Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 10 September 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 09 July 2024	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Board Story – Community Health Inpatients	Debbie Fulton, Director of Nursing and Therapies/Caroline Edwards, Community Inpatients Lead	Verbal
6.1	Patient Experience Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 27 August 2024 b) Changes to the Committee's Terms of Reference c) Learning from Deaths Quarterly Report d) Guardians of Safe Working Report	Sally Glen, Chair, Quality Assurance Committee Dr Minoo Irani, Medical Director	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 04 2024/25 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 04 2024/25 Performance Report	Tehmeena Ajmal, Chief Operating Officer	Enc.

No	Item	Presenter	Enc.
8.2	a) Finance, Investment and Performance Committee Meeting held on 24 July 2024 b) Finance, Investment and Performance Committee's Terms of Reference – updated for ratification	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal Enc.
STRATEGY			
9.0	Workforce Race Equality Standard Report	Alex Gild, Deputy Chief Executive/Ash Ellis, Deputy Director Leadership, Inclusion and Organisational Experience	Enc.
9.1	Workforce Disability Equality Standard Report	Alex Gild, Deputy Chief Executive/Ash Ellis, Deputy Director Leadership, Inclusion and Organisational Experience	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting – 24 July 2024	Rajiv Gatha, Chair of the Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting –12 November 2024	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

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

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Rebecca Burford	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Deputy Chief Executive
	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
	Victor Ovenseri	Service Lead, CREST *(present for agenda item 6.0)*
	Angela Miller	Clinical Specialist Occupational Health Therapist *(present for agenda item 6.0)*
	Karim Musah	Specialty Doctor *(present for agenda item 6.0)*
	Natraj Sauba	Senior Out of Area Placements Manager *(present for agenda item 6.0)*
	Mike Craissati	Freedom to Speak Up Guardian *(present for agenda item 6.1)*
	Kate Penhaligon	Head of Research and Development *(present for agenda item 6.5)*
	Jane Nicholson	Director of People *(present for agenda items 9.0 and 10.1)*
	Mark Davison	Chief Information Officer *(present for agenda item 9.1)*
	Ash Ellis	Deputy Director for Leadership, Inclusion and Organisational Experience (present for agenda item 10.1)

24/106	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting.
24/107	**Apologies** (agenda item 2)
	Apologies were received from: Rajiv Gatha, Non-Executive Director.
24/108	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
24/109	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
24/110	**Minutes of the previous meeting held on 14 May 2024 –** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 14 May 2024 were approved as a correct record.
24/111	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
24/112	**Board Story – Community Rehabilitation Enhanced Support Team (CREST) (**agenda item 6.0)
	The Chair welcomed Victor Ovenseri, Service Lead, Community Rehabilitation Enhanced Support Team (CREST), Angela Miller, Clinical Specialist Occupational Health Therapist, Karim Musah, Specialty Doctor and Natraj Sauba, Senior Out of Area Placements Manager to the meeting. The Director of Nursing and Therapies reported that CREST had won the clinical team of the year award at the Trust's All-Star Awards on 5 July 2024. The Chair congratulated the CREST service on winning the clinical team of the year award. Dr Karim Musah gave a presentation and highlighted the following points: • The Trust had established CREST as a community rehabilitation service for people with complex psychosis in 2023.

	• The service benefitted people who were currently being cared for in specialist rehabilitation placements, which were costly, and were often based far away from patients' homes and support networks. • CREST was established in line with guidance from NHS England, the Community Mental Health Framework and was set up in accordance with NICE guidelines. • CREST was a multidisciplinary service designed to help people live fulfilling lives independently, preventing hospital readmissions and enabling earlier discharge from out of area rehabilitation hospitals. • The aims of CREST were to deliver the service in the community where the patient lived and provide specialist psychological treatment for complex psychosis, tailored occupational therapy interventions, social engagement work and family work Victor Ovenseri presented the story of AB who was born premature at 28 weeks. AB's father died when she was 13 years old, and she began obsessive compulsive disorder rituals and developed a fear of walking in the hallway. AB received a formal Autistic Spectrum Disorder diagnosis when she was 15 years old, and she was also placed on the child protection register. She was admitted to the Priory Hospital as an informal patient when she was 20 years old after jumping out of her sister's bedroom window. AB's GP expressed concerns around her looking frail and thin due to poor dietary intake and was she unable to sleep in her own bed and to use the toilet in the house. AB was admitted under section to Prospect Park Hospital when she was 26 years old after impulsively drinking bleach. AB was transferred to Lakeside Hospital in Milton Keynes. AB progressed through the step-down residential placement at Pathway House, but she started to refuse her medication after a few months. She was also self-neglecting, and her weight had dropped. AB returned to Lakeside Hospital where she was diagnosed with Paranoid Schizophrenia and started on Clozapine. AB was then transferred to Rosebank House for open ward rehabilitation. AB was given escorted leave during section 17 periods of leave due to ongoing concerns about road safety due to talking to herself on most occasions. At the age of 32, AB was discharged to a supported accommodation unit in Berkshire after spending a total of seven years in hospital due to the complexity of her presentation and associated risks. Alison Miller reported that AB was referred to the CREST service in April 2023 and was CREST's first patient. AB needed to be fully escorted in the community, had poor personal care, had not developed basic living skills, had poor social skills, displayed risky behaviour and was at high risk of a road traffic accident, was unable to plan and prioritise, had difficulty in expressing herself and had a poor sense of purpose and belonging. Alison Miller said that when the service started working with AB, she could not tolerate being in the same room as a healthcare professional for more than ten minutes. Over a three to four months period, the team built a rapport with AB and slowly helped her to build her confidence and supported her to be able to take the bus independently and to take more control over her personal care. Alison Miller said that AB was now volunteering three-four days a week and was able to socialise and had joined an art group. AB now had clear goals around what she wanted to achieve which included finding paid employment and continuing with her education. Victor Ovenseri added that he had worked with AB when she was at Rosebank Hospital, and it had been assumed that she would spend the rest of her life in hospital.

	Sally Glen, Non-Executive Director said that she was a trustee of a social care organisation that supported people with serious mental health issues in the community. Ms Glen asked whether there was any learning around how the Trust worked with social care providers and supported them to work with AB. Angela Miller said that AB had an excellent placement, and the staff were willing to work collaboratively alongside the CREST service to support AB. The presentation slides are attached to the minutes. Aileen Feeney, Non-Executive Director asked how the service made sure that there was a safety net if AB's health deteriorated. Alison Miller said that as part of the discharge planning process, CREST worked with the services who would be providing ongoing support and would set out key information around how the individual liked to be supported and any other relevant information. Victor Oveneri added that there was a form on RiO (electronic patient record system) which summarised the patient's mental health history and social history etc so any future service the patient had contact with would have access to the patient's full history. Ms Feeney commented that the CREST service provided intensive support and asked about the service's capacity. Angela Miller said that CREST was a small service and because of the intensive nature of their work, there was a limit on the number of patients who could be referred to the service at any one time. Ms Miller said that the service followed NICE guidelines and only people with the most complex needs were accepted. The Chief Executive congratulated the CREST service on being awarded the clinical team of the year. The Chief Executive reminded the meeting that the Trust's mission was to "maximise independence and quality of life" and commented that the CREST service's work with AB embodied this mission. The Chief Executive said that now that the CREST service had demonstrated that a more personalised care model for people with complex conditions was better for the individual and for the taxpayer. The Chief Executive said that at a system level, there was scope to extend the model to other client groups, for example, people who met the criteria for continuing care under section 117 of the Mental Health Act. Mark Day, Non-Executive Director commented that it was an inspiring presentation and asked whether developing peer support was part of the service. Angela Miller said that the CREST model had been co-produced, and the team also included a Lived Experience Worker. Ms Miller said that clients towards at the end of their time with the CREST service often wanted to give something back by sharing their experiences with others. The Chair thanked. Victor Ovenseri, Service Lead, CREST, Angela Miller, Clinical Specialist Occupational Health Therapist, Karim Musah, Specialty Doctor and Natraj Sauba, Senior Out of Area Placements Manager for their presentation.

24/113	**Annual Complaints Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented paper and reported that it was a statutory requirement for the Board to receive an Annual Complaints Report. It was noted that the Trust reported complaints on a quarterly basis alongside other patient experience measures. The Director of Nursing and Therapies said that at the request of the Board, the report now included a table which showed the percentage breakdown of whether a complaint was upheld, partially upheld or not upheld against each of the compliant themes. **The Trust Board**: noted the report.
24/114	**Freedom to Speak Up Guardian's Report** (agenda item 6.2)
	The Chair welcomed Mike Craissati, Freedom to Speak Up Guardian and the Director of People to the meeting. The Freedom to Speak Up Guardian presented the report and highlighted the following points: • 22% of cases during the period had been referrals from the Trust's Wellbeing Matters Support Service. • The responses to the 2023 NHS National Staff Survey were being used to provide a "Culture Barometer" for services, thus enabling a targeted approach towards team building and culture improvement. • There remained barriers to staff Speaking Up, including concerns around the possible impact on their careers, a reluctance to talk about their experience and in the case of poor behaviours, the impact on working relationships. • The timescale for investigating a Speak Up concern could be lengthy, particularly if an individual accused of poor behaviour, for example of bullying and harassment went off sick and the investigation had to be paused, adding to the timescale for resolving concerns. The People Directorate would be reviewing the investigation process at the end of the year. • The turnover of staff who had raised a Speaking Up concern and who subsequently left the Trust remained high. • More work was needed to be done to encourage staff to raise concerns with their line manager rather than going through the Speak Up process. The Director of People confirmed that the Freedom to Speak Up Guardian would be involved in the Human Resources investigation process review. **Action: Director of People** The Chair said that the Board was committed to getting the culture right and said that he would welcome any specific actions the Board could take to improve the Speak Up process. The Chief Operating Officer said that staff had the right to raise anonymous concerns via the whistleblowing process, but it needed to be recognised that this could have a significant impact on a small team and lead to distrust and uncertainty because no one

	knew who had raised the concern. It was also challenging for the person responsible for investigating the issue. The Chief Operating Officer said that in a recent anonymous whistleblowing case, the investigation was undertaken by a psychologist who approached the investigation in a different way by trying to understand how the team was working and the culture within the team and the impact this may have on new people joining the team and the working within the team and managing the team. The Chief Operating Officer said that the psychologist also made some helpful observations about when a team or service was under pressure or challenge for a period of time, there was a tendency for people from a more senior tier of management to intervene on a regular basis and that this could undermine the team/service management. The Chief Operating Officer said that focussing on the psychological aspects of team working had provided a lot of learning around using different approaches to investigations. The Chief Operating Officer also pointed out that the Trust's Anti-Racism focus was likely to lead to an increase in concerns about racism and racist behaviour and that this should be viewed as being positive and evidence that people were more confident about reporting racism. Sally Glen, Non-Executive Director noted the Freedom to Speak Up Guardian's recommendations included improving the Listening Up culture and commented that the Lucy Letby conviction had highlighted the importance of staff being listened to. The Freedom to Speak Up Guardian said that an important part of Listening Up was to demonstrate active listening and then taking action. Ms Glen asked whether there would be more focus around training managers and leaders around Listening Up. The Freedom to Speak Up Guardian said that he delivered a slot on the Trust's new leaders and manager training programme which included active listening and compassion. The Deputy Chief Executive added that an important part of the Trust's Anti-Racism work was around providing closure for individuals who raised concerns around racism, and this included feeding back to them about the outcome of their concerns. The Director of People pointed out that there also needed to be sensitivity around feeding back especially in cases which had resulted in a sanction against an individual. Naomi Coxwell, Non-Executive Director asked whether the Freedom to Speak Up Guardian Report included the number of whistleblowing cases. The Freedom to Speak Up Guardian confirmed that his report only included concerns raised via the Freedom to Speak Up process and that there was a separate process for dealing with whistleblowing cases. Ms Coxwell said that it would be useful to understand the interface between the two processes. The Director of People confirmed that she would send a process map for investigations. **Action: Director of People** **The Trust Board**:

	a) noted the report. b) supported the Freedom to Speak Up Guardian's Board recommendations.
24/115	**Freedom to Speak Up Self-Assessment Improvement Plan Report** (agenda item 6.3)
	The Freedom to Speak Up Self-Assessment Improvement Plan had been circulated. The Director of Nursing and Therapies reminded the meeting that the latest version of the self-reflection and planning tool was approved at the Trust Board in March 2024 and that within the tool, areas for ongoing improvement were identified. It was agreed that progress against these would be presented to the Board on a six-monthly basis. **Action: Director of Nursing and Therapies** The Director of Nursing and Therapies reported that the Trust's Internal Auditors were undertaking a review of the Trust's Freedom to Speak Up processes and any findings and/or recommendations from the review would be added to the improvement plan. **Action: Director of Nursing and Therapies** **The Trust Board**: noted the report.
24/116	**Medical Appraisal and Revalidation Annual Board Report** (agenda item 6.4)
	The Medical Appraisal and Revalidation Annual Report 2023-24 had been circulated. The Medical Director reported that 138 appraisals had been completed during 2023-24 for 139 doctors with a connection to the Trust. One consultant appraisal was approved as delayed because they were on a sabbatical. The Medical Director said that he was keen to encourage more doctors to become medical appraisers. Sally Glen, Non-Executive Director asked whether non-doctors could be medical appraisers. The Medical Director explained that the regulations allowed appropriately trained persons to appraise doctors and confirmed that this did not necessarily mean a registered medical professional. The Medical Director added that he was not aware of any non-doctors being interested in becoming medical appraisers. **The Trust Board:** a) Noted the report. b) Approved the Trust Chair signing the statement of compliance.
24/117	**Research and Development Annual Report** (agenda item 6.5)
	The Chair welcomed Kate Penhaligon, Head of Research and Development to the meeting. The Medical Director presented the report and explained that the scope of the Trust's Research and Development activity had changed from primarily accepting portfolio studies from the National Institute of Health Research to a much broader range of studies and

	collaborations. The Medical Director paid tribute to the leadership of the Head of Research and Development for her work in engaging and encouraging as many clinical and non-clinical services to engage in research as possible. The Medical Director extended an invitation to members of the Board to visit the Research and Development team. The Chief Executive asked the Head of Research and Development about her plans for the Trust's research and development activity over the next three years. The Head of Research and Development said that the national focus was on NHS organisations increasing their research capacity and capability. The Head of Research reported that the Trust's Research and Development Strategy was due to be refreshed and said that she was working with colleagues with a view to encouraging every clinical service to be research active. It was noted that the Department of Health and Social Care would be reviewing how research was funded. Changes to the way research was funded would influence the Trust's research activity. The Head of Research and Development said that her department supported clinical services to deliver research and helped to increase the Trust's research capacity by supporting those professions which had research as part of their professional standards to help them use research in their day-to-day work. The Research and Development team also supported staff to link in with other research activities in the Trust, for example, the Quality Improvement Programme team and Clinical Audit etc. Sally Glen, Non-Executive Director asked whether doctors' work plans included time off for research. The Medical Director confirmed that the Trust did not give additional payments for doctors to undertake research and that research was considered to be part of their professional development. Ms Glen asked whether including research as part of doctors' work plans would encourage doctors to work for the Trust. The Medical Director pointed out that doctors had different interests and that research was only one aspect of why they chose to work for the Trust. **The Trust Board**: noted the report.
24/118	**Safe Staffing Six Monthly Report** (agenda item 6.6)
	The Director of Nursing and Therapies reported that the Trust was in the process of revising the format of the Safe Staffing Six Monthly Report and therefore only the highlight report was presented to the Board. The Director of Nursing and Therapies referred to the Medical and Nursing Directors' Safe Staffing Declaration (page 157 of the agenda pack) and confirmed that over the last six months, the wards had been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. However, there continued to be staffing challenges due to vacancies, absence and temporary staffing availability.

	The Chair commented that the high level of nursing vacancies on mental health wards was a concern. The Director of Nursing and Therapies agreed but pointed out that there was stronger leadership on the wards with all the ward managers being in post for a little while compared with the previous six months. **The Trust Board:** a) Noted the report b) Noted the Medical and Nursing Directors' safe staffing declaration (page 157 of the agenda pack).
24/119	**Quality Assurance Committee** (agenda item 6.7)
	a) Minutes of the Quality Assurance Committee Meeting held on 28 May 2024 The minutes of the Quality Assurance Committee meeting held on 28 May 2024 together with the Learning from Deaths and Guardian of Safe Working Hours Quarterly Reports had been circulated. Sally Glen, Chair of the Quality Assurance Committee reported that the meeting had discussed the national safety alert pertaining to medical beds, trolleys, bed rails, bed grab handles and lateral turning devises and the risk of entrapment. It was noted that the alert required seven actions to be completed by 1 March 2024. Ms Glen reported that the Trust had completed the required actions in relation to inpatient units but was not able to complete the two actions for pieces of equipment being used in the community where the prescribers of the equipment were no longer seeing these patients. The Trust was working with the equipment provider, the Integrated Care Board and with other providers in the system to complete the outstanding actions. The Quality Assurance Committee would receive a progress update at its next meeting in August 2024. Sally Glen reported that the Committee had received an update on the Trust's work to implement the new national Patient Safety Incident Response Framework and commented that the Trust was ahead of many other trusts in implementing the national patient safety strategy. Sally Glen reported that the Committee had also received an update on the progress made to implement the action plan following the never event at Prospect Park Hospital involving a non-collapsible shower rail and pointed out that the clinical action plan had been completed but there were two open actions on the estates action plan which were taking longer to implement because they involved liaising with external agencies. The Committee would continue to receive updates on progress until all the estates related actions had been completed. **b) Learning from Deaths Quarterly Report** the Medical Director reported that the format of the Learning from Deaths Report had changed and now included all deaths (serious incidents and all other deaths). The Medical Director confirmed that of the second stage reviews concluded in quarter four, none of the deaths were a governance cause for concern. The Chair asked whether the learning from deaths process included diversity data.

	The Medical Director said that there was no national requirement to collect ethnicity data in respect of deaths. The Trust was trying to collect diversity data, but this was not always recorded on the RiO (electronic patient record) system. **c) Guardian of Safe Working Hours Quarterly Report** It was noted that there had been nine exception reports in the quarter. The majority of the exception reports related to workload in the inpatient mental health wards. The Head of Medical Workforce and 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. T**he Trust Board:** a) Noted the minutes of the Quality Assurance Committee held on 28 May 2024 b) Noted the Learning from Deaths Quarterly Report c) Noted the Guardian of Safe Working Hours Quarterly Report. d)
24/120	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The Chair congratulated the Trust on being awarded external recognition for its Unity Against Racism Programme. The Race Equality Matters organisation had recognised the Trust as a “Silver Trailblazer.” Silver Trailblazer status was given to organisations in the UK that had made significant impactful strides in race equality and was assessed by an independent judging panel. Rather than starting at the bronze level, the Trust had been awarded silver status, which was valid for two years and was currently the highest available award. **The Trust Board**: noted the report.
24/121	**Month 02 2024-25 Finance Report** (agenda item 8.0)
	The Chief Financial Officer presented the report and highlighted the following points: • The External Auditors had completed their audit of the Annual Report and Accounts 2023-24 which had been submitted to NHS England a week ahead of the deadline. • The final deficit was £ 6.5m resulting from changes to the accounting treatment of the PFI liabilities and a revaluation of the PFI assets. Adjustments were made for the purpose of measuring performance leaving the Trust with a £3.8 surplus which was in line with the revised plan for 2023/24. • The planned outturn position for the Trust was a £1.9m surplus for 2024-25. This included additional funding for depreciation, £0.6m, agreed System Development Funding slippage (Buckinghamshire, Oxfordshire and Berkshire West system) £0.5m and further Cost Improvement Plan schemes to be identified amounting to £0.8m.

	• The Trust had a £13.8m Cost Improvement Plan. The Trust was on track year to date, but there were some small variances on individual plans which would be reported from month three onwards. • Income included the current cost uplift for 2024/25 but this would be updated as and when the 2024/25 pay awards were agreed. • Cash was below plan due in part to phasing but also delayed payments from local authorities and Frimley Health NHS Foundation Trust. • The Trust's performance against the Better Payment Practice Code continued to improve following the marginal miss on one of the targets in 2023/24. The Trust was now achieving the target across all four measures year to date. • Capital spend was slightly under plan for CDEL schemes. • The agency target was achieved year to date. NHS England had reduced the agency ceiling to 3.2% and the Trust was currently running at 3% of overall pay costs. The Chair commented that the Trust had a large Cost Improvement Programme in 2024-25 and asked whether there would be challenges in delivering the efficiencies. The Chief Financial Officer said that the majority of the Cost Improvement Programme had been embedded within the divisional control totals for the year so providing the divisions could manage within their control totals, around 60-70% of the Cost Improvement Programme would be delivered. It was noted that around £3m-£4m of the Cost Improvement Programme was in relation to non-recurrent and reserve positions which the Trust was able to cover. The Chief Financial Officer confirmed that at this stage, he was confident that the majority of the Cost Improvement Programme would be delivered. **The Trust Board**: noted the report.
24/122	**Month 02 2024-25 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Chief Financial Officer presented the report and highlighted the following points: • Clinically Ready for Discharge (including Out of Area Placements) performance was at 351 against a target of 250 bed days. Reading Borough Council was the top contributor with eight patients. The Trust was working with the Berkshire West's Place team who were undertaking some deep dives into flow around the Reading area to identify what more could be done to minimise delays and increase discharges. • Bed Days Occupied by Patients who were Discharge Ready (Community Physical Health) performance was at 650 against a 500 bed days target. In May 2024, there were 51 patients waiting for a package of care. • I Want Great Care performance compliance rate performance was at 7.3% against a target of 10%. The Trust had changed the scope of the target, so it counted individual patients rather than the overall number of contacts. • The proportion of patients referred for diagnostic tests who had been waiting for less than 6 weeks (Audiology) performance was at 71% against a target of 95%. Performance for June 2024 had improved, and the target was met. **The Trust Board**: noted the report.

24/123	**People Strategy and Equality and Inclusion Strategy Update Report** (agenda item 9.0)
	An assurance paper setting out the progress in delivering the People and Equality, Diversity and Inclusion Strategies had been circulated. **The Trust Board**: noted the report.
24/124	**Digital Strategy Update Report** (agenda item 9.1)
	The Chair welcomed the Chief Information Officer to the meeting. The Deputy Chief Executive introduced the item and pointed out that in addition to delivering the Digital Strategy, the Trust was also horizon scanning to identify whether the latest developments in technology had potential applications for the Trust. The Chair commented that the Trust was doing a lot of work in the digital space and asked whether there was more the Trust could do to support colleagues across the two systems who may not be as digitally advanced as the Trust. The Chief Information Officer confirmed that the Trust was very active across the local health and care system both at the regional and at the integrated care board level. The Chief Information Officer reported that the Trust was supporting Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare Trust with the deployment of their Electronic Patient Records (EPR) system. It was noted that the Trust was also sharing its expertise and supporting system colleagues to deploy the Connected Care shared record system in their organisations. It was noted that staff from East London NHS Foundation had recently spent three days with the Trust to learn more about the Trust's digital strategy. Naomi Coxwell, Non-Executive Director said that it was very positive that the Trust was supporting less digitally mature organisations and asked whether the Trust was able to keep up to date with what other digitally advanced trusts were doing so as to avoid "reinventing the wheel". The Chief Information Officer said that the Trust was part of a number of national forums, and these provided an opportunity to share learning. The Chief Information Officer added that the Trust was also proactive in identifying learning outside of healthcare. The Chief Executive referred to the summary section of the report and commented that a number of the actions listed were hard to deliver but had huge benefit. The Chief Executive said that the Digital Team's work around finding a solution for the voluntary and charity sector partners to receive referrals from and provide information back to the Trust's Care Records was an important development. The Deputy Chief Executive reminded the meeting that Dr Amit Sharma, Chair of Berkshire West GP Leadership and Primary Care Alliance had attended the June 2024 Trust Board Discursive meeting and had explained about how he was encouraging his GP colleagues to use a population health segmentation system which placed patients in one of eleven categories according to a number of factors, for example, age and underlying health conditions etc. This system was then used to triage patients for GP appointments

	etc. The Deputy Chief Executive said that the Trust was reviewing the merits of using a segmentation approach for some services. The Director of People reported that the People Directorate would shortly be undertaking a recruitment improvement and transformation project, part of which would be to consider opportunities for using digital to improve efficiency and reduce staff time. The Chair thanked the Chief Information Officer and his team for all their work. The Chair said that it would be helpful for the Board to have a discussion about how digital could be used to improve both the quality and efficiency in the way the Trust delivered care in an ideal world which was not constrained by a lack of resources. The Chair said that the Trust could then start to have a conversation around how much investment this would require. **Action: Deputy Chief Executive** **The Trust Board**: noted the report.
24/125	**Fit and Proper Persons Test Assurance Paper** (agenda item 10.0)
	The Company Secretary presented the report which provided assurance that all members of the Board met the requirements of the Fit and Proper Persons Test. The Company Secretary drew attention to the Board's declarations of interests (appendix 1 of the report) and pointed out that Naomi Coxwell, Non-Executive Director's interests were listed but her name had been omitted). The Company Secretary reported that the declarations of interests' paper published on the Trust's website had been corrected. The Chair thanked the Company Secretary for undertaking the Fit and Proper Persons Test checks. **The Trust Board**: noted the report.
24/126	**Trust Behaviour Framework and Trust Leadership Competency Framework Report** (agenda item 10.1)
	The Chair welcomed the Deputy Director for Leadership, Inclusion and Organisational Experience to the meeting. The Deputy Chief Executive said that the new behaviours and leadership competencies underpinned the Trust's values, mission and vision and were an important part of the Trust's refreshed leadership and management training programme. The Chair referred to the leadership competencies and commented that behaviours was a good way of judging whether an individual was behaving appropriately but queried whether there also needed to be an emphasis on delivery. The Deputy Director for Leadership, Inclusion and Organisational Experience explained that the leadership competencies aimed to have a balance between psychological safety and emotional intelligence elements and the operational excellence elements in delivering high quality care. The Deputy Director for Leadership, Inclusion and Organisational Experience added that the Trust behaviours underpinned the leadership competencies.

	The Trust Board: noted the report
24/127	**External Well-Led Review Recommendations and Action Plan** (agenda item 10.2)
	The Company Secretary presented the paper and reported that the Trust's Well-Led External Reviewer's conclusions and recommendations had all been considered and where appropriate had been implemented. The Company Secretary proposed that the action plan be closed. The Deputy Chief Executive pointed out that the full update in relation to section 5 (Shadow Board) was not included. The full text is set out below" "Staff with protected characteristics and lived experience are increasingly engaged in strategic initiatives including: • anti-racism programme workstreams • strategic scenario planning • implementation of the Patient, Carer and Race Equality Framework • MHA Detentions project • neurodiversity strategy development • mental health Provider collaborative • Community MH services redesign (One Team) Our Organisational Development team is shaping proposal for junior to mid-level talent identification and development which will systematise opportunity for junior staff engaging in improvement initiatives." The Company Secretary agreed to circulate the updated Action Plan to members of the Board. **Action: Company Secretary** **The Trust Board:** a) Notes the report b) Agreed that the action plan was completed and could be closed.
24/128	**Audit Committee Meeting – 19 June 2024** (agenda item 10.3)
	The minutes of the Audit Committee meeting held on 19 June 2024 had been circulated. **The Trust Board**: noted the minutes.
24/129	**Council of Governors Update** (agenda item 10.4)
	The Chair reported that John Jarvis, Public Governor had sadly passed away. The Chair paid tribute to John Jarvis and said that he was a committed governor who was very supportive to the Trust and would be missed. The Chair said that Brian Wilson, Lead Governor had regular meetings with his counterparts in the local systems and reported that he had accepted an invitation to attend

	a meeting of Lead Governors in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board area to talk about system issues.
24/130	**Schedule of Meetings for 2025** (agenda item 10.5)
	The Schedule of Meetings for 2025 had been circulated. **The Trust Board:** noted the dates of the meetings for 2025.
24/131	**Any Other Business** (agenda item 11)
	There was no other business.
24/132	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 10 September 2024.
23/090	**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 July 2024.

Signed……. Date 10 September 2024

(Martin Earwicker, Chair)

CREST

Community Rehabilitation Enhanced Support Team

Case Presentation

Angela Miller
Dr Karim Musah

CREST SERVICE

- Berkshire Healthcare Foundation Trust (BHFT) established CREST as a community rehabilitation service for people with complex psychosis in 2023.
- The service benefits people who are currently being cared for in specialist rehabilitation placements, which are costly, and often based far away from patients' loved ones and community support systems.
- CREST was established in line with guidance from NHS England The Community Mental Health Framework and was set up in accordance with NICE guidelines.
- CREST is a multidisciplinary service designed to help people live a fulfilling lives independently, preventing hospital readmissions and enabling earlier discharge from out of area rehabilitation hospitals.
- The aims of CREST is to deliver our service rooted in the community where the patient resides:
    - Specialist psychological treatment for complex psychosis
    - Tailored occupational therapy interventions
    - Social engagement work
    - Family work

Background History

Birth to late 20's

Birth

Born premature at 28 weeks term due to mother getting pre-eclampsia.

Childhood

Lived at home with mother father, little sister.

Bullied by peers in primary school.

Father died of amyloidosis when she was 13.

13 years old

Reported 'nervous breakdown' after father died.

OCD rituals began, doing tasks a certain order, having toileting rituals.

Developed fear of walking in the hallway.

15 years old

Formal diagnosis of ASD.

She was placed on child protection register

Evidence of physical abuse? and self-neglect

20 years old

A.B. was admitted informally to Priory Hospital after jumping out of her sister's room window.

GP referral due AB looking frail and thin, poor dietary intake, unable to sleep in her own bed, sometimes sleeping in car.

26 years old

Admitted under section to Prospect Park Hospital.

A B had impulsively drunk bleach.

A.B. Transferred to Lakeside Hospital in Milton Park for people for psychosis and ASD.

28 years old

AB progressed through the step-down residential placement at Pathway House, but she started to refuse her medication after a few months. She also self-neglected and her weight dropped as a result

Background History cont'd

Late 20's to present

A.B. returned to Lakeside Hospital where she was diagnosed with Paranoid schizophrenia and started on Clozapine.

29 years old

Transferred to Rosebank House for open ward rehabilitation.

30 years old

A.B. was discharged to a supported accommodation in Berkshire

32.5 years old

On clozapine treatment

A B appeared calmer with less incidents of assaults, more communicative, good food and fluid intake.

Appeared to be responding to voices despite treatment

Her weight gain improved.

Open ward rehab

Continued with clozapine treatment with fluctuations in her presentation

Given escorted s17 leave at all times due ongoing concerns about road safety due to talking to herself most occasions

How has AB coped with living in the community?

Background Summary

- AB
- 33-year-old female who now lives in a supported accommodation in Berkshire.
- Both parents are deceased, but she has one younger sister whom she has a fractured relationship.
- A family friend is her advocate, she visits her frequently.
- She was discharged from a rehabilitation hospital into the community in January 2023 after a total 7 years in hospital due to complexity of presentation and the associated risks.
- She has a diagnosis of Schizophrenia and ASD.

CREST Rehabilitation Journey: April 2023 – Present

Co-Produced Rehabilitation Care Planning

- Fully escorted in the community.
- Poor personal care.
- Unable to tolerate difficult conversations.
- Poor social skills.
- Unable to plan and prioritise.
- Difficulty accepting support.
- Difficulty expressing herself.
- Poor sense of purpose and belonging.
- Inability to independently adopt strategies for managing stress levels.

Road to Independence and Recovery

- Total independence accessing the community.
- Independently attending to her personal care.
- Tolerates some difficult conversations with increased resilience.
- Improved social interactions with others. More jovial and adopting meaningful social engagements.
- Increased independence using a diary to plan appointments.
- Requesting help when things get difficult.
- Improvements in expressing her needs and articulating what she finds difficult.
- Working 3-4 days a week – sense of purpose and belonging.
- Improved independence identifies stress triggers and strategies that help her when she's feeling stressed.

AB’s Personal Words

As of January 2023, I was in a bit of a state.

I had been injured both physically and mentally whilst serving in the military, and then bounced around unhelpful mental health facilities. Finally (with help from some of my former colleagues,) I ended up where I am living now where I later met the CREST team.

Over the next few months, I was supported in doing a variety of things.

From walking long(ish) distances without panicking, to remembering how to do groceries shopping, to learning how to understand bus timetables, and gaining the confidence to catch the bus to places further and further away (at first with help and then on my own). We’ve also done some plans and lists identifying things I find easy and difficult to talk about and acknowledging progress.

CREST also supported me in on finding an art group, so I could pursue my interest in art and crafts.

Also, on a more practical level CREST have been helping me practice life skills, like comparing utilities and other bills as well as how to find the right cleaning supplies and so on, with a view to helping me move into a flat of my own as soon as possible.

Now it’s been a year and a half. I have gone from being afraid to leave the house, to going out every day, doing groceries shopping every week, and have been working for a charity shop, where I am now an assistant manager.

So, this is it. I’ve been to see a couple of flats (on my own which was scary!) and I continue to work hard at the charity shop. I’ve even tried my hand at interior design long distance, with my aunt’s company.

Next up; reconnecting with the rest of my family and friends – wish me luck!

What is next…

- Step down – reduced support needs and increase independence.
- Travelling further afield
- Paid employment
- Education
- Relationships
- Continued growth in self-confidence and self-esteem.
- Supporting others on their recovery journey.

Questions & Answers

Thank You

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 10.09.24

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
14.05.24	24/081	Reducing, Preventing and Managing Violence and Aggression Report	The Board to receive an another Reducing, Preventing and Managing Violence and Aggression Report in November 2024.	November 2024	**DF**		
09.07.24	24/114	Freedom to Speak Up Guardian's Report	The Freedom to Speak Up Guardian to be involved in the review of the Human Resources investigation processes.	November 2024	**JN**		
09.07.24	24/114	Freedom to Speak Up	The Director of People to present a paper to the Board to explain the	November	**JN**		

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
		Guardian's Report	Speaking Up and Whistleblowing processes.	2024			
09.07.24	24/115	Freedom to Speak Up Self-Assessment an Improvement Plan Report	The Freedom to Speak Up Improvement Plan be presented to the Board in six months' time.	January 2025	**DF**		
09.07.24	24/116	Freedom to Speak Up Self-Assessment an Improvement Plan Report	The Freedom to Speak Up Improvement Plan to be updated to include any recommendations from the Internal Auditors.	January 2025	**DF**		
09.07.24	24/124	Digital Strategy Update Report	The Board to have an opportunity to discuss how digital could be used to improve both the quality and efficiency in the way the Trust delivered care in an ideal world that was not constrained by a lack of resources.	TBC	**AG**		
09.07.24	24/127	External Well-Led Review Recommendations and Action Plan	The Company Secretary to circulate an updated action plan to include the additional commentary about the shadow board recommendations to members of the Board.	July 2024	**JH**	Completed	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10th September 2024
Title	**Patient Experience Report - Quarter 1 (April – June 2024)**
	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 One 2024/25

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	23/24 Year-end position	Q1
Total patient contacts recorded (inc discharges from wards)	Number			151,330
Number of iWGC responses received	Number	**61,000 year** (based on Q1 contact)	**29,229** (8,337 Q4)	9,149
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**10%** by Mar '25		6.04%
iWGC 5-star score	Number	**4.75**	**4.79 average**	4.78
iWGC Experience score – FFT (good or very good experience)	%	**95%**	94.88%	94.1%
Compliments received directly by services	Number	Total 22.23 **4522**	**5,127**	1237

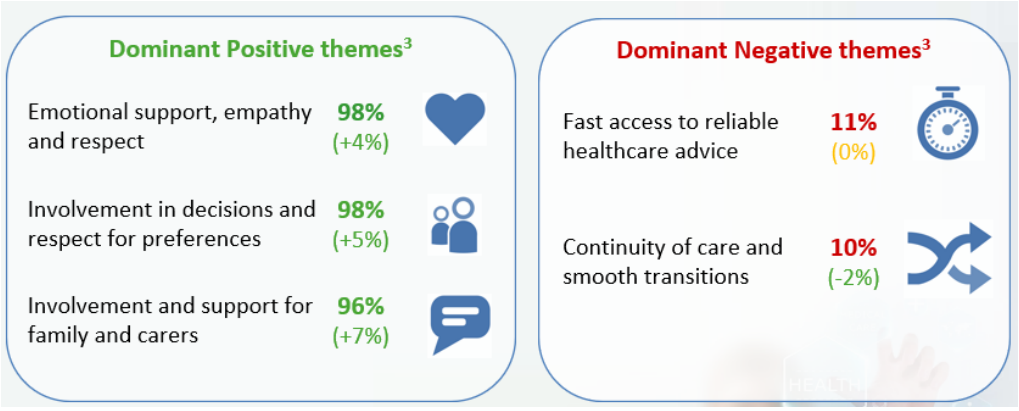
Patient Experience – overall Trust Summary		Target	23/24 Year-end position	Q1
Formal Complaints received	Number/ %	Total 22/23 **240** **0.043%**	281 **0.030%**	68
Formal Complaints Closed	Number	Total 22/23 **247**	257	41
Formal complaints responded to within agreed timescale	%	**100%**	**100%**	100%
Formal Complaints Upheld/Partially Upheld	%	Target 50%	56.42%	51.7%
Local resolution concerns/ informal complaints Rec	Number	Total 2022/23 **134**	149 3*	28
MP Enquiries Rec	Number	2022/23 total **88**	**73**	5
Complaints upheld/ partially by PHSO	Number	Total 2022/23 **0**	**0**	1

The data continues to show only small variations each quarter although we did see a significant reduction in number of MP enquires during the quarter which is unsurprising given the general election preparations. We are planning to proactively communicate with the new MP offices across Berkshire to aid their understanding of how best to contact us.

Although we continue to increase the percentage of feedback received through iWGC we are still not achieving our target currently. A rapid Improvement event was undertaken during the quarter with each division agreeing countermeasure and stretch targets. We are starting to see more focus on ‘you said we did’, with more of these being reported; Examples are included within the main report.

The lowest sub scores across all divisions were previously within the mental health inpatient services where feeling involved and listened to had remained lower in terms of star rating throughout last year; this quarter there has been a significant positive shift in scores received in these areas with the involved score moving from 3.89 to 4.73, the listened to score moving from 3.96 to 4.79 and feeling safe score also having a positive shift from 4.10 to 4.72. The wards all have ongoing work to support improvement and 3 of our wards have just commenced an NHS England Culture of Care programme which was offered to all Mental Health Trusts as part of their transformation programme. This programme aims to improve the culture of inpatient mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work.

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.

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
Asian/Asian British	9.86%	8.10%	10.58%
Black/Black British	4.23%	3.40%	3.35%
Mixed	8.45%	2.80%	3.42%
Not stated	5.63%	11.40%	2.08%
Other Ethnic Group	1.41%	4.30%	2.59%
White	70.42%	70.10%	77.95%

In terms of gender, for this quarter unlike previous quarters we have not seen a slightly higher percentage of males making formal complaints compared to attendance although we have continued to see a lower percentage of males completing the survey than either females or those identifying as non-binary/ other. The percentage of those not stating their gender when completing the survey has remained fairly constant over time.

A meeting has taken place with iWGC to see how we might be able to achieve improved data analysis to support diversity, inclusion and inequalities work being undertaken across the trust and also to enable us to understand peoples' experiences by particular profiles and characteristics combinations. Filters will be added to our dashboard to enable us to look at experience through the lens of specific person profiles, for example the experience of people who are neurodivergent and identify as a different gender than at birth. We will continue to work with iWGC to review how we can gain further meaningful data that is able to combine characteristic data with experience data to support our ongoing work.

The 15 steps programme has recommenced from April 2024 following a period of pause and review, with a number of visits undertaken during the quarter as detailed in appendix 3

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 one patient Experience report. For areas where there is concern or identified needs for improvement 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 continued 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 1 2024/25

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.

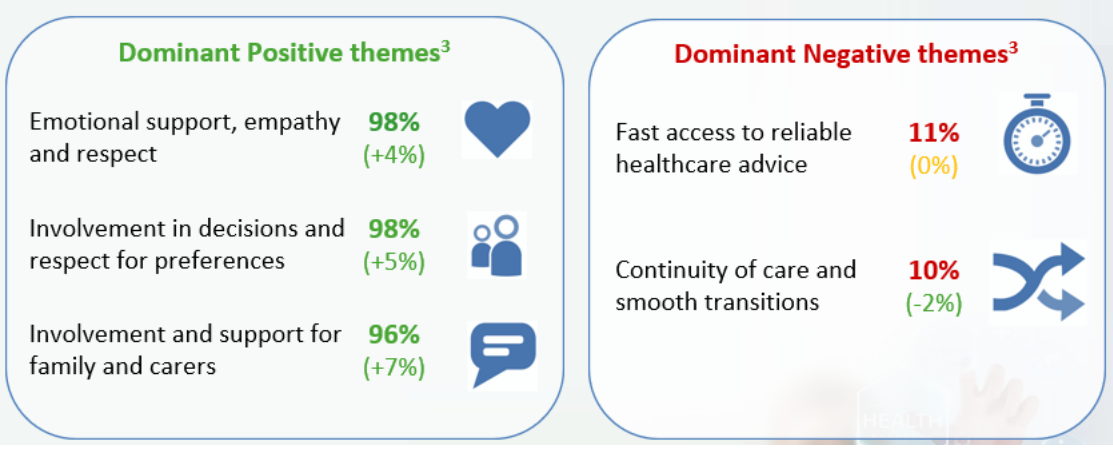
From April 2024, the response rate has been calculated using the number of unique/distinct clients rather than the total number of contacts. Patients will continue to be offered the opportunity to give feedback at each appointment.

Table 1

Patient Experience – overall Trust Summary		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Distinct patient numbers recorded (inc discharges from wards)	Number	151,330			
Number of iWGC responses received	Number	9,149			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	6.04%			
iWGC 5-star score	Number	4.78			
iWGC Experience score – FFT	%	94.1%			
Compliments received directly by services	Number	1237			
Formal Complaints Rec	Number	68			
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	3			
Formal Complaints Closed	Number	41			
Formal complaints responded to within agreed timescale	%	100%			
Formal Complaints Upheld/Partially Upheld	%	51%			
Local resolution concerns/ informal complaints Rec	Number	28			
MP Enquiries Rec	Number	5			
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	7			

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 reduced to 5 from 19 during this quarter, in the most part due to the election process. There was one PHSO complaint that was upheld in Q1 and the outcome of this was for an apology to be given to the complainant.

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 4. (+) means that there has been an increase since the last report, (-) means a decrease since the last report.

There has been continued increase in patients feeling involved in decisions and respect for their preferences (up 5%). This also shows that the negative theme for continuity of care and smooth transition has decreased from 12% to 10% (meaning an increase in satisfaction). Fast access to reliable healthcare advice, while a negative theme, has not decreased since the previous quarter.

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

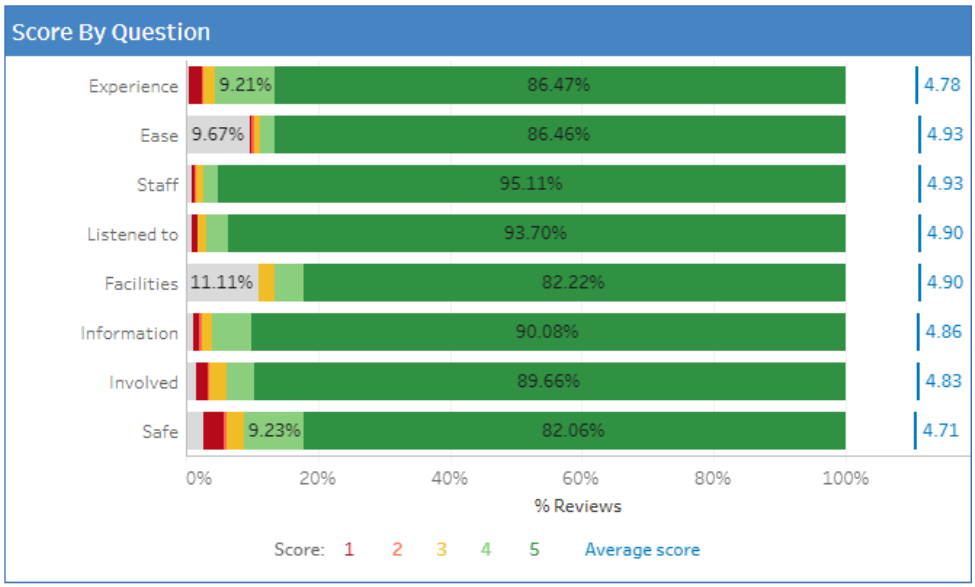
What the data is telling us

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

Children, Families and All Age Pathways including learning disability services.

