Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 12 November 2024

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Mark Day, Vice Chair	Verbal
2.	Apologies	Mark Day, Vice Chair	Verbal
3.	Declaration of Any Other Business	Mark Day, Vice Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Mark Day, Vice Chair	Verbal
5.1	Minutes of Meeting held on 10 September 2024	Mark Day, Vice Chair	Enc.
5.2	Action Log and Matters Arising	Mark Day, Vice Chair	Enc.
QUALITY			
6.0	Board Story – East Berkshire Earlier Supported Discharge Team for Stroke	Debbie Fulton, Director of Nursing and Therapies/Lisa Ellis, Service Manager, Neuro-rehabilitation/Keely Butler, Specialist Physiotherapist, Community Based Neuro Rehabilitation Team	Verbal
6.1	a) Freedom to Speak Up Guardian's Six-Monthly Report b) Freedom to Speak Up Improvement Plan Report	Mike Craissati, Freedom to Speak Up Guardian Debbie Fulton, Director of Nursing and Therapies	Enc. Enc.
6.2	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.3	Six Monthly Safe Staffing Report *(NB the Finance, Investment and Performance Committee reviews the monthly Safe Staffing Reports)*	Debbie Fulton, Director of Nursing and Therapies	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
7.1	Health and Wellbeing Update Report	Jane Nicholson, Director of People/Steph Moakes, Health, Wellbeing and Engagement Manager	Enc.
7.2	Reducing Violence and Aggression Update Report	Debbie Fulton, Director of Nursing and Therapies	Enc.

No	Item	Presenter	Enc.
PERFORMANCE			
8.0	Month 06 2024/25 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 06 2024/25 Performance Report	Tehmeena Ajmal, Chief Operating Officer	Enc.
8.2	Finance, Investment and Performance Committee 30 October 2024	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	Estates Strategy Update Report	Paul Gray, Chief Financial Officer/Martin Mannix, Director of Estates and Facilities	Enc.
CORPORATE GOVERNANCE			
10.0	Audit Committee Meeting – 30 October 2024	Rajiv Gatha, Chair of the Audit Committee	Enc.
10.1	Trust Policies – Changes for Ratification a) Trust Standing Financial Instructions b) Reservation of Powers to the Board and Delegation of Powers c) Application of Financial Limits to the Scheme of Delegation	Paul Gray, Chief Financial Officer	Enc.
10.2	Trust Seal Report	Paul Gay, Chief Financial Officer	Enc.
10.3	Council of Governors Update	Mark Chair, Vice Chair	Verbal
Closing Business			
11.	Any Other Business	Mark Day, Vice Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 14 January 2025	Mark Day, Vice 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.	Mark Day, Vice Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 10 September 2024

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Rebecca Burford	Non-Executive Director *(present from 10.35)*
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	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 (*present from 10.50)*
In attendance:	Julie Hill	Company Secretary
	Caroline Edwards	Community Inpatients Lead *(present for agenda item 5.0)*
	Sagal Ali	Ward Manager, Jubilee Ward *(present for agenda item 5.0)*
	Ash Ellis	Deputy Director for Leadership, Inclusion and Organisational Experience *(present for agenda items 9.0 and 9.1)*

24/148	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting.
24/149	**Apologies** (agenda item 2)
	There were no apologies. Apologies for lateness were received from Tehmeena Ajmal, Chief Operating Officer and Rebecca Burford, Non-Executive Director.

24/150	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
24/151	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** Dr Minoo Irani, Medical Director reported that with effect from 1 September 2024, he was a Non-Executive Director at the Royal Berkshire NHS Foundation Trust. The Board's Register of Interests published on the Trust's website had been updated to include this appointment.
	ii. **Agenda Items** – none
24/152	**Minutes of the previous meeting held on 09 July 2024 –** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 09 July 2024 were approved as a correct record.
24/153	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
24/154	**Board Story – Community Inpatients (**agenda item 6.0)
	The Chair welcomed Sagal Ali, Jubilee Ward Manager and Caroline Edwards, Inpatient Community Patients Lead to the meeting. Sagal Ali gave a presentation and highlighted the following points: • The Board Story concerned an older gentleman admitted to Wexham Park Hospital after a fall which resulted in him sustaining a humerus fracture. The person was born deaf and communicated using British Sign Language and had progressing Dementia. His daughter was his carer. • The gentleman was admitted to Jubilee ward for rehabilitation after a 56-day admission at Wexham Park Hospital. • In view of the gentleman's communication needs, a range of things were put in place prior to his admission onto Jubilee Ward, including booking a Sign Language interpreter, briefing all staff about the admission, informing the Therapy Team and the Doctors of the times when the Interpreter was booked and making sure that all communication aides were easily accessible. • Once admitted, the gentleman was assessed, and a personal fire evacuation plan was drawn up together with a communication needs care plan. The gentleman's daughter was anxious about her father's wellbeing, so the ward arranged for her to have more flexible visiting times

	• The gentleman attended strength and balance therapy sessions and wellbeing groups. His daughter was also invited to several joint therapy sessions. • On admission the gentleman's Ageing Well Outcome score was 16 and at discharge this had increased to 34. • The discharge planning was complex due to the gentleman's cognitive impairment and communication needs. A best interest meeting took place with the gentlemen, his daughter and the interpreter were also present. It was agreed that the most suitable option was for the gentleman to go into a home. • The gentleman was also referred to the Memory Clinic and Community Physiotherapy. The daughter was referred to a community carer support group. • The gentleman forwarded a thank you card to the ward. • The admission provided a good learning opportunity for the Trust around how best to prepare for and support a patient who was deaf. Sally Glen, Non-Executive Director asked whether it was surprising that the gentleman's cognitive decline was not assessed until the at the point of discharge. The Director of Nursing and Therapies explained that a best interest assessment would always be undertaken near to the point of making a decision about a person's care as a person's mental capacity was a point in time and was not generic. Caroline Edwards commented that in her presentation, Sagal Ali had underplayed the significant amount of thought and work she had put in to support the gentlemen both prior to and during his admission. This ensured that his transfer to the ward was very smooth. The Chair commented that the Board Story was an exemplar of effective partnership working between the acute sector, the local authority and the Trust and asked what more could be done to improve the interface. Sagal Ali said that there was strong partnership working with the in-reach team, therapy team and with the doctors and confirmed that things were currently working well. Caroline Edwards added that the relationship between the ward and with the local authority had greatly improved and this had been essential in order to support the complex discharge process. The presentation slides are attached to the minutes of the meeting. The Chair thanked Sagal Ali, Jubilee Ward Manager and Caroline Edwards, Inpatient Community Patients Lead for their presentation.
24/155	**Patient Experience Report** (agenda item 6.1)
	The Director of Nursing and Therapies presented paper and highlighted the following points: • There had been a positive shift in the number of I Want Great Care Five Star ratings across the Mental Health Wards which was very positive • The Trust re-started the programme of 15 Step Visits to services.

	Sally Glen, Non-Executive Director referred to the complaints data and commented that it was difficult to know whether the number of complaints the Trust received was in line with other similar Trusts and asked whether there was benchmarking data available The Director of Nursing and Therapies confirmed that the Trust received a relatively low number of complaints and said that the national Model Hospital data included an element of complaints benchmarking and agreed to share the information with the Board. **Action: Director of Nursing and Therapies** The Director of Nursing and Therapies said that the volume of Parliamentary and Health Service Ombudsman (PHSO) complaints provided a useful point of reference because these reflected those complaints which trusts were unable to resolve locally. The Director of Nursing and Therapies said that the Trust had received one PHSO complaint this quarter which was the first one in over a year. The Director of Nursing and Therapies also pointed out that half of the complaints received by the Trust were not upheld. Naomi Coxwell, Non-Executive Director asked whether there was any feedback from other Trusts who were using the I Want Great Care Tool. The Director of Nursing and Therapies explained that trusts used the I Want Great Care tool in different ways and therefore it was not possible to benchmark the data. The Chair said that it would be helpful if the Trust could define a sub-set of important patient experience issues that could be used to benchmark the different Trust services. The Chair requested that the issue be discussed at a future Quality Assurance Committee with a report back to the Board. **Action: Director of Nursing and Therapies** **The Trust Board**: noted the report.
24/156	**Quality Assurance Committee** (agenda item 6.2)
	a) Minutes of the Quality Assurance Committee Meeting held on 27 August 2024 The minutes of the Quality Assurance Committee meeting held on 27 August 2024 together with the Learning from Deaths, Guardian of Safe Working Hours Quarterly Reports had been circulated. Sally Glen, Chair of the Quality Assurance Committee reported that the Committee had discussed the Trust's work around complying with the requirements of the National Patient Safety Alert in relation to bed rails. It was noted that along with other organisations, the Trust was still in the process of assessing the equipment used in the community and therefore had not met the deadline for March 2024 to complete the work. The Director of Nursing and Therapies commented that the issue was challenging because there was a large cohort of patients who had received Trust services for a very short period of time who had been prescribed equipment and who had been discharged from the Trust's services but who continued to need the equipment. The Director of Nursing and Therapies pointed that this group of patients may be receiving services from local authorities and other agencies and said that the Trust was working with

	the system to agree which organisation was best placed to conduct the assessment of the equipment. Ms Glen reported that the meeting had discussed the Quality Concerns Register and which had been updated to remove the quality concerns relating to Community Nursing and the Eating Disorder Service. It was noted that Neuro-rehabilitation service had been added to the Quality Concerns Register due to demand exceeding capacity. Ms Glen reported that the Committee had discussed how the Trust was piloting an approach to "Martha's Law" at Prospect Park Hospital. In its current form. "Martha's Law" was more suited to an acute hospital setting. Ms Glen reported that the Committee had also discussed the Trust's progress in implementing the Sexual Safety Charter. b**) Changes to the Committee's Terms of Reference** Ms Glen reported that the Committee had reviewed its terms of reference and had agreed to include the Mental Health Act and Place of Safety Annual Reports which were submitted to the Committee and to update the Committee' attendees to include the attendance at meetings of the Patient Safety Partner and Patient Safety Specialists. **c) Learning from Deaths Quarterly Report** The Medical Director reported that at the request of the Trust Board, the format of the report had been updated to include a section on ethnicity. The Chief Executive reported that the Lampard Public Inquiry had opened this week. The Inquiry would be investigating the deaths of over 2,000 mental health patients in NHS Trusts in Essex. The Medical Director agreed to keep the Board appraised of any recommendations from the Inquiry which were relevant to the Trust. **Action: Medical Director** **d) Guardian of Safe Working Hours Quarterly Report** The Medical Director reported that the Head of Medical Workforce and Medical Education and the Guardian of Safe Working Hours 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 the Learning form Deaths Quarterly Report c) Noted the Guardian of Safe Working Hours Quarterly Report. d) Ratified the changes to the Quality Assurance Committee's Terms of Reference
24/157	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following item was discussed further:

	a) **Care Quality Commission (CQC) Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust** The Chief Executive reported that the review was focussing on people with severe mental illness that was amenable to treatment and medication in the light of the conviction of Valdo Calocane for the killings of three people. The Chief Executive said that the Medical Director, the Director of Nursing and Therapies and the Chief Operating Officer would be reviewing how best to care for this cohort of patients in the light of the CQC's report. The Chief Executive said that the Trust was using NHS England's self-assessment tool to identify any gaps in the current care provision for this patient group. It was noted that the results of the self-assessment would be reported to the Trust Board. Naomi Coxwell, Non-Executive Director asked whether the Trust's work was internally focussed. The Chief Executive said that the Trust would also be working closely with Oxford Health NHS Foundation Trust as part of the Mental Health Provider Collaborative work. Sally Glen, Non-Executive Director asked whether there were any lessons learnt from the Trust's work around improving the risk assessment systems and processes. The Chief Executive said that effective risk assessment was an important aspect of caring for this cohort of patients and pointed out that Valdo Calocane had displayed alarming antecedent behaviour. The Chair thanked the Chief Executive for his update. **The Trust Board**: noted the report.
24/158	**Month 04 2024-25 Finance Report** (agenda item 8.0)
	The Chief Financial Officer corrected an error in the report. The average number of out of area placements in July 2024 was 29 and not 19 as stated in the report. The Chief Financial Officer presented the report and highlighted the following points: • The planned outturn position for the Trust was a £1.9m surplus. 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 Programme schemes to be identified of £0.8m. • The Trust had a £13.8m Cost Improvement Programme which was on track year to date, but there were some small variances on individual plans. • The national pay award would be paid in October 2024. NHS England was expected to apply an additional inflation uplift to contracts to cover the pay award. • Cash was below plan, due in part to phasing but also delayed payments from local authorities. • 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 achieving the target across all 4 measures at month 3 but one target had been missed in month 4 due to 7 medical staffing invoices being paid late.

	• Capital spend was slightly under plan for CDEL schemes. • The agency target was achieved year to date. • The Finance Team would be producing a mid-year forecast in the next six weeks. Naomi Coxwell, Non-Executive Director asked whether there were any penalties if trusts breached the agency cap. The Chief Financial Officer said it would impact the Trust's reputation with NHS England, but there were no penalties. The Chair referred to the staffing detail graphs in the report and commented that in all three clinical divisions, the total hours worked was less than the plan and asked whether the gap was filled by bank and agency staff. The Chief Financial Officer said that the Finance team had worked hard with the Operational Divisions over the past couple of years to get a better alignment between the actual staffing numbers and the financial plan and explained that the contracted hours line would include bank and agency staff and any additional hours undertaken by Trust staff. The Chief Financial Officer said it remained challenging to recruit to planned numbers. The Chair commented that the Trust's finances were tightly managed. **The Trust Board**: noted the report.
24/159	**Month 04 2024-25 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 04 2024-25 "True North" Performance Scorecard Report had been circulated. Sally Glen, Non-Executive Director noted that there had been an increase in the number of falls (28 falls in July 2024 compared with 18 falls in June 2024) and asked whether the increase was a cause for concern. The Director of Nursing and Therapies said that the nationally the Trust had a relatively low number of falls, and it was important to look at performance over a period of time rather than to focus on changes from one month to the next. Rebecca Burford, Non-Executive Director noted that Rose Ward had a higher number of physical assaults on staff than other wards. The Director of Nursing and Therapies explained that the high incidence of physical assaults on staff related to a single patient on Rose Ward. The Chair referred to the Health Visiting New Birth Visits within 14 days metric and noted that performance was at 96.6% against a target of 90% after four consecutive months of being below the target. The Chair asked whether there was anything to explain the increased performance. The Chief Operating Officer agreed to find out more information and to circulate a response to the Trust Board. **Action: Chief Operating Officer** Naomi Coxwell, Non-Executive Director referred to the Clinically Ready for Discharge and Bed Days Occupied by Patients who were Discharge Ready metrics and asked whether

	there was a way of measuring any negative impacts on patients' health of staying in hospital longer than they clinically needed to. The Chief Operating Officer said that in addition if a patient was occupying a bed they did not need, it meant that a patient who needed to be hospitalised may have to be placed out of area. The Chief Operating Officer said there maybe particular reasons why a patient could not be discharge, for example, they may need to wait for a package of care to be in place or for adaptations to be made to their home before they were able to be discharged. The Medical Director explained that the Trust did not have a systematic process in place to collect data about any harm impacts on patients of being in hospital but pointed out that the literature particularly identified increased risks around hospital acquired infections. The Medical Director added that patient experience was also negatively impacted. Naomi Coxwell thanked the Chief Operating Officer and Medical Director for their responses. **The Trust Board**: noted the report.
24/160	**Finance, Investment and Performance Committee Meeting – July 2024 and Changes to the Committee's Terms of Reference** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that in addition to the standing items on the agenda, the meeting held on 24 July 2024 had discussed the People Strategy Closure 2021-2024 Report which set out the progress that had been made to implement the strategy. Ms Coxwell reported that the Committee had also reviewed its terms of reference and had agreed to delete section 5.2.6 "to review at least annually, credit ratings, report on benchmarking of investments and borrowing activities since the date of the last meeting" because this was no longer relevant. The Chair thanked Naomi Coxwell for her update. **The Trust Board:** ratified the change to the Finance, Investment and Performance Committee's Terms of Reference.
24/161	**Workforce Race Equality Standard Report** (agenda item 9.0)
	The Chair welcomed the Deputy Director for Leadership, Inclusion and Organisational Experience to the meeting. The Deputy Chief Executive reported that the Workforce Race Equality Standard (WRES) results indicated that there was more work to be done but said that it was pleasing that some of the indicators had improved compared with last year's results. The Deputy Director for Leadership, Inclusion and Organisational Experience presented the report and highlighted the following points: • The WRES was a national framework through which NHS Trusts were required to measure their performance against nine key indicators for staff representation and experience regarding race.

	• The number of ethnically diverse staff had increased by 154 compared with the previous year. The Trust had more ethnically diverse staff and less white staff compared to the Berkshire population. • There were 124 staff, mainly clinical, who had not declared their ethnicity on the ESR (employee staff record system). • Overall, the Trust had seen some positive change and improvement across six of the nine indicators. However, there was a decline in performance in three indicators. • The declining scores were in relation to: o **Indicator 3** – the relative likelihood of ethnically diverse staff entering the formal disciplinary process compared with white staff • The Trust would be launching a review of its approach to case work in January 2025. In the meantime, the Trust would be providing racial inclusivity training for case work investigators and Human Resources staff in September 2024. o **Indicator 4** – the relative likelihood of white staff accessing non-mandatory training and continuous development (CPD) compared to ethnically diverse staff • The Trust received relatively few applications for non-mandatory training and CPD from ethnically diverse staff compared with white staff. The Trust was seeking to understand the reasons for this and was planning to ensure open conversations with ethnically diverse staff to hear how the Trust could better support and motivate applications for these opportunities. Once an application was submitted, the Trust's data showed that there were no differences in the likelihood of staff being offered training. o **Indicator 8** – the percentage of staff who experienced discrimination at work from manager/team leader or other staff. • The data has shown that ethnically diverse staff experience discrimination 8.3% more than white staff. The Trust was addressing this issue as part of its violence prevention work and was also reviewing the appraisal process. The Deputy Chief Executive reported that every individual case had been reviewed by the Director of People and her team and they had provided assurance that in each case, the nature of the issues needed to be investigated as part of the formal process. Sally Glen, Non-Executive Director commented that NHS Providers had highlighted that some bank and agency staff reported that they felt discriminated against and did not feel psychologically safe. Ms Glen asked whether the Trust gathered feedback from bank and agency staff. The Deputy Director for Leadership, Inclusion and Organisational Experience reported that the Trust conducted a WRES survey for bank staff and said that the Trust was doing a lot of work around engaging with the Trust's temporary workforce, particularly those staff who were based at Prospect Park Hospital. Rebecca Burford, Non-Executive Director, said that she found the report very helpful. Ms Burford asked whether there was a distinction around how staff applied to do non-mandatory and CPD training compared with mandatory training. The Deputy Director for Leadership, Inclusion and Organisational Experience confirmed that the Trust had conducted a deep dive into access to non-mandatory and CPD training and was planning to do another deep dive this year. It was noted that the issue was complicated because non-mandatory training encapsulated a broad range of training from e-learning packages to university courses.

	Ms Burford commented that in some cases, there may be a confidence issue which meant that some groups did not put themselves forward for training. The Deputy Director for Leadership, Inclusion and Organisational Experience said that the Trust was engaging with the Staff Networks to understand the issues in more detail and was also offering staff coaching to improve their self-confidence if this was an issue. Ms Burford pointed out that some staff may need encouragement to apply for training on a one-to-one basis. The Deputy Chief Executive said that the Trust would be sending out guidance for managers on conducting the mid-year appraisals in the next couple of weeks and confirmed that this would include conversations around training opportunities. Ms Burford asked whether the Trust had conducted any analysis into whether there was a higher proportion of ethnically diverse staff working in roles/locations where it was more likely that staff would be subject to disciplinary action. The Deputy Chief Executive said that this was definitely the case at Prospect Park Hospital given the nature of the work. Naomi Coxwell, Non-Executive Director requested that the Finance, Investment and Performance Committee receive a paper on the outcome of the Case Work Review. **Action: Director of People** Ms Coxwell commented that it was important that that Trust did everything it could to reduce the likelihood of staff being subjected to formal disciplinary processes. The Chair said that this was a really important issue for the Trust and commented that he hoped the training for investigating officers was focussed and practical rather than generic training. **The Trust Board**: noted the report.
24/162	**Workforce Disability Standard Report** (agenda item 9.1)

	The Deputy Director for Leadership, Inclusion and Organisational Experience presented the report and highlighted the following points:
	
	• The Workforce Disability Equality Standard (WDES) was a national framework through which trusts are required to measure their performance against 13 key metrics for staff representation and experience with regard to disability.
	• The number of disabled staff in the Trust had increased by 60 compared with the previous year.
	• 389 staff had not declared their disability status, although the proportion of staff declaring their disability status was increasing year on year. Around 44% of medical staff had not declared disability status.
	• The results were mixed with four of the 13 metrics declining, five improving and three staying the same. The areas of focus for the Trust were:
	  o To increase disability disclosure rates on ESR (electronic staff record), particularly for medical staff
	  o Inclusive recruitment as likelihood of shortlisting had 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. Rebecca Burford, Non-Executive Director commented that some staff may choose not to disclose their disability status because they did not know how the data was going to be used. Ms Burford asked whether there was anything that could be done to make the process of updating information on ESR easier and shared that she had found it difficult to update her own equality information. The Deputy Director for Leadership, Inclusion and Organisational Experience said that the Trust was engaging with the Purple (Disability) Staff Network around what could be done to make it easier for staff to declare their disability status on the ESR system. Sally Glen, Non-Executive Director commented that it was important that the Trust also took account of the impact of inter-sectionality issues rather than focussing on individual protected characteristics. The Deputy Director for Leadership, Inclusion and Organisational Experience agreed but pointed out the WRES and WDES were nationally prescribed frameworks. The Medical Director referred to the relatively high number of medical staff who had not declared their disability status and pointed out that the national definition of disability was vague and suggested that a workshop session with doctors to discuss their reasons for not declaring their disability status would be helpful. **The Trust Board**: noted the report.
24/163	**Audit Committee Meeting – 24 July 2024** (agenda item 10.0)
	The minutes of the Audit Committee meeting held on 24 July 2024 had been circulated. Rajiv Gatha, Non-Executive Director reported that in addition to the standard items on the agenda, the meeting had received a presentation from the Chief Information Officer on Artificial Intelligence and how it was being used in the Trust. Mr Gatha also reported that Ernst and Young, External Auditors had appointed Ben Lazarus to replace Maria Grindley who was shortly retiring. Aileen Feeney, Non-Executive Director asked whether it would be helpful for the Board to receive regular updates on the Trust's use of Artificial Intelligence. The Chair suggested that updates on Digital at Board Discursive meetings should include any developments in the Trust's use of include Artificial Intelligence. **Action: Deputy Chief Executive** The Chair thanked Rajiv Gatha for his update. **The Trust Board**: noted the minutes.
24/164	**Council of Governors Update** (agenda item 10.1)

	The Chair reported that he had met with some of the Lead Governors in the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board.
24/165	**Any Other Business** (agenda item 11)
	Medical Director's Forthcoming Retirement The Chief Executive reported that Dr Minoo Irani, Medical Director, had announced that he would be retiring from the Trust on 10 March 2025. The Chief Executive commented that Dr Irani would be a hard act to follow. It was noted that the recruitment process to find a new Medical Director would commence shortly.
24/166	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 12 November 2024.
23/167	**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 10 September 2024.

Signed……. Date 12 November 2024

(Martin Earwicker, Chair)

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Patient Journey

Sagal Ali
Jubilee ward manager
Community inpatients

Background information

Berkshire Healthcare NHS Foundation Trust

- Admitted to WPH after fall and Sustained left Humerus fracture
- Patient was born Deaf and communicated using British sign Language
- Progressing Dementia
- Daughter was Carer
- Long acute admission of 56 days
- Lived alone
- Admitted to Jubilee on the 08/02 for Rehabilitation

Acute referral to In Reach

Berkshire Healthcare NHS Foundation Trust

- Referred as a pathway 2
- Handover from In reach about patient's communication needs
- Morning admission to facilitate daughter being present

Things we planned before the admission:

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- Contact Remark interpreting services, book sessions
- Informative handover to all staff about this admission
- Large print food menu
- Informing therapy team and Doctors of the times the BSL interpreter was booked
- Communication pack, communication board
- Making sure that all communication aides are easily accessible.

Things we did during admission:

Berkshire Healthcare NHS Foundation Trust

- PEEP- Personal fire evacuation plan- due to fire risk on unit
- Booking interpreter in advance for important interventions- using Remark
- Regular Updates from the Multidisciplinary team
- Flexible visiting times for daughter
- Communication needs preference form
- Communication needs care plan

Therapy Engagement

- Attended strength and balance groups
- Wellbeing groups
- Daughter invited to several Joint therapy sessions
- Patient enjoyed attending the group therapy sessions

Therapy Engagement

- Ageing well outcome: Arrival:16 Discharge: 34
- Therapy sessions attended:36
- Therapy sessions offered but declined: 1

Discharge planning

- Discharge was complex
- Best interest meeting held with interpreter and daughter
- Communicate options with both patient and daughter
- Brochures given for several different care homes

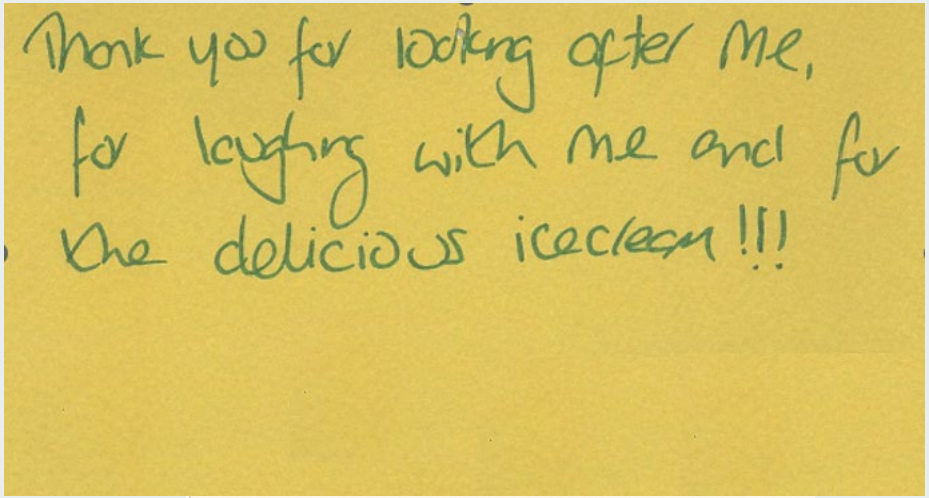
Onward referrals

- Memory clinic
- Anticoagulation review for Pulmonary embolism
- Community Physiotherapy
- Daughter referred to carer support group in community-
- Living well programme

Patients experience:

Berkshire Healthcare NHS Foundation Trust

- Patient felt listened to and included in all aspects of his care
- Feedback from daughter that patients received excellent care
- We got a lovely written card at the end of the patient's admission
- We bridged the interpreting sessions for him for 3 days to help patient settle into care home


Thank you for looking after me,
for laughing with me and for
the delicious icecream !!!


Thank
You!

NHS
Berkshire Healthcare
NHS Foundation Trust

Thank you

Questions…?

BOARD OF DIRECTORS MEETING 12.11.24

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**	On the agenda for the meeting.	
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**	The Freedom to Speak Up Guardian will be involved in the review of Human Resources investigation	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						processes.	
09.07.24	24/114	Freedom to Speak Up Guardian's Report	The Director of People to present a paper to the Board to explain the Speaking Up and Whistleblowing processes.	November 2024	**JN**	Attached at appendix A	
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.	November 2024	**DF**	On the agenda for the meeting.	
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.	November 2024	**DF**	The Freedom to Speak Up Improvement Plan has been updated to include the recommendations from the Internal Audit Review	
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.	December 2024	**AG**	On the agenda for the December 2024 Trust Board Discursive meeting.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
10.09.24	24/155	Patient Experience Report	The Director of Nursing and Therapies to share with the Board the Model Hospital complaints benchmarking information.	November 2024	**DF**	The Model Hospital benchmarking data for 2022-23 showed that the Trust had 69 complaints per £100m of income compared with the Trust's peer group of 83 complaints per £100m of income (nationally the number was 69 complaints per £100m of income.	
10.09.24	24/155	Patient Experience Report	The Director of Nursing and Therapies to consider defining a sub-set of important patient experience data that could be used to benchmark different Trust services to be discussed by the Quality Assurance Committee and reported back to the Board.	November 2024	**DF**	The Director of Nursing and Therapies will discuss what would be helpful with the Chair of the Quality Assurance Committee.	
10.09.24	24/155	Patient Experience Report	The Medical Director to keep the Board appraised of any recommendations from the Lampard Inquiry into the deaths of over 2,000 mental health patients in NHS trusts	November 2024	**MI**	The Board will be kept informed about any recommendations from the Lampard Inquiry.	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			in Essex.				
10.09.24	24/159	True North Performance Scorecard	The Chief Operating Officer to provide further information to explain the increased performance in relation to Health Visiting New Birth Visits.	November 2024	**TA**	Although the Trust scorecard demonstrated a 96.6% compliance for New Birth Visits (NBV) across the four local authorities, internally it flagged a concern that there is a potential discrepancy between the Trust and service data, which we are in the process of exploring. Currently the 0-19 leads are completing a robust piece of QI work to understand more fully why we are not reaching the NBV target across the 4 local authorities, identifying top contributors and agreeing	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						countermeasures to put in place.	
10.09.24	24/161	WRES Report	The Finance, Investment and Performance Committee to receive a report setting out the outcome of the Trust's Case Work Review.	January 2025	**JN**	On the agenda for the January 2025 Finance, Investment and Performance Committee meeting.	
10.09.24	24/163	Audit Committee	Future Board updates on Digital to include any developments in the Trust's use of Artificial Intelligence.	December 2024	**AG**	On the agenda or the December 2024 Trust Board Discursive meeting.	

Appendix 1: The Berkshire Healthcare process for raising and escalating a concern

Step one
If you have a concern about a risk, malpractice or wrongdoing at work, we hope you will feel able to raise it first with your line manager, lead clinician or tutor (for students). This may be done verbally or in writing.
If you are a member of a Trade Union/Professional Body you may wish to seek advice from them.

Step two
If step one does not address your concerns or you feel unable to raise the matter with your line manager, lead clinician or tutor, for whatever reason, you could raise the matter with any of the following:

- Your Divisional Director
- The Berkshire Healthcare Freedom to Speak Up Guardian (speakup@berkshire.nhs.uk 07920 503352)
- The Berkshire Healthcare executive director with responsibility for whistleblowing. This is Deborah Fulton, Director of Nursing and Therapies and her contact details are Deborah.Fulton@Berkshire.nhs.uk; Telephone 0300 247 3000
- The Local Counter Fraud Specialist: Jenny Loganathan – jenny.loganathan@tiaa.co.uk

The people above have been given special responsibility and training in dealing with whistleblowing concerns. They will:

- Treat your concern confidentially unless otherwise agreed
- Make sure you receive timely support to progress your concern
- Escalate to the board any indications that you are being subjected to detriment for raising your concern
- Remind the organisation of the need to give you timely feedback on how your concern is being dealt with
- Make sure you have access to personal support since raising your concern may be stressful.

Step three
If these steps have been followed and you still have concerns, or if you feel that the matter is so serious that you cannot discuss it with any of the above, please contact Julian Emms the Berkshire Healthcare Chief Executive (contact email address: Julian.Emms@berkshire.nhs.uk) or Mark Day, a non-executive director of Berkshire Healthcare - Mark.Day@berkshire.nhs.uk

Alternatively, you can write to either of them at the Berkshire Healthcare's Head Office: London House, London Road, Bracknell, RG12 2UT; Tel: 0300 247 3000.

Step four
You can raise concerns formally with external bodies as listed below.

You can raise your concern outside the organisation with:

- **NHS England** for concerns about:
    - How NHS Trusts and Foundation Trusts are being run
    - Other providers with an NHS provider licence
    - NHS procurement, choice and competition
- **Care Quality Commission** for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.
- **NHS Counter Fraud Authority** for concerns about fraud and corruption using their online reporting form or calling 0800 028 4060
- **Your professional association or trade union** if applicable. If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix 3: What to expect if you raise a concern.

We are committed to developing and promoting a culture where everyone feels safe and confident to raise any concerns they have, whether they're about patient safety, poor practice, anything fraudulent or illegal in nature, or something which affects their experience of working for the Trust.

Raising concerns openly and at an early stage means that we can take swift action, with a focus on learning and making improvements to prevent issues escalating, or poor practice being repeated.

We will listen to any genuine concern that you raise.

There are many ways in which you can raise a concern, and these are detailed on Nexus:

Report a problem | Nexus (berkshirehealthcare.nhs.uk)

Further information about the process we will use to deal with concerns can also be found in the freedom to speak up policy:

Freedom to speak up policy

On most occasions, concerns are resolved informally and swiftly without any further investigation or action being needed. This guidance outlines what you can expect if a concern you raise progresses to an investigation.

We understand that you may feel worried about raising a concern. Please be assured that we will not tolerate the harassment or victimisation of anyone who raises a concern, or indeed any behaviour which is intended to discourage someone from raising a concern or treat them detrimentally for doing so.

We hope that you will feel able to raise any concerns you have openly, but we also recognise that you may want to remain anonymous. It is helpful if you do feel able to participate in the process as it means that we can speak to you if we need more information about your concern. It also means that we can keep you updated on progress and let you know the outcome of your concern. We can also make sure that you get any support you need.

What support will I receive if I raise a concern?

We will always ask you whether there is any particular support that you feel you might need whilst your concern is being investigated.

We will send you weekly updates on the progress of the investigation and even if there has been no progress in a particular week, we'll let you know that this is the case.

We'll explore with you whether you would like to have a specific point of contact, e.g. someone who is assigned to keep in regular contact with you to provide regular updates and/or emotional support.

There are also the following sources of support available to you at any time:

- Occupational Health
- Wellbeing Matters: 0300 365 8880 (9am-4pm Monday to Friday) or wellbeingline@berkshire.nhs.uk
- Health Assured (Employee Assistance Programme) provide independent confidential advice, legal information, financial planning, dept management and counselling 24 hours a day at 0800 028 0199. The wellbeing portal can also be accessed at Home | Health Assured (healthassuredeap.co.uk): Username: wellbeing | Password: CakeCoinMile
- Nexus resources on health and wellbeing available at: https://nexus.berkshirehealthcare.nhs.uk/wellbeing

These sources of support remain available to you even after the investigation is concluded.

If you feel you're not receiving the right support, then you should contact speakup@berkshire.nhs.uk

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	Tuesday 12th November 2024
Title	**Freedom to Speak Up Report**
	For noting
Reason for the Report going to the Trust Board	It is mandated by NHS England and the National Guardian's Office that all Freedom to Speak Up Guardians submit a Board report at least every 6 months. The Care Quality Commission also assesses the Trust's Speaking Up Culture as part of its Well-Led Inspection. The Board is asked to note the contents and support the recommendations.
Business Area	Quality
Author	Mike Craissati, Freedom to Speak Up Guardian
Relevant Strategic Objectives	**Workforce** **Ambition:** We will make the Trust a great place to work for everyone To strengthen our highly skilled workforce and provide a safe working environment where staff feel safe to speak out, are listened to and the Trust evidence action taken to deal with issues raised with no detriment suffered by staff.

Highlight Report – Freedom to Speak Up
July – November 2024

1. Why is this coming to the Board?

This report is written to provide information and assurance to the Board in relation to the activities of the Freedom to Speak Up (FTSU) Guardian, the National Guardian's Office (NGO) and to highlight relevant data of concerns raised and other activity generated during the period.

Both NHS England and the NGO set out guidelines and expectations that the FTSU Guardian works alongside Trust Leadership Teams to support the Organisation in becoming a more open and transparent place to work where all staff are encouraged and enabled to speak up safely. Part of the learning process is that the Guardian reports to Trust Board on, at least, a 6 monthly basis outlining the key activities of the Guardian, giving a fair presentation of data around concerns raised and notifies the Board of points of specific interest for the Board to take note of.

2. What are the key points?

Communication: It is key that the FTSU Guardian is seen as being visible and accessible to all staff groups both to raise awareness but also to be available for staff who wish to make contact. To do that the Guardian uses all forms of communication including, but not restricted to, presence at all Inductions, supporting all staff networks as an ally, membership of all groups or committees that are people focussed and promote an inclusive or just culture. During the period the Guardian has played a keen part in helping to promote the Trust's Anti-Racism stance, working with colleagues to help with Violence Prevention & Reduction and Anti Bullying & Harassment workstreams. The introduction of all staff "Lunch & Learn" webinars help communicate to proactive support for a positive culture change towards greater compassion.

Data on Concerns raised: Numbers of cases raised for Q1 24/25 to date (end October 2024) remain level with no significant change. Levels of concerns that have an element of Bullying & Harassment have decreased but that is mainly due to the recent introduction of a new category "Inappropriate behaviours". The majority of concerns are raised by non-managerial staff (84%) and mainly from the Midwife & Nursing staff group (26%). Poor behaviour between staff accounts for 58% of cases raised with 1 case that had an element of patient safety (these cases are always immediately raised to the Director of Nursing & Therapies, the relevant Divisional or Clinical Director as well as patient safety colleagues).

The responses to the 2023 NHS National Staff Survey are being used to provide a "Culture Barometer" for services, thus enabling a targeted approach towards team building and culture improvement.

Impact on staff (Protected characteristics, detriment):

16% of cases raised contained an element of detriment towards the person raising a concern. This compares to 23% for the previous period. Work is ongoing regionally to try and address this and the Trust is looking at internal processes such as formal or informal grievances to try and reduce this.

It is recognised that certain staff groups, such as those with protected characteristics, have barriers to overcome before raising a concern. The Guardian is working closely with the staff networks to understand and try to reduce or eliminate these barriers. 3 of the cases raised during the period involve issues around protected characteristics, however it would appear that more staff with ethnically diverse backgrounds are approaching the Guardian for advice or support (if not actually formally raising a concern).

Culture & Learning: The period has shown a greater number of staff completing the FTSU E-Learning packages. These courses are also a pre-enrolment requirement for all Leaders & Managers attending the Leading for Impact Management training course with the Guardian delivering a module on Civility, Communication & Psychological Safety.

3. Conclusions and Recommendations for consideration by the Board

Whilst numbers of cases raised to the Guardian remain steady and the Guardian's proactive work in raising awareness of FTSU and helping to promote the right behaviours and values within the Trust remains a busy as ever, it seems clear that the staff experience when raising a concern, still needs more effort. Staff are approaching the Guardian at a late stage, when poor behaviours are already embedded, thus making resolution more challenging.

The time taken to deal with concerns and provide an outcome or resolution is something mentioned by staff as being a negative. This is partly the reason for feelings of detriment and still a reason for staff to not raise concerns (whether to the Guardian or elsewhere). There is also still a general feeling of not being listened to and not getting appropriate feedback when Managers or Leaders are approached to deal with issues.

In light of the above, the Board is asked to support the following:

- Support and encourage initiatives to address subjective "Staff Experience" concerns, specifically those that include an element of bullying & harassment and/or microaggressions.
- Support and encourage initiatives to minimise the risk of detriment.
- Support and encourage initiatives to improve a Listening Up culture.
    - As October's theme nationally is "Listening Up" the Board are specifically asked to concentrate on supporting this initiative. An effective gauge is for the Board to ask, "Did you feel heard?", this can be done as part of the various ways the Board communicates with staff but also when visiting services. If staff feel heard, then that takes into account potential barriers such as Neurodiversity & Cultural differences. It is also just as relevant when getting feedback from our Communities or service users.

Mike Craissati - Freedom to Speak Up Guardian

November 2024

Berkshire Healthcare
NHS Foundation Trust

Report to the Meeting of the

Berkshire Healthcare NHS Foundation Trust
Board of Directors

Freedom to Speak up Report for

June 2024 – November 2024

Background

A Freedom to Speak up Guardian (FTSUG) within every Trust was a key recommendation made by Sir Robert Francis QC in the Freedom to Speak Up review 2015. FTSU has also become part of the CQC Well Led inspection component since October 2016.

A standard integrated FTSU policy for the NHS issued in April 2016 is the basis of the Trust's Raising Concerns policy. This national policy has been reviewed with an update published in Q2 22/23.

In line with the above and as part of our regular policy review process, the Berkshire Healthcare FTSU policy was reviewed and updated in September 2023.

The FTSU Strategy 2023-26 was also published in June 2023.

The National Guardian's office (NGO) was established in October 2016 at the same time as it became a contractual obligation for every NHS Provider Organisation to have appointed a FTSU Guardian.

The Role of the Freedom to Speak Up Guardian

"The Freedom to Speak Up Guardian will work alongside Trust leadership teams to support the organisation in becoming a more open and transparent place to work, where all are actively encouraged and enabled to speak up safely." (NGO 2018)

The FTSUG is independent and impartial. The Guardian reports directly to the Chief Executive and has access to anyone in the organisation. There are two main elements to the role.

- To give independent, confidential advice and support to members of staff who wish to speak up that have an impact on patient and staff safety or issues around malpractice,

wrongdoing and fraud. This is not exclusive to permanent members of staff but extends to temporary or agency staff, trainees or students, volunteers and trust governors.

- To promote a culture where members of staff feel safe to raise concerns and do not fear adverse repercussions or detriment as a consequence of doing so.

Debbie Fulton, Director Nursing and Therapies is Executive Lead for Freedom to Speak Up and Mark Day, Non-Executive Director, is nominated Non-Executive Director for Freedom to Speak Up.

Communication

It is crucial that the FTSU role is visible and accessible to all staff. The communications plan outlines how this is achieved.

The plan includes the following (Showing progress on plans and relevant target dates):

- Raising Concerns presence on Nexus
- Presentations and attendance at management/team meetings (ongoing)
- Production and dissemination of posters, leaflets and cards etc (ongoing)
- Virtual or F2F presence at Corporate Induction, Junior Doctor's Induction, International Nurses Induction & Student's Induction
- Supporting all EDI/Staff Networks as an Ally.
- Membership of the Safety Culture Steering Group, Strategic People Group, Diversity Steering Group, Anti-Racism Taskforce, Violence Prevention & Reduction Working Group amongst others
- Chair of Bullying & Harassment Reduction Task & Finish Group
- Managing a cohort of 28 FTSU Champions. The role of the Champions is to support the Guardian by raising awareness of the FTSU process locally and to signpost to the Guardian should any staff member wish to raise a concern. The Champions cover a wide range of pay bands with representation within all Divisions. 39% of Champions are declared staff network members and 34% have also raised concerns to the Guardian prior to becoming a Champion. It is hoped that the cohort fairly represent the diversity of the Organisation.
- During the period the Guardian has delivered an ongoing series of "Lunch & Learn" webinars which are available for all staff. October was Freedom to Speak Up Month and the theme this year was "Listening Up". During October the Guardian was visible across the Organisation, visiting sites, raising awareness of the process and asking staff to sign a "Listening Up" pledge. To date there have been some 130 signatories. Some of the site visits were in conjunction with members of the EDI Team. 3 new Champions (all ethnically diverse) were recruited during October as the Guardian supported events to recognise Black History Month.
- The Guardian is using the 2023 NHS National Staff Survey to develop a "Culture Barometer" which can be applied to services at Locality 5 where sub-scores can be rated against an average sub-score of the Trust, thus allowing for a targeted approach for service support and culture improvement. This can also be done for responses sorted by protected characteristics.

Independent feedback from Corporate Induction, afternoon of day one, where 7 “marketplace” presentations are given to new starters:

Q. How would you rate the following Information sessions in terms of usefulness/relevance?

Jan – March 2024

April – June 2024

July – September 2024

Contribution to the Regional and National Agenda

The Guardian is Chair of the Southeast Regional FTSU Guardian Network consisting of all NHS Trusts and private providers (including Primary Care) this numbers 235 Guardians representing 137 Organisations and provides input to quarterly meetings between the NGO & regional Chairs.

The Guardian is a member of both a Frimley and a Berkshire West, Oxfordshire & Buckinghamshire (BOB) Guardian ICB Network, members include Guardians from the ICB’s and all Provider Trusts within the two systems including SECAMB & SCAS.

During October the Guardian co-hosted a Frimley System webinar on the importance of good listening. The National Guardian was invited as keynote speaker.

The Guardian supports a pan-sector networking group which includes Whistleblowing & Speak Up Leads from non-healthcare Organisations such as Berkshire Fire & Rescue, John Lewis Partnership, NatWest Group, ACAS, Compass Group & the Nuclear Decommissioning Authority. This group allows for shared learning outside of the Healthcare model of Speaking Up.

Quarterly submissions to the National Guardian's Office (NGO)

The NGO requests and publishes quarterly speaking up data.

Contacts are described as "enquiries from colleagues that do not require any further support from the FTSUG".

Cases are described as "those concerns raised which require action from the FTSUG".

Outlined below are Berkshire Healthcare's submissions to the NGO for FY 2024/25 to date (end of October).

It's difficult to make comparisons with other similar organisations as the data does not provide a narrative regarding how many guardians or champions there are, how many days a week they work and if they have recorded both cases and contacts.

Both cases and contacts are required to be reported to the NGO

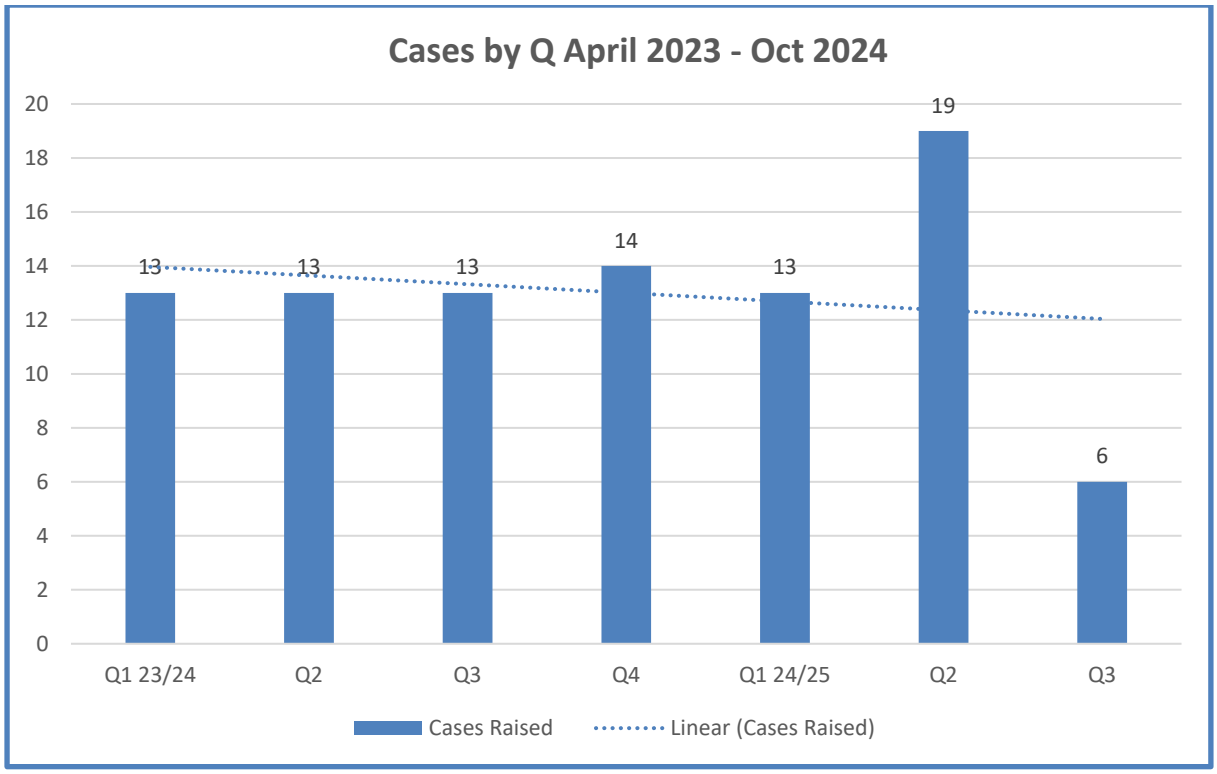
The following tables show a comparison between national and local reporting.

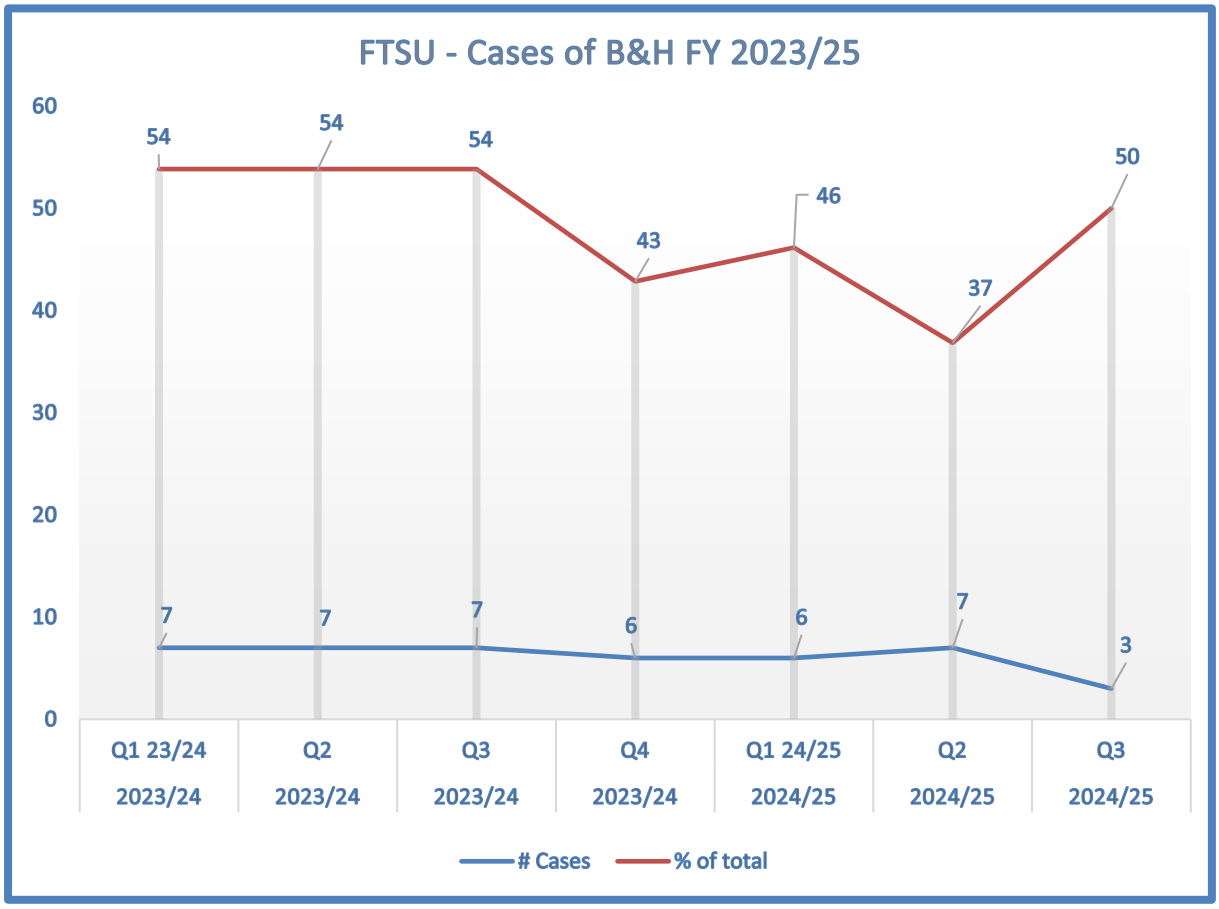
Cases per 1,000 FTE for Q4 2023/24	Berkshire Healthcare	Peer average	National
Total cases reported to FTSUG	3.11	4.1	5.53
Element of Bullying and harassment	1.33	0.84	0.88
Element of Patient safety and quality	0.44	0.73	0.91
Element of Worker safety cases	0	1.58	1.54
Element of inappropriate behaviour	2	1.76	2
Element of anonymity (to the Guardian)	0.44	0.2	0.24

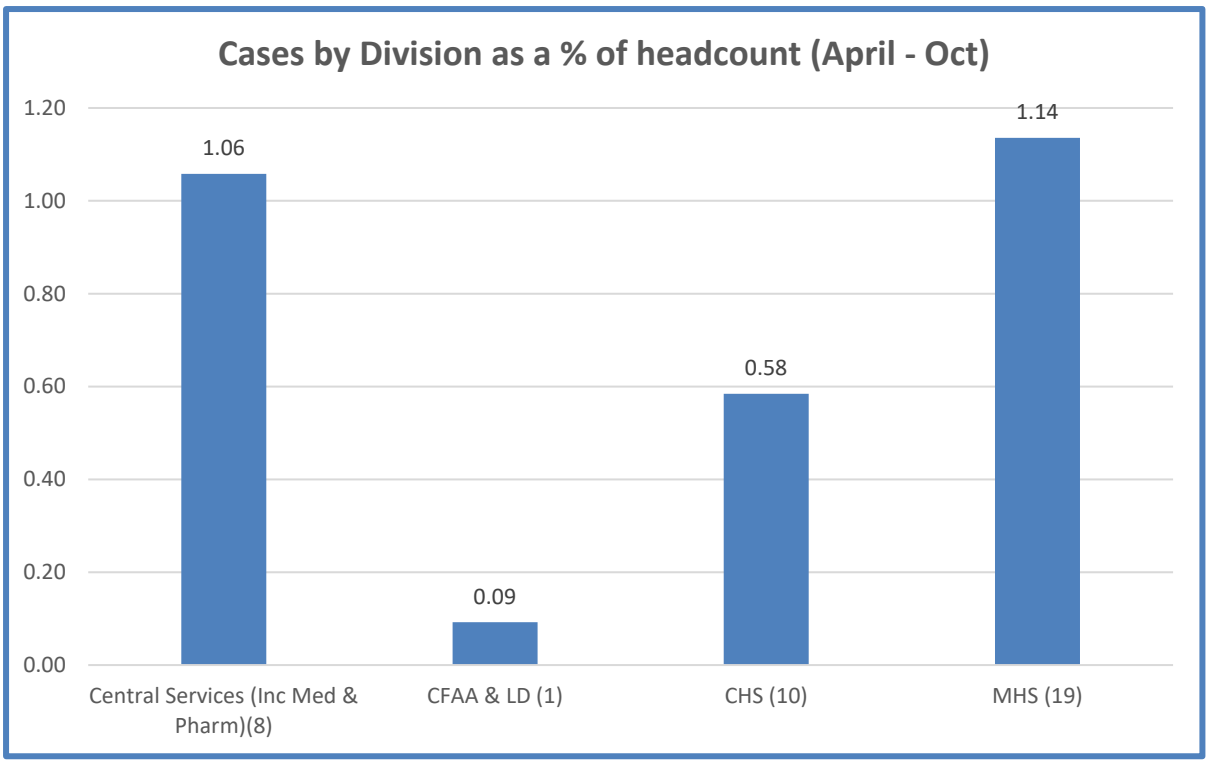
Source: NHS England Model Hospital

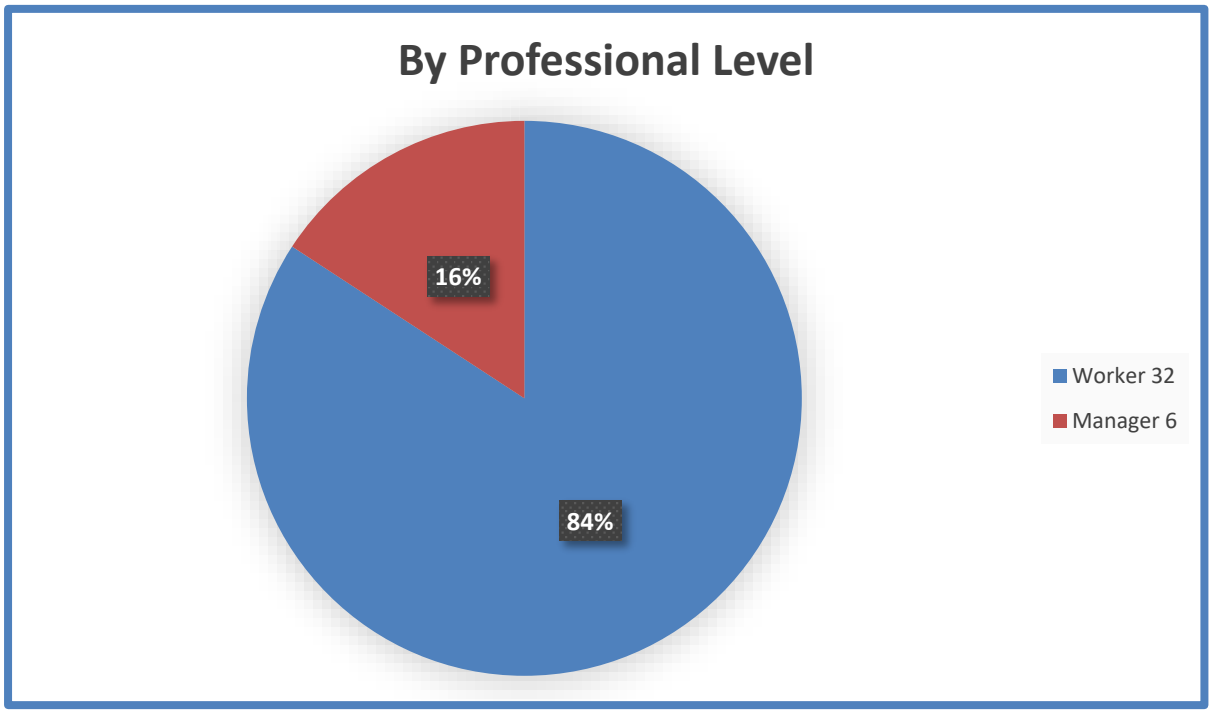
Type	National	% change on 2022/23	Local	% change on 2022/23
Total Cases reported to NGO	**32,167**	**+27.60%**	**53**	**-21.00%**
Element of Patient Safety	18.70%	-0.70%	8.00%	+2.00%
Element of Bullying & Harassment	19.80%	-2.00%	51.00%	-16.00%
Element of worker safety & Wellbeing	32.30%	+4.70%	0.00%	-4.00%
Element of Inappropriate behaviours	38.50%	New	43.00%	New
Anonymous (to the Guardian)	9.50%	+0.10%	4.00%	+4.00%
Detriment	4.00%	0.00%	25.00%	+19.00%

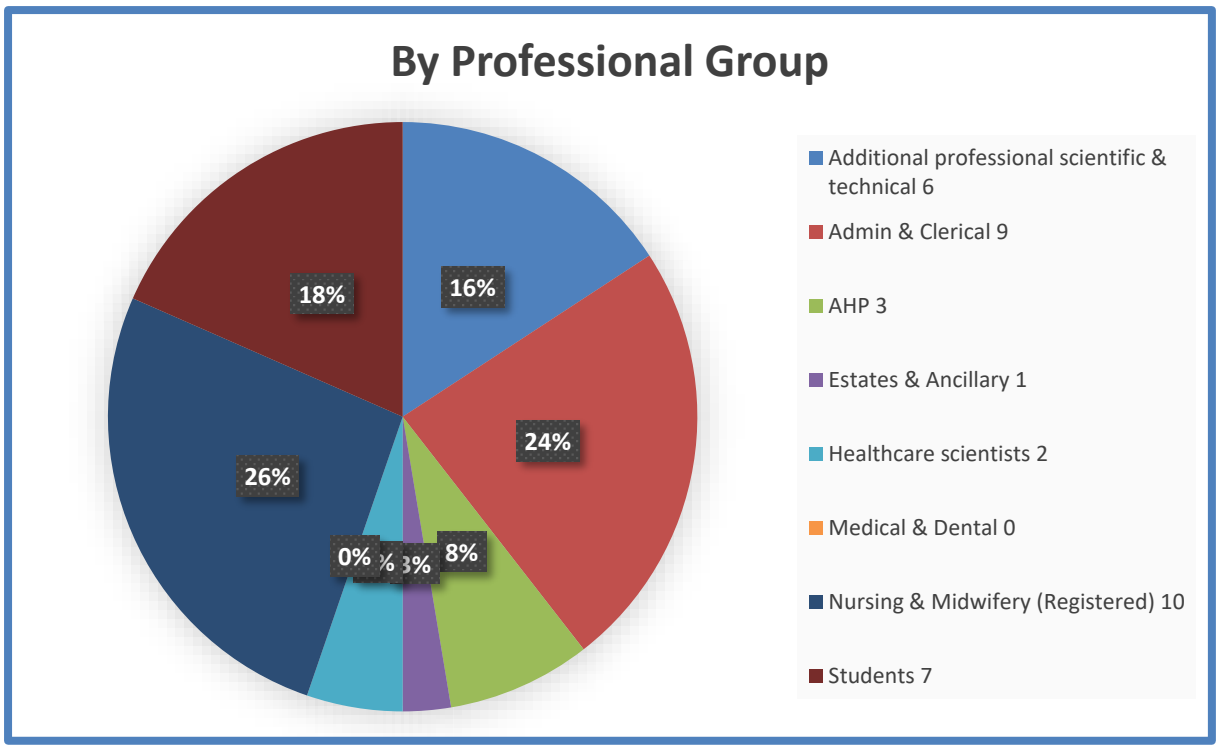
Source: National Guardian's Office Annual Report July 2024 (April 2023 – March 2024)

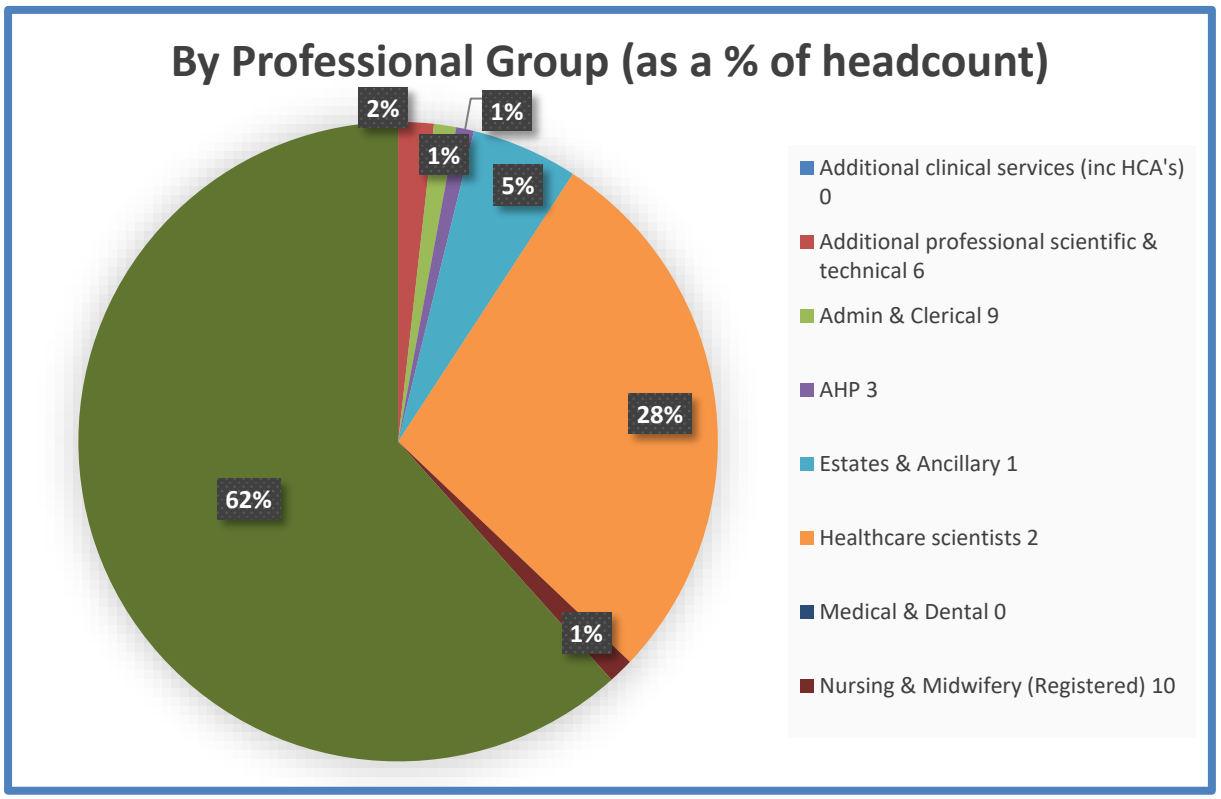

Cases by Q April 2023 - Oct 2024
20
18
16
14
12
10
8
6
4
2
0
13
13
13
14
13
19
6
Q1 23/24
Q2
Q3
Q4
Q1 24/25
Q2
Q3
Cases Raised
Linear (Cases Raised)

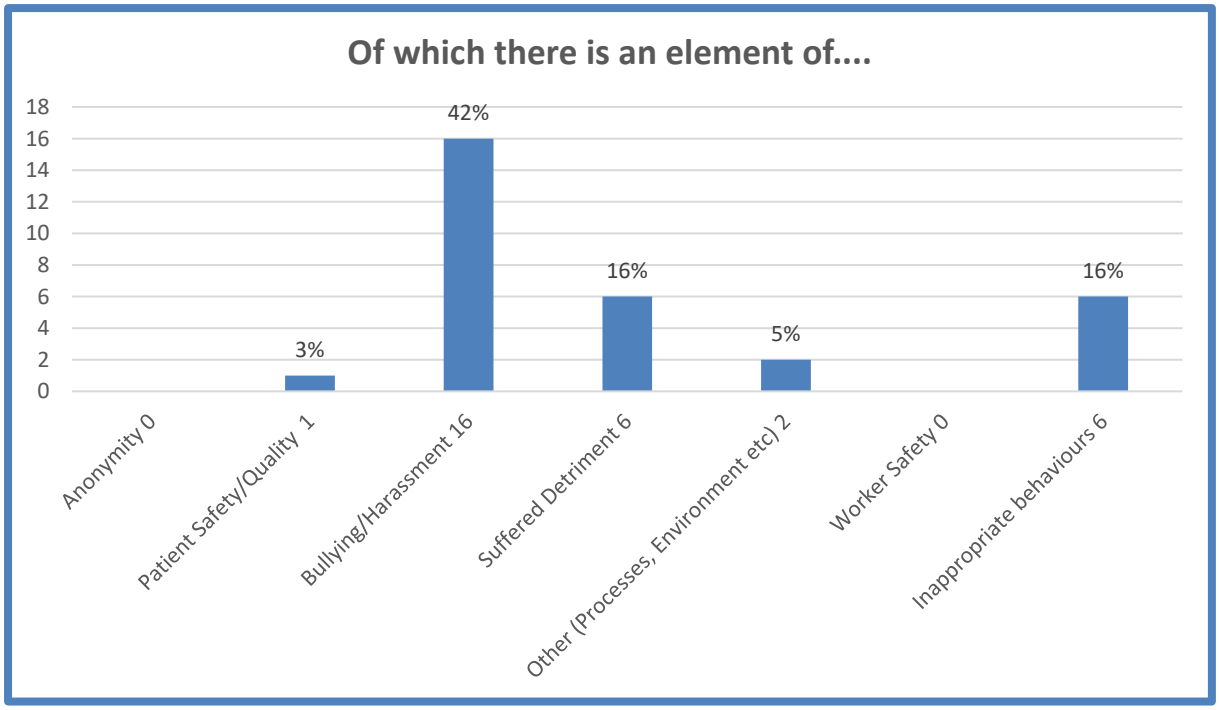

FTSU - Cases of B&H FY 2023/25
60
50
40
30
20
10
0
54
54
54
43
46
37
50
7
7
7
6
6
7
3
Q1 23/24
2023/24
Q2
2023/24
Q3
2023/24
Q4
2023/24
Q1 24/25
2024/25
Q2
2024/25
Q3
2024/25
Cases
% of total


Cases by Division as a % of headcount (April - Oct)
1.20
1.00
0.80
0.60
0.40
0.20
0.00
1.06
0.09
0.58
1.14
Central Services (Inc Med & Pharm)(8)
CFAA & LD (1)
CHS (10)
MHS (19)


By Professional Level
16%
84%
Worker 32
Manager 6


By Professional Group
16%
24%
8%
0%
26%
18%
Additional professional scientific & technical 6
Admin & Clerical 9
AHP 3
Estates & Ancillary 1
Healthcare scientists 2
Medical & Dental 0
Nursing & Midwifery (Registered) 10
Students 7


By Professional Group (as a % of headcount)
2%
1%
1%
5%
28%
62%
1%
Additional clinical services (inc HCA's) 0
Additional professional scientific & technical 6
Admin & Clerical 9
AHP 3
Estates & Ancillary 1
Healthcare scientists 2
Medical & Dental 0
Nursing & Midwifery (Registered) 10



Inappropriate behaviours – “Any attitude or behaviour that doesn’t constitute bullying or harassment e.g. incivility, actions contrary to an organisation’s values, microaggressions” NGO

Assessment of Issues

- The number and type of cases raised fit into the general pattern of cases from previous periods and could be considered the norm.
- Returns show that 1 case raised via FTSU contains an element of patient safety, the Board can be assured that any other patient safety issues are raised via other routes, handovers etc.
- A high proportion of cases raised are done so where the person raising the concern wishes some form of anonymity or confidentiality having spoken to the Guardian. In such circumstances the Guardian acts as a “go-between” between those raising a concern and the service concerned. Generally, a Commissioning Manager and Investigating Officer will know the identity of the person to aid progress of the case.
- During the period the Guardian received no anonymous concerns.
- A significantly high proportion of cases are around the “staff experience” and specifically from staff who are stating the cause is bullying & harassment (B&H) from fellow staff members (no cases have been received where B&H has been reported as coming from patients or from the public at large – this would normally be highlighted via Datix).

