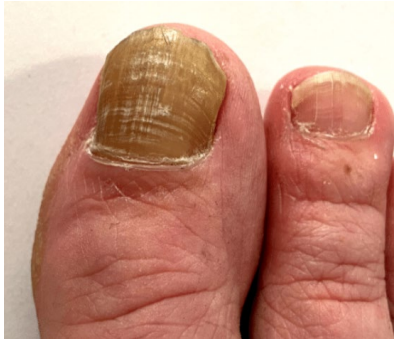
Patient: Mr x

- The Podiatry service received a referral for Mr X from his GP on 21st October 2022.
- The reason for referral stated by the GP was: U*nable to attend to his own foot health and has no-one else who could help. He has dystrophic nails which are causing a risk of skin breakdown and future ulceration which would be very difficult to heal with his long-standing steroid treatment.*



An example of a typical dystrophic nail

- *Mr x is 86 years old and has a past medical history which includes: Kidney disease, Polymyalgia rheumatica and hypertension.*

Patient: Mr X

- The Podiatry service carried out their triaging process and, as per the Podiatry triage criteria, determined the urgency of the referral to be routine based on the current Podiatric symptoms described within the referral form. The referral form did state that there was a risk of skin breakdown, it did not state that there was an existing breakdown of the skin.
- The management of toenails as well as toenail deformities, such as dystrophic nails, is considered a routine podiatric problem.
- Mr X's referral was triaged as routine on the 21st October 2022 and was placed on the routine waiting list. On the 12th January 2023 Mr X was contacted by letter to request that he contact the department for an appointment and that the appointment would be with a private provider
- Mr X was treated by the private provider on the 7th February 2023, 15 weeks after his initial referral to BHFT Podiatry, where they discovered puss underneath the toenail when carrying out routine treatment and after cutting the nail back further exposed a lesion that was present underneath the toenail. As per the outsourcing process, the patient was then referred to back to BHFT Podiatry as Mr X had developed an urgent podiatric problem.

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Patient: Mr X

- Mr X was seen by BHFT Podiatry on 7th March 2023, at this appointment the wound on the toe was dressed and it was determined that Mr X would require continuing follow up care with Podiatry to provide re-dressings to the wound. At the second appointment with Podiatry, on 23rd March 2023, the Podiatrist expressed concern that the lesion on the nail bed was increasing in size. An urgent referral was made by the Podiatrist to the dermatology team to investigate if there could be an underlying dermatological condition preventing the lesion from healing.

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Complaint:

- On April 2023 Mr X's family lodged a complaint to the Podiatry Service citing:
  - Concerns at the length of time Mr X had to wait for a Podiatry appointment after being referred by the GP. The referral from the GP flagged Mr X as high risk and so they felt that this should have been picked up and their father seen urgently.
  - a concern as to why their father was sent to a private Podiatry clinic who only deal with routine/low risk problems.
  - As a result of having to wait for an appointment the toe has now deteriorated to the point where weekly dressings are required at the GP surgery and fortnightly dressings with the Podiatry service.
  - Mr X has also been referred to the dermatology department and has a biopsy scheduled of the affected area. The amount of treatment required is causing a lot of stress for Mr X who is 86 years old.

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In Conclusion and Learning:

- On 1st June 2023 a biopsy of the lesion was reported as “right first toe: Malignant neoplasm”
- By August 2023 the wound on the toe had healed
- Mr X was discharged from the Podiatry service in September 2023
- Mr X remains under the care of oncology as the cancer had spread beyond the lesion of the toe to Lymphoma.

Learning

- The Podiatry Service are reviewing our referral form so that our referrers understand what is a true podiatric high-risk foot
- The incident highlighted a need for Podiatry staff to understand how to manage non-Podiatry related test results that can be accessed on ICE
- This incident has highlighted that there are potential associated risks when referring a patient for outsourcing.

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Thank you

Questions

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BOARD OF DIRECTORS MEETING 12.03.23

Board Meeting Matters Arising Log – 2024 – 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
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**	Completed	
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	July 2024	**DF**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			themes to indicate the number of complaints which were upheld, partially upheld and not upheld.				
09.01.24	24/007	Board Story	The Board to have a discussion about the Trust's approach to outsourcing services at a future Trust Board Discursive meeting.	June 2024	**AG**	Scheduled for the June 2024 Trust Board Discursive meeting.	
09.01.24	24/011	"Green Plan" Sustainability Strategy Update	FIP to have a discussion about the sources of available funding for sustainability initiatives in order to take a longer-term strategic perspective.	March 2024	**PG**	On the agenda for the March 2024 Finance, Investment and Performance Committee meeting.	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Patient Experience Report - Quarter 3 (October – December 2023)**
	Paper for Noting
Reason for the Report going to the Trust Board	This report is written to provide information to the Board in relation to a range of patient experience data available to us. It also provides assurance in relation to the Trust handling of formal complaints as set out within The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and by the CQC through the Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 16 receiving and acting on complaints.
Business Area	Trust wide
Author	Elizabeth Chapman, Head of Patient Experience (Full report) Debbie Fulton; Director Nursing and Therapies (Highlight Report)
Relevant Strategic Objectives	Understanding the experience of our patients, how we respond to this, capture and learn from all forms of feedback is fundamental to the provision of safe, caring and effective services. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement. **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities

Highlight Patient Experience Report
Quarter Three 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.

The handling of Complaints is set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.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.

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		233,201		
Number of iWGC responses received	Number	**16,000** (based on Q1 contact)	6,450	↑	7,156	↑	7,286	↑	
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%	↑	3.1%	↓	
iWGC 5-star score	Number	**4.75**	4.71	↑	4.79	↑	4.77	↓	
iWGC Experience score – FFT (good or very good experience)	%	**95%**	93.8%	↑	94.5%	↑	93.7%	↓	
Compliments received directly by services	Number	Total 22.23 **4522**	1091	↑	1229	↑	1408	↑	
Formal Complaints received	Number	Total 22/23 **240**	68	↑ 1*	64	↓	75	↑	
Formal Complaints Closed	Number	Total 22/23	53	2*	64	2*	69	2*	

Patient Experience – overall Trust Summary		Target	Qtr. 1		Qtr. 2		Qtr. 3		Qtr. 4
		247							
Formal complaints responded to within agreed timescale	%	**100%**	100%	↔	100%	↔	100%	↔	
Formal Complaints Upheld/Partially Upheld	%	Total 2022/23 **56%** total complaint	62%	↑	55%	↓	52%	↓	
Local resolution concerns/ informal complaints Rec	Number	Total 2022/23 **134**	36	↑ **3***	50	↑	30	↓	
MP Enquiries Rec	Number	2022/23 total **88**	24	↔	11	↓	19	↑	
Complaints upheld/ partially by PHSO	Number	Total 2022/23 **0**	0	↔	0	↔	0	↔	

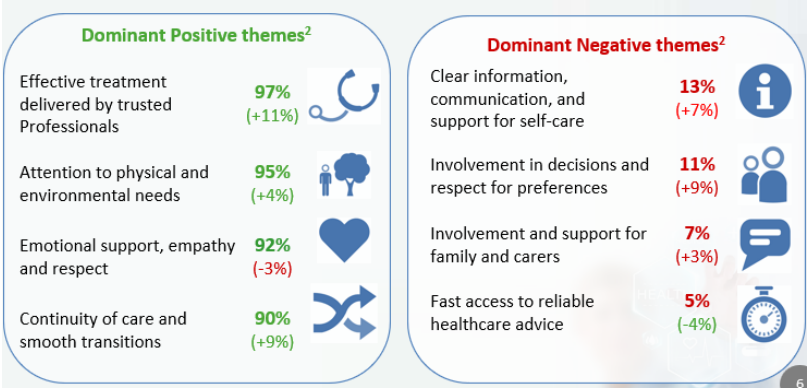
1*Increased from Q4 but within quarterly control limits based on previous quarters over last year
2* Lower than Q4 but less complaints opened in Q4 will result in less to close in Q1, more complaints received in Q1 therefore number closed has increased for Q2.
3* increased from Q4 but within quarterly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

The data shows small variations when looking at the overall year to date, MP inquires have increased this quarter although remain lower thank Q1 and are related to a wide number of topics , 3 were related to wait times in our integrated pain and spinal service and CAMHS but others related to care and treatment of individual cases and parking at West Berkshire Community hospital.

In the last quarter report, it was identified that there had been a significant drop in satisfaction in relation to not feeling listened to across East Mental Health services with 5 star rating having dropped to 3.83 although there was no information available to understand this further and it did not triangulate with other feedback received, this quarter the scores have increased back to 4.52.

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; this will include a Rapid Improvement Event using quality improvement methodology which is being undertaken in April to look at how we might further improve uptake of the feedback tool given that the percentage of feedback received has remained around 3% against our ambition to achieve 10%. For our Mental health wards there is also work in progress to identify alternative ways of capturing patient experience

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 from 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. In previous quarters we have seen higher numbers of white British making formal complaints in comparison to % split of attendances and a more representative sample of survey completion against attendance by ethnicity. For this quarter we have seen that the percentage of patient survey responses are not representative for some ethnic groups particularly Asian/ Asian British although complaints received by people identifying as this ethnicity are representative.

In terms of gender, like last quarter 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, we have a lower percentage of those completing the survey not providing gender at 13.7% compared to 29% in last quarter.

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of attendances
Asian/Asian British	12%	3.2%	10.30%
Black/Black British	0%	2.3%	3.26%
Mixed	2.70%	1.6%	3.19%
Not stated	13.30%	6.3%	2.95%
Other Ethnic Group	1.30%	3.8%	2.60%
White British	70.70%	82.9%	77.70%

4. Conclusions and Recommendations for consideration by the Board

It is the view of the Director of Nursing and Therapies that there are no new themes or trends identified within the quarter three 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.

Patient Experience Report Quarter 3 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.

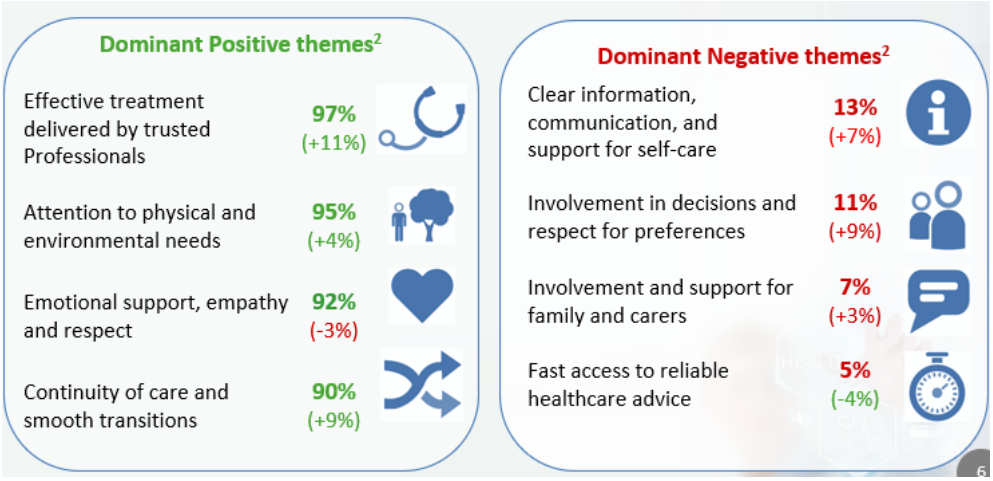
The iWCG tool is used as our primary patient survey programme and is offered to patients following a clinical outpatient contact or, for inpatient wards, on discharge via a variety of platforms. The tool uses a 5-star rating which is comparable across all services within the organisation and is based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

Table 1

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	233,201	
Number of iWGC responses received	Number	6,450	7,156	7,286	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3%	3.3%	3.1%	
iWGC 5-star score	Number	4.71	4.79	4.77	
iWGC Experience score – FFT	%	93.8%	94.5%	93.7%	
Compliments received directly by services	Number	1091	1229	1408	
Formal Complaints Rec	Number	68	64	75	
Number of the total formal complaints above that were secondary (not resolved with first response)		11	10	11	
Formal Complaints Closed	Number	53	64	69	
Formal complaints responded to within agreed timescale	%	100%	100%	100%	
Formal Complaints Upheld/Partially Upheld	%	62%	55%	52%	
Local resolution concerns/ informal complaints Rec	Number	36	50	30	
MP Enquiries Rec	Number	24	11	19	
New Complaints open to PHSO	Number	3	3	5	

There are no significant changes identified in analysis of data that differs from previous reports, the highest number of complaints continued to relate to specific care and treatment concerns. The number of MP enquiries received has increased from 11 to19. Physical Health in West Berks received the highest number of MP enquiries. We have received secondary complaints from two complainants.

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 brackets () in the picture above shows the comparison to the report for quarter two. This demonstrates that there has been an improvement in three of the positive themes, and two of the negative themes. An area that will be monitored over the next quarter is 'involvement in decisions and respect for preferences', which has shown a 9% decrease in satisfaction compared to last quarter.

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

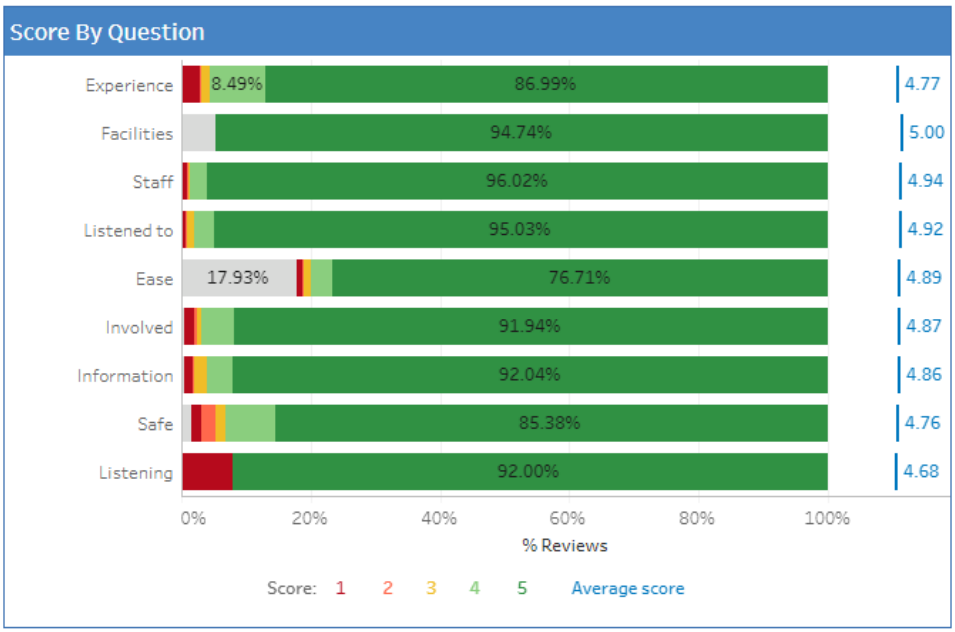
What the data is telling us

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

Children and Young Peoples division including learning disability services.

Table 2: Summary of patient experience data

Patient Experience - Division CYPF and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	556	1169	930	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.1%	3.4%	2.7%	
iWGC 5-star score	Number	4.59	4.7	4.87	
iWGC Experience score – FFT	%	89.3%	96.6%	95.5%	
Compliments received directly by services	Number	72	55	81	
Formal Complaints Rec	Number	14	15	9	
Formal Complaints Closed	Number	14	14	5	
Formal Complaints Upheld/Partially Upheld	%	93%	57%	80%	
Local resolution concerns/ informal complaints Rec	Number	6	14	8	
MP Enquiries Rec	Number	15	7	4	



For children's services the iWGC feedback has seen a drop in the responses from last quarter, further work with the services is continuing to improve this, 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 930 responses, 899 responses related to the children's services within the division; these received 96.1% positivity score, with positive comments about staff being helpful and kind and a few suggestions for further improvement, this included 6 reviews for Phoenix House where comments about staff being supportive and nurturing were very positive and there were some suggestions for further improvement regarding more detail about what to expect from the service and how to cope at home. 12 of the responses related to learning disability services and 19 to eating disorder services.

From the feedback that was received, ease and feeling listened to 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. One for School Nursing, one for Children's Occupational Therapy and for the Immunisation service

846 of the 899 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Health Visiting team, Wokingham and Health Visiting, Bracknell; the Health Visiting team in Wokingham received 268 of these responses which scored positively receiving a five-star rating of 4.93 and feedback included "*[name removed] was very open attentive, supportive and communicated very important information with warmth. I felt seen, heard and cared for." "We were warmly welcomed and made to feel very comfortable early in the session. Having a safe space with toys means conversation is easy and as a parent I can relax and pay attention to the conversation. The topics and points to discuss were easily approached and [name removed] made me and my child's development feel very normal, which is great!"*. There are also some responses that are associated with Health Visiting incorrectly which affects the overall rating for CYPF negatively. We are, along with iWGC, looking into this to ensure it is rectified.

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were 7 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 3 enquiries via MPs, a reduction from 7 in Q2. Most of these related to waiting times.

There have been 50 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.

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.

'I just wanted to thank you for everything you've done for Young Person and for our family. I'm grateful for all the time and effort you have put in to try and understand and help support us at this tricky time for both our children.'

'I'm very grateful. I didn't think it would have made such a difference in a short time'.

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 Campion Ward regarding care and treatment on the ward.

Overall, there were 12 responses for all Learning Disability services from the patient survey received, responses were for the Community Teams for People with a Learning Disability, the Learning Disability Intensive Support Team and Campion Unit the Learning Disability inpatient unit. These received a 66.7% positive score, this was skewed by 1 response not having a score; other feedback included that staff were kind, "*Very positive and caring experience.*", "*Always kind, understanding and willing to help outside of box.*" and "*Welcoming staff was good.*", there were comments for improvements including staff need to listen and patients want more information. 2 of the 4 responses that received with a score below 4 left no comments in the free text boxes, the remaining 2 had comments which included wanting more information, for staff to be polite, respectful, show kindness and treat people with dignity.

Eating disorders

There was one complaint for eating disorders regarding the transition of a young person from children to adult services.

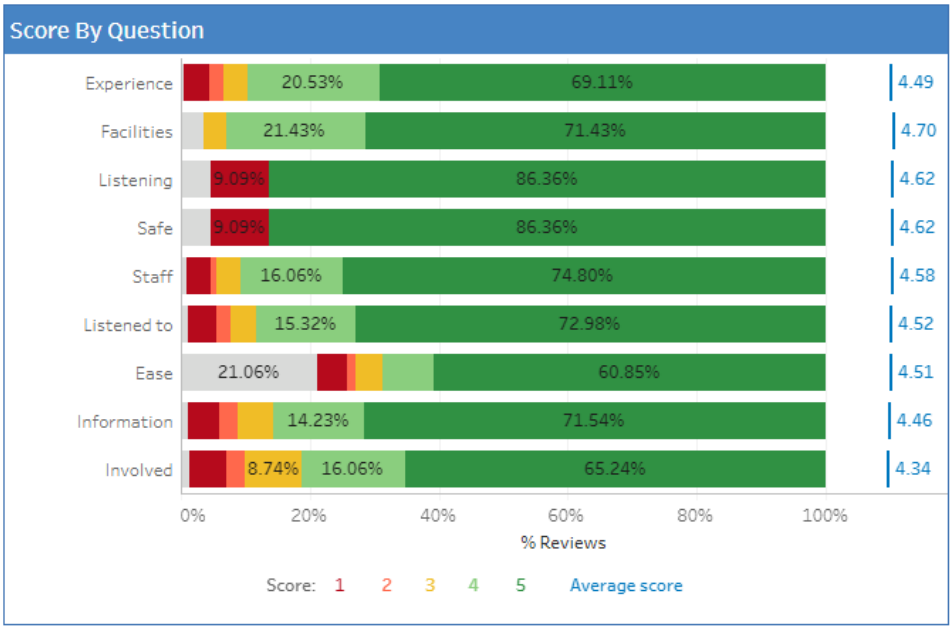
Of the 19 feedback responses received, 13 scored a 5 with comments such as "*The staff showed endless patience and cared deeply for me. They taught me so much and gave me the tools I need to be able to go forward, even though I still struggled with putting measures into practice by the time I left. I don't know if I'll ever fully recover but BEDS at least have me a fighting chance.*", "*The nurse that treated me was excellent. She spent a lot of time answering my complex questions and put me at ease throughout my treatment. Thank you.*", *"Everyone is very lovely and helpful.*". Areas for improvement included better communication and that the waiting time was too long.

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	492	
Response rate (calculated on number contacts)	**%**	2.7%	2.2%	2.5%	
iWGC 5-star score	**Number**	4.64	4.58	4.49	
iWGC Experience score – FFT	**%**	92.7%	89.1%	89.6%	
Compliments received directly by services	**Number**	37	26	20	
Formal Complaints Rec	**Number**	16	12	14	
Formal Complaints Closed	**Number**	16	13	15	
Formal Complaints Upheld/Partially Upheld	**%**	37%	23%	33%	
Local resolution concerns/ informal complaints Rec	**Number**	4	2	2	
MP Enquiries Rec	**Number**	1	2	0	



14 formal complaints were received into the division during this quarter; in addition, there were 2 informal/ locally resolved complaints. 15 complaints were closed during the quarter. 5 of these were either fully or partially upheld and 10 were not upheld. Four of the complaints related to communication or care and treatment, and a further four related to attitude of staff. Two complaints were from the same patient.

The services receiving the majority of iWGC responses were CRHTT East 147 responses, Psychological Medicine Service East, 117 responses, Memory Clinic Bracknell 37 responses and CMHT Bracknell 18 responses.

Across the CRHTT East survey responses the average 5-star score was 4.27 with 83.7% positive feedback, a decrease from last quarter. 123 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; "*CMHT gave me an appointment at short notice. Dr and the crisis team were very professional and kind, helped me to get my medication quickly too.*" 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 like they were not listened to, discharged without being seen and lack of communication.

Feedback from compliments for the service included, *'you are amazing, I just can't get over how you have changed my life in 5 weeks'.*
The Psychological Medicine Service - East received 83.8% positive score (4.25-star rating) and received positive feedback about staff being helpful, understanding, caring and supportive. "*My issues or needs were dealt with very, very professionally by all the wonderful staff here at Wexham Park Hospital who were and are extremely understanding to my needs and to what has happened and how I suffered and had been affected and my sufferings in all sense or forms. They took me under their wing and have guided me through most sympathetically and will be continuing to carefully closely with connection and help from my own GP account. I am truly thankful and most grateful. They are wonderful people here at the hospital are very, very supportive and They and will be continuing to be supportive and for that I am also extremely grateful along with my family's happiness and gratitude for what has been given and offered to me, so thank you. It has been an incredible journey just last week here at the amazing Wexham Park Hospital which I call hotel so thank you all of you I feel like the I've got my me back and I'm more than willing to continue whatever is required to help me and what has already been.*"

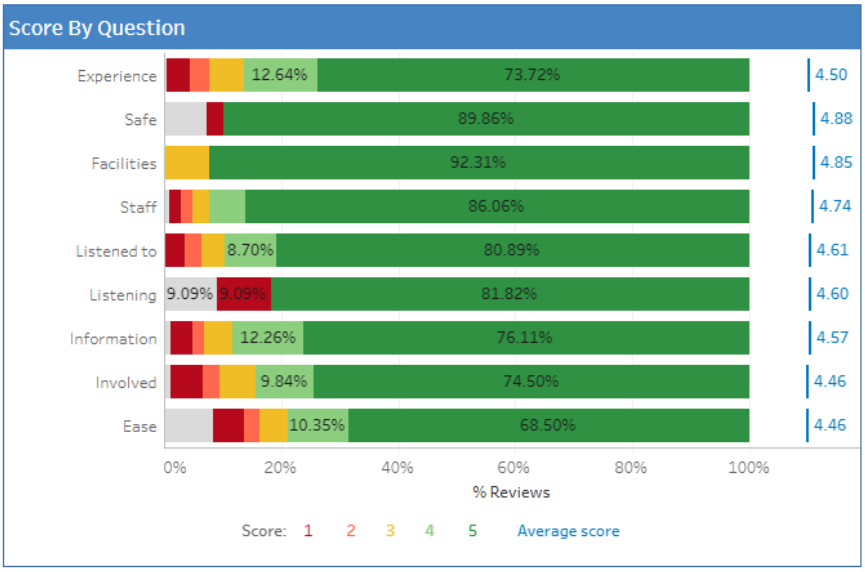
Memory Clinic Bracknell received 100% positive feedback (4.91-star rating), many of the comments were positive about staff being kind, friendly and listened to them. "*[name removed] was friendly and welcoming. She showed strong empathy and was very professional. I enjoyed talking to her. I left feeling more positive and looking forward to being taken out by a support worker."*

CMHT received 41 responses (Bracknell 19, WAM 4 and Slough 18) with 97.6% positive score and 4.61 star with 1 of the total responses scoring less than a rating of 4; comments included '' *psychiatrists have listened well and explained their decision and advice thoroughly*; '*there is nothing negative to say about the treatment I got', 'this is the first time I'm actually listened to' and* 'I'm happy with the whole experience' There were a number of positive comments about being listened to, staff being caring, helpful and kind.
Some of the suggestions for improvement included having better phones lines for Slough
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	997	
Response rate (calculated on number contacts)	**%**	2.5%	2.3%	2.1%	
iWGC 5-star score	**Number**	4.61	4.58	4.56	
iWGC Experience score – FFT	**%**	89.3%	88.4%	86.4%	
Compliments received directly by services	**Number**	557	403	312	
Formal Complaints Rec	**Number**	12	15	12	
Formal Complaints Closed	**Number**	7	13	15	
Formal Complaints Upheld/Partially Upheld	**%**	43%	54%	53%	
Local resolution concerns/ informal complaints Rec	**Number**	7	5	5	
MP Enquiries Rec	**Number**	4	0	4	



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 520 responses, CRHTT West 90 responses and PMS West 69 responses.

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

This division received 12 formal complaints during the quarter with CMHT receiving 7 and CRHTT receiving 2. There were 15 formal complaints closed with 8 being found to be upheld or partially upheld and 6 not upheld. One was resolved locally.

Mental Health West also received 5 informal complaint/locally resolved complaints and 4 MP enquiries.

For CRHTT there were 90 feedback questionnaires completed with an 83.3% positivity score and 4.42-star rating; with lots of positive comments about staff being supportive, kind and listening, *“The team was really sensitive and caring. They made an effort to fully understand my condition and truly understood that my physical health condition was causing my mental health decline. It was groundbreaking for me; I'd never been treated like that before. Kudos to the team for listening to me clearly, it has resulted in me receiving the support I needed for my condition.”;* a number of the less positive reviews talked about lack of communication and information about the service, not informed about planned discharge and wanting the staff members who they are being seen by to be consistent.

There were 41 responses received for West CMHT teams with 85.4% positivity score and 4.48-star rating, 35 of these were positive with comments received that staff were professional and helpful, there were 6 negative responses with reviews stating that patients felt like staff didn’t listen, wanted more information on medication given and the treatment being provided.

Older adult and memory clinic combined have received 90 patient survey responses during the quarter with a 95.6% positivity rating (4.84-star rating) some of the feedback included *“The overall staff had a next-door neighbour feeling about what they say and do & are genuinely friendly & understanding. You can see it’s genuine from the top to the bottom from everybody and wish them all well as they deserve to get recognise for their kindness, knowledge, and understanding of what the person and direct family are going through. You are all the unsung heroes, and everybody should be supported. Thank you.”*

The West Psychological medicine service received 69 responses with an 81.2% positive score and 4.38-star rating (9 responses scored less than 4) many of the comments were positive about staff listening, being helpful and understanding.

For Talking Therapies received 502 responses during the quarter, their patient survey responses gave a positivity score of 85.2% (4.55-star rating), 76 of the reviews scored less than 4. The vast majority of comments were still very positive about the staff, including that they listened, were helpful and kind. A number of the comments/areas for improvement were that the wait was too long, felt that they were not given any help or support and discharged too quickly. For example, *"They said they couldn't help and gave me other services to self-refer to. There is now an 8-month waiting list, so I still haven't received any help."*

Examples of positive feedback about Talking Therapies included, *"All the people I spoke to were very skilled. They listened and provided excellent care. Were very knowledgeable and non-judgmental. Excellent service. Feel very happy with the service. Certainly, helped me."*, "*I received incredibly helpful careers advice which made me feel more optimistic about the opportunities out there and how to find them. I thought the advice was appropriate to my needs and being given to me in a pdf booklet means I can access support subsequently whenever I need. I think careers advice is such a good part of talking therapy because it contributes a lot to my mental health and being able to receive practical support for that is great."* and *"My therapist, [name removed], was amazing! She listened without judgement, showed me empathy and compassion. She provided me with invaluable support, every session, that I could put into practice in the weeks and months that followed. I will forever be grateful for her knowledge and the tool kit that she provided me with. I often return to this when I experience challenges. It has made me more resilient and given me a more realistic self-perception. Her support, has been truly life changing for me and my family!"* Patients reported that they felt *"My therapist [name removed] was amazing. She listened but also spoke rather than waiting for me to try and figure stuff out. I definitely felt it was a 2-way conversation and she gave me an insight into a different version or way of thinking.", "[name removed] was personable, professional and courteous. She listened when I spoke and advised me clearly and with care. I felt confident in her expertise."" and "[name removed] makes me feel listened to & understood. He teaches me strategies to help me understand and manage my depression, and homework to do between sessions."*

Op Courage

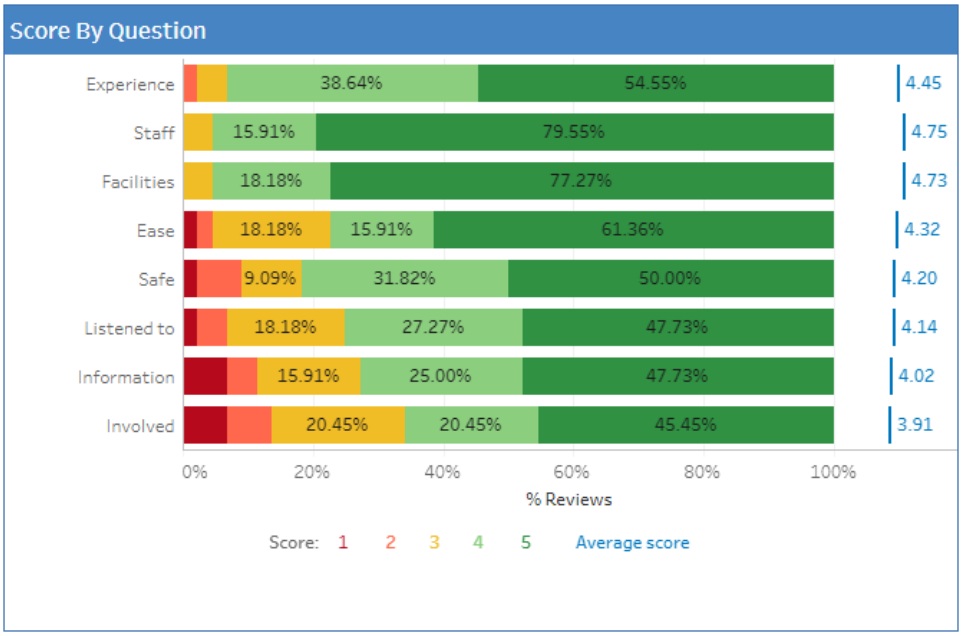
Op COURAGE is an NHS mental health specialist service designed to help serving personnel due to leave the military, reservists, armed forces veterans and their families. During this quarter, the Trust did not receive any complaints about this service.

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	44	
Response rate	**%**	28.3%	28.5%	23.5%	
iWGC 5-star score	**Number**	4.30	4.05	4.32	
iWGC Experience score – FFT	**%**	88.4%	78.4%	93.2%	
Compliments	**Number**	12	11	13	
Formal Complaints Rec	**Number**	10	4	8	
Formal Complaints Closed	**Number**	5	5	7	
Formal Complaints Upheld/Partially upheld	**%**	80%	60%	57%	
Local resolution concerns/ informal complaints Rec	**Number**	0	0	0	
MP Enquiries Rec	**Number**	0	0	2	



The satisfaction rate was 93.24% with 3 of the 44 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 for this question being 3.91 and 15 of the 44 giving a score of 3 or less to this question.

There were 8 formal complaints received for mental health inpatient wards during the quarter across Place of Safety, Daisy, Bluebell and Sorrel wards; they were mainly regarding care and treatment.

There were 7 complaints closed for this division during the quarter and of these 4 were partially or fully upheld and three were not upheld.

There were many positive comments received in the feedback including comments such as staff were friendly, kind, caring and helpful. There were some comments for improvement about more opportunities to go outside, better communication from staff to patients and more activities on the wards. Examples of the feedback left are "*Because they met all my needs made me feel safe in the environment for me to be ready for the outside world Made me want to be a key worker after what I've been doing in the hospital, I have done for myself to be better now I'm ready to be a dad again to my kids have to thank you to all the staff love every step.*" "*Because I think it's helped me to have a greater understanding of mental health and how much of an invisible illness it can be and how hard the staff work to help get people better.", "The care and dedication of the staff is excellent. I was in a very dark place and the staff were very caring and supportive and have helped me to recover my mental health. Thank you for giving me my life back."* There were no responses for a Place of Safety.

Focus groups were arranged on each of the four adult acute wards at PPH facilitated by Nurse Consultants with 20 patients attending this quarter. The aim was to look at how the environment on the acute wards could be improved from the patients perspective. The focus groups explored four areas.

1) Views on single gender wards vs mixed wards: *There was an overwhelming preference for mixed wards with an option for single gender wards for those who needed for safety reasons.*

2) Moving between wards for different stages of treatment (diagnosis, treatment and recovery). *There were mixed feelings about this, overall the patients could understand how the concept looks good in theory but are concerned about how it would translate to practice - fear around changing relationships being the number one concern.*

3) Best use of space to improve environment/experience. *The patients would like increased sense of community in layout, more activities (evenings and weekends), more quiet spaces and sensory area.*

4) Experience of having treatment in an Out of area bed. *There were mixed feelings about being in an out of area placement, with a thought from some who had been in out of area placements believing that the ward environment and ability to provide individualised care at PPH was needed to compete with the better placements.*

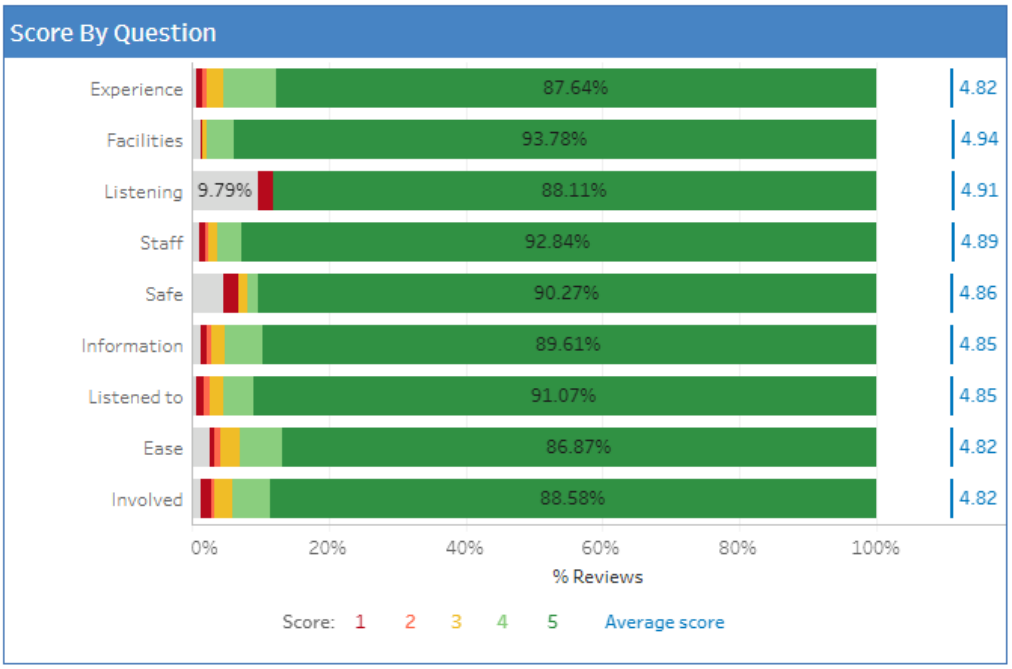
There is ongoing work at Prospect Park to increase feedback including work within the Therapy department.

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	2136	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.5%	7.1%	5.3%	
iWGC 5-star score	Number	4.86	4.88	4.85	
iWGC Experience score – FFT	%	97%	96.7%	95.5%	
Compliments received directly into the service	Number	217	401	636	
Formal Complaints Rec	Number	2	6	10	
Formal Complaints Closed	Number	2	5	8	
Formal Complaints Upheld/Partially Upheld	%	50%	40%	62%	
Local resolution concerns/ informal complaints Rec	Number	1	8	1	
MP Enquiries Rec	Number	1	1	0	



Of the 10 complaints received this quarter, three were for Henry Tudor Ward which included transfer arrangements alongside care and treatment; three for District Nursing (two were for the Slough team and one was about the team in Windsor, Ascot and Maidenhead). Care and Treatment, and Attitude of Staff were the main themes.

There were eight complaints closed, two partially upheld and three upheld and two not upheld. One complaint has been progressed as an incident review.

Hearing and balance received 154 responses to the patient experience survey with a 94.8% positive score and 4.87-star rating.

East Community Nursing/Community Matrons received 274 patient survey responses during the quarter with a 98.9% positive scoring, many comments were about staff being professional and kind, for example "*The Matron and OT lady were extremely kind, helpful and professional. They were so supportive to me at a very difficult time, and it is greatly appreciated. Not everyone has the ability to help older folk, but these two ladies were truly excellent, I cannot stress this highly enough.", "[name removed] was very professional, she contacted me to arrange a convenient time to visit. I felt listened to and I was given valuable information. very patient and caring.",* "*The nurses were very kind as they came to check on me even when I was not answering their calls. They were both respectful and listened to my concerns and offered support."* and *"[name removed] is very kind, respectful and supportive. She brought joy with her smile into our home and managed to offer the support to make my life manageable. Very grateful for her support."* There were also some comments around some nurses needing more training for example *"Better training for Nurses. More Band 5 Nurses are needed, because of their broader knowledge. Nurses with less knowledge can't provide the throughout service that the patient needs."*

The wards received 122 feedback responses (69 responses for Jubilee ward 94.2% positive score and 53 Henry Tudor ward 90.6% positive score). Most of the comments for improvement were related to staff communication, patients wanting more physio and the patient experience of the food was very variable ranging from food needing to improve and limited choice to being impressed with the food, food so good. There were many comments about staff being kind, compassionate and helpful.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 92.8 % (4.81-stars), comments were very complimentary about staff being professional and helpful, *"From arrival, to being seen by the physiotherapist, all staff were friendly, polite and professional. I was asked lots of questions to determine my knee problem and my treatment plan was demonstrated and discussed appropriately. I have access to videos to remind me how to do the exercises properly. I have a follow up appointment in a timely manner. Thank you.".* The reoccurring improvement suggestion for this quarter was for a sooner appointment.

