BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

TRUST BOARD MEETING

(conducted electronically via Microsoft Team because of the COVID-19 pandemic)

10:00am on Tuesday 14 September 2021

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 13 July 2021	Martin Earwicker, Chair	Enc.
5.2	Action Log and Matters Arising	Martin Earwicker, Chair	Enc.
	QUALITY		
6.0	Crisis Resolution Home Treatment Team (CRHTT) Case Studies	Debbie Fulton, Director of Nursing and Therapies and members of the CRHTT Nurissa Kayani, Kerean Peeters, Temba Murefu, Lucy Saunders Tich Mubaira and Reuben Pearce	Verbal
6.1	Patient Experience Report – Quarter 1	Debbie Fulton, Director of Nursing and Therapies	Enc.
6.2	Quality Assurance Committee a) Minutes of the meeting held on 24 August 2021 b) Learning from Deaths Quarterly Report c) Guardians of Safe Working Quarterly Report	David Buckle, Chair of the Quality Assurance Committee	Enc.
	EXECUTIVE UPDATE		
7.0	Executive Report	Julian Emms, Chief Executive	Enc.
	PERFORMANCE		
8.0	Month 04 2021/22 Finance Report	Paul Gray, Acting Chief Financial Officer	Enc.
8.1	Month 04 2021/22 Performance Report	Paul Gray, Acting Chief Financial	Enc.

No	Item	Presenter	Enc.
		Officer	
8.2	a) Finance, Investment and Performance Committee Meeting held on 16 August 2021 b) Finance, Investment and Performance Committee's Terms of Reference – minor amendments	Naomi Coxwell, Chair, Finance, Investment and Performance Committee	Verbal Enc.
	STRATEGY		
9.1	Equality, Diversity and Inclusion Strategy Mid-Year Review Report	Alex Gild, Deputy Chief Executive/Nathalie Zacharias, Director of Equality, Diversity and Inclusion	Enc.
9.2	Workforce Disability Equality Standard Report	Alex Gild, Deputy Chief Executive/ Nathalie Zacharias, Director of Equality, Diversity and Inclusion	Enc.
9.3	Workforce Race Equality Standard Report	Alex Gild, Deputy Chief Executive/ Nathalie Zacharias, Director of Equality, Diversity and Inclusion	Enc.
9.4	Wellbeing Guardian Report	Alex Gild, Deputy Chief Executive/Jane Nicholson, Director of People	Enc.
9.5	Strategy Implementation Plan Report	Alex Gild, Deputy Chief Executive	Enc.
	CORPORATE GOVERNANCE		
10.0	Audit Committee Meeting held on 21 July 2021	Chris Fisher, Chair of the Audit Committee	Enc.
10.1	Council of Governors Update	Martin Earwicker, Trust Chair	Verbal
10.2	Schedule of Meetings	Martin Earwicker, Trust Chair	Enc.
	Closing Business		
11.	Any Other Business	Martin Earwicker, Chair	Verbal
12.	Date of the Next Public Trust Board Meeting – 09 November 2021	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 13 July 2021

(Conducted via Microsoft Teams)

Present:	Martin Earwicker	Chair
	Chris Fisher	Non-Executive Director
	David Buckle	Non-Executive Director
	Naomi Coxwell	Non-Executive Director
	Mark Day	Non-Executive Director
	Aileen Feeney	Non-Executive Director
	Julian Emms	Chief Executive
	Alex Gild	Chief Financial Officer
	Debbie Fulton	Director of Nursing and Therapies
	Dr Minoo Irani	Medical Director
	David Townsend	Chief Operating Officer
	Paul Gray	Acting Chief Financial Officer
In attendance:	Julie Hill	Company Secretary
	Melissa James	District Nursing Team (*present for agenda item 5.0)*
	Samantha McEndoo	Community Nursing Team (*present for agenda item 5.0*
	Saiyad Allymamod	Community Nursing Team (*present for agenda item 5.0)*
	Mike Craissati	Freedom to Speak Up Guardian (*present for agenda items 6.1 and 6.2)*

21/112	**Welcome and Public Questions** (agenda item 1)
	The Chair welcomed everyone to the meeting. There were no public questions.
21/113	**Apologies** (agenda item 2)
	Apologies were received from: Mehmuda Mian, Non-Executive Director.

21/114	**Declaration of Any Other Business** (agenda item 3)
	There was no other business.
21/115	**Declarations of Interest** (agenda item 4)
	i. **Amendments to Register** – none
	ii. **Agenda Items** – none
21/116	**Minutes of the previous meeting – 11 May 2021** (agenda item 5.1)
	The Minutes of the Trust Board meeting held in public on Tuesday 11 May 2021 were approved as a correct record.
21/117	**Action Log and Matters Arising** (agenda item 5.2)
	The schedule of actions had been circulated. **The Trust Board:** noted the action log.
21/118	**Patient Stories – Community and District Nursing (**agenda item 6.0)
	The Chair welcomed members of the Community and District Nursing Teams: Melissa James, Samantha McEndoo and Saiyad Allymamod. The Director of Nursing and Therapies reported that members of the Community and District Nursing Teams would present three patient case studies to illustrated how the Community and District Nursing Teams in West Berkshire were adapting their services to better support patients. The slides presented at the meeting are attached to the minutes. **a) HITEC Integration - District Nursing Team - Physical Health West** The case study concerned a 52 year old woman with breast cancer who lived in Thatcham, West Berkshire. The woman had a PICC (peripherally inserted central catheter) line inserted and used to have to travel over 30 miles to the Royal Berkshire Hospital to receive regular chemotherapy treatment and to have blood tests. The patient was referred to the specialist Newbury District Nursing HITEC service. The HITEC service was able to give the patient her chemotherapy and to take blood tests at West Berkshire Community Hospital which was 1.5 miles from the patient's home. The Newbury District Nursing Team was also able to ensure that the patient was supported by the wider team at home as well. Feedback from patients about the service has been very positive. **b) Wound Care – Reading Community Nursing Innovation** The case study concerned a 29 year old male who had no previous medical history who

	had an unhealed wound to his inter-gluteal region. The patient had had three failed surgical interventions to close the wound over a three year period. The patient was referred to the Wound Care Nurse. The Wound Care Nurse developed a treatment plan which resulted in a reduced dressing change frequency from daily to twice weekly and this enabled him to return to work. At the end of the treatment, the wound had healed. (The patient's testimony is included with the slides attached to the minutes). **c) Catheter Clinic – Wokingham Community Nursing** The case study concerned a 52 year old woman with Spina Bifida and a number of other co-morbidities. The patient had a catheter and was anxious about catheter changes because there was a tendency for the catheter to adhere to the bladder wall causing pain and discomfort. For this reasons, catheter changes used to be undertaken at the Royal Berkshire Hospital with pain medication. The patient was referred to the Wokingham Community Nursing Catheter Clinic in May 2020. The Catheter Nurse used calming techniques and used pain relief gel to change the catheter. The frequency of the catheter changes was decreased from weekly to monthly. Since the patient's new treatment plan, there had been no hospital admissions for catheter related issues and the patient had reported that she felt more able to self-manage her condition. The Chair thanked the presenters for sharing the three patient stories. The Chair said that all three case studies highlighted the importance of providing more personalised care in the community and asked whether there were lessons that could be shared across the Trust. Sam McEndoo said that there needed to be more sharing of innovations and developments across the Trust and reported that the Wokingham Catheter Clinic was sharing its practice with East Berkshire. Aileen Feeney, Non-Executive Director said that a family member used the Wokingham Catheter Clinic and said that it provided an excellent service. Chris Fisher, Non-Executive Director pointed out that Community and District Nursing Services were sometimes filling gaps in service provision which used to be provided by other healthcare professionals, for example. primary care and said that it was important that the Integrated Care Systems ensured that services were wrapped around patients. Naomi Coxwell, Non-Executive Director asked whether there was an interface between the Community and District Nursing services and the voluntary sector. Sam McEndoo said that the West Berkshire locality had a good working relationship with the Sue Ryder charity. On behalf of the Board, the Chair thanked Melissa James, Samantha McEndoo and Saiyad Allymamod for attending the meeting and also thanked them for their work.
21/119	**Freedom to Speak Up Guardian's Report (December 2020 to July 2021)** (agenda item 6.1)
	The Chair welcomed Mike Craissati, Freedom to Speak Up Guardian to the meeting.

	The Freedom to Speak Up Guardian presented the paper and highlighted the following points: • It was important that the Freedom to Speak Up Guardian role was visible and accessible to all staff. This included: attending various team meetings; attending corporate, junior doctor and student induction sessions; attending the Essential Knowledge for New Managers training session; supporting all the Equality, Diversity and Inclusion staff network events and production and dissemination of posters and leaflets • The Freedom to Speak Up Guardian was also a member of the Safety Culture Steering Group, the Organisational Development Steering Group and the Diversity Steering Group • The Freedom to Speak Up Guardian was the lead for the microaggressions and bullying and harassment workstreams for the BAME Transformation Group • There were 49 cases (cases are those concerns raised which require action from the Freedom to Speak Up Guardian) during 2020-21. This was an increase of 18 cases compared with the previous financial year • Since the establishment of the Freedom to Speak Up Guardian role in March 2017, there had been a steady year on year increase in the number of cases as staff gained a better understanding of the Freedom to Speak Up Guardian role • The majority of the cases related to staff experience and relationships, for example bullying and harassment. • During the reporting period, there had been no patient safety concerns raised with the Freedom to Speak Up Guardian. The Trust Board can be assured that any patient safety issues were raised via other routes • The Freedom to Speak Up Guardian was the Chair of the Thames Valley and Wessex Regional Freedom to Speak Up Guardian Network consisting of all NHS Trusts and private providers (including primary care) within the region • The COVID-19 pandemic had not impacted the work of the Guardian. Very few concerns directly related to COVID-19 • The Freedom to Speak Up “Status Exchange” between the Guardian, Chief Executive, Director of Nursing and Therapies and Head of Occupational Human Resources continued to provide a good forum for structured information exchange, triangulation of information and ensuring action was completed regarding concerns raised. The Guardian now also met with the nominated Non-Executive Director Lead for Freedom to Speak Up (Mark Day) every six months David Buckle, Chair of the Quality Assurance Committee thanked the Guardian for his helpful and clear report and for the work he did. Dr Buckle commented that the increase in the number of Freedom to Speak Up cases was positive as it reflected that staff felt more confident in using the Freedom to Speak Up process. Mark Day, Non-Executive Director Lead for Freedom to Speak Up paid tribute to the work of the Freedom to Speak Up Guardian both in the Trust and in the region. Mr Day said that he was encouraged by the support the Chief Executive, Director of Nursing and Therapies and other Executive Directors gave to the Guardian. Naomi Coxwell, Non-Executive Director said that it would be helpful to the Board if future reports could include some anonymised examples of follow-up actions taken in response to issues raised via with the Guardian. **Action: Freedom to Speak Up Guardian** **The Trust Board**: a) Noted the contents of this report by the Freedom to Speak Up Guardian; and

	b) Supported the Freedom to Speak Up Guardian's recommendations as detailed in the report. This included supporting initiatives to reduce barriers to communication about the role of the Guardian and further work to develop a "listening up" culture across the Trust.
21/120	**Freedom to Speak Up Self-Assessment Report** (agenda item 6.2)
	The Director of Nursing and Therapies presented the paper and reported that the Freedom to Speak Up tool was designed to assist Boards in undertaking a self- assessment of the Trust Freedom to Speak Up processes and to ensure that these processes were in line with NHS England and Improvement and the National Guardians Office requirements as detailed in ''Guidance for Boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts'' The Director of Nursing and Therapies reminded the meeting that the Board had discussed the draft version Freedom to Speak Up self-assessment report at the Trust Board Discursive meeting in June 2021. The self-assessment report had been updated to reflect the Board's comments. The Director of Nursing and Therapies pointed out that the National Guardians Office had informed Trusts that there were reviewing the national Freedom to Speak Up Policy and had therefore suggested that Trusts delay updating their own policies until the revised national policy had been published. The Chair thanked the Director of Nursing and Therapies, Mark Day, Non-Executive Director Lead for Freedom to Speak Up and Mike Craissati, Freedom to Speak Up Guardian for their work in supporting the Trust's Freedom to Speak Up work. **The Trust Board**: approved the Freedom to Speak Up Self-Assessment and proposed actions to address any gaps.
21/121	**Annual Complaints Report (**agenda item 6.3)
	The Director of Nursing and Therapies presented the paper and reminded the meeting that the Board had received quarterly updates on the Trust's Patient Experience work which included a section on complaints. It was noted that during 2020-21, the Trust had received 213 formal complaints which was less than in the previous year (231 formal complaints were received during 2019-20). The Director of Nursing and Therapies cautioned against being able to make a comparison with previous years due to the impact of the COVID-19 pandemic during 2020-21. **The Trust Board**: noted the report.
21/122	**Research and Development Annual Report 2020-21** (agenda item 6.4)
	The Medical Director presented the paper and reported that during the first wave of the COVID-19 pandemic there was a national directive that Trusts' Research and

	Development work should be paused to enable Trusts to divert resources to support COVID-19 related research activities. The Medical Director reported that in 2020/21 Berkshire Healthcare was ranked 4th out of the 48 benchmarked mental health and community trusts for the number of research projects that the Trust recruited to. The Trust ranked 11th in the same benchmarked group for the number of individuals who participated in research projects. It was also noted that during 2020/21, the had Trust delivered 96 research projects; this compared with 79 in 2019/20. The Medical Director said that during 2021-22, the Trust would be refocussing its research and development activity on the Trust's core priorities. This would include offering research opportunities in the areas of physical health in people with severe mental illness, self-harm, suicidality, pressure ulcers, falls, digital interventions and supportive technology COVID-19. This would be guided by the Trust's new Research and Development Strategy which would be launched in 2021. Chris Fisher, Non-Executive Director said that it was a very informative report and particularly welcomed the section headed: "Impacts and benefits – what difference did research that we participated in really make?". Mr Fisher paid tribute to the Medical Director's leadership of the Trust's Research and Development work and also paid tribute to the Head of Research and Development. The Deputy Chief Executive said that he thought that the Board would welcome an opportunity to find out more about the Trust's Research and Development Strategy and proposed scheduling a slot at a future Board meeting. **Action: Medical Director/Company Secretary** **The Trust Board**: noted the report.
21/123	**Annual Medical Revalidation Report** (agenda item 6.5)
	The Medical Director presented the paper and reported that the annual board report for medical revalidation for 2020-21 was presented in the standard format prescribed by NHS England and Improvement. The Medical Director confirmed that the appraisal process in the Trust was not suspended or paused during any of the surge periods related to the COVID-19 pandemic in 2020/21. Appraisers and doctors followed the Principles of 'Appraisal 2020' for appraisals in the Trust, although everything else remained unchanged in terms of process and documentation. It was noted that 138 completed appraisals were confirmed for 2020/21, for 143 doctors with connection to the Trust. The Medical Director reported that three Consultant appraisals and one Specialty Doctor appraisal were approved as missed because the doctors were on long term sick leave and/or maternity leave. One Specialty Doctor appraisal was approved as delayed where workload was cited as a reason for the delay. David Buckle, Chair of the Quality Assurance Committee thanked the Medical Director and said that the report provided a high level of assurance. Dr Buckle asked whether there were any concerns around the appraisal process for doctors with a connection to the Trust but who had external Responsible Officers for their annual appraisals.

	The Medical Director said that although annual medical appraisals provided assurance that doctors were safe and fit to practice, governance systems and processes outside of the appraisal process were equally important. The Medical Director said that WestCall GPs, sessional GPs and some Geriatricians employed by the Royal Berkshire Hospital NHS Foundation Trust were appraised by Responsible Officers outside the Trust. The Medical Director said that he had a close working relationship with the other Responsible Officers and would share information if there were any concerns about a doctor's fitness to practice. Dr Buckle said that in the past there had been national concern about a small number of notorious doctors where there were serious concerns about their practices but when they moved to another job, these concerns had not been shared with their new employer. Dr Buckle asked for assurance that there were systems and processes in place to ensure that any concerns from a previous employer were followed up. The Medical Director confirmed that there was a national Medical Practice Information Transfer (MPIT) form and system in place which meant that whenever a doctor joined the Trust, the Berkshire Healthcare Responsible Officer requested information from the Responsible Officer of the doctor's previous trust via the MPIT which would include any concerns about their practice. Naomi Coxwell, Non-Executive Director asked whether the medical revalidation process was supported digitally. The Medical Director said that he was in discussion with a provider for a digital platform for medical appraisals and consultant job planning in order to reduce the administration of the process. **The Trust Board**: a) Noted the assurance provided by the Responsible Officer (Medical Director) that the medical appraisal and revalidation process was compliant with the regulations and was operating effectively within the Trust; and b) Authorised the Trust Chair to sign the Statement of Compliance
21/124	**Infection Prevention and Control Board Assurance Framework Report** (agenda item 6.6)
	The Director of Nursing and Therapies reminded the meeting that the Infection Prevention Infection and Control (IPC) Board Assurance Framework was first published in May 2020 with the aim of supporting all healthcare providers to effectively self-assess their compliance with Public Health England and other COVID-19-related infection prevention and control guidance. The had updated its self-assessment against the latest version of the IPC Board Assurance Framework (V1.6) published on 30 June 2021. The Director of Nursing and Therapies informed the Board that the lifting of COVID-19 related restrictions from 19 July 2021 would not apply to healthcare settings. This included maintaining two metre social distancing and wearing masks (both staff and visitors to the Trust's sites). The Director of Nursing and Therapies reported that there was national concern that the government's communications had not informed the public that COVID-19 restrictions would remain for healthcare settings.

	The Chair asked whether the Trust's website provided information for patients and visitors about the requirements around wearing masks and maintaining social distance. The Director of Nursing and Therapies confirmed that this was the case and said that the Trust was also using social media to inform patients and visitors. Aileen Feeney, Non-Executive Director asked about the changes to the provision of lateral flow tests for staff. The Medical Director explained that the Trust used to provide staff with lateral flow tests but the national guidance had changed and now staff were responsible for ordering their own supply of lateral flow tests. It was noted that staff would continue to report the results of their lateral flow tests via the Trust's reporting system. **The Trust Board**: noted the report.
21/125	**Quality Assurance Committee** (agenda item 6.7)
	The minutes of the Quality Assurance Committee meeting held on 1 June 2021 together with the quarterly Learning from Deaths Report and the quarterly Guardians of Safe Working Practices report had been circulated. David Buckle, Chair of the Quality Assurance Committee reported that the meeting had received a presentation on the new West Berkshire MSK Pathway and reported that the Committee fully supported the new pathway. Dr Buckle said that the Learning from Deaths quarterly report was very informative. Dr Buckle reported that he would be writing to the Trust's two Guardians of Safe Working Practices who were stepping down from the role to thank them for their work. **The Trust Board noted:** a) The minutes of the Quality Assurance Committee held on 1 June 2021. b) The Learning from Deaths Quarterly Report; and c) The Guardians of Safe Working Practice Quarterly Report.
21/126	**Quality Improvement Programme Update Report** (agenda item 6.8)
	The Chief Operative Officer presented the paper which provided the Trust Board with an update on the development of the Quality Improvement Programme which continued to be rolled out across the Trust. The Chief Operating Officer said that there were different approaches to implementing quality improvement systems and that the Trust's had decided to take a whole organisation approach which involved training all teams rather than a project based model. The Trust's approach took longer, but was more sustainable in the long term because once all teams were trained, quality improvement would be business as usual. The Chief Operating Officer outlined the Board's contribution to the quality improvement system delivery and highlighted the following points:

	• The biggest threat to the benefits of the quality improvement system was a lack of leadership and support and changes to Executive and Non-Executive Board positions resulting in a loss of understanding and changes to organisational ways of working. To avoid this, it was recommended there was a quality improvement induction programme for new board members and a refresher training programme for Board members • The Board's Vision Metrics, True North Strategic Initiatives, Corporate Projects and Breakthrough Projects would be reviewed to ensure focus on continuous improvement and maximising benefits delivery and to support the reduction of overburdening and waste from the System • The Board had a key role to play in leading by example and supporting frontline staff. It was proposed to introduce "Gemba" (frontline staff) visits for Non-Executive Directors (there was already a programme of Executive Director Gemba visits) so they could observe and learn and support the quality improvement maturity and help with the prioritisation of quality improvement activity. It was also proposed that Board members should complete leadership fundamental behaviours self-assessment. The Chief Operating Officer reported that the Trust was starting to have conversations with the Integrated Care Systems about the importance of adopting a quality improvement system approach to partnership working, for example, to identify a few key things to focus and do these things really well on in order to avoid over-burdening. The Chair asked for an example of external over burdening staff. The Chief Operating Officer said that being part of two Integrated Care Systems meant that the Trust was involved in a plethora of meetings with partners, including Place level meetings and Primary Care Networks etc. The Chief Operating Officer said that it was important that the Trust used the Quality Improvement training whilst in those meetings to identify those actions which would have the most impact rather than spreading resources too thinly across a multitude of actions. The Chair agreed that it was important that the Trust's partnership worked focused on the big outcomes. Mark Day, Non-Executive Director asked about the progress in training staff in quality improvement methodology. The Chief Operating Officer confirmed that prior to the COVID-19 pandemic around 50% of teams had completed their training. It was noted that the Quality Improvement Programme training had re-started. **The Trust Board**: a) Noted the report; and b) Agreed the proposals for the Board's role in the quality improvement programme.
21/127	**Executive Report** (agenda item 7.0)
	The Executive Report had been circulated. The following issues were discussed further: **Health and Social Care Bill – Second Reading**

	The Chief Executive reported that the Health and Social Care Bill had completed its parliamentary second reading. The Chief Executive said that his concern about the Health and Social Care Bill was that the original focus on closer integration between health and social care could be diluted because of a multiple power centres. The Chief Executive said that the Secretary of State for Health and Care's decision on the Frimley Health and Care Integrated Care System boundaries was due to be published shortly. The Chair said that at the local level, it was important for the Trust and other providers to do the right things for patients regardless of the organisational boundaries. **The Trust Board**: noted the paper.
21/128	**Month 02 2121-22 Finance Report** (agenda item 8.0)
	The Acting Chief Financial Officer presented the paper and highlighted the following points: • The Trust was reporting a surplus of £1m to the end of May 2021 which was £0.6m better than planned. • The financial plan for H1 (April – September 2021) had been amended to reflect the final plan submission to NHS England and Improvement on 22 June 2021 with the Trust planning for a breakeven position during this period. • The amended plan reflected assumed system allocated Elective Recovery Income and increased revenue costs following the review of planned capital spend. • Cash balances remained strong at £39.7m. • Planned capital expenditure had been reduced in line with the agreed Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System allocation. • All providers across the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System had now submitted plans which collectively aligned to the system capital allocation. The Trust had agreed to a capital allocation of £5.9m, in addition to the £2.0m of spend outside of system control total, with the overall plan being £7.9m. • Capital Spend overall was £0.6m behind the financial plan and this reflected delays due to Brexit and the COVID-19 pandemic. • Although there had been a small increase in staffing costs, contracted and worked hours fell in May 2201. It was crucial that the Trust increased recruitment over the coming months in order to keep pace with the level of investment reflected in this year's financial settlement into both Community and Mental Health Services. Chris Fisher, Non-Executive Director asked why £2m of capital funding was outside the system control total. The Acting Chief Financial Officer explained that capital expenditure relating to PFI buildings was excluded from the system control total. Naomi Coxwell, Non-Executive Director asked how the run rate for the non-pay forecast of £38.1m compared with the position last year. The Acting Chief Financial Officer reported that the non-pay run rate had increased this year and that this was partly due to misclassification of COVID-19 related costs in the previous financial year.

	Ms Coxwell asked whether there were any implications for the Trust if it delivered the forecasted year-end financial surplus. The Acting Chief Financial Officer said that the Trust would look to utilise the financial surplus during the course of the financial year rather than deliver a significant financial surplus at year-end. Ms Coxwell commented that the messaging around the reasons behind the financial surplus would be important The Chief Executive said that at the moment being part of the system control total did not present the Trust with any significant challenges because the planned investments at Prospect Park Hospital which was a PFI building did not count towards the system capital control total. The Chief Executive cautioned that being part of the system control total for capital funding may have implications for the Trust's capital spending in subsequent years. **The Trust Board:** noted the report.
21/129	**Month 02 2121-22 "True North" Performance Scorecard Report** (agenda item 8.1)
	The Month 02 "True North" Performance Scorecard had been circulated. The Chair referred to the inappropriate out of area placement performance (page 279 of the agenda pack) and asked why the performance was RAG rated green when the number of inappropriate out of area placements had increased. The Chief Operating Officer explained that the figure was cumulative and therefore the target was re-set at the start of the new financial year. Naomi Coxwell, Non-Executive Director commented that she was unclear about how the Trust's inappropriate out of area placement performance was measured. The Chief Operating Officer agreed to update the Trust Board at the next meeting and to present a summary which explained the Trust's target, current performance against the target together with the actions the Trust was taking to reduce the number of inappropriate out of area placements. **Action: Chief Operating Officer** **The Trust Board:** noted the report.
21/130	**Vision Metrics Report** (agenda item 8.2)
	The Chair commented that the Vision Metrics report was helpful because it enabled the Trust Board to have a broader view of the Trust's performance. The Chair suggested that moving forward, the Vision Metrics should be expanded to also measure the system performance so that the Trust Board could gain a better understanding of how the Trust's performance fitted into the overall performance of the system. **Action: Acting Chief Financial Officer** **The Trust Board:** noted the report.

21/131	**COVID-19 Pandemic Recovery Plan Update Report** (agenda item 9.0)
	The Deputy Chief Executive presented the paper and reported that the COVID-19 Recovery and Restoration programme of work had completed its task and was now closed. The continuation of recovery and restoration of services would be incorporated into the operational planning of services and implementation of the new three- year strategy. **The Trust Board**: noted the report.
21/132	**Audit Committee Meeting Held on 26 May 2021** (agenda item 10.0)
	Chris Fisher, Chair of the Audit Committee reported that the extraordinary meeting of the Audit Committee held on 26 May 2021 had approved the Trust's Annual Accounts 2020-21 on behalf of the Trust Board. Mr Fisher also reported that the meeting had discussed the Internal Audit Strategy and had made some amendments for the annual audit plan for 2021-22. Mr Fisher paid tribute to the work of the finance team who had supported the external audit of the Annual Accounts 2020-21 which was conducted remotely due to the pandemic. The Chair thanked Chris Fisher for his update. **The Trust Board:** noted the minutes of the Audit Committee held on 26 May 2021.
21/133	**Council of Governors Update** (agenda item 10.1)
	The Chair reported that following the recent Governor elections, all public governor seats on the Council of Governors had been filled. The Chair reported that the Council of Governors' Appointments and Remuneration Committee would be interviewing candidates for the Chair of the Audit Committee to replace Chris Fisher, Non-Executive Director whose term of office was due to expire on 30 September 2021.
21/134	**Any Other Business** (agenda item 11)
	There was no other business.
21/135	**Date of Next Public Meeting** (agenda item 12)
	The next Public Trust Board meeting would take place on 14 September 2021.
21/136	**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.

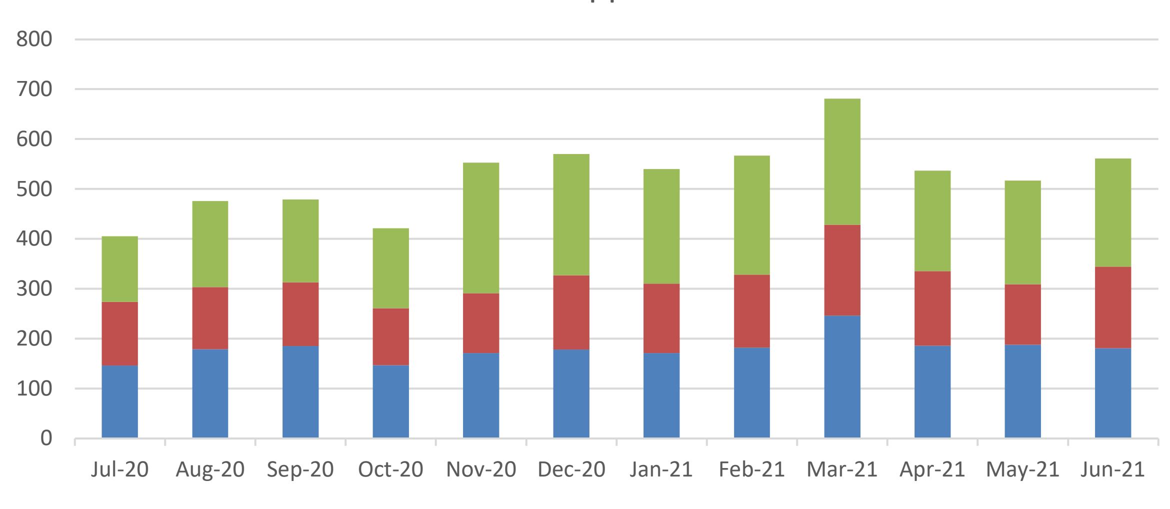
I certify that this is a true, accurate and complete set of the Minutes of the business conducted at the Trust Board meeting held on 13 July 2021.

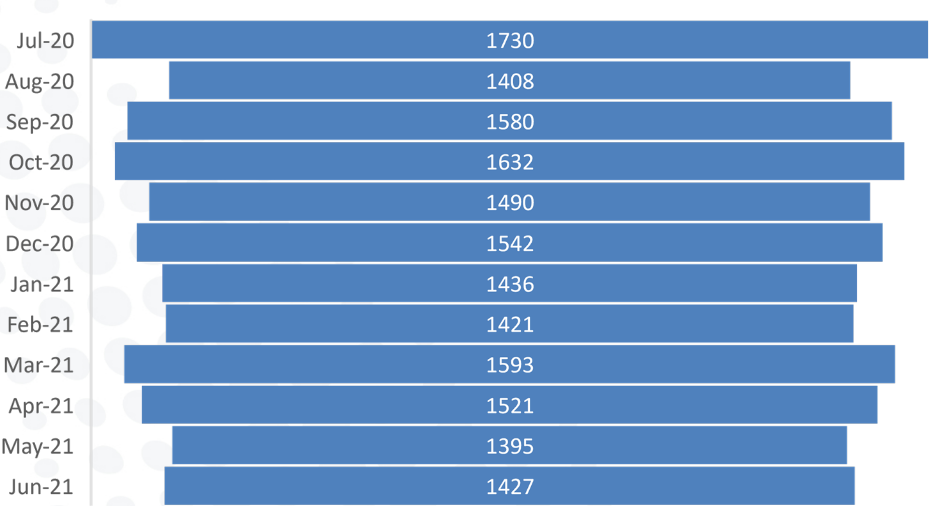
Signed………………………………………………………. Date 14 September 2121

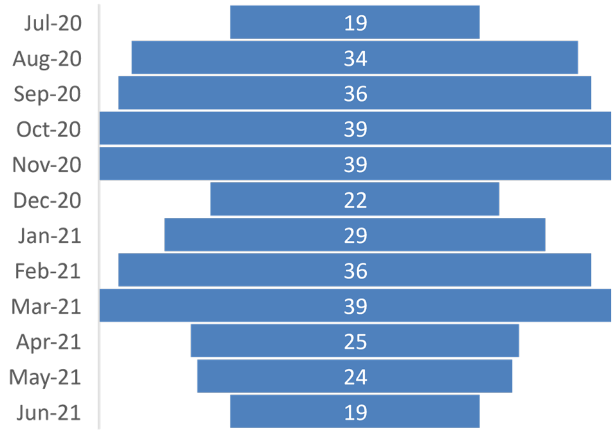
(Martin Earwicker, Chair)

District Nursing-
Physical Health West

Why do we need specialist roles?







HITEC Integration

- **HITEC – One of two specialist services within District Nursing in Newbury**
- **Specialist IV Nurse leads clinics**
  Supported by:
  Clinical Nurse Advisors who also work in Triage
  Link Champions from DN teams
- Why?

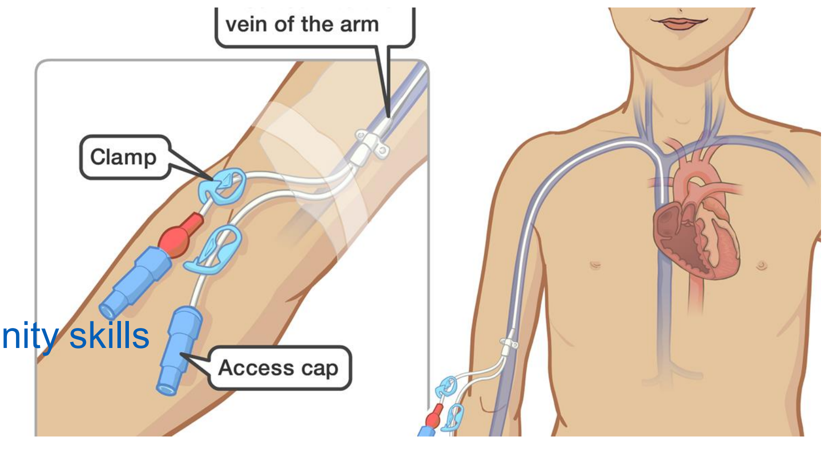
  To ensure our workforce retain both clinic and community skills

  Clinics not cancelled due to sickness/Annual leave

  Specialist skills are shared

  Patients can be seen at home or in clinic

  Patients will receive the same treatment regardless of location/clinician (consistency)



A Patients Journey

A patients journey –key points

Local to patients home
Holistic care by familiar staff –support
Supported by the wider team at home as well
Journey will be from start of patients treatment to the completion of it.

Patient Experience

- ‘Brilliant’
- ‘HITEC nurses are just wonderful’
- ‘I was sent parking instructions’
- ‘Pleasant staff’
- ‘Great being local, some appointments I have to drive Bracknell’
- ‘Minimal waiting times’
- ‘Very professional service at all clinics/home visits’
- ‘Same service from most nurses’

‘

Reading Community Nursing Innovation

Specialists roles and the impact on patient care

Wound Care Nurse

Case Study (Published article)

Introduction

- 29 year-old male with no previous medical history
- The patient presented with a wound to his inter-gluteal region.
- Since the initial surgical treatment for the pilonidal sinus, the patient had been treated both with conservative dressings and further surgical interventions that left the patient with an unhealed wound of three year duration.
- Following a third failed surgical intervention, the patient was reviewed by the wound care nurse.

Outcomes

The treatment plan resulted in a reduced dressing change frequency from daily to twice weekly and enabled him to return to work and re-establish a financial income.
As a result of using PICO 7 sNPWT, the patient experienced a decrease in pain levels, increased comfort and an improvement in his mental health.

Health, economics and resource outcome

The impact of this plan of care was also positive for the healthcare providers as the nursing resources required for daily dressings were reduced to twice weekly with PICO 7 sNPWT. Additionally the complete closure of the wound prevented the potential need for additional costly surgical procedures being undertaken that could further impact healthcare resources and costs.

Patient Testimony

Since January 2017, I was visiting my local GP almost every other day to either have my wound packed & dressed, where a number of different treatments including different gauzes, patches, manuka honey, silver nitrate etc were used to no avail.
From meeting the wound care nurse in November 2019, it was clear to see that she had experienced similar wounds in her past and seemed confident that she could assist in healing the wound. At the time, I was dubious as I had heard this multiple times but through her consistent care and determination with the use of a VAC and then PICO dressings, my 3 year old wound eventually healed closed in February 2020 to which I am pleased to say is still closed.

I cannot thank the wound care nurse enough as during the years with my wound, I have struggled to sit or lay down at times, have cancelled trips, holidays and other work opportunities but most of all I hadn't been able to do things with my 2 year old son which I am now able to do.

Hopefully this testimonial goes a little way to show my gratitude and my thanks for giving me a better quality of life!

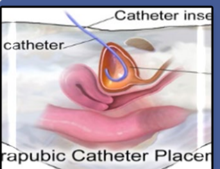
Wokingham Community Nursing Catheter Clinic

Patient Journey & Case study

Beverley , 52 years young, jovial and friendly character. Anxious about catheter changes.

Personal circumstances: Married, lives with spouse, grown up children, grandchildren (one on the way). Cat & dogs, independently mobile with w-chair, frame and mobility scooter.

Past medical history: Spina Bifida, Compartment Syndrome, T2DM, IDDM (2018), OA, Obesity BMI was 45+ had bariatric surgery, Hyperlipidaemia,

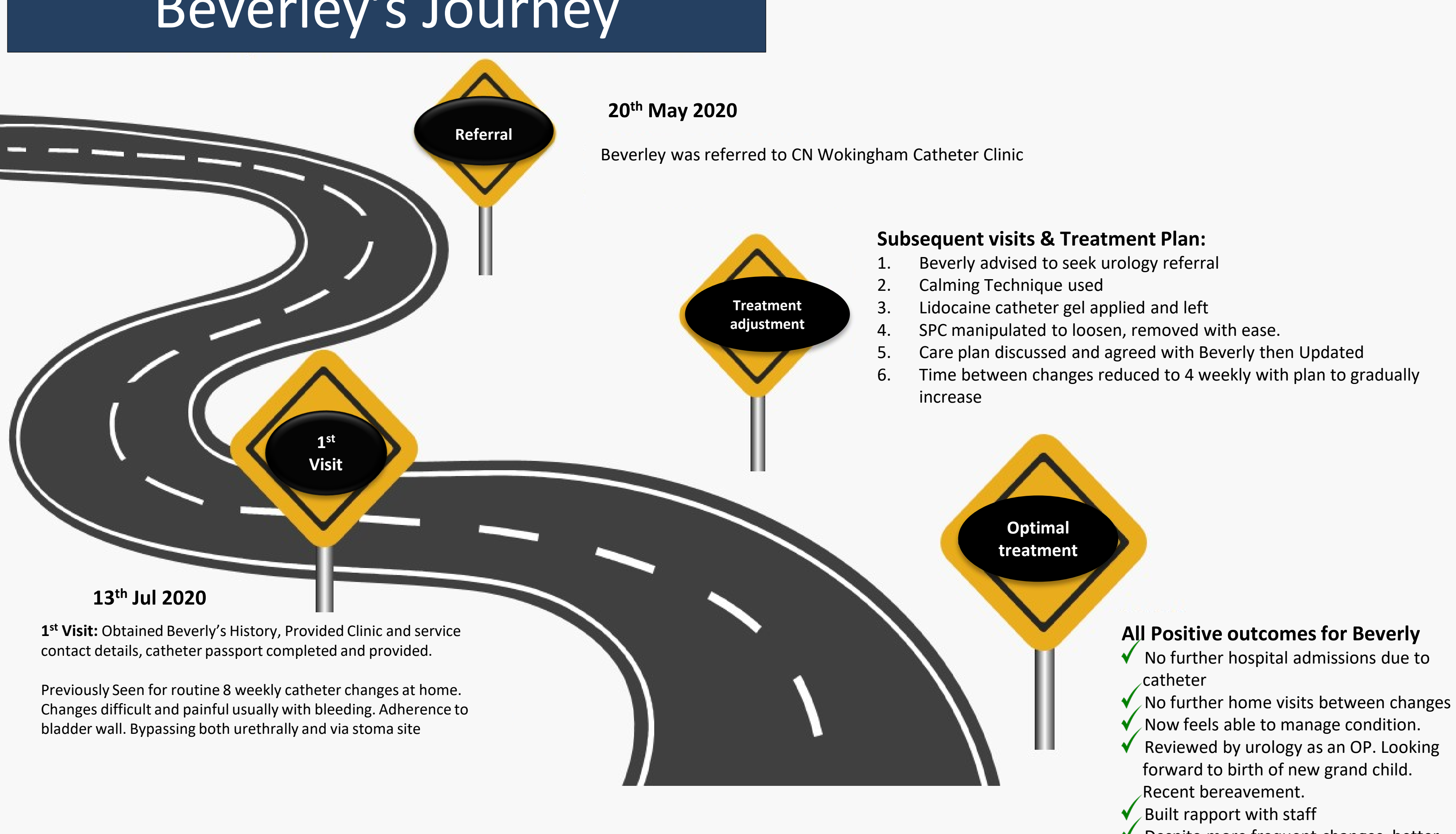


SPC since before 2011 – Problematic – adhering to bladder wall, painful +++ changes done in the acute with entinox.

Usual specialist nurse retired

Re-assessed and deemed safe for community.

Beverley’s Journey



20th May 2020

Beverley was referred to CN Wokingham Catheter Clinic

Subsequent visits & Treatment Plan:

1. Beverly advised to seek urology referral
2. Calming Technique used
3. Lidocaine catheter gel applied and left
4. SPC manipulated to loosen, removed with ease.
5. Care plan discussed and agreed with Beverly then Updated
6. Time between changes reduced to 4 weekly with plan to gradually increase

13th Jul 2020

1st Visit: Obtained Beverly’s History, Provided Clinic and service contact details, catheter passport completed and provided.

Previously Seen for routine 8 weekly catheter changes at home. Changes difficult and painful usually with bleeding. Adherence to bladder wall. Bypassing both urethrally and via stoma site

All Positive outcomes for Beverly

- ✓ No further hospital admissions due to catheter
- ✓ No further home visits between changes
- ✓ Now feels able to manage condition.
- ✓ Reviewed by urology as an OP. Looking forward to birth of new grand child. Recent bereavement.
- ✓ Built rapport with staff
- ✓ Despite more frequent changes, better QOL and reduced anxiety & trauma
- ✓ Experienced practitioners

Patient Experience & Feedback

- Knowledgeable staff
- Freedom to choose appointments – Not a morning person!
- Continuity of care
- Advice
- Connection with acute/Urology
- Kind & Caring
- Would recommend to friends and family
- 'Always treat me with dignity & respect'

Benefits to CN Service, BHFT and patients

- Reduced need for home visits
- Able to see ambulant patients
- Upskill staff/Competencies
- Financial benefit
- Able to work closely with CAS
- Able to care for patients with catheter emergencies (depending on capacity)
- Able to provide safe care
- True North goals
- Expert staff on catheter management and maintenance reducing the need for urgent visits.
- Ambient – Able to provide calm and relaxing surrounding for patient.
- Clinical setting – PPE and safety measures taken in light of COVID pandemic.

What is next?.....

- Develop a Standard of work (QMIS)
- Assist with development of questionnaire for specific feedback on service provision
- Continual Service development/improvement – streamline service
- Research & development (EBP)

Thank You for listening

BOARD OF DIRECTORS MEETING 14/09/21

Board Meeting Matters Arising Log – 2021 – 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
10.12.19	19/248	Vision Metrics	The Deputy Chief Executive to present options for linking True North and the Vision Metrics to the Finance, Investment and Performance Committee.	October 2021	**AG**	Carry forward to autumn strategy Trust Board Away Day – ICS System Oversight Framework has just been published the Trust needs to consider its impact.	
12.05.20	20/067	Patient Experience Report	The Director of Nursing and Therapies to consider including more detail of the 15 Step Visit	December 2021	**DF**	15 Step Visits were paused during the	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			Reports as part of the Patient Experience Report.			COVID-19 pandemic.	
13.04.21	21/044	Patient Story	The Quality Assurance Committee to review the Tissue Viability Service at a future meeting.	November 2021	**DF**	The Quality Assurance Committee Forward Planner has been updated to include a review of the Tissue Viability Service. The item will be on the November 2021 QAC agenda.	
13.04.21	21/050	Finance Report	The Trust to undertake work to understand the impact of the new ways of working so it would be in a position to develop its post-COVID-19 funding financial plan for the second half of 2021-22.	September 2021	**AG**	COVID funding likely to be in place for H2. Change in cost base being reviewed to assess recurrent and non-recurrent changes that have arisen during the pandemic, which will feed into H2 and 22/23 planning.	
11.05.21	21/084	Patient Experience	The breakdown of complaints by age data to be amended to highlight those age groups which submitted a	September 2021	**DF**	Included in the September 2021 Patient Experience	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			disproportionate number of complaints.			Report	
11.05.21	21/085	Safe Staffing	Future reports to draw together and summarise the information from the different safe staffing tools.	November 2021	**DF**	To be included in the next Six-Monthly Safe Staffing Report	
11.05.21	21/087	Executive Report – CAMHs Tier 4 Service Changes	The Chief Operating Officer to publicise that staff were redeployed into other Trust services following the decision to change the CAMHs Tier Service model.	September 2021	**DT**	This has been planned as part of a good news story for the service which will include information on new starters in the service, feedback on the success and recognition externally of the delivery of the new service and pictures of the newly refurbished premises which were completed as planned at the end of August.	
11.05.21	21/089	Finance Report	An analysis of the management and admin posts to be presented to the Finance, Investment and Performance Committee to provide	August 2021	**PG**	A paper was presented to the August 2021 Finance, Investment and Performance	

Meeting Date	Minute Number	Agenda Reference/Topic	Actions	Due Date	Lead	Update	Status
			assurance.			Committee.	
13.07.21	21/119	Freedom to Speak Up Guardian Report	The Freedom to Speak Up Guardian to include some anonymised examples of follow-up actions taken in response to issues raised via the Guardian in future reports.	December 2021	**MC**	To be included in the next update to the Committee.	
13.07.21	21/122	Research and Development Annual Report	The Board to be updated on the Trust's Research and Development Strategy at a future meeting.	September 2021	**MI**	On the agenda for the September 2021 Trust Board In Committee meeting.	
13.07.21	21/129	Trust North Performance Scorecard	The Board to receive an update on how the Trust's performance in relation to inappropriate out of area placements was measured together with a summary on the current performance and the actions being taken by the Trust to reduce the number of inappropriate out of area placements.	September 2021	**DT**	Attached at Appendix 1	
13.07.21	21/130	Vision Metrics	The Vision Metrics to be expanded to include System performance.	December 2021	**PG**		

Board Update reducing MH Pressures – the position on Acute Out of Area Placements (OAPs).

1. Background & Context

This paper provides an update to the Board regarding the Acute Out of Area Placement (OAP) position for the Trust. From 2018 to 2020 there were 2 consecutive programmes of work within the Trust looking at bed optimisation and particularly the elimination of inappropriate acute OAP's. There was a national drive to eliminate inappropriate Acute OAPs by April 2021 and the 2 programmes were the Trusts response to this requirement.

The programmes moved to business as usual in July 2020, as at that point the number of Inappropriate Acute OAPs had remained relatively stable and low. Covid had required us to pause the programme and the central reporting, but in its first wave also saw a reduction in bed requests which carried on until June 2020. From July 2020 demand for inpatient beds saw a surge, in line with a national trend. Many of the patients presenting for admission were in crisis and previously unknown to services.At that point it was unclear if this was a blip or likely to be a sustained position, 14 months on the latter appears to be the case. Alongside this surge it was also necessary, due to an NHSE(i) requirement, to close all dormitory style MH bed provision. This entailed losing 3 beds at PPH, where we had double rooms. During the pandemic we have also had to close beds to admission when there has been an outbreak of Covid. In August 2021 this took a further 12 beds out of use, on Bluebell ward. The national picture has also changed and as a result NHSE(i) has issued new guidelines and trajectories for Trusts to use in informing their inappropriate Acute OAPs elimination work.

2. Refreshed trajectories and definitions

In 2021, NHSi updated it's 2016 definition of OAPs. The update was around continuity of care and made it possible to use extra-contractual beds provided 4 continuity principles were followed. These principles were agreed between providers and NHSi.

	Annex A: Principles of Continuity.
Principle 1	Clear shared pathway protocols between units/organisations – particularly around admissions and discharge.
Principle 2	An expectation that a person's care coordinator visits as regularly as they would if the patient was in their most local unit and retains their critical role in supporting discharge/transition.
Principle 3	Robust information sharing, including the ability to identify cross-system capacity and access full clinical records with appropriate Information Governance in place where necessary.
Principle 4	Support for people to retain regular contact with their families, carers and support networks e.g., this might be achieved with optional use of technology, transport provision etc.

Page 64. Annex F1: Activity and Performance technical definitions. NHSi 2021.

At the same time as this new guidance was provided Trusts were also asked to provide an updated trajectory and plan to how they would achieve elimination of inappropriate OAPs by

a revised timeline of April 2022. For the Trust an updated OAPs trajectory and recovery plan was submitted in June 2021.

Trajectory for reducing inappropriate acute MH OAPs (provider level)

2021/22	Q1	Q2	Q3	Q4
Total active inappropriate OAPs at end of Quarter	9 (inappropriate today)			
Total Inappropriate OAPs bed days across Quarter	588 (YTD) - 960 trajectory	490	220	90

Existing key actions underway to address OAPs:

Please list the top three primary actions underway to address OAPs within this system. Alternatively or in addition, please attach any existing recovery plans.

Action	Expected impact:
Relaunched programme board to focus on the delivery of zero OAPS by the end of Q4. Key areas of focus will be on the reducing the LOS for acute and PICU admissions. We have implemented a daily partnership post admission review meeting to ensure the objectives of the admission are clear and an IDD can be set, this will also focus on removing unwarranted variation between treating teams. Monitoring of the trajectory will be overseen by this board. In addition, we have successfully implemented our QI EUPD pathway which has delivered a decrease in OBD for this cohort and we will use QI methodology to make improvements across other clinical pathways.	The aim by the end of 21/22 is that we have reduced our LOS to 40 days from our current position of 46 days.
Pre-commission 5 independent sector acute beds where we are confident that continuity of care principles can be achieved. We have a dedicated OAP placement reviewing officer who provides the link between patient, support network, provider and host Trust. We have developed SOP's to support mutual aid across BOB and Frimley and into the SE region. The Bed management function with the Trust provides robust overview and scrutiny of the bed allocations and links with bed management colleagues across the region to make sure we are able to access NHS beds where available.	Patients will have timely access to an IS bed that is within a reasonable travel period from Berkshire where continuity of care principles are met.
Increasing the therapy input into our acute and PICU wards. This includes extending the OT provision to 7 days a week to minimise delays for OT assessments. By the end of 21/22 all wards will have a dedicated psychologist to support clinical formulation and the positive risk management.	Extending OT provision to 7 days a week will reduce the time from request to assessment by 2 working days

3. Current and Historic Position

The information below illustrates when the OAP numbers became extremely high (December 2020 to May 2021). We are now seeing a reduction in the inappropriate OAPs and this is in part due to the redefinition of OAPs, but also due to the work programme now underway. Our numbers are back on trajectory and therefore we are now able to report the programme as green. The position in September has improved further as we are now fully utilising procured extra contractual beds, which meet the 4 continuity principles and we have also been able to reopen the beds which were closed due to Covid.

As indicated in the Trust revised trajectory and action plan we recognise that this work now needs more focussed attention to achieve the plan, to this end a project board has been reconvened to complete this work. The work is led by Jayne Reynolds. The initial outputs and plans from this group are provided below

The data below illustrates both our current position and the historical information going back to 2019/20

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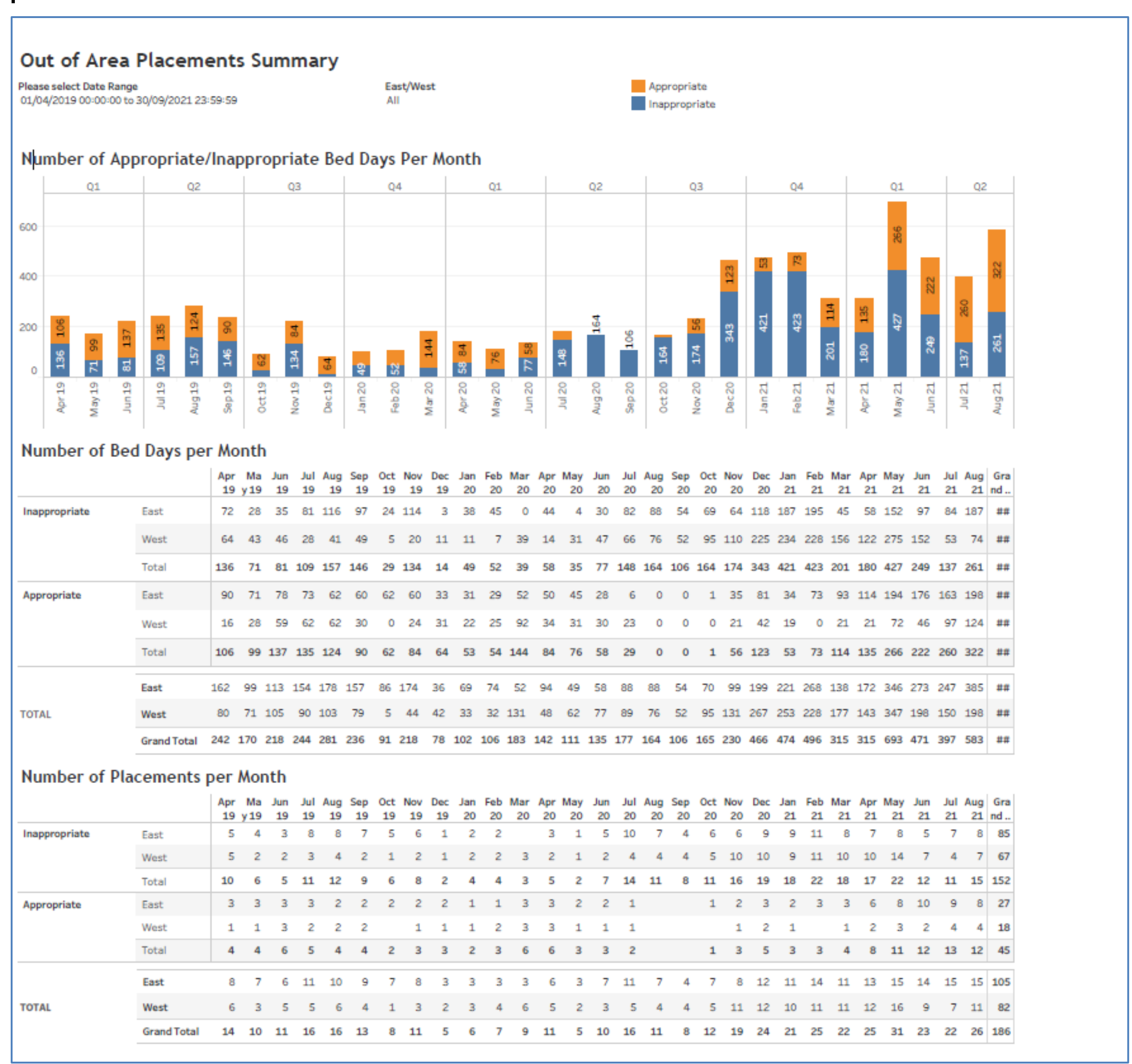

Number of Bed Days per Month

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Grand..
Inappropriate	East	72	28	35	81	116	97	24	114	3	38	45	0	44	4	30	82	88	54	69	64	118	187	195	45	58	152	97	84	187	##
	West	64	43	46	28	41	49	5	20	11	11	7	39	14	31	47	66	76	52	95	110	225	234	228	156	122	275	152	53	74	##
	Total	136	71	81	109	157	146	29	134	14	49	52	39	58	35	77	148	164	106	164	174	343	421	423	201	180	427	249	137	261	##
Appropriate	East	90	71	78	73	62	60	62	60	33	31	29	52	50	45	28	6	0	0	1	35	81	34	73	93	114	194	176	163	198	##
	West	16	28	59	62	62	30	0	24	31	22	25	92	34	31	30	23	0	0	0	21	42	19	0	21	21	72	46	97	124	##
	Total	106	99	137	135	124	90	62	84	64	53	54	144	84	76	58	29	0	0	1	56	123	53	73	114	135	266	222	260	322	##
TOTAL	East	162	99	113	154	178	157	86	174	36	69	74	52	94	49	58	88	88	54	70	99	199	221	268	138	172	346	273	247	385	##
	West	80	71	105	90	103	79	5	44	42	33	32	131	48	62	77	89	76	52	95	131	267	253	228	177	143	347	198	150	198	##
	Grand Total	242	170	218	244	281	236	91	218	78	102	106	183	142	111	135	177	164	106	165	230	466	474	496	315	315	693	471	397	583	##

Number of Placements per Month

		Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Grand..
Inappropriate	East	5	4	3	8	8	7	5	6	1	2	2		3	1	5	10	7	4	6	6	9	9	11	8	7	8	5	7	8	85
	West	5	2	2	3	4	2	1	2	1	2	2	3	2	1	2	4	4	4	5	10	10	9	11	10	10	14	7	4	7	67
	Total	10	6	5	11	12	9	6	8	2	4	4	3	5	2	7	14	11	8	11	16	19	18	22	18	17	22	12	11	15	152
Appropriate	East	3	3	3	3	2	2	2	2	2	1	1	3	3	2	2	1			1	2	3	2	3	3	6	8	10	9	8	27
	West	1	1	3	2	2	2		1	1	1	2	3	3	1	1	1				1	2	1		1	2	3	2	4	4	18
	Total	4	4	6	5	4	4	2	3	3	2	3	6	6	3	3	2			1	3	5	3	3	4	8	11	12	13	12	45
TOTAL	East	8	7	6	11	10	9	7	8	3	3	3	3	6	3	7	11	7	4	7	8	12	11	14	11	13	15	14	15	15	105
	West	6	3	5	5	6	4	1	3	2	3	4	6	5	2	3	5	4	4	5	11	12	10	11	11	12	16	9	7	11	82
	Grand Total	14	10	11	16	16	13	8	11	5	6	7	9	11	5	10	16	11	8	12	19	24	21	25	22	25	31	23	22	26	186

4. Current Programme work plan.

As a result of the programme board being reset a few challenges have been identified and actions put in place to address these (see table below). Some of these are short-term, but others will require longer term commitment.