Improving FTSU Culture

Creating a culture where all staff feel able to speak up and feel valued for doing so is dependent on the organisation showing it is listening and taking their concerns seriously. Giving feedback is one important way the Trust can demonstrate it values staff that speak up. The importance of this stage of the process is not always recognised by managers. Staff who speak up to the FTSUG fear suffering detriment as a result and this can present a barrier.

From personal observations and feedback from those who have spoken up, the following is highlighted:

- To achieve an open culture around speaking up, all elements of good, effective communication need to be included in the process. Speaking Up is only part of this and is relatively easy to address.
- An effective process is only achievable if the other elements are addressed, namely improving the Listening Up Culture, and removing barriers to communication.
- Part of the Listening Up process should include improved feedback to those who raise concerns, including timescales, expectations around outcomes.

Learning and Improvement

The FTSU Status Exchange between the Guardian, Chief Executive, Director of Nursing and Therapies and Deputy Director of People continues to provide a good forum for a structured information exchange, triangulation of information, and ensuring action is completed regarding concerns raised.

A regular meeting between the FTSUG and the Deputy Director of People & Senior HR Managers continues as a standard piece of work to enable direct communication about case work in a confidential manner.

The Guardian meets on a six-monthly basis with the nominated Non-Executive Director lead.

The Guardian ensures that any learning from cases raised is communicated to the Organisation through this status exchange, through regular 1:1's with the Executive lead for Freedom to Speak Up. All cases are audited on a quarterly basis to ensure any learning is taken into account and actioned.

Those who raise concerns are offered continual feedback on any investigation work undertaken as a result of speaking up and are supported throughout the whole process, the Guardian also obtains feedback from those who raise concerns on their views of the process and this learning is reviewed and considered by the Guardian.

In the majority of cases, feedback from those who have raised concerns to the Guardian on the process and level of support and advice offered by the Guardian is very positive.

On occasions where reports of case reviews undertaken by the National Guardian's Office are published, the Guardian will review these reports and communicate recommendations to the Organisation.

The National Guardian's Office have released a series of E-Learning packages, there are 3 packages aimed at various levels within the Organisation.

All three modules are available for staff on the Trust Nexus e-learning platform, Totara.

- **Speak Up** – Core training for all workers, volunteers, students and trainees, aimed at giving all staff an understanding what speaking up is, how to do so and what to expect when they do so.
- **Listen Up** – Aimed at all line managers, raising awareness of the barriers that can exist when staff wish to speak up and how to minimise them.
- **Follow Up** – For Senior Management groups and Trust Executives, ensuring the Organisation acts on concerns raised, learns from them and uses feedback to help create an open & just culture where all workers are actively encouraged to use their voices to suggest improvements or raise concerns. For ease, this is set at AFC 8A and above.

Completion of these E-Learning packages has been determined as essential training for the following staff groups:

- Board, Executive & SLT
- Elements of the People Directorate (Business Partners, OD/ EDI, L&D)
- Elements of the Nursing & Governance Directorate (Patient Safety & Quality, Safeguarding, Patient Experience)
- All FTSU Champions
- All Leading for Impact Management & Leadership course delegates
- The training has been introduced as a requirement for all staff attending Corporate Induction with guidance given re which level(s) are appropriate.

E-Learning Course completions			
	Speak Up Core training	**Listen Up Managers**	**Follow Up Leaders**
2023	130	42	26
2024 (to Oct)	52	20	7
TOTAL	**182**	**62**	**33**

The Guardian and all Champions continually promote the E-Learning packages as well as a link for staff to request Speak Up Awareness sessions for their Teams or Service via their email signatures. This is also available on the Raising Concerns pages on Nexus.

The Guardian now presents a module as part of the recently introduced Leaders & Managers training course, Leading for Impact. The module deals with the following subjects, Civility, Communications skills, Difficult Conversations & Psychological Safety. These topics align with many of the proactive activities attributed to Freedom to Speak Up principles.

Learning – Some follow up actions from cases raised.

- All cases are audited on a quarterly basis to ensure any learning is actioned.
- Where appropriate Services now have the support of an MDT/Organisational Development team. This includes representatives from HR, OD, Psychological Services, FTSU, Patient Safety, EDI leads. Concerns raised from staff within these services have helped to highlight some dysfunctionality or friction within the service. The aim of the MDT is to assist Heads of Service with improving morale, behaviours and efficiency of the service.
- In several cases where the standard of management may be in question, support will be given on a more individual basis to improve management techniques.

It has been highlighted that with larger more complex cases where there may have been a collective concern or group of concerns that, due to the time taken to investigate these concerns, that staff concerned should get better and more frequent feedback. This is being addressed with HR colleagues to align the FTSU process with HR processes.

Examples of non-implementation of learning from concerns raised:

During the period there were no examples where learning from concerns raised (from cases that have been closed) had not been fully implemented.

Recommendations from the FTSU Guardian

The Trust Board is asked to support the following:

- Support and encourage initiatives to address subjective “Staff Experience” concerns, specifically those that include an element of bullying & harassment and/or microaggressions.
- Support and encourage initiatives to minimise the risk of detriment.
- Support and encourage initiatives to improve a Listening Up culture.
    - As October’s theme nationally is “Listening Up” the Board are specifically asked to concentrate on supporting this initiative. An effective gauge is for the Board to ask, “Did you feel heard?”, this can be done as part of the various ways the Board communicates with staff but also when visiting services. If staff feel heard, then that takes into account potential barriers such as Neurodiversity & Cultural differences. It is also just as relevant when getting feedback from our Communities or service users.

Mike Craissati - Freedom to Speak Up Guardian

November 2024

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

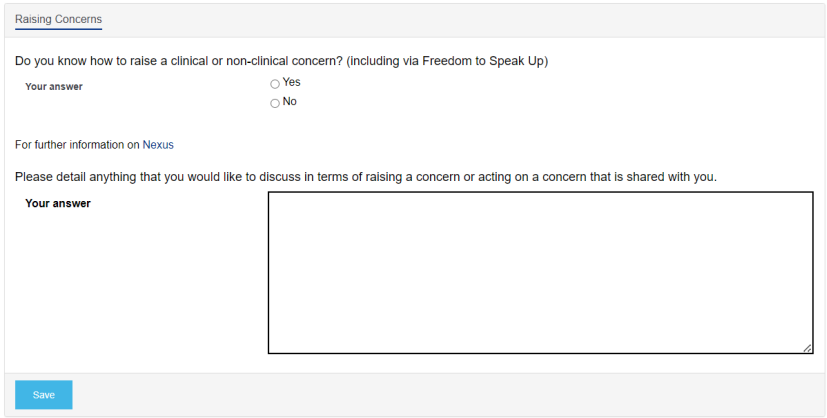
Board Meeting Date	12 November 2024
Title	**Freedom To Speak Up - Self Assessment Improvement Plan**
	for Noting
Reason for the Report going to the Trust Board	It is good practice, as detailed by NHS England for the freedom to speak up, self-reflection tool to be reviewed by organisations at least every 2 years, the aim being to identify gaps and areas for improvement as well as areas of good practice on a regular basis. The latest version of our self-reflection and planning tool was approved at Board in March 2024; within the tool areas for ongoing improvement were identified areas. It was agreed that progress against these would be presented to the Board on a six-monthly basis, with timing to be such that the plan is available to the Board for the same meetings as the Freedom to Speak Up Guardians Report.
Business Area	Organisational
Author	Debbie Fulton Director Nursing and Therapies
Relevant Strategic Objectives	The Plan is relevant to all strategic objectives, **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **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
Summary	Since this self-assessment improvement plan was last presented ot the board the following has been completed: 1. There is now a process for ensuring that all new starters are aware of the FTSU on-line modules 2. A question has been added to mid-year appraisal documentation to enable a conversation in relation to understanding how to speak up. 3. The internal audit has been completed demonstrating substantial assurance with 2 low risk actions agreed as below: • A timescale will be put into place from when the Freedom to Speak Up Guardian / Leadership Associate gains all information and then passing the information to the right teams/ personnel to address the concern. Agreed to have in place for end December. • The Trust will continue to raise awareness of FTSU through a variety of means. 4. Methods to improve circulation of positive stories as part of Freedom to Speak up Month (October) has been agreed

Freedom to Speak Up self-assessment action Plan

The latest self-assessment action plan was signed off by the board in March 2024. The action plan below details the actions agreed to support further improvement of out speak up/ listen up / follow up culture.

Action agreed	Action Owner / Lead	Progress	Date completed
Recorded process for decisions on external v internal investigation.	Tracey Slegg	To be completed by end May, to include explanation of decision making around use of internal staff, external staff from People pool or contracting of a separate agency (TIAA / Beachcroft etc) for HR related investigations.	May 2024
Staff crib sheet around detriment what it means (what is detriment) and how to escalate if you feel you have suffered detriment.	Mike Craissati	Documents and presentation around Detriment co-authored by SE Regional Guardians has been reviewed and will be adapted for local use within Organisation and inserted into Raising Concerns Policy (and possibly Early Resolution Policy). **November update:** NGO are finalising their documentation to provide clarity around definitions of detriment; this is anticipated to be released by end December 24 - we will review this when published and ensure that it meets need for us.	
Consideration of mandating of training for certain groups • Board • Governance teams • Networks • SLT • People Directorate • Staff who manage people	Debbie Fulton / Jane Nicholson	The directorates detailed have been made aware of this ask and completion can be monitored each quarter To address 'staff who manage people' undertaking the modules, it is suggested that this form part of the Leading for Impact Course; this has raised with learning and development and will be considered as part of a general review of this course.	October 2024

Action agreed	Action Owner / Lead	Progress	Date completed
• Staff in teams that have had an OD intervention/support relating to poor culture. All staff to complete FTSU e-learning module as part of induction - following this MS teams' questionnaire for staff to ensure understand process.		Induction has been reviewed, the online FTSU session continues as part of that with feedback form last 3 quarters rating this as highly valued. 1. L&D include a link to training as part of inductee's resource pack 2. Slide included in FTSUG induction presentation to remind re the online training 3. Link to e-learning in FTSUG follow up email to inductees 3 months after their induction.	
Add question to Appraisal paperwork in relation to 'do you know how to speak up'?	Tracey Slegg	A question has been added to the mid-year appraisal review for all staff as below **Freedom to Speak Up** It is important that we raise any concern we have about risk, malpractice or wrongdoing at work. We can do this via one of the routes set out in the Freedom to Speak Up policy.	September 2024

Action agreed	Action Owner / Lead	Progress	Date completed
		Raising Concerns  	
Mike participating in regional group looking at detriment and developing a tool kit for providers, explore how we can understand what detriment looks like for staff and what we can do to mitigate against this.	Mike Craissati	Documents and presentation around Detriment co-authored by SE Regional Guardians has been reviewed and will be adapted for local use within Organisation and inserting into Raising Concerns Policy (and possibly Early Resolution Policy). **November update:** NGO are finalising clarity around definitions of detriment anticipated to be released by end December 24- we will review this when published and ensure that it meets need.	
Improve circulation of positive speak up stories and learning from speak up.	Mike Craissati / Marcomms	Positive aspects of FTSU are currently promoted via Lunch & Learn Webinars, FTSU awareness sessions, Leading for Impact module & general proactive work. Promoting stories via Team Brief, Nexus etc to be started during Q1 **November update:** These will be included in the all-staff newsletter (Team brief) as part of Freedom to speak up month and are now on the trust intranet (nexus) - review of further showcasing to be agreed	

Action agreed	Action Owner / Lead	Progress	Date completed
Internal Re-Audit of Freedom to Speak up processes (2024/25)	Debbie Fulton	Included in 2024/25 internal audit plan **November Update:** finalised report demonstrated substantial assurance, it was shared at the October Audit Committee and will be shared to November safety culture group. 2 low actions identified 1. A timescale will be put into place from when the Freedom to Speak Up Guardian / Leadership Associate gains all information and then passing the information to the right teams/ personnel to address the concern. Agreed to have in place for end December. 2 The Trust will continue to raise awareness of FTSU through a variety of means.	September 2024
Consider how we encourage staff to raise concerns at an earlier stage and support appropriate response to reduce escalation of concerns and possible detriment.	Mike Craissati	To be discussed at Safety Culture Group Engage staff during Gemba and face to face opportunities with FTSU gain learning and insights that can be used to support. Use of national staff survey data to understand areas for focus where confidence in raising concerns appears lower. Visibility of FTSUG and champions across staff networks and key trust events promote Psychological Safety via Webinars, Leadership course, management training/awareness. Engagement with People Directorate (HR/OD) to support this by reviewing policy and casework to encourage early raising of concerns	
Review investigatory processes to ensure that they are as timely as possible and	Tracey Slegg	Short term – Deputy Director People has weekly call with team to enable oversight of case work and timeliness. An employee relations	To commence Jan 25

Action agreed	Action Owner / Lead	Progress	Date completed
that those involved are kept updated appropriately		casework is joining the team to review current processes and have oversight of progress/ timeliness. Medium Term - Case work review to be undertaken using QI processes to commence in Jan 25, this is part of 3 programmes work agreed across organisation. This programme of work will include trust wide representation and agreement of countermeasures to enable improvement of processes.	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12th November 2024
Title	**Patient Experience Report -Quarter 2 (July – September 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 Two 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 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 and 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 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 year's total are included to provide some context.

Patient Experience – overall Trust Summary		Target	Q1	Q2
Patient numbers (inc discharges from wards)	Number		151,330	169,235
Number of iWGC responses received	Number	**61,000 year**	9,149	9,041
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**10%** by Mar '25	6.04%	5.34%
iWGC 5-star score	Number	**4.75**	4.78	4.80
iWGC Experience score – FFT (good or very good experience)	%	**95%**	94.1%	94.5
Compliments received directly by services	Number	Total 23/24 **4522**	1237	1012
Formal Complaints received	Number/ %	Total 23/24 **281** **0.030%**	68	64
Formal Complaints Closed	Number	Total 232/4 **257**	41	59
Formal complaints responded to within agreed timescale	%	**100%**	100%	100%
Formal Complaints Upheld/Partially Upheld	%	Target 50%	51.7%	55%
Local resolution concerns/ informal complaints Rec	Number	Total 2023/24 **149**	28	42
MP Enquiries Rec	Number	2023/24 total **73**	5	6
Complaints upheld/ partially by PHSO	Number	Total 2023/24 **0**	1	0

Our total number formal complaints per £100m income for 2023/24 was in line with peer and national average. Data demonstrates that we have a slightly lower percentage of fully upheld complaints compared to peer average and a slightly higher percentage not upheld 38.7% compared to 29.6% peer average).

The data continues to show only small variations each quarter although we have continued to see a lower number of MP enquires compared to previous years. We have also seen slightly fewer formal complaints and an increased number of concerns able to be resolved locally this quarter.

During quarter 2 we have seen a small reduction in the number of feedback forms received; term time only services not operating for 6 weeks over this period (less opportunity to collect) will have had some impact on this. Alongside this high numbers of primary school children have received their flu vaccine (over 17,000) in September, this has contributed to an increased number of unique patients receiving care and treatment. These children are much less likely to complete a patient experience survey, given the way the clinics run and because this is a one-off encounter for a nasal spray. Both factors have contributed to a lower percentage response rate for this quarter.

We have received a higher than usual number of secondary complaints (those not resolved with first response); there were no specific themes or services associated with this and not all were upheld (69% upheld/ partially upheld); we will continue to monitor this and the standard of our responses to ensure that initial responses are clear and answer all concerns being raised.

We are continuing to see more focus on ‘you said we did,’ with more examples of how feedback has been used to make changes and improvements to services 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 than other services throughout last year; During quarter 1 there was a significant positive shift in scores received 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. For this quarter, these scores have all remained above Q4 scoring and above 4.0 which is positive although they are slightly lower than Q1. The Ease question was the lowest rated score for Mental Health inpatients, this asks whether the place they received their care, assessment and/or treatment is suitable for their needs.

The wards all have ongoing work to support improvement and 3 of our wards participating in 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 and learning disability wards for patients and staff so that they are safe, therapeutic, and equitable places to be cared for, and fulfilling places to work.

The lowest overall sub scores this quarter was for facilities in Mental Health community West, feedback received around this question related to parking.

Overall feedback remains overwhelmingly positive; clear information, communication, and support for self-care, along with the involvement in decisions and respect for preferences continue to be areas that our patients report that we do well. There has also been improved satisfaction for continuity of care and smooth transition, this improvement is a sustained from Quarter 4

The themes of Involvement and support for family and carer as well as people feeling emotionally supported both saw some decline in positive percentage scoring this quarter and are both just below 90%, the scoring for these two themes fluctuate over the quarters. Services will continue to use the feedback received to make improvements in these areas.

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 Q2 attendances
Asian/Asian British	6.20%	7.50%	10.44%
Black/Black British	1.50%	2.80%	3.54%
Mixed	6.25%	2.50%	3.40%
Not stated	9.38%	10.90%	5.33%
Other Ethnic Group	3.13%	4.30%	2.21%
White	73.44%	72.10%	75.08%

The data indicates that Asian/Asian British and Black/Black British people appear to be less likely to complain and give feedback through the patient survey; this data is consistent with data from last quarter. Whilst the survey is provided in easy read and several differing languages it is important for services to ensure that they are explaining about the survey when having contact with patients, their families, and interpreters to enable the opportunity for all patients to provide feedback.

In terms of gender, as in most previous quarters we see a slightly higher percentage of males making formal complaints compared with attendance and we have continued to see a lower percentage of people stating that they are male completing the survey than either females or those identifying as non-binary/ other. We continue to see around 20% percentage of people completing the survey who are not completing some of the demographic questions including gender.

In terms of age the data would indicate that those over 60 years of age are more likely to complete the survey and less likely to make a formal complaint than those in younger age brackets.

During this Quarter, we introduced further filters into the dashboard, which means that services can drill down into the feedback given by people by characteristic, including those who are Neurodiverse. This not only helps services to ensure that they are being as inclusive and accessible as possible, but also supports wider pieces of work such as the Neurodiversity Strategy and Patient and Carer Race Equality Framework (PCREF).

The 15 steps programme has continued with several visits undertaken during the quarter as detailed in appendix 3.

3. Conclusions and Recommendations for consideration by the Board

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

We continue to work to increase the number of responses received through the patient experience tool and we are seeing the use feedback to inform improvement across services. Board members should continue, as part of their contact with services to explore how patient feedback is being used for improvement.

Berkshire Healthcare
NHS Foundation Trust

Patient Experience Report Quarter 2 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 (inc patient discharges)	Number	151,330	169,235		
Number of iWGC responses received	Number	9,149	9,041		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	6.04%	5.34%		
iWGC 5-star score	Number	4.78	4.80		
iWGC Experience score – FFT	%	94.1%	94.5%		
Compliments received directly by services	Number	1237	1012		
Formal Complaints Rec	Number	68	64		
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	3	13		
Formal Complaints Closed	Number	41	59		
Formal complaints responded to within agreed timescale	%	100%	100%		
Formal Complaints Upheld/Partially Upheld	%	51%	55%		
Local resolution concerns/ informal complaints Rec	Number	28	42		
MP Enquiries Rec	Number	5	6		
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	7	4		

There was an increase during this Quarter of the number of complaints that were re-opened however, there are no themes identified within this. These are from differing patients across mental health and physical health services, of these re-opened complaints 69.2% were upheld or partially upheld.

There was also an increase in the number of complaints that were able to be dealt with locally and we closed 18 more cases when compared to the previous Quarter.

There were no notifications of the outcome of any PHSO investigations this Quarter.

From the iWGC feedback received, clear information, communication and support for self-care, along with the involvement in decisions and respect for preferences continue to be areas that our patients report that we do well. There has also been a decrease in the negative theme for continuity of care and smooth transition from 10% to 6%, which is a sustained improvement from 12% in Quarter 4 (meaning an increase in satisfaction).

The themes of Involvement and support for family and carer as well as people feeling emotionally supported both saw some decline in positive percentage scoring this quarter and are both just below 90%, these 2 scores fluctuate over the quarters. Services will continue to use the feedback received to make improvements in these areas.

Appendices 1 and 2 contain our PALS and Complaints information for Quarter Two. Appendix 3 shows the Board Report from iWGC.

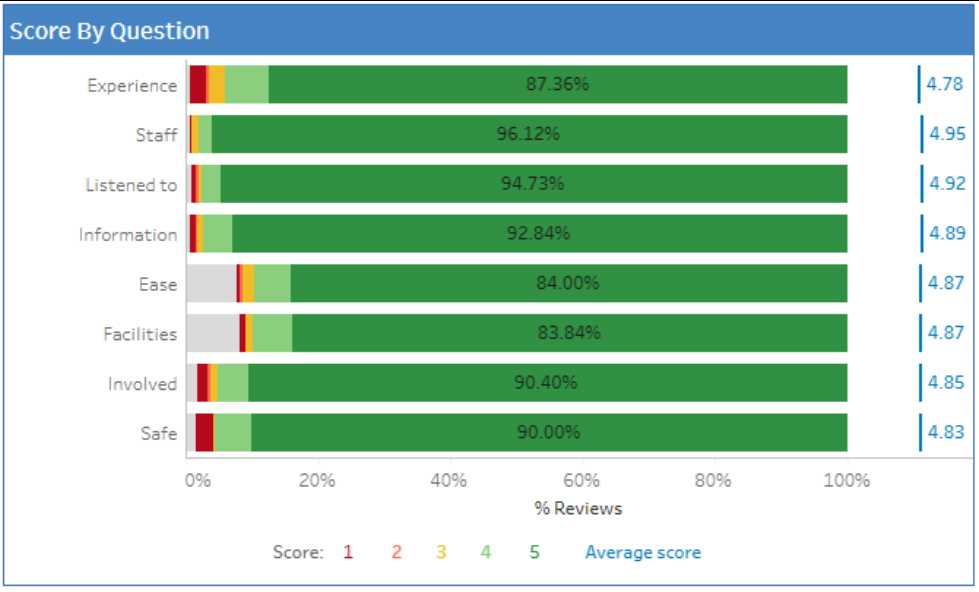
What the data is telling us

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	1,313		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3.9%	2.7%		
iWGC 5-star score	Number	4.9	4.88		
iWGC Experience score – FFT	%	95.3%	94.1%		
Compliments received directly by services	Number	98	70		
Formal Complaints Rec	Number	17	17		
Formal Complaints Closed	Number	6	14		
Formal Complaints Upheld/Partially Upheld	%	33.33%	35.2%		
Local resolution concerns/ informal complaints Rec	Number	6	1		
MP Enquiries Rec	Number	3	3		



For children's services the iWGC feedback has seen a decrease in responses from last Quarter, further work with the services continues and 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 1313 responses, 1154 responses related to the children's services within the division; these received 94.4% positivity score, with positive comments about staff being helpful and kind and a few suggestions for further improvement, this included 1 review for Phoenix House. 73 of the responses related to learning disability services and 45 to eating disorder services.

From the feedback that was received, ease of access and facilities were the most frequent reasons for responses being scored below 4. Areas with the highest positive responses were about staff attitude and feeling listened to.

Children's Physical Health Services

There were 4 formal complaints for children's physical health services received this Quarter: 2 for the Community Team for People with Learning Disabilities, 1 for Children's Occupational Therapy and 1 for Health Visiting.

786 of the 1154 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 Wokingham – 2 Year Development Review; the Health Visiting Bracknell Team received 95 of these responses which scored positively receiving a five-star rating of 4.95 and feedback included they listened, kind and were helpful. "*Our health visitor was extremely supportive and kind. She listened to my anxiety's and help our family through our challenges*".

Child and Adolescent Mental Health Services (CAMHS)

For Child and Adolescent Mental Health Services there were 13 complaints received (including one each for the Key working team and Phoenix House), these were primarily in relation to care, and treatment received and waiting times. The CAMHS ADHD service is the area with the most concerns about waiting times.

There have been 364 responses for CAMHS services received through our patient survey for this Quarter. Currently the survey is accessed through paper surveys, online, QR codes or configured tablets in the departments.

There was a significant increase in the activity figures due to the Immunisation Team giving the annual flu nasal spray in primary schools, with very low numbers of feedback received and a potential reduction in responses due to term-time only services. The Patient Experience Team are continuing to work with individual services to help them to collect more responses and facilitate the iWGC drop in to answer any questions services have and assist them in collecting more responses.

Learning disability

There were 2 complaints received for the Community Team for People with a Learning Disability.

Overall, there were 73 responses for all Learning Disability services; responses were for the Community Teams for People with a Learning Disability and Learning Disability Intensive Support Team. These received an 89% positive score; feedback included that staff listened, "*You listened to what I needed to say, because I lack time to say what I need to say but you*

waited and gave me time.", "*I liked the fact that you used things I like - like Disney's Inside Out - and incorporated it into the group. Everyone was treated with respect and dignity and was heard and listened to. I miss being able to talk and doing the techniques with other people.*", there were comments for improvements including signage needed for the Reading site to let visitors know they need a parking permit and reduce the time of the appointment as patients get restless. The 8 responses that received with a score below 4 left comments in the free text boxes, comments included needing help to get to the meeting, and how they felt about staff speaking with them about their weight and supporting with healthy eating.

Eating disorders

There were no complaints received for either the adult or young people's Eating Disorder Services.

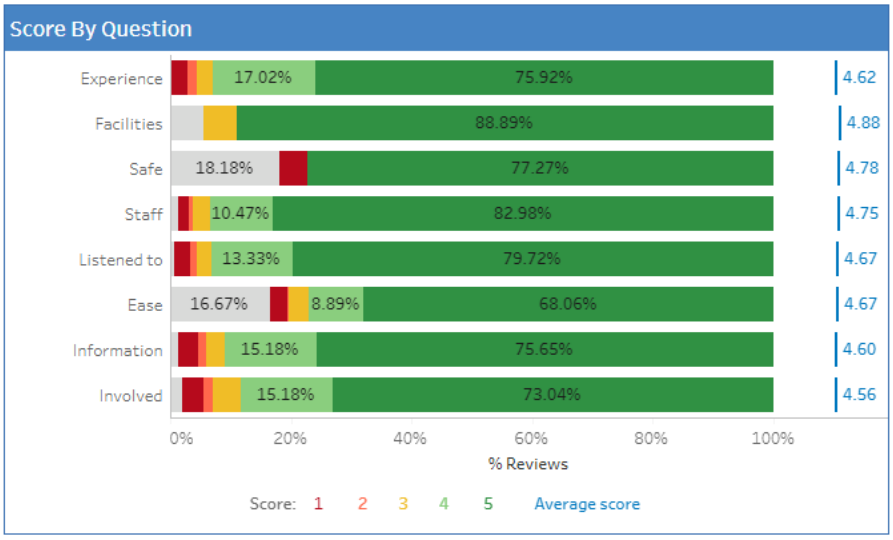
Of the 45 feedback responses received, 38 scored a 5 with comments such as "*[name removed] is brilliant. She has adapted the sessions to specifically meet my needs and understand why my eating patterns are the way they are and is massively helping me to develop strategies to adapt a more healthy approach to my condition. I have been under the care of the NHS for difficulties since I was 19 and I can honestly say I have progressed further in the last few months than I have over the past 30 years. [name removed]'s understanding of other conditions that impact my eating habits has meant that I haven't just gone down yet another rabbit hole and I'm finally coming to terms with what is really going on for me.*", "*Staff lovely. Young receptionist very attentive and asks about my daughter's treatment progress when I'm alone in reception and I feel it is genuine and that she too cares. My daughter has seen a lot of different staff and Dr's and nurses and they have really done a wonderful job so far! Hours slightly difficult with work but appreciate you are a 9~5 service but would be helpful for later appointments if possible. Thank you for all your continued support.", "[name removed] was amazing, she explained exactly how the guided sessions would work and was so supportive. If I had questions or was struggling at any point I would email and she would reply quickly and was able to help and support.*" Areas for improvement included making the waiting room more welcoming and having evening appointments.

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	382		
Response rate (calculated on number contacts)	**%**	4.5%	4.1%		
iWGC 5-star score	**Number**	4.70	4.65		
iWGC Experience score – FFT	**%**	93.7%	92.9%		
Compliments received directly by services	**Number**	34	25		
Formal Complaints Rec	**Number**	12	11		
Formal Complaints Closed	**Number**	10	10		
Formal Complaints Upheld/Partially Upheld	**%**	70%	60%		
Local resolution concerns/ informal complaints Rec	**Number**	1	2		
MP Enquiries Rec	**Number**	0	1		



11 Formal Complaints were received into the division; in addition, there were 2 informal/locally resolved complaints. 10 complaints were closed during the Quarter. 6 of these were either fully or partially upheld.

Feedback through IWGC indicates that the opportunity for most improvement is in relation to information and the feeling of being involved in your care and treatment.

The services receiving the majority of iWGC responses were CRHTT East with 85 responses, Memory Clinic Bracknell with 29 responses and CMHT Bracknell with 29 responses.

Across the CRHTT East survey, the average 5-star score was 4.39 with 90.6% positive feedback, a decrease in the 5-star score and an increase in the percentage positive feedback from last Quarter. 77 of the (overall number of responses received) scored a 4 or 5-star rating with many comments about staff being helpful, listened, professional and supportive; "*I have been seen by the lovely Dr [name removed], Consultant Psychiatrist today for a medication review. He spoke to me so kindly and I felt that he treated me with dignity and respect. He was honest and knowledgeable and I felt he took great interest and genuine care to support me understand my circumstances and I was given options for treatment, explaining them to me the step we needed to take to help me recover my psychological robustness. I have also been in close contact with the rest of the Crisis team who have been the only people who checks up on me when I seem to have no one else. I am so grateful for your kindness and support. Thank you all.*" 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 there was miscommunication, staff didn't listen and patients felt rushed.

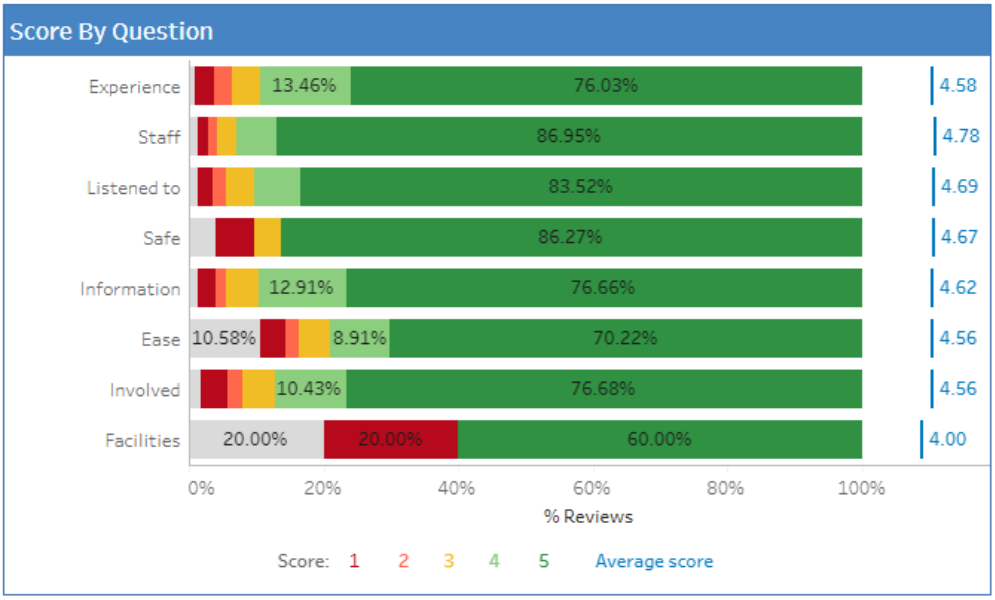
The Memory Clinic Bracknell received 100% positive score (4.91-star rating) and received positive feedback about staff being pleasant, helpful, kind and listened. "*From getting an appointment and needing to change the date, staff were extremely helpful and kind, which helped me a lot. [name removed] was excellent, put me at ease, listened well. Thanks.*" CMHT Bracknell received 100% positive score with feedback comments including *"I worked with [name removed] for several weeks and could not ask for a better experience. I felt uplifted by her even on days where I felt that I had let myself down by not achieving my goals. [name removed] let me do the appointments in a way that wasn't overwhelming yet was still progressive which in turn made sure that I felt more motivated and had less setbacks which I found extremely beneficial. She was professional yet at the same time it felt like I could talk to her about anything. She truly found the perfect balance which makes her extremely great at her job."*

CMHT received 67 responses (Bracknell 29, WAM 18 and Slough 20) with 92.5% positive score and 4.56 star with 5 of the total responses scoring less than a rating of 4; comments included "*The therapist called me this morning u had appointment to go too she was meant to call back between 4/5 I didn't hear back I find this extremely worrying especially with my mental health I need that support your not giving me great confidence in your service when your meant to be supporting me*". There were several positive comments about being listened to, that staff were kind, supportive and helpful. Some of the suggestions for improvement included better communication. 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	1218		
Response rate (calculated on number contacts)	**%**	6.06%	6.01%		
iWGC 5-star score	**Number**	4.51	4.62		
iWGC Experience score – FFT	**%**	84.8%	89.5%		
Compliments received directly by services	**Number**	435	375		
Formal Complaints Rec	**Number**	12	12		
Formal Complaints Closed	**Number**	6	3		
Formal Complaints Upheld/Partially Upheld	**%**	33.32%	27.2%		
Local resolution concerns/ informal complaints Rec	**Number**	1	1		
MP Enquiries Rec	**Number**	0	1		



The Mental Health West division has a wide variety of services reporting into it, including the Talking Therapies service and Court Justice Liaison and Division service, as well as secondary mental health services. The 3 services with the most feedback through the patient survey were Talking Therapies Step 2 with 250 responses, Talking Therapies with 210 responses and CRHTT West with 188 responses.

Questions relating to ease, involvement and facilities have the least number of positive responses. Examples of feedback include parking at Prospect Park Hospital for people accessing CRHTT West and MHICS.

This division received 12 Formal Complaints during the Quarter including CMHT receiving 5, CRHTT receiving 2 and CPE with 2. There were 3 Formal Complaints closed, all being found to be upheld or partially upheld.

For CRHTT West there was an 81.4% positivity score and 4.20-star rating; with lots of positive comments about staff listening, being helpful and kind, "*From the initial call back (following a referral from NHS 111) everyone I spoke with or met were genuinely kind, responsive, informative and empathetic. I never felt rushed in any session or call with the CRHTT team. Between the people I have met, they each had sufficiently read prior notes to make the session as productive as possible. What's more, there were no contradictions in care plan or approach. The team ([name removed], [name removed], [name removed], [name removed], [name removed], [name removed] and visiting consultant [name removed] - apologies if I missed anyone else!) have really done their best to provide a platform for my recovery to continue with various referrals undertaken on my behalf. Thank you all."*

Some of the areas for improvement included wanting to see the same person for all appointments, poor communication and staff attitude.

Talking Therapies Step 2 received a 93.6% positive score and 4.76-star rating (16 responses scored less than 4) many of the comments were positive about staff having listened, and that they were helpful and understanding.

The Older Adult Mental Health Service and Memory Clinic combined have received a 97.8% positivity rating (4.91-star rating) some of the feedback included *"All members of staff were courteous, helpful and discussed issues appropriately. They listened and dealt with me and my wife, who accompanied me, professionally. Allocated parking spaces very helpful."*

There were 54 responses received for West CMHT teams with 79.6% positivity score and 4.27-star rating, 43 of these were positive with comments received that staff listened and were kind, there were 8 negative responses with reviews stating that patients felt like staff didn't listen, didn't explain and that they felt that the staff needed more training.

Talking Therapies a positivity score of 84.3% (4.53-star rating), 33 of the reviews scored less than 4.

Most comments were still very positive about the staff, including that they listened, were kind and understanding. Several of the comments/areas for improvement were that the wait was too long, issues with Silver Cloud software and wanting face to face appointments. For example, *"I found the use of modern technology a little challenging at times and not without its own problems, however once I got to grips with it, it was acceptable. Of course nothing compares to face to face human contact!"*

Examples of positive feedback about Talking Therapies included, *"My therapist was always kind, caring, supportive and encouraging in all my sessions with her and helped me process something very traumatic in my personal life. She also helped me to feel empowered in how I dealt with this very difficult time in my life. It really made a big difference to me and helped me cope with what I was going through with all its associated anxiety and depression.* "*The treatment I received from [name removed] from NHS Berkshire, was excellent as she listened and adapted the treatment to best suit my needs. Her friendly and disarming natural manner is much appreciated, and ensures a fantastic patient experience. Thank you."* and *"[name removed] was a great therapist. She was kind, comparing and compassionate. She always listened and she was very good at explaining all the theory and concepts that were introduced to me during therapy. She was able to accommodate appointments later in the evening that worked for my schedule. And when I couldn't use a tool or understand something she went back over it in a way that worked for me. I couldn't really fault her or therapy service."* Patients reported that they felt "*[name removed] was fantastic, it felt like she really understood me and what I'm going through, she was endlessly patient and caring. She checked in regularly and made sure I was ok. It felt like this wasn't a process to get through to get to the next step, she was genuinely caring, genuinely helpful and was really trying to help. She made me feel valued, she made me feel like I mattered and what I*

wanted mattered. She helped me to make decisions and answer questions in the best way that was what I wanted, even when I struggled to make choices or didn't want to be an inconvenience. She was incredible.", "The whole experience was fast, simple and stress free. I was surprised at how soon my first therapy session was after my assessment. My therapist was friendly and made me feel comfortable to open and work with her. I am truly grateful to the service and my therapist."' and "[name removed] was a lovely lady , easy to understand solutions to my problems we spoke about, happy to listen and understand how I felt , made me feel relaxed from the very start so I found it so easy to talk to her and she has helped me believe in myself again so a big thank you to [name removed]".

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.

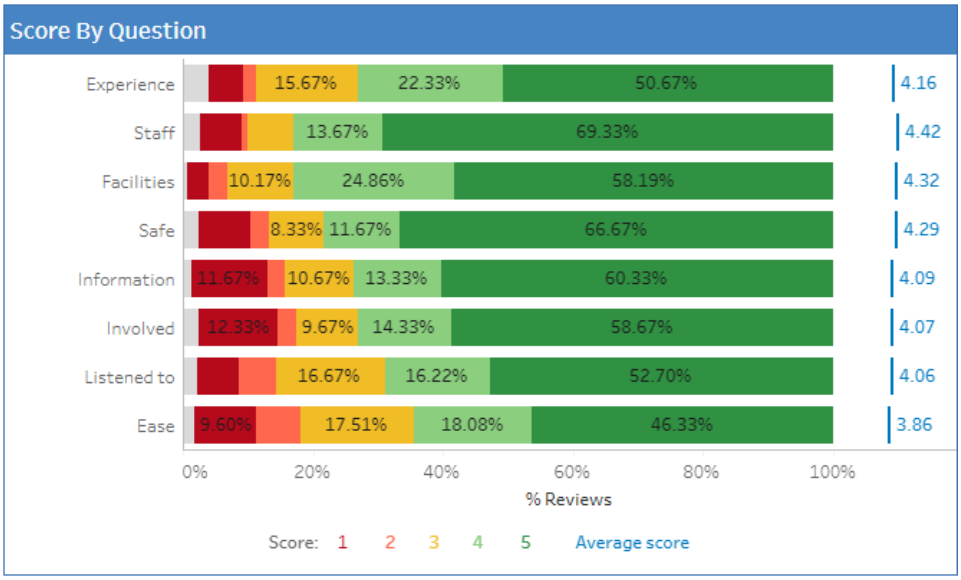
Op COURAGE received 51 responses during the Quarter, their patient survey responses gave a positivity score of 90.2% (4.84-star rating), 5 of the reviews scored less than 4.

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	300		
Response rate	**%**	111.3%	180.7%		
iWGC 5-star score	**Number**	4.07	4.17		
iWGC Experience score – FFT	**%**	71.7%	73%		
Compliments	**Number**	12	20		
Formal Complaints Rec	**Number**	11	11		
Formal Complaints Closed	**Number**	8	11		
Formal Complaints Upheld/Partially upheld	**%**	37.5%	63.6%		
Local resolution concerns/ informal complaints Rec	**Number**	1	0		
MP Enquiries Rec	**Number**	1	0		

- 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 response rate is 180.7% due to patients in mental health wards completing more than one survey during their stay.

The satisfaction rate was 73% with 69 of the 300 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 3.86 and 60 of the 247 giving a score of 3 or less to this question. The Ease question asks whether the place they received their care, assessment and/or treatment is suitable for their needs, comments relating to feeling listened to and involved in terms of needs also received lower scores with some comments relating to staff needing to listen to their needs, need more staff to meet their needs and feeling the care wasn't suitable for their needs. Some of the wards are currently participating in a national mental health ward culture of care programme which focuses on safety and involvement of patients; there is also ongoing work in relation to improving 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 Formal Complaints closed 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, kind and helpful. There were some comments for improvement about more activities, better communication and better food. Examples of the feedback left are "*Food is good I have a good room. I like the courtyard. Staff are friendly. The medicine has made me better.*" "*The staff always ask if I am ok, if I need water. Staff are there for me. Good doctors they listen to my needs.,*" *"Staff are amazing and caring, the room is good and clean. Very happy with overall treatment from hospital."*

In addition to the feedback about the wards, there were 29 responses for a Place of Safety and the average 5-star score was 4.66. Some comments received were "*The treatment I received while being assessed at prospect park hospital in reading was outstanding. I was treated like a VIP. All staff were highly respectful towards me, non-judgmental compassionate, clear transparent communication, warm and friendly. A great team working together effectively and showing close bands within the dynamics of this happy working*

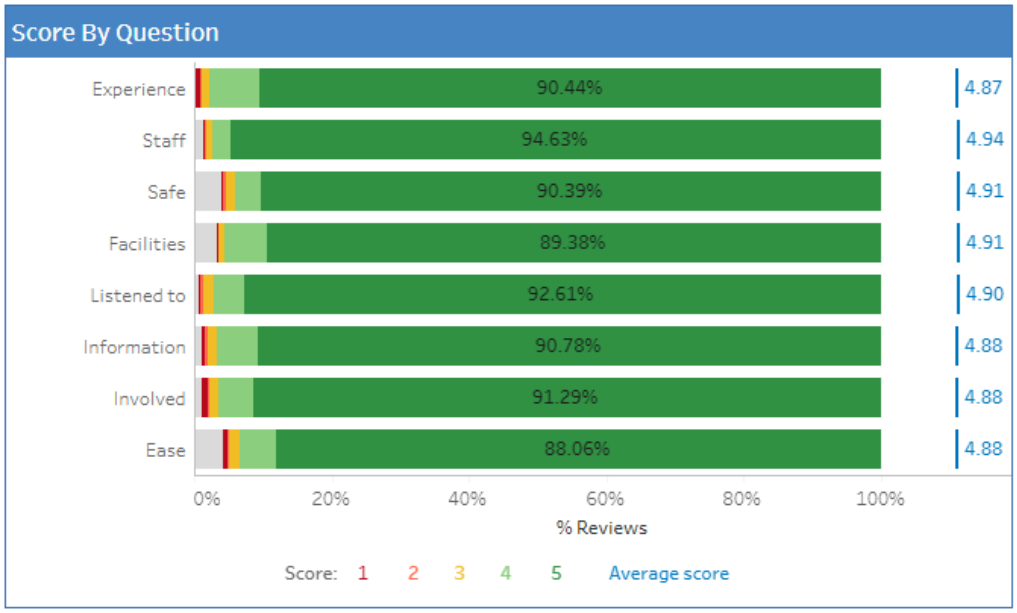
environment." , "*Staff were kind and supportive towards my needs, understanding to my mental health and been validating.*" And "*The staff was caring and when the other patient was shouting, staff closed the door and came and sat inside with me.*".

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	2364		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.4%	7.1%		
iWGC 5-star score	Number	4.89	4.89		
iWGC Experience score – FFT	%	97.6%	97.8%		
Compliments received directly into the service	Number	382	136		
Formal Complaints Rec	Number	4	2		
Formal Complaints Closed	Number	5	1		
Formal Complaints Upheld/Partially Upheld	%	100%	0%		
Local resolution concerns/ informal complaints Rec	Number	3	9		
MP Enquiries Rec	Number	0	0		



Of the 2 Formal Complaints received this Quarter, 1 was for Henry Tudor Ward and 1 was for Hearing and Balance.

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

The Hearing and Balance Service received 122 responses to the patient experience survey with a 95.1% positive score and 4.88-star rating.

East Community Nursing/Community Matrons received 554 patient survey responses with a 99.3% positive scoring, many comments were about staff being kind and professional, for example "*NHS is a great service, district nurses should have more recognition, every time you call the hub they call and arrange for a visit to redress my wounds and are always very*

professional and kind.," "The nurses are always good when they come and listen to me when I discuss about my plan with the hospital. They are always kind and professional.," "*The nurse was very kind, skilful and professional, her warm smile made my pain more tolerable during the dressing change, all the nurses are caring and am very thankful"* There were also some comments around wanting a time slot for the appointment for example *"Would like to know a time when nurse will come."*

The wards received 105 feedback responses (58 responses for Jubilee ward 94.8% positive score and 47 responses for Henry Tudor ward with a 87.2% positive score). Most of the comments for improvement were related to wanting more physiotherapy, buzzer to be answered quickly and food needs improvement. There were many comments about staff being kind, friendly and helpful. For Henry Tudor ward there were 6 responses that scored below 4 and comments were that staff need a pay rise, staff need to listen more and be honest, felt like they were not seen as a patient and felt staff need more time for individual patients.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 98.5% (4.90-stars), comments were very complimentary about staff being professional and helpful, *"The staff at Foundation House were brilliant. I was given all exercises on line and shown how to do them. Every physiotherapist listened and understood the pain and restrictions I had and gave me realistic manageable plans. They were all friendly and professional and made me feel comfortable.".* The reoccurring improvement suggestion for this Quarter was for more parking.

Outpatient services within the locality received a positivity score of 97.6% with 4.91 stars from the 571 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"Every single person that has visited from this team has been amazing. They talk to my husband instead of talking at or over him and they took their time when visiting. We didn't feel rushed and felt all our questions were answered. Great service."*

The Diabetes Service received 71 feedback responses with 95.8% positivity and some lovely comments including "*The session was very simple and easy to understand. There were pictures, examples and materials to ease my understanding. There was no pressure. And the message was clear. Look after your health by making sensible choices to eat & drink. So many unhealthy food & drinks in the market. But we need to make an educated choice . The course speaker was excellent. I felt very educated and motivated. Thank you.*" Alongside some helpful suggestions for the service to consider around appointments to be closer together "*My follow up with the consultant was after a year. Lower waiting times would be good.".*

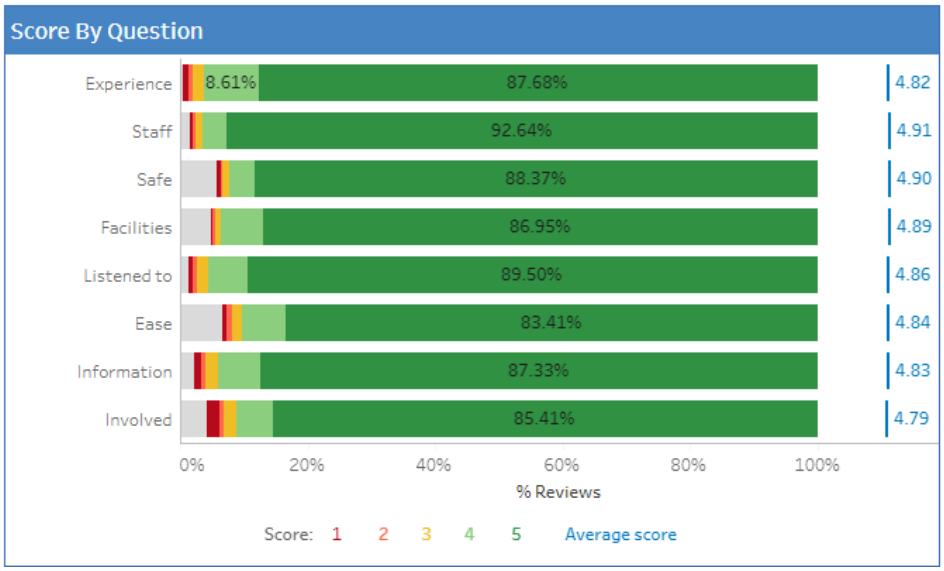
The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*I had a thorough examination relative to my problem, ALL members of the staff were user friendly and professional. And the follow up was excellent, my blood test results came back the same day and I was offered an MRI appointment 3 days after my assessment. So over all very impressed.*"

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	3426		
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.9%	5.9%		
iWGC 5-star score	Number	4.83	4.84		
iWGC Experience score - FFT	%	96.4%	96.3%		
Compliments (received directly into service)	Number	260	95		
Formal Complaints Rec	Number	12	10		
Formal Complaints Closed	Number	6	10		
Formal Complaints Upheld/Partially Upheld	%	83.3%	70%		
Local resolution concerns/ informal complaints Rec	Number	16	23		
MP Enquiries Rec	Number	1	0		



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 because 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 96.3% positive satisfaction and 4.84-star rating and the question on staff receiving a 96.4% positive scoring from the 3426 responses received.

There were 10 Formal Complaints received compared to 12 in Q1, these were split across several different services.

The community hospital wards have received 191 responses through the patient survey receiving an 91.6% positive score and 4.56-star rating, (12 responses scored 3 and below) questions around listened to and feeling involved receive the most results of 3 and below. Comments include *"It's brilliant here. Everyone is so caring. I haven't heard about this place before coming here but I'm so happy I came here and received the outstanding care I did. The food is quite good as well. I told my son and family how good this place is."*, *"All the staff were so kind and caring . The doctor listened to my concerns about another problem and took a action about it."*., *"All staff are very friendly and kind. They all work so hard and to a very high*

standard. I feel safe and content in my environment. The food is quite nice." And *"I gave maximum stars because I felt like I was listened to its been ages since I felt someone has listened and helped me and I left with the feeling I'm not alone and can get help with my struggles."* there were some individual comments where patients were less satisfied with food as it was cold, long wait for help after ringing the bell, wanted more physiotherapy and more therapy. Comments for reviews with responses that scored below 4 included food needed improvement, early morning staff are challenging, wanted a table that worked, wanted more physiotherapy, more considerate night staff and patients wanted to be more involved in their care. There were 3 reviews which received a score of 1 and received positive comments.

Of the 2 Formal Complaints for the Out of Hours GP service, 1 related to medication and 1 was about delayed response times.

WestCall received 88 responses through the iWGC questionnaire this Quarter (93.2% positive score, 4.78-star rating, 6 scores received below 4. Positive comments included "*I called 111, within an hour I had an out of hours GO appointment booked, there was no waiting around, everyone was professional and kind. There was no rush. I was seen by [name removed] [name removed], a lovely doctor who listened to me and put my mind et ease. He checked come vitals and reassured me there was nothing seriously wrong with me. I appreciated his kindness and just listening to me more than anything on the late Wednesday evening. NHS, I give you a massive high five and thank you from my heart for doing what you are doing. [name removed] is a gem, look after him please so he can extend his kindness and medical experience to others. Thank you." "The reception team were very kind and very helpful. The doctor saw me very quickly and was wonderful and very thorough. The waiting room was very cosy and I felt very relaxed while I was there." "I was seen by Dr [name removed] in the Westcall unit and wanted to say a huge thank you to him. He was a kind, caring and empathetic doctor. I was in a lot of pain and he took the time to listen, understand and help. His manner and expertise were hugely appreciated and I felt in very good hands.".*

The Podiatry Service received 209 patient survey responses. Most responses were very positive receiving 5 stars (overall 96.7% positivity 4.83-star rating) with examples including *"Very kind, helpful and informative through the whole process. Very patient and hardworking with a reassuring attitude throughout the procedure. [name removed] and [name removed] were fantastic.*", *"Very friendly, knowledgeable, kind, helpful team from reception to doctors. Felt cared for, listened to in a happy relaxed atmosphere, where information and suggestions were given in an easily understood manor, with a hint of humour from smart well turned out professionals."* and *"My treatment has always been superb and at last I believe my foot is healed; thanks to the caring and efficient treatment from the podiatrists at WBH, [name removed] in particular. Many thanks for your lovely support and terrific treatment!".*

There was 1 Formal Complaint for the Community Nursing Service regarding a lack of treatment provision.

To provide some context across our East and West District Nursing teams combined there were 16,948 unique patients this Quarter. Lots of comments included nurses were kind, helpful, and friendly, *"The nurse who came was very helpful and understanding, they contacted my GP and as I'm low mood now, they will refer me to pink where I can off load. What a great service."*, *"The nurses who came were very good, I always have problems with my Catheter and they changed it with no problems and found that I had a urine infection and got me antibiotics straight away." and "I had some questions about my catheter and the nurse on triage answered all of them and really put me at ease. sounded very friendly and ever so kind so thank you."* There were several positive comments about nurses being caring and there were very few suggestions for improvement, would like to know when they will visit and would like the staff to be paid more.

MSK Physio has received 1 Formal Complaint in the Quarter. The service has received 769 patient survey responses with a 98.4% positive score (4.91 -star rating), very few areas for

improvement were included in the feedback there were a few suggestions including parking, referrals to be put through to different services, would like to be seen sooner and privacy in the rooms and the overall feedback was extremely positive with lots of comments about staff were helpful, professional, friendly and listened.

Demographic profile of people providing feedback

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q2 attendances
Asian/Asian British	6.20%	7.50%	10.44%
Black/Black British	1.50%	2.80%	3.54%
Mixed	6.25%	2.50%	3.40%
Not stated	9.38%	10.90%	5.33%
Other Ethnic Group	3.13%	4.30%	2.21%
White	73.44%	72.10%	75.08%

The table above indicates that Asian/Asian British and Black/Black British people are less likely to complain and give feedback through the patient survey. Intelligence such as this feeds into our wider work to ensure that we capture the outcomes and experience of all people who use our services.

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

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q2 attendance
Female	48.40%	44.70%	54.70%
Male	48.40%	32.60%	45.28%
Non-binary/ other	0%	2.80%	0%
Not stated	3%	19.80%	0.00%

This shows that comparatively, we received more formal complaints from men as whilst the percentage of complaints were evenly split, we saw less men than women; 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 Q2 attendance
0 to 4	3.13%	11.70%	7.01%
5 to 9	3.13%		2.22%
10 to 14	9.38%		3.86%
15 to 19	10.94%		4.85%
20 to 24	10.94%	4.30%	3.44%
25 to 29	1.56%		3,12%
30 to 34	12.50%	6.00%	3.28%
35 to 39	1.56%		3.78%
40 to 44	6.25%	7.60%	3.74%
45 to 49	1.56%		3.67%
50 to 54	12.50%	11.30%	4.02%
55 to 59	6.25%		5.04%
60 to 64	0.00%	14.00%	5.24%
65 to 69	3.13%		4.82%
70 to 74	3.13%	16.20%	6.09%
75 to 79	6%		8.46%
80 to 84	0.00%	15.10%	9.54%
85 +	6.25%		17.83%
Not known	2%	13.40%	0%

Comparatively, people over 60 years old are more likely to give feedback via the patient survey and are less likely to make a formal complaint. Interestingly, we are seeing more patient feedback from people over 60 years old being received via paper, which could indicate more proactive staff promotion of the survey in this way.

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).

From next Quarter, we are going to start reporting on the outcome of the Complaint Investigation, by demographic, to see if there are any themes and areas we can investigate further.

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. During this Quarter, we introduced further filters into the dashboard, which means that services can drill down into the feedback given by people by characteristic, including those who are Neurodiverse. This not only helps services to ensure that they are being as inclusive and accessible as possible, but also supports wider pieces of work such as the Neurodiversity Strategy and Patient and Carer Race Equality Framework (PCREF).

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
Henry Tudor Ward and Jubilee Ward	The groups on the wards are helpful for patients and their loved ones. We would like these to continue.	Regular groups during the week and families are invited to join. These groups promote cognitive stimulation and mobility. It promotes peer group interaction, patient wellbeing and allows relatives to be involved with patients rehab and recovery. Joint assessments are done with patients and their carers. Patients on Jubilee Ward were invited to Memory clinic Garden opening and are now using that garden for activities.
Community Inpatients: Ascot and Windsor Ward	Food is poor, cold, not enough options etc	Work being completed with food supplier and local teams to make improvements. Aware that new trollies have been purchased to improve food temp coming from kitchen to ward. Staff complete food hygiene training to ensure that food is served at the correct temperature.
Children and Young People [CYP] Eating Disorder Service [BEDS]	A participant suggested “a Q&A with a recovered individual”.	Discussed as part of quality improvement . Due to ethical boundaries, it was suggested that the idea evolved to a ‘from me to you’ therapeutic letter. Next step: To plan how to deliver a ‘from me to you’ therapeutic support letter.
	Greater support for parents.	Appointed parent participation champion and launched parent participation group
Adult BEDS	Patients found it triggering to watch staff eat their lunch through the window in the St Marks Hospital waiting room.	In response we have ensured that it is not possible to see through the window.
	First Steps Group [FSG](psychoeducation and motivational group that most patients go through to start treatment), would be helpful if there was more of a focus on positive body image, introducing that idea earlier in treatment process.	The content has been reviewed to add more info on what an eating disorder is and body image.
	Felt SHaRON not as visually pleasing, not very easy to navigate.	Feedback about SHaRON was passed onto the SHaRON campions. Having more information on what SHaRON is and it being introduced earlier. Leaflet has been reviewed and SHaRON posters have been adapted and refreshed. They are displayed in more places around St. Marks and Erlegh house.

CAMHS Common Point of Entry [CPE]	The clocks in rooms in Erlegh House are too loud.	The clocks were replaced with quieter models.
CAMHS Anxiety Disorders Treatment Team	Make groups easier to attend and the environment feel safe.	Introduced ground rules in each session, fidget toys and games available throughout.
	Clinic rooms and the waiting room should be more sensory friendly and welcoming.	Introduced Fidget toys, softer lighting and bean bags in clinic rooms. Fewer posters which are changed monthly and music in the waiting room.
	The music is sometimes too loud or not required.	A poster has been displayed to inform people that they can ask reception to turn music off or down .
	Attending groups online can be awkward.	Most groups are now delivered in person.
CAMHS Phoenix	More games for the Nintendo Switch.	We ordered more games for young people to use during their free time.
	Young people asked to make the quiet room more accessible	We received got allocated funds to buy more sensory items for the quiet room so it can be used more regularly.
	Request to make the garden more usable and aesthetic.	We ordered bird feeders, bird baths and bird houses to attract more wildlife. We ordered more flowers and benches to make the garden more usable.
	Make the ward environment more appealing.	We ordered wall stickers and allocated time for young people to make posters for the walls.
	Families and carers expressed that travel to and from the unit is challenging at time.	We are exploring ways to support families with the cost of travel.
	Families mentioned that on days they are working they do not know where locally they can sit to attend meetings.	We have begun putting together a list of local places parents/carers can go to attend their meetings, such as coffee shops/libraries.
	Young people expressed that the art room is not accessible and that they would like more art based activities.	We have cleared and tidied the art room so that it can be used more frequently.
	Young people expressed that they would like a book club.	We have shared this with school in the hopes to develop a book club as part of a school-based activity.
	Young people requested that the evening dinner options provided by the	The Dietician liaised with the community hospital canteen to develop a wider menu with more options.

	canteen to be amended and broadened. Young people requested to have hot meal options for lunch.	We explored this with young people further by creating a focus group to identify what hot meal options for lunch we could offer. We now offer hot paninis and jacket potatoes.
Talking Therapies – Step 2:	Long wait times for assessment and step 2 treatments.	We have successfully reduced wait times for assessment and treatment at Step 2 by looking at wasted appointments and shifting resources to use those appointments better. We continue to look at the flow and demand for all interventions to prevent wait times from building up again. We've also talked with all supervisors and will discuss with the team how we can help clients make informed choices about their treatment. This includes sharing our recommendations on what treatment options might work best for their needs.
	Impersonal or scripted treatment by clinicians.	Feedback has been shared with clinical supervisors and the Talking Therapies leadership team regarding the importance of personalised care. This feedback was discussed during a Step 2 training morning and included in the staff brief, an email distributed to the team bi-weekly. The roll-out of extended clinical case management supervision has commenced and supervisor training on the importance of focusing on our supervisees' interpersonal skills has been delivered. We are liaising with our partners at the University of Reading to request that trainees being observed at the university receive feedback on their interpersonal skills. We have reworded suggested template messages sent to clients using the Silvercloud platform to ensure they are more patient-centred.
	Requests for face-to-face step 2 treatment.	The efficacy of delivering step 2 treatment via telephone is well researched, however we have encouraged the team to offer video treatment sessions to those who request it to support engagement with treatment. Clients with a clinical need for face-to-face sessions can be offered this option. During a recent training workshop, we discussed the adaptations we can offer to support our clients in engaging with treatment. Feedback was shared with clinical supervisors and the Talking Therapies leadership team.
	Poor discharge procedures (clients expressing they did not receive appropriate communication about their discharges).	Feedback shared with clinical supervisors and supervisors will have additional time to ensure correct discharge policies are being followed in clinical case management. The correct discharge procedures for those who are assessed as being a risk to themselves were shared in the Step 2 risk training to the wider team. Quality deep dives are regularly completed by the Step 2 Training and Quality lead and individual feedback is shared with the supervisor and clinician .

	Treatment not fitting their needs or feeling they were able to make an informed choice.	Short video's detailing the evidence base of a range of treatment modalities have been recorded and shared with the team, so meaningful discussions can be held to support the clinicans to ensure the client is making an informed choice. Feedback shared with clinical supervisors and Talking Therapies leadership team.
Talking Therapies – Step 3	Clinical Rooms are not conducive to a therapeutic environment.	Decor has been added to the rooms to provide a more relaxing environment. Pictures have been hung, and plants have been added. In some locations, white noise machines have been installed to minimise noise from other clinical areas.
	Concerns over wait times. Clients feel by the time they enter intro treatment the issues they have needed help with have passed.	There have been changes to the way clients are allocated to therapists. Clients can now be seen across East and West Berkshire locations rather than being placed on a locality-based waitlist. This should even out the wait times and reduce waits for more congested localities.
	Concerns over early discharge.	Supervision practices are being reviewed and renewed to ensure that discharge is being discussed and is suitable for individual clients. Audits are being done to check all cases taken to supervision
Respiratory Service	Larger print available for patient handouts.	All staff aware of printing or enlarging in a larger font.
	Buzzer at Coley Clinic too high if you are in a wheelchair.	Patients who are in wheelchairs are asked to phone when they arrive and will be given access to the building via the ramp.
Community Dental Service	When I called to make an appointment, it took quite a time to get through, get a call back and get a date and time .	Employed part time receptionists for Langley and West Berks clinic they are now in post. We have volunteers at Whitley and Skimped Hill clinics.
MSK Physio West	Space, noise and privacy.	We are reviewing spaces that we do not own alongside estates to see what is possible.
	Expectations - hands on, scans and advice given.	Expectations to be discussed in first session
	Physio reception at Bath Road - staffing and facilities	Reception now moved to main desk so more room for seating, review of admin staffing underway.
Nutrition and Dietetics	Could you please educate me on portion size I should eat on the day.	In addition to links on portions sizes provided during the group session, extra portion size guidance, with attached resources and infographics sent.
Intermediate Care	Would've been better if we had known the reason for delay.	Staff are to contact patients if their visits are going to be delayed.
	Unable to see standard format on exercise prescriptions.	Changed the font size on the exercise prescription for visually impaired clients/carers.