Outpatient services within the locality received a positivity score of 96.8% with 4.86 stars from the 617 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"The service is amazing, and I am very pleased and thankful. Everyone in this team is wonderful and provide great care. did not know this service exist. So happy for the care given to me. five stars for the team."*

The diabetes service received 71 feedback responses with 94.4% positivity and some lovely comments including "*The DSN was very knowledgeable and listened to my concerns about my diabetes control. Together we have come up with a plan to adjust my insulin and have weekly telephone consultations to go through my diabetes changes*. *Feel well supported and know I can contact the team at any time. Very happy*." Alongside some helpful suggestions for the service to consider around improving the room layout such as "*The layout of the room was not conducive to the projection of the speaker's voice, and to seeing the projection on the screen. A horseshoe shape would have been easier!"*

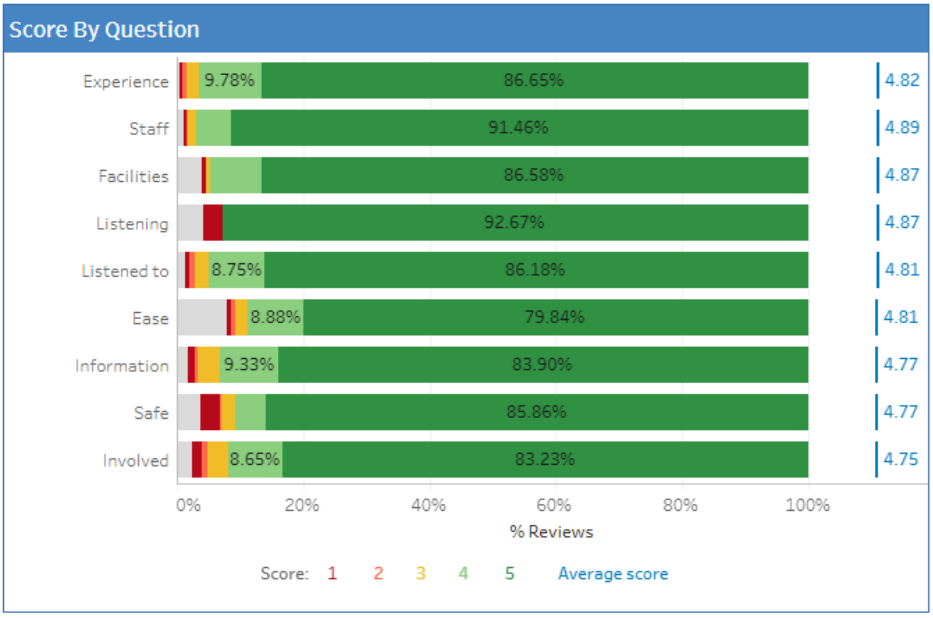
The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*Everybody from the Lady receptionist right through the physiotherapists, and the doctor were all exceptionally pleasant and exceptionally competent. I am very impressed and realise that for all the problems that the NHS has, it is a very skilled and pleasant organisation. Thank you*."

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	2659	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	2.5%	2.8%	2.9%	
iWGC 5-star score	Number	4.81	4.82	4.81	
iWGC Experience score - FFT	%	95.1%	96.3%	96.4%	
Compliments (received directly into service)	Number	196	298	345	
Formal Complaints Rec	Number	12	10	16	
Formal Complaints Closed	Number	7	14	14	
Formal Complaints Upheld/Partially Upheld	%	86%	86%	57%	
Local resolution concerns/ informal complaints Rec	Number	18	25	14	
MP Enquiries Rec	Number	3	2	4	



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 96.4% positive satisfaction and 4.81-star rating and the question on staff receiving a 96.9% positive scoring from the 2659 responses received.

There were 16 formal complaints received during the quarter, these were split across several different services. Of these the Out of Hours GP service (WestCall) received 7. The Urgent Treatment Centre, District Nursing and Community Dental Services received two complaints each during the quarter.

There were 14 complaints closed for the division during the quarter with 2 being upheld, 6 partially upheld, and 5 not upheld. One of the complaints raised has been progressed as a serious incident investigation.

During this quarter the community hospital wards have received 176 responses through the patient survey receiving an 92.6.% positive score and 4.60-star rating, (13 responses scored 3 and below) questions around feeling involved and listened to receive the most results of 3 and below; comments include staff were friendly and caring, "*From the beginning of my stay in Oakward it has been a real 'lift' to heat the staff being so friendly and professional together while bringing both into the patients rooms.*", "*All staff were very friendly and helpful.*", "*Staff was very helpful in getting me back on my feet very caring and polite at all times.*" And "*From day one my progress advanced steadily, supported by professionally caring people.*", there were some individual comments where patients were less satisfied, with comments including better communication, better food, not ignore patients and some staff need to improve their attitudes.

Of the 7 complaints for the Out of Hours GP service, four related to care and treatment (three of which were raising concerns about the diagnosis and clinical management), one was relating to Access to Services, one for Medical Records and one regarding Discrimination and/or Cultural Issues.

WestCall received 8 responses through the iWGC questionnaire this quarter (87.5% positive score, 4.66-star rating, 1 score received below 4. Positive comments included *"[name removed] [name removed] was so lovely. I rang up as I was positive for covid, and I can have anti-viral treatment. I was a bit worried as I only had it a month ago and fully vaccinated. [name removed] [name removed] was so kind and reassuring. [name removed] [name removed] even looked up my recent sputum results for me and really assessed me holistically. They had a lovely manner and organised everything that I needed for the antivirals." "Very efficient service always keeping you up to date. Very thorough with examinations just in case leaving nothing left unchecked."* WestCall received 19750 contacts during the quarter.

Podiatry services received 206 patient survey responses. Most responses were very positive receiving 5 stars (overall 99.5% positivity 4.95-star rating) with examples including "*My podiatrist and podiatry assistant were fantastic, everything was fully explained, I was listened to, and the procedure and follow-up appointment were excellent*." and "*The care, thoroughness, and kindness provided by both people who looked after me at the Tilehurst podiatry clinic was outstanding."*

There were two complaints for Community Nursing, relating to attitude of staff and discharge arrangements.

To provide some context across our East and West District Nursing teams combined there were 59,817 contacts this quarter. Lots of comments included nurses were kind, helpful and friendly, "*Very grateful to the Chalfont team for care of husband whilst he was on a syringe driver. All of the team were wonderful, everyone that visited was really kind, very thankful for all the support.", "The care that [name removed] gave to both of us today was excellent [name removed] was very helpful understanding very good at her job." and "The District Nurses were amazing, and he very much appreciated the great care and friendly nurses that visited."* There were several positive comments about nurses being caring and there were very few suggestions for improvement, would like to know when nurse is visiting and to let patient know if visit is cancelled.

MSK Physio has received one complaint in the quarter relating to the clinical care the patient received. The service has received 315 patient survey responses with a 96.2% positive score (4.90-star rating), very few areas for improvement were included in the feedback there were a few suggestions including parking, provide more sessions and have more privacy in the rooms and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, kind and listened.

The services across the division received many compliments including "*I'm sure you're all aware he passed away on Saturday evening, just wanted to thank every single one of you for the help that you gave and making it possible for him to stay at home. He wanted so much to pass away at home and obviously I wanted that as well, so you made that possible. I just like to thank you even though I could be tricky at times, but I hope you understand that he was my whole life any away thank you ladies you have been amazing I will write in at some point as well as I sure you don't always accept the praise that you should so again thank you so much."*

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

Demographic profile of people providing feedback (Breakdown up to date as at the end of Quarter 3; from our Business Intelligence Team)

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
Asian/Asian British	12%	3.2	10.30%
Black/Black British	0%	2.3	3.26%
Mixed	2.70%	1.6	3.19%
Not stated	13.30%	6.3	2.95%
Other Ethnic Group	1.30%	3.8	2.60%
White	70.70%	82.9	77.70%

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 Q3 attendance
Female	50.67%	53.7	55%
Male	48%	32.1	45.32%
Non-binary/ other	0%	1.6	0.03%
Not stated	1.33%	13.7	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 continues to be a high number of patients who have not completed their age on the patient survey (this is not a mandatory field).

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendance
0 to 4	3%	1%	7.27%
5 to 9	4%		2.20%
10 to 14	9.33%		3.50%
15 to 19	5.33%		4.86%
20 to 24	8.00%	1.9%	3.06%
25 to 29	5.33%		3.07%
30 to 34	2.67%	1.3%	3.08%
35 to 39	6.67%		3.56%
40 to 44	5.33%	10.2%	3.57%
45 to 49	4.00%		3.43%
50 to 54	5.33%	21.6%	3.99%
55 to 59	5.33%		5.31%
60 to 64	6.67%	25.7%	5.27%
65 to 69	6.67%		4.89%
70 to 74	6.67%	28.6%	6.04%
75 to 79	2.67%		8.71%
80 to 84	4.00%	5.4%	9.77%
85 +	4.00%		18.42%
Not known	5.33%	4.4%	0%

Ongoing improvement

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

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

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

Some examples of services changes and improvements are detailed below.

Service	You said	We did
CAMHS Specialist Community Team	Young people/families requested resources.	More relevant resources made available in waiting rooms.
	Young people/families requested access to Wi-Fi.	Posters put in waiting rooms with NHS WiFi details.
CAMHS Phoenix	'We'd like more staff support for service users'	Continuing professional development slots for all staff held weekly to ensure that all staff are able to positively support service users during meal times and in the service.

		Weekly clinical team meeting feedback given to all service users after the meeting has taken place. Weekly team meetings to review care plans.
Immunisation Team	Young people wanted more information about immunisations.	The immunisation team have been delivering assemblies in schools. Fact sheets given directly to young people.
Community Inpatient Wards (Wokingham)	Families said that they did 'not always feel listened to' and that it was sometimes difficult to find and speak with the staff that they wanted to speak with to understand fully their loved ones care and treatment. Patients and families wanted to understand 'what does it mean when you say I'm independent or aiming to be independent'.	bookable face to face 'catch up sessions' for families with any speciality have been introduced with sessions have been well received. Patients often attend the sessions with their family. The therapy team will be trialling a patient held document with information on their goals during admission and goals for discharge. This will engage patients to have a better understanding of where they are in their rehab journey, and hopefully also make clearer what aspects of care they can be independent.
Heart Failure (East)	Patients have reported they can sometimes get lost going to the WAM clinic.	The service is working with Estates to improve signage.
Hearing and Balance	Wheelchair users and those with difficulty standing would like hand mirrors to view their new hearing aids.	Hand mirrors are now provided in clinic rooms
Diabetes Service	We received lots of feedback from patients asking for recyclable insulin pens.	The team worked with BFHT sustainability lead and a manufacturer to source a recyclable pen. Although we only prescribe not dispense, they have worked with local pharmacy providers to set them up with the scheme and provided the drop off boxes so our patients have a more sustainable option.

15 Steps

There were no 15 step visits this quarter. The Head of Patient Experience is leading an end-to-end review of the 15 Steps programme, looking at how these are planned, reported, and how any improvements are implemented. Our review is providing information into to national NHSE review of the 15 Steps programme. Insight from our services, Governors and Non-Executive Directors is integral to this piece of work.

Summary

Whilst the majority of feedback about our staff and the experience of those using our services has remained very positive, we recognise that this is not the experience for everyone and value all feedback to help us understand peoples experience and make improvements where this is needed.

Continuing to increase feedback to enable services to understand the experience of those using their services and to use this for improvement remains a key strategic ambition for the Trust and, all of our divisions are reviewing how they ensure that patients understand the value that we place on receiving this feedback to further increase the amount of feedback received.

Formal Complaints closed during Quarter Three 2023.24

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
9063	West Berks	Phlebotomy	Minor	Attitude of the staff member taking blood	Partially Upheld	Blood test patient leaflet to be developed to include possible side effects such as pain and bruising	Attitude of Staff
9083	Reading	A Place of Safety	Low	further review into the incident at Burgess Hill required ORIGINAL BELOW Pt unhappy at being taken to POS and attitude and actions of staff. Unhappy that police broke into his home when he had an assessment booked at PPH the following day.	Not Upheld		Attitude of Staff
9125	Reading	Out of Area Placements	Minor	Care provided by the Priory prior to pt death	Not Upheld		Care and Treatment
9119	West Berks	Crisis Resolution and Home Treatment Team (CRHTT)	Moderate	Following a medication error pt has had to start again with their clozapine medication. Family are concerned for the pt's welfare due to the amount they are smoking and the lack of food intake. The complainant wishes a full investigation so as to provide the correct level of care including a MH assessment, to see a psychiatrist and have regular contact with CPN	Partially Upheld	Apology offered that CRHTT did not record any contact with fire service. Gap in prescription process as two requests went missing. Process being reviewed to fill gap. Apology made for not returning two calls from mother.	Medication
9137	Reading	Adult Acute Admissions - Rose Ward	Low	Patient says she has no paperwork re her detention. Unhappy with many aspects of care; Was brought in using excessive force. There are no disabled toilets in POS. Issues with the room she is in. Needs to have her legs raised due to her disability but request for more pillows has been refused. Lots of issues in complaint.	Partially Upheld	To feedback to manager of POS around disabled access to the toilets. Feedback to the ward doctors around reviews of patients.	Care and Treatment
9138	Reading	District Nursing	Minor	Patient unhappy with care from DN service and contradictory information given between DN and St George's hospital, London regarding her leg ulcer. Patient feels the level of care given is extremely poor.	Partially Upheld	Staff to receive update that potassium permanganate can in some circumstances be used. Risk assessment to be shared. To consider referring to out of hours team if there is nil capacity within the service For wound care plan to be created in liaison, vascular and lymphedema MDT team, tissue viability nurses and community nurses. Copy of wound care plan to be in the home. To share, update and explain any changes to wound care plan and document this. Consider using patient choice paperwork if non-compliant with jointly agreed wound care plan. For specialists dressing orders to be completed using form available on Nexus and sent to Tissue Viability Nursing inbox allowing time for delivery. Ensure staff are aware of this. When completing joint visits to ensure lead nurse writes main body of notes with second person then checking notes and adding to these as required	Care and Treatment
9133	Slough	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	Complainant unhappy that his father attended an appointment with another son, who, according to the son who has complained, is trying to get LPA and attended the meeting with his own agenda.	Not Upheld	Advocate to be appointed. Dr to see client for final review and diagnostic indication. LPA information given.	Other
9150	West Berks	Neuropsychology	Low	Despite local resolution the pt states he has not had a written response ORGINAL BELOW Pt has just received an Autism diagnosis and feels all previous diagnosis are incorrect	Local Resolution		Care and Treatment
9153	Reading	CMHT/Care Pathways	Minor	Pt unhappy at the 1 year wait it took for the Dr to send them their assessment report and then angry such personal information was shared with their GP	Upheld	Learning for Dr on delay in sending clinic letter	Confidentiality
9159	Reading	CMHT/Care Pathways	Low	Family feel the pt has been disregarded. Appts made but no one turns up, call handler hung up as did not like the complainants tone	Not Upheld	No consent received	Waiting Times for Treatment
9164	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Minor	Pt states their medical records were shared with Housing Solution without their consent	Upheld	Confirmed that consent was not sought again following new contact.	Confidentiality
9165	Bracknell	Hearing and Balance Services	Minor	Unhappy with Hearing tests at King Edwards wishes to be moved to Bracknell	Partially Upheld	Discussion at team meeting regarding managing expectations of patients when running late Monitoring of times that appointments start compared to intended start times to see if there are issues requiring further investigation Discussion at paediatric team meeting how best to: •Document discussions with families regarding aetiological investigations, cochlear implant candidacy, management plans agreed for fluctuating hearing losses and deferred decisions •Encourage a positive atmosphere and positive patient experience for all •Discuss patient centred care and non-verbal communication Review hearing aid review template to make it clear how speech test results are reported, and to set any expectations for subsequent appointments Document on patient record that the family have declined to be referred for an MRI scan at this time. Await decision from family about where they would prefer their care to be delivered	Care and Treatment

9170	Wokingham	Children's Occupational Therapy - CYPIT	Low	Unhappy with the OT report written to support an EHCPNA application	Partially Upheld	Information on website explaining commissioning and referencing Dingley is reviewed to ensure that this is as clear to parents and other professionals as possible. CYPIT to review the information on the website and information that is sent to parents at the point of receipt of an EHCNA request to explain the process (i.e. written supporting information will be reviewed and recommendations made but that the initial assessment will not involve a face to face contact. (LA SEND colleagues can also support this by explaining it to parents at the point of making the request). Reminder to go to all CYPIT staff stating that 'For assessments completed during the summer holidays for children transitioning from primary to secondary school, the report will acknowledge this and state the previous and future schools with end and start dates for clarity'. Therapists are reminded to reference sources of information in reports (e.g. the class teacher reports that XX is kind, honest…') CYPIT to review the images and wording within strategy/advice sheets issued following EHCNAs and consider producing standard recommendations sheets for different age groups e.g. infant, junior, secondary age Remind all CYPIT staff to sense-check their recommendations in the context of the child's needs in every area of development so that recommendations in one area do not rely on a skill that the child does not yet demonstrate.	Communication
9181	Bracknell	Other	Low	GDPR request originally dated 1/8/23 asking for a note to be added to the system has not been responded to or advised where the email has been sent to	Partially Upheld	Ack'd that we could have let pt know this was not SAR.	Medical Records
9192	Reading	Common Point of Entry	Low	pt wishes notes removed from records that were not discussed in appt.	Partially Upheld	Staff member to always inform patients of her access to RIO and any other BHFT record keeping such as IAPTus when this has been reviewed by the clinician in terms of assessment and decision making for that patient. And where there is a clinically appropriate need to make reference to any such documentation, to inform the patient of this and make it explicit in the notes where and when this has come from and why it is relevant. All ARRS West MHPs to be reminded and informed of the above clinical practice expectations. IO to seek advice within BHFT initially about the request for the notes to be amended to the content of discussion only – how this should and can be appropriately managed. IO to feed back to PCN regarding governance outcome.	Medical Records
9195	Windsor, Ascot and Maidenhead	District Nursing	Minor	Patient complaining that DNs have no knowledge on how to manage a chemo drug pump and caused her great pain when taking it out. She is also unhappy at hygiene saying they did not wash their hands, which was a risk to the patient.	Upheld	Staff to receive refresher training on Port Care Staff to receive refresher training on care of immune compromised patients Staff to be reminded of the need to wear masks at patients request and that they should have a supply with them at all times	Care and Treatment

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 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	Discharge Arrangements
9055	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	Pt insisting they need a Diagnostic Second Opinion assessment ORIGINAL COMPLAINTS 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
8634	Slough	Assessment and Rehabilitation Centre (ARC)	Low	1. Clearer response required with assessment info 2. why was the pt not listened to? 3. unhappy with the complaints process Additional points regarding ARC ORIGINAL COMPLAINT BELOW Pt felt pre-judged by the ARC physio and Dr following communication from her GP. Pt is unhappy with the way the IO spoke to her. Pt states the letter containing the diagnosis of their condition is peppers with mistakes.	Not Upheld		Attitude of Staff
9108	West Berks	Talking Therapies - PWP Team	Minor	DECEASED Pt - Why was there a lack of treatment provided to the pt by Berkshire Healthcare and why was there a cavalier attitude towards this lack of treatment. Complainant states the pt died without ever seeing anyone f2f	Not Upheld		Care and Treatment
9168	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	lack of response from the Crisis team emails after feeling harassed with calls and visits from the Team. Entered property without consent engaged in conversation with a family member despite records indicating family abuse	Partially Upheld	We have apologised for the call from crisis and have confirmed pt will not be contacted again	Care and Treatment
9172	Reading	Talking Therapies - Practical Support Services	Moderate	Believes the counsellor acted inappropriately by not following correct processes making a referral the pt did not want or consent to. Feels no adjustment has been made for them being autistic. Unhappy with the informal investigation to date. Element regarding comments written in records from CPE	Partially Upheld	For all Talking Therapies Staff to be reminded of the policy Org CCR 107 regarding copying letters to clients. This policy as well as highlighting the general principle that all clinical letters should be copied to the patient, also highlights that the letter should be written in plain English and should be factual and clinically accurate. For all Talking Therapies Staff to be reminded of the policy Clinical Record Keeping Standards ORG096 which gives guidance on how to write clinical notes emphasising that Clinical Records should be factual and without personal opinion or judgement. For therapists to attend the neuro -diversity clinical supervision sessions when working with neuro-diverse clients To discuss with the Senior Leadership Team a review of the current processes in place to ensure note keeping is of an acceptable standard.	Attitude of Staff
9176	Reading	CAMHS - Specialist Community Teams	Low	Historic complaint - pt wishes to know if the content of a report was a ridiculous thing to write after one question	Not Upheld		Communication
9191	Reading	District Nursing	Moderate	DECEASED Pt. Pt required dexamethasone injections daily, which were not given. Family unhappy about to pain and stress this caused	Serious Untoward Incident Investigation	Not an SI, but being dealt with via PS team	Care and Treatment

9189	West Berks	CAMHS - Getting Help East	Minor	referral made from school June 2020. Parent chased but service say never received, school say sent, stalemate resulting in patient not being on wait list and parent having to do all the chasing. Frustrating and support needed	Partially Upheld	Staff to be reminded that all service user contact should be recorded in RIO. Staff to be reminded that all information in the referral should be considered in the CPE assessment, especially where there is more than one focus of concern in the referral.	Care and Treatment
9194	Reading	Older Adults Inpatient Service - Rowan Ward	Low	Daughter complaining about lack of communication with ward Dr. Particularly around the DOLS application. Family do not understand why DOLS was applied for. They want to take her out of PPH.	Upheld	Leaflets to be made available to the families on Rowan ward (and across the inpatient services) about Mental Capacity Act Assessment, DOLS, Best Interest Meeting, CPA and to be added to the carers' information pack' Educate the team about the role of the LPOA Carers' clinic should be considered for the wider family	Communication
9198	Bracknell	Podiatry	Low	Unhappy could not have big toe nail clipped and then when they tried to complain the leaflet given by the department had the old PALS and Complaints numbers on	Partially Upheld	An apology to pt that he was given an old leaflet. Contact the Governance Leads to advise that the numbers have changed and for previous versions to be destroyed.	Access to Services
9196	Reading	Out of Hours GP Services	Minor	Patient was experiencing symptoms of infection following a second operation on his penis for hypospadias. He had a small white pus spot on the wound, which the Dr said needed to be squeezed. Caused a lot of trauma to the three year old patient. She then prescribed antibiotics, which pharmacy said were too much.	Not Upheld	Complaint will be discussed at next WestCall Clinical Meeting to share learning.	Care and Treatment
9197	West Berks	District Nursing	Low	Patient says DNs up unannounced and she doesn't want them there. She has cancelled all appointments but they still show up. Threatening police welfare checks and intimidating patient. Says nurse has poor attitude 'huffing and puffing'. Wants no contact from DN service.	Partially Upheld	Discuss with the GP surgery if Community Nurses unable to gain entry to the patient's property to make them aware. Contact Patients prior to visiting if they have requested this by the patient, not to turn up unannounced	Attitude of Staff
9202	Slough	Community Dental Services	Minor	emergency dental treatment, no xray was offered, extreme pain before and worse afterwards. Pt ended up needing to stay in the John Radcliffe for 3 days	Partially Upheld	Learning point 1: It may be helpful when a patient suspects they have had a swelling or recurrent pain to take a temperature reading Possible improvement opportunity: It may be helpful for the rollout of intra-oral scanners/cameras as clinical imaging of the affected area may be useful for diagnosis and medico-legal purposes. Whilst they would not replace radiography, they may help form part of the clinical picture and back up the narrative in the notes. There would be a cost implication to this.	Care and Treatment
9206	Reading	CMHT/Care Pathways	Low	Complainant wishes a formal response despite local resolution - Family want to know what support the pt will get when discharged from RBH to prevent a further suicide attempt	Not Upheld	No consent received	Care and Treatment
9211	Slough	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Attitude of call handler to distressed pt	Partially Upheld	Staff member has apologised and will undertake clinical supervision to reflect on this episode of care.	Attitude of Staff
9213	Reading	Out of Hours GP Services	Low	Inappropriate racist language/conversation with westcall Dr	Upheld	To Discuss Case at WestCall Monthly meeting as part of learning from clinical incidences	Discrimination, Cultural Issues
9217	Slough	District Nursing	Low	unable to take responsibility of administering insulin to pt, complainant felt pressurised and intimidated and not listened to. No consideration given to family member working. Unhappy they received a letter regarding their attitude from BHFT	Upheld	new progress notes will need to be re-written by the clinicians using the same date and time first, once this is done the original progress notes will need to be struck out as written in error. Rio support desk will then need to be contacted to remove the progress notes completely. GP letter will need to be sent out again advising that the previous letter written to them was inaccurate and request that they delete it from their system. IO to confirm to complainant when the actions of writing to the GP and updating mother's RiO records have been completed.	Attitude of Staff
9220	Bracknell	IMPACTT	Low	Patient alleges two members of staff have conspired to 'contain' him due to his agenda to hold people accountable. Also wants to see unredacted version of the email as he says it is clearly about him.	Not Upheld		Attitude of Staff
9221	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt unhappy about the entry made on medical records and wishes the statements removed	Not Upheld		Medical Records

9224	Reading	Community Dental Services	Minor	re-opened complaint - pt unhappy with response. He says is referral is routine, whereas he believes it should be urgent. He also said there is no solution to his general dental care. He is autistic and doesn't like being touched, so he needs general anaesthetic. He is also unhappy that he was given a story board. He said he is a high functioning person with autism and doesn't need a story. ORIGINAL complaint - pt states they have not had any Dental treatment despite being in considerable pain with their teeth	Not Upheld		Care and Treatment
9225	Reading	Adult Acute Admissions - Bluebell Ward	Low	Via CQC Medication side effect causing urine leakage, unable to order new trousers. Not enough pull-ups available. CC always off sick	Not Upheld		Care and Treatment
9222	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Minor	8 new points raised . Trf arrangements (manhandling) . DNACPR in place but pt was given CPR resulting in bruising . BP low but anti-hypertensive meds were still given . Junior Dr changed treatment plan re blood pressure meds . Meds given before breakfast instead of after . Identity req of HCA and staff involved in resus and final hours . Location of death . Meeting minutes removed from Trust system ORIGINAL COMPLAINT :- Following SJR - 6 points to investigate •Staff behaviour during admission •Patient treated any differently due to skin colour / ethnicity •Staff response to call bells (particular attention on DOD 08.00-09.00) •Who found pt collapsed? •What does collapse mean? •Staff reporting of unacceptable behaviour.	Not Upheld	Sharing visiting hours and mealtimes with families and carers prior to patient being admitted to the wards	Attitude of Staff
9227	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt felt caller handler had a brusque manner and made then feel worse	Upheld	Staff member has reflected on incident and has apologised.	Attitude of Staff
9233	Reading	Pharmacy	Low	Concerns about mental health and wellbeing	Not Upheld	We are unable to share information relating to matters that sit outside the complaint regulations. We have however offered direct, named support to the complainant and his children.	Other
9258	Slough	District Nursing	Moderate	Pt given B12 injection 2 days after given by a different DN. DN did not listen to the pt when they said they had already had it	Serious Untoward Incident Investigation		Medication
8992	Wokingham	Immunisation	Low	Vaccination given to YP without consent. Complainant wishes to know why she was told the YP had been confused with another with the same name and why the service lead refused to put their conversation in writing	Upheld	When entering any response on Cinnamon from a parent/carer, child's ID must be checked against: Name, DOB, NHS number (if on Cinnamon) address and parent/carer's name. Only once these are correct should a response be added to Cinnamon. The name of the parent/carer should be named on the triage notes. If a parent/carer changes their mind from consent to non consent or vice versa, before a triage note is added on Cinnamon and before the response is amended, child's ID is checked against: name, DOB, NHS number (if on Cinnamon) address and parent/carer's name. Parent/carer name to be added to triage note so that the vaccinating nurse can clearly identify a change in response. It should also be clearly documented on the triage notes that the response has been changed/amended from one decision to the other and the parent/carer changing the decision should be named on the triage notes. Service to explore whether vaccinating nurse's identity can be removed from the automated e-mail sent to parents/carers and replaced with a code- to protect and support staff. Parents/carers can request the name of the nurse as required	Medication
9162	Wokingham	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	Complainant unhappy with the service and medication provided and documentation of communication in records. Feels paperwork and administration puts the pt at risk and also that unfavourable things have been written about the complainant	Partially Upheld	learning point for the team is to ensure we pass that information over the same day regardless of the time. learning point for the team is to ensure that all medication changes that are discussed are clearly documented in writing to the GP and a copy sent to the patient.	Care and Treatment

9193	West Berks	CAMHS - ADHD	Minor	Urgent medication review requested July 2023. Took place Sept 2023, Dr said could not email due to GDPR but emailed GP. Delay has caused child to feel very unwell	Partially Upheld	1.Dr has been very keen to reflect on the learning from this complaint for himself and for the team. To support this, a session was arranged for Dr and the Lead Consultant Child and Adolescent Psychiatrist to meet and have the opportunity to review the learning from this investigation. 2.In addition we have provided a reminder session for the entire team on height and weight monitoring with an emphasis that the focus should not simply be on monitoring centiles and the importance of identifying significant changes and the appropriate actions to take when these are identified. 3.The reflection from this complaint has also highlighted that the team would benefit from better systems to support the tracking of physical observations and we are exploring digital solutions for this. 4.We have also reminded all of the clinicians in the ADHD Team that, when they are on leave or out of the office, they must have a clear out of office message with details of who to contact for any issues that should not wait for the clinician to return.	Medication
9207	Wokingham	CMHT/Care Pathways	Minor	Pt unhappy with the psychiatrist from Wokingham, unhappy with medication given. Very unhappy at the number of police to take them to PPH and the handling of the process, not allowed to take their medication (insulin)	Not Upheld		Care and Treatment
9223	Bracknell	CMHTOA/COAMHS - Older Adults Community Mental Health Team	Low	Medication prescribed caused issues resulting in a visit to hospital where they were told they conflicted with their meds prescribed for COPD. Dr advised they stop driving which pt says is against DVLA guidelines. Pt feels life changes decisions have been made regarding driving without the Dr even meeting the pt	Partially Upheld	The main points of the complaint will be shared in team meeting and all the learning will be shared with the team Supervision meeting will be recorded into RiO notes All staff to understand the importance of transparency and open line of communication when discussing matters which will have significant impact on the person's life. Improved documentation in Rio notes or in letter of risk, benefits and possible side-effects when prescribing and giving out medication / prescriptions.	Medication
9215	Reading	CMHT/Care Pathways	Low	Unwell pt admitted to RBH with Lithium Toxicity. Partner unhappy that all their concerns of MH have been attributed to Diabetes. Partner believes pt was given the incorrect dose of Lithium	Partially Upheld	Multi agency professional meeting to be called	Medication
9235	Reading	Out of Hours GP Services	Minor	19 Sept pt attending OOO appt at RBH with abdominal pain, Dr came across as dismissive despite the fact the pt had been told to attend the hospital if pain due to having a cyst (waiting to be removed). pt does not understand why no blood tests were taken. same Dr the next day requested pt goes back in. 24 Sept pt recieved blood tests following call to 111 and appt at a&e RBH	Not Upheld	Complaint will be discussed, and findings shared with WestCall clinicians at monthly clinical meeting	Care and Treatment
9237	Reading	Out of Hours GP Services	Low	2 yr old taken to WestCall as mother not happy to wait in A&E, told to call 111. Complainant wishes to know why they can not be seen as a walkin and why babys are not prioritised like they used to be	Not Upheld	Will be discussed at next westcall clinical meeting.	Access to Services
9236	Bracknell	CMHT/Care Pathways	Low	concerned about the way BHFT handle their information after text their spouse again	Upheld	Increased awareness of text messaging process. To contact DAC team with any future queries or concerns. Any concerns regarding multiple phone numbers should be checked on Rio to confirm correct number. Staff to be refreshed quarterly on digital appointment correspondence systems.	Confidentiality
9243	Wokingham	District Nursing	Low	Services discontinued to pt of 90 yrs old after 6 years	Partially Upheld	Team Leads to liaise with governance, Rio and other localities to investigate how they are managing patient expectations around eligibility criteria for their respective services. Team leads to organise for letters to be sent to all service users advising of caseload review for eligibility criteria. All staff to ensure that the service eligibility criteria is discussed with each patient on admission to the caseload. Triage team to fully assess housebound status at the point of referral and to ensure that non housebound patients are signposted to appropriate support/services.	Discharge Arrangements

9246	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Low	would like to look into past care for the pt following discharge from S3, and if s117 would have changed the actions of the 30th Oct. Family do not understand why patient was not deemed ill enough to be in hospital ORIGINAL BELOW CMHT not replying to emails sent	Not Upheld	Discuss outcome of the meeting with Band 7 Lead Allocate a CC Assist patient with accommodation issues.	Communication
9247	Reading	Early Intervention in Psychosis - (EIP)	Low	Service did not reply to complainants emails	Not Upheld		Communication
9240	Wokingham	Community Hospital Inpatient Service - Ascot Ward	Low	DECEASED Pt: family feel there were many areas of inadequate care for their loved one with poor attitude from staff.	Upheld	Infection control study day/ Infection control topic of the month. Random infection control spot checks. Pressure ulcer classification/care Repositioning patients – Adhoc learning Patient safety and governance random spot checks New curtain gliders Unit meeting held and points addressed/newsletters and learning lunches.	Care and Treatment
9241	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Family unhappy with the Dr who visited to do an assessment. Felt the assessment was too long and not all of it was appropriate	Not Upheld		Attitude of Staff
9249	Reading	Adult Acute Admissions - Daisy Ward	Low	pt was told their wife had passed away 10 days ago and was refused leave. personal possessions missing, also said they were threatened by another pt, believes the staff take drugs,	Not Upheld		Care and Treatment
9254	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Pt feels their confidentiality was breached by not asking people present to leave during personal discussions. Further questions regarding entries on their medical records. ORIGINAL BELOW Pt received their medical records to find many inaccuracies. Now feels they can not reach out for help going forward due to what has been written about them	Upheld	Records to be amended as per investigation	Medical Records
9259	West Berks	Estates	Low	Unhappy with the outcome ORIGINAL BELOW Relative sat in their car while pt was receiving a blood test, received a parking fine. Complainant is stating there are no 'no waiting' signs, there was no time to appeal and not enough time given in the letters to pay on time so as not to incur further cost penalties	Not Upheld		Communication
9262	Reading	Adult Acute Admissions - Bluebell Ward	Minor	Feels the Move on Coordinator has been unsupportive missing deadlines and not attending prearranged meetings	Partially Upheld	1.Staff to utilise trauma-informed approach in their practice and develop care plan for waking the patient, in collaboration with the patient 2.Staff to reflect on their communication with patient in terms of informing about progress, and arranging appointments	Communication
9275	West Berks	Out of Hours GP Services	Moderate	Attended Westberks on 8 May 23, had stitches, was told no need to use crutches. foot became infected. Eventually after several trips to RBH was told EHL had ruptured and that had it have been spotted on the 1st visit it would have been possible to sort but not now after 4 months options are surgery or leave.	Partially Upheld	MIU to move to Webex phone system so that calls can be recorded. This will require a telephony project with IT department. All telephone advice given to be recorded on Adastra Patients who attend with a laceration over a tendon will have the strength of the tendon documented.	Care and Treatment
9270	Reading	Podiatry	Minor	Podiatrist removed part of a ganglion having asked the pt if he should remove it 2 years ago. Family say pt has been suffering since this, is diabetic and has been advised worse they may lose their foot.	Partially Upheld	To ensure that Clinicians are taking good quality digital images of wounds or a deteriorating foot to assist in the measurement of healing and/or deterioration. Talk to clinicians about the importance of good record keeping. Foot Protection Leads and Podiatry Team Leaders to conduct more medical record clinical notes reviews at 121s and clinical supervision To present this complaint anonymously at a Podiatry Study day so learning can happen	Care and Treatment
9301	West Berks	Estates	Low	DECEASED Pt. Family visiting EOL pt received multiple parking fines whilst visiting despite having registered at reception as advised	Upheld	parking fines cancelled with TCP training for ward staff in how parking works for families of EOL patients.	Communication

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2022/23						2023/24							
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q 1**	**Q 2**	**Compared to previous quarter**	**Q 3**	**Q3 no. of contacts**	**% contacts Q3**	**Total for year**	**% of Total**
CMHT/Care Pathways	11	10	18	14	53	**22%**	16	6	↑	13	8727	0.15%	35	**17.00%**
CAMHS - Child and Adolescent Mental Health Services	4	6	13	10	33	**14%**	8	11	↓	7	8404	0.08%	26	**12.00%**
Crisis Resolution & Home Treatment Team (CRHTT)	3	9	6	4	22	**9%**	5	10	↓	5	12421	0.04%	20	**9.50%**
Acute Inpatient Admissions – Prospect Park Hospital	13	7	9	6	35	**15%**	10	2	↑	4	183	2.18%	16	**8.00%**
Community Nursing	3	0	4	5	12	**5%**	3	6	↓	5	59935	0.008%	14	**7.00%**
Community Hospital Inpatient	4	3	2	1	10	**4%**	1	2	↑	5	550	0.9%	8	**4.00%**
Common Point of Entry	0	1	3	1	5	**2%**	1	3	↓	0	992	0%	4	**2.00%**
Out of Hours GP Services	1	0	1	2	4	**1.5%**	1	2	↑	7	4677	0.15%	10	**5.00%**
PICU - Psychiatric Intensive Care Unit	1	2	0	4	7	**3%**	0	0	↑	1	4	25%	1	**0.50%**
Urgent Treatment Centre	1	0	0	0	1	**0.5%**	1	1	↑	2	4032	0.05%	4	**2.00%**
Older Adults Community Mental Health Team	1	1	0	0	2	**1%**	1	2	↓	1	4558	0.02%	4	**2.00%**
Other services during quarter	19	11	15	11	56	**23%**	21	19	↑	25	128718	0.02%	65	**31.00%**
Grand Total	61	50	71	58	240	100	68	64		75	233201		207	100.00 %

Locally resolved concerns received

Division	Oct	Nov	Dec	Qtr 3
CYPF	1	3	1	5
Community Mental Health East		1	1	2
Community Mental Health West		1		1
Physical Health	4	5	2	11
Total	**5**	**10**	**4**	**19**

Informal Complaints received

Division	Oct	Nov	Dec	Qtr 3
CYPF		1	2	3
Community Mental Health West	3		1	4
Physical Health	2	1	1	4
Total	**5**	**2**	**4**	**11**

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 however when reviewing the first annual report from NHS Digital, they are no longer reporting to Trust level. The Head of Service Engagement and Experience has queried this and is awaiting a response.

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**	**Q2**	**Higher or lower than previous quarter**	**Q3**	**Total for year**	**% of 23/24**
Locally resolved	0	0	0	0	0	4	↓	1	5	4%
Not Upheld	23	22	23	38	20	25	↑	30	57	42.00%
Partially Upheld	21	30	26	25	22	26	↓	24	50	37.00%
Upheld	12	9	7	8	11	9	↑	12	21	15.50%

SUI	0	0	0	0	0	0	↑	2	2	1.50%
Grand Total	**57**	**61**	**57**	**72**	**53**	**64**		**69**	**135**	**100.00%**

52% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 55% in Quarter). 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	Confidentiality	Discharge Arrangements	Discrimination, Cultural Issues	Medical Records	Medication	Grand Total
Adult Acute Admissions - Bluebell Ward				1						1
Adult Acute Admissions - Daisy Ward						1				1
Adult Acute Admissions - Rose Ward			1							1
CAMHS - ADHD									1	1
CAMHS - Getting Help East			1							1
Children's Occupational Therapy - CYPIT				1						1
CMHT/Care Pathways					3				1	4
CMHTOA/COAMHS - Older Adults Community Mental Health Team			1						1	2
Common Point of Entry								1		1
Community Dental Services			1							1
Community Hospital Inpatient Service - Ascot Ward			1							1
Crisis Resolution and Home Treatment Team (CRHTT)		2	1					1	1	5
District Nursing		2	2			1				5
Estates				1						1
Hearing and Balance Services			1							1

Immunisation									1	1
Older Adults Inpatient Service - Rowan Ward				1						1
Other								1		1
Out of Hours GP Services			1				1			2
Phlebotomy		1								1
Podiatry	1		1							2
Talking Therapies - Practical Support Services		1								1
Grand Total	1	6	11	4	3	2	1	3	5	36

Care and Treatment complaint outcomes

Care and Treatment complaint outcomes	Not Upheld	Partially Upheld	Upheld	Grand Total
Adult Acute Admissions - Bluebell Ward	1			1
Adult Acute Admissions - Daisy Ward	1			1
Adult Acute Admissions - Rose Ward		1		1
CAMHS - Getting Help East		1		1
CMHT/Care Pathways	3			3
CMHTOA/COAMHS - Older Adults Community Mental Health Team		1		1
Community Dental Services	2	1		3
Community Hospital Inpatient Service - Ascot Ward			1	1
Crisis Resolution and Home Treatment Team (CRHTT)		1		1
District Nursing		1	1	2
Hearing and Balance Services		1		1
Out of Area Placements	2			2
Out of Hours GP Services	2	1		3
Podiatry		1		1
Talking Therapies - PWP Team	1			1
Grand Total	**12**	**9**	**2**	**23**

23 complaints related to care and treatment. Of these 12 were not upheld, 9 were partially upheld and 2 were fully upheld.