Issue identified	Action	Current Position	Actual/potential benefit
1. OAPs reviewer.	Teams identified cover for OAPs review as person in post leaving. Recruitment of new reviewer underway.	Review work covered off in interim. Recruitment underway.	Robust review is essential for the 4 continuity principles. Regular review ensures patients are not held in a placement longer than is therapeutically necessary.
2. Length of Stay (LoS) key contributors	To understand what the data is saying so that	EUPD patients are no loner the major contributor to long	Continuation of EUPD pathway approach across further clusters to ensure

	appropriate action can be taken.	LoS. Now need to do pathway work on other MH Clusters, particularly the psychosis clusters. This work to be led by Clinicians.	we are not outliers in terms of best practice and that patients are getting the most effective and timely treatment options for their presentations.
3. Responsible Clinicians (RC) – availability of.	In the short term to address the lack of RC's and their availability across 52 weeks. Longer term looking at developing the RC role across professions.	Increased medical posts so that there is more robust cover particularly during leave periods. Also looking at job role to ensure it is more attractive so that we can recruit and retain medical staff. Starting to explore training options and appetite across professions to take on RC role.	Increased availability and continuity of medical RC support. Building a more sustainable model.
4. Additional Bed capacity.	Procure 8 additional Acute beds and 5 PICU beds from independent sector to run until end of September.	Beds procured in July. All 8 Acute beds utilised, 4 of 5 PICU beds utilised. Currently reviewing extension until end of Q3.	Takes pressure off system. Ensures beds are procured in correct manner considering the continuity principles and the quality requirements of the Trust. Helps with management of Covid outbreaks.
5. Therapeutic Offer – need to strengthen.	Strengthening therapeutic offer through appointment of further therapy staff.	Currently looking to recruit more psychologists and more Occupational Therapists for PPH.	Strengthening therapy offer has potential to reduce LoS and potentially minimises patient dependency on inpatient services.
6. Need for PALM reviews.	Identified that PALM reviews (Multi-disciplinary reviews for EUPD patients), have not all been taking place due to capacity issues.	Looking to increase roles in IMPACCT team so that PPH support can be accommodated.	Maintenance of robust EUPD pathway.

Board	14th September 2021
Title	Patient Experience Report Quarter 1 (April – June 2021)
Purpose	The purpose of this report is to provide the Board with an overview of the patient experience information and activity for Quarter 1
Business Area	Nursing & Governance
Author	Elizabeth Chapman, Head of Patient Experience
Relevant Strategic Objectives	True North goals of Harm free care, Supporting our staff and Good patient Experience
CQC Registration/Patient Care Impacts	Supports maintenance of CQC registration and supports maintaining good patient experience
Resource Impacts	N/A
Legal Implications	N/A
Equality and Diversity Implications	Protected Characteristic data is set out at section 5 of the report.
SUMMARY	This report is to note and provides information collected across the Trust in relation to patient experience during quarter 1 (April – June 2021). The QPEG is asked to note the information provided within the report During the quarter the number of formal complaints received was comparable with quarter four 2020/21; although the numbers were higher than in quarter 1 2020/21, they are comparable with 2019/20 and 2018/19 and it is recognized that it is likely that the lower number of complaints received in quarter one of 2020/21 of the covid pandemic. This report includes a summary of the findings of an internal audit undertaken around Trust patient experience during quarter four 2021/21. **Highlights of the report** • 59 complaints were received: of these 2 related specifically to covid/ covid pandemic. • Prospect Park Hospital saw a further increase in complaints (14 in total this quarter compared to 11 in Q4 2020/21); this will be monitored to ensure that there is not an increasing trend with any themes emerging. • CAMHS complaints were comparable to Q4 2020/21 with 5 this quarter complied to Q4 (6). In addition, there were 6 MP enquiries received this quarter in relation to CAMHS with 5 of these being in relation to wait times. • CMHT saw a significant reduction in complaints this quarter with 5 compared to 12 in Q4 (34 in total 2020/21) • The services with the highest number formal complaints during the quarter were Prospect Park Hospital (11 in relation to acute wards and 3 PICU) and Community Hospital Inpatients (6). The complaints received were all specific to the patient's situation, • 3 complaints received were linked to the Covid pandemic

	• Of the 55 complaints closed in the quarter 64% were partially or fully upheld, this is comparable to all quarters in 2020/21 except Q3 • There were 1076 compliments recorded on our system. • Demographic data within the report now represents the % split of patient attendances during the previous quarter to provide better analysis of complaint numbers compared to patient population instead of local ONS data. • For 14% (8) of our complaints the ethnicity of the complainant is unknown whilst this is a reduction on previous quarters work is still required to improve the capture of ethnicity data for all complainants. • Over the last year there has been a sustained increase in MP enquiries received 8 in Q2, 10 Q3 and 11 in Q4 for 2021/ and 17 this quarter. during this quarter. Unlike last quarter there were no enquires related to CRHTT, there were 6 related to CAMHS (6 relating to wait times and 1 to care/ treatment) and 7 to CMHT (spread across access, care / treatment, and communication). • The ombudsman has advised that due to the impact of the pandemic they have a significant backlog of complaints waiting review and will be focusing on those that are more serious / resulted in significant impact. There were no complaint themes or trends of note in the quarter 1 patient experience data. There has however been an increase in wait times for CAMHS. Most complaints are in relation to care and treatment specific to an individual and their circumstances. **New patient Experience Tool** A contract has been awarded to I Want Great Care to develop a new patient experience measure tool with us. The project started in April and will take approximately 9 months. Co-production workshops with all our services, their patients and carers took place between May and June to hear what questions they think are important to ask, building on the themes identified in phase one of the project last year. The survey is now being designed over the summer and tested for a month in all services at the end of October. Rollout of the new survey will start in January 2022.
ACTION REQUIRED	The Board is asked to note the report.

Quarter One – Patient Experience Report (April 2021 to June 2021)

1. Introduction

This report is written for the board and contains the quarterly patient experience information for Berkshire Healthcare (The Trust) incorporating; complaints, compliments, the Friends and Family Test, PALS and our internal patient survey programme (which is collected using paper, online, text, kiosks and tablets).

An internal audit of Patient Experience took place during Quarter four. A summary of the findings is detailed in section 13 of the report.

2. Complaints received

2.1 All formal complaints received

Table 1 below shows the number of formal complaints received into Berkshire Healthcare for years 2020-21 and 2021-22 by service, enabling a comparison. During Quarter one 2021-22 there were 59 complaints received (including re-opened complaints). This is an increase compared to 2020-21 where there were 56 for the same period.

There were 121,544 reported contacts and discharges from our inpatient wards, giving a complaint rate of 0.05%.

Table 1: Formal complaints received

	2020-2021						2021-22			
Service	**Q1**	**Q2**	**Q3**	**Q4**	**Total for year**	**% of Total**	**Higher or lower than previous quarter**	**Q1**	**Total for year**	**% of Total**
CMHT/Care Pathways	4	11	7	12	34	**15.96**	↓	5	5	**8.47**
CAMHS - Child and Adolescent Mental Health Services	2	3	3	6	14	**6.57**	↓	5	5	**8.47**
Crisis Resolution & Home Treatment Team (CRHTT)	4	2	3	4	13	**6.10**	↑	5	5	**8.47**
Acute Inpatient Admissions – Prospect Park Hospital	7	4	1	9	21	**9.86**	↑	11	11	**18.64**
Community Nursing	2	1	5	2	10	**4.69**	↑	4	4	**6.78**
Community Hospital Inpatient	5	6	3	4	18	**8.45**	↑	6	6	**10.17**
Common Point of Entry	1	1	3	1	6	**2.82**	↓	0	0	**0.00**
Out of Hours GP Services	4	0	3	1	8	**3.76**	=	1	1	**1.69**
PICU - Psychiatric Intensive Care Unit	2	0	0	2	4	**1.88**	↑	3	3	**5.08**
Urgent Treatment Centre	1	0	1	0	2	**0.94**	↑	1	1	**1.69**
Older Adults Community Mental Health Team	1	1	1	2	5	**2.35**	↓	0	0	**0.00**
18 other services in Q1	11	33	21	13	78	**36.62**	↑	18	18	**30.51**
Grand Total	44	62	51	56	213			59	59	

The 18 'other services' complaints were split over 16 different services, and there is nothing of note to report as these services only saw numbers of one or two complaints.

3 out of the 59 formal complaints received were about Covid, these were:

- A patient contracted Covid whilst on an inpatient ward, and the family are questioning why she was sent to a ward for rehabilitation rather than going home.
- A family are concerned around waiting times due to Covid.
- A patient attended the out of hours GP service following a reaction to the covid vaccine and felt the doctor said some concerning things about the vaccination.

Complaints are reported against the geographical locality where the care was received which is the most meaningful way of recording. The following tables show a breakdown of the formal complaints that have been received during Quarter one and where the service is based. Complaints relating to end of life care are considered as part of the Trust mortality review processes.

2.2 Adult mental health service complaints received in Quarter one

30 of the 59 (51%) complaints received during Quarter one were related to adult mental health service provision.

Table 2: Adult mental health service complaints

	Geographical Locality						
Service	Bracknell	Reading	Slough	WAM	West Berks	Wokingham	Grand Total
Adult Acute Admissions - Bluebell Ward		4					4
Adult Acute Admissions - Daisy Ward		6					6
Adult Acute Admissions - Rose Ward							
Adult Acute Admissions - Snowdrop Ward		1					1
CMHT/Care Pathways		1		1	2	1	5
Crisis Resolution and Home Treatment Team (CRHTT)		4	1				5
IMPACTT							
Older adults inpatient service - Orchid Ward		1					1
Older adults inpatient service - Rowan Ward		2					2
PICU - Psychiatric Intensive Care - Sorrel Ward		3					3
Psychology Service		1					1
Talking Therapies	1					1	2
Traumatic stress service							
Other							
Grand Total	1	23	1	1	2	2	30

2.2.1 Number and type of complaints made about a CMHT

5 of the 59 complaints (8.5%) received during Quarter one related to the CMHT service provision, detail below. There were 11,428 reported attendances for CMHT and the ASSiST service during Quarter one, giving a complaint rate of 0.04%, compared to 0.10% in Quarter 4 and 0.04% in Quarter 3.

Table 3: CMHT complaints

	Geographic Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	WAM	Wokingham	Grand Total
Care and Treatment		1		1	1		3
Communication				1			1
Medical Records						1	1
Grand Total		1		2	1	1	5

Three of the complaints about the CMHT related to care and treatment, these were;

- Family concerned about the care and support the patient is receiving to prevent them being sectioned.
- A second opinion wanted.
- Care in an out of area placement.

There were no formal complaints received for the CMHT in the East.

2.2.2 Number and type of complaints made about CPE

There were no complaints received about CPE in quarter one out of 1,429 contacts.

2.2.3 Number and type of complaints made about Mental Health Inpatient Services

During Quarter one, 14 of the 59 complaints (24%) related to Adult Acute mental health inpatient wards. This is an increase to numbers received in the previous three quarters. Six were for Daisy Ward, four for Bluebell one for Snowdrop ward and three for Sorrel ward.

There were 199 reported discharges from mental health inpatient wards (including Sorrel Ward) during Quarter one giving a complaint rate of 7%, which is a noticeable increased to the 4.5% for Quarter 4 and 0.9% in Quarter three.

Table 4: Mental Health Inpatient Complaints

Main subject of complaint	Bluebell Ward	Daisy Ward	Rose Ward	Snowdrop Ward	Sorrel Ward	Grand Total
Abuse, Bullying, Physical, Sexual, Verbal		1			1	2
Attitude of Staff	1				1	2
Care and Treatment	2	1		1	1	5
Communication	1	3				4
Medication		1				1
Grand Total	4	6	0	1	3	14

There were 14 complaints raised for Mental health Inpatients, and six of these were raised by patients contacting the CQC helpline. Of the 14, five complaints related to Care and Treatment. Four of the complaints have been investigated and were found to be not upheld. In one case, there were also concerns raised around a patient's lack of privacy and dignity, but the investigation showed that staff followed correct processes when they did not hear the patient respond to the door of his room being knocked. One complaint investigation is still ongoing.

Daisy Ward received six complaints during quarter one. Three of these complaints related to communication, which have been either fully or partially upheld, and learning identified, where appropriate. A focus to ensure all staff are up to date on Information Governance training and Mental Health Act training is in place across the ward.

2.2.4 Number and type of complaints made about Crisis Resolution/ Home Treatment Team (CRHTT)

In Quarter one, 5 of the 59 complaints (8%) were attributed to CRHTT, an increase from 4 in Quarter four.

There were 16,766 reported contacts for CRHTT during Quarter one giving a complaint rate of 0.03%, compared to 0.02% reported for Quarters three and two and 0.01% in Quarter two and 0.02% in Quarter one.

Table 5: CRHTT complaints

	Geographic Locality						
Main subject of complaint	Bracknell	Reading	Slough	West Berks	WAM	Wokingham	Grand Total
Attitude of Staff		2	1				3
Care and Treatment		1					1
Communication		1					1
Grand Total		4	1				5

Four of the five complaints received were for the service based in Reading, one of these being an SI, which was investigated and reported on in quarter four 2020/21, but further issues have been raised by the family. A further one was from a patient who was unhappy about being informed that swearing to staff was not acceptable.

2.3 Community Health Service Complaints received in Quarter one

During Quarter one, 17 of the 59 complaints (29%) related to community health service provision. The table below shows further details.

Table 6: Community Health service complaints

	Geographical Locality					
Service	Reading	Slough	West Berks	WAM	Wokingham	Grand Total
Ascot Ward					1	1
Henry Tudor Ward				1		1
Oakwood Ward	4					4
Community Respiratory	1					1
Community Physiotherapy						0
District Nursing (Community Nursing)	3				1	4
East Berks Wheelchair Service				1		1
IPASS					1	1
Out of Hours GP	1					1
Rapid Response					1	1
Sexual Health		1				1
Urgent Treatment Centre			1			1
Grand Total	9	1	1	2	4	17

2.3.1 Community Health Inpatient Ward Complaints

During Quarter one, 6 of the 59 complaints (7%) received related to inpatient wards. This is compared to 4 in Q4 2020/21, 3 in Q3 and 5 in Q2. There were 566 reported discharges from community health inpatient wards during Quarter one giving a complaint rate of 1%, compared to 0.6% for quarters four and three, and to 1.10% in Quarter two and 0.81% in Quarter one.

Table 7: Community Health Inpatient complaints

	Ward			
Main subject of complaint	Ascot Ward	Henry Tudor Ward	Oakwood Ward	Grand Total
Care and Treatment			2	2
Discharge Arrangements	1		1	2
Medication		1		1
Patients Property/valuables			1	1
Grand Total	1	1	4	6

From the seven community health inpatient wards, complaints were received for three wards. The top themes were care and treatment and discharge arrangements.

Four of the six community health inpatient complaints were for Oakwood; two for care and treatment, one regarding medication and one for property (engagement and wedding ring) that has been mislaid.

2.3.2 Community Nursing Service Complaints

District Nursing received four complaints in Quarter one, equal to Quarter 4 and five complaints in Quarter 3, 20/21. There was one complaint regarding confidentiality, which was from a family complaining that staff had talked loudly about the patient within earshot of neighbours.

There were 74,019 reported attendances for the Community Nursing Service during Quarter one giving a complaint rate of 0.005%. Complaints against the Community Nursing Service continues to be a very small complaint rate, which is well below the Trust overall rate of complaints per contact.

Table 8: Community Nursing Service complaints

	Geographic Locality		
Main subject of complaint	Reading	Wokingham	Grand Total
Care and Treatment	2	1	3
Confidentiality	1		1
Grand Total	3	1	4

2.3.3 GP Out of Hours Service (WestCall) Complaints and Urgent Care Centre

There was one complaint in Quarter one for Westcall, out of 18,819 reported attendances, giving a complaint rate of 0.005%, compared to 0.01% for Quarter 4, 0.02% for Quarter three and 0% in Quarter two.

The one complaint in Quarter one related to a doctor's comments regarding the Covid vaccination, which has been investigated by the service manager.

There were no complaints for the Urgent Care Centre, which had 4,931 attendances.

2.4 Children, Young People and Family service Complaints

2.4.1 Physical Health services for children complaints

During Quarter one, 4 of the 59 complaints (8%) were about children's physical health services, which are listed by service and geographic locality below. There were no themes as all four complaints covered different services.

Table 9: Children and Young People service physical health service complaints

	Geographical Locality			
Service	Reading	Slough	West Berks	Grand Total
Children's Occupational Therapy		1		1
Community Paediatrics		1		1
Health Visiting	1			1
Immunisation	1			1
Grand Total	**2**	**2**	**0**	**4**

2.4.2 CAMHS complaints

During Quarter one, 5 of the 59 complaints (8%) were about CAMHS services. There were 7,936 reported attendances for CAMHS during Quarter one giving a complaint rate of 0.06% compared to 0.07% for Quarter 4 and 0.034% for Quarter 3.

Table 10: CAMHS Complaints

	Main subject of complaint				
Service	Care and Treatment	Communication	Confidentiality	Waiting Times	Grand Total
CAMHS - Anxiety and Depression Pathway				1	1
CAMHS - Specialist Community Teams	2	1	1		4
Grand Total	2	1	1	1	5

Care and Treatment was the most common reason for the complaints within CAMHS, with two of the five falling into this category. Waiting times was the cause for the complaint received regarding the CAMHS Anxiety and Depression Pathway.

2.5 Learning Disabilities

There were no complaints about the community-based team for people with a Learning Disability or Learning Disability Inpatient Ward (Campion Unit) during Quarter one.

3. KO41A return

Each quarter the complaints office submits a quarterly return, called the KO41A.

The return looks at the number of new formal complaints that have been received by profession, category, age, and outcome. The information is published a quarter behind. The table below shows the information for Mental Health Trusts, up to and including Quarter four 2020-21. Information for Quarter one 2021/22 will be provided in Quarter two.

Table 11: KO41A Return

	2018-19				2019-20				2020-21			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Mental Health complaints - nationally reported	**3,598**	**3,651**	**3,391**	**3,450**	**3,507**	**3,502**	**3,335**	**3,303**	**2,058**	**3,049**	**2,753**	**2,854**
2Gether NHS Foundation Trust	17	14	21	20	24	16	..	..	..	..	..	..
Avon and Wiltshire Mental Health Partnership NHS Trust	78	72	77	51	56	67	59	63	42	67	48	65
Berkshire Healthcare NHS Foundation Trust	**49**	**45**	**38**	**51**	**47**	**52**	**56**	**51**	**40**	**47**	**37**	**51**
Cornwall Partnership NHS Foundation Trust	31	28	20	30	24	22	23	19	12	27	15	8
Devon Partnership NHS Trust	44	56	33	45	52	46	56	49	15	31	49	40
Dorset Healthcare University NHS Foundation Trust	91	90	92	54	61	60	64	88	60	109	98	95
Kent and Medway NHS and Social Care Partnership Trust	87	115	121	118	121	128	124	90	70	111	78	80
Oxford Health NHS Foundation Trust	50	56	58	56	52	61	72	68	44	54	54	55
Somerset Partnership NHS Foundation Trust	17	14	24	18	24	24	17	19	45	90	NA	NA
Southern Health NHS Foundation Trust	91	95	82	68	73	51	52	51	29	51	40	31
Surrey and Borders Partnership NHS Foundation Trust	26	36	16	26	22	28	32	27	9	27	24	17
Sussex Partnership NHS Foundation Trust	209	192	181	173	178	217	219	194	99	164	154	198

4. 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). During Quarter one there were 55 complaints closed.

Appendix one contains a listing of the formal complaints **closed** during Quarter one.

4.1 Outcome of closed formal complaints

Table 12: Outcome of formal complaints closed

	2020-2021						2021-2022		
Outcome	**Q1**	**Q2**	**Q3**	**Q4**	**Total**	**% of 20/21**	**Higher or lower than previous quarter**	**Q1**	**% of 21/22**
Not Upheld	9	25	19	18	71	36%	↑	27	49%
Partially Upheld	13	34	20	28	95	48%	↓	19	35%
Upheld	12	6	0	7	25	12.50%	↑	9	16%
Disciplinary Action required	0	0	0	0	0	0	-	0	0
Grand Total	**34**	**65**	**39**	**53**	**191**			**55**	

51% of complaints closed were either partly or fully upheld in the quarter, these were spread across several differing services. Of these, 6 were about staff attitude, 5 were in relation to communication and 12 related to care and treatment received. This equates to 21% for staff attitude, 18% for communication and 43% for care and treatment in Quarter one.

Table 13: Complaints upheld and partially upheld

	Main Subject of Complaint								
Service	**Abuse, Bullying, Physical, Sexual, Verbal**	**Attitude of Staff**	**Care and Treatment**	**Commun ication**	**Confide ntiality**	**Discharge Arrangement s**	**Discrimination, Cultural Issues**	**Medic ation**	**Grand Total**
Adult Acute Admissions - Bluebell Ward				1					1
Adult Acute Admissions - Daisy Ward				3					3
Adult Acute Admissions - Rose Ward	1								1
CAMHS - Specialist Community Teams			3	1					4
Children's Occupational Therapy - CYPIT			1						1
CMHT/Care Pathways		1	2			1			4
Community Hospital Inpatient Service - Henry Tudor Ward			1					1	2
Community Physiotherapy			1						1
Crisis Resolution and Home Treatment Team (CRHTT)		1							1
District Nursing			1		1				2
Health Visiting			1						1
Immunisation			1						1
Older Adults Inpatient Service - Orchid ward			1						1
Other							1		1

Rapid Response		2							2
Sexual Health		1							1
Urgent Treatment Centre		1							1
Grand Total	**1**	**6**	**12**	**5**	**1**	**1**	**1**	**1**	**28**

4.2 Response Rate

The table below shows the response rate within a negotiated timescale, as a percentage total.

Weekly open complaints situation reports (SITREP) are sent to Clinical Directors, as well as on-going communication with the Complaints Office throughout the span of open complaints to keep them on track as much as possible.

Table 14: Percentage response rate within timescale negotiated with complainant

2021-22	2020-21				2019-20			
Q1	Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
100	100	100	99	100	100	98	100	100

All complaints closed in Quarter one were closed within an agreed timescale.

5. Characteristic data

5.1 Ethnicity

One of the ways that the Trust can monitor the quality of its services is by seeking assurance through the complaints process, that people are not treated negatively as a result of their ethnicity or other protected characteristic.

The tables below show the characteristics of patients who have had complaints raised about their care between 1 April and 30 June 2021. This does not include where a different organisation was leading the investigation but does include re-opened complaints. The population data has been aligned to the information provided by the Trust Business Intelligence Team and is based on the characteristics of attendances during quarter 4 2020/21

Table 15: Ethnicity

Ethnicity	Number of patients	% complaints received	% breakdown of attendance in previous quarter
Asian or Asian British	5	8.47	9.67
Black or Black British	4	6.78	2.67
Mixed	3	5.08	3.49
Not Stated	8	13.56	15.89
Other Ethnic Group	2	3.38	1.62
White	37	62.71	66.66
Grand Total	59		

As a way of improving ethnicity recording, information is sent back to services where this is not documented on RiO. The Complaints Office also discuss the importance of capturing this information when delivering the Complaint Handling Training

5.2 Gender

There were no patient complaints where the person identified as anything other than male or female during Quarter one (there was one case where gender was not stated).

Table 16: Gender

Gender	Number of patients	% complaints received	% breakdown of attendance in previous quarter
Female	34	57.63	53
Male	24	40.68	46.98
Not stated	1	1.69	0.009
Grand Total	59		

5.3 Age

Table 17: Age

Age Group	Number of patients	% complaints received	% breakdown of attendance in previous quarter
0 to 4	3	5.08	18.41
5 to 9	1	1.69	4.14
10 to 14	6	10.17	4.34
15 to 19	4	6.78	4.52
20 to 24	4	6.78	2.87
25 to 29	8	13.56	3.14
30 to 34	2	3.39	3.56
35 to 39	1	1.69	3.58
40 to 44	5	8.47	3.52
45 to 49	1	1.69	3.73
50 to 54	4	6.78	4.32
55 to 59	5	8.47	4.46
60 to 64	3	5.08	4.63
65 to 69	0	0	4.53
70 to 74	3	5.08	5.56
75 to 79	3	5.08	6.16
80 to 84	2	3.39	6.55
85 +	2	3.39	11.98
Not known	2	3.39	0
Grand Total	59		

6. Parliamentary and Health Service Ombudsman

6.1 The Parliamentary and Health Service Ombudsman (PHSO) activity related to the Trust

The Parliamentary and Health Service Ombudsman (PHSO) are independent of the NHS and facilitate the second stage of the complaints process.

There have been no new formal investigations taken on by the PHSO in Quarter one, but we have received three enquiries where they have asked for further information.

Month open	Service	Month closed	Current Stage
Dec-18	Psychological Medicines Service	Open	Investigation Underway
Nov-19	CAMHS	Open	PHSO have requested information to aid their decision on whether they will investigate
Mar-20	CMHT/Care Pathways	Open	Underway
Sept 20	CPE	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	CMHT/Care Pathways	n/a	PHSO have requested information to aid their decision on whether they will investigate
Oct 20	Community Inpatient Services	Open	PHSO have requested we have a final meeting with family
Nov 20	CMHT/Care Pathways	Open	PHSO have requested we attempt to reach resolution with mother of patient who has not given consent to share
Jan 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate
Feb 21	Community Inpatient Services	n/a	PHSO have requested information to aid their decision on whether they will investigate
April 21	Veterans TILS	n/a	PHSO have requested information to aid their decision on whether they will investigate
May 21	Talking Therapies	n/a	PHSO have requested information to aid their decision on whether they will investigate
Jun 21	Community Nursing	n/a	PHSO have requested information to aid their decision on whether they will investigate

The PHSO have advised that the COVID-19 pandemic continues to have a significant impact on their workforce, service and delays by Trusts in responding to enquiries. For other complaints (where someone has faced less of an impact) they will consider whether there is anything they can do to help resolve things quickly, but if not, they will close the complaint.

7. Multi-agency working

In addition to the complaints detailed in the report, the Trust monitors the number of multi-agency complaints they are involved in but are not the lead organisation (main area of complaint is about another organisation and therefore that organisation takes the lead). There were seven complaints received that were led by another organisation during Quarter one, three led by SCAS and four through the CCG.

8. MP enquiries, locally resolved complaints and PALS

8.1 MP enquiries

In addition to raising formal complaints on behalf of their constituents, Members of Parliament (MPs) can also raise service and case specific queries with the Trust.

Table 18: MP Enquiries

	Main theme of enquiry						
Service	Access to Services	Care and Treatment	Communication	Discrimination, Cultural Issues	Other	Waiting Times for Treatment	Grand Total
CAMHS - AAT		1				1	2
CAMHS - ADHD						1	1
CAMHS - Specialist Community Teams						3	3
CMHT/Care Pathways	2	4	1				7

Common Point of Entry						1	1
Community Hospital Inpatient Service - Jubilee Ward			1				1
Immunisation					1		1
Other				1			1
Grand total	2	5	2	1	1	6	17

There was a noticeable increase in the number of enquiries raised through MP Offices in Quarter 1. The total received was 17, compared to the 5 received for the same period in 2020-21.

Seven of the MP enquiries related to care and treatment and communication in the CMHT (2 for Reading and Wokingham teams and 3 for West Berkshire). Six were spread across CAMHS services and these were primarily regarding waiting times.

8.2 Local resolution complaints

Complaints can be raised directly with the service, where the service will discuss the options for complaint management with those raising the complaint to give them the opportunity to make an informed decision as to whether they are looking to make a formal complaint or would prefer to work with the service to resolve the complaint locally, without involvement of the Complaints Office. These are called Local Resolutions and services log these so that we can see how services are doing at a local level.

Table 19: Concerns managed by services – Local Resolution complaints

Service	Number of concerns resolved locally
Adult Acute Admissions - Rose Ward	1
Berkshire Integrated Hub	1
CAMHS - Rapid Response	1
Children's Speech and Language Therapy - CYPIT	3
CMHT/Care Pathways	1
CMHTOA/COAMHS - Older Adults Community Mental Health Team	1
Common Point of Entry	1
Community Hospital Inpatient Service - Oakwood Ward	1
District Nursing	2
Health Visiting	2
Immunisation	6
IMPACTT	1
Intermediate Care	1
Out of Hours GP Services	1
Physiotherapy Musculoskeletal	2
PICU - Psychiatric Intensive Care - Sorrel Ward	1
Podiatry	4
Respite Care	1
School Nursing	1
Grand Total	32

There were 32 local resolution complaints logged in Quarter one, down by one from Quarter 4 2020/21. Care and treatment was the most common theme for the local resolutions that were logged with 11 relating to this subject. 10 of the complaints logged related to communication, 7 related to mental health services and 25 to physical health services continuing the theme that more concerns are resolved through local resolution within physical health services compared with mental health services.

Of the six concerns logged by the Immunisation service, three were regarding consent with vaccinations.

The four podiatry concerns were regarding care and treatment.

8.3 Informal complaints received

An informal complaint is managed locally by the service through discussion with the Complaints Office. It is a concern raised through the complaints office but can be resolved without the need of a full investigation. Complainants are offered the option to resolve informally, but the option to escalate to a formal complaint remains.

There have been 32 informal complaints received in Quarter one. compared to 31 in Quarter 4.

Table 20: Informal complaints

	Main theme of concern								
Service	**Attitude of Staff**	**Care and Treatment**	**Communication**	**Confidentiality**	**Discharge Arrangements**	**Other**	**Patients Property and Valuables**	**Waiting Times for Treatment**	**Grand Total**
Adult Acute Admissions - Bluebell Ward			1						1
Adult Acute Admissions - Daisy Ward		1	1						2
Adult Acute Admissions - Rose Ward							1		1
CAMHS - AAT		1						1	2
CAMHS - ADHD		1						4	5
CAMHS - Anxiety and Depression Pathway		1						1	2
CAMHS - Rapid Response		1							1
CAMHS - Specialist Community Teams								1	1
CMHT/Care Pathways	2	1	2						5
Community Dental Services								1	1
Community Dietetics		1							1
Community Hospital Inpatient Service - Windsor Ward		1			1	1			3
Community Physiotherapy	1								1
Complaints			1						1
Crisis Resolution and Home Treatment Team (CRHTT)				1					1
District Nursing						1			1
Physiotherapy (Adult)								1	1
PICU - Psychiatric Intensive Care - Sorrel Ward							1		1
Talking Therapies - Admin/Ops Team			1						1
Grand Total	**3**	**8**	**6**	**1**	**1**	**2**	**2**	**9**	**32**

8.4 NHS Choices

There were ten postings during Quarter one; six were negative and four were positive. PALS responded to these with contact information and the offer of a further conversation about their experience. It was also sent on to the services for their attention.

Table 21: NHS Choices

Service	No of postings	Positive	Negative
Urgent Treatment Centre, West Berkshire Community Hospital	4	*I was looked after today by a very skilled, caring and compassionate paramedic practitioner and matron in the urgent care unit. I had a particularly trying and frustrating day trying to access healthcare and was directed there by 111. Thank you so much I felt safe and cared for. You are a fabulous team thank you so much.* *I am really impressed with the service I received today after spraining my ankle. I had an appointment and was seen promptly. The Nurse Practitioner was very thorough and explained to me about ankle sprains and fractures. She sent me for an x-ray, again, very prompt and efficient service. Very efficient and friendly service.* *Very caring. All the team in this department were very kind, efficient and helpful. Felt very confident about my procedure.*	*I went in for a muscular injury to my shoulder and back, was told I may need an x-ray booked for the next day, the doctor who saw me barely checked anything, just made me raise my arm a few times (whilst still in a baggy hoodie so couldn't see my muscles working) placed my arm in a sling and told me to buy painkillers. I had been in so much pain I literally could not breathe and could hardly move. They never felt along the muscles or gave much advice. It felt very rushed and I was not assured, had to book an appointment with my local GP just so i could get it checked out correctly. Felt like the doctor could not be bothered to do their job properly and just wanted me gone as soon as possible.*
Talking Therapies	2	*During a difficult time in my life, my doctor suggested that I seek out some extra help from talking therapies Berkshire. I was able to start of with CBT, whilst this was useful both me and the therapist decided I needed an alternative therapy which was IPT Therapy, this therapy has been the most effective I have had over 10 years in and out of counselling and I have grown to be in such a better place now, my therapist was amazing and so helpful and I built a great relationship with her, this was hands down the best thing I*	*Very let down* *Referred and was told would hear within a certain time frame, its now been 10 months, just got an email from a 'Psychological Wellbeing Practitioner' basically say its seems we forgot you, email back if you need help or we are discharging you.* *What a joke.* *I'm lucky I have a very supportive family who have helped me because otherwise, with just talking therapies I would have topped myself a long time ago.* *Disgusting service.*

		have done and I am so grateful. If you are thinking about getting extra help I would highly suggest talking therapies.	
Westcall OOH GP	2		*Don't know what they are doing* *Rang 111 on the Saturday morning as I had a temperature after finishing a cause of antibiotics for a urine infection they put me through to west call and I spoke with a doctor who advised that I see a doctor at the royal Berkshire hospital but that was going to be at 6:30 that evening. So I turned up on time as requested but had to wait half an hour before I was called to go in. Things just seemed to go downhill rapidly from there the doctor was ok did what he had to then he said that he wanted to run some tests on the urine sample I had provided. I was just left in there for what seemed like an age then a nursing assistant come in saying she needed to do a blood test she then used one of those prickers for blood sugar test then started to squeeze the blood out without much success but she persisted till she was satisfied she had enough in the small syringe she had and of she went only to come back a short while later saying that she had been using the little syringe incorrectly so she was going to have another go. We went through the whole process again with similar results so she decided to take blood from my arm imagine my dismay when she came back with the necessary equipment only to look at it obviously with no idea how to use it fortunately she broke the needle before trying put it in my arm so she went to get the doctor who gave me a prescription for more antibiotics. When I then presented it in my local pharmacy I was told that it could not be dispensed as the script was incorrectly filled out so I then had to get in touch with west call to get a new script which they sent directly to the pharmacy but when I picked it up the dosage was different from the original and the amount of tablets is incorrect so I don't have enough to complete the course so will now have get back in touch later when there back at the royal Berkshire hospital.* (This has been followed up with WestCall) *My son had come out in a rash ALL over his body. As I was about to go to A&E, it was suggested by a friend that I try the 111 service, as once I'd been through this service, they would let A&E know I was coming. The 111 service was sadly just an operator who took me through a very long winded series of questions, and then told me a Dr would phone me back in 2 hours. I should have realised at this point given it was late evening, that driving to A&E was now a better option. 3 hours later and when my child said I just want to go to sleep now,*

			we gave up on receiving a call. After nursing my phone for 3 hours I finally put him to bed after giving him allergy medicine and putting cream all over him. It was at this moment the call finally came and I missed it by about 2 seconds. Sadly that was it. No repeated call. Nothing. Beyond disappointing the entire service and I would never use it again. The next day I got an immediate appointment at my local Dr's. He said it was the worst case of urticaria he had ever seen.
New Horizons Slough CMHT	1		*I have had cause to use Slough mental health services from New Horizons on three separate occasions. On all three occasions because I was not a classic text book case and couldn't be placed into this or that category the treatment was ended somewhat abruptly. The first occasion was definitely the worst of the three because I didn't see eye to eye with the occupational therapist it was they who gave the recommendation that I be discharged from the mental health services. To keep this short the other two occasions faired just as badly but maybe not as bad. They say they can work with complex cases but I say that is not the case. They have let me down three times out of three. In all honesty I got more help from my GP than I ever did from the mental health team based in Slough. It was my GP and my wife who provided the support at the times I most needed it. If the CMHT have improved within the past 12 months then that would be a step in the right direction. However if they haven't then providing you are a text book case you should gain some benefit from their services; for anyone with a more complex situation be prepared to find support from additional avenues.*
CRHTT	1		*No connection with my health or understanding.* *I stopped using the crisis team because I felt I was on a timer, ran out of credit and they put the phone down on me as busy! I was told by government rep I would be cared for! But lost in the conversation between them. I felt that not appreciated at all in crisis, secondary to other patients, even that need support. So found alternative suicide charity that would support me and not put the phone down on me as chronic pain and disability. Over time got to know the services why so frustrated as seam work on their needs and mine just secondary and screaming out for care planning central to self-care, but that neither happens finding kept being told services there for me but just a mirage and now completely on my own fending for myself in isolation. I get the feeling more about conforming as a patient than service than sitting down me writing any care plan safeguard me. The problem don't end there as finding myself outside the system for being late diagnosis of autism only after many mental health labels only find Autistic, on my*

			own, no mental health as just about conforming than my care as a disabled person in crisis.

8.4.1 PALS Activity

PALS has continued to provide a signposting and information service throughout the pandemic response. 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 was available across all inpatient areas. PALS has held regular meetings with advocates, with those working at Prospect Park Hospital having returned on a reduced basis.

There were 506 queries received during Quarter one, compared with 533 during Quarter four. In addition, there were 309 contacts which were related to non-trust services. The main reasons for contacting PALS were:

- Concerns and queries around communication. This included queries from external organisations.
- Access to services. People needing information on eligibility criteria and referral pathways across a range of services.
- Information requests.
- Concerns around waiting times. Particularly with regard to CAMHS and children's services.

Of the 506 queries, 17 were Covid-19 related. There is concern about visiting restrictions at Wokingham Community Hospital and how this is affecting patients. A general feeling that this needs to be reviewed as comparisons are being made with Prospect Park Hospital arrangements. Inpatient visitor guidelines were reviewed in line with the government roadmap. Since the closure of the vaccination clinic at Wokingham Hospital, enquirers have been signposted to external bodies for information and resolution.

Of the 506 contacts, 16 were escalated to the formal complaints process.

9. The Friends and Family Test

The NHS Friends and Family Test (FFT) gives an opportunity for patients and their carers to share their views in a consistent way across the Health Service. Berkshire Healthcare has aligned its Strategic Objectives to support a 15% response rate for the FFT in both physical and mental health services. The results of the NHS England national review of the FFT have been published and the FFT question was due to change from April 2020 to *Overall, how was your experience of our service.*

NHSE/I issued a national pause on the mandatory active collection and reporting of the FFT in March 2020. The Trust has continued to collect the FFT via non-contact methods such as SMS, online link and by telephone for local learning and service development. The Patient Experience Team has worked with wards in both physical and mental health services, to enable them to telephone patients who have given consent to be telephoned after their discharge. The feedback has been positive, and staff were able to also speak with family members and carers on several calls. From May 2020, in addition to the FFT, patients were prompted to share their experience of being in hospital during the pandemic (*Q2: Please can you tell us why you gave your answer?* (Prompt to find out more about PE, feeling safe, assured, hand hygiene, visiting restrictions).

FFT reporting to NHSE started again from January 2021 with the new FFT question (rating of care rather than recommendation to others) which was due to be launched from 1 April 2020 (and paused). The Trust started the new FFT locally from 1 September 2020 in readiness for the NHSE launch.

Wards are also continuing to promote the Message to a Loved One service which is well used and receives positive feedback.

9.1.1 Overall responses

During the 2020/21 -2021/22 reporting period figures have dropped considerably due to the pandemic and a pause of the FFT service. The SMS tool continues to be the most popular method of collection mode, the Patient Experience Team are continuing to work with to support those services who use RiO. Due to the pandemic, the transformation team have had reduced resources from a reporting perspective, which means that some non-RiO services have not been able to utilise SMS as a way to gather feedback.

Table 22: FFT Response Rate

		Number of responses	Response Rate
2021-22	Q1	5788	5.66%
2020-21	Q4	4259	4.66%
	Q3	4597	4.66%
	Q2	3018	3.33%
	Q1	3572	4.66%
2019-20	Q4	10,083	9.29%
	Q3	10,933	10.69%
	Q2	11,095	10.86%
	Q1	11,721	12.20%
2018-19	Q4	11,919	22%
	Q3	7631	12.82%
	Q2	5443	14.82%
	Q1	6625	11.64%

Table 23: Recommendation rate

	2020-21				2021-22
	Q1	Q2	Q3	Q4	Q1
Community Mental Health Services	70%	90%	85%	89%	93%
Mental Health Services	60%	85%	81%	83%	75%
Trust Total	59%	90%	85%	89%	87%

Table 24: Recommendation rate for inpatient wards

		2021/2022	2020/2021				2019/20			
Ward	**Ward type**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1%**	**Q4%**	**Q3%**	**Q2%**	**Q1%**
Oakwood Ward	Community Inpatient Ward	52%	100%	0%	0%	0.00%	100%	100%	100%	95.83%
Highclere Ward		81%	0%	67%	50%	0%	100%	100%	100%	100%
Donnington Ward										
Henry Tudor Ward		70.66	100	93%	100.00%	98.30%	-	85%	90.48%	97.44%
Windsor Ward		100%	100%	93%	0%	100%	-	-	91.89	-
Ascot Ward		95%	100%	100%	90%	100%	-	-	100%	-
Jubilee Ward		100%	98%	50%	100%	0%	89.13%	99%	96.34%	95.45%
Bluebell Ward	Mental Health Inpatient Ward	75%	0%	100%	0%	0%	56.25%	53%	65.22%	60%
Daisy Ward		67%	100%	100%	100%	50%	50%	87%	62.50%	75%
Snowdrop Ward		100%	85%	67%	0%	100%	80.76%	67%	74.49%	71.11%
Orchid Ward		92%	0%	75%	100%	0%	76.66%	76%	77.78%	84.48%
Rose Ward		100%	0%	100%	0%	100%	87.50%	70%	76.92%	62.50%
Rowan Ward		100%	0%	0%	0%	0%	54.16%	80%	86.67%	93.33%
Sorrel Ward		100%	0%	100%	0%	100%	50%	29%	-	-

Table 25: Carer FFT

	2020/21	2019/20	2018/19	2017/18
Q1	18	335	67	111
Q2		408	201	32
Q3		242	314	39
Q4		411	258	86

The Trust has appointed a designated Carer Lead who will be working alongside the Patient Experience Team and services to increase the response rate for the FFT question. As the new patient experience measure tool does not include capturing carer feedback, a specific card and methodologies (such as our website) will be used to capture this vital feedback.

10. Our internal patient survey

The existing patient survey programme was paused in response to the pandemic from mid-March 2020, alongside the collection and reporting of the FFT. Some services have continued to collect this information for internal service monitoring and development use.

I Want Great Care have been awarded to develop the new Patient Experience Measurement tool, and the aim of this is to improve Berkshire Healthcare's measurement, analysis and dissemination of patient feedback across all Community and Mental Health Services. They have been working with services and other stakeholder to design and build the surveys and reports, and a soft launch is scheduled for the end of October 2021.

11. Updates: Always Events and Patient Participation and Involvement Champions, Healthwatch

There is no activity to report for Always Events, Patient Participation and Involvement Champions and 15 Steps as these were not carried out as part of the pandemic response. The 15 Steps Programme has restarted during Q2.

There continues to be open and regular channels of communication between the Patient Experience Team and the Healthwatch organisations across Berkshire, on individual cases and for sharing communication with communities and meeting on a monthly basis. The Healthwatch organisations in the East of Berkshire have been awarded to one provider and there is work underway to link the new teams to our clinical Divisions.

12. Compliments

There were 1076 compliments reported during Quarter one. The services with the highest number of recorded compliments are in the table below.

Table 26: Compliments

Service	Number of compliments
Talking Therapies - Admin/Ops Team	418
District Nursing	147
Intermediate Care	59
Community Matron	38
CMHTOA/COAMHS - Older Adults Community Mental Health Team	31
Other	29
Community Dietetics	24
Community Based Neuro Rehab - CBNRT	24
Diabetes	22
Physiotherapy Musculoskeletal	20
Community Respiratory Service	20

Table 28: Examples of compliments received during Quarter one

Community Respiratory Care service *The PR Team have been amazing and supportive and I feel so much more positive now. The reassurance you have given me has really helped and I feel more capable. The exercise sessions were very enjoyable and she made me laugh and smile. Thank you to all the team.*	CRHTT *The client thanked Support Worker for "caring about their child* as well as the client*" The client said Hub Manager explained the medication, CPN and Support Worker gave constant support and care, now feels well to deal with the future and life stressors. Was very grateful for our support.*
Children's SALT *'Please may I take this opportunity to say a big 'Thank You' for your help and support with x. He has come on leaps and bounds with your help, as well as the help from other Wokingham Healthcare Services. It's very comforting to know*	LD Intensive Support Service *'Thank you so much for being there for x and the family at today's EHCP meeting. I know you didn't get to say much but what you did say was great and very much appreciated. I did use your pearls of wisdom as best as I could! As you can see I am a woman on a mission and will not stop until I*

that x will be in your Teams care as he starts his journey on finding his little voice.'	*have got the best outcomes for x. Hope it works in getting x back to college - He does work hard and he has done academically well. I want him to be offered an ASD college place where he can be supported and thrive again from September.* *Thanks in advance for saying you'd forward a report to his case officer (if you haven't done already!)'*
MSK Physiotherapy *'I feel much better after your advice on which exercises to do and how to do them properly. A few weeks ago I wondered if I would be in pain for the rest of my life, which was miserable, and now the pain is nearly gone. I can't thank you enough for that.'*	Perinatal Mental Health Service *'Gosh I am so sorry too we never got to say goodbye properly. Thank you so much for incredible support and care (and patience) over the course of our time together.* *Take good care of yourself and your family.* *Very very best wishes.'*
Covid Vaccination Clinic *'Brilliantly quick but friendly service they are managing to provide.* *The nurse that vaccinated was one of those nurses who have that old school disarming smiling manner, so relaxing for people. It's good to know we still have this kind of nurse in the NHS.* *Well done to all concerned, even the lady signing people in was lovely.'*	Community Matrons *'Thank you for taking time to sort out my husbands PEG issues, been problematic for a long time and finally someone has listened to me.'*
Community Respiratory Service *'1) Very thorough and helpful* *2) The care the Nurse took in explaining everything to me.* *3) All questions answered with clear information.* *4) Helpful in so many ways, ie information telephone calls, tips.* *5) Always there when needed questions.* *6) Everyone is very supportive in the program.* *7) Makes me feel positive – makes me feel good, look forward to doing the exercise.* *Everyone very helpful, clear, easy to understand. People are nice, friendly and committed. If I didn't understand, someone available to clarify things. Just thank you, this course and the people have made a huge difference.'*	CAMHS Specialist Community Team *'I hope this finds you well.* *I wish to express my gratitude towards all your help and support for the two young girls that are in my care.* *Your support through CAMHS has been invaluable.'*

MSK Physiotherapy

'*My wife and I would like to bring to your attention the exceptional support we feel we have received from x. From the initial telephone consultation he came across succinctly, understanding and supportive. He has carried out everything he has said he would, phoning to discuss the next steps, checking we were happy with proposed plans etc and explaining the rational behind them.*

It has been a huge relief to have someone professional and understanding, as I don't feel I have been listened to in the past and this time I am desperate! Not only have I suffered considerable knee pain since the beginning of December and the inactivity this has caused, but I have found as time has progressed it has affected my mood and I have been feeling very down. I've not suffered from depression in the past so can only put the low mood down to the strain of the knee issue and inactivity. I couldn't even go to an appointment with SpecSavers in Broad Street as I was unable to walk from the nearest drop off point to the shop. x has been understanding in what I am going through and was sympathetic and supportive in what he said - which mentally helps one a great deal.

I've suffered from painful hips for a good ten years now and when I've brought this to the attention of my doctor I have been turned away saying I was too young to be referred. I expected to be dismissed on this occasion so it was really encouraging to feel that what I was feeling and reporting to x was taken seriously and being analysed accordingly and that something would be done. My other concern is that my "gait" is so bad when I do walk that further damage will be done to my frame - thus time is of an essence!

But this is not to bring my issues to your attention, it is to ask you to say a huge thank you to x. He has given us hope and we really do feel he is working alongside us. I feel "valued" as an individual and not just another patient. That's a huge gift to give someone - and a quality which not every practitioner possesses. We know your workload is heavy and stressful, but x has never rushed us with our queries and told us to make contact if we had further questions.

I feel very lucky to have x as my practitioner and intermediary - he is exceptional in his role.'

Table 28: Compliments, comparison by quarter

	2019/20					2020/21					2021/22
	Q1	Q2	Q3	Q4	2019/20	Q1	Q2	Q3	Q4	2020/21	Q1
Compliments	1,404	1,389	1,437	1,436	5,666	873	975	1,010	1,319	4,177	1076

13. Feedback on the complaints process

13.1 Internal audit

Our internal auditors undertook an audit of Patient Experience processes in quarter 4 as part of the Trust 2020/21 Internal Audit plan. The review looked at the mechanisms in place for the monitoring and management of feedback received from patients and carers of the Trust and how the Trust use this information to improve patient experience. The audit was positive providing reasonable assurance, with 2 low and one medium recommendation made.

Positive assurance was received in relation to:

✓	Complaints Policy
✓	Reporting and Managing Complaints
✓	Complaint Timeframe
✓	Complaint training
✓	Complaint Feedback/Resolution
✓	Patient Advice and Liaison Service (PALS)
✓	Working with Patient-led Groups - Healthwatch
✓	Reporting of patient experience internally and to the Board

Recommendations:

The 2 low recommendations were in relation to continuing to improve capture of ethnicity data in relation to complaints and to continue to strengthen existing processes for demonstrating actions taken across the trust as a result of feedback(building on the current processes in place)

The medium recommendation was in relation to undertaking deep dive analysis across services to identify wider themes providing opportunity to make further improvements to the patient experience. The report recognised that this already takes place at divisional level and that a process led by the patient safety team to look across incidents, safeguarding and patient experience has already commenced. The Trust's new patient experience tool in development will also support improvement in this area.

13.2 Feedback from complainants

During quarter one the following feedback was received on the complaints process

'Thank you for your letter. I was pleased with the thorough way in which you and your staff dealt with the complaint. I appreciated the call from the Investigating Officer and felt that she understood my concerns. She impressed me with her caring attitude and I am confident that she will make substantial improvements to the service.'

'Firstly I would like to apologise for not coming back to you sooner but has been a busy week and wanted to have time to reflect and read through the report in full.

Having read through I am thoroughly satisfied with the report and the diligence to review the situation to make improvements. Although it was a distressing experience we appreciate that was not anyone's intention. We accept the apology in relation to how it was handled and are pleased that the event can perhaps in some way improve and enhance the policy moving forward which is all we wanted to see.

Thanks so much to yourself and the Investigating Officer for managing this investigation and providing such a satisfactory report it really is very much appreciated.'

'I refer to my letter of x regarding the diagnosis report for my son and wanted to pass my heartfelt thanks for you, and your team for the swift resolution and provision of these reports.

I have now been able to pass these onto the school and health providers which will enable us to access the help and support our child needs.'

