Berkshire Healthcare
NHS Foundation Trust

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Teams)

10:00am on Tuesday 11 March 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 14 January 2025	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
QUALITY			
6.0	Board Story – Paediatric ADHD	Debbie Fulton, Director of Nursing and Therapies//Michelle Walton, Advanced Mental Health Practitioner, CAMHS	Verbal
6.1	Patient Experience Quarterly Report	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 25 February 2025 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	Sally Glen, Chair, Quality Assurance Committee/Dr Minoo Irani, Medical Director	Enc.
6.3	Nottingham Independent Mental Health Homicide Review – Trust Action Plan	Tehmeena Ajmal, Chief Operating Officer/Theresa Wyles, Director of Mental Health Service	Enc.
EXECUTIVE UPDATE			
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
PERFORMANCE			
8.0	Month 10 2024/25 Finance Report	Paul Gray, Chief Financial Officer	Enc.
8.1	Month 10 2024/25 Performance Report	Tehmeena Ajmal, Chief Operating Officer	Enc.

No	Item	Presenter	Enc.
8.2	Finance, Investment and Performance Committee meeting on 22 January 2025	Naomi Coxwell, Chair of the Finance, Investment and Performance Committee	Verbal
STRATEGY			
9.0	Annual “Green Plan” Update Report	Paul Gray, Chief Financial Officer	Enc.
CORPORATE GOVERNANCE			
10.0	Council of Governors Update	Martin Earwicker, Chair	Verbal
10.1	Audit Committee Meeting – 22 January 2025	Rajiv Gatha, Chair of the Audit Committee	Enc.
10.2	Use of the Trust Seal Report	Paul Gray, Chief Financial Officer	Enc.
Closing Business			
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 13 May 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

Unconfirmed minutes

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Minutes of a Board Meeting held in Public on Tuesday, 14 January 2025

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Trust Chair
	Mark Day	Non-Executive Director
	Rebecca Burford	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Rajiv Gatha	Non-Executive Director
	Sally Glen	Non-Executive Director
	Julian Emms OBE	Chief Executive
	Alex Gild	Deputy Chief Executive
	Debbie Fulton	Director of Nursing and Therapies
	Paul Gray	Chief Financial Officer
	Dr Nav Sodhi	Associate Medical Director *(deputising for Dr Minoo Irani* | *Medical Director)*
	Tehmeena Ajmal	Chief Operating Officer
In attendance:	Julie Hill	Company Secretary
	Pauline O'Callaghan	Service Manager, Liaison and Diversion Service
	Kate Francis	Criminal Justice Lead Speech and Language Therapist

25/001	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. On behalf of the Board, the Chair congratulated the Chief Executive on being awarded an OBE for services to the NHS in the 2025 New Year Honours List. The Chair said that the award was in recognition of the Chief Executive's outstanding leadership of the Trust.
25/002	**Apologies** (agenda item 2)
	Apologies were received from: Aileen Feeney, Non-Executive Director and Dr Minoo Irani, Medical Director.
25/003	**Declaration of Any Other Business** (agenda item 3)

	There was no other business.
25/004	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** With effect from 1 January 2025, the Trust Chair was also the Chair of Hampshire Hospitals NHS Foundation Trust.
	ii. **Agenda Items** – none
25/005	**Minutes of the previous meeting held on 12 November 2024 –** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday, 12 November 2024 were approved as a correct record.
25/006	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
25/007	**Speech and Language Therapist, Liaison and Diversion Board Story – (**agenda item 6.0)
	The Chair welcomed Pauline O'Callaghan, Service Manager, Liaison and Diversion Service and Kate Francis, Criminal Justice Lead Speech and Language Therapist to the meeting. The Director of Nursing and Therapies said that this Board story had been selected to highlight the innovative use of speech and language therapy in the Liaison and Diversion service to support people with speech and language communication difficulties, including neurodivergent individuals and those with learning disabilities. Kate Francis, Criminal Justice Lead Speech and Language Therapist gave a presentation and highlighted the following points: • The use of Speech and Language Therapy as part of the Trust's Liaison and Diversion work was a new and innovative service which integrated traditional health services into the criminal justice system to address communication vulnerabilities. • There was a high prevalence of speech, language, and communication needs amongst individuals in the criminal justice system. • Around 60% of young offenders had speech and language communication needs and 79-84% of service users referred to a Forensic Support Service for adults with learning disabilities were thought to have behaviours linked to communication difficulties. Around 40% of adult offenders found it difficult or were unable to benefit from and access programmes which were verbally mediated such as anger management, substance misuse or drug rehabilitation which in turn increased the likelihood of reoffending.

	• The Speech and Language Therapy (SALT) was introduced initially in the Thames Valley Liaison and Diversion service. The Thames Valley Liaison and Diversion service created a new job role for a Speech and Language Therapist and conducted a pilot to identify referral numbers and the level of speech and language communication needs within the Thames Valley Liaison and Diversion service • The pilot identified that there was significant demand, and an additional Speech and Language Therapist was appointed, and the service was expanded into the Hampshire Liaison and Diversion service. • The Police custody setting was one of the most challenging environments a person could experience in terms of communication requirements. Being interviewed by the police or giving evidence in court required a person to focus on, process and understand information and tell their story, arrange the information in the correct order and to explain and justify complex and abstract concepts such as intention, motivation and decision-making. • People with learning disabilities may need visual aids and simplified language to help them to understand their situation and to support them giving evidence. Neurodivergent individuals may need more time to process information etc. **Case Study** Kate Francis presented a case study which concerned a nonverbal man (referred to as X) who had a diagnosis of Autism and Severe Learning Difficulties who was brought into police custody and made the following points: • X had a supported living placement and was taken into police custody because he had hit one of his carers. • X used a Picture Exchange Communication System (PECS) to communicate, however this was not brought into custody. • As significant communication difficulties were evident, the Police referred the case to the Speech and Language Therapist. • When the police opened the cell door, X thinking that the door was opened because the police wanted him to leave, made a bid to exit the room. The police were about use restraint to stop X from leaving. The Speech and Language Therapies used Makaton signing to explain the situation to X who complied and went back into the room without the need for police intervention. • The Liaison and Diversion service team and the police agreed that X was not suitable to be held in custody and should return home due to a lack of awareness, insight and capacity. An easy read resource was created and shared with X to enhance his understanding of the planned next steps. • The Speech and Language Therapist raised awareness with the police of the need for Makaton and visual resources to be used routinely. • The police fed back that using Makaton was “like a superpower” which enabled the Speech and language Therapies to communicate with X. Kate Francis reported that individuals referred to the Liaison and Diversion service would be assessed and if they had speech and language communication need, a communication passport would be created for the individual to support the police for this and any future arrests. If individuals were required to attend court, a more thorough assessment would be completed, and a report would be created to support individuals with speech and language communication needs. Kate Francis extended an invitation to Board members to visit the service.

	Mark Day, Non-Executive Director commented that it was a fascinating presentation and shared that he was surprised about the prevalence of people arrested who had speech and language communication needs. Mr Day asked who undertook the initial assessment to determine who was referred to the Speech and Language Therapy service. Kate Francis explained that the initial assessment would be undertaken by a member of the Liaison and Diversion service which was a multi-disciplinary team. There was a specialist practitioner for children and young people. Sally Glen, Non-Executive Director commented that the case study had highlighted the importance of training for the police when dealing with people with learning disabilities and dementia etc and highlighted the potential for misinterpreting their behaviour as aggressive. Kate Francis agreed and said that the Liaison and Diversion service was involved in police training programmes and provided training for detention officers and police sergeants. It was noted that it was unusual for individuals with severe learning disabilities to come through the criminal justice system. The Chief Executive asked how the Liaison and Diversion service was going to attract and retain Speech and Language Therapists in the service. Kate Francis said that deploying Speech and Language Therapists in the Liaison and Diversion service was new and exciting and this would attract people. Once in the role, staff enjoyed dealing with the complexity of needs and the autonomy that was afforded to the role. Naomi Coxwell, Non-Executive Director asked how the good practice may be shared with other trusts. Kate Francis pointed out that there were around 12 Lead Speech and Language Therapist across England and there was a learning and development network which met monthly to share best practice and learning. The Chair thanked Pauline O'Callaghan, Service Manager, Liaison and Diversion Service and Kate Francis, Criminal Justice Lead Speech and Language Therapist for their presentation. The presentation slides are attached to the minutes.
25/008	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following issue was discussed further: **National Elective Recovery Plan** The Chief Executive mentioned that NHS England had not yet been published the NHS Operational Planning and Contracting Guidance for 2025-26 but said that the Government had indicated that a key priority would be a focus on elective recovery. It was noted that the Government had also committed to retaining the Mental Health Investment Standard funding.

	The Chair asked whether the timescale for the publication of the NHS Operational Planning and Contracting Guidance would coincide with the publication of the NHS Ten Year Plan. The Chief Executive explained that the NHS Operational Planning and Contracting Guidance and the NHS Long Term Plan were two separate but interconnected documents. It was noted that the NHS Operational Planning and Contracting Guidance was the tactical plan for the NHS over the next financial year whilst the NHS Ten Year Plan set out the Government's high-level long-term plan for the NHS which was due to be published in May 2025. **The Trust Board**: noted the report.
25/009	**Month 08 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 Plan schemes to be identified (£0.8m). The year-to-date surplus was in line with plan. • 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. • Cash was above plan due to some slippage year to date on the capital programme, which would be resolved by year end as Estates projects were completed, and IT equipment was delivered. • The Trust's performance against the Better Payment Practice Code was achieved for 3 targets and was marginally below for the NHS by value target. • Capital spend was under plan year to date for CDEL schemes, but the forecast outturn was as per the plan. • Good controls were in place to manage temporary staffing, and the Trust was working within the national agency spend ceiling. • The average number of inappropriate Out of Area Placements had decreased from 24 in October 2024 to 19 in November 2024. The high level of placements continued to be driven by demand. Patient flow through the hospital continued to improve, with more discharges and fewer lost bed days per patient. The monthly costs were £0.6m which was above plan and reflected the high level of Psychiatric Intensive Care Unit patients. The Chair commented that it was a stable position in relation to the Trust's finances. The Chair referred to the dashboard and summary narrative page in the agenda pack and commented that the Trust had so far achieved £8.8m of cost improvement plan schemes against a target of £13.6m and asked whether the Trust was on track to deliver the remaining cost improvement plan schemes. The Chief Financial Officer explained that the level of cost improvement plan schemes was initially set at £13.6m in order to deliver the financial plan but as the Trust's financial position had improved the Trust did not have to deliver the target figure in order to deliver the plan.

	Naomi Coxwell, Non-Executive Director referred to elective recovery funding and asked how much the Trust was spending on the provision of services or beds in the private sector. The Chief Financial Officer explained that he did not have the numbers to hand but said that the Trust had outsourced some services such as MSK physiotherapy to reduce the waiting time for patients. The Chief Financial Officer added that the systems as the commissioners were aware of how much the Trust was spending with the independent sector and that would form part of the conversations around next year's financial plan in terms of the level in investment needed. Ms Coxwell commented that at a strategic level, there was an issue around the private sector's capacity to support the Government's priority around bringing down waiting lists. The Chief Financial Officer agreed and pointed out that most of the medical workforce in the private sector also worked in the NHS. The Chief Financial Officer said that there was likely to be more detail about the Government's plans and targets in the NHS Operational Planning and Contracting Guidance which was due to be published shortly. **The Trust Board**: noted the report.
25/010	**Month 08 2024-25 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 08 2024-25 "True North" Performance Scorecard Report had been circulated. The Chief Operating Officer presented the report and highlighted the following points: • Performance in relation to the number of fall incidents in Community and Older Adult Mental Health Inpatient wards target had been RAG rated green for two consecutive months and reflected the Trust's work around reducing falls • Performance in relation to Health Visiting New Birth Visits within 14-day target was RAG rated red at 89.1% against a target of 90% but performance was improving • Performance in relation to the Self-Harm Incidents on Mental Health Wards target was RAG rated red (92 incidents against a target of 61 incidents per month). • Mental Health Acute Occupancy rate (excluding home leave) was at 97.6% against a target of 85% occupancy. Sally Glen, Non-Executive Director referred to performance in relation to the Restrictive Interventions in Mental Health Inpatient Wards target which had remained RAG rated green for the whole year and asked whether the target needed to be more challenging. Dr Nav Sodhi, Associate Medical Director said that it was important to get the balance right and said that some patients needed be restrained. Dr Sodhi said that the Trust's work needed to focus on reducing inappropriate use of force rather than on necessarily reducing the number of restrictive interventions. The Chair referred to the Talking Therapies performance targets and asked how you measured whether a Talking Therapies course of treatment had been successful. The Chief Executive explained that there were a number of ways of assessing the outcome of Talking Therapies including professional assessment, self-assessment by the patient, compliance with the course of treatment and whether the patient was able to maintain employment.

	The Trust Board: noted the report.
25/011	**2025 Strategy Outcome Measures Mid-Year Update Report** (agenda item 9.0)
	The Deputy Chief Executive presented the paper which provided a progress overview against the agreed Board level outcomes for the implementation of the Trust's Strategy. The Deputy Chief Executive highlighted the following points: • The Trust's Mental Health Act Detentions project was progressing well. • As part of the Health Inequalities strategic initiative, a corporate level Quality Improvement programme had been initiated to scope, engage and address key identified health inequalities. Part of this programme aimed to support a small number of Quality Improvement projects addressing specific health inequalities in our services and our local populations in Reading and Slough. • The Trust was continuing to undertake measures to reduce carbon emissions and had reduced its Co2 tones of emission by 5% in 2023-24 but this was less than the target of 13%. • The Trust had reduced its staff turnover from 17% to 11.5%. • The improved mental health services outcome measure was focused around reducing ward sizes • The operational excellence outcome measure was focussed on increasing productivity. Naomi Coxwell, Non-Executive Director referred to the carbon emissions reduction outcome measure and asked whether the Trust was looking to install solar panels on its buildings. The Chief Financial Officer confirmed that the Trust was installing solar panels wherever possible on the Trust's buildings. Ms Coxwell asked about the funding for the installation of solar panels. The Chief Financial Officer confirmed that the Trust used a small amount of funding from the Capital Programme to pay for the solar panels and in return there would be a modest level of efficiency that would feed into revenue savings. Sally Glen, Non-Executive Director referred to the Mental Health Act Detentions Project and asked whether the reduction in the number of people detained was for the overall number of people or whether it referred to a reduction of black individuals detained. Dr Nav Sodhi, Associated Medical Director explained that nationally the overall number of people detained under Section 2 of the Mental Health Act had declined. Dr Sodhi added that it was too soon to ascertain whether the Trust's actions to reduce the number of black individuals detained were having a positive effect. The Deputy Chief Executive reported that the NHS Race and Health Observatory was supporting the Trust in its work around reducing the number of black individuals detained and would be holding a partnership conference in the spring to discuss actions for reducing disproportionate detentions. The Deputy Chief Executive extended an invitation to Board members to attend the conference.

	The Chair asked whether given the change in national priorities following the last election meant that the Trust needed to change any of its priorities over the next year. The Chief Executive said that some priorities may need to be tweaked to reflect the shift of focus put pointed out that those national priorities which the Trust was already good at would be monitored as part of the performance framework rather than included as strategy outcome measures. The Chief Executive added that there would be more clarity on the Government's priorities for the coming when the NHS Operational Planning Guidance was published. **The Trust Board**: noted the report.
25/012	**Appointment of a New Senior Independent Director** (agenda item 10.0)
	The Chair reported that Naomi Coxwell, Non-Executive Director, would be leaving the Trust in the spring. It was noted that Ms Coxwell was the Trust's Senior Independent Director. The Chair proposed that Aileen Feeney, Non-Executive Director, be appointed as the Trust's Senior Independent Director. It was noted that the Board was responsible for appointing the Senior Independent Director in consultation with the Council of Governors. The Chair reported that he would recommend Ms Feeney's appointment to the Council of Governors at the next meeting in March 2025. **Action: Chair** The Trust Board approved the appointment of Aileen Feeney, Non-Executive Director subject to the Council of Governors ratifying the Board's decision at their March 2025 meeting.
25/013	**Council of Governors Update** (agenda item 10.1)
	There was no update at the meeting.
25/014	**Any Other Business** (agenda item 11)
	There was no other business.
25/015	**Date of Next Public Meeting** (agenda item 11)
	The next Public Trust Board meeting would take place on 11 March 2025.
25/016	**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 14 January 2025.

Signed…….. Date 11 March 2025

Berkshire Healthcare NHS
NHS Foundation Trust

Speech and Language Therapy

Berkshire, Hampshire & Isle of Wight Liaison and Diversion Service

Healthcare from the heart of your community

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Innovation – a need for SLT was discovered

Berkshire Healthcare NHS Foundation Trust

Prevalence of Speech, Language and Communication Needs (SLCN)

Speech, language and communication needs (SLCN) are more prevalent in criminal justice settings than in the wider population (Holland et al., 2023).

Prevalence of Speech, Language and Communication Needs (SLCN)

Berkshire Healthcare NHS Foundation Trust

Young Offenders

At least 60% of young offenders have SLCN (Bryan et al., 2015).

Approximately one third of young offenders (10 years - 17years, 11months old) have speaking and listening skills below the tested level of an 11-year-old, resulting in difficulty accessing education and justice treatment programmes due to poor language and literacy skills (Davies et al., 2004).

Prevalence of Speech, Language and Communication Needs (SLCN)

Berkshire Healthcare NHS Foundation Trust

Adult Offenders

79-84% of service users referred to a Forensic Support Service for adults with learning disabilities were thought to have offending behaviours linked to communication difficulties (McNamara, 2012).

In one study, all adults known to a single probation service had “below average” speech, language and communication abilities (Pierpoint, Iredale & Parow, 2010).

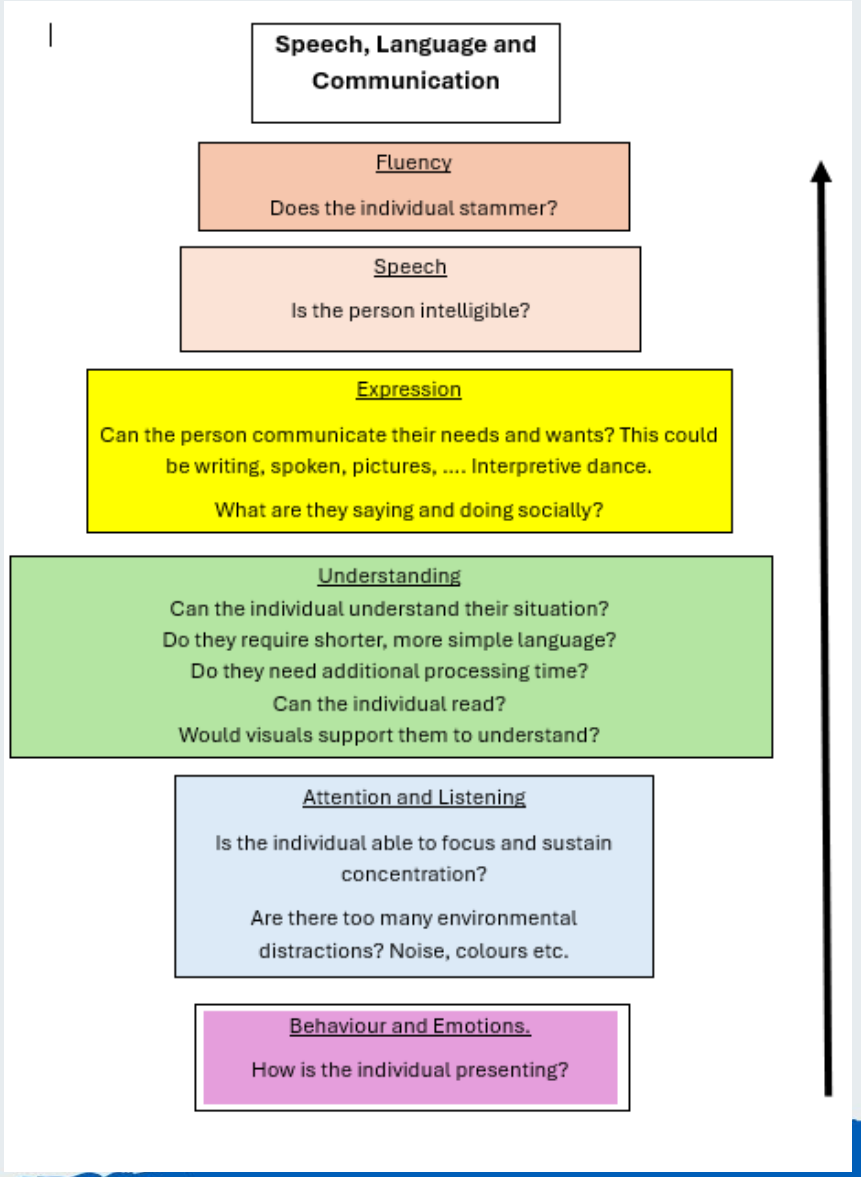
Around 40% of adult offenders find it difficult or are unable to benefit from and access programmes which are verbally mediated, such as anger management, substance misuse or drug rehabilitation; which in turn increases the likelihood of reoffending (Bryan 2004).

SALT in Thames Valley & Hampshire

Berkshire Healthcare NHS Foundation Trust

- SALT was introduced within our partnership Trust, initially in Thames Valley (TV) L&D, considering positive information shared from other L&D services (with SALT services) within the UK
- TV L&D created a job role for a SLT and conducted a SALT pilot to identify referral numbers and the level of SLCN within TV L&D
- Discovered there was demand and need for SALT within TV L&D; and as such, an additional SLT was appointed, enabling 2 SLTs to cover TV (Berkshire, Buckinghamshire & Oxfordshire)
- Following the success of the SALT service within TV L&D, the service has expanded to Hampshire L&D who are in the process of setting up a SALT service

Speech, Language and Communication Needs (SLCN)



Impact of SLCN in the CJS

Berkshire Healthcare NHS Foundation Trust

The police custody setting is one of the most challenging environments a person can experience in terms of communication requirements (Holloway et al., 2020).

Being interviewed by the police or giving evidence in court requires a person to, firstly, focus on, process and understand information and, secondly, tell their story, arrange the information in the correct order, and to explain and justify complex and abstract concepts such as intention, motivation and decision-making.

SLCN identification is vital to ensure access to fair justice outcomes (Nolan, 2018).

Examples:

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A 10yr old child who has been arrested – Do they know the following words: ‘Processing’, ‘Solicitior’, ‘Liaison and Diversion’, ‘NHS’, ‘Indecent images of minors’, ‘bailed with conditions’.

A man with reduced cognition being required to sequence events of what happened.

A young woman who was known to be a frequent attender as a child whos offences were escalating. She has a stammer.

Example from Portsmouth Custody

A non-verbal man who had a diagnosis of Autism (ASD) and Severe Learning Difficulties (SLD) was brought into police custody. He had a placement in supported living whereby he received 2:1 care in the daytime due to displaying behaviours which challenge. He uses a **Picture Exchange Communication System (PECS)** to communicate however, this was not brought to custody.

As we are an all vulnerabilities service, police staff were encouraged to send a referral to our team (which was a great opportunity to emphasise that our scope goes beyond acute mental health). As significant communication difficulties were noted, the Speech and Language Therapist in the team led the support for engagement and interaction.

The man appeared settled but was keen to leave the room and return home. Through using **Makaton signing** and **visual resources**, the SLT was able to support this man with several aspects of his care including: food, drink, hand washing and understanding his situation.

The HLDS team shared their **thoughts which echoed those of the police**; he was not suitable to be held in custody and should return home due to a lack of awareness, insight and capacity.

Throughout the afternoon, the HLDS team support this individual to have regular snacks, drinks and access to the yard. An **easy read resource** was created and shared to enhance his understanding of the planned next steps.

The SLT shared understanding of the situation during the afternoon handover and raised awareness of the need for Makaton and visual resources to be used routinely which was received very positively. The police actively sought advice from HLDS and **worked collaboratively throughout**.

Feedback:

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Police:
‘Its like a superpower that you can communicate like that with him’ (Makaton)

‘If you hadn’t been here to explain in that way, physical interventions would have had to have been used more’.

Social worker:
Thank-you for the support HLDS gave during this stressful time for X.

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Next steps:

- **Individuals will be referred to HLDS**
- **Assessed**
- **Communication passport created to support the police for this and any future arrests.**
- **If going to court, a more thorough assessment will be completed, and report will be created to support with needs.**
- **Continue working with partner agencies to support.**
- **Looking into the best way to gain service user feedback for those with SLCN.**

Thank you for listening

Any questions?

If anyone would like to visit then we would welcome that.

Berkshire Healthcare NHS Foundation Trust

BOARD OF DIRECTORS MEETING 11.03.25

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
10.09.24	24/161	WRES Report	The Finance, Investment and Performance Committee to receive a report setting out the outcome of the Trust's Case Work Review.	TBC	**JN**	The timing of the Case Work Review has been postponed because of the additional work required to meet the national requirements of the nursing job evaluation review. The casework review will commence in the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
						Autunm.	
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.	
12.1.24	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**		
14.01.25	25/012	Appointment of a New Senior Independent Director	The Chair to recommend Aileen Feeney as the Trust's new Senior Independent Director to the Council of Governors.	March 2025	**ME**	A report recommending the appointment of Aileen Feeney as the Trust's new Senior Independent Director is on the agenda of the Council of Governors meeting on 12 March 2025.	

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	March 11th 2025
Title	**Patient Experience Report -Quarter 3 (October – December 2024)**
	Paper for noting
Reason for the Report going to the Trust Board	This report is written to provide information to the Board in relation to a range of patient experience data available to us. It also provides assurance in relation to the Trust handling of formal complaints as set out within The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 and by the CQC through the Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 16 receiving and acting on complaints.
Business Area	Trust Wide
Author	Elizabeth Chapman, Head of Patient Experience (full report) Debbie Fulton; Director Nursing and Therapies (Highlight Report)
Relevant Strategic Objectives	Understanding the experience of our patients, how we respond to this, capture and learn from all forms of feedback is fundamental to the provision of safe, caring and effective services. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities** **Ambition:** We will reduce health inequalities for our most vulnerable patients and communities

Highlight Patient Experience Report - Quarter Three 2024/25

1. Why is this coming to the Board?

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

The handling of Complaints is set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.Both the CQC and Parliamentary Health Service Ombudsman (PHSO) set out expectations in relation to the handling of complaints; these are based on the principles that complaints are a valuable insight for organisations and should be seen as a learning opportunity to improve services. There is a requirement for complaints to be reviewed robustly in a timely manner that is fair, open, and honest.

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

2. What are the key points?

The iWGC tool enables patients to provide a review of their experience using a 5-star rating for several areas (facilities, staff, ease, safety, information, involvement and whether the person felt listened to) as well as making suggested improvements. The trust has an ambition as part of the Trust strategy to increase the volume of feedback received and to increase the use of the information received to support improvement. All divisions have a performance metric that they are monitoring to improve levels of feedback.

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

Patient Experience – overall Trust Summary		Target	Q1	Q2	Q3
Patient numbers (inc discharges from wards)	Number		151,330	169,235	221,601
Number of iWGC responses received	Number	**61,000 year**	9,149	9,041	9,921
iWGC Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	**10%** by Mar '25	6.04%	5.34%	4.48%
iWGC 5-star score	Number	**4.75**	4.78	4.80	4.8
iWGC Experience score – FFT (good or very good experience)	%	**95%**	94.1%	94.5%	94.7%
Compliments received directly by services	Number	Total 23/24 **4522**	1237	1012	1289
Formal Complaints received	Number/ %	Total 23/24 **281** **0.030%**	68	64	50
Formal Complaints Closed	Number	Total 232/4 **257**	41	59	57
Formal complaints responded to within agreed timescale	%	**100%**	100%	100%	100%
Formal Complaints Upheld/Partially Upheld	%	Target 50%	51.7%	55%	50%
Local resolution concerns/ informal complaints Rec	Number	Total 2023/24 **149**	28	42	53
MP Enquiries Rec	Number	2023/24 total **73**	5	6	6
Complaints upheld/ partially by PHSO	Number	Total 2023/24 **0**	1	0	1

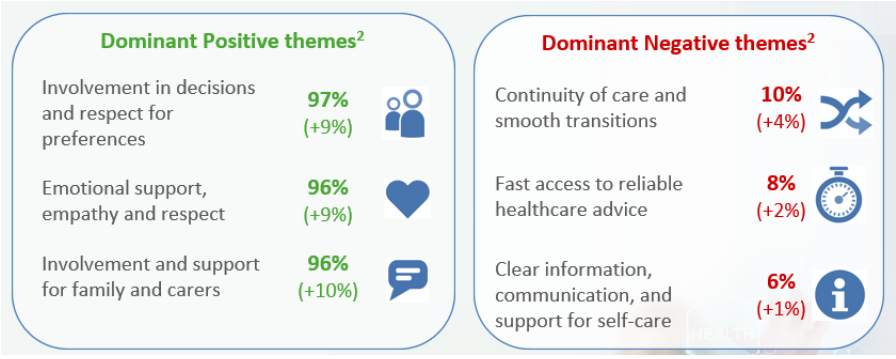
The data continues to show only small variations each quarter although we have continued to see a lower number of MP enquires compared to previous years. We have also continued to see fewer formal complaints and a continued increase in the number of concerns able to be resolved locally.

During this quarter we have seen an increase in the number of feedback forms received; however high numbers of primary school children having seasonal flu vaccine (over 72,456) during the quarter which has resulted in an increased number of unique patients receiving care and treatment means that despite this we are showing a lower percentage response rate for the quarter (these children are much less likely to complete a patient experience survey, given the way the clinics run and because this is a one-off encounter for a nasal spray).

We are continuing to see more focus on 'you said we did,' with more examples of how feedback has been used to make changes and improvements to services being reported; Examples are included within the main report.

The lowest sub scores across all divisions are within the mental health inpatient services where feeling involved and listened to remain lower in terms of star rating than other services; at the beginning of the year some improvement had been seen for these scores, however for this quarter whilst remaining above Q4 of last year the star rating are lower than in the first 2 quarters of this year. The wards all have ongoing work to support improvement and 3 of our wards participating in NHS England Culture of Care programme which was offered to all Mental Health Trusts as part of their transformation programme. This programme aims to improve the culture of inpatient mental health and learning disability wards for patients and staff so that they are safe, therapeutic, and equitable places to be cared for, and fulfilling places to work.

Overall feedback remains overwhelmingly positive with questions around our staff and involvement continuing to be dominant positive themes.



*Number in brackets shows change from previous quarter

What are the implications for EDI and the Environment?

We aim to receive feedback that is representative of the diversity across the population. The below table shows the split of both complaint and survey responses by ethnicity.

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
Asian/Asian British	6.25%	8.00%	10.16%
Black/Black British	1.56%	2.50%	3.54%
Mixed	6.25%	2.10%	3.29%
Not stated	9.38%	14.40%	7.44%
Other Ethnic Group	3.13%	4.20%	2.07%
White	73.44%	68.80%	73.59%

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

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

In terms of age the data would indicate that those over 60 years of age are more likely to complete the survey and less likely to make a formal complaint than those in younger age brackets, this is also unchanged from previous quarters.

During Quarter 2, we introduced further filters into the patient survey dashboard, which means that services can now drill down into the feedback given by people by characteristics. This not only helps services to ensure that they are being as inclusive and accessible as possible, but also supports wider pieces of work such as the Neurodiversity Strategy and Patient and Carer Race Equality Framework (PCREF).

Below are some of the themes that emerge when reviewing our survey data since commencement of the tool in December (69,228 surveys completed).

People feeling treated with kindness and respect was positively responded to regardless of view by demographics with 1.14% of respondents reporting a negative experience to this question.

Age:

- Those in the 19–50-year old age bracket are least satisfied with ease of access to our services.
- 11-18 year olds and 72-80 year olds are most likely to answer less positively to the question around identifying health needs.
- 94% of our responses are received from adults, 3% from young people and 2.6% from carers. Therefore we are not hearing the voice of the young person as readily as that of an adult through this survey.

Disability:

- 32% of our respondents identify as having a disability
- Those identifying as having a disability are slightly more likely to answer less positively to feeling involved in their care than those who declare not to have a disability (89.9% and 92%), and feel less listened to (95.5% v 92.6%)
- Of those who report a disability learning difficulty and Neurodiversity are least likely to feel listened to or involved (for feelings of involvement those reporting mental health disability also have lower scores)
- People declaring a disability are more likely to answer less positively to the question around identifying health needs compared to those without.
- Those with mental health illness are most likely to respond negatively around ease of access (77%) whilst physical impairments (including visual and hearing score at 91%)
- The overall positivity score for those who are disabled is 93.66% compared to those who answer no to this question having a positivity score of 95.44% . However further review of this demonstrates that for those with a learning disability/ difficulty this is 89%, for those with a mental health disability this is 91% and for those with a neurodivergence this is 87.8%; whilst those with physical disability including hearing and visual impairment and

mobility concerns score slightly higher than the overall positivity score across all responses.

Gender:

- We receive more complete surveys from those identifying as women 42.7% versus men 31.3% (recognising that 22.9% do not complete demographic questions)
- Overall % positivity score for men is 95.25% for women 94.56% and for non-binary only 88.41%.
- Men are more likely than women to respond positively to the questions about identifying health need (77.5% v 67.7%)

Ethnicity:

- There is no discernible difference in reported overall experience by ethnicity
- Pakistani are most likely to report negatively around ease of access and Chinese are most positive about this question (84.7% v 90.1%)
- 69% of total responses are from white British, this is a slightly lower percentage than our attendance breakdown which demonstrates white British attendance to be around 73%-75% of total attendances.
- Black Caribbean , African and white Irish are most likely to respond negatively to questions about being involved in their care with Chinese the most positive

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

3. Conclusions and Recommendations for consideration by the Board

It is the view of the Director of Nursing and Therapies that there are no specific new themes or trends identified within this patient experience report. For areas where there is concern or identified needs for improvement there are service and quality improvement programmes of work in place. There is also an on-going programme of work involving staff, service users and those with lived experience that is reviewing the service delivery model of our community mental health services, this aims to provide clarity around care and treatment as well as improved access to the right services and therefore a better patient experience.

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

Patient Experience Report Quarter 3 2024/25

Introduction

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

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

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

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

Table 1

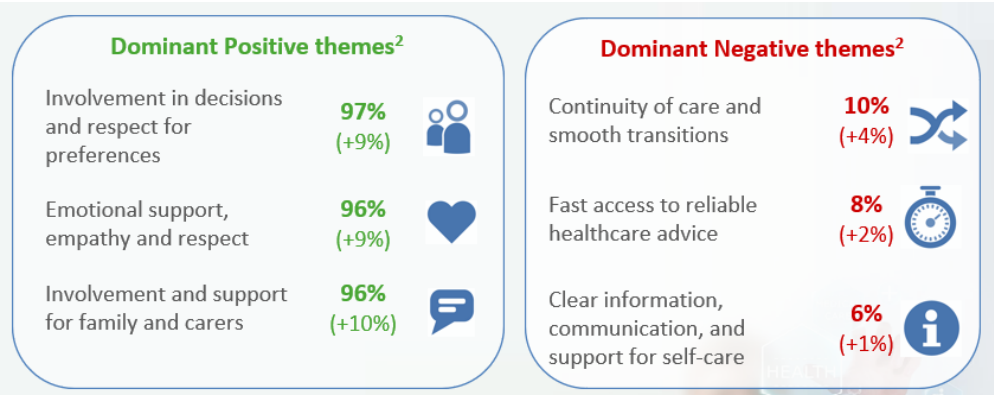
Patient Experience – overall Trust Summary		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Distinct patient numbers (inc patient discharges)	Number	151,330	169,235	221,601	
Number of iWGC responses received	Number	9,149	9,041	9,921	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	6.04%	5.34%	4.48%	
iWGC 5-star score	Number	4.78	4.80	4.80	
iWGC Experience score – FFT	%	94.1%	94.5%	94.7%	
Compliments received directly by services	Number	1237	1012	1289	
Formal Complaints Rec	Number	68	64	50	
Number of the total formal complaints above that were secondary (not resolved with first response)	Number	3	13	12	
Formal Complaints Closed	Number	41	59	57	
Formal complaints responded to within agreed timescale	%	100%	100%	100%	
Formal Complaints Upheld/Partially Upheld	%	51%	55%	50%	
Local resolution concerns/ informal complaints Rec	Number	28	42	53	
MP Enquiries Rec	Number	5	6	6	
Total Complaints open to PHSO (inc awaiting decision to proceed)	Number	7	4	6	

There was a decrease during this quarter of the number of formal complaints received although an increase in the number of complaints that were able to be dealt with locally or were informally resolved.

The PHSO concluded two investigations during this quarter, one complaint was not upheld and in the other they asked us to give a written apology, which was actioned.

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

Although the below positive themes look to have increased significantly this quarter , historically they have been our top themes receiving similar positivity percentages most quarters, the exception to this was the last quarter were a dip in positive scores were received, it was not possible to see from the feedback any specific reason for this and it is positive to see that these themes have increased back to previous quarters.



The brackets () in the picture above shows the comparison to the report for quarter 4. (+) means that there has been an increase since the last report, (-) means a decrease since the last report.