PHSO

The table below shows the PHSO activity since April 2023:

Month opened	Service	Month closed	Current stage
Apr-23	CMHT/Care Pathways	Sep-23	LGO not progressing, but now with PHSO to consider
Jul-23	CMHT/Care Pathways	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
Jul-23	CAMHS – Specialist Community Team	Sep-23	PHSO have reviewed file and are not progressing
Sep-23	CRHTT	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
Sep-23	CAMHS	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
Nov-23	Neurodevelopmental services	Awaiting update	File sent to PHSO on to aid their decision on whether or not to investigate
Dec-23	Heart Function	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.

In Q3 we received three complaints via the CQC.

Compliments

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

Fin Year	2022/23					2023/24			
Quarter	Q1	Q2	Q3	Q4	Total 2022/23	Q1	Q2	Q3	Total to date 2023/24
Compliments	1076	1119	1403	924	4522	1091	1229	1408	3728

Patient Advice and Liaison Service (PALS)

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. 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 and office space has been identified at Wokingham 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 385 queries recorded during Quarter three. An increase of 70 since Quarter two. 383 queries were acknowledged within the 5 working day target. The recording of queries has improved with the involvement of other team members. Team members have been working with the PALS Manager to familiarise with the response and recording processes. The volume of calls and e mails coming into the service continues to be high.

The Patient Experience Team has undertaken work to standardize and streamline the PALS process, 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. To do this we have introduced Excel spreadsheets to capture queries which do not necessitate recording on Datix. These include queries relating to HR, Estates/Site Services, Access to Medical Records and Pensions/Finance. 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 helped to raise the profile of the service by providing services with publicity and information.

In addition, there were 194 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.	26
CAMHS AAT	20
Community Dental Services	14
District Nursing	13
Other	13
CMHTOA/COAMHS	13
Continence service	11
CAMHS ADHD	11
Neuropsychology	10

Berkshire Healthcare NHS Foundation Trust

Trust Board Meeting Paper

Board Meeting Date	12 March 2024
Title	**Freedom to Speak Up - A Reflection and Planning Tool**
	Paper for Approval
Reason for the Report going to the Trust Board	It is good practice, as detailed by NHS England for the freedom to speak up, self-reflection tool to be reviewed by organisations at least every 2 years, the aim being to identify gaps and areas for improvement as well as areas of good practice on a regular basis. The self -reflection tool was last taken to public Board in July 2023 after internal review; however, a new version of the tool is available. One of the actions we agreed in response to the August 2023 letter from NHS England following the trial verdict of Lucy Letby which urged Boards to review their Freedom to Speak Up processes, was to revisit our own self-assessment using the new tool. The tool has been through internal review and is here today for approval.
Business Area	Trust wide
Author	Debbie Fulton; Director Nursing and Therapies
Relevant Strategic Objectives	The ability for all staff to speak up about anything that concerns them in the knowledge that they will be listened to and their concerns will be followed up is relevant to the following strategic objectives. **Patient safety; Health inequalities; Workforce**

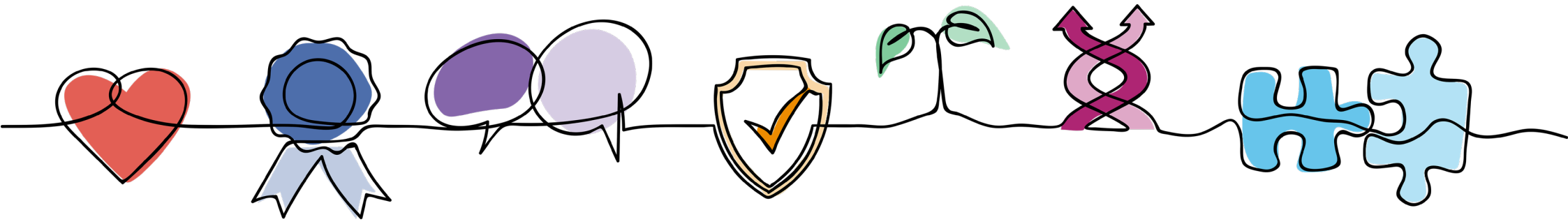
National Guardian
Freedom to Speak Up

NHS

Freedom to Speak up

A reflection and planning tool

Review undertaken Jan 2024



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide.

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I have led a review of our speaking-up arrangements at least every two years	5
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5

Enter summarised commentary to support your score.

Senior Leader responsible for FTSU is Director Nursing and Therapies.

Self- assessment review (using 2019 tool) last undertaken 2023.

Guardian recruited through Trust recruitment processes.

Guardian works 5 days a week across reactive and proactive FTSU/ OD and leadership (2 days ringfenced for reactive FTSU work - the guardian is supported by a Champions network and is also supported to be chair of SE FTSU guardian network.

Monthly 1:1 with exec lead and FTSU Guardian, monthly meetings between Guardian, CEO, Deputy Director HR, and Exec Lead. Regular meetings with Non-Executive Director responsible for FTSU

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up	5
I effectively monitor progress in board-level engagement with the speaking-up agenda	5
I challenge the board to develop and improve its speaking-up arrangements	5
I am confident that our guardian(s) is recruited through an open selection process	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	5
I am involved in overseeing investigations that relate to the board	5
I provide effective support to our guardian(s)	5
Enter summarised evidence to support your score. 1:1 catch up between FTSUG and Non-Exec Director Lead/ regular pertinent updates provided and discussed Proactive engagement in self-assessment process Engagement in Trust activity related to FTSU and wider staff wellbeing / organisational culture.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture.

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	4
We regularly and clearly articulate our vision for speaking up	4
We can evidence how we demonstrate that we welcome speaking up	4
We can evidence how we have communicated that we will not accept detriment	3
We are confident that we have clear processes for identifying and addressing detriment	3
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	4
We regular discuss speaking-up matters in detail	

Enter summarised evidence to support your score.

The Board and Senior Leadership team proactively support FTSU agenda; the area of focus for the organisation is to ensure that all who line manage staff at every level in the organisation act in a manner which supports staff to speak up, that they feel listened to when they do and that their concerns are followed up / escalated appropriately.

Strategy refreshed in 2023.

Clear message at induction re FTSU

Use of newsletters / intranet pages/ posters alongside visibility of FTSUG, champions who are supporting messaging into their teams/ services, executive/ Non-Executive Gemba, promotion through FTSU month. Safety culture work across the Trust promotes vision for everyone to feel safe to speak up, promotion of FTSU in training such as PMVA. FTSU month. Regular engagement form FTSUG with

networks and attendance at network meetings. FTSUG and a champion part of safety culture steering group chaired by Director Nursing & Therapies Feedback from staff who have spoken up collated by FTSUG, used as part of Board reporting, within safety culture programme of work and also work in relation to violence and aggression / anti-racism. Monthly training / networking for Champions Attendance by FTSUG at safety Culture Group, Diversity Steering Group and Strategic People Group, Anti Racism Taskforce FTSUG is Involved in current SE region work in relation to producing a tool kit on detriment for organisations to use. Region looking at detriment to produce toolkit for providers, clear one pager explaining detriment and what to do if you think you have experienced detriment to be put together for staff.
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)
1.Ensuring that we can evidence how we have communicated that we will not accept detriment
2 Staff crib sheet around detriment what it means (what is detriment) and how to escalate if you feel you have suffered detriment
3. Consider how we encourage staff to raise concerns at an earlier stage and support appropriate response to reduce escalation of concerns and possible detriment.
4. Review investigatory processes to ensure that they are as timely as possible and that those involved are kept updated appropriately

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up	5
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	5
We support our guardian(s) to make effective links with our staff networks	5

We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	4

Enter summarised evidence to support your score.

OD led is an ex-Associate Guardian from a previous Trust.

Implementation of a Just Culture, embracing Safety Culture work & Early Resolution framework via HR policies

FTSU data is reviewed alongside HR Heatmap to determine hotspots or teams with poor culture and any EDI links such as microaggressions or other abuse against staff with protected characteristics.

Leadership programme includes speak up, listen up, follow up.

FTSUG well linked into all staff networks

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about how much time the guardian(s) has to carry out their role	**Score 1–5 or yes/no**
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	5
We have reviewed the ringfenced time our Guardian has in light of any significant events	5
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	5

Enter summarised evidence to support your score.
The Guardian is able to follow NGO guidance, attends working events and training opportunities and chairs the Southeast FTSUG network. Guardian is part of ICB and other networks including a speak up network outside of the NHS. Time for Guardian has been part of self-assessment in 2021 and 2023 and FTSUG is in agreement that his time is sufficient. The Trust have clear agreement with FTSU champions and their managers to demonstrate commitment to fulfil the role and to be able to attend network meetings to support their role alongside their substantive positions within the organisation.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	5
We can evidence that our staff know how to find the speaking-up policy	4

Enter summarised evidence to support your score.

Policy has been reviewed in 2023 and is aligned with the NHSE policy. This includes review by staff-side, network leads, diversity steering group.

The policy is held within the policy section of our staff intranet and also within the safety culture / FTSU section there is however always ongoing work to ensure that all staff are aware. Staff network intranet pages also link to FTSU page where there's a link to the policy. This is covered in induction and staff are reminded at key times throughout the year such as FTSU month, at events and all staff newsletters.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	4
We have an annual plan to raise the profile of Freedom to Speak Up	4
We tell positive stories about speaking up and the changes it can bring	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up	3

Enter summarised evidence to support your score.

Guardian is part of corporate induction, Student Induction, International Nurses Induction & Junior Doctor induction; posters newsletters, intranet, attendance at meetings and events, champion and staff networks, training such as PMVA references FTSU, FTSU month activities, visibility of FTSUG - this is an ongoing endeavour to continually raise.

Our staff survey results for 2022 demonstrate that 80% of staff feel secure raising concerns about unsafe clinical practice and this alongside confidence that it would be acted on have seen year on year improvement since 2018 with scores currently 3.5% above national average scores for feeling secure raising the concern and 11.5% above national average scores for confidence that they would be addressed. In terms of feeling safe to speak up about anything of concern, around 75% feel safe to do this and 65% believe that their concerns would be acted on. We have a focus on demonstrating positive and decisive action in terms of bullying, harassment and racism experienced by our staff with the aim of supporting improvement in relation to this.

Positive stories to demonstrate positive outcomes and impact of speaking up are used at Board and to support some of our improvement work.

Programme of workshops aimed at encouraging staff to speak up, compassionate leadership and safe cultures being undertaken across the Mental Health wards - series of video clips used to support this and will be delivered over Sept and Oct 23 by a multi-professional group of staff including psychology, nurse consultants and Junior Doctors; following PDSA approach this can be rolled out further.

Guardian has individual objectives for the role and the safety culture steering group has workplan and actions that include continuing to improve on the speak up, listen up, follow up culture across the organisation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 increase of positive story telling
2 measurement of effectiveness is currently through annual staff survey, explore other ways to measure effectiveness

Principle 4: When someone speaks up, thank them, listen and follow up.

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	2*
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	5
Our HR and OD teams measure the impact of speaking-up training	2*

Enter summarised evidence to support your score.

FTSUG attends mandated guardian training.

To date we have promoted the 3 FTSU e-learning modules and they are available on our training platform but have not mandated. We have agreed staff groups to prioritise for essential training and our FTSU champions promote this training.

FTSU features in corporate induction and Junior Doctor Induction and is part of other essential and mandated training / programmes for staff including PMVA, leadership programme for managers, all staff webinars, safety culture training, L1 patient safety training (93% staff have completed this)

*We recognise that achieving a culture that encourages speaking up and ensures that staff are listened to, and action taken when they do require a multi-faceted and long-term approach and that e-learning alone will not achieve that. We ensure that encouraging speaking up is included in induction, the essence of all three e-learning modules is included within leadership and training opportunities. We have made the e-learning essential for certain staff groups such as the people directorate.

We measure the impact of our approach through the national staff survey and culture work undertaken into teams and services.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1. Agree on cohorts of staff to focus mandating training or alternative and roll this out
2. MS feedback from to be devised for everyone following induction.
3. Explore potential for staff understanding around their role in FTSU being part of annual appraisal

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	4
All managers and senior leaders have received training on Freedom to Speak Up	2*
We have enabled managers to respond to speaking-up matters in a timely way	4
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

Enter summarised evidence to support your score.

To date we have promoted the 3 FTSU e-learning modules and they are available on our training platform but have not mandated. We have agreed staff groups to prioritise for essential training.

FTSU features in corporate induction and is part of other essential and mandated training / programmes for staff including PMVA, leadership programme for managers, all staff webinars, safety culture training, L1 patient safety training (93% staff have completed this).

Our staff survey results indicate that 73% staff are confident that if they raised a clinical concern, it would be acted on and around 66% are confident that if they raised any concern, it would be acted upon, this is 11.5% and 10.7% respectively higher than national average but also indicates that we have further work to do to continue the improvement, Journey.

There is much focus on safety culture and supporting environments that is psychologically safe and this is included in leadership programme for all managers.

Programme of workshops aimed at encouraging staff to speak up, compassionate leadership and safe cultures being undertaken across the Mental Health wards - series of video clips used to support this and will be delivered over Sept and Oct 23 by a multi-professional group of staff including psychology, nurse consultants and Junior Doctors; following PDSA approach this can be rolled out further.

*We recognise that achieving a culture that encourages speaking up and ensures that staff are listened to, and action taken when they do require a multi-faceted and long-term approach and that e-learning alone will not achieve that. We ensure that encouraging speaking up is included in induction, the essence of all three e-learning modules are included within leadership and training opportunities. We have made the e-learning essential for certain staff groups such as the people directorate.

We measure the impact of our approach through the national staff survey and culture work undertaken into teams and services.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Listen up / follow e-learning modules to be rolled out for all managers/ leaders.

2. Speak up, listen up and follow up part of our leadership programme need to ensure that these values are promoted and practiced by all managers across the organisation and that supportive action is taken when they are not.

Principle 5: Use speaking up as an opportunity to learn and improve.

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	5
We use triangulated data to inform our overall cultural and safety improvement programmes	4

Enter summarised evidence to support your score.

Our FTSUG interacts regularly with our staff networks to identify areas of concern and is part of our trust safety culture and strategic people groups, visible and priorities areas of known concern.

Data is triangulated including heat map and nation staff survey as well as softer intelligence is used to prioritise FTSUG focus and also safety culture steering group and improvement work across the organisation.

Data used from staff survey to inform areas for improvement for example safety culture programme of work at PPH, anti-racism work at PPH and within Wokingham community Nursing which will be used as a pilot PDSA for further programmes of work.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	4
We use this information to add to our Freedom to Speak Up improvement plan	4
We share the good practice we have generated both internally and externally to enable others to learn	3

Enter summarised evidence to support your score.

Review of all nationally available FTSU related reports; self- assessment undertaken by Board in 2021 and 2023

Shared learning and practice through FTSU network, webinars related to FTSU and safety culture, leadership programmes National Guardian attended Board, FTSUG has attended system meetings for sharing practice.

Sharing of good practice with FTSUG attending regional and national speak up groups and sessions. ICB have guardian/ exec and non-exec lead meetings established to support cross organisational learning.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. consideration for sharing good practice wider.

2

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	5
Our guardian(s) has been trained and registered with the National Guardian Office	5
Enter summarised evidence to support your score. Guardian appointed through usual trust recruitment processes. Guardian registered with National Guardian office and trained, aware of need for annual refresher training.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
Our guardian(s) has access to a confidential source of emotional support or supervision	5
There is an effective plan in place to cover the guardian's absence	5
Our guardian(s) provides data quarterly to the National Guardian's Office	5

Enter summarised evidence to support your score.

Guardian has annual appraisal with Director Nursing and Therapies this includes setting and agreeing objectives for the coming year.

Monthly 1:1 meeting with Director Nursing & Therapies and HR Deputy Director, monthly catch up between guardian, CEO, Director Nursing & Therapies and Deputy Director HR.

Guardian also meets with the non-exec Director responsible for FTSU.

Guardian has access to wellbeing team for support and also FTSUG network.

In the Guardians absence Director of Nursing & Therapies covers along with champion's network

Data provided to guardian office quarterly and is shared with Board through 6 monthly reports.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	4
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4
We are assured that confidentiality is maintained effectively	4
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	4
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience	3

Enter summarised evidence to support your score.

Policy in place and aligned with national policy.

Process in place for recording all contacts with FTSUG and quarterly review of cases between Director Nursing & Therapies and Deputy Director HR

Ongoing work as detailed in previous sections to ensure that all staff receive a confidently positive experience when speaking up within teams.

Questionnaire to staff who have used FTSU process to ensure that they are satisfied with how the FTSUG approached their concern this includes details of how to raise concerns to either the non-exec or Exec lead if the process/ experience could be improved.

Monthly meet between CEO, FTSUG, Director Nursing and Therapies and Deputy Directo People to ensure that cases are being progressed.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Actions to increase consistency to response (as detailed in Principle 4)
2

Principle 7: Identify and tackle barriers to speaking up.

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	4
We know who isn't speaking up and why	3
We are confident that our Freedom to Speak Up champions are clear on their role	4
We have evaluated the impact of actions taken to reduce barriers?	3

Enter summarised evidence to support your score.

FTSU champions have quarterly sessions with Guardian to support, clarity provided regarding role to both champions and their managers.

Ongoing conversations with staff network chairs to determine barriers network members face, with network members voices raised to Board through Board report.

Attendance of FTSUG at Junior Doctor induction and staff events, proactive visits to sites and teams

We know from staff survey services and groups of staff that find speaking up more difficult, targeted work in relation to anti-racism, services where speak has been evidenced as harder - for example PPH programme of work.

Use of national staff survey to ascertain confidence in speaking up.

Previous results below

	2018 score	2022 score	Movement	Distance from peer average scoring 2022
I would feel secure raising concerns about unsafe clinical practice	76.1%	80.2%	**+ 4.1%**	**+3.5%**
I am confident that my organisation would address my concerns	67.9%	73%	**+5.1%**	**+11.5%**
I feel safe to speak up about anything that concerns me in this organisation	74.8% (2020 first time asked)	74.9%	**+0.1%**	**+7.9%**
If I spoke up about something that concerned me, I am confident my organisation would address my concern	65.8% (2020 first time asked)	65.7%	**-0.1%**	**+10.7%**

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. review of 2023 national staff survey results once available to ascertain improvement / evaluate actions taken to reduce barriers and agree further actions.

2

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	3
We monitor whether workers feel they have suffered detriment after they have spoken up	4
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	4
Our Non-Executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	

Enter summarised evidence to support your score.

Exit interviews for those leaving and internal move interviews.

Staff experience of speaking up captured, with support for those who feel they have suffered detriment.

Review of feedback from staff who have used FTSU process.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. Add in crib sheet for staff on detriment and what to do
2. Collation of detriment from staff who perceive they have suffered detriment to understand what this looks and feels like and what would have mitigated this

Principle 8: Continually improve our speaking up culture.

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	4
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	4
Our improvement plan is up to date and on track	4

Enter summarised evidence to support your score.

Strategy refresh signed off at Board in July 23, aligns with overarching trust strategy, review of metrics to support on-going improvement. Strategy had cross organisational input including from staff networks. Improvement plan to be refreshed with any actions agreed from this self-assessment.

Introduction of case studies of issues being raised to aid Board insight and understanding.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1. formulation of updated improvement plan

2. Ensure that the safety Culture group is sighted on any organisational improvements identified to enable them to inform plans of workstreams that are relevant to safety culture work across the organisation.

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	4
Our speaking-up arrangements have been evaluated within the last two years	5
Enter summarised evidence to support your score. We measure improvement through National staff survey. We use exit interviews and questionnaires to support understanding. We have evaluated our FTSU arrangements and as part of this re- invigorated our champion network across the organisation, they now have a clear role descriptor and agreement of managers to fulfil this role including attendance at relevant training and development. The network is representative of the organisation including protected characteristics and varying bands/ roles. We have undertaken a self-assessment which was received into the in-committee Board in May 23 and Public Board in July 23; this was taken alongside our FTSU strategy refresh and the 6 monthly FTSUG Board report.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	

2

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
We have we evaluated the content of our guardian report against the suggestions in the guide	4
Our guardian(s) provides us with a report in person at least twice a year	5
We receive a variety of assurance that relates to speaking up	4
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	

Enter summarised evidence to support your score.

Introduction of case studies of issues being used to aid Board insight and understanding.

FTSUG attends board 6 monthly to present report in person and support discussions re FTSU.

QAC receives updates on safety culture as part of PSIRF implementation.

Case work report and updates in relation to diversity, anti-racism work received at Board.

Board -Gemba visits to services including out of hours.

Internal audit of FTSU processes undertaken 2019/20 re-audit to be undertaken 2024/25
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1
2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months.

Development areas to address in the next 6–12 months	Target date	Action owner
1. Recorded process for decisions on external v internal investigation.		
2. Staff crib sheet around detriment what it means (what is detriment) and how to escalate if you feel you have suffered detriment.		
3. Consideration of mandating of training for certain groups Board Governance teams Networks SLT People Directorate Staff who manage people		

Staff in teams that have had an OD intervention/support relating to poor culture. All staff to complete FTSU e-learning module as part of induction - following this MS teams' questionnaire for staff to ensure understand process.		
4. Add question to Appraisal paperwork in relation to 'do you know how to speak up'?		
5. Mike participating in regional group looking at detriment and developing a tool kit for providers, explore how we can understand what detriment looks like for staff and what we can do to mitigate against this.		
6. Improve circulation of positive speak up stories and learning from speak up.		
7. Internal Re-Audit of Freedom to Speak up processes (2024/25)		
8. Consider how we encourage staff to raise concerns at an earlier stage and support appropriate response to reduce escalation of concerns and possible detriment.		
9. Review investigatory processes to ensure that they are as timely as possible and that those involved are kept updated appropriately		

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote.

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Quality Assurance Committee Meeting – 27 February 2024**
	Item for Noting
Reason for the Report going to the Trust Board	The Quality Assurance Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. Circulated with the minutes are the quarterly Learning from Deaths and Guardians of Safe Working Hours Reports. NHS England requires NHS provider organisations to present these reports to the Trust Board. The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and associated reports and to note the content.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice**

	Ambition: We will leverage our patient experience and voice to inform improvement

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 27 February 2024

(a hybrid meeting held at London House, Bracknell and conducted via MS Teams)

Present:	Sally Glen, Non-Executive Director (Chair) Rebecca Burford, Non-Executive Director Aileen Feeney, Non-Executive Director Tehmeena Ajmal, Chief Operating Officer Debbie Fulton, Director of Nursing and Therapies Minoo Irani, Medical Director Guy Northover, Lead Clinical Director Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Julie Hill, Company Secretary Daniel Badman, Deputy Director of Nursing Reuben Pearce, Lead Nurse Consultant, Urgent Care Pathway *(present for agenda item 5.0)* Eve Tsapayi, Professional Lead for Clinical Quality and Governance *(present for agenda item 5.0)* Gilbert Orwako, Deputy Inpatient Service Manager, Prospect Park Hospital *(present for agenda item 5.0)* Garyfallia Fountoulaki, Clinical Director Community Mental Health *(present for agenda item 6.0)* Jodie Holtham, Deputy Director of Allied Health Professionals *(present for agenda item 6.0)*

Opening Business

1 Apologies for absence and welcome

Apologies were received from: Julian Emms, Chief Executive. Apologies for lateness because of a meeting clash were received from: Minoo Irani, Medical Director.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 28 November 2023

The minutes of the meeting held on 28 November 2023 were confirmed as an accurate record of the proceedings after a correction had been made to minute number 5.0 (Role of the Family Liaison Officer):

Paragraph 11 was amended to read: “The Director of Nursing and Therapies explained that there were multiple factors including to the complexity of the circumstances and in cases where families had raised a number of concerns and/or questions etc.”

4.2 Matters Arising

The Matters Arising Log had been circulated.

The action log was noted.

Patient Safety and Experience

5.0 Reducing Restrictive Practices Presentation

The Chair welcomed Reuben Pearce, Lead Nurse Consultant, Urgent Care Pathway, Eve Tsapayi, Professional Lead for Clinical Quality and Governance and Gilbert Orwako, Deputy Inpatient Service Manager, Prospect Park Hospital to the meeting.

During the presentation, the following points were highlighted:

- The Operational Group for Restrictive Interventions at Prospect Park Hospital was set up in August 2023 to ensure work on restrictive interventions was making progress. The Group was chaired by the Clinical Director and had operational and clinical leads to drive the work
- The Group reported to the Trust Oversight Group chaired by the Deputy Director of Nursing.
- The Reduction in Restrictive Interventions work was driven by data which helped to identify the keys areas to focus on.
- The aim was to reduce restrictive practices by 15%. This year (2023-24), the Trust’s overall performance from August 2023 had been below the threshold. The focus was now on reducing the most restrictive practices, for example, long term seclusions and physical restraints.
- Each incidence of the use restrictive practices was recorded on the DATIX system and was reviewed in detail. This work led to the introduction of a number of countermeasures, for example, the use of safety huddles each morning to discuss where there may be potential issues and bespoke safety plans for individuals
- There was a strong focus on neurodiversity at both the national and local level. There was a higher prevalence of neurodiverse patients self-harming and being subject to restrictive interventions. Work was underway to get a better understanding of the kinds of adaptations to practice and environmental factors which would better support neurodivergent patients. This included conducting sensory audits and making environmental improvements such as reducing clutter, signage and more neutral colour schemes. The Trust had introduced “sensory trolleys” which were evidence based and were designed to de-escalate situations
- The Use of Force Act 2022 required that each use of force needed to be recorded including the views of patients and any psychological impacts on the patient as a result of the restrictive intervention.
- Work was underway to improve the quality of the recording of the post incident support conversations with patients. The Trust was also working with

the Mental Health Advocates to ensure that any learning from their conversations with patients post-incident was captured.

The Chair asked whether restrictive intervention incidents were triangulated with other sources of data, for example, the use of agency/temporary staff who may not know the patients.

Gilbert Orwako confirmed that data from a number of different sources was reviewed. For example, there was a correlation between patients being prescribed psychotropic medicines but refusing to take the medication which led to the use of restraint in order to inject the drugs.

The Chief Operating Officer commented that the Trust's decision to reduce the size of mental health wards at Prospect Park Hospital would be helpful in creating a more therapeutic environment for patients.

The Chair commented that getting the views of patients post incident was very important and asked whether this information was fed into the patients' advanced care plans.

Eve Tsapayi confirmed that this was the case and explained that gaining a better understanding of the circumstances which led up to the need to use force would hopefully reduce similar incidents in the future.

Aileen Feeney, Non-Executive Director asked whether patients were happy to share their views post incident.

Eve Tsapayi said that each patient was different, and it often depended upon whether the patient had a good relationship with the member of staff. Ms Tsapayi said that some patients preferred to talk to the independent Mental Health Advocates.

The Chair thanked Reuben Pearce, Lead Nurse Consultant, Urgent Care Pathway, Eve Tsapayi, Professional Lead for Clinical Quality and Governance and Gilbert Orwako, Deputy Inpatient Service Manager, Prospect Park Hospital for their presentation and commented that it was clear that a significant amount of work had been undertaken to reduce the use of restrictive practices.

5.1 Quality Concerns Register Status Report

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

- **Quality Concerns No1: Workforce, No11: Community Nursing** and **No15: CMHT** had been rewritten for clarity of the current position and the actions/work in progress.
- Since the Quality Concerns Register was last presented to Committee, the following services had been added:
    - **Perinatal Mental Health** - this was due to the impact of staff vacancies alongside high numbers of referrals meaning that there was insufficient capacity to meet demand.
    - **Early intervention in Psychosis –** this was due to the outcome of the national audit and benchmarking findings compared to national median/mean, impact of fragmented pathways and alongside this the impact of low staffing.
- Since the Quality Concerns Register was last presented to Committee, the following service had been removed:

- **Campion Unit** due to an improved picture in terms of the environment and leadership/staffing challenges on the Unit

The Director of Nursing and Therapies reported that the Community wards were in a much better position in terms of staffing. It was noted that 23 International Registered Nurses had been recruited.

Rebecca Burford, Non-Executive Director referred to Quality Concern No 1 (Workforce) and noted that other financial incentives were being considered to bring recruitment in line with other Trusts and asked for more information.

The Director of Nursing and Therapies explained that a number of trusts had moved away from appointing staff on Agenda for Change Band 2 and said that the Trust was currently reviewing whether or not to appoint staff directly onto Band 3.

The Committee noted the report.

5.2 Sexual Safety of NHS Staff and Patients Update Report

The Director of Nursing and Therapies presented the paper and reported that the Trust had signed up to NHS England's Sexual Safety Charter which comprised ten commitments to be achieved by July 2024.

The Director of Nursing and Therapies reported that the Sexual Safety Charter was being incorporated into the Trust's Violence Reduction work.

The Director of Nursing and Therapies reported that the Sexual Safety work included both patients and staff. It was noted that the national NHS Staff Survey included two new questions around staff sexual safety.

The Director of Nursing and Therapies said that the Sexual Safety Report was presented to the Committee every six months but confirmed that there would be an update report on the Trust's work around the Sexual Safety Charter at the next meeting ahead of NHS England's July 2024 deadline for completion of the Sexual Safety Charter work.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.4 Serious Incidents Quarterly Report

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

- The report detailed the quarter three activity in relation to serious incidents reported under the Serious Incident Framework and also those where a differing patient safety review was undertaken
- The report detailed some of the learning activity being undertaken as a result of findings from incident reviews
- Supporting both staff and families post incident remained a key focus for the Trust
- Toward the end of this quarter, following sign-off both internally and by the Integrated Care Board of the Trust's Patient Safety Incident Response Plan, the Trust had started to transition from the 2015 Serious Incident Framework to the new National Patient Safety Response Framework. As a result of this less serious incident were reported and there was an increase in differing methodologies for Patient Safety Reviews being undertaken.

- From 1 January 2024 all incidents were being reviewed in line with the new Framework

The Deputy Director of Nursing invited feedback on the format of the report.

The Chair confirmed that she liked the format of the report and particularly welcomed the section on improvement activity.

The Chair said that she would appreciate an opportunity to understand the Trust's work around restorative supervision in relation to incidents.

The Deputy Director of Nursing explained that Prospect Park Hospital had introduced a process where a very experienced mental health nurse would review the CCTV footage of incidents with the relevant staff member(s) and facilitate a reflective discussion about the incident and what could have been done differently etc.

Aileen Feeney, Non-Executive Director asked whether reviewing the CCTV footage of incidents would help with the Trust's work around improving the environment for neurodiverse patients.

The Medical Director reported that he also reviewed the CCTV footage of incidents with the mental health nurse and commented that all factors relating to an incident were reviewed, including whether there were too many people involved in an intervention and environmental factors etc.

Rebeca Burford, Non-Executive Director referred to the section on Patient Safety Reviews and noted that there were three pressure ulcer incidents where a "lapse in care" had been identified and asked whether there was any learning to prevent any similar lapses in care.

The Director of Nursing and Therapies said that in all cases where a lapse in care had been identified, there would be an individual action plan. The Director of Nursing and Therapies said that any learning would also be fed into the Trust wide Pressure Ulcer Improvement Plan.

The Committee noted the report.

5.4 Never Event Action Plan Update Report

The Director of Nursing and Therapies presented the paper and reported that the original clinical actions had been completed. The Director of Nursing and Therapies said that the Director of Estates and Facilities had acknowledged that his original timescales for completing the estates related actions had been optimistic especially as some of the PFI (Private Finance Initiatives) related actions required national and legal sign off. It was noted that the Director of Estates and Facilities was in the process of reviewing the timescales for the outstanding actions.

Action: Director of Estates and Facilities

The Chief Operating Officer paid tribute to the work of the Director of Estates and Facilities and his team who had worked extraordinarily hard to drive the required environmental changes in response to the Never Event.

The Committee noted the report.

5.5 National Patient Safety Strategy Implementation Report

The Deputy Director of Nursing presented the report and highlighted the following points:

- The Policy and Patient Safety Implementation plan was aligned to the national Patient Safety Framework and had been signed off both internally and externally and was now being used in place of the previous Serious Incident Framework.
- The implementation of the Patient Safety Partner role had been slow and presented significant challenges in Mental Health services. Health and wellbeing issues had to be carefully considered and how these individuals would be vetted and supported. Work was underway to identify opportunities for utilising the Patient Safety Partners in patient safety initiatives and reviews.
- Quarter 3 was very challenging because of the Learning from Patient Safety Events (LFPSE) implementation. There were incompatibility issues between LFPSE and the DATIX incident reporting system. The Risk Team and Patient Safety Team continued to work together to resolve the compatibility issues.

The Chair congratulated staff on their work in implementing the Patient Safety Strategy.

The Committee noted the report.

5.6 Quarterly Infection Prevention and Control Report

The Quarterly Infection Prevention and Control Report had been circulated.

The Chair reported that she had had a conversation with the Director of Nursing and Therapies about the national increase in the incidence of Measles.

The Director of Nursing and Therapies pointed out that there was a high number of Measles cases in the West Midlands and said that in response NHS England had required NHS trusts to complete an assurance template to confirm that action was being taken to reduce the risk of Measles infections.

Aileen Feeney, Non-Executive Director asked whether Measles affected both adults and children.

The Director of Nursing and Therapies confirmed that both adults and children could catch Measles but said that young children were most at risk of Measles complications. The Director of Nursing and Therapies added that unvaccinated staff who had contact with a patient or individuals who had contracted Measles were required to be off work for three weeks and therefore the Trust was encouraging all unvaccinated clinical staff to be vaccinated.

Ms Feeney asked about Measles vaccination take up rates for babies.

The Medical Director said that vaccination take up rates across the board had reduced following the COVID-19 pandemic.

The Director of Nursing and Therapies said that the Infection and Prevention Control Board Assurance Framework had been circulated with the paper and pointed out that during the COVID-10 pandemic, this paper had been presented to the Trust Board but going forward it would be submitted to the Committee.

The Chair said that it was a very comprehensive and informative report.

The Committee noted the report.

5.8 Quality Related BAF Risks Report

The Chair said that the Board Assurance Framework had been refreshed to ensure that the risks were aligned with the updated Trust Strategy. It was noted that two new quality related risks had been added:

- **Patient Experience and Voice** - There is a risk that that the Trust will fail to "hear the patient voice" and take account of patient experience when shaping, adapting and designing services
- **Reducing Health Inequalities** - Given the complexity of the determinants of health including non-health related factors, there are risks around delivering an ambitious programme of work aimed at reducing health inequalities given the long lead in time to see any improvements and outcomes impacted by factors outside of health and social care

The Director of Nursing and Therapies said that in respect of the patient voice risk, the Trust was keen to develop a more coherent approach to co-production. It was noted that the Trust had agreed to engage an external consultant to undertake a mapping exercise to identify areas where co-production was being used and to identify areas for improvement. Other actions included increasing the take up rate of the I Want Great Care Tool and developing the Lived Experience workforce.

The Chief Operating Officer added that there were a number of different tools and techniques for co-production. The Chief Operating Officer said that one of the lessons from the One Team Programme was that patients could have been involved at an earlier stage in the process.

The Chair asked where the outcome of the co-production mapping exercise would be reported.

The Director of Nursing and Therapies confirmed that a report would be presented to to the Quality and Improvement Executive Group for discussion and then the report would be presented to the Committee.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.8 Learning from Deaths Quarterly Report

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

- During quarter 3, 108 deaths had met the criteria to be reviewed by the Executive Mortality Review Group and the outcomes were as follows:
    - 61 were closed with no further action
    - 46 required a "second stage" review. 1 case was awaiting further information
- Of the second stage reviews concluded in quarter 3, none of the deaths were a governance cause for concern (avoidability score of 1,2 or 3).
- 13 reviews related to patients with a learning disability. All were reported in line with national guidance to LeDeR (Learning Disabilities Mortality Review) who completed independent reviews covering the full patient pathway
- This was the last report in the current format. From January 2024, the report would include all deaths rather than the Mortality Review process being separated from the Serious Incident Reporting process
- During quarter 3, the Medical Examiner had not raised any issues or concerns

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Chair welcomed Garyfallia Fountoulaki, Clinical Director Community Mental Health to the meeting.

The Medical Director reported that the following national clinical audit reports had been received and presented to the Clinical Effectiveness Group since the last meeting:

- POMH Topic 7g: Monitoring of patients prescribed lithium (2023)
- Sentinel Stroke National Audit Programme (SSNAP) 2023
- National Audit of Inpatient Falls and Fractures (NAIF)

a) Monitoring of Patients Prescribed Lithium

The Medical Director reported that the overall results of the audit were positive and showed improvement in 12 out of 13 areas since the last audit was undertaken in 2019.It was noted that an action plan had been developed to further improve the systematic recording of side effects and to ensure that all relevant blood monitoring tests were undertaken.

Dr Fountoulaki reported that the actions had nearly all been completed. It was noted that a presentation and training session on the Lithium Standard requirements would be given at the Academic Meeting scheduled to take place on 7 March 2024.

The Medical Director reported that work was being undertaken to see if the recording of blood tests could be automated on the system.

The Chair noted that the audit had highlighted that some patients were not informed about the side of effects of Lithium and asked whether this was a recording issue.

Dr Fountoulaki confirmed that there was a recording issue and said that the training session on 7 March 2024 would be used to remind clinicians about the requirement to provide both written and verbal communication and the need to document this. The Academic Meeting would also update staff on the use of the Lithium Side-Effect Rating Scale (LISERS) to support systematic reviewing of side-effects.

The Chair noted that five people with learning disabilities were included in the audit sample and commented that there was a national focus around ensuring that people with learning disabilities were not over medicated.

Dr Fountoulaki reported that there was a very easy read version of the leaflet explaining the side effects of Lithium for people with learning disabilities. The leaflet could also be translated into other languages.

b) Sentinel Stroke National Audit Programme

The Medical Director reported that the national report made five Key recommendations, of which three out of the five recommendations were relevant to the Neuro-Rehabilitation service in the Trust. The Neuro-Rehabilitation lead had completed a comprehensive review of the national recommendations and had identified areas for further improvement.

c) National Audit of Inpatient Falls and Fractures Summary Report

The Chair welcomed Jodie Holtham, Deputy Director of Allied Health Professionals to the meeting.

The Medical Director reported that the national report had made five recommendations based on national rather than Trust level data, all of which were relevant to Mental Health and Community Health Inpatient wards.