Elizabeth Chapman

Head of Service Engagement and Experience

Formal Complaints closed during Quarter one 2021/22

Geo Locality	Service	Complaint Severity	Description	Outcome code	Outcome	Subjects
Bracknell	Other	Low	Pt believes EB/CCG made a funding request disseminated to BHFT but there is nothing on the pts records regarding this matter	Not Upheld		Medical Records
Reading	Talking Therapies - Admin/Ops Team	Low	pt was told GP would not be informed of contact with TT service verbally and in the policy on the website plus delays in DPA requests	Not Upheld		Communication
Wokingham	Rapid Response	Low	Complainant wishes an appropriate apology for the severe emotional impact inflicted on the family ORIGINAL COMPLAINT DECEASED PT: Complainant unhappy with a staff member's care and attitude	Partially Upheld	Team to receive additional training regarding safeguarding processes and informing patients/family members Team assessment form to now include section regarding social situation to ensure the team gather all information needed regarding a patient's care and any family involvement Team to be reminded to only contact patients/family members within team operation hours Team session to be carried out regarding trust expectations r.e. documentation writing and timescales to enter information onto RIO Internal processes to be followed in regards to team member that Ms De Meyer raised concerns about	Attitude of Staff
Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	Pt attacked by female staff member who also took the pt's training shoes	Not Upheld		Abuse, Bullying, Physical, Sexual, Verbal
Reading	Adult Acute Admissions - Rose Ward	Minor	Pt feels staff member was overly heavy handed when restraining them holding them round the neck and then being told to strip	Partially Upheld	Ward teams to ensure decisions and actions from MDT are communicated to patients so that they are aware of their care and treatment. Actions to be assigned to identified staff members to ensure a named person takes responsibility Debriefs with patients to happen after episodes of seclusion to support patients	Abuse, Bullying, Physical, Sexual, Verbal
Reading	Adult Acute Admissions - Daisy Ward	Minor	Pt feels she was assaulted and abused on the ward by 3 to 4 female staff members in her room at night	Not Upheld	Staff are to take gently care when assisting patients with personal care and ensuring they always communicate empathetically.	Abuse, Bullying, Physical, Sexual, Verbal
Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward		Following previous investigation family feel there are some discrepancies, 4 additional points to answer	Partially Upheld	Previous complaint 7674 was upheld, this complaint is seeking clarification on some points, but one new service failure was acknowledged, so this is partially upheld	Care and Treatment
West Berks	CMHT/Care Pathways	Moderate	CPN on long term absence, someone found to support but they went on annual leave. Pt feels left with no support	Not Upheld	Given patient's level of distress it is acknowledged that we, as a service, alongside Adult Social Care, need to work collaboratively with pt to highlight the most appropriate support in a timely manner. A professionals meeting will be planned to develop strategies to support Richard in an attempt to reduce his distress	Care and Treatment

Reading	PICU - Psychiatric Intensive Care - Sorrel Ward	Low	Patient is unhappy with his care, his leave and says staff are racist	Not Upheld		Care and Treatment
Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Low	Family feel there was a lack of physio on the ward. Felt bullied to sign a DNR when the pt does not want one, unhappy a statements recorded about the pt being stubborn and challenging	Not Upheld	Share incident with staff Staff to be aware that patients in pain should have painkillers routinely prior to physio sessions Ward Doctors to try and engage next of kin in DNACPR discussion with consent of the patient	Care and Treatment
Windsor, Ascot and Maidenhead	IMPACTT	Minor	Family wish the pt to be funded for an EUPD Inpt facility	Not Upheld	Community Mental Health Team (CMHT) in WAM will formally accept transfer of care from Bethnal Green CMHT, East London Foundation Trust	Care and Treatment
Bracknell	CMHT/Care Pathways	Low	Patient unhappy with phone consultation and what has been written. Dr said husband was threatening.	Partially Upheld	Another follow up review be scheduled ASAP	Attitude of Staff
Reading	Health Visiting	Low	Complainant has submitted 11 points of complaint against Health Visitor. However, nine of these will not be responded to under the UPC status, but two relate to domestic violence allegations and the complaint is about what evidence the HV had to make the allegations she did	Not Upheld		Communication
Reading	Community Physiotherapy	Minor	Friend of patient is complaining about care from community OT. Friend alleges that the OT failed to recognise the severity of the patient's illness or knew he had a terminal diagnosis	Partially Upheld	For staff to be reminded that if equipment patients and or carers request is not available from NRS and there is not a clinical need for it that support should be given to explore private purchase options, and this is clearly documented For staff to receive additional training in recognising the deteriorating patient For the name of the allocated senior clinician for the Integrated Care Home Service and Rapid Response/Home First services at the weekend to be shared with the Reading DN triage team For staff knowledge regarding care for patients with a terminal illness/at end of life to be considered as part of the team's gap analysis	Care and Treatment
West Berks	CMHT/Care Pathways	Low	Family dispute appt's have happened and wish a referral to UCL Queen Sq Institue of Neurology ORIGINAL - Poor transition from CAMHS to adults. Complainant feels they have to keep chasing in order to get any form of service and states the complaint is that there is NO treatment for the patient	Partially Upheld	Service Manager to discuss further with medical staff to ensure that appropriate medical input is in place. Discuss content of concerns with CC. This will help both to be aware of treatment plans and goals. Transition between CAMHS and CMHT to be considered with clear information given regarding what Adult Mental Health Services are able to offer.	Care and Treatment
West Berks	CAMHS - ADHD	Moderate	Complainant wishes to know why we are not providing an assessment or a date when this will happen and why we are not keeping in contact with them	Not Upheld	There are no specific actions identified to prevent recurrence. However, the team is working closely with the CCG on a project to model demand and capacity, workforce and transformation in order to compare and cost options for the service. In addition, caseload management continues supported by the Team Lead and the team has a driver metric of reducing DNAs to try to improve capacity and reduce waits.	Waiting Times for Treatment

Reading	Adult Acute Admissions - Daisy Ward	Minor	Pt admitted to PPH then Cygnet then back to PPH - no communication to family to say any of these moves had happened. PPt went AWOL and family not communicated again, pt turned up at home having walked a long distance	Upheld	All broken front ward door mechanisms must be raised immediately when discovered with ISS and on call ISS manager/ PPH on call manager and whilst waiting for repair must have a member of staff allocated to sit by the door and support safe entrance/ exit. Bed management team will use the standard work developed about maintaining communication with families for patients in OOA beds and review at the end of month 1 adapting accordingly. Communication with carers/ families is timely and invites to meetings take due consideration of working families and their needs. The CDLs on the wards will develop an email address for each ward and also be in contact with them on admission ensuring they know of this communication channel. Installation of solenoid bolts into the walls of the front doors of the wards (rather than the floors and ceilings) will be commenced in June 2021	Communication
Windsor, Ascot and Maidenhead	Community Hospital Inpatient Service - Henry Tudor Ward	Minor	Pt looking for financial redress for costs incurred for private physio etc ORIGINAL COMPLAINT - Pt discharged from the ward without blood thinning meds. Needed to go back into hospital via paramedic. Pt had a care plan in place involving carers which was discontinued and has meant the pt has had to wait in hospital till put in place. Pt & family have found this very traumatic	Upheld	Indication for anti-coagulant medication to be included on the drug chart e.g. treatment/surgical prophylaxis. This may help to avoid assumptions Stop date of medication to be recorded in clerking notes & on handover sheet. Medication conversations can / should be had prior to discharge – once medication is on the ward Identified improvement to consider push back to support safety and state the ward team need longer to co-ordinate a discharge safely To request Acute trusts to provide the full course of LMWH. Further investigation regarding use of one medical prophylaxis on wards.	Medication
Reading	District Nursing		Deceased pt: Family feel the pt was left to die without adequate pain relief and without dignity	Not Upheld	No consent obtained	Care and Treatment
Wokingham	CAMHS - Specialist Community Teams		Family unhappy with the care and treatment received from Psychiatrist	Upheld	Local resolution	Care and Treatment
Reading	CAMHS - Specialist Community Teams	Minor	Transition from CAMHS to CMHT	Partially Upheld	Ensure Rapid Response update their processes to ensure that young people are not discharged when they turn 18 until ongoing care plan is devised from Adult Services or other relevant agency. Also ensure Patients are given the Adult Crisis Team number once they turn 18.	Care and Treatment
Reading	Older Adults Inpatient Service - Orchid ward	Minor	Friend of pt is generally unhappy with the care, communication and compassion from the staff on the ward. Believes addimission stemmed from a medication issue that the ward has exasperated.	Partially Upheld	Key nurses to review family contact and documentation. Consider weekly family contact with intent to update them on patient progress. Team to device a Standard operation for meetings PALS to improve on feed back and communication with complainants. Ward manager to liase with PALS for a discussion over strategies to enhance communication All attendees of best interest meeting to be communicated with all relevant prior to meeting. Team to device a Standard operation for meetings	Care and Treatment

West Berks	CMHT/Care Pathways	Moderate	Family of patient have sent their complaint regarding their sister's care in OAP. She has been there for two years (since May 2019) and they have had concerns about her care but now the Dr there is saying patient does not need to go to NPU, which goes against the long standing plan.	Upheld	Point of contact to be identified from within the family for liaison with patient's key nurse Family members to be offered the opportunity to attend CPA meetings in accordance with CPA policy regarding the rights of families and carers CMHT to attend CPA meetings and to be invited to Ward Rounds monthly for updates. CMHT to take responsibility for liaison with NPU and facilitating admission when a bed becomes available. To confirm date of completion for Patients bathroom to improve living conditions.	Care and Treatment
Reading	Community Respiratory Service	Minor	pt called service to enquire how to make contact with the stop smoking service and the person who called back became rude and derogatory toward the patient leaving them feeling quite horrified. Pt nolonger feels able to contact the service. Pt is also very upset at comments that the person read out from their notes. pt hopes the call was recorded and wishes a full apology.	Not Upheld	Service lead to ensure that all staff are reminded to upload referrals to Rio soon after the activity in line with record keeping requirements. To ensure all administrator staff have undertaken conflict resolution training for effective management of difficult telephone conversations.	Attitude of Staff
Reading	Health Visiting	Moderate	Father is complaining about how things were handled by health visitor when she found bruising on his son. She informed them she would have to report to social services and made parents feel they had done something to unintentionally hurt the baby. Later discovered the bruising was mongolian blue spot. Father wants a full review of the HV's conduct.	Upheld	All health visitors to carry a crib card with bruising protocol process plus telephone numbers for Safeguarding Named Nurses, Safeguarding Duty line, health visiting managers Royal Berkshire Hospital to ensure advice is sought before leaving the family home All health visitors to carry a What Happens Next leaflet to give to parents when bruising policy evoked All health visitors including those employed by NHSP to have attended or watch a recording of training given on 22/2/21 & 22/3/21 by consultant in Children's Specialist Services, regarding the presentation of Mongolian Blue Spots & Naevi Named Nurses Children's Safeguarding to discuss with practitioner how they will have the difficult conversation with the family when evoking bruising policy, no matter what the level of practitioner's experience. Training update on the bruising protocol to be given to all Berkshire Healthcare and NHSP staff Review of bruising protocol Safeguarding team to feedback to pan Berkshire safeguarding policies to consider whether social care only informed/involved if bruising considered to be abuse when examined by medical professional rather than before this examination. (Unless social care already involved). Include a section on compassion and how to have discussion with parent/carer	Care and Treatment

Slough	Sexual Health	Minor	Unhappy with the attitude of the member of staff who kept questioning the pt's life choices.	Upheld	Clinician to explore opportunities the Trust can provide on motivational interviews Reflect on wording used during consultations	Attitude of Staff
Slough	Children's Occupational Therapy - CYPIT		OT f2f assessment, needed to rearrange due to COVID and was told no future appt available. It has now been 2yrs 3 mths since the referral. Family feels this is now an unacceptable time lapse.	Partially Upheld	closed as local res - appt given	Care and Treatment
West Berks	CAMHS - Specialist Community Teams	Moderate	Further concerns and questions raised from response. Family feel urgent action is required as they feel the pt has been left without care for a significant time ORIGINAL COMPLAINT Parents complaining regarding the care their daughter has received from CAMHS and A&E. They feel there has been a lack of age appropriate treatment from August 2020 to date and CAMHS contact has been minimal. They have asked for an urgent review, which we have asked the service to do	Partially Upheld	To ensure that there is a system in place for the suggestion of therapeutic input/support from external agencies, so that this may be shared with families at the relevant time in the care pathway	Care and Treatment
Wokingham	Rapid Response	Low	Complainant wishes an appropriate apology for the severe emotional impact inflicted on the family ORIGINAL COMPLAINT DECEASED PT: Complainant unhappy with a staff member's care and attitude	Partially Upheld	Team to receive additional training regarding safeguarding processes and informing patients/family members Team assessment form to now include section regarding social situation to ensure the team gather all information needed regarding a patient's care and any family involvement Team to be reminded to only contact patients/family members within team operation hours Team session to be carried out regarding trust expectations r.e. documentation writing and timescales to enter information onto RIO Internal processes to be followed in regards to team member that complainant raised concerns about	Attitude of Staff
Wokingham	Talking Therapies - PWP Team	Low	Pt wishes to know why they were only given help lines and on line forums by Talking Therapies when presenting with depression and expressing suicidal feelings. Why did Eating Disorders only offer group sessions when already known pt had mild Asperger's and would have difficulty engaging?	Not Upheld	Patient was given information and clear guidance on who to contact and how to get support.	Care and Treatment
West Berks	CMHT/Care Pathways	Low	Complainant feels there is no accountability from the Trust, no ownership of failings, no empathy and no clear indication of the way forward. ORIGINAL COMPLAINT:- Family unhappy with pt discharge and no communication with them before this happened. Family also unhappy in the lack of support for them as a family	Partially Upheld	Further emphasis on carer involvement during treatment and at the point of discharge will be discussed with CMHT Discharge audit to ensure carer involvement becomes embedded into practice Pt will be offered a further out-patient appointment to explore diagnosis. This will inform any further intervention needed by secondary mental health services, including psychological input as well as the need for medication.	Discharge Arrangements

Reading	Adult Acute Admissions - Daisy Ward	Moderate	Unhappy with response, believes Dr fabricated information and wants it taken off the records, also wanting disciplinary action on Dr's and nurses. ORGINAL COMPLAINT Pt unhappy with reports written for tribunal hearing. Pt feels we have given their contact details to someone and they are demanding to be moved to a different address.	Partially Upheld	All staff to ensure that they are up to date with Information Governance and Mental Health Act training. Reading Borough Council to meet with pt and look at options re Nearest Relative displacement if appropriate Revisit information re access to Independent Mental Health Advocate Await outcome of formal complaint made to Catalyst Housing- Feedback to pt	Communication
Bracknell	Complaints		Pt feels an investigation, no matter how small needs to be conducted. ORIGINAL BELOW Documentation recorded on East CCG system by their PALS officers stating BHFT involvement with the pt which is factually incorrect	Not Upheld	no consent granted to discuss	Medical Records
Reading	PICU - Psychiatric Intensive Care - Sorrel Ward		pt states physically assaulted by a fellow pt, reported to police. Pt also says they were verbally abused by a night staff member a while ago and says nothing has come of it	Not Upheld	Complaint withdrawn	Abuse, Bullying, Physical, Sexual, Verbal
West Berks	Urgent Treatment Centre	Minor	Complainant attended UTC with young pt, staff refused to see them as no appt booked, eventually a Dr did see the pt but did not examine, advised UTI. Later family took pt basingstoke A&E to find there was an issue with the pt's bowl.	Upheld	Reflections • Receptionist • Nurse Practitioner • GP Nurse Practitioner To attend Compassionate Leadership course Nurse Practitioner To complete online modules “Spotting the sick child” https://spottingthesickchild.com/ Doctor Recommend online modules “Spotting the sick child” https://spottingthesickchild.com/ Doctor Offer a clinical one to one with GP Lead To distribute this complaint anonymously through the clinical governance newsletter, which is disseminated across all staff groups in Urgent Care. To discuss at individual team meetings for GP’s and Practitioners, Nurses and HCA’s	Attitude of Staff
Wokingham	Rapid Response	Minor	Complainant wishes an appropriate apology for the severe emotional impact inflicted on the family	Not Upheld	as learning identified in original complaint	Attitude of Staff

Wokingham	Health Visiting		Mother wishes the report written for child protection case to be amended, unhappy that HV made a Dr's appt without asking mother first, report states they just left services	Not Upheld	Complainant withdrew complaint	Communication
Reading	District Nursing	Low	Family unhappy with response ORIGINAL Family unhappy at the lack of care for the pt	Not Upheld	Meeting arranged with family	Care and Treatment
Reading	Adult Acute Admissions - Bluebell Ward		Pt unhappy with care and treatment from Bluebell Ward, dating back over time, also unhappy with care from Bracknell CMHT	Not Upheld	IO unable to speak with complainant. S17 leave was appropriate (on one occasion delayed due to a fire on site but reinstated shortly after). Not able to investigate/substantiate concerns relating to incidents on the ward as no evidence found.	Care and Treatment
Bracknell	Talking Therapies - Admin/Ops Team		pt states they did not miss an appt but did not have the right technology, feels there is a lack of support	Not Upheld	Local resolution	Care and Treatment
Wokingham	Talking Therapies - PWP Team		Pt unhappy with previous 2 response and has 2 further questions for clarity Pt wishes to know why they were only given help lines and on line forums by TT when presenting with depression & expressing suicidal feelings	Not Upheld	as providing clarity on previous responses	Care and Treatment
Reading	Adult Acute Admissions - Bluebell Ward	Minor	Complainant still unhappy with communication from the ward and wishes to understand what happened when the pt was attacked by another pt	Upheld	The ward have recruited more staffing enable the to provide consistent care and support of our patients, their families and carer Carer's contact letter will be sent to families /NOK of the patient at the point of admission with all the appropriate phone numbers for the ward. The second and the third family contact will take place 72hrs and one week after the admission by the ward to inform the carer about their loved ones progress and any treatment plan and to inform and invite them to carer's group. Introduction of Daily safety Huddle after the handover to identify any risks, incidents or safeguarding issues to put appropriate actions in place tomitigate nay risk to patient or staff Introduction of MS Teams group for the ward to improve communication between the medical and nursing team	Communication
Reading	Crisis Resolution and Home Treatment Team (CRHTT)		phone kept ringing, ansafone said full, when they got through pt says they were made to feel it was all their fault, complainant feels there was no manners or human decency in they way they were treated and feels training needs to take place.	Partially Upheld	Patient was misadvised that CRHTT is a suicide hotline. There were telephone line issues which meant that some calls did not connect. Advise was appropriate and the patient acknowledged that they may have misinterpreted the staff they spoke with as they were unwell.	Attitude of Staff

Reading	Immunisation	Low	Pt vaccinated when fasting due to Ramadan, family unhappy as the pt requested for this not to be done despite consent from parents	Partially Upheld	As soon as complaint received by IO, guidance circulated to BHFT School Immunisation Team to highlight that it was Ramadan, that pupils could be fasting and Team would need to be sensitive to this and be aware of potential issues around receiving a vaccination when fasting (eg: whether to eat/drink post-vaccine, etc). Any pupils raising concern to be advised to speak with their parents/carers for advice. The BHFT Immunisation Team have already acted to address some of the issues around ensuring parents are aware of planned vaccination dates. They have created a written SOP for the Lead Nurse for a school. This states that the Lead Nurse will ensure information regarding dates and other vaccine info will be circulated to the school. The Lead Nurse needs to inform the school that all this info should be circulated to the parents/carers of students eligible for vaccination. Dates for planned vaccination sessions will be sent to BHFT Digital Content Officer. These dates will be uploaded to the BHFT CYPF website Information on how to access these dates on the CYPF website will be included in the info pack sent to schools by the Lead Nurse. Schools advised to include this when they send information to parents	Care and Treatment
Reading	Community Hospital Inpatient Service - Oakwood Ward		Complainant believes the pt's discharge was poor. pt wasn't aware what meds to take. CRT had not visited. Many Healthcare professionals visited expecting Husband to sort everything with his medical conditions. Pt eventually readmitted to RBH with severe infection and injuries form falls. Family complaining to multiple agencies was numerous questions	Not Upheld	No consent received	Discharge Arrangements
Reading	District Nursing	Minor	Member of staff approached a pts family member and starting to talk about the family members health conditions loudly in front of the pt's neighbours. Family and pt extremely unhappy about this public breach of confidentiality	Upheld	Now HR investigation	Confidentiality
Wokingham	Integrated Pain and Spinal Service - IPASS	Minor	Referal sent from GP, letter received to say not serious enough so on a wait list. Pt ended up having surgery and feels they were misdiagnosed which has added to the seriousness of the problem	Not Upheld	No failings by us based on info received from GP We will discuss with the GP surgery to ensure they are aware to complete the referral form fully when sending for triage. We will remind clinicians to be aware patients may not have had a physical examination at time of referral.	Care and Treatment
Windsor, Ascot and Maidenhead	East Berkshire Wheelchair Service	Low	Complainant unhappy that clinician was listening to the telephone conversation between parents of pt. Feels it was a breach of DP legislation, they feel the accusations of behaviour are false and has caused distress to the pt. Family wish no direct contact with service	Not Upheld		Support Needs (Including Equipment, Benefits, Social Care)
Reading	Adult Acute Admissions - Daisy Ward	Low	pt feels they are not being listened to by staff on the ward or at the MH Tribunal.	Partially Upheld		Communication
West Berks	Other	Low	Staff member was not wearing a clear mask and would not take off their mask so the carer could lip read	Partially Upheld	We acknowledge that it was difficult for carer as she could not lipread through the facemask, making her role as carer difficult.	Discrimination, Cultural Issues
Reading	CAMHS - Anxiety and Depression Pathway		Waiting 2 and half yrs, despite being moved up the list, still no time frame given	Not Upheld	Clinical wait time is appropriate and the young person has been reassessed accordingly.	Waiting Times for Treatment

Wokingham	District Nursing	Low	Family very unhappy with care from DN who is dealing with pt wounds. Family want a review of care by someone more senior	Partially Upheld	Ensure regular band six review Ensure staff are correctly bandaging legs Ensure regular monitoring of pressure areas	Care and Treatment
Reading	Adult Acute Admissions - Bluebell Ward	Low	Pt feels we did not take into consideration their physical health issues and medication when prescribing and that we denied physical health meds when the pt was in PPH	Not Upheld		Care and Treatment
Reading	Crisis Resolution and Home Treatment Team (CRHTT)	Moderate	Complainant unhappy about the final paragraph stating they swore to staff members ORIGINAL COMPLAINT BELOW: Pt unhappy with a diagnosis given to him which he only found out through his GP some months later. Disagrees with the letter received that he accepted this when he met with psychiatrist in January	Not Upheld	The information documented about aggressive behaviour was appropriate.	Communication
West Berks	CAMHS - Specialist Community Teams	Minor	Complainant unhappy with the minutes of the meeting the report was sent to as clinician said things complainant does not agree with ORIGINAL COMPLAINT Mother unhappy with a report which went to a Child Protection conference, believes the clinician needs to make sure the information is correct before writing.	Partially Upheld	Staff to be reminded to make every effort to share child protection reports with families, where possible. IO to speak to Dr regarding concerns.	Communication

Trust Board Paper

Board Meeting Date	14 September 2021
Title	**Quality Assurance Committee – 24 August 2021**
Purpose	To receive the unconfirmed minutes of the meeting of the Quality Assurance Committee of 24 August 2021
Business Area	Corporate
Author	Julie Hill, Company Secretary for David Buckle, Committee Chair
Relevant Strategic Objectives	To provide good outcomes from treatment and care.
CQC Registration/Patient Care Impacts	Supports ongoing registration
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The unconfirmed minutes of the Quality Assurance Committee meeting held on 24 August 2021 are provided for information. Attached to the minutes are the following reports which were discussed at the Quality Assurance Committee meeting and are presented to the Trust Board for information: • Learning from Deaths Quarterly Report • Guardians of Safe Working Hours Quarterly Report
ACTION REQUIRED	The Trust Board is requested to: a) receive the minutes and the quarterly Guardians of Safe Working Hours and Learning from Deaths Reports and to seek any clarification on issues covered.

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Minutes of the Quality Assurance Committee Meeting held on Tuesday, 24 August 2021

(the meeting was conducted via MS Teams because of COVID-19 social distancing requirements)

Present:	David Buckle, Non-Executive Director (Chair) Aileen Feeney, Non-Executive Director Mehmuda Mian, Non-Executive Director Aileen Feeney, Non-Executive Director David Townsend, Chief Operating Officer Dr Minoo Irani, Medical Director Debbie Fulton, Director of Nursing and Therapies Guy Northover, Lead Clinical Director Jason Hibbitt, Quality Account and NICE Lead (*deputising for Amanda Mollett, Head of Clinical Effectiveness and Audit)*
In attendance:	Linda Jacobs, Deputy Office Manager & Executive Assistant Sara Fantham, Clinical Director & Lead Nurse Katie Humphrey, Carers Lead

Opening Business

1 Apologies for absence and welcome

Apologies were received from: Julian Emms, Chief Executive, Amanda Mollett, Head of Clinical Effectiveness and Audit, Julie Hill, Company Secretary and Jayne Reynolds, Regional Director for East Berkshire.

The Chair welcomed everyone to the meeting, Jason Hibbitt deputising for Amanda Mollett and Sara Fantham deputising for Jayne Reynolds.

The Chair said that he had been asked to provide examples of Board papers and suggested Horizon scanning. He asked Executive Directors if they could provide him with examples.

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 01 June 2021

The minutes of the meeting held on 01 June 2021 were confirmed as an accurate record of the proceedings.

4.2 Matters Arising

The Chair and the Medical Director noted the wider governance issues in relation to the Mental Health Act and a paper will be presented to the November 2021 meeting.

The Matters Arising Log had been circulated.

Patient Safety and Experience

5.0 Carer's Strategy Update

The Chair welcomed Katie Humphrey, Carers Lead to the meeting. Katie provided an update on the Carers Strategy: The Impact of Covid-19, Overview, Six Standards, what has been achieved, developed and plans for the future and made the following points:

- There were up to 13.6 million people could be providing unpaid care in the United Kingdom today. There were an additional 4.5 million unpaid carers in the United Kingdom since the coronavirus outbreak.
- Based on the Triangle of Care (ToC) national guidance and best practice has identified six standards for services to work towards
- The Trust's Carers Strategy aligned with direction of travel set by NHS England/Improvement and six local authorities in Berkshire
- The principles were consistent with NICE guidelines
- A Trust Carers Lead had been appointed
- There was engagement with ICS partners
- Friends, Family and Carers Steering Group
- Implementation Plan; identified key priorities and initiatives, Task & Finish Groups and Action Plans.

Mehmuda Mian, Non-Executive Director, endorsed the initiative and thanked Katie for the presentation and asked whether there was a particular reason why the definition of a carer was listed as not living with the person being cared for.

Katie Humphrey reported that the emphasis was that a carer did not need to be living in the same household, a carer was someone who provided anything from emotional to financial support.

Ms Mian asked what a patient being cared for within the Trust could expect to have changed for the better as a result of the Carers Strategy.

Katie Humphrey said communication and understanding were key as expectations of the service may be new therefore having information which could be referred to would help the experience.

Aileen Feeney, Non-Executive Director said she was supportive of the Strategy and asked if permission would be gained from carers before the Trust started recording their data. It was also noted that the Purple Network supported staff who were Carers.

Katie Humphrey confirmed consent would be required from Carers.

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Aileen Feeney asked how the Trust was connecting with Carers on the Steering Group and if they were staff or external.

Katie Humphrey reported there was currently one member of staff on the Steering Group and a couple were from different services who were not staff.

The Chair asked when the Committee should have a further update and noted the Governors also had an interest in the Carers Strategy.

It was proposed that there should be an annual review of the Strategy.

Action: Chief Operating Officer

The Chair asked if engagement from other departments was taking place.

Katie Humphrey confirmed services were engaged.

The Chair thanked Katie Humphrey for her presentation.

The Committee noted the presentation.

5.1 Quality Concerns Status Report

The Director of Nursing and Therapies reported that there no new concerns raised since the last meeting.

The Chair noted the good progress with physical health and would like to share this paper with other organisations.

Mehmuda Mian, Non-Executive Director, asked if there was any further update on the vacancies on Sorrell Ward.

The Director of Nursing and Therapies advised that the position was stable with little turnover and no more vacancies than other wards.

The Committee noted the report.

5.2 Serious Incidents Report

Mehmuda Mian, Non-Executive Director, asked what the situation was for the member of staff at Prospect Park Hospital who had concussion.

The Director of Nursing and Therapies confirmed the member of staff received support and was now back at work.

The Chair asked if a preliminary assessment on the suicide at Prospect Park Hospital had been undertaken.

The Director of Nursing and Therapies confirmed that an initial findings review was always carried out following a serious incident and the main finding in this case was to ensure that staff carried lone worker devices.

The Chair said that he was is assured that an initial findings review had been undertaken and that there was nothing of major significance to be undertaken at this time.

The Committee noted the report.

5.3 Learning from Deaths Quarterly Report

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The Chair noted a number of deaths where there was some partial failure of care.

The Medical Director set the context of the report, which was slightly different in terms of numbers after the Covid-19 surge, December 2020 - February 2021, which included deaths following hospital infections that were declared as serious incidents and fed into the overall review.

Three lapses in care were noted in the same quarter but there was not a pattern:

- A patient on Clozapine developed constipation and received treatment which caused obstruction intestinal perforation and the patient died. There was no direct correlation between the medication and patient outcome. Lessons learned, which was ongoing, included clozapine side effect monitoring and use of laxatives.
- An elderly patient on an inpatient community health ward had signs of intestinal bleeding, the patient became unwell and was transferred to an acute hospital where the patient died. Melena and its associated signs and symptoms were not promptly recognised by staff.
- Recognition of wound infections and recognition and management of associated sepsis should have been dealt with quickly.

The Medical Director reported that a new section on medical examiners was included in the report to be implemented by April next year.

The Chair summarised the first two cases as a window of opportunity for management to initiate quicker responses, there were numerous conditions that could occur and asked how the Trust ensured staff understand drugs and how to recognise side effects.

The Medical Director said learning and additional special measures were in place including an antipsychotic medication side-effects monitoring tool.

The Director of Nursing and Therapies added that ward staff received deteriorating patient training as well as basic life support.

Guy Northover, Lead Clinical Director said the incident review had raised the point of Clozapine Clinic responsibilities and the monitoring side effects and acting on them.

The Committee noted the report.

5.4 CQC “Must Do” and “Should Do” Action Plans

The Director of Nursing and Therapies confirmed the CQC “Must Dos” mainly at Prospect Park Hospital, delays due to Covid related staffing and materials, but progress being made.

Funding was in place for the attention deficit hyperactivity disorder pathway and autism assessment. Recruitment to agreed funding has commenced, it was recognised that recruitment may be challenging and exploration of digital options in partnership with private providers to use income while recruiting substantive staff.

Aileen Feeney, Non-Executive Director asked for an update on the wristband trial at Prospect Park Hospital.

The Director of Nursing and Therapies reported this is being installed on Bluebell Ward and funding secured for the other three acute wards.

The Committee noted the report.

5.5 CQC Inspection Changes Report

The Director of Nursing and Therapies highlighted the following

- CQC would be using the intelligence available to them to assess risk and changes in service quality.
- On-site inspections would be more targeted and timelier/unannounced rather than announced and following a rigid inspection regime
- Large data requests ahead of inspection would no longer be requested, but information would be requested post inspection (to date providers have experienced that this remains very onerous and significant in quantity)
- Ratings can be changed without the need for planned on-site inspection (either up or down)
- More flexibility and potentially more frequent ratings changes
- There would be a less planned approach to inspections with the need for services to be always ready for an inspection and consistent in their care provision
- A move away from aggregated trust level ratings based on core service ratings
- Increased focus on inclusion and organisational safety culture/leadership alongside safety and quality of services and system working.

It was noted that services would brief their staff on CQC inspections and mock inspections were taking place.

The Chair commented that we need a clear assurance that a plan in place in every services for when they turn up.

The Committee noted the report.

5.6 Annual Infection Prevention and Control Report

The Director of Nursing and Therapies reported that much of the activity during this year had included the organisational response to the Covid-19 pandemic with the IPCT supporting both clinical and non-clinical teams and strategic workstreams including phase 2 planning and recovery for reinstating services. In addition to collaborating with key stakeholders in regional and national health economies.

Aileen Feeney, Non-Executive Director asked what the plans were for the Covid-19 Booster Vaccination.

The Director of Nursing and Therapies reported that the Trust was awaiting final clarity, but it was likely to be in two phases; healthcare workers, care home residents and people with long term conditions were expected to receive their Booster first in mid-October, most likely the Pfizer vaccine. The Wokingham Hub would be used as the vaccination centre again and the flu vaccination was likely to be given separately.

The Chair commented that the cases of flu were very low last year, and other viruses rose in the summer months and that the Trust should not be complacent this year.

The Committee noted the report.

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5.7 Sexual Safety Action Plan Update Report

The Director of Nursing and Therapies updated on the CQC report published in September 2018 on sexual safety on mental health wards, the report concluded that sexual incidents are commonplace on mental health wards, that they affect both staff and patients and that they may cause significant and lasting distress. People with mental health conditions have just as much right as everyone else to safe and fulfilling sexual relationships. However, people affected by mental ill health can be vulnerable, lack capacity to make sound decisions about relationships and may have experienced abuse in the past.

A lot of work was taking place to encourage and support staff to have conversations with patients.

Aileen Feeney, Non-Executive Director asked why dates were not mentioned in the report.

The Director of Nursing and Therapies said those without dates were part of the PDSA ongoing cycle.

The three key workstreams were: Sexual Safety, Restricted Practice and Ligatures (self-harming).

The Chair asked for a clarity of the target to improve the sexual safety of patients and staff on inpatient mental health units and within learning disability services by 50% above baseline by March 2024.

The Director of Nursing and Therapies said the baseline was based on 2020/2021 a 50% reduction in incidents was expected by March 2024.

The Chair questioned how achievable this figure was and asked for numbers.

Action: Director of Nursing & Therapies

The Committee noted the report.

5.8 National Patient Safety Strategy Update Report

The Director of Nursing and Therapies reported that the Strategy had expanded and updated to include improvement work and priorities.

The National patient safety strategy published in July 2019, sets out what the NHS would do to achieve its vision to continuously improve patient safety. Several of the original strategy timelines had been revised to reflect the disruption and uncertainty arising from the pandemic.

The plan detailed progress toward implementation of the National Patient Safety Strategy. This includes:

- Support the development of a safety culture in the NHS
- Align reporting to systems which replace NRLS & StEIS
- Implement the new Patient Safety Incident Response Framework (PSIRF)
- Implement the medical examiner system
- Compliance with Patient Safety Alerts
- Patient involvement in patient safety
- Patient safety training and education

- Contribute to a network of patient safety specialists

Mehmuda Mian, Non-Executive Director asked what the reason for the change was.

The Director of Nursing and Therapies advised the aim is to improve safety and identify things that make a real change and difference.

The Committee noted the report.

5.9 COVID-19 Related BAF and CRR Risks

The Director of Nursing and Therapies reported that there had been two recent outbreaks on Ascot Ward, a patient from Royal Berkshire Hospital and two other patients were now asymptomatic. A patient on Bluebell Ward had tested positive and two more had tested positive.

There was work being done on legislation as, from 11th November 2021, staff working in care homes must be vaccinated which impacted a lot of staff.

People no longer had to self-isolate if in contact with someone that had had a positive Covid test except for healthcare unless it was a household contact when staff must not come into work and do a PCR test and lateral flow for 10 consecutive days.

Mehmuda Mian, Non-Executive Director asked if any staff were suffering from Covid symptoms.

The Director of Nursing and Therapies advised only a small number but no ward staff, small number of staff reporting absence due to Covid, most of which was not work related.

The Committee noted the report.

Clinical Effectiveness and Outcomes

6.0 Quality Accounts Report 2021-22

The Chair welcomed Jason Hibbitt Quality Account and NICE Lead.

Jason Hibbitt highlighted the report consisted of three main sections in line with Department of Health and NHS Improvement requirements. The document mirrored the Trust's Objectives each year and performance quarter on quarter was shown.

David thanked all contributors to the report.

The Chair said a more detailed discussion of the report would take place in Quarter 3.

Mehmuda Mian, Non-Executive Director noted the number of falls and asked if there were initiatives in place and what progress had been made.

The Director of Nursing and Therapies advised, our target was a stretch, the national target was 8.1 per thousand bed stays and now the target was 4.0. The targets were being refreshed as wards were experiencing more sub-acute patients and quicker turnovers.

The Committee noted the report.

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6.1 Clinical Audit Report

The Medical Director reported that the supplementary Valproate Audit report had been reviewed by the Clinical Effectiveness Group, all actions which were identified in the action plan previously presented at QAC were confirmed to have been completed at the July Clinical Effectiveness Group. The national reaudit of Valproate prescribing was scheduled for 2022.

The Committee noted the report.

Corporate Governance

7.0 Annual Review of Effectiveness and Terms of Reference

The Chair thanked everyone for completing the Review.

The suggestion for discussion at the meeting:

• Holding seminars on key topics before or outside of the main meetings.
It was agreed topics should be set for aligning with Audit Committee to provide Non-Executive Directors with a better understanding.

Action: The Chair to discuss with Chris Fisher, NED

The Chair felt this discussion should be part of the Horizon Scanning, predicting future risks.

No changes were made to the Terms of Reference.

The Committee noted the report.

Update Items for Information

8.0 Guardians of Safe Working Hours Quarterly Report

The Committee noted the report.

8.1 Quality Executive Committee Minutes - May, June and July 2021

Mehmuda Mian, Non-Executive Director asked about the CCTV and outsourcing the Podiatry service.

The Director of Nursing and Therapies acknowledged that CCTV was useful but recognised it was difficult for staff to access the footage and an external source would be brought in to manage the system.

There were quality concerns and challenges within the Podiatry service and have successfully recruited into roles. Some of the MSK work had been outsourced to private providers to support this as we did not have the capacity.

Aileen Feeney, Non-Executive Director asked if it was a problem that local authorities were not granting the vast majority of the authorisations due to the DoLS application not being assessed prior to the patient being discharged from the ward.

The Director of Nursing and Therapies said it will be the providers responsibility to ensure everything was in place.

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Mehmuda Mian, Non-Executive Director commented on the increase in place of safety numbers amongst minors.

Guy Northover, Lead Clinical Director said not enough data was collected on admission of minors in comparison to adults. It was noted 7 of the minors were admitted after the end of lockdown and this may be due to Covid rather than anything else.

The Committee noted the report.

8.2 Annual Safeguarding Report

The Committee noted the report.

8.3 Annual Place of Safety Report

The Committee noted the report.

8.4 Annual Mental Health Act Report

The Committee noted the report.

Closing Business

9.0 Quality Assurance Committee Horizon Scanning

The Committee noted the report.

9.1. Any Other Business

The Chair thanked the Committee for a good selection on summaries but noted some contained grammatical errors. He suggested the less important information be placed into an appendix rather than the paper.

Aileen Feeney, Non-Executive Director said that she relied on the summaries and referred to the main body of the report if she needed further information.

Mehmuda Mian, Non-Executive Director said she was pleased with the quality of papers.

The Chair asked the Executive Directors to pass on his thanks to all everyone involved in contributing to the papers and suggested inviting the authors of papers to attend the Committee.

The Medical Director confirmed he was happy for the papers to be shared.

9.2. Date of the Next Meeting

The next meeting is scheduled to take place on 30 November 2021 starting at 10.00.

These minutes are an accurate record of the Quality Assurance Committee meeting held on 24 August 2021.

Signed:- ____

Date: - 24 August 2021 ______________________________

DRAFT

QPEG / QAC/ Trust Board	August 2021
Title	**Learning from Deaths Quarter 1 Report 2021/22**
Purpose	To provide assurance to the Trust Board that the trust is appropriately reviewing and learning from deaths
Business Area	Clinical Trust Wide
Authors	Head of Clinical Effectiveness and Audit, Medical Director
Relevant Strategic Objectives	1 – To provide accessible, safe, and clinically effective services that improve patient experience and outcomes of care
Resource Impacts	The trust mortality review and Learning from Deaths process has operated without any additional resource allocation since it was launched in 2016. Additional resource will be required to progress the statutory medical examiner process and this is detailed within the report.
Legal Implications	None
Equality Diversity Implications	A national requirement is that deaths of patients with a learning disability are reviewed to promote accessibility to equitable care. This report provides positive assurance of learning from these deaths
Summary	759 deaths were recorded on the clinical information system (RiO) during Q1 where a patient had been in contact with a trust service in the year before they died. Of these 110 met the criteria to be reviewed further. All 110 were reviewed by the Executive Mortality Review Group (EMRG) and the outcomes were as follows: • 60 were closed with no further action • 50 required 'second stage' review (using an initial finding review (IFR)/ Structured Judgement Review (SJR) methodology). • Of the 50, 10 were classed as Serious Incident Requiring Investigation (SI) During Q1, the trust mortality review group (TMRG) received the findings of 66 2nd stage review reports, of which 15 related to patients with a learning disability (these are cases reviewed in Q1 and will include cases reported in previous quarters). **Lapse in care (LIC)** A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient. Of the 66 reviews received by the TMRG in Q1 and using the current definition for lapse in care, 3 deaths were confirmed as a lapse in care. Learning events have been held by individual teams and learning shared trust wide through the patient safety briefing. The following learning was identified from the 3 lapses in care (full details of learning within the report): 1. Clozapine-Induced Gastrointestinal Hypomotility (CIGH), Management of constipation related to medications which have constipation as a side effect. Staff must be vigilant in monitoring and managing constipation particularly when patients are prescribed medication that increases the risk. 2. Recognising Melena and its associated signs and symptoms. 3. Recognition of wound infections and recognition and management of associated sepsis. **COVID 19 reported inpatient deaths.**

	No deaths have been reported for patients receiving inpatient care in Q1 due to Covid 19, all outstanding 2nd stage reviews for cases reported in Q4 of 2020/21 have been completed and closed as follows: • 2 pre admission infections • 4 probable healthcare acquired infection whilst an inpatient under our care • 6 definite healthcare acquired infections whilst an inpatient under our care Following detailed review of all aspects of care provided for the patients, there were no deficits in infection control measures, errors or omissions during the care of patients who acquired Covid 19 infection while an inpatient within our services. **Learning from deaths** Significant learning has been identified and implemented in Q1 to improve patient safety and care, the themes identified are: • Clozapine-Induced Gastrointestinal Hypomotility (CIGH) • Aspiration pneumonia and choking risks associated with antipsychotic medication • Notification of deaths on the talking therapies electronic patient records system. • Review of learning from serious incidents associated to standards set out within the care programme approach (CPA) • Learning from Healthcare Acquired Covid infections • Recognising and acting on the symptoms of melena • Recognising Wound Infections and Sepsis • Recognising patients as palliative or End of Life **Medical Examiners** In February 2021, the government published *Working together to improve health and social care for all*, the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur. RBFT Medical Examiner Office will provide this service for BHFT. Subject to additional resource approval, we are aiming to pilot the process in early autumn 2021 at West Berkshire community hospital, with full implementation across all inpatient wards by December 2021, this will allow us to fully embed the process in line with the March 2022 national requirement.
ACTION REQUIRED	The committee is asked to receive and note the Q1 learning from deaths report to provide assurance to the Trust Board that the Trust is complying with CQC and NHS Improvement requirements in respect of learning from deaths.

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1.0 Purpose

It has become increasingly important for trusts to evidence that they are systematically and continuously reviewing patient outcomes including mortality (patients who have died).

It is acknowledged that most deaths do not occur as a result of a direct patient safety incident. None the less, it is important that opportunity for learning from deaths and learning from the review of the care provided and patient experience of our services in the period prior to the person's death are not missed and that when deaths are deemed not to require any further investigation the rationale and justification for this is clearly documented.

2.0 Scope

This report supports the Trust learning from deaths policy which was published in August 2017 and updated in March 2019.

3.0 Introduction

Berkshire Healthcare is a combined community and mental health trust, providing a wide range of services to people of all ages living in Berkshire. The trust employs over 4,200 staff who operate from our many sites as well as out in people's homes and in various community settings. This report sets out how we review deaths of patients who have been under our care at any point in the year before they died, to ensure that the most appropriate care was given.

The first part of the report identifies the total numbers of patients who have died, in most cases these are expected deaths but where a specific 'red flag' or concern is noted (as identified in our policy) we then review these deaths further. First stage review is through weekly review of Datix reported deaths by the Executive Mortality Review Group (EMRG). Second stage reviews (using IFR/SJR) are discussed at the monthly Trust Mortality Review Group (TMRG) where learning is identified, and service improvement actions are followed through.

The level of review will depend on whether certain criteria are met, the report sets out the numbers which were reviewed and the type of review we conducted.

We review the care provided for all patients who had a learning disability and died. We are required to notify the National Learning Disability Mortality Review Process (LeDeR) of all patients who have died with a learning disability, LeDeR carry out an independent review which also involves contacting the person's family. The purpose of this is to learn from all aspects of care (primary, secondary, community and social care) and inform national learning.

Following second stage review, any death where there is suspected to be a lapse in care which could have potentially contributed to the death of the patient would be escalated to a full investigation using a Root Cause Analysis (RCA) approach.

The final section of this report looks at the learning we have identified from the review of deaths in the quarter.

Definitions:

2nd stage Case Review (SJR/IFR): A review is usually a proactive process, often without a 'problem', complaint, or significant event. It is often undertaken to consider systems, policies, and processes. A review is a broad overview of a sequence of events or processes. It can draw on the perceptions of a range of individuals and a range of sources. The resulting report does not make findings of fact, but it summarises the available information and makes general comments. A review may identify some areas of concern that require investigation e.g. if there is some evidence of poor practice, in which case the appropriate recommendation for an investigation should be made.

Investigation (RCA and SI): An Investigation generally occurs in response to a 'problem', complaint, or significant event. An investigation is often initiated in relation to specific actions, activities, or questions of conduct. It is a systematic analysis of what happened, how it happened and why. An investigation draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded the event to understand how and why it occurred and to reduce the risk of future occurrence of similar events.

4. Summary of Deaths and Reviews completed in 2021/22.

Figure 1	18/19 total	19/20 total	20/21 total	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22	Total 21/22
Number of deaths seen by a service within 365 days of death	3961	3884	4805	**759**	-	-	**-**	**759**
Total deaths screened (Datix) 1st stage review	320	406	510	**110**	-	-	**-**	**110**
Total number of 2nd stage reviews requested (SJR/IFR/RCA)	134	198	269	**50**	-	-	**-**	**50**
Total number of deaths reported as serious incidents	40	43	48	**10**	-	-	**-**	**10**
Total number of deaths judged > 50% likely to be due to problems with care (lapse in care)	3	3	1	**3**	-	-	**-**	**3**
Number of Community Hospital Inpatient deaths reported (Including patients at the end of life and unexpected deaths)	144	124	185	**37**	-	-	**-**	**37**
Total number of deaths of patients with a Learning Disability (1st stage reviews)	28	47	53	**12**	-	-	**-**	**12**
Total number of deaths of patients with LD judged > 50% likely to be due to problems with care	0	0	0	**0**	-	-	**-**	**0**

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

4.1 Total Number of deaths in Q4

The trust electronic patient record (RiO) is directly linked to the national spine which allows information regarding deaths to be shared amongst providers of health care. Figure 2 identifies all deaths where a patient had any contact with one or more of the trust services in the preceding 365 days before their death and was on an active caseload of the service at the time of death.

Figure 2:

Specialty last seen	June 2021	May 2021	April 2021	Grand Total
Nursing episode	95	123	142	**360**
Community health services medical	19	23	19	**61**
Palliative medicine	18	26	16	**60**
Dietetics	17	17	23	**57**
Old age psychiatry	12	8	17	**37**
Podiatry	6	12	10	**28**
Rehabilitation	4	12	11	**27**
Physiotherapy	6	14	5	**25**
Adult mental illness	4	7	9	**20**
General medicine	2	7	7	**16**
Cardiology	1	2	12	**15**
Respiratory medicine	2	7	3	**12**
Genito-urinary medicine	3	3	4	**10**
Speech and language therapy	3	4	2	**9**
Intermediate care	2	4	2	**8**
Learning disability	1	3	1	**5**
Geriatric medicine		2	1	**3**
Clinical psychology			2	**2**
Occupational therapy		1	1	**2**
Psychotherapy		1		**1**
Liaison psychiatry	1			**1**
Grand total	**196**	**276**	**287**	**759**

Figure 3 below details the age of the patients; this has allowed us to also ensure we are aware of all children's deaths which are reviewed in detail by the child death overview panel (CDOP) hosted by the Local Authority. The highest

number of deaths is in the over 75 age group with the majority of these in receipt of community nursing services in their homes/ care homes/ receiving care at the end of life.

Figure 3.

Figure 3	April 2021 to June 2021				
	A:0-17	B:18-65	C:66-75	D: Over 75	Grand Total
Grand Total	**4**	**120**	**130**	**505**	**759**

4.2 Total Deaths Screened (1st stage review)

The Trust learning from deaths policy identifies several criteria which if met require the service to submit a Datix form for review on the Trust incident management system following the notification of a death.

First stage reviews occur weekly by the Executive Mortality Review Group (EMRG) which consists of the Medical Director, Director of Nursing and Governance, Lead Clinical Director, Deputy Director of Nursing and Quality and the Head of Clinical Effectiveness & Audit.

There are four outcomes upon EMRG review (as identified in the learning from deaths policy):

1. Datix form advised to be closed, no 'red flags'/ concern identified.
2. Further information requested to be able to make a decision, to be reviewed at next EMRG
3. Identified as a serious incident (SI)
4. Identified as requiring a second stage review (SJR/IFR) report

110 (Q4 141) deaths were submitted by services through the trust Datix reporting system for a first stage review by the EMRG. Of these 110 deaths reviewed, EMRG advised closing 60 cases, 11 were referred for SI investigation with one case subsequently downgraded to a 2nd stage review, 39 were referred for a second stage review.

5. Involvement of families and carers in reviews and investigations

There are established processes to involve all families and carers where a death is reported as an SI or a death which relates to an individual with a learning disability, and these are detailed with regards to the level of involvement for those deaths reported in Q4. In addition, for all expected inpatient end of life deaths or deaths where a 2nd stage review (SJR) is undertaken, the family will receive a letter of condolence and the bereavement booklet, with the opportunity to raise any concerns about the care provided to the patient.

6. 2nd Stage Reviews Completed

The purpose of the 2nd stage review of deaths is to determine if any potential problem or lapse in care may have contributed to the person's death, to identify learning and to utilise the learning to guide necessary changes in services in order to improve the quality of patient care. It is expected that, over a period, these improvements in response to learning from deaths will nationally contribute to reduction in premature deaths of people with learning disabilities and severe mental illness.

The Trust-wide mortality review group (TMRG) meets monthly and is chaired by the Medical Director; 66 second stage reviews have been received and considered by the group in Q1 Figure 4 details the service where the review was conducted.

Figure 4: 2nd Stage Reviews Completed in Q1

	Total Number: 66	Divisions
April 2021	**36 SJR** **4 IFR** **40 Total**	Children's and Young Persons:1 IFR Learning Disabilities: 12 SJR East Physical Health: 3 SJRs West Physical Health: 15 SJR and 1 IFR West Mental Health: 6 SJR and 2 IFR
May 2021	**8 SJR** **5 IFR** **13 Total**	Learning Disabilities: 2 SJR East Physical Health: 1 SJR West Physical Health: 5 SJR 1 IFR East Mental Health: 1 IFR West Mental Health: 3 IFR
June 2021	**11 SJR** **2 IFR** **13 Total**	Learning Disabilities: 1 SJR East Physical Health: 2 SJR West Physical Health: 1 IFR 4 SJR West Mental Health: 4 SJR Children's and Young Persons: 1 IFR

Upon review the trust mortality review group will agree one of the following:

- Request further information (if required) from trust services or other providers
- Agree to close the case and note any actions on the action log
- Agree to close and make recommendation for service and trust level learning and improvements
- Identify a potential lapse in care and recommend investigation using RCA approach.

An action log is maintained and reviewed by the group to ensure that all actions are completed.

7. Concerns or Complaints

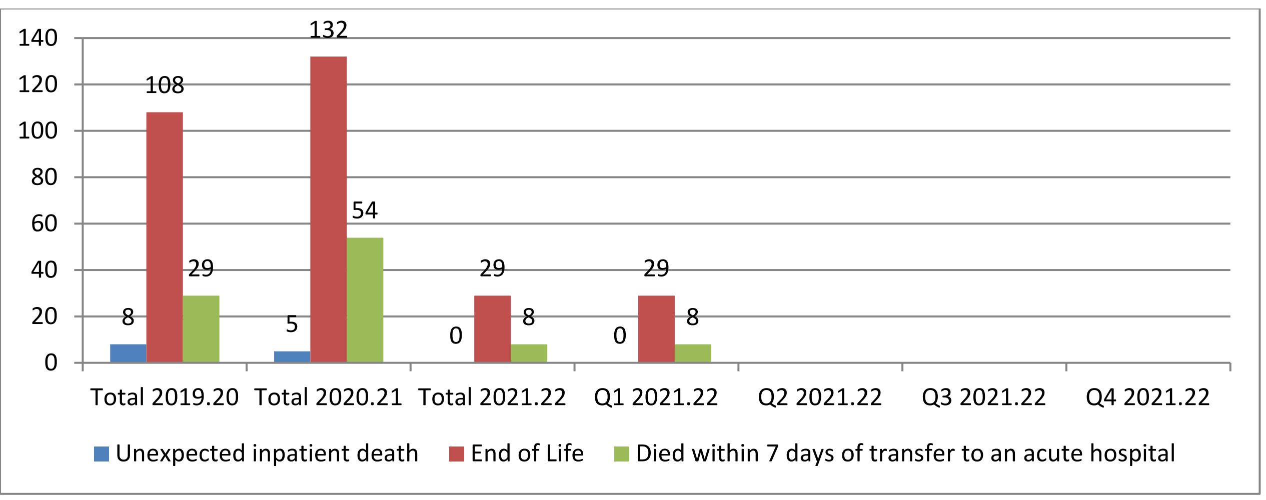
In Q1 2 (Q4 6) complaints in total were received from families following the death of a relative, 2nd stage reviews were requested for all. None of the complaint related SJR reviews at TMRG raised concern about a lapse in care (LIC).

8. Deaths of patients (including palliative care) on Community Health Inpatient Wards

For community health inpatients we require all deaths to be reported on the Datix system including patients who are expected to die and receiving palliative care. Figure 6 details these.

In addition, we are required to complete a national submission to the Covid Patient Notification System (CPNS) on inpatient deaths where the patient had a positive Covid result within 28 days of death or had Covid 19 stated on the medical certificate of cause of death (MCCD).

Figure 5: Deaths occurring on the community health inpatients wards or following deterioration and transfer to an acute hospital.



In Q1 there were 37 deaths reported by Community Inpatient Wards, of which:

- 29 were expected deaths and related to patients who were receiving end of life care (EOLC).
- 8 were classed as unexpected deaths due to ill health deterioration where they were transferred to an acute hospital and died within 7 days.

Of the 29 EOLC deaths reviewed by the EMRG, 26 were closed where enough information had been provided to give assurance that appropriate end of life care had been given. 3 cases were reviewed as 2nd stage reviews.

Of the 8 unexpected deaths, 1 was closed following receipt of further information and 7 2nd stage reviews were requested.

8.1 Covid-19 Inpatient deaths or following transfer to an acute hospital.

No new Covid deaths have been reported in Q1. 2 SJRs fromQ4of 2020/21 have been reviewed at TMRG and closed in Q1 (both patients were noted as Covid positive pre admission).

9 SI reviews relating to deaths of an inpatient who acquired Covid 19 in our care have been concluded in May and June 2021, 5 were definite healthcare acquired infections whilst an inpatient under our care and 4 were probable healthcare acquired infection whilst an inpatient under our care. 1 IFR was reviewed as a definite healthcare acquired infection and was closed and not declared as an SI as Covid 19 was stated on part 2 of the Medical Certificate of Cause of Death (MCCD).

Following detailed review of all aspects of care provided for the patients, there were no deficits in infection control measures, errors or omissions during the care of patients who acquired Covid 19 infection while an inpatient within our services.

Learning from these 9 cases is identified in the learning section 12.4.

9. Deaths of Children and Young People

In Q1 10 deaths were submitted as a Datix for 1st stage review. All 10 cases were closed at EMRG following 1st stage review. Cause of death was either extreme prematurity or complex disability in most cases. All deaths of children and young people are reviewed by the Berkshire Child Death Overview Panel.