Community Nursing Service – Reading/West Berks	We would like a call when our visit is moved.	We have changed the process regarding calling patients when visits are moved aligning Reading and West Berkshire processes.
Heart Function Team East	Chairs are needed for relatives in the clinic.	Chairs are in place.
	Better signage at the WAM clinic – again – needed to be bigger.	Better signage has been put up
Wheelchair Service	Signs for disabled parking confusing – family's coming without blue badges not sure they can park in the designated bays.	New signs, clearer that not only blue badge holders can park there but also any patients.
Inpatients – West Berkshire Community Hospital	Introduction of menu cards for patients to complete suggested.	Menu cards for patients are now being used
Sexual Health Service	Finding the clinic can be difficult.	Walk through social media videos and signage updated.
	The website is confusing.	Developing a guide video for social media.
Integrated Services - East	Contact info for Groups, unsure who to call if need to cancel/unable to attend.	Letters being sent out as well as telephone call to book in for 1st class session.
Berkshire West Urgent Care	The option to purchase a drink; the café was closed and coffee machine not working.	There is a water dispenser in the waiting room as well as vending machines in the café. A new costa coffee machine has recently been installed in the café.
	I was seen quickly but I think everyone would benefit from a wait time.	All staff have been informed to update patients and notify them on arrival of the current wait time. Staff are reminded regularly on this. We also have a poster on our notice board that should be displaying the current wait times within the clinic. Staff are also reminded regularly to have the notice board out on each shift and to update wait times.
Berkshire West UCR/VFW Service	Wish could give a time of am or pm.	We now ask all patients/carer are asked if they would like to be contacted to inform them of when clinician will be visiting.

15 Steps

There have been fifteen '15 Steps' visits during Quarter two. We are receiving consistently positive feedback about the visits, with services relaying how helpful they are.

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 Two 2024/25

ID	Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
9530	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)		medication concerns, family do not understand why the pt has not been sections. Pt now living in a Hotel	Not Upheld	Consent not obtained	Care and Treatment
9542	Windsor, Ascot and Maidenhead	Common Point of Entry		Unhappy with the response, wishes clarity about around sharing information and where the information was found ORIGINAL COMPLAINT BELOW Staff member spoke with landlord regarding pt. Pt is extremely unhappy as they feel the landlord is abusing and harrassing them	Partially Upheld	It was found that the email should have stated there was a presumption of capacity on how you were conducting your affairs and no reason to doubt this. Where an individual informs BHFT services of potentially criminal behaviour it would be usual practice for staff to advise that individual to consider reporting such behaviour to the police, that is why this advice was given	Communication
9521	Unknown	Complaints	Low	Patient raising concerns that she has not had a sufficient response to her formal complaints	Partially Upheld	Apology for delay in recording meeting and which complaints are to be discussed. Review complaints process against PHSO report Making Complaints Count report.	Communication
9526	Reading	Adult Acute Admissions - Daisy Ward		1. Attitude of 2 staff members toward pt following food selection from the menu. 2. Unhappy the Dr said they could be downgraded to informal one day then suggested an increase to S3 on the next Pt expects to be treated fairly and discharged	Local Resolution	This was resolved locally with senior staff speaking to the patient. At the end of the conversation the patient was satisfied that she had been given a chance to discuss her concerns and some explanation/responses given to her about actions taken and possible considerations.	Attitude of Staff

9520	Slough	Community Team for People with Learning Disabilities (CTPLD)		Patients carer raising a number of concerns in relation to the patients interactions with their clinician and the clinical care provided	Not Upheld	No consent provided	Care and Treatment
9372	Slough	CAMHS - ADHD		Father complaining about the service delivery of ADHD assessments for his daughter. He complains about the waiting times and the environment at Fir Tree House especially for someone, like his daughter, who has autism and sensory issues. Re-Opened - complainant does not feel all elements of his complaint have been addressed.	Partially Upheld	It is acknowledged that the waiting room is in need of reconsideration and there is a project being taken place around this. The appointment was booked into the clinicians diary however, they were late to the appointment which caused the issue complained about. No breach of confidentiality or data protection was found	Waiting Times for Treatment
9511	Windsor, Ascot and Maidenhead	Children's Occupational Therapy - CYPIT	Minor	history of sensory and emotional issues. family feel fobbed off having had referral from CYPT/CAMHS refused	Partially Upheld	IO to discuss in L&P - CPE and GH re assessing need for OCD assessment ahead of sensory referral and when to do this. RBWM Getting Help team to offer face to face assessment. CYPIT OT to honour functional and sensory assessment after CYP turns 18. Feedback parent concerns regarding signposting information confusing and difficult to navigate.	Care and Treatment
9531	Reading	Early Intervention in Psychosis - (EIP)		Autistic Pt allegedly told home treatment would be for 3 yrs from Jan 23 but discharged in March 24 to Neuropsychology. Complainant unhappy they were not involved in this decision	Upheld	It is agreed that EIP making the decision to move toward discharge was wrong and that an open and honest conversation with Keyan and yourself would have been more supportive and appropriate.	Communication

9481	Reading	Adult Acute Admissions - Snowdrop Ward		CQC - complaiant states pt was held down by 9 men and they are now black and blue. Pt feels threatened, states transport to PPH was not appropriate. Pt also not allowed out to smoke	Not Upheld	Consent not obtained	Care and Treatment
9501	Wokingham	CMHT/Care Pathways	Low	Pt feels a lack of support from CMHT and wishes an apology. Pt wishes a thorough assessment of their MH issues other than EUPD and support and care to accompany this. Pt wishes a meeting with advocate rather than a written response	Not Upheld	Not upheld	Care and Treatment
9544	Reading	Adult Acute Admissions - Daisy Ward		Pt feels their seizures were caused by medication being introduce to their other medication, they feel this was clinical negligence	Partially Upheld	Medication was monitored by the ward staff however, the patient refused certain recommended medications so alternatives had to be prescribed. The patient did have a seizure which required hospitalisation.	Medication
9529	Reading	Cardiac Rehab		Unhappy with the care provided to pt, believes the nurse did not refer the pat to the next stage rehab Phase 4	Not Upheld	NO consent given. Investigation in doc section	Care and Treatment
9516	Wokingham	Phoenix		Complainant unhappy at the way information was given to them, feels the service need to remember who the parent is and who the trained professionals are	Not Upheld	no consent received IO spoke to Mum directly to hear the concerns and will feed back any learning to the services	Care and Treatment
9486	Reading	CAMHS - Rapid Response	Minor	(Joint complaint with Oxford Health) complex YP, family beleive BHFT failed to meet our responsibilities as directed by the MHA code of conduct. Admitted to RBH, S2 then S3 been there 3 weeks. Oxford Health to answer failure to provide a T4 bed	Partially Upheld	Whilst the clinical rationale and decision making were sound, there were delays with and missed communication with the patient and their family on what the plans were for their treatment.	Care and Treatment

9489	Wokingham	CMHT/Care Pathways		poor and slow decision making, with multiple changes in care management has contributed towards significantly increased distress to pt and carer 1. inadequate support on discharge from Yew tree Lodge 2. poor support with monitoring (psychoactive) medication changes 3. delay in referral to social services / discharge from CMHT complainant wants an apology for the distress caused and answers to several points	Not Upheld	The patient was diagnosed with organic psychosis which is not classed as a mental disorder but is a result of their history of traumatic brain injury. The CMHT recognised the need for a longitudinal assessment over a period of time and this resulted in a longer period of waiting for the appropriate treatment pathway to be determined.	Care and Treatment
9507	Slough	CMHT/Care Pathways		3 points to address regarding current care going forward ORIGINAL BELOW 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 ever elements of the patients 17 year history. Re-Opened - Complainant feels response was vague in terms of plans for future care.	Attitude of Staff
9594	Reading	Community Team for People with Learning Disabilities (CTPLD)		FICB to provide a response. Pt angry that the funding has not been approved yet for their move	Not Upheld	The ICB and Slough council are responsible for this funding. The patient was therefore directed to the ICB to raise this complaint with them as BHFT do not have input into this process.	Financial Issues/Policy

9589	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Low	Feels CRHTT are being unsupportive and have hung up on them, disagrees with dicharge from TT with a referral to MHICS	Not Upheld	Not Upheld	Care and Treatment
9565	Slough	CAMHS - ADHD	Low	Mother unhappy as son is unable to obtain the medication that he needs. Has not been able to access CBT and no referal has been made to OT, states it has been going on for 2/3 years	Partially Upheld	Partially Upheld; the advise that CBT is not commissioned for ADHD was correct. However, the member of staff did not inform the young person and their family that they were leaving, and it did not handover actions from last appointment.	Care and Treatment
9605	West Berks	District Nursing		DN reported they saw the patient walking to a car so advised the DN's would not visit anymore. They wish us to reinforce training on the correct assessment for house bound status	Partially Upheld	It was found that the service acted in line with their policies to inform the patient that if they were able to travel they would not be eligible to have a District Nurse come to their home. The patient did deteriorate further and once again became eligible for this care.	Communication
9577	Unknown	Continence		Concerns raised in relation to the change in products provided by the continence service and the impact this has had on the patients lifestyle	Upheld	At the time of the complaint a review of the patients needs were taking place. In light of this, the original product was reinstated.	Care and Treatment
9632	Wokingham	Community Hospital Inpatient Service - Windsor Ward		Possible complaint to be discussed with PSM at PSLEG	Serious Untoward Incident Investigation	moved to PSM process	

9557	Reading	Other	Low	Unhappy with response, does not understand why the Dr does not remember him. Wants a meeting with staff who are still working at BHFT ORIGINAL BELOW Historical Fair Mile Hospital complaint. Disagrees with diagnosis and the way they were treated whilst in the hospital. States they have only just discovered their diagnosis of Acute Schizophrenia. Have also requested their medical records from around this time (1999)	Not Upheld	Not Upheld.	Care and Treatment
9623	Wokingham	Musculoskeletal Community Specialist Service		left hip replacement in 2019, no physio received. right hip replacement in 2024, patient on crutches with 2 damaged shoulders, now needs physio on right shoulder and 4 months on no treatment received. Does MSK only work on one lot of physio at a time?	Upheld	There is no policy that states a patient cannot be seen for more than one condition at a time and apologies were made if there was a misunderstanding of the policy from staff	Care and Treatment
9374	Reading	Adult Acute Admissions - Bluebell Ward		CQC - 1.Pt believes they have lost the key to their room and feels people have entered without their permission moving and taking items 2. Believes they have radiation poisoning, leave cancelled due to being rude, swollen legs - has not seen a Dr, has been told they cannot take their own medication. 3. illegally detained, no medication for Edema, alleged assault 13/2/24 @ 11:15	Partially Upheld	There was no evidence to substantiate the majority of concerns raised however, there was no fob available on admission and this was apologised for.	Care and Treatment

9613	Reading	Out of Hours GP Services		Unhappy with response, wishes to see accountability from the Dr and for them to admit the pt confronted them and they were made to feel uncomfortable. Also wishes a further apology ORIGINAL COMPLAINT BELOW Felt the Doctor was rude, when he was paying attention	Not Upheld	The clinician had been attempting to complete the notes during the appointment which may have been seen as rude during the patient but is best practice for accurate note keeping. The clinician had prescribed medication from stock rather than referring to the Pharmacy in an attempt to support the patient. Upon review, the issue was diagnosed and treated in the correct manner.	Attitude of Staff
9563	Reading	CMHT/Care Pathways	Low	concerns around the discharge from Cygnet hospital with no medication, pt ended up in PPH within 3 days,lack of interventions from CMHT and a question why the pt wasn't sectioned immediatley	Not Upheld	Not Upheld.	Care and Treatment
9561	Wokingham	Community Hospital Inpatient Service - Windsor Ward		Unhappy with the response would like points reviewed ORIGINAL BELOW Discharge planning and care 1.Delivery and proper functioning of all necessary equipment. 2.A clear and immediate plan for community physiotherapy. 3.Assurance of continued care and support to ensure both pt and carer's well-being.	Partially Upheld	The husband was involved in the discharge planning process and proper checks were carried out to ensure the equipment worked in the home. There was some equipment that was not delivered on time but assessments were made on the furniture in the homes which were found to be useable. There was learning around communication with the family.	Care and Treatment

9586	Windsor, Ascot and Maidenhead	Hearing and Balance Services	Low	Attitude of staff saying the pt needs to have 2 aids because the service are being audited this year, if the complainant refuses they state they will raised a safeguarding Have requested copies of relevant paperwork	Not Upheld	Not Upheld.	Attitude of Staff
9602	Windsor, Ascot and Maidenhead	Common Point of Entry	Low	Pt unhappy with the staff member and the message given that the NHS still after 20 years won't consider drug users for MH services	Not Upheld	Not Upheld	Attitude of Staff
9503	Bracknell	Mental Health Integrated Community Service		meeting arranged and clinician did not turn up, lack of communication form the service, arranged a meeting with an unknown male clincian when males are a trigger for the patient. unhappy with TT	Partially Upheld	The patient was appropriately referred to other service when their presentation fell outside of what Talking Therapies can support with. This was communicated with the patient and their further referral was not acknowledged as it was understood this would be done outside of Talking Therapies.	Care and Treatment
9588	West Berks	CAMHS - ADHD	Low	unhappy having to wait 2 more years for ADHD assessment	Not Upheld	Not Upheld.	Waiting Times for Treatment

9619	Unknown	CAMHS - ADHD		Parents concerned that the child was discharged from the ADHD waiting list with no explanation and without an assessment	Partially Upheld	There has been a significant increase in demand for assessments which has added to a delay in the initial screening process. There is a dedicated piece of work happening to reduce waits for screening and triage, including the recruitment of additional administration and clinical staff. The IO found the letter sent to the family was generic and didn't provide information that would have been helpful for them. The IO has spoken to the clinicians who look at the information provided when a patient is referred and has asked them to ensure that letters include more detail about the reason referrals are not accepted. The information presented at the initial referral stage did not meet the criteria to transfer to the ADHD team. The IO has spoken to the Common Point of Entry Team Service manager and highlighted this concern.	Discharge Arrangements

9587	Reading	A Place of Safety - Patient Admitted to POS		concerns about pain treament and quality of care in POS plus historic data breach regarding a fellow patient	Partially Upheld	It was found that patient names could be seen from the POS. The board displaying patient details has been repositioned to prevent this from being seen through the door. The Assessment Team are to use another location within the hospital to discuss other patients; this is to ensure that another patient cannot hear this discussion. The Trust process was followed in relation to this a Datix incident form was completed. There is evidence that joint working was taking place between POS managers and the patients care team up north. PMVA was appropriately used to remove a telephone from the patient when they used it to call emergency services. There was a legal basis for the detention and this was communicated with the patient.	Care and Treatment
9601	Windsor, Ascot and Maidenhead	CMHT/Care Pathways		1971, misagnosis, patient wishes for this to be removed without being reassessed	Not Upheld	The patient is contesting a historic diagnosis for which they received treatment over many years. As we are not able to amend records the patient was offered the option of adding an note to her file stating she refutes the diagnosis.	Medical Records

9593	Reading	CAMHS - Specialist Community Teams		Father feels that YP needs a broader input from CAMHS	Partially Upheld	It is accepted that the waiting times for treatment are longer than the Trust would like but work to improve this is being undertaken. There is evidence that despite the long waiting time the patient was being appropriately managed and risks monitored. The investigation found that joined up working with other agencies is taking place.	Access to Services
9515	Reading	Crisis Resolution and Home Treatment Team (CRHTT)		Partner concerned about patient discharge.	Not Upheld	No consent received	Care and Treatment
9535	West Berks	Community Hospital Inpatient Service - Highclere Ward		Complainant unhappy with the response relating to the incident, several additional complaints raised ORIGINAL COMPLAINT BELOW incorrect dispensing of medication. Cancer scans booked for 3.6.24, ward stated it was August so no priority had been made for the pt to attend. Complainant extremely unhappy	Partially Upheld	the team responsible for the electronic prescribing (ePMA) have been contacted to see how improvements can be made with the system to highlight, at the time of the drug round, if a medication has been omitted. This should mitigate the risk of human error and prevent similar errors occurring. In these incidents, the nurses have since completed reflective accounts. On the occasion of these near miss errors, it has been identified that the handling of the drug error was not acceptable. This has been discussed with the team to reiterate their responsibility to report when a drug error or near miss errors occur. Training will be undertaken for all staff administering medication, specifically in the area of medicines administration for patients with difficulties in swallowing, due to the high risk of choking, as you have highlighted. Following the investigation no other concerns regarding nursing practice and the care Mrs Garrett received have been identified	Medication

9592	Reading	Community Team for People with Learning Disabilities (CTPLD)		In the last yr pt has had 4 different psychiatrists which has had servious consequences to their MH. Whats to know why BHFT do not have enough permanent psychiatrists with LD	Not Upheld	Local resolution	Care and Treatment
9642	Wokingham	Health Visiting		Unhappy with information sharing in children services child protection assessment report by health visiting service. Complainant believes the colour of their skin plays a big part in what is written about them, they feel their is systemic racist	Not Upheld	Local resolution - no racisum on BHFT part	Confidentiality
9457	Reading	Adult Acute Admissions - Daisy Ward		Relative very concerned for the pt's wellbeing and their welfare. Wishes the pt could have escorted leave. ultimately believes they should be discharged to the community to prevent the risk of MRSA or other infections	Partially Upheld	The investigation found the patient remains very unwell and this is the reason they are unable to have leave or be discharged. The patient withdrew consent for his information to be shared with his father which is why at times he may have felt alienated. It was however felt that there could have been more effort made to involve the patients father in MDT meetings so that he could have his voice heard.	Care and Treatment
9649	Bracknell	Out of Area Placements		Following a yr stay in PPH pt trfd to Kewstoke Hosptial, complainant believes pt made significant progress at Kewstoke but bed management brought the pt back to Sorrel which the complainant feels is unsafe	Not Upheld	The patient did make improvements during their time in Kewstroke ward however, during this time his father was sleeping in his car and showering in the gym in order to be close by. The clinical decision was made to move the patient back to Prospect Park where the improvements could continue and the father could be better supported by living at home	Care and Treatment

9608	West Berks	Phlebotomy		Painful blood test, staff member ignored when told it was hurting	Partially Upheld	The investigation found that the appointment did take place 22 minutes after it was scheduled. The patient did not mention during the test that it was painful and no staff members can verify her account of screaming in pain. The staff's was fully trained to provide the procedure and had undergone the appropriate supervision prior to being allowed to undertake this alone.	Care and Treatment
9583	Wokingham	CMHT/Care Pathways		Concerns raised in relation to the care provided by the CMHT and that the response to their local resolution complaint contained a number of inaccuracies	Not Upheld	The CMHT doctors were not keen to prescribe new medications before some blood tests were done as the previous blood tests had shown some deficiencies, hence why physical health checks were required first. At that time, in March 2023, it was decided that it may not be the appropriate time to proceed with psychological therapeutic options as Kelis was unable to commit to this due to childcare and limited concentration due to sleep issues. Therefore, consideration was given to involve a care coordinator and the possibility of medication options starting with the GP reviewing options. Record shows that all efforts were being made to get the housing association to act.	Care and Treatment

9597	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward		allegations of sexual assault on the Sorrel and physical abuse on Snowdrop in May put in to seclusion and clothing removed	Partially Upheld	Due process was followed in relation to the allegations made, these were raised with the ward and Police at the time. There is no evidence that an assault took place and the Police have closed the case due to a lack of evidence. There is evidence however, that the patient was hostile and aggressive towards staff and at times became violent and destructive. As per Trust Policy the CCTV footage was deleted after 31 days, as the complaint was raised after this time the footage was deleted. The patient was offered to view the footage that we do still hold, with support from staff. The patient was not alone at any time with less than two staff due to her presentation and aggression in seclusion and therefore we were unable to substitute the claim of sexual assault. The patient was stripped naked as she had used her clothes multiple times in seclusion to fashion and ligature. She was offered anti ligature clothing but declined this. The patient also damaged the room and harmed herself superficially with objects she was able to get. There is	Abuse, Bullying, Physical, Sexual, Verbal

9618	Reading	Older Adults Inpatient Service - Rowan Ward		• Why did your mum remain on Haloperidol once she was discharged from Wexham Park Hospital. You understood that Haloperidol was to be discontinued and a different antipsychotic medication prescribed • Why was your mum not seen by a Community Old Age Psychiatrist	Partially Upheld	The patient was appropriately placed under level two observations during visits with the complainant due to safeguarding concerns. Relatives of patients are usually asked to travel separately to patients' appointments rather than accompanying them on escorted transport such as in an ambulance and in taxis however, considering the anxiety the patient has experienced when attending some subsequent appointments, Vicki has asked the Ward Manager to request a larger taxi to enable the complainant to travel with her mother and staff escorts to future appointments so that she can reassure her if necessary.	Care and Treatment
9603	Reading	Older Adults Inpatient Service - Orchid ward		Relative of pt upset at how the pt now presents, feel the changes have happened due to multiple medication changes, despite feeling the ward staff have done a good job they feel the patient has been failed and wonders if it is due to funding	Consent Not Granted		Medication
9610	Slough	CMHT/Care Pathways		COmplainant unhappy with the attitude of the consultant toward patient	Partially Upheld	The appointment was terminated due to aggression from the patient which is in line with Trust policy and a behaviour letter was sent following this. It was found that appointments were cancelled in previous years and this was apologised for. There were no concerns about the current care being provided as this was in line with current procedures.	Attitude of Staff

8845	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Very unhappy with members of the Crisis team, from being hung up on and not understood	Partially Upheld	Apology offered by staff as appropriate. Offer made to pt to work to find a way he find therapeutic	Attitude of Staff
9447	Reading	Adult Acute Admissions - Daisy Ward	Moderate	Unhappy with their inpt 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	Discrimination, Cultural Issues

9507	Slough	CMHT/Care Pathways	Low	3 points to address regarding current care going forward ORIGINAL BELOW Attitude of Dr at pt 3 month review	Not 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 ever elements of the patients 17 year history. Partially Upheld. Re-Opened - Complainant feels response was vague in terms of plans for future care. This is not Upheld.	Attitude of Staff
9546	Bracknell	CMHT/Care Pathways		Wishes a review of the response as not happy ORIGINAL BELOW 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 familarise 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
9542	Windsor, Ascot and Maidenhead	Common Point of Entry		Unhappy with the response, wishes clarity about around sharing information and where the information was found ORIGINAL COMPLAINT BELOW Staff member spoke with landlord regarding pt. Pt is extremely unhappy as they feel the landlord is abusing and harrassing them	Partially Upheld	It was found that the email should have stated there was a presumption of capacity on how you were conducting your affairs and no reason to doubt this. Where an individual informs BHFT services of potentially criminal behaviour it would be usual practice for staff to advise that individual to consider reporting such behaviour to the police, that is why this advice was given	Communication

9372	Slough	CAMHS - ADHD		Father complaining about the service delivery of ADHD assessments for his daughter. He complains about the waiting times and the environment at Fir Tree House especially for someone, like his daughter, who has autism and sensory issues. Re-Opened - complainant does not feel all elements of his complaint have been addressed.	Partially Upheld	It is acknowledged that the waiting room is in need of reconsideration and there is a project being taken place around this. The appointment was booked into the clinicians diary however, they were late to the appointment which caused the issue complained about. No breach of confidentiality or data protection was found	Waiting Times for Treatment
9613	Reading	Out of Hours GP Services		Unhappy with response, wishes to see accountability from the Dr and for them to admit the pt confronted them and they were made to feel uncomfortable. Also wishes a further apology ORIGINAL COMPLAINT BELOW Felt the Doctor was rude, when he was paying attention	Not Upheld	The clinician had been attempting to complete the notes during the appointment which may have been seen as rude during the patient but is best practice for accurate note keeping. The clinician had prescribed medication from stock rather than referring to the Pharmacy in an attempt to support the patient. Upon review, the issue was diagnosed and treated in the correct manner.	Attitude of Staff

9511	Windsor, Ascot and Maidenhead	Children's Occupational Therapy - CYPIT	Minor	Family feel the response is missing the bigger picture and no reasonable adjustments were made for the pt, they believe all the service did was signpost ORIGINAL BELOW history of sensory and emotional issues. family feel fobbed off having had referral from CYPT/CAMHS refused	Partially Upheld	IO to discuss in L&P - CPE and GH re assessing need for OCD assessment ahead of sensory referral and when to do this. RBWM Getting Help team to offer face to face assessment. CYPIT OT to honour functional and sensory assessment after CYP turns 18. Feedback parent concerns regarding signposting information confusing and difficult to navigate.	Care and Treatment
8845	Bracknell	Crisis Resolution and Home Treatment Team (CRHTT)	Minor	Very unhappy with members of the Crisis team, from being hung up on and not understood	Partially Upheld	Apology offered by staff as appropriate. Offer made to pt to work to find a way he find therapeutic	Attitude of Staff
9561	Wokingham	Community Hospital Inpatient Service - Windsor Ward		Unhappy with the response would like points reviewed ORIGINAL BELOW Discharge planning and care 1.Delivery and proper functioning of all necessary equipment. 2.A clear and immediate plan for community physiotherapy. 3.Assurance of continued care and support to ensure both pt and carer's well-being.	Partially Upheld	The husband was involved in the discharge planning process and proper checks were carried out to ensure the equipment worked in the home. There was some equipment that was not delivered on time but assessments were made on the furniture in the homes which were found to be useable. There was learning around communication with the family.	Care and Treatment

9489	Wokingham	CMHT/Care Pathways		Unhappy with the response and the lack of care being provided ORIGINAL COMPLAINT BELOW poor and slow decision making, with multiple changes in care management has contributed towards significantly increased distress to pt and carer 1. inadequate support on discharge from Yew tree Lodge 2. poor support with monitoring (psychoactive) medication changes 3. delay in referral to social services / discharge from CMHT complainant wants an apology for the distress caused and answers to several points	Not Upheld	The patient was diagnosed with organic psychosis which is not classed as a mental disorder but is a result of their history of traumatic brain injury. The CMHT recognised the need for a longitudinal assessment over a period of time and this resulted in a longer period of waiting for the appropriate treatment pathway to be determined.	Care and Treatment

Appendix 2: complaint, compliment and PALS activity

All formal complaints received.

	2023/24						2024/25						
Service	**Q 1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q 1**	**Q 2**	**Compared to previous quarter**	**Q2 no. of contacts**	**% contacts Q2**	**Total for year**	**% of Total**
Acute Inpatient Admissions – Prospect Park Hospital	10	2	4	7	23	**8.19**	8	3	↓	49	6.12	11	**8.33**
CAMHS - Child and Adolescent Mental Health Services	8	11	7	9	35	**12.46**	10	13	↑	1914	0.68	23	**17.42**
CMHT/Care Pathways	16	6	13	14	49	**17.44**	12	13	↑	2047	0.64	25	**18.94**
Common Point of Entry	1	3	0	0	4	**1.42**	2	3	↑	816	0.37	5	**3.79**
Community Hospital Inpatient	1	2	5	4	12	**4.27**	4	4	No change	180	2.22	8	**6.06**
Community Nursing	3	6	5	3	17	**6.05**	6	3	↓	5585	0.05	9	**6.82**
Crisis Resolution & Home Treatment Team (CRHTT)	5	10	5	6	26	**9.25**	5	3	↓	1307	0.23	8	**6.06**
Older Adults Community Mental Health Team	1	2	1	0	4	**1.42**	1	0	↓	1521	0.00	1	**0.76**
Out of Hours GP Services	1	2	7	4	14	**4.98**	2	2	No change	1823	0.11	4	**3.03**
PICU - Psychiatric Intensive Care Unit	0	0	1	0	1	**0.36**	0	2	↑	2	100.00	2	**1.52**
Urgent Treatment Centre	1	1	2	1	5	**1.78**	1	0	↓	1306	0.00	1	**0.76**
Other services during quarter	21	19	25	26	91	**32.38**	17	18	↑	50213	0.04	35	**26.52**
Grand Total	68	64	75	74	281	100	68	64		11724		132	**100.00**

Locally resolved concerns received.

	Month Received			
Division	**July**	**August**	**September**	**Grand Total**
Children, Young persons & Families	1			1
Community Mental Health East		1		1
Community Mental Health West				0
Physical Health	9	9	10	28
Grand Total	**10**	**10**	**10**	**30**

Informal Complaints received.

	Month Received			
Division	**July**	**August**	**September**	**Grand Total**
Children, Young persons & Families	2	1	1	4
Community Mental Health East	1	2		3
Community Mental Health West			1	1
Mental Health Inpatients				0
Physical Health		3	1	4
Grand Total	**3**	**6**	**3**	**12**

KO41a Return

NHS Digitals 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**
Consent not granted	0	0	0	0	0	↑	1			
Locally resolved/not pursued	0	4	1	3	0	↑	1			

	2023/24				2024/25					
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Higher or lower than previous quarter**	**Q2**	**Q3**	**Total for year**	**% of 24/25**
Not Upheld	20	25	30	25	19	↑	24			
Partially Upheld	22	26	24	32	9	↑	29			
Upheld	11	9	12	9	12	↓	3			
SUI	0	0	2	2	1	No change	1			
Grand Total	**53**	**64**	**69**	**71**	**41**		**58**			

55% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 51% in Q1, 54% in Q4 and 55% in Q3. These were spread across several differing services.

Complaints upheld and partially upheld.

Row Labels	Abuse, Bullying, Physical, Sexual, Verbal	Access to Services	Attitude of Staff	Care and Treatment	Communication	Discharge Arrangements	Discrimination, Cultural Issues	Medication	Waiting Times for Treatment	Grand Total
A Place of Safety - Patient Admitted to POS				1						1
Adult Acute Admissions - Bluebell Ward				1						1
Adult Acute Admissions - Daisy Ward				1			1	1		3
CAMHS - ADHD				1		1			2	4
CAMHS - Rapid Response				1						1
CAMHS - Specialist Community Teams		1								1
Children's Occupational Therapy - CYPIT				2						2
CMHT/Care Pathways			2	1						3
Common Point of Entry					2					2
Community Hospital Inpatient Service - Highclere Ward								1		1
Community Hospital Inpatient Service - Windsor Ward				2						2
Complaints					1					1
Continence				1						1
Crisis Resolution and Home Treatment Team (CRHTT)			2							2
District Nursing					1					1
Early Intervention in Psychosis - (EIP)					1					1
Mental Health Integrated Community Service				1						1

Row Labels	Abuse, Bullying, Physical, Sexual, Verbal	Access to Services	Attitude of Staff	Care and Treatment	Communication	Discharge Arrangements	Discrimination, Cultural Issues	Medication	Waiting Times for Treatment	Grand Total
Musculoskeletal Community Specialist Service				1						1
Older Adults Inpatient Service - Rowan Ward				1						1
Phlebotomy				1						1
PICU - Psychiatric Intensive Care - Sorrel Ward	1									1
Grand Total	**1**	**1**	**4**	**15**	**5**	**1**	**1**	**2**	**2**	**32**

Care and Treatment complaint outcomes.

Row Labels	Partially Upheld	Upheld	Grand Total
A Place of Safety - Patient Admitted to POS	1		1
Adult Acute Admissions - Bluebell Ward	1		1
Adult Acute Admissions - Daisy Ward	1		1
CAMHS - ADHD	1		1
CAMHS - Rapid Response	1		1
Children's Occupational Therapy - CYPIT	2		2
CMHT/Care Pathways	1		1
Community Hospital Inpatient Service - Windsor Ward	2		2
Continence		1	1
Mental Health Integrated Community Service	1		1
Musculoskeletal Community Specialist Service		1	1
Older Adults Inpatient Service - Rowan Ward	1		1
Phlebotomy	1		1
Grand Total	**13**	**2**	**15**

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	July-23	PHSO have reviewed file and are not progressing
Jul-23	CAMHS – Specialist Community Team	Aug -23	PHSO have reviewed file and are not progressing

Month opened	Service	Month closed	Current stage
Sep-23	CRHTT	Oct-23	PHSO have reviewed file and are not progressing
Sep-23	CAMHS	Oct-23	PHSO have reviewed file and are not progressing
Nov-23	Neurodevelopmental services	Nov-23	PHSO have reviewed file and are not progressing
Dec-23	Heart Function	Dec-23	PHSO have reviewed file and are not progressing
Feb-24	CAMHS - Specialist Community Team	Awaiting update	Complaint referred to PHSO
Feb-24	CAMHS - Specialist Community Team	Sept-24	Apology given
Sept-2024	Community Dental Service	Ongoing	Documents sent to PHSO
Sept-2024	CMHT/Care Pathways	Ongoing	Awaiting update from PHSO on information needed

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 Q2 we received one complaint 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	Q2
Received	1119	1403	924	4522	1091	1229	1408	1399	4036	1237	1012

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. Two postings were responded to during this period.

Physiotherapy in Bracknell: Negative – staff attitude.

WestCall: Negative – communication issues.

Arrangements have been made to attend community meetings on wards at Prospect Park Hospital and in the community. 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 659 queries recorded during Quarter 2. An increase of 41 since Quarter 1. 658 of these queries were acknowledged within the five 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. Via the QMIS process we have implemented and updated Standard Works which help to provide consistency and continuity and adopted a skills matrix which highlights areas where individuals may need support.

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 is supported by 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. They have also attended Reading Pride and taken part in 15 Steps visits The PALS manager has produced a volunteer Role Description to standardise the expectations of volunteers and their input.

In addition, there were 378 non-BHFT queries recorded. 249 originated from the Royal Berkshire Hospital. The Head of Service Engagement and Experience has met with colleagues at the Royal Berkshire Hospital to work together to reduce these. Meetings have been held with the Intelligent Automation Transformation Team to develop an automated response method when dealing with non BHFT queries. It is hoped that this will provide a timelier response for patients and the public and free up more time to develop our service.

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 and with the RBH service committed to attending. A framework for a Term of Reference has been agreed and distributed. 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.
CMHT Care Pathways	50
CAMHS AAT	27
Neuropsychology	20
CAMHS ADHD	20
CMHTOA	19
District Nursing	14
Physiotherapy - Adult	11

Appendix 3

15 Steps; Quarter Two 2024/25

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

Mental Health Services Division		
Prospect Park Hospital		
Ward	**Positives**	**Observations**
Rowan Ward	Let in promptly by NHSP staff who clearly knew processes for people coming onto the ward. At the ward entrance there were a good supply of relevant leaflets. There was also good up to date information on the walls either side of the door. Staffing number on duty was clear. Photo board was up to date and current. Photographs also used on the board to demonstrate who was looking after who and which rooms. Hand gel and masks available and team were encouraged to use should they need. The Rowan tree on the wall was a lovely feature. Staff reported that patients and visitors always commented. Several staff asked if they could help, were we ok etc. The ward felt calm and well managed. The ward manager was on leave, but all staff seem to be aware of their duties. Uncluttered environment. The ward was bright. Rooms were clearly labelled with pictures and writing. Quality Improvement work was clear, and some clear improvement seen in reducing falls. Staff seen actively engaging with patients in a positive way. Activity board in situ and current. A patient asked for assistance when we mentioned to staff someone went straight away. There were several sitting areas around the ward. In all of them there were staff who were engaging with patients. All patients appeared to be treated as individuals.	There was a picture on the dining area door which did not reflect the multicultural vision of the trust. The TV in one area had the sound off despite being on.
Daisy Ward	The ward had welcoming signage outside. The visitor's book was outside the unit and clearly visible to encourage completion. There was a staff photo board which we were told was work in progress.	It took a long time for someone to answer the buzzer on the door.

	There were some nice touches under some staff giving background info/hobbies however this was not consistent. Appeared calm. We were informed that there were sufficient staff on duty. The service users we spoke to had no issues and appeared calm initially and showed us the garden and introduced other patients. There was a variety of seating available which was all being used by various service users. Some interactions observed of activity coordinator in main area with some service users. Garden area was nice and had recently been attended.	It was unclear who was to fill in the book as there was no signage to say. It was unclear who was in charge. Not all staff were wearing name badges and staff wore a mixture of tunics and own clothes. It was not clear who anyone was. Leaflets in the entrance were all creased and some all jumbled up. Some were old versions. Not clear who was monitoring or managing these. Staff seem to be standing around communal areas rather than interacting with patients. Television was on but sound off. There was a radio blaring in the same area. Ward areas looked tired and uninviting. The above observations were shared with the lead, and actions to address were agreed.
Physical Health Services Division		
Community Inpatient Wards		
Ward	**Positives**	**Observations**
Highclere Ward	We did not wait long for the bell to be answered. Photo boards were up to date, along with contact info for other key staff, such as Safeguarding, the Patient Safety Team, Governance Lead etc The ward proactively reviewed patient feedback. The ward appeared calm. The outside space was welcoming, and staff described supporting patients from the Rainbow Room to sit outside. Information on the journey for patients was clearly on display, which helped to explain what is going to happen and manage expectation.	There is no communal space for patients to eat lunch or socialise; other than the outdoor area (weather dependent).

	Nurses on duty and staffing levels were clearly on display and up to date. The ward was clean and uncluttered. The ward was preparing for lunchtime, which smelt appetising. Staff were seen talking with patients in a pleasant and respectful way. Very few call bells were ringing and were answered swiftly by staff. Staff were busy but it did not seem to be chaotic. Walkways were clear of obstruction and housekeepers were actively on the ward. Equipment was accessible and stored in clearly labelled areas. An example of the extended support for patients and their families is to offer the ward food service to people visiting loved ones in the Rainbow Room. The information on iWGC was up to date and included qualitative feedback.	
Donnington Ward	The ward had welcoming signage outside. Hand gel available. Staff were welcoming. There was a staff photo board which was up to date. The number of staff on duty for the day and the nurse in charge were clearly displayed. Ward felt calm even though it was busy. Ward felt well managed and organised. Quality improvement board up to date and evidence of patient centred improvements. Current up to date information for carers (relating to carers week) Informed this would be changed this week for a new topic. Staff were all wearing ID badges and visible. Ward was uncluttered and clean. Good interactions observed of staff with service users. Noticeboard for service users and staff were up to date and clearly visible. Evidence of acting on feedback.	
Jubilee Ward	The ward had welcoming signage outside. There was lots of up-to-date relevant information on IWGC, QMIS, Trust values in the stairway up to the ward. Staff were welcoming.	Equipment in the corridor. Some of the patient thank you cards were a bit out of date (2017/8) perhaps needed a refresh. However, were

	There was a staff photo board which was up to date. The number of staff on duty for the day and the nurse in charge were clearly displayed. Ward felt calm. Ward felt well managed and organised. QMIS board up to date and evidence of patient centred improvements. Current up to date information and leaflets readily available. Staff were all wearing ID badges and visible. Quality improvement board current and positive work being undertaken. Ward was clean and no smells. Number of staff on duty clearly displayed. Uniforms of who is who clearly displayed. Good interactions observed of staff with service users. Noticeboard for service users and staff were up to date and clearly visible. Evidence of acting on feedback.	clearly using IWGC and feedback to good effect. Men's day room was a bit sparse although bright. Maybe more pictures/ activities could be available. The above observations were shared with the ward manager, and actions to address will be taken.
Community Physical Health Services		
Service	**Positives**	**Observations**
Podiatry - Bracknell	Staff welcoming and friendly. The waiting area was clean, and clear of clutter. Information on how to give feedback is on display.	There is no reception area for the service and patients are called in from the waiting area. The Exec poster is out of date, and it would be good to see some 'You Said, We Did' on display. There is limited information about what the service offer compared to other Podiatry Services in the Trust, possibly due to the shared environment and location of the service in the building. The above observations were shared with the team manager, and actions to address will be taken.
Podiatry King Edward VII	There is no reception area and patients wait to be called by staff, rather than check in. The waiting area was clean, and clear of clutter. There was relevant patient information, and it did not feel cluttered.	There is a notice that patients may not be seen if they are late and would need to rebook. There is no information on how to do this shown, and as

	Information on how to give feedback via online link and QR code is available.	there is no reception area, how would patients know if the clinic is running behind. Would it be possible to add photos of who is on duty as there is positive feedback about patients knowing who is working in a clinical area, and their role. It would be good to look at how the information is displayed – A4 information drops down and the leaflet racks refer to the family planning service. 'You Said, We Did' is from June 2023. There were no iWGC paper forms that could be seen. The above observations were shared with the lead, and actions to address will be taken
Podiatry **West Berkshire**	Staff were welcoming. There is information for patients on what to do when they arrive for their appointment, as there is no reception area in the separate waiting area. Waiting area was comfortable. Clinic rooms appeared tidy and ready for the next patient. Information for patients was not cluttered, and up to date. 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.	
Physio **Upton**	We were welcomed without delay by the receptionist. There are up to date posters on the wall in the reception area, reporting on the very positive feedback the service has received from patients. There is a prominent poster advising patients to let the reception staff know, if they have been waiting for more than 10 minutes IWGC feedback invitations are displayed prominently, with additional copies available at reception as patients are leaving.	The poster displaying the Exec team needs to be updated. There is a large blue notice board standing behind some chairs in the waiting area, which may benefit from being removed or better utilised.

	The unit is light and airy, spacious, and clean, with no unpleasant smells. The unit was calm and quiet. We were seen to quickly and welcomed for our visit. The unit was clean with no visible litter or clutter. There is a large blue notice board standing behind some chairs in the waiting area, which may benefit from being removed or better utilised. The Quality improvement board in the staff area has tangible goals and outcomes, although the tickets are now out of date. We were advised that QI is regularly discussed in the team. There were information posters around the unit and also well organised leaflets, with information about a range of conditions relating to the service.	
MSK Physio Bracknell	All staff we saw were welcoming. Staff welcome patients to raise Quality Improvement Huddle Board tickets, with what they are working on visible, and empty tickets in the waiting area. It is clear from the waiting area about the staff, their roles and who is the lead clinician on that day. The waiting area was clean, and clear of clutter. There were some bright paintings on the walls. The admin area staff work in is not cluttered, and as this is an area that patients walk through, there was no patient identifiable information on show. The clinical spaces were clean, well laid out and set up ready for the next patient. Information on how to give feedback is on available, along with 'You Said, we Did.' Information that is relevant to patients accessing the Physio Service, including support in the local area is easily accessible.	
Dellwood Physio	There was plenty of parking. There was a reception area inside Bath Road. The noticeboard in reception appeared to be informative but difficult to see behind the makeshift reception. Other clinics ran in the buildings on other days i.e., Continence and had access to a private separate room. The main areas were uncluttered, and it smelt clean. The clinic had a calm atmosphere. All information is sent to patients regarding what to do at appointment prior. Also, texts to patients to remind them of details etc. No details of staff or who worked there. Some staff had name badges.	We were not aware that the department had moved over a year ago. It was only by chance that we saw the information on the back of the front door. The sign at the front by Dellwood still says the physiotherapy is there. At Bath Road (current location of clinic) there was no signage to say this was BHFT physio. There were 2 receptions and the BHFT one was

		very makeshift. It was unclear who was working the reception. The clinic had been at the new base for over a year but still felt temporary and there did not appear to be much effort to make it welcoming for patients. The notice boards were disorganised. There was information relating to oncology clinics mixed in with trust info etc. No information around the department for patients to provide any feedback. Feedback was provided to the service for them to review.
Physio WBCH	Made to feel very welcome by the admin/reception staff member. Clinic was easy to find, and signage was good. Waiting area was busy but organised and shared with the Xray department. Staff in the department were observed positively interacting with patients. There were also rooms where staff were interacting with patients both face to face and remotely. All clinic areas were clean and well organised. Equipment in the gym area was clean and clearly laid out. There was a lovely view of the garden from the treadmill. The gym was spacious. Board dedicated to staff wellbeing and support with good information. All staff were positively engaged in patient related duties. Clinic appeared to be running smoothly. Noticeboards in the department with relevant information for patients. Leaflets available. Clear information regarding non urgent clinic appointment waiting time displayed.	
Minor Injuries Unit **WBCH**	Main reception area for both departments then a receptionist for the MIU at the department desk. Staff were welcoming and engaging. The unit felt calm and organised.	Was slightly confusing as to which department was BHFT led, and which was run by RBH. Both shared the same working

	Waiting area was clean with facilities for children and adults. Area was quiet. All patients were seen in individual rooms with good privacy, and all were clean and uncluttered. Good seating and wheelchair access available throughout the department. Clear information on how many patients were treated last month. Information on large board in waiting area.	area. Perhaps clearer signage would be appropriate.
Community Dental Services Bracknell	Staff in the clinic were welcoming and friendly. There is a list of staff along with their roles and registration numbers in reception. The waiting area was clean, and clear of clutter. The clinic room was clean and tidy. Information on how to give feedback is on display. There was 'You Said, We Did' on show.	It would be good to see photos of staff alongside this. The contact information was out of date for the complaints office. The feedback was out of date and needs to be updated.
Hearing and Balance Service King Edward VII	All staff we saw were welcoming and friendly. The reception and waiting areas are clean, and the paediatric area in particular is brightly coloured. It is clear from the waiting area about the staff, their roles and who is in the clinic on that day. The waiting area was clean, and clear of clutter. There was relevant information on the walls in most of the waiting areas and it did not feel cluttered. The admin area staff work in is not cluttered and had age-appropriate toys and information on show. The clinical spaces were clean, well laid out and set up ready for the next patient. There is a separate paediatric area, which you walk through to get to two of the other waiting/clinic areas. Separate sensory areas for children (in the first instance) are being set up. The feedback tree is up, and there are plans to start posting the 'You Said, we Did' as red and green apples. Information that is relevant to patients accessing wellbeing support is easily accessible. There are opportunities to give feedback readily available.	The further waiting area (near MHICS) did not have any posters or information on display for people waiting to be seen.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	12 November 2024
Title	**6 monthly Safe Staffing Highlight Report (April - September 24)**
	for Noting
Reason for the Report going to the Trust Board	This report is presented to the Board to provide assurance in relation to safe staffing on our reports in line with the requirements of the NHS England / Improvement Developing Workforce Safeguards (2018).
Business Area	Organisational
Author	Debbie Fulton Director Nursing and Therapies
Relevant Strategic Objectives	The Plan is relevant to the following strategic objectives, **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **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

Highlight Report

Six monthly safe staffing report for Board

1. Why is this coming to the Board?

In line with the requirements of the NHS England / Improvement Developing Workforce Safeguards (2018); a report is provided to the Board twice yearly. The expectations under the Developing Workforce Safeguards is that staffing establishments are reviewed and published annually, with a mid-year review and that the review takes into account patient acuity, service developments, staff supply, temporary staffing requirements and quality / safety measures for staff and patients. This report covers the retrospective period April – September 24.
As part of the safe staffing review, it is also a requirement that both the Director of Nursing and Therapies and the Medical Director confirm in a statement that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable. This statement is detailed below in the summary.

2. What are the key points?

There are ongoing challenges, particularly in relation to mental health registered nursing recruitment and retention, with registered nursing vacancy across the mental health wards currently around 30%, most vacancy being in band 5. We have been successful in recruiting several newly qualified staff just completing their training who will commence over the next couple months, we have seen some reduction in overall registered nursing vacancy and turnover across our Mental health urgent care services (wards and Crisis teams) have a lower than the Trust overall turnover rate currently at 10.5% (compared to just over 12% organisationally) For the community wards the registered nursing vacancy rate is slightly lower at around 26%.

In line with national reporting, shifts with less than two registered nurses are monitored each month. We have continued to see a downward trend in this with 3.5% shifts with less than 2 registered staff compared to 7.49% in previous six months and over 12% this time last year. The community wards have a stable rate of shifts with less than 2 registered nurses with around 2% for wards in west and less than 1% for wards in East,
This positive picture is due in main to our ability to secure temporary staffing where we also continue to see a downward trend in unfilled temporary staffing gaps reducing to 3.55% compared to 5.38% in previous 6 months and 7.85% a year ago, the total number of temporary staff used has increased slightly in this 6-month period compared to the previous six months although still lower than a year ago.

During this reporting period sickness absence across the wards has generally remained higher than Trust average. The top three sickness absence reasons in terms of number of working days lost due to illness are anxiety/ stress/ depression and other psychiatric illness, chest and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems and cold, cough, flu. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness.

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

The main ways used to review safe staffing establishments are:

1. Professional judgement (this is what staff and managers believe to be staffing needed).
2. Staffing review tool -Safecare / MHOST tool (this is a national recognised/ NICE approved tool that calculates staffing needed to meet the care of the patients factoring in their acuity and dependency. The safecare tool enables reporting in terms of actual and required staffing expressed in care hours per patient day.

Review of ward staffing indicates that for the mental health and learning disability wards, the agreed current establishment can meet the baseline rotas agreed, and that sufficient staffing appears to have been used over the last 6 months to meet the needs/ acuity of the patients. It is recognised that the significant vacancy across the wards mean that a high level of temporary staffing is used to achieve this, and that the resource is not always in the right place. This means that staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need. Every effort continues to be made to increase permanent staffing and therefore decrease the reliance on temporary workforce. It is recognised that to meet fluctuating need and acuity some flexibility through temporary staffing is beneficial.

For the community wards, all of the wards have an establishment to meet the rotas agreed, however, with the exception of Jubilee ward staffing levels appear to be just below optimal for the acuity of the patients. On the wards there are other staff who are not captured in the data such as occupational and physiotherapists, senior clinical staff and ward managers who also provide care to patients; factoring this in the wards were deemed to be safe. To triangulate this perspective a review of the patient feedback was undertaken, this indicates that of the 691 reviews completed in the period, 23 mentioned staffing in terms of timeliness of response / wish for more staff. The data demonstrated that there was over 92% positivity of those completing the feedback survey and scores of 4.69 out of 5 for feeling safe and 4.71 out of 5 for their experience in relation to staff.
Jubilee ward continues to have additional staff on shift at night as agreed.

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

Within the trust we have strategic initiatives related to workforce and several workstreams in place that are supported by Quality Improvement methodology to focus on identified areas including staff retention. We also have significant ongoing programmes of work to support our staff including our violence reduction and anti-racism programmes, these are reported to the Board.

There are several initiatives in place to grow the workforce across the wards, this includes Nurse Associate posts that have now been successfully embedded in several services, nursing and AHP apprenticeships and a small amount of international recruitment. These recruitment pipelines will continue over the coming year. There is also a temporary to permanent initiative at PPH for healthcare support workers which has proved to be successful.

Most of the newly recruited nursing staff continue to be recently registered and therefore less experienced. There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. Alongside this we have Advanced Nurse Practitioners, senior nurses and Allied Health Professionals who are supernumerary to the ward establishment and can support the less experienced staff on duty. For our mental health wards there is also a senior leadership structure of Nurse Consultants, Associate Nurse Consultants, Advanced Mental Health Practitioners, specialist practitioners including the Physical Health and Drug & Alcohol leads and a Duty Senior Nurse is available 24/7. An internal leadership programme and a programme called 'Reaching my potential' which is open to all band 5 staff and aimed at supporting improved resilience and confidence is also available.

To support staff resilience and wellbeing in all areas of the trust the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021, we currently have 75 qualified PNAs with further staff in training. The PNA programme is a Health Education England initiative with the PNA providing restorative supervision which is aimed at improving wellbeing as staff feel supported and listened to, this in turn supports staff retention.

In Community Nursing, the new national Community Nursing Safer Staffing Tool (CNSST) was rolled out. The aim of the tool was to support objective assessment of staffing need based on patient acuity. Nationally the use of this tool has been paused as of April 2024 and we are therefore waiting to understand the rational for this and next steps prior to undertaking further data collation locally.

3. Ongoing Improvement Work

- Support the community health division with agreeing right mix of permanent and temporary staffing making up their total establishment.

- Support the Health Roster team in rolling out the Safecare module to Campion.

- Facilitate the relaunch and roll out of the CNSST to community services in order that data can be collected once available.

- Continued recruitment and retention effort as detailed within recruitment and retention workstream of the People plan.

- Encourage consistent and continued use of the Safecare tool to give an accurate picture of staffing needs across the wards and use it to assist in deployment of staffing to meet patient acuity.

4. Summary

The Safe staffing declaration provides the opinion of the medial and Nursing Directors in relation to the position of our staffing across our wards over the last 6 months.

Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. It is however recognised that during the period there were some shifts where staffing was sub-optimal and consequently there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised. Proactive work continues to support increased recruitment and improve retention and therefore sustainability of our permanent workforce.

Medical staffing numbers remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. Out of hours medical cover is provided by GPs for all our community health wards and Campion Unit. Out of hours medical cover is provided by Resident Doctors for the mental health wards with Consultant Psychiatrists providing on-call cover from home.

Berkshire Healthcare
NHS Foundation Trust

Six-monthly Safe Staffing Board Report: October 2024

Executive overview.

The purpose of this report is to provide the board with a twice-yearly assessment and assurance in relation to safe staffing on our wards, as required in the NHS Improvement, Developing Working Safeguards document published in 2018.

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

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

This report is in addition to the monthly safe staffing report provided to the Finance Improvement and Performance Committee and Quality Performance Executive Group and published on the Trust internet; it provides detail on metrics and information used to assess both retrospective staffing safety and prospective staffing requirements.

The main ways used to review safe staffing establishments are:

1. Professional judgement (this is what staff and managers believe to be staffing needed).
2. Staffing review tool -SNCT /MHOST tool (these are nationally recognised/ NICE approved tools that calculate staffing needed to meet the care of the patients factoring in their acuity and dependency). Wards enter data twice a day (except Campion currently) into the Safecare facility on Health Roster using the appropriate recognised tool for the ward speciality; this is presented as care hours per patient day (CHPPD). In this way data is collected consistently rather than previously as a 20-day snapshot. For Campion, the 20-day data collection is still undertaken until they are added to Safecare.

Care Hours Per Patient Day (CHPPD) is calculated, which looks at an average number of hours each patient has of care provision each day, this allows us to benchmark across wards. Across our wards CHPPD does not include supernumerary staff such as the Ward Managers, Doctors, or Allied Health Professionals / Psychologists and therefore the actual hours of total care received from all professionals is slightly more than the CHPPD indicates.

The minimum staffing expectation of at least two registered staff on each ward for every shift remains a requirement. The exception to this minimum is on Campion Unit where it was agreed that a skill-mix of one registered with three support workers was best able to meet with patient need at night. In line with national reporting, shifts with less than two registered nurses are monitored each month; for this reporting period 3.5% of the shifts across the mental health wards had less than 2 registered staff (7.49% in previous 6 months), whilst the west community wards had 2.33% of their shifts and the east community wards had 0.09% of shifts with less than 2 registered nurses. This demonstrates an improved position and although this is due in main to the ability to secure temporary staffing rather than a decrease in vacancy, we have seen a small decrease in registered vacancy and many of our temporary workforce are well known to the wards on which they work which provides a level of consistency and continuity.

Across the wards the e-roster tool (Optima) is used to support with rota completion. Temporary staffing, primarily through NHSP (and agency where this is not possible) provides support to fill any gaps in the rota or additional need. During the last 6 months 3.55% of our temporary staffing

requests were unfilled. This is a reduction on the previous 6 months where 5.38% requests were unfilled.

Sickness absence in general is higher than Trust average across our inpatient wards (table 7 & 8). The top three sickness absence reasons in terms of number of working days lost due to illness are: chest anxiety/ stress/ depression and other psychiatric illness and respiratory problems and musculoskeletal problems. Temporary staffing is used to fill gaps in the rota as required when staff absence occurs due to sickness.

Workforce.

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

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

Within the trust we have strategic initiatives related to workforce and several workstreams in place that are supported by Quality Improvement methodology to focus on identified areas including staff retention. Details of these initiatives and quality improvement programmes are covered within workforce reporting to the Board.

There are several initiatives in place to grow the workforce, these include Nurse Associate posts that have now been successfully embedded in several services across the organisation, apprenticeships, and a small amount of international recruitment. Most of the newly recruited nursing staff, particularly those across our mental health wards continue to be newly registered and less experienced. There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. To improve staff resilience, support and wellbeing, the Professional Nurse Advocate (PNA) programme commenced roll out in June 2021 and there are now 75 PNAs across the trust.

In Community Nursing the Community Nursing Safer Staffing Tool (CNSST) was paused in June 2024 by NHSE whilst it was reviewed, a date for a relaunch is still awaited. Therefore, there is no report for community nursing in this six-monthly review.

Prospective changes to wards and staffing

During Quarter 4 2024/25 the acute working age adult wards will start to reduce their ward capacity from 20 down to 18 beds on each of the four wards, this is more aligned to best practice for acute mental health wards and capacity has been procured elsewhere ensure that there continues to be sufficient mental health beds for Berkshire patients. This change will not make a difference to the baseline staffing required for the wards.
There are no other changes anticipated across the wards that will impact staffing.

Summary

In summary, this review of ward staffing indicates that for the mental health and learning disability wards, the agreed establishment can meet the baseline rotas deemed necessary, and that sufficient staffing appears to have been available to meet the needs/ acuity of the patients. It is recognised that the significant vacancy across the wards mean that a high level of temporary staffing is used to achieve this, and that the resource is not always in the right place. This means

that staff are moved around the hospital to ensure that staffing is in the right place to best meet patient need.

For the community wards, the safe care tool indicates that there was some shortfall in number of staff assessed as being needed for the acuity of the patients across all the wards except Jubilee. The division have ongoing work to review this, the divisional leadership and ward staff believe that with the additional therapy staff available across the wards that their staffing was generally sufficient although suboptimal at times. A review of the patient feedback would support this with 691 reviews being completed in the time period and 23 of the reviews mentioned staffing in terms of timeliness of response / wish for more staff to be available.

Declaration of safe staffing

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

Declaration by Director of Nursing and Therapies and Medical Director.

Over the last 6 months the wards have been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. It is however recognised that during the period there were some shifts where staffing was sub-optimal and consequently there is limited assurance that care was always of a high quality, and it is possible that patient experience was compromised. Proactive work continues to support increased recruitment and improve retention and therefore sustainability of our permanent workforce.

Medical staffing numbers remain stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. Out of hours medical cover is provided by GPs for all our community health wards and Campion Unit. Out of hours medical cover is provided by Resident Doctors for the mental health wards with Consultant Psychiatrists providing on-call cover from home.

Main report

Right Skills, right place, and time.

Berkshire Healthcare NHS Foundation Trust has the following wards:
1 Learning disability unit
7 Community hospital wards
7 Mental health wards

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

All our Mental Health and Community Wards are staffed to provide two registered staff on every shift and the shifts with less than two registered staff on duty are seen as a red flag and highlighted in the local dashboard (table 2). For Campion Unit (Learning Disability unit) the agreed staffing levels are two registered nurses during the day and one registered nurse at night.

On shifts with less than two registered nursing staff there were senior clinical staff on the wards (Ward Manager, Matron and for the mental health wards there is also a Clinical Development Lead/Charge Nurse) and therapy staff based on the wards 9-5pm during the week that provide support. Out of Hours there is a senior nurse covering Prospect Park mental health wards as well as on call arrangements covering all wards. At Prospect Park staff were moved across hospital (including APOS staff) to assist wards including where there less than 2 registered staff on duty to support meeting their minimal staffing requirements (shifts with less than 2 registered nursing staff are detailed in table 4). The provision of these staff who

are not counted within the safer care tool need to be factored in when assessing the provision of safe and appropriate care.

Table 1: Staffing establishment September 2024

Ward	Beds	FTE Establishment in budget 24/25	Professional judgement FTE	Planned shift pattern. (Early-late-night)
Bluebell	**20**	42.92	40wte + 1 ward manager + 0.5 DSN + 1 MHP = 42.5 FTE	7-8-6 activity coordinator inc on the late shift
Daisy	**20**	42.92	40wte + 1 ward manager + 0.5 DSN + 1 MHP =42.5 FTE	7-8-6 activity coordinator inc on the late shift
Rose	**20**	42.92	40wte + 1 ward manager + 0.5 DSN + 1 MHP = 42.5 FTE	7-8-6 activity coordinator inc on the late shift
Snowdrop	**20**	42.92	40wte + 1 ward manager + 0.5 DSN + 1 MHP = 42.5 FTE	7-8-6 activity coordinator inc on the late shift
Orchid	**20**	61.32	57wte + 1 ward manager + 0.5 DSN + 1 MHP = 59.5 FTE	10-10-10
Rowan	**20**	61.32	57wte + 1 ward manager + 0.5 DSN + 1 MHP = 59.5 FTE	10-10-10
Sorrel	**11**	42.92	40.6 + 1 ward manager + 0.5 DSN + 1 MHP = 43.1 FTE	7-7-7
Campion	**9**	33	32+ 1 ward manager = 33FTE	7-7-5
WBCH	44	64.3	63.7 + 0.3 on Donnington and 0.3 Highclere as matron development lead. Ward Manager not in budget. = 64.3TFE	14-11-11
Oakwood	**24**	41.7	39.7 + 1 ward manager and 1 dep. ward manager/ matron = 41.7FTE	9-7-4
Wokingham	**46**	55.8	54+ 1 ward manager + 0.8 matron = 55.8FTE	13-10-7
Henry Tudor	**29(24)**	41.5 (for 24 beds)	40.5 + 1 ward manager (When there is an increase in patient numbers temp staffing is used to achieve rota pattern). 41.5FTE	10-9-6
Jubilee	**16(22)**	35.4 (does not factor in additional night staff member being used currently)	34.4 + 1 ward manager *There is a need to provide the additional nurse at night from a safety perspective (This is sourced via NHSP). =53.1FTE	Current 7-5-5 (usual pattern is 7-5-4) additional staff member at night

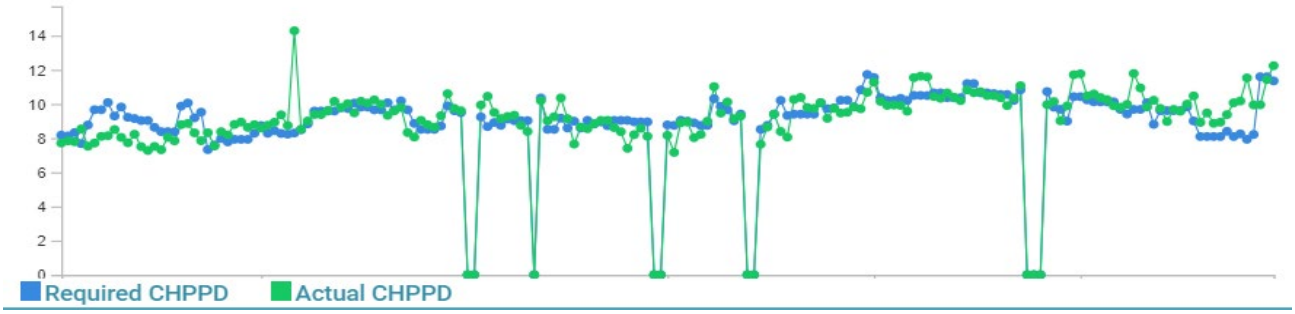
The Safecare tool is a software module within the Optima E- Roster system, it provides information on actual staff levels together with the acuity/ dependency of patients, this has been implemented across the community and mental health wards and aids understanding of staffing need daily. When workforce modelling is undertaken for the wards, the Keith Hurst dependency modelling

tools are used to assist in the evidence data (this is a nationally recognised, NICE approved tool), alongside benchmarking and professional judgement. For Mental Health wards the modelling tool used is the Mental Health Optimal Staffing Tool (MHOST) and the community wards use the SNCT as a basis for the dependency calculations. The wards now enter this data via Safecare twice a day so average dependency is undertaken throughout the year rather than as a 20-day snapshot as it was previously. Campion still undertake the 20-day dependency currently. It is also recognised that there is no tool specifically for dementia wards at present. These and older adult Mental Health wards often require increased staffing due to a combination of physical and mental health need that does not appear to be reflective of the available tools.

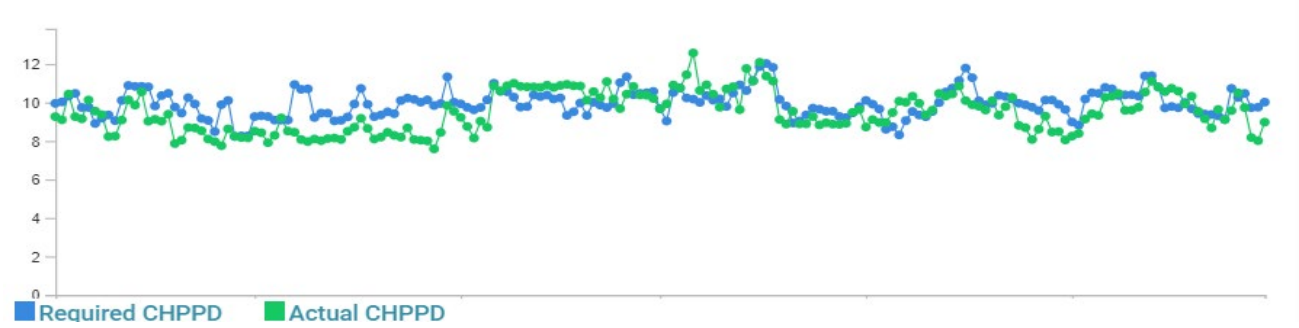
Establishment Review using Safecare data April to September 2024

Acute Mental Health Wards.