Jodie Holtham, Deputy Director of Allied Health Professionals said that the Trust's approach to reducing inpatient falls was around continuous improvement. Ms Holtham added that countermeasures such as the introduction of multi-factorial risk assessments for patients, the use of falls technology and post fall management had all contributed to reducing the number of inpatient falls at the Trust.

The Chair thanked Garyfallia Fountoulaki, Clinical Director Community Mental Health and Jodie Holtham, Deputy Director of Allied Health Professionals for attending the meeting.

The Committee noted the report.

6.1 Quality Accounts 2023-24 Quarter 3 Report

The Quality Accounts 2023-24 Quarter 3 Report had been circulated.

The Head of Clinical Effectiveness and Audit reminded the meeting that the Quality Accounts Quarter 3 Report would be the version shared with stakeholders including the Lead Governor and the Integrated Care Boards etc.

The Head of Clinical Effectiveness and Audit invited members of the Committee to forward her any comments on the draft Quarter 3 Report by Tuesday, 5 March 2024.

It was noted that the Quality Accounts Quarter 4 Report would be circulated to members of the Committee electronically for any final comments before being presented to the May 2024 Trust Board meeting for final approval.

The Committee noted the report.

7.0 Guardian of Safe Working Hours Quarterly Report

The Medical Director presented the paper and reported that during the reporting period (1 November 2023 to 6 February 2024) the Trust had received 17 exception reports.

The Medical Director reported that the increase in exception reporting this quarter had been analysed by the Guardian of Safe Working who had confirmed that the majority of the exception reports related to workload and prioritisation on one acute inpatient ward. A smaller number related to emergency work on one older adult inpatient ward and a couple were due to over-running of regional training.

It was noted that the Guardian and Head of Medical Workforce & Medical Education had identified several actions to mitigate some of the factors which had contributed to the exception reports.

The Head of Medical Workforce & Medical Education and the Guardian of Safe Working gave assurance to the Trust Board that no unsafe working hours had been identified, and no other patient safety issues requiring escalation had been identified.

The Committee noted the report.

7.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meeting held on 15 November 2023 had been circulated.

The Chair commented that the minutes were very comprehensive.

The Medical Director highlighted that the Health Inequalities (Detention Rates of Black Patients) project was in the audit phase which involved a significant amount of detailed work reviewing patient notes to ascertain whether or not detentions were appropriate in all cases and whether there was anything that could have been done to better support the patient prior to the detention.

The Chair noted that there was also a focus on Community Treatment Orders.

The Medical Director said that the MHA Office was regularly auditing services and processes around the Community Treatment Orders.

The Committee noted the minutes.

8.5 Quality and Performance Executive Group Minutes – November 2023, December 2023 and January 2024

The minutes of the Quality and Performance Executive Group minutes for November 2023, December 2023 and January 2024 had been circulated.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

The following Governor Service Visit Reports had been circulated:

- Neurodiversity Service (ADHD and Autism Assessment Team) - CFAA & Learning Disability
- Assessment and Rehabilitation Centre, St Marks Hospital

The Chair thanked the Governors for their reports.

The Committee noted the Governors' service visit reports.

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

The Chair said that it would be helpful for the Committee to receive a paper on the implications of "Martha's Law" for the Trust.

The Director of Nursing and Therapies said that the current requirements about seeking an urgent second opinion related to acute hospitals but agreed to present a paper to a future meeting on "Martha's Law" and what it would mean for the Trust in terms of deteriorating patients.

Action: Director of Nursing and Therapies

The Lead Clinical Director reported that following the decision by NHS England to close the Tavistock Gender Identity Development Service (GIDS) for children and young people at the end of March 2024, existing CAMHS services would be

responsible for reviewing those young people on the waiting list for the GIDS service who had an existing mental health problem.

The Chair asked whether this would include assessing for gender identity issues.

The Medical Director confirmed that the proposal was that the assessment would not include gender identity issues.

9.1. Any Other Business

National Patient Safety Alert issued in on 30 August 2023 following serious bed rail incidents

The Director of Nursing and Therapies reported that the Medicines and Healthcare Products Regulatory Agency (MHRA) had issued a national patient safety alert in September 2023 following a number of incidents relating to bedrails and associated equipment. Some of these had caused patient harm or death due to entrapment or falls.

The Director of Nursing and Therapies reported that the MHRA had issued updated guidance which required NHS provider organisations to risk assess all patients in the last three years who had been issued with a bed rail or bed stick by March 2024.

The Director of Nursing and Therapies said that this was a significant piece of work and said that the Trust would not be able to complete the work by the end of March 2024.

It was noted that most NHS provider organisations had indicated that they would not be able to complete the risk assessments by the deadline.

The Director of Nursing and Therapies said that she would present a paper on the implementation of the new bed rails and associated equipment to the next meeting of the Committee.

Action: Director of Nursing and Therapies

Aileen Feeney, Non-Executive Director asked whether the risk assessments needed to be completed face to face.

The Director of Nursing and Therapies confirmed that the initial risk assessments would need to be completed in patient's home.

Ms Feeney asked whether the issue needed to be added to the Quality Concerns Register.

The Director of Nursing and Therapies said that the February 2024 Quality and Performance Executive Group meeting had requested an update on the system approach to the MRHA bedrail alert for the March 2024 meeting. A decision would then be taken as to whether or not the issue needed to be included on the Quality Concerns Register.

Action: Director of Nursing and Therapies

9.2. Date of the Next Meeting

The next meeting was scheduled to take place on 28 May 2024 at 10am. The meeting would be held face to face at London House, Bracknell with the option of attending the meeting via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 27 February 2024.

Signed:-

Date: - 28 May 2024

Berkshire Healthcare
NHS Foundation Trust

Board Meeting Date	February 2024
Title	**Learning from Deaths Quarter 3 Report 2023/24**
	Item for assurance and noting. Discussion where additional assurance required about quality of care, data or learning.
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Format of the Report	The overall format of the report is not nationally prescribed, however there are a number of prescribed metrics detailed in Table 1 & Section 1.2 which are nationally mandated to be included within this report.
Business Area	Clinical Trust Wide
Author	Head of Clinical Effectiveness and Audit
Relevant Strategic Objectives	The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below: **Patient safety** We will reduce harm risk for our patients by continuous learning from review of deaths. **Patient experience and voice** We will review all complaints, concerns and feedback (from patient's families and staff, Medical Examiner, Coroner) to inform improvement in the quality and safety of clinical care in our services. **Health inequalities** We will reduce health inequalities for our most vulnerable patients (patients with learning disability, autism, severe mental illness) by reviewing the care provided to patients leading up to their death and learning for improvement.
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	None
Equality, Diversity and Inclusion Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths. We are currently reviewing the ethnicity data held which will be included in future analysis.
SUMMARY	Patient safety Of the second stage reviews concluded in quarter 3, none of the deaths were a governance cause for concern (avoidability score of 1,2 or 3). Patient Experience and Voice All complaints received from families of individuals who have died result in a second stage review of the care provided. Concerns raised by the medical examiner on behalf of the next of kin have also resulted in a review of the care provided. Health inequalities 13 reviews related to patients with a learning disability, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway.

	Learning themes arising from second stage reviews were identified for service improvement.
ACTION	The committee is asked to receive and note the Q3 learning from deaths.

Figure 1. Summary of Deaths and Reviews completed in 2023/24.

Figure 1	20/21 total	21/22 total	Total 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24	Total to date 23/24
Total deaths screened (Datix) 1st stage review	510	467	456	109	121	**108**		**338**
Total number of 2nd stage reviews requested (SJR/IFR/PSR)	269	209	192	50	48	**46**		**144**
Total number of deaths reported as serious incidents (from SI report)	48	35	31	8	8	**10**		**26**
Total Expected Deaths	-	-		46	51	**47**		**144**
Total Unexpected Deaths	-	-		63	70	**61**		**194**
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)	1	4	0	0	0	**0**		**0**
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	185	156	157	37	43	**29**		**109**
Total number of deaths of patients with a Learning Disability (1st stage reviews)	53	51	36	10	14	**14**		**38**
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	0	**0**		**0**

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

Total number of expected and unexpected deaths is a new additional metric for 2023/24

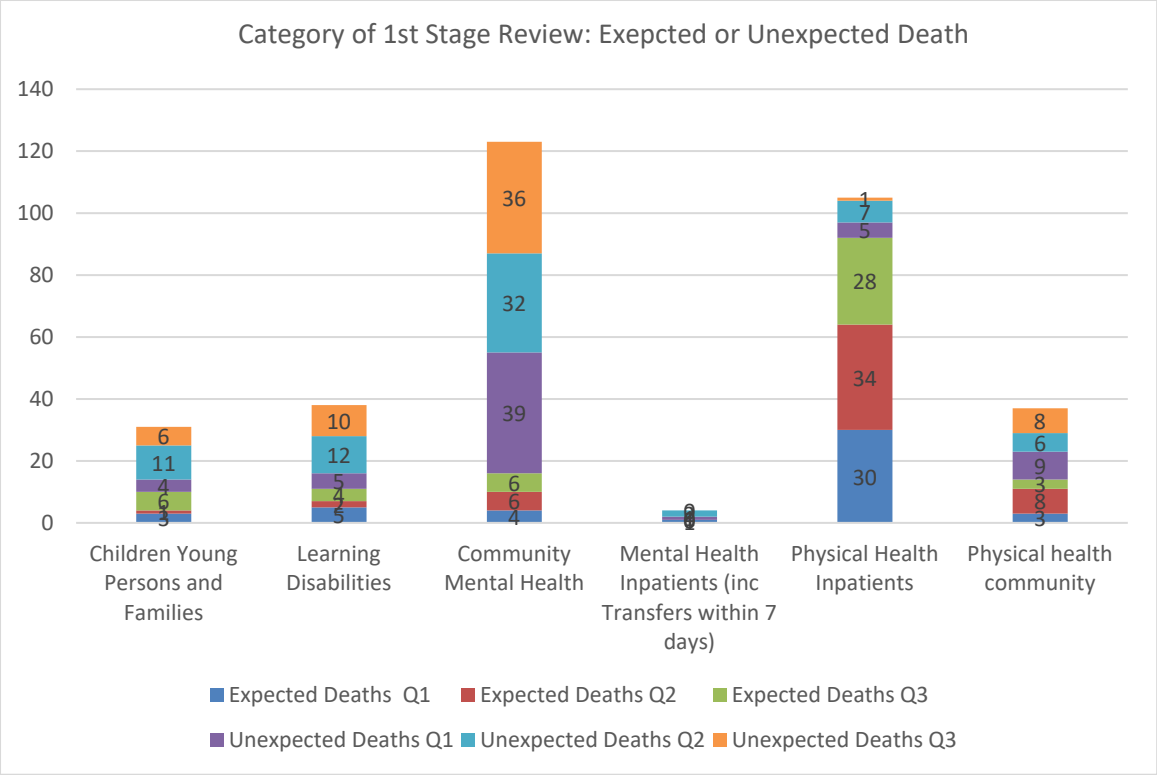
1.1Total Deaths Screened (1st stage review)

108 deaths were submitted by services through the trust Datix reporting system for a first stage review by the Executive Mortality Review Group (EMRG).

Of these 108 deaths reviewed, EMRG advised closing 61 cases, 46 were referred for a second stage review and 1 awaiting further information at the time of writing this report.

Figure 1 details the first stage reviews by division and whether the death was expected or unexpected based on the first stage review and cause of death.

Figure 1:



1.2. 2nd Stage Reviews Completed

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 32 second stage reviews have been received and considered by the group in Q3. Figure 3 details the service where the review was conducted.

Figure 3: 2nd Stage Reviews Completed in Q3

October 2023	5 SJR 0 IFR **5 Total**	Learning disability: 2 SJR Neurodiversity and Universal services: 1 SJR Urgent Care Services: 1 SJR Scheduled Care Services: 1 SJR
November 2023	14 SJR 2 IFR **16 Total** New Complaints: 1	Learning disability: 6 SJR Community Mental Health: 1 IFR, 2 SJR Mental Health Specialist Services: 1 IFR Urgent Care Services: 3 SJR(1 is combined SJR with MH service) Scheduled Care Services: 3 SJR (1 PMS completed)
December 2023	7 SJR 4 IFR **11 Total** New Complaints: 2	Learning disability: 5 SJR Community Mental Health: 2 IFR Mental Health Urgent Care: 2 IFR Urgent Care Services: 1 SJR Scheduled Care Services: 1 SJR

2. Concerns or Complaints

In Q3, 3 new complaints or concerns were received from families following the death of a relative and 2 concerns were raised by families to the Medical Examiner (See Medical Examiner Section)

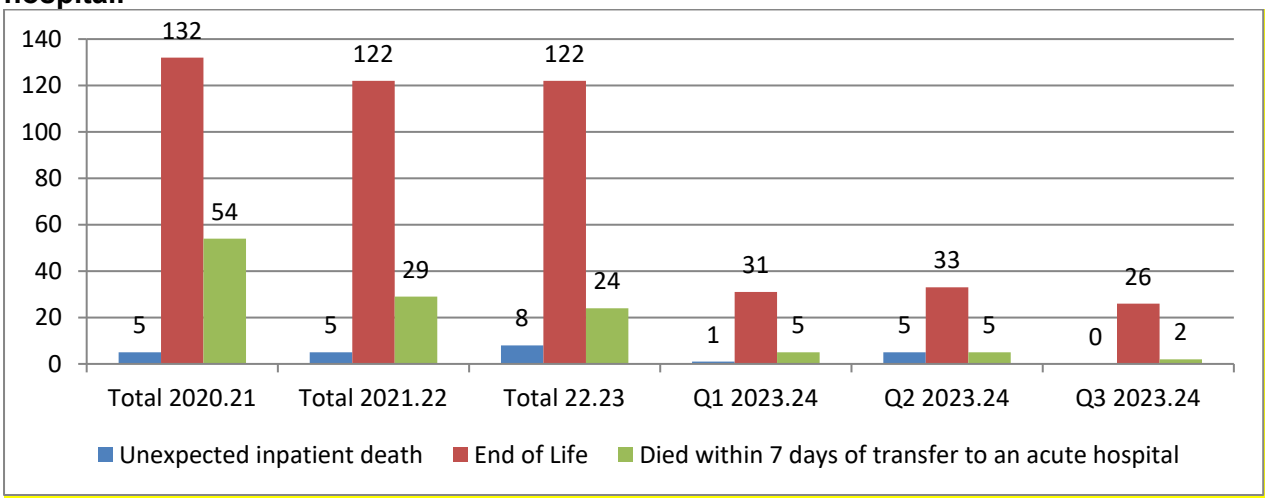
- District Nursing (End of life Clinical Care)
- Inpatient physical health (clinical care)
- Inpatient physical health (clinical care)

None of the complaint related SJR reviews at TMRG raised concern that the quality of care provided had contributed to the patient's death. Learning was noted and has been shared with relevant teams.

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

All inpatient deaths are reported on the Datix system, including patients who are expected to die and receiving palliative care and patient deaths following transfer to an acute hospital. Figure 3 details these.

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



In Q3 there were 28 deaths reported by community inpatient wards and no mental health inpatient deaths. of which:

- 26 were expected deaths and related to patients who were receiving end of life care (EOL) on our wards. 25 were closed at 1st stage review 1 SJR requested by Medical Examiner.
- 1 unexpected death due to ill health deterioration where they were transferred to an acute hospital and died within 7 days. Closed at first stage review.
- 1 transfer related to a patient on and end of life pathway and was an expected death.

3.3 Medical Examiner (ME)

All 26 inpatient deaths have been independently scrutinised by a Medical Examiner. The medical certificate of cause of death (MCCD) was agreed and processed for all (2 cases were referred by the ME to the coroner who agreed with the proposed cause of death (100a) one due to initial concerns by the family and one due to previous surgery).

The ME process allows for the Medical Examiner to also recommend cases for structured judgement review and notify us of any family concerns. 2 cases were identified for a structured judgement following next of kin concerns received by the ME:

- 1 physical health inpatient death, concern over care leading to death.
- 1 Concern raised about community mental health team and communication around changes to medication

4. Deaths of Children and Young People

In Q3, 12 deaths were submitted as a Datix for 1st stage review, 6 unexpected and 6 expected deaths.

Of the 6 unexpected deaths:

- 2 were closed at 1st stage review as the children died in an acute hospital related to physical health conditions.
- 4 will have 2nd stage reviews conducted of which 2 relate to potential suicide, 1 homicide and 1 sudden infant death.

The 6 expected deaths were all closed at 1st stage review and related to malignancy, complex needs or neurodegenerative disorders.

All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP).

5. Deaths of adults with a learning disability

In Q3 the Trust Mortality Review Group (TMRG) reviewed a total of 13 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 13 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the heart & circulatory system	3
Diseases of the respiratory system	4*
Other (Sepsis)	2
Other (Urosepsis)	1
Other (Parkinson's Disease Dementia)	1
Other (Dementia)	1
Advised that COD could not be given as it was not "clear cut".	1

1 case related to community acquired Covid 19

Demographics:

Gender:

Female	6
Male	7

Age:

The age at time of death ranged from 43 to 86 years of age (median age: 65 yrs.)

Severity of Learning Disability:

Mild	1
Severe	4
Profound	1
Not Known	7

Ethnicity:

White British	13

Engagement and feedback with family members

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

6. Deaths categorised as Serious Incidents

In Q3, 10 deaths were reported as serious incidents and met the criteria for further review (See SI Q3 report for details).

7. Avoidability of deaths scale/ score

Judging the level of the avoidability of a death is a complex assessment, for all deaths in physical health services where a second stage review is conducted, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made, this score is confirmed at TMRG.

- Score 1 Definitely avoidable
- Score 2 Strong evidence of avoidability
- Score 3 Probably avoidable (more than 50:50)
- Score 4 Possibly avoidable, but not very likely (less than 50:50)
- Score 5 Slight evidence of avoidability
- Score 6 Definitely not avoidable

A score of 3,2, or 1 would indicate a governance cause for concern. All deaths reviewed in Q3 were assessed as scoring a 4,5, or 6 and did not raise a governance concern, although this does not prevent learning from being identified when care could have been better.

8.Learning from Deaths

Immediate learning from all deaths is shared by Clinical Directors and Governance Leads through locality governance and quality meetings. Where the need for more focussed learning is identified following 2nd stage review, an Internal Learning Review is facilitated by the Patient Safety Team.

Learning themes are identified at each TMRG from second stage reviews, which are shared via the divisional governance meetings and in the trust clinical Circulation brief to all staff and also where relevant, with the ICS mortality review group for system learning.

Below details some of the key learning identified by services in Q3:

- Teams to ensure mental capacity assessments and risk summaries are formally recorded within the clinical record and that these are reviewed regularly and updated. In one case the reason for referral was for a mental capacity assessment relating to attending a CT scan. Whilst appropriate de-sensitisation work was offered, no formal recording of capacity could be found (learning disability service).
- Teams to ensure that referrals reflect all the professionals involved. This will enable the complexity of individuals, and the activity of professionals to be accurately recorded (learning disability service).
- When allocating a student to work with an individual, teams must ensure that the individual is also allocated to the student's mentor/supervisor (learning disability service).
- The importance of consistent levels of communication between both teams irrespective of whether the child is being cared for at home or in a hospice (Childrens and Young Persons).
- System learning regarding Advanced Care Plans being updated correctly (Childrens and Young Persons).
- Learning around safety planning for those with co-existing substance and alcohol disorders – 83% of people who died in the 6-cases had self-neglect and this was an area that we had not addressed previously in the safety plans. Work will be done with teams around signposting and helping people. There was also issue within that cohort around other mental health complexities being overshadowed by alcohol – 87% were refused a service because of their alcohol misuse.

Thematic learning on deaths from both the Trust Serious Incident process and mortality review for the year will be summarised in this report in Q4 2023/24.

9.Conclusion

During Q3 the executive mortality review group (EMRG) reviewed 108 first stage reviews of which 47 related to expected deaths and 61 were classed as unexpected. 46 2nd stage reviews were requested.

During Q3 the trust mortality review group (TMRG) received the findings of 32 2nd stage review reports. All hospital inpatient deaths were reviewed by a medical examiner.

All deaths of a physical health cause subject to a 2nd stage review were reviewed using an avoidability scale, and these reviews did not raise a governance cause for concern.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	February 2024
Title	Guardian of Safe Working Hours Quarterly Report (November 2023 to February 2024)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Authors	Ian Stephenson & Malar Sandilyan
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly Guardian of Safe Working report for consideration by Trust Board. This report focusses on the period the 1st of November 2023 to the 6th of February 2024. Since the last report to the Trust Board, we have received 17 exception reports. This increase in exception reporting this quarter has been analysed by the Guardian and the majority of the exception reports relate to workload and prioritisation on one acute inpatient ward. A smaller number relate to emergency work on one older adult inpatient ward and a couple due to over-run of regional training. The Guardian and Head of Medical Workforce & Medical Education have identified several actions to mitigate some of the factors which contribute to the exception reports. These actions are detailed in the report.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the report and actions suggested by the Head of Medical Workforce & Medical Education and the GOSW to mitigate the factors associated with increased exception reports.

QUARTERLY REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This report covers the period 1st November 2023 to the 6th of February 2024

Executive summary

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

This report focusses on the period the period 1st November 2023 to the 6th of February 2024. Since the last report to the Trust Board, we have received 16 '*hours & rest'* exception reports and one combined '*education and hours & rest*' report.

Introduction

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

High level data

Number of doctors in training (total):	51 (FY1 – ST6)
Number of doctors in training on 2016 TCS (total):	51
Amount of time available in job plan for guardian to do the role:	1PA
Admin support provided to the Guardian (if any):	Medical Staffing
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	17	13	4
Sexual Health	0	0	0	0
Total	0	17	13	4

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	9	7	2
CT	0	8	6	2
ST	0	0	0	0
Total	0	17	13	4

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry OOHs	0	5	4	1

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Total	2	2	9	4

In this period, we have received 17 exception reports.

Two reports arose from the overrun of the Oxford Postgraduate Psychiatry Course (OPPC) in Oxford, which frequently overruns. Trainees have been advised by the BMA to exception report it, as the travel time (from PPH to Oxford and return) is also included as work. This overrun is a recurrent problem, if not always reported, and over the years this has been discussed at the Medical Education Meetings and also brought to the attention of the School of Psychiatry who run the course. This issue will be raised again with the School.

The majority of the exception reports relate to workload and prioritisation in acute inpatient wards and out of hours on call; the GOSW has initially raised this with the relevant consultants to ascertain if this is addressed in supervision. The consultant assured the GOSW that these points have come up in supervision and the consultants have repeatedly asked trainees to hand over the pending work rather than stay back. As most of these reports are from a couple of inpatient wards at Prospect Park Hospital and to ensure that the cause is not more complex, the GOSW has scheduled further meetings with the relevant consultants. The GOSW has also suggested to the new trainees last week during their induction to make sure the trainees discuss the exception reports at the earliest opportunity with their clinical supervisor, so the issue can be addressed without delay. Trainees have also been made aware that exception reporting should not be used if they chose to stay beyond their scheduled working time, for example for any learning opportunities.

The GOSW will discuss this matter in the forthcoming Postgraduate Doctors Forum (PDF, formerly the Junior Doctors Forum (JDF)) to see if OOHs work is spilling over the scheduled finish time. If so, the Guardian will explore the reasons for this, from previous discussions they are generally acute emergencies that happen close to end of shift, often physical health related, that cannot be handed over but need immediate medical attention.

There are delays in addressing the exception reports beyond the recommended 7 days from date of submission, the GOSW has emailed the respective consultants to remind them to discuss and action the reports on DRS4 and will continue to do so. The GOSW will discuss this issue at the MSC meeting to remind consultants about prompt action on exception reports of their trainees.

Exception reporting is a neutral action and is encouraged by the Guardian and Director of Medical Education. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports.

It is the opinion of Medical Staffing and the Guardian of Safe Working that "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work.

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 1st Nov 2023 to 6th of Feb 2024)

Psychiatry	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
	88	84	55	29	0	875	847	582.5	264.5	0

Reason	Number of shifts requested	Number of shifts worked	Number of shifts worked by:			Number of hours requested	Number of hours worked	Number of hours worked by:		
			Bank	Trainee	Agency			Bank	Trainee	Agency
Gap	18	18	16	2	0	215	215	192	23	0
Sickness	70	66	39	27	0	660	632	390.5	241.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	88	84	55	29	0	875	847	582.5	264.5	0

d) **Fines**

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

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

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

Qualitative information

The OOH rota is currently operating at 1:14 and our system for cover works efficiently, with gaps generally being quickly filled. Our bank doctors continue to be an asset, and we continue to increase this pool. We had four unfilled gaps in this period. For these unfilled gaps, patient safety was not an issue and we always had one junior doctor on duty out of hours at Prospect Park Hospital.

Issues arising

The issues are detailed above on page 2 and involve workload on one inpatient ward, prioritization of tasks, admission of patients around handover time for day shift doctors and Oxford training course overruns.

Actions taken to resolve issues:

The GOSW is meeting with the relevant consultants and the trainees (postgraduate doctors forum) to engage them collectively in finding solutions to the issues identified. The Medical Director, GOSW and Head of Medical Staffing & Medical Education will have bi-monthly meetings to review reports and trends to ensure timely action going forward. The GOSW will request data from our neighboring mental health trusts to put our exception reporting figures and issues into context. The OPPC course overrun will be raised with the School of Psychiatry (Health Education England).

Next report to be submitted May 2024.

Summary

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

The Head of Medical Workforce & Medical Education and the GOSW give assurance to the Trust Board that no unsafe working hours have been identified, and no other patient safety issues requiring escalation have been identified.

Trainees are strongly encouraged to make exception reports by the Guardian at induction and at every Junior Doctor Forum. Junior Doctors are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the Trust.

Questions for consideration

The Head of Medical Workforce & Medical Education and the GOSW asks the Board to note the report and the proposed actions.

Report compiled by Ian Stephenson, Head of Medical Workforce & Medical Education and Dr Malar Babu Sandilyan, GOSW.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Executive Report**
	Item for Noting
Reason for the Report going to the Trust Board	The Executive Report is a standing item on the Trust Board agenda. This Executive Report updates the Trust Board on significant events since it last met. The Trust Board is requested to seek note the report and to seek any clarification on the issues covered in the report.
Business Area	Corporate Governance
Author	Chief Executive
Relevant Strategic Objectives	The Executive Report is relevant to all the Trust's Strategic Objectives

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 12 March 2024

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. Doctor and Nursing Training

The number of applications to nursing courses at UK universities has fallen sharply. The number of nurse student applicants fell by 7.4% in January 2024 compared with the previous year, according to data from UCAS.

Ministers have also delayed plans to double the number of doctors being trained in England by 2031. In June last year, ministers announced a long-term plan to expand the NHS workforce and among other things pledged, to double the number of medical school places. But a letter written jointly by the Health Minister Andrew Stephenson and the Minister for Skills, Apprenticeships and Higher Education, Robert Halfon, to the independent regulator the Office for Students, says that they will fund only 350 additional places for trainee doctors in 2025-26. This is less than a quarter of the annual number widely expected.

Executive Lead: Julian Emms, Chief Executive

3. Hospital Admissions for Eating Disorders

NHS data highlights that hospital admissions for eating disorders have risen by more than 50% since the first lockdown, with the greatest surge seen amongst young children. The figures show that there were almost 30,000 patients whose illness was so severe that they required inpatient treatment in 2022-23, compared with 19,000 before the pandemic.

Executive Lead: Julian Emms, Chief Executive

4. Dental Care

Dentists who set up practices in areas of England with poor access to NHS care will be offered a £20,000 bonus. The government has also announced higher payments for dentists who take on new patients and teeth-cleaning in schools as part of a plan to improve levels of dental care.

Executive Lead: Julian Emms, Chief Executive

5. NHS Funding

Analysis by the Institute for Fiscal Studies (IFS) shows NHS funding faces the biggest cuts in real terms since the 1970s.

The IFS analysis suggests that health spending in England is due to experience a 1.2% cut – worth £2bn – in the new financial year starting next month.

The health budget is to go from £168.2bn in 2023-24 to £166.2bn in 2024-25, after adjustment for inflation, in 2022-23 prices.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
12 March 2024

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	2023 National Staff Survey Results Report
	For Noting
Reason for the Report going to the Trust Board	The NHS Staff Survey is nationally mandated. The 2023 National Staff Survey results are summarised in the paper. Our results have remained high, achieving top scores in many areas and seen statistically significant improvements across 28 questions and 5 people promise elements/themes. Our Staff Engagement remains at the top of our peer group (7.45 score) for the fourth year. As we work towards our vision of being a great place to get care, a great place to give care, it's encouraging that we received the top scores for 'care of patients is my organisation's top priority', and 'I would recommend my organisation as a place to work'. Our response rate has increased by another 2% points to 67% representing an additional 250 replies. While all of this is good news, there's still much more to do to make this an outstanding place to work for everyone. The results show we need to continue our focus on reducing the inequalities and negative experiences faced by ethnically diverse, LGBTQ+ and disabled colleagues. New questions around experience on sexual safety and access to nutritious food show that we're doing better than average but there's still a gap to close to get the best scores.

Business Area	Workforce
Author	Jane Nicholson, Director of People
Relevant Strategic Objectives	**Workforce** **Ambition:** We will make the Trust a great place to work for everyone

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Making Berkshire Healthcare…

a great place to give care

National staff survey results: 2023

CareQuality Commission Inspected and rated Outstanding

Berkshire Healthcare Charity Reg. charity 1049733

disability confident LEADER

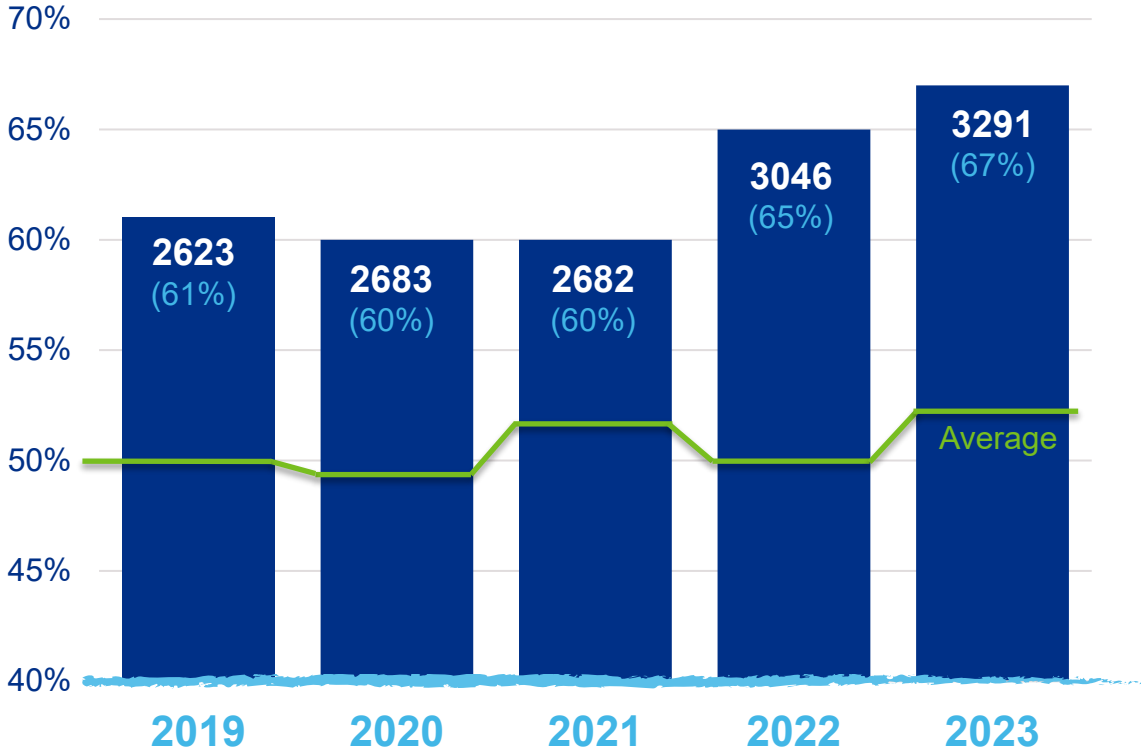
VETERAN AWARE

Stonewall LGBTQ+ INCLUSIVE EMPLOYER TOP 100 2023

Steph Moakes

National staff survey response rates – year on year

Berkshire Healthcare NHS Foundation Trust

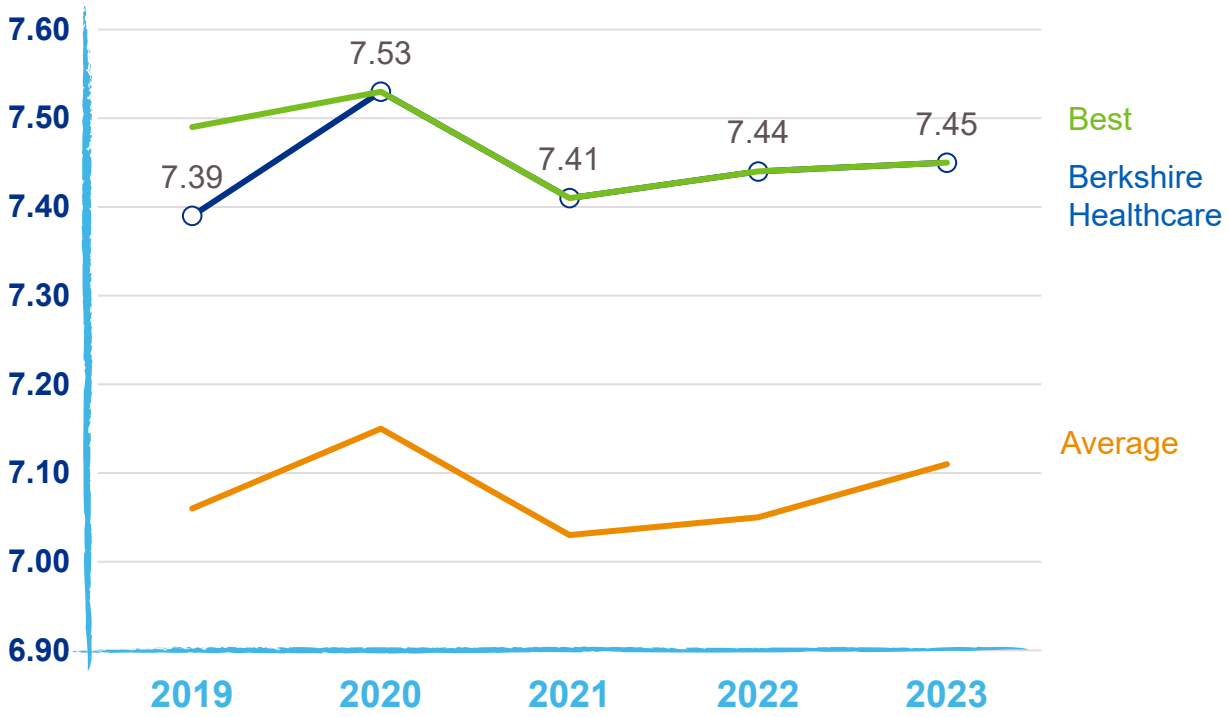


In 2023 **67%** of you took the time to tell us what it feels like to work here. Thank you!

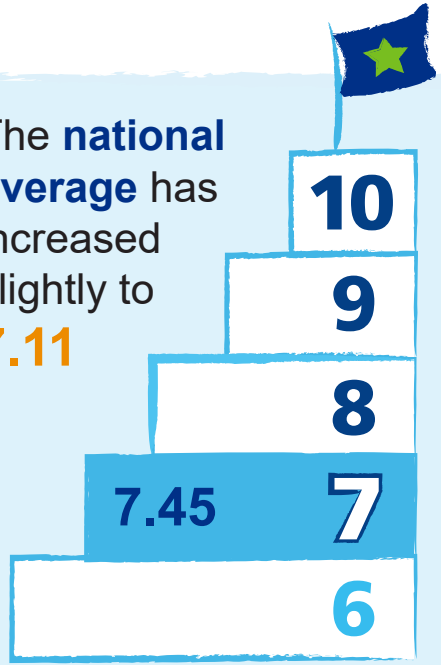
We remain **15% points above the average response rate** for 51 Mental Health / Learning Disability and Community combined Trusts (52%).

Overall engagement score

Our overall engagement score is now **7.45.** We are still achieving the **best score for our group** and have maintained this for 4 years.



The **national average** has increased slightly to **7.11**



(10 being the highest score available)

Overall engagement score

– how it's calculated

Berkshire Healthcare NHS Foundation Trust

The overall staff engagement score is calculated as an average of the three grouped scores on **"Motivation"**, **"Advocacy"** and **"Involvement"**

NHS National Staff Survey			Berkshire Healthcare		
EEI	Qs	Statement	2021	2022	2023
Motivation	2a	Often/always look forward to going to work	61.4%	63.8%	63%
	2b	Often/always enthusiastic about my job	74.1%	75.2%	74.3%
	2c	Time often/always passes quickly when I am working	79.7%	80.5%	77.8%
Advocacy ★	18a	Care of patients/service users is organisation's top priority	86.5%	86.4%	88%
	18c	Would recommend organisation as a place to work	73.6%	73%	75.4%
	18d	If friends or relatives needed treatment, would be happy with the standard of care provided by organisation	76.9%	76.5%	77.6%
Involvement	4a	Opportunities to show initiative in my role	77.2%	79.9%	79.1%
	4b	Able to make suggestions to improve the work of team/dept	80.3%	80%	81.1%
	4d	Able to make improvements happen in my area of work	65.1%	65.1%	65.9%
Response rate			60%	65%	67%

Staff survey results – themes

Berkshire Healthcare NHS Foundation Trust

The **nine themes** from the survey reflect the **People Promise**, along with **Staff Engagement and Morale**.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff engagement	Staff morale
Your org	7.80	6.60	7.27	6.56	6.33	7.09	7.34	7.45	6.42
Best result	7.93	6.90	7.34	6.68	6.45	7.25	7.47	7.45	6.61
Average result	7.58	6.41	7.01	6.38	5.93	6.84	7.18	7.11	6.17
Worst result	7.14	6.04	6.23	5.84	5.17	6.23	6.90	6.46	5.21
Responses	3283	3281	3254	3263	3142	3269	3283	3282	3283

Our scores are **above average** for combined Trusts in **all ten themes.**

Key:

Top score

Statistically significant improvement

Headlines – top scoring questions

Berkshire Healthcare NHS Foundation Trust

We've got the top score on this question for the last 5 years…

	Average	Our Top Score!
Care of patients is my organisations top concern	79.5%	88%
My organisation acts on concerns raised by patients / service users	75.8%	85.5%
I would recommend my organisation as a place to work	65.6%	75.4%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	53.2%	48.6%
My organisation is committed to helping me balance my work and home life	59.3%	67.4%
The team I work in has a set of shared objectives	77.1%	83.5%
I have adequate materials, supplies and equipment to do my work	64.3%	74%

…and this one for the last 6 years

Significant improvements

Berkshire Healthcare NHS Foundation Trust

We saw a **statistically significant improvement in 28 questions** compared to 2022 – last year, there were only three.

		2022	2023
Burnout sub-score	**Often/always find work emotionally exhausting**	33.8%	**31.2%**
	Often/always feel burnt out because of work	25.6%	**23.7%**
	Often/always frustrated by work	30.7%	**27%**
	Often/always exhausted by the thought of another day/shift at work	22.4%	**20.9%**
	Often/always worn out at the end of work	36.8%	**35.9%**
Recognised & rewarded sub-score	**Satisfied with recognition for good work**	63.9%	**66.8%**
	Satisfied with extent organisation values my work	58.6%	**61.2%**
	Satisfied with level of pay	29.4%	**34.9%**

Significant improvement (cont.)

