Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 14 January 2025

AGENDA

No	Item	Presenter	Enc.
OPENING BUSINESS			
1.	Chairman's Welcome and Public Questions	Martin Earwicker, Chair	Verbal
2.	Apologies	Martin Earwicker, Chair	Verbal
3.	Declaration of Any Other Business	Martin Earwicker, Chair	Verbal
4.	Declarations of Interest i. Amendments to the Register ii. Agenda Items	Martin Earwicker, Chair	Verbal
5.1	Minutes of Meeting held on 12 November 2024	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Board Story – Speech and Language Therapist, Court Diversion Service	Debbie Fulton, Director of Nursing and Therapies/ Pauline O'Callaghan, Service Manager, Liaison and Diversion Service/Kate Franics, Criminal Justice Lead Speech and Language Therapist	Verbal
6.1	Quality Assurance Committee a) Minutes of the meeting held on 26 November 2024 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working	*Due to an administrative error, this report was emailed to members of the Trust Board on 22 January 2025*	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 08 2024/25 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 08 2024/25 Performance Report	Tehmeena Ajmal, Chief Operating Officer	Enc.
STRATEGY			

No	Item	Presenter	Enc.
9.0	Strategy implementation Plan Report	Alex Gild, Deputy Chief Executive	Enc.
CORPORATE GOVERNANCE			
10.0	Appointment of a New Senior Independent Director	Martin Earwicker, Chair	Enc.
10.1	Council of Governors Update	Martin Earwicker, Chair	Verbal
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 11 March 2025	Martin Earwicker, Chair	Verbal
13.	**CONFIDENTIAL ISSUES:** To consider a resolution to exclude press and public from the remainder of the meeting, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.	Martin Earwicker, Chair	Verbal

Berkshire Healthcare
NHS Foundation Trust

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 12 November 2024

(Conducted via Microsoft Teams)

Present: OBJ	Mark Day	Vice Chair (meeting Chair)
	Rebecca Burford	Non-Executive Director *(present from 10.35)* OBJ
	Naomi Coxwell	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms	Chief Executive
	Jane Nicholson	Director of People *(deputising for Alex Gild, Deputy Chief Executive)* OBJ
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Minoo Irani	Medical Director
	Tehmeena Ajmal	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Lisa Ellis	Service Manager, Neuro-Rehabilitation (*present for agenda item 6.0)*
	Keely Butler	Specialist Physiotherapist, Community Based Neuro-Rehabilitation Team *(present for agenda item 6.0)*
	Helena Gruenstern	Speech and Language Therapist *(present for agenda item 6.0)*
	Mike Craissati	Freedom to Speak Up Guardian *(present for agenda item 6.1)*
	Steph Moakes	Health, Wellbeing and Engagement Manager *(present for agenda item 7.1)*
	Martin Mannix	Director of Estates and Facilities *(present for agenda item 9.0)*

24/183	**Welcome and Public Questions** (agenda item 1)
	The Vice-Chair welcomed everyone to the meeting.
24/184	**Apologies** (agenda item 2)

	Apologies were received from Martin Earwicker, Chair, Aileen Feeney, Non-Executive Director and Alex Gild, Deputy Chief Executive.
24/185	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
24/186	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** There were no amendments to the Register.
	ii. **Agenda Items** – none
24/187	**Minutes of the previous meeting held on 10 September 2024 –** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 10 September 2024 were approved as a correct record.
24/188	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. Sally Glen, Non-Executive Director referred to the action (min 24/155) on providing the Model Hospital data on complaints and asked whether the comparison with the Trust's "peer group" was in relation to similar mental health trusts or trusts in the same geography. The Director of Nursing and Therapies confirmed that the Trust's peer group was other mental health and learning disability trusts. Ms Glen reported that the November 2024 Quality Assurance Committee meeting would be considering the action (min 24/155) from the last meeting around whether it would be useful to identify a sub-set of patient experience data to benchmark the Trust's performance with its peer group. **The Trust Board:** noted the action log.
24/189	**Board Story – East Berkshire Earlier Supported Discharge Team for Stroke (**agenda item 6.0)
	The Vice-Chair welcomed Lisa Ellis, Service Manager, Neuro-Rehabilitation, Keely Butler, Specialist Physiotherapist, Community Based Neuro-Rehabilitation Team and Helena Gruenstern, Speech and Language Therapist. Keely Butler, Specialist Physiotherapist presented a case study concerning Mr D. (name redacted) and highlighted the following points:

	• The East Berkshire Earlier Supported Discharge (ESD) Team for Stroke was part of the Community Based Neuro-rehabilitation team in East Berkshire. This service was specifically commissioned for stroke rehabilitation and involved treating patients in the community following early discharge from acute hospitals. • The multi-disciplinary team included physiotherapists, occupational therapists, speech and language therapists, stroke specialist nurses, neuro-psychologists, and therapy assistants. The service provided patient-centered and goal-focused therapy for a maximum of six weeks • Mr D was a 52-year-old gentleman who suffered a stroke in the left side of his brain, resulting in various physical and cognitive impairments. The ESD team provided comprehensive assessments and treatment planning, addressing his emotional changes, coordination issues, speech difficulties, and memory deficits. • Mr D lived with his brother, and he was registered as his brother's carer and assisted in helping him with his medications for his mental health. • Following his stroke, Mr. 'D's brother's mental health deteriorated, which impacted Mr. 'D's ability to participate in his own rehabilitation. The team had to coordinate with external services and make safeguarding referrals to ensure both Mr. D and his brother received the necessary support. • Mr D had two goals – to return to work and to 'get myself back – I've lost myself.' • The outcomes of the intervention were positive, with Mr. 'D' regaining some independence and improving his communication skills. However, there were outstanding needs, such as further cognitive rehabilitation and support for returning to work. Mr D fed back that he felt that "he had come quite a long way in six weeks. I'm quite pleased with it". • Mr D did not receive all of the cognitive assessment and rehabilitation that would have been recommended if there were no other additional social challenges. Following discussion with Social Services, a referral was made to Headway Thames Valley (a Brain Injury Charity) for some ongoing cognitive rehabilitation. • The learning from the case study included the importance of early ccollaboration with other services and external agencies and maintain regular contact to ensure that the necessary action was taken and followed up The Vice-Chair thanked Keely Bulter for sharing the patient's story which provided an insight into work of the ESD team and the need to co-ordinate with a wide range of internal services and external agencies. The Chief Operating Officer said that she had spent some time with the ESD team in West Berkshire and she had been particularly impressed about how the team worked with the whole family and not just with the patient. The Chief Executive discussed the challenges around capturing the extensive co-ordination work which was done behind the schemes especially in the context of productivity. Keely Bulter agreed that it was difficult to capture all the interactions but pointed out that all conversations were recorded on the RiO (electronic patient record system). Sally Glen, Non-Executive Director asked whether the six-week time limit for the ESD service was nationally or locally determined. Keely Bulter confirmed that the six-week time limit was locally prescribed. It was noted that as the end of the six weeks, the ESD service could refer patients to the Community Rehabilitation Team as well and to other services, for example, Speech and Language Therapy, Mental Health Services etc.

	Naomi Coxwell, Non-Executive Director asked about the challenges around working with Social Services. Keely Bulter said that the Trust had to work with six different local authority social services departments, all of which worked differently. Lisa Ellis, Service Manager, Neuro-Rehabilitation added that the Trust was undertaking some training for social services staff, including hosting a conference and case study presentations which had been well received. The Vice-Chair thanked Lisa Ellis, Service Manager, Neuro-Rehabilitation, Keely Butler, Specialist Physiotherapist, Community Based Neuro-Rehabilitation Team and Helena Gruenstern, Speech and Language Therapist for attending the meeting and for the work they did. The presentation slides are attached to the minutes.
24/190	**Freedom to Speak Up** (agenda item 6.1)
	a) Freedom to Speak Up Guardian's Six-Monthly Report The Vice Chair welcomed Mike Craissati, Freedom to Speak Up Guardian to the meeting. The Freedom to Speak Up Guardian presented the paper and highlighted the following points: • The number of cases raised over the last six months remained consistent with the previous reporting period. Levels of concerns that had an element of Bullying and Harassment had decreased but that was mainly due to the recent introduction of a new category "Inappropriate behaviours". • The Freedom to Speak Up Guardian used a range of communication methods to raise the importance of speak up, including attendance at Corporate Induction sessions, supporting all the Staff Networks as an ally, membership of groups and committees that were people focused and promoted an inclusive or just culture • The Freedom to Speak Up Guardian had played a key role in helping to promote the Trust's Anti-Racism stance and had worked with colleagues to help with the Violence Prevention and Reduction and Anti-Bullying and Harassment workstreams. • The introduction of all staff "Lunch and Learn" webinars had also helped to communicate proactive support for a positive culture change towards greater compassion • The topic for the Freedom to Speak month (October) was "Listening Up" and providing feedback. Sally Glen, Non-Executive Director asked whether it was a concern that there were no cases from medical and dental staff. The Freedom to Speak Up Guardian said that he had done a lot of work raising awareness about speaking up amongst doctors including attending the resident doctors' induction sessions. It was noted that compared with many trusts, Berkshire Healthcare did not have a large cohort of doctors and dentists.

	Ms Glen asked whether there was a Freedom to Speak Up Champion for doctors and dentists.
	
	The Freedom to Speak Up Guardian confirmed that there was no champion at the moment but said that he regularly reviewed the network of champions to identify where there were gaps, and these areas would be targeted in the next round of recruitment for champions.
	
	The Vice-Chair said that he shared the Freedom to Speak Up Guardian's view about the importance of ensuring that newly appointed managers received training around their role in listening to and responding to concerns.
	
	Naomi Coxwell, Non-Executive Director said that it was also important that people did not rush to judgement and pointed out that there were invariably two sides to every case.
	
	The Freedom to Speak Up Guardian agreed and said that it was important to remain objective.
	
	The Director of People added that the Freedom to Speak Up Guardian would be involved with the Human Resources Case Work Review which would start in the new year.
	
	The Freedom to Speak Up Guardian requested that the Board support work in the following areas:
	
	• Support and encourage initiatives to address subjective "Staff Experience" concerns, specifically those that include an element of bullying and harassment and/or microaggressions.
	• Support and encourage initiatives to minimise the risk of detriment.
	• Support and encourage initiatives to improve a Listening Up culture.
	  o As October's theme nationally was "Listening Up" the Board was specifically asked to concentrate on supporting this initiative.
	  o An effective gauge was 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 took into account potential barriers such as neurodiversity and cultural differences. It was also just as relevant when getting feedback from our communities or service users.
	
	The Trust Board:
	
	a) Noted the report.
	b) Expressed its full support for the areas identified above by the Freedom to Speak Up Guardian.
	
	c) Freedom to Speak Up Improvement Plan Report
	
	The Director of Nursing and Therapies reminded the meeting that the Board had agreed that the Freedom to Speak Up Improvement Plan Report would be presented to the Board on a six-monthly basis.
	
	It was noted that since the last update, the following actions had been completed:
	
	• There was now a process for ensuring that all new starters were aware of the Freedom to Speak Up on-line training modules

	• A question had been added to mid-year appraisal documentation to enable a conversation around how to speak up • The Internal Auditor had completed an audit on the Trust's Freedom to Speak Up systems and process and had given an assurance level of "substantial asssurance" • Methods to improve circulation of positive stories as part of Freedom to Speak up Month (October) had been agreed. The Vice-Chair and Non-Executive Director Lead for Freedom to Speak Up commended the Freedom to Speak Up Guardian and the Trust for achieving a substantial assurance rating from the Internal Auditors for the Freedom to Speak Up systems and processes. **The Trust Board**: noted the report.
24/191	**Patient Experience Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented paper and highlighted the following points: • There was a higher than usual number of secondary complaints (those not resolved with the first response) this quarter. There were no specific themes or services associated with this, and not all were upheld. The Trust would continue to monitor this and the standard of the Trust's responses to ensure that the initial responses were clear and answered all the concerns being raised. • The data indicated that Asian/Asian British and Black/Black British people appeared to be less likely to complain and give feedback through the patient survey; this data was consistent with data from last quarter. Whilst the survey was provided in easy read and several differing languages it was important for services to ensure that they were explaining about the survey when having contact with patients, their families and interpreters to enable the opportunity for all patients to provide feedback • The Trust was continuing to focus on "You Said, We Did" examples of how patient feedback had been used to make changes and improvements to services. • The programme of 15 Step Visits had re-started. The Vice-Chair said that he had recently visited the Wokingham Memory Clinic on a 15 Step Visit along with Sally Glen, Non-Executive Director and reported that they had fed back that there was an iPad available for patients to use to complete the I Want Great Care Survey, but it was hidden from view. The Vice-Chair said that it was a small example of how useful it was to have lay people visiting services with fresh pairs of eyes and encouraged Non-Executive Directors and Governors to undertake 15 Step Visits. **The Trust Board**: noted the report.
24/192	**Six Monthly Safe Staffing Report** (agenda item 6.3)
	The Director of Nursing and Therapies presented the paper and reported that the Trust was continuing to use a high number of temporary members of staff, although many of them were Trust staff undertaking additional hours. It was noted that there was a

	downward trend over the last year with fewer shifts with less than two registered nurses at Prospect Park Hospital. The Director of Nursing and Therapies reported that there was also a slightly improved position in the number of Band 5 vacancies at Prospect Park Hospital. The Director of Nursing and Therapies drew attention to the Safe Staffing declaration below: **The Safe staffing declaration provided 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 had been considered to have been safe with no significant patient safety incidents occurring because of staffing levels. It was however recognised that during the period there were some shifts where staffing was sub-optimal and consequently there was limited assurance that care was always of a high quality, and it was possible that patient experience was compromised. Proactive work continued to support increased recruitment and improve retention and therefore sustainability of our permanent workforce medical staffing numbers remained stable with adequate medical cover available during routine working hours for inpatient mental health and community health wards. Out of hours medical cover was provided by GPs for all our community health wards and Campion Unit. Out of hours medical cover was provided by Resident Doctors for the mental health wards with Consultant Psychiatrists providing on-call cover from home. The Vice-Chair reminded the meeting that the Finance, Investment and Performance Committee reviewed the monthly safe staffing reports. T**he Trust Board:** a) noted the report b) noted the safe staffing declaration by the Director of Nursing and Therapies and Medical Director.
24/192	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following item was discussed further: **Staff Winter Flu Vaccination Campaign** The Vice Chair asked how the Staff Flu Vaccination Campaign take up rate compared with the same time last year. The Director of Nursing and Therapies said that there was a slightly higher take-up rate this year but pointed out that all trusts were struggling to encourage staff to take up vaccinations. **The Trust Board**: noted the report.

24/193	**Health and Wellbeing Update Report** (agenda item 7.1)
	The Vice-Chair welcomed Steph Moakes, Health, Wellbeing and Engagement Manager to the meeting. The Director of People reported that the Trust Director of Nursing and Therapies had led a review of the Trust's Staff Wellbeing activities. The Health, Wellbeing and Engagement Manager presented the paper and highlighted the following points: • As part of the Wellbeing Review, all staff were invited to complete a questionnaire. Over 850 staff responded to the questionnaire, and this was followed up by an engagement event which was attended by 60 staff. The responses showed a range of opportunities for improvement but importantly when staff needed to access the available Wellbeing services, they were generally happy with the support they had received. • 69% of the 850 staff who completed the questionnaire said that the health and wellbeing support they had received had enabled them to stay at work or had reduced their time off work. • The questionnaire also highlighted that a lot of staff did not know what support was available. The working environment was also important to staff including the provision of restrooms, microwaves and access to drinking water/hot water etc. Staff also responded that they were sometimes unsure about whether or not they could take breaks etc. • At the end of the review, there would be an outcome report listing both quick wins and longer-term projects which would be shared with the Board. **Action: Director of People** • Wellbeing Matters, the Trust's internal psychological support service for staff and teams was working well with positive feedback from staff. Demand for support on the Wellbeing Line had increased by 43%. Demand for Staff Support Post Incident had increased more than two-fold since the last report. The Chief Financial Officer reminded the Board that when national funding was withdrawn for staff health and wellbeing services post-COVID, the Trust had taken the decision to continue to provide wellbeing services. The Chief Financial Officer said that the questionnaire had highlighted the positive impact wellbeing support had on reducing staff sickness and enabling staff to return to work sooner. The Vice-Chair and Non-Executive Director Champion for Staff Health and Wellbeing commented that the activities listed in the report were only the tip of the iceberg and said that there was a huge amount of work going on to support staff. The Vice-Chair commented that he looked forward to receiving the outcome of Wellbeing Review in due course. **The Trust Board**: noted the report.

24/194	**Reducing Violence and Aggression Report** (agenda item 7.2)
	The Director of Nursing and Therapies presented the paper and reminded the Board, that NHS England had written to all NHS organisations in April 2024 asking them to sign the Sexual Safety Charter and to report progress and actions to their respective boards. The Director of Nursing and Therapies said that the Trust's Reducing Violence and Aggression work was aligned with the new Workers Protection Act and the duty to prevent and address workplace sexual harassment. It was noted that the majority of incidences of violence and aggression continued to be experienced by mental health staff. The Director of Nursing and Therapies said that the Trust was proactively encouraging staff to report incidents of violence and aggression, both physical and non-physical. **The Trust Board**: noted the report.
24/195	**Month 06 2024-25 Finance Report** (agenda item 8.0)
	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 of £0.6m, agreed System Development Funding slippage (Buckinghamshire, Oxfordshire and Berkshire West system) of £0.5m and further Cost Improvement Programme schemes to be identified of £0.8m. • The Trust had a £13.6m Cost Improvement Plan. The Trust was on track year to date, but there were some small variances on individual plans. • Income included the planned cost staff salary uplift for 2024/25, but this would be updated for the actual cost uplift of 2024/25 pay awards in October 2024. • Cash was above plan but would reduce once the back dated pay awards were made. • The Trust was continuing to see an increase in the number of substantive staff which was aligned with the investments agreed with the systems. • The Trust's performance against the Better Payment Practice Code was 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 in month 6 has meant that our position had not yet recovered on this indicator. • Capital spend was under plan year to date for CDEL schemes. • NHS England's agency target was achieved year to date. • The Finance, Investment and Performance Committee had reviewed the financial forecast position. The Trust was confident that the 2024-25 financial plan would be delivered. **The Trust Board**: noted the report.
24/196	**Month 06 2024-25 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 04 2024-25 "True North" Performance Scorecard Report had been circulated.

	The Chief Operating Officer highlighted the current pressures and challenges around mental health beds and pointed out that there were currently 12 people in out of area placements and 10 patients who were clinical ready of discharge and 8 patients who had been referred into a bed. The Chief Operating Officer suggested inviting the Bed Team to attend a future Trust Board Discursive meeting to inform the Trust Board about how they managed the mental health bed pressure. **Action: Chief Operating Officer/Company Secretary** The Chief Operating Officer said that over the winter period, there was likely to be pressure from the acutes within Berkshire and from the neighbouring London hospitals to accept referrals. The Chief Operating Officer added that the Trust would have to manage the balance between being responsive and supportive, recognising the pressure they were under whilst also maintaining a grip on what was happening in terms of out of area placements. Sally Glen, Non-Executive Director noted that the Finance Report made reference to three or four male discharge beds in the community and asked whether there were some female discharge beds. The Chief Operating Officer agreed to forward more information about the male discharge community beds and whether there were also female discharge beds in the community to Sally Glen, Non-Executive Director. **Action: Chief Operating Officer** **The Trust Board**: noted the report.
24/197	**Finance, Investment and Performance Committee Meeting – October 2024** (agenda item 8.2)
	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee reported that in addition to the standing items, the Committee had received a presentation and demonstration of the Tableau Performance People's Dashboard which in concert with a data warehouse pulled in staff related data across the Trust and enabled managers to drill access data at a granular level. Ms Coxwell reported that the meeting had also received a paper which set out the key metrics which underpinned the People Strategy and had received an update on the Trust's recruitment and retention work. The Vice-Chair thanked Naomi Coxwell for her update.
24/198	**Estates Strategy Update** (agenda item 9.0)
	The Vice-Chair welcomed the Director of Estates and Facilities to the meeting. The Director of Estates and Facilities gave a presentation and highlighted the following points: • At the national level, the NHS was struggling financially. The total cost of running the NHS estate was £13.6bn

	• Two recently published reports – the Grenfell Tower Inquiry Phase Two Report and the Independent Investigation of the NHS in England by Lord Darzi had implications for the NHS estate.
	• Regionally, both local Integrated Care Boards were struggling financially and both Frimley Health and the Royal Berkshire Hospitals had major estates related problems requiring new sites and rebuilds
	• Locally, the Trust had a number of achievements over the last year. This included:
	  o Remaining above the national and regional averages for all Trusts in the PLACE rankings and being either first or second of Mental Trust Trusts regionally in all indicators and second amongst Mental Health Trusts for cleaning
	  o Conducting a Modern Equivalent Asset review which resulted in around a £1m of recuring revenue saving
	  o Work to mitigate the fire evacuation of Jubilee Ward, Upton Hospital
	  o SALIX grant of £2.6m from the Government's Public Sector Decarbonisation Scheme to replace the fossil fuel heating system at West Berkshire Community Hospital with efficient heat pumps
	  o National NHS Staff Survey Results 2023 for the Estates and Facilities directorate had staff engagement score of 81.5%.
	• The Trust had received some additional funding to complete additional anti-ligature works.
	• Work had recently started on the new Place of Safety at Prospect Park Hospital
	• The Trust was continuing with works to improve sustainability and reduce carbon emissions
	• The Prospect Park Hospital PFI provider had agreed to undertake a fire survey, condition survey and a mental health survey of the Prospect Park estate
	• The Frimley Integrated Care System's Integrated Care Hub programme was only going ahead in Bracknell with a new facility being built next to Skimped Hill Health Centre. There was a small amount of work that was planned at King Edwards Hospital but there was insufficient system funding to take forward the other Frimley integrated care hubs.
	• The Slough Community Diagnostic Centre was going ahead at Upton Hospital and construction had started.
	• The Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Efficiency programme resources had been removed, and the programme had stalled.
	• Bath Road had been identified as the location for the Trust consolidate in Reading, subject to the Integrated Care Board relocating their staff to another part of the building.
	• The new Estates Strategy 2025-2030 was currently being developed.
	
	Sally Glen, Non-Executive Director commented that she was very pleased work on the new Place of Safety at Prospect Park Hospital had commenced and asked about the timescale for completion.
	
	The Director of Estates and Facilities confirmed that he hoped the new Place of Safety would be ready to admit patients in May 2025.
	
	Ms Glen requested that the Quality Assurance Committee have an opportunity to discuss the outcome of the Prospect Park Hospital mental health survey.
	Action: Director of Estates and Facilities
	
	The Vice-Chair thanked the Director of Estates and Facilities for his presentation.
	
	The Trust Board: noted the report.

24/199	**Audit Committee Meeting – October** (agenda item 10.0)
	The minutes of the Audit Committee meeting held on 30 October 2024 had been circulated. Rajiv Gatha, Chair of the Audit Committee reported that in addition to the standing items, the Committee had also approved the Charitable Funds Annual Report and Accounts 2023-24 (which would be presented to the Corporate Trustees meeting immediately after the Trust Board In Committee for ratification). Rajiv Gatha 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. It was noted that the Committee had also reviewed and approved 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. The Vice-Chair thanked Rajiv Gatha for his update. **The Trust Board**: noted the minutes.
24/200	**Trust Policies – Changes for Ratification** (agenda item 10.1)
	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 confirmed that the proposed changes to the policies had been approved by the Audit Committee at its meeting on 30 October 2024 and were presented to the Trust Board for ratification. **The Trust Board**: ratified 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.
24/201	**Trust Seal** (agenda item 10.2)
	The Chief Financial Officer reported that the Trust's seal had been fixed to a five-year lease relating to rooms at the Harry Pitt Building, University of Reading, and Earley Gate to be used by the Trust's Research and Development Team.