10. Deaths of adults with a learning disability

In Q1 the Trust Mortality Review Group (TMRG) reviewed a total of 15 deaths of adults with learning disabilities who had received services from Berkshire Healthcare in the 12 months prior to their death. The Structured Judgement Review methodology was used for all reported deaths with these reviews appraised by the LD Clinical Review Group (CRG) prior to review and sign off by the TMRG.

Of these 15 deaths there were no identified lapses in care provided by Berkshire Healthcare.

The deaths were attributed to the following causes:

Immediate cause of death	Number of deaths
Diseases of the respiratory system	9
Diseases of the heart & circulatory system	1
Cancer	2
Infections	1
Other - extreme frailty	1
Not known - unable to obtain information from the GP Surgery	1

Number of COVID related deaths:

COVID related – Acute Hospital	5
COVID related - Community	2
Not applicable	8

Demographics:

Gender:

Female	7
Male	8

Age:

The age at time of death ranged from 31 to 80 years of age (median age: 64yrs)

Severity of Learning Disability:

Mild	4
Moderate	4
Severe	3
Not Known	4

Ethnicity:

White British	14
Asian / Asian British	1

Engagement and feedback with family members

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

Work undertaken to mitigate risks/impact of Covid-19:
There were 7 deaths reported where the person with a Learning Disability had been identified as having Covid-19. Of these deaths, 5 people were over the age of 60. For each of the Covid-19 related deaths, the patient had either comorbid physical health or mental health conditions and for some they had both physical health and mental health conditions. Within the reviews there was evidence of advice regarding shielding where people had been identified as at high risk from Covid-19.

It is difficult to identify wider themes relating to comorbidity at this point in time, but the learning disability service will continue to:

1. review emerging themes and trends alongside the wider national work involving the rapid review of a sample 50 people whose death was Covid-19 related
2. actively work with people open to the service to reduce the risks from Covid-19 and to promote access to the Covid-19 vaccination programme.

The learning disability service continues to support the local LeDeR programmes by supplying the details of our SJR's in relation to those people whose death was linked, or suspected to be linked, to Covid-19 in the community and acute hospitals.

11. Deaths categorised as Serious Incidents (In line with Trust SI policy and Learning from deaths policy)
In Q1, 11 deaths (Q4 23) were initially reported as serious incidents (one of subsequently downgraded) leaving a total of 10; figure 5 details the service where the SI occurred.

Figure 9. Service (Source Q1 Serious Incident Report)	**Number**
Slough Community Mental Health	1
Wokingham Community Mental Health	2
Reading Community Mental Health	2
Talking Therapies	1
Crisis Resolution and Home Treatment Team West	1
Children's and Young Persons and Berkshire Eating Disorder Service	1
Community Physical Health	2
Total	**10**

11.1 For all deaths which are categorised as an SI
The family is contacted in line with our duty of candour (DoC) policy and advised of the process of investigation. Someone from the service (usually a senior clinician or manager) contacts the family as soon as it is known that an incident causing death has occurred. This contact will include:

1. Telling the relevant person, face-to-face (if possible), that a notifiable safety incident has taken place.
2. Apologising.
3. Providing a true account of what happened, explaining what is known at that point.
4. Explaining to the relevant person what further enquiries or investigations we believe to be appropriate.

This initial contact either on the phone and/or face to face is then followed up by providing this information, and the apology, in writing, and providing an update on any enquiries.

Duty of Candour (DoC) applied to 12 deaths in Q1. 10 of these are currently under or have completed SI investigation. Of the deaths being reviewed as SIs, 7 were reported as suspected suicides and 3 were reported as unexpected deaths. In addition, there were 2 deaths (1 suspected suicide and 1 unexpected death) which have been investigated as an ILR following review by TMRG for which DoC applied.

If phone numbers are available, phone contact has been attempted with all families or nominated next of kin (NoK). However, if there has been no phone number in the patient's clinical record and other sources also do not have one (e.g the GP) then the first communications have been made via emails or letters (if the address is known). In summary, 9 families received a phone call, 2 families received initial communications via email and 1 family received initial communications via a letter. 8 of the 9 phone contacts were followed up by written correspondence; the outstanding letter is currently being followed up.

1 of the families in Q1 took up the offer of a further meeting with the service after the initial phone call / initial correspondence. Some families may not take up the offer of an initial meeting with the service but have met later or spoken with a member of the review team as part of the review process. In addition, further opportunities to meet or talk, should they wish, are always offered at the point of sharing any outcomes in written format from the review or investigation.

11.2 Lapse in Care

A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient.

Of the 66 reviews received by the TMRG in Q1 (and using the current definition for lapse in care), 3 deaths were confirmed as a lapse in care. Learning events have been held by individual teams and shared trust wide through the patient safety briefing. The following learning was identified from the 3 lapses in care (full details of learning in section 12):

1. Clozapine-Induced Gastrointestinal Hypomotility (CIGH), Management of constipation related to medications which have constipation as a side effect. Staff must be vigilant in monitoring and managing constipation particularly when patients are prescribed medication that increases the risk.
2. Recognising Melena and its associated signs and symptoms.
3. Recognition of wound infections and recognition and management of associated sepsis

12.Learning from Deaths

The aim of the trust policy and process is to ensure that we learn from deaths and improve care even when the death may not be due to a lapse in care. The following section details areas of quality improvement identified in Q1.

12.1 Learning from Serious Incidents (Source: Q1 SI Report)

Specific activity that has occurred in Q1 relating to themes previously identified from serious incident reviews.
Specific activity that has occurred or being continued in Q1 relating to themes previously identified from serious incident reviews has included:

Mental health services

Work has begun to review the latest national update with regards to improving the current risk assessment, management and safety planning process of all patients in need of mental healthcare. This includes:

- Plans to introduce a National safety plan to enable a genuine shared approach to suicide prevention across all services. The aim is for this standardised content to be shared nationally on the NHS spine so that if a patient is picked up outside of their locality/region clinical and emergency services can access the crisis/safety plan. The ask is that all patients under secondary mental health care co design their plan with a key worker using a standard template. The suggested safety plan aligns with changes BHFT were already intending to make to our current safety plan whilst also updating our approach to risk documentation.
- Further to this in relation to the care programme approach (CPA), in July 2021 NHS England and NHS Improvement published a position statement to confirm the shift away from CPA classification so that everyone in need of mental healthcare has a named key worker and a high quality co produced holistic approach to their care (including risk and safety planning). The National Community Mental Health Framework published in 2019 proposed replacing CPA and sets out a programme of guidance to achieve

this and to ensure place based integrated mental health services. The care plan will include timescales for review, which should be discussed and agreed with the person and those involved in their care at the outset. Digital technologies can be used to maximise the interoperability of plans, and to allow users to manage their care or record advance choices. This is a significant transformation program and documentation is only a small part of it.

In order to address these two areas, BHFT propose that using quality improvement methodology we work towards a new model and preferred future state where BHFT has a trusted single assessment process that is based on:

1. What has happened to the person?
2. What do they need?

Following this a single MDT plan will be created that sets out how needs will be met to minimise risk and promote recovery with all patients having a dedicated key worker to ensure a consistent and trusted relationship can be developed. Whilst this approach requires a complete overhaul of the existing community model, the risk and CPA process, we propose to commence this work by focusing on the framework for documentation as a priority.

Work continues in the way that mental health training is being delivered to share serious incident learning utilising the interactive sessions and the theatre forums. Many aspects of the patient's journey and aspects where we have identified need for improvement are addressed and discussed in this way (e.g safety planning, transition, documentation of clinical reasoning behind rationale for decision making, involvement of carers etc).

Physical Health Services

Community Nursing have been exploring improvement options with regards to no response visits and also missed visits. This is being addressed via QI methodology. Teams are also being encouraged to take up training opportunities with regards to assessing capacity and understanding when to consider safeguarding. The medical team on Oakwood provided a training session on the signs of melena and the importance of escalation. This has been offered to all inpatient physical health wards.

The Patient Safety Team has also introduced a new fortnightly Learning Brief which is being circulated electronically across the Trust. It aims to share learning so that we can reduce the risk of incidents reoccurring and improve safety for patients and staff. It has input from the Patient Safety Team as well as Infection Control, Medications Safety Officer, Safeguarding, Professional Nursing and Complaints.

12.2 Learning from deaths of patients with a learning disability (LD)

Actions and learning identified during the previous quarter have been completed / shared. In Q1, there were no identified actions for the LD service to take forward, however there was ongoing evidence of good MDT working and communication with families, support staff and across local services. There was also ongoing evidence to show BHFT services were responsive to people's needs and that care was delivered in a timely way, despite a period of national lockdown due to the Covid-19 pandemic.

The Learning Disability service continues to provide regular updates to staff via the monthly operational leadership meeting and bi-monthly Learning Disability Service Patient Safety Quality meeting in order to share learning and promote good practice. Feedback is also provided to the relevant teams regarding any lessons learned, following completion of the CRG and TMRG processes.

12.3 Learning from Mental Health Services

Clozapine-Induced Gastrointestinal Hypomotility (CIGH)

Some degree of gastric hypomotility has been demonstrated in 80% of clozapine-treated patients due to its antimuscarinic and antiserotonergic effects. For every 1000 patients treated with clozapine, it is estimated that 300 to 600 will suffer constipation, and at least four will develop serious gastrointestinal complications, from which one or more may die. Fatal cases arise as constipation progresses to ileus, intestinal obstruction, bowel ischaemia, or toxic

megacolon. CIGH has also been shown to have a negative impact on patients' quality of life. Prevention and treatment is largely comes down to addressing modifiable lifestyle risk factors and a range of available laxatives.
The following actions have been taken to reduce the risk of CIGH

1. A pharmacy review identified the concerns that there if prescribed and documented on connect care that a patient is being treated with clozapine there is no alert regarding the risks of concomitant opioid prescribing, these concerns will be raised directly with the British national formulary (BNF).
2. In the interest of patient safety, prophylactic laxatives should be considered for all patients taking clozapine and this approach should be included in the clozapine pathway
3. Side effects question specific to constipation and prophylactic treatment with laxative and diet advice to be added to the clozapine pathway.

Aspiration pneumonia and choking risks associated with antipsychotic medication
It is known that antipsychotic drugs are associated with a variety of movement disorders including swallowing difficulties. Where there is evidence of reduced motor co-ordination, the effect of this on swallowing should be considered. Referral for assessment by a speech and language therapist should be made, and this should provide advice on choking risks and appropriate food and fluid consistency.
The following actions have been taken:

1. To increase dysphagia awareness and knowledge of the referral process for swallowing assessment. This was completed in May for the community mental health team and was provided by Prospect Park Hospital Associate Medical Director and Speech and Language Therapist.

A review of cases where patients had been under the care of talking therapies services highlighted that there does not appear to be an automated way that IAPTUS (Talking Therapies electronic patient record) is updated to identify when an individual is deceased. A system to receive information about deaths of patients who have been under their care is required; this would be essential for service level governance and learning and is being reviewed by the Clinical Director for the Division.

Review of learning from serious incidents associated with standards set out within the care programme approach (CPA), The Medical Director requested a review to be completed with the following terms of reference:

1. The number of SI's where the safety netting of care coordination has been raised as concern between Jan 2019 and 2021 with a brief context/narrative
2. Learning and recommended actions in those SIs specific to this matter
3. Possible reasons for this learning not being effective/ Standard Operating Procedure (SOP) implementation not being effective at service and operational level
4. Next steps for improvement and accountability at operational level

The outcome of this review and further learning will be reported in Q2.

12.4 Learning from Healthcare Acquired Covid infections.
9 cases reviewed as serious incidents in Q1 were due to probable or definite healthcare acquired infection whilst in our care. Although there was no deficit in care identified, the following learning was identified which was the same as those actions previously identified in Q4:

- Limited recording in the electronic progress notes of pertinent Covid-19 information on admission; teams to improve the use of the alerts to identify positive, suspected and recovered patients.
- Taking of swabs and recording of results is inconsistently recorded on eObs swabbing tool. To support both of the actions, ensure staff are familiar with the process for using the alert system and the swabbing tool as outlined in the trust guidance by sharing findings in team meetings to discuss how to improve use of the RiO swabbing tool (in eObs) for recording Covid-19 information. Wards will then review their compliance with the RiO swabbing tool using the tableau report.

- Handover sheets will be used to encourage a daily conversation about the Covid-19 status of patients on the ward.
- Staff to be aware of the guidance contained within the standard operating procedure for visiting and regarding discharge criteria to ensure consistent and correct advice is given.
- Wards to document patient risk assessments for face masks in the RiO progress notes.

12.5 Learning from Community Physical Health

Melena refers to black tarry stools, which usually occurs as a result of upper gastrointestinal bleeding, recognising and acting on the symptoms of melena was identified as significant learning.

The following specific points of learning and actions have been taken:

1. Episode of mild melena were not included on handover. Staff expressed that the content of the handover can focus on information that is already known as opposed to significant events. Staff will now specifically ask the question "has anything significant / different happened during the last shift?"; "is there anything that the medical team need to be made aware of?"
2. Staff were not able to describe correctly what melena is, a training session on melena has been delivered by Medic on ward and has been made available electronically so that a wide range of staff can access it.
3. Test Results: Not recorded in the Doctor's diaries which should have been the system to utilise. Lab made attempts to phone results through but phones unanswered, staff did not check and follow up. Medical team to determine how to ensure blood tests get checked before they leave the unit – it was agreed that they would write the test in the diary so that others knew that there may be a result to check SLT on Unit to explore with Estates and IT how the phone system can be improved.
4. Ward to cover red flags in training session / ward meeting about what should be escalated to medics and handed over.
5. To explore whether the stool charts can be amended to include a section to describe colour/blood/other factors in addition to just the Bristol stool consistency

Recognising Wound Infections and Sepsis

Recognising and acting on the symptoms of wound infection and sepsis were identified as significant learning, including importance of holistic care of a patient, formal assessment of wound, referral to wound care nurse where appropriate, recording sepsis screen and monitoring the patient's nutritional status.
Learning events are being held and an action plan developed to ensure that the required actions for improvement are implemented.

Recognising patients who are for palliative or End of Life care

If a patient is for palliative or End of Life Care, it would be good practice to assess/visit on a regular basis, monitor the patient's care and progress or decline in health. The patient would also be added to the team's Palliative Care list and discussed at MDT/GSF meetings. There would be an opportunity to discuss and document the patient's wishes and a more "holistic" approach may have ensued including an End of Life care plan.

13. Medical Examiner Process and Requirements

Introduction

A national network of medical examiners was recommended by the Shipman, Mid-Staffordshire and Morecambe Bay public inquiries.

NHS England and NHS Improvement launched the new NHS Patient Safety Strategy on Tuesday 2 July 2019. This highlighted that, despite implementation of the Learning from Deaths programme in acute and community trusts in 2017/18, independent scrutiny of all deaths was still missing. For many years, coroners have fulfilled this role for deaths referred to them and it is now a statutory requirement that medical examiners fulfil this role for non-coronial deaths to ensure that every death is independently scrutinised, and every bereaved family is given the answers they need.

In February 2021, the government published Working together to improve health and social care for all, the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur. Implementation of this next phase will take place incrementally, to allow time for capacity and processes to be put in place.
The purpose of the medical examiner system is to:

- provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- ensure the appropriate direction of deaths to the coroner
- provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased
- improve the quality of death certification
- improve the quality of mortality data.

Acute trusts Medical examiner offices are required to put in place measures to extend medical examiner scrutiny of non-coronial deaths across all non-acute sectors as early as possible in 2021/22, so that all deaths are scrutinised by the end of March 2022. Community Trusts will need to work with one established medical examiner office.

Implementation for BHFT
In August 2019 we began preparation for implementing the ME process, recognising that it would become a requirement in the future for community deaths. We conducted a review of the current death certification process in the trust. All six community health inpatient wards were visited and the medical certificate cause of death (MCCD) counterfoils were reviewed. Areas for improvement were identified and recommendations were implemented.
The majority of deaths on our community health inpatient wards in the West of Berkshire are deaths of patients receiving palliative/ End of Life Care, this is due to a higher number of beds and commissioned palliative care beds in the West compared to the East of Berkshire. We therefore approached the Royal Berkshire Hospital Foundation Trust (RBFT) to potentially provide a medical examiner service for BHFT.

The Medical Director and Head of Clinical Effectiveness have worked with the RBFT to formulate an implementation plan, this was paused in 2020 at the request of RBFT and was restarted in April 2021.

Following the publication of the national recommendations and timescales for community deaths, RBFT have confirmed that they will formally provide this service for BHFT and the Head of Clinical Effectiveness has been working with RBFT and our clinical staff to develop the process for BHFT.

Additional administrative resource will be required to ensure that BHFT can implement and monitor the proposed process and embed it within our established learning from deaths process. A request for additional resource will be presented to the Trust Executive for approval in September.

Subject to resource approval we are aiming to pilot the process in early autumn 2021 at West Berkshire community hospital, with full implementation across all inpatient wards by December 2021, this will allow us to fully embed the process in line with the March 2022 national requirement.

14.Conclusion

During Q1, the trust mortality review group (TMRG) received the findings of 66 2nd stage review reports.

Lapse in care (LIC)
A lapse in care is defined as greater than 50% likelihood that problems in care of the patient could have contributed to the death of the patient.

Of the 66 reviews received by the TMRG in Q1 and using the current definition for lapse in care, 3 deaths were confirmed as a lapse in care. Learning events have been held by individual teams and shared trust wide through the patient safety briefing. The following learning was identified from the 3 lapses in care (full details of learning within the report):

1. Management of constipation related to medications which have constipation as a side effect. Staff must be vigilant in monitoring and managing constipation particularly when patients are prescribed medication that increases the risk.
2. Recognising Melena and its associated signs and symptoms, staff training on the understanding of the implications if left untreated or unrecognised.
3. Post op wound infection management of sepsis. Sepsis is a common and potentially life-threatening condition triggered by an infection.

COVID 19 inpatient deaths.
No deaths have been reported for patients receiving inpatient care in Q1 due to Covid 19.
All outstanding 2nd stage reviews for deaths due to Covid 19 HCAI reported in Q4 have been completed and confirmed as follows:

- 2 pre admission infection
- 4 probable healthcare acquired infection whilst an inpatient under our care
- 6 definite healthcare acquired infections whilst an inpatient under our care

Following detailed review of all aspects of care provided for the patients, there were no deficits in infection control measures, errors or omissions during the care of patients who acquired Covid 19 infection while an inpatient within our services.

Learning from deaths
Significant learning has been identified and implemented in Q1 to improve patient safety and care, the themes identified are:

- Plans to introduce a National safety plan to enable a genuine shared approach to suicide prevention across all services.
- The national shift away from CPA classification so that everyone in need of mental healthcare has a named key worker and a high quality co produced holistic approach to their care (including risk and safety planning).
- Clozapine-Induced Gastrointestinal Hypomotility (CIGH)
- Aspiration pneumonia and choking risks associated with antipsychotic medication
- Notification of deaths on the talking therapies electronic
- Review of learning from serious incidents associated to standards set out within the care programme approach (CPA),
- Learning from Healthcare Acquired Covid infections
- Recognising and acting on the symptoms of melena
- Recognising Wound Infections and Sepsis
- Recognising patients as palliative or End of Life

Medical Examiner Process
In February 2021, the government published *Working together to improve health and social care for all*, the white paper which includes provisions for medical examiners to be put on a statutory footing. During 2021/22, the role of these offices is being extended to include all non-coronial deaths, wherever they occur. RBFT Medical Examiner Office will provide this service for BHFT. Subject to additional resource approval, we are aiming to pilot the process in early autumn 2021 at West Berkshire community hospital, with full implementation across all inpatient wards by December 2021, this will allow us to fully embed the process in line with the March 2022 national requirement.

QAC Meeting Date	24 August 2021
Title	Guardian of Safe Working Hours Quarterly Report (May to August 2021)
Purpose	To assure the Trust Board of safe working hours for junior doctors in BHFT
Business Area	Medical Director
Author	Ian Stephenson
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
SUMMARY	This is the latest quarterly report for consideration by Trust Board from the Guardians of Safe Working. This report focusses on the period 5th May to 3rd August 2021. Since the last report to the Trust Board we have received three *'hours & rest'* exception reports and no '*education*' reports. We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.
ACTION REQUIRED	The QAC/Trust Board is requested to: Note the assurance provided by the Guardians

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

This report covers the period 5th May to 3rd August 2021

Executive summary

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

This report focusses on the period the period 5th May to 3rd August. Since the last report to the Trust Board, we have received three *'hours & rest'* exception reports and no '*education*' reports.

We do not foresee any problems with the exception reporting policy or process; neither do we see a significant likelihood of BHFT being in frequent breach of safe working hours in the next quarter.

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): 37 (FY1 – ST6)

Included in the above figure are 2 MTI (Medical Training Initiative) trainees.

Number of doctors in training on 2016 TCS (total): 37

Amount of time available in job plan for guardian to do the role: 1PA

Admin support provided to the guardian (if any): Medical Staffing

Amount of job-planned time for educational supervisors: 0.25 PAs per trainee

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

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	3	3	0
Sexual Health	0	0	0	0
Total	0	3	3	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1	0	0	0	0
CT	0	3	3	0
ST	0	0	0	0
Total	0	3	3	0

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Psychiatry	0	3	3	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
FY1	0	0	0	0
CT1-3	1	0	2	0
ST4-6	0	0	0	0
Total	1	0	2	0

In this period, we have received three '*hours and rest'* exception reports where the trainees worked hours in excess of their work schedule, totaling an extra 7.5 hours worked over and above the trainees' work schedules. The reports relate to less than full time trainees working on non-working days. All related to a less than full time trainee attending to management activities and non-clinical activities needing to take place on a non-working day. These are all within the scope of the purpose of exception reporting, allowing trainees to complete important work outside of their standard working hours on rare occasions and providing a system whereby taking TOIL so that they do not become overworked because of it.

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

There have been no systemic concerns about working hours, within the definitions of the 2016 TCS.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum.

b) Work schedule reviews

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

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

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

c) **Gaps**

(All data provided below for bookings (bank/agency/trainees) covers the period 5th May to 3rd August 2021)

Psychiatry	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts worked by:**			**Number of hours requested**	**Number of hours worked**	**Number of hours worked by:**		
			Bank	**Trainee**	**Agency**			**Bank**	**Trainee**	**Agency**
	102	100.6	62	38.6	0	994	977.5	621	356.5	0

Reason	**Number of shifts requested**	**Number of shifts worked**	**Number of shifts worked by:**			**Number of hours requested**	**Number of hours worked**	**Number of hours worked by:**		
			Bank	**Trainee**	**Agency**			**Bank**	**Trainee**	**Agency**
Gap	60	59.6	43	16.6	0	599	595	447.5	147.5	0
Sickness	42	41	19	22	0	395	382.5	173.5	209	0
Maternity	0	0	0	0	0	0	0	0	0	0
Total	102	100.6	62	38.6	0	994	977.5	621	356.5	0

d) **Fines**

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

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

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

Qualitative information

The OOH rota continues operating at 1:11 and our system for cover continues to work as normal, with gaps generally being quickly filled. Although we have had 1.4 unfilled gaps this rotation, which is unusual for the Trust. Our bank doctors in particular have continued to be an asset, and we continue to increase this pool.

Gaps as a result of trainee numbers being slightly down and the constraints of the new contract which do not allow too heavy a rota pattern remain the primary reason for cover and this will continue into the next rotation from August.

Covid-19 has become far less of a problem and has only affected one trainee who has long Covid-19; therefore, the figures have been included in sickness. General sickness is up compared to the first half of the rotation and last-minute weekend sickness contribute to one of the gaps we were unable to fill.

The other slight gap we were unable to fill have came at the very last weekend of this rotation and resulted from a trainee leaving early as a result of their visa expiring. We filled most of the weekend long day shift, but for a four-hour period we only had one trainee on at PPH. The on-call director and consultants were, as usual, kept updated.

No immediate patient safety concerns have been raised to the guardian in this quarter.

Issues arising

Exception reporting remains at a level consistent with previous GOSW Board reports. None of these reports indicate problems with posts that have required the work schedules to be reviewed. The current level of exception reporting suggests that Junior Doctors are not working unsafe hours, and this is confirmed by the qualitative information from the Junior Doctors Forum. However, it is possible that there is under-reporting of small excess hours worked.

The outgoing guardians prepared a brief summary report for the board covering their five years in post. Dr Ghazirad took over as Guardian on the 1st of July 2021.

Actions taken to resolve issues

Next report to be submitted November 2021.

Summary

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

The Guardian gives assurance to the Trust Board that no unsafe working hours have been identified, and no other patient safety issues requiring escalation have been identified.

We remain mindful of the possibility of under-reporting by our trainees, whilst having no evidence of this. Trainees are strongly encouraged to make reports by the Guardian at induction and at every Junior Doctor Forum. They are assured that it is a neutral act and asked to complete exceptions so that the Guardian of Safe Working can understand working patterns in the trust.

Questions for consideration

The Guardian ask the Board to note the report and the assurances given above.

The Guardian make no recommendations to the Board for escalation/further actions.

Report compiled by Ian Stephenson, Medical Workforce Manager.

Appendix A: Glossary of frequently used terms and abbreviations

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

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

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

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

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

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

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

Appendix B

Factsheet: Safety limits and rest

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

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

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

Trust Board Paper

Board Meeting Date	14 September 2021
Title	**Executive Report**
Purpose	This Executive Report updates the Board of Directors on significant events since it last met.
Business Area	Corporate
Author	Chief Executive
Relevant Strategic Objectives	N/A
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	None
Equality and Diversity Implications	N/A
SUMMARY	This Executive Report updates the Board of Directors on significant events since it last met.
ACTION REQUIRED	To note the report and seek any clarification.

Trust Board Meeting 14 September 2021

EXECUTIVE REPORT

1. Never Events

Directors are advised that no 'never events' have occurred since the last meeting of the Trust Board.

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

2. Staff Vaccination Programme 2021

Introduction

The Government has asked the NHS to prepare to deliver a Flu Vaccination Programme alongside a COVID-19 Vaccination Programme from September 2021. The staff flu programme is planned to commence late September as in previous years, a decision by the Joint Committee of Vaccinations and Immunisation (JCVI) on the COVID-19 booster programme is expected by 8 September 2021.

NHS staff (especially patient-facing staff) will be part of the first priority grouping for both the flu vaccine and the COVID-19 boosters, meaning that as soon as either vaccine is confirmed and stock is available, Berkshire Healthcare staff should start to be vaccinated. The JCVI have issued interim advice which suggests that early evidence supports the delivery of both vaccines at the same time where appropriate, but NHS England have advised the campaign must not be delayed waiting for both vaccines to be available.

The Flu Letter of 17th July highlighted that flu vaccinations should be offered to 100% of frontline and patient facing staff, with an ambition of vaccinating at least 85% nationally. COVID-19 boosters are expected to be offered to staff who have previously received at least one COVID-19 vaccine.

Operational Delivery Plan - Communication strategy

Our communication strategy, summarised at the end of the report will provide regular briefings in Team Brief, screensavers, information to the Directorate flu champions and communication through the Live Team Briefing to staff. The Nexus staff

vaccination information will be maintained and updated regularly. The communications team has worked closely with the campaign leads to support the delivery of the clinics booking systems and IT detail.

Delivery of the campaign

This year's campaign will be managed by the Lead Nurse for Immunisations and will be delivered through a series of clinics at the Wokingham Vaccine centre, clinics at the main Trust sites and roving peer vaccinators. Drive thru's will not be used this year as they were a very expensive option and were not utilised to their full potential.

Vouchers for Flu vaccine will also be available for those who would find receiving their vaccine at a local pharmacy a better option.

Dependent on availability of vaccines, the campaign will run from mid-September to 31st December 2021 for the influenza vaccine and from late September to 17th October 2021 for COVID-19 booster, in line with national guidance for the delivery of the COVID-19 booster vaccine to health and social care staff. The influenza vaccination is expected to be delivered to the trust around the third week of September, and the COVID-19 boosters towards the end of September. Where possible co-administration is advised, however, the delay of one vaccine being deliver should not delay the campaign for the other starting.

The local booking and consenting system will be via the Cinnamon system for both the flu vaccine and COVID-19 booster, and all vaccines will be recorded on the National Immunisation and Vaccination System (NIVS).

As in previous years all board members are expected to have the flu vaccination and a clinic for the board to receive their flu vaccinations is booked for the end of September. The board will be invited to the vaccination centre for their COVID vaccination.

Monthly reporting on vaccination uptake for both immunisations will be provided to the Board and Divisional Directors and weekly figures will be shared weekly throughout the campaign.

Vaccination supply/logistics

Influenza vaccine

- This year's vaccine will be Sequiris Quadrivalent, and can be given to all adults 18+, a different vaccine for the over 65's is not required in this year's campaign.
- The vaccine delivery for the influenza vaccine has been confirmed as 4000 doses. Further vaccine can be requested as required.

- Vouchers will be used for those that prefer to receive their vaccination at a local pharmacy and further vouchers can be procured mid campaign if required.

COVID-19 vaccine

- At this stage we believe the COVID-19 vaccine will be the Pfizer vaccine for all (Cominarty), the previous vaccine given for doses 1 and/or 2 does not affect which brand of booster is given.

Key elements of our communication Plan

Objectives

The aim of this communication plan is to help us reach our ambition of vaccinating 85% staff for flu and COVID booster. We will:

- Create awareness and interest amongst staff about the vaccination programme

- Use clinical evidence to dispel myths and encourage the belief among staff that having the booster and flu vaccination is the best way to protect themselves, their patients and their colleagues

- Highlight the positive benefits and motivate staff to book an appointment for flu and COVID-19 booster vaccinations

Strategy

- Make it easy for those who are keen to have the vaccines to get them (adopters)
- Provide reassurance, information, and motivation for those who are uncertain or unkeen about having the vaccines (hesitant/resistant)
- Use trusted voices/ influencers to build trust, provide validation, provide authentic voices and proof of safety
- Provide low-cost incentives like stickers, pens and lollipops.
- Celebrate success weekly to encourage uptake, foster friendly competition between divisions.

Targeted communications will be developed for our key audiences. These could include managers' briefings, text messaging, briefings to targeted teams, video clips. Email will be used to support, however we're aware that many frontline staff don't access email regularly so will need support from managers to cascade messages. We'll also distribute posters, information leaflets and use social media to promote opportunities to have the jab, as well as sharing staff photos and stories about why they chose to get vaccinated.

We will use established channels such as Nexus, Team Brief, Covid-19 News, screensavers Executive Live briefings to support the communications.

Key Messages for Flu

- Having your free annual flu vaccine remains the best way to protect against catching or spreading flu.
- Everyone working in healthcare has a responsibility to protect their patients, for nurses this is enshrined in the NMC code. Flu vaccination for health care workers helps to stop the transmission of the flu virus and is fully supported by professional bodies like the RCN and British Medical Association (BMA)
- Influenza (flu) is a virus that infects the respiratory system, and the spread of the virus within health care settings is a huge concern.
- Due to repeated exposure of the virus, one in four health care staff is estimated to be infected in any flu season. We know that health care staff transmit the virus and, as a result, put their patients at risk of developing serious complications from the flu.
- The flu vaccine is effective in preventing the serious complications of influenza and in helping to stop its spread. This could be the difference between life and death. The vaccine cannot give you flu, although it can make your arm feel a bit sore and sometimes cause a slight temperature. Other reactions are very rare.
- The antibodies that protect you from flu decline over time, and flu strains can also change from year to year, so you need an updated vaccination against the virus every year.
- Pending further messaging from Public Health England

Barriers and mitigation

Barriers	Mitigation
COVID-19 booster: Concerns about safety of co-administration, or mixing vaccines – lack of information, speed of creation, side effects	Provide essential information about the safety and efficacy of the chosen Booster vaccine. Use trusted voices to reinforce safety messages
Lack of trust in Government and pre-existing disparity in health experience amongst those from a BAME background	Use trusted voices to counteract myths and misinformation, promote the proportion of BAME people involved in the trials, provide information about ingredients, promote visibility of BAME spokespeople
People wanting to wait until more people have had the booster /belief they can wait for a different brand of vaccines	Encourage people to act now, by building a sense of urgency, promote reasons why the vaccines are needed, build sense of collective responsibility
Lack of urgency amongst those who are fit and healthy	Focus on helping others, helping return to normal, reducing pressure on health services
Misinformation and mistrust due to conspiracy theories	Use trusted voices to dispel myths and conspiracy theories, present vaccine information factually and link to scientific evidence

Practical barriers to accessing the vaccines (travel, time, etc.)	Provide information about how to access the vaccines, travel expenses, etc.

Timings for communications

Phase 1: September – Go Live	Phase 2: Live – end Oct	Phase 3 – Nov-Dec
• Promote the benefits of vaccines and why they are safe and important • Identify trusted voices/ key influencers • Update Nexus page with information about how to book vaccines, travel expenses, transport, etc., plus links to all information about safety, efficacy, etc. • Update FAQS (once received from NHSE) • Develop all staff email outlining vaccination programme/booking • Support development of booking system to ensure its easy and secure for staff. • Identify positive PR opportunities • Prepare managers pack – incl. email. • Continue to share vaccines social media graphics (from NHSE) • Collate feedback and use this to shape our comms • Promote how to access the vaccines via our existing channels	• Highlight Exec and Board having their flu vaccines • Promote positive stories via our existing channels • Promote how to access the vaccines via our existing channels • Promote information to show the vaccines is safe and effective • Comms to dispel myths and misinformation • Posters and flyers to target inpatient unit staff and EFM • Target managers to help them understand their role in supporting us to drive levels of uptake of the vaccination (managers' pack) • Exec to promote the vaccines on the Exec Live briefing (16 Sept) • Work with BAME influencers and network to reassure BAME colleagues • Influencers to promote the vaccines on their own social media channels, share on BH channels • Continue to collate feedback and use it to shape communications	• Promote remaining availability • Alternative options e.g., flu vouchers, national routes

Executive Lead: Debbie Fulton, Director of Nursing and Therapies

3. Integrated Care Systems

The Department of Health and Social Care has now concluded the work around Integrated Care System Boundary issues. The Secretary of State recognised there was no alternative option to the status quo and has decided to make no changes to existing boundaries for Frimley and the surrounding Integrated Care Systems.

The recruitment process for the Buckinghamshire, Oxfordshire and Berkshire West and Frimley Health and Care Integrated Care System Chairs is currently in the final stages and at the beginning of September 2021, the process for recruiting to the Chief Executive Officer posts commenced.

Executive Lead: Julian Emms, Chief Executive

Presented by Julian Emms
Chief Executive
September 2021

Trust Board Paper

Board Meeting Date	14 September 2021
Title	Financial Summary Report July 2021
Purpose	To provide the Trust Board the financial position for the period ending 31 July 2021.
Business Area	Finance
Author	**Acting Chief Financial Officer**
Relevant Strategic Objectives	3. - Strategic Goal: To deliver financially sustainable services through efficient provision of clinical & non-clinical services
CQC Registration Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting regulatory requirements
Equalities / Diversity Implications	N/A
SUMMARY	The Trust is reporting a surplus of £1.4m surplus to the end of July 2021, £0.9m better than planned. Workforce growth is lower than planned, with elements of investment income deferred as a result. Marginal COVID costs continue to reduce. The agreed financial plan for H1 (April – September) has the Trust planning for breakeven against which the forecast is currently £0.9m surplus. Planned capital expenditure year to date is £0.6m, £0.8m behind plan. Cash balances remain strong at £42.7m
ACTION REQUIRED	The Board is invited to note the report.

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

Finance Report

Financial Year Ending 2021/22

July 2021

Purpose

To provide the Board & Executive with a summary of the Trusts financial performance for the period ending 31st July 2021.

Version	*Date*	*Author*	*Comments*
1.0	17/08/2021	Paul Gray	Final

Distribution

All Directors

All staff needing to see this report.

Confidentiality

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

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2.0	Balance Sheet and Working Cash	7-8
3.0	Capital Expenditure	9

1.0 Income & Expenditure

M4 Jul 2020	In Month Act £'m	In Month Plan £'m	In Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m	H1 Plan £'m
Operating Income	23.4	24.2	(0.8)	94.3	95.3	(1.0)	143.9
Elective Recovery Fund	0.1	0.5	(0.4)	0.2	1.0	(0.7)	3.4
Top Up Funding	0.5	0.5	0.0	2.1	2.1	0.0	3.1
COVID Funding	0.8	0.8	0.0	3.2	3.2	0.0	4.8
Donated Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Income	***24.8***	***26.0***	***(1.2)***	***99.8***	***101.5***	***(1.7)***	***155.2***
Staff In Post	15.6	17.1	(1.4)	62.7	65.2	(2.5)	99.7
Bank Spend	1.6	1.4	0.2	6.1	5.9	0.2	8.7
Agency Spend	0.4	0.3	0.1	1.6	1.3	0.4	1.8
Total Pay	***17.7***	***18.7***	***(1.1)***	***70.5***	***72.4***	***(1.9)***	***110.2***
Purchase of Healthcare	1.5	1.7	(0.2)	6.6	6.6	0.0	10.0
Drugs	0.5	0.5	(0.0)	1.8	1.8	(0.1)	2.8
Premises	1.4	1.8	(0.4)	5.6	6.3	(0.7)	10.8
Other Non Pay	1.8	1.9	(0.1)	7.4	7.3	0.1	11.5
PFI Lease	0.5	0.5	(0.0)	2.1	2.1	0.0	3.2
Total Non Pay	***5.6***	***6.4***	***(0.7)***	***23.5***	***24.1***	***(0.6)***	***38.3***
Total Operating Costs	***23.3***	***25.1***	***(1.8)***	***93.9***	***96.5***	***(2.6)***	***148.5***
EBITDA	***1.5***	***0.9***	***0.7***	***5.8***	***5.0***	***0.9***	***6.7***
Interest (Net)	0.3	0.3	0.0	1.3	1.3	0.0	2.0
Depreciation	0.7	0.7	(0.0)	2.7	2.7	(0.0)	4.0
Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
PDC	0.1	0.1	(0.0)	0.5	0.5	(0.0)	0.7
Total Financing	***1.1***	***1.1***	***(0.0)***	***4.5***	***4.5***	***(0.0)***	***6.7***
Reported Surplus/ (Deficit)	***0.4***	***(0.3)***	***0.7***	***1.4***	***0.5***	***0.9***	***0.0***

Key Messages

The table above illustrates financial performance against our plan for H1 (Q1 and Q2) 21/22.

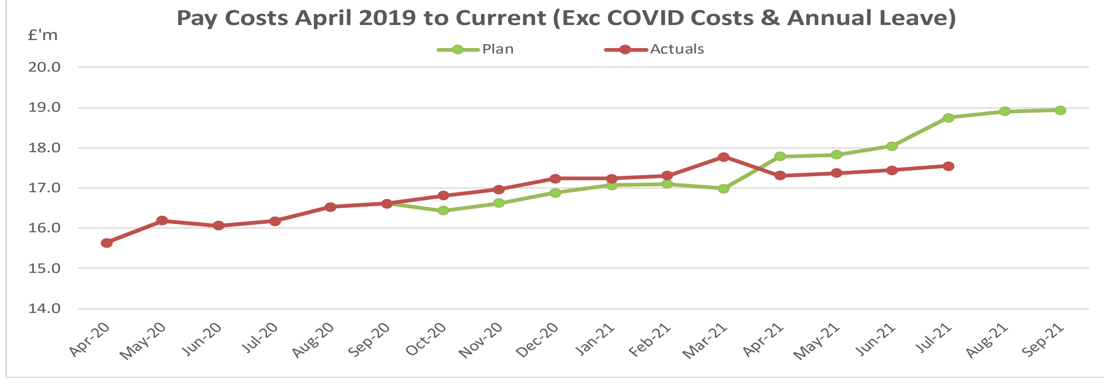
The plan reflects our agreed system contribution for the period and the revised assumptions on additional system Elective Recovery Income to be allocated and offsetting increases in expenditure.

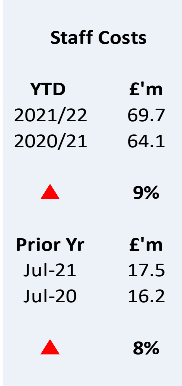
The Trust reported a £0.4m surplus for July against a planned deficit of £0.3m. The Trust remains ahead of plan YTD with a £1.4m surplus, £0.9m higher than planned.

Moving into Q2, the plan assumed that Service Development and Spending Review Funding would be recognised, matching planned increases in expenditure. Further ERF funding was also planned covering increased marginal activity related costs as well as increased costs in IT and Estates. Costs have not materialised as planned, as is evident in the £1.8m underspend in month. This underspend has resulted in £0.7m of income being deferred and £0.4m of ERF continuing to be held by commissioners.

In addition, marginal costs attributable to COVID continue to be lower than anticipated and these are further adding to our better than planned performance.

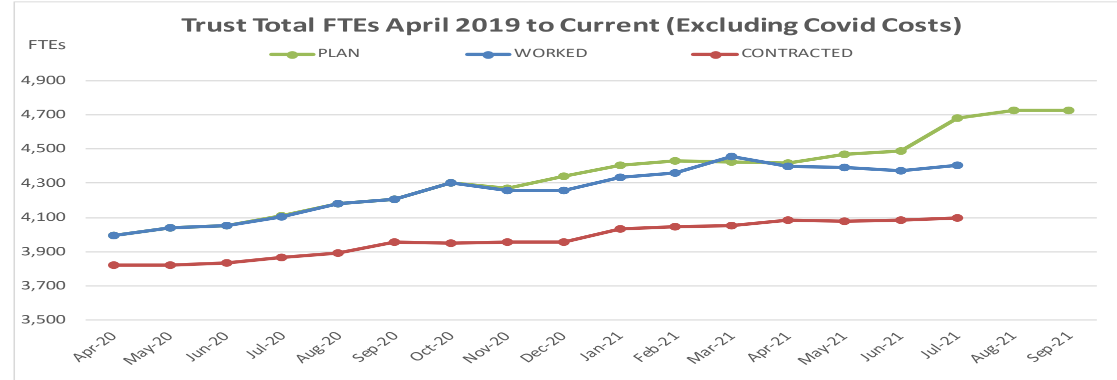
Workforce

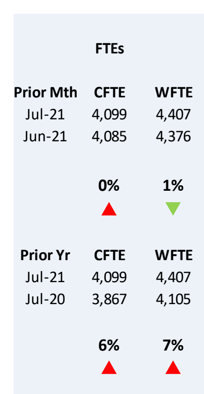




Staff Costs

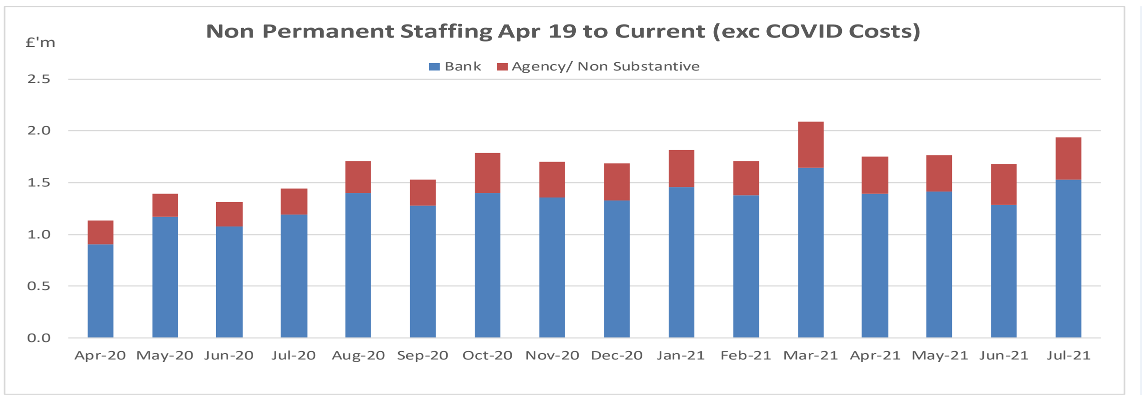
YTD	£'m
2021/22	69.7
2020/21	64.1
▲	9%
Prior Yr	**£'m**
Jul-21	17.5
Jul-20	16.2
▲	8%





FTEs

Prior Mth	CFTE	WFTE
Jul-21	4,099	4,407
Jun-21	4,085	4,376
	0% ▲	1% ▼
Prior Yr	**CFTE**	**WFTE**
Jul-21	4,099	4,407
Jul-20	3,867	4,105
	6% ▲	7% ▲



Staff Costs

YTD	Bank £'m	Agency £'m
2021/22	5.6	1.5
2020/21	4.3	0.9
	29% ▲	64% ▲
Prior Yr	**Bank £'m**	**Agency £'m**
Jul-21	1.5	0.4
Jul-20	1.2	0.2
	28% ▲	66% ▲

Key Messages

Pay costs in June were £17.6m, with overall pay costs continuing to hold at relatively static level overall.

Although overall monthly spend overall shows little increase, underlying pay excluding COVID costs have risen monthly, with costs in July £0.2m higher than April, as reflected in the chart above. This is offset by marginal COVID related costs which have continued to fall, with July's cost £0.2m lower than in April.

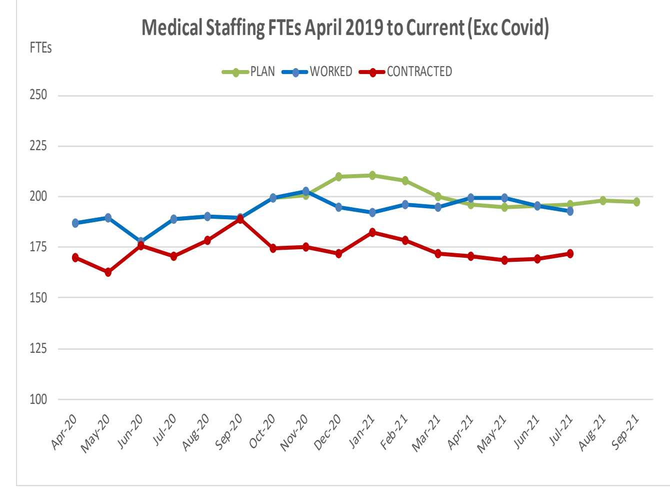
Despite the increase in underlying costs, the level of recruitment remains well below planned levels, with costs in the month £1.1m below expectations, including offsetting non permanent staffing costs.

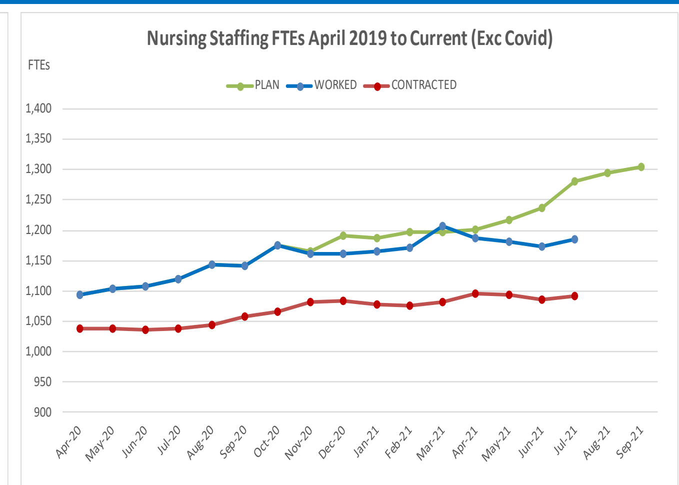
The level of staffing costs attributable to COVID continue to fall with costs just above £0.1m in July and less than fore-cast.

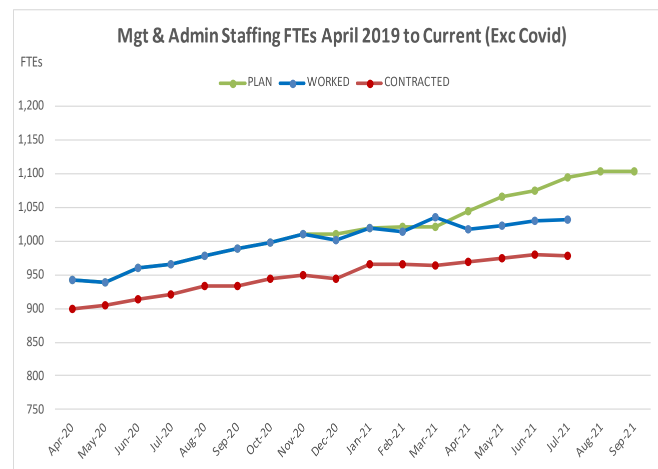
Non Permanent staffing cost increased by £0.3m, related to higher bank costs in all staffing groups and across all divi-sions apart from Corporate, with annual leave cover increasing.

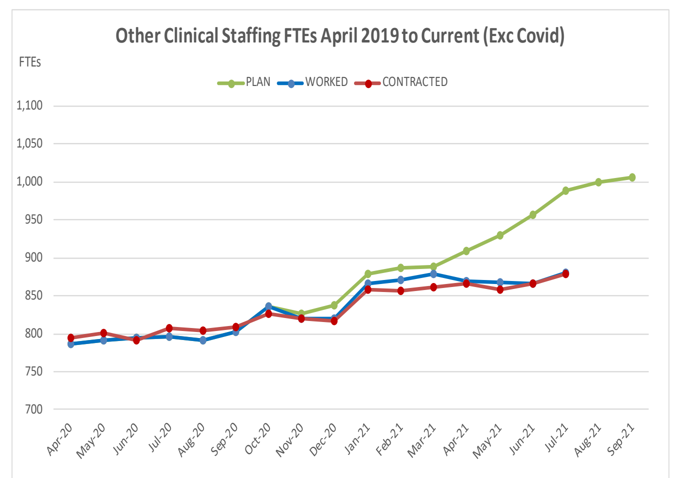
Contracted FTEs increased by 14 in July, with worked FTE also increasing driven by the higher levels of bank usage.

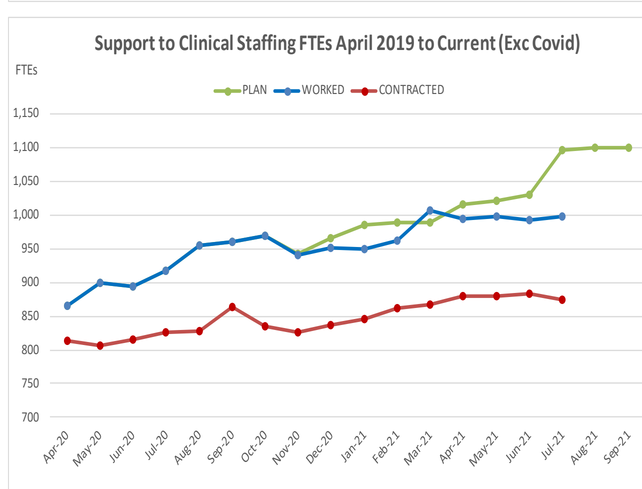
Staffing Detailed

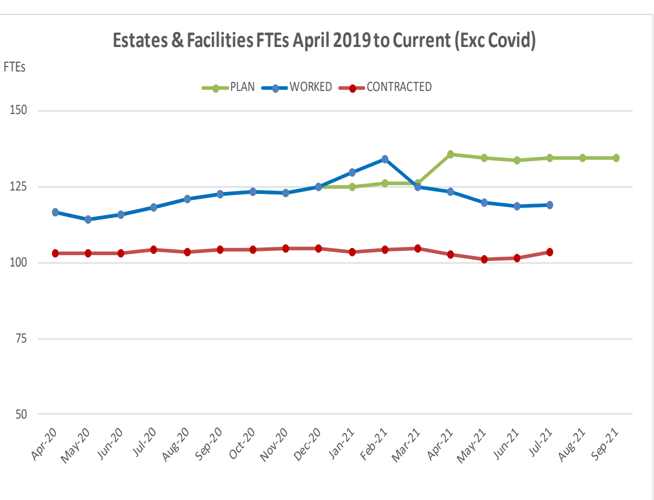










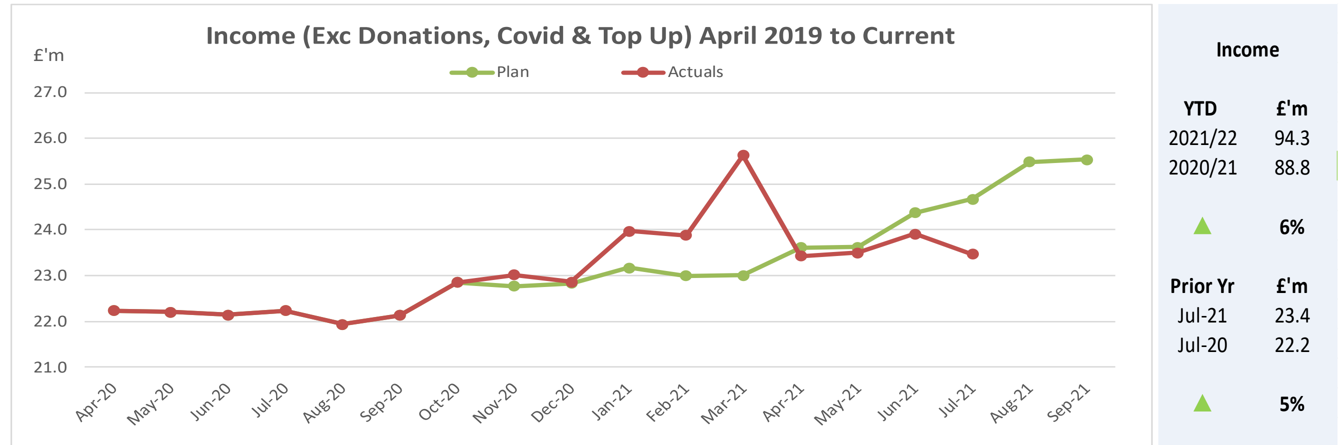


Key Messages

The tables above provide illustrate current staffing number broken down into core staffing groups. The planned levels reflects assumptions on underlying recruitment, as well as expectation of staffing increases funded through commissioner investment. Some CCG investments are still to be agreed and actual staff groups recruited may differ to plan.

This month there were increases in contracted numbers across a number of staffing groups. Nursing numbers increased by 7 FTE, with recruitment in CAMHS, Health Visiting and Community Wards in the East. CAMHS saw further increases in Other Clinical staffing, as did Community Health West. There were also small increases in Domestics.