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		2022	2023
Health & Safety Climate sub-score	Able to meet conflicting demands on my time at work	47%	**50.6%**
	Enough staff at organisation to do my job properly	34.1%	**40%**
Work Pressures sub-score	Never/rarely have unrealistic time pressures	26.4%	**29%**
Appraisals sub-score	Received appraisal in the past 12 months	91.9%	**93.6%**
	Appraisal helped me improve how I do my job	25.5%	**28.3%**
	Appraisal helped me agree clear objectives for my work	37%	**40.7%**
Negative experiences sub-score	Have experienced musculoskeletal (MSK) problems as a result of work activities (last 12 months)	26.3%	**24.5%**
	Have felt unwell due to work related stress (last 12 months)	38.9%	**35.8%**
	Have come to work when not feeling well enough to perform duties (last 3 months)	51.5%	**48.6%**

Significant declines

Across all the questions asked in both 2022 and 2023, there were three that saw a **statistically significant decrease** since last year.

	2022	2023
Time often/always passes quickly when I am working	80.5%	**77.8%**
Feel a strong personal attachment to my team	70.7%	**68.2%**
Would feel confident that organisation would address concerns about unsafe clinical practice	73%	**70.6%**

Workforce Race Equality Standard (WRES)

The experience of our black and ethnic minority colleagues is **considerably poorer** than those who are white, and **this is not acceptable**.

REN Race Equality Network

NHS Berkshire Healthcare NHS Foundation Trust

	Question		2021	2022	2023
5	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the general public in the last 12 months	White	19.9%	18.5%	17.1%
		BAME	**29.4%**	**29.4%**	**26.7%**
6	Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	White	14.1%	15.4%	13.7%
		BAME	**22.9%**	**20.8%**	**20.4%**
7	Percentage believing that the trust provides equal opportunities for career progression or promotion	White	67.5%	68.1%	68.4%
		BAME	**45.7%**	**51.7%**	**53.2%**
8	In the last 12 months, have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White	5.3%	5.2%	5%
		BAME	**14.5%**	**13.3%**	**13.3%**

We continue to see positive trends across the WRES staff survey indicators. The past 3 years have shown between a 0.7% and 7.3% improvement for our ethnically diverse colleagues across all indicators. Our scores remain better than average.

Despite this, the inequality remains and is why we have made a commitment to become an anti-racist organisation

Workforce Disability Equality Standard (WDES)

NHS
Berkshire Healthcare
NHS Foundation Trust

The experience of colleagues with disabilities is **considerably poorer** than those without, and **this is not acceptable**.

Question		2021	2022	2023
4a Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the general public in the last 12 months	Non-disabled	20%	19.8%	18.1%
	Disabled	**30%**	**26.8%**	**24.5%**
4c Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Non-disabled	11.1%	11.5%	10.5%
	Disabled	**19.3%**	**18.1%**	**17.1%**
5 Percentage believing that the trust provides equal opportunities for career progression or promotion	Non-disabled	64.3%	64.5%	66%
	Disabled	**52.9%**	**60.6%**	**57.8%**
6 Percentage of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	Non-disabled	16.3%	16%	14.3%
	Disabled	**19.8%**	**22.5%**	**22.3%**
7 Percentage of staff satisfied with the extent to which their organisation values their work	Non-disabled	61.1%	61.4%	64.2%
	Disabled	**51.6%**	**51.9%**	**53.8%**

Over the past 3 years, we have seen positive trends across 7 of the WDES staff survey indicator, 1 decline and 1 that has seen no change.

We are scoring better than average in 7 of the 9 indicators.

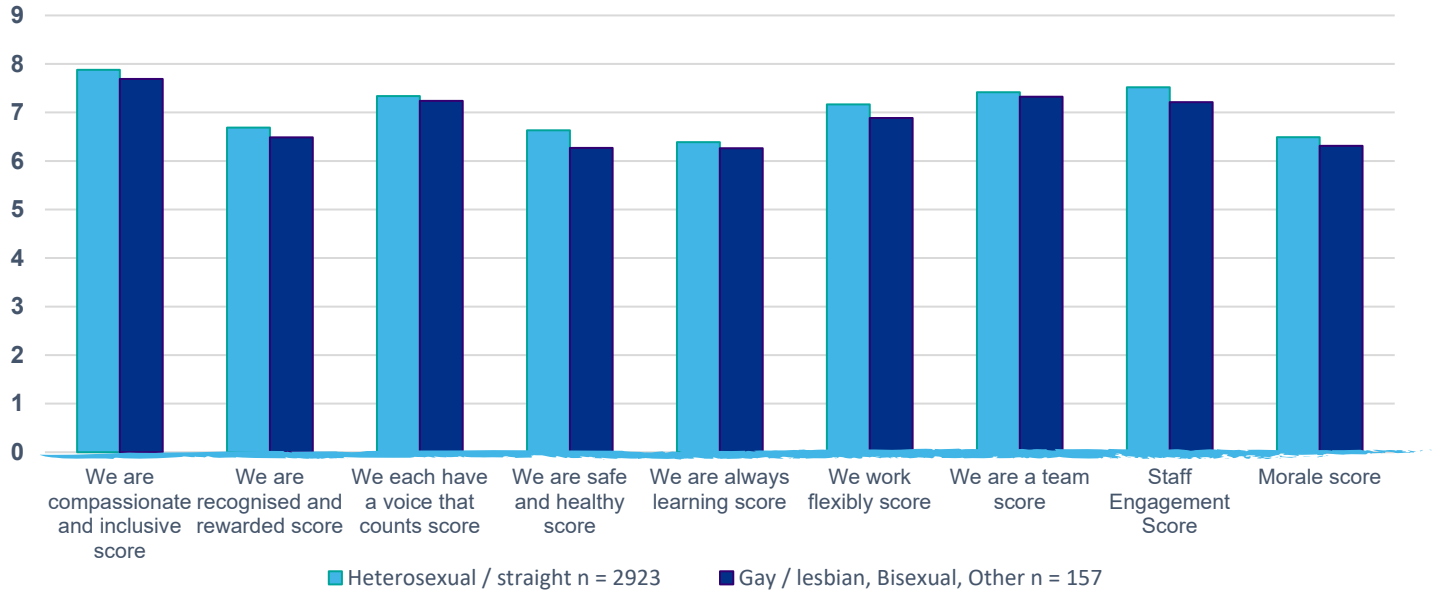
As with ethnicity, **inequalities remain.**

PURPLE Network

disability confident LEADER

Sexual orientation

The report indicates that colleagues who identify as gay/ lesbian/ bisexual/ other have a **poorer experience** compared to their heterosexual/straight colleagues, **this is not acceptable.**



A further 5.5% (183) of respondents did not want to share their sexual orientation.

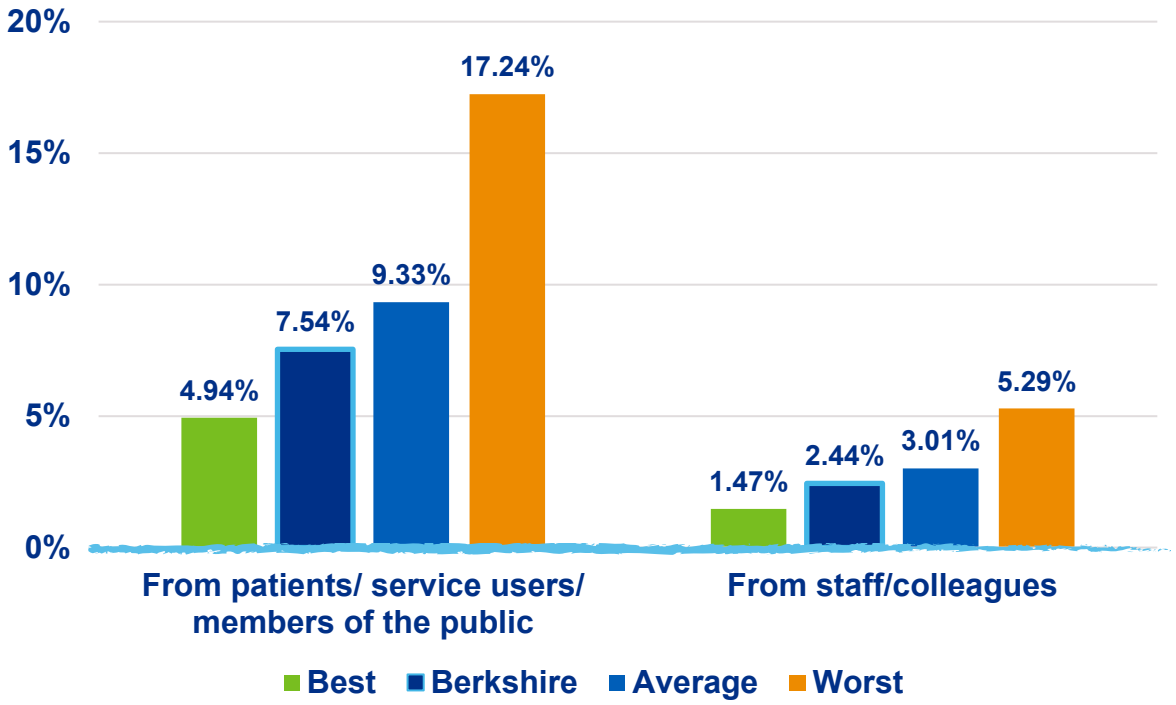
Over the past year, the experience of our LGB colleagues has improved across all elements/themes and most sub-scores by an average of 0.32.

Despite this, the inequality remains.

Sexual safety

Berkshire Healthcare NHS Foundation Trust

This year, the survey included new questions around sexual safety in the workplace



Our results show that we're above average but still have work to do to move us to the best. We can see some inequalities in results for those with protected characteristics.

To support improvements, we have signed the **NHS Sexual Safety Charter**. This means we are committed to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours within the workplace, and to implement ten commitments by July 2024.

Focus areas

Berkshire Healthcare NHS Foundation Trust

This year showed another strong set of results, which have improved in many areas. This indicates that work has happened over the past year and projects that are ongoing are having a positive impact.

We are focused on continuing work that impacts on staff experience including:

- Anti-racism workstream
- Big Conversations and Bright Ideas
- Violence prevention and reduction
- NHS Sexual Safety Charter workstream
- Refreshed Leadership, and team development support

We also want to target support to the service areas who need it most. Divisional management teams are looking at the results and discussing next steps and action plans.

Next steps…

NHS
Berkshire Healthcare
NHS Foundation Trust

The results have been shared in an email from Julian, as well as on the All Staff Briefing on the Thursday 21 March.

We have also shared the information with our **Staff Networks and unions** and will be supporting them with next steps and actions.

The most important action for our leaders and managers is to **review the results with your team** and look at what actions you can take to improve experiences locally.

The top-level results are live on **Nexus** along with this presentation, with some additional slides containing prompts about how to discuss the results with your teams. If you need further breakdown, please contact **Steph Moakes** or **Hardip Johal**.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Finance Report January 2024**
	The paper is for noting.
Reason for the Report going to the Trust Board	This is a regular report which provides an update to the Board on the Trust's Financial Performance.
Business Area	Finance
Author	Chief Finance Officer
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value The report gives an overview of the Trust's financial performance including use of revenue and capital funding and delivery against the cost improvement programme. The Trust's results contribute to the performance of BOB ICS.

Berkshire Healthcare NHS
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year 2023/24

January 2024

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 January 2024.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	07/02/24	Rebecca Clegg	Draft
2.0	07/02/24	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Confidentiality

Where indicated by its security classification above, this document includes confidential or commercially sensitive information and may not be disclosed in whole or in part, other than to the party or parties for whom it is intended, without the express written permission of an authorised representative of Berkshire Healthcare NHS Foundation Trust.

Dashboard & Summary Narrative

Target		Year to Date			Forecast Outturn		
		Actual	Plan		Forecast	Plan	
		£m	£m	Achieved	£m	£m	Achieved
1a	Income and Expenditure Plan	2.1	0.1	Yes	3.8	1.3	Yes
2a	CIP - Identification of Schemes	12.3	14.1	No	14.1	14.1	Yes
2b	CIP - Delivery of Identified Schemes	10.7	10.7	Yes	14.1	14.1	Yes
3a	Cash Balance	54.9	50.6	Yes	48.1	48.1	Yes
3b	Better Payment Practice Code Volume Non-NHS	96%	95%	Yes	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	94%	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	97%	95%	Yes	95%	95%	Yes
4f	Capital Expenditure not exceeding CDEL	5.9	7.5	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 £2.1m surplus year to date, which is £1.9m better than planned. The year to date position includes £0.6m of additional income which is the Trust's share of the additional £800m made available nationally to help bridge the financial gap caused by industrial action. As a result of the change of accounting treatment for PFI liabilities we have also included a £0.4m reduction in PDC dividend but await further guidance from NHSE as to whether this should be an adjustment to our performance.

- We have increased our forecast outturn surplus to £3.8m following receipt of £0.6m industrial action funding and agreement of £1.3m of elective over performance funding. The forecast also assumes £0.7m of benefit through reduced PDC dividend and depreciation from a project to review the PFI asset values.

- Delivery against the cost improvement plan is on track linked to control total compliance. However, we have significant variances MH inpatient staffing for which remedial action is underway to improve the run rate into 24/25.

- The 23/24 Agenda for Change and Doctors pay awards have been made. 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.

- Cash is now above plan with ICB cash payments in line with contracts.

- Our BPPC continues to improve with the % of non-NHS invoices paid within the deadline now above the target and the value of invoices paid continuing to improve each month.

- Capital is underspent against plan year to date mainly due to the phasing of estates projects but with planned expenditure to utilised the CDEL element of the plan by the end of the year. 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

Jan-24	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2023/24 Plan £'m
Operating Income	30.3	29.6	0.7	294.9	291.9	3.0	351.0
Elective Recovery Fund	1.5	0.3	1.2	4.6	3.3	1.3	4.0
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**31.8**	**29.9**	1.9	**299.5**	**295.2**	4.3	**355.0**
Staff In Post	20.0	20.3	0.2	193.1	200.5	7.4	241.2
Bank Spend	2.7	1.6	(1.0)	21.9	17.1	(4.7)	20.3
Agency Spend	0.7	0.4	(0.3)	7.0	4.3	(2.7)	5.1
Total Pay	**23.4**	**22.3**	**(1.1)**	**221.9**	**222.0**	**0.0**	**266.5**
Purchase of Healthcare	1.7	1.6	(0.0)	18.3	17.6	(0.7)	20.6
Drugs	0.5	0.5	(0.1)	5.3	4.5	(0.8)	5.4
Premises	1.4	1.5	0.1	14.1	15.4	1.3	18.5
Other Non Pay	2.2	1.5	(0.7)	18.1	14.9	(3.2)	17.9
PFI Lease	0.7	0.8	0.1	7.0	7.5	0.5	9.0
Total Non Pay	**6.5**	**5.9**	**(0.6)**	**62.9**	**59.9**	**(3.0)**	**71.4**
Total Operating Costs	**29.8**	**28.1**	**(1.7)**	**284.9**	**281.9**	**(2.9)**	**337.9**
EBITDA	**1.9**	**1.8**	**0.1**	**14.6**	**13.3**	**1.3**	**17.1**
Interest (Net)	0.0	0.2	0.2	6.3	2.5	(3.8)	3.0
Depreciation	0.9	0.9	(0.0)	9.3	9.0	(0.4)	10.7
Impairments	0.0	0.0	(0.0)	0.2	0.0	(0.2)	0.0
Disposals	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0
PDC	0.2	0.2	0.0	1.2	1.8	0.6	2.2
Total Financing	**1.1**	**1.3**	**0.2**	**17.0**	**13.2**	**(3.8)**	**15.9**
Reported Surplus/ (Deficit)	**0.8**	**0.5**	**0.4**	**(2.4)**	**0.1**	**(2.5)**	**1.2**
Adjustments	**0.0**	**0.0**	**0.0**	**0.1**	**0.1**	**0.0**	**0.1**
PFI IFRS16 Adjustment	**(0.2)**	**0.0**	**(0.2)**	**4.4**	**0.0**	**4.4**	**0.0**
Adjusted Surplus/ (Deficit)	**0.7**	**0.5**	**0.2**	**2.1**	**0.1**	**1.9**	**1.3**

Key Messages

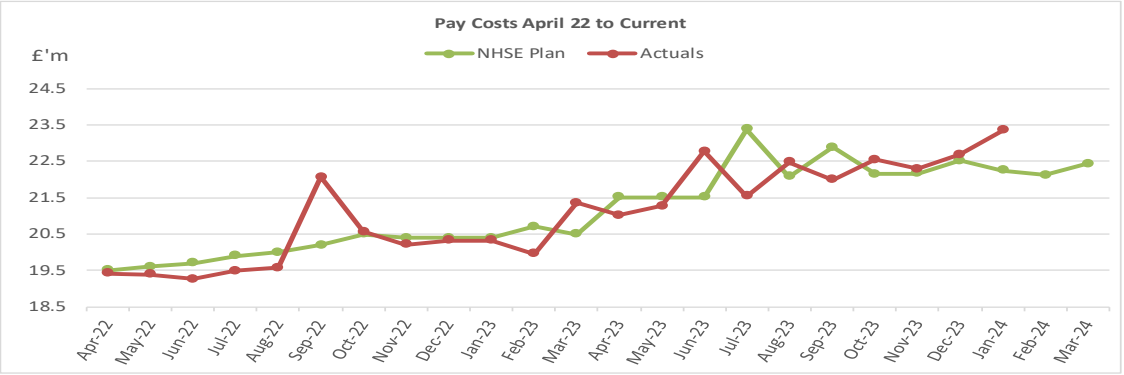
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 January 2023.

At Month 10, the Trust is reporting a £2.1m surplus year to date which is £1.9m better than plan. The increased surplus year to date is the result of additional income for elective recovery (£1.3m) and for industrial action (£0.6m). The Trust is also expecting to have a reduced PDC dividend and depreciation charge as a result of work on the valuation of the PFI assets which is being undertaken as a BOB ICS efficiency project and which will be realised in month 12. These variances mean that the Trust can now forecast a £3.8m surplus as a contribution to improving the forecast outturn of BOB ICS.

Without the non-recurrent income, the Trust would have a small surplus year to date and a £0.5m deficit in month which is the result of continued overspend on MH inpatient staffing.

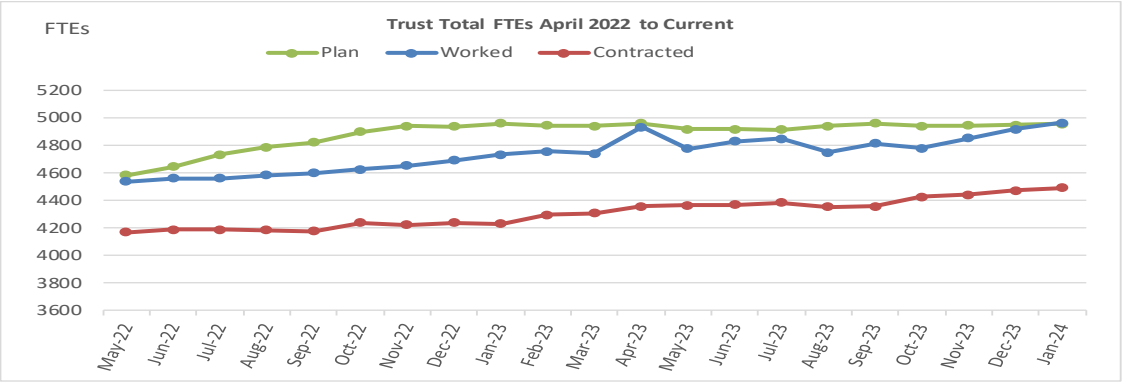
Amendments to the accounting treatment of the PFI liabilities which happened at month 9 have also resulted in a reduction of £0.4m on the PDC dividend. This is reflected in the year to date position but not the forecast outturn. Further guidance is expected from NHSE on the treatment of this PDC dividend reduction.

Workforce



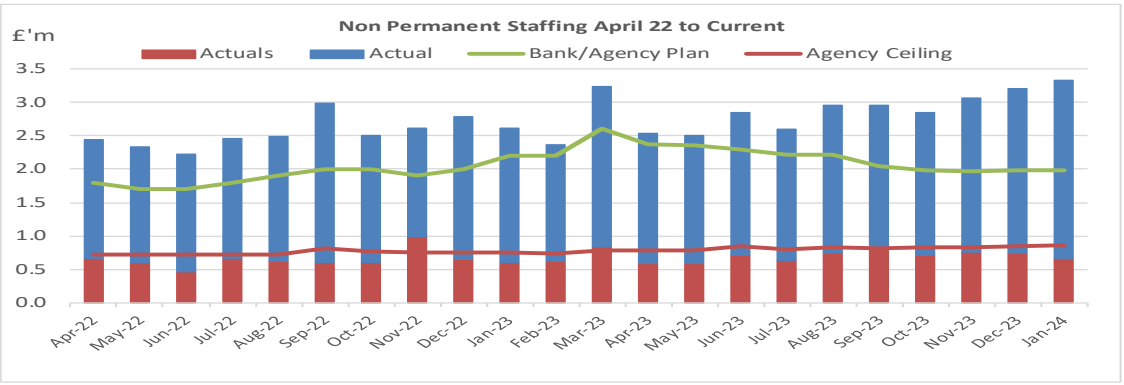
Staff Costs

YTD	£'m
2023/24	221.9
2022/23	200.6
▲	11%
Prior Yr	**£'m**
Jan-24	23.4
Jan-23	20.3
▲	15%



FTE's

Prioir Mth	CFTE	WFTE
Jan-24	4,552	5,099
Dec-23	4,496	4,967
	1% ▲	3% ▲
Prior Yr		
Jan-24	4,552	5,099
Jan-23	4,297	4,760
	6% ▲	7% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2023/24	21.9	7.0
2022/23	19.0	6.5
	15% ▲	8% ▲
Prior Yr	**£'m**	**£'m**
Jan-24	2.7	0.7
Jan-23	2.0	0.6
	32% ▲	12% ▲

Key Messages

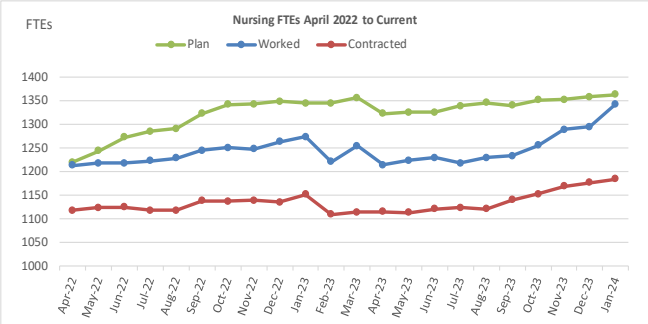
Pay costs in month were £23.4m which includes bank and agency cover for the January bank holiday.

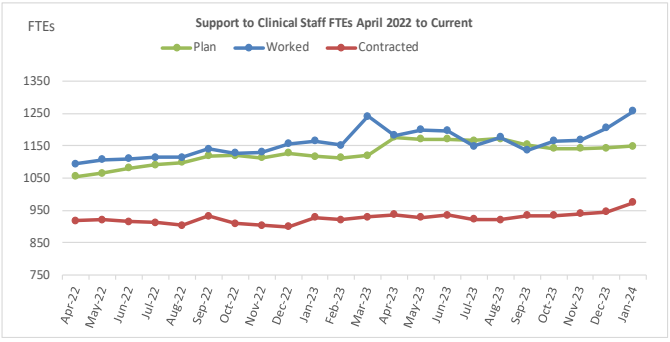
We are continuing to offset some vacancies with higher levels of temporary staffing although actuals are much closer to plan year to date than in the previous year, in part due to the work undertaken to align financial and workforce planning. The underspend on substantive staffing is also offsetting the cost pressure caused by the higher than plan pay award. The cost pressure is a £1m full year effect offset in part by vacancies in year.

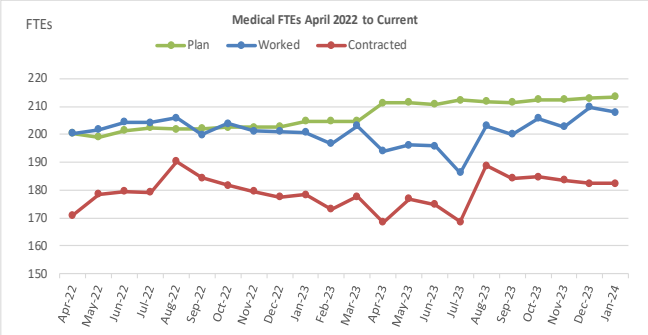
We are operating below the NHSE System Agency Ceiling of 3.7%, currently running at 3.2% of overall pay costs YTD but with costs running close to the ceiling in recent months. Agency price cap breaches, although low compared to other trusts, are being reviewed.

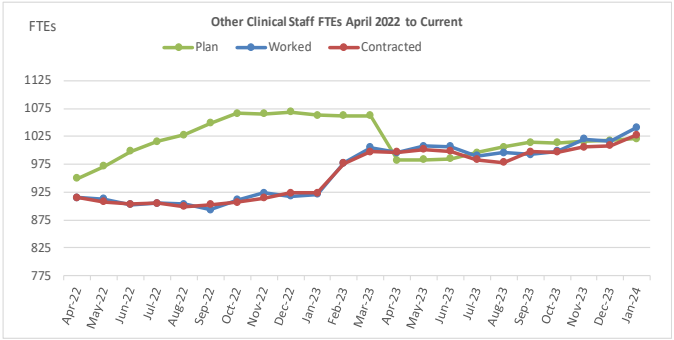
In month, we have seen an increase in contracted WTEs (56). Some of the increase is funded from specific investment income. The increased WTEs includes 11 CAMHS IAPT trainees.

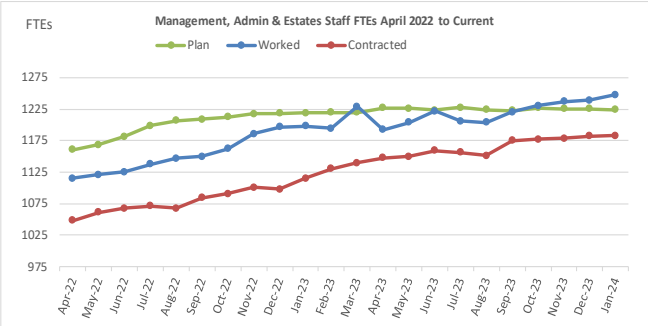
Staff Detail









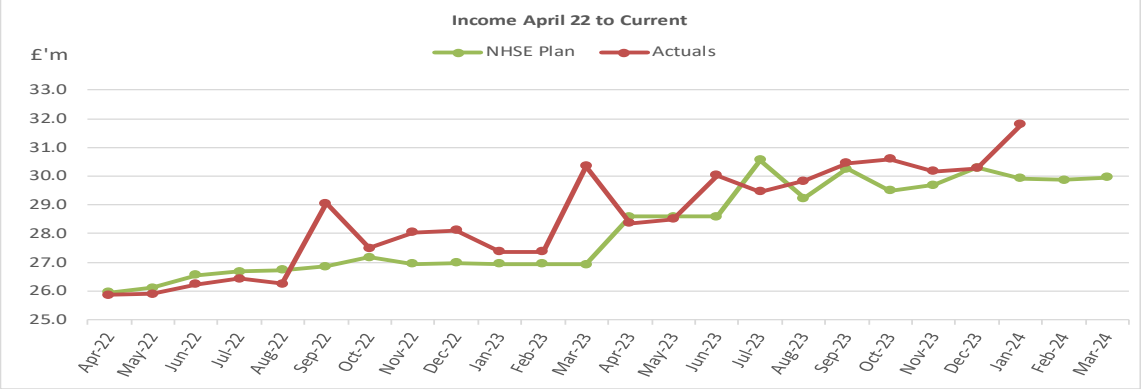


Key Messages

Worked WTE actuals are much closer to plan in 2023/24 than in the previous year due to the reset of control totals at the start of the year.

We are still seeing a gap between worked and contracted WTEs for some graphs which highlights the continued use of agency and bank above planned levels.

Income & Non Pay



Income

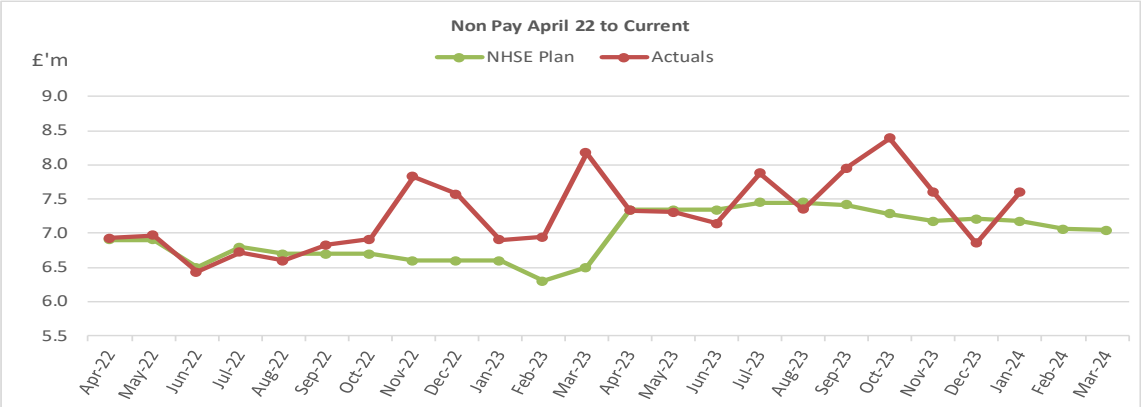
YTD	£'m
2023/24	299.5
2022/23	270.8
▲	11%
Prior Yr	**£'m**
Jan-24	31.8
Jan-23	27.4
▲	16%

Key Messages

In response to the impact of industrial action, NHSE have reduced the average level of activity increase required to maintain ERF payments by 4%. As part of the work to improve the forecast outturn of BOB ICB a final position on elective over performance has been agreed with BOB ICB and therefore £1.2m of additional income has been included in the month 10 position, with a further £0.1m having already been included earlier in the year. The Trust has received additional income of £0.5m from the £800m made available nationally to assist Trust's with the financial challenges caused by industrial action and this is reflected in the year to date position.

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 £1.8m year to date in interest over the planned levels.



Non Pay

YTD	£'m
2023/24	75.4
2022/23	69.7
▲	8%
Prior Yr	**£'m**
Jan-24	7.6
Jan-23	6.9
▲	10%

Key Messages

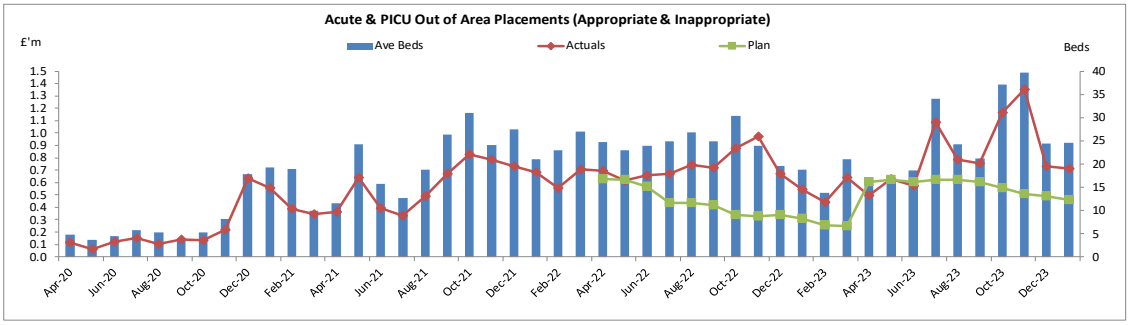
Non Pay spend was £7.6m in month. The chart has been amended to take out the adjustments related to the changes to the accounting treatment of the PFIs under IFRS16.

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.

An additional specialist placement was added to the non-pay spend including back dated costs of £400k.

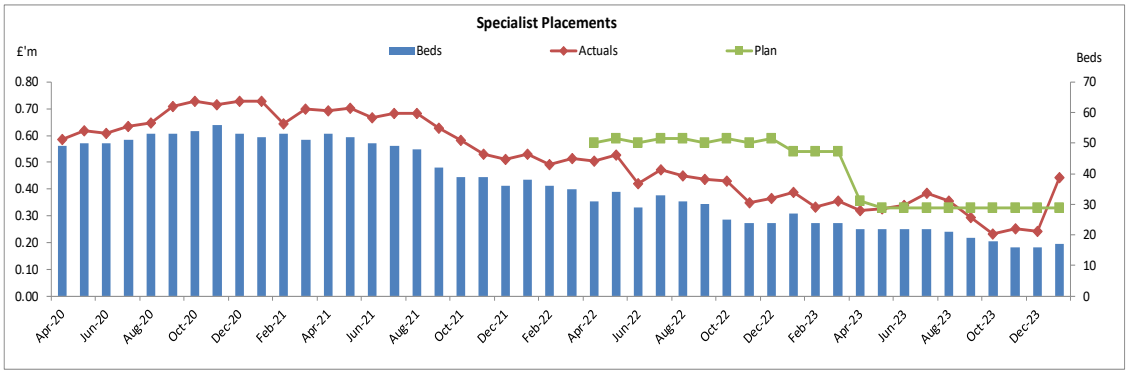
We have offset some of the non-pay overspends with balance sheet release which was included in the plan.

Placement Costs



OAPs

YTD	£'m
2023/24	8.3
2022/23	7.2
▲	*16%*
Prior Yr	**£'m**
Jan-24	0.7
Jan-23	0.5
▲	*32%*



Specialist Placements

YTD	£'m
2023/24	3.2
2022/23	4.3
▼	*-27%*
Prior Yr	**£'m**
Jan-24	0.4
Jan-23	0.4
▲	*14%*

Key Messages

Out of Area Placements. The average number of placements has remained stable with 24 in December and 25 in January. 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 have remained stable at £0.7m.

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. Several of the patients with very long LOS are patients who were in long term specialist placements but have had to return to an acute or PICU bed due to a deterioration in mental state.

Following a paper to board the acute bed base at PPH has been reduced from 86 to 80 and there are plans to reduce this down to 72 beds from Q3 in 2024/25. These beds will be reprovisioned to provide an overall acute bed base of 90 beds. We currently have 91 made up of 80 at PPH and 11 commissioned on a block booked basis. Additionally, we have 3 male discharge to assess beds to support flow from PHH when patients are CRFD but a placement or support package is delayed.

Specialist Placements. The average number of placements have increase from 16 to 17 following notification from Frimley ICB that the Trust had not been charged for an existing long term placement. Additional cost of £400k has been accrued and further work is being undertaken to ensure that any liability that the Trust has, is captured in 2023/24.

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	0	227	-227	1,064	1,975	-911	2,503
Contract Contribution	134	134	0	1,340	1,340	0	1,608
Additional ICB Stretch	750	750	0	1,555	1,555	0	3,055
Estates Schemes	23	23	0	230	230	0	276
Telephony Project	5	29	-24	117	290	-173	350
Divisional Control Total Alignment - CH	-430	194	-624	1,760	1,942	-182	2,330
Divisional Control Total Alignment - MH	-334	195	-529	-1,128	1,954	-3,082	2,344
Divisional Control Total Alignment - CFAA	484	66	418	2,053	664	1,389	796
Divisional Control Total Alignment - Central Services	1,031	44	987	3,398	440	2,958	528
Operational Management Team Restructure	28	28	0	280	280	0	336
Total Cost Improvement	**1,691**	**1,691**	**0**	**10,669**	**10,670**	**-1**	**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 £3.8m surplus on receipt of additional funding.

For month 10, 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 in part the under achievement related to OAPs.

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 and medical staffing costs. Further work is planned for the new year to review the drivers of the overspend and implement remedial action and reset for the 24/25 plan.

The telephony project is now showing an under delivery linked to higher than anticipated activity.

Contract Contribution includes schemes are where 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 10, the Trust is reporting a £1.3m YTD over performance on elective recovery within BOB ICS. This is based on the final agreement with BOB ICB regarding payment for overperformance for the year. The actual over performance year to date is given in the table below.

ERF Performance	January	
	Activity	Value £
Target	6,574	1,440,709
Actual	7,450	1,634,359
Variance	876	193,651
Cumulative		**1,995,455**

Elective Recovery activity includes all physical health first outpatient appointments assessed against the 2019/20 baseline with a target improvement of 10%. The Trust's contract with Frimley ICB does not include any funding for elective recovery.

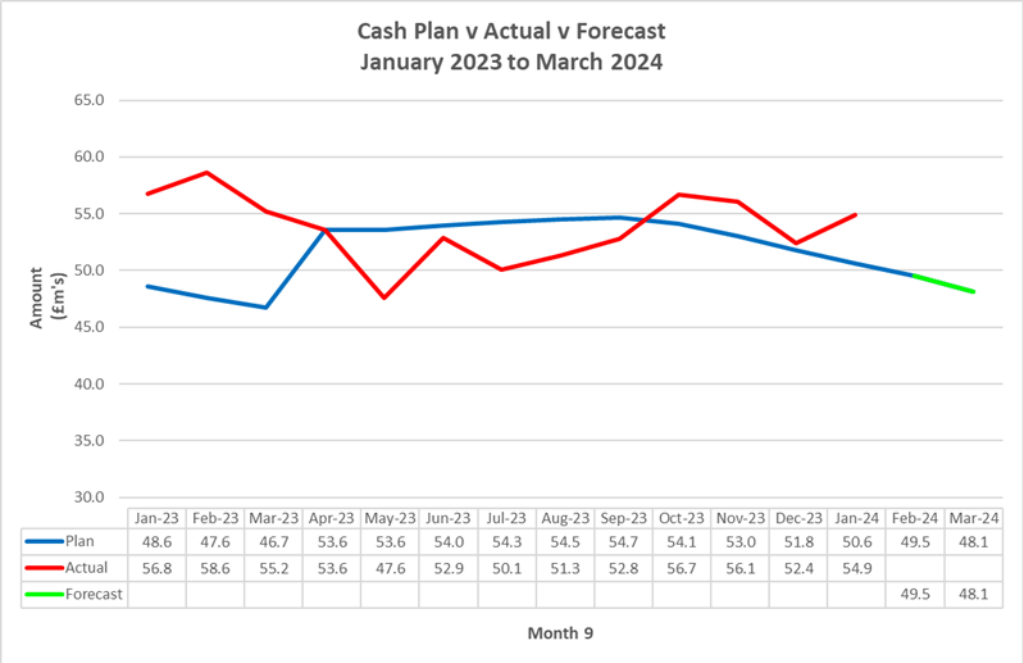
2. Balance Sheet & Cash

	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	1.7	3.8	(2.1)	1.7	3.8	(2.1)
Property, Plant & Equipment (non PFI)	45.6	48.3	47.4	0.9	48.3	47.4	0.9
Property, Plant & Equipment (PFI)	72.1	70.5	72.3	(1.8)	70.5	72.3	(1.8)
Property, Plant & Equipment (RoU Asset)	15.5	14.5	14.7	(0.2)	14.5	14.7	(0.2)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**137.4**	**135.2**	**138.4**	**(3.2)**	**135.2**	**138.4**	**(3.2)**
Trade Receivables & Accruals	18.9	15.4	18.7	(3.3)	15.4	18.7	(3.3)
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	55.2	54.9	50.6	4.3	54.9	50.6	4.3
Trade Payables & Accruals	(48.2)	(40.9)	(45.6)	4.7	(40.9)	(45.6)	4.7
Borrowings (PFI and RoU Lease Liability)	(4.2)	(7.9)	(4.1)	(3.8)	(7.9)	(4.1)	(3.8)
Other Current Payables	(11.8)	(15.8)	(12.2)	(3.6)	(15.8)	(12.2)	(3.6)
Total Net Current Assets / (Liabilities)	**10.2**	**6.0**	**7.7**	**(1.7)**	**6.0**	**7.7**	**(1.7)**
Non Current Borrowings (PFI and RoU Lease Liability)	(34.8)	(52.8)	(33.5)	(19.3)	(52.8)	(33.5)	(19.3)
Other Non Current Payables	(2.0)	(2.1)	(2.0)	(0.1)	(2.1)	(2.0)	(0.1)
Total Net Assets	**110.8**	**86.3**	**110.6**	**(24.3)**	**86.3**	**110.6**	**(24.3)**
Income & Expenditure Reserve	31.6	7.2	32.3	(25.1)	7.2	32.3	(25.1)
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**	**86.3**	**110.6**	**(24.3)**	**86.3**	**110.6**	**(24.3)**

Key Messages

The balance sheet is largely as expected year to date with exception of Non Current Borrowings where there has been a change of accounting treatment with the NHS adopting IFRS16 for PFI liabilities from month 9. This increases the PFI lease liability. This also impacts on the I&E reserve.