	The Trust Board: noted the report.
24/202	**Council of Governors Update** (agenda item 10.3)
	The Vice-Chair reported that the Joint Trust Board and Council of Governors meeting held on 6 November 2024 had received a strategic update by the Chief Executive, an update on system finances from the Chief Financial Officer, updates from the Deputy Chief Executive on the process for refreshing the Trust's Strategy along with an update on the Trust's Anti-Racism Strategy work. The Vice-Chair mentioned that during the small informal breakout sessions with Non-Executive Directors and Governors, some of the newer Governors had expressed an interest in getting more involved with service visits. The Vice-Chair requested that the Company Secretary ensure that Governors were informed about any opportunities to visit services. **Action: Company Secretary**
24/203	**Any Other Business** (agenda item 11)
	There was no other business.
24/204	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 14 January 2025.
23/205	**CONFIDENTIAL ISSUES:** (agenda item 13)
	The Board resolved to meet In Committee for the remainder of the business on the basis that publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be conducted.

I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 12 November 2024.

Signed……. Date 14 January 2025

Berkshire Healthcare
NHS Foundation Trust

Patient case study

East Berkshire Earlier Supported Discharge Team (ESD) for Stroke

East Berks ESD service

Berkshire Healthcare NHS Foundation Trust

- Part of the Community Based Neuro-rehabilitation team
- East Berkshire only commissioned for Stroke Rehabilitation
- Treating patients in the community following (early) discharge from acute hospitals for ongoing stroke rehabilitation
- Multi-disciplinary team intervention – Physiotherapy, Occupational Therapy, Speech and Language Therapy, Stroke Specialist Nursing, Neuro-Psychology and therapy assistants
- Time led service for a maximum of 6 weeks
- Patient centred and goal focused therapy

History of presenting condition

Berkshire Healthcare NHS Foundation Trust

- Mr. ‘D’ suffered a stroke in the left of his brain; he woke up at home, slumped to the right and unable to move his right arm and was feeling unwell. He was unable to talk properly. Mr ‘D’s brother contacted a friend, who then called an ambulance, who took him to RBH.
- ESD team received a referral for ongoing rehabilitation at home. Information handed over included:
  - Mr. ‘D’ lived with his brother, but his NOK was his ex-wife
  - Prior to his stroke, he was working as a cleaner in 2 separate jobs
  - Upon discharge, his ex-wife would help manage his medication
  - Mr. ‘D’ had residual difficulties with his communication – struggled to follow complex instructions, had difficulties finding the correct word in conversations at times, and was unable to write.
  - Mr. ‘D’ had also undergone a cognitive assessment, which he scored below the cut-off, presenting with reduced visuospatial awareness, language deficits, poor memory, and inability to think in abstract ways.

ESD initial assessment

Berkshire Healthcare NHS Foundation Trust

First visit

- Identified that Mr. ‘D’ and his brother live in a co-dependent type setup, and that Mr. ‘D’ was registered as his brother’s carer and assisted in helping him with his own medications for his Mental Health. They shared roles such as shopping and cooking. Brother expressed his own concerns about the support he needs whilst his Mr. ‘D’ was unwell – finances, ?needing to find his own job, looking after the house.
- Mr. ‘D’ and his family/friends recognised that since the stroke, his speech was different, he was forgetting things and sometimes confused, his vision was blurred and his right arm was weak and uncoordinated. Brother demonstrated difficulty in understanding rehabilitation, and that Mr.‘D’ should improve.
- Mr. ‘D’ had 2 goals – to return to work, and to ‘**get myself back – I’ve lost myself’.**

Therapy assessments

Berkshire Healthcare NHS Foundation Trust

- Over the first week at home, Mr. ‘D’ was seen by Stroke Specialist Physiotherapist, Occupational Therapist, Speech and Language Therapist, Nurse and Neuro-Psychologist for assessments and treatment planning.
- Found to have:
    - Changes in his emotions – getting more easily stressed and frustrated, laughing at inappropriate times. Fearful of dying and being unable to care for brother
    - Reduced coordination and control around his shoulder, impacting on functional use of the right upper limb (e.g cooking). Some difficulty with using objects correctly.
    - Word-finding difficulties in speech, difficulty in understanding the written word
    - Deficits with memory, information processing, attention and sequencing tasks
- Impact on every day life – struggling to manage food prep, ex-partner managing medication but long term management of this would need assistance, relationship between Mr. ‘D’ and brother beginning to break down

ESD actions

Berkshire Healthcare NHS Foundation Trust

Referrals and work with external services

- Early referral made to Bracknell LAP team (Locality Access Point) to request joint assessment for Mr. ‘D’ and his brother to look at care needs (in line with stroke deficits), social needs and mental health needs (primarily for brother)
- Delay in this being picked up; eventually able to complete a joint assessment with ESD OT and Reablement to handover how to support Mr. ‘D’ with his physical and cognitive deficits when managing functional tasks to expand rehabilitation opportunities (meal prep, personal care), however, difficulty in SS understanding the neuro-rehab approach and Mr. ‘D’ unable to see the value in their support, therefore therapeutic activity was not practiced.
- Neuro-Psychologist liaised with Mental Health services, with consent, re. brother to ensure support was available
- Therapy focus initially agreed to be on speech/language skills, right upper limb, and functional task practice to work towards desired goals

ESD challenges

Berkshire Healthcare NHS Foundation Trust

- Brother began to experience a deterioration in his mental health, advised that he had stopped taking his medication.
- Vulnerability of Mr. ‘D’ and brother highlighted as they both disclosed their own interactions with likely scammers – via social media and telephone. Mr. ‘D’ reports he would previously have monitored his brothers’ interactions, but was no longer able to do so. Safeguarding referral made.
- Mr. ‘D’s ability to participate in his rehabilitation became compromised as his brother’s mental health deteriorated – Mr. ‘D’ began expressing his own frustration and anxiety with the scenario, vocalised that he **‘couldn’t cope’,** and asked for help.
- Brother also made a request for help - referenced an increased frequency in paranoid and suicidal thoughts – appropriate questions asked by visiting OT and attempted contact with CRISIS team in the moment, however, voicemail facility available only and no call back received. Required further calls by ESD to try and enable contact, and then a subsequent CPE referral (for brother).

ESD challenges

Berkshire Healthcare NHS Foundation Trust

- Further acute episode of mental health breakdown resulted in brother being found by the Police and taken to A&E. ESD required to call SS to escalate the need to review, however, deemed non-urgent and required further follow up the following day.
- Brother's mental health crisis detracted from patient's therapy involvement – Mr. 'D' understandably worried, and ESD required to support and advocate for both to help them get the input they required.
- Rehabilitation focus had to be re-evaluated – ESD team unable to provide all of the therapy that would be recommended, **and** coordinate additional referrals, support and professionals' involvement to ensure both Mr. 'D' and his brother remained safe
- MDT agreement that rehab focus would continue to work on communication to help with social interaction, and physiotherapy to work on his arm and general community access as Mr. 'D' most keen on these aspects, and could see their role in achieving his goals.

ESD actions

Berkshire Healthcare NHS Foundation Trust

- Set-up of ‘family meeting’, with inclusion of Social Services (Mr. ‘D’s care coordinator from his Re-ablement support), Mr.’D’ and his brother, his ex-wife (NOK) and a friend.
- Consent gained for brother’s Social Worker to also be included in any actions
- Allowed for an open discussion; Mr. ‘D’ expressed that (as brothers we) **‘Love each other, but I cannot support (…) anymore. I feel hopeless. I couldn’t do anything to help (due to stroke deficits) when (…) was ‘freaking out’ the other day.’**

  Brother: **‘I don’t want to see (…) struggle anymore, I want to be a brother again. Want that bond back. I feel helpless too but I can’t support (…) either. I put a lot on (…) because he has always been a father figure to me. I lean on him by accident because he has always been there for me and I think the world of him. I can’t control my emotions and then I see red and snap at (…). I feel ignored when talking to people on the phone’.**
- Agreed that Mr. ’D’ would undergo a full Social Services assessment, with the recommendation of allocation of a support worker to assist with general day-to-day management and advocacy, e.g with appointments. A housing assessment would also be requested for both Mr.’D’ and brother.

Outcomes

Berkshire Healthcare NHS Foundation Trust

- He was able to access the local community and complete simple shopping tasks and walk for pleasure; ESD supported to explore social groups, and Mr.'D' was keen to pursue this in the future. Was also known to attend a monthly Stroke Group after discharge.
- Mr. 'D's reading returned to his pre-stroke level, and his communication improved so that he was having successful conversations with friends and family.
- Appropriate support was in place / being organised for both Mr.'D' and his brother – Social Worker/support worker allocation for both, housing review, mental health review – Mr.'D' was referred to the PINC service for anxiety and stress.
- With support in place for the brother, this enabled Mr.'D' to have more freedom to engage in the activities he wanted/needed to, and removed a lot of stress. As his wellbeing and mental health were better, Mr. 'D' commented that he had a much improved relationship with brother and was no longer having to 'care' for him.
- **'I have come quite a long way in 6 weeks. I'm quite pleased with it. '**

Outstanding needs

- Mr. ‘D’ did not receive all of the cognitive assessment and rehabilitation, that would have been recommended if there were no additional social challenges. Currently in East Berkshire there is not a provision for this for these patients outside of ESD.
- Following discussion with Social Services, a referral was made by ESD to Headway Thames Valley (brain injury charity) for some ongoing cognitive rehabilitation, but this is a paid-for service. A request was made for SS to support this funding, and accessing the service, and it was recently confirmed that this was followed through.
- Mr.D ‘’ is of working age, but was unable to return to work. As he was not ready at point of discharge to consider this, ESD were unable to make appropriate onward referrals to allow him access to other services.

Learning

- Following previously challenging cases where complex social needs impact on patient's ability to engage in their Stroke Rehabilitation, ESD team have become more conscious of the need to collaborate with other services and external agencies ASAP and maintain regular contact to ensure the necessary action is taken and followed up.
- Rehabilitation provision is now slightly altered in these cases – prioritisation of their rehab needs/desires, to enable other team members to support with the extra liaison required to coordinate the other services.
- Revision of ESD referral form (to be used by acute teams); further clarity around patient's home make-up and whether they are/have dependents, and what this looks like.

NHS
Berkshire Healthcare
NHS Foundation Trust

Thank you

Questions…?

www.berkshirehealthcare.nhs.uk

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 14.01.25

Board Meeting Matters Arising Log – 2025 – 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
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**	Discussed at the December 2024 Trust Board Discursive meeting.	
10.09.24	24/161	WRES Report	The Finance, Investment and Performance Committee to receive a report setting out the outcome of the	January 2025	**JN**	The January 2025 Finance, Investment and Performance Committee meeting	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Trust's Case Work Review.			will receive a report setting out the remit of the case work review and will receive the outcome report in due course.	
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**	Discussed at the December 2024 Trust Board Discursive meeting.	
12.11.24	24/193	Health and Wellbeing Update Report	The outcome report of the Wellbeing Review to be presented to a future Board meeting.	May 2025	**JN**		
12.11.24	24/196	Performance Report	The Trust's Bed Team to attend a future Trust Board Discursive meeting to inform the Trust Board how they managed the mental health bed pressure.	April 2025	**TA/JH**	On the agenda for the April 2025 Trust Board Discursive meeting.	
12.11.24	24/196	Performance Report	The Chief Operating Officer to forward more information about the male discharge community beds to Sally Glen, Chair of the Quality Assurance Committee.	January 2025	**TA**	The Chief Operating Officer emailed Sally Glen with the following information: We currently have 3 male Discharge to	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						Assess hospital beds (Woking). There is no local inpatient provider with female capacity although we will be reviewing in the new year. We also have access to both male and female supported discharge beds within local supported living providers.	
12.1.24	24/198	Estates Strategy Update	The Quality Assurance Committee to have an opportunity to discuss the Prospect Park Hospital mental health survey.	January 2026	**MM**		
12.11.24	24/202	Council of Governors Update	The Company Secretary to ensure that new Governors were aware of how they could participate in service visits.	December 2024	**JH**	All Governors were emailed with information about how they could participate in service visits.	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	Due to an administrative error, this report was circulated via email to members of the Board on 22 January 2025.
Title	**Quality Assurance Committee Meeting – 26 November 2024**
	Item for Noting
Reason for the Report going to the Trust Board	The Quality Assurance Committee is a sub-committee of the Trust Board. The minutes are presented for information and assurance. Circulated with the minutes are the quarterly Learning from Deaths and Guardians of Safe Working Hours Reports. NHS England requires NHS provider organisations to present these reports to the Trust Board. Members of the Trust Board are required to identify any areas for further clarification on issues covered by the meeting minutes and associated reports and to note the content.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary (on behalf of Sally Glen, Committee Chair
Relevant Strategic Objectives	**Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice**

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

Berkshire Healthcare
NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 26 November 2024

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

Present:	Sally Glen, Non-Executive Director (Chair) Rebecca Burford, Non-Executive Director Aileen Feeney, Non-Executive Director Julian Emms, Chief Executive *(present from 11.00 hours)* Debbie Fulton, Director of Nursing and Therapies Alex Gild, Deputy Chief Executive Daniel Badman, Deputy Director of Nursing for Patient Safety and Quality Guy Northover, Chief Clinical Information Officer Tehmeena Ajmal, Chief Operating Officer Dr Nav Sodhi, Associate Medical Director *(deputising for Dr Minoo Irani, Medical Director)* Amanda Mollett, Head of Clinical Effectiveness and Audit Tiziana Ansell, Patient Safety Specialist John Barrett, Patient Safety Partner
In attendance:	Julie Hill, Company Secretary Theresa Wyles, Divisional Director of Mental Health Services *(present for agenda items 5.0 and 5.1)*

Opening Business

1 Apologies for absence and welcome

Apologies for absence were received from: Dr Minoo Irani, Medical Director. Apologies for lateness due to a meeting clash were received from Julian Emms, Chief Executive who joined the meeting at 11.00 hours.

The Chair welcomed everyone to the meeting and in particular welcomed John Barrett, Patient Safety Partner, Tiziana Ansell, Patient Safety Specialist and Theresa Wyles, Divisional Director of Mental Health Services to the meeting.

2. Declaration of Any Other Business

There was no other business declared.

3. Declarations of Interest

There were no declarations of interest.

4.1 Minutes of the Meeting held on 27 August 2024

The minutes of the meeting held on 27 August 2024 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

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

a) Prospect Park Hospital Asset Surveys

The Director of Nursing and Therapies reported that the timescales for the Prospect Park Hospital surveys on the action log needed to be revised. The condition survey should be changed to August 2025 with the fire and mental health surveys revised to February 2026.

Action: Company Secretary

b) Diabetes Intermediate Service

The Head of Clinical Effectiveness and Audit reported that the establishment of a Diabetes Intermediate Service was an open action on the Clinical Audit Plan. It was noted that because of pressures on Integrated Care Systems' finances, the Diabetes Intermediate Service had not yet been commissioned.

The action log was noted.

Patient Safety and Experience

5.0 Trust Response to the CQC Special Review of Mental Health Services at Nottinghamshire Healthcare NHS Foundation Trust

The Chair welcomed Theresa Wyles, Divisional Director of Mental Health Services to the meeting.

The Divisional Director of Mental Health Services gave a verbal update and highlighted the following points:

- The CQC had undertaken a special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust following the conviction of Valdo Calocane in January 2024 for the killings of two students and a school caretaker. Valdo Calocane was known to Nottinghamshire Healthcare, but he had poor engagement with the Trust and poor compliance with taking his medication.
- When unwell, Valdo Calocane had a pattern of breaking into properties and being violent and had frequent detained admissions under section 2 of the Mental Health Act including one under section 3 of the Mental Health Act.
- The CQC required NHS mental health providers to provide assurance and that issues raised by the case were being shared with the Trust Board. NHS England also required NHS mental health providers to complete a self-assessment maturity matrix which covered several areas, including one around the model that the Trust would adopt to deal with patients with a similar profile to Valdo Calocane. This included sub-forensic patients who had a history of poor compliance with medication and had a history of violence and/or risky behaviour when they were unwell.
- The Trust had also conducted a clinical review in October 2024 with psychiatry colleagues and the community mental health teams to look at the CQC's recommendations for identifying high-risk patients and ensuring that there was assertive engagement and follow-up.
- The Trust had identified 250-280 patients across Berkshire who fitted the criteria for assertive outreach, focussing on those with psychotic illnesses and high-risk behaviours.
- The Trust had submitted a high-level business case to both local Integrated Care Boards for dedicated Assertive Outreach Teams in Slough and Reading, based on data showing the highest population need in these areas. The other four localities would operate an integrated care model.

- The assertive outreach model involved proactive engagement with patients, daily visits for medication compliance, ensuring follow up if appointments were missed and smaller caseloads for named workers.
- Assertive Outreach used to be part of the National Service Framework in the early 2000s, but it had been disbanded. NHS England was now reconsidering the model due to its effectiveness in managing high-risk patients.
- Each Assertive Outreach Team would cost around £1.1m per annum posing a significant funding challenge for the Integrated Care Boards.

Aileen Feeney, Non-Executive Director asked why the Assertive Outreach model had been disbanded given its effectiveness.

The Divisional Director of Mental Health Services explained that the original model had been rolled out on a population-based model rather than in terms of deprivation and the acuity of the local population, so it was very expensive in areas such as Bracknell which had a small caseload of patients.

The Divisional Director of Mental Health Services said that the Trust had taken some practical steps within the existing model, for example, if a patient had psychosis and had not attended appointments, any decision to discharge the patient had to be referred to a Multi-Disciplinary Team. The Trust was also doing some work across the six localities around the repeat use of Section 2 of the Mental Health Act.

The Divisional Director of Mental Health Services said that the Valdo Calocane case had highlighted the risks around very short admissions which made it difficult to do proper discharge planning and work with the family. It was noted that as part of the work around implementing the One Team, the Trust had developed in partnership with service users and carers, a new risk formulation approach.

The Divisional Director of Mental Health Services said that the Trust was also working with the Probation Service and Police to ensure that high risk patients were flagged on their systems.

The Deputy Chief Executive asked how the cohort of patients were identified.

The Divisional Director of Mental Health Services explained that the previous Assertive Outreach Team model had been very prescriptive and had included people with psychosis, but the criteria of at-risk patients was now covered a broader range of patients.

The Chief Operating Officer pointed out that most people with psychosis did not pose a risk to others.

The Chair asked how the Trust Board would be kept updated on progress and any risks associated with the proposed model.

The Director of Nursing and Therapies said that she would keep the Committee informed of any developments and would update the Trust Board about the outcome of the Trust's high level businesses cases to the Integrated Care Boards for the establishment of an Assertive Outreach Team for Reading and Slough.

Action: Director of Nursing and Therapies

John Barrett, Patient Safety Partner asked if only one of the Trust's business cases was approved, would the Trust go ahead and implement one Assertive Outreach Team.

The Director of Nursing and Therapies confirmed that the Trust would implement one Assertive Outreach Team.

The Divisional Director of Mental Health Services said that it was important that this work was also seen in the context of the Police's Right Care, Right Person approach.

The Chair said that it would be helpful for the Committee to receive an update on the Trust's work around the Right Care Right Person initiative.

Action: Chief Operating Officer

Ms Feeney asked whether there was scope for digital systems to help flag individuals who may be at risk.

The Divisional Director of Mental Health Services said that the Trust had identified the cohort of patients by a number of means, for example, poor engagement and attendance at appointments, high level of admissions to in patient mental health services and co-morbidities such as substance abuse.

The Chair thanked the Divisional Director of Mental Health Services for her update.

The Committee noted the presentation.

5.1 Co-Production Report Mapping Exercise Report

Mapping Coproduction in Berkshire Healthcare slides by the Director of Strategic Planning had been circulated.

The Chair commented that the Director of Strategic Planning's slides highlighted that there were pockets of good practice around co-production but there needed to be more work to ensure that there was a consistent approach across the Trust.

The Divisional Director of Mental Health Services said that the first step was to identify all the co-production work that was taking place across the Trust and to ensure that there was a shared understanding about what co-production was and how to use co-production to shape the Trust's strategy and approach.

John Barrett, Patient Safety Partner pointed out that not all patients wanted to be involved in co-production.

The Divisional Director of Mental Health Services said that there was often confusion around the differences between community engagement and co-production.

The Chief Operating Officer pointed out that not everything needed to be co-produced, for example, the NHS 10 Year Plan was nationally prescribed.

The Chief Operating Officer also pointed out that a significant amount of time and effort needed to be invested to undertake effective co-production.

The Chair suggested that the Committee receive an update on the development of the Trust's work on co-production in due course.

Action: Chief Operating Officer

The Chair thanked the Divisional Director of Mental Health Services for her update.

5.2 NHS England's Culture of Care Programme

The Director of Nursing and Therapies reported that in April 2024, NHS England had released new inpatient standards for mental health care alongside its national Culture of Care Programme run by a national collaborative. The programme aimed to support mental health wards through facilitation and external support. It was noted that the programme focused on leadership, anti-racism, personalised risk approaches, and Quality Improvement. The Trust had selected four wards to participate in the programme.

The Director of Nursing and Therapies reported that the Trust had been placed in a network along with Oxford Health NHS Foundation Trust, Essex Partnership University NHS Foundation Trust, Cambridgeshire and Peterborough NHS Foundation Trust and Northamptonshire Healthcare NHS Foundation Trust

The Director of Nursing and Therapies reported that the Lead Consultant Nurse had been invited to give a presentation on the Trust's work in relation to the Culture of Care Programme to the February 2025 meeting.

Action: Director of Nursing and Therapies

The Chair asked whether there was a psycho-social element to the Culture of Care Programme.

The Director of Nursing and Therapies confirmed that psycho-social was an important part of the Culture of Care Programme.

The Chair commented that she looked forward to the presentation at the February 2025 meeting. The Chair thanked the Director of Nursing for her update.

5.3 Quality Concerns Register Report

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

- Talking Therapies had been added to the Quality Concerns Register due to service performance relating to access targets, waits, and face to face appointments steadily declining. Staff feedback received through a variety of means had also indicated some dissatisfaction.
- There had been no services removed since the Register was last presented to the Committee, although it had been agreed at the November 2024 Quality and Performance Executive Group that the Community Based Neuro-Rehabilitation Team was removed due to a sustained improved picture

The Director of Nursing and Therapies reported that the Talking Therapies service had presented to the Quality and Performance Executive Group meeting setting out how they were taking a quality improvement approach to addressing their service challenges. The Director of Nursing and Therapies proposed inviting the Talking Therapies service to present to the February 2025 meeting.

Action: Director of Nursing/Company Secretary

The Chair noted that the additional mental health beds due to open in January 2025 were referred to as "the outsourced ward".

The Chief Operating Officer said that the Trust was describing the additional beds as the Trust's "fifth mental health ward" and was keen to ensure that it had the feel of Prospect Park Hospital.

The Chair suggested that the Committee receive a presentation on the new ward when this was up and running.

Action: Chief Operating Officer

The Committee noted the report.