Income & Non Pay

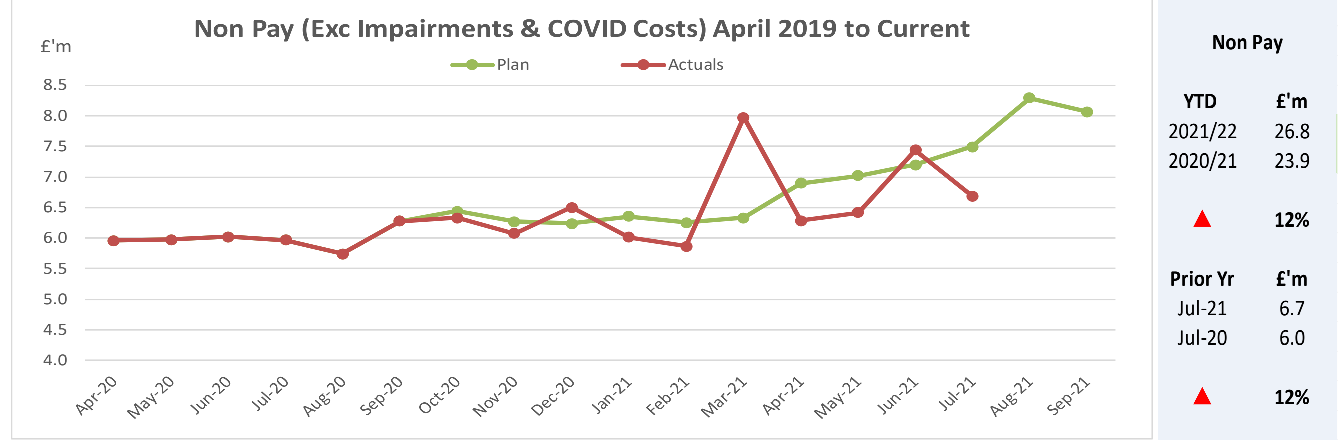


Key Messages

The income plan, above, reflects the latest view of agreed block contracts for H1, but excludes our agreed £4.8m COVID allocation and £3.1m deficit support and further assumes CCG, Service Development Funding and Spending Review Funding is recognised from Q2, offsetting planned increased in cost.

To the end of July, the Trust has contributed £5.3m to the overall level of ERF earnt across the system. As per our agreement with partners we have received funding for actual costs incurred and to support revenue impact of capital, which is £0.2m and £0.7m less than planned. YTD.

Aside from ERF, income was £1.0m below plan, reflecting deferment in commissioner investments aligned to costs.



Key Messages

Non Pay spend overall was £5.6m in month, including £0.1m of ongoing COVID related costs. This was £0.7m below plan, moving the YTD underspend to £0.6m.

The key movement in spend this month was the impact on the non recurrent adjustment to provisions last month.

The variance to plan has increased this month as planned increased in estate and IT costs of £0.3m have not materialised and are likely to occur later than expected in Q2 and into H2.

The Trust continues to experience pressure on IP Mental Health beds and OAP costs in July were £0.3m, although this is less than in June driven by a reduction in usage equating to 3 beds over the month.

2.0 Balance Sheet and Cash

Balance Sheet	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Intangibles	5.4	4.6	4.8	(0.2)	4.6	4.8	(0.2)
Property, Plant & Equipment (non PFI)	38.4	37.2	37.6	(0.4)	37.2	37.6	(0.4)
Property, Plant & Equipment (PFI)	55.5	55.3	55.6	(0.3)	55.3	55.6	(0.3)
Total Non Current Assets	**99.3**	**97.1**	**98.0**	**(0.9)**	**97.1**	**98.0**	**(0.9)**
Trade Receivables & Accruals	13.9	16.7	9.4	7.3	16.7	9.4	7.3
Other Receivables	0.2	0.1	0.2	(0.0)	0.1	0.2	(0.0)
Cash	39.1	43.6	38.9	4.7	43.6	38.9	4.7
Trade Payables & Accruals	(34.5)	(33.4)	(28.2)	(5.2)	(33.4)	(28.2)	(5.2)
Current PFI Finance Lease	(1.6)	(1.6)	(1.6)	(0.0)	(1.6)	(1.6)	(0.0)
Other Current Payables	(6.1)	(11.0)	(6.7)	(4.3)	(11.0)	(6.7)	(4.3)
Total Net Current Assets / (Liabilities)	**10.9**	**14.5**	**12.0**	**2.5**	**14.5**	**12.0**	**2.5**
Non Current PFI Finance Lease	(25.5)	(24.9)	(24.9)	0.0	(24.9)	(24.9)	0.0
Other Non Current Payables	(2.8)	(3.5)	(2.5)	(0.9)	(3.5)	(2.5)	(0.9)
Total Net Assets	***82.0***	***83.2***	***82.5***	***0.7***	***83.2***	***82.5***	***0.7***
Income & Expenditure Reserve	30.6	31.3	31.1	0.2	31.3	31.1	0.2
Public Dividend Capital Reserve	20.0	20.0	20.0	0.0	20.0	20.0	0.0
Revaluation Reserve	31.4	32.0	31.4	0.6	32.0	31.4	0.6
Total Taxpayers Equity	***82.0***	***83.2***	***82.5***	***0.7***	***83.2***	***82.5***	***0.7***

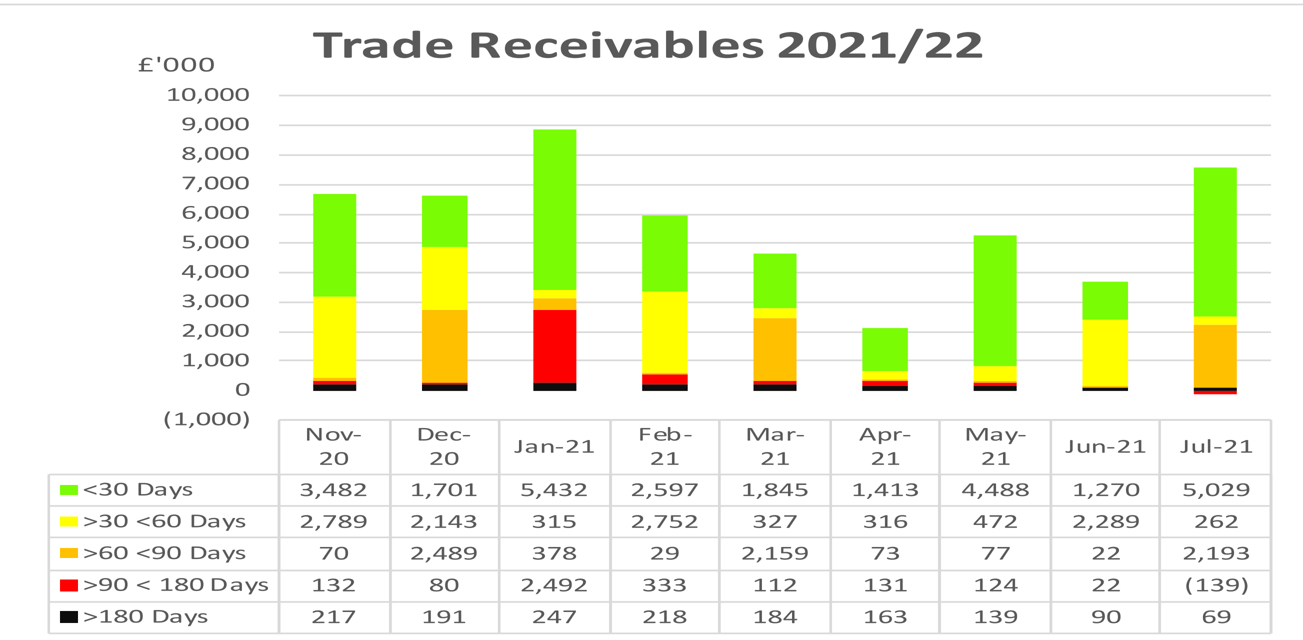
Cashflow	20/21 Actual £'m	Current Month Act £'m	Current Month Plan £'m	Current Month Var £'m	YTD Act £'m	YTD Plan £'m	YTD Var £'m
Operating Surplus/(Deficit)	4.9	0.7	0.2	0.6	3.0	2.1	0.9
Depreciation and Impairments	10.3	0.7	0.7	(0.0)	2.7	2.0	0.7
Operating Cashflow	***15.2***	***1.4***	***0.9***	***0.6***	***5.7***	***4.1***	***1.6***
Net Working Capital Movements	***11.0***	***0.1***	***(0.1)***	***0.2***	***2.4***	***(0.4)***	***2.8***
Proceeds from Disposals	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Donations to fund Capital Assets	(0.0)	0.0	0.0	0.0	(0.0)	0.0	(0.0)
Donated Capital Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital Expenditure (Net of Accruals)	(7.9)	(0.1)	(0.2)	0.1	(1.8)	(2.7)	0.9
Investments	***(7.9)***	***(0.1)***	***(0.2)***	***0.1***	***(1.8)***	***(2.7)***	***0.9***
PFI Finance Lease Repayment	(1.5)	(0.1)	(0.1)	0.0	(0.5)	(0.4)	(0.1)
Net Interest	(4.0)	(0.3)	(0.3)	(0.0)	(1.3)	(1.0)	(0.3)
PDC Received	0.8	0.0	0.0	0.0	0.0	0.0	0.0
PDC Dividends Paid	(1.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)
Financing Costs	***(5.7)***	***(0.5)***	***(0.5)***	***(0.0)***	***(1.8)***	***(1.4)***	***(0.5)***
Other Movements	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Cash In/(Out)Flow	***12.7***	***0.9***	***0.1***	***0.9***	***4.5***	***(0.3)***	***4.8***
Opening Cash	26.4	42.7	38.8	3.9	39.1	39.1	0.0
Closing Cash	***39.1***	***43.6***	***38.9***	***4.7***	***43.6***	***38.9***	***4.7***

Key Messages

The closing cash balance for July was £43.6m, £4.7m ahead of plan. The Trust continues to report a strong cash balance and expects to retain this through the first half of the year, given that we are planning for revenue breakeven and revised capital spend is planned to be in line with depreciation funding.

The other factors contributing to the higher balance are slippage of capital expenditure (£0.9m) as well as the delay in issuing invoices by NHSPS due to the VAT issues, which are expected to be resolved in Q3.

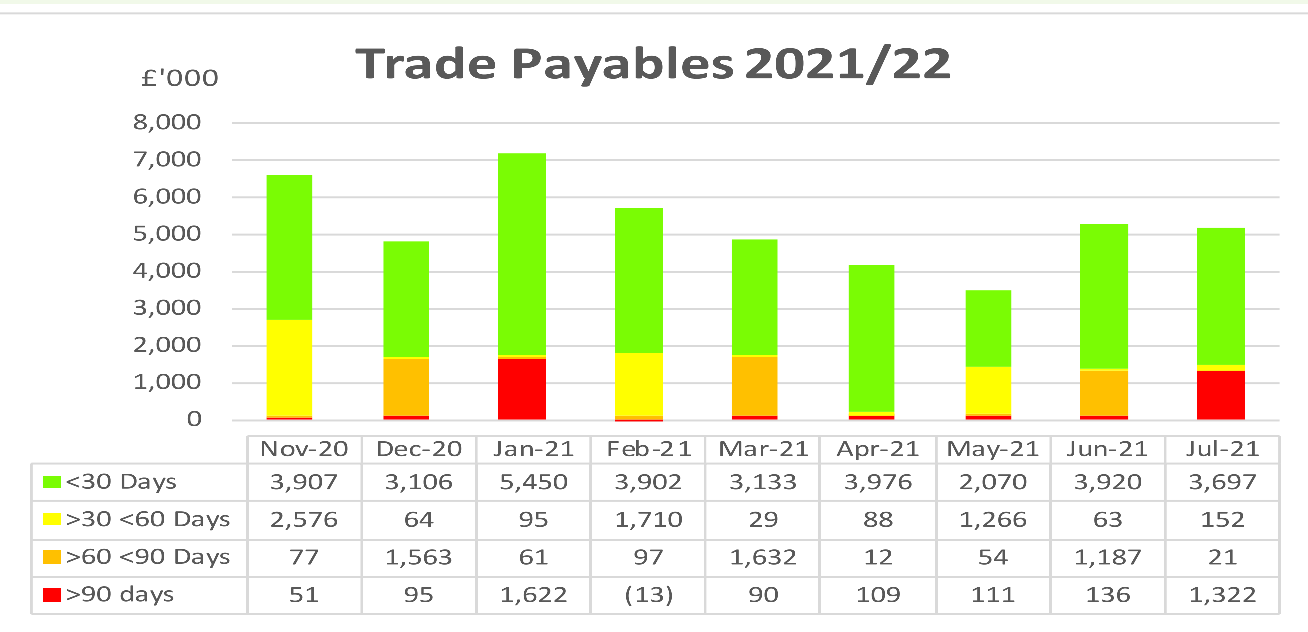
Cash Management



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
<30 Days	3,482	1,701	5,432	2,597	1,845	1,413	4,488	1,270	5,029
>30 <60 Days	2,789	2,143	315	2,752	327	316	472	2,289	262
>60 <90 Days	70	2,489	378	29	2,159	73	77	22	2,193
>90 < 180 Days	132	80	2,492	333	112	131	124	22	(139)
>180 Days	217	191	247	218	184	163	139	90	69

Key Messages

Overall debtors balances increased by £3.7m, seen mainly in current balances. There has been a increase of £2.2m in 60 to 90 day balances offset by a decrease of £2m in 30 to 60 day balances due to both the Trust and NHSPS holding charges until overall agreement on the balances can be reached. We are continuing to work with NHSPS to resolve the outstanding issues.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
<30 Days	3,907	3,106	5,450	3,902	3,133	3,976	2,070	3,920	3,697
>30 <60 Days	2,576	64	95	1,710	29	88	1,266	63	152
>60 <90 Days	77	1,563	61	97	1,632	12	54	1,187	21
>90 days	51	95	1,622	(13)	90	109	111	136	1,322

Key Messages

Overall creditors reduced by £0.1m, mainly due to a decrease in current balances by £0.2m offset by increase in 30 to 60 days by £0.1m. The over 90 days balance includes £1.2m reciprocal payment with NHSPS and will be paid once the AR balances are settled.

Capital Expenditure

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
Estates Maintenance & Replacement Expenditure							
Erlegh Road (LD etc works)	0	5	(5)	0	24	(24)	135
Other Trust Owned Properties	20	0	20	0	0	0	0
Leased Non Commercial (NHSPS)	35	14	21	18	43	(25)	370
Head Office Relocation	0	32	(32)	0	64	(64)	800
Leased Commercial other	18	5	13	0	14	(14)	135
Wokingham Willow House Projects	76	250	(174)	104	300	(196)	950
Environment & Sustainability	0	2	(2)	0	12	(12)	49
Various All Sites	0	4	(4)	0	30	(30)	130
Statutory Compliance	12	8	4	(0)	68	(68)	240
Subtotal Estates Maintenance & Replacement	**161**	**320**	**(159)**	**123**	**555**	**(432)**	**2,809**
IM&T Expenditure							
IM&T Business Intelligence and Reporting	13	0	13	(0)	0	(0)	0
IM&T Refresh & Replacement	(7)	13	(20)	4	38	(34)	2,102
IM&T System & Network Developments	87	16	71	110	96	14	466
IM&T GDE & Community Projects	23	13	10	88	168	(80)	465
Subtotal IM&T Expenditure	**117**	**42**	**75**	**202**	**302**	**(100)**	**3,033**
Subtotal CapEx Within Control Total	**278**	**362**	**(84)**	**325**	**857**	**(533)**	**5,842**
CapEx Expenditure Outside of Control Total							
PPH - LD to Jasmine	(0)	0	(0)	144	131	13	131
PPH Fire Doors	116	0	116	117	116	1	116
PPH Place of Safety	0	8	(8)	0	64	(64)	200
PPH Zonal Heating Controls	0	18	(18)	0	33	(33)	350
PPH Ward Bedroom Door Mechanisms - Swipe Access	0	11	(11)	0	126	(126)	320
Service change/redesign (not included in ICH)	0	3	(3)	0	12	(12)	200
Other PFI projects	0	37	(37)	0	94	(94)	631
PPH Elimination of Dormitories - PDC Funded	0	6	(6)	0	11	(11)	120
Donated Assets	0	0	0	8	0	8	0
Subtotal Capex Outside of Control Totals	**116**	**83**	**33**	**260**	**576**	**(316)**	**2,068**
Total Capital Expenditure	**394**	**445**	**(51)**	**585**	**1,433**	**(848)**	**7,910**

Key Messages

The Trust has a capital allocation of £5.8m, in addition to the £2.1m of spend outside of system control total, with the overall plan being £7.9m.

Overall YTD spend is £0.8m behind plan. This is the result of the delay in agreeing the 21/22 capital plan as well as supply delays resulting from COVID and Brexit.

Estates and maintenance is £0.4m behind plan, with £0.2m related to the profiling of expenditure on Willow House, which commenced in July and is expected to complete by the end of summer.

IM&T is underspend by £0.1m YTD with spend on GDE related projects delayed, including Community Electronic Prescribing , which has been impacted by resources allocated to Covid testing.

Spend against PFI schemes is £0.3m behind plan. The Fire Door replacement programme has now been completed. The new door locking mechanisms, flagged as a requirement by CQC, have now been approved so it is expected that expenditure will commence imminently.

We continue to work across the ICS to maximise the use of our capital allocations and monitoring of spend and accurate forecasting will be of significant importance in the coming year.

Trust Board Paper - Public

Board Meeting Date	14th September 2021
Title	**True North Performance Scorecard** **Month 4 (July 2021) 2021/22**
Purpose	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 2021/22.
Business Area	Trust-wide Performance
Author	Chief Financial Officer
Relevant Strategic Objectives	2 - 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.
CQC Registration/Patient Care Impacts	All relevant essential standards of care.
Resource Impacts	None.
Legal Implications	None.
Equality and Diversity Implications	None.
Summary	The True North Performance Scorecard for Month 4, 2021/22 (July 2021) is included. Individual metric review is subject to a set of clearly defined “business rules” covering how metrics should be considered dependent on their classification for driver improvement focus, and how performance will therefore be managed. The business rules apply to three different categories of metric:

	• **Driver metric**: the few key improvement drivers with target performance and will be the focus of meeting attention.
	• **Tracker Level 1 metric**: no attention required if within set threshold for the period. Threshold performance usually defined by regulator / external body and relates to "must do" national standards or areas of focus. Update required if threshold performance is missed in one month.
	• **Tracker metric**: no attention required unless performance is deteriorating from threshold for a defined period (over four months). Threshold set internally, where sustained underperformance will trigger a review of threshold level or need to switch to a driver metric dependent on capacity.
	
	Note - several indicators have been temporarily suspended nationally or locally due to the COVID-19 pandemic. These are highlighted in grey to indicate this status.
	Month 4
	Performance business rule exceptions, red rated with the True North domain in brackets:
	Driver Metrics
	Context and update to driver performance to be provided in discussion of counter measure action and development:
	• Falls incidents in Community & Older Adult Mental Health Inpatient Wards **(Harm Free Care) –** red at 27 against a target of 20. Red for 9 months against a stretch target. Rowan (7), Orchid (6) were the highest contributors. Existing countermeasures are in place, but additional measures are being implemented:
	  ○ Celebrate success – Oakwood and Donnington with significant reductions.
	  ○ Challenges have been increased acuity of patients with high levels of cognitive impairment.
	  ○ Technical issues with new falls technology – working with the supplier to address.
	  ○ Increased number at PPH (older adult wards) have led to more admissions into higher risk beds to support patient flow. Countermeasures being reviewed.

	• Self-harm incidents on mental health wards (excluding LD) **(Harm Free Care)** – 124 incidents against a target of 42. Bluebell ward was the highest contributor with 74 incidents. Headbanging was the highest contributory self-harm type, followed by superficial cutting and ligatures. The reduction in ligatures is being attributed to countermeasures. 'Safe wards' interventions are being used such as the 'zen den' and use of positive words, a 'getting to know you folder' and self-soothing bag on admission. Safety huddles continue. • Patient Friends and Family Test (FFT) recommend rate: % **(Patient Experience)** - at 79% against a 95% target. Newly reinstated post-COVID suspension. There is a project underway to implement a new system, so this measure is under review until switchover in Q3. • Patient Friends and Family Test (FFT) response rate: % **(Patient Experience)** - at 6% against a 15% target. Newly reinstated post-COVID suspension. There is a project underway to implement a new system, so this measure is under review until switchover in Q3. • Mental Health Clustering **(Patient Experience)** - at 77.2% against an 80% target. Services are operating in a challenging environment which is impacting their ability to keep this above target. There has been a significant improvement in performance but remains below target. Action plans are in place to improve this metric. • Physical assaults on staff **(Supporting our Staff)** – at 66 incidents against a target of 44. Campion (18), Rose (16), and Bluebell (9) wards were the highest contributors this month. Snowdrop continues to do well with 1 incident for their driver and Sorrel have reduced from being the highest contributor. Work on tackling racial abuse is on-going, as is restrictive practices (i.e. restraint, rapid tranquilisation and observations). Sorrel ward has introduced a new countermeasure based on analysis of their data by implementing a review and planning process prior to seclusion. • Mental Health: Acute Average Length of Stay (bed days) **(Money Matters) –** at 49 days against a target of 30 days. Pressures continue, and length of stay remains a focus for teams. The Trust is participating in a project across the South with the Benchmarking network about Length of Stay in Mental Health acute wards of

	patients with a stay of over 90 days. An improvement project is also underway. **Tracker Metrics (where red for 4 months or more)** • Statutory Training: Fire **(Supporting our Staff)** - Moving to a driver whilst countermeasures are developed to improve compliance. This month was 90.8% against a 95% target. Within our ward environments Daisy (74.1%) and Snowdrop (75%) wards have the lowest levels of compliance whilst all Community Health wards are above target. • Statutory Training: Information Governance **(Supporting our Staff)** – recently moved from the suspended (due to COVID) list. At 92% against a 95% target with 7 months red. • Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias **(Regulatory Compliance)** – currently one identified against a target of 0, which will be subject to an internal review to determine if this was due to a lapse in care. • Sickness rate **(Regulatory Compliance)** – red at 3.83% against a target of 3.5%. This is not a "hard" compliance focus with NHSI but is tracked. One month red.
Action	The Board is asked to note the new True North Scorecard.

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**)

Harm Free Care

Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Falls incidents in Community & Older Adult Mental Health Inpatient Wards	20 per month	25	17	17	22	24	46	26	34	37	28	27	27
Self-Harm Incidents on Mental Health Inpatient Wards (excluding LD)	42 per month	40	57	67	76	46	110	127	177	76	39	128	124
Pressure ulcers acquired at BHFT due to lapse in care - Grade 3 & 4 (Cumulative YTD)	<18 per year	0	3	0	0	5	6	7	0	0	0	0	0
Number of suicides (per month)	Equal to or less than 3 per month	1	1	4	3	1	1	4	3	2	1	4	0
Physical Health Checks 7 Parametres	30% for the 1st 3 months and then 60% by March 22										19%	31%	43%
Gram Negative Bacteraemia	1 per ward per year	0	0	0	0	0	0	0	0	0	1	1	0

Patient Experience

Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Patient FFT Recommend Rate: %	95% compliance				87%	78%	85%	88%	93%	90%	92%	79%	
Patient FTT response rate: %	15% compliance				87%	4%	3%	6%	5%	5%	5%	6%	
Mental Health Clustering within target: %	80% compliance	82.7%	81.5%	81.7%	80.9%	78.5%	75.7%	76.2%	74.9%	73.9%	73.5%	71.5%	77.2%

Performance Scorecard - True North Drivers (July 2021)

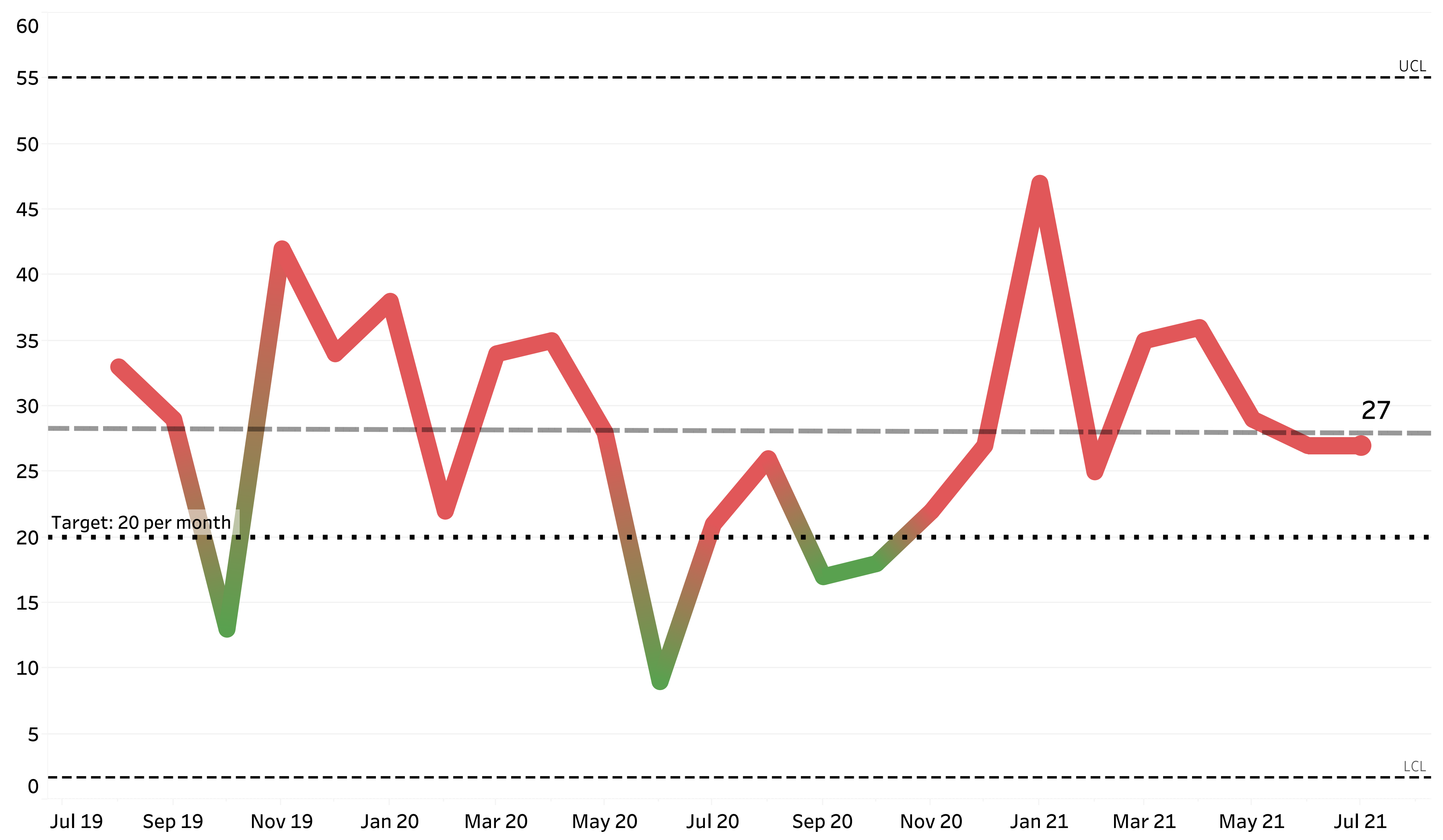
Supporting our Staff

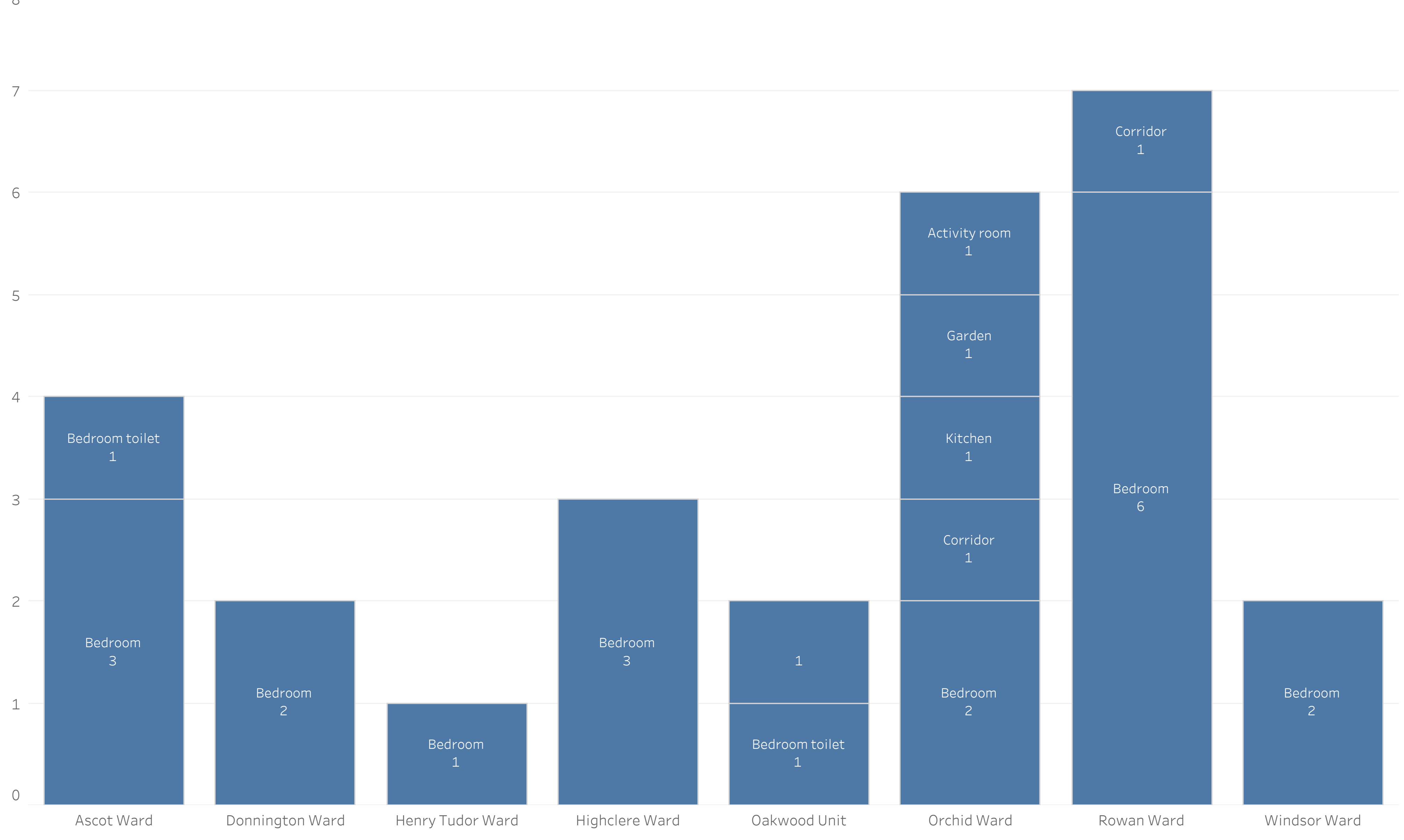
Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Physical Assaults on Staff	44 per month	51	26	34	44	73	58	52	54	54	66	50	66
Staff Engagement Score (Annual Staff Survey) [Suspended centrally in April due to COVID]	Score of 10	7.40	7.40	7.40	7.40	7.40	7.40	7.5	7.5	7.5	7.5	7.5	7.5

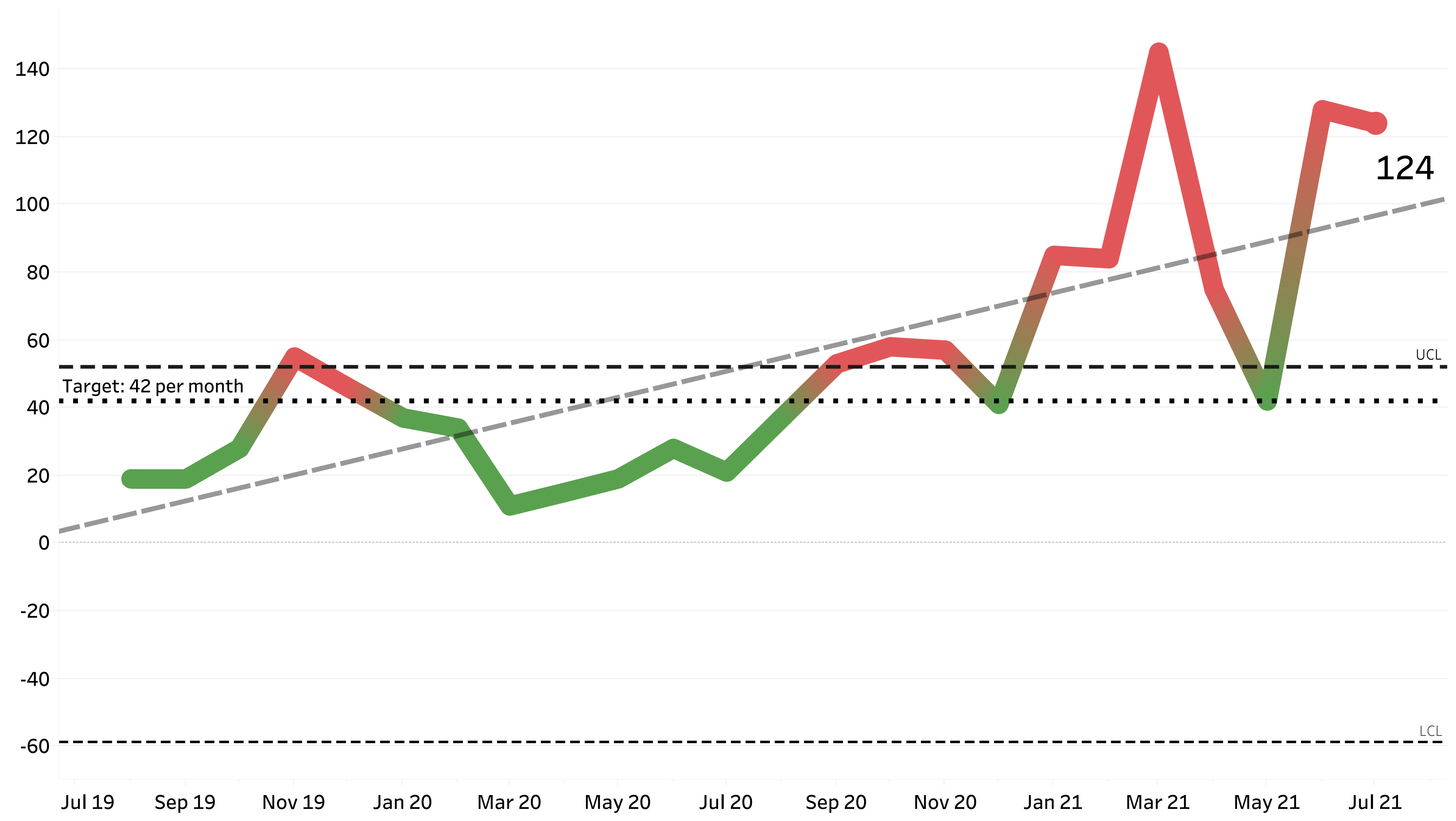
Money Matters

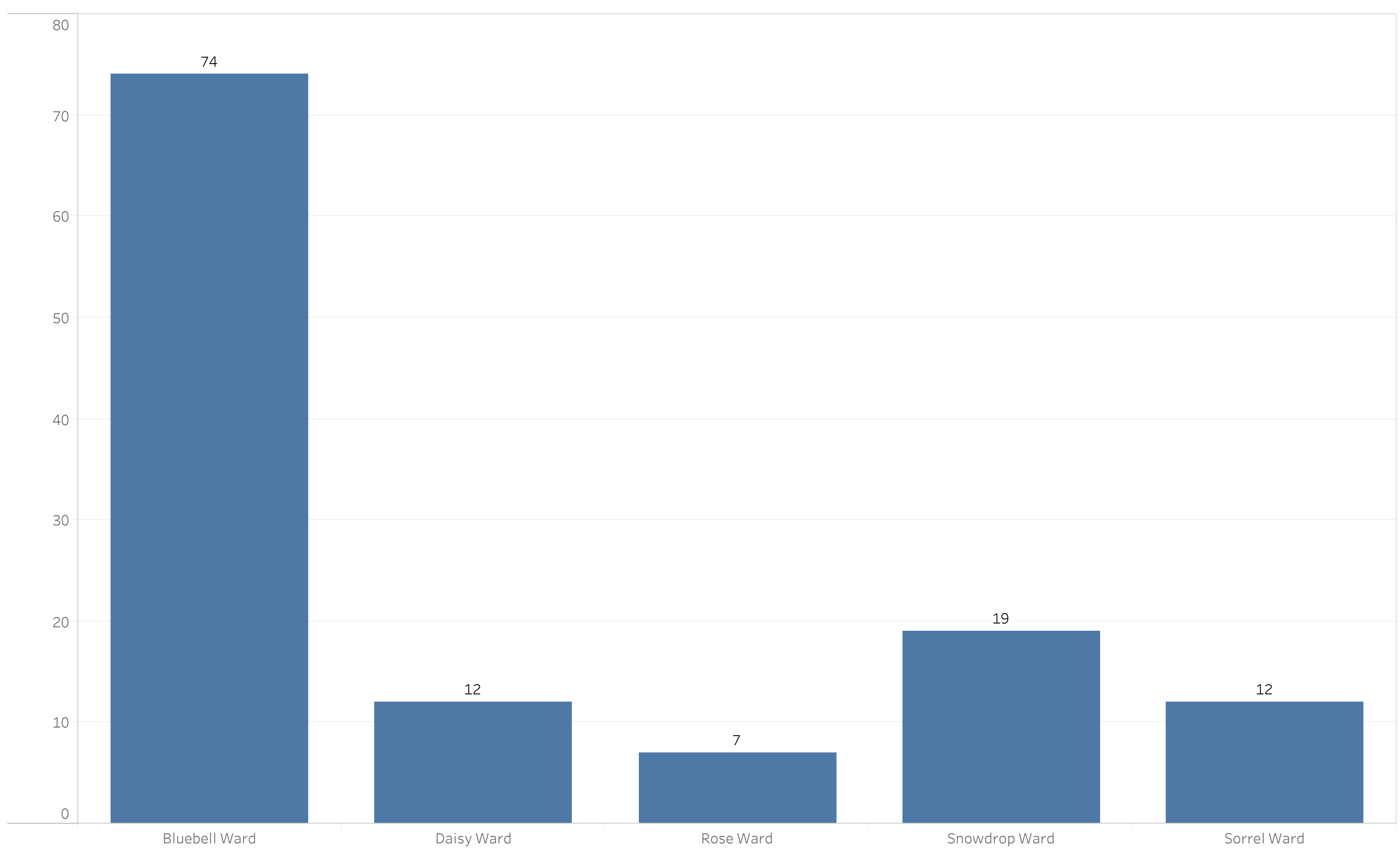
Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
CIP target (£k): (Cumulative YTD) [Suspended centrally due to COVID]	£4m (annual)												
Financial surplus £k (excl. STF): (Cumulative YTD to plan) [Suspended centrally due to COVID]	-£0.4m												

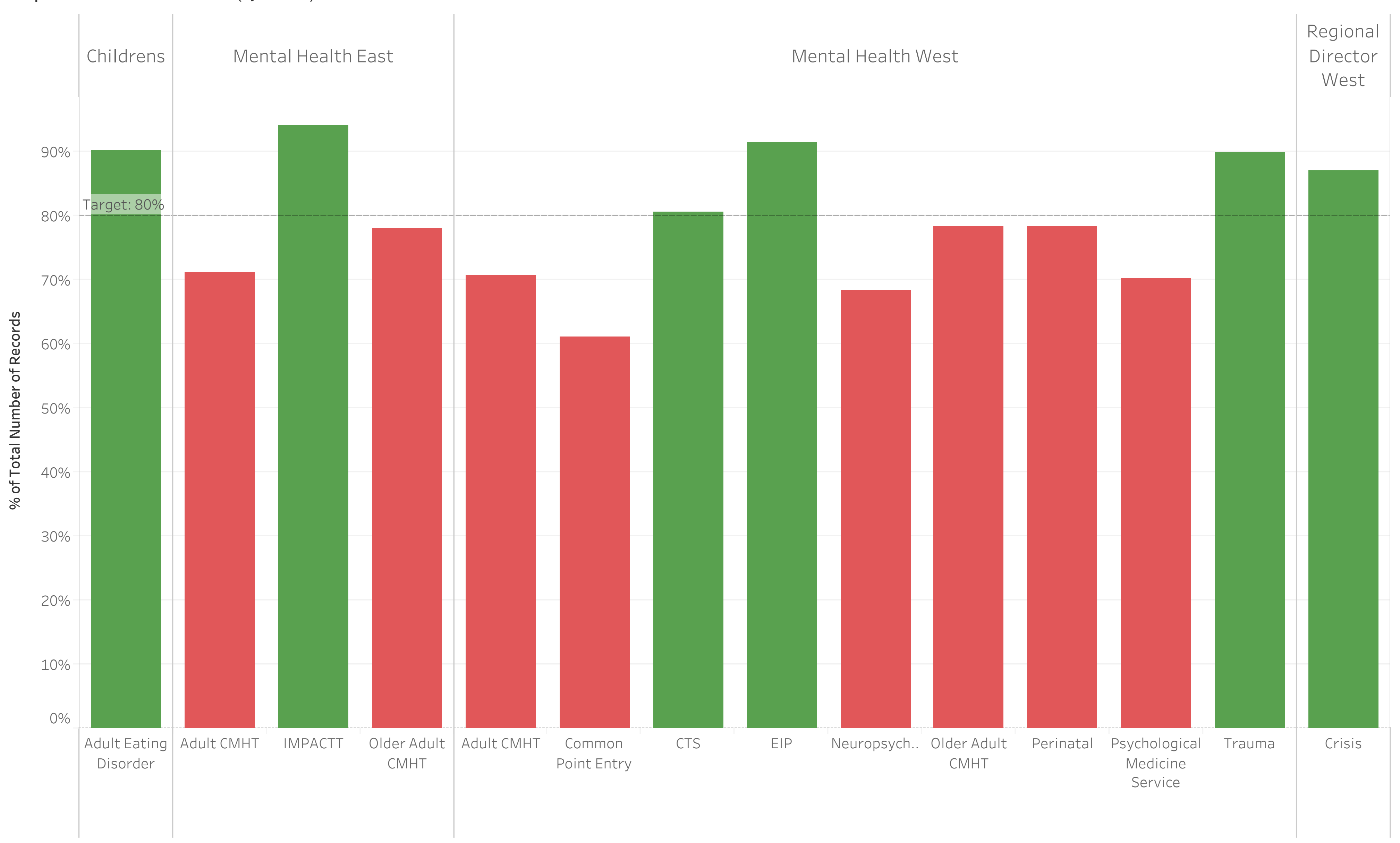
Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Mental Health: Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	85% Occupancy	97.2%	92.6%	90.6%	90.5%	91.8%	83.3%	86.1%	91.9%	97.4%	97.6%	96%	96.0%
Mental Health: Acute Average Length of Stay (bed days)	30 days	47	40	43	43	46	45	42	46	47	50	50	49
Staff turnover (excluding fixed term posts)	<16% per month	13.3%	13.9%	13.8%	13.7%	13.1%	13.1%	13.1%	12.4%	12.5%	12.5%	13.1%	13.8%
Staff turnover (including fixed-term posts)	<16% per month	15.9%	17.1%	16.9%	16.9%	16.4%	15.4%	15.4%	14.7%	14.7%	14.6%	15.1%	15.8%
Inappropriate Out of Area Placements	490 Cumulative Total Q2 240 July 21 390 Aug 21..	164	270	164	338	681	421	844	1,045	180	607	856	126

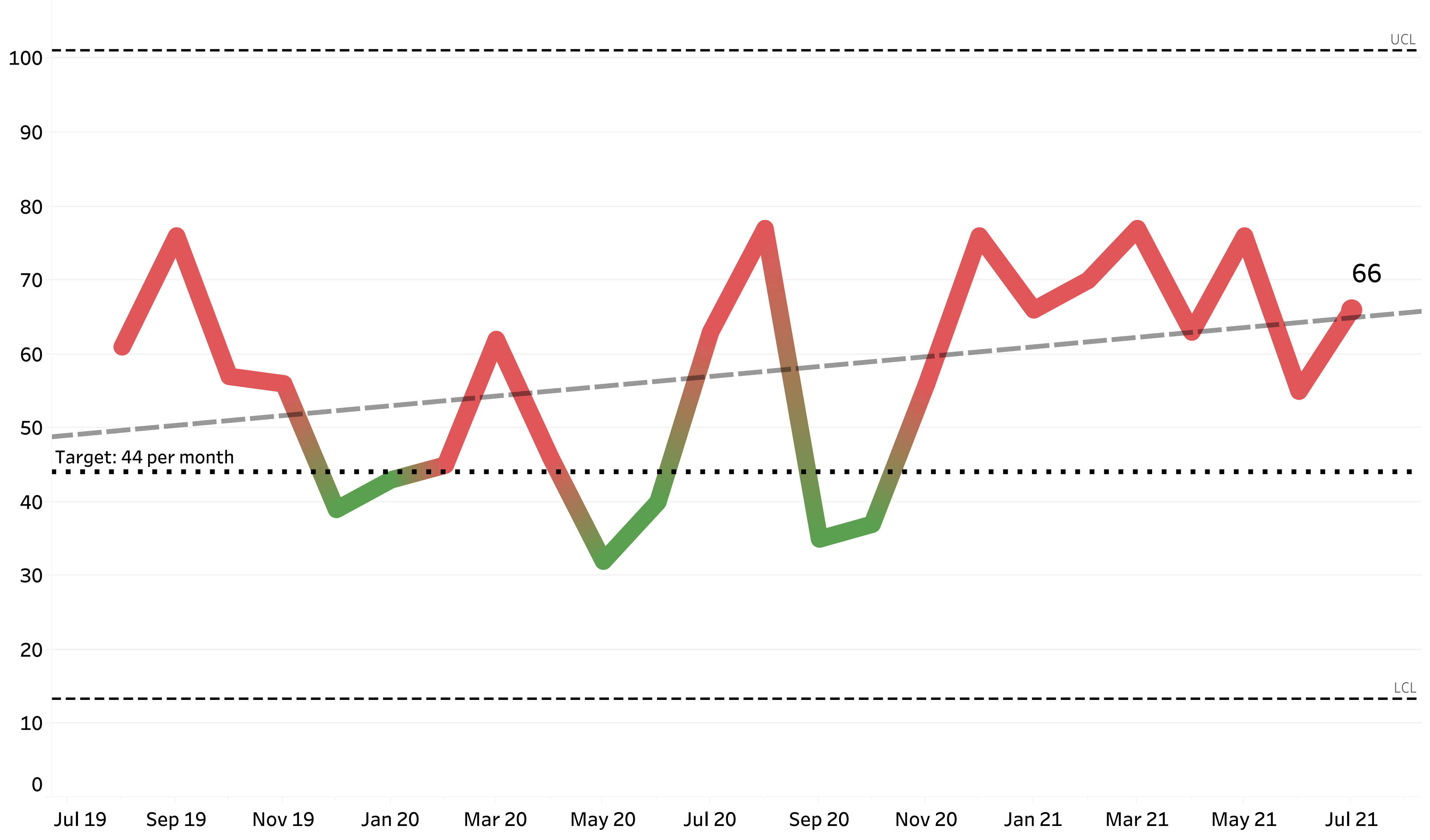

Harm Free Care Driver: Fall incidents in Community & Older Adult Mental Health Inpatient Wards (Aug 19 to Jul 21)
Any incident (all approval statuses) where sub-category excluding Sat or lowered to floor & near miss, Location exact excluding Patient/staff home and incident type = patient
60
55
50
45
40
35
30
25
20
15
10
5
0
UCL
LCL
Target: 20 per month
27
Jul 19
Sep 19
Nov 19
Jan 20
Mar 20
May 20
Jul 20
Sep 20
Nov 20
Jan 21
Mar 21
May 21
Jul 21

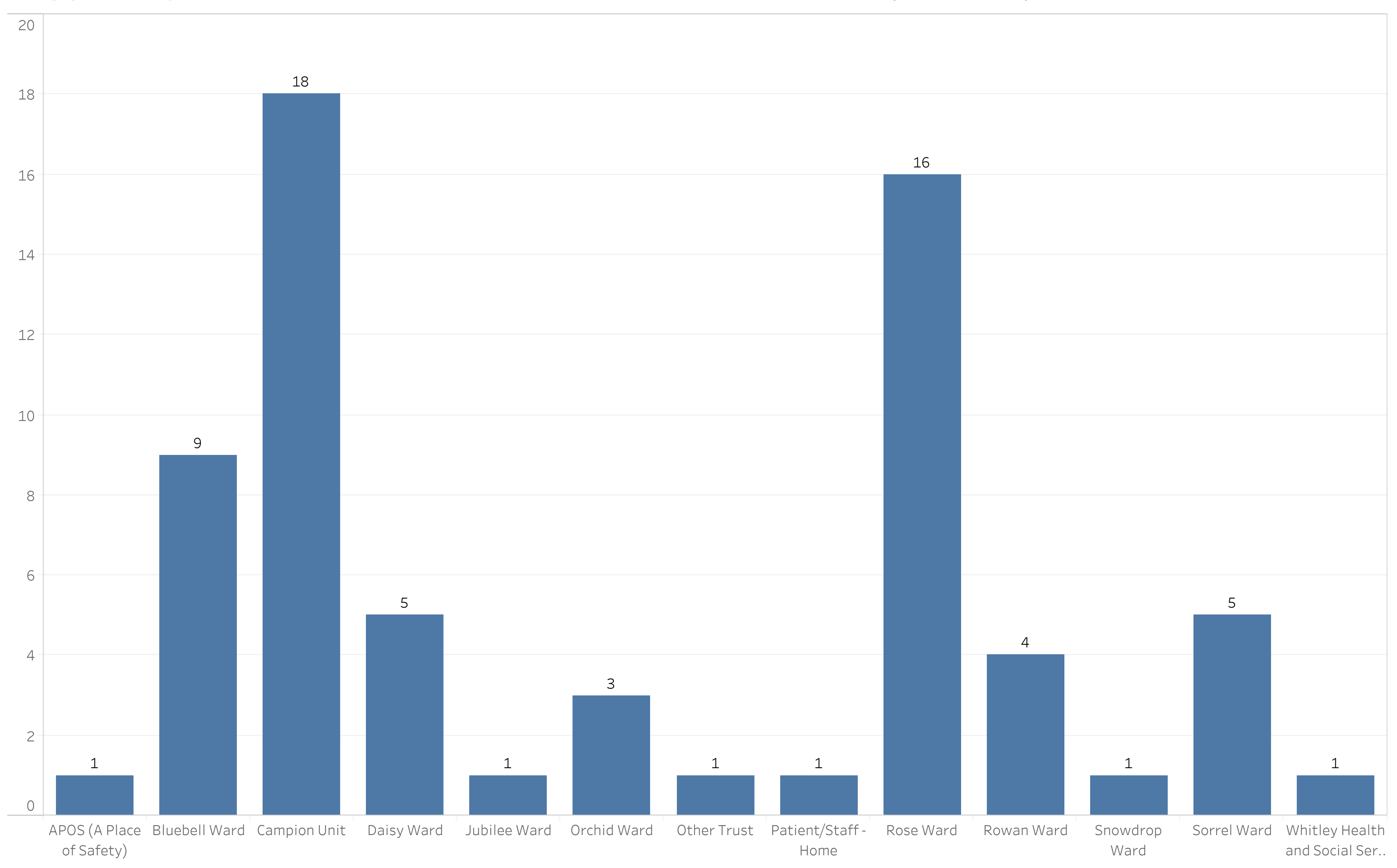

Harm Free Care Driver: Fall incidents in Community and Older Adult Mental Health Inpatient Wards (July 21)
8
7
6
5
4
3
2
1
0
Bedroom toilet
1
Bedroom
3
Bedroom
2
Bedroom
1
Bedroom
3
1
Bedroom toilet
1
Activity room
1
Garden
1
Kitchen
1
Corridor
1
Bedroom
2
Corridor
1
Bedroom
6
Bedroom
2
Ascot Ward
Donnington Ward
Henry Tudor Ward
Highclere Ward
Oakwood Unit
Orchid Ward
Rowan Ward
Windsor Ward


Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) (Aug 19 to Jul 21)
Any incident (all approval statuses) where category = self harm
140
120
100
80
60
40
20
0
-20
-40
-60
124
UCL
LCL
Target: 42 per month
Jul 19
Sep 19
Nov 19
Jan 20
Mar 20
May 20
Jul 20
Sep 20
Nov 20
Jan 21
Mar 21
May 21
Jul 21

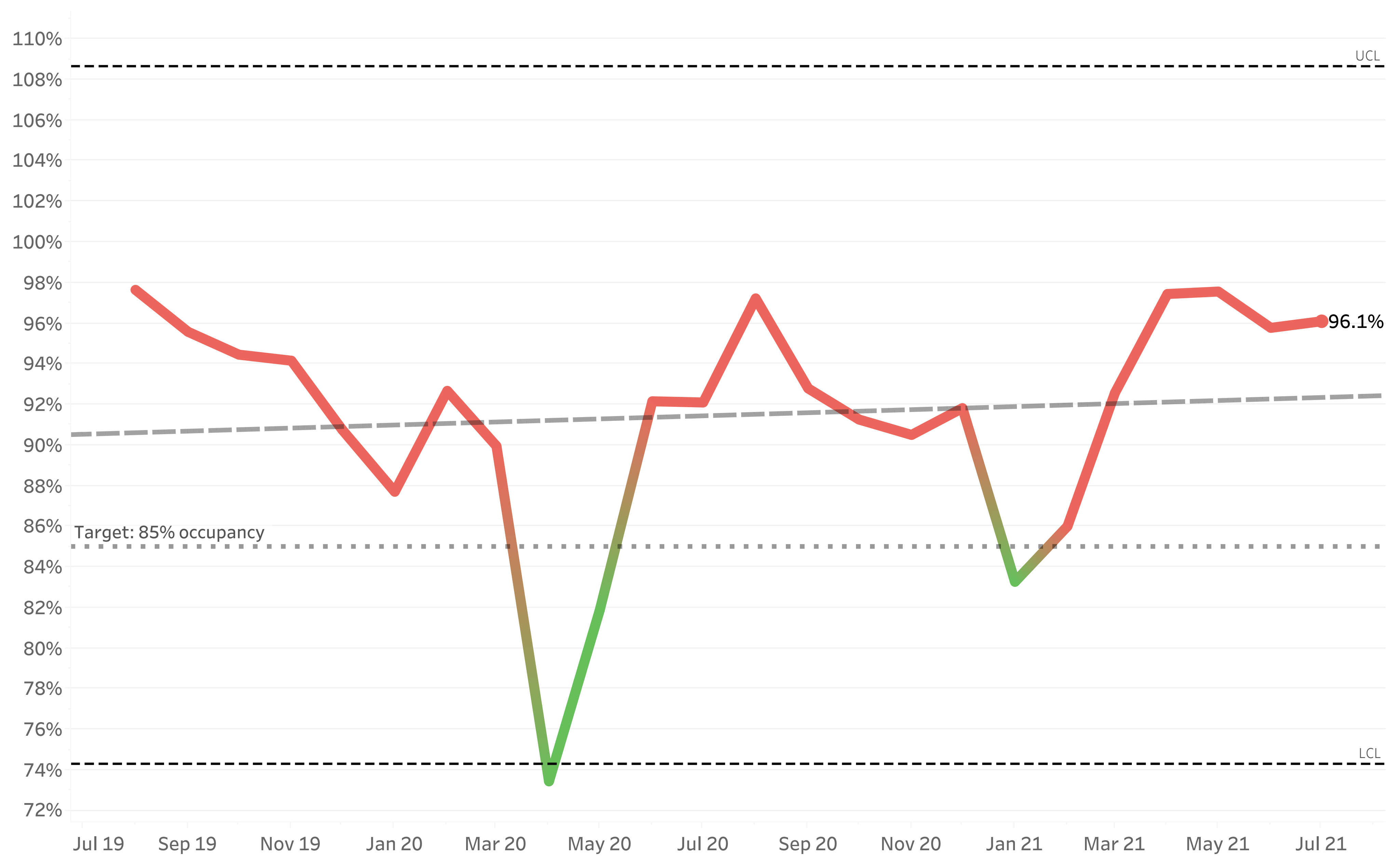

Harm Free Care Driver: Self-Harm incidents on Mental Health Inpatient Wards (excluding LD) by location (July 21)
80
70
60
50
40
30
20
10
0
74
12
7
19
12
Bluebell Ward
Daisy Ward
Rose Ward
Snowdrop Ward
Sorrel Ward