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

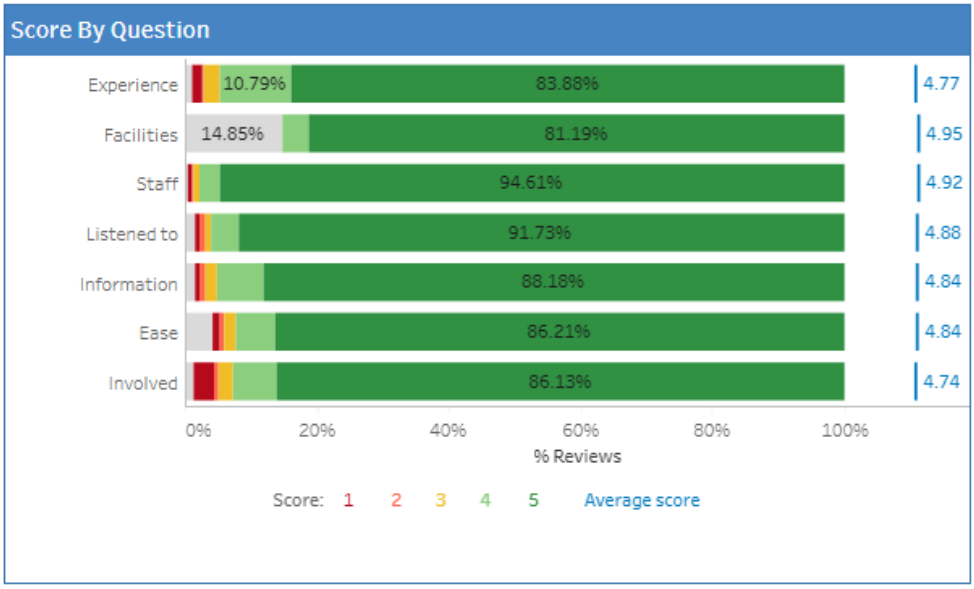
What the data is telling us

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

Children, Families and All Age Pathways including Learning Disability services.

Table 2: Summary of patient experience data.

Patient Experience - Division CFAA and LD		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	1,530	1,313	1,557	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	3.9%	2.7%	1.5%	
iWGC 5-star score	Number	4.9	4.88	4.83	
iWGC Experience score – FFT	%	95.3%	94.1%	94.7%	
Compliments received directly by services	Number	98	70	90	
Formal Complaints Rec	Number	17	17	8	
Formal Complaints Closed	Number	6	14	15	
Formal Complaints Upheld/Partially Upheld	%	33.33%	35.2%	46.6%	
Local resolution concerns/ informal complaints Rec	Number	6	1	18	
MP Enquiries Rec	Number	3	3	4	



For children's services further work is being undertaken with the services and young people and parents/carers to promote increasing the number of responses, this has included the design and layout of the new posters that will now be used across CFAA services. The total contacts this quarter includes a high number of younger children receiving a seasonal flu vaccination in schools, these children are much less likely to complete a feedback questionnaire and as a result the percentage response rate which is based on number of contacts has decreased.

Of the 1557 responses, 1443 responses related to the children's services within the division; these received 95.1% positivity score, with positive comments about staff being friendly and kind and a few suggestions for further improvement, this included 5 reviews for Phoenix House. 40 of the responses related to learning disability services and 48 to eating disorder services.

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

Children's Physical Health Services

There was 1 formal complaint for children's physical health services received this quarter which relates to Immunisation services (the immunisation team had over 72,000 contacts during the quarter).

970 of the 1443 patient survey responses were in relation to children's physical health services. The 2 services with most responses were the Immunisation and Health Visiting Bracknell; the Immunisation Team received 394 of these responses which scored positively receiving a rating of 4.80 and feedback included they were kind; injection was quick, and nurses were friendly. "*Because it was very quick, and they were very kind.*." health visiting services also receive very positive feedback with positivity score of 98.94%- and 5-star rating of 4.94.

Child and Adolescent Mental Health Services (CAMHS)

For Child and Adolescent Mental Health Services there were 7 complaints received (including one each for the Key working team and Phoenix House), these were primarily in relation attitude of staff.

Campion Ward and the CAMHS rapid response service is the area with the most concerns this quarter. The two CAMHS RRT complaints related to the way staff communicated with the patients and showing a lack of compassion or understanding. There has been no patient experience survey forms completed by young people receiving the CAMHS rapid response service this quarter.

There have been 441 responses for CAMHS services received through our patient survey for this Quarter. These include 334 received from those attending our neurodiversity services (positive score 94.31% and star rating of 4.88 with lots of positive comments about staff and the experience).

Learning disability

There were no complaints received for the Community Team for People with a Learning Disability.

Overall, there were 40 responses for all Learning Disability services; responses were for the Community Teams for People with a Learning Disability, Learning Disability Inpatient Unit and Learning Disability Intensive Support Team. These received an 87.5% positive score; feedback included that staff listened, "*[name removed] was very kind, thoughtful, made sure we understood what was happening and all the implications of this. She took the time to listen to us and explain everything very clearly. She then went on to work very hard to resolve problems and get the best outcome possible for myself and my son. I will always be so grateful to her.*," there were comments for improvements including better access for wheelchair users, parking could be better, and some staff need to be more understanding of patient's needs. The 8 responses that received with a score below 5 left comments in the free text boxes, comments included missing property and improved support with medication.

Eating disorders

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

Of the 48 feedback responses received, 37 scored a 5 with comments such as Everyone's been very kind and involved me in decision making. They've been quite proactive in the support given to me and made sure I always know what the next plan for my treatment is and have made sure I'm comfortable and supported along the way.", "S*een really quickly with the same psychologist before who assessed me with a great deal of empathy and expertise. She gave me options on my treatment plan and made me feel very involved in my care.," "I feel so grateful for the support i was given during a really difficult time in my life. [name removed] my first steps therapist was so caring and really went above and beyond for me in helping me to feel supported throughout the whole process. I can't thank you and all your hard work enough."* Areas for improvement included making the waiting room more welcoming and having evening appointments.

Mental Health Division

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

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	365	382	365	
Response rate (calculated on number contacts)	**%**	4.5%	4.1%	4.3%	
iWGC 5-star score	**Number**	4.70	4.65	4.60	
iWGC Experience score – FFT	**%**	93.7%	92.9%	91.7%	

Patient Experience - Division MHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Compliments received directly by services	**Number**	34	25	28	
Formal Complaints Rec	**Number**	12	11	8	
Formal Complaints Closed	**Number**	10	10	8	
Formal Complaints Upheld/Partially Upheld	**%**	70%	60%	62.5%	
Local resolution concerns/ informal complaints Rec	**Number**	1	2	2	
MP Enquiries Rec	**Number**	0	1	0	

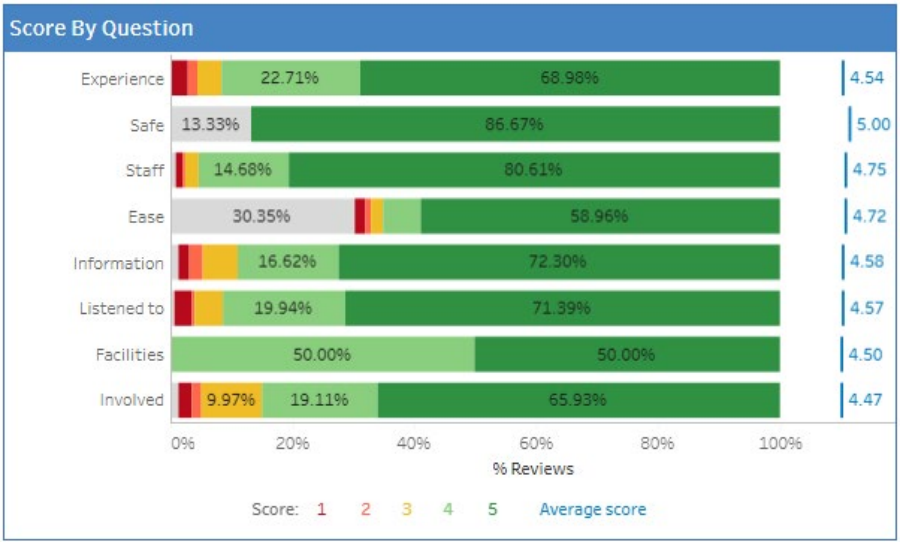


Table 3: Summary of patient experience data

8 Formal Complaints were received into the division; in addition, there were 2 informal/locally resolved complaints. 8 complaints were closed during the Quarter. 5 of these were either fully or partially upheld.

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

The services receiving the majority of iWGC responses were CRHTT East with 139 responses, Memory Clinic Bracknell with 35 responses and Memory Clinic - Slough with 22 responses.

Across the CRHTT East survey, the average 5-star score was 4.39 with 90.7% positive feedback, a decrease in the 5-star score and an increase in the percentage positive feedback from last Quarter. 126 of the overall number of responses received (139) scored a 4 or 5-star rating with many comments about staff being helpful, listened, professional and supportive; "*I was in a very low state of live so i reached out. I was given the utmost care immediately and they listened and understood without judging and made sure I was feeling okay again and again*" This Quarter, questions relating to feeling involved and information were least likely to be positive with areas for improvement and dissatisfaction with the service about feeling like there was miscommunication, staff didn't listen and problems with technology.

The Memory Clinic Bracknell received 100% positive score (4.97-star rating) and received positive feedback about staff being understanding, helpful, caring, and friendly. "*It was very lovely and rewarding to see the same Consultant that I saw previously. Of which I think is so lovely for continuity of care. He is very detailed, patient, thorough and caring. He outlined what the plans are and what I should expect in the future. Of which I think is very good and helpful, hence I can start thinking ahead of time. From my perspective everything was*

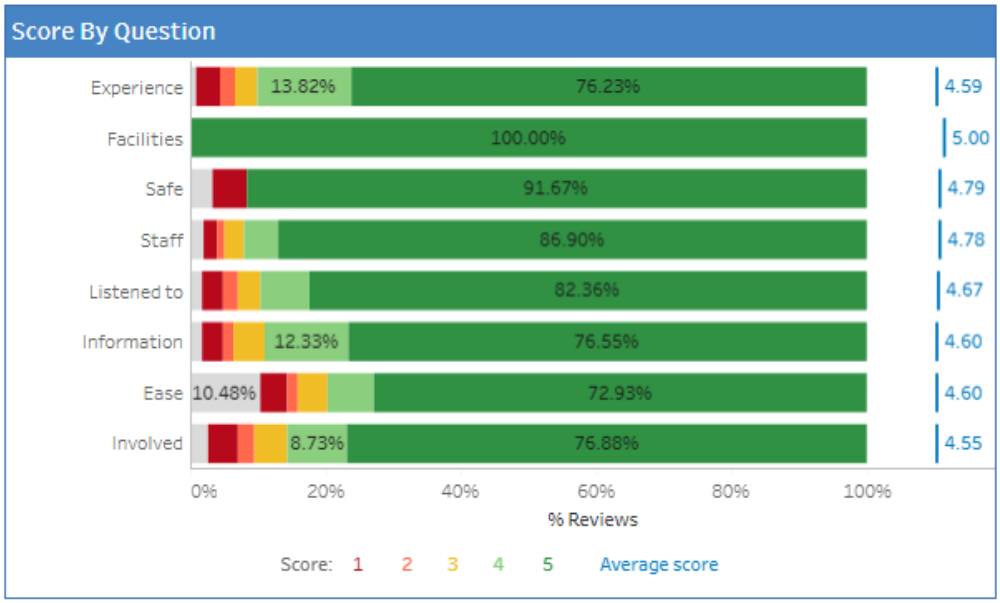
wonderful. Thanks" Memory Clinic Slough received 100% positive score with feedback comments including *"It's nice having someone who listens and knows what you're going through. They take their time and never seem to be in. A hurry, it's nice to get feedback from them."*

CMHT received 45 responses (Bracknell 16, WAM 17 and Slough 12) with 80.0% positive score and 4.55 star with 9 of the total responses scoring less than a rating of 4; comments included "*My appointment lasted 5 minutes. A new consultant. He didn't know my support worker. He didn't read my notes. Definitely no continuity of care. Appointments with my previous consultant were 30-60 minutes.*". There were several positive comments that staff were caring, kind, understanding and professional. Some of the suggestions for improvement included listen more. Further work is being carried out with Mental Health services to improve uptake as part of the wider patient experience improvement plan.

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

Table 4: Summary of patient experience data.

Patient Experience - Division MHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	**Number**	1281	1218	1237	
Response rate (calculated on number contacts)	**%**	6.06%	6.01%	5.66%	
iWGC 5-star score	**Number**	4.51	4.62	4.63	
iWGC Experience score – FFT	**%**	84.8%	89.5%	90.1%	
Compliments received directly by services	**Number**	435	375	339	
Formal Complaints Rec	**Number**	12	12	5	
Formal Complaints Closed	**Number**	6	3	4	
Formal Complaints Upheld/Partially Upheld	**%**	33.32%	27.2%	75%	
Local resolution concerns/ informal complaints Rec	**Number**	1	1	4	
MP Enquiries Rec	**Number**	0	1	2	



The Mental Health West division has a wide variety of services reporting into it, including the Talking Therapies service and Court Justice Liaison and Division service, as well as secondary mental health services. Of these complaints the CMHT received 3, CRHTT received 2 and MHICS had 1. The 3 services with the most feedback through the patient

survey were Talking Therapies Step 2 with 273 responses, Talking Therapies – Step 3 with 147 responses and CRHTT West with 129 responses.

Questions relating to ease, involvement and facilities have the least number of positive responses. Examples of feedback include waiting times were long for people accessing Talking Therapies, CPE and CMHT.

For CRHTT West there was an 72.9% positivity score and 4.12-star rating (this is lower than in previous quarters of this year where the positivity score has been around 80%). There were lots of positive comments about staff listening, being helpful and kind, "*Everyone who's come to see me has been kind, listened and been helpful. I wasn't familiar with the process or what the outcome would be and still not clear, but I trust that the process will be helpful."* Some of the areas for improvement included staff need to be consistent as different staff give differing advice, didn't call when they said they would and staff to listen and understand.

The Older Adult Mental Health Service and Memory Clinic combined have received a 98.1% positivity rating (4.90-star rating) some of the feedback included *"As soon as I arrived, the receptionist was warm and welcoming and explained where I had to go. Dr [name removed] could not have been kinder and more thorough in his efforts to solve my problem. He asked a lot of questions and was sensitive to the fact that some of the questions might make me feel uncomfortable. It was very easy to speak to him and trust him and I feel confident that he will sort out the problem."*

There were 72 responses received for West CMHT teams with 88.9% positivity score and 4.57-star rating, 64 of these were positive with comments received that staff listened and were friendly, there were 6 negative responses with reviews stating that patients felt like staff didn't listen, patients need to be told what to expect and communication needs improvement.

Most comments were still very positive about the staff, including that they listened, were supportive and caring. Several of the comments/areas for improvement were that they would like to be seen in person, appointments were cancelled or missed by therapist. For example, *"Waited months for an assessment, assessment booked from 9am to 10am on 24/10/2024. I arrived 10-15min early for appointment waited in the virtual waiting room until. 9:13 when I called talking therapies on a land line to see what's going on. 9:15 kicked out of waiting room. Told by lady on phone she will find out what's happening and call me back. 9:20 get an email say I didn't attend! And because of this my referral is closed!"*

For Talking Therapies, the overall scores were 92.48% positivity and 4.92 star rating with the more intensive pathways getting the highest scores. Many of the comments were positive about staff having listened, and that they were kind and understanding.

Examples of positive feedback about Talking Therapies included, "*The therapist I worked with took time to listen to my problems and worries and offered judgment free advice and guidance. My therapist was kind, open-minded and down to earth - they made me feel comfortable opening up during my sessions. I appreciated my therapist encouraging me to take part in a research-based task to help curb my overthinking/concerns about a certain issue I was facing. I have recommended TT to others since being discharged."* "*I have given 5 stars for the service I received as I was able to get a face-to-face appointment with a therapist which provided me with a safe and private space that I was able to really open up to my therapist."* and "*[name removed] was my therapist, who has been absolutely amazing, she has given me the techniques to be able to handle everyday situations and I implement as and when I need to. She was very caring and supportive, listened to everything very carefully. And I'm very pleased with the progress I've made."* Patients reported that they felt "*My counsellor was very in tune with my needs and very caring. Felt very comfortable opening up. I feel she has helped me a great deal for that I am very grateful. She is a happy very positive person and more importantly, wants to help.,"*

Op Courage

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

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

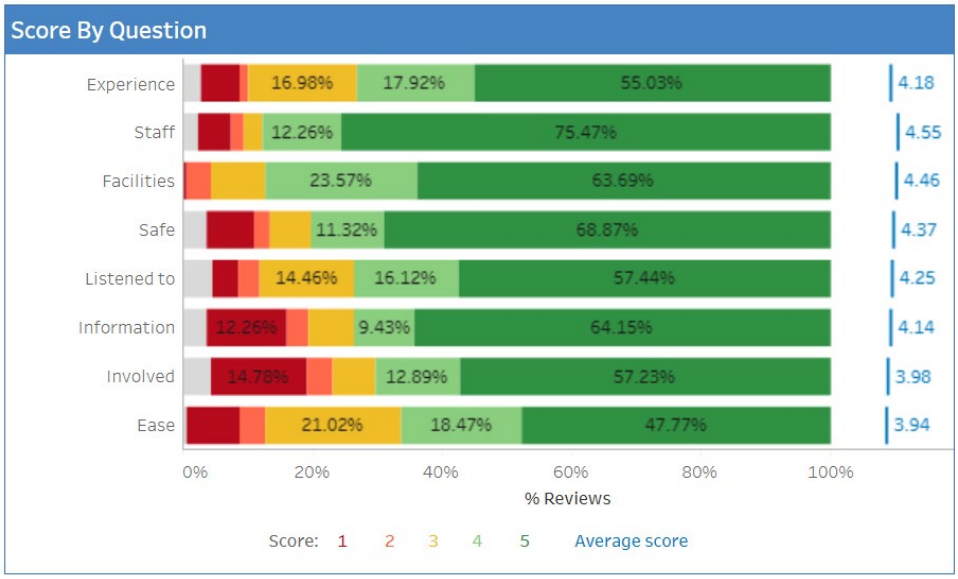
Op COURAGE received 64 responses during the Quarter, their patient survey responses gave a positivity score of 85.9% (4.59-star rating), 5 of the reviews scored less than 4.

Mental Health Inpatient Division

Table 5: Summary of patient experience data.

Patient Experience - Division MH Inpatients (wards)		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received*	**Number**	229	300	318	
Response rate	**%**	111.3%	180.7%	163.1%	
iWGC 5-star score	**Number**	4.07	4.17	4.24	
iWGC Experience score – FFT	**%**	71.7%	73%	73%	
Compliments	**Number**	12	20	19	
Formal Complaints Rec	**Number**	11	11	9	
Formal Complaints Closed	**Number**	8	11	12	
Formal Complaints Upheld/Partially upheld	**%**	37.5%	63.6%	33.3%	
Local resolution concerns/ informal complaints Rec	**Number**	1	0	2	
MP Enquiries Rec	**Number**	1	0	0	

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



There has been an increase in the number of IWGC responses received. The Activity Co-ordinators and PALS Volunteer have been on the wards encouraging patients to share their feedback, which has had a positive impact in the response rate. The response rate is 163.1% due to patients in mental health wards completing more than one survey during their stay.

The satisfaction rate was 73% with 77 of the 318 completed questionnaires giving scores of 1-3. The individual question themes would indicate that the question relating to ease received the least positive scores with overall 5-star rating for this question being 3.94 and

52 of the 157 giving a score of 3 or less to this question. The Ease question asks whether the place they received their care, assessment and/or treatment is suitable for their needs, comments relating to information and feeling involved in terms of needs also received lower scores with some comments relating to staff needing to listen to their needs, wish to be discharged sooner and would like more activities. Some of the wards are currently participating in a national culture of care programme which focuses on safety and involvement of patients; there is also ongoing work in relation to improving communication and the involvement of patients making decisions about their care, particularly around managing risk.

There were 9 Formal Complaints received for mental health inpatient wards during the quarter across all wards. They were regarding Individual care and treatment and discharge planning/arrangements.

There were 12 Formal Complaints closed during the quarter and of these 4 were partially upheld and 8 found to be not upheld.

There were many positive comments received in the feedback including comments such as staff were friendly, caring, understanding and helpful. There were some comments for improvement about more information, better communication, and better food. Examples of the feedback left are "*Seen so many improvements staff happy greeting and saying good morning ….meetings are so, so good everybody's input staff and patients feedback to improve the rose ward and make a difference now recognising staff and their names I'm in a much better place and that is down to you all as professionals*" "*Hygiene standard extremely good- cleaners constantly working round all the areas. Food was excellent too. Everything hot and well-cooked. Pamper and relaxation classes were excellent- people falling asleep is a good indicator of how well the class went! Other activities were also good." "The consultant is good. She cares about her patients and listens. The staff are friendly and do all their checks properly."*

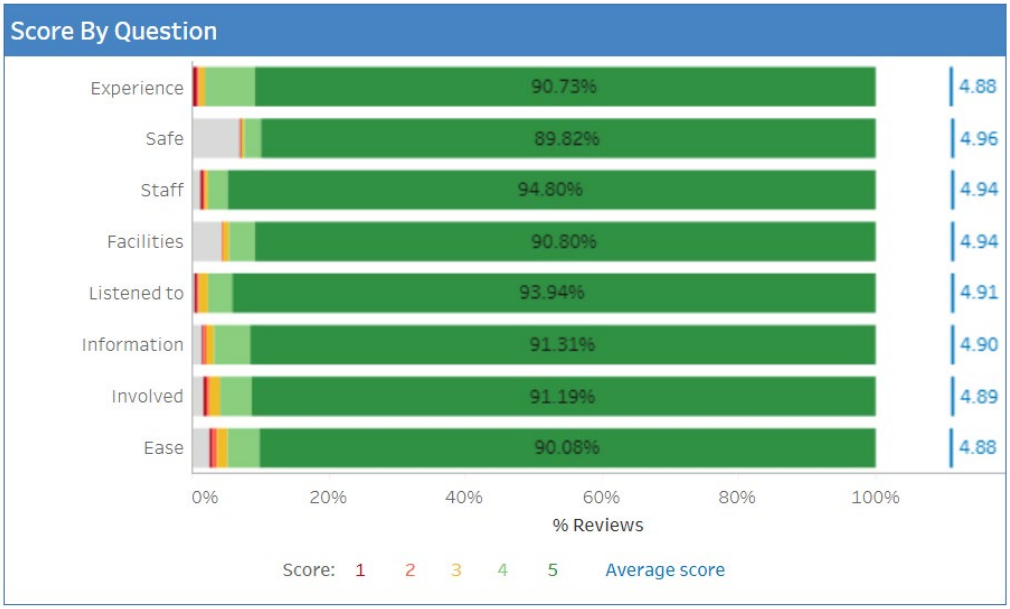
In addition to the feedback about the wards, there were 26 responses for a Place of Safety and the average score was 4.76. Some comments received were "*Because I was kept safe at all times. Also was listened to very much. Staff always met my needs and integrated to getting clean. Cleanliness it was 100% clean!*", "*Because you have a worker called [name removed] and he made me feel I am someone and wealth, and that goodness brings goodness.*" And "*The team working here is wonderful. I appreciate it. They are welcoming kind and very caring. Lovely!*."

Community Health Services Division

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

Table 6: Summary of patient experience data.

Patient Experience - Division CHE		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	2462	2364	2405	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	8.4%	7.1%	7.2%	
iWGC 5-star score	Number	4.89	4.89	4.91	
iWGC Experience score – FFT	%	97.6%	97.8%	97.9%	
Compliments received directly into the service	Number	382	136	245	
Formal Complaints Rec	Number	4	2	4	
Formal Complaints Closed	Number	5	1	3	
Formal Complaints Upheld/Partially Upheld	%	100%	0%	100%	
Local resolution concerns/ informal complaints Rec	Number	3	9	7	
MP Enquiries Rec	Number	0	0	0	



The 4 Formal Complaints received this quarter all related to different services. It should be noted that the division receives very few formal complaints but those received are generally upheld/ partially upheld.

The Hearing and Balance Service received 145 responses to the patient experience survey with a 96.6% positive score and 4.87-star rating.

East Community Nursing/Community Matrons received 509 patient survey responses with a 99.8% positive scoring, many comments were about staff being kind and professional, for example "*Nurses were very kind and professional with good communication skills, explained what the were doing, listened to me and answered my questions.,*" *"Always attentive to my mother's needs, completely professional and always informative with regards to the care needed for my mother's wounds. Treating her with the utmost respect. Added bonus of speaking her language so she is aware of what's going on.,"* "*The district nursing team have looked after me on and off for years. They are very good and kind. They used to look after my catheter. They are looking after me for a wound now. I always feel reassured and confident under their care."* There were also some comments around wanting a time slot for the appointment for example *"Perhaps some indication of the time of arrival would be appreciated."*

The wards received 94 feedback responses (43 responses for Jubilee ward 100% positive score and 50 responses for Henry Tudor ward with a 96% positive score). Positive comments were received in relation to food, kindness of staff and everyone having time to listen and being treated with dignity. Only 2 of the responses scored less than 4, comments for improvement related to staffing, equipment, and improved menu for those on a restricted diet.

Within MSK physio in the East, there was a high number of responses to the patient survey and a high positivity score of 97.8% (4.91-stars), comments were very complimentary about staff being professional and helpful, *"All staff were extremely helpful and friendly. I was seen promptly at my appointment time. My physiotherapist,[name removed],was exceptionally helpful in explaining how to proceed with strengthening exercises which has resulted in my conditions improvement. Thankyou to the whole department for their professional help.."* The reoccurring improvement suggestion for this Quarter was for more parking.

Outpatient services within the locality received a positivity score of 98.4% with 4.91 stars from the 633 responses received. With some very positive feedback including for the UCR & Virtual Community Ward, *"All the nurses that visited me in my home were fantastic they put*

me at ease they explained everything they had to do, they collect medication for me that they had requested after taking a sample, they also had a red flag situation with me that they handle carefully and gave me full instructions of what would happen. I cannot recommend this service highly enough"

The Diabetes Service received 78 feedback responses with 100% positivity and some lovely comments including "*[name removed] and the wider team have been fantastic with me since day 1. You really feel like you are being spoken to as a person and they really do care for you. Although I was ineligible for an insulin pump, the team really understood the mental toll multiple daily injections was having on me - they were advocates and fought for the approval and I am so grateful. My quality of life, and my head space has dramatically improved over the last few months and that is all down to the Diabetes Team at King Edward.*" Alongside some helpful suggestions for the service to consider around the rooms being cold "*Make sure some heating is available. Too cold in room.."*

The Assessment and Rehabilitation Centre (ARC) also received positive feedback including "*It was an extremely and thoroughly professional experience. Excellent, friendly, and helpful people, i.e. Physio Therapist, Nurse, and Doctor. I am so glad I was referred to them and as a result will hopefully improve my problems.*"

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

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

Table 7: Summary of patient experience data.

Patient Experience - Division CHW		Qtr 1	Qtr 2	Qtr 3	Qtr 4
Number of responses received	Number	3227	3426	4029	
Response rate (calculated on number contacts for out-patient and discharges for the ward-based services)	%	5.9%	5.9%	7.1%	
iWGC 5-star score	Number	4.83	4.84	4.85	
iWGC Experience score - FFT	%	96.4%	96.3%	96.1%	
Compliments (received directly into service)	Number	260	95	149	
Formal Complaints Rec	Number	12	10	11	
Formal Complaints Closed	Number	6	10	3	
Formal Complaints Upheld/Partially Upheld	%	83.3%	70%	75%	
Local resolution concerns/ informal complaints Rec	Number	16	23	22	
MP Enquiries Rec	Number	1	0	0	

Community Health West saw a significant increase in responses this Quarter. The Patient Experience team held a Rapid Improvement Event (RIE) in May which included staff from Community Heath West services and concentrated on those finding it more challenging to increase their response rate; the expectation is that an increase in responses will be seen because of this. There are a significant number of services within the division and a generally high level of satisfaction received as detailed in the overall divisional scoring of 96.1% positive satisfaction and 4.85-star rating and the question on staff receiving a 96.9% positive scoring from the 4029 responses received.

There were 11 Formal Complaints received compared to 10 in Q2, these were split across several different services.

The community hospital wards have received 172 responses through the patient survey receiving an 94.2% positive score and 4.64-star rating, (9 responses scored 3 and below) questions around listened to and feeling involved receive the most results of 3 and below. Comments include *"To The Manager Oakwood WardI would just like to express my gratitude and appreciation for the care, encouragement and professional treatment that I have received from all the team without exception. Especially [name removed] (Advanced Nurse Practitioner) whose calm reassurance and experience, knowledge looked after me during my treatment. [name removed] (staff nurse) day to day care, dressing my leg and being available for help and support, [name removed] (HCA) again all of the above with lovely attitude and totally willing and approachable. The welcoming atmosphere at Oakwood puts the patients at ease and most certainly help recovery also not forgetting [name removed] (physio) for his perseverance. I would totally recommend. Yours with thanks," "I have been looked after extremely well. Staff have taken time with me and patience. They are remarkable human beings. They should be looked after as well as I have been looked after. Food has been lovely.," "All of your staff were absolutely lovely and made me feel welcome. Having had an accident, could not have hoped to come to a better place. Thank you all so much, you are a credit to your profession. Also, given that this is a hospital and not a hotel, found the food perfectly acceptable."* And *"Kind, friendly staff. I have been looked after with a lot of kindness, which is lovely. I would like to thank [name removed] who has helped me to get back on my feet and he talks to me and makes me laugh, good lad he is."* there were some individual comments where patients were less satisfied with noise on the wards, long wait for help after ringing the bell, wanted to go for walks and more staff. Comments for reviews with responses that scored below 4 included food needed improvement, wanted more exercise, felt their needs were not understood or listened to, do not wish to be asked what they want as they feel their notes should say what they need, felt medication errors were covered up, response to bell is slow and lack of privacy. There was 1 review which received a score of 1.

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

WestCall received 354 responses through the iWGC questionnaire this Quarter (88.7% positive score, 4.70-star rating, 39 scores received below 4. Positive comments included "*I was very grateful to be seen on Boxing Day. Although the unit was very busy, all the staff were so pleasant and helpful that the wait to be seen was well worth it. The doctor was very knowledgeable and helpful, listened very patiently and I will act on her advice as soon as possible. So grateful to have a face to face examination and even leave with the medication needed." "[name removed] was really kind and knowledgeable. She gave me enough time to explain my problems and was kind enough to help me understand what was going on. Her prescription helped me a lot and I am feeling much better now." "I spoke to a lovely lady at 111 who arranged for me to go to West Berks hospital pm on Saturday. The receptionists were just as lovely and treated me with a smile and were very helpful. When I went in to see the nurses they were just as friendly and helpful and very thorough. I came out of there with some antibiotics feeling very lucky that we have such a great NHS! I couldn't fault anyone or anything that happened on Saturday, they were all great!."*

The Podiatry Service received 195 patient survey responses. Most responses were very positive receiving 5 stars (overall 97.4% positivity 4.85-star rating) with examples including *"I use this service often and the team know my needs and are very attentive to ensure that I am safe and well looked after. They take me on time and deal with me efficiently. And consider any changes that might need a change in Care. I get Rolls-Royce treatment. I am very happy with the service. The team are all personable and caring what more can one ask for. Merry Christmas.*," *"Really accessible clinic for me, super fast referral as well! Seen on time for appointment. Clinic clean and tidy. Nurse was really friendly and welcoming, listened fully, offered really good advice. Treated my problem and gave follow-up advice. She was knowledgeable and professional but showed her wonderful personality and gave a personalised and down to earth manner. Really impressed."* and *"During my recent visit to the podiatrist, I was treated with exceptional professionalism by an experienced specialist. The podiatrist conducted a thorough assessment, explained the diagnosis clearly, and provided tailored treatment. Their friendly demeanour and expertise immediately put me at ease. The treatment was effective and pain-free, leaving my feet healthier and more comfortable. I also received valuable aftercare advice to maintain long-term foot health. This experience exceeded my expectations, and I highly recommend their services for anyone seeking expert podiatry care.."*

There were no Formal Complaints for the Community Nursing Service.

To provide some context across our East and West District Nursing teams combined there were 16,846 unique patients this Quarter. Lots of comments included nurses were kind, helpful, and friendly, *"the nurses who visit us are so kind and always friendly, [name removed] came today and was a breath of fresh air helping [name removed] with her catheter and wound It was so good that she called me before she came so I could get [name removed] ready for her visit"*, *"I have leg ulcers. The nurses have helped one to heal and the other one is close to healing. The nurses have been very helpful and tell me a lot about how I can help myself to keep the leg ulcers away. I am so happy with the care I am receiving."* and *"Excellent, full of praises for all the staff who looks after me, there is great continuity of care. Every staff is friendly, respectful to me, caring and patient, all team work together to handover my care."* There were several positive comments about nurses being caring and there were very few suggestions for improvement, would like to know when they will visit and would like the nurses to stay longer.

MSK Physio has received 1 Formal Complaint in the Quarter. The service has received 762 patient survey responses with a 96.1% positive score (4.88 -star rating), very few areas for improvement were included in the feedback there were a few suggestions including parking, the cubicles were too noisy, would like to be seen sooner and privacy in the rooms and the

overall feedback was extremely positive with lots of comments about staff were helpful, professional, friendly and listened.

Bladder and Bowel (continence) services received 109 survey responses with 98.2% positivity and 4.89 star rating, with comments about sensitive and kind approach.

Demographic profile of people providing feedback

Table 8: Ethnicity

Ethnicity	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
Asian/Asian British	6.25%	8.00%	10.16%
Black/Black British	1.56%	2.50%	3.54%
Mixed	6.25%	2.10%	3.29%
Not stated	9.38%	14.40%	7.44%
Other Ethnic Group	3.13%	4.20%	2.07%
White	73.44%	68.80%	73.59%

The table above indicates that Asian/Asian British and Black/Black British are less likely to complain and give feedback through the patient survey .Those identifying as white and of mixed race are also less likely to provide feedback via our survey; although it is recognised that we have a high rate of patients who do not completed the ethnicity section of the feedback survey (14%). Intelligence such as this feeds into our wider work to ensure that we capture the outcomes and experience of all people who use our services.

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

The Patient Experience Team will be working with the EDI Team to ask for the experiences of people in the CommUNITY forum in terms of what encourages or discourages giving their feedback.

Table 9: Gender

Gender	% Complaints received	% Patient survey responses	% Breakdown of Q3 attendances
Female	45.16%	44.90%	55.13%
Male	50.00%	32.20%	44.86%
Non-binary/ other	0%	2.40%	0%
Not stated	5%	20.50%	0.00%

This shows that whist we saw less men, there were comparatively more formal complaints received from them; we are still more likely to hear the voice of the patient through the patient survey if they are female.

As we start to look into the data further, we are starting to see if there are any themes or areas of note by looking at the outcome of complaints by characteristic. To start, we have looked at this information for complaints by gender. The data shows us that:

Table 9A: Gender by outcome code

	Outcome			
Gender – as stated	**Not Upheld**	**Partially Upheld**	**Upheld**	**Grand Total**
Female	54.55%	45.45%	0.00%	100.00%
Male	75.00%	12.50%	12.50%	100.00%
Grand Total	66.67%	25.93%	7.41%	100.00%

Table 10: Age

Age Group	% Complaints received	% Patient Survey Responses	% Breakdown of Q3 attendances
0 to 4	0.00%	10.30%	6.91%
5 to 9	1.61%		1.86%
10 to 14	6.45%		3.47%
15 to 19	6.45%		4.56%
20 to 24	3.23%	4.90%	3.28%
25 to 29	9.68%		3.50%
30 to 34	11.29%	5.90%	3.33%
35 to 39	3.23%		4.08%
40 to 44	3.23%	7.30%	3.64%
45 to 49	1.61%		3.77%
50 to 54	9.68%	11.50%	4.08%
55 to 59	4.84%		4.91%
60 to 64	11.29%	13.70%	5.29%
65 to 69	3.23%		4.95%
70 to 74	3.23%	15.20%	6.21%
75 to 79	5%		8.39%
80 to 84	4.84%	12.80%	9.79%
85 +	4.84%		17.99%
Not known	6.45%	18.50%	0

Comparatively, people over 60 years old are more likely to give feedback via the patient survey and are less likely to make a formal complaint. Interestingly, we are seeing more patient feedback from people over 60 years old being received via paper, which could indicate more proactive staff promotion of the survey in this way. The Patient Experience Team have been supporting the Immunisation service to collect paper feedback at the clinics they hold in schools, which is showing as an increase in school age patient survey feedback.

There continues to be a high number of patients who have not completed their age on the patient survey (this is not a mandatory field).

Ongoing improvement

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

All services have access to a tableau dashboard detailing response to our patient survey including free text comments and this is refreshed daily to enable live data to be used by services alongside improvement work being undertaken. During this Quarter, we introduced further filters into the dashboard, which means that services can drill down into the feedback given by people by characteristic, including those who are Neurodiverse. This not only helps services to ensure that they are being as inclusive and accessible as possible, but also supports wider pieces of work such as the Neurodiversity Strategy and Patient and Carer Race Equality Framework (PCREF).

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

Some examples of services changes and improvements are detailed below.