5.4 National Patient Safety Alert – Bed Rails Report

The Director of Nursing and Therapies presented the paper and reported that it had become evident locally as well as nationally that achieving some of the actions set out the Medicines Healthcare Products Regulatory Agency (MHRA) Bed rail Alert in relation to pieces of equipment being used in the community where the prescribers of the equipment were no longer seeing these patients was a significant task and would take much longer than the current deadline allowed. This was particularly relevant to the need for risk assessments and review

The Director of Nursing and Therapies said that the Trust was taking a proportionate approach in line with other local authority and health colleagues by sending out letters to all patients who had been prescribed bed rails over the last three years. The letter offered patients an assessment if they wanted one now or in the future. Work was ongoing across the system to establish a process for reviewing patients in the community who were no longer open to a clinical team.

The Director of Nursing and Therapies commented that the MHRA alert was issued with the right intentions but there were significant practical issues around implementing all the actions given that there were over 6,000 pieces of equipment.

The Director of Nursing and Therapies confirmed that there would be an update report at the February 2025.

Action: Director of Nursing and Therapies

The Committee noted the report.

5.5 Paediatric Audiology Services Update Report

The Director of Nursing and Therapies presented the paper which provided a summary of the Trust's Paediatric Audiology Services in relation to the national NHS England review of all Paediatric Audiology Services and the Trust's accreditation with the UK Accreditation Services.

It was noted that the UKCAS review had identified four cases where there was potential harm, all of these have been followed up in our clinical, with onward referrals to secondary care where this was indicated. The review identified that the delay in recall/between appointments (some were due to not being brought back and this not being followed up). Each case had been assessed, and the duty of candour was applied as appropriate

The Director of Nursing and Therapies reported that following the suspension of the Trust's IQIPS accreditation in February 2024, the Trust implemented a range of improvement actions but unfortunately when IQIPS had re-assessed the Trust in October 2024, the Trust could not demonstrate that all the actions had been embedded. It was noted that IQIPS was always satisfied with the Trust's clinical care and that the issues were around polices and documentation.

John Barrett, Patient Safey Partner noted that the Trust had previously been accredited by IQIPS and asked whether the accreditation process was now a more demanding process.

The Director of Nursing and Therapies said that she did not think that there had been a fundamental shift around what was expected but there was a greater national focus on Paediatric Audiology Services.

The Committee noted the report.

5.6 Reducing Restrictive Practice Six Monthly Report

The Deputy Director of Nursing for Patient Safety and Quality presented the report and said that there was a positive downward trend in the use of injectable rapid tranquilisation from 20 cases in August 2024 to 8 cases in September 2024.

It was noted that the Trust had commissioned the Advocacy People to undertake a post incident review project at Prospect Park Hospital to give patients who had been restrained whilst at Prospect Park Hospital the opportunity to discuss their experiences with an independent advocate.

The Deputy Director of Nursing for Patient Safety and Quality said that one of the key findings of the review was around the need to improve communication particularly prior to the use of restraint.

The Deputy Director of Nursing for Patient Safety and Quality reported that the Consultant Nurse Network were leading improvement work focussed on length of time in seclusion which included clear plans for when seclusion should end were made and documented.

The Chair referred to the reduction in the use of injectable rapid tranquilisation and commented that its use was heavily dependent upon the cohort of patients at any given time.

The Deputy Director of Nursing for Patient Safety and Quality agreed and pointed out that developing personalised care plans for individuals was helpful in reducing the use of restraint.

The Chair commented that there was clearly a lot of work being done to reduce restrictive practices at the Trust.

The Committee noted the report.

5.7 National Patient Safety Strategy Implementation Report

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and reminded the meeting that the Trust went live with the Patient Safety Incident Response Framework in October 2023 and had made good progress in moving over to the new process.

The Deputy Director of Nursing for Patient Safety and Quality said that work was underway to find ways of getting the learning from incidents to the frontline in a more timely manner.

The Deputy Director of Nursing for Patient Safety and Quality said that the Patient Safety Specialists (Tiziana Ansell and Helen Degruchy) had found the Patient Safety Syllabus Levels 3 and 4 training very useful.

It was noted that the Trust had appointed two Patient Safety Partners (John Barrett who was attending the Quality Assurance Committee meetings and Simon Lawson-Brown who attended the Quality and Performance Executive Group meetings).

Tiziana Ansell, Patient Safety Specialist said that the Trust needed to rethink its approach to Patient Safety training as the national two-day training programme was not sufficient to create a culture of safety across the Trust. It was noted that the Patient Safety Syllabus Levels 3 and 4 training was a yearlong university course.

The Committee noted the report.

5.8 Patient Safety and Learning Report

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and referred to the categories of incidents investigated as a patient safety incident investigation and commented that there was a shift towards learning from near miss incidents as well as mortality cases.

It was noted that patient safety review activity demonstrated use of a range of review methodologies from the Patient Safety Incident Response Framework toolkit, including “swarm huddles” for timely responses to incidents for more immediate learning opportunities.

The Deputy Director of Nursing for Patient Safety and Quality reported that the Royal College of Psychiatry had re-accredited the Trust’s patient safety response systems and processes.

The Chair commented that the Trust’s Family Liaison Officer was doing a good job supporting bereaved families.

The Deputy Director of Nursing for Patient Safety and Quality agreed and said that there were plans in place for the Family Liaison Officer to share her skills more widely as part of communication training for staff.

The Committee noted the report.

5.9 Infection Prevention and Control Quarterly Report

The Infection Prevention and Control Quarterly Report had been circulated.

The Director of Nursing and Therapies reported that the latest Information Prevention and Control Board Assurance Framework report had also been included as part of the agenda item.

The Director of Nursing and Therapies reported that the take up of the staff flu vaccination was around 43% which was lower than she would like but was higher than the Trust's neighbouring trusts.

The Committee noted the report.

5.10 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

The Committee noted the report.

5.11 Action from the Trust Board: to consider a sub-set of patient experience measures to benchmark different Trust Services

The Director of Nursing and Therapies reported that there was an action from the Trust Board for the Quality Assurance Committee to consider whether it would be useful to identify a sub-set of patient experience measures to benchmark the different Trust services. The Director of Nursing and Therapies said that she had circulated an extract from the Model Hospital which detailed a range of patient experience related metrics for the Committee to consider.

The Committee agreed that upon reflection having a sub-set of patient experience measures would not add value to the current patient experience performance metrics.

The Chair thanked the Committee for their comments and agreed that for the time being, the current patient experience metrics were sufficient.

5.12 Learning from Deaths Quarterly Report

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

- Of the second stage reviews concluded in quarter 2, none of the deaths were a governance cause for concern
- All complaints received from families of individuals who had died had resulted in a second stage review of the care provided.
- Concerns raised by the Medical Examiner on behalf of the next of kin also resulted in a review of the care provided
- 8 reviews related to patients with a learning disability. All were reported in line with national guidance
- Ethnicity data was now included and was detailed in line with second stage review outcomes of avoidability (for deaths of a physical health cause) and overall assessment of care (for all deaths)

The Head of Clinical Effectiveness and Audit pointed out that whilst no second stage reviews were a governance cause for concern, the reviews had identified poor case in three cases. It was noted that the poor case had not contributed to the deaths and learning had been identified.

The Chair referred to page 94 of the agenda pack and asked for more information about the deaths which had occurred seven days of admission to a virtual ward.

The Director of Nursing and Therapies explained that admission to a virtual ward was treated in the same way as admission to a physical ward and any deaths within seven days of admission would be the subject of a structured judgement review.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Associate Medical Director reported that since the last meeting the following national audit had been published: Breathing Well – National Respiratory Audit Programme (NRAP) July 2024.

The Associate Medical Director reported that the report had made four key national recommendations with two relevant to the Pulmonary Rehabilitation Service:

- A minimum 50% case ascertainment in NRAP audits by May 2026 – The service currently achieved this and submitted 90% case ascertainment.
- Services should work towards a target of 70% of patients starting a Pulmonary Rehabilitation (PR) Programme within 90 days of referral, and 70% of patients with acute exacerbation of COPD starting within 30 days of referral, by May 2026.

The Associate Medical Director reported that the audit reports presented to the Committee in March 2021 highlighted waiting times which averaged 387 days as a key area for improvement and the service was added to the Quality Concerns Register.

It was noted that subsequently waiting times had improved and the service had been removed from the Quality Concerns Register. The average waiting time for the Pulmonary Rehabilitation Service in May 2024 was 165 days. The Director of Nursing and Therapies reported that the waiting time was currently around 120 days.

The Associate Medical Director reported that the action plan to address the long waiting time remained open and progress was monitored by the Clinical Effectiveness Group.

The Committee noted the report.

6.1 Quality Accounts 2024-25 – Quarter 2 Report

The Quality Accounts Report 2024-25 – Quarter 2 Report had been circulated.

The Head of Clinical Effectiveness and Audit reminded the meeting that the next report (quarter 3) would be shared with external stakeholders.

The Committee noted the report.

Update Items for Information

8.0 Guardian of Safe Working Hours Quarterly Report

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

The Associate Medical Director presented the paper and reported that there had been four exception reports since the last report. It was noted that the exception reports related to workload in the patient mental health wards because of temporary staffing shortage and emergency work arising at the end of the shift. Two of the exception reports were breaches of the working time director and had occurred a Guardian of Safe Working fine due to these shifts exceeding 13 hours. This was due to unscheduled/unanticipated emergency work that arose at the end of the shift.

The Associate Medical Director reported that the Guardian of Safe Working gave assurance that overall, no unsafe working hours patterns had been identified and there were no other patient safety issues requiring escalation.

The Committee noted the report.

8.1 Minutes of the Mental Health Act Governance Board

The minutes of the Mental Health Act Governance Board meetings held on 23 October 2024 had been circulated.

The Chair commented that the minutes of the meeting were comprehensive. The Chair noted that there were issues around the collating ethnicity data as it was not currently possible to change the categories on the RiO (electronic patient record) system.

The Associate Medical Director confirmed that there was ongoing work to resolve the issue.

The Committee noted the minutes.

8.5 Quality and Performance Executive Group Minutes – August 2024, September 2024 and October 2024

The minutes of the Quality and Performance Executive Group minutes for August 2024, September 2024 and October 2024 had been circulated.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

The following Governor Service Visit Reports had been circulated:

- Bluebell Ward
- Oakwood Unit
- Podiatry

The Chair thanked the Governors for their reports.

Closing Business

8.0 Quality Assurance Committee Horizon Scanning

The following items were identified for future agendas:

- Talking Therapies Performance (February meeting)
- Culture of Care Programme (February meeting)
- Right Care, Right Place (May meeting)
- New Mental Health Ward (date to be determined)

Action: Company Secretary

8.1. Any Other Business

There was no other business.

8.2. Date of the Next Meeting

The next meeting was scheduled to take place on 25th February 2025 at 10am. The meeting would be held face to face at London House, Bracknell with the option of attending the meeting via MS Teams.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 25th February 2025

Signed:-

Date: - 25th February 2025

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	November 2024
Title	**Learning from Deaths Quarter 2 Report 2024/25**
	Item for assurance and noting. Discussion where additional assurance required about quality of care, data or learning.
Purpose	To provide assurance to the Trust Board that the Trust is appropriately reviewing and learning from deaths
Format of the Report	The overall format of the report is not nationally prescribed for Mental Health & Community Health NHS Trusts, however there are a number of metrics which are nationally required and are included within this report.
Business Area	Clinical Trust Wide
Author	Head of Clinical Effectiveness and Audit
Relevant Strategic Objectives	The systems and processes for learning from deaths align with and give assurance against the three strategic objectives below: **Patient safety** We will reduce harm risk for our patients by continuous learning from review of deaths. **Patient experience and voice** We will review all complaints, concerns and feedback (from patient's families and staff, Medical Examiner, Coroner) to inform improvement in the quality and safety of clinical care in our services. **Health inequalities** We will reduce health inequalities for our most vulnerable patients (patients with learning disability, autism, severe mental illness) by reviewing the care provided to patients leading up to their death and learning for improvement.
CQC Registration/Patient Care Impacts	No impact
Resource Impacts	None
Legal Implications	New Statutory requirements for Medical Examiners from 9th September 2024 noted, actions taken to ensure that these requirements are fully met in advance of this date.
Equality, Diversity and Inclusion Implications	A national requirement is that deaths of patients with a learning disability & Autism are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths. Ethnicity data is included in the report.
SUMMARY	Since January 2024 the Mortality and Patient Safety meeting (MAPs) brings together the processes for review, Quality Assurance and Learning from all deaths in the trust and this report represents a summary of that function. **Patient safety** Of the second stage reviews concluded in quarter 2, none of the deaths were a governance cause for concern (avoidability score of 1,2 or 3). **Patient Experience and Voice** All complaints received from families of individuals who have died, result in a second stage review of the care provided. Concerns raised by the medical examiner on behalf of the next of kin have also resulted in a review of the care provided. **Health inequalities** 8 reviews related to patients with a learning disability, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway. Ethnicity data is now included and is detailed in line with 2nd stage review outcomes of avoidability (for deaths of a physical health cause) and overall assessment of care (for all deaths). Learning themes arising from second stage reviews were identified and noted by Clinical Directors and Governance leads for implementation for service improvement.
ACTION	The committee is asked to receive and note the Q2 learning from deaths.

Learning From Deaths Q2 Report (2024/25)

NHS Berkshire Healthcare NHS Foundation Trust

Figure 1-	2021/2022	2022/2023	2023/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total 2024/2025
Total deaths screened (Datix) 1st stage review	467	456	453	110	**141**	-	-	251
Total number of 2nd stage reviews requested (SJR/IFR)	209	192	203	53	**61**	-	-	114
Total number of deaths to be reviewed through patient safety (PSII and PSR)	35	31	31	6	**6**	-	-	12
Total Expected Deaths	-	-	183	51	**57**	-	-	108
Total Unexpected Deaths	-	-	270	59	**84**	-	-	143
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)	4	0	0	0	**0**	-	-	0
Number of Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths following transfer)	156	157	141	30	**43**	-	-	73
Total number of deaths of patients with a Learning Disability (1st stage reviews)	51	36	53	14	**12**	-	-	26
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	**0**	-	-	0

Q2 2024/25

790 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 141 were submitted for a 1st stage review in line with the learning from deaths policy (18%).

All 141 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q2, 2nd Stage reviews were requested for 61 (54%). 49 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q2.

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

Of the reviews concluded in Q2 three were assessed as overall poor care, and learning is detailed for both physical health and mental health in the report.

2nd stage Mortality reviews completed (SJR/IFR)	Q2 (47)	Total 2024/2025 (89)
Adult Learning Disabilities Services	8	19
Mental Health community, specialist, and inpatient services	23	42
Childrens and Young people's Services	0	1
Physical Health community and Inpatient Service	16	27

	Avoidabilty score for 2nd Stage Reviews (only death due to a physical health cause) 2024/2025	Q2 (47)	Total to date (89)
Score 1	Definitely avoidable	0	0
Score 2	Strong evidence of avoidability	0	0
Score 3	Probably avoidable (more than 50:50)	0	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	2	3
Score 5	Slight evidence of avoidability	4	8
Score 6	Definitely not avoidable	24	46
N/A	Non physical health cause	17	32

	Overall Assessment of Care Q2 (47)	Physical health	Learning Disability	Mental Health	Children s and Young People (CYPF)	Total to date 2024/25 (89)
1	Very poor care	0	0	0	0	0
2	Poor Care	2	0	1	0	3
3	Adequate Care	5	2	9	0	25
4	Good Care	9	6	13	0	58
5	Excellent Care	0	0	0	0	3

Ethnicity April 2024 -September 2024 (Rolling data to be updated each quarter)	1st Stage Review 2024/25	2nd Stage Review Requested 2024/25	% 2nd stage review requested
Asian or Asian British	8	6	75
Black or Black British	4	4	100
Mixed - White and Asian	2	1	50
Mixed - White and Black Caribbean/African	2	0	0
Mixed - any other mixed background	3	1	33
Not Known - Waiting for first appointment/not recorded	18	8	44
Not stated - refused	3	3	100
Other ethnic category	4	0	0
White - any other white background	13	7	54
White - English/Welsh/Scottish/Northern Irish/British	194	84	43
Total	**251**	**114**	**45%**

Ethnicity April 2024 -September 2024 Rolling data April - September to date will include cases reported as 1st stage reviews in 2023/24	Score 1 Definitely Avoidable	Score 2 Strong Evidence of Avoidability	Score 3 Probably Avoidable	Score 4 Possibly Avoidable	Score 5 Slight Evidence of Avoidability	Score 6 Definitely not avoidable	N/A (MH related deaths)	Total
Asian or Asian British	0	0	0	0	2	2	1	5
Black or Black British	0	0	0	0	0	1	2	3
Mixed - White and Asian	0	0	0	0	0	0	0	0
Mixed - White and Black Caribbean/African	0	0	0	0	0	0	0	0
Mixed - any other mixed background	0	0	0	0	0	0	0	0
Not Known - Waiting for first appointment/not recorded	0	0	0	0	0	0	0	0
Not stated - refused	0	0	0	0	0	0	0	0
Other ethnic category	0	0	0	0	0	0	0	0
White - any other white background	0	0	0	0	1	1	2	4
White - English/Welsh/Scottish/Northern Irish/British	0	0	0	3	6	41	27	77
Total	**0**	**0**	**0**	**3**	**9**	**45**	**32**	**89**

Ethnicity
Avoidability (Cause of death related to a physical cause)
& Overall Assessment of Care (All deaths)

Berkshire Healthcare NHS Foundation Trust

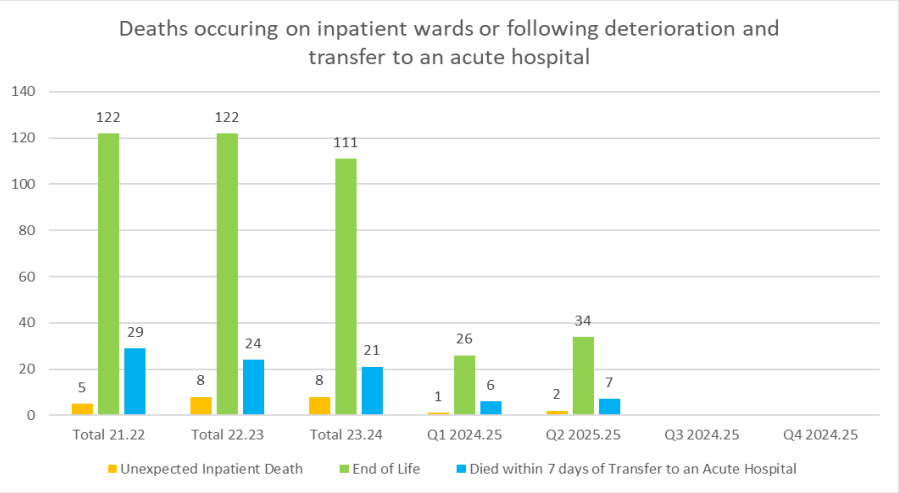
Overall Assessment of Care all 2nd stage reviews completed in 2024/25 (April - September to date will include cases reported as 1st stage reviews in 2023/24)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Total
Asian or Asian British	0	0	2	1	2	5
Black or Black British	0	0	0	3	0	3
Mixed - White and Asian	0	0	0	0	0	0
Mixed - White and Black Caribbean	0	0	0	0	0	0
Not Known - Waiting for first appointment/not recorded	0	0	0	0	0	0
Not stated - refused	0	0	0	0	0	0
Other ethnic category	0	0	0	0	0	0
White - any other white background	0	0	3	1	0	4
White - English/Welsh/Scottish/Northern Irish/British	0	3	20	53	1	77
Total	**0**	**3**	**25**	**58**	**3**	**89**

Equality & Diversity Summary Q2 2024/25

The data for our 1st stage reviews shows an adequate conversion rate to 2nd stage reviews for BAME groups to allow a full review of care.

Of the 2nd stage reviews concluded none were identified as probably avoidable (3) or poor care.

Inpatients (Physical Health and Mental Health) Learning From Deaths Q2 Report



In Q2 EMRG reviewed:

- 43 deaths reported by physical health inpatient wards

Of the physical health deaths:

- 34 were expected deaths and related to patients who were receiving end of life care (EOL) on our wards. 2 2nd stage reviews were requested to review the EOL process.
- Of the 9 unexpected deaths 2nd stage reviews were requested for 8 .
- 4 2nd stage reviews were concluded, overall care was good or adequate with an avoidability score of 6 or 5.

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

Month of death	2023/24	April 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Total Inpatient deaths reviewed by the Medical Examiner	113	9	11	7	11	13	11						
SJRs requested for Inpatient deaths by Medical Examiner	2	0	1	0	0	0	0						
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	0	0	0	0	1	0						

Coroners' outcomes for referred Inpatient Deaths	Q2	2024/25 Total
Postmortem	1	1
Forensic Postmortem	0	0
Inquest	0	0
100A	0	0

EOL Audit Q1	Total	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	29	Since Q1 the division have reviewed the process of documenting the patients emotional / psychological needs which has supported improvement in this area. In Q2 all 29 patients had their emotional / psychological needs assessed and all patients had evidence of this documented on a daily basis..

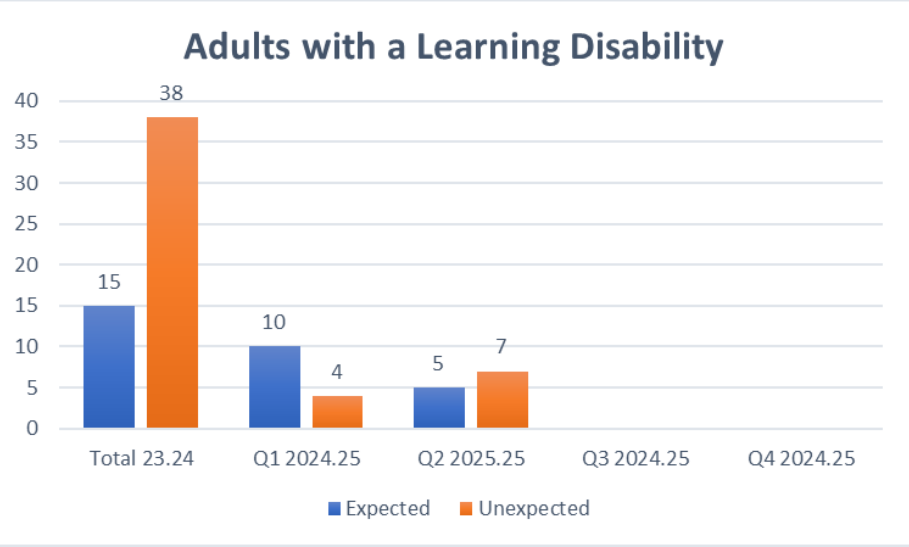
Q2 2024/25

All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed, 1 case was referred to the coroner due to asbestos exposure with an outcome of postmortem.

In line with our learning from deaths policy, 2nd stage reviews are requested and reviewed for all unexpected deaths and death within 7 days of transfer. 1 case was closed at 1st stage review as the patient was transferred back to the acute immediately following review.

The Clinical Director for PH Urgent Care will look to undertake a review of inpatient admissions which have required transfer back to the acute within 48 hours, considering the appropriateness of the initial transfer and admission to BHFT community health wards.

Adults with a Learning Disability Learning From Deaths Q2



In Q2, 12 deaths of adults with learning disability were reviewed by the Trust mortality meeting. 3 were closed following first line review by the Executive Mortality Review Group (EMRG).

9 2nd stage reviews were reviewed in Q2, of these, 8 reviews were undertaken by the LD service and 1 by Scheduled Community Services as patient was not in receipt of LD services.

The age at time of death ranged from 19 to 80 years of age (median age: 63yrs.)