Patient Experience: Clustering breakdown (July 2021)
Outpatient Cluster Status (by Service)
Childrens
Mental Health East
Mental Health West
Regional Director West
% of Total Number of Records
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Target: 80%
Adult Eating Disorder
Adult CMHT
IMPACTT
Older Adult CMHT
Adult CMHT
Common Point Entry
CTS
EIP
Neuropsych..
Older Adult CMHT
Perinatal
Psychological Medicine Service
Trauma
Crisis

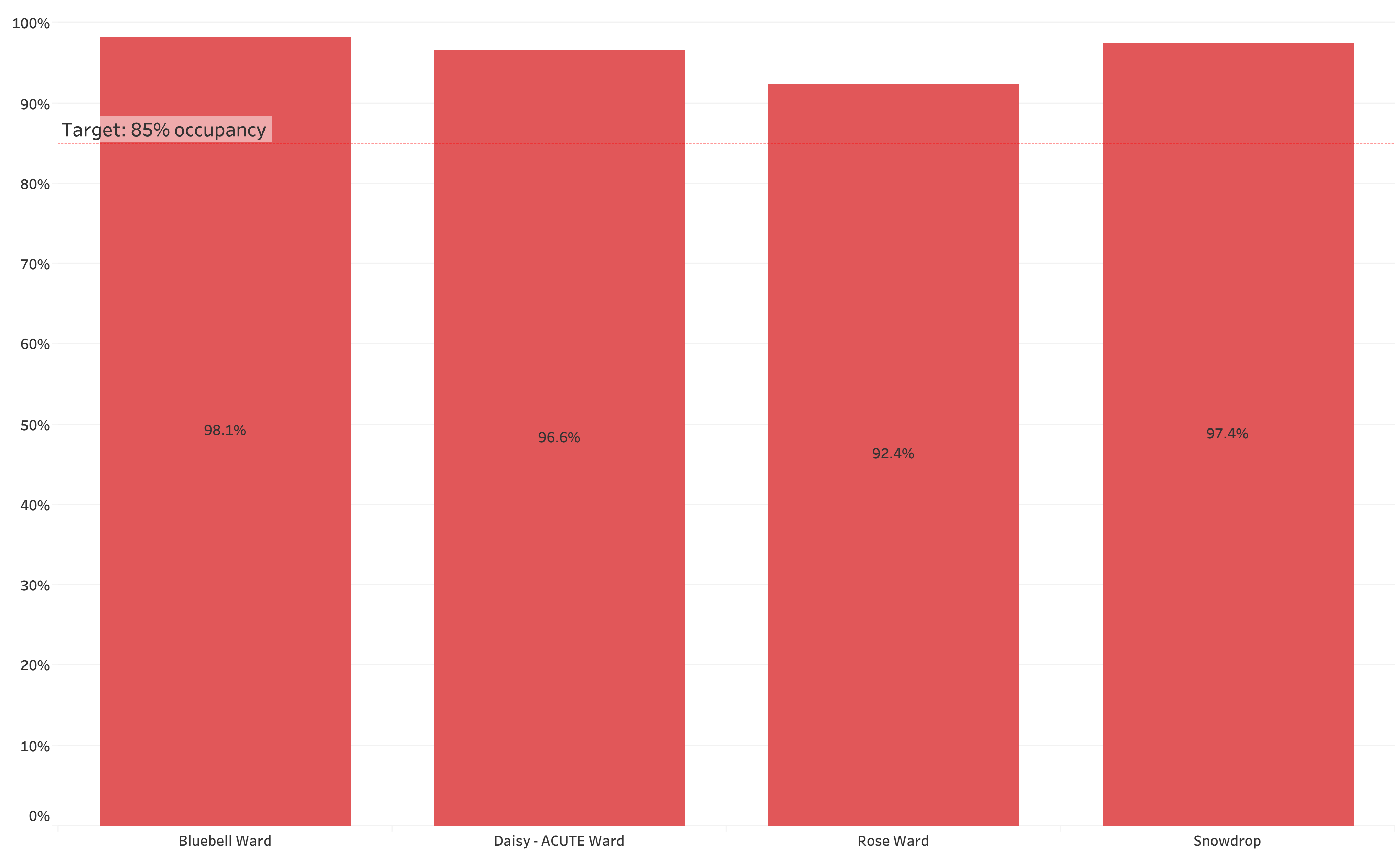

Supporting Our Staff Driver: Physical Assaults on Staff (Aug 19 to Jul 21)
Any incident where sub-category = assault by patient and incident type = staff
UCL
LCL
Target: 44 per month
66
100
90
80
70
60
50
40
30
20
10
0
Jul 19
Sep 19
Nov 19
Jan 20
Mar 20
May 20
Jul 20
Sep 20
Nov 20
Jan 21
Mar 21
May 21
Jul 21

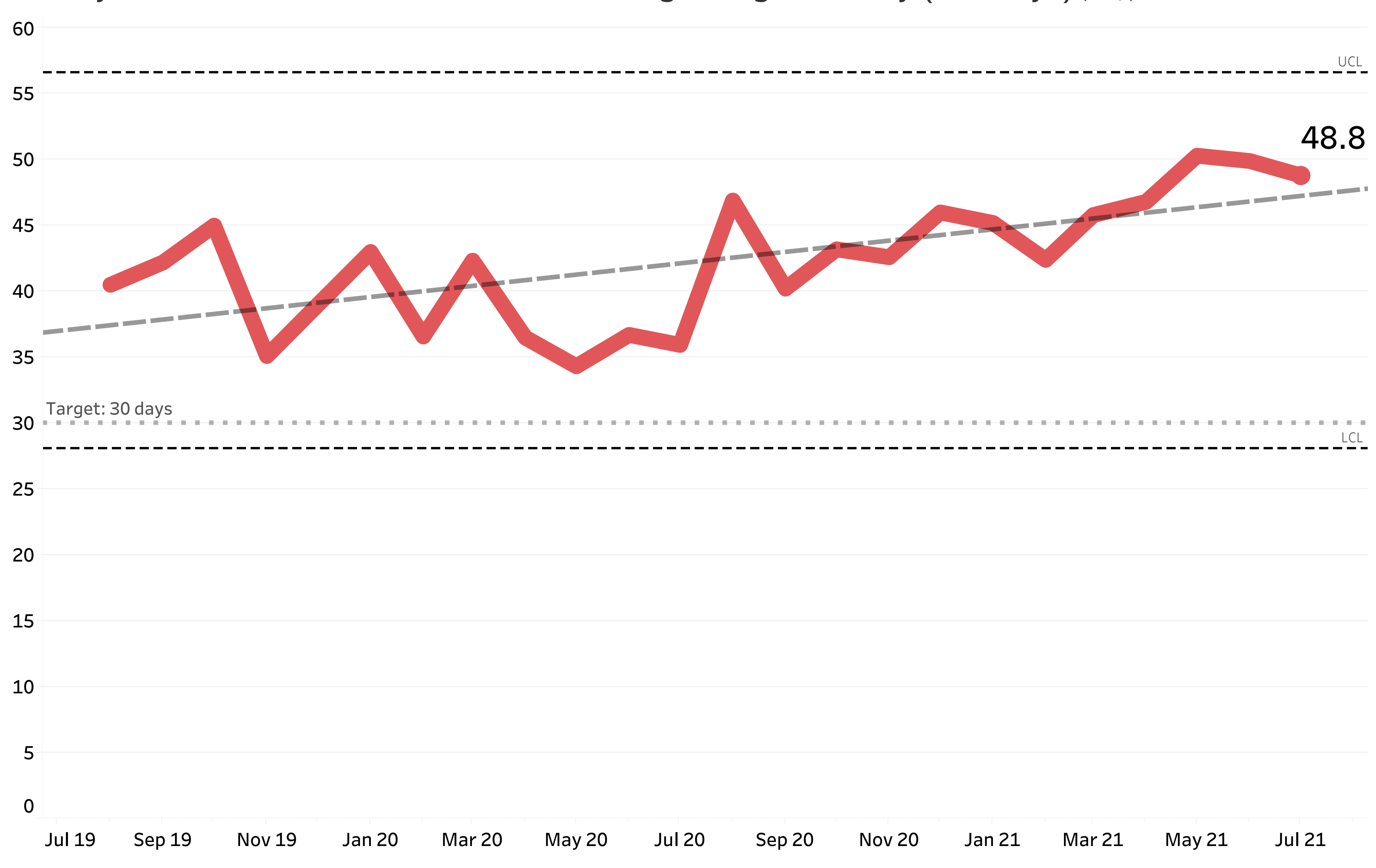


Supporting Our Staff Driver: Physical Assaults on Staff by Location (July 2021)
20
18
16
14
12
10
8
6
4
2
0
18
9
5
1
3
1
1
1
16
4
1
5
1
APOS (A Place of Safety)
Bluebell Ward
Campion Unit
Daisy Ward
Jubilee Ward
Orchid Ward
Other Trust
Patient/Staff - Home
Rose Ward
Rowan Ward
Snowdrop Ward
Sorrel Ward
Whitley Health and Social Ser..

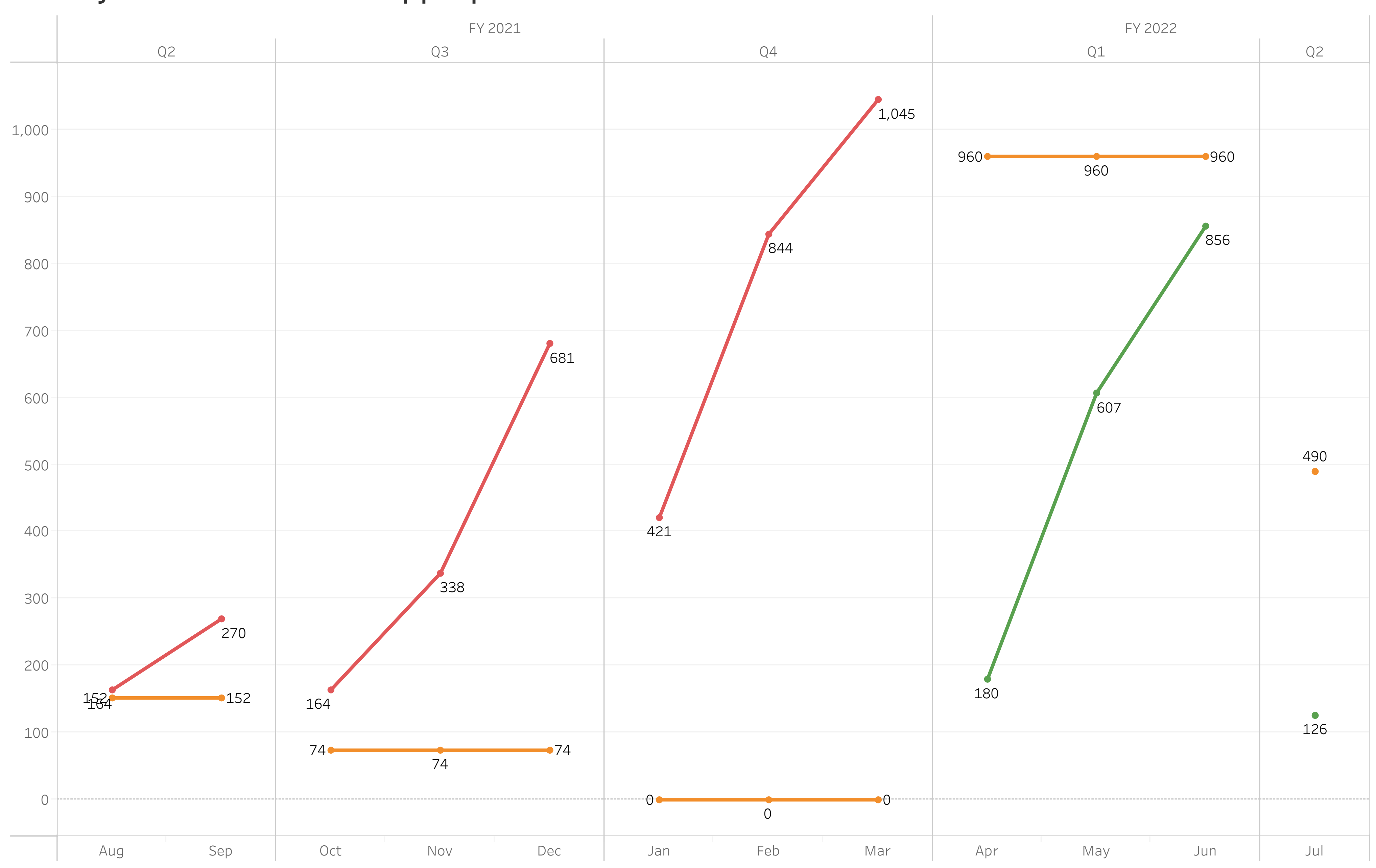


Money Matters: Mental Health Acute Bed Occupancy Rate (Aug 19 to Jul 21)
110%
108%
106%
104%
102%
100%
98%
96%
94%
92%
90%
88%
86%
84%
82%
80%
78%
76%
74%
72%
UCL
LCL
96.1%
Target: 85% occupancy
Jul 19
Sep 19
Nov 19
Jan 20
Mar 20
May 20
Jul 20
Sep 20
Nov 20
Jan 21
Mar 21
May 21
Jul 21


Money Matters Driver: MH Acute Bed Occupancy by Unit (July 2021)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Target: 85% occupancy
98.1%
96.6%
92.4%
97.4%
Bluebell Ward
Daisy - ACUTE Ward
Rose Ward
Snowdrop


Money Matters: Mental Health: Acute Average Length of Stay (bed days) (July)
60
55
50
45
40
35
30
25
20
15
10
5
0
UCL
48.8
Target: 30 days
LCL
Jul 19
Sep 19
Nov 19
Jan 20
Mar 20
May 20
Jul 20
Sep 20
Nov 20
Jan 21
Mar 21
May 21
Jul 21

Money Matters Driver: Inappropriate Out of Area Placements



True North Harm Free Care Summary

Tracker Metrics

Metric	Threshold / Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Pressure ulcers acquired due to lapse in (Inpatient Wards)	<10 incidents	0	0	0	0	0	1	1	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community East)	< 6 incidents	0	0	0	0	2	0	0	0	0	0	0	0
Pressure ulcers acquired due to lapse in (Community West)	< 6 incidents	0	1	0	0	0	0	0	0	0	0	0	0
Mental Health: AWOLs on MHA Section	16 per month	2	2	3	9	3	3	2	10	5	3	4	8
Mental Health: Absconsions on MHA section(Excl: Failure to return)	8 per month	3	4	4	3	0	9	10	4	5	11	13	9
Mental Health: Readmission Rate within 28 days: %	<8% per month	4.95	6.33	7.43	6.65	5.89	7.09	8.59	8	6.60	7.29	8.40	8.30
Patient on Patient Assaults (LD)	4 per month	4	2	0	3	0	3	1	1	0	0	1	1
Uptake of at least one patient outcome measure (ReQoL) in adult Mental Health for new referrals from April 2019[Suspended c..	15% by March 2020; 20% by June 2021	13.6%	13.7%	13.4%	12.6%	12.9%	13%	12.9%	13.9%	14.4%	14.2%	13.1%	13.8%
Suicides per 10,000 population in Mental Health Care (annual)	8.3 per 10,000	5.2	5.2	5.2	5.2	5.2	5.2	4.9	4.9	4.9	4.9	4.9	4.9
Self-Harm Incidents within the Community [Suspended centrally due to COVID]	31 per month	0	2	1	1	0	1	0	1	2	4	0	0
Smoking Status Recorded	55% until Sep 21										48%	60.1%	65.4%

True North Patient Experience Summary

Tracker Metrics

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Mental Health: Prone (Face Down) Restraint	4 per month	2	3	1	5	1	6	7	5	4	6	9	5
Patient on Patient Assaults (MH)	38 per month	12	21	7	14	11	9	25	8	18	17	15	16
Health Visiting: New Birth Visits Within 14 days: %	90% compliance	91.1%	91.1%	92.7%	92.0%	91.2%	94.5%	95.0%	91.2%	88.2%	94.3%	94.1%	96.7%
Mental Health: Uses of Seclusion	13 in month	16	8	15	11	9	4	12	4	11	15	13	15

True North Supporting Our Staff Summary

Tracker Metrics

Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Gross vacancies: % [Suspended centrally due to COVID]	<10%												
Statutory Training: Fire: %	95% compliance	91.3%	92.9%	92.4%	91.1%	92.3%	91.5%	85.0%	83.7%	90.2%	91.5%	91.5%	90.8%
Statutory Training: Health & Safety: %	90% compliance	95.6%	95.9%	96.0%	95.0%	95.9%	95.7%	92.5%	92.5%	95.1%	95.1%	95.1%	95.0%
Statutory Training: Manual Handling: %	90% compliance	91.1%	92.3%	92.5%	93.1%	94.0%	93.8%	86.0%	95.0%	87.8%	88.6%	88.9%	90.0%
Mandatory Training: Information Governance: %	95% compliance	92.2%	94.7%	94.0%	94.8%	95.2%	93.8%	89.0%	88.4%	92.0%	91.9%	94.7%	92.0%
PDP (% of staff compliant) Appraisal: %	95% compliance 'by 30th June 2021'	87.3%	95.5%	95.3%	94.4%	91.9%	88.9%	88.1%	86.1%	10.0%	74.4%	90.7%	95.4%

Mental Health Inpatient Services – Fire training compliance

Competence (group)	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Fire Safety Training - Whole Service	95%	94.8%	96.5%	96.6%	94.4%	96.6%	95.6%	88.4%	90.5%	92.7%	94.1%	93.5%	93.3%

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
371 Bluebell Ward PPH	95%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%	84.8%	93.5%	92.9%	83.3%
371 Daisy Ward PPH	95%	96.2%	93.8%	100.0%	96.3%	100.0%	93.3%	84.4%	86.7%	88.9%	74.1%
371 Orchid Ward PPH	95%	92.0%	96.2%	82.8%	92.6%	93.1%	96.4%	87.5%	93.3%	93.5%	96.7%
371 Rose Ward PPH	95%	96.3%	100.0%	100.0%	96.4%	100.0%	96.0%	76.7%	87.1%	90.0%	90.3%
371 Rowan Ward PPH	95%	100.0%	100.0%	94.1%	91.7%	94.1%	91.4%	80.6%	91.7%	100.0%	100.0%
371 Snowdrop Ward PPH	95%	96.9%	100.0%	96.6%	96.0%	96.2%	92.0%	67.7%	75.0%	81.5%	75.0%
371 Sorrell Ward PPH	95%	93.3%	100.0%	100.0%	100.0%	97.1%	96.8%	87.9%	90.6%	90.6%	90.3%

Community Health – Fire training compliance

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
371 Community Health East Services	Fire Safety Training - Whole Service 95%	96.4%	97.8%	96.0%	93.1%	96.3%	94.9%	89.0%	91.7%	92.1%	94.1%	94.6%	93.1%
371 Community Health West Services	Fire Safety Training - Whole Service 95%	93.8%	95.6%	97.0%	95.2%	96.7%	96.0%	87.9%	89.8%	93.1%	94.1%	92.7%	93.5%

CH IP Fire Safety Breakdown

		Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21
371 Henry Tudor Ward	95%	89.7%	100.0%	92.9%	92.9%	100.0%	86.7%	87.5%	97.0%	97.0%	97.0%
371 Jubilee Ward	95%	93.5%	100.0%	100.0%	96.8%	96.6%	96.9%	87.9%	96.9%	100.0%	100.0%
371 Oakwood Ward	95%	95.2%	95.7%	95.5%	97.9%	100.0%	97.7%	79.6%	80.4%	88.2%	96.2%
371 WBCH Inpatient Wards	95%	96.3%	96.2%	96.1%	91.5%	96.1%	96.2%	90.6%	90.0%	95.3%	95.3%
371 Wokingham InPatient Unit	95%	93.5%	96.7%	98.4%	98.4%	98.3%	95.2%	86.7%	90.8%	100.0%	100.0%

Campion & Willow House – Fire training compliance

Org Level7	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
371 LD - Campion Unit	95%	93.3%	96.9%	97.1%	91.2%	100.0%	94.6%	94.9%	97.4%	97.4%	97.2%	97.2%	94.6%
371 Willow House	95%	100.0%	100.0%	94.7%	88.0%	95.0%	90.5%	86.2%	86.2%	90.9%	100.0%	100.0%	

True North Money Matters Summary

Tracker 1

Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Mental Health: Delayed Transfers of Care (NHSI target) Monthly and Quarterly [Suspended centrally due to COVID]	7.50%	2.60	4.29	9	4.29	3.59	3.30	2	3.50	3.10	3	4	5.09

Tracker Metrics

Metric	Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Community Inpatient Occupancy: % [Suspended centrally due to COVID]	80-85% Occupancy	73.5%	72.8%	74.7%	72.7%	79%	83.5%	75.0%	70%	82.0%	83.5%	86%	85%
Mental Health: Non-Acute Occupancy rate (excluding Home Leave): % [Suspended centrally due to COVID]	80% Occupancy	67.06%	75.68%	75.68%	65.10%	66.21%	73.42%	73.04%	69.89%	74.37%	77.48%	78.36%	86.46%
DNA Rate: % [Suspended centrally due to COVID]	5% DNAs	4.29%	4.59%	4.29%	4.39%	4.20%	4.29%	4%	4.29%	4.5%	4.29%	7.5%	4.90%
Community: Delayed transfers of care Monthly and Quarterly [Suspended centrally due to COVID]	7.5% Delays	6.5%	5.29%	10.1%	2.5%	7.29%	10.6%	6.70%	10.6%	7.79%	7.19%	5.60%	9.70%

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
Mental Health: 7 day follow up (Quality Domain): %	95% seen	94.1	97.7	98.6	97.2	100	96.2	93.7	96.5	96.6	91.2	95.8	95
C.Diff due to lapse in care (Cumulative YTD)	0	0	0	0	0	0	0	0	0	0	0	0	0
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in inpatient wards: %	90% treated	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1	42.1
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in EIP: %	90% treated	88	88	88	88	88	88	88	88	88	88	88	88
Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the Audit of Community Health Services (people on CPA): %	65% treated	21	21	21	21	21	21	21	21	21	21	21	21
Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia infection rate per 100,000 bed days	2 in East; 4 in West	0	0	0	0	0	0	0	1	0	0	0	1
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemias	0	0	0	0	0	0	0	0	0	0	0	0	1
Mixed-sex accommodation breaches [Suspended centrally due to COVID]	Zero tolerance	0	0	0	1	0	0	0	0	0	0	0	0
Count of Never Events in rolling six- month period (Safe Domain)	0	0	0	0	0	0	0	0	0	0	0	0	0
Number of children and young persons under 16 who are admitted to adult wards (Safe Domain)	Zero tolerance	0	0	0	0	0	0	0	0	0	0	0	0
EIP: People experiencing a first episode of psychosis treated with a NICE approved package of care within 2 weeks of referral: %	56% treated	100	100	91.7	100	100	88.9	75	88.9	90.9	75	80	67
A&E: maximum wait of four hours from arrival to admission/transfer /discharge: %	95% seen	98.2	98.7	97.8	98.6	98.0	98.9	98.0	99.2	98.4	99.3	99.3	98.9
People with common mental health conditions referred to IAPT will be treated within 6 weeks from referral: %	75% treated	96	98	98	98	98	98	98	99	98	98	98	98
People with common mental health conditions referred to IAPT will be treated within 18 weeks from referral: %	95% treated	100	100	100	100	100	100	100	100	100	100	100	100

Regulatory Compliance - Tracker Level 1 Summary

Metric	Threshold / Target	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21
People with common mental health conditions referred to IAPT completing a course of treatment moving to recovery: %	50% treated	56.1	57.4	58.5	60.5	53.3	54.9	52.7	53.8	54	55.0	54	54
% clients in Mental Health Services in Settled Accommodation	58% in Settled Accommodation	59	69	69	69	69	69	69	68	68	71	71	71
% clients in Mental Health Services in Employment [Suspended centrally due to COVID]	9% in Employment	12	14.0	14.0	14.0	14.0	14.0	14.0	14.0	14.0	15	15	15
Proportion of patients referred for diagnostic tests who have been waiting for less than 6 weeks (DM01 - Audiology): % [Suspended centrally due to COVID]	99% seen	97.8	98.2	100	100	99.5	99.6	99.1	99.6	99.3	99.2	99.7	100
Diabetes - RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	100	100	100	100
CPP- RTT (Referral to treatment) waiting times - Community: incomplete pathways (how many within 18 weeks): %	95% seen	100	100	100	100	100	100	100	100	98.6	100	98	100
Sickness Rate: %	<3.5%	3.23	3.25	3.60	4.29	4.08	4.73	3.50	3.04	3.46	3.43	3.83	
Staff - Count of those categorised as extremely likely or likely to recommend (Quality of Care Domain) - For IP, A&E, MH & Community	Null	83	83	83	83	83	83	83	83	83	83	83	83
Finance Score - Was Continuity of Services Risk Rating now Use of Resources [Suspended centrally due to COVID]	Month 1=3, months 2 to 5 =2 then month 6 onward=1												
MHSDS DQMI score (Figures reported are 3 months in arrears)	95% achieved	98.9	98.7	98.9	99.0	99	97.0	97.5	97.5	99	97.3	99.0	98.9
Patient Safety Alerts not completed by deadline	0	0	0	0	0	0	0	0	0	0	0	0	0

Trust Board Paper

Board Meeting Date	14 September 2021
Title	**Finance, Investment and Performance Committee – Terms of Reference**
Purpose	To ratify the proposed changes to the Committee's Terms of Reference as highlighted in red type.
Business Area	Corporate
Author	Company Secretary on behalf of Mark Day, Committee Chair
Relevant Strategic Objectives	True North Goal – Finance
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equalities and Diversity Implications	N/A
SUMMARY	The Finance, Investment and Performance Committee has reviewed its terms of reference. The Committee agreed that its remit would be extended from overseeing the Trust's Recruitment and Retention activity to overseeing the implementation of the People Strategy.
ACTION REQUIRED	The Trust Board is requested to ratify the proposed changes to the Committee's Terms of Reference.

Finance, Investment & Performance Committee

Terms of Reference

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Document Control

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

1. Authority

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

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

2. Purpose

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

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

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

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

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

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

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

2.1.7 review the relevant risks on the Board Assurance Framework.

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

2.1.9 Review the Trust's Employee Casework

3. Membership

3.1 The members of the Committee shall be as follows:

- Three Non-Executive Directors

- Chief Executive
- Chief Financial Officer (Lead Executive Director)
- Chief Operating Officer
- Director of Nursing & Therapies or Deputy Director of Nursing
- Director of Finance will be in attendance at the meetings

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

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

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

4. Frequency and Administration of Meetings

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

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

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

5. Remit

5.1 Financial Policy and Performance

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

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

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

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

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

5.2 Investment Policy and Performance

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

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

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

5.2.4 To ensure adequate safeguards on investment of funds.

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

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

5.2.7 To review investment performance and risk.

5.3 Organisational Performance Assurance

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

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

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

Amended: ~~August 2020~~ August 2021

Approved by Trust Board:

For review August 202~~1~~2

Trust Board Paper

Board Meeting Date	14th September 2021
Title	Equality, Diversity and Inclusion (EDI) activity mid-year review
Purpose	The production of an Annual Equality report is required as part of our compliance with the Equality Act 2010 and provides an important overview of information about the people who use our services, our staff and our progress against key objectives. This mid-year review serves to update Trust Boars on our progress in achieving these objectives.
Business Area	Corporate
Author	Nathalie Zacharias- Director of Equality, Diversity and Inclusion
Relevant Strategic Objectives	Supports all strategic objectives
CQC Registration/Patient Care Impacts	Our Equality, Diversity and Inclusion Strategy supports delivery of safe, good quality care and a good experience of care for patients, and this report is relevant to the CQC "well led" domain.
Resource Impacts	None
Legal Implications	Equality Act 2010
Equality and Diversity Implications	This report provides a summary of progress regarding both patient and workforce priorities identified in our Equality, Diversity and Inclusion Strategy 2021-2024.
SUMMARY	Our EDI strategy identifies five key priorities for our people and six priorities for our patients and communities. Our focus is on creating a culture of inclusion and belonging and eliminating differentials in experience.
ACTION	The Board is asked to note the progress made against the strategy priorities and support the recommended areas of focus for the following six months.

Equality, Diversity and Inclusion activity mid-year review

1. Introduction

This report provides a mid-year review to the Trust Board on the progress made against the Trust's Equality, Diversity and Inclusion (EDI) Strategy 2021-24 and highlights the achievements made over the past six months. It also sets out the key areas of focus for the next 6 months, to ensure delivery of our key workforce and patient objectives.

The Diversity Steering Group (DSG) continues to provide leadership, scrutiny and accountability to ensure all Equality, Diversity and Inclusion initiatives are in line with these objectives.

Since the launch of the new strategy in February 2021, the Equality and Diversity work focusing on our staff and patients has continued to build momentum with some positive outcomes being achieved. This is in line with the objectives of our strategy, building a clear communication around eliminating differentials in experience and opportunity, making Berkshire Healthcare outstanding for everyone.

We have communicated our priority to focus on EDI as a Trust, linking in with the People Strategy priorities in a series of roadshows over July and August. These were attended by nearly 500 staff.

There is now a dedicated EDI team, including a lead for workforce and a lead for patients with administrative support for the 3 staff networks. As of July 2021, this team also includes the Organisational Development (OD) leadership team as well as the personal safety and violence reduction team as these strands of work are key priorities in our strategy, reporting to the Director of People.

This alignment of the EDI has enabled closer collaboration between Human Resources, Communications, Learning Development and the OD team.

2. Equality Strategy: current progress towards our goals

Our 2021-2024 strategy identifies five key priorities for our people and six priorities for our patients and communities. Our focus is on creating a culture of inclusion and belonging and eliminating differentials in experience:

Our People:

- Address and reduce inequalities and differentials in experience, focusing on bullying, harassment and microaggressions, disciplinaries and grievances and career progression - aligned to workforce retention in the people strategy.
- Embed inclusive and compassionate leadership approaches.
- Develop workforce career progression and talent management.
- Strengthen and develop our staff networks including making them more inclusive to facilitate allyship.
- Develop and deliver our inclusive "Ready for Change" programme which builds on the "Making it Right" programme and will focus on the culture change required based on allyship and a greater appreciation of the different cultural norms that can cause misunderstandings and miscommunication. This is referred to as "cultural intelligence".

Our Patients:

- Embed the Accessible Information Standard for disabled patients across all services.
- Embed reasons for and recording of patient demographics to improve health outcomes.
- Identify actions and resources needed to identify health inequalities through community engagement.
- Continue to promote LGBT+ engagement and support through Stonewall and Reading Pride.
- Develop strengths-based inclusive recruitment with services.
- Co-produce actions and resources needed for Trans patient’s pathways.

The table below provides a summary of progress against the five priorities for our workforce.

Equality Strategy - Goal	Progress
1. Address and reduce inequalities and differentials in experience, aligned to workforce retention in the people strategy.	The focus on differentials in experience includes 3 areas: **Bullying, harassment, and microaggressions**. A targeted QI project at PPH focusing on racial abuse. It is recognised that the staff in this service are subject to a number of incidents daily and there is significant under reporting and a lack of support for those affected. The following priority countermeasures have been identified via an A3: 1. Standard work/flow chart about all the steps that will be taken to respond to incidents. 2. Use QMIS to reverse de-sensitisation of staff - all wards tracker metric about racial abuse. 3. Run a campaign - safety cross visual info about how we are doing on any forms of racial abuse, raise awareness and sense of openness, comms, posters, celebrating each day of success. 4. PPARET service (Prospect Park advocacy for racial equality team) - safe space for people to be able to speak up, facilitate, mediate, reconciliate, recommend, communication channels. Reduction of bullying and harassment is also a workstream of the BAME transformation programme. The EDI team, violence reduction team and Freedom to Speak up Guardian are running drop-in sessions in a dedicated space at PPH for staff to share their experiences and get support. 5. Staff racial crisis team/line - line or service that is an immediate platform to offload. 6. Standard work/formal escalation process to give different options when informal/local resolution hasn't worked - would include follow up conversations, feedback on outcomes, support from SLT. 7. Make Datix form more user friendly for reporting these kinds of incidents and coaching sessions with staff to build confidence in reporting. 8. Customised follow up message following the submission of the Datix form when reporting these incidents and option to indicate whether you are satisfied, follow up actions to take if not satisfied.

Equality Strategy - Goal	Progress
	A training programme to educate staff regarding micro aggressions and their impact on others is in development and will be piloted in the Learning Disability services prior to wider roll out. **Disciplinaries and grievances** The disciplinaries and grievances BAME transformation programme workstream is focused on PPH which accounts for the highest number of disciplinaries involving our BAME staff. The aim is to reduce disciplinaries involving BAME staff by 50% in the next 12 months. The impact of the new Just Culture approach is already evident with a significant reduction in disciplinaries and suspension of staff in all areas and feedback from staff that they feel the approach is fairer. **Career progression**: Career progression is the third workstream of the BAME transformation programme. A survey is in progress to understand what our staff mean by career progression and to help identify the key areas for focus. A training programme targeting band 2-6 has been developed and rolled out for all staff who wish to progress in their career. This is called “Reaching My Potential”. In March 2021 the National EDI team launched the six national key actions to overhaul recruitment and address the issues with career progression (race disparity ratio). The objective is to support the target set by Sir Simon Stevens in 2020 of achieving 19% BME (Black and Minority Ethnic) representation across all staff pay bands by 2025. These actions align to the priorities that we have set in both the people and EDI strategies and the action plans Berkshire Healthcare have submitted reflect the work we have already identified as a priority. The South East EDI team is supporting the six Integrated Care Systems (ICS) and 34 providers in the South East Region to establish structures, processes and performance measures to deliver on the six actions. The six actions are aligned with indicators 2 and 9 of the WRES. The action plan set out by Berkshire Healthcare is in Appendix 1. To support the new reasonable adjustments policy for our disabled staff, the EDI team produced a quick guide to support both staff and managers and ran a number of drop-in sessions to discuss concerns and answer questions. There is now a centralised budget managed by the EDI team to ensure all staff that need any equipment purchased to support their reasonable adjustments can access the funding.
3.Develop workforce career progression and talent management at all levels.	The focus for the next six months is to review and improve the Trust’s recruitment process to ensure it is more inclusive and results in the employment and retention of a more diverse workforce. This will include the action plan we have set to address the six national actions. The recruitment to a new talent management post is in progress and will support the talent management processes already in place for the

Equality Strategy - Goal	Progress
	Trust's senior leadership team but will also focus on developing a pipeline of talent at the lower bands. The regional NHE E/I team has set up a South East Talent and Leadership Alliance and the priorities identified by this group will continue to inform our work in this area. There is already strong alignment across talent, leadership and EDI in the Trust.
4.Strengthen and develop our staff networks including making them more inclusive to facilitate allyship.	The role of the network chair has been operationalised for our three staff networks. Each of the network chairs has a role descriptor, a half a day a week protected time and one day a week administration support. We are ensuring parity in process across all three networks and at the end of March 2022, the network chair role in all three networks will be re-elected for a two-year term. The executive sponsor and BAME network committee members completed the two modules of the "Ready for Change" programme in July and this will be offered to the remaining two networks over the coming months. The feedback from all participants was excellent confirming the training had increased their awareness of challenges of staff with different protected characteristics and the importance of developing the culture of allyship and inclusion across the organisation.
5.Develop and deliver our inclusive "Ready for Change" programme which builds on the "Making it Right" programme and will focus on the culture change required based on allyship and a greater appreciation of the different cultural norms that can cause misunderstandings and miscommunication. This is referred to as "cultural intelligence".	The review of the "Making it Right" programme suggested that an alternative approach was required to ensure there is a sustained cultural change in the organisation. The new "Ready for Change" programme will focus on our leaders and managers and includes 2 modules: Module 1: Towards Allyship Module 2: Emotional and Cultural Intelligence The roll out of this programme is in progress with the pilot including the HR and OD teams. The current focus is on managers and leaders at PPH. A roll out plan informed by services with highest need and business case to recruit and train additional trainers for a wider roll out is in progress. Further detailed information regarding the two modules is in Appendix 2.

The table below provides a summary of progress against the 6 priorities for our patients.

Equality Strategy- Goal	Progress
1.Embed the Accessible Information Standard for disabled patients across all services. The Accessible Information Standard is legislation introduced in 2016. It is designed to capture the communication needs of disabled people accessing services to make sure they are not treated unfavourably in comparison to non-disabled people by providing information in formats that are accessible to them, with a particular focus on patients with visual and hearing impairment. Berkshire Healthcare has a legal requirement to meet all communication needs of our disabled patients.	This work will be the focus over the next six months: • To adapt the communication form within RiO and other platforms used in our services to include the four questions within the standard. • To develop and roll out training/engagement and communication for all services to understand the legal requirements within the standard and how to complete the form on RiO. • To purchase and distribute communication grab bags for all services and provide training for teams on how to use them.
2.Embed reasons for and recording of patient demographics to improve health outcomes. Patient equality, diversity and inclusion data relating to the nine protected characteristics is not captured, recorded, or reported consistently or in the same way across the Trust.	The demographic data sets for all of the nine protected characteristics have been identified using ONS guidance and best practice. This will be the focus for the next 6 months. These will be signed off by DSG in September and shared with system partners in BOB and Frimley who wish to align their patient demographic data with ours. These data sets will then need to be updated in RIO and other electronic patient records followed by a communication campaign educating staff as to the importance of asking and recording patient demographics.
3.Identify actions and resources needed to identify health inequalities through community engagement.	Berkshire has a reducing health inequalities steering group that monitors progress in current health inequalities workstreams across the Trust. In addition to this, the EDI team support services who have identified health inequalities and support them to identify appropriate actions and are currently working with the MSK Physio services who have poorer outcomes regarding pain management for SE Asian women.
4.Continue to promote LGBT+ engagement and	Berkshire Healthcare is leading on a larger NHS health space with Royal Berkshire Trust at Reading Pride in September.

Equality Strategy- Goal	Progress
support through Stonewall and Reading Pride.	We will showcase health and wellbeing services within the local area and will be running a programme of mini events, workshops and sessions throughout the day. We continue as Stonewall Diversity Champions for the 8th year and are working towards our 2021 submission at the end of September. The process of our annual submission provides assurance that Berkshire Healthcare is making improvements that impact on our LGBT + community; including procurement, workforce and people who use our services.
5.Develop strengths-based inclusive recruitment with services. Less than 6% of people with a Learning disability, 15% of people with Autism and 20% of people with a severe and enduring mental health condition, have access to paid employment, yet 68% of people want a paid job. Recruitment processes remain the greatest barrier to accessing talented people from within these communities.	This is a key focus for the next six months. Working with HR and recruitment colleagues, the EDI team will establish a recruitment and induction process that is accessible and inclusive for people with lived experience of severe and enduring mental health conditions to take up employment in our mental health service in lived experience/peer mentor roles. This will include recruitment using a strength- based approach, producing accessible job descriptions, considering job carving in suitable roles and identifying training support required. As the inclusive recruitment work and review of our current processes progresses, these two strands of work will be combined with the overall focus on inclusive recruitment for all.
6.Co-produce actions and resources needed for Trans patient's pathways. Berkshire Healthcare receives a disproportionate number of complaints from Tran's patients and our people consistently report not being confident supporting Trans patients.	The aim is to develop a clear pathway for improving the systems and addressing health inequalities with Berkshire Healthcare. These will be based on the agreed priorities following engagement and co-production with Trans patients, Trans community groups and national Trans charities. The project team has been established including representation from all divisions. Work is in progress with the transformation team and IG to map how Trans people who use our services can have clinical records reflecting their gender identity.

3. Statutory reporting

Workforce Race Equality Standard

In 2021, progress was made in 4 of the indicators, however there is stagnation and/or regression in 5 of the metrices. Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BME representation at Board level.

Overall, BAME staff have a poorer work experience than White staff – this has been the trend since the WRES was mandated in 2015. Areas that saw an improvement include:

- As at 31st March 2021 the Trust grew by 248 employees (from 4,460 in 2020) to 4,708 members of staff: 3,299 (71%) were White and 1216 (26%) were from a BAME background. This represents an increase of 1% in the BAME staff population since 2020. The BAME staff population at Berkshire Healthcare has continued to rise gradually annually and currently sits at 5% above national average - see the snapshot in Table 13 (Appendix 1).
- A reduction in the percentage of staff experiencing harassment, bullying or abuse from their colleagues.
- A slight decrease in the percentage of staff experiencing discrimination at work from manager / team leader or other colleagues.
- An increase in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion.

However:

- There is underrepresentation of BAME staff with voting membership on the Board.
- BAME staff are less likely to be appointed from shortlisting than White staff.
- BAME staff are more likely to enter the formal disciplinary process than White staff.
- BAME staff are less likely to access non-mandatory training and continued professional development compared to White staff.
- BAME staff are more likely to experience harassment, bullying or abuse from patients, relatives and the public than White staff.
- BAME staff are more likely to experience discrimination at work from either their manager, team leader or colleagues than White staff.
- BAME staff are less that likely to believe the Trust provides equal opportunities for career progression or promotion than White staff.

Workforce Disability Equality Standard

The key findings from the 2021 report showed that Berkshire Healthcare continues to make incremental progress in tackling and removing barriers faced by staff with a Disability and individuals seeking employment with the Trust. Notable improvements were made in 6 out of the 10 WDES indicators of disability equality. However, Disabled staff have a poorer work experience than Non-Disabled staff overall. Areas that saw an improvement include:

- The number of Disabled staff has remained consistent at 5% of the total workforce.
- The Trust has taken action to facilitate the voices of Disabled staff – the role of the Chair of the Purple Network has been operationalised and allocated protected time (half a day a week).
- An increase in the National Staff Survey engagement score for Disabled staff for the third year running.
- 77% of Disabled staff report that the Trust has made adequate reasonable adjustments to enable them to carry out their work.
- Increase in the likelihood of Disabled staff being appointed from shortlisting, though still behind Non-Disabled staff.

- A significant reduction in the likelihood of Disabled staff entering the formal capability process.
- A reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from their manager and colleagues.

However:

- 11% of the workforce have not declared their disability status.
- Disabled staff are more likely to experience harassment, bullying or abuse from patients, service users, relatives, the public, their manager and colleagues than Non-Disabled staff.
- Disabled staff are more likely to report harassment, bullying or abuse than Non-Disabled staff.
- Disabled staff are less likely to believe the Trust provides equal opportunities for career progression or promotion that Non-Disabled staff.
- Presenteeism: Disabled staff are more likely to come to work despite not feeling well enough than Non-Disabled staff.
- An increase in the percentage of Disabled staff saying that they felt pressure from their manager to come to work despite not feeling well enough to perform their duties.
- Decline in the percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion.
- There is no Disabled staff representation on the Board with voting membership.

4. Recommendations for future reporting

In 2019 it was agreed that EDI reports to Board would be in November and an annual report in May from 2021. This did not happen due to the COVID pandemic as well as the new EDI strategy that was signed off by Board in February.

This paper provides the midway update, so the next EDI report will be the annual report in May 2022, with the midway report in November 2022.

APPENDIX 1:

ACTION PLAN FOR IMPLEMENTION NATIONAL 6 KEY ACTIONS; AN OVERHAUL OF RECRUITMENT AND PROMOTION

#	Key Action	Steps to achieve action
1.	Ensure Executive Senior Managers own the agenda, as part of culture changes in organisations, with improvements in BAME representation (and other under-represented groups) as part of objectives and appraisal by: a) Setting specific KPIs and targets linked to recruitment. b) KPIs and targets must be time limited, specific and linked to incentives or sanctions.	The Trust board has agreed a three-year EDI strategy from 2021-24 to address the differentials in experience between BAME and white staff with regards to bullying and harassment/career progression and grievances and disciplinaries.
2.	Introduce a system of 'comply or explain' to ensure fairness during interviews This system includes requirements for diverse interview panels, and the presence of an equality representative who has authority to stop the selection process, if it was deemed unfair.	Emphasis will be on transparency and accountability. We will progress with equality representatives on interview panels, but work is needed to identify and recruit these individuals as well as the development and delivery of their required training across all protected characteristics to ensure they are confident and competent to intervene if not fair or if the agreed process is not being followed.
3.	Organise talent panels to: a) Create a 'database' of individuals by system who are eligible for promotion and development opportunities such as Stretch and Acting Up assignments must be advertised to all staff. b) Agree positive action approaches to filling roles for under-represented groups. c) Set transparent minimum criteria for candidate selection into talent pools.	The EDI strategy has identified the need to develop a robust talent management programme, but the focus will be in years 2/3. We are developing a new role to lead on this work from band 7 and above.
4.	Enhance EDI support available to: a) Train organisations and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies. b) Ensure that for Bands 8a roles and above, hiring managers include requirement for candidates to demonstrate EDI work / legacy during interviews.	An updated EIA has been agreed and is used for all clinical and HR policies. This is also now part of the business case process and signed off by clinical Directors. The review of the interview and recruitment process will include a requirement that all interviews for band 8a and above will include a question/ round table discussion or presentation requiring applicants to demonstrate EDI work/ legacy to replace the current question regarding EDI related experience.

#	Key Action	Steps to achieve action
5.	Overhaul interview processes to incorporate: a) Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. b) Ensure adoption of values-based shortlisting and interview approach. c) Consider skills-based assessment such as using scenarios.	Details will be agreed following the reviews outlined in the action plan for improving the race disparity ratio This work forms part of a two-year fundamental review of recruitment and onboarding which will be built around inclusive attraction and recruitment processes.
6.	Adopt resources, guides and tools to help leaders and individuals have productive conversations about race.	An inclusive Ready for Change programme has been designed and tested and roll out focusing on managers and leaders approved. The EDI team have developed and are supporting services in using inclusion cards with their teams to have discussions about real life scenarios shared by our network members. Reverse mentoring offer is in progress for board and VSM's with the aim to grow and roll out across the trust working with the 3 staff networks.

ACTION PLAN FOR IMPROVING RACE DISPARITY RATIO (RDR)

#	Driver of Race Disparity Ratio	Actions taken to improve RDR
1.	Understand what the barriers are in Berkshire Healthcare limiting career progression for the BAME workforce- applications for posts (internal and external)	Analysis of a sample of job applications over a period of six months to understand the ethnicity profile of applicants and why certain groups may not apply for posts/ jobs at certain bands.
2.	Understand what the barriers are in Berkshire healthcare limiting career progression for the BAME workforce- shortlisting	Analysis of sample of BAME applicants not shortlisted over a period of six months for external recruitment and identify why not progressed/ possible barriers for BAME staff being offered interview. This will include identification of where applications may be lacking information to meet shortlisting criteria and identify trends and themes for targeted training and support for staff currently employed and inform the training for recruiting managers.

#	Driver of Race Disparity Ratio	Actions taken to improve RDR
3.	Understand what the barriers are in Berkshire healthcare limiting career progression for the BAME workforce- appointment from interview.	Analysis of outcomes of interviews from the past three months and interview recruiting managers to understand why the staff was appointed and reasons for those not being appointed. This will include reviewing notes taken by the interview panel to check for consistency ins scoring and identification of where there may be inconsistency in scoring between applicants and identify trends and themes for targeted training and support for BAME staff currently employed if found to not be answering certain types of questions well and inform the training delivered to recruiting managers.
4.	Improving the transparency and fairness of the internal secondment process which currently has loose guidelines and no governance or oversight by the recruitment team. Recruiting managers to these secondments have limited accountability to evidence a fair process.	Develop a more formal process for secondments: 1. Visibility of opportunities for staff who do not have access to the internal website. 2. Central system to monitor where line managers are refusing to support secondment applications and why 3. Formalisation and standardisation of the shortlisting and interview process for secondments. 4. Recruiting managers providing HR with a written report detailing why BAME applicants not selected were unsuccessful.

APPENDIX 2: READY FOR CHANGE

Introduction

The Ready for Change programme is an exciting, thought-provoking, inclusive and collaborative developmental tool designed to support staff and leaders at Berkshire Healthcare. It aspires to ensure that all staff have a sense of belonging irrespective of their background, and that managers and leaders are equipped with an inclusive ethos and behaviours so that that they consistently take equitable action and build an organisational culture that supports inclusion for all. It has two modules that are built on feedback sought from multiple stakeholders from within Berkshire Healthcare: representatives from the three staff networks (BAME, Pride and Purple), staff network sponsors, management, staff side and general members of staff willing but reluctant to engage with issues of Equality, Diversity and Inclusion at work as they can be daunting. This programme is divided into two modules that are delivered over two full days. Everyone taking part in this programme will benefit and broaden their understanding of diversity and inclusion and thus contributing to the Trust's journey towards becoming an Outstanding workplace for everyone.

Towards Allyship

This module has three parts.
Part 1: Participants will immerse themselves in the lived experiences of BAME, LGBT+ and staff with a disability to facilitate appreciation of the scale of the challenge faced by certain sections of the workforce.

Part 2: Participants will engage critically with notions of social power and privilege. It will be highlighted that privilege can stem from a range of sources such as one's language, religion, gender, sexual orientation, ability, race, country of origin, socio-economic status etc. However, due to time constraints this module will particularly focus on sexual orientation, gender identity and gender expression, ability status and race as they are central to the Trust's Equality, Diversity and Inclusion Strategy. Participants will be challenged to acknowledge and own their privileges. However, it must be emphasised that the goal is not to make anyone feel guilty but challenged to use their privilege and take an active role as an ally and support disadvantaged colleagues. It must be highlighted here that privilege does not diminish a person's own struggles in life, nor does it mean that they do not deserve the things that they have – they only had fewer barriers to surmount because of who they are.

Part 3: Participants will explore practical steps towards Allyship.

Emotional and Cultural Intelligence

As we are a diverse workforce, this module aims to help staff develop skills to engage strategically in diverse groups. This module is divided into two parts:

Part 1: Participants will explore how they could be themselves with more social-emotional skills.

Part 2: Is designed to equip delegates with essential social intelligence competencies to enable them to read emotions and adapt culturally in order to improve interaction with colleagues from diverse backgrounds.

Is this programme for me?

Yes, if you are willing to:

- challenge yourself and broaden your understanding of inclusion.
- get out of your comfort zone and immerse yourself in difficult but civil and progressive conversations about how social power, privilege, advantage and disadvantage work.
- contribute to Berkshire Healthcare's journey towards being an Outstanding workplace for everyone.

TRUST BOARD PAPER

Board Meeting Date	14th September 2021
Title	Workforce Disability Equality Standard (WDES)
Purpose	To update the Board on the Workforce Disability Equality Standard (WDES) and the progress made over the past 12 months as well as areas of focus over the next 12 months in our action plan.
Business Area	Corporate
Author	Thanda Mhlanga (Equality, Diversity and Inclusion Manager-workforce) Nathalie Zacharias (Director of Equality, Diversity and Inclusion)
Relevant Strategic Objectives	The Trust Equality Diversity and Inclusion strategy and People strategies 2021-2024: • Continue to build a culture of belonging and ensure Berkshire Healthcare is 'Outstanding for everyone' • Have a duty of care for staff with existing disabilities and members of staff who may develop a disability whilst employed by the Trust. • To facilitate an inclusive, supportive and fair organisational culture that is underpinned by allyship where every member of our diverse workforce has a sense of belonging and a positive working experience. • Recognise the added value that a diverse workforce brings.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty
Equality and Diversity Implications	The NHS WDES became a requirement as of 1st April 2019 to enable NHS organisations to capture and compare the experiences of disabled staff with those of non-disabled staff. The WDES is underpinned by the Social Model of Disability which argues that people are disabled because of societal barriers, rather than long-term health conditions.
EXECUTIVE SUMMARY	The WDES is underpinned by ten metrics that cover the workforce profile, recruitment and capability processes, experiences of disabled staff, board make up, and the opportunity for disabled staff to voice and air their concerns and to be heard.

	Berkshire Healthcare continues to make progress against previous years with notable improvements made in six out of the ten indicators of disability equality. Our disabled staff however continue to have a poorer experience than their non- disabled colleagues in all areas.
ACTION REQUIRED	To note the WDES results and consequent action plan and approve their publication.

Berkshire Healthcare NHS Foundation Trust

Equality Diversity & Inclusion

Workforce Disability Equality Standard (WDES) Annual Report 2021

To find out more about what Berkshire Healthcare NHS Foundation Trust is doing to be an 'Outstanding and Equal Employer and Care Provider for Everyone', please contact: EDITeam@berkshire.nhs.uk

Executive Summary

The Workforce Disability Equality Standard (WDES) is a requirement for all NHS organisations to publish data and action plans against 10 indicators of workforce disability equality.

This report shows Berkshire Healthcare's latest workforce disability equality data (as at 31st March 2021) and identifies where improvements have been made and where data has stagnated or deteriorated.

The key findings from the 2021 report

Berkshire Healthcare continues to make incremental progress in tackling and removing barriers faced by staff with a Disability and individuals seeking employment with the Trust. Notable improvements were made in 6 out of the 10 WDES indicators of disability equality. However, Disabled staff have a poorer work experience than Non-Disabled staff overall - there is stagnation and/or regression in some of the metrices.

- The number of Disabled staff has remained consistent at 5% of the total workforce.
- The Trust has taken action to facilitate the voices of Disabled staff – the role of the Chair of the Purple Network has been operationalised and allocated protected time (half a day a week).
- An increase in the National Staff Survey engagement score for Disabled staff for the third year running.
- 77% of Disabled staff report that the Trust has made adequate reasonable adjustments to enable them to carry out their work.
- Increase in the likelihood of Disabled staff being appointed from shortlisting, though still behind Non-Disabled staff.
- A significant reduction in the likelihood of Disabled staff entering the formal capability process.
- A reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from their manager and colleagues.

However:

- 11% of the workforce have not declared their disability status.
- Disabled staff are more likely to experience harassment, bullying or abuse from patients, service users, relatives, the public, their manager and colleagues than Non-Disabled staff.
- Disabled staff are more likely to report harassment, bullying or abuse than Non-Disabled staff.