Table 2: Summary of patient experience data

Patient Experience - Division CFAA and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	1,530			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3.9%			
iWGC 5-star score	Number	4.9			
iWGC Experience score – FFT	%	95.3%			
Compliments received directly by services	Number	98			
Formal Complaints Rec	Number	17			
Formal Complaints Closed	Number	6			
Formal Complaints Upheld/Partially Upheld	%	33.33%			
Local resolution concerns/ informal complaints Rec	Number	6			
MP Enquiries Rec	Number	3			



For children's services the iWGC feedback has seen an increase in the responses from last quarter, further work with the services continues 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 CFAA services.

Of the 1530 responses, 1412 responses related to the children's services within the division; these received 95.7% positivity score, with positive comments about staff being helpful and friendly and a few suggestions for further improvement, this included 2 reviews for Phoenix House where comments about staff being supportive and understanding were very positive. 56 of the responses related to learning disability services and 23 to eating disorder services.

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

Children's Physical Health Services

There were 3 formal complaints for children's physical health services received this quarter. 1 for School Nursing, 1 for the Community Team for People with Learning Disabilities and 1 for Children's Occupational Therapy

1120 of the 1412 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Health Visiting Bracknell and Health Visiting Reading; the Health Visiting Bracknell Team received 227 of these responses which scored positively receiving a five-star rating of 4.96 and feedback included They were friendly and helpful. And informative. "[*name removed] was lovely and informative. She had a very calming relaxed approach and I felt she really helped me with any questions I had." "I love coming to this centre because everyone is friendly and happy to help and answer to any questions I have"*

Child and Adolescent Mental Health Services (CAMHS)

For child and adolescent mental health services there were 13 complaints received (including one for the Key working team and Phoenix House), these were primarily in relation to care, and treatment received and communication. Themes around this included clinical care received. In addition to this, the service received 3 enquiries via MPs.

There have been 274 responses for CAMHS services received through our patient survey for this quarter. Currently the survey is accessed through paper surveys, one way SMS, online, QR codes or configured tablets in the departments.

In addition to the current feedback tools, 3 focus groups were held with service users from across the Child and adolescent ADHD pathway and Autism assessment team. Themes from these included transitions, waiting times and more information on the impact of ADHD and Autism on people's bodies and relationships.

The School Nursing Team held 2 focus groups with service users this quarter. Children's Community Nursing and Specialist School Nursing: 2 focus/participation group(s) were held with service users across Q3 and Q4. One was held in East Berkshire and one in West Berkshire. Having reviewed the focus group feedback themes included: greater visibility; changes around the NCMP, including links to parental support; introducing workshops for enuresis due to long waiting times. Actions have been taken around these areas.

The Adult Berkshire Eating Disorder Service (BEDs) and Children and Young People (CYP) Service invited service users to attend two focus groups (one for each service) during the quarter. Having reviewed the focus group feedback themes included: Improving the reception area; more support during the holiday period; additional support other than group therapy. This feedback is currently being considered.

Learning disability

There was 1 complaint received this quarter for the Community Team for People with a Learning Disability.

Overall, there were 56 responses for all Learning Disability services from the patient survey received, responses were for the Community Teams for People with a Learning Disability and Learning Disability Intensive Support Team. These received a 92.9% positive score; feedback included that staff listened, "*I like the way staff listened to me and understood my concerns. The resources staff provided really helped me with my goals. I feel supported and comfortable in these sessions.*", "*The doctor listened to me and gave me advice.*" and "*The doctor listened really well and took interest.*", there were comments for improvements including wanting more follow up appointments and more seating in the waiting room. The 4 responses that received with a score below 4 left comments in the free text boxes, comments included listen to the patient rather than their support workers, changing the care company and happy with services.

Eating disorders

There was 1 complaint received for either the adult or young people's s Eating Disorder Services.

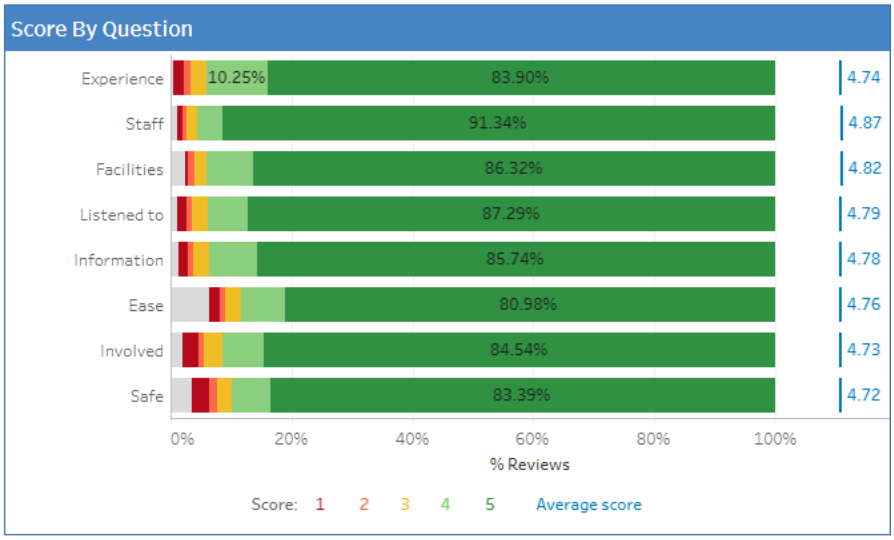
Of the 23 feedback responses received, 15 scored a 5 with comments such as "*I was treated with utmost kindness, compassion and respect throughout. I was very nervous going in but was immediately put at ease. I'm used to feeling rushed / 'processed' at services like these, but they were keen to listen, be thorough, and get the whole picture which was so refreshing. As a result, I am more hopeful I will get the help I need. Very impressed at how knowledgeable the staff were on various intricacies of different health problems. I have never felt more heard by a group of mental health professionals, thank you so much for what you do.*", "*[name removed] is an extremely kind, caring and patient psychologist who always appears to have endless time to support me. She answers queries between sessions and is always ready to support me, even being prepared to undergo further training. [name removed] has a phenomenal memory for detail, she remembers everything! I am finding my sessions extremely disturbing and hard to digest, so ending sessions and transitioning back to 'life' is very tricky but [name removed]'s calm voice and psychology phrasing keeps me going in the week between sessions, as I hear her phrases repeat in my head! Thank you"*, *"Calm, quiet place. I've received lots of help and advice what to do in the future when I will start feeling worse.*" Areas for improvement included different types of appointments and more sessions.

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**	365			
Response rate (calculated on number contacts)	**%**	4.5%			
iWGC 5-star score	**Number**	4.70			
iWGC Experience score – FFT	**%**	93.7%			
Compliments received directly by services	**Number**	34			
Formal Complaints Rec	**Number**	12			
Formal Complaints Closed	**Number**	10			
Formal Complaints Upheld/Partially Upheld	**%**	70%			
Local resolution concerns/ informal complaints Rec	**Number**	1			
MP Enquiries Rec	**Number**	0			



There has been a reduction in the number of responses on the iWGC system this quarter.

12 formal complaints were received into the division during this quarter; in addition, there was 1 informal/locally resolved complaint. 10 complaints were closed during the quarter. 7 of these were either fully or partially upheld and 3 were not upheld; 8 of these complaints related to communication or care and treatment, 3 were about a failure to visit or a delay and 2 were about a healthcare professional

The services receiving the majority of iWGC responses were CRHTT East 74 responses, Memory Clinic Bracknell 31 responses and CMHT Bracknell 30 responses.

Across the CRHTT East survey responses the average 5-star score was 4.46 with 90.5% positive feedback, an increase in the 5-star score and an increase in the percentage positive feedback from last quarter. 67 of the (overall number of responses received) scored a 4 or 5-star rating with many comments about staff being helpful, understanding, listened, and supportive; "*Everyone was extremely understanding, helpful, and kind. Although my circumstances are dire, but their help made it a very wonderful and receptive experience. Therefore, a massive thank you to the staff that interacted with me.*" 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 the staff did not listen, were unsupportive and not understanding.

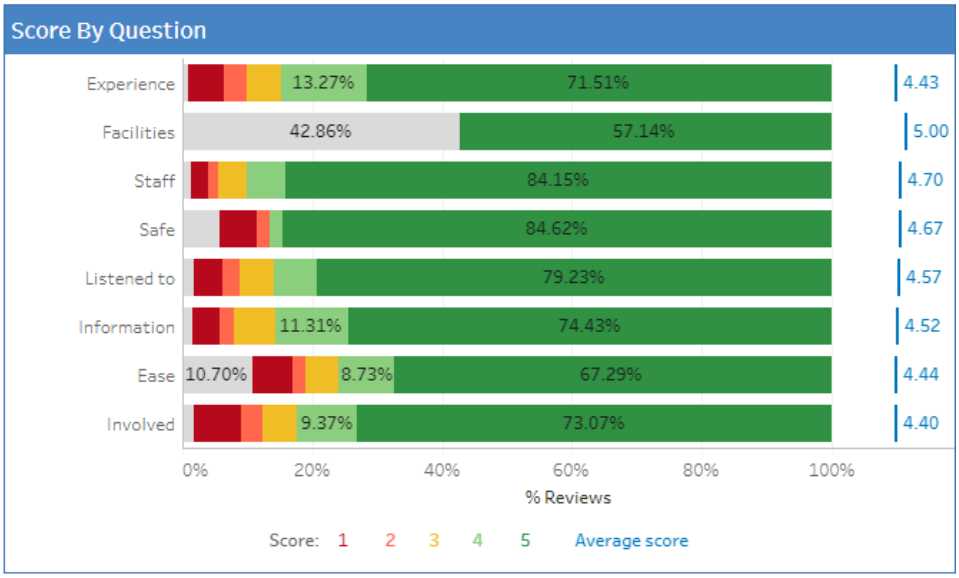
The Memory Clinic Bracknell received 100% positive score (4.98-star rating) and received positive feedback about staff being helpful, listening, informative and caring. "*The nurse was very professional, and she made it easy to explain how things were. She also listened to our concerns and was able to provide sound advice and recommendations.*" CMHT Bracknell received 93.3% positive feedback (4.74-star rating), many of the comments were positive about staff were helpful, listened and kind Was treated with respected, felt very listened to and supported throughout my time with the adult community mental health team. The tools, reading materials, visual supports and methods to assist in my treatment were all of benefit. I have to say my therapist was wonderful, very kind and patient and extremely supportive.*"*

CMHT received 62 responses (Bracknell 30, WAM 18 and Slough 14) with 93.6% positive score and 4.69 star with 4 of the total responses scoring less than a rating of 4; comments included "They listened to my problem"; "*The health care person was very nice, and we had a pleasant chat. However, I did not need someone to tell me how tall I was, how much I weighed or what my blood pressure was - all of these I can do for myself. My actual health concerns, obesity, cancer and bipolar affective disorder and incontinence, were not within the advisor's remit. Had I appreciated this before my visit, I would have cancelled. This seems to me to be a waste of NHS money, a box ticking exercise that has little value. I suggest retraining the healthcare person to nurse where she would have infinitely more value. She mentioned this had been offered to her as an option but that the training would take four years (part-time). This seems an excessive amount of time for anyone to commit to - especially given these retrain individuals are likely to be mature employees (my health care lady was in her early 60's). I am an ex nurse so feel I have insight into this issue.", "Felt I wasn't listened to, was interrupted a few times and the psychiatrist had his own agenda to push on to me as opposed to working with me.*". There were several positive comments about being listened to, staff were kind, listened and helpful. Some of the suggestions for improvement included the rooms were uncomfortable. 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**	1281			
Response rate (calculated on number contacts)	**%**	6.06%			
iWGC 5-star score	**Number**	4.51			
iWGC Experience score – FFT	**%**	84.8%			
Compliments received directly by services	**Number**	435			
Formal Complaints Rec	**Number**	12			
Formal Complaints Closed	**Number**	6			
Formal Complaints Upheld/Partially Upheld	**%**	33.32%			
Local resolution concerns/ informal complaints Rec	**Number**	1			
MP Enquiries Rec	**Number**	0			



The Mental Health West division has a wide variety of services reporting into it, including Talking Therapy services and Court Liaison as well as secondary mental health services. The 3 services with the most feedback through the patient survey were Talking Therapies 476 responses, CRHTT West 122 responses and Talking Therapies Step 2 had 79 responses.

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

This division received 12 formal complaints during the quarter with CMHT receiving 6 and CRHTT receiving 2. There were 6 formal complaints closed with 2 being found to be upheld or partially upheld and 4 not upheld.

Mental Health West also received 1 informal complaint/locally resolved complaints and 0 MP enquiries.

For CRHTT West there were 122 feedback questionnaires completed with an 79.5% positivity score and 4.33-star rating; with lots of positive comments about staff listening, helpful and kind, *"[name removed] and [name removed] were very kind, polite, kind, helpful and professional they showed sympathy and understanding to my mum which was very helpful and put my mum at ease, very lovely people;"* some of the areas for improvement included discharged too soon, poor communication and staff attitude.

Talking Therapies Step 2 received 79 responses with an 87.3% positive score and 4.63-star rating (10 responses scored less than 4) many of the comments were positive about staff listened, were helpful and professional.

Older adult and memory clinic combined have received 98 patient survey responses during the quarter with a 98% positivity rating (4.89-star rating) some of the feedback included *"Explained condition and required treatment for my Parkinsons in a thorough and friendly manner. Made me feel at ease and confident I was receiving the most effective treatment. Dr [name removed] consultation feedback covered all the key points. His friendly manner and listening skills always make me feel at ease. A first-class representative of the NHS."*

There were 60 responses received for West CMHT teams with 81.7% positivity score and 4.37-star rating, 49 of these were positive with comments received that staff listened and were helpful, there were 8 negative responses with reviews stating that patients felt like staff didn't listen, waiting area was unwelcoming and didn't call back.

Talking Therapies received 476 responses during the quarter, their patient survey responses gave a positivity score of 76.9% (4.30-star rating), 107 of the reviews scored less than 4.

Most comments were still very positive about the staff, including that they listened, were helpful and understanding. Several of the comments/areas for improvement were that the wait was too long, issues with Silver Cloud software and wanting more frequent appointments. For example, *"I have been on the waiting list to receive help from Talking Therapies since last year. I was triaged, given an appointment, appointment cancelled by provider. I was Asked if I wanted another appointment- I said yes- no answer. Very disappointing especially as I have struggled with my mental health this year in a very pressured Service set up. I have given up on receiving anything."*

Examples of positive feedback about Talking Therapies included, "*[name removed] literally saved my life. She helped to regulate my emotional baggage and temper.my perfectionism with practical solutions. I was given lots of verbal help and reading material to think about and took advantage of her skills but actively tried out the experiments. I would highly recommend this service and [name removed] to anyone who is struggling. She helped me like myself as a mother, have boundaries as an employee, and think more gently about me. I now know how to silence the inner, unhelpful mind chatter. I cannot thank her enough. She is a wonderful human being and is perfectly suited to what she does. I am so grateful for her time and kindness.",* "*The material and support given really did help me during a very difficult time in life. My supporter gave me valuable feedback and even added a further module to help me after a couple of bereavements in the family. I am currently going through another difficult time in life but finding the material and modules given are guiding and helping me."* and *"My therapist was excellent, and I engaged with her to improve my mental health dramatically. It really helped me to get face to face sessions, and I wouldn't be where I am now without them. She was very kind and caring. I felt this was genuine too. A wonderful lady. Thank you!"* Patients reported that they felt *I found the therapist I spoke to very kind and understanding. She gave good advice and information that I could follow and use.",* "I received the best care ever in which I appreciate so very much The therapist was amazing and listened to my needs and gave amazing care and understanding and this has helped me so very much. The best therapy I must say :)*"' and "[name removed] was so helpful and keen to confirm I understood the process and why things were happening and in what order. She was brilliant, I couldn't have asked for a better service.*

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.

Op Courage received 54 responses during the quarter, their patient survey responses gave a positivity score of 88.9% (4.59-star rating), 5 of the reviews scored less than 4.

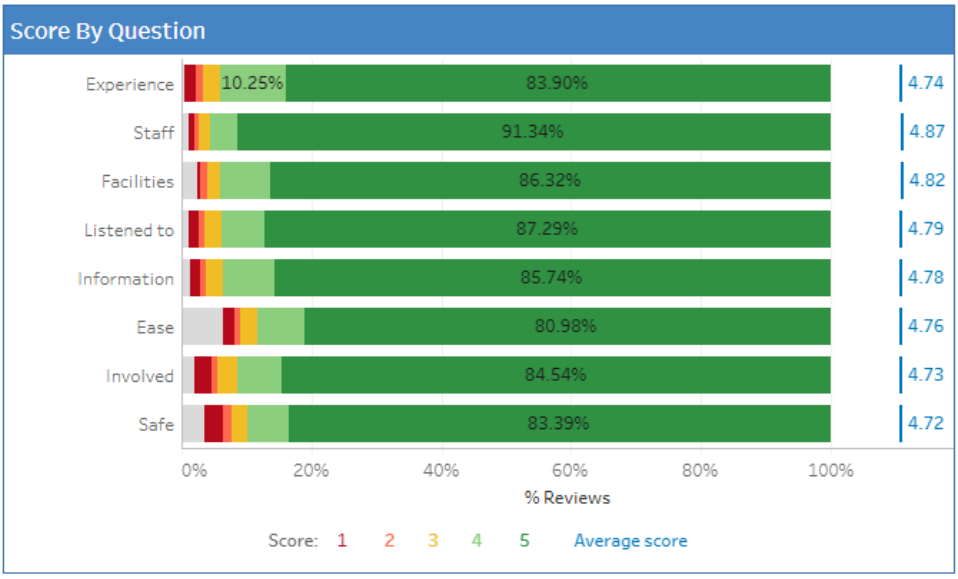
Mental Health Inpatient Division

Table 5: Summary of patient experience data

Patient Experience - Division MH Inpatients (wards)		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received*	**Number**	229			
Response rate	**%**	111.3%			
iWGC 5-star score	**Number**	4.07			
iWGC Experience score – FFT	**%**	71.7%			
Compliments	**Number**	12			
Formal Complaints Rec	**Number**	11			
Formal Complaints Closed	**Number**	8			

Patient Experience - Division MH Inpatients (wards)		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Formal Complaints Upheld/Partially upheld	**%**	37.5%			
Local resolution concerns/ informal complaints Rec	**Number**	1			
MP Enquiries Rec	**Number**	1			

- This excludes the number of surveys completed for Place of Safety, as whilst we collect feedback on people's experience, it is not an inpatient ward.



There has been a significant increase in the number of IWGC responses received. The Activity Co-ordinators and PALS Volunteer have been on the wards encouraging patients to share their feedback, which has had a positive impact in the response rate.

The satisfaction rate was 71.7% with 60 of the 247 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to ease received the least positive scores with overall 5-star rating for this question being 3.83 and 43 of the 247 giving a score of 3 or less to this question. Work continues to take place on the wards to improve communication and the involvement of patients making decisions about their care, particularly around managing risk.

There were 11 formal complaints received for mental health inpatient wards during the quarter across Snowdrop, Daisy, Bluebell wards and the Mental Health Act; they were mainly regarding care and treatment.

There were 8 complaints closed for this division during the quarter and of these 3 were partially upheld and 5 found to be not upheld.

There were many positive comments received in the feedback including comments such as staff were friendly, caring, understanding and helpful. There were some comments for improvement about more activities, not have the toilets always locked and better food. Examples of the feedback left are "*The staff including the cleaning and catering staff excellent. The support workers are so hands on supportive, they are instrumental in navigating the patient's recovery. They have so much patience and excellent listening skills and are so resourceful.*" "*I have always felt staff have time for me and listen to my needs. The environment feels safe and encouraging,*" "*Staff, nurses and drs are always listening to what patients would like and they come up with ways we can achieve them. Some staff are very supportive in the goals I want to achieve and help me to get better.*"

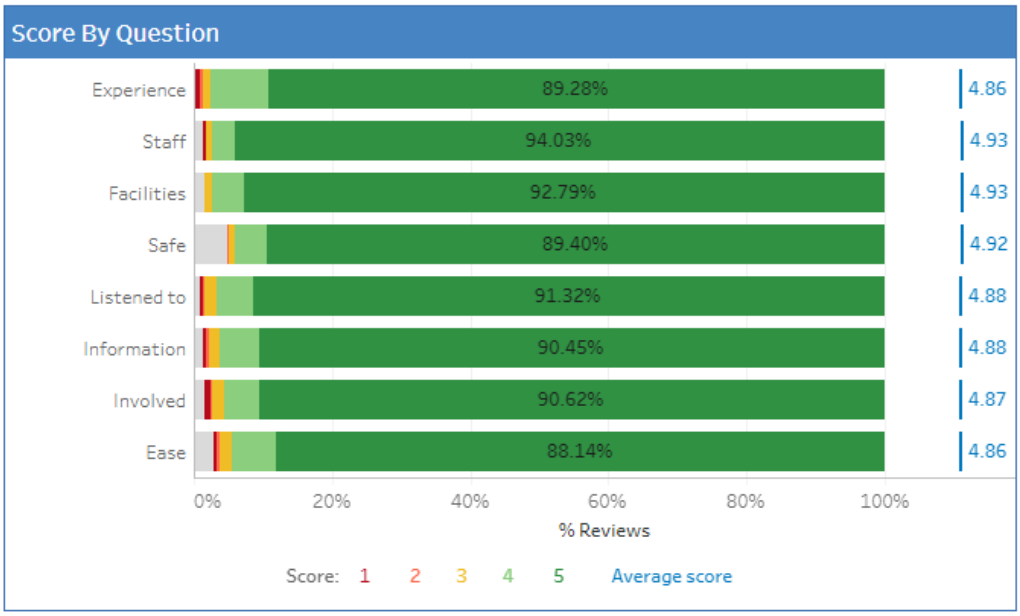
In addition to the feedback about the wards, there were 18 responses for a Place of Safety and the average 5 star score was 3.87. Their response rate is not included in this report as people are not admitted to the hospital. activity figures are not included

Community Health Services Division

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

Table 6: Summary of patient experience data

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2462			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.4%			
iWGC 5-star score	Number	4.89			
iWGC Experience score – FFT	%	97.6%			
Compliments received directly into the service	Number	382			
Formal Complaints Rec	Number	4			
Formal Complaints Closed	Number	5			
Formal Complaints Upheld/Partially Upheld	%	100%			
Local resolution concerns/ informal complaints Rec	Number	3			
MP Enquiries Rec	Number	0			



Of the 4 complaints received this quarter, 1 was for Jubilee Ward, 2 were for The Community Matrons and 1 was for the District Nursing service.

There were 5 complaints closed, all of which were upheld or partially upheld. There were no discernible themes within these complaints.

Hearing and balance received 144 responses to the patient experience survey with a 95.1% positive score and 4.83-star rating.

East Community Nursing/Community Matrons received 512 patient survey responses during the quarter with a 100% positive scoring, many comments were about staff being caring and kind, for example "*Nurses are seeing me regularly and each one of them is very kind, caring, will ask me a lot of questions and also have a chat with me when I feel lonely. I really appreciate it.,*" "*The nurse was kind and listened to my concerns and offered support as*

needed. Made me feel well assured. Very grateful for care received," "*The nurses are always very kind and compassionate play. Always let me know when my next injection is due and that I have plenty of supplies."* There were also some comments around wanting a time slot for the appointment for example *"No apart from having the possibility to be given the time slot so she can ask somebody to be present during visit."*

The wards received 150 feedback responses (72 responses for Jubilee ward 100% positive score and 78 Henry Tudor ward 92.3% positive score). Most of the comments for improvement were related to wanting more information regarding their discharge, staff needing more training and felt the wait time for the toilet was too long. There were many comments about staff being kind, caring 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 97% (4.89-stars), comments were very complimentary about staff being friendly and helpful, *"I was seen on time, made feel welcome, treated professionally, the physiotherapist was very friendly, clear and helpful in the advice she gave me.".* 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 4.87 stars from the 496 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Everyone that visited me was so kind and nice and lovely from this team. I felt comfortable and listened to! I'm very happy with this team because I've had bad experiences in the past with NHS staff visiting me in my home, I was slightly apprehensive, but UCR made me feel so at ease. THANK YOU"*

The diabetes service received 50 feedback responses with 96% positivity and some lovely comments including "*I'm very happy after seeing my diabetes nurse because I was able to shares with my diabetes nurse how well I think my diabetes daily testing through sensors. It has greatly helped me manage and improved my diabetes, health and mental wellbeing. Thank you so much for all your support, I couldn't have done it without your support.*" Alongside some helpful suggestions for the service to consider around appointments to be closer together "*Maybe a closer follow up in terms of appointment, in 2 months lot can happen.*

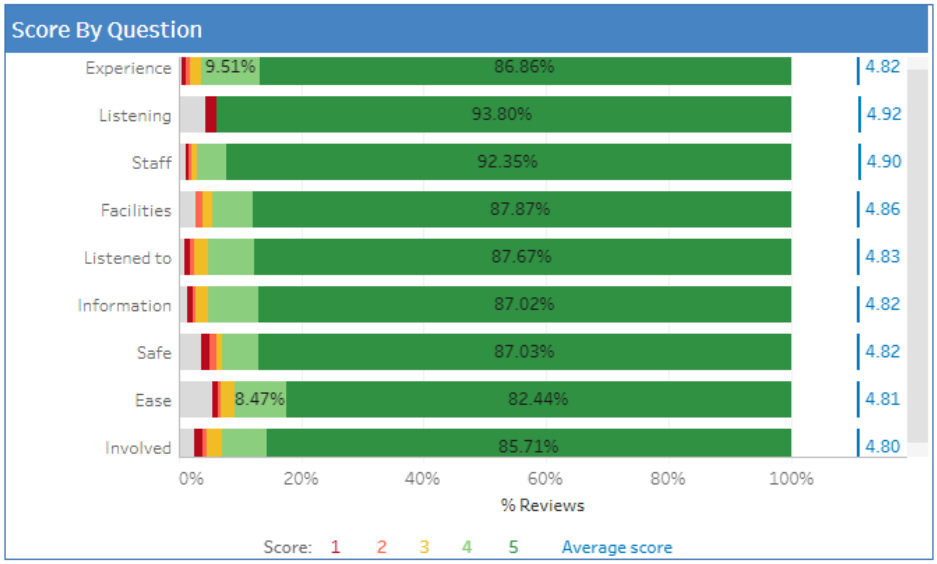
The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*I was listened to I felt cared for and felt the staff really wanted to help me. They are patient and friendly and I do feel they have helped me.*"

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

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

Table 7: Summary of patient experience data

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	3227			
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.9%			
iWGC 5-star score	Number	4.83			
iWGC Experience score - FFT	%	96.4%			
Compliments (received directly into service)	Number	260			
Formal Complaints Rec	Number	12			
Formal Complaints Closed	Number	6			
Formal Complaints Upheld/Partially Upheld	%	83.3%			
Local resolution concerns/ informal complaints Rec	Number	16			
MP Enquiries Rec	Number	1			



Community Health West saw a slight decrease in responses this quarter. The Patient Experience team held a Rapid Improvement Event (RIE) in May which included staff from Community Heath West services and concentrated on those finding it more challenging to increase their response rate; the expectation is that an increase in responses will be seen as a result of this. 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 4.83-star rating and the question on staff receiving a 97% positive scoring from the 3227 responses received.

There were 12 formal complaints received during the quarter (similar to 11 in Q4), these were split across several different services. Of these the Out of Hours GP service (WestCall) received 2 and IPASS received 3.

There were 6 complaints closed for the division during the quarter with 5 being upheld or partially upheld, 1 was not upheld

During this quarter, the community hospital wards have received 238 responses through the patient survey receiving an 92.4% positive score and 4.58-star rating, (16 responses scored 3 and below) questions around listened to and feeling involved receive the most results of 3 and below; comments include *"All staff were friendly and helpful"*, *"Cannot think of anything else to say. Thanks, a thousand times"*., *"My stay on Oakwood has been excellent. Cheerful, kind and supportive staff team, from doctors to night staff. I am on my own so facilities have been invaluable"* And *"Staff at Donnington Ward were cheerful, friendly, monitored me well, picked up when my blood pressure dropped, and I needed support. I felt safe and well looked after following a bad experience at another hospital. All staff were great including kitchen assistants, health workers, nurses, doctors/practitioners, physios etc"* there were some individual comments where patients were less satisfied with some of the staff, with comments including a few staff members can be a bit sharp and could be quieter at night, need for improvement in food, more information and not left lying in bed wondering what was going on and more physio.

Of the 4 complaints for the Out of Hours GP service, 1 related to medication and 1 was about delayed response times.

WestCall received 40 responses through the iWGC questionnaire this quarter (85% positive score, 4.54-star rating,6 scores received below 4. Positive comments included "*The person I spoke to on 111 was kind, helpful, listened and gave us good advice about where to go for further help. Dr [name removed] was superb - friendly, caring, thorough, he listened. He*

booked us into SDEC for follow up treatment." "It was the third night after my operation, and I needed help, and they had a nice and professional service. Special thanks to Mr [name removed] and Mrs [name removed]." "Dr [name removed], and Nurse [name removed], went above and beyond! I was very scared, nervous as to what my issue was, and Dr [name removed] put me at ease. Even managed to crack a joke or 2! Great caring and considerate manner. Listened to my concerns and helped me understand problems at hand! A heartfelt thank you to both of you".

Podiatry services received 229 patient survey responses. Most responses were very positive receiving 5 stars (overall 96.5% positivity 4.83-star rating) with examples including *"Everything went smoothly & efficiently*", *"name removed] is a very kind young man. He dressed my foot explaining the process as he went. My foot has been very comfortable since my appointment, and I look forward to seeing him next week."* and *"All staff were really caring and kind. They eased my nerves completely. I also had a great laugh with them all. Such a fantastic team!!".*

There was 1 complaint for Community Nursing regarding lack of treatment provision.

To provide some context across our East and West District Nursing teams combined there were 14,178 distinct patients this quarter. Lots of comments included nurses were professional, helpful, and friendly, *"Nurses were very gentle during a wound care, very kind and compassionate, I`m very grateful for their support."*, *"The nurses that visit me have been great, always smiling and friendly, brightens up my day" and "Nurses are incredible, they always have a chat with me which is very important for me as I feel very lonely and I`m very happy to see nurses coming every day to see me."* There were several positive comments about nurses being caring and there were very few suggestions for improvement, would like a bit more of a plan of care and sometimes long nursing jargon is difficult to translate/know what it means.

MSK Physio has received no complaints in the quarter. The service has received 730 patient survey responses with a 97.4% positive score (4.89 -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 space, air flow and privacy in the rooms and the overall feedback was extremely positive with lots of comments about staff were friendly, professional, kind and listened.

Demographic profile of people providing feedback (Breakdown up to date as at the end of Quarter 1; from our Business Intelligence Team)

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendances
Asian/Asian British	9.86%	8.10%	10.58%
Black/Black British	4.23%	3.40%	3.35%
Mixed	8.45%	2.80%	3.42%
Not stated	5.63%	11.40%	2.08%
Other Ethnic Group	1.41%	4.30%	2.59%
White	70.42%	70.10%	77.95%

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 several 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 Q1 attendance
Female	59.15%	39.50%	54.66%
Male	40.85%	29.90%	45.33%
Non-binary/ other	0%	2.70%	0%
Not stated	0%	27.80%	0.01%

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.

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q1 attendance
0 to 4	2.82%	14.40%	7.25%
5 to 9	1.41%		2.39%
10 to 14	7.04%		3.74%
15 to 19	11.27%		4.94%
20 to 24	7.04%	4.70%	3.36%
25 to 29	5.63%		3.07%
30 to 34	12.68%	5.10%	3.19%
35 to 39	8.45%		3.91%
40 to 44	4.23%	7.30%	3.71%
45 to 49	7.04%		3.53%
50 to 54	11.27%	11.40%	4.12%
55 to 59	4.23%		4.85%
60 to 64	4.23%	13.70%	5.03%
65 to 69	2.82%		4.89%
70 to 74	1.41%	16.00%	6.02%
75 to 79	0%		8.65%
80 to 84	1.41%	14.10%	9.57%
85 +	7.04%		17.79%
Not known	0%	13.20%	0%

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).

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
Talking Therapies	Lack of clear communication from therapists.	Created a training on how to better communicate policies and therapy expectations. Includes discussions on the importance of effective and clear communication.
	Lack of clarity around discharges.	Updated guidelines on pathway for discharges and follow up sessions. Made the guidance clearer for therapists so they can pass on accurate and up to date information about discharge policies.
	Clients shared they feel over-assessed	We shared this with a workstream who are reviewing the pathway into treatment and looking at ways of reducing over-assessment and supporting our clients to access treatment sooner.
	The clinicians can lack empathy and lack a collaborative approach.	We have discussed this at our co-ordinators meeting, our recovery workstream and quality meeting, we are looking at piloting the use of session rating scales as a discussion tool in our assessment appointment better ensure collaboration between the clinician and client. We are sharing the importance of collaboration and empathy in our local newsletter in a special section which details what our clients are telling us. We will include informed choice as a clinical skills topic. We have asked our university partners to feedback to our trainee's when observing their role-plays at university the importance of interpersonal effectiveness.
Immunisation Service	More information to be given in advance of immunisation session.	Tailored emails will be sent to young people's school email addresses via schools regarding vaccination information.
	More distractions in advance of immunisation	Fidget toys/ grab boxes taken out to all sessions.

Service	You said	We did
		Social story used at Special Educational Needs [SEN] schools.
Berkshire Eating Disorders (BEDS) Adult Service	Provide service users with recommended and evidence-based resources whilst waiting for treatment to start.	List of resources is available on SHaRON (online support and recovery network). SHaRON champion and moderators to signpost service users to forums where resources are listed periodically. Participation champion to take feedback to MDT meeting to consider alternative ways of sharing resources with service users apart from SHaRON.
	Service users are requesting more lived experience involvement.	Service users who have recovered from their eating disorder are being invited to hold lived experience session in day programme and recovery from chaotic eating groups. Videos of recovery stories on SHaRON (online support and recovery network) are being re-shared regularly by SHaRON moderators to highlight them to service users. SHaRON champion has trained three former service users as lived experience moderators. However, lived experience moderators are not yet active on SHaRON as BEDS is still looking into how remuneration can be facilitated. Day programme team are considering involving former service users in planning days and are looking into how remuneration can be facilitated.
Berkshire children and young people's Eating Disorder Service (BEDS)	Theme of greater support needed for psychological overwhelm alongside physical health recovery requested earlier on in treatment.	This feedback has been discussed in QMIS raised as a ticket. The team are now exploring providing a 1:1 therapeutic space to enable service users to engage in psychological therapy. This utilises two clinician roles within the Family Based Treatment weight restoration phase for people with Anorexia Nervosa (FBT-AN).
	To have a Q&A with an expert by experience patient, and to ask them how they managed. 'To see if it's possible despite the difficulties.	This was raised in QMIS. This has led to the service users, from the participation group, who raised this being invited to create a 'from me to you' letter. This will be provided to newly diagnosed young people starting treatment in their service and written from point of you view of a young person who is now ready for discharge.

Service	You said	We did
Adult Autism and ADHD teams	The main service-user priority for service development identified from feedback is communication; more specifically, the communication between the team and service-users/their families whilst they wait for an appointment.	In response to the feedback on communication whilst on the waitlist, the autism service has introduced a new letter template that is sent to clients who enquire about their position on the waitlist. This letter gives the client updated information and signposting to support services whilst they wait for a diagnostic/medication appointment. This is in addition to the service updating all existing letter templates to make the language more neuro-affirmative and accessible to our client group to improve communication.
	We'd like to understand more about the information sharing with GP surgeries.	Clinicians now spend more time discussing confidentiality, consent, and what information will be shared with their GP at the beginning of each assessment.
CAMHS West Specialist Community Teams (West Berkshire, Reading, Wokingham)	Please make sanitary products available in bathrooms.	Provided free sanitary products in all service user bathrooms.
	We would like information leaflets in waiting rooms.	Information folder and information boards have been created for waiting areas, with existing information being reviewed and updated.
	Some patients feel anxious about not knowing what to expect at initial appointments.	The service has created team booklets with details of what to expect, car parking, rooms, building, etc. and updated boards with clinician photos in waiting areas.
Community Inpatient Services	Food choices were limited with more ethnically appropriate food choices needed	We contacted estates and now have electronic menu booklet with a variety of Dietary options and more diversity of meal choices
	The visiting times were awkward	Visiting times have now changed trust wide, we plan to introduce 10-20:00pm.
Phlebotomy Services	Please can there be chair with arms	We have purchased a new chair for phlebotomy

15 Steps

There have been 13 '15 Steps' visits during Quarter one, with the visits being refreshed and relaunched in April 2024.

The Head of Service Engagement and Experience is continuing to lead 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 and a schedule of visits has been shared which has resulted in a vast increase in the participation of this programme.