The cash balance at M10 was £4.3m above the plan. Payments from the ICBs have now caught up with final contract values as expected.



	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	56.7	56.1	52.4	54.9		
Forecast														49.5	48.1

3. Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast
	Actual	Plan	Variance	Actual	Plan	Variance	Plan	Outturn
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates Maintenance & Replacement Expenditure								
25 Erleigh Road Upgrades - Internal & External	2	0	2	11	250	(239)	250	250
General Upgrades & Damp Issues CHH	1	0	1	6	250	(244)	250	200
Wokingham Reprovision - Move from Old Forge	2	0	2	307	200	107	200	335
Bariatric Facilities Wokingham	2	0	2	178	230	(52)	230	230
Leased Non Commercial (NHSPS) Other projects	6	0	6	202	356	(154)	235	477
HQ Relocation/MSK Relocation - AV	(2)	0	(2)	148	121	27	121	150
Resource House, Denmark Street	4	0	4	855	800	55	800	865
Environment & Sustainability	10	50	(40)	186	348	(162)	450	474
Service change/redesign	0	25	(25)	0	175	(175)	244	0
Various All Sites	17	90	(88)	69	445	(390)	515	401
Statutory Compliance	9	50	(41)	44	325	(281)	390	305
Subtotal Estates Maintenance & Replacement	**52**	**215**	**(178)**	**2,005**	**3,500**	**(1,509)**	**3,685**	**3,685**
IM&T Expenditure								
Business Intelligence and Reporting	(3)	10	(13)	29	100	(71)	120	120
Hardware Purchases - Refresh & Replacement	72	777	(705)	3,722	3,147	575	4,677	5,270
Digital Strategy incl. EMIS and ePMA re-tender	38	122	(84)	132	488	(356)	733	441
RiO Re-procurement	0	25	(25)	0	250	(250)	300	0
Subtotal IM&T Expenditure	**107**	**934**	**(827)**	**3,883**	**3,985**	**(102)**	**5,830**	**5,830**
Subtotal CapEx Within Control Total	**159**	**1,149**	**(1,004)**	**5,889**	**7,485**	**(1,611)**	**9,515**	**9,515**
CapEx Expenditure Outside of Control Total								
Low Carbon Heating System WBCH	0	203	(203)	0	203	(203)	610	0
PPH 'Place of Safety'	0	333	(333)	0	1,182	(1,182)	1,850	0
Statutory Compliance	0	20	(20)	14	90	(76)	110	89
Environment & Sustainability / Zero Carbon	0	17	(17)	0	116	(116)	150	150
Other PFI projects	(1)	40	(41)	11	120	(109)	185	205
Garden Renovation – Wokingham Hospital (Donated)	0	0	0	11	0	11	0	22
Subtotal Capex Outside of Control Totals	**(1)**	**613**	**(614)**	**36**	**1,711**	**(1,675)**	**2,905**	**466**
Central Funding								
Cyber Security	0	0	0	0	0	0	0	125
Sub Total Central Funding Outside of Control Totals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**125**
Total Capital Expenditure	**158**	**1,762**	**(1,619)**	**5,924**	**9,196**	**(3,286)**	**12,420**	**10,106**

Key Messages

Spend YTD is £1.6m below plan for schemes within the CDEL control total. The majority of the underspend is in Estate schemes however a high number of planned schemes have now been approved and are expected to be completed this year. The IM&T Refresh & replacement programme spend is on track and expected to be as planned. IM&T Additional 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. Part of the EMIS and ePMA re-tender costs has now moved to next year. RiO Re-procurement project has also moved to next year and the cost is expected to be charged mainly to revenue.

The capital plan currently includes £0.3m of over programming which we are assuming will be offset with underspends in other Trusts within BOB ICS. 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.

NHSE has also updated its approach regarding IFRS16 with CDEL allocations being uplifted for ICSs based on planning requirements. We have some new leases which were not captured in the plan for which CDEL cover from the ICS will also now be required.

The Place of Safety scheme which was due to commence and complete in year will now not complete until Autumn 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 Meeting Paper

Board Meeting Date	12th March 2024
Title	**True North Performance Scorecard Month 10 (January 2024) 2023/24**
	For Noting
Reason for the Report going to the Trust Board	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.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. 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. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities**

	Ambition: We will reduce health inequalities for our most vulnerable patients and communities **Workforce** **Ambition:** We will make the Trust a great place to work for everyone **Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value

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**)

Berkshire Healthcare NHS
NHS Foundation Trust

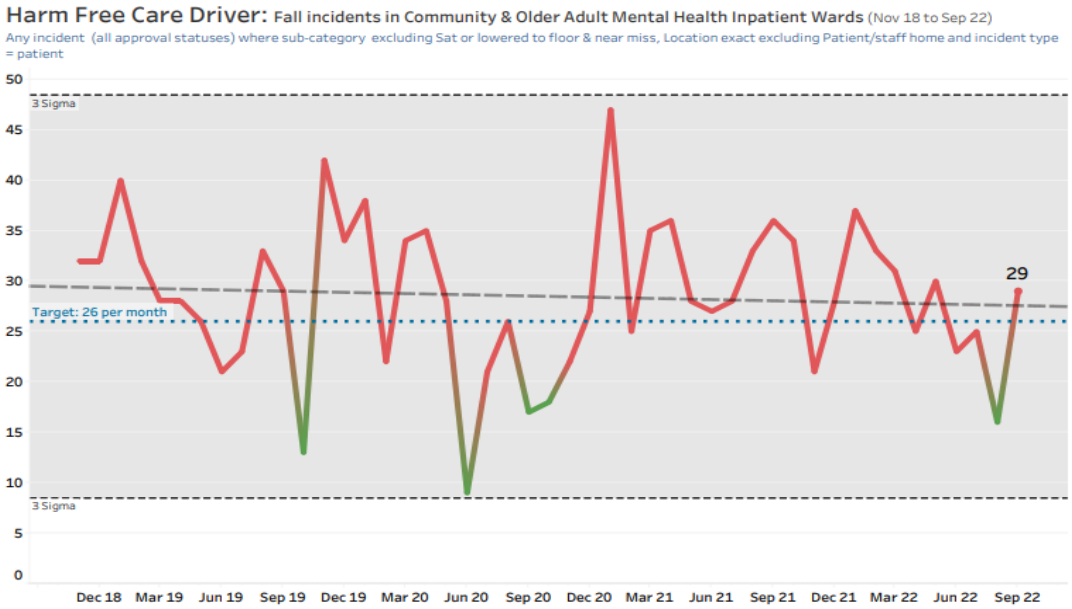
Business Rules for Statistical Process Control (SPC) Charts

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.

True North Performance Scorecard Highlight Report – January 2024

The True North Performance Scorecard for Month 10 2023/24 (January 2024) is included. Performance business rule exceptions, red rated with the True North domain in brackets.

The business-based rules and definitions are included, along with an explanation of Statistical Process Control (SPC) Charts, which are used to support the presentation of Breakthrough metrics: Definitions and Business Rules [Link] and Understanding Statistical Process Control Charts [Link]

Breakthrough and Driver Metrics

- Clinically Ready for Discharge by Wards including Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – a new indicator for 2023/24, is at 371 against a 250-bed day target.
    - The number of lost bed days remain high but decreased over the last 3 months. Remains a key focus for timely discharge and flow through the wards. The average delay has improved to 13.3 days from 18 days in December 2023. Older adults are the top contributor with a couple of Local Authority's having challenges finding suitable beds.
- Bed Days Occupied by Patients who are Discharge Ready (Community Physical Health) – **(Patient Experience)** – a new indicator for 2023/24, is at 888 against a 500-bed day target.
    - In January 135 patients contributed to the delays. Two patients have long delays, but one has now been discharged and the other has a plan. Jubilee ward was the top contributor with 58% of the delays. Initial findings from the 'voice of the patient' feedback project identified wards needing to improve communications around delays to patients and carers. There is now visibility of delays on the Frimley system dashboard which will help focus the issue.
- Physical Assaults on Staff **(Supporting our Staff)** – 48 against a target of 44.
    - There is an increase in incidents in Place of Safety (POS) including physical assaults. The ward have a new role for staff support and the Operational group are reviewing escalations. There is a focus on learning from past incidents to inform care for patients.

The following Breakthrough metric is Green and are performing better than agreed trajectories or plan.

- Self-harm Incidents on Mental Health Inpatient Wards (excluding Learning Disability) **(Supporting our Staff) –** at 25 against a target of 61.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Positive Score **(Patient Experience)** – at 94.7% against a 95% target.
- I Want Great Care Compliance Rate **(Patient Experience)** – at 3.3% against a 10% target.
- Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 50 against a 0 quarterly bed day target.
    - Impacted by continuing levels of high demand coupled with higher levels of bed occupancy and lost bed-days. The division are reprofiling for 2024/25.

The following metrics are Green and are performing better than agreed trajectories or plan.

- Staff turnover **(Supporting our Staff)** – 12.33% against a 14% target by March 2024.
- Year to Date Variance from Control Total **(Efficient Use of Resources)** -£1.7m better than plan.

Tracker Metrics

- Community Inpatient Occupancy **(Efficient Use of Resources)** – at 89.2% against a target of 80-85%.
- Health Visiting: New Birth Visits Within 14 Days **(Patient Experience)** – at 81.6% against a 90% target.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 93.8% against an 85% target. Red for 12 months.
- Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – increased to 45 days against a target of 30 days. Red for 12 months.
- Meticillin-susceptible Staphylococcus Aureus (MSSA) bacteraemias year to date **(Regulatory Compliance)** – 1 for the year to date, with one incident in May 2023. An incident in November has been investigated and deemed not compliant.
- People with Common Mental Health Conditions Referred to Talking Therapies Completing a Course of Treatment Moving to Recovery - **(Regulatory Compliance)** – at 48.5%, below the 50% target.
- Sickness rate **(Regulatory Compliance)** – red at 4.8% against a target of 3.5%.
- Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder will access NICE treatment <1 week (Urgent) **(Regulatory Compliance)** – red at 50% against a 95% target.
- Children and Young People (CYP) referred for an assessment or treatment of an Eating Disorder will access NICE treatment <4 weeks (Routine) **(Regulatory Compliance)** – red at 87.5% against a 95% target.

Performance Scorecard - True North Drivers

Harm Free Care

Metric	Target	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Breakthrough Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	162	31	22	24	19	55	37	43	53	28	17	25
Breakthrough Restrictive Interventions	TBC	422	402	337	409	324	320	301	246	294	198	196	158

Patient Experience

		Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
IWGC Positive Score %	95% compliance from April 22	92.4%	93.7%	94.0%	94.2%	94.1%	95.2%	95.2%	94.3%	93.3%	94.3%	94%	94.7%
IWGC Compliance %	10% compliance	2.3%	3.1%	2.6%	3.3%	3.7%	3.5%	4.2%	3.3%	3.6%	3.2%	2.7%	3.3%

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	300	415	468	484	565	712	460	348	465	390	542	371

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	386	657	583	799	876	823	768	731	895	785	746	888

Performance Scorecard - True North Drivers

Supporting our Staff

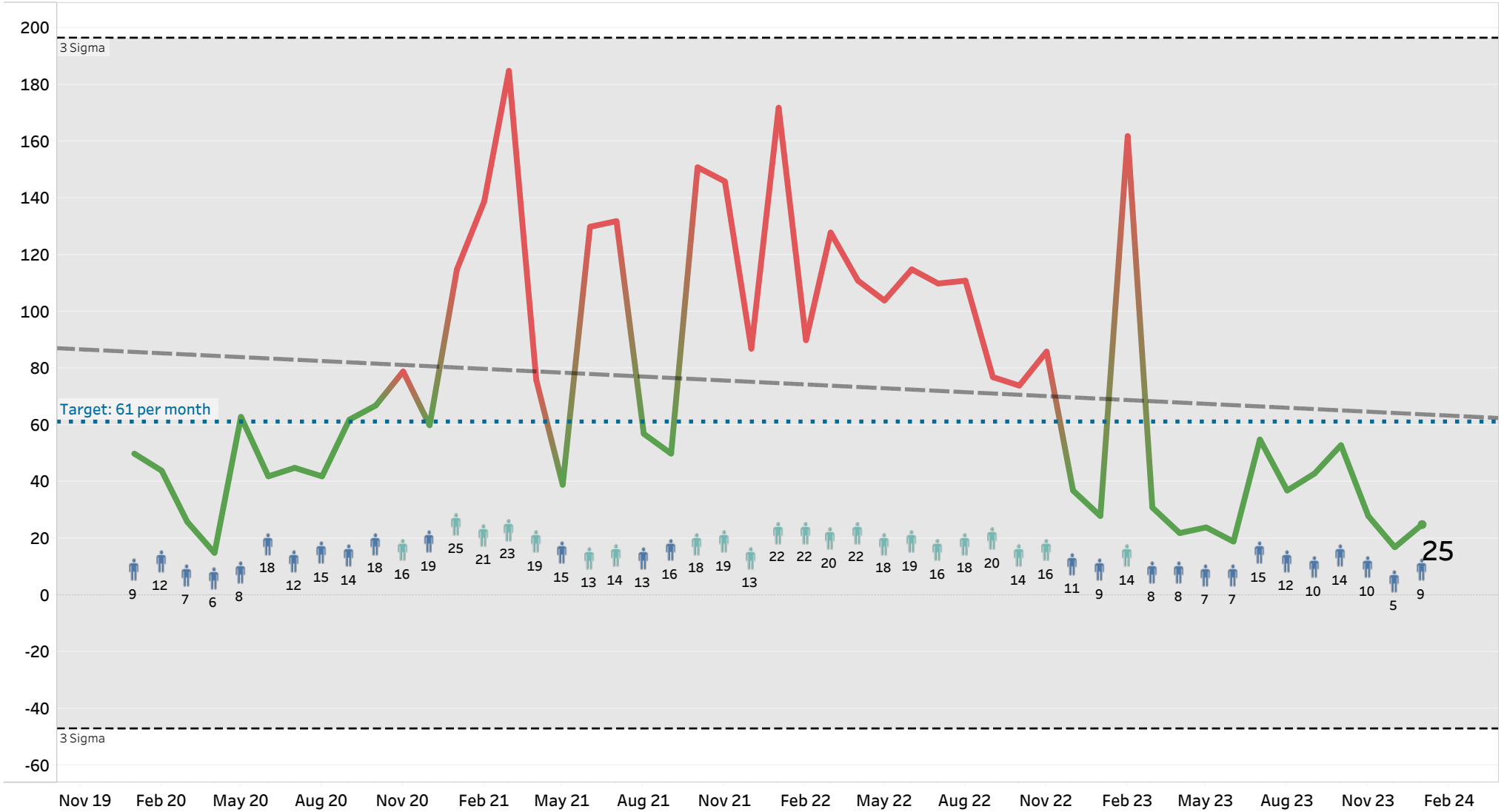
Metric	Target1	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Breakthrough Physical Assaults on Staff	44 per month	84	109	78	45	58	70	61	52	46	71	92	48
Staff turnover (excluding fixed term posts)	<=16% per month, 14% by March 2024, 13% by March 2025, 12% by March 26	15.69%	15.85%	15.85%	14.87%	14.54%	14.35%	14.09%	13.63%	13.42%	13.03%	12.87%	12.33%

Efficient Use of Resources

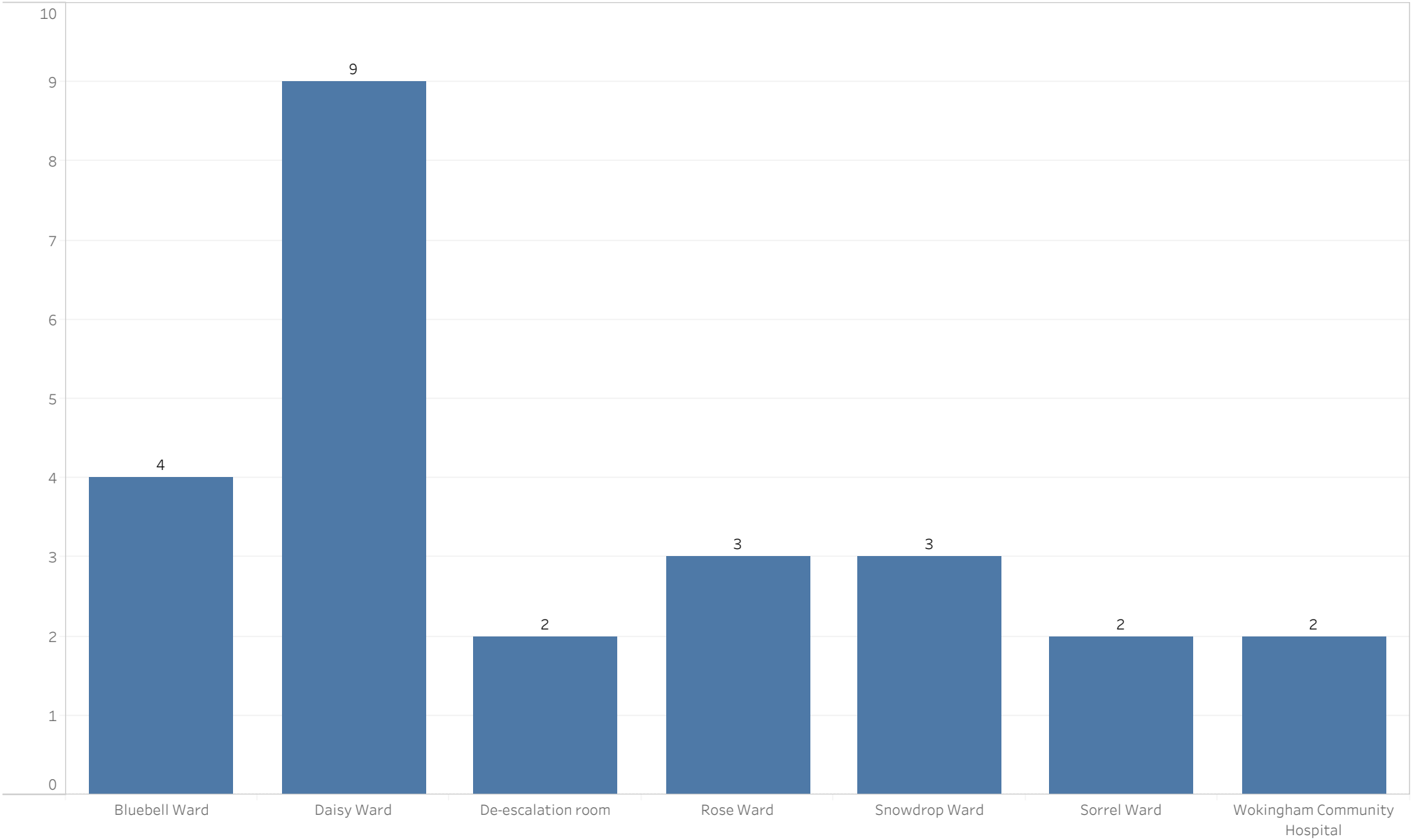
		Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
YTD variance from control total (£'k)	1.3m	-1818	-989	-261	-441	-805	-1116	-1430	-1983	-1492	-1459	-1712	
Inappropriate Out of Area Placements	0 Cumulative Total Q4 2023/24	62	169	110	144	180	327	633	786	350	834	975	50

Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Jan 20 to Jan 24)

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 (January 2023)



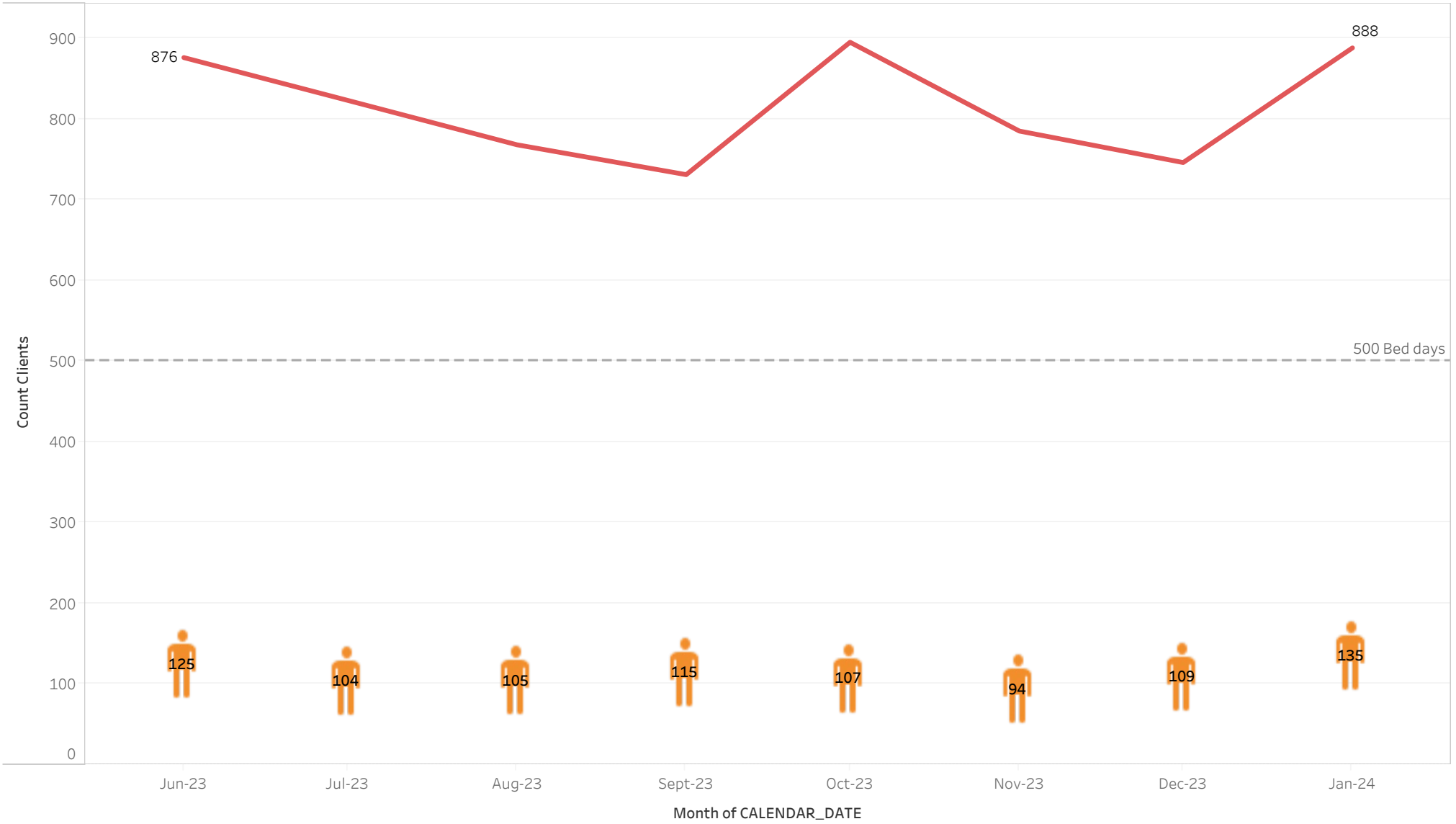
Patient Experience: Breakthrough Clinically Ready for Discharge by Wards MH (Including OAPS) (Feb 2023-Jan 2024)

All Mental Health wards excludes Campion ward (Learning Disability)

Patient Experience: Breakthrough Bed days occupied by patients who are discharge ready Community

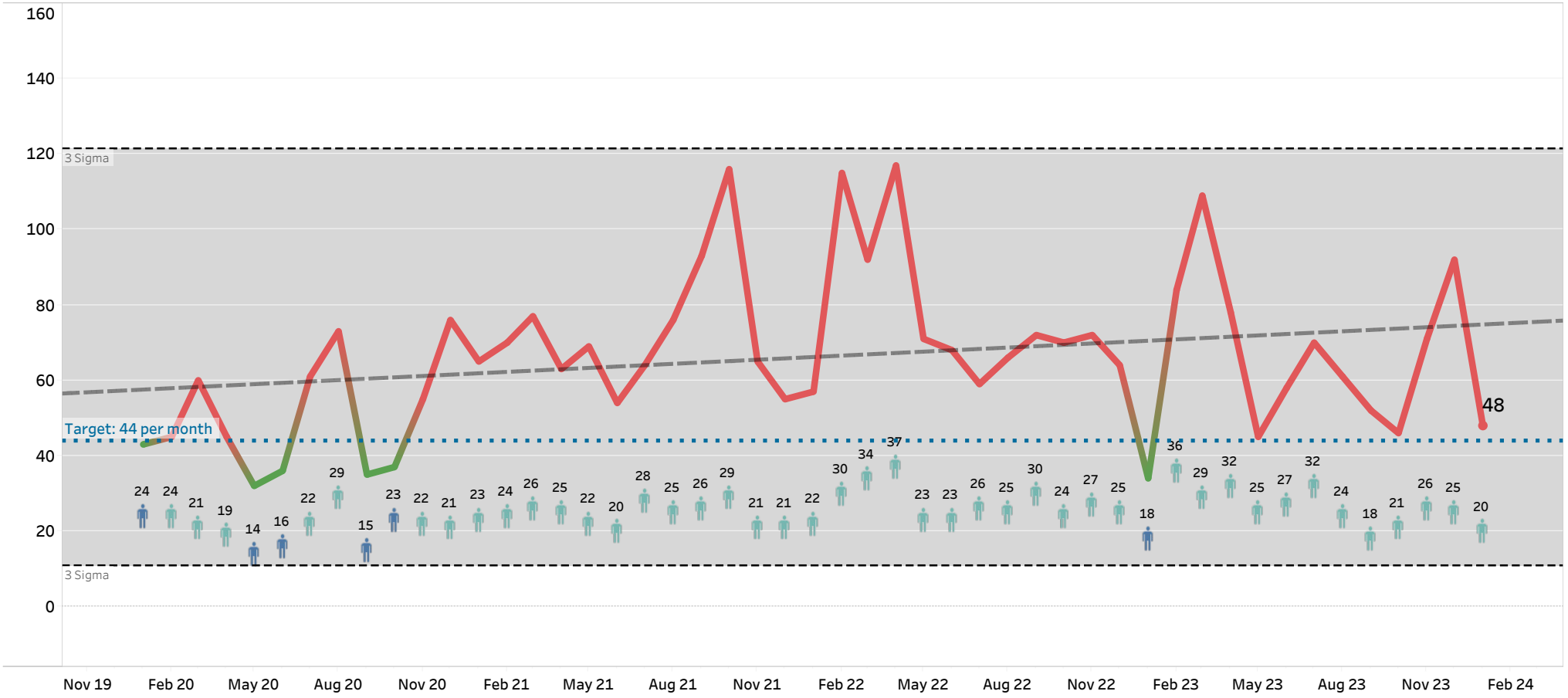
(June 2023-Jan 2024)

All Community health wards

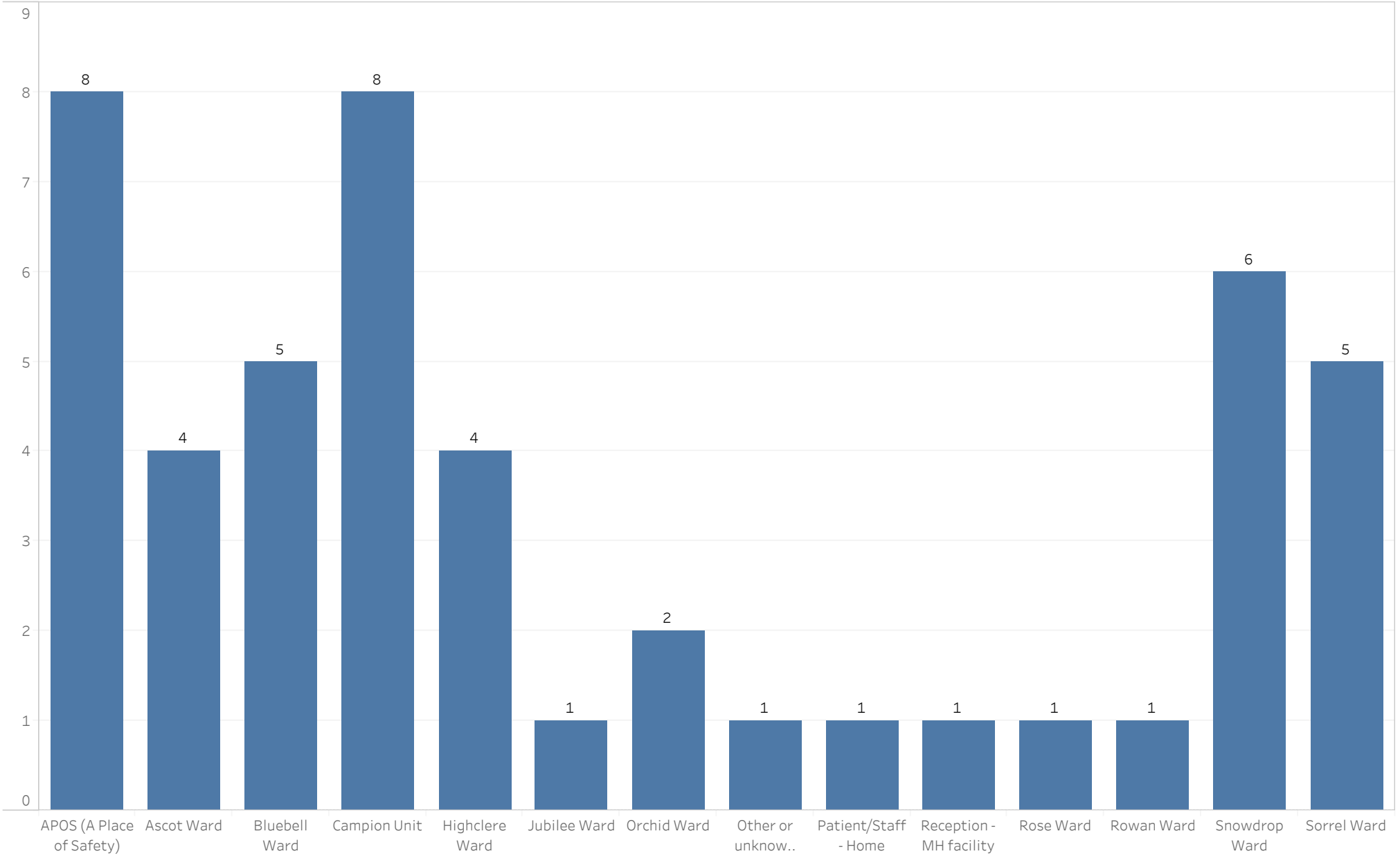


Supporting Our Staff Driver: Physical Assaults on Staff (Jan 20 to Jan 24)

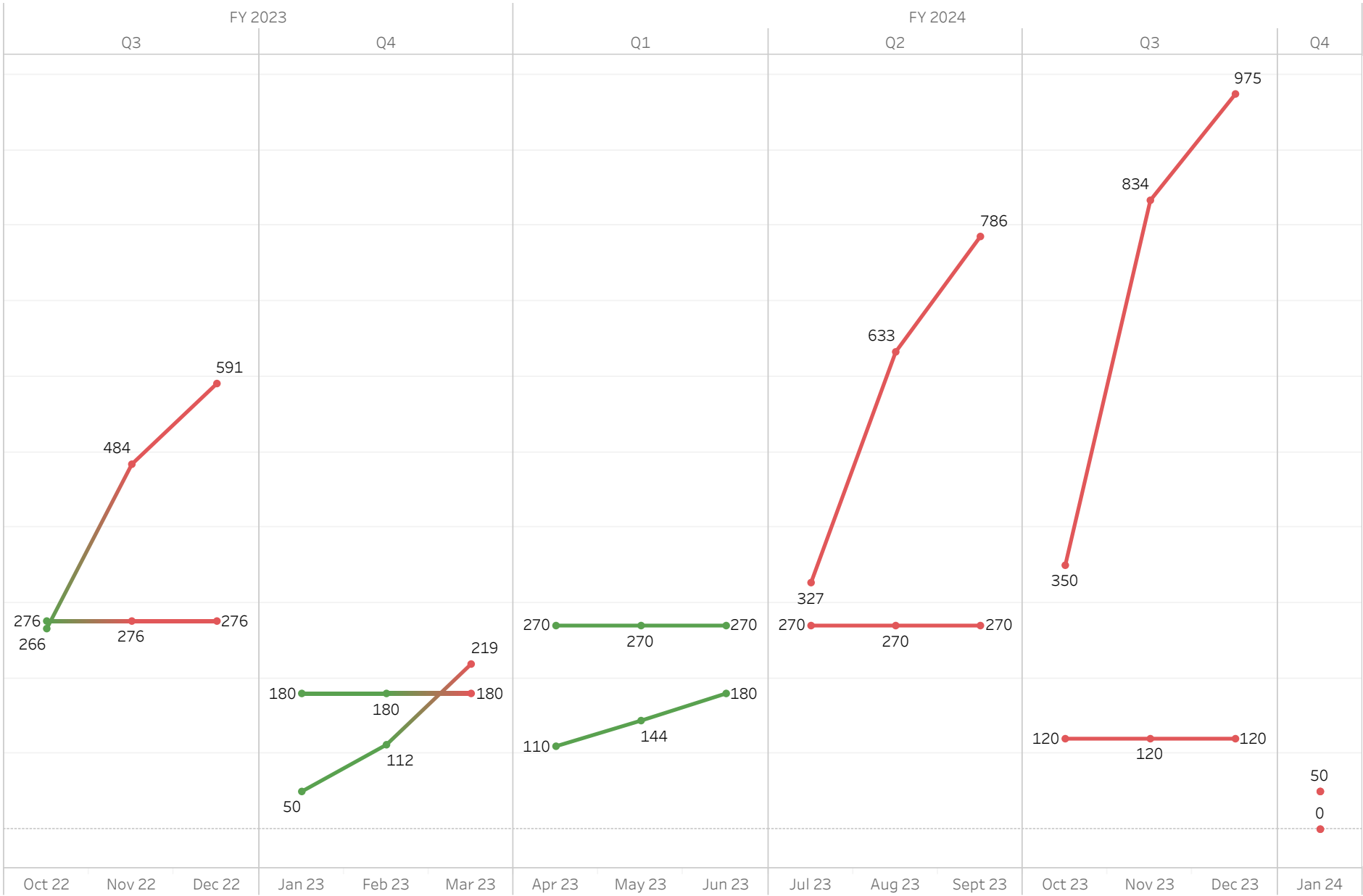
Any incident where sub-category = assault by patient and incident type = staff



Supporting Our Staff Driver: Physical Assaults on Staff by Location (January 2024)



Efficient Use of Resources Driver: Inappropriate Out of Area Placements



True North Supporting Our Staff Summary

Tracker Metrics

		Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Statutory Training: Fire: %	90% compliance	92.8%	93.2%	93.0%	94.1%	94.3%	94.2%	93.5%	93.1%	93.4%	94.0%	93.9%	93.9%
Statutory Training: Health & Safety: %	90% compliance	96.2%	95.9%	95.9%	95.9%	96.4%	96.4%	96.3%	96.4%	96.5%	96.4%	96.5%	96.4%
Statutory Training: Manual Handling: %	90% compliance	92.6%	94.3%	94.5%	93.2%	94.0%	94.3%	94.3%	93.4%	93.4%	93.7%	93.0%	93.3%
Mandatory Training: Information Governance: %	95% compliance from April 22	96.8%	97.0%	97.4%	97.7%	98.0%	98.2%	97.7%	97.4%	97.5%	97.6%	97.4%	97.5%

True North Patient Experience Summary

		Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Mental Health: Prone (Face Down) Restraint	4 per month	13	8	3	2	1	3	3	1	0	2	1	3
Patient on Patient Assaults (MH)	25 per month	13	28	22	15	21	10	12	11	8	10	14	9
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	86.8%	85.9%	77.6%	76.7%	88.4%	86.8%	90.0%	88.8%	84.6%	86.5%	89.2%	81.6%
Mental Health: Uses of Seclusion	13 in month	6	6	5	12	4	10	10	4	6	6	14	12

		Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	37	21	23	27	23	25	24	21	26	28	24	29
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	85%	81%	84%	83%	87%	84%	85%	85%	86%	90%	87%	90%	91%

True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Mental Health: AWOLs on MHA Section	10 per month from April 2022	10	3	11	6	11	4	7	10	7	5	2	3	6
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	0	1	1	2	0	2	4	2	3	7	0	0	0
Mental Health: Readmission Rate within 28 days: %	<8% per month	1.40	1.68	2.62	2.90	5.70	4.04	3.89	1.35	10.2	1.42	1.40	0	3.03
Patient on Patient Assaults (LD)	4 per month	1	1	5	0	1	2	2	1	1	2	2	5	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	5.7
Self-Harm Incidents within the Community	31 per month	57	51	52	44	44	32	32	29	23	18	21	9	21
Pressure Ulcer with Learning	Tbc				2	2	1	1	5	2	4	4	1	0
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	1	0	1	

Efficient Use of Resources

		Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24
Community Inpatient Occupancy	80-85% Occupancy	89.3%	89.4%	87.8%	83.5%	86.6%	78.7%	77.8%	83.5%	88.0%	92.9%	87.7%	89.2%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	86.82%	78.12%	91.18%	92.60%	92.87%	87.59%	87.29%	89.92%	90.82%	87.18%	77.85%	72.48%
DNA Rate: %	5% DNAs	4.76%	4.92%	5.02%	4.79%	5.29%	5.22%	4.85%	4.65%	4.88%	5.05%	4.76%	4.70%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	97.1%	95.3%	94.8%	94.4%	94.4%	96.4%	96.8%	93.3%	94.6%	97.2%	93.6%	93.8%
Mental Health: Acute Average Length of Stay (bed days)	30 days	43	50	55	41	43	45	70	62	64	43	57	45

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
C.Diff due to lapse in care (Cumulative YTD)	6	2	2	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	3	3	0	1	1	1	1	1	1	1	1	1
Count of Never Events (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	87.5	90	88	75	80	87.5	100	100	81.82	100	80	85.70
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	99.37	99.39	99.26	99.35	99.42	99.40	99.42	99.17	99.22	99.20	99.14	99.5
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	95	94	94	93	91	91	87	88	89	88	88
People with common mental health conditions referred to Talking Therapies completing a course of treatment moving to recovery	50% treated	46	46.5	46.5	48	45	49.95	46.15	46	43.5	45	48.39	48.5
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	72.42	69.06	61.26	83.45	92.09	97.79	100	99.00	99.07	95.93	97.79	95.18
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	99.57	99.53	100	100	100	100
Sickness Rate: %	<3.5%	4.3%	4.1%	3.7%	4.0%	3.8%	3.9%	3.7%	3.9%	4.6%	4.6%	4.6%	4.8%
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	66.6%	50%	42.8%	83.3%	75%	100%	75%	100%	100%	100%	50%	50%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	78.6%	75%	83.2%	75%	85.7%	60%	100%	100%	100%	100%	100%	87.5%
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Regulatory Compliance - System Oversight Framework

Metric	Threshold / T..	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24
Community Health Services: 2 Hour Urgent Community Response %.	80%	88.5%	89.3%	83.1%	84.2%	87.8%	87.6%	85.2%	86.3%	88.5%	82.0%	81.8%	82.5%
E-Coli Number of Cases identified	Tbc	0	0	0	1	1	0	1	0	1	0	1	1
Mental Health 72 Hour Follow Up	80%	88.6%	93.0%	96.4%	91.6%	90.7%	98.0%	87.5%	92%	89.1%	86.9%	86.2%	95.1%
Adult Acute LOS over 60 days % of total discharges	TBC	50%	27.3%	24.1%	25.8%	22.8%	24%	25%	24%	24%	24%	30%	28.9%
Older Adult Acute LOS over 90 days % of total discharges	TBC	40.8%	60%	66.7%	66.7%	50%	36%	32%	28.9%	42%	42%	66%	57.9%

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Fit and Proper Person Test Policy**
	For Approval
Reason for the Report going to the Trust Board	The Government introduced the Fit and Proper Person Test (FPPT) requirement via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Following a review of the FPPT by Tom Kark KC, NHS England published a new Fit and Proper Person Test Framework for Board Members in August 2023. The Framework does not change the existing legislation, but aims to support NHS organisations' compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements. The Trust's Fit and Proper Person Policy has been updated to reflect NHS England's Fit and Proper Person Test Framework.
Business Area	Trust wide
Author	Julie Hill, Company Secretary
Relevant Strategic Objectives	The Fit and Proper Person Test Policy is relevant to all the strategic objectives.