	Q2 24/25	Total 24/25
Male	4	12
Female	5	8

Severity of LD	Q2 24/25	Total 24/25
Mild	3	6
Mild to Moderate		0
Moderate	2	6
Moderate to Severe		1
Severe	2	3
Profound	2	3
Not Known		1

Ethnicity	Q2 24/25	Total 24/25
White British	9	19
Black or Black British - Caribbean		0
Asian or Asian British - Pakistani		1

The deaths attributed to the following causes:	Q2 24/25	Total 24/25
Diseases of the heart & circulatory system		0
Diseases of the respiratory system	5	0
Diseases of the heart & circulatory system	1	2
Sepsis or Infection		1
Cancer		1
Disease of the nervous system		0
Dementia /cerebrovascular		0
Other	3	6
Not known		1

	Avoidabilty score for 2nd stage reviews	Learning Disability Q2 24/25
Score 1	Definitely avoidable	0
Score 2	Strong evidence of avoidability	0
Score 3	Probably avoidable (more than 50:50)	0
Score 4	Possibly avoidable, but not very likely (less than 50:50)	0
Score 5	Slight evidence of avoidability	2
Score 6	Definitely not avoidable	9

	Overall Assessment of Care	Learning Disability Q2 24/25
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	
4	Good Care	
5	Excellent Care	

Berkshire Healthcare NHS Foundation Trust

Q2 2024/25

All deaths related to patients in the community. Of the 9 cases, all were scored as 6 (definitely not avoidable).

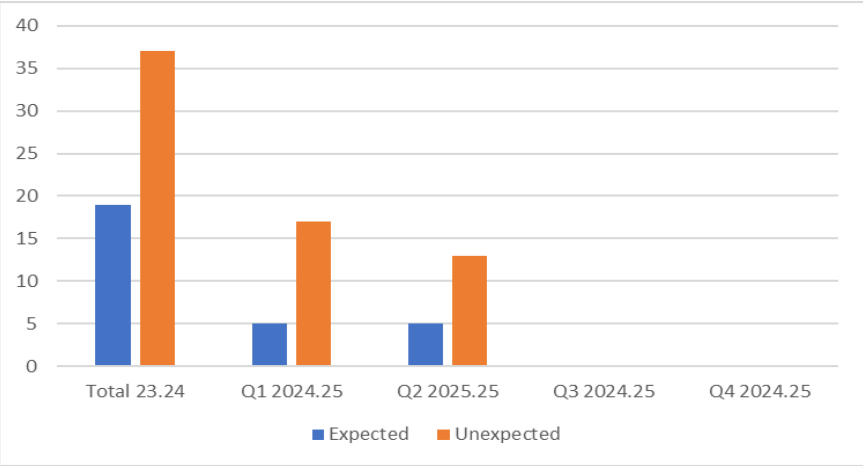
In Q2 there was ongoing evidence of good MDT working, coordination of care and communication with families, support staff and across local services.

There was ongoing evidence to show services were responsive to people's needs and that care was delivered in a timely way. Evidence of interprofessional working to prevent unnecessary hospital admissions, with clear ceilings of care and advanced care plans in place.

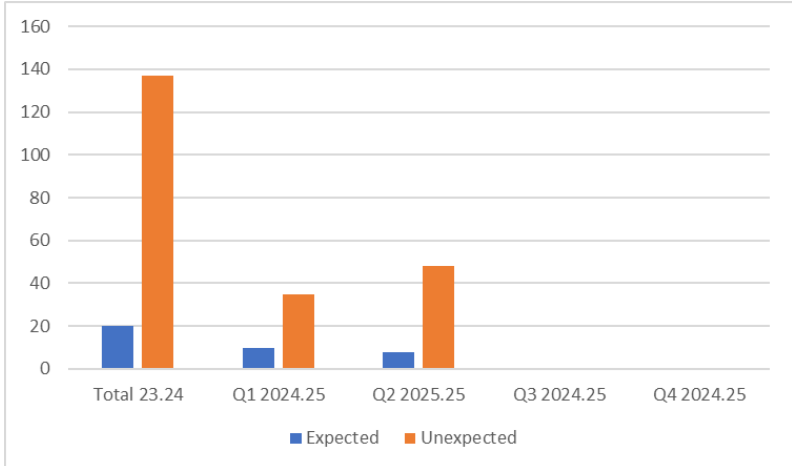
The following learning was shared within the LD service:

- The importance of ensuring capacity is recorded clearly and consistently within the clinical record.
- The value of MDT discussion and involvement in DNACPR & End of Life planning.
- A plan was also made to review the Sepsis information packs and to reissue / circulate these via CTPLD contacts for health promotion purposes.

Community Physical Health Learning From Deaths Q2



Community Mental Health Learning From Deaths Q2



Berkshire Healthcare NHS Foundation Trust

EMRG received 18 1st stage reviews in Q2 of which 2nd stage reviews were requested for 11. 2 cases remain opening awaiting further information on cause of death. 5 were closed at 1st stage review.
The 11 cases were under a range of community nursing services and virtual wards, of which 2 related to end of life deaths and 9 unexpected deaths. Rationale for reviews included:

- Clinical Decision and Management
- 7 days of admission to a virtual ward
- Mental health care

12 2nd stage reviews were completed and whilst no reviews were a governance cause for concern (Avoidability score of 1,2 or 3). 2 reviews identified poor care and the following learning was identified:

- This was a complex case involving District Nursing and Urgent Care
- The management of wound and pressure ulcer care was rated as poor, learning in relation to care plans and the management of wounds has been identified in a similar coroner case and an improvement plan is already in place and is currently being actioned by the services involved.
- It was identified that more could have been done more to engage the patient (who refused aspects of care).
- It was identified that we need more robust systems and processes for making sure that actions agreed at joint meetings across health and social care are robust. Action plans are in place to fully improve record keeping and ensure that actions identified are followed through.

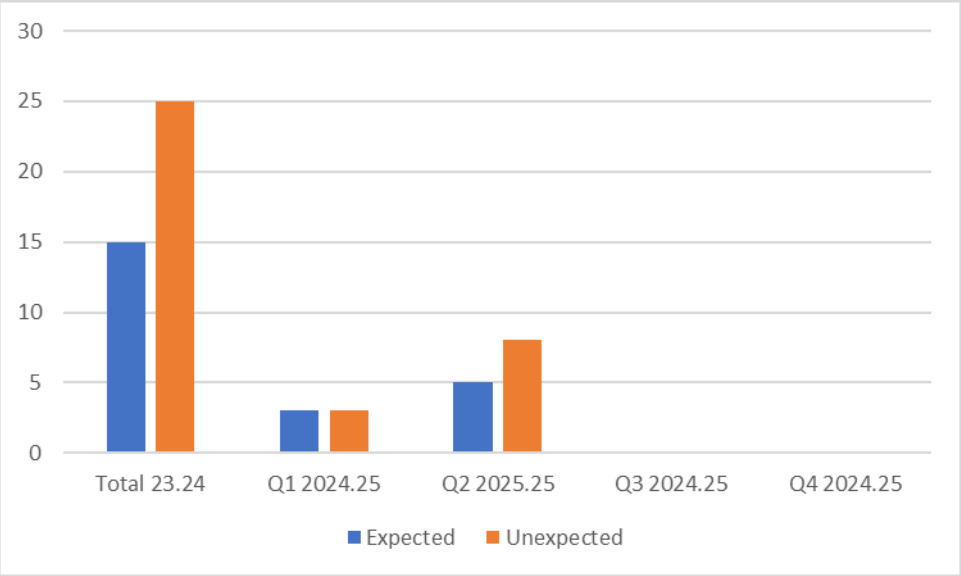
EMRG completed 56 1st stage reviews in Q2 of which 2nd stage reviews were requested for 34. 18 were closed at 1st stage review/
The 34 cases were from a range of community mental health or specialist mental health services 30 were unexpected deaths and 4 expected. Rationale for reviews included:

- Management of Clozapine
- Clinical Decision and Management
- Safeguarding
- Support whilst awaiting another service

23 2nd stage reviews (13 related to suicide, 6 physical health cause of death, and 4 other MH related cause of death) were concluded and whilst none of the deaths relating to a physical health cause identified a governance cause for concern (Avoidability score of 1,2 or 3). 1 review identified poor care and the following learning was identified:

- Professional curiosity and increased awareness of working with people who have a dual diagnosis of mental health concerns and drug and alcohol problems would have prompted a full assessment of presentation, risks, and needs for further intervention or assessment by other services.
- Assessments, discussions with patients and other professionals, and rationale for interventions need to be adequately documented in both patient notes and onward communications with other professionals to ensure the patient receives appropriate onward care and interventions.
- The need for liaison and communication with drug and alcohol services were considered but not completed within best practice guidelines as set out in the psychological medicines service drug and alcohol treatment pathway and the MHICS standard operating procedure for working with patients with both mental health and drug and alcohol issues.
- The process for ensuring patients are brough back for discussion at MHICS led to a delay in the care pathway .

Childrens & Young People: Learning From Deaths Q2



Q2 2024/25

In Q2 13 deaths reported as 1st stage reviews of which 5 were expected and 8 unexpected.
The 5 expected deaths were children who died in an acute hospital and either had complex health condition or an acute illness at the time of their death.

Of the 8 unexpected deaths 6 were neonatal deaths due to prematurity, congenital anomaly or complex health need. One death of an infant in the neonatal period following significant birth trauma and one death following suspected carbon monoxide poisoning whilst staying out of area.

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

No 2nd stage reviews were open or concluded in Q2.

Complaints and Inquiries Learning From Deaths Q2

Complaints and MP Inquiries	Q2 24/25	Total 24/25
Communication and Clinical Care (District Nursing)	0	2
Clinical Care (Community Mental Health)	0	0
Community podiatry.	0	0
District Nursing (End of life Clinical Care)	0	0
Westcall Out of Hours GP (End of Life care provision	0	0
Inpatient physical health (clinical care)	1	0
Out of area placement (mental health clinical care)	0	0

1 complaint was received in total in Q2 relating to aspects of care or treatment prior to death. A 2nd stage review was requested in addition to the formal complaint response.

1 2nd stage review was concluded which related to a complaint, adequate care and an avoidability score of 4 (Possibly avoidable, but not very likely (less than 50:50).

In Q2 2 Freedom of Information Requests (FOI) were received relating to deaths and were responded to.

Berkshire Healthcare NHS Foundation Trust

Prevention of Future Deaths (PFD) reports 2024/25
The table details the PFD's received by the Trust in 2024/25 –No new PFD have been received in Q2.

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

Overall Learning and Summary From Deaths Q2

Q2 2024/25

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

3 reviews identified poor care, learning is identified and being implemented .

All complaints received from families of individuals who have died resulted in a second stage review of the care provided. No concerns were raised by the medical examiner.

9 reviews related to patients with a learning disability, all were reported in line with national guidance to LeDeR, who complete independent reviews covering the full patient pathway.

Learning themes arising from second stage reviews were identified and noted by Clinical Directors and Governance Leads for implementation and service improvement.

Key Themes

- Wound care management in Community Nursing Services
- Local area partnership (LAP) communication is a theme as it has been present in a few cases under review and previous learning.
- Psychological Medicines Services (PMS) –lack of safety plan or limited risk assessment – this is going to be added to the wider review already underway.
- Face to face vs Telephone contacts and limitations on exploration of mental state
- Management of Drug and Alcohol pathways for patients with co-existing mental health and drug and alcohol dependencies.

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	November 2024
Title	Guardian of Safe Working Hours Quarterly Report (May to July 2024)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Authors	Dr Malarvizhi Babu Sandilyan
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and safe patient care
Resource Impacts	Currently 1 PA medical time
Legal Implications	Statutory role
Equalities and Diversity Implications	N/A
SUMMARY	This is the latest quarterly Guardian of Safe Working report for consideration by Trust Board. This report focusses on the period 6st August to 28th October 2024. Since the last report to the Trust Board, we have received four exception reports. Two of these reports are breach of the WTD and have incurred GOSW fine due to these shifts exceeding maximum 13 hours. This was due to unscheduled/unanticipated emergency work that arose at the end of the shift and no work schedule review or rota redesign are required. We do not foresee any problems with the exception reporting policy or process. We do not foresee any significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the GOSW.

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

This report covers the period 7th of August to the 28th October 2024

Executive summary

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

This report focusses on the period the period the 7th August to the 28th of October 2024. Since the last report to the Trust Board, we have received six '*hours & rest'* exception reports. However upon reviewing them, two of those exception reports relate to the F1 doctor working additional time during the elderly care placement at Royal Berkshire hospital, these have been duly highlighted to GOSW counterpart at the RBH. Therefore, the total number of exception reports for BHFT would be four.

Introduction

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

High level data

Number of doctors in training (total):	51 (FY1 – ST6)
Number of doctors in training on 2016 TCS (total):	51
Amount of time available in job plan for guardian to do the role:	1PA
Admin support provided to the Guardian (if any):	None
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

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

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

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY	0	2	2	0
CT	0	2	2	0
ST	0	0	0	0
Total	0	4	4	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry OOHs	0	2	2	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
Total	0	0	4	0

In this period, we have received four exception reports.

Two of these four exception reports relate to workload in inpatient mental health wards and two of the exception reports relate to OOH, late finish at the end of the shift. The exception reports that arose from the inpatient ward, was because of temporary workforce shortage and emergency work arising at the end of the shift (SAS doctor on leave) which now has been resolved. The two exception reports that arose during OOH were due to an emergency at the end of the 12.5 hours shift (fire in Sorrel ward) which was unanticipated. This led to breach of the maximum 13 hour shift by 1.75 hours for both trainees who worked on that night shift and therefore a GOSW fine of £186.33 was levied upon the department. This will be discussed in the forthcoming RDF (resident doctors forum) and appropriately spent/accrued for the benefit of trainee doctors. The two trainees will get £55.90 each via the payroll. None of these reports have necessitated review of work schedule or the OOH rota, because they are not indicative of any pattern or repeated breaches of shift working hours.

The GOSW has discussed with trainees regarding the exception reports at the Resident Doctors' Forum (RDF) on 26th September 2024, there were no concerns raised by trainees in getting their TOIL for the time they have worked extra; trainees have been encouraged to raise the exception reports if they have worked beyond their work schedule and if in doubt to contact GOSW or their supervisor, this will be discussed on a regular basis at the RDF. This quarter two of the exception reports are raised are from the mental health inpatient unit, because of the acute nature of the job and due to patients/admissions/discharges often requiring immediate attention and two in relation to out of hours on call rota, again due to urgent and unforeseen matter arising closer to the end of the shift . There are no outstanding exception reports waiting to be actioned, TOIL and payment compensation where appropriate have all been agreed with trainees. The number of reports that we have received are keeping in line with historical mean data for this Trust and GOSW meets the trainees via the PDF and trainee representatives through the MEM medical education meetings, to encourage raising exception reports where applicable and to address any barriers that trainees may face in doing so, this was also be highlighted by the GOSW in new trainees induction on the 7th of August 2024.

During this quarter, there have not been any exceptions reported in relation to the OPPC course overruns, which historically had been a problem. We will continue to monitor and raise any issues when they arise. There continues to remain some delay in addressing the exception reports within the recommended 7 days from date of submission, the GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so, individual emails are also sent to respective supervisors to remind them to action the reports (if not actioned within 7 days and overdue) and agree TOIL when appropriate. The GOSW continues to remind supervisors at the Medical Staff Committee meeting about prompt action on exception reports for their trainees, an email reminder has been sent to all consultants explaining the flowchart of exception reporting process and the timescale to action them, consultants have been reminded the onus is on them to action these reports and discuss with trainees if appropriate.

Exception reporting is a neutral action and is encouraged by the Guardian and Directors of Medical Education. We continue to promote the use of exception reporting by trainees, and make sure that they are aware that we will support them in putting in these reports. It is the opinion of Guardian of Safe Working that "time off in lieu" (TOIL) is the most appropriate action following an exception report to minimize the effects of excessive work.

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 7th august to 28th of October 2024)

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Gap	45	43	440.5	416.5
Sickness	16	14	146	129
Maternity	0	0	0	0
Total	61	57	586.5	545.5

d) **Fines**

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

Fines by department		
Department	Number of fines levied	Value of fines levied
psychiatry	2	186.33 total
Total	2	186.33 total

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£0	£186.33	£0	£186.33

Qualitative information

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

Issues arising

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

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

Actions taken to resolve issues:

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

Inpatient consultants reminded by GOSW about the work schedule for trainees and address any workforce shortage on the acute inpatient wards.

Next report to be submitted February 2025

Summary

All work schedules are currently compliant with the Contract Terms and Conditions of Service. No review of OOH rota required. The GOSW give assurance to the Trust Board that overall, no unsafe working hours patterns have been identified, and no other patient safety issues requiring escalation have been identified. The two breaches of 13 hours shifts were due to unprecedented emergency work and have been appropriately compensated.

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

The GOSW asks the Board to note the report and the proposed actions.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 January 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 – 14 January 2025

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. Staff Winter Flu Vaccination Report December 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 (JCVI) 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.

Whole organisational uptake of flu vaccination as of end December is 42.86%
Frontline workers update of flu vaccination as of end December is 48.3%

Directorate	% Uptake
Central Services	**46.74%**

Directorate	% Uptake
Mental Health Services	**36.95%**
Community Health Services	**42.3%%**
Children, Family and All Age Services	**50.56%**

During December 2024, we continued to offer vaccinations at key locations including sites with wards. Vouchers continued to be available to those who preferred to use this method for vaccination, and we continued to collate information of staff who have received their vaccination elsewhere.

The formal programme/vaccination offer across the Trust has now concluded. However, we will continue to collect information on staff vaccinated elsewhere.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Elective Recovery Plan

On the 6th January, the Prime Minister set out how the NHS will return to the standard of treating 92% of elective patients within 18 weeks. Currently it is hovering around 60%. The waiting list currently stands at 7.5 million, with more than 3 million having already waited longer than the 18-week target.

Trusts will be handed individual targets and will be expected to improve their performance by at least five percentage points by next March. Community diagnostic centres will be required to open for longer hours, and the existing performance management regime will be stepped up. Meanwhile, NHS England will begin to redesign the financial architecture that funnels money to different parts of the health service. Prices paid for treatments with the biggest waits will be reviewed and potentially increased, at least in part to make them more attractive to independent sector providers. Trusts and GPs will get dedicated funding to pay for Advice and Guidance services, which helps to avoid unnecessary hospital referrals. More specific detail will be known when the NHS Operating Plan is published.

Executive Lead: Julian Emms, Chief Executive

4. Engagement Update: Jubilee Ward

Frimley Integrated Care Board as the responsible body has coordinated the following programme of public engagement in Slough and Maidenhead to discuss the proposed change of location for Jubilee Ward

- Overall public, patient/carer engagement process: September 2024 - February 2025
- Engagement live (including web info, survey via digital, media and community channels, drop-in sessions, face to face conversations with inpatients, and focus groups): Mid-October 2024 – February 2025

- Analysis and write up of results/insight: February 2025
- Formal engagement with the relevant local authority officers, councillors and overview and scrutiny committees
- Final reporting: End of February/Early March 2025

Opportunities have primarily focused on survey and web-based feedback to date; the ICB are working to set up face to face meetings in January and February.

Survey feedback to date includes:

- The importance of having visitors, with the majority reporting having a visitor/visiting on most days
- All visitors so far have travelled to both wards by car and all have found it easy or very easy to get there.
- Both patients and visitors are reporting the two most important considerations as
    1) access to physical rehabilitation and activities
    2) visibility of staff in case they need support or to ask a question.
- Narrative comments are mixed in terms of sentiment - many expressing concern about moving services away from Slough, however some understanding of the requirement to move and supportive of services in Maidenhead - this seems to be linked to where the patient/visitor currently resides and the impact on them personally.

The Trust has at the same time initiated a programme of staff engagement activities with ward staff on both the Upton and St Marks sites. This includes spending time on the wards speaking to staff, as well as more formal sessions for questions, queries and concerns. Their primary concerns relate to travel to the new ward and maintaining a strong team identity.

Executive Lead: Tehmeena Ajmal, Chief Operating Officer

Presented by: Julian Emms
Chief Executive
14 January 2025

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	14 January 2025
Title	**Finance Report November 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

November 2024

Purpose

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

Document Control

Version	*Date*	*Author*	*Comments*
1.0	11/12/24	Rebecca Clegg	Draft
2.0		Paul Gray	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Year to Date Actual £m	Year to Date Plan £m	Year to Date Achieved	Outturn Actual £m	Outturn Plan £m	Outturn Achieved
1a	Income and Expenditure Plan	1.9	1.9	Yes	1.9	1.9	Yes
2a	CIP - Identification of Schemes	8.8	8.8	Yes	8.8	13.6	No
2b	CIP - Delivery of Identified Schemes	8.8	8.8	Yes	8.8	8.8	Yes
3a	Cash Balance	56.1	52.1	Yes	46.8	46.8	Yes
3b	Better Payment Practice Code Volume Non-NHS	98%	95%	Yes	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	98%	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	95%	95%	Yes	95%	95%	Yes
4	Capital Expenditure not exceeding CDEL	1.6	4.6	Yes	8.6	8.6	Yes
5	Agency Ceiling	2.9%	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 year to date surplus is in line with plan.
- The Trust has a £13.6m Cost Improvement Plan. We on track year to date, but there are some small variances on individual plans.
- Cash is above plan due to some slippage year to date on the capital programme, which will be resolved by year end as Estates projects completed and IT equipment is delivered.
- Our performance against the Better Payment Practice Code is achieved for 3 targets and is marginally below for the NHS by value target.
- Capital spend is under plan year to date for CDEL schemes but forecast outturn is as per the plan.
- The Trust is working within the agency ceiling.

System Position

- BOB ICS submitted a combined plan of £60m deficit which is in line with the control total agreed by NHSE. NHSE have provided 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.
- BOB continues behind its plan to date and continues to pursue options to ensure the system meets if financial target for the year. PwC have completed and presented their assessment as part of the Investigation and Intervention regime, with organisations implementing a number of actions recommended in the report.