Summary

Whilst most of the 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 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 one 2024/25

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
9444	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)		Missing pt, relative blaming BHFT for their input, or lack of on the day the pt went missing	Serious Untoward Incident Investigation	moved to PSM process	Care and Treatment
9458	Wokingham	CAMHS - Common Point of Entry (Children)		Complainant unhappy their referrals to CAMHS keep not being accepted without any discussion	Not Upheld	Local resolution	Communication
9441	West Berks	CMHT/Care Pathways		pt wishes to be discharged from CMHT as unhappy with the way they are being treated, feels they cannot trust anyone	Not Upheld	Service have discharged pt against professional advice. Pt requested this be closed as no longer wished to pursue	Care and Treatment
9448	Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Unhappy with the telephone appt for MH review, felt clinician was argumentative.	Not Upheld	local resolution	Attitude of Staff
9450	Reading	Adult Acute Admissions - Daisy Ward		Pt feels a staff member is showing a distasteful use of power, using their size inappropriately to threaten others	Not Upheld	IFR process	Abuse, Bullying, Physical, Sexual, Verbal
9476	Reading	Mental Health Act Department		Complaint concerned about the detention and the process	Not Upheld	advised the concerns are for the local authority	Care and Treatment
9409	Slough	Crisis Resolution and Home Treatment Team (CRHTT)		Family flabbergasted the pt has not been sectioned. Pt MH severely declined, family member says the pt knows how to work the system, every time they held by police or seen, AMPH team has discharged leaving the family in a very vulnerable position. Mother in particular feels petrified. Bad communication between services and family have also caused problems.	Not Upheld	No consent received	Care and Treatment
9493	Reading	Out of Hours GP Services	Low	medication prescribed for 4 month old was too high for the age of the child	Upheld	Share at next Clinical meeting for wider learning. Report lack of clarity in BNFC with BNF Publications. Contact Adastra to add in the standard dose of Laxido for children under 1 year.	Medication
9468	Reading	Older Adults Inpatient Service - Orchid ward	Low	Medication issues whilst on leave. Time leave started late so wasting a day. Leave was left open but no one from the ward contacted the pt. Feels the ward is shambolic	Upheld	The investigation also highlighted some incidental learning. Patients would benefit from a care plan/overview of the MDT discharge discussion.	Care and Treatment

9367	Slough	Community Hospital Inpatient Service - Jubilee Ward	Low	Spouse unhappy with aspects of care provided and communication with staff	Upheld	It was found that there could be more work done to ensure initial discussions with families about key aspects in the Admission Pack take place. It was acknowledged that changes that families may be going through should be taken into consideration and there is a need being mindful of their capabilities. Doctors/ANPs will now have an initial conversations with patients and relatives and then set up follow up meetings as requested. Learning was also put in place to ensure communication is effective and that staff speak in a clear and professional manner, noting their tone and volume at all times of the day.	Care and Treatment
9484	Windsor, Ascot and Maidenhead	Common Point of Entry	Low	Psychiatrist advised on medication without seeing the pt. Pt feels they were put at risk.	Not Upheld	CPE Psychiatrists do not prescribe medication, their recommendations are given as advice to GPs for consideration. Usual practice would be for GP's to then have a discussion with individuals in order for individuals to make an informed decision about the suitability of any recommendations. At the time of providing this advice, the doctor wasn't aware of any allergy to Vortioxetine as it wasn't recorded on the referral form or in Rio, nor was it clear within connected care.	Care and Treatment
9451	Reading	Out of Hours GP Services	Minor	Autistic 14 yr old. 111 put on a 2 hr call back list but no call within 2 days	Partially Upheld	Although 111 recommended a call back within two hours, the service was not able to accommodate this due to service pressures. There is evidence that the service tried to bring in more staff to help relieve the pressure however, they were unsuccessful. Although they were unable to call within two hours they did make attempts to contact the complainant however, these calls went to voicemail.	Care and Treatment
9479	Bracknell	District Nursing	Minor	Unexpected visit from Nurses causing distress. DN's left without changing pt's pad that was wet, they had spoken to the carer who said they would be there around 10:30 to sort	Upheld	Shared through DN forum expectations of staff to provide holistic care and carry out required assessment. Staff have completed reflective statements.	Care and Treatment
9449	Wokingham	Integrated Pain and Spinal Service - IPASS	Low	Staff member did not ask to touch the pt and they feel the fact they did has caused then increased pain	Upheld	It was accepted that although the clinician asked for permission to touch the patient he did not ask for permission to perform movements with their neck. The movement described by the patient and clinician was not thought to be the cause of the patients pain however, they have been referred to appropriate services to help with this. In future, more information will be sent to patients prior to their appointments to explain what will happen during the appointment and that this can cause their condition to flair up.	Care and Treatment
9437	Wokingham	CMHT/Care Pathways	Low	Care working and pt extremely unhappy with the care and treatment provided by Wokingham CMHT.	Not Upheld	No actions.	Care and Treatment

9391	West Berks	Keyworking Team	Low	Complainant feels no support is being offered to the YP	Not Upheld	It is usual practice for the team to respond to letters with the team name as multiple staff are involved in the decision however, they will in future ensure this is clear in the body of the letter. A referral was made to the key working team but this was declined as the patient did not meet the criteria and the patient declined to be seen by them. It was found that there are no deliberate barriers in place to prevent the patient access to the service. The patient was deemed to have capacity, at the point of the discussions around the key working team and the referral. Previous consent from the patient with regards to their parents being able to make decisions was therefore negated by the patients on decision, which they had capacity to make.	Care and Treatment
9422	Reading	Adult Acute Admissions - Snowdrop Ward	Low	Family feel pt has been denied escorted leave due to lack of staff and unhappy about the lack of vapes available	Upheld	Patients are given vapes on day one of their admission after which they buy their own vape or make use of Nicotine Replacement Therapy. There was however, an issue with the Nicotine Replacement being prescribed so the patient did experience a delay. In terms of the leave, the patient had leave at least once a day during admission except during times where the ward could not maintain safe staffing levels whilst escorting patients on leave.	Care and Treatment
9469	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Pt made a complaint around Dec 2022 which was never responded to due to medication that made the pt extremely ill. Pt has been received withheld phone calls from people saying they are the Crisis team and then being abusive but quoting info pt has told Crisis. Pt feels system has been hacked	Not Upheld	A review of the medical records by an independent practitioner found that the prescribed medication was appropriate give the patients distress. Attempts were made to review this with the patient but they had already stopped taking the medication. There is no evidence that the calls received came from the service and all call recordings with this patient were revived which found no concerning content in the calls made by the team.	Communication
9426	Reading	Adult Acute Admissions - Snowdrop Ward	Low	Missing expensive personal items. Complainant has listed the items and is looking to claim	Not Upheld	Some items were able to be recovered from the ward and were returned to the patient. For the items that were unable to be found, re-imbursement was offered	Patients Property and Valuables
9442	Reading	Traumatic Stress Service	Low	Pt unhappy that in order to stay under our services funding will be needed as they now live OOA. Feel very let down	Upheld	Although the current process in the service SOP and the process were followed it was concluded that this was not a compassionate approach and learning was put in place to allow for extra time for GP's to respond. As well as more communication with patients to allow them the opportunity to chase the GP's	Communication

9413	Reading	CMHT/Care Pathways	Low	Pt suffering with MH since 2022, unhappy with several clinicians and care given	Not Upheld	The waiting times the patient experienced were a result of the team working through the options available and trying to find the right treatment option for her. The team felt that they worked hard to keep the patient engaged with the therapeutic plan and getting her to reach a level of stability to help her address the longstanding psychological issues.	Care and Treatment
9411	Reading	Adult Acute Admissions - Bluebell Ward	Low	Unhappy with labels that have been put on them the MHA and their inpatient stay in 2020	Not Upheld	There is evidence that the patient and their family were informed throughout their care and that their physical health concerns had been explored. With regard to medication, it is recorded that medication was changed due to the patient experiencing adverse side effects	Care and Treatment
9546	Bracknell	CMHT/Care Pathways	Low	Injection given one day early and the wrong size needle was used resulting in excruciating pain. Pt feels it is clinical negligence as the nurse did not familiarise themselves with the instructions	Partially Upheld	It was found that the medication was given early as it was due on a weekend when the team were not working so this was done one day early, on the Friday. The medication can be administered up to 7 days early safely. The member of staff did not read the instructions on the medication as they were very familiar with it and did not feel this was necessary. They did however, use the wrong size needle for the patients body weight.	Care and Treatment
9507	Slough	CMHT/Care Pathways	Low	Attitude of Dr at pt 3 month review	Partially Upheld	The evidence suggests that the case was not discussed in the case conference as it was suggested it would be however, the concerns about the staff attitude came as a surprise to the clinician as their recollection differs. It was found that the clinician did review the notes before the appointment and it was reasonable that they were not aware of elements of the patients 17 year history.	Attitude of Staff
9443	Reading	CAMHS - Rapid Response	Low	Attitude of RRT staff member and the delay endured by the pt on the ward waiting for the staff member to arrive when they were ready for discharge	Partially Upheld	Although the patient did wait a long time to be seen this is due to their being a gap during the evening in someone being on site so they were contacted by phone. When someone did arrive on site they were unable to immediately see the patient as they had start of shift activities to complete. It is accepted that there could have been clearer communication around this. The patient was discharged after a short consultation as the clinician was unable to build a rapport with her and felt she had enough information from the notes to formulate a plan. The staff member was also very aware the patient had waited a long time and an A&E environment was not the best place for them since they had been medically discharged.	Attitude of Staff
9536	Slough	Community Hospital Inpatient Service - Jubilee Ward		RESPECT form completed without consultation with NOK/LPA holder having ticked there is no legal proxy in place. Unhappy about the access to BSL translator for Pt and wish this to be inline with what is provided at the care home	Partially Upheld	Local resolution sort - RESPECT has been changed and the new one has been put on RiO	Communication

9502	Reading	IMPACTT	Low	problems being caused by fellow pt living in the same place and being in the same group therapy. wishes to move therapy group days	Not Upheld	The team did not grant the patients request to move to a different group. This was because the only alternative group was full and also because the team were trying to support the patient to deal with difficult interpersonal relationships which is what the treatment they are undergoing aims to do	Care and Treatment
9505	Wokingham	Integrated Pain and Spinal Service - IPASS	Low	pt arrived 15 mins early, waited 45 mins to be told she wasn't checked in so needed to come back having waited a long time for the appt	Upheld	The patient was incorrectly directed to the wrong waiting area so she was not able to see when she was called for the appointment. Staff will, in future, check both waiting rooms and signage will be put up to ensure this doesn't happen again	Care and Treatment
9512	Slough	CMHT/Care Pathways		Pt unhappy that CMHT have consistently failed to attend their last 5 scheduled appts	Not Upheld	local resolution	Care and Treatment
9472	Windsor, Ascot and Maidenhead	CMHT/Care Pathways		Discharged from IMPACTT to CMHT no contact for 4 months despite being categorised as high risk of suicide	Upheld	As learning from the complaint the service will be reviewing discharge procedures and look to ensure these are followed correctly. They will also look to identify any communication breakdown between the Intensive Management Team and the Community Mental Health Team.	Care and Treatment
9403	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward		DECEASED Pt. Spouse wishes to know why the decision to try pt to Wexham instead of Frimley was made, and an explanation into the way the spouse was informed of the try	Partially Upheld	The patient was moved from the ward to Wexham Park as her condition deteriorated and she required care above that of what the ward could provide. She was not transferred to Frimley, where she came from, as this was further away and as she required an ambulance to transport her they would not have agreed to take her any further than necessary given her condition. The investigation did find that the communication with the patient and family could have been better around this and learning has been put in place to ensure families are able to attend ward rounds and hear the care plan.	Discharge Arrangements
9497	Reading	CAMHS General		Family feels decisions made were not lawful and are a data breach 1.asking us to re-issue the assessment report (removing information in the report relating to a Child Protection Plan) 2.to raise this as a formal data breach in the organisation and confirm this has been actioned.	Partially Upheld	There was a lawful basis to share the information that was shared. The information contained in the record is an accurate reflection of the information known to us at the time that was used for diagnostic purposes and must therefore remain documented in the record in line with NHS record keeping obligations. On reflection, it would seem that this statement of confidentiality could be open to interpretation and therefore, the Autism Assessment Team will revise the wording as a consequence of your complaint to ensure that the meaning is clear to all future recipients.	Confidentiality

9499	Bracknell	Community Matron		Unhappy there seems to be no accountability for staff. Wishes to understand the HUBs involvement. Complainant feels there must be consequences for the lack of care ORIGINAL COMPLAINT BELOW Care and treatment provided by the Community Matrons What happened between the referral from GP to nursing service? Why was there no follow up on the episode/referral. Who is responsible for this, what action will be put in place to prevent this happening.	Upheld	The referral to the GP did not happen on the day of the visit and was delayed until two days later. It has also been recognised that The Community Matron could have also referred to BHFTs Urgent Community response team for further assessment on the day of her visit. This learning has been shared with the individual and will also be shared with the wider team. There was a breakdown in communication that resulted in the patient not receiving a follow up from the Community Nurses one evening as they had not considered the closing of the GP Surgery. This has been shared with the team for learning.	Care and Treatment
9545	Reading	CAMHS - ADHD		waiting times due to admin saying they have not received required documents over the last 5 years	Not Upheld	local resolution	Waiting Times for Treatment
9445	Reading	Adult Acute Admissions - Bluebell Ward		CQC Complaint regarding tribunal to take place on 3.4.24. Unhappy with being detained	Not Upheld	Not pursued by patient	Care and Treatment
9504	Wokingham	Community Matron	Low	lack of care and treatment provided by the community matron	Upheld	The Community Matron service is a non-emergency response service. Therefore, if a patient requires a rapid response due to deterioration in their condition, then the GP or in some cases an ambulance would be contacted. In this case, the Community Matron could have also referred the patient to BHFTs Urgent Community Response team and learning has been shared with the staff member involved around this. The Community Matron service is currently being reviewed and as part of the review, new response times are to be introduced and workload prioritisation is being explored.	Care and Treatment
9485	West Berks	Phlebotomy	Minor	provision on blood tests for under 12's at West berks	Not Upheld	Not upheld	Access to Services

9447	Reading	Adult Acute Admissions - Daisy Ward	Moderate	Unhappy with their input admission Dec 2023. Feels their MS diagnosis was not known so their needs were not taken into consideration. Not provided with the notes as requested from a meeting they were told they could not record - feel their Neurodiversity was not taken into consideration, also refused advocacy support	Partially Upheld	1.BHFT is currently undertaking a wide scale initiative relating to Neurodiversity Strategy. This strategy is aimed at individuals who are neuro diverse, that includes patients, staff, and other service users within the inpatient setting. •We have received feedback from Autism Berkshire who visited our wards and given valuable feedback on improvements that can be made. •This feedback has already been added to BHFT's Quality Improvement projects to explore and find solutions regarding adaptation of ward environments to foster optimal-patient experience whilst admitted as an inpatient. •There is also a dedicated project group specifically tasked with researching and communicating improvements to the various aspects of the neurodiversity strategy, this includes a multi-disciplinary and interprofessional collaborative approach, with the use of SMART action plans to ensure longevity. Some of these include the use of specific, bespoke training for clinicians working within inpatient wards specifically designed to improving Care and Support plans example Positive Behavioural Support (PBS) specific to those with Autism. •Another aspect of the Trust's action plan has been the collaboration, and use of individuals with lived experience of Autism that is, patients, staff, other	Discrimination, Cultural Issues
9465	Wokingham	CMHT/Care Pathways	Low	poor care and treatment from CRHTT and CMHT staff. Inappropriate examples of other pts circumstances used in appt. poor communication between services. Family request pt is seen by a specific Dr	Partially Upheld	Overall, the complainants concerns appear to be due to misunderstanding comments and processes, and workers may have not explained things well, or could have communicated in a more sensitive manner, which are explained in the response letter. However, in view of grievance agreed to change worker.	Care and Treatment
9405	Windsor, Ascot and Maidenhead	IPS - Individual Placement support	Low	link 9084. PHSO won't accept as LRM required. Additional qu raised regarding confidentiality, IPS staff having access to Rio. IPS staff arranging meetings in cafes and pt's homes. Concerns over future safeguarding	Upheld	Patient not given information leaflet on MHICS, which would have outlined service and managed expectation.	Communication
9418	West Berks	Family Safeguarding	Low	Unhappy they were not contacted by the IO. Believes we did not address answer why the clinician has not contacted them. Wishes clarity regarding why BHFT disseminated the BWCSP email ORIGINAL COMPLAINT BELOW Complainant unhappy about lack of cooperation in sharing staff members email address 1. Why will the Trust not share the staff members email address and why is she not replying to emails? 2. why will the Trust not share safeguarding's generic email address 3. how did we get the safeguarding email from LA	Not Upheld	It is reasonable that the Trust wont provide an individual staff members email address and the generic email address requested was for professionals only, which is why this was not provided. The email from Safeguarding at BWCSP was shared as they were conversing with the complainant in relation to our member of staff. Further Re-opened complaint - not upheld. Unable to respond to any additional specific concerns about named staff as complainant did not respond to requests for information. Complaint aspect about a potential breach was not upheld.	Communication

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2023/24						2024/25				
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Compared to previous quarter**	**Q1 no. of contacts**	**% contacts Q1**	**% of Total**
CMHT/Care Pathways	16	6	13	14	49	**17.44**	12	↓	5145	3.31	**17.65**
CAMHS - Child and Adolescent Mental Health Services	8	11	7	9	35	**12.46**	10	No change	4209	2.71	**14.71**
Crisis Resolution & Home Treatment Team (CRHTT)	5	10	5	6	26	**9.25**	5	↓	3637	2.34	**7.35**
Acute Inpatient Admissions – Prospect Park Hospital	10	2	4	7	23	**8.19**	8	↑	176	0.11	**11.76**
Community Nursing	3	6	5	3	17	**6.05**	6	↑	14993	9.65	**8.82**
Community Hospital Inpatient	1	2	5	4	12	**4.27**	4	No change	476	0.31	**5.88**
Common Point of Entry	1	3	0	0	4	**1.42**	2	↓	993	0.64	**2.94**
Out of Hours GP Services	1	2	7	4	14	**4.98**	2	↓	5854	3.77	**2.94**
PICU - Psychiatric Intensive Care Unit	0	0	1	0	1	**0.36**	0	No change	8	0.01	**0**
Urgent Treatment Centre	1	1	2	1	5	**1.78**	1	No change	4161	2.68	**1.47**
Older Adults Community Mental Health Team	1	2	1	0	4	**1.42**	1	↑	4326	2.78	**1.47**
Other services during quarter	21	19	25	26	91	**32.38**	17	↓	111443	71.70	**25**
Grand Total	68	64	75	74	281	100	68				

Locally resolved concerns received

	Month Received			
Division	**April**	**May**	**June**	**Grand Total**
Children, Young persons & Families		3	2	5
Community Mental Health East				0
Community Mental Health West				0
Physical Health		8	9	17
Grand Total	**9**	**5**	**8**	**22**

Informal Complaints received

	Month Received			
Division	**April**	**May**	**June**	**Grand Total**
Children, Young persons & Families	1		1	1
Community Mental Health East			1	1
Community Mental Health West			1	1
Mental Health Inpatients			1	1
Physical Health	3		3	6
Grand Total	**4**	**0**	**7**	**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 still awaiting a response in terms of being able to benchmark our activity.

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

	2023/24				2024/25					
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Higher or lower than previous quarter**	**Q2**	**Q3**	**Total for year**	**% of 24/25**
Locally resolved/not pursued	0	4	1	3	0	↓				
Not Upheld	20	25	30	25	19	↓				
Partially Upheld	22	26	24	32	9	↓				
Upheld	11	9	12	9	12	↑				
SUI	0	0	2	2	1	↓				
Grand Total	**53**	**64**	**69**	**71**	**41**					

51% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 57% in Q4, 55% in Q3 and 56% in Q2). These were spread across several differing services.

Complaints upheld and partially upheld

	Main subject of complaint							
Service	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Confidentiality**	**Discharge Arrangements**	**Discrimination, Cultural Issues**	**Medication**	**Grand Total**
Adult Acute Admissions - Daisy Ward						1		1
Adult Acute Admissions - Snowdrop Ward		1						1
CAMHS - Rapid Response	1							1
CAMHS General				1				1
CMHT/Care Pathways	1	3						4
Community Hospital Inpatient Service - Henry Tudor Ward					1			1
Community Hospital Inpatient Service - Jubilee Ward		1	1					2
Community Matron		2						2
District Nursing		1						1
Integrated Pain and Spinal Service - IPASS		2						2
IPS - Individual Placement support			1					1
Older Adults Inpatient Service - Orchid ward		1						1
Out of Hours GP Services		1					1	2
Traumatic Stress Service			1					1
Grand Total	**2**	**12**	**3**	**1**	**1**	**1**	**1**	**21**

Care and Treatment complaint outcomes

	Outcome				
Service	**Not Upheld**	**Partially Upheld**	**Serious Untoward Incident Investigation**	**Upheld**	**Grand Total**
Adult Acute Admissions - Bluebell Ward	2				2
Adult Acute Admissions - Snowdrop Ward				1	1
CMHT/Care Pathways	4	2		1	7
Common Point of Entry	1				1
Community Hospital Inpatient Service - Jubilee Ward				1	1
Community Matron				2	2
Crisis Resolution and Home Treatment Team (CRHTT)	1		1		2
District Nursing				1	1
IMPACTT	1				1
Integrated Pain and Spinal Service - IPASS				2	2
Key working Team	1				1
Mental Health Act Department	1				1

	Outcome				
Service	**Not Upheld**	**Partially Upheld**	**Serious Untoward Incident Investigation**	**Upheld**	**Grand Total**
Older Adults Inpatient Service - Orchid ward				1	1
Out of Hours GP Services		1			1
Grand Total	**11**	**3**	**1**	**9**	**24**

PHSO

There have been no new complaints brought by the PHSO since April 2024, although two cases to remain open with them.

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
Feb-24	CAMHS - Specialist Community Team	Ongoing	Complaint referred to PHSO

Month opened	Service	Month closed	Current stage
Feb-24	CAMHS - Specialist Community Team	Ongoing	Confirmed we will enter into Dispute Resolution process; awaiting update.

CQC

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 Q1 we received four 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.

Year	**2022/23**				**2023/24**					**2024/25**
Quarter	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total	Q1
Received	1119	1403	924	4522	1091	1229	1408	1399	4036	1237

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 to triage queries which may merit a formal investigation.

PALS has continued to facilitate the ‘Message to a loved one’ service, which involves collating messages for patients, which are then delivered on the ward. This is available across all inpatient areas. The PALS Manager continues in the role Armed Forces Service Network champion. PALS is also responsible for responding to postings on the NHS website which refer to Trust services. Arrangements have been made to attend community meetings on wards at Prospect Park Hospital and office space has been identified at Prospect House and 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 618 queries recorded during Quarter One. An increase of 130 since Quarter four. 617 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 have also refined 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. The PALS manager has produced a volunteer Role Description to standardise the expectations of volunteers and their input.

In addition, there were 461 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. Most queries relate to the Royal Berkshire Hospital, followed by Frimley Park Hospital, BOB ICB/GP and Wexham Park Hospital.

To improve dialogue with other PALS services and share information and best practice, the PALS Manager has contacted PALS services across Berkshire, with a view to reconvening the Berkshire PALS network.

An inaugural meeting has been held with Frimley Park PALS with the RBH service committed to attending. A framework for a term of reference has been agreed. The aims of the group are to improve communication, share themes and local developments and raise the profile of PALS in general. Further meetings have been planned with other organisations invited to attend.

PALS recorded queries from a wide range of services but the services with the highest number of contacts are in the table below:

Service	Number of contacts
Work experience/placements	36
CMHT/ Care Pathways	27
Access to medical records	22
District Nursing	14
Pensions and Finance	14
IPASS	12
Adult acute admissions PPH	12
Site Services/Estates	12
IT queries	12
CAMHS AAT	11

Appendix 3

15 Steps; Quarter One 2024/25

The 15 Steps programme was relaunched in April 2024, and during quarter one, there were 13 visits:

Mental Health Services Division		
Prospect Park Hospital		
Ward	**Positives**	**Observations**
Rose Ward	We were welcomed to the ward with a smile from the staff that we met. Photos of staff and their interests is welcoming. Clear information on visiting and process were on the outer door. The tree with patient quotes offers a warm welcome to the ward. The ward appeared busy but calm, with call bells answered promptly; we witnessed staff from off ward responding to a call bell promptly. The ward appeared well organised and was not cluttered. Staff were seen interacting with patients on the ward, who appeared settled and happy. Information on MHA and IMHA/Advocacy is accessible in the communal area. Information on how to give feedback was available. There are multiple garden areas which are well used by patients.	It would be good to balance the visiting information with positive patient feedback. There were some toilets off the main communal area that are signed as not in use and blocked off by a sofa. The ward is waiting for several improvements and furniture to be delivered to the ward. Some of the noticeboards have information that has slipped down. There is graffiti and bad language on the communal garden wall. They have tried to remove some using a pressure washer. The idea of patients being involved with painting a mural would be a good engagement activity as well as promoting taking ownership of the area. More seating would make the spaces more inviting along with the raised beds being planted.
Snowdrop Ward	We were welcomed to the ward with a smile from the staff that we met. QMIS was underway with staff and patients were engaging. Photos of staff as you enter the ward is welcoming. The ward appeared busy but calm, with call bells answered	It would be good to see more ‘You said, we did’ on display.

	promptly; we witnessed staff from off ward responding to a call bell promptly. The ward appeared well organised and was not cluttered. The paint refresh in the dining room was scheduled around patient use and helps the ward feel well cared for. Staff visibly on Observations. Staff were seen interacting with patients on the ward, who appeared settled and happy. Information on MHA and IMHA/Advocacy is accessible in the communal area. Spoke with staff about collecting iWGC feedback, and the Activities Co-ordinator is actively doing this.	
Physical Health Services Division		
Community Inpatient Wards		
Ward	**Positives**	**Observations**
Ascot Ward	We were welcomed to the ward with a smile from all the staff that we met. The 'bus stop' is lovely addition to the ward as a safe space for people to go if they feel lost. The ward appeared busy but calm. The ward appeared well organised and was not cluttered. Information on staffing was clearly visible. Call bells were answered promptly. iWGC patient feedback information was up to date. Information for staff and patients is visible. Staff were seen interacting with patients on the ward, who appeared settled and happy. A wonderful noticeboard celebrating International Nurses day.	The Unit Manager explained that there had been some delays with some of estates and facilities repairs, these were followed up during the visit.

Henry Tudor Ward	We did not wait long for the bell to be answered. Lots of information for carers is available on the racks in the main corridor. The ward proactively reviewed patient feedback. The ward appeared calm. Staff said that they were short staffed but were managing well. Very few call bells were ringing and were answered swiftly by staff. Nurses on duty and staffing levels were clearly on display and up to date. The open plan day room, dining area and physio area makes this a multipurpose space. Staff said about the business case they are writing to add a sensory section to the day room. The ward was clean and uncluttered. Walkways were clear of obstruction and housekeepers were actively on the ward. The ward was preparing for lunchtime, which looked (and smelt) appetising. We saw staff (including the Activities Co-ordinator) sat with patients preparing them for their meal. They were chatting and the patients looked engaged and were smiling.	Feedback on iWGC about the physio equipment being in the dining area – can this be screened off safely? Large toilet – equipment storage including BP machines and drip stands. The door is open onto the lounge with patients and visitors. Ward Manager explained that there is an issue with storage, and it was hoped to be able to use the empty space next door. She was going to go to the area and see what could be moved, particularly the BP monitors.
Windsor Ward	We were welcomed to the ward with a smile from all the staff that we met. The recent paint refresh helps the ward feel welcoming and well cared for. The second nurses station makes a positive impact to the visibility and accessibility to both patients and staff. The introduction of a bariatric room has ensured that we can provide care in a safe way iWGC patient feedback information was up to date.	The ward Manager explained that they are in the process of moving patient information to the centre of the ward with staff information to either end to make this more accessible.

	Information for staff and patients is visible. Staff were seen interacting with patients on the ward, who appeared settled and happy.	
Community Physical Health Services		
Service	**Positives**	**Observations**
Podiatry - Reading	Staff were welcoming, friendly and knowledgeable. There is information for patients on what to do when they arrive for their appointment, as there is no reception area. The door to the clinic was approachable with an automatic opening. This was intermittently working. Information on the clinics would be helpful on the door itself. Waiting area was comfortable, with a radio on. Staff were calm and the clinic room appeared tidy and ready for the next patient. There are some bariatric chairs and those of different heights which makes the patient experience more comfortable for those who need them. An open waiting area with clear information –user friendly with a range of helpful leaflets which were up to date and relevant. Lots of information about how to give feedback and up to date scores and You Said, We Did on display. The service work hard to encourage feedback and have all methodologies readily available.	Some of the guidance next to the buzzer was confusing; do you wait or buzz for staff. The buzzer was identified as not working during the visit and reported. The Team Leader explained that this has been reported. Patients are sent a map and explanation on how to find the clinic; they get lots of Community Dental Service patients coming to the clinic so there is signage on the door signposting them to the correct entrance. Covid Social Distancing information poster on outside wall next to entrance door; this is no longer relevant and is to be removed.
Podiatry - Slough	Staff were welcoming, friendly and knowledgeable. There is clear information for patients on what to do when they arrive for their appointment, as there is no reception area. The door to the clinic was approachable, and colourful.	There was a printer in the waiting room – which is not ideal however may be there to be accessible to print info for patients and the clinic rooms would not accommodate it.

	Staff were calm and the clinic room appeared tidy and ready for the next patient. There are some bariatric chairs which makes the patient experience more comfortable for those who need them. A small space with clear information – user friendly with a range of helpful leaflets which were up to date and relevant. Footwear options physically on show to help inform patients.	
Podiatry – Maidenhead	Staff were welcoming, friendly and knowledgeable. There is clear information for patients on what to do when they arrive for their appointment, as there is no reception area. There is a list of the clinic staff in the waiting room. Staff were very welcoming and offered helpful advice on footwear and a local SMAYS college in Maidenhead which is useful information for PALS to have. Staff were calm and the clinic room appeared tidy. A small space with clear information – more user friendly with a range of helpful leaflets which were up to date and relevant. iWGC feedback was visible and up to date. Information on the Neurodiversity passport was accessible. Staff advised us that more clinically sensitive patient information, such as amputation, was held in the clinic room to reduce anxiety to support confidentiality.	
Podiatry - Wokingham	Clear guidance on the door of what patients need to do when they arrive for their appointment.	

	The doors to the admin office and clinic rooms were open, making the space light and approachable. There was a clear, laminated staff on duty board with photos of staff. A selection of relevant and up to date patient information was available, with plenty of stock. The clinic room was prepped and ready for use – not cluttered and appeared clean and tidy – including the workstation. A selection of relevant and up to date patient information was available, with plenty of stock. iWGC patient feedback was displayed and up to date.	
ARC - Slough	Staff were welcoming, friendly and knowledgeable. There is clear information for patients on in the waiting area. The clinic was well signposted. There are 2 reception tables with at least one staff member always seen. Staff were calm and the clinic rooms appeared tidy and ready for the next patient. A group was underway, with light music in the background which helped with a really nice atmosphere. In the different treatment areas, there were stocks of specific diagnosis information leaflets. A small space with clear information – user friendly with a range of helpful leaflets which were up to date and relevant.	Recommend sharing the positive feedback from iWGC in the waiting area.
The Garden Clinic - Slough	Staff were welcoming, friendly and knowledgeable. There is clear information for patients on what to do if they have been waiting for more than 10 minutes past their appointment time.	A patient said that some of the text is a bit small on the 'you said, we did'.

	The door to the clinic was approachable, and colourful. Staff were calm and friendly, clerking in patients as they arrive. The reception and waiting areas were not cluttered. Clinicians were moving around between rooms in a calm, and efficient manner. A small space with clear information (waiting room C) – user friendly with a range of helpful leaflets which were up to date and relevant. iWGC feedback was clear and up to date.	
Physio – St Marks	Staff in reception were friendly and welcoming. Explained what the process for patients who arrive for a clinic is. Information on what to do if no-one is in reception was clear. Noticeboards with helpful and up to date information was on the corridor on the way to the clinic and waiting areas. The clinic spaces were set up ready for the next patients. The clinic areas were clean and had equipment laid out and accessible in each bay. Lots of relevant information for patients, not just about physio. Evidence of acting on patient feedback; iWGC information was up to date. It was great to see information on the Neurodiversity passport so readily available and accessible.	There were no staff in the clinic to feedback our visit to, a suggestion is to replace/recover 2 well used stools in the clinic area as these are cracked and peeling.
PICC Clinic - Wokingham	There is a welcoming admin desk in the clinic, and staff were welcoming and friendly. Staff know their patients well, and the patient we met spoke highly of the staff and service.	The clinic is an open environment to receive care – patients did not appear to be concerned by this and spoke openly with others in the room- no facility seen to draw a curtain.

	There is no visible signage, however patients were observed to be greeted in reception and brought to the clinic. There were clear patient care areas, with bed/chair, trolley and the equipment needed. The clinic appeared clean and tidy. Limited patient information on display due to being a shared space.	No iWGC information visible.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2024
Title	**Quality Assurance Committee Meeting – 27 August 2024**
	Item for Noting and Ratification of Changes to the Quality Assurance Committee's Terms of Reference
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. The Committee made changes to its terms of reference (shown in tracked changes). The Trust Board is requested to ratify the changes. 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 August 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 Debbie Fulton, Director of Nursing and Therapies Alex Gild, Deputy Chief Executive Minoo Irani, Medical Director Tehmeena Ajmal, Chief Operating Officer Amanda Mollett, Head of Clinical Effectiveness and Audit
In attendance:	Cheryl Gardner, Deputy Executive Office Manager Katie Humphrey, Carers Lead

Opening Business

1 Apologies for absence and welcome

Apologies for absence were received from:

Julian Emms, Chief Executive Officer
Aileen Feeney, Non-Executive Director
Daniel Badman, Deputy Director of Nursing for Patient Safety and Quality
Guy Northover, Lead Clinical Director
Sara Fantham, Clinical Director & Lead Nurse - East Adult Physical Health Division
Julie Hill, Company Secretary

The Chair noted that the day after a bank holiday is not an ideal time for the Quality Assurance Committee due to it being peak holiday time. The Chair noted however that moving the meeting may not be possible due to the need to have papers available for Trust Board but raised that she would discuss with the Company Secretary.

Action: Chair

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 May 2024

The minutes of the meeting held on 28 May 2024 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Matters Arising Log had been circulated. The following actions were discussed further:

5.0 National Patient Safety Alert – Bed Rails
The Chair queried with the Director of Nursing and Therapies if the action around the outstanding National Patient Safety Alert needed to remain open on the action log. The Director of Nursing and Therapies advised that the Bed Rails Report will remain as an agenda item for oversight at Quality Assurance Committee and therefore can be removed from the action log.

Action: Company Secretary

6.0 Clinical Audit Reports – Update on the Intermediate Diabetes Service
The Chair noted there is no date for this action. The Chief Operating Officer shared that she is following up with the relevant Clinical Director and will advise when this will be brought to Quality Assurance Committee.

The Director of Nursing and Therapies noted in the minutes of the last meeting it was raised that the Never Event Action Plan was to come back to the Quality Assurance Committee. The Director of Nursing and Therapies advised that this has not been included as an agenda item for this meeting as the only outstanding action is the Estates and Facilities asset survey audits. The Director of Nursing and Therapies shared these are taking place over a period of time or are currently with legal teams before commencing. The Director of Nursing and Therapies noted there are three asset survey audits taking place:

- Mental Health survey
- Fire survey
- General Estates and Facilities Survey

The Director of Nursing and Therapies recommended to the committee that it would be more advantageous to present an update on the Never Event Action Plan to the Quality Assurance Committee after the estates and facilities asset surveys have been completed and gaps and challenges identified.

Action: Director of Nursing and Therapies

The action log was noted.

Patient Safety and Experience

5.0 Carers Strategy Update Presentation

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

Katie Humphrey gave a presentation and highlighted the following points:

- The Trust Strategy comprises of six standards, with an expectation all services should be able to achieve the first 3 standards and several services in particular Mental Health Services should be aiming to meet all 6 standards.
- The Strategy is underpinned by the Carers Charter which consists of 4 pillars:
    - Identify Carers
    - Recognise Carers
    - Inform & Involve
    - Guide & Support
- A self-assessment against the standards has been completed to enable the Trust to measure compliance. The data is available in a dashboard format on Nexus which can be filtered at Trust, Directorate and Service level. The self-assessment is

currently being repeated for 24/25 and includes additional free text questions to allow teams to provide further information to underpin the RAG ratings.

- Friends, Family and Carers e-learning has been launched for all staff to access. Work has also progressed in embedding a Carers element to relevant existing training including our Preceptorship Programme, Clinical Risk training.
- Making Every Carer Contact Count training has been funded through the Frimley ICB.
- Looking at leadership training with a focus on supporting our working carers within our workforce. It was noted that we have a high proportion of females over 50 who are in a caring role.
- 25 Carer Champions have been recruited who attend monthly meetings for peer support, sharing good practice and raising challenges.
- RiO is being amended to include a carer prefix, which is to be used when outcoming appointments to help enable greater reporting.
- Intelligent Automation is being considered to help reduce the amount of time it takes to log a Carer on Rio. The current process takes approximately 10 minutes to complete and is not consistently completed across all services. A pilot is taking place in Wokingham Older Adults Mental Health and Early intervention in Psychosis.
- The RiO transformation team are assisting in developing a Friends, Family and Carer Passport that will include additional Information on how the person being cared for presents and any triggers that will help our staff provide informed care.
- There has been a delay in progressing the Carers module for Silver Cloud. However, a Programme Manager and a representative from the Wellbeing Team have now been allocated and work has progressed on mapping and scoping, the module is likely to incorporate existing programmes such as building resilience, mindfulness and money worries.
- Carer questions have been incorporated into the new One Team assessment documentation, Mental health risk assessment, safety and care plans to ensure we are capturing Carer's views.
- Following a suggestion at a One Team event, the Mental Health first aider course has been offered to Carers of which 11 people have completed the course. There was a mixed response on how successful the course is, and the offer is currently being evaluated.
- Collaborative work has continued with our ICS partners including attending boards/groups, contributing to strategy updates and active participation in working groups and action plans.
- Internally a Carer perspective has been incorporated into the Trust Equality, Diversion and Inclusion (EDI), Multi -faith, Health Inequalities and Lived Experience programmes of work.
- The health bus completed a tour of Berkshire as part of Carers Week in conjunction with Royal Berkshire Hospital and a variety of representation from our Internal teams which was well received by the general public.
- Next steps include:
    - A strategy refresh
    - Continuing the work to improve reporting
    - Recording of Carer activity on Rio
    - Ensuring there is meaningful information available for carer
    - Improving the carer feedback process
    - Engagement work with diverse communities.

The Chair acknowledged the hard work over the last year and praised the development of the dashboard. The Chair highlighted the length of time it currently takes to register a carer on RiO and praised the work to reduce this.

The Chair queried if there is any triangulation completed with patient safety incidents, where issues have been cited around communication between physical healthcare and carers. Katie Humphrey advised she works closely with the Director of Nursing and Therapies and Deputy Director of Patient Safety and Quality around identifying themes and an information sheet for staff has been shared as part of the thematic review. This has been shared via Circulation and is available on Nexus.

The Chair questioned if there are any priority areas for the work to support Carers. Katie Humphrey shared that she is working with Prospect Park Hospital who have highlighted that new starters and agency staff may not be familiar with our practices and how to interact with Carers. A one-page summary sheet has been developed to help with inducting staff and also utilising the support provided by the Carers Champions.

The Chair raised the potential overlap with the Mental Health Panel that is being set up for Families and Carers that have concerns around suicide. Katie Confirmed she will be sitting on the panel

The Chair thanked Katie for her presentation and acknowledged her enthusiasm and hard work in progressing the work to support carers.

The Committee noted the presentation.

5.1 National Patient Safety Alert – Bed Rails Report

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

- The report details the action plan for the outstanding MHRA requirement that has not been met. It was noted that this is in line with the national picture with the majority of Trusts still progressing work to achieve compliance with the MHRA alert.
- Two actions remain outstanding, both of which relate to community services rather than inpatient. The first action is around carrying out risk assessments for bed sticks and grab rails in the home environment which have historically not been required. The second action is around who will carry out ongoing risk assessments given that the vast number of people affected are not BHFT patients.
- In order to address the action around risk assessments for bed sticks and grab rails we will be adopting the approach taken by the local authority which involves writing out to everybody who has been prescribed a grab rail asking them to contact if they would like us to complete a risk assessment. This should reduce the number of risk assessments given that some people will have only used the equipment on a short-term basis for example following a hip replacement.
- All patients that are still on a healthcare caseload are being worked through and risk assessments are being completed for those with bed rails.
- Concerns around meeting the requirements for the MRHA alert have been escalated both regionally and nationally.

The Chair asked if we are liaising with POTS, the Director of Nursing and Therapies confirmed that we are and noted that there is a BOB workstream looking at Bed rails which Jodie Holtham is heavily involved in.

The Chair asked if we have had an incident relating to bed rails, bed sticks or grab rails within the Trust. The Director of Nursing and Therapies confirmed that we have not, but deaths have been linked to their usage nationally. The Director of Nursing and Therapies advised the cohort of patients are those that we may have been asked to prescribe kit to following a couple of weeks community nursing input. These patients are then subsequently discharged but may require the kit long-term and are being supported either by CHC or Social Care via the local authority.

The Chair thanked and supported the work being done by the Director of Nursing and Therapies and her team. The chair acknowledged the impact on resources.

The Committee noted the report.

5.2 Quality Concerns Register Status Report

The Director of Nursing and Therapies presented the report and highlighted the following changes since the Quality Concerns Register was last reviewed by the Committee:

- **Nuero-rehabilitation** had been added to the Quality Concerns Register due to concerns over demand exceeding capacity. The impact from a quality perspective is that if patients do not receive neurorehabilitation in a timely manner there is increased risk of reduced mobility and other complications.
- **Community Nursing:** had been removed from the Quality Concerns Register following an improved position with planned and unplanned visits now separated out resulting in less moved/ missed visits.
- **Eating Disorder Services:** was removed from the Quality Concerns Register due to improved waiting times for urgent referrals.

The Chair queried the comment in the report that states the Trust have received 200 applications for Mental Health nursing roles following an advert for international recruitment. The Director of Nursing and Therapies clarified that although the number of applications were approximately 200 the vast majority of applications are created via artificial intelligence (AI) and are not legitimate applications. The Director of Nursing and Therapies advised only 9 of the applicants made it to the interview stage and 5 Nurses have been offered roles. The Chair and Director of Nursing and Therapies discussed that the shortage of Mental Health Nurses remains a concern. The Director of Nursing and Therapies shared that the process had been trialled as part of the workforce group, however it is proving a time-consuming process. Rebecca Burford questioned if there is a technical solution to prevent the AI applications being accepted. The Director of Nursing and Therapies noted that the system is owned by NHS Jobs and is out of our control, but this has been flagged nationally by our Director of People.

The Chair discussed the One Team assessment that was launched on the 8th July and asked if an evaluation will be taking place in September. The Chief Operating Officer advised that this is correct and noted in addition each Executive Director will be carrying out initial visits to teams and a subsequent follow up visit to identify any issues with the assessment. The Chair asked if the evaluation would come to the Quality Assurance Committee and noted that the Quality and Performance Executive Group (QPEG) will have oversight. The Chief Operating Officer advised that the evaluation report will only be escalated if concerns are identified.

The Chief Operating Officer welcomed the Chair to attend an evaluation visit. The Chair advised that she would be interested in attending. The Chief Operating Officer will arrange for the Chair to accompany an executive director on a One Team assessment evaluation visit.

Action: Chief Operating Officer

The Committee noted the report.

5.3 Sexual Safety Charter Report

The Director of Nursing and Therapies presented the quarterly report that details the progress against the NHS England Sexual Safety Charter which comprised ten commitments to be achieved by July 2024. The Director of Nursing and Therapies highlighted that since the papers were published action 5 around staff communications has now also turned green and a draft of the training referred to in Action 7 has also been reviewed.

The Director of Nursing and Therapies advised there is a lot of work ongoing from both a staff and patient perspective in particular around domestic abuse. The Director of Nursing and Therapies highlighted that we have a specialist domestic abuse worker within the safeguarding team that supports patients and staff. The Director of Nursing and Therapies noted there is also support available through the wellbeing service and information is provided by our Nexus pages.

The Chair raised the training for sexual safety in dementia patients and queried if there is also bespoke training for Learning Disabilities who are also vulnerable. The Director of

Nursing and Therapies noted that the work has come through Prospect Park Hospital for dementia as patients are not only vulnerable but can be dis-inhibited and there is a need to ensure and maintain safety for patients and staff, recognising the unique set of circumstances for this cohort of patients.

The Chair queried if an update on the Sexual Safety charter work will come back to the Quality Assurance Committee for oversight. The Director of Nursing and Therapies confirmed the update report will be provided on a six-monthly basis.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.4 Responses to Prevention of Future Deaths Reports

The Director of Nursing and Therapies presented the paper

The Chair noted that she has not previously seen responses to prevention of future death reports and raised that she found them very helpful and was interested in the developments noted in the responses.

The Director of Nursing and Therapies shared that the responses are in the public domain as they are published on the Chief Coroners website and therefore all responses to prevention of future deaths and Regulation 28 reports are always sighted at this committee.

The Director of Nursing and Therapies advised this is the last of the responses to the recent run of prevention of future deaths reports. The Director of Nursing and Therapies highlighted the action plan attached which covers all five of the recently received reports due to the overlapping themes, in particular the overlap with the One Team work.

The Chair acknowledged the work involved and the pressure on the One Team solution. The Chief Operating Officer discussed that One Team is being developed with the actions from the Prevention of Future Deaths at the forefront and noted the need to cross check regularly to ensure actions are being addressed as One Team develops. The Director of Nursing and Therapies advised that Theresa Wyles has been involved with both the One development and the Response reports. The Director of Nursing and Therapies highlighted the key themes are around key worker and risk assessments

The Chair discussed the outcome measures for One Team that are being developed and raised that she had learnt a lot from the reports in particular the Harm to Others Panel and the right to a second opinion. The Chair noted these are topical issues following the Nottingham incident. The Chief Operating Officer shared that the Trust are working with Oxford Health and a workshop has been arranged.

The Chair asked about the policy or expectation for correspondence with primary care after patient discharge. The Chair discussed whether we would revisit the thinking about who was suitable for primary care discharge. The Chair clarified that this is in reference to the Nottingham patient who was not compliant with taking antipsychotic medication and had an escalating history of violence prior to discharge. The Director of Nursing and Therapies advised it is a concern and the actions that are being taken on the back of the Nottingham incident will be presented to the Board. The Director of Nursing and Therapies raised that both the Medical Director and herself, often see cases where patients are discharged due to non or dis-engagement. The actions from the Nottingham case focus on ensuring this does not happen. The Director of Nursing and Therapies shared that the CREST team who support people likely to end up in long term placement or have potential to harm others are doing some focused work looking at how we support those that are not engaging or disengaged. The Chair thanked The Director of Nursing and Therapies for addressing her question around discharge to primary care. The Director of Nursing and Therapies Highlighted that we have no legal powers to force somebody to engage but are looking at taking a more assertive approach such as going to places where we know patients may hang out.

The Chair asked if the action plan will come back to the Quality Assurance Committee for oversight. The Director of Nursing and Therapies advised it will be brought back to the meeting in six months.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.5 'Martha's Law' Report

The Chair discussed that Martha's Law was originally focused on acute trusts. The Director of Nursing and Therapies advised that there was a clear steer that they would be looking to adapt Martha's law for Mental Health and Community Trusts. The Director of Nursing and Therapies advised that the Trust have made the decision to be on the front foot and look at what would work for the Trust rather than have something imposed on us. Work has taken place to proactively explore solutions.

The Director of Nursing and Therapies advised we are fortunate that all our Mental Health wards are on one site and that we have a robust on call structure with duty and senior nurses on site. The Director of Nursing and Therapies noted that a detailed flow chart, standard operating procedure and escalation procedures are in place. The Director of Nursing and Therapies advised a pilot will be taking place in September.

The Director of Nursing and Therapies shared that she has been in contact with the Health Innovation Hub who are supporting the national acute roll out and they are keen to work with us on evaluation, metrics and audit for our approach.

The Director of Nursing and Therapies raised that we are looking at how we implement a solution to Martha's Law for Community Health, but this is more complex due to there being seven wards across five sites. The Director of Nursing and Therapies also noted we have different out of hours providers for the East and West of Berkshire as well as differing on call structures. The Director of Nursing and Therapies shared that it is taking time to develop plan and ensure it is not a burden or too democratic.

The Chair praised the collaborative approach with the Health Innovation Hub and queried if any other Mental Health Trusts are also looking at solutions. The Director of Nursing and Therapies advised that she didn't but suspects there will be Trusts also working on solutions. The Director of Nursing and Therapies raised that we will be advertising this through the Carers leaflets and noted that Katie Humphrey has been involved in the work.

The Chair suggested considering submitting an article to the health journals. The Director of Nursing and Therapies suggested that this would sit with the Health Innovation Hub to write up. The Chair discussed that she would be interested to see how many people opt to use Martha's Law. The Director of Nursing and Therapies discussed that feedback from the Acute Trusts is that it gets used very infrequently and referenced the Royal Berkshire Hospital who receive 5 to 6 calls per month and so we are not anticipating it being heavily used. The Director of Nursing and Therapies noted that issues are likely to be flagged to the duty senior nurse. The flow chart and training, staff have received is focused on sign posting to appropriate places rather than escalating up with a need for an urgent response either from a physical or mental health perspective.

The Chair asked if an update on the progress of Martha's Law will come back to the Quality Assurance Committee for oversight. The Director of Nursing and Therapies advised it will be brought back to the meeting when there is an evaluation, a substantial update or development on the community approach.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.6 National Patient Safety Strategy Implementation Report

The Chair shared that she had a very interesting meeting with Helen DeGruchy and Tiziana Ansell (Patient Safety Specialists) around the Patient Safety Strategy. The Director of Nursing and Therapies shared that Jon Barrett will be attending the Quality Assurance Committee from November in his new role as a Patient Safety Partner and Simon Lawson-Brown will be attending the Quality and Performance Executive Group as a Patient Safety Partner from September.