Service	You said	We did
Berkshire Eating Disorders (BEDS) Adult Service	Patients reported that they wanted Information being included in groups on newer weight loss products.	We cannot currently give general advice on weight loss products like injections – but we can give advice on a case-by-case basis.
CAMHS Specialist Community Teams [East]	Young people have said that clinic space is not very friendly or comfortable when coming for appointments.	We have recorded a video of our site so that people know in advance about the physical layout of the service and are working with young people to get their feedback on the physical environment.
	Young people would like to know more about the clinician they are seeing.	We have developed a biography for all our clinicians with their picture.
	There are no tissues in clinic rooms or sanitary products in the toilet.	These are now available.
Family Safeguarding	Requests for more mindfulness practice and mindfulness resources.	We are offering a ‘coffee and cake’ morning to support face to face connection in between online therapy groups, We also responded to stakeholder requests for increased Motivational Interviewing training including training for foster care services.

Service	You said	We did
Talking Therapies	There are long wait times for assessment and Step 2 treatments.	Our waiting times for an assessment are currently longer than we would like; however, we are looking at ways to reduce this. This includes a new cohort of staff starting in February, who will soon be supporting with these. We have done a lot of work around monitoring the flow and waits for our Step 2 treatments and waits are currently much improved. We have also been doing a lot of work around reducing our wait times for patients who require an interpreter for treatment and now have a whole new system in place to ensure these patients are not waiting any longer than others for their treatment.
	Requests for Face-to-Face Treatment.	The efficacy of delivering Step 2 treatment via telephone is well researched, however, we have encouraged the team to offer video treatment sessions to those who request it to support engagement with treatment. Clients with a clinical need for face-to-face sessions can be offered this option. We are always reviewing our offerings and ensuring we keep a certain amount of clinical space available to offer face-to-face sessions where this is required.
	Concerns About Eligibility and Accessibility.	Clients felt concerned that they would open up to a therapist, only to find out they are not eligible for treatment in Talking Therapies. While an assessment to determine suitability is a necessary and helpful tool, we have also clarified our inclusion/exclusion criteria to help signpost clients at the front door, rather than getting into therapy only to later find out that another service is more suitable.
	Communication and Transparency Issues.	Clients reported that they were not given information about the type of therapy they would be receiving or how many sessions they would have. We have now provided in-house training on how to ensure clear communication during the step 3 assessment regarding which therapy will be offered and for how long. Additionally, we will be creating a verbal patient agreement, accompanied by an information leaflet for patients to read. We are also exploring digital methods of sending information about therapy types to clients while they are on the waitlist, ensuring that clients are awaiting the therapy they expect to receive.
Musculoskeletal Community Specialist Service (MSK CSS)	Improve the signage and patient information about how to get to Wokingham Clinic.	This is being done.

Service	You said	We did
Sexual Health Service	Patients have reported the website is confusing to navigate.	We are currently reviewing the website to see what improvements can be made.
Speech and Language Therapy Service	Patient have asked the service to speed up how quickly our reports are sent to GPs.	Reports for dysphagia now sent the same or next day, and communication reports within 2 weeks.
Respiratory Service	Patients have asked for a better venue than one of the sites used which can feel cold.	We are looking for an alternative Reading venue. The temperature is checked each session and heaters used accordingly.
Musculoskeletal Service	Patients have reported they are not happy with the information given, and it can sometimes feel rushed.	The service has reviewed shared decision-making strategies with the team and supervision with opportunities for case discussion.
	Unhappy about the waiting times for appointments.	The team are introducing Saturday and additional clinics to help address longer waits.
Westcall	More space and privacy and an option to go somewhere darker if needed while waiting	We have introduced the use of a pager system to enable patients to move away from the department waiting room
Minor Injury Unit	It is an excellent service but would be better having x-ray available at weekends and evenings	We have worked with the Royal Berkshire Hospital who run the x-ray department to extend the hours and now have x-ray 9am-5pm at weekends
Community Based Neuro Rehab team	The test message reminders for appointments were confusing	We are looking at the functionality of text reminders to see how we can make them more suitable
Intermediate Care	Timing of calls are not always when the patient would like to be seen	Staff will contact patients and plan to ensure timings work for individual patients
Phlebotomy	The monitor is too far away for patients being alerted to their turn	We have increased the print on the screen and are looking to get a larger screen/ placing in a better position.

15 Steps

There have been ten ‘15 Steps’ visits during Quarter three. We are receiving consistently positive feedback about the visits, with services relaying how helpful they are.

The Head of Service Engagement and Experience is continuing to lead an end-to-end review of the 15 Steps programme, looking at how these are planned, reported, and how any improvements are implemented. Our review is providing information into to national NHSE review of the 15 Steps programme. Insight from our services, Governors and Non-Executive

Directors is integral to this piece of work and a schedule of visits has been shared which has resulted in a vast increase in the participation of this programme.

Summary

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

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

Formal Complaints closed during Quarter Three 2024/25

ID	Geo Locality	Service	Description	Outcome code	Outcome	Subjects
9674	Wokingham	CMHT/Care Pathways	Care and treatment provided to the pt following several discharges from inpt stays at PPH and Cardinal Clinic. Complainant wishes to know how many calls had been made from the pt from Jan to March, believes this should have been an indication as to how unwell they were.	Not Upheld	There was evidence of regular follow up's communication and support did take place. The records also show that a lot of professional discussions took place around the patient to try and find suitable treatment options. The patient was seen more frequently via video consultation that in person as this was their preference.	Care and Treatment
9582	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Patient raising concerns that the lack of care from the CMHT has impacted his quality of life. He raises that letters are not sent to him following appointments, questions why his treatment fell apart and has questions in relation to his diagnosis and onward referrals		It was found that the consultant had not corresponded with the counselling services as this is not part of usual process. A second opinion was offered due to the patients unhappiness with his clinician and current diagnosis. It was also agreed that a referral would be made for EMDR treatment. Feedback was taken on board about the outside placement provider and this will be feedback to them although they are not being used by the Trust anymore.	Care and Treatment

9695	Reading	Adult Acute Admissions - Rose Ward	CQC concerns. Autistic pt unhappy there was no spiritual support. Report was shared with a social worker. Blankets withheld and sedation given. All medication stopped from private pyschiatrist without weaning them off dating back to Feb 24.	Not Upheld	The patient was only ever given medication by injection to calm them down during a period of prolonged distress. Records show they were provided with food and water whilst in seclusion. There is no evidence the patient asked fir spiritual support. The medication prescribed privately were the cause of her manic episodes hence it was clinically appropriate to stop the antidepressants and start alternative medication immediately.	Care and Treatment
9752	Reading	Admin teams and office based staff	Due to inaccuracies in letters and reocrds family wish to know the pt section status. What is happening with GDPR breach where correspondecen was sent to an incorrect email address with Pt indentifiable info within. General inaccuracies made by admin staff	Partially Upheld	There was an error on the original section paperwork however, this was amended and replaced on the notes once identified. The team have been reminded to check letters before sending to ensure accuracy. in the time period between when the Urgent Authorisation had lapsed and the Standard Authorisation was granted the record keeping was poor and this will be reviewed as part of learning from this complaint. An email was sent to an incorrect email address however, it bounced back so there was not breach of confidentiality.	Communication

9620	Windsor, Ascot and Maidenhead	CMHT/Care Pathways	Concerns raised in relation to a letter that was shared with the patients GP, which he would like removed from the records. There are also multiple concerns in relation to clinicians involved in the care including an assessment taking place without his knowledge	Not Upheld	It was found that it was communication with the patient clearly and consistently indicate the limits of the therapeutic offer from the service. The patient was also told that his GP would be updated about his care.	Communication
9730	Reading	CAMHS - Rapid Response	Unhappy with the assessment process from RRT in the RBH	Not Upheld	Having reviewed all the documents and the chronology of the events that took place, the IO is of the opinion that CAMHS RRT Clinician assessment and recommendation were appropriate for the nature crisis and difficulties KB were facing at the time.	Care and Treatment

9689	Windsor, Ascot and Maidenhead	Crisis Resolution and Home Treatment Team (CRHTT)	Some elements of the response were felt to be confusing and conflicting with fact. Complainant wishes to go to the PHSO and seek financial compensation. ORIGINAL COMPLAINT BELOW Pt in Crisis unable to access help as front line crisis team kept stating they were under CMHT (recently accepted referral so not seen yet). Complainant feels pt should never have been discharged from CMHT due to diagnosis. Complainant wishes all the calls to be listened to so all the mismanagement can be noted. Why did the team that they had been told were there to help deny help?	Partially Upheld	As well as reflecting this learning with the team, an in-house triage skills role-in training is now being designed for all our staff, especially our duty team, to ensure that this practice does not happen again. Additionally, all our triage staff have been reminded to discuss cases with their allocated supervisor on duty before making decisions similar to the one made in this case. This case has been reflected to the team and will form part of our monthly internal learning events within the service. It is hoped that our clinicians will learn from this and ensure that our other service users don't have a similar experience in future. A checking system will be put in place. This will be in the form of a handover process where every shift Lead routinely checks for missed messages throughout their shift (20-30mins intervals) and will ensure that messages have been cleared/attended to before handover to the next shift Lead.	Access to Services

9736	Reading	Out of Hours GP Services	PT told to go to W/C by nurse despite presentation at triage. Complainant wonders if the fact they are Black has anything to do with why they were sent there.	Partially Upheld	Given the patients oxygen saturation they should have remained in the Emergency Department and not signposted to Westcall. The member of staff will undertake supervised practice following this. Observations were not undertaken when the patient arrived as staff were dealing with an urgent incident however, the patient only waited 28 minutes before being seen. A review of this case will take place with the whole service and the importance of prompt observations taking place will be reiterated.	Attitude of Staff
9513	Reading	Adult Acute Admissions - Daisy Ward	Via CQC - concerns over property search not taking place in front of the pt. Generally not happy with the way the ward is run, blades and drugs allegedly being bought in, staff allegedly smoking despite smkoke free hospital.	Not Upheld	Patient withdrew complaint	Care and Treatment
9675	Slough	CAMHS General	Family feel there is a lack of help and support to the pt and the carer. Following 16 A&E visits over the summer holidays, they were offered an assessment and then told 24-27 months wait.	Upheld	There was a delay in support in an assessment taking place and the service have developed learning as a result of this. There is a long wait for ADHD services for all patients due to increased demand and details of what support is available.	Care and Treatment
9801	Reading	CAMHS - Rapid Response	Attitude of staff member who spoke with YP in A&E, total lack of compassion	Not Upheld	Does not want formal response. Service keeping in touch	Attitude of Staff

9753	Reading	Mental Health Integrated Community Service	Pt wishes acknowledgement of harm caused, immediate action to rectify the misrepresentation in Trust communication to the council and for the service to advocate with the council for them to reconsider the pts housing application ORIGINAL COMPLAINT BELOW Pt with PTSD diagnosis unhappy at the lack of follow up appts and the sharing of incorrect info to the LA	Upheld	There was a delay in following up with agreed care plans information included within documents was unclear and included the wrong names	Communication
9757	Reading	Adult Acute Admissions - Snowdrop Ward	poor communication on the ward, families not listened to. Promises made and not fulfilled. Went from Sec2 to 3 without communication,discharged with no care plan and CC as promised and now pt is showing strong signs of relapsing	Not Upheld	No consent given	Discharge Arrangements

9696	Reading	Adult Acute Admissions - Rose Ward	family unhappy with the communication from PPH to them, property is missing. Family felt it was important to write to the Trust giving their concerns regarding the pt's young family before the Tribunal hearing. Now the complainants feel distraught their concerns were not read and they feel following discharge the pt is exhibiting negative behaviour to their child and they feel they will need sectioning again. They do not want the pt to end up in PPH again	Upheld	In this instance, there was information provided by the complainant that was recorded as part of the social circumstances report required for the tribunal hearing. These reports are shared with the patient however, it was acknowledged that consideration should have been given to the complainants request for the information you provided to not be shared with the patient.	Communication
9707	Reading	Adult Acute Admissions - Rose Ward	DECEASED PT - family angry they were not informed the pt had been transferred to the RBH and thus state time was stolen from them through PPH's neglect to stick to basic protocol. Concerns also about Lithium Toxicity.	Partially Upheld	It was accepted that there should have been more communication with the family around the patients transfer and that the deterioration mentioned in the complaint happened after the transfer, not before.	Communication
9756	West Berks	Continence	Continence pads rip, inside and out, don't fit waist having a huge sag in the crotch, leak onto clothes	Not Upheld	Local resolution	Support Needs (Including Equipment, Benefits, Social Care)

9706	Reading	CAMHS - ADHD	waiting times for ADHD pathway, concerns by the GP of medication being taken from Turkey. Family wish YP to be moved up the wait list as also suffering from vomiting bouts	Partially Upheld	CPE requested information from the GP in relation to the patients previous diagnosis in another country. When this was not received the patient was discharged. apologises were made as the CPE team did not contact the complainant earlier to advise that the report from Egypt had not been received. The patient was placed back on the list at the same place he was so there has been no impact on when he will receive care. He is expected to wait 6 months earlier than expected due to the service prioritising them. The patient is receiving an ADHD medication prescribed from a doctor in another country. One of these is an anti-psychotic and both medications he has been prescribed have side effects of sickness, which the patient is experiencing. The response was clear these medications will not be offered if they are assessed to have ADHD in the UK.	Waiting Times for Treatment
9749	Reading	Adult Acute Admissions - Daisy Ward	Complainant raising concerns about the pt's assessment and subsequent sectioning	Not Upheld	CQC advised that this needs to be taken to the PHSO	Care and Treatment
9733	Reading	Older Adults Inpatient Service - Orchid ward	DECEASED PT: Pt with scissors on the PPH ward went to RBH for dialysis and used the scissors to cut their central line. Complaintant needs MH support but has been discharged from Crisis and they feel this is wrong	Not Upheld	The Trust are unable to investigate due to the ongoing Police investigation taking place. The investigation found mental health services did try to engage with the complainant however, they cancelled their appointment.	Other

9764	West Berks	Site Services	Driver received a ticket after emergency visit to MIU on 4 October 2024	Not Upheld	The car park is pay on exit to allow patients to pay after they have received treatment. There was found to be adequate signage outlining this and therefore the fine remained in place	Other
9745	Reading	Learning Disability Service Inpatients - Campion Unit - Ward	Enquirer concerned about patient welfare and safety on the ward	Not Upheld	Not pursued	Attitude of Staff
9665	Bracknell	CMHT/Care Pathways	Staff member contacted by telephone and stated they had been told by the panel the support they believed they could offer wasn't suitable. Dismissive attitude and no further support offered. Staff member wrote a summary of the communication which was sent to their GP. No consent had been sought to do this and the report/letter was factually incorrect. Feels this is a DPA issue	Partially Upheld	We accept that we should have asked the patient prior to sending this letter and that our Privacy Notice could be more widely. A reminder has been given to clinicians to ensure they are making their patients aware of this. There was information recorded in relation to the patients abuse on the record but this is relevant clinical information.	Attitude of Staff
9658	Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Complainant concerned about patient on the ward,not enough checks for medication as pt was neally given the wrong meds. Staff constantly on their phones when escorting pts on leave	Not Upheld	No consent given	Care and Treatment

9703	West Berks	Site Services	Unhappy with the response, raising additional points regarding taking the blue badge to reception, and why we even have mother and toddler spaces ORIGINAL COMPLAINT Unhappy with parking arrangements at WBCH. Does not think disabled bays should be used by mother/toddler as well	Not Upheld	The parent and child parking spaces were put in following a complaint that there were none of these spaces on the site. So as not to spend lots of money repainting the lines in the car park some disabled spaces were converted. An audit was carried out on the car park and at no time were all of the disabled spaces in use	Communication
9660	Reading	CAMHS General	Felt that clinicians cannot make decsions as always need to refer to the psychiatrist despite the pt not having seen one yet. Reluctant for medication due to cardiology concerns who have not been contacted yet. wishes to know why the YP is complex, why an autism course for Mum has been suggested. need assistance with funding application	Partially Upheld	Medication is not deemed appropriate for this patient so their has been no need to reach out to their cardiologist to check if medication would be safe to provide. The term 'fix' was used by a member of staff but this was immediately retracted and apologised for. The fund is unable to part fund theraplay as this is outside of the remit of the what they are commissioned to provide and was being explored prior to CAMHS involvement.	Care and Treatment

9482	Wokingham	Integrated Pain and Spinal Service - IPASS	Unhappy with recent IPASS assessment. Felt the assessment focused on neurological reflex and sensory tests and inference that pt's MH would be prioritised over physical wellbeing. Feels pt's neurodiversity means healthcare professionals look to MH before and over physical health. Complainant feels the pt has been misdiagnosed with Bipolar disorder and wants this and all other MH conditions removed from the pt's records	Not Upheld	The patient has been referred to another area to receive an assessment independent from the team complained about. No elements relating to the Physio service were upheld	Care and Treatment
9656	Slough	CMHT/Care Pathways	Unhappy that they are being discharged from services. Feel they do not fit into the new treatment pathways, and as they are only on the early stages of recovery they feel this discharge to be detrimental to their MH. Wish to understand how pts are discharged from services	Partially Upheld	An administrator, in reposing to a question from the patient, told them a discussion was due to take place around referring them back to their GP. It was accepted that this was not best practice but a meeting was arranged to discuss next steps.	Discharge Arrangements
9678	Wokingham	CAMHS - AAT	Family feel child has Autistic traits but the Dr disagrees and appears not to entertain the idea, they also will not discuss it. family wish to see a different consultant	Refered to other organisation	Not for us to answer	Attitude of Staff

9477	Reading	CAMHS General	The complaint relates to the actions and inactions of the keyworking team in relation to daughter. This includes: - Failure to support patient and family - Team enforcing their views outside of the agreed actions - Errors in reports and actions - Failure to advise family of apparent concerns - Failure to provide evidence to support actions - Conflating evidence during meetings	Not Upheld		Communication
9690	West Berks	CMHT/Care Pathways	Therapist crossed ethical boundaries being far too personnal with the pt casuing great distress	Serious Untoward Incident Investigation	Moved to a different investigation process	Attitude of Staff
9627	Reading	Other	Pt claims to being hurt by male staff 5 years ago (2018), restrained and given medication under force	Not Upheld	The patient did not have a en-suite but did have access to a bathroom. It was found that a lot of care was provided in the community and that the administration of medication under restraint was done so in line with policy.	Care and Treatment
9645	Reading	CMHT/Care Pathways	Pt non compliant with medication leading to personal neglect and not eating. Issues with the place they live	Not Upheld	No consent given	Care and Treatment
9677	West Berks	CAMHS General	Care and treatment from services. Concerns raised by Senco Medical Tuition	Not Upheld	Local resolution direct with parent	Care and Treatment

9609	Reading	CMHT/Care Pathways	Complainant feels the service are not supporting the pt following recent cries for help	Upheld	The investigation found that the patient has been prematurely discharged back to the care of their GP. This was due to a lack of due process being followed by their care coordinator. It was also found that the patient did not have the proper safety plans in place and was not given information about how to get back in touch with the service should their mental health worsen in the community. The cc involved will have to undergo training and have their cases reviewed to ensure patient safety	Access to Services
9661	Reading	Common Point of Entry	unhappy with the way the MHP spoke to them, felt judged by the way they sound as opposed to their actual gender. asked to relive traumic memories, left to feel distressed. 6 points raised, does not wish to see the same clinician going forward	Partially Upheld	The clinician did not verity the patients identity upon answering the phone and did not fully explore the patients suicidality or heart palpitations. When the call cut out they also did not call the patient back. This has been discussed with the clinician involved for learning and further support will be offered.	Attitude of Staff
9679	Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Pt received a call from CRHTT (male clinician), which they described as “extremely forceful” and difficult. They said the conversation was not supportive and they felt very upset by the manner in which they was spoken to during the call, so asked to speak to someone else. They was passed onto a female clinician and said that it was better.	Not Upheld	Local resolution sought	Attitude of Staff

9651	Reading	CAMHS - Learning Disabilities	Attitude of Consultant, very unsupportive when the YP was clearly distressed. Dr did not provide perscription as mother questioned whether she would be happy for the YP to take this. Family would like to see a different consultant	Not Upheld	Closed as local resolution	Attitude of Staff
9657	Wokingham	District Nursing	DECEASED PT - continence assessment did not take place from the community nurses, family wish to know why not as they feel it could have made the pt more comfortable leading to their death	Partially Upheld	There were delays in the assessment being carried out, someone has now been recruited to the role which has significantly reduced the waiting times. The confusing messaging has been addressed and a leaflet will be provided in future. There was also a communication issue which led to confusion.	Care and Treatment
9629	Windsor, Ascot and Maidenhead	CAMHS - Anxiety and Depression Pathway	Lack of Psychiatric cover in ADTT, pt in need but no one able to assess	Partially Upheld	There was a wait for treatments to commence however, this was in the context of finding the correct service to treat the patient, each of which had a waiting time. There are two part time psychiatrists in the ADTT however one has been absent long term due to sickness and the team had been unable to secure a temporary replacement. This has led to an increased wait for patients but every effort was made to recruit.	Care and Treatment

9670	Reading	Psychological Medicine Service	Pt seen by W/C Dr who allegedly said there was nothing wrong with them. They were admitted to hospital for a week the next day	Partially Upheld	It was found that the proper examinations were carried out but that support could have been given to help the patient attend the emergency department. Apologies were made for the staff's attitude but they made it clear it was not their intention to be dismissive.	Care and Treatment
9561	Wokingham	Community Hospital Inpatient Service - Windsor Ward	Unhappy with the response would like points reviewed ORIGINAL BELOW Discharge planning and care 1.Delivery and proper functioning of all necessary equipment. 2.A clear and immediate plan for community physiotherapy. 3.Assurance of continued care and support to ensure both pt and carer's well-being.	Partially Upheld	The husband was involved in the discharge planning process and proper checks were carried out to ensure the equipment worked in the home. There was some equipment that was not delivered on time but assessments were made on the furniture in the homes which were found to be useable. There was learning around communication with the family.	Care and Treatment

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

9705	Bracknell	CMHT/Care Pathways	Incidents took place at Thornford Park Hosptial where the pt was place by BCMHT OAP. Pt believes as we were responsible for their care we should provide the response	Not Upheld	Luggage was not sent by CMHT or other BHFT staff. This concern will need to be discussed directly with Thornford Park as we have no record of where the suitcase may have originated from. Staff mentioned are not an employee of BHFT, we are not aware of the incident mentioned and direct the complainant to Thornford Park Prescribing at Thornford Park was the responsibility of the Responsible Clinician on the ward of Thornford Park. The ward doctor did liaise with the community doctor as per good practice but Clopixol was not prescribed by the community team and this was the decision of Thornford Park. Therefore, it would be most appropriate to discuss this concern directly with Thornford Park.	Care and Treatment

9697	Reading	Adult Acute Admissions - Bluebell Ward	staff mixed up the pt's, solicitor letter not passed on, incorrect medication administered, no escorted leave, inaccurate info added to records, missing property	Partially Upheld	There were delays in the patient receiving their post and the ward are trying to recruit and administrator to support with this. As part of the admission process on the ward patient's belongings should be documented and listed however, this documentation was missing in this case. The ward is also reviewing its processes around documenting patient property on admission to try and avoid any future occurrences of property going missing. The ward are exploring ways of ensuring fobs are returned when patients leave the hospital in order to minimise the number that are lost which then impact on those coming into the ward at a later stage.	Care and Treatment
9638	Reading	Adult Acute Admissions - Daisy Ward	Historic sexual assault on the ward	Upheld	There is evidence that action was taken following the incident however, the patient was not removed from the ward and continued to harass the patient. The investigation found they would now move the patient immediately if anything like this was to happen again. There is no evidence that the call bell was pushed by the patient however, the ward do not check if they are working so there is no way to know if it was broken on the day	Abuse, Bullying, Physical, Sexual, Verbal
9361	Reading	CAMHS - ADHD	Extreme behaviour from all the YP x 3, parent does not know what to do but wants to change the therapist	Not Upheld	Closed due to time and family not engaging with the process	Care and Treatment

9663	Reading	Psychological Medicine Service	Unhappy with the way the clinican dealt with them whilst in A&E causing great distress	Not Upheld	The recollection of the conversation differs between the patient and the two members of staff in attendance. It was found that information about the patient suicidality was shared with her mum. This was because of the risk the patient posed to herself and the staff felt it was important her mother was aware. This was done to mitigate risk and after much forethought. The mother told staff she was already aware of this.	Care and Treatment
9723	Reading	Immunisation	Parent feels the form to withdraw consent for YP vaccines at school is too ambiguous	Partially Upheld	The current generic letter sent to the person(s) with parental responsibility gives two options: To consent via QR code for flu nasal spray or to give consent via QR code for injectable flu. There is no separate QR code to not give consent. The only way to not consent at present is to click into the consent QR code to then advise that you do not consent. It was accepted that this is ambiguous so as to make this easier and clearer in future the immunisation team are amending the current letter to request that parents/legal guardians complete a yes or no consent. A yes or no consent form would only be completed by a member of the immunisation team if the person(s) with parental responsibility has requested and agreed for the team to complete this on their behalf, either verbally or in writing.	Communication

9714	West Berks	Community Dental Services	Pt not afforded a private and confidential space to discuss concerns regarding appts	Upheld	The first appointment was booked on a day the Dentist did not work. This was an error due to the receptionist is new in post. They have now received additional support. The rebooking of the appointment resulted in an incorrect appointment letter where the appointment day and date did not match. There is a problem with the dental software and this has been escalated. All of the staff have been been reminded this is an issue and of the importance of checking the details. There is no designated quiet areas at West Berkshire Community hospital for patients to speak confidentially with staff. This has been escalated to Estates to explore future options.	Communication
9712	Reading	IMPACTT	Pt felt interrogated by therapist and believes they used the session to transfer their own worries onto the pt in the group therapy session. Pt feels they can no longer trust therapists	Partially Upheld	It was found that letters the patient received were of poor quality and this is being reviewed by the service. The group is patient led so had there been any specific topic they wished to raise they had the freedom to do this. The incident complained about is recalled differently by the staff in attendance.	Attitude of Staff

9701	Reading	Out of Hours GP Services	Dr recommended Ibruprofen to an asthma pt causing distress and potential hard to the pt	Not Upheld	The clinician did not prescribe steroids as his medical assessment was that the problem was musculoskeletal and not due to asthma. He was aware of the side effects needlessly prescribing steroids could have and therefore recommended alternative options. The patient was concerned that the clinician had recommended ibuprofen which negatively impact his asthma however, the clinician remembered mentioning that ibuprofen was counter indicated in cases such as this patient and did not at any stage recommend that he takes them. The complainant believes the clinician should have had information on his previous medical conditions however, this is contained within his GP medical record and not available to the out of hours clinician	Medication

9719	Windsor, Ascot and Maidenhead	Out of Hours GP Services	Family feel the Dr's dismissive attitude and resulting care is to blame for the pt's current medical presentation of their foot	Partially Upheld	The triaging GP considered circulatory issues as a differential for toe discolouration. The assessing GP checked for vascular occlusion. Signs pointing towards this possibility include the absence of peripheral lower limb pulses in key areas (popliteal, posterior tibial and dorsalis pedis) as well as appearance of a cold and pale foot. Limbs showing signs of critical ischaemia feel cool to touch and show lack of palpable pulses. Such signs being absent led the Doctor to conclude an alternative cause for the discoloration. That is of mechanical bruising aggravated by the use of DOACS or anticoagulants increasing susceptibility to bruising. This was unable to be verified due to patients Alzheimer's	Care and Treatment

9666	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	1.Signature Care Home Ascot – Email regarding bruising and body marks. 2.Communication – If you asked three different people the same question who all were involved with his care you would get three different answers. 3.Communication – Being sent to Wexham Park Hospital without informing anyone in the family and then the A&E doctor ringing late at night asking if they knew why he had been sent. Returned to St Marks at 4am in the morning. 4.Infectious Control – Urine Infections, Gallbladder infection and C Diff infection all within 6 weeks. 5.Care and Respect – Pt was shaven at SMH but not with their own cut protective shaver but with a hospital shaver that cut their face to pieces	Not Upheld	Withdrawn	Communication

9710	Reading	CAMHS - Rapid Response	family felt the clinician communicated poorly with the pt and family whilst in RBH A&E on 8/10/24 and they did not understanding the pt diagnosis of PDA	Partially Upheld	The clinician felt she had lost her professionalism and admitted to shouting at the complainant. She was mindful she had not responded appropriately in the meeting and has reflected on this. Other elements of the conversation are recalled differently by the complainant and the staff member involved but this does not detract from the overarching fact that the meeting should not have been the cause of so much upset and distress.	Attitude of Staff
9737	Reading	Urgent Community Response - UCR	Pt under UCR for a week from 8 October. On evening of 11 Oct 2 wedding rings were forcibly removed from the Pt's left hand in the dark. Incident reported to the police	Not Upheld	Police investigation	Patients Property and Valuables

9732	Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Complaint feel the response is inadequate and wishes further points addressed ORIGINAL COMPLAINT BELOW patient with Cellulitus discharged from WPH to HT on 4th Oct. Dr's seemed not to be aware of the pts condition. Pt discharged back to WPH on 16th Oct and UKHSA contacted family the next day re IGAS. Family also unhappy with the attitude of staff on the ward. They do not want them readmitted to HT under any circumstances.	Partially Upheld	It was found that body mapping was completed upon admission which did not show any signs of cellulitis. There was learning for the ward around keeping proper records of patients bowel movements as some were missing from this patients records. It was found that the complainant was not informed her mother was deteriorating as this happened over night and she was improving however, she did become unwell again and needed to be taken to an acute hospital. Communication training has also taken place to support ward staff with having empathetic conversations with staff.	Care and Treatment
9650	Reading	Adult Acute Admissions - Rose Ward	Complainant states a private conversation with the Dr regarding the pt has been relayed to the pt putting the family relationship in jeopardy. Complainant concerned for when pt is discharged	Not Upheld	Information can be shared for reports and used for care and risk planning along with legal proceedings for lawful purposes. The does not mean that families cannot request that information is not shared, however if the information is deemed to be affecting the patient's risk, decisions can be made to share for purposes of managing risk and the safety of the patient.	Confidentiality

9617	Wokingham	CAMHS - Specialist Community Teams	Parent unhappy with the lack of support and treatment being offered to the YP	Not Upheld	It is accepted that waiting times are longer than we would like however, the patient has now had an assessment for their autism and is due to have an ADHD assessment early next year. All the previous assessments that were carried out were done so in line with the patients presentation at the time.	Care and Treatment
9716	Slough	Psychological Medicine Service	WPH Lead - Discharged from A&E after 2nd suicide attempt in 6 months. Complainant unhappy the MH assessor did not speak to them at all as NOK	Upheld	The investigation found that the assessment by the Mental Health Nurse was in depth and thorough and they were able to articulate the rationale for their plan following the assessment. The patient asked for the complainant not to be called upon discharge as he was aware she was resting at home with the children and did not want to disturb her. The complaint has been discussed in detail with the mental health nurse and he is understanding of the issues raised.	Discharge Arrangements

Appendix 2: complaint, compliment and PALS activity

All formal complaints received

	2023/24						2024/25							
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Q1**	**Q2**	**Q3**	**Compared to previous quarter**	**Q3 no. of contacts**	**% contacts Q3**	**Total for year**	**% of Total**
Acute Inpatient Admissions – Prospect Park Hospital	10	2	4	7	23	**8.19**	8	3	11	↑	174	1.57	22	**12.09**
CAMHS - Child and Adolescent Mental Health Services	8	11	7	9	35	**12.46**	10	13	3	↓	5868	0.22	26	**14.29**
CMHT/Care Pathways	16	6	13	14	49	**17.44**	12	13	7	↓	5517	0.24	32	**17.58**
Common Point of Entry	1	3	0	0	4	**1.42**	2	3	0	↓	816	0.37	5	**2.75**
Community Hospital Inpatient	1	2	5	4	12	**4.27**	4	4	4	No change	514	2.22	12	**6.59**
Community Nursing	3	6	5	3	17	**6.05**	6	3	1	↓	16846	0.02	10	**5.49**
Crisis Resolution & Home Treatment Team (CRHTT)	5	10	5	6	26	**9.25**	5	3	2	↓	4270	0.07	10	**5.49**
Older Adults Community Mental Health Team	1	2	1	0	4	**1.42**	1	0	0	No change	1521	0.00	1	**0.55**
Out of Hours GP Services	1	2	7	4	14	**4.98**	2	2	3	↑	1823	0.11	7	**3.85**
PICU - Psychiatric Intensive Care Unit	0	0	1	0	1	**0.36**	0	2	2	No change	0	100.00	4	**2.20**
Urgent Treatment Centre	1	1	2	1	5	**1.78**	1	0	0	No change	1306	0.00	1	**0.55**
Other services during quarter	21	19	25	26	91	**32.38**	17	18	17	↓	50213	0.04	52	**28.57**
Grand Total	68	64	75	74	281	100	68	64	50				182	

Informal Complaints received

	Month Received			
Division	**October**	**November**	**December**	**Grand Total**
Children, Young persons & Families	5	1	2	8
Community Mental Health East		1		1
Mental Health Inpatients			2	2
Mental Health West	3		1	4
Physical Health	1	2		3
Grand Total	**9**	**4**	**5**	**18**

Locally resolved concerns received

	Month Received			
Division	**October**	**November**	**December**	**Grand Total**
Children, Young persons & Families	5		4	9
Physical Health	11	5	10	26
Grand Total	**16**	**5**	**14**	**35**

KO41a Return

NHS Digitals are no longer collecting and publishing information for the KO41a return on a quarterly basis but are now doing so on a yearly basis. We submitted our information when requested however when reviewing the first annual report from NHS Digital, they are no longer reporting to Trust level. The Head of Service Engagement and Experience has queried this and is still awaiting a response in terms of being able to benchmark our activity.

Formal complaints closed.

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

Outcome of formal complaints closed

	2023/24				2024/25					
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Higher or lower than previous quarter**	**Total for year**	**% of 24/25**
Consent not granted	0	0	0	0	0	1	0	↓	1	0.64
Locally resolved/not pursued	0	4	1	3	0	1	1	No change	2	1.27
Not Upheld	20	25	30	25	19	24	29	↑	72	45.86
Partially Upheld	22	26	24	32	9	29	19	↓	57	36.31
Upheld	11	9	12	9	12	3	7	↑	22	14.01
SUI	0	0	2	2	1	1	1	No change	3	1.91
Grand Total	**53**	**64**	**69**	**71**	**41**	**58**	**57**		**157**	

46% of complaints closed last quarter were either partly or fully upheld in the quarter (compared to 55% in Q2 and 51% in Q1). These were spread across several differing services with no themes identified.

Complaints upheld and partially upheld

	Main Subject of Complaint							
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Access to Services**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Discharge Arrangements**	**Waiting Times for Treatment**	**Grand Total**
Admin teams and office based staff					1			1
Adult Acute Admissions - Bluebell Ward				1				1
Adult Acute Admissions - Daisy Ward	1							1
Adult Acute Admissions - Rose Ward					2			2
CAMHS - ADHD							1	1
CAMHS - Anxiety and Depression Pathway				1				1
CAMHS - Rapid Response			1					1
CAMHS General				2	1			3
CMHT/Care Pathways		1	1			1		3
Common Point of Entry			1					1
Community Dental Services					1			1
Community Hospital Inpatient Service - Henry Tudor Ward				1				1
Crisis Resolution and Home Treatment Team (CRHTT)		1						1
District Nursing				1				1
Immunisation					1			1
IMPACTT			1					1
Mental Health Integrated					1			1

	Main Subject of Complaint							
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Access to Services**	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Discharge Arrangements**	**Waiting Times for Treatment**	**Grand Total**
Community Service								
Out of Hours GP Services			1	1				2
Psychological Medicine Service				1		1		2
Grand Total	**1**	**2**	**5**	**8**	**7**	**2**	**1**	**26**

Care and Treatment complaint outcomes

	Outcome of Complaints about Care and Treatment				
Service	**Not Upheld**	**Not Upheld**	**Partially Upheld**	**Upheld**	**Grand Total**
Adult Acute Admissions - Bluebell Ward			1		1
Adult Acute Admissions - Daisy Ward	2				2
Adult Acute Admissions - Rose Ward	1				1
CAMHS - ADHD	1				1
CAMHS - Anxiety and Depression Pathway			1		1
CAMHS - Rapid Response	1				1
CAMHS - Specialist Community Teams	1				1
CAMHS General	1		1	1	3
CMHT/Care Pathways	3	1			4
Community Hospital Inpatient Service - Henry Tudor Ward			1		1
District Nursing			1		1
Integrated Pain and Spinal Service - IPASS	1				1
Other	1				1
Out of Hours GP Services			1		1
PICU - Psychiatric Intensive Care - Sorrel Ward	1				1
Psychological Medicine Service	1		1		2
Grand Total	**14**	**1**	**7**	**1**	**23**

PHSO

There have been 3 new complaints brought by the PHSO in Q3 and four cases to remain open with them.