Berkshire Healthcare
NHS Foundation Trust

Policy number

Fit and Proper Person Test Policy and Procedures

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: **Please record version number only. Version history is further down.**

<table>
<tr><td>Policy Number:</td><td></td></tr>
<tr><td>Title of Policy:</td><td>Fit and Proper Person Test Policy and Procedures</td></tr>
<tr><td>Category:</td><td>Organisational</td></tr>
<tr><td>Committee responsible for final sign off</td><td>Trust Board</td></tr>
<tr><td>Re-issued:</td><td>Date of last release of policy</td></tr>
<tr><td>Review Date:</td><td>Two years</td></tr>
<tr><td>Designated Lead:

Policy author (authors)</td><td>Company Secretary</td></tr>
<tr><td>Version History</td><td>This policy has been updated to reflect NHS England’s Fit and Proper Person Test Framework published in August 2023.</td></tr>
<tr><td>Individuals ratified by:</td><td><table><tr><td>Name</td><td>Date Ratified</td></tr><tr><td>Director of People</td><td>03 January 2024</td></tr><tr><td>Trust Chair</td><td>09 January 2024</td></tr><tr><td>Executive Team</td><td>02 January 2024</td></tr></table></td></tr>
<tr><td>Relevant meetings, groups, committees ratified by</td><td>Formal Executive Committee meeting – 02 February 2024</td></tr>
<tr><td>Date endorsed by Policy Scrutiny Group:

Date endorsed by Committee responsible for final sign off:</td><td>09 February 2024</td></tr>
<tr><td>For policy information:</td><td>Policy Administration
Berkshire Healthcare NHS Foundation Trust
London House
London Road
Bracknell
RG12 2UT
0300 247 3000</td></tr>
</table>

This policy has been assessed for compliance with CQC (Care Quality Commission) Fundamental Standards.

1 Contents

2 INTRODUCTION 4

3 PURPOSE OF POLICY 4

4 SCOPE OF POLICY 5

5 ROLES AND RESPONSIBLIIES 5

6. PROCEDURE 8

7. PERSONAL DATA 9

8. BOARD MEMBER REFERENCE 10

9. DEALING WITH CONCERNS 10

10. REFERENCES: 11

11. APPENDICES 11

APPENDIX 1 – Board Member/Very Senior Manager Annual Self-Attestation Form 11
APPENDIX 2 – Board Member/Very Senior Manager Reference Template 11
12. EQUALITY IMPACT ASSESSMENT 19

2 INTRODUCTION

The ‘fit and proper person’ test set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 came into force on 27 November 2014 and is aimed at making sure that those individuals who have authority in organisations that deliver care are responsible for the overall quality and safety of that care, and as such can be held accountable if standards of care do not meet legal requirements.

The Government commissioned a review of the Fit and Proper Person Test by Tom Kark, KC in July 2018 to examine the scope, operation and purpose of the Fit and Proper Person Test. In October 2023, NHS England published the Fit and Proper Person Test Framework which incorporates most of the recommendations from the Kark Review.

The legislation has not changed, but NHS England’s Fit and Proper Person Test Framework aims to support NHS organisations compliance with the regulations and makes some changes to the checks and balances that are intended to ensure directors satisfy the regulatory requirements.

This Policy applies to all Board Directors – Executive and Non-Executive, staff on Very Senior Manager contracts and the Company Secretary. It applies to all permanent, acting and interim Board level positions where arrangements exceed six weeks. Individuals in these roles must meet the requirements on appointment and continue to meet these requirements whilst holding office as a Director.

In the event that the Trust determines on reasonable grounds that a Director has ceased to be a fit and proper person within the meaning of the Regulations, then the appointment may be terminated with immediate effect (subject to the Trust’s Human Resources processes for Executive Directors and approval by the Council of Governors for Non-Executive Directors).

3 PURPOSE OF POLICY

The aim of this document is to provide the policy and procedures by which the Trust will support its commitment to the fit and proper person test requirements, and to ensure it is not managed or controlled by individuals who present an unacceptable risk either to the Trust or to the people receiving a service: that Trust’s directors are fit and proper to assume responsibility for the overall quality and safety of care delivered.

As part of the recruitment, selection and induction processes, the Trust will ensure that all directors and non-executive directors have a general understanding of the core competencies set out in the NHS Leadership Competency Framework for Board Level Roles (not yet published).

In response to the Kark Review, NHS England published its Fit and Proper Person Test Framework for Board Members in August 2023. The new framework strengthens the Fit and Proper Person Test requirements but does not amend Regulation 5 of the Health and Social Care Act (2008 (Regulated Activities) Regulations 2014 (the “Regulations”).

Whilst providers have a general obligation to ensure that they only employ individuals who are fit for their role, the ‘fit and proper person’ test must be applied for all new Directors and there must be systems and processes in place to provide ongoing assurance that the requirements are met. There is a duty on the organisation to take such action as is necessary and proportionate to ensure ongoing compliance.

The requirements are that:

(a) The individual is of good character;
(b) The individual has the qualifications, competence, skills and experience which are necessary

for the relevant office or position or the work for which they are employed;
(c) The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks which are intrinsic to the office or position for which they are appointed or to the work for which they are employed;
(d) The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity; and
(e) None of the grounds of unfitness specified in part 1 of Schedule 4 apply to the Individual (as per the Regulated Activities Regulation detailed below).

The grounds of unfitness specified in Part of Schedule 4 to the Regulated Activities Regulations are:

(a) the person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged;
(b) the person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland;
(c) the person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986;
(d) the person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it;
(e) the person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland;
(f) the person is prohibited from holding the relevant office or position, or in the case of an individual for carrying on the regulated activity, by or under any enactment.

The good character requirements referred to in Regulation 5 as specified in Part 2 of Schedule 4 to the Regulated Activities Regulations relate to:

(a) whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committee in any part of the United Kingdom, would constitute an offence
(b) whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

4 SCOPE OF POLICY

The Guidance describes "directors" as Executive and Non-Executive Directors and any other persons performing the functions of or similar functions, to a director. The Trust has agreed that the Fit and Proper Person Test requirements should apply to all Executive Directors, Non-Executive Directors, the Company Secretary and staff on Very Senior Manager Contracts. This will be kept under review taking account of the emerging national guidance.

Where Interim Executive Directors are in place for six weeks or more, the requirement to comply with and meet the standards also applies. All Directors will be required to complete a self-attestation form annually and a DBS check at least every 3 years. (Appendix 1).

5 ROLES AND RESPONSIBLIIES

The Chair

The Chair is accountable for taking all reasonable steps to ensure the Fit and Proper Person Test process is effective and that the desired culture of their NHS organisation is maintained to support an effective Fit and Proper Person Test regime. As such, chairs' responsibilities are:

a) Ensure the Trust has proper systems and processes in place so it can make the robust assessments required by the Fit and Proper Person Test.

b) Ensure the results of the full Fit and Proper Person Test, including the annual self-attestations for each board member are retained by the Trust.

c) Ensure that the Fit and Proper Person Test data fields within ESR (Electronic Staff Record) are accurately maintained in a timely manner.

d) Ensure that the board member references/pre-employment checks (where relevant) and full Fit and Proper Person Test (including the annual self-attestation) are complete and adequate for each board member/very senior manager.

e) Ensure an appropriate programme is in place to identify and monitor the development needs of board members.

f) On appointment of a new board member, consider the specific competence, skills and knowledge of board members to carry out their activities, and how these fit with the overall board.

g) Conclude whether the board member is fit and proper.

h) Chairs will also complete an annual self-attestation form that they themselves are in continued adherence with the Fit and Proper Person Test requirements. On an annual basis, chairs should confirm that all board members have completed their own Fit and Proper Person Test self-attestation and that the Fit and Proper Person Test is being effectively applied in their NHS organisation.

i) Ensure that for any board member approved to commence work or continue in post despite there being concerns about a particular aspect of the Fit and Proper Person Test they document the reason(s) as to why there has been an issue about whether a board member might not be fit and proper and the measures taken to address this. A local record of this should be retained. A summary of this should also be included in the annual Fit and Proper Person Test submission form to the relevant NHS England regional director.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director who oversees the application of the Fit and Proper Person role for the Chair.

Annually, the Senior Independent Director will review and ensure that the Chair is meeting the requirements of the Fit and Proper Person Test.

Additionally, with the support of the Company Secretary, the Senior Independent Director can undertake investigations into any concerns raised about the Chair, including where the Chair has notified the Senior Independent Director that they may no longer comply with the Fit and Proper Person Test requirements.

Chief Executive

The Chief Executive is subject to the requirements of the Fit and Proper Person checks and is also accountable to the Board for the Trust's compliance with statute and regulation.

All Directors (Executive, Non-Executive, Staff on Very Senior Manager Contracts Permanent, Acting, Interim)

All Executive, Non-Executive Directors and Staff on Very Senior Manager contracts are in the scope of this policy and are accountable for ensuring they meet the requirements of the Fit and

Proper Person policy on appointment and for completing an annual self-declaration. They are also responsible for informing the Chair, if during the course of their employment or term of office, they no longer meet the requirements of the Fit and Proper Person Test and therefore are deemed “unfit.”

All Directors need to make an annual self-attestation that they meet the requirements of the Fit and Proper Person Test and to provide any additional information or evidence requested in order to demonstrate compliance with Fit and Proper Person Test requirements.

Company Secretary

It is the responsibility of the Company Secretary to ensure:

- All Board members and staff on Very Senior Manager contracts complete the annual Fit and Proper Person Test Self-Attestation Form
- That tests are completed for individual Board Members and staff on Very Senior Manager contracts and to maintain and collate evidence of the outcome of those in the individual electronic Fit and Proper Person Test files for each Board Member/Very Senior Manager
- Fit and Proper Person Test outcomes are entered onto the ESR system (other than the final Chair sign off)
- That the annual Fit and Proper Person Test submission is completed and returned to the NHS England Regional Office

The Company Secretary must inform the Chair of any concerns relating to individual self-declarations or arising from other checks such as insolvency registers and registers of disqualified directors

Director People

It is the responsibility of the Director of People to:

- maintain oversight and due diligence in respect of appointment processes for Executive/Very Senior Managers, Company Secretary and Non-Executive Directors including pre-employment checks and adequacy of references;
- ensure that employment contracts (terms and conditions for Non-Executive Directors) refer to the requirement to comply with the Regulations and Code of Conduct for Board Directors;
- ensure DBS checks are conducted on appointment and thereafter at intervals of no greater than 3 years

Trust Board

The Trust Board is responsible for the performance management of this policy.

Appointments and Remuneration Committees

- The Trust has two Appointments and Remuneration Committees dealing with the appointment and remuneration of Non-Executive Directors and Executive Directors and remuneration of Very Senior Managers, respectively. These Committees are responsible for ensuring the assessment of candidates for Board positions and in the case of Non-Executive Directors, the recommendation of candidates for appointment by the Council of Governors. Each committee must ensure that the appropriate due diligence is undertaken in respect of the preferred candidate, prior to appointment. Where any issue comes to light, this must be investigated and documented in support of the final recruitment decision.

- For issues arising in respect of existing Directors, the Chair may refer any concerns of on-going tenure to the relevant Appointments and Remuneration Committee. Any interim arrangements required pending a Fit and Proper Person investigation will be considered by the relevant Appointments and Remuneration Committee.

Council of Governors

The appointment and removal of a Non-Executive Director will be a decision for the Council of Governors following a recommendation from the Appointments and Remuneration Committee.

Care Quality Commission (CQC)

The regulations give the Care Quality Commission powers to assess whether both Executive and Non-Executive Directors are fit to carry out their role and whether providers have in place adequate and appropriate arrangements to ensure that directors are fit and proper persons both on recruitment and whilst in post.

In undertaking inspections, the Commission will assess compliance as part of the well-led domain. Where compliance cannot be demonstrated, this will be addressed as appropriate through the regulatory process.

NHS England

NHS England Regional Director is responsible for ensuring that individual NHS organisations within the designated regions are completing their Fit and Proper Person Tests via the Trust's Annual Fit and Proper Person Test Submission (and any ad hoc submissions if a Fit and Proper Person Test breach has been identified). NHS England's Fit and Proper Person Test Team will collate records from NHS England regions.

6. PROCEDURE

6.1 Process for New Appointments

In order to confirm that the individual is of good character, the Trust will make pre-employment checks which will include the following:

- Full employment history with documented explanation of any gaps
- Obtaining two references (using the Board member reference template), one of which should be from the most recent employer
- qualification and professional registration checks
- right to work checks
- proof of identity
- occupational health clearance
- Social media search of the individual
- appropriate DBS clearance
- search of insolvency and bankruptcy register
- Removal as a Charity Trustee check
- Due diligence in relation to previous misconduct, mismanagement or professional disqualification
- Previous settlement agreements
- Employment Tribunal judgements

The selection process for all Director posts will be robust ensuring that the specific skills and experience required for the role are set out in a person specification and thoroughly tested.

The above will be overseen by the Director of People and evidence of the checks will be documented on the individual's personal Fit and Proper Person Test file

On appointment, the individual will be required to complete a 'Fit and Proper Person' self-attestation form (Appendix 1). This will be retained on the individual's personal file.

6.2 Process for Existing Staff and On-going Review of Existing Directors

An assessment of on-going fitness will be undertaken each year as part of the annual appraisal process and all Directors will be required to update their self-attestation forms (Appendix 1) annually. DBS clearance will also be renewed every three years. The Chair is accountable for maintaining oversight of ongoing fitness.

The Company Secretary will ensure an assessment of on-going fitness is undertaken each year in April and will form part of the annual appraisal process.

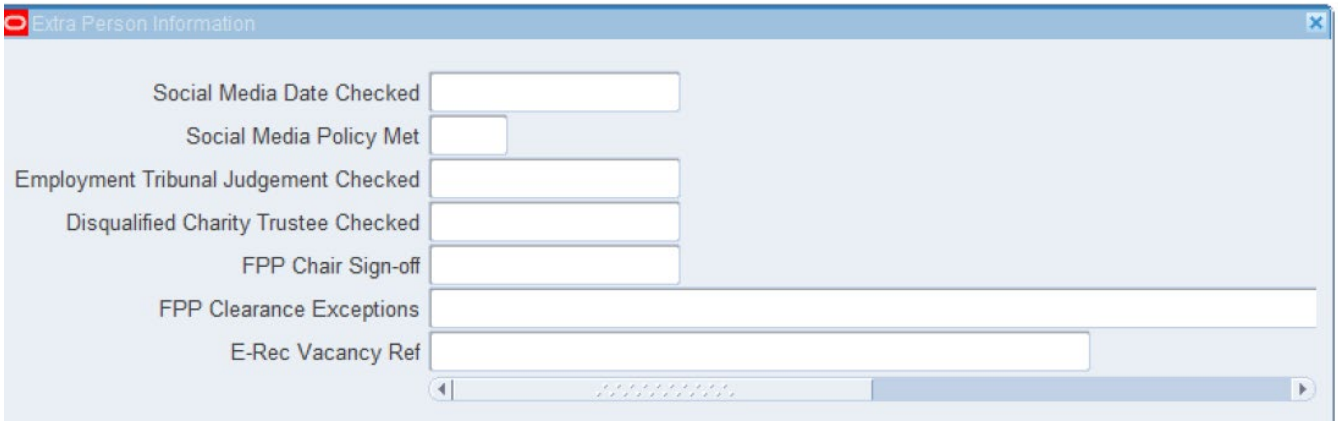
The annual checks will include:

- Insolvency, bankruptcy and disqualified director's registration
- Removal from Charity Trustees
- Professional qualifications checks (if relevant)
- Social Media checks
- The completion of an annual self-attestation by individuals within the scope of the policy (appendix 1)
- Employment Tribunal Judgement Check
- Upheld disciplinary findings relevant to the Fit and Proper Person Test assessment, including those arising from grievances and complaints against the Board Member/Very Senior Manager and "Speak Up" concern raised about the individual
- Maintenance of the register of declared interests
- Completion of mandatory and statutory training

7. PERSONAL DATA

Personal data relating to the Fit and Proper Person Test assessment will be retained in local record systems and specific data fields in the NHS Electronic Staff Record (ESR) system.

Fig 1 – Fit and Proper Person Test ESR Data Fields



Fit and Proper Person Test outcomes must be entered onto ESR and ESR Fit and Proper Person Test Dashboard generated for the Chair's review. Once satisfied with the test, the Chair must update and sign off each Board member on ESR.

An annual submission form will be generated for Chair sign off and submitted to the NHS England Regional Director. The NHS England Fit and Proper Person Test central team will collate records from NHS England regions.

8. BOARD MEMBER REFERENCE

NHS organisations will need to request board member references (Appendix 2), and store information relating to these references so that it is available for future checks; and use it to support the full Fit and Proper Person Test assessment on initial appointment.

NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of whether there has been a request from another NHS employer and including in circumstances of retirement. Both the initial and board member references should be retained locally on ESR.

Board member references will apply as part of the Fit and Proper Person Test assessment when there are new board member appointments, either internal to a particular NHS organisation, internal to the NHS, or external to the NHS. This applies whether permanent or temporary where greater than six weeks; specifically:

a. New appointments that have been promoted within an NHS organisation.

b. Existing board members at one NHS organisation who move to another NHS organisation in the role of a board member.

c. Individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside of the NHS.

d. Individuals who have been a board member in an NHS organisation and join another NHS organisation not in the role of board member, that is, they take a non-Board level role.

9. DEALING WITH CONCERNS

If the Trust discovers at any point, information that suggests an individual Director does not meet the 'Fit and Proper Person' criteria, the matter shall be referred immediately to the Chair (or the Senior Independent Director if the concern relates to the Chair).

The Chair shall take appropriate and timely action to investigate and rectify the matter, taking expert advice as necessary and ensuring any issues are dealt with in accordance with the Trust's Human Resources policies. Any concerns will be referred to the relevant Appointments and Remuneration Committee. Where appropriate, findings in relation to a person's fitness may be referred to the relevant professional/regulatory body/bodies.

The Chair, in discussion with the relevant Appointments and Remuneration Committee, will put in place interim arrangements, if required, during any period of investigation. The removal of any Director will be in accordance with the Trust's Constitution, with the decision to remove resting with the Trust Board's Appointments and Remuneration Committee for Executive Directors and Council of Governors for Non-Executive Directors.

10. REFERENCES:

- Regulation 5 Fit and Proper Person: Directors and Regulation 20 Duty of Candour, Guidance for NHS Bodies, Care Quality Commission November 2014.
- Guidance for Providers on Meeting the Regulations, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) (as amended), Care Quality Commission (Registration) Regulations 2009 (Part 4) (as amended), Care Quality Commission February 2015.
- Regulation 5 Fit and Proper Person: Directors, Information for NHS Bodies, Care Quality Commission March 2015.
- Regulation 5 Fit and Proper Person: Directors, Information for providers of Adult Social Care, Primary Medical and Dental Care, and independent Healthcare, Care Quality Commission March 2015.
- Care Quality Commission (2018) Regulations 5: Fit and Proper Person: Directors – Guidance for providers and CQC inspectors
- Kark Review of the Fit and Proper Person Test – February 2019
- NHS England's Fit and Proper Person Test Framework and Guidance – August 2023

11. APPENDICES

APPENDIX 1 – Board Member/Very Senior Manager Annual Self-Attestation Form

APPENDIX 2 – Board Member/Very Senior Manager Reference Template

Appendix 1 – Annual Self-Attestation Form

Fit and Proper Person Test annual/new starter self-attestation

Berkshire Healthcare NHS Foundation Trust

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (e.g. directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, and if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	

Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

Berkshire Healthcare
NHS Foundation Trust

Appendix 2 – NHS England's Board Member Reference Template

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

External/NHS organisation receiving request

Recruitment officer

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public-facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)
B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered).

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:

6. Please confirm all Learning and Development undertaken during employment:

(this question only applies to Executive Director board positions applied for)

7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		
9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS) (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)		
Date DBS check was last completed.	Date	
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level	
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □	
10. Did the check return any information that required further investigation?	Yes □	No □
If yes, please provide a summary of any follow up actions that need to/are still being actioned:		
11. Please confirm if all annual appraisals have been undertaken and completed. (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS** • **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		

14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12)

Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

12. EQUALITY IMPACT ASSESSMENT

To be completed by the policy author or lead.

Equality Analysis – Template
'Helping you deliver person-centered care and fair employment'

Title of policy/programme/service change being assessed:	Fit and Proper Persons Test Policy
Date of Assessment:	
Assessment Author:	Julie Hill, Company Secretary

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

The Policy aims to ensure that all Board Members and Staff on Very Senior Manager contracts meet the requirements of the Fit and Proper Persons Test.

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

All Board Members and Staff on Very Senior Manager Contracts.

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 & Pregnancy		X		All groups will be treated equitably
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
N/A			

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

Trust Board Paper Meeting Paper

Board Meeting Date	12th March 2024
Title	**Annual Health & Safety Report 2023**
	This paper is for noting
Reason for the Report going to the Trust Board	To provide the Board with the Trust's annual Health & Safety Report, highlighting key areas of performance and providing assurance on relevant internal processes.
Business Area	Operations and Estates
Author	Jill Griffiths, Risk Team Manager
Relevant Strategic Objectives	**Ambition:** We will use our resources efficiently and focus investment to increase long term value

Berkshire Healthcare
Health & Safety - Annual Report 2023

Executive Summary

This report provides an update to the Board on Berkshire Healthcare's Health and Safety performance statistics for the calendar year 2023.

The report reviews Trust performance on a range of categories, comparing results to the previous year and national figures. Key points of note include:

- The Trust received no Enforcement Notices from the HSE or the Local Authorities in 2023.

- There were eleven incidents reported under the RIDDOR regulations in the year 2023, (with no false reports) showing an increase of seven incidents compared to 2022. The highest number of incidents (six) occurred in the Slips, Trips & Falls category – where all six were staff injuries.

- During 2023 the Trust reported 809 physical assaults against staff. This is a decrease of 121 (13%) compared to 2022. The Trust also reported 925 non-physical assaults against staff, a decrease of 152 (14%) on the previous year.

- During 2023 the Royal Berkshire Fire and Rescue Service undertook four fire safety visits to ensure the Trust is compliant with the Regulatory Reform (Fire Safety) Order 2005.

- There were two cases of arson reported for 2023, and eleven cases of a risk of fire being identified. Six out of eleven of the incidents were community based with the remainder being on Trust property. Three of the eleven incidents occurred at Prospect Park Hospital (PPH) which is the same number of PPH incidents for this category as the previous year.

- Compliancy in statutory training: Fire Awareness – The number of staff trained throughout 2023 has averaged **92.71**%. This is a 1.04% increase from last year (2022 average = 91.67%). This falls 2.29% short of the Trust's fire training target of 95% compliance.

- Compliancy in statutory training: Health & Safety - The number of staff trained throughout 2023 has averaged **96.25** % (0.5 % increase). This is above the Trust's target of 90% compliance.

- The overall sickness rate for 2023 was 4.17%, a reduction of 0.5% from 4.68% in 2022. The most common reason for absence remains anxiety/stress/depression, accounting for 29.1% of all sickness in the 12-month period. Absences attributed to musculoskeletal/back problems have remained consistent with 2022, at 10.3%.

- The number of FTE days lost to sickness in 2023 has decreased by 6.4% when compared to 2022.

1. Key Figures for Great Britain 2023

The most recent data from the Health and Safety Executive highlights the following issues:

- **1.8 million** working people were suffering from a work-related illness (No change).

  ✓ **875,000** workers suffering work-related stress, depression or anxiety
  ✓ **473,000** workers suffering from a work-related musculoskeletal disorder

- **135** workers were killed at work (up from 123 in 2022).

- **60,645** injuries to employees reported under RIDDOR (down from **61,713**).

- **561,000** injuries occurred at work according to the Labour Force Survey (down from **565,00**).

- **35.2 million** working days lost due to work-related illness and workplace injury

- **20.7 billion** estimated cost of injuries and ill health from current working conditions

2. Enforcement

There have been no enforcement actions from the Royal Berkshire Fire & Rescue Service or the Health & Safety Executive during 2023.

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

During 2023 there were 11 RIDDOR incidents which fell into the following categories:

RIDDOR Incident Type	2021	2022	**2023**
Manual Handling	2	1	**1**
Assault	4	1	**1**
Injured during physical restraint	-	-	
Slip, Trip or Fall	2	1	**6**
Sharps Injury	-	-	
Collision Struck by moving object	-	1	**2**
Trapped Body Part	-	-	**1**
Case of disease	-	-	**-**
Total	8	4	**11**

RIDDOR incident reports, including root cause analysis and remedial actions taken, are included in quarterly Trust performance reports at the Non-Clinical Risk Committee and tabled at the Joint Staff Consultative Committee.

Health & Safety

Training Compliancy 2023

All staff under-take statutory training in Health & Safety and Moving & Handling every 5 years.

The number of staff trained in Health & Safety throughout 2023 has averaged **96.25 %.** This is above the training target of 90%.

The number of staff trained in Low Risk MH throughout 2023 has averaged: **94.24 %**.
The number of staff trained in Medium Risk MH throughout 2023 has averaged: **94.24 %**.
The number of staff trained in High Risk MH throughout 2023 has averaged: **92.55 %**.

This is above the training target of 90%.

Health & Safety Training Compliancy 2023 (Statistics provided by Tableau Trust Summary Dashboard												
Statutory Training	**Jan 2023 %**	**Feb 2023 %**	**Mar 2023 %**	**Apr 2023 %**	**May 2023 %**	**Jun 2023 %**	**Jul 2023 %**	**Aug 2023 %**	**Sep 2023 %**	**Oct 2023 %**	**Nov 2023 %**	**Dec 2023 %**
Health & Safety	**96.14**	**96.22**	**95.95**	**95.54**	**95.97**	**96.47**	**96.43**	**96.38**	**96.43**	**96.51**	**96.46**	**96.59**
LR* Moving & Handling	**94.73**	**94.56**	**94.90**	**94.42**	**91.86**	**93.58**	**93.87**	**94.39**	**94.34**	**94.60**	**94.66**	**95.00**
MR* Moving & Handling	**93.74**	**95.68**	**96.37**	**93.34**	**94.39**	**94.68**	**94.69**	**93.08**	**94.52**	**94.86**	**94.12**	**93.94**
HR* Moving & Handling	**89.11**	**93.50**	**92.78**	**93.82**	**95.40**	**95.92**	**93.74**	**93.04**	**91.82**	**90.97**	**90.45**	**90.04**

LR* = Low Risk Moving & Handling - Refreshed Every 5 Years.
MR* = Medium Risk Moving & Handling – Refreshed every 3 Years
HR* = High Risk Moving and Handling – Refreshed every 3 years

Ligature Management

The assessment and management of ligature points is a key requirement for all mental health services, with Berkshire Healthcare working towards policy updates following national guidance commissioned by the mental health forum published in Dec 2023. This guidance highlights the procedure, scope, responsibilities, monitoring, assessment and risk reduction strategies to manage and reduced risk of harm from ligatures in mental health and Learning Disability wards. It includes a ligature point recording template that has been designed to support staff in identifying and recording ligature risk points, controls and actions required to mitigate risks associated with the built environment. The Trust piloted this tool at Prospect Park Hospital on behalf of the network in 2023. Following the pilot assessment, the Trust also sought an external peer review from expert colleagues at Surrey and Borders NHS Foundation Trust. This review took place in November 2023 with findings and recommendations now being managed in an action plan by the Trust's Lead for Suicide Prevention.

All other Mental Health Services review their Ligature Risk Assessments annually and report all findings to the Compliance and Risk Team where a prioritised risk reduction programme is implemented and managed.

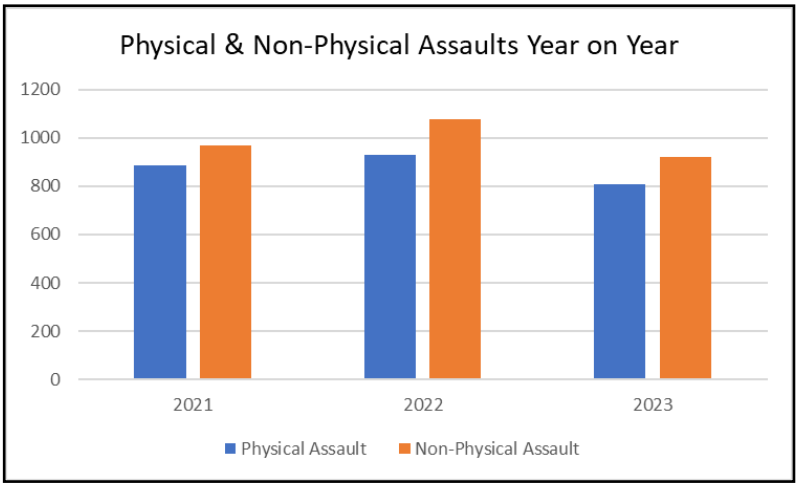
4. Violence and Aggression

- 809 physical assaults against staff were reported during the period, which is a decrease of 121 (13%) compared to 2022.
- 614 (76%) of the assaults took place on the mental health adult admission wards, PICU and older persons MH wards which is a reduction of 7% on the previous year.
- The number of reported non-physical assaults has decreased from 1077 (2022) to 925 (2023) which is a 152 (14%) year on year reduction. 813 of these incidents were carried out by patients (88%).
- 60% of physical assaults against staff were categorised as “Low – no injury/harm”
- 81% of non-physical assaults were categorised as “Low -no injury /harm”
- 2% of physical and non-physical assaults against staff were categorised as Moderate – significant but non-permanent harm.
- 129 (16%) of Staff physical assaults occurred in Children, Young Persons & Families Service
- 47 (6%) of Staff Physical Assaults occurred in the Physical Health Service

The Health, Safety & Security Management Specialists continue to raise the importance of reporting security-related incidents, particularly incidents of violence and aggression, via the Trust’s incident reporting system. The majority of physical and non-physical assaults are the result of a patient’s mental health or medical condition. Year on year there has been a drop in the number of reported physical and non-physical assaults for 2023 compared to 2022. This reduction is 13% for physical assaults and 14% for non-physical assaults.

As part of the National Patient Safety Strategy we have implemented significant changes to our Datix Integrated Risk Management System. This has forced some changes that staff are getting used to and that has potentially led to a reduction in reporting. The Risk and Patient Safety Teams are working with and supporting services to ensure that all staff are confident in the new categories of reporting and requirements to ensure that we have accurate reporting.

Physical Assaults “V” Non-Physical Assaults

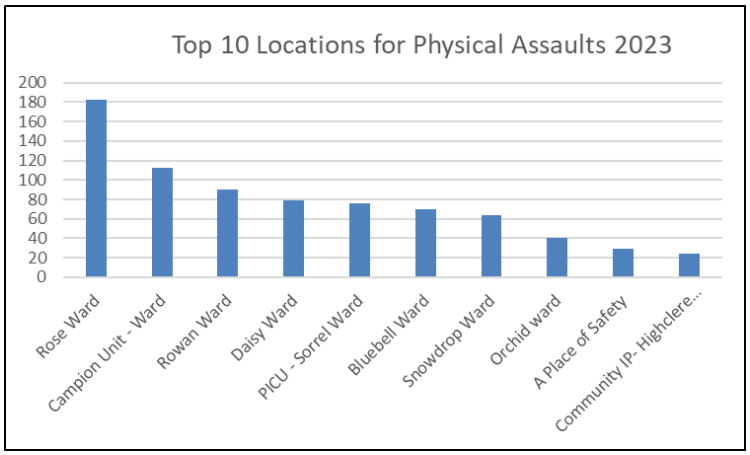


Physical Assaults by Locality

Physical Assaults 2023	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Total
Mental Health Inpatients	21	74	88	58	36	45	52	44	43	32	49	72	**614**
Physical Health	2	2	4	7	1	2	2	1	1	7	13	5	**47**
Community Mental Health East	2	0	1	0	0	3	0	0	1	0	1	0	**8**
Community Mental Health West	2	0	2	1	0	0	1	1	0	2	1	0	**10**
Children, Young persons & Families	8	8	13	11	8	8	16	13	12	13	5	14	**129**
Corporate	0	0	0	0	0	0	0	0	0	0	0	1	**1**
Total	**35**	**84**	**108**	**77**	**45**	**58**	**71**	**59**	**57**	**54**	**69**	**92**	**809**

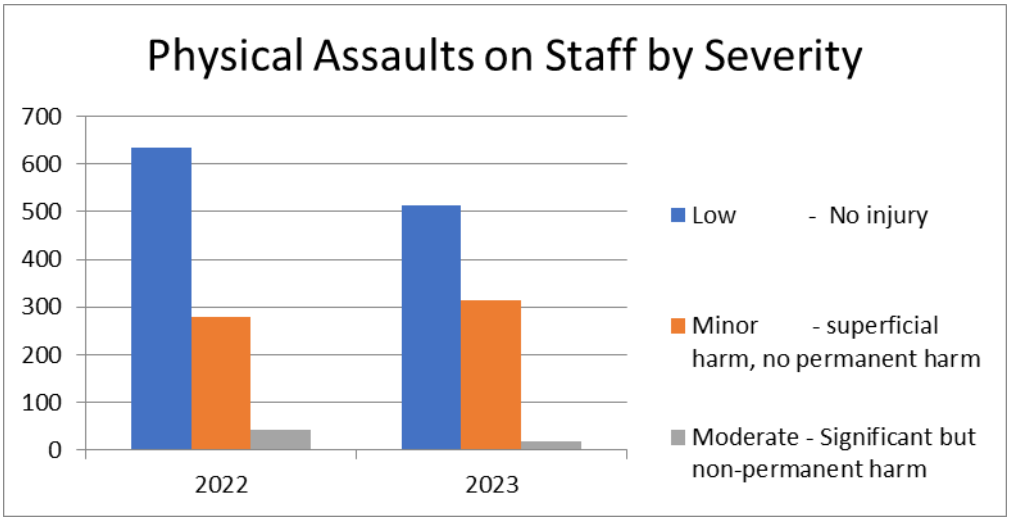
Rose Ward and Campion Unit at Prospect Park Hospital, were the top two locations for incidents in 2023, with 7 other wards at Prospect park accounting for 9 of the 10 top locations. Highclere Ward at West Berkshire Community Hospital reported 21 physical assaults during 2023, which is a year on year increase. Most incident were due to medical factors affecting patient behaviours.

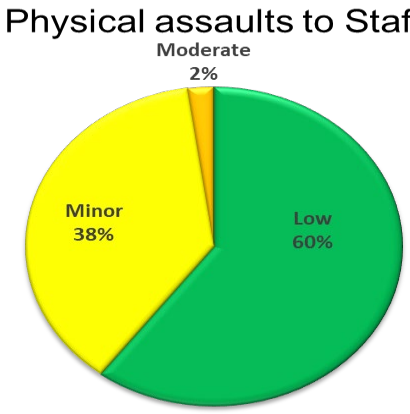
Physical Assaults by Location



The severity of the physical assaults across the Trust in 2023 can be seen in the table below, which shows 60% of physical assaults resulted in Low – No injury, 38% resulted in Minor – superficial harm, and 2% resulted in Moderate – significant but non-permanent harm.

Severity of Staff Physical Assaults





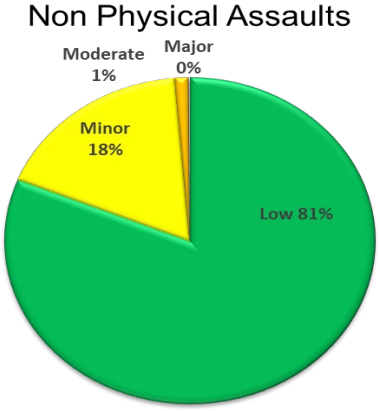
Staff **non-physical assaults** are categorised as seen in the tables below:

88% of all non-physical assaults (813) are caused by abusive patients with 9% categorised as "abuse by other" and 3% of all recorded incidents being caused by abusive staff.

Staff Non Physical Assaults	Jan 23	Feb 23	Mar-23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Total
Abuse by Patient	61	83	146	74	67	61	51	68	56	50	56	40	813
Abuse by Staff	6	8	5	1	3	2	5	0	2	2	3	2	39
Abuse by Other	2	4	5	6	10	11	4	5	5	11	4	6	73
Total	**69**	**95**	**156**	**81**	**80**	**74**	**60**	**73**	**63**	**63**	**63**	**48**	**925**

Non-Physical Assaults by Locality

Non-Physical Assaults 2023	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Total
Mental Health Inpatients	34	49	127	39	40	36	31	41	48	41	34	24	**544**
Physical Health	8	6	8	26	8	10	7	13	1	5	11	8	**111**
Community Mental Health East	4	3	6	3	7	9	2	1	3	4	7	1	**50**
Community Mental Health West	9	11	3	1	2	2	4	9	3	0	3	0	**47**
Children, Young persons & Families	4	14	2	5	10	4	7	4	1	0	1	7	**59**
Corporate	2	0	0	0	0	0	0	0	0	0	0	0	**2**

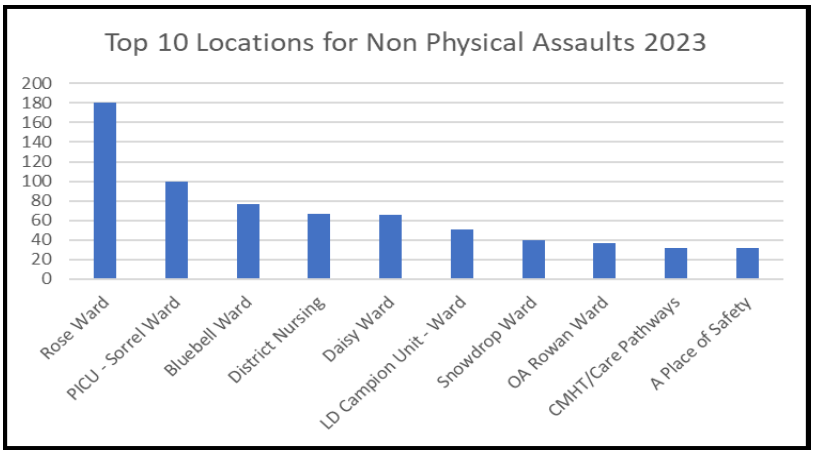


Whilst the majority of all non-physical assaults occur at Prospect Park Hospital, the district Nursing Teams and the Community Mental Health Teams are also ranking in the top ten locations. There has been an increase in verbal aggression towards staff since Covid-19, and this is logged both in face to face contact, or via electronic/telephone communications with staff.