The Director of Nursing and Therapies raised that the Trust is exploring having Patient Safety Partners in the Divisional Quality and Safety meetings. The Director of Nursing and Therapies shared that the theory is that they should be involved at every level for patient safety and quality within an organisation, but we need to ensure there is value and it is not a tokenistic approach. The Director of Nursing and Therapies advised she will be meeting both Jon and Simon both before and after meetings initially to help signpost to relevant papers and address any queries. The Chair raised that it is easy to become daunted by the number of abbreviations used.

The Chair shared that the Patient Safety Specialists raised the inclusion of Patient Safety Partners is one of the more challenging aspects of the implementation of the new strategy. As there is a need to ensure it is not a 'tick box exercise' and that support is in place. The Director of Nursing and Therapies agreed and shared that we have ensured both Simon and Jon have attended our corporate induction. The Director of Nursing and Therapies advised that both Jon and Simon know our organisation with Simon having been involved in the implementation of the Patient Safety Incident and Risk Framework and Jon has previously been a Trust Governor.

The Director of Nursing and Therapies discussed that there is a Patient Safety Partner support group. The Director of Nursing and Therapies shared that we have taken our time to implement the use of Patient Safety Partners as it is important the right approach is taken, and the support is in place. The Director of Nursing and Therapies advised there will be reviews and amendments as needed.

The Chair asked if there are any other areas from the implementation of the strategy that the Director of Nursing and Therapies would like to highlight. The Director of Nursing and Therapies advised that there was not and hoped the report is clear on the progress made and what the next steps are. The Chair noted it is a cultural change. The Director of Nursing and Therapies agreed and shared that we are seeing less serious incidents focused on suicide under the new approach and are using different review processes that focus on thematic reviews and events that historically would not have been reviewed such as near misses that have the potential to cause harm.

The Chair noted she looks forward to Jon Barrett joining the committee in November.

The Committee noted the report.

5.7 Patient Safety and Learning Report

The Director of Nursing and Therapies advised the report details the investigation review processes.

The Committee noted the report.

5.8 Infection Prevention and Quarterly Report

The Infection Prevention and Control Annual Report had been circulated.

The Director of Nursing and Therapies raised that Covid vaccinations are being offered to healthcare workers again this year, The Director of Nursing and Therapies noted it was not a recommendation from the Joint Committee for Vaccines and Immunisations, however the Government have decided they are going to offer the vaccine again this year. The Director of

Nursing and Therapies advised the Flu and Covid campaign will start at the beginning of October.

The Director of Nursing and Therapies discussed MPOX and noted that many will have seen a number of MRHA and Infection, Prevention and Control reminders on what we need to do should cases present. The Director of Nursing and Therapies advised West call and Sexual Health have been briefed on the actions that need to be taken from an NHS planning and preparation perspective. The Chair enquired if we offer the MPOX vaccination. The Director of Nursing and Therapies advised that the smallpox vaccine can be offered in a limited way through our Sexual Health team.

The Committee noted the report.

5.9 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

The Chair noted that descriptions have been amended and includes a new risk in relation to the patient voice and reducing health inequalities.

The Medical Director raised that the majority of the risks are rated as 'Severe' and wondered how we compare against other Trusts given that we are an outstanding Trust. The Medical Director asked if we are being too cautious as a Trust. The Medical Director raised that the same is seen with the Corporate Risk Register where the majority of risks are rated 'Red' however the assurance received at the Quality and Performance Executive Group is positive. The Medical Director acknowledge that the risks may be high, but the mitigations are in place.

The Chief Operating Officer discussed that at a previous Trust the Chief Executive Officer advised that no more than 2 risks should be rated as 'Severe'. The Group discussed that the Board Assurance Framework includes strategic risks that are of concern. The Chair acknowledge that it is an interesting point. The Chief Operating Officer shared that from an operational perspective, risks should be held at the level where you can sufficiently mitigate them and if unable to then they should then be escalated up. The Chief Operating Officer surmised that by definition the risks included on the Corporate Risk register are those risks that the division can not manage to mitigate by itself.

The Director of Nursing and Therapies discussed that even with mitigation some of our standing risks such as suicide it would be difficult to rate down when looking at the risk matrix.

The Director of Nursing and Therapies suggested the question around benchmarking risk ratings is a question to ask the Audit Committee and the External Auditors.

Action: Company Secretary

The Chair raised that she is interested in the implementation of the Patient Care and Race Equality Framework. The Director of Nursing and Therapies advised the work is in the early stages of mapping and a face-to-face workshop has been arranged for October to progress the work. The Director of Nursing and Therapies noted it may be useful to bring an update to either this meeting or Full Board. The Director of Nursing and Therapies advised we are working with neighbouring Trusts to ensure learning is shared. Rebecca Burford queried if the target scores are set for us or if we have devised our own. The Chief Operating Officer confirmed they have been set by the Trust.

The Deputy Chief Executive raised a comment referring to the previous discussion around risk rating as and noted that the Board Assurance Framework could help indicate by when the target risk rating would be achieved and which of the actions are critical to the target risk level, to prevent the drift of severe ratings all the time. The Deputy Chief Executive agreed that the Audit Committee is best placed to have a have a look how risk ratings are assigned.

The Committee noted the report

5.10 Improving the Lives of Doctors in Training Report

The Chair noted that papers include the actions that the Trust are going to take in response to the national letter received on improving the lives of Doctors. The Chair highlighted that the letter itself is out of sync in the papers and can be seen on page 127 of the meeting pack.

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

- NHS England wrote to all organisations around improving lives for Junior doctors. The request focuses on 3 main areas:
    - Ensuring there are advanced rotas to allow Junior Doctors to plan their lives outside of work.
    - Reducing or eliminating errors in pay that require Junior Doctors to chase payroll.
    - Reducing the repetition of inductions and training.
- The Medical Director, Tutors and a Guardian attended a Junior Doctors Forum, and no major concerns were raised for the Trust.
- The Trust have developed an action plan from the letter
- Historical payroll errors have been identified.
- Induction has been slimmed down and a more flexible approach adopted. Feedback on the new induction was overwhelmingly positive. The Trust will continue to review and implement improvements where necessary.

The Medical Director advised this is a one-off report and that the overall Trust picture is that the Junior Doctors are very satisfied and do not have concerns. The Chair agreed with the Medical Directors comments and raised if NHS passports for mandatory training could be transferable to other staff groups. The Medical Director advised that in reality it is a manual process to download the proof of training to send to other NHS organisations. The Director of Nursing and Therapies shared that there is a training passport for Nurses and Allied Health Professionals which means that if they can prove they have completed training elsewhere they are not required to complete the training again, however this is not a ESR to ESR approach it remains a manual process. The Director of Nursing and Therapies advised there is no national electronic solution currently. The Chair noted the waste of resources.

The Committee noted the report.

5.11 Learning from Deaths Quarterly Report

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

- No cases with an avoidability scores of 3 or less
- The ethnicity data has been included after the Chairman of the Trust requested for it to be included. The numbers included in the data are small and can be cut a number of ways. The intention is to try to identify if there are differences in the quality of care given to different groups.
- Similar reports that go to ICB are less detailed than the Trust report which includes a large amount of detail.

The Chair thanked the Medical Director for the inclusion of the ethnicity data and asked what the data is telling us. The Medical Director advised the data is not currently showing anything of concern. The Medical Director discussed that an organisation where there is very poor care, it becomes much easier to identify if the reduced quality of care sits more with certain ethnic groups than others.

The Chair highlighted the change in death certificates. The Medical Director advised it is a significant change that will be statutory for all. The Medical Director noted the revised digital

version of certificates remains in the near future. The Medical Director shared that the Trust have already adopted the new approach to death certificates and report on our Medical Examiner process.

The Chair thanked the Medical Director for the report

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Medical Director advised that there is no service representation at the meeting but there is nothing of concern arising from the Audits noted in the report.
It was noted that three national audit reports have been published and reviewed at the Clinical Effectiveness Group:

- POMH Topic 22a: The use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
- National Audit of Cardiac Rehabilitation Quality and Outcomes Report 2023 – Summary Report (9323)
- The National Diabetes Foot Care Audit (NDFA) (9325)

The Medical Director highlighted that for the Cardiac Rehabilitation report the data is not Trust data but advises on national recommendations. The Report details the benchmarking against the national recommendations and the service action plan to address any gaps. There is nothing that has been raised of concern with six out of seven key performance indicators (KPIs) being met. The outstanding area is expected to improve.

The Medical Director advised both the anticholinergic medication and the Diabetes foot care audit both include Trust data. The Medical Director advised that the anticholinergic medication audit is a standard review that is best practice in clinical practice to ensure patients are not overloaded with anticholinergic medication. The Medical Director highlighted that an action plan has been created to look at improvements but no areas of concern or a risk to patients were noted.

The Medical Director advised the standards are very specific for the Diabetes foot care audit and overall, the Trust are doing much better than the national standard. The medical Director shared that improvements have been identified for streamlining data collection and ensuring appointments are logging correctly as diabetes foot care appointments. The Medical Director confirmed no areas of concern were identified.

The Chair thanked the Medical Director for the report and raised the prescribing practice for older people with mental health issues and queried if a holistic assessment is completed taking into consideration both their mental and physical health medications which can be complex. The Medical Director advised that it is vital that all medicines are reconciled as the total can add up to too high a level of anticholinergics.

The Chair asked if we mitigate the risk in the way that we deliver our services and that we have Clinicians or who can see an overview from a mental health, physical health and pharmaceutical perspective. The Medical Director advised the audit report gives assurance that we have not had a problem, but it does depend on the expertise of Clinicians. The Medical director noted that we have layers in place to help prevent errors and that he hopes EPMA becomes a standard in all outpatient services it should be able to identify when you have too many medications which interact with each other. The Medical Director highlighted that we currently depend on human mitigation through Doctors, GPs and Pharmacists. The chair noted that we are becoming more alert to polypharmacy particularly in older people. The Medical Director advised that staff in particular our psychiatrists are reminded about the risks around anticholinergic medications.

The Chair noted that the Diabetic footcare audit is positive and that we are seeing patients quickly.

The Committee noted the report.

6.1 Quality Accounts 2024-25 – Quarter 1 Report

The Medical Director advised the report covers Quarter 1 of 2024/25.

The Chair discussed that other NHS Trust Quality accounts include data on how many patients they see and how many sites they have. The Head of Clinical Effectiveness and Audit advised there is some brief information included in the first section of the Quality accounts but raised it is a huge document and so are ideally trying not to include additional items.

The Head of Clinical Effectiveness and Audit advised there are operational leads identified for each section of the report to ensure it is updated throughout the quarter. The Head of Clinical Effectiveness and Audit noted the report has been updated in line with the new Trust branding templates.

The Chair noted that on Page 154 under complaints we list all the services however the majority are noted against 'other services'. The Head of Clinical Effectiveness and Audit advised the Quality Account is driven by reports that go to other committees. The Medical Director raised that in order to see more detail the complaints report will need to include the detail so that it can be included in the quality account.

The Chair acknowledged the work involved in producing the quality account and highlighted it is a good indicator of what is going on in any NHS Trust.

The Committee noted the report.

Corporate Governance

7.0 Quality Assurance Committee - Annual Review of Effectiveness and Terms of Reference Review

The Chair raised question six from the Quality Assurance Committee Self-evaluation report on hybrid meetings and noted that the question was instigated by herself as she feels it is good to meet people face to face especially when new in role but acknowledged that it is not always best use of time for Clinicians and Senior staff. The Chair advised she is open to online only meetings if preferred. Rebecca Burford advised she likes the flexibility of hybrid. The Chief Operating Officer advised that the Executive team are normally in the office.

The Committee agreed to keep the meetings as hybrid.

The Chair questioned the comment on the terms of reference that advises that the lead Clinical Director will no longer be attending the Quality Assurance Committee. The Chief Operating Officer advised that the lead Clinical Director should remain on the attendance list in the short-term but highlighted that this may need to be revisited as the role of the lead Clinical Director is currently being reviewed. The Chief Operating Officer discussed that the Committee may want to consider what representation it requires from Clinical Directors going forward. The Medical Director advised changes to Clinical Director roles will be in place by November 2024.

The Chair noted the addition to the Terms of Reference of ensuring the Patient voice is heard.

The Chair noted the update to include the following papers that are brought to the Committee:

- Mental Health Act report
- Annual Place of Safety report.

The Medical Director advised the reports noted above have been presented to the Quality Assurance Committee historically, this is merely an update to the Terms of Reference to reflect.

The Director of Nursing and Therapies noted that Patient Safety Representative should read Patient safety Partner. The Chair agreed.

The Medical Director suggested amending the Terms of reference to read Lead/Clinical Director on the basis that there will be a need for Clinical director representation to attend to discuss audit or safety issues as they provide the next level assurance/ governance within the Trust. The Chair agreed.

The Committee approved the Terms of Reference with minor changes noted above.

Action: Company Secretary

Update Items for Information

8.0 Guardian of Safe Working Hours Quarterly Report

The Guardian of Safe working hours quarterly report has been circulated.

The Medical Director advised there are no concerns that Junior Doctors are working well beyond their hours. The Medical Director noted that if a Junior Doctor does have to extend hours due to seeing a patient, then that time is recovered in Lieu. It was noted only three exception reports were raised for the quarter of which two counts related to mental Health Inpatients and one count to ADHD outpatients.

The Committee noted the Report

8.1 Annual Place of Safety Report 2023-4

The Annual Place of Safety Report 2023-4 has been circulated.

The Medical Director noted the report is very data focused and produced by the operational teams at Prospect Park Hospital. The medical Director highlighted the following points:

- There has been a reduction in the use of the Place of Safety, there is reference to this being due to ‘Right Care, Right Person’ however it maybe too early in the implementation to statically show through in the data.
- The expected exponential increase in use of place of safety has not been seen in 2023/24. Although the Place of safety remains busy.
- The majority of assessments are completed within 4 hours, with 124 patients being seen in less than 1 hour and no patients waiting over 24 hours.
- Improvements have been made to doctors rotas to ensure cover and availability of Advanced Mental Health Practitioners.

The Medical Director discussed that there is a risk of Place of safety beds being used as inpatient beds when beds and placements are full. Mitigations are in place should an admission happen in Place of Safety to ensure they are reviewed as they would be in an inpatient bed.

The Medical Director advised the new Place of safety facility should be available by late spring/early summer 2025.

The Chair noted the slight decrease in numbers of discharges by Place of Safety and queried if this is due those referred being more relevant to our services and therefore more are admitted. The Medical Director agreed, and this may be due to better system awareness

in line with Right Care, Right Person. The Chair noted that Slough is one of our biggest areas for use of Place of Safety, however there was a large decrease in numbers from 160 to 78. The Chair and Medical Director discussed that Reading remains the highest area in terms of use of Place of Safety.

The Chair raised that it is quite a distance for relatives to travel from Slough to Reading.

The Committee noted the Report

8.2 Annual Mental Health Act Report 2023-4

The Annual Mental Health Act Report 2023-4 has been circulated.

The Medical Director advised there are no concerns raised in the report and that he is fully sighted on the Mental Health Act Governance Board minutes.

The Medical Director advised the report provides data on the number of detentions, ethnicity, community treatment orders and complaints.

The Chair discussed that the timing of the report and the ability to benchmark. The Chair questioned if it would be better to delay the report until when benchmarking is available although appreciated it is difficult to benchmark. The Medical Director advised a retrospective review is completed when the benchmarking is available, and any significant statistical variation reviewed in the Mental Health Governance Board meeting. The Medical Director noted that previous reviews highlighted that the number of detentions were high. The Medical Director advised there would be a significant delay in reporting if we were to wait for the benchmarking data to be released.

The Chair raised the recent CQC visit to Daisy, Snowdrop and Campion wards and noted the issues identified have not been included in the report. The Medical Director advised that the services produce action plans in response to the CQC reports which are reported through and monitored by the Director of Nursing. The Medical Director noted the action plans are also monitored via the Mental Health Act Governance Board as reflected in the minutes but are not included in the Annual Mental Health Act Report due to being mindful of ensuring our reports are not too long

The Chair discussed the themes in the annual CQC report around reading of rights as a theme. The Medical Director advised this is not an issue that the CQC has raised. The Medical Director reported that the themes for Trust are more focused on our estates and the use of blanket restrictions for example around smoking.

The Chair asked if the Trust have received the CQC report on Campion. The Director of Nursing and Therapies advised the report has been received and was very positive with no Mental health Act concerns raised. The Director of Nursing and Therapies noted that there are 2 to 3 actions to address.

The Chair thanked the Medical Director for a comprehensive report.

The Committee noted the Report

8.3 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meetings held on 15/07/2024 had been circulated.

The Medical Director advised the Board receives information from the following areas:

- Detentions and Ethnicity projects
- Divisional scorecards
- Community services are now being included

The Medical Director advised he has requested greater scrutiny on where the Trust detain patients outside of our physical environment such as at the Royal Berkshire Hospital or Wexham Park Hospital and also more feedback on when Children are admitted to the Place of safety to ensure there is full oversight.

The Chair noted that the Health Inequalities (Detentions) Project appears to be progressing well. The Medical director advised he is looking to see the output of the audit on detentions to help with root cause analysis. The Medical Director raised that we are yet to move into the implementation phase of the Quality Improvement (QI) approach as still reviewing data. The Chair noted that feedback on QI is that the data collection phase is often prolonged. The Medical Director noted it is a small team involved with the Health Inequalities work and discussed that South London and Maudsley NHS rust are doing similar work however they have a large grant to assist with the work.

The Committee noted the minutes.

8.4 Annual Safeguarding Report

The Annual Safeguarding Report had been circulated.

The Director of Nursing and Therapies advised the report has been provided as assurance that the Trust are meeting our statutory and regulatory requirements for children's and adults safeguarding. The Director of Nursing and Therapies advised she has no concerns that the Trust is not complying with safeguarding requirements.

The Chair asked if there are any quiet areas/services that are not reporting safeguarding concerns. The Director of Nursing and Therapies noted that we are receiving alerts form all areas that we would expect to see them raised. The Director of Nursing and Therapies highlighted we have a proactive safeguarding team who have a presence in Prospect Park on a weekly basis. There is high visibility in Pheonix our tier 4 CAMHS provision. The Director of Nursing and Therapies noted that there are a minority of cases identified where safeguarding concerns should have been raised sooner.

The Chair queried if there are difficulties liaising with 6 local authorities. The Director of Nursing and Therapies advised it is a challenge however the safeguarding team have good working relationships with each of the local authorities.

The Committee noted the report.

8.5 Quality and Performance Executive Group Minutes – May 2024, June 2024 and July 2024

The minutes of the Quality and Performance Executive Group minutes for May 2024, June 2024 and July 2024 had been circulated.

No questions noted
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:

- Berkshire Community Dental Services
- Lower Limb Service - Physical Health East
- Clinical Nurse/Direct Nursing – Physical Health East
- Bladder and Bowel Service at Wokingham Hospital

Closing Business

8.0 Quality Assurance Committee Horizon Scanning

There were no horizon scanning items identified.

8.1. Any Other Business

There was no other business.

8.2. Date of the Next Meeting

The next meeting was scheduled to take place on 26th November 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 27th August 2024

Signed:-

Date: - 26th November 2024

Berkshire Healthcare
NHS Foundation Trust

TRUST BOARD

Quality Assurance Committee

Terms of Reference

Purpose

This document describes the terms of reference for the Trust's Quality Committee, a standing Committee of the Board.

Document Control

Version	Date	Author	Comments
1.0	25.7.12	John Tonkin	Initial draft
2.0	31.7.12	John Tonkin	Amendments following Exec Discussion on 30 July 2012
3.0	20.8.12	John Tonkin	Amendments following Exec Discussion on 16 August 2012
4.0	11.9.12	John Tonkin	Post Board approval – 11 September 2012
5.0	5.4.14	John Tonkin	Post review with Director of Nursing & Governance
6.0	3.6.14	John Tonkin	For Board approval post QAC discussion 22 May 2014 APPROVED AT JUNE 2014 Board meeting
7.0	21.2.17	Julie Hill	Updated to include the Committee's new responsibilities in relation to receiving the Guardians of Safe Working reports and providing oversight of the Trust's mortality review process. Approved at July 2017 Trust Board meeting
8.0	July 2018	Julie Hill	Minor changes - approved by the September 2018 Trust Board meeting
9.0	June 2019	Julie Hill	Minor changes – approved by the September 2019 Trust Board meeting

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10	August 2024	Julie Hill	Changes to the attendees including a Patient Safety Partner and the Patient Safety Specialists to be invited to attend the meeting. Mental Health Act Governance Board minutes added Reference made to hearing the patient voice

This document is unrestricted.

Quality Assurance Committee - Terms of Reference

1. Constitution

Berkshire Healthcare NHS Foundation Trust (BHFT) Board has established a Quality Assurance Committee which will act as a formal sub-committee of the Board with terms of reference as set out in this document and approved by the Trust Board.

2. Membership

The Committee's membership will comprise:

- 3 Non-Executive Directors
- Chief Executive
- Chief Operating Officer
- Medical Director
- Director of Nursing and Therapie~~s~~
- ~~The Lead Clinical Director will routinely attend Committee meetings~~
- ~~Other directors and managers will attend meetings when requested by the Committee~~
- ~~The Clinical Lead(s) for the Clinical Audit(s) under discussion will be invited to attend the meeting.~~
  A Patient Safety Partner will be invited to attend the meeting.
  The Patient Safety Specialists to be invited to attend the meeting.

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The Board will nominate the Committee Chair from amongst the Non-Executive Director members of the Committee. In the Chair's absence, another Non-Executive Director will chair the Committee.

The Chair of the Quality Assurance Committee will be the designated Non-Executive Director with responsibility for providing oversight of the Trust's mortality review systems and processes.

The Lead Clinical Director, the Deputy Chief Executive, the Deputy Director of Patient Safety and the Head of Clinical Audit and Effectiveness will routinely attend Committee meetings and other directors and managers will attend meetings when requested by the Committee.

The Clinical Lead(s) for the Clinical Audit(s) under discussion will be invited to attend the meeting.

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In order for the meeting to be quorate, 3 members must be present, including at least one Non-Executive Director and one Executive Director. The Board will approve any changes in membership and will approve any changes to these terms of reference.

3. Frequency of Meetings

The Committee will meet on not less than four occasions a year. The Chair may agree requests for additional meetings according to business requirements and urgency.

4. Purpose

The Quality Assurance Committee fulfils a scrutiny role on behalf of the Board on service quality. This will include, but not be restricted to, review of infection control performance, organisational learning from serious incidents, performance against quality priorities, CQC inspection reports, Trust safeguarding assurance, quality concerns relating to staffing, ~~and~~ mortality review systems and processes assurance and ensuring there are processes in place to hear the patient voice.~~.~~

- The Committee will also review any quality indicators as requested by the Trust Board
- Progress in implementing action plans to address shortcomings in the quality of services, should they be identified

The Quality Assurance Committee will provide assurance to the Trust Board as to the quality of service delivery with particular focus on the areas of patient safety, clinical effectiveness and patient experience. The Trust Board may request that the Quality Assurance Committee reviews specific issues where it requires additional assurance about the effectiveness of the governance, risk management and internal control systems in place relating to quality.

On behalf of the Trust Board, the Quality Assurance Committee will receive the update report from the Guardians of Safe Working and will report any issues of concern to the Trust Board.

The Quality Assurance Committee will also be responsible for reviewing, on behalf of the Trust Board, the quality improvement targets set in the annual plan and Quality Account. It will provide assurance to the Trust Board that improvement targets are based on achievable action plans to deliver them and that quality performance issues are followed up and acted on appropriately.

The Trust's Audit Committee will have overall responsibility for independently monitoring, reviewing and reporting to the Trust Board on all aspects of governance, risk management and internal control. On behalf of the Trust Board, the Audit Committee has overall responsibility for overseeing the Board Assurance Framework. The Quality Assurance Committee will be responsible for reviewing the quality related risks on the Board Assurance Committee. Any comments made by the Committee will be reported to the Audit Committee as part of the Board Assurance update report.

Section 5 of these terms of reference sets out the reporting arrangements which will support the Audit Committee in discharging this responsibility.

5. Reporting

The Quality Assurance Committee will receive exception reports covering issues escalated from the Executive quality governance process.

The minutes of the Quality Assurance Committee's meetings will be received by the Trust Board along with the quarterly Learning from Deaths and Guardians of Safe Working Hours for Doctors and Dentists in training reports. The Committee will also refer the Quality Concerns report to the In Committee Trust Board meeting. The Chair of the Committee will provide an oral report to the next convenient Trust Board after each Committee meeting. The Chair of the Committee shall draw to the attention of the Trust Board any issues that require disclosure to the full Board.

The minutes of Quality Assurance Committee meetings will be included on the Audit Committee agenda for information and comment.

6. Duties

a. Governance, internal control and risk management

To provide in-depth scrutiny on behalf of the Trust Board of the delivery of high quality care through an effective system of governance in relation to clinical services.

b. Audit

To receive and review the findings of Internal and External Audit reports covering patient safety, quality and experience. If there is any perceived ambiguity regarding the relative roles of the Audit Committee and the Quality Assurance Committee in this respect, the committee chairs will liaise to agree a satisfactory approach. Through its reporting to the Audit Committee, the Quality Assurance Committee will ensure that the Audit Committee is informed of its work in this area

To receive summary reports of national clinical audits.

c. Quality and safety

To receive reports on compliance with the Care Quality Commission's Fundamental Standards. To receive all reports on the Trust produced by the Care Quality Commission and to seek assurance on the actions being taken to address recommendations and other issues identified.

To ensure that the Trust learns from national and local reviews and inspections and implements all necessary recommendations to improve the safety and quality of care.

To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to clinical quality and safety and the actions being taken by management to address these.

To receive and consider reports from the Health Service Ombudsman

To monitor and review the systems and processes in place in the Trust in relation to Infection Control and to review progress against identified risks to reducing hospital acquired infections.

To review aggregated analyses of adverse events (including serious incidents), complaints, claims and litigation to identify common themes and trends and gain assurance that appropriate actions are being taken to address these.

To receive reports on national mandated clinical audits conducted within the Trust.

To review available benchmarking information on quality, safety and patient experience in support of the realisation of continuous improvement.

To review and contribute to the Trust's annual Quality Account and make recommendations as appropriate for Trust Board approval.

To receive the Mental Health Act Governance Board minutes.

To receive the Annual Mental Health Act Report and the Annual Place of Safety Report

To be responsible for endorsing the Trust's criteria for the scope of the mortality review process.

To review the quarterly reports from the Trust's Mortality Review Group.

To review the quarterly Guardians of Safe Working for Doctors and Dentist in Training reports

7. Reporting to the Board

The minutes of the meetings of the Committee will be presented to the Trust Board.

Version 10~~9~~ Approved by the Trust Board in September ~~2019~~

For review: August 202~~4~~5

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	August 2024
Title	**Learning from Deaths Quarter 1 Report 2024/25**
	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 for Mental Health & Community Health NHS Trusts, however there are a number of metrics which are nationally required and are 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	New Statutory requirements for Medical Examiners from 9th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
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. Ethnicity data is included in the report.
SUMMARY	Since January 2024 the Mortality and Patient Safety meeting (MAPs) brings together the processes for review, Quality Assurance and Learning from all deaths in the trust and this report represents a summary of that function. **Patient safety** Of the second stage reviews concluded in quarter 1, 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** 11 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. Ethnicity data is now included and is detailed in line with 2nd stage review outcomes of avoidability (for deaths of a physical health cause) and overall assessment of care (for all deaths). Learning themes arising from second stage reviews were identified and noted by Clinical Directors and Governance leads for implementation for service improvement.
ACTION	The committee is asked to receive and note the Q1 learning from deaths.

Learning From Deaths Q1 Report (2024/25)

Berkshire Healthcare NHS Foundation Trust

Figure 1	2021/2022	2022/2023	2023/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total 2024/2025
Total deaths screened (Datix) 1st stage review	467	456	453	121				121
Total number of 2nd stage reviews requested (SJR/IFR)	209	192	203	55				55
Total number of deaths to be reviewed through patient safety	35	31	31	6				6
Total Expected Deaths	-	-	183	55				55
Total Unexpected Deaths	-	-	270	66				66
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)	4	0	0	0				0
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	156	157	141	33				33
Total number of deaths of patients with a Learning Disability (1st stage reviews)	51	36	53	14				14
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0				0

Q1 2024/25

807 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 121 were submitted for a 1st stage review in line with the learning from deaths policy (15%).

All 121 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q1, 2nd Stage reviews were requested for 55 (46%). 47 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q1.

Of the second stage reviews concluded, none of the deaths were a governance cause for concern (Avoidability score of 1,2 or 3).

Of the reviews concluded in Q1 none were assessed as overall poor care.

2nd stage Mortality reviews completed (SJR/IFR)	Q1 (47)	Total 2024/2025
Adult Learning Disabilities & Autism Services	11	11
Mental Health community, specialist, and inpatient services	20	20
Childrens and Young people's Services	1	1
Physical Health community and Inpatient Service	15	15

	Avoidabilty score for 2nd Stage Reviews (only death due to a physical health cause) 2024/2025	Total Q1 (47)
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	2
Score 5	Slight evidence of avoidability	4
Score 6	Definitely not avoidable	22
N/A	Non physical health cause	19

	Overall Assessment of Care (SJR/IFR) 2024/2025	Physical health	Learning Disability	Mental Health	Childrens and Young People (CYPF)
1	Very poor care	0	0	0	0
2	Poor Care	0	0	0	0
3	Adequate Care	7	3	3	0
4	Good Care	6	7	17	0
5	Excellent Care	2	1	0	1

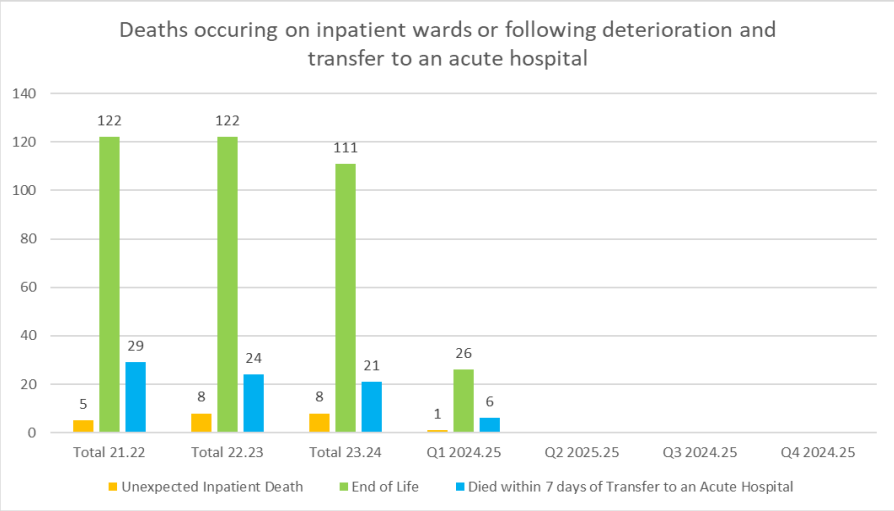
Ethnicity
Avoidability (Physical Health) & Overall Assessment of Care (All)

NHS Berkshire Healthcare

Ethnicity April 2024 - June 2024 (Rolling data to be updated each quarter)	1st Stage Review	2nd Stage Review	% 2nd stage review requested	Score 1 Definitely Avoidable	Score 2 Strong Evidence of Avoidability	Score 3 Probably Avoidable	Score 4 Possibly Avoidable	Score 5 Slight Evidence of Avoidability	Score 6 Definitely not avoidable	N/A (MH deaths)	Review in progress
Asian or Asian British - Indian	1	1	100	0	0	0	0	0	0	0	1
Asian or Asian British - Pakistani	2	2	100	0	0	0	0	0	0	0	2
Black or Black British - African	1	1	100	0	0	0	0	0	0	1	0
Black or Black British - Caribbean	2	2	100	0	0	0	0	0	0	0	2
Mixed - White and Asian	2	1	50	0	0	0	0	0	0	1	0
Mixed - White and Black Caribbean	2	0	0	0	0	0	0	0	0	0	0
Not Known - Waiting for first appointment/not recorded	5	1	20	0	0	0	0	1	0	0	0
Not stated - refused	1	1	100	0	0	0	0	0	0	1	0
Other ethnic category	2	0	0	0	0	0	0	0	0	0	0
White - any other white background	5	3	60	0	0	0	0	0	1	0	2
White - English/Welsh/Scottish/Northern Irish/British	98	43	44	0	0	0	1	2	14	2	24
Total	121	55									

Overall Assessment of Care all reviews completed in 2024/25 (April - June to date)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British - Indian	0	0	2	0	1	3
Asian or Asian British - Pakistani	0	0	1	0	1	2
Black or Black British - African	0	0	0	1	0	1
Black or Black British - Caribbean	0	0	0	0	0	0
Mixed - White and Asian	0	0	0	0	0	0
Mixed - White and Black Caribbean	0	0	0	0	0	0
Not Known - Waiting for first appointment/not recorded	0	0	0	0	0	0
Not stated - refused	0	0	0	0	0	0
Other ethnic category	0	0	0	0	0	0
White - any other white background	0	0	1	0	0	1
White - English/Welsh/Scottish/Northern Irish/British	0	0	9	29	2	40
Total	0	0	13	30	4	47

Inpatients (Physical Health and Mental Health) Learning From Deaths Q1 Report



In Q1 EMRG reviewed:

- 31 deaths reported by physical health inpatient wards
- 2 deaths reported by older adults' mental health Inpatients, both unexpected death following transfer and 2nd stage reviews requested.

Of the physical health deaths:

26 were expected deaths and related to patients who were receiving end of life care (EOL) on our wards. All 26 were closed at 1st stage review.

1 unexpected death on a ward, reviewed by Medical Examiner and closed at 1st stage review.

4 deaths occurred within 7 days of transfer to an acute hospital, SJR were requested for all.

NHS Berkshire Healthcare NHS Foundation Trust

Q1 2024/25

All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed, none were referred to the Coroner.

In line with our learning from deaths policy, 2nd stage reviews are requested and reviewed for all unexpected deaths and death within 7 days of transfer. The Medical Examiner requested 1 SJR to be completed, this was resolved directly with the family and was around communication after death.

Statutory Medical Examiner System

Since 2020, NHS England has been working with trusts to implement the medical examiner system on a non-statutory basis. In April 2024, the government announced that death certification reforms, including implementing a statutory medical examiner system, will come into force on 9 September.

From this date, all deaths in any health setting that are not investigated by a coroner will be reviewed by NHS medical examiners. We have worked with the Medical Examiner's office to ensure that the minor updates required to meet the new requirements are embedded before 9th September 2024 and are working in shadow form for inpatients. We are in the process of implementing this for physical health urgent care services when we have a small number of end-of-life deaths we complete the medical certificate of cause of death for.

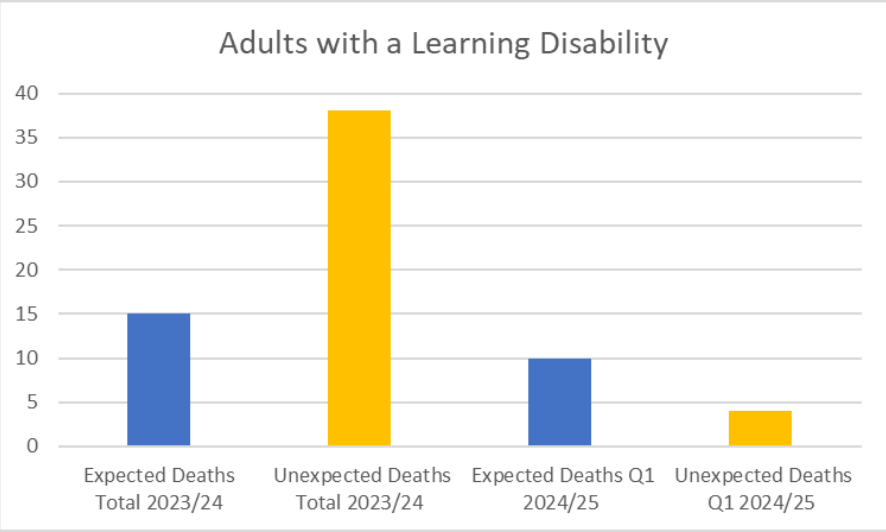
All Inpatient deaths are independently scrutinised by a Medical Examiner to confirm the cause of death to be detailed on the Medical Certificate of cause of Death (MCCD) or confirm a referral for a coroner review.

Month of death	2023/24	April 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Total Inpatient deaths reviewed by the Medical Examiner	113	9	11	7									
SJRs requested for Inpatient deaths by Medical Examiner	2	0	1	0									
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	0	0	0									

Coroners' outcomes for referred Inpatient Deaths	Q1	2024/25 Total
Postmortem	0	0
Forensic Postmortem	0	0
Inquest	0	0
100A	0	0

EOL Audit Q1	Total	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	22	All 22 patients had their emotional/psychological needs assessed, however only 12/22 had evidence of this documented on a daily basis, The division have reviewed this and will look at the documentation process as the staff are confident that this is being constantly reviewed on a daily basis.

Adults with a Learning Disability Learning From Deaths Q1



In Q1, 11 deaths of adults with learning disability were reviewed by the Trust mortality meeting , of these, 1 was investigated as a Patient Safety Incident Investigation (PSII).

The age at time of death ranged from 23 to 82 years of age (median age: 62yrs.)

	Total 2023/2024	Q1 2024/25
Male	29	8
Female	24	3

Severity of LD	Total 23/24	Q1 24/25
Mild	7	3
Mild to Moderate	1	0
Moderate	9	4
Moderate to Severe	0	1
Severe	14	1
Profound	4	1
Not Known	18	1

Ethnicity	Total 23/24	Q1 24/25
White British	47	10
Black or Black British - Caribbean	1	0
Asian or Asian British - Pakistani	5	1

The deaths attributed to the following causes:	Total 23/24	Q1 24/25
Diseases of the heart & circulatory system	6	0
Diseases of the respiratory system	25	4
Diseases of the heart & circulatory system	1	1
Sepsis or Infection	9	1
Cancer	3	1
Disease of the nervous system	1	0
Dementia /cerebrovascular	3	0
Other	3	3
Not known	2	1

	Avoidabilty score for 2nd stage reviews	Learning Disability 24/25
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	0
Score 5	Slight evidence of avoidability	2
Score 6	Definitely not avoidable	9

	Overall Assessment of Care	Learning Disability 24/25
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	3
4	Good Care	7
5	Excellent Care	1

Berkshire Healthcare NHS Foundation Trust

Q1 2024/25

All deaths related to patients in the community.

Key points of learning Q1

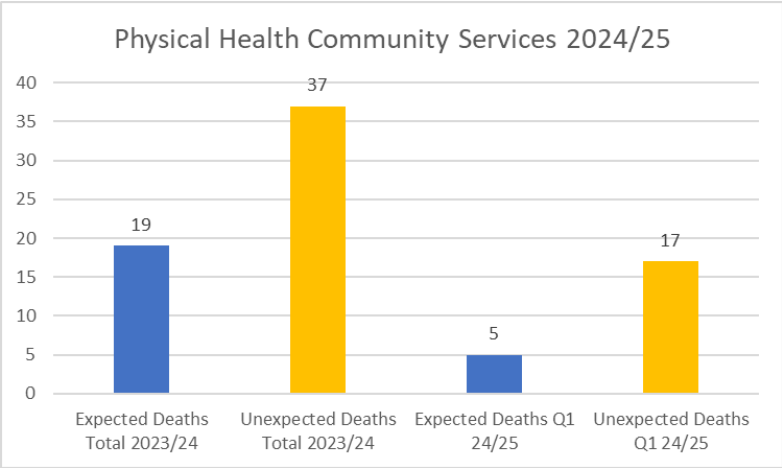
In Q1 the following learning was shared within the LD service:

- accuracy of the clinical letters - including when changes are made to medications.
- action should be taken to ensure any necessary referrals or requests are undertaken and actions recorded
- appropriate arrangements for monitoring and closing referrals when people move out of area in a timely fashion
- completion of safeguarding referrals when potential risks are identified.
- Reviewing the process for managing risk information and identifying appropriate referrals. (Including police reports)
- A robust process of triaging needs to be identified for review of cases within the medical caseload for the Reading CTPLD to minimise the risk of delay in access to care.

In Q1 there was also ongoing evidence of:

- multi-disciplinary and multi-agency working in primary and secondary care and other services including the Police.
- good communication across services, timely response to referrals and evidence of reasonable adjustments to ensure needs were met.
- follow up requests, seeking psychiatric records from an out of area team.
- Person-centred, evidence-based care delivery.

Community Physical Health Learning From Deaths Q1



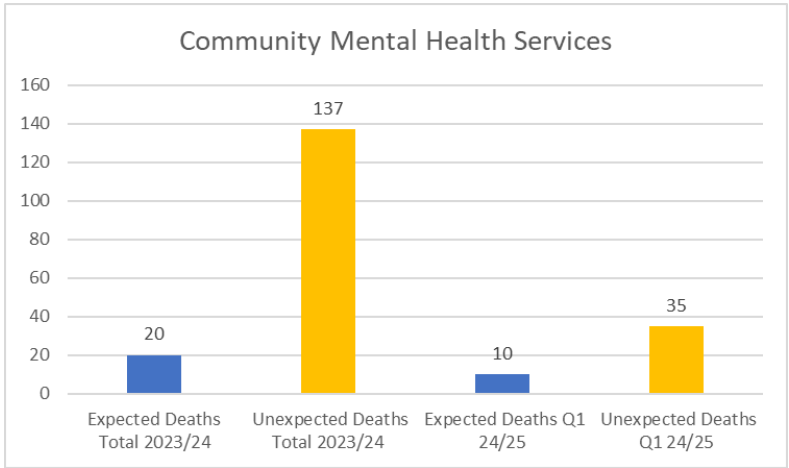
EMRG completed 22 1st stage reviews in Q1 of which 2nd stage reviews were requested for 14. All 14 cases were under the care of community nursing, of which 2 related to end of life deaths and 12 unexpected deaths. Rationale for reviews included:

- Sepsis
- Catheter Care
- Safeguarding
- Wound Care treatment and Management
- 7 days of admission to a virtual ward
- Bowel care and management
- Mental health care

In Q1 the following learning was identified:

- Lack of documentation of visits
- Appropriateness of delegation to junior staff and follow up with advice and clinical decision making
- Documentation relating to patient choice
- Review of medication
- Timely use of interpreter and issues with copy and paste of the notes
- Completion of the sepsis tool, fluid and food
- Bowel management
- Safeguarding referrals
- Management of handover for community nursing with oversite and involvement from senior clinicians

Community Mental Health Learning From Deaths Q1



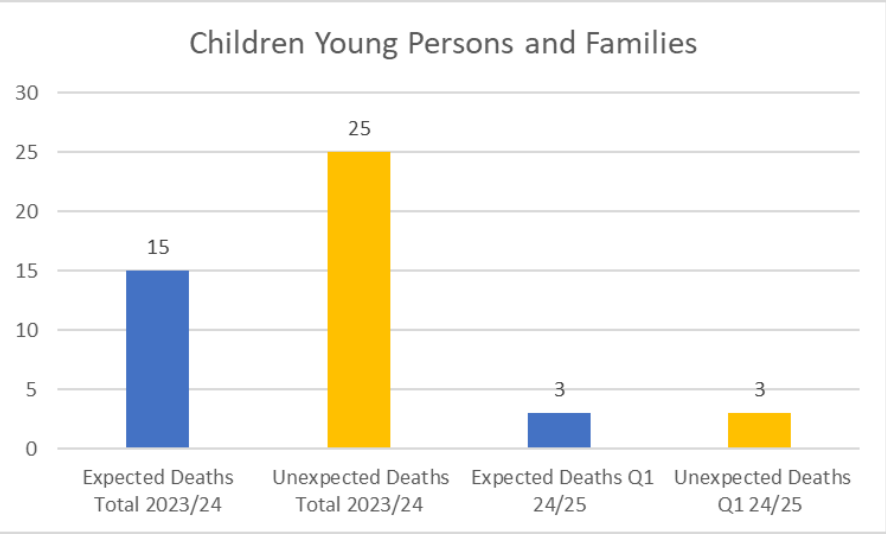
EMRG completed 45 1st stage reviews in Q1 of which 2nd stage reviews were requested for 23. The 23 cases were from a range of community mental health or specialist mental health services, and 22 were unexpected deaths and 1 expected. Rationale for reviews included:

- Safeguarding
- Discharge planning and communication
- Review of assessment
- Medication review
- Suspected suicide

In Q1 the following learning was identified:

- A detailed learning event was held to look at aspects of the duty function within community health teams, escalation and absence policy, handover between crisis resolution and psychological medicines services and named key workers within the community mental health framework.
- Learning identified around the Mental Capacity Act specifically when a capacity assessment needs to be completed
- Communication and interaction with care agencies.
- Use of the neurodiversity passport,
- Interface with Reconnect when there is an early release from prison. A wider piece of work is being completed around this. Another piece of learning is for MHICS Slough team is how to try and engage patients who are initially difficult to engage.
- Learning event to be organised to reflect on the themes identified including record keeping, discharge processes, risk assessment, alcohol management referral.