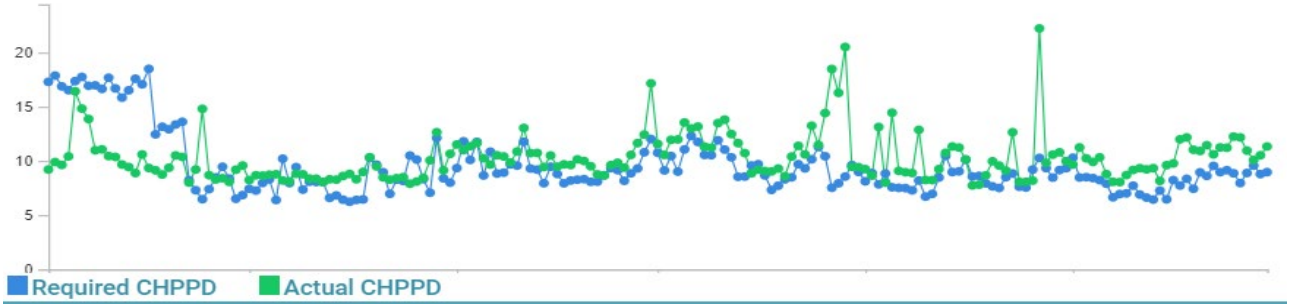
Bluebell Ward



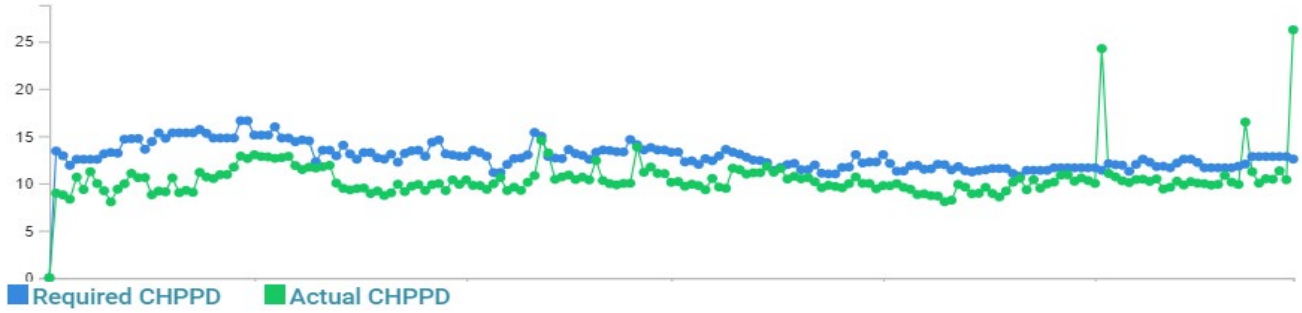
Daisy Ward



Rose Ward

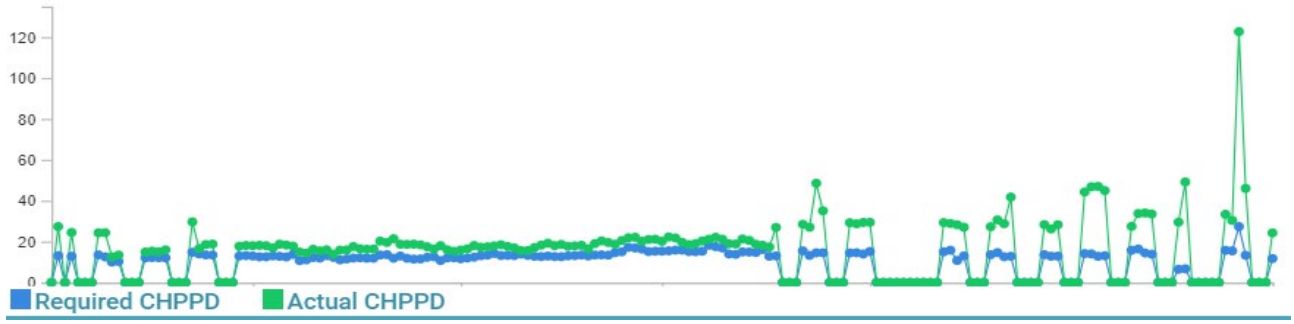


Snowdrop Ward



From the data, 3 of the acute mental health wards appear to have sufficient staff for the acuity of the patients with snowdrop ward figures appearing suboptimal. However total hospital staffing is considered throughout the day/ night with staff moving to ensure all wards are safely staffed (it does not show in these charts when staff move across wards to help). In addition, the figures do not include supernumerary staff such as the Ward Managers or Allied Health Professionals / Psychologists who also provide care. Taking the view of all the wards together it was assessed that the wards were all assessed as safe.

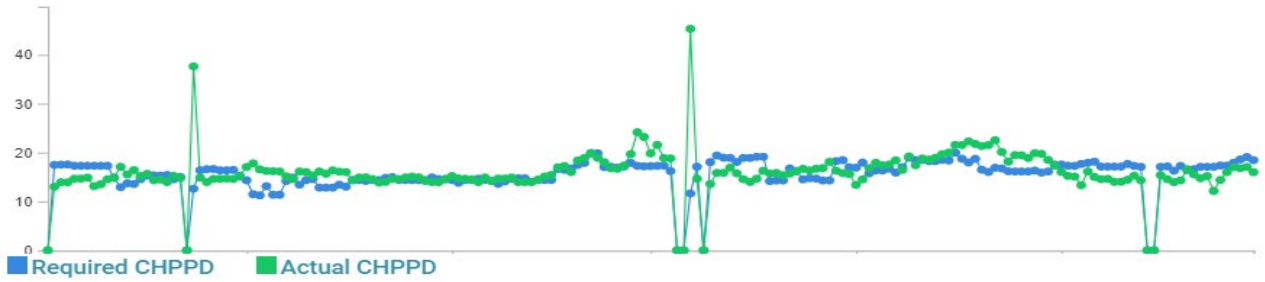
Older Mental Health Wards.
Orchid Ward



Rowan Ward

There have been some challenges with the data reporting on Orchid ward and this accounts for the graph having data missing during April/early May and August/September. There is support for the ward staff via Associate Nurse Consultants and senior managers to improve their data collation. From the data it appears that both older mental health wards have sufficient staff for the acuity of the patients.

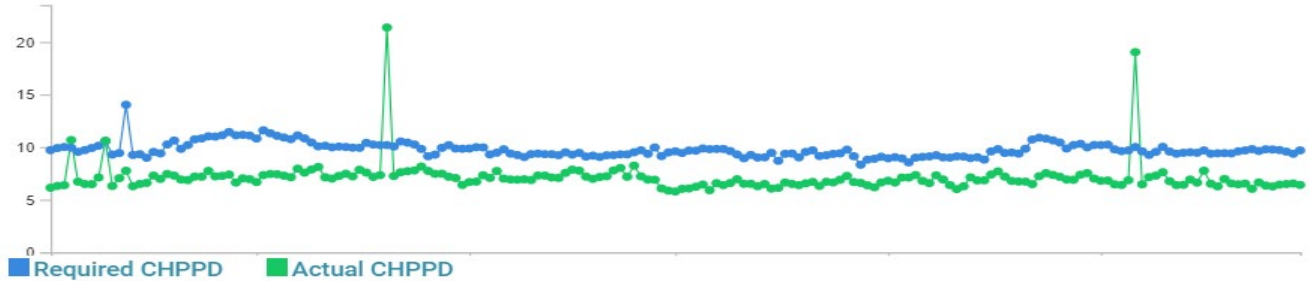
PICU
Sorrel Ward



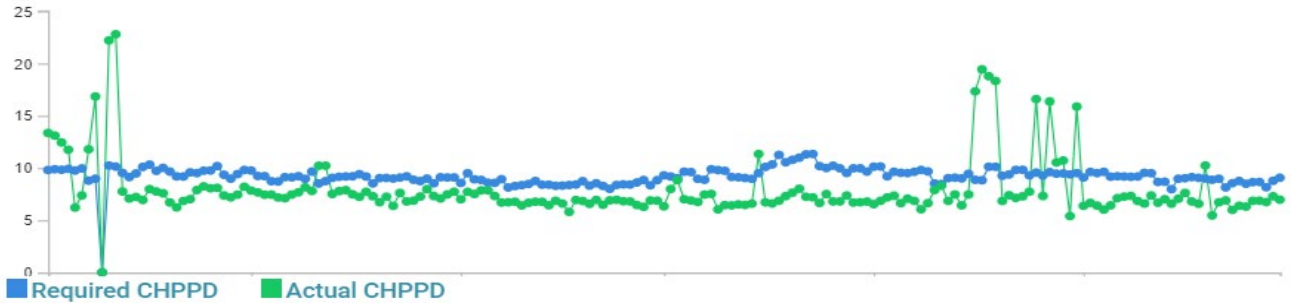
The spikes indicate lack of data entry on a few days during the period, however, from the data the staffing levels appear to be sufficient for the acuity of the patients.

Safecare data Community Health Wards

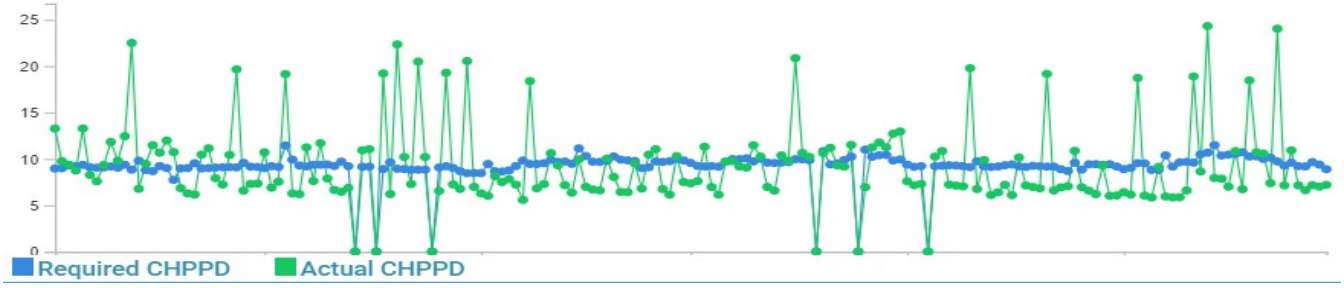
Oakwood Ward



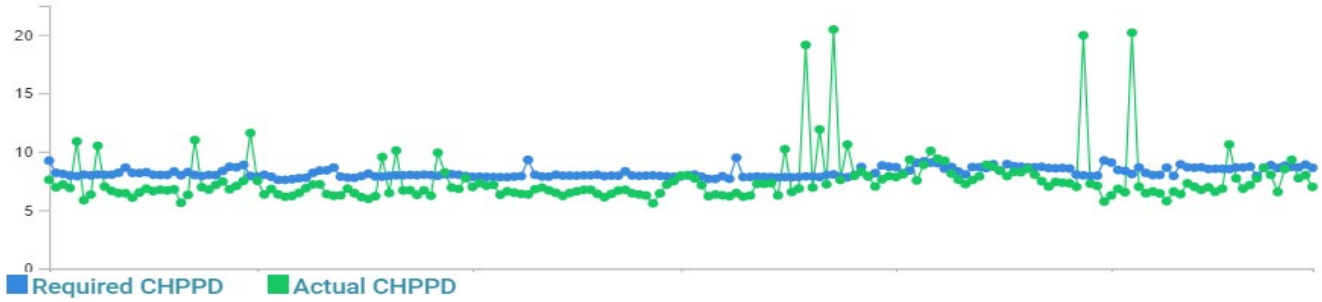
West Berkshire Inpatient Wards



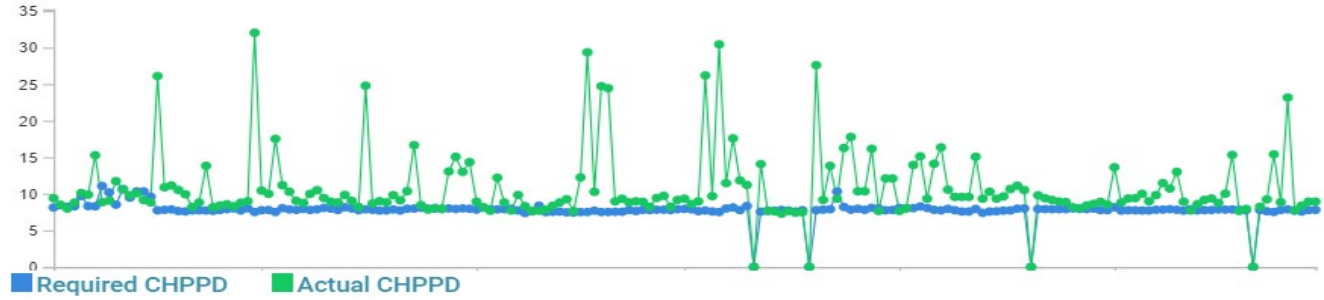
Wokingham Wards



Henry Tudor Ward



Jubilee Ward



Except for Jubilee ward, all the community wards demonstrate that their staffing levels are just below optimal for the acuity of the patients. In addition, Wokingham and Jubilee wards show an inconsistency in reporting. On the wards there are other staff who are not captured in the data such as occupational and physiotherapists, senior clinical staff and ward managers who also provide care to patients; factoring this in the wards were deemed to be safe.
Jubilee ward continues to have additional staff on shift at night as agreed.
To triangulate this perspective a review of the patient feedback was undertaken, this indicates that of the 691 reviews completed in the period, 23 mentioned staffing in terms of timeliness of response / wish for more staff. The data demonstrated that there was over 92% positivity of those completing the feedback survey and scores of 4.69 out of 5 for feeling safe and 4.71 out of 5 for their experience in relation to staff.

Campion Ward

A 20-day review was undertaken in September 2024 using the current available Keith Hurst tools. Due to the high level of acuity of the patients actual staffing levels required are far higher than the budgeted workforce and were deemed to be safe.

Red flags

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

Table 2 demonstrates the number of occasions by ward and month where there were less than two registered nursing staff on a shift. All wards apart from Snowdrop ward, Highclere ward and Oakwood ward showed a decrease in the number of shifts where there were less than 2 RNs. The overall total fell from 355 to 203.
For all the wards where there are less than two registered nurses, senior staff, and ward managers (who are supernumerary to the safe staffing numbers) as well as other clinical staff such as Physiotherapy and Occupational Therapy provide support when available. For the wards at Prospect Park Hospital, the Duty Senior Nurse is also available and able to take an overview of the wards and redeploy staff to areas of most need, as necessary.

Table 2: wards and number of occasions where there were less than two registered nursing staff on duty*

(From July 2024 data was collected as total shifts not day and night)

	April 24		May 24		June 24		July 24	Aug 24	Sept 24	Total for ward
	Day	Night	Day	Night	Day	Night	Total	Total	Total	
Bluebell	0	0	0	3	2	2	1	1	3	**12**
Daisy	4	0	2	0	0	0	3	2	2	**13**
Rose	2	0	3	0	1	0	2	6	7	**21**
Snowdrop	8	0	4	0	8	0	0	0	0	**20**
Orchid	0	0	4	1	8	2	14	13	10	**52**
Rowan	0	0	0	0	0	0	0	2	0	**2**
Sorrel	0	0	0	0	0	0	8	0	10	**18**
Campion	0	0	0	0	0	0	0	0	0	**0**
Donnington	0	0	0	0	0	0	0	0	0	**0**
Highclere	8	0	10	0	3	0	6	4	9	**40**
Oakwood	2	0	0	0	0	0	0	0	0	**2**
Ascot	0	1	2	0	4	0	0	11	3	**21**
Windsor	0	0	0	0	0	0	0	0	1	**1**
Henry Tudor	0	0	0	0	0	0	0	0	0	**0**
Jubilee	0	0	0	0	0	0	0	0	1	**1**
Total for month	**25**		**29**		**30**		**34**	**39**	**46**	**203**

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

Safety on our wards

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

Quality indicators.

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

The indicators we use for this are:

Community Wards:

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

Mental Health Wards:

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

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

Table 3: Quality metric for mental health inpatient wards and Campion (April- September)

Ward	AWOL	Falls	Patient on Patient Assault	Patient on Staff Assaults	Prone Restraint	Seclusion	Self-harm
Bluebell	14		4	8	0	1	211
Daisy	9	1	6	17	2	3	64
Rose	26	4	2	36	2	11	49
Snowdrop	9	4	12	37	1	14	42
Orchid	1	15	6	6	0	0	2
Rowan		29	2	21	0	4	0
Sorrel	2	2	10	18	2	16	1
Campion			5	7	0	6	7
Total	**61**	**55**	**47**	**150**	**7**	**55**	**376**

* Correct at time of report

There were no incidents reported to have occurred due to staffing levels during this period.

There are several Quality Improvement programmes and initiatives being undertaken across the Trust including reducing restrictive practice; self-harm and reducing assaults are also breakthrough objectives for the trust receiving specific focus. The mental health wards are participating in the national mental health ward Culture of Care programme; this supports the embedding of the NHS England Culture of Care Standards using quality improvement and co-production. An element of the programme focuses on safety including risk, violence reduction and reducing restrictive practice.

Table 4: Quality metric for community physical health inpatient wards (April to September)

Ward	Medication incidents (moderate harm and above)	Falls	Pressure Ulcers Grade 2 and above	Patient on Staff Assaults
Donnington	0	25	7	5
Highclere	0	11	5	2
Oakwood	0	13	6	3
Wokingham	1	37	9	8
Henry Tudor	0	12	2	1
Jubilee	0	4	0	0
Total	**1**	**102**	**29**	**19**

* Correct at time of report

There have been no incidents reported as a direct result of staffing levels during this period.

The Trust falls group considers all falls and identifies any areas for improvement. There has been a decrease in alleged patient on staff assaults (38 to 19) and pressure ulcers (59 to 29). However there has been an increase in pressure ulcers (36 to 42). In October 2024 there has been a relaunch of the Pressure Ulcer Oversight Group chaired by the Deputy Director of Safety and Quality with a focus on reducing and minimising the incidents of pressure damage across both in patient and community settings.

Table 5: Percentage Bed Occupancy April-September 2024

	April	May	June	July	Aug	Sept	Average
Bluebell	99.15	98.7	96.1	97.9	97.3	92.8	97
Daisy	98.5	93.7	98	98.4	98.3	99.3	98
Rose	98.15	100	97.5	94.9	98.5	97.8	98
Snowdrop	98.5	97.9	97	98.4	100	98	98
Orchid	92.5	86.5	86.5	85.5	86.3	83.5	87
Rowan	81.6	71.1	66.9	73.1	89.1	91.9	79
Sorrel	86.49	95.6	97.3	97.9	90.9	99.1	95
Campion	65.88	63.1	87.4	88.9	95.7	100	83
Donnington	85.1	89.9	92.8	88.5	85.5	88.3	88
Highclere	88.6	85.2	90.6	88.4	84.7	91.8	88
Oakwood	96.12	94.8	91.7	96.4	91.7	94	94
Ascot	86.11	91.4	89.1	89.2	78.3	90.5	87
Windsor	79.64	95.7	91.8	90.7	89.7	92.6	90
Henry Tudor	89.41	92	91.7	81.6	77	89.7	87
Jubilee	73.84	91	93.1	87.6	89	100	89

*Over 95% occupancy is flagged as a potential cause for concern.

The adult mental health wards average occupancy has risen from 92.6% to 97.75% with only 3 occasions where levels were below 95%. Sorrel occupancy averaged at 95%. Campion occupancy has also increased over the last 6 months (72.28% - 83%). All other ward occupancy figures are similar to the previous 6 months.

Right skills

Recruitment and Retention

Berkshire Healthcare have a people strategy with proactive work streams focusing on improved diversity, reducing violence, recruitment and retention including workforce pipeline, wellbeing, sickness absence.

Vacancies

Across the mental health wards registered nurse vacancies has varied during the last six months, with recruitment remaining challenging, vacancies have varied between 27.39 FTE and 38.24 FTE, with most of the vacancy being at Band 5; this is however showing some improvement and is slightly lower than the previous 6-month where vacancy varied between 38.97-42.95 FTE. Unregistered vacancies have also varied widely between 93.1 and 130.87.

The CHS wards have also had some staffing challenges with vacancy levels increasing over this six-month period.

Temporary staffing, primarily through NHS Professionals (and agency where this is not possible) provides support to fill any gaps in the rota or additional need. During the last 6 months 3.55% of temporary staffing requests were unfilled this is less than the previous 6 months (5.38%). Campion unit continues to have low vacancy rates but has challenges filling specialist RN positions and support workers' long term.

Table 6: Full Time Equivalent (FTE) vacancy of registered nursing and healthcare worker combined for September 2024.

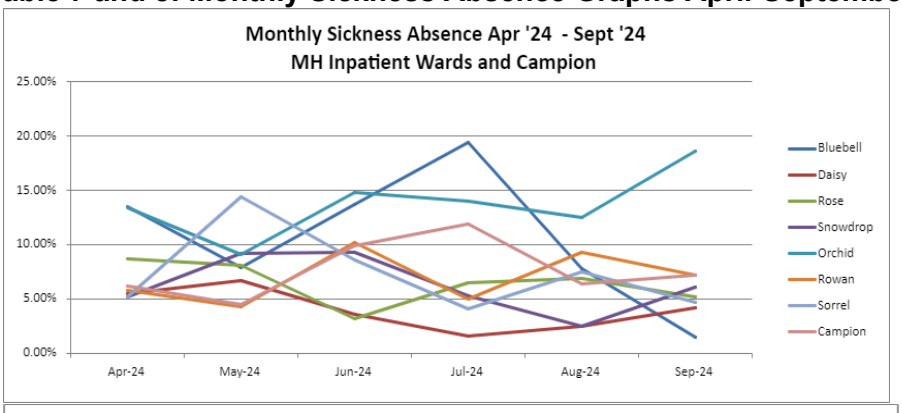
Ward	Grade of Staff	September 2024
MH Wards	Registered	27.39 (29.58%)
	Unregistered	130.87 (38.10%)
CHS Wards	Registered	28.25 (26.77%)
	Unregistered	60.84 (45.67%)
Campion	Registered	2.56 (23.7%)
	Unregistered	5.93 (26.71%)

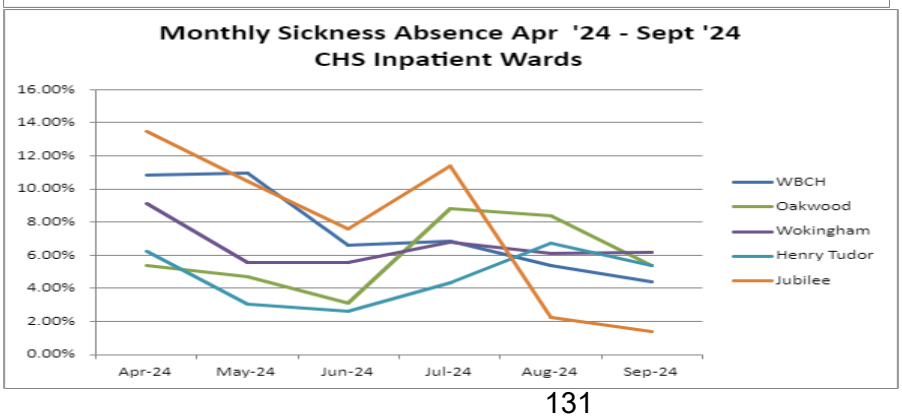
Sickness absence

During this reporting period there continues to be challenges which have impacted staffing due to sickness absence amongst our permanent workforce. Sickness absence in general is higher than the trust target of 3.5% and the organisational average of 4.5% as can be seen in table 7 and 8; this is due to a mix of long and short-term absence. The top three sickness absence reasons in terms of number of working days lost due to illness are, chest anxiety/ stress/ depression and other psychiatric illness and respiratory problems and musculoskeletal problems; the most frequent reason in terms of number of staff affected are chest and respiratory problems, and cold, cough, and flu.

The Trust has a sickness absence policy which with support from the people directorate, ensures that appropriate action is taken to support staff and managers with sickness related absenteeism. The Trust also has a Health, Wellbeing and Engagement Manager and team. In addition, there are several initiatives which are widely advertised to address both physical and mental health care needs of staff including a health and wellbeing hub for staff and the Professional Nurse Advocacy programme. These can be accessed by all staff via Nexus the Trust internet site or via Occupational Health referral if appropriate.

Table 7 and 8: Monthly Sickness Absence Graphs April-September





Temporary staffing

Table 9: Temporary staffing usage April -September

	Total number temporary staffing shifts requested	Number of temporary shifts requested to fill registered staff gap	Total temporary shifts unfilled
PPH	19988	2827	440 (2.20%)
West Community Wards	6068	1663	517 (8.52%)
East Community Wards	2211	410	60 (2.71%)
Campion	2177	554	65 (2.98%)

The total number of temporary staff requests was 30444 compared to 28714 in previous 6 months. The unfilled shifts were 3.55% which is an improvement on the previous 6 months which was 5.38% The need for temporary staff continues to be driven by vacancy, absence, and the need to increase staffing numbers to meet acuity and need of patients.

Staff training

Staff training compliance along with clinical supervision is monitored by the divisions and into relevant committees, this along with preceptorship and supportive training and upskilling programmes ensures that staff have the right skills for the roles that they are undertaking. This is provided in detail into the 6 monthly report. NHS professionals staff also have a training matrix agreed as appropriate for the roles that they are undertaking, with access to Berkshire Healthcare training where this is more specialist such as PMVA.
Ward staff are required to complete a number of statutory, mandatory, and essential trainings, for the purpose of this report, the below training in included.

Table 10: Overview of wards training compliance.

UNIT	Manual Handling (%)	IPC (%)		PMVA (%)	Inpatient Fire (%)		
		Once Only	Yearly			Resus	Safeguarding
Rose Ward	93.6	100	90.3	89.3	93.8	87.0	85.5
Snowdrop Ward	74.3	100	85.7	71.0	86.1	90.5	94.2
Bluebell Ward	91.2	100	97.1	93.6	97.2	95.4	97.7
Daisy Ward	93.9	100	100.0	90.6	97.1	93.1	97.6
Sorrel Ward	64.0	100	96.0	95.7	100.0	72.4	91.8
Rowan Ward	97.6	100	92.9	93.3	90.7	83.3	99.1
Orchid Ward	92.7	100	92.7	73.5	88.1	83.0	81.55
Henry Tudor Ward	90.3	100		N/A	94.4	86.4	94.8
Jubilee Ward	96.6	100	93.6	N/A	93.8	89.5	93.8
WBCH	91.6	100	94.4	N/A	93.7	91.9	98.2
Oakwood Ward	93.0	100	90.9	N/A	95.9	97.2	98
Wokingham	95.2	100	87.1	N/A	97.1	78.5	93.2
Campion Unit	84.9	100	82.4	N/A	91.4	75.0	98.9

*The aim for all areas is to achieve 85% compliance. the exception to this is safeguarding where we aim for 90%.

There continues to be a focus on areas where compliance is not quite at the level we are aiming to achieve, with improvement seen over the last 6 months in these areas and targeted training provided. Compliance is monitored through relevant groups.

The mental health wards have access to ward managers and a senior leadership structure of Associate Nurse Consultants, Advanced Mental Health Practitioners and specialists such as the

Nurse Consultant, Physical Health and Drug & Alcohol leads and Allied Health Professionals who are supernumerary to the ward establishment and able to provide clinical support and advice. There is a senior nurse on for the hospital 24/7.

The physical health wards have ward managers, senior nurses, advanced nurse practitioners and a senior leadership structure able to offer advice and support.

Nurse Associates and nurses in training

The Trust currently has 27 nurse associates employed (from 17 in March 2024) and further 8 in training (7 in March 2024).
Other nursing and Allied Health Professional apprenticeships are also being undertaken by our staff; this assists with supporting a pipeline of new staffing in addition to traditional recruitment.

Preceptorship

There is a preceptorship programme and structured supervision sessions in place to support these staff which runs through their first year of employment. In addition, there is a programme called 'Reaching my potential' which is open to all band 5 staff and aimed at supporting improved resilience and confidence.

Professional Nurse Advocate (PNA) programme

We currently have 75 qualified PNAs and 1 staff member currently in training across the trust. The PNA role involves providing restorative supervision which is aimed at improving wellbeing as staff feel supported and listened to, this in turn supports staff retention. The PNA programme is a Health Education England initiative which has been a requirement in midwifery for some years. It is now being rolled out nationally across healthcare. At Berkshire Healthcare the current PNA focus is to assist with ensuring the availability of SPACE (reflective supervision) groups for clinical physical healthcare staff, this is well established across the mental health clinical staff teams. Work is currently underway and is being undertaken in collaboration with our psychological support and mental health teams. PNA trained staff are currently being developed and supported to deliver their own sessions across all areas. Cohort 2 have recently completed training and are being supported by more experienced staff.

Ongoing improvement work

- Support the community health division with agreeing right mix of permanent and temporary staffing making up their total establishment.

- Support the Health Roster team in rolling out the Safecare module to Campion.

- Facilitate the relaunch and roll out of the CNSST to community services in order that data can be collected once available.

- Continued recruitment and retention effort as detailed within recruitment and retention workstream of the People plan.

- Encourage consistent and continued use of the Safecare tool to give an accurate picture of staffing needs across the wards and use it to assist in deployment of staffing to meet patient acuity.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

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

Berkshire Healthcare
NHS Foundation Trust

Trust Board Meeting – 12 November 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. Child Autism and ADHD Diagnoses

Hundreds of thousands of children with suspected neurodevelopmental conditions in England, including autism and ADHD, face unacceptably long waits to be diagnosed, the Children's Commissioner has warned.

Dame Rachel de Souza's report into the issue said that the system has failed to keep up with rising demand. The report calls for urgent change to a needs-led, not a diagnosis-led, system of support.

Dame Rachel said it was currently "impossible" to use published national data to get an overview of how long children were typically waiting, since they can be assessed through both community and mental health services. Instead, she said she used her legislative powers to access unpublished NHS England data for 2022-2024.

According to her report:

- about 3% of children, or 400,000 in all, were still waiting to get a first appointment after being referred.
- children with suspected cerebral palsy faced the highest waits - three years and four months, on average.
- nearly a quarter of children with ADHD had waited more than four years to get diagnosed following a referral.
- almost one in six waited more than four years for an autism diagnosis via the community health service route.
- disadvantaged children were disproportionally impacted, with some parents unable to "fight" for their child to access their legal entitlements.

Interviews with families revealed those who could afford to, opted to pay privately for assessment and support. The report calls for earlier identification but also more support in mainstream schools "to prevent over-reliance on diagnosis as the "silver bullet".

It also recommends a national framework for special educational needs support in nurseries and schools, more appointments and better support for families whilst they wait for their child's assessment.

Executive Lead: Julian Emms, Chief Executive

3. An Independent Review of the Care Quality Commission (CQC)

In October 2024, the Government published two reviews of the Care Quality Commission (CQC). The first, by Dr Penny Dash, chair of Northwest London Integrated Care Board, considered the operational effectiveness of the CQC. The second, by Professor Sir Mike Richards, former Chief Inspector of Hospitals, considered the CQC's single assessment framework.

The Dash review found significant failings in the CQC, which it says 'has lost credibility in the health and social care sectors'. It finds that the CQC's ability to identify poor performance and support quality improvement had deteriorated. The review says this has undermined the health and social care sector's capacity and capability to improve care.

It found problems with the single assessment framework, the provider portal and regulatory platform and the organisational structure – previously raised by CQC staff.

The Dash review recommends that the CQC should rapidly improve operational performance; fix data infrastructure; improve the quality and timeliness of reports; rebuild expertise and relationships; review the single assessment framework; make ratings more transparent; improve local authority assessments; and pause Integrated Care System assessments for six months.

Sir Mike Richards' report considers the introduction of the single assessment framework, the new provider portal and regulatory platform and the organisational restructure. It recommends a fundamental reset of the organisation and a return to the previous organisational structure, with at least three chief inspectors leading sector-based inspection teams at all levels.

At this stage, the use of one-word ratings will remain, although both reports suggested this should be reviewed by CQC.

Over the next four months, Penny Dash will conduct a further review of the wider landscape for quality of care and patient safety, including the roles of the different national bodies involved.

Executive Lead: Julian Emms, Chief Executive

4. The Budget

Board members will have heard the announcement from the Chancellor of the Exchequer of an extra £22bn for the NHS. It is too early to understand what impact this will have on service developments, but this will become clearer in the coming months. We know that the NHS currently has an underlying deficit of nearly £5bn and pay awards and the increased national insurance contributions will also come out of the £22bn.

I expect the clarity we are after will come with the publication of the NHS England's Planning Guidance which is usually published just before Christmas.

Executive Lead: Julian Emms, Chief Executive

5. Staff Winter Flu Vaccination Report October 2024

Seasonal flu vaccination remains a critically important public health intervention and a key priority for 2024-25 as part of protecting the public and staff over the winter months.

In the Core NHS standard contract for 2024/25, flu vaccinations for frontline healthcare workers is retained as an employer responsibility to offer and deliver the flu vaccine. For the Covid vaccination, it is advisable for healthcare staff, but not in this year's contract. Berkshire Healthcare have chosen to offer the Covid-19 vaccine to their staff.

The Joint Committee on Vaccination and Immunisation advise that the primary reason to vaccinate frontline healthcare workers is to avoid sickness absences, rather than to protect against transmission or because they are at greater risk of respiratory illness. The aim is to offer the vaccinations to 100% of frontline healthcare workers, with a minimum uptake of 75% for flu.

We commenced our vaccination programme at the beginning of October 2024 and are providing vaccinations through a variety of means including clinics, peer vaccinators and, recognising that many staff live outside of Berkshire and/or work from home also offer vouchers for flu vaccination. Staff are also encouraged to let us know if they have received their vaccine through other means such as GP or local clinic.

Organisational uptake of flu vaccination as of 31st October 2024 is 28%

Directorate	% Uptake
Central Services	**34%**
Mental Health Services	**23%**
Community Health Services	**27%**
Children, Family and All Age Services	**32%**

Next steps

- Clinics will continue until the 26th of November 2024; we will be focussing on sites and areas where uptake has been lower.
- The clinics will either be bookable or roving, meaning that the vaccinations are taken round to staff working on site.

- There will also be more targeted provision for services, or where services have requested us to attend a large team meeting.
- Ongoing promotion within Service meetings and Trust wide events and Communications.
- Staff can continue to request flu vouchers up until December 2024.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

Presented by: Julian Emms
Chief Executive
12 November 2024

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	Tuesday 12th November 2024
Title	**Health & Wellbeing Update Report**
	Discussion
Reason for the Report going to the Trust Board	The Health and Wellbeing update is scheduled for review every six months. The paper is presented for information and discussion.
Business Area	People Directorate
Author	Jane Nicholson, Director of People Steph Moakes, Health, Wellbeing & Engagement Lead
Relevant Strategic Objectives	**Workforce** **Ambition:** We will make the Trust a great place to work for everyone **Our health and wellbeing offer is a key part of our employee retention strategy**

Report to Trust Board – November 2024

Health, Wellbeing, Engagement & Rewards Update

Introduction

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

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

Review:

The Health and Wellbeing team have delivered the following outcomes, since the last board update in May.

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
Wellbeing Review In line with the People Directorate 24/25 strategic workstreams, a review of the trust wellbeing provision has been conducted over the past 4 months. The aim of the review is to ensure that the service we are delivering is effective, cost-efficient and fit for purpose. This started with a questionnaire sent to all staff	All Staff	At the end of the review, there will be an outcome report listing both quick wins and longer-term projects. This will support the health and wellbeing service to be effective and cost-efficient whilst meeting the needs of our staff

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
which received an unprecedented 850 responses and was followed up by an engagement event which was attended by 60 staff. The responses showed a range of opportunities for improvement but importantly, that when our people have needed to access the wellbeing services available, they are generally happy with them. The insights generated and reviewed by the engagement event have resulted in a list of quick wins, longer term projects and areas where we need to engage with existing workstreams. This will be shared with the board in a separate report. The feedback also gave great insight into the support that has most impact on sickness absence. 69% of the 850 staff who completed the questionnaire said that the health and wellbeing support enabled them to stay at work or reduce their time off. The majority of responses highlighted Occupational Health, Ergonomics and Early Intervention Physiotherapy services being the most helpful. Wellbeing Matters and manager support were also mentioned. One specific outcome of the review was a decision to renew our contract with Peppy Health who provide menopause and men's health support to staff (and their partners). The feedback showed that staff were happy with the service when they accessed it but we need to do more to improve the visibility of the support. By renewing for another year, this will give time to explore if there are any more cost-effective alternatives.		

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
Wellbeing Matters is our internal psychological support service for staff and teams. The most recent six-monthly data report from January – June 2024 has the key points summarised below: 1) Demand for support on the Wellbeing Line has increased by 43%. 2) Evaluation data shows significant positive impact and added value of the Wellbeing Line support, in relation to improving goal-based change, improving psychological wellbeing and supporting staff to feel valued and remain in work. 3) Demand for Staff Support Post Incident has increased more than two-fold since last reporting period, with particularly high and unprecedented engagement within PPH. Opt-in via Datix and subsequent uptake of support has also increased. 4) Satisfaction and engagement with Team Support remains consistently positive, with essential principles of social connectedness, psychological safety, self and community-efficacy, and hope being rated as stronger after intervention (Professional Tree of Life). 5) Training and organisational/cultural developments that promote wellbeing across Berkshire Healthcare are being consolidated and grown, aiming to improve impact and reach.	All Staff	User data and feedback between January and June 2024: **Wellbeing Line Assessments** – 99 Average rating of 4.8/5 stars. **Goal Based Outcome Measure (GBO)** GBO's are rated from 0-10 in terms goal achievement (0 being not at all and 10 fully achieved). **All individuals made positive improvements in their GBO** when comparing pre and post WBL support. Average improvement was three steps (range 1-6 steps) **WEMWBS (Warwick Edinburgh Mental Wellbeing Scale)** The WEMWBS total score is between 14 and 70, with higher scores representing better wellbeing. **The vast majority of those supported on WBL experienced "meaningful" positive change to their wellbeing as indicated by their WEMWBS scores.** Almost all individuals (39/40) had improved WEMWBS scores after WBL support with the average improved from 35 to 45. 95% achieved a 3-point shift or more (range 0-25) which Johnson et al. (2012) note as "meaningful" change. **Investigative support – 4 (18 sessions)** **Psychological skills/coaching – 2** **Wellbeing Hubs** – 26 with 179 attendees Average rating of 4.3/5 for how valuable staff found these sessions.

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
		Workshops – 8 with 264 attendees Average rating of 4.3/5 for how valuable staff found these sessions. **Staff Support Post Incident (SSPI):** Team – 22 with 185 attendees Average rating: 4.6/5 for how valuable staff found them, and 9.6 out of 10 respondents said that they would recommend these sessions to a colleague. Individual – 68 **Facilitated Group Process – 8 with 128 attendees** **Feedback** We also collect qualitative feedback and wanted to include the following quotes. This first quote was from a caller to the wellbeing line: *"It took me a while to call the wellbeing line, but I only wish I had done it sooner.* [Counsellor] *doesn't know it but* [they] *probably saved my life by making me feel like someone really cared about getting me the right help."* The second quote came from a participant within a Wellbeing Hub: *"What a great service to be able to provide for BHFT staff - I think it is often overlooked that staff also need support as well*

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
		as patients - I think many teams could benefit from this - I hope we will be able to have another session again in the future."
Our **NHS Charities Together funded projects** are coming towards the end. The Wellbeing Facilitator project has finished and an update on the rest rooms is below: **Project 2: Update rest areas and staff kitchens** across the trust. All rooms for the initial application have now been completed. As we had an underspend from the initial budget and combined that with the small underspend from the wellbeing facilitator project, we have been able to work with our facilities team and scope out two final rest rooms. One being Fir Tree House, which was in desperate need for some rest room/wellbeing space, somewhere to have lunch and move away from desks and the other Skimped Hill Health Centre, which is currently work in progress. We have also used the funds to create some wellbeing spaces. Upton Hospital is almost complete, we are currently upholstering the furniture we already had which was not fit for purpose. A room at Prospect Park is also being scoped for some wellbeing space. Identifying space has been a challenge and has been one of the reasons for delay in completing this project.	Staff in teams who received the grant funding	Improved working environment. We are still working on obtaining feedback for the rooms that have been upgraded. Once the wellbeing spaces are complete the aim is to launch the rooms, inviting all staff within the site to create awareness of the space and focus on gaining feedback to understand the impact of improvements.

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
We continue to offer and administrate various wellbeing support and benefits as part of business as usual. This includes: - Peppy App for menopause and men's health support, - Access to eye test vouchers - Early access physio service (provided by Optima Health) - Salary Finance - Milestone awards including Long Service - Cycle to Work and access to vouchers through Vivup We have highlighted some key data from these services on the right	All eligible staff	**Peppy** **Oct 21 – Jun 24** 381 Menopause users, 78 Men's Health users. Over 90 consultations and 589 live events booked. NPS score of 75. 57% of users are still actively using Peppy after 1 year, 73% after 180 days. **Salary Finance** Jul 23 – Jul 24 **Borrow:** 104 applications 26 full loans offered 15 starter loans offered 42 rejected and debt advice signposted Of the 12 loans issued. 19 – debt consolidation 3 – Home 5 – car 14 – other **Advance:** 70 active users 674 advances @ average £147.71 **Save:** 8 active save accounts £108.13 average savings (£3430 total) **Milestone Awards**

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
		In 2024, we have issued: BHFT service milestone (1-40 years): 2327 NHS Milestones (5-40 years): 871 Retirement and new starter card data unavailable at this point but will be provided in the next report. **Vivup** (Aug 23 – Jul 24) Cycle to Work 23 orders, 15 accepted Average order value £727 Employer savings £3,063 Lifestyle Savings (Vouchers) 664 gift cards purchased £72,508* (£4337 savings) Top suppliers: Tesco, Sainsbury's & Asda Most saved: Airbnb, Ikea & Currys
Health Assured We are currently paying close attention to our contract with our Employee Assistance Programme (EAP) supplier, Health Assured following adverse publicity around them. Health Assured provides in the moment emotional support and counselling as well as access to legal and financial advice/signposting. Wellbeing Matters refer regularly to Health Assured to support our staff access counselling, where it is deemed appropriate.	All Staff	**Health Assured** (Aug 23 – Jul 24) Calls – 323 294 for emotional support/counselling (top themes - anxiety, low mood and family) 29 for advice (top themes – employment, housing and property) After engaging in structured therapy: • Generalised Anxiety Disorder (GAD-7) average score reduced from **1.8** to **1.0**

Activity	**Target staff group**	**Data and impact** (including feedback and uptake where appropriate)
Health Assured have continued to hit the news as the BBC published a second article with new allegations against Health Assured. The BACP responded by suspending Health Assureds organisational accreditation until an inspection could be carried out (due November 2024). It should be noted that Health Assured were the only large-scale provider who had this accreditation so does not impact on their service delivery. Exit opportunities were explored including questioning Health Assured about potential breaches to contract. However, there was no route to exit the contract and therefore they will remain our provider until July 2025. The process to source a new supplier will begin shortly – a joint approach across the BOB system is being explored as part of our system scaling people services work.		• Average Patient Health Questionnaire (PHQ-9) score reduced from **1.3** to **0.8** • Workplace Outcomes Suite (WOS): • At the start of therapy **10%** of employees were not at work (sickness etc) • After engaging in therapy this reduced to **0%** with 100% of employees returning to work.
We have implemented a new administrative process to support our ergonomics team. This has aimed to reduce the administrative burden on the clinical team, monitor waiting times and ultimately, improve the experience of those accessing the service – something that was fed back as part of the wellbeing review. The process is still in the early stages of implementation but initial feedback appears positive and we are hoping that we will soon be able to more easily monitor and report usage data and waiting times.	All staff	Usage data for May to Oct 24: 114 new referrals for ergonomics assessments 44 reports completed.

Future Roadmap:

Upcoming project delivery and likely timescales are captured below.

Activity	Target staff group	Intended benefit
Wellbeing Review Whilst the engagement element of the review is coming to an end, the next six months will be key for the team to look at as many quick wins as possible, whilst also planning in the longer-term projects. This will mean looking at existing projects and considering how to best manage our capacity to deliver this alongside existing projects and business as usual work. One of the first steps will be looking at both communicating the outcomes of the review to staff. On top of this, the team is also reviewing all questionnaire feedback to look at any specific comments or additional trends that can be used to improve the service.	All staff	An effective, cost-efficient service which meets the needs of our staff
Wellbeing Matters has several ongoing projects over the next six months: <u>Procurement of digital system:</u> As outlined in the previous board report, Wellbeing Matters is procuring a dedicated records system for both individual and team provision. The contracts have now been signed and construction of system	All staff	Development of the service in line with organisational need.

Activity	Target staff group	Intended benefit
has begun. This will continue to be a large project for the upcoming six months Proactive outreach: Once the above system is procured, we will be moving to a proactive outreach approach to staff affected by assault, unexpected patient or staff death, or who are physically or emotionally affected by any work-related incident, removing the reliance on individuals to opt in. Relevant communications about this change will be go out in advance to ensure staff are aware that they will be contacted. This change should reduce the risk of staff not being offered support post incident. We will monitor demand when implemented as there is a risk that it could exceed our capacity. Increase outreach: With the procurement and build of our own digital system, our aim is to be able to scrutinise our reach and uptake more closely to guide our outreach.		
Whilst most of the review outcomes will be reported separately, a key theme was that often staff did not know about our services or struggled to find the details when they needed it. This links closely into one of the team objectives from our plan on a page - to improve the visibility of the Health & Wellbeing service and access to increase the number of staff accessing health and wellbeing support, including post incident support and paid for services. This also links with our aim to better understand barriers and obstacles to staff accessing health and wellbeing support.	All staff	Increased engagement and uptake of services

Activity	Target staff group	Intended benefit
This is an area that we know is a challenge across the trust so we will be working with the Marketing and Communications Team, our Senior Comms Officer and also the networks to look at both quick wins and longer-term projects to improve this.		
Working with networks Over the past six months, we have been developing a closer partnership with the staff networks within the trust. This has started with identifying a member of the team to be a link point with each of the networks as well as finding the best space to work with the network leads This work has already led to the following interventions. - Attendance and delivery at the Armed Forces network launch and the Women's Network launch - Scheduling of bitesize sessions for the working carer's network - Quarterly support group facilitated for the international professionals group - A joint session with the women's network to focus on maternity leave. This resulted in a request for guidance (no change to policy) to improve the experience for someone going through the maternity process (staff and managers supporting) which is now in process Our aim over the next six months is to continue these projects and event support but also be able to work more strategically together on common issues (e.g. comms)	All staff	Increased engagement and service visibility

Activity	Target staff group	Intended benefit
There are two main aims in the ergonomics space in 24/25. The first we have nearly completed, which was to improve the systems and administrative processes and therefore reduce the waiting times for ergonomic assessments and reports. Our administrative process is now developed and the team are currently adjusting to this new way of working. The second aim is to create more capacity in the clinical team and enable them to start targeting (through data) hotspots areas and take a more proactive approach. This is reliant on the admin process and also training up our new starters. We are hoping this work can start within the next 6 months. An action that came out of the wellbeing review which sits across both of these aims is to create some training/guidance on how to undertake a first level DSE assessment.	All staff	Improved waiting times for ergonomic assessments and reports. Capacity for proactive approach to tackling MSK issues and potential sickness
In addition to providing MHFA training (and the refresher training after three years) for BHFT staff, an agreement has been reached to provide this training to Oxford University Hospital staff at a significantly reduced rate compared to the market. This has created the opportunity to both support system partners and start income generation.	System partners	System working, cost saving for system partners and income generation for the Wellbeing service.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	12 November 2024
Title	**Reducing, Preventing and Managing Violence and Aggression Assurance Report**
	for Noting
Reason for the Report going to the Trust Board	As part of the NHS contract and the National violence prevention standards self-assessment we are required to share our violence prevention and reduction performance with the Board. All NHS organisations were written to in April 2024 asking them to sign the Sexual Safety Charter if they hadn't already and to report progress and actions around this to the Board. Violence reduction is a key initiative for us and therefore we have agreed that we will provide an update to the Board 6 monthly.
Business Area	Organisational
Author	Ash Ellis, Deputy Directo Leadership, Inclusion and organisational Experience and Development. Debbie Fulton Director Nursing and Therapies – Highlight report
Relevant Strategic Objectives	The Plan is relevant to all strategic objectives **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

Highlight Violence [Prevention and Reduction
Quarter Two 2024/25

1. Why is this coming to the Board?

This report is written to provide information and assurance to the Board around our progress towards reducing violence and aggression experienced by staff. This includes progress against the National Violence Prevention and Reduction Standards, and in relation to the Sexual Safety and Employers Initiative Domestic Abuse Charters which we have signed.

Detail against the standards and charters can be found in appendix 2 of the main report.

2. What are the key points?

This report builds on the first assurance report presented to the Board in May 2024, providing updates and progress since that time.

A survey was undertaken with all staff able to participate and 194 responses received from a range of services, roles, and bands; key findings I from this included that:

- If you are ethnically diverse, under 30 years of age, male, work in mental health or CFAA services and in the lower pay bands you are most likely to have experienced workplace aggression or abuse in the last year.
- 55% feel confident dealing with violence/abuse, 58% feel confident using de-escalation or communication skills.
- 38% are satisfied with how we prepare them to deal with violence and abuse.
- 34% satisfied with how the Trust responds to abuse or violence.
- 38% are aware of the VPR work and working group. 73% aware of the anti-racism work. 36% aware of sexual safety work (before all staff comms) 37% aware of domestic abuse work.
- Majority of colleagues also felt Datix was the easiest way to report.
- 56% were satisfied with their managers support, whilst managers confidence in supporting colleagues was 72% showing a potential mismatch between confidence and effectiveness.

These findings will assist in shaping our ongoing work over the coming months, to include a focus on education, resources / equipment, culture, and support following incidents.

Workforce risk assessments are currently being undertaken, we have around 85% services completed this to date and results will inform a training needs analysis to provide guidance and recommendations about the training required by our staff in supporting them to prevent, reduce and manage violence and aggression.

Our commitment to achieving the 10 commitments within the sexual safety charter has progressed with all actions to achieve these now in place. We recognise that we have more to do in terms of continued engagement, awareness raising and education and will continue to monitor our progress through available data and staff survey results when available. Up to September we have had no HR cases related to sexual safety this financial year.

Achievement of these commitments also ensures that the organisation is prepared for the new Workers Protection Act 2023, this became law on October 26, 2024. The Act introduces a new anticipatory legal duty on UK employers to actively prevent and address sexual harassment and aims to address this pervasive issue by encouraging employers to create safer and more inclusive work environments.

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

Data (as detailed in appendix 1) demonstrates that staff in our mental health division are most likely to experience physical and non-physical assaults, and also racial abuse, with these assaults being predominantly perpetrated by patients/ public. We have received an increased number of reports of non-physical assaults compared to last year and slightly lower numbers of physical assaults and racial abuse reported (factoring in that the data is currently reporting 9 months of 2024).

Physical Assaults against staff remain a breakthrough objective for the organisation and Prospect Park Hospital has specific actions using a Quality Improvement approach to support violence reduction of all forms including racial abuse. These are being undertaken alongside our more general organisational actions.

Berkshire Healthcare
NHS Foundation Trust

Reducing, Preventing and Managing Violence and Aggression Assurance Report

1. Introduction

This paper provides an update on our assessment of, and our focus on Violence Prevention and Reduction (VPR) in Berkshire Healthcare.

This work overlaps with our Unity Against Racism programme, and includes our work on sexual safety, domestic abuse as well as violence, abuse and aggression.

In May 2024 our first assurance report came to Board which outlined our position, and progress. This paper builds on that and provides further progress as to our updated position.

Our Trust VPR Working Group continues to meet 6 weekly chaired by the Deputy Director for Leadership, Inclusion and Organisational experience with representatives from across the organisation including staff networks and unions. The Group reports to the Safety Culture Steering Group. The group has been focusing on ascertaining a baseline position against the sexual safety charter, and domestic abuse charter, identifying gaps and actions.

2. Our Progress

1. Staff experience – Abuse Survey

We developed an abuse survey to provide us with a baseline now and in the future in which we could measure our progress but also to use staff voice and experience to help inform our current violence prevention work. The survey was shared to all staff across an 8 week period and we received 194 responses from a range of services, roles, professions, locations, seniority (bands 1 – 8c+) and protected groups. The results do give us some helpful but unfortunate insights, which will help our violence work focus;

- ✓ If you are ethnically diverse, under 30 years of age, male, work in mental health or CFAA services and in the lower pay bands you are most likely to have experienced workplace aggression or abuse in the last year.
- ✓ 55% feel confident dealing with violence/abuse, 58% feel confident using de-escalation or communication skills.
- ✓ 38% are satisfied with how we prepare them to deal with violence and abuse.
- ✓ 34% satisfied with how the Trust responds to abuse or violence.
- ✓ 38% are aware of the VPR work and working group. 73% aware of the anti-racism work. 36% aware of sexual safety work (before all staff comms) 37% aware of domestic abuse work.
- ✓ Majority of colleagues also felt Datix was the easiest way to report.
- ✓ 56% were satisfied with their managers support, whilst managers confidence in supporting colleagues was 72% showing a potential mis-match between confidence and effectiveness.

The areas where our colleagues told us we could do more or better in, are summarised here:

- **Education** – more appropriate training, more refreshers, training in verbal abuse, bullying and harassment, racism, how to cope with stress/trauma, and training for managers in supporting staff.
- **Resources** – make sure they are effective, known about. Including; Security, equipment, support services, alarms, no clear policy in managing abuse, body warn cameras, CCTV, recorded phone calls and improve our environmental factors.

- **Culture** – clearer on behaviours we expect from all. Encourage to report more, more timely feedback from incidents, improve awareness/education of abuse/violence, accountability – action against perpetrators and share learning/improvements from incidents, recognise and reward for being involved in incidents, set expectations/boundaries of the public.
- **Support** – better feedback, access to counselling, debriefs – and how to access. Better support from security, HR, senior management, a vent-buddy, restorative meetings, knowing who to contact for what.

2. Workforce Risk Assessments and Training Needs Analysis

A Trust-wide workforce risk assessment is currently being undertaken to understand and establish the level of risk of violence and aggression (physical and non-physical) to all roles and services – we have now risk assessed around 85% of all services (clinical and non-clinical). Once the assessment is complete, a workforce Training Needs Analysis (TNA) will be undertaken to provide guidance and recommendations about the training required by our staff in supporting them to prevent, reduce and manage violence and aggression.

3. Post-Abuse Guidance

We want our managers to be able to support any member of staff to respond to, manage, take action and cope with incidences of this type of unacceptable behaviour. We developed a toolkit that provides information for incidents of abuse from patients/carers/members of the public, as well as abuse between colleagues. The toolkit outlines:

- Actions to take in the first 24 hours after an incident
- Follow up actions within 72 hours of an incident
- What to do if a staff member is sick or injured as a result
- Advice on sanctions and prosecutions
- Support available for the individual affected and the wider team

4. Bullying and Harassment

A task and finish group has been established from the VPR Group, and is taking a QI approach to addressing bullying and harassment. The group are focusing in on 3 areas of work; reporting/routes to raise awareness, support for managers and victims, lowering the number of incidents.

5. Behaviours, and conflict pathway

Our new Trust behavioural framework will be launching shortly and embedded over the coming months throughout all of our systems, structures, people processes, training and policies. This will help with setting the behaviours expected and also make it easier to identify the unwanted behaviours and reduce these.
We are developing a resolution pathway for staff, this includes our challenging conversations training session including kindness and civility, our internal network of accredited Coaches, and an internal mediation scheme that is being developed – we currently have 18 colleagues undertaking their workplace mediation certification training.

6. Sexual Safety

Our main focus since the last report has been on our sexual safety work and progressing our commitments as part of the sexual safety charter but also ensuring the organisation is prepared for the new Workers Protection Act 2023, set to take effect on October 26, 2024, which aims to address this pervasive issue by encouraging employers to create safer and more inclusive work environments. The Act introduces a new anticipatory legal duty on UK employers**.** For the first time, UK employers will have a clear anticipatory duty to actively prevent and address sexual harassment. We have achieved several things:

- Self-assessed ourselves against the sexual safety charter commitments and the new NHS England sexual safety assurance framework. (see Appendix 2)

- Developed a new sexual safety learning package and promoted to all staff.
- Launched an all staff communication on our commitment to eliminating sexual misconduct in our workplace, along with our update dedicated Nexus page.
- Developed and launched our new staff sexual safety policy to all staff.
- We developed videos for staff on sexual safety to raise awareness.

Data on sexual safety is shared in Appendix 1 including, students, staff, and HR cases.

7. Domestic Abuse

After signing the Employers Initiative Domestic Abuse (EIDA) charter we self assessed ourselves against the EIDA charter commitments and the recommended implementation plan. We have been working on several key actions, some of which include:

- Developed a staff domestic abuse policy to be launched in November 2024.
- All staff comms planned for November to raise awareness, signpost.
- All staff webinar scheduled for October, the Exec Briefing in November, as well as a Managers Support Network session in December.
- Reviewing our procurement social value questions to encourage partners and suppliers to commit to supporting their workforce around sexual safety, domestic abuse, anti-racism.
- We attended the National Employers Initiative Domestic Abuse Conference representing Berkshire Healthcare, sharing best practice and connecting with partners such as NHSE, Police, Ambulance services and more.

Since 2018 there has been a total of 29 contacts made to our Specialist Practitioner for Domestic Abuse by a staff member directly or a line manager requesting advice on how to support a staff member. All have been intimate or ex intimate partner relationships and all heterosexual relationships. Of those, 27 were female, and 8 of the 29 have been since April 2024. The support requested includes risk assessment and safety planning, referring to domestic abuse services. Sometimes this has meant working with staff security and HR. Some cases required referral to Children's Social Care and some reporting to the Police. Most requests are for psychological support post abuse/separation when the risk has greatly reduced but the effect of the abuse is having a significant impact on their wellbeing

8. Incidents, Empowerment and Support Anti-racism Workstream

The VPR Group also oversees the action plan for one of the five Exec led antiracism workstreams. Some good progress has been made, some progress includes:

- We reviewed and re-publicised our abuse statement, making explicit reference to racism and abuse, and our stance against it. This is now embedded in all patient letter templates on RiO, Nexus, and is being introduced as signage at all our sites.
- We have amended our wellbeing line assessment to include a question regarding experience of racism at work. All our specialist psychological support is trauma-informed, and we always work from a position of acceptance, validation and compassion. We've added a question in our user feedback "Did you feel the care you received from Wellbeing Matters was respectful of your culture, belief and values".
- Through the wellbeing conversation as part of our appraisal process we have introduced questions which ask "do you feel equipped to handle conversations about racism and If you're a manager "do you know what to do if a member of staff raises racism to you". We signpost to our conversation toolkit on Nexus learning.
- We delivered a trial of new training facilitated by Roger Kline and Joy Warmington based on the learning from their "Too Hot to Handle" report into the way the NHS handles casework. Drawing on recent NHS cases involving racism, the training was specifically designed for those who investigate and manage case work. We were pleased to have 14 participants from our trust, including investigating officers and people partners, as well as 5 colleagues from the Frimley and BOB systems.

3. Progress against National Standards/Charters

The assessments, gaps and actions can be seen in more detail in Appendix 2. The goal of assessing ourselves and acting against the standards/charters is to:

- Stabilise and reduce abuse and violence against colleagues.
- Identify the causes of abuse and violence and co-ordinate action across the Trust to tackle them systematically, delivering a long- term reduction in associated harm.
- Work collaboratively to deliver the best long-term results to reduce abuse.

Alongside these assessment we also have our colleagues and patient experience to inform the actions we take in this space.

VPR Standards

There are 4 sections to the assessment: **Plan, Do, Check & Act.** Undertaking the assessment requires significant engagement from the VPR Group given there are 14 criteria areas and 42 indicators. Our assessment is as follows:

- 14 indicators for '**Plan**' (5 compliant, 7 partially, 2 non-compliant) – the non-compliance is related to not having a VPR strategy, policy and subsequent equality impact assessment in place- these are now in the planning phase.
- 11 indicators for '**Do**' (8 compliant, 1 partially, 2 non-compliant) – the non-compliance is related to regularly providing communications on the VPR objectives, this will change once we refresh our strategy.
- 12 indicators for '**Check**' (10 compliant, 2 non-complaint) – the non-compliance relates to not having an audit process for VPR, this needs to be developed more robustly.
- 6 indicators for '**Act**' (3 partially, 3 partially) – the non-compliance relates to timely responses to incidents, and policy not in situ,

We conclude that the Organisation is **Partially Compliant** at the time of presenting this review. Compliant across 26 indicators, partially compliant across 11 indicators and non-compliant with 6 indicators – although actions are in place for all indicators.

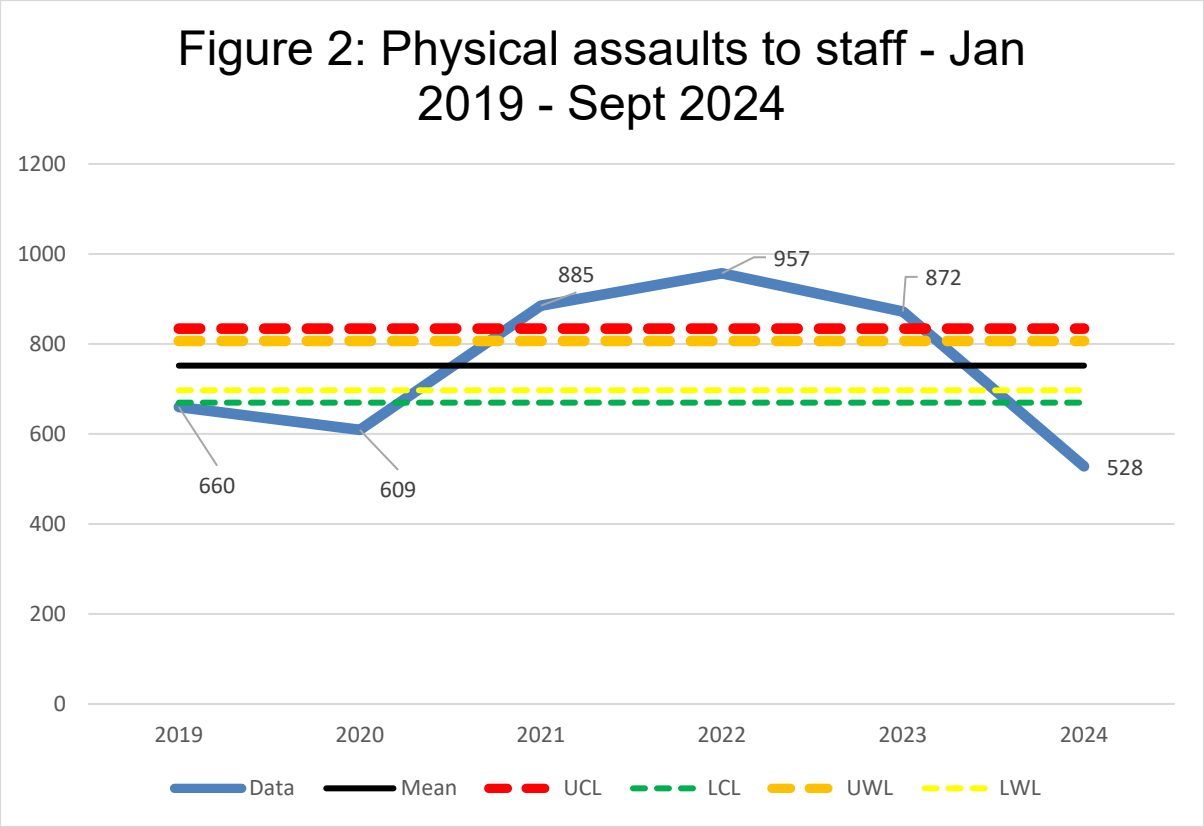
Sexual Safety Charter

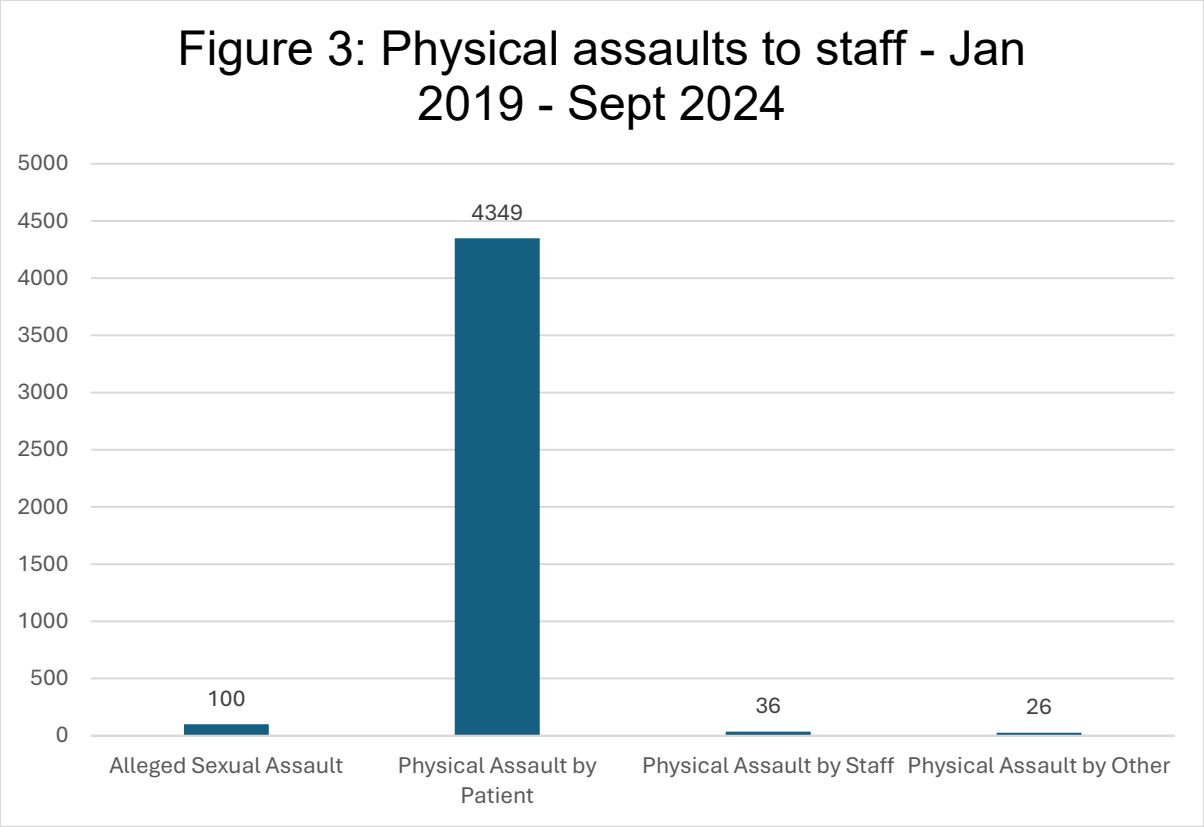
When we first assessed ourselves from September 2023 onwards, we had one green RAG rating which was principle 8. The rest we rated as either red or amber. We now have active actions in place for all principles and commitments of the Charter, which has been evidenced through the table in Appendix 2. Although we have more to do, this is around engagement, awareness raising and education, we will also need to continuously monitor quantitative and qualitative data to respond pro-actively to any learning and trends.

Domestic Abuse Charter

We have recently self-assessed ourselves against the Employers Domestic Abuse Charter commitments and implementation plan, which provides us with a framework to support our organisational response. We have active actions in place for all commitments of the Charter, which has been evidenced through the table in Appendix 2. Although we have more to do, this is generally around continuous engagement, awareness raising and education.