The table below shows the PHSO activity since April 2024:

Month opened	Service	Month closed	Current stage
Apr-23	CMHT/Care Pathways	Sep-23	LGO not progressing, but now with PHSO to consider
Jul-23	CMHT/Care Pathways	July-23	PHSO have reviewed file and are not progressing
Jul-23	CAMHS – Specialist Community Team	Aug -23	PHSO have reviewed file and are not progressing
Sep-23	CRHTT	Oct-23	PHSO have reviewed file and are not progressing
Sep-23	CAMHS	Oct-23	PHSO have reviewed file and are not progressing
Nov-23	Neurodevelopmental services	Nov-23	PHSO have reviewed file and are not progressing
Dec-23	Heart Function	Dec-23	PHSO have reviewed file and are not progressing
Feb-24	CAMHS - Specialist Community Team	Awaiting update	PHSO have requested further information
Feb-24	CAMHS - Specialist Community Team	June-24	Apology given and closed by the PHSO
Sept-24	Community Dental Service	Ongoing	Documents sent to PHSO
Sept-24	CMHT/Care Pathways	Ongoing	Documents sent to PHSO

Month opened	Service	Month closed	Current stage
Oct-24	Older Adults Inpatient Service - Rowan Ward	Ongoing	Documents sent to PHSO
Oct-24	IPS - Individual Placement support	Ongoing	Small financial remedy offered
Dec-24	District Nursing	Ongoing	Documents requested by PHSO

CQC

At the point of triage, the Mental Health Act (MHA) complaints team within the CQC will consider whether any of the concerns raised could be dealt with as an early resolution by Trusts.

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

In Q3 we received one complaint via the CQC.

Compliments

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

Year	2023/24					2024/25				
Quarter	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Received	1091	1229	1408	1399	4036	1237	1012	1289	-	3538

Patient Advice and Liaison Service (PALS)

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

PALS has continued to facilitate the ‘Message to a loved one’ service, which involves collating messages for patients, which are then delivered on the ward. This is available across all inpatient areas. The PALS Manager continues in the role Armed Forces Service Network champion. PALS is also responsible for responding to postings on the NHS website which refer to Trust services. 3 postings were responded to during this period:

District Nursing (Reading). Positive. Care from PICC Line nurse.

WBCH MIU. Positive. Excellent care. Very efficient.

Talking Therapies. Negative. Unhappy with wait and interaction with therapist.

There was 1 posting on the Patient Opinion website:

CAMHS AAT. Negative. Parental concerns about lack of support whilst waiting for an assessment.

Arrangements have been made to attend community meetings on wards at Prospect Park Hospital and in the community. A visit to a supported living service has been arranged for February following an invitation to talk about PALS and PPI opportunities. Office space has been identified at Prospect House and Wokingham Hospital.

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

There were 705 queries recorded during Quarter 3. An increase of 46 since Quarter 2. 695 of these queries were acknowledged within the 5 working day target. The recording of queries has improved with the involvement of other team members. Team members have been working with the PALS Manager to familiarise with the response and recording processes. The volume of calls and e mails coming into the service continues to be high.

The Patient Experience Team has undertaken work to standardize and streamline the PALS process, to make it more user friendly for the wider team and enable the service to be covered consistently during the absence of the PALS Manager. Via the QMIS process we have implemented and updated Standard Works which help to provide consistency and continuity and adopted a skills matrix which highlights areas where individuals may need support. The PALS organisational policy has also been updated.

To publicise the PALS service across the Trust, a meeting has been held with the Learning and Development team and the complaints manager. It has been agreed that the Patient Experience Team will be allocated space on the induction process. The Patient Experience Team will be convening to discuss the content to be put forward.

We have also refined the number of queries which need to be recorded on Datix, replacing this with a method which enables us to record more quickly and efficiently. To do this we have introduced Excel spreadsheets to capture queries which do not necessitate recording on Datix. These include queries relating to HR, Estates/Site Services, Access to Medical Records and Pensions/Finance.

PALS has a volunteer on a part time basis, and this has improved direct access to the service. The volunteer is also recording queries which has improved the rate of data collection. Our volunteer has also helped to raise the profile of the service by providing services with publicity and information. They have also taken part in 15 Steps visits. The PALS manager has produced a volunteer Role Description to standardise the expectations of volunteers and their input.

In addition, there were 338 non-BHFT queries recorded. Another member of the Patient Experience Team is consistently helping with the recording process to improve the rate of data collection.

Meetings have been held with THE IA Transformation Specialist to develop an automated response method when dealing with non BHFT queries. A financial appraisal was held, and it was determined that the PALS Manager will undertake the Citizen Development Programme to implement an MS Form for the website. It is hoped that this will provide a timelier response for patients and the public and free up more time to develop our service.

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

Service	Number of contacts.
CMHT Care Pathways	44
CAMHS AAT	28
MSK Physiotherapy	22
Continence	21
CAMHS ADHD	20
District Nursing	18
CDS	15

Appendix 3

15 Steps; Quarter Three 2024/25

The 15 Steps programme was relaunched in April 2024, and during quarter three, there were 10 visits:

Mental Health Services Division		
Prospect Park Hospital		
Ward	**Positives**	**Observations**
Oakwood	The area from the lift was colourful, with a visitors sign in book and information for carers. Staff were friendly when they came to the door. The ward was well decorated and appeared to be well maintained. There is a donation box. Coffee machine and table at entrance for visitors/carers. The ward appeared calm and was not cluttered. There was a feedback box.	From a sensory perspective, there was a lot of humming and buzzing in the main reception area. Could the donation box be updated with the BHFT charity information. From a sensory perspective a dimmer light may be more welcoming They did not have any of the feedback forms It would be great to see more 'You said, we did' and ways to give feedback more accessible to patients and their carers. The door to a 'garden route' was open and the corridor appeared to be storage for a lot of chairs. Feedback shared with ward to address observations.
Orchid	The area from the lift route was colourful, with a visitors sign in book and information for carers. Staff were friendly when they came to the door. Information about who was on duty was clearly displayed. Wall colour choices remove the clinical look of the ward. The Community Board had information about what was happening and when. The date and time were accurate. The ward appeared calm and was not cluttered. Visual picture signage for patient areas.	If you come up via the stairs, you cannot see the duty information. Some people may not understand the term 'absconsion' on the posters on the door. The font on the Community Board was very small and it would be good to make this bigger and accessible to patients. From a sensory perspective, there were some lights not on in the corridor. A dimmer light may be more welcoming. Unable to see information board due to lighting near entrance. It would be great to see more 'You said, we did' and ways to give

	A great board about de-escalation and positive communication skills – it would be great to see this across other inpatient areas. There was information about falls awareness. Patients appeared settled with positive interactions seen with staff. The Feedback Tree which is being developed looks inviting. Staff interacted positively towards each other; positive communication seems to be a strength for the ward. Staff body language supported positive communication towards patients.	feedback more accessible to patients and their carers. Feedback shared with ward to address observations.
Bluebell	Greeted and shown around areas by the deputy ward manager who was very enthusiastic about the ward and what they were achieving. QMIS and huddle board evident Ward was clean and light/airy. No clutter. Up to date pictures of staff on the ward. Patients seen positively interacting with staff. Clear evidence of activities available for patients. Who is looking after which patient and who is on duty was clearly demonstrated for both visitors and patients. Ward seemed well organised and calm. Clear information for visitors as to times of case reviews which patients attended plus drug rounds, meal times etc. Ward felt well run and no safety issues identified. Activity boards current. Patients invited to daily huddles. Staff spoke of great activity when the European football was on which both patients and staff collaborated on. Demonstrated good interaction with patients and staff. Communal areas clean and tidy. Areas available for de-escalation.	The supervision graph was not up to date to demonstrate the work which had gone on to improve take up. This was a pity as we were told September was 97% but last year was 0. It would be great to evidence the good practice and how the ward had progressed. Ward had recently been painted a neutral colour in main area but there were multi other colours in the corridors. No signage to rooms. We were informed that a patient had removed them when unwell and they were due to be replaced. Feedback shared with ward to address observations.

Campion	Greeted positively by staff nurse and asked to sign in so ward could account for people in an emergency. Photograph board of staff was current. All nursing staff had name badges evident. Ward was quiet and calm. Evidence of QMIS/safety huddles happening regularly. Staff observed with patients in the communal area. Ward was clean and tidy with no smells. Asked to sign in (mentioned earlier). Escorted by nursing staff. Thank you cards and staff messages from patients were displayed and current. Information regarding staff well being evident.	There was no demonstration of how visitors could be assured of area being safely staffed and who was looking after patients on that shift/who was on duty. There were 2 bells to ring at the entrance but there was no instruction as to which to ring or what visitors should do. At the entrance patient full names and photographs were clearly displayed. It was felt that perhaps it should be just first name and photo to reduce ability of visitors to identify specific patients It was unclear whether patients were happy to display individual staff messages in public. Perhaps author name could be covered/removed so that patient could not be identified. No information on what was available regarding activities for patients Feedback shared with ward to address observations.
Sorrel	Bell at entrance clearly labelled with instructions and expectations for visitors. Staff member was welcoming and accommodating. We were directed to the nurse in charge. Pictures and information in the corridor leading up to the entrance. Appeared calm, well organised and no smells Uncluttered There was a clear process to utilise and ensure staff cover to the patients. Patients were involved in daily safety huddles. Rooms and facilities were basic but that ensured patient risk of self-harm was minimal. Clear evidence on reducing patient on staff assaults via QMIS.	No staff member pictures or demonstration of who/how many on duty. Records all in the office. Feedback shared with ward to address observations.
Place Of Safety (POS) 3	POS was clean, tidy and not cluttered It felt calm There was a bed and solid foam seating which appeared to be clean.	There were strong smells from the CRHTT kitchen coming through The lack of natural light, windows and colour made it feel very clinical

	There was a clock which was showing the correct time. This is a small space, to support people to be managed safely The toilet area seems large, could this be used in some way as a sensory area – or is a trolley utilised as needed? There was an iWGC QR link on the door to the main room	Due to the layout of the room, there is a small gap between the corner of the bed and seating to gain access to the toilet. From a sensory perspective, the bright lighting in the main room would have been eased with a dimmer. There was a humming in the room which could cause an issue. The iWGC QR Link was not branded as such it did not say how we value the feedback. Feedback shared with POS staff to address observations. **To note:** New POS facility is currently under construction
Physical Health Services Division		
Community Physical Health Services		
Service	**Positives**	**Observations**
Wokingham Physiotherapy Service, WBCH	All staff we saw were welcoming and friendly. There is a staff photo board with names and roles. The reception area was clean, and clear of clutter. There was relevant information on the walls. The admin area staff work in is not cluttered. The clinical cubicles were clean, well laid out and set up ready for the next patient. The clinic space was peaceful, and patients were not left waiting. 'You Said, we Did' is colourful with patient quotes. Information that is relevant to patients is easily accessible. Staff are knowledgeable about the service, what it provides and how it adapts based on patient need. There are opportunities to give feedback readily available through paper surveys and the QR codes for iWGC are visible.	There is some redecoration needed between the two noticeboards. Some of the exercise information may not be easily read by patients. They have run out of the leaflet about back pain. Feedback shared with the service to address observations made.
The Memory Clinic, WBCH	All staff we saw were welcoming and friendly. The service areas were well decorated and maintained, with calming colours. There is a staff photo board with names and roles.	The service uses two different names which can be confusing. The location of the iPad for feedback may be more accessible if placed in eyesight of people as they leave the service.

	Staff knew their patients by name and were kind. The service area was clean, and clear of clutter There was a positive buzz coming from the group that was underway. There are opportunities to give feedback. There was relevant information for carers on the walls and certificates of the service's achievements. Staff are knowledgeable about the service, what it provides and how it adapts based on patient need.	Feedback shared with the service to address observations made.
ARC, **St Mark's**	Welcoming from staff on duty. Waiting area open and airy. Pictures of staff visibly displayed. Lots of information available for patients and carers. QMIS board evidence up to date and current. Clinic rooms clean Rehab area clean with good assortment of equipment. Clear who was in charge. Atmosphere calm and relaxed. Everyone clear on what they were doing and their job role. Manager monitored IWGC and had recently had a coffee morning for feedback from patients. This was being worked through currently.	Dates would be useful as unsure how current patient feedback was. TV maybe could be on a bracket to facilitate space for information leaflets board. Some leaflets had been stuck on the wall. Some of the leaflets were out of date or from other trusts. Other area information could be adapted for our trust to use. There was a IWGC QR code on a laminate with no real information of what it was etc. Purpose was good though. Feedback shared with the service to address observations made.
East Berkshire Wheelchair Service	Welcomed positively by all staff. Open and airy waiting area with many facilities at appropriate height for wheelchair users. Pictures of staff current and clear. Calm atmosphere Staff were clear of objectives Mobility equipment and bariatric facilities available Clear who was working and who they were. Good selection of information for patients and carers which were current. IWGC actively encouraged.	Parking limited one space was blocked with bins. Some leaflets were obscured by chairs in the waiting area. Feedback shared with the service to address observations made.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

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

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

Berkshire Healthcare NHS Foundation Trust

Minutes of the Quality Assurance Committee Meeting held on Tuesday, 25 February 2025

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

Present:	Sally Glen, Non-Executive Director (Chair) Mark Day, Non-Executive Director *(deputising for Aileen Feeney, Non-Executive Director)* Debbie Fulton, Director of Nursing and Therapies Alex Gild, Deputy Chief Executive Daniel Badman, Deputy Director of Nursing for Patient Safety and Quality Tehmeena Ajmal, Chief Operating Officer 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 Reuben Pearce, Lead Nurse Consultant Theresa Wyles, Director of Mental Health Service

Opening Business

1 Apologies for absence and welcome

Apologies for absence were received from: Julian Emms, Chief Executive, Aileen Feeney, Non-Executive Director and Rebecca Burford, Non-Executive Director.

The Chair welcomed everyone 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 26 November 2024

The minutes of the meeting held on 26 November 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) Outcome of the High-Level Businesses Cases to the Integrated Care Boards for the Establishment of an Assertive Outreach Team for Reading and Slough

It was noted that the Integrated Case Board had indicated that there would be no extra funding available for the establishment of an Assertive Outreach Team for Reading and Slough. Further information was contained in the Independent Mental Health Homicide Review (Nottingham) Report on the agenda for the meeting. The action was closed.

b) Poppy Ward Update

It was noted that the Bed Management Team would be presenting to the April 2025 Trust Board Discursive meeting and therefore it was agreed that the Committee would receive an update on Poppy Ward in six months' time.

Action: Interim Chief Operating Officer

The action log was noted.

Patient Safety and Experience

5.0 NHS England's Culture of Care Programme

The Chair welcomed Reuben Pearce, Lead Nurse Consultant to the meeting.

Reuben Pearce gave a presentation and highlighted the following points:

- The Culture of Care Programme was developed as part of NHS England's Mental Health, Learning Disability and Autism Inpatient Quality Transformation Programme (2022) which was part of the NHS Long Term Plan.
- The focus was on cultural change and to develop a reimagined model of care for inpatient settings with the aim of achieving consistent access and choice of therapeutic support and for patients to be and feel safe.
- The Culture of Care Programme's vision and 12 standards were coproduced with people with lived experience, staff, patients and carers.
- The Culture of Care Programme was developed by the Royal College of Psychiatrists in partnership with the National Collaborating Centre for Mental Health, Global Back Thrive, Neurodiverse Connection and the National Confidential Inquiry into Suicide and Safety in Mental Health. Participation in the programme was voluntary (61 organisations including the Trust were currently participating in the programme)
- The four key interventions to support wards to provide safe, trauma informed, therapeutic and equity focussed care were:
    - Ward Level Quality Improvement (underway)
    - Organisational Level Quality Improvement (to start in March 2025)
    - Leadership Support (underway)
    - Personalised approach to risk (underway)
- An external Culture of Care Coach was working with three wards at Prospect Park Hospital (Sorrel, Rose, and Orchid wards). Each ward had a Quality Improvement Project Team consisting of representatives from the multi-disciplinary team and lived experience experts. Project teams were also supported by an internal Quality Improvement Coach to ensure that the Culture of Care Programme was aligned to Trust principles
- Grassroot change ideas from the wards included some practical improvements such as torch filters for night visits, more support for staff who were abused, sensory and quiet spaces, and protected time for staff to be with patients. Change ideas were mapped to the 12 core commitments of the Culture of Care Programme, providing a framework for implementing these ideas.

- The Trust was keen to integrate the Culture of Care Standards into its existing Prospect Park Hospital workstreams, for example reducing restrictive interventions, reducing physical assaults, and reducing length of stay to ensure alignment and to avoid duplication
- The Nurse Consultant Network had developed a range of different teaching strategies and tools to support the programme including:
    - "Turbo Tens" – bitesize coaching for response to learning
    - Clinical Risk
    - Sexual Safety Workshops and Champions
    - Neuro- inclusion Workshops and Champions
    - Ward Managers, Newly Qualified Nurses, Band 4 Development Programme
    - Psychosocial interventions
- The Trust's work around reducing physical assaults included zero tolerance messaging, letters to patients from the Chief Executive, Thames Valley Police attending status exchange meetings to provide advice and support, capacity assessments post incident and post incident support.
- Feedback from semi structured interviews with staff post-incident had suggested that staff felt supported by their immediate colleagues but had mixed feelings about the support provided by the senior leadership team.
- A gatekeeping project was underway to improve pre-planning for patients with a history of violence and aggression.
- Physical assaults on staff were reducing. Initial feedback from Rose ward had suggested that the introduction of ward-based activity coordinators and the "Who's caring for me?" initiative had made a significant difference.
- Work had been undertaken to ensure that the Culture of Care Programme aligned with the Trust's other key initiatives, for example, Anti-Racism Strategy, Neurodiversity Strategy, Patient and Carers Race Equality Framework, Co-production Working Group and Health Inequalities Strategy.
- The Director of Nursing and Therapies and Chief Operating Officer were receiving coaching from the national Culture of Care Programme team.

The Chair commented that the Culture of Care Programme was an umbrella term underneath which there were multiple Trust workstreams and initiatives.

The Director of Mental Health Service said that participating in the Culture of Care Programme had helped to validate the Trust's existing work programmes and provided a framework to describe the Trust's work externally.

The Director of Mental Health Service commended the work of Reuben Pearce and the Nurse Consultant Network who had skilfully identified those aspects of the Culture of Care Programme which would add the value to the Trust's work.

The Deputy Chief Executive said that it would be interesting to see if the Trust's work around the Culture of Care Programme was reflected in the national NHS Staff Survey Results.

Mark Day, Non-Executive Director asked whether the Culture of Care Programme had identified any significant gaps where additional work was required.

Reuben Pearce said that the Culture of Care 12 Standards had provided a helpful framework for the Trust to map its existing programmes of work and said that one area where the Trust needed to do more work was around more support for staff who were the subject of a sexual safety allegation.

The Director of Nursing and Therapies said that the Trust was part of a Culture of Care Network, and this provided an opportunity to share learning and ideas.

The Chair commented that the Committee would welcome another update at the end of the Culture of Care Programme.

Action: Director of Nursing and Therapies

The Chair thanked Reuben Pearce, Lead Nurse Consultant for his presentation.

The Committee noted the presentation.

5.1 Financial Planning 2025-26 – Quality Impact Assessment Process Report

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

- Quality Impact Assessment (QIA) was an embedded part of the Trust's governance processes with written guidance available that detailed when a QIA should be undertaken; this included:
    - Cost Improvement Programmes (CIPs) usually as part of the annual planning cycle
    - Service changes which had a potential impact on quality, safety, and workforce or on the working arrangements for staff; any
    - New business or commissioned changes: in these circumstances the business case or commissioned change would not be approved by the Trust Business Group until the QIA had been completed

The Chair asked which committee/group was responsible for reviewing the proposed changes to services where there was a potential impact on quality.

The Director of Nursing and Therapies said that the Quality and Performance Executive Group would review the quality impact assessments which would then be referred to the Quality Assurance Committee. The Director of Nursing and Therapies pointed out that since the COVID-19 pandemic, the Trust had not had to make any decisions which impacted on quality but said that this was likely to change given the challenging financial position for 2025-26.

The Deputy Chief Executive reminded the meeting that the Trust Chair had indicated at the February 2025 Trust Board Discursive meeting that he was keen for the March 2025 Trust Board meeting to have a full discussion about the quality impact assessments prior to the Board approving the Financial Plan 2025-26.

The Committee agreed to:

a) Note the report
b) Discuss the quality impact assessments undertaken as part of the financial planning process for 2025-26 at the May 2025 meeting.

Action: Director of Nursing and Therapies

5.2 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:

- **Perinatal Mental Health Services** had been added to the Quality Concerns Register due to operational challenges in meeting access targets, backlogs in screening and initial assessment, high caseloads, and inability to meet demand.
- **Community based Neuro-Rehabilitation Service** had been removed from the Quality Concerns Register due to an improved position in wait times.

The Committee noted the report.

5.3 National Patient Safety Alert – Bed Rails Report

The Director of Nursing and Therapies presented the paper and reported that the Trust was taking a proportionate approach to the National Patient Safety Alert regarding bed rails, along with other local authority and health colleagues. This included sending out letters to all patients who had been prescribed grab rails over the last three years (following a review of the data to ensure that patients were still alive and were still living in the area). The letter offered a patient assessment, where to contact if they wanted this now or in the future and also to inform us if they did not still have the grab handle that was prescribed.

It was noted that the total number of patients requesting a review to date was 50 with 44 reviews completed.

The Director of Nursing and Therapies reported that work was ongoing across the system to establish a process for reviewing patients in the community no longer open to a clinical team. The challenge had been escalated thought to regional safety and quality groups through the Integrated Care Board.

It was noted that the required training package was now in place with relevant staff being asked to complete this by the end of March 2025.

The Chair commented that she fully supported the proportionate approach being taken by the Trust.

The Committee noted the report.

5.4 Sexual Safety Highlight Report

The Director of Nursing and Therapies presented the paper and commented that the Trust had undertaken a significant amount of work across the Trust to reduce sexual safety related incidents for staff and patients.

It was noted that the work being progressed across the Mental Health Inpatient Services in relation to sexual safety was underpinned by the Royal College of Psychiatry, Sexual Safety Collaborative Standards and Guidance (2020) which was based around four key principles of people's rights, organisational responsibility, a trauma informed approach and safeguarding.

The Director of Nursing and Therapies reported that as part of the wider violence reduction programme of work, the Trust had signed a new NHS Organisational Sexual Safety Charter in September 2023 which committed the Trust to taking and enforcing a zero-tolerance approach to any unwanted, inappropriate, and/or harmful sexual behaviours.

It was noted that the national NHS Staf Survey now included questions on sexual safety.

The Committee noted the report.

5.5 Martha's Rule – Progress Against Implementation of an Adapted Approach for Community and Mental Health Wards Report

The Director of Nursing and Therapies presented the paper

It was noted that in February 2024, NHS England had written to all provider NHS trusts and integrated care boards announcing the implementation of the first phase of Martha's Rule. Whilst the first phase of implementation was focused on acute providers, NHS England had been clear that they would be looking to implement an adapted form of Martha's Rule for Community and Mental Health services.

The Director of Nursing and Therapies reported that the Trust had decided to work on finding our own solution to the implementation Martha's Rule than waiting for national direction.

The Director of Nursing and Therapies said that the paper set out the Trust's current plans for implementation of processes whereby patient families, friends and staff had a way of escalating outside of the ward where they did not feel that their concerns had been heard.

It was noted that for mental health wards, the processes would be piloted from the end of February 2025. For community health wards, there were proactive conversations and planning in place to agree a workable solution. It was more challenging given the geography of the wards and it was likely that an in hours solution would be piloted initially.

The Director of Nursing and Therapies reported that there was significant interest nationally about the Trust's adapted approach of Martha's Rule. It was noted that NHS England had commissioned the Health Innovation Hub to support acute trusts to implement Martha Rule but was also supporting the Trust's Martha's Rule pilot on mental health wards.

The Chair asked whether the use of Martha's Rule would be tracked.

The Director of Nursing and Therapies said that the national outcome measures were largely acute based and reported that the Trust was working with the Health Innovation Hub to develop measures relevant to Mental Health trusts.

The Medical Director commented that it was important to acknowledge the potential health inequalities aspects of Martha's Rule especially vulnerable patients who did not have regular visits from friends and family who could raise concerns on their behalf and where language was a barrier etc.

The Director of Nursing and Therapies pointed out that staff concerned about a patient could also advocate on behalf of the patient if they had concerns.

Mark Day, Non-Executive Director commended the Trust's leadership for taking the initiative by developing an adaptive approach of Martha Rule for Mental Health Wards. Mr Day asked whether any other Mental Health trusts had developed an adaptive approach to Martha's Rule.

The Director of Nursing and Therapies said that she thought the Trust was the first to apply Martha's Rule to a mental health setting. The Director of Nursing and Therapies added that the Trust was grateful for the support provided by the Health Innovation Hub who would also be evaluating the Trust's pilot.

The Chair added her thanks to the Trust's leadership team for their innovative work in adapting Martha's Rule.

The Committee noted the report.

5.6 Prevention of Future Deaths Action Plan Update Report

The Deputy Director of Nursing for Patient Safety and Quality presented the paper and pointed out that most of the outstanding actions in relation to the Coroner's Prevention of Future Deaths reports related to the full implementation of the One Team approach across community mental health services. There were no areas where progress was not being made against the agreed actions.

The Deputy Director of Nursing for Patient Safety and Quality said that the One Team approach was operational but changes such as the move away from the Care Programme Approach (CPA) to the Name Worker system was a significant undertaking and further work was needed before the Trust was confident that the changes had been embedded across the Trust. It was noted that the first audits of the new risk process which included a streamlined safety plan were underway.

The Chair noted that a Prevention of Harm to Others Steering Group had been set up to review patients who were potentially at risk of harming others and asked whether a multi-disciplinary team approach would be taken.

The Director of Mental Health Service said that the Prevention of Harm to Others Steering Group had been set up in the wake of the Forbury Gardens incident and included representation from Thames Valley Police, Forensic Services, Criminal Justice System, and the Probation Service.

The Director of Mental Health Service reminded the meeting that one of the recommendations from the Independent Mental Health Homicide Review (Nottingham) Report was around the establishment of Assertive Outreach Teams, but the National Planning Guidance 2025-26 had not included any additional resources for this work. As a result, the Trust would need to refine the cohort of potential patients at risk of harming others.

The Chair asked when the Committee would receive an update on the action plan.

The Director of Nursing and Therapies confirmed that an update would be presented to the August 2025 meeting.

Action: Director of Nursing and Therapies/Company Secretary

The Committee noted the report.

5.7 Independent Mental Health Homicide Review (Nottingham) Report

The Director of Mental Health Service presented the paper and highlighted the following points:

- In September 2024, NHS England had instructed Integrated Care Boards to collaborate with all Mental Health Trusts to formulate a costed proposal for Assertive Outreach Team and Intensive Case Management.
- In response, the Trust conducted a Community Mental Health Team review maturity index to evaluate the Trust's standing across 14 domains. This also included information related to assertive outreach and intensive support, guidance on dual diagnosis and substance misuse, risk assessment processes and DNA/cancellation/missed contacts procedures.
- An action plan was developed following this self-assessment exercise and was under regular review.
- In November 2024, the Trust submitted a funding proposal to NHS England to set up an Assertive Outreach Team model. The Trust had expected some dedicated investment, but this was not included in the National Planning Guidance.
- The Trust's focus was now on adapting and enhancing its approach to meeting the needs of this patient population within existing resources.
- The Independent Homicide Review Report (Nottingham) was published in early February 2025 and NHS England wrote to all Mental Health Trusts detailing specific actions in response.
- Key areas of focus included:
    - Personalised risk assessments across community and inpatient teams
    - Joint discharge planning involving the person, their family, the inpatient team, and the community team along with other involved agencies
    - Multi-agency collaboration and information sharing
    - Working closely with families
    - Eliminating Out of Area Placements in line with the Integrated Care Board's three-year plan.
- The Mental Health Divisional leadership team would be monitoring the work around this patient cohort through a dedicated workstream of the Prevention of Harm to Others Steering Group.

John Barrett, Patient Safety Partner asked whether the Integrated Care Board's three-year plan to eliminate Out of Area Placements referred to placements outside of the Integrated Care Board's geographic area or referred to placements outside of Prospect Park Hospital.

The Director of Mental Health Service confirmed that the Integrated Care Board wanted patients to be treated closer to home and not hundreds of miles away.

The Director of Nursing and Therapies reported that NHS England's letter to Mental Health Trusts included a requirement for the full Board to discuss Trust's responses to the Independent Mental Health Homicide Review (Nottingham) Report.

Action: Director of Mental Health Services/Company Secretary

The Committee noted the report.

5.8 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 the Trust was doing some more work on the DATIX online incident reporting system including developing a feedback function so people reporting incidents were informed how managers had responded to the incident.

The Deputy Director of Nursing for Patient Safety and Quality said that the Trust was also doing some work around influencing the system to develop more effective multi-agency working.

The Chair commented that the Trust had clearly undertaken a significant amount of work to implement the National Patient Safety Strategy and asked going forward whether the Committee should continue to receive quarterly progress reports.

The Director of Nursing and Therapies said that the National Patient Safety Strategy was now business as usual and proposed including any updates as part of the Patient Safety Incident Response Framework quarterly report. The Director of Nursing and Therapies added that the Patient Safety Specialist now attended each meeting, and the Committee had the option of requesting more detailed presentation on key aspects of the strategy if and when required.

Action: Deputy Director of Nursing for Patient Safety and Quality/Company Secretary

The Committee

a) Noted the report.
b) Agreed that updates on the implementation of the National Patient Safety Strategy would be included in the Patient Incident Response Framework quarterly reports.

5.9 Patient Safety Incident Response Framework Report on Trends and Learning

The Patient Safety Incident Response Framework Report on Trends and Learning had been circulated.

The Committee noted the report.

5.10 Patient Safety Syllabus Level 3 and 4 – Learning for the Patient Safety Specialists

Tiziana Ansel, Patient Safety Specialist gave a presentation and highlighted the following points:

- All staff were required to complete the Patient Safety Syllabus Levels 1 and 2 training.

- The Patient Safety information on the staff intranet had been updated to include several resources and bite size training videos to support staff and to promote that patient safety was everyone's responsibility
- Patient Safety Specialists were required to complete the Patient Safety Syllabus Levels 3 and 4 programme which was a 9–12 month university course.
- The five key components of the course were:
    - Unpacking system issues
    - Risk analysis and resilience
    - Cultural, legal, and regulatory factors
    - Involving those affected
    - Designing solutions
- The Patient Safety Incident Response Framework had four pillars: proportionate responses, applying system approaches, compassionate engagement, and oversight.
- A key focus of the course was around moving away from a simplistic view of the healthcare system and incidents to the application of human factors ergonomics system thinking approach and its frameworks to patient safety incident learning responses
- The Trust was integrating Human factors ergonomics system thinking into Quality Management Information System (QMIS) methodology.

The Chair thanked the Patient Safety Specialist for her presentation and commented that she was pleased that the Trust was integrating the learning from the Patient Safety Syllabus Levels 3 and 4 training into the Trust's Quality Improvement Programme and other improvement initiatives.

The Committee noted the report.

5.11 Infection Prevention and Control Quarterly Report

The Infection Prevention and Control Quarterly Report had been circulated.

The Committee noted the report.

5.12 Quality Related Board Assurance Framework Risks Report

The quality related Board Assurance Framework Risks had been circulated.

It was noted that the full Board Assurance Framework had been presented to the January 2025 meeting of the Audit Committee.

The Committee noted the report.

5.13 Learning from Deaths Quarterly Report

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

- Of the second stage reviews concluded in quarter 3, none of the deaths were a governance cause for concern. Eight reviews had identified poor care, and learning had been identified and was being implemented through the relevant divisions.
- All complaints received from families of individuals who had died had resulted in a second stage review of the care provided. No concerns were raised by the Medical Examiner on behalf of the next of kin.
- Ten 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)

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

The Chair referred to the ethnicity data and commented that there had been 14 second stage reviews for Asian and British Asian people and asked whether this was a disproportionately high number compared with the demography of the local population.

The Medical Director commented that it was difficult to draw this conclusion from the ethnicity data because the numbers were so small. The Medical Director said that if a theme was identified around certain ethnicities having a higher proportion of care rated poor, that would be meaningful but pointed out that this was not the case.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Clinical Audit Report

The Medical Director reported that since the last meeting the following national audits had been published and reviewed at the Clinical Effectiveness Group:

- National Clinical Audit of Psychosis – Early Intervention in Psychosis Re-Audit 2023-24
- POMH 16c: Rapid Tranquilisation in the context of the pharmacological management of acutely disturbed behaviour
- National Audit of Dementia – Memory Assessment Services Spotlight Re-Audit 2023
- National Respiratory Audit Programme – Pulmonary Rehabilitation Organisational Report
- National Audit of Inpatient Falls and Fracture Audit Report
- Sentinel Stroke National Audit Report

a) **National Clinical Audit of Psychosis – Early Intervention in Psychosis Audit Re-Audit 2023-24**

It was noted that there were separate audits for adults and children this time round and that this had identified that there were further improvements needed to be made to the Children and Young People's Early Intervention in Psychosis service.

The Trust's overall score for Adult Early Intervention in Psychosis was "performing well." Standard 3 (Family Intervention) was rated as "needs improvement" and an action plan was being implemented.

The audit identified three areas requiring improvement as set out below in relation to the Children and Young People's Early Intervention in Psychosis service and an action plan was in place.

- percentage of service users with first episode psychosis that took up Cognitive Behavioral Therapy for Psychosis (Greatest need for improvement)
- Percentage of service users with their first episode of Psychosis who had had a physical health review and relevant interventions in the last year (Greatest need for improvement)
- Percentage of service users for whom two or more outcome measures (from HoNOS/HoNOSCA, DIALOG, QPR ReQoL-10 and GBO) were recorded at least twice (assessment and one other time point) (Needs improvement)

b) **POMH 16c: Rapid Tranquilisation in the context of the pharmacological management of acutely disturbed behaviour**

Since the previous national audit in 2018 there had been an overall decrease in standards achieved, with 5 out of 8 standards scoring lower. For a further 2 standards which were new (1b and 1c), the Trust scored below the national average, and 1 standard, (standard 2) had stayed the same at 100%. The service had identified 4 key areas for improvement to address these findings.

The Medical Director explained that conversations with staff had identified that staff were probably conducting more physical health monitoring after the use of rapid tranquillisation but were not always recording this on the RiO system. Staff were also not always recording instances where patients had declined physical health monitoring checks. It was noted that staff had been reminded of the importance of recording information on the RiO system and if a patient declines, to re-visit the request.

c) **National Audit of Dementia – Memory Assessment Services Spotlight Re-Audit 2023**

There are 6 key areas of this audit where the Trust's results were either lower when benchmarked against other trusts or where there was significant variation between localities in terms of compliance with national standards.

The main area for improvement was Memory Clinic waiting times. A sustained and continued reduction in service waiting times from referral to assessment and diagnosis was a priority for the memory clinic service There was also a piece of work in progress to review the unwarranted variation across all the Berkshire Memory Clinics.

The Medical Director pointed out that the waiting times to access the Memory Clinics was a patient experience issue and did not pose a safety risk for patients.

d) **National Respiratory Audit Programme – Pulmonary Rehabilitation Organisational Report**

This is a continuous audit; the service is currently meeting the required KPI, but it was unable to meet the recommendation to offer enrolment to Pulmonary Rehab within 4 weeks post hospital admission. The waiting lists had previously been a quality concern, and the service had an on-going open action plan. Status in December 2024: 126 patients were on the waiting list and the anticipatory waiting time (the number of days, under the current circumstances, that a patient referred to today, might wait on average) for December 2024 was 171 days.

e) **National audit of Inpatient Falls and Fractures Audit Report**

A continuous audit with a small sample (4 patients). The Trust was meeting 3 of the 4 KPIs at 100%. The Trust did not meet KPI 3: Safe lifting equipment used to move the patient from the floor.

Since the 2023 data collection the Trust had reviewed the post fall protocol in line with the Royal College of Physician's guidelines to not move patients with a suspected injury and to use flat lifting equipment where available. The National report made 5 recommendations; actions had been identified for implementation.

f) **Sentinel Stroke National Audit Report**

The annual national report was published in November 2024 for the 2023/24 national data. No Trust level data was provided. The report makes 5 high level recommendations aimed at

Integrated Care Boards's and Local Health Board's, of which 2 areas were relevant to Berkshire Healthcare services.

The Committee noted the report.

6.1 Quality Accounts 2024-25 – Quarter 3 Report

The Quality Accounts Report 2024-25 – Quarter 3 Report had been circulated.

The Head of Clinical Effectiveness and Audit reminded the meeting that the Quarter 3 version of the Quality Accounts 2024-25 would be shared with stakeholders for their comments.

The Head of Clinical Effectiveness and Audit requested that members of the Committee forward any comments on the Quarter 3 Quality Accounts Report in the next week. It was noted that the final Quality Accounts Report would be circulated to members of the Committee for approval via email and would then be presented to the May 2205 Trust Board meeting for approval.

The Chair acknowledged the work that went into preparing the Quality Accounts Report.

Mark Day, Non-Executive Director said that at a recent Council of Governors meeting, new Governors had shared that they found it difficult to understand about the range of the Trust's services and commented that the Quality Accounts Report was a useful document for governors to find out more about the Trust.

The Company Secretary agreed to forward a copy of the latest published Quality Accounts Report to new Governors as part of their induction handbook.

Action: Company Secretary

The Head of Clinical Effectiveness and Audit confirmed that all Governors would receive a copy of the Quarter 3 Quality Accounts Report and any comments would be collated by the Lead Governor and would be included in the final report.

The Chair added that the Quality Accounts Report was also an excellent document for newly appointed Non-Executive Directors to receive as part of their induction documentation.

Action: Company Secretary

John Barrett, Patient Safety Partner referred to the Trust's Annual Plan on a Page 2025-26 and said that he was pleased that the Good Patient Experience section made reference to including carers in changes to services. Mr Barrett suggested that the sentence would read better if the word "partners" was replaced with the word "families" to read: "We will also include patients, carers and families as we make changes to the services."