Childrens & Young People: Learning From Deaths Q1



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

Q1 2024/25
In Q1 6 child deaths were submitted through Datix for first stage review. There were 3 expected and 3 unexpected deaths this quarter.

The 3 expected deaths were children who died in an acute hospital and either had complex health condition or an acute illness at the time of their death. One had an advance care plan and there was evidence of close working between Community Children's Nursing team, hospice and acute services.

There were 3 unexpected deaths this quarter. One death was a neonate in an acute hospital. The other two deaths were in the community and resulted in the Community Children's Nursing teams completing Rapid response home visits with the Police. One of these children was unknown to Berkshire Healthcare. Initial learning has focussed on safe sleeping and the importance of information sharing and communication with multi-agency partners.

All of the unexpected deaths were closed at first stage review. Deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel (CDOP) and there is cooperation with local authority safeguarding practice reviews as required.

One case concluded in Q1 with an overall outcome of Excellent Care and an avoidability score of 6.

Complaints and Inquiries Learning From Deaths Q1

Complaints and MP Inquiries	Total 23/24	Q1 24/25
Communication and Clinical Care (District Nursing)	4	2
Clinical Care (Community Mental Health)	2	0
Community podiatry.	1	0
District Nursing (End of life Clinical Care)	2	0
Westcall Out of Hours GP (End of Life care provision	1	0
Inpatient physical health (clinical care)	4	0
Out of area placement (mental health clinical care)	1	0

2 complaints have been received in total in Q1 relating to aspects of care or treatment prior to death. Both related to community nursing care and treatment and 2nd stage reviews were requested for both in addition to the formal complaint response.

NHS Berkshire Healthcare NHS Foundation Trust

Prevention of Future Deaths (PFD) reports 2024/25
The table details the PFD's received by the Trust in 2024/25

Prevention of Future Deaths reports 2024/2025.	Service	Questions Raised by His Majesty's Corners	Timeframe for Implementation
March 2024	Community Mental Health and Crisis Resolution And Home Treatment Team	Concerns regarding the 72-hour review meeting. Training and guidance did not specifically address how to deal with service users declining a visit or meeting.	May 2024 - submitted
April 2024	Community Mental health	Care coordination for patients who have been discharged from a mental health setting, particularly in the context of detained/recently detained patients. Reliance on telephone rather than face to face appointments.. Regularity / thresholds for MDT discussions. Absence of a clear route for family to report concerns, even where a patient does not wish confidential information to be given to their family. Policy / expectation for correspondence with primary care, particularly in the time after discharge from hospital.	June 2024 – submitted
May 2024	Community Mental health	Forbury Gardens Inquest Number of factors including care coordination and adequate mental healthcare support in the community	July 2025 – submitted

Overall Learning and Summary From Deaths Q1

Q1 2024/25

Since January 2024, there is a single mortality reporting, reviewing and quality assurance process, with assurance through a single board report covering all deaths (SIs and all other deaths) to ensure themes and learning are more meaningful.

Of the second stage reviews concluded, none of the deaths were a governance cause for concern (avoidability score of 1,2 or 3).

All complaints received from families of individuals who have died resulted 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.

11 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 and noted by Clinical Directors and Governance Leads for implementation and service improvement.

Medical Examiner
We are on track to meet the full statutory requirements from 9th September 2024, currently we are working in shadow form for inpatients where all aspects are being met and finalising the process for physical urgent care services where for a small number of end-of-life deaths we may complete the medical certificate of cause of death. Communications have been sent out to individual teams and doctors as well as through TEAM brief and Circulation.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	August 2024
Title	Guardian of Safe Working Hours Quarterly Report (May to July 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 1st May to 6th August 2024. Since the last report to the Trust Board, we have received three exception reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Head of Medical Workforce & Medical Education and the GOSW.

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

This report covers the period 1st of May to the 6th of August 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 the 1st of May to the 6th of August 2024. Since the last report to the Trust Board, we have received three *'hours & rest'* exception reports.

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	3	3	0
Sexual Health	0	0	0	0
Total	0	3	3	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	0	0	0
CT	0	3	3	0
ST	0	0	0	0
Total	0	3	3	0

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

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Total	1	0	2	0

In this period, we have received 3 exception reports.

Two of these three exception reports relate to workload in inpatient mental health wards. One of the exception reports relates to the outpatient ADHD service.

The GOSW has discussed with trainees regarding the exception reports at the Postgraduate Doctors' Forum (PDF) on 18th of July 2024, there were no concerns raised by trainees in getting their TOIL for the time they have worked extra; trainees have been encouraged to raise the exception reports if they have worked beyond their work schedule and if in doubt to contact GOSW or their supervisor, this will be discussed on a regular basis at the PDF. The main area where the exception reports are raised are from the mental health inpatient unit, because of the acute nature of the job and due to patients/admissions/discharges often requiring immediate attention. During this quarter there have been no reports raised in relation to out of hours on call rota, although historically this is another area we get exception reports frequently. There are no outstanding exception reports waiting to be actioned, TOIL where appropriate have all been agreed with trainees. There has been a reduction in the number of exception reports during this quarter (compared to previous quarter, but keeping in line with historical mean data for this Trust) and GOSW meets the trainees via the PDF and trainee representatives through the MEM to encourage raising exception reports where applicable and to address any barriers that trainees may face in doing so, this will also be highlighted in new trainees induction on the 7th of August 2024.

During this quarter, there have not been any exceptions reported in relation to the OPPC course overruns, which historically had been a problem. This had previously been brought to the attention of the School of Psychiatry who run the course, and any further issues will be monitored in due course. There is some delay in addressing the exception reports within the recommended 7 days from date of submission, although there has been an improvement in this (one report was actioned within 48 hours). The GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so, individual emails are also sent to respective supervisors to remind them to action the reports (if not actioned within 7 days and overdue) and agree TOIL when appropriate. On the two occasions when the reports were addressed after the stipulated 7-day period- the delay was due to the consultant being on leave but were promptly actioned upon their return from leave. The GOSW continues to remind supervisors at the Medical Staff Committee meeting about prompt action on exception reports for their trainees, an email reminder has been sent to all consultants explaining the flowchart of exception

reporting process and the timescale to action them, consultants have been reminded the onus is on them to action these reports and discuss with trainees if appropriate.

Exception reporting is a neutral action and is encouraged by the Guardian and Directors 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 May to 6th of August 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
	89	84	56	28	0	930.5	889	602	287	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	17	17	12	5	0	177.5	177.5	129	48.5	0
Sickness	72	67	44	23	0	753	711.5	473	238.5	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	89	84	56	28	0	930.5	889	602	287	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 five unfilled gaps in this period. For this unfilled gap, patient safety was not an issue and we have always had at least one junior doctor on duty out of hours at Prospect Park Hospital.

Issues arising

Exception reporting is at a level more consistent with previous GOSW Board reports. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours.

There is some delay in addressing the exception reports within the recommended 7 days from date of submission, the GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so.

Actions taken to resolve issues:

GOSW to remind consultants at MSC of importance of addressing exception reports.

Next report to be submitted November 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.

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	10 September 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 – 10 September 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. Trust Anti-Racism Response to Public Violent Disorder

I communicated with Trust staff in the week following violent public disorder at the beginning of August 2024. Widespread threats of further violence were being made, driven by racism, islamophobia, and anti-immigrant hatred.

Berkshire Healthcare condemns racism. We are proud of our multi-cultural workforce and will act to ensure our staff and patients are safe and treated with dignity and respect.

I attended a very helpful partner briefing with Thames Valley Police Commander Assistant Chief Constable (ACC) Christian Bunt. ACC Bunt (also on national command response) provided assurance that police intelligence suggested further violent disorder was unlikely in Berkshire. I was able to brief staff to reassure teams of their safety in the face of fear inducing misinformation about planned action in Slough and Reading circulating on social media. Feedback from divisions the communication calmed staff, reduced onward transmission of misinformation and ensured we maintained services to patients through a frightening period of uncertainty for many of our staff, patients, and communities.

The Trust's anti-racism commitment and action plan preceded this violent disorder, which serves to intensify our commitment in taking action to dismantle all forms of racism.

I am pleased to note Frimley Integrated Care Board and the Frimley Integrated Care System Integrated Care Partnership are making time in September 2024 for system leaders to consider forming an anti-racism alliance for wider collective impact on racism. The Trust has been asked to support this activity.

Executive Lead: Alex Gild, Deputy Chief Executive

3. Care Quality Commission (CQC) Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust

Following the conviction of Valdo Calocane in January 2024, for the killing of Ian Coates, Grace O'Malley-Kumar and Barnaby Webber in Nottingham in June 2023, the CQC were commissioned by the Secretary of State for Health and Social Care to undertake a special review.

The first part of the review was published in March 2024, with the final parts being published on 13th August 2024.

The review recognises that whilst *'it is not possible to say that the devastating events of 13 June 2023 would not have happened if Valdo Calocane had received appropriate support, what is clear is that the risk he presented to the public was not managed well and that opportunities to mitigate that risk were missed"*.

The report also highlights '*the importance of recognising that treatment for people with serious mental health issues is not straightforward – either for those providing it or those receiving it, and that there is a clear need for improved oversight and guidance at both a provider and a national level'.*

Although the review was focused on Nottinghamshire Healthcare, it was acknowledged that the enduring areas of concern (demand for services and access to care, staffing challenges and leadership of oversight of risk) are not unique to that one trust.

The key findings from the review were:

1. The quality of risk assessment and record keeping including capacity to consent considerations.
2. Care planning and engagement this including use of out of area placements, communication with families and hearing their concerns, actions when someone does not engage with services, allocation of timely care coordination.
3. Medicines management and optimisation including consideration of Depot and Community Treatment Orders.
4. Discharge planning including communicating discharge decisions and difficulties in transitions of care between inpatient and community services.

From the review several recommendations have been made and actions taken nationally including:

- All providers and commissioners will need to ensure that they have the necessary understanding of their roles and that the required review of relevant models of care is carried out.
- Providers will need to ensure that 'lessons are learnt' from the review in relation to discharge planning, risk assessment, patient and family engagement, capacity assessments and the use of the Mental Health Act, including Community Treatment Orders.
- The CQC are beginning to look in detail at the standard of community mental health across the county to fully understand the gaps in the quality of care, patient safety, public safety, and staff experience in community mental health services

- The CQC working with NHS England to improve data on the quality and safety of community mental health services.
- Guidance to integrated care boards on intensive and assertive community mental health care was published in July 2024, this includes Key messages around services having a duty to engage with people with Severe Mental Illness and their families/carers, intensive and assertive community care requiring dedicated staff, a 'No wrong door' approach is needed and that continuity of care that is holistic and engaging is vital.

There was a requirement within this for all Integrated Care Boards (ICBs) to "review their community services by Quarter 2 2024/25 to ensure that they have clear policies and practice in place for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge"

To support this review, NHS England published in July 2024 a Community Mental Health Service Review, ICB Maturity Index Self-Assessment Tool, for completion by all NHS provider organisations for return through their ICB up to NHS England by the end of September 2024.

There is also a recommendation of NHS England around the development of new guidance setting out national standards for high-quality, safe care for people with complex psychosis and paranoid schizophrenia.

Locally, we are currently reviewing and completing the self-assessment tool and have a workshop planned for September to work through how as a provider we can address any gaps identified in current care provision in relation to the guidance on intensive and assertive community mental health care. Following completion this will be reported back to the Trust Board.

We have an ongoing mental health transformation programme with updates to Board that has a focus on ensuring that our assessment, care and treatment pathways across our mental health services are effective and robust, and a new risk assessment and formulation tool being introduced with more focus on harm to others.

We have a team that work with a small group of patients who have spent significant periods of time in hospital either due to persistent psychotic symptoms or a high risk to other people. This team is a highly skilled multi-disciplinary team (MDT) who work with the patient, carers and wider support networks; however, the current approach relies on the patient demonstrating a willingness to engage with the team to identify rehabilitation goals, therefore we recognise that we need to adapt to meet the needs of the patient group who are more difficult to engage with.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

4 Staff Vaccination Programme 2024-25

Flu

Flu vaccination remains a critically important public health intervention to reduce morbidity and mortality in those most at risk including older people, pregnant women and those in clinical risk groups. It helps the health and social care system manage

winter pressures by helping to reduce demand for GP consultations and likelihood of hospitalisation. Vaccinating health and care workers also play an important role in helping to prevent transmission of flu, protecting themselves and those they care for.

All frontline health care workers, including both clinical and non-clinical staff who have contact with patients, should be offered flu vaccine from October 2024 to reduce staff absenteeism and prevent the transmission of flu. The aim is to offer the vaccinations to 100% of frontline healthcare workers, with aim for a minimum uptake of 75%.

Covid-19

The primary aim of the national COVID-19 vaccination programme remains the prevention of severe illness (hospitalisations and deaths) arising from COVID-19. As currently available COVID-19 vaccines provide limited protection against mild and asymptomatic disease, the focus of the programme is on offering vaccination to those most likely to directly benefit from vaccination, particularly those with underlying health conditions that increase their risk of hospitalisation following infection.

The Joint Committee on Vaccination and Immunisation (JCVI) advice in terms of COVID-19 vaccination for staff was ‘’*that health and social care service providers may wish to consider whether vaccination provided as an occupational health programme to frontline health and social care workers is appropriate in future years; and that ahead of such considerations, health departments may choose to continue to extend an offer of vaccination to frontline health and social care workers and staff working in care homes for older adults in autumn 2024”.*

The NHS England letter Flu and COVID-19 Seasonal Vaccination Programme: autumn/winter 2024/25 published 15th August 2024 has advised that ‘*the government has decided that frontline health and social care workers and staff working in care homes for older adults will continue to be offered COVID-19 vaccination in the autumn 2024 programme in England*.’’ Therefore, we will continue to offer this as alongside flu vaccination this year.

Proposed delivery model

For the 2024 staff vaccination campaign, we plan to use a mixed model approach for offering and administering vaccinations to Berkshire Healthcare Staff, including:

- Bookable staff clinics across all 6 of the Berkshire localities (including main Berkshire Healthcare sites)
- Roving vaccinations at all main Berkshire Healthcare sites, including visiting all inpatient settings
- Flu vouchers
- For staff eligible for flu/covid due to age or underlying health issues raising awareness and signposting to GP/pharmacy services, whereby they may be able to access quicker and at a more convenient location

- The campaign will be led by the Lead Nurse for Vaccinations, with support from an experienced Senior Immunisation Nurse and clinic staff with peer vaccinators ranging from several different specialities across the Trust.

Vaccine

Supplier	Name of product	Vaccine type	Staffing Group	Ovalbumin (egg) content micrograms per dose
CSL Seqirus UK	Cell-based quadrivalent influenza vaccine Seqirus ▼	QIVc (cell-based quadrivalent influenza vaccine), surface antigen, inactivated	Staff under the age of 65 years	Egg-free
CSL Seqirus UK	Adjuvanted quadrivalent influenza vaccine Seqirus ▼	aQIV (adjuvanted egg grown quadrivalent influenza vaccine) surface antigen, inactivated, adjuvanted with MF59C.1	From 65 years	Equal to or less than 1 micrograms per 0.5 ml dose

¶

Timings of the vaccinations

Based on the evidence that flu vaccine's effectiveness can wane over time in adults, the JCVI have advised moving the start of the programme for most adults to the beginning of October. This is on the understanding that many of the vaccinations will be completed by the end of November, closer to the time that the flu season commonly starts. It is preferable to vaccinate individuals closer to the time when the flu virus is likely to circulate (which typically peaks in December or January), as this will provide optimal protection during the highest risk period.

Staff clinics have been scheduled from Monday 7th October, with a planned launch to Trust Leaders on Friday 4th October 2024.

Communication Plan

A detailed comms plan has been developed in conjunction with the Operational leads. Below demonstrates the objectives and strategy.

Objectives

- The aim of this communication plan is to ensure all staff at Berkshire Healthcare are informed about the upcoming vaccination programme, understand its importance, and know how to participate if they wish to do so. We will:

- **Increase staff vaccination rates** from 48% (last year) measured by achieving a high number of consent forms completed and appointments booked by a specific timeframe.
- **Educate and inform staff about the vaccines** by sharing clear, comprehensive information, including its benefits, side effects, and the vaccination process. Addressing any concerns and misinformation to build trust and encourage staff to get vaccinated.
- **Make vaccinations easy to access** by ensuring the process is convenient and accessible for all staff, including clear instructions on where and how to get vaccinated. Reducing barriers will help increase participation rates.

Strategy

- **Regular communication via multiple sources** – using managers to communicate key information with their teams and the Comms Champion Network to disseminate key information and place posters in their staff areas.
- **Making it easy for frontline staff** by using roving vaccination model to fill in the gaps, including flexible hours to accommodate different shifts and busy colleagues.
- **Offering small incentives**: entry into a prize draw for completing a consent form to encourage participation. Reduce the amount of merch ordered to pens only to reduce costs.
- **Peer engagement** by using trusted voices to build trust and share personal experiences.
- **Refresh campaign materials** to keep it eye-catching for staff and reflect the objectives. Involve staff in this process.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

5. Martha's Rule

In February 2024, NHS England wrote to all provider NHS trusts and Integrated care Boards announcing the implementation of the first stage of Martha Rule. Martha's Rule is a significant patient safety initiative established in response to the tragic case of Martha Mills, a young girl who passed away due to complications that were not adequately addressed by her healthcare providers.

The components of the rule are set to be implemented across English NHS hospitals with the first phase commencing across around 100 acute Trusts from April 2024; these trusts are being supported to devise and agree a standardised approach to the 3 elements of Martha's rule.

The 3 proposed components of Martha's Rule are:

1. All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, which they can contact should they have concerns about a patient.

2. All patients, their families, carers and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact via mechanisms advertised around the hospital and more widely if they are worried about the patient's condition.

3. The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

The aim of the rule is to empower patients and their families, ensuring their concerns are heard and acted upon promptly, potentially saving lives by providing a second opinion when it's most needed; it allows patients, families, carers, and hospital staff to request a rapid review from a critical care outreach team if they have concerns about a patient's deteriorating condition.

Whilst this first phase of implementation of the rule is targeted at acute providers, there is also an expectation that the wider NHS will also identify ways to roll out an adapted Martha's Rule model across other settings, including community and mental health hospitals, where the processes may not apply in the same way.

We are therefore starting to explore how we can implement something that meets the principles and ethos of the rule across our Community and Mental Health inpatient wards. We are initially exploring implementation across our Mental health Inpatient wards.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

6. Culture of Care Programme

In April 2024, the ‘*’Culture of care standards for mental health inpatient services, including those for people with a learning disability and autistic people”* was published by NHS England. The standards were published as part of the Mental Health, Learning Disability and Autism inpatient transformation programme which was established in 2022 to support change in culture and models of care. The standards were co- produced with wide stakeholder engagement including those with lived experience, carers, staff and voluntary sector organisations. The core commitments of the standards are:

1. **lived experience**: We value lived experience, including in paid roles, at all levels – design, delivery, governance and oversight
2. **safety:** People on our wards feel safe and cared for
3. **relationships:** High-quality, rights-based care starts with trusting relationships and the understanding that connecting with people is how we help everyone feel safe
4. **staff support:** We support all staff so that they can be present alongside people in their distress.
5. **equality:** We are inclusive and value difference; we take action to promote equity in access, treatment and outcomes

6. **avoiding harm:** We actively seek to avoid harm and traumatisation, and acknowledge harm when it occurs
7. **needs led:** We respect people's own understanding of their distress
8. **choice:** Nothing about me without me – we support the fundamental right for patients and (as appropriate) their support network to be engaged in all aspects of their care
9. **environment:** Our inpatient spaces reflect the value we place on our people
10. **things to do on the ward**: We have a wide range of patient requested activities every day
11. **therapeutic support**: We offer people a range of therapy and support that gives them hope things can get better
12. **transparency:** We have open and honest conversations with patients and each other, and name the difficult things

To support these standards, a Culture of Care Programme led by the National Collaborating Centre for Mental Health has been established with all Mental Health providers of care being invited to participate in this quality Improvement programme. The programme is designed and delivered in collaboration with people with lived experience and professionals. We, like all other mental health providers are participating in this programme with an acute adult ward, an older adult ward and our intensive care unit being selected to be part of the programme.

The programme overview as detailed below has guiding principles and elements that will build on and enhance organisational programmes of work such as Unity against racism, reducing restrictive practice and our Violence Reduction Programmes, underpinned by our quality improvement programme.

Progress and updates on this two-year programme will be provided into our Quality Assurance Committee.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

7. Care Quality Commission (CQC) Update

At the end of July 2024, the Department of Health and Social Care (DHSC) published an interim report from Dr Penny Dash into the operational effectiveness of the Care Quality Commission (CQC). Dr Dash's full report will be published in the autumn. The Secretary of State for Health and Social Care responded to the report announcing steps the department and CQC would take immediately as a result. The CQC's interim chief executive also issued a response.

Dr Dash, chair of Northwest London Integrated Care Board, was commissioned to undertake this review of CQC's operational effectiveness in May 2024 by the previous government as part of an assessment of public bodies under the Cabinet Office Public Bodies Review Programme.

On assuming the office of Secretary of State for Health and Social Care, Wes Streeting asked Dr Dash to produce an urgent interim report. Dr Dash has conducted interviews with around 170 senior managers, caregivers and clinicians across the health and care sector, as well as more than 40 senior managers and national advisers at CQC. Interviews with patients and service users are scheduled and will take place prior to the publication of the more detailed final report to ensure the final recommendations reflect their needs. The interim report is therefore a 'high-level summary of emerging findings'. The review will consider CQC's approach to

assessing local authorities and integrated care systems in its final report but does not do so here. The interim report sets out five emerging findings and articulates six concerns about the single assessment framework (SAF). It then makes five recommendations.

The five emerging findings are:

1. Poor operational performance
2. Significant challenges with the provider portal and regulatory platform
3. Considerable loss of credibility within the health and care sectors due to the loss of sector expertise and wider restructuring
4. Concerns around the Single Assessment Framework
5. Lack of clarity about how ratings are calculated and the use of previous inspection outcomes

The review recommends:

1. Rapidly improve operational performance
2. Fix the provider portal and regulatory platform
3. Rebuild expertise within the organisation and relationships with providers in order to resurrect credibility
4. Review the Single Assessment Framework to make it fit for purpose
5. Clarify how ratings are calculated and make the results more transparent particularly where multiyear inspections and ratings have been used.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
10 September 2024

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	10 September 2024
Title	**Finance Report July 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 2024/25

July 2024

Purpose

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

Document Control

Version	*Date*	*Author*	*Comments*
1.0	23/08/24	Rebecca Clegg	Draft
2.0	03/09/24	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 Actual £m	Year to Date Plan £m	Year to Date Achieved	Outturn Actual £m	Outturn Plan £m	Outturn Achieved
1a	Income and Expenditure Plan	0.8	0.7	Yes	1.9	1.9	Yes
2a	CIP - Identification of Schemes	4.2	4.2	Yes	8.8	13.6	No
2b	CIP - Delivery of Identified Schemes	4.2	4.2	Yes	8.8	8.8	Yes
3a	Cash Balance	52.1	53.6	No	46.8	46.8	Yes
3b	Better Payment Practice Code Volume Non-NHS	97%	95%	Yes	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	97%	95%	Yes	95%	95%	Yes
3d	Better Payment Practice Code Volume NHS	95%	95%	Yes	95%	95%	Yes
3e	Better Payment Practice Code Value NHS	92%	95%	Yes	95%	95%	Yes
4	Capital Expenditure not exceeding CDEL	0.6	1.0	Yes	8.6	8.6	Yes
5	Agency Ceiling	2.8%	3.2%	Yes	3.2%	3.2%	Yes

Key Messages

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

- The planned outturn position for the Trust is a £1.9m surplus. This includes additional funding for depreciation £0.6m, agreed SDF slippage (BOB system) £0.5m and further CIPs to be identified £0.8m.
- The Trust has a £13.8m Cost Improvement Plan. We are reporting that we are on track year to date, but there are some small variances on individual plans.
- Income includes the current cost uplift for 24/25 but this will be updated as and when 24/25 pay awards are agreed.
- Cash is below plan due in part to phasing but also delayed payments from local authorities.
- Our performance against the Better Payment Practice Code continues to improve following marginal miss on one of the targets in 23/24. We were achieving the target across all 4 measures at month 3 but one target has been missed in month 4 due to 7 medical staffing invoices being paid late.
- Capital spend is slightly under plan for CDEL schemes.
- The agency target is achieved year to date.

1. Income & Expenditure

Jul-24	In Month			YTD			2024/25
	Act	Plan	Var	Act	Plan	Var	Plan
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	30.6	30.3	0.3	121.3	121.0	0.3	364.2
Elective Recovery Fund	0.3	0.3	0.0	1.3	1.3	0.0	4.0
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**31.0**	**30.6**	0.3	**122.7**	**122.3**	0.3	**368.2**
Staff In Post	20.4	20.7	0.2	81.9	82.1	0.2	249.5
Bank Spend	1.9	2.1	0.2	7.6	8.0	0.4	24.9
Agency Spend	0.7	0.7	(0.1)	2.5	2.6	0.1	8.0
Total Pay	**23.0**	**23.4**	**0.4**	**92.0**	**92.7**	**0.625**	**282.5**
Purchase of Healthcare	1.8	1.6	(0.2)	7.6	7.4	(0.2)	19.5
Drugs	0.5	0.5	(0.0)	2.1	2.1	(0.1)	6.1
Premises	1.3	1.4	0.0	5.8	5.7	(0.1)	17.1
Other Non Pay	1.8	1.5	(0.3)	6.9	6.4	(0.6)	18.4
PFI Lease	0.6	0.7	0.1	2.8	2.9	0.1	8.8
Total Non Pay	**6.1**	**5.7**	**(0.5)**	**25.3**	**24.5**	**(0.8)**	**70.0**
Total Operating Costs	**29.2**	**29.1**	**(0.1)**	**117.3**	**117.2**	**(0.1)**	**352.4**
EBITDA	**1.8**	**1.5**	**0.2**	**5.4**	**5.2**	**0.2**	**15.8**
Interest (Net)	(0.0)	0.1	0.1	0.1	0.2	0.2	1.0
Depreciation	0.9	0.9	0.0	3.7	3.7	0.0	11.2
Impairments	0.3	0.0	(0.3)	0.3	0.0	(0.3)	0.0
Disposals	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0
Remeasurement of PFI	0.0	0.0	0.0	1.3	2.0	0.7	2.0
PDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Financing	**1.2**	**1.0**	**(0.2)**	**5.4**	**6.0**	**0.6**	**14.3**
Reported Surplus/ (Deficit)	**0.6**	**0.5**	**0.1**	**(0.0)**	**(0.8)**	**0.8**	**1.5**
Adjustments	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.1**
PFI IFRS16 Adjustment	**(0.1)**	**(0.1)**	**0.0**	**0.8**	**1.4**	**(0.7)**	**0.3**
Adjusted Surplus/ (Deficit)	**0.5**	**0.4**	**0.1**	**0.8**	**0.7**	**0.1**	**1.9**

Key Messages

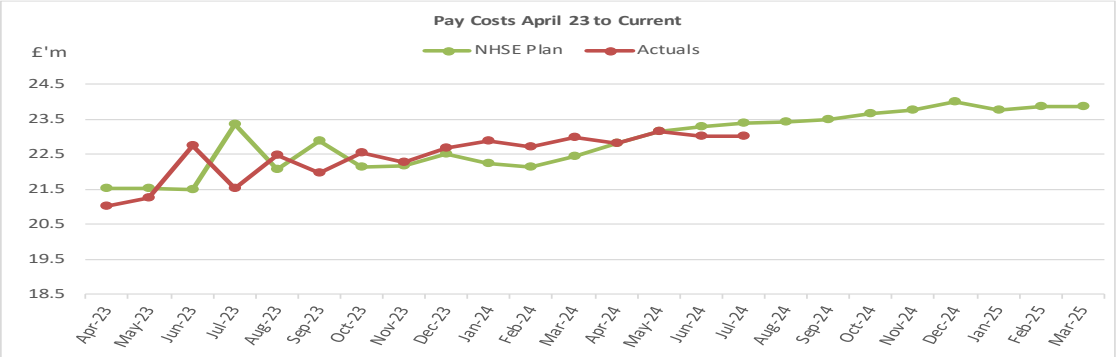
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 July 2024.

The Trust is planning for a £1.9m surplus. The planned position is a further improvement on breakeven agreed with BOB ICB as part of the over all improvement required to the system financial plan for 2024/25. The £1.9m surplus will be delivered through £0.6m of additional funding for deprecation, £0.5m of SDF slippage and a further £0.8m of cost improvements which are still to be identified.

The Trust now has a cost improvement programme of £13.6m.

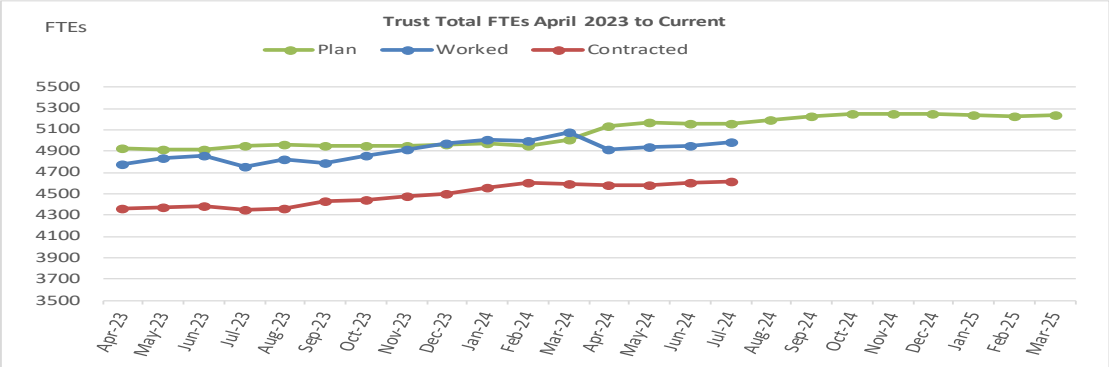
Month 4 variances are not material and overall the Trust is slightly head of plan with a £0.8m surplus year to date.

Workforce



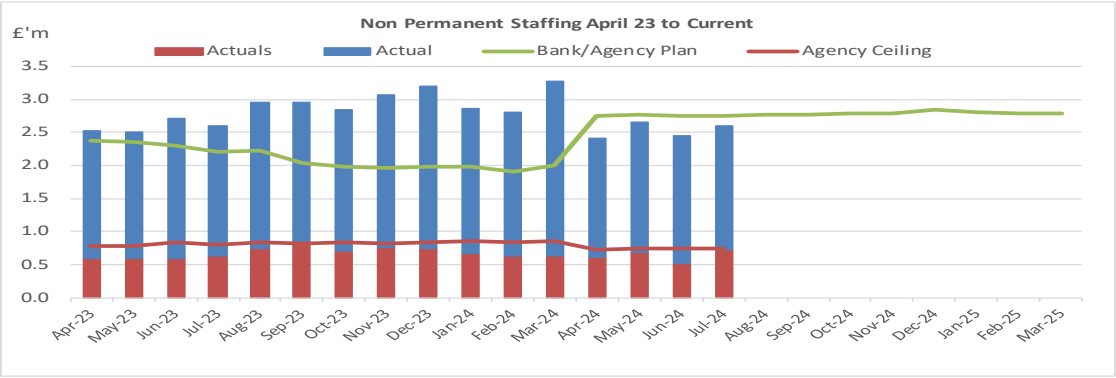
Staff Costs

YTD	£'m
2024/25	92.0
2023/24	86.5
▲	6%
Prior Yr	**£'m**
Jul-24	23.0
Jul-23	21.5
▲	7%



FTE's

Prior Mth	CFTE	WFTE
Jul-24	4,606	4,982
Jun-24	4,582	4,952
	1%	1%
	▲	▲
Prior Yr		
Jul-24	4,606	4,982
Jul-23	4,388	4,750
	5%	5%
	▲	▲



Staff Costs

YTD	Bank	Agency
	£'m	£'m
2024/25	5.7	2.5
2023/24	6.0	2.4
	-5%	5%
	▼	▲
Prior Yr	**£'m**	**£'m**
Jul-24	1.9	0.7
Jul-23	2.0	0.6
	-5%	14%
	▼	▲

Key Messages

Pay costs in month were £23m.

In month, contracted WTEs increased by 24 and worked WTEs increased by 30.

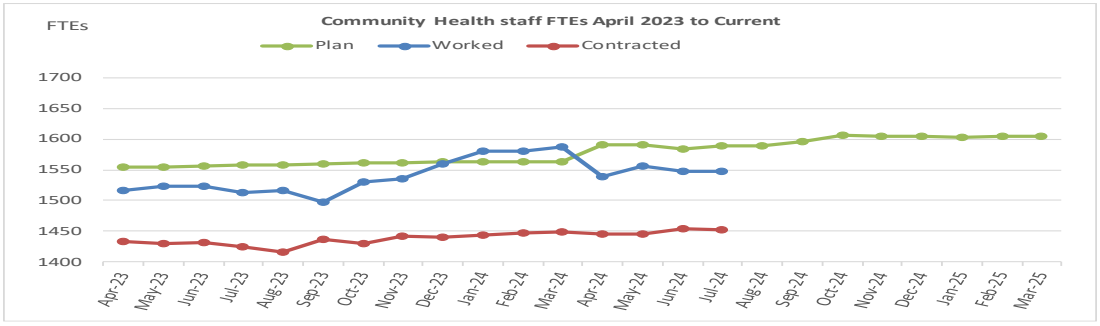
Overall temporary staffing costs £0.3m lower than the same period last year. Agency costs are slightly higher than last year, whilst bank costs have reduced.

We are operating below the NHSE System Agency Ceiling of 3.2%, currently running at 2.8% of overall pay costs YTD .

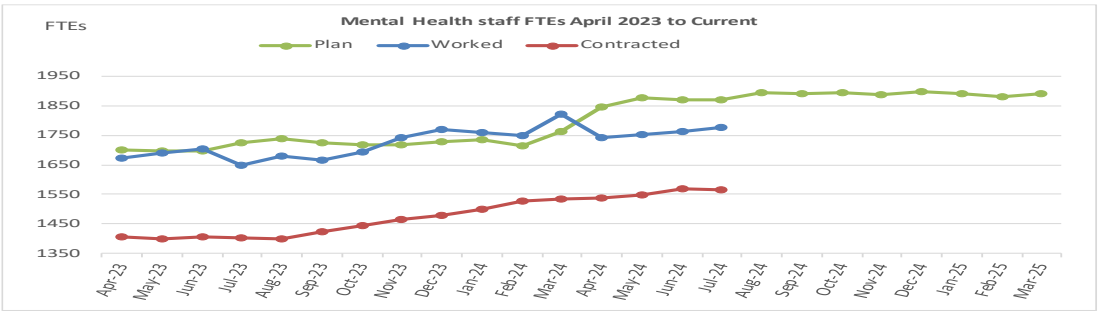
Agency price cap breaches, although low compared to other trusts, continue to be reviewed every month. Non-medical price cap breaches were in OPMH, Westcall (for ANPs/ACPs/Pharmacist), ASLT, Pharmacy and CAMHS Rapid Response.

Non-framework agency usage decreased from 8% in June to 6% in July, with most usage concentrated in our dental and nursery services.

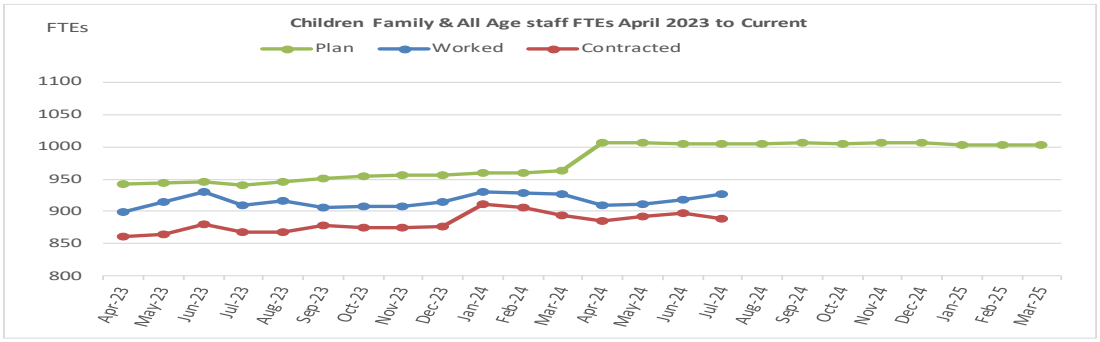
Staff Detail (Division)



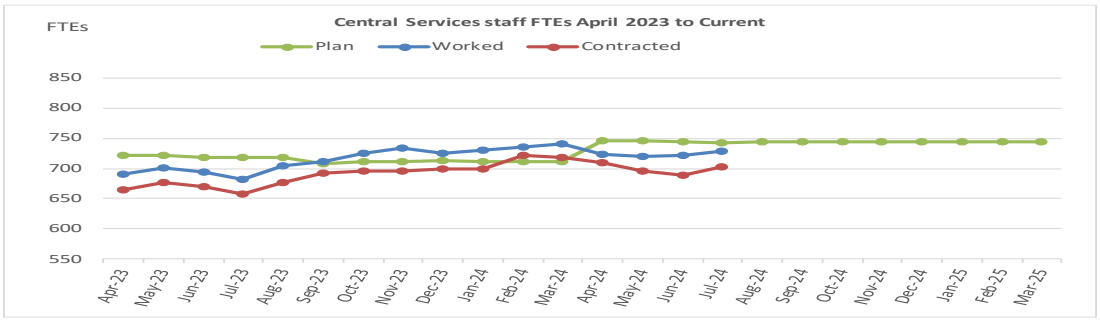
FTE's		
Prior Mth	CFTE	WFTE
Jul-24	1,453	1,548
Jun-24	1,446	1,547
	1% ▲	0% ▲
Prior Yr		
Jul-24	1,453	1,548
Jul-23	1,432	1,512
	2% ▲	2% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jul-24	1,567	1,778
Jun-24	1,547	1,764
	1% ▲	1% ▲
Prior Yr		
Jul-24	1,567	1,778
Jul-23	1,407	1,647
	11% ▲	8% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jul-24	897	927
Jun-24	893	918
	0% ▲	1% ▲
Prior Yr		
Jul-24	897	927
Jul-23	880	909
	2% ▲	2% ▲

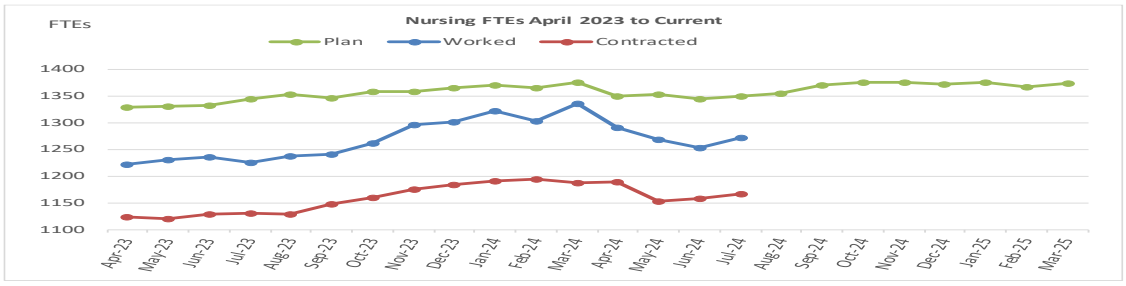


FTE's		
Prior Mth	CFTE	WFTE
Jul-24	688	729
Jun-24	696	722
	-1% ▼	1% ▲
Prior Yr		
Jul-24	688	729
Jul-23	669	682
	3% ▲	7% ▲

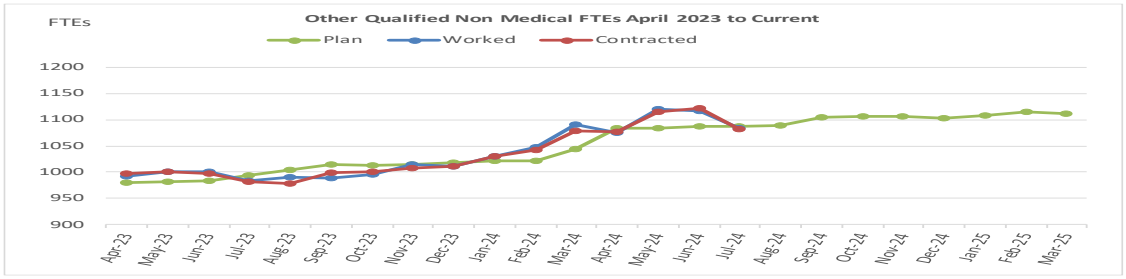
Key Messages

Worked WTEs are below plan for all divisions and central services.