Appendix 1 – Violence and Aggression prevalence in Berkshire Healthcare





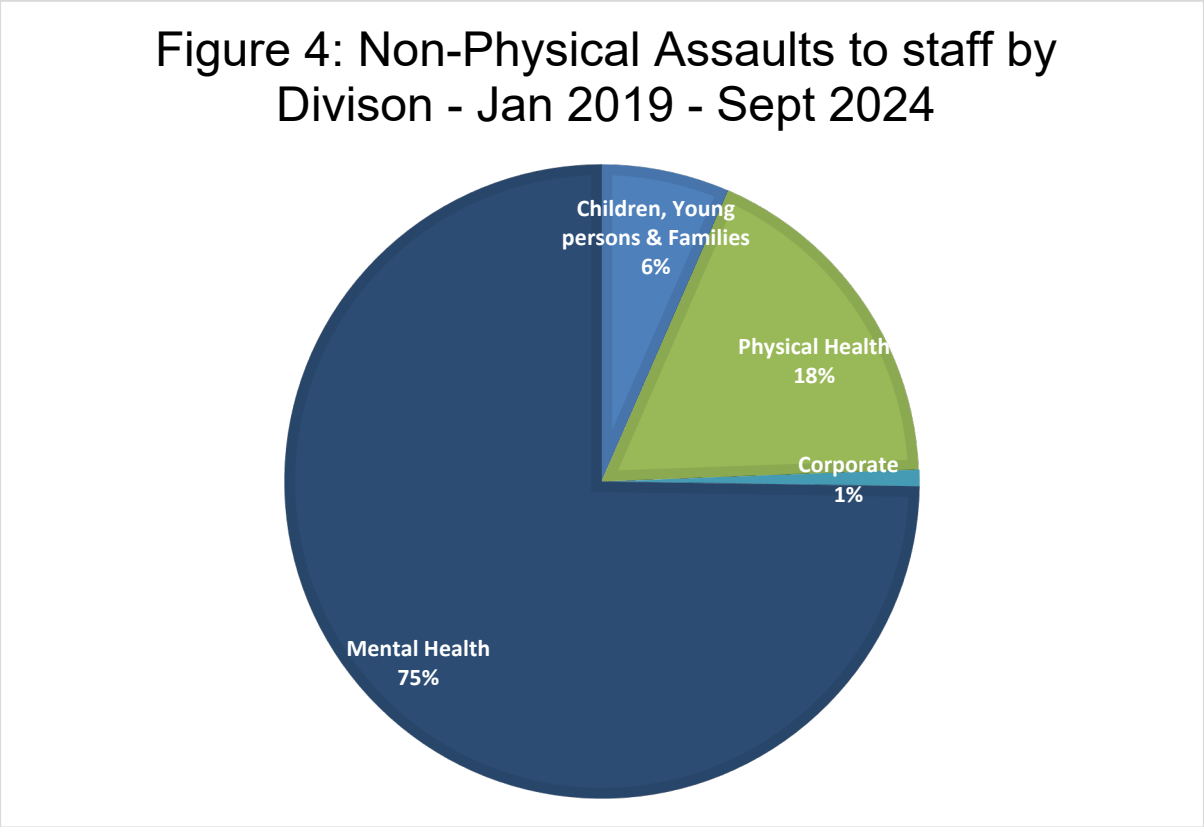


Figure 5: Non-Physical Assaults and type reported over the last 3 years

	Sexual aspect	Racial aspect	Perceived threat	Allegations	Disability discrimination	Religious discrimination	Discrimination against gender or sexual identity	Other type of abuse	Total
Abuse by Patient	263	623	1288	201	2	19	78	765	3239
Abuse by Other	7	27	73	26	0	4	2	133	272
Abuse by Staff	2	6	27	14	0	0	1	44	94
Threatening Behaviour	0	1	2	0	0	0	0	0	3
Verbal Abuse by Patient	0	0	3	0	0	0	0	0	3
Racial Abuse by patient	0	1	0	0	0	0	0	0	1
Total	272	658	1393	241	2	23	81	942	3612

Figure 6: Non - Physical assaults to staff - Jan 2019 - Sept 2024

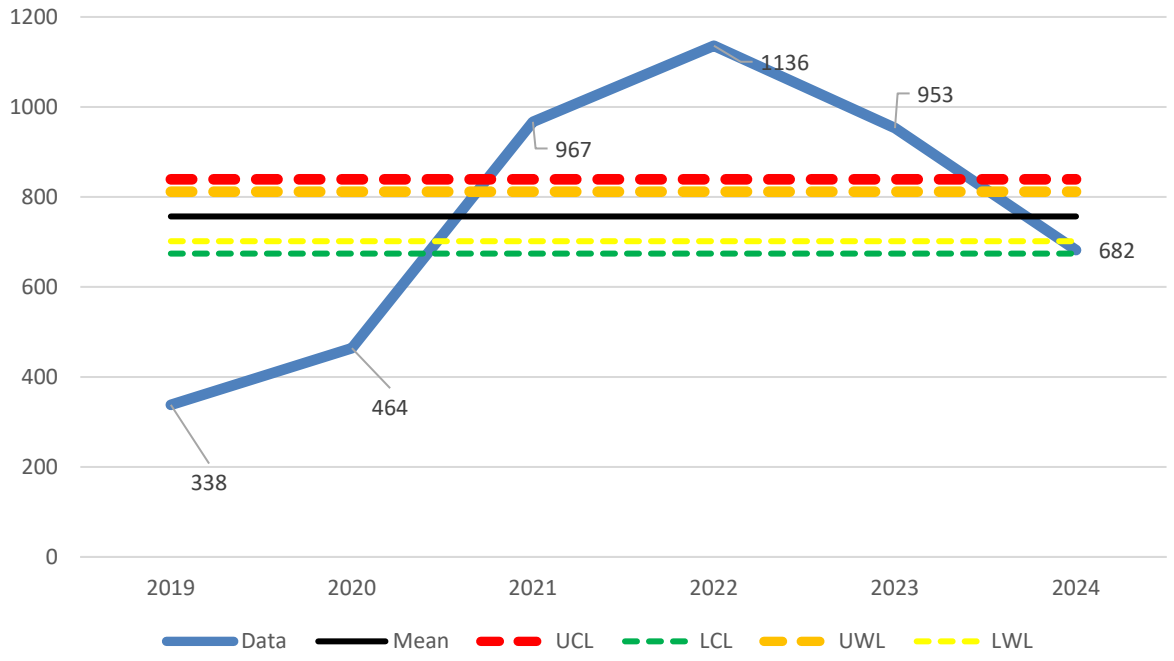


Figure 7: Physical Sexual assaults to staff by Division - Jan 2019 - Sept 2024

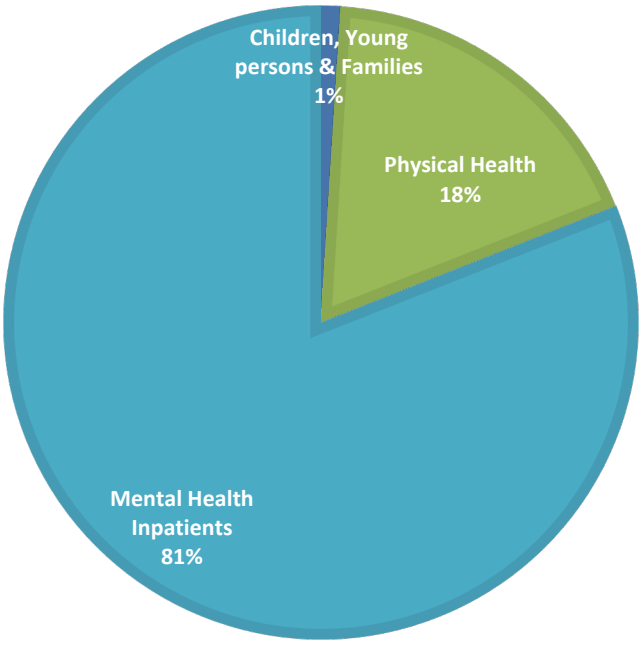


Figure 8: Physical Sexual assaults to staff - Jan 2019 - Sept 2024

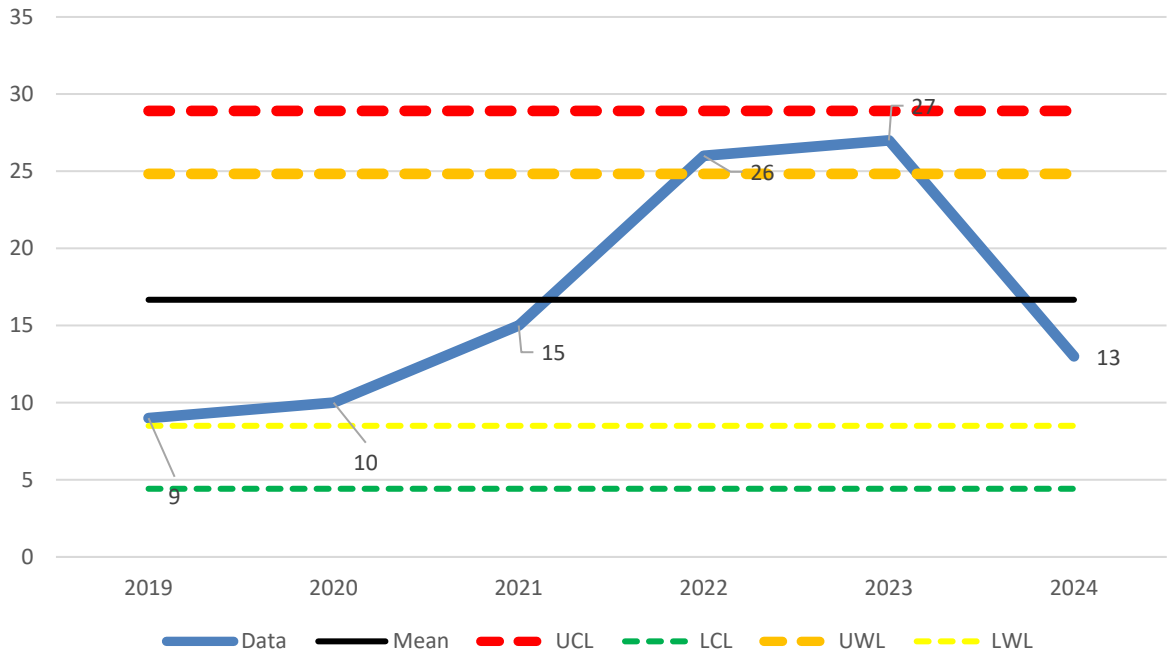


Figure 9: Non-physical Sexual assaults to staff by Division - Jan 2019 - Sept 2024

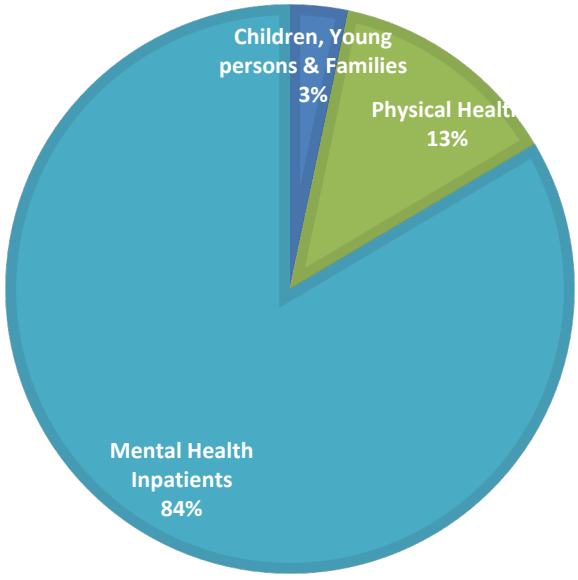


Figure 10: Non-physical Sexual assaults to staff - Jan 2019 - Sept 2024

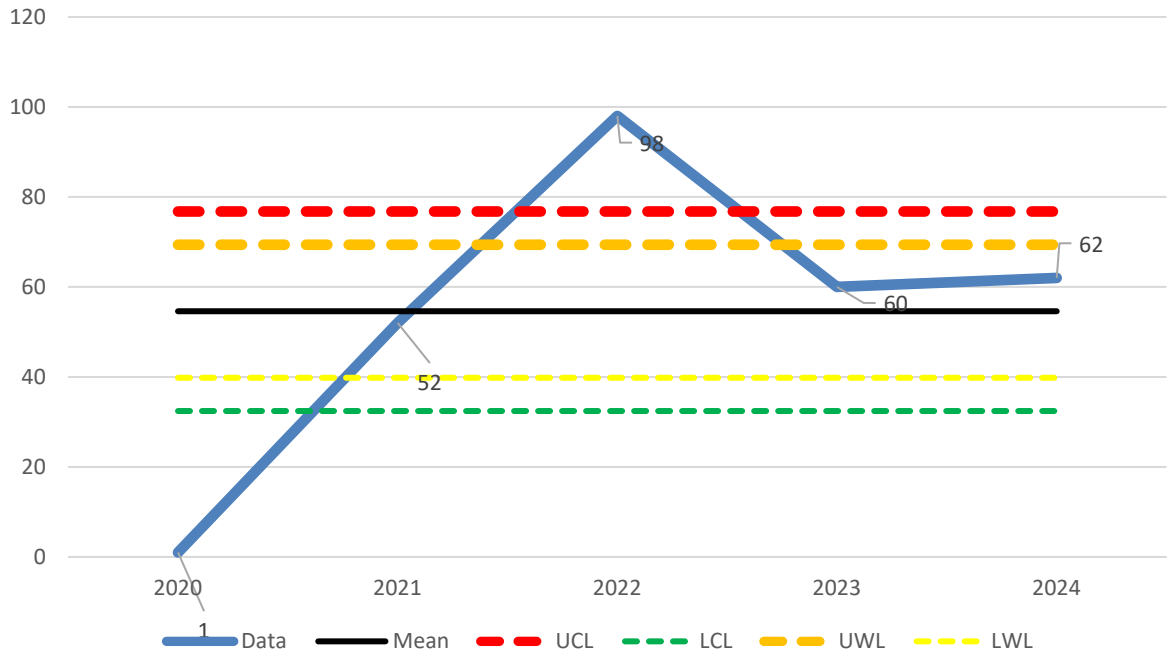
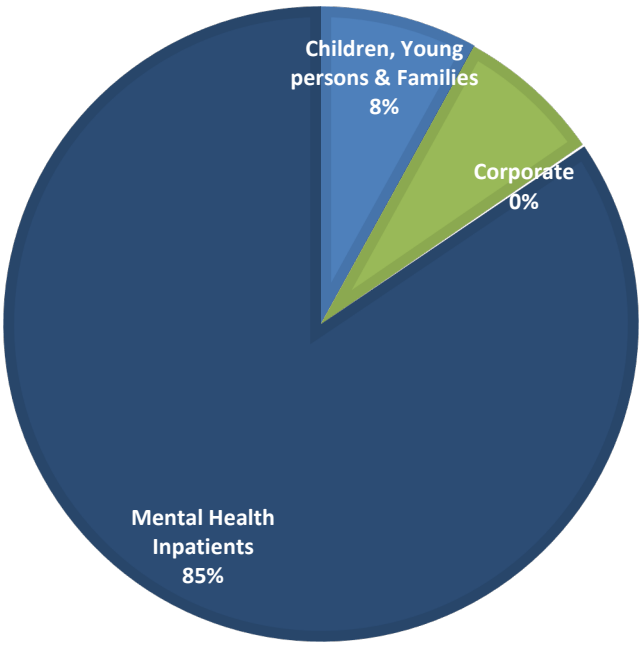


Figure 11: Racial Abuse to staff by Division - Jan 2019 - Sept 2024



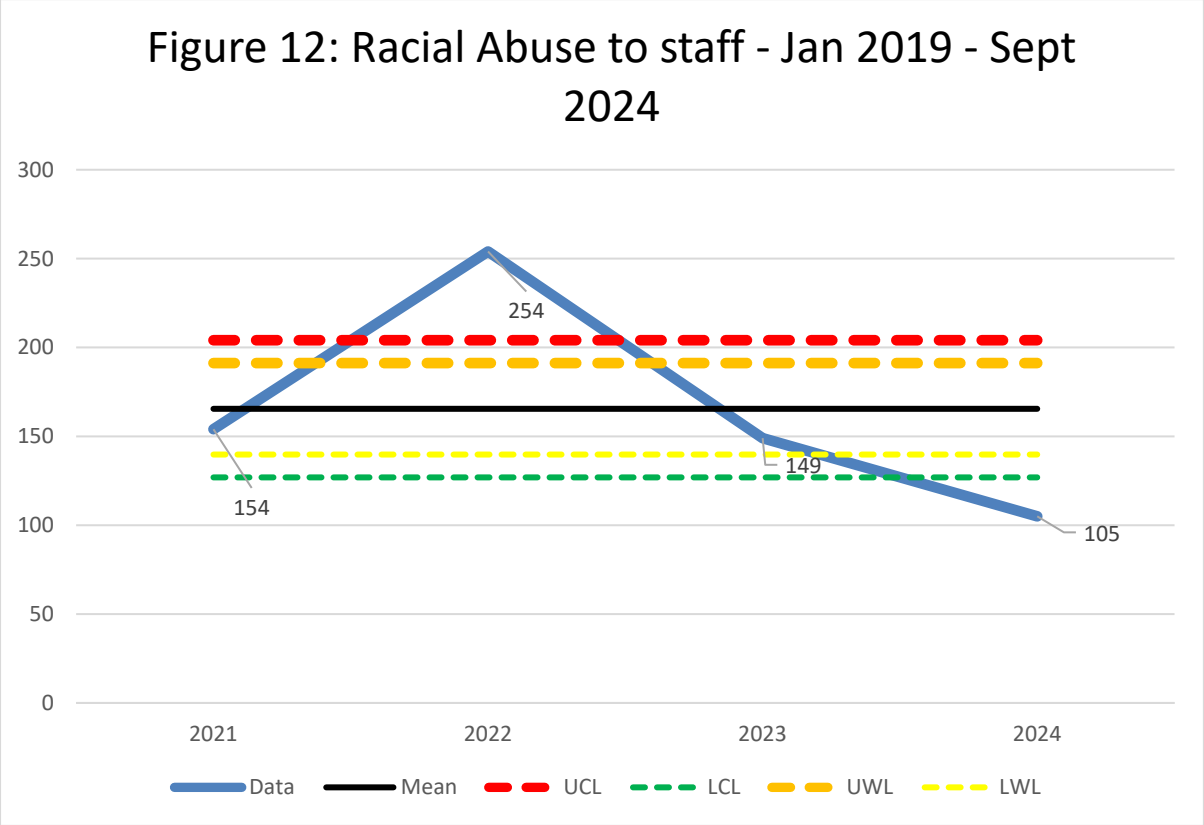
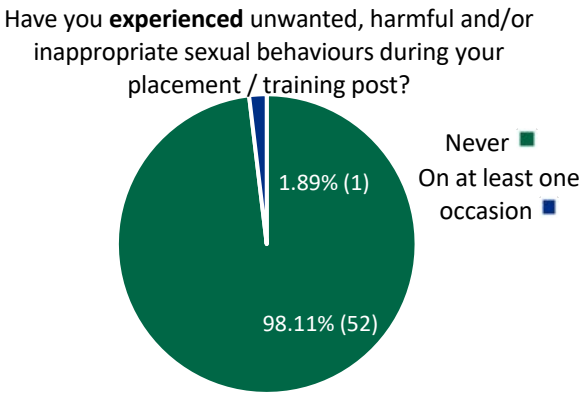
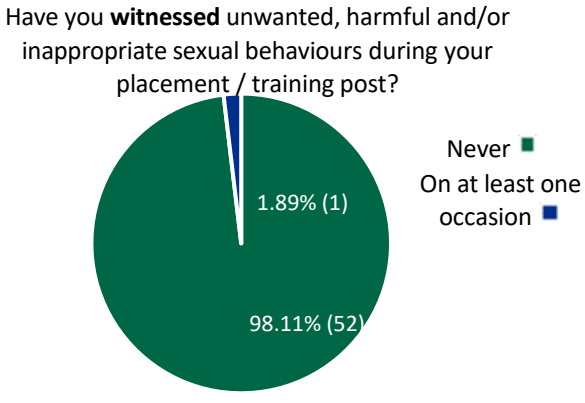
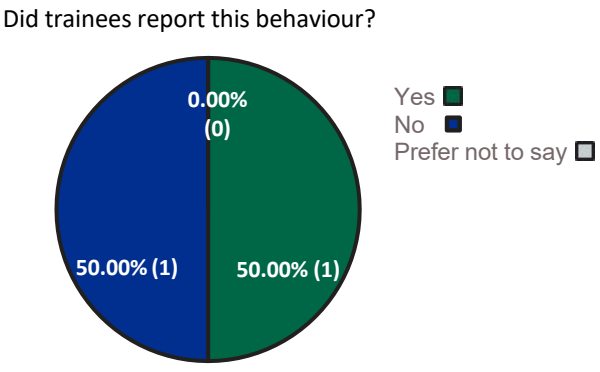


Figure 13: NHS National Education and Training Survey – experience of Sexually Inappropriate behaviours for students/learners/trainees







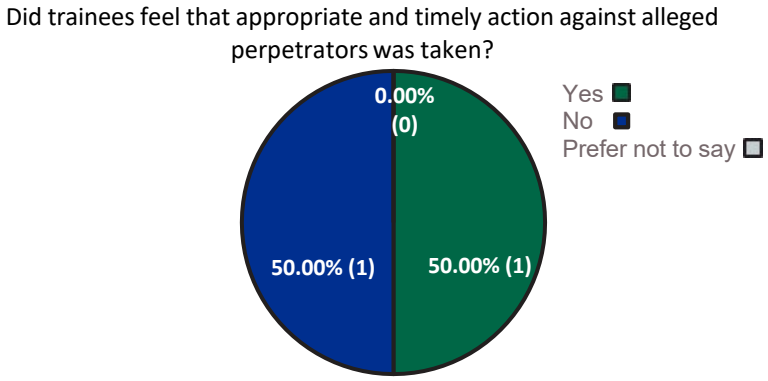


Figure 14: Sexual Safety HR Cases April 2019 to September 2024

Date	Early Resolution	Disciplinary	Whistleblowing
April 2024 – September 2024	0	0	0
April 2023 – March 2024	0	2	0
April 2022 – March 2023	1	4	0
April 2021 – March 2022	0	1	0
April 2020 – March 2021	0*	11	0
April 2019 – March 2020	0*	4	0

*Grievance and Dignity at Work Policy. We made some changes to our policies and trackers in April 2021 (replaced grievance and dignity at work policies with early resolution)

Notes:

- Most allegations are against males and of these, the majority are from ethnically diverse backgrounds.
- Most incidents occurred in mental health services and pertain to allegations between patients and staff members.
- Most cases close at fact find with no case to answer; where cases have progressed to a hearing via a disciplinary process, the staff members have all been summarily dismissed.

In April 2020 – March 2021, 3/11 cases related to simultaneous allegations (i.e. same allegation opened on the same day) from the same patient towards different staff members and a further 2/11 cases relate to the simultaneous allegation from the same patient towards different staff members

Appendix 2– VPR Standards, Sexual Safety Charter Commitments and Domestic Abuse Charter Commitments

Sexual Safety Charter			
Principle	**Commitments**	**Active Actions (RAG)**	**Evidenced**
1	We will actively work to eradicate sexual harassment and abuse in the workplace.		We have an abuse statement that explicitly includes sexual safety and have gone into patient communication templates and is going on site signage. We have a named Executive Lead and Workforce Lead. The work behind this will be discussed/overseen in VPR Group, and Safety Culture group. Sexual safety is included as part of a wider risk of violence on our corporate risk register. We have developed a sexual safety policy for staff which is now live. Sexual safety policy for patients in place. No excuse for abuse web pages updated with sexual safety resources. We have a safety culture charter. A Trust behaviours framework has been developed that supports us to uphold the behaviours we want to see and expect in each other. An all-staff comms was launched about our commitment along with the resources and support available. An all-staff survey about abuse went out to staff through June and July and collected nearly 200 responses. VPR report went to Board in May 2024, with data
2	We will promote a culture that fosters openness and transparency, and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours		We developed a Trust behaviours framework. Freedom to Speak up work supports this and has developed more reference to sexual safety within materials and correspondence i.e. Induction. There is slight touch on Hyper sexualisation of protected groups in Trust Induction - calling in and calling out behaviour. Safety culture charter in place and has been refreshed. We have an abuse statement refreshed. We developed a workforce sexual safety policy. We have a personal safety policy in place. (with EqIAs) A working group focused on patients at PPH and their sexual safety. We have included sexual safety in our EDI policy refresh. We developed a staff support guidance for managers We have launched a women's staff network and engaged them and our other networks in this agenda. EDI team is very much part of this work. We have developed videos on sexual safety and domestic abuse which are live on our Intranet and shared in all staff comms. We analysed and shared our sexual safety staff survey data widely.
3	We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.		
4	We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.		Developed a sexual safety policy for staff which outlines support available. Nexus Intranet pages re-developed with sexual safety resources and signposting. Usual support routes e.g. line manager, EAP, OH, wellbeing champions, some sexual safety champions at PPH, staff networks, and wellbeing matters– which now includes Sexual Assault Referral Centres (SARCS). We reviewed our well-being data and no requests to well-being service so far, this will be monitored. Staff support guidance developed and launched to managers. Sexual champions workshop for sexual safety champions at PPH, ongoing cohort of people looking at this. We will be sense checking with our staff network about appropriate support.
5	We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful sexual behaviour.		Our new sexual safety policy outlines a lot of this. Freedom to speak up route and work to promote this. Civility, kindness within leadership programme. Behaviours framework developed which sets out behaviours we expect to see from everyone, but this will need embedding. Comms plan developed. An all staff comms launched about our commitment along with the resources and support available, and behaviours expected. We developed videos for staff on sexual safety about what it is to raise awareness. New learning package developed and launched for all staff. Sexual safety is embedded at induction with EDI and FTSU sessions.
6	We will ensure appropriate, specific, and clear policies are in place. They will include appropriate and timely action against alleged perpetrators.		A raising concerns policy is in place. A new sexual safety staff policy is in place. A patient promoting sexual safety policy is in place. A personal safety policy is in place.

			Prevention and management of violence and aggression (PMVA) in Mental health services policy in place. A Lone worker policy in place. Physical Security (Premises & Access) policy is in place. A patient domestic abuse policy is in place. A staff domestic abuse policy has been developed.
7	We will ensure appropriate, specific, and clear training is in place.		Safety culture charter in place. Lone worker devices and training is in place. Domestic abuse training is available. Personal safety training is available. (updated to include sexual safety info) A sexual safety eLearning clinical package is available and was reviewed but is lengthy. We developed videos for staff on sexual safety about what it is to raise awareness. A workforce risk assessment and TNA is underway to ensure all staff have the right level of training for personal safety. We are embedding in our safeguarding and domestic abuse training. We are developing an approach to theatre forum. An eLearning package has been developed and launched for all staff to access. A Manager Support Network Session is scheduled for December and all staff webinar scheduled for November
8	We will ensure appropriate reporting mechanisms are in place for those experiencing these behaviours.		Freedom to speak up, (FTSY Guardian heavily involved in this work) FTSU Champions asked to complete eLearning package Line Managers, (guidance developed) HR, Incident reporting, (Datix you can report anonymously, is provided in training, and how to do this) Grievance route. Staff survey / Pulse Staff Networks Policy in place that also support other reporting routes available
9	We will take all reports seriously and appropriate and timely action will be taken in all cases.		We want to encourage more reporting. We don't want a culture where rely on Datix for incident reporting. People need to feel safe to talk about it. Average time to investigate incident, and response to staff, is 68 days for process to be complete. - We'd want a quicker response. Exploring an automated function to close the feedback loop and other options. Average disciplinary case is 87 days (not specifically sexual safety). We use external IO's for all casework. We will also be exploring how long it takes us to report things to the police. All data and casework numbers shared in VPR report to Board in May 2024.
10	We will capture and share data on prevalence and staff experience transparently		Self-reported data (on violence/B+H) is collected in the NHS NSS through two separate questions. NSS introduced two specific questions to sexual violence or sexual harassment. We also capture data on NETS and have shared this. We capture patient on staff via DATIX but not report/share it currently. We also capture HR data and we need to share this more widely. Our staff survey, HR and incident data have been shared amongst DSG, VPR Group and Board but not much wider and we have a plan to do this.. We get a lot of FOI on sexual assault, and supply data to NHSE as patient safety events.

Domestic Abuse Charter		
	Indicator	**Evidenced (how)**
We commit to:	Raising awareness among their employees of the many forms domestic abuse can take	Exec named lead. DA training is available throughout the year on how to support our patients and client group. We share domestic abuse learning via circulation. We share in our all staff comms for the national promotion days/weeks. (DA awareness month) We work with the system on raising awareness and knowledge. We created and shared a domestic abuse video to all staff. Abuse survey went out to all staff - captures who is aware of the DA work. We've got some comms planned for November 2024 for all staff, which will include; learning, new policy, support and guidance. We will be adding to our external website that we are part of EIDA.

	Fostering a safe, supportive and open environment to allow domestic abuse to be effectively tackled in their workplace	Safety Culture Charter in place, Freedom to Speak up work and policy, shared at FTSU induction. Security management support with emergency personal safety devices that they issue for personal use. REACT - training - for managers in place - to help open honest conversations, with safe spaces for staff to be listened to. Conversation toolkit for inclusive conversations live on Nexus. DA policy in development. All staff webinar and managers support network session planned. Staff Network involvement and engagement.
	Supporting employees who are affected by domestic abuse and those that report it by providing access to information and services	Security management support with emergency personal devices. Domestic Abuse Nexus pages linked to Well Being Matters, and our WellBeing Service - to be able to talk to someone and be signposted to our Domestic Abuse Lead and others. Safeguarding Advice Line. Specialist role for domestic abuse in place- holds case numbers of who contacts wanting support. We make referrals to BRAVE for males (currently closed to females). Brightsky app. available to staff. Promoted on Nexus with dedicated page.
	Providing education and support to help perpetrators of domestic abuse to stop	We are able to signpost to RESPECT an external service (on Nexus page). Also have the wellbeing line - first level to disclose and be referred on. Draft DA Policy discusses bystanders.
	Sharing best practice with other employers	Signed up to EIDA network and charter. Part of the BOB safer workplaces group. East Domestic Abuse Health Network. South East NHS England Crossing Pathways: a network for improving health response to domestic abuse EIDA National conference. We encourage our suppliers and partners to sign up to EIDA and we're looking to include in our procurement processes.

Violence Prevention and Reduction Standards

Plan			
	Indicators	**Compliant (RAG)**	**Evidenced**
The Board (Non-Exec and Exec members) endorses the violence prevention and reduction policy	The Organisation has developed a violence prevention and reduction strategy which has been endorsed by the board and is underpinned by the relevant legislation and government guidance.		We have a violence prevention and reduction strategy initially agreed but has never been communicated/embedded - requires refreshing.
	The organisation has developed a violence prevention and reduction policy which has been endorsed by the board and is underpinned by workforce and workplace risk assessments.		We have no Trust-wide violence prevention and reduction policy. We do have a PMVA in mental health services policy, and a Personal Safety policy. Will be developed.
	The organisation has engaged with key stakeholders, including trade unions, health and safety representatives and other appropriate stakeholders.		Through Terms of Reference for the VPR working Group. Engagement in ICS working groups.
	The organisational risks associated with violence have been assessed and shared with appropriate stakeholders in the sustainability and transformation partnership (STP) or integrated care system (ICS).		TNA Staff Risk Based Training RA (In review) Lone Working Device Risk Assessments, Divisional Lead Community Based RA, Individual Patient RA, Datix & Rio Dashboards and Reports, Risk Registers, Monthly Reviews, Regional BOB Meetings
	The senior management (the chief Executive and the board) is accountable for the violence prevention and reduction strategy and policy, and this is clearly set out in both documents.		Statement of commitment is included in the Trust's Security Policy and other associated documents such as the Personal Safety Policy etc. These documents will inform all new strategies and policies in conjunction with these standards. The Trust has a dedicated board member that is accountable for violence prevention and aggression
	Senior management is informed about any disparity trends for violence and aggression against groups with protected characteristics, and a full equality impact assessment has been developed and made available to all stakeholders.		Risk Registers, DATIX and RIO all inform on the disparity trends but specific report need to be generated for this purpose. There is no equality impact assessment, this will be developed with the new policy and strategy.

Clearly defined objectives and performance criteria	The violence prevention and reduction objectives and expected performance criteria outcomes have been incorporated into the policy.		To be completed when the strategy and policy is developed.
	There are practical and efficient methods for measuring status against the objectives identified and agreed by the senior management team in consultation with key stakeholders.		No audit process in place currently. The Trust will also need to create relationships with partner Trusts to measure and benchmark our progress with this work.
	The organisation is compliant with relevant health and safety legislation and any other applicable statutory legislation, and this has been validated, i.e. via the organisation's auditors.		CQC Audit\process and independent external audits. HSE Investigations. Workplace Inspection Checklist. Reporting Processes. Lone working risk assessment also completed
	Inequality and disparity in experience for any staff groups with protected characteristics have been addressed, and this is clearly referenced in the equality impact assessment.		The EqiA will be developed as part of the strategy refresh and policy development. Staff groups with protected characteristics have been reviewed and shared.
Violence prevention and reduction plans recorded, implemented and maintained.	Plans have been developed and documented for achieving violence prevention and reduction objectives, and the outcomes are clearly set out in the policy.		Work is in progress as the strategy and policy are aligned to the Violence Prevention & Reduction Standards.
	The plans are updated and maintained to consider improvements, lessons learnt and updated risk assessments, annually as a minimum schedule.		Risk register has been updated. Workforce risk assessment is being undertaken. Datix Investigations and lessons learnt to continue to be shared across the Trust.
	Risk assessments are available to managers, their staff, trade union representatives and other relevant stakeholders.		Risk assessments are available to relevant persons pertaining to clinical risk/EFM Risks. Tools are available to use for this purpose, including the Risk Strategy. Workplace Inspection Checklist. Risk Assessment and Root Cause approach to investigations. Workforce risk assessments are also being completed for V+A in all services.
	The plans are reviewed in consultation with subject matter experts pertaining to the Equality Act 2010.		EDI representation at the Policy Scrutiny Group for patient facing policies. All HR policies are sent to DSG for review. There is EDI team, staff network and union representation on the VPR working group.
Do			
	Indicators	**Compliant (RAG)**	**Evidenced**
Board Members approve resources.	The senior management assesses and provides the resources required to deliver the violence prevention and reduction objectives.		PPH has a responsible person for VPR. Deputy Director for OD is workforce lead for VPR and leads personal safety team. Named Exed lead.
	A designated board-level (director) manages the violence prevention and reduction workstream and ensures appropriate and sufficient resources are allocated to the function (which is underpinned by an organisational risk assessment).		Director of Nursing, Therapies and Quality (Exec Lead for VPR/Sexual safety) Chief Medical Officer (MH Use of Force Lead),
Regular workforce engagement	The senior management team regularly provides accessible communications on the violence prevention and reductions objectives and priorities.		Once objectives have been set this will be monitored, reviewed and shared appropriately via the Divisions and other relevant channels
	Communications cover all staff groups and functions within the organisation.		Includes: Finance, IT, IG, Networks, JSCC, HS & E Group, Safety Culture Group, Strategic People Group, as well as the corporate comms channels but more VPR messaging is needed.
	The recognised trade unions are consulted and involved in the development of violence prevention and reduction objectives.		JSCC Minutes - HS & E Group. Unions are represented and attend the VPR working group and Safety Culture Steering Group (Meeting notes)
	A diversity lens is applied to objectives development, to provide due diligence for Public Sector Equality Duty, and this is validated by the subject matter expert pertaining to the Equality Act 2010.		Data has been reviewed from DATIX, WRES/WDES, staff survey - evidenced through meeting notes. EDI team represented and participates in VPR working Group.

Clear roles, responsibilities and training.	The organisational roles and responsibilities across all levels are clearly set out in a violence prevention and reduction policy.		This will be better established once the strategy and policy are developed.
	A training needs analysis (violence) informed by the risk assessment has been undertaken, and suitable and sufficient training and support are accessible and provided to all staff.		There are target groups in place and compliance monitored for conflict resolution, PMVA, breakaway, SCIP, PSTS training. Trust-wide TNA and risk assessment work has commenced. We are also developing our search training, and looking to develop training for our managers to support staff.
Regular Risk Assessment	Violence prevention and reduction workforce and workplace risk assessments are managed and reviewed as part of an ongoing process and documented in the appropriate organisational risk registers.		Current practices are to capture Risk Assessments at service level and to inform the Risk Register through Non clinical risk group of any high risk groups.
	Violence risks are co-ordinated across the organisation, and are accessible and shared with senior management and all appropriate stakeholders.		PPSQ/ SMT Groups and meetings coordinate and manage local risk registers, through Divisional Directors and Service Leads.
	Identified violence risks and their mitigations/controls are communicated to all staff in regular bulletins.		Senior & Exec messaging through corporate all staff broadcasts, TeamBrief and nexus messaging. Health, Safety & Security Management Specialist communications to Service Managers and through the Health, Safety & Environment Governance Group, and the Non Clinical Risk Group. Which subsequently results in Divisional Directors and Service Leads cascading messages to all Teams.
Check			
	Indicators	**Compliant (RAG)**	**Evidenced**
Process to assess violence prevention and reduction performance	The efficiency and effectiveness of the violence prevention and reduction plans and processes are assessed and reviewed as a minimum every six months or following organisational changes or serious incidents.		There has been in a gap in reviewing these but this is now in the plan, and strategy and policy needs to be in place.
	The senior management is directly accountable for ensuring that the system is working effectively and providing assurance that the violence prevention and reduction objectives are being achieved.		Exec Lead is now part of the VPR working Group. Updates to Safety Culture Steering group and SPG. Evidenced in Board Assurance Framework review. VPR paper going to Board x2 yearly.
	Staff members are actively encouraged to report all incidents including near misses.		Compliance and risk team offer Datix training across the Trust. This is also evidenced in PSTS presentations for community mental health staff. Staff at PPH receive a 90 minute Datix training session during the 6 day PMVA and 3 day PMVA refresher courses. Reporting is a duty outlined in Policy ORG007 Wellbeing Matters - not getting all incidents of assault, assaults/experiences as normalised. Wellbeing matters asking datix handlers to capture emotional harm and ensure support is proactive for all incidents, comms to support and included in policy - opt out rather than an opt in approach. IG and IT to create new algorithm. New collaboration with Police - PPH Criminal Justice Panel meeting now set up, working on service line agreement. Communication and transparent with actions important to share with staff to build confidence. police officers now on site on PPH and attending more meetings.
	Violence data is managed in accordance with the General Data Protection Regulations (GDPR).		All Trust reporting processes and review of data is completed in accordance with the Trust Policy and Governance processes.

Data is traceable, retrievable and accessible.	Violence data is frequently analysed using primary metrics to support the violence prevention and reduction assessments and inform the audit process.		Staff incidents are reviewed by the appropriate teams and reported into the non-clinical risk group.
	Violence data is analysed using the demographic make-up of the workforce, including age, sex, ethnicity, disability and sexual orientation.		We partially capture protected characteristics, but more work is underway to improve the current systems we use to report incidents. Security Management Reporting into the Non- Clinical Risk Group captures protected characteristics, and diversity elements of V&A reporting. IS also captured, analysed and shared from staff survey.
	The protection and storage of data about violence follows the organisation's information governance policies.		All Trust policies and protocols are followed.
	Data collected about violence assures that the processes are effective and identifies where lessons can be learnt and that the policy objectives are being achieved.		The Datix form captures all relevant information for handlers and managers such as lessons learnt, root cause analysis and Occupational Health referrals.
Established audit and assurance process for violence prevention and reduction.	A process exists for auditing violence prevention and reduction performance and ensuring that associated systems are effectively managed and assessed regularly.		Compliance and risk team audit regularly how incident forms within Datix are completed. The Trust will need to build on this by auditing compliance against the entire strategy not individual forms.
	The audit outcomes inform a regular senior management review held at least twice a year.		This will be in place once the Strategy and Policy are completed.
Process for corrective and preventative actions for violence prevention and reduction.	All incidents are logged, reviewed, assessed and any corrective actions are recorded within acceptable timeframes, and where this may be prolonged by investigations and or staff support, this is recorded and communicated to senior management, relevant staff and stakeholders.		This is the Trust Datix process for reviewing the forms. Some of the Triage is completed via the Compliance & Risk Team Health, Safety & Security Management Specialists. Next steps will be to include this in the policy, then we can audit it. However this process relies on all staff reporting incidents in a timely manner.
	The violence prevention and reduction risk registers are updated accordingly.		Completed through Trust governance structures. A corporate risk is in place.
Act			
	Indicators	**Compliant (RAG)**	**Evidenced**
Board reviews the violence prevention and reduction performance.	A senior management review is undertaken twice a year and **as required or requested** to evaluate and assess the violence prevention and reduction programme, **the findings of which are shared with the board**.		There is a QI breakthrough objective monitoring staff assaults. VPR report goes to Board x2 a year.
	Inputs to the process include: local risk management system (data about violent incidents), Risk registers - audit and governance reports that include violence performance, lessons learned (STP and ICS level), review of the violence prevention and reduction processes, risk assessments (workplace and workforce), triangulated with WRES and WDES, staff experiences (causation themes, impact on health and wellbeing, consequences, etc), Serious incidents, NHS staff survey, local or pulse surveys, local HR intelligence (staff recruitment and leavers rates, absenteeism or retention rates), key stakeholders, trade union concerns, raised through the health and safety committee meetings with chief constable or designated representative police and crime commissioners, etc.		We have risk register and a risk on our CRR. Lessons learnt – ICS group meets to share, system perspective. Workforce risk assessments and training needs analysis for whole workforce underway. We look at NHS Staff Survey staff experiences. Data on leavers rates looked at - FTSUG triangulation of three or more incidents and leavers. Key stakeholders, trade union are in the group. We have Non-clinical risk committee, which look at this from a health and safety lens.
Violence prevention and reduction policy updated with lessons learned.	Following the senior management review (twice a year) the violence prevention and reduction lead updates as necessary the objectives, policy, plans and supporting processes required to deliver the outcomes.		To develop VPR policy

Informed decisions at senior management level.	Senior management has enough information from the violence prevention and reduction performance inputs to make informed decisions about the violence prevention and reduction policy, and this information is based on credible intelligence and risk assessments.		Board received x2 yearly updates, and progress is also shared through QPEG. To develop VPR policy
	Violence prevention and reduction forms part of the overall organisational strategy and workforce planning process and is closely aligned to the STP and ICS planning arrangements.		It is part of the strategy in making Berkshire ethe best place to work and staff experience. It is also on the Trust POAP for the year ahead. It is also a breakthrough objective
	Staff receive timely responses to incident investigations, and where this may be prolonged by process requirement, this is recorded and communicated to staff, senior management and relevant stakeholders.		RIDDOR incidents are completed within the legal timeframes. The victims receive updates/feedback provided by the compliance and risk team. Managers are required as a minimum to document their support and any other actions to victims of violence and aggression as part of the final approval process from the datix and risk information team as agreed with the health, safety and security managers. However feedback from Listening into Action and other forums has shown that staff do not receive timely responses or not hear anything. (what are learning outcomes, changes happening because of incident) Exploring turning on automatic function on DATIX, emails the incident reporter and staff involved once investigation complete to close feedback loop. A new role is in place to provide additional support to victims of workplace violence - Staff wellbeing role.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	12 November 2024
Title	**Finance Report September 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

September 2024

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 30 September 2024.

Document Control

Version	*Date*	*Author*	*Comments*
1.0	08/10/2024	Rebecca Clegg	Draft
2.0	16/10/24	Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Year to Date Actual £m	Year to Date Plan £m	Year to Date Achieved	Outturn Actual £m	Outturn Plan £m	Outturn Achieved
1a	Income and Expenditure Plan	1.4	1.4	Yes	1.9	1.9	Yes
2a	CIP - Identification of Schemes	6.4	6.4	Yes	8.8	13.6	No
2b	CIP - Delivery of Identified Schemes	6.4	6.4	Yes	8.8	8.8	Yes
3a	Cash Balance	57.2	54.0	Yes	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	96%	95%	Yes	95%	95%	Yes
3e	Better Payment Practice Code Value NHS	93%	95%	No	95%	95%	Yes
4	Capital Expenditure not exceeding CDEL	1.0	1.8	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 £13.6m Cost Improvement Plan. We on track year to date, but there are some small variances on individual plans.
- Income includes the planned cost uplift for 24/25 but this will be updated for the actual cost uplift of 24/25 pay awards in October.
- Cash is above plan but will reduce once the back dated pay awards are made.
- Our performance against the Better Payment Practice Code is achieved for three of the targets. One target was missed in month 5 due to 7 medical staffing invoices being paid late. The late payment of one invoice for the Sexual Health Service in month 6 has meant that our position has not yet recovered on this indicator.
- Capital spend is under plan year to date for CDEL schemes.
- The agency target is achieved year to date.

System Position

- BOB ICS submitted a combined plan of £60m deficit which is in line with the control total agreed by NHSE. NHSE will be providing offsetting, but repayable £60m of deficit support funding to the system in order to mitigate potential liquidity issues that may arise in year. Frimley ICS submitted a combine plan of £25m deficit, again, in line with NHSE's expectations and offset with support funding.
- Given the level of financial risk, NHSE has placed BOB into the 'Investigation and Intervention' regime and has appointed PwC to undertake work.

1. Income & Expenditure

Sep-24	In Month			YTD			2024/25
	Act	Plan	Var	Act	Plan	Var	Plan
	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Operating Income	30.1	30.3	(0.2)	180.9	181.6	(0.7)	364.2
Elective Recovery Fund	0.5	0.3	0.1	2.8	2.0	0.8	4.0
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**30.6**	**30.6**	(0.0)	**183.7**	**183.6**	0.1	**368.2**
Staff In Post	20.8	20.7	(0.1)	123.3	123.4	0.1	249.5
Bank Spend	1.7	2.1	0.4	11.4	12.2	0.8	24.9
Agency Spend	0.6	0.7	0.0	3.9	4.0	0.0	8.0
Total Pay	**23.2**	**23.5**	**0.3**	**138.6**	**139.6**	**1.0**	**282.5**
Purchase of Healthcare	1.5	1.5	(0.0)	10.4	10.5	0.1	19.5
Drugs	0.5	0.5	(0.0)	3.2	3.1	(0.2)	6.1
Premises	1.6	1.4	(0.2)	9.1	8.5	(0.6)	17.1
Other Non Pay	1.6	1.5	(0.1)	10.1	9.4	(0.7)	18.4
PFI Lease	0.7	0.7	0.0	4.2	4.4	0.2	8.8
Total Non Pay	**5.9**	**5.7**	**(0.2)**	**37.0**	**35.9**	**(1.1)**	**70.0**
Total Operating Costs	**29.1**	**29.2**	**0.1**	**175.6**	**175.4**	**(0.2)**	**352.4**
EBITDA	**1.5**	**1.5**	**0.0**	**8.1**	**8.2**	**(0.1)**	**15.8**
Interest (Net)	0.0	0.1	0.1	0.1	0.4	0.4	1.0
Depreciation	0.9	0.9	0.0	5.5	5.5	0.0	11.2
Impairments	0.0	0.0	(0.0)	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	**0.9**	**1.0**	**0.1**	**7.2**	**8.0**	**0.8**	**14.3**
Reported Surplus/(Deficit)	**0.6**	**0.4**	**0.1**	**0.9**	**0.2**	**0.7**	**1.5**
Adjustments	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.1**
PFI IFRS16 Adjustment	**(0.2)**	**(0.1)**	**(0.1)**	**0.5**	**1.2**	**(0.7)**	**0.3**
Adjusted Surplus/(Deficit)	**0.3**	**0.3**	**0.0**	**1.4**	**1.4**	**0.0**	**1.9**

Key Messages

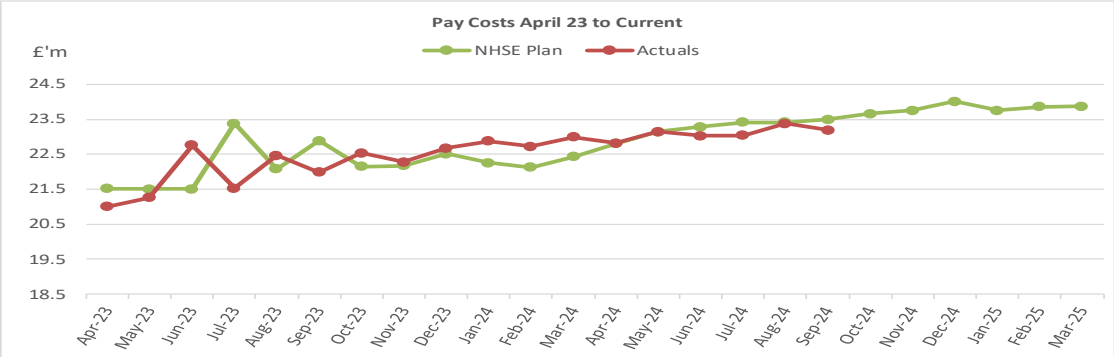
The table above gives the financial performance against the Trust's income and expenditure plan as at 30 September 2024.

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 depreciation, £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.

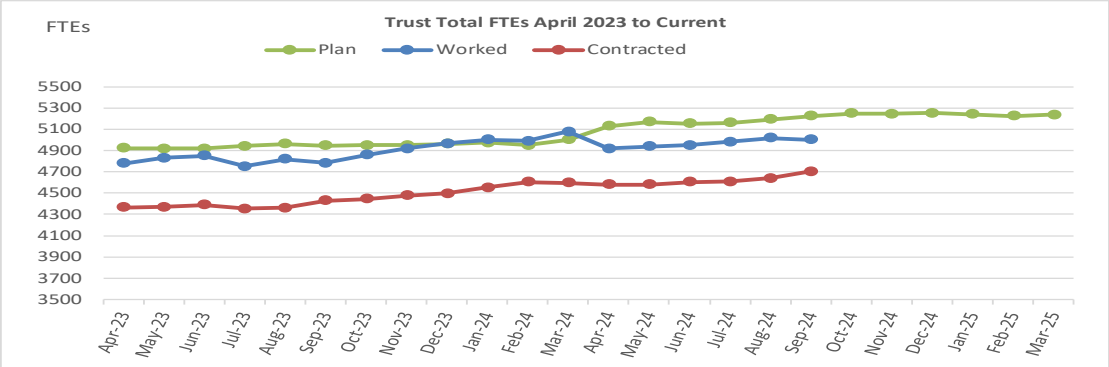
Month 6 variances are not material and overall the Trust on plan year to date.

Workforce



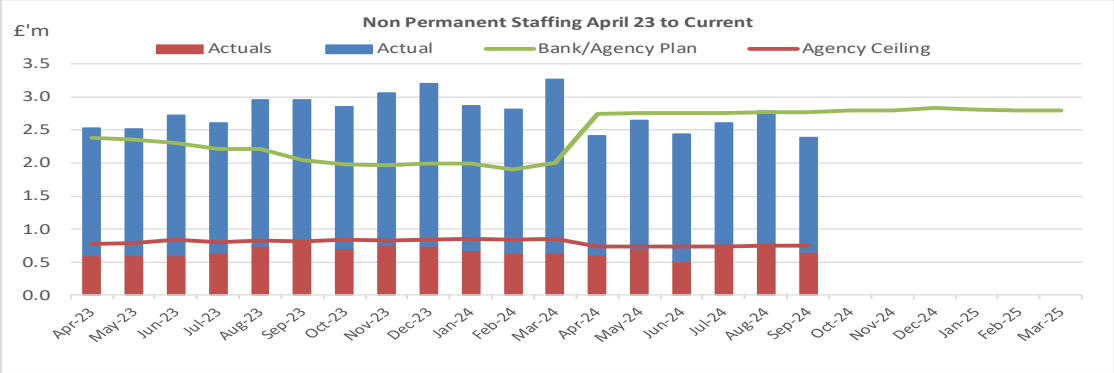
Staff Costs

YTD	£'m
2024/25	138.6
2023/24	131.0
▲	6%
Prior Yr	**£'m**
Sep-24	23.2
Sep-23	22.0
▲	6%



FTE's

Prior Mth	CFTE	WFTE
Sep-24	4,704	5,000
Aug-24	4,641	5,019
	1% ▲	0% ▼
Prior Yr		
Sep-24	4,704	5,000
Sep-23	4,430	4,784
	6% ▲	5% ▲



Staff Costs

YTD	Bank	Agency
	£'m	£'m
2024/25	11.4	3.9
2023/24	12.3	4.0
	-8% ▼	-1% ▼
Prior Yr	**£'m**	**£'m**
Sep-24	1.7	0.6
Sep-23	2.1	0.8
	-18% ▼	-23% ▼

Key Messages

Pay costs in month were £23.2m. In month, contracted WTEs increased by 61 and worked WTEs decreased by 19.

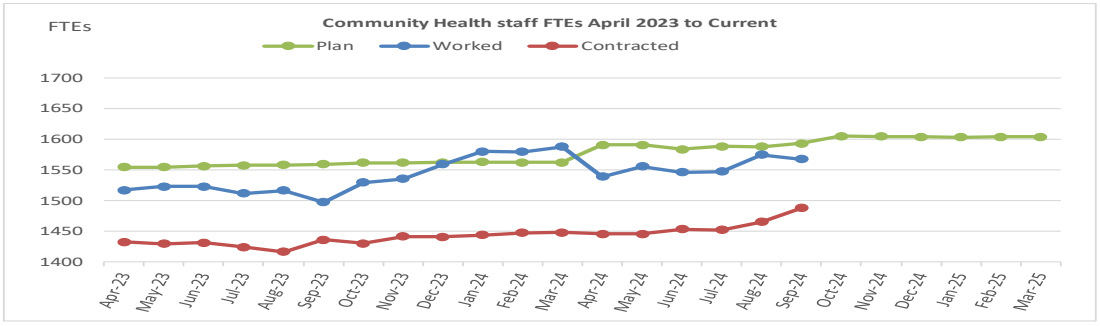
We are operating below the NHSE System Agency Ceiling of 3.2%, currently running at 2.8%. Overall temporary staffing costs are £0.4m lower than the same period last year.

Our bank fill rate remains steady, currently covering 85% of our temporary staffing demand.

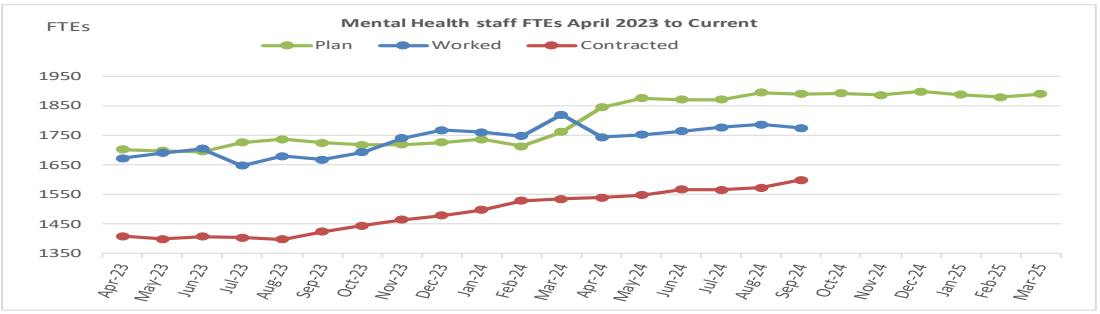
Off-framework usage has held at 6%, primarily within our dental and nursery services. While we are actively working to onboard additional framework suppliers, our recent partnership with a framework agency has unfortunately not been successful. As a result, we may see a potential increase in off-framework usage in the coming months as we continue sourcing suitable framework suppliers.

Non-medical price cap breaches were recorded in OPMH, Westcall (for ANPs/ACPs), ASLT, and CAMHS Rapid Response. We are supporting these services to work towards agreed end dates, with a number of agency staff already no longer in post.

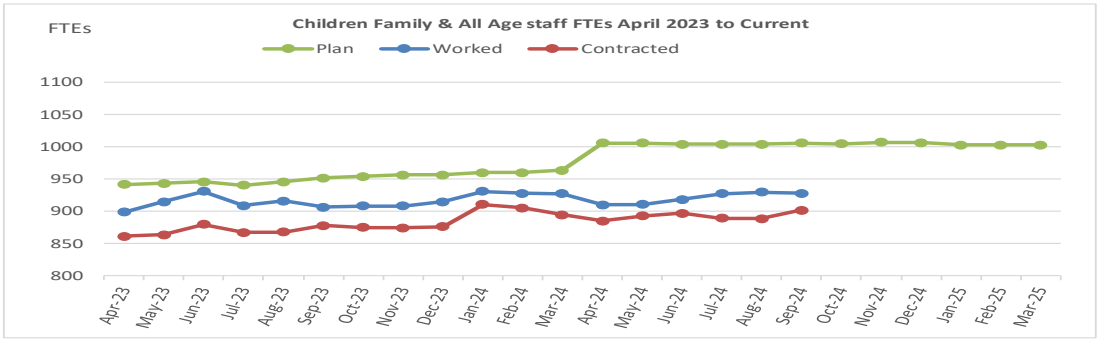
Staff Detail (Division)



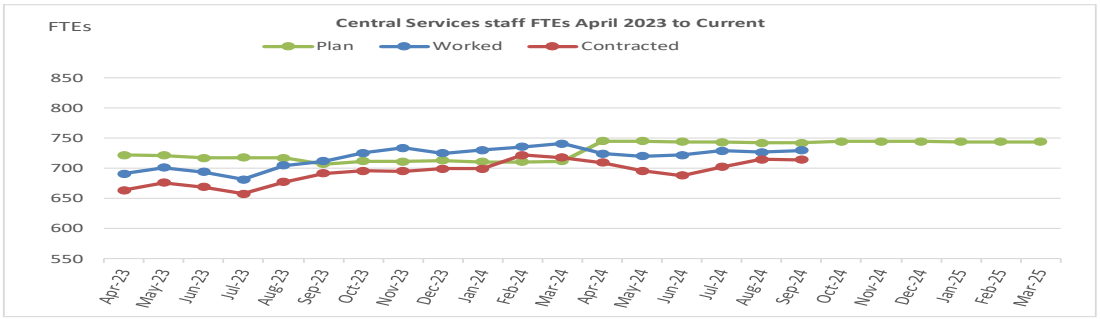
FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,488	1,568
Aug-24	1,465	1,575
	2% ▲	0% ▼
Prior Yr		
Sep-24	1,488	1,568
Sep-23	1,436	1,498
	4% ▲	5% ▲



FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,599	1,775
Aug-24	1,572	1,787
	2% ▲	-1% ▼
Prior Yr		
Sep-24	1,599	1,775
Sep-23	1,424	1,667
	12% ▲	6% ▲



FTE's		
Prior Mth	CFTE	WFTE
Sep-24	902	928
Aug-24	889	930
	2% ▲	0% ▼
Prior Yr		
Sep-24	902	928
Sep-23	878	907
	3% ▲	2% ▲

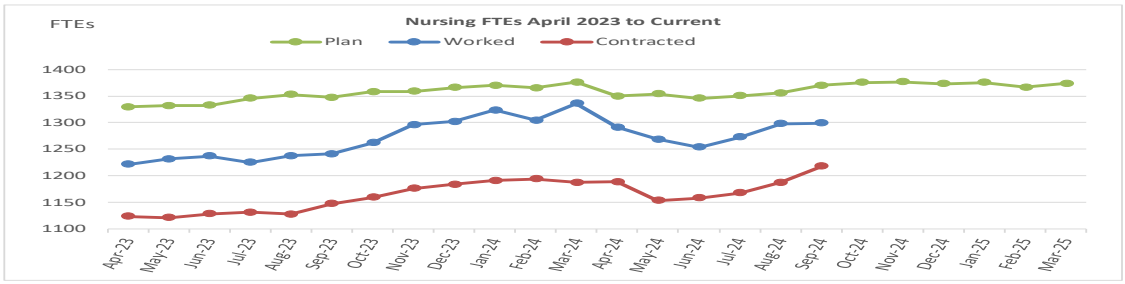


FTE's		
Prior Mth	CFTE	WFTE
Sep-24	714	730
Aug-24	715	727
	0% ▼	0% ▲
Prior Yr		
Sep-24	714	730
Sep-23	692	712
	3% ▲	2% ▲

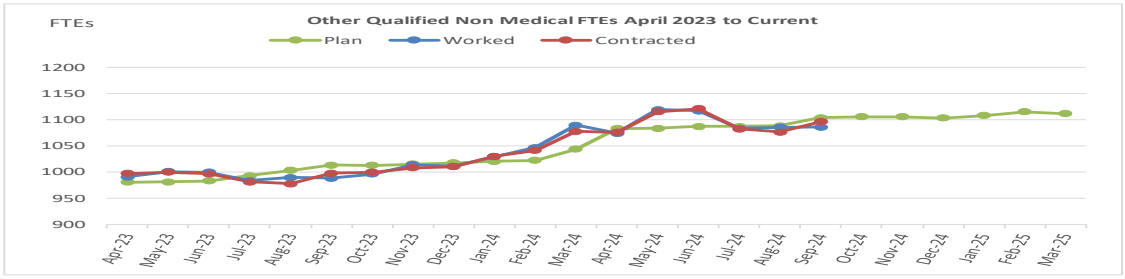
Key Messages

Worked WTEs are below plan for all clinical divisions and central services. Increases in contract WTEs in month include Talking Therapies (16), MSK services (9) and Community Inpatients (6) and Community Nursing (6).

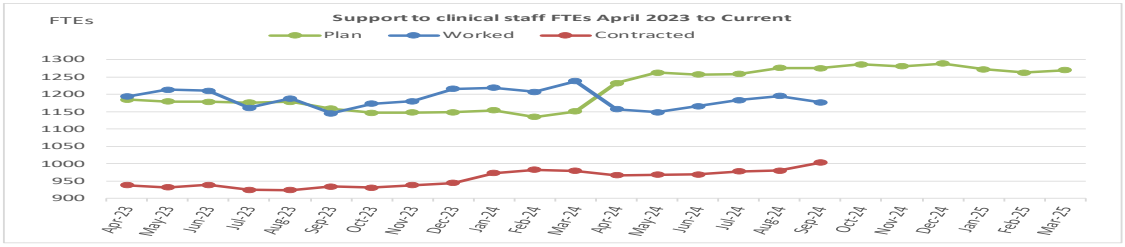
Staff Detail (Staff Group)



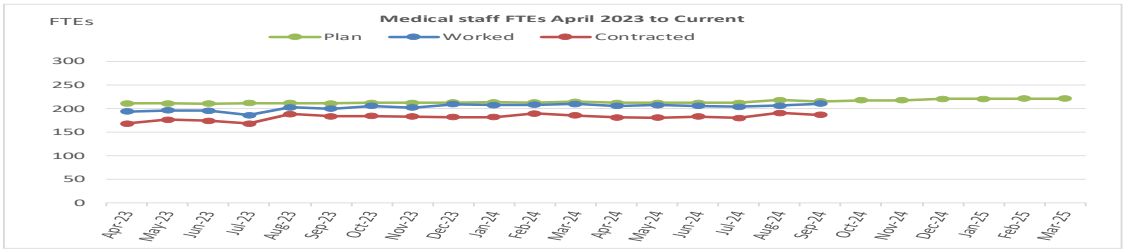
FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,218	1,299
Aug-24	1,188	1,298
	3% ▲	0% ▲
Prior Yr		
Sep-24	1,218	1,299
Sep-23	1,147	1,241
	6% ▲	5% ▲



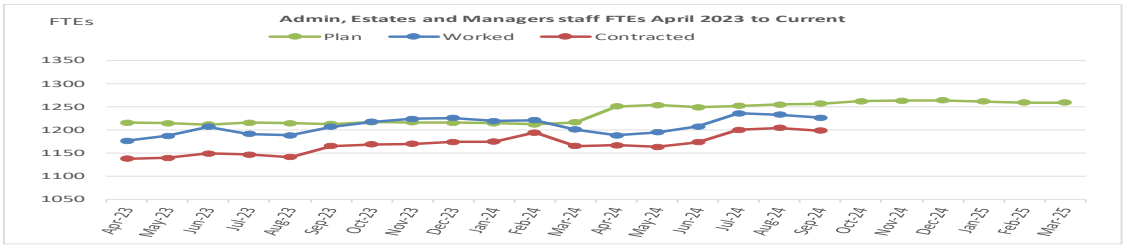
FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,097	1,086
Aug-24	1,077	1,085
	2% ▲	0% ▲
Prior Yr		
Sep-24	1,097	1,086
Sep-23	998	989
	10% ▲	10% ▲



FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,003	1,177
Aug-24	980	1,195
	2% ▲	-1% ▼
Prior Yr		
Sep-24	1,003	1,177
Sep-23	934	1,145
	7% ▲	3% ▲



FTE's		
Prior Mth	CFTE	WFTE
Sep-24	187	211
Aug-24	191	207
	-2% ▼	2% ▲
Prior Yr		
Sep-24	187	211
Sep-23	184	200
	1% ▲	5% ▲



FTE's		
Prior Mth	CFTE	WFTE
Sep-24	1,199	1,227
Aug-24	1,205	1,233
	0% ▼	-1% ▼
Prior Yr		
Sep-24	1,199	1,227
Sep-23	1,166	1,207
	3% ▲	2% ▲

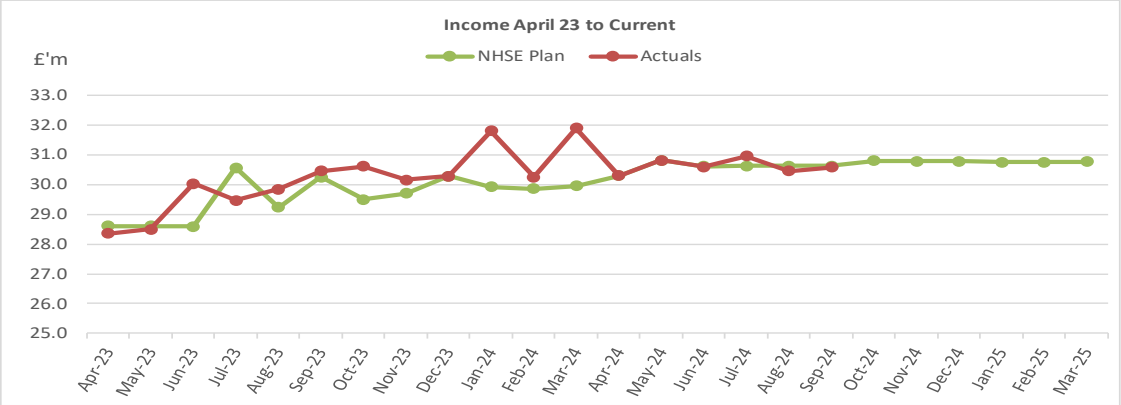
Key Messages

Worked WTE actuals are much closer to plan since the 2022/23 financial reset.