1. Income & Expenditure

Nov-24	In Month			YTD			2024/25
	Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m	Plan £'m
Operating Income	31.2	31.2	(0.0)	248.2	248.9	(0.6)	373.8
Elective Recovery Fund	1.2	0.3	0.9	4.6	2.7	1.9	4.1
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**32.5**	**31.6**	0.9	**252.9**	**251.6**	1.3	**377.9**
Staff In Post	22.3	21.7	(0.7)	171.3	170.9	(0.3)	258.0
Bank Spend	1.9	2.2	0.2	15.9	17.0	1.1	25.8
Agency Spend	0.8	0.7	(0.1)	5.5	5.5	(0.0)	8.3
Total Pay	**25.0**	**24.6**	**(0.5)**	**192.7**	**193.4**	**0.7**	**292.1**
Purchase of Healthcare	1.6	1.5	(0.1)	13.7	13.4	(0.3)	19.5
Drugs	0.6	0.5	(0.1)	4.4	4.1	(0.3)	6.1
Premises	1.5	1.4	(0.0)	12.2	11.3	(0.8)	17.1
Other Non Pay	1.8	1.5	(0.3)	13.5	12.5	(1.1)	18.4
PFI Lease	0.7	0.7	0.0	5.7	5.9	0.2	8.8
Total Non Pay	**6.1**	**5.7**	**(0.5)**	**49.5**	**47.2**	**(2.3)**	**70.0**
Total Operating Costs	**31.2**	**30.2**	**(1.0)**	**242.2**	**240.6**	**(1.6)**	**362.1**
EBITDA	**1.3**	**1.4**	**(0.1)**	**10.7**	**11.0**	**(0.3)**	**15.8**
Interest (Net)	(0.0)	0.1	0.1	0.0	0.6	0.6	1.0
Depreciation	1.0	0.9	(0.0)	7.4	7.4	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	**1.0**	**1.0**	**0.1**	**9.0**	**10.0**	**1.0**	**14.3**
Reported Surplus/(Deficit)	**0.3**	**0.3**	**(0.0)**	**1.7**	**1.0**	**0.7**	**1.5**
Adjustments	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**(0.0)**	**0.1**
PFI IFRS16 Adjustment	**(0.1)**	**(0.1)**	**(0.0)**	**0.2**	**0.9**	**(0.7)**	**0.3**
Adjusted Surplus/(Deficit)	**0.2**	**0.2**	**(0.0)**	**1.9**	**1.9**	**0.0**	**1.9**

Key Messages

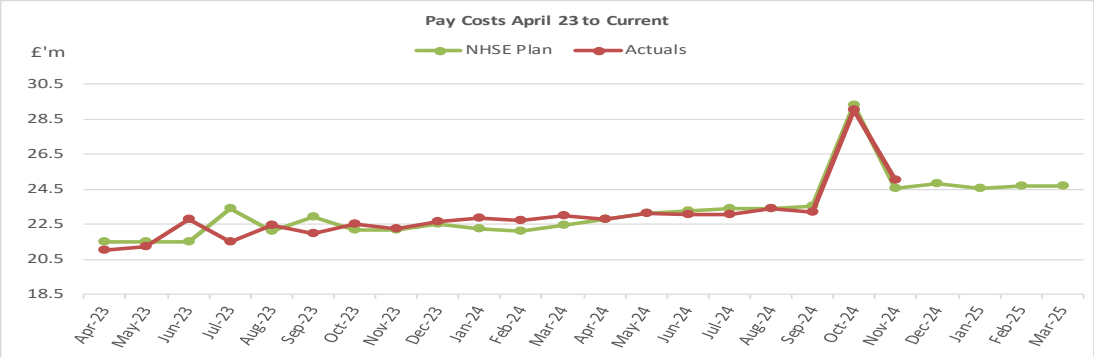
The table above gives the financial performance against the Trust's income and expenditure plan as at 31 October 2024.

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.

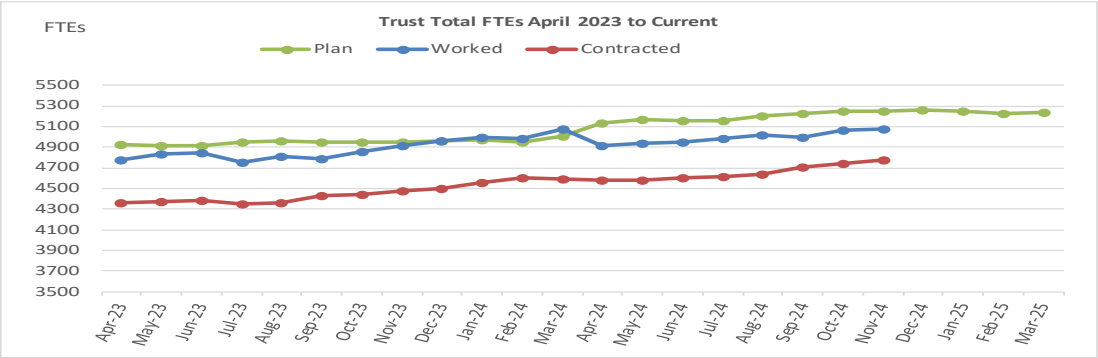
Month 8 variances are not material and overall the Trust on plan year to date. Income and expenditure plans have been updated to take account of the higher than planned pay award which was paid in month along with the back dated element. The final elements of the pay award, including back –dating, which were made in month were higher than the accruals entered in month 7 resulting in a small spike in expenditure in month. Overall, £1.1m of the pay award was unfunded due to the way the tariff cost uplift factor is calculated.

Workforce

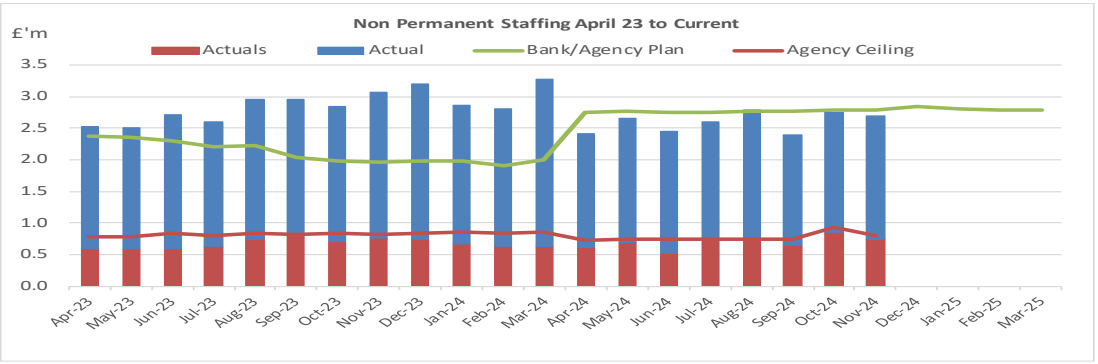


Staff Costs

YTD	£'m
2024/25	192.7
2023/24	175.8
▲	10%
Prior Yr	**£'m**
Nov-24	25.0
Nov-23	22.3
▲	12%



Prior Mth	CFTE	WFTE
Nov-24	4,773	5,081
Oct-24	4,738	5,059
	1% ▲	0% ▲
Prior Yr		
Nov-24	4,773	5,081
Nov-23	4,476	4,917
	7% ▲	3% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2024/25	13.3	4.8
2023/24	14.4	4.7
	-8% ▼	2% ▲
Prior Yr	**£'m**	**£'m**
Nov-24	1.9	0.8
Nov-23	2.3	0.8
	-15% ▼	-1% ▼

Key Messages

Pay costs in month were £295m but this includes the final elements of the back dates pay award. In month, contracted WTEs increased by 22 and worked WTEs increased by 33

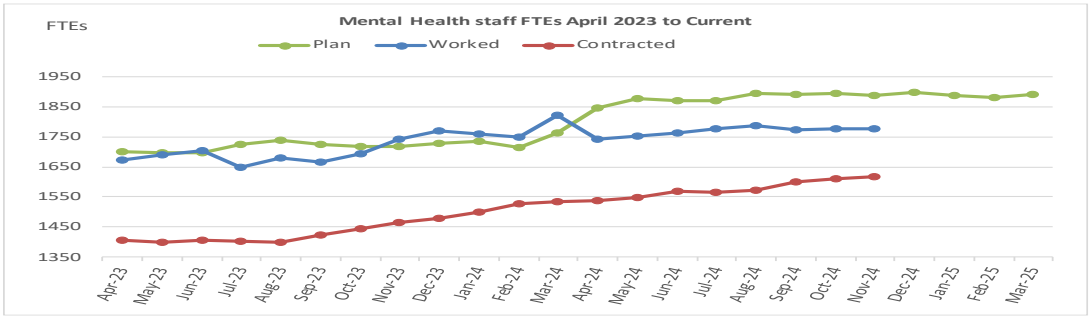
We are operating below the NHSE System Agency Ceiling of 3.2%, currently running at 2.9%. Overall temporary staffing costs are lower than the same period last year.

From November, there have been further reductions for AFC NHSE price cap breaches. Price breaches are now isolated to days shifts within CAMHS Rapid Response (x 3 B7), 1 x SLT, dental nursing ad hoc cover and B7 shifts only in Westcall.

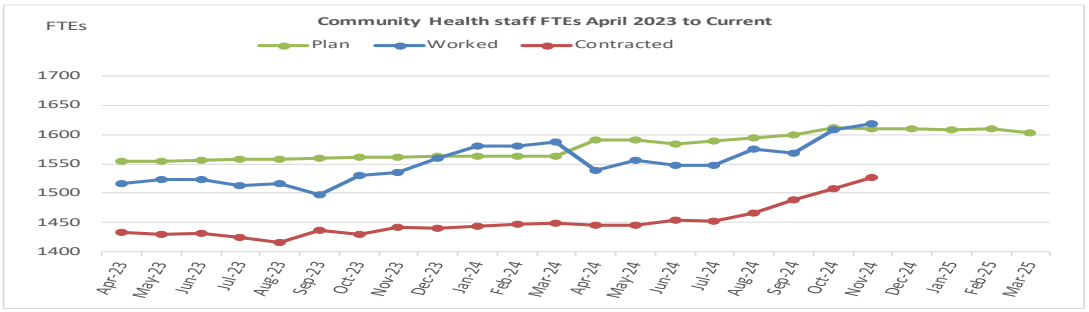
All medical shifts are at breached rates reflecting the challenges in this market, and service declaration of medical agency use has increased to improve the accuracy of breach reporting to NHSE.

Off-framework usage is only within nurseries and dental services. Both are also above price cap but reported to NHSE under off-framework as per the guidance, as well as weekly national and regional reporting.

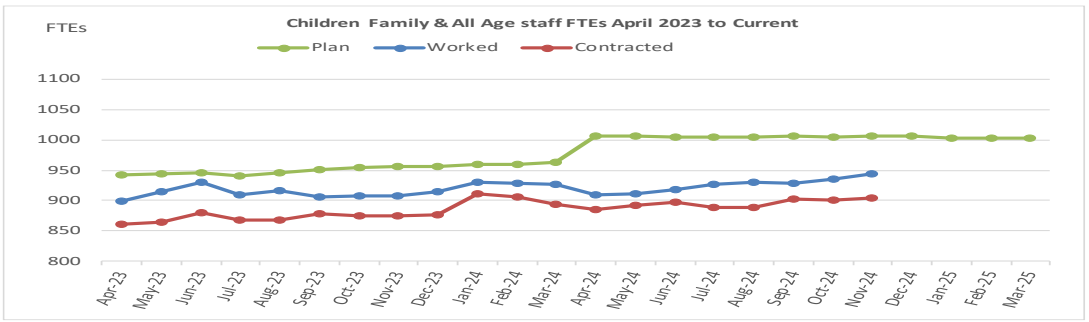
Staff Detail (Division)



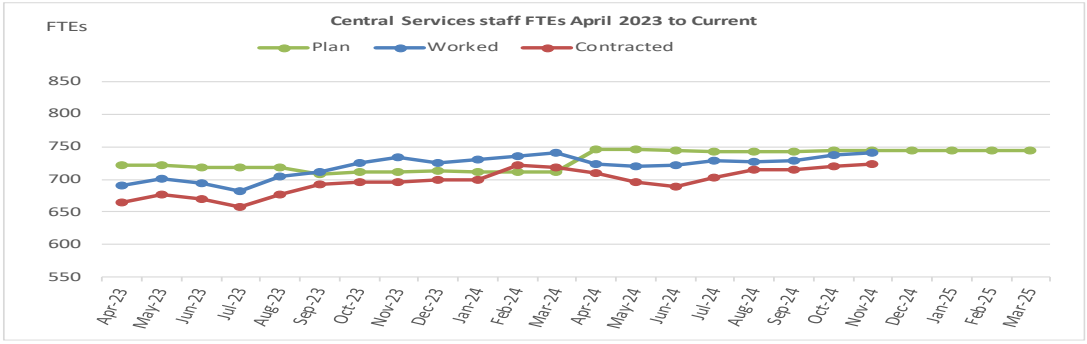
FTE's		
Prior Mth	CFTE	WFTE
Nov-24	1,618	1,777
Oct-24	1,610	1,778
	1% ▲	0% ▼
Prior Yr		
Nov-24	1,618	1,777
Nov-23	1,465	1,741
	10% ▲	2% ▲



FTE's		
Prior Mth	CFTE	WFTE
Nov-24	1,526	1,618
Oct-24	1,508	1,607
	1% ▲	1% ▲
Prior Yr		
Nov-24	1,526	1,618
Nov-23	1,442	1,536
	6% ▲	5% ▲



FTE's		
Prior Mth	CFTE	WFTE
Nov-24	904	944
Oct-24	900	936
	0% ▲	1% ▲
Prior Yr		
Nov-24	904	944
Nov-23	874	909
	3% ▲	4% ▲

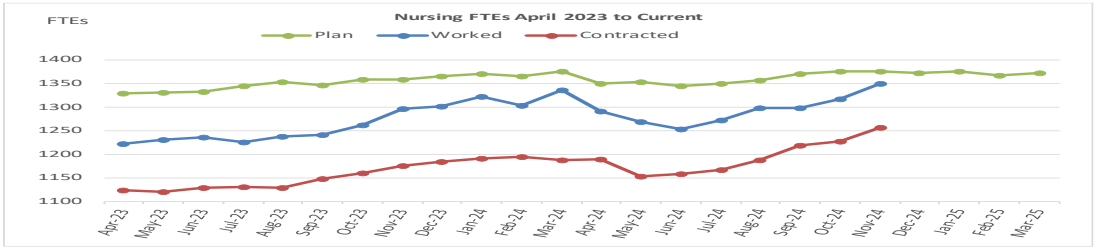


FTE's		
Prior Mth	CFTE	WFTE
Nov-24	724	741
Oct-24	721	738
	1% ▲	0% ▲
Prior Yr		
Nov-24	724	741
Nov-23	695	734
	4% ▲	1% ▲

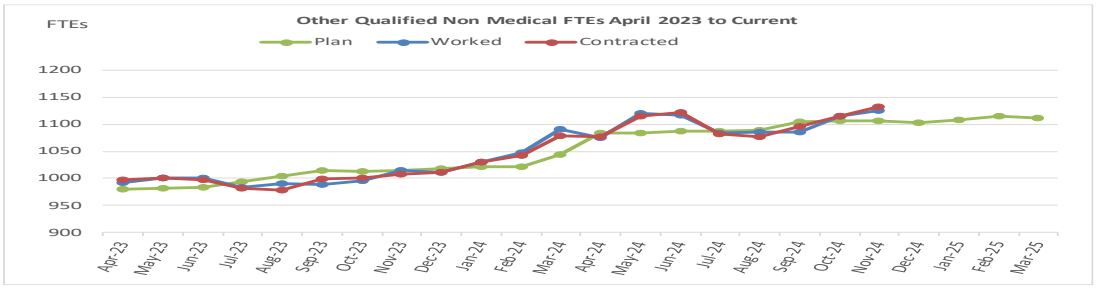
Key Messages

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

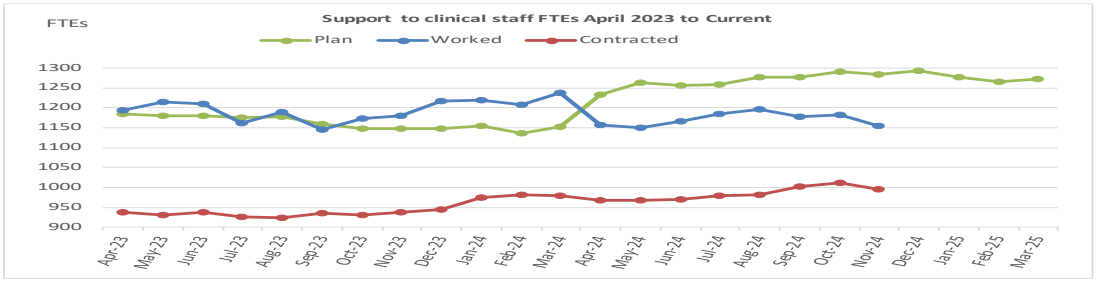
Staff Detail (Staff Group)



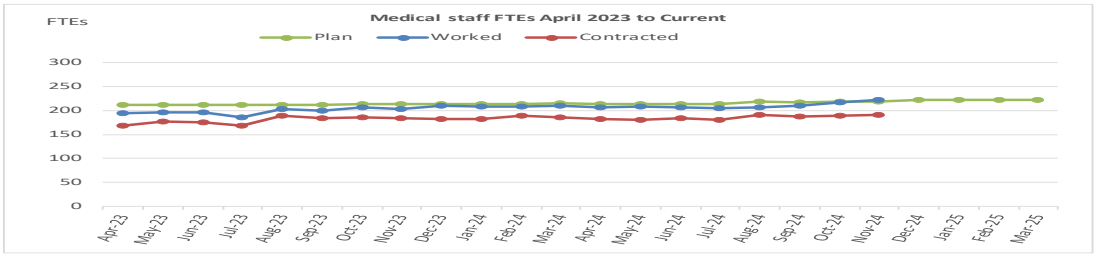
FTE's		
Prior Mth	CFTE	WFTE
Nov-24	1,257	1,349
Oct-24	1,227	1,317
	2% ▲	2% ▲
Prior Yr		
Nov-24	1,257	1,349
Nov-23	1,176	1,296
	7% ▲	4% ▲



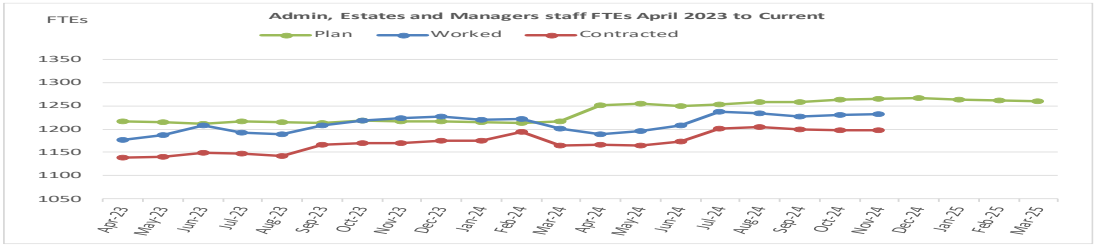
FTE's		
Prior Mth	CFTE	WFTE
Nov-24	1,132	1,125
Oct-24	1,115	1,114
	2% ▲	1% ▲
Prior Yr		
Nov-24	1,132	1,125
Nov-23	1,009	1,014
	12% ▲	11% ▲



FTE's		
Prior Mth	CFTE	WFTE
Nov-24	996	1,153
Oct-24	1,010	1,181
	-1% ▼	-2% ▼
Prior Yr		
Nov-24	996	1,153
Nov-23	938	1,180
	6% ▲	-2% ▼



FTE's		
Prior Mth	CFTE	WFTE
Nov-24	190	222
Oct-24	188	217
	1% ▲	2% ▲
Prior Yr		
Nov-24	190	222
Nov-23	183	203
	4% ▲	9% ▲



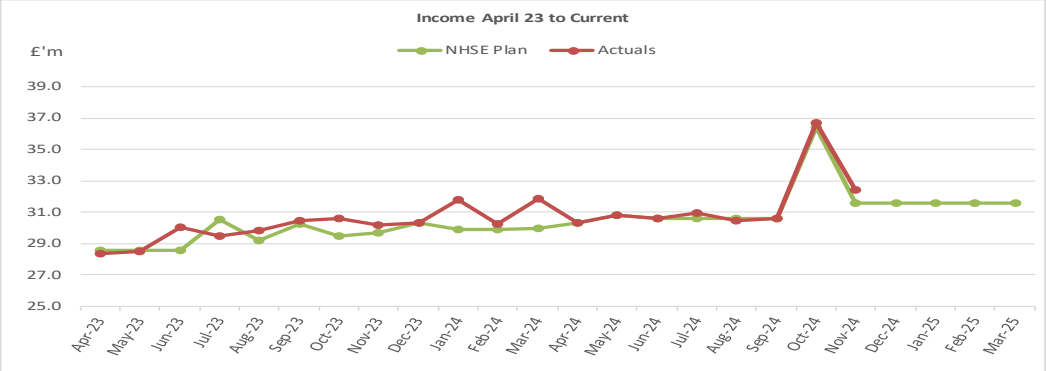
FTE's		
Prior Mth	CFTE	WFTE
Nov-24	1,198	1,231
Oct-24	1,197	1,231
	0% ▲	0% ▲
Prior Yr		
Nov-24	1,198	1,231
Nov-23	1,170	1,224
	2% ▲	1% ▲

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.

Income & Elective Recovery Fund



Income

YTD	£'m
2024/25	252.9
2023/24	237.4
▲	7%

Prior Yr	£'m
Nov-24	32.5
Nov-23	30.2
▲	8%

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 Year to Date: November 2024	BOB £000s	Frimley £000s	Total £000s
Baseline	10,398	10,743	21,141
Actual	15,447	10,309	25,755
Value of activity above baseline	5,048	-434	4,614
Income target £4.132m			2,755
CIP £1m			667
Variance (+/-)			1,193

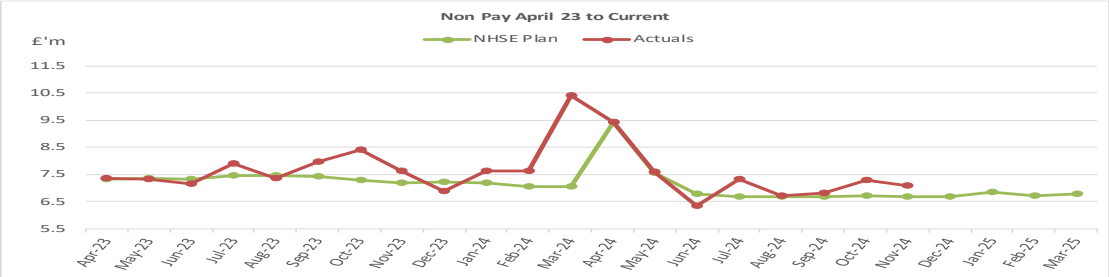
The Trust will receive payment for all activity above the 19/20 baseline which is higher than for 23/24 as it has been adjusted for working days and the current activity prices. The target and income earned will be updated for further price changes resulting from pay awards as they are agreed.

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

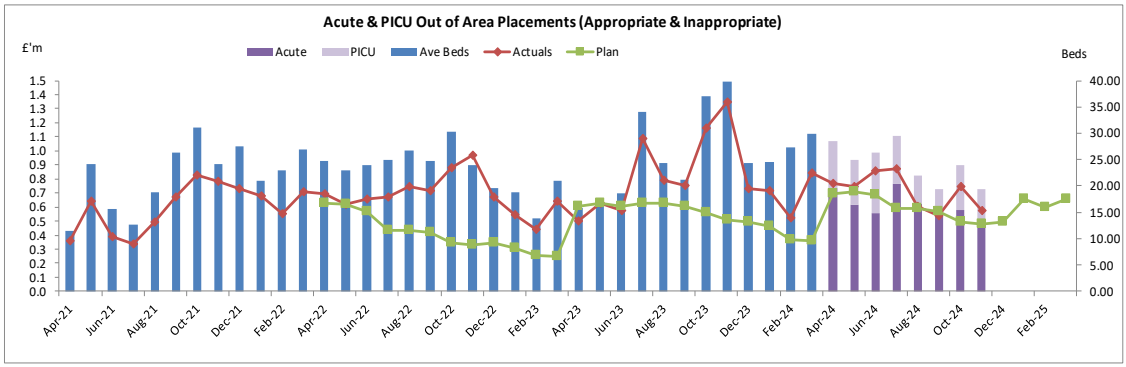


Non Pay

YTD	£'m
2024/25	58.5
2023/24	61.1
▲	-4%
Prior Yr	**£'m**
Nov-24	7.1
Nov-23	7.6
▲	-7%

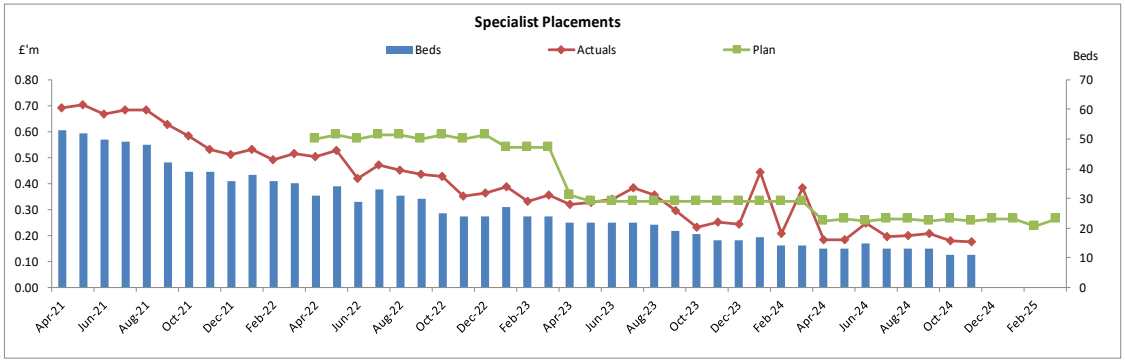
Key Messages

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



OAPs

YTD	£'m
2024/25	5.7
2023/24	6.8
▼	*-17%*
Prior Yr	**£'m**
Nov-24	0.6
Nov-23	1.4
▼	*-57%*



Specialist Placements

YTD	£'m
2024/25	1.6
2023/24	2.5
▼	*-37%*
Prior Yr	**£'m**
Nov-24	0.2
Nov-23	0.3
▼	*-30%*

Key Messages

Out of Area Placements. The average number of placements has decreased from 24 in October to 19 in November. Analysis highlights that the high level of placements continues to be driven by demand, and that flow through the hospital continues to improve, with more discharges and fewer lost bed days per patient. The monthly costs were £0.6m which is above plan and reflects the high level of PICU placements.