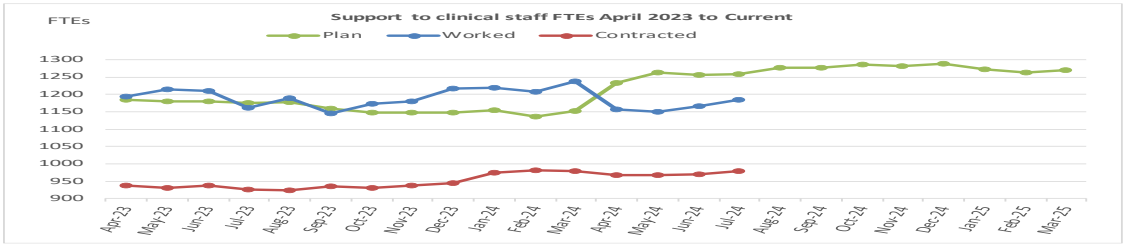
Staff Detail (Staff Group)



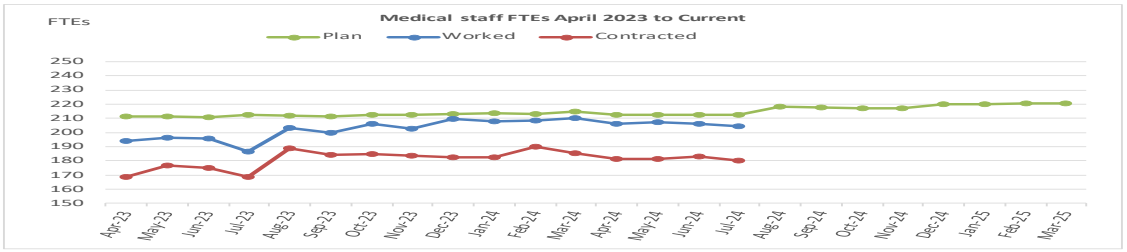
FTE's		
Prior Mth	CFTE	WFTE
Jul-24	1,158	1,273
Jun-24	1,153	1,254
	0% ▲	2% ▲
Prior Yr		
Jul-24	1,158	1,273
Jul-23	1,128	1,225
	3% ▲	4% ▲



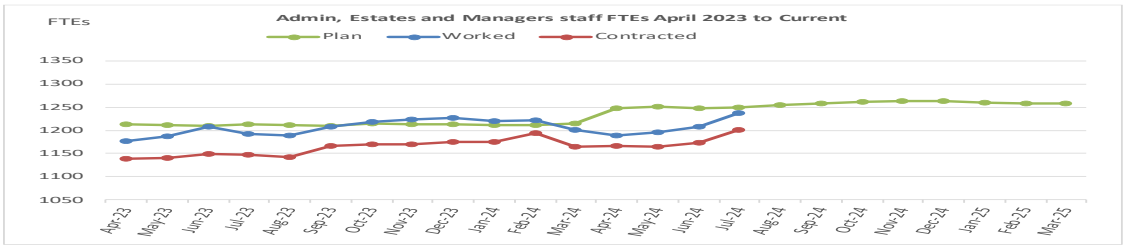
FTE's		
Prior Mth	CFTE	WFTE
Jul-24	1,121	1,084
Jun-24	1,116	1,118
	1% ▲	-3% ▼
Prior Yr		
Jul-24	1,121	1,084
Jul-23	997	984
	13% ▲	10% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jul-24	969	1,184
Jun-24	968	1,166
	0% ▲	1% ▲
Prior Yr		
Jul-24	969	1,184
Jul-23	939	1,161
	3% ▲	2% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jul-24	183	205
Jun-24	181	206
	1% ▲	-1% ▼
Prior Yr		
Jul-24	183	205
Jul-23	175	186
	5% ▲	10% ▲



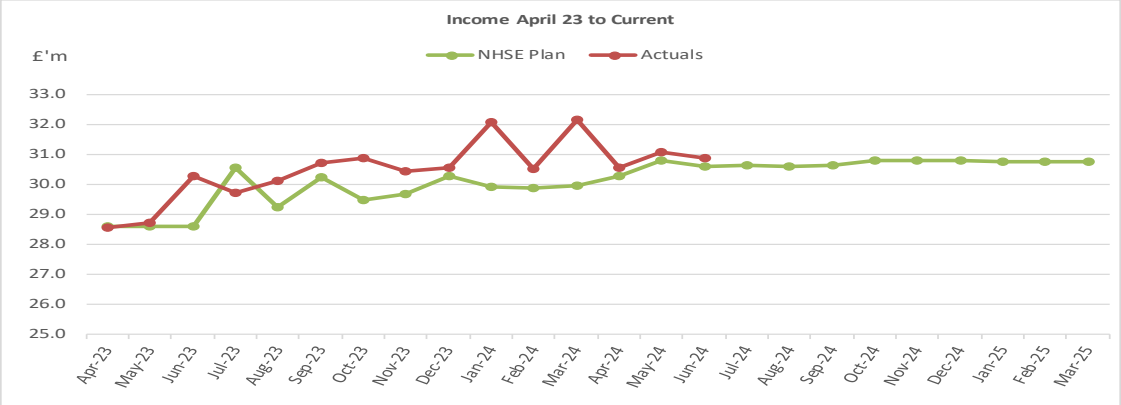
FTE's		
Prior Mth	CFTE	WFTE
Jul-24	1,174	1,208
Jun-24	1,164	1,208
	1% ▲	0% ▼
Prior Yr		
Jul-24	1,174	1,208
Jul-23	1,149	1,192
	2% ▲	1% ▲

Key Messages

Worked WTE actuals are much closer to plan since the 2023/24 financial reset.

We are still seeing a gap between worked and contracted WTEs for some graphs which highlights the continued use of agency and bank staff to fill substantive vacancies.

Income & Elective Recovery Fund



Income	
YTD	£'m
2024/25	123.8
2023/24	117.3
▲	6%
Prior Yr	£'m
Jul-24	31.3
Jul-23	29.7
▲	5%

Key Messages

Income is in line with plan. The contract with Frimley ICB and BOB ICB has been signed by the Trust and both our ICBs. . There are no material outstanding matters.

The financial plan for elective activity has been set at £4m but we targeting higher performance and added a further CIP of £1m. The chart below shows current outpatient activity for each of the ICBs compared with the stretch target of £5m which has been phased evenly across the year. There will also be some inpatient activity included in our performance against plan but further work is require to forecast this accurately, with current values being based on prior year averages.

Elective Activity Performance

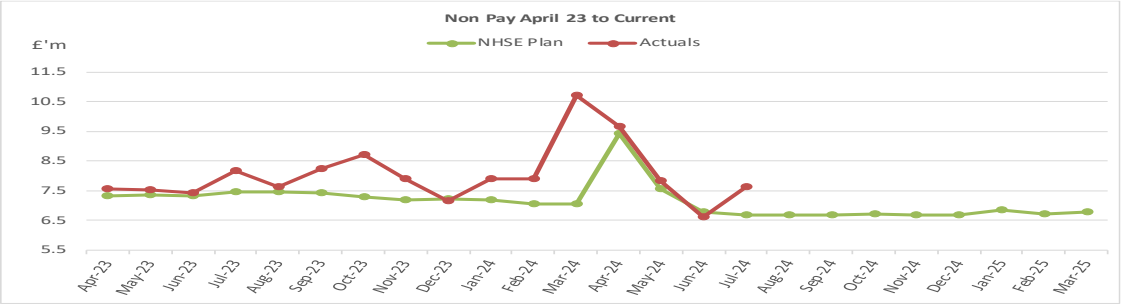
ERF Performance against target	BOB		Frimley		Total	
Year to Date: July 2024	Activity	£000s	Activity	£000s	Activity	£000s
Baseline	22,098	4,886,143	22,878	5,003,589	44,976	9,889,732
Actual	29,820	7,071,673	21,209	4,916,208	51,029	11,987,881
Variance	7,722	2,185,530	-1,669	-87,380	6,053	2,098,149
Income target		1,666,667		0		1,666,667
Variance (+/-)		518,863		-87,380		431,482

The Trust will receive payment for all activity above the 19/20 baseline which is higher than for 23/24 as it has been adjusted for working days and the current activity prices. The target and income earned will be updated for further price changes resulting from pay awards as they are agreed.

In order to deliver the plan of a £1.9m surplus, the Trust will also need to find additional CIPs of £0.8m and there is potential to secure a contribution from Frimley ICB elective income.

We are incurring additional cost for outsourcing to deliver Frimley activity which will need to be offset against any over performance but which is included in the Trust's run rate.

Non Pay & Placement Costs

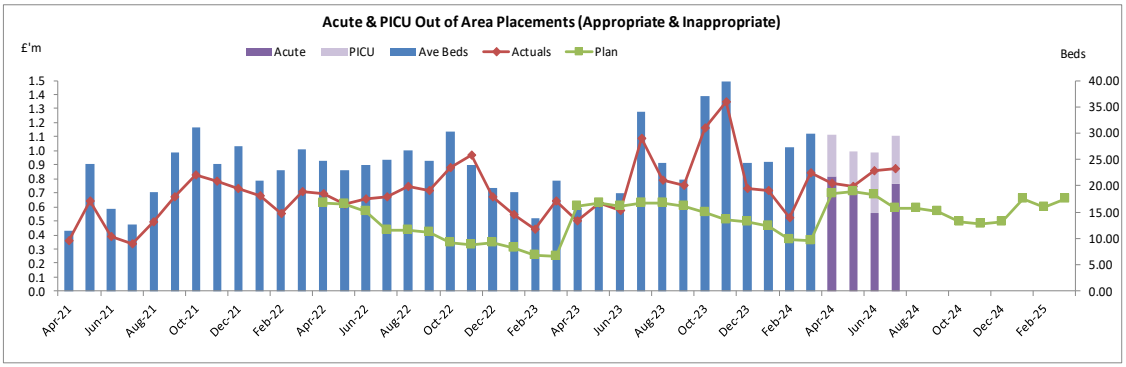


Non Pay

YTD	£'m
2024/25	31.8
2023/24	30.7
▲	4%
Prior Yr	**£'m**
Jul-24	7.6
Jul-23	8.2
▲	-7%

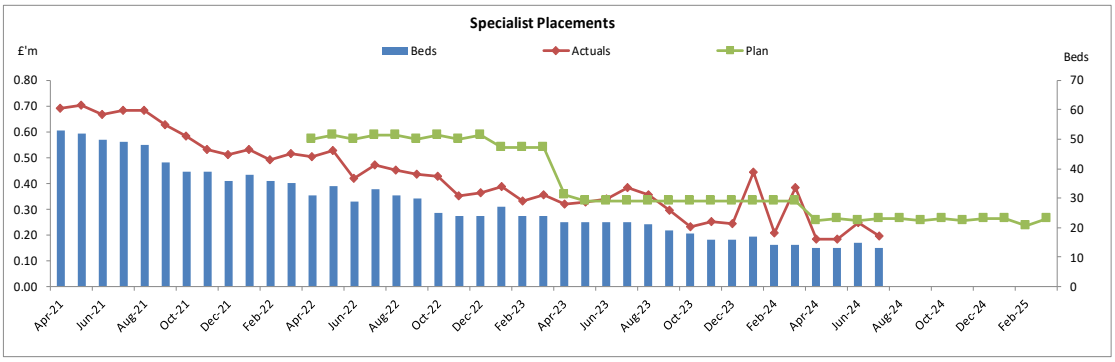
Key Messages

The non-pay variance includes an overspend on OAPs.



OAPs

YTD	£'m
2024/25	3.2
2023/24	2.8
▲	*16%*
Prior Yr	**£'m**
Jul-24	0.9
Jul-23	1.1
▼	*-20%*



Specialist Placements

YTD	£'m
2024/25	0.8
2023/24	1.4
▼	*-41%*
Prior Yr	**£'m**
Jul-24	0.2
Jul-23	0.3
▼	*-40%*

Key Messages

Out of Area Placements. The average number of placements has increased from 26 in June to 19 in July. 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 are £0.9m which is above plan. Work is ongoing to ensure that the costs are reported accurately each month and an adjustment was made in month 3 to correct an under reporting in the previous month.

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.

The Board has agreed a reduction in acute bed at PPH to 72 from Q3. 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 has increased from 13 to 15, costs are slightly below plan.

Cost Improvement Programme

Description	Directorate	Development Status	Risk	Plan £k	YTD Actual £k	YTD Plan £k	Variance £K
Contribution from new income - CJLD	Mental Health	Fully developed	Low	354	118	118	0
Contribution from new income - MHICS	Mental Health	Fully developed	Low	175	58	58	0
Contribution from new income - Imms	Children families and All Age Services	Fully developed	Low	444	148	148	0
Contribution from new income - small CH schemes	Cimmunity Health	Fully developed	Low	124	41	41	0
Contribution from new income - small CYP schemes	Children families and All Age Services	Fully developed	Low	154	51	51	0
Contribution from new income - seasonal bed occupancy	Community Health	Fully developed	Medium	80	27	27	0
Other small divisional schemes	Various	Fully developed	Low	670	223	223	0
New contract with EE	Central Services - IM&T	Fully developed	Low	106	35	35	0
Estates & Facilities Control Total review	Central Services - Estates & Facilities	Fully developed	Low	376	125	125	0
Increased Contribution to Central Costs	Central Services - Pharmacy Procurement	Fully developed	Low	98	33	33	0
LPS Admin Posts	Central Services - Nursing & Governance	Fully developed	Low	66	22	22	0
Increased Contribution to Central Costs	Central Services - R&D	Fully developed	Low	102	34	34	0
PICU Placement reduction	Mental Health	Fully Developed - not yet started	Medium	1,049	0	350	-350
Asset revaluation to Modern Equivalent Asset	Central Services - Finance	Fully Developed	Low	670	224	223	0
Opt to tax - frimley	Central Services - Finance	Plans in progress	Medium	300	0	100	-100
Liaison VAT, AP review etc	Central Services - Finance	Plans in progress	Medium	100	0	33	-33
Overseas Visitors	Central Services - Finance	Opportunity	Medium	50	0	17	-17
Bank Interest	Central Services - Finance	Fully Developed	Low	230	377	77	300
Balance Sheet Review	Central Services - Finance	Fully Developed - not yet started	Medium	2,106	0	702	-702
Scheduled Care Cost Avoidance	Community Health	Fully Developed	Low	399	133	133	0
Expenses Controls	Community Health	Fully Developed - not yet started	Low	120	0	40	-40
Elective Recovery	Community Health	Fully Developed	Medium	1,000	633	333	300
Operational Slippage Against Control Total	Operations	Fully Developed	Low		1,412	0	1,412
Agreed Investment Slippage	Operations	Fully Developed	Low	500	500	167	333
Recurrent Schemes to be developed	To be confirmed	Opportunity	High	4,327	0	1,104	-1,104
			Total	13,600	4,195	4,195	0

Key Messages

The Trust's initial financial plan included £12.6m of CIPs to get to breakeven. A further £0.8m has been added due to the Trust agreeing a final plan of £1.9m.

Schemes are broadly phased in equal 12ths although some schemes will likely begin to delivery later in the year.

The PICU placement reduction scheme is phased in line with the MH beds paper approved by the Trust Board and is currently behind plan due to demand pressure on our beds.

The expenses control scheme is linked to a specific initiative and although originally phased across the year, will now start in Q2.

Most of the divisional schemes are already in place and operating with control totals already reduced accordingly. Further slippage against control total is being used to balance the overall position. Balance sheet review will be used to ensure that the overall target is achieved later in the year.

Some schemes are not yet started and therefore variances against plan are shown. In the case of the tax schemes, the schemes are likely to deliver savings but the phasing will not be equal across the year.

Bank interest continues to be higher than planned due to higher than expected average cash balances.

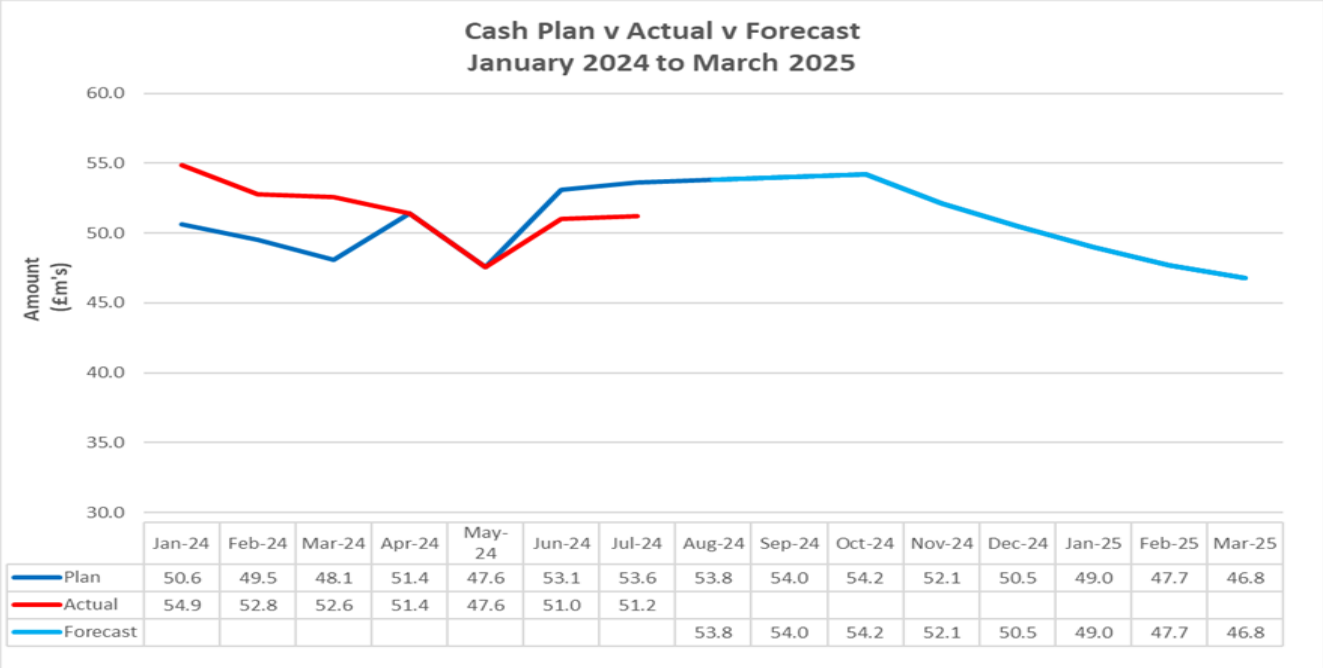
Recurrent schemes are to be developed as part of the closing the gap programme.

Balance Sheet & Cash

	2023/24 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	1.8	1.5	1.5	0.0	1.5	1.5	0.0
Property, Plant & Equipment (non PFI)	33.0	31.6	31.6	0.0	31.6	31.6	0.0
Property, Plant & Equipment (PFI)	45.9	45.4	45.7	(0.3)	45.4	45.7	(0.3)
Property, Plant & Equipment (RoU Asset)	15.2	14.5	14.5	0.0	14.5	14.5	0.0
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.1**	**93.2**	**93.5**	**(0.3)**	**93.2**	**93.5**	**(0.3)**
Trade Receivables & Accruals	12.1	17.7	16.9	0.8	17.7	16.9	0.8
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	52.6	51.2	53.6	(2.4)	51.2	53.6	(2.4)
Trade Payables & Accruals	(37.2)	(37.0)	(39.4)	2.4	(37.0)	(39.4)	2.4
Borrowings (PFI and RoU Lease Liability)	(6.2)	(4.2)	(7.4)	3.2	(4.2)	(7.4)	3.2
Other Current Payables	(12.0)	(14.1)	(13.2)	(0.9)	(14.1)	(13.2)	(0.9)
Total Net Current Assets / (Liabilities)	**9.6**	**13.9**	**10.8**	**3.1**	**13.9**	**10.8**	**3.1**
Non Current Borrowings (PFI and RoU Lease Liability)	(54.9)	(56.2)	(54.6)	(1.6)	(56.2)	(54.6)	(1.6)
Other Non Current Payables	(2.1)	(2.4)	(2.2)	(0.2)	(2.4)	(2.2)	(0.2)
Total Net Assets	**48.7**	**48.5**	**47.5**	**1.0**	**48.5**	**47.5**	**1.0**
Income & Expenditure Reserve	5.3	5.1	17.2	(12.1)	5.1	17.2	(12.1)
Public Dividend Capital Reserve	21.4	21.4	21.4	0.0	21.4	21.4	0.0
Revaluation Reserve	22.0	22.0	9.0	13.0	22.0	9.0	13.0
Total Taxpayers Equity	**48.7**	**48.5**	**47.5**	**1.0**	**48.5**	**47.5**	**1.0**

Key Messages

Our cash balance remains below plan. Work is underway with Local Authority commissioners to secure cash payment for activity. For Reading Borough Council, where the invoice for 0-19 for months 1-4 totalling £2.2m was not issued until the 16th July. Actions are being taken to follow up that RBC have the invoice and there are no issues preventing settlement.



	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Plan	50.6	49.5	48.1	51.4	47.6	53.1	53.6	53.8	54.0	54.2	52.1	50.5	49.0	47.7	46.8
Actual	54.9	52.8	52.6	51.4	47.6	51.0	51.2								
Forecast								53.8	54.0	54.2	52.1	50.5	49.0	47.7	46.8

Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast	FY
	Actual	Plan	Variance	Actual	Plan	Variance	Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	53	57	(4)	150	154	(3)	477	527	50
Nicholson House Relocation	0	0	0	0	0	0	500	500	0
Jubilee Ward Relocation Upton/St Marks	0	0	0	0	0	0	150	150	0
Additional Dental Surgery St Marks	0	7	(7)	0	7	(7)	185	185	0
Leased Non Commercial (NHSPS)	6	17	(11)	21	17	5	275	312	37
West/Reading Consolidation - Bath Road, Cremyll Road, Coley Cli	9	133	(124)	9	133	(124)	800	800	0
Leased Commercial	(8)	0	(8)	44	60	(16)	135	130	(5)
Environment & Sustainability	10	22	(12)	13	22	(8)	150	143	(7)
Audiology Equipment	0	30	(30)	0	30	(30)	181	160	(21)
Various All Sites	7	36	(30)	41	56	(15)	306	319	13
Statutory Compliance	13	20	(7)	15	20	(5)	160	94	(66)
Subtotal Estates Maintenance & Replacement	**90**	**321**	**(232)**	**295**	**498**	**(204)**	**3,319**	**3,319**	**0**
IM&T Expenditure									
Business Intelligence and Reporting	0	10	(10)	14	40	(26)	160	160	(0)
Hardware Purchases - Refresh & Replacement	2	0	2	30	0	30	3,447	3,447	0
Additional Divisional Spend	5	37	(31)	113	182	(68)	687	687	0
Digital Strategy	42	50	(8)	188	200	(12)	650	650	0
EMIS and ePMA systems re-tender project	0	5	(5)	0	50	(50)	207	207	0
Pharmacy System Procurement	0	0	0	0	0	0	100	100	0
Subtotal IM&T Expenditure	**49**	**102**	**(53)**	**346**	**472**	**(126)**	**5,251**	**5,251**	**(0)**
Subtotal CapEx Within Control Total	**138**	**423**	**(285)**	**640**	**970**	**(330)**	**8,570**	**8,570**	**0**
CapEx Expenditure Outside of Control Total									
Place of Safety	9	0	9	12	0	12	2,600	2,592	(8)
Anti-Ligature Toilet Pans & Basins	135	77	58	135	307	(172)	681	681	0
Low Carbon Heating Scheme	5	0	5	5	0	5	406	406	0
LED Lighting Upgrades	0	17	(17)	0	17	(17)	250	250	0
Other PFI projects	1	73	(73)	1	77	(76)	575	583	8
Subtotal Capex Outside of Control Totals	**149**	**167**	**(18)**	**152**	**400**	**(248)**	**4,512**	**4,512**	**(0)**
Total Capital Expenditure	**288**	**590**	**(302)**	**793**	**1,370**	**(577)**	**13,082**	**13,082**	**(0)**
IFRS16 RoU ASSETS - New Leases									
Lower Henwick Farm lease	169	0	169	169	200	(31)	200	200	0
Cremyll Road Lease	325	0	325	325	450	(125)	450	450	0
Chalvey Lease	0	0	0	0	0	0	750	750	0
Bath Road	0	0	0	0	0	0	100	100	0
Bracknell Healthspace	0	0	0	0	0	0	500	500	0
Calcot Surgery	23	0	23	23	24	(1)	24	24	0
Lake Road Health Centre - rent review	7	0	7	7	0	0	0	7	7
CoIN	(97)	42	(139)	(97)	164	(261)	500	493	(7)
Total IFRS 16 RoU Assets - New leases	**427**	**42**	**385**	**427**	**838**	**(418)**	**2,524**	**2,524**	**0**

Key Messages

At M04, CDEL schemes were underspend by £0.3m for the month and £0.3m YTD. Estate was underspend by £0.2m mainly due to West Reading consolidation, which is still in design stage. IM&T was underspend by £0.1m due to lower spend on additional divisional spend and EMIS and ePMA systems.

Non-CDEL spend for PFI sites was broadly in line with plan for the month and for YTD it was underspend by £0.2m, mainly due to anti-ligature toilets pans and basins project, which is now progressing and due to be delivered. PFI Place of Safety project continues to be under the Deed of Variation process and is expected to start in September.

There has been £0.4m spend on IFRS 16 leases, which reduced the YTD underspend to 0.4m YTD. The underspend on IFRS 16 is mainly due to CoIN leases and is due to timing difference between the financial plan and lease agreements being in place.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	10th September 2024
Title	**True North Performance Scorecard Month 4 (July 2024) 2024/25**
	The Board is asked to note the True North Scorecard.
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 2024/25.
Business Area	Trust-wide Performance
Author	Chief Operating 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

True North Performance Scorecard Highlight Report – July 2024

The True North Performance Scorecard for Month 4 2024/25 (July 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, has reduced to 262 against a 250-bed day target.
    - A backlog in Bracknell has been cleared and an improved position in West Berkshire. Eleven admissions were avoided using a new prioritization tool. The team are reviewing whether a high need's unit in the locality is contributing to pressures within Reading.
- Bed Days Occupied by Patients who are Discharge Ready (Community Physical Health) – **(Patient Experience)** – a new indicator for 2023/24, has increased to 979 against a 500-bed day target.
    - Highest levels seen in the last 12 months with 183 discharges and 186 admissions. Only 7 patients were delayed over 21 days. Average length of stay down to 23 days. The bed numbers are available on system dashboards, and we are working with partner organizations promote these.

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

- Restrictive Interventions **(Harm Free Care)** – 265 against a target of 309. A stretch revised target is being developed.
- Physical Assaults on Staff **(Supporting our Staff)** – 41 against a target of 44.
    - Remains a key focus at the site. Will review the target given performance. The team are focusing on top contributor Rose ward. Ascot ward featured this month with a challenging patient on the ward. One of the top contributing factors with assaults is linked to restraint of a patient and refusal of a leave request. The team are working on countermeasures for these insights.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Positive Score **(Patient Experience)** – at 94.5% against a 95% target.
- I Want Great Care Compliance Rate **(Patient Experience)** – at 5.7% against a 10% target.

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

- Staff turnover (excluding fixed term posts) **(Supporting our Staff)** – at 12.49% against a revised stretch target of 10% target by March 2025.

- Year to Date Variance from Control Total (£'k) **(Efficient Use of Resources)** -£103 against a target of 0.
- Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 3 against a quarter 2 target of 3 patients. Note change in measure from bed days to active patients.

Tracker Metrics

- Sickness rate **(Supporting Our Staff)** – red at 3.7% against a target of 3.5%.
- Talking Therapies Reliable Improvement for those Completing a Course of Treatment (Frimley) **(Patient Experience)** – 62% against a target of 67%.
- Talking Therapies Reliable Improvement for those Completing a Course of Treatment (BOB) **(Patient Experience)** – 64% against a target of 67%.
- Talking Therapies Reliable Recovery for those Completing a Course of Treatment (Frimley) **(Patient Experience)** –47% against a target of 48%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (Frimley) **(Patient Experience)** – 20% against a target of less than 10%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (BOB) **(Patient Experience)** – 18% against a target of less than 10%.
- Estimated Diagnosis Rate for Dementia (BOB) **(Patient Experience)** – 64.9% against a target 66.67%.
- Patient Safety Alerts not Completed by Deadline (year to date) **(Patient Experience)** – 1 against a target of 0.
- Community Inpatient Occupancy **(Efficient Use of Resources)** – at 88.8% against a target of 85%.
- Community Inpatient Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 21.7 days against a target of less than 21 days.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 97.3% against an 85% target.
- Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 49.6 days against a target of 30 days.
- Mental Health: Non-Acute Occupancy Rate (excluding home leave) **(Efficient Use of Resources)** – at 83.7% days against a target 80%.
- Community Virtual Ward Occupancy (Frimley) **(Efficient Use of Resources)** – at 57.59% against a target of 80%.

True North Performance Scorecard – Business Rules & Definitions

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

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

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

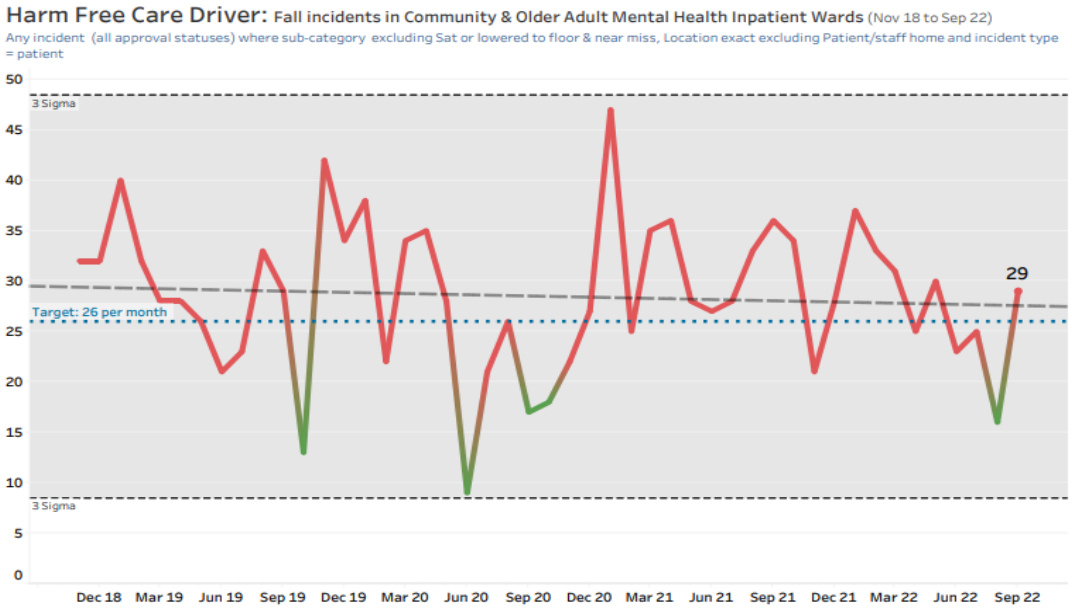
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

We intend to use SPC charts to gain a better understanding about what our data is telling us. We can use this understanding to support making improvements. It will ensure we don't overreact to normal variation within a system.

Components of an SPC Chart

The charts have the following components with an example below:



- A target line (the blue dotted line)
- A longer series of data points
- Upper Control Limit (UCL) to 3 Sigma
- Lower Control Limit (LCL) to 3 Sigma
    - These process limits (UCL & LCL) are defined by our data and calculated automatically. If nothing changes with the process, we can expect 99% of data points to be within these limits. They tell us what our system is capable of delivering. Our data will vary around these process limits. It provides a context for targeting improvement.

Variation

There are 2 types of variation:

1. Common cause variation, which is 'normal' variation (within the UCL & LCL)
2. Special cause variation (or unusual variation) which is something outside of the normal variation and outside of the process control limits (UCL & LCL)

Rules

- A series of 6 or more data points above or below the target is statistically relevant. It indicates that something in process has changed.
- A trend: either rising or falling of more than 6 data points – we should investigate what has happened.
    - We should reset baseline following a run of 6 data points (either up or down).
- Follow the True North Performance business rules for other metric actions.

Performance Scorecard - True North Drivers

Harm Free Care

Metric	Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Restrictive Interventions in Mental Health Inpatient Wards	309	Internal	301	246	294	198	196	160	200	172	221	267	233	265

Patient Experience

			Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Positive Patient Experience Score %	95% compliance	External	95.2%	94.3%	93.3%	94.3%	94%	94.7%	94.0%	94.5%	93.6%	94.3%	93.9%	94.5%
Patient Experience Compliance Rate %	10% compliance	External	4.2%	3.3%	3.6%	3.2%	2.7%	3.3%	3.5%	3.2%	7.0%	7.3%	6.5%	5.7%

			Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	677	460	348	465	390	559	371	268	353	248	351	275	262

			Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	External	766	727	895	779	738	850	752	663	554	648	820	979

Performance Scorecard - True North Drivers

Supporting our Staff

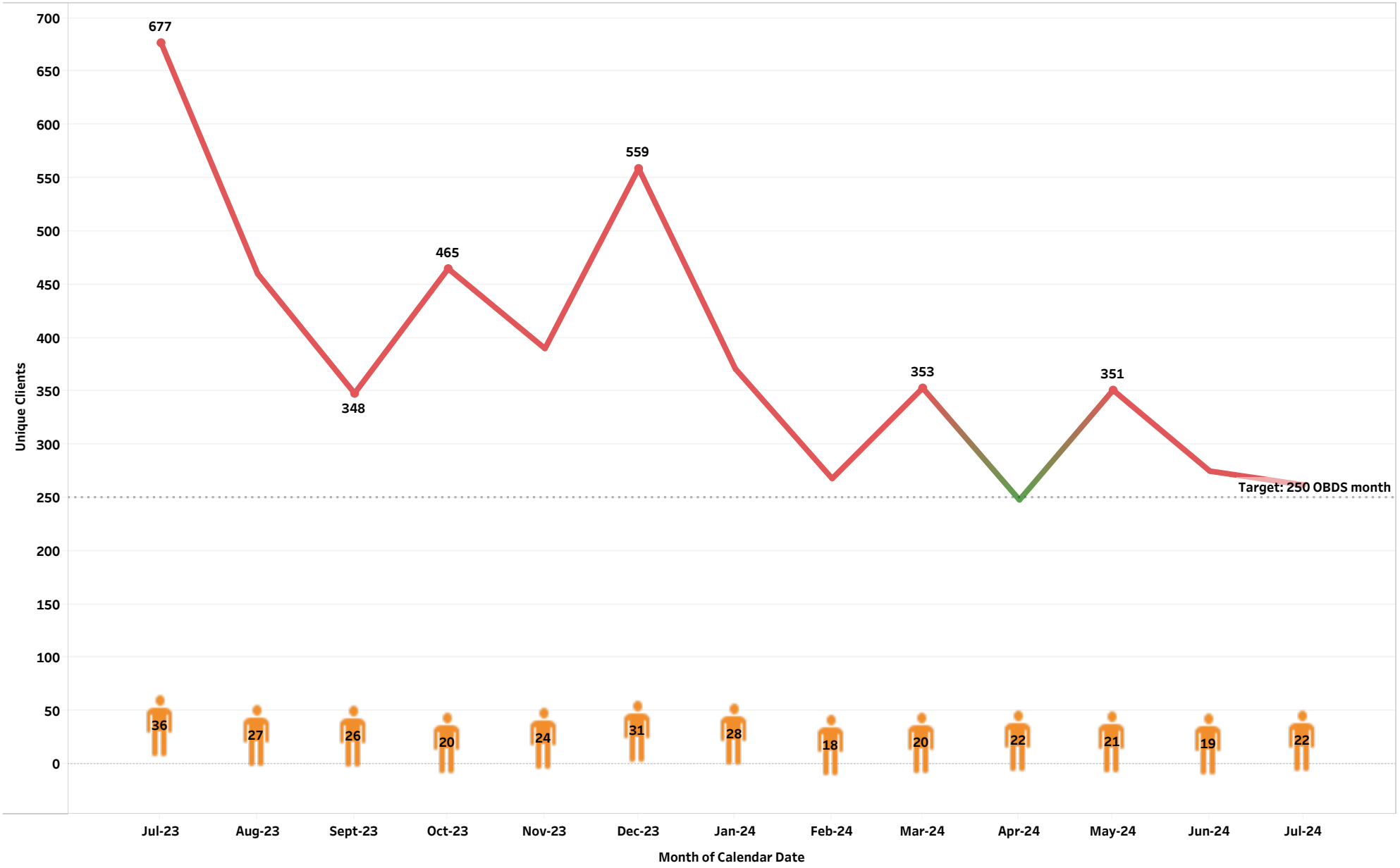
Metric	Threshold / Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Breakthrough Physical Assaults on Staff	44 per month	Internal	61	52	52	74	108	66	72	57	28	39	40	41
Staff turnover (excluding fixed term posts)	10% by March 2025	External	14.09%	13.63%	13.42%	13.03%	12.87%	12.33%	12.83%	12.28%	12.4%	12.60%	12.59%	12.49%

Efficient Use of Resources

YTD variance from control total (£'k)	0	External	-1430	-1983	-1492	-1459	-1712	-1914	-1648	-2476	0	0	-26	-103
Active Inappropriate OAPS at end of month	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External									5	3	4	3

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

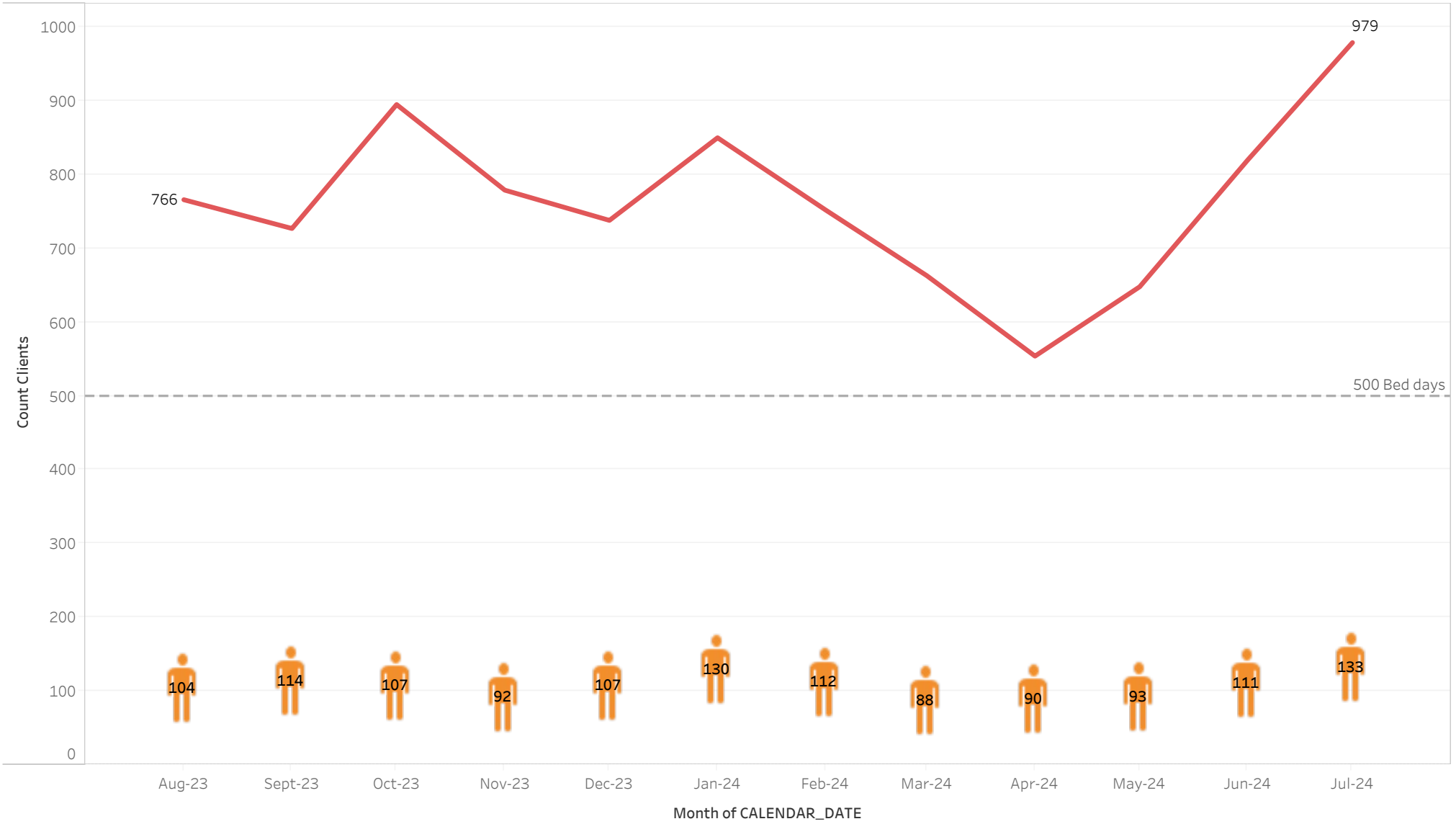
All Mental Health wards excludes Campion ward (Learning Disability)



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

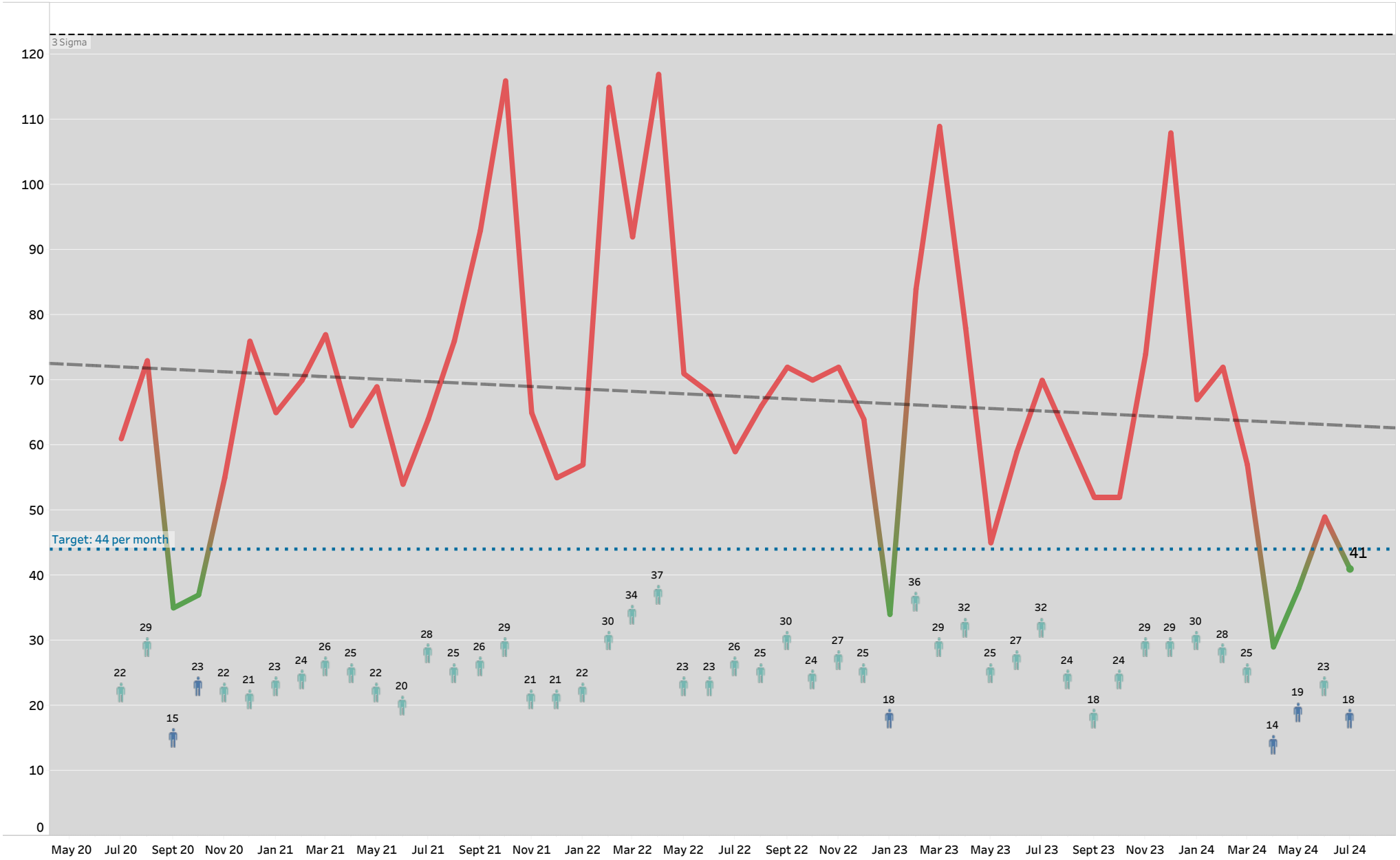
(July 2023- June 2024)