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

In the Nursing staff group we have seen an increase in worked WTEs in month which including 14 band 5s which will include new graduates with the rest of the increase in band 6/7 distributed against across the Trust. 15 are in MH and 10 in CFAA.

Income & Elective Recovery Fund



Income	
YTD	£'m
2024/25	183.7
2023/24	176.6
▲	4%
Prior Yr	£'m
Sep-24	30.6
Sep-23	30.4
▲	0%

Key Messages

Income is ahead of plan year to date due to the recognition of variable income for elective performance which is offset in part by some deferral of income for use in later months.

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 a percentage of prior year average monthly performance.

Elective Activity Performance

ERF Performance against target	BOB		Frimley		Total	
Year to Date: September 2024	Activity	£000s	Activity	£000s	Activity	£000s
Baseline	33,221	7,283,292	33,490	7,620,159	66,712	14,903,450
Actual	43,760	10,443,637	32,033	7,286,813	75,793	17,730,451
Variance	10,539	3,160,346	-1,457	-333,346	9,081	2,827,000
Income target £4m		2,000,000		0		2,000,000
Variance (+/-)		1,160,346		-333,346		827,000
CIP £1m				0		500,000
Variance (+/-)						327,000

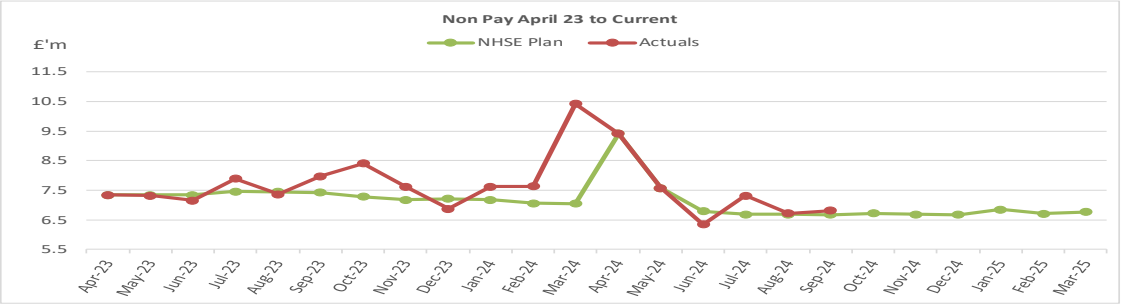
The Trust will receive payment for all activity above the 19/20 baseline which is higher than for 23/24 as it has been adjusted for working days and the current activity prices. The target and income earned will be updated for further price changes resulting from pay awards as they are agreed.

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 although a prudent view of the value of the activity is currently assumed along with a return of £135k under performance from 2023/24 to support the Frimley ICS position.

Final outturn for 2023/24 for BOB ICS was higher than forecast and discussion is ongoing with the ICB regarding the treatment of this in 2024/25.

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

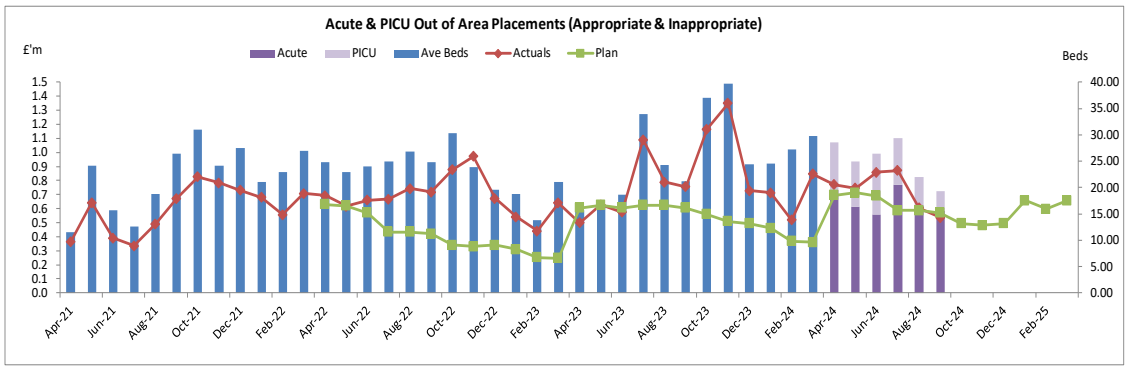


Non Pay

YTD	£'m
2024/25	44.2
2023/24	45.0
▲	-2%
Prior Yr	**£'m**
Sep-24	6.8
Sep-23	8.0
▲	-14%

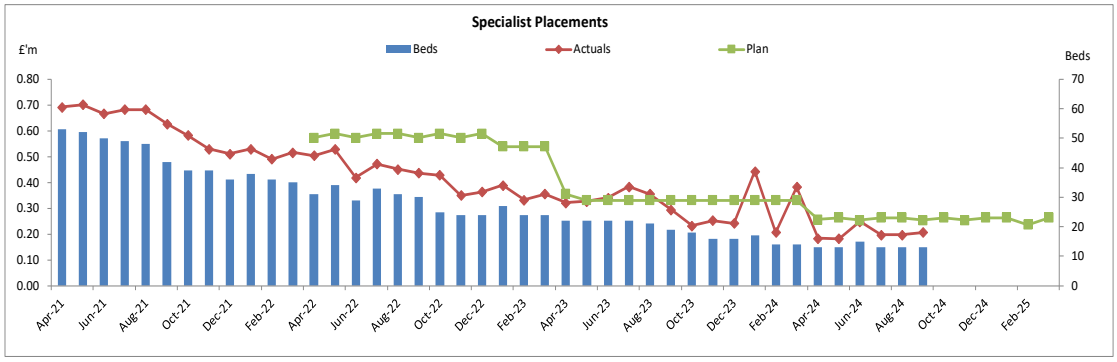
Key Messages

The non-pay variance includes an overspend on OAPs year to date.



OAPs

YTD	£'m
2024/25	4.4
2023/24	4.3
▲	*1%*
Prior Yr	**£'m**
Sep-24	0.5
Sep-23	0.8
▼	*-29%*



Specialist Placements

YTD	£'m
2024/25	1.2
2023/24	2.0
▼	*-40%*
Prior Yr	**£'m**
Sep-24	0.2
Sep-23	0.3
▼	*-30%*

Key Messages

Out of Area Placements. The average number of placements has decreased from 22 in August to 21 in September. Analysis highlights that the high level of placements continues to be driven by demand, and that flow through the hospital continues to improve, with more discharges and fewer lost bed days per patient. The monthly costs are £0.5m which is slightly below plan.

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 agreed a reduction in acute bed at PPH to 72 from Q3, which is delayed until Q4 to support the transition of patients to the new outsourced ward and minimise cross over between the 2 independent sector providers. 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 is in line with plan at 13. We have one **LD placement.**

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	177	177	0
Contribution from new income - MHICS	Mental Health	Fully developed	Low	175	88	88	0
Contribution from new income - Imms	Children families and All Age Services	Fully developed	Low	444	222	222	0
Contribution from new income - small CH schemes	Cimmunity Health	Fully developed	Low	124	62	62	0
Contribution from new income - small CYP schemes	Children families and All Age Services	Fully developed	Low	154	77	77	0
Contribution from new income - seasonal bed occupancy	Community Health	Fully developed	Medium	80	40	40	0
Other small divisional schemes	Various	Fully developed	Low	670	335	335	0
New contract with EE	Central Services - IM&T	Fully developed	Low	106	53	53	0
Estates & Facilities Control Total review	Central Services - Estates & Facilities	Fully developed	Low	376	188	188	0
Increased Contribution to Central Costs	Central Services - Pharmacy Procurement	Fully developed	Low	98	49	49	0
LPS Admin Posts	Central Services - Nursing & Governance	Fully developed	Low	66	33	33	0
Increased Contribution to Central Costs	Central Services - R&D	Fully developed	Low	102	51	51	0
PICU Placement reduction	Mental Health	Fully Developed - not yet started	Medium	1,049	0	525	-525
Asset revaluation to Modern Equivalent Asset	Central Services - Finance	Fully Developed	Low	670	336	335	1
Opt to tax - frimley	Central Services - Finance	Plans in progress	Medium	300	0	150	-150
Liaison VAT, AP review etc	Central Services - Finance	Plans in progress	Medium	100	120	50	70
Overseas Visitors	Central Services - Finance	Opportunity	Medium	50	0	25	-25
Bank Interest	Central Services - Finance	Fully Developed	Low	230	480	115	365
Balance Sheet Review	Central Services - Finance	Fully Developed - not yet started	Medium	2,106	0	1,053	-1,053
Scheduled Care Cost Avoidance	Community Health	Fully Developed	Low	399	200	200	0
Expenses Controls	Community Health	Fully Developed - not yet started	Low	120	10	60	-50
Elective Recovery	Community Health	Fully Developed	Medium	1,000	827	500	327
Operational Slippage Against Control Total	Operations	Fully Developed	Low		2,553	0	2,553
Agreed Investment Slippage	Operations	Fully Developed	Low	500	500	500	0
Recurrent Schemes to be developed	To be confirmed	Opportunity	High	4,327	0	1,513	-1,513
			Total	13,600	6,399	6,399	0

Key Messages

The Trust's initial financial plan included £12.8m 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.

We are recognising ERF income in line with current forecasts.

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. The VAT scheme is complete with £120k of savings (net of fees), slightly higher than plan.

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

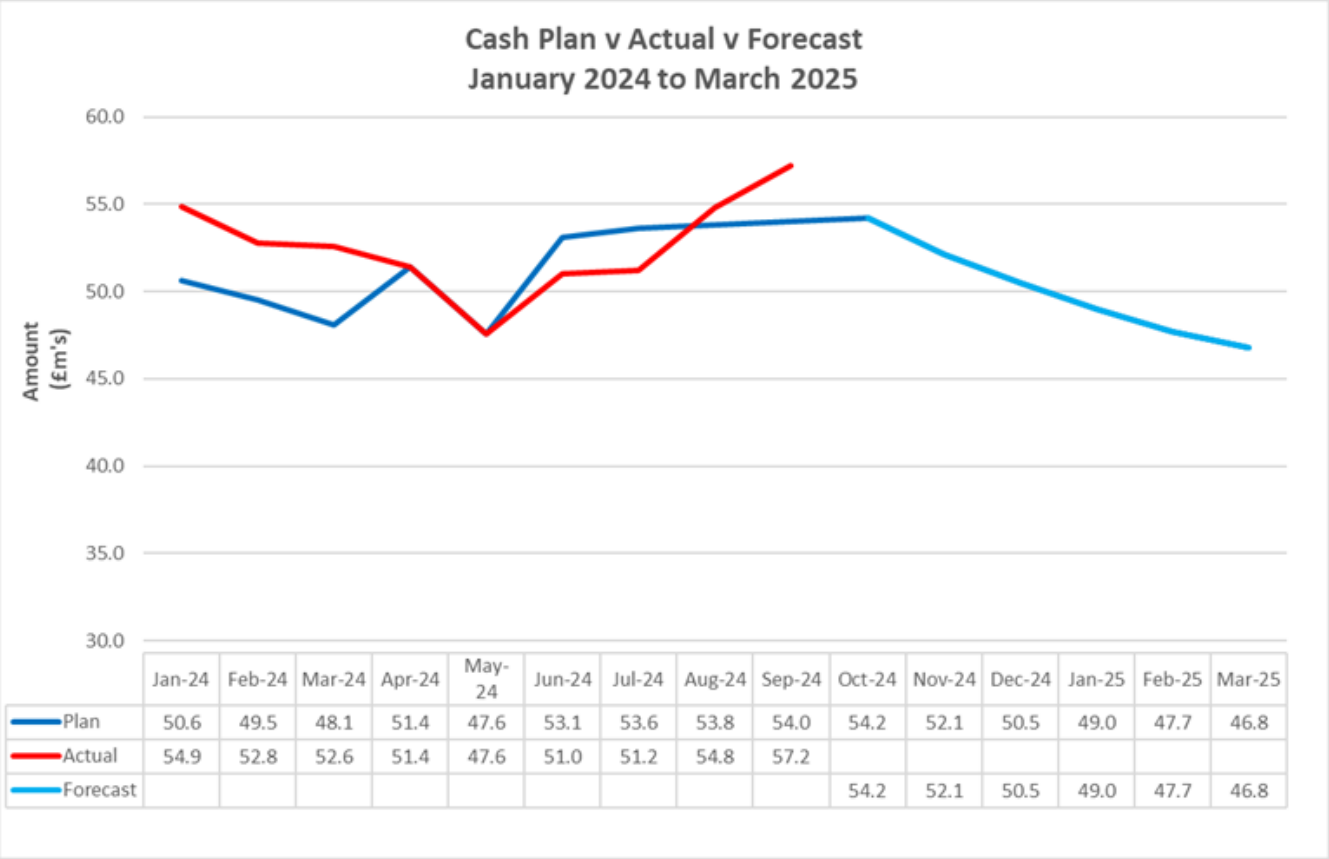
Recurrent schemes are to be developed as part of the closing the gap programme.

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	1.4	1.4	0.0	1.4	1.4	0.0
Property, Plant & Equipment (non PFI)	33.0	31.2	31.6	(0.4)	31.2	31.6	(0.4)
Property, Plant & Equipment (PFI)	45.9	45.2	45.7	(0.5)	45.2	45.7	(0.5)
Property, Plant & Equipment (RoU Asset)	15.2	14.4	14.3	0.1	14.4	14.3	0.1
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.1**	**92.4**	**93.2**	**(0.8)**	**92.4**	**93.2**	**(0.8)**
Trade Receivables & Accruals	12.1	16.4	16.9	(0.5)	16.4	16.9	(0.5)
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	52.6	57.2	53.8	3.4	57.2	53.8	3.4
Trade Payables & Accruals	(37.2)	(40.8)	(39.1)	(1.7)	(40.8)	(39.1)	(1.7)
Borrowings (PFI and RoU Lease Liability)	(6.2)	(3.6)	(7.4)	3.8	(3.6)	(7.4)	3.8
Other Current Payables	(12.0)	(13.7)	(13.2)	(0.5)	(13.7)	(13.2)	(0.5)
Total Net Current Assets / (Liabilities)	**9.6**	**15.8**	**11.3**	**4.5**	**15.8**	**11.3**	**4.5**
Non Current Borrowings (PFI and RoU Lease Liability)	(54.9)	(56.2)	(54.3)	(1.9)	(56.2)	(54.3)	(1.9)
Other Non Current Payables	(2.1)	(2.4)	(2.2)	(0.2)	(2.4)	(2.2)	(0.2)
Total Net Assets	**48.7**	**49.6**	**48.0**	**1.6**	**49.6**	**48.0**	**1.6**
Income & Expenditure Reserve	5.3	6.2	17.7	(11.5)	6.2	17.7	(11.5)
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**	**49.6**	**48.0**	**1.6**	**49.6**	**48.0**	**1.6**

Key Messages

Our cash balance is higher than plan in month. This is due to the funding that we received in our ICB contracts which included some planned funding for the pay award. We will receive further funding in October to support payment of the final agreed pay awards.



	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	54.8	57.2						
Forecast										54.2	52.1	50.5	49.0	47.7	46.8

Capital Expenditure

Capital Programme

Schemes	Current Month			Year to Date			FY	Forecast	FY
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Plan £'000	Outturn £'000	Variance £'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	28	57	(28)	272	267	5	477	573	96
Nicholson House Relocation	0	0	0	0	0	0	500	0	(500)
Jubilee Ward Relocation Upton/St Marks	0	0	0	0	0	0	150	53	(97)
Additional Dental Surgery St Marks	0	7	(7)	0	20	(20)	185	185	0
Leased Non Commercial (NHSPS)	11	17	(5)	32	50	(18)	275	547	272
West/Reading Consolidation - Bath Road, Cremyll Road, Coley Cli	14	133	(119)	30	400	(370)	800	800	0
Leased Commercial	0	0	0	47	60	(13)	135	122	(13)
Environment & Sustainability	14	22	(7)	30	65	(35)	150	154	4
Audiology Equipment	0	30	(30)	0	90	(90)	181	160	(21)
Various All Sites	81	36	45	124	129	(5)	306	628	322
Statutory Compliance	16	20	(4)	34	60	(26)	160	96	(64)
Subtotal Estates Maintenance & Replacement	**165**	**321**	**(157)**	**569**	**1,141**	**(572)**	**3,319**	**3,319**	**(0)**
IM&T Expenditure									
Business Intelligence and Reporting	0	10	(10)	14	60	(46)	160	160	(0)
Hardware Purchases - Refresh & Replacement	0	0	0	30	0	30	3,447	3,447	0
Additional Divisional Spend	2	37	(35)	121	255	(134)	687	687	0
Digital Strategy	39	50	(11)	270	300	(30)	650	650	0
EMIS and ePMA systems re-tender project	0	5	(5)	0	60	(60)	207	207	0
Pharmacy System Procurement	0	0	0	0	0	0	100	100	0
Subtotal IM&T Expenditure	**41**	**102**	**(61)**	**436**	**675**	**(239)**	**5,251**	**5,251**	**(0)**
Subtotal CapEx Within Control Total	**206**	**423**	**(217)**	**1,004**	**1,816**	**(812)**	**8,570**	**8,570**	**(0)**
CapEx Expenditure Outside of Control Total									
Place of Safety	2	0	2	15	0	15	2,600	2,592	(8)
Anti-Ligature Toilet Pans & Basins	72	77	(5)	325	460	(135)	681	681	0
Low Carbon Heating Scheme	1	0	1	13	0	13	406	406	0
LED Lighting Upgrades	0	17	(17)	0	50	(50)	250	250	0
Other PFI projects	0	73	(73)	42	220	(178)	575	583	8
Subtotal Capex Outside of Control Totals	**75**	**167**	**(92)**	**395**	**730**	**(335)**	**4,512**	**4,512**	**(0)**
Total Capital Expenditure	**281**	**590**	**(309)**	**1,400**	**2,546**	**(1,146)**	**13,082**	**13,082**	**(0)**
IFRS16 RoU ASSETS - New Leases									
Lower Henwick Farm lease	0	0	0	169	200	(31)	200	200	0
Cremyll Road Lease	0	0	0	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	0	0	0	23	24	(1)	24	24	0
Lake Road Health Centre - rent review	0	0	0	7	0	0	0	7	7
CoIN	0	42	(42)	(97)	248	(345)	500	493	(7)
Total IFRS 16 RoU Assets - New leases	**0**	**42**	**(42)**	**427**	**922**	**(502)**	**2,524**	**2,524**	**0**

Key Messages

At M06, CDEL schemes were underspent by £0.2m for the month, with YTD total underspend of £0.8m. Estates was underspent by £0.6m mainly due to the West Reading consolidation project, which is still in design stage. IM&T was underspent by £0.2m due to lower spend on additional divisional projects, EMIS and ePMA systems.

Non-CDEL spend for PFI sites was underspent by £0.1m for the month and YTD it was underspent by £0.3m, mainly due to the anti-ligature toilets and basins project, which is now progressing and due to be delivered. The PFI Place of Safety project continues to be under the Deed of Variation process and is now due to commence in November with expected completion by mid March.

There is an underspend on IFRS16 Right of Use Assets of £0.5m and we are awaiting further information on lease renewal. The underspend on IFRS 16 is mainly due to CoIN leases and is due to the 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	12th November 2024
Title	**True North Performance Scorecard Month 6 (September 2024) 2024/25**
	Item for Noting
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 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 – September 2024

The True North Performance Scorecard for Month 6 2024/25 (September 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 and Understanding Statistical Process Control Charts (attached)

Breakthrough and Driver Metrics

- Clinically Ready for Discharge by Wards including Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – increased to 306 against a 250-bed day target.
    - Metric now includes Out of Area Placements and Psychiatric Intensive Care Unit (PICU) data, so showing higher. Top contributor is Reading with 128 days, then Royal Borough of Windsor and Maidenhead. The is to look at length of stay with Bluebell identified as highest. The team are tracking historic data to identify patients with multiple admissions to mitigate admissions if possible.
- Bed Days Occupied by Patients who are Discharge Ready (Community Physical Health) – **(Patient Experience)** – a new indicator for 2023/24, has increased to 899 against a 500-bed day target.
    - There were 899 bed days lost this month from 137 patients. Only 5 patients with a discharge of over 21 days this month. On average patients are waiting 6.6 days over the agreed date. Highest contributor is awaiting package of care affecting over 45% of patients.
- Physical Assaults on Staff **(Supporting our Staff)** – 59 against a revised stretch target of 36.
    - Target revised down to 36 incidents per month as a stretch target. Top contributing wards are Snowdrop (15), Rose (9) and A Place of Safety (8). Increases this month relate to acuity of individual patients. It was noted the 'patient voice' is missing from the workstream, so a series of interviews are being planned to include this. Feedback from staff about the post incident support requires more work based on staff feedback. Working with staff groups to understand why staff don't report all incidents.

  The following Breakthrough metric is Green and are performing better than agreed trajectories or plan.
- Restrictive Interventions **(Harm Free Care)** – 185 against a revised target of 241.
    - There has been a reduction in the numbers and the severity of incidents this month. The team are ensuing advanced care plans are in place. Looking at length of time in seclusion and how we can reduce duration of stay, as there is a correlation between time in seclusion and assaults and other incidents. Independent reviews are carried out by nurse consultant network to ensure any learning is captured.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Compliance Rate **(Patient Experience)** – at 4.39% against a 10% target.
- Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 7 against a quarter 2 target of 5 patients.

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

- I Want Great Care Positive Score **(Patient Experience)** – at 95.09% against a 95% target.
- Staff turnover (excluding fixed term posts) **(Supporting our Staff)** – at 12.07% against a revised stretch target of 10% target by March 2025.
- Year to Date Variance from Control Total (£'k) **(Efficient Use of Resources)** -£16k against a target of 0.

Tracker Metrics

- Sickness rate **(Supporting Our Staff)** – red at 4.1% against a target of 3.5%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (Frimley) **(Patient Experience)** – 18.5% against a target of less than 10%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (BOB) **(Patient Experience)** – 20% 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 year to date against a target of 0.
- Community Inpatient Occupancy **(Efficient Use of Resources)** – at 92.4% against a target of 85%.
- Community Inpatient Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 24.7 days against a target of less than 21 days.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 96.8% against an 85% target.
- Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 46.1 days against a target of 30 days.
- Mental Health: Non-Acute Occupancy Rate (excluding home leave) **(Efficient Use of Resources)** – at 90.1% days against a target 80%.
- Community Virtual Ward Occupancy (Frimley) **(Efficient Use of Resources)** – at 61.29% against a target of 80%.
- Community Virtual Ward Occupancy (BOB) **(Efficient Use of Resources)** – at 79.4% 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**)

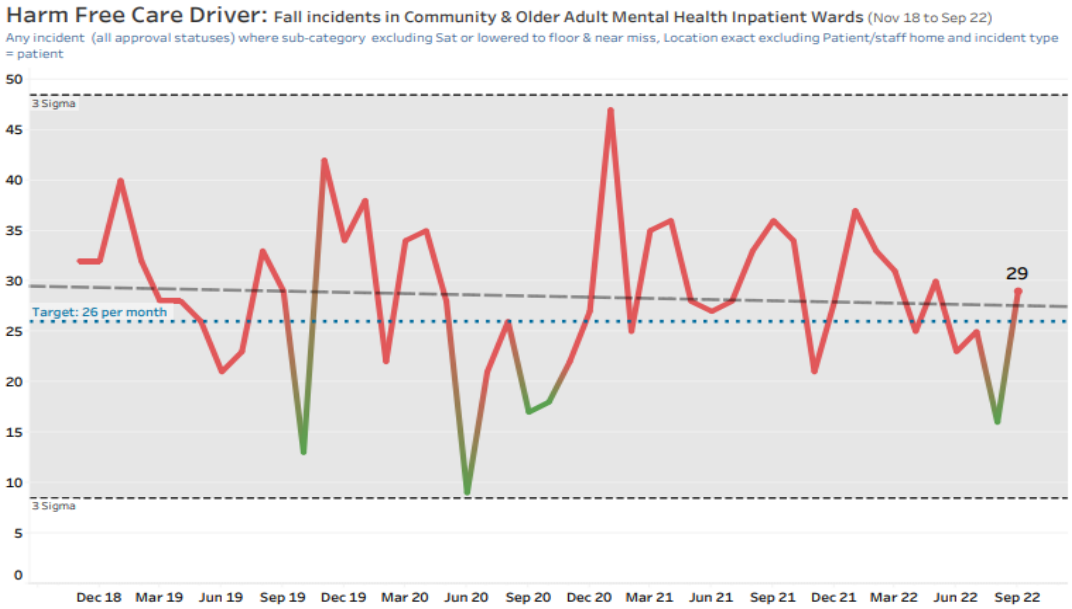
Business Rules for Statistical Process Control (SPC) Charts

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	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Breakthrough Restrictive Interventions in Mental Health Inpatient Wards	241 from 1st August 2024 previously 309	Internal	249	155	157	156	199	172	213	274	242	261	233	185

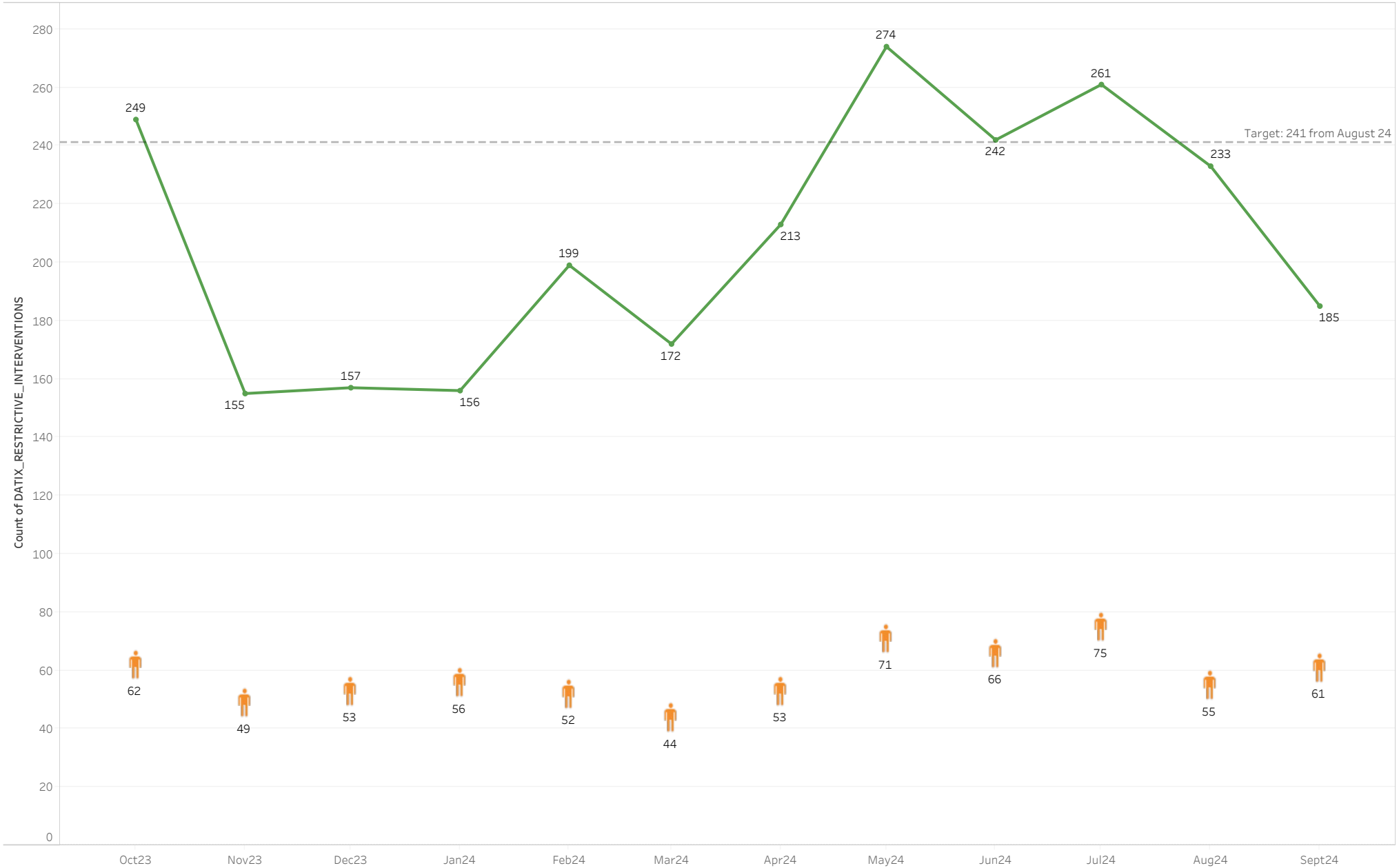
Patient Experience

			Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Positive Patient Experience Score %	95% compliance	External	93.30%	94.39%	94%	94.71%	94.09%	94.59%	93.67%	94.37%	93.97%	94.19%	94.19%	95.09%
Patient Experience Compliance Rate %	10% compliance	External	3.69%	3.20%	2.70%	3.30%	3.50%	3.20%	7.09%	7.39%	6.5%	5.70%	6.20%	4.39%

			Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	465	390	559	371	268	353	248	351	275	249	248	306

			Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	External	895	776	738	842	752	663	554	647	813	1,004	840	899

Harm Free care-Breakthrough Objective: Restrictive Interventions in Mental Health Inpatient Wards



Performance Scorecard - True North Drivers

Supporting our Staff

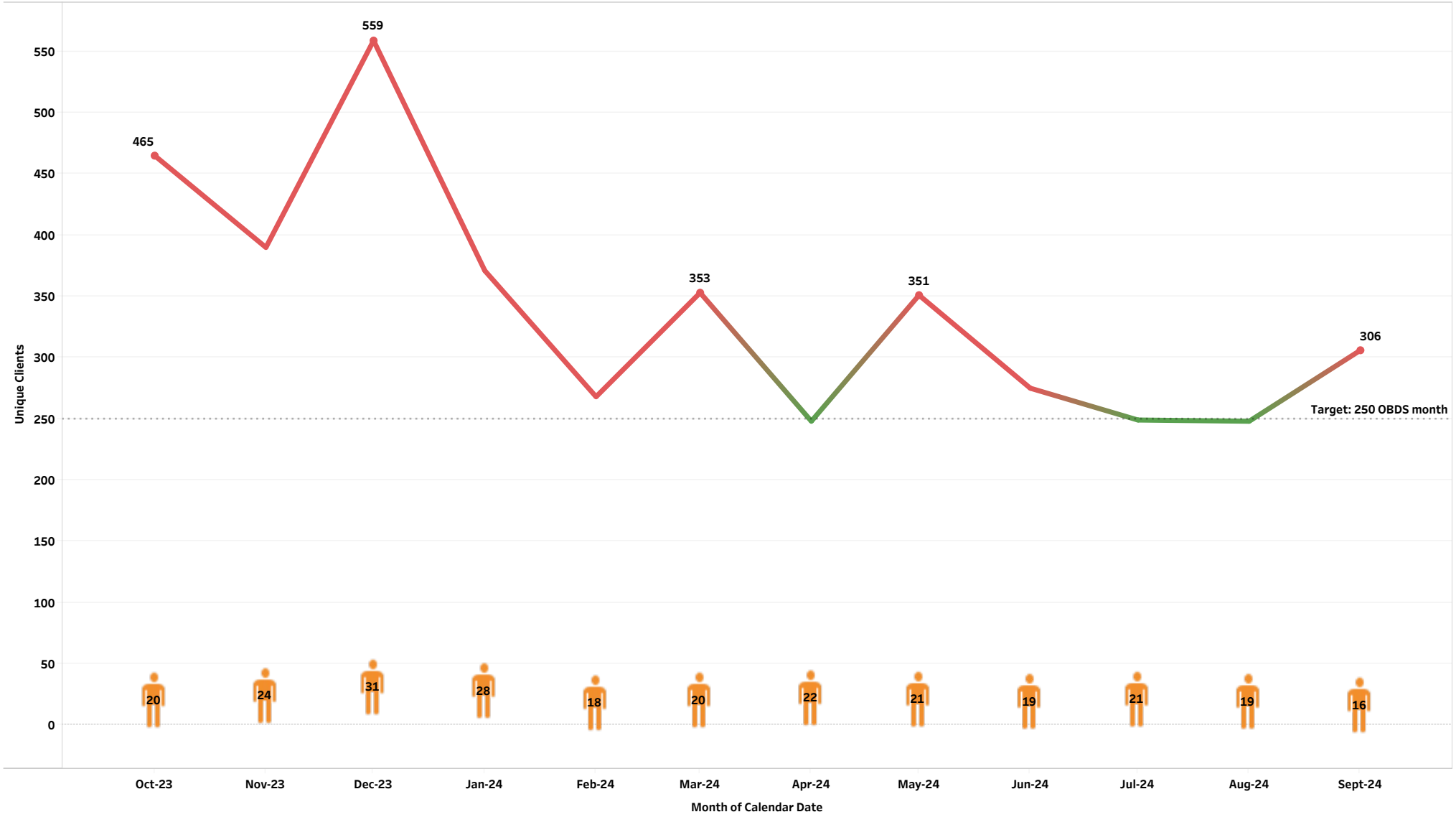
Metric	Threshold / Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Breakthrough Physical Assaults on Staff	36 per month Sept 2024	Internal	52	74	108	67	75	58	30	38	55	59	45	59
Staff turnover (excluding fixed term posts)	10% by March 2025	External	13.42%	13.03%	12.87%	12.33%	12.83%	12.28%	12.4%	12.60%	12.59%	12.49%	12.32%	12.07%

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
YTD variance from control total (£'k)	0	External	-1492	-1459	-1712	-1914	-1648	-2476	0	0	-26	-103	-9	-16
Active Inappropriate OAPS at end of month	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External							5	3	4	3	4	7

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

All Mental Health wards excludes Campion ward (Learning Disability)



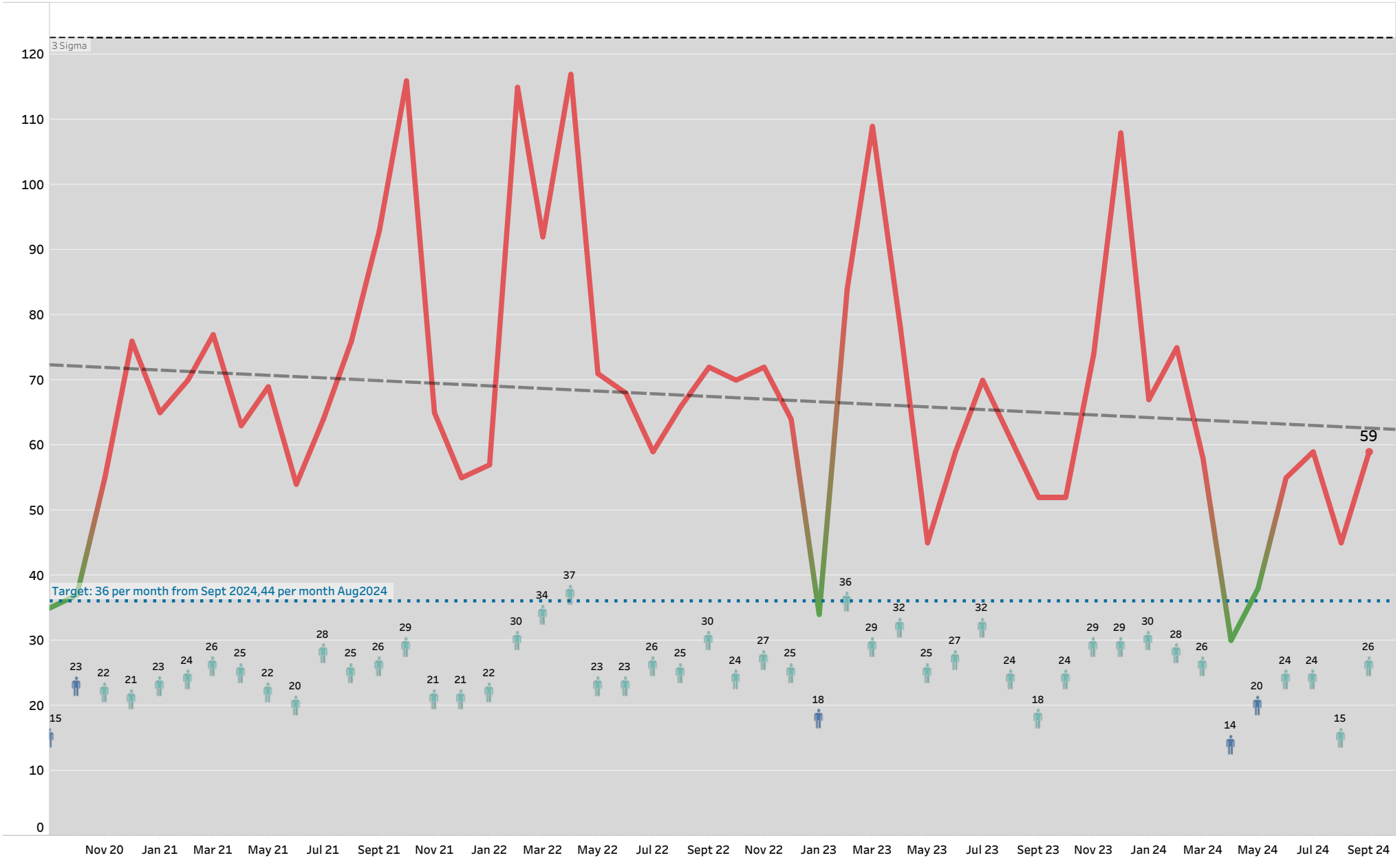
Patient Experience- Breakthrough Objective: Bed days occupied by patients who are discharge ready Community

(July 2023- June 2024)

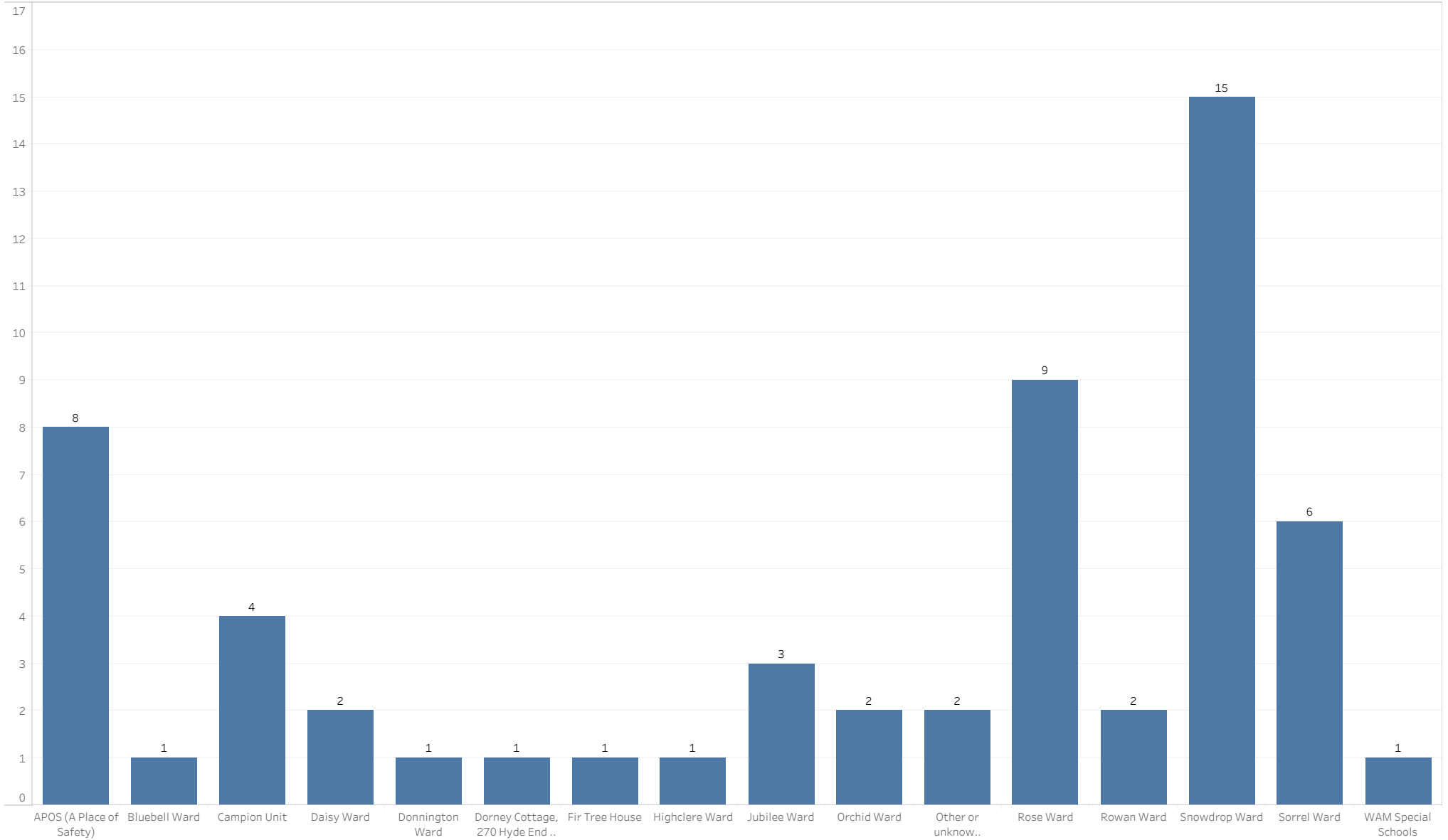
All Community health wards

Supporting Our Staff - Breakthrough Objective :Physical Assaults on Staff (Sept 20 to Sept 24)

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



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



True North Supporting Our Staff Summary

Metric	Threshold / Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Statutory Training: Fire: %	90% compliance	Internal	93.4%	94.0%	93.9%	93.9%	93.5%	93.5%	94.6%	95.5%	95.3%	95.7%	95.5%	95.9%
Statutory Training: Health & Safety: %	90% compliance	Internal	96.5%	96.4%	96.5%	96.4%	96.6%	96.7%	96.9%	97.0%	97.3%	97.3%	97.6%	97.6%
Statutory Training: Manual Handling: %	90% compliance	Internal	93.4%	93.7%	93.0%	93.3%	93.0%	92.2%	93.7%	93.7%	94.3%	94.8%	94.9%	94.2%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.5%	97.6%	97.4%	97.5%	97.1%	96.7%	97.7%	98.2%	98.1%	98.2%	98.4%	98.5%
Sickness Rate: %	<3.5%	External	4.6%	4.6%	4.6%	4.8%	4.1%	3.7%	3.9%	3.8%	3.7%	4.1%	4.1%	

True North Patient Experience

Metric	Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: %	95%	External	99.22	99.20	99.14	99.5	99.40	99.35	98.60	99.37	98.89	98.76	99.31	99.17
Community Health Services: 2 Hour Urgent Community Response %.	80%+	External	88.5%	82.0%	81.8%	82.5%	86.7%	87.7%	86.2%	84.6%	84.7%	88.7%	91.4%	89.2%
Number of Adults on community Health waiting lists by system (BOB)	No Trust Target	External	7240	6880	6819	7039	6596	7095	6936	7231	7432	7102	7409	7786
Number of Adult on community Health waiting lists by system (Frimley)	No Trust Target	External	7006	6086	5962	5798	5796	5678	6124	6376	6223	5882	6188	6307
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	6026	7034	7359	8412	9349	9827	725	1441	2116	2314	4560	4723
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	100	100	100	100	100	100	100	100	100	99.59	100	100
Number of Patients not seen on RTT waiting over 52 weeks	0	External	0	0	1	1	0	1	0	1	0	0	0	0
Number of Patients not seen on RTT waiting over 65+ weeks	0	External	0	0	1	1	0	1	0	1	0	0	0	0
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): %	95% seen	External	99.07	95.93	97.79	95.18	99.53	97.03	98.21	71	98.92	96.20	96.39	98.40

True North Patient Experience

Metric	Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	28	24	29	26	31	26	23	15	19	27	28	38
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	84.6%	86.5%	89.2%	81.6%	91.4%	86.1%	80.2%	86.6%	85.8%	96.6%	94.6%	90.2%
Number of CYP (0-17 years) on Community Health waiting lists by system Frimley (YTD)	No Trust Target	External	2317	2304	2201	2284	2165	2244	2206	2359	2347	2113	2081	2149
Number of CYP (0-17 years) on Community Health waiting lists by system BOB (YTD)	No Trust Target	External	1681	1763	1573	1531	1351	1374	1281	1370	1433	1305	1241	1351
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	Internal	100%	100%	50%	50%	100%	100%	40%	50%	100%	100%	60%	100%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	Internal	100%	100%	100%	87.5%	85.7%	60%	100%	90.9%	66.7%	80%	100%	100%
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	4618	4757	4859	5011	5167	5318	5481	5645	5808	6071	6221	6370
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	6584	6802	6962	7191	7385	7587	7801	8030	8234	8478	8638	8821
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	2573	2665	2732	2824	2881	2954	3025	3112	3179	3279	3339	3430
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	1755	1828	1860	1927	1977	2037	2087	2156	2194	2263	2327	2385

True North Patient Experience

Metric	Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Talking Therapies Referral to Treatment 75% within 6 weeks BOB	75%	External	86%	89%	86%	88%	90%	93%	99%	91%	91%	88%	87%	90%
Talking Therapies Referral to Treatment 75% within 6 weeks Frimley	75%	External	90%	89%	91%	88%	92%	90%	90%	91%	93%	87%	87%	90%
Talking Therapies Referral to Treatment 95% within 18 weeks BOB	95%	External	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%
Talking Therapies Referral to Treatment 95% within 18 weeks Frimley	95%	External	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%
Numbers of OA receiving a course of treatment (2+ contacts) as a % of total BOB	0.06	External							5.7%	6.5%	7.0%	7.0%	7.0%	7.7%
Numbers of OA receiving a course of treat (2+ contacts) as a % of total Frimley	0.07	External							9%	5.7%	6.2%	10%	7.7%	6.7%
Talking Therapies Overall receiving a course of treatment (2+ contacts) BOB	0.6	External								61%	64%	63%	64%	61%
Talking Therapies Overall receiving a course of treatment (2+ contacts) Frimley	0.6	External								56%	61%	55%	60%	56%

True North Patient Experience

Metric	Proposed Target..	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Talking Therapies Recovery rates BOB	50%	External	42%	49%	49.39%	49%	44%	49.5%	50%	52.80%	46%	53%	52.5%	51.60%
Talking Therapies Recovery rates Frimley	50%	External	45%	41%	47.39%	48%	44%	47%	45%	51%	47%	50%	51.39%	54.40%
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67%	External							59%	63.80%	65%	62%	65.40%	69%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67%	External							64%	62.79%	63%	64%	64.5%	69%
Talking Therapies Reliable Recovery for those completing a course of treatment Frimley	48%	External							43%	45.5%	44%	47%	51.39%	52%
Talking Therapies Reliable Recovery for those completing a course of treatment BOB	48%	External							46%	48.5%	46%	49%	48.19%	48%
Talking Therapies In treatment pathway waits 90 day for 2nd Appointment Frimley	<10%	External	13%	11.7%	12.8%	11%	9.80%	11.5%	15.2%	16.1%	18.6%	20%	14.7%	18.5%
Talking Therapies in treatment pathway waits 90 day for 2nd Appointment BOB	<10%	External	17%	15.6%	17.8%	22%	18.1%	16.1%	16.4%	15.9%	15.1%	18%	19.4%	20%

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	81.82	100	80	85.70	100	100	100	100	100	83	100	100
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 BOB Target 7860	External	5677	5871	6028	6227	6445	6700	6903	7869	8076	8370	8569	8799
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	4529	4740	4852	5014	5162	5349	5509	6172	6325	6508	6676	6834
Access to Perinatal Services- Assessments Frimley	7.5% live birth rate - 409 Oct 23 439 March 2023. 37 per Month	External	30	37	25	40	23	22	20	22	32	34	25	23
Access to Perinatal Services - Assessments BOB	10% live birth rate - 611 per annum 51 per month	External	31	43	43	39	44	30	44	30	38	50	27	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	87%	90%	91%	91%	92%	96%	90%	93%	94%	95%	94%	90%
Mixed Sex Breaches on Ward	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Patient on Patient Assaults (MH Inpatients)	25 per month	Internal	8	10	14	9	14	18	17	14	10	10	5	8
Estimated Diagnosis rate for Dementia Frimley	66.67%	External	64.48%	64.71%	65.25%	65.56%	64.88%	64.98%	66.10%	66.14%	66.53%	68%	68%	66.71%
Estimated Diagnosis rate for Dementia BOB	66.67%	External	64.20%	64.29%	64.54%	64.39%	64.54%	64.12%	64.60%	65.60%	65.36%	64.92%	64.90%	64.90%

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24
Mental Health: AWOLs on MHA Section	10 per month	Internal	5	2	3	6	7	3	5	7	5	7	7	9
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	7	0	0	1	1	1	1	1	1	1	1	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	1.42	1.40	0	3.03	3.37	4	0	0	0	3.45	5.25	3.83
Pressure Ulcer with Learning	Tbc	Internal	4	4	1	0	3	2	2	4	1	4	0	0
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	89.1%	86.9%	86.2%	95.1%	100%	86.0%	91.5%	93.1%	94.1%	91.0%	91.4%	100%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	Internal	53	28	17	26	41	73	79	66	63	64	46	71
Self-Harm Incidents within the Community	31 per month	Internal	18	21	9	21	35	30	28	29	10	10	7	17
Gram Negative Bacteraemia	No Trust target	External	0	1	0	1	0	0	0	0	0	0	0	0
E-Coli Number of Cases identified	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External	1	0	1	1	1	1	1	0	0	1	0	0
C.Diff with learning (Cumulative YTD)	0	External	0	0	0	0	0	0	0	0	1	1	1	0
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	0	External	0	0	0	0	0	0	0	0	0	0	0	0
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias (YTD)	0	External	1	1	1	1	1	1	0	0	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 ytd	0	External	0	0	0	0	0	1	1	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	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24
Community Inpatient Occupancy	85%	Internal	88.0%	92.9%	87.7%	89.2%	89.4%	90.3%	90.6%	91.8%	91.6%	88.8%	86.9%	92.4%
Community Inpatient Average Length of Stay (bed days)	<21 days	Internal	23.6	28.8	37.3	24.5	28.1	26.5	33.3	25.8	26.2	21.7	24.5	24.7
Mental Health: Adult Acute LOS over 60 days % of total discharges	TBC	External	24%	24%	30%	28.9%	30%	34%	31%	28.0%	28.0%	33%	35.1%	24.3%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges	TBC	External	42%	42%	66%	57.9%	55.0%	52%	59%	63%	63%	50%	41.6%	55.5%
DNA Rate: %	5% DNAs	Internal	4.88%	5.05%	4.76%	4.70%	4.66%	4.66%	4.70%	5.26%	4.79%	4.83%	4.97%	4.96%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	97.2%	93.6%	93.8%	95.9%	98.5%	99.4%	98.5%	97.7%	97.1%	97.3%	99.2%	96.8%
Mental Health: Acute Average Length of Stay (bed days)	30 days	Internal	43.2	56.6	45.1	72.6	41.7	36.4	60.6	58.7	47.2	49.6	58.8	46.1
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	90.82%	87.18%	77.85%	72.48%	79.31%	84.04%	95.34%	82.42%	81.71%	83.87%	88.40%	90.10%
Community Virtual Ward Occupancy Frimley	80%	External	51.20%	49.79%	46%	56.59%	46.40%	54%	42.19%	50.60%	52.5%	57.59%	51.30%	61.29%
Community Virtual Ward Occupancy BOB	80%	External	78.5%	74.20%	91.60%	95.5%	82.39%	75.79%	88.90%	91.90%	94.79%	82.59%	87.90%	79.40%
Agency Spend within Ceiling	3.2%	External							2.70%	3%	2.19%	3.10%	3.20%	2.90%
Elective Recovery Performance vs Target	11,614	External							12238	11898	12179	13710	11888	12951

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	November 12th 2024
Title	**Estates strategy update 2024**
	Noting
Reason for the Report going to the Trust Board	Annual update
Business Area	Business, Finance & Strategy
Author	Paul Gray, Chief Finance Officer Martin Mannix, Director of Estates & Facilities
Relevant Strategic Objectives	**This report provides updates on progress within Estates and Facilities towards the achievement of the current Estates strategy. The report also includes a forward look to future projects focusing on enhancing patient safety and experience, making BHFT a great place to work, sustainability and efficient use of resources.**
Summary (only required if the report does not contain a highlight report or an executive summary)	**This report highlights:** • Achievements over the last 12 months • Progress with Jubilee Ward • Prospect Park environmental risk actions • Future plans for development of the estate

NHS
Berkshire Healthcare
NHS Foundation Trust

Estates update 2024 - 2025

Working together,
we can be
outstanding
for everyone

Agenda

Berkshire Healthcare NHS Foundation Trust

- Regional / National context
- The Estate's performance
    - Achievements
    - Compliance
    - Condition
    - Budget
- Risks & opportunities
- NHSPS
- PFIs
- Estates Strategy and forward look

Regional / National Context

Berkshire Healthcare NHS Foundation Trust

- Inflation - 2024 RPI (April) 13.5%

- 2024 ERIC data

- The total costs of running the NHS estate were £13.6 billion
- The total energy usage from all energy sources across the NHS estate was 11.1 billion kWh.
- The total cost to eradicate High and significant risk backlog was £13.8 billion (increase of circa £2b since last year and excluding professional fees, VAT & NHS properties).
- The total cost for cleaning services was £1.5 billion.
- The total cost of providing inpatient food was £0.8 billion.

- Grenfell enquiry – publication of phase 2 – impact on Government, regulators and the Trust
- Darci Report – left shift has become a right shift

- Regionally – both ICS struggling financially and both Frimley and Royal Berks have major problems requiring new sites and rebuilds, increasing pressure to find collaborative system solutions.

Achievements

Berkshire Healthcare NHS Foundation Trust

- PLACE results (see separate slide)
- MEA revaluation (Circa £1m revenue recurring)
- Maple House completion
- Salix Grant (£2.6m)
- Jubilee ward
- Prospect Park – Asset surveys and reset plan, DHSC sponsorship, ISS & PHR restructures and additional resources
- Listening in action activities – Staff welfare / security / confidentiality / comms improvements
- Staff Survey 2023 - 81.5% engagement
- Sickness rates below Trust average (2.3% Vs 4.14 – June 2024)

PLACE

Berkshire Healthcare NHS Foundation Trust

BHFT - for all indicators

- Remain above national and regional averages for all Trusts.
- 1st and 2nd of MH Trusts regionally in all indicators
- 2nd of MH Trusts for cleaning

- BHFT - Absolute performance

- 2nd Highest average score MHTs regionally (6 organisations).
- 6th highest average score all MH Trusts nationally (42).
- 25th highest average score all Trusts nationally (236).

BHFT – Site specific

- All sites significantly above national

	Ranking comparison		
	MHTs regional	MHTs national	All Trusts
Cleaning	1	2	Joint 2nd
Food	1	4	53
Privacy & Dignity	2	6	20
Condition	2	8	45
Dementia	2	7	24
Disability	2	10	7
No of Trusts	6	42	236

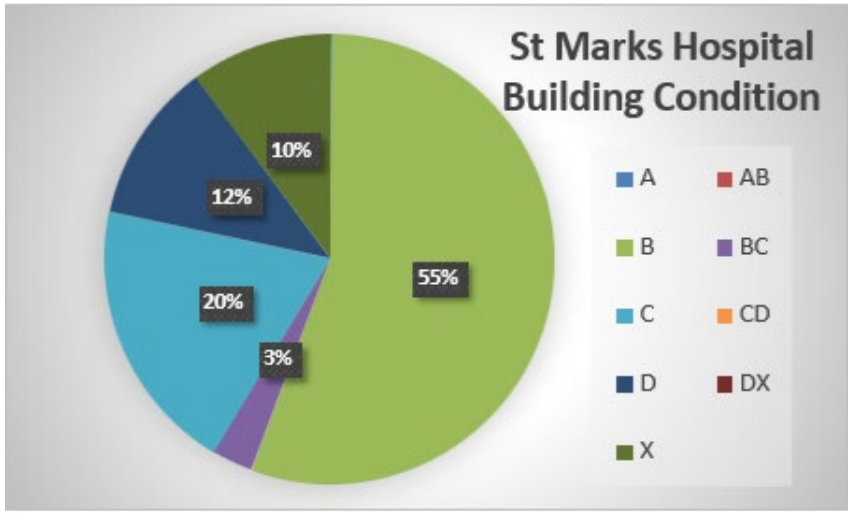
Berkshire Healthcare NHS Foundation Trust

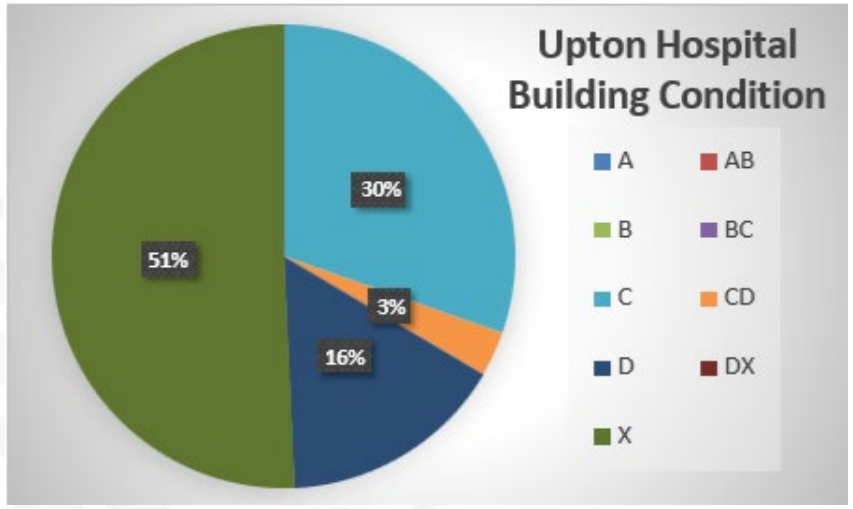
Compliance

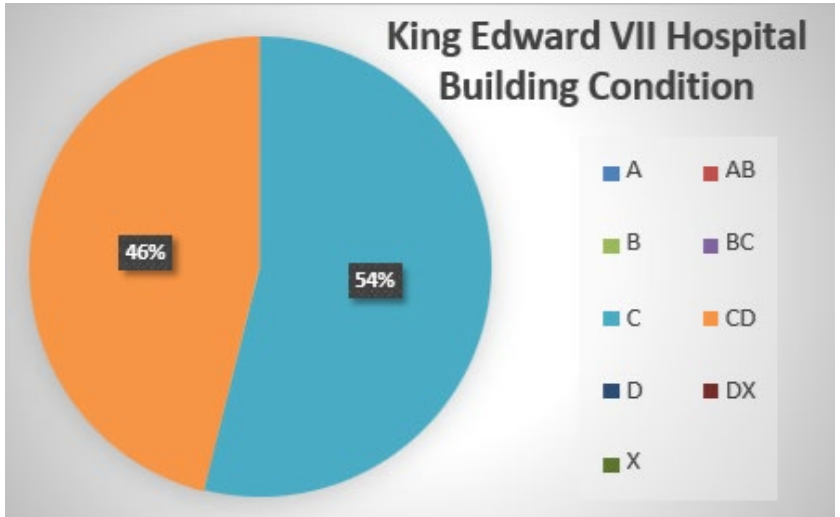
EFM Key Metrics					
Metric	***Target***	***Aug***	***Rolling year Ave***	***vs Jul***	***Note***
'Statutory' Pre-planned Maintenance complete (BHFT sites)	95%	100%	99%	↑1pt	
Reactive requests attended in response time (BHFT sites)	95%	100%	98%	↑10pts	
Fire risk assessments and audits completed	95%	100%	100%	—	
Compliancy performance for BHFT sites	95%	99%	95%	↑2pts	
Compliancy performance for NHSPS properties	97%	100%	92%	—	
Compliancy performance for PFIs	97%	99%	93%	↑ 4pts	WBCH 100% PPH 98%
Cleaning audit score BHFT sites	95%	99%	98%	↑ 2pts	
Cleaning audit score NHSPS	95%	99%	98%	—	
Cleaning audit score PFIs	95%	96%	97%	↓2pts	WBCH 95% PPH 97%
Overall NHSPS performance audit score	■	■	n/a		

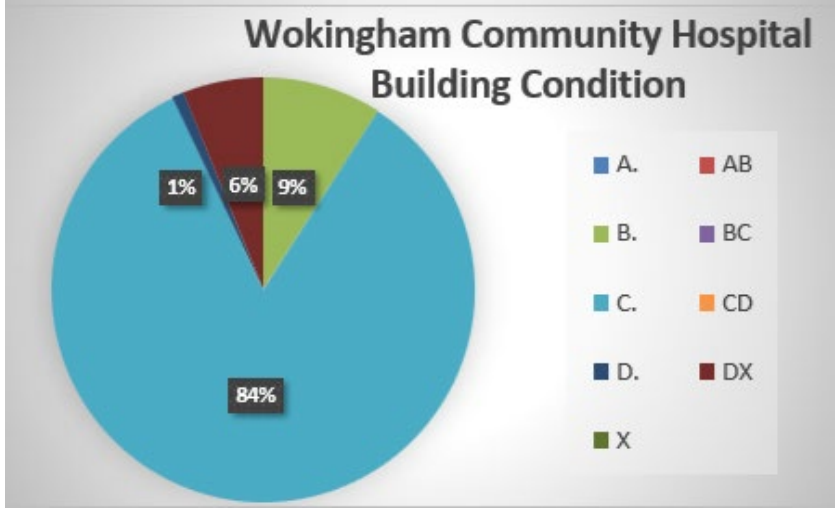
Condition – community hospitals

Berkshire Healthcare NHS Foundation Trust









Risks and opportunities

Berkshire Healthcare NHS Foundation Trust

Key risks

- Prospect Park environment
- Jubilee
- Ligature risks
- Place of Safety
- Relocation of services

Key Opportunities

- Rightsizing of the estate and adapting to recent clinical changes
- Disposal of lower quality sites
- Derisking our sites
- Sustainability initiatives

Sustainability

Berkshire Healthcare NHS Foundation Trust

- Successful Salix bid £2.6M
- Roof Solar installations at Erlegh House and Churchill House completed
- Additional site EV charging points
- EV vans
- Heat Decarbonisation survey completed
- Sustainability checklist

NHS Property Services

Berkshire Healthcare NHS Foundation Trust

Progress

- Turnaround plan initiated in late 2023 has been largely completed
- Relationship and NHSPS corporate support has improved since last year, more strategic relationship developing
- NHSP compliance rates have also improved

Issues

- Sufficient experienced staff
- Property investment
- NHSPS national contracts / processes
- BTA / market rates

ICS updates

Berkshire Healthcare NHS Foundation Trust

Frimley ICS

- Integrated Care Hubs
- Only Bracknell going ahead with construction, planning permission applied for, size insufficient to meet original requirements.
- A small amount of work will be undertaken at King Edwards
- The land for a future Sunningdale option is being considered for purchase
- Slough CDC is going ahead. Demolition completed in August, completion now expected to be around May 2025
- ICS estates infrastructure strategy was completed

BOB ICS

- ICS Efficiency programme resources removed, programme stalled
- ICS estates strategy being developed using internal ICS resource
- Bath Road identified as location for BHFT consolidation in Reading, subject to ICB relocating their staff to another part of the building

PFIs – Prospect Park

Berkshire Healthcare NHS Foundation Trust

- Asset surveys agreed (deed to be signed by all parties)
  - Fire survey begun
  - Condition survey appointed
  - Mental Health Survey (DHSC sponsored) – specification being completed
- IPA Healthcheck completed
- Contract Reset agreed (deed to be completed and signed by all parties)
  - 20 workstreams covering all aspects of the contract – effectively a remobilisation of the contract
- Restructuring of PHR &ISS mgmt. teams and additional resources brought in to support the services
- Place of Safety - Expect work on site to commence November 5th for completion end March 2025
- Benchmarking – Paused pending successful contract reset

PFIs – West Berkshire Community Hospital

Berkshire Healthcare NHS Foundation Trust

- RBH MRI scanner
    - Inhealth pulled out of contract. RBH now engaging Phillips to deliver the project. BHFT supporting as necessary
- RBH CDC
    - Works agreed and underway
- RBH & BHFT continue to work on maximising the patient Experience and utilisation at WBCH
- RBH Neurorehab service – remains in part of Highclear ward. Discussions with RBH regarding a system solution for this service
- Sustainability – successful bid for a Salix grant of £2.6m to replace the site's gas boilers with Air Source heat pumps
- Funding for an additional solar farm proposal for the field being investigated.
- Dementia Hub proposal – discussions with Age UK regarding potential dementia hub development on the field continue

Estates Strategy 2025 - 2030

Berkshire Healthcare NHS Foundation Trust

- New strategy approved as QMIS project end June 2023
- 6 workstreams:
  - 1 - Identification of E&F costs associated with each service
  - 2 – space utilisation
  - 3 – space management – review of policies and governance affecting use of space
  - 4 – Transformation of operational services
  - 5 – sustainability
  - 6 – Writing the strategy

- 3 stages:
- Where we are – up to Mar 2024
- Where we want to be – up to July 2024
- How we get there – up to Dec 2024

Key projects 2025 – 2030 - ICH

Berkshire Healthcare NHS Foundation Trust

Key events	When (indicative)
Upton - Birch house vacation - to chalvey, we expect to be at birch until january 25	Jan-25
Chalvey opens - with podiatary and outpatients from Upton	Jan-25
Bracknell ICH opens with MSK from Skimped hill and Churchill house, plus district nurses from Churchill house and Great Hollands)	Aug-25
Great hollands closes	Sep-25
Skimped hill becomes admin block plus dental (plus 4th dental survery), sexual health and hearing &balance	Sep-25
Churchill house (space review with Mental Health services after ICH opens) - potentially a mental health centre of excellence	Oct 25 onwards

Key projects 2025 – 2030 - Consolidation

Berkshire Healthcare NHS Foundation Trust

Key events	When (indicative)
Dellwood handback	Nov-24
Bath Road MSK moves to permanent location (Project phases 1 - 3)	May-25
Bath Road (Phase 4-7) - adaptations for Cremyll road complete, Cremyll staff relocated	Jul-25
Cremyll road closes	est Aug/ sept 25
Bath Road (phase 8) - construction of additional clinical rooms to accommodate coley clinic and southcote (subject to suitable space idfentified at Bath road	Mar /May 26
Southcote closes	est July 26
Coley clinic - conversion to staff studios (subject to sufficient funding	After Aug 26

Key projects 2025 – 2030 – Prospect Park

Berkshire Healthcare NHS Foundation Trust

Key events	When (indicative)
Prospect Park new POS opens	May-25
PPH - contract reset	Dec-25
PPH - asset surveys	approx July 26
PPH - asset survey remedial works	July 27 (except complex works)
PPH - Oakwood MH / neurorehab?	TBD

Key projects 2025 – 2030 – West Berks CH

Berkshire Healthcare NHS Foundation Trust

Key events	When (indicative)
West Berks - air source Heat Pumps	Mid 2027
West Berks - Cladding	TBD
West Berks - RBH MRI projects	TBD
West Berks - solar farm	TBD
West Berks - Neurorehab?	TBD
West Berks - Dementia hub	TBD

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 November 2024
Title	**Audit Committee Meeting – 30 October 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, 30 October 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 Rebecca Clegg, Director of Finance Graham Harrison. Head of Financial Services Debbie Fulton, Director of Nursing and Therapies Dr Nav Sodhi, Associate Medical Director *(deputising for Dr Minoo Irani, Medical Director)* Clive Makombera, RSUM, Internal Auditors Loreta Valskyte, RSM, Internal Auditors David Kenealy, TIAA *(deputising for Jenny Loganathan, TIAA)* Ben Lazarus, Ernst and Young, External Auditors Alison Kennett, Ernst and Young, External Auditors Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Dr Minoo Irani, Medical Director, Amanda Mollett, Head of Clinical Effectiveness and Audit and Jenny Loganathan, TIAA.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 24 July 2024**	

	The Minutes of the meeting held on 24 July 2024 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.A	**Board Assurance Framework**	
	The latest Board Assurance Framework (BAF) had been circulated. The Chief Financial Officer presented the paper and highlighted the following points: • **BAF Risk 1 (Workforce)** – the risk had been updated to align with the areas of focus set out in the new People Strategy: attracting a diverse and talented workforce, supporting the development of staff, retaining staff and promoting a culture of continuous learning and improvement • **BAF Risk 2 (Demand and Capacity)** – a new referral process for Children and Young People Neurodiversity services had been implemented to ensure that Children and Young People received the appropriate intervention and support. The tender process for the 18-bed mental health inpatient beds contract had concluded and the Trust had moved into the mobilisation phase. • **BAF Risk 4 (System Working)** – the Trust was represented on the Building Berkshire Together Programme Board (the Royal Berkshire NHS Foundation Trust's new hospital programme) • **Risk 6 (Finance)** – the risk had been updated to include PwC's review into the drivers and potential short-term remedies to return the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System to plan. Naomi Coxwell, Non-Executive Director referred to BAF Risk 2 (Demand and Capacity) and asked whether the risk had been updated to reflect the recommendations set out in the Internal Auditors review of mental health adult acute admissions. The Chief Financial Officer said that the Board Assurance Framework had been updated prior to the issuing of the mental health adult acute admissions report. The Chief Financial Officer agreed that it would be helpful to include the actions from the mental health adult acute admissions review when the risk was next updated. The Committee noted the report.	**PG/TA**
5.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)** – the Trust was continuing with work to replace all patient toilets at Prospect Park Hospital to an anti-ligature version. • **CRR 7 (Physical Environment – Prospect Park Hospital)** – the Trust was working with the Prospect Park Hospital PFI provider to develop a contract reset plan. • **CRR 8 (Jubilee Ward)** – Frimley Integrated Care Board had started the engagement process on the re-provision of the Jubilee ward. The Chair referred to CRR 11 (Fraud) and asked whether the target date of January 2024 should read January 2025. The Chief Financial Officer confirmed that this was a typing error, and the correct date was January 2025. Naomi Coxwell, Non-Executive Director referred to CRR 12 (Violence and Aggression) and asked whether the risk should be updated to reflect the new legislation on sexual harassment in the workplace. The Director of Nursing and Therapies pointed out that the risk had been updated prior to the legislation coming into force on 26 October 2024 and agreed to make reference to the new legislation when the risk was next updated. The Director of Nursing and Therapies added that the sexual harassment in the workforce legislation was reflected in the Trust's Sexual Safety Charter work. The Committee noted the report.	**DF**
6.	**Single Waiver Tenders and Provider Selection Regime Direct Awards Report**	
	A paper setting out the Trust's single waivers approved from July 2024 to September 2024 had been circulated. The Chief Financial Officer presented the paper and pointed out that the high value single waiver was for a two-month extension to the current contract for parenteral nutrition and was to allow for the completion of the tender process for a new contract. It was noted that the Trust ran the procurement process on behalf of the Southeast Pharmacy Procurement Service. The Chief Financial Officer said that the high value direct award contract related to the Anxiety and Depression in Young People Clinic ran by the University of Reading. The Committee noted the report.	
7.	**Bank Mandate and User Roles Report**	
	The Chief Financial Officer presented the paper and reported that an internal review of Accounts Payable in 2023 had made a recommendation for a report to be presented annually to the Audit Committee to provide members with the details of the Trust Bank Account Mandates (signatories) and to confirm the	

	detail of the roles and responsibilities of users of the Bankline online banking portal operated by NatWest. The Chair asked Clive Makombera, Internal Auditors whether the number of bank signatories was in line with their other clients. Clive Makombera, Internal Auditors said that the number of bank signatories was not out of line but said producing the Bank Mandate and User Roles Report annually meant that the Audit Committee had an opportunity to keep this under review. The Chief Financial Officer also pointed out that the Trust had a number of part time staff and therefore there needed to be more signatories. The Head of Financial Services added that staff were signatories on a rota basis. t was also noted that executive directors were included as signatories as part of the Trust's Business Continuity arrangements but would only be expected to be a signatory as a last resort. 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 six indicators were audited during the quarter: o Diabetes - Referral to treatment waiting times - Community: incomplete pathways (how many within 18 weeks) %: (Green for Data Assurance and Amber for Data Quality o Community Consultant Paediatrics - Referral to treatment waiting times -Community: incomplete pathways (how many within 18 weeks) %: (Green for Data Assurance and Amber for Data Quality) o Number of Patients not seen on Referral to Treatment waiting over 52 weeks: (Green for Data Assurance and Amber for Data Quality) o Number of Patients not seen on Referral to treatment waiting over 65+ weeks: (Green for Data Assurance and Amber for Data Quality) o Mental Health: Readmission rate within 28 days (Green for Data Assurance and Amber for Data Quality) o Physical Assaults on Staff: (Green for Data Assurance and Amber for Data Quality) • Corrective actions and improvements were in progress for the relevant indicators. The Chief Financial Officer reported that in most cases, the issues around data quality were due to human error. The Chief Financial Officer referred to the Community Diabetes Referral to Treatment Target and pointed out that the audit had identified discrepancies in relation to the date referrals were received and when the referral was recorded. It was noted that patients were seen within the nationally prescribed 18-week referral to treatment target.	