- Disabled staff are less likely to believe the Trust provides equal opportunities for career progression or promotion that Non-Disabled staff.
- Presenteeism: Disabled staff are more likely to come to work despite not feeling well enough than Non-Disabled staff.
- An increase in the percentage of Disabled staff saying that they felt pressure from their manager to come to work despite not feeling well enough to perform their duties.
- Decline in the percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion
- There is no Disabled staff representation on the Board with voting membership.

WDES – Introduction

The Workforce Disability Equality Standard (WDES) was mandated by the NHS Standard Contract in 2018; 2021 is its third year. It comprises of 10 measures (metrics) that compare the working and career experiences of Disabled and Non-Disabled staff in the NHS. The WDES is underpinned by the Social Model of Disability which argues that people are disabled because of societal barriers, rather than long-term health conditions.

With the Social Model of Disability in mind, the WDES seeks to help unmask barriers that have a negative impact on the experiences and career opportunities of Disabled staff in the NHS or disabled applicants seeking employment in the NHS, and thus facilitates transparency and informs year on year improvement.

Through providing comparative data between Disabled and Non-Disabled staff, the WDES illuminates where key differences lie, and thus provides the foundation for the development of Action Plans to enable the tracking of year-on-year progress and amelioration of the challenges.

The data for indicators 1 to 3 and 10 are taken from the Trust's workforce data as at 31st March 2021 and data for indicators 4 to 9 are taken from the Trust's 2020 National Staff Survey results.

The aim of this report is to present the Trust's latest Disability Equality Data and identify where improvements have been made and where there has been stagnation and/or regression.

Workforce Disability Equality Standard Progress in 2020/21

It is pleasing to note improvements in 6 out of the 10 indicators of disability equality:

- Increase in the likelihood of Disabled staff being appointed from shortlisting.
- A reduction in the likelihood of Disabled staff entering the formal capability process.
- A reduction in the percentage of Disabled staff experiencing harassment, bullying or abuse from their manager or colleague.
- An increase in the National Staff Survey engagement score for Disabled staff for the third year running.
- An increase in the number of Disabled staff saying that they are satisfied with the extent to which the Trust values their work.
- 77% of Disabled staff report that the Trust has made adequate reasonable adjustments to enable them to carry out their work.

A number of actions have been taken in the last WDES reporting year that will have attributed to the above improvements, these include:

- Supporting our Purple Network to achieve their objectives: operationalisation of the role of the network Chair (4 hours protected time a week).
- Launch of new Equality Diversity and Inclusion training programme on Allyship.
- Embedding of Equality, Diversity and Inclusion in Leadership and Management training programmes.
- Relaunch of the Reasonable Adjustments Policy with support/guidance given to both managers and staff.
- Work on more inclusive Adverts and Job Descriptions.
- Organisational focus on Bullying and Harassment.
- All Divisions provided with granular data on Equality, Diversity and Inclusion to facilitate targeted interventions.
- Launch of Just and Learning Culture approach to investigations and disciplinaries

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

Table 1: Workforce Profile - Non-Clinical Cohort

Overall Workforce Profile - 2020				Overall Workforce Profile - 2021		
	Disabled	Not Disabled	Missing or Unknown	Disabled	Not disabled	Missing or Unknown
Workforce Total	5%	83%	13%	236 (5%)	3698 (84%)	504 (11%)
Non-Clinical Cohort - 2020				**Non-Clinical Cohort - 2021**		
Cluster 1: Bands 1-4	6.1%	79.7%	14.2%	42 (6%)	574 (82%)	86 (12%)
Cluster 2: Bands 5-7	3.8%	86.4%	9.9%	15 (4%)	306 (87%)	30 (9%)
Cluster 3: Bands 8a-8b	5.2%	82.6%	12.2%	7 (6%)	108 (85%)	12 (9%)
Cluster 4 Bands 8c-9&VSM	2%	78.4%	19.6%	0 (0%)	41 (76%)	13 (24%)

The data presented in Table 1 indicates that 236 staff (5% of the Workforce) have declared a Disability on the Trust's ESR. However, it is important to note that 493 (19% of the NHS Staff Survey respondents) were comfortable to declare their disabilities – this is a significant difference. The declaration rate within the Trust has been consistently at 5% with 504 (11%) members of staff withholding their disability on ESR as at 31 March 2021. However, this is an improvement of 2%: the non-declaration rate was 13% in 2020. Although high non-declaration rates are a national issue, Berkshire Healthcare continues to work on fostering a culture where employees are comfortable to declare. This year, all Divisions within the Trust were given granular data that highlighted their non-declaration rates. Rather than placing emphasis on encouraging staff to declare disabilities, Divisions were encouraged to work on facilitating a Disability Confident Culture through embracing the Trust's Reasonable Workplace Adjustments Policy to support staff.

Table 1 also presents the numbers of disabled and non-disabled staff employed at Berkshire Healthcare at various Agenda for Change (AfC) pay-bands. Whilst there was an increase of 0.8% at Cluster 3 (Bands 8a-8b); Cluster 4 (Bands 8c-9&VSM) shrunk by 2% to 0%.

Table 2: Workforce Profile - Clinical Cohort

Overall Workforce Profile 2020				Overall Workforce Profile 2021		
	Disabled	**Not Disabled**	**Missing or Unknown**	**Disabled**	**Not Disabled**	**Missing or Unknown**
Workforce Total	5%	83%	13%	236 (5%)	3698 (84%)	504 (11%)
Clinical Cohort - 2020				**Clinical Cohort - 2020**		
Cluster 1: Bands 1-4	4.52%	84.97%	10.51%	51 (5%)	845 (87%)	76 (8%)
Cluster 2: Bands 5-7	4.79%	84.76%	10.45%	99 (5%)	1703 (87%)	164 (8%)
Cluster 3: Bands 8a-8b	4.07%	88.89%	7.04%	11 (4%)	260 (91%)	14 (5%)
Cluster 4: Bands 8c-9&VSM	8.89%	80%	11.11%	4 (9%)	37 (82%)	4 (9%)
Cluster 5: Medical and Dental Consultants	2.44%	53.66%	43.90%	3 (3%)	47 (48%)	48 (49%)
Cluster 6: Medical and Dental staff, Non-Consultant Career Grade	5.32%	58.51%	36.17%	4 (5%)	47 (54%)	36 (41%)
Cluster 7: Medical and Dental Staff, Medical and Dental Trainee Grades	0.00%	3.57%	96.43%	0 (0%)	0 (0%)	21 (100%)

The clinical cohort data presented in Table 2 above indicates that there were no substantial changes in the workforce profile.

The NHS WDES Indicators: Metrics 2-4

The following indicators are taken from Berkshire Healthcare data and will be used as a benchmark for the future.

Table 3:Relative likelihood of appointment from shortlisting

Metric	Descriptor	2019/20	2020/21
2	Relative likelihood of Non-Disabled staff compared to Disabled staff being **appointed from shortlisting** across all posts. **A figure below 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to be appointed from shortlisting.*	**1.22**	**1.13**

The data in Table 3 indicates that whilst recruitment trends still favour Non-Disabled staff, the likelihood of Disabled staff being appointed from shortlisting has improved since 2020: Non-Disabled staff are currently 1.13 times more likely to be appointed from shortlisting. However, one would note here that Metric 2 should be used cautiously as it does not capture an accurate picture – not all shortlisted candidates attend their interviews and not all staff will declare that they have a disability at application stage, yet the metric is based on shortlisting figures.

Table 4: Relative likelihood of entering formal capability process.

Metric	Descriptor	2019/20	2020/21
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the **formal capability process**, as measured by entry into the formal capability procedure. **This metric will be based on data from a two-year rolling average of the current year and the previous year.* ** A figure above 1:00 indicates that Disabled staff are more likely than Non-Disabled staff to enter the formal capability process.*	**9.61**	**4.30**

The data in Table 4 shows significant improvement in the relative likelihood of Disabled staff compared to Non-Disabled peers entering the formal capability process based on performance since 2020 which may reflect the new Just Culture approach to casework. However, there are validity concerns with comparing the 2020 and 2021 figures. Previously, calculations were based on annual data, but from 2021 criteria will be based on data from a two-year rolling average of the current year and the previous year, thus the two figures are not directly comparable.

Table 5: Harassment, bullying or abuse in the last 12 months

Metric	Percentage of Disabled staff compared to Non-Disabled staff experiencing harassment, bullying or abuse in the last 12 months from:	Disabled 2018/19	Non-Disabled 2018/19	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21
4 Staff Survey Q13a-d	(a) Patients/Service users, their relatives or other members of the public	35%	22%	30%	23%	30%	20%
	(b) Managers	19%	9%	16%	9%	15%	17%
	(c) Other Colleagues	26%	13%	23%	14%	21%	13%
	(d) Percentage of Disabled staff compared to Non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	60%	55%	53%	61%	54%	59%

Table 5 indicates that the percentage of Disabled staff saying they have experienced harassment, bullying or abuse at work in the last 12 months:

(a) From patients/service users, their relatives or other members of the public has remained consistent at 30%, this is 10% higher than Non-Disabled staff experience.

(b) From managers has decreased by 1%.

(c) From other colleagues has reduced by 2%, however there is still a significant gap of 8% with Non-Disabled staff.

(d) And they or a colleague have reported it has increased by 1%, however it is important to note that Non-Disabled staff are more likely to report their experiences of harassment, bullying or abuse.

Table 6: Opportunities for career progression or promotion

Metric	Equal opportunities for career progression or promotion	Disabled 2018/19	Non-Disabled 2018/19	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21
5 Staff Survey Q14	Percentage of Disabled staff compared to Non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	83%	86%	86%	88%	84%	90%

Table 6 indicates that the percentage of Disabled staff believing the Trust provides equal opportunities for career progression or promotion has decreased since last year by 2% and is 6% less than Non-Disabled staff.

Table 7: Presenteeism

Metric	Presenteeism	Disabled 2018/19	Non-Disabled 2018/19	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21
6 Staff Survey Q11e	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	27%	17%	23%	17%	24%	15%

Table 7 demonstrates that Disabled staff are 9% more likely to feel pressure from their manager to come to work, despite not feeling well enough than Non-Disabled staff. This figure has worsened by 1% since 2020.

Table 8: Satisfaction rate on how organisation values staff's work

Metric	Disabled staff's views / satisfaction with the extent to which their organisation values their work.	Disabled 2018/19	Non-Disabled 2018/19	Disabled 2019/20	Non-Disabled 2019/20	Disabled 2020/21	Non-Disabled 2020/21
7 Staff Survey Q5f	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	44%	58%	54%	61%	55%	67%

Table 8 indicates that 55% of Disabled staff say they are satisfied with the extent to which their organisation values their work, however this is 12% less than Non-Disabled staff. The percentage number of Disabled staff saying this has improved by 1% on 2020 results.

Table 9: Reasonable Adjustments

Metric	Reasonable Adjustments for Disabled staff	2018/19	2019/20	2020/21
8 Staff Survey Q26b	Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	74%	75%	77%

Table 9 indicates that 77% of Disabled staff say that their employer has made adequate adjustments to enable them to carry out their work, meaning that 23% have not had the adjustments required. However, whilst this figure represents an improvement of 2% on 2020's results, it is still 4% behind the national average of 81%.

Table 10: The Engagement of Disabled Staff

Metric	NHS Staff Survey and the engagement of Disabled staff	Disabled 2018/19	Disabled 2019/20	Disabled 2020/21
9 National Survey Staff Engagement Score	(a) The staff engagement scores for Disabled and Non-Disabled staff	7.0	7.0	7.2
	(b) Has Berkshire Healthcare taken action to facilitate the voices of Disabled staff in your organisation to be heard?	**Yes**		

Table 10 shows that the staff engagement score for Disabled staff has increased since last year to 7.2 – a figure that is well above benchmark average of 6.8. However, this is lower than the overall workforce engagement score which is 7.5.

It is worth noting that the Trust has answered 'Yes' to this question and voices of Disabled staff are heard via an active, up and running Purple Staff Network, whose Chair has protected time of half a day each week. The Purple Staff Network has Executive level sponsorship (Deputy Chief Executive Officer). The voice of disabled staff was sought in the co-production of the new People and EDI strategies.

Table 11: Board Representation

Metric	Board Representation: the difference for Disabled and Non-Disabled staff.	Disabled 2018/19	Disabled 2019/20	Disabled 2020/21
10 Board Representation	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.	2%	2%	-5%

The data in Table 11 shows that there is no Disabled staff representation on the Board with voting membership. Staff not declaring their disability status on ESR is prevalent throughout all levels of the organisation, this is demonstrated by 11% of the workforce not reporting their disability status on ESR.

Conclusion and Next Steps

Based on the 2020-21 data the following have been identified as areas of concern that the Trust must focus on for improvement:

- Lack of parity in the recruitment and selection process
- Presenteeism
- Staff who have not declared their disability status
- Disabled staff experiencing harassment, bullying or abuse from patients, service users, relatives or members of the public, their manager and colleagues
- Disabled staff believing the Trust provides equal opportunities for career progression or promotion
- Lack of Disabled representation on the Board with voting membership

With these concerns in mind, the Trust's EDI Improvement Plan (see Appendix 1) outlines actions the Trust will take to respond to the WDES and achieve improvements against the following themes:

- 'De-biasing' and 'inclusivisation' of the recruitment and selection processes
- Eradication of discrimination, bullying and harassment in the workplace
- Equalisation of career opportunities for development
- Increasing disability declaration rates
- Compassionate and inclusive leadership
- Allyship

Appendix 1: EDI Improvement Plan

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
Continue to increase disability declaration rates on ESR	*Staff engagement scores for Disabled* *Declaration rates*	• Discussion of granular Divisional data with EDI Leads. • Continue to promote Reasonable Adjustments Policy – people need to see the benefits of declaring • Communication strategy to raise awareness about ESR data - people need to feel safe to declare.	• Continue to promote Reasonable Adjustment Policy • Continue to offer drop-in sessions to guide managers and staff about Reasonable Adjustment Policies. • Communicate a reminder about the importance of declaration to all staff, and how they can use ESR Self Service functionality to update their personal information.	Ongoing
Rollout of new Ready for Change Programme	*Allyship* *Emotional and Cultural Intelligence*	• Extensive rollout of the programme	• Identify and prioritise Divisions or Teams with greatest EDI need • 'Train the trainer' – have a pool of trainers to increase speed of rollout of programme. • Review delivery and impact of programme	November 2021 December 2021 December 2021
Increase the likelihood of Disabled staff being appointed from shortlisting through improved and inclusive recruitment processes	*Recruitment Processes*	• Place inclusion at the centre of people recruitment • Monitor candidate profiles at all stages of recruitment	• Work with Purple Network and review recruitment process (including job adverts) • Deliver inclusive recruitment training (including unconscious bias) • Invest in a pool of EDI champions to sit on interview panels.	September 2021 January 2022 February 2022
Continue to address the poorer experience of disabled staff reported through the NSS for Bullying and Harassment	*Inequalities and differentials in experience:* • *Just Culture* • *Bullying and Harassment*	• Promote Trust's Zero-Tolerance Policy about bullying and harassment, supported by Comms to reduce violence against our staff by patients and their families. • Appointment of an OD violence reduction lead to tackle issues of violence against our staff.	• Reduction of Bullying and Harassment to be a key deliverable of the newly formed EDI Team. • Continue to promote Reasonable Adjustment Policy. • Continue to offer drop-in sessions to guide managers and staff about Reasonable Adjustment Policies.	Ongoing

		• Continue to promote reasonable adjustments policy and provide guidance and clarity for our staff with a disability and managers. • Work with the Purple Network to improve use of soft intelligence about people's experience, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes.	• Embed Reasonable Adjustments Policy work EDI into Leadership Training for managers • Continue to promote the Reasonable Adjustments Policy through the internal communication channels for staff and managers.	
Continue to invest in developing compassionate and inclusive leadership	*Leadership and Management*	• Continue to thread EDI into Leadership and Management Training	• Review all Leadership and Management Training through EDI lenses. • Embed EDI in Leadership and Management Training. • Alignment of the EDI and OD leadership team, both reporting to the Director of EDI	December 2021 Ongoing
Provide inclusive career progression opportunities for development	*Inequalities and differentials in experience:*	• Use of reliable and robust data – to understand the experiences of our staff and proactively use data to address areas of concern. Work with the Purple Network to improve our use of soft intelligence about people's experiences, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes.	• Career conversations embedded into the annual appraisal process • Implement and fully embed an inclusive talent management system, to support the development of a talent pipeline • Promote and support inclusive access to training, learning and development opportunities, at national, regional and local level, • Identify any specific gaps requiring some targeted or bespoke • Alignment of the EDI and OD leadership team, both reporting to the Director of EDI. A new talent lead post will be recruited to that will report into this new wider team incorporating talent, leadership and EDI.	Ongoing

TRUST BOARD PAPER

Board Meeting Date	14th September 2021
Title	Workforce Race Equality Standard (WRES)
Purpose	To update the Board on the Workforce Race Equality Standard (WRES) and the progress made over the past 12 months as well as areas of focus over the next 12 months in our action plan.
Business Area	Corporate
Author	Thanda Mhlanga (Equality, Diversity and Inclusion Manager-workforce) Nathalie Zacharias (Director of Equality, Diversity and Inclusion)
Relevant Strategic Objectives	The Trust Equality Diversity and Inclusion strategy and People strategies 2021-2024: • Continue to build a culture of belonging and ensure Berkshire Healthcare is 'Outstanding for everyone' • Have a duty of care for our ethnic minority staff (BAME). • To facilitate an inclusive, supportive and fair organisational culture that is underpinned by allyship where every member of our diverse workforce has a sense of belonging and a positive working experience. • Recognise the added value that a diverse workforce brings.
CQC Registration/Patient Care Impacts	Improving employee well-being will positively impact patient care outcomes.
Resource Impacts	N/A
Legal Implications	The Equality Act 2010. Public Sector Equality Duty
Equality and Diversity Implications	The WRES was mandated by the NHS Standard Contract in 2015; 2021 is its sixth year. The WRES is underpinned by a desire to equalise experience between staff who come from BAME backgrounds and their White counterparts. It aims to facilitate an inclusive, supportive and fair culture in organisations to ensure that every member of the NHS' diverse workforce has a sense of belonging and a positive working experience.
EXECUTIVE SUMMARY	The WRES allows NHS Trusts to measure workplace inequalities through nine metrics that compare the working and career experiences of Black, Asian and Minority Ethnic (BAME) and White staff in the NHS. Four of the nine WRES indicators focus on workforce

	composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BAME representation at Board level. Berkshire Healthcare continues to make progress against previous years with notable improvements made in four out of the nine indicators of race equality. Our BAME staff however continue to have a poorer experience than their White colleagues in all areas.
ACTION REQUIRED	To note the WRES results and consequent action plan and approve their publication.

Berkshire Healthcare NHS Foundation Trust

Equality Diversity & Inclusion

Workforce Race Equality Standard (WRES) Annual Report 2021

To find out more about what Berkshire Healthcare NHS Foundation Trust is doing to be an 'Outstanding and Equal Employer and Care Provider for Everyone', please contact: EDITeam@berkshire.nhs.uk

Executive Summary

The Workforce Race Equality Standard (WRES) is a requirement for all NHS organisations to publish data and action plans against nine indicators of workforce race equality.

This report presents Berkshire Healthcare's latest workforce race equality data (as at 31st March 2021) and identifies where improvements have been made and where data has stagnated and/or deteriorated.

The key findings from the 2021 report

Berkshire Healthcare continues to make incremental progress in unmasking and tackling workplace inequalities between Black, Asian and Minority Ethnic (BAME) and White staff that are captured through nine WRES indicators. Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BME representation at Board level. It is pleasing to note that progress was made in 4 of the indicators, however there is stagnation and/or regression in 5 of the metrices. Overall, BAME staff have a poorer work experience than White staff – this has been the trend since the WRES was mandated in 2015:

- As at 31st March 2021 the Trust grew by 248 employees (from 4,460 in 2020) to 4,708 members of staff: 3,299 (71%) were White and 1216 (26%) were from a BAME background. This represents an increase of 1% in the BAME staff population since 2020. The BAME staff population at Berkshire Healthcare has continued to rise gradually annually and currently sits at 5% above national average in the NHS - see the snapshot in Table 13 (Appendix 1).
- A reduction in the percentage of staff experiencing harassment, bullying or abuse from their colleagues
- A slight decrease in the percentage of staff experiencing discrimination at work from manager / team leader or other colleagues
- An increase in the percentage of staff believing the Trust provides equal opportunities for career progression or promotion

However:

- There is underrepresentation of BAME staff with voting membership on the Board
- BAME staff are less likely to be appointed from shortlisting than White staff
- BAME staff are more likely to enter the formal disciplinary process than White staff
- BAME staff are less likely to access non-mandatory training and continued professional development compared to White staff
- BAME staff are more likely to experience harassment, bullying or abuse from patients, relatives and the public than White staff
- BAME staff are more likely to experience discrimination at work from either their manager, team leader or colleagues than White staff
- BAME staff are less that likely to believe the Trust provides equal opportunities for career progression or promotion than White staff

WRES – Introduction

The Workforce Race Equality Standard (WRES) was mandated by the NHS Standard Contract in 2015; 2021 is its sixth year. It is a mirror that allows NHS Trusts to visualise workplace inequalities through 9 measures (metrics) that compare the working and career experiences of Black, Asian and Minority Ethnic (BAME) and White staff in the NHS. The WRES is underpinned by a desire to equalise experience between staff who come from BAME backgrounds and their White counterparts. It aims to facilitate an inclusive, supportive and fair culture in organisations to ensure that every member of the NHS' diverse workforce has a sense of belonging and a positive working experience.

With that ethos in mind, the WRES seeks to help unmask barriers that have a negative impact on the experiences and career opportunities of BAME staff in the NHS or applicants from BAME backgrounds seeking employment in the NHS, and thus facilitates transparency and informs strategies for the amelioration of the challenges that are reviewed annually.

Four of the nine WRES indicators focus on workforce composition and people management, four are based on data from the national NHS Staff Survey (NSS) questions, and one indicator focuses on BME representation at Board level.

Through providing comparative data between BAME and White staff, the WRES illuminates where key differences lie, and thus provides the foundation for the development of Action Plans to enable the tracking of year-on-year progress. This year's Action Plan was built around the Race Disparity Ratio (RDR): the difference in proportion of BAME staff in AfC Band 8 and above vs AfC Band 5 and below in the Trust compared to the proportion of White staff at those Bands. It looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM.

Drawing on the Race Disparity Ratio, this year, 2021, NHS England and NHS Improvement South East proposed a South East Approach where Trusts in the region were tasked with coming up with Six National Actions to address the Race Disparity Ratio in their organisations.

Correspondingly, the aim of this report is to present Berkshire Healthcare's latest WRES data, identify where improvements have been made and where there has been stagnation and/or regression and embed the Trust's Six National Actions that were perceived central to facilitating improvement.

Workforce Race Equality Standard Progress in 2020/21

It is encouraging to note improvements in 4 out of the 9 indicators of race equality:

- Increase in the percentage of the BAME workforce
- A reduction in the percentage of BAME staff experiencing harassment, bullying or abuse from colleagues
- A reduction in the percentage of staff experiencing discrimination at work from manager / team leader or other colleagues
- An increase in the percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion

A number of actions have been taken in the last WRES reporting year that will have attributed to the above improvements, these include:

- Supporting our BAME Network to achieve their objectives: operationalisation of the role of the network Chair (4 hours protected time a week).
- Launch of a new Equality Diversity and Inclusion training programme on Allyship.
- Embedding of Equality, Diversity and Inclusion in Leadership and Management training programmes.
- Commissioning of the BAME Transformation Project.
- Organisational focus on Bullying and Harassment.
- All Divisions provided with granular data on Equality, Diversity and Inclusion to facilitate targeted interventions.
- Launch of Just and Learning Culture approach to casework which is aimed at reducing the disparity in experience between BAME and White Staff in investigations and disciplinaries

Indicator 1: Percentage of staff in each AfC Bands 1 to 9 and VSM compared with the percentage of Black and Ethnic staff in the overall workforce.

Table 1: Workforce Profile - Non-Clinical Cohort 2019-21

Pay Band	2019 Non-Clinical Workforce Data				2020 Non-Clinical Workforce Data				2021 Non-Clinical Workforce Data			
	Total Non-Clinical Staff	White	BME	Ethnicity Unknown	Total Non-Clinical Staff	White	BME	Ethnicity Unknown	Total Non-Clinical Staff	White	BME	Ethnicity Unknown
Under Band 1	10	3 (30%)	1 (10%)	6 (60%)	9	5 (56%)	3 (33%)	1 (11%)	3	2 (67%)	1 (33%)	0 (0%)
Band 1	38	24 (63%)	11 (29%)	3 (8%)	19	12 (63%)	6 (32%)	1 (5%)	13	9 (69%)	3 (23%)	1 (8%)
Band 2	130	107 (82%)	16 (12%)	7 (5%)	144	116 (81%)	25 (17%)	3 (0%)	144	113 (78%)	28 (19%)	3 (2%)
Band 3	261	214 (82%)	42 (16%)	5 (2%)	261	203 (78%)	52 (20%)	6 (0%)	276	217 (79%)	56 (20%)	3 (1%)
Band 4	241	175 (73%)	53 (22%)	13 (5%)	255	191 (75%)	54 (21%)	10 (4%)	266	193 (73%)	63 (24%)	10 (4%)
Band 5	112	84 (75%)	21 (19%)	7 (6%)	121	90 (74%)	24 (20%)	7 (6%)	129	97 (75%)	28 (22%)	4 (3%)
Band 6	124	91 (73%)	29 (23%)	4 (3%)	129	96 (74%)	30 (23%)	3 (2%)	135	95 (70%)	34 (25%)	6 (4%)
Band 7	85	54 (64%)	25 (29%)	6 (7%)	92	60 (65%)	32 (35%)	3 (3%)	87	56 (64%)	28 (32%)	3 (3%)
Band 8a	68	55 (81%)	10 (15%)	3 (4%)	74	58 (78%)	15 (20%)	1 (1%)	88	68 (77%)	19 (22%)	1 (1%)
Band 8b	32	28 (87%)	2 (6%)	2 (6%)	41	37 (90%)	2 (5%)	2 (5%)	39	35 (90%)	3 (8%)	1 (3%)
Band 8c	31	25 (81%)	6 (19%)	0 (0%)	32	26 (81%)	5 (16%)	1 (3%)	32	27 (84%)	4 (13%)	1 (4%)
Band 8d	10	6 (60%)	2 (20%)	2 (20%)	12	8 (67%)	1 (8%)	3 (25%)	14	9 (64%)	2 (14%)	3 (21%)
Band 9	4	2	1	1	4	1	1	2	4	1 (25%)	1 (25%)	2 (50%)
VSM	3	1	0	2	3	2	0	1	4	1 (25%)	0 (0%)	3 (75%)
Total	1149	869	219	61	1119	905	250	44	1234	923	270	41

The data in Table 1 above (non-clinical workforce) and Table 2 below (clinical workforce) indicate that overall, there is an increase in the workforce from a BAME background since 2020.

Non-Clinical Workforce (Table 1): The most significant increases are at Band 8a (22%), which represents 4 additional recruitments/promotion. There was 1 additional recruitment at Band 8b, hence an increase from 5% to 8%. There was also 1 more additional recruitment/promotion at Band 8d which resulted in an improvement of 6% from 1 (8%) to 2 (14%). However, Band 8b shrunk by 3% (1 member of staff).

Clinical Workforce (Table 2): The most notable increases are at Band 7 (25%), 8a (22%) and 8b (16%) which equates to 34 additional recruits and/or promotions at Band 7, and 5 at Bands 8a and 8b respectively. However, Bands 8c and 8d shrunk by 1 member of staff respectively.

One would note here that the issue of staff opting to withhold their ethnicity is prevalent across the AfC Pay Bands: this significantly compromises both the accuracy and integrity of the data, particularly where the respective cohorts have low numbers. For instance, the total number of non-clinical VSM staff is 4; 3 of them represent 75% of that cohort yet have not declared their ethnicity. This shows the sensitivity of the data to small changes in staff numbers at higher levels.

Overall, whilst the improvements are encouraging, the Trust recognises that there is still significant work to be done to achieve race equality within the workforce. In line with the Model Employer strategy and NHS People Plan the Trust is currently setting targets to increase representation of BME staff at Bands 8a to VSM - a concern that has resulted in the launch of a new indicator: the Race Disparity Ratio (RDR).

Table 2: Workforce Profile - Clinical Cohort 2019-21

Pay Band	2019 Clinical Workforce Data				2020 Clinical Workforce Data				2021 Clinical Workforce Data			
	Total Clinical Staff	White	BME	Ethnicity Unknown	Total Clinical Staff	White	BME	Ethnicity Unknown	Total Clinical Staff	White	BME	Ethnicity Unknown
Under Band 1	15	7 (47%)	3 (11%)	5 (33%)	8	5 (63%)	2 (25%)	1 (135)	7	5 (71%)	1 (14%)	1 (14%)
Band 1	0	0	0	0	0	0	0	0	1	1 (100%)	0 (0%)	0 (0%)
Band 2	166	77 (46%)	81 (49%)	8 (5%)	162	71 (44%)	84 (51%)	7 (1%)	171	80 (48%)	83 (49%)	8 (5%)
Band 3	370	270 (73%)	87 (24%)	13 (4%)	371	266 (72%)	98 (26%)	7 (2%)	406	279 (69%)	118 (29%)	9 (2%)
Band 4	340	264 (78%)	58 (17%)	18 (5%)	344	264 (77%)	68 (20%)	12 (3%)	387	295 (76%)	82 (21%)	10 (3%)
Band 5	358	262 (73%)	129 (36%)	29 (8%)	428	266 (62%)	138 (32%)	24 (6%)	438	261 (60%)	162 (37%)	15 (3%)
Band 6	824	606 (74%)	183 (22%)	35 (4%)	838	601 (69%)	199 (24%)	38 (5%)	876	653 (75%)	193 (22%)	30 (3%)
Band 7	558	422 (76%)	121 (22%)	15 (3%)	591	448 (76%)	126 (21%)	17 (3%)	652	472 (72%)	160 (25%)	20 (3%)
Band 8a	194	155 (80%)	33 (17%)	6 (3%)	207	163 (79%)	42 (20%)	2 (1%)	215	166 (77%)	47 (22%)	2 (1%)
Band 8b	59	53 (90%)	6 (10%)	0 (0%)	63	57 (90%)	6 (10%)	0 (0%)	70	59 (84%)	11 (16%)	0 (0%)
Band 8c	23	18 (78%)	3 (13%)	2 (7%)	22	16 (73%)	6 (27%)	0 (0%)	21	16 (76%)	5 (24%)	0 (0%)
Band 8d	18	18 (100%)	0 (0%)	0 (0%)	18	16 (89%)	2 (11%)	0 (0%)	20	19 (95%)	1 (5%)	0 (0%)
Band 9	3	3 (100%)	0 (0%)	0 (0%)	5	5 (100%)	0 (0%)	0 (0%)	4	4 (100%)	0 (0%)	0 (0%)
VSM	0	0	0	0	0	0	0	0	0	0	0	0
Total	2990	2155	704	131	3057	2178	771	108	3268	2310	863	95

Table 3: Clinical (Medical & Dental) Workforce Data 2019-2021

Pay Band	2019 Clinical (Medical & Dental) Workforce Data				2020 Clinical (Medical & Dental) Workforce Data				2020 Clinical (Medical & Dental) Workforce Data			
	Total Medical & Dental Staff	White	BME	Ethnicity Unknown	Total Medical & Dental Staff	White	BME	Ethnicity Unknown	Total Medical & Dental Staff	White	BME	Ethnicity Unknown
Consultants	107	39 (36%)	54 (50%)	14 (13%)	82	29 (35%)	38 (46%)	15 (18%)	98	31 (32%)	43 (44%)	24 (24%)
Snr Medical Manager	0	0	0	0	0	0	0	0	0	0	0	0
Non-consultant Career Grade	63	23 (37%)	28 (44%)	12 (19%)	94	35 (37%)	43 (46%)	16 (17%)	87	33 (38%)	38 (44%)	16 (18%)
Trainee Grade	19	2 (11%)	1 (5%)	16 (84%)	28	2 (7%)	4 (14%)	22 (79%)	21	2 (10%)	2 (10%)	17 (81%)
Other	0	0	0	0	0	0	0	0	0	0	0	0
Total	189	64	83	42	204	66	85	53	206	66	83	57

According to the Clinical (Medical & Dental) Workforce Data in Table 3, the highest percentage of Ethnic Minority staff are Consultants (44%) and Non-Consultant Career Grade (44%). This is in line with the greater numbers of BAME graduates entering medical degrees.46% of entrants to medical profession are from BAME backgrounds with 30% from Asian backgrounds. On the surface, there is underrepresentation at Trainee Grade, however this grade has a consistent and significant non-declaration rate of 81%.

Indicator 2: Relative likelihood of staff being appointed from shortlisting

The following indicators are taken from Berkshire Healthcare data and will be used as a benchmark for the future.

Table 4:Relative likelihood of appointment from shortlisting

WRES Indicator	Metric Descriptor		2018/19	2019/20	2020/21
2	Relative likelihood of White applicants being appointed from shortlisting across all posts compared to BAME applicants	Berkshire Healthcare	**1.27**	**1.46**	**1.46**
		NHS Trusts	**1.45**	**1.46**	**1.61**

From a BAME perspective, the data in Table 4 shows a concerning disparity in comparison with White staff. The likelihood of BAME staff being appointed from shortlisting has not improved since 2020 – White staff are 1.46 times more likely to be appointed from shortlisting than BAME applicants. According to Table 4, our recruitment practice is worse than it was 3 years ago. The Trust has adopted the WRES' Six National Actions to address disparities that exist in our recruitment practice – see Appendix 2 for more detail.

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

Table 5: Relative likelihood of entering formal capability process

WRES Indicator	Metric Descriptor		2018/19	2019/20	2020/21
3	Relative likelihood of BAME staff entering the formal disciplinary process compared to White staff	Berkshire Healthcare	**5.56**	**1.76**	**1.81**
		NHS Trusts	**1.24**	**1.22**	**1.16**

The data in Table 5 indicates that the disparity in the likelihood of BAME staff and White staff entering the formal disciplinary process has significantly reduced from what it was 3 years ago with no consistency in progress being made – a new Just Culture Approach has been adopted which will make a significant impact in the coming years. However, our data tells us that BAME staff are currently still more likely to enter this process. Currently we are behind national average.

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

Table 6: Relative likelihood of staff accessing non-mandatory training and CPD

WRES Indicator	Metric Descriptor		2018/19	2019/20	2020/21
4	Relative likelihood of White staff accessing non-mandatory training and continuous professional development (CPD) compared to BAME staff	Berkshire Healthcare	**0.97**	**1.59**	**1.51**
		NHS Trusts	**1.5**	**1.15**	**1.14**

This data in Table 6 Illustrates that White staff are 1.51 times more likely to access non mandatory training and continued professional development than BAME staff. This disparity is rather disappointing because national data suggests that most Trust now fall within the non-adverse range of 0.80 to 1.25, based on the four-fifths rule.

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

Table 7: Harassment, bullying or abuse in the last 12 months (patients, relatives & public)

WRES Indicator	Metric Descriptor		BAME 2018/19	White 2018/19	BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21
5 Staff Survey Q13a	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Berkshire Healthcare	31%	23%	30%	22%	31%	20%
		NHS Trusts	33%	28%	36%	28%	32%	25%

This data in Table 7 indicates that BAME staff are 11% more likely to experience harassment, bullying or abuse from patients, relatives and the public than White staff. This represents a regression from the previous year's data and is almost consistent with the national average score. There has been no consistent progress since 2018. The Trust has prioritised tackling harassment, bullying and/or abuse of staff in its new Equality, Diversity and Inclusion Strategy and has launched a number of initiatives this year such as the BAME Transformation Project, a new training programme on Allyship, and a three-day Rapid Improvement Event that targeted racial abuse of staff where a number of short term and long-term projects were agreed supported by our Comms team. There is a commitment to facilitating change.

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

Table 8: Harassment, bullying or abuse in the last 12 months (staff)

WRES Indicator	Metric Descriptor		BAME 2018/19	White 2018/19	BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21
6. Staff Survey Q13c	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Berkshire Healthcare	26%	20%	25%	20%	23%	18%
		NHS Trusts	27%	21%	25%	21%	25%	20%

The data in Table 8 indicates that there has been a 2% improvement in the harassment, bullying or abuse of BAME staff by their colleagues. However, staff from BAME backgrounds are still 5% more likely to experience harassment, bullying or abuse from staff than their White counterparts. This is unacceptable – the Trust has prioritised tackling harassment, bullying and/or abuse of staff in its new Equality, Diversity and Inclusion Strategy and has facilitated a number of initiatives this year such as the BAME Transformation Project, a new training programme on Allyship, and a three-day Rapid Improvement Event that targeted racial abuse of staff where a number of short terms and long-term projects were launched. BAME staff have also been given opportunities to share their lived experiences with the Board to raise awareness.

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

Table 9: Opportunities for career progression or promotion

WRES Indicator	Metric Descriptor		BAME 2018/19	White 2018/19	BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21
7. Staff Survey Q14	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.	Berkshire Healthcare	74%	89%	76%	91%	78%	92%
		NHS Trusts	77%	87%	72%	87%	73%	89%

This data in Table 9 indicates that 78% of BAME staff believe that the Trust provides equal opportunities for career progression or promotion compared to 92% of White staff. This is better than the national average score, but the discrepancy is acknowledged. The Trust has commissioned a BAME Transformation project that aims to look at career progression and or internal promotion processes to equalise experience. This has also been put at the centre of the Trust's new Equality, Diversity and Inclusion Strategy as well as the People Strategy. Career progression is also one of the drivers of the Trust's Six WRES National Actions.

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

Table 10: Experience of discrimination at work from manager/team leader or colleagues

WRES Indicator	Metric Descriptor		BAME 2018/19	White 2018/19	BAME 2019/20	White 2019/20	BAME 2020/21	White 2020/21
8. Staff Survey Q13b	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months	Berkshire Healthcare	17%	7%	13%	6%	12%	5%
		NHS Trusts	14%	6%	13%	6%	15%	6%

The data in Table 10 demonstrates that 12% of BME staff have personally experienced discrimination at work from either their manager, team leader or colleagues in comparison to 5% of White staff. The Trust is committed to tackling harassment, bullying and/or abuse of staff. It continues to deliver a suite of Leadership and Management programmes that aim to foster inclusive and compassionate leadership behaviours in management teams across the Trust and this team now reports to the Director of EDI, working collaboratively with the EDI team. Also, there is a new Equality, Diversity and Inclusion Strategy, a number of initiatives such as the BAME Transformation Project, a new training programme on Allyship, and a range of project targeted at raising awareness as well as changing a culture that still has pockets of discrimination. BAME staff have been given opportunities to share their lived experiences with the Board to raise awareness and profile of the scale of the challenge.

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

Table 11: Board Representation

WRES Indicator	Metric Descriptor		2018/19	2019/20	2020/21
9	Percentage difference between Board voting membership and its overall	Berkshire Healthcare	**15%**	**15%**	**15%**

Board Representation	workforce	NHS Trusts	7%	8%	10%

The data presented in Table 11 indicates that as at 31st March 2021, BAME Board Membership remained consistent at 15% as there were no changes at Board level in the last 3 years.

Berkshire Healthcare Race Disparity Ratio

Table 12: BOB ICS Race Disparity Ratio Heat Map

Trust Name	% BME Staff	Disparity Ratio		
		Lower to Middle	Middle to Upper	Lower to Upper
Berkshire Healthcare NHS Foundation Trust	24.8%	1.16	1.56	1.81
Buckinghamshire Healthcare NHS Trust	24.3%	1.48	1.15	1.70
Oxford Health NHS Foundation Trust	17.1%	1.73	1.53	2.65
Oxford University Hospitals NHS Foundation Trust	22.5%	1.53	2.26	3.45
Royal Berkshire NHS Foundation Trust	28.3%	1.72	2.06	3.53
South Central Ambulance Service NHS Foundation Trust	5.0%	0.90	0.59	0.53

Building on the challenges highlighted by the 9 WRES indicators presented in this report, Table 12 above presents Berkshire Healthcare's Race Disparity Ratio (RDR) and juxtaposes it with the Trust's partners in the BOB ICS. It is worth noting that the above RDR is based on the previous year's data.

The RDR is underpinned by the principle that once recruited into an organisation progression/promotion chances should be equally accessible to everyone – an issue that is highlighted as problematic by our WRES' data. Table 2 suggests that across the ICS, there is a disparity in proportion of BAME staff in AfC Band 8 and above vs AfC Band 5 and below compared to the proportion of White staff at those Bands.

With the understanding that the RDR looks at the probability of White staff being promoted from lower Bands to Bands 8 and 9 and VSM these are the implications of the Berkshire Healthcare's RDR presented in Table 12:

- Lower to Middle: White staff are 1.16 times more likely to progress through the organisation than BAME staff.
- Middle to Upper: White staff are 1.56 times more likely to progress through the organisation than BAME staff.

- Lower to Upper: White staff are 1. 81 times more likely to progress through the organisation than BAME staff.

Both BOB and Frimley ICS have appointed EDI leads that will support and oversee the action plans submitted to address the six national key actions.

Conclusion and Next Steps

Based on the 2020-21 data the following have been identified as areas of concern that the Trust must focus on for improvement:

- Underrepresentation of BAME staff in senior posts (bands 8a and above)
- Likelihood of BAME staff being appointed from shortlisting
- Likelihood of BAME staff accessing non-mandatory training and continued professional development
- Percentage of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public
- Percentage of BAME staff experiencing harassment, bullying or abuse from staff
- Percentage of BAME staff experiencing discrimination at work from their manager, team leader or colleagues
- Percentage of BAME staff believing the Trust provides equal opportunities for career progression or promotion
- Underrepresentation of BAME on the Board with voting membership

With these areas for improvement in mind, the Trust's EDI Improvement Plan (see Appendix 2) outlines actions the Trust will take to respond to the WRES and achieve improvements against the following themes:

- 'De-biasing' and 'inclusivisation' of the recruitment and selection processes (this will be integrated with the Six National Actions): the aim is to increase representation of Black, Asian and Ethnic minority staff in Bands 8a to VSM
- Eradication of discrimination, bullying and harassment in the workplace
- Inclusive practicse for equalisation of career opportunities for development
- Compassionate and Inclusive Leadership
- Allyship
- Continuation of the Just Culture work

Appendix 1: BAME Staff Population

Table 13: BAME staff population at Berkshire Healthcare

Overall Percentage of BAME Staff		2018/19	2019/20	2020/21
Percentage of BAME staff in overall Berkshire Healthcare workforce compared with other NHS Trusts in England	Berkshire Healthcare	**23%**	**25%**	**26%**
	NHS Trusts	**19%**	**20%**	**21%**

Appendix 2: EDI Improvement Plan

Action	EDI Strategy Objectives	Progress	Next steps	Timescales
Rollout of new Ready for Change Programme	*Allyship* *Emotional and Cultural Intelligence*	• Extensive rollout of the programme	• Identify and prioritise Divisions or Teams with greatest EDI need • 'Train the trainer' – have a pool of trainers to increase speed of rollout of programme. • Review delivery and impact of programme	November 2021 December 2021 December 2021
Increase the likelihood of BAME staff being appointed from shortlisting through improved and inclusive recruitment processes	*Recruitment Processes*	**National Action 1**: Set specific recruitment targets **National Action 2:** Introduce a system of 'comply or explain' to ensure fairness during interviews **National Action 3:** mandate new policy where all hiring managers include evidence of EDI work / understanding as essential criteria for Bands 8a and above roles.	• Work with BAME Network and review recruitment process (including job adverts) • Deliver inclusive recruitment training (including unconscious bias) • Invest in a pool of EDI champions to sit on interview panels.	September 2021 Jan 2022 Feb 2022

Continue to address the poorer experience of BAME staff reported through the NSS for Bullying and Harassment	*Inequalities and differentials in experience:* • *Just Culture* • *Bullying and Harassment*	• Promote Trust's Zero-Tolerance Policy about bullying and harassment. • Work with the BAME Network to improve use of soft intelligence about people's experience, in combination with data from Human Resources, EDI Team and Freedom to Speak Up processes. • **National Action 4:** Adapt and adopt resources, guides and tools to help leaders and individuals have productive conversations about race (normalise conversations about race).	• Reduction of Bullying and Harassment to be a key deliverable of the newly formed EDI Team. • Embed conversations about race into Leadership Training for managers • Continue to promote the inclusion through the internal communication channels for staff and managers.	Ongoing
Continue to invest in developing compassionate and inclusive leadership	*Leadership and Management*	• Continue to thread EDI into Leadership and Management Training • **National Action 4:** Adapt and adopt resources, guides and tools to help leaders and individuals have productive conversations about race (normalise conversations about race).	• Review all Leadership and Management Training through EDI lenses. • Embed EDI in Leadership and Management Training.	December 2021 Ongoing
Provide inclusive career progression opportunities for development	*Inequalities and differentials in experience:*	• Use of reliable and robust data – to understand the experiences of our staff and proactively use data to address areas of concern. Work with the BAME Network to improve our use of soft intelligence about people's experiences, in combination with data from Human Resources,	• Career conversations embedded into the annual appraisal process • Implement and fully embed an inclusive talent management system, to support the development of a talent pipeline • Promote and support inclusive access to training, learning and development opportunities, at national, regional and local level,	Ongoing

		EDI Team and Freedom to Speak Up processes. **National Action 5:** Organise talent panels or internal promotion panels: • Create a 'database' of individuals eligible for promotion and development opportunities • Design a transparent promotion system / criteria **National Action 6:** Overhaul interview processes to incorporate: • Training on good practice with instructions to hiring managers to ensure fair and inclusive practices are used. • Enhance EDI support available to train organisation and HR policy teams on how to complete robust / effective Equality Impact Assessments of recruitment and promotion policies	• Identify any specific gaps requiring some targeted or bespoke • Development of a new talent lead post	

Trust Board Paper

Board Meeting Date	14 September 2021
Title	**Wellbeing Guardian Update**
Purpose	**The purpose of this paper is to provide an update on the role and plans of the Wellbeing Guardian**
Business Area	**People Directorate**
Author	**Hardip Johal**
Relevant Strategic Objectives	True North Goal 2: Supporting our staff. We will protect and sustain the health & wellbeing of our staff, reducing sickness absence.
CQC Registration/Patient Care Impacts	Staff wellbeing is one of the NHS People priorities. Improving the wellbeing of our staff will positively impact on our Staff Engagement Score and help to reduce sickness absence which improves our patient care outcomes.
Resource Impacts	We have now appointed a NED Wellbeing Guardian - Mark Day
Legal Implications	The health and safety of our staff is covered by HSE legislation and we are guided by this in our approach to wellbeing.
Equality and Diversity Implications	Positive implication as assurance on the delivery of the Equality Act, particularly in relation to wellbeing is one of the proposed principles of the Wellbeing Guardian and out wellbeing work.
SUMMARY	The 2020-21 NHS People Plan recommends that all organisations should have a Wellbeing Guardian to look at the organisation's activities from a health & wellbeing perspective and act as a critical friend,

	while being clear that the primary responsibility for our people's health and wellbeing lies with chief executive officers or other accountable officers. This paper provides an update on the plans following the appointment of Mark Day as the Trust's wellbeing guardian role.
ACTION	To share an update on the progress to date, with confirmation that we have successfully met the criteria for phase 1. To share plans for the remainder of the year (until Mar 2022) and provide assurance that BHFT are in line with national requirements.

Board Paper

Purpose

The purpose of this paper is to provide an update to the Trust Board, following the recent appointment of Mark Day, Non-Executive Director, as the Trust's wellbeing guardian role.

Background

The 2020-21 NHS People Plan which was launched in July 2020 places a large focus on staff health and wellbeing and includes a number of recommendations. Every NHS Trust is recommended to appoint a wellbeing guardian to oversee activities from a health and wellbeing perspective and 'act as a critical friend', while being clear that the overall responsibility for health and wellbeing lies with the chief executive or other accountable officers. In February 2021 Mark Day, one of our non-executive Directors took on the role of the wellbeing guardian.

The Role

The national guidance indicates that the Trust's wellbeing guardian should:

Care about people, find ways to connect with staff and staff networks and listen well.

Work closely with and support the HR Director and other executives who lead in this area.

Feel confident in challenging the Board and other senior leaders, questioning decisions that could impact on the wellbeing of our NHS people, and challenging behaviours or aspects of the culture that are likely to be detrimental to others.

Be fully cognisant of the protected characteristics outlined in the Equality Act and be committed to ensuring that disparities on the basis of a protected characteristic are eradicated.

Wellbeing Guardian principles

The information below sets out the nine principles which the wellbeing guardian should be seeking assurance on, and also includes guidance about how they will be achieved.

The nine Principles	Current Actions	Actions in development
The mental health and wellbeing of NHS staff and those learning in the NHS should not be compromised by the work they do for the NHS.	Appraisals currently have a question on health & wellbeing. The annual risk and wellbeing assessment also has a section on wellbeing and managers are encouraged to have wellbeing conversations as part of the assessment. Nexus is updated to include guidance for managers on 'how to have wellbeing conversations'. The executive briefings have held a session to reflect on our staff survey results.	

The nine Principles	Current Actions	Actions in development
The wellbeing guardian will ensure that where there is individual or team exposure at a clinical event which is distressing, time is made available to check the impact on those NHS staff and learners.	Our recently introduced staff support post incident provisions enable the staff support team to ensure risks to the mental wellbeing of people are identified, and that support is in place. Feedback questionnaire will be sent to the individuals concerned as a way to monitor uptake of and success of the support offer.	Data will be presented to the wellbeing guardian at monthly meetings between the guardian and wellbeing lead.
The wellbeing guardian will ensure that wellbeing 'check in' (aka 'Wellness induction') meetings will be provided to all new staff on appointment and to all learners on placement in the NHS as outlined in the Commission recommendations.	HWB is included in our current induction. HWB Lead delivers HWB presentation to all new staff recruited.	The wellbeing guardian will be updated in a monthly meeting with the wellbeing Lead on feedback from new joiners.
All NHS staff and those learning in the NHS will have ready access to self-referral, proactive and confidential occupational health service that promotes and protects wellbeing.	Details of our occupational health services (team Prevent), the staff support hub (wellbeing matters) and our self-referral to MSK services are all available under the wellbeing page in Nexus.	The Wellbeing Guardian will receive monthly updates on proactive/preventative, health-promotion activities, levels of participation and staff feedback through the wellbeing lead and director of psychology & psychological therapies.
The death by suicide of any member of staff or a learner working in the NHS organisation will be independently examined and the findings reported through the wellbeing guardian to the board.	The wellbeing guardian will commission an independent investigation and present findings from 'death by suicide reviews' to the Board.	

The nine Principles	Current Actions	Actions in development
The NHS will ensure that all staff and learners have an environment that is both safe and supportive of their mental wellbeing.	We have a HWB calendar with a HWB topic each month to support physical and psychological wellbeing. This is shared through Team Brief each month. HWB has a dedicated page on Nexus. Regular posts are made to support our psychological support for staff on social media. Input from the safety culture steering group to ensure safe environment.	
The NHS will ensure that the cultural and spiritual needs of its staff and those learning in the NHS are protected and will ensure equitable and appropriate wellbeing support for overseas staff and learners who are working in the NHS.	Regular promotion and signposting to our staff support network groups. Chaplaincy service based at Prospect Park is available to all staff. Staff support hubs available for specific cultures that struggle to access support. (e.g. covid crisis in India).	Will need to consider needs of overseas staff as we progress with overseas recruitment.
The NHS will ensure the wellbeing and make necessary adjustments for the nine groups protected under the Equality Act 2010.	Regular promotion and signposting of HWB to our staff support networks for BAME, LGBTQ and Purple. Executive sponsorship of each group	Will organise for the wellbeing guardian to join some network meetings during Q3/Q4.
The wellbeing guardian, working with system leaders and regulators, will ensure that wellbeing is given equal weight in organisational performance assessment.	The wellbeing guardian will use the people plan and nine principles to hold the board to account on delivery of agreed action.	

Implementation of the role through the three phases

As NHS Trusts have made varying degrees of progress with the nine recommendations above, the guidance from NHE/I suggests s the following timescales about introducing and developing the guardian over a 12-month period. Given this, our phased plan is as follows: -

Phase 1: Health and wellbeing has limited coverage at board level – April – July 21

Undertake NHS Health and wellbeing Diagnostic to assess current health and wellbeing performance and identify priority activities (Principle 1)

The diagnostic tool was completed in November 2020. The outcome of this self-assessment were some areas for improvement, which in turn, formed the HWB project plan for the next 12 months. In July 2021 the framework was revalidated and shared with Mark Day.

Identify a wellbeing guardian

As stated, above Mark Day has been appointed as the Trust's wellbeing guardian.

Agree the priority actions to be included in the wellbeing guardian role description and how the nine wellbeing principles will be phased in.

- Updates between the wellbeing guardian and HWB lead are suggested to take place monthly, and include actions from the above nine principles and updates on the wellbeing plan.
- Revalidation of the HWB framework every three months and updates shared with the wellbeing guardian.
- HWB report to be shared to the Board every 6 months.
- The guardian will be invited to NHS E/I guardian network meetings and BHFT HWB Ambassador network group on a quarterly basis.
- As and when required the guardian may be invited to speak at particular events about their role and advocate any wellbeing initiatives within our Trust.

Phase 2: Principles of the wellbeing guardian role are largely embedded – Aug-Nov 21

Wellbeing guardian role is established and functioning well within the board.

Most of the nine principles are routinely evidenced at board meetings.

A holistic health and wellbeing strategy is in place (either standalone or as part of a wider people strategy) and being delivered.

Staff experience measures indicate a compassionate culture is in place or being created.

WB Phase 3: Health and wellbeing is routinely considered and included in board activity – Dec-Mar 22

All board members routinely consider the holistic health and wellbeing of our NHS people in their strategic and operational plans and performance reporting.

The board regularly hears feedback, including in the form of staff stories.

All nine principles are being delivered.

The NHS Health and wellbeing diagnostic tool dashboard is green.

Conclusion

Given the progress to date, we have successfully met the criteria for phase 1, and therefore will progress to phase two. This paper sets out the action taken so far and outlines future action. Additionally, it provides a Board assurance that we are in line with national requirements and our own local planning.

Trust Board Paper

Board meeting date	14th September 2021
Title	Status Report on Trust Strategic Initiatives
Purpose	This document updates Board members on the current status of the Trust's key programmes and projects
Business Area	Corporate
Author	Director of Projects
Presented by	Alex Gild
Relevant Strategic Objectives	The portfolio of initiatives addresses all the Trust's True North goals
CQC Registration/Patient Care Impacts	The portfolio of programmes and projects includes activities to maintain our CQC registration and improve standards of patient care, outcomes and experience
Legal implications	As per individual programmes and projects
Equality & Diversity Implications	The portfolio of initiatives includes those progressing the delivery of our Equality and Inclusion Strategy. Equality and Diversity implications of each initiative are the responsibility of its governing body.
Brief Executive Summary	The report provides a status update on the Trust's combined programme, project and strategy implementation.
Recommendation/ Action Required	The Board is asked to note the status of the Trust's key initiatives.