All Community health wards

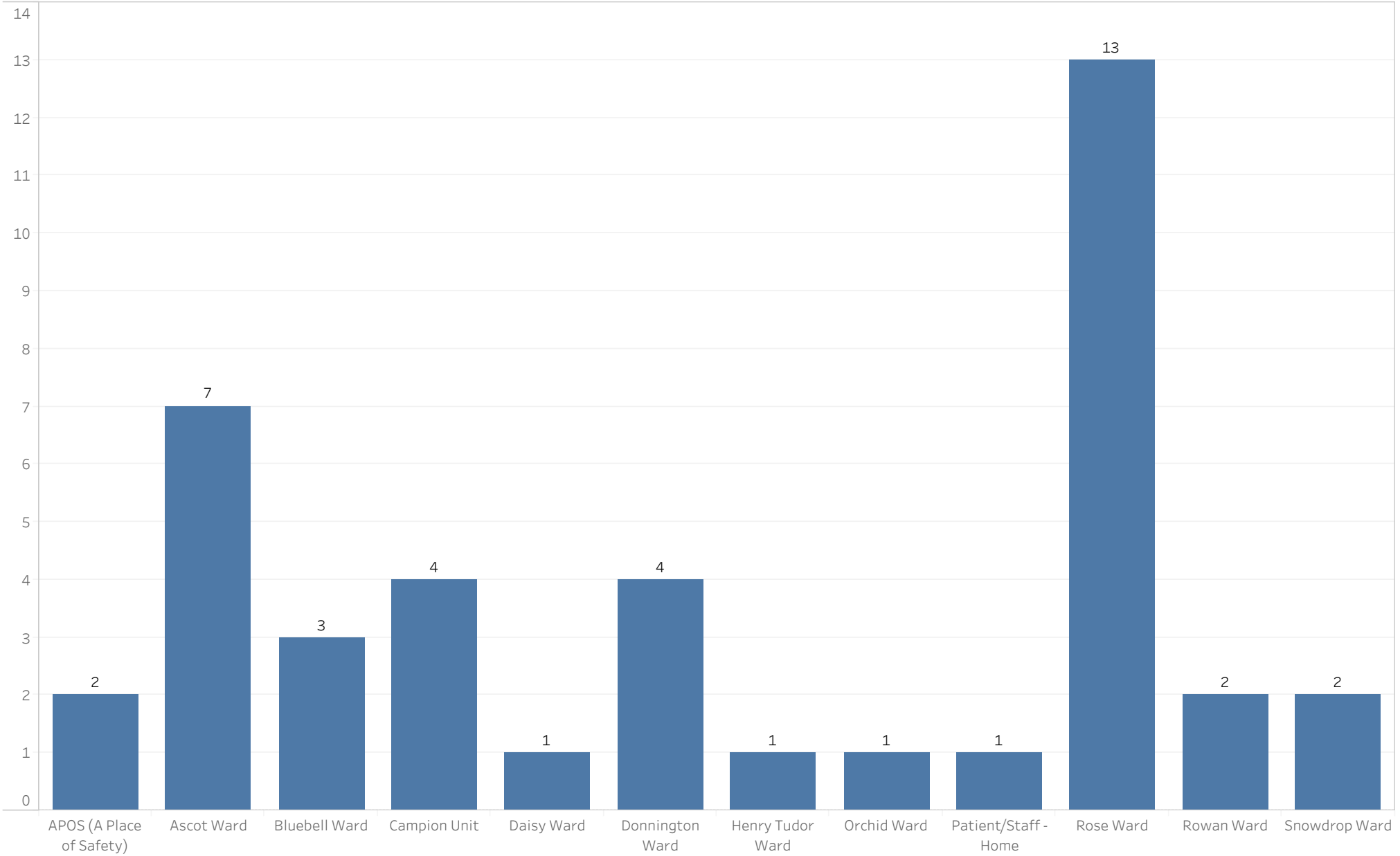


Supporting Our Staff Driver: Physical Assaults on Staff (Jul 20 to Jul 24)

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



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



True North Supporting Our Staff Summary

Metric	Threshold / Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Statutory Training: Fire: %	90% compliance	Internal	93.5%	93.1%	93.4%	94.0%	93.9%	93.9%	93.5%	93.5%	94.6%	95.5%	95.3%	95.7%
Statutory Training: Health & Safety: %	90% compliance	Internal	96.3%	96.4%	96.5%	96.4%	96.5%	96.4%	96.6%	96.7%	96.9%	97.0%	97.3%	97.3%
Statutory Training: Manual Handling: %	90% compliance	Internal	94.3%	93.4%	93.4%	93.7%	93.0%	93.3%	93.0%	92.2%	93.7%	93.7%	94.3%	94.8%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.7%	97.4%	97.5%	97.6%	97.4%	97.5%	97.1%	96.7%	97.7%	98.2%	98.1%	98.2%
Sickness Rate: %	<3.5%	External	3.7%	3.9%	4.6%	4.6%	4.6%	4.8%	4.1%	3.7%	3.9%	3.8%	3.7%	
PDP (% of staff compliant) Appraisal: %	95% compliance by 31 May 2025	Internal	92.5%									34.2%	89.1%	96.3%

True North Patient Experience

Metric	Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: %	95%	External	99.42	99.17	99.22	99.20	99.14	99.5	99.40	99.35	98.60	99.37	98.89	98.76
Community Health Services: 2 Hour Urgent Community Response %.	80% local, 70% National	External	85.2%	86.3%	88.5%	82.0%	81.8%	82.5%	86.7%	87.7%	86.2%	84.6%	84.7%	88.7%
Number of Adults on community Health waiting lists by system (BOB)	No Trust Target	External	7694	7253	7240	6880	6819	7039	6596	7095	6936	7231	7432	7102
Number of Adult on community Health waiting lists by system (Frimley)	No Trust Target	External	7448	7625	7191	7006	6086	5962	5798	5796	5678	6124	6376	6223	5882
Community Dentistry Activity	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	3519	4273	5112	6026	7034	7359	8412	9349	9827	725	1441	2116	2314
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	External	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	External	99.57	99.53	100	100	100	100	100	100	100	100	100	99.59
Number of Patients not seen on RTT waiting over 52 weeks	0	External	0	0	0	0	0	1	1	0	1	0	1	0	0
Number of Patients not seen on RTT waiting over 65+ weeks	0	External	0	0	0	0	0	1	1	0	1	0	1	0	0
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	100	99.00	99.07	95.93	97.79	95.18	99.53	97.03	98.21	71	98.92	96.20

True North Patient Experience

Metric	Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	21	26	28	24	29	26	31	26	23	15	18	28
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	90.0%	88.8%	84.6%	86.5%	89.2%	81.6%	91.4%	86.1%	80.2%	86.6%	85.8%	96.6%
Number of CYP (0-17 years) on Community Health waiting lists by system Frimley	No Trust Target	External	2399	2381	2376	2317	2304	2201	2284	2165	2244	2206	2359	2347	2113
Number of CYP (0-17 years) on Community Health waiting lists by system BOB	No Trust Target	External	1864	1820	1681	1763	1573	1531	1351	1374	1281	1370	1433	1305
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	Internal	75%	100%	100%	100%	50%	50%	100%	100%	40%	50%	100%	100%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	Internal	100%	100%	100%	100%	100%	87.5%	85.7%	60%	100%	90.9%	66.7%	80%
Access to Children and Young People's Mental Health Service 0-17 1+ Contact Frimley	Cumulative Year to Date Target for Frimley for 2024/25 Minimum 2353. Cumulative YtD figures shown	External	4337	4487	4618	4757	4859	5011	5167	5318	5481	5645	5808	6071
Access to Children and Young People's Mental Health Service 0-17 1+ Contacts BOB	Cumulative Year to Date Target for Frimley for 2024/25 Minimum 2353.Cumulative YtD figures shown	External	6158	6407	6584	6802	6962	7191	7385	7587	7801	8030	8234	8478
Access to Children and Young People's Mental Health Service Aged 18-24 1+ Contacts measured from Data Set BOB	Cumulative Year to Date figure given 2024/25 Minimum BOB target 222	External	2393	2489	2573	2665	2732	2824	2881	2954	3025	3112	3179	3279
Access to Children and Young People's Mental Health Service 18-24 1+ Contact Frimley	Cumulative Year to Date figure given 2024/25 Minimum BOB target 222	External	1582	1631	1690	1755	1828	1860	1927	1977	2037	2087	2156	2194

True North Patient Experience

Metric	Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Talking Therapies Referral to Treatment 75% within 6 weeks BOB	75%	External	91%	88%	86%	89%	86%	88%	90%	93%	99%	91%	91%	88%
Talking Therapies Referral to Treatment 75% within 6 weeks Frimley	75%	External	91%	85%	90%	89%	91%	88%	92%	90%	90%	91%	93%	87%
Talking Therapies Referral to Treatment 95% within 18 weeks BOB	95%	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Talking Therapies Referral to Treatment 95% within 18 weeks Frimley	95%	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%

True North Patient Experience

Metric	Proposed Target..	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Talking Therapies Recovery rates BOB	50%	External	48.79%	46%	42%	49%	49.39%	49%	44%	49.5%	50%	52.80%	46%	53%
Talking Therapies Recovery rates Frimley	50%	External	43.5%	46%	45%	41%	47.39%	48%	44%	47%	45%	51%	47%	50%
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67%	External									59%	63.80%	65%	62%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67%	External									64%	62.79%	63%	64%
Talking Therapies Reliable Recovery for those completing a course of treatment Frimley	48%	External									43%	45.5%	44%	47%
Talking Therapies Reliable Recovery for those completing a course of treatment BOB	48%	External									46%	48.5%	46%	49%
Talking Therapies In treatment pathway waits 90 day for 2nd Appointment Frimley	<10%	External	7.79%	11.4%	13%	11.7%	12.8%	11%	9.80%	11.5%	15.2%	16.1%	18.6%	20%
Talking Therapies in treatment pathway waits 90 day for 2nd Appointment BOB	<10%	External	12.3%	13.8%	17%	15.6%	17.8%	22%	18.1%	16.1%	16.4%	15.9%	15.1%	18%

True North Patient Experience

EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	External	100	100	81.82	100	80	85.70	100	100	100	100	100	83
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illness 2+ contacts BOB	Cumulative Year to Date 24/25 Minimum Frimley Target 7860	External	5305	5498	5677	5871	6028	6227	6445	6700	6903	7869	8076	8370
Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illness 2+ contacts Frimley	Cumulative Year to Date 24/25 Minimum Frimley Target 7860	External	4216	4368	4529	4740	4852	5014	5162	5349	5509	6172	6325	6508
Access to Perinatal Services- Assessments Frimley	7.5% live birth rate - 409 Oct 23 439 March 2023. 37 per Month	External	31	21	30	37	25	40	23	22	20	22	32	34
Access to Perinatal Services - Assessments BOB	10% live birth rate - 611 per annum 51 per month	External	52	24	24	31	43	43	39	44	30	44	30	38
Access to Perinatal Services - % Birth Rate BOB	Target 10% live birth rate per Quarter	External												
Access to Perinatal Services- % Birth Rate Frimley	7.5 % live birth rate per Quarter	External												
Physical Health Checks 7 Parameters for people with severe mental illness (SMI)	90% from 1st July 2024. Previously 85%	Internal	86%	90%	87%	90%	91%	91%	92%	96%	90%	93%	94%	95%
Mixed Sex Breaches on Ward	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Patient on Patient Assaults (MH)	25 per month	Internal	12	11	8	10	14	9	14	18	17	14	10	10
Estimated Diagnosis rate for Dementia Frimley	66.67%	External	63.88%	64.62%	64.48%	64.71%	65.25%	65.56%	64.88%	64.98%	66.10%	66.14%	66.53%	68%
Estimated Diagnosis rate for Dementia BOB	66.67%	External	63.88%	64.20%	64.29%	64.54%	64.39%	64.54%	64.12%	64.60%	65.60%	65.36%	64.92%	64.90%

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Mental Health: AWOLs on MHA Section	10 per month	Internal	10	7	5	2	3	6	7	3	5	7	5	7
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	2	3	7	0	0	1	1	1	1	1	1	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	1.35	10.2	1.42	1.40	0	3.03	3.37	4	0	0	0	3.45
Pressure Ulcer with Learning	Tbc	Internal	5	2	4	4	1	0	3	2	2	4	1	4
Mental Health 72 Hour Follow Up	80% local, 70% National	External	87.5%	92%	89.1%	86.9%	86.2%	95.1%	100%	86.0%	91.5%	93.1%	94.1%	91.0%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	Internal	37	43	53	28	17	26	41	73	79	65	61	63
Self-Harm Incidents within the Community	31 per month	Internal	32	29	23	18	21	9	21	35	30	28	29	10
Gram Negative Bacteraemia	1 per ward per year	External	0	0	0	1	0	1	0	0	0	0	0	0
E-Coli Number of Cases identified	< 8 Q1, 5 Q2, 3 Q3, 1 Q4	External	1	0	1	0	1	1	1	1	1	0	0	1
C.Diff with learning (Cumulative YTD)	0	External	0	0	0	0	0	0	0	0	0	0	1	1
Meticillin-resistant Staphylococcus aureus (MRS..	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSS..	0	External	1	1	1	1	1	1	1	1	0	0	0	0
Count of Never Events (Safe Domain)	0	Internal	0	0	0	0	0	0	0	0	0	0	0	0
Patient Safety Alerts not completed by deadline	0	External	0	0	0	0	0	0	0	1	1	1	1	1
Unnatural MH inpatient deaths	0	Null	0	0	0	0	0	0	0	0	0	0	0	0
PHSO Upheld Complaints	0	Null	0	0	0	0	0	0	0	0	0	0	0	0

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Community Inpatient Occupancy	85%	Internal	77.8%	83.5%	88.0%	92.9%	87.7%	89.2%	89.4%	90.3%	90.6%	91.8%	91.6%	88.8%
Community Inpatient Average Length of Stay (bed days)	<21 days	Internal	25.1	24.0	23.6	28.8	37.3	24.5	28.1	26.5	33.3	25.8	26.2	21.7
Mental Health: Adult Acute LOS over 60 days % of total discharges	TBC	External	25%	24%	24%	24%	30%	28.9%	30%	34%	31%	28.0%	28.0%	33%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges	TBC	External	32%	28.9%	42%	42%	66%	57.9%	55.0%	52%	59%	63%	63%	50%
DNA Rate: %	5% DNAs	Internal	4.85%	4.65%	4.88%	5.05%	4.76%	4.70%	4.66%	4.66%	4.70%	5.26%	4.79%	4.83%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	93.3%	94.6%	97.2%	93.6%	93.8%	95.9%	98.5%	99.4%	98.5%	97.7%	97.1%	97.3%
Mental Health: Acute Average Length of Stay (bed days)	30 days	Internal	62.4	64.3	43.2	56.6	45.1	72.6	41.7	36.4	60.6	58.7	47.2	49.6
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	87.29%	89.92%	90.82%	87.18%	77.85%	72.48%	79.31%	84.04%	95.34%	82.42%	81.71%	83.87%
Community Virtual Ward Occupancy Frimley	80%	External	54%	55.30%	51.20%	49.79%	46%	56.59%	46.40%	54%	42.19%	50.60%	52.5%	57.59%
Community Virtual Ward Occupancy BOB	80%	External	96.79%	94.29%	78.5%	74.20%	91.60%	95.5%	82.39%	75.79%	88.90%	91.90%	94.79%	82.59%
Agency Spend within Ceiling	3.2%	External									2.70%	3%	2.19%	3.10%
Elective Recovery Performance vs Target	11614	External									12238	11898	12179	13710

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2024
Title	**Finance, Investment and Performance Committee Meetings – Updated Terms of Reference**
	Item for Ratification
Reason for the Report going to the Trust Board	The Finance, Investment and Performance Committee is a sub-committee of the Trust Board. The Committee reviewed its terms of reference at its meeting on 24 July 2024 and agreed that section 5.2.6 relating to reviewing credit ratings, benchmarking of investments and borrowing activities" should be deleted as this was no longer relevant to the Committee's work.
Business Area	Corporate
Author	Company Secretary for Naomi Coxwell, 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

Finance, Investment & Performance Committee

Terms of Reference

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Document Control

Version	Date	Author	Comments
1.0	28 Jan 08	Philippa Slinger	
2.0	5 Feb 08	Philippa Slinger	Following comments by F&I Chair
3.0	5 March 08	Garry Nixon	Following Approval by Board
4.0	7 May 09	John Tonkin	Amendments following F&I Committee meeting 29 April 2009
5.0	16 August 2010	John Tonkin	Amendments following F&I Committee meeting 28 July 2010
6.0	10 March 2011	John Tonkin	Amendment to include scrutiny of integrated performance information following agreement at Board meeting 8 March 2011
7.0	8 May 2012	John Tonkin	Amendment to membership on recommendation of Committee following Board consideration on 8 May 2012
8.0	25 February 2015	John Tonkin	Amended following review by F,I&P Committee – for Board approval – June 2015
9.0	22 February 2017	Julie Hill	Amended following review by F,I&P Committee – for board approval July 2017
10	June 2019	Julie Hill	Amended following review by F,I&P Committee – for board approval September 2019
11	August 2020	Julie Hill	Updated in August 2020
12	July 2021	Julie Hill	Updated in August 2021 following review by F,I &P Committee approval August 2021 –Board approved September 2021
13	July 2024	Julie Hill	Updated in July 2024 - Section 5.2.6 relating to reviewing credit ratings benchmarking of investments and borrowing activities was deleted

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1. Authority

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

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

2. Purpose

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

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

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

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

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

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

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

2.1.7 review the relevant risks on the Board Assurance Framework.

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

2.1.9 Review the Trust's Employee Casework

2.10 Review any ad hoc areas delegated by the Trust Board

3. Membership

3.1 The members of the Committee shall be as follows:

- Three Non-Executive Directors
- Chief Executive
- Chief Financial Officer (Lead Executive Director)

- Chief Operating Officer
- Director of Nursing & Therapies or Deputy Director of Nursing

The Director of Finance will be in attendance at the meetings

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

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

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

4. Frequency and Administration of Meetings

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

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

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

5. Remit

5.1 Financial Policy and Performance

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

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

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

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

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

5.2 Investment Policy and Performance

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

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

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

5.2.4 To ensure adequate safeguards on investment of funds.

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

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

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

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

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

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

5.4 Other areas delegated to the Committee by the Trust Board

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

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

Amended: July 2022

Approved by Trust Board: September 2022

For review July 2024

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2024
Title	Workforce Race Equality Standard (WRES)
	Item for Discussion
Reason for the Report going to the Trust Board	This report sets out our 2024 data and approach to action against the Workforce Race Equality Standard (WRES) metrics that are part of the NHS Standard contract
Business Area	People Directorate
Author	Ash Ellis, Deputy Director for Leadership, Inclusion, Organisational Experience. Alex Gild, Deputy Chief Executive (Executive Sponsor)
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Anti-racism commitment in addressing staff experience differential.
SUMMARY	This paper provides the Board with an overview of any inequalities experienced by our workforce. It provides data, benchmarking and highlights where we are doing well and where we need to do better.

Workforce Race Equality Standard 2024

Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This report sets out our 2024 data and approach to action against the Workforce Race Equality Standard (WRES) metrics

Executive Summary

- The WRES is the national framework through which Trusts are required to measure their performance against nine key indicators for staff representation and experience with regard to race. This comprises Trust workforce data indicators (1 – 4) Nationally set, Trust Staff Survey data indicators (5 – 8) and an indicator (9) focused on ethnically diverse Board representation.

- The number of ethnically diverse colleagues has increased by 154 to 1,565 from 1,411. 29.99% of our colleagues are ethnically diverse, compared to 28.40% last year. 1,565 are ethnically diverse. We have more ethnically diverse colleagues, and less white colleagues compared to the Berkshire population. Recruitment data shows we are recruiting an increasing number of ethnically diverse candidates and that the number of international applicants skews our data on chances of being appointed if you are from an ethnically diverse background due to right to work in the UK.

- Overall, we have seen positive change and improvement across 6 of the 9 indicators, with three moving in the wrong direction.

- Indicator 3 is the 'Relative likelihood of ethnically diverse staff entering the formal disciplinary process compared to White staff'. This has declined from 1.21 to 2.43, meaning ethnically diverse colleagues are more likely to enter the formal disciplinary process than our white colleagues.

- Indicator 4 is the 'Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to ethnically diverse staff'. It has declined from 1.44 to 1.55, meaning white colleagues are 1.55 times more likely to access CPD than ethnically diverse colleagues.

- Indicator 8 is the 'Percentage of staff who experienced discrimination at work from manager / team leader or other colleagues in last 12 months'. It has declined slightly from 13.2 to 13.3.

- Although improvement can be seen, we must not pause in our work to reduce inequality of experience for our colleagues. We must acknowledge that we are moving in the right direction but a lot more progress needs to be made, and targeted work has already begun, particularly with the three indicators where we have not improved, as part of our Anti-racism action plan.

- Our anti-racism strategy to dismantle racism, and become an anti-racist organisation forms our WRES action plan. This has been developed and co-created by

	engagement with our Race Equality Network (REN) and Trust-wide colleagues, and our communities.
Recommendation	The Board is asked to acknowledge the WRES report and subsequent approach to actions.

1. Background

This paper provides an overview of our annual performance against the Workforce Race Equality Standard (WRES) metrics for 2023-24. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The NHS Equality and Diversity Council (EDC) introduced WRES as a framework for NHS Trusts to focus specifically on race. This was in response to the 2014 study by Roger Kline titled 'The snowy white peaks of the NHS', which highlighted the link between good patient care and an NHS workforce that is representative of the local population it serves.

The WRES came into effect on 1st April 2015. The standard is designed to improve the representation and experience of ethnically diverse staff at all levels of the organisation – particularly senior management.

In the context and requirement of the WRES, we will be using language set out in the WRES technical guidance. White staff comprises White British, White Irish and White Other (Ethnic codes A, B, C) whereas ethnically diverse staff comprise all other categories excluding 'not stated'. We have tried to consider further breakdown of ethnically diverse, and other ethnic groups refers to; Chinese and any other ethnic group.

Overall, there are nine indicators that make up the NHS WRES. These comprise:

- Workforce indicators (1 – 4),
- Staff Survey indicators (5 – 8)
- and an indicator focused on board representation (9).

The WRES is now mandated as part of the standard NHS Contract, and this supports closer scrutiny of the progress we make and outcomes we achieve.

2. What is our Workforce data telling us?

Data in 2024 shows our total staff is at 5,212, an increase of 244 from 4,968 in 2023.
The number of ethnically diverse colleagues has increased by 154 to 1,565 from 1,411.
29.99% of our colleagues are represented in the ethnically diverse category, compared to 28.40% last year. 1,565 are ethnically diverse, 3,530 are White and 124 have not stated.
Figure 1 below shows our ethnicity profile.

Figure 1: Workforce ethnicity profile 2023/2024

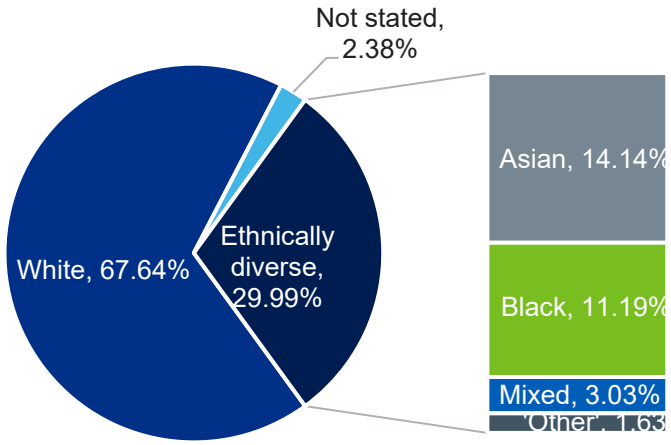


Figure 2: BHFT Workforce compared to Berkshire Population (from census data,2021)

	Ethnically diverse	White	Not stated
BHFT Workforce	29.99%	67.64%	2.38%
Berkshire Population	26.92%	73.08%	0

Further breakdown of ethnicity

	Asian or Asian British *(Indian, Pakistani, Bangladeshi, any other Asian background)*	Black or Black British *(Caribbean, African, any other black background)*	Mixed *(White & Black Caribbean, White & Black African, White & Asian, any other mixed background)*	Other Ethnic Groups *(Chinese, any other ethnic group)*	White *(British, Irish, any other white background)*	Not stated
BHFT Workforce	14.14% (738)	11.19% (584)	3.03% (158)	1.63% (85)	67.64% (3530)	2.38% (124)
Berkshire Population	17.13%	3.33%	3.56%	2.42%	73.08%	0

It is also useful to look at how representative our workforce is of our local population (Figure 2). The data shows that our workforce is more ethnically diverse by 3.07% compared to overall Berkshire population. The data also shows that our workforce is made up of 5.44% less White population compared to overall Berkshire population. The further breakdown of ethnicity shows that we are underrepresented in our workforce population for Asian, Mixed and Other Ethnic Groups, and overrepresented for Black groups compared to the overall Berkshire population.

(caveat, the census includes non-working age).

Figure 3: Workforce Full time Equivalent (FTE)

	Average FTE contract	Total	Total who work full time (37.5 hours)	% who work full time
White	0.83	3607	1993	55.3
Not stated	0.87	118	80	67.8
Ethnically diverse	0.9	1681	1253	74.5

This year we also looked at FTE, and we have found that there is a significant difference between Ethnically diverse staff who work 1 FTE vs anyone who works less than this compared to White staff. Only 55% of White staff work 37.5 hours a week, whereas 75% of Ethnically Diverse staff work 37.5 hours per week. This data needs more exploration to understand the disparity.

3. WRES Indicators

Indicator 1: Percentage of White staff in Bands 1 to 9 and VSM compared with the percentage of Ethnically Diverse staff in the overall workforce.

Figure 4: Workforce Profile – Non-Clinical Staff 2022-24 (across 3 years)

Pay Band	2022 Non-Clinical Workforce Data				2023 Non-Clinical Workforce Data				2024 Non-Clinical Workforce Data			
	Total Non-Clinical Staff	White	Ethnically diverse	Ethnicity Unknown	Total Non-Clinical Staff	White	Ethnically diverse	Ethnicity Unknown	Total Non-Clinical Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	5	2 (40%)	3 (60%)	0 (0%)	2	1 (50%)	1 (50%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	70	56 (80%)	14 (20%)	0 (0%)	60	48 (80%)	12 (20%)	0 (0%)	65	49 (75%)	16 (25%)	0 (0%)
Band 3	274	216 (79%)	55 (20%)	3 (1%)	275	215 (78%)	58 (21%)	2 (1%)	298	221 (74%)	74 (25%)	3 (1%)
Band 4	272	199 (73%)	64 (24%)	9 (3%)	298	208 (70%)	77 (26%)	13 (4%)	305	217 (71%)	79 (26%)	9 (3%)
Band 5	130	99 (76%)	30 (23%)	1 (1%)	143	107 (75%)	34 (24%)	2 (1%	153	110 (72%)	41 (27%)	2 (1%)
Band 6	134	95 (71%)	36 (27%)	3 (2%)	153	107 (70%)	42 (27%)	4 (3%)	163	111 (68%)	50 (31%)	2 (1%)
Band 7	103	65 (63%)	34 (33%)	4 (4%)	123	80 (65%)	40 (33%)	3 (2%)	126	84 (67%)	39 (31%)	3 (2%)
Band 8a	84	58 (69%)	24 (29%)	2 (2%)	95	65 (68%)	27 (29%)	3 (3%)	95	69 (73%)	22 (23%)	4 (4%)
Band 8b	58	51 (88%)	6 (10%)	1 (2%)	66	54 (82%)	11 (17%)	1 (1%)	55	40 (73%)	14 (25%)	1 (2%)
Band 8c	36	28 (78%)	7 (19%)	1 (3%)	33	28 (85%)	4 (12%)	1 (3%)	35	29 (83%)	5 (14%)	1 (3%)
Band 8d	15	11 (73%)	1 (7%)	3 (20%)	16	13 (81%)	1 (6%)	2 (13%)	15	12 (80%)	1 (7%)	2 (13%)
Band 9	7	3 (43%)	1 (14%)	3 (43%)	8	5 (62%)	3 (38%)	0 (0%)	4	3 (75%)	1 (25%)	0 (0%)
VSM	4	1 (25%)	0 (0%)	3 (75%)	9	6 (67%)	2 (22%)	1 (11%)	8	6 (75%)	1 (12.5%)	1 (12.5%)
Total	1192	**884**	**275**	**33**	**1272**	**937**	**312**	**32**	**1329**	**956 (72%)**	**344 (26%)**	**29 (2%)**

- NB. Exec Board Members excluded prior to 2023 as part of WRES submission.
- 29 people have not declared their ethnicity, although this has decreased year on year. It is worth noting for those in pay Bands 8d, and VSM, due to the small numbers, where colleagues have not declared their ethnicity, this can potentially skew the figures.
- Our ethnically diverse representation has grown in bands 2,3,4,5,6, 8b, and 8c. It has decreased in bands 7, 8a, 9 and VSM.
- In comparison with our overall ethnically diverse workforce (29.99%) we have over-representation of ethnically diverse colleagues in bands 6 and 7, under-representation of ethnically diverse colleagues compared to overall workforce in bands 2, 3, 4, 5, 6, 8a, 8b, 8c, 8d, 9 and

VSM. We have under-representation of ethnically diverse colleagues by more than 10% of overall ethnically diverse workforce in bands 8c, 8d and VSM.

- In comparison with our overall white workforce (67.64%) we have over-representation in all bands with the exception of band 7 which is the same. We have over-representation of white colleagues by more than 10% compared to our overall white workforce in bands 8c and 8d.

Figure 5: Workforce Profile - Clinical Staff 2022-24 (across 3 years)

Pay Band	2022 Clinical Workforce Data				2023 Clinical Workforce Data				2024 Clinical Workforce Data			
	Total Clinical Staff	White	Ethnically diverse	Ethnicity Unknown	Total Clinical Staff	White	Ethnically diverse	Ethnicity Unknown	Total Clinical Staff	White	Ethnically diverse	Ethnicity Unknown
Under Band 1	7	2 (29%)	4 (57%)	1 (14%)	13	9 (69%)	4 (31%)	0 (0%)	7	5 (71%)	2 (29%)	0 (0%)
Band 1	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)	0	0 (0%)	0 (0%)	0 (0%)
Band 2	180	83 (46%)	88 (49%)	9 (5%)	167	79 (47%)	83 (50%)	5 (3%)	183	70 (38%)	105 (58%)	8 (4%)
Band 3	368	242 (66%)	119 (32%)	7 (2%)	358	235 (66%)	114 (32%)	9 (2%)	354	226 (64%)	122 (34%)	6 (2%)
Band 4	439	340 (77%)	91 (21%)	8 (2%)	484	363 (75%)	110 (23%)	11 (2%)	515	384 (75%)	122 (24%)	9 (1%)
Band 5	462	260 (56%)	183 (40%)	19 (4%)	468	254 (54%)	200 (43%)	14 (3%)	500	268 (54%)	219 (44%)	13 (2%)
Band 6	862	628 (73%)	205 (24%)	29 (3%)	811	580 (71%)	207 (26%)	24 (3%)	784	542 (69%)	225 (29%)	17 (2%)
Band 7	682	504 (74%)	158 (23%)	20 (3%)	760	557 (73%)	181 (24%)	22 (3%)	869	631 (73%)	218 (25%)	20 (2%)
Band 8a	243	182 (75%)	59 (24%)	2 (1%)	271	203 (75%)	60 (22%)	8 (3%)	296	222 (75%)	68 (23%)	6 (2%)
Band 8b	81	68 (84%)	12 (15%)	1 (1%)	98	79 (81%)	17 (17%)	2 (2%)	113	91 (81%)	19 (17%)	3 (2%)
Band 8c	23	17 (74%)	6 (26%)	0 (0%)	26	20 (77%)	6 (23%)	0 (0%)	35	31 (89%)	4 (11%)	0 (0%)
Band 8d	18	17 (94%)	1 (6%)	0 (0%)	18	18 (100%)	0 (0%)	0 (0%)	20	18 (90%)	2 (10%)	0 (0%)
Band 9	3	3 (100%)	0 (0%)	0 (0%)	3	3 (100%)	0 (0%)	0 (0%)	6	6 (100%)	0 (0%)	0 (0%)
VSM	0	0 (0%)	0 (0%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)	1	0 (0%)	1 (100%)	0 (0%)
Total	**3368**	**2346**	**926**	**96**	**3478**	**2400**	**983**	**95**	**3683**	**2494 (68%)**	**1106 (30%)**	**82 (2%)**

- NB. Exec Board Members excluded prior to 2023.
- Our ethnically diverse representation has grown in bands 2, 3, 4, 5, 6, 7, 8a, 8b and 8d. Stayed the same in band 9. It has decreased in band 8c.
- In comparison with our overall ethnically diverse workforce (29.99%) we have over-representation of ethnically diverse colleagues in bands 2, 3, 5 and VSM, under-representation of ethnically diverse colleagues compared to the overall ethnically diverse workforce in bands 4, 6, 7, 8a, 8b, 8c, 8d and VSM. We have under-representation of ethnically diverse colleagues by more than 10% of overall ethnically diverse workforce in bands 8b, 8c, 8d and 9.

- In comparison, with our overall white workforce (67.64%) we have over-representation in bands 4, 6, 7, 8a, 8b, 8c, 8d and 9. We have over-representation of white colleagues by more than 10% of overall white workforce in bands 8b, 8c, 8d and 9. We have under-representation of white colleagues in bands 2, 3, 5 and VSM.
- 82 people have not declared their ethnicity, although this has decreased by 13 since last year.

Figure 6: Workforce Profile – Medical & Dental staff 2022-2024 (across 3 years)

Pay Band	2022 Clinical (Medical & Dental) Workforce				2023 Clinical (Medical & Dental) Workforce				2024 Clinical (Medical & Dental) Workforce			
	Total Medical & Dental Staff	White	Ethnically Diverse	Ethnicity Unknown	Total Medical & Dental Staff	White	Ethnically Diverse	Ethnicity Unknown	Total Medical & Dental Staff	White	Ethnically Diverse	Ethnicity Unknown
Consultants	**100**	37 (37%)	51 (51%)	12 (12%)	**93**	39 (42%)	52 (56%)	2 (2%)	**91**	37 (41%)	52 (57%)	2 (2%)
Snr Medical Manager	**0**	0	1	0	**0**	0	1	0	**1**	0	1 (100%)	0
Non-consultant Career Grade	**82**	33 (40%)	43 (53%)	6 (7%)	**82**	30 (37%)	48 (58%)	4 (5%)	**81**	30 (37%)	44 (54%)	7 (9%)
Trainee Grade	**25**	9 (36%)	15 (60%)	1 (4%)	**27**	11 (41%)	14 (52%)	2 (7%)	**35**	13 (37%)	18 (51%)	4 (11%)
Other	**0**	0	0	0	**0**	0	0	0	**0**	0	0	0
Total	**207**	**79**	**109**	**19**	**202**	**80 (40%)**	**114 (56%)**	**8 (4%)**	**208**	**80 (39%)**	**115 (55%)**	**13 (6%)**

- The ethnicity declaration being ‘unknown’ has gone up from 8 to 13 for this year.
- We have more ethnically diverse medical colleagues overall than white medical colleagues. We have a QI project already underway looking at the reasons for this and how we can improve people sharing this.
- Our medical workforce has increased by 6 since last year.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to ethnically diverse applicants *(A value above 1 indicates that white candidates are more likely to be appointed than ethnically diverse candidates, and a value below 1 indicates that white candidates are less likely to be appointed than ethnically diverse candidates)*	**Berkshire Healthcare**	**1.46**	**1.53**	**1.51**	**1.4**
		NHS Trusts	**1.61**	**1.61**	**1.54**	

This year we have made improvements that is bringing us down closer to the target of below 1. Please also see Appendix 1 on our recruitment data.
We have an increasing number of applicants from candidates residing outside of the UK who do not have the right to work in the UK and will not qualify for a UK visa. This means that a disproportionately high number of ethnically diverse applications are not shortlisted. Even when we can employ international applicants, the sheer volume of applications means that a significant number of candidates are not shortlisted. For example, a recent advertisement for a Mental Health Nurse attracted 274 international applicants, many of whom were from diverse ethnic backgrounds. Due to the high number of applications, we could not interview all candidates, resulting in over 200 diverse candidates not being shortlisted.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24
3	Relative likelihood of ethnically diverse staff entering the formal disciplinary process compared to White staff *(A value of "1.0" for the likelihood ratio means that ethnically diverse and white staff are equally likely to enter formal disciplinary proceedings, whilst a value above 1 indicates that ethnically diverse staff are more likely to enter formal disciplinary proceedings than white staff, and a value below 1 indicates that ethnically diverse staff are less likely to enter formal disciplinary proceedings than white staff)*	Berkshire Healthcare	1.81	4.59	1.21	2.43
		NHS Trusts	1.16	1.14	1.14	

Last year we made the most progress we have made in this area for 3 years. However, this year this metric has declined by a whole point and more, taking us further way from the target of 1 or less. As part of our anti-racism work, we will be reviewing our approach to our casework in January 2025. We are also launching racial inclusivity training for investigators and HR colleagues in September 2024.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to ethnically diverse staff *(A value of "1.0" for the likelihood ratio means that white and ethnically diverse staff are equally likely to access non-mandatory training or CPD, whilst a value above 1 indicates that white staff are more likely to access non-mandatory training or CPD than ethnically diverse staff, and a value below 1 indicates that white staff are less likely to access non-mandatory training or CPD than ethnically diverse staff.)*	Berkshire Healthcare	1.51	1.28	1.44	1.55
		NHS Trusts	1.14	1.14	1.12	

This indicator has declined by 0.11 moving us away from our target of 1 or under. We receive relatively fewer applications for non-mandatory training and CPD from our ethnically diverse staff compared to our white staff. We are seeking to understand the reasons for this and will engage in open conversations with our ethnically diverse staff to hear how we can better support and motivate applications for these opportunities. However, once an application is submitted, our data shows, there are no significant differences in the likelihood of staff being offered training.

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

WRES Indicator	Metric Descriptor		Ethnically diverse 2020/21	White 2020/21	Ethnically diverse 2021/22	White 2021/22	Ethnically diverse 2022/23	White 2022/23	Ethnically diverse 2023/24	White 2023/24
5 Staff Survey Q14a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**Berkshire Healthcare**	31%	20%	29.4%	19.9%	29.4%	18.5%	**26.7%**	**17.1%**
		NHS Trusts	32%	25%	32%	26%	29.2%	27%	**%**	**%**

This indicator has improved for white colleagues over the past 4 years, and after having made no consistent progress since 2020/21, this indicator has improved this year by over 2.5%. Although progress is being made, the data indicates that ethnically diverse colleagues are 9.6% more likely to experience harassment, bullying or abuse from patients, relatives and the public than white colleagues.

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

WRES Indicator	Metric Descriptor		Ethnically diverse 2020/21	White 2020/21	Ethnically diverse 2021/22	White 2021/22	Ethnically diverse 2022/23	White 2022/23	Ethnically diverse 2023/24	White 2023/24
6 Staff Survey Q14b/c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	**Berkshire Healthcare**	23%	18%	23%	14%	20.8%	15.4%	**20.4%**	**13.7%**
		NHS Trusts	25%	20%	23%	18%	27.6%	22.5%	**%**	**%**

An improvement of 0.4% from 22/23 for ethnically diverse colleagues and a 1.7% improvement for our white colleagues. However, based on the above our ethnically diverse colleagues are still 6.7% more likely to experience harassment, bullying or abuse from colleagues than their white counterparts.

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

WRES Indicator	Metric Descriptor		Ethnically diverse 2020/21	White 2020/21	Ethnically diverse 2021/22	White 2021/22	Ethnically diverse 2022/23	White 2022/23	Ethnically diverse 2023/24	White 2023/24
7 Staff Survey Q15	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	**Berkshire Healthcare**	50%	70%	45.7%	67.5%	51.7%	68.1%	**53.3%**	**68.4%**
		NHS Trusts	46%	61%	47%	61%	44.4%	58.7%	**%**	**%**

We have seen an improvement for both our white colleagues (0.3%) and our ethnically diverse colleagues (1.6%) in their beliefs that the Trust provides equal opportunities for career progression or promotion. There is still a difference of 15.1% in favour of our white colleagues' perceptions.

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

WRES Indicator	Metric Descriptor		Ethnically diverse 2020/21	White 2020/21	Ethnically diverse 2021/22	White 2021/22	Ethnically diverse 2022/23	White 2022/23	Ethnically diverse 2023/24	White 2023/24
8 Staff Survey Q16b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	**Berkshire Healthcare**	12%	5%	14%	5%	13.2%	5%	**13.3%**	**5%**
		NHS Trusts	15%	6%	14%	6%	17%	6.8%	**%**	**%**

For our white colleagues this continues the 3-year trend staying at 5% but for our ethnically diverse colleagues, this has declined by 0.1%. Far too many of our colleagues' experience discrimination from their colleagues whilst at work. Also, our ethnically diverse colleagues experience discrimination 8.3% more than our white colleagues.

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

WRES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24
9 Board Representation	Percentage difference between Board voting membership and its overall workforce	**Berkshire Healthcare**	**(-) 15%**	**(-) 4.4%**	**+2.4%**	**+6.8%**
		NHS Trusts	**10%**	12.6%	**13.2%**	**%**

The indicator above shows that we have made great progress over 3 years going from -15% to +6.8% with a marked improvement this year. The difference between percentage ethnically diverse representation on the Board and in the workforce overall is 6.8%
Our ethnically diverse workforce is 29.99% and our ethnically diverse Board Membership is 33%. Executive Board Member is 33% ethnically diverse, and Non-Executive Board Member is 14% ethnically diverse.

4. Berkshire Healthcare Race Disparity Ratio

Figure 9: Race Disparity Ratio (RDR) – Comparison of Ethnically diverse Staff Progression with white staff progression in the ICS

Trust Name	% Ethnically diverse Staff	Disparity Ratio					
		Lower to Middle *(from B2,B3, B4, B5 to B6&B7)*		Middle to Upper *(from B6, B7 to B8a and up incl VSM)*		Lower to Upper *(from B2, B3, B4, B5 to B8a and up incl VSM)*	
		Clinical	Non-clinical	Clinical	Non-clinical	Clinical	Non-clinical
Berkshire Healthcare NHS Foundation Trust	28.4%	1.63	0.66	1.18	1.71	1.93	1.13
Buckinghamshire Healthcare NHS Trust	30.7%	2.51	1.26	1.13	0.66	2.84	0.82
Oxford Health NHS Foundation Trust	19.7%	2.17	1.38	1.50	1.20	3.24	1.67
Oxford University Hospitals NHS Foundation Trust	28.3%	2.59	1.38	2.77	1.10	7.16	1.53
Royal Berkshire NHS Foundation Trust	31.5%	1.79	2.63	1.65	1.74	2.95	4.59
South Central Ambulance Service NHS Foun Trust	4.8%	0.68	1.07	-	1.25	-	1.34
Frimley Health NHS Foundation Trust	40.4%	1.89	1.66	1.92	2.04	3.64	3.37
Surrey and Borders Partnership NHS Foun Trust	30.3%	1.99	0.46	1.62	1.35	3.22	0.62

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

The RDR is underpinned by the principle that once recruited into an organisation progression/promotion chances should be equally accessible to everyone – an issue that is highlighted as problematic by our WRES data.

Figure 9 suggests that across the ICS, there is a disparity in proportion of Ethnically diverse staff progressing to Agenda for Change Band 8 and above compared to the proportion of White staff.

With the understanding that the RDR looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM these are the implications of the Berkshire Healthcare's RDR presented in Figure 5:

- Lower to Middle: White staff are 1.63 (clinical) and 0.66 (non-clinical) times more likely to progress through the organisation than Ethnically diverse staff.

- Middle to Upper: White staff are 1.18 (clinical) and 1.71 (non-clinical) times more likely to progress through the organisation than Ethnically diverse staff.
- Lower to Upper: White staff are 1.93 (clinical) and 1.13 (non-clinical) times more likely to progress through the organisation than Ethnically diverse staff.

A value of “1.0” indicates equity in representation at higher and lower levels, a value greater than “1.0” indicates that Ethnically diverse staff are underrepresented at the higher pay bands, and a value below “1.0” indicates Ethnically diverse staff are overrepresented at the higher pay bands.

5. Conclusion and next steps

Conclusion

Overall, across the past 4 years we have seen general improvements of between 0.4% to 7.3% across our indicators. Progress is being made but it is not as quickly as we would like. Based on the data outlined in this report we have clear areas where we need to improve and do better for our colleagues, this is across most indicators. However, 6 of the 9 indicators have seen improvement from last year. Three Indicators declined over the last year:

- Indicator 3 is the 'Relative likelihood of ethnically diverse staff entering the formal disciplinary process compared to White staff'. This has moved from 1.21 to 2.43, meaning ethnically diverse colleagues are more likely to enter the formal disciplinary process than our white colleagues.