	The Chief Financial Officer said that normally indicators were received annually but given the volume of inaccuracies in the referral to treatment indicators, he had requested that the audits were re-done in six months' time. The Chair referred to the commentary in relation to the Mental Health: Readmission rate within 28 days which referred to a patient being discharged in error and asked whether this comment related to a recording error on the system or whether a patient had been discharged in error. The Director of Nursing and Therapies clarified that the comment related to a reporting error. The Chair suggested that it would be useful to have a discussion at a future Trust Board Discursive meeting around whether there was scope for digital processes to be used to reduce human error and to improve data quality. The Committee noted the report.	**PG** **TA/MD**
9.	**Losses and Special Payments Report**	
	The Losses and Special Payments Report covering quarters 1 and 2 had been circulated. Mark Day, Non-Executive Director referred to a settlement payment for a personal injury claim in respect of an employee and asked if the Executive Team was confident that actions had been taken to address the issues. The Director of Nursing and Therapies confirmed that the case had gone through a number of review processes and actions been identified and implemented along with the learning from the case. The Committee noted the report.	
10.	**Clinical Claims and Litigation Report**	
	The Director of Nursing and Therapies presented the paper and reported that during quarter 2 there were seven new litigation claims (four were made under clinical negligence and three were compensation claims under legal obligation. The Committee noted the report.	
11.	**Clinical Audit Report**	
	The Clinical Audit Report had been circulated. It was noted that: • At present there were14 projects planned to data collect, and 16 projects due to be published in 2024/25. • In July 2024 we reported 10 open action plans as being carried forwards into 2024/2025. 4 have been subsequently closed by the	

	Clinical Effectiveness Group and the remaining 6 are being monitored by the Clinical Effectiveness Group • The National Respiratory Audit Programme – State of nation report results will be presented to the November 2024 Quality Assurance Committee meeting. • Clinical Audits in the Trust remained on track for completion. The Committee noted the report.	
12.	**Trust Policies – Trust Standing Financial Instructions, Reservation of Powers to the Board and Delegation of Powers and Application of Financial Limits to the Scheme of Delegation**	
	The Chief Financial Officer presented the paper and reported that the following policies were reviewed and updated every two years. The proposed amendments were highlighted in red and related to changes in legislation, policy and guidance: • Trust Standing Financial Instructions • Reservation of Powers to the Board and Delegation of Powers • Application of Financial Limits to the Scheme of Delegation The Chief Financial Officer referred to the Reservation of Powers to the Board of Delegation of Powers Policy and pointed out that policy had been further amended to include the Deputy Chief Executive. The Chair referred to the Reservation of Powers to the Board and Delegation of Powers Policy (page 215 of the agenda pack) which referred to a "Requisitioning Officer" and asked whether the Trust had such a person in post. The Head of Financial Services explained that the term "Requisitioning Officer" referred to the person, usually an administrator who had made the original requisition to order the goods. Subject to the additional change to the Reservation of Powers to the Board and Delegation of Powers Policy to include the role of the Deputy Chief Executive, the Committee approved the changes to the Trust Standing Financial Instructions, Reservation of Powers to the Board and Delegation of Powers and Application of Financial Limits to the Scheme of Delegation policies.	**RC**
13.	**Anti-Crime Specialist Report**	
	David Kenealy, Anti-Crime Specialist, TIAA presented the report and highlighted the following points: • TIAA had run a number of training and awareness sessions for Trust staff with high levels of attendance • The NHS Counter Fraud Agency Procurement Benchmarking Exercise was in progress and was on target to meet the deadline for completion (8 November 2024). The NHS Counter Fraud Agency would be publishing a benchmarking report based on the data in due course. • The National Fraud Initiative Exercise 2024-25 data privacy notice compliance was completed in May 2204 and a payroll message was	

	included in the August payslips for staff. The National Fraud Initiative 2024-25 data extraction would be completed in October 2204 and the data matches would be made available in February 2025. Any matches requiring further investigation would be dealt with in the normal way by TIAA. • TIAA had identified an increasing trend in the use of fake QR codes. TIAA had issued a Fraud Alert warning of the risks around using QR codes. • Across the public sector there had been a significant drop in the number of referrals and investigations opened by TIAA compared with the previous two years. Mark Day, Non-Executive Director commented that the drop in the number of referrals and investigations compared with the previous two years could reflect different ways of working due to the pandemic. **The Committee**: noted the report.	
14.	**Internal Audit Progress Report**	
	a) Internal Audit Progress Report Loreta, Valskyte, Internal Auditors, RSM presented the paper and highlighted the following points: • There was good progress against the Annual Audit Plan 2025. Since the last meeting four final reports had been issued: o Mental Health Acute Admissions (partial assurance) o Healthcare Financial Management Association (HFMA) Follow Up – Finance/Culture/Training (reasonable assurance) o Raising Concerns (reasonable assurance) o Mortality (substantial assurance) • The two remaining reviews were underway – Key Financial Controls and Risk Management • There was only one overdue action relating to the Out of Area – Long Term Placements review and this was in the process of being implemented. The Director of Nursing and Therapies noted that the Raising Concerns review and commented that the review had made two low priority recommendations around continuing to raise staff awareness regarding the Freedom to Speak Up process and a timescale to be put in place from when the Freedom to Speak Up Guardian gained all the information and then passed the information to the right teams/personnel to address the concern. The Director of Nursing and Therapies queried why the assurance level was “reasonable” rather than “substantial”. Mark Day, Non-Executive Director Lead for Speaking Up reported that he met regularly with the Freedom to Speak Up Guardian and pointed out that this action was around maintaining what was already in place rather than a fresh action. Clive Makombera, Internal Auditors, RSM agreed to discuss the Raising Concerns review report with the Director of Nursing and Therapies and to review the assurance level.	**CM**

	The Chair referred to the Mental Health Acute Admissions review which had identified two high priority actions and queried whether the implementation date for the two actions should be brought forward from 28 February 2025. Clive Makombera said that the implementation dates were agreed with the relevant executive director and said that RSM would request that the Trust provide a progress update in relation to the tow high priority actions to give the Committee line of sight on progress being made to implement the two actions which would be included in the Internal Audit Progress Report. **b) Information Reports** The following information Reports had also been circulated: • NHS News Briefing • Healthcare Benchmarking Report • Risk Radar Report • Global Internal Audit Standards • Internal Audit Code of Practice The Chair commented that the Healthcare Benchmarking Report was particularly helpful. The Committee: a) Noted the Internal Audit Progress Report b) Noted the information reports	**CM**
15.	**External Audit Report**	
	Ben Lazarus, External Auditors, Ernst and Young (E&Y) reported that E&Y were in the planning stage for next year's audit and would present the action plan at the next Audit Committee meeting. **Berkshire Healthcare Charity's Annual Report and Accounts 2023-24** The Berkshire Healthcare Charity's Annual Report and Accounts 2023-24 and draft Management Representation Letter had been circulated. Ben Lazarus reported that E&Y had undertaken an independent review of the Trust's Charitable Funds and there were no issues of significance. The Charity's Annual Report and Accounts 2023-24 would be presented to the Trust's Corporate Trustees for approval on 12 November 2024. The Chair noted that the Trust charged the Charity £15,000 for account preparation and asked what this included. The Head of Financial Services explained that this covered the transactional costs associated with the Charity and the cost of the Finance team preparing the accounts and annual report. It was noted that the £15,000 cost had remained the same for a number of years. Mark Day, Chair of the Charitable Funds Committee said that the Head of Financial Services and his team provided a lot of support to the Committee during the year in addition to preparing the Charities annual report and accounts.	**BL**

	The Committee approved the Berkshire Charity's Annual Report and Accounts 2023-24 which would be submitted to the Corporate Trustees meeting on 12 November 2024 for final approval.	**JH**
16.	**Minutes of the Finance, Investment and Performance Committee meeting held on 24 July 2024**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 24 July received and noted. The Committee noted the minutes.	
17.	**Minutes of the Quality Assurance Committee held on 27 August 2024**	
	The minutes of the Quality Assurance Committee meetings held on 27 August 2024 were received and noted.	
18.	**Minutes of the Quality Executive Committee Minutes – 15 July 2024, 19 August 2024 and 16 September 2024**	
	The minutes of the Quality Executive Committee meetings held on: 15 July 2024, 19 August 2024 and 16 September 2024 and were received and noted.	
19.	**Board Sub-Committees Annual Review of Effectiveness and Terms of Reference Review**	
	The results of the Finance, Investment and Performance Committee and Quality Assurance Committee's annual reviews of effectiveness had been circulated for assurance. The Company Secretary confirmed that the outcome of both Committee's annual reviews of effectiveness was very positive and there were no issues to highlight. The Committee noted the report.	
20.	**Annual Work Plan**	
	The draft Annual Audit Committee Report to the Council of Governors had been circulated. The Company Secretary reported that she would update the report to include the salient points from today's meeting. The Committee's Annual Work Plan was noted.	
21.	**Any Other Business**	
	There was no other business.	
22.	**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 30 October 2024.

Signed: - _____

Date: - **22 January 2025** _____

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 November 2024
Title	**Approval of:** • **Standing Financial Instructions** • **Reservation of Powers to the Board and Delegation of Powers** • **Scheme of Delegation**
	For approval
Reason for the Report going to the Trust Board	Regular review of documentation which requires Board approval following approval by the October 2024 Audit Committee.
Business Area	Governance/Financial Governance
Author	Policy requirement and recommendation from Audit Committee.
Relevant Strategic Objectives	The SFIs and the scheme of delegation outline the governance and controls required to ensure that the Trust meetings its statutory requirements in respect of finance, procurement and contracting. The Reservation of Powers to the Board and Delegation of Powers is a broader document outlining how power is delegated from the board across all business areas. **Efficient use of resources**

	Ambition: We will use our resources efficiently and focus investment to increase long term value
Summary	The documents have a regular review scheduled every 2 years. Amendments to the SFIs and Scheme of Delegation are listed in the version control sections of the documents. The Reservation of Powers to the Board and Delegation of Powers has been updated to reflect the content of the SFIs. Versions with all changes tracked are available.

Berkshire Healthcare
NHS Foundation Trust

ORG001b

STANDING FINANCIAL INSTRUCTIONS FOR THE BOARD OF DIRECTORS

Berkshire Healthcare NHS Foundation Trust

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

Re-issued:	**October 2024~~2~~**
Review Date:	**October 2026~~4~~**
Version:	**1~~0~~**

Berkshire Healthcare
NHS Foundation Trust

Policy Number:	**ORG001b**
Title of Policy:	**STANDING FINANCIAL INSTRUCTIONS**
Category:	Organisational
Distribution Areas:	All Departments
Index:	Page 4
Total number of pages:	55
Approved by:	Trust Audit Committee – October 2024~~2~~ ~~to be confirmed~~
Re-issued:	November 2024~~2~~
Review Date:	October 2026~~4~~
Replaces Policy:	Version 11~~9~~
Designated Lead:	Chief Financial Officer
For policy information:	Policy Administration Berkshire Healthcare NHS Foundation Trust London House~~2nd Floor~~ London Road~~Fitzwilliam House~~ ~~Skimped Hill Lane~~ Bracknell RG12 2UT~~1BQ~~ ~~01344 415623~~

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POLICY DEVELOPMENT

ORG001b - Standing Financial Instructions

History:	Version 11: Updated for current legislation, policy and guidance. Minor updates for changes to process e.g. as a result of new technology. Removal of references to SSC. Update where for changes in responsibilities of Directors. Stock section updated in line with current controls. Removal of gender-specific pronouns. Version 10: Updated for current legislation and guidance. Appendix 1 reviewed and updated by Head of Procurement. Section on Approved Suppliers has been deleted as we either go to advert or use a framework. Version 9: Updated for current legislation and guidance. References to Monitor changed to NHS Improvement. References to Director of Finance, Performance & Information, changed to Chief Financial Officer. References to NHS Protect amended to NHS Counter Fraud Authority. Remuneration Committee details amended to Appointments & Remuneration Committee, and amendments to Terms of Reference. Version 8: Updated throughout in line with current legislation and guidance primarily relating to Risk Assessment Framework. Version 7: Updated throughout in line with current legislation and guidance. Section 5 updated to cover Commercial and Government Banking Service ("GBS") Bank Accounts. Sections 5.3.6; 5.4.2; 7.1.2 updated accordingly. Version 6: Minor amendments in line with the implementation of the new Bribery Act. Sections 2.4.3; 2.4.5 and 18.2 updated. Reference to CFSMS removed and replaced with NHS Protect. Version 5: Approved by the Audit Committee on 29th July 2009. Sections updated: 14.2.2 Losses & Special Payments; 2.4.1 Fraud & Corruption; 18.1 Acceptance of Gifts and Appendix 1 Tendering Procedure. Version 4: Approved by the Trust Board March 2008. Version 3: Approved by the Trust Board February 2006.

	Version 2: Reviewed and approved by Trust Board December 2003. Version 1: Approved by Trust Board April 2001
Designated Lead:	Chief Financial Officer
Distributed for comments:	Audit Committee - October 2024~~2~~

INTRODUCTION

The **BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST** (the "Trust") became a Public Benefit Corporation on 1st May 2007 following approval by the Independent Regulator of NHS Foundation Trusts (the office previously known as NHS Improvement, now part of NHS Englandknown as NHS Improvement) pursuant to the National Health Service Act 2006 (the "2006 Act").

The principal place of business of the Trust is at the Trust Headquarters at Berkshire Healthcare NHS Trust, London House, London Road, Bracknell, RG12 2UT.Second and Third Floors, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ.

The Trust is governed by the 2006 Act, its Constitution and Authorisation granted by NHS Improvement (the Regulatory Framework). The functions of the Trust are conferred by the Regulatory Framework. The Regulatory Framework and in particular paragraph 28 of the Constitution requires the Board Directors of the Trust to adopt Standing Orders for the regulation of its proceedings and business, and the Trust incorporates these Standing Financial Instructions as part of the Standing Orders.

The Trust is also required to comply with the NHS Provider Licence (April 2023May 2014); SingleNHS Oversight Framework for NHS providers (June 2022/23); NHS England's Code of Governance for Provider Truststhe NHS Foundation Trust Code of Governance (April 2023July 2014), the Audit Code for NHS Foundation Trusts (December 2016), the NHS Foundation Trust Annual Reporting Manual (FebruaryMay 20242) as updated from time to time, and any other relevant guidance issued by NHS ImprovementEngland or any other relevant body.

These Standing Financial Instructions together with the Standing Orders and the Scheme of Delegation provide a comprehensive business framework for the functions of the Trust and have effect as if they all are incorporated into the Standing Orders. All Executive and non-Executive Directors, and Officers should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law, Regulatory Framework and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

These SFIs identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations. including Trading Units and Shared Services Centres. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. **All financial procedures must be approved by the Chief Financial Officer.**

Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer **MUST BE SOUGHT BEFORE ACTING.** The user of these SFIs should also be familiar with and comply with the provisions of the Trust's Standing Orders (SOs).

Interpretation

Save as otherwise permitted by law, at any meeting of the Board of Directors the Chair~~man~~ shall be the final authority on the interpretation of Standing Financial Instructions (on which the Chair~~man~~ should be advised by the Chief Executive or Chief Financial Officer) and the Chair~~man~~'s decision shall be final and binding except in the case of manifest error.

Wherever a financial limit is stipulated but no value given, reference should be made to the Trust's Financial Limits contained within the Scheme of Delegation, which shall be issued to accompany the Standing Orders and the Standing Financial Instructions. The Board of Directors should periodically review the Financial Limits.

Any expression to which a meaning is given in the National Health Service Act 2006 shall have the same meaning in these instructions and in addition:

"Accounting Officer"
means the Officer responsible for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act. For this Trust it shall be the Chief Executive.

"Audit Committee"
means the Audit Committee established in accordance with the Constitution and SFI 2.1.

"Auditor"
means the auditor as appointed by the Council of Governors in accordance with the Constitution.

"**Authorisation"**
means the Authorisation provided by NHS ~~Improvement~~England.

"Board of Directors"
means the board of directors as constituted in accordance with the Constitution.

"Budget"
means a resource, expressed in financial terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

"Budget Holder"
means the director or Officer with delegated authority to manage finances (Income and Expenditure) for a specific area of the organization.

"Chair~~man~~"
means the person appointed in accordance with the Constitution to ensure that the Board of Directors and Council of Governors successfully discharge their overall responsibilities for the Trust as a whole. The expression "Chair~~man~~" shall be deemed to include the Deputy Chair~~man~~ and any other non-Executive Director appointed if the Chair~~man~~ is absent from the meeting and is otherwise unavailable.

"Chief Executive"
means the chief Executive officer of the Trust appointed in accordance with the Constitution.

"Constitution"
means the Constitution of the Trust as authorised by NHS ~~Improvement.~~ Improvement.

“Council of Governors”
means the Council of Governors as constituted in accordance with the Constitution, which has the same meaning as the Board of Governors in Paragraph 7 to Schedule 7 of the 2006 Act.

“Executive Director”
means a Member of the Board appointed as an executive director in accordance with the Constitution.

"Chief Financial Officer"
means the chief financial officer of the Trust appointed in accordance with the Constitution.

“Financial Limits”
means the financial limits set out in the Scheme of Delegation.

"Funds held on Trust"
means those funds which the Trust holds on its date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.40 of the NHS Act 2006, as amended. Such funds may or may not be charitable.

“Internal Audit”
means the function described in SFI 2.3.

“Member of the Board”
means an Executive Director or Non-Executive Director (including for the avoidance of doubt the Chair~~man~~) or both, as the context requires

“NHS ~~Improvement~~England”
means the Independent ~~-~~Regulator of NHS Foundation Trusts established under section 31 and Schedule 8 of the 2006 Act, previously called “NHS Improvement but part of NHS England from 1 July 2022. ~~-~~

"Nominated Officer"
means an Officer charged with the responsibility for discharging specific tasks within SOs and SFIs.

“Non-Executive Director”
means a Member of the Board appointed as a non- executive director in accordance with the Constitution.

“Officer”
Means an employee of the Trust or any other staff member or person holding a paid appointment or office with the Trust. Any employee shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

“Regulatory Framework”
means the 2006 Act, the Constitution and the Authorisation as authorised by NHS Improvement.

“Scheme of Delegation”
means both the document containing the Reservation of Powers to the Board of Directors and the Scheme of Delegation for The Trust

"SFIs"
means these Standing Financial Instructions and Instructions shall be construed accordingly.

~~**"Shared Services Centre"** (SSC) means those Centre(s) that are designated by the Trust to carry out financial processes and other processes of the Trust and "Shared Services" shall be interpreted accordingly. Financial and other processes delegated to the SSC will be set out in a legally binding Agreement agreed between the Trust and the SS. The Agreement will ensure that adequate arrangements are in place to enable the Chief Executive of the Trust to make the necessary Statement of Internal Control.~~

"SOs"
means the Standing Orders of Directors.

" the 2006 Act"
means the National Health Service Act 2006.

"Tendering Procedure"
means the procedure set out at SO 9 and Appendix 1 in these SFI's.

"Trust"
means the Berkshire Healthcare NHS Foundation Trust; and

"Trust Headquarters"
means Berkshire Healthcare NHS Trust, London House, London Road, Bracknell, RG12 2UT.~~Second and Third Floors, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ~~

Compliance

If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit Committee for referring action or ratification. All Board of Directors and Officers have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER THAT COULD RESULT IN DISMISSAL

1 RESPONSIBILITIES AND DELEGATION

The Board of Directors

1.1.1 The Board of Directors exercises financial supervision and control by:

1.1.1.1 formulating the financial strategy;

1.1.1.2 requiring the submission and approval of budgets within approved allocations/overall income;

1.1.1.3 defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

1.1.1.4 approving Shared Service provision of service; and

1.1.1.5 defining specific responsibilities placed on the Board of Directors and Officers as indicated in the Scheme of Delegation containing the powers of delegation and reservation as the Trust has established.

1.1.2 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the Reservation of Powers to the Board in the Scheme of Delegation.

1.1.3 The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation adopted by the Trust.

The Chief Executive and the Chief Financial Officer

1.1.4 Within these SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors and as Accounting Officer, to NHS ~~Improvement~~England for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive Officer will at all times comply with the NHS Foundation Trust Accounting Officer Memorandum (August 2015). The Chief Executive has overall executive responsibility for the Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.1.5 The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.1.6 It is a duty of the Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within these SFIs.

The Chief Financial Officer

1.1.7 The Chief Financial Officer is responsible for:

1.1.7.1 implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

1.1.7.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

1.1.7.3 ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose with reasonable accuracy, the financial position of the Trust at any time;

and without prejudice to any other functions of the Directors and Officers to the Trust, the duties of the Chief Financial Officer include:

1.1.7.4 the provision of financial advice to the Trust, other Board of Directors and Officers;

1.1.7.5 the design, implementation and supervision of systems of internal financial control;

1.1.7.6 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties; and

1.1.7.7 ensuring that there are proper arrangements for the estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties~~ as prepared and maintained by the SSC.~~

Board Members and Officers

1.1.8 All Directors and Officers, severally and collectively, are responsible for:

1.1.8.1 the security of the property of the Trust;

1.1.8.2 avoiding loss;

1.1.8.3 exercising economy and efficiency in the use of resources; and

1.1.8.4 conforming to the requirements of Standing Orders, Standing Financial Instructions, relevant financial procedures and the Scheme of Delegation.

Contractors and their employees

1.1.9 Any Officer including a contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these SFIs. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

~~1.1.10~~ For any and all Directors and Officers who carry out a financial function, the form in which financial records are kept and the manner in which Directors and Officers discharge their duties must be to the satisfaction of the Chief Financial Officer. ~~In the case of the SSC such arrangements will be established and agreed through appropriate Agreements with the SSC as approved by the Board.~~

1.1.10

2 AUDIT

2.1 Audit Committee

2.1.1 In accordance with the Constitution and Standing Orders the Board of Directors shall formally establish an Audit Committee, with clearly defined terms of reference and in accordance with guidance in the ~~foundation trust~~ Code of Governance for Foundation Trusts (April 2023), ~~issued by NHS Improvement in July 2014~~, the Audit Code for NHS Foundation Trusts ~~(December 2014)~~ and any other relevant directions and guidance issued by NHS ~~Improvement~~England or any other relevant body, which will provide an independent and objective view of internal control by:

2.1.1.1 overseeing Internal and External Audit services;

2.1.1.2 reviewing financial and information systems and monitor the integrity of the financial statements and reviewing significant financial reporting judgments;

2.1.1.3 reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the Trust's objectives;

2.1.1.4 monitor compliance with Standing Orders and Standing Financial Instructions;

2.1.1.5 reviewing schedules of losses and compensations and making recommendations to the Board of Directors;

2.1.1.6 reviewing the information prepared to support the controls assurance statements prepared on behalf of the Board of Directors and advising the Board of Directors accordingly; and

2.1.1.7 receiving and reviewing the minutes of the Finance, ~~&~~ Investment and ~~Committee~~ Quality and Performance Executive Group and Quality Assurance Committee. ~~and the Executive Governance Committee.~~

2.1.2 Where the Audit Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Audit Committee wishes to raise, the Chair~~man~~ of the Audit Committee should raise the matter at a full meeting of the Board of Directors. (to the Chief Financial Officer in the first instance). Exceptionally the matter may need to be referred to NHS ~~Improvement~~England.

2.1.3 It is the responsibility of the Chief Financial Officer to ensure an adequate internal audit service is provided and the Audit Committee shall be involved in the selection process when an internal audit service provider is changed.

~~2.1.4 In the case of the SSC, the Chief Financial Officer shall ensure that the provision of an adequate Internal Audit Service is specified in any Agreement with the SSC and shall further specify assurance arrangements between the Trust's Auditors and the SSC Auditors.~~

2.2 **Chief Financial Officer**

2.2.1 The Chief Financial Officer is responsible for:

2.2.1.1 ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function.

2.2.1.2 ensuring that the internal audit is adequate and meets NHS ~~Improvement~~England's mandatory audit standards.

2.2.1.3 deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption; liaising with NHS ~~Improvement~~England as appropriate.

2.2.1.4 ensuring that an annual internal audit and governance report (the Annual Governance Statement) is prepared for the consideration of the Audit Committee and the Board of Directors. The report must cover:

2.2.1.4.1 a clear opinion on the effectiveness of internal control in accordance with current controls assurance guidance issued by NHS ~~Improvement~~England including for example compliance with control criteria and standards;

2.2.1.4.2 major internal financial control weaknesses discovered;

2.2.1.4.3 progress on the implementation of internal audit recommendations;

2.2.1.4.4 progress against plan over the previous year;

2.2.1.4.5 strategic audit plan covering the coming three years; and

2.2.1.5 a detailed plan for the coming year.

2.2.2 The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

2.2.2.1 access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

2.2.3 access at all reasonable times to any land, premises held by the Board of Directors or Officers of the Trust

2.2.3.1 the production of any cash, stores or other property of the Trust under a Member of the Board's or Officer's control; and

2.2.3.2 explanations concerning any matter under investigation.

2.3 **Role of Internal Audit**

2.3.1 Internal audit will review, appraise and report upon:

2.3.1.1 the extent of compliance with, and the financial effect of relevant established policies, plans and procedures;

2.3.1.2 the adequacy and application of financial and other related management controls;

2.3.1.3 the suitability of financial and other related management data;

2.3.1.4 the extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

2.3.1.4.1 fraud and other offences;

2.3.1.4.2 waste, extravagance, inefficient administration;

2.3.1.4.3 poor value for money and other causes; and

2.3.1.4.4 the adequacy and appropriateness of remedial action taken by the Board following the issue of an adverse audit report or audit comment

2.3.1.5 ~~Internal Audit are required to review the self certification processes completed to support the Standards for Better Health declaration made by the Trust and provide comment on whether the statement of internal control is consistent with the findings of their work during the year.~~ External Audit will provide a formal opinion on the statement of internal control as part of their account opinion and use of resources conclusion in line with the Audit Code of Practice issued by NHS ~~Improvement~~England.

2.3.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately, or in their~~his~~ absence the Internal Audit Department.

2.3.3 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chair~~man~~ and Chief Executive of the Trust.

2.3.4 The Head of Internal Audit shall report to the Chief Financial Officer who shall refer audit reports to the appropriate officers designated by the Chief Executive. Failure to take any necessary remedial action within a reasonable period shall be reported to the Chief Executive by the Chief Financial Officer. Where in exceptional circumstances the use of normal reporting channels could be seen as a possible limitation

on the objectivity of the audit the Head of Internal Audit shall seek the advice of the Chair~~man~~ of the Trust.

2.3.5 The reporting system for internal audit shall be recorded in writing and shall comply with the guidance on reporting contained in the Audit Code for NHS Foundation Trusts and NHS Foundation Trust Financial Reporting Manual and the NHS Foundation Trust Accounting Officer Memorandum. The reporting system shall be reviewed at least every three years.

2.4 **Fraud and Corruption**

2.4.1 In line with their responsibilities, the Chief Executive and Chief Financial Officer shall monitor and ensure compliance both with guidance issued by the Department of Health and Social Care and NHS ~~Improvement~~England on fraud and corruption and the requirements of the NHS Standard ~~Mental Health~~ C~~c~~ontract.

2.4.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Directions to NHS Bodies on Counter Fraud Measures 2004 (the "Directions") as amended.

2.4.3 The Local Counter Fraud Specialist shall report to the Trust Director of Finance, Performance & Information and shall work with staff at NHS ~~Improvement~~England and NHS Counter Fraud Authority.

2.4.4 The Chief Financial Officer must also prepare a "fraud response plan" that sets out the action taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

2.4.5 Any Officer discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Chief Financial Officer or inform an Officer charged with responsibility for responding to concerns involving loss or fraud or confidentially. This Officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the relevant Local Counter Fraud Specialist (LCFS) and NHS Counter Fraud Authority in accordance with Department of Health and Social Care guidance; in any event.

2.4.6 The Chief Financial Officer must notify NHS Counter Fraud Authority, NHS ~~Improvement~~England and the External Auditor of all frauds.

2.4.7 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Chief Financial Officer must immediately notify:

2.4.7.1 the Board of Directors; and

2.4.7.2 the Auditor.

2.5 **External Audit**

2.5.1 The Auditor is appointed in accordance with the provisions of paragraph 35.2 of the Constitution by the Trust and paid for by the Trust. The Auditor must ensure a cost efficient service and comply with NHS ~~Improvement~~England's Audit Code.

2.5.2 The Trust shall ensure that the Auditor is provided with every facility and all information which he may reasonably require for the purposes of their~~his~~ functions under Schedule 10 of the 2006 Act

3 ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITOR

INCOME/PCT ALLOCATIONS

3.1.1 The Chief Financial Officer will:

3.1.1.1 periodically review the bases and assumptions used for compiling budgets and ensure that these are reasonable and realistic. Periodically review allocations and all other sources of income to ensure the Trust is obtaining all the funds due;

3.1.1.2 prior to the start of each financial year submit to the Board for approval a report showing the total expected contract income received and the proposed allocation to budgets including any sums to be held in reserve; and

3.1.1.3 regularly update the Board on significant changes to contract income/allocations and the uses of such funds.

3.1.2 Operational Managers will:

3.1.1.4 report on performance levels within their Directorate to the Chief Executive on a monthly basis in a form prescribed by the Chief Executive.

3.2 **Preparation and approval of business plans and budgets:**

3.2.1 The Chief Executive will compile and submit to the Board of Directors an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

3.2.1.1 a statement of the significant assumptions on which the plan is based; and

3.2.1.2 details of major changes in workload, delivery of services or resources required to achieve the plan.

3.2.2 Prior to the start of the financial year, the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board of Directors. Such budgets will:

3.2.2.1 be in accordance with the aims and objectives set out in the Trust's annual business plan;

3.2.2.2 accord with workload and manpower plans;

3.2.2.3 be produced following discussion with appropriate budget holders;

3.2.2.4 be prepared within the limits of available funds; and

3.2.2.5 identify potential risks.

3.2.3 The Chief Financial Officer shall monitor financial performance against budget and business plan, periodically review them, and report to the Board of Directors.

~~3.2.4~~ All Budget Holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled. ~~In the case of the SSC such requirements will be specified in an Agreement with the SSC.~~

3.2.4

3.2.5 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

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3.3 **Budgetary delegation**

3.3.1 The Chief Executive may delegate the management of a Budget to permit the performance of a defined range of activities including pooled Budget arrangements under section 75 of the NHS Act 2006. This delegation must be in writing and be accompanied by a clear definition of:

3.3.1.1 the amount of the Budget;

3.3.1.2 the purpose(s) of each Budget heading;

3.3.1.3 individual and group responsibilities;

3.3.1.4 authority to exercise virement;

3.3.1.5 achievement of planned levels of service; and

3.3.1.6 the provision of regular reports.

3.3.2 The Chief Executive and delegated Budget Holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.3.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement. However, broad control totals are set for each service and division which allow maximum flexibility to support deliver of objectives and value for money.

3.3.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive.

3.4 **Budgetary control and reporting**

3.4.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

3.4.1.1 monthly financial reports to the Board in a form approved by the Board containing:

3.4.1.1.1 income and expenditure to date showing trends and forecast year-end position;

3.4.1.1.2 movements in working capital;

3.4.1.2 movements in cash and capital;

3.4.1.2.1 capital project spend and projected outturn against plan;

3.4.1.2.2 explanations of any material variances from plan;

3.4.1.2.3 details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's views of whether such actions are sufficient to correct the situation;

3.4.1.3 the issue of timely, accurate and comprehensible advice and financial reports to each Budget Holder, covering the areas for which they are responsible;

3.4.1.4 investigation and reporting of variances from financial, workload and manpower budgets;

3.4.1.5 Monitor of management action to correct variances;

3.4.1.6 arrangements for the authorisation of budget transfers; and

3.4.1.7 reports for individual service lines clearly indicating whether each income-earning department / service is operating at a profit or loss.

3.4.2 Each Budget Holder is responsible for ensuring that:

3.4.2.1 any significant or willful deviation likely to result in overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the line manager.

3.4.2.2 the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement as set out in the Scheme of Delegation;

3.4.2.3 no permanent Officers are appointed without the approval of the Chief Executive other than those provided for within the available resources and manpower establishment approved by the Board; and

3.4.2.4 they provide information as requested by the Chief Financial Officer to discharge theirhis duties as in 3.4.1 above.

3.4.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan.

3.5 **Capital Expenditure**

3.5.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 12).

3.6 **NHS EnglandMonitor Returns**

3.6.1 The Chief Executive is responsible for ensuring that the appropriate Monitor forms are submitted to NHS ImprovementEngland and any other requisite regulatory organisation.

3.6.2 Where the documents referred to in 3.6.1 above are prepared by the SSC, detailed requirements in relation to Monitor will be specified in a Legally Binding Agreement between the Trust and the SSC. However accountability for such documents will remain with the Chief Financial Officer.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 The Chief Financial Officer, on behalf of the Trust, will:

4.1.1 prepare financial returns in accordance with the accounting policies and guidance given by NHS ImprovementEngland and HM Treasury, the Trust's accounting policies, and generally accepted accounting practice;

4.1.2 prepare and submit annual financial reports to NHS ImprovementEngland certified in accordance with current guidelines;

4.1.3 submit financial returns to NHS ImprovementEngland for each financial year in accordance with the timetable prescribed by NHS ImprovementEngland; and

4.1.3.1 where such documents as set out in 4.1.1 – 4.1.3 are prepared by the Shared Service Centres, detailed requirements will be specified in an Agreement with the Shared Service Centre. However accountability for such documents will remain with the Chief Financial Officer.

4.2 In accordance with paragraph 37 and 39 of the Constitution, the Trust's annual accounts must be audited by an auditor appointed by the Council of Governors at a general meeting of the Council of Governors. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with the Constitution and guidelines on local accountability and NHS ~~Improvement~~England's NHS Foundation Trust Financial Reporting Manual and send it to NHS ~~Improvement~~England.

4.4 In accordance with paragraph 38.6 of the Constitution, the Trust shall give information prepared by the Board of Directors, with regard to the Council of Governors views as to its forward planning in respect of each financial year, to NHS ~~Improvement~~England.

5 COMMERCIAL BANK AND GOVERNMENT BANKING SERVICE ("GBS") ACCOUNTS

5.1 General

5.1.1 The Chief Financial Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance issued from time to time by NHS ~~Improvement~~England.

5.1.2 The Board of Directors shall approve the banking arrangements including the investment of surplus funds.

~~5.1.3 Where banking processes are undertaken by a SSC they will be operated under instructions approved by the Chief Financial Officer as set out in a Legally Binding Agreement between the Trust and the SSC.~~

5.2 Commercial Bank and GBS Accounts

5.2.1 The Chief Financial Officer is responsible for:

5.2.1.1 commercial bank accounts and GBS accounts;

5.2.1.2 establishing separate bank accounts for the Trust's non-exchequer funds;

5.2.1.3 ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account where arrangements have been made;

5.2.1.4 reporting to the Board of Directors all arrangements made with the Trust's bankers for accounts to be overdrawn (together with remedial action taken);

5.2.1.5 negotiation and control of any necessary working capital facility (i.e. overdraft); and

5.2.1.6 Monitor compliance with Department of Health and Social Care guidance and any guidance issued by NHS ~~Improvement~~England or any other relevant guidance on the level of cleared funds.

~~5.2.2 Where the processes specified in 5.2.1 above are undertaken by a SSC these will be specified in a Legally Binding Agreement with the SSC. In particular the Chief Financial Officer will approve the detailed bank mandate procedures with the SSC and will ensure that an agreed panel of Officers responsible for the Shared Services approve transactions on behalf of the Trust.~~

5.3 **Banking Procedures**

5.3.1 The Chief Financial Officer will ensure that detailed instructions on the operation of bank and GBS accounts are prepared which must include:

5.3.1.1 the conditions under which each bank and GBS account is to be operated

5.3.1.2 the limit to be applied at any overdraft, and

5.3.1.3 those authorised to sign cheques or other orders drawn on the Trust's bank and GBS accounts.

~~5.3.2 5.3.1 above will also be specified if applicable to the SSC by the Chief Financial Officer~~

~~5.3.3~~5.3.2 Where an agreement is entered into with ~~the SSC or~~ any other body for payment to be made on behalf of the Trust from bank accounts maintained in the name of that Trust or other body, or by Electronic Funds Transfer (BACS, CHAPS or Faster Payment), the Chief Financial Officer shall ensure that satisfactory security regulations of the~~ SSC or~~ other body relating to bank accounts exist and are observed. This will be specified in a Legally Binding Agreement with the appropriate body**.**

~~5.3.4~~5.3.3 All funds shall be held in accounts in the name of the Trust

~~5.3.5~~5.3.4 No officer other than the Chief Financial Officer shall open any bank account in the name of the Trust.

~~5.3.6~~5.3.5 All payments shall be supported by more than one authorised signature on the cheque or authority to pay, as appropriate.

~~5.3.7~~5.3.6 No cheque signatory shall sign cheques or other orders where they are~~he is~~ the named payee.

5.4 **Tendering and review**

5.4.1 The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders for commercial bank accounts should be sought at least every 3 years. The results of the tendering exercise should be reported to the Board of Directors. This review is not necessary for GBS accounts.

5.4.3 The Tendering Procedure is set out at SO 9 and Appendix 1 of these SFI's for the Board of Directors.

~~5.4.4 Where the Trust's banking arrangement are undertaken by a SSC, adequate value for money arrangements should be demonstrated at periodic intervals to the Trust by the Shared Services Centre. These will be incorporated in a Legally Binding Agreement with the SSC.~~

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due and including income from income generation schemes of all types.

6.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

~~6.1.3 Where income matters are dealt with by the SSC, such arrangements will be incorporated in a Legally Binding Agreement with the SSC.~~

6.2 Fees and charges

6.2.1 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS ~~Improvement~~England or by Statute. Independent professional advice on matters of valuation should be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the Department of Health and Social Care's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

~~6.2.2 The Chief Financial Officer shall notify the approved level of all fees and charges to the SSC and will undertake suitable periodic checks against actual amounts collected or billed. These will be specified in the Legally Binding Agreement with the SSC.~~

~~6.2.3 In receiving cash payments, it should be noted that the maximum value of any single transaction is limited to €15,000 (equivalent to around £10,850 based on a spot exchange rate of €1.38243 to the £1 as at 22 September 2015) or more (or equivalent in any currency). This is in line with Money Laundering Regulations 2007.~~

~~6.2.4~~6.2.2 All Officers must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all

contracts, leases, tenancy agreements, private patient undertakings and other transactions.

~~6.2.5~~6.2.3 Any income generated from the activities of Officers working in their employment hours, and/or utilising any of the Trust's facilities shall be declared as Trust Exchequer Income and dealt with in line with the Trust's official income systems and controls and any relevant aspects of an Officer's terms and conditions of employment.

~~6.2.6~~6.2.4 All income generation activities shall be approved, before they are undertaken, by the appropriate budget holder/manager, and comprehensive and detailed records retained for audit. Such approval shall only be granted where the scheme generates a minimum of break even after taking account of all overheads and after further approval of prices by the Chief Financial Officer under SFI paragraph 6.2.1 above.

6.3 **Debt recovery**

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures. (see SFI 14)

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 **Security of cash, cheques and other negotiable instruments**

6.4.1 The Chief Financial Officer is responsible for:

6.4.1.1 approving the form of all receipt books~~, agreement forms,~~ or other means of officially acknowledging or recording monies received or receivable;

6.4.1.2 ordering and securely controlling any such stationery;

6.4.1.3 the provision of adequate facilities and systems for Officers whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

~~6.4.1.4 prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.~~

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 Subject to SFI 6.2.2, all cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

~~6.4.4~~ All Officers who hold cash will be provided with a safe, or lockable cash box which shall normally be deposited in a lockable safe. ~~The Nominated Officer will hold one key. The Nominated Officer shall arrange for a duplicate key to be lodged in the Trust Headquarters safe. Instructions for the release of this duplicate key should be prepared by the Nominated Officer and approved by the Chief Financial Officer. Loss of any key should be reported immediately to the Chief Financial Officer. During the absence of the key holder, the Officer who acts in their place shall be subject to the same controls as the key holder. A written discharge of the contents of the safe or cash box on the transfer of responsibilities should be retained for audit purposes with consideration to operational practices. The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.~~

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~~6.4.5~~6.4.4 ~~The opening of incoming post shall be undertaken by two Officers and all cash, cheques, postal orders and other forms of payment shall be entered immediately in an approved form or remittance register, which should be countersigned by a senior Officer.~~

~~6.4.6~~6.4.5 An official receipt will be made out for all cash receipts when requested, showing the type of remittance and the reasons for payment.

~~6.4.7~~6.4.6 A special receipt will be issued, on request for ~~all~~ charitable fund donations which will enable the donor to express their wishes as to the purpose of the donation.

~~6.4.8 The opening of coin operated machines (including telephones) and the counting and recording of the takings shall be undertaken by two officers together, except as may be authorised in writing by the Chief Financial Officer and the coin box keys shall be held by a nominated manager.~~

~~6.4.9~~6.4.7 All unused cheques and other orders shall be subject to the same security precautions as are applied to cash: bulk stocks of cheques shall normally be retained by the Trust's bankers and released by them only against a requisition signed by the Chief Financial Officer or a nominated officer.

~~6.4.10 The use of a cheque signing machine and/or cheques with a pre-printed signature included shall be subject to such special security precautions as may be required from time to time by the Chief Financial Officer.~~

~~6.4.11~~6.4.8 Staff shall be informed on their appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

6.4.126.4.9 Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses.

7 AGREEMENTS FOR PROVISION OF SERVICES

7.1 Legally Binding Agreements

7.1.1 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable legally binding Agreements with service commissioners for the provision of NHS services. All Agreements should aim to implement the agreed priorities contained within the plans of the Integrated Care Systems and NHS EnglandLocal Delivery Plan (LDP) and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

7.1.1.1 the standards of service quality expected;

7.1.1.2 the relevant national service framework (if any);

7.1.1.3 the provision of reliable information on cost and volume of services;

7.1.1.4 that Agreements build where appropriate on existing partnership arrangements;

7.1.1.5 that Agreements are based on integrated care pathways;

7.1.1.6 any model contracts issued by the Department of Health and Social Care.

7.1.2 A good Agreement will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The Agreement will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

The Chief Executive, as the Accounting Officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the Agreements. This will include information on the costing arrangements for the service(s) and will based on the most appropriate currency in use for that service(s).

7.1.3 Where the Trust makes arrangements for the provision of services by non-NHS providers it is the Chief Executive, as the Accounting Officer, who is responsible for ensuring that the agreements put in place have due regard to the quality and the cost-effectiveness of the services provided. Before making any agreement with non-NHS providers, the

Trust should explore fully the scope to make maximum cost-effective use of NHS facilities.

8 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS

8.1 Remuneration and Terms of Service

8.1.1 In accordance with SOs the Board of Directors shall establish a Appointments and Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Appointment and Remuneration Committee will:

8.2 Appointments Role

The Committee shall, in respect of appointments:

8.2.1 The Chief Executive shall consult with the Committee annually about the structure, size and composition of the Executive Team and staff on Very Senior Manager contracts (including skills, knowledge and experience) and agree any changes.[1]

8.2.2 Ensure that the Trust has robust succession plans in place by reviewing the feedback provided by the Talent Management Review Board.

8.2.3 Oversee the identification and nomination of a candidate, for approval by the Council of Governors, to fill the position of Chief Executive.

8.2.4 Ensure that there is a formal, rigorous and transparent procedure in place to identify suitable candidates to fill Executive Director and Very Senior Manager vacancies as they arise.

8.2.5 Ensure that the appointments process for Chief Executive, Executive Director and Very Senior Manager posts includes the requirements of the 'Fit and Proper' Persons Test.

8.2.6 Consider any matter relating to the continuation in office of the Chief Executive, any Executive Director at any time, including the suspension or termination of service of an individual as an employee of the NHS Foundation Trust.

8.2.7 Consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of the Committee's responsibilities.

8.3 Remuneration Role

[1] The Council of Governors' Appointments and Remuneration Committee are responsible for reviewing the structure, size and compositions (including skills, knowledge and diversity) in respect of the Non-Executive Directors)

The Committee shall in respect of remuneration:

8.3.5 Establish and keep under review a remuneration policy for Chief Executive, Executive Director and Very Senior Manager posts.

8.3.6 Consult the Chief Executive about proposals relating to the remuneration of Executive Directors and Very Senior Managers.

8.3.7 In accordance with all relevant laws, regulations and the NHS Foundation Trust's policies, determine the terms and conditions of office of the Chief Executive, Executive Director and Very Senior Manager posts, including all aspects of salary and any performance related pay or bonus and the provision of other benefits (for example, cars, allowances or payable expenses).

8.3.8 Determine the levels of remuneration and terms of employment for the Chief Executive, Executive Director and Very Senior Manager posts.

8.3.9 Ensure that the Chief Executive, Executive Directors and Very Senior Managers are fairly rewarded for their individual contribution to the NHS Foundation Trust – having proper regard to the NHS Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff.

8.3.10 Use national guidance and market benchmarking analysis in the annual determination of remuneration of the Executive Directors.

8.3.11 Approve the arrangements for the termination of employment of the Chief Executive, Executive Directors and Very Senior Managers and other contractual terms, having regard to any national guidance.

8.3.12 Approve contractual payments over £100,000 to all staff. Contractual payments between £50,000-£99,000 will be approved by an Executive Committee and reported to the Committee for information.

8.3.13 Approve any non-contractual payments that have to be reported to HM Treasury (via NHS ~~Improvement~~England.

8.3.14 Monitor and evaluate the performance of the Chief Executive, individual Executive Directors and Very Senior Managers ensuring that they each receive an annual appraisal and that they continue to meet the requirements of the Fit and Proper Persons Test.

Membership and attendance

8.4 The Committee shall comprise the Trust Chair and all of the Non-Executive Directors.

8.5 The Committee shall appoint a Chair.

8.6 The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding their~~his/term~~ terms of condition and remuneration.

8.7 The Director of People shall provide advice to the Committee as required.

8.8 Other members of staff and external advisers may attend all or part of a meeting by invitation of the Committee Chair where required.

8.9 For any decisions relating to the appointment or removal of the executive directors, membership of the Committee should include the Chief Executive as required under Schedule 7 of the NHS Act 2006.

Authority

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

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

8.12 The Committee will consider the latest guidance produced by NHS ~~Improvement~~England and the annual Senior Salary Review (NHS) report and where appropriate seek the necessary opinion and/or approval.

8.13 **Funded establishment**

8.13.1 The workforce~~manpower~~ plans incorporated within the annual budget will form the funded establishment.

8.13.2 The funded establishment of any department may not be varied to the extent that is it not affordable recurrently without the approval of the Chief Executive.

8.14 **Appointments**

8.14.1 No Executive Director or Officer may engage, re-engage, or regrade Officers, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

8.14.1.1 unless authorised to do so by the Chief Executive; and

8.14.1.2 within the limit of their~~his~~ approved budget and funded establishment.

8.14.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, and condition of service for Officers.

8.14.3 A signed copy of the Contract of employment / appointment form and such other documents as may be required shall be sent to the Director of People prior to the Officer commencing duty. Under no circumstances shall anyone be placed onto the payroll system unless a correctly authorised Contract of employment/ appointment form has been completed.

8.15 **Processing of Payroll**

8.15.1 The Chief Financial Officer is responsible for :

8.15.1.1 specifying timetables for submission of properly authorised time records and other notifications;

8.15.1.2 making payment on agreed dates in conjunction with the Director of People having regard to the general rule not to make payments in advance;

8.15.1.3 agreeing method of payment; and

8.15.2 approving the form of all the records, pay sheets, other pay records and notification together with certification requirements.

8.15.3 The Director of People shall be responsible for the final determination of pay including the verification that rates of pay and relevant conditions of service are in accordance with current agreements and the proper compilation of the payroll.

8.15.4 The Chief Financial Officer will issue instructions regarding:

8.15.4.1 verification and documentation of data;

8.15.4.2 the timetable for receipt and preparation of payroll data and the payment of Officers;

8.15.4.3 maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

8.15.4.4 security and confidentiality of payroll information;

8.15.4.5 checks to be applied to completed payroll before and after payment;

8.15.4.6 authority to release payroll data under the provisions of the Data Protection Act 2018;

8.15.4.7 methods of payment available to various categories of Officers;

8.15.4.8 procedures for payment by cheque, bank credit, or cash to Officers;

8.15.4.9 procedures for the recall of cheques and bank credits ;

8.15.4.10 pay advances and their recovery;

8.15.4.11 maintenance of regular and independent reconciliation of pay control accounts;

8.15.4.12 separation of duties of preparing records and handling cash; and

8.15.4.13 a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

8.15.5 Appropriately nominated managers have delegated responsibility for:

8.15.5.1 submitting time records, and other notifications in accordance with agreed timetables;

8.15.5.2 completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer;

8.15.5.3 submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement. Where an Officer fails to report for duty or to fulfill obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately; and

8.15.5.4 submitting signed Change of Circumstances forms to the Director of People immediately upon the effective date of any change in state of employment or personal circumstances of an Officer being known which will include:

8.15.5.4.1 Base
8.15.5.4.2 Department
8.15.5.4.3 Expenditure Code
8.15.5.4.4 Budget
8.15.5.4.5 Grade
8.15.5.4.6 Contract Hours
8.15.5.4.7 Residential/Non Residential Status
8.15.5.4.8 Marital Status
8.15.5.4.9 Address
8.15.5.4.10 Beverages/Meals.

8.15.6 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.15.7 All Officers shall be paid monthly by bank credit transfer unless otherwise agreed by the Chief Financial Officer.

8.16 **Contracts of Employment**

8.16.1 The Board of Directors shall delegate responsibility to a manager for:

8.16.1.1 ensuring that all Officers are issued with a contract of employment in a form approved by the Board of Directors and which complies with employment legislation; and

8.16.1.2 dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 **Delegation of Authority**

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

9.1.2 The Chief Executive will set out:

9.1.2.1 the list of managers who are authorised to place requisitions for the supply of goods and services; and

9.1.2.2 the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 **Choice, Requisitioning, Ordering, Receipt and Payment of Goods and Services**

Requisitioning

9.2.1 Responsibilities for effective purchasing, including obtaining tenders and quotations for goods and services required is delegated to the Procurement ~~& Logistics~~ Department or authorised requisition department with the exception of works – responsibility of the ~~Associate~~ Director of Estates & Facilities; and drugs – responsibility of the Chief Pharmacist.~~Trust Pharmaceutical Office.~~

9.2.2 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Procurement Team~~& Logistics Manager~~ shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

9.2.3 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

System of Payment and Verification

9.2.4 The Chief Financial Officer will:

9.2.4.1 advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained and, once approved, the thresholds should be incorporated in SOs and SFIs and regularly reviewed; such threshold will be ~~advised to the SSCs and~~ monitored on a regular basis to ensure ongoing compliance.

9.2.4.2 prepare procedural instructions (where not already provided in the Scheme of Delegation or procedure notes for Budget Holders) on the obtaining of goods, works and services incorporating the thresholds;

9.2.4.3 be responsible for the prompt payment of all properly authorised accounts and claims;

9.2.4.4 be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

9.2.4.4.1 maintain a list of Board of Directors of Directors/ Officers ~~(including specimens of their signatures)~~ authorised to certify invoices and authorise receipt of goods;

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9.2.4.4.2 certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets; the rates of labour are in accordance with the appropriate rates; the materials have been checked as regards quantity, quality, and the price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment;

9.2.4.4.3 a timetable and system for submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment;

9.2.4.4.4 instructions to Officers regarding the handling and payment of accounts within the Finance Department;

9.2.4.5 be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as set out at 9.2.5 below); and

9.2.4.6 prepare and issue procedures regarding Value Added Tax (VAT).

Prepayments

9.2.5 Prepayments are only permitted where exceptional circumstances apply as approved by the Chief Financial Officer. In such instances:

~~9.2.5.1~~ prepayments are only permitted where the financial advantages outweigh the disadvantages. ~~(i.e. cashflows must be discounted to Net Present Value using the National Loans Fund (NLF) rate plus 2%).~~

9.2.5.1

9.2.5.2 the appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet their~~his~~ commitments;

~~9.2.5.3~~ the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed ~~(taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);~~

9.2.5.3

9.2.5.4 the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and they~~he/she~~ must immediately inform the appropriate Director or Chief Executive if problems are encountered; and

~~9.2.5.5 every prepayment will be individually approved and notified to the SSCs by the Chief Financial Officer.~~

Official Orders

9.2.6 Official orders must :

9.2.6.1 be consecutively numbered;

9.2.6.2 be in a form approved by the Chief Financial Officer;

9.2.6.3 state the Trust's terms and conditions of trade; and

~~9.2.6.4~~ only be issued to, and used by, those duly authorised by the Chief Executive. ~~Such lists will be notified to the SSC and specified in a Legally Binding Agreement with the SSC.~~

9.2.6.4

9.2.7 Verbal orders may be made by authorised procurement ~~credit~~ card holders and subsequent statements will be checked against the Credit Limit in line with the agreed/authorised cost of the "required" purchase by managers, ensuring no penalty days for late payment. ~~Credit limits will be agreed between the Trusts and SSCs and included with a Legally Binding Agreement~~.

Duties of Officers

9.2.8 Officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that :

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9.2.8.1 all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made;

9.2.8.2 contracts above specified thresholds are advertised and awarded in accordance with ~~the EU~~the ~~–~~rules on public procurement; all expenditure should be "aggregated" and where anticipated expenditure for the lifetime of a potential contract is in excess of thresholds the procurement route shall be followed. Where there is doubt as to the expected lifetime of the contract, "aggregation" should be undertaken on an annual basis. The current thresholds will be notified to all managers annually;

9.2.8.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS ~~Improvement~~England and/or the Department of Health and Social Care;

9.2.8.4 where an officer certifying accounts relies upon other officers to undertake preliminary checking, the certifying officer, wherever possible, must ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

9.2.8.5 no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Board of Directors, Directors or Officers, other than:

9.2.8.5.1 isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

9.2.8.5.2 conventional hospitality, such as lunches in the course of working visits;

9.2.8.6 no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

9.2.8.7 all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases by purchase card or from petty cash or other variation agreed with the Chief Financial Officer;

9.2.8.8 verbal orders must only be issued very exceptionally – by an Officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked “Confirmation Order”;

9.2.8.9 orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

9.2.8.10 goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase; arrangements made by the P~~urchasing & Supplies Department~~; in particular, any trial or loan arrangements should define the time period of trial/loan; include an assessment of the trial documented by the Procurement Department~~Purchasing & Supplies Department~~; ensure compliance with Health and Safety obligations; include notification prospectively to the insurance/litigation department and under no circumstances may an oral commitment be given prior to the assessment by the Procurement~~urchasing & Supplies~~ Department~~;~~

9.2.8.11 ~~changes to the list of Directors/Officers authorised to certify invoices are notified to the Chief Financial Officer and the SSC;~~

9.2.8.12 purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer; and

9.2.8.13 petty cash records are maintained in a form as determined by the Chief Financial Officer.

9.2.9 The Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Health Building Note~~CONCODE and~~ ;ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Executive - Director.

9.2.10 In the case of contracts for building or engineering works which require payment to be made on account during progress of the work, the Chief Financial Officer shall make payment on receipt of a certificate from the appropriate technical consultant or officer. Without prejudice to the responsibility of any consultant, or estates officer appointed to a particular building or engineering contract a contractors account shall be subjected to such financial examination by the Chief Financial Officer and such general examination by the Director of Estates and Facilities~~Associate Director of Facilities~~ as may be considered necessary before the person responsible to the Trust for the contract issues the final certificate.

10 JOINT FINANCE ARRANGEMENTS WITH LOCAL AUTHORITIES AND VOLUNTARY BODIES

10.1 Payments to local authorities and voluntary organisations made under the powers of section 75 of the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with these Acts.

11 EXTERNAL BORROWING

11.1 The Chief Financial Officer will advise the Board of Directors concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors concerning the PDC debt and all loans and overdrafts.

11.2 The Board of Directors will agree the list of Officers who are authorised to make short term borrowings on behalf of the Trust. This must contain the Chief Executive and the Chief Financial Officer.

11.3 The Chief Financial Officer must prepare detailed procedural instructions on:

11.3.1 applications for loans and overdrafts; and

11.3.2 the operations of investment accounts and the records to be maintained.

11.4 All short-term borrowings should be kept to a minimum period of time and consistent with the cashflow position, representing good value for money, and complying with the latest guidance issued by NHS ~~Improvement~~England.

11.5 Any short-term borrowing must be with the authority of 2 members of the authorised panel, one of which must be the Chief Executive or the Chief Financial Officer. The Board of Directors must be made aware of all short term borrowings at the next Board meeting.

11.6 All long term borrowing must be consistent with the plans outlined in the current Business Plan agreed by the Board.

11.7 Temporary cash surpluses must be held only in such public or private sector investments as notified by NHS ~~Improvement~~England and/or the Secretary of State and authorised by the Board.

11.8 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board and to NHS ~~Improvement~~England concerning the performance of investments held and on ensuring the Trust acts in accordance with the Best Practice Guidance in Making investments for NHS Foundation Trusts.

12 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

12.1 **Capital Investment**

12.1.1 The Chief Executive:

12.1.1.1 shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

12.1.1.2 is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

12.1.1.3 shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

12.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

12.1.2.1 that a business case (in line with the guidance contained within the Risk Assessment Framework and the Supporting NHS providers: guidance on transactions for NHS foundation trusts and any other guidance published by NHS ~~Improvement~~England) is produced setting out:

12.1.2.1.1 an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

12.1.2.1.2 appropriate project management and control arrangements; and

12.1.2.1.3 the involvement of appropriate Trust personnel and external agencies; and

12.1.2.2 that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

12.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management~~, incorporating the recommendations of "CONCODE"~~. The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue and Customs guidance. The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of a capital programme shall not constitute approval for expenditure on any scheme. The Chief Executive shall issue to the manager responsible for any scheme:

12.1.4.1 specific authority to commit expenditure; The Trust requires that no variation order can be raised without the Project Manager's prior written permission when:

12.1.4.1.1 it increases the total contract figure to a sum above the authorised sum, or

12.1.4.1.2 it has a net effect of expending in excess of £500.

12.1.4.2 authority to proceed to tender;

12.1.4.3 approval to accept a successful tender.

12.1.5 The Chief Executive will issue a Scheme of Delegation for capital investment management in accordance with "Protection of Assets Guidance for NHS Foundation Trusts" issued by NHS ~~Improvement~~England, "Estatecode" guidance and the SOs.

12.1.6 The Chief Financial Officer shall:

12.1.6.1 issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account:

~~12.1.6.1.1~~ the delegated limits for capital schemes as set by NHS England. ~~included in Annex C of HSC 1999/246 and guidance issued by NHS Improvement relating to the Prudential Borrowing Code which determines the limits of borrowing by an NHS Trust and~~

~~12.1.6.1.2~~ ~~the best practice advice issued by NHS Improvement in "Risk Evaluation for Investment Decisions by Foundation Trusts".~~

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12.1.7 ensure the Department of Health and Social Care Group Accounting Manual ~~NHS Foundation Trust Financial Reporting Manual which outlines the application of Financial Reporting and Statements of Standard Accounting Practice (SSAPs)~~ is followed in the production of the Trust's annual accounts and annual reports.

12.2 Private Finance

12.2.1 When the Trust proposes to use finance that is to be provided other than through its allocations, the following procedures shall apply:

12.2.1.1 The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

12.2.1.2 The proposal must be specifically agreed by the Board of Directors.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2 ~~Each~~The Trust ~~(and SSC if applicable)~~ shall maintain an asset register recording fixed assets. ~~The minimum data set to be held within these registers shall be as specified in the "The asset register and disposal of assets: guidance for providers of commissioner requested services (April 2014)" issued by NHS Improvement.~~

12.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to :

12.3.3.1 properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

12.3.3.2 stores, requisitions and wages records for own materials and labour including appropriate overheads; and

12.3.3.3 lease agreements in respect of assets held under a finance lease and capitalised.