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 remains at 11. We have 2 **LD placements** causing an in month cost pressure of £0.1m, but it expected that these will be short term**.**

Cost Improvement Programme

Description	Directorate	Development Status	Risk	Plan	YTD Actual	YTD Plan	Variance
				£k	£k	£k	£K
Contribution from new income - CJLD	Mental Health	Fully developed	Low	354	236	236	0
Contribution from new income - MHICS	Mental Health	Fully developed	Low	175	117	117	0
Contribution from new income - Imms	Children families and All Age Services	Fully developed	Low	444	296	296	0
Contribution from new income - small CH schemes	Cimmunity Health	Fully developed	Low	124	83	83	0
Contribution from new income - small CYP schemes	Children families and All Age Services	Fully developed	Low	154	103	103	0
Contribution from new income - seasonal bed occupancy	Community Health	Fully developed	Medium	80	53	53	0
Other small divisional schemes	Various	Fully developed	Low	670	447	447	0
New contract with EE	Central Services - IM&T	Fully developed	Low	106	71	71	0
Estates & Facilities Control Total review	Central Services - Estates & Facilities	Fully developed	Low	376	251	251	0
Increased Contribution to Central Costs	Central Services - Pharmacy Procurement	Fully developed	Low	98	65	65	0
LPS Admin Posts	Central Services - Nursing & Governance	Fully developed	Low	66	44	44	0
Increased Contribution to Central Costs	Central Services - R&D	Fully developed	Low	102	68	68	0
PICU Placement reduction	Mental Health	Fully Developed - not yet started	Medium	1,049	0	699	-699
Asset revaluation to Modern Equivalent Asset	Central Services - Finance	Fully Developed	Low	670	448	447	1
Opt to tax - frimley	Central Services - Finance	Plans in progress	Medium	300	0	200	-200
Liaison VAT, AP review etc	Central Services - Finance	Plans in progress	Medium	100	120	67	53
Overseas Visitors	Central Services - Finance	Opportunity	Medium	50	0	33	-33
Bank Interest	Central Services - Finance	Fully Developed	Low	230	699	153	546
Balance Sheet Review	Central Services - Finance	Fully Developed - not yet started	Medium	2,106	0	1,404	-1,404
Scheduled Care Cost Avoidance	Community Health	Fully Developed	Low	399	266	266	0
Expenses Controls	Community Health	Fully Developed - not yet started	Low	120	30	80	-50
Elective Recovery	Community Health	Fully Developed	Medium	1,000	1,911	667	1,244
Operational Slippage Against Control Total	Operations	Fully Developed	Low		2,980	0	2,980
Agreed Investment Slippage	Operations	Fully Developed	Low	500	500	500	0
Recurrent Schemes to be developed	To be confirmed	Opportunity	High	4,327	0	2,437	-2,437
			Total	13,600	8,786	8,786	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.

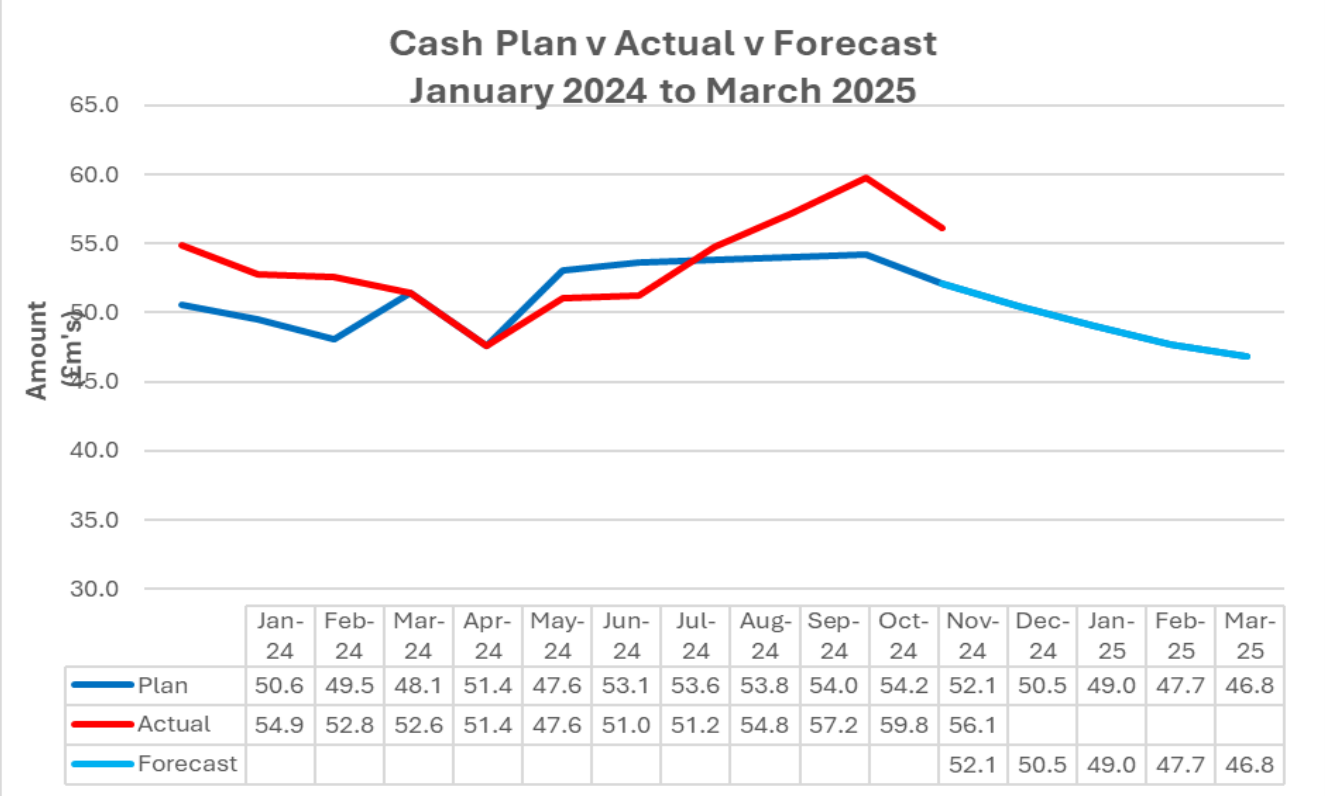
Recurrent schemes are to be developed as part of the closing the gap programme.

Balance Sheet & Cash

	2023/24 Actual (Audited) £'m	Current Month			YTD		
		Act £'m	Plan £'m	Var £'m	Act £'m	Plan £'m	Var £'m
Intangibles	1.8	1.2	1.2	0.0	1.2	1.2	0.0
Property, Plant & Equipment (non PFI)	33.0	31.3	33.3	(2.0)	31.3	33.3	(2.0)
Property, Plant & Equipment (PFI)	45.9	45.0	46.9	(1.9)	45.0	46.9	(1.9)
Property, Plant & Equipment (RoU Asset)	15.2	13.9	14.5	(0.6)	13.9	14.5	(0.6)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.1**	**91.6**	**96.1**	**(4.5)**	**91.6**	**96.1**	**(4.5)**
Trade Receivables & Accruals	12.1	19.3	16.9	2.4	19.3	16.9	2.4
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	52.6	56.1	52.1	4.0	56.1	52.1	4.0
Trade Payables & Accruals	(37.2)	(41.6)	(39.5)	(2.1)	(41.6)	(39.5)	(2.1)
Borrowings (PFI and RoU Lease Liability)	(6.2)	(2.5)	(7.6)	5.1	(2.5)	(7.6)	5.1
Other Current Payables	(12.0)	(14.3)	(13.2)	(1.1)	(14.3)	(13.2)	(1.1)
Total Net Current Assets / (Liabilities)	**9.6**	**17.3**	**9.0**	**8.3**	**17.3**	**9.0**	**8.3**
Non Current Borrowings (PFI and RoU Lease Liability)	(54.9)	(56.2)	(53.5)	(2.7)	(56.2)	(53.5)	(2.7)
Other Non Current Payables	(2.1)	(2.4)	(2.2)	(0.2)	(2.4)	(2.2)	(0.2)
Total Net Assets	**48.7**	**50.3**	**49.4**	**0.9**	**50.3**	**49.4**	**0.9**
Income & Expenditure Reserve	5.3	6.9	19.0	(12.1)	6.9	19.0	(12.1)
Public Dividend Capital Reserve	21.4	21.4	21.4	0.0	21.4	21.4	0.0
Revaluation Reserve	22.0	22.0	9.0	13.0	22.0	9.0	13.0
Total Taxpayers Equity	**48.7**	**50.3**	**49.4**	**0.9**	**50.3**	**49.4**	**0.9**

Key Messages

Our cash balance is higher than plan in month. The employer's pension and NI contributions related to the pay award were be paid in November along with some final elements of the pay award. The higher than planned balance relates to slippage in the capital programme.



	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	59.8	56.1				
Forecast											52.1	50.5	49.0	47.7	46.8

Capital Expenditure

Schemes	Current Month			Year to Date			FY	Forecast	FY
	Actual	Plan	Variance	Actual	Plan	Variance	Plan	Outturn	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	33	70	(37)	334	407	(73)	477	903	426
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	100	(50)
Additional Dental Surgery St Marks	0	33	(33)	0	87	(87)	185	311	126
Leased Non Commercial (NHSPS)	39	60	(21)	113	170	(57)	275	522	247
West/Reading Consolidation - Bath Road, Cremyll Road, Coley Cli	16	133	(117)	112	667	(554)	800	800	0
Leased Commercial	(1)	25	(26)	57	110	(53)	135	186	51
Environment & Sustainability	17	22	(5)	62	129	(67)	150	64	(86)
Audiology Equipment	33	30	2	42	151	(109)	181	160	(21)
Various All Sites	3	44	(41)	127	217	(90)	306	234	(72)
Statutory Compliance	3	30	(27)	41	120	(79)	160	82	(78)
Subtotal Estates Maintenance & Replacement	**143**	**448**	**(305)**	**889**	**2,057**	**(1,168)**	**3,319**	**3,362**	**43**
IM&T Expenditure									
Business Intelligence and Reporting	0	15	(15)	14	90	(76)	160	144	(16)
Hardware Purchases - Refresh & Replacement	48	741	(693)	78	1,482	(1,404)	3,447	3,447	0
Additional Divisional Spend	57	53	3	275	362	(87)	687	810	123
Digital Strategy	38	62	(24)	365	423	(58)	650	600	(50)
EMIS and ePMA systems re-tender project	0	5	(5)	0	70	(70)	207	207	0
Pharmacy System Procurement	0	33	(33)	0	67	(67)	100	0	(100)
Subtotal IM&T Expenditure	**143**	**909**	**(767)**	**732**	**2,494**	**(1,761)**	**5,251**	**5,208**	**(43)**
Subtotal CapEx Within Control Total	**285**	**1,357**	**(1,072)**	**1,621**	**4,551**	**(2,929)**	**8,570**	**8,570**	**0**
CapEx Expenditure Outside of Control Total									
Place of Safety	17	400	(383)	263	800	(537)	2,600	2,592	(8)
Anti-Ligature Toilet Pans & Basins	65	74	(9)	405	607	(202)	681	681	0
Low Carbon Heating Scheme	6	69	(62)	124	137	(13)	406	406	0
LED Lighting Upgrades	0	33	(33)	0	117	(117)	250	250	0
Other PFI projects	0	68	(68)	63	357	(294)	575	583	8
Subtotal Capex Outside of Control Totals	**88**	**644**	**(556)**	**855**	**2,018**	**(1,163)**	**4,512**	**4,512**	**(0)**
Central Funding									
Critical Infrustructure Risk funding	0	0	0	0	0	0	0	364	364
Subtotal Central Funding	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**364**	**364**
Sub Total Central Funding &Outside of ControlTotals	**88**	**644**	**(556)**	**855**	**2,018**	**(1,163)**	**4,512**	**4,876**	**364**
Total Capital Expenditure - all funding sources	**373**	**2,001**	**(1,628)**	**2,476**	**6,569**	**(4,092)**	**13,082**	**13,446**	**364**
IFRS16 RoU ASSETS - New Leases									
Lower Henwick Farm lease	0	0	0	169	200	(31)	200	169	(31)
Cremyll Road Lease	(145)	0	(145)	118	450	(332)	450	118	(332)
Chalvey Lease	0	0	0	0	750	(750)	750	600	(150)
Bath Road	0	0	0	0	100	(100)	100	0	(100)
Bracknell Healthspace	0	0	0	0	0	0	500	0	(500)
Calcot Surgery	0	0	0	23	24	(1)	24	23	(1)
Lake Road Health Centre - rent remeasurement	0	0	0	7	0	7	0	7	7
Harry Pitt Property lease	0	0	0	0	0	0	0	68	68
Lease cars	(13)	0	(13)	(2)	0	(2)	0	(2)	(2)
CoIN	(126)	42	(168)	15	332	(317)	500	124	(376)
Total IFRS 16 RoU Assets - New leases	**(284)**	**42**	**(326)**	**330**	**1,856**	**(1,526)**	**2,524**	**1,107**	**(1,417)**

Key Messages

At M08, CDEL schemes are underspent by £1.1m for the month, with the YTD total underspend being £2.9m. Estates is underspent by £1.2m mainly due to the West Reading consolidation project, which is still in design stage. IM&T is underspent by £1.8m mainly due to underspend on Refresh & Replacement project, however order has since been raised for £2.9m, which will bring the spend in line with the plan.

Non-CDEL spend for PFI sites was underspent by £0.6m for the month and YTD it is underspent by £1.2m, mainly due to the anti-ligature toilets and basins project, which is now progressing and due to be delivered. The work on PFI Place of Safety project has now commenced and cost is expected to flow from next month with expected completion by mid March.

There is an underspend on IFRS16 Right of Use Assets of £1.5m Year to date, mainly due to Chalvey Lease which will not be completed until March. CoIN leases are underspent by £0.3m due to the timing difference between the financial plan and lease agreements being in place. Combined forecasted spend is expected to be £1.4m lower than planned for the year, mainly as a result of slippage on projects which involve system partners i.e. West Reading Consolidation (Cremyl Road and Bath Road) and Bracknell Healthspace.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	14th January 2025
Title	**True North Performance Scorecard Month 8 (November 2024) 2024/25**
	The Board is asked to note the True North Scorecard.
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2024/25.
Business Area	Trust-wide Performance
Author	Chief Operating Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities**

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

True North Performance Scorecard – 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**)

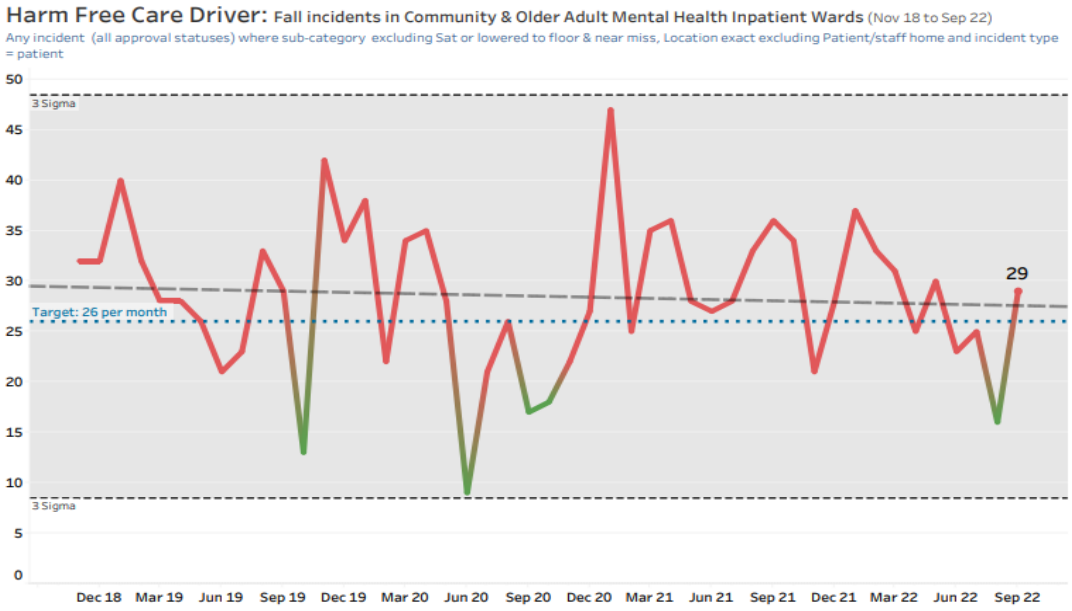
Business Rules for Statistical Process Control (SPC) Charts

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.

True North Performance Scorecard Highlight Report – November 2024

The True North Performance Scorecard for Month 8 2024/25 (November 2024) is included. Performance business rule exceptions, red rated with the True North domain in brackets.

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

Breakthrough and Driver Metrics

- Bed Days Occupied by Patients who are Discharge Ready (Community Physical Health) – **(Patient Experience)** – has reduced to 856 against a 500-bed day target.
    - Reduced figure from last month to 856 consisting of 145 patients averaging 6.1 days delay. Only 8 patients with a discharge of over 21 days this month which accounted for 202 days. Highest contributing factor is awaiting package of care affecting over 37% of bed days lost. 33.7% of patients were discharged without delay.

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

- Restrictive Interventions **(Harm Free Care)** – 236 against a revised target of 241.
    - The number of patients requiring rapid tranquilisation has increased this month. Seclusion and duration are top contributors, so the team are looking at how this can be reduced, including de-escalation and patients having a clear exit plan. Out of 54 instances of PMVA (Prevention and Management of Aggression), 22 were for one patient on Rose ward to prevent them from self-harming; as part of their care plan. Main contributors to PMVA are self-harm and aggressive behaviours. Countermeasures include reducing time in seclusion and implementing audit actions in the new year.
- Clinically Ready for Discharge by Wards including Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – is at 186 against a 250-bed day target.
    - The data now includes Out of Area Placements and Psychiatric Intensive Care Unit (PICU), older adults but excludes Learning Disability patients. Top contributor is Reading with 103 bed days lost for 4 patients. Top contributing wards were Rose, Rowan and Bluebell. For several months Bluebell has had the longest length of stay, which is being reviewed. Both Daisy and Snowdrop wards have had no bed days lost for 2 months. Countermeasure include using the last 3 years data to inform Crisis and Community teams to work with patients identified to try to avoid admission.
- Physical Assaults on Staff **(Supporting our Staff)** – 32 against a revised stretch target of 36.
    - Target revised down to 36 incidents per month as a stretch. Top contributing wards are Daisy (7), Campion (5) and Rowan (4). There is a slow reduction in incidents. Staff are reporting they are feeling reassured as they receive outcome updates from actions taken such as the prosecution of perpetrators and regular inclusion of the Police at weekly huddles. Rose ward is piloting semi-structured co-production with patients to understand triggers and contributing factors to assaultive behaviour. Learning will be applied across all wards once findings available.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Compliance Rate **(Patient Experience)** – at 3.69% against a 10% target.

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 11.57% against a stretch target of 10% target by March 2025.
- Year to Date Variance from Control Total (£'k) **(Efficient Use of Resources)** – at -£2k against a target of 0.
- Inappropriate Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – at 0 against a quarter 3 target of 3 patients.

Tracker Metrics

- Sickness rate **(Supporting Our Staff)** – red at 4.7% against a target of 3.5%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (Frimley) **(Patient Experience)** – 22% against a target of less than 10%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (BOB) **(Patient Experience)** – 23% against a target of less than 10%.
- Estimated Diagnosis Rate for Dementia (BOB) **(Patient Experience)** – 66.25% 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 91.3% against a target of 85%.
- Community Inpatient Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 24.3 days against a target of less than 21 days.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 97.6% against an 85% target.
- Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 40.5 days against a target of 30 days.
- Mental Health: Non-Acute Occupancy Rate (excluding home leave) **(Efficient Use of Resources)** – at 86.14% days against a target 80%.
- Community Virtual Ward Occupancy (BOB) **(Efficient Use of Resources)** – at 79.6% against a target of 80%.