- Indicator 4 is the 'Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to ethnically diverse staff'. It has moved from 1.44 to 1.55, meaning white colleagues are 1.55 times more likely to access CPD than ethnically diverse colleagues.

- Indicator 8 is the 'Percentage of staff who experienced discrimination at work from manager / team leader or other colleagues in last 12 months. It has moved from 13.2 to 13.3.

Our race disparity ratio from last year shows us that white colleagues were 1.93 (clinical roles) and 1.13 (non-clinical roles) times more likely to progress through the organisation than ethnically diverse colleagues with regards to their career progression.

Next Steps

Actions to further improve the Trust's WRES performance align with the Trust's strategic ambitions and priorities, in particular making Berkshire Healthcare a great place to work for our people. To meet this goal the Trust has committed to becoming an anti-racist organisation to address unwarranted differences in staff experience.

In committing to become an anti-racist organisation we have a comprehensive anti-racism strategy and action plan, which our actions have been developed in collaboration with our workforce and our communities. Our Anti-racism Task Group, Diversity Steering Group, Race Equality Network, Trade Unions and other stakeholders are regularly updated and engaged with our progress against our Anti-racism action statement. The action plan, is made up of 5 workstreams led by our Executive team, with each Executive taking a lead on one of the following workstreams each:

- **Recruitment, conditions and progression**
- **Incidents, empowerment and support**
- **Anti-racism policy and practice**
- **Anti-racism education and engagement**
- **Patient, Access, outcomes and experience.**

Staff can find out more about our actions on our Unity Against Racism Nexus pages: Unity Against Racism | Nexus (berkshirehealthcare.nhs.uk)
Our communities can find out more by looking on our website under Unity Against Racism: Unity Against Racism | Berkshire Healthcare NHS Foundation Trust
Contact for further information: Ash Ellis ash.ellis@berkshire.nhs.uk 07342061967

Appendix 1: Recrutiment data

According to the 2021 census, 26.92% of Berkshire's population identifies as ethnically diverse. Over the past year, at least 41% of our hires were ethnically diverse, potentially more, as 8% of hires' ethnicities are unknown. Notably, 60% of hires at Band 8c and above were ethnically diverse.

Hiring Data Summary:

- **Total Hires:** 903.5 FTE
- **Band 8c and Above Hires:** 8.6 FTE
- **Ethically diverse hires:** 372.9 FTE (41%)
- **Ethically diverse hires at Band 8c and Above:** 5.2 FTE (60%)

Our ethnically diverse hiring surpasses the local population proportion, particularly in senior roles. However, this contrasts with the WRES findings, as recruitment likelihood is determined by the total applications per group. This led to us reviewing application data from February to August 2024, where it appears as though 88% of applications were from ethnically diverse candidates, exceeding local demographics significantly.

Application Data:

- **Total Applications:** 23,491
- **Ethnically diverse Applications:** 20,616 (88%)

Whilst the Trust posted 1,258 adverts in this time, we analysed the top 20 adverts in terms of total applications. In total across these 20 adverts we received a staggering 4,432 applications of which 4,310 (97.2%) applications were from ethnically diverse candidates versus 94 (2.1%) from white candidates.

To obtain WRES data, it is necessary to use a pre-set report on TRAC. This report does not allow us to include or exclude applications based on their right to work status or their country of origin. While it is still possible to obtain this data through a manual process, applicant data reported this way only stretches back 10 months.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2024
Title	Workforce Disability Equality Standard (WDES)
	Item for Discussion
Reason for the Report going to the Trust Board	This report sets out our 2024 data and approach to action against the Workforce Disability Equality Standard (WDES) metrics that are part of the NHS Standard contract
Business Area	People Directorate
Author	Ash Ellis, Deputy Director for Leadership, Inclusion, Organisational Experience. Alex Gild, Deputy Chief Executive (Exec Sponsor)
Relevant Strategic Objectives	Make Berkshire Healthcare a great place to work for our people. Commitment in addressing staff experience differential.
SUMMARY	This paper provides the Board with an overview of any inequalities experienced by our workforce. It provides data, benchmarking and highlights where we are doing well and where we need to do better.

Workforce Disability Equality Standard 2023

Author	Ash Ellis, Deputy Director for Leadership, Inclusion and OD
Purpose of Report	This report sets out our 2024 data and approach to action against the Workforce Disability Equality Standard (WDES) metrics

Executive Summary

- The WDES is the national framework through which Trusts are required to measure their performance against 13 key metrics for staff representation and experience with regard to disability. This comprises Trust workforce data indicators (1 – 3) Nationally set, Trust Staff Survey data indicators (4 – 9a), Indicator 9b focuses on disabled staff engagement, and indicator 10 focuses on disabled Board representation.

- The number of Disabled colleagues has increased by 60 to 378 from 318 last year. 7.2% of our colleagues are represented in the Disabled category, compared to 6.4% last year. The data shows that BHFT Disabled workforce is underrepresented by 5.8% compared to overall Berkshire population (13% - caveat, includes non-working age). Nationally 24% of the working age population is disabled, 13% are in employment.

- We still have a large number (389) of the overall workforce (7.5%) who have not shared their disability status. Although overall, the unknown figures are reducing year on year, and the number of people sharing is increasing year on year.

- Our medical colleague's declaration status has been similar over 3 years, with almost half or more (44%+) in each group not declaring their disability status.

- For clinical colleagues Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 5.6%. The largest group of colleagues who haven't declared is cluster 2 (Bands 5-7) with 8.3%.

- For non-clinical colleagues Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 3.2%. However, it also has the largest group of colleagues who haven't declared (21%).

- We have seen mixed results this year with 4 of the 13 metrics declining, 5 improving and 3 staying the same. The areas that need more focus on:
    - To increase disability disclosure rates on ESR, particularly for medical colleagues.
    - Inclusive recruitment as likelihood of shortlisting has slipped this year.
    - Encouraging and improving the reporting of harassment, abuse and bullying.
    - To change perceptions about opportunities for career progression.
    - Review our casework approach and processes for disciplinaries.

- Overall, more progress needs to be made, and in co-production with our Purple Network.

Recommendation	The Board is asked to acknowledge the WDES report and subsequent approach to actions.

1. Background

This paper provides an overview of our annual performance against the Workforce Disability Equality Standard (WDES) metrics for 2023-24. The data will be published on our public website, along with our action plan, in line with regulatory requirements.

The Workforce Disability Equality Standard (WDES) was introduced in April 2019 as a mandated data collection. The WDES is a collection of 13 metrics across 10 indicators that aim to compare the workplace and career experiences of Disabled and non-disabled staff.

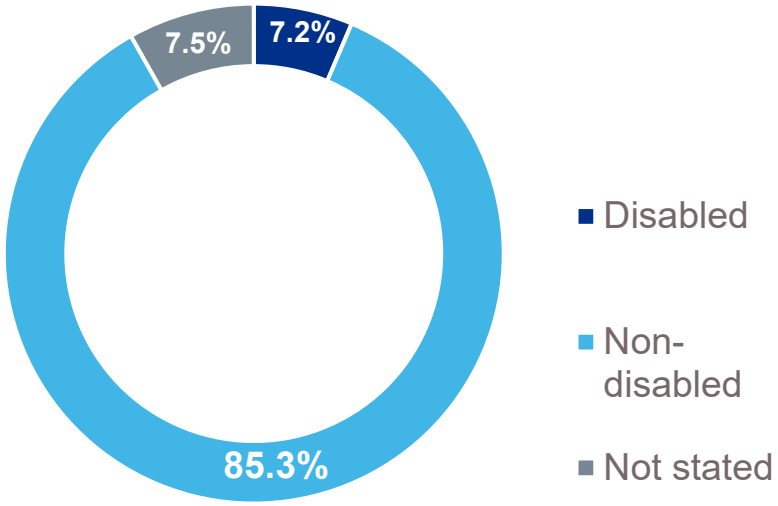
The standard is designed to improve the representation and experience of disabled staff at all levels of the organisation. We can use the data to better understand where the inequalities for our Disabled colleagues exist. This helps us to progress specific actions, to work towards year-on-year improvements.

The WDES is now mandated as part of the standard NHS Contract, and this supports closer scrutiny of the progress we make and outcomes we achieve.

2. What is our Workforce data telling us?

Data in 2024 shows our total staff headcount is at 5,219.
The number of Disabled colleagues has increased by 60 to 378 from 318.
7.2% of our colleagues are declared Disabled, compared to 6.4% last year, and 5% the year before that.
378 colleagues are Disabled, and 4,452 are non-disabled, and 389 (7.5%) down from 413 last year, have not stated.
Figure 1 below shows our Disabled workforce profile.

Figure 1: BHFT Disabled Profile 2023/24



'Unknown/Not stated'

Our key steps to reduce the unknown/not stated have involved promoting voluntary declaration on ESR, making it easier to share status through network registration, and improving internal data tracking mechanisms around workforce disability data. We've revised induction training to emphasize the importance of sharing protected characteristics. Targeted interventions to engage with medical staff about equality monitoring. Launched initiatives to improve Board sharing of personal information. Promoted declaring disability and caring status on the Electronic Staff Record (ESR) where staff feel comfortable and in our Joint Equality staff Network Registration form. Ongoing work to develop an EDI data dashboard to better track and monitor workforce equality data like disability status too.

Our neurodivergent colleagues have shared that they don't consider themselves to have a disability. However, we also know that being neurodivergent will often amount to a disability. As part of our Purple staff Network, we now have a neurodivergent support group called 'Through the looking glass' which is linked to Purple but is specifically to support our neurodiverse colleagues. NHSE and the WDES National team are aware of the subsequent issue of recording neurodiversity on ESR, and they recognise and are working on this issue.

We recently had a session within the purple coffee house to discuss some subjects including sharing status. Some members reported that they themselves had not recorded due to the complexity of recording on ESR/ not knowing how to do this/ not having the time/ worried about who could see this data.

Figure 2: Workforce Full time Equivalent (FTE)

	Average FTE contract	Total	Total who work full time (37.5hours)	% who work full time
Disabled	0.86	424	277	65.3
Non disabled	0.86	4588	2846	62.0
Not disclosed	0.81	394	200	50.8

This year we also looked at FTE, and we have found that there is a difference between Disabled staff who work 1 FTE vs anyone who works less than this compared to non-disabled staff. This data needs more exploration to understand the disparity.

Figure 3: Disabled staff in Berkshire healthcare compared to NHS Trusts

Overall Percentage of Disabled Staff		2020/21	2021/22	2022/23	2023/24
Percentage of Disabled staff in overall Berkshire Healthcare workforce compared with other NHS Trusts in England	**Berkshire Healthcare**	5%	5%	6.41%	**7.2%**
	NHS Trusts	3.4%	3.7%	4.2%	4.9%

- At Trust level, across the Country disability declaration rates vary from 2.2% to 13.7%.

- The trust type with the lowest disability declaration rate is acute (4.2%): the highest is mental health (7.4%).
- The best-performing trust in terms of 'unknown' declarations has a rate of 1.8%: 10 trusts have an 'unknown' declaration rate of less than 5%.
- We have more colleagues in our Trust who have declared a disability compared to most NHS Trusts' in England by almost 3%.

Figure 4: BHFT Workforce compared to Berkshire Population (from census data,2021)

	Disabled	Non-disabled	Not stated
BHFT Workforce	7.2%	85.3%	7.5%
Berkshire Population	13%	87%	0%

It's also useful to look at how representative our workforce is of our local population (Figure 4). The data shows that BHFT disabled workforce is underrepresented by 5.8% compared to overall Berkshire population. The caveat is that we still have 7.5% of our workforce who have not shared their disability status which could potentially increase the representation in line with the Berkshire population (caveat, the census includes non-working age). National data shows that 10.21m people or 24% of the working age population is disabled, of which 5.53 million or 13% are in employment (ONS, 2023).

3. WDES Indicators

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

Figure 5: Workforce Profile – Non-clinical Staff 2021-24 (across 4 years)

	Overall Workforce Profile 2021			Overall Workforce Profile 2022			Overall Workforce Profile 2023			Overall Workforce Profile 2024		
	Disabled	Non-disabled	Unknown	Disabled	Disabled	Unknown	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)	318 (6.41%)	4,237 (85.41%)	413 (8.18%)	378 (7.5%)	4,452 (85.3%)	389 (7.5%)
	Non-clinical staff - 2021			Non-clinical staff - 2022			Non-clinical staff - 2023			Non-clinical staff - 2024		
Cluster 1: Bands 1-4	42 (6%)	574 (82%)	86 (12%)	31 (5%)	538 (87%)	52 (8%)	33 (5.2%)	554 (87.2%)	48 (7.6%)	37 (5.5%)	586 (87.7%)	45 (6.7%)
Cluster 2: Bands 5-7	15 (4%)	306 (87%)	30 (9%)	22 (6%)	324 (88%)	21 (6%)	27 (6.4%)	370 (88.3%)	22 (5.3%)	29 (6.6%)	390 (88.2%)	23 (5.2%)
Cluster 3: Bands 8a-8b	7 (6%)	108 (85%)	12 (9%)	6 (4%)	125 (88%)	11 (8%)	13 (8.1%)	136 (84.5%)	12 (7.5%)	14 (9.3%)	128 (85.3%)	8 (5.3%)
Cluster 4: Bands 8c-9&VSM	0 (0%)	41 (76%)	13 (24%)	1 (1%)	45 (73%)	16 (26%)	3 (4.5%)	51 (77.3%)	12 (18.2%)	2 (3.2%)	47 (75.8%)	13 (21%)
Total non-clinical	**64 (5.2%)**	**1,029 (83.4%)**	**141 (11.4%)**	**60 (5.2%)**	**987 (86%)**	**100 (8.7%)**	**76 (5.9%)**	**1,111 (86.7%)**	**94 (7.3%)**	**82 (6.2%)**	**1151 (87.1%)**	**89 (6.7%)**

- Our highest representation is within cluster 3 (8a—8b) with 9.3% of colleagues in this group declaring a disability.
- Cluster 4 (8c -9, VSM) is the most underrepresented group compared to overall disability declaration with 3.2%. However, it also has the largest proportion of colleagues who haven't declared (21%).
- We have 89 non-clinical colleagues who haven't declared their disability status, down by 5 from last year.
- Although overall the number 'not declaring' is reducing year on year, 4 years ago from 11.4% (141) to this year 6.7% (89)
- The number of non-clinical staff declaring a disability has increased this year by 0.3%.

Figure 6: Workforce Profile – Clinical Staff 2021-24 (across 4 years)

	Overall Workforce Profile 2021			Overall Workforce Profile 2022			Overall Workforce Profile 2023			Overall Workforce Profile 2024		
	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown	Disabled	Non-disabled	Unknown
Workforce Total	236 (5%)	3698 (84%)	504 (11%)	255 (5%)	4082 (86%)	430 (9%)	318 (6.41%)	4,237 (85.41%)	413 (8.18%)	378 (7.5%)	4,452 (85.3%)	389 (7.5%)
	Clinical staff - 2021			Clinical staff - 2022			Clinical staff - 2023			Clinical staff - 2024		
Cluster 1: Bands 1-4	51 (5%)	845 (87%)	76 (8%)	56 (5%)	872 (88%)	66 (7%)	68 (6.7%)	893 (87.4%)	61 (6%)	71 (6.7%)	933 (88.1%)	55 (5.2%)
Cluster 2: Bands 5-7	99 (5%)	1703 (87%)	164 (8%)	115 (6%)	1747 (87%)	144 (7%)	145 (7.1%)	1766 (86.6%)	128 (6.3%)	189 (8.8%)	1848 (85.8%)	116 (5.4%)
Cluster 3: Bands 8a-8b	11 (4%)	260 (91%)	14 (5%)	14 (4%)	300 (93%)	10 (3%)	20 (5.4%)	334 (90.5%)	15 (4.1%)	23 (5.6%)	371 (90.7%)	15 (3.7%)
Cluster 4: Bands 8c-9&VSM	4 (9%)	37 (82%)	4 (9%)	3 (7%)	37 (84%)	4 (9%)	2 (4.2%)	42 (87.5%)	4 (8.3%)	5 (8.1%)	54 (87.1%)	3 (4.8%)
Total Clinical	**165 (5.1%)**	**2845 (87%)**	**258 (7.9%)**	**188 (5.6%)**	**2956 (87.8)**	**224 (6.6%)**	**235 (6.8%)**	**3035 (87.3%)**	**208 (6%)**	**288 (7.8%)**	**3,206 (87%)**	**189 (5.1%)**
Medical and Dental Consultants	3 (3%)	47 (48%)	48 (49%)	3 (3%)	48 (48%)	49 (49%)	3 (3.23%)	48 (51.61%)	42 (45.16%)	4 (4.4%)	47 (51.6%)	40 (44%)
Medical and Dental staff, Non-Consultant Career Grade	4 (5%)	47 (54%)	36 (41%)	4 (5%)	46 (56%)	32 (39%)	4 (4.48%)	42 (51.22%)	36 (43.90%)	3 (3.7%)	42 (51.9%)	36 (44.4%)
Medical and Dental Staff, Medical and Dental Trainee Grades	0 (0%)	0 (0%)	21 (100%)	0 (0%)	0 (0%)	25 (100%)	0 (0%)	1 (3.70)	26 (96.30%)	1 (2.9%)	1 (2.9%)	33 (94.3%)
Total medical	**7 (3.4%)**	**94 (45.6%)**	**105 (51%)**	**7 (3.4%)**	**94 (45.4%)**	**106 (51.2%)**	**7 (3.47%)**	**91 (45.05%)**	**104 (51.49%)**	**8 (3.9%)**	**90 (43.5%)**	**109 (52.7%)**

- For clinical colleagues all disability declarations have increased or stayed the same across all pay band clusters this year, with the exception of non-consultant career grade where the number of colleagues declaring disability has decreased from 4 to 3.
- Our highest representation is within cluster 2 (5—7) with 8.8% of colleagues in this group declaring a disability.
- Medical and dental trainees is the most underrepresented group compared to overall disability declaration with 2.9%. However, it also has the largest group of colleagues who haven't declared (94.3%).
- We have 189 (5.1%) clinical colleagues who haven't declared their disability status.
- Medical colleagues' declaration status has stayed very similar over 3 years, with almost half or more in each group not declaring their disability status.
- We have more clinical colleagues with a declared disability than non-clinical colleagues, although more non-clinical colleagues than medical colleagues.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

WDES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	2023/24
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts. *(*A figure below 1:00 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting.)*	**Berkshire Healthcare**	1.13	1.08	0.93	**1.15**
		NHS Trusts	1.20	1.11	1.08	**0.99**

This metric has declined this year, with now non-disabled staff 0.15 more likely to be shortlisted than disabled staff.
As a Disability Confident Leader, we've made a commitment as an organisation that should someone share with us that they are disabled at the application stage and select that they want to take part in the scheme, they're guaranteed an interview if they meet the advert's minimum requirements.
Disability Confident Leader Accreditation promotes our commitment to inclusive recruitment practices. The core requirement is to offer an interview to disabled applicants who meet the minimum criteria for the job vacancy.
We offer and ensure all necessary accommodations (Reasonable Adjustments) are made during the application and interview process. This may include sending interview questions out in advance of interview. Our Neurodiversity Strategy includes specific recruitment initiatives aimed at neurodivergent individuals.

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

WDES Indicator	Metric Descriptor		2020/21	2021/22	2022/23	
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. *(*A figure above 1:00 indicates that Disabled staff are more likely than non-disabled staff to enter the formal capability process.)*	**Berkshire Healthcare**	4.30	5.34	1.90	**3.92**
		NHS Trusts	1.53	1.94	2.01	**2.17**

Last year we made the most progress we have made in this area for 3 years. However, this metric has declined this year, meaning disabled staff are more likely to go through a formal process than non-disabled colleagues.
As part of our wider anti-racism work, we will be reviewing our approach to our casework in January 2025 with an intersectional lens. We are also launching inclusivity training for investigators and HR colleagues in September 2024.

Indicator 4a: Harassment, bullying or abuse in the last 12 months – From patients, their relatives or public

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
4a Staff Survey Q14a	Percentage of disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	30%	20%	30%	20%	27%	20%	**24.5%**	**18.1%**
		NHS Trusts	32%	25%	33%	25%	33%	26%		

Progress has been made with 2.5% less Disabled staff experiencing harassment, bullying or abuse from patients, their relatives or the public. However, 6.9% more of Disabled staff experienced this compared to non-disabled staff, which we need to understand and address.

Indicator 4b: Harassment, bullying or abuse in the last 12 months – from Managers

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
4b Staff Survey Q14b	Percentage of disabled staff experiencing harassment, bullying or abuse from managers in last 12 months	Berkshire Healthcare	15%	7%	12%	5%	12%	5%	11.4%	4.9%
		NHS Trusts	18.5%	10.6%	17%	9.6%	16.1%	9.2%		

This indicator has improved this year by 0.6% but disabled staff still experience harassment, bullying or abuse from managers 6.5% more than non-disabled staff. We need to address this differential in experience, but equally for both groups our managers need to be role modelling the behaviours we expect and need in BHFT.

Indicator 4c: Harassment, bullying or abuse in the last 12 months – from colleagues

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
4c Staff Survey Q14c	Percentage of disabled staff experiencing harassment, bullying or abuse from colleagues in last 12 months	**Berkshire Healthcare**	21%	13%	19%	11%	**18%**	**12%**	**17.1%**	**10.5%**
		NHS Trusts	25.6%	16.7%	25%	16.4%	24.8%	16.5%		

This indicator has seen year on year progress over the last 4 years, with a 0.9% improvement on last year. However, 6.6% more of Disabled staff have experienced harassment, bullying or abuse from colleagues. We need to address this differential in experience, but equally for both groups our colleagues need to be demonstrating our Trust behaviours that we expect and need in BHFT.

Indicator 4d: Harassment, bullying or abuse – reporting it

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
4d Staff Survey Q14d	Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	**Berkshire Healthcare**	54%	59%	56%	63%	**59.8%**	**57.3%**	**59.3%**	**62.2%**
		NHS Trusts	49.8%	48.2%	49.9%	48.6%	51.3%	49.5%		

This indicator has seen year-on-year progress over the previous 3 years, but with a 0.5% decline on last year. Non- Disabled staff report more than disabled staff by 2.9%. We have some work to do here as we are below the national NHS Trust average, and we want our colleagues to be able to report in safety and confidence.

We've implemented a comprehensive strategy that includes Initiatives like the "No Excuse for Abuse" campaign, which aims to reduce violence and aggression against staff through awareness-raising and support mechanisms. We've developed a Violence Reduction Strategy, focusing on training, policy development, and collaboration with partners like the police to improve sanctions and prosecutions for violent incidents. Additionally, the organisation provides support for managers to respond effectively to incidents, including post-incident support and guidance. Training programs such as Promoting Safer Therapeutic Services, Conflict Resolution, and Communication Skills equip staff with the tools to handle difficult situations

compassionately. Furthermore, resources like posters, virtual meeting backgrounds and a mutual respect statement reinforce a culture of zero tolerance for abuse. These efforts demonstrate a proactive approach to creating a safe and inclusive work environment, while ongoing initiatives like surveys and support services ensure continuous improvement and support for staff wellbeing.

Indicator 5: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
5 Staff Survey Q15	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	**Berkshire Healthcare**	59%	67%	53%	64%	61%	65%	**57.8%**	**66%**
		NHS Trusts	51.5%	57.7%	51.3%	57.2%	52.1%	57.7%		

This has declined by 3.2% this year. This means 8.2% more of non-disabled colleagues believe the Trust provides equal opportunities for career progression or promotion, so this remains an inequality of experience.

BHFT's Median Disability Pay Gap in 2023-2024 was 0**.** This means that on average our disabled colleagues earn the same as our non-disabled colleagues. In comparison the latest 2021 Office of National Statistics states that the disability pay gap is 13.8% for the UK.

Indicator 6: Percentage of staff feeling pressured to come to work when unwell

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
6 Staff Survey Q11e	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	**Berkshire Healthcare**	24%	15%	20%	16%	22.5%	16%	**22.3%**	**14.3%**
		NHS Trusts	31.1%	22.9%	29.9%	22.1%	27.7%	19.9%		

This metric has improved this year ever so slightly by 0.2%. Although 8% more of non-disabled colleagues don't feel pressure from their manager to come to work so this remains an inequality of experience.

Indicator 7: Percentage of staff saying that they are satisfied with the extent to which the organisation values their work

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
7 Staff Survey Q4b	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	Berkshire Healthcare	55%	67%	52%	61%	52%	61%	**53.7%**	64.2%
		NHS Trusts	39.4%	50.7%	35.1%	44.9%	35.2%	45%		

This indicator had stayed the same for the previous 2 years for both disabled and non-disabled colleagues. However, both have improved this year a 1.7% improvement for disabled colleagues. Both scores are above the average for NHS Trusts. This indicator needs more exploration amongst our workforce, particularly with how our colleagues feel or think the organisation can show or do more, to demonstrate that their work is valued. Disabled colleagues are 10% less satisfied than non-disabled colleagues with how the organisation values their work.

Indicator 8: Percentage of staff saying the organisation has made adequate adjustments for them in their role

WDES Indicator	Metric Descriptor		Disabled staff 2020/21	Disabled staff 2021/22	Disabled staff 2022/23	Disabled staff 2023/24
8 Staff Survey Q30b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Berkshire Healthcare	77%	81%	81%	81%
		NHS Trusts	76.6%	72.2%	73.4%	

This indicator has stayed the same for the past 3 years but is above the national NHS Trusts average. However, there are still 19% of disabled colleagues who feel we haven't made adequate adjustments to enable them to carry out their work. We have made changes to the way people can request adjustments and have embarked on a Quality Improvement project to improve the timeliness of support for colleagues requesting adjustments.

Indicator 9: NHS Staff Survey and the engagement of Disabled staff

WDES Indicator	Metric Descriptor		Disabled 2020/21	Non-disabled 2020/21	Disabled 2021/22	Non-disabled 2021/22	Disabled 2022/23	Non-disabled 2022/23	Disabled 2023/24	Non-disabled 2023/24
9 National Survey Staff Engagement Score	a. The staff engagement scores for Disabled and Non-Disabled staff	**Berkshire Healthcare**	7.2	7.6	7.1	7.5	7.1	7.5	**7.1**	**7.58**
		NHS Trusts	6.7	7.2	6.5	7.0	6.4	6.9		
	b. Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard? Please provide an example		**Yes**							
	The voices of disabled colleagues are heard via an active, up and running Purple Staff Network, whose Chair has protected time of half a day each week, admin support and a budget for network activities, and a dedicated team's channel for members It also has a Deputy Network Chair and committee members. The Purple Staff Network has Executive level sponsorship (Chief Financial Officer). We had additional sub-groups of carers network and the 'Through the Looking Glass' support group for neurodivergent colleagues The voice of disabled staff is also sought in the co-production of new strategies, policies, and our Staff Network leads have regular meetings with our EDI Leads to help support the implementation of our strategies, as well as being pivotal members on forums such as Diversity Steering Group (DSG), and Staff Network Steering Group.									

The engagement score of our disabled colleagues is still 0.5 less than our non-disabled colleagues. For both groups, the engagement scores have remained very similar for the past 4 years.

Indicator 10: Board membership 2022/23

WDES Indicator	Metric Descriptor			Total	Voting	Non-voting	Exec	Non-exec	Overall Workforce
10 Board representation	Percentage difference between the organisation's Board voting membership	**Berkshire Healthcare**	**Disabled**	**1 (7.69%)**	**1 (7.69%)**	**0**	**1 (16.67%)**	**0 (0%)**	**378 (7.2%)**
		NHS Trusts		*8%*	*8%*	*3.9%*	*3.8%*	*3.6%*	*3.7%*

	and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	**Berkshire Healthcare**	**Non-disabled**	**9 (%)**	**9 (%)**	**0**	**4 (66.67%)**	**5 (71%)**	**4,452 (85.3%)**
		NHS Trusts		*69%*	*69%*	*73.3%*	*75.6%*	*69.6%*	*74.9%*
		Berkshire Healthcare	**Unknown**	**3 (%)**	**3 (%)**	**0**	**1 (16.67%)**	**2 (29%)**	**389 (7.5%)**
		NHS Trusts		*23%*	*23%*	*22.8%*	*20.6%*	*26.9%*	*21.3%*
			Total Trust Members	**13**	**13**	**0**	**6**	**7**	**5,219**

Figure 7: Board membership compared with overall workforce over 3 years.

	% Difference compared with overall workforce 2020/21			% Difference compared with overall workforce 2021/22			% Difference compared with overall workforce 2022/23			% Difference compared with overall workforce 2023/24		
	Disabled	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**	**Disabled**	**Non-disabled**	**Unknown**
Difference Total Board – Overall Workforce	-5%	-38%	43%	2%	-47%	45%	1%	-39%	38%	0.44%	-16.09%	15.65%
Difference Voting Membership – Overall workforce	-5%	-38%	43%	2%	-47%	45%	1%	-39%	38%	0.44%	-16.09%	15.65%
Difference Executive Membership – Overall Workforce	-5%	-18%	-23%	11%	-19%	8%	10%	-19%	8%	9.42%	-18.65%	9.24%

- The total Board membership of colleagues declaring a disability is 0.44%% higher than the overall workforce, meaning that disabled people are overrepresented at Board compared to our overall workforce.
- Our Executive membership is 9.42% higher than the overall workforce, meaning that disabled people are overrepresented at Executive membership compared to our overall workforce.
- There is a high number of undeclared/unknown amongst the Board, which is not representative of the workforce, this is particularly evident with our Non-executive Directors.
- Compared to NHS Trust's Nationally, we are above the average for representation but below average for the number of our Board who have not declared their disability status.

4. Conclusion and next steps

Conclusion

Based on the data outlined in this report we have clear areas where we need to improve and do better for our colleagues, this is across most indicators. However, we've had mixed results this year with 4 of the 13 metrics declining, 5 improving and 3 staying the same:

- Indicator 2 is 'Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts, this has declined from 0.93 to 1.15.
- Indicator 3 is 'Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure' declining from 1.90 to 3.92.
- Indicator 4d is 'Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it' which declined from 59.8% to 59.3%.
- Indicator 5 is 'Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion'. This declined from 61% to 57.8%.

Three indicators stayed the same over the last year:

- Indicator 8 is 'the percentage of disabled staff who feel their employer has made adequate adjustments to enable them to do their job'. This indicator has stayed the same for the past 2 years, but is above the national NHS Trusts average, at 81%. However, there are still 19% of disabled colleagues who feel we haven't made adequate adjustments to enable them to carry out their work.
- Indicator is the staff engagement scores for Disabled and Non-Disabled staff. This has stayed the same for the last 3 years.
- Indicator 10 is Board representation. There is 1 voting Board member declared disabled which has stayed the same for 3 years.

We still have a large number (389) of the overall workforce (7.5%) who have not declared their disability status. On the whole, the number not sharing is reducing year on year, and therefore the number sharing is increasing year on year.

Next Steps

Actions to further improve the Trust's WDES performance align with the Trust's strategic vision, ambitions and priorities, in particular making Berkshire Healthcare a great place to work for our people.
The action plan will be co-created with our PURPLE network, carers network and 'Through the Looking Glass' neurodivergent support group, and Diversity Steering Group (DSG). It is likely we will focus on areas being informed by our problem statements in the above report:

- To increase disability disclosure rates on ESR, particularly for medical colleagues.
- Inclusive recruitment – we have already commenced a recruitment steering group quality improvement project.
- Encouraging and improving the reporting of harassment, abuse and bullying.
- To change perceptions about opportunities for career progression.
- Review our casework approach and processes for disciplinaries.

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Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	10 September 2024
Title	**Audit Committee Meeting – 24 July 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, 24 July 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 Debbie Fulton, Director of Nursing and Therapies Dr Minoo Irani, Medical Director) Tehmeena Ajmal, Chief Operating Officer Amanda Mollett, Head of Clinical Effectiveness and Audit Sharonjeet Kaur, RSM, Internal Auditors Clara Agyekumhene, RSM, Internal Auditors Jenny Loganathan, TIAA Ben Lazarus, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Mark Davison, Chief Information Officer *(presented for agenda item 5.0)* 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**	
	Maria Grindley, Ernst and Young, External Auditors.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 17 April 2024 and 19 June 2024**	
	The Minutes of the meetings held on 17 April 2024 and 19 June 2024 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.	
5.0	**The Trust's Use of Artificial Intelligence (AI) Presentation**	

	The Chair welcomed the Chief Information Officer to the meeting.
	
	The Chief Information Officer gave a presentation and highlighted the following points:
	
	• The five key components of Artificial Intelligence were:
	  ○ Expert System Based on Rules
	  ○ Robotic Process Automation
	  ○ National Language Processing
	  ○ Large language Models
	  ○ Machine Learning
	• It was important to understand the constraints of AI and how it could be applied in local healthcare settings. All AI processes in healthcare settings needed safety checks and implementation controls
	• The Trust was already using robotic process automation but there was more that could be done, for example, referral triage, staff expense approvals etc
	• More could be done around Population Health Management analytics – using data from Connected Care, NHS Federated Data Platform and the Trust's Data Warehouse to cohort patients based on holistic records in order to prioritise patients for treatment and to identify interventions etc.
	• Two of the Trust's Psychiatrists were piloting using clinical ambient documentation. The Trust was also piloting Microsoft's Co-Pilot to help with some administrative tasks, for example meeting notes.
	
	The Medical Director said that it would be helpful if the clinical audit process could be more automated. The Medical Director also mentioned that a process to flag when a patient's detention under the Mental Health Act was due to expire would also be helpful.
	
	The Director of Finance pointed out that the Trust was making more use of the Patient Level Information Costing System (PLICS) and suggested that AI could be used to automatically identify variations rather than relying on staff to identify anomalies.
	
	Jenny Loganathan, Anti-Crime Specialist, TIAA commented that there was a definite role for AI to assist with TIAA's investigative and proactive work.
	
	The Chief Information Officer said that before investing in AI systems, it was important to undertake a benefit realisation exercise to identify the likely costs and savings. It was noted that Microsoft's Co-Pilot licence costed around £300 per person per annum.
	
	The Director of Finance said that the business cases for AI investment also needed to be considered in terms of any productivity gains especially given the staffing constraints in many clinical areas.	

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	The Chief Information Officer pointed out that the Trust needed to be clear about the potential risks and limitations of using AI, including risks around bias and discrimination. The Chief Information Officer said that by focussing on two small scale and controlled projects, the Trust was able to explore the use of AI in a safe way. The Chair thanked the Chief Information Officer for his presentation. **The Committee**: noted the report.	
6.A	**Board Assurance Framework**	
	The latest Board Assurance Framework (BAF) had been circulated. The Chief Financial Officer presented the paper and highlighted the following points: • **BAF Risk 1 (Workforce)** – the workforce risk was currently being refreshed to ensure alignment with the new People Strategy. There were no updates this quarter. • **BAF Risk 3 (Patient Voice)** – a common approach to co-production across the Trust was in development. The implementation of the national Patient and Carer Race Equality Framework (PCREF) was being linked to the Trust's anti-racism and community engagement work through the PCREF Task and Finish Group. • **BAF Risk 4 (System Work)** – both local Integrated Care Boards were undertaking a process to reduce their workforce which may result in gaps in commissioning relationships as staff left. • **BAF Risk 6 (Finance)** – there was an emerging risk in terms of system performance. • **BAF Risk 7 (Digital)** – the Trust had retained its National CyberEssentials+ accreditation. The Committee noted the report.	
6.B	**Corporate Risk Register**	
	The Corporate Risk Register (CRR) had been circulated. The Chief Financial Officer presented the paper and highlighted the following points: • **CRR 2 (Ligature risk)** – there was a programme to replace all patient toilets at Prospect Park Hospital to an anti-ligature version • **CRR 5 (Acute Inpatient Bed Pressures risk)** – the tender for the procurement of an 18 bedded acute ward had commenced. The scoring of tenders and the award of the contract was scheduled for the beginning of September 2024. • **CRR 7 (Physical Environment Prospect Park Hospital risk)** – the risk had been updated the reflect the Trust's work around monitoring the performance of the PFI provider. The Committee noted the report.	

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7.	**Single Waiver Tenders and Provider Selection Regime Direct Awards Report**	
	A paper setting out the Trust's single waivers approved from April 2024 to June 2024 had been circulated. The Chief Financial Officer reported that the Single Waiver Tender report had been expanded to include Provider Selection Regime Direct Award contracts. The Chair referred to the award of a contract for wheelchair maintenance and asked for more information. The Director of Nursing and Therapies explained that in addition to in-patient wheelchairs, the Trust also provided wheelchairs to patients in the community. The Committee noted the report.	
8.	**Information Assurance Framework Update Report**	

	The Chief Financial Officer presented the paper and highlighted the following points:
	• A total of four indicators were audited during the quarter:
	  ○ **Mental Health Readmission Rate within 28 days** (green for data assurance and data quality)
	  ○ **Mental Health Crisis Resolution Home Treatment Team Gate Keeping of Inpatient Admissions** (amber for data quality)
	  ○ **Did Not Attend Percentage** (green for data assurance and amber for data quality)
	  ○ **Mental Health 72 Hour Follow Up Appointment Percentage** (green for data assurance and red for data quality)
	• Of the indicators audited, there remained persistent errors in recording of dates and some knowledge gaps which were being addressed.
	• Timeliness issues were also identified in relation to the Mental Health 72 Hour Follow Up indicator.
	• Corrective actions and improvements were in progress for the relevant areas. Additional measures included consolidating guidance and a series of bite-size training videos as well as RiO (electronic patient record system) refresher training planned for quarter 3 this year.
	
	The Chief Financial Officer reminded the meeting that the Trust audits 100% of patients in respect of the Mental Health 72 Hour Follow Up indicator.
	
	The Committee noted the report.	

9.	**Losses and Special Payments Report**	
	Due to the low number of losses and special payments, there was no update at this meeting. Any losses and special payments relating to quarter 1 will be included as part of the quarter 2 report.	
10.	**Clinical Claims and Litigation Report**	

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	The Director of Nursing and Therapies presented the paper and reported that during quarter 1 there were four new litigation claims opened, all were Employee Liability claims. The Committee noted the report.	
11.	**Clinical Audit Report**	

	The Medical Director presented the paper and highlighted the following points:
	
	• The following Clinical Audit Reports would be presented to the Quality Assurance Committee meeting in August 2024:
	  ○ POMH 22a: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services
	  ○ National Audit of Cardiac Rehabilitation
	  ○ National Diabetes Footcare Audit
	• None of the audits had raised concerns around the safety of the care provided by the Trust.
	• There was a slight delay in the publication of the national reports following the pre-election period
	• Clinical Audits remained on track for completion
	
	The Committee noted the report.	

12.	**Anti-Crime Specialist Report**	
	Jenny Loganathan, Anti-Crime Specialist, TIAA presented the report and highlighted the following points: • The NHS Counter Fraud Authority had launched a procurement local proactive exercise looking at due diligence and contract management. The exercise was due for completion by 30 September 2024. • TIAA was liaising with the Trust's Governance Team to finalise the data protection impact assessment to commence the ongoing proactive review around declaration of interests. • TIAA was also conducting a review of the Trust's policies in a number of areas. • TIAA was currently investigating seven cases. Since the last report, there had been two new referrals concerning working whilst sick. The Chair asked how the Trust's referrals compared with other NHS trusts and whether there were any common themes. Jenny Loganathan said that the common themes across all NHS trusts included working whilst sick, mileage claim fraud and staff not having the correct car insurance in place and confirmed that the Trust's referrals in these areas were not out of line with other NHS trusts. Naomi Coxwell, Non-Executive Director said that it would be helpful if future reports could include the number of investigations in previous years so the Committee could compare the current activity.	

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	Jeny Loganathan confirmed that this information was included in TIAA's Annual Report but agreed that the information could also be included in the quarterly reports. **The Committee**: noted the report.	**JL**
13.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	
	Sharonjeet Kaur, Internal Auditors, RSM presented the paper and highlighted the following points:
	
	• Since the last meeting, the following reports had been issued:
	  o Bed Management and Discharge Processes (partial assurance)
	  o Data Security and Protection Toolkit (moderate assurance)
	• At the request of the Trust, the Audit on Safety Planning and Risk Assessment Process had been postponed to January 2025 as processes had recently changed and would need time to embed prior to the audit.
	• One medium rated action was overdue relating to the Cost Improvement Plan audit and a revised implementation date had been agreed with the Trust.
	
	Bed Management and Discharge Processes Audit
	
	Sharonjeet Kaur reported that the Bed Management and Discharge Processes review had highlighted a number of issues, for example, significant delays between when a patient was ready for discharge and when they were discharged. There was no formal policy or procedure in place for the recording and calculation of the medically optimised for discharge date and issues had been identified in both the sample testing and data analytics testing in relation to this.
	
	Ms Kaur added that the new Operational teams' re-structure into three divisions had highlighted inconsistencies in the discharge processes across the East and West of Berkshire. There was no procedural documentation in place for how Board Rounds and Multi-Disciplinary Team meetings should be conducted.
	
	The Chair asked the Chief Operating Officer if she was surprised by the findings.
	
	The Chief Operating Officer said that it was important to make sure that the right inferences were being made from the findings and pointed out that unlike in East Berkshire, the West Berkshire data also included Neuro Rehabilitation patients and End of Life patients and that this would significantly skew the overall average length of stay.
	
	The Chief Operating Officer said that the Operational teams' re-structure had highlighted a number of inconsistencies between East and West Berkshire and added that it would take time to work through these and to move to a more consistent approach.
	
	Data Security and Protection Toolkit	

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	Sharanjeet Kaur reported that the methodology for the Data Security and Protection Toolkit audit was set by NHS England. It was noted that there was one medium rated action in relation to updating the Trust's Information Security Policy to include provisions for logs to be temper-proof. Ms Kaur explained that the prescribed scoring methodology meant that a single medium action meant that the Trust's rating was moderate assurance. **b) Information Reports** The following information Reports had also been circulated: • NHS News Briefing • Procurement Reform The Committee: a) Noted the Internal Audit Progress Report b) Noted the information reports	
14.	**External Audit Report**	
	Ben Lazarus, External Auditors, Ernst and Young reported that he would be taking over from Maria Grindley who would shortly be retiring. Mr Lazarus said that he was working closely with Ms Grindley to ensure that there was a smooth handover and said that he had met with the Chief Financial Officer and Director of Finance. The Chair welcomed Ben Lazarus to the Committee.	
15.	**Minutes of the Finance, Investment and Performance Committee meeting held on 17 April 2024**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 17 April received and noted. The Committee noted the minutes.	
16.	**Minutes of the Quality Assurance Committee held on 28 May 2024**	
	The minutes of the Quality Assurance Committee meetings held on 28 May 2024 were received and noted.	
17.	**Minutes of the Quality Executive Committee Minutes – 15 April 2024, 20 May 2024 and 17 June 2024**	
	The minutes of the Quality Executive Committee meetings held on: 15 April 2024, 20 May 2024 and 17 June 2024 and were received and noted.	
18.	**Audit Committee Annual Review of Effectiveness and Terms of Reference Review**	
	The Company Secretary reported that the results of the Committee's Annual Review of Effectiveness Survey were positive. It was noted that one	

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	respondent had suggested that the Committee hold at least one in person meeting per year. The Company Secretary also pointed out that one respondent had suggested that the External Audit Report papers were overly detailed. The Chair commented that similar individual comments were made in the previous year's survey. The Chair said that he would reflect on the comments. The Chair thanked everyone for completing the Committee's Annual Review of Effectiveness Survey. The Company Secretary asked whether there were any changes required to the Committee's Terms of Reference. The Committee confirmed that the current Terms of Reference remained valid and that there were no changes requested. The Committee: noted the report.	
19.	**Annual Work Plan**	
	The Committee's Annual Work Plan was noted.	
18.	**Any Other Business**	
	There was no other business.	
19.	**Date of Next Meeting**	
	The next meeting of the Committee was scheduled for 30 October 2024.	

The minutes are an accurate record of the Audit Committee meeting held on 24 July 2024.

Signed: - _____

Date: - 30 October 2024 _____

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