The Deputy Chief Executive thanked John Barrett for his comments but pointed out the Annual Plan on a Page 2205-26 had already been published so it was too late to make any changes to the wording.

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. It was noted that since the last report, there had been two exception reports both had been closed with agreed time off in lieu.

The 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 27 January 2025.

The Chair noted that the meeting had had a long discussion about the Right Care Right Person initiative.

The Medical Director explained that the Committee was keen to have a better understanding of the Right Care Right Person initiative and how it was working.

The Committee noted the minutes.

8.5 Quality and Performance Executive Group Minutes – November 2024, December 2024, and January 2025

The minutes of the Quality and Performance Executive Group minutes for November 2024, December 2024 and January 2025 had been circulated.

The Committee noted the minutes.

8.6 Council of Governors Quality Assurance Group – Visits to Services

The following Governor Service Visit Report had been circulated:

- **Minor Injuries Unit, Thatcham Community Hospital**

The Director of Nursing and Therapies said that the Governors had raised the issue of the fire door at the Minor Injuries Unit, Thatcham Community Hospital and provided assurance that the fire door was not a safety concern. It was noted that a replacement fire door was on order.

The Chair thanked the Governors for their report.

Closing Business

8.0 Quality Assurance Committee Horizon Scanning

The following items were identified for future agendas:

- Talking Therapies Presentation
- Right Care, Right Place
- Poppy Ward

8.1. Any Other Business

Farewell to Minoo Irani, Medical Director and Tehmeena Ajmal, Chief Operating Officer

On behalf of the Committee, the Chair thanked Minoo Irani and Tehmeena Ajmal for their contribution to the work of the work of the Committee and for their support to her personally in her role as Committee Chair.

8.2. Date of the Next Meeting

The next meeting was scheduled to take place on 27th May 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: - 27th May 2025

Berkshire Healthcare NHS
NHS Foundation Trust

Trust Board Paper

Board Meeting Date	February 2025
Title	**Learning from Deaths Quarter 3 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 3, none of the deaths were a governance cause for concern (avoidability score of 1,2 or 3). 8 reviews identified poor care, learning is identified and being implemented through the relevant divisions. **Patient Experience and Voice** 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 on behalf of the next of kin. **Health inequalities** 10 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 Q3 learning from deaths.

Learning From Deaths Q3 Report (2024/25)

Berkshire Healthcare NHS Foundation Trust

Figure 1-	2021/2022	2022/2023	2023/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25	Total 2024/2025
Total deaths screened (Datix) 1st stage review	467	456	453	110	141	**133**	-	384
Total number of 2nd stage reviews requested (SJR/IFR)	209	192	203	54	63	**54**	-	171
Total number of deaths to be reviewed through patient safety (PSII and PSR) declared in Quarter	35	31	31	6	9	**7**	-	22
Total Expected Deaths	-	-	183	51	57	**48**	-	156
Total Unexpected Deaths	-	-	270	59	84	**87**	-	230
Total number of deaths judged > 50% likely to be due to problems with care (Avoidability score of 1, 2 or 3)(concluded in quarter)	4	0	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	**36**	-	109
Total number of deaths of patients with a Learning Disability (1st stage reviews)	51	36	53	14	12	**13**	-	39
Total number of deaths of patients with Learning Disability where care was rated as poor	0	0	0	0	0	**0**	-	0

Q3 2024/25

871 deaths were identified on RiO where a patient had died from any cause within a year of contact with any Trust service, of these 133 were submitted for a 1st stage review in line with the learning from deaths policy (15%).

All 133 deaths had first stage review by the Executive Mortality Review Group (EMRG) in Q3, 2nd Stage reviews were requested for 54 (41%). 71 2nd stage reviews were concluded by the Mortality and Patient Safety Review Group during Q3 compared to 49 in 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 Q3 8 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)	Q3 (71)	Total 2024/2025 (160)
Adult Learning Disabilities Services	10	29
Mental Health community, specialist, and inpatient services	32	74
Childrens and Young people's Services	2	3
Physical Health community and Inpatient Service	27	54

	Avoidabilty score for 2nd Stage Reviews (only death due to a physical health cause) 2024/2025	Q3 (71)	Total to date (160)
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)	5	8
Score 5	Slight evidence of avoidability	9	17
Score 6	Definitely not avoidable	30	76
N/A	Non physical health cause	27	59

	Overall Assessment of Care Q3 (71)	Physical health	Learning Disability	Mental Health	Childrens and Young People	Total to date 24/25 (160)
1	Very poor care	0	0	0	0	0
2	Poor Care	7	0	1	0	11
3	Adequate Care	16	3	15	0	59
4	Good Care	4	5	15	2	84
5	Excellent Care	0	2	0	0	5
	N/A					

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	17	10	59%
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	6	2	33%
Not Known - Waiting for first appointment/not recorded	20	5	25%
Not stated - refused	12	7	58%
Other ethnic category	5	1	20%
White - any other white background	17	10	59%
White - English/Welsh/Scottish/Northern Irish/British	299	131	44%
Total	**384**	**171**	**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	1	3	6	4	14
Black or Black British	0	0	0	0	0	1	2	3
Not Known - Waiting for first appointment/not recorded	0	0	0	0	0	1	3	4
White - any other white background	0	0	0	0	1	5	4	10
White - English/Welsh/Scottish/Northern Irish/British	0	0	0	7	13	63	46	129
Total	**0**	**0**	**0**	**8**	**17**	**76**	**59**	**160**

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

Berkshire Healthcare NHS Foundation Trust

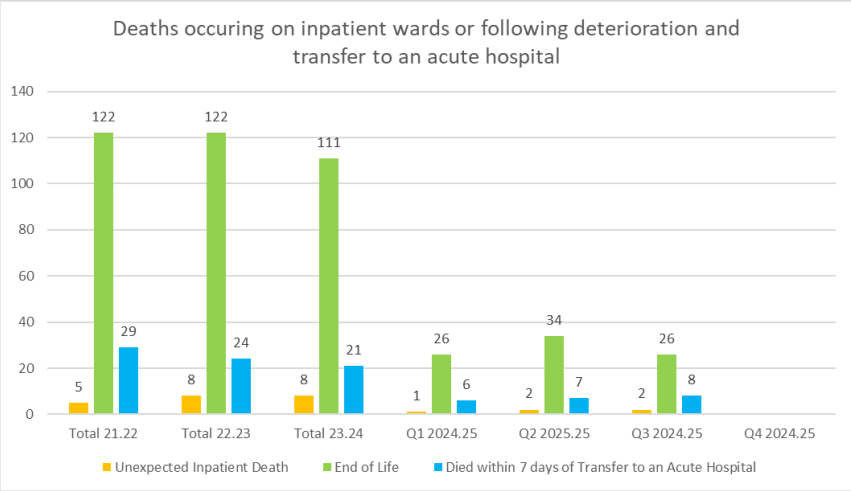
Overall Assessment of Care all 2nd stage reviews completed in 2024/25 (April - September to date will include cases reported as 1st stage reviews in 2023/24)	1 Very Poor Care	2 Poor Care	3 Adequate Care	4 Good Care	5 Excellent Care	Not Applicable	Total
Asian or Asian British	0	0	7	5	2	0	14
Black or Black British	0	0	0	3	0	0	3
Mixed - White and Asian	0	0	0	0	0	0	0
Mixed - White and Black Caribbean	0	0	0	0	0	0	0
Not Known - Waiting for first appointment/not recorded	0	0	2	0	0	0	2
Not stated - refused	0	0	0	2	0	0	2
Other ethnic category	0	0	0	0	0	0	0
White - any other white background	0	1	6	3	0	0	10
White - English/Welsh/Scottish/Northern Irish/British	0	10	44	71	3	1	129
Total	**0**	**11**	**59**	**84**	**5**	**1**	**160**

Equality & Diversity Summary Q3 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 Q3 Report



In Q3 EMRG reviewed:

- 36 deaths were reported by inpatient services, 3 by mental health wards following transfer to acute or nursing home and 33 by physical health wards .
- 26 were expected deaths and 10 were categorised as unexpected deaths. 2nd stage reviews were requested for all unexpected deaths.
- 13 2nd stage reviews were concluded in Q3. In 10 cases overall care was agreed as good or adequate with an avoidability score of 6 or 5.
- 3 cases whilst not deemed to be avoidable were classed as poor care.

Berkshire Healthcare NHS Foundation Trust

Q3 2024/25

All inpatient deaths were reviewed by the Medical Examiner and the cause of death was confirmed,.

In line with our learning from deaths policy, 2nd stage reviews are requested and reviewed for all unexpected deaths and death within 7 days of transfer.

The following learning was identified:.

- Lack of appropriate escalation of non responsive episodes
- Management of heart failure
- Wound Care
- Laxative Management and use of Bristol stool chart
- Communication of diagnostic information
- Bowel care management

Learning is addressed through the divisions.

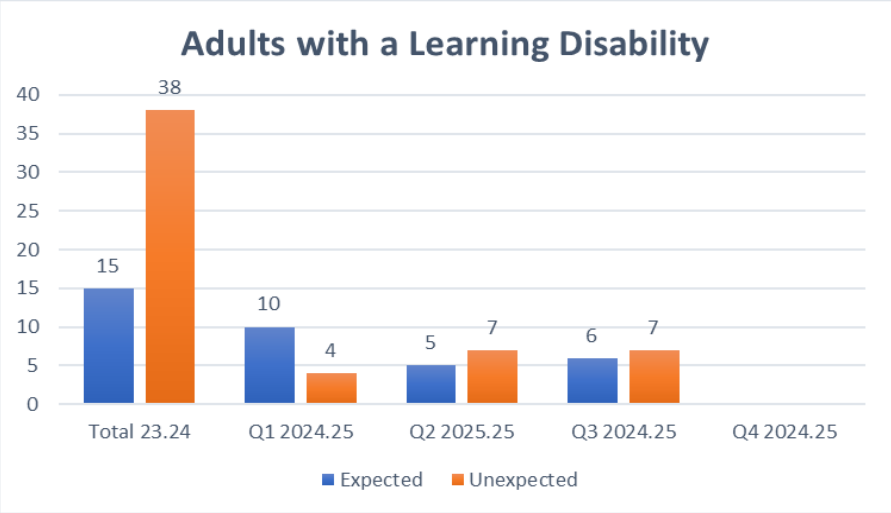
All Inpatient deaths are independently scrutinised by a Medical Examiner in line with the statutory requirement to confirm the cause of death to be detailed on the Medical Certificate of cause of Death (MCCD) or confirm a referral for a coroner review.

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	8	8	10			
SJRs requested for Inpatient deaths by Medical Examiner	2	0	1	0	0	0	0	0	0	0			
Coroner Referrals advised by Medical Examiner for Inpatient Deaths	11	0	0	0	0	1	0	0	0	0			

Coroners' outcomes for referred Inpatient Deaths	Q3	2024/25 Total
Postmortem	0	1
Forensic Postmortem	0	0
Inquest	0	0
100A	0	0

EOL Audit Q3	Total Q3	Narrative
New continuous audit which reviews all physical health inpatient planned End of Life deaths.	20	Since Q1 the division have reviewed the process of documenting the patients emotional / psychological needs which has supported improvement in this area. In Q3 all 20 patients had their emotional / psychological needs assessed and all patients had evidence of this documented on a daily basis.

Adults with a Learning Disability Learning From Deaths Q3



In Q3, 13 deaths of adults with learning disability were reviewed at 1st stage review. 7 were classed as unexpected and 6 as expected deaths, 2nd stage reviews were requested for all.

10 2nd stage reviews were concluded in Q3 (detailed below).

The age at time of death ranged from 41 to 87 years of age (median age: 70yrs.)

NHS Berkshire Healthcare NHS Foundation Trust

Q3 2024/25

All deaths related to patients in the community. Of the 10 cases, all were scored as 6 (definitely not avoidable).

In Q3 the following learning was shared within the LD service:

- Reminder of completing relevant care plans, risk assessments and MCA assessments in the relevant sections of RiO, and for these to be completed / updated at the point of opening new referrals.
- Reminder that when an individual has a life limiting illness, it would be helpful to consider the value of the end-of-life care planning tool to ensure support is provided proactively and as holistically as possible – or to document the reasons for not undertaking this.

Severity of LD	Q3 24/25	Total 24/25 (29)
Mild	3	9
Moderate	2	8
Moderate to Severe	0	1
Severe	1	4
Profound	0	3
Not Known	4	4

Ethnicity	Q3 24/25	Total 24/25 (29)
White British	9	27
Asian or Asian British - Pakistani	1	2

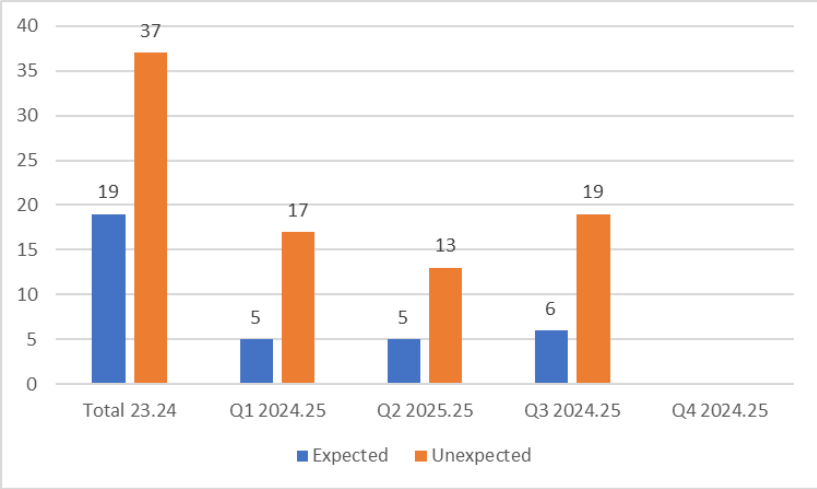
	Q3 24/25	Total 24/25 (29)
Male	7	19
Female	3	10

The deaths attributed to the following causes:	Q3 24/25	Total 24/25 (29)
Diseases of the respiratory system	4	9
Diseases of the heart & circulatory system	3	5
Sepsis or Infection	0	1
Cancer	2	3
Other	0	9
Not known	1	2

	Avoidabilty score for 2nd stage reviews (10)	Learning Disability Q3 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	0
Score 6	Definitely not avoidable	10

	Overall Assessment of Care	Learning Disability Q3 24/25
1	Very poor care	0
2	Poor Care	0
3	Adequate Care	3
4	Good Care	5
5	Excellent Care	2

Community Physical Health Learning From Deaths Q3



EMRG received 25 1st stage reviews in Q3 of which 2nd stage reviews were requested for 9.

13 2nd stage reviews were completed and whilst no reviews were a governance cause for concern (Avoidability score of 1,2 or 3).

4 reviews identified poor care the following key aspects of learning was identified:

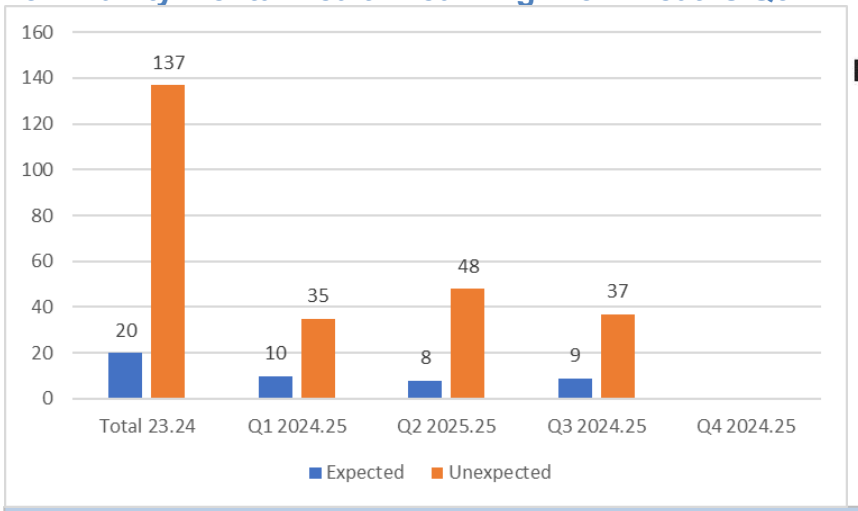
Sepsis (2 cases)
- Wound care documentation
- Process for taking wound swabs
- Communication with families

Complex cases on Matrons caseload
- Capacity and non engagement with treatment
- Clinical Supervision model to discuss complex cases
- Communication with different agencies

Frailty Pathway
- Communication between services and continuity of care

Learning is implemented by the divisions and a number of projects are in place to address the key issues identified above.

Community Mental Health Learning From Deaths Q3

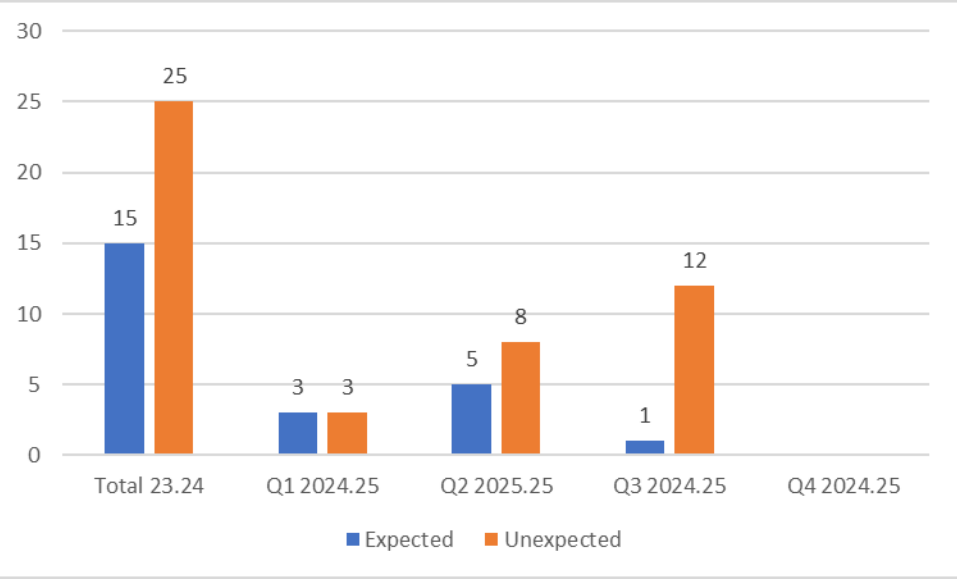


EMRG received 46 1st stage reviews in Q3 of which 2nd stage reviews were requested for 18.

32 2nd stage reviews were completed in Q3 from a range of community mental health or specialist mental health services. 1 review identified poor care and the following learning was identified:

- Patient discussed by multiple teams which led to a delay in the identifying the correct treatment pathway (EUPD,CMHT,MDT and MHICs) this aspect of learning has been addressed by the implementation of One Team.
- Patient did not respond to messages re support, MHICs has implemented regular reviews of patients on the waiting list to ensure escalation where required and prompts to engage.
- Lack of evidence of multiagency working to support where there was a history of domestic violence.

Childrens & Young People: Learning From Deaths Q3



Q3 2024/25
EMRG received 13 1st stage reviews in Q3 of which 2nd stage reviews were requested for 2.

11 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.

Two 2nd stage reviews were concluded in Q2 both identified good care, with one being under mental health services and one under physical health services (6 definitely not avoidable).

Complaints and Inquiries Learning From Deaths Q3

Complaints and MP Inquiries	Q3 24/25	Total 24/25 (9)
Communication and Clinical Care (District Nursing)	1	3
Inpatient physical health (clinical care)	1	2
Urgent Community response	1	1
Mental health Inpatients	2	2
Community Mental Health	1	1

6 complaints were received in total in Q3 relating to aspects of care or treatment prior to death. A 2nd stage review was requested in addition to the formal complaint response.

In Q3 4 Freedom of Information Requests (FOI) were received relating to deaths and were responded to.

NHS Berkshire Healthcare NHS Foundation Trust

Prevention of Future Deaths (PFD) reports 2024/25
Three PFD's have been received by the Trust in 2024/25 and all have been responded to (Q1). No new PFD have been received in Q2 or Q3.

Overall Learning and Summary From Deaths Q3

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

8 reviews identified poor care, learning is identified and being implemented through the relevant divisions.

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.

10 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 Learning from Poor Care cases

- Wound care management in Community Nursing Services remains an area of concern and was identified in 2 of the poor case cases.
- Modern Matron Model, division to review the model
- Frailty Pathway, division in the process of reviewing the pathway
- Engagement of patients and process with Mental Health of allocating appropriate Team, addressed by the implementation of One Team.
- Escalation of patients requiring transfer for acute care
- Bowel Management

Berkshire Healthcare NHS Foundation Trust

Quality Assurance Committee Paper

Meeting Date	February 2025
Title	Guardian of Safe Working Hours Quarterly Report (29-10-2024 to (9-2-2025)
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 29th October 2024 to 9th February 2025. Since the last report to the Trust Board, we have received two exception reports, both have been closed with agreed time off in lieu (TOIL). 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 29th October 2024 to the 9th February 2025

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 29-10-2024 t0 9-02-2025. Since the last report to the Trust Board, we have received two '*hours & rest'* exception reports.

Introduction

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

High level data

Number of doctors in training (total):	61 (FY1 – ST6)
Number of doctors in training on 2016 TCS (total):	61
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	2	2	0
Sexual Health	0	0	0	0
Total	0	2	2	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	0	0	0
ST	0	0	0	0
Total	0	2	2	0

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

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

In this period, we have received two exception reports. Both reports relate to workload in old age inpatient mental health ward, the additional time worked were 0.3 and 1 hour respectively and time off in lieu has been agreed by the named supervisor within 7 days. These were related to the concerned doctor having to stay back to complete documentation and clerking of complex patient. None of these reports have necessitated review of work schedule because they are not indicative of any recurrent pattern or repeated breaches of shift working hours.

The GOSW has regular discussions with resident doctors regarding the exception reports at the Resident Doctors' Forum (RDF)- these were on 31-10-24, 2-1-25 and on 6-2-25 there were no concerns raised by resident doctors in getting their TOIL for the time they have worked extra; resident doctors 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, which now happens monthly. There are no outstanding exception reports waiting to be actioned, TOIL where appropriate, have all been agreed with resident doctors. The number of reports that we have received are keeping in line with historical mean data for this Trust and GOSW meets the resident doctors via the RDF and resident doctors representatives through the MEM (medical education meetings), to encourage raising exception reports where applicable and to address any barriers that resident doctors may face in doing so, this was also be highlighted by the GOSW in new trainees induction on the 5th of February 2024. Newly joined resident doctors will be sent log in details for the DRS4 online system which is used to exception report.

During this quarter, there have not been any exceptions reported in relation to missed educational opportunities or OOH Rota. We will continue to monitor and raise any issues when they arise. 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 the resident doctors attached to them, 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 resident doctors 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 resident doctors, 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/resident doctors) covers the period 29-10-2024 to 09-02-2025)

Reason	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
Gap	43	41	443.5	418.5
Sickness	45	41	448.5	407.5
Maternity	0	0	0	0
Total	88	82	892	826

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	0	0
Total	0	0

Fines (cumulative)			
Balance at end of last quarter	Fines this quarter	Disbursements this quarter	Balance at end of this quarter
£186.3	£0	£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 four 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.

GOSW and the new RDF resident doctors representative have jointly devised the new ToR (terms of reference) for the resident doctors forum, this will go to next LNC to be ratified.

There has been no delay in addressing the exception reports within the recommended 7 days from date of submission during this quarter, the GOSW continues to remind the respective consultants to discuss and action the reports on DRS4 and will continue to do so.

There is a significant increase in number of shifts that were gaps due to sickness compared to previous quarter, although majority of these have been filled. The GOSW will highlight this is the next MEM meeting.

Actions taken to resolve issues:

GOSW to continues to engage with resident doctors during induction and resident doctors forum on a regular basis, any issues arising are escalated to DME or LNC, as appropriate.

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

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

GOSW will bring the increase in sickness gaps in rota to the attention of DME in next MEM meeting.

Next report to be submitted in May 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.

Resident doctors are strongly encouraged to make exception reports by the Guardian at induction and at every resident doctor forum. Resident 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.

Report compiled by Dr Malarvizhi Babu Sandilyan, GOSW.

Appendix A: Glossary of frequently used terms and abbreviations

Guardian of Safe working hours: A new role created by the Junior Doctors Contract that came into effect for the majority of trainees in BHFT in February 2017. The Guardian has a duty to advocate for safe working hours for resident 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 resident 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- Specialty 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.

Resident doctors' forum – A formalized meeting of Resident Doctors that is mandated in the Resident Doctors Contract. The Resident 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 Resident 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.

Highlight Report - Action plan relating to the Independent Mental Health Homicide review (Nottingham)

Why is this coming to the Board?

The independent homicide review report (Nottingham) was published in early February 2025[1] reviewing the Valdo Calocane case, triple homicide by patient open to mental health services. NHSE has detailed specific actions to be taken by Integrated Care Boards (ICB's)in response to the key areas identified as having failed to prevent the tragedy.

The report recommendations and action plan must be noted by board before the end of June 2025.

Key highlights to note

In September 2024, ICBs were required to collaborate with all Mental Health NHS Trusts to formulate a costed proposal for Assertive Outreach Teams (AOT) and Intensive Clinical Management Teams (ICM). In response, we conducted a Community Mental Health Team (CMHT) review using a maturity index to evaluate our standing across 14 domains and have developed a local action plan to address any areas for improvement.

In November 2024, we submitted a funding proposal to NHSE to deliver an AOT model for Reading and Slough and an Intensive Clinical Management model for the other 4 localities. Initially, we expected some dedicated investment, however it was not included in the planning guidance. Consequently, we do not anticipate any specific funding for dedicated AOT/ICM teams. Therefore, our focus is now on adapting and enhancing our approach to meet the needs of this patient population within our existing workforce.

The review identified 5 high level recommendations

This paper provides an update on the recommendations made by the independent review and the actions in response to these (appendix 1)

1. Personalised risk assessments across mental health community and inpatient teams
2. Joint discharge planning involving the person, their family, the inpatient team, and the community team, along with other involved agencies
3. Multi-agency collaboration and information sharing
4. Working closely with families
5. Eliminating Out of Area Placements in line with the ICB 3-year plan

Personalised risk assessments

As part of our roll out of our transformed mental health services we have moved to a personalised formulation approach to risk assessment and management. This work is overseen by our well-established nurse consultant network and is supported by a 5-day training programme with a focus on risk to self and others. Several cohorts have been through the training programme and additional cohorts prioritised for CMHT and inpatient colleagues.

There is formal review periods built into the programme and adaptations made based upon the feedback from participants and any learning from incidents.

Joint discharge planning

Our inpatient services at prospect park have been working to improve discharge planning through the multi-disciplinary team process. They aim to ensure that discharge meetings are held a minimum of 48 hours before the discharge date with carers, community teams and other support services invited. There is

[1] https://www.england.nhs.uk/midlands/publications/independent-investigation-reports-for-midlands/

a housing worker based within the hospital whose role is to support discharge planning for patients who are homeless or at risk of homelessness, and there is a complex discharge social worker post who becomes actively involved in planning for patients who are likely to have challenges to discharge.

In our community teams, patients with psychosis who fail to attend planned appointments should be discussed by the MDT prior to any discharge decision. We are also in the process of developing an automated report that alerts clinical leads for our community teams which patients with psychosis have missed planned appointments which will support a more proactive approach to try and reengage with services.

Multi-agency collaboration and information sharing

There has been a significant amount of progress made in partnership working with Forensic services and probation. This work is being led by our lead Nurse Consultant with the lead for Preventing Harm to Others. There is a monthly steering group where the most complex patients are discussed and any concerns regarding their care addressed. This work is also supported by the development of our Criminal Justice Panels where inpatients who have assaulted other patients and staff are discussed and partnership plans agreed.

We have a dedicated lead with the Trust for Right Care, Right Person and this postholder has proactively been engaging with Police, Approve Mental Health Professionals and Trust staff to improve the response to mental health patients who encounter the Police. This has included developing advanced care plans and the consideration of part 3 of the Mental Health Act for instances where significant crime has been committed. This work is shared into the Thames Valley Strategic Group, chaired by Thames Valley Police.

Working closely with families

Building on the principes of Martha's Rule, Prospect Park Hospital have implemented a discharge panel which provides a platform for carers to seek an independent review or consultation regarding care and treatment, specifically concerning safety and offers expert guidance, recommendations, signposting and support. Once evaluated we plan to extend this to our community teams.

Our carers lead is working closely with our clinical teams to understand the current offer and provides dedicated support to teams who are working to improve their collaborative work with carers and wider support networks.

Eliminating Out of Area Placements

The teams who are assigned to this cohort are working collaboratively to support timely discharge into appropriate placements commissioned within the bed framework. These teams include bed management, right care right person, out of area placements team and the community rehabilitation enhanced support team.

What are the implications for EDI and the Environment?

Whilst there are no specific EDI recommendations our data shows high levels of inequalities for this patient cohort and our work to improved service models and delivery for this population should address some of the inequalities related to access, experience and outcomes.

Outside of these specific recommendations local efforts are underway to scope and Assertive Outreach and or an Intensive Case Management model within our community services. This will need to be developed within current services because of budget constraints. The clinical leads for this work are currently working to identify the specific patient cohort who would most benefit from this approach.

Conclusions and Recommendations for consideration by the Board

In line with the requirements from NHSE the board is required to have oversight of the recommendations and subsequent action plan. The action plan will be reviewed by the Frimley and BOB mental health boards and published on their website.

Our preventing harm to others steering group will provide the internal oversight of this action plan and updates will be taken to our Quality Executive meetings.

Theresa Wyles
Divisional Director Mental Health
March 2025

Independent review Nottingham – Action Plan February 2025 (appendix 1)

This reflects the key areas identified in the independent review and requirement for Board oversight

Recommendation	Current state	Responsible/Timescales	Identified Gaps	Mitigation
Personalised assessment of risk across community and inpatient teams	The new personalised approach to risk is in place. The new named worker model and individualised care plan was launched in January 2025. Work is underway with each team and collectively to embed the holistic approach to risk and care planning. An audit tool has been developed to capture important areas of focus (including family concerns being acted upon). A concern about safety planning panel is being piloted from Feb 2025. A survey of patients and carers views on the new model has been designed and will be sent out on March 3rd.	Lead Nurse Consultant for suicide prevention and Lead Nurse Consultant for transformation March 2026		

	Trust Clinical Risk Advisory Panel in place to support clinical teams with decision making around risk assessment and management			
Joint discharge planning arrangements between the person, their family, the inpatient and community team (alongside other involved agencies)	Inpatient teams have reviewed their Multi-Disciplinary Team (MDT) arrangement to ensure that families, carers and other support services are included in discharge planning and informed when the discharge date has been set. Community patients who have a psychotic illness should be discussed at an MDT meeting prior to any discharge decision. Development of discharge passports that enable family and carer involvement, it will identify relapse indicators, support needs and easy access back into community mental health services. Developing an automated reporting tool that alerts	Mental Health Clinical Director & Divisional Nurse for inpatients July 2025	Not always clear who is involved with the patient and issues with consent to engage with family members. Not all teams proactively review waiting lists to see who has been missing appointments to decide how to proceed	Improvements being tested in the preadmission process to ensure inpatient colleagues are aware who they need to involve in treatment discussions. Performance, Patient Safety and Quality meeting regularly discuss and share best practice

	community teams to patients with psychosis who have missed planned appointments so this can generate a safety huddle discussion within the MDT.			
Multi-agency working and information sharing	Regular interface meeting with Probation, Thames Valley Police and Forensic colleagues Regular representation at the Forensic provider collaborative, criminal justice panels implemented and demonstrating effective partnership working Right Care, Right Person – focus on increasing use of Part 3 of the Mental Health Act 1983	Lead Nurse Consultant for Prevention of Harm to others Sept 2025	Shared access to records/information across organisations	Use of connected Care for information sharing between BHFT services and GP's. 4 community mental health teams are fully integrated with Adult Social Care and health staff able to access to each other's patient records. In Reading and West Approved Mental Health Professionals are able to access RIO (patient clinical record)
Working closely with families	Carers lead working with teams to improve their collaborative	Carers Lead		

	approach which is underpinned by our carer's strategy. Development of discharge passports that enable family and carer involvement, it will identify relapse indicators, support needs and easy access back into community mental health services. Well established carers support group delivered via Crisis Resolution Home Treatment Team (CRHTT)	Dec 2025		
Eliminating out of area placements	Robust process for clinical review of patients being considered for an inpatient locked rehab bed. Any patient admitted has a clearly documented rehabilitation care plan and review dates agreed and compliance monitored through the Out of Area placement panel. Contracted with Priory Newbury to provide 18 acute beds within the Berkshire footprint providing	Divisional Director for Mental Health services	Female Psychiatric intensive Care (PICU) beds are not provided locally and an out of area bed will be sourced if PICU is required	Being considered with Buckinghamshire, Oxfordhsiare and Berkshire West Integrated Care Board (ICB) colleagues as part of the mental health Provider Collaborative

	a total of 90 acute beds for the Berkshire population.			

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 March 2024
Title	**Executive Report**
	Item for Noting and Approval of the Modern Day Slavery Statement
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 – 11 March 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. Executive Director Appointments

Our Medical Director, Dr Minoo Irani, will be retiring at the end of March. Minoo has worked for Berkshire Healthcare since 2001, when he joined as a Consultant Paediatrician. Since then, he has taken on many leadership roles, including Lead Paediatrician, Locality Clinical Director, and Lead Clinical Director. In 2015, he became Medical Director. He will have a week to handover to the new medical director Dr Tolu Olusoga who joins the Trust in the final week of March. Tolu joins us from Tees, Esk, and Wear Valleys NHS Foundation Trust (TEWV), where he was the Group Medical Director for the North Yorkshire-York Care Group.

Our Chief Operating Officer (COO), Tehmeena Ajmal, will be leaving Berkshire Healthcare on the 14th March. She is moving on to an exciting new role as Chief Operating Officer at Betsi Cadwaladr University Health Board, which provides community, mental health, and hospital care across North Wales. Tehmeena joined us in May 2022, bringing a wealth of experience from her NHS career, which started in 1994. Theresa Wyles who is currently Director of Mental Health services has been appointed interim COO. The post will be recruited to on a substantive basis later in the year following a national recruitment campaign.

Executive Lead: Julian Emms, Chief Executive

3. Modern Slavery Statement

The Modern Slavery Act 2015 is designed to consolidate various offences relating to human trafficking and slavery. The provisions in the Act create a requirement for an annual statement to be prepared that demonstrates transparency in supply chains. In line with all businesses with a turnover greater than £36 million per annum, the NHS is obliged to comply with the Act.

Summary
The legislation addresses slavery, servitude, forced or compulsory labour and human trafficking and links to the transparency of supply chains.

Section 54 of the Act specifically addresses the point about transparency in the supply chains. It states that a commercial organisation (defined as a supplier of goods or services with a total turnover of not less than £36million per year) shall prepare a written slavery and human trafficking statement for the financial year. The statement should include the steps an organisation has taken during the current financial year to ensure that slavery and human trafficking is not taking place in any part of the supply chain or its business. The statement must be approved by the Trust Board.

NHS England is planning to publish new regulations and guidance on modern slavery in the autumn. The Trust's systems and processes will be updated to reflect the new guidance when published.

The Trust's Modern-Day Slavery Statement is attached at appendix 1.

The Trust Board is requested to approve the Modern-Day Slavery Statement which will be included as part of the Trust's Annual Report for 2024-25.

4. New Hospitals Programme

The Department of Health and Social Care's plan for the New Hospital Programme will see almost half of the 40 new hospitals promised by 2030 by the previous Government delayed with work on 18 hospitals now not set to begin until 2032 and beyond. Plans to rebuild Frimley Park Hospital which was built using autoclaved aerated centre (RACC) will go ahead. Construction on the new Royal Berkshire Hospital will not start until 2037-39.

Executive Lead: Julian Emms, Chief Executive

5. Leadership Changes at NHSE

Amanda Pritchard will step down as NHS England CEO at the end of March, with Sir Jim Mackey taking over as interim CEO, possibly for a period of up to two years. Ms Pritchard took up the role in 2021, having before been NHSE Chief Operating Officer and previously CEO of Guy's and St Thomas' Foundation Trust.

A few weeks prior to this announcement The Department of Health and Social Care confirmed its preferred candidate to be the new chair of NHS England. Dr Penny Dash, the chair of Northwest London Integrated Care Board, is set to take over from Richard Meddings who steps down at the end of the month. Dr Dash will be subject to a pre-appointment hearing with the Commons Health and Social Care Committee. MPs can recommend for or against the appointment, although the government is not required to take its advice.

Executive Lead: Julian Emms, Chief Executive

6. Local Authority Devolution

Just before Christmas the government published the English Devolution White Paper. It is hugely ambitious, seeking to both spread and deepen devolution. This is to be achieved through the principal vehicle of strategic authorities – regional aggregations of local authorities. The goal is for all areas of England to be covered by strategic authorities, designed around how places interrelate as economies, or 'functional economic areas'. This builds on the voluntary evolution of bespoke devolution deals, where national government have given existing combined authorities more control over decisions and funding streams in key areas such as skills, transport and employment support.