Performance Scorecard - True North Drivers

Harm Free Care

Metric	Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Breakthrough Restrictive Interventions in Mental Health Inpatient Wards	241 from 1st August 2024 previously 309	Internal	157	156	199	172	213	274	242	261	233	183	180	236

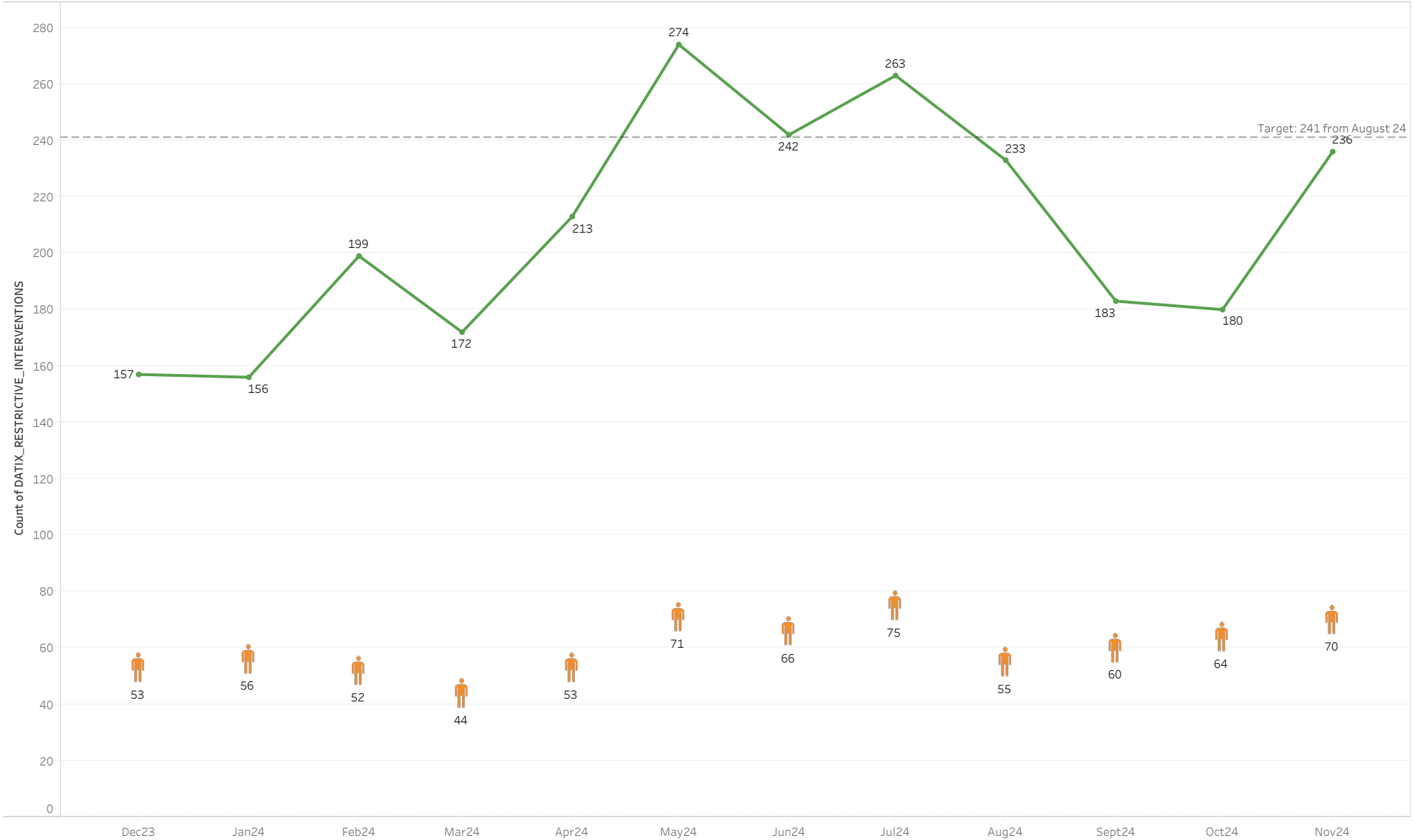
Patient Experience

Positive Patient Experience Score %	95% compliance	External	94%	94.71%	94.09%	94.59%	93.67%	94.37%	93.97%	94.19%	94.19%	95.09%	94.07%	95.09%
Patient Experience Compliance Rate %	10% compliance	External	2.70%	3.30%	3.50%	3.20%	7.09%	7.39%	6.5%	5.70%	6.20%	4.39%	4%	3.69%

			Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	559	374	268	353	248	351	275	249	248	306	154	186

			Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	External	738	842	752	663	554	647	813	1,004	836	889	882	856

Harm Free care-Breakthrough Objective: Restrictive Interventions in Mental Health Inpatient Wards (Dec23 to Nov24)



Performance Scorecard - True North Drivers

Supporting our Staff

Metric	Threshold / Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Breakthrough Physical Assaults on Staff	36 per month Sept 2024	Internal	108	67	75	58	30	38	55	64	46	70	66	32
Staff turnover (excluding fixed term posts)	10% by March 2025	External	12.87%	12.33%	12.83%	12.28%	12.4%	12.60%	12.59%	12.49%	12.32%	12.07%	11.54%	11.57%

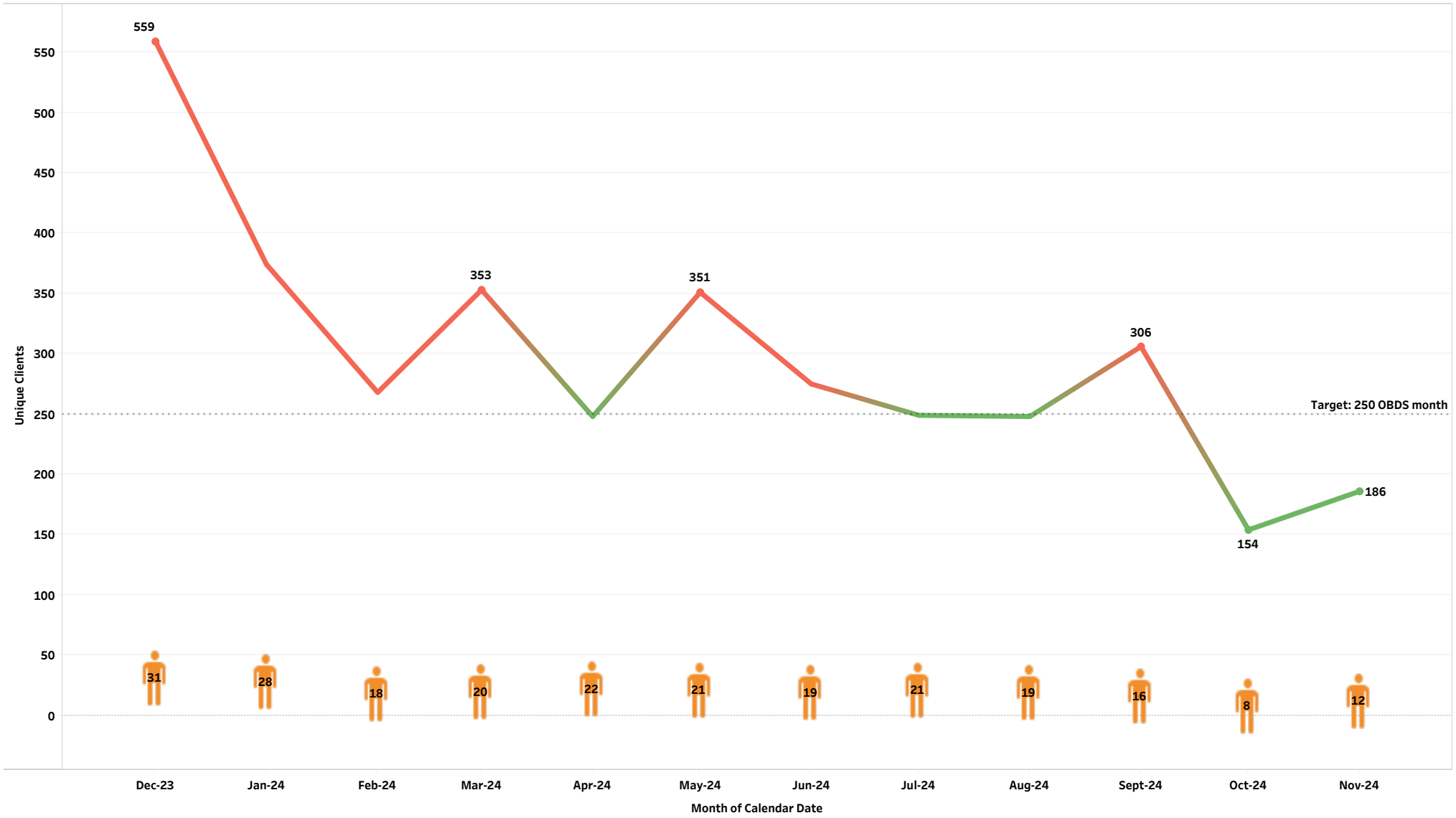
Efficient Use of Resources

YTD variance from control total (£'k)	0	External	-1712	-1914	-1648	-2476	0	0	-26	-103	-9	-16	-17	-2

			Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Active Inappropriate OAPS at end of month	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External					5	3	4	3	4	7	4	0

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

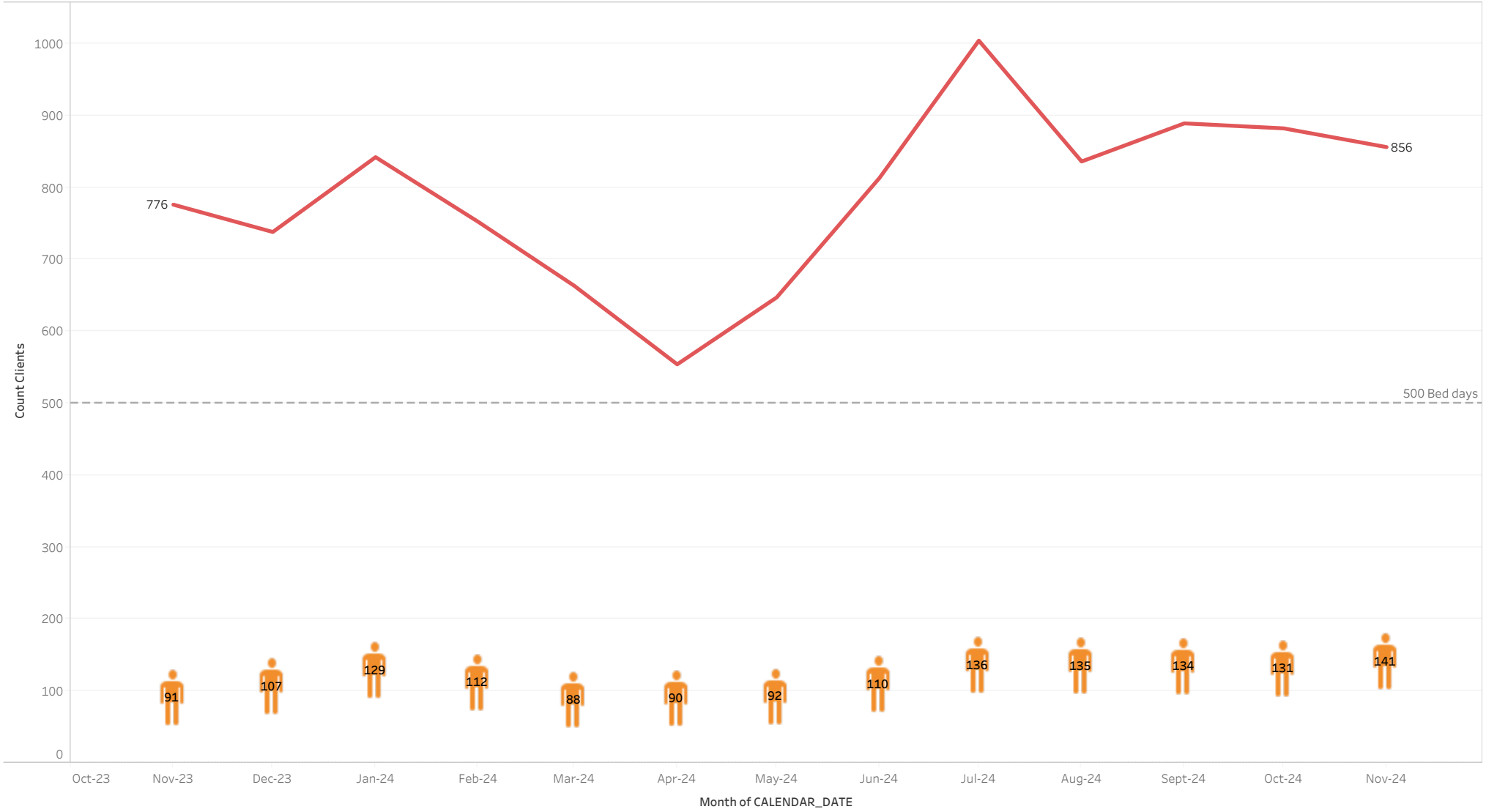
All Mental Health wards excludes Campion ward (Learning Disability)



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

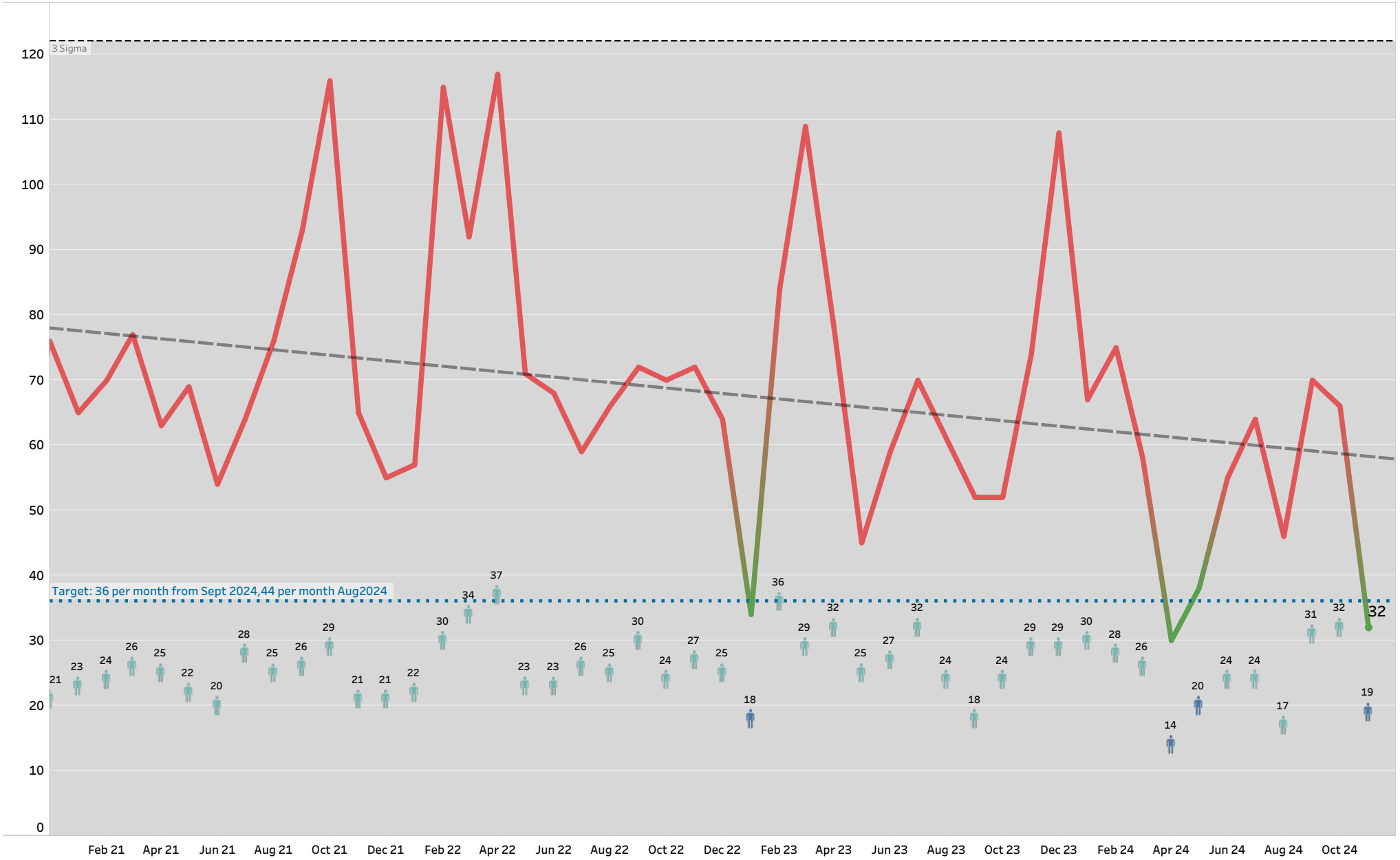
(Nov 2023- Nov 2024)

All Community health wards

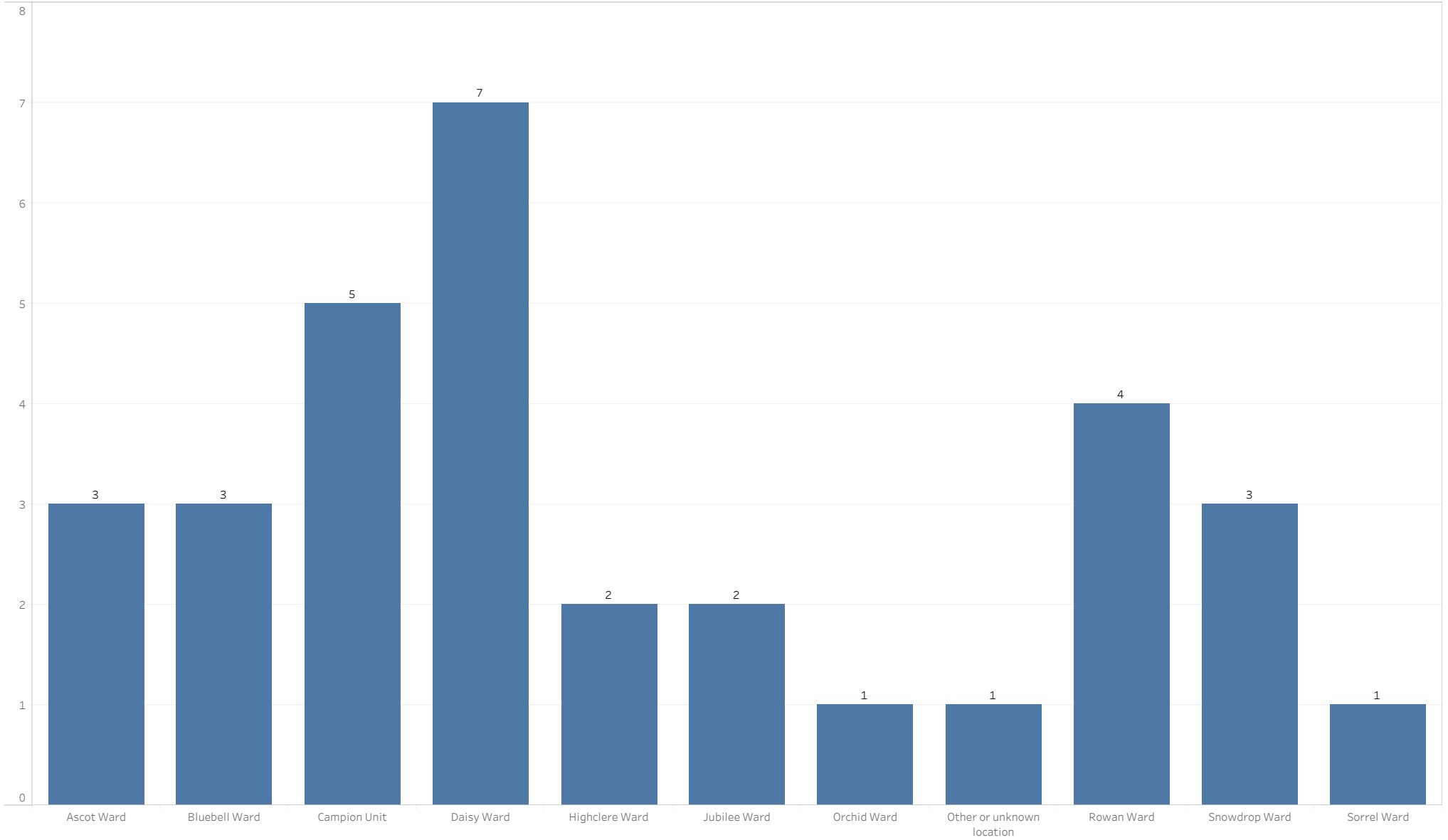


Supporting Our Staff - Breakthrough Objective :Physical Assaults on Staff (Nov 20 to Nov 24)

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



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



True North Supporting Our Staff Summary

Metric	Threshold / Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Statutory Training: Fire: %	90% compliance	Internal	93.9%	93.9%	93.5%	93.5%	94.6%	95.5%	95.3%	95.7%	95.5%	95.9%	96.0%	96.1%
Statutory Training: Health & Safety: %	90% compliance	Internal	96.5%	96.4%	96.6%	96.7%	96.9%	97.0%	97.3%	97.3%	97.6%	97.6%	97.6%	97.8%
Statutory Training: Manual Handling: %	90% compliance	Internal	93.0%	93.3%	93.0%	92.2%	93.7%	93.7%	94.3%	94.8%	94.9%	94.2%	94.5%	93.7%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.4%	97.5%	97.1%	96.7%	97.7%	98.2%	98.1%	98.2%	98.4%	98.5%	97.9%	98.9%
Sickness Rate: %	<3.5%	External	4.6%	4.8%	4.1%	3.7%	3.9%	3.8%	3.7%	4.1%	4.1%	4.5%	4.7%	

True North Patient Experience

Metric	Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: %	95%	External	99.14	99.5	99.40	99.35	98.60	99.37	98.89	98.76	99.31	99.17	99.05	99.31
Community Health Services: 2 Hour Urgent Community Response %.	80%+	External	81.8%	82.5%	86.7%	87.7%	86.2%	84.6%	84.7%	88.7%	91.4%	89.2%	91.4%	90.9%
Number of Adults on community Health waiting lists by system (BOB)	No Trust Target	External	6819	7039	6596	7095	6936	7231	7432	7102	7409	7786	7523	7092
Number of Adult on community Health waiting lists by system (Frimley)	No Trust Target	External	5962	5798	5796	5678	6124	6376	6223	5882	6188	6307	5968	5792
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	7359	8412	9349	9827	725	1441	2116	2314	4560	4723	5576	6383
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	99.59	100	100	100	100
Number of Patients not seen on RTT waiting over 52 weeks	0	External	1	1	0	1	0	1	0	0	0	0	0	0
Number of Patients not seen on RTT waiting over 65+ weeks	0	External	1	1	0	1	0	1	0	0	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	97.79	95.18	99.53	97.03	98.21	71	98.92	96.20	96.39	98.40	98.62	98.48

True North Patient Experience

Metric	Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	29	26	31	26	23	15	19	27	28	37	9	19
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	89.2%	81.6%	91.4%	86.1%	80.2%	86.6%	85.8%	96.6%	94.6%	90.2%	84.3%	89.1%
Number of CYP (0-17 years) on Community Health waiting lists by system Frimley (YTD)	No Trust Target	External	2201	2284	2165	2244	2206	2359	2347	2113	2081	2149	2100	2047
Number of CYP (0-17 years) on Community Health waiting lists by system BOB (YTD)	No Trust Target	External	1573	1531	1351	1374	1281	1370	1433	1305	1241	1351	1315	1282
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	Internal	50%	50%	100%	100%	40%	50%	100%	100%	60%	100%	100%	100%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	Internal	100%	87.5%	85.7%	60%	100%	90.9%	66.7%	80%	100%	100%	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	4859	5011	5167	5318	5481	5645	5808	6071	6221	6370	6538	6719
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	6962	7191	7385	7587	7801	8030	8234	8478	8638	8821	9054	9275
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	2732	2824	2881	2954	3025	3112	3179	3279	3339	3430	3546	3653
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	1860	1927	1977	2037	2087	2156	2194	2263	2327	2385	2446	2511

True North Patient Experience

Metric	Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Talking Therapies Referral to Treatment 75% within 6 weeks BOB	75%	External	86%	88%	90%	93%	99%	91%	91%	88%	87%	90%	93%	94%
Talking Therapies Referral to Treatment 75% within 6 weeks Frimley	75%	External	91%	88%	92%	90%	90%	91%	93%	87%	87%	90%	91%	92%
Talking Therapies Referral to Treatment 95% within 18 weeks BOB	95%	External	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	99%	100%
Talking Therapies Referral to Treatment 95% within 18 weeks Frimley	95%	External	100%	100%	100%	100%	100%	100%	99%	100%	99%	100%	100%	100%
Numbers of OA receiving a course of treatment (2+ contacts) as a % of total BOB	6%	External					5.7%	6.5%	7.0%	7.0%	7.0%	7.7%	5.2%	6%
Numbers of OA receiving a course of treat (2+ contacts) as a % of total Frimley	7%	External					9%	5.7%	6.2%	10%	7.7%	6.7%	7.0%	6%
Talking Therapies Overall receiving a course of treatment (2+ contacts) BOB	60%	External						61%	64%	63%	64%	61%	64%	65%
Talking Therapies Overall receiving a course of treatment (2+ contacts) Frimley	60%	External						56%	61%	55%	60%	56%	57%	53%