~~12.3.4~~ Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records. ~~and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).~~

~~12.3.4~~

12.3.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

12.3.6 The value of each land and building asset shall be reviewed annually and where appropriate indexed to current values. ~~in accordance with methods specified in the Financial Reporting Manual issued by NHS Improvement.~~

12.3.7 The value of each asset shall be depreciated using methods and rates. ~~as specified in the Financial Reporting Manual issued by NHS Improvement.~~

12.3.8 The Chief Financial Officer shall calculate and pay capital charges. ~~as specified in the Financial Reporting Manual issued by NHS Improvement.~~

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques ~~and negotiable instruments, and also~~ including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

12.4.2.1 recording managerial responsibility for each asset;

12.4.2.2 identification of additions and disposals;

12.4.2.3 identification of all repairs and maintenance expenses;

12.4.2.4 physical security of assets;

12.4.2.5 periodic verification of the existence of, condition of, and title to, assets recorded;

12.4.2.6 identification and reporting of all costs associated with the retention of an asset;

12.4.2.7 reporting, recording and safekeeping of cash, cheques, and negotiable instruments; and

~~12.4.3 where any asset control procedure is undertaken by the SSCs it shall be subject to detailed requirements in a Legally Binding Agreement except for BSS services which shall be detailed in a Service Level Agreement.~~

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~~12.4.4~~12.4.3 Items on the asset register shall be physically checked at least annually by budget holders and all discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Chief Financial Officer who may also undertake such other independent checks as considered necessary.

~~12.4.5~~12.4.4 Whilst each Officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior Officers in all disciplines to apply such appropriate routine security practices in relation to Trust property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

~~12.4.6~~12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and Officers in accordance with the procedure for reporting losses.

~~12.4.7~~12.4.6 Where practical, assets should be marked as Trust property.

13 STORES AND RECEIPT OF GOODS

13.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be :

13.1.1.1 kept to a minimum;

13.1.1.2 subjected to annual stock take;

13.1.1.3 valued at the lower of cost and net realisable value.

Control of Stores, Stocktaking, condemnations and disposal

13.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stocks should be delegated to the appropriate Head of Service. ~~and stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer.~~ The control and security of any Pharmaceutical stocks shall be the responsibility of the Chief Pharmacist, ~~a designated Pharmaceutical Officer; the control of any fuel oil and coal shall be the responsibility of the designated Estates Manager~~.

13.3 ~~The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager. Wherever practicable, stocks should be marked as "Trust Property".~~

13.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores, including records for receipt of goods, issues, and returns to stores, and losses.

13.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer ~~and there shall be a physical check covering all items in store at least once a year~~.

13.6 Where a complete system of stores control is ~~not~~ justified, ~~alternative~~ arrangements shall require the approval of the Chief Financial Officer.

13.7 The designated manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items~~ and for condemnation, disposal, and replacement of all unserviceable articles~~. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also SFI 14 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

~~13.8 For goods supplied via the NHS Purchasing and Supplies Agency central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Chief Financial Officer who shall satisfy himself that the goods have been received before accepting the recharge.~~

14 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

14.1 Disposals and Condemnations

14.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets in accordance with the Regulatory Framework and guidance issued by NHS ~~Improvement~~England, including condemnations, and ensure that these are notified to managers.

14.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

14.1.3 All unserviceable articles shall be :

14.1.3.1 condemned or otherwise disposed of by an Officer authorised for that purpose by the Chief Financial Officer;

14.1.3.2 recorded by the condemning Officer in a form approved by the Chief Financial Officer which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Chief Financial Officer.

14.1.4 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

14.2 Loss and Special Payments

14.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

14.2.2 The Board of Directors shall approve the writing-off of losses above £10,000, the level delegated to the Chief Executive and Chief Financial Officer contained in the Scheme of Delegation.

14.2.3 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

14.2.4 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

14.2.5 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

14.2.6 No special payments exceeding delegated limits shall be made without the prior approval of NHS ~~Improvement~~England.

15 INFORMATION TECHNOLOGY

15.1 Responsibilities and duties of the Chief Financial Officer

15.1.1 The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

15.1.1.1 devise and implement any necessary procedures to ensure adequate protection of the Trust's data, programs and computer hardware for which they~~he/she~~ is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018 and any subsequent legislation;

15.1.1.2 ensure that adequate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

15.1.1.3 ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

15.1.1.4 ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as they~~he/she~~ may consider necessary are being carried out.

15.1.2 The Chief Financial Officer shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurance of adequacy will be obtained from them prior to implementation.

15.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

15.2.1 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of

Trusts in the Region wish to sponsor jointly) all responsible Directors and Officers will send to the Deputy Chief Executive~~Chief Financial Officer:~~

15.2.1.1 details of the outline design of the system;

15.2.1.2 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

15.3 **Contracts for computer services with other health bodies or outside agencies**

15.3.1 The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

15.3.2 Where another health organisation or any other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

15.4 **Risk Assessment**

The Deputy Chief Executive~~Chief Financial Officer~~ shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

15.5 **Requirements for computer systems which have an impact on corporate financial systems**

15.5.1 Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall satisfy him/herself that:

15.5.1.1 systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

15.5.1.2 data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

15.5.1.3 Chief Financial Officer Officers have access to such data; and

15.5.1.4 such computer audit reviews as are considered necessary are being carried out.

15.5.2 The Chief Financial Officer will devise procedures which ensure that orders for the acquisition of computer hardware, software and services

(other than consumables) are placed in accordance with the Trust's information strategy.

15.5.3 The Chief Financial Officer will ensure that separate control procedures are put in place for computer systems. This procedure will include:

15.5.3.1 the acquisition and disposal of IT, systems and equipment;

15.5.3.2 the decommissioning of systems containing confidential data; and in accordance with guidance issued by NHS ~~Improvement~~England and the Department of Health and Social Care.

16 PATIENTS' PROPERTY

16.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in possession of patients dying in hospital or dead on arrival.

16.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

16.2.1 notices and information booklets;

16.2.2 hospital admission documentation and property records;

16.2.3 the oral advice of Officers responsible for admissions into Trust premises;

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

16.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty it is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

16.4 Where NHS ~~Improvement~~England's instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Chief Financial Officer.

16.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates (Small Payments) Act 1965 as amended), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

16.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

16.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

17 FUNDS HELD ON TRUST

17.1 Introduction

17.1.1 This Standing Financial instruction identifies the Trust's responsibilities as a corporate trustee for the management of Funds it holds on Trust and defines how those responsibilities are to be discharged. It explains that although the management processes may overlap with those of the organisation of the Trust, the trustee responsibilities must be discharged separately and full recognition must be given to the dual accountabilities to the Charity Commission for charitable Funds held on Trust and to NHS ~~Improvement~~England for all Funds held on Trust.

17.1.2 The Scheme of Delegation makes clear where decisions regarding the exercise of dispositive discretion are to be taken and by whom. Directors and Officers must take account of that guidance before taking action. SFIs are intended to provide guidance to persons who have been delegated to act on behalf of the corporate trustee.

17.1.3 As management processes overlap most of the sections of these SFIs will apply to the management of Funds held on Trust. This section covers those instructions which are specific to the management of Funds held on Trust.

17.1.4 The overriding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

17.2 Existing Donated Funds

17.2.1 The Chief Financial Officer shall arrange for the administration of all existing donated funds. They shall ensure that a governing instrument exists for every donated fund and shall produce detailed codes of procedure covering every aspect of the financial management of donated funds, for the guidance of all Officers. Such guidelines shall identify the restricted nature of certain funds.

17.2.2 The Chief Financial Officer shall periodically review the funds in existence and shall make recommendations to the Board regarding the potential for rationalisation of such funds within guidelines issued by NHS ~~Improvement~~England and under Statute.

17.2.3 The Chief Financial Officer may recommend an increase in the number of funds where this is consistent with the Trust's policy for ensuring the safe and appropriate management of restricted funds, e.g, designation for specific wards or departments.

17.3 New Donated Funds

17.3.1 The Chief Financial Officer shall arrange for the creation of a new donated fund where funds and/or other assets, received in accordance with the Trust's policies, cannot adequately be managed as part of an existing Charitable Fund.

17.3.2 The Chief Financial Officer shall present the governing document to the Board for each new donated fund. Such a document shall clearly identify, inter alia, the objects of the new donated fund, the capacity of the Trust to delegate powers to manage and the power to assign the residue of the donated fund to another fund contingent upon certain conditions, eg, discharge of original objectives.

17.4 Sources of New Funds

17.4.1 In respect of Donations, the Chief Financial Officer shall:

17.4.1.1 provide guidelines to Officers of the Trust as to how to proceed when offered funds. These are to include:

17.4.1.1.1 the identification of the donors intentions;
17.4.1.1.2 where possible, the avoidance of new trusts;
17.4.1.1.3 the avoidance of impossible, undesirable or administratively difficult objects;
17.4.1.1.4 sources of immediate further advice; and
17.4.1.1.5 treatment of offers for personal gifts; and
17.4.1.2 provide secure and appropriate receipting arrangements which will indicate that funds have been accepted directly into the Trust's donated funds and that the donor's intentions have been noted and accepted.

17.4.2 In respect of Legacies and Bequests, the Chief Financial Officer shall:

17.4.2.1 provide guidelines to Officers of the Trust covering any approach regarding:

17.4.2.1.1 the wording of wills;
17.4.2.1.2 the receipt of funds/other assets from executors;

17.4.2.2 where necessary, obtain grant of probate, or make application for grant of letters of administration, where the Trust is the beneficiary;

17.4.2.3 be empowered, on behalf of the Trust, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;

17.4.2.4 be directly responsible for the appropriate treatment of all legacies and bequests; and

17.4.2.5 keep a register of all enquiries.

17.4.3 In respect of Fund-raising, the Chief Financial Officer shall:

17.4.3.1 deal with all arrangements for fund-raising by and/or on behalf of the Trust and ensure compliance with all statutes and regulations;

17.4.3.2 be empowered to liaise with other organisations/persons raising funds for the Trust and provide them with an adequate discharge. The Chief Financial Officer shall be the only Officer empowered to give approval for such fund-raising subject to the overriding direction of the Board;

17.4.3.3 be responsible for alerting the Board to any irregularities regarding the use of this Trust's name or its registration numbers; and

17.4.3.4 be responsible for the appropriate treatment of all funds received from this source.

17.4.4 In respect of Trading Income, the Chief Financial Officer shall:

17.4.4.1 be primarily responsible for any trading undertaken by the rust as corporate trustee; and

17.4.4.2 be primarily responsible for the appropriate treatment of all funds received from this source.

17.4.5 In respect of Investment Income, the Chief Financial Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

17.5 Investment Management

17.5.1 The Chief Financial Officer shall be responsible for all aspects of the management of the investment of donated funds. The issues on which he / she shall be required to provide advice to the Board shall include:

17.5.1.1 the formulation of investment policy within the powers of the Trust under statute and within governing instruments to meet its requirements with regard to income generation and the enhancement of capital value;

17.5.2 the appointment and agreement of the terms of appointment of advisers, brokers, and, where appropriate, fund managers (the Chief Financial Officer shall agree the terms of such appointments for which written agreements shall be signed by the Chief Executive);

17.5.2.1 the pooling of investment resources in accordance with the scheme approved by the Charity Commission;

17.5.2.2 the participation by this Trust in common investment funds and the agreement of terms of entry and withdrawal from such funds;

17.5.2.3 that the use of trust assets shall be appropriately authorised in writing and charges raised within policy guidelines;

17.5.2.4 the review of the performance of brokers and fund managers;

17.5.2.5 the reporting of investment performance;

17.5.2.6 all share and stock certificates and property deeds shall be deposited either with Trust Charitable fund bankers or in a safe, or a compartment within a safe, to which only the Chief Financial Officer or person nominated by him, will have access.

17.6 Expenditure Management

17.6.1 The exercise of this Trust's expenditure discretion shall be managed by the Chief Financial Officer in conjunction with the Board. In so doing he / she shall be aware of the following:

17.6.1.1 the objects of various funds and the designated objectives;

17.6.1.2 the availability of liquid funds within each donated fund;

17.6.1.3 the powers of delegation available to commit resources;

17.6.1.4 the avoidance of the use of exchequer funds to discharge donated fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by donated funds at the earliest possible time;

17.6.1.5 that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of this Trust; and

17.6.1.6 the definitions of 'charitable purposes' as agreed by the NHS Executive with the Charity Commission.

17.6.2 Expenditure of any donated funds shall be conditional upon the item being within the terms of the appropriate fund and the procedures approved by the Trust.

17.7 Banking Services

17.7.1 The Chief Financial Officer shall advise the Board and, with its approval, shall ensure that appropriate banking services are available to this Trust as corporate trustee. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission. ~~Where such banking services are undertaken by the SSC detailed requirements will be set out in a Legally Binding Agreement with the SSC~~.

17.8 Asset Management

17.8.1 Assets in the ownership of or used by the Trust as corporate trustee, shall be maintained along with the general estate and inventory of assets of the Trust. The Chief Financial Officer shall ensure:

17.8.1.1 that appropriate records of all assets owned by the Trust as corporate trustee are maintained, and that all assets, at agreed valuations, are brought to account;

17.8.1.2 that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

17.8.1.3 that donated assets received on trust shall be accounted for appropriately;

17.8.1.4 that all assets acquired from donated funds which are intended to be retained within the donated funds are appropriately accounted for.

~~17.8.2 Where any aspect of asset management as set out in SFI 17.8.1 is undertaken by a Shared Service Centre detailed requirements will be set out in a Legally Binding Agreement with the Shared Service Centre.~~

17.9 Reporting & Accounting and Audit

~~17.9.1~~ The Chief Financial Officer shall ensure that regular reports are made to the Charity~~Policy and Resources~~ Committee of the Board with regard to, inter alia, the receipt of funds, investments, and the disposition of resources. ~~Where any financial records are maintained and produced by a SSC detailed requirements will be specified in a Legally Binding Agreement with the SSC.~~

17.9.1

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17.9.2 The Chief Financial Officer shall prepare annual accounts in the required manner which shall be submitted to the Board within agreed timescales.

17.9.3 The Chief Financial Officer shall prepare an annual trustees' report (separate reports for charitable and non-charitable trusts) and the required returns to the NHS Executive and to the Charity Commission for adoption by the Board.

17.9.4 The Chief Financial Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

17.9.5 The Chief Financial Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. They~~He / she~~ will liaise with external audit and provide them with all necessary information.

17.9.6 The Board shall be advised by the Chief Financial Officer on the outcome of the annual audit. The Chief Executive shall submit the Management Letter to the Board.

18 ACCEPTANCE OF GIFTS

18.1 The Chief Financial Officer shall ensure that all Officers are made aware of the Trust policy on acceptance of gifts and other benefits in kind by Officers. This policy should follow the guidance contained in the Department of Health and Social Care Standards of Business Conduct for NHS Staff and the Code of Governance for NHS Provider Trusts~~NHS Foundation Trust Code of Governance~~.

18.2 The Trust Guidelines on The Standards of Business Conduct are included in the personnel reference book. They require that a declaration of gifts, benefits, hospitality or sponsorship of any kind, whether refused or accepted, will be entered in a register. A central ~~Trust~~ register is held by the Trust. ~~Secretary.~~

19 RETENTION OF DOCUMENTS

19.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in Parts 1 and 2 of "Records Management: NHS Code of Practice (August 2021) (the "Records Management Code").

19.2 The documents held in archives shall be capable of retrieval by authorised persons.

19.3 Documents held under the Records Management Code shall only be destroyed at the express instigation of the Chief Executive, records shall be maintained of documents so destroyed.

19.4 Where any documents are held by a third party delivering services to the Trust ~~SSC~~ detailed requirements relating to 19.2 and 19.3 will be set out in a Legally Binding Agreement with the third party~~SSC.~~

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20 FREEDOM OF INFORMATION

20.1 The Chief Executive ~~Financial Officer~~ shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the Information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information that the Trust makes publicly available

21 RISK MANAGEMENT AND INSURANCE

21.1 The Chief Executive shall ensure that the Trust has a programme of risk management in accordance with current directions and guidance in relation to assurance frameworks as issued by NHS ~~Improvement~~England which will be approved and monitored by the Board of Directors.

21.2 The programme of risk management shall include:

21.2.1 a process for identifying and quantifying risks and potential liabilities;

21.2.2 engendering among all levels of Officer a positive attitude towards the control of risk;

21.2.3 management processes to ensure all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

21.2.4 contingency plans to offset the impact of adverse events;

21.2.5 audit arrangements, including internal audit, clinical audit, health and safety review;

21.2.6 decisions on which risks shall be insured;

21.2.7 arrangements to review the risk management programme.

21.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control as required by the NHS Foundation Trust Reporting Manual.

21.4 The Board of Directors shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self insure for some or all of the risks covered by the risk pooling schemes. If the Board of Directors decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.5 The Trust may not enter into insurance arrangements with commercial insurers except:

21.5.1 for the purpose of insuring motor vehicles owned by the Trust including insuring third party liability arising from their use;

21.5.2 where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into; and

21.5.3 where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the NHS Resolution. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should consult the NHS Resolution.

21.6 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

21.7 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of

the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

21.8 All the risk-pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Chief Financial Officer should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

22 ADMINISTRATION COSTS

22.1 The Chief Financial Officer shall identify all costs directly incurred in the administration of charitable funds and, in agreement with the Board, shall charge such costs to the appropriate charitable funds.

23 TAXATION AND EXCISE DUTY

23.1 The Chief Financial Officer shall ensure that any charitable fund liability to taxation and excise duty is managed appropriately, taking full advantage of available concessions, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

APPENDIX 1

TENDERING PROCEDURE

1 Invitation to Tender

1.1 All invitations to tender on a formal competitive basis shall state that no tender will be considered for acceptance unless submitted in either:

1.1.1 a plain, sealed package bearing a pre-printed label supplied by the Trust (or bearing the word `Tender' followed by the subject to which it relates and the latest date and time for the receipt of such tender); or

1.1.2 in a special envelope supplied by the Trust to prospective tenderers and the tender envelopes/packages shall not bear any names or marks indicating the sender.

1.2 Where an e-tendering software package is used the suppliers response will be completed on-line and uploaded into a secure electronic mailbox until the opening time.

1.3 Every tender for goods, materials, manufactured articles supplied as part of a works contract and services shall embody such of the main contract conditions as may be appropriate in accordance with the contract forms described in Section 1.43 and 1.54 below.

1.4 Every tender for building and engineering works, except for maintenance work only where Estatecode guidance should be followed, shall embody or be in the terms of the current edition of the appropriate Joint Contracts Tribunal (JCT) or Department of the Environment (GC/Wks) standard forms of contract amended to comply with Concode. When the content of the works is primarily engineering, tenders shall embody or be in the terms of the General Conditions of Contract recommended by the Institutions of Mechanical Engineers and the Association of Consulting Engineers (Form A) or, in the case of civil engineering work, the General Conditions of Contract recommended by the Institution of Civil Engineers. The standard documents should be amended to comply with Concode and, in minor respects, to cover special features of individual projects. Tendering based on other forms of contract may be used only after prior consultation with the DoH and/or NHS ~~Improvement~~England as appropriate.

1.5 Every tender for goods, materials, services (including consultancy services) or disposals shall embody such of the NHS Standard Contract Conditions as are applicable. Every tenderer must have given or give a written undertaking not to engage in collusive tendering or other restrictive practice.

1.6 A minimum of three weeks must be allowed from the date upon which the invitation to tender issued to the date for return of tenders.

2 Receipt, Safe Custody and Record of Formal Tenders

~~2.1 Formal competitive tenders shall be addressed to the Chief Financial Officer.~~

~~2.2~~2.1 The date and time of receipt of each tender shall be recorded and maintained within an official log. This log must be kept safely and securely at all times.

2.32.2 The Chief Executive shall designate an officer or officers, not from the originating department, to receive tenders on theirhis behalf and to be responsible for their endorsement and safe custody until the time appointed for their opening, and for the records maintained in accordance with Section 3.

2.42.3 Where an electronic tendering package is used the tender documents will be stored in the electronic mailbox until the closing date and time. An audit log within the e-tendering system will record the date and time the offer documents are received.

3 Opening Formal Tenders

3.1 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders they shall be opened in the presence of two senior officers designated by the Chief Executive and not from the originating department.

3.2 Where an electronic tendering package is used the system must have a time lock preventing any tender being opened until the tender is due. After that time the tender documents may be opened electronically by a procurement professional providing the system can produce a detailed log covering all tenders that had been received at the time of opening.

3.3 Every tender received shall be stamped with the date of opening and initialed by two of those present at the opening.

3.4 Where an electronic tendering package is used the details of the persons opening the documents will be recorded in the audit trail together with the date and time of the document opening

3.5 A permanent record shall be maintained to show for each set of competitive tender invitations dispatched:

3.5.1 the names of firms/individuals invited;

3.5.2 the names of and the number of firms/individuals from which tenders have been received;

3.5.3 the total price(s) tendered;

3.5.4 closing date and time;

3.5.5 date and time of opening;

and the record shall be signed by the persons present at the opening.

3.6 Where an electronic tendering package is used all actions by both procurement staff and suppliers are recorded within the system audit reports.

3.7 Except as in Section 3.8 below, a record shall be maintained of all price alterations on tenders, i.e. where a price has apparently been altered, and the final price shown shall be recorded. Every price alteration appearing on a tender and the record should be initialed by two of those present at the opening.

3.8 A report shall be made in the record if, on any one tender, price alterations are so numerous as to render the procedure in Section 3.5 unreasonable.

4 Admissibility and Acceptance of Formal Tenders

4.1 In considering which tender to accept, if any, the designated officers shall have regard to whether value for money will be obtained by the Trust and whether the number of tenders received provides adequate competition. In cases of doubt they shall consult the Chief Executive.

4.2 Tenders received after the due time and date may be considered only if the Chief Executive or Nominated Officer decides that there are exceptional circumstances, e.g. where significant financial, technical or delivery advantages would accrue, and is satisfied that there is no reason to doubt the bona fides of the tenders concerned. The Chief Executive or Nominated Officer shall decide whether such tenders are admissible and whether re-tendering is desirable. ~~Retendering may be limited to those tenders reasonably in the field of consideration in the original competition.~~ If the tender is accepted the late arrival of the tender should be reported to the Board at its next meeting. The same procedure will apply where an e-tendering system is used.

4.3 Technically late tenders (ie those dispatched in good time but delayed through no fault of the tenderer) may at the discretion of the Chief Executive be regarded as having arrived in due time. The same procedure will apply where an e-tendering system is used.

4.4 Incomplete tenders (ie those from which information necessary for the adjudication of the tender is missing) and amended tenders (ie those amended by the tenderer upon their~~his~~ own initiative either orally or in writing after the due time for receipt) should be dealt with in the same way as late tenders under Section 4.2 The same procedure will apply where an e-tendering system is used.

4.5 Where examination of tenders reveals errors which would affect the tender figure, the tenderer is to be given details of such errors and afforded the opportunity of confirming or withdrawing their~~his~~ offer. The same procedure will apply where an e-tendering system is used.

4.6 Necessary discussions with a tenderer of the contents of their~~his~~ tender, in order to elucidate technical points etc, before the award of a contract, need not disqualify the tender.

4.7 While decisions as to the admissibility of late, incomplete, or amended tenders are under consideration and while re-tenders are being obtained, the tender documents shall remain strictly confidential and kept in safekeeping by an officer designated by the Chief Executive.

4.8 Where only one tender/quotation is received the Chief Executive or Nominated Officer shall, as far as practicable, ensure that the price to be paid is fair and reasonable.

4.9 A tender other than the lowest (if payment is to be made by the Trust), or other than the highest (if payment is to be received by the Trust) shall not be accepted unless for good and sufficient reason the Trust decides otherwise and records that decision in the tender evaluation report and in the record referred to in 3.3 above.

4.10 Where the form of contract includes a fluctuation clause all applications for price variations must be submitted in writing by the tenderer and shall be approved by the Chief Executive or Nominated Officer.

4.11 All Tenders should be treated as confidential and should be retained for inspection.

6. E-Auctions

6.1 E-auction technology may be used as part of the tender process as long as the system used:

(a) Maintains equality as part of the tender process; and has a clear audit trail for every bid submitted.

Berkshire Healthcare
NHS Foundation Trust

ORG001c

RESERVATION OF POWERS TO THE BOARD AND DELEGATION OF POWERS

Policy & Procedures

Berkshire Healthcare NHS Foundation Trust

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

Re-issued: **October 2022**
Review Date: **October 2024**
Version: **9**

Berkshire Healthcare
NHS Foundation Trust

Policy Number: **Title of Policy:**	**ORG001c** **Reservation of Powers to the Board and Delegation of Powers**
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Designated Lead:	Chief Financial Officer
For policy information:	Policy Administration Berkshire Healthcare NHS Foundation Trust London House London Road Bracknell RG12 2UT 0300 247 3000

POLICY DEVELOPMENT

ORG001c - RESERVATION OF POWERS TO THE BOARD AND DELEGATION OF POWERS

History:	Version 10: Approved by Audit Committee 30 October 2024 and ratified by the Trust Board 10 November ~~December~~ 2024 (to be confirmed)
	Version 9: Approved by Audit Committee 26 October 2022 and ratified by the Trust Board 8 November 2022
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	Version 7: References to Finance Director amended to Chief Financial Officer. References to NHS Improvement amended to NHS Improvement. Approved by Audit Committee January 2019.
	Version 6: Minor update for changes in statute and regulatory guidance. Approved by Audit Committee – 29th October 2015
	Version 5: approved by Audit Committee - 24th October 2013.
	Version 4: approved by the Audit Committee on 29th July 2009.
	Version 3: approved by the Trust Board, March 2008.
	Version 2: approved by the Trust Board, February 2006.
Designated Lead:	Chief Financial Officer
Policy Consultants:	Trust Board

Distributed for comments: Audit Committee

INDEX

1. INTRODUCTION

The NHS Foundation Trust Code of Governance (July 2014, updated 1 April 2023) for NHS Boards requires the Board of Directors to draw up a Schedule of decisions reserved to the Board only and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation. However, the Board of Directors remains accountable for all of its functions, including those, which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain its monitoring role.

All powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to a Board Committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions, which the Chief Executive shall perform personally and those delegated to other Directors or Officers. All powers delegated by the Chief Executive can be reassumed by him/her should the need arise.

The Chief Executive Officer should also ensure he or she complies with the NHS Foundation Trust Accountable Officer Memorandum.

2. FUNCTIONS WHICH ARE RESERVED FOR DECISION BY THE BOARD OF DIRECTORS:

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
NA	THE BOARD OF DIRECTORS	**General Enabling Provision** The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.
NA	THE BOARD OF DIRECTORS	**Regulations and Control** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in public session in accordance with SO 4.2.1 5. Approve a scheme of delegation of powers from the Board to committees, Officers or other bodies. 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. For clarity this would comprise details of the structure of the Board and its sub-committees and the Directorate structure of the Trust. Organisational structures below Executive and Clinical Director are the responsibility of the Chief Executive. 10. Receive reports from committees including those that the Trust is required by the Secretary of State, NHS England~~Improvement~~ or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 13. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients'

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		property. 14. Approval of arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust. 15. Authorise use of the seal. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 4.5 17. Approval of the disciplinary procedure for Officers of the Trust. 18. Discipline members of the Board or Officers who are in breach of statutory requirements or SOes. 19. Approval of the Trust's Major Incident Plan 20. Specification of Financial and Performance Reporting Arrangements
NA	THE BOARD OF DIRECTORS	**Appointments/ Dismissal** 1. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 2. Through the Appointments and Remuneration Committee, appoint, appraise, discipline and dismiss Executive Directors (subject to S 25 of the Trust's Constitution). 3. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 4. Approve proposals of the Appointments and Remuneration Committee regarding directors.
NA	THE BOARD OF DIRECTORS	**Strategy, Business Plans and Budgets** 1. Define the strategic aims and objectives of the Trust. 2. Identify the key strategic risks, evaluate them and ensure adequate responses are in place and are monitored 3. Approve proposals for ensuring quality and developing clinical governance, risk management in services provided by the Trust, having regard to any guidance issued by the Secretary of State and/or NHS ~~Improvement~~England. 4. Approve the Trust's policies and procedures for the management of risk. 5. Approval annually of integrated business plan 6. Approve Final Business Cases for Capital Investment above £300K 7. Approve budgets and annual financial plans. 8. Approve Trust's proposed organisational development proposals. 9. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		10. Approve PFI proposals. 11. Approve the opening and closing of any commercial bank accounts 12. Approve any Working Capital Facility 13. Approve proposals on individual contracts of a capital or revenue nature amounting to, or likely to amount to Investment in Fixed Assets < £1m, Contracts / services generating Income < £2.5m pa. 14. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Financial Officer (for losses and special payments) previously approved by the Board. 15. Approve individual compensation payments made outside of legal / statutory or mandatory requirements. 16. Approve proposals for action on litigation against or on behalf of the Trust. 16. Review use of NHS Resolution risk pooling schemes (LPST/CNST/RPST). 17. Approve, subject to Council of Governors agreement, proposals to enter into significant or material transactions as defined by NHS England's ~~Improvement's Single~~ Oversight Framework 18. Approve, subject to Council of Governors agreement, any proposal for the merger, acquisition, disaggregation, separation or dissolution of the Trust.
	THE BOARD OF DIRECTORS	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff.
	THE BOARD OF DIRECTORS	**Audit** 1. Receive the annual management letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee.
NA	THE BOARD OF DIRECTORS	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. The Board of Directors may choose to delegate authority to approve the Annual Accounts to the Audit Committee in order to meet NHS ~~Improvement~~England's deadline for submission of the Annual

REF	THE BOARD OF DIRECTORS	DECISIONS RESERVED TO THE BOARD
		Accounts. 2. Receipt and approval of the Trust's Annual Quality Account
NA	THE BOARD OF DIRECTORS	**Monitoring** 1. Receive such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require of reports from directors, committees, and Officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and/or NHS ~~Improvement~~England and the Charity Commission shall be reported, at least in summary, to the Board. 3. Receive reports from Chief Financial Officer on financial performance against income and expenditure budget and business plan.

3. DECISIONS/DUTIES DELEGATED BY THE BOARD TO COMMITTEES

REF	COMMITTEE	DUTIES DELEGATED BY THE BOARD TO COMMITTEES
SFI 2.1.1 & SO 5.1	AUDIT COMMITTEE	See Terms of reference As mentioned above, The Board of Directors may choose to delegate authority to approve the Annual Accounts to the Audit Committee in order to meet NHS ~~Improvement~~England's deadline for submission of the Annual Accounts.
SO 5.1	FINANCE, INVESTMENT & PERFORMANCE COMMITTEE	See Terms of reference
SO 5.1	APPOINTMENTS & REMUNERATION COMMITTEE	See Terms of reference
	QUALITY ASSURANCE COMMITTEE	See Terms of Reference
SO 5.1	CHARITABLE FUNDS COMMITTEE	See Terms of reference

4. SCHEME OF DELEGATION FROM STANDING ORDERS

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
3.2.2	CHAIRMAN	Call meetings.
3.7	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.8.1	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity (including procedure on handling motions) of meetings and the interpretation of any SO or SFI.
3.13.1	CHAIRMAN	Having a second or casting vote
3.15.1	BOARD	Suspension of Standing Orders
3.15.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.16	BOARD	Variation and amendment of Standing Orders
4.2.1	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency or in the need for an urgent decision be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive members.
4.4.2	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
7.1	THE BOARD	Declare any actual or potential, direct or indirect, financial interests which is material to any discussion or decision the Board of Directors are involved or likely to be involved in making in relation to any contract, proposed contract or other matter under consideration by the Board of Directors.
7.16.4	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
8.1.1	ALL STAFF	Comply with national guidance on Managing Conflicts of Interest (September 2017) and the Code of Governance for NHS Provider Trusts (February 2023) and the Code of Conduct for NHS Managers

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		2002.~~Comply with national guidance contained in HSG 1993/5 "Standards of Business Conduct for NHS Staff" the Code of Conduct for NHS Managers 2002 and Code of Governance for NHS Foundation Trusts (July 2014)~~
8.4.2	DIRECTORS AND EVERY MEMBER AND OFFICER	Disclose to the CEO any relationship between self and candidate for staff appointment. (CE to report the disclosure to the Board)
9.	CHIEF EXECUTIVE	Tendering and contract procedure.
9.3.2	CHIEF EXECUTIVE/ CHIEF FINANCIAL OFFICER	Waive formal tendering procedures and make Direct Awards.
9.3.4	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
APPENDIX 1 PARA 2.3 of SFI	CHIEF EXECUTIVE OR NOMINATED OFFICER	~~Responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.~~ Ensure electronic systems for receipt of tenders are appropriate to maintain security and equal treatment of tenders received.
APPENDIX 1 PARA 4.8 of SFI	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Where only one tender is sought and/or received shall as far as practicable ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
APPENDIX 1 PARA 4.3 of SFI	CHIEF EXECUTIVE OR NOMINATED OFFICER	Responsible for treatment of 'late tenders'.
9.4.5	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
~~APPENDIX 1 PARA 5.1 of SFI~~	~~CHIEF EXECUTIVE~~	~~Will appoint a manager to maintain a list of approved firms.~~
APPENDIX 1 PARA 4.2 of SFI AND 5.3	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote where it is impractical to use a potential contractor from the list of approved firms/individuals or where a list has not been prepared. Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CEO.

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
9.4.8	CHIEF EXECUTIVE OR NOMINATED OFFICER	The Chief Executive or his nominated officer should evaluate the tenders~~quotation~~ and select the most advantageous tender.~~quote which gives the best value for money.~~
9.5.1.1	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
9.5.1.3	BOARD OF DIRECTORS	All PFI proposals, including material variation to existing agreements must be agreed by the Board of Directors.
9.7.1	CHIEF EXECUTIVE	The Chief Executive shall nominate Officers with delegated authority to enter into and manage contracts of employment of other Officers and enter into contracts for the employment of agency staff or temporary staff service contracts.
9.4.8	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house.
11.4	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
12.1.1 AND 12.3.1	CHIEF EXECUTIVE OR NOMINATED OFFICER	Keep seal in safe place and maintain register of sealing
13.1	CHIEF EXECUTIVE	Approve and sign all documents which will be necessary in legal proceedings

5. SCHEME OF DELEGATION FROM STANDING FINANCIAL INSTRUCTIONS

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
Introduction	CHIEF FINANCIAL OFFICER	Approval of all financial procedures.
Interpretation	THE CHAIRMAN ON THE ADVICE OF THE CHIEF EXECUTIVE AND THE CHIEF FINANCIAL OFFICER	Advice on interpretation or application of SFIs.
Compliance	ALL MEMBERS OF THE BOARD AND OFFICERS	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible together with full details of the non-compliance and the circumstances around non-compliance.
1.1.4	CHIEF EXECUTIVE	Responsible as the Accountable Officer to ensure that the Board of Directors meets its obligations to perform its functions within the available financial resources, and has overall executive responsibility for the Trusts' activities, is responsible to the Chairman and the Board of Directors for ensuring that its financial targets and obligations are met and has overall responsibility for the System of Internal Control.
1.1.5	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
1.1.6	CHIEF EXECUTIVE	To ensure all existing Directors and Officers and all new appointees, present and future, are notified of and understand Standing Financial Instructions.
1.1.7	CHIEF FINANCIAL OFFICER	Responsible for: a) Implementing the Trust's financial policies and for coordinating corrective action necessary to further these policies; b) Maintaining an effective system of internal financial control including ensuring detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained;

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position; d) Providing financial advice to the Trust, other than to the Board of Directors and Officers; e) Preparing and maintaining such accounts, certificates, estimates, records and reports as are required for the Trust to carry out its statutory duties. f) The design, implementation and supervision of systems of internal control.
1.1.8	ALL MEMBERS OF THE BOARD AND OFFICERS	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Standing Financial Instructions the Scheme of Delegation.
1.1.9	CHIEF EXECUTIVE	Ensure that any Officer including a contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
2.1.3	CHAIR OF THE AUDIT COMMITTEE	Where there is evidence of ultra vires transaction or improper acts or other important matters these should be raised with the Chief Financial Officer
2.2.2~~1~~	CHIEF FINANCIAL OFFICER	a) Ensure that there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function b)Ensure that the internal Audit Function meets NHS ~~Improvement~~England's internal Audit standards and provides sufficient independent and objective assurance to the Audit Committee and the Accounting Officer c) decide at what stage to involve the police in cases of misappropriation and fraud d) Ensure the annual audit and Governance report is prepared for consideration by the Audit Committee and the Board of Directors covering the detail specified at SFI 2.2.1.4
2.3.1-2.3.4	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Standards and best practice and provide to the Audit Committee a risk based plan of internal audit work, regular updates, reports on the management progress on the implementation of action agreed as a result of internal audit findings, an annual opinion, a report supporting assurances to the Healthcare Commission and any additional reports as required by the Audit Committee.
2.4	CHIEF EXECUTIVE & CHIEF FINANCIAL OFFICER	~~NHS Improvement and e~~Ensure compliance with the guidance issued by the D~~O~~HSC and NHS ~~Improvement~~England on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
2.4.4	CHIEF FINANCIAL	Preparation of the Fraud Response Plan

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	
2.4.5	ANY OFFICER	Immediately inform their Head of Services or Department on the discovery or suspicion of any loss.
2.4.5	ANY OFFICER	Immediately inform the Chief Executive and Chief Financial Officer or an Officer charged with investigating loss or fraud or confidentiality on receipt of any information concerning the discovery of or suspicion of fraud
2.4.5	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Immediately inform the LCFS and Operational Fraud Team on receipt of information concerning the discovery or suspicion of fraud.
2.4.5 – 2.4.7	CHIEF FINANCIAL OFFICER	Immediately inform the police if theft or arson is involved but in the case of fraud or corruption will determine the appropriate stage in which to involve the police based on the facts of the case. Notify the Board and the Auditor of losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness except if trivial or where fraud is not suspected.
2.5.1	EXTERNAL AUDIT	Ensure cost-effective External Audit and compliance with NHS ~~Improvement~~England's Audit Code.
3.2.1	CHIEF EXECUTIVE	Compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
3.2.2 & 3.2.3	CHIEF FINANCIAL OFFICER	Submit revenue and capital budgets annually to the Board for approval. NHS ~~Improvement~~England performance against budgets and the business plan; periodically review them and report to the Board of Directors.
3.2.5	CHIEF FINANCIAL OFFICER	Ensure adequate training is delivered on an on going basis to budget holders.
3.3.1	CHIEF EXECUTIVE	Delegate the management of a budget to permit the performance of a defined range of activities to budget holders.
3.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board of Directors.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
3.4.1	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.
3.4.2	BUDGET HOLDERS	Ensure that a) any significant or wilful deviation likely to result in overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the line manager. b) the amount provided in the approved budget is not used in whole or in part for any other than specified purpose , subject to rules of virement; c) no permanent Officers are appointed without the approval of the CEO other than those provided for within available resources and manpower establishment as approved by the Board of Directors.
3.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Business Plan.
3.6.1	CHIEF EXECUTIVE	Submit monitoring returns
4.1	CHIEF FINANCIAL OFFICER	Preparation of financial returns, annual accounts and reports to HM Treasury and NHS ~~Improvement~~England as necessary.
5.1 – 5.3	CHIEF FINANCIAL OFFICER	Managing banking arrangements, advising the Trust on the provision of banking services and operation of accounts including: a) the provision and operation of bank accounts and GBS accounts, establishing: bank accounts and GBS accounts and separate bank accounts for Exchequer funds, ensuring payments do not exceed the amount credited to the account, reporting to the Board of Directors all arrangements for accounts to be overdrawn and monitoring compliance with guidance issued by the Department of Health and Social Care~~OH~~, NHS ~~Improvement~~England and any other relevant guidance on the level of cleared funds. b) ensuring that detailed instructions are in place for the operation of bank and GBS accounts, the conditions under which such accounts are to be operated, the limits to be applied to any overdraft and specify the authorised signatories to sign cheques and orders drawn on the Trusts accounts c) advising the GBS of the conditions under which each account will operate, the limits to be applied to any overdraft, the limitation on single signatory payments and details of any officers authorised to release money or draw cheques. (Board approves arrangements.)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
5.4	CHIEF FINANCIAL OFFICER	a) Review the banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trusts' commercial banking business. b) Ensure competitive tenders are sought at least every 3 years for commercial bank accounts and the results of such a tendering exercise reported to the Board of Directors.
6.1 – 6.2.	CHIEF FINANCIAL OFFICER	Designing and maintaining and ensuring compliance with systems for the proper recording, invoicing and collection of monies and coding of all monies including but not limited to prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for Officers whose duties include collecting or holding cash.
6.2.4<u>2</u>	ALL OFFICERS	Duty to inform Chief Financial Officer promptly of money due from transactions which they initiate/deal with.
7.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable legally binding agreements with service commissioners for the provision of NHS services
8.1.1	BOARD OF DIRECTORS	Establish an Appointments and Remuneration Committee
8.1.2	APPOINTMENTS & REMUNERATION COMMITTEE	Advise the Board on and make recommendations on the remuneration and terms of service of the CEO and Executive Directors and other Very Senior Managers to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements; NHS ~~Improvement~~<u>England</u> and evaluate the performance of individual Executive Directors and Senior Managers of the Trust; Advise on and oversee appropriate contractual arrangements for all Directors and Very Senior Managers including proper calculation and scrutiny of termination payments taking account of such national guidance as appropriate.
~~8.1.3~~	~~APPOINTMENTS & REMUNERATION COMMITTEE~~	~~Report in writing to the Board of Directors its advice and its basis about remuneration and terms of service of the Chief Executive and other Executive Directors and senior Officers.~~
~~8.1.4~~	~~BOARD OF DIRECTORS~~	~~Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those officers not covered by the Remuneration Committee.~~
8.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
8.<u>1</u>3.<u>2</u>	CHIEF EXECUTIVE	Authorisation of the engagement, re-engagement, re-grade, hire or change in remuneration of any Officer

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		including agency staff engaged either on a temporary or permanent basis, within the limit of the approved budget and funded establishment.
8.154.1 ~~8.4.2~~	CHIEF FINANCIAL OFFICER	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; ~~d)~~ agreeing method of payment; ; d) issuing instructions.
8.154.5	NOMINATED MANAGERS	Submission of time records and notifications in accordance with agreed timetables. Completion of time records and other notifications in accordance with the Chief Financial Officer's instructions and in a form prescribed by the Chief Financial Officer. Submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement Notifying the Chief Financial Officer immediately where an Officer fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice.
8.154.6	CHIEF FINANCIAL OFFICER	Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
8.165	NOMINATED OFFICER MANAGER	Ensure that all Officers are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
9.1.1	BOARD OF DIRECTORS	Approve the level of non-pay expenditure on an annual basis
9.1.1. AND 9.1.2	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to Budget Managers, including a list of Officers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level.

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SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
9.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
9.2.2	REQUISITIONING OFFICER	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Team. ~~and Logistics Manager on supply shall be sought~~. Where this advice is not acceptable to the requisitioner the advice of the Chief Financial Officer and or the Chief Executive should be consulted. For requisitions over £139,688~~72,514~~ (excluding VAT) the requisitioning Officer should consult the Head of Procurement.
9.2.4.3	CHIEF FINANCIAL OFFICER	Shall be responsible for the prompt payment of accounts and claims.
9.2.4	CHIEF FINANCIAL OFFICER	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable which shall provide for the matters listed at SFIs 9.2.4.4.1 - 9.2.4.4.4; e) Be responsible for a timetable and submission to the Chief Financial Officer of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to Officers regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received except those obtained by pre-payment.
9.2.5.2	APPROPRIATE EXECUTIVE DIRECTOR	Make a written case to support the need for a prepayment, setting out all the relevant circumstances of the purchase and the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments
9.2.5.3	CHIEF FINANCIAL OFFICER	Approve proposed prepayment arrangements taking into account the ~~EU~~ public procurement rules where the contract is above a stipulated financial threshold.
9.2.5.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform as necessary

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		the appropriate Director or the Chief Executive Officer if problems are encountered).
9.2.6.2	CHIEF FINANCIAL OFFICER	Approve the form of Official Orders
9.2.6.4	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
9.2.8	OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and the requirements detailed at SFI 9.2.8.1 to 9.2.8.13.
9.2.9	CHIEF FINANCIAL OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within Hospital Building Note 00-08;ESTATECODE. ~~CONCODE and ESTATECODE~~. The technical audit of these contracts shall be the responsibility of the relevant Executive Director.
10.1	CHIEF FINANCIAL OFFICER	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 75 of the NHS Act 2006.
11.1	CHIEF FINANCIAL OFFICER	The Chief Financial Officer will advise the Board of Directors on the Trust's ability to pay dividend on, and repay PDC and any proposed new borrowing and report, periodically, concerning the PDC debt and all loans and overdrafts.
11.2	BOARD OF DIRECTORS	Agree a list of Officers (including specimens of their signatures) authorised to make short term borrowings on behalf of the Trust. (This must include the Chief Executive and Chief Financial Officer.)
11.3	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
11.5	CHIEF EXECUTIVE OR CHIEF FINANCIAL OFFICER	Be on an authorising panel comprising one other member for short term borrowing approval and inform the Board of Directors of all short term borrowings at the next Board Meeting.
11.7	BOARD OF DIRECTORS	Authorise temporary cash surpluses
11.8	CHIEF FINANCIAL OFFICER	Will advise the Board on investments and report, periodically to the Board on performance of same.
12.1.1– 12.1.2	CHIEF EXECUTIVE	Capital investment programme:

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans b) be responsible for the management of all stages of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without confirmation of purchaser support and the availability of resources to finance all revenue consequences, including capital charges; d) ensure that a business case is produced for every capital proposal setting out the matters referred to at SFI 12.1.2.1.1 – 12.1.2.1.3.
12.1.2.2	CHIEF FINANCIAL OFFICER	Certify the costs and revenue consequences detailed in the business case for capital investment and involve appropriate Trust personnel and external agencies in the process.
12.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts for capital schemes involving stage payments incorporating the recommendations of Concode
12.1.3	CHIEF FINANCIAL OFFICER	Assess on an annual basis the requirement for the operation of the construction industry taxation deduction scheme in accordance with HMRC guidance.
12.1.3	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
12.1.4 – 12.1.5	CHIEF EXECUTIVE	Issue to the Officer responsible for any capital scheme specific authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
12.1.6	CHIEF FINANCIAL OFFICER	Issue procedures governing financial management, including variations to contracts of capital investment projects and valuation of accounting processes fully taking into account the delegated limits for capital schemes as referenced in guidance issued by NHS ~~Improvement~~England
12.1.7	CHIEF FINANCIAL OFFICER	Ensure that NHS ~~Improvement~~England's Annual Reporting Manual ('ARM') is followed in the production of the Trust's annual accounts and reports
12.2.1.1	CHIEF FINANCIAL OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
12.2.1.2	BOARD OF DIRECTORS	Proposal to use PFI must be specifically agreed by the Board.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
12.3.1	CHIEF EXECUTIVE	Maintenance of asset registers taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.
12.3.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
12.3.8	CHIEF FINANCIAL OFFICER	Calculate and pay capital charges as specified in the Annual Reporting Manual issued by NHS ~~Improvement~~England.
12.4.1	CHIEF EXECUTIVE	Overall responsibility for the control of fixed assets.
12.4.2	CHIEF FINANCIAL OFFICER	Approval of asset control procedures.
12.4.5	MEMBERS OF THE BOARD, SENIOR OFFICERS	Responsibility to apply routine security practices in relation to Trust property as may be determined by the Board of Directors. Any breach should be reported in accordance with agreed procedures.
13.2	CHIEF EXECUTIVE AND NOMINATED OFFICER	Overall responsibility for control of stocks and stores may be delegated to an Officer. Further delegation for day-to-day responsibility to departmental Officers subject to such delegation being recorded in a record available to the Chief Financial Officer.
13.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for the control of any Pharmaceutical stocks
13.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
13.3	DESIGNATED MANAGER	Responsibility for defining in writing the security arrangements relating to the custody of keys for all stores and locations
13.4	CHIEF FINANCIAL	Set out procedures and systems to regulate the stores including receipt of goods, issues, returns to stores

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	and losses.
13.5	CHIEF FINANCIAL OFFICER	Agree stocktaking arrangements.
13.5~~6~~	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where a complete system of stores control is not justified.
13.6~~7~~	CHIEF FINANCIAL OFFICER	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable articles.
13.6~~7~~	DESIGNATED MANAGER*	Operate a system approved by the Chief Financial Officer for slow moving and obsolete stock, for condemnation, disposal and replacement of unserviceable articles and report to the Chief Financial Officer evidence of significant overstocking and any negligence or malpractice.
13.6~~8~~	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores
13.8	REQUISTIONING OFFICER	Check receipt of goods against the delivery note before forwarding the note to the Chief Financial Officer
13.8	CHIEF FINANCIAL OFFICER	Satisfy themselves that the goods received from the NHS Supplies Store have been received before accepting the recharge.
14.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for disposal of assets in accordance with the 'Asset register and disposal of assets: guidance for providers of commissioner requested services (April 2014)' guidance issued by NHS ~~Improvement~~England including condemnations and ensure that these are notified to managers.
14.1.2	HEAD OF DISPOSALS AND CONDEMNATIONS OR AUTHORISED DEPUTY	Inform the Chief Financial Officer of the estimated market value of any disposal item taking account of professional advice where appropriate
14.2.1	CHIEF FINANCIAL OFFICER	Prepare procedural instructions on the recording of and accounting for condemnations, losses and special payments
14.2.2	BOARD OF DIRECTORS	Approve write off of losses above the level delegated to the CEO and Chief Financial Officer in the Financial Limits specified in the SFIs.
14.2.3	CHIEF FINANCIAL	Take the necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	OFFICER	
14.2.4	CHIEF FINANCIAL OFFICER	Consider whether any insurance claim can be made.
14.2.5	CHIEF FINANCIAL OFFICER	Maintain losses and special payments register in which write off action is recorded
15.1.1	CHIEF FINANCIAL OFFICER	Responsibility for the accuracy and security of computerised financial data and ensuring that the adequate controls, procedures and management trails as specified at SFI 15.1.1.1 to 15.1.1.4 are in place.
15.1.2	CHIEF FINANCIAL OFFICER	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurance of adequacy must be obtained from them prior to implementation.
15.2.1	OTHER DIRECTORS AND OFFICERS	Send proposals for general computer systems to the Deputy Chief Executive~~Chief Financial Officer~~ specifying the details of the outline design of the system and any operational requirements in the cases of packages acquired from either a commercial organisation, the NHS or from another public sector organisation.
15.3.1– 15.3.2	CHIEF FINANCIAL OFFICER	Ensure that contracts for computer services for financial applications with other health organisations or any other agency shall clearly define the responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review. Seek periodic assurances from the provider that adequate controls are in operation where such a computer service is provided for financial applications.
15.4	CHIEF FINANCIAL OFFICER	Ensure that risks to the Trust arising from the use of ~~IT~~ computer services for financial services are effectively identified and considered and appropriate action taken to migrate or control risk including the preparation and testing of appropriate disaster recovery and business continuity plans.
15.5.1	CHIEF FINANCIAL OFFICER	Where computer systems have an impact on corporate financial systems satisfy themselves that: a) systems acquisition, development and maintenance are in line with corporate policies such as the Information Technology Strategy; b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
		management audit trail exists; c) The Chief Financial Officer and staff have access to such data; d) Such computer audit reviews are being carried out as are considered necessary.
15.5.3	CHIEF FINANCIAL OFFICER	Ensure that separate control procedures are put in place for computer systems including: the acquisition and disposal of IT systems and equipment and the decommissioning of systems containing confidential data.
16.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed before or at admission either by notices or information booklets or orally that the Trust will generally not accept responsibility or liability for patients' property unless it is deposited for safe custody and a copy of the patient's property record is obtained as a receipt.
16.3	CHIEF FINANCIAL OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients.
16.4	CHIEF FINANCIAL OFFICER	Approve arrangements put in place for the opening and operation of separate accounts for the management of patient moneys
16.6	DEPARTMENTAL MANAGERS	Inform Officers on appointment of their responsibilities and duties for the administration of the property of patients.
17.1 -17.9	CHIEF FINANCIAL OFFICER	Ensure compliance with the obligations specified at SFI 17.1 to 17.9 relating to Funds held on Trust
18.1	CHIEF FINANCIAL OFFICER	Ensure all Officers are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by Officers
19.1	CHIEF EXECUTIVE	Maintaining Archives for all documents Retention of document procedures in accordance with the Records Management Code.
19.3	CHIEF EXECUTIVE	Authorise the destruction of documents
20.1	DIRECTOR OF NURSING	Publish and maintain a Freedom of Information Publication Scheme or adopt a model Publication scheme

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED OR RESERVED
	& GOVERNANCE	approved by the Information Commissioner.
21.1	CHIEF EXECUTIVE	Ensure that the Trust has a risk management programme which shall contain the detail specified at SFI 21.2
21.1	BOARD OF DIRECTORS	Approve and monitor risk management programme.
21.4	BOARD OF DIRECTORS	Decide whether the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling scheme. Decisions to self-insure should be reviewed annually.
21.6-21.7	CHIEF FINANCIAL OFFICER	Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Chief Financial Officer shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for any one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
21.8	CHIEF FINANCIAL OFFICER	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

6. DELEGATION BY FUNCTIONAL AREA

	FUNCTIONAL AREA	SCOPE	RESPONSIBILITY
1.	Competitive Tendering	- See S0 9	
2.	Sealing Documents	- See SO12	
2.1	The seal		Held by the Chief Executive or a Nominated Officer
2.2	Sealing Documents		Board of Directors
3.	Budgets	See SFI 3	Reported to: Chief Executive, Chief Financial Officer and Trust Board
3.1	Business Plan		Chief Executive and Trust Board
	Overall Income & Expenditure Annual Plan		Overall responsibility led by: Chief Financial Officer
3.2	Expenditure Budgets		Chief Financial Officer
3.4	Capital Programme - Business Cases		Chief Executive
	- Initiating spending on Capital schemes		Chief Executive and Chief Financial Officer
	- Managing Capital Projects		Chief Executive
3.5	Capital Expenditure		Chief Executive

4.	Bank Accounts and Procedures Opening Bank Accounts	See SFI 5	Chief Financial Officer and Board of Directors Chief Financial Officer
5.1 5.2	Legally binding Agreements Signing Agreements with Commissioners. Amendment to Agreements	SFI 7	Chief Executive Chief Executive Chief Executive
6.	Management of Stocks General Drugs Fuel, Oil and Coal	SFI 13	Chief Financial Officer & Departmental Managers/Officers Pharmaceutical Officer Estates Manager
7.	Management and Control of Computer Systems	SF1 15 – Specialist and general systems	Deputy Chief Executive~~Chief Financial Officer~~ & all responsible Directors and Officers
8.	Losses and Condemnations	SFI 14	Chief Financial Officer and Board of Directors

Summary of Key Changes

Page	Amendment
6	Tender Limits - OJEU limit of £189,330 replaced with FTS limit of £139,688

Summa

Berkshire Healthcare
NHS Foundation Trust

ORG001d

APPLICATION OF FINANCIAL LIMITS TO SCHEME OF DELEGATION

Policy & Procedures

Berkshire Healthcare

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

Re-issued: **October 2024**
Review Date: **October 2027**
Version: **5**

Policy Number:	**ORG001d**
Title of Policy:	**APPLICATION OF FINANCIAL LIMITS TO SCHEME OF DELEGATION**
Category:	Organisational To be read in conjunction with ORG001c – Reservation of Powers to the Board and Delegation of Powers
Distribution Areas:	All Trust Departments
Index:	Page 4
Total number of pages:	10
Approved by:	Audit Committee – October 2024
Re-issued:	October 2024
Review Date:	October 2027
Replaces Policy:	Version 4
Designated Lead:	Head of Financial Services
For policy information:	Governance Administration Manager Berkshire Healthcare NHS Foundation Trust 2nd Floor Fitzwilliam House Skimped Hill Lane Bracknell RG12 1BQ 01344 415623

POLICY DEVELOPMENT

History:	Version 5 – Update to competition and tendering limits Version 3: Amendment to Scheme of Delegation limits Version 2: Corporate and Tendering Limits revised as set by the OJEU.
Designated Lead:	Head of Financial Services
Policy Consultants:	Audit Committee Finance & Investment Committee Board Secretary Head of Procurement

INDEX

1. INTRODUCTION

1.1 Berkshire Healthcare Policy ORG001c Reservation of Powers to the Board and Delegation of Powers is a document that forms part of Berkshire Healthcare NHS Foundation Trust's (hereinafter referred to as Berkshire Healthcare) Constitution and defines the following:

- Functions that are reserved for decision by the Board of Directors of Berkshire Healthcare
- Decisions and/or duties delegated by the Board to the various sub-Board Committees
- Scheme of Delegation from Standing Orders
- Scheme of Delegation from Standing Financial Instructions, and
- Delegation by Functional Area.

1.2 ORG001c Reservation of Powers to the Board and Delegation of Powers does not define the financial limits that apply to the scheme of delegation and this document defines the values that can be authorised by delegated officers of Berkshire Healthcare.

1.3 The purpose of this document is to define the financial limits associated within the ORG001c Reservation of Powers to the Board and Delegation of Powers.

1.4 This policy links to ORG001c Reservation of Powers to the Board and Delegation of Powers, but which will be kept separate from that policy to enable flexibility in being able to amend financial limits without the need to amend or update the constitution.

2. FINANCIAL LIMITS

2.1 Details of the financial limits to be applied are provided to Appendix 1.

3. LEVELS

3.1 The following table provides a guide the tiers of management in the Trust. Please be aware that there may be local variation depending on the locality or service, so if unsure, please check with line management or Head of Financial Services.

Management Tier	Post	Applicable Roles	Authority Limit
Tier 1	CEO	CEO	>£300k
Tier 2	Executive Director	CFO, COO, Deputy CEO Director of Nursing Medical Director	Up to £300k
Tier 3	Director	Director of People, Director of Finance, Director of IM&T, Director of Estates, Regional Directors,	Up to £100k
Tier 4	Locality Directors	Locality Directors, Heads of Service, etc.	Up to £50k
Tier 5	Locality Managers	Locality Managers, etc.	Up to £20k
Tier 6	Service Manager	Ward Manager, Department Manager, etc.	Up to £5k

Appendix 1: Financial Limits applied to Scheme of Delegation

Income & Non-Pay Expenditure Limits

Type	Limit (£)	Management Tier
Commitment to generate all income that creates a liability for pay and/or non-pay costs Commitment to incur costs for all revenue non pay expenditure. A forecast assessment of likely costs is required before proceeding to determine the appropriate level of authorization and determine Procurement route. *Please also refer to Competition & Tendering Limits below*	>£300k CEO	Tier 1
	Up to £300k	Tier 2
	Up to £100k	Tier 3
	Up to £50k	Tier 4
	Up to £20k	Tier 5
	Up to £5k	Tier 6

Competition & Tendering Limits

Type	Limit (£) All Excluding VAT	Requirement
All contracts for purchase of goods and services Limits are based on total value of expenditure over standard contract term, not the amount in one year.	< £10K ex-VAT	No Competition
	£10K to £50K ex-VAT	3 Competitive Quotes
	£50K to £139,688 inc.-VAT	Competitive Tenders
	Over £139,688 inc.-VAT	FTS advertised tender
	Single Tender Waivers ➢ can only be used in exceptional circumstances ➢ may be obtained up to the FTS limit of £139,688 ➢ can only be approved by DoF / CFO *Any queries, please contact Head of Procurement*	

Pay Costs

Type	Limit (£)	Management Tier
For existing or replacement posts - commitment to incur costs as a result of contract of employment for permanent or temporary staff	All	Tier 1-4
For new posts - commitment to incur costs as a result of contract of employment for permanent or temporary staff. Also reference New Investments - (Revenue & Capital Expenditure) section below.	All	Tier 1-4

Budget Virements

Type	Limit (£)	Authorised Role(s)
Within Locality / Corporate Functions	<£100k	Locality Director or Head of Financial Mgt
	£100K to £250k	Locality Director or Director of Finance
	>£250k	CFO
Across Localities / Corporate Functions	<£100k	Each Locality Director or Head of Financial Mgt
	£100K to £250k	Each Locality Directors or Director of Finance
	>£250k	CFO

Temporary Pay Expenditure Limits

Type	Limit (£)	Management Tier
Non-Medical Bank Spend	All	Via NHSP
Non-Medical Agency Spend	All	Direct via LD for direct engagements/placements. Via NHSP safe staffing requests
Agency band 2-3 Healthcare Support Workers	All	CFO or DoN or COO
Agency Admin & Clerical (ALL)	All	CFO or DoN
Medical Agency Spend	>£300k CEO	Tier 1
	Up to £300k	Tier 2
	Up to £100k	Tier 3
	Up to £50k	Tier 4
	Up to £20k	Tier 5
	Up to £5k	Tier 6

NHSI Bank/Agency Rules to adhere to

Agency charge rate £100 per hour or greater (excluding VAT and Fees)
Approval is required from the Chief Executive Officer before proceeding. Reportable to NHSI

Agency charge rate is below £100 per hour (excluding VAT and Fees), but is 50% above the published price cap rate

Approval is required by an Executive Director. Reportable to NHSI

All Bank shifts over £100 per hour (excluding VAT and Fees) hour
Approval is required from the Chief Executive Officer before proceeding. Reportable to NHSI

Type	Limit (£)	Management Tier
Very Senior Managers ('VSM') Defined as all non-clinical, non-medical posts on local terms and conditions above band 9 Agenda for Change. Appointments that have been approved via the VSM approval process are recommended to be for one year at most. This document assumes a 'daily rate' will apply to a working day of at least 7.5 hours.	New contracts where the daily rate exceeds £750, including on costs	CEO followed by: NHSI Approval via Business Case Template NHSI
	Extending or varying existing contracts where the daily rate exceeds £750, including on costs	
	Incurring extra expenditure to which they are not already committed, where the daily rate for an agency VSM exceeds £750	

Setting Fees & Charges

Type	Limit (£)	Management Tier
Private Patient, Overseas Visitors, Income Generation and other patient related services.	All	CFO
Price of NHS Contracts	All	CFO

New Investments - (Revenue & Capital Expenditure)

Type	Limit (£)	Management Tier
New developments or investments in posts, functions or activities for both Revenue and Capital Expenditure	Up to £100k	Trust Business Group (TBG) Capital Review Group (CRG)
	£100k to £300k	Formal Executive Meeting (Following Recommendation of TBG/CRG)
	>£300k	Trust Board (Following Recommendation of Exec Meeting)

Losses, Write Offs & Special Payments inc Compensations (Reportable to Audit Committee)

Type	Limit (£)	Management Tier
Claims made under the NHSLA Liability to Third Parties Scheme (LTPS) or Property Equipment Scheme (PES)	All	Audit Committee On recommendation of CFO
Fines, Penalties or Late Payment Interest	All	Audit Committee On recommendation of CFO
Write off Bad or Unrecoverable Debt (including salary overpayments)	All	Audit Committee On recommendation of CFO
Losses relating to Employees or other workers	+£300k	Tier 1 & HMT via NHSI
	Up to £300k	Tier 2
	Up to £100k	Tier 3
	Up to £50k	Tier 4
	Up to £20k	Tier 5
	Up to £5k	Tier 6
Losses relating to Patients (excluding patient money but including personal belongings and possessions)	<£1k	Tier 6
	£1k to £5k	Tier 5
	£5k to £20k	Tier 4 and CFO
	>£20K	COO and CFO
Losses of Cash (including patients money)	All	CFO
Non-IM&T assets	Estimated fair value to £500	Tier 6
	Estimated fair value >£500	CFO
IM&T Assets (including mobile phones / tablets)	All	All redundant IM&T assets should be notified to IT Systems Helpdesk for recovery and safe disposal

Cash Investments in Commercial Deposit Account(s)

Type	Limit (£)	Management Tier
Investment of cash in short-term deposits	<£5m	CFO & CEO
Investment of cash in short-term deposits	£5m +	CFO & CEO & Chair of Finance & Investment Committee & one other Non-Executive Director

Borrowing

Type	Limit (£)	Management Tier
Loans, finance leases, overdrafts, and Working Capital Facility	All	Foundation Trust Board

Removal Expenses

Type	Limit (£)	Management Tier
Relocation expenses for newly appointed employee. (Tax Free Allowance)	Maximum £8k	Director of People (Prior agreement needed)

Employee Loans & Advances

Type	Limit (£)	Management Tier
Travel to Work loans (Including rail and bus season tickets)	Up to a Maximum £5k	Tier 6 & DoF
Advance of salary following error	Up to 100% of employee's standard monthly payroll, including any regular allowances and/or enhancements	Head of Payroll Services
Salary Advance to cover financial hardship (Maximum 12 months repayment)	No greater than 25% of employee's standard monthly basic salary (excluding allowances and enhancements), up to a maximum of £5k	CFO
Advance of salary to cover financial hardship (100% repayment in next month).	All	CFO

Invoice Cancellations

Type	Limit (£)	Authorised Role(s)
Cancellation of debtor invoice raised erroneously	<£5k	Head of Financial Management
	£5k to £50k	DoF
	>£100k	CFO

Severance Payments

Type	Limit (£)	Authorised Role(s)
Above and beyond standard NHS and/or Agenda for Change contractual terms and conditions	All	Recommendation from the Director of People to the Remuneration Committee Subject to approval by HMT via NHSI
Within standard NHS and/or Agenda for Change contractual terms and conditions	Under £49,999	Director of People & CFO
	£50k to £99,999	Finance Executive Committee (Reported to Remuneration Committee)
	>£100k	Remuneration Committee (Recommendation via Finance Exec)

Disposals and Condemnations of Land and Buildings

Type	Limit (£)	Authorised Role(s)
Protected Land and Buildings	All	Foundation Trust Board subject to approval by NHS Improvement
Unprotected Land and Buildings	All	Foundation Trust Board

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	12 November 2024
Title	**The Use of the Trust Seal Report**
	Item for Noting
Reason for the Report going to the Trust Board	In accordance with the Trust's Standing Orders, the Trust Board is informed each time the Trust's Seal is affixed to documents. The Trust's Seal was affixed to a five year lease relating to rooms at the Harry Pitt Building, University of Reading, Earley Gate to be used by the Trust's Research and Development team.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value