The White Paper is a step change in pace, coverage and approach. Existing deals have developed slowly and been stop-start over the last 10 years or so, seen intense negotiation over powers and funding, and each one has been different. The White Paper seeks to break this mould. These strategic authorities will be a regional tier of government, essentially larger jigsaws created from existing local authorities. They will be at one of three levels with each gaining progressively more powers:

- The base level are Foundation Strategic Authorities which will include non-mayoral combined authorities and combined county authorities automatically, and any local authority designated as a Strategic Authority without a Mayor.

- The next level will be Mayoral Strategic Authorities - the Greater London Authority, all Mayoral Combined Authorities and all Mayoral Combined County Authorities will automatically begin as Mayoral Strategic Authorities.

- Finally, those who meet specified eligibility criteria may be designated as Established Mayoral Strategic Authorities. This final stage unlocks further devolution, most notably an 'integrated settlement', much more control over funding streams from central government.

The government intends this to happen voluntarily at first, calling for local authorities that are not already part of combined authorities (mainly further south and more rural or semi-rural) to propose future boundaries of new strategic authorities. Things are moving very quickly, the first set of six additional areas to go through the process has already been announced. The White Paper is clear that over time if any areas resist the move to becoming strategic authorities the government will act to impose that status.

Executive Lead: Julian Emms, Chief Executive

Presented by: Julian Emms
Chief Executive
11 March 2025

Appendix 1

Modern Slavery Statement

This statement is made pursuant to Section 54 of the Modern Slavery Act 2015 and sets out the steps that Berkshire Healthcare NHS Foundation Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain during the year ending 31 March 2024.

Modern slavery encompasses slavery, servitude, human trafficking and forced labour. Berkshire Healthcare has a zero-tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the Trust or our supply chain.

Our Policies on Slavery and Human Trafficking

Berkshire Healthcare is aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Standard NHS Contracts and the Trust's contract specifications contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with Berkshire Healthcare's anti-slavery policy. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high-risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate several internal policies which ensure we are conducting business in an ethical and transparent manner. These include:

- **Recruitment** - We operate a robust recruitment policy, including conducting eligibility to work in the United Kingdom checks for all directly employed staff. Agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will.
- **Fair and Equitable Employment Terms** - We have a range of controls to protect staff from poor treatment and/or exploitation, which complies with all respective laws and regulations. These include provision of fair pay rates, fair

terms and conditions of employment, and fair access to training and development opportunities.

- **Safeguarding** - We adhere to the principles inherent within both our safeguarding children and adults' policies. These are compliant with the Berkshire multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain.
- **Whistleblowing** - We operate a whistleblowing/raising concerns policy so that everyone in our employment knows that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals, and the various ways in which they can raise their concerns.
- **Standards of business conduct** - This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes.
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials.
- Ensuring invitation to tender documents contain a clause on human rights issues.
- Ensuring invitation to tender documents also contains clauses giving the Trust the right to terminate a contract for failure to comply with labour laws.
- Using the standard Supplier Selection Questionnaire (which includes a section on Modern Day Slavery), Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.
- Supplier adherence to our values. We are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.
- Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our corporate induction training which is mandatory for all our new starters. We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our Performance Indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our business or supply chain if there are no reports received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	11 March 2025
Title	**Finance Report January 2025**
	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 FOUNDATION TRUST

Finance Report

Financial Year 2024/25

January 2025

Purpose

To provide the Board and Executive with a summary of the Trust's financial performance for the period ending 31 January 2025.

Document Control

Version	Date	Author	Comments
1.0	11/02/25	Rebecca Clegg	Draft
2.0	17/02/25	Rebecca Clegg	Final

Distribution

All Directors.

All staff as appropriate.

Dashboard & Summary Narrative

Target		Year to Date Actual £m	Year to Date Plan £m	Year to Date Achieved	Forecast Outturn Actual £m	Forecast Outturn Plan £m	Forecast Outturn Achieved
1a	Income and Expenditure Plan	4.9	1.9	Yes	4.9	1.9	Yes
2a	CIP - Identification of Schemes	11.2	11.2	Yes	11.2	13.6	Yes
2b	CIP - Delivery of Identified Schemes	11.2	11.2	Yes	11.2	8.8	Yes
3a	Cash Balance	53.9	49.0	Yes	46.8	46.8	Yes
3b	Better Payment Practice Code Volume Non-NHS	97%	95%	Yes	95%	95%	Yes
3c	Better Payment Practice Code Value Non-NHS	97%	95%	Yes	95%	95%	Yes
3d	Better Payment Practice Code Volume NHS	97%	95%	Yes	95%	95%	Yes
3e	Better Payment Practice Code Value NHS	96%	95%	Yes	95%	95%	Yes
4	Capital Expenditure not exceeding CDEL	4.6	6.8	Yes	8.6	8.6	Yes
5	Agency Ceiling	2.8%	3.2%	Yes	3.2%	3.2%	Yes

Key Messages

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

- The planned outturn position for the Trust is a £1.9m surplus. This includes additional funding for depreciation £0.6m, agreed SDF slippage (BOB system) £0.5m and further CIPs to be identified £0.8m.
- Following receipt of £3m funding from BOB ICB for 2023/2024 elective activity, the Trust is now forecasting a £4.9m surplus.
- The Trust has a £13.6m Cost Improvement Plan. We on track to deliver this year to date, but there are some small variances on individual plans.
- Cash is higher than plan due to the receipt of the funding for 2023/2024 elective performance and is expected to increase further once in-year performance has been settled.
- The Better Payment Practice Code is achieved for all 4 targets.
- Capital spend is under plan year to date for CDEL schemes but the 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 offsetting, but repayable £60m of deficit support funding to the system in order to mitigate potential liquidity issues that may arise in year. Frimley ICS submitted a combined plan of £25m deficit, again, in line with NHSE's expectations and offset with support funding.
- BOB continues to be behind plan to date and continues to pursue options to ensure the system meets its 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

Jan-25	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	2024/25 Plan £'m
Operating Income	31.3	31.2	0.1	310.9	311.3	(0.4)	373.8
Elective Recovery Fund	0.8	0.3	0.5	9.5	3.4	6.1	4.1
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	**32.1**	**31.6**	0.6	**320.4**	**314.7**	5.7	**377.9**
Staff In Post	21.6	21.7	0.1	214.8	214.5	(0.4)	258.0
Bank Spend	2.5	2.2	(0.3)	20.3	21.4	1.1	25.8
Agency Spend	0.7	0.7	0.0	6.8	6.9	0.1	8.3
Total Pay	**24.7**	**24.6**	**(0.2)**	**241.9**	**242.8**	**0.8**	**292.1**
Purchase of Healthcare	1.8	1.6	(0.2)	17.1	16.5	(0.6)	19.5
Drugs	0.6	0.5	(0.1)	5.6	5.1	(0.5)	6.1
Premises	1.5	1.4	(0.0)	15.5	14.2	(1.3)	17.1
Other Non Pay	1.7	1.5	(0.2)	17.4	15.5	(1.9)	18.4
PFI Lease	0.7	0.7	0.0	7.1	7.4	0.3	8.8
Total Non Pay	**6.3**	**5.8**	**(0.5)**	**62.7**	**58.6**	**(4.1)**	**70.0**
Total Operating Costs	**31.1**	**30.3**	**(0.7)**	**304.6**	**301.4**	**(3.2)**	**362.1**
EBITDA	**1.1**	**1.2**	**(0.2)**	**15.8**	**13.3**	**2.5**	**15.8**
Interest (Net)	0.0	0.1	0.1	0.1	0.8	0.7	1.0
Depreciation	0.9	1.0	0.1	9.2	9.3	0.1	11.2
Impairments	0.0	0.0	0.0	0.3	0.0	(0.3)	0.0
Disposals	0.0	0.0	(0.0)	(0.0)	0.0	0.0	0.0
Remeasurement of PFI	0.0	0.0	0.0	1.3	2.0	0.7	2.0
PDC	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Financing	**0.9**	**1.1**	**0.2**	**10.9**	**12.1**	**1.2**	**14.3**
Reported Surplus/(Deficit)	**0.2**	**0.2**	**(0.0)**	**4.9**	**1.2**	**3.7**	**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**	**(0.1)**	**0.6**	**(0.7)**	**0.3**
Adjusted Surplus/(Deficit)	**0.0**	**0.0**	**(0.0)**	**4.9**	**1.9**	**3.0**	**1.9**

Key Messages

The table above gives the financial performance against the Trust's income and expenditure plan as at 31 January 2025.

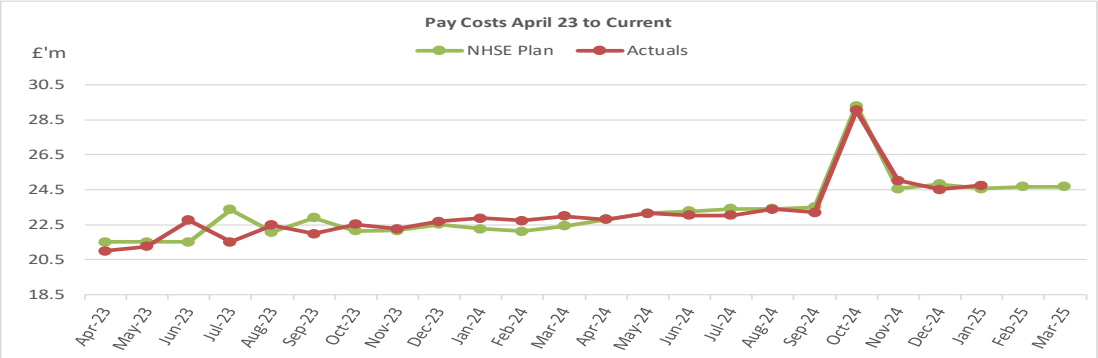
The Trust is planning for a £1.9m surplus. The planned position is a further improvement on breakeven agreed with BOB ICB as part of the over all improvement required to the system financial plan for 2024/25.

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

Income and expenditure plans were updated to take account of the higher than planned pay award. £1.1m of the pay award was unfunded due to the way the tariff cost uplift factor is calculated.

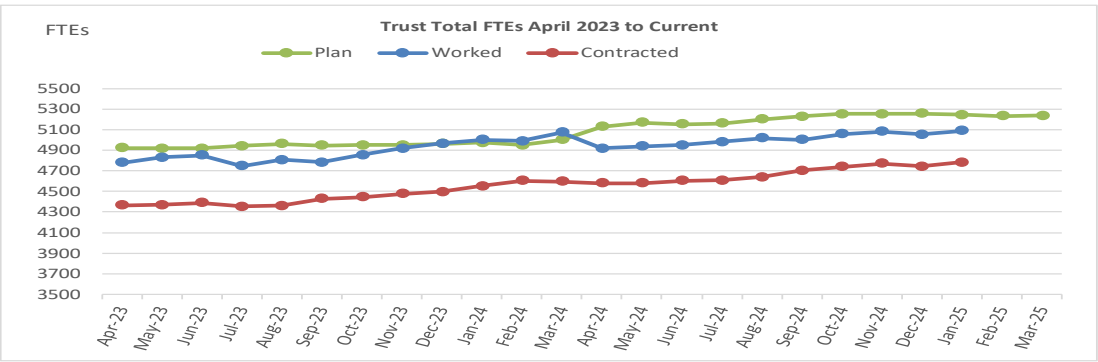
Year to date and forecast outturn income includes £3m of 2023/2024 ERF funding from BOB ICB and income for in year over performance.

Workforce



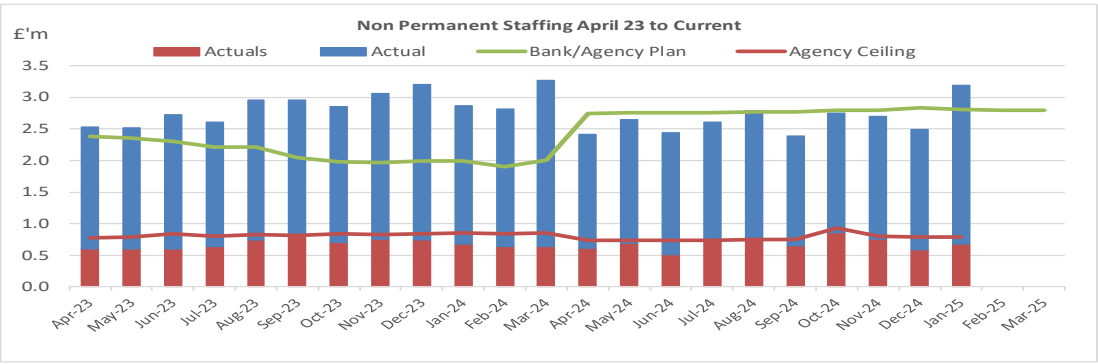
Staff Costs

YTD	£'m
2024/25	241.9
2023/24	221.3
▲	9%
Prior Yr	**£'m**
Jan-25	24.7
Jan-24	22.9
▲	8%



FTE's

Prior Mth	CFTE	WFTE
Jan-25	4,784	5,091
Dec-24	4,745	5,054
	1% ▲	1% ▲
Prior Yr		
Jan-25	4,784	5,091
Jan-24	4,552	5,001
	5% ▲	2% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2024/25	20.3	6.8
2023/24	21.4	6.9
	-5% ▼	-1% ▼
Prior Yr	**£'m**	**£'m**
Jan-25	2.5	0.7
Jan-24	2.2	0.7
	15% ▲	0% ▼

Key Messages

Pay costs in month were £24.7m. In month, contracted WTEs increased by 39 and worked WTEs increased by 37.

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

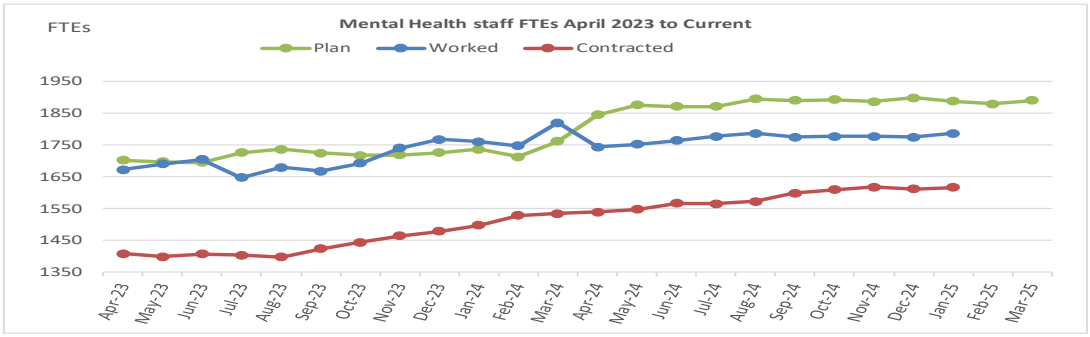
Our bank fill rate has remained stable, currently meeting 85% of our temporary staffing requirements.

Off-framework agency usage remains stable at 5.7%, primarily concentrated in our dental and nursery services. To address this, we continue to actively engage additional framework suppliers with the goal of ultimately eliminating off-framework usage.

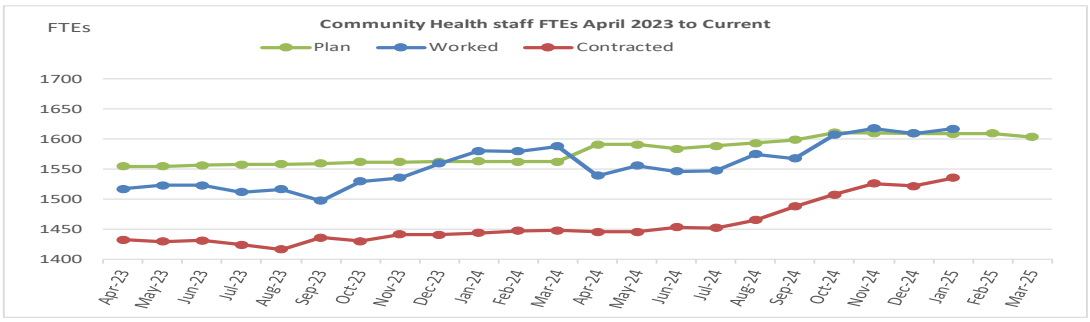
Non-medical price cap breaches have seen a significant decrease from 274 shifts this time last year to 60 shifts in January 2025 and are limited to ASLT and CAMHS Rapid Response. Targeted support is in place to ensure a smooth transition to agreed end dates, with several agency staff already off-boarding.

Due to staff sickness and a COVID outbreak, a small number of unqualified shifts in two inpatient wards required agency staff. However, the number of these shifts remains minimal. Our focus remains on supporting the wards by prioritising the use of bank workers whenever possible.

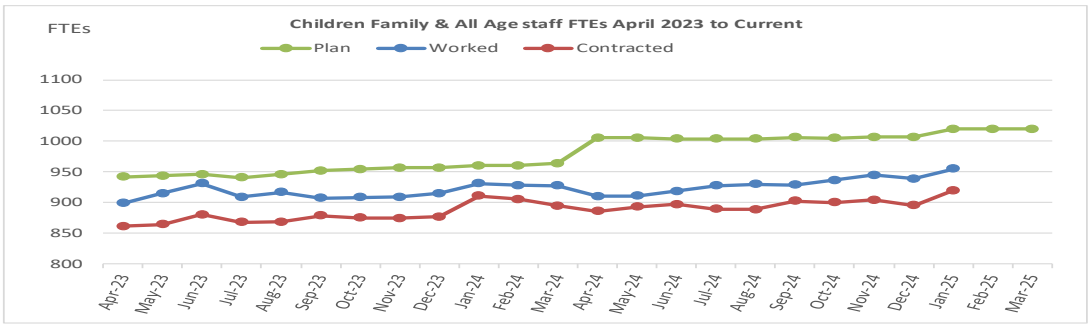
Staff Detail (Division)



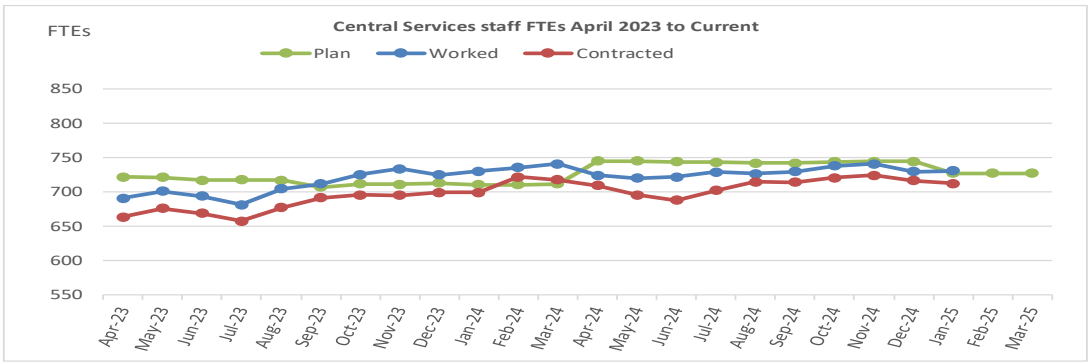
FTE's		
Prior Mth	CFTE	WFTE
Jan-25	1,617	1,787
Dec-24	1,611	1,775
	0% ▲	1% ▲
Prior Yr		
Jan-25	1,617	1,787
Jan-24	1,498	1,761
	8% ▲	2% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jan-25	1,536	1,618
Dec-24	1,522	1,610
	1% ▲	0% ▲
Prior Yr		
Jan-25	1,536	1,618
Jan-24	1,444	1,581
	6% ▲	2% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jan-25	920	955
Dec-24	895	939
	3% ▲	2% ▲
Prior Yr		
Jan-25	920	955
Jan-24	911	931
	1% ▲	3% ▲

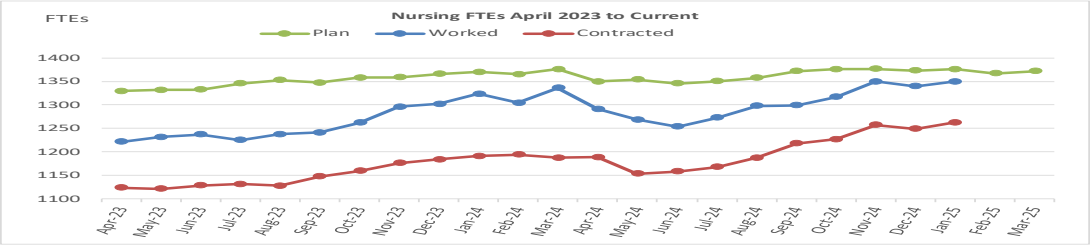


FTE's		
Prior Mth	CFTE	WFTE
Jan-25	713	731
Dec-24	717	730
	-1% ▼	0% ▲
Prior Yr		
Jan-25	713	731
Jan-24	699	730
	2% ▲	0% ▲

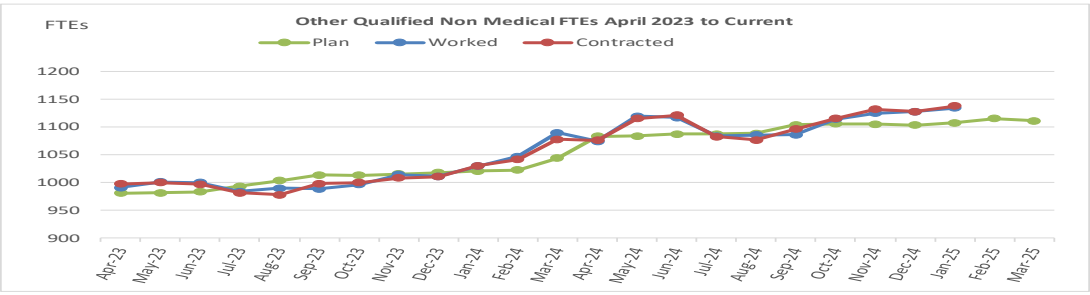
Key Messages

Worked WTEs are below plan for MH and CFAA division and slightly above plan for CH and Central Services. Increases in month were mainly in the MH and CFAA divisions linked to investments.

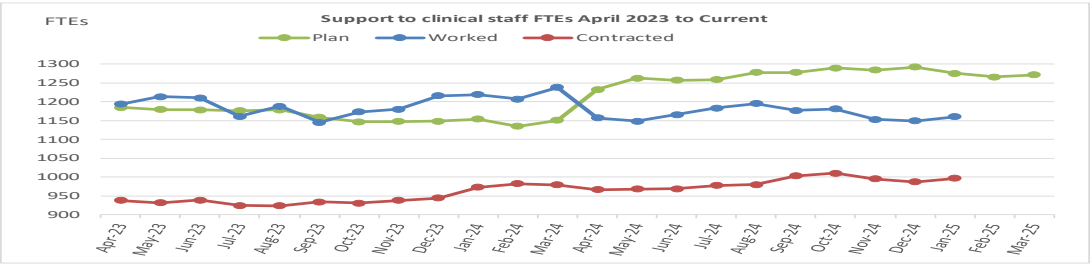
Staff Detail (Staff Group)



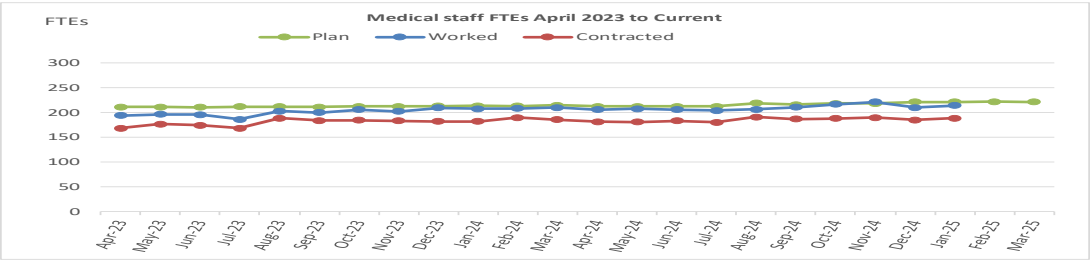
FTE's		
Prior Mth	CFTE	WFTE
Jan-25	1,263	1,350
Dec-24	1,249	1,340
	1% ▲	1% ▲
Prior Yr		
Jan-25	1,263	1,350
Jan-24	1,191	1,323
	6% ▲	2% ▲



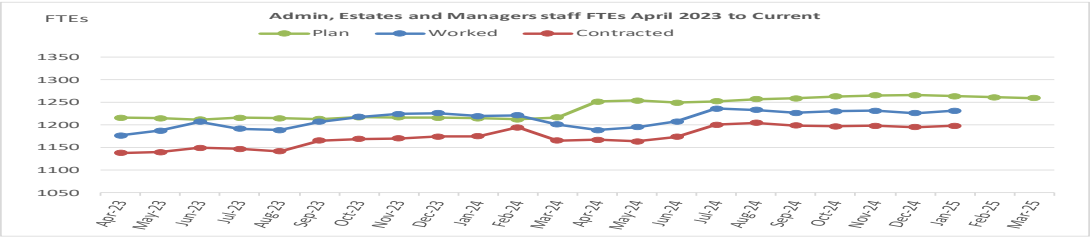
FTE's		
Prior Mth	CFTE	WFTE
Jan-25	1,138	1,134
Dec-24	1,128	1,128
	1% ▲	1% ▲
Prior Yr		
Jan-25	1,138	1,134
Jan-24	1,030	1,030
	10% ▲	10% ▲



FTE's		
Prior Mth	CFTE	WFTE
Jan-25	997	1,160
Dec-24	988	1,149
	1% ▲	1% ▲
Prior Yr		
Jan-25	997	1,160
Jan-24	973	1,219
	2% ▲	-5% ▼



FTE's		
Prior Mth	CFTE	WFTE
Jan-25	189	214
Dec-24	185	210
	2% ▲	2% ▲
Prior Yr		
Jan-25	189	214
Jan-24	182	208
	3% ▲	3% ▲



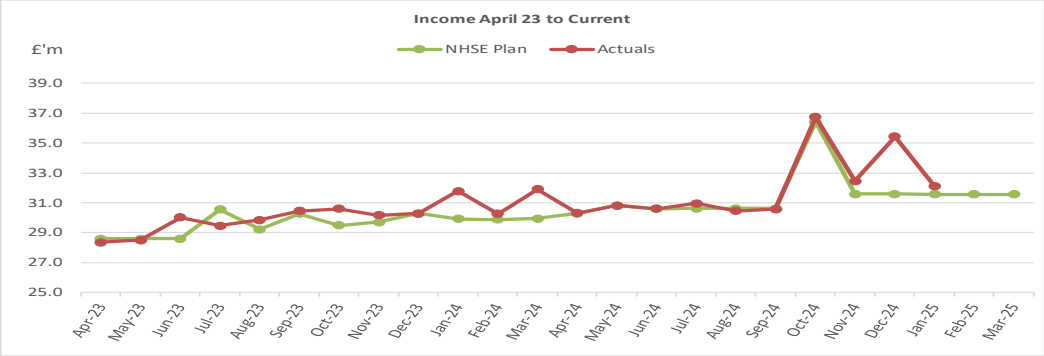
FTE's		
Prior Mth	CFTE	WFTE
Jan-25	1,198	1,232
Dec-24	1,195	1,226
	0% ▲	0% ▲
Prior Yr		
Jan-25	1,198	1,232
Jan-24	1,174	1,226
	2% ▲	0% ▲

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	320.4
2023/24	299.5
▲	7%
Prior Yr	**£'m**
Jan-25	32.1
Jan-24	31.8
▲	1%

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. Additional income for 2023/24 elective overperformance was recognised in month 9.

Elective Activity Performance

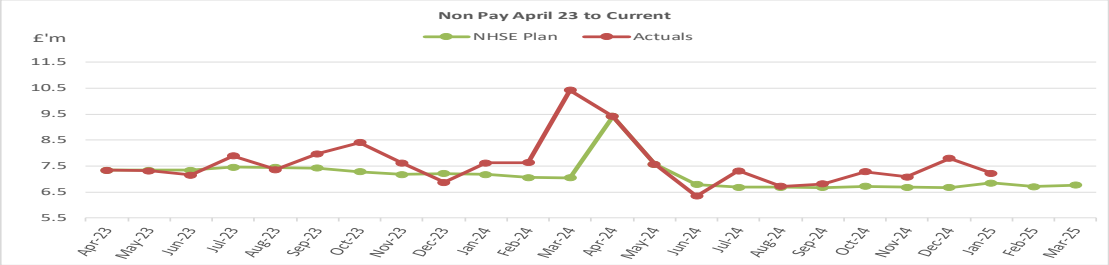
ERF Performance against target	BOB	Frimley	Total
Year to Date	**£000s**	**£000s**	**£000s**
Baseline	12,943	13,181	26,124
Actual	20,071	13,364	33,435
Value of activity above baseline	7,128	183	7,312
Income target £4.132m			3,378
CIP £1m			833
Variance (+/-)			3,100

The Trust will receive payment for all activity above the 2019/2020 baseline which is higher than for 2023/2024 as it has been adjusted for working days and the current activity prices.

Final outturn for 2023/2024 for BOB ICS was £3m higher than forecast and this has been reflect in our year to date and outturn position in addition to the in year over-performance.

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



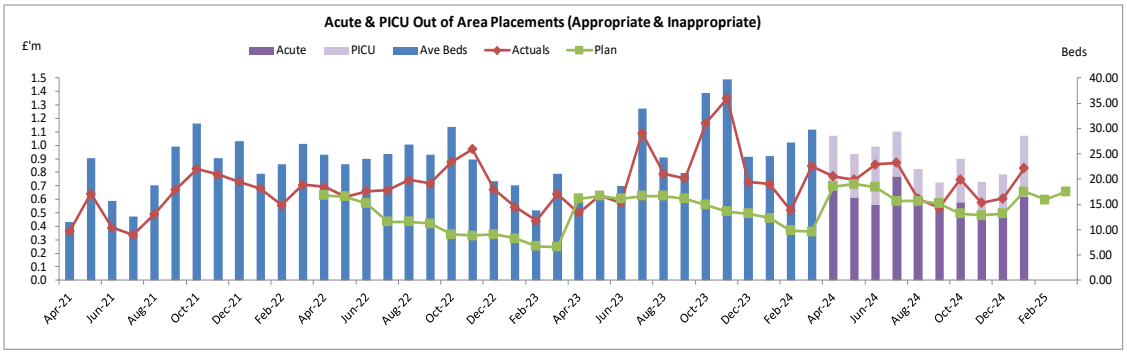
Non Pay

YTD	£'m
2024/25	73.6
2023/24	75.5
▲	-3%

Prior Yr	£'m
Jan-25	7.2
Jan-24	7.6
▲	-5%

Key Messages

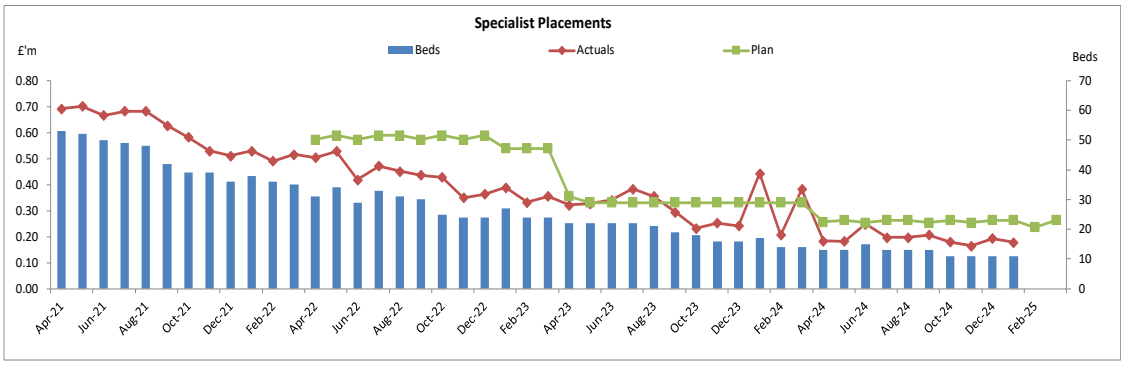
The non-pay variance includes an overspend on OAPs and LD placements year to date.



Specialist Placements

YTD	£'m
2024/25	1.9
2023/24	3.2
▼	-40%

Prior Yr	£'m
Jan-25	0.2
Jan-24	0.4
▼	-60%



Specialist Placements

YTD	£'m
2024/25	1.9
2023/24	3.2
▼	-40%

Prior Yr	£'m
Jan-25	0.2
Jan-24	0.4
▼	-60%

Key Messages

Out of Area Placements. The average number of placements was 21 in December and 29 in January. Analysis highlights that the high level of placements continues to be driven by demand, and that flow through the hospital continues to improve, with more discharges and fewer lost bed days per patient. The monthly costs were £0.8m which is above plan and reflects the high level of PICU placements.

We 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.

We are now opening our new outsourced 18 bedded Poppy Ward on a phased basis before reducing the beds at PPH from 80 to 72. Additionally, we continue to 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.

LD placements. We have 1 LD placement 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	295	295	0
Contribution from new income - MHICS	Mental Health	Fully developed	Low	175	146	146	0
Contribution from new income - Imms	Children families and All Age Services	Fully developed	Low	444	370	370	0
Contribution from new income - small CH schemes	Cimmunity Health	Fully developed	Low	124	103	103	0
Contribution from new income - small CYP schemes	Children families and All Age Services	Fully developed	Low	154	128	128	0
Contribution from new income - seasonal bed occupancy	Community Health	Fully developed	Medium	80	67	67	0
Other small divisional schemes	Various	Fully developed	Low	670	558	558	0
New contract with EE	Central Services - IM&T	Fully developed	Low	106	88	88	0
Estates & Facilities Control Total review	Central Services - Estates & Facilities	Fully developed	Low	376	313	313	0
Increased Contribution to Central Costs	Central Services - Pharmacy Procurement	Fully developed	Low	98	82	82	0
LPS Admin Posts	Central Services - Nursing & Governance	Fully developed	Low	66	55	55	0
Increased Contribution to Central Costs	Central Services - R&D	Fully developed	Low	102	85	85	0
PICU Placement reduction	Mental Health	Fully Developed - not yet started	Medium	1,049	0	874	-874
Asset revaluation to Modern Equivalent Asset	Central Services - Finance	Fully Developed	Low	670	560	558	1
Opt to tax - frimley	Central Services - Finance	Plans in progress	Medium	300	0	250	-250
Liaison VAT, AP review etc	Central Services - Finance	Plans in progress	Medium	100	120	83	37
Overseas Visitors	Central Services - Finance	Opportunity	Medium	50	0	42	-42
Bank Interest	Central Services - Finance	Fully Developed	Low	230	885	192	693
Balance Sheet Review	Central Services - Finance	Fully Developed - not yet started	Medium	2,106	0	1,755	-1,755
Scheduled Care Cost Avoidance	Community Health	Fully Developed	Low	399	332	333	-1
Expenses Controls	Community Health	Fully Developed - not yet started	Low	120	50	100	-50
Elective Recovery	Community Health	Fully Developed	Medium	1,000	3,104	833	2,271
Operational Slippage Against Control Total	Operations	Fully Developed	Low		3,330	0	3,330
Agreed Investment Slippage	Operations	Fully Developed	Low	500	500	500	0
Recurrent Schemes to be developed	To be confirmed	Opportunity	High	4,327	0	3,360	-3,360
			Total	13,600	11,171	11,171	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.

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. These will be carried forward into 2025/26.

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.

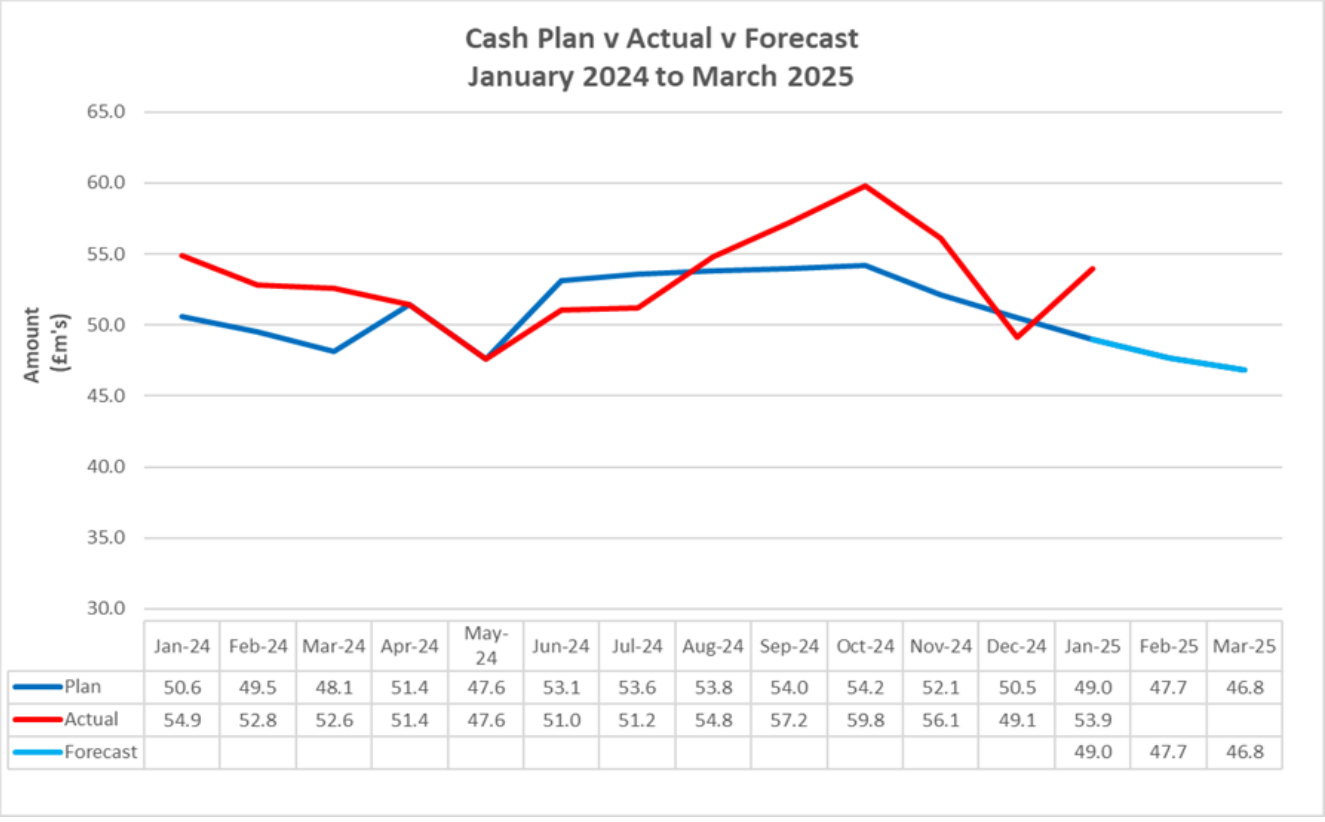
Recurrent schemes are to be developed as part of the closing the gap programme.