True North Patient Experience

Metric	Proposed Target..	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Talking Therapies Recovery rates BOB	50%	External	49.39%	49%	44%	49.5%	50%	52.80%	46%	53%	52.5%	51.60%	52.70%	52.70%
Talking Therapies Recovery rates Frimley	50%	External	47.39%	48%	44%	47%	45%	51%	47%	50%	51.39%	54.40%	51.80%	54.60%
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67%	External					59%	63.80%	65%	62%	65.40%	69%	68%	66%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67%	External					64%	62.79%	63%	64%	64.5%	69%	69%	71%
Talking Therapies Reliable Recovery for those completing a course of treatment Frimley	48%	External					43%	45.5%	44%	47%	51.39%	52%	50%	51%
Talking Therapies Reliable Recovery for those completing a course of treatment BOB	48%	External					46%	48.5%	46%	49%	48.19%	48%	50%	51%
Talking Therapies In treatment pathway waits 90 day for 2nd Appointment Frimley	<10%	External	12.8%	11%	9.80%	11.5%	15.2%	16.1%	18.6%	20%	14.7%	18.5%	20%	22%
Talking Therapies in treatment pathway waits 90 day for 2nd Appointment BOB	<10%	External	17.8%	22%	18.1%	16.1%	16.4%	15.9%	15.1%	18%	19.4%	20%	18%	23%

True North Patient Experience

			Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	External	80	85.70	100	100	100	100	100	83	100	100	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	6028	6227	6445	6700	6903	7869	8076	8370	8569	8799	9582	9857
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	4852	5014	5162	5349	5509	6172	6325	6508	6676	6834	7399	7581
Access to Perinatal Services- Assessments Frimley	7.5% live birth rate - 409 Oct 23 439 March 2023. 37 per Month	External	25	40	23	22	20	22	32	34	25	23	30	29
Access to Perinatal Services - Assessments BOB	10% live birth rate - 611 per annum 51 per month	External	43	39	44	30	44	30	38	50	27	38	33	35
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	91%	91%	92%	96%	90%	93%	94%	95%	94%	90%	91%	93%
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	14	9	14	18	17	14	10	10	5	8	7	9
Estimated Diagnosis rate for Dementia Frimley	66.67%	External	65.25%	65.56%	64.88%	64.98%	66.10%	66.14%	66.53%	68%	68%	66.71%	66.49%	66.85%
Estimated Diagnosis rate for Dementia BOB	66.67%	External	64.39%	64.54%	64.12%	64.60%	65.60%	65.36%	64.92%	64.90%	64.90%	66.14%	66.04%	66.25%

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24
Mental Health: AWOLs on MHA Section	10 per month	Internal	3	6	7	3	5	7	5	7	7	9	5	3
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	0	1	1	1	1	1	1	1	1	1	1	1
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	0	3.03	3.37	4	0	0	0	3.45	5.25	3.83	0	1.53
Pressure Ulcer with Learning	Tbc	Internal	1	0	3	2	2	4	1	4	0	0	2	1
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	86.2%	95.1%	100%	86.0%	91.5%	93.1%	94.1%	91.0%	91.4%	100%	91.0%	80.6%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	Internal	17	26	42	73	79	66	63	64	46	72	60	92
Self-Harm Incidents within the Community	31 per month	Internal	9	21	35	30	28	29	10	10	7	17	15	25
Gram Negative Bacteraemia	No Trust target	External	0	1	0	0	0	0	0	0	0	0	0	0
E-Coli Number of Cases identified	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External	1	1	1	1	1	0	0	1	0	1	4	0
C.Diff with learning (Cumulative YTD)	0	External	0	0	0	0	0	0	1	1	1	0	1	1
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	0	0	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	1	1	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	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24
Community Inpatient Occupancy	85%	Internal	87.7%	89.2%	89.4%	90.3%	90.6%	91.8%	91.6%	88.8%	86.9%	92.4%	91.7%	91.3%
Community Inpatient Average Length of Stay (bed days)	<21 days	Internal	37.3	24.5	28.1	26.5	33.3	25.8	26.2	21.7	24.5	24.7	24.6	24.3
Mental Health: Adult Acute LOS over 60 days % of total discharges	TBC	External	30%	28.9%	30%	34%	31%	28.0%	28.0%	33%	35.1%	24.3%	29.3%	24%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges	TBC	External	66%	57.9%	55.0%	52%	59%	63%	63%	50%	41.6%	55.5%	50%	61.5%
DNA Rate: %	5% DNAs	Internal	4.76%	4.70%	4.66%	4.66%	4.70%	5.26%	4.79%	4.83%	4.97%	4.96%	4.91%	4.87%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	93.8%	95.9%	98.5%	99.4%	98.5%	97.7%	97.1%	97.3%	99.2%	96.8%	97.4%	97.6%
Mental Health: Acute Average Length of Stay (bed days)	30 days	Internal	45.1	72.6	41.7	36.4	60.6	58.7	47.2	49.6	58.8	46.1	50.8	40.5
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	77.85%	72.48%	79.31%	84.04%	95.34%	82.42%	81.71%	83.87%	88.40%	90.10%	80.82%	86.14%
Community Virtual Ward Occupancy Frimley	80%	External	46%	56.59%	46.40%	54%	42.19%	50.60%	52.5%	57.59%	51.30%	61.29%	77.29%	84%
Community Virtual Ward Occupancy BOB	80%	External	91.60%	95.5%	82.39%	75.79%	88.90%	91.90%	94.79%	82.59%	87.90%	79.40%	76.90%	79.60%
Agency Spend within Ceiling	3.2%	External					2.70%	3%	2.19%	3.10%	3.20%	2.90%	2.90%	3%
Elective Recovery Performance vs Target	11,614	External					12238	11898	12179	13710	11888	12951	13862	13180

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 January 2025
Title	**2025 Strategy Outcome Measures Mid-Year Update**
	Item for discussion
Reason for the Report going to the Trust Board	Presentation of mid-year review, on a bi-annual cycle, to update against Board Level Outcome Measures and progress to date.
Business Area	Strategy
Author	Alex Gild, Deputy Chief Executive
Relevant Strategic Objectives	The Mid-Year update highlights the key activities, progress to date and potential risks associated with the identified Board level outcome measures which in turn impact all of the relevant strategic objectives, as outlined in the Trust Strategy.

NHS
Berkshire Healthcare
NHS Foundation Trust

2025 Strategy
Outcome Measures

Mid-Year Update Year 2 – 18 months

Care Quality Commission Inspected and rated Outstanding

Berkshire Healthcare Charity Reg. charity 1049733

disability confident LEADER

VETERAN AWARE

Stonewall TOP 100 EMPLOYER 2022

Decemeber 2024

TRUST STRATEGY OUTCOMES – MID POINT (YEAR 2) PROGRESS UPDATE

The paper provides a progress overview against the agreed Board Level outcomes for Trust strategy for mid-year within year 2 of the overarching strategy, effectively the 18 month point within the 3-year strategy. The following gives a high-level picture of the key activities that have been driving performance outcomes and current data to indicate position to date.

Inclusion of an additional outcome Reduced Inequalities Projects can be seen within the paper, as part of the Health Inequalities strategic initiative. A corporate-level QI programme has been initiated to scope, engage and address key identified health inequalities. Part of this programme aims to support a small number of QI projects addressing specific Health Inequalities in our services and our local populations.

Previous outcomes included an outcome of Reduced Higher Risk Waiting Times aiming to work with services with long waiting times to reduce risks associated with their long waits. This outcome looked, as measure of harm from waiting, to focus on services currently on our Quality Concerns Register and will support them to reduce their waiting times so that they can be removed from the Register. This agenda is encompassed within the existing outcome of Operational Excellence and the refreshed approach to Waiting and Patient Journey supporting services with waiting times, access and flow.

Most outcome metrics are showing progress as expected in line with the intended targets set for the current reporting period. There are no metrics flagging significant concern, due to the planned mitigating actions or realisation of work to date. It remains that, despite the unmet target for *Carbon Emissions Reduction* metric, there are activities in place that see expected benefits realise from 2025.

Outcome Measure	Current Status
IMPROVED PATIENT SAFETY	
A GREAT PLACE TO WORK	
REDUCED INEQUALITIES (Detentions of Black Adults)	
REDUCED INEQUALITIES QI PROJECTS (Access, Outcomes, Experience)	
OPERATIONAL EXCELLENCE	
IMPROVED MH INPATIENT SERVICES	
IMPROVED CARE DRIVEN BY PATIENT EXPERIENCE	
RELEASING STAFF TIME TO CARE	
FINANCIAL SUSTAINBILITY ACHIEVED	
CARBON EMISSIONS REDUCED	

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
IMPROVED PATIENT SAFETY **We will have proportionally fewer moderate harm and above incidents**	A new system is being implemented for the recording of incidents. Due to work on the implementation of the system and further analysis that will be required to determine areas of focus, it is unlikely that there will be a change in the first 12 months. We will use this period to build knowledge of incidents and highlight areas to focus on in future years.	Deborah Fulton	N/A	N/A	TBC	TBC

OUTCOME: IMPROVED PATIENT SAFETY	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	Baseline for metric still not able to be set, as part of the national patient safety strategy there was a new national reporting platform developed (LSPFE). The new platform took longer to be aligned with our local incident reporting systems than first envisaged. As a result, the data has proved challenging to obtain. At present data is available for the period Sept 23-Aug 24. In April 25 there will be a full year of data available on the new system and thus targets can be expected in the next cycle.
Performance at 12-month target:	N/A

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
A GREAT PLACE TO WORK **We will sustain and improve our turnover rate**	Reducing turnover demonstrates the stability of the organisation, limiting wasted resource via recruitment, handover and lost organisational memory.	Jane Nicholson	15.7	14	11%	10%

OUTCOME: A GREAT PLACE TO WORK	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	We have set ourselves an aspirational target of turnover of 10%, our turnover is currently hovering around 12% and this is the lowest rates since prior to Covid.
Performance at 12-month target:	Current Turnover: 12%

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
REDUCED INEQUALITIES **We will reduce ethnicity-based variation in Mental Health Act Section 2 detentions** *(further inequality outcomes to be added in year 2/3 as initiatives scoped)*	Project initially focuses on reducing section 2 Mental Health Act Detention variation across localities in Berkshire.	Kathryn MacDermott	The 2021-23 data shows us that Black people are currently 3.07x more likely than white people to be detained across	Reduce variation across localities by 10% Reduce MHA detentions against baseline by 5%	Reduce variation across localities by 20% Reduce MHA detentions against previous year by 5%	Reduce variation across localities by 25% Reduce MHA detentions against previous year by 5%

OUTCOME: REDUCED INEQUALITIES	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	We have developed a Mental Health Act Detentions tableau dashboard which is now live. For year 23/24 we have successfully met the 10% target. The Trust has achieved a 22% reduction on a baseline of 51 patients for the year 22/23. This is based on data provided by the Mental Health Act Office. We continue to scope variation across the localities by: - Received 32 responses from Thames Valley Police Officers across Berkshire, currently summarising this and socialising as next steps. - Positive feedback from Berkshire AMPHs and socialising the findings with them to come up with recommendations and actions for Phase 2 - Currently working on the delivery plan for Phase 2 MHAD 2025/26 with Mental Health Ops Teams & PMO Team
Performance at 12-month target:	For year 24/25, as of the end of December we have had 27 detentions of black people which if extrapolated forward would demonstrate roughly 36 detentions across a 12-month period. This would mean we continue to be in line with meeting our proposed 24-month target (which equates to 36 detentions across the 12-month period).

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
REDUCED INEQUALITIES PROJECTS **Trust QI programme: key influenceable health inequalities identified and reduced** **Outcome added November 2024**	As part of the Health Inequalities strategic initiative, a corporate-level QI programme has been initiated to scope, engage and address key identified health inequalities. Part of this programme aims to support a small number of QI projects addressing specific health inequalities in our services and our local populations. Three service-specific, health inequalities projects have been prioritised and initiated to date.	Kathryn MacDermott	No QI projects reporting improvement in outcomes and reducing specific health inequalities measures.	2 QI projects reporting improvement in outcomes and reducing specific health inequalities measures.	4 QI projects reporting improvement in outcomes and reducing specific health inequalities measures.	8 QI projects reporting improvement in outcomes and reducing specific health inequalities measures.

OUTCOME: REDUCED INEQUALITIES	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	QI projects initiated: 1.Improving physical health outcomes for people with severe mental illness (SMI). Reading is an outlier for the inequality in life expectancy for people with SMI and in premature mortality due to cancer in adults with SMI. 2. Improving access to our Nutrition and Dietetics service by reducing the proportion of Black and Asian service users who are discharged, unseen, not responding to opt-in letters. 3. Improving access to our MSK Physiotherapy service by reducing the proportion of Black and Asian service users who DNA their appointments. Following discussion at Board, October 2024, there is an exec review of a further two high impact initiatives within both Slough and Reading.
Performance at 12-month target:	All three projects have created their problem statements and moved to root-cause analysis / countermeasure stage. However, as countermeasures are still being identified, no demonstrable reductions in health inequalities have been made. The work continues to deliver results in this financial year.

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
OPERATIONAL EXCELLENCE **We will work with services to improve their business intelligence capabilities to understand operational delivery pressures and improve the management of demand and waiting lists across our services.**	We will support services across the organisation to develop the capabilities to improve their confidence and understanding of data, improve data quality and ensure effective management of demand and waiting lists, supported by clear definitions of waiting.	Tehmeena Ajmal	Baseline established across all services	65% (of services)	70% (of services)	80% (of services)

OUTCOME: OPERATIONAL EXCELLENCE	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	This work is targeted initially to transformation pieces in MH and CFAA services and will include : Learning Disabilities /CAMHS MSK Physio East /ASLT/CSS /Diabetes Education /Bladder & Bowel (Continence) /CBNRT/Dental – Non-Rio service / Hearing Balance – Non-Rio service One Team work in Community MH Initial meetings have showcased that there has been significant work to date across the divisions on this agenda which has resulted in greater understanding of both the challenges faced as well as potential countermeasures/approaches to the work required. Much has already happened in the waiting space but focus now needs to include the totality of the patient journey and the difference the interventions have made. The programme has identified several key metrics which aim to provide a view across services and identify any outliers / areas for further support as well as make the programme accessible and services aware of data as reported. This work links closely to the launch of the Productivity programme which has highlighted 3 teams, Eating Disorders, MSK East and Talking Therapies, which have undertaken significant work on this agenda and will help to outline a blueprint for productivity, defining key elements and determining metrics, which will be applied across all services in due time.
Performance at 12-month target:	The reset target will look to deliver within an 18-month refreshed timeframe and expect to achieve 75% compliance of those services included in this phase, by the end of March 25. We have agreed metrics and visibility via Tableau dashboard to begin to track included services.

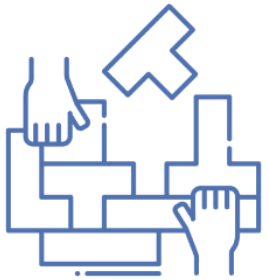
OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
IMPROVED MH INPATIENT SERVICES **We will reduce the maximum ward sizes at Prospect Park Hospital (PPH)**	Reducing the maximum ward size at PPH for adult acute wards will yield a range of benefits including an enhanced therapeutic environment, improvements to staff and patient safety and experience and allow us to deliver a modern standard of mental health care that aligns with our vision to be a great place to get care, a great place to give care.	Tehmeena Ajmal	1 ward x 20 beds 3 wards x 22 beds	Max ward size 20	Max ward size 18	Max ward size 18

OUTCOME: IMPROVED MH INPATIENT SERVICES	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	All wards are now 20beded, toilets re-fitting for two of the wards completed, the last two is set to complete in Q4 Capacity contracted awarded to priory group – 18 bedded mix sex ward due to open in January
Performance at 12-month target:	On target for end Q4- bed reduction to 18 starts in January as soon as the capacity ward opens.

PATIENT EXPERIENCE & VOICE FOR CO-DESIGN

Lead – Deborah Fulton



OUTCOME	CONTEXT	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
We will increase the overall amount of feedback the Trust collects via IWGC	Increasing the volume of feedback collected via IWGC will help us to make informed improvements to the care we offer.	3.5%	10%	12.5%	15%

OUTCOME: IMPROVED CARE DRIVEN BY PATIENT EXPERIENCE	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	Response rate calculation changed from April 2024 to be based on unique patients rather than all contacts; this is following feedback from patients and staff that there was a high risk of survey fatigue. The option to give feedback always remains open. The number of responses to iWGC also continues to increase. There has been a slight decrease in RR since Q1. The number of surveys with 0 responses during Q2 were 124 out of 519. The Pt Experience Team is working with individual services to find a methodology that works for their patients. We are undertaking a data cleanse exercise to remove any teams that do not collect individual feedback, in these instances the 'team' might undertake activity with a patient but the feedback would be attributed to the wider/overarching service/ward that the patient is being treated by.
Performance at 12-month target:	Trust wide: Qtr2 5.34%.

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
RELEASING STAFF TIME TO CARE **We will increase productivity as a result of implementation of digital initiatives**	This measure demonstrates time saved for staff via the implementation of digital initiatives. Outcome achieved via reduction of wasteful processes and administrative burden, releasing productive time to clinicians to meet demand and waiting list pressures. Calculation of hours saved is cumulative, directly linked to specific digital strategy initiatives, including automation.	Mark Davison	79k hours	169k hours	243k hours	299k hours

OUTCOME: RELEASING STAFF TIME TO CARE	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	We are on track in relation to forecast, although Intelligent Automation (IA) team have reported less than plan, whilst technology projects have exceeded plan.
Performance at 12 month target:	193,183 hours This figure is derived from the financial savings analysis from clinical technologies (Docman/hybrid mail/digital appointment correspondence/digital dictation), each have a savings profile per year that is monitored based on usage. The team have translated the financial saving to an hourly figure using a mid-point band 5 salary (£23ph including on-costs). There are also IA team projects and associated savings, based on 8 automations currently live. After creating a positive pull for IA technology in year 1, oversight and benefits targeting will now shift to delivery of care capacity benefits in priority areas of demand or service pressure, with now proven automation capability and impact.

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
FINANCIAL SUSTAINABILITY ACHIEVED **We will achieve a reduction in underlying Trust deficit**	The Trust is currently reliant on non-recurrent funding streams to meet its breakeven plan. We will work to phase out reliance on these funding streams to improve financial sustainability.	Paul Gray	£12m	£10m	£5m	£0

OUTCOME: FINANCIAL SUSTAINBILITY ACHIEVED	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	Further work to reduce the underlying deficit is being undertaken as part of financial planning. Key will be impending National Guidance due December.
Performance at 12-month target:	

OUTCOME MEASURES

OUTCOME	CONTEXT	LEAD	Baseline	12 MONTH TARGET	24 MONTH TARGET	36 MONTH TARGET
CARBON EMISSIONS REDUCED **Reduction in direct measurable carbon emissions**	Targets are ambitious, and based on the assumption that a number of contributory projects will receive funding.	Paul Gray	4,728 tonnes CO2e	13% annual reduction (3,924 tonnes CO2e)	13% annual reduction (3,257 tonnes CO2e)	13% annual reduction (2,703 tonnes CO2e)

OUTCOME: CARBON EMISSIONS REDUCED	
Summary Report; including Key Activity, Drivers of performance and Key Issues:	Continuing to undertake measure to reduce emissions. Recently commissioned surveys and audits identified decarbonisation of WBCH and PPH making the most significant reduction, the former of which is in progress thanks to Salix / Trust funded scheme which will deliver from 2026.
Performance at 12-month target:	The Trust reduced its CO2 tonnes of emission by 5% in 23/24, less than the target of 13%.

Berkshire Healthcare
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	14 January 2025
Title	**Appointment of a New Senior Independent Director**
	Item for Approval
Reason for the Report going to the Board	Naomi Coxwell is stepping down as the Trust's Senior Independent Director. The Trust Board is responsible for appointing one of the Non-Executive Directors as the Trust's Senior Independent Director in consultation with the Council of Governors. The next Council of Governors meeting is on 12 March 2025. The Chair will consult with the Council about the Trust Board's preferred candidate for the role. The Senior Independent Director Role Profile is attached at appendix 1. The Board is requested to approve the appointment of Aileen Feeney as the Trust's Senior Independent Director subject to the views of the Council of Governors.
Business Area	Corporate Governance
Author	Julie Hill, Company Secretary
Relevant Strategic Objectives	This relates to Good Governance

Berkshire Healthcare
NHS Foundation Trust

SENIOR INDEPENDENT DIRECTOR ROLE DESCRIPTION

In consultation with the council of governors, the board should appoint one of the independent non-executive directors to be the senior independent director to serve as an intermediary for the other directors when necessary.

The senior independent director should be available to governors if they have concerns that contact through the normal channels of chair, chief executive, deputy chief executive, or company secretary has failed to resolve, or for which such contact is inappropriate. The senior independent director could also be the vice chair.

Led by the senior independent director, the non-executive directors should meet without the chair present, at least annually, to appraise the chair's performance, and on other such occasions as are deemed appropriate.

Where directors have concerns that cannot be resolved about the running of the trust or a proposed action, they should ensure that their concerns are recorded in the board minutes. On resignation, a director should provide a written statement to the chair for circulation to the board, if they have any such concerns.

In addition to the duties described here the senior independent director has the same duties as the other non-executive directors.

THE SENIOR INDEPENDENT DIRECTOR, THE CHAIR AND NON-EXECUTIVE DIRECTORS

The senior independent director should hold a meeting with the other non-executive directors in the absence of the chair at least annually as part of the appraisal process.

There may be other circumstances where such meetings are appropriate. Examples might include the appointment or re-appointment process for the chair, where governors have expressed concern regarding the chair or when the board is experiencing a period of stress as described below.

THE SENIOR INDEPENDENT DIRECTOR AND THE COUNCIL OF GOVERNORS

While the council of governors determines the process for the annual appraisal of the chair, the senior independent director is responsible for carrying out the appraisal of the chair on their behalf as set out as best practice in the code of governance.

As part of the chair's appraisal process, the senior independent director will seek feedback on the chair's performance from the governors. The senior independent director will attend a meeting of the Council of Governors' Appointments and Remuneration Committee to present the outcome of the chair's appraisal process.

The senior independent director might also take responsibility for an orderly succession process for the chair role where a reappointment or a new appointment is necessary.

The senior independent director should also be available to governors as a source of advice and guidance in circumstances where it would not be appropriate to involve the chair; chair's appraisal or setting the chair's objectives for example.

In rare cases where there are concerns about the performance of the chair, the senior independent director should provide support and guidance to the council of governors in seeking to resolve concerns or, in the absence of a resolution, in taking formal action. Where the trust has appointed a lead governor the senior independent director should liaise with the lead governor in such circumstances.

THE SENIOR INDEPENDENT DIRECTOR AND THE BOARD

In circumstances where the board is undergoing a period of stress the senior independent director has a vital role in intervening to resolve issues of concern. These might include unresolved concerns on the part of the council of governors regarding the chair's performance; where the relationship between the chair and chief executive is either too close or not sufficiently harmonious; where the trust's strategy is not supported by the whole board; where key decisions are being made without reference to the board or where succession planning is being ignored. In the circumstances outlined above the senior independent director will work with the chair, other directors and/or governors, to resolve significant issues.

Boards of directors and councils of governors need to have a clear understanding of the circumstances when the senior independent director might intervene so that the senior independent director's intervention is not sought in respect of trivial or inappropriate matters.