All Assaults, Abuse & Behaviour Incidents by Month - 2023

All Assaults, abuse and behaviour incidents	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Total
Abuse by Patient	61	83	146	77	45	58	71	59	57	54	69	92	**872**
Physical Assault by Patient	35	84	108	74	67	61	51	68	56	50	56	40	**750**
Abuse by Other	6	8	5	6	10	11	4	5	5	11	4	6	**81**
Attitude	3	3	1	1	3	2	5	0	2	2	3	2	**27**
Abuse by Staff	2	4	5	3	3	0	4	0	2	1	6	2	**32**
Alleged Sexual Assault	2	0	4	1	3	2	1	0	0	0	0	0	**13**
Property/Criminal Damage	0	2	0	2	0	0	1	0	1	0	1	1	**8**
Physical Assault by Other	0	0	0	0	2	0	1	1	0	0	0	0	**4**
Physical Assault by Staff	0	0	0	0	0	0	1	0	0	0	2	0	**3**
Patient refusing treatment	0	0	0	0	0	0	0	2	0	0	1	0	**3**
Dirty Protest	0	0	0	0	0	1	0	0	0	0	0	0	**1**
Total	**109**	**184**	**269**	**164**	**133**	**135**	**139**	**135**	**123**	**118**	**142**	**143**	**1794**

Non-Physical Assaults by Location



81% of non-physical assaults resulted in “Low” impact on staff, but it is concerning that 18% of all non-physical assaults have “Minor” impact on staff and often result in staff becoming increasing worried or concerned around their workplace safety. This can result in prolonged long term sickness and staff shortfalls in the workplace.

NB: Low = No injury, Minor = superficial harm, and Moderate = significant but non-permanent harm.

Of the 1794 reported incidents in Berkshire Healthcare during 2023 there were 25 alleged sexual assaults.

1 incident was an alleged staff on patient sexual assault, 1 incident was an alleged patient on patient sexual assaut, and 23 incidents were alleged patient on staff sexual assaults.

Berkshire Healthcare has committed and signed up to the NHS England's Sexual Safety Charter where all signatories to this charter, commit to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards the workforce. The Trust will be working to make further progress with the ten Actions, and this will be completed in conjunction with the ongoing Violence Prevention & Reduction work.

Hate Crimes

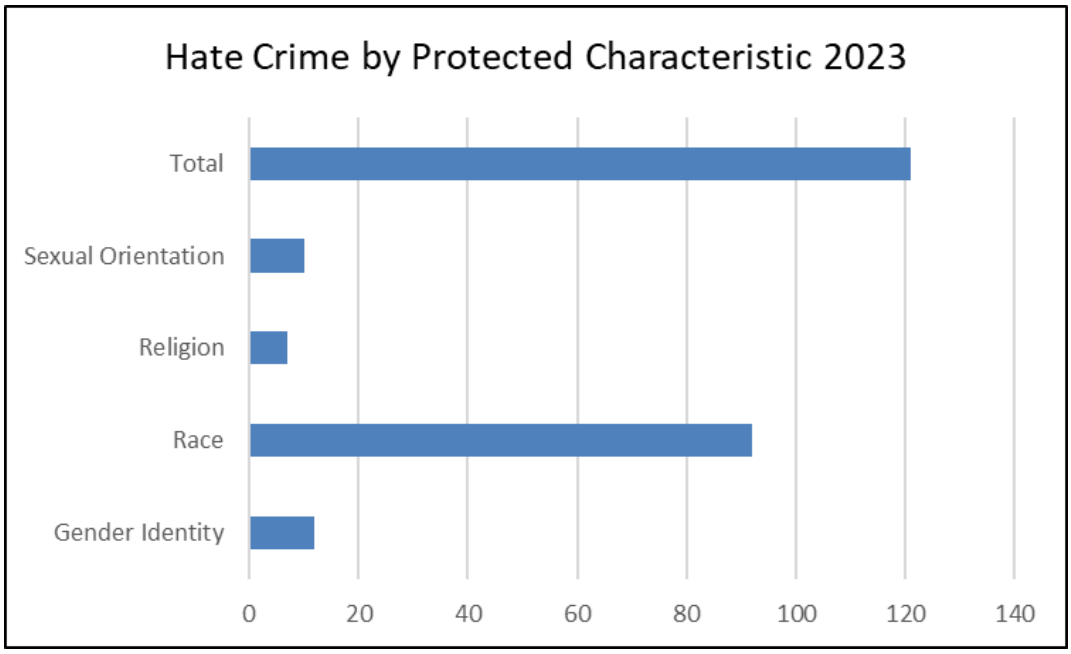
- There were 121 hate crime incidents reported during 2023. This is a decrease of 38 (from 159) - 24% from 2022. Hate crimes incidents can be reported by any of the 5 protected characteristics that come under the definition, disability, race, religion, gender identity or sexual orientation (or any combination thereof). The category includes both "Hate Crimes" and "Hate Incidents". (NB. One incident can often log more than one protected characteristic)

- Hate Crime Incidents can be reported alongside another category of incident e.g. "patient breaks door and is racially abusive to attending staff member". This would be categorised as "Criminal Damage" with the racial element "bolted" on.

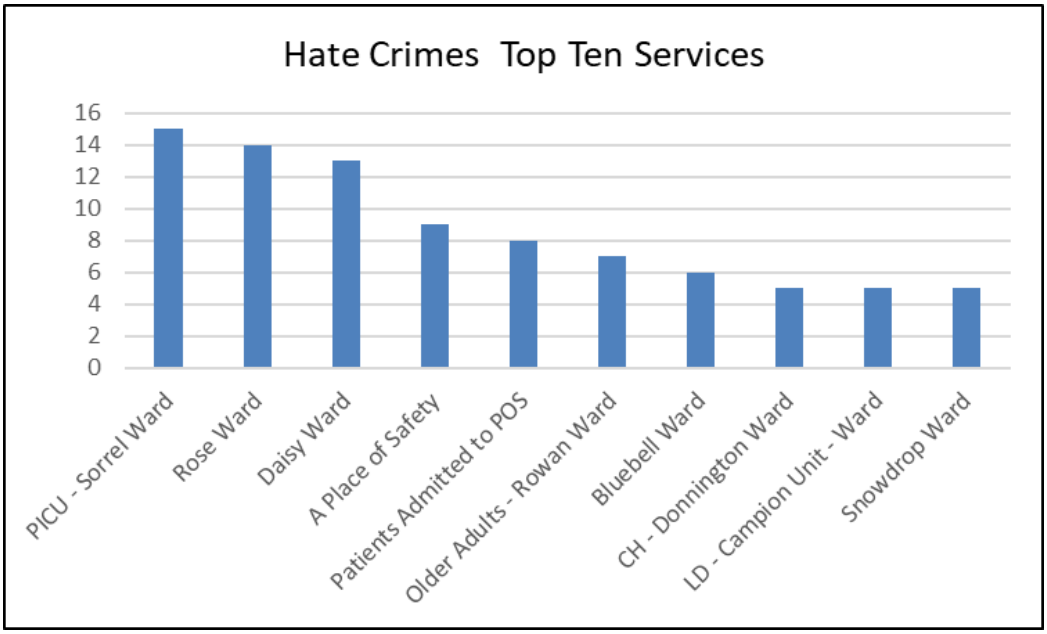
- 76% of the reported hate crime incidents in 2023 had an element of bias against race
- 96% of all hate crimes occur at Prospect Park Hospital

- 51% of all hate crime incidents occur on 3 wards and in APOS or by patients that are in the process of being admitted to APOS

<u>Hate Crime Incidents by Protected Characteristic for 2023</u>



Hate Crime Incidents by Location for 2023



5. Security Management

Physical Security is reported to the quarterly Health, Safety and Environment Group and Non-Clinical Risk Committee.

Policy

The Trust has the following Security Policies with scheduled biennial review timeframes:

- Personal Safety Policy (HS002)
- Physical Security Policy (HS026)
- Lone Worker Policy (HS029)
- Lockdown Policy (HS031)
- Surveillance and CCTV Policy (ORG036)

There have been a number of working 'Task and Finish groups', to analyse reports/incidents of discrimination and racial abuse.

The Violence Prevention and Reduction Working Group met regularly during the period both internally and with our ICB (BOB) colleagues (Safer Workplaces Meeting). The Trust matched itself against the current standards, working through an Action Plan. The Trust's Violence Prevention and Reduction Strategy and Policy are still in development, whilst NHS England are reviewing the standards at present and hope to disseminate those during the first quarter of 2024.

Targeted work continues at Prospect Park Hospital to address the high levels of racial abuse, offering greater post incident support to all Trust staff to support their health and wellbeing.

The Criminal Justice Panel Group was implemented at Prospect Park to establish and bolster positive working processes and operation with Thames Valley Police. A new Service Level

Agreement is awaiting final approval to assist in promoting positive outcomes with police investigations.

The Health, Safety and Security Managers continue to support colleagues, delivering a variety of training where security responsibility is captured which includes Principles of Risk Management, which was a new training delivery in 2023.

Conflict Resolution Training is delivered at Trust Induction and on a three-year refresher cycle for all relevant staff according to the Training Needs Analysis.

Training compliance for Conflict Resolution Training (CRT) can be seen below.

Mandatory Training	Jan 2023 %	Feb 2023 %	Mar 2023 %	Apr 2023 %	May 2023 %	Jun 2023 %	Jul 2023 %	Aug 2023 %	Sep 2023 %	Oct 2023 %	Nov 2023 %	Dec 2023 %
Conflict Resolution	**97.08**	**97.18**	**97.56**	**97.65**	**97.37**	**97.65**	**98.06**	**97.54**	**97.85**	**98.22**	**98.12**	**98.10**

The training average for 2023 is **97.7%** which is above the Trust's CRT training target of 90%.

The National Association of Healthcare Security, (NAHS), are in the final process of a new set of NHS Security Standards, these will replace the NHS Protect standards which were discontinued in 2018. They will include definitive Competency standards and qualifications for Security professionals, which in turn will lead to a new training delivery across all NHS Organisations.

Berkshire Healthcare continue to monitor Violence and Aggression (V&A) and Musculoskeletal (MSK) Disorders in the work place in line with the Health & Safety Executive letter that was circulated in 2023. The Trust have a V&A and MSK Action plan that has made good progress throughout 2023 and will be concluded in March 2024.

Closed Circuit Television (CCTV)

Following the transfer from NHS PS of the management of the CCTV provision to be exclusively Berkshire Healthcare responsibility, a contract for an annual planned preventative maintenance schedule has been implemented across the whole of Berkshire Healthcare estate and all passwords have been changed to standardise with MICAD referencing.

Security and CCTV annual audits and reviews continue across all sites, with the 2023 /2024 reviews due to conclude by the end of March 2024. Remedial action plans are reviewed and managed in conjunction with the Head of EDTS and Estates, and shared via the Health, Safety and Environment Governance Group.

Looking Forward

In 2024 the Trust will be required to meet a new statutory obligation known as the Prevent Duty, also known as Martyn's Law. The Prevent Duty is forthcoming legislation that will place a statutory requirement on those responsible for certain publicly accessible locations to consider the threat from terrorism and implement appropriate and proportionate mitigation measures. In preparation for its arrival and in addition to maintaining existing security arrangements and measures already outlined in this report, additional proposals will be made to further strengthen the organisations security profile to mitigate relevant threats.

6. Personal Safety and Lone Working

- During 2023 a new contract for the lease of lone worker devices was agreed with Peoplesafe for 800 devices and 200 App Licences. This contract commenced on the 1st November 2023.

- Reports show an average usage per month of approximately **42%** over the year by all divisions for the 850 devices under contract up to September 2023 and the 800 devices from November to December 2023 (**up 4%** from previous year).

- Work continues to improve the Service Lead Risk Assessment process and Trust engagement with staff on Lone Working Protocols.

A roll out of brand new (Peoplesafe MySOS) lone working devices will commence in April 2024 – where old (Microguard Devices) will be swapped out for new amongst existing services. During the latter part of 2023 Services were asked to review their lone worker risk assessments (annual review) and to check that staff profiles on the Peoplesafe portal were current and up to date. Low risk groups – rare occasional lone workers in central town locations may be eligible to use the Lone Working Device App through the risk assessment process as we move into 2024.

7. Fire Safety

There have been no enforcement actions from the Royal Berkshire Fire and Rescue Service (RBFRS) during 2023, and the Compliance and Risk Team continue to work closely with the authority.

During 2023 the Royal Berkshire Fire and Rescue Service undertook four follow up visits to ensure the management of fire safety within Berkshire Healthcare following their attendance to site for incidents.

1. 01/08/2023 Donnington Ward, West Berkshire Community Hospital
2. 03/08/2023 Rowan Ward Prospect Park Hospital
3. 10/10/2023 Donnington Ward, West Berkshire Community Hospital
4. 28/10/2023 Daisy Ward Prospect Park Hospital

In each case the Trust was found to be **Broadly Compliant** (Compliance Level 1) with some Informal Actions and Minor Deficiencies, which have been rectified.

OUTCOME OF AUDIT
Initial Enforcement Expectation (IEE)

Compliance Level 1	Compliance Level 2	Compliance Level 3	Compliance Level 4	Compliance Level 5
Score of 0-25	Score of 26-35	Score of 36-45	Score of 46-55	Score of 56 plus
Broadly Compliant Inform & Educate	Notifications of Minor Deficiencies	Notifications of Deficiencies	Enforcement Notice	Enforcement Notice "Fast Track"

The external Authorising Engineer (Fire) will carry out a fire safety management audit in line with Health Technical Memorandum 05-01 in February / March 2024.

This agreement commenced in October 2021 and all completed reports should be read in conjunction with the initial Fire Risk Management System (FSMS) audit carried out on 6th /7th October 2021.

The Trust commissioned an audit of the Fire Door Maintenance Programme at Prospect Park Hospital, to provide the Authorising Engineer AE (Fire Safety) services as recommended in the Health Technical Memorandum 05-01. This audit was to support ISS in ensuring that the appropriate fire safety arrangements were in place for refurbishment work, new capital schemes and to advise on suitable maintenance programs for various active and passive fire safety features as required. This audit was carried on the 10th of May 2023.

Conclusion: audit summary: the overall risk within the wards observed, in terms of the standard of fire doors installed and those with minor damage - with the implementation of an appropriate risk-based repair procedure **was low** and therefore tolerable.

8. Fire Incidents 2023

Summary of key fire incidents:

There were five incidents of "Accidental Fire" in 2023:

- WEB1486589: Community Nursing – Microwave damaged due to fire and removed
- WEB152678: Community: Safeguarding
- WEB152962: Community: Safeguarding
- WEB153139: Block 14 Upton Hospital accidental activation of fire call point
- WEB157904: Bluebell – Patient punched Fire Alarm call point

Two incidents of Arson were reported:

- WEB152483: Daisy - Deliberate ignition of clothing
- WEB159018: Daisy - Patient set fire to their trainer shoe

Five incidents were reported where Equipment Failed:

- WEB151729: Memory Clinic – faulty final exit
- WEB155877: WBCH: small fire due to faulty kettle
- WEB158357: Donnington – Faulty microwave
- WEB158626: PPH BLD 1 - Magloc in corridor faulty
- WEB158698: Whitley Health – Faulty Alarm Printed Circuit Board

All fire related incidents were investigated, escalated where necessary and follow up actions implemented where required.

Fire Related Incident by Type:

Type of Fire Incident	2020	2021	2022	2023	Total
Accidental	1	1	7	5	**14**
Arson	3	7	1	2	**13**
Equipment Damaged	1	8	1	0	**10**
Equipment Failure	2	2	2	5	**11**
False Alarm Accidental Use of Call Point	5	2	2	1	**10**
False Alarm Malicious	0	2	1	1	**4**
False Alarm Other	20	6	6	4	**36**
Other Fire Incident	2	7	12	10	**31**
Risk of Fire Identified	5	10	10	11	**36**
Total	**39**	**45**	**42**	**39**	**165**

Fire Related Incident by Directorates:

Directorate	2020	2021	2022	2023	Total
Mental Health Inpatients	10	24	11	11	**56**
Physical Health	5	7	18	15	**45**
Corporate	17	9	8	5	**39**
Children, Young persons & Families	2	1	2	5	**10**
Community Mental Health West	5	2	1	1	**9**
Community Mental Health East	0	2	2	2	**6**
Total	**39**	**45**	**42**	**39**	**165**

Smoking Incidents – Top 14 sub- categories by year 2021 – 2023

Smoking Sub Catagory	2021	2022	2023	Total
Smoking Policy Reinforced	92	121	66	345
Physical Assault by Patient	36	22	23	99
Abuse by Patient	34	28	18	80
Abuse of Drugs or Alcohol	6	16	30	60
Damaging Property/Criminal Damage	8	7	6	28
Failure to return from leave - Sectioned Patient	3	4	6	18
Threatening Behaviour - Deactivated	2	0	0	17
Inappropriate Behaviour	2	0	0	16
Attitude	7	2	4	13
Ingestion	3	2	2	10
Risk of Fire Identified	4	1	3	9
Arson	5	1	0	8
Left Ward Without Permission (on site) - Sectioned	3	2	1	8
Ligature	6	2	0	8
Total	**211**	**208**	**159**	**578**

Smoking related incidents by service: 2021 – 2023

Smoking related incidents by service	2021	2022	2023	Total
Mental Health Inpatients	241	216	168	**625**
Children, Young persons & Families	0	4	6	**10**
Community Mental Health West	0	2	0	**2**
Total	**241**	**222**	**174**	**637**

Smoking related incidents for 2023 at Prospect Park Hospital are down by 25% on the previous year. The e-cigarette used at PPH is currently under review. The Smoke Free Steering Group is working to further promote the use of vapes, for patients, as we move into 2024.

Tight management of any vapes endorsed or used in the Trust by patients must be in place, to ensure the recharging of patient devices, with controlled supervision of charging processes to minimise associated fire risks. This process will ensure that we do not create extra sources of ignition (or create ligature risks for patients with charging cables) on the wards, or further health and safety risks associated with oils or liquids used for refilling reusable vapes.

9. Fire Safety Improvements

The Fire Safety Specialist and the Health, Safety & Security Management Specialists have worked closely with the Estataes and EDTS Teams on the following Berkshire Healthcare Projects in 2023:

- Adlam Gardens
- Fairacres
- 25 Erlegh Road
- London House
- Resource House
- Magnolia Project (APOS / YPPOS)

Collaborative work continues on our PFI and NHS PS Sites to have a coordinated response to Fire Remedial Actions that are highlighted through the annual Fire Risk Asessment and Risk Assessment Review processes. Upton Hospital – Jubilee Ward Action Trackers have been closely monitored and managed to capture improvements and completion to remedial actions that have been highlighted through the Fire Risk Assessment process and direct comparison with Fire Code Health Technical Memorandums: 05:01, 05:02 & 05:03.

10. Fire training

The Fire Safety Specialist has developed a new National Fire Safety online programme in partnership with Skills for Health to ensure greater success for neurodiverse colleagues and colleagues whose first language is not English.

The Inpatient Fire Evacuation Training continues to evolve and capture bespoke site-specific training throughout the Trust – this has been most noticeable on Jubilee Ward at Upton Hospital.

All members of staff undergo statutory fire safety training every 12 months. Those not on wards have Fire Awareness Training but those who work with inpatients have Inpatient Fire Evacuation Training. Whichever one they complete counts as their statutory training.

Each service / department requires a Fire Warden to be present whilst the service is operating, Fire Warden Training also counts as statutory training. 261 colleagues were trained as fire wardens in 2023.

The Trust sets an overall target of **95%** for Fire Training Compliance and the table below shows the monthly training statistics for 2023:

363 colleagues were trained in the use of fire extinguishers and first aid firefighting in 2023.
The table below shows the monthly training statistics for 2023:

Fire Safety Training Compliancy 2023 (Statistics provided by Tableau Trust Summary Dashboard												
Statutory Training	**Jan 2023 %**	**Feb 2023 %**	**Mar 2023 %**	**Apr 2023 %**	**May 2023 %**	**Jun 2023 %**	**Jul 2023 %**	**Aug 2023 %**	**Sep 2023 %**	**Oct 2023 %**	**Nov 2023 %**	**Dec 2023 %**
Fire Safety	**92.81**	**93.26**	**93.06**	**94.11**	**94.35**	**94.25**	**93.55**	**93.17**	**93.43**	**94.01**	**93.99**	**93.91**
IPFE*	**92.54**	**89.46**	**91.89**	**90.91**	**93.56**	**94.04**	**93.15**	**92.46**	**91.24**	**87.48**	**91.77**	**92.77**

IPFE*= Ward Based - Inpatient Fire Evacuation Training

The Trust continues to strive for 95% Fire Training compliance across all directorates, but ward areas, with current staffing and recruitment issues and the use of NHS P staff makes this task more complex. There has been a small improvement throughout the year on inpatient wards, with an average compliance per month now sitting above 90%. Targeted training and a more flexible approach to training delivery on the wards has enabled the training figures to slowly continue to rise.

2023 Averages: Fire Safety = **93.66%** IPFE = **91.77%** **Combined average = 92.71%**

This is a **increase of 1.04%** on the 2022 combined average of **91.67%.**

11. Days Lost through Sickness

The total number of FTE days lost to sickness in 2023 has decreased by 6.4% when compared to 2022. The most common reason for absence remains anxiety/stress/depression, accounting for 29.1% of all sickness in the 12-month period, a proportional increase from 24.7% in 2022. There has also been a 10.7% increase in the number of FTE days lost for this reason.

The overall sickness rate for 2023 was 4.17%, a reduction of 0.5% from 4.68% in 2022. Analysis of the monthly sickness rates in the 12-month period shows a reduction in the sickness absence rate in the first four months of the year. The sickness rate then remained fairly stable at around 4% from May to September 2023, with an increase towards the end of 2023, ending the year at 4.61%

The following table shows the number of FTE days lost to sickness, by reason, for the calendar year January 2023 to December 2023.

Absence Reason	Headcount	Abs Occurrences	FTE Days Lost	%
S10 Anxiety/stress/depression/other psychiatric illnesses	669	931	19,459.44	29.1
S13 Cold, Cough, Flu - Influenza	1991	2,961	8,883.41	13.3
S15 Chest & respiratory problems	963	1,138	6,722.54	10.1
S25 Gastrointestinal problems	1222	1,663	5,587.19	8.4
S12 Other musculoskeletal problems	387	497	4,777.46	7.2
S28 Injury, fracture	165	183	2,913.40	4.4
S26 Genitourinary & gynaecological disorders	281	362	2,622.62	3.9
S17 Benign and malignant tumours, cancers	35	56	2,570.41	3.8
S16 Headache / migraine	773	1,084	2,213.59	3.3
S30 Pregnancy related disorders	101	181	2,094.89	3.1
S11 Back Problems	211	252	2,079.15	3.1
S21 Ear, nose, throat (ENT)	313	374	1,534.97	2.3
S29 Nervous system disorders	46	71	982.80	1.5
S19 Heart, cardiac & circulatory problems	81	95	881.97	1.3
S23 Eye problems	92	109	774.10	1.2
S98 Other known causes - not elsewhere classified	68	79	554.62	0.8
S24 Endocrine / glandular problems	38	44	396.43	0.6
S22 Dental and oral problems	111	131	381.68	0.6
S31 Skin disorders	66	76	326.39	0.5
S18 Blood disorders	13	16	281.10	0.4
S27 Infectious diseases	37	38	235.97	0.4
S20 Burns, poisoning, frostbite, hypothermia	12	12	187.87	0.3
S14 Asthma	28	29	161.87	0.2
S99 Unknown causes / Not specified	25	26	140.61	0.2
S32 Substance abuse	2	3	9.00	0.0
		Total	**66,773.47**	

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**Audit Committee Meeting – 17 January 2024**
	Item for Noting
Reason for the Report going to the Trust Board	The Audit Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. The Trust Board is required to identify any areas for further clarification on issues covered by the meeting minutes and to note the content.
Business Area	Corporate
Author	Company Secretary for Rajiv Gatha, Chair of the Audit Committee
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 17 January 2024

(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 Amanda Mollett, Head of Clinical Effectiveness and Audit Nav Sodhi (deputising for Minoo Irani, Medical Director) Sharonjeet Kaur, RSM, Internal Auditors Jenny Loganathan, TIAA Maria Grindley, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Mark Davison, Chief Information Officer *(present for agenda items 5 and 6)* 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: Minoo Irani, Medical Director.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meeting held on 25 October 2023**	
	The Minutes of the meeting held on 25 October 2023 were confirmed as a true record of the proceedings.	

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4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.	**Annual Cyber Security Report**	
	The Chair welcomed Mark Davison, Chief Information Officer to the meeting. A copy of the Annual Cyber Security Report had been circulated. The Chair referred to paragraph 2.3 of the report which stated that the Trust had no cyber security incidents during 2023 and asked how the Trust had assured itself that there were no cyber security incidents. The Chief Information Officer said that the Trust closely monitored the IT infrastructure and external assurances were received from several different sources, including from penetration checking and testing companies and from the National Cyber Security Centre who issued various alerts throughout the year which often related to things which the Trust was already doing. The Chief Information Officer said that the Trust also took assurance from the certification process for the ISO 2701 and cyber essentials plus. The Chair referred to paragraph 5.15 which stated that it was good practice to have between 12 and 15 Information Asset Owners at Director level and who had accountability for any risks identified with an information system within their directorate and noted that the Trust had 16 Information Asset Owners and asked whether they were all at director level. The Chief Information Officer reported that for small services, for example, the Community Dental Service which ran its own information systems, the Information Asset Owner was the Head of Service rather than the Divisional Director. The Chair congratulated the Trust for the very positive results of the Phishing exercise. The Committee: noted the report.	
6.	**Annual Information Governance Report**	
	The Annual Information Governance Report had been circulated. The Chair referred to paragraph 3.7 of the report which included a table setting out the categorisation of reported Information Governance incidents and requested that for future reports, the category “failure to follow policy/process” be broken down to show which policies/processes were most commonly not followed. The Chair referred to paragraph 5.9 of the report which highlighted that there had been an increase during 2023 in operational services procuring systems through their service budgets without seeking support and guidance from IT, Security, Information Governance and the Procurement Teams. The Chair asked what subsequent controls had been put in place to mitigate this risk.	**MD**

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	The Chief Information Officer explained that a lot of work had been done to make sure that services understood the governance and contracting processes. Mr Davison pointed out that many computer systems were now hosted on the internet which was more challenging to control. The Chair suggested seeing if there were ways of monitoring network traffic to identify whether staff were using web-based applications or tools which the Trust was not aware off. The Chair said that it would be helpful for the Committee to understand more about the Trust's current strategy in relation to the development of Artificial Intelligence. Mark Davison said that the Trust had started to engage with the Senior Leadership Team about the potential of Artificial Intelligence for clinical services. Mr Davison said that he would be happy to give a presentation on the Trust's thinking around the development of Artificial Intelligence to a future meeting. Naomi Coxwell, Non-Executive Director asked whether the Trust had considered taking out cyber security insurance. Mark Davison explained that the Trust's preference was to focus on preventing cyber security attacks. The Chief Financial Officer reported that he met with the Trust's Insurance Broker on an annual basis to discuss the Trust's insurance requirements for the forthcoming year and agreed to discuss issue of cyber security insurance. The Committee noted the report.	**MD** **MD** **PG**
7.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 risks on both the Board Assurance Framework and the Corporate Risk Register should be aligned to the Trust's refreshed Strategy. The Chief Financial Officer highlighted the following key changes: • **Risk 1** (Workforce) – unchanged • **Risk 2** (Demand and Capacity) – amended to focus on the risk of harm to patients. • **Risk 3** (Patient Voice) – a new risk • **Risk 4** (System Working) – unchanged. • **Risk 5** (Health Inequalities) – a new risk • **Risk 6** (Finance) - unchanged • **Risk 7** (Digital Risk) – amended to focus on capital constraints and level of funding available to invest in new technologies. • **Risk 8** (Sustainability) – a new risk The Chair commented that he liked the format of the Board Assurance Framework which aligned the risks to the Trust's strategic ambitions.	

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	It was noted that the Trust Board would be discussing the refreshed Board Assurance Framework and Corporate Risk Register at the February 2024 Trust Board Discursive meeting. The Committee noted the report.	**JH**
7.B	**Corporate Risk Register**	
	The Corporate Risk Register had been circulated. The Chief Financial Officer reported that the Corporate Risk Register had been aligned to the Trust's refreshed strategy and included the following new risks: • CRR 6 – Third Party Service Providers Risk • CRR 8 – Physical Environment Risk – Jubilee Ward • CRR 9 – Risk Care, Right Person Risk • CRR 10 – Long Waiting Times for Services Risk • CRR 12 – Violence and Aggression Risk The Committee noted the report.	
8.	**Single Waiver Tenders Report**	
	A paper setting out the Trust's single waivers approved from 1 October 2023 to 31 December 2023 had been circulated. The Chief Financial Officer presented the paper and reported that the Trust had used a single waiver to appoint a company to conduct a condition survey of Prospect Park Hospital and had used the same company to undertake an investigative report following an incident at Prosect Park Hospital. It was noted that there were very few companies who had specialist knowledge of PFI Buildings. The Chief Financial Officer reported that a single waiver had been used for a one-year contract with Mind in Berkshire to support the development and implementation of the new services bridging primary and secondary care. The Chair asked whether the number of single waiver contracts had increased this quarter. The Chief Financial Officer explained that it was a timing issue and pointed out that during quarter four there tended to be more single waiver contracts with the voluntary sector. The Chair asked about the financial thresholds for approving single waiver contracts. The Chief Financial Officer said that single waivers under £100,000 were approved by the Director of Finance. Single waiver contracts over £100,000 would be approved by the Chief Financial Officer and the Chief Financial Officer would consult with the Chair of the Audit Committee before approving single waiver contracts above £300,000. Mark Day, Non-Executive Director asked whether the Trust ensured that third party providers, for example, a voluntary sector organisation such as Mind in	

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	Berkshire had the same level of cyber security controls and review as with a commercial organisation. The Chief Financial Officer confirmed that the single waiver approval process included the same Information Governance and Cyber Security checks as for any other contract. The Director of Finance added that the Head of Contracting worked closely with the Associate Director of Information Governance as part of the contract process to ensure compliance with the Trust's Information Governance and Cyber Security requirements. The Committee noted the report.	
9.	**Information Assurance Framework Update Report**	
	The Chief Financial Officer presented the paper and highlighted the following points: • A total of five indicators were audited during quarter 3: • Mental Health: Gatekeeping (green for data assurance and amber for data quality) • Mental Health: 72 Hour Follow Up Appointment (green for data assurance and red for data quality) • Mental Health Acute Occupancy Rate (green for data assurance and data quality) • Mental Health Readmission rates (green for data assurance and data quality) • Action plans had been put in place to address the identified issues and previous actions were tracked in the report. The Chief Financial Officer referred to the Mental Health: 72 Hour Follow Up Appointment indicator and explained that the red rating for data quality was around incomplete data and timing of data entries and did not reflect a systemic failure around recording data. The Chief Financial Officer reported that work was underway to ensure that staff understood when the data needed to be imputed onto the system. The Committee noted the report.	
10.	**Losses and Special Payments Report**	
	The Chief Financial Officer presented the paper which provided a list of the Trust's losses and special payments made during quarter 3 2023-24. The Committee approved the losses and special payments made during quarter 3 2023-24.	
11.	**Clinical Claims and Litigation Report**	
	The Director of Nursing and Therapies presented the paper and highlighted the following points:	

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	• During quarter three, there were seven new claims (four clinical negligence claims and three employer liability claims) • Four claims were closed during quarter three. The Committee noted the report.	
12.	**Clinical Audit Report**	

	The Head of Clinical Effectiveness and Audit presented the paper and highlighted the following points:
	
	• The following national clinical audit reports had been published since the last meeting:
	  ○ Sentinel Stroke National Audit Programme (SSNAP) – Annual Report (reporting to February 2024 Quality Assurance Committee)
	  ○ National Falls Inpatient Audit annual report (Reporting to February 2024 Quality Assurance Committee)
	  ○ National diabetes Core audit report (Reporting to May 2024 Quality Assurance Committee)
	  ○ National Diabetes – Type 1 report (Reporting to May 2024 Quality Assurance Committee)
	  ○ National Diabetes – Young Type 2 report (Reporting to May 2024 Quality Assurance Committee)
	• The report provided assurance to the Audit Committee that the Clinical Audit Plan 2023-24 was on track.
	• 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.	

13.	**Anti-Crime Services Report**	
	Jenny Loganathan, Anti-Crime Specialist, TIAA presented the report and highlighted the following points: • TIAA and the Trust's Security Team had conducted some joint site visits during International Fraud Awareness week to raise awareness of fraud issues. • A survey on whistleblowing had been circulated to the Trust's Freedom to Speak Up Champions to gain feedback on whistleblowing within the Trust. • TIAA would be delivering training to the Freedom to Speak Up Champions • The fraud check on agency staffing was underway. • TIAA was discussing with the Finance team to establish what interests/gifts and hospitality had been declared over the year and will include a section on declarations in the next update report. • Two referrals had been received since the last Audit Committee meeting which were investigated as minor enquiries. There were five ongoing investigations, one of which had been referred to the NHS Counter Fraud Agency. The other investigations were progressing with the support of the Trust's Human Resources team.	

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	The Chair noted that one of the referrals concerned alleged queue jumping but the referral contained minimal information alleging that a member of staff (no name) had given preferential treatment to a patient in the Accident and Emergency Department allowing them to receive expedited treatment. It was noted that as the Trust did not have an Accident and Emergency Department, it was assumed that this related to another Trust most likely the Royal Berkshire NHS Foundation Trust because of the similar name. The Chair asked whether TIAA would refer the allegation to the Royal Berkshire Hospital. Jenny Loganathan explained that if the referral had contained more information, for example the name of the staff member, then the referral would be re-directed to the relevant Trust. Noami Coxwell, Non-Executive Director asked about the controls in relation to gifts and hospitality. Ms Loganathan said that the Trust's Business Conduct Policy required gifts and hospitality over £25 to be declared. The Committee noted the report.	
14.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Sharonjeet Kaur, RSM, Internal Auditors presented the paper and highlighted the following points:
	
	• Since the last meeting, the following reports had been issued:
	  ○ Temporary Staffing final report (reasonable assurance)
	  ○ Out of Area Placements draft report
	  ○ Key Financial Controls draft report
	  ○ Board Assurance Framework draft report
	• The two remaining reviews (Transformational Plans/Cost Improvement Programme Schemes and Bed Management and Discharge Processes) were in progress.
	• The key recommendations from the Temporary Staffing review included making sure that staffing rosters and annual leave requests were completed on time and making sure that the Temporary Staffing Policy was reviewed and updated.
	• The report included Integrated Care Systems Health Matters Update, Building Resilience in Healthcare Report and relevant Client Briefings
	
	b) Annual Internal Audit Strategy 2024-27 and Internal Audit Plan 2024-25
	
	The draft Annual Internal Audit Strategy 2024-27 and Internal Audit Plan 2024-25 had been circulated.
	
	Sharonjeet Kaur reported that the draft Internal Audit Strategy had been developed in consultation with the Chief Financial Officer and wider Executive Team. It was noted that RSM's approach to developing the Internal Audit Plan was based on analysing the Trust's corporate objectives, risk profile and board assurance framework as well as taking account of factors affecting the Trust in the year ahead, including changes within the sector.	

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	The Chair asked how the Internal Auditors went about identifying topics for internal audit reviews in years 2 and 3. Ms Kaur explained that some of the audits were done on a cyclical basis and were therefore included in the plan and the other topics were proposed for consideration and would be agreed on an annual basis. Naomi Coxwell, Non-Executive Director asked whether there was scope to include additional audit review(s) in year if required. The Chief Financial Officer said that the Internal Audit Plan was kept under review and if required, other audits would be substituted if necessary and pointed out that there was also scope to commission additional review(s) even if all the audit days had been used up. The Committee: a) Noted the Internal Audit Progress Report b) Approved the Internal Audit Strategy 2024-27 c) Approved the Internal Audit Plan 2024-25	
15.	**External Audit – External Audit Strategy 2024**	
	Maria Grindley, Ernst and Young, External Auditors presented the External Audit Strategy 2024 and highlighted the following points: • A new inherent risk had been identified around the implementation of IFRS 16 on PFI scheme liabilities. The External Auditors were not expecting this to be an issue for the Trust, but as this was an update from the Department of Health and Social Care Accounting Manual this year, the risk needed to be flagged. • The External Auditors had also identified an inherent risk in relation to accounting for IFRS 16 due to the inconsistencies around valuation methods used for Right of Use assets, particularly NHS Property service properties. The External Auditors had held early discussions with the Trust and most of the work around this had been completed. • Ernst and Young had increased the performance materiality to 75% from 50%. The change reflected the limited adjustments needed to the prior year's financial statements. The Chair referred to the increase in performance materiality and asked whether 75% was the highest level of materiality. Ms Grindley confirmed that this was the case. The Chair asked whether the new risk around the PFI assets was a valuation risk. Ms Grindley confirmed that that the risk was around scheme liabilities. Naomi Coxwell, Non-Executive Director referred to the section on valuation of property, plant and equipment, land and buildings (page 278 of the agenda pack) and noted that the report stated that this was an area of significant work and review last year and therefore remained an area of significant risk for this year and asked for more information.	

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	Ms Grindley explained said that the risk would remain for this year but if there were no significant issues identified during the 2023-24 External Audit, it was likely that the risk would be removed for the following year. The Committee: noted the External Audit Strategy 2024.	
16.	**Minutes of the Finance, Investment and Performance Committee meeting held on 26 October 2023**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 26 October 2023 received and noted. The Committee noted the minutes.	
17.	**Minutes of the Quality Assurance Committee held on November 2023**	
	The minutes of the Quality Assurance Committee meetings held 28 November 2023 were received and noted.	
18.	**Minutes of the Quality Executive Committee Minutes – October 2023, November 2023 and December 2023**	
	The minutes of the Quality Executive Committee meetings held on: 16 October 2023, 20 November 2023 and 18 December 2023 were received and noted.	
19.	**Annual Work Plan**	
	The Committee's Annual Work Plan was noted.	
20.	**Any Other Business**	
	There was no other business.	
21.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled for 17 April 2024.	

The minutes are an accurate record of the Audit Committee meeting held on 17 January 2024.

Signed: - _____

Date: - 17 April 2024 _____

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Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 March 2024
Title	**The Use of the Trust Seal Report**
	Item for Noting
Reason for the Report going to the Trust Board	In accordance with the Trust's Standing Orders, the Trust Board is informed each time the Trust's Seal is affixed to documents. The Trust's Seal was affixed to a lease renewal in respect of the 1st Floor, Thatcham Health Centre, Bath Road, Thatcham.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value