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	1.1	1.0	0.1	1.1	1.0	0.1
Property, Plant & Equipment (non PFI)	33.0	33.9	34.6	(0.7)	33.9	34.6	(0.7)
Property, Plant & Equipment (PFI)	45.9	44.8	47.9	(3.1)	44.8	47.9	(3.1)
Property, Plant & Equipment (RoU Asset)	15.2	13.2	14.6	(1.4)	13.2	14.6	(1.4)
Receivables	0.2	0.2	0.2	0.0	0.2	0.2	0.0
Total Non Current Assets	**96.1**	**93.2**	**98.3**	**(5.1)**	**93.2**	**98.3**	**(5.1)**
Trade Receivables & Accruals	12.1	19.7	16.9	2.8	19.7	16.9	2.8
Other Receivables	0.3	0.3	0.3	0.0	0.3	0.3	0.0
Cash	52.6	53.9	49.0	4.9	53.9	49.0	4.9
Trade Payables & Accruals	(37.2)	(40.6)	(38.8)	(1.8)	(40.6)	(38.8)	(1.8)
Borrowings (PFI and RoU Lease Liability)	(6.2)	(0.9)	(7.7)	6.8	(0.9)	(7.7)	6.8
Other Current Payables	(12.0)	(13.4)	(13.2)	(0.2)	(13.4)	(13.2)	(0.2)
Total Net Current Assets / (Liabilities)	**9.6**	**19.0**	**6.5**	**12.5**	**19.0**	**6.5**	**12.5**
Non Current Borrowings (PFI and RoU Lease Liability)	(54.9)	(56.2)	(52.9)	(3.3)	(56.2)	(52.9)	(3.3)
Other Non Current Payables	(2.1)	(2.4)	(2.2)	(0.2)	(2.4)	(2.2)	(0.2)
Total Net Assets	**48.7**	**53.6**	**49.7**	**3.9**	**53.6**	**49.7**	**3.9**
Income & Expenditure Reserve	5.3	10.2	19.3	(9.1)	10.2	19.3	(9.1)
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**	**53.6**	**49.7**	**3.9**	**53.6**	**49.7**	**3.9**

Key Messages

Our cash balance is now better than plan due to the receipt of income for elective over performance and as a result of the slippage in the capital programme. Further cash for in year over performance is expected in Q4.



	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	49.1	53.9		
Forecast													49.0	47.7	46.8

Capital Expenditure

Capital Programme

Schemes	Current Month Actual £'000	Current Month Plan £'000	Current Month Variance £'000	Year to Date Actual £'000	Year to Date Plan £'000	Year to Date Variance £'000	FY Plan £'000	Forecast Outturn £'000	FY Variance £'000
Estates Maintenance & Replacement Expenditure									
Trust Owned Properties	95	0	95	431	477	(46)	477	998	521
Nicholson House Relocation	0	167	(167)	0	167	(167)	500	0	(500)
Jubilee Ward Relocation Upton/St Marks	0	50	(50)	0	50	(50)	150	0	(150)
Additional Dental Surgery St Marks	1	22	(20)	5	142	(137)	185	311	126
Leased Non Commercial (NHSPS)	78	15	63	226	245	(19)	275	495	220
West/Reading Consolidation - Bath Road, Cremyll Road, Coley Clinic	29	0	29	203	800	(597)	800	800	0
Leased Commercial	4	0	4	63	135	(72)	135	288	153
Environment & Sustainability	3	7	(4)	65	137	(72)	150	62	(88)
Audiology Equipment	0	0	0	86	181	(95)	181	160	(21)
Various All Sites	39	15	24	166	276	(110)	306	233	(108)
Statutory Compliance	7	3	4	45	153	(109)	160	41	(119)
Subtotal Estates Maintenance & Replacement	**257**	**278**	**(21)**	**1,291**	**2,762**	**(1,471)**	**3,319**	**3,388**	**34**
IM&T Expenditure									
Business Intelligence and Reporting	38	18	20	67	123	(57)	160	144	(16)
Hardware Purchases - Refresh & Replacement	18	420	(402)	2,255	2,678	(423)	3,517	3,517	0
Teams Rooms Refresh ONLY	0	17	(17)	8	67	(59)	100	100	0
Additional Divisional Spend & Teams Room Additions	103	62	40	499	392	107	517	683	166
Digital Strategy	37	55	(18)	442	540	(98)	650	600	(50)
Pharmacy System Procurement (EMIS & ePMA)	0	44	(44)	0	219	(219)	307	207	(100)
Subtotal IM&T Expenditure	**195**	**616**	**(421)**	**3,270**	**4,019**	**(749)**	**5,251**	**5,251**	**0**
Subtotal CapEx Within Control Total	**452**	**894**	**(443)**	**4,561**	**6,781**	**(2,220)**	**8,570**	**8,639**	**34**
CapEx Expenditure Outside of Control Total									
Place of Safety	264	467	(203)	809	1,667	(858)	2,600	1,950	(650)
Anti-Ligature Toilet Pans & Basins	0	0	0	402	681	(279)	681	531	(150)
Low Carbon Heating Scheme	6	67	(61)	183	273	(90)	406	406	0
LED Lighting Upgrades	0	33	(33)	0	183	(183)	250	0	(250)
Other PFI projects	17	50	(33)	80	475	(395)	575	230	(345)
Subtotal Capex Outside of Control Totals	**287**	**617**	**(330)**	**1,473**	**3,279**	**(1,806)**	**4,512**	**3,117**	**(1,395)**
Central Funding									
Critical Infrustructure Risk funding	12	0	12	19	0	19	0	364	364
Subtotal Central Funding	**12**	**0**	**12**	**19**	**0**	**19**	**0**	**364**	**364**
Sub Total Central Funding &Outside of ControlTotals	**299**	**617**	**(318)**	**1,492**	**3,279**	**(1,786)**	**4,512**	**3,481**	**(1,031)**
Total Capital Expenditure - all funding sources	**750**	**1,511**	**(761)**	**6,054**	**10,060**	**(4,006)**	**13,082**	**12,120**	**(997)**
IFRS16 RoU ASSETS - New Leases Net of Disposals and Remeasurements									
Lower Henwick Farm lease	0	0	0	169	200	(31)	200	169	(31)
Cremyll Road Lease	0	0	0	99	450	(351)	450	99	(351)
Chalvey Lease	0	0	0	0	750	(750)	750	0	(750)
Bath Road	0	0	0	0	100	(100)	100	0	(100)
Bracknell Healthspace	0	500	(500)	0	500	(500)	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	0	0	0	(2)	0	12	0	(8)	12
CoIN	0	42	(42)	156	416	(260)	500	503	3
Total IFRS 16 RoU Assets - New leases	**0**	**542**	**(542)**	**452**	**2,440**	**(1,974)**	**2,524**	**861**	**(1,643)**

Key Messages

At M10, CDEL schemes are underspent by £0.4m for the month, with the YTD total underspend being £2.2m. Estates is underspent by £1.5m mainly due to the West Reading consolidation project, which is still in design stage. IM&T is underspent by £0.7m mainly due to underspend on Pharmacy System re-procurement, which in case of slippage will be re-distributed to fund additional hardware purchases as well as cover off any risks of overspend on additional locality spend.

Non-CDEL spend for PFI sites was underspent by £0.3m for the month and YTD it is underspent by £1.8m, mainly due to the Place of Safety delayed start and expected completion moving to May 2025. There was also an underspend on anti-ligature toilets and basins project, which is progressing, however some work will be slipping into next year.

There is an underspend on IFRS16 Right of Use Assets of £2.0m year to date. CoIN leases are underspent by £0.3m due to the timing difference between the financial plan and lease agreements being in place. The outturn position is expected to be £1.6m lower than planned for the year, mainly as a result of slippage on projects which involve system partners i.e. West Reading Consolidation (Cremyll Road and Bath Road), Bracknell Healthspace and Chalvey.

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper Meeting Paper

Board Meeting Date	11th March 2025
Title	**True North Performance Scorecard Month 10 (January 2025) 2024/25**
	The Board is asked to note the True North Scorecard.
Reason for the Report going to the Trust Board	To provide the Board with the True North Performance Scorecard, aligning divisional driver metric focus to corporate level (Executive and Board) improvement accountability against our True North ambitions, and Quality Improvement (QI) break through objectives for 2024/25.
Business Area	Trust-wide Performance
Author	Chief Operating Officer
Relevant Strategic Objectives	The True North Performance scorecard consolidates metrics across all domains. To provide safe, clinically effective services that meet the assessed needs of patients, improve their experience and outcome of care, and consistently meet or exceed the standards of Care Quality Commission (CQC) and other stakeholders. **Patient safety** **Ambition:** We will reduce waiting times and harm risk for our patients **Patient experience and voice** **Ambition:** We will leverage our patient experience and voice to inform improvement **Health inequalities**

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

True North Performance Scorecard Highlight Report – January 2025

The True North Performance Scorecard for Month 10 2024/25 (January 2025) is included. Performance business rule exceptions, red rated with the True North domain in brackets.

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

Breakthrough and Driver Metrics

- Restrictive Interventions **(Harm Free Care)** – 282 against a revised target of 241.
    - The number of patients requiring rapid tranquilisation has increased for the third month in a row. A total of 61 patients have contributed to this month's total. Patient acuity, time in seclusion and incidents where the patient has requested via their care plan an intervention when attempting to self-harm when other strategies have failed are contributory factors. Countermeasures include reducing time in seclusion and implementing audit actions.
- Bed Days Occupied by Patients who are Discharge Ready (Community Physical Health) – **(Patient Experience)** – at 890 against a 500-bed day target.
    - Reduced from last month to 890 bed days lost, consisting of 146 patients averaging 6.3 days delayed. The highest contributing factor was Package of Care accounting for 41% of delays. There were only 6 patients with a delay of over 21 days this month for 156 bed days lost. The highest area was West Berkshire with 39 patients and 214 bed days lost. 52% of patients were discharged without delay. Next steps in the new financial year is to shift focus to length of stay.
- Physical Assaults on Staff **(Supporting our Staff)** – 42 against a target of 36.
    - Stretch target revised to 36 incidents per month. 23 patients contributed to the total. Top contributing wards/locations were Bluebell (9), A place of Safety (POS) (8), Campion (7). There is a downward trend in incidents. Patient acuity is a contributing factor. Staff have a process to support other wards if additional staff are required. Support remains in place for staff post incident.

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

- Clinically Ready for Discharge by Wards including Out of Area Placements (OAPs) (Mental Health) – **(Patient Experience)** – is at 240 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. The metric has been green for 4 months. Top contributing area is Reading with 142 bed days lost for 8 patients. Top contributing wards were Bluebell with 149 bed days lost for 7 patients and Rowan ward contributed 32 days across 3 patients. Snowdrop ward has had no delays for 3 months. Poppy ward at the Priory has opened initially with 11 beds and the team are ensuring they understand our requirements for this metric. Countermeasure include developing an A3 with community colleagues around Lenth of Stay which is the new breakthrough objective for 2025/26.

Driver Metrics

The following metrics are Red and not performing to plan.

- I Want Great Care Patient Experience Compliance Rate **(Patient Experience)** – at 5.5% against a 10% target.

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

- I Want Great Care Positive Patient Experience Score **(Patient Experience)** – at 95.06% 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 -£3,000k against a target of 0.
- Inappropriate Out of Area Placements (OAPs) at the end of the month (Mental Health) – **(Patient Experience)** – at 1 against a quarter 4 target of 1 patient.

Tracker Metrics

The following metrics are Red and not performing to plan according to business rules.

- Sickness rate **(Supporting Our Staff)** – red at 4.8% against a target of 3.5%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (Frimley) **(Patient Experience)** – 28% against a target of less than 10%.
- Talking Therapies in Treatment pathway waits of 90 days for 2nd appointment (BOB) **(Patient Experience)** – 25% against a target of less than 10%.
- Access to Perinatal Services – Assessments (BOB) **(Patient Experience)** – 28 against a target of 37 per month.
- Access to Perinatal Services – Assessments (Frimley) **(Patient Experience)** – 37 against a target of 51 per month.
- Estimated Diagnosis Rate for Dementia (Frimley) **(Patient Experience)** – 65.93% against a target 66.67%.
- Estimated Diagnosis Rate for Dementia (BOB) **(Patient Experience)** – 65.67% against a target 66.67%.
- Clostridioides Difficile (C.Diff) Incidents with Learning (Cumulative year to date) **(Harm Free Care)** – 4 against a target of 0. None since November 2024.
- Patient Safety Alerts Not Completed by Deadline (year to date) **(Harm Free Care)** – 1 year to date against a target of 0.
- Community Inpatient Occupancy **(Efficient Use of Resources)** – at 93.9% against a target of 85%.
- Community Inpatient Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 23.9 days against a target of less than 21 days.
- Mental Health Acute Occupancy rate (excluding home leave) **(Efficient Use of Resources)** – at 98.2% against an 85% target.

- Mental Health: Acute Average Length of Stay (bed days) **(Efficient Use of Resources)** – at 60.8 days against a target of 30 days.
- Mental Health: Non-Acute Occupancy Rate (excluding home leave) **(Efficient Use of Resources)** – at 89.75% days against a target 80%.

True North Performance Scorecard – Business Rules & Definitions

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

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

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

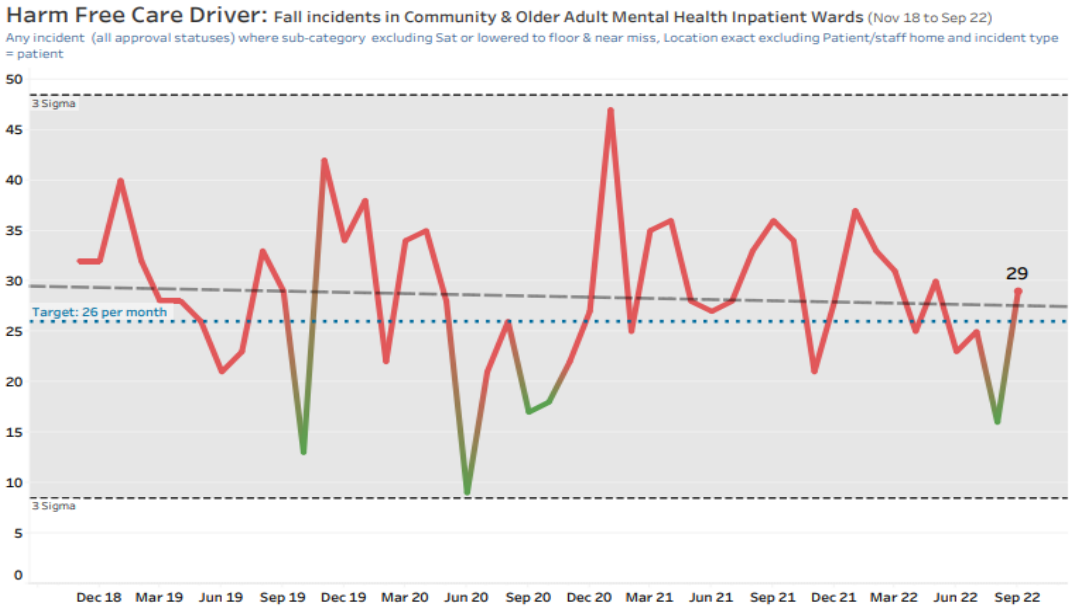
Business Rules for Statistical Process Control (SPC) Charts

Why Use SPC Charts

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

Components of an SPC Chart

The charts have the following components with an example below:



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

Variation

There are 2 types of variation:

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

Rules

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

Performance Scorecard - True North Drivers

Harm Free Care

Metric	Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Breakthrough Restrictive Interventions in Mental Health Inpatient Wards	241 from 1st August 2024 previously 309	Internal	199	172	213	274	242	263	233	183	186	244	256	282

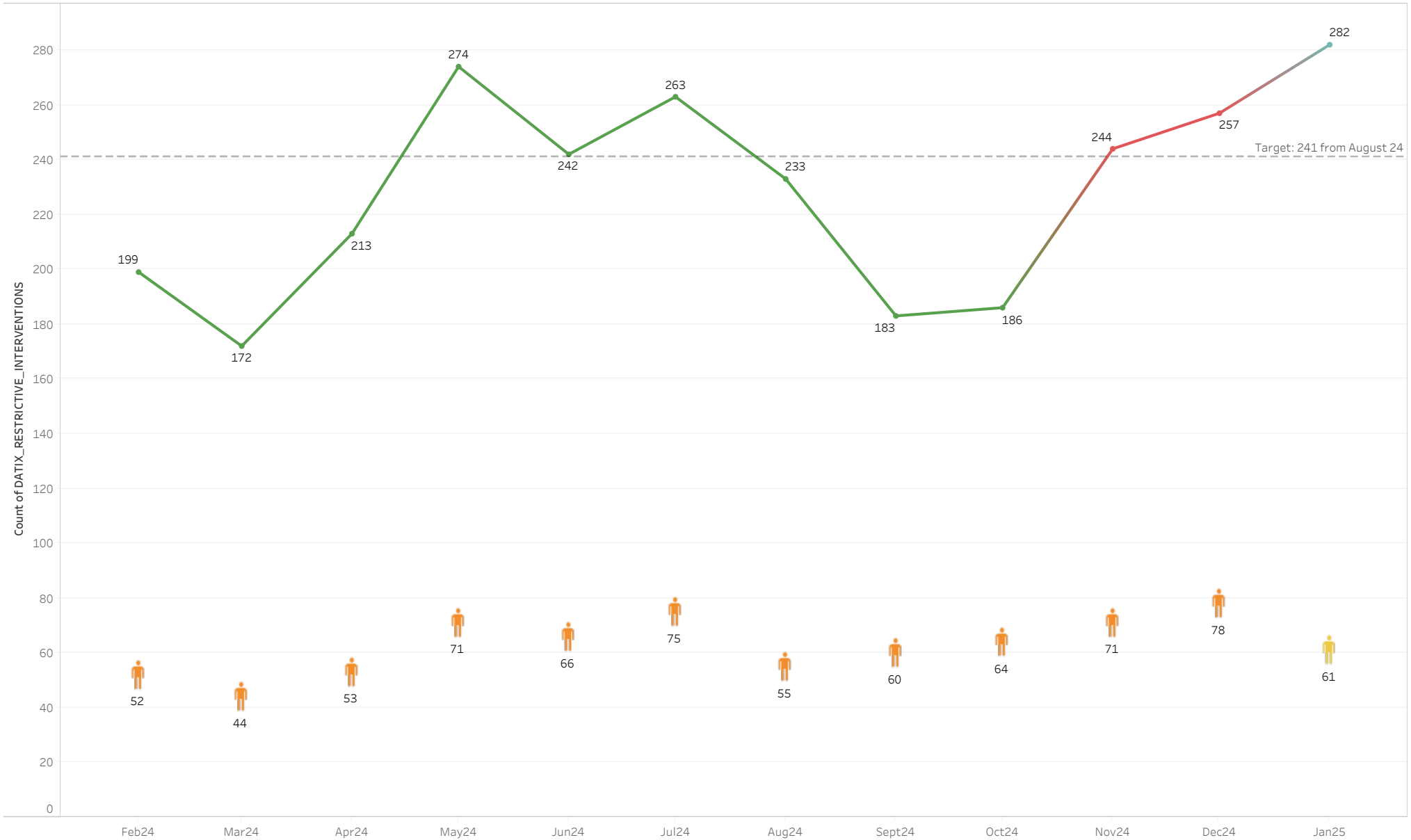
Patient Experience

			Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Positive Patient Experience Score %	95% compliance	External	94.09%	94.59%	93.67%	94.37%	93.97%	94.19%	94.19%	95.09%	94.07%	95.09%	94.71%	95.06%
Patient Experience Compliance Rate %	10% compliance	External	3.50%	3.20%	7.09%	7.39%	6.5%	5.70%	6.20%	4.39%	4%	3.69%	5.24%	5.5%

			Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25
Breakthrough Clinically Ready for Discharge by Wards MH (including OAPS)	250 bed days	External	364	266	353	248	351	275	249	248	306	154	186	224	240

			Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25
Breakthrough Bed days occupied by patients who are discharge ready Community	500 bed days	External	752	663	554	643	812	1,004	836	886	876	849	977	890

Harm Free care-Breakthrough Objective: Restrictive Interventions in Mental Health Inpatient Wards (Feb24 to Jan25)



Performance Scorecard - True North Drivers

Supporting our Staff

Metric	Threshold / Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Breakthrough Physical Assaults on Staff	36 per month Sept 2024	Internal	75	58	30	38	55	64	47	70	73	37	54	42
Staff turnover (excluding fixed term posts)	10% by March 2025	External	12.83%	12.28%	12.4%	12.60%	12.59%	12.49%	12.32%	12.07%	11.54%	11.57%	11.51%	11.57%

Efficient Use of Resources

Metric	Threshold / Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
YTD variance from control total (£'k)	0	External	-1648	-2476	0	0	-26	-103	-9	-16	-17	-2	-1	-3000
Active Inappropriate OAPS at end of month	< 8 Q1, 5 Q2, 3 Q3 , 1 Q4	External			5	3	4	3	4	7	4	0	1	1

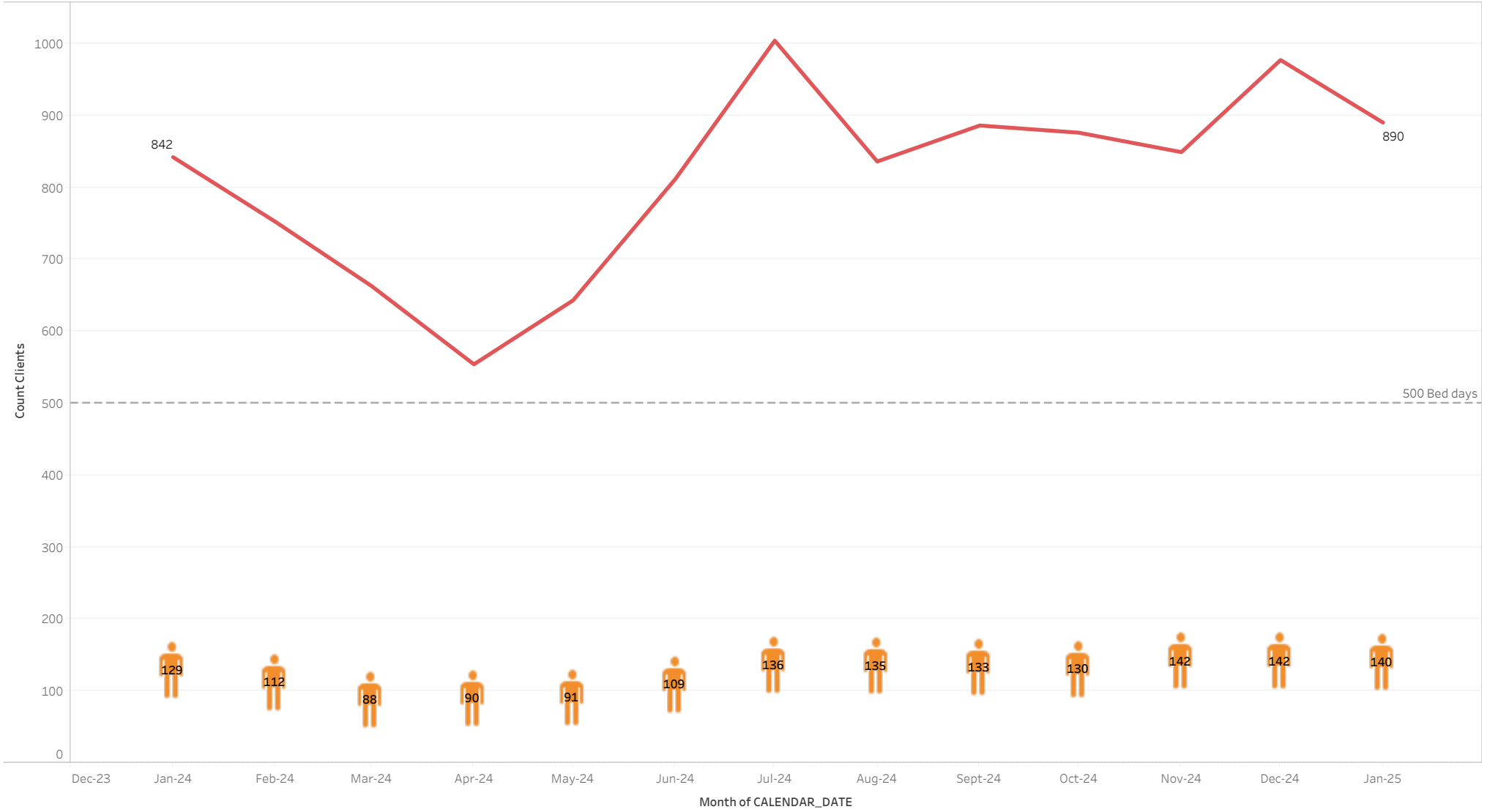
Patient Experience: Breakthrough Objective Clinically Ready for Discharge by Wards MH (Including OAPS)

(Jan 2025- Jan 2025)

All Mental Health wards excludes Campion ward (Learning Disability)

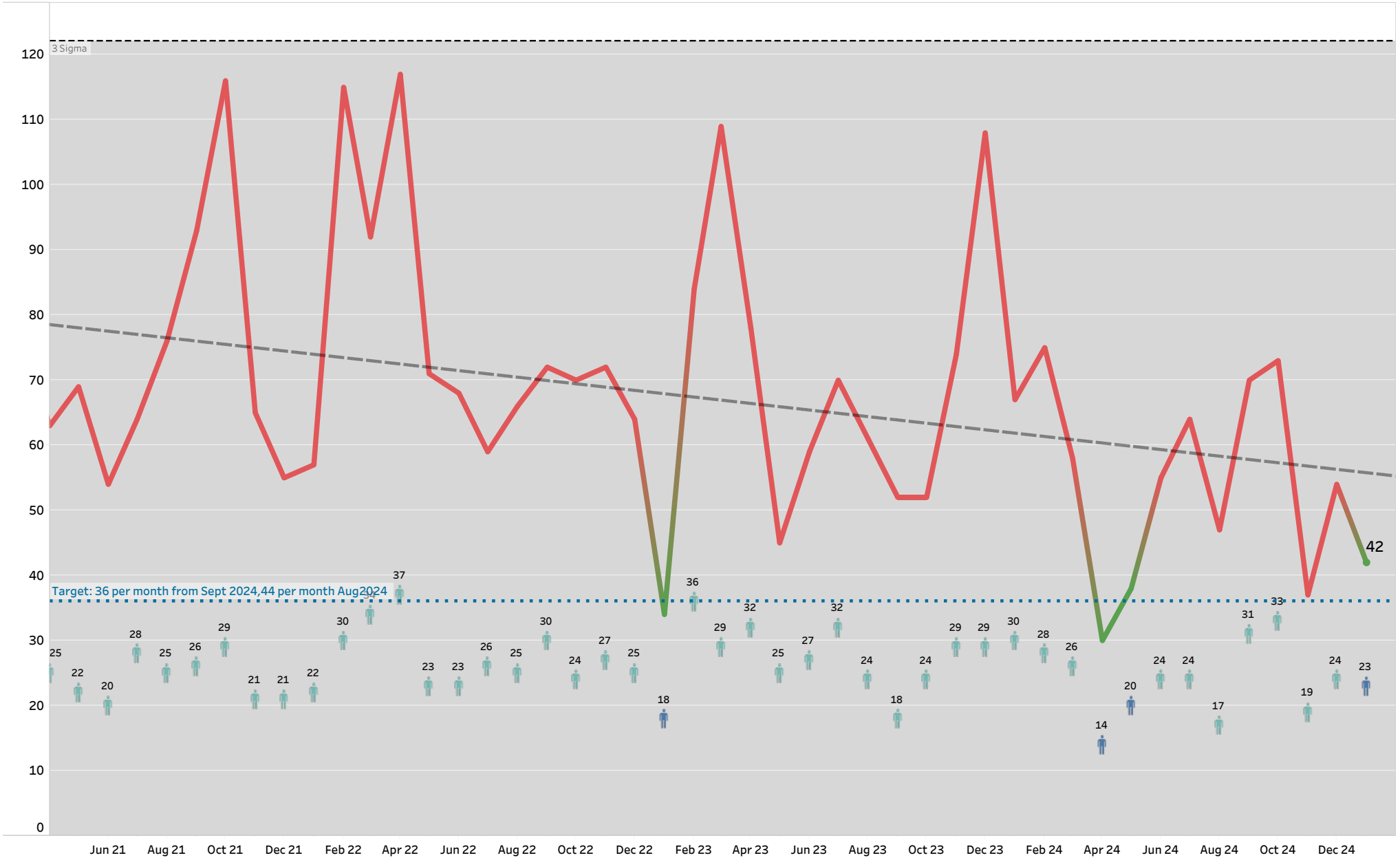
Patient Experience- Breakthrough Objective: Bed days occupied by patients who are discharge ready Community (Jan 2024- Jan 2025)

All Community health wards

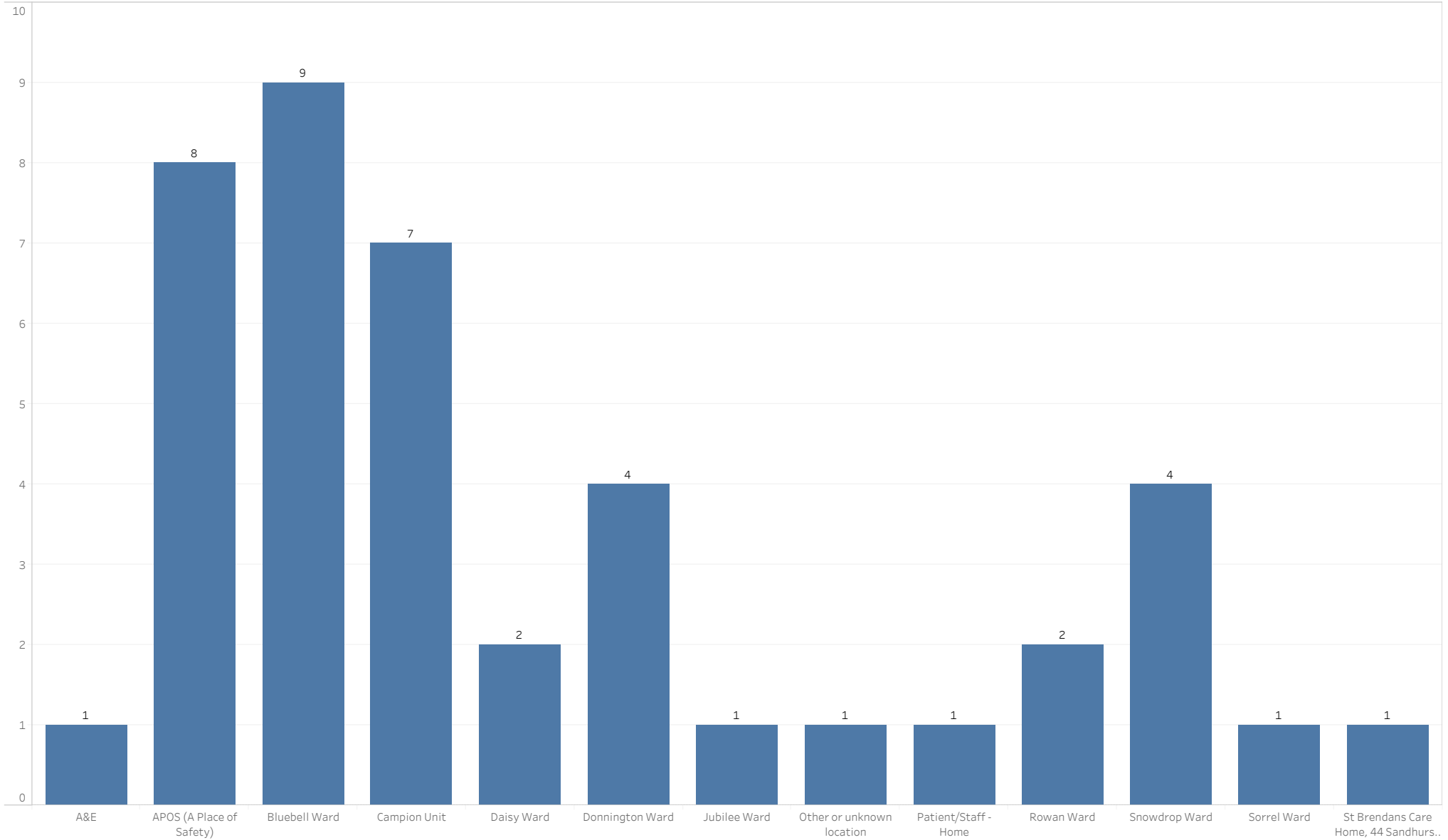


Supporting Our Staff - Breakthrough Objective :Physical Assaults on Staff (Jan 21 to Jan 25)

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



Supporting Our Staff : Physical Assaults on Staff by Location (January 2025)



True North Supporting Our Staff Summary

Metric	Threshold / Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Statutory Training: Fire: %	90% compliance	Internal	93.5%	93.5%	94.6%	95.5%	95.3%	95.7%	95.5%	95.9%	96.0%	96.1%	96.2%	94.2%
Statutory Training: Health & Safety: %	90% compliance	Internal	96.6%	96.7%	96.9%	97.0%	97.3%	97.3%	97.6%	97.6%	97.6%	97.8%	98%	98.0%
Statutory Training: Manual Handling: %	90% compliance	Internal	93.0%	92.2%	93.7%	93.7%	94.3%	94.8%	94.9%	94.2%	94.5%	93.7%	94.9%	94.6%
Mandatory Training: Information Governance: %	95% compliance	Internal	97.1%	96.7%	97.7%	98.2%	98.1%	98.2%	98.4%	98.5%	97.9%	98.9%	98.2%	98.1%
Sickness Rate: %	<3.5%	External	4.1%	3.7%	3.9%	3.8%	3.7%	4.1%	4.1%	4.5%	4.7%	4.8%	4.8%	

True North Patient Experience

Metric	Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
A&E: Maximum wait of four hours from arrival to admission/transfer /discharge: %	95%	External	99.40	99.35	98.60	99.37	98.89	98.76	99.31	99.17	99.05	99.31	99.03	98.72
Community Health Services: 2 Hour Urgent Community Response %.	80%+	External	86.7%	87.7%	86.2%	84.6%	84.7%	88.7%	91.4%	89.2%	91.4%	90.9%	91.9%	91%
Number of Adults on community Health waiting lists by system (BOB)	No Trust Target	External	6596	7095	6936	7231	7432	7102	7409	7786	7523	7092	7342	7603
Number of Adult on community Health waiting lists by system (Frimley)	No Trust Target	External	5796	5678	6124	6376	6223	5882	6188	6307	5968	5792	5716	5908
Community Dentistry Activity (ytd)	Total Trust UDA per Annum 9037 CDS & 2000 DAC. 919 per month	External	9349	9827	725	1441	2116	2314	4560	4723	5576	6383	7167	8248
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	99.59	100	100	100	100	100	100
Number of Patients not seen on RTT waiting over 52 weeks	0	External	0	1	0	1	0	0	0	0	0	0	0	0
Number of Patients not seen on RTT waiting over 65+ weeks	0	External	0	1	0	1	0	0	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	99.53	97.03	98.21	71	98.92	96.20	96.39	98.40	98.62	98.48	96.32	96.81

True North Patient Experience

Metric	Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	26 per month	Internal	31	26	23	15	19	27	28	37	10	18	21	17
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	Internal	91.4%	86.1%	80.2%	86.6%	85.8%	96.6%	94.6%	90.2%	84.3%	89.1%	90.1%	83.1%
Number of CYP (0-17 years) on Community Health waiting lists by system Frimley (YTD)	No Trust Target	External	2165	2244	2206	2359	2347	2113	2081	2149	2100	2047	2000	1954
Number of CYP (0-17 years) on Community Health waiting lists by system BOB (YTD)	No Trust Target	External	1351	1374	1281	1370	1433	1305	1241	1351	1315	1282	1273	1308
CYP referred for an assessment or treatment of an ED will access NICE treatment <1 week (Urgents): %	95%	Internal	100%	100%	40%	50%	100%	100%	60%	100%	100%	100%	100%	80%
CYP referred for an assessment or treatment of an ED will access NICE treatment <4 weeks (Routines): %	95%	Internal	85.7%	60%	100%	90.9%	66.7%	80%	100%	100%	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	5167	5318	5481	5645	5808	6071	6221	6370	6538	6719	6857	7002
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	7385	7587	7801	8030	8234	8478	8638	8821	9054	9275	9466	9677
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	2881	2954	3025	3112	3179	3279	3339	3430	3546	3653	3716	3824
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	1977	2037	2087	2156	2194	2263	2327	2385	2446	2511	2569	2632