COMBINED PROJECTS AND SIP REPORT

TRUE NORTH GOALS

1

2

3

4

INITIATIVE	SUMMARY DESCRIPTION (as required)	Key True North Goal	Planned Completion Date	Lead	Current Status (RAG)	COMMENTARY ON CURRENT STATUS (including new Significant Risks & Issues or change in RAG)	PLANNED ACTIVITY (Including mitigations for emerging risks and issues)	2021/22 Reporting Periods	Date report last updated
Mission Critical Projects / Initiatives (as defined through the Strategic Prioritisation Filter)									
Berkshire West Ageing Well Accelerator Site	To increase the capacity and responsiveness of intermediate care services to provide crisis response within two hours of need and reablement within two days to both avoid unnecessary hospital admission and support early discharge for medically optimised older people to leave hospital on time. BHFT has been appointed as the BOB System-wide lead for the programme.	3	Oct-21	KM/RS		Overall, both UCR schemes making progress and are on track. Consideration being given as to whether the BOB and Frimley AW programmes could be combined into a single report. Trajectory exceeded for 2H performance but under for 2 day. the main risk remains lack of care capacity to meet demand, case for additional resources in train to access Community Development Funding. Demand modelling for OOH and care capacity has slipped. Criteria for 2 day awaiting sign off. Work on improving data quality continues. Planning for perfect days with SCAS 999 crews completed to run in August.	Commence recruitment for hybrid care roles to support 2H pathway. Patient experience survey- draft service specification and project to go live from 23/08/21. Incorporate feedback from stakeholders into 2 H patient leaflet. Shared learning event across BOB planned for 24/08/21.Initial planning meeting to deliver a BW TIPs event with BW Primary Care, aiming for Sept or Oct event.	Monthly to Nov	Aug-21
CAMHS Clinical Pathways	Formerly "Improving CAMHS waiting times" this initiative is centred around clarifying what should be delivered, where this should be delivered, a review of the current clinical provision and any skills gaps. Several initiatives are being undertaken alongside this project to support the reduction of CAMHS waiting times while the pathways are being implemented.	1	Dec-21	BG with Hayley Clarke		All clinical pathways have been signed off with draft ePathways built. Transition pathway developed as a supplementary pathway - final sign off and epathway build over Aug 2021. Skills mapping (capacity) and pathway mapping (demand) currently underway in CAMHS teams.	Analysis of demand and capacity mapping to completed over Aug/early Sept 2021 and considered by Steering Group to inform operational delivery of the pathways. Update and next steps to be presented to CAMHS staff end of Sept 2021. Remaining outcome measures (ROMS) to be built on RiO once drafts approved by CAMHS and have copyright approval.	Monthly to Dec	Aug-21
People Strategy	Comparatively, both nationally and regionally our turnover rates are high. Between 40% and 50% of those who leave each year leave within the first two years of joining our Trust. We need to grow and retain our staff for the future. This indicates a need to focus on retaining developing and supporting people in the right roles. Failure to do so will impact safe, compassionate, high-quality care.	2	Mar-23	AG/JN		Overall status at green but Attracting & retaining staff / Training & Clinical Education / Addressing Disparities of experience rated at amber. **Attracting & Retaining Staff** - Amber Turnover at 12.53% - has remained fairly static for last 3 months **Training & Clinical Education** - Amber survey of services commissioned and plan ahead of timescales **Wellbeing & Rewards** - Plan to support people post COVID developed and ready for launch **Just Culture** - New disciplinary & early resolution policies fully agreed, Training underway **Talent & leadership** - part of EDI strategy - leadership work is progressing well **Disparities of experience** - role descriptions and dedicated time agreed for network leads. Work underway with all 3 BAME Transformation workstreams **Remote Working & Digital Transformation** - collaborative project with colleagues in ITC. Engagement workshops have been completed and project meetings set.	**Attracting & Retaining Staff** - actively working with divisions and departments to agree individualised targets for turnover. Engaging with early leavers and monitoring more closely the experience of new joiners Developing model for international recruitment. **Training & Clinical Educatio**n - Phase 1 review commenced - Lead appointed to review the clinical education processes and gaps. Survey to services commissioned Phase 2 - review of stat man training underway. Clear governance to be developed for any changes to training or processes. Working with Estates to evaluate physical space options for training delivery post-covid. **Wellbeing & Rewards** - Staff support offer including our wellbeing hubs are fully resourced and now well established. Continue to work with system partners to expand collaboration through the ICS using system funding. BHFT wellbeing plan seeks to address the particular needs of our staff post-Covid and has been aligned with the Every Action Counts and is monitored through the Safety Culture Group. **Just Culture** - The new disciplinary and early resolution policies are now fully agreed and in use. Two investigators (NHSP Bank) recruited. Training is underway. and the Additional ICS funding is being requested to expand this work to all ICS partners to enable a pooled resource **Talent & Leadership** - Review approach to talent management at other key grades (below senior management) and key groups to ensure we have clear career pathways **Disparities of experience** - three day Rapid Improvement Event held by PPH at the end of June. Role descriptions and dedicated time have been agreed for network leads **Remote working and digital transformation** - continuing to support staff to work in new ways.	Monthly to Mar	Aug-21
EDI Strategy	Programme to identify and address some of the health inequalities experienced by the patients and communities who use our services. We are recognised as a CQC outstanding organisation. However, this is not the experience of everyone, due to inequalities and discrimination experienced by our patients and our people with protected characteristics. Programme incorporates - BAME Transformation, Equality Employment Programme, Equality Delivery System, Workforce race Equality, Achieving a minimum of Bronze in this years Stonewall submission	3	Mar-23	JN/NZ		Programme incorporates - BAME Transformation, Equality Employment Programme, Equality Delivery System, Workforce Race Equality, Achieving a minimum of Bronze in this years Stonewall submission The strategy was signed off by board in February 2021 with a detailed action plan for our people and patients, agreed by the Diversity Steering Group (DSG) for year 1. DSG provides the oversight of the implementation of both people and patient priorities for the strategy.	EDI strategy has been published and will be promoted at the People and EDI strategy roadshows in July/August 2021 The bullying, harassment and microaggression and disciplinaries and grievances workstreams will focus on PPH The career progression workstream will align with the 6 national actions Targeted project at PPH focusing on racial abuse using a QI approach Priority countermeasures include: Std work for incident response, use of QMIS to reverse de-sensitisation of staff, campaign to raise awareness, PPARET service (PP advocacy for racial equality team) to be set up, Staff racial crisis team/line, Standard work/formal escalation process to give different options when informal/local resolution hasn't worked, improvements to Datix form and coaching sessions and customised follow up message. Increase trainer capacity and promote the new staff support post.	Jun / Aug / Oct / Dec Feb	Aug-21

INITIATIVE	SUMMARY DESCRIPTION (as required)	Key True North Goal	Planned Completion Date	Lead	Current Status (RAG)	COMMENTARY ON CURRENT STATUS (including new Significant Risks & Issues or change in RAG)	PLANNED ACTIVITY (Including mitigations for emerging risks and issues)	2021/22 Reporting Periods	Date report last updated
Transfer of EFM Services to NHS Property Services	To ensure the timely, efficient transfer of the Estates and Facilities Management contract from Berkshire Healthcare NHS FT (BHFT) to NHS Property Services Ltd (NHSPS) with the minimum of disruption for Trust services and the appropriate support for members of Trust staff transferring. Change initiated by NHS Property Services after the contract came to term and all possible extensions completed. This is part of a wider national strategy as NHSPS wish to follow an in-house model and do not wish to renew the BHFT EFM contract beyond 30 September 2021.	2	Oct-21	SG/IG		Red rating due to proximity of services transfer date, 1st October. There are risks and issues which remain, and we are continuing to work with NHSPS to resolve these or have mitigation plans in place. These include – Scope of NHSPS service provision Service Level Agreement Confirmation of costs of new service Business continuity and health and safety responsibilities		Monthly to Oct	Aug-21
East Childrens Therapies	As part of the ongoing work around collaboration across East Berks, the three Directors of Children Services and the CCG have committed to work jointly on exploring opportunities for developing a more integrated approach to the commissioning and delivery of Speech and Language Therapy, Occupational Therapy and Physiotherapy. The Bracknell Forest Commissioning Team will be leading the project management.	3	Mar-23	KC		Project rated at amber due to risks being identified. Discovery phase of project complete; although outcomes of the phase require further clarification to support the modelling, dialogue and testing phase Project SROs currently meeting monthly (1x LA rep, 1x Frimley CCG rep and 1 x BHFT rep). Project to be discussed at East Berkshire Directors meeting (CCG and LA representation) in July 2021. LA and CCG to source new commissioned project lead, as Bracknell Forest lead is leaving her role. System governance process in development. BHFT Project Manager appointed (30 hours per wk) - commenced June 21 BHFT clinical lead established General lack of clarity regarding project aim and scope across the system. BHFT finance team working through 'current state' to share finance detail of block contract.	Meeting with CCG Clinical lead planned for 14th July 2021 to revisit project aim and outcomes to be achieved. Communication out to stakeholders re: agreed project aim and outcomes, and next steps /action plan. Clarification of project aim, scope, outcomes and benefits to be realised. Clarification of outcomes of discovery phase. Ensure awareness of required project team to deliver the project in a timely manner. Internal and external communications regarding the agreed way forward and project plan.	Jul / Sep / Nov / Jan / Mar	Jul-21
CAMHS Tier 4 Service Transformation	Following the Commissioner decision not to support the transfer of Willow House to Prospect Park, a new out of hospital service is to be established, coordinated with the closure of Willow House on 30th April 2021.	3	Nov-21	KC		Willow House closed as an inpatient unit on 30th April 2021 and transitioned to an out of hospital tier 4 unit. There has been a positive recruitment period with the majority of the Willow House staff transferring to the new model, and positive external recruitment in the multi disciplinary team. New staff will be starting by September including psychology, occupational therapy, social worker, psychiatrist and dietician posts offered. However the core CAMHS are having to provide additional support whilst waiting for the new members of the team to start. An ongoing training programme is in place for staff to provide to the new model of care and this is currently being reviewed There are 7 young people attending. Home treatment has not yet started but the service remains on track for current plans The provision will move to Magnolia House on site at Prospect Park Hospital whilst the estates team undertake a plan of major works to be completed during school summer holiday in August which will include sorting the roof issue.	Plan for estates work to be completed during the summer holidays. Communications with stakeholders. Amendments to website. Review project timelines. Review staffing model and revenue costs	May / Jul / Sep / Nov / Jan	Jul-21
Information Technology Architecture Strategy	Implementation of new technology and Cloud computing. Comprises six elements including Office 265 migration to Cloud and movement of departmental systems to Cloud. Email upgrade/replacement and Wide Area Data Network to be completed this financial year.	3	~~Mar 20~~ Oct 21	MD		Rated as amber due to delays being experienced as services dealing with Covid19 do not have the capacity to engage with the programme. Completion date revised in June 21 to October 21 CoIN completed, e-mail migration completed, secure e-mail implemented, Windows 10 migration completed, Home Drive and Outlook Personal folders migrated. Shared Drive & System migrations underway – delays being experienced as services dealing with Covid19 do not have the capacity to engage with the programme and all have differing abilities to deal with the new method of working. Shared Drive & System migrations underway.	Completion of migration of Shared Drives to SharePoint / Teams Progress migrations of local systems to their hosted cloud versions in line with the project plan Completion date revised in June 21 to October 21	Jun / Sep / Dec	Jun-21
Frimley ICS Community Mental Health Transformation - (phase 2)	Transformation of CMH services in line with LTP and CMH Framework, to re-design place-based, multi disciplinary service across health, social care and VCSE sectors, aligned to PCNs. Improve access to MH service for people with SMI, including provision for people with personality disorder eating disorder and community rehabilitation. Phase 2 – Roll out to remaining five E Berks PCNs, commence implementation of enhanced eating disorder and community rehab elements, and alignment with CMHTs.	3	Mar-22	SY		**MHICS - MH Integrated Community service** All four first-wave PCNs are now fully live. Outcomes continue to be positive. MHICS has completed QMIS training; ; 4ww identified as Driver Metric Q1 report submitted to NHSE Roll-out: MHICS is to be implemented in Ascot and Maidenhead PCNs during Q2. Good engagement being established with Maidenhead Primary Care Teams; more challenging to engage with Ascot PCN currently. Extension to CCG's MoU with Bucks Mind has been confirmed for expansion of voluntary sector roles. Working with IG to amend and finalise DPIA for roll-out sites; **PD** - Managing Emotions Programme co-designed with service users and courses offered, workforce issues delayed full roll out. Recruitment to SUN is complete and the service is operational. Primary Care PICT has some vacancies but is operational, supporting primary care colleagues with training and case management. **Eating disorder and rehab** - these new elements of the programme are being scoped **CMHT alignment** -pathways for 'easy in /easy out' and interface between primary care and CMHT are being worked up	**MHICS** - Recruitment, engagement for roll out sites - Ascot and Maidenhead Scheduled meetings with NHSE for monitoring and assurance Finalise scope for Independent Evaluation, supported by Kent, Surrey & Sussex and Oxford AHSNs. Seeking solutions to Community Connector/Admin access and IT issues Roll out: Continue engagement with Ascot & Maidenhead PCNs to progress implementation; **Primary Care PD services** - Continued implementation / recruitment to key posts **Eating disorder and rehab -** scoping of programme plans and reporting milestones **CMHT alignment** Finalise the management structure for Place based models, support QI approach to review interface between primary and secondary care and implications of the CMH Framework for CMHTs.	Aug / Oct / Dec / Feb	Aug-21

INITIATIVE	SUMMARY DESCRIPTION (as required)	Key True North Goal	Planned Completion Date	Lead	Current Status (RAG)	COMMENTARY ON CURRENT STATUS (including new Significant Risks & Issues or change in RAG)	PLANNED ACTIVITY (Including mitigations for emerging risks and issues)	2021/22 Reporting Periods	Date report last updated
BOB Community Mental Health Transformation	Region wide transformation programme to improve access to Mental Health Services for people with SMI. Although regionally focussed, the programme is place-based and ensuring it meets the needs of patients in the Berkshire West Catchment. By 2023/24, the Community Mental Health Framework Delivery Group will ensure that Berkshire West has a Community Mental Health Framework that breaks down the current barriers between: mental health and physical health, health, social care, Voluntary, Community and Social Enterprise (VCSE) organisations and local communities, and primary and secondary care; to deliver integrated, personalised, place-based and well-coordinated care, in line with the NHS Long Term Plan for Mental Health.	3	Mar-23	TW		The programme remains to work at pace and to plan, with all project leads and task & Finish group working effectively. Relation building in Wave 1 PCN continues to be positive, with strong links to the clinical directors in place, continue on with inviting all GPs to review the clinical development. A GP has been recruited into the Project, allowing direct conversations to the GPS to ensure the programme provides the right level of support within the practices. A Partnership Task & Finish group is in developmental stages of setting up, with a focus on developing a Partnership Forum over the next year. Recruitment has commenced on roles within the first implementation wave, however some roles are not attracting applications and may need some consideration on how they could be filled. Information Governance has been highlighted as a risk both within the Governance Board and externally at BOB ICS levels. A solution is being devised to mitigate the risk. Further details in the risk log.	There has been engagement events for GPs and PCNs across Berkshire West with positive feedback. Members of the Integration Board are on board with the transformation programme. Key actions include: Recruitment of key leadership members (GP, Clinical Director, Programme Manager) Review the EUPD services for a possible early launch date. Develop the co-produced Clinical offer and ensure systems and other services can withstand the increased activity (Gateway) Commence the Partnership Task & Finish Group Continuing recruitment to key roles Exploring IT/IG solutions with colleagues within BHFT and ICS	Jul / Aug / Sep / Nov / Jan / Mar	Aug-21
Gateway to all Mental Health Services (previously Mental health Wellbeing - CPE/IAPT)	A phased approach to transform entry into mental health services combining IAPT/CPE/Third Section.	3	Apr-20	JC		There has been a positive impact of the new model and service alignment. Over the coming period we will continue to embed and evaluate the service model and the future impact and reach of the CMHT transformation. Rich data has started to be available that requires deeper analysis to identify trends and compare with previous years; however, it is not easy to determine the additional effects of Covid19 on current demand. It suggests that the service reconfiguration is enabling a robust approach to managing the current demand rather than seeing a reduction in activity. A decision will be made by the Gateway Senior Overview group in September as to whether a further ticket is required or if the transformation programmes are delivering sufficient improvements to the patient journey that unites our pathway clinical decision making between teams . The introduction of a CMHT capacity tool plus a refreshing of the e-pathways and clustering tool should also support the adoption of a Gateway assessment as made by a trusted assessor.	A Senior Overview Group was initiated in June 2021 to review service demand, patient journeys, patient safety and risk points and staffing pressures chaired by Sue McLaughlin CD. IPCN MH pilot and links to the ARRS roles will ensure easy in and easy out primary care patient pathways that will deflect away from specialist assessments within CPE. ISilver Cloud launched into MHICs and will expand into ARRs roles for early pure digital support or to augment clinical treatment pathways Ongoing review of data and monitoring for impact on pathways and internal assessment pressure within all components of the Gateway Full data review to be carried out in September 2021.	May / Jun / Sep	Jun-21
EUPD Pathway implementation	Delivery of an operational end to end pathway for EUPD patients which will be based upon the Trust's True North Objectives.	3	Sep-21 (for transition and project closure)	MI/SY		**TRANSITIONING TO BUSINESS AS USUAL.** The project is continuing to transition to business as usual. The BAU plan identifies the current status of each element of the pathway and the task to be addressed. The EUPD Oversight Group has closed and the Steering Group will close in August. The EUPD pathway monitoring group led by the Head of IMPACTT has held its first meeting and Terms of Reference have been approved. Data and reporting required to provide evidence of progress of the pathway implementation is being finalised.	Continue to implement the action plan to complete the transition to business as usual in August 2021. Project Closure report to be submitted for the Sept Business & Finance Executive meeting.	Apr / Sep	Apr-21
Quality Improvement Programme (inc QMIS)	Introduction of quality improvement systems and methodology via the following work streams: QI Office; Strategy Deployment; Quality Management & Improvement System (QMIS); Improvement Projects.	1	Dec-21 (for transition)	DT/MI		TRANSITIONING TO BUSINESS AS USUAL. Activities to complete the transition were submitted in the QI plan in April 2021 these will be undertaken to Sept 21 with a target for transition to business partnering model as Dec 21. Activities in the QI Plan include support to strategic initiatives inc. the implementation of elements of the People Strategy, access & flow, plus QI itself;	Completion of activities to move to Business as usual as laid out in the QI Plan update submitted in July 21. Transition to business partnering model Dec 21. The QI programme continues to run all workstreams and rated green on all Road map milestones for 2021. The QI team capacity remains at 50% due to vacancies this has created challenges in capacity and demand of the QI programme. However, the Roadmap have not been affected	Jul / Sep / Nov / Jan	Jul-21
Important Projects / Initiatives (as defined through the Strategic Prioritisation Filter)									
Connected Care - BOB and Frimley STP areas		3	Dec-21	MD		GP Transfer of Care notification to be embedded in Shared Care Record and available for use; Initiation of CareFlow Connect to support hospital discharge opportunity; Ongoing development and planning for BHFT API's - Assessment Form and Progress Notes; Further progression of Children's Social Care engagement and IG; Transfer of care concept agreement from stakeholders; BUPA engagement to progress access to Shared Care Record; Engagement with Community Pharmacy Progress regarding pathology functionality is unlikely to resumed for another year, given the commitments of the pathology laboratories with regard to COVID activities and the impact of COVID on other activity.	A new delivery roadmap is being produced to close the gaps in the shared records coverage and develop new functionality. Working with CIPHA on Suicide prevention analysis Trial loading data into LHCRE, including consultation notes into the record, etc.	Jul / Sep / Nov	Jul-21
Patient Experience Measure	Project to improve the measurement, analysis and dissemination of patient feedback. BHFT has contracted with I Want Great Care to develop a patient experience measurement to be used across all services in community and mental health. This will complement the Friends and Family Test (FFT) which is nationally mandated, as well as any other national patient survey programmes the Trust participates in. **The project reports to QPEG quarterly**	3	Mar-22	NZ/AJ		The report and recommendations from the tendering process for Phases 2 and 3 i presented to the January 2021 Business & Finance and it was agreed to award the contract to I Want Great Care (IWGC). Phase 2 - to include development of testing of a survey - will commence from April and is expected to take 8 months. Phase 3 (rolling out and embedding the survey) duration is four months. Workshops with all services completed in July. Work has commenced on development of the Tableau reporting. The project reports to QPEG quarterly	Question set emerging from workshops has been presented to the Core Project Group - responses expected by the 19th August. Aiming for soft launch by 1st November with next steps as follows: Approval and sign off of question set and move to build phase Service set up - hierarchy by service and reporting metrics aligned "how to" and training to be provided by iWGC to services Process and booking schedule in place Develop education material for service users / assisted responders - to aid understanding of the need for feedback System set up and development of Tableau reporting Direction to services on the Trusts expectations re response rate and quantity of feedback required to be effective.	TBC	Aug-21

INITIATIVE	SUMMARY DESCRIPTION (as required)	Key True North Goal	Planned Completion Date	Lead	Current Status (RAG)	COMMENTARY ON CURRENT STATUS (including new Significant Risks & Issues or change in RAG)	PLANNED ACTIVITY (Including mitigations for emerging risks and issues)	2021/22 Reporting Periods	Date report last updated
CHS ePMA	Project to extend the use of ePMA into community health wards following the successful implementation at PPH and Willow House.	1	~~Mar 22~~ Sep 22	CP/AW		A high level plan was submitted in April 21 outlining the phases to go live which includes transformation and pre go-live activities, template building, system configuration, user acceptance testing and CHS ward go-live activities.	Aug 2021 Update: project start somewhat delayed by recruitment of project staff and two changes of project manager, but most significantly by a) Pharmacy service vacancies impacting ability to support the project team, and b) a maintenance release/update of the EPMA software programme (the first we've done since go-live on MH wards in 2017) that should have completed in Summer 2020 and is now due in Oct 2021. This will be followed by another, albeit smaller, upgrade in early 2022, to update essential security settings). Both updates are necessary for the CHS EPMA project to proceed, and to support the existing MH wards EPMA. We are currently scoping out the impact of these delays and the impact on the timelines and milestones, any additional resources required (including enhanced pharmacy recruitment proposals). The Project Board met on 9th August and agreed in principle that the Go-Live moved by 6 months, from March to September 2022, and this is now being discussed with stakeholders.	Aug / Oct / Dec / Feb	Aug-21
Safety Strategy	To ensure that the organisation is compliant with the national Patient safety strategy and to promote delivery of an improved safety culture across the organisation, through ensuring a consistent restorative approach to learning , that promotes an environment where we put equal emphasis on accountability and learning and foster a culture that instinctively asks in the case of an adverse event: "what was responsible, not who is responsible ; improve consistency in staff experience of learning processes both when things go wrong and when things go well, ensuring that staff feel safe in decision making/ positive risk taking and are able to be open and honest when things go wrong. Alongside this at its core, a positive culture requires kindness and civility. There are a number of pieces of work already in progress that support this including the people plan, bullying and harassment, well-being and staff support initiatives **The project reports to QPEG quarterly**	1	Mar-22	DF/Dan Badman		An action plan is in place to deliver the elements of the National Patient Safety Strategy: **1. Support the development of a safety culture in the NHS** We are in a strong position with our safety culture as demonstrated in the latest published National Staff Survey Results. **2. Align reporting to systems which replace NRLS & StEIS** Awaiting further instruction from the national team regarding implementation of NPSIMMS (NRLS replacement). **3. Implement the new Patient Safety Incident Response Framework (PSIRF)** Awaiting publication of the PSIRF from the national team following its trial at early adopter trusts. **4. Implement the medical examiner system** NHS England have published guidance stating roll out in Community Trusts by April 2022. **5. Implement the National Patient Safety Alerts Committee** We are fully compliant with this element of the strategy. **6. Patient involvement in patient safety** NHS England released their 'Framework for involving patients in patient safety' in June 2021. **7. Patient safety training and education** We continue to await publication of the National Patient Safety Syllabus. **8. Contribute to a network of patient safety specialists** The second Patient Safety Specialist has been successfully appointed and will start in post at the beginning of September 2021.	**1. Support the development of a safety culture in the NHS** Continuing to take forward initiatives aimed at further developing our safety culture Includes work on Civility and Kindness and Bullying and harassment. **2. Align reporting to systems which replace NRLS & StEIS** Awaiting further instruction from the national team regarding implementation of NPSIMMS (NRLS replacement). Actively engaged with Datix and the National Team to ensure compatibility between Datix and NPSIMMS. **3. Implement the new Patient Safety Incident Response Framework (PSIRF)** Initiatives are being taken forward relating to how we investigate falls resulting in harm and specific categories of suicide. Working with the Frimley ICS Patient Safety Specialist Forum to implement an improved approach to investigations where patients have accessed services from multiple agencies. **4. Implement the medical examiner system** We have agreed a plan with the RBH to achieve this roll out as detailed in the action plan. **5. Implement the National Patient Safety Alerts Committee** We are fully compliant with this element of the strategy. **6. Patient involvement in patient safety** Scoping meeting scheduled for August 2021 to identify all current similar roles, such as experts by experience. A plan will be developed to take forward the role which will either be building on existing or identifying our approach to developing an entirely new role. **7. Patient safety training and education** Taking forward a number of initiatives to improve the education and training on offer, relating to patient safety. **8. Contribute to a network of patient safety specialists** Continue to engage in National, Regional and Local networks. The responsibilities of Patient Safety Specialists (aligned to the areas of focus) have been built into the Patient Safety Team 'Plan on a Page' and the Patient Safety Specialists annual objectives.	Jul / Oct / Jan	Jul-21
Key Capital Programme Schemes									
Redevelopment of East Community Hospitals (Frimley ICS integrated care hub programme)	Delivery of the Integrated Care Hubs across the ICS to enable the implementation of the ICDM. Projects include ICHs or equivalent in Fleet (NE Hants), Surrey Heath, Ascot, Bracknell, Windsor, Slough, Maidenhead. These will be a mixture of new build and refurbishments with NHS and partner assets used	4	end 2024	IG		IG / Exec have provided initial comments on draft Programme Business Case. Concerns include focus of project stated in PBC and also significant increase in capital estimated (almost double the STP capital award). Overall project status is amber but capital budget and preparation are recorded as Red. At the Estates Review Group, IG reported that prioritisation was being conducted, with St Marks and Upton likely to be prioritised. The estates group is still not meeting, but plans should developed over the next four months. additional work for BHFT to provide their part of this information for the OBC will require significant pull on clinical departments as well as Informatics, Finance, and EFM, all of which are already very busy.	It is understood that the OBCs are required to be submitted by the centre by March 2022 (KEVII may be later) and that the capital needs to be spent by March 2024. this will be challenging. The commissioned consultants are developing project plans and action lists. For a robust OBC they will require at least the following at this stage; oService model and activity (especially projected), oFinancial and contractual implications of service model, oSchedule of accommodation and outline design of premises works, oCost (capital and revenue) of premises works, oTown & Country Planning advice and Environmental assessment (BREEAM), oMonetisation of benefits and risks to enable option assessment, oNotion of the communication and consultation required. BHFT Board will be asked to consider the OBC by February at the latest, requiring Executive approval in January if not before to ensure that it can be submitted in Mar 22.	Monthly	Aug-21
Replacement for Fitzwilliam House including Trust Headquarters	Replacement accommodation for the services and functions currently based at Fitzwilliam House prior to expiry of lease arrangements or notice period (if served). Includes Acquisition, fit out and move to a suitable office space. Introduction of smarter working practice and new workplace strategies; specialist design, tender, build & commissioning of the building; supporting the implementation of change management protocols.	4	Early 2022 (Previously mid 2021)	IG/Lee Dougal		Fitzwilliam House needs to be vacated in 2022. Office Principles engaged with stakeholders to design/create a change management strategy. OBC approved. Moving to detailed design phase with stakeholder engagement and contractor appointed. Preferred Option updated following withdrawal of first choice. The Project Team have now been notified that the date we can have access to undertake M&E Surveys at the preferred option have been delayed from 26th July to mid-August, at the earliest. In view of this a recommendation will be presented to the Project Board.	The Project Team have now been notified that the date we can have access to undertake M&E Surveys at the preferred option have been delayed from 26th July to mid-August, at the earliest. In view of this a recommendation will be presented to the Project Board on Wednesday 11th August. Further financial impact will be analysed to determine whether capital/revenue expenditure can be spent before March 2022. Design workshop for Project Team Review to take place at an agreed date in August. Approval of final design.	Monthly	Aug-21
Move of Assessment & Treatment Unit from Campion Unit to Jasmine Ward	Project to move the assessment & treatment unit from Campion Unit to Jasmine ward.	3	May 2021 (previously Jan 21)	NP		Project has been progressing with good feedback from staff on the conduct of the contract. Handover was due in March and then 6th April, but is now due in mid May with the occupation of the ward anticipated in week commencing 24th May. Commissioning activities include on-ward training is being revised as a consequence. The ward will not be occupied until padding work in the seclusion room (dependent on a company in Ireland) has been completed	Move is now complete with some snagging issues to be addressed. The Project has now completed and the project closure and evaluation report is being completed.	Monthly to Sep 21	Aug-21

INITIATIVE	SUMMARY DESCRIPTION (as required)	Key True North Goal	Planned Completion Date	Lead	Current Status (RAG)	COMMENTARY ON CURRENT STATUS (including new Significant Risks & Issues or change in RAG)	PLANNED ACTIVITY (Including mitigations for emerging risks and issues)	2021/22 Reporting Periods	Date report last updated
Reading Estates (part 2) Reading Review	To review the estate and supporting infrastructure required to support services located and / or operating in the Reading area. Overarching objectives: Improve the efficiency of the estate, including better utilization Support changing service models, especially in the light of greater use of digital Ensure a higher quality estate, including improved environmental performance Provide greater direct influence and control of the estate Creating facilities with greater flexibility to reflect likely changes in need Accommodate space requests from service expansion and required relocations	3	TBC	IG/Colin Almond		The premises included within the review are as follows. In total their running cost is over £0.6m pa and they cover 2,600m2 of space: **Dellwood and Southcote Clinics** **Cremyll Road** **Bath Road** **Erlegh Road** **Coley Clinic**	Major strategic review of accommodation in Reading underway and business case in development. Finalise selection of options. As properties come on and off the market constantly, we will use mean numbers where more than one property exists for an option in the OBC. The FBC will have the final absolute costs. Undertake qualitative and economic assessment of options to provide preferred option. Deliver an OBC for approval to the Estates Review Group then to an Executive Group. This is expected for submission in October. Subsequently FBC(s) will be produced for however many schemes are approved. These are likely to be presented in mid 2022 with new premises realized by mid 2023.	Monthly	Aug-21
Other Initiatives (That are not on the prioritisation board or are awaiting prioritisation)									
Delivery of the Trust's Green Plan	Formulate and implement the Trust's Green Plan to affect change that will result in a more sustainable and environmentally responsible healthcare provision by the Trust. This will directly contribute to NHS England's for a greener NHS programme and the Net Zero carbon emissions 2045 target.	4	Mar-25	JR/ Paul Harrison		NHS England launched it's For a Greener NHS programme in January 2020 and one of the principle outcomes from this new approach to sustainability across the NHS is that all Trusts require a Green Plan, which will provide a clear strategic pathway to facilitate change leading to net zero and a sustainable NHS. NHS England launched in September 2020 a strategy entitled Delivering a Net Zero NHS, which commits the NHS to a net zero carbon emissions target by 2045. The work will focus on the removal of greenhouse gas emissions from the Trusts operational activities and ensure that it will have as minimal an impact upon the environment as is realistically possible.	The green plan guidance from NHS E/I was made available to the trust on the 24th June 2021. This is now being utilised to shape the Trusts Green plan which will establish goals and actions to meet net zero carbon emissions targets. Continue preparing draft Green Plan in for the Green Plan group to review. Review impact on the Trust of the NHSE 2045 net zero carbon emissions target. Determine the climate emergency declaration and subsequent commitment and actions for the Trust.	Apr / Jul / Oct / Jan	Jul-21
Neurodiversity Strategy	Project to develop, and operationalise a strategy that addresses the health inequalities, both physical and mental, that exist in service users with diagnosed or suspected neurodiversity. This will improve patient experience, make all services more effective and efficient whilst driving quality. Neurodiversity is a viewpoint that brain differences are normal, rather than deficits. This concept can help reduce stigma around learning and thinking differences, whilst the main focus will be on autism spectrum condition and ADHD it is certainly not limited to these conditions.	3	Mar-24	ME		A Trust level approach to neurodiversity awareness, training, support and management is required. It is proposed that by developing a comprehensive strategy along with an operational plan to implement it will drive higher quality, more effective and efficient care. The project has completed its initial scoping phase and is now ready to move towards the implementation phase. In addition, the Trust has been identified as an NHS pilot site for the Oliver McGowan autism training with 5 sessions booked for September October which are proving very popular. There is a requirement to have a strategy under diversity legislation and in addition, the NHSE autism strategy has a deadline between 2021 (short term) and 2024 (long term) with current EOI's for sensory environment and improvement to diagnostic pathways.	Development of a project plan development of the full strategy (outline strategy in place) Recruitment (secondment) of a band 5/6 project support officer. Agree workstreams to be taken forward Scoping and initial A3 development for the greenbelt elements of the project Draft comms plan Scope the requirements for the creation of an Expert by Experience advisory board. Develop and adapt learning materials for staff	TBC	Aug-21
Reducing MH Pressures	The project looks to build on the work previously focused on eliminating the use of Out of Area beds and reducing length of stay locally due to current pressures	4	TBC	JR/EN		Following a sustained period of increased demand for acute and PICU MH beds, leading to rising and maintained high levels of OAPs beds, there has been a slight decrease in our current bed numbers out of area, however we are still consistently utilising a greater number of OAPs bed than pre-Covid and are unlikely to meet the trajectory based on current bed usage. The length of stay in PPH is currently 50 days and occupancy rates are putting pressure on the staffing teams.	The project has identified a number of quick wins to support the bed management team and inpatient wards; block booking of OAPs beds, daily Partnership Post Admission Reviews to ensure inpatient stay purpose was understood. Recommendations for a number of longer term objectives aiming to reduce Length of Stay in the form of QI informed workstreams to consolidate the efforts to address the length of stay and need for additional capacity as well as internal challenges within PPH. Project management resources will be required to support the leads of the following potential workstreams: - Contributors to length of stay/outliers from GIRFT report. This needs to be a medical lead piece of work of pathways. - RC challenges; longer term piece of work to be addressed due to recruitment challenges and consideration of alternatives. - Consideration of ward size and impact on LOS.	TBC	Jul-21

Trust Board Paper

Board Meeting Date	14 September 2021
Title	**Audit Committee – 21 July 2021**
Purpose	To receive the unconfirmed minutes of the meeting of the Audit Committee of 21 July 2021
Business Area	Corporate
Author	Company Secretary for Chris Fisher, Audit Committee Chair
Relevant Strategic Objectives	4. – True North Goal: deliver services that are efficient and financially sustainable
CQC Registration/Patient Care Impacts	N/A
Resource Impacts	None
Legal Implications	Meeting requirements of terms of reference.
Equality and Diversity Implications	N//A
SUMMARY	The unconfirmed minutes of the Audit Committee meeting are attached.
ACTION REQUIRED	The Trust Board is asked: a) To receive the minutes and to seek any clarification on issues covered

Unconfirmed Draft Minutes

Minutes of the Audit Committee Meeting held on

Wednesday, 21 July 2021

(Conducted via Microsoft Teams)

Present: Chris Fisher, Non-Executive Director, Committee Chair
Naomi Coxwell, Non-Executive Director
Mehmuda Mian, Non-Executive Director

In attendance:
Graham Harrison, Head of Financial Services (deputising for Paul Gray, Acting Chief Financial Officer)
Debbie Fulton, Director of Nursing and Therapies
Amanda Mollett, Head of Clinical Effectiveness and Audit
Clive Makombera, RSM, Internal Auditors
Melanie Alflatt, TIAA
Maria Grindley, Ernst and Young, External Auditors
Jayne Reynolds, Regional Director, East
Julie Hill, Company Secretary

Item		Action
1.A	**Chair's Welcome and Opening Remarks**	
	Chris Fisher, Chair welcomed everyone to the meeting and in particular welcomed Maria Grindley, Ernst and Young, the Trust's new External Auditors.	
1.B	**Apologies for Absence**	
	Apologies for absence were received from: Paul Gray, Acting Chief Financial Officer and Minoo Irani, Medical Director.	
2.	**Declaration of Interests,**	
	There were no declarations of interest.	
3.	**Minutes of the Previous Meetings held on 21 April 2021 and 26 May 2021**	
	The Minutes of the meetings held on 21 April 2021 and 26 May 2021 were confirmed as a true record of the proceedings.	
4.	**Action Log and Matters Arising**	

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	The Action Log had been circulated. The following items were discussed further: **a) Audit Committee Board Development Session – Bribery Act** The Chair reminded the meeting that the development sessions held prior to the Audit Committee meetings had been paused because of the pandemic. The Chair reported that the Committee's annual review of effectiveness had highlighted that these sessions were well received by regular attendees of the Committee and commented that he hoped a session on the Bribery Act could be scheduled when in person meetings were resumed. **b) Overseas Nurse Recruitment** The Director of Nursing and Therapies reported that the Trust was in the process of recruiting some community-based staff from overseas and pointed out that it was more challenging to recruit mental health staff from abroad. Naomi Coxwell, Non-Executive Director asked whether the pilot overseas recruitment project would end this year or whether it would be a rolling programme. The Director of Nursing and Therapies said that the Trust was participating in Oxford Health NHS Foundation Trust's overseas recruitment pilot project to ascertain whether overseas recruitment was a viable option for filling community and mental health vacancies. The Committee noted the action log.	
5.A	**Board Assurance Framework**	
	The Board Assurance Framework had been circulated. The Company Secretary presented the paper and reported that the description for risk 1 (workforce) and risk 2 (finance) had been amended to reflect the challenges around delivering services to match the increased funding because of the national shortage of qualified staff. The Company Secretary also highlighted that a new gap in assurance had been identified in respect of risk 1 because of consultant vacancies at Prospect Park Hospital. The following risks were discussed further: **a) Risk 1 (Workforce)** The Chair asked for more information about the consultant vacancies at Prospect Park Hospital. The Director of Nursing and Therapies reported that a number of consultants were leaving at round about the same time due to a variety of reasons. The Medical Director was working with the Medical Staffing team to try and recruit locum cover. It was noted that consultant vacancies at Prospect Park Hospital had been added to the Trust's Quality Concerns Register.	

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	b) Risk 4 (Other Providers) The Chair referred to discussions about options for delegating commissioning and budgets to the “Place” level within the Integrated Care Systems and asked whether there were systems in place to ensure that the Trust retained financial control of its budgets. The Head of Financial Services said that discussions around any delegation of budgets was at an early stage The Chair said that it would be important for the new Chair of the Audit Committee to ensure that the Trust’s internal controls would remain in force even if budgets were delegated at Place level. **Risk 6 (Demand)** The Chair noted that the Trust had established a Bed Pressures Team and commented that there was a national shortage of mental health beds and therefore it may be challenging to secure out of area placements. The Regional Director, East reported that the Bed Pressures Team met weekly and had developed an action plan to reduce pressures, including reducing the length of stay. The Regional Director, East reported that the Trust had recently procured five more Psychiatric Intensive Care Unit beds and five acute beds. The Regional Director, East reported that the Trust’s Associate Medical Director was leading a piece of work as part of the national “Getting it Right First Time” programme around reducing length of stay and would be reporting to the Trust Board in September 2021. **c) Risks 8A and Risk 8B (Covid-19)** Naomi Coxwell, Non-Executive Director referred to the two COVI-19 risks (8A and 8B) and asked whether the two risks could be combined into a single risk. The Director of Nursing and Therapies said that risk 8A referred to the current COVID-19 position whereas risk 8B related to the longer term service recovery post-pandemic and suggested that the two risks remain as two separate risks for the time being with a view to combining them into a single risk once the current COVID-19 wave was over. **Action: Director of Nursing and Therapies/Company Secretary** The Chair asked for an update on the Trust’s latest COVID-19 situation. The Director of Nursing and Therapies reported that there was a rise in the number of positive COVID-19 cases across Berkshire but pointed out that although there was a small increase in hospitalisations, the number of COVID-19 hospital admissions was significantly lower than in the previous COIVD-19 two waves. The Director of Nursing and Therapies reported that the Trust currently had no COVID-19 in-patients although there had been a small number of cases over the last few weeks, but these had not translated into outbreaks. The Director of Nursing and Therapies said that there was a concern that the national messaging about the lifting of COVID-19 restrictions had not made it	**New Chair** **DF/JH**

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clear that social distancing and masks would continue to be required in healthcare settings. It was noted that the Trust continued to encourage to ask visitors to Trust buildings to take a lateral flow test before visiting.

The Director of Nursing and Therapies said that there had been reports in the press that healthcare staff may not have to self-isolate if they were contacted via Track and Trace pointed out that this would only happen in exceptional circumstances.

Mehmuda Mian, Non-Executive Director asked how many staff were currently self-isolating or who had tested positive for COVID-19.

The Director of Nursing and Therapies reported that as of today there were around 39 staff who were self-isolating or who had tested positive for COVID-19 and confirmed that there were currently no members of staff who were really unwell with COVID-19.

The Committee:

a) Noted the report; and

b) Approved the new risk description for Risk 1 (workforce)

5.B	**Corporate Risk Register**	

The Corporate Risk Register had been circulated. The Company Secretary highlighted that the risk in relation to Willow House had been closed following the closure of the in-patient facility and that there was a new risk description in relation to the Mental Health Act Office risk.

The following risks were discussed further:

a) Ligature Risk

The Chair asked whether there were any new actions following the annual ligature audit.

The Director of Nursing and Therapies confirmed that the annual ligature audit had not identified any new ligature risks.

b) Willow House Risk

Naomi Coxwell, Non-Executive Director asked what the Trust was doing with the Willow House building now that the in-patient service had closed.

The Director of Nursing and Therapies confirmed that the building was now used as the day service.

c) Nosocomial Risk

The Chair asked whether there was any news about the Trust’s staff COVID-19 booster and Flu vaccination for winter 2021.

The Director of Nursing and Therapies confirmed that the current plan was for staff to receive both the COVID-19 booster and the Flu vaccination at the same time. It was noted that as the COVID-19 vaccination was likely to be Pfizer,

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	there would be less flexibility about where staff would receive their vaccinations that it was likely that Wokingham Hospital would be the main vaccination centre. The Regional Director, East ported that the Trust's lateral flow test reporting performance had increased to 77% which was the second highest performance in the region out of 29 trusts. **d) Mental Health Act Compliance** Mehmuda Mian, Non-Executive Director asked for more information about the impact of bed pressures at Prospect Park Hospital meaning that people were sometimes held in the Place of Safety. The Chair proposed that the Committee received an update about the Trust's plans around mitigating the risk at the next meeting. **Action: Medical Director** **The Committee:** a) Noted the report b) Approved the lower risk score for the Ligature Risk c) Approved the higher risks core the Bed Pressures Risk d) Approved the new risk description for the Mental Health Act Compliance Risk e) Approved the closure of the Willow House Risk	 **MI**
6.	**Single Waiver Tenders Report**	
	A paper setting out the single waivers approved from April 2021 to 30 June 2021 had been circulated. The Chair referred to the waiver in relation to private assistance for the COVID-19 recovery in the Podiatry Waiting List and asked for more information. The Director of Nursing and Therapies explained that Podiatry was one of the Trust's Quality Concerns in relation to waiting list times and had therefore agreed a contract across four private providers to address the waiting list. The Chair asked how the Trust had ensured value for money. The Director of Nursing and Therapies said that she was involved in assuring clinical quality but had no involvement in terms of procurement and financial considerations of the contract. Mehmuda Mian, Non-Executive Director asked whether the contract was across Berkshire. The Director of Nursing and Therapies that this was the case. Naomi Coxwell, Non-Executive Director asked for more information about the risk to patients on the Podiatry waiting list. The Regional Director, East explained that key risk was around managing Diabetic Foot issues. The Director of Nursing and Therapies added that one of	

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	the key concerns around longer wait times was in terms of potential complications arising if problems were left untreated. The Chair referred to single waiver in relation to an online assessment for ADHD which had been procured because the Care Quality Commission had required the Trust to take action to reduce the wait for an autism and ADHD assessment and express concern that the normal procurement processes had not been undertaken. The Chair agreed to contact the Head of Procurement and Acting Chief Financial Officer to agree a process whereby the Chair of the Audit Committee would be involved in high cost single waivers which fell outside of the standard procurement processes. **Action: Chair of the Audit Committee** The Committee noted the paper.	**CF**
7.	**Information Assurance Framework Update Report**	
	The Head of Financial Services the paper and amended an error in the report as follows: section 1.4 to be read: "A total of 7 indicators were audited during Quarter 1. One was rated Green (High Confidence) for both Data Assurance and Data Quality. Six were rated as Amber (Medium Confidence) for Data Quality". The Head of Financial Services presented the paper and said that during the reporting period, the following indicators were audited: • Mental Health Crisis Resolution Gatekeeping of inpatient admissions (Green) • Mental Health 7-Day Follow-Up (audited monthly) (Amber) • Mental Health Prone (Face Down) Restraint (Amber) • Mental Health Readmissions within 28 days (audited quarterly) (Amber) • Referral to Treatment (RTT) Diabetes incomplete pathway (Amber) • Referral to Treatment (RTT) CCP incomplete pathway (Amber) • Self-harm incidents on inpatients wards (excluding Learning Disabilities) (Amber) Mehmuda Mian, Non-Executive Director referred to sections 6.12 and 6.13 of the report which related to the prone (face-down) restraint indicator and asked whether there were any particular reasons why the audit had identified that there were recording errors which had resulted in duplicate incidents etc. The Director of Nursing and Therapies said that this was likely to be due to human error and pointed out that the Clinical Director, Prospect Park Hospital personally reviewed every incident of prone restraint in order to gain a full understanding around the circumstances that lead to the use of prone restraint. It was noted that recording issues sometimes arose because the Patient Record System (RiO) and the Incident Reporting System (Datix) did not link together. The Director of Nursing and Therapies reported that the Quality and	

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	Performance Executive Group had also discussed the report and had requested that the Assistant Director of Performance and Information review the wording in relations to the actions in future reports to ensure that it was in line with the quality improvement and human factors approach that the Trust was taking in term so of quality improvement and that reminding staff was not effective and was probably not the action that was taking place. The Committee noted the report.	
8.A	**Losses and Special Payments Report**	
	The Losses and Special Payments Report covering April 2021 to June 2021 had been circulated. The Head of Financial Services pointed out that even though the payments were written off and provision made in the accounts, the Trust would continue its efforts to recover any monies written off. The Committee noted the report.	
9.	**Clinical Claims and Litigation Quarterly Report**	
	The Director of Nursing and Therapies presented the paper and reported that during Quarter 1 there were two new claims (both were clinical negligence claims). The Director of Nursing and Therapies reported that that as requested by the Audit Committee, she had added an additional column in the report to set out the context of the claim together with the actions put in place to address any learning identified following the claim. It was noted that the report also included a section on: "Learning from Litigation Claims: The Getting It Right First Time and NHS Resolution Best Practice Guide for Clinicians and Managers" published in May 2021. The Director of Nursing and Therapies reported that NHS Resolution had selected the Trust as one of five high performing Trusts in relation to the application of the Duty of Candour to help them develop guidance to support a national culture around linking claims with incidents and complaints. The Committee noted that report.	
10.	**Clinical Audit Report**	
	Head of Clinical Effectiveness and Audit presented the paper and reported that The Clinical Audit Plan 2020-21 and all registration and data submission requirements had been met or were on track. The Committee noted the report.	

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11.	**Counter Fraud Report**	
	Melanie Alflatt, TIAA presented the paper and reported that the Counter Fraud Functional Standard Return had been submitted and an overall assessment of "Green" had been achieved by the Trust. . It was noted that the Trust was rated "Red" in respect of two requirements and rated "Amber" in relation to three requirements. Work had commenced to address any non-Green components The Chair requested that the Committee receive regular updates on the steps being taken to address the red and amber areas of non-compliance. Ms Alflatt said that her quarterly Counter Fraud Progress Report to the Committee would include an update on the progress made by the Trust to comply with the requirements. Naomi Coxwell, Non-Executive Director asked about the number of requirements. Ms Alflatt confirmed that there were thirteen requirements. Ms Alflatt reported that the results of the Trust's Fraud Awareness Survey had demonstrated that the level of fraud awareness was high with responses providing assurance that the Trust was continuing to make good progress in engaging staff in creating an environment that sought to reduce fraud, bribery and corruption. It was noted that the full results of the Fraud Survey would be included in the next Counter Fraud Report to the Committee. Naomi Coxwell, Non-Executive Director referred to the reactive work section of the report and asked whether the Trust used anonymised case studies to identify the learning from investigations. The Director of Nursing and Therapies confirmed that the Trust did use anonymised case studies as learning opportunities but pointed out that case studies were often from other trusts because of confidentiality issues. The Chair thanked Melanie Alflatt for her support to the Committee. The Committee noted the report.	**MA** **MA**
12.	**Internal Audit Progress Report**	
	a) Internal Audit Progress Report Clive Makombera presented the paper and highlighted the following points: • Since the last meeting work had started on the 2021-22 audit plan. Scopes and start dates had been agreed with the respective executive leads for a majority of the audits on the plan and scoping meetings with the respective executive lead were planned in for the remaining reviews. • The Medical Director had requested that the Quality Improvement audit takes place in 2022-23 to allow the management actions from the previous internal audit to be embedded. • The review of learning from the COVID-19 pandemic has been discussed with management and it was agreed that the review would focus on service users and would also include waiting lists	

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	• Since the last audit committee meeting, five actions (four medium and one low) have been marked as implemented and internal audit reviewed evidence where relevant. One medium action relating to the Equality and Diversity review was overdue and in progress and a revised implementation date had been agreed. **b) RSM Integrated Care Systems Briefing** The RSM Integrated Care Systems Briefing had been circulated. The Chair requested that the Company Secretary circulate the briefing to the relevant staff. **Action: Company Secretary** **c) Non-Executive Director Network Report** The Chair reported that he had attended a number of RSM events and had found them very informative. Mehmuda Mian, Non-Executive Director said that she would try and attend the RSM Non-Executive Director Network meetings. Naomi Coxwell, Non-Executive Director asked whether RSM had any intelligence about how Trusts were contributing to the global agenda of reducing greenhouse gases. Clive Makombera said that he would share any information on this issue he received. The Chair personally thanked Clive Makombera for his help and support since he had chaired the Audit Committee. Mr Makombera in turn thanked Mr Fisher. The Committee noted the reports.	**JH**
13.	**External Audit**	
	There was no external audit report.	
14.	**Minutes of the Finance, Investment and Performance Committee meeting held on 29 April 2021**	
	The minutes of the Finance, Investment and Performance Committee meeting held on 29 April 2021 were received and noted.	
15.	**Minutes of the Quality Assurance Committee held on 1 June 2021**	
	The minutes of the Quality Assurance Committee meetings held on 1 June 2021 were received and noted.	
16.	**Minutes of the Quality Executive Committees held on 19 April 2021, 17 May 2021 and 21 June 2021**	
	The minutes of the Quality Executive Committee meetings held on 19 April 2021, 17 May 2021 and 21 May 2021 were received and noted.	

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17.	**Annual Review of Effectiveness and Review of the Committee's Terms of Reference**	
	The results of the Committee's annual review of effectiveness had been circulated. The Company Secretary said that the results had been very positive and thanked everyone for completing the survey. Naomi Coxwell, Non-Executive Director asked whether the Trust should commission an external independent assessment of the Board's performance. The Company Secretary reported that the Trust's last external review of governance was in 2015 and said that the Trust had been due to commission a new external review, but this had been paused because of the COVID-19 pandemic. The Company Secretary agreed to discuss the timing of the external review with the Trust Chair. **Action: Company Secretary**	
18.	**Annual Work Plan**	
	The Audit Committee's work programme had been circulated. The Chair noted that there was supposed to be a post audit review at this meeting. The Company Secretary explained that the previous External Auditors were not present at the meeting and said that the May 2021 meeting which had approved the annual accounts 2020-21 had included a discussion about the external audit process. The Committee's Annual Work Plan was noted.	
19.	**Any Other Business**	
	Outgoing Chair of the Audit Committee Mehmuda Mian, Non-Executive Director reminded the meeting that this was Chris Fisher's last Audit Committee meeting. He would step down as a Non-Executive Director on 30 September 2021. On behalf of the Committee, Ms Mian thanked Chris Fisher for being an excellent Chair of the Audit Committee. Ms Mian listed the qualities of an Audit Committee Chair and said that Mr Fisher embodied all the qualities and more. Ms Mian said that Mr Fisher had jointed the Trust as a Non-Executive Director in 2014 and had chaired the Audit Committee from 2016. He had brought a lifetime of financial management experience both in the commercial world and within the NHS. Ms Mian said that Mr Fisher brought a laser like focus on the numbers as well as the ability to home in those things which were necessary and relevant. Ms Mian said that Mr Fisher was an excellent forward-thinking leader and made sure that all stakeholders were brought into the discussion. Ms Mian added that Mr Fisher also brough warmth and humour and commented that it was a pleasure being a member of the Audit Committee under Mr Fisher's chairmanship. Ms Mian said that Mr Fisher would be a very hard act to follow. Ms Mian's comments were warmly endorsed by other members and those in attendance at the Audit Committee.	

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	Chris Fisher thanked Ms Mian for her kind words and said that it had been a pleasure to work with such competent and nice people and thanked everyone for their support.	
20.	**Date of Next Meeting**	
	27 October 2021	

These minutes are an accurate record of the Audit Committee meeting held on 21 July 2021.

Signed: - ______________________________

Date: - **27 October 2021**

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Trust Board - Meeting Dates for 2022

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Discursive Trust Board	11		8			14				11		
Trust Board		8		12	10		12	9 (if required)	13		8	13
Audit Committee	19			20	18		20			26		
Finance, Information and Performance (FIP)	27		24	28			28			27		
Quality Assurance Committee (QAC)			1			7		30			29	

Council of Governors Dates 2022

Meeting	January	February	March	April	May	June	July	August	September	October	November	December
Formal Council Meeting			9			15			21			7
Trust Board / Council Meeting		02 (NED)			04 (Board)		20 (NED)				02 (Board)	