True North Patient Experience

Metric	Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Talking Therapies Referral to Treatment 75% within 6 weeks BOB	75%	External	90%	93%	99%	91%	91%	88%	87%	90%	93%	94%	94%	93%
Talking Therapies Referral to Treatment 75% within 6 weeks Frimley	75%	External	92%	90%	90%	91%	93%	87%	87%	90%	91%	92%	92%	93%
Talking Therapies Referral to Treatment 95% within 18 weeks BOB	95%	External	100%	100%	100%	100%	100%	99%	100%	100%	99%	100%	100%	100%
Talking Therapies Referral to Treatment 95% within 18 weeks Frimley	95%	External	100%	100%	100%	100%	99%	100%	99%	100%	100%	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%	7.0%	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%	6.9%	8%
Talking Therapies Overall receiving a course of treatment (2+ contacts) BOB	60%	External				61%	64%	63%	64%	61%	64%	65%	61%	67%
Talking Therapies Overall receiving a course of treatment (2+ contacts) Frimley	60%	External				56%	61%	55%	60%	56%	57%	53%	60%	60%

True North Patient Experience

Metric	Proposed Target..	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Talking Therapies Recovery rates BOB	50%	External	44%	49.5%	50%	52.80%	46%	53%	52.5%	51.60%	52.70%	52.70%	48.39%	54%
Talking Therapies Recovery rates Frimley	50%	External	44%	47%	45%	51%	47%	50%	51.39%	54.40%	51.80%	54.60%	53.20%	50%
Talking Therapies Reliable Improvement for those completing a course of treatment Frimley	67%	External			59%	63.80%	65%	62%	65.40%	69%	68%	66%	67.60%	67%
Talking Therapies Reliable Improvement for those completing a course of treatment BOB	67%	External			64%	62.79%	63%	64%	64.5%	69%	69%	71%	64.60%	65%
Talking Therapies Reliable Recovery for those completing a course of treatment Frimley	48%	External			43%	45.5%	44%	47%	51.39%	52%	50%	51%	50.20%	49%
Talking Therapies Reliable Recovery for those completing a course of treatment BOB	48%	External			46%	48.5%	46%	49%	48.19%	48%	50%	51%	45.70%	50%
Talking Therapies In treatment pathway waits 90 day for 2nd Appointment Frimley	<10%	External	9.80%	11.5%	15.2%	16.1%	18.6%	20%	14.7%	18.5%	20%	22%	22%	28.0%
Talking Therapies in treatment pathway waits 90 day for 2nd Appointment BOB	<10%	External	18.1%	16.1%	16.4%	15.9%	15.1%	18%	19.4%	20%	18%	23%	20%	25%

True North Patient Experience

			Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	60% treated	External	100	100	100	100	100	83	100	100	100	100	100	67
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	6445	6700	6903	7869	8076	8370	8569	8799	9582	9857	10035	10315
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	5162	5349	5509	6172	6325	6508	6676	6834	7399	7581	7717	7903
Access to Perinatal Services- Assessments Frimley	7.5% live birth rate - 409 Oct 23 439 March 2023. 37 per Month	External	23	22	20	22	32	34	25	23	30	29	18	28
Access to Perinatal Services - Assessments BOB	10% live birth rate - 611 per annum 51 per month	External	44	30	44	30	38	50	27	38	33	35	42	37
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	92%	96%	90%	93%	94%	95%	94%	90%	91%	93%	94%	91%
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	18	17	14	10	10	5	8	7	9	14	10
Estimated Diagnosis rate for Dementia Frimley	66.67%	External	64.88%	64.98%	66.10%	66.14%	66.53%	68%	68%	66.71%	66.49%	66.85%	66.29%	65.93%
Estimated Diagnosis rate for Dementia BOB	66.67%	External	64.12%	64.60%	65.60%	65.36%	64.92%	64.90%	64.90%	66.14%	66.04%	66.25%	66.37%	65.67%

True North Harm Free Care Summary

Metric	Threshold / Target	External/Internal	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sept 24	Oct 24	Nov 24	Dec 24	Jan 25
Mental Health: AWOLs on MHA Section	10 per month	Internal	7	3	5	7	5	7	7	9	5	3	11	7
Mental Health: Absconsions on MHA section (Excl: Failure to return)	8 per month	Internal	1	1	1	1	1	1	1	1	1	1	1	2
Mental Health: Readmission Rate within 28 days: %	<8% per month	Internal	3.37	4	0	0	0	3.45	5.25	3.83	0	1.53	1.47	1.62
Pressure Ulcer with Learning	Tbc	Internal	3	2	2	4	1	4	0	0	2	1	1	
Mental Health 72 Hour Follow Up after Inpatient discharge	80%+	External	100%	86.0%	91.5%	93.1%	94.1%	91.0%	91.4%	100%	91.0%	88.3%	93.4%	89.4%
Self-Harm Incidents on Mental Health Inpatient Wards (ex LD)	61 per month	Internal	42	73	79	66	63	64	46	72	67	101	55	93
Self-Harm Incidents within the Community	31 per month	Internal	35	30	28	29	10	10	7	17	15	25	23	30
Gram Negative Bacteraemia	No Trust target	External	0	0	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	0	0	1	0	1	4	0	0	0
C.Diff with learning (Cumulative YTD)	0	External	0	0	0	0	1	2	3	3	4	4	4	4
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	0	0	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	1	1	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	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sept-24	Oct-24	Nov-24	Dec-24	Jan-25
Community Inpatient Occupancy	85%	Internal	89.4%	90.3%	90.6%	91.8%	91.6%	88.8%	86.9%	92.4%	91.7%	91.3%	91.8%	93.9%
Community Inpatient Average Length of Stay (bed days)	<21 days	Internal	28.1	26.5	33.3	25.8	26.2	21.7	24.5	24.7	24.6	24.3	24.9	23.9
Mental Health: Adult Acute LOS over 60 days % of total discharges	TBC	External	30%	34%	31%	28.0%	28.0%	33%	35.1%	24.3%	29.3%	24%	16.9%	26.4%
Mental Health: Older Adult Acute LOS over 90 days % of total discharges	TBC	External	55.0%	52%	59%	63%	63%	50%	41.6%	55.5%	50%	61.5%	60%	50%
DNA Rate: %	5% DNAs	Internal	4.66%	4.66%	4.70%	5.26%	4.79%	4.83%	4.97%	4.96%	4.91%	4.87%	4.47%	4.66%
Mental Health: Acute Occupancy rate (excluding Home Leave):%	85% Occupancy	Internal	98.5%	99.4%	98.5%	97.7%	97.1%	97.3%	99.2%	96.8%	97.4%	97.6%	98.4%	98.2%
Mental Health: Acute Average Length of Stay (bed days)	30 days	Internal	41.7	36.4	60.6	58.7	47.2	49.6	58.8	46.1	50.8	40.5	36	60.8
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): %	80% Occupancy	Internal	79.31%	84.04%	95.34%	82.42%	81.71%	83.87%	88.40%	90.10%	80.82%	86.14%	87.79%	89.75%
Community Virtual Ward Occupancy Frimley	80%	External	46.40%	54%	42.19%	50.60%	52.5%	57.59%	51.30%	61.29%	77.29%	84%	73.5%	79.80%
Community Virtual Ward Occupancy BOB	80%	External	82.39%	75.79%	88.90%	91.90%	94.79%	82.59%	87.90%	79.40%	76.90%	79.60%	91.29%	100.2%
Agency Spend within Ceiling	3.2%	External			2.70%	3%	2.19%	3.10%	3.20%	2.90%	2.90%	3%	2.39%	2.70%
Elective Recovery Performance vs Target	11,614	External			12238	11898	12179	13710	11888	12951	13862	13180	11808	13567

NHS
Berkshire Healthcare
NHS Foundation Trust

Sustainability update

for greening Berkshire Healthcare

Justine Alford and Ailsa Leach, Sustainability Lead Managers
Compliance & Risk

March 2025

The **case for net zero**

Berkshire Healthcare NHS Foundation Trust

Through the Climate Change Act (2008), the UK is legally bound to reach **net zero by 2050**.

The NHS has embedded net zero into legislation, through the **Health and Care Act 2022,** committing to **reach net zero by 2040**.

We also know that beyond the law, there is an irrefutable human case – **reducing emissions reduces admissions.**

Healthy environments lead to:

- ✓ Fewer cases of disease
- ✓ Improved mental health
- ✓ Shorter hospital stays
- ✓ Lower care burden

* Climate policies addressing air quality, physical activity, and dietary changes led to a median mortality reduction of 1·5% *The public health co-benefits of strategies consistent with net-zero emissions: a systematic review*

What we **need to do**

Berkshire Healthcare NHS Foundation Trust

NHS Standard Contract:

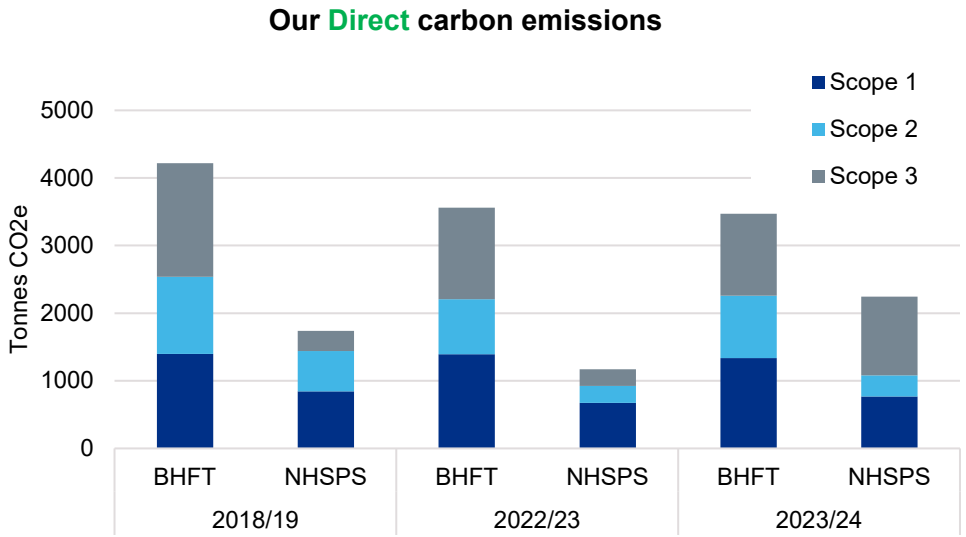
- **Reduce greenhouse gas emissions** in line with targets in Delivering a ‘Net Zero’ National Health Service
- **Phase out fossil fuel heating** and replace them with less polluting alternatives
    - UK legislation: no new gas boilers by 2035
- **Reduce waste and water** through best practice and innovations

NHS Travel and Transport Strategy

- From 2027, **all new vehicles** owned and leased by the NHS will be zero emission vehicles

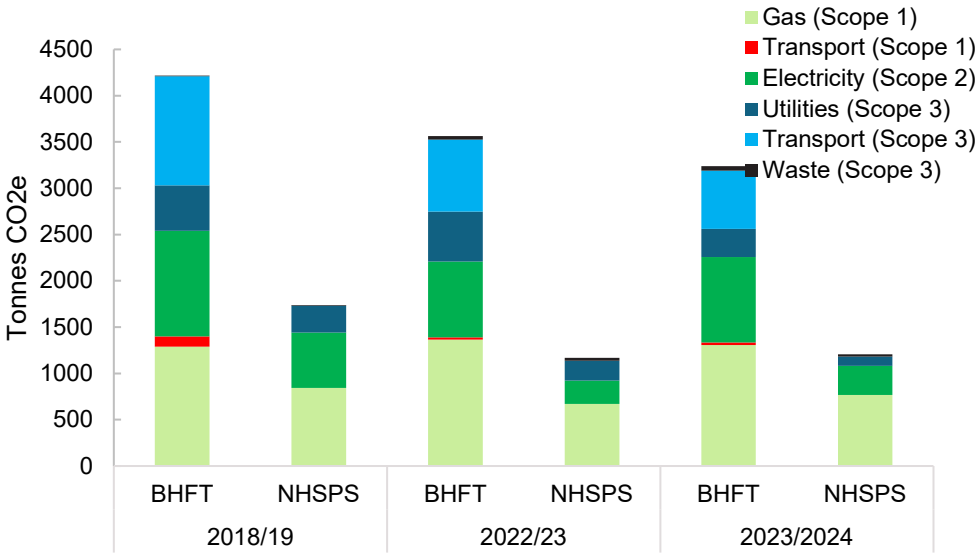
Our progress: reducing emissions

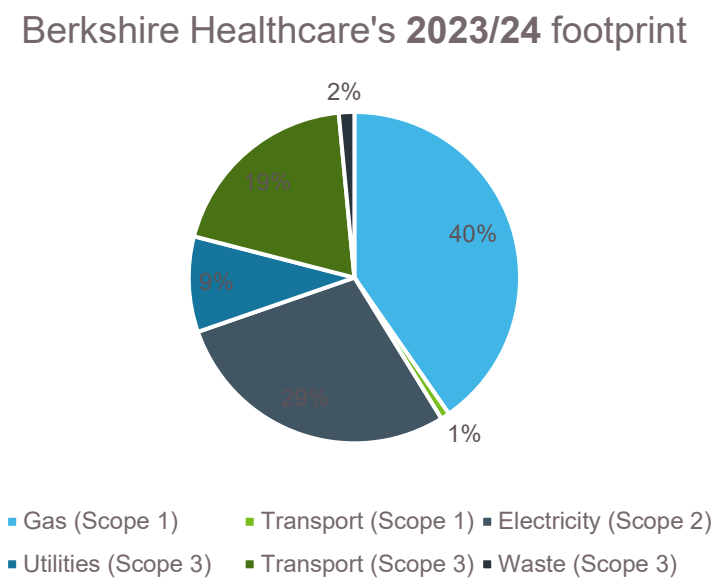
Berkshire Healthcare NHS Foundation Trust



- Our carbon intensity – how much CO_2 we emit per sqm – has dropped by 58% over 5 years
- To achieve an 80% reduction by 2032, we need to triple our rate of carbon reduction to 15% a year

Our carbon footprint



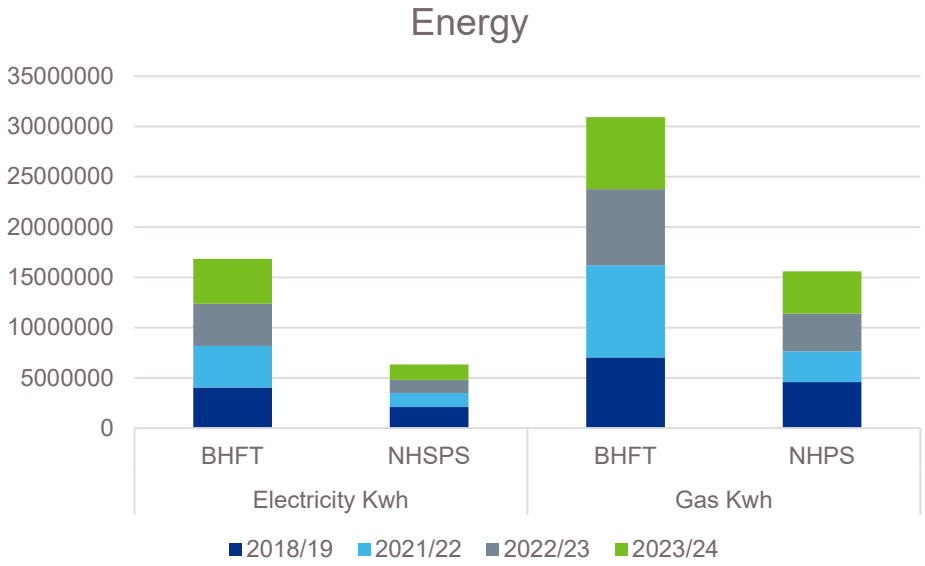


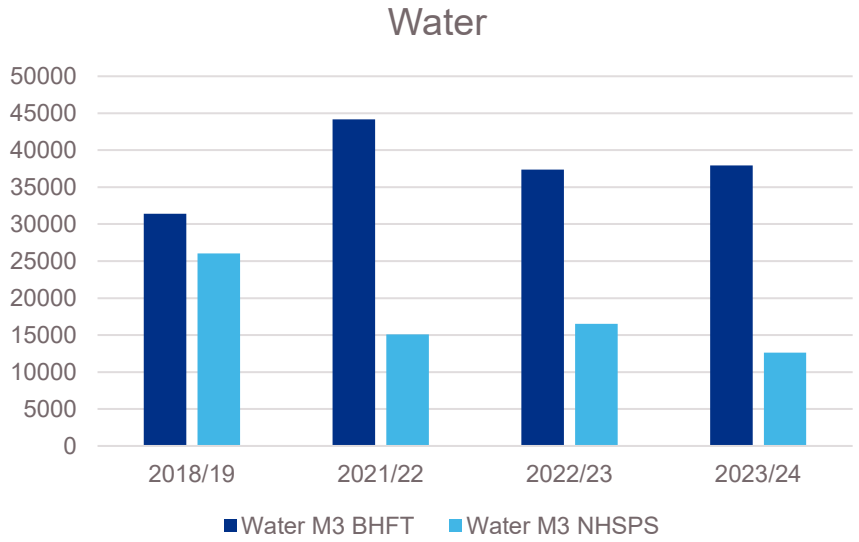
Our progress: utilities

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Install renewable energy technology	✓Solar panels installed at 2 sites - Erlegh House and Church Hill House, saving over 14.5 tonnes of CO2 (equivalent to 900 trees), with 2 further sites progressing (London House, Abell Gardens) ✓Project Initiation Document in development for solar farm at WBCH
Decarbonise heating across all sites	✓£2.6m awarded to replace gas at WBCH with clean air source heat pumps ✓Decarbonisation plans / energy audits completed at all major BHFT sites and are guiding net zero planning
Reduce overall utility consumption	✓Energy consumption intensity has fallen ✓LED lighting installed at all BHFT sites ✓Smart meters being introduced ✓Propelair loos saved 31,000 litres of water in 2 months
Increase and improve utility management, measuring and monitoring	✓Sustainable Estates Strategy developed as part of wider Estates Strategy refresh

Our progress: utilities





Our progress: travel and transport

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Roll out an electric vehicle charging network across all the larger sites	✓ 34 EV charging spaces installed at 8 sites, further expansion and upgrade to network being explored ✓ All 8 estates fleet vehicles are now electric
Review and implement Trust wide Green Travel Plan and site-specific plans	✓ Travel and transport review completed and sustainable travel strategy in development, due March 2025 ✓ Clean Air Plan developed and approved
Measure and monitor all travel data from service delivery and commuting	✓ 1 million fewer miles driven in 2023/24 compared to baseline (19/20), but mileage has slightly increased recently (by 250k miles/year)
Promote, develop and encourage active travel	✓ Awareness days shared via Green Newsletter and Nexus, such as Cycle to Work Day and National Walking Month

Our progress: waste

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Increase and improve the measuring and monitoring of all waste	✓ Waste audit completed and has informed the development of a new waste strategy ✓ New BHFT Waste Procedure Manual available on Nexus
Introduce medical equipment and office furniture reuse scheme	✓ Daisy-grip reusable tourniquet trial complete and is recommended. Implementation would save £11,286/year and a tonne of landfill waste ✓ Insulin pen recycling implemented in pharmacy and diabetes teams
Increase Trust wide recycling	✓ General waste has reduced by 19.4 % since 2017/18 ✓ Recycling an average of 113 tonnes of waste per year
Cut confidential waste	× Confidential waste is increasing and remains high, however all paper purchased by Trust is recycled

Our progress: people

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Develop and support network of Net Zero Heroes	✓ 33 recruited across 14 sites ✓ Members develop regular comms content for staff to engage workforce in environmental action
Invest and maintain high quality internet / intranet information and guidance for staff and stakeholders	✓ Green newsletter sent quarterly, read by two-thirds of staff (63% open rate – higher than Team Brief). Top article on sustainable food.
Increase in training to all staff	✓ Trained 46 to become Carbon Literate ✓ Waste training in development

Our progress: estate

Berkshire Healthcare NHS Foundation Trust

Our Green Plan Goals	What we've done
Increase planting and tree cover on all sites	✓ 65 planted at 3 sites, more ordered ✓ Wellbeing and nature gardens installed at Wokingham Hospital and Church Hill House, and nature installations underway at Abell Gardens and Whitley
Net zero to be a key consideration for all building and site selection	✓ Sustainability checklist being applied during assessment of potential new properties
All capital projects to contribute to net zero and sustainability	✓ Environmental impact assessment being used for all new capital projects
Develop and implement Trust wide biodiversity strategy	✓ Pilot survey commissioned at West Berkshire Community Hospital

Actions for 2025/26

Berkshire Healthcare NHS Foundation Trust

- Develop new 3-year Trust Green Plan aligned with national and statutory guidance
- Implement sustainable estates strategy
- Continue to use recommendations from decarbonisation plans and energy audits to identify effective measures that can reduce costs, consumption, and carbon emissions
- Implement waste strategy to reduce production, costs and carbon
- Engage and educate staff on energy saving
- Develop and implement a sustainable travel and transport strategy, due March 2025
- Continue to expand EV charging infrastructure
- Investigate further opportunities for solar panel installation and pursue solar farm at WBCH
- Develop and implement biodiversity strategy

NHS
Berkshire Healthcare
NHS Foundation Trust

Thank you

questions…?

- ✓ Since 2017/18 we've increased the amount of waste we recycle by

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 22 January 2024

(Conducted via Microsoft Teams)

Present:	Rajiv Gatha, Non-Executive Director, Committee Chair Sally Glen, Non-Executive Director *(deputising for Mark Day, Non-Executive Director)* Naomi Coxwell, Non-Executive Director
In attendance:	Paul Gray, Chief Financial Officer Rebecca Clegg, Director of Finance Graham Harrison. Head of Financial Services Debbie Fulton, Director of Nursing and Therapies Dr Minoo Irani, Medical Director Clive Makombera, RSM, Internal Auditors Sharonjeet Kaur, RSM, Internal Auditors Amanda Mollet, Head of Clinical Effectiveness and Audit Jenny Loganathan, TIAA Ben Lazarus, Ernst and Young, External Auditors Julie Hill, Company Secretary Mark Davison, Chief Information Officer *(present for agenda items 1-7)* Ian Hayward, Assistant Director of Performance and Information *(present for agenda item 5)*
Observer:	Samina Hussain, Frimley Integrated Care Board

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Rajiv Gatha, Chair welcomed everyone the meeting.	
1.B	**Apologies for Absence**	
	Apologies were received from: Mark Day, Non-Executive Director and Alison Kennett, Ernst, and Young.	
2.	**Declaration of Interests**	
	There were no declarations of interest.	

3.	**Minutes of the Previous Meetings held on 30 October 2024**	
	The Minutes of the meeting held on 30 October 2024 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	
	The Action Log had been circulated. The Committee noted the Action Log.	
5.	**Data Quality Presentation**	
	The Chair welcomed Mark Davison, Chief Information Officer and Ian Hayward, Assistant Director of Performance and Information to the meeting. The Assistant Director of Performance and Information gave a presentation and highlighted the following points: • Data quality errors needed to be viewed in the context of the Trust's activity. The Trust currently had approximately 113,000 patients and had around 940,000 patient appointments per annum. • The main reasons for inaccurate data were transcription errors, process issues and human error in data entry such as recording the wrong date and times. Errors also occurred when data needed to be transcribed from one system to another, for example, incidents were recorded on the DATIX system but also needed to be manually inputted onto the Rio (electronic patient record) system. • Nationally trusts' data performance was measured against the Data Quality Maturity Index. The Trust was currently ranked fifth for mental health data quality. • The Trust's Digital Clinical Leaders Group had agreed to introduce Rio refresher training for staff. The training would be broken down into bite-size elements with videos and guidance available to help staff understand system updates and processes. • The Trust was working with the supplier to try and make the Rio system more user-friendly and intuitive • The Trust was also exploring ways of automating data transcription between systems, for example, between the DATIX and Rio systems to reduce human error in incident recording. The Chair asked if the success of data quality mitigations and improvement measures, such as the refresher training was measured. The Assistant Director of Performance and Information said that whilst specific staff cohorts would not be tracked, the upcoming refresher training in February 2025 would be a good test to measure improvement. Sally Glen. Non-Executive Director asked whether there was a sense that important information was not being recorded onto the Rio system due to the complexity around inputting data.	

	The Director of Nursing and Therapies said that incident investigations had not highlighted concerns around information not being recorded due to the complexity of the Rio system. Naomi Coxwell, Non-Executive Director said that it was helpful for the Committee to understand how the Trust benchmarked against other trusts in terms of data quality and to be informed about the Trust's ongoing work to improve data quality. The Chair thanked the Assistant Director of Performance and Information for his presentation. The Committee noted the presentation.	
6.	**Annual Cyber Security Report**	
	The Chief Information Officer presented the report and confirmed that there had been no cybersecurity incidents during 2024 which was testament to the technical and cultural measures the Trust had taken to protect the Trust's digital infrastructure. It was noted that the National Cyber Security Team and the NHS Chief Security Officer had indicated that cyber-attacks against the NHS appeared to be plateauing. The Chair noted that the Trust used Microsoft Sentinel as the Security Information and Event Management product and asked whether this was the best monitoring system. The Chief Information Officer explained that the Sentinel system was part of Microsoft and was therefore a core part of the Trust's infrastructure and was able to penetrate and monitor parts of the Trust's digital systems that other products may not be able to access. The Chair asked whether there was more that the Board and the Executive Team could do to protect the Trust against cyber-attacks. The Chief Information Officer said that the biggest challenge was around the supply chain whether this was public or private sector partners and getting the requirements to be a little less flexible and involving the IT team earlier in the procurement cycle. Sally Glen, Non-Executive Director referred to the recent cyber-attack at Guy's and St Thomas NHS Foundation Trust and asked whether the lessons learnt from that incident had been shared across the NHS. The Chief Information Officer said that it often took around two years before any official lessons were shared although lessons were shared informally in a timelier fashion. The Committee noted the report.	

7.	**Annual Information Governance Report 2024**	
	The Annual Information Governance Report 2024 had been circulated. The Chief Information Officer presented the report and highlighted the following points: • There were no current or historical conditions or cautions against the Trust's data protection registration. • The NHS Data Security and Protection Toolkit (annual) assessment of Standards was exceeded. • Of the 1,381 Subject Access Requests (SARs) the Trust received, 0 deadlines were extended and only 2 exceeded the timeframe for response. • Of the 467 internally reported incidents, 1 met the threshold of a reportable breach to the Information Commissioner's Office who had confirmed that they would be taking no action in this case. • 3 complaints were made directly to the Information Commissioner's Office by members of the public, none resulted in further action by the Information Commissioner's Office against the Trust. • 97.7% of staff were compliant with information governance training (95% is the requirement). • The volume of Freedom to Information requests received continued to increase year on year and this placed a burden on the Trust. The Chair referred to the chart (section 3.4 of the report) which showed the top three incident types over the last three years and noted that the number of incidents had significantly increased. The Chief Information Officer said that there had not been an increase in the number of complaints or Data Protection Officer contacts and therefore it was surmised that the increase was due to better reporting. The Chair referred to the chart (section 3.6 of the report) which showed the 2024 incident volume by type which highlighted that the most common incident was data sent by email to the incorrect recipient and asked how this occurred. The Chief Information Officer explained that there were a number of reasons, for example, information sent to an old email or where someone had more than one email address or where the email was incorrectly inputted. The Chief Information Officer said that data sharing arrangements between the Trust and third parties remained a challenging area of work. The Committee noted the report.	
8.A	**Board Assurance Framework**	
	The latest Board Assurance Framework (BAF) had been circulated. The Chief Financial Officer presented the report and highlighted the following points:	

	• Risk 1 (Workforce) had been updated to include the recruitment and selection strategy and the work the Trust was doing as part its Anti-Racism Strategy • Risk 2 (Demand and Capacity) had been updated to include the work being undertaken with the Priory to ensure that the environment of the new Poppy Ward at the Priory Hospital, Newbury met the Trust's standards • Risk 3 (Patient Voice) had been updated to include the Trust's work around reducing mental health act detentions of black individuals • Risk 6 (Finance) had been updated to include the Trust's work around developing the financial plan 2025-26 • Risk 7 (Digital) included an update on the Trust's work around multi-factor authentication standards (76 systems were complete with 25 systems capable of supporting multi-factor authentication not yet implemented). The Committee noted the report.	
8.B	**Corporate Risk Register**	
	The Corporate Risk Register (CRR) had been circulated. The Chief Financial Officer presented the paper and highlighted the following points: • CRR Risks 1 (Absconsion) and CRR 2 (Ligature) had been updated to reflect the Trust work around ensuring that the new outsourced mental health ward (Poppy ward) at the Priory Hospital met the Trust's requirements • CRR Risk 6 (Third Party Service Providers) had been updated to make reference to monthly contract meetings between the Trust and the Priory • CRR Risk 7 (Physical Environment Risk – Prospect Park Hospital) had been updated to include the Trust's work with the Prospect Park Hospital PFI Provider which included the PFI Provider commissioning an asset condition survey, a fire risk survey, and a mental health survey. • CRR 8 (Physical Environment Risk - Jubilee Ward) – had been updated to include the public consultation on relocating Jubilee Ward being undertaken by the Frimley Integrated Care Board • CRR 10 (Long Waits for Services) had been updated to include the oversight meeting which had been established to review services with long waits. The Committee noted the report.	
9.	**Single Waiver Tenders and Provider Selection Regime Direct Awards Report**	
	A paper setting out the Trust's single waivers approved from October 2024 to December 2024 had been circulated.	

	The Chief Financial Officer presented the paper and pointed out that a number of the single waiver tenders this quarter were to provide more time to undertake the tender process for new contracts. The Chief Financial Officer reported that the Trust had made two awards under the Provider Selection Regime. The Chair confirmed that he was happy with the two directly awarded contracts. The Committee noted the report.	
10.	**Information Assurance Framework Update Report**	

	The Chief Financial Officer presented the paper and highlighted the following points:
	• A total of five indicators were audited during the quarter:
	  ○ Active Inappropriate Out of Area Placements at the end of the month (high assurance for data quality, green)
	  ○ Mental Health: Readmission Rate within 28 Days (high assurance for data quality, green)
	  ○ Clinically Ready for Discharge by Ward (Mental Health (moderate assurance for data quality, amber)
	  ○ Crisis Resolution/Home Treatment team Gate Keeping of Inpatient Admissions (moderate assurance for data quality, amber)
	  ○ 72 Hour Follow Up from Discharge from a Mental Health Ward (low assurance or data quality red)
	• Of the indicators audited, there remained persistent errors in recording of dates and some knowledge gaps which were being addressed. Timeliness issues were also identified in respect of the 72 Follow Up indicator.
	
	The Committee noted the report.	

11.	**Losses and Special Payments Report**	
	Due to low numbers, there was no report this quarter.	
12.	**Clinical Claims and Litigation Report**	
	The Director of Nursing and Therapies presented the paper and reported that during the quarter, there were three new claims all relating to employee liability (two were as a result of staff being assaulted at work and one related to a fall with injury whilst undertaking a home visit). It was noted that four litigation claims were closed during the quarter. The Committee noted the report.	

13.	**Clinical Audit Report**	
	The Clinical Audit Report had been circulated. The Medical Director presented the report and reported that following reports would be presented to the February 2025 Quality Assurance Committee meeting: • National Clinical Audit Psychosis – Early Intervention in Psychosis Audit • National Audit of Dementia – Memory Clinic Services • POMH 16c: Rapid Tranquilisation • National Audit of Inpatient Falls report • National Respiratory Audit Programme – combined organisational report • Sentinel Stroke National Audit Report The Medical Director commented that publishing so many reports in a short space of time had put pressure on the Clinical Audit Team, but the Trust remained on track to complete the Annual Clinical Audit Plan by the end of March 2025. The Committee noted the report.	
14.	**Anti-Crime Specialist Report**	
	Jenny Loganathan, Anti-Crime Specialist, TIAA presented the report and highlighted the following points: • The Anti-Crime Specialist had submitted a fraud awareness article which was included in the Trust's Team Brief electronic newsletter. The Anti-Crime Specialist had also made site visits across the Trust during International Fraud Awareness Week (17-23 November 2024), visiting teams to raise awareness. • The NHS Counter Fraud Authority's had launched a procurement local proactive exercise focussing on due diligence and contract management. The Interim Report together with a management action plan would be submitted to the Trust for review and agreement of the management actions • The National Fraud Initiative Exercise 2024-25 to identify staff with dual employment, for example, working elsewhere whilst on sick leave etc payroll data matches were released on 20 December 2024. The Trust's Human Resources team were currently reviewing all the potential matches • Creditor and Companies House matches were due to be released shortly and would be reviewed in conjunction with the Trust's Finance Team • The Anti-Crime Specialist was checking staff records to identify staff who had not declared relevant outside interests. • The report included updates on the current investigations. Sally Glen, Non-Executive Director referred to the investigation section of report and asked in cases of proven fraud concerning a registered healthcare	

	professional who was responsible for informing the individual's professional body. Jenny Loganathan said that if the Trust had disciplined the member of staff, the Human Resources team would contact the relevant professional body. **The Committee**: noted the report.	
15.	**Internal Audit Progress Report**	

	a) Internal Audit Progress Report
	Sharonjeet Kaur, Internal Auditors, RSM presented the paper and highlighted the following points:
	
	• Since the last Audit Committee meeting, the following reports had been issued:
	  o Key Financial Controls – Accounts Receivables (substantial assurance)
	  o Risk Management (reasonable assurance)
	• The scope and revised start date of the remaining audit relating to Safety Planning and Risk Assessments had been agreed with the respective Executive Lead.
	• Since the last meeting, four follow up actions had been closed. One medium action relating to the Out of Area – Long Term Placement review was overdue and was in the process of being implemented. A revised implementation date had been agreed with management.
	
	b) Internal Audit Plan 2025-26
	
	Sharonjeet Kaur reported that the Internal Audit Plan for 2025-26 had been agreed with the Executive Directors and was based on an analysis of the Trust's organisational objectives, risk profile and assurance framework as well as other factors affecting the Trust in the year ahead, including changes within the sector.
	
	The Chair asked whether the volume of audits proposed for 2025-26 was in line with previous years.
	
	The Chief Financial Officer pointed out the national requirements for the Data Security and Protection Toolkit audit were currently being reviewed, and it was expected that the changes would be significant. The number of reviews had been reduced from eight to seven to accommodate the anticipated additional work.
	
	c) Information Reports
	
	The following information Reports had also been circulated:
	
	• NHS News Briefing
	• Healthcare Benchmarking Report
	• Risk Radar Report
	• Global Internal Audit Standards
	• Internal Audit Code of Practice
	
	The Committee:	

	a) Noted the Internal Audit Progress Report b) Approved the Internal Audit Plan 2025-26 c) Noted the information reports	
16.	**External Audit Report**	
	Ben Lazarus, External Auditors, Ernst, and Young (E&Y) reported that planning for the 2024-25 was progressing well. It was noted that Ernst and Young had a positive relationship with the Trust. Ben Lazarus confirmed that the External Auditors remained independent from the Trust. Naomi Coxwell, Non-Executive Director said that the Internal Audit Plan included a review of the Trust's Ledger and commented that she thought that this was an area which the external audit would cover. The Chief Financial Officer explained that the internal audit would provide a more in-depth review of the Trust's financial controls around the Ledger. The Committee noted the report.	
17.	**Minutes of the Finance, Investment and Performance Committee meeting held on 30 October 2024**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 30 October received and noted. The Committee noted the minutes.	
18.	**Minutes of the Quality Assurance Committee held on 26 November 2024**	
	The minutes of the Quality Assurance Committee meetings held on 26 November 2024 were received and noted.	
19.	**Minutes of the Quality Executive Committee Minutes – 21 October 2024, 18 November 2024, and 16 December 2024**	
	The minutes of the Quality Executive Committee meetings held on: 21 October 2024, 18 November 2024 and 16 December 2024 were received and noted.	
20.	**Annual Work Plan**	
	The Committee's Annual Work Plan was noted.	
21.	**Any Other Business**	
	There was no other business.	

22.	Date of Next Meeting	
	The next meeting of the Committee was scheduled for 23 April 2025.	

The minutes are an accurate record of the Audit Committee meeting held on 22 January 2025.

Signed: - _____

Date: - 22 January 2025 _____

Berkshire Healthcare NHS Foundation Trust

Trust Board Paper

Board Meeting Date	11 March 2025
Title	**The Use of the Trust Seal Report**
	Item for Noting
Reason for the Report going to the Trust Board	In accordance with the Trust's Standing Orders, the Trust Board is informed each time the Trust's Seal is affixed to documents. The Trust's Seal was affixed to documents pertaining to the Trust's new Place of Safety at Prospect Park Hospital.
Business Area	Corporate
Author	Company Secretary
Relevant Strategic Objectives	**Efficient use of resources** **Ambition:** We will use our resources efficiently and focus investment to